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CONNECTICUT OFFICE OF HEALTH CARE ACCESS

February 26, 2010

Via facsimile 860/418-7053

Honorable Cristine A. Vogel
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Letter of Intent for Corporate Affiliation

Dear Commissioner Vogel:

Please find enclosed a completed Letter of Intent regarding a proposed affiliation of New Milford Hospital, Inc. with Danbury Health Systems, Inc. This proposal does not involve the addition or termination of services, change in the service areas of either applicant, or capital expenditure. Both hospitals are committed to working together for the betterment of the community by exploring ways to create an integrated regional health care delivery system focused on providing the highest quality and most cost-effective care.

Thank you in advance for your assistance. If you have any questions that the following submission does not answer, please contact me directly at 860/350-7205 so that we may provide whatever additional information you need. I will be the primary contact for your office during this Certificate of Need process.

Respectfully submitted,

Sally F. Herlihy

Sally F. Herlihy, FACHE
VP, Regulatory Compliance

Cc: Richard Henley, Frank Kelly, John Murphy

Attachment: OHCA Form 2030

State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

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

	Applicant One	Applicant Two
Full legal name	The Danbury Hospital	New Milford Hospital
Doing Business As	The Danbury Hospital	New Milford Hospital
Name of Parent Corporation	Danbury Health Systems, Inc.	New Milford Hospital, Inc.
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	24 Hospital Avenue, Danbury CT 06810	21 Elm Street New Milford, CT 06776
Identify Applicant Status: P for Profit or NP for Nonprofit	NP	NP
Does the Applicant have Tax Exempt Status?	[Yes] No	[Yes] No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Frank Kelly President and CEO	Sally Herlihy VP, Regulatory Compliance (primary contact)
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	24 Hospital Avenue, Danbury CT 06810	21 Elm Street New Milford, CT 06776
Contact Person Telephone Number	203-739-7066	860-350-7205
Contact Person Fax Number	203-739-7799	860-210-5075
Contact Person e-mail Address	frank.kelly@danhosp.org	herlihys@nmhct.org

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Corporate Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

b. Project Proposal:

Response: The proposed transaction involves a corporate affiliation between Danbury Health System (DHS) and New Milford Hospital (NMH). The member substitution model involves renaming of DHS to "Newco" (temporary name) and Newco becoming the sole member of NMH, as the term is applied under the provisions of Connecticut Nonstock Corporation Act. In the proposed transaction Newco will continue to be the sole member of The Danbury Hospital (DH) and the sole member or controlling shareholder of DH's affiliated entities, and also become the parent corporation for all corporations for which NMH currently serves as sole or controlling member or shareholder. The proposal does not involve the addition or termination or services or a change in service areas of either applicant.

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
☐ Trauma Center ☐ Transplantation Programs
☐ Rehabilitation *(specify type)* ____________
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Inpatient *(specify)* ____________

Outpatient Service(s):

☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
☐ Rehabilitation *(specify type)* ____________ ☐ Central Services Facility
☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
☐ Other Outpatient *(specify)* ____________

Imaging:

☐ MRI ☐ CT Scanner ☐ PET Scanner
☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
☐ Cineangiography Equipment ☐ New Technology: ________

Non-Clinical:

☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations

☒ Change in Ownership or Control ☐ Land and/or Building Acquisitions

☒ Organizational Structure (Mergers, Acquisitions, & Affiliations)

☐ Other Non-Clinical: ____________

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☒ Yes ☐ No

If you checked "Yes" above, please check the appropriate box below:

☐ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service

☐ Reduction ☒ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☒ No

If you checked "Yes" above, please check the boxes below, as appropriate:

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☒ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

Response: The Danbury Hospital, 24 Hospital Avenue, Danbury CT 06810
New Milford Hospital, Inc. 21 Elm Street, New Milford, CT 06776

g. List each town this project is intended to serve:

Response: The primary service area for this proposed affiliation involves the primary service areas of both Danbury Hospital and New Milford Hospital, which collectively includes the towns of Bridgewater, Bethel, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, Southbury, Warren, and Washington in Connecticut. The secondary service area draws patients from portions of adjacent towns and the service area also includes several towns in New York due to each Hospital's proximity to the New York State line. There is no limitation of the towns to be served by the combined system.

h. Estimated starting date for the project:

Response: The target date for the proposed affiliation is on or about October 1, 2010 (FY 2011), and is based upon receipt of all required regulatory approvals.

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ 0

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:______________	
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☒ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

Response: N/A

e. Type of financing or funding source (more than one can be checked):

- ☐ Applicant's Equity
- ☐ Capital Lease
- ☐ Conventional Loan
- ☐ Charitable Contributions
- ☐ Operating Lease
- ☐ CHEFA Financing
- ☐ Funded Depreciation
- ☐ Grant Funding
- ☐ Other *(specify)* ______ ________________________

Response: N/A

SECTION IV. PROJECT DESCRIPTION

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

The vision of the leadership of The Danbury Hospital and New Milford Hospital is to create an integrated health care delivery system capable of bringing best practices in health care delivery to enhance the health and well being of the residents within the region of Western Connecticut and eastern New York State. This vision will be accomplished through optimizing resources available within the region, maintaining financial vitality of both hospitals, and ensuring the highest caliber of patient experience. Through one Board and one management team, the resulting organization will enhance and standardize its multiple parts and will offer one integrated standard of care.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

Response: Danbury Hospital and New Milford Hospital are both licensed by the State of Connecticut as acute care providers. The proposal does not involve the addition or termination of services for either applicant. Copies of their respective licenses are enclosed as Attachment A.

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

Response: There is no change in the licensed services of either hospital proposed in this application.

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

Response: The service area for this proposed affiliation involves the primary service areas of both Danbury Hospital and New Milford Hospital, which collectively includes a core population of approximately 247,000 in the towns of Bridgewater, Bethel, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, Southbury, Warren, and Washington

in Connecticut. The secondary service area draws patients from portions of adjacent towns and the service area also includes several towns in New York due to each Hospital's proximity to the New York State line. There is no limitation of the towns to be served by the combined system.

4. Identify any unmet need and describe how this project will fulfill that need.

Response: The proposed affiliation will allow for the continued sustainability of Danbury Hospital and New Milford Hospital and their practitioners to enhance the delivery of health care and promote the health status of the residents of the communities served.

5. Are there any similar existing service providers in the proposed geographic area?

Response: There are no other hospital providers in the service area. It is recognized that some residents do seek hospital care outside the region.

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

Response: The proposed affiliation of the two health care organizations will enhance the delivery of health care through provision of more coordinated and enhanced scope of clinical services for the populations of both service areas, with the goals of increased access, quality, and cost-effectiveness of care, enhanced ability to recruit physician providers, realization of economies of scale, and improvements in patient flow and communications.

7. Who will be responsible for providing the service?

Response: Danbury Hospital and New Milford Hospital will each continue to provide services according to their hospital license.

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

Response: The proposed affiliation will not have an effect on the current payers. Each hospital contracts with all major payers, including Medicare, Medicaid, and major insurance carriers, and will continue to do so in the interest of assuring access to care for all residents within the service area.

AFFIDAVIT

Petitioner: The Danbury Hospital

Project Title: Corporate Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

I, Frank J. Kelly, president and CEO of Danbury Hospital being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Danbury Hospital complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature: Frank J. Kelly — Date: 2/24/10

Subscribed and sworn to before me on 2/24/10

Susan McKenna
Notary Public/Commissioner of Superior Court

My commission expires: 2/28/2015

AFFIDAVIT

Petitioner: New Milford Hospital, Inc.

Project Title: Corporate Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

I, Richard J. Henley, Interim President and CEO of New Milford Hospital being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that New Milford Hospital complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature: [signature]　　Date: 2-24-10

Subscribed and sworn to before me on February 24, 2010

[signature] Laura Sue Wallace
Notary Public/Commissioner of Superior Court

LAURA SUE WALLACE
NOTARY PUBLIC
State of Connecticut
My Commission Expires
November 30, 2012

My commission expires: ______

Attachment A

Department of Public Health License for:

The Danbury Hospital

New Milford Hospital

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0039

General Hospital

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

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

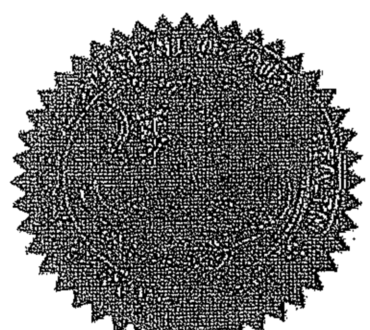
Danbury Hospital, The is located at 24 Hospital Avenue, Danbury, CT 06810

The maximum number of beds shall not exceed at any time:
345 General Hospital beds
26 Bassinets

This license expires **September 30, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2009. RENEWAL.

Satellites
Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
Community Center for Behavorial Health (ADH-PHP), 152 West Street, Danbury, CT
The Pediatric Health Center, 70 Main Street, Danbury, CT
Southbury Geriatric Center, 22 Old Waterbury Road, Southbury, CT
Seifert & Ford Community Health Center, 70 Main Street, Danbury, CT



J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0032

General Hospital

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

New Milford Hospital, Inc. of New Milford, CT, d/b/a New Milford Hospital is hereby licensed to maintain and operate a General Hospital.

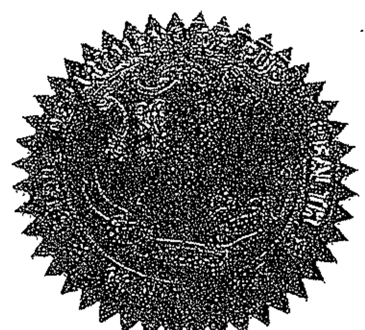
New Milford Hospital is located at 21 Elm Street, New Milford, CT 06776

The maximum number of beds shall not exceed at any time:
- 10 Bassinets
- 85 General Hospital beds

This license expires **June 30, 2011** and may be revoked for cause at any time.

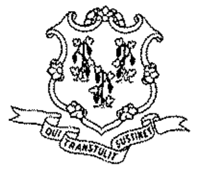
Dated at Hartford, Connecticut, July 1, 2009. RENEWAL.

Satellites
New Milford Hospital Community Mental Health Services, 23 Poplar Street, New Milford, CT



J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

March 4, 2010

Facsimile Only

Sally F. Herlihy, FACHE
VP, Regulatory Compliance
New Milford Hospital
21 Elm Street
New Milford, CT 06776

Re: Letter of Intent; Docket Number: 10-31560
Danbury Hospital
Corporate Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Dear Ms. Herlihy,

On February 26, 2010, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Danbury Hospital ("Applicant") for the corporate affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc. in New Milford, with no capital expenditure.

A notice to the public regarding OHCA's receipt of a LOI was published in *The News Times* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 4, 2010 Requisition # 30561

The News Times
333 Main Street
Danbury, CT 06810

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, March 9, 2010.**

Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Alexis Fedorjaczenko or Paolo Fiducia at 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:AF:PF:lmg

c: Danielle Pare, DPH

The News Times
Docket Number: 10-31560

Letter of Intent
March 4, 2010

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Danbury Hospital
Town:	New Milford
Docket Number:	10-31560-LOI
Proposal:	Corporate affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between April 27, 2010 and June 26, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 410 Capitol Avenue, MS13HCA, P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at www.ct.gov/OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

Greer, Leslie

From: ads [ads@graystoneadv.com]

Sent: Thursday, March 04, 2010 4:23 PM

To: Greer, Leslie

Subject: Re: Legal Notice 10-31560

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061
E-mail: ads@graystoneadv.com
http://www.graystoneadv.com/

On 3/4/10 4:03 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice in The News Times by 3/9/10. For billing purposes please refer to requisition 30561, if you have any questions feel free to call me.
>
> Thank you,
>
> Leslie M. Greer
> Office of Health Care Access
> A Division of Department of Public Health
> State of Connecticut
> 410 Capitol Avenue, MS#13HCA
> Hartford, CT 06134
> Phone: (860) 418-7001
> Fax: (860) 418-7053
> *Website:* www.ct.gov/ohca <http://www.ct.gov/ohca>
> Please consider the environment before printing this message

****
*** TX REPORT ***
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERLIHY, FACHE

FAX: (860) 210-5075

AGENCY: NEW MILFORD HOSPITAL

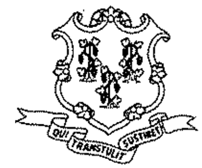
FROM: ALEXIS FEDORJACZENKO

DATE: 3/5/10 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 10-31560

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 12, 2009

via fax and email only

Frank Kelly
President & CEO
The Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810

Sally Herlihy
VP, Regulatory Compliance
New Milford Hospital
21 Elm Street
New Milford, CT 06776

RE: Certificate of Need Application Forms, Docket Number 10-31560-CON
The Danbury Hospital and New Milford Hospital
Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Dear Mr. Kelly and Ms. Herlihy:

Enclosed are the application forms for The Danbury Hospital and New Milford Hospital's Certificate of Need ("CON") proposal for the affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc. with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between April 27, 2010, and June 26, 2010.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. Failure to observe these requirements will require follow-up work on your part to correct the filing.

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.
- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

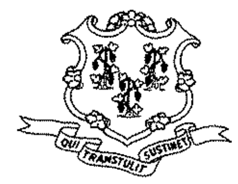
The analysts assigned to the CON application are Olga Armah, Alexis Fedorjaczenko, and Paolo Fiducia. Please contact them at (860) 418-7001 if you have questions.

Sincerely,

Kaila Riggott

Kaila Riggott
Planning Specialist

Enclosure



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than April 27, 2010, and may be submitted no later than June 26, 2010. The Analysts assigned to your application are Olga Armah, Alexis Fedorjaczenko, and Paolo Fiducia. They may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	10-31560-CON	
Applicants Name:	The Danbury Hospital	New Milford Hospital
Contact Person: **Contact Title:**	Frank Kelly President & CEO	Sally Herlihy VP, Regulatory Compliance
Contact Address:	24 Hospital Avenue Danbury, CT 06810	21 Elm Street New Milford, CT 06776
Project Location:	New Milford, CT	
Project Name:	Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.	
Type proposal:	Section 19a-638, C.G.S.	
Est. Capital Expenditure:	$ 0	

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).

c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).

d. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.

e. Regarding clinical services:
   i. Identify and explain any changes to either Applicant's clinical services that result from this proposal.
   ii. Describe the Applicant's plans to enhance the delivery of health care through provision of more coordinated and enhanced scope of clinical services as a result of this proposal.

f. Describe the plans and timeline for any centralization of administrative, clinical, or other functions. Identify whether any of these centralizations would involve a program termination.

g. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.

h. Existing Providers
   i. List all existing providers (name, address, services provided) of the services involved in this proposal in the towns served by the facility changing ownership or control, and in nearby towns.
   ii. Describe the effect of this proposal on existing providers.

i. For each Applicant (and any new entities to be created as a result of the proposal), provide the following <u>prior to</u> and <u>after</u> this proposal:
   i. Legal chart of corporate or entity structure including all affiliates.
   ii. List of owners and the % ownership and shares of each.
   iii. Board of Directors composition.

j. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

2. **Actual and Projected Volume**

   a. Provide volumes for the most recently completed FY by town for each hospital, separately.

   b. Complete the following table for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each hospital separately.

Table 1: Historical, Current, and Projected Volume

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***	**Projected Volume (First 3 Full Operational FYs)****		
	FY ***	FY ***	FY ***	FY ***	FY ***	FY ***	FY ***
Med/Surg Discharges							
Pediatric Discharges							
Newborn Discharges							
Psychiatric Discharges							
Maternity Discharges							
Rehab Discharges							
Total Discharges							
ED Visits							
Ambulatory Surgery							

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Fill in years. In a footnote, identify the period covered by the Applicants' FY (e.g. July 1-June 30, calendar year, etc.).

   c. Explain any increases and/or decreases in volume seen in the tables above.

   d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

3. Quality Measures

a. Submit a list of **all** key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

4. Organizational and Financial Information

a. Identify the Applicants' ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Do the Applicants have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the each Applicant and indicate any licensure changes related to this proposal.

d. Financial Statements

i) <u>If the Applicant is a Connecticut hospital:</u> Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii) <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books).

e. Submit a final version of all capital expenditures/costs as follows:

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	**$**
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Patient Population Projections

a. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for each Applicant.

Table 3: Patient Population Mix

	Current FY **	**Year 1 FY ****	**Year 2 FY ****	**Year 3 FY ****
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided in Table 1.

b. Provide the basis for/assumptions used to project the patient population mix.

6. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

c. Provide the assumptions utilized in developing both **Financial Attachments I & II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

d. Identify whether there will be any changes to billing as a result of the proposal.

e. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

g. Describe how this proposal is cost effective for each applicant, separately.

h. Describe detail, cost savings that will result as a direct result of the proposed affiliation/merger for each of the Applicants involved. Provide specific examples and supporting documentation.

7. Other Review Criteria

a. Describe the proposal's relationship to each of the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

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

Total Hospital Health System: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

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

Total Facility: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gain/(Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
FY ______	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0		$0				$0	$0	$0
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
FY ____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0		$0				$0	$0	$0
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: ______________________ PROJECT TITLE: ______________________ DATE: ______________________	FOR OHCA USE ONLY:	DATE	INITIAL
	1. Check logged (Front desk)	______	______
	2. Check rec'd (Clerical/Cert.)	______	______
	3. Check correct (Superv.)	______	______
	4. Check logged (Clerical/Cert).)	______	______

SECTION A – NEW CERTIFICATE OF NEED APPLICATION

1. Check statute reference as applicable to CON application (see statute for detail):

_____ 19a-638.Additional function or service, change of ownership, service termination.
No Fee Required.

_____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator.
Fee Required.

_____ 19a-638 and 19a-639.
Fee Required.

2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.

3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000

4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):

a. Base fee: ______________________	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)______________________	$_______.00
(To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($______________ x .0005)	$_______.00
c. Sum of base fee plus additional fee: (Lines A4a + A4b)______________________	
d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).	

SECTION B TOTAL FEE DUE: ______________________ $_______.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

HOSPITAL AFFIDAVIT

Applicant: ______________________________________

Project Title: ______________________________________

I, ______________________________, ________________________________
(Name) (Position – CEO or CFO)

of ______________________________ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

____ ____________________
Signature Date

Subscribed and sworn to before me on________________________

____

Notary Public/Commissioner of Superior Court

My commission expires: ________________________

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1356
RECIPIENT ADDRESS	918602105075
DESTINATION ID	
ST. TIME	03/12 15:37
TIME USE	02'50
PAGES SENT	14
RESULT	OK

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

FAX SHEET

TO: SALLY HERLIHY

FAX: 860.210.5075

AGENCY: NEW MILFORD HOSPITAL

FROM: ALEXIS FEDORJACZENKO

DATE: 3-12-10 **TIME:** 2:30 PM

NUMBER OF PAGES: 13
(including transmittal sheet

Comments:

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From:	Fedorjaczenko, Alexis
Sent:	Friday, March 12, 2010 2:40 PM
To:	'herlihys@nmhct.org'
Cc:	'frank.kelly@danhosp.org'; Greer, Leslie
Subject:	Application Forms 10-31560; Affiliation of Danbury Health System and New Milford Hospital
Attachments:	10-31560 Affidavit-Hospital.doc; 10-31560 FA I (New Milford).xls; 10-31560 FA I (Danbury Health System).xls; 10-31560 Application.doc; 10-31560 CoverLetter.doc; 10-31560 FA II.xls; 10-31560 CONFEE.doc

Sally, Attached please find an electronic copy of the application forms that have also been faxed to your attention. Let me know if you have any questions.

Alexis G. Fedorjaczenko, MPH
Department of Public Health
Office of Health Care Access
860.418.7017

Cyan Magenta Black

10-31560

PUBLIC NOTICES

ORDINANCE
City of Danbury

AN ORDINANCE APPROPRIATING $1,840,000 FOR SETTLEMENT OF LITIGATION AGAINST THE CITY IN THE MATTER OF METCALF & EDDY, INC. V. THE CITY OF DANBURY AND AUTHORIZING THE ISSUANCE OF $1,840,000 BONDS OF THE CITY TO MEET SAID APPROPRIATION AND PENDING THE ISSUANCE THEREOF THE MAKING OF TEMPORARY BORROWINGS FOR SUCH PURPOSE

BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF DANBURY:

Section 1. The sum of $1,840,000 is appropriated as consideration for the settlement of litigation against the City in the matter of Metcalf & Eddy, Inc. v The City of Danbury, Docket No. UWY-CV05-4009584-S Judicial District of Waterbury, Complex Litigation Docket, pursuant to a Stipulated Settlement Agreement And Mutual Releases, between the parties, dated November 16, 2009, providing for a mutual withdrawal of the above matter in return for payment of the Settlement Amount by the City, and for the cost of interest on any temporary borrowings and costs of issuance related to the issuance of the bonds and notes authorized hereunder.

Section 2. To meet said appropriation $1,840,000 bonds of the City, or so much thereof as shall be necessary for such purpose, ...

PUBLIC NOTICES

ORDINANCE
City of Danbury

Be it ordained by the City Council of the City of Danbury:

That Sec. 2-176 of the Code of Ordinances of Danbury, Connecticut, is hereby amended to read as follows:

Sec. 2-176. Schedule of termination of government entities.

(a) The following governmental entities are terminated, effective June 30, 2011, unless reestablished in accordance with the provisions of section 2-184:
(1) The Danbury Parks and Recreation Commission.
(2) The Aviation Commission.
(3) The Youth Commission.

(b) The following governmental entities are terminated, effective June 30, 2012, unless reestablished in accordance with section 2-184:
(1) The Commission for Persons with Disabilities.
(2) The Danbury Aquifer Protection Agency.
(3) The Fair Rent Commission.
(4) The Board of Ethics.
(5) The Charles Ives Authority for the Performing Arts.

(c) The following governmental entities are terminated, effective June 30, 2013, unless reestablished in accordance with section 2-184:
(1) The Stanley Lasker Richter Memorial Park Authority.
(2) The Conservation Commission.
(3) The Environmental Impact Commission.
(4) The Danbury Museum and Historical Society Authority

(d) The following governmental entities are terminated, effective June 30, 2014, unless reestablished in accordance with section 2-184:
(1) The City of Danbury Cultural Commission.
(2) The Commission on Aging.
(3) The Parking Authority of the City of Danbury.
(4) The Danbury Housing Partnership.
(5) The Lake Kenosia Commission.

(e) The following governmental entities are terminated, effective June 30, 2015, unless reestablished in accordance with the provisions of section 2-184:
(1) The Flood and Erosion Control Board of the City of Danbury.
(2) The Tarrywile Park Authority.

EFFECTIVE DATE: This Ordinance shall take effect thirty days (30) days after adoption and publication, as provided by law and section 3-10 of the Charter of the City of Danbury.

Adopted by the City Council – March 2, 2010
Approved by Mayor Mark D. Boughton – March 4, 2010

ATTEST: S/S JEAN A. NATALE
JEAN A. NATALE
Legislative Assistant

PUBLIC NOTICE

Statute Reference:	19a-638
Applicant:	Danbury Hospital
Town:	New Milford
Docket Number:	10-31560-LOI
Proposal:	Corporate affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.
Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between April 27, 2010 and June 25, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 410 Capitol Avenue, MS13HCA, P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at www.ct.gov/OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant.

LEGAL NOTICE

Pursuant to §§ 16-11, 16-19 and 16-19e of the General Statutes of Connecticut and Public Notice filed with the Secretary of the State on February 1, 2010, the Department of Public Utility Control will conduct a public hearing, concerning Docket No. 09-12-05, Application of The Connecticut Light and Power Company to Amend Its Rate Schedules, ...

PUBLIC NOTICES

LEGAL NOTICE

The Zoning Commission of Brookfield, CT will hold a Public Hearing in Room #133 of the Brookfield Town Hall at 8:00 p.m. on March 11, 2010 on the following:

Revisions to the Brookfield Flood Plain District Regulations, Sections 242-202 and 242-503, as directed by the Department of Environmental Protection.

At this hearing interested persons may appear and be heard and written communications will be received. Copies of the proposals are on file in the Office of the Brookfield Zoning Commission.

Dated in Brookfield, Connecticut, this February 26, 2010 & March 8, 2010.

Stanley Parker, Chairman
Brookfield Zoning Commission

LEGAL NOTICE

The Zoning Commission of Brookfield, CT will hold a Public Hearing in Room #133 of the Brookfield Town Hall at 8:00 p.m. on March 11, 2010 on the following:

Revisions to the Brookfield Flood Plain District Regulations, Sections 242-202 and 242-503, as directed by the Department of Environmental Protection.

At this hearing interested persons may appear and be heard and written communications will be received. Copies of the proposals are on file in the Office of the Brookfield Zoning Commission.

Dated in Brookfield, Connecticut, this February 26, 2010 & March 8, 2010.

Stanley Parker, Chairman
Brookfield Zoning Commission

LEGAL NOTICE
LIQUOR PERMIT
Notice of Application
This is to give notice that I,
MATT STANCZAK
66 CLEARVIEW AVE
DANBURY, CT 06811-3374
Have filed an application placarded 03/01/2010 with the Department of Consumer Protection for a RESTAURANT WINE & BEER PERMIT for the sale of alcoholic liquor on the premises at:
35LAKE AVENUE EXT #A
DANBURY, CT 06811-5247
The business will be owned by:
STANZIATO'S LLC
Entertainment will consist of: None
Objections must be filed by: 04/11/2010
MATT STANCZAK

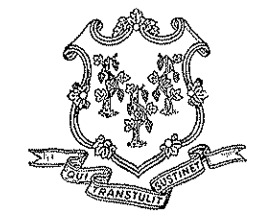
MERCHANDISE FOR SALE

BED, Queen size bed/dark wood head board, frame, box spring and mattress, good condition. $150 Call 203-775-4700

CARRY ON bags for computer,ski,train, travel,picnic/food,school brandnew,never used orig. $50-$300, $10-$50. 203 426-6476

DRUM SET with hardware and cymbals, exc cond. $250. 203-866-4679

DUNLOP P205-60-...



State of Connecticut

GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

RECEIVED
2010 JUN -3 A 11:30
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

June 1, 2010

Deputy Commissioner Cristine Vogel
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134

Dear Commissioner Vogel,

It is our understanding that New Milford Hospital and Danbury Hospital are in the final stages of developing a formal affiliation after many months of discussions. If realized, this affiliation will be a benefit to the residents, employers and the communities now served by both institutions. The proposed partnership has our strong support as a rational means to regionalize health care and maximize the use of resources and medical talent and expertise.

The proposed health care system alliance would provide a network that will offer:

- Quality care convenient to residents
- Cross privileges for physicians
- Uniformly high quality standards and patient satisfaction
- Improved access to all levels of care throughout a large geographic region and a deeper pool of resources---more places, more choices
- Improved operating performance
- Better access to capital
- Integration of services to best meet the challenges of health care reform trends and legislation.

We hope your agency will give the requisite approval to this proposed partnership between New Milford and Danbury Hospitals, together with the Visiting Nurses Associations in both regions, so that the new organization can move quickly to implement essential plans to provide an even higher level of service to area residents.

Thank you for your consideration of our comments.

Sincerely yours,

Clark J. Chapin
State Representative, 67th District

Andrew W. Roraback
State Senator, 30th District

State of Connecticut

Department of Public Health

Office of Health Care Access

Docket No. 10-31560-CON

Affiliation of
New Milford Hospital, Inc.
and
Danbury Health Systems, Inc.

June 9, 2010

A Higher Level of Care

RECEIVED

2010 JUN -9 P 2:54

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

June 3, 2010

Via Hand Delivery

The Honorable Cristine A. Vogel
Deputy Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: **CON Application in Docket No. 10-31560-CON**
Affiliation of New Milford Hospital Inc. with Danbury Health Systems, Inc.

Dear Commissioner Vogel,

Enclosed please find the original CON application for the affiliation of New Milford Hospital, Inc. with Danbury Health Systems, Inc. as well as six copies of the application and a CD with the full document.

We are pleased to be submitting this application to your office because it is the culmination of a great deal of work that both hospital systems have undertaken in the hope that the patients in our collective service area will benefit from the affiliation. We anticipate that if the application is approved by OHCA, we can join the two organizations at the end of September so that we can begin the new fiscal year as a combined entity.

We look forward to providing any additional information you may need and thank you, in advance, for your consideration of this application. If you have any questions, please do not hesitate to call.

Respectfully submitted,

New Milford Hospital, Inc.

By: ______________________
Richard Henley
Interim President and CEO

Danbury Health Systems Inc.

By: ______________________
Frank J. Kelly
President and CEO

Danbury Health Systems, Inc.

By: ______________________
John M. Murphy, M.D.
Executive Vice President

HOSPITAL AFFIDAVIT

RECEIVED

2010 JUN -9 P 2:54

CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Applicant: New Milford Hospital, Inc.

Project Title: Affiliation of Danbury Health Systems, Inc. and New Milford Hospital, Inc.

I, Richard Henley, Interim President and CEO

of New Milford Hospital, Inc. being duly sworn, depose and state that the New Milford Hospital information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☒ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☒ No

[signature]
Signature

5-28-10
Date

Subscribed and sworn to before me on May 28, 2010

Laura Sue Wallace

Notary Public/Commissioner of Superior Court

My commission expires: LAURA SUE WALLACE ~~NOTARY PUBLIC~~ State of Connecticut My Commission Expires November 30, 2012

Hospital Affidavit
Revised 7/02

HOSPITAL AFFIDAVIT

RECEIVED
2010 JUN -9 P 2:54
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Applicant: Danbury Health Systems, Inc.

Project Title: Affiliation of Danbury Health Systems, Inc. and New Milford Hospital, Inc.

I, Frank J. Kelly, President and CEO

of Danbury Health Systems, Inc., being duly sworn, depose and state that the Danbury Health Systems, Inc. and Danbury Hospital information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☒ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☒ No

Frank J. Kelly ______________________ Signature

6/1/10 ______________ Date

Subscribed and sworn to before me on June 1, 2010

Alberta B. Riccardi ______________________

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2014

Alberta B. Riccardi
Notary Public-Connecticut
My Commission Expires
May 31, 2014

HOSPITAL AFFIDAVIT

RECEIVED
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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Applicant: Danbury Health Systems, Inc..

Project Title: Affiliation of Danbury Health Systems, Inc. and New Milford Hospital, Inc.

I, John Murphy, M.D., Executive Vice President

of Danbury Health Systems, Inc., being duly sworn, depose and state that the Danbury Health Systems, Inc. and Danbury Hospital information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☒ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☒ No

John M. Murphy
Signature

6/1/10
Date

Subscribed and sworn to before me on June 1, 2010

Alberta B. Riccardi
Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2014

Hospital Affidavit
Revised 7/02

Alberta B. Riccardi
Notary Public-Connecticut
My Commission Expires
May 31, 2014

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: Danbury Health Systems, Inc. and New Milford Hospital, Inc. PROJECT TITLE: Affiliation of Danbury Health Systems, Inc. and New Milford Hospital, Inc. DATE: June 3 , 2010	FOR OHCA USE ONLY:	DATE	INITIAL
	1. Check logged (Front desk)	______	______
	2. Check rec'd (Clerical/Cert.)	______	______
	3. Check correct (Superv.)	______	______
	4. Check logged (Clerical/Cert).)	______	______

SECTION A – NEW CERTIFICATE OF NEED APPLICATION

1. Check statute reference as applicable to CON application (see statute for detail):

__X_ 19a-638.Additional function or service, change of ownership, service termination.
No Fee Required.

____ 19a-639 Capital expenditure exceeding $3,000,000, or capital expenditure exceeding $3,000,000 for major medical equipment, or CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment or linear accelerator.
Fee Required.

____ 19a-638 and 19a-639.
Fee Required.

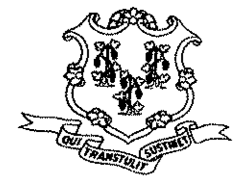
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.

3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator less than $3,000,000

4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $3,000,000 or other capital expenditure exceeding $3,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):
   a. Base fee: ______ $ 1,000.00
   b. Additional Fee: (Capital Expenditure Assessment) ______ $____.00
   (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($______ x .0005) $____.00
   c. Sum of base fee plus additional fee: (Lines A4a + A4b) ______
   d. Enter the amount shown on line A4c. on "Total Fee Due" line (SECTION B).

SECTION B TOTAL FEE DUE: ______ $ 0 .00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than April 27, 2010, and may be submitted no later than June 26, 2010. The Analysts assigned to your application are Olga Armah, Alexis Fedorjaczenko, and Paolo Fiducia. They may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 10-31560-CON

Applicants Name:	Danbury Health Systems, Inc.	New Milford Hospital, Inc.
Contact Person:	Frank Kelly	Sally Herlihy
Contact Title:	President & CEO	VP, Regulatory Compliance
Contact Address:	24 Hospital Avenue Danbury, CT 06810	21 Elm Street New Milford, CT 06776

Project Location: New Milford, CT and Danbury, CT

Project Name: Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $ 0

1. Project Description and Need

a. Provide a narrative detailing the proposal.

This proposal involves the affiliation of Danbury Health Systems, Inc. ("DHS") and The Danbury Hospital ("DH" or "Danbury Hospital") with New Milford Hospital, Inc. ("NMH" or New Milford Hospital") to become a stronger regional healthcare system without sacrificing the quality that each system brings to health care in Connecticut.

The applicants listed on page 1 of this application propose that DHS become the sole member of NMH as follows: Upon approval of this proposal, DHS and NMH will adopt amended and restated Certificates of Incorporation and amended bylaws. The changes made by these amendments include, without limitation, (i.) changing DHS's name from "Danbury Health Systems, Inc." to a name mutually agreeable to the applicants (NEWCO), and (ii.) replacing the current member of NMH with NEWCO as the sole corporate member. (The name of the new parent organization will change to reflect the more regional nature of the resulting health care system.)

Specifically, DHS, a Connecticut non-stock 501 (c)(3) organization ("Applicant 1"), the parent corporation of Danbury Hospital and other providers of health care along the health care continuum, is the planning and integrating body for that system of health care entities. New Milford Hospital, Inc., a Connecticut non-stock 501(c)(3) organization ("Applicant 2") is a specially chartered Connecticut non-stock 501(c)(3) organization and short-term acute care hospital, which is the planning and integrating body for NMH and its affiliated healthcare entities.

Applicant 1 and Applicant 2 shall collectively be referred to as the "Applicants."

Pursuant to the proposal, New Milford Hospital and Danbury Hospital will remain separate legal entities, with independent medical staffs and hospital licenses. Please refer to Exhibit 6 provided in response to question 1.i for the organization charts of the Applicants prior to, and following application approval. Upon approval of this proposal by all appropriate regulatory authorities, NMH, and DH and its affiliates will become wholly owned/ controlled subsidiaries of NEWCO, the new parent company created by this proposal.

No changes in licensing of either hospital or affiliated home care agencies will result from this proposal. The Applicants intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions. Danbury Hospital will serve as the primary provider of tertiary level inpatient and outpatient care to the western CT region and New Milford Hospital will be the provider of inpatient and outpatient services in its service area as follows:

Danbury Hospital

Inpatient Services
- Intensive and Cardiovascular Care Units
- Adult and Pediatric Medical/ Surgical Units
- Obstetrical Unit with NICU
- High Acuity Rehabilitation Unit
- Behavioral Health/Psychiatry

Ancillary Services
- Level II Emergency Department
- Surgical Services
- Medical Imaging
- Praxair Regional Heart and Vascular Center
- Praxair Cancer Center
- Center for Advanced Orthopedic and Spine Care
- Women and Children's Service
- System-wide Reference Lab

Physician Services
- Distributed locations of primary and specialty physicians (DOPS and independent)

New Milford Hospital

Inpatient Services
- Adult Medical/ Surgical Unit
- ICU/ Stepdown/ acuity adaptable unit
- Family Birthing Center
- Low Acuity Rehabilitation (pending space)

Ancillary Services
- 24-hour Emergency Department
- Surgical Services
- Medical Imaging
- Cardiovascular screening/ diagnostics and clinics
- Regional Cancer Center
- OP Neurodiagnostics and other specialty clinics
- Expanded women's health and wellness programs
- Phase 1 Research Center office

Physician Services
- Increased availability of currently unavailable specialists in community from Danbury, as needed (for example, Nephrology, Dermatology, Endocrinology)
- Distributed locations of primary and specialty physicians (DOPS and independent)

Over time, decisions concerning services will be made using a strategic planning process considering local community needs and the state-wide health care facilities and services plan as well as established evidence-based quality of care considerations, thus ensuring optimal access to the highest quality and most cost effective services. The medical communities of both organizations will be integral partners in this process. Any future clinical service changes will be made only subject to regulatory approval as required and will therefore be justified based on quality of care, or cost effectiveness considerations, and adequate access for the communities served.

b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).

Danbury Health Systems, Inc.:

Danbury Health Systems has pursued a strategic plan to establish Danbury Hospital as a regional medical center, providing selected tertiary services to an ever greater number of people from a growing, broader geographic region. To support its plan, DHS has developed an operationally integrated health care delivery system (the "System") comprised of health care entities that coordinate services along the health care continuum, enabling patients to receive care in the most appropriate settings. The DHS model is defined by a strong focus on the patient, quality outcomes supported by evidence-based best practices, coordinated care along the inpatient, outpatient and home care continuum, a focus on good stewardship and financial accountability.

During its strategic planning process in 2008 and 2009, DH conducted an assessment of its service area and examined alternatives to the option of constructing a new tower and emergency department. (See DH CON re: Facility Expansion, Docket # 09-31490-CON) One alternative considered during that assessment was the establishment of one or more hub and spoke arrangements with surrounding hospitals as part of an effort to seek potential higher and better uses of capital funds. (See Docket # 09-31490-CON, pp. 33 - 35) The assessment did not result in identifying a better alternative than constructing a new patient tower, but it did establish a direction for considering a relationship with other providers to engage in a more regional planning effort and to provide a more complete continuum of services. It should be noted that DH already provides inpatient services for approximately 30% percent of the New Milford service area. Moreover, the recent completion of the Route 7 bypass dramatically reduces by half the time required to travel from NMH to DH. Also, in 2009, OHCA determined that NMH was not achieving the volume requirements to operate its emergency angioplasty service. NMH recognized that DH offered the closest full service cardiac services program. DH offered to assist NMH in the orderly transition that followed. Shortly thereafter, when NMH representatives initiated a dialogue with DH, it became clear that both DH and NMH Board members saw the potential value in establishing a broader, more integrated relationship.

The Applicants believe they share a common vision and core values for the establishment of an innovative and collaborative community-based health care delivery system. The shared vision from the initial meetings of the representatives of DHS and NMH, Inc. is as follows:
The Parties believe that the affiliation will create an integrated health care delivery system capable of bringing best practices in health care delivery to enhance the health and well being of the residents within the region of Western Connecticut and eastern New York State. This vision will be accomplished through optimizing resources, financial vitality of the Parties, highest caliber of patient experience, one board vision through one management team, optimizing and standardizing of the Parties multiple parts and one integrated standard of care. See **Exhibit 1**, Letter of Intent for Corporate Affiliation between Danbury Health Systems, Inc. and New Milford Hospital, Inc. dated Feb. 8, 2010.

Following initial discussions, the Applicants determined that most of the complementary clinical services that NMH does not provide could be provided through a relationship with DH. It became apparent that prudent regional planning could be conducted utilizing the resources available at both institutions if done in an integrated fashion. The Applicants believe that the recent passage of federal health care reform and the current fiscal crisis in Connecticut combined obligate hospital leaders to consider ways to ensure continued access to essential health care services. Coordinating the core capabilities of each organization was thought to be the best approach to addressing the pressures of future increasing demand and lower reimbursements from both governmental and private payers, from both a cost and a service delivery perspective.

New Milford Hospital:

Specifically, through collaborative planning, responsible decision making and appropriate sharing of services, resources and technologies, NMH expects that upon approval of this Proposal, it will be well positioned to meet the challenges and demands of the health care industry, while remaining strong enough to sustain its commitment to offering access to the highest quality services to the communities it serves.
During 2007 and 2008 there was concerted effort to develop a new strategic plan and identify priorities to position NMH for growth and success in an increasingly competitive and resource constrained environment. The activities involved engagement of an external planning consultant, focus groups of internal and external constituents (including the medical staff), and active involvement of the senior management team and Board Planning Committee.

From a strategic context, it was identified that community hospitals of the future would possess:

- Programs and services targeted at specific needs of the local community that are differentiated on the basis of value delivered (cost and quality)
- An appropriate size for inpatient care with a distributed network of ambulatory access points in strategic locations in the communities served

- Ability to accept, treat, triage emergency cases appropriately
- Heavy focus on ambulatory/outpatient services (on and off campus) with corresponding ambulatory/patient focused culture
- Critical mass of closely aligned/affiliated/employed physicians (PCPs and specialists)
- Strategic affiliations with marquee regional and/or national providers that provide access to specialized services, physicians, capital, IT insurance contracts, research and education.

Challenges in the healthcare environment for New Milford included:

National	Regional
Decreasing inpatient volumes due to competition, technology, insurance coverage	Declining inpatient admissions (net loss of 500 or 14.7% since 2004)
Growth in consumerism along with greater demands for transparency related to cost, quality and outcomes	Increasing competition from several leading competitors in growth mode
Dramatic changes in hospital-physician relationships	Shifting physician referral patterns and patient preferences
Payment declines from both government and commercial payers	Growing need to address/upgrade the physical, clinical and technological infrastructure to meet community needs
Increased push towards pay for performance and evidenced-based medicine	Physician shortages in primary care and specialties

The Strategic Plan developed by NMH and adopted by its Board of Directors includes the following pillars:

QUALITY: Improve outcomes; specifically, meet and exceed national quality standards for patient safety and clinical outcomes. Position and maintain New Milford Hospital as a leader in clinical excellence, with demonstrated optimal quality, safety and risk outcomes.
WORKFORCE DEVELOPMENT: Improve recruitment, retention, professional growth, job satisfaction.
FINANCIAL STEWARDSHIP: Achieve and maintain a level of financial performance that - creates positive operating margins, ongoing capital investment, and philanthropic support to ensure our viability as an essential community resource.
INFRASTRUCTURE DEVELOPMENT: Make targeted investments in facilities, technology and programs to advance and maintain clinical excellence, consistent with strategic goals. In all cases, strive to make these projects as environmentally-friendly as possible, in recognition of our responsibility to embrace "green" technology and its relationship to health promotion and disease prevention.

COMMUNITY OUTREACH: Promote and sustain engagement with the local community in order to increase knowledge of the hospital's services, promote the overall health of the area, and maintain awareness of health care concerns.
PHYSICIAN RELATIONSHIPS: Create a model of physician relationships based on shared ownership, shared responsibility for the fate and future of the hospital, shared opportunity for practice and income growth, and shared accountability.

During the ongoing dialogue with DHS over the past year oriented toward development of a regional health care delivery system, NMH and NewYork-Presbyterian Healthcare System ("NYP System") reached a mutual decision to end their affiliation effective June 30, 2010. This follows a 15-year relationship between NMH and NYP System, a major metropolitan system that helped establish more advanced health services in Litchfield County. NMH values the educational and networking opportunities of its relationship with the NYP System and their instrumental clinical role in establishing the regional heart and cancer centers at the hospital. The decision to change this relationship evolved as the clinical and business partnerships with other organizations were evaluated to ensure the hospital has the right support and resources available to remain a strong, effective health care provider. The timing coincided with the changing needs of both organizations.

Both Applicants strongly believe that as NMH further develops its role with DH in a regional health care delivery network, there will be many new opportunities in patient care, education, research and quality performance to provide services locally to residents of our combined communities.

Therefore, some of the factors considered by NMH in the decision to pursue affiliation with DHS included:

- Need for Capital. NMH will need access to significant capital to maintain state-of-the-art facilities as its physical plant and infrastructure ages, and as it pursues replacement and expansion of its IT and telecommunication systems. Examples of some of the larger capital expenses are in the area of: i) information technology to support legacy systems as well as clinical applications (i.e.- CPOE) (ii) implementation of an electronic medical record and other advanced clinical technologies designed to improve care, quality and efficiency; (iii) enhanced PACS and voice dictation systems; (iv) renovation and upgrades to patient care units; (v) facility improvements such as upgrading mechanicals and introducing green technologies; and (vi) general plant maintenance associated with an aging facility. The Applicants believe that the cost efficiencies realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH.

- Access to Advanced and Expensive Technologies. NMH seeks to ensure that the

communities it serves have access to the latest in diagnostic and therapeutic technologies, such as robotic surgery and the latest in genomic therapies, etc.

These are currently available to patients at a premium cost by sending out to commercial laboratories or sending patients out of the region. At the same time, NMH recognizes that local demand alone may not justify the associated acquisition costs for certain expensive technologies. The Applicants believe that a more prudent, cost effective approach is to employ a regional planning approach, deploying expensive and complex technologies as appropriate within the region to provide proximate access for patients and physicians alike. Thus, upon regulatory approval of this Proposal, future decisions related to technology acquisitions will be based on addressing need and access issues across the region to avoid creating redundancies and unnecessary capital expenditures.

- Access to Primary Care Services. The Applicants plan to enhance their current primary care networks through a collaborative approach focused on wellness, prevention and disease management and directly linked to specialty clinics for prompt access and seamless care coordination. Critical to this primary care network is the recruitment and retention of talented primary care clinicians. NMH has identified this issue as a key need to be addressed as part of its medical staff planning activities. However, recognizing the challenges that exist in recruiting from a limited pool of primary care physicians, the Applicants believe that a combined effort and a more robust and integrated system will be more effective in recruiting primary care physicians. Once successfully established, this primary care infrastructure will yield greater capacity to care for uninsured and underinsured patients (and post-health care reform, the increasing numbers of insured patients seeking care) and to support the outreach and preventative care that is necessary to improve the health of the vulnerable and at-risk populations. These joint system-wide efforts will be critical in dealing with the financial pressures of a rising demand in the number of patients in a growing community. DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. DHS also houses Danbury Office of Physician Services ("DOPS"), a multi-specialty faculty practice plan whose mission is to support the DH in its objective of meeting the needs of all patients, including the underserved. DOPS has the infrastructure to support the expansion of a stronger primary care network within the NMH service area now and in the future.

- Physician Recruitment/Cross Coverage Arrangements. In recent years, the Applicants have found it increasingly difficult to recruit specialist physicians to their respective service areas. NMH has identified key specialties in which an unfilled need exists, such as endocrinology, nephrology, neurology, and selected surgical subspecialties. And while in some cases there may be enough patients in a specific specialty to justify a specialist, it is practically impossible for one

physician to cover a given specialty 24/7/365 days per year. However, demand for certain needed specialty services is typically not great enough to justify the recruitment of a second physician. Again, the infrastructure at DHS provides for a vehicle for recruitment and for the provision of selected specialties that will fill a need in the greater NMH service area.

These realities, coupled with the fact that the State of Connecticut's cost of living and malpractice rates are high compared to other states, further contribute to the challenges associated with recruiting physicians to Connecticut as further supported by the State of Connecticut's Hospital System Strategic Task Force Report (2008) which states the following:

"Workforce shortages are one of the leading factors influencing the rising cost of providing care in Connecticut's hospitals. Hospitals report struggling with expense related to recruiting and retaining health professionals... Connecticut currently faces personnel shortages in physicians, surgeons, specialty areas... the demand for health care services already exceeds the number of health care workers and the shortages are expected to continue into the foreseeable future, as baby boomers age and the need for health care grows. In addition to aging patients, many physicians ... are among the baby boomers who will retire in the next three to five years ... [as] one third of Connecticut's practicing physicians are age 55 or above...

Connecticut's physicians, along with representatives from the Connecticut State Medical society, highlighted the severity of physician shortages in our state, particularly in subspecialty areas. The shortage is linked to several issues. Since Connecticut has one of the highest costs of living in the nation, it is difficult for the state to retain or attract recent medical student graduates, as they cannot afford to establish and maintain a practice, raise a family and pay back significant student loans. It is believed that physicians and recent medical school graduates are choosing to practice in other states with a lower cost of living, limitations on medical malpractice claims and few on-call requirements ...

Connecticut is unable to meet the growing need for surgeons and subspecialty surgeons mainly due to the high cost of malpractice premiums and the on-call burden. Attempting to decrease their liability risk, some surgeons and subspecialty surgeons with high malpractice premiums are either choosing to leave the state or are narrowing their practice by no longer providing surgical, emergency room and trauma care. On-call physicians are also burdened with the possibility of having to provide care in a subspecialty area that is not their area of expertise."

See **Exhibit 2**, State of CT Hospital System Strategic Task Force Report, 2008, pages 8 to 9.

The Applicants believe that by developing System-wide cross-coverage arrangements along with greater access to technology and clinical research, access to the most qualified physicians for the residents of western Connecticut will become a permanent reality. A joint recruitment and appointment structure will also allow potential applicants to enjoy expanded professional, educational and collegial relationships that will provide professional and personal opportunities beyond those normally available in stand-alone community-based hospitals.

- Quality Improvement Efforts. Effective quality improvement efforts are typically derived from a combination of clinical expertise, core patient values and evidence-based findings. To develop the best evidence-based practices, a provider must have access to a large clinical data repository (for statistical validity) and the associated capital for the development of such best practices. Given the development costs, most hospitals are limited to developing one or two evidence-based best practices per year. NMH firmly believes that as a stand-alone system, it would neither have access to a meaningful and reliable data repository, nor the resources for extensive development of evidence-based best practices. Accordingly, it is in the best interests of the Applicants to spread the cost for development of evidence-based best practices across a broader system. Shared evidence-based best practices across NEWCO will undoubtedly lead to top performance measures, greater patient safety, and improved clinical outcomes.

  As a result of its emphasis on quality, DH has been recognized by HealthGrades, an independent health care benchmarking organization, as performing in the top 5% of all U.S. hospitals for clinical excellence and patient safety. Similarly, Regional Hospice of Western Connecticut and the Danbury Visiting Nurse Association (two DHS subsidiaries) have been recognized as top performing home care agencies nationally. For several consecutive years, DH has also been cited as providing a high community value index, indicating a lower cost to charge ratio by Cleverly Associates, an independent healthcare financial benchmarking organization.

  NMH and DH are both recipients of the HealthGrades "Outstanding Patient Experience Award" for performing in the top 10% of hospitals on the publicly reported patient satisfaction HCAPS data from July 2008 – June 2009. Of 3,700 hospitals nationwide, the Applicants were two of 370 hospitals in the nation to receive this award. *See* **Exhibit 3** for additional demonstrated DH and NMH quality recognition awards.

  The Applicants are each participating Planetree hospitals that share a common philosophy of patient and family-centered care, each subscribing to the Planetree philosophy which promotes the development and implementation of innovative models of healthcare that focus on healing and nurturing body, mind and spirit. NMH became a Planetree affiliate in 2008 and DH joined in 2009. Through its initial efforts NMH earned the 2009 "Spirit of Planetree" Award in 2009

recognizing the Hospital's patient-centered approach to providing care in the category of Nutritional and Nurturing Aspects of Food for transforming the food and dining services at the hospital.

- Efficiencies. Health care reform legislation has been enacted; regulations need to be developed. Nonetheless providers will be expected to provide greater value to consumers while operating with lower reimbursement from payers. Moreover, according to the 2009 Acute Care Utilization report by the Office of Health Care Access, the number of patients covered by commercial insurance has been declining, while the number of patients who are uninsured, receiving Medicaid, Medicare, or other public assistance has been rising. While this may change somewhat under reform, the industry-wide expectations, including rating agencies such as Moody's, are that demand will be accompanied by lower reimbursements and the need for significant cost reduction by providers. The Applicants are proposing the described change of ownership so that they may position themselves to maximize efficiencies and control costs.

- Employee and Nursing Satisfaction. DHS human resource practices are rated among the best in the health care field and have been published in numerous publications, including The Health Care Advisory Board. Nurses and other employees will directly benefit from working in a financially stable setting with a culture committed to the patients, the community, quality improvement, innovation, staff education and workforce development. The ability to attract and retain competent staff is a crucial component of delivering top level care. DH has a turnover rate that consistently falls well below industry standards. Its employee climate surveys have consistently demonstrated high levels of satisfaction when compared to industry standards. Management believes these ratings correlate to the DH year after year recognition for quality outcomes. NMH also maintains a favorable turnover margin below industry standards.

  The Applicants believe that through their collaborative efforts they will be able to invest more in workforce development, and thus retain the talent they have and attract others to their institutions to minimize employee vacancies. In particular, NMH anticipates utilizing DHS's leadership and organizational process to help develop employees and leaders in current and future roles. NMH staff have already begun to take advantage of educational and development opportunities at DHS. It is worth noting that the State of Connecticut has also recognized the challenges hospital employers will face with respect to nursing satisfaction and retention

  "Patient workload strains due to rising patient acuity levels sometimes associated with an aging population and inadequate staffing also contribute to the departure of nurses from hospital-based jobs. Hospitals need to become more desirable places to work and develop plans that take into consideration national "best practices." For example, additional physical challenges face hospital nurses who

care for elderly, frail and obese patients. Hospitals that are financially distressed are unable to invest in equipment that may prevent worker injuries, such as specialized patient lifts and carriers. High vacancy rates are being seen in specialty fields such as emergency department and psychiatric nursing. These are specialty areas that often deal with challenging and complex patients and typically experience higher patient loads."

See Exhibit 2, State of CT Hospital System Task Force Report, 2008, p.9.

c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).

- Summer 2009: Senior management and representatives of the respective Applicant boards met to engage in exploratory discussion to determine if there was a sufficient interest in pursuing discussion regarding a possible affiliation.

- August 17, 2009: Applicants entered into a Confidentiality Agreement.

- Fall 2009: The Applicants each appointed Board Affiliation teams and jointly engaged a facilitator to assist with a preliminary "due diligence" process to determine the opportunities to realize the shared vision of a regional delivery system through a potential strategic partnership. The Applicants met on a monthly basis between October 2009 and January 2010.

- Winter to Spring 2010:

  - Senior management met with DH's and NMH's medical and hospital staffs to discuss the Letter of Intent for Corporate Affiliation as contemplated.

  - Initial due diligence was completed. A Letter of Intent between the parties was approved by both applicant Boards and was signed February 15, 2010.

  - Letter of Intent for Corporate Affiliation was submitted to OHCA on February 26, 2010.

  - The Applicants conducted a detailed "Phase two due diligence"

- Spring 2010: Multiple meetings with constituencies were held during this time period. A list of the constituents and dates is included in Exhibit 5.

- Spring to Summer 2010: A definitive Affiliation Agreement was negotiated, approved by each Board, and will be signed by the Applicants at the completion of the due diligence process.
  - The Medical Executive Committee at NMH endorsed the proposed affiliation on June 1, 2010.

Communication efforts regarding a potential affiliation of both organizations have been broad to incorporate constituents and include the following:

Danbury and New Milford Hospital Medical Staffs – Ongoing dialogue has occurred at Medical Executive Committee, Quarterly Medical Staff and Departmental/Section on multiple occasions between the fall of 2009 and the present. Physician providers are fully engaged in dialogue regarding the potential affiliation and opportunities to develop a regional health care delivery system. *See* **Exhibit 4** for a list of the Medical Staff Meetings for physicians at both Danbury Hospital and New Milford Hospital.

Employees, Volunteers, and Board of Directors – Both Applicant organizations have provided hospital-wide communications concerning the potential affiliation since the determination in September 2009 to engage a consultant to help facilitate a dialogue and the signing of the Letter of Intent for Corporate Affiliation in February 2010. Direct correspondence from hospital leadership via letters, open forums and committee discussions has provided multiple opportunities for education and clarification to all these stakeholder groups.

Community Awareness – Periodic updates regarding the vision and discussion of progress toward development of the potential affiliation has occurred in different forums, including press releases, news articles surrounding the annual meetings of both organizations and individual inquiries. A series of focus groups and leadership meetings with both organizations have occurred and will continue moving forward as the vision for the regional delivery network is realized with affiliation of the two Applicants.

A list of hospital meetings with core groups and constituents, and a summary of focus group sessions are included in **Exhibit 5.**

d. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.

There is no transition plan in the traditional sense because there will be no disruption of services for NMH or DH patients. The initial transition will be directed at steps toward operational integration and will have no impact on the delivery of clinical services. Once approved by OHCA, the Applicants plan on

developing an extensive integration plan to assure that efforts to achieve efficiencies and quality and access improvements are implemented.

e. Regarding clinical services:

i. Identify and explain any changes to either Applicant's clinical services that result from this proposal.

No changes to clinical services provided by either hospital are planned at this time. Subject to OHCA and other regulatory approval with respect to this Proposal, the Applicants will engage in a strategic planning process for the development of a cohesive integrated health care delivery system for the benefit of residents of the region. Clinical service delivery decisions will be based on the results of this strategic planning process. As stated above, Applicants will share access to advanced and expensive technologies in accordance with applicable laws and regulations and in a manner consistent with patient need and applicable credentialing requirements. The overarching delineation of the services intended to be provided by NEWCO is outlined in response to 1.A. above.

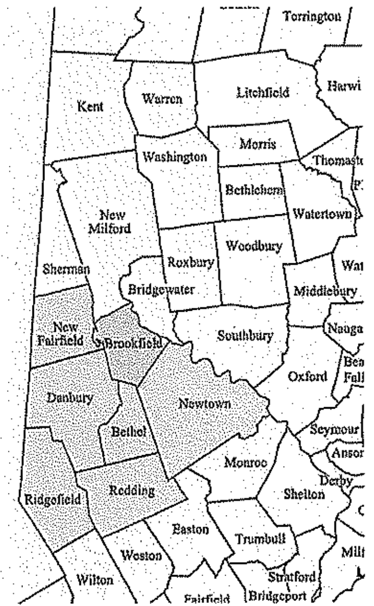
ii. Describe the Applicant's plans to enhance the delivery of health care through provision of more coordinated and enhanced scope of clinical services as a result of this proposal.

The Applicants are already coordinating on Cardiac interventional services and hi-risk pregnancy/neonatology. Other opportunities for sharing include access to technology, such as the da Vinci robot. DH has a faculty that can train NMH physicians with interest. Technological advances in medicine are escalating, yet access to capital for most hospitals is limited. By integrating planning and capital acquisition decisions, the applicants believe they will maximize the available future technologies within the NEWCO System for its patients. Through integration, the patients served by the system will have a coordinated continuum of care within the region, thereby improving immediate access by proximity to services.

f. Describe the plans and timeline for any centralization of administrative, clinical, or other functions. Identify whether any of these centralizations would involve a program termination.

Immediately following approval of this Proposal, Applicants will initiate actions to address the efficiency opportunities identified in responses to question 1b. No change in service distribution is planned at this time.

g. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.



In the map above, New Milford Hospital's Primary Service Area ("PSA") towns are pictured in green, Danbury Hospital's PSA towns are pictured in blue, and Brookfield is in purple as both hospitals include this town in their PSAs. [1]

The Applicants believe that the proposed change of ownership will not have an adverse impact on the existing populations served by NMH. Conversely, the Proposal is intended to ensure the future strength and continued viability of NMH.

Please see **Figure 1** below for a list of the towns in NMH's primary service areas and the associated projected populations for 2009 as reported by the Connecticut Economic Resource Center, Inc.(http://www.cerc.com/TownProfiles/default.asp).

.Figure 1

Primary Service Area Town	County	2009 Population
Bridgewater	Litchfield	1.848
Brookfield	Fairfield	16,469
Kent	Litchfield	2,938
New Milford	Litchfield	27,743
Roxbury	Litchfield	2,267
Sherman	Fairfield	3,777
Warren	Litchfield	1,270
Washington	Litchfield	3,583
Connecticut Subtotal		**59,895**
NY State Towns	Dutchess	8,100
TOTAL		**67,995**

[1] New York areas served by both hospitals are not included in this map.

h. Existing Providers
   i. List all existing providers (name, address, services provided) of the services involved in this proposal in the towns served by the facility changing ownership or control, and in nearby towns.

      There are no other acute care hospitals located in the towns served by NMH.

   ii. Describe the effect of this proposal on existing providers.

      There will be no negative effect on existing providers in the towns served by NMH by virtue of the proposed change of ownership. Discussions with community providers (particularly physicians) indicate that they are pleased with the opportunity for expanded specialty coverage provided through this proposal, that they will benefit from the recruitment of talented specialists who offer sophisticated and state of the art care, greater access to clinical trials for their patients and access to greater continuing education opportunities.

i. For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:
   i. Legal chart of corporate or entity structure including all affiliates.
   ii. List of owners and the % ownership and shares of each.
   iii. Board of Directors composition.

   Please see **Exhibit 6** attached hereto for the corporate structures of each organization and the proposed combined entity.

   Both applicants are non profit tax-exempt entities.

   The list of Boards of Directors for DHS/DH and NMH are provided in **Exhibit 7.**

j. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

   Key documents are the Letter of Intent between DHS and NMH dated February 8, 2010 and the draft Affiliation Agreement. *See* **Exhibit 1** for the Letter of Intent. The Affiliation Agreement is attached as **Exhibit 8**, and is expected to be finalized in the summer of 2010.

2. **Actual and Projected Volume**

a. Provide volumes for the most recently completed FY by town for each hospital, separately.

New Milford Hospital:

Primary Service Area Town	**County**	**2009 Discharges**
Bridgewater	Litchfield	62
Brookfield	Fairfield	86
Kent	Litchfield	184
New Milford	Litchfield	1.341
Roxbury	Litchfield	55
Sherman	Fairfield	86
Warren	Litchfield	50
Washington	Litchfield	151
Primary CT Subtotal		**2,015**
Primary NY State Towns	Dutchess	**192**
PSA		**2,207**
Other Connecticut Zip codes		486
Other Out of State Zip codes		81
TOTAL		**2,774**

Danbury Hospital

Primary Service Area Town	**County**	**2009 Discharges**
Bethel	Fairfield	1,645
Brookfield	Fairfield	1,124
Danbury	Fairfield	7,996
New Fairfield	Fairfield	865
Newtown	Fairfield	1,648
Redding	Fairfield	482
Ridgefield	Fairfield	1,359
PSA		**15,119**
Other Connecticut Zip codes		3,874
Other Out of State Zip codes		1,506
TOTAL		**20,499**

b. Complete the following table for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each hospital separately.

Table 1: Historical, Current, and Projected Volume for Danbury Hospital

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY 2007	FY 2008	FY 2009	FY2010	FY 2011	FY2012	FY2013
Med/Surg Discharges	14,420	14,486	14,894	7,392	15,217	15,437	15,656
Pediatric Discharges	419	342	329	169	351	355	360
Newborn Discharges	2,272	2,127	1.956	950	1,947	1,967	1,986
Psychiatric Discharges	812	794	769	354	752	760	768
Maternity Discharges	2,502	2,379	2,248	1,077	2,289	2,312	2,335
Rehab Discharges	377	337	303	157	321	324	328
Total Discharges	**20,752**	**20,465**	**20,499**	**10,099**	**20,877**	**21,156**	**21,433**
ED Visits	67,929	67,553	69,582	34,094	70,560	71,053	71,551
Ambulatory Surgery	13,092	12,277	11,668	5,657	12,047	12,228	12,411

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Fill in years. In a footnote, identify the period covered by the Applicants' FY (e.g. July 1-June 30, calendar year, etc.).[2]

Table 1: Historical, Current, and Projected Volume for New Milford Hospital

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY2012	FY2013
Med/Surg Discharges	2,178	2,292	2,131	1,968	2,037	2,052	2,070
Pediatric Discharges	68	58	47	24	24	24	24
Newborn Discharges	294	342	296	252	250	248	246
Psychiatric Discharges	–	–	–	–	–	–	–
Maternity Discharges	306	341	300	252	250	248	246
Rehab Discharges	–	–	–	–	–	–	–
Total Discharges	**2,845**	**3,033**	**2,774**	**2,496**	**2,561**	**2,572**	**2,586**
ED Visits	19,309	19,553	19,146	19,131	19,273	19,418	19,571
Ambulatory Surgery	2,414	2,335	2,461	2,677	2,704	2,732	2,761

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Fill in years. In a footnote, identify the period covered by the Applicants' FY (e.g. July 1-June 30, calendar year, etc.).[3]

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[2] The fiscal year for Danbury Hospital is October 1 through September 30.
* The period covered for FY 2010 at Danbury Hospital is from October 1, 2009 through March 30, 2010.
[3] The fiscal year for New Milford Hospital is October 1 through September 30.

* CFY Volume for 2010 for New Milford Hospital is listed in the chart as the projected FY2010 total volume. The volume for the first 5 months of FY2010 (from October 1, 2010 to March 1, 1010) is 1,040.

c. Explain any increases and/or decreases in volume seen in the tables above.

Danbury Health Systems, Inc.: Although Inpatient Discharges have decreased during FY2008 through FY2010, this is attributed to a significant shift in patients to an observation status and recently, in FY2010, to extended stay (See chart below). Overall growth is attributed to growth in programs and services as well as a changing population.

	FY2007	FY2008	FY2009	FY2010
Total Discharges	20,752	20,465	20,499	20,577
Observation Patients	1,257	2,632	2,868	2,983
Extended Stay				504
Total	22,009	23,097	23,367	24,064
Annual Growth		4.9%	1.2%	3.0%

New Milford Hospital: Although Inpatient discharges have decreased during FY 2008 through FY 2010; this is attributed to a significant shift in patients to an observation status and recent loss of market share in FY 2009.

	FY2007	FY2008	FY2009	FY2010
Total Discharges	2,845	3,033	2,774	2,496
Observation Patients	333	384	567	520
Total	3,178	3,417	3,341	3,016
Annual Growth		7.5%	-2.2%	-9.7%

d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

Danbury Hospital.:

Baseline Assumptions:
Inpatient volume: Med/Surg/Peds expected to grow at 1.4% annually while Newborn, Maternity, Psych and Rehab includes a 1% annual increase.

Incremental inpatient volume associated with the project is expected from a reduction in outmigration of Med/Surg. Cases.

Below is a chart that identifies the incremental inpatient volume to Danbury Hospital as a result of the project:

	FY2011	FY2012	FY2013
Med/Surg Discharges	120	140	160

New Milford Hospital:

Baseline assumptions:
Inpatient volume: Medical is expected to grow at 0.9% to 1.0%, Surgical at 0.4% to 0.5%, while Ob/Gyn is (0.8%) and pediatrics is flat, resulting in an average daily census of between 25 and 26 patients. Outpatient services reflect a 0.4% to 1.1% increase.

Incremental volume as a result of the project relates to a 1% growth in market share (due to a projected reduction in out migration) and a 1% growth in outpatient services:

	FY2011	FY2012	FY2013
Inpatient Discharges	54	54	54
ED Visits	142	291	448
Ambulatory Surgery	27	55	85

3. Quality Measures

a. Submit a list of **all** key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

New Milford Hospital

Administration:
Richard J. Henley, FACHE, FHFMA, Interim President and CEO
Dana P. Diggins, Vice President of Finance and CFO
Susan Iovino, BSN, MSN, Executive Vice President COO, CNO
Sally F. Herlihy, MBA, FACHE, Vice President, Regulatory Compliance
Robert D. Sommer, Vice President, Human Resources
Frederick A. Browne, M.D., M.B.A., Chief Medical Officer

Medical Executive Committee:

Henry C. Allen, M.D., FAAFP, President, Medical Staff
Joseph Bargellini, M.D., Medical Director, Radiation Oncology
George B. Barth II, M.D., Chairman, Department of Medicine
Courtney Emerson Chambers, M.D., F.A.C.S., Dept. of Surgery
Andrea Q. Crowley, M.D., Chairman, Department of Diagnostic Radiology
Frank R. Fanella, Jr., M.D., Chairman, Department of Pediatrics
Robert F. Fitton, M.D., Board of Directors, Family Medicine
Evan R. Hack, M.D., Medical Staff: Vice President/President Elect
Thomas J. Koobatian, M.D., Chairman, Department of Emergency Medicine
Michael Levine, M.D., FACC, Director of the Division of Cardiology
John E. Mullen, M.D., Chairman, Orthopedics
Emily R. O'Keiff, D.D.S., M.S., Chairman, Dentistry
Carol S. Papov, M.D., Chairman, OB/GYN
Joan F. Puglia, M.D., Past President

Peasant A. Rodrigues, M.D., Chairman, Department of Pathology
Peter H. Wilson, M.D., FACS, Chairman, Department of Surgery
Edward A. Zane, M.D., Chairman, Department of Anesthesiology

Danbury Health Systems, Inc./Danbury Hospital

Administration

Frank J. Kelly, President and Chief Executive Officer
John M. Murphy, M.D. Executive Vice President
William Roe, Senior Vice President, Chief Financial Officer and Treasurer
Matthew Alan Miller, M.D., FACP Chief Medical Officer
Maureen Donahue, DNP, RN, NEA-BC, Senior Vice President, Patient Care Services & Chief Nurse Executive

Medical Staff

Beth Sandy Aaronson, M.D., Medical Director, Main Street Physical Rehabilitation Center
Raul Arguello, M.D., Chairman of Pediatrics
Alyson Blanck, MSN, RN, NEA-BC, Director, Nursing Practice
Stanford Robert Broder, M.D., Physician Associate, Urology Associates of Danbury, P.C.
Patrick Broderick, M.D., F.A., C.E.P., Chairman, Dept. of Emergency Medicine
Theresa L. Champagne, RN, MSN, CNOR, Clinical Director, Perioperative Services
Neil W. Culligan, M.D., Chief of Neurology

William M. Delaney, M.D., Executive Director, Seifert & Ford Community Health Center
Alan M. Dietzek, M.D., FACS, Chief, Section of Vascular & Endovascular Surgery
Kristy Dixon, Director of Patient Care: Critical Care, Cardiology, Emergency Medicine/Trauma
Gregory Dworkin, M.D., Chief, Pediatric Pulmonology
Halana M. Finnie, MS, PMHCNS-BC, NPP, FNP, Clinical Director, Behavioral Health
Joseph J. Fioito, M.D., Chief, Division of Gastroenterology
Daniel Nelson Fish, M.D., Chief, Section of Orthopaedic Surgery
Tara Franco, RN, BS, MHA, LNC, CNML, Director, Patient Care Services
William James Gemmell, M.D., Vice Chairman, Dept. of Medicine
Charles Herrick, M.D., Chairman, Dept. of Psychiatry
Edward Kevin James, M.D. Chief, Section of Neonatology
Eric Jimenez, M.D., Chief, Medical Information Officer
William D. Johns, Chief of Nuclear Medicine
Andrew M. Keller, M.D., Chief, Cardiology
Jay H. Klarsfeld, M.D., Medical Director, Ridgefield Surgical Center
Robert A. Kloss, M.D., Medical Director, Regional Hospice of Western CT
Ramon N. Kranwinkel, M.D., Chairman, Dept. of Pathology and Laboratory Medicine
Thorsten L. Krebs, M.D., Chairman, Dept. of Radiology
Ann Marie Lavery, Clinical Director, 9 & 10 Tower
Richard J. Lee, M.D., Chief, Division of Allergy & Immunology
David A. Oelberg, M.D., FRCP(C), D, ABSM, Chief, Pulmonary Section
Cary Steven Passik, M.D., Chief, Section of Cardiothoracic Surgery
Pierre Frank Saldinger, M.D. Chair, Dept. of Surgery
Robert R. Savino, D.O., Chief, Dept. of Endocrinology and Metabolism
Gary S. Schleiter, M.D., Chief, Infectious Disease Department
Martin J. Serrins, M.D., Chairman, Dept. of Anesthesiology
Shohreh Shahabi, M.D., Chair, Dept. of Obstetrics & Gynecology
S. Javed Shahid, M.D., Chief of Neurosurgery
David Shapiro, M.D., Section Chief, General Internal Medicine
Winton Y. Shih, M.D., Chief, Nephrology & Hypertension
Lisa Smith, RN, MSN, DNP, Director, Nursing, Education and Research
Mary Sullivan-Shields, RN, BSN, Mobile Admission Co-ordinator
Patricia A. Tietjen, M.D., Chair, Dept. of Medicine
Shawn Tittle, M.D., FACS, FCCP, Chief, Thoracic Surgery
David Trock, M.D., FACP, FACR, Chief, Section of Rheumatology
Lewis C. Trusheim, DMD, MS, Chief, Oral/Maxillofacial Surgery
Mary Zajc, RNC, MSN, Clinical Director, Women's and Children's Services
Keith A. Zuccala, M.D., Chief, Section of General Surgery

The Curriculum Vitae for all of the above individuals are located in **Exhibit 9.**

b. Explain how this proposal contributes to the quality of health care delivery in the region.

This proposal provides for improved access to subspecialty medical services and offers residents additional choices for high quality tertiary services closer to home. The quality outcomes produced by DH which have been nationally recognized will be accessed through a coordinated care system. Other quality improvements include better access for providers and patients alike to research initiatives, more proximate clinical technologies, and access to state of the art information technology. Expanded primary care access through DHS will improve patients' ability to be served in their own communities.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

No changes in payer mix or in the philosophy of rate negotiations are anticipated with this proposal. Multiple variables exist in the current healthcare and economic environment that contribute to uncertainty, however, this proposal offers the opportunity to lower costs and create efficiencies that are ultimately passed on to the consumer. In addition, consumers in the region will have increased choices for medical and surgical subspecialty care and for tertiary hospital services without having to leave the region. Consumers will further benefit from the improvements noted in the response to question 3b. (above.)

Letters of support from elected officials, employers and employees in the region are included in **Exhibit 10**.

4. Organizational and Financial Information

a. Identify the Applicants' ownership type(s) (e.g. Corporation, PC, LLC, etc.).

Both Applicants are corporations.

b. Do the Applicants have non-profit status?
☒ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the each Applicant and indicate any licensure changes related to this proposal.

The hospital licenses are attached as **Exhibit 11**.

d. Financial Statements

i) If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii) If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books).

DH and NMH have filed their most recently completed fiscal year audited statements with OHCA.

e. Submit a final version of all capital expenditures/costs as follows:

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	**$ N/A**
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$ N/A

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

There is no capital cost associated with this proposal.

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

Not Applicable.

5. Patient Population Projections

a. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for each Applicant.

Table 3: Patient Population Mix for Danbury Hospital

	Current FY **	Year 1 FY **	Year 2 FY **	Year 3 FY **
Medicare*	32.2%	32.2%	32.2%	32.2%
Medicaid*	14.5%	14.5%	14.5%	14.5%
CHAMPUS & TriCare	0.0%	0%	0%	0%
Total Government	**46.7%**	**46.7%**	**46.7%**	**46.7%**
Commercial Insurers*	46.3%	46.3%	46.3%	46.3%
Uninsured	6.5%	6.5%	6.5%	6.5%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	**53.3%**	**53.3%**	**53.3%**	**53.3%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided in Table 1.

Table 3: Patient Population Mix for New Milford Hospital

	Current FY **	Year 1 FY **	Year 2 FY **	Year 3 FY **
Medicare*	45.8%	45.8%	45.8%	45.8%
Medicaid*	10.0%	10.0%	10.0%	10.0%
CHAMPUS & TriCare	0.1%	0.1%	0.1%	0.1%
Total Government	**55.9%**	**55.9%**	**55.9%**	**55.9%**
Commercial Insurers*	40.6%	40.6%	40.6%	40.6%
Uninsured	2.8%	2.8%	2.8%	2.8%
Workers Compensation	0.7%	0.7%	0.7%	0.7%
Total Non-Government	**44.1%**	**44.1%**	**44.1%**	**44.1%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided in Table 1.

b. Provide the basis for/assumptions used to project the patient population mix.

Danbury Hospital's Patient Population mix above is based on the FY2010 budget, with no change in mix anticipated or projected.

New Milford Hospital's Patient Population mix above is based on the FY2010 budget, with no change in mix anticipated or projected.

6. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

See **Exhibit 12** for Financial Attachment I with assumptions.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

See **Exhibit 13** for Financial Attachment II with assumptions.

c. Provide the assumptions utilized in developing both **Financial Attachments I & II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

See **Exhibit 12** and **Exhibit 13** for all assumptions utilized in developing the financial attachments

d. Identify whether there will be any changes to billing as a result of the proposal.

There will be no changes in billing as a result of this proposal.

e. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.

There will be no changes to existing reimbursement contracts between the Applicants and the payers.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

There will be no incremental losses from operations that result from the implementation and operation of the CON proposal.

g. Describe how this proposal is cost effective for each applicant, separately.

Danbury Health Systems, Inc.: The proposal is cost effective as it is anticipated to increase patient volume in terms of tertiary care.

New Milford Hospital, Inc.: Overall savings of approximately 2% is anticipated through savings in productivity via economies of scale and supply savings from changes in group purchasing.

By way of further example, set forth below are some of the key areas where both Applicants intend to achieve greater efficiencies:

"*Operating Efficiencies:* The Applicants plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs. Some of the potential areas for centralization of administrative functions are in the areas of facilities and materials management, risk and claims management, finance, legal, compliance, accounting, and human resources to name a few. These initiatives are expected to dominate the initial post approval period.

Clinical Coordination and Efficiencies: The Applicants will consider centralizing certain clinical functions, such as clinical laboratory. In addition, the Applicants recognize that there are numerous opportunities for the development of System-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g., stroke management) and behavioral health. For example, in the case of behavioral health, inadequate reimbursement and lack of community resources are current factors that present challenges for the proper disposition of patients with behavioral health diagnoses.
The applicants believe that through integration, they will be able to pool their resources (i.e. economic and expertise) and engage in more outreach, research and clinical innovation. More generally, the applicants plan to centralize clinically related operations such as: (i) bed management to assure smooth and efficient access to inpatient hospital beds across NEWCO; (ii) medical staff credentialing operations to allow for a single credentialing process across NEWCO; (iii) the therapeutics selection process so that there is uniformity and consistency in the use of medical therapeutics; and (iv) institutional review board operations to allow for increased access to clinical trials on a System-wide basis.

Information Systems: Currently, NMH is faced with a need to update its IT infrastructure. Subject to OHCA and other regulatory approvals relating to this Proposal, NMH plans to obtain its information system services and infrastructure from NEWCO. DHS has proven capability and an established modern IT platform and expertise in the area of information systems. It is expected that the proposed affiliation will allow the NMH to benefit from this expertise along with

an integrated, user-friendly technology interface for its hospital operations and for integrating information technology with its physicians through HealthLink, a health information exchange operated by DHS. In addition to capital avoidance, this integrated information technology will contribute significantly to more coordinated care, a reduction in the duplication of services and costs, less errors and faster and more efficient treatment.

Shared Management Talent: As the DHS expands its integrated model, a certain sector of the senior management team will be accountable to the System as a whole. Hence, each System member will have access to management expertise and professional resources at a more competitive cost than it could as a stand-alone organization, particularly in the areas of finance, planning, education, legal and other executive leadership. Moreover, it is anticipated that the use of outside consultants will be coordinated system-wide to avoid unnecessary duplication or cost.

Shared Knowledge, Research and Teaching Opportunities: By virtue of being a NEWCO member, each participant will have: (i) exposure to valuable clinical information and knowledge exchange; (ii) opportunities to have a more robust role in graduate and undergraduate medical education (already initiated) and (iii) access to translational research, clinical trials, and research infrastructure. All of the forgoing opportunities require significant capital investment and expertise, and by centralizing and coordinating efforts, the Applicants can increase opportunities for all System participants.

Greater Value, Controlled Costs and Innovation: The Applicants are confident that the efficiencies described above will result in reduced overhead and lower costs. Moreover, the opportunities for knowledge exchange will stimulate more ideas and innovation flow all of which will yield innovations and improvements in service delivery.

h. Describe detail, cost savings that will result as a direct result of the proposed affiliation/merger for each of the Applicants involved. Provide specific examples and supporting documentation.

Savings that are anticipated to be achieved include the following:

a. Management Savings achieved by having a single centralized management team;
b. Productivity Improvements in back office functions such as Patient Accounting, Human Resources and Purchasing
c. Medical supply costs – savings anticipated through larger purchasing base
d. Malpractice Insurance

In addition, please see the answer to Question 7.b.

7. Other Review Criteria

a. Describe the proposal's relationship to each of the Applicant's long-range plans. Provide supporting documentation.

Danbury Hospital: As described in section 1.b., this application supports DHS's long range plans to develop a regional approach to delivering tertiary health care services to our region. Further planning for prudent integration of services across the shared service areas will position both hospitals for future changes supported by health care reform and they need to develop continuous patient care models to improve quality care efficiently.

New Milford Hospital:

As highlighted in response to Question 1.b above, there was concerted effort during 2007 and 2008 to develop a new strategic plan and identify priorities to position NMH for growth and success in an increasingly competitive and resource constrained environment. Affiliation with other providers was a potential opportunity identified through discussion with focus groups of internal and external constituents (including the medical staff), and active involvement of the senior management team and Board Planning Committee.

The Strategic Plan was adopted by its Board of Directors October 24, 2008 and included the following:

> Goal: Infrastructure Development - Make targeted investments in facilities, technology and programs based on review of infrastructure requirements and to advance and maintain clinical excellence, consistent with strategic goals.
>
> Strategy: Explore Regional Collaboration and network relationships to facilitate development of mutually beneficial service-specific strategic partnerships.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.

i. Voluntary efforts to improve productivity and contain costs;

Applicants have taken numerous steps to contain costs through such efforts as Lean6/Sigma, productivity benchmarking, use of evidence-based medical practices, group purchasing, and containment of discretionary expenses. In addition, NMH has taken steps recently to freeze salary increases and to modify benefits.

The Applicants also intend to improve productivity and contain costs by developing economies in operations, establishing evidence-based quality decisions on services and care protocols, and developing an integrated plan that allows both organizations to address the needs in the greater region without the unnecessary duplication in services that has characterized the past. Initially, the hospitals will concentrate on administrative services which will not directly impact patient access to services, but which do provide opportunities for increased efficiencies.

- In 2011, applicants will initiate integration of various "back office" functions.
- Efforts will be undertaken to integrate NMH into DH's IT system for creating an integrated electronic medical record ("EMR") at a far lower cost than NMH could achieve on its own. Currently, DH operates an electronic Health Information Exchange called HealthLink which enables the hospital to link with other providers through a web-based architecture. NMH will obtain access to the IT expertise and systems currently in place at DH, accelerating its adoption of an EMR and creating seamless information access and connectivity among all entities for optimal clinical quality and operational efficiency.
- Future integrated planning will eliminate redundancies in capital and operational spends and will allow each hospital to pursue and strengthen its core services.

It is anticipated that other opportunities will arise through ongoing reviews.

ii. Changes to the Applicant's teaching or research responsibilities; and/or

DH is engaged in various research initiatives, from basic science to translational research. DH will extend its research capabilities by creating a research center at NMH. In addition, the programs at DH (NSQIP, Lyme registry, etc) will be made available to NMH physicians and patients creating opportunities for greater involvement and collaboration.

iii. Special characteristics of the Applicant's patient or physician mix.

It is not expected that there will be a change in the characteristics of the Applicants' patient or physician mix at the outset. To the extent that some patient services are consolidated at one hospital or the other in the future, there may be a slight change in both patient and physician mix. However, all services now available are expected to remain available at either of the Applicants' hospitals.

OHCA Docket No. 10-31560

Affiliation of Danbury Health Systems, Inc.
And New Milford Hospital, Inc.

List of Exhibits

1. Letter of Intent for Corporate Affiliation between Danbury Health Systems, Inc. And New Milford Hospital, Inc. dated February 8, 2010 .... .p. 32

2. State of Connecticut, "Hospital System Strategic Task Force Report, Findings and Recommendations", June 8, 2008 ....p. 41

3. New Milford Hospital and Danbury Hospital Quality Recognition Awards ....p. 73

4. List of Medical Staff Meetings: Danbury Hospital and New Milford Hospital ...p. 76

5. List of Hospital Meetings with Core Groups and Constituents and Summary of Focus Group Sessions, May 10-11, 2010 ....p. 78

6. Corporate Organizational Charts ....p. 81

7. Composition of Boards of Directors ....p. 85

8. Affiliation Agreement By and Between Danbury Health Systems, Inc. and New Milford Hospital, Inc. ....p. 92

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11. License for New Milford Hospital and License for Danbury Hospital ....p. 311

12. Financial Attachments I ....p. 314

13. Financial Attachments II ....p. 322

Exhibit 1

DANBURY HEALTH SYSTEMS

February 8, 2010

Mr. Richard Henley
Interim President & CEO
New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

Dear Mr. Henley:

Re: **Letter of Intent for Corporate Affiliation**

This letter of intent (this "Letter") sets forth a non-binding agreement in principle between Danbury Health Systems, Inc., a Connecticut nonprofit corporation ("DHS"), and New Milford Hospital, Inc., a Connecticut nonprofit corporation ("NMH"), covering certain of the terms and conditions of the proposed transaction (the "Proposed Transaction") pursuant to which DHS will be renamed to "Newco" (temporary name) and Newco will become the sole Member (the "Member"), as that term is applied under the provisions of Connecticut Nonstock Corporation Act, of NMH, and will continue to be the sole member of The Danbury Hospital ("DH") and the sole member or controlling shareholder of DH's affiliated entities. DHS and NMH may be referred to herein individually as a "Party" and collectively as the "Parties." The Parties believe that the transactions contemplated by this Letter will, among other things, create an integrated health care delivery system capable of bringing best practices in health care delivery to enhance the health and well being of the residents within the region of Western Connecticut and eastern New York State. This vision will be accomplished through optimizing resources, financial vitality of the Parties, highest caliber of experience, one board vision through one management team, optimizing and standardizing of the Parties multiple parts and one integrated standard of care.

Subject to performance of due diligence by both Parties and to the terms of a definitive agreement (the "Definitive Agreement"), certain of the principal terms and conditions of the Proposed Transaction are as follows:

1. **Structure of Proposed Transaction**.

(a) Membership/Ultimate Parent. The Proposed Transaction shall be structured and concluded in form and substance mutually agreeable to DHS and NMH and will result in Newco becoming the sole Member of the NMH. The Parties intend that by the Proposed Transaction Newco will continue to be the sole member of DH and the sole member or controlling shareholder of DH's affiliated entities, and also become the parent corporation for all those corporations for which NMH currently serves as sole or controlling member or shareholder ("the NMH Entities"), including but not limited to NMH, New Milford Visiting Nurse Association, New Milford Visiting Nurse Association Foundation, and New Milford Hospital

Foundation, Inc.. Unless otherwise agreed to by the Parties, each of the NMH Entities will become an affiliate of Newco and thus a part of the Newco System. DHS shall change its name to better reflect the regional market that it serves (used here as Newco). The name will be determined by the mutual agreement of the Parties in the Definitive Agreements.

(b) NMH Board Operations. From and after the Closing, NMH and DH shall continue in existence as Connecticut nonprofit corporations, each of which is exempt from taxation under IRC Section 501(c)(3), with full power and authority to govern and manage its assets, subject to reserved powers maintained by Newco.

(c) Corporate Governance. Upon the Closing, the Parties will amend their articles of incorporation and bylaws to effect the following changes to their respective corporate governance structures:

(i) The Newco Board of Directors shall replace the existing NMH Board of Directors and shall serve as the Board of Directors of NMH.

(ii) The Newco Board of Directors will establish a NMH Community Board consisting of up to twelve (12) members. The responsibilities of the NMH Community Board will include serving as a liaison with the community served by NMH, and other duties as agreed by the Parties in the Definitive Agreements. The initial members of the NMH Community Board of Directors shall be determined by NMH in consultation with Newco and will be documented in the Definitive Agreements. Members of the NMH Community Board shall be eligible for service on committees of the Newco Board. Three years after Closing and periodically thereafter, the Parties shall determine whether the NMH Community Board is achieving its objectives and whether to continue the NMH Community Board.

(iii) Upon Closing, Newco will include in its Board of Directors four (4) voting members from the newly appointed NMH Community Board. Note: It is suggested that at least one member shall serve on Newco's Governance Committee. The initial terms of these directors will be consistent with the bylaws of Newco. Thereafter, Newco Board of Directors shall be self-perpetuating, consistent with its bylaws.

(d) Reserved Powers. Upon the Closing, Newco shall hold such reserved and related powers with respect to the governance and operations of NMH as may be agreed upon by the parties in the Definitive Agreements. Similar to DHS's authority with respect to all of its existing subsidiary organizations ("DHS Entities"), Newco's authority with respect to the NMH Entities will incorporate "powers of initiation" or similar directive powers in the Newco Board to specifically direct certain action to be taken at the NMH Entities.

(e) New Milford Foundation. Subsequent to the Closing Date, New Milford Foundation, a Connecticut nonprofit corporation ("Foundation"), shall remain in existence as a Connecticut nonprofit corporation that is exempt from federal income tax under Section 501(c)(3) of the Code and its corporate purposes shall remain to raise funds and make grants to support the inpatient, outpatient and other hospital or community-based activities and projects of New Milford Hospital. The principal role and responsibilities of the Foundation Board shall be

the local direction, supervision and guidance for Foundation's fundraising and support activities, the oversight and review of Foundation's finances and operations, the review and approval of Foundation's operating and capital budgets, and such other matters as may be related to the direction and supervision of Foundation's fundraising and support activities. All grants or funds received by a NMH Entity, shall belong to or be the property of such NMH Entity. Prior to Closing, the current Foundation Board of Directors will be terminated and at Closing, a new Foundation Board of Directors will be established by NMH in consultation with DHS. Subsequent to the Closing Date, Newco will also provide support and counsel to the Foundation's operations and planned giving efforts.

2. **Operations**.

(a) Management. Initially, Newco, Danbury Hospital and NMH will be managed by a single management team. The management team will be determined by the mutual agreement of the Parties and documented in the Definitive Agreements.

(b) No Change In Employment Status. New Milford Hospital Employees (*i.e.*, employees of any New Milford Entity as of the Closing Date) will remain employees of the same New Milford Entities after the Closing Date. All current New Milford Employee policies, promises, commitments and benefit plans disclosed to DHS will remain in effect after the Closing Date until the same are amended, modified, replaced or terminated in accordance with the provisions of those policies, promises, commitments, and benefit plans and as governed by applicable law. New Milford Employees shall receive full recognition/credit for current employment experience with any New Milford Entity as being continuous under the affiliation for purposes of seniority recognition, benefits eligibility and accruals, vesting of benefits, *etc.* The foregoing commitments are subject to performance of due diligence to the satisfaction of Newco, and applicable requirements of law and of the involved plans.

(c) Medical Staff. The Closing will not impact or change the medical staff appointment or clinical privileges of members of the medical staff of NMH on the Closing Date. The NMH medical staff shall remain independent of the medical staff of Danbury Hospital. It is the parties intention that NMH's medical staff bylaws, rules and regulations and credentialing procedures will be amended so that they are consistent with Danbury Hospital's medical staff bylaws, rules and regulations, and credentialing procedures. From and after the Closing, Newco and NMH shall work with the medical staffs to evaluate and where feasible pursue opportunities for medical staff/clinical integration where doing so offers opportunities for advancement in quality and cost-effectiveness of care.

(d) Clinical Services. The Parties have considered the potential range of clinical services that can be made available through DHS affiliates and the NMH Entities should the Proposed Transaction close. These services are attached herein as Appendix A.

3. **Integration Planning Committee**. Following the execution of this Letter when deemed appropriate by both Parties and their counsel, DHS and NMH shall meet to form an integration planning committee. The committee will seek appropriate antitrust counseling.

4. **Consummation of the Transactions**.

(a) Due Diligence. Immediately following acceptance of this Letter, the Parties and their financial advisor shall develop a due diligence plan and, consistent with such plans, permit the other Party and its employees, lenders, financial advisors, attorneys, accountants and other authorized representatives, reasonable access to its premises, employees, accountants, and books and records to complete such due diligence investigations customary for transactions of this nature. Each Party shall cause all requested due diligence documents and information to be delivered to the other promptly. All inspections will only occur at times and in a manner as will not disrupt the delivery of care to patients.

(b) Definitive Agreement. The Parties will commence good faith negotiations to develop a mutually acceptable Definitive Agreement embodying the terms contained herein, terms normal and customary in a transaction of this type, and such other terms as they may agree upon, including, without limitation, provision for allocation of expenses.

(c) Time Line. The Parties and their financial advisor shall promptly following the execution of this Letter agree upon a time for completion of major milestones necessary to expeditiously close the transaction described herein. It is the parties intention to complete this transaction by September 30, 2010.

(d) Closing and Conditions. The consummation and closing of all the Proposed Transaction (the "Closing") shall occur at such place and on such date to which the Parties shall mutually agree in the Definitive Agreement (the "Closing Date"). NMH and DHS agree that the consummation of the Proposed Transaction is expressly conditioned upon customary closing conditions, including: (i) delivery of appropriate legal opinions; (ii) the satisfactory completion of due diligence by both Parties; (iii) the receipt of all necessary third party consents and governmental approvals, including the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act, if applicable, and the obtaining of certificate of need approvals from the CT Office of Health Care Access; (iv) the obtaining of all necessary board and member approvals, including the approvals of the boards and members of NMH and DHS; and (v) satisfaction of such other closing conditions as may be set forth in the Definitive Agreement.

5. **Term and Termination of Letter**.

(a) Term. The term of this Letter shall commence on the date of execution by both parties, and continue in full force and effect until the earlier of: (i) the date on which it is superseded by the Definitive Agreement; (ii) the date of termination pursuant to paragraph 6(b); or (iii) September 30, 2010, which expiration date may be extended by mutual agreement of the Parties.

(b) Termination of Letter. This Letter may be terminated, by either Party or by the mutual agreement of the Parties, at any time, with or without cause, without any obligation or liability, except for the obligations of the Parties under paragraphs 5, 6, 8, and 11 through and including 16. Notice of any such termination shall be provided in writing to the signatories to this Letter.

6. **Confidentiality; Disclosure**. DHS and NMH agree to keep this Letter and its contents confidential and not disclose the same to any third party without the written consent of the other Party, except as required by law and to (a) consultants, attorneys or accountants hired by them, (b) the applicable governmental or non-governmental agencies in connection with any required notification or application for a license, permit, accreditation or approval or exemption therefrom, and (c) such other third parties whose consent or approval is legally or contractually required to effect the Proposed Transaction. With respect to the information provided to each other in connection with the Proposed Transaction, each Party agrees that: (i) it will keep all such information confidential that is not in the public domain; (ii) it will exercise the same care in handling such information as it would exercise with similar information of its own; (iii) it will restrict access to such information in accordance with guidelines developed by antitrust counsel; (iv) it will not use such information for any business purpose unconnected with the Proposed Transaction; and (v) if requested, it will return any such written information to the other Party in the event negotiations are not pursued.

7. **Public Announcement**. DHS and NMH shall consult with each other before issuing or making any public announcements, reports, statements or releases with respect to this Letter or the Proposed Transaction, and shall use good faith efforts to obtain each other's approval of the text of any public announcement, report, statement or release to be made on behalf of such Party. If a Party is unable to obtain the approval of its public announcement, statement or release from the other Party and such announcement, statement or release is, in the opinion of legal counsel, required to discharge the Party's legal obligations, then such Party may make or issue the legally required announcement, statement or release and shall promptly furnish the other Party with a copy thereof.

8. **Exclusivity**. During the term of this Letter, the Parties shall negotiate only with each other, and neither Party shall solicit, entertain, support or accept any inquiry, proposal or offer from any other Party regarding the sale, conveyance, transfer, lease, membership substitution, merger or other similar transaction involving the assets directly or indirectly owned or controlled by that Party (without the approval of the other Party) contemplated by this Letter to be subject to the Proposed Transaction. NMH and DHS each shall promptly notify the other of any such inquiries, proposals or offers.

9. **Good Faith**. The Parties agree to cooperate and negotiate in good faith with respect to execution of the Definitive Agreement, but each Party reserves the right of final approval or disapproval, for any reason, of the Definitive Agreement.

10. **Non-binding Effect; No Contract**. It is expressly understood that this Letter, except for paragraphs 6, 8, and 11 through and including 16, which are binding on the Parties, is not a contract and that no Party shall be entitled to any recourse, in the form of damages, or otherwise, for expenses incurred or benefits conferred or lost before or after the date of this Letter in the event that there is a failure, for any reason, of the Parties to agree to the Definitive Agreement, except for paragraphs 6, 8, and 11 through and including 16.

11. **Amendments**. This Letter may not be amended in whole or in part except by a written instrument signed by the Parties.

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12. **Waiver**. No waiver of any binding provision, condition or covenant of this Letter shall be effective as against the waiving Party unless such waiver is in writing and signed by the waiving Party.

13. **Severability**. If any covenant or provision hereof, which is binding on the parties, is determined to be void or unenforceable in whole or in part, it shall not be deemed to affect or impair the validity of any other binding covenant or provision, each of which shall be separate and distinct. If any binding provision of this Letter is so broad as to be unenforceable, such provision shall be interpreted to be only so broad as is enforceable. If any binding provision of this Letter is declared invalid or unenforceable for any reason other than overbreadth, the offending provision will be modified so as to maintain the essential benefits of the bargain between the Parties to the maximum extent possible, consistent with law and public policy.

14. **Headings**. The division of this Letter into sections and the insertion of headings are for convenience of reference only and shall not affect the construction or interpretation of this Letter.

15. **Governing Law**. This Letter shall be governed by and construed in accordance with the internal substantive laws of the State of Connecticut without regard to conflict of interest principles. The Parties agree to submit to the jurisdiction of Connecticut courts to resolve any disputes which may arise from or as a result of this Letter, with venue in Fairfield County, Connecticut.

16. **Third Party Beneficiary**. None of the provisions contained in this Letter are intended by the parties, nor shall they be deemed, to confer any benefit on any person not a party to this Letter, except as otherwise expressly provided herein.

If you are in agreement with the terms of this Letter, please sign two originals and deliver them to us. This Letter may be executed in two counterparts, each of which shall be deemed to be an original and both of which taken together shall constitute one and the same instrument.

Sincerely,

DANBURY HEALTH SYSTEMS, INC.

By: [Name]
Title: Chairman, Board of Directors

Accepted and agreed to this
15th day of February, 2010.

NEW MILFORD HOSPITAL, INC.

By: [James E. Preston]
Title: Chairman, Board of Directors

Appendix A

Danbury Hospital
Serve as the primary provider of most tertiary and inpatient care to the Western CT Region

Inpatient Services
- Intensive and Cardiovascular Care Units
- Adult and Pediatric Medical/ Surgical Units
- Obstetrical Unit with NICU
- High Acuity Rehabilitation Unit
- Behavioral Health/Psychiatry

Ancillary Services
- Level II Emergency Department
- Surgical Services
- Medical Imaging
- Praxair Regional Heart and Vascular Center
- Praxair Cancer Center
- Center for Advanced Orthopedic and Spine Care
- Women and Children's Service
- System-wide Reference Lab

Physician Services
- Distributed locations of primary and specialty physicians (DOPS and independent)

New Milford Hospital
Provider of basic inpatient and extended-stay outpatient services in its service area

Inpatient Services
- Adult Medical/ Surgical Unit
- ICU/ Stepdown/ acuity adaptable unit
- Family Birthing Center
- Low Acuity Rehabilitation (pending space)

Ancillary Services
- 24-hour Emergency Department
- Surgical Services
- Medical Imaging
- Cardiovascular screening/ diagnostics and clinics
- Regional Cancer Center
- OP Neurodiagnostics and other specialty clinics
- Expanded women's health and wellness programs
- Phase 1 Research Center office

Physician Services
- Increased availability of currently unavailable specialists in community from Danbury, as needed (Nephrology, Dermatology, Endocrinology)
- Distributed locations of primary and specialty physicians (DOPS and independent)

Exhibit 2

State of Connecticut

Hospital System Strategic Task Force Report

Findings and Recommendations

January 8, 2008

Co-chairs:

Robert Genuario, Secretary
Office of Policy and Management

Cristine Vogel, Commissioner
Office of Health Care Access

Task Force Members

Governor Rell appointed the following individuals to the Hospital System Strategic Task Force:

Co-Chairs:

Robert L. Genuario
Secretary, Office of Policy & Management

Cristine A. Vogel
Commissioner, Office of Health Care Access

Members:

Evelyn Barnum, *Chief Executive Officer, Connecticut Primary Care Association*

Polly T. Barey RN, MS, *Executive Director, Connecticut Nurses Association*

Arthur W. Brodeur, *Chair, Planning Committee, Windham Hospital*

David Cappiello, *State Senator, 24th District*

Christopher Dadlez, *President/CEO, St. Francis Hospital & Medical Center*

Kevin M. DelGobbo, *State Representative, 70th District*

J. Robert Galvin, MD, MPH, *Commissioner, Department of Public Health*

Richard Gray, *Executive Director, Connecticut Health & Educational Facilities Authority*

Toni Nathaniel Harp, *State Senator, 10th District*

Jennifer Jackson, *President & Chief Executive Officer, Connecticut Hospital Association*

Matthew Katz, *Executive Director, Connecticut State Medical Society*

Thomas Kirk, Jr., PhD, *Commissioner, Department of Mental Health & Addiction Services*

Paul E. Knag, Esq., *Murtha Cullina LLP*

Kevin Lembo, *Executive Director, Office of Healthcare Advocate*

Lawrence Levine, MD, FACEP, *President, Connecticut College of Emergency Physicians*

Denise W. Merrill, *State Representative, 54th District*

Timothy Meyer, *President, Connecticut Association of Health Plans*

Kevin Murphy, *Senior Vice President, Finance/CFO, Eastern Connecticut Health Network, Inc.*

Mary Anne O'Neill, *Associate Legal Counsel, Office of the Governor*

John Rathgeber, *President, Connecticut Business & Industry Association*

Michael Starkowski, *Commissioner, Department of Social Services*

Robert Trefry, *President/CEO, Bridgeport Hospital*

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Foreword

Concerned about the condition of Connecticut hospitals and Connecticut residents' access to health care, in April 2007, Governor M. Jodi Rell announced the formation of a task force (Appendix A) to develop strategies to stabilize and chart the future course of hospitals in Connecticut, many of which are facing financial hardship. Governor Rell appointed Robert L. Genuario, Secretary of the Office of Policy and Management (OPM), and Cristine A. Vogel, Commissioner of the Office of Health Care Access (OHCA), to chair the Hospital System Strategic Task Force. Task Force members included state agency commissioners, legislators, and individuals representing hospitals, the business community, community health clinics, consumer advocates, primary care providers, physicians, emergency department physicians, nurses, and insurance companies (Appendix B). The Task Force organized itself into three subcommittees to address the major issues facing hospitals: Finance, Utilization and Planning, and Workforce. In addition to input from Task Force members, on November 13, 2007, the Task Force held a public hearing to encourage feedback in response to preliminary recommendations made by the Task Force subcommittees.

The Governor requested that the Task Force examine the current financial health of Connecticut's hospitals, access to care, emergency room utilization, affordability, alternative delivery of primary care and the 'Certificate of Need' process.

The Task Force is part of Governor Rell's broader effort to ensure that all residents of Connecticut have access to quality, affordable health care. In December of 2006, the Governor announced her Charter Oak Health Care benefit plan, which is expected to provide low-cost health insurance to single people and families who cannot currently afford private insurance. The plan – targeted at lower income people, newly graduated college students, and self-employed people, many of whom may not have access to employer-sponsored health insurance and do not qualify for programs such as HUSKY or Medicaid – is intended to provide health insurance for about $250 a month, and includes state subsidies. In addition, Governor Rell has strongly supported Bond Commission funding for expansion and equipment at community health centers, announcing in September 2006 nearly $26 million for expanded medical and dental facilities in communities all across the state, enabling the centers to serve some 85,000 additional new patients.

This report of the Governor's Task Force builds upon the work completed by the Legislative Program Review and Investigations Committee and the action taken by the Administration and Legislature in the 2008–2009 biennium budgets to increase Medicaid funding for hospitals. The goal of this report is to provide recommendations that will further stabilize the health care delivery system in Connecticut as it explores serious workforce challenges, access limitations and some fundamental financial structural issues.

I. Highlights of the Task Force

Health care has changed significantly in recent years from hospital-based to outpatient-based services. More diagnostic and treatment procedures are provided to patients from an office or freestanding facility instead of a hospital. Hospitals, however, have remained cornerstones in their communities both as health care providers and as a safety net for patients who may not have access to the outpatient options due to facilities' suburban locations or patients' insurance status. The role as safety net provider, combined with escalating costs, has financially stressed many hospitals. In hospital Fiscal Year (FY) 2006 (covering the period October 1, 2005 through September 30, 2006), the average statewide hospital total margin was reported at 2.51% and the average statewide hospital operating margin was 0.62%. This low operating margin indicates that hospitals' patient revenue and expenses are practically breaking even. This report, and the recommendations that follow, focus mainly on the hospital delivery system of care and offer some short and long-term strategies to sustain the financial viability of the hospital system.

Due to the complexity of the subject, three task force subcommittees were formed to focus on specific areas of concern: (1) system-wide utilization and planning, (2) workforce issues, and (3) financial structure. The Task Force received recommendations from each subcommittee, from which several themes emerged:

- Connecticut has a relatively strong employer-sponsored health insurance coverage population that could be jeopardized if premiums continue to increase, which may in turn lead to fewer people having coverage.
- Ongoing cost increases, coupled with low reimbursement, have resulted in financial instability for many of Connecticut's hospitals.
- The economic pressure to make up for low operating margins by focusing on the highest-paying reimbursement sources (typically commercial insurance) leads to overlap in services and competition among hospitals for the services they provide.
- Emergency departments continue to experience an increase in volume of non-emergent cases more than likely related to a lack of access to primary care services.
- Emergency departments continue to struggle to provide appropriate and timely access for persons with psychiatric and/or substance abuse disorders (i.e., behavioral health patients in need of diversion or step-down to inpatient, residential, outpatient or other levels of care).
- Cost shifting from government-sponsored programs to private/commercial payers due to relatively low reimbursement rates from the former is unsustainable for both commercial payers as well as hospitals.
- The shortage of health care professionals (e.g., physicians, nurses, and allied health) limits access to primary care, medical specialties and exacerbates emergency department "on-call" coverage pressures.
- The fragile financial stability of many Connecticut hospitals is directly impacting their ability to obtain capital funding in order to provide modern facilities and keep pace with changing technology and patient and workforce safety.

There is no single solution to ensure hospital financial viability, but a combination of strategies will need to be applied before success can be realized. Connecticut has a strong health care delivery system that provides excellent care; this report focuses on the areas of weakness within the system and provides robust recommendations that should have a lasting impact.

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II. Discussion of the Connecticut Hospital System

A. Overview of Connecticut Hospitals

Utilization, payer mix and competition are among the key factors that determine the financial strength of a hospital. Utilization is a measure of demand for health care services and directly impacts the revenue stream. Hospitals develop their budget projections using historical utilization measures and the reimbursement that will be received based on the payer source. The payer sources are generally grouped into five major categories: Medicare, Medicaid, commercial/private payers, the "uninsured," and "other" public programs. A hospital charges the same amount for a service to all patients, but what a hospital receives in payment for that service varies among payers. Competition enters into the financial condition of a hospital as they directly market and advertise for the most profitable patients and the most qualified professional staff.

Competition in the health care marketplace has changed. Hospitals compete for patients that require the more profitable services, such as elective angioplasty, specialized diagnostic technology for cancer care, inpatient orthopedic surgery and outpatient imaging and surgery. The nature of competition has also changed. Not only do the hospitals compete against other hospitals, but they also compete against privately-owned, free-standing facilities. Although Connecticut's Certificate of Need program may have slowed the growth and proliferation of such private outpatient facilities in comparison to other states, it is of great concern to hospitals because, unlike private outpatient facilities, hospitals must provide care to all patients regardless of insurance status and provide continuous emergency access. The shift in hospital payer mix attributable to the influx of privately-owned, free-standing facilities may hinder hospitals' ability to reinvest in their facilities and the health of the communities they serve.

The Task Force discussed the impact these issues have on the hospitals' bottom-line, and the report provides recommendations that specifically address these issues. Additional appendices have been included in this document for reference purposes.

B. Utilization of health care services

The Connecticut hospital system consists of 30 acute care hospitals (29 acute general hospitals and one children's hospital) totaling 9,256 licensed beds, with 7,231 of these beds staffed for patient care. Each hospital operates an Emergency Department 24 hours per day, seven days a week with an additional five emergency departments considered satellite facilities to the hospital (Appendices C and D). In FY 2006, there were 424,475 discharges from hospital inpatient services and 1.4 million hospital emergency department visits. It is important to note that statewide, inpatient staffed beds were occupied 78% in FY 2006, however, there are differences among individual hospitals. For example, New Milford Hospital is at 47% while Norwalk Hospital is at 98% occupancy.[1] This indicates that the demand for inpatient services is different throughout the state, and with such variation general statewide assumptions may be misleading. Many hospitals which are at or near capacity of their staffed beds have additional licensed beds that could be used to alleviate crowding within the emergency department. However, there are multiple issues to overcome before these beds can be added to the existing system including: staffing shortages, lack of space to bring the beds into operation and the capital costs associated with adding beds due to high construction/renovations costs.

The number of inpatient discharges has been increasing slightly from 416,300 in 2004 to 424,475 in 2006. Along with increases in discharges, the number of staffed inpatient beds has also increased from 7,182 to 7,231 in the same period. Full time equivalents (FTEs) for the same timeframe have increased from 45,741 to 47,524. However, when comparing number of discharges with the population, the utilization rate has declined overall, as shown in Table 1. In FY 2004, the number of discharges per 1,000 population was 123 while in FY 2006 it was reported at 121 discharges per 1,000 population.

Table 1: Inpatient Acute Care Utilization Rate for CT Discharges, FYs 2004-2006

	FY 2006	FY 2005	FY 2004
Discharges	424,475	423,179	416,300
CT Population	3,504,809	3,394,751	3,389,483
Utilization Rate (discharges/1,000 population)	121	125	123

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database and U.S. Census Bureau 2004-2006 Population Estimates

With the nearly 2% increase in inpatient discharges from 2004 to 2006, the hospitals with the largest three-year percent increases in total discharges were Johnson (+16%), Hospital of Central Connecticut (formerly New Britain) (+13%) and MidState (+9%). Hospitals with the largest three-year percent decreases were Day Kimball (-12%), Rockville General (-10%) and Backus (-8%). As shown in Table 2, a wide variation in inpatient utilization exists and issues of demand and capacity are regional (if not local) and are not statewide.

Table 2: Connecticut Acute Care Discharges, FYs 2004 & 2006

Hospitals	Discharges		Change	
	FY 2004	FY 2006	#	%
Bradley Memorial **	2,319	2,369	50	2
Bridgeport Hospital	20,091	19,582	-509	-3
Bristol Hospital	8,357	7,954	-403	-5
Charlotte Hungerford	6,304	6,195	-109	-2
Connecticut Children's Medical Center	5,498	5,615	117	2
Danbury	19,522	20,403	881	5
Day Kimball	6,475	5,668	-807	-12
Essent-Sharon	3,040	2,880	-160	-5
Greenwich	11,391	12,348	957	8
Griffin	7,341	7,430	89	1
Hartford	37,734	39,490	1,756	5
Hospital of Saint Raphael	25,378	25,354	-24	0
John Dempsey	9,556	9,923	367	4
Johnson Memorial	3,624	4,212	588	16
Lawrence and Memorial	14,869	14,696	-173	-1
Manchester Memorial	8,668	8,958	290	3
Middlesex Memorial	12,089	12,866	777	6
MidState Medical Center	9,038	9,812	774	9
Milford Hospital	5,058	4,971	-87	-2
New Britain General**	16,663	18,623	1,960	12
New Milford	3,316	3,116	-200	-6
Norwalk	15,945	15,341	-604	-4
Rockville General	4,017	3,600	-417	-10
Saint Francis	32,527	31,647	-880	-3
Saint Mary's	12,069	12,984	915	8
Saint Vincent's Medical Center	19,182	19,672	490	3
Stamford	17,231	17,003	-228	-1
Waterbury	15,027	15,003	-24	0
William W. Backus	11,923	11,021	-902	-8
Windham Community Memorial	5,091	5,385	294	6
Yale-New Haven	46,957	50,354	3,397	7
Statewide	**416,300**	**424,475**	**8,175**	**2**

Source: CT Office of Health Care Access Acute Care Hospitals Discharge Database

** Effective 10/1/2007, the two hospitals merged to become the Hospital of Central Connecticut.

System capacity is generally measured by the number of inpatient beds. When compared with the population to determine a "use rate," Connecticut is below the national average with 2 hospital beds per 1,000 population versus the national average of 3 beds per 1,000 population.[2] Given such a difference, a review to identify the specific contributors and what interventions will be implemented should be completed.

Connecticut's hospitals serve as the safety net, caring for all patients regardless of their ability to pay. In Connecticut, like the nation, emergency departments (ED) are experiencing an overall trend of increased utilization. A small portion of the increase is due to population growth, while a larger percentage is attributable to more frequent use. In FY 2005, there were 1.4 million visits

to Connecticut EDs. For every 1,000 Connecticut residents there were 415 ED visits in FY 2005. This is higher than the national use rate of 387 per 1,000 population.[3] This ED use rate also changes significantly depending upon the hospital and the payer source. For instance, according to Connecticut Hospital Association (CHA) data, privately insured patients seek care at an ED at a rate of 250 visits per 1,000 population as compared to State-Administrated General Assistance (SAGA) patients at 1,578 visits per 1,000 population (Table 3).

Table 3: ED Utilization Rates by Payer Category, FY 2006

Payer Category	# visits/1,000 population
Privately Insured	250
Uninsured Patients	455
Medicare	615
Medicaid Managed Care	791
Medicaid FFS	1,092
SAGA	1,578

Source: *Connecticut Hospital Association*

The Task Force focused on the volume of primary care visits as a major contributor to ED "over-utilization." According to CHA, nearly one quarter, or just under 1,000 ED patients, are treated for non-urgent care on a daily basis. CHA also reported that Medicaid patients are four times more likely and the uninsured are two times more likely than the privately insured to visit the emergency department for non-urgent care. This care could be more appropriately provided in more cost effective settings such as a physician's office or a medical clinic, which would improve the continuity of care since EDs are organized to deliver acute and episodic care, not to address disease management or prevention. The demand for primary care is not adequately being met elsewhere, and consequently hospitals are experiencing noticeable increases in demand for this service, especially during evening hours and on weekends. Some of our larger urban hospitals reported that on an evening shift between 3:00 p.m. and 11:00 p.m., there are approximately 30 patients daily that could have been seen in a clinic or a physician's office.

Connecticut is mirroring a national trend, where more people are becoming dependent on the emergency departments for their primary care. Some reasons patients are choosing the ED for non-urgent care include the shortage of primary care physicians, limited evening and weekend hours in private offices and the convenience of not needing an appointment to receive care. High ED utilization by the Medicaid population is also attributable to the decreased number of primary care physicians accepting Medicaid patients due to the state's low reimbursement rates and administrative difficulties; lack of information regarding the assignment of a primary care physician; and the overflow from Federally Qualified Health Centers (FQHC) due to lack of expanded hours and specialty services. The FQHCs could play a larger role in the care of these patients but they have limited evening and weekend hours during the period of highest utilization and often do not have specialists on staff. Although some FQHCs may be less accessible to the Medicaid population in some areas of the state (see Appendix E), concerted efforts may be needed to educate and direct patients to these facilities before they turn to emergency departments for their primary health care needs. As the demand for primary care continues to increase, the State should examine the number and locations of services and address redirecting non-urgent care from the emergency departments to more appropriate and cost effective settings.

Increased patient wait times are further exacerbated by a shortage of emergency department nurses and "on-call" physician specialists. It is not uncommon for a patient to wait up to two

hours for a specialist to arrive (e.g., a hand surgeon). In prior years, hospitals required physicians to provide a number of hours of on-call coverage, but due to a shortage of physicians, medical liability issues, competition among hospitals and physicians making "quality of life" choices, some physicians are now paid for "on-call" hours -- an additional cost to hospitals. Hospitals are also faced with the difficult challenge of recruiting and retaining nurses in high demand clinical areas such as the emergency department. Nurses in these settings are particularly challenged by high utilization and staffing shortages, complex patients with behavioral health and substance abuse needs, difficult patients who are violent or suicidal, and patients recently released from state prisons. The state contracts with the University of Connecticut to provide health care for inmates, but there are limited options for their health care needs once they are released, so they frequently seek care at emergency departments.

The American Hospital Association (AHA) states that behavioral health disorders are a major public health issue.[4] Hospital EDs are typically the only or the last alternative for patients with behavioral health or substance abuse needs. There is inadequate access to inpatient, residential, skilled nursing, specialized housing and other intermediate and "step-down" levels of care to meet the growing needs of this population. It is common that these patients will present with both mental health and substance abuse issues, as well as physical health problems. Numerous hospitals reported the complexity involved in caring for these patients -- high average length of stay in the emergency department, resource-intensive services, inadequate medical staff training to address their needs, lack of appropriate referral options and a need for more intermediate mental health beds. Hospital EDs are not structured for long stay admissions such as these, which require extensive care. Some of the State's larger hospitals gave anecdotal evidence of very long wait times to place patients in an appropriate mental health inpatient facility. The Task Force heard input that the behavioral health network is fragmented, lacks appropriate inpatient and outpatient facilities, mental health workers and continuity of care. Despite several successful initiatives by the Department of Mental Health and Addiction Services (DMHAS) over the past few years, and over $15 million in expenditures per year to hospitals for those efforts, there is consensus that significant challenges remain in ensuring timely access to preferred, less expensive and appropriate care for some persons presenting at EDs with psychiatric and/or substance abuse disorders.

Utilizing emergency departments for non-urgent care results in excessive waits, lack of continuity of care, costly duplication of testing and services, limited access to specialists, and detracts from the care for those with true medical emergency needs. The emergency departments cannot continue to be the safety net for primary care and mental health/substance abuse visits and maintain the quality care our citizens expect from our hospitals.

Along with the utilization of health care services, the Task Force members acknowledged and agreed that the state should look to the State Health Plan and a State Health Care Facilities Plan to chart the direction of the health care system in the future. Many states in the nation operate under an approved state health plan which provides guidance and direction for the expansion or the reduction of health care services and facilities.

State health planning is the process of assessing health services for and the health status of Connecticut residents and identifying needs for state, local, public and private resources to address identified gaps through policy development and program implementation. A State Health Plan provides the framework for program planning and evaluation with goals and objectives that focus on health status (to reduce death, disease, and disability), risk reduction (to

reduce the prevalence of risks to health), and services and prevention (to increase comprehensiveness, accessibility, and quality of preventive services and interventions). The Facilities Plan addresses the access issues regarding the functions and/or services that providers offer to patients based on the population and disease incidence, according to the State Health Plan, in a particular region of the state.

Having stated the need for more health planning, members did not feel that the financial condition of some of the hospitals was directly related to duplicative services or lack of regionalizing hospital resources. Given the disparity in inpatient bed utilization levels in some regions as noted in Table 2 of this report, this topic may warrant further review. There was some discussion at the subcommittee level that regionalizing certain functions and/or services would reduce competitive costs, overhead costs and may assist in the work force shortage issue. The Task Force felt that a more concentrated effort with state health planning, in particular the facilities component, would benefit the Certificate-of-Need (CON) process. Some states have adopted facilities plans that provide principles, criteria, standards and methodologies that serve as the basis for CON decision-making. Therefore, the current CON process would be adjusted to respond to such a plan.

C. Workforce supply and demand challenges

Workforce shortages are one of the leading factors influencing the rising cost of providing care in Connecticut's hospitals. Hospitals report struggling with expenses related to recruiting and retaining health professionals. The health care industry in Connecticut currently faces personnel shortages in physicians, surgeons, specialty areas, nurses and allied health professionals. The demand for health care services already exceeds the number of health care workers and the shortages are expected to continue into the foreseeable future, as baby boomers age and the need for health care grows. In addition to aging patients, many physicians and nurses are among the baby boomers who will retire in the next three to five years. The Task Force heard testimony that one third of Connecticut's practicing physicians are age 55 or above and the average age of registered nurses in Connecticut is in the mid-to-late forties.

Connecticut's physicians, along with representatives from the Connecticut State Medical Society, highlighted the severity of physician shortages in our state, particularly in subspecialty areas. The shortage is linked to several issues. Since Connecticut has one of the highest costs of living in the nation, it is difficult for the state to retain or attract recent medical student graduates, as they cannot afford to establish and maintain a practice, raise a family and pay back significant student loans. It is believed that physicians and recent medical school graduates are choosing to practice in other states with a lower cost of living, limitations on medical malpractice claims and fewer on-call requirements.

There is an inadequate health care workforce within the state to meet all the needs of every hospital. In some areas of the state, physicians and surgeons are affiliated with more than one hospital in an attempt to meet patient and hospital staffing needs. Consequently, physicians are required to be on-call at more than one institution (either as primary or backup), and when needed, must travel from hospital to hospital to provide on-call services. The Task Force heard anecdotal evidence that one Connecticut subspecialty practice spent five years trying to hire an additional surgeon, while its two surgeons served as backup to each other at two different hospitals.

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Connecticut is unable to meet the growing need for surgeons and subspecialty surgeons mainly due to the high cost of malpractice premiums and the on-call burden. Attempting to decrease their liability risk, some surgeons and subspecialty surgeons with high malpractice premiums are either choosing to leave the state or are narrowing their practice by no longer providing surgical, emergency room and trauma care. On-call physicians are also burdened with the possibility of having to provide care in a subspecialty area that is not their area of expertise.

The President of the University of Connecticut (UCONN) provided additional written testimony stating that in the past three years, more of UCONN's medical school graduates receive their advanced training residencies in the state than anywhere else in the country (32% in 2007). It appears, however, that once residencies are completed, these newly-trained physicians may be choosing to practice outside of Connecticut. According to the Association of American Medical Colleges (AAMC), Connecticut ranks in the bottom quartile of physicians under age 40 and in the top quartile of physicians age 60 and older. So, Connecticut is faced with the dilemma of a limited number of new physicians to replace a large number of aging physicians as they retire.

Medical students stated at the public hearing that work/life balance is a top influencer of how they select a specialty; and that they are choosing areas with fewer hours and on-call obligations and higher salaries. Compounding the specialty shortage, aging physician workforce and high costs of living is the decreasing number of medical students choosing to practice in underserved areas. Medical students are also not specializing in primary care due to patient load, long hours, and lower wages.

The medical professional shortage facing the state is not limited to physicians. The federal government has projected that Connecticut will have the fifth highest nursing shortage in both 2015 and 2020.[5] While comprehensive data on hospital costs associated with recruiting and retaining health care employees are not available, preliminary findings from a recent survey by the CHA for the Task Force's Workforce Subcommittee found that hospitals reported significant annual expenditures on travel/agency nurses and other health care professional activities, continuing education, recruiter fees, sign-on bonuses, and tuition reimbursement.

Hospitals face several significant cost issues involving recruiting and the retention of nurses. First, hospitals are continuously competing for available nurses, offering sign-on bonuses and other incentives in an effort to attract staff. In addition, hospitals spend considerable dollars in the recruitment and training of newly hired nurses, whose turnover is the highest in the first two years. Moreover, many advanced degree nurses who are needed to manage and train new nurses move into non-hospital work settings that offer increased salaries, more appealing work hours and environment, and a less stressful workplace. Patient workload strains due to rising patient acuity levels sometimes associated with an aging population and inadequate staffing also contribute to the departure of nurses from hospital-based jobs. Hospitals need to become more desirable places to work and develop plans that take into consideration national "best practices." For example, additional physical challenges face hospital nurses who care for elderly, frail and obese patients. Hospitals that are financially distressed are unable to invest in equipment that may prevent worker injuries, such as specialized patient lifts and carriers. High vacancy rates are being seen in specialty fields such as emergency department and psychiatric nursing. These are specialty areas that often deal with challenging and complex patients and typically experience higher patient loads.

Compounding the problem is the fact that nursing colleges and universities face challenges to expand enrollment levels to meet the rising demand for nursing care. Traditionally, schools of nursing respond to workforce shortages by expanding enrollments. However, it is difficult for academic institutions to attract qualified nursing faculty because they must compete with higher nursing salaries offered in hospital settings or in non-clinical professional positions. Due to the shortage of nursing faculty, the Task Force heard that the state has had to deny a considerable number of nursing school applications. In 2005, Connecticut turned away 2,000 qualified nursing school applicants. Nationally, the number of denied applicants for nursing school is at its highest ever, increasing almost six fold since 2002.[6] According to the written testimony of UCONN's president, a 2005 report issued by the Connecticut League of Nursing Deans and Directors Council states that an additional 33 full-time faculty are needed to combat the current shortage. These positions are in addition to the existing 26 faculty vacancies that exist at UCONN today. The state will continue to see nursing shortages until it can adequately staff its nursing education programs to allow a sufficient number of people into the nursing program to meet the needs of the growing aged population.

Currently, there is no cohesive state action plan that looks at recruitment, retention, mentoring, marketing and education of health care professionals; the Task Force heard that Connecticut's current approach is fragmented. More than one agency is responsible for licensing and student loan forgiveness. Some allied health professionals in Connecticut are not required to be licensed (e.g., ultrasonographers and diagnostic imaging technicians), therefore it is difficult to assess the existing shortages in these fields without adequate data. The state cannot identify the numbers of *licensed and practicing* health professionals in order to accurately project the location, specific professions and extent of workforce shortages. It cannot currently determine if the health professionals being educated in Connecticut remain and work in the state or live here but work in neighboring states, or leave the state entirely. There is a clear need for better data on health care professionals that can be used for education, recruitment, marketing and forecasting purposes.

D. Financial status and challenges

The statewide average total margin for Connecticut hospitals in FY 2006 was 2.5% down from 3.3% in FY 2005. The operating margin average also declined in FY 2006 to 0.6% from 1.7% in FY 2005. Six of the 31 hospitals in FY 2006 reported negative total margins with an additional eight hospitals at or below 1.0% total margin. However, there is significant variation among the individual hospitals. For example, total margins for FY 2006 ranged between -8% and +9.1% (Table 4). The variation is due to the payer mix, reimbursement rates from those payers, investment income, and the competitive market forces faced by each hospital.

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Table 4: Five Year Average Total Margin FY 2002 - FY 2006

	FY 2002-2006 5 YEAR AVERAGE	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
CTCMC	**-4.05%**	**-12.87%**	**-2.88%**	1.95%	**-3.54%**	**-4.61%**
BRISTOL	**-3.13%**	0.08%	**-0.22%**	**-3.00%**	**-3.89%**	**-7.99%**
BRADLEY	**-2.08%**	**-3.95%**	**-5.43%**	**-2.01%**	**-0.24%**	0.16%
WATERBURY	**-1.23%**	**-0.30%**	**-4.72%**	1.17%	**-0.01%**	**-2.39%**
SAINT MARY	**-1.15%**	**-10.48%**	0.38%	7.33%	**-4.32%**	0.44%
WINDHAM	**-0.85%**	0.14%	**-5.66%**	**-0.24%**	0.79%	0.27%
JOHNSON	**-0.45%**	0.29%	**-1.11%**	2.02%	1.21%	**-4.30%**
SAINT RAPHAEL	**-0.32%**	**-1.37%**	1.27%	1.62%	**-0.86%**	**-2.11%**
MANCHESTER	0.20%	**-0.90%**	**-2.50%**	**-0.81%**	4.56%	0.12%
NEW MILFORD	0.38%	1.98%	0.94%	1.04%	1.16%	**-2.42%**
GRIFFIN	0.61%	1.98%	**-1.80%**	1.30%	0.35%	1.05%
NORWALK	0.84%	0.25%	0.99%	0.98%	1.82%	0.12%
ROCKVILLE	1.01%	5.45%	**-0.12%**	**-2.12%**	**-4.33%**	5.42%
MILFORD	1.10%	**-0.63%**	0.28%	1.73%	0.72%	2.94%
HARTFORD	1.17%	0.11%	0.26%	2.02%	1.61%	1.58%
SAINT FRANCIS	1.36%	3.02%	2.35%	0.02%	0.80%	0.96%
STAMFORD	1.70%	**-2.52%**	**-5.06%**	1.64%	5.13%	6.06%
HUNGERFORD	1.82%	**-0.60%**	2.86%	3.73%	1.75%	1.15%
DEMPSEY	2.14%	0.64%	1.89%	1.75%	3.85%	2.05%
BRIDGEPORT	2.31%	1.14%	0.41%	1.87%	3.43%	4.06%
NEW BRITAIN	2.31%	**-0.97%**	**-3.73%**	3.57%	6.04%	4.28%
DAY KIMBALL	2.61%	0.79%	3.55%	2.92%	4.11%	1.53%
BACKUS	3.50%	3.56%	3.52%	3.71%	2.17%	4.52%
MIDSTATE	3.84%	3.55%	3.86%	3.46%	5.64%	2.67%
LAWRENCE & MEMORIAL	4.31%	0.03%	1.56%	10.75%	2.78%	5.25%
GREENWICH	4.33%	5.80%	4.89%	3.71%	5.60%	2.16%
SHARON	4.48%	**-1.44%**	2.67%	7.14%	7.02%	2.97%
MIDDLESEX	4.58%	0.90%	2.63%	4.53%	8.46%	5.01%
YALE-NEW HAVEN	5.01%	5.27%	4.84%	4.87%	6.30%	3.88%
SAINT VINCENT	5.88%	**-2.21%**	**-0.02%**	7.90%	10.88%	9.10%
DANBURY	6.66%	6.17%	5.71%	5.56%	7.30%	8.04%
STATEWIDE (Note A)	**2.27%**	**0.85%**	**1.14%**	**3.06%**	**3.34%**	**2.51%**
AVERAGE (Note B)	**1.58%**	**0.09%**	**0.37%**	**2.59%**	**2.46%**	**1.68%**
Median (Note C)	**1.36%**	**0.14%**	**0.41%**	**1.95%**	**1.82%**	**1.58%**

Source: *Audited Financial Statements*

Note A: Weighted average by dollar amounts. Revenue in excess of expenses/(revenue from operations+(revenue in excess of expenses - gain/loss from operations))

Note B: Sum of margins divided by number of hospitals.

Note C: Middle margin in numerical order.

Connecticut hospitals are the safety net for the communities they serve and their ability to remain financially viable ensures continuous access to necessary services. Hospitals struggle with increasing expenses related to recruiting and retaining health professionals, acquiring advanced technology, improving and maintaining their facilities, and providing charity care for those without the means to pay for their care. They rely on patient revenue to cover their operating expenses.

Unlike other service industries, health care is an industry in which the patient receives a "service" prior to paying for it. Payment amounts vary by insurance plan and are often subject to negotiation. Rates paid to hospitals by state and federal programs are typically fixed and non-negotiable. Some payers reimburse above the cost of providing the care and some below the cost of providing care. A commonly-used measure that indicates the amount above or below hospitals' average costs and the reimbursement they receive is the "payment to cost" ratio. A ratio result that is higher than 1.0 is favorable (indicates reimbursement is greater than cost) and a ratio that is less than 1.0 indicates reimbursement is less than the cost of providing the service. In FY 2006, the statewide ratio of payment to cost was 0.95 for Medicare; 0.70 for Medicaid; and 1.21 for commercial/private payers. The variation of the payment to cost ratio among hospitals can be significant based upon their geographic location (e.g., two-hospital town, rural versus urban) and the degree to which patients from each of those payer sources utilize services. Hospitals with a large percentage of commercially covered patients and Medicare patients are typically financially stronger than those hospitals that provide services to a large percentage of Medicaid recipients and those without insurance. For a breakdown of inpatient discharges and percentage of total patient base by payer category, refer to Appendix F. The term "cost-shifting" refers to the shifting of reimbursement surplus (above costs) to cover reimbursement deficit (below costs). The Task Force discussed this topic extensively as one of the leading drivers to the financial instability of Connecticut's health care delivery system as it relates to utilization of the emergency departments, access to primary care services, behavioral health care services and inpatient care.

Of concern to the Task Force is the cost shifting to commercial or privately insured patients to cover the losses incurred from treating Medicaid Fee for Service (FFS), HUSKY and SAGA patients. The Task Force concluded that this is an unsustainable practice and leads to false expectation that employers will continue to pay higher premiums to cover shortfalls from public programs. Historically, Connecticut has had strong employer-sponsored insurance (ESI) coverage and a low uninsured rate. However, in recent years the state, like the nation, has seen the erosion of employer based coverage, with fewer employers offering health benefits, less comprehensive benefits packages and higher out-of-pocket costs for employees. If this pattern continues, hospitals' overall margins will be affected negatively by a decreasing share of commercial payers, as some of Connecticut's employers will no longer be able to offer their employees health care coverage. This is compounded by the fact that hospitals are also large employers and are faced with the same increases in employee benefits. It is vital to Connecticut's hospital system to maintain a strong commercial payer base.

Currently, about 60% of the state's residents have ESI, but with increasing premiums some employers, large firms in particular, either no longer provide health insurance coverage, have raised minimum eligibility requirements or have increased employee contribution requirements. Rising premiums are unsustainable for both employers and employees, rendering ESI inaccessible to employees and potentially adding to the ranks of the uninsured and potentially perpetuating the cycle of underpayments.

A close examination by the Financial Structure Subcommittee of costs and payments verified the gains and losses by each payer category. Table 5 shows the breakdown by payer on a statewide basis; however, there is significant variation among individual hospitals. For FY 2006, the losses experienced by hospitals totaled $-220.7 million for Medicaid programs and an additional $-98.3 million for other medical assistance programs. After considering Disproportionate Share Hospital (DSH) payments this $-319 million gap decreased to $-220 million. The loss attributed to Medicare patients was $-95.8 million; and the loss from patients without insurance was $-116.2 million. The only payer category where hospitals realized gains was from commercial payers, the statewide figure was $553.3 million. The statewide "bottom-line" for FY 2006 was a gain of $121 million from $6.4 billion of expenses.

Table 5: Statewide Acute Care Hospital Losses and Gains Attributable to Major Payers, FY 2006 (in Millions)

	Cost		Payment			
Payer	#	%	#	%	Gain/(Loss)	Payment to Cost
Medicaid	$746.9	12	$526.2	8	($220.7)	0.70
Other Medical Assistance	$188.4	3	$90.1	1	($98.3)	0.48
Total Medical Assistance Before DSH	$935.3	15	$616.3	9	($319.0)	0.66
UCP DSH	-	-	$57.5	-	-	-
Urban DSH	-	-	$31.6	-	-	-
Other DSH	-	-	$10.0	-	-	-
Hardship Fund	-	-	$0.0	-	-	-
Total Medical Assistance After DSH	$935.3	15	$715.4	11	($220.0)	0.76
Medicare	$2,659.4	41	$2,563.6	39	($95.8)	0.96
Tricare	$29.5	0	$29.2	0.4	($0.3)	0.99
Total Government Before DSH	$3,624.2	57	$3,209.1	49	($415.1)	0.89
Total Government After DSH	$3,624.2	57	$3,308.2	51	($316.1)	0.91
Commercial	$2,597.5	41	$3,150.8	48	$553.3	1.21
Uninsured	$189.1	3	$72.9	1	($116.2)	0.39
Total Nongovernment	$2,786.7	43	$3,223.7	49	$437.1	1.16
Total Before DSH	$6,410.9	100	$6,432.8	98	$22.0	1.00
Total After DSH	$6,410.9	100	$6,531.9	100	$121.0	1.02

Source: *CT Office of Health Care Access Hospital Budget System 12-Month Filings Schedule UCT & Department of Social Services*

Although the resulting payment to cost ratio was 1.02 (essentially a break-even) there is such variation among hospitals that this does not accurately reflect the individual hospital experience. The Task Force recommends conducting a comprehensive analysis of the current reimbursement system and of the multiple hospital reimbursement systems applicable to these state-funded programs in order to better align hospital reimbursement and costs associated with providing the care.

Today, the annual cost to operate all Connecticut hospitals is about $6.5 billion (Table 6). The single largest expense to a hospital is the people it employs to deliver the care patients need. The cost of employee salaries and benefits is 58% of overall cost. The largest increases to cost in the last five years are in non-physician salaries and benefits. It is this area where competitive tactics in recruiting nurses and other health professionals occur at significant cost to hospitals.

According to OHCA data, a review of the top hospital executive salaries shows an increase of 95% from an aggregated total of $22.9 million to $44.6 million between FYs 2002 and 2006 and a 200% increase (from $4.4 million to $13.7 million) in executive benefits; this accounts for a combined 2% of cost increases. Other areas that experienced significant increases are: "medical supplies and pharmaceuticals," (up 40%) which accounts for 17% of the increase in cost and "other than supplies and drugs," which includes leases and utilities, (up 27%) which also accounts for 17% of the increase in cost. Malpractice insurance grew by 66% and accounts for 3% of the five-year increase in cost. According to CHA, the average annual increase in hospital costs has been 6.3% for the last decade.

Table 6: Statewide Cost of Acute Patient Care

	FY 2002		FY 2006		% Share of	% Change
Expense Item	**(in Millions)**	**% of Total**	**(in Millions)**	**% of Total**	**Increase in Total Expenses**	**between '02 & '06**
Physician Salaries	$184.3	4%	$238.3	4%	3%	29%
Physician Benefits	$41.7	1%	$64.0	1%	1%	54%
Non-Physician Salaries	**$2,124.7**	**44%**	**$2,680.5**	**41%**	**35%**	26%
Top Ten+	$76.4	2%	$96.4	1.5%	1%	26%
Executives*	$22.9	0.5%	$44.6	0.7%	1%	95%
Non-Physician Benefits	**$481.0**	**10%**	**$763.7**	**12%**	**18%**	59%
Top Ten+	$14.1	0.3%	$22.8	2%	1%	61%
Executives*	$4.4	0.1%	$13.7	0.2%	1%	213%
Physician Fees	$180.2	4%	$210.4	3%	2%	17%
Supplies & Drugs	**$686.6**	**14%**	**$963.3**	**15%**	**17%**	40%
Other Than Supplies & Drugs	**$1,021.6**	**21%**	**$1,298.3**	**20%**	**17%**	27%
Malpractice Expense	$78.4	2%	$130.4	2%	3%	66%
Depreciation Expense	$285.0	6%	$355.5	5%	4%	25%
Interest Expense	$65.8	1%	$64.1	1%	-0.1%	-2%
Expense Recoveries	($266.3)	-5%	($286.7)	-4%	-1%	8%
Total Expenses	**$4,883.1**	**100%**	**$6,482.0**	**100%**	**100%**	**33%**

Source: *CT Office of Health Care Access Hospital Budget System Schedule 300*

+ Includes both physicians and non-physicians

* Includes presidents, chief executive, operating, finance and operating officers, and (senior) vice presidents. Does not imply exact comparisons of titles and salaries were made.

Every year Connecticut hospitals must overcome three significant fiscal challenges: covering the annual $95.5 million in losses from serving seniors enrolled in the Medicare program; covering the annual $319 million in losses from serving the disabled, mothers and children enrolled in the Medicaid, HUSKY and SAGA programs; and covering the annual $116 million in losses from serving individuals without health insurance. Although these shortfalls vary among individual hospitals, the Task Force heard that some hospitals handle reimbursement shortfalls by postponing much needed investment in technology and infrastructure. Statewide revenue for hospital operations totaled $7 billion last year, just $100 million more than statewide operating expenses. This narrow margin does not allow hospitals to reinvest adequately in their aging physical plants or in new technology necessary to keep them competitive. Hospitals lack access to capital investment funds which limits their ability to reinvest into new technology or plant improvements.

III. Recommendations of the Task Force

The Task Force's recommendations are intended to address many of the obstacles that hinder the financial strength of many Connecticut hospitals and the system as a whole. Although a combination of many recommendations will result in a more stable environment, the one issue that was most widely discussed was the commercial payer essentially "subsidizing" the deficit created by the reimbursement shortfall of the federal and state-funded programs. On the cost side of the equation, hospitals' largest expense is associated with salaries and benefits. There is such competition for qualified health care professionals that hospitals must compete aggressively. When they are not able to fill vacancies, hospitals pay high prices for travel/agency nurse coverage as well as premiums for specialty physician ED coverage. The shortage of physicians in Connecticut and the reimbursement shortfall is leading to access issues resulting in increased utilization of the emergency departments for primary care services and behavioral health services. The following 29 recommendations were developed by the Task Force and Subcommittee members to target the issues of utilization and planning, workforce, and the financial structure of the health care delivery system.

Related to state-funded health care programs:

1. Conduct a comprehensive study of the multiple hospital reimbursement systems applicable to the Medicaid fee-for-service, HUSKY and State Administered General Assistance (SAGA) programs to determine the most appropriate system for Connecticut. This study should be completed by October 31, 2008.

2. Increase hospital reimbursement to reflect reasonable costs to provide care to patients in the Medicaid fee-for-service, HUSKY and SAGA programs to ensure continued access to health care services.

3. Adjust hospital reimbursement rates based on Recommendation #1.

4. Support system changes using financial or other incentives to promote cost-effective service delivery that maintains and improves the quality of care offered by hospitals. Such changes should include, but not be limited to, enhancements in information technology that promote the interoperability of systems and/or organizations, electronic medical records and revenue cycle software systems.

Related to federally-funded health programs:

5. The Department of Social Services (DSS) should explore an application to the federal Centers for Medicare and Medicaid Services (CMS) for the inclusion of SAGA in Medicaid so that hospitals can receive all available Medicare DSH dollars. In exploring this application, DSS should consider the impact on state expenditures, hospital reimbursement and federal revenue to the state and to hospitals, and the likelihood of success of such application.

6. The Administration, business, and insurance industries should support Connecticut hospital initiatives to obtain adequate funding from the Medicare program.

Related to Access to Capital:

7. The Connecticut Health and Educational Facilities Authority (CHEFA) should establish a program to provide proceeds from revenue bonds backed by contract assistance of the state that would assist in making needed investments. The revenue bonds would be issued by CHEFA and the debt service paid by the State of Connecticut. Criteria to access such funding will be established by the Department of Public Health (DPH), DSS, CHEFA and the Office of Health Care Access (OHCA) in consultation with the Office of Policy and Management (OPM). Such criteria may include, but not be limited to, the improvement of quality and safety of patient care, work force safety, financial need, and/or consistency with the State Health Plan to include the state facilities plan. Proceeds of bonds may be made available to hospitals and federally qualified health centers in the form of grants, forgivable loans and very low interest rate loans for investment in plant and equipment or to repay higher costing debt.

Related to Utilization & Planning:

8. Reduce the inappropriate use and/or the extended lengths of stay for emergency department patients waiting to receive mental health and/or substance abuse services by increasing the capacity to provide such services in the appropriate setting within identified "high-demand" areas. The Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and DSS should work collaboratively to accomplish this goal that should include but not be limited to the following:
   - Develop recommendations for each identified "high-demand" area that will include the appropriate combination of services and be measured based on cost and quality outcomes.
   - Assess the existing capacity and volume of community mental health services and other programs as necessary to identify the gaps in services and adjust the funding allocation, services designs and geographic service areas as appropriate.
   - DMHAS, DCF and DSS, in consultation with OHCA and working with the Connecticut Hospital Association, providers and other stakeholders, should identify effective and feasible models of care for psychiatric emergency assessment or crisis response centers in order to expand access to behavioral health crisis and/or emergency services for adults and children.

9. Reduce the number of primary care visits that are being provided by emergency departments. This reduction can only occur with the development or expansion of alternative locations for patients to access primary care services; therefore, recommendations include, but are not limited to:
   - Develop a program to educate and inform patients as to appropriate ways to access primary care services and the choices available to them to receive such care.
   - Develop a program to encourage a shift in patient behavior to utilize available primary care services rather than accessing emergency departments for such care.
   - Support the on-going expansion of hours of operations and locations of primary care services.
   - DSS should implement a pilot program to schedule primary care services in the most appropriate setting utilizing, to the maximum extent possible, federal and other available non-state funding sources.

- The state should implement programs to facilitate information technology initiatives to better enable primary care providers to interrelate with hospitals and other providers in terms of scheduling and patient care.
- DSS, in concert with the Department of Correction (DOC), DMHAS, and the Judicial branch, should identify gaps in services and explore primary care services and other programs available to serve persons recently released from prisons so that they are not inappropriately directed to hospital emergency departments and so that they can be appropriately served in the community.
- DSS should explore the development of and reimbursement structure for specialist services in addition to primary care at the Federally Qualified Health Centers (FQHC) as a way of helping to alleviate hospital emergency department patient traffic.
- OHCA, in collaboration with state agencies, providers and industry stakeholders will conduct a study to measure current capacity of primary care services to identify geographical locations or segments of the population that are in need of additional access. This study should be completed by October 31, 2008.

10. Reduce the number of inpatients that have extended lengths of stay within the emergency department. Due to the complexity of this issue and variation among hospitals, individual hospitals should be allowed the flexibility to develop a plan in conjunction with DPH and in accordance with state and federal regulations.

11. Develop a State Health Plan to identify short-term and long-term strategies to effectively address the issues of access, cost and quality of health care services in Connecticut. The Commissioners, or their designees, of DPH, DMHAS and OHCA, and in consultation with other state agencies as appropriate, should include in the planning process, but not be limited to the following:
    - Update such plan every 5 years.
    - Establish an advisory body (or use existing bodies) that will include, but not be limited to, other state agencies, health care providers, consumers and other stakeholders as deemed appropriate.
    - Consider the unmeet needs of groups at risk such as:
        i. Persons with behavioral health issues;
        ii. Medicaid recipients;
        iii. Uninsured persons;
        iv. Person with specific and/or chronic illnesses or disabilities such as HIV/AIDS, autism, diabetes, etc.
    - Consider and adopt, as appropriate, the advice, guidelines and recommendations of authoritative organizations such as the Institute of Medicine,[7] the American Hospital Association, [8] and others.
    - Develop a communication process for (1) hospitals to encourage incorporation of the health plan into the hospital long range planning process and hospital long range planning into the state-wide health care facilities plan; and (2) other state agencies to be aware of progress, changes and other information that may be necessary.
    - Recommend legislative changes that may be necessary to pursue this overall recommendation.

12. Hospital leaders should consider, for adoption, the American Hospital Association's Recommendations for Behavioral Health Challenges in the General Hospital, published in 2007. This report includes recommendations regarding community needs assessments, hospital behavioral health plans, community collaboration, adequate financing, employer practices and advocacy.

Related to work force issues:

13. Designate one state agency to coordinate all programs designed to increase the training, recruitment and retention of health care workers in conjunction with other work force initiatives such as Connecticut's Mental Health Transformation initiative and its Behavioral Health Workforce project.

14. All programs designed to enhance recruitment and retention of healthcare professionals in Connecticut should include a mechanism for monitoring and evaluation to determine program effectiveness, with an appropriate funding allocation.

15. Expand the capacity of the on-line licensure system approved during the 2007 legislative session to include all healthcare professionals by 2010 and establish a comprehensive database of licensed healthcare professionals that includes, but is not limited to, the following information about the licensee: type of license held, whether the licensee is working, position held, how long at current position, name of employer, employer's type of industry, highest level of education, number of hours providing direct patient care per week.

16. Prior to January 1, 2009, the Department of Public Health should complete a survey of all health care professionals licensed in Connecticut to initially populate the comprehensive database.

17. The State Health Plan should include a health care workforce planning component that includes analyzing projected trends in the health care workforce, identifying demographics of the health care workforce and the patient population, establishing priorities for allocation of resources and development of a strategic workforce plan that includes an evaluation by DMHAS and DPH of mental health services and access to such services as they relate to hospital EDs and the availability of inpatient, intermediate, residential, outpatient and other levels of care.

18. Expand current loan repayment and forgiveness programs for physicians in the following ways: i) Create a loan forgiveness program that links loan forgiveness to the number of years that a physician is "on- call" at a hospital; ii) Create a loan forgiveness program for physicians at the residency level. If a physician accepts a residency in a defined geographic or physician specialty shortage area, loan forgiveness will be linked to the number of years of post-residency, in-state practice in the defined shortage area.

19. Provide funding to medical schools for scholarships to physicians who are willing to practice in a defined geographic or physician specialty shortage area in the state for at least 5 years after completing their residency programs.

20. Create a pilot program, including loan forgiveness, for a community-based physician residency focusing on primary care to support FQHCs. The loan forgiveness component of such pilot program should require that the physician remain in a community-based primary care practice in Connecticut in collaboration with a FQHC for at least five years after completing the residency program. The purpose of this program is to train physicians in community-based primary care, to improve access to primary care and to alleviate pressure on hospital emergency departments.

21. Evaluate and make necessary adjustments to the Connecticut definition of a health care professional shortage area (contained in DPH regulations) to better reflect specific geographic, demographic and physician specialty shortages.

22. Expand current loan repayment and forgiveness programs for 1) nursing students and 2) advanced practice registered nurses in a primary care residency program.

23. Work with the joint standing committee having cognizance of higher education and employment advancement to ensure an adequate number of slots for nursing students in schools of nursing.

24. Establish a pilot nursing residency program to provide mentoring to first-year hospital-based nurses in order to increase nurse retention rates and to smooth their transition from school to clinical practice.

25. The University of Connecticut and the Connecticut State University System should establish Masters level programs to prepare baccalaureate nurses to serve as educators in nursing schools to address the shortage of nursing faculty.
    - Nurses who become educators under this program may be eligible for loan forgiveness programs if they remain members of the nursing faculty in Connecticut for at least five years.
    - Provide methods to increase compensation and/or the availability of nurse educators consistent with applicable state laws and collective bargaining agreements.

26. To increase the availability of health care services for persons covered by public health insurance programs or who are uninsured, we recommend the establishment of a pilot program to address the problem of recruiting and retaining physicians practicing at FQHCs.

27. Establish a working group consisting of representatives of physicians, hospitals, insurance industry, other stakeholders, state legislators and regulators to develop a comprehensive tort reform proposal for submission by January 1, 2009 to the Governor and the joint standing committees having cognizance of public health, judiciary, and insurance matters. This proposal would complement the review of professional liability insurance rates for physicians and surgeons, hospitals, advanced practice registered nurses and physician assistants in Connecticut to be conducted by the Insurance Commissioner pursuant to Public Act 05-275.

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28. For each fiscal year from 2009 through 2013, allocate $500,000 to OHCA to provide matching grants to hospitals and FQHCs, not to exceed $50,000 per hospital or FQHC in any year, to be used to implement national "best practices" relating to recruitment and retention of staff. Such grants should be awarded on a competitive basis and should require that each hospital or FQHC awarded a grant provide matching funding equal to the amount of the state grant.

29. Review the composition and membership of the Connecticut Allied Health Workforce Policy Board to ensure that the work force needs of the entire health care field are represented. At a minimum, membership should be expanded to include physicians and representatives of organized labor. The new board should 1) assist the Office of Workforce Competitiveness (OWC) in developing and evaluating programs to increase training, recruitment and retention of physicians, nurses and other health care workers providing care in hospitals in Connecticut; 2) monitor employment satisfaction and attrition rates of all health care professionals in Connecticut; 3) provide support to DPH in its development of the hospital-based health care workforce planning component of the State Health Plan; 4) work with the State Department of Education (DOE) to develop programs at the middle school and high school levels to increase student enrollment in mathematics and science courses necessary to pursue a bachelor or post-graduate degree in health care fields; and (5) collaborate with the State DOE to develop programs aimed at middle school and high school students to encourage an understanding of and promote careers in health care.

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Appendix A

STATE OF CONNECTICUT
EXECUTIVE CHAMBERS
HARTFORD, CONNECTICUT 06106

M. JODI RELL
GOVERNOR

FOR IMMEDIATE RELEASE
April 18, 2007

Contact:
Rich Harris
860-524-7313
Rich.Harris@ct.gov

Governor Rell Announces Task Force to Develop Strategies to Stabilize Connecticut Hospitals

Governor M. Jodi Rell today announced she is forming a task force to develop strategies to stabilize and chart the future course of hospitals in Connecticut, many of which face are facing financial hardship.

The Hospital Task Force will be co-chaired by Robert L. Genuario, Secretary of the Office of Policy and Management (OPM), and Christine A. Vogel, Commissioner of the Office of Health Care Access. Members will include state agency commissioners, legislators, industry representatives and labor leaders.

"All of us count on having a hospital available – close by, there when we need it and prepared for almost any kind of medical emergency, day or night," Governor Rell said. "Yet many of the hospitals in Connecticut are struggling. Some of the largest hospitals in some of our biggest cities, including Hartford and Waterbury, face serious financial problems, while smaller community hospitals battle daily to attract and retain doctors and nurses and buy the high-tech equipment that modern medicine requires.

"This panel will be charged with reviewing a number of issues," the Governor said. "We need to examine not only the current financial health of Connecticut's hospitals but residents' access to care. Another key issue, especially as we work toward making better health care available for all, is emergency room utilization, affordability and alternative delivery of primary care. And the 'Certificate of Need' process – the state permitting process for determining where certain medical services are provided, when hospitals may close or expand and so on – also needs to be reviewed."

The Governor said she like the panel to hold its first meeting no later than June 30 and to report its findings by December 31.

The task force is part of Governor Rell's broader efforts to ensure that all residents of Connecticut have access to quality, affordable health care. In December, the Governor announced her Charter Oak health care proposal, which would provide low-cost health insurance to single people and families who cannot now afford insurance of their own. The plan – targeted at low-income people, many of whom are employed but may not have access to employer-sponsored health insurance and do not qualify for programs such as HUSKY or Medicaid – is intended to provide health insurance for about $250 a month, and includes state subsidies to assist people who find the monthly premium too high.

In addition, Governor Rell has strongly supported Bond Commission funding for expansion and equipment at community health centers, announcing in September nearly $26 million for expanded medical and dental facilities in communities all across the state, enabling the centers to serve some 85,000 additional new patients.

Appendix B

Financial Structure Subcommittee, Facilitator: Cristine A. Vogel, Commissioner, Office of Health Care Access
Participants:
David Benfer, Hospital of Saint Raphael
Patrick Charmel, Griffin Hospital
Kevin DelGobbo, State Representative
Stephen Frayne, Connecticut Hospital Association
J. Robert Galvin, MD, MPH, Department of Public Health
Martin Gavin, Connecticut Children's Medical Center
Eric George, Connecticut Business & Industry Association
Richard Gray, Connecticut Health & Education Facilities Authority
Jennifer Jackson, Connecticut Hospital Association
Timothy Meyer, Connecticut Association of Health Plans
David Parrella, Department of Social Services
John Rathgeber, Connecticut Business & Industry Association
Gary Richter, Department of Social Services
James Staten, Yale-New Haven Hospital
Paul Storiale, Hospital of Saint Raphael
Keith Stover, Robinson & Cole, LLP, representing Connecticut Association of Health Plans
Michael Starkowski, Department of Social Services
Robert Trefry, Bridgeport Hospital
Katherine Yacavone, Southwest Community Health Center

System Wide Utilization & Planning Subcommittee, Facilitator: **Robert L. Genuario,** Secretary, Office of Policy & Management
Participants:
Evelyn Barnum, Connecticut Primary Care Association
Arthur Brodeur, Planning Committee, Windham Hospital
Christopher Dadlez, St. Francis Hospital & Medical Center
Stephen Frayne, Connecticut Hospital Association
J. Robert Galvin, MD, MPH, Department of Public Health
Meg Hooper, Department of Public Health
Jennifer Jackson, Connecticut Hospital Association
Kevin Kinsella, Hartford Hospital
Thomas Kirk, Jr., PhD, Department of Mental Health & Addiction Services
Paul Knag, Esq., Murtha, Cullina LLP
Lawrence Levine, MD, FACEP, Connecticut College of Emergency Physicians
David Parrella, Department of Social Services

Work Force Issues Subcommittee, Facilitator: **Mary Anne O'Neill,** Legal Counsel, Office of the Governor
Participants:
Polly T. Barey RN, MS, Executive Director, Connecticut Nurses Association
Elizabeth Beaudin, Connecticut Hospital Association
David Cappiello, State Senator
Joanne Chapin, American Federation of Teachers Labor Union
Ken Ferrucci, Connecticut State Medical Society
J. Robert Galvin, MD, MPH, Department of Public Health
Matthew Katz, Connecticut State Medical Society
Kevin Lembo, Office of Healthcare Advocate
Denise Merrill, State Representative
Kevin Murphy, Eastern Connecticut Health Network, Inc.
Arvind Shaw, Generations Family Health Center
Colleen Smith, RN, Middlesex Hospital
Kristin Sullivan, Department of Public Health

Appendix C

Connecticut Acute Care Hospitals, FY 2006

Hospital Name	Affiliation/Parent Corporation	Town	County	Teaching	Licensed Beds*	Staffed Beds*
Bradley Memorial**	Central Connecticut Health Alliance	Southington	Hartford		84	46
Bridgeport	Yale-New Haven Health Services Corporation	Bridgeport	Fairfield	√	425	334
Bristol	Bristol Hospital & Health Care Group	Bristol	Hartford		154	154
Charlotte Hungerford	Charlotte Hungerford Hospital	Torrington	Litchfield		122	101
CT Children's Medical Center	CCMC Corporation, Inc.	Hartford	Hartford		135	122
Danbury	Danbury Health Systems, Inc.	Danbury	Fairfield	√	371	251
Day Kimball	Day Kimball Healthcare Inc.	Putnam	Windham		122	72
Essent-Sharon	Essent Healthcare Inc. of Connecticut	Sharon	Litchfield		94	47
Greenwich	Yale-New Haven Health Services Corporation	Greenwich	Fairfield	√	206	201
Griffin	Griffin Health Services Corporation	Derby	New Haven	√	180	94
Hartford	Hartford Health Care Corporation	Hartford	Hartford	√	867	749
John Dempsey	University of Connecticut Health Center	Farmington	Hartford	√	224	224
Johnson Memorial	Johnson Memorial Corporation	Stafford	Tolland		101	85
Lawrence & Memorial	Lawrence & Memorial Corporation	New London	New London	√	308	249
Manchester Memorial	Eastern Connecticut Health Network, Inc.	Manchester	Hartford		283	140
Middlesex	Middlesex Health System, Inc.	Middletown	Middlesex	√	297	177
MidState Medical Center	Hartford Health Care Corporation	Meriden	New Haven		142	136
Milford	Milford Health and Medical Incorporated	Milford	New Haven		118	64
New Britain General***	Central Connecticut Health Alliance	New Britain	Hartford	√	362	321
New Milford	New Milford Hospital Holding Corporation	New Milford	Litchfield		95	72
Norwalk	Norwalk Health Services Corporation	Norwalk	Fairfield	√	366	224
Rockville General	Eastern Connecticut Health Network, Inc.	Vernon	Tolland		118	66
St. Francis & Medical Center	Saint Francis Care, Inc.	Hartford	Hartford	√	682	574
St. Mary's	Saint Mary's Health System, Inc.	Waterbury	New Haven	√	379	178
St. Raphael	Saint Raphael Healthcare System, Inc.	New Haven	New Haven	√	533	474
St. Vincent's Medical Center	St. Vincent's Health Services Corporation	Bridgeport	Fairfield	√	444	336
Stamford	Stamford Health System	Stamford	Fairfield	√	330	319
William W. Backus	Backus Corporation	Norwich	New London		233	188
Waterbury	Greater Waterbury Health Network	Waterbury	New Haven	√	393	271
Windham Community Memorial	Windham Community Memorial Hospital	Willimantic	Windham		144	87
Yale-New Haven	Yale-New Haven Health Services Corporation	New Haven	New Haven	√	944	875
		Statewide			**9,256**	**7,231**

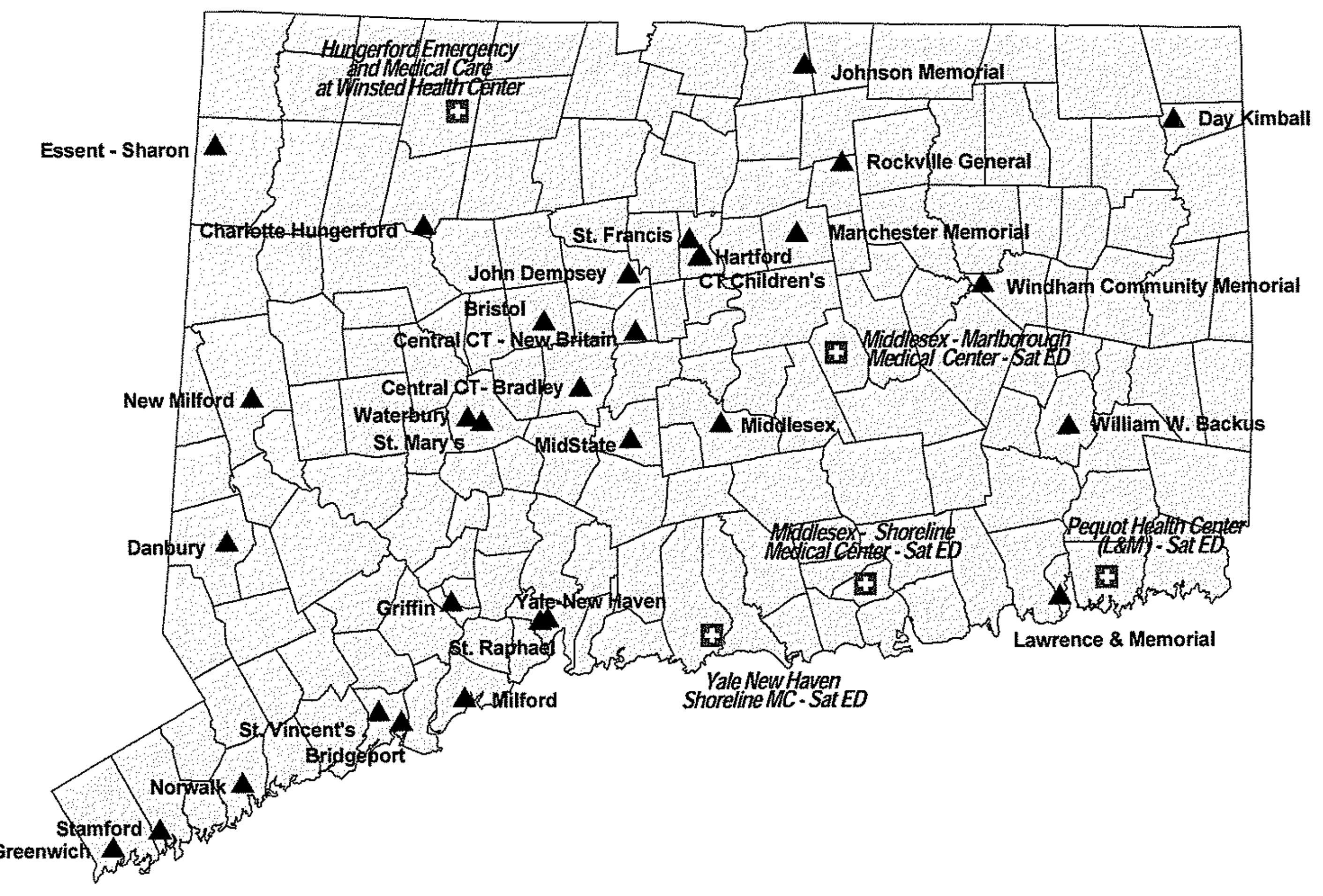
Source: CT Office of Health Care Access Budget System Schedule 500

*Includes newborn bassinets

** Effective 10/1/2007, the two hospitals merged to become the Hospital of Central Connecticut.

Appendix D

Acute Care Hospitals, Medical Centers and Satellite Emergency Centers



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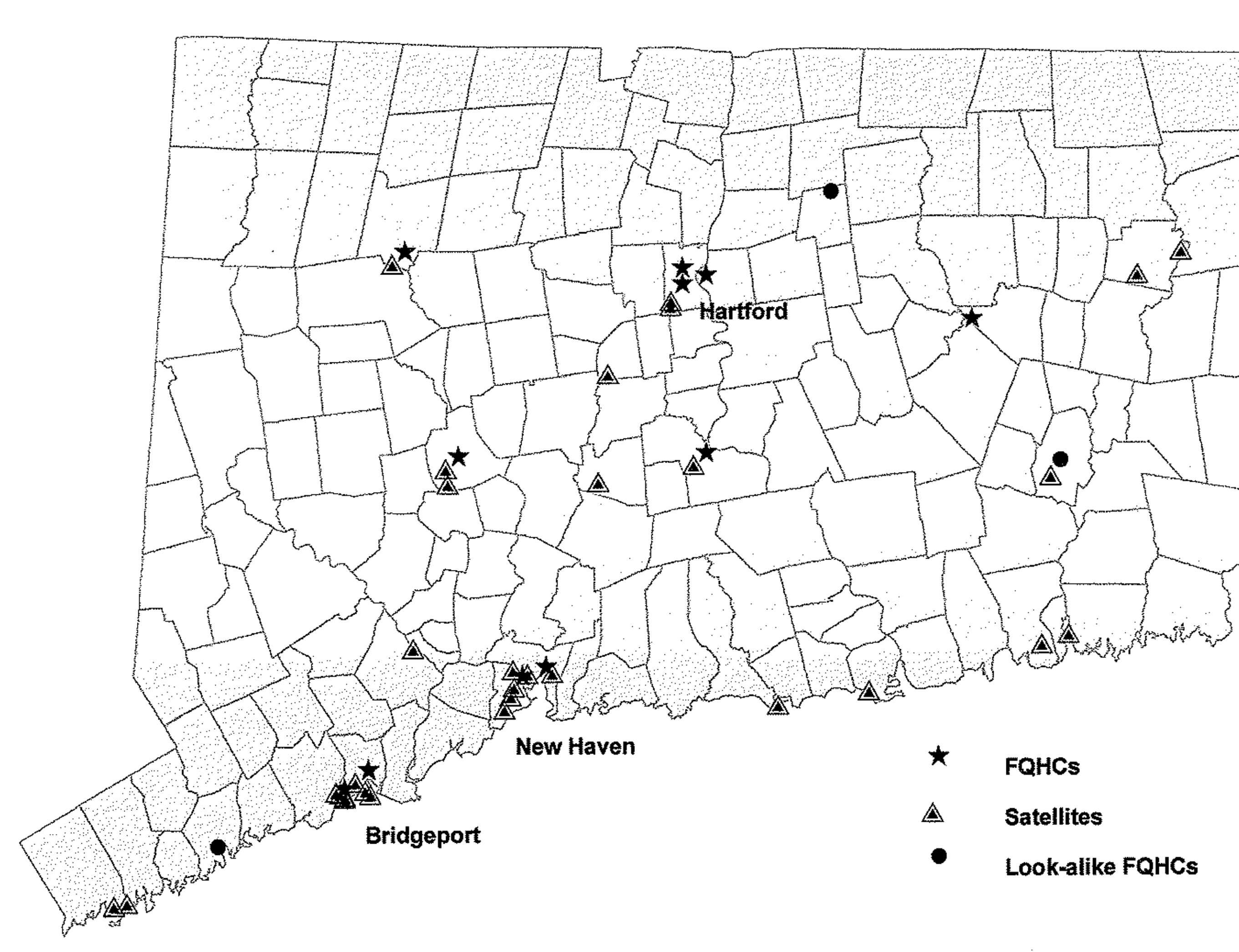
Appendix E

Connecticut Federally Qualified Health Centers (FQHCs), Satellites and Look-Alike FQHCs



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Appendix E: Federally Qualified Health Centers (FQHCs), Satellites and Look-alike FQHCs, 2007

TYPE	NAME	STREET	TOWN	ZIP
Main	Bridgeport Community Health Center, Inc.	471 Barnum Avenue	Bridgeport	06608
Main	Charter Oak Health Center	21 Grand Street	Hartford	06106
Main	Community Health Center, Inc.	635 Main Street	Middletown	06457
Main	Community Health Services	500 Albany Avenue	Hartford	06120
Main	East Hartford Community Health Center	94 Connecticut Boulevard	East Hartford	06108
Main	Fairhaven Community Health Center, Inc.	374 Grand Avenue	New Haven	06513
Main	Generations Family Health Center, Inc.	1315 Main Street	Willimantic	06226
Main	Hill Health Center	400 Columbus Avenue	New Haven	06519
Main	Southwest Community Health Center	361 Bird Street	Bridgeport	06605
Main	StayWell Health Center	80 Phoenix Avenue	Waterbury	06702
Main	Community Health & Wellness Center of Greater Torrington	157 Litchfield Street	Torrington	06790
Satellites	Charter Oak Health Center	1 New Britain Avenue	Hartford	06106
Satellites	Charter Oak Health Center	282 Washington Street	Hartford	06106
Satellites	Community Health & Wellness Center of Greater Torrington	157 Litchfield Street	Torrington	06790
Satellites	Community Health Center, Inc.	114 Eat Main Street	Clinton	06413
Satellites	Community Health Center, Inc.	333 Long Hill Road	Groton	06340
Satellites	Community Health Center, Inc.	134 State Street	Meriden	06450
Satellites	Community Health Center, Inc.	635 Main Street	Middletown	06457
Satellites	Community Health Center, Inc.	1 Washington Square	New Britain	06051
Satellites	Community Health Center, Inc.	1 Shaw's Cove	New London	06320
Satellites	Community Health Center, Inc.	263 Main Street	Old Saybrook	06475
Satellites	Fair Haven Community Health Center	339 Eastern Street	New Haven	06513
Satellites	Generations Family Health Center, Inc.	330 Washington Street	Norwich	06360
Satellites	Generations Family Health Center, Inc.	54 Reynolds Street	Danielson	06239
Satellites	Generations Family Health Center, Inc.	23 Wauregan Road	Brooklyn	06234
Satellites	Hill Health Center	226 Dixwell Avenue	New Haven	06511
Satellites	Hill Health Center	232 Cedar Street	New Haven	06519
Satellites	Hill Health Center	62 Grant Street	New Haven	06519
Satellites	Hill Health Center	911 State Street	New Haven	06511
Satellites	Hill Health Center	285 Main Street	West Haven	06516
Satellites	Hill Health Center	121 Wakelee Avenue	Ansonia	06401
Satellites	Southwest Community Health Center	510 Clinton Avenue	Bridgeport	06605
Satellites	Southwest Community Health Center	1046 Fairfield Avenue	Bridgeport	06605
Satellites	Southwest Community Health Center	743 South Avenue	Bridgeport	06605
Satellites	StayWell Health Center	1302 South Main Street	Waterbury	06706
Satellites	StayWell Health Center	80 Phoenix Avenue	Waterbury	06702
Satellites	Bridgeport Community Health Center, Inc.	928 East Main Street	Bridgeport	06608
Satellites	Park City Primary Care Center, Inc.	64 Black Rock Avenue	Bridgeport	06605
Satellites	Ralphola Taylor Center	790 Central Avenue	Bridgeport	06607
Satellites	Stratford Community health Center	727 Honeyspot Road	Bridgeport	06615
Satellites	Stamford Community Health Center	137 Henry Street	Stamford	06902
Satellites	Stamford Community Health Center	245 Selleck Street	Stamford	06902
Look-alike	Norwalk Community Health Center, Inc.	121 Water Street	Norwalk	06854
Look-alike	United Community and Family Services Health Center	47 Town Street	Norwich	06360
Look-alike	Vernon Area Community Health Center	43 West Main Street	Vernon	06066

Source: *Community Health Center Association of Connecticut*

Appendix F:
Acute Care Hospitals Payer Mix, FY 2006

	Discharges						Share of Hospital Total					
Acute Care Hospital	Medicare	Medicaid	Other Public[1]	Private[2]	Uninsured[3]	Total	Medicare	Medicaid	Other Public[1]	Private[2]	Uninsured[3]	Total
Bridgeport	6,738	4,906	68	7,489	381	19,582	34%	25%	0%	38%	2%	100%
Backus	4,331	1,739	264	4,222	465	11,021	39%	16%	2%	38%	4%	100%
Bradley	1,728	65	< 6	530	43	2,369	73%	3%	0%	22%	2%	100%
Bristol	3,583	1,329	21	2,899	122	7,954	45%	17%	0%	36%	2%	100%
CTCMC	45	2,430	31	3,043	66	5,615	1%	43%	1%	54%	1%	100%
Danbury	8,257	2,367	20	9,271	488	20,403	40%	12%	0%	45%	2%	100%
Day Kimball	2,489	1,075	37	1,995	72	5,668	44%	19%	1%	35%	1%	100%
Greenwich	4,318	401	6	7,127	496	12,348	35%	3%	0%	58%	4%	100%
Griffin	3,603	1,131	23	2,588	85	7,430	48%	15%	0%	35%	1%	100%
Hartford	15,056	6,979	64	16,016	1,375	39,490	38%	18%	0%	41%	3%	100%
Hungerford	2,957	1,075	15	1,990	158	6,195	48%	17%	0%	32%	3%	100%
John Dempsey	4,048	1,546	41	3,583	705	9,923	41%	16%	0%	36%	7%	100%
Johnson	2,207	563	22	1,337	83	4,212	52%	13%	1%	32%	2%	100%
Lawrence &Memorial	6,097	2,455	1,069	4,612	463	14,696	41%	17%	7%	31%	3%	100%
Manchester	3,890	1,115	17	3,710	226	8,958	43%	12%	0%	41%	3%	100%
Middlesex	6,029	1,451	24	4,907	455	12,866	47%	11%	0%	38%	4%	100%
MidState	4,620	1,487	14	3,338	353	9,812	47%	15%	0%	34%	4%	100%
Milford	2,557	351	7	1,898	158	4,971	51%	7%	0%	38%	3%	100%
New Britain	7,625	3,995	13	6,452	538	18,623	41%	21%	0%	35%	3%	100%
New Milford	1,318	231	< 6	1,488	74	3,116	42%	7%	0%	48%	2%	100%
Norwalk	6,189	1,322	50	6,675	1,105	15,341	40%	9%	0%	44%	7%	100%
Rockville	1,556	531	26	1,388	99	3,600	43%	15%	1%	39%	3%	100%
Saint Francis	13,000	6,260	87	11,801	499	31,647	41%	20%	0%	37%	2%	100%
Saint Mary's	5,385	2,865	46	4,152	536	12,984	41%	22%	0%	32%	4%	100%
Saint Raphael	13,371	3,176	17	8,421	369	25,354	53%	13%	0%	33%	1%	100%
Saint Vincent's	9,098	2,684	21	6,792	1,077	19,672	46%	14%	0%	35%	5%	100%
Sharon	1,580	257		907	136	2,880	55%	9%	0%	31%	5%	100%
Stamford	5,900	2,686	7	7,791	619	17,003	35%	16%	0%	46%	4%	100%
Waterbury	6,768	2,726	13	5,207	289	15,003	45%	18%	0%	35%	2%	100%
Windham	2,388	907	33	1,742	315	5,385	44%	17%	1%	32%	6%	100%
Yale-New Haven	14,065	12,589	506	22,056	1,138	50,354	28%	25%	1%	44%	2%	100%
Statewide	**170,796**	**72,694**	**2,570**	**165,427**	**12,988**	**424,475**	**40%**	**17%**	**1%**	**39%**	**3%**	**100%**

Source: *CT Office of Health Care Access Acute Care Discharge Database*

[1] Other public includes primary payer categories Other federal, CHAMPUS/TRICARE and Title V

[2] Private includes primary payer categories commercial, Blue Cross , HMO, PPO & Workers' Compensation

[3] Uninsured includes primary payer categories self-pay, other and no charge.

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Endnotes

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[1] Office of Health Care Access, *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2006.*

[2] Kaiser Family Foundation/statehealthfacts.org., 2005 AHA Annual Survey Copyright 2006 by Health Forum LLC, an affiliate of the American Hospital Association, special data request, March 2007. 2005 population data from Annual Population Estimates by State, July 1, 2005 Population, U.S. Census Bureau.

[3] Kaiser Family Foundation / statehealthfacts.org.

[4] American Hospital Association, *Behavioral Health Challenges in the General Hospital, Practical Help for Hospital Leaders, Recommendations*, February 2007, Page 2.

[5] Health Resources and Services Administration. *The Registered Nurse Population: Findings From the 2004 National Sample Survey of Registered Nurses*, Pages 17-18.

[6] PriceWaterhouseCoopers, What Works*Healing the healthcare staffing shortage, 2007, Page 1.

[7] http://www.iom.edu/CMS/3809/16107/35007/35040.aspx

[8] http://www.aha.org/aha/issues/Mental-Health-Services/taskforcereport.html

Exhibit 3

New Milford Hospital Quality Awards and Recognition 2006-2010

Designations

- ★ Primary Stroke Center Designation by the CT Department of Public Health, 2009
- ★ "Approval with Commendation" by the American College of Surgeons, Commission on Cancer, for NMH's Regional Cancer Center, 2009
- ★ "Top Ten Best Performer" Outstanding Achievement Award to NMH Behavioral Health Services Department from Department of Mental Health and Addiction Services (3rd consecutive year recognizing quality and satisfaction), 2008
- ★ Planetree Affiliate hospital, 2008

Planetree

- ★ Spirit of Planetree Award for Nutritional and Nurturing Aspects of Food, Planetree Annual National Conference, 2009

Voluntary Hospitals of America (VHA)

- ★ VHA Leadership Award for Clinical Excellence for prevention of ventilator-associated pneumonia for 12 consecutive months, 2008

NewYork-Presbyterian Healthcare System

- ★ Award Finalist for *Changing Hearts, Minds and Actions: A Restraint Reduction Initiative,* 2009
- ★ Award Finalist for *Concurrent Review Improves Teaching for Heart Failure Patients,* 2008
- ★ Poster Presentations at the Annual Meeting of NYP Healthcare System for the *Surgical Care Improvement Project* (SCIP) that enhanced key processes aimed at preventing surgical complications, and for *Medication Reconciliation* that improved communication regarding patient medications from admission to discharge, 2007
- ★ Quality Signature Award for innovation in quality improvement initiatives, 2006
- ★ Award Finalist for Rapid Response Team to respond to early signs of trouble and prevent patient transfers to the intensive care unit and Fall Prevention Program, 2006
- ★ Award Finalist for the Fall Prevention Program that reduced patient falls and injuries to well below the national average, 2006

Institute for Healthcare Improvement (IHI)

- ★ "*Mentor Hospital*" designation to assist other hospitals in improving patient safety through medication reconciliation, 2008
- ★ Poster Presentation at the IHI 21th Annual National Forum on Quality Improvement for *Changing Hearts, Minds and Actions: A Restraint Reduction Initiative,* 2009
- ★ Poster Presentation at the IHI 20th Annual National Forum on Quality Improvement for *Concurrent Review Improves Teaching for Heart Failure Patients* and *Early Results: MRSA Inpatient Surveillance Program,* 2008
- ★ Poster Presentations at the IHI 19th Annual National Forum on Quality Improvement for *Medication Reconciliation, SCIP* and the *Emergency Angioplasty Program,* implemented for acute heart attack without onsite cardiac surgery services and demonstrated patient outcomes equivalent or better than state and national results, 2007
- ★ Poster Presentation at the IHI 18th Annual Nation Forum on Quality Improvement for the *Fall Prevention Program,* 2006

Other Awards and Presentations

- ★ Scientific Session Presentation at the National Lipid Association Annual Conference, *Physician Prompts and Chart Audits Improve Compliance with Preventive Guidelines in the Elderly,* 2009
- ★ Glynnwood Harvest Award for support of nutrition and agriculture, 2009
- ★ Poster Presentation at the American Heart Association (AHA) Beyond Core Measure Conference, *Concurrent Review Improves Teaching for Heart Failure Patients,* 2008

Danbury Hospital

2009-2010	Quality Awards and Recogitions	Organization
2009 - 2010	Women's Health Excellence Award – Top 5 Percent in Women's Health	HealthGrades
Mar 2009	Joint Commission Hospital Accreditation: 2007-2011	Per Dawn Myles
Mar 2009	Joint Commission Primary Stroke Center Certification 2008-2010	Per Dawn Myles
Mar 2009	Department of Public Health Stroke Center Designation - effective 2007) – Primary Stroke Center Designation	Per Dawn Myles
Nov. 2009	American Diabetes Association awarded Education Recognition to the Diabetes Self-Management Program at Danbury Health Systems	American Diabetes Association
Nov. 2009	Commission on Cancer (CoC) - 3 year Accreditation with Commendation	Commission on Cancer
Dec.2009	Danbury Hospital Sleep Disorders Center receiver reaccreditation by the American Academy of Sleep Medicine	American Academy of Sleep Medicine
Mar 2010	CoC Outstanding Achievement Award - Praxair Cancer Center	Commission on Cancer
2010	American College of Surgeons (ACS) National Surgical Quality Improvement Program – 1 of 25 ACE NSQIP participating hospital in the United States	NSQIP
2010	The Center for Advanced Orthopedic and Spine Care at Danbury Hospital is one of only five in the state to hold Blue Care designation in both programs (total joint and spine)	Blue Care Designation-United Healthcare
2010	Accredited Chest Pain Center by Society of Chest Pain Centers – one of only two hospitals in state to carry this designation.	Society of Chest Pain Centers
2010	Nuclear Medicine Laboratory is accredited by the Intersocietal Commission for the Accreditation of Laboratories	Intersocietal Commission for the Accreditation of Laboratories
2010	Weight Loss Surgery Center – Accredited by the Bariatric Surgery Center Network Accreditation Program of the American College of Surgeons	ACS – Bariatric Surgery Center Network Accreditation Program
		As of 5/24/10 - dmb

Exhibit 4

Danbury Hospital-New Milford Hospital List of Physician Meetings

Specialty Meeting	Initial Meeting Date	Lead Participants	Agenda Topics/Goal of Discussions
Pathology	January 20, 2010	DH - Ramon Kranwinkel, M.D. NMH – Phrasant Rodrigues, MD	- Process for access to pathology
Obstetric and Pediatric	January 22, 2010	DH – Edward James, MD NMH – Evan Hack, MD and Carol Papov, MD	- Facilitation of effective NICU transfers
Emergency Medicine and Service Chairs	February 8, 2010	DH – Patrick Broderick, MD NMH – Tom Koobatian, MD	- Facilitation of seamless patient transfers based on clinical needs
Medical Staff	March 2, 2010	DH – John Murphy, MD NMH – Alphonse Altorelli, MD	- Building Medical Staff relationships and synergies
Medical Staff	March 10, 2010	DH – John Murphy, MD NMH –Henry Allen, MD	- Development of a regional health care system - Clinical integration opportunities
Cardiology	March 13, 2010	DH - Andrew Keller, M.D. NMH – Mike Levine, MD	- Access and clinical needs - Barriers to Cardiology services
Surgery	March 16, 2010	DH - Pierre Saldinger, M.D. NMH – Peter Wilson, MD	- Current and potential future collaboration - Clinical standardization to support referrals and transfers
Anesthesia	April 6, 2010	DH - Martin Serrins, M.D. NMH – Ed Zane, MD	- Standardization of practice and policies across both hospitals - Cross coverage and opportunities for economy of scale if affiliation ensues
Medical Staff Integration Council	April 8, 2010	DH – Matt Miller, MD NMH – Fred Browne, MD	- Discussion of opinions and biases regarding delivery of quality health care - Opportunities for collaboration to address community needs
Psychiatry and Behavioral Health	April 9, 2010	DH - Charles Herrick, M.D. NMH – Fred Browne, MD and Lisa Diamond, MD	- Review current programming and clinical needs - Ensure operational consistency
Medicine	April 13, 2010	DH – Patricia Tietjen, MD NMH – George Barth, MD	- Opportunities for collaboration to address community needs
Women's Services	May 3, 2010	DH – Stuart Ault, MD NMH – Susan Iovino, COO/ CNO; Marydale DeBor	- Scope of programs and services offered at both hospitals

Exhibit 5

Focus Group Sessions – May 10-11, 2010

Conducted by Myers Research on Behalf of Danbury and New Milford Hospitals

Who were the participants?

- May 10 groups - residents in the New Milford area, one group of residents living in the area for more than five years, and one group of mostly newer residents who had been living in the area for less than ten years, all who had some familiarity with New Milford Hospital, and also had utilized services at New Milford Hospital.
- May 11 groups were of a similar composition, comprised of residents in the Danbury area, one group of long-term residents and one group of newer residents, all who had some familiarity with Danbury Hospital, and also had utilized services at Danbury Hospital.

Key Findings:

- In 3 of the 4 groups, including both Danbury groups and the New Milford group of newer residents, there was a sense of ambivalence towards a possible affiliation.
- The fourth group comprised of longer-term NMH-oriented residents skewed towards being older and were less open to any kind of change in what they see as an important service they regularly need, and with which they are currently highly satisfied.
- The level of satisfaction with both hospitals was remarkable, particularly when the participants were asked to communicate opinions of their specific local hospital.
    - For the most part, Danbury residents saw Danbury Hospital as efficient, well-staffed and convenient, and New Milford residents saw New Milford Hospital as small, local, friendly, welcoming and also convenient.
    - Opinions of the other town's hospital were less positive as Danbury respondents viewed New Milford Hospital as inferior to their own and somewhat distant, and New Milford respondents saw Danbury Hospital as the busy, bustling big city hospital with long wait times and less personal attention.
- Notably the concepts of *big* and *small* hospitals emerged as an important dynamic in participants' perceptions of the two hospitals. The general consensus across the groups was that New Milford Hospital is small and Danbury Hospital is big. However these descriptions carried with them very different connotations dependent on where the respondents lived.
    - To New Milford residents, small meant inviting, comfortable and friendly, while to Danbury residents it meant inferior and not adequately resourced.
    - In contrast, Danbury residents saw their big local hospital as a state of the art facility filled with a competent and professional staff.
    - To New Milford residents, big meant that Danbury Hospital was a crowded facility with long wait times and an impersonal staff.
- Unprompted, respondents saw clear advantages to an affiliation: better doctors, better technology and the positive effect of shared resources.
- The possible disadvantages were more diffuse, though less competition, collusion and resulting service cuts and higher costs did emerge to some extent.
- Coming up with names for the affiliation was one of the less salient exercises in these groups. It will be important to avoid using the word —system and referring to Eastern New York, and though regional was greeted warmly by some, others thought it made the hospitals sound too far away from each other.
- Key words and concepts to use -- BETTER CARE, strengthen, advanced, best practices, highest quality, strong local component, synergy, consistent access.

Danbury Hospital-New Milford Hospital Outreach Plan as of 5/30/10

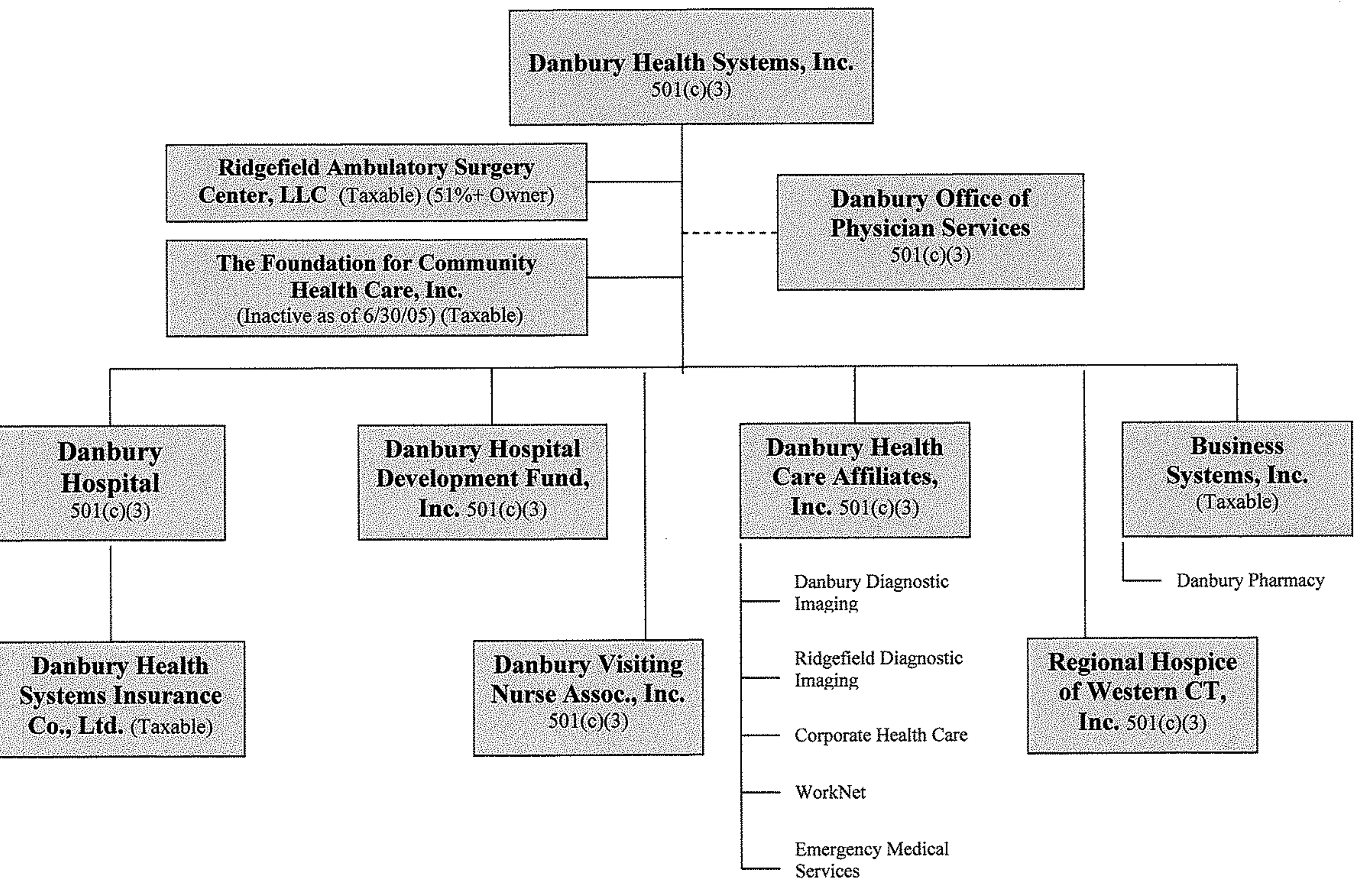
Last fall, Danbury Hospital and New Milford Hospital announced plans to explore working together to improve the health care delivery network for residents of its combined service areas. During the process of determining the feasibility of a formal affiliation between the hospitals, information has been shared with residents and businesses to ensure that the right plan is developed to meet the needs of the community.

Date	Community Group	Agenda/Comments
September 2009 and Ongoing	Responsiveness to various Media inquiries, including joint DH & NMH Press releases	- Informational
December 1, 2009	NMH - State Legislators	- Informational - Healthcare for the northwest region
January 8, 2010	DH - State Legislators	- Review potential affiliation - Seek comments and endorsement
January 28, 2010 and January 29, 2010	DH & NMH - Annual meetings	- Review potential affiliation - Seek comments and endorsement
March 1, 2010	NMH – New Milford Mayor	- Potential affiliation update
May 10 and 11, 2010	DH & NMH - Community Focus Groups	- Informational - Seek input on concerns and opportunities
May 20, 2010	DH & NMH - Housatonic Valley Council of Elected Officials - 10 Towns Municipal Leadership	- Informational - Seek input on concerns and opportunities - Unanimous endorsement
May 26, 2010	DH & NMH - Community Leadership breakfast (Faith, Business, Donor, Education, Agency)	- Informational - Seek comments and endorsement - Positive feedback
June 1, 2010	On-line Community Comment Portal	- Informational - Seek comments and questions
June 3, 2010	NMH - NW CT Council on Government	- Informational - Seek comments and endorsement
June 9, 2010	Open Community Forum (at-large) – supported by print ad open invite to public 5/24/10 and 5/31/10	- Informational - Seek comments and endorsement
July 2010	Anticipated Public Hearing	- Informational - Seek comments, questions and approval
TBD	Other as deemed necessary	

Exhibit 6

Prior to Affiliation

Danbury Health Systems - Family of Organizations

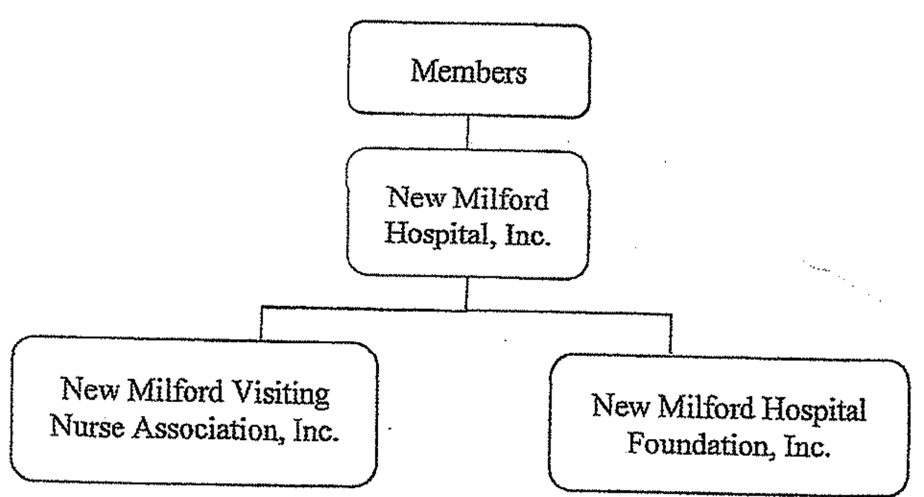


1.1.1.1OrgChart-DHS-...Ins-Foundation2010.docx

Prior to Affiliation

ORGANIZATIONAL CHART
for

NEW MILFORD HOSPITAL, INC.



Proposed Organization After Affiliation

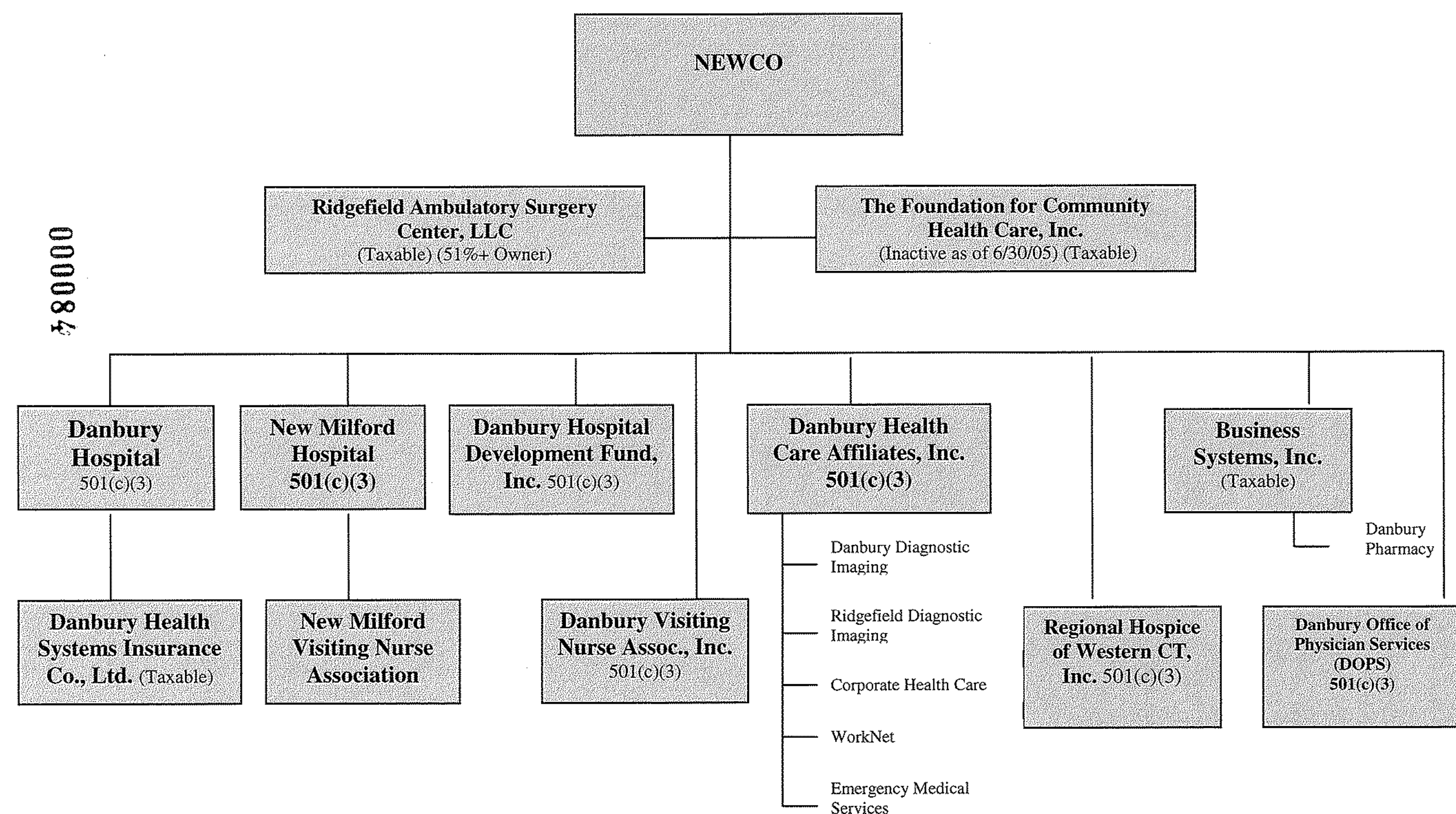


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Exhibit 7

DANBURY HEALTH SYSTEMS, INC. and
THE DANBURY HOSPITAL
DIRECTORS – 2010

	Term
CULLIGAN, Neil, M.D.	**(2008-2010)** **1st Term**
CYGANOWSKI, David	**(2008-2010)** **1st Term**
JABARA, Richard G.	**(2008-2010)** **1st Term**
KELLY, Frank J.	**PRESIDENT** **(2008-2010)**
KENNEDY, James	**VICE CHAIRMAN** **(2010-2012)** **2nd Term**
KLINE, John C.	**(2010-2012)** **2nd Term**
KRAMER, David, M.D.	**(2008-2010)** **2nd Term**
MARTOCCI, John J.	**CHAIRMAN** **(2009-2011)** **3rd Term**
MURPHY, John M.	**INCOMING PRESIDENT** **(July 1, 2010)**
PATRICK, John R.	**(2010-2012)** **3rd Term**
SKRZYPCZAK, Joseph D.	**(2009-2011)** **1st Term**
WHITE, Brian C.	**(2009-2011)** **1st Term**

Feb. 2010

2010 TRUSTEES
NEW MILFORD HOSPITAL, INC.

HONORARY BOARD OF TRUSTEES

William Chappell
Robert deCourcy
Lawrence Greenhaus
Stephen N. Hume
Milnor Morrison, MD
Thomas Mulvihill
David Murphy
Terry Pellegrini
Max Scheman
Walter Southworth

TRUSTEE EMERITUS

Ruth Henderson
Patricia Shea

TRUSTEES IN MEMORIAM

Forrest Arnold
Willis Barton
George Bates
Marian Beach Barlow
Daniel Bianchi
Mary Miller Blood
Paul Bruning
Rose Crohn
Ruppert S. Day, MD
Maurice Goldstein
John Griner
Mary M. Hadlow
Covington Hardee
Alan Himelick
Edward F. Jonas
Martin Kornbluth
Mrs. Edward Ives
Kenneth Maxwell
Ernest Miller
Andrew Mygatt
Helen Mygatt
Roland F. Mygatt
Ross R. Ormsby
John Owen
Mary Philpot
Frederick Planz
Edward Plumb
Kurt Porges
Bruce Randall
Mrs. Bruce Randall, Sr.
Harold Robbins
Walter Sheehan
Donald Smith
Henry Smithwick
Benjamin Stone
Adaline B. Strong
Bertram Thornhill
Dianne Toman
Walter VonEgidy
Norris Wildman

1-Feb-10

2010 OFFICERS
NEW MILFORD HOSPITAL, INC.

Chairman of the Board	James E. Preston
Secretary	Theodore Hollander
President	Richard Henley
Compliance Officer	Sally Herlihy

Note: The above officers were elected at the 2009 Annual Meeting of the Hospital held on January 29, 2010

2/1/2010

TERMS OF OFFICE
BOARD OF DIRECTORS, NEW MILFORD HOSPITAL

Term: January 2008 to January 2011
- Charles B. Barlow
- Pamela Cantor, MD
- Lynette Cornell
- Anthea Disney
- Kevin Dumas
- Robert Fitton, MD
- Holly Flor
- Evan Hack, MD
- Kenneth Hecken
- Jay Lent
- Robert Lenz
- Thomas Pilla
- Thomas Rosenwald

Term: January 2009 to January 2012
- Martin Begun
- Patty Dyer
- Barry Ginsburg
- Theodore Hollander
- James Preston
- Peter Mullen
- Carol Nelson
- Ellen Rittman
- Walter Rothschild
- Thomas Sides
- Arthur Weinshank
- Edward Zane, MD

Term: January 2010 to January 2013
- Roberta Buddle
- Gary Goldring
- Spencer Houldin
- Harold Kamm, MD
- Adriana Mnuchin
- Stella Gilrod Newman
- John Novogrod
- Jackie Markham Priaulx
- C. Carter Walker
- Frank Wargo

Ex Officio:
President of New Milford Hospital (Richard Henley)
Immediate Past Chairman of the Board (Theodore Hollander)
New Milford VNA Executive Director (Andrea Wilson)

2/1/2010

2010 EXECUTIVE COMMITTEE
NEW MILFORD HOSPITAL, INC.

Charles Barlow

Pamela Cantor, MD

Anthea Disney

Robert Fitton, MD

Barry Ginsburg

Evan Hack, MD

Kenneth Hecken

Theodore Hollander

Spencer Houldin

Robert Lenz

John Novogrod

James Preston

Thomas Rosenwald

Edward Zane, MD

Ex Officio

Richard J. Henley, Interim President/CEO

NEWCO
DIRECTORS – FY 2011

1. ALTORELLI, Alphonse, M.D. (New Milford)
2. CULLIGAN, Neil, M.D.
3. CYGANOWSKI, David
4. DISNEY, Anthea (New Milford)
5. HOULDEN, Spencer (New Milford)
6. JABARA, Richard G.
7. LENT, Jay (New Milford)
8. KELLY, Frank J.
9. KENNEDY, James
10. KLINE, John C.
11. KRAMER, David, M.D.
12. MARTOCCI, John J. - Chairman of the Board
13. PATRICK, John R.
14. SKRZYPCZAK, Joseph D.
15. WHITE, Brian C.

Exhibit 8

AFFILIATION AGREEMENT BY AND BETWEEN DANBURY HEALTH SYSTEMS, INC. AND NEW MILFORD HOSPITAL, INC.

This Affiliation Agreement (the "Agreement") is entered into as of this [___] day of [_______], 2010 between Danbury Health Systems, Inc., a Connecticut nonprofit corporation ("Danbury") and New Milford Hospital, Inc., a Connecticut nonprofit corporation ("New Milford"). Each of Danbury and New Milford is referred to herein as a "Party" and collectively as the "Parties." All capitalized terms used herein and not defined upon initial use have the respective meanings set forth in Section 8.

WHEREAS, Danbury is the parent of The Danbury Hospital ("Danbury Hospital"), a nonprofit regional medical center and university teaching hospital;

WHEREAS, Danbury controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, Danbury Hospital and The Danbury Visiting Nurse Association, Incorporated (collectively, with Danbury, the "Danbury Entities");

WHEREAS, New Milford is a nonprofit, full-service, community hospital;

WHEREAS, New Milford is currently affiliated with the New York-Presbyterian Healthcare System, Inc., and New Milford and the New York-Presbyterian Healthcare System, Inc. have mutually agreed to terminate their affiliation no later than June 30, 2010;

WHEREAS, New Milford controls, either directly or indirectly, certain subsidiaries and affiliates, including The New Milford Visiting Nurse Association, Incorporated ("New Milford Visiting Nurse Association"), and New Milford Hospital Foundation, Inc. ("New Milford Foundation") (collectively, with New Milford, the "New Milford Entities");

WHEREAS, the current members (the "Current Members") of New Milford consist of certain persons or entities who have made contributions for the benefit of New Milford during New Milford's most recently concluded fiscal year;

WHEREAS, on February 8, 2010, Danbury and New Milford executed a Letter of Intent for Corporate Affiliation (the "Letter of Intent") confirming their understanding with respect to a proposed affiliation (the "Affiliation") between Danbury and New Milford whereby Danbury would be renamed to reflect the creation of a regional health care system (as so renamed, "Newco"), the Current Members of New Milford would be replaced by Newco, and Newco would serve as the sole member of New Milford;

WHEREAS, by entering into the Affiliation, the Parties intend to create an integrated health care delivery system capable of bringing best practices in health care delivery to enhance the health and well being of residents within the region of western Connecticut and eastern New York State; and

WHEREAS, by entering into the Affiliation, the Parties intend to expand the availability of tertiary care services in the New Milford area, including endocrinology, nephrology, and certain surgical sub-specialties.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and in order to effectuate the Affiliation, the Parties agree as follows:

1. **AFFILIATION STEPS AND EFFECTIVE DATE.**

1.1 Effectuation of the Affiliation and Change of Ownership.

1.1.1 Newco Actions. Prior to the execution of this Agreement, the board of directors of Danbury has taken all necessary actions to approve and adopt, effective as of the Effective Date and subject to the satisfaction or waiver of all the conditions to closing set forth in Section 3, an Amended and Restated Certificate of Incorporation substantially in the form set forth in Exhibit A-1 and the Amended and Restated Bylaws substantially in the form set forth in Exhibit B-1. Among other changes, the Amended and Restated Certificate of Incorporation as set forth in Exhibit A-1 and Amended and Restated Bylaws as set forth in Exhibit B-1 make the following changes: (i) the name of Newco is changed from "Danbury Health Systems, Inc." to the name mutually agreed upon by the Parties prior to the Effective Date, (ii) the composition of the board of directors of Newco is amended to include four (4) voting members from the New Milford Community Board (as defined in Section 1.1.2) as set forth on Schedule 1.1.1, and (iii) the composition of the Committee on Governance of the board of directors of Newco is amended to include one (1) of the members of the New Milford Community Board who serves on the board of directors of Newco as set forth on Schedule 1.1.1.

1.1.2 New Milford Actions. Prior to the execution of this Agreement, the board of directors of New Milford has taken all necessary actions to approve and adopt, effective as of the Effective Date and subject to the satisfaction or waiver of all the conditions to closing set forth in Section 3, an Amended and Restated Certificate of Incorporation substantially in the form set forth in Exhibit A-2 and Amended and Restated Bylaws substantially in the form set forth in Exhibit B-2. Among other changes, the Amended and Restated Certificate of Incorporation as set forth in Exhibit A-2 and Amended and Restated Bylaws as set forth in Exhibit B-2 make the following changes: (i) Current Members are replaced with Newco serving as the sole member of New Milford; (ii) the board of directors of New Milford is replaced with those persons serving as the directors of Newco; and (iii) a New Milford community board ("New Milford Community Board") is established.

1.1.3 New Milford Community Board. Three (3) years after the Closing Date and periodically thereafter, the Newco board of directors shall discuss and reach consensus on whether the New Milford Community Board is achieving its objectives and whether the New Milford Community Board should continue to exist. If the Newco board of directors determines that the New Milford Community Board should not continue to exist, (i) the Newco board of directors shall amend Newco's Amended and Restated Bylaws to remove references to the

New Milford Community Board, and (ii) Newco, as the sole member of New Milford, shall amend New Milford's Amended and Restated Bylaws to remove the New Milford Community Board and references thereto.

1.2 Closing Memorandum. Upon satisfaction or waiver of all of the conditions precedent set forth in Section 3 and unless this Agreement is earlier terminated pursuant to Section 4, the respective Presidents of Newco and New Milford shall execute a written memorandum (the "Closing Memorandum") which shall confirm their agreement, on behalf of their respective institutions, that all of the conditions precedent to the closing of the Affiliation (the "Closing") have been satisfied or waived as of the date of execution of the Closing Memorandum and that the Closing shall occur on such date ("Closing Date"). The Closing shall occur at New Milford at 21 Elm Street, New Milford, CT 06776. The Affiliation will be deemed to become effective as between the Parties as of 12:00:01 AM Eastern Time on the Closing Date (the "Effective Date").

1.3 New Milford Entities. Upon Closing, the New Milford Entities will retain ownership of their respective assets and will remain responsible for their respective operations and liabilities, except as otherwise stated in this Agreement.

2. **INTERIM COVENANTS.** The Parties agree that during the period from the date of execution of this Agreement to the earlier to occur of the Effective Date or the termination of this Agreement:

2.1 Commercially Reasonable, Good Faith Efforts. Each Party shall use commercially reasonable efforts and act in good faith to obtain all necessary regulatory, corporate and other approvals and to take all such other actions as may be necessary or appropriate to effectuate the Affiliation as described in this Agreement, including such actions as may be reasonably necessary or appropriate to cause the conditions to the Closing in Section 3 to be satisfied.

2.2 Standstill. Neither Party nor any of its respective affiliates will enter into discussions with any third party concerning a possible sale, conveyance, transfer, lease membership substitution, merger, or other similar transaction involving the assets directly or indirectly owned or controlled by that Party or its affiliates (without the approval of the other Party) contemplated to be affected by this Agreement. Neither the current members of each of the New Milford Entities nor any of the New Milford Entities shall amend the certificates of incorporation or the bylaws of any of the New Milford Entities, other than as described in Section 3.1.

2.3 Conduct of Business. Each New Milford Entity shall continue to operate in its usual, regular and ordinary manner consistent with past practices and to comply in all material respects with all applicable laws, rules and regulations. Without limiting the generality of the foregoing, no New Milford Entity will take any of the following actions without the prior written consent of Newco, which shall not be unreasonably withheld or delayed: (i) enter into any Material Transaction or (ii) make any distributions of cash or other assets except in the ordinary course of its business and consistent with past practice. The New

Milford Entities will provide Newco ten (10) business days advance written notice of any transfer of assets to any entity other than the New Milford Entities that is not in the usual, regular and ordinary course of business as set forth in the New Milford Entities' Fiscal Year 2010 capital and operating budgets and consistent with past practice.

2.4 Public Statements. Except as may be required by applicable laws or as otherwise contemplated herein, none of the Danbury Entities or New Milford Entities will make any public statements or communications to the public, the press or any third party (other than to their respective affiliates and to their or their affiliates' respective officers, employees, accountants, attorneys, and agents who require access to such information in order to be able to perform necessary duties) regarding the existence or terms of the Affiliation or this Agreement without the other Party's prior written consent. Further, the Parties agree that in the event that the Affiliation described herein is not consummated for any reason, the Parties will mutually agree on a statement to that effect prior to any such disclosure to the public or the press.

2.5 Expenses. Danbury shall be responsible for seventy-five percent (75%) and New Milford shall be responsible for twenty-five percent (25%) of the combined legal, professional, and consulting fees incurred by the Parties in connection with the Affiliation, whether or not the Affiliation is consummated, including (i) expenses associated with any Hart-Scott-Rodino Act filing; (ii) expenses associated with obtaining other government approvals and making related filings, including any certificate of need, licensure, or change of ownership filings; and (iii) expenses of transaction counsel.

2.6 Communications with Government Officials. Unless the Parties agree otherwise after the effective date of this Agreement, the Parties shall communicate jointly with government officials with respect to the Affiliation and shall work together to develop a plan for coordinated communications by the Parties and by other Danbury Entities and other New Milford Entities. From the effective date of this Agreement until the earlier of the Effective Date or the date that this Agreement is terminated in accordance with its terms, none of the Danbury Entities or the New Milford Entities shall, except as required by applicable law, communicate separately with government officials regarding the Affiliation without the prior approval of the other Party. Notwithstanding the foregoing, (i) counsel to Danbury and/or counsel to New Milford may, with transaction counsel, communicate with representatives from the State of Connecticut Office of the Attorney General ("Attorney General"); and (ii) the Danbury Entities and the New Milford Entities shall be free, without prior approval of the other Party, to communicate with government officials in the ordinary course and with respect to matters unrelated to the Affiliation.

2.7 Additional Diligence Information. Pursuant to the Letter of Intent, Newco and New Milford furnished each other with certain requested information in order to permit each of the Parties to perform a due diligence analysis of the Affiliation. From the date of this Agreement through the Closing Date, (i) each Party shall disclose to the other Party any information known to such first mentioned Party's senior management team that, if not disclosed, would make the Due Diligence Information provided to the other Party taken as a whole, in light of the circumstances under which such information was provided,

materially incomplete, inaccurate or misleading in any material respect; (ii) New Milford shall provide to Newco, on a monthly basis, a financial information packet on the financial condition of the New Milford Entities in the same form provided to the New Milford board of directors; (iii) New Milford shall provide to Newco a copy of each Medicare cost report filed by a New Milford Entity after the date hereof within five (5) days of such filing; and (iv) New Milford shall provide to Newco and Newco shall provide to New Milford updates to any Schedules to this Agreement necessary to make such Schedules complete and accurate in all material respects as of the date on which the update is provided, including as of the Closing Date.

3. **CONDITIONS PRECEDENT**. The Affiliation shall not occur until each of the following conditions is satisfied or waived by the Party it is intended to benefit:

3.1 Organizational Documents.

3.1.1 Newco. The board of directors of Newco (and if necessary, the members of Newco) shall have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, (i) an Amended and Restated Certificate of Incorporation in the form set forth in Exhibit A-1 and (ii) Amended and Restated Bylaws in the form set forth in Exhibit B-1.

3.1.2 New Milford. The Current Members and the board of directors of New Milford shall have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, (i) an Amended and Restated Certificate of Incorporation substantially in the form set forth in Exhibit A-2 and (ii) Amended and Restated Bylaws substantially in the form set forth in Exhibit B-2.

3.1.3 New Milford Entities. The member and the board of directors of New Milford Foundation shall have taken all necessary action (i) to approve and adopt, conditional on and effective as of the Effective Date, Amended and Restated Bylaws substantially in the form set forth in Exhibit B-3 and (ii) to replace the current members of the board of directors of New Milford Foundation with those individuals mutually agreed upon by the Parties. The Amended and Restated Bylaws substantially in the form set forth in Exhibit B-3 grant Newco the authority to direct the New Milford Foundation to take certain actions in Newco's discretion. The member and the board of directors of New Milford Visiting Nurse Association shall have taken all necessary action to approve and adopt, conditional on and effective as of the Effective Date, Amended and Restated Bylaws in such form as the Parties may mutually agree.

3.2 Hart-Scott-Rodino. In the event that a Hart-Scott-Rodino Act filing is required, the applicable waiting period under the Hart-Scott-Rodino Act amendments to the Antitrust Improvement Act shall have expired without any challenge by the Federal Trade Commission ("FTC") or the Department of Justice ("DOJ") to the implementation of the Affiliation, or in the event that the FTC or DOJ initiate a challenge, including through the

issuance of a second request, the matter shall have been resolved to the reasonable satisfaction of each of Newco and New Milford.

3.3 Attorney General. The Attorney General shall not have challenged the implementation of the Affiliation, or if the Attorney General initiates a challenge, the matter shall have been resolved to the reasonable satisfaction of each of Newco and New Milford.

3.4 Government Approvals and Filings. Each Party shall have made the filings with governmental or regulatory authorities and shall have received the governmental permits, licenses, or other approvals in each case described on Schedule 3.4 (other than filings described on Schedule 3.4 as post-closing filings), which shall not be subject to any conditions, limitations or other terms not reasonably acceptable to the Parties.

3.5 Non-Governmental Consents. New Milford shall have obtained and delivered to Newco the consents from non-governmental third parties described on Schedule 3.5, which shall not be subject to any conditions, limitations or other terms that would result or be reasonably likely to result in a New Milford Material Adverse Effect.

3.6 No Investigation or Enforcement Action. The implementation of the Affiliation shall not be the subject of any litigation or regulatory investigation or enforcement action; provided, however, that if the implementation of the Affiliation is subject to any litigation or regulatory investigation or enforcement action, the Affiliation shall not be implemented without the agreement of each of Newco and New Milford.

3.7 Compliance with Interim Covenants. Each Party shall have determined in its sole discretion that the other Party has complied with the terms of Section 2.

3.8 Management Team. The Chief Executive Officer of Newco shall have selected a management team to manage Newco, Danbury Hospital, and the New Milford Entities after the Closing.

3.9 Opinions of Counsel. Each Party shall have received opinions of the other Party's counsel in customary form reasonably acceptable to the Parties.

3.10 No Material Adverse Effect. Unless waived by New Milford, between the date of this Agreement and the Closing Date, a Danbury Material Adverse Effect shall not have occurred. Unless waived by Newco, between the date of this Agreement and the Closing Date, a New Milford Material Adverse Effect shall not have occurred.

3.11 Representations and Warranties. Unless waived by New Milford, all representations and warranties made by Newco in Section 6 shall be true, accurate, and complete in all material respects as of the Closing Date. Unless waived by Newco, all representations and warranties made by New Milford in Section 6 shall be true, accurate, and complete in all material respects as of the Closing Date.

3.12 Additional Conditions Related to Diligence Findings. Newco shall have performed to New Milford's satisfaction all actions identified in Schedule 3.12.1, which actions are

intended to address certain findings of New Milford during the due diligence process. New Milford shall have performed to Newco's satisfaction all actions identified in Schedule 3.12.2, which actions are intended to address certain findings of Newco during the due diligence process.

4. **TERMINATION OF AGREEMENT.**

4.1 Term. This Agreement shall become effective upon execution by the Parties and may be terminated by either Party by written notice to the other Party if the Closing has not occurred by December 31, 2010 absent a mutual written consent by the Parties to extend the term.

4.2 Termination by Mutual Written Consent. This Agreement may be terminated prior to the Closing Date by the mutual written consent of the Parties.

4.3 Survival. In the event of termination pursuant to Section 4.1 or Section 4.2, all rights and obligations under the Agreement shall cease and the terms and provisions of the Agreement will have no further effect, except that Section 2.4 [Public Statements], Section 2.5 [Expenses] and Section 7.4 [Confidentiality] shall survive termination of this Agreement in the event that the Affiliation is not consummated. In the event that the Affiliation is consummated, only the provisions of Section 5 [Post-Closing Covenants] and Section 7 (not including Section 7.4) [Miscellaneous] shall survive beyond the Closing Date. Protections provided under the Mutual Confidentiality & Nondisclosure Agreement by and between New Milford Hospital, Danbury Hospital, and Danbury dated as of August 17, 2009, as amended by the First Amendment to the Mutual Confidentiality & Nondisclosure Agreement dated as of April 6, 2010, with respect to communications and all information exchanged during the term of such Mutual Confidentiality & Nondisclosure Agreement shall survive the termination of this Agreement.

5. **POST CLOSING COVENANTS.** From and after the Closing Date, the Parties shall take the following actions and observe the following covenants:

5.1 General Operation as Nonprofit Corporations. Newco and New Milford shall continue in existence as Connecticut nonprofit corporations exempt from taxation under Section 501(c)(3) of the Code. Each Party shall retain full power and authority to govern and manage such Party's assets; provided, however, that New Milford's authority to govern and manage its assets shall be subject to the reserved powers of Newco acting as New Milford's sole member.

5.2 Clinical Services. The clinical services to be provided by the Danbury Entities and the New Milford Entities immediately following the Closing are set forth on Schedule 5.2. Newco is committed to assisting New Milford in maintaining the competitiveness of New Milford with respect to its clinical operations and physical infrastructure relative to other hospitals in its service area through the development of appropriate business plans for new and existing programs and initiatives.

5.3 Operation of New Milford Entities.

5.3.1 General. After the Closing Date, New Milford's operations will be overseen by its board of directors, which will consist of those persons serving from time to time as the directors of Newco. To the extent practicable, after the Closing Date, the New Milford Entities shall operate in compliance with Newco policies generally applicable to the Danbury Entities (e.g., with respect to choice of auditor, maintenance of and signatory authority with respect to bank accounts, etc.). It is understood and agreed that while the Parties may endeavor to harmonize policies relating to employees, benefits, etc., not all policies and practices will be completely integrated as of the Closing Date.

5.3.2 Operation in Accordance with Newco Policies. The New Milford Entities shall operate in accordance with the rights, obligations, duties, and requirements applicable to all Danbury Entities, as such rights, obligations, duties and requirements are from time to time established by Newco. The New Milford Entities shall comply with the all policies, procedures, practices and other requirements of Newco as applied from time to time to all Danbury Entities, including those addressing governance and management, charity care, standards for just wage and benefits, and those requiring timely reporting and coordination with other Danbury Entities regarding aggregate liens and debt. Newco shall have, in its sole discretion, the right to change or alter at any time the policies, procedures, practices, and other requirements of Newco as applied to all Danbury Entities.

5.3.3 Medicare Form 855A. After the Closing Date, each New Milford Entity which is a participating provider in Medicare or Medicaid shall submit a Form 855A change of information filing to its fiscal intermediary within the time frame required under applicable laws and regulations.

5.3.4 New Milford Foundation. For a period of not less than ten (10) years following the Effective Date, New Milford Foundation shall continue to exist as a Connecticut nonprofit corporation that is exempt from federal income tax under Section 501(c)(3) of the Code and its corporate purposes shall remain to raise funds and make grants to support the inpatient, outpatient, and other hospital or community-based activities and projects of New Milford. The principal role and responsibilities of the New Milford Foundation board of directors shall be the local direction, supervision, and guidance of the New Milford Foundation's fundraising and support activities, the oversight and review of the New Milford Foundation's finances and operations, the review and approval of the New Milford Foundation's operating and capital budgets, and such other matters as may be related to the direction and supervision of the New Milford Foundation's fundraising and support activities. All grants or funds received by a New Milford Entity shall belong to or be the property of such New Milford Entity. Newco shall provide support and counsel to the New Milford Foundation's operations and planned giving efforts.

5.3.5 New Milford Employees. To the extent permitted by any applicable collective bargaining agreement, each employee of a New Milford Entity as of the Closing Date who becomes an employee of Newco or any Newco affiliate after the Closing Date shall receive full recognition and credit for pre-Closing length of employment with any New Milford Entity, including for purposes of seniority recognition, benefits eligibility and accruals, and vesting of benefits.

5.3.6 Medical Staff. As of the Closing Date, the Affiliation shall not impact or change the medical staff appointment or clinical privileges of members of the medical staff of New Milford as existing on the Closing Date. The New Milford medical staff shall remain independent of the medical staff of Danbury Hospital immediately following the Closing Date. Subject to the approval of New Milford's medical staff, if necessary, New Milford's medical staff bylaws, rules and regulations, and policies will be amended to be consistent with Danbury Hospital's medical staff bylaws, rules and regulations, and policies and such amended bylaws, rules and regulations, and policies shall take effect upon the Closing or at such later date as the Parties may agree. Newco and New Milford shall work with the medical staffs to evaluate and where feasible pursue opportunities for medical staff/clinical integration where doing so offers opportunities for advancement in quality and cost-effectiveness of care.

5.4 Access to Newco Insurance Programs. New Milford may have access to insurance programs offered by Newco's insurance plans, subject to New Milford's eligibility for and acceptance by those programs. Such insurance programs may or may not provide tail coverage, depending on the nature of the programs and New Milford's eligibility for and acceptance by those programs.

5.5 Annual Capital Allocation Process. Newco will include the New Milford Entities in Newco's annual capital allocation process for capital expenditures, which expenditures shall be governed by Newco's normal capital allocation policy from time to time in effect for Newco's affiliates. The Parties agree that one of the principle purposes of the Affiliation is to enhance capital access for both Parties so as to maintain the ability to offer medical care of the highest quality at all sites.

6. REPRESENTATIONS AND WARRANTIES.

6.1 By Each Party. As a condition to entry into this Agreement, each Party represents and warrants to the other Party that as to itself and as to each of its affiliates the statements set forth in this section are true and correct as of the date hereof:

6.1.1 Due Organization and Authority. Newco and each of the New Milford Entities is a corporation duly organized and validly existing under the laws of the State of Connecticut. Each such corporation has all requisite corporate or other power and authority to own, lease, and operate its properties and to carry on its business as it is now being conducted. The copies of the certificates of incorporation and bylaws of Newco and each of the New Milford Entities heretofore delivered to or

made available for review by Newco and New Milford are complete and correct, and no amendments thereto are pending or contemplated, other than the Amended and Restated Certificates of Incorporation and the Amended and Restated Bylaws of each of Newco and New Milford as described in Section 1.1.

6.1.2 Corporate Power. Each of the Parties has full corporate power and authority to enter into and carry out the terms and provisions of this Agreement and the transactions contemplated hereby; all corporate proceedings have been duly called and conducted; and all corporate authorizations have been obtained by each of the Parties and the other New Milford Entities which are necessary to authorize the execution, delivery and performance of this Agreement and to adopt the Restated Certificates of Incorporation and Amended and Restated Bylaws in the respective forms set forth in Exhibit A-1, Exhibit A-2, Exhibit B-1, and Exhibit B-2. No other corporate proceedings on the part of either Newco or the New Milford Entities are necessary to authorize such execution, delivery and performance of this Agreement or to adopt the Amended and Restated Certificates of Incorporation and Amended and Restated Bylaws in the respective forms set forth in Exhibit A-1, Exhibit A-2, Exhibit B-1, and Exhibit B-2. This Agreement is, and is intended to be, a legal, valid, and binding obligation of each of the Parties, enforceable in accordance with its terms; provided, however, that (i) such enforcement may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws currently now or hereafter in effect relating to creditors' rights generally; and (ii) the remedy of specific performance may be subject to equitable defenses and to the discretion of the court before which any proceeding therefor may be brought.

6.1.3 Audited Financial Statements. Danbury has provided New Milford with the audited balance sheets and related statements of income and statements of cash flow of Danbury for the fiscal years ended September 30, 2006, 2007, 2008 and 2009, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of Danbury. New Milford has provided Danbury with the audited balance sheets and related statements of income and statements of cash flow of the New Milford Entities for the fiscal years ended September 30, 2006, 2007, 2008 and 2009, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of the New Milford Entities. (Such audited balance sheets and related statements of income and statements of cash flow, including the notes thereto, are referred to herein as the "Financial Statements." Such unaudited balance sheets and related statements of income and statements of cash flow are referred to herein as the "Interim Financial Statements.") The Financial Statements (i) were prepared from the respective books and records of Danbury or the New Milford Entities, as the case may be, (ii) fairly present the financial condition and results of operations and cash flows for Danbury or the New Milford Entities, as the case may be, as of the dates and for the periods indicated, and (iii) were prepared in accordance with generally

accepted accounting principles applied on a consistent basis (except as may be expressly indicated therein or in the notes thereto). Neither Danbury nor any of the New Milford Entities, as the case may be, have any material liabilities or obligations, whether contingent or absolute, direct or indirect, or matured or unmatured, which are not shown or provided for in the most recent of such Financial Statements or which have not otherwise been disclosed in writing to the other Party. The Interim Financial Statements were prepared from the respective books and records of Danbury or the New Milford Entities, as the case may be, consistent with the methods used to prepare the audited Financial Statements and any other adjustments expressly described therein or in the notes thereto.

6.1.4 Execution of Agreement. Neither the execution and delivery of this Agreement nor the consummation of any of the transactions contemplated hereby will (i) constitute a breach or a default under any contractual obligation of Newco or any New Milford Entity; (ii) result in acceleration in the time for performance of any obligation of Newco or any New Milford Entity under any contractual obligation; (iii) result in the creation of any lien upon any asset of Newco or any New Milford Entity; (iv) require any notice, consent, waiver or amendment to any contractual obligation other than those set forth on Schedule 6.1.4.1 for Newco or Schedule 6.1.4.2 for New Milford; (v) give rise to any severance payment, right of termination or any other right or cause of action under any contractual obligation; or (vi) violate or give rise to a default or any other right or cause of action under any law, except for the events or conditions described in clauses (i) through (vi) above which do not and would not be reasonably likely to, individually or in the aggregate, have a Danbury Material Adverse Effect or a New Milford Material Adverse Effect, as the case may be. Except for the consents, waivers, approvals, and authorizations of, and the filings registrations, and qualifications with, governmental or regulatory authorities identified in Schedule 3.4, no consent, waiver, approval or authorization of, or filing, registration or qualification with, any governmental or regulatory authority which if not made or obtained could have a Danbury Material Adverse Effect or New Milford Material Adverse Effect, as the case may be, individually or in the aggregate, is required to be made or obtained by Newco or a New Milford Entity, in connection with the execution, delivery or performance of this Agreement by Newco or a New Milford Entity.

6.2 Additional Representations and Warranties by New Milford. As a condition to Newco's entry into this Agreement, New Milford as to itself and as to each of the New Milford Entities further represents and warrants to Newco that, except as disclosed in the Due Diligence Information, the statements set forth in this section are true and correct as of the date hereof:

6.2.1 Legal Proceedings. There is no potentially material incident report related to the operations or services of a New Milford Entity, and there is no litigation, at law or in equity, or any proceeding before or investigation by any foreign, federal, state or municipal board or other governmental or administrative agency or any arbitrator, or any fiscal intermediary or contractor pending or, to the knowledge of

the New Milford Entities, threatened against any New Milford Entity or against any New Milford Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such New Milford Entity which would result or be reasonably likely to result in any uninsured loss, which, individually or in the aggregate, would result or be reasonably likely to result in any material liability, or which could otherwise, individually or in the aggregate, result or be reasonably likely to result in any New Milford Material Adverse Effect. There is no litigation at law or in equity, or any proceeding before or, to the knowledge of a New Milford Entity, any investigation by, any foreign, federal, state or municipal board or other governmental or administrative agency or any arbitrator pending which seeks rescission of, seeks to enjoin the consummation of, or which questions the validity of, this Agreement or any of the transactions contemplated hereby. No New Milford Entity has received notice of any judgment, decree or order of any foreign, federal, state or municipal court, board or other governmental or administrative agency or arbitrator, or any fiscal intermediary or contractor which has been issued against it or any of its members, trustees, directors, officers, or employees which would have or be likely to have a New Milford Material Adverse Effect, individually or in the aggregate. Neither (i) any attachments, or execution proceedings, nor (ii) any assignments for the benefit of creditors, insolvency, bankruptcy, reorganization or other similar proceedings are pending or threatened against any New Milford Entity. The New Milford Due Diligence Information contains a complete and accurate listing of all litigation, at law or in equity, or any proceeding before or investigation by any foreign, federal, state, or municipal board, other governmental or administrative agency or arbitrator, or any fiscal intermediary or contractor pending or, to the knowledge of the New Milford Entities, threatened against any New Milford Entity or against any New Milford Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such New Milford Entity.

6.2.2 Compliance with Laws. The business and operations of each New Milford Entity have been and are being conducted in compliance with all material and applicable laws, ordinances, and rules and regulations of all authorities, and any non-compliance would not have a New Milford Material Adverse Effect, individually or in the aggregate. Except for federal and state laws and regulations that apply commonly to all hospitals in the State of Connecticut, and except for those matters, if any, expressly disclosed in the Financial Statements, no New Milford Entity is subject to any restriction of any kind or character, which may have a New Milford Material Adverse Effect on any New Milford Entity, individually or in the aggregate. No New Milford Entity is in receipt of any written notice of any violation of any law, statute, rule, regulation, judgment, order, decree, permit, concession, franchise or other governmental authorization or approval applicable to it or to any of its properties, except for violations which, individually or in the aggregate, would not have or result or be likely to have or result in a New Milford Material Adverse Effect. The New Milford Due Diligence Information provided

by New Milford contains complete and accurate information regarding (i) each New Milford Entity's compliance with all applicable laws, ordinances, and rules and regulations of all authorities; and (ii) any written notice of any violation of any law, statute, rule, regulation, judgment, order, decree, permit, concession, franchise, or other governmental authorization or approval applicable to any New Milford Entity or any of their respective properties.

6.2.3 Insurance. Each New Milford Entity has insurance contracts in full force and effect, with financially sound and reputable insurers licensed to write insurance in the State of Connecticut, which insurance contracts provide for coverages that are usual and customary for the risks attending the operations of such New Milford Entity as to amount and scope. No New Milford Entity has received notice from any insurance carrier of, or has knowledge of, defects or inadequacies in its property or improvements or any other condition which if not corrected would result in termination of directors and officers, hazard, liability or other insurance coverage or increase in its cost.

6.2.4 Tax Exempt Status. Each New Milford Entity is an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), or corresponding provisions of prior law, as set forth in a determination letter issued by the Internal Revenue Service and no such letter has been modified, limited, or revoked. Each New Milford Entity is in material compliance with the terms, conditions, and limitations in such letter, and the facts and circumstances that form the basis of such letter as represented to the Internal Revenue Service continue to substantially exist. No proceedings are pending with respect to which any New Milford Entity has been served or threatened in any way contesting or adversely affecting such entity's status as an organization described in Section 501(c)(3) of the Code or as an organization described in Sections 509(a)(1), (2) or (3) of the Code, or which would subject any income of such entity to federal income taxation to such an extent as would result in loss of such status. No New Milford Entity has knowledge of any challenge, investigation or inquiry that the Internal Revenue Service has made regarding its status as an organization described in Section 501(c)(3) of the Code or as an organization described in Section 509(a)(1), (2) or (3) of the Code. The New Milford Due Diligence Information provided by New Milford contains a complete and accurate set of all reports, filings, correspondence, or other documents to or from the Internal Revenue Service or the Connecticut Department of Revenue Services on any tax, compliance, or other issue related to any of the New Milford Entities.

6.2.5 Titles, Leases, and Licenses. Each New Milford Entity has good and marketable title to, or in the case of leased or licensed property, has valid leases or licenses under which it enjoys peaceful and undisturbed possession of, all of its properties and assets (whether real or tangible personal), including all properties and assets reflected in the Financial Statements and Interim Financial Statements of the New Milford Entities (except as sold or otherwise disposed of since the date of such Financial Statements or Interim Financial Statements in the ordinary course of

business and consistent with past practice). Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the New Milford Entities as now conducted. All such assets and properties, other than assets and properties in which the New Milford Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the New Milford Entities' Financial Statements or the footnotes thereto. Each New Milford Entity has complied in all material respects under all leases to which it is a party and under which it is in occupancy, and all such leases are in full force and effect. There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the New Milford Entities as now conducted that are licensed by the State of Connecticut Department of Public Health other than those properties, assets, and facilities set forth in Schedule 6.2.5.

6.2.6 Environmental Laws. Each New Milford Entity has been and remains in compliance in all material respects with all applicable environmental laws, except for noncompliance that would not result in a New Milford Material Adverse Effect. To the knowledge of the New Milford Entities, there are no circumstances or conditions present at or arising out of the present or former assets, properties, leaseholds, businesses or operations of a New Milford Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs. No New Milford Entity nor any of its assets, properties, businesses, leaseholds or operations (i) has received or is subject to, or within the past three (3) years has received or been subject to, any order, decree, judgment, complaint, agreement, claim, citation, or notice or (ii) is subject to any judicial or administrative proceeding or any investigation indicating that the New Milford Entity is or may be (a) in violation of any environmental law; (b) responsible for the on-site or off-site storage or release of any chemical substance; or (c) liable for any environmental liabilities and costs. No New Milford Entity has reason to believe that it will become subject to a matter identified in this Section 6.2.6; and no investigation or review with respect to such matters is pending or threatened, nor has any governmental authority or other third party indicated an intention to conduct the same. No New Milford Entity is subject to, or as a result of the transactions contemplated by this Agreement would be subject to, the requirements of any environmental laws that require notice, disclosure, cleanup or approval prior to or upon the Effective Date or which would impose liens on the assets or business of a New Milford Entity.

6.2.7 Labor Unions and Collective Bargaining Agreements. Employees of New Milford Entities are currently represented only by the collective bargaining organizations listed on Schedule 6.2.7. Except in relation to the foregoing collective bargaining organizations, no New Milford Entity is a party to any labor union or collective bargaining agreement with respect to its employees or has, within the previous three (3) years, been the subject of any organizing, petition or election with respect to the unionization of any of its employees. There is no strike or other

work stoppage currently in effect or, to the knowledge of any New Milford Entity, threatened with respect to any employees of any New Milford Entity.

6.2.8 Employee Benefit Matters. Each of the employee benefit, welfare, pension or similar plans that any of the New Milford Entities sponsors or provides to its employees (each, a "Plan" and collectively, the "Plans") has been fully and completely described, with all applicable agreements and Plan documents, in the Due Diligence Information.

6.2.8.1. Multiemployer Plans. None of the New Milford Entities nor any other person that would be considered as a single employer with the New Milford Entities under the Code or ERISA has ever maintained, contributed to, or been required to contribute to any "multiemployer plan" within the meaning of Section 3(37) or Section 4001(a)(3) of ERISA.

6.2.8.2. Plan Qualification. Each Plan that is intended to be qualified under Section 401(a) of the Code is so qualified. Each Plan, including any associated trust or fund, has been administered in all material respects in accordance with its terms and with all applicable law, and nothing has occurred with respect to any Plan that has subjected or could subject any of the New Milford Entities to a penalty or other liability under ERISA or an excise tax under the Code.

6.2.8.3. All Contributions and Premiums Paid. All required contributions to and premium payments with respect to each Plan have been made on a timely basis. No event has occurred that has resulted in or could subject any of the New Milford Entities to a tax under Section 4971 of the Code or its assets to a lien under Section 412(n) of the Code.

6.2.8.4. Defined Benefit Pension Plans. In the case of each Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the Plan equals or exceeds the present value of all benefit liabilities under the plan determined on a plan termination basis, and (ii) no "reportable event" (as defined in Section 4043 of ERISA) has occurred. No event has occurred that could subject any of the New Milford Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

6.2.8.5. Claims. There is no pending or, to New Milford's knowledge, threatened action relating to a Plan, other than routine claims in the ordinary course of business for benefits provided for by the Plans. No Plan is, or within the last six (6) years has been, the subject of an examination or audit by a governmental authority, is the subject of an application or filing under, or is a participant in, a government-sponsored amnesty, voluntary compliance, self-correction or similar program.

6.2.8.6. Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment.

6.2.8.7. No Restrictions On Termination. No provision of any Plan would result in any limitation on the ability of any of the New Milford Entities to terminate the Plan, and, in the case of any such Plan subject to Title IV of ERISA, to receive any excess assets after the satisfaction of all liabilities.

6.2.8.8. Severance. The transactions contemplated by this Agreement shall not, whether alone or upon the occurrence of any additional or subsequent event, result in any payment of severance or other compensation to, or acceleration, vesting or increase in benefits under any Plan for the benefit of any current or former director, officer or employee of any of the New Milford Entities.

6.2.9 Health Care Kickbacks. No New Milford Entity has engaged in any activity which is prohibited under the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, or the regulations promulgated thereunder, or related state or local fraud and abuse statutes or regulations.

6.2.10 Prohibited Health Care Referrals. No New Milford Entity has established or maintains a "financial relationship," as that term is defined by The Ethics in Patient Referrals Act, 42 U.S.C. § 1395nn, and the regulations promulgated thereunder (the "Stark Law"), with any physician or with an immediate family member of any physician who makes referrals to any New Milford Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. The New Milford Due Diligence Information contains a complete and accurate set of all agreements between any of the New Milford Entities and referring physicians, immediate family members of referring physicians, physician organizations, other health care providers, and other referral sources. None of the New Milford Entities has any arrangements with referring physicians, immediate family members of referring physicians, physician organizations, or other health care providers that are not memorialized in a writing.

6.2.11 Actions, Investigations, and Inquiries. There are no actions, investigations, or inquiries pending (whether or not any formal written notification or any subpoena has been issued in connection therewith), threatened, anticipated or contemplated (nor is there any basis therefor) against or affecting any New Milford Entity, before or by any governmental authority or agency, accreditation body or third-party payor (including the Medicare and Medicaid programs and the Office of Inspector General of the United States Department of Health and Human Services) which relate to antitrust matters, billing practices, third-party

relationships or any other matter: (i) which could prevent or hinder the consummation of the transactions contemplated by this Agreement or call into question the validity of any action taken or to be taken in connection with the transactions contemplated by this Agreement; or (ii) which in any single case or in the aggregate might have a New Milford Material Adverse Effect or result in any material impairment to the right or ability of any New Milford Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs. No New Milford Entity has received any warning or notice of decertification, revocation, suspension or termination, or of threatened or potential decertification, revocation, suspension or termination, with respect to the Medicare and Medicaid programs. The New Milford Due Diligence Information contains complete and accurate information regarding all actions, investigations, or inquiries pending (whether or not any formal written notification or any subpoena has been issued in connection therewith) or, to the knowledge of the New Milford Entities, threatened, anticipated or contemplated against or affecting any New Milford Entity before or by any governmental authority or agency, accreditation body, or third-party payor (including the Medicare and Medicaid programs and the Office of Inspector General of the United States Department of Health and Human Services).

6.2.12 Permits. Each New Milford Entity possesses all permits, licenses, franchises, easements, authorizations, certificates, accreditations, registrations, provider numbers, assignments, consents, rights and privileges necessary under laws applicable to the conduct of their business (collectively, the "Permits"), the non-possession of which would have a New Milford Material Adverse Effect. No New Milford Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of the Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of the Permits is pending or has been commenced or, to the knowledge of the New Milford Entities, threatened and no notification thereof has been received by any New Milford Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a New Milford Material Adverse Effect. The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties shall not limit, restrict, revoke, suspend or terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of the Permits.

6.2.13 Medicare Cost Reports. New Milford and New Milford Visiting Nurse Association have made available to Newco true, correct and complete copies of their Medicare cost reports filed for the following years: 2007, 2008, and 2009. The status of all Medicare and Medicaid cost reports of New Milford and New Milford Visiting Nurse Association for the last two (2) cost-reporting years has been disclosed in the New Milford Due Diligence Information, and there are no

pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open such cost reports.

7. MISCELLANEOUS.

7.1 Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut (without reference to or application of any conflicts of laws principles).

7.2 Successors; Assignment. This Agreement shall inure to the benefit of, and shall be binding upon, the respective successors and permitted assignees of the Parties, including successors by merger or consolidation or any entity to which all or substantially all of the assets of any Party hereto may be transferred. Except as expressly provided in the preceding sentence, no Party may assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of the other Party.

7.3 Amendment. The provisions of this Agreement may be amended or waived only in writing by the Parties. The failure of either Party to enforce at any time any provision of this Agreement shall not be construed to be a waiver of such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any Party thereafter to enforce each and every provision. No waiver of any breach of this Agreement shall be held to constitute a waiver of any other or subsequent breach.

7.4 Confidentiality.

7.4.1 Prohibited Disclosures. Each Party, individually and on behalf of its affiliates, and their respective members, directors, officers, employees, and other agents, agrees to hold in confidence all Confidential Information of the other Party disclosed to it by the other Party and to limit disclosure of such Confidential Information to only those members, directors, officers, employees, agents and advisors of the receiving Party or of its affiliates who have a need to know such Confidential Information for purposes of implementing or carrying out the Affiliation. Each receiving Party will take reasonable measures to ensure that such Confidential Information is not distributed beyond the members, directors, officers, employees, agents and advisors of the receiving Party or its affiliates with such a need to know. Each Party shall require all members, directors, officers, employees, agents and advisors of the Party or its affiliates who have access to Confidential Information of the other Party to agree to confidentiality restrictions limiting their use and disclosure of such Confidential Information to purposes associated with the Affiliation and prohibiting them from disclosing such Confidential Information to third parties. No Party nor any of the Parties' affiliates shall disclose the Confidential Information of the other Party to any other person or entity (except as required by a facially valid judicial or governmental request, requirement or order) regardless of a pre-existing relationship or claim of interest in such Confidential Information.

7.4.2 Permitted Use. Each Party may use the Confidential Information of the other Party disclosed to it only for the purpose of implementing and carrying out the Affiliation and may not otherwise use the Confidential Information of the other Party for its own benefit (or for the benefit of another person or entity). If a receiving Party is requested or required in a judicial, administrative or governmental proceeding to disclose any Confidential Information of the other Party, it will notify the disclosing Party as promptly as practicable so that the disclosing Party may either seek an appropriate protective order or waive the provisions of this Agreement. If, in the absence of any protective order or waiver, the receiving Party is, in the written opinion of its counsel, required to disclose Confidential Information in any court or tribunal, or pursuant to compulsory process of a governmental agency, it may disclose such Confidential Information without liability hereunder.

7.4.3 Excepted Information. The obligations of a Party as recipient of Confidential Information of the other Party under this Agreement shall not apply to any such information (i) which is or becomes generally available to the public or otherwise in the public domain; (ii) which was or is otherwise available to or disclosed to the receiving Party on a non-confidential basis, other than by virtue of a breach of this Agreement; or (iii) which is approved for release by written authorization of an authorized officer of the Party whose Confidential Information is to be disclosed.

7.4.4 Marking Confidential Information. Each disclosing Party shall use reasonable efforts to mark all tangible materials that disclose or embody Confidential Information of such Party as "Confidential," "Proprietary" or the substantial equivalent thereof and to identify Confidential Information that is disclosed orally or visually as confidential at the time of disclosure.

7.4.5 Return and Destruction. Should this Agreement terminate prior to the Effective Date, each Party agrees (i) that it shall promptly return to the disclosing Party or, with the permission of the disclosing Party, destroy all Confidential Information obtained from the other Party and all notes, memoranda and other material which reflect, interpret, evaluate or are derived from such Confidential Information; and (ii) that it will not use such Confidential Information in its future decision-making. Notwithstanding the foregoing provisions of this Section 7.4.5, in no event shall any Party (or such Party's attorneys or other advisors) be required to return or destroy any due diligence analyses or attorney work product prepared in contemplation of the Affiliation.

7.4.6 Remedies. The Parties acknowledge and agree that any breach of the obligations under this Section 7.4 will result in irreparable injury to the Party whose Confidential Information is or is to be disclosed and that the Party so injured shall have the right to specific enforcement of the restrictions of this Section 7.4 as well as all rights that it may have in accordance with the provisions of Section 7.9 hereof.

7.5 Headings. The headings in this Agreement are for purposes of reference only and shall not limit or otherwise affect the meaning hereof. Each covenant contained herein shall be construed as being independent of each other covenant contained herein, so that compliance with any one covenant shall not be deemed to excuse compliance with any other covenant.

7.6 Interpretation. Except where expressly stated otherwise in this Agreement, the following rules of interpretation apply to this Agreement: (i) "include", "includes" and "including" are not limiting and mean include, includes and including, without limitation; (ii) definitions contained in this Agreement are applicable to the singular as well as the plural forms of such terms; (iii) references to an agreement, statute or instrument mean such agreement, statute or instrument as from time to time amended, modified or supplemented; (iv) references to an "Exhibit," "Section" or "Schedule" refer to a Section of, or any Exhibit or Schedule to, this Agreement unless otherwise indicated; (v) the word "will" shall be construed to have the same meaning and effect as the word "shall"; (vi) the word "any" shall mean "any and all" unless otherwise indicated by context; (vii) the word "day" shall mean calendar day, and days shall be counted by excluding the first and including the last day, provided that when the last day falls on a Saturday, Sunday, or holiday, the last day shall be the next day which is not a Saturday, Sunday, or holiday; and (viii) references to an hour of the day mean such hour of the day in Eastern Time.

7.7 Severability. In case any provision in this Agreement shall be determined by a court of competent jurisdiction to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

7.8 Entire Agreement. This Agreement, together with the Exhibits and Schedules attached hereto, shall be deemed for all purposes to constitute the entire agreement of the Parties pertaining to the subject matter hereof and supersedes and cancels all prior agreements, whether oral or written, pertaining to the subject matter hereof. Each Party confirms that it is not relying on any representations, warranties or covenants of the other Party except as specifically set out in this Agreement.

7.9 Exclusive Remedies. The Parties hereto expressly waive and agree to forgo any and all rights to seek and obtain any form of monetary, economic or other damages (including actual, consequential, punitive and other forms of monetary or economic damages), and each of the Parties further agrees that each of the Parties shall be entitled to injunctive relief to prevent a violation of this Agreement and to obtain specific performance to require adherence to the obligations created by this Agreement. Before either Party brings legal action against the other Party (the "Defaulting Party") for failure to perform in any material respect any of its obligations under this Agreement, the entity alleging the breach (the "Alleging Party") shall first give the Defaulting Party written notice setting forth such failure in reasonable detail and stating that the Alleging Party requires such obligation to be performed, and shall give the Defaulting Party the opportunity to perform such obligation in all material respects within sixty (60) days of its receipt of such notice, or such longer period as is necessary if for reasons outside the control of the Defaulting

Party such obligation cannot be performed within such sixty (60) day period, so long as the Defaulting Party is continuing in good faith to use its best efforts to perform such obligation. If any legal action relating to the enforcement of this Agreement is brought by a Party against the other Party, the prevailing Party shall be entitled to recover its reasonable costs, expenses and attorneys' fees.

7.10 No Third Party Beneficiaries. This Agreement is not intended to confer upon any person other than the Parties any rights or remedies hereunder. No person other than the Parties shall have any rights, interest or claims hereunder or be entitled to any benefits under or on account of this Agreement as a third-party beneficiary or otherwise.

7.11 Notices. Any notice hereunder may be given by facsimile transmission, with confirmation of transmission; by hand; by certified mail, return receipt requested; or by overnight delivery service, delivered to the Parties at their respective addresses or facsimile numbers set forth below, or to such other address or facsimile number as a Party may specify by notice to the other Party. Notices shall be deemed given when actually received.

If to Danbury/Newco:

John M. Murphy, M.D.
Executive Vice President
Danbury Health Systems, Inc.
24 Hospital Avenue
Danbury, CT 06810

with copies to:

Lisa M. Boyle
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103

If to New Milford:

Richard J. Henley
Interim President/CEO
New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

with copies to:

David E. Daniels
Daniels and Porco, LLP
517 Route 22
P.O. Box 668

Pawling, NY 12564

7.12 Counterparts. This Agreement may be executed in any number of counterparts and by the Parties on separate counterparts, but all such counterparts shall together constitute but one and the same instrument.

8. DEFINITIONS.

8.1 "Affiliation" has the meaning set forth in the Preamble.

8.2 "Agreement" has the meaning set forth in the Preamble.

8.3 "Alleging Party" has the meaning set forth in Section 7.9.

8.4 "Attorney General" has the meaning set forth in Section 2.6.

8.5 "Closing" has the meaning set forth in Section 1.2.

8.6 "Closing Date" has the meaning set forth in Section 1.2.

8.7 "Closing Memorandum" has the meaning set forth in Section 1.2.

8.8 "Code" has the meaning set forth in Section 6.2.4.

8.9 "Confidential Information" means, with respect to a Party, all confidential or proprietary information concerning the business, finances or other affairs of such Party or of its affiliates disclosed in any manner, whether orally, visually or in written or other tangible form (including documents, devices and computer readable media) and all copies thereof, whether created by the discloser or recipient, by such Party or by its agents or employees to the other Party or its agents prior to, on or after the Effective Date.

8.10 "Current Members" has the meaning set forth in the Preamble.

8.11 "Danbury" has the meaning set forth in the Preamble.

8.12 "Danbury Entities" has the meaning set forth in the Preamble.

8.13 "Danbury Hospital" has the meaning set forth in the Preamble.

8.14 "Danbury Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a Danbury Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to Danbury, including suspension, surrender, revocation or restriction in any manner of a Danbury Entity's (a) participation in any government health care reimbursement program, including Medicare and Medicaid, or (b) license, registration, or certificate necessary to provide health care services; (ii) any adverse circumstance or change in or effect on a Danbury Entity's business, operations, assets, prospects or condition, financial or otherwise, which, when considered together with all other adverse changes and effects with respect to which such

phrase is used in this Agreement, is material to the Danbury Entities considered as a single enterprise; or (iii) any change which would impair the ability of Danbury or any of the Danbury Entities to perform its obligations hereunder.

8.15 "Defaulting Party" has the meaning set forth in Section 7.9.

8.16 "DOJ" has the meaning set forth in Section 3.2.

8.17 "Due Diligence Information" means the information disclosed by Newco to New Milford and the information disclosed by New Milford to Newco in writing as part of the due diligence process or in writing pursuant to Section 2.7.

8.18 "Effective Date" has the meaning set forth in Section 1.2.

8.19 "ERISA" means Title IV of the Employee Retirement Income Security Act of 1974, as amended.

8.20 "Financial Statement" has the meaning set forth in Section 6.1.3.

8.21 "FTC" has the meaning set forth in Section 3.2.

8.22 "Interim Financial Statement" has the meaning set forth in Section 6.1.3.

8.23 "Letter of Intent" has the meaning set forth in the Preamble.

8.24 "Material Transaction" means the execution, amendment, or extension of an employment or consulting agreement for any Vice President or higher level executive; the incurrence of any indebtedness other than endorsement for deposit in the ordinary course of business; or entering into any contract, obligation, or other undertaking that has a term of a year or greater or that requires any New Milford Entity to make annual payments greater than $250,000, unless such New Milford Entity has a right to terminate without cause and without penalty on no more than thirty (30) days notice, excluding therefrom ordinary course renewals of the agreements listed on Schedule 8.24.

8.25 "Newco" has the meaning set forth in the Preamble.

8.26 "New Milford" has the meaning set forth in the Preamble.

8.27 "New Milford Community Board" has the meaning set forth in Section 1.1.2.

8.28 "New Milford Due Diligence Information" means the information disclosed by New Milford to Newco in writing as part of the due diligence process or disclosed by New Milford in writing pursuant to Section 2.7 as well as any reports on New Milford delivered to Newco at the direction of New Milford.

8.29 "New Milford Entities" has the meaning set forth in the Preamble.

8.30 "New Milford Foundation" has the meaning set forth in the Preamble.

8.31 "New Milford Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a New Milford Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to New Milford, including suspension, surrender, revocation or restriction in any manner of a New Milford Entity's (a) participation in any government health care reimbursement program, including Medicare and Medicaid, or (b) license, registration, or certificate necessary to provide health care services; (ii) any adverse circumstance or change in or effect on its business, operations, assets, prospects or condition, financial or otherwise, which, when considered together with all other adverse changes and effects with respect to which such phrase is used in this Agreement, is material to the New Milford Entities considered as a single enterprise; or (iii) any change which would impair the ability of New Milford or any of the New Milford Entities to perform its obligations hereunder.

8.32 "New Milford Visiting Nurse Association" has the meaning set forth in the Preamble.

8.33 "Party" has the meaning set forth in the Preamble.

8.34 "Permit" has the meaning set forth in Section 6.2.12.

8.35 "Plan" has the meaning set forth in Section 6.2.8.

8.36 "Stark Law" has the meaning set forth in Section 6.2.10.

[*Remainder of page intentionally left blank.*]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their respective, duly authorized officers as of the date first above written.

Witness	**DANBURY HEALTH SYSTEMS, INC.**
______________________________	**By:** ______________________________
[*Name*] [*Title*]	[*Name*] [*Title*]
Witness	**NEW MILFORD HOSPITAL, INC.**
______________________________	**By:** ______________________________
[*Name*] [*Title*]	[*Name*] [*Title*]

List of Schedules:

- Schedule 1.1.1 – New Milford Community Board Members on Newco Board of Directors
- Schedule 3.4 – Government Approvals and Filings
- Schedule 3.5 – New Milford Non-Governmental Consents
- Schedule 3.12.1 – Additional Actions to Be Completed by Newco Based on Diligence Findings
- Schedule 3.12.2 – Additional Actions to Be Completed by New Milford Based on Diligence Findings
- Schedule 5.2 – Clinical Services
- Schedule 6.1.4.1 – Newco Notices, Consents, Waivers and Amendments to Contractual Obligations
- Schedule 6.1.4.2 – New Milford Notices, Consents, Waivers and Amendments to Contractual Obligations
- Schedule 6.2.5 – New Milford Facilities Licensed by the Department of Public Health
- Schedule 6.2.7 – New Milford Collective Bargaining Organizations
- Schedule 8.24 – New Milford Ordinary Course Renewals

Exhibit 9

Curriculum Vitae

for

New Milford Hospital, Inc.

Richard J. Henley, FACHE, FHFMA

Education:

The City College of the City University of New York
Master of Arts in Economics, June 1978.
Bachelor of Arts in Economics, June 1978.

Both degrees were earned simultaneously, Summa cum Laude, after a four year period of study.

Experience:

Interim President & CEO — September 2009-Present
New Milford Hospital
New Milford, CT

President & CEO — 2008-Present
Healthcare Strategic Solutions, LLC
Easton, CT

President & CEO — 2005-2008
Pocono Health System
East Stroudsburg, PA

Executive Vice President, COO & CFO — 1999-2005
Health Quest
Poughkeepsie, NY

Executive Vice President — 1997-2005
Senior Vice President for Administration — 1992-1997
Vice President for Finance & CFO — 1985-1992
Vassar Brothers Hospital
Poughkeepsie, NY

Professional Affiliations:

Board of Governors, American College of Healthcare Executives
National Chairman, Healthcare Financial Management Association
Fellow, American College of Healthcare Executives
Fellow, Healthcare Financial Management Association

DANA P. DIGGINS

EDUCATION: Framingham State College, Framingham, MA
Master of Arts, concentration in Business Administration, 1982
Bentley College, Waltham, MA
Bachelor of Science, Accounting, 1971

ADMINISTRATIVE EXPERIENCE:

SUMMARY

Extensive knowledge gained through over 25 years of experience in healthcare financial management in the role of Chief Financial Officer. Responsibilities included all treasury functions, capital planning, operating budgets, information systems, third-party payer contract negotiations, compliance initiatives, case management, materials management and human resources.

NEW MILFORD HOSPITAL, INC., New Milford, CT
An 85 licensed bed full service acute care hospital located in northwest CT.
June 2009 to
Present Vice President for Finance & Chief Financial Officer

LANDMARK HEALTH SYSTEMS, INC., Woonsocket, RI
A two hospital system located in northern RI. Landmark Medical Center located in Woonsocket is a 233 licensed bed acute full service community hospital. Rehabilitation Hospital of Rohde Island located in North Smithfield, RI is an 83 bed rehabilitation hospital.
November 2008 to
June 2009 Interim Chief Financial Officer

HARRINGTON MEMORIAL HOSPITAL, Southbridge, MA
A 100 bed community hospital located in South Central Worcester County.
January 2008 to
October 2008 Interim Chief Financial Officer

EMERSON HEALTH SYSTEM, INC., Concord, MA
Parent company of Emerson Hospital, a 170 bed full service community hospital; Emerson Healthcare Foundation, the fundraising arm of the system; and Emerson Property Development Corporation, a for-profit organization.
1999 to
2007 Senior Vice President for Finance and Administration/Chief Financial Officer

MOUNT AUBURN HOSPITAL, Cambridge, MA
A 300 bed academic medical center affiliated with Harvard Medical School. Subsidiary of CareGroup, Inc., and the sole member of Mount Auburn Professional Services, Inc., a multi-specialty physician practice with practice sites located throughout the hospital's primary service area.
1988 to
1999 Vice President of Finance/Chief financial Officer

CHOATE-SYMMES HEALTH SERVICES, INC., Woburn, MA
Merger of two community hospitals. Choate Hospital in Woburn and Symmes Hospital in Arlington
1984 to
1988 Vice President for Fiscal Services
1981 to
1984 Director of Financial Operations
1980 to
1981 Controller/Chief Financial Officer
1979 to
1980 Assistant Controller

WELLINGTON NURSING HOME, INC./TEK ASSOCIATES REALTY TRUST, Arlington, MA

1971 to
1979 Controller/Business Manager

SUSAN IOVINO, BSN, MSN

Education: Oakland University, Michigan
Doctor of Nursing Practice, Administration, 2009-present

Western Connecticut State University, Danbury, CT.
Masters in Nursing Administration, 1995

New York University Institute of Rehabilitation Medicine, New York, NY.
Graduate certification in Advanced Physical Rehabilitation, 1978

Adelphi University, Long Island, NY.
Bachelor of Science, Nursing, 1977

Norwalk Community College, Norwalk, CT
Associate of Applied Science in Nursing, 1974

ADMINISTRATIVE EXPERIENCE:

NEW MILFORD HOSPITAL, New Milford, Connecticut

2007 to Present — Executive Vice President, COO, CNO
Oversees 21 Clinical Departments inclusive of Administrative direct reports in Nursing, Pharmacy, Radiology, Laboratory the Regional Cancer Center and hospital-based medical staff. Supervises, analyzes and coordinates the operations of all clinical services and oversees the Performance Improvement Program.

1989 to 2007 — Vice President Patient Care Services, CNO

1988 to 1989 — Assistant Director of Nursing

BRIDGEPORT HOSPITAL, Bridgeport, Connecticut

1986 to 1988 — Director of Nursing (OR, PACU, Open Heart/Surgical ICU, Urology, Endoscopy, Ambulatory Surgery, Medical Ambulatory, Burn Center, Adolescent Medical-Surgical, Oncology, Rehabilitation, Neurosurgical ICU, General Surgery, Neurology and Orthopedics

DANBURY HOSPITAL, Danbury, Connecticut

1983 to 1986 — Clinical Director of Surgical Services (OR, PACU, Surgery, Orthopedics, Neurosurgery, Rehabilitation)

1980 to 1983 — Rehabilitation Coordinator/ Nurse Manager

1977 to 1980 — Staff Nurse for Rehabilitation Unit (Orthopedics, Neurosurgery, Rehabilitation and I.V. Therapy)

SALLY F. HERLIHY, MBA, FACHE

Education	University of New Haven New Haven, CT *MBA (concentration in Health Care Management) - 1995*	
	University of Connecticut Storrs, CT *BS Degree, School of Allied Health (Clinical Dietetics) – 1980*	
Work Experience	VP, Regulatory Compliance	2007 – Present
	VP, Planning and Marketing	1997 – 2007
	VP, General Services	1988 – 1997
	Corporate Project Planner	1985 – 1988
	New Milford Hospital New Milford, CT	
	Director, Food Services	1983 – 1985
	Chief Dietitian	1981 – 1983
	Clinical Dietitian	1980 – 1981
	The Seiler Corporation New Milford Hospital, New Milford, CT and St. Elizabeth's Hospital, Utica, NY	
Professional	Fellow, American College of Health Care Executives American Dietetic Association, *Registered Dietitian – 1980 - 2000*	

Diverse responsibilities and experience including organizational planning and certificate of need activities, corporate compliance, regulatory accreditations, and direct administrative reports: Risk Management, Quality Management, Management Information Systems, Health Information Management, Admitting, Public Relations & Marketing, Case Management (Utilization Review, Social Work), medical staff office, Pharmacy, Laboratory, Food Service, and Environmental Service functions and administrative support for various Board committees.

ROBERT D. SOMMER

Education: The American University, Washington, D.C.
Bachelor of Science, Business Administration, 1969

ADMINISTRATIVE EXPERIENCE:

DANBURY HOSPITAL, Danbury, Connecticut

May 1974 to
May 1979 Assistant Director of Personnel

NEW MILFORD HOSPITAL, New Milford, Connecticut

May 1979 to
Present Vice President Human Resources

Plans, organizes and directs all aspects of the human resource function of the hospital for the employment, compensation, employee and labor relations of employees. Additionally directs the activities of the Food Services, Environmental Services, Plant Operations, Facilities, Biomedical Services, Security, Behavioral Health Services, and Volunteer Services departments.

Frederick A. Browne, M.D., M.B.A.

WORK EXPERIENCE

Aug 2006 – Present
New Milford Hospital, New Milford, CT
Chief Medical Officer (9/09 - present)
Director of Medical Affairs (8/08 – 9/09)
Hospital Epidemiologist
Infectious Diseases Physician

BOARD CERTIFICATION/ELIGIBILITY

Sept. 2006 — **Board Eligible - ABP-Medical Microbiology Subspecialty**

Oct. 2005 — **Board Certified - ABIM-Infectious Diseases Subspecialty**

Aug. 2003 — **Board Certified - American Board of Internal Medicine**

EDUCATION

Feb. 2006- Jan. 2008
The University of New Haven, West Haven, CT
Masters of Business Administration

Sept. 1994- June 1998
American University of the Caribbean School of Medicine
Medical Doctorate

Sept. 1990- Dec. 1993
The University of Connecticut, Storrs, CT
Cum Laude Bachelors of Science, Molecular and Cellular Biology

RESIDENCY/FELLOWSHIP

July 2003- June 2006
Yale University School of Medicine, New Haven, CT
Academic Infectious Disease Fellow, Winchester Medical Microbiology Fellow and Winchester Hospital Epidemiology Fellow

July 2001- June 2003
Penn State Hershey Medical Center, Hershey, PA
Internal Medicine Residency

July 1999 - June 2001
Penn State Hershey Medical Center, Hershey, PA
Resident in Anatomic and Clinical Pathology

July 1998 - June 1999
Abington Memorial Hospital, Abington, PA
Internal Medicine Internship

000125

HENRY C. ALLEN, MD, FAAFP
Associated Family Physicians
146 Danbury Road
New Milford, Connecticut 06776
(203) 350-4000

CURRENT APPOINTMENTS:
President, Medical Staff, New Milford Hospital
Member, Board of Directors, New Milford Visiting Nurses Association
School Physician, New Milford High School, Schagticoke Middle School, Sarah Noble School
Department Physician, New Milford, Gaylordsville, Northville, Bridgewater Fire Departments

PREVIOUS EMPLOYMENT:
Brookfield Family Medicine, Brookfield, CT
July 1988 through February 1991.

POSTGRADUATE TRAINING:
Hunterdon Medical Center Family Practice Residency Program Flemington, New Jersey - June 1985 - June 1988

MEDICAL EDUCATION:
University of Vermont College of Medicine
Burlington, Vermont
M.D. Degree, May 1985

UNDERGRADUATE EDUCATION:
Harvard College
Cambridge, Massachusetts
B.A. Social Anthropology, June, 1980
Graduated Cum Laude in General Studies

MEMBERSHIPS:
American Academy of Family Physicians
Connecticut State Medical Society
Litchfield County Medical Society
New Milford Rotary

LICENSES AND CERTIFICATIONS:
Diplomate, National Board of Medical Examiners, July 1986
Licensed to Practice Medicine in State of Connecticut, May 1988
Board Certified in Family Practice, July 1988
Recertified 1994, 2000, 2006
Certificate of Added Qualifications in Geriatrics, 1992
Recertified 2001
Fellowship, American Academy of Family Physicians, September 1994

References available upon request.

JOSEPH BARGELLINI, M.D.

Medical Director, Radiation Oncology, New Milford Hospital, New Milford, CT
Responsible for building a practice in a hospital based setting where radiation therapy was a new service.
Implemented prostate brachytherapy program and high dose rate brachytherapy program.
Implemented Intensity Modulated Radiation Therapy using Varian Eclipse Software.
Implemented radiopharmaceutical therapy program.
Responsible for developing and implementing policies, procedures, and quality assurance programs for the different radiation therapy modalities offered.
Radiation Oncology representative to hospital committees, including Medical Executive Committee, weekly Cancer Conference, and Multidisciplinary Cancer Committee.
Radiation Safety Officer, New Milford Hospital, New Milford, CT
Chairman, New Milford Hospital Institutional Review Board

Academic Training
Yale University, New Haven, Connecticut, B.S., 1986
University of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark, New Jersey, M.D., 1993

Licensure: Connecticut State, September 1998, #037262
Internship: The New York Hospital - Cornell Medical Center, New York, NY
Internal Medicine, 1993-1994
Residency: Mallinckrodt Institute of Radiology, St. Louis, MO;
Resident in Radiation Oncology, 1994-1995
Columbia-Presbyterian Medical Center, New York, NY
Resident in Radiation Oncology, 1995-1998
Chief Resident July 1996 through February 1997

Board Certification
Diplomate, National Board of Medical Examiners, 1994
Diplomate, American Board of Radiology – Radiation Oncology, 1998, Certificate #43451
American Board of Radiology – Radiation Oncology Recertification 2008

Work Experience

1987-1989 Analyst, Domestic and International Fixed Income Securities
Drexel Burnham Lambert
New York, NY

Teaching
Faculty leader of Columbia-Presbyterian Residency Journal Club.
Columbia-Presbyterian Resident teaching through case conferences.
MCAT Instructor, Stanley Kaplan Educational Centers, Location, 1990-1991.

George B. Barth II, MD

Associated Family Physicians, PC

Current Appointment:

New Milford Hospital, 21 Elm Street, New Milford, CT 06776
Medical and Pediatric Privileges Chairman, Department of Medicine 2007-present
New Milford Visiting Nurse Association, Board of Directors 1989-present

Education:

1978 B.A. University of Colorado, Boulder, CO; Molecular Biology, With Honors, Phi Beta Kappa
1982 M.D. New Jersey Medical School University of Medicine and Dentistry of New Jersey, Newark, NJ

Residency: 7/82-6/85 Southside Hospital Family Practice Residency Bay Shore, NY

Licensure: Connecticut #029085

Medical Experience:

1/91 –Present	Associated Family Physicians, PC
11/90-Present	Hospice Medical Director Visiting Nurse Association of New Milford, New Milford, CT
9/89-Present	School Physician- New Milford High School; Schaghticoke Middle School (1996-present)
1991-Present	Fire Department Physician for New Milford, Gaylordsville, Northville and Bridgewater Fire Departments; US Post Office Medical Contract Physician
1995-Present	Physician's Choice IPA Board of Directors; 1997-2000 Vice President for Contracting, responsible for physician oversight of direct contracting with insurers
1989-1997	FIDCO-Food Ingredients Development Company Consulting Physician for 400+ employees administering annual examinations and assessing and treating work-related injuries
1993-2004	Co-Medical Director; New Milford Nursing Home
8/88-1/91	Family Physician; Brookfield Family Medicine-New Milford Office
8/85-8/88	National Health Service Corps; Raeford, NC
8/85-8/88	Clinical Instructor, Family Medicine; FAHEC Family Practice Residency Program, Fayetteville, NC
8/85-8/88	Medical Examiner, Hoke County, NC
2/86-8/88	Founding Medical Director, Hospice of Hoke County
1985-86	Hoke County Task Force on Adolescent Pregnancy
6/81-6/82	Director, Student Family Health Care Clinic New Jersey Medical School, Newark, NJ
Summers of '74 &'76	Medical Orderly 121st Evacuation Hospital, Seoul, Korea

COURTNEY EMERSON CHAMBERS, M.D., F.A.C.S.

Licensure:

State of California, 2000, G85771 – Active
State of Connecticut, 2007, 034618-Active

Certifications:

ATLS, recertification July 2007
Undersea and Hyperbaric Medicine Society, June 2004
Diplomate, American Board of Surgery, June 2002
Diplomate, National Board of Medical Examiners, July 1992

Education:

Doctor of Medicine, 1990
University of Connecticut School of Medicine, Farmington, CT 1985-1990
B.S. Chemistry & Biology (joint major) 1985
University of Hartford, Bloomfield, CT 1981-1985

Post Doctoral Training:

Chief Resident: - General Surgery, 1994-1995
Hospital of Saint Raphael, New Haven, CT. (Yale affiliate program)
Resident: - General Surgery, 1991-1994
Hospital of Saint Raphael, New Haven, CT
Intern: - General Surgery, 1990-1991
Hospital of Saint Raphael, New Haven, CT.

Experience:

August 2007 – Present
General Surgery, private practice.
New Milford Hospital, New Milford, CT.

August 2003 – August 2007
General Surgery, private practice.
NorthBay Medical Center, Fairfield, CA.
Solo, general surgery. Special interest in breast surgery. On staff,
NorthBay Center for Wound Care and Hyperbaric Oxygen Therapy.
Performed dialysis/vascular access surgery.

August 2002 – August 2003
General Surgery, private practice.
Solano Regional Medical Group, Fairfield, CA.

April 2002 – May 2003
Attending – Assistant Clinical Instructor in General Surgery,*
Central California Faculty Medical Group.
UCSF-Fresno, General Surgery Program.
General surgery coverage including level I trauma –
University Medical Center, Fresno, CA.

July 2001 – July 2002
Attending – General Surgery, Department of Veterans Affairs
Central California Health Care System, Fresno, CA.
Assistant clinical instructor UCSF-Fresno General Surgery

July 2000 – July 2001
General Surgery Residency Program, UCSF-Fresno, Fresno, CA.
Tertiary care referral center. Level I trauma center.

September 1996 – July 2000
Solo Practice – General & Vascular Surgery
North Shore Medical Center, Miami, FL.
On staff at The Wound Healing Center, North Shore Medical Center, Miami, FL. (1998-2000.)

September 1995 – September 1996
Group Practice – General & Vascular Surgery
Surgical Partners, P.A., Miami, FL.
(Sergio Villegas, M.D.)

July - August 1995
Attending night coverage – Cardio-thoracic Intensive Care Unit
Hospital of Saint Raphael, New Haven, CT.

Professional Organizations:

American College of Surgeons – Fellow, October 2007
American Society of Breast Surgeons – Active Member, 2003
American Medical Association – Active Member, 2000

* Position held during and after tenure at VA Hospital.

ANDREA Q. CROWLEY, M.D.

EDUCATION

1979- 1983	Case Western Reserve University School of Medicine, Cleveland, OH M.D., 1983; Honors in Internal Medicine, Nephrology and Psychiatry
1973- 1977	Ohio Wesleyan University, Delaware, OH B.A., Zoology, 1977

POSTGRADUATE TRAINING

1988 – 1989	**Fellow** Angiography / Neuroradiology / MRI Boston Veterans Administration Hospital, Boston, MA Tufts University School of Medicine
1986 - 1987	**Chief Resident** Diagnostic Radiology Boston City Hospital and University Hospital, Boston, MA Boston University School of Medicine
1984 - 1988	**Resident** Diagnostic Radiology Boston City Hospital and University Hospital, Boston, MA Boston University School of Medicine
1983 - 1984	**Intern** Transitional Medicine Malden Hospital, Malden, MA Boston University School of Medicine

EXPERIENCE

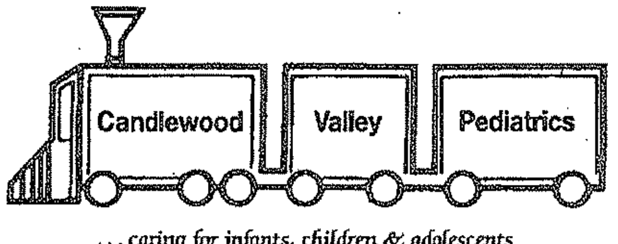
2004 - Present	**Chairman** Department of Diagnostic Radiology New Milford Hospital, New Milford, CT
2002 - Present	**Radiologist** Northeast Radiology PC New Milford Hospital, New Milford
1998 - 2002	**Associate Chief** Department of Diagnostic Radiology North Shore Medical Center, Union Hospital, Lynn, MA
1992 - 2002	**Chief** Section of Angiography and Interventional Radiology North Shore Medical Center, Union Hospital, Lynn, MA
1989 - 2002	**Radiologist** Commonwealth Radiological Associates, Inc., Lynn, MA (formerly Essex Radiological Associates, Inc.) North Shore Medical Center, Union Hospital, Lynn, MA
1977 - 1979	**Research Technologist** Division of Nephrology Cleveland Metropolitan General Hospital, Cleveland, OH

ACADEMIC APPOINTMENTS

1988 - 1989	**Instructor** Radiology Tufts University School of Medicine, Boston, MA
1989 - 1992	**Instructor** Radiology Boston University School of Medicine, Boston, MA

CERTIFICATION & LICENSURE

1988	Board Certification, American Board of Radiology
1984- Present	Medical License, Massachusetts
2002 - Present	Medical License, Connecticut
2003 - Present	Medical License, New York



... caring for infants, children & adolescents

Evan R. Hack, M.D.
Frank Fanella Jr., M.D.
Matthew G. Abel, M.D.
Wendy H. Drost, M.D.
Kristi F. Beck, M.D.

120 Park Lane
Suite A-101
New Milford, CT 06776
(860) 355-8190

Frank Fanella, MD
120 Park Lane, Suite A-101
New Milford, CT 06776

EDUCATION:	Fairfield University Fairfield, CT. BS-Biology 09/1985-05/1989
	Albert Einstein College of Medicine of Yeshiva University, Bronx, New York 08/1989-06/1993
DEGREE:	Medical Doctor
INTERNSHIP/RESIDENCY:	Schneider Children's Hospital, New Hyde Park, NY 07/1993-05/1997
BOARD CERTIFICATION:	American Board of Pediatrics, 10/09/2003

FELLOW OF THE AMERICAN ACADEMY OF PEDIATRICS

EMPLOYMENT HISTORY: Candlewood Valley Pediatrics, PC 06/1997 to Present

HOSPITAL AFFILIATIONS: New Milford Hospital-Active/Attending

CHAIRMAN DEPARTMANT OF PEDIATRICS, New Milford Hospital-01/09 to Present

ROBERT F. FITTON, M.D.
246 Federal Road, Unit C 31
BROOKFIELD, CT 06804
(203) 740-5111(office)
Email: drfitton@drfitton.com

TRAINING AND EXPERIENCE

Private Practice, 2000 - Present
Brookfield, Connecticut

Housatonic Medical Services, 2004-Present
Brookfield, CT. Owner/Medical Director
Provider of Mid-level Personal to Regional Nursing Homes

PROs Medical Services, 2002-2004
Brookfield, CT.
Medical Director of Regional Occupational Health Company

Resident Physician, 1997 – 2000
New York Medical College at St. Joseph Family Practice Residency Program
Yonkers, New York

CLINICAL AFFLIFIATIONS
Attending Physician
New Milford Hospital
New Milford, Connecticut

Assistant Medical Director
Bethel Rehabilitation and Health Care Center
Bethel, Connecticut

ACADEMIC APPOINTMENTS
Clinical Instructor
Department of Family Medicine
New York Medical College
Valhalla, New York

EDUCATION
NEW YORK MEDICAL COLLEGE, VALHALLA, NY
Medical Degree, May 1997

AMERICAN UNIVERSITY, WASHINGTON, D.C.
M.S. Justice, December 1987
Graduate Scholarship Award for Academic Achievement

DOMINICAN COLLEGE, BLAUVELT, NY
B.A. Social Science, January 1985
Departmental Honors, Dean's List 3 Semesters

CERTIFICATION
American Academy of Family Practice July, 2000
American Board of Family Practice July, 2000
Medical Review Officer (In Progress)

MEDICAL LICENSURE
Connecticut
New York

PREVIOUS EMPLOYMENT
Information Technology Consultant, 1993 – 1995
Manhattan District Attorney's Office
New York, NY

Intelligence Research Specialist, 1987 – 1993
Unites States Customs Service
New York, Cleveland, Washington, DC

Institute Coordinator, 1987
Institute on Drugs, Crime and Justice
Imperial College, London, England/American University, Washington, DC

SKILLS
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Basic Life Support

ACTIVITIES/COMMITTEES/VOLUNTEER WORK
New Milford Hospital, New Milford, Connecticut
Workmen's Compensation Coordinator (Ongoing)
Hospitalist Implementation Committee (Ongoing)
Health Information Technology Committee (Ongoing)
Medical Executive Committee (2007)

Chairperson, Resident Recruitment Committee, 1998 – 2000
St. Joseph's Medical Center

Member, AMA/AAMC Liaison Committee on Medical Education, 1998 – 1999
New York Medical College

Resident Preceptor, 1997 – 2000
3rd Year Medical Student Family Practice Clerkship;
2nd Year Medical Student Physical Diagnosis Course
St. Joseph's Medical Center/New York Medical College

PROFESSIONAL ORGANIZATIONS
American Academy of Family Practice
Connecticut Academy of Family Practice

Evan R. Hack, M.D.
Frank Fanella Jr., M.D.
Matthew G. Abel, M.D.
Wendy H. Drost, M.D.
Kristi F. Beck, M.D.

120 Park Lane
Suite A-101
New Milford, CT 06776
(860) 355-8190

EVAN R. HACK, M.D.

Academic Training:

Washington University
St. Louis, Missouri
B.A. - History; Cum Laude, Phi Beta Kappa
1977-1981

Albany Medical College
Albany, New York
M.D., Alpha Omega Alpha Medical Honor Society
1981-1985

Tufts University- New England Medical Center
Boston Floating Hospital for Infants & Children
Boston, Massachusetts
Pediatric Internship and Residency
1985-1988

Neuroscience Education Institute
Center for the Advancement of Children's Mental Health
Mini-Fellowship for Primary Care Clinicians: The Safe and Effective Use Of Psychiatric Medication in Children and Adolescents
2007

Board Certification:

American Board of Pediatrics - 1989
Recertification - 1996, 2003

Medical Licensure:

State of Connecticut - 1988

Hospital Appointments/ Positions:

Attending Physician
New Milford Hospital
New Milford, Connecticut
1988 - present

Medical Staff President Elect
New Milford Hospital
New Milford, Connecticut
2009-2011

	Chairman, Department of Pediatrics New Milford Hospital New Milford, Connecticut 1995 - 2008
	Board Member, Board of Directors New Milford Hospital New Milford, Connecticut 2005 - present
	Attending Physician Danbury Hospital Danbury, Connecticut 1988 - 2005
Professional Organizations:	Fellow, American Academy of Pediatrics 1988 - present
	School Health Committee CT Chapter American Academy of Pediatrics 2004 - present
Community Organizations Service & Positions:	School Medical Advisor New Milford Public School District 1998 - present
	Plow to Plate Coalition New Milford Hospital 2007 - present
	New Milford Healthy Community 2020 United Way of Western Connecticut 2007 - 2008
Employment:	Cofounder and Senior Partner Candlewood Valley Pediatrics New Milford, Connecticut 1988 - present
	Camp Physician Bucks Rock Camp New Milford, Connecticut Summer 1998 - present
	Medical Coordinator Kenmont/Kenwood Camp Kent, Connecticut Summer 2007 – present

THOMAS J. KOOBATIAN, M.D.

Staff Appointments/Positions:

New Milford Hospital, New Milford, CT
Chairman, Department of Emergency Medicine
1997 – Present

President of New Milford Hospital Medical Staff
Chairman, Medical Staff Executive Committee
2003 – 2005

Bradley Memorial Hospital, Southington, CT
Associate Chairman, Emergency Medicine; Director, Emergency Medical Services;
Associate Attending Physician
1996 – 1997

St. Francis – St. George Hospital, Cincinnati, Ohio
Associate Attending Physician
1994 – 1996

Providence Hospital, Cincinnati, Ohio
Associate Attending Physician
1994 – 1996

Mercy Anderson Hospital, Cincinnati, Ohio
Associate Attending Physician
1994 – 1996

Cermont Mercy Hospital, Batavia, Ohio
Associate Attending Physician
1994 – 1996

Good Samaritan Hospital, Cincinnati, Ohio
Associate Attending Physician
1994 – 1996

Education:
Tufts University; Medford, Massachusetts; B.S. – Biology - 1986
Tufts University; Medford, Massachusetts; M.S. – Public Health – 1987
University of Vermont; Burlington, Vermont; M.D. – 1991
The Medical College of Pennsylvania; Residency in Emergency Medicine 1991 – 1994

Medical Licensure: State of Connecticut – May 1996

Board Certification: American Board of Emergency Medicine
Diplomate - 1995

Michael Levine, MD, FACC

11 Old Park Lane
New Milford, CT 06776

CURRENT POSITIONS
Director of the Division of Cardiology, New Milford Hospital
Partner, New Milford Medical Group

EDUCATION

1987	Bachelor of Arts	Dartmouth College, major: Chemistry Hanover, NH
1991	Medical Degree	New York University School of Medicine New York, NY

POSTDOCTORAL TRAINING

1991-1994	Internal Medicine Resident, Thomas Jefferson University Hospital Philadelphia, PA
1994-1995	Chief Medical Resident, Thomas Jefferson University
1995-1998	Cardiology Fellow, University of CT/Hartford Hospital, Hartford, CT

LICENSURE/CERTIFICATIONS

1995 – PRESENT	Connecticut state license
1994-2004	Diplomat of the American Board of Internal Medicine
1998-2008, 2009 – present	Diplomat of the ABIM, Cardiovascular Disease, recertified
1998-2008, 2009 – present	Diplomat of the Certification Council of Nuclear Cardiology, recertified
1998-2008, 2009 – present	Testamur of the American Society of Echocardiography Examination, recertified
1998	Achievement in Electrocardiography Interpretation by ACC
1998 – Present	Fellow of the American College of Cardiology
1989 – Present	Basic life Support with multiple recertifications
1989 – Present	Advanced Cardiac life Support with multiple recertifications

HOSPITAL APPOINTMENTS

1994-1995	Thomas Jefferson University Hospital
1995-1998	Hartford Hospital – Emergency department
1996-1998	Manchester Memorial Hospital – House Physician and ER
1996-1998	Sharon Hospital - Cardiologist
1997-1998	Charlotte Hungerford Hospital – Cardiologist
1998 - Present	New Milford Hospital – Cardiologist Director of Cardiology

PROFESSIONAL SOCIETIES

1991	American Medical Association
1993	American College of Physicians
1995	American College of Cardiology
1999	American Society of Nuclear Cardiology
1999	American Society of Echocardiography

Oral Presentations, Research, Publications and Abstracts available upon request

John E. Mullen, M.D.

Education

July, 1999 – June, 2002	Resident Department of Orthopaedic Surgery Hospital for Special Surgery New York, New York Director: Russell F. Warren, M.D.
July, 1998 – June, 1999	Resident Department of Orthopedic Surgery Mount Sinai Medical Center Cleveland, Ohio Director: William H. Seitz, Jr., M.D.
July, 1997 – June, 1998	Internship General Surgery Mount Sinai Medical Center Cleveland, Ohio Director: Steven Steinberg, M.D.
July, 1993 – June, 1994	Internship Transitional Saint Vincent's Medical Center Bridgeport, Connecticut Director: Marvin Garrell, M.D.
August, 1989 – May, 1993	New York Medical College Valhalla, New York Degree: Doctor of Medicine
September, 1985 – May, 1989	Providence College Providence, Rhode Island Degree: Bachelor of Science Major: Biology
September, 1981 – June, 1985	New Milford High School New Milford, Connecticut

Work Experience

April, 2008 – Present	Stadium Physician Yankee Stadium Bronx, New York
October, 2002 – Present	House Physician Madison Square Garden New York, New York
August, 2002- Present	Orthopedic Surgeon New Milford Orthopedic Associates New Milford, Connecticut
April, 2000 – October, 2000	Stadium Physician Shea Stadium New York Mets Baseball Team

	Queens, New York
April, 1998 – April, 2002	Medical Officer, Lieutenant Commander PRIMUS Naval Reserve Fleet Hospitals # 9 and 500 Cleveland, Ohio and Bronx, New York
August, 1997 – March, 1999	Team Physician Varsity Football, Wrestling, and Hockey Euclid, Eastlake and Hawkin Schools
August, 1998 – September, 1998	Clinical Instructor Anatomy Case Western Reserve University School of Medicine
June, 1995 – June, 1997	Emergency Room Physician Coastal Physicians Durham, North Carolina
July, 1994 – June, 1997	Battalion Surgeon Second Marine Division Camp Lejeune, North Carolina

EMILY R. O'KEIFF, D.D.S., M.S.

EDUCATION

Division of Orthodontics
Department of Diagnositic and Surgical Sciences
University of Minnesota
Master of Science and Certificate in Orthodontics
2004

Baltimore College of Dental Surgery, Dental School
University of Maryland
Doctor of Dental Surgery, *magna cum laude*
2002

The University of Notre Dame
Bachelor of Science, biology and Spanish, *cum laude*
1998

PROFESSIONAL MEMBERSHIPS

American Association of Orthodontists
American Dental Association
Connecticut State Dental Association
Greater Danbury Dental Society
Active Staff, New Milford Hospital (Chairman, Dental Department)

POSITIONS HELD

Private Solo Practice, O'Keiff Orthodontics, New Milford, CT (2006-current)
Private Practice, Watertown and Woodbury, CT (2004-2006)
Private Practice, Yorktown Heights, NY (2004)

30 BRIDGE STREET, SUITE 202, NEW MILFORD, CT 06776

PHONE (860) 354 –6006 ♦ FAX (860) 354 - 5343

Carol S. Papov, M.D.

Office Address:
131 Kent Road Suite 203
New Milford, CT 06776
(860)210-0082

Current Status

New Milford Hospital Active Staff (August 1999 – present)
OB/GYN Chief (2005 – present)

Professional Interests

Pelvic Ultrasound, Colposcopy, Adolescent Gynecology

Education

Boston University School of Medicine (1991-1995)	Boston, MA
University of Massachusetts – Amherst (1985-1989) Bachelor of Science, *Magna cum Laude*, May, 1989 Major in Animal Science	Amherst, MA

Post-graduate Training

University of Connecticut Health Center
Department of Obstetrics and Gynecology
Chief Resident and Clinical Instructor, 1998-1999
Resident Physician, 1995-1999

Licensure

Fellow, American College of Obstetrics and Gynecology	Dec 2001
National Board of Medical Examiners	completed 1996
State of Connecticut Medical License	August 1999-present
State on New York Medical License	July 2000- 2006

Honors/ Awards

Connecticut Top Docs (2005)

Residency:

- American Society for Colposcopy and Cervical Pathology Award for Top Senior Resident in Colposcopy
- Heart and Hands Award for Outstanding GYN Cancer Care
- University of CT Health Center 1999 Alumni Award for Excellence in Undergraduate Teaching
- Berlex Laboratories' Resident Teaching Award: *"Best 2nd year teaching resident"*
- Selected as Resident Reporter, ACOG 1997 meeting (Puerto Rico)

Medical School Honors and Awards:

- Alpha Omega Alpha
- Samuel L. Poplack Award for Superior Clinical Competence and Excellence in Patient Care
- Henry J. Bakat Award in Community Medicine

Undergraduate Honors and Awards:

- Alpha Lambda Delta Freshman Academic Honorary
- Alpha Zeta, College of Agriculture Academic Honorary
- Golden Key National Honor Society
- National American Society of Animal Science Award
- Phi Kappa Phi, Academic Honorary
- University of Massachusetts Alumni Scholarship Recipient
- Who's Who Among Students in American Universities & Colleges

Experience

Pfizer Central Research Groton, CT
Research Assistant (1989-91): Primary responsibility for *in vivo* screens of oral and intravenous antihypertensive agents in rodents.

University of Massachusetts Amherst, MA
Department of Veterinary and Animal Sciences
Independent Study (1988-89): *In vitro* fertilization of rabbit oocytes and artificial acrosomal reaction with rabbit sperm.
Laboratory Technician (1986): Micro-manipulation of embryos in vitiligo research using a chicken model.

Committees:

Continuing Graduate Medical Education Subcommittee on Educational Policy
Combined Residency Education Curriculum Committee

Senior Resident Research Project:

Atypical Glandular Cells of Undetermined Significance (AGUS)

Professional Associations

American College of Obstetricians and Gynecologists, Fellow
American Medical Association

CURRICULUM VITAE

JOAN F. PUGLIA, MD
30 BRIDGE STREET, SUITE 102
NEW MILFORD, CT 06776

EDUCATION

1974-1978	BS, Biology	St. John's University	Jamaica, New York
1978-1981	MS, Biology	New York University	New York, New York
1981-1985	MD	Albany Medical College	Albany, New York

POSTGRADUATE MEDICAL TRAINING

1985-1986	Internal Medicine Internship	Montefiore Hospital Hospitals of the University Health Center of Pittsburgh	Philip Troen, MD Chairman, Department of Medicine
1986-1989	Neurology Residency	Hospitals of the University Health Center of Pittsburgh	Oscar M. Reinmuth, MD Chairman, Department of Neurology
1989-1990	Electroencephalography Fellowship	Hospitals of the University Health Center of Pittsburgh	Richard Brenner, MD Director

WORK HISTORY

7/1990-Present	Solo Practice	Northwest Hills Neurology, P.C. New Milford, CT

CERTIFICATION

1986	National Board of Medical Examiners
1992	American Board of Psychiatry and Neurology

LICENSING

1990	State of Connecticut
1990(re-instated 2004-2008)	State of New York

HONORS

1978	Summa Cum Laude	St. John's University
1985	The Frederick H. Hesser Award in Neurology	Albany Medical College
1988-1989	Co-Chief Resident, Department of Neurology	UPMC, Pittsburgh
1989	Winner, Residents' Day Presentation	UPMC, Pittsburgh

MEMBERSHIP IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

1987-Present	American Academy of Neurology
1990-Present	Connecticut State Medical Society
1990-Present	Litchfield County Medical Association (LCMA)
1990-Present	Connecticut Neurologic Society
1990-Present	Fairfield County Neurology Society
1993-Present	Executive Committee, LCMA
1993-2007	Medical Advisory Board-Western CT Chapter, National Multiple Sclerosis Society
1995-1997	Chairman, Department of Medicine-New Milford Hospital
1999-2001	Secretary-Treasurer, LCMA
2001-2003	Vice-President, LCMA
2003-2005	President, LCMA
2004-Present	Medical Advisory Committee-New Milford VNA
2005-2007	Immediate Past President, LCMA
2005-2006	President-Elect, New Milford Hospital Medical Staff
2007-2008	President, New Milford Hospital Medical Staff
2007-2009	Credentials Committee, LCMA
2009-2010	Immediate Past President, New Milford Hospital Medical Staff

PUBLICATIONS

1. PROCEEDINGS:
   Martinez AJ, Puglia J. The Neuropathology of Liver, Heart, and Heart-Lung Transplantation. Transplantation Proceedings 1988; 20(Suppl 1):806-809.

2. ABSTRACTS:
   Puglia Joan F, Eidelman BH, Ruben Frederick, Banks GE. Delayed Lyme Encephalopathy. Neurology 1988; 38(Suppl 1): 322. Presented in part at the 40th Meeting of the American Academy of Neurology, Cincinnati, May 1988)

3. PAPERS:
   Puglia Joan F, Brenner Richard P, Soso Michael J. Relationship Between Prolonged and Self-Limited Photoparoxysmal Responses and Seizure Incidence: Study and Review. Journal of Clinical Neurophysiology 1992; 9(1): 137-144. (Presented in Part at the 42nd Meeting of the American Academy of Neurology, Miami Beach, May 1990).

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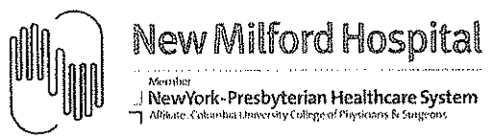


21 Elm Street
New Milford, Connecticut 06776-2915
Telephone: (860) 355-2611
www.newmilfordhospital.org

Prashant A. Rodrigues, MD

Medical Training:

Fellowship: 1977-1978 Surgical Pathology, Beth Israel Medical Center, New York, NY
Residency: 1973-1977 Anatomic and Clinical Pathology, Mount Sinai Hospital Services, Elmhurst General Hospital, Mount Sinai Hospital
Rotating Internship: 1972-1973 Deaconess General Hospital, Buffalo, NY

Education:

1964-1969 Bombay University, MB; BS
1962-1964 St. Xavier's College, Bombay, Int. Sc.

Board Certification:

1977 Anatomical and Clinical Pathology

Medical Licensure:

Connecticut, New York

Hospital Appointment:

Chairman, Department of Pathology, 1978-present
Chairman, Infection Control Committee, 1980-2005
Chairman, Transfusion Committee, 1978-1996

Membership Professional Organization:

College of American Pathologists

Peter H. Wilson, M.D., F.A.C.S.

Hospital Appointment:

- July 1987-present
  Active Staff, Department of Surgery
  New Milford Hospital
  New Milford, Connecticut

Medical Staff Leadership

- 1992–present - Medical Staff Executive Committee
  - 2002–2004 - Past President of Medical Staff
  - 2001–2002 - President of Medical Staff
  - 1999–2000 – President Elect of Medical Staff
  - 1997–1998 - Chairman, Department of Surgery
  - 1994–1996 - Member, Board of Directors, New Milford Hospital
  - 1992–1994 - Secretary / Treasurer
- 2006–present - Chairman, Department of Surgery

Cancer Committee

- 2007 – present – Chairman, Cancer Committee
- 2000–2007 - Physician Chairman, Breast Care Committee
- 2003-2007 Physician Liaison to American College of Surgeons Commission on Cancer

Committee Appointments

- 2006-present - Quality Steering Council
- 2007-present - Hospital Board Quality Oversight Committee
- 2006-present - ICU Committee

Residency

July 1982-June 1987

- Hartford Hospital, Hartford, CT - General Surgery

Education

University of Connecticut School of Medicine -Farmington, CT

- Degree: M.D. -1982

- Tufts University
  Degree: B.A. Cum Laude - 1976
  Major: English

Societies

- Fellow, American College of Surgeons
- New England Surgical Society
- American Society of Breast Surgeons
- Connecticut State Medical Society
- Litchfield County Medical Society

Certification

- Board Certified General Surgery, November 1988
- Recertification - 1998,2008

Licensure

- State of Connecticut

Edward A. Zane, M.D.

Professional Experience

2001-present, 1992-1994	Chairman, Department of Anesthesiology New Milford Hospital
2008-present 1999-2001	Member, Executive Board of Directors Member, Board of Directors New Milford Hospital
1997-1998	President of the Medical Staff and Chairman of the Medical Executive Committee New Milford Hospital
1995-1996	President-elect of the Medical Staff New Milford Hospital
1988-present	Active Staff, Department of Anesthesiology New Milford Hospital

Professional Licenses and Board Certification

Board Certification
American Board of Anesthesiology – November 1988

Medical Licenses

State of Connecticut 1988
State of New York 1984

Education and Medical Training

July 1987-June 1988	Fellowship in Cardiothoracic Anesthesiology Mount Sinai Medical Center; New York, N.Y.
July 1986-June 1987	Chief Resident in Anesthesiology Mount Sinai Medical Center; New York, N.Y.
July 1985-June 1987	Resident in Anesthesiology Mount Sinai Medical Center; New York, N.Y.
July 1984-June 1985	Internship in Internal Medicine Mount Sinai Medical Center; New York, N.Y.
August 1980- June 1984	Medical School State University of New York at Buffalo, M.D. degree with honors – AOA Honor Society Buffalo, New York

September 1975- January 1979	Undergraduate Education Johns Hopkins University, BA degree; Baltimore, MD

Hospital Service and Awards

Board of Directors, Executive Committee Member (2008-present)
Board of Directors Real Estate Committee (2008-present)
Board of Directors Nominating Committee (2009-present)
Board of Directors Member (1999-2001)
Family Birthing Center Steering Committee (2009-present)
Chairman, Medical Performance Improvement Committee (2009)
TQM (Total Quality Management) Employee of the Year 1999
Operating Room Committee Co-Chairman (current)
Medical Executive Committee 1992-present (Chairman 1997-98)
Chairman, Medical Staff Nominating Committee 1999-2000
Director, Department of Anesthesiology Quality Improvement
Member, Board of Directors-The New York Presbyterian Healthcare Network 1997-1998
New York Presbyterian Healthcare Network- Medical Directors Committee 1997-1998
Board of Directors Long Range Planning Committee 2002-2004

Other Previous Committee Appointments

Co-Chairman, Operating Room Total Quality Management
ICU Committee
Capital Budget Committee
Transfusion Committee
Planning and Development Committee
Ad-hoc Committee for One Day Surgery Renovation Project
Served on hospital committee for evaluating merger or affiliation leading to the affiliation with New York Presbyterian Healthcare Network

Curriculum Vitae

for

Danbury Health Systems, Inc.

A Higher Level of Care

CURRICULUM VITAE
Frank J. Kelly
President and Chief Executive Officer

EDUCATION:

Wagner College, Staten Island, New York
Master of Business Administration in Health Services Administration, 1997.

Wagner College, Staten Island, New York
Bachelor of Arts Degree, magna cum laude, June 1969.

ADMINISTRATIVE EXPERIENCE:

DANBURY HEALTH SYSTEMS, INC., Danbury, Connecticut

February 1998 to Present
President and Chief Executive Officer
Danbury Health Systems, Inc.
Danbury Health Care Affiliates
Business Systems, Inc.

1994 to Present
President and Chief Executive Officer
The Danbury Hospital

1988 to 1994
Vice Chairman and Chief Executive Officer
The Danbury Hospital

February 1987 to January 1988
Executive Vice President and Chief Operating Officer
Danbury Health Systems, Inc.
Danbury Health Care Affiliates

Implemented diversified strategies involving practice acquisitions, joint venture and medically related satellite locations resulting in increased market share, new patient revenues and niche market opportunities. Developed a corporate health services program serving as a value added service providing new source of revenues plus serving as a precursor to managed care services for the business community. Directed corporate restructuring activities resulting in improved competitive position for Hospital and its new affiliates.

THE DANBURY HOSPITAL, Danbury, Connecticut - employed since 1977

February 1984 to January 1987

Vice President of Planning

Developed strategic, facilities, and operations plans and marketing strategies. Developed new programs and services to enhance the Hospital's position as a health provider. Administered the Hospital's Information Systems Program to assure computer support and information for patient care services and management decision making.

January 1981 to February 1984

Vice President for Operations

Planned, directed and coordinated the functions and activities of the Ambulatory Services and Clinical Support Services divisions of the Hospital, as well as the Departments of Admitting, Medical Records, Social Services, and Quality Assurance. Responsible for twenty-seven (27) cost centers involving direct patient care and clinical support.

Responsible for the Hospital's Quality Assurance Program, Risk Management Program and Information Systems.

August 1980 to April 1981

Assistant Administrator – Administrator for Nursing

Assumed temporary responsibility for the overall administration and operational management of the Nursing Service, an organization of approximately 500 full time equivalents covering a full range of nursing services, including: Medical/Surgical, OB-GYN, Pediatrics, Oncology, Telemetry, Critical Care, IV Therapy, Alcohol Detoxification, Rehabilitation and Staff Development.

Reorganized the Nursing Service structure and involved nursing management in redefinition of roles and responsibilities; developed a flexible staffing program and initiated a comprehensive nursing education plan for staff development; revised recruitment policies and procedures; established off-shift orientation program; initiated clinically related inservice programs including nursing process orientation; initiated a critical care training program; reinstituted the nursing audit program; and involved staff in the establishment of standards of nursing performance on each patient unit.

October 1979 to January 1981

Assistant Administrator – Administrative Director of Information Systems and Quality Assurance

Responsible for administrative management of all functions and activities of the Departments of Admitting, Medical Records, Utilization Review and Social Services.

Directed the Hospital's Quality Assurance/Risk Management Program and coordinated all PSRO-related programs and activities. Responsibilities included development and coordination of information management programs including computer applications.

Developed and implemented a comprehensive hospital Quality Assurance/Risk Management Program as part of the medical care information system; initiated an admission scheduling and control system; integrated selected departmental functions and combined positions for more cost-effective operations and increased productivity. Developed applications for a hospital computer system for patient identification and inpatient registration and census; and created a program to coordinate all external requests for hospital information.

August 1977 to October 1979

Administrative Assistant

Responsible for administrative management of the Departments of Admitting and Medical Records. Activities during this period included departmental program development and organization. Responsible for the relocation of both departments, including the move of over 200,000 medical records, and developed multiple records management systems including an on-going microfilming program.

Responsible for coordinating the Hospital employee opinion survey program (beginning April 1979). Chaired the hospital committees which developed and monitored the program and conducted training programs in management and communication skills.

PROFESSIONAL AND COMMUNITY AFFILIATIONS

Member, American College of Healthcare Executives
Member, Housatonic Valley Council of Elected Officials
Member, Western Connecticut University 100 Society
Member, Connecticut Hospital Association
Member, Board of Directors –Connecticut Red Cross Blood Services Region
Member, Board of Directors –Greater Danbury Chamber of Commerce
Member, Board of Directors –United Way
Member, Board of Trustees –Bridgewater Congregational Church
Fellow, American College of Healthcare Executives – as of 1/1/07

CURRICULUM VITAE
John M. Murphy, MD
Executive Vice President

PROFESSIONAL EXPERIENCE
Danbury Health Systems, Danbury, CT **July 2008 - Present**
Executive Vice President

Associated Neurologists, P.C., Danbury, CT **1989- 2008**

EDUCATION:
Fordham University, Bronx, NY
Major: Biology
Summa cum Laude (G.P.A. 4.0)
B.S., May 1981

UMDNJ -Rutgers Medical School
Piscataway, NJ
M.D., May 1985

MEDICAL TRAINING:
1985-1986: Internship, Internal Medicine
UMDNJ-Rutgers Medical School
Middlesex General University Hospital
New Brunswick, NJ

1986-1988: Resident in Neurology
UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

1988-1989: Chief Resident in Neurology
UMDNJ-New Jersey Medical School
University Hospital
Newark, NJ

MEDICAL LICENSURE:
Connecticut
New Jersey

DIPLOMATE:
National Board of Medical Examiners
American Board of Psychiatry and Neurology

HONORS & AWARDS:

1980: Rhodes Scholarship Candidate

1981: Graduated Summa Cum Laude, Fordham University

1985: Alpha Omega Alpha National Medical Honor Society

1986: Intern of the Year Award, Middlesex General University Hospital

1995: Recipient of the Melville G. Magida Award for "Demonstrated Notable Capability in Patient Treatment and Care". Presented jointly by the Fairfield County Medical Association and the Richard and Hinda Rosenthal Foundation.

Listed in Connecticut Magazine's "Best Doctors in Connecticut"

Listed in "Best Doctors in New York Metropolitan Area"

Listed in New York Magazine's "Best Doctors in New York"

Listed in "Best Doctors in America"

MEMBERSHIPS:

American Heart Association, Council on Stroke
American Academy of Neurology
Connecticut State Medical Society
Connecticut State Neurological Society
The Movement Disorder Society
Fairfield County Medical Society
Fairfield County Neurology Society
Parkinson's Study Group (PSG)

APPOINTMENTS:

Attending Neurologist, Danbury Hospital
Danbury, CT.
1989-Present

American Heart Association, Connecticut Affiliate
Statewide Stroke Task Force
1993-1995

Consultant in Neurology
Southbury Training School, Southbury, CT.
1990-Present

Treasurer, Connecticut State Neurological Society
1993-Present

Fellow, American Academy of Neurology

Clinical Assistant Professor of Neurology
New York Medical College
1994-Present

Executive Committee, Danbury Hospital
1992-2001

Board of Directors, Danbury Hospital and Danbury Health Systems
1995-2008

Medical Affairs Committee
Danbury Hospital Board of Directors
1997-2000

Governance Committee
Danbury Health Systems Board of Directors
2003-2008

President of the Medical Staff, Danbury Hospital
1998- 2000

Board of Trustees, Connecticut Hospital Association
2000

Danbury Health Systems & Danbury Hospital,
Vice Chairman, Board of Directors, 2003-2005

Danbury Hospital & Danbury Health Systems, Inc
Chairman, Board of Directors,
2005-2008

Union Savings Bank
Board of Trustees
2006-Present

A Higher Level of Care

CURRICULUM VITAE
William Roe
Senior Vice President, Chief Financial Officer and Treasurer

Education

1990 — Marywood University, Dunmore, PA
- M.B.A. with a concentration in Finance

1974 – 1979 — University of Scranton, Scranton, PA
- B.S. in Accounting
- Served on the adjunct faculty at the University of Scranton form 1990 – 1998. Teaching both graduate and undergraduate courses.

Professional Experience

February 2009 – Present	Danbury Health System, Danbury, CT Senior Vice President, Chief Financial Officer and Treasurer
2006 - January 2009	West Central Ohio Region of CHP, Lima, OH. Vice President and CFO
1998 – 2006	Moses Taylor Healthcare System, Scranton, PA. CFO for System, COO for Mid-Valley Hospital
1990 – 1998	Marian Community Health System, Carbondale, PA Vice President and CFO
1982 – 1990	Moses Taylor Healthcare System, Scranton, PA. Accountant – Controller – Assistant Vice-President

CURRICULUM VITAE
Matthew Alan Miller, MD, FACP
Chief Medical Officer

Education:

1968	BA	Amherst College, Amherst, Massachusetts
1972	M.D.	New York University School of Medicine, New York, NY

Postdoctoral Training:

1972-73	Intern, Internal Medicine, Bellevue Hospital, New York, NY
1973-75	Resident, Internal Medicine, Bellevue Hospital, New York, NY
1975-76	Chief Medical Resident, Bellevue Hospital, New York, NY
1976-78	Clinical and Research Fellow, Pulmonary Unit, Massachusetts General Hospital; Research Fellow, Harvard Medical School, Boston, MA

Hospital Appointments:

1978-79	Clinical Assistant in Medicine, Massachusetts General Hospital
1979-80	Assistant in Medicine, Massachusetts General Hospital Assistant Director, Medical Intensive Care Unit, Massachusetts General Hospital
1980-94	Chief, Pulmonary Medicine and Respiratory Services, Danbury Hospital, Danbury, CT
1980-94	Director, Medical Intensive Care Unit, Danbury Hospital
1991-Present	Vice President for Medical Affairs, Danbury Hospital
1994-Present	President, Healthcare Partners (Danbury Physician Hospital Organization)
1996-Present	President, Foundation for Community Health Care, Inc.
2004-Present	Chief Medical Officer, Danbury Hospital

Academic Appointments:

1979-80	Instructor in Medicine, Harvard Medical School
1980	Assistant Clinical Professor, Yale University School of Medicine
1986	Associate Clinical Professor of Medicine, Yale University School of Medicine

Memberships and Awards:

1975	Diplomat, American Board of Internal Medicine

A Higher Level of Care

CURRICULUM VITAE
Moreen Donahue, DNP, RN, NEA-BC
Senior Vice President, Patient Care Services & Chief Nurse Executive

Education
Case Western Reserve University, Cleveland, OH
Frances Payne Bolton School of Nursing
DNP

Case Western Reserve University, Cleveland, OH
Frances Payne Bolton School of Nursing
MSN

State University of New York, Cortland, NY
MS, Education

Boston College, Boston, MA
BS, Nursing

Licensure
Connecticut Nursing License: Registered Nurse (RN)
New York Nursing License: Registered Nurse (RN)

Professional Experience
Senior Vice President, Patient Care Services & Chief Nurse Executive 2006 - Present
Danbury Hospital, Danbury, CT

Consultant, Special Projects 2006
Bridgeport Hospital, Bridgeport, CT

Grant Coordinator 2006
Case Western Reserve University, Cleveland, OH

Senior Vice President, Patient Care Services & Chief Nursing Officer 2000 – 2005
Greenwich Hospital, Greenwich, CT

Director, Home Care & Hospice *1997 – 2000*
Greenwich Hospital, Greenwich, CT

Vice President, Patient Care Services *1990 – 1997*
United Home Care, Fairfield, CT

Supervisor, Maternal-Child Health Program & School Nurse Supervisor 1984 – 1990

Trumbull Public Health Nursing Service, Trumbull, CT

In-Service Education Coordinator — *1980 – 1983*
Bridgeport Hospital, Bridgeport, CT

Pediatric Nurse Clinician & Program Director — 1972 – 1979
Bridgeport Hospital, Bridgeport, CT

Charge Nurse — *1969 – 1972*
Thompkins County Hospital, Ithaca, NY

Staff Nurse — 1968 – 1969
Bridgeport Hospital, Bridgeport, CT

Certifications

- Nurse Executive Advanced – Board Certified — 2008 – 2013
- Certified Nurse Administrator — 2003 - 2008
- Certified Home/Hospice Care Executive (CHCE) — 1998 – 2002
- Professional Educator (State of Connecticut)

Professional Memberships

- Sigma Theta Tau International Honor Society of Nursing
- American Nurses Association
- Connecticut Nurses' Association
- Connecticut League for Nurses
- American Organization of Nurse Executives
- American Organization of Nurse Executives – CT
- National Association for Home Care/Hospice
- Connecticut Association for Home Care/Hospice
- Connecticut Association for Home Care/Hospice Delegation to Capitol Hill
- Connecticut Hospital Association Patient Care Executive Committee
- Connecticut Hospital Association Subcommittee on Nurse Staffing
- VHA Northeast CNO Network

Honors

- Dean's Legacy Award, Case Western Reserve University
- Visionary Leader Award, Greenwich Hospital
- Quality Award, Greenwich Hospital
- Boston College School of Nursing Honor Society

Educational Program Development Activities

- The Advisory Board Company Nursing Executive Center, Washington, D.C.
  - Nursing Leadership Academy Curriculum Development Committee
- Center for Nursing Education and Research (CEREF) and University of Padua, Italy
  - Patient safety and quality program development

- University College Cork, Cork, Ireland
  - Collaboration regarding research development
- National University of Ireland, Galway, Ireland
  - Student Clinical Placements
- Case Western Reserve University, Cleveland, OH
  - DNP Program Development
  - Cohort Partnership design and implementation
  - Co-taught management and leadership courses
- Fairfield University School of Nursing, Fairfield, CT
  - Coordinator, Transition to Professional Practice, Greenwich Hospital
  - Coordinator, Student Nurse Internship Program
  - Clinical Nurse Leader Partnership
- Trumbull High School, Trumbull, CT
  - Curriculum Author & Instructor, Introduction to Nursing
- State University of New York, Cortland, NY
  - Instructor, Health Education Program

A Higher Level of Care

CURRICULUM VITAE

Beth Sandy Aaronson, M.D.

Medical Director, Main Street Physical Rehabilitation Center

Medical Director: 07/1994 to Present.
Danbury Hospital, 24 Hospital Avenue, Danbury, CT 06810. 12 East Inpatient Rehabilitation Unit.

Attending Physiatrist 07/1994 to Present.
Danbury Office of Physician Services, 235 Main Street, Danbury, CT 06810, Physiatry Department.

Medical Director: 01/1997 to Present.
Main Street Physical Rehabilitation Center, 235 Main Street, Danbury, CT 06810.

Consulting Physiatrist: 01/1995 to 06/1999.
Mediplex, 90 Osborne Street, Danbury, CT 06810.
Harborside Healthcare-Glen Hill, 3 Glen Hill Road, Danbury, CT 06810.
Heritage Heights, Hospital Avenue, Danbury, CT 06810.
Bethel Healthcare, 13 Park Lawn Drive, Bethel, CT 06801.

Medical Technician* 06/1983 to 09/1986
Metronick, Forest Hills, New York.
MedAlert, New York City, New York.

Education/Training

09/1979 to 06/1983: *Bachelor of Arts*, Psychology.
State University of New York at Binghampton.
Binghampton, New York.

09/1986 to 06/1990: *Doctor of Medicine Degree*, State University of New York at Stony Brook School of Medicine.
Stony Brook, New York.

07/1990 to 06/1991: *Internship*, Internal Medicine, Norwalk Hospital.
Maple Street, Norwalk, CT.

07/1991 to 06/1994: *Resident*, Physical Medicine & Rehabilitation,
Columbia Presbyterian Medical Center,
New York, New York.

07/1993 to 06/1994: *Chief Resident*, Physical Medicine & Rehabilitation,
Columbia Presbyterian Medical Center,
New York, New York.

Licensure
Licensed in New York and Connecticut.

Hospital Affiliation
Danbury Hospital, 24 Hospital Avenue, Danbury, CT.

Board Certification
American Board of Physical Medicine and Rehabilitation, 05/1995.
American Board of Independent Medical Examiners (ABIME), 06/1998.
American Board of Spinal and Injury Medicine, 06/2000.

CURRICULUM VITAE
Raul Arguello, M.D.
Chairman of Pediatrics

Education

1979-1983	Lycee Brancais a El Salvador, Santa Tecla Bachelor of Science
1983-1991	Evangelical University of El Salvador, San Salvador, El Salvador Medical Doctor
199-1993	University of Minnesota Medical Center, St Paul, MN Neurology Research Assistant
1993-1996	Winthrop University Hospital, Mineola, NY Pediatric Residency
1996-1999	Winthrop University Hospital, Mineola, NY Pediatric Endocrinology Fellow

Certification and Licensure

1991	El Salvador, Medical Licensure (#4266)
1992	ECFMG (#0-479-607-4)
1996	Diplomate, American Board of Pediatrics (#057977)
1997	New York State Licensure (#208369)
2008	Connecticut State Licensure (#046833)

Professional Appointments and Experience

2008 - Present	Chairman of Pediatrics, Danbury Hospital, Danbury, CT
2004-2008	Chief, Pediatric Diabetes Program, Winthrop University Hospital
2001-2008	Associate Professor, New York College of Osteopathic Medicine
2000-2004	Chairman of Pediatrics, South Nassau Community Hospital
1999-2008	Assistant Professor, SUNY Stony Brook

1999-2008	Attending, Pediatric Endocrinology, Winthrop University Hospital
1990-1991	Director-San Jose Villanueva Department of Health, El Salvador Health Center

Professional and Scientific Societies

1991-Present	El Salvador Medical College
1993-Present	American Medical Association
1993-Present	American Academy of Pediatrics
2003-Present	American Diabetes Association

Honors

1995-1996	Pediatric Chief Resident
2005	Principal Investigator for Tercica MS301 study (IGF-1 Study)

A Higher Level of Care

CURRICULUM VITAE
Alyson Blanck, MSN, RN, NEA-BC
Director, Nursing Practice

EDUCATION	**MSN, Nursing Administration** October 2005 University of Phoenix Phoenix, Arizona	**BSN** May 1988 Sacred Heart University Fairfield, CT	**RN DIPLOMA** May 1984 Bridgeport Hospital School of Nursing Bridgeport, CT

MEMBERSHIP

Fairfield University School of Nursing Partnership Council
Connecticut Hospital Association Patient Safety Organization
Connecticut Hospital Association Patient Care Executives Work Group
Sigma Theta Tau International Honor Society of Nursing

WORK EXPERIENCE & PROJECT MANAGEMENT

DANBURY HOSPITAL December 2006 - Present
Director of Nursing Practice

BRIDGEPORT HOSPITAL May 2006 – December 2006
Staff Educator

GREENWICH HOSPITAL 1997- May 2006 Greenwich, CT
Patient Education Coordinator 2004-2006

Staff Clinical Education Coordinator 2002-2004

Manager of Clinical Services for Home Care Department 1997-2002

UNITED HOME CARE 1986-1997 Fairfield, CT
Director of Patient Care Services 1991-1997

Nursing Supervisor 1987-1991

Nurse Case Manager/Staff Nurse 1986-1987

BRIDGEPORT HOSPITAL 1984-1986 Bridgeport, CT

Staff Nurse

CURRICULUM VITAE
Stanford Robert Broder, M.D.

Physician Associate, Urology Associates of Danbury, P.C.

EDUCATION

Cornell University Medical College, New York, NY
Doctor of Medicine, May 1993

Cornell University, Ithaca, NY
B.S., Biological Sciences – Neurobiology and Behavior, 1989

RESIDENCY TRAINING and WORK EXPERIENCE

1999 – Present — Physician Associate, Urology Associates of Danbury, P.C., Danbury, CT

1995 – 1999 — Resident in Urology, University of Virginia Health Sciences Center, Charlottesville, VA. Chairman: Dr. William D. Steers.

1993-1995 — Intern and Resident in General Surgery, Mt. Sinai Medical Center, Miami Beach, FL. Chairman: Dr. Manuel Sivina.

1995- 1998 — Surgical House Officer, Columbia Chippenham Medical Center, Richmond, VA.

1995-1996 — Emergency Department Physician, Page Memorial Hospital, Luray, VA.

LICENSURE and SOCIETIES

- Connecticut State Board of Medicine
- New York State Board of Medicine
- Virginia State Board of Medicine
- Fairfield County Medical Society
- Society of Laparoscopic Surgery
- National Board of Medical Examiners.
- Member American Urological Assn.
- Member Danbury Medical Society.
- Connecticut State Medical Society

CURRICULUM VITAE
HALANA M. FINNIE MS, PMHCNS-BC, NPP, FNP

Clinical Director, Behavioral Health

Professional Experience

Clinical Director, Behavioral Health Nursing — 2009 - Present
Danbury Hospital, Danbury, CT

Magnet Program Director, Department of Nursing — 2008 – 2009
Manager, Nursing Quality
Mount Sinai Hospital, New York, NY

Clinical Nurse Manager, Child and Adolescent Psychiatry — 2005 – 2008
Department of Psychiatry
Mount Sinai Hospital, New York, NY

Nurse Practitioner, Child and Adolescent Psychiatry — 2004 – 2005
Psychiatry Care Center,
Mount Sinai Hospital, New York, NY

Clinical Nurse Manager, Child and Adolescent Psychiatry — 1998 – 2004
Psychiatry Care Center
Mount Sinai Hospital, New York, NY

Nurse Practitioner, Institute of Neurology and Neurosurgery — 1997 – 1998
Beth Israel Medical Center, New York, NY

Nurse Manager, Infectious Diseases/AIDS — 1996
Beth Israel Medical Center, New York, NY

Nurse Manager, Adult Psychiatry — 1994 – 1995
Beth Israel Medical Center, New York, NY

Nurse Manager, Child and Adolescent Psychiatry — 1991 – 1994
South Oaks Hospital, Amityville, NY

Head Nurse, Adolescent Psychiatry — 1988 – 1991
South Oaks Hospital, Amityville, NY

Clinical Nurse Supervisor — 1988
Holliswood Hospital, Hollis, NY

Head Nurse, Eating Disorders — 1986 – 1988

South Oaks Hospital, Amityville, NY

Nurse Practitioner 2005
Private Practice, New York, NY
Consultant 2004 – Present
Forensic Psychiatry, New York, NY

Nurse Practitioner 2001 – 2004
Family Health Associates, New York, NY

Nurse Practitioner 1998 – 1999
Child Psychiatry Outpatient
Mount Sinai Hospital, New York, NY

Nurse Practitioner/Coordinator 1996 – 1997
ALS Center, Beth Israel Medical Center, New York, NY

Patient Services Director 1996 – 1997
ALS Association, Greater New York Chapter, New York, NY

Family Nurse Practitioner 1995 – 1996
Institute for Urban Family Health, Inc., New York, NY

Psychotherapist 1991 – 1992
Mid-Island Rehabilitation Center, Bayshore, NY

Clinical Nurse Specialist 1990 – 1991
West Nassau Mental Health Center, Franklin Square, NY

EDUCATION

- Doctor of Philosophy, Nursing, Duquesne University, Pittsburgh, PA. Coursework completed. Dissertation in progress. Graduation December 2010.
- Post-Masters Certificate, Forensic Nursing, Duquesne University, Pittsburgh, PA. 2004.
- Certificate of Advanced Graduate Study, Family Nurse Practitioner, Pace University, New York, NY. 1996.
- Master of Science, Nursing, SUNY Stony Brook, NY. 1991.
- Diploma, Registered Nurse, Crouse-Irving Memorial Hospital School of Nursing, Syracuse, NY. 1984.
- Bachelor of Arts, Psychology, Syracuse University, Syracuse, NY. 1982.

CERTIFICATIONS

- Family Nurse Practitioner, New York State, 1996.
- Nurse Practitioner, Psychiatry, New York State, 1994.
- Advanced Practice Registered Nurse, Board Certified, Clinical Specialist, Child and Adolescent Mental Health/Psychiatric Nursing, American Nurses

Credentialing Center, 1993.

- Certified Hypnotherapist, Hypnodyne Foundation, Clearwater, Fl. 1992.

PROFESSIONAL AFFILIATIONS

- Phi Kappa Phi, Chapter 187, Duquesne University, Pittsburgh, PA. Inducted 2009.
- Sigma Theta Tau, Epsilon Phi Chapter, Duquesne University. 2005-present.
- Advisory Board Member, Creative Alternatives of New York, 2004-present.
- International Society of Psychiatric-Mental Health Nurses, 2004-present.
  ISPN Divisions: Association of Child and Adolescent Psychiatric Nursing.
  ISPN Divisions: Society for Education and Research in Psychiatric-Mental Health Nursing.
- American Psychiatric Nurses Association, 2004-present.
- International Association of Forensic Nurses, 2002-present.
- American Association of Neuroscience Nurses, 1998.

CURRICULUM VITAE
Patrick Broderick MD F.A.C.E.P.
Chairman, Department of Emergency Medicine

EDUCATION
B.S. Biology, S.U.N.Y. @ Stonybrook, 1979
MD, S.U.N.Y. @ Downstate Medical Center, 1983
Internal Medicine Internship and Residency, Staten Island University Hospital, 1986
Board Certification Internal Medicine, Diplomat A.B.I.M., 1986
Board Certification Emergency Medicine, Diplomat A.B.E.M., 1994
Recertification Emergency Medicine, 2004
F.A.C.E.P., Fellowship American College Emergency Physicians, 1994

EMPLOYMENT
1986-1987 *Assistant Director Emergency Department, Walkill Valley Hospital, NJ*
Full Time Emergency Physician with both clinical and administrative responsibilities

1987-1993 *Director Emergency Medicine, Staten Island University Hospital, S.I.,NY*
Full Time Director and Attending running a very busy Emergency Department. Responsibilities included clinical and administrative duties. Developed and implemented the Department of Emergency Medicine at S.I.U.H.. Started and was President of Staten Island Physician Services P.C., and staffed the E.D., and the children's and adult's Urgent Care Centers. Reviewed medical legal cases as part of additional activities at S.I.U.H..

1993-1994 *Attending Physician Emergency Medicine, Overlook Hospital, NJ*
Full time Attending in Emergency Medicine.

1994-2001 *Attending Physician Emergency Medicine, Danbury Hospital, CT*
Full time Attending in Department of Emergency Medicine. Large volume, Level II Trauma Center.

2002 - present *Chairman, Department of Emergency Medicine, Danbury Hospital*
EMS Medical Director, Greater Danbury Area
Full Leadership responsibility for a high volume, high acuity Level II Emergency Medicine Department. Sit on a full gamut of Hospital based, community based, and EMS based committees, including Departmental and Hospital Risk Management and Patient Safety Committee. Continue to practice Clinically in high volume, high acuity ED.

2003 - present *Provide expert review of medical record to several law firms in Connecticut and Rhode Island*

2004 – present *President Danbury Office of Physician Services, Danbury Health Systems,*
175 member Physician Group functioning essentially as the Danbury Health System faculty

practice.

2006 – present *Clinical Adjunct Assistant Professor, Quinnipiac University, Hamden, CT*
Physician Assistant Student Precepting Program

2007 – present *Adjunct Associate Professor of Medicine/Emergency Medicine, New York Medical College*

PRESENTATIONS
Attaining 99th Percentile in ED Patient Satisfaction
VHA Northeast Service Excellence 2005 Conference
Providence, Rhode Island
November 8, 2005

DANBURY HOSPITAL
A Higher Level of Care

CURRICULUM VITAE
Theresa L Champagne RN, MSN, CNOR
Clinical Director, Perioperative Services

EDUCATION:

DNP program Oakland University
Anticipate completion in fall 2012

Western Connecticut State University, Danbury, Connecticut
MS in Nursing: Clinical Nurse Specialist 2007

St. Anselm College, Manchester, New Hampshire
BSN 1977

LICENSES AND CERTIFICATIONS:

Current CT RN license
CNOR
BLS
Black Belt in Six Sigma

EMPLOYMENT HISTORY:

2007- Present Director Perioperative Services

- Plans and Manages capital and FTE budget for all areas in perioperative services including OR, PACU, Ambulatory Surgery (ASU) , Endoscopy(ENDO), and Sterile processing (SPD) that performs 12,000 surgical procedures and 10,000 endoscopy procedures annually.
- Collaborates with Service Line director of the Surgical Care, CNO, COO and department chairs.
- Responsible for hiring, evaluating, and providing discipline for 6 direct reports and 210 indirect reports.
- Assists with Purchasing supplies, contract negotiations, and implementing equipment trials
- OR, PACU and ASU.

Maintains unit readiness for all regulatory inspections.
Oversight of all renovation activity in all areas
Co-Chairperson of Clinical Quality Value Analysis Team for Perioperative services
Oversight of all process improvement initiatives for Perioperative Services
Utilizing black belt skill for data analysis and process improvement.
Assist with managing all surgical and endoscopy block time allocation
Assist with Program development and growth initiatives in surgical services.

2002-2007 Nurse Manager OR/ CTOR:

Duties include:
Managed day to day operations for 14 operating rooms with an
Responsible for hiring, evaluating and providing discipline for 79 FTEs including 35 OR nurses, 20 CSTs, 10 ancillary staff, 3 nurse educators, 6 CTOR staff
OR scheduling staff
Revises and implements department and hospital Policies and Procedures.
Center on budget development for OR, CTOR and OR
Education Units.
Maintains budget for OR, CTOR and OR Education Units.

1978 - 2002 Staff Nurse-Operating Room Danbury Hospital

1977 - 1978 Staff Nurse-Operating Room, Yale New Haven Hospital

PROFESSIONAL MEMBERSHIPS:
- Association of Operating Room Nurses (AORN)
- Connecticut Hospital Association (CHA)
- Sigma Theta Tau International
- American Society for Quality (ASQ)

COMMITTEE MEMBERSHIPS:
- Nursing Management Team Committee
- Surgery Committee
- Safety Committee
- Performance Improvement Committee
- Clinical Quality Value Analysis Team co-chair
- Organ Donation Committee

AWARDS RECEIVED:
- Service Recognition Award from Newtown High School for participation in Externship program. Performed over 25 hours of service working closely with a high school senior perusing a health care career, (2000)
- Nurse Exemplar Award, Feb, 2002 (DHS)
- Organizational TOPS award for Cardiothoracic OR implementation (2005)
- Departmental TOPS award for CDM project (2006)
- Service Excellence 2009, OR Benchmarking Collaborative

CURRICULUM VITAE
Neil W. Culligan, MD
Chief of Neurology

Certifications
American Board of Psychiatry and Neurology, Neurology, Diplomate
American Board of Psychiatry and Neurology, Vascular Neurology Certificate 5/08
American Board of Electrodiagnostic Medicine, Diplomate

Licensure
Connecticut MD – 032113
New Jersey MD-50643
Pennsylvania MD039634-E

Academic Degrees
BA – Biology, University of Pennsylvania, Philadelphia, PA, cum laude 1975-1979
NIH funded Research Associate – Neurobiology, Princeton University, Princeton, NJ 1979-1982
MD – George Washington University School of Medicine, Washington, DC 1982-1986

Residencies and Internships

Internship – Internal Medicine, University of Medicine and Dentistry of New Jersey /Robert Wood Johnson University Hospital, New Brunswick, NJ 1986 – 1987
Residency – Neurology, Thomas Jefferson University Hospital, Philadelphia, PA 1987 – 1990

Fellowships
Electrodiagnostic Medicine and Neuromuscular Disease– Thomas Jefferson University Hospital, Philadelphia, PA 1990 - 1991

Employment
Neurological Services, Inc, Allentown, PA - private practice, general neurology and EMG/neuromuscular disease 1991 – 1992
Muscular Dystrophy Association Clinic, Allentown, PA – staff neurologist 1991 – 1992
Associated Neurologists, PC, Danbury, CT – private practice, general neurology, cerebrovascular, and EMG/neuromuscular disease 1992 – present

Appointments
1. President, Danbury Hospital Medical Staff, 2008- present
2. **Chief of Neurology, Danbury Hospital, Danbury Connecticut, 2003-present**
3. Medical Director, Danbury Hospital Stroke Center (JCAHO and State of Connecticut certified), 2005-present

4. Danbury Health Systems Board of Directors, 2008- present
5. Medical Executive Committee Chair, Danbury Hospital 2005-present
6. Professional Practice Evaluation Committee, Danbury Hospital 2006-present
7. Medical Affairs Committee, Danbury Hospital, 2008- present
8. Credentials Committee, Danbury Hospital, 2008- present
9. Performance Improvement Committee, Danbury Hospital 2005-2008
10. Connecticut State Stroke Care Committee, 2005-present
11. Co-Chairman-Operation Stroke, Fairfield County, American Stroke Association/ American Heart Association 2004

Professional Societies

- American Academy of Neurology
- American Association of Neuromuscular and Electrodiagnostic Medicine – Fellow
- American Heart Association Stroke Council
- National Stroke Association, Professional Member
- Northeast Cerebrovascular Consortium
- American Medical Association
- Connecticut and Fairfield County Neurologic Societies

Awards

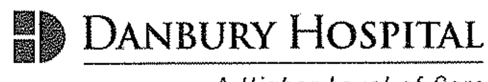
- Best Doctors in America, 1998, 2002, 2003, 2005-2006, 2007-2008
- Top Doctors for Women, Connecticut Magazine, 2002
- BA Degree, Biology, Cum Laude – University of Pennsylvania, Philadelphia, PA 1979

Current Hospital Affiliations

Attending, Department of Medicine, Danbury Hospital, Danbury, CT

Teaching

Clinical Assistant Professor – Department of Neurology, New York Medical College, Valhalla, NY, 1994-present
Teaching 3rd and 4th year medical students and 1st through 3rd year medical residents in neurology rotation, noon conferences, grand rounds, morning report, stroke rounds
Chosen for Chairman's Rounds 2009-2010



CURRICULUM VITAE
William M. Delaney, M.D.

Executive Medical Director, Seifert & Ford Community Health Center

EDUCATION:

LaSalle Academy - Providence, Rhode Island	1974
B.A., University of New Hampshire	1978
M.D., Brown University Program of Medicine	1982

POSTDOCTORAL TRAINING

Intern, Internal Medicine Training Program Danbury Hospital - Danbury, CT Yale/New Haven Affiliated Program	1982-1983
· Junior Resident - Danbury Hospital	1983-1984
· Senior Resident - Danbury Hospital	1984-1985

TEACHING APPOINTMENT:

· Chief Resident in Internal Medicine Danbury Hospital - Danbury, CT	1985-1986
· Clinical Instructor in Medicine Yale University School of Medicine	1985-1986
· Clinical Assistant Professor of Medicine New York Medical College	2000-Present

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP OBLIGATION

· U.S. Public Health Service #55283 0-3 Senior Assistant Surgeon (Lieutenant) Duty Station - Bureau of Prisons Federal Correction Institution, Danbury, CT Staff Medical Officer	1986-1987
· Promoted to 0-4 Full Surgeon (Lieutenant Commander) Chief of Health Programs Federal Correction Institution, Danbury, CT	1987-1990

PROFESSIONALEXPERIENCE:

· Danbury Officer of Physician Services, P.C.		
· Primary Care Center of Danbury - Staff Physician		1990-1993
· Primary Care Center of Danbury - Assistant Medical Director		1993-1995
· Primary Care Center of Danbury - Medical Director		1995-1997
· Full-Time Hospitalist	- Danbury Hospital	1998-1999
· Hospitalist Service	- Medical Director	1999-2006

CURRENT POSITION

Seifert & Ford Community Health Center of Danbury Hospital Executive Medical Director	2006-Present

· Danbury Hospital Credentials Committee	1993- Present
· Secretary to Department of Medicine	1993-Present
· Northeast Regional Council-Society of Hospital Medicine	2002-2006

· American College of Physicians – Active	1986
· Society of Hospital Medicine	2000-2006
· Commissioned Officer Corps, U.S. - P.H.S.	1987-1990
· Board of Directors, Danbury Office of Physicians Services, P.C.	1995-2006

CERTIFICATION:

· National Board of Medical Examiners	1983
· American Board of Internal Medicine	
Diplomat # 111085	1986

LICENSURE:

· Connecticut #261131	1985

CURRICULUM VITAE
Alan M. Dietzek, M.D., F.A.C.S.
Chief, Section of Vascular & Endovascular Surgery

Education

1977 B.S. Biology State University of New York at Albany, Graduated with Honors
1983 M.D. Loyola Stritch School of Medicine

Post Graduate Training

7/1983 – 6/1988 Internship and Residency in General Surgery, Long Island Jewish Hospital, New Hyde Park, NY
7/1988 – 6/1990 Fellowship in Vascular Surgery, Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, NY

Employment

7/1/1990 – 6/30/93 North Shore University Hospital, Manhasset, NY

7/1/1993 – 10/31/97 Vascular Associates of Long Island, Great Neck, NY

11/1/1997 – 9/1/00 Integrated Cardiovascular Therapeutics, Woodbury, NY

8/15/2000- Present Danbury Office of Physician Services, Danbury Hospital, Danbury, CT

Academic Appointments

7/1986 – 6/1988 Assistant Clinical Professor of Surgery, State University of New York at Stony Brook

7/1990 – 5/1993 Assistant Professor of Surgery, Cornell University Medical College

5/1993 – 2000 Adjunct Clinical Assistant Professor of Surgery, New York University

7/2002 – 3/2009 Clinical Assistant Professor of Surgery, New York Medical College

3/2009 – present Clinical Associate Professor of Surgery, New York Medical College

Hospital Appointments

1990 – 2003 Attending Vascular Surgeon, North Shore University Hospital, Manhasset, NY

1993 – 2003 Attending Vascular Surgeon, Long Island Jewish Medical Center, New Hyde Park, NY

1998 – 2000	Attending Vascular Surgeon, St. Francis Hospital, Roslyn, NY
2000 – Present	Chief, Section of Vascular & Endovascular Surgery, Danbury Hospital, Danbury, CT
2000 – Present	Director, Noninvasive Vascular Laboratory, Danbury Hospital, Danbury, CT
2007 – Present	Director, Center for Wound Care and Hyperbaric Medicine, Danbury Hospital, Danbury, CT

Board Certification

9/1989	American Board of Surgery #34478
1992	Added Qualifications in General Vascular Surgery #044623
10/1992	Registered Vascular Technologist
10/1999	Recertification in General Surgery
10/2001	Recertification in General Vascular Surgery
2005	Registered Physician in Vascular Interpretation (RPVI) #32438

Fellowships, Awards, Grants and Contracts

6/1977	Graduated with Honors, SUNY at Albany
1984	Academic Achievement Award, Department of Surgery, Long Island Jewish Medical Center
6/2002, 6/2007	Danbury Hospital Surgical Teaching Attending of the Year, Awarded from Sound Shore Medical Center, Westchester, NY
9/2007	Obtained Endowed Chair "The Linda & Stephen R. Cohen Chair in Vascular Surgery."

Licensure

1986	New York #167208
2000	Connecticut #038845

Professional Society Memberships

1990	American Medical Association
1991	Nassau County Medical Society
1991	New York Society for Vascular Surgery
1991	Association for Academic Surgery
1992	New York State Society for Surgeons
1993	Nassau Surgical Society
1993	Fellow of the American College of Surgeons
1993	Peripheral Vascular Surgery Society
1994	Fellow of the Nassau County Academy of Medicine
1994	Society for Clinical Vascular Surgery
1996	Eastern Vascular Society

1996	North American Chapter of the International Society for Cardiovascular Surgery
1998	Nassau Surgical Society Co-Chairman Annual General Surgery Section, Member at Large Program Director Vascular Surgery Section
1999	Society for Vascular Surgery
2003	New England Society for Vascular Surgery
2004	Vascular Surgical Society of Southern Connecticut, President

Professional and Educational Appointments

2004 - Present	President, Vascular Surgical Society of Southern Connecticut
2006 - Present	Chair of Two Special Interest Groups Breakfast Sessions (Challenging Cases Session, Topics of Special Interest Session), Annual Meeting for the Society of Clinical Vascular Surgery
3/1/2007 – 3/1/10	Membership Committee, Society for Clinical Vascular Surgery
1/1/2008 – 1/1/11	Board of Directors, Intersocietal Commission for the Accreditation of Vascular Laboratories
1/1/2008 – 1/1/11	Board Member of the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL). Society for Clinical Vascular Surgery Representative for ICAVL
2009- present	Chair, Membership Committee, Society for Clinical Vascular Surgery
2009- present	Member-at-Large, Council of the Society for Clinical Vascular Surgery
5/11/09	Elected to Editorial Advisory Board of V-Aware

Educational Activities

2000 – Present	Vascular Surgical Conference, General Surgery Residents and Medical Students, One Hour Every Friday Morning
2002 – Present	NYMC Medical Student Rotations, One-on-one, Three-Week Rotations on the Vascular Surgical Service throughout the year
2006 – Present	Topics in Vascular Disease and Surgery, Cardiology Fellows, Three-two hour lectures per year

Administrative Responsibilities

2000 – Present	Chief, Section of Vascular & Endovascular Surgery, Danbury Hospital, Danbury, CT
2000 – Present	Director, Noninvasive Vascular Laboratory, Danbury Hospital, Danbury, CT
2007 – Present	Director, Center for Wound Care and Hyperbaric Medicine, Danbury Hospital, Danbury, CT

Hospital Committees

1991 – 1992	Medical Records Committee, North Shore University Hospital
1992 – 1993	Blood Utilization Committee, Long Island Jewish Medical Center

1992 – 2000	Peer Review Committee, Nassau County Medical Society
1994 – 2000	Quality Management Committee
1997 – 2000	Physician Organizational Board Member, North Shore University Hospital
7/1997 – 2000	Peri-operative Executive Committee, North Shore University Hospital
1998 – 2000	Medical Staff Affairs Committee, North Shore University Hospital
7/2002 – Present	Professional Standards Quality Management Committee, Danbury Hospital
2001 – Present	Surgical Operations Committee, Danbury Hospital

DANBURY HOSPITAL

A Higher Level of Care

CURRICULUM VITAE

Kristy Dixon

Director of Patient Care:
Critical Care, Cardiology, Emergency Medicine/Trauma

Education

University of Bridgeport, Bridgeport, CT
Master of Science, Education

Quinnipiac University, Hamden, CT
Bachelor of Science, Nursing

Professional Experience

Director of Patient Care: 2007 - Present
Critical Care, Cardiology, Emergency Medicine/Trauma
Danbury Hospital, Danbury, CT

- Responsible for oversight of daily operations, clinical care, staffing, evaluation and budgetary management of the critical care and cardiology units and the Emergency/Trauma department
- Responsible for assuring coordinated and efficient quality patient care in collaboration with fellow healthcare team members
- Reviews patient care standards and develops quality and safety initiatives reflective of the Joint Commissions, Department of Public Health and other regulatory agencies
- Facilitates the development of and interprets clinical practice procedures, standards, policies, goals and philosophy (i.e. IV medication titration, blood and tissue usage, telemetry utilization and discontinuation, lean six sigma initiatives)
- Nursing Co-Chair of the Code 99 Committee, responsible for evaluating all Code 99 events, rapid response team events and implementing new policies, procedures and initiatives related to code management; Nursing Co-chair of the Organ Donation Committee, responsible for evaluating organ donation statistics, education and development of new programs (Donation After Cardiac Death) in collaboration with the Emergency Department, ICU and Operating Room; Chair of Vascular Access Committee standardizing vascular access and practice across the hospital
- Coaches staff and managers formally and informally
- Serves as a mentor to the nursing management team by coordinating and serving as a liaison between the medical, support and nursing staff

Clinical Educator: 2002 – 2007
Cardiothoracic ICU, CT Stepdown Unit, ICU and Telemetry Unit;
Training Center Coordinator for the American Heart Association
Danbury Hospital, Danbury, CT

- Participated in initial planning and preparation for CON proposal for Cardiac Surgery and Angioplasty at Danbury Hospital
- Developed an educational training plan for the CTICU, Cardiothoracic Step Down Unit and Angioplasty Unit and developed clinical practice guidelines, procedures, standards and goals
- Served as Nurse Champion of the Cardiac Surgery Patient Education Committee- coordinating the development of patient education materials between various disciplines and departments.
- Assisted in the development and implementation of the FAST Team and Code Green Team
- Planned, coordinated, implemented, evaluated and revised numerous educational/training programs
- Evaluated staff in application of new knowledge/clinical practice skills
- Identified, planned, assisted in the implementation and evaluation of performance improvement strategies
- Functioned as a mentor/role model to staff and as a preceptor for advanced degree nursing students
- Responsible for evaluating performance, education and maintaining records of over 100 BLS instructors; implanted, planned and coordinated ongoing education through the American Heart Association

Emergency Room Registered Nurse, ICU/CCU Registered RN, Charge RN 2000 – 2002
Danbury Hospital, Danbury, CT

- Responsible for triage, patient care, teaching and education of disease processes, treatments and medications and therapies for critically ill patients

ICU/CCU Registered Nurse, Charge RN 1998 - 2000
New Milford Hospital, New Milford, CT

- Responsible for patient care, teaching and education of disease processes, treatments, medications and therapies
- Floating RN to Medical/Surgical Floor, PACU, Emergency Room and Nursery

Registered Nurse- Cardiac Step Down Unit/Coronary Care Unit 1997 – 1998
Westchester Medical Center/White Plains Medical Center, Westchester, NY

- Responsible for patient care, teaching and education of cardiac disease processes, treatments and medications

Teacher- Biology, Anatomy and Physiology and Environmental Science 1998 – 2001
New Fairfield High School, New Fairfield, CT

- Responsible for three Tenth Grade Biology Classes, one Twelfth Grade Environmental Science Class and two Eleventh/Twelfth Grade Anatomy and Physiology Classes
- Implemented and designed daily lesson plans and exams
- Planned, prepared and supervised weekly Biology Labs
- Evaluated the performance of 99 students
- Enhanced projects and instruction through use of Power Point presentations/media materials

- Administered and evaluated CAPT science labs and exams
- Actively participated in parent/teacher conferences and school activities

Long Term Substitute, High School Chemistry

- Responsible for Tenth Grade Honors and Academic Chemistry Classes
- Designed and implemented daily lesson plans and exams
- Planned, prepared and supervised weekly Chemistry labs
- Evaluated the performance of 93 students

Supplemental Instructor of High School Chemistry

- Hired by New Fairfield Public School System as a Chemistry Tutor
- Held weekly Saturday morning Chemistry sessions
- Assisted students with classroom lessons and labs

Certifications

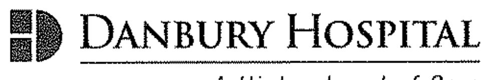
- ACLS Certified/ACLS Instructor
- ACLS EP Certified/ACLS EP Instructor
- PALS Certified/PALS Instructor
- CPR Certified/CPR Instructor
- First Aid Certified/ First Aid Instructor
- TNCC Certified/TNCC Instructor
- NRP Certified
- Currently preparing to take the Nurse Executive (NE-BC) Certification Exam

Professional Memberships

- Member of Emergency Cardiovascular Care Committee for the State of CT
- ACLS, PALS, BLS Regional Faculty for the State of Connecticut through the American Heart Association
- Professional Member of the American Heart Association
- Member- American Heart Association Council on Cardiopulmonary, Perioperative & Critical Care
- Member- American Heart Association Council on Cardiovascular Nursing
- Member- American College of Cardiology -Cardiac Care Associate
- Member- American Association of Critical Care Nurses
- Member- Emergency Nurses Association

Honors

- Nightingale Award Recipient, 2004
- Member of Phi Kappa Phi Honor Society
- Member of Sigma Theta Tau Nursing Honor Society
- American Heart Association ACLS National Faculty for the State of Connecticut 2007-2011
- American Heart Association Regional Faculty for ACLS, PALS and BLS- 2007- 2011
- Speaker at the Northeast Horizons Critical Care Conference in 2006 and 2008



A Higher Level of Care

CURRICULUM VITAE

Gregory Dworkin, M.D.

Chief, Pediatric Pulmonology

Education: B.S. Life Sciences, Massachusetts Institute of Technology, 1977
M.D. Albany Medical College, 1982

Career/Academic Appointments:

7/1982- 6/1983	Intern, Pediatrics, Mount Sinai Hospital, New York, NY
7/1983-6/1985	Resident, Pediatrics, Mount Sinai Hospital, New York, NY
7/1985-6/1986	Chief Resident, Pediatrics, Mount Sinai Hospital, New York, NY
7/1986-6/1989	Fellow, Pediatric Pulmonary Medicine, Mount Sinai Hospital, New York, NY
1990-1992	Clinical Instructor, Department of Pediatrics, Yale University School of Medicine, New Haven, CT
1993-1997	Assistant Clinical Professor, Department of Pediatrics, , Yale University School of Medicine, New Haven, CT
1997-Present	Assistant Clinical Professor, Department of Pediatrics, New York Medical College, Valhalla, NY

Administrative Positions:

7/ 2003-Present	Medical Director, Pediatric Inpatient Unit
7/1990-Present	Course Director, Pediatric Advanced Life Support, Danbury Hospital, Danbury, CT
7/1989-Present	Chief, Pediatric Pulmonology, Danbury Hospital, Danbury, CT
1998-2002	Vice President, Danbury Office of Physician Services
2000-2002	Board of Directors, Danbury Office of Physician Services

Board Certification:

National Board of Medical Examiners, 1983
American Board of Pediatrics, 1987
Subspecialty, Pediatric Pulmonology, American Board of Pediatrics ,1989

Professional Honors and Recognition:

2004: Connecticut's Hospital Association Community Service Award (Danbury Hospital) for its Pediatric Asthma Management Program

Professional organizations:

Fellow, American Academy of Pediatrics
Fellow, American College of Chest Physicians
American Thoracic Society

A Higher Level of Care

CURRICULUM VITAE
Gregory Dworkin, M.D.
Chief, Pediatric Pulmonology

Education: B.S. Life Sciences, Massachusetts Institute of Technology, 1977
M.D. Albany Medical College, 1982

Career/Academic Appointments:

7/1982- 6/1983	Intern, Pediatrics, Mount Sinai Hospital, New York, NY
7/1983-6/1985	Resident, Pediatrics, Mount Sinai Hospital, New York, NY
7/1985-6/1986	Chief Resident, Pediatrics, Mount Sinai Hospital, New York, NY
7/1986-6/1989	Fellow, Pediatric Pulmonary Medicine, Mount Sinai Hospital, New York, NY
1990-1992	Clinical Instructor, Department of Pediatrics, Yale University School of Medicine, New Haven, CT
1993-1997	Assistant Clinical Professor, Department of Pediatrics, , Yale University School of Medicine, New Haven, CT
1997-Present	Assistant Clinical Professor, Department of Pediatrics, New York Medical College, Valhalla, NY

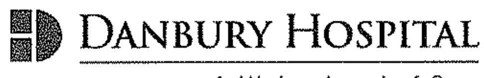
Administrative Positions:

7/ 2003-Present	Medical Director, Pediatric Inpatient Unit
7/1990-Present	Course Director, Pediatric Advanced Life Support, Danbury Hospital, Danbury, CT
7/1989-Present	Chief, Pediatric Pulmonology, Danbury Hospital, Danbury, CT
1998-2002	Vice President, Danbury Office of Physician Services
2000-2002	Board of Directors, Danbury Office of Physician Services

Board Certification:
National Board of Medical Examiners, 1983
American Board of Pediatrics, 1987
Subspecialty, Pediatric Pulmonology, American Board of Pediatrics ,1989

Professional Honors and Recognition:
2004: Connecticut's Hospital Association Community Service Award (Danbury Hospital) for its Pediatric Asthma Management Program

Professional organizations:
Fellow, American Academy of Pediatrics
Fellow, American College of Chest Physicians
American Thoracic Society



A Higher Level of Care

CURRICULUM VITAE
HALANA M. FINNIE MS, PMHCNS-BC, NPP, FNP

Clinical Director, Behavioral Health

Professional Experience

Clinical Director, Behavioral Health Nursing Danbury Hospital, Danbury, CT	2009 - Present
Magnet Program Director, Department of Nursing *Manager, Nursing Quality* Mount Sinai Hospital, New York, NY	2008 – 2009
Clinical Nurse Manager, Child and Adolescent Psychiatry Department of Psychiatry Mount Sinai Hospital, New York, NY	2005 – 2008
Nurse Practitioner, Child and Adolescent Psychiatry Psychiatry Care Center, Mount Sinai Hospital, New York, NY	2004 – 2005
Clinical Nurse Manager, Child and Adolescent Psychiatry Psychiatry Care Center Mount Sinai Hospital, New York, NY	1998 – 2004
Nurse Practitioner, Institute of Neurology and Neurosurgery Beth Israel Medical Center, New York, NY	1997 – 1998
Nurse Manager, Infectious Diseases/AIDS Beth Israel Medical Center, New York, NY	1996
Nurse Manager, Adult Psychiatry Beth Israel Medical Center, New York, NY	1994 – 1995
Nurse Manager, Child and Adolescent Psychiatry South Oaks Hospital, Amityville, NY	1991 – 1994
Head Nurse, Adolescent Psychiatry South Oaks Hospital, Amityville, NY	1988 – 1991
Clinical Nurse Supervisor Holliswood Hospital, Hollis, NY	1988
Head Nurse, Eating Disorders	1986 – 1988

South Oaks Hospital, Amityville, NY

Nurse Practitioner 2005
Private Practice, New York, NY

Consultant 2004 – Present
Forensic Psychiatry, New York, NY

Nurse Practitioner 2001 – 2004
Family Health Associates, New York, NY

Nurse Practitioner 1998 – 1999
Child Psychiatry Outpatient
Mount Sinai Hospital, New York, NY

Nurse Practitioner/Coordinator 1996 – 1997
ALS Center, Beth Israel Medical Center, New York, NY

Patient Services Director 1996 – 1997
ALS Association, Greater New York Chapter, New York, NY

Family Nurse Practitioner 1995 – 1996
Institute for Urban Family Health, Inc., New York, NY

Psychotherapist 1991 – 1992
Mid-Island Rehabilitation Center, Bayshore, NY

Clinical Nurse Specialist 1990 – 1991
West Nassau Mental Health Center, Franklin Square, NY

EDUCATION

- Doctor of Philosophy, Nursing, Duquesne University, Pittsburgh, PA. Coursework completed. Dissertation in progress. Graduation December 2010.
- Post-Masters Certificate, Forensic Nursing, Duquesne University, Pittsburgh, PA. 2004.
- Certificate of Advanced Graduate Study, Family Nurse Practitioner, Pace University, New York, NY. 1996.
- Master of Science, Nursing, SUNY Stony Brook, NY. 1991.
- Diploma, Registered Nurse, Crouse-Irving Memorial Hospital School of Nursing, Syracuse, NY. 1984.
- Bachelor of Arts, Psychology, Syracuse University, Syracuse, NY. 1982.

CERTIFICATIONS

- Family Nurse Practitioner, New York State, 1996.
- Nurse Practitioner, Psychiatry, New York State, 1994.
- Advanced Practice Registered Nurse, Board Certified, Clinical Specialist, Child and Adolescent Mental Health/Psychiatric Nursing, American Nurses

Credentialing Center, 1993.

- Certified Hypnotherapist, Hypnodyne Foundation, Clearwater, Fl. 1992.

PROFESSIONAL AFFILIATIONS

- Phi Kappa Phi, Chapter 187, Duquesne University, Pittsburgh, PA. Inducted 2009.
- Sigma Theta Tau, Epsilon Phi Chapter, Duquesne University. 2005-present.
- Advisory Board Member, Creative Alternatives of New York, 2004-present.
- International Society of Psychiatric-Mental Health Nurses, 2004-present.
  ISPN Divisions: Association of Child and Adolescent Psychiatric Nursing.
  ISPN Divisions: Society for Education and Research in Psychiatric-Mental Health Nursing.
- American Psychiatric Nurses Association, 2004-present.
- International Association of Forensic Nurses, 2002-present.
- American Association of Neuroscience Nurses, 1998.

CURRICULUM VITAE
Joseph J. Fiorito, MD.
Chief, Division Of Gastroenterology

Education:	LaSalle Academy, New York, NY. Honors: Class Valedictorian Extra Curricular Activities: Varsity Track Team Captain; State Champion 600 yd. run, 1975
1975-1979	Columbia University, New York, NY BA Extra Curricular Activities: Varsity Track; Student Commuters Association
POSTGRADUATE	Columbia University of Physicians and Surgeons, New York, NY MD degree, 1983
1983-1986	Mount Sinai Hospital, New York, NY. Internship and Residency in Internal Medicine
1986-1988	Montefiore Medical Center, Bronx, NY. Fellowship in Gastroenterology
1990-1992	Firm leader in Internal Medicine Training Program, Montefiore Medical Center, Attending Gastroenterology
1990-1992 **1990-1993**	Gastroenterology Director of Fellowship Program North Central Bronx Hospital/Montefiore Medical Center
Work History **1992 – present**	 Danbury Office of Physicians Services Chief, Department of Gastroenterology
BOARD **CERTIFICATION:**	American Board of Internal Medicine-9/86 American Board of Internal Medicine, Gastroenterology-11/89
LICENSER:	Connecticut License#030804 New York License #160919
PROFESSIONAL **SOCIETY**	American College of Gastroenterology American College of Physicians

MEMBERSHIPS: American Gastrointestinal Association
American Society of Gastrointestinal Endoscopy
American Medical Association

HOSPITAL Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810
Chief, Division Of Gastroenterology
February, 1992-Present
Albert Einstein College of Medicine
Assistant Clinical Professor of Medicine
1990-Present

HONORS: Attending of the Year, Danbury Hospital
Housestaff Teaching Program, 1993.

Voted to "Best Doctors in America",
Connecticut Magazine, July, 1996.

ACP: Physicians achievement award 2003
Physician achievement award 2006

TEACHING: Co-chairman GI-Tumor Board
Chairman GI-Surgery Case Conference
GI Consult Service Teaching Residents/Medical Students
Attending Rounds
Journal Club
Noon Conference
Grand Rounds
Community Health Care Seminars:
- Colorectal Cancer Screening
- Gastroesophageal Reflux
- Inflammatory Bowel Disease

Physician Assistant Teaching – in office
Research: Hydrotherapy/Colorectal Cancer Screening

A Higher Level of Care

CURRICULUM VITAE
Daniel Nelson Fish, M.D.
Chief, Section of Orthopaedic Surgery

EDUCATION:
Undergraduate: Bachelor of Science, 1982
Chemistry and Economics
St. Lawrence University, Canton, NY

Graduate: Department of Biochemistry, 1983
University of Rochester
Rochester, NY

Medical Education: Doctor of Medicine, 1987
University of Rochester School of Medicine
Rochester, NY

POST DOCTORAL TRAINING:
Internship: Department of Surgery, 1987-8
University of Michigan
Ann Arbor, Michigan

Residency: Section of Orthopaedic Surgery, 1988-92
University of Michigan
Ann Arbor, Michigan

Fellowship: Department of Orthopaedic Surgery, 1992-3
Sports Medicine (Bertram Zarins, M.D., director)
Massachusetts General Hospital
Harvard Medical School Boston, MA

LICENSURE AND CERTIFICATION:
Board Certified, American Board of Orthopaedic Surgery, 1995, recertified 2003
Expires July 2015
Certificate of Added Qualification, Sports Medicine, American Board of Orthopaedic Surgery , Nov 2008.
Michigan, Permanent License #4301057246 1990-7
Massachusetts, Permanent License #75072 1991-6
Connecticut, Permanent License #033073 1993-present
Vermont Permanent License 2004-present
New York State, Permanent License, 2001-3
Federal Licensure Examination, certified 7/87

HOSPITAL APPOINTMENTS:

Chief, Section of Orthopaedic Surgery, Danbury Hospital 2009-present
Danbury Hospital, Danbury CT, Attending 1993-present
Danbury Surgical Center, Danbury, CT, Attending 1993-present
New Milford Hospital, 2000-2

AWARDS AND ACTIVITIES:

Connecticut Magazine, "Top Docs" voted as a best surgeon by peers in orthopaedic surgery. April 2007, April 2008, April 2010.
Associate Team Physician, New England Patriots Football Club, Foxboro, MA, 1992-3
Associate Team Physician, Boston Bruins Hockey Club, Boston, MA 1992-3
National Football League Combine, National Invitational Camp, New England Patriots team physician, 1993
Instructor, Harvard Primary Care Orthopaedic Course, Cambridge, MA, May 1993
Co-chairman, American Orthopaedic Association Residents' Conference, Ann Arbor, MI, March, 1992
Finalist-1993 Richmond Cerebral Palsy Center Award, American Academy for Cerebral Palsy and Developmental Medicine.
Finalist-1992 O'Connor Research Award, Arthroscopy Association of North America .
Admissions committee, University of Michigan orthopaedic residency. 1989-1991
Samuel Clausen Fellowship, awarded for clinical studies in pediatric orthopaedics, University of Rochester. Summer, 1985
Omicron Delta Epsilon, national economics honorary, St. Lawrence University, 1981

PEER REVIEW BOARDS/ LEADERSHIP POSITIONS :

Danbury Hospital Executive Committee, Danbury, CT 2004-2008
Medical Director, Kimberly Clark Corporation, New Milford, CT 2000-present
Medical Director, Healthsouth, Danbury, CT (Physical Therapy) 2002-present
Secretary and Treasurer, Danbury Surgical Center 1998-2002
Medical Executive Committee and Credentials Committee, Danbury Surgical Center, Danbury, CT 1997-present
Trauma Operations Committee, Danbury Hospital, Danbury, CT 1997-2003
Foundation Contract Work Group, Danbury Hospital, Danbury, CT 1997-2000
Co-Director, Joint Arthoplasty Section, Danbury Hospital 2005-7

MEMBERSHIP IN SOCIETIES:

Member, Eastern Orthopaedic Association, 1997-present
Carl Badgley Orthopaedic Society, University of Michigan, Ann Arbor, MI. 1992-present
Fellow, American Academy of Orthopaedic Surgeons 1997-present
American Medical Association 1984-2006
Resident Member, Michigan Orthopaedic Society 1990-3
Member, Connecticut State Medical Society 1993-present
Member, Fairfield County Medical Association 1993-present
Member, Danbury Medical Society 1994-present
Member, Connecticut Orthopaedic Society, 2000-present

A Higher Level of Care

CURRICULUM VITAE

Tara Franco, RN, BS, MHA, LNC, CNML

Director, Patient Care Services

Education

University of Phoenix
Master of Science, Nursing (in progress)

Warren National University
Master of Science, Health Administration

Post University
Bachelor of Science, Management (Cum Laude)

Bridgeport Hospital School of Nursing
Diploma in Nursing
Excellence in Leadership Award
Excellence in Pediatric Nursing Award

Professional Experience

Director, Patient Care Services — *2006 – Present*
Danbury Hospital – Danbury, CT

Nurse Manager, Inpatient Oncology — 2003 – 2006
Danbury Hospital – Danbury, CT

Nurse Manager, Cardiac Service Line — 2001 – 2003
Mid State Medical Center- Meriden, CT

Patient/Administrative Care Manager — 1999 – 2001
Hospital of St. Raphael – New Haven, CT

Medical-Legal Associates — 1997 – Present

Additional Clinical Experience

- Surgical ICU/Cardiac surgery: including patient receiving CABG, valve replacements, Neuro/Surgical Trauma, balloon pump experience.
- Anesthesia Surgical Post Op monitoring of intensive care patients.
- Anesthesia Associates: Monitored patients post op anesthesia. Pain Management Specialists.
- Monitored and recommended changes in therapy for patients receiving PCA, IV/Epidural.

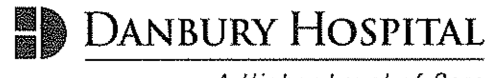
- Assisted in the OR with pump implants and spinal cord stimulator trials, as well as refilling of permanent pumps for chronic pain and oncology patients.
- Oncology: Managed all aspects of care for oncology, palliative care and hospice patients.

Certifications

Legal Nurse Consulting Certificate – September 1997
Project Management Certificate
DELETCC ~ City of Hope, CA
Obtained CNML ~ May 2009
Geriatric Assessment Course ~ November 2009

Memberships

American Organization of Nurse Executives
Connecticut Organization of Nurse Executives
Health Care Finance Management Organization



CURRICULUM VITAE
William James Gemmell, MD
Vice Chairman, Department of Medicine

Education:	1972-1976 University of Pennsylvania Medical School
Training:	1976 – 1977 Internship Danbury Hospital, Danbury, CT 1977 – 1979 Residency Danbury Hospital, Danbury, CT Internship and Residency in Internal Medicine ACLS ATLS PALS
Board Certifications:	10/19/84 Emergency Medicine 9/12/79 Internal Medicine
Employment:	1979 – Present Danbury Hospital Department of Emergency Medicine 1982 – Present Vice Chairman, Department of Emergency Medicine
Membership:	American College of Emergency Physicians Connecticut College of Emergency Physicians

CURRICULUM VITAE
Charles Herrick, MD
Chairman, Department of Psychiatry

Work History

2006 – Present	Chairman Department of Psychiatry Danbury Hospital, Danbury, CT
2003 – 2006	Vice-Chairman Department of Psychiatry Danbury Hospital, Danbury, CT
2000 – 2006	Medical Director Intensive Psychiatric Services, including Inpatient Psychiatry, Crisis Intervention and Consultation Liaison Psychiatry Danbury Hospital, Danbury, CT
2004 – 2005	Acting Medical Director Methadone Clinic Danbury Hospital, Danbury, CT
1999 – 2000	Acting Medical Director Center for Child & Adolescent Treatment Services Department of Psychiatry Danbury Hospital, Danbury, CT
1998 – 2000	Medical Director Consultation Liaison Psychiatry Department of Psychiatry Danbury Hospital, Danbury, CT
1998 - Present	Assistant Clinical Professor New York Medical College, Valhalla, New York
1994-1998	Comprehensive Psychiatric Emergency Program Attending Department of Psychiatry Jacobi Medical Center Albert Einstein College of Medicine, Bronx, New York
1995-1996	Unit Chief Department of Psychiatry Jacobi Medical Center

	Albert Einstein College of Medicine, Bronx, New York
1994-1995	Inpatient Attending Department of Psychiatry Jacobi Medical Center Albert Einstein College of Medicine, Bronx, New York
1994-1998	Clinical Instructor and Supervisor Department of Psychiatry Albert Einstein College of Medicine, Bronx, New York
1995-1998	Outpatient Attending Department of Psychiatry Jacobi Medical Center Albert Einstein College of Medicine, Bronx, New York
1995-1998	Consultant Jewish Board of Family and Children's Services Bronx, New York
1991-1994	Staff Psychiatrist Outpatient Department Kaiser Permanente Medical Center South San Francisco, California
1988-1989	Psychiatrist On-Duty Carney Hospital Boston, Massachusetts
1988-1989	Psychiatrist On-Duty Solomon Mental Health Center Lowell, MA
1988-1989	Psychiatrist On-Duty Lemuel Shattuck Hospital Boston, Massachusetts
1984-1986	Research Investigator Departments of Pharmacology and Psychiatry Southern Illinois University School of Medicine Springfield, Illinois

Fellowship

1989 – 1991	Child Psychiatry Fellow University of California at San Francisco Langley Porter Psychiatric Institute

San Francisco, California

Residency

1987 – 1989	Psychiatry Resident Tufts University New England Medical Center Hospitals Boston, Massachusetts

Internship

1986 – 1987	Psychiatry & Medicine Intern Tufts University New England Medical Center Hospitals Boston, Massachusetts

Medical School

1982 - 1986	MD Southern Illinois University Springfield, Illinois

Other Education

1978 - 1982	BS Biology University of Illinois Urbana, Illinois

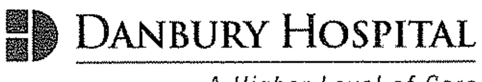
Hospital Affiliation Danbury Hospital, Danbury CT

Boards

1992	Diplomate: American Board of Psychiatry and Neurology (#35817)
1987	Diplomate: National Board of Medical Examiners (#335535)

Licensure

CT	(036877)
NY	(195460)
MA	(58782)
CA	(G68576)
DEA	(BH1273490)
UPIN	(F10910)



CURRICULUM VITAE
Edward Kevin James, M.D.
Chief, Section of Neonatology

EDUCATION
Cornell University Medical College
M.D., May 1980

University of Pennsylvania
B.A., May 1976 - cum laude

POST-GRADUATE TRAINING

Sept., 1994 – Present	Chief, Section of Neonatology Danbury Hospital Danbury, CT
July, 1990 - Aug., 1994	Neonatologist, The Reading Hospital & Medical Center, Reading, PA
July, 1985 - July, 1990	Neonatologist, Danbury Hospital Danbury, Connecticut
July, 1984 - June, 1985	(FELLOW) Columbia-Presbyterian Medical Center - New York, NY NEONATOLOGY (PGY-5)
July, 1983 - June, 1984	(FELLOW) Columbia-Presbyterian Medical Center – New York,NY NEONATOLOGY (PGY-4)
July, 1982 - June, 1983	Bronx Municipal Hospital Center (Albert Einstein College of Medicine, Bronx, NY) PEDIATRICS (PGY-3)
July, 1981 - June, 1982	Bronx Municipal Hospital Center Albert Einstein College of Medicine, Bronx, NY) PEDIATRICS (PGY-2)
July, 1980 - June, 1981	Bronx Municipal Hospital Center (Albert Einstein College of Medicine, Bronx, NY) PEDIATRICS (PGY-1)

BOARD CERTIFICATION

1981	Diplomate, National Board of Medicine Examiners,
1986	Board Certified, Pediatrics
1990	Board Certified, Neonatal-Perinatal Medicine

APPOINTMENTS

1996 – Present	Assistant Clinical Professor Department of Pediatrics New York Medical College
1995 – 2000	Clinical Instructor, Department of Pediatrics, Section - Neonatology, Yale Medical School
1994 - Present	Associate Attending, Department of Pediatrics Danbury Hospital
1993 - 1994	Clinical Assistant Professor, Department of Pediatrics The College of Medicine of the Pennsylvania State University
1989 - 1990	Associate Clinical Professor, Department of Pediatrics, Section - Neonatology Yale-New Haven Medical School.
1988 - 1990	Associate Attending, Department of Pediatrics, Danbury Hospital

PROFESSIONAL ACTIVITIES

Reading Hospital

1990 – 1994	Member, Critical Care Subcommittee, Neonatal Intensive Care/Pediatric Intensive Care

Danbury Hospital:

1994 – present	Chair, Perinatal Services Committee
1995 – 2004	Ethics Committee
1995 – 2004	Pastoral Care Committee
1995 - Present	Pediatric Peer Review
1995 - 2005	Finance Committee, Danbury Office of Physician Services
1986 – 1990	Member, Pharmacy and Therapeutics Committee

1985- 1989	Member, Utilization Review Committee
Neonatal Resuscitation 1989 - Present	 Regional Trainer, Neonatal Resuscitation Program
Fellowship:	Head Ultrasound - Technical Training in administration and interpretation
Medical School:	Chapter President/Student National Medical Assn. (SNMA) Cornell University, 1977-1978 Speaker of The House/National Convention (SNMA) New Haven, CT. 1980 Member/Admissions Committee Cornell University, 1979-1980

A Higher Level of Care

CURRICULUM VITAE

Eric Jimenez, MD

Chief, Medical Information Officer
Medical Director, Adult Intensive Care Unit

Work History:

05/08 – Present	Chief, Medical Information Officer
01/85 – Present	Danbury Office of Physician Services Pulmonary, Critical Care & Sleep Disorders
6/94 – 05/08	Chief, Pulmonary Department Medical Director, Respiratory Services Danbury Hospital Danbury, CT
01/85 – Present	Medical Director, Adult Intensive Care Unit Danbury Hospital Danbury, CT
7/88 - 6/91	Assistant Clinical Professor, Internal Medicine Yale University New Haven, CT
7/86 - 6/88	Clinical Instructor, Internal Medicine Yale University New Haven, CT

Fellowship:	1/83 – 12/84	Danbury Hospital – Pulmonary Medicine Danbury, CT
Residency:	1/81 – 12/82	Danbury Hospital – Internal Medicine Danbury, CT
Internship:	1/80 – 1/81	Danbury Hospital – Internal Medicine Danbury, CT
Medical School:	9/76 – 12/79	Universidad Nacional Pedro Henriquez Urena Santo Domingo, Dominican Republic (MD)
Other Education:	09/72 – 06/76	Universidad Nacional Pedro Henriquez Urena Santo Domingo, Dominican Republic
Boards:	9/83	Certified, Internal Medicine
	11/86	Certified, Pulmonary Medicine
	1987	Certified, Critical Care
	2006	Re-certified, Pulmonary

	2007	Re-certified, Critical Care	

Licensure:		
	CT Controlled Substance	10729
	CT License	023557
	DEA	AJ1723130

Professional Membership:

1983 – Present	American Thoracic Society
1985 – Present	American College of Chest Physicians
1986 – Present	Connecticut Thoracic Society
1991 – Present	Society of Critical Care Medicine
1995 – Present	American College of Physicians

CURRICULUM VITAE
William D. Johns, MD
Chief of Nuclear Medicine

Current Position
Danbury Hospital, (Yale University Affiliated Hospital)

Chief of Nuclear Medicine (September 2008 – Present)

Assistant Medical Director of Nuclear Medicine (July 1988- August 2008)

Attending Physician Internal Medicine- Hospitalist Team (March 1999-Present - Moonlighter)

Primary Care Center (July 1988-February 1999)

Award: Attending of the Year- 1995-96 (Medical Housestaff)

Chairman of Radiation Safety Committee Danbury Hospital (September 2008 – Present)

Radiation Safety Officer Danbury Hospital (October 2002-August 2008)

Committee Member: Physician Advisory Group for Information Technology, PACS. Committee

Assistant Clinical Professor of Nuclear Medicine (July 1988-Present), UCONN School of Medicine, Farmington, CT

Adjunct Professor of Medicine (July 2000-Present), New York Medical College, Valhalla, NY

Education
Sept 2003-June 2005 **New York Medical College**, School of Public Health, Valhalla, NY, Certificate in Medical Informatics (5 courses- IT). Enterprise PACS, Computerized Physician Order Entry, Electronic Medical Records.

July 1986-June 1988 Joint Program in Nuclear Medicine- Residency Training, **Harvard Medical School**, Department of Radiology; Chief Resident 1987-88.

July 1983-June 1986 Internal Medicine Residency, Danbury Hospital, Danbury, CT, affiliated with Yale University School of Medicine.

Sept 1979-June 1983 M.D., **University of Connecticut School of Medicine**, Farmington, CT.

Sept 1977-June 1979 M.S., **Yale University** (Organic Chemistry), New Haven, CT. Teaching & Research Assistantship. Research involved photo-oxidation of organic heterocyclic compounds.

Sept 1973-June 1977 Sc.B., **Brown University** (Chemistry & Biochemistry), Providence, RI. Magna Cum Laude with Honors in Chemistry. Senior research thesis in synthetic organic chemistry.

Licensure

Connecticut, since 8/85 #026668
Massachusetts, since 7/86 #56219

Certification

American Board of Nuclear Medicine (ABNM)- 1988
American Board of Internal Medicine (ABIM) - 1986
American Board of Medical Examiners (ABME) - 1984

Memberships

Society of Nuclear Medicine (SNM) - 1987-Present
American College of Nuclear Physicians (ACNP) - 1987-Present
American College of Physicians (ACP) &
American Society of Internal Medicine (ASIM) - 1984-Present
Society of Hospitalist Medicine (SHM) - 1999 (Charter Member)
American Medical Association (AMA) - 1984
Society of Sigma Xi (Science Honors) - 1977
Danbury Medical Society- 1988
American Medical Informatics Association (AMIA) - 2003

CURRICULUM VITAE
Andrew M. Keller, M.D.

Chief, Cardiology

Undergraduate Education	Ithaca College, Ithaca New York. BA Physics, Magna Cum Laud, 1971-1975
Graduate education	The Ohio State University, Columbus, Ohio. Doctorate of Medicine, 1975-1979
Medical Internship	Duke University Medical Center Hospitals, Durham, North Carolina. 1979-1980
Medical Residency	Duke University Medical Center Hospitals, Durham, North Carolina. 1980-1982
Cardiology Fellowship	The University of Texas, Health Science Center Southwestern Medical School. Dallas, Texas 1982-1985

Basic clinical training in radioisotope administration

The University of Texas, Health Science Center Southwestern Medical School. Dallas, Texas 1982-1985, (550 hours)

Basic radioisotope handling techniques

The University of Texas, Health Science Center at San Antonio, San Antonio, Texas. 1985, 200 hours

Qualifications and certification

1979	State of Ohio Medical License, by FLEX examination, #43955
1982	State of Texas Medical License, #G2410
1982	Diplomat of the American Board of Internal Medicine, #84693
1985	State of New York Medical License, #163584-1
1985	Authorized user radioactive materials under the City of New York Radioactive Materials License for Columbia University #62-3
1986	Diplomat of the American Board of Internal Medicine Cardiology Subspecialty, #84693

1989	Authorized user radioactive materials under the Radioactive Materials License for Danbury Hospital, Danbury CT #06-08544-01 Amendment 66
1989	State of Connecticut Medical License #030360
1990	Fellow of the American College of Cardiology
1995	Fellow of the American College of Physicians
1996	American Society of Echocardiography Examination of Special Competency
2004	Fellow of the American Society of Echocardiography

Professional organizations and societies

1987-Present	Fellow, The American Heart Association, Clinical Council.
1987-Present	Member, The American Heart Association, Basic Science Council
1987-Present	Member, The American Heart Association, Circulation Council
1987-Present	Member, The American Heart Association, Cardiovascular Radiology Council
1988-Present	Member, The American Society of Echocardiography
1991-Present	Fellow, The American College of Cardiology
1995-Present	Fellow, The American College of Physicians

Academic appointments

Columbia University, College of Physicians and Surgeons, New York, New York

1999-Present	Associate Clinical Professor of Medicine
1989-1999	Assistant Clinical Professor of Medicine
1985-1989	Assistant Professor of Medicine and Radiology
1987-1989	Director, Cardiac Magnetic Resonance Spectroscopy Research Unit at the College of Physicians and Surgeons

Hospital Appointments

1985-1999	Assistant Attending, Presbyterian Hospital, New York, New York
1999-Present	Associate Attending, Presbyterian Hospital, New York, New York
1989-1995	Assistant Attending, Danbury Hospital, Danbury Connecticut
1995-1999	Associate Attending, Danbury Hospital, Danbury Connecticut
1999-Present	Attending, Danbury Hospital, Danbury Connecticut
1985-1987	Attending in Nuclear Cardiology, Presbyterian Hospital, New York, New York
1987-1989	Medical Director Adult Echocardiography, Presbyterian Hospital, New York, New York
1989-Present	Director of Echocardiography, Danbury Hospital, Danbury, Connecticut

2003-2004	Director (interim), Cardiology Section, Danbury Hospital
2004-Present	Director (Chief), Cardiology Section, Danbury Hospital
2004-Present	Medical Executive, Cardiovascular Service Line, Danbury Hospital

Honors

1975	University Fellow at the Ohio State School of Medicine
1987	New York Heart Association, M. Robert Gallop, Esq. Award
1993	Fellow in The American Heart Association Council of Clinical Cardiology
2003	American Society of Echocardiography Meritorious Service Award.

Fellowship and grant support

1983-1984	NIH Cardiovascular Fellow, The University of Texas, Health Science Center Southwestern Medical School. Dallas, Texas
1987-1989	New York Heart Association Investigatorship Award #6-41647. 3 year award at $28,000 per year plus fringe
1987-1989	NIH R29 HL40719-02, Cardiac Glutathione Redox Cycle in Reperfusion Injury. Direct annual funding of $120,062

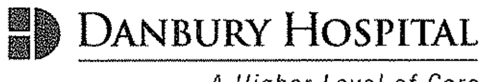
Teaching activities

1985-1989	Ward and Coronary Care Attending, Presbyterian Hospital, New York, New York.
1989-Present	Ward and Coronary Care Attending, Danbury Hospital, Danbury, Connecticut
1989-Present	Attending, Adult Echocardiography Laboratory, Presbyterian Hospital

Other Professional activities

2005-2008	Member – American College of Cardiology, Cardiosource Steering Committee
2003-2008	Co-Chair, American College of Cardiology, Task Force to Integrating Healthcare Enterprise (IHE)
2002-2003	Member, House Staff Evaluation Committee, Danbury Hospital, Department of Medicine
2003-2004	Chair, Special Sessions, American College of Cardiology Scientific Program Committee
2002-2004	Member – American College of Cardiology Scientific Sessions Program Committee
2000-2003	Chair, ASEUniversity Editorial Board.
1999-2002	Member – Board of Directors – American Society of Echocardiography.

1997-Present	Chair, American Society of Echocardiography, Information Technology Committee.
1996-2004	Secretary-Treasurer, the Connecticut Chapter of the American College of Cardiology.
1994-1999	Chair, Publications and Education Committee of the Connecticut Chapter of the American College of Cardiology, and Editor, The Connecticut Cardiologist.
1995-1996	Co-Chair, Connecticut Chapter of the American College of Cardiology Task Force on the Clinical Application of Echocardiography
1996-1998	Co-Chair, Connecticut Chapter of the American College of Cardiology, Third Party Reimbursement Committee.
2000-2002	Member – American Society of Echocardiography – Standard report committee
2001-2003	Member – American Society of Echocardiography – Digital echocardiography task force
2005-2007	Member – The State of Connecticut, Department of Public Health, special task force on reporting outcomes in Cardiovascular Services.
2005-Present	Member – American Society of Echocardiography Quality Task Force.
2007-Present	Member, American College of Cardiology Information Technology Committee.



CURRICULUM VITAE
Jay H. Klarsfeld, M.D.

Medical Director Ridgefield Surgical Center

BOARD CERTIFICATION

Fellow of the American Academy of Otolaryngology Head and Neck Surgery – 1986

HIGHER EDUCATION

1977 Brandeis University – Double Major – Biochemistry and Biology

1981 Mount Sinai School of Medicine – M.D.

POST GRADUATE TRAINING

1979 Anesthesia Preceptor Program. The Mount Sinai Medical Center, New York

1981 – 1982 Internship General Surgery. The Mount Sinai Medical Center, New York

1982 – 1983 Resident General Surgery. The Mount Sinai Medical Center, New York

1983 – 1985 Resident, Department of Otolaryngology. The Mount Sinai Medical Center, New York

1985 – 1986 Chief Resident, Department of Otolaryngology. The Mount Sinai Medical Center, New York

MEDICAL EMPLOYMENT

1994 – Present President, Advanced Specialty Care, PC. – Multi-Specialty Surgical Group

- 16 Physicians; 4 Audiologists; 4 Estheticians - covering the specialties of Otolaryngology-Head & Neck Surgery, Plastic Surgery, General Surgery, Colo-Rectal Surgery, Pediatric Surgery, Hand Surgery and Allergy
- 4 Locations

January 2008 Coordinator of the Advanced Specialty Care, PC. affiliation with Beth Israel Medical Center, NY and Continuum Cancer Centers of New York

1990 – 1994 Partner– Advanced Ear, Nose & Throat Care, P.C.

1986 – 1990 Employee Physician & Surgeon – Gary Townsend, MD, P.C.

HOSPITAL AND SURGICAL POSITIONS

2006 – Present Medical Director Ridgefield Surgical Center

2005 – Present Editorial Board Outpatient Surgery Magazine

2004 – Present Chairman - Section of Otolaryngology – Danbury Hospital

2003 – 2006 Chairman - Surgical Services Committee – Danbury Hospital

1992 – 1995 Medical Advisory Board Danbury Surgical Center

1991 – 1993 Secretary / Treasurer, Department of Surgery – Danbury Hospital

CLINICAL AFFILIATIONS

- Danbury Hospital
- Ridgefield Surgical Center

TEACHING APPOINTMENTS

Attending Surgeon, Section Otolaryngology; Head& Neck Surgery; Danbury Hospital

Clinical Instructor – Otolaryngology Mount Sinai Service, Elmhurst Queens till 1997

Clinical Instructor – Otolaryngology University Medical Center, Yale New Haven,
New Haven, CT till 2002

EDUCATIONAL AWARDS

1977 Cum Laude – Brandeis University

1981 Lester R. Tuchman Award for Clinical Excellence - Mount Sinai School of Medicine

MEDICAL LICENSE

- State of New York - #152750
- State of Connecticut - #027179

PROFESSIONAL MEDICAL SOCIETIES

- Alpha Omega Alpha Medical Honor Society
- American Academy of Otolaryngology – Head and Neck Surgery - Fellow
- American Rhinologic Society
- Connecticut State Medical Society
- Danbury Medical Society
- Fairfield County Medical Society
- New York Facial Plastic Surgery Society – Charter Member

CURRICULUM VITAE
Robert A. Kloss, MD
Medical Director, Regional Hospice of Western Connecticut

Work History

11/1993 - Present
Private Practice in Hematology/Oncology
Danbury Office of Physician Services, PC
Praxair Cancer Center
95 Locust Avenue
Danbury, CT 06810

07/1981 – 11/1993
Associated Internists of Danbury, P.C.
67 Sand Pit Road
Danbury, CT 06810

1985 - Present
Regional Hospice of Western Connecticut
Medical Director
30 West Street
Danbury, CT 06810

Fellowship
07/79 – 06/81 Hematology/Oncology
Columbia Presbyterian Medical Center, New York, NY

Residency
1977 - 1979 First and Second Year Resident
SUNY at Buffalo
Buffalo, NY

Internship
1976 - 1977 Medical Intern, SUNY at Buffalo
Buffalo, NY

Medical School
1972-1976 Jefferson Medical College
Thomas Jefferson University
Philadelphia, PA

Other Education
1968-1972 University of Pennsylvania
College of Arts and Sciences
Philadelphia, PA

Hospital Affiliation
1981-Present Attending Physician, Danbury Hospital
Danbury, CT

1985-Present Medical Director of Regional Hospice
Danbury, CT

	1995-2005	Medical Director of Inpatient Oncology Danbury Hospital Danbury, CT
Boards	09/1979	Board Certified - Internal Medicine
	11/1981	Board Certified - Medical Oncology
	12/1996	Board Certified – Hospice & Palliative Medicine
	01/2005	Recertified – Hospice & Palliative Medicine
	10/2008	ABIM Board Certified – Hospice & Palliative Medicine

Licensures

CT - 022825
DEA - AK1262930
UPIN – D80876
NPI -- 1649207770

Honors

Graduation Cum Laude from University of Pennsylvania

Professional Membership

Fairfield County Medical Society
American Medical Association
American Society of Clinical Oncology
American Academy of Hospice and Palliative Medicine

CURRICULUM VITAE
Ramon N. Kranwinkel, M.D.
Chairman, Department of Pathology and Laboratory Medicine

EDUCATION

College: J. P. Duarte Lycee, Santo Domingo, Dominican Republic
Medical School: University of Santo Domingo, Dominican Republic, 1954-1960
1957-1960: Clerkship Internal Medicine, Hospital Salvador B. Gautier, Santo Domingo, Dominican Republic
1960-1961: Internship Internal Medicine, Hospital Salvador B. Gautier, Santo Domingo, Dominican Republic
1961-1962: Fellow in Pathology, Danbury Hospital, Danbury, Connecticut
1962-1966: Resident in Clinical and Anatomical Pathology, Danbury Hospital, Danbury, Connecticut
1966-1967: Chief Resident in Hematology, Mt. Sinai Services at Elmhurst General Hospital,
Elmhurst, New York
1967-1968: Teaching Fellow in Pathology-Hematopathology at Mt. Sinai Services at Elmhurst General Hospital, Elmhurst, New York

LICENSURE

New York State License: No. 101033 - April 30, 1968
Connecticut State License: No. 13264 - 1967
Republica Dominicana Exequator License: No. 3394

Board Certified: Anatomical and Clinical Pathology, November 1969
Board Certified: Hematology, 1977

STAFF APPOINTMENTS

1968-1969: Attending Pathologist, Director of Hematology and Blood Bank, Danbury Hospital, Danbury, Connecticut
1969-1971: Major, M.C., Chief of Laboratories, Dewitt Army Hospital, Fort Belvoir, Virginia, U.S.A.
1971-1990: Vice Chairman, Department of Laboratory Medicine,
Danbury Hospital, Danbury, Connecticut;
1971-Present: Director, Residency Program-Laboratory Medicine;
Director of Hematology, Immunohematology, Immunology, Hematology Consultant, Department of Internal Medicine; Instructor, Department of Medicine, Danbury Hospital, Danbury, Connecticut;
1990-Present: Chairman, Department of Pathology and Laboratory Medicine, Danbury Hospital, Danbury, Connecticut
1990-Present Medical Editorial Board of Connecticut Medicine

1998-Present Attending Danbury Hospital Medical Staff Consultant, New Milford Hospital

PREVIOUS COMMITTEE MEMBERSHIPS

- Board of Directors, Heritage Individual Practice Association, Connecticut
- Connecticut Peer Review Organization: Sanctions and Quality Assurance Committee
- District Advisor, American Association of Blood Banks
- Medical Mortality Review Committee, Department of Medicine
- Oncology Committee, Department of Medicine
- Pharmacy and Therapeutics Committee
- Institutional Review Board (Human Investigation Committee), Chairman
- Trauma Patient Care Peer Committee
- Medical Progress Committee, Danbury Hospital
- Organ Donor Committee, Danbury Hospital
- Utilization Review Committee, Chairman – Danbury Hospital
- Inspector, American Association of Blood Banks (AABB)
- Northeast Area Chairman, Inspection and Accreditation Program - AABB
- Member, Inspection and Accreditation Committee - AABB
- Member, International Relations Committee – AABB
- Pan American Health Organization – Advisor, Blood Program

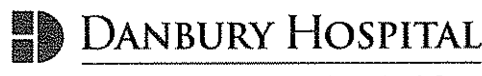
DANBURY HOSPITAL PRESENT COMMITTEE MEMBERSHIPS

- Blood and Tissue Committee
- Medical Education Committee

SOCIETIES AND OTHER MEMBERSHIPS

- American Medical Association
- American College of Pathology
- American Society of Clinical Pathologists
- American Association of Blood Banks
- American Society of Hematology
- Society for Hematopathology – Charter Member
- International Academy of Pathology
- Latin American Pathology Foundation
- Sociedad Medica Dominicana
- Connecticut State Medical Society:
  - Member Committee on Organ and Tissue Transfers, Connecticut – Chairman, presently
  - State Medical Society (Advisory Committee to the Connecticut
  - Red Cross Blood Service)
  - Member Committee on Editorial Review, Connecticut Medicine
- Connecticut State Pathologists Society
- Assistant Clinical Professor-Pathology, Yale University, New Haven, CT
- Adjunct University of Vermont

- Inspector Accreditation Committee, College of American Pathology
- Clinical Associate Professor, Allied Health Professions, University of Connecticut, Storrs, Connecticut
- Scientific Advisor, Biomedic Institute, Universidad Nacional Pedro Henriquez Urena



CURRICULUM VITAE
Thorsten L. Krebs, M.D.
Chairman, Department of Radiology

Current Appointment

Chairman, Department of Radiology, Danbury Hospital, Danbury, CT
Attending Radiologist, Danbury Radiological Associates, Danbury, CT 1999 – Present
Attending Radiologist, Putnam Imaging Associates, Putnam Hospital, Carmel, NY 7/2002-present
Visiting Associate Clinical Professor, University of Maryland 1999- 2005
New York Medical College Associate Professor, Valhala, NY - present

Past Appointments

Clinical Assistant in Radiology, Massachusetts General Hospital, Boston, MA 1990-1991
Staff Radiologist, Chief of Genitourinary Radiology, Cedars-Sinai Medical Center, Los Angeles, CA 1991-1992
Staff Radiologist and Head of Body Imaging, University of Maryland Medical Center, Baltimore, MD 1993-1999
Consultant Staff, Diagnostic Radiology, Kernan Hospital, Baltimore, MD 1996-1999
Consultant Staff, Diagnostic Radiology, Mercy Hospital, Baltimore, MD 1997-1999

Post Graduate Medical Training

Abdominal Imaging and Interventional Radiology Fellowship 1990 - 1991
Massachusetts General Hospital
Harvard Medical School, Boston, MA

Diagnostic Radiology Residency 1986 - 1990
Columbia- Presbyterian Medical Center
Columbia University College of Physicians and Surgeons, New York, NY

Internship 1985 - 1986
Department of Medicine
The Staten Island Hospital, Staten Island, NY

Medical Education

State University of New York, Downstate Medical Center, Brooklyn, NY 1981 - 1985
Doctor of Medicine, June, 1985

Undergraduate Education

Washington University, St. Louis, MO 1978 - 1981

Honors and Awards

- Dean's List, six semesters
- Phi Beta Kappa 1980
- Cum Laude, Biology, Washington University 1981
- Honorary Academic Scholarship 1982 - 1984
- Alpha Omega Alpha 1984
- Cum laude, SUNY Downstate Medical Center 1985
- AUR Picker Fellowship, Association of University Radiologists 1996
- 1st place, unknown case quiz, AFIP Musculoskeletal Conference 1999
- Teacher of the Year, University of Maryland, Department of Radiology 1999
- Resident Teacher of the Year, Danbury Hospital, Department of Medicine, 2001

Licensure and Certification

- New York State License 166617-1
- Massachusetts State License 72916, inactive
- California State License G070974
- Maryland State License D44767, inactive
- Connecticut State License 037641
- American Board of Radiology 1990
- Diplomate, National Board of Medical Examiners 1986

Professional Society Memberships and Activities

- Radiological Society of North America
- American College of Radiology
- American Roentgen Ray Society
- Society for Urologic Radiology
- Fairfield County Medical Society
- Connecticut Radiological Society

Faculty Positions

- Clinical Fellow in Radiology, Harvard Medical School, Boston, MA 1990 - 1991
- Assistant Clinical Professor of Radiology, University of California School of Medicine, Los Angeles, CA 1991 - 1993
- Assistant Professor of Diagnostic Radiology, University of Maryland School of Medicine, Baltimore, MD 1993 - 1999
- Visiting Scientist, Armed Forces Institute of Pathology, Washington, D.C. 1998 - 1999
- Visiting Associate Clinical Professor of Radiology, University of Maryland School of Medicine, Baltimore, MD 1999 - 2005

A Higher Level of Care

CURRICULUM VITAE
Ann Marie Lavery
Clinical Director, 9 & 10 Tower

EMPLOYMENT HISTORY:

Clinical Director, 9 & 10 Tower Danbury Hospital Danbury, Connecticut	7/08-present
Nurse Manager – 9 Tower Danbury Hospital Danbury, Connecticut	6/05-7/08
Nurse Manager-Critical Care Unit **Nurse Manager-Intermediate Care Unit** Lawrence Hospital Center Bronxville, New York	11/98 – 5/05
Clinical Care Coordinator CCU & MICU Montefiore Medical Center Bronx, New York	10/97 – 10/98
Nurse Manager – Critical Care Unit **Nurse Manager – 3 North Telemetry** Lawrence Hospital Bronxville, New York	2/95 – 10/97
Nurse Manager – Critical Care Unit Lawrence Hospital Bronxville, New York	9/93 – 2/95
Staff Nurse – Critical Care Unit Lawrence Hospital Bronxville, New York	1/89 – 9/93
Staff Nurse – Medical/Surgical Unit Lawrence Hospital Bronxville, New York	9/86 – 12/88

EDUCATION:

Iona College New Rochelle, New York **MS – Health Services Administration**	1994
College of New Rochelle New Rochelle, New York **BSN – Nursing**	1986

LICENSES:

New York 395817
New Jersey 26NR11174500
Connecticut 070146

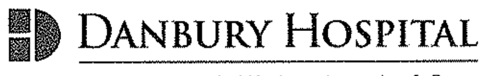
- **CERTIFICATIONS:**

Advanced Cardiac Life Support
Arterial Blood Gases
Venipuncture and IV Therapy
Nursing Administration (CNA)
PRI Certification

MEMBERSHIPS:

- American Association of Critical Care Nurses
- AONE

1975	American Thoracic Society
1978	Diplomat, American Board of Internal Medicine in Pulmonary Disease
1981	Fellowship American College of Chest Physicians
1985	President, Connecticut Thoracic Society
1986	Fellowship, American College of Physicians (FACP)
1986	Founder and President, Connecticut Critical Care Society
1987	Diplomat, American Board of Internal Medicine in Critical Care Medicine
1994	Associate, American College of Healthcare Executives



CURRICULUM VITAE
Richard J. Lee, M.D.
Chief, Div. of Allergy & Immunology

EDUCATION:

	University of Connecticut, Storrs, CT Bachelor of Science – Microbiology	1976
	Univ. Central del Este, Facultad de las Ciencias Medicas San Pedro de Macoris, Dominican Republic Physician & Surgeon – Medical Degree	1980
	State University of New York – Downstate Medical School Brooklyn, New York Fifth Pathway Certificate	1981

POST GRADUATE TRAINING:

Internship:	UMDNJ – Rutgers Medical School New Brunswick, New Jersey Internal Medicine	7/81 – 6/82
Residency:	UMDNJ – Rutgers Medical School New Brunswick, New Jersey Internal Medicine	7/82 – 6/84
Fellowship:	Brown University School of Medicine Rhode Island Hospital, Providence, Rhode Island Allergy and Clinical Immunology	7/84 – 6/86

PROFESSIONAL LICENSURES:

Connecticut Professional License	027285
American Board of Internal Medicine Diplomate September 11, 1985	098494
American Board of Allergy & Immunology Diplomate October 5, 1987	2857

MEMBERSHIPS:

American College of Physicians
American Academy of Allergy, Asthma & Immunology – Fellow
American College of Allergy, Asthma & Immunology – Fellow
Connecticut Society of Allergy & Immunology (Secretary 1990-1994), (President – Elect 1994-1996), (President 1996-1998), (President-Ex Oficio 1998-2000), (Executive Committee 1990-Present)
Connecticut State Medical Society (Alt. Delegate 1988-1989)
Connecticut Thoracic Society – Member

New England Society of Allergy (Director – Allied Health Education Section Director, 1987–1995), (Executive Council Member 1993–2000), (C.M.E. Chairman 1993–1996), (President – Elect 1997-1998), (President 1998-1999), (Immediate Past President 1999-2000)

AWARDS:

Rhode Island Lung Association: Scholarship	1984
Rhode Island Lung Association: Scholarship	1985
American Academy of Allergy: Immunology Travel Grant	1986

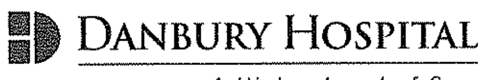
APPOINTMENTS:

Clinical Instructor of Medicine
UMDNJ – Rutgers Medical School
New Brunswick, New Jersey — 12/82-6/84

Assistant Instructor of Medicine
Brown University, Div. of Biology & Medicine
Providence, Rhode Island — 7/84-6/86

Attending Physician
Chief, Div. of Allergy & Immunology
Dept. of Internal Medicine
Danbury Hospital
Danbury, Connecticut — 6/86-Current

Assistant Clinical Professor of Medicine
Department of Pediatrics
New York Medical College — 10/97-Current



CURRICULUM VITAE
David A. Oelberg, M.D. FRCP(C), D, ABSM
Chief, Pulmonary Section

Current Positions Chief, Pulmonary Section, Danbury Hospital
Attending, Department of Medicine, Danbury Hospital
Executive Director, Internal Medicine Subspecialties, DOPS
Chairman, Danbury Office of Physician Services (DOPS) Practice Oversight Committee

Education
1986 B.Sc. Eng. (Mechanical Engineering), McGill University, Montreal
1990 M.D., C.M., McGill University, Montreal

Postgraduate Training

Internship and Residency:

1990-91 Straight Internship, Internal Medicine, S.M.B.D.-Jewish General Hospital McGill University, Montreal, Canada
1991-93 Resident in Medicine, S.M.B.D.-Jewish General Hospital McGill University, Montreal, Canada
1993-94 Chief Medical Resident, S.M.B.D.-Jewish General Hospital McGill University, Montreal, Canada

Fellowship:

1994-98 Fellow in Pulmonary and Critical Care, Massachusetts General Hospital Harvard University, Boston

Hospital Appointments

1995-98 Vencor Hospital Boston
1998-present Danbury Hospital

Academic Appointments

1998-present Clinical Instructor in Medicine, Yale University
2006-present Clinical Assistant Professor of Medicine, New York Medical College

Medical Licensure

1990 FLEX
1991 Licentiate of the Medical Council of Canada (LMCC)
1995-98 Massachusetts Medical License # 81413
1998 Connecticut Medical License # 036628

Board Certification

1993	Internal Medicine, American Board of Internal Medicine
1994	Internal Medicine, Royal College of Physicians and Surgeons of Canada Internal Medicine, College des Medecins du Quebec
1996	Pulmonary Disease, American Board of Internal Medicine
1997	Critical Care Medicine, American Board of Internal Medicine
2001	Diplomate, American Board of Sleep Medicine
2002	Respirology, Royal College of Physicians and Surgeons of Canada
2003	Recertification, Internal Medicine, American Board of Internal Medicine
2006	Recertification, Pulmonary Disease, American Board of Internal Medicine
2007	Recertification, Critical Care Medicine, American Board of Internal Medicine

Affiliations

1994-present	Royal College of Physicians and Surgeons of Canada
1995-present	American Thoracic Society
1995-present	American College of Chest Physicians
1998-present	Connecticut Thoracic Society

Honors

1982	Dean's Honor List, Vanier College
1985	Summer Research Bursary Department of Mining and Metallurgical Engineering McGill University
1990	Stewart Prize Finalist (1/5 medical students) Awarded to the medical student with the "highest qualifications to practice medicine", McGill University University Scholar Faculty of Medicine, McGill University
1993	Ezra Lozinski Prize in Clinical Medicine Department of Medicine, McGill University
1993	Sheldon Zemelman Memorial Award S.M.B.D. - Jewish General Hospital
1995-97	Will Rogers Memorial Fellowship
1997	Canadian Lung Association / Medical Research Council Fellowship Grant
1999	Attending of the Year (teaching award), Danbury Hospital
2002	Teaching Award (for "outstanding contributions"), Third Year Medicine Clerkship, New York Medical College
2003	Teaching Award (for "outstanding contributions"), Third Year Medicine Clerkship, New York Medical College
2004	Attending of the Year (teaching award), Danbury Hospital

Committees:

2000	Chairman, DVT Task Force, Danbury Hospital
2000-2004	Danbury Office of Physicians Services (DOPS) Ethics & Compliance Committee.
	Chairman, DOPS Contracting and Credentialing Committee
2001-2006	Physician Champion, COPD Exacerbation Treatment Pathway, Danbury Hospital
2001-present	Medicine Residency Training Committee, Danbury Hospital
2004-present	Pharmacy & Therapeutics Committee, Danbury Hospital
2006-present	Chiefs Meeting, Department of Medicine, Danbury Hospital
2006-present	DOPS Board of Directors
2006-present	Chairman, DOPS Medical Sub-Specialties Business Meeting
2006-2007	DOPS Finance Committee
2006-2007	Medical Education Committee, Danbury Hospital
2006-2007	Medical Executive Committee, Danbury Hospital
2006-2007	Performance Improvement Committee, Danbury Hospital
2006-present	DOPS / Danbury Health System Executive Committee, Danbury Hospital
2007-2008	Danbury Hospital CEO Medical Advisory Committee, Danbury Hospital
2007-2008	DOPS Physician Compensation Steering Committee
2008-present	Chairman, Practice Oversight Committee, Danbury Hospital

Past Positions

1998-2004	Medical Director, Pulmonary Function Laboratory, Danbury Hospital
2004-2008	Medical Director, Sleep Disorders Center, Danbury Hospital
2004-2008	Medical Director, Pulmonary Rehabilitation Program, Danbury Hospital

A Higher Level of Care

CURRICULUM VITAE

Cary Steven Passik, M.D.

Chief, Section of Cardiothoracic Surgery

EDUCATION

B.S., 1978	Center for Biomedical Education City College of New York (C.C.N.Y.), NY, NY
M.D. 1980	New York University School of Medicine, NY,NY

POSTGRADUATE TRAINING

1980-1981	Internship (Surgery/Medicine)
1981-1984	Assistant Resident (Surgery)
1984-1985	Chief Resident in Surgery all at Albert Einstein College of Medicine Montefiore Medical Center, Bronx N.Y.
1985-1988	Resident, Chief Resident in Cardiothoracic Surgery, Mayo Clinic and Foundation, Rochester, MN

EMPLOYMENT

1988-2003	Cardiothoracic Surgeons of New Haven, P.C.
2004-2007	Cardiothoracic Surgical Associates, P.C. New Haven, CT (www.ctsa-ct.com)
2007-present	Praxair Regional Heart and Vascular Center, Danbury Hospital, 24 Hospital Ave, Danbury , CT

SPECIAL INTERESTS

Adult Cardiothoracic Surgery including extended arterial revascularization, SVR procedure (surgical ventricular restoration for CHF) Maze procedure, valve repair/replacement, reoperative surgery, pacemaker and AICD placement. Medical Inventing.

HOSPITAL APPOINTMENTS

Yale New Haven Hospital, Attending Surgeon, Associate Section Chief of Cardiac surgery (2000-2007)
Hospital of Saint Raphael, Attending Surgeon Chief, Division of Cardiothoracic Surgery, Danbury Hospital(2007-present)

ACADEMIC APPOINTMENT

	Clinical Instructor in Surgery, Yale University School of Medicine(2005-2007)

PROFESSIONAL LICENSURE

029281	Connecticut	Expires: 08-31-09
16427	Connecticut DEA	Expires: 02-28-09
AP1307025	Federal DEA	Expires: 03-31-09

BOARD CERTIFICATION

1986	Diplomate, American Board of Surgery
1989	American Board of Thoracic Surgery
1999-2009	Recertification-Thoracic Surgery

ACADEMIC HONORS

1978	Summa Cum Laude, City College of NY. New York State Regents Scholarship. Rudin Foundation Scholarship, New York University School of Medicine.
1984-85	Leo M. Davidoff Society, AlbertEinstein College of Medicine-Certificate of Distinction for Outstanding Achievement as a House Officer in the Teaching of Medical Students
2005	Elected for membership in America's "Best Doctors" by bestdoctors.com

MEMBERSHIPS

American College of Surgeons Society for Thoracic Surgery
Priestley Surgical Society of the Mayo Clinic
Connecticut State Medical Society
New Haven County Medical Association
American Medical Association

CURRICULUM VITAE
Pierre Frank Saldinger, MD
Chair, Department of Surgery

Education:

1981	Matura	Gymnasium am Kohlenberg, Basel, Switzerland
1987	MD	University of Bern, School of Medicine, Switzerland

Postgraduate Training:

1988	Assistant in Surgery, Kantonsspital Liestal, University of Basel, School of Medicine, Switzerland
1989	Assistant in Surgery, Inselspital Bern, University of Bern, School of Medicine, Switzerland
1990-1992	Resident in Surgery, Beth Israel Hospital, Boston
1992-1993	Chief Resident in Surgery, Hôpital de Zone, Payerne, Switzerland
1993-1994	Chief Resident in Surgery, Beth Israel Hospital, Boston
1994-1995	Surgical Coordinator, Beth Israel Hospital, Boston
1995-1997	Research Fellow, Division of Gastroenterology, University Hospital, Lausanne, Switzerland
1997-1998	Fellow in Hepatobiliary Surgery, Memorial Sloan-Kettering Cancer Center, NY

Academic Appointments:

1990-1994	Clinical Fellow in Surgery, Harvard Medical School
1994-1995	Instructor in Surgery, Harvard Medical School
1998-2000	Instructor in Surgery, Harvard Medical School
2000-2003	Assistant Professor of Surgery, Harvard Medical School
2001-2003	Assistant Professor of Surgery, New York Medical College
2003-2008	Associate Professor of Clinical Surgery, New York Medical College
2008-present	Professor of Clinical Surgery, New York Medical College
2008-present	Senior Associate Dean, New York Medical College

Hospital Appointments:

1994-1995	Associate in Surgery, Beth Israel Hospital, Boston
1994-1995	Trauma Surgeon, Beth Israel Hospital, Boston
1995–1997	Attending Surgeon, Hopital de Zone, Payerne, Switzerland
1998-2001	Active Staff Member, Department of Surgery, Beth Israel Deaconess Medical Center
1998-2002	Attending Surgeon, Trauma Service, Beth Israel Deaconess Medical Center
2001-2004	Chief, Section of General Surgery, Danbury Hospital, Danbury
2001-2009	Carmen L. and Peter Buck Chair in Surgical Oncology
2004-present	Chairman, Department of Surgery, Danbury Hospital
2009-present	Carmen L. and Peter Buck Chair of Surgery

2009-present Consultant Attending, Memorial Sloan-Kettering Cancer Center, NY, NY

Licensure and Certification:

1990 ECFMG
1991 Massachusetts Licensure Registration
1994-2000 Instructor in Advanced Trauma Life Support
1994 Swiss Board of Surgery
1996 American Board of Surgery
2000 Connecticut Licensure Registration
2001 ATLS

Awards and Honors:

1996 Annual award Swiss Society for Research in Surgery for research on the immunological response induced by mucosal vaccination against Helicobacter pylori.
2005 Annual Award, People against domestic violence, Putnam County, NY
2006 Honorary member, sixth beach battalion, Unites States Navy

Professional Societies:

1987 Swiss Medical Association, Member
1996 Swiss Society of Surgery, Member
1997-2000 Swiss Society for Research in Surgery, Member
1998 American College of Surgeons, Fellow, Member Committee on Applicants, CT District #1
1998-2001 Society for Mucosal Immunology, Member
1998-2001 American Society for Microbiology, Member
1998 Memorial Hospital Alumni Society, Member
1999 American Gastroenterological Society, Member
1999 American College of Surgeons Oncology Group, Member
1999 American Hepato-Pancreato-Biliary Association, Member
1999 Society for Surgery of the Alimentary Tract, Member
2001 International Society for Digestive Surgery, Member
2001 American Association for the Study of Liver Diseases, Member
2001 Society of Surgical Oncology, Fellow
2001 American Society of Clinical Oncology, Member
2006 Member, Surgical Outcomes Club
2007 Member, New York Surgical Society
2008 The Society of Surgical Chairs
2009 Association for Surgical Education
2009 Association of Program Directors in Surgery, Associate Member

Other Professional Positions:

1998-2001 Harvard Digestive Disease Center
(NIH-funded, multi-hospital research center),
Associate Member

Hospital and Health Care Organizational Clinical Responsibilities:

1998-2001 Surgical Director, Liver and Gastrointestinal Cancer Program, Beth Israel Deaconess Cancer Center, Boston
2001-2007 Co-Director Gastrointestinal Tumor Board, Praxair Cancer Center, Danbury Hospital
2002-2004 Co-Chair, Colorectal Cancer Program, Praxair Cancer Center, Danbury Hospital
2002-2006 Chair, QA/Peer Review Committee, Praxair Cancer Center, Danbury Hospital
2005-present Surgeon Champion, NSQIP, Danbury Hospital

Major Administrative Responsibilities:

1993-1995 Administrative Coordinator, Surgical Residency Program, Beth Israel Hospital, Boston
1996 Interim Surgeon-in-Chief , Hopital de Zone, Payerne, Switzerland
1999-2001 Surgical Director, Liver and Gastrointestinal Cancer Program, Beth Israel Deaconess Cancer Center, Boston
1998-2001 Webmaster, Department of Surgery Website, Beth Israel Deaconess Medical Center
1998-2001 Organization of Surgical Grand Rounds, Beth Israel Deaconess Medical Center
2000 – 2001 Chair, Volume tactical group, subcommittee General Surgery, GI, Obesity, Beth Israel Deaconess Medical Center
2001- 2004 Chief, Section of General Surgery, Danbury Hospital, Danbury
2001-present Associate Program Director, Surgical Residency, Danbury Hospital, Sound Shore Medical Center, New York Medical College
2002-present Program Site Director, Student Clerkship Department of Surgery, New York Medical College
2003-present Member, Board of Directors, Development Fund, Danbury Hospital
2004-present Chairman, Department of Surgery, Danbury Hospital

Major Committee Assignments:

1993-1995 Surgical House Staff Committee, Beth Israel Hospital, Boston
1993-1995 Trauma Care Committee, Beth Israel Hospital, Boston
1998-2001 Trauma Care Committee, Beth Israel Deaconess Medical Center, Boston
1999-2001 Program Directors Committee, Beth Israel Deaconess Cancer Center, Boston
2001- Cancer Committee, Danbury Hospital
2001- Surgery Committee, Danbury Hospital
2001-2002 Credentialing and Contracting Committee, Danbury Office of Physician Services
2001-2004 Steering Committee, Breast Care Program, Praxair Cancer Center, Danbury Hospital
2003-2007 Vice-Chair, Medical Education Committee, Danbury Hospital
2002- Medical Affairs Committee of the Board, Danbury Hospital
2003- Executive Committee of the Medical Staff, Danbury Hospital
2004- Technology Committee of the Board, Danbury Hospital
2007- Chair, Medical Education Committee, Danbury Hospital

Medical School Courses New York Medical College at Danbury Hospital, Danbury, CT

2002-2008	Program Site Director, Student Clerkship Department of Surgery, Danbury Hospital, NYMC
2002-	3rd Year Clerkship, Department of Surgery, NYMC Preceptor for physical diagnosis, history taking, and oral presentations 10 students per year Surgical Residency, Danbury Hospital (Integrated program with Sound Shore Medical Center, NYMC)
2001-	Associate Director Surgical Residency Sound Shore Medical Center/ Danbury Hospital
2001-	Attending Surgeon, General Surgery, Danbury Hospital Six-10 residents, 12 months per year Walk rounds, operating room teaching, supervision in the emergency room and morbidity and mortality conference

A Higher Level of Care

CURRICULUM VITAE

Robert R. Savino, D.O.

Chief, Department of Endocrinology and Metabolism

EDUCATION

1984-1988	New York College of Osteopathic Medicine Old Westbury, NY; D.O.
1980-1984	New York University; New York, NY BA in Psychobiology; Minor in Spanish

POST-GRADUATE TRAINING

1993-1994	Fellow, Division of Endocrinology Joslin Diabetes Center New England Deaconess Hospital Boston, MA
1992-1994	Clinical Fellow, Harvard Medical School Boston, MA
1992-1993	Fellow, Division of Endocrinology LAhey Clinic Medical Center Burlington, MA
1989-1992	Resident , Primary Care Internal Medicine Long Island Jewish Medical Center Albert Einstein College of Medicine Ne Hyde Park, NY
1988-1989	Rotating Internship Coney Island Hospital Brooklyn, NY

LICENSES

1995	Connecticut – active
1992	Massachusetts – retired
1989	New York – active

CERTIFICATION

2006	License in Nuclear Medicine to Administer I131 for Thyroid Disorders
2003	American Association of Clinical Endocrinology Certification in Nuclear Medicine

2002	Recertified Diplomate American Board of Internal Medicine Subspecialty in Endocrinology, Diabetes and Metabolism (expires 2015)
2002	Recertified Diplomate American Board of Internal Medicine Specialty in Internal Medicine (expires 2012)
2001	American Association of Clinical Endocrinology Certification in Thyroid Ultrasonography
1995	Diplomate American Board of Internal Medicine Specialty in Internal Medicine
1992	Diplomate American Board of Internal Medicine Specialty in Internal Medicine
1989	Diplomate American Board of Osteopathic Medical Examiners

ACADEMIC APPOINTMENTS

2008-present	Clinical Instructor Yale University School of Medicine New Haven, CT
2007-2008	Assistant Clinical Professor of Medicine Yale University School of Medicine New Haven, CT
2001-present	Adjunct Assistant Professor of Medicine New York Medical College Valhalla, New York
1998-2007	Clincal Instructor in Medicine Yale University School of Medicine New Haven, CT
1995	Instructor in Medicine Harvard Medical School Boston, MA

HOSPITAL APPOINTMENTS

1997-present	Chief, Department of Endocrinology and Metabolism Danbury Hospital Danbury, CT
1996-present	Medical Director, Diabetes Management Program

Danbury Health Systems
Danbury, CT

1996-present Attending Physician
Danbury Hospital, Danbury, CT

1994-1995 Associate Clinical Staff Member
Joslin Diabetes Center
Boston, MA

1994-1995 Clinical Staff Member
New England Deaconess Hospital
Boston, MA

1994-1995 Clinical Staff Member
Lahey Clinic
Burlington, MA

1994-1995 Assistant Medical Director
Joslin-Lahey Diabetes and Endocrine Center
Peabody, MA

HONORS AND AWARDS

2008 First Place Connecticut ACP
Poster Presentation
Hyperglycemia management in a Hospital Inpatient Population

2008 First Place Danbury Hospital 23rd Annual Joseph Belsky, MD
Research Day
Hyperglycemia management in a Hospital Inpatient Population

2003 Third Place Danbury Hospital 18th Annual Joseph Belsky, MD
Research Day
Case presentation: Man with thyrotoxicosis and Diffuse
Lymphadenopathy

2002 US NEWS AND WORLD REPORT ranked Danbury Hospital
Among Top fifty Hospitals in U.S. for treatment of Hormonal
Disorders

2002,2001 Outstanding Contributor to Third-Year Medicine Clerkships
New York Medical College

2001 Nominated for Magida Award

1999-2000 Outstanding Participation in Housestaff Education
Danbury Hospital
Danbury, CT

1996,1997 Teaching Attending of the Year
Danbury Hospital
Danbury, CT

1992	Resident of the Year Long Island Jewish Medical Center New Hyde Park, NY
1990	Mayor's Recognition Award Avianca Airline Crash Rescue Glen Cove, NY
1985	Honors in Pathology New York College of Osteopathic Medicine Old Westbury, NY
1983,1984	Dean's List New York University New York, NY

PROFESSIONAL SOCIETIES

2003-2004	President, Connecticut State Endocrine Society
1997-present	Member, Connecticut State Endocrine Society
1997-present	Fellow, American College of Physicians
1997-present	Fellow, American Association of Clinical Endocrinologists
1996-present	Member, The Endocrine Society
1993-present	American Diabetes Association
1993-1997	Member, American College of Physicians
1992-present	Member, American Association of Clinical Endocrinologists

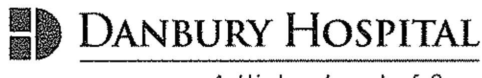
PRINCIPLE CLINICAL RESPONSIBILITIES

2008	Developed Template for entering computerized insulin orders for Hospitalized patients at Danbury Hospital
2008	Drafted Protocol for thyroid function testing in hospitalized Patients at Danbury Hospital
2008-present	Education Committee, Danbury Hospital
2007-present	As Medical Director of the Diabetes Management Program for Danbury Health Systems: established an American Diabetes Association-certified Diabetes Self-Management and Education Program; the program has been recertified by the American Diabetes Association. Monthly meetings with the Diabetes Education committee To measure attainment of patient defined goals, patient outcomes, Effectiveness of the education process and opportunities for Improvement.

Regular meetings with Danbury Hospital administrators. We are working to expand diabetes education to the patients in our Catchment area and better integrate the education process from the Inpatient to the outpatient setting.

2004-2007 Human Resources Committee, Danbury Hospital

1994-1995 Committee to Revise Joslin Diabetes Center Education Materials, Physician Reviewer



CURRICULUM VITAE
Gary S. Schleiter, MD
Chief, Infectious Disease Department

Work History

5/2000-present	DOPS – Chief, Infectious Disease Department Danbury Health Systems
8/1985-present	Infectious Diseases Consultant Chairman, Infection Control Hospital Epidemiologist Danbury Hospital 24 Hospital Avenue Danbury, CT
	Consulting Physician Infectious Diseases New Milford Hospital New Milford, CT
	Assistant Clinical Professor of Medicine Yale University New Haven, CT
1/1996-8/1999	Board of Directors CT AIDS Residence Coalition
1996-1999	Council, Connecticut Infectious Disease Society

Fellowship

7/1983-6/1985	University of Massachusetts Medical Center Instructor, University of Massachusetts Medical School Infectious Diseases

Residency

7/1981-6/1983	University of Connecticut Health Center Internal Medicine Instructor, University of Connecticut School of Medicine

Internship

7/1980-6/1981	University of Connecticut Health Center Internal Medicine Instructor, University of Connecticut School of Medicine

Medical School	1980 Bowman Gray School of Medicine Wake Forest University Maryland
Other Education	1974 BS, Duke University Magna Cum Laude
Hospital Affiliation	Danbury Hospital, Danbury CT
Boards	11/1986 American Board of Infectious Diseases 9/1983 American Board of Internal Medicine
Licensure	CT – 024247 CT CSR- 13301 DEA- AS3285738 UPIN-D80848

Awards and Honors

King's Fund Scholarship, 1979
Awarded by the Duke Foundation to a selected number of medical students from North Carolina Schools, to study the British Health Service in a course given at King's Fund College, London

Professional Membership

Member, American Society for Microbiology
Connecticut Infectious Disease Society
Danbury Medical Society
Connecticut AIDS Residential Committee
American Society of Tropical Medicine & Hygiene
Member, Infectious Disease Society of America

CURRICULUM VITAE
Martin J. Serrins, M.D.
Chairman, Department of Anesthesiology

Education
Residency in Anesthesiology (1981 – 1983)
Yale-New Haven Medical Center
New Haven, Connecticut

Surgical House Physician (1980 – 1981)
Barberton Hospital
Barberton, Ohio

Residency General Surgery (1978 – 1980)
Cleveland Clinic Foundation
Cleveland, Ohio

Doctor of Medicine (1978)
Howard University College of Medicine
Washington, DC

B.A. Biology Cum Laude
Case Western Reserve University (1974)
Cleveland, Ohio

Certifications
Maintenance of Certification in Anesthesiology 2005
Diplomate, American Board of Anesthesiology
Diplomate, National Board of Medical Examiners

Licensure
State of Connecticut, No. 24243
State of New York
State of Ohio

Organizations
American Society of Anesthesiologists
Connecticut State Society of Anesthesiologists
International Anesthesia Research Society
American Academy of Medical Acupuncture
Society of Cardiovascular Anesthesiologists
Society for Obstetric Anesthesia and Perinatology

Society of Ambulatory Anesthesia
Society of Perioperative Assessment and Quality Improvement
American Academy of Medical Acupuncture

Appointments

10/05 – Present	Chairman, Department of Anesthesiology Danbury Hospital Danbury, Connecticut
7/05 – Present	Assistant Clinical Professor New York Medical College Valhalla, New York
6/85 – Present	Danbury Office of Physician Services Danbury, Connecticut Department of Anesthesiology
1992 – Present	Danbury Hospital Department of Anesthesiology Medical Director, Main Operating Room
8/85 – 8/89	Assistant Clinical Professor Department of Anesthesiology Yale – New Haven Medical Center
5/83 – 8/85	Assistant Professor and Attending Physician Department of Anesthesiology Yale-New Haven Medical Center Specializing in Cardiovascular and Pediatric Anesthesia Director of Residency Training Program Department of Anesthesiology Yale, College of Medicine
9/80 – 4/81	Surgical House Physician Barberton Citizen's Hospital Barberton, Ohio Value Analysis Committee

A Higher Level of Care

CURRICULUM VITAE
Shohreh Shahabi, M.D.

Chair, Department of Obstetrics & Gynecology

Education

M.D.	Universite Libre De Bruxelles, Belgium 06/1992
M.S.	Universite Libre De Bruxelles, Belgium, 07/1988

Career/Academic Appointments

7/2010	Associate Clinical Professor Yale School of Medicine – Department of OB/GYN, New Haven, CT, USA
7/2006 – Present	Assistant Professer Albert Einstein College of Medicine – Montefiore Medical Center. Bronx, NY, USA
07/2003 – 06/2006	Instructor , Obstetrics & Gynecology and Women's Health, Albert Einstein College of Medicine- Montefiore Medical Center, Bronx, NY, USA.
07/2003 – 06/2006	Fellow, Gynecologic Oncology. Albert Einstein College of Medicine- Montefiore Medical Center, Bronx, NY, USA.
07/1999 – 06/2003	Resident, Obstetrics & Gynecology Yale New Haven Hospital, CT, USA.
02/1998 - 02/1999	Postdoctoral Research Fellowship - hCG Research Laboratory, Yale School of Medicine, New Haven, CT, USA. Department of Obstetrics and Gynecology.
02/1999 - 09/1999	Associate Research Scientist - hCG Research Laboratory Department of Obstetrics and Gynecology Yale School of Medicine, New Haven, CT, USA.
10/1992 - 09/1997	Resident, Obstetrics & Gynecology Faculte De Medecine et De Pharmacie, Universite Libre De Bruxelles, Belgium.
10/1995 - 10/1996	University of Paris V, René Descartes, Paris, France. University Diploma in Breast Diseases.
10/1994 - 09/1995	University of Paris V, René Descartes, Paris, France.

	University Diploma in Ultrasound applied in Obstetrics and Gynecology & Breast Diseases.
10/1992 - 09/1993	University of Paris V, René Descartes, Paris, France University Diploma in Maternal Fetal Medicine.

Academic Appointments

10/2009 - present	Chair, Department of Obstetrics & Gynecology, Danbury Hospital, Danbury, Connecticut.
07/2006 - 09/2009	Director Gynecologic Oncology, Moses Division, Montefiore Medical Center. Assistant Professor, Department of Obstetrics & Gynecology and Women's Health, Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY, USA.

Hospital Appointments

10/2009 - present	Chair of Reproductive Tumor Biology Research Program, Danbury Hospital, CT.
7/2006 - 9/2009	Director Gynecologic Oncology, Moses Division, Montefiore Medical Center. Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, NY.
7/2006 - 9/2009	Director Ovarian Tumor Immunobiology, Gynecologic Oncology Laboratory, Montefiore Medical Center. Albert Einstein College of Medicine, Bronx, NY.

Board Certification

Belgium Board Certification in Obstetrics and Gynecology, 1997
France Board Certification in Obstetrics and Gynecology, 1998
American Board of Obstetrics and Gynecology, 2007
American Board of Obstetrics and Gynecology, Gynecologic Oncology , board eligible.

B) National

2007 Awarded a three-year start up funding by Albert Einstein College of Medicine to establish Gynecologic Oncology Tumor-Immunology Laboratory at Montefiore Hospital.

2005 New York Obstetrical Society, Research Award for Outstanding Abstract.

2005 Awarded to be a part of Cancer Education Consortium, Clinical Pharmacology of Anticancer Agents workshop, Virginia, USA.

2004 Awarded to be a part of Cancer Education Consortium in translational research in oncology, Virginia.

2003 The John. Meehan – Clifford R. Miller Award for the graduating resident who most exemplifies the scholarly attributes of Obstetrics & Gynecology.

2003 Akzo-Nobel Resident Research Award for outstanding research on "ITA (Invasive Trophoblast Antigen). Trophoblastic diseases & False positive hCG".

2000 American Association for Clinical Chemistry, Outstanding Contribution to Clinical Chemistry (for publication of "Hyperglycosylated hCG (Invasive Trophoblast Antigen) Immunoassay: a New Basis for Gestational Down Syndrome Screening" and research with hCG).

Medical School Committees

2009 Member, The Hispanic Center of Excellence Class of 2009 Summer Undergraduate Mentorship Program's Student, Albert Einstein College of Medicine.

2008 Member, The Hispanic Center of Excellence Class of 2008 Summer Undergraduate Mentorship Program's Student, Albert Einstein College of Medicine.

Departmental Committees

2006 – 2009 Director Gynecologic Oncology Moses Division and site administrative team, Department of Obstetrics, Gynecology & Women's Health, Albert Einstein College of Medicine.

2006 – 2008 Member, Obstetrics & Gynecologic Teaching Advisory Committee, Resident School, Albert Einstein College of Medicine.

2006 - 2008 Member, Gynecologic Oncology Fellows Teaching Advisory Committee, Albert Einstein College of Medicine.

2006 - 2009 Member, Department Committee, Department of Obstetrics, Gynecology & Women's Health, Albert Einstein College of Medicine.

2009 Chair of the Department of Obstetrics and Gynecology Business Meeting, Danbury Hospital, CT.

2009 Medical Education Committee, Department of Obstetrics and Gynecology, Danbury Hospital, CT

2009 Chair, Resident Selection Committee, Department of Obstetrics and Gynecology, Danbury Hospital, CT

Hospital Boards & Committees

2009	Chair, Search Committee, MFM Section Chief, Danbury Hospital, CT.
2009	Medical Executive Committee, Danbury Hospital, CT.
2009	Performance Improvement Committee, Danbury Hospital, CT.
2009	Hospital Leadership Team Meeting, Danbury Hospital, CT.

CURRICULUM VITAE
S. Javed Shahid, M.D.
Chief of Neurosurgery

College	Government College Hyderabad, Pakistan 1966 with Honors
Medical Education	Dow Medical College University of Karachi, Pakistan 1972 with Honors Gold Medalist for finishing at the top of the graduating class
Internship	Kingsbrook Jewish Medical Center Brooklyn, New York November 1972- June 1973
Residencies	Junior Resident, General Surgery Downstate Medical Center Kings County Hospital Brooklyn, New York July 1973-June 1974
	Junior Resident, Neurological Surgery Downstate Medical Center Kings County Hospital Brooklyn, New York July 1974-June 1975
	Junior Resident, Neurological Surgery Long Island College Hospital Brooklyn, New York January 1976-June 1976
	Junior Resident, Neurological Surgery Downstate Medical Center Kings County Hospital Brooklyn, New York July 1976- December 1976
	Resident, Neurology Columbia Presbyterian Medical Center

New York, New York
January 1977- to June 1977
Chief Resident, Neurosurgery

Downstate Medical Center
Kings County Hospital
Brooklyn, New York
July 1977- January 1980

Board Certification Diplomate of American Board of Neurological Surgery 1983

Appointments

Danbury Hospital
Danbury, Connecticut
Attending and Chief of Neurosurgery
Member of Trauma Service Committee
Co-director of the Spine Center

Norwalk Hospital
Norwalk, Connecticut
Attending and Chief of Neurosurgery
Member of Executive Committee of Department of Surgery
Member of Trauma Service Committee

Medical Licenses

New York, 1978
Connecticut, 1980 (#21966)

A Higher Level of Care

CURRICULUM VITAE
David Shapiro, M. D.
Section Chief, General Internal Medicine

Bethel Medical Group, P. C.
General Internal Medicine
1976 to present

Resident, Internal Medicine, PGY III
Danbury Hospital
Danbury CT
1975-1976

US Navy, LtCdr
1973-1975
General Medical Officer

Resident, Internal Medicine, PGY I and II
Metropolitan Hospital Center
New York Medical College
New York, NY
1971-1973

New York Medical College
Valhalla, NY
MD 1971

Union College
Schenectady, NY
BS 1967

Currently:
Section Chief, General Internal Medicine
Danbury Hospital
Danbury, CT

Credentials Committee
Danbury Hospital
Danbury, CT

Previously:
Search Committee for Chief of Medicine

Danbury Hospital, Danbury CT

President
Danbury Area IPA
Danbury CT
(no longer in existence)

Board of Directors
Greater Danbury Health Plan
(PHO with Danbury Hospital and IPA, no longer in existence)

Board of Directors
Physicians Health Services

Committee on Insurability
Fairfield County Medical Association

President
Danbury Medical Society

Charter Revision Commission
Town of Bethel
Bethel, CT

A Higher Level of Care

CURRICULUM VITAE
Winston Y. Shih, MD, F.A.C.P.
Chief, Nephrology & Hypertension

Present Position

Chief, Nephrology & Hypertension
Danbury Office of Physician Services and
Danbury Hospital, Danbury, CT

Director, Nelson Gelfman Dialysis Unit
Danbury Hospital, Danbury, CT

Assistant Clinical Professor of Medicine
Yale University School of Medicine

Education

B.S.E. Chemical Engineering (Summa cum laude) 1979
Princeton University, Princeton, NJ

M.D. New York University School of Medicine, 1983
New York, NY

Career

1983 – 1984 Intern in Internal Medicine
Hospital of the University of Pennsylvania, Philadelphia, PA

1984 - 1986 Resident in Internal Medicine
Hospital of the University of Pennsylvania, Philadelphia, PA

1986 - 1987 Renal Fellow (Clinical)
Hospital of the University of Pennsylvania, Philadelphia, PA

1987 - 1988 Chief Medical Resident
Hospital of the University of Pennsylvania, Philadelphia, PA

1988 - 1989 Renal Fellow (Research)
Hospital of the University of Pennsylvania, Philadelphia, PA

1989 – present Danbury Office of Physician Services, PC

1989 - 1995 Associate Director, Renal Dialysis Program, Danbury Hospital, Danbury, CT

1991- 2006 Associate Program Director, Internal Medicine Residency Program, Danbury Hospital, Danbury, CT

1991 - 1993 Clinical Instruction of Medicine, Yale University School of Medicine, New Haven, CT

1993 - present Assistant Clinical Professor of Medicine, Yale University School of Medicine, New Haven, CT

1996 - present Director, Nelson Gelfman Dialysis Unit, Danbury Hospital, Danbury, CT

1998 – present Adjunct Assistant Professor of Medicine, New York Medical College, Valhalla, NY

5/06 – 12/07 Adjunct Clinical Assistant Professor of Medicine, New York College of Osteopathic Medicine of New York Institute of Technology, Old Westbury, NY

10/06 – present Chief, Nephrology & Hypertension, Danbury Hospital, Danbury, CT

04/07 – present Program Director, Internal Medicine Residency Training, Danbury Hospital, Danbury, CT

Licensure

Connecticut MD - 029813

Certifications

American Board of Internal Medicine, 1986, Internal Medicine
American Board of Internal Medicine, 1990, Nephrology; Recertified, 2000

Memberships

American College of Physicians (ACP)
American Society of Nephrology (ASN)
International Society of Nephrology (ISN)
National Kidney Foundation (NKF)
Association of Program Directors in Internal Medicine (APDIM)
Renal Physicians Association (RPA)

CURRICULUM VITAE
Lisa Smith, RN, MSN, DNP
Director, Nursing Education and Research

Professional Experience

2007 **Danbury Hospital, Danbury, CT**
April, 2007- Present Director, Nursing Education and Research

1986-2007 **Greenwich Hospital, Greenwich, CT**

2005-March 2007 Nurse Manager, Dept of Women's & Children's Services

1992–2005 Greenwich Hospital Home Care and Hospice

2002-2005 Clinical Manager

2001-2002 Senior Clinical Coordinator

1995-2001 Clinical Services Supervisor

1992-1995 Primary Care Nurse

1986-1992 Pediatric Clinical Level III Staff Nurse

1982-1986 **Stamford Hospital Psychiatric Unit** **Stamford, CT**
Clinical Level II Staff Nurse

Education

2006 Case Western Reserve University Cleveland, OH
DNP Doctor of Nursing Practice- Educational Tract
Included courses in Curriculum and Instruction, Educational Testing and Evaluation,
Research and Program Evaluation, and a Teaching Practicum
Thesis Research: The Effect of a Computerized Discharge Plan on Information Communicated From Hospital to Home Health Agency
2005 Case Western Reserve University Cleveland, OH
MSN Master of Science in Nursing

1996-1999 Iona College New Rochelle, NY
MS Master of Science in Health Care Administration
1978-1982 Fairfield University Fairfield, CT
BSN Bachelor of Science in Nursing
2006 Dale Carnegie Training Greenwich, CT

Awards, Licensure and Certification

Greenwich Hospital Quality Award, 2003
ANCC Home Care Nurse Certification 1996 - 2007
Sigma Theta Tau Nursing Honor Society 2000 - present
State of Connecticut Registered Nurse License 1982 – present

A Higher Level of Care

CURRICULUM VITAE
Mary T. Sullivan-Shields, RN, BSN
Mobile Admission Co-Coordinator

Experience

2003-Present Danbury Hospital, Danbury, CT
Mobile Admission Co-coordinator

1999-20003 Danbury Hospital, Danbury, CT
Critical Care Nurse / Neurosurgical Case Manager

1997-1999 Northern Westchester Hospital Center, Mount Kisco, NY
Care Manager of 14 bed telemetry unit

1995-1997 Northern Westchester Hospital Center, Mount Kisco, NY
Critical Care Float

1991-1995 Stanford University Hospital, Palo Alto, CA
ICU Primary Nurse / Clinical Preceptor for New RN's & Nursing Students

1989-1991 TravCorp. Inc., Malden, MA
ICU Primary Nurse

1988-1989 Danbury Hospital, Danbury, CT
ICU / CCU Primary Nurse / Clinical Preceptor

1986-1988 Albany County Health Department, Albany, NY
Public Health Nurse

1984-1986 St. Peter's Hospital, Albany, NY
ICU Primary Nurse / Clinical Preceptor

1983-1984 Westchester County Medical Center, Valhalla, NY
Primary Nurse – Swan Ganz Unit / Neurosurgical Unit

Education **Plattsburgh State University**, New York

Bachelor of Science in Nursing.

Fairfield University, Connecticut

Currently enrolled in MS Program

Licenses & Certifications

Registered Nurse (State of New York – 1982) (State of Connecticut – 1989)

Advanced Cardiac Life Support

Basic Life Support

IV Certified

Phlebotomy Certified

PRI Assessor

CURRICULUM VITAE
Patricia A. Tietjen, M.D.
Chair, Department of Medicine

Education:

Fordham University, New York
B.S. Biology, June 1980

State University of New York, Downstate Medical Center, Brooklyn, New York
M.D. June 1984

Postdoctoral Training:

Fellow - Critical Care Medicine
St. Vincent's Hospital and Medical Center
New York City, NY
July 1990 - June 1991

Fellow - Pulmonary Medicine
Memorial Sloan-Kettering Cancer Center
New York City, NY
July 1988 - June 1990

Chief Resident - Internal Medicine
St. Vincent's Hospital and Medical Center
New York City, NY
July 1987 - June 1988

Residency - Internal Medicine
St. Vincent's Hospital and Medical Center,
New York City, NY
July 1985 - June 1987

Internship - Transitional
St. Vincent's Hospital and Medical Center
New York City, NY
July 1984 - June 1985

Positions and Appointments:

Chair, Department of Medicine
Danbury Hospital
Danbury, CT
January 2008-present

Assistant Professor of Medicine
Yale School of Medicine
New Haven, CT
April 2009- present

Associate Professor of Clinical Medicine
New York Medical College
Valhalla, NY
June 2002-June 2009

Professor of Clinical Medicine
New York Medical College
Valhalla, NY
June 2009-present

Program Director, Pulmonary and Critical Care Fellowship
Saint Vincent's Hospital and Medical Center
New York City, NY
April 1996 – December 2007

Section Chief, Pulmonary Medicine
Saint Vincent's Hospital and Medical Center
New York City, NY
December 11, 2000- December 2007

Attending Physician
Department of Medicine, Pulmonary Service
Saint Vincent's Hospital and Medical Center
NYC, NY
April 1996 – December 2007

Assistant Director of the Adult Cystic Fibrosis Program
Saint Vincent's Hospital and Medical Center
April 1999- December 2007

Director of Multidisciplinary Lung Cancer Clinic
Saint Vincent's Hospital and Medical Center
New York City, NY
January 2004 – December 2006

Assistant Professor of Medicine
New York Medical College
Valhalla, NY
April 1996 – June, 2002

Acting Section Chief, Pulmonary Medicine

Saint Vincent's Hospital and Medical Center
New York City, NY
May 15, 2000 – December 11, 2000

Assistant Member
Memorial Sloan-Kettering Cancer Center
July 1995 - March 1996

Assistant Physician
Department of Medicine
Pulmonary Service
Memorial Hospital
July 1995 - March 1996

Assistant Professor of Medicine
Department of Medicine
Cornell University Medical College
July 1995 - March 1996

Director of Pulmonary Fellowship Program
Memorial Sloan-Kettering Cancer Center, NYC
July 1991 - March 1996

Co-Director Internal Medicine Residency Program
Memorial Sloan-Kettering Cancer Center
February 1994 - March 1996

Clinical Assistant Member
Memorial Sloan-Kettering Cancer Center
July 1991 - June 1995

Assistant Clinical Physician
Department of Medicine
Pulmonary Service
Memorial Hospital
July 1991 - June 1995

Instructor of Medicine
Department of Medicine
Cornell University Medical College
July 1991 - June 1995

Attending Physician - Emergency Department
St. Vincent's Hospital and Medical Center, NYC
July 1987 - June 1992

Licensed Physician:	#167332	1986	New York
	#046232	2008	Connecticut

Board Certification:

Internal Medicine	**Year:**	1987
Pulmonary Disease		1990
(Recertification)		2000
Critical Care Medicine		2005
BLS/ACLS Certification		2007

Scientific and Medical Societies:

American College of Chest Physicians, Fellow
American College of Physicians, Fellow
American Thoracic Society, Member
Society of Critical Care Medicine, Member
New York Thoracic Society, Member

A Higher Level of Care

CURRICULUM VITAE
Shawn Tittle MD FACS FCCP
Chief, Thoracic Surgery

Education

August 1989 – May 1993	David Lipscomb University, Nashville TN (cum laude)
August 1993 – June 1997	Wayne State University School of Medicine, Detroit MI

Post-Doctoral Training

July 1997 – June 1998	Saint Joseph Mercy Hospital, Ann Arbor MI – Preliminary Surgery
July 1998 – June 2000	Saint Mary's Hospital, Waterbury CT – Categorical Surgery
July 2000 – June 2001	Yale University School of Medicine, New Haven CT – Post-Doctoral Research Fellow in Cardiothoracic Surgery
July 2001 – June 2003	Saint Mary's Hospital, Waterbury CT – Categorical Surgery
July 2003 – June 2005	Yale University School of Medicine, New Haven CT – Cardiothoracic Surgery Residency

Academic and Hospital Appointments

July 2004 – June 2005	Instructor in Surgery, Yale University School of Medicine, New Haven CT
July 2005 – June 2007	Clinical Instructor in Surgery, Yale University School of Medicine, New Haven CT
July 2005 – June 2007	Attending Surgeon, Cardiothoracic Surgery, VA Hospital, West Haven CT
October 2005 – August 2007	Attending Surgeon, Thoracic Surgery, Saint Mary's Hospital, Waterbury CT
October 2005 – August 2007	Director of Thoracic Surgery, Saint Mary's Hospital, Waterbury, CT
October 2005 – August 2007	Assistant Program Director, General Surgery Residency Program, Saint Mary's Hospital, Waterbury CT
2007	Attending Surgeon, Cardiothoracic Surgery, Yale-New Haven Hospital, New Haven CT
2007	Attending Surgeon, Thoracic Surgery, The Waterbury Hospital, Waterbury CT
August 2007 – April 2009	Attending Surgeon, Lakeshore Cardiothoracic and Vascular Surgery, Lakeland Health System, St. Joseph MI
April 2009 – Present	Chief, Thoracic Surgery, Danbury Hospital, Danbury CT
April 2009 – Present	Director of Lung Cancer Program, Danbury Hospital, Danbury CT
April 2009 – Present	Assistant Professor of Clinical Surgery, New York Medical College, Valhalla NY
April 2009 – Present	Assistant Program Director, General Surgery Residency Program, Sound Shore Medical Center/Danbury Hospital, Danbury CT

Society Memberships

1999 – Present: American College of Surgeons

2004 – Present: Society of Thoracic Surgery

2004 – 2010: American College of Cardiology

2006 – Present: Wayne State University School of Medicine Alumni Association

2007 – 2009: The Michigan Society of Thoracic and Cardiovascular Surgery

2008 – Present: Fellow of the American College of Surgeons #03046857

2009 – Present: The Association for Surgical Education

2009 – Present: Fellow of the Society of Surgical Oncology #103705

2009 – Present: Association of Program Directors in Surgery

2009 – Present: American Society of Clinical Oncology #91077

2009 – Present: American College of Chest Physicians

2010 – Present: Fellow, American College of Chest Physicians #296718

Board Certification

2006: American Board of Thoracic Surgery #7253

Licensure

Connecticut #042777

Michigan #4301070580

DEA Number BT9451408

UPIN 142544

NPI 1396778601

A Higher Level of Care

CURRICULUM VITAE
David Trock, MD, FACP, FACR
Chief, Section of Rheumatology

Current Position Chief, Section of Rheumatology, Danbury Hospital, 1994-present

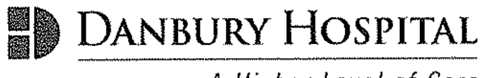
Faculty Appointment Clinical Assistant Professor of Medicine,
Yale University School of Medicine

Professional Certification and Licensure

1985 National Board of Medical Examiners #395118
1985 Licensed, State of Connecticut #027556
1986 ABIM certified in Internal Medicine #117098
1990 ABIM certified in Rheumatology #117098
2000 ABIM re-certified in Rheumatology

Education and Training

1977-1982 BS, Biomedical Science, Sophie Davis School for Biomedical Education, New York City
1982-1984 MD, New York Medical College
1984-1987 Internship and Residency, Danbury Hospital
1987-1989 Rheumatology Fellowship, Yale University School of Medicine, New Haven, CT



CURRICULUM VITAE
Lewis C. Trusheim, DMD, MS
Chief Oral/Maxillofacial Surgery

Present Positions

11/92 to Present	Private Practice of Oral/Maxillofacial Surgery, Associated Oral/Maxillofacial Surgeons, PC-partner and President 107 Newtown Road, Danbury, CT 901 Ethan Allen Hwy, Ridgefield, CT Partner: Drs. Roger Badwal, Anthony Camillo
11/83 to Present	Chief Oral/Maxillofacial Surgery Dept of Surgery,Danbury Hospital, Danbury, CT
11/97 to Present	Chief OMS, General Dental Practice Residency Faculty, Danbury Hospital (member of teaching faculty since 1979).
2001-Present	Huntington Dental Group-independent contractor
Education:	Attended public schools in Plainfield. Graduated from Plainfield High School in June 1967. 1967-1971 Attended and graduated fom MUHLENBERT COLLEGE,Allentown, PA. Major: Natural Sciences: May, 1971-BS degree. 1971-1972 Attended Graduate School,Rutgers University, New Brunswick,NJ, Department of Physiology. 1972-1975 Attended and graduated from Tufts University School of Dental Medicine,Boston.MA May,1975-DMD Degree. June, 1979 Certificate of Oral/Maxillofacial Surgery,University of Rochester-Strong Memorial and The Genesee Hospitals 1975-1979 Oral/Maxillofacial Surgery Resident,University Of Rochester,NY Chieft Resident: July, 78-June 1979.
Education:	July, 1981 Defense and acceptance of MS Thesis, University of Rochester. January,1982 MS (Physiology), University of Rochester, School of Medicine and Dentistry. March, 1982 Board Certification, American Board of Oral/Maxillofacial Surgery.

Past Positions:

9/85 to 1997 Chairman, Department of Dentistry, Danbury Hospital, Danbury, CT.
8/79-8/81 Research Associate,Department of Oral/ Maxillofacial Surgery, University of Connecticut Health Center, Farmington, CT.

8/79-4/83 Private Practice of Oral/Maxillofacial Surgery 16 Hospital Avenue, Danbury, CT.

7/79-1/83 Part-time associate of Drs.William Stephanak and Richard Lyon, Norwalk, CT.

7/81-6-95 Section-chief,OMS, General Practice Residency/ Department of Dentistry, Danbury Hospital.
4/38-10/92 Private Practice of OMS: Kelly,Ragona and Trusheim,PC 85 North Street,Danbury and 38-B Grove St. Ridgefield, CT.

5/98-5/2000 President,Connecticut Society of Oral/ Maxillofacial Surgeons

11/96-2000 Norwalk Dental Group:independent Contractor.

Hospital Affiliations:

1979 to Present Danbury Hospital,Danbury CT.- Attending Departments of Surgery and Dentistry.
1979 to 2006 Norwalk Hospital,Norwalk,CT. Courtesy Dept. of Surgery, Section of Dentistry.
1972-75 Student, New England Medical Ctr. Boston, MA.
1975-79 Resident,OMS, Strong Memorial Hospital And The Genesee Hospitals,University of Rochester,NY

CURRICULUM VITAE
Keith A. Zuccala, MD
Chief, Section of General Surgery

Education

1985-1989	BS – Bio/Chem. S.U.N.Y. at Albany, Albany, N.Y.
1991-1995	MD - S.U.N.Y. at Buffalo, Buffalo, N.Y.

Postdoctoral Training

1995-1996	Intern in Surgery, St. Elizabeth Health Center, Youngstown, OH
1996-1999	Resident in Surgery, St. Elizabeth Health Center, Youngstown, OH
1999-2000	Chief Resident Surgery, St. Elizabeth Health Center, Youngstown, OH
2000-2001	Fellowship, Endoscopic Surgery, Cleveland Clinic Foundation, OH

Licensure and Certification

1993	USMLE Step 1
1995	USMLE Step 2
1997	USMLE Step 3
2000	Ohio Licensure Registration 2000 Qualifying Exam for American Board of Surgery
2001	Connecticut Licensure Registration
2001	American Board of Surgery Certification

Academic Appointments

1999 – 2000	Clinical Instructor in Surgery, Northeastern Ohio University College of Medicine
1999 – 2001	Limited Clinical Practitioner, The Cleveland Clinic Foundation, Cleveland, OH
2001 – 2002	Instructor of Surgery, New York Medical College
2002-Present	Clinical Assistant Professor of Surgery, New York Medical College

Hospital Appointments

2000-2001	Limited Clinical Practitioner, The Cleveland Clinic Foundation, Cleveland
2001- Present	Director of Laparoscopic Surgery, Danbury Hospital, Danbury, CT
2005-Present	Chief, Section of General Surgery, Danbury Hospital, Danbury, CT
2008- Present	Harold & Myra Spratt Chair, MinimallyInvasive Surgery, Danbury,CT

Other Professional Positions

2000 – 2001	Endoscopic/Laparoscopic Lab Instructor, Ethicon Labs, Cincinnati,OH
11/2004	Bariatric Instructor, USSC Laparoscopic Fellows Course, Norwalk, CT

Major Administrative Responsibilities

1999-2000	Administrative Chief Resident, St. Elizabeth Health Center
2001- Present	Director Laparoscopic Surgery, Danbury Hospital, Danbury

Major Committee Assignments:

1995-1999	Emergency Department Committee, St. Elizabeth Health Center, Youngstown, OH
1999 – 2000	Trauma & Critical Care Committee, St. Elizabeth Health Center, Youngstown, OH
1999 – 2001	Graduate Medical Education Committee, St. Elizabeth Health Center, Youngstown, OH
1999 – 2000	Ethics Committee, St. Elizabeth Health Center, Youngstown, OH
2001 - Present	Pharmacology Committee, Danbury Hospital, Danbury, CT

Professional Societies:

- Mahoning County Medical Society
- American College of Surgeons, Initiate
- Society of Laparoscopic Surgeons, Candidate
- Society of American Gastrointestinal Endoscopic Surgeons
- Fairfield County Medical Society
- American Society of Bariatric Surgeons

A Higher Level of Care

CURRICULUM VITAE
Mary Zajc, RNC, MSN

Clinical Director, Women's and Children's Services

Education

University of Pennsylvania Philadelphia, PA
Master of Science in Nursing
Women's Health - OB/GYN Nurse Practictioner
Bachelor of Science in Nursing

Professional Experience

Director of Women's and Children's Services 2008 – Present
Danbury Hospital, Danbury, CT

Director of Women's and Children's Services 2006 – 2008
Northern Westchester Hospital, Mt. Kisco, NY

Director of Patient Care Standards and Practice 2002 – 2006
Northern Westchester Hospital, Mt. Kisco, NY

Maternal Child Health Clinical Nurse Specialist 1989 – 2006
Northern Westchester Hospital, Mt. Kisco, NY

Staff Development Instructor for Maternal Child Health 1987 – 1989
St. Vincent's Hospital, New York, NY

OB/GYN Nurse Practitioner 1985 – 1987
Pennsylvania Hospital, Philadelphia, PA

Assistant Head Nurse and Staff Nurse on Maternity 1980 – 1985
University of Pennsylvania, Philadelphia, PA

Certifications

Certified as an OB/GYN Nurse Practitioner through AWHONN
BLS Instructor through the American Heart Association
NRP Instructor through the American Academy of Pediatrics

Memberships

AWHONN

Exhibit 10

State of Connecticut

SENATE

STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

SENATOR MICHAEL A. McLACHLAN
TWENTY-FOURTH SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 3400
HARTFORD, CT 06106-1591
CAPITOL: (800) 842-1421
E-mail: Michael.McLachlan@cga.ct.gov
WEB SITE: www.SenatorMcLachlan.cga.ct.gov

MINORITY WHIP

RANKING MEMBER
GOVERNMENT ADMINISTRATION AND ELECTIONS COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
JUDICIARY COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
TRANSPORTATION COMMITTEE

To whom it may concern,

I have been apprised by New Milford Hospital and Danbury Hospital that they are exploring the possibility of a more formal affiliation. If realized, an affiliation such as this would be a benefit to residents, employers and our community at large and has my full endorsement.

The proposed health alliance would provide a network that would allow for:

- Quality care right here at home
- Cross privileges for physicians
- Uniformly high quality standards and patient satisfaction
- Improved access throughout a larger region and pool of resources-more places, more choices
- Improved operating performance
- Better access to capital
- Integration of services to best meet health care reform demands

I hope you'll give this endorsement your full consideration and the proposed affiliation the necessary approvals to move forward. Thank you.

Sincerely,

Michael A. McLachlan

State Senate – 24th District

TOWN OF NEW MILFORD

Town Hall
10 Main Street
New Milford, Connecticut 06776
Telephone (860) 355-6010 • Fax (860) 355-6002

Office of Patricia Murphy, Mayor

June 2, 2010

To whom it may concern,

Concerning the progress of planning between New Milford Hospital and Danbury Hospital who are working to develop a formal affiliation, I have kept current and am familiar with the discussions that have been taking place.

If realized, this affiliation will be a benefit to the residents, employers and the communities now served by both institutions. The proposed partnership has my strong support as a rationale means to regionalize health care and maximize the use of resources, medical talent and expertise.

The proposed health care system alliance would provide a network that will offer:

- Quality care right here at home with an organized healthcare network within the region, ensuring our residents have consistent access to uniformly high quality standards, leading to greater patient satisfaction
- Cross privileges for physicians, with the potential to bring more of the best practices in healthcare to Western Connecticut
- Improved operating performance with better access to cost efficiencies, capital and technology, allowing for growth and expansion of healthcare programs
- Integration of services to best meet the challenges of health care reform trends and legislation, thus providing a stronger role as advocates for the health and wellness of the community patients and needs

I sincerely support this affiliation and ask that your agency give this proposed partnership between New Milford and Danbury Hospitals, together with the Visiting Nurses Associations in both regions, the requisite approval so that the new organization can move quickly to implement essential plans and services. Thank you for your consideration of my comments.

Sincerely,

Patricia Murphy
Mayor

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE JASON W. BARTLETT
2nd ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4005
HARTFORD CT 06106-1591
HOME (203) 733-4266
CAPITOL (860) 240-8585
E-MAIL Jason.Bartlett@cga.ct.gov

VICE CHAIRMAN
APPROPRIATIONS COMMITTEE

MEMBER
EDUCATION COMMITTEE
PUBLIC HEALTH COMMITTEE

June 1, 2010

To Whom It May Concern:

I have been apprised by New Milford Hospital and Danbury Hospital that they are exploring the possibility of a more formal affiliation. If realized, an affiliation such as this would be a benefit to residents, employers and our community at large and has my full endorsement.

The proposed health alliance would provide a network that would allow for:

- Quality care right here at home
- Cross privileges for physicians
- Uniformly high quality standards and patient satisfaction
- Improved access throughout a larger region and pool of resources-more places, more choices
- Improved operating performance
- Better access to capital
- Integration of services to best meet health care reform demands

I hope you'll give this endorsement your full consideration and the proposed affiliation the necessary approvals to move forward. Thank you.

Sincerely,

Jason W. Bartlett

Representative Jason Bartlett

Bethel, Danbury & Redding

HOUSATONIC VALLEY
COUNCIL OF ELECTED OFFICIALS
OLD BROOKFIELD TOWN HALL
162 WHISCONIER ROAD, BROOKFIELD, CT 06804
203-775-6256 FAX 203-740-9167 HVCEO.ORG

May 21, 2010

Mr. Frank J. Kelly
Chief Executive Officer
Danbury Hospital, 24 Hospital Avenue
Danbury, CT 06810

Dear Mr. Kelly:

Thank you for your presentation yesterday to area mayors and first selectmen concerning the plan for affiliation of Danbury Hospital and New Milford Hospital.

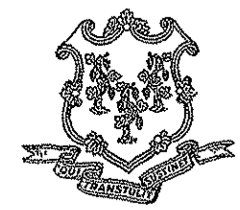
HVCEO members heartily agree that this enhanced health network will yield significant benefits to the regional community, especially in terms of cost containment, service enhancement and institutional growth opportunity.

HVCEO voted unanimously to issue this letter of support for the affiliation, for your inclusion in applications for state and federal approvals.

On behalf of the area public, they also wished to thank you and the other presenters for creative action to enhance health care.

Sincerely yours,

Jonathan Chew
Executive Director



State of Connecticut

GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

June 1, 2010

Deputy Commissioner Cristine Vogel
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134

Dear Commissioner Vogel,

It is our understanding that New Milford Hospital and Danbury Hospital are in the final stages of developing a formal affiliation after many months of discussions. If realized, this affiliation will be a benefit to the residents, employers and the communities now served by both institutions. The proposed partnership has our strong support as a rational means to regionalize health care and maximize the use of resources and medical talent and expertise.

The proposed health care system alliance would provide a network that will offer:

- Quality care convenient to residents
- Cross privileges for physicians
- Uniformly high quality standards and patient satisfaction
- Improved access to all levels of care throughout a large geographic region and a deeper pool of resources---more places, more choices
- Improved operating performance
- Better access to capital
- Integration of services to best meet the challenges of health care reform trends and legislation.

We hope your agency will give the requisite approval to this proposed partnership between New Milford and Danbury Hospitals, together with the Visiting Nurses Associations in both regions, so that the new organization can move quickly to implement essential plans to provide an even higher level of service to area residents.

Thank you for your consideration of our comments.

Sincerely yours,

Clark J. Chapin
State Representative, 67th District

Andrew W. Roraback
State Senator, 30th District

Northwestern Connecticut Council of Governments
17 SACKETT HILL ROAD WARREN CT 06754
Telephone (860) 868-7341 Fax (860) 868-1195

June 3, 2010

Mr. Frank Kelly, Chief Executive Officer
Danbury Hospital, 24 Hospital Avenue
Danbury, CT 06810

Mr. Richard Henley, Interim President and CEO
New Milford Hospital
21 Elm Street
New Milford, CT 06776

Dear Mr. Henley,

Thank you for your presentation on June 3, 2010 to the Northwestern Ct. Council of Governments Board regarding the plan for New Milford and Danbury Hospitals to create a partnership to strengthen health care service delivery in our region. Our members understand that this affiliation between the two hospitals will yield significant benefits to residents of the Northwestern Connecticut region, especially in terms of service enhancement and access to care.

At its June 3rd meeting, the NWCCOG Board voted unanimously to issue this letter of support for the proposed partnership so that it could be included in the materials now being submitted to the Connecticut Department of Health and other regulatory agencies.

We appreciate the efforts of both hospitals to insure that high quality healthcare is always available to the public we all serve.

Sincerely,

Dan McGuinness
Executive Director

cc: file

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May 26, 2010

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- Greater access to capital
- Integration of service to best meet health care reform demands

We hope you'll give this endorsement your full consideration and the proposed affiliation the necessary approvals to move forward for our community. Thank you.

Name	Organization	Phone	Signature
Dianne Yamin	Greater Danbury Chamber Commerce, Danbury Prospect	203 744 709[illegible]	[signature]
Donald Mitchell	Norbert E. Mitchell Co.	203 7440600	[signature]
RALPH MCINTOSH	DEL-TRON PRECISION	203-778-2727	[signature]

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Name	Organization	Phone	Signature
Michael Johnston	United Way of West CT	203-792-5330	[signature]
Marie Miszewski	Regional YMCA of WCT	203-740-3432	[signature]
Joseph C Ryan	Arigna Assoc.	860-355-5284	[signature]

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Name	Organization	Phone	Signature
ANN FARAGONA	Danbury VNA	7305230	[signature]
Linda L. Rankin	WCSU	203-837-8275	[signature]
Donna M. Culbert	Newtown Health District	203-270-4291	[signature]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
CRAIG FROEHLICH	Heating + Co	14 ABRAMS CIR	203-775-6644	FROBALLS@AOL	[illegible]
FRANK CANNETO	Danbury Auto	74 NEWTOWN RD	203 730 8400	[illegible]	[illegible]
BILL SABATINI SR	DANBURY Hyundai	110 FEDERAL Rd	203 [illegible]-2017	CAST. NET	

May 2010

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Name	Organization	Address	Phone	Signature
Laura Mitchell	Danbury Hospital	6 Kent Road Newtown, CT 06470	(203)426-2223	Laura K. Mitchell
Greg Steiner	Berkshire Corporate Park	2 Parklawn Drive Bethel, CT	203-743-7201	Gregory L. Steiner
Tony Rizzo Sr.	Rizzo Companies	6A Triangle Street Danbury, CT 06810	203-731-3131	[illegible]
Michael R. Kaufman	Jones, Damia, Kaufman, Borofsky & DePaul, LLC	93* Sugar Loaf Mtn Rd Ridgefield, CT 06877	203 770-9148	[illegible]
Paul L. Sirois	Paul L. Sirois, LLC	33 Main St. Newtown, CT 06470	(203) 253-7679	[illegible]
Jennifer Brakenwagen		38 Wood Creek Rd New Fairfield, CT 06812	203/312-8139	[illegible]
Dana L Zucchini	Danbury Hospital	155 Currituck Rd Newtown, CT	203-240-1170	Dana L Zucchini
Craig Lenahan	WeddingLines USA	79 [illegible] Ridgefield CT	2038293461	[illegible]
[illegible]	Colucci [illegible], PC	209 [illegible] Rd Redding CT 06896	203 [illegible]	[illegible]

June 2010

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Name	Organization	Address	Phone	E-Mail	Signature
Janet Robinson	Newtown Schools	3 Primrose	426-7621	robinsonj@newtown.k12.ct.us	[signature]
Patti Struna	Advantage Realty	39 Katrina Cir Bethel	798-9345	Patti@AdvantageRealtyCT.com	[signature]
Terri Rotella	Wm Pitt Sotheby's	213 Greenwood	748-7488	[illegible]@Aol.	[signature]
Diane Kozel	Fletcher Thompson	30 Sugar Rd Brookfield	2037462903	DKozel@FTAE.com	[signature]
H. Schuurmans	Fletcher Thompson	3 Corp Dr. Shelton	203 225-6800	HSCHUURMANS@FTAE.com	[signature]
Holly Robinson	Carmody & Torrance LLP	50 Leavenworth Street	203.573.1200	hrobinson@carmodylaw.com	[signature]

May 26, 2010

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Name	Organization	Phone	Signature
Anthony Rizzo Jr.	Rizzo Companies	203-731-3131	[signature]
Karin A. NeJame	Rietberg, Smart, Donohue & NeJame PC	203-2489259	[signature]

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Name	Organization	Phone	Signature
John R Patrick	ATTITUDE LLC	203-438-7447	[signature]
John A. Coveri	Coveri + Co. LLC	203-438-0654	[signature]
[illegible]	[illegible] USA	203.948.9408	[signature]
[illegible]	KEITH AUNS[illegible] LLC	203-994-1300	[signature]

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Name	Organization	Address	Phone	E-Mail	Signature
HERBERT JAFFE M.D	PHYSICIAN DKH	DANBURY	203-798-9990	[illegible]	[signature]
Diane Jaffe	" "	18 Sunset Dr.	"		[signature]
ED GOLDBERG	Ridgewood Ter	15 SUNSET DR.	748-[illegible]	[illegible] 7881	[signature]
DOROTHY GOLDBERG				@GMAIL.COM	[signature]
Joan Addesi	[illegible]	103 Logging Tr. Rd	743-7213		[signature]

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Name	Organization	Phone	Signature
Joyce C. Ligi	Ridgefield Bank	203 431-7520	[signature]
Paul P. Pinto	Paul Pinto Elec Cont	203 575 9473	[signature]
Bruce Dresner	Retired	203 304 1282	[signature]

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Name	Organization	Address	Phone	Signature
MARILYN POLITE		85 CEDAR LANE RIDGEFIELD	203-431-9755	Marilyn S. Polite
Cecelia Ruggles		23 Goodsell Hill Rd Redding CT 06896	203 938-3900	[illegible]
PATRICIA WEEDEN		85 MIDDLE RIVER DANBURY CT 06811	203 744 6898	Patricia Weeden
RICHARD JABARA	M. J. Hotels	7 KENOSIA AVE DANBURY CT	203 798-1099	[illegible]
HAROLD SPRATT		793 RIDGEBURY Rd RIDGEFIELD CT	730-0214	[illegible]
WILLIAM TOTTEN		6 High Fields Dr Danbury CT.	203-791-8057	W Totten
NOEL ROY	CCI	7 Finance Dr. Danbury, Ct.	203 792-0220	[illegible]
JOHN PEZZIMENTI	DH	24 Hospital Ave Danbury, Ct	203 739-7029	[illegible]
BOB REBY	REBY & CO	87 HOUSATONIC HTS	(203) 790-4949	[illegible]
Ronald Tietjen	Danbury Orthopedic Associates, PC	73 Sandpit Rd Danbury Ct	203 797 1500	[illegible]
Jerry Walter	BMW of the Hudson Valley	2068 South Rd Poughkeepsie NY	845 462 1030	[illegible]
Joe Plataro	Westco Scientific	117 old State Rd Brookfield, CT	203/740-2999	[illegible]
Mary Elizabeth Salame	Albert Salame Assoc.	P.O. Box 7406 Danbury, CT 06813	203-417-4897 // 203-744-2000	[illegible]

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Name	Organization	Address	Phone	Signature
VICTORIA DAVIS		141 HARMONY RD PAWLING NY 12564	845 878 6717	[signature]
Robert Davis	Critical Response Network	PO Box 248 Patterson, NY 12563	845-242 1541	[signature]
MAYOR Rob Liffland		10 Liffland LN Pawling	845 629 2122	[signature]
Former Mayor Glenn C. Carey		61 Kings Way Pawling	845-855-3039	[signature]
Supervisor David P Kelly		41 Overlook Dr Pawling	845-855 5460	[signature]
Former Town of Edward P. Hauser	Pawling Supervisor	118 Hurds Corner Rd Pawling, NY 12564	845-855 1569	[signature]
Headmaster Trinity-Archibald A. Smith III	Pawling School	700 Rt 22 Pawling NY 12564	845-855-3100	[signature]
John M Thomes	Dutchess Cty Legislator Dist 23	P.O. Box 628 Pawling 12564	845 855 1655	[signature]
BRIAN Smith	FAIRWAY Accounting Inc	517 RT 22 PAWLING NY 12564	845-350 1109	[signature]
John Daniels MD		14 Timberline Trail, Pawling	845-855-5891	[signature]

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Name	Organization	Phone	Signature
Susan V. Thomas	DRCAC	203 748-4542	Susan V. Thomas
Stephen Bull	Gr. Danbury CofC	203 743-5565	[signature]

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Name	Organization	Phone	Signature
ERVIE HAWLEY	HAWLEY CO	203-748-8709	E. Hawley
Michael Daglio	Danbury Hospital	203 739 7941	[illegible]
VINCENT NOLAN	TOWN OF NEW MILFORD	860-355-5001	[illegible]
Gary W. Hawley	Hawley company	203-748-8709	[illegible]
Dorothy Christman	New Milford Hospital	860-350-7216	[illegible]
Linda Wiseman	New Milford Hospital	860-350-7360	Linda Wiseman

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Name	Organization	Phone	Signature
Peter Cris	Pawling Chamber	845 855 7000	[signature]
Marshar Miller	DH Commun	203.560-5549	[signature]
[illegible]	D.H. Volunteer	203) 748-5800	[signature]
[illegible]	DHS	203-739-6032	[signature]
M. Gallagher-[illegible]	D.H Voluntee	203-775-3959	[signature]
Patricia Ford	D.H. Voluntee	203-775-2335	[signature]
[illegible]	"	203-797-9385	[signature]
[illegible]	DHS	203 798-0878	[signature]

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Name	Organization	Address	Phone	E-Mail	Signature
Lichtenberger	PX Pepsico Retired	Ridgefield	438-5738		[illegible]
GRENEet	PEPSICO-RETIRED	Ridgefield	431-8033		[illegible]
Merullo		Danbury	744-1223		John Merullo
Betsy Merullo	hospital volunteer	Danbury	744-1223	jbmerullo@yahoo	Betsy L. Merullo
Tim Merullo	Danbury Hosp.	Danbury	744-6499	[illegible]	[illegible]
Jason Rich	Danbury Hosp	Southbury	203-262-5891	jayrich37@yahoo	[illegible]
Haywood Jabberg	Danbury Hosp	Danbury	203 734-7000	[illegible]	[illegible]
Michael Emond	Danbury Hospital	Danbury	203 739 7101	M Emond	[illegible]

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Name	Organization	Address	Phone	E-Mail	Signature
Paul LaDoce		Danbury			[illegible]
HUGH BURRAL	Attorney	DANBURY-N/M	748-4888		[illegible]
STEVEN M. OLIVO	ATTORNEY	DANBURY			[illegible]
Paul T Hart	HIDC	Danbury	(203) 743-7380		[illegible]
James C Visdalle	HIDC	Bethel	203 744 5600		[illegible]
GARY LEHMAN	FAIRFIELD ASSOC.	DANBURY	748-5825		[illegible]
Roy Young	"	Bridgewater	744-2090		[illegible]
Jordan Young	"	Ridgefield	744-2090		[illegible]
SCOTT MACKAY	DELOITTE TAX LLP	STAMFORD	240-447-12[illegible]		[illegible]
SANDY KAUFMAN	SCOTT DOMINATING	DANBURY	203 744-1319		[illegible]
DAVID LAJOIE	Omar Beck	124 chambers	748-2651		[illegible]

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Paul McNamara	Fairfield County	Brook	43?-7582		[signature]
Bob McCarthy	Children Center	New Milford	860-354-1885	[illegible]	[signature]
Brian Magee		Redding	203 733 0019	bmagee20 optonline.net	[signature]
~~[illegible]~~					
Marc Pace			203-791-8733	[illegible]	[signature]
Hal Wibling		Danbury			[signature]

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Name	Organization	Address	Phone	E-Mail	Signature
Art Cummings	The News-Times	333 Main St.	203-512-0242	acummings@	[signature]
[illegible]	[illegible]	Danbury		newstimes.com	
Gary Scribner	Scribner Painting	15 Mill St	860 354 1544		[signature]
		New Milford		scrib2121 @	
x Geoff Klinger	Window M[illegible]	PO Box 426		att.net	
		Bridgewater CT	203 313-0670	CKlinger[illegible]@aol.com	
					[signature]

000297

June 2010

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Name	Organization	Address	Phone	E-Mail	Signature
Lowell Barek		79 [illegible] River Rd	[illegible]	[illegible]	[signature]
[illegible]	Colliers Intl	[illegible]	733 [illegible]	[illegible]	[signature]
W. R. [illegible]	N. E. Mitchell Co	7 [illegible]	744-0600		[signature]
[illegible]		19 [illegible]	733 4613		[signature]
Tom Henson		20 Arapaho Rd	775-1136		[signature]
Betty Hensel		20 Arapaho Rd Bk	775-1136		[signature]

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Philip C Bonanno	Pawling Mt Land Corp	306 Penny Rd Pawling NY	914-242-7624	[signature]
C. Ross Daniel		12 Berry Lane Pawling NY	845-855-1474	[signature]
Fayne Laird	Rotary	12 Berry Lane	845-855-1244	[signature]
Keir Donaldson		16 Bridle Way	845 855-5634	[signature]
John Ammatuna	Pawling Rotary	13 Woods End Rd Lagrange	845-855-3010	[signature]
Joseph Secortino	Superintendent of Pawling Schools	Rt 22 515 Pawling, NY	845 855 4602	[signature]
Richard W. Harshbarger	President Pawling Rotary	13 Banks Hill Rd Pawling, NY 12564	845-855-5024	[signature]
Steve Cash	Mizzentop Day School Pawling Rotary	8 Time Cr., Dover Plain NY	423-736-0601	[signature]

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- Improved access throughout a larger region and pool of resources-more places, more choices
- Improved operating performance
- Improved access to capital
- Integration of services to best meet health care reform demands

I hope you'll give this endorsement your full consideration and the proposed affiliation the necessary approvals to move forward. Thank you.

Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
MaryAnn Boone		1 Rock Ridge Court	203-312-9673		[signature]
Ed Boone		"	"		[signature]
Jim Kennedy	TASC	111 Grant Hook	791-8596		[signature]
Chris Burnell	Bronson	5232 Avalon Valley	240-9158		[signature]
Bob Tibbetts	Bronson	3 Yeoman's	270-8270		[signature]
Jim Piasecki	Bronson	12 Crossbow Wood	245-760-4410		[signature]

June 2010

To whom it may concern,

We have been apprised by New Milford Hospital and Danbury Hospital that they are exploring the possibility of a more formal affiliation. If realized, an affiliation such as this would be a benefit to residents, employers and our community at large and has our full endorsement.

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
E. Rezzick	Hollandia Nursery	103 Old Hawleyville Rd			[signature]
RB Doyle		Bethel.	CT.	CT.GROWN@AOL.	
[signature]		Newtown	CT	RDOYLEY@CHARTER.NET	[signature]
R. GECKLE		Newtown, Ct		ROBERT.GECKLE@GMAIL.COM.	
BERNARD FENNELLY		NEWTOWN, CT		BERNARDFENNELLY@YAHOO.COM	[signature]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
T. M. STRUWA		39 KATRINA	203-798 9345		[signature]
BOB CAMASTRO	NEIGHBORS-BBR	100 FEDERAL	203-778-6333		[signature]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
David Verner		17 [illegible] Lane, Danbury CT	203-748-3579	[illegible]@snet.net	[signature]
John Martocci		4 Pinnacle Dr Newtown	203-270-7196	jonmartoc@aol.com	[signature]
Terri-Ann Martocci		4 Pinnacle Dr Newtown	203-270 7196	termartoc@aol.com	[signature]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
Kathleen [illegible]		38 Tanglewood Dr.	203 794 0321	kma[illegible]@comcast.net	K [illegible]
Amy Dietz		10 Country Squire Ln.	203 426-		[illegible]
[illegible] Grau		Sandy Hook, CT	8796		
Justine Grau		75 Rita Dr., NF	203/746-1418		
Linda Connolly		3 Sullivan Farm, N.M.			Linda Conno[illegible]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
Regina Morgan		64 Wooster Hghts			Regina Morgan
Wilbert Morgan		64 Wooster Hgts			[signature]
Charles Miller		42 Benson Dr.			Charles Miller
Lou Cavafello		64 Old Ridgebury	~~203~~	2037431285	Lou Cavafello
Pat Curtice		64 Old Ridgebury Rd		2037431285	Pat Curtice

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
Ethel Omasta		7 Seneca Rd	203-792-9163		
Leora Richter		7 Field Rd			
Anne McCarthy	Danbury	175 Lake Pl S	203-790-4541		
Ellen Ciaszki	DA	17 Lakeview Dr	203 798-9164		
Chris Ciesrich		41 Tamarack Ave	203-798-8956		
Grace Johnson		14 Tara Dr Brkfld. CT	203-775-1925		[signature]
Tina Velandia		13 Alpine Rd. NF	203 241 8941		

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
James Knipe		17 Henry St	(203) 948-15[illegible]		
Paul Hewitt		4768 Rt 209 [illegible] NY	845 626 5557		
Jeff Knipe		164 Hoyt's Hill Rd	203 797 0588		
Harry Zelinski		2 [illegible] dr	203 748 5029		
Howie Busse		6 Mabel Ave		H Busse@[illegible].com	
Dean [illegible]		65 Hussars Camp	203 770 1643		
Michael Reller		6 Old Stilson Hill Rd	203 830 9250		

June 2010

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Sincerely,

Name	Organization	Address BETHEL	Phone	E-Mail	Signature
RICHARD STEINER		2 PARKLAWN DR	203 744-3784	richard.steiner[illegible].com	[signature]
Christine Steiner		116A Tower Rd Brookfield	203-775-0090		[signature]
MARTIN ONORATO		21 Meadowridge Ln			[signature]
Stephen W. Aronson		12 Pioneer Drive			[signature]
Greg [illegible]		27 Murphy DR			[signature]
Mary Elizabeth [illegible]		14 Claremont AVE, Danbury			[signature]
[illegible]		98 [illegible] RD Ridgefield			[signature]
Wayne Skelly		1 Bittersweet Drive	203 746-0631		[signature]
MARK PRINCIPI		12 SCHOOLHOUSE	2035129135		[signature]
John Couri		162 Ramapoo Rd Ridgefield Ct.	203-438-0664		[signature]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
John Borruso		7 Galilee Way Newtown	(203)2707332		[signature]

June 2010

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Sincerely,

Name	Organization	Address	Phone	E-Mail	Signature
Chris Smith		Washington CT	203 494-2638	ChrisWestSmith@gmail.com	

Exhibit 11

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0032

General Hospital

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

New Milford Hospital, Inc. of New Milford, CT, d/b/a New Milford Hospital is hereby licensed to maintain and operate a General Hospital.

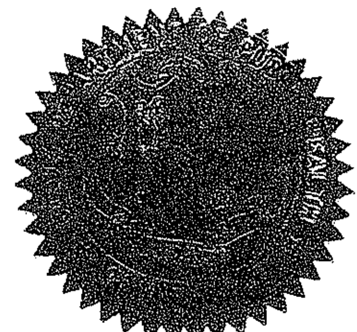
New Milford Hospital is located at 21 Elm Street, New Milford, CT 06776

The maximum number of beds shall not exceed at any time:
- 10 Bassinets
- 85 General Hospital beds

This license expires **June 30, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2009. RENEWAL.

Satellites
New Milford Hospital Community Mental Health Services, 23 Poplar Street, New Milford, CT



J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0039

General Hospital

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

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

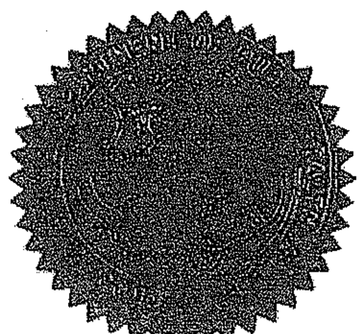
Danbury Hospital, The is located at 24 Hospital Avenue, Danbury, CT 06810

The maximum number of beds shall not exceed at any time:
345 General Hospital beds
26 Bassinets

This license expires **September 30, 2011** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2009. RENEWAL.

Satellites
Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
Community Center for Behavorial Health (ADH-PHP), 152 West Street, Danbury, CT
The Pediatric Health Center, 70 Main Street, Danbury, CT
Southbury Geriatric Center, 22 Old Waterbury Road, Southbury, CT
Seifert & Ford Community Health Center, 70 Main Street, Danbury, CT



J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA,
Commissioner

Exhibit 12

DANBURY HEALTH SYSTEM

6.A Financial Attachment I. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

(Dollars are in thousands) Total Facility: Description	FY 2009 Actual Results	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE													
Non-Government	$310,354	$338,681	-	$338,681	$357,910	$472	$358,382	$377,864	$585	$378,449	$398,929	$707	$399,636
Medicare	161,158	158,601	-	158,601	165,153	449	165,602	171,808	537	172,345	178,732	625	179,357
Medicaid and Other Medical Assistance	28,605	28,626	-	28,626	29,661	108	29,769	30,703	127	30,830	31,782	145	31,927
Other Government	-	-	-	-	-	0		-	0		-	0	
Total Net Patient Patient Revenue	$500,117	$525,908	-	$525,908	$552,723	$1,030	$553,753	$580,375	$1,249	$581,624	$609,444	$1,477	$610,921
Other Operating Revenue	$12,260	$9,656	-	$9,656	$9,753	$0	$9,753	$9,850	$0	$9,850	$9,949	$0	$9,949
Revenue from Operations	$512,377	$535,564	-	$535,564	$562,476	$1,030	$563,506	$590,225	$1,249	$591,474	$619,393	$1,477	$620,870
OPERATING EXPENSES													
Salaries and Fringe Benefits	$249,886	$269,917	-	$269,917	$278,015	$535	$278,550	$293,302	$649	$293,951	$309,431	$768	$310,199
Professional / Contracted Services	38,638	40,125	-	40,125	42,131	34	42,165	44,238	43	44,281	46,450	51	46,501
Supplies and Drugs	83,197	84,384	-	84,384	88,603	219	88,822	93,033	265	93,298	97,685	313	97,998
Bad Debts	17,035	18,212	-	18,212	22,109	41	22,150	23,215	50	23,265	24,378	59	24,437
Other Operating Expense	61,875	66,394	-	66,394	69,714	14	69,728	73,199	17	73,216	76,859	20	76,879
Subtotal	$450,631	$479,032	-	$479,032	$500,572	$843	$501,415	$526,988	$1,024	$528,012	$554,803	$1,211	$556,014
Depreciation/Amortization	25,228	27,369	-	27,369	27,601	0	27,601	27,781	0	27,781	27,970	0	27,970
Interest Expense	5,130	5,281	-	5,281	5,114	0	5,114	5,019	0	5,019	4,914	0	4,914
Lease Expense	5,023	5,250	-	5,250	5,408	0	5,408	5,570	0	5,570	5,737	0	5,737
Total Operating Expenses	$486,011	$516,932	-	$516,932	$538,693	$843	539,537	$565,357	$1,024	566,381	$593,424	$1,211	594,635
Income (Loss) from Operations	$26,366	$18,632	-	$18,632	$23,782	$187	23,969	$24,868	$225	25,093	$25,969	$266	26,235
Non-Operating Income	$11,776	$12,687		$12,687	$10,468	$0	$10,468	$12,647	$0	$12,647	$15,191	$3	$15,194
Income before provision for income taxes	$38,141	$31,319	-	$31,319	$34,250	$187	$34,437	$37,515	$225	$37,740	$41,160	$269	$41,429
Provision for income taxes													
Net Income	$38,141	$31,319	-	$31,319	$34,250	$187	$34,437	$37,515	$225	$37,740	$41,160	$269	$41,429
Retained earnings, beginning of year		$38,141		$38,141	$69,460	$0	$69,460	$103,710	$187	$103,897	$141,225	$412	$141,637
Retained earnings, end of year	$38,141	$69,460		$69,460	$103,710	$187	$103,897	$141,225	$412	$141,637	$182,385	$681	$183,066
FTEs	2,498.2	2,452.5	-	2,452.5	2,452.5	5.3	2,457.8	2,470.0	6.2	2,476.3	2,487.7	7.1	2,494.8
*Volume Statistics:													
Inpatient Days	93,430	92,767	-	92,767	91,705	484	92,189	92,887	567	93,454	94,084	647	94,731
Inpatient Discharges	20,499	20,577	-	20,577	20,842	120	20,962	21,111	140	21,251	21,383	160	21,543
Emergency Room Visits	69,582	70,070	-	70,070	70,560	-	70,560	71,053	-	71,053	71,551	-	71,551
Ambulatory Surgery Visits	11,668	11,869	-	11,869	12,047	-	12,047	12,228	-	12,228	12,411	-	12,411

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NEW MILFORD HOSPITAL, INC.

6.A Financial Attachment I. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

(Dollars are in thousands) **Total Facility:** Description	FY 2009 Actual Results	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE													
Non-Government	$60,956	$64,222	$0	$64,222	$67,110	$593	$67,703	$70,139	$1,037	$71,176	$73,355	$1,545	$74,900
Medicare	28,780	24,199	0	24,199	24,972	357	25,328	25,771	450	26,221	26,614	556	27,170
Medicaid and Other Medical Assistance	3,191	5,015	0	5,015	5,061	60	5,120	5,097	84	5,181	5,137	111	5,248
Other Government			0			0			0			0	
Total Net Patient Patient Revenue	$92,926	$93,436	$0	$93,436	$97,143	$1,009	$98,152	$101,007	$1,571	$102,578	$105,106	$2,212	$107,317
Other Operating Revenue	$5,298	$4,942	$0	$4,942	$4,970	$0	$4,970	$5,000	$0	$5,000	$5,030	$0	$5,030
Revenue from Operations	$98,224	$98,378	$0	$98,378	$102,113	$1,009	$103,122	$106,007	$1,571	$107,578	$110,136	$2,212	$112,347
OPERATING EXPENSES													
Salaries and Fringe Benefits	$56,228	$52,664	$0	$52,664	$54,705	($414)	$54,291	$56,308	($394)	$55,914	$57,977	($325)	$57,652
Professional / Contracted Services	2,942	3,186	0	3,186	3,285	8	3,293	3,389	12	3,401	3,496	15	3,511
Supplies and Drugs	31,562	28,694	0	28,694	29,913	(885)	29,028	31,187	(866)	30,321	32,520	(839)	31,681
Bad Debts	3,239	3,104	0	3,104	3,289	35	3,324	3,484	56	3,540	3,695	81	3,776
Other Operating Expense	3,986	4,170	0	4,170	4,298	5	4,303	4,429	7	4,436	4,566	8	4,574
Subtotal	$97,957	$91,818	$0	$91,818	$95,490	($1,251)	$94,239	$98,797	($1,185)	$97,612	$102,254	($1,060)	$101,194
Depreciation/Amortization	4,989	5,580	0	5,580	6,194	0	6,194	6,670	0	6,670	7,039	0	7,039
Interest Expense	676	555	0	555	405	0	405	288	0	288	206	0	206
Lease Expense			0		0	0	0	0	0	0	0	0	0
Total Operating Expenses	$103,622	$97,953	$0	$97,953	$102,089	($1,251)	$100,838	$105,755	($1,185)	$104,570	$109,499	($1,060)	$108,439
Income (Loss) from Operations	($5,398)	$425	$0	$425	$24	$2,260	$2,284	$252	$2,756	$3,008	$637	$3,272	$3,909
Non-Operating Income	$335	$95	$0	$95	315	$2	317	230	$66	296	196	$125	321
Income before provision for income taxes	($5,063)	$520	$0	$520	339	$2,262	2,601	482	$2,822	3,304	833	$3,397	4,230
Provision for income taxes					0		0	0		0	0		0
Net Income	($5,063)	$520	$0	$520	$339	$2,262	$2,601	$482	$2,822	$3,304	$833	$3,397	$4,230
Retained earnings, beginning of year	$43,565	$36,645	$0	$36,645	$34,493	$0	$34,493	$34,832	$2,262	$37,094	$35,314	$5,084	$40,398
Retained earnings, end of year	$36,645	$37,165	$0	$37,165	$34,832	$2,262	$37,094	$35,314	$5,084	$40,398	$36,145	$8,481	$44,626
FTEs	490.8	486.7	0.0	486.7	486.1	(3.7)	482.4	487.5	(3.4)	484.1	489.1	(2.7)	486.4
*Volume Statistics:													
Inpatient Days	9,893	9,254	-	9,254	9,307	234	9,540	9,360	233	9,593	9,422	235	9,657
Inpatient Discharges	2,774	2,496	-	2,496	2,507	54	2,561	2,518	54	2,572	2,532	54	2,586
ED Visits	19,146	19,131	-	19,131	19,273	142	19,415	19,418	291	19,709	19,571	448	20,019
Ambulatory Surgery Visits	2,735	2,677		2,677	2,704	27	2,731	2,732	55	2,787	2,761	85	2,846

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

COMBINED DANBURY AND NEW MILFORD HEALTH SYSTEMS

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(Dollars are in thousands)

Total Facility: Description	FY 2009 Actual Results	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE													
Non-Government	$371,310	$402,904	$0	$402,904	$425,020	$1,065	$426,086	$448,002	$1,623	$449,625	$472,284	$2,252	$474,536
Medicare	189,938	182,800	0	182,800	190,124	806	190,930	197,579	987	198,566	205,346	1,182	206,527
Medicaid and Other Medical Assistance	31,795	33,641	0	33,641	34,721	168	34,889	35,801	211	36,012	36,919	256	37,175
Other Government	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Net Patient Patient Revenue	$593,044	$619,344	$0	$619,344	$649,866	$2,039	$651,905	$681,382	$2,820	$684,202	$714,550	$3,689	$718,238
Other Operating Revenue	$17,558	$14,598	$0	$14,598	$14,723	$0	$14,723	$14,850	$0	$14,850	$14,979	$0	$14,979
Revenue from Operations	$610,602	$633,942	$0	$633,942	$664,589	$2,039	$666,628	$696,232	$2,820	$699,052	$729,528	$3,689	$733,217
OPERATING EXPENSES													
Salaries and Fringe Benefits	$306,114	$322,581	$0	$322,581	$332,720	$121	$332,841	$349,610	$255	$349,865	$367,408	$443	$367,851
Professional / Contracted Services	41,580	43,311	0	43,311	45,416	42	45,458	47,627	55	47,682	49,946	66	50,012
Supplies and Drugs	114,759	113,078	0	113,078	118,516	(666)	117,850	124,220	(601)	123,619	130,205	(526)	129,679
Bad Debts	20,274	21,316	0	21,316	25,398	77	25,475	26,699	106	26,805	28,073	140	28,213
Other Operating Expense	65,861	70,564	0	70,564	74,012	19	74,031	77,628	24	77,652	81,425	28	81,453
Subtotal	$548,588	$570,850	$0	$570,850	$596,062	($407)	$595,654	$625,785	($161)	$625,624	$657,057	$151	$657,208
Depreciation/Amortization	30,217	32,949	0	32,949	33,795	0	33,795	34,451	0	34,451	35,009	0	35,009
Interest Expense	5,806	5,836	0	5,836	5,519	0	5,519	5,307	0	5,307	5,120	0	5,120
Lease Expense	5,023	5,250	0	5,250	5,408	0	5,408	5,570	0	5,570	5,737	0	5,737
Total Operating Expenses	$589,633	$614,885	$0	$614,885	$640,782	($407)	$640,375	$671,112	($161)	$670,951	$702,923	$151	$703,074
Income (Loss) from Operations	$20,968	$19,057	$0	$19,057	$23,806	$2,447	$26,253	$25,120	$2,981	$28,101	$26,605	$3,538	$30,143
Non-Operating Income	$12,111	$12,782	$0	$12,782	$10,783	$2	$10,785	$12,877	$66	$12,943	$15,387	$128	$15,515
Income before provision for income taxes	$33,079	$31,839	$0	$31,839	$34,589	$2,449	$37,038	$37,997	$3,047	$41,044	$41,993	$3,666	$45,659
Provision for income taxes													
Net Income	$33,079	$31,839	$0	$31,839	$34,589	$2,449	$37,038	$37,997	$3,047	$41,044	$41,993	$3,666	$45,659
Retained earnings, beginning of year	$43,565	$74,786	$0	$74,786	$103,953	$0	$103,953	$138,542	$2,449	$140,991	$176,539	$5,496	$182,035
Retained earnings, end of year	$74,786	$106,625	$0	$106,625	$138,542	$2,449	$140,991	$176,539	$5,496	$182,035	$218,530	$9,162	$227,692
FTEs	2,989.0	2,939.2	0.0	2,939.2	2,938.6	1.6	2,940.2	2,957.6	2.8	2,960.4	2,976.8	4.5	2,981.3
*Volume Statistics:													
Inpatient Days	103,323	102,021	0	102,021	101,012	718	101,729	102,247	800	103,046	103,506	882	104,388
Inpatient Discharges	23,273	23,073	0	23,073	23,349	174	23,523	23,629	194	23,823	23,915	214	24,129
Emergency Room Visits	88,728	89,201	0	89,201	89,833	142	89,975	90,471	291	90,762	91,122	448	91,570
Ambulatory Surgery Visits	14,403	14,546	0	14,546	14,751	27	14,778	14,960	55	15,015	15,172	85	15,257

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

DANBURY HOSPITAL

6.A Financial Attachment I. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

(Dollars are in thousands)

Total Facility: Description	FY 2009 Actual Results	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON
NET PATIENT REVENUE							
Non-Government	$283,389	$309,279	-	$309,279	$326,838	$472	$327,311
Medicare	150,022	146,752	-	146,752	152,814	449	153,264
Medicaid and Other Medical Assistance	26,686	26,867	-	26,867	27,838	108	27,947
Other Government	-	-	-	-	-	0	
Total Net Patient Patient Revenue	$460,096	$482,898	-	$482,898	$507,491	$1,030	$508,521
Other Operating Revenue	$11,773	$9,937	-	$9,937	$10,036	$0	$10,036
Revenue from Operations	$471,869	$492,835	-	$492,835	$517,527	$1,030	$518,557
OPERATING EXPENSES							
Salaries and Fringe Benefits	$234,011	$250,556	-	$250,556	$258,073	$535	$258,608
Professional / Contracted Services	38,638	40,125	-	40,125	42,131	34	42,165
Supplies and Drugs	70,642	71,242	-	71,242	74,804	219	75,023
Bad Debts	16,695	17,897	-	17,897	20,300	41	20,341
Other Operating Expense	52,784	58,416	-	58,416	61,337	14	61,351
Subtotal	$412,772	$438,235	-	$438,235	$456,644	$843	$457,487
Depreciation/Amortization	23,126	25,299	-	25,299	25,634	0	25,634
Interest Expense	4,668	4,818	-	4,818	4,665	0	4,665
Lease Expense	3,961	4,432	-	4,432	4,565	0	4,565
Total Operating Expenses	$444,526	$472,784	-	$472,784	$491,508	$843	492,351
Income (Loss) from Operations	$27,342	$20,051	-	$20,051	$26,020	$187	26,206
Non-Operating Income	$11,172	$10,000		$10,000	$8,251	$0	$8,251
Income before provision for income taxes	$38,515	$30,051	-	$30,051	$34,270	$187	$34,457
Provision for income taxes							
Net Income	$38,515	$30,051	-	$30,051	$34,270	$187	$34,457
Retained earnings, beginning of year		$38,515	-	$38,515	$68,566	$0	$68,566
Retained earnings, end of year	$38,515	$68,566	-	$68,566	$102,836	$187	$103,023
FTEs	2,498.2	2,452.5	-	2,452.5	2,452.5	5.3	2,457.8
*Volume Statistics:							
Inpatient Days	93,430	92,767	-	92,767	91,705	484	92,189
Inpatient Discharges	20,499	20,577	-	20,577	20,842	120	20,962
Emergency Room Visits	69,582	70,070	-	70,070	70,560	-	70,560
Ambulatory Surgery Visits	11,668	11,869	-	11,869	12,047	-	12,047

Total Facility: Description	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE						
Non-Government	$345,060	$585	$345,645	$364,297	$707	$365,004
Medicare	$158,973	537	159,509	$165,379	625	166,004
Medicaid and Other Medical Assistance	$28,817	127	28,944	$29,830	145	29,975
Other Government	-	0		-	0	
Total Net Patient Patient Revenue	$532,849	$1,249	$534,098	$559,506	$1,477	$560,983
Other Operating Revenue	$10,137	$0	$10,137	$10,238	$0	$10,238
Revenue from Operations	$542,986	$1,249	$544,235	$569,744	$1,477	$571,221
OPERATING EXPENSES						
Salaries and Fringe Benefits	$272,264	$649	$272,913	$287,236	$768	$288,004
Professional / Contracted Services	44,238	43	44,281	46,449	51	46,500
Supplies and Drugs	78,544	265	78,809	82,471	313	82,784
Bad Debts	21,314	50	21,364	22,380	59	22,439
Other Operating Expense	64,404	17	64,421	67,624	20	67,644
Subtotal	$480,763	$1,024	$481,787	$506,160	$1,211	$507,371
Depreciation/Amortization	25,716	0	25,716	25,801	0	25,801
Interest Expense	4,578	0	4,578	4,483	0	4,483
Lease Expense	4,702	0	4,702	4,843	0	4,843
Total Operating Expenses	$515,759	$1,024	516,783	$541,288	$1,211	542,499
Income (Loss) from Operations	$27,227	$225	27,452	$28,456	$266	28,722
Non-Operating Income	$9,968	$0	$9,968	$11,974	$0	$11,974
Income before provision for income taxes	$37,195	$225	$37,420	$40,430	$266	$40,696
Provision for income taxes						
Net Income	$37,195	$225	$37,420	$40,430	$266	$40,696
Retained earnings, beginning of year	$102,836	$187	$103,023	$140,031	$412	$140,443
Retained earnings, end of year	$140,031	$412	$140,443	$180,461	$678	$181,139
FTEs	2,470.0	6.2	2,476.3	2,487.7	7.1	2,494.8
*Volume Statistics:						
Inpatient Days	92,887	567	93,454	94,084	647	94,731
Inpatient Discharges	21,111	140	21,251	21,383	160	21,543
Emergency Room Visits	71,053	-	71,053	71,551	-	71,551
Ambulatory Surgery Visits	12,228	-	12,228	12,411	-	12,411

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NEW MILFORD HOSPITAL

6.A Financial Attachment I. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

(Dollars are in thousands)

Total Facility: Description	FY 2009 Actual Results	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE													
Non-Government	$60,956	$64,222	$0	$64,222	$67,110	$593	$67,703	$70,139	$1,037	$71,176	$73,355	$1,545	$74,900
Medicare	25,519	20,840	0	20,840	21,443	357	21,799	22,064	450	22,514	22,719	556	23,275
Medicaid and Other Medical Assistance	3,191	5,015	0	5,015	5,061	60	5,120	5,097	84	5,181	5,137	111	5,248
Other Government			0			0			0			0	
Total Net Patient Patient Revenue	$89,665	$90,077	$0	$90,077	$93,614	$1,009	$94,623	$97,300	$1,571	$98,871	$101,211	$2,212	$103,422
Other Operating Revenue	$3,834	$3,502	$0	$3,502	$3,502	$0	$3,502	$3,502	$0	$3,502	$3,502	$0	$3,502
Revenue from Operations	$93,499	$93,579	$0	$93,579	$97,116	$1,009	$98,125	$100,802	$1,571	$102,373	$104,713	$2,212	$106,924
OPERATING EXPENSES													
Salaries and Fringe Benefits	$53,210	$49,625	$0	$49,625	$51,508	($414)	$51,094	$52,946	($394)	$52,552	$54,439	($325)	$54,114
Professional / Contracted Services	2,458	2,687	0	2,687	2,772	8	2,780	2,860	12	2,872	2,951	15	2,966
Supplies and Drugs	30,889	28,194	0	28,194	29,398	(885)	28,513	30,657	(866)	29,791	31,974	(839)	31,135
Bad Debts	3,239	3,104	0	3,104	3,289	35	3,324	3,484	56	3,540	3,695	81	3,776
Other Operating Expense	3,606	3,629	0	3,629	3,740	5	3,745	3,855	7	3,862	3,974	8	3,982
Subtotal	$93,402	$87,239	$0	$87,239	$90,707	($1,251)	$89,456	$93,802	($1,185)	$92,617	$97,033	($1,060)	$95,973
Depreciation	4,989	5,580	0	5,580	6,194	0	6,194	6,670	0	6,670	7,039	0	7,039
Interest Expense	676	555	0	555	405	0	405	288	0	288	206	0	206
Lease Expense			0		0	0	0	0	0	0	0	0	0
Total Operating Expenses	$99,067	$93,374	$0	$93,374	$97,306	($1,251)	$96,055	$100,760	($1,185)	$99,575	$104,278	($1,060)	$103,218
Income (Loss) from Operations	($5,568)	$205	$0	$205	-$190	$2,260	$2,070	$42	$2,756	$2,798	$435	$3,272	$3,707
Non-Operating Income	$335	$95	$0	$95	305	$2	307	216	$66	282	177	$125	302
Income before provision for income taxes	($5,233)	$300	$0	$300	115	$2,262	2,377	258	$2,822	3,080	612	$3,397	4,009
Provision for income taxes					0		0	0		0	0		0
Net Income	($5,233)	$300	$0	$300	$115	$2,262	$2,377	$258	$2,822	$3,080	$612	$3,397	$4,009
Retained earnings, beginning of year	$43,565	$36,475	$0	$36,475	$34,103	$0	$34,103	$34,218	$2,262	$36,480	$34,476	$5,084	$39,560
Retained earnings, end of year	$36,475	$36,775	$0	$36,775	$34,218	$2,262	$36,480	$34,476	$5,084	$39,560	$35,086	$8,481	$43,567
FTEs	488.8	484.7	0.0	484.7	486.1	(3.7)	482.4	487.5	(3.4)	484.1	489.1	(2.7)	486.4
*Volume Statistics:													
Inpatient Days	9,893	9,254	-	9,254	9,307	234	9,540	9,360	233	9,593	9,422	235	9,657
Inpatient Discharges	2,774	2,496	-	2,496	2,507	54	2,561	2,518	54	2,572	2,532	54	2,586
ED Visits	19,146	19,131	-	19,131	19,273	142	19,415	19,418	291	19,709	19,571	448	20,019
Ambulatory Surgery Visits	2,735	2,677		2,677	2,704	27	2,731	2,732	55	2,787	2,761	85	2,846

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

COMBINED DANBURY AND NEW MILFORD HOSPITALS

6.A Financial Attachment I. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

(Dollars are in thousands) Total Facility: Description	FY 2009 Actual Results	FY 2010 Projected W/out CON	FY 2010 Projected Incremental	FY 2010 Projected With CON	FY 2011 Projected W/out CON	FY 2011 Projected Incremental	FY 2011 Projected With CON	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON
NET PATIENT REVENUE													
Non-Government	$344,344	$373,501	$0	$373,501	$393,949	$1,065	$395,014	$415,198	$1,623	$416,821	$437,652	$2,252	$439,903
Medicare	175,541	167,592	0	167,592	174,257	806	175,063	181,037	987	182,023	188,098	1,182	189,280
Medicaid and Other Medical Assistance	29,876	31,882	0	31,882	32,899	168	33,067	33,914	211	34,125	34,967	256	35,222
Other Government	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Net Patient Patient Revenue	$549,761	$572,975	$0	$572,975	$601,105	$2,039	$603,144	$630,149	$2,820	$632,969	$660,716	$3,689	$664,405
Other Operating Revenue	$15,607	$13,439	$0	$13,439	$13,538	$0	$13,538	$13,639	$0	$13,639	$13,740	$0	$13,740
Revenue from Operations	$565,368	$586,414	$0	$586,414	$614,643	$2,039	$616,682	$643,788	$2,820	$646,608	$674,456	$3,689	$678,145
OPERATING EXPENSES													
Salaries and Fringe Benefits	$287,221	$300,181	$0	$300,181	$309,581	$121	$309,702	$325,210	$255	$325,465	$341,675	$443	$342,118
Professional / Contracted Services	41,096	42,812	0	42,812	44,903	42	44,945	47,098	55	47,153	49,400	66	49,466
Supplies and Drugs	101,531	99,436	0	99,436	104,202	(666)	103,536	109,201	(601)	108,600	114,445	(526)	113,919
Bad Debts	19,934	21,001	0	21,001	23,589	77	23,665	24,798	106	24,904	26,075	140	26,215
Other Operating Expense	56,390	62,045	0	62,045	65,077	19	65,096	68,259	24	68,283	71,598	28	71,626
Subtotal	$506,174	$525,474	$0	$525,474	$547,351	($407)	$546,943	$574,565	($161)	$574,404	$603,193	$151	$603,344
Depreciation/Amortization	28,115	30,879	0	30,879	31,828	0	31,828	32,386	0	32,386	32,840	0	32,840
Interest Expense	5,344	5,373	0	5,373	5,070	0	5,070	4,866	0	4,866	4,689	0	4,689
Lease Expense	3,961	4,432	0	4,432	4,565	0	4,565	4,702	0	4,702	4,843	0	4,843
Total Operating Expenses	$543,593	$566,158	$0	$566,158	$588,814	($407)	$588,406	$616,519	($161)	$616,358	$645,566	$151	$645,717
Income (Loss) from Operations	$21,775	$20,257	$0	$20,257	$25,829	$2,447	$28,276	$27,269	$2,981	$30,250	$28,890	$3,538	$32,428
Non-Operating Income	$11,507	$10,095	$0	$10,095	$8,556	$2	$8,558	$10,184	$66	$10,250	$12,151	$125	$12,276
Income before provision for income taxes	$33,282	$30,352	$0	$30,352	$34,385	$2,449	$36,834	$37,453	$3,047	$40,500	$41,041	$3,663	$44,704
Provision for income taxes													
Net Income	$33,282	$30,352	$0	$30,352	$34,385	$2,449	$36,834	$37,453	$3,047	$40,500	$41,041	$3,663	$44,704
Retained earnings, beginning of year	$43,565	$74,990	$0	$74,990	$102,669	$0	$102,669	$137,054	$2,449	$139,503	$174,507	$5,496	$180,003
Retained earnings, end of year	$74,990	$105,341	$0	$105,341	$137,054	$2,449	$139,503	$174,507	$5,496	$180,003	$215,547	$9,159	$224,706
FTEs	2,987.0	2,937.2	0.0	2,937.2	2,938.6	1.6	2,940.2	2,957.6	2.8	2,960.4	2,976.8	4.5	2,981.3
*Volume Statistics:													
Inpatient Days	103,323	102,021	-	102,021	101,012	718	101,729	102,247	800	103,046	103,506	882	104,388
Inpatient Discharges	23,273	23,073	-	23,073	23,349	174	23,523	23,629	194	23,823	23,915	214	24,129
ED Visits	88,728	89,201	-	89,201	89,833	142	89,975	90,471	291	90,762	91,122	448	91,570
Ambulatory Surgery Visits	14,403	14,546	-	14,546	14,751	27	14,778	14,960	55	15,015	15,172	85	15,257

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

6.C. FINANCIAL ASSUMPTIONS

Net Patient Revenue:
- Without Project: Determined using historical payment experience, combined with an annual 5% price increase and changes in projected volume.
- With Project: Based on current payment experience and mix, combined with an annual 5% price increase applied to projected volume.

Volume:
- Without Project: Assumption is based on 3% volume increase per year declining to 2.75% in 2014 forward due to space constraints. No change in payormix.
- With Project: Increases expected in Inpatient discharges as a result of the project. Volume was spread based on historical payormix.

Incremental:	FY2011	FY2012	FY2013	
Inpatient Discharges	120	140	160	Note: Med/Surg volume

Other Operating Revenue:
- Without Project: Assumes 1% increase annually
- With Project: N/A

Salaries and Fringe Benefits:
- Without Project: Assumption is based on historic expense combined with FTE increases and inflationary increases between of approx 4.5% annually.
- With Project: Incremental expense based on anticipated FTE increases associated with project.

Professional / Contracted Srvs:
- Without Project: Based on historical expense plus 5% annual inflation increase per year.
- With Project: Incremental expense based on anticipated increase in MD Fees associated with project.

Supplies and Drugs:
- Without Project: Assumption is based on historical expenses plus 5% inflation increases per year.
- With Project: Projected using historical actuals plus 5% inflation annually as % of net revenue applied to incremental volume.

Bad Debt:
- Without Project: Assumption is based on 4% of annual net revenue consistent annually.
- With Project: Project assumption is based on 4% of net revenue related to incremental volume.

Other Op Expense:
- Without Project: Includes a 5% annual increase on expenses annually.
- With Project: Project assumption is based on experience applied to incremental volume (includes overhead i.e. purch srv, maintenance, other nonsal

Depreciation:
- Without Project: Assumption is based on historic annual capital spending.
- With Project: N/A

Interest:
- Without Project: Based on current interest of existing debt rolled forward annually.
- With Project: N/A

Lease Expense:
- Without Project: Includes a 3% annual increase on expenses annually.
- With Project: N/A

FTEs:
- Without Project: Includes a <1% annual increase in FTEs comprised of staffing required to support annual growth and productivity initatives currently underway.
- With Project: Incremental staffing increases per year to support incremental volume.

Exhibit 13

Docket Number: 10-31560-CON

DANBURY HOSPITAL

(Dollars are in thousands)

6B. Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	**Inpatient Volume**
Type of Unit Description:	**Discharges**
# of Months in Operation	**12 months**

FY 2011	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
FY Projected Incremental										
Total Incremental Expenses:	$802									
Total Facility by Payer Category:										
Medicare		$24	52	$1,248	$799	-	-	$449	$436	$13
Medicaid		15	19	285	177	-	-	108	100	9
CHAMPUS/TriCare		-	-	-	-	-	-	-	-	-
Total Governmental		$22	71	$1,533	$976	$0	$0	$558	$535	$22
Commercial Insurers		16	47	736	271	4	36	426	257	169
Uninsured		20	1	27	-	17	5	5	10	(5)
Total NonGovernment		$16	49	$764	$271	$21	$41	$431	$267	$164
Total All Payers		$19	120	$2,297	$1,246	$21	$41	$989	$802	$187

FY 2012	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
FY Projected Incremental										
Total Incremental Expenses:	$974									
Total Facility by Payer Category:										
Medicare		$25	61	$1,535	$998	-	-	$537	$529	$7
Medicaid		15	23	350	224	-	-	127	121	6
CHAMPUS/TriCare		-	-	-	-	-	-	-	-	-
Total Governmental		$23	83	$1,885	$1,222	$0	$0	$664	$650	$13
Commercial Insurers		16	55	905	328	5	43	529	312	217
Uninsured		21	2	34	-	21	7	6	12	(6)
Total NonGovernment		$17	57	$939	$328	$25	$50	$535	$324	$212
Total All Payers		$20	140	$2,824	$1,550	$25	$50	$1,199	$974	$225

FY 2013	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
FY Projected Incremental										
Total Incremental Expenses:	$1,152									
Total Facility by Payer Category:										
Medicare		$27	69	$1,840	$1,215	-	-	$625	$626	($1)
Medicaid		16	26	420	275	-	-	145	143	2
CHAMPUS/TriCare		-	-	-	-	-	-	-	-	-
Total Governmental		$24	95	$2,261	$1,491	$0	$0	$770	$769	$1
Commercial Insurers		17	63	1,085	388	5	51	641	369	271
Uninsured		22	2	40	-	25	8	7	14	(6)
Total NonGovernment		$17	65	$1,125	$388	$30	$59	$648	$383	$265
Total All Payers		$21	160	$3,386	$1,879	$30	$59	$1,418	$1,152	$266

6.C. FINANCIAL ASSUMPTIONS

Net Patient Revenue:
- Without Project: Determined using historical payment experience, combined with an annual 5% price increase and changes in projected volume.
- With Project: Based on current payment experience and mix, combined with an annual 5% price increase applied to projected volume.

Volume:
- Without Project: Assumption is based on 3% volume increase per year declining to 2.75% in 2014 forward due to space constraints. No change in payormix.
- With Project: Increases expected in Inpatient discharges as a result of the project. Volume was spread based on historical payormix.

Incremental:	FY2011	FY2012	FY2013	
Inpatient Discharges	120	140	160	Note: Med/Surg volume

Other Operating Revenue:
- Without Project: Assumes 1% increase annually
- With Project: N/A

Salaries and Fringe Benefits:
- Without Project: Assumption is based on historic expense combined with FTE increases and inflationary increases between of approx 4.5% annually.
- With Project: Incremental expense based on anticipated FTE increases associated with project.

Professional / Contracted Srvs:
- Without Project: Based on historical expense plus 5% annual inflation increase per year.
- With Project: Incremental expense based on anticipated increase in MD Fees associated with project.

Supplies and Drugs:
- Without Project: Assumption is based on historical expenses plus 5% inflation increases per year.
- With Project: Projected using historical actuals plus 5% inflation annually as % of net revenue applied to incremental volume.

Bad Debt:
- Without Project: Assumption is based on 4% of annual net revenue consistent annually.
- With Project: Project assumption is based on 4% of net revenue related to incremental volume.

Other Op Expense:
- Without Project: Includes a 5% annual increase on expenses annually.
- With Project: Project assumption is based on experience applied to incremental volume (includes overhead i.e. purch srv, maintenance, other nonsal

Depreciation:
- Without Project: Assumption is based on historic annual capital spending.
- With Project: N/A

Interest:
- Without Project: Based on current interest of existing debt rolled forward annually.
- With Project: N/A

Lease Expense:
- Without Project: Includes a 3% annual increase on expenses annually.
- With Project: N/A

FTEs:
- Without Project: Includes a <1% annual increase in FTEs comprised of staffing required to support annual growth and productivity initatives currently underway.
- With Project: Incremental staffing increases per year to support incremental volume.

New Milford Hospital

(Dollars are in thousands)

6B. Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: Inpat Discharges & OP Visits
Type of Unit Description: Inpat Discharges & OP Visits
# of Months in Operation: 12

FY 2011 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by Payer Category:**	(1) ($1,286)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$47	34	$1,581	$1,224			$356	($696)	$1,052
Medicaid		$60	3	$180	$120			$60	($79)	$139
CHAMPUS/TriCare				$0				$0	$0	$0
Total Governmental		$48	37	$1,761	$1,344	$0	$0	$416	($775)	$1,191
Commericial Insurers		$72	15	$1,075	$545		$4	$527	($473)	$1,000
Uninsured		$43	2	$85	$22		$32	$32	($37)	$69
Total NonGovernment		$47	17	$1,160	$567	$0	$35	$558	($511)	$1,069
Total All Payers		$47	54	$2,921	$1,911	$0	$35	$974	($1,286)	$2,260

FY 2012 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by Payer Category:**	(1) ($1,241)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$65	34	$2,197	$1,747			$450	($610)	$1,060
Medicaid		$92	3	$277	$193			$84	($77)	$161
CHAMPUS/TriCare				$0				$0	$0	$0
Total Governmental		$67	37	$2,474	$1,940	$0		$534	($687)	$1,221
Commericial Insurers		$124	15	$1,862	$921		$8	$933	($517)	$1,450
Uninsured		$66	2	$132	$36		$48	$48	($37)	$85
Total NonGovernment		$65	17	$1,994	$957	$0	$56	$981	($554)	$1,535
Total All Payers		$83	54	$4,468	$2,897	$0	$56	$1,515	($1,241)	$2,756

FY 2013 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by Payer Category:**	(1) ($1,141)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$86	34	$2,921	$2,365			$556	($531)	$1,087
Medicaid		$130	3	$390	$279			$111	($71)	$182
CHAMPUS/TriCare				$0				$0	$0	$0
Total Governmental		$89	37	$3,311	$2,644	$0		$667	($602)	$1,269
Commericial Insurers		$185	15	$2,779	$1,367		$15	$1,398	($505)	$1,903
Uninsured		$94	2	$187	$54		$67	$67	($34)	$100
Total NonGovernment		$174	17	$2,966	$1,421	$0	$81	$1,464	($539)	$2,003
Total All Payers		$116	54	$6,277	$4,065	$0	$81	$2,131	($1,141)	$3,272

6.C. FINANCIAL ASSUMPTIONS

Net Patient Revenue:
- Without Project: Determined using historical payment experience, combined with an annual 5% price increase and changes in projected volume.
- With Project: Based on current payment experience and mix, combined with an annual 5% price increase applied to projected volume.

Volume:
- Without Project: Assumption is based on FY 10 estimated actual results with a .4% annual increase in patient admissions. Outpatient services reflect a 0.9% annual increase. No change in payor mix.
- With Project: Incremental volume as a result of the project relates to growth in inpatient and outpatient services:

	FY2011	FY2012	FY2013
Inpatient Discharges	54	54	54
ED Visits	142	291	448
Ambulatory Surgery	27	55	85

Other Operating Revenue:
- Without Project: Assumes 2% increase annually
- With Project: N/A

Salaries and Fringe Benefits:
- Without Project: Assumption is based on historic expense combined inflationary increases of approx 2.5% annually.
- With Project: Incremental expense associated with increased volume combined with salary/benefit savings from productivity efficiencies in staffing related to the project (see below for details)

	FY2011	FY2012	FY2013	
Sal/Ben Savings	797K	855K	876K	Annual impact from base case

Professional / Contracted Srvs:
- Without Project: Based on historical expense plus 3% annual inflation increase per year.
- With Project: Incremental expense based on anticipated increase in MD Fees associated with project.

Supplies and Drugs:
- Without Project: Assumption is based on historical expenses plus 4% inflation increases per year.
- With Project: Projected using historical actuals plus 4% inflation annually as % of net revenue applied to incremental volume combined with projected supply savings from group purchasing (see below)

	FY2011	FY2012	FY2013	
Supplies/Drugs	1.016M	1.057M	1.099M	Annual impact from base case

Bad Debt:
- Without Project: Assumption is based on 3.5% of annual net revenue consistent annually.
- With Project: Project assumption is based on 3.5% of net revenue related to incremental volume.

Other Op Expense:
- Without Project: Includes a 3% annual increase on expenses annually.
- With Project: Project assumption is based on experience applied to incremental volume (includes overhead i.e. purch srv, maintenance, other nonsal)

Depreciation:
- Without Project: Assumption is based on historic annual capital spending.
- With Project: N/A

Interest:
- Without Project: Based on current interest of existing debt rolled forward annually.
- With Project: N/A

Lease Expense:
- Without Project: Includes a 3% annual increase on expenses annually.
- With Project: N/A

FTEs:
- Without Project: Includes a <1% annual increase in FTEs comprised of staffing required to support annual growth and productivity initatives currently underway.
- With Project: Incremental staffing increases per year to support incremental volume combined with FTE savings from productivity improvements/economies of scale related to the project (see below)

	FY2011	FY2012	FY2013	
FTE Savings	7.5	7.9	7.9	Annual impact from base case

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 23, 2010

Frank Kelly
President & CEO
Danbury Health Systems, Inc.
24 Hospital Avenue
Danbury, CT 06810

Sally Herlihy
VP, Regulatory Compliance
New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

RE: Certificate of Need Application Forms, Docket Number 10-31560-CON
Danbury Health Systems, Inc. and New Milford Hospital, Inc.
Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Dear Mr. Kelly and Ms. Herlihy:

On June 9, 2010, the Office of Health Care Access ("OHCA") received the initial Certificate of Need ("CON") submission of Danbury Health Systems, Inc. ("DH") and New Milford Hospital, Inc. ("NMH"), (collectively identified as the "Applicants") regarding their proposal for the affiliation of DH and NMH. There is no cost associated with this proposal.

OHCA has reviewed the CON application pursuant to Section 19a-643-74 of OHCA's Regulations and finds that the information submitted is deficient, and that additional information and/or clarification is required as outlined below:

Clear Public Need:

1. On page 91 of the application you list the 15 members of the board of directors of NEWCO including the four with voting rights from NMH Hospital. Does this mean both hospitals have equal ownership of NEWCO? If not, which hospital has control and by what percentage?

2. Describe any existing relationship(s) between the two hospitals (e.g., shared services, staffing and administration etc.) and provide specific details on how they operate.

3. In section 2.b, page 18 of the application, ambulatory surgery data provided in Table 1 for DH is inconsistent with data the hospital reported through OHCA's Hospital Reporting System in Reports 400 and 450. Please explain and reconcile the discrepancy.

Ambulatory Surgery	FY 2007	FY 2008	FY 2009
Application	13,092	12,277	11,668
HRS Report 450	9,524	8,293	7,902

4. Provide year-to-date and annualized data for hospital fiscal year (FY) 2010 as in Table 1, page 18 of the application, for both hospitals. Also, describe the methodology you use to annualize the data.

5. Explain the significant growth in observation status stays from FY2007 to FY2010 on page 19 of the application, and provide reasons for the shift from inpatient to observation and extended stay for both hospitals. Also provide projections for FY2011 to FY2013 for observations patients and extended stays for both hospitals.

6. Provide projections for FY2011 to FY2013 for ED and ambulatory surgery visits at DH and the associated assumptions.

7. Provide projected patient volumes for total discharges, observation patients, extended stay, ED visits and ambulatory surgery visits for DH and NMH for FY2011 to FY2013 without the proposed affliation. Provide details of any other associated assumptions.

Financial Feasibility:

8. On page 27 of the CON Application, the Applicants stated that "this proposal is cost effective for each applicant on the basis that DHS anticipates to increase patient volume in terms of tertiary care and NMH will have overall savings of approximately 2% through savings in productivity via economics of scale and supply savings from changes in group purchasing." Provide in detail the following:

    a. The number of "tranfers" out of NMH to other tertiary providers and to which providers;

    b. The rational for the projected increase in total patients for tertiary care;

    c. What the projected increase in patient volume is and which service lines will be the basis for the increase?

    d. What is the dollar amount that will translate in a 2% savings for NMH and by which cost category?

9. On page 27 of the CON Application the Applicants stated that "they plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claims management, finance, legal, compliance, accounting, and human resources". Provide details on how the Applicants plan to achieve these and quantify the specific cost savings?

10. On page 26 of the CON Application, the Applicants stated that they "will consider centralizing certain clinical functions, such as clinical laboratory and develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health". With regards to the above statement what will be the cost savings and will these result in any reduction in FTEs at either DH or NMH?

11. On page 7 of the CON Application the Applicant stated that they believe that the cost efficiencies realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH". Provide in detail the following:

    a. Specific details regarding "secure needed financing;" and

    b. How it will enhance the credit worthiness of NMH?

12. On page 30 of the CON Application, the Applicants stated "that DH will extend its research capabilities by creating a research center at NMH". Provide details on:

    a. What programs will be affected at the proposed research center;

    b. How the Applicants will identify need for specific research at NMH;

    c. If there will be any duplication of programs between the existing research center at DH and the proposed research center at NMH, how will the two coordinate and/or collaborate on the identified program(s)?

13. Do the Applicants anticipate cumulative savings from the proposed project? If yes, what are the total and annual savings for the next five FY by cost category?

14. In FY 09, NMH indicated an income loss from operations of ($5.063 million). In the next four FYs NMH projected without the CON, a gain from operations of $520,000, $339,000, $482,000, and $833,000, respectively. Discuss in detail the action undertaken by NMH that is leading to a gain from operation in FY 2010.

15. On page 2 of the CON Application the Applicants stated that they "intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions." What steps will NEWCO take to prevent future losses at NMH?

16. Exhibit 12, beginning on page 314, the presentation of the Financial Attachment 1, please provide the following:

    a. Revised Attachment I's that allocate the projected cost savings previously noted to the appropriate cost categories as opposed to reporting all of the savings in the Other Operating Expense category.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date your response, i.e., each page in its entirety. Information filed must be numbered sequentially from the Applicants' document preceding it.** For example, if the application concludes with page 100, your completeness response letter would begin with page 101. Please reference "Docket Number: 10-31560-CON" and submit one (1) original and five (5) hard copies of your response. In addition, please submit a scanned copy of your response, including all attachments, on CD using MS Word format and Adobe Acrobat.

Upon receipt of the responses to this letter and after incorporating the provided information into the initial submission, OHCA staff will perform a detailed review of the entire CON application.
If you have any questions concerning this letter, please feel free to contact Alexis Fedorjaczenko, Olga Armah or me at (860) 418-7001.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

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*********************
***   TX REPORT   ***
*********************

TRANSMISSION OK

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DESTINATION ID
ST. TIME                    06/23 15:09
TIME USE                    01'04
PAGES SENT                    5
RESULT                      OK
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERLIHY

FAX: 860 210 5075

AGENCY: NEW MILFORD HOSPITAL

FROM: OLGA ARMAH

DATE: 6/23/10 **TIME:** 3 pm

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:
10-31560-CON
COMPLETENESS LETTER

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** ERROR TX REPORT ***
****

TX FUNCTION WAS NOT COMPLETED

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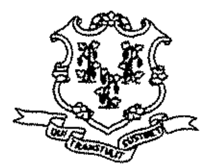


STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: FRANK FELLY

FAX: 203 739 7799

AGENCY: DANBURY HOSPITAL

FROM: OLGA ARMAH

DATE: 6/23/10 **TIME:** 3 pm

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:
10-31560-CON
COMPLETENESS LETTER

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Fiducia, Paolo
Sent: Wednesday, June 23, 2010 3:41 PM
To: Greer, Leslie
Subject: FW: Affiliation of Danbury Health Systems, Inc. and New Milford Hospital, Inc. Completeness Letter
Attachments: 10-31560- Completeness Letter.doc

FYI

From: Fiducia, Paolo
Sent: Wednesday, June 23, 2010 3:17 PM
To: 'frank.kelly@danhosp.org'; 'herlihys@nmhct.org'
Cc: Riggott, Kaila; Lazarus, Steven
Subject: Affiliation of Danbury Health Systems, Inc. and New Milford Hospital, Inc. Completeness Letter

Mr. Kelly and Ms. Herlihy,

Please find attached completeness letter for the above CON project. Let me know if you have any questions.

Thank you,

Paolo Fiducia
Associate Health Care Analyst
Office of Health Care Access
A DIVISION OF DEPARTMENT OF PUBLIC HEALTH
paolo.fiducia@ct.gov
860.418.7035 Direct Line
860.418.7053 Fax

STATE OF CONNECTICUT :
DEPARTMENT OF PUBLIC HEALTH :
OFFICE OF HEALTH CARE ACCESS : **JUNE 30, 2010**

RECEIVED
2010 JUN 30 A 10:10
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

Docket Number 10-31560-CON
Affiliation of Danbury Health Systems, Inc. and
New Milford Hospital, Inc.

Answers to Completeness Questions

Clear Public Need:

1. On page 91 of the application you list the 15 members of the board of directors of NEWCO including the four with voting rights from NMH Hospital. Does this mean both hospitals have equal ownership of NEWCO? If not, which hospital has control and by what percentage?

   Response:

   NEWCO is the acronym for the new name for Danbury Health Systems, recognizing that the "System" will now be comprised of two hospitals and a broader geographic area. As such, the Board of NEWCO will be comprised of 11 members of DHS and 4 members of NMH. The members of NEWCO will also serve as members of the Boards of the Danbury Hospital (DH) and of the New Milford Hospital (NMH). The parent NEWCO, (formerly DHS), will control all entities, including both hospitals.

2. Describe any existing relationship(s) between the two hospitals (e.g., shared services, staffing and administration etc.) and provide specific details on how they operate.

   Response:

   Currently, there are no shared services, staffing or administrative relationships between the two hospitals. Informally, nursing personnel from New Milford have partaken in educational programs offered at DH. For many years, the DH Pathology Department has provided vacation coverage for the Pathologist at NMH.

   As noted in our response to 1.b in the CON application (p.4), Danbury Hospital began offering a full service interventional cardiac program assisting in the transition following closure of the NMH catheterization laboratory when the

program closed in 2009. Also in our response to 1.e.ii in the CON (p.14) we address coordination of cardiac interventional services as well as hi-risk pregnancy/neonatology. These are coordinated, but not shared services.

3. In section 2.b, page 18 of the application, ambulatory surgery data provided in Table 1 for DH is inconsistent with data the hospital reported through OHCA's Hospital Reporting System in Reports 400 and 450. Please explain and reconcile the discrepancy.

Ambulatory Surgery	FY 2007	FY 2008	FY 2009
Application	13,092	12,277	11,668
HRS Report 450	9,524	8,293	7,902

Response:

The application volumes incorrectly included total surgery, not just ambulatory surgery. The OHCA HRS Report 450 correctly reported the total ambulatory surgery. Therefore, the correct volumes for the application should be 9,524 in 2007, 8,293 in 2008, and 7,902 in 2009.

4. Provide year-to-date and annualized data for hospital fiscal year (FY) 2010 as in Table 1, page 18 of the application, for both hospitals. Also, describe the methodology you use to annualize the data.

Response:

Year to Date and Annualized FY10 Volume

Danbury Hospital:

	Budget	CFY	CFY
	FY10	FY10 May YTD	Annualized
Med/Surg Discharges	14,984	9,944	14,916
Pediatric Discharges	336	222	333
Newborn Discharges	1,928	1,296	1,944
Psychiatric Discharges	745	474	711
Maternity Discharges	2,266	1,472	2,208
Rehab Discharges	318	210	315

Total Discharges	**20,577**	**13,618**	**20,427**
ED Visits	70,070	46,044	71,098
Ambulatory Surgery	11,869	7,469	11,204

Reported May Actual YTD FY2010. Method used to annualize is as follows:
Discharges: May YTD divided by 8 times 12.
ED Visits: Seasonalized to include summer historical increase in volume.
Ambulatory Surgery: May YTD divided by 8 times 12.

New Milford Hospital:

	Budget	CFY	CFY
	FY 10	FY 10 May YTD	Annualized
Med/Surg Discharges	2,120	1,322	1,983
Pediatric Discharges	47	10	15
Newborn Discharges	294	176	264
Psychiatric Discharges	N/A	N/A	N/A
Maternity Discharges	298	177	266
Rehab Discharges	N/A	N/A	N/A
Total Discharges	**2,759**	**1,685**	**2,528**
ED Visits	19,131	12,002	19,173
Ambulatory Surgery	2,718	1,858	2,787

Reported May Actual YTD FY2010. Method used to annualize is as follows:
Discharges: May YTD divided by 8 times 12.
ED Visits: Seasonalized to include summer historical increase in volume.
Ambulatory Surgery: May YTD divided by 8 times 12.

5. Explain the significant growth in observation status stays from FY2007 to FY2010 on page 19 of the application, and provide reasons for the shift from inpatient to observation and extended stay for both hospitals. Also provide projections for FY2011 to FY2013 for observations patients and extended stays for both hospitals.

Response:

In recent years, CMS and third party payers have increasingly focused on eliminating unnecessary inpatient care through the introduction of "short stay" or "observation programs," whereby patients with selected medical conditions are

treated usually in inpatient beds or observation units for 24 hours or less, but are not considered "inpatients." In response to this, towards the end of fiscal year 2005, the DH dedicated several beds to an "Observation Unit" to treat patients who met specific diagnoses; including chest pain, syncope, CHF, abdominal pain, and head injuries; and required observation (OBV) services rather than an inpatient admission. In FY 2009, DH also established new protocols for specific surgical procedures to be managed in an extended recovery unit as opposed to a traditional one night inpatient stay. These units are efficient in isolating short stay patients and caring for them on an outpatient basis. Since DH has established these dedicated units in response to payer regulations, there has been a noticeable increase in volumes in these two categories. Now that the observation program has matured, and the extended stay program is reaching that state, DH's projections slow the growth in both of these units to a rate that matches the Hospital's historical growth experience. Therefore, although inpatient discharges have decreased during FY2008 thru FY2010, this is attributed to a significant shift in "short stay" patients to an observation or extended stay status (see chart below.) Overall growth is attributed to program and service growth and a growing and aging population.

Danbury Hospital:

	FY2007	FY2008	FY2009	FY2010
Total Discharges	20,752	20,465	20,499	20,577
Observation patients	1,257	2,632	2,868	2,983
Extended Stay				504
	22,009	23,097	23,367	24,064
Annual Growth		4.9%	1.2%	3.0%

New Milford Hospital

	FY2007	FY2008	FY2009	FY 2010
Total Discharges	2,845	3,033	2,774	2,496
Observation patients	333	384	567	520
Extended Stay	N/A	N/A	N/A	N/A
	3,178	3,417	3,341	3,016
Annual Growth		7.5%	-2.2%	-9.7%

Please refer to answer to Question 7 on page 5 and 6 for projections for FY2011 to FY2013 for observation patients and extended stays for both hospitals.

6. Provide projections for FY2011 to FY2013 for ED and ambulatory surgery visits at DH and the associated assumptions.

Response:

FY2011 to FY2013 ED and Amb. Surg. Projections and Assumptions

Danbury Hospital	Projected Volume		
	FY2011	FY2012	FY2013
ED Visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411

Assumptions: Danbury Hospital is projecting an increase in ED visits annually of 0.7% as well as an increase in ambulatory surgery cases of approximately 1.5% annually. Based on our review of ambulatory surgery cases performed at DH and its joint venture, Ridgefield Surgical Center, the shift from DH to the Center has essentially taken place, and each enterprise is expected to grow following population-based trends and the technology-driven shift to ambulatory surgery.

7. Provide projected patient volumes for total discharges, observation patients, extended stay, ED visits and ambulatory surgery visits for DH and NMH for FY2011 to FY2013 without the proposed affiliation. Provide details of any other associated assumptions.

Response:

Projections FY2011 thru FY2013
without affiliation

	New Milford Hospital Projections Without Proposed Affiliation		
	Projected Volume		
	FY2011	FY2012	FY2013
Total Discharges	2,507	2,518	2,532
Observation	522	524	527
Extended Stay	N/A	N/A	N/A
ED Visits	19,273	19,418	19,571

Ambulatory Surgery	2,704	2,732	2,761

NMH Assumptions Without Proposed Affiliation:
Inpatient volume: Inpatient Discharges are projected to increase 0.4% in 2011, 0.4% in 2012 and 0.6% in 2013.
Observation patients: Observation patients are projected to increase 0.4% in 2011, 0.4% in 2012 and 0.6% in 2013.
Emergency Room volume is projected to increase 0.7% in 2011, 0.8% in 2012 and 0.8% in 2013.
Ambulatory Surgery is projected to increase 1% in 2011, 1% in 2012 and 1.1% in 2013.

	Danbury Hospital Projections without proposed affiliation		
	Projected Volume		
	FY2011	**FY2012**	**FY2013**
Total discharges	20,842	21,111	21,383
Observation	3,072	3,164	3,228
Extended stay	554	610	653
ED Visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411

DH Assumptions Without Proposed Affiliation:
Volume: Med/Surg/Peds expected to grow at 1.4% annually while Newborn, Maternity, Psych and Rehab expected to grow at 1% annually.
Observation patients are projected to increase 3% in FY2012 and 2% in FY2013.
Extended stay volume is projected to increase 10.1% in FY2012 and 7% in FY2013.
Emergency Room volume is projected to increase 0.7% annually.
Ambulatory Surgery is projected to increase 1.5% annually.

Financial Feasibility:

8. On page 27 of the CON Application, the Applicants stated that "this proposal is cost effective for each applicant on the basis that DHS anticipates to increase

patient volume in terms of tertiary care and NMH will have overall savings of 2% through savings in productivity via economics of scale and supply savings from changes in group purchasing." Provide in detail the following:

a. The number of "tranfers" out of NMH to other tertiary providers and to which providers;

b. The rational for the projected increase in total patients for tertiary care;

c. What the projected increase in patient volume is and which service lines will be the basis for the increase?

d. What is the dollar amount that will translate in a 2% savings for NMH and by which cost category?

<u>Response</u>:

a. The number of "tranfers" out of NMH to other tertiary providers and to which providers;

The data available are tertiary outmigration data for 2008 from the New Milford Primary Service area. These data reflect the following:

Connecticut Children's Med. Center	2
John Dempsey Hospital	2
Bridgeport Hospital	4
Waterbury Hospital	6
St. Francis Medical Center	9
Hospital of St. Raphael	10
Other Connecticut Hospitals	15
Other NY Hospitals	35
Hartford Hospital	36
NY Presbyterian	36
Yale-New Haven Hospital	41

These data do not include psychiatric referrals.

b. The rational for the projected increase in total patients for tertiary care;

Response: Applicants anticipate that the majority of the transfers from NMH as well as other patients served by the added primary care physicians and specialists seeing patients in the New Milford area will comprise the largest component of the projected increase. These

assumptions are based on discussions with the NMH medical staff and early evidence of success in the field of cardiology.

As noted on page 23 of the CON, our response to question 3.b indicates that health care delivery in the region will benefit from improved access to subspecialty medical services and offering residents additional choices for high quality tertiary services closer to home.

c. The projected increase in patient volume is and which service lines will be the basis for the increase.

Increases related to the project are 120 in FY2011; 140 in 2012; and 160 in 2013. Approximately 80% of the increase is related to tertiary services as a result of lower outmigration or through improved access to one of our specialists. The remaining admissions involve other sources, such as the occasional ICU patient that the doctor wishes to move to a higher level unit or improved EMS coverage and road access improvements.

Based on the 2008 data referenced in response to question 8a above, the service lines most likely affected include cardiology and cardiac surgery, major GI surgery, ENT surgery, neurosurgery, orthopedic and spine surgery, trauma, thoracic surgery and vascular surgery.

d. The dollar amount that will translate in a 2% savings for NMH and by which cost category.

The 2% Savings for NMH by category is reflected below. The dollar savings have been categorized as appropriate in the Financial Attachment I (see below).

	FY2011	FY2012	FY2013
Salary and Fringe Benefits	$ 797,000	$ 855,000	$ 876,000
Supplies and Drugs	$ 1,016,000	$ 1,057,000	$ 1,099,000
	$ 1,813,000	$ 1,912,000	$ 1,975,000

9. On page 27 of the CON Application the Applicants stated that "they plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claims management, finance, legal, compliance, accounting, and human resources". Provide details on how the Applicants plan to achieve these and quantify the specific cost savings?

Response:

The application notes savings in the range of $800,000 per year for a total of $2,558,000 over the three year period. Given the current average rate per FTE this would equate to a reduction of 8 FTE's per year for the first three years of the affiliation.

There are several areas of potential savings in combining each of the back office areas, starting with the management of each area. There are several know retirements within the organization which will not need to be filled once the affiliation takes place.

Further, It is anticipated that ~~this~~ through assessment of productivity and benchmarking with the Premier data base (allowing comparison to like organizations in the industry) ~~tool.~~, coupled with the elimination of certain management positions and normal attrition will allow the organizations together to achieve the savings included in the Application at a minimum.

10. On page 26 of the CON Application, the Applicants stated that they "will consider centralizing certain clinical functions, such as clinical laboratory and develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health". With regards to the above statement what will be the cost savings and will these result in any reduction in FTEs at either DH or NMH?

Response:

In the current application there are no savings associated with the reduction, elimination, or combination of any clinical service. While these areas are viewed as potential areas of increased efficiencies in the future there are no plans to implement savings in these areas in the short term.

11. On page 7 of the CON Application the Applicant stated that they believe that the cost efficiencies realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH". Provide in detail the following:

    a. Specific details regarding "secure needed financing;" and

    b. How it will enhance the credit worthiness of NMH?

Response:

a. Specific details regarding "secure needed financing;" are:

DH has recently applied for a CON to conduct a $150m building project. The submitted CON application was presented to Shattuck and Hammond to ascertain the impact on the potential bond rating of NEWCO. It was determined that the NEWCO's numbers would support an "A" rating and the strategic value of affiliating with another hospital would at least equal any dilutive financial impact in the short term.

This financing is planned to take place early next fiscal year and the impact is included in the numbers presented within the CON application. It is anticipated that $125m will be borrowed in 2011 and the capital spent will take place over a three year period starting in 2011 and ending in 2013.

b. How it will enhance the credit worthiness of NMH.

The principal way that NMH credit worthiness will be enhanced by the affiliation is that NMH will enjoy the guarantee of NEWCO, an organization whose numbers would support an "A" rating, which is significantly better than NMH would be able to achieve on its own.

12. On page 30 of the CON Application, the Applicants stated "that DH will extend its research capabilities by creating a research center at NMH". Provide details on:

    a. What programs will be affected at the proposed research center;

    b. How the Applicants will identify need for specific research at NMH;

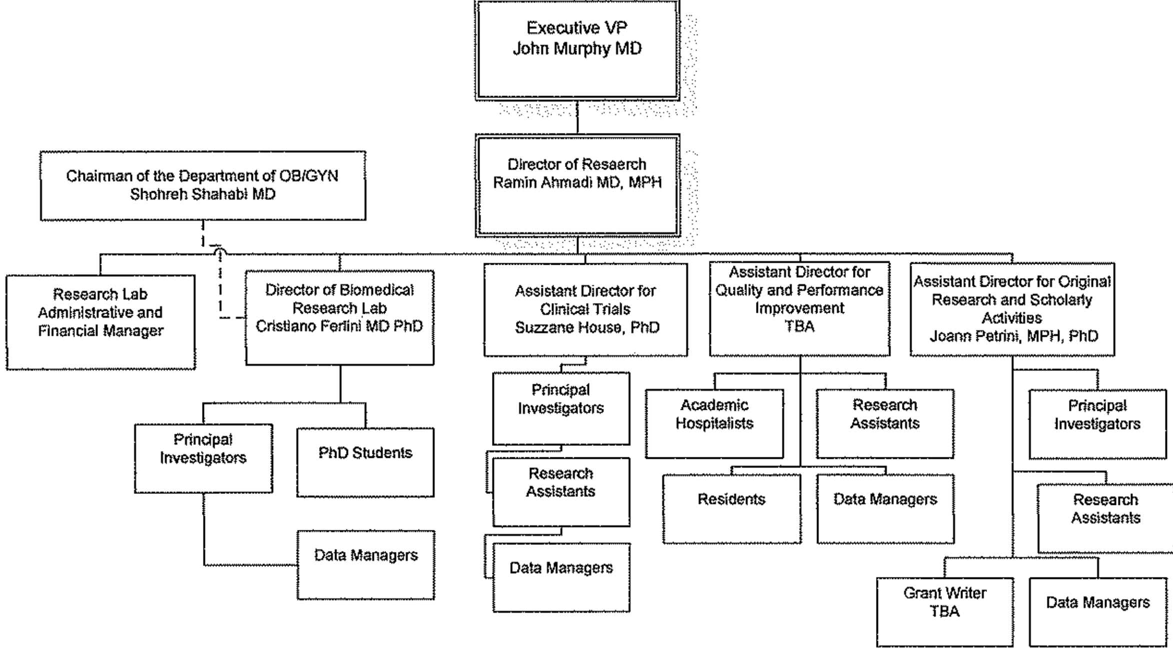
    c. If there will be any duplication of programs between the existing research center at DH and the proposed research center at NMH, how will the two coordinate and/or collaborate on the identified program(s)?

Response:

Danbury Hospital Research Department provides infrastructure and coordinates all of the research and scholarly activities for the entire institution. The research Department plans to develop a satellite center at New Milford Hospital in order to integrate the existing and future research and scholarly activities of NMH into the Department research activities and provide a seamless collaboration and coordination of the research efforts.

The Research Department is composed of four sections that work collaboratively but each have a distinct focus. The original research and scholarly activities section focuses on original clinical and epidemiologic studies and help conduct collaborative research with academic medical centers. The clinical trial section is primarily responsible for the identification and conduct of appropriate multi-centered industry sponsored clinical trials. The quality improvement section conducts studies that help evaluate the extent, severity and impact of a need or problem; assess and compare the effectiveness of various clinical or administrative approaches to resolution; identify areas for educational efforts; set performance goals; and track performance improvements. The basic science section is responsible for Danbury Biomedical Research Program.

There will be no duplication of programs. There will only be one program. The organizational chart for the research Department is shown below. The sections of the Research Department that will be presented in the satellite center at NMH are Clinical Trials and Original Scholarly activities. The activities of those sections and their impact at NMH are further described in the sections below.



Original Research and Scholarly Activities Section

The Original Research section of the Department of Medical Education and Research works with the faculty and staff at Danbury Hospital to design and conduct epidemiologic studies. These studies help to locate where diseases occur in the population to help identify the causes and those at greatest risk. The Original Research Section is also actively involved in Health Services Research which will lead to new approaches to improve performance in the delivery of high quality medical care.

The Original Research section is directing projects in Cardiology, Pulmonary, Gastroenterology, Internal Medicine, Neonatology and Obstetrics and Gynecology.

The original research section also directs educational programs in research methods open to all Danbury Hospital staff, including a Research Seminar co-lead by faculty from the Yale School of Public Health.

We plan to make the support of this valuable infrastructure available to NMH Physicians. Those who are interested in original scholarly activities at NMH could use the support of this section to develop and implement their ideas. The research training conferences will also be made available to the physicians and staff at the NMH via the live audio-video conferencing or internet. The research staff at the satellite center will be in daily contact and communication with physicians and staff at NMH. The Research Department also will maintain an intranet site with all the ongoing research activities in the entire organization and send regular notices for the new initiatives that need a PI or Co-PI as well as potential collaborators.

The Clinical Trials Section

The Danbury Hospital Department of Research established the Clinical Trials section to assist Principal Investigators with the business aspects of clinical research, attract more important research work to the Danbury Health System and to assist the general public and patients in their search for clinical trials information.

This section will work with potential Principal Investigators at NMH to bring in a wide spectrum of clinical trials based on the needs of the target population and availability and experience of the investigators at NMH. The satellite center will also be used for some of the clinical trials that require inpatient monitoring. The section will work with the Cancer Center at NMH to help coordinate their research and create collaborative research projects with the Cancer Center at Danbury Hospital. This will help increase the patient participation at the cancer clinical trials and avoid duplications and waste of resources of the research infra structure that already exists in the two institutions. Like the Original Research and Scholarly Activity section, the Clinical Trial section will maintain an intranet site with all the ongoing Clinical Trials activities in the entire organization and send regular notices for the new initiatives that need a PI or Co-PI as well as potential collaborators.

13. Do the Applicants anticipate cumulative savings from the proposed project? If yes, what are the total and annual savings for the next five FY by cost category?

Response:

	FY2011	FY2012	FY2013	FY2014	FY2015	Total
Salary and Fringe Benefits	$ 797,000	$ 855,000	$ 876,000	$ 893,520	$ 11,390	$4 ,332,910
Supplies and Drugs	$ 1,016,000	$ 1,057,000	$ 1,099,000	$ 1,142,960	$ 1,188,678	$ 5,503,638
	$ 1,813,000	$ 1,912,000	$ 1,975,000	$ 2,036,480	$ 2,100,069	$ 9,836,549

For Salary and Benefits the savings are based on the historic expense combined with an inflationary increase of 2.5% per year and incremental expenses for additional volume. Productivity savings are then taken from the base in the amounts shown in the chart.

Supply and Drug savings are based on the historical expense plus a 4% annual inflation and incremental expenses for additional revenue based on the historical ratio of expense to net revenue. The anticipated savings are estimated based on a review of the purchasing contracts in place at New Milford and Danbury and the improved price point for the New Milford purchases as a combined organization. These savings are based solely on rate and appear to be achievable given Danbury's current purchasing agreements already in place.

14. In FY 09, NMH indicated an income loss from operations of ($5.063 million). In the next four FYs NMH projected without the CON, a gain from operations of $520,000, $339,000, $482,000, and $833,000, respectively. Discuss in detail the action undertaken by NMH that is leading to a gain from operation in FY 2010.

Response:

Response: The actions taken to improve NMH's operating performance in FY2010 were primarily cost reductions that took place in FY2009 that created annualized savings in FY2010 and decisions made during the FY2010 budget cycle that were implemented in the new year. The following are cost reductions in specific categories:

Expense avoidance by freezing Defined benefit pension plan	$2,000,000
Staff salary and administrative reductions	$1,895,000
Closure of Cardiac Cath Lab	$1,304,000
Eliminated bonuses and SERP	$1,219,000
Freezing wages	$1,100,000
Termination of building lease	$ 272,000
Employee recruitment savings	$ 245,000

OB MD not replaced	$ 160,000
Price concessions from vendors	$ 152,000
Reduced FICA (lower salaries)	$ 127,000

Other "actions" included projection of continued outpatient volume growth.

15. On page 2 of the CON Application the Applicants stated that they "intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions." What steps will NEWCO take to prevent future losses at NMH?

Response:

New Milford has been unable to attract admissions and subspecialty care because of a documented shortage of both primary care physicians and sub-specialists. NEWCO will provide increased availability of these specialists to the existing physicians and patients, reducing the need for people to either leave the community or be referred out of the community. As a result of this improved access, the inpatient and outpatient volumes at New Milford Hospital, and the associated revenues, will increase. The NMH medical staff has expressed support for this plan, and initial evidence exists in the cardiology area that the relationship will be successful. For example, following the closure of the cardiac catheterization lab at NMH, DH has received 110 referrals from NMH physicians in FY2010 YTD (Oct – May) versus 51 referrals for the same period in FY2009, a 116% increase. Applicants believe similar results will occur in a wide array of medical/surgical services for specialized care.

From a cost perspective, in addition to the savings identified elsewhere in this completeness response letter, DH will apply its Lean/Six sigma strategies and its Premier benchmarking tool to ensure that staffing to demand occurs. That is, staffing practices that tie patient care needs to the availability of personnel at the right times. These practices have proven to demonstrate where waste in systems occurs and where excess staffing exists. DH also maintains a "best practices" human resources program to ensure stability in the workforce, reducing turnover rates to about half the industry standard.

16. Exhibit 12, beginning on page 314, the presentation of the Financial Attachment 1, please provide the following:

    a. Revised Attachment I's that allocate the projected cost savings previously noted to the appropriate cost categories as opposed to reporting all of the savings in the Other Operating Expense category.

Response:

We believe the Financial attachment I's were correct as reported. All projected cost savings were reported within both NMH and NMH, Inc. as well as the consolidated statements. Cost savings were included in the appropriate categories as follows, not in the Other Operating Income Category:

Savings	FY2011	FY2012	FY2013
Salary and fringe benefits	$ 797,000	$ 855,000	$ 876,000
Supplies and drugs	1,016,000	1,057,000	1,099,000
	1,813,000	**1,912,000**	**1,975,000**

The Law Office of Patricia A. Gerner, LLC
240 Ramstein Road
New Hartford, CT 06057
Phone: (860) 794-1907 Fax: (860) 489-9380

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Facsimile Transmittal

Date: JULY 16, 2010

To: OLGA ARMAH
OFFICE OF HEALTH CARE ACCESS

Fax #: (860) 418-7053

Phone#: (860) 418-7001

From: Pat Gerner

Fax #: (860) 489-9380

Phone #: (860) 794-1907

Number of Pages 2 (including cover)

RE: AFFILIATION OF NEW MILFORD HOSPITAL, INC. AND DANBURY HEALTH SYSTEMS, INC. DOCKET NO. 10-31560-CON.

OLGA,

ATTACHED PLEASE FIND A CORRECTED "PROPOSED ORGANIZATION AFTER AFFILIATION" CHART WHICH APPEARS ON PAGE 84 OF THE CON APPLICATION. IT WAS AN OVERSIGHT TO HAVE LEFT THE NEW MILFORD HOSPITAL FOUNDATION, INC. OUT OF THE CORPORATE CHART AFTER THE AFFILIATION. THE CORRECTED PAGE INCLUDES THE NMH FOUNDATION.

THANK YOU,
PAT GERNER

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Proposed Organization After Affiliation

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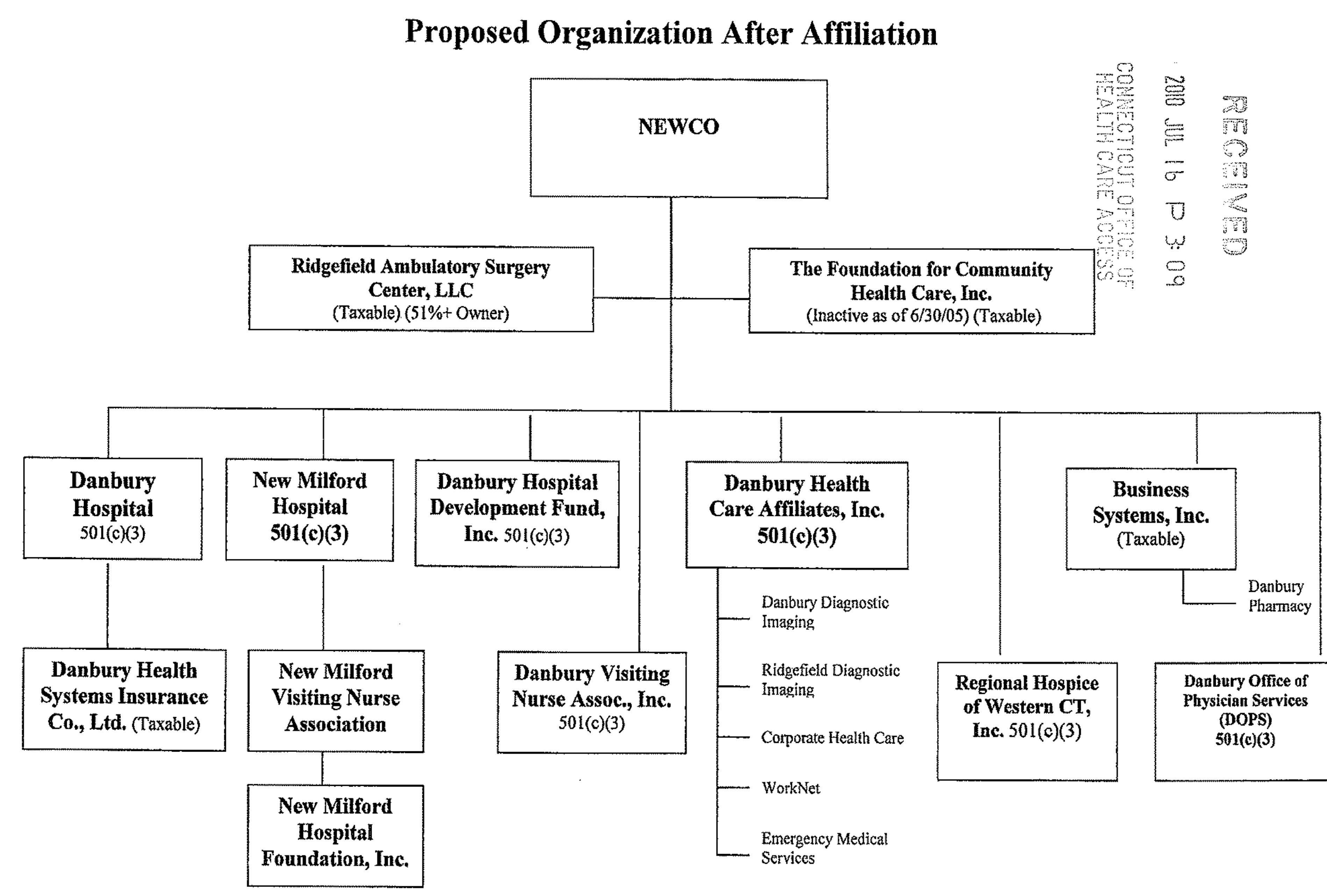
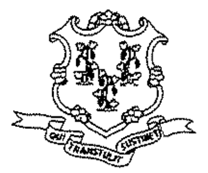




STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

September 23, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:

Danbury Health System, Inc. and New Milford Hospital, Inc.

Notice of Final Decision
Office of Health Care Access
Docket Number: 10-31560-CON

Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

To:

John Murphy
CEO
Danbury Health Systems, Inc.
24 Hospital Avenue
Danbury, CT 06810

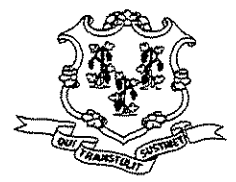
Sally Herlihy
VP, Regulatory Compliance
New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

Dear Mr. Murphy and Ms. Herlihy:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Sections 19a-638, C.G.S. On September 23, 2010, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:pf



Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	**Danbury Health System, Inc. and New Milford Hospital, Inc.**
Docket Number:	**10-31560-CON**
Project Title:	**Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.**

Project Description: Danbury Health System, Inc. ("DHS") and New Milford Hospital, Inc. ("NMH") propose an affiliation, with no associated total capital expenditure.

Nature of Proceedings: On June 30, 2010, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") for the above-referenced project. DHS and NMH (collectively known as the "Applicants") are considered health care facilities pursuant to Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent ("LOI") was published on March 8, 2010 in *The News Times* pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S). OHCA received no responses from the public concerning the Applicants' LOI.

Pursuant to Section 19a-638, C.G.S. three individuals or an individual representing an entity with five or more people had until July 21, 2010, the twenty-first calendar day following the filing of the CON application, to request that OHCA hold a public hearing on the Applicants' proposal. OHCA received no hearing requests from the public by July 21, 2010.

OHCA's authority to review and approve, modify or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of The Danbury Hospital ("DH"), in Danbury. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

2. DH is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury, and is licensed by the Connecticut Department of Public Health for 345 general hospital beds and 26 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

3. NMH is a Connecticut non-stock 501(c)(3) organization, located at 21 Elm Street, New Milford, and is licensed by the Connecticut Department of Public Health for 85 general hospital beds and 10 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

4. On February 8, 2010, DHS and NMH executed an LOI for a Corporate Affiliation confirming their understanding with respect to a proposed affiliation between DHS and NMH whereby DHS will be renamed to reflect the creation of a regional health care system. *(June 9, 2010 Applicants' Initial CON Application, 10-31560-CON Exhibit 8 page 93)*

5. With respect to the proposed affiliation, the Applicants state the following:

   i. Summer 2008 – Senior management and representatives from both Applicants' Boards met to discuss if there was sufficient interest to pursue discussion of a possible affiliation.

   ii. August 17, 2009 – Applicants entered into a Confidentiality Agreement.

   iii. Fall 2009 – Applicants each appointed a Board Affiliation team and jointly engaged a facilitator with a preliminary "due diligence" process, to determine the opportunities to realize through a potential strategic partnership, and met on a monthly basis from October 2009 to January 2010.

   iv. Winter to Spring 2010 – Senior management from both hospitals met with medical and hospital staff to discuss the Letter of Intent for Corporate Affiliate as contemplated. Due diligence was completed and the Letter of Intent between the two parties was approved and signed by both Applicants' Boards on February 15, 2010. Detailed "Phase two due diligence" was conducted by both Applicants.

   v. Spring 2010 – Multiple meetings with constituencies held.

   vi. Spring to Summer 2010 – Definitive Affiliation Agreement was negotiated and approved by each Board and will be signed by Applicants at the completion of the due diligence process to be finalized in summer of 2010. Ongoing dialogue was held with DH and NMH medical staff, employees, volunteers, Board of Directors and community

education regarding the potential affiliation and opportunities to develop a regional health care delivery system and benefits.
(June 9, 2010 Initial CON Application Exhibit 8, pages 12-13)

6. Under the proposed affiliation, DHS will become the sole corporate member of NMH and will change its name from "Danbury Health Systems, Inc." to a name mutually agreeable to both applicants prior to the effective date of the affiliation. The proposed new entity was temporarily named NEWCO for this application. *(June 9, 2010 Initial CON Application Exhibit 8, page 93)*

7. The draft affiliation agreement requires NMH to replace its current four-member board of directors with a "New Milford Community Board" who shall also serve as members of the board of directors of NEWCO with voting rights. *(June 9, 2010 Initial CON Application Exhibit, page 94)*

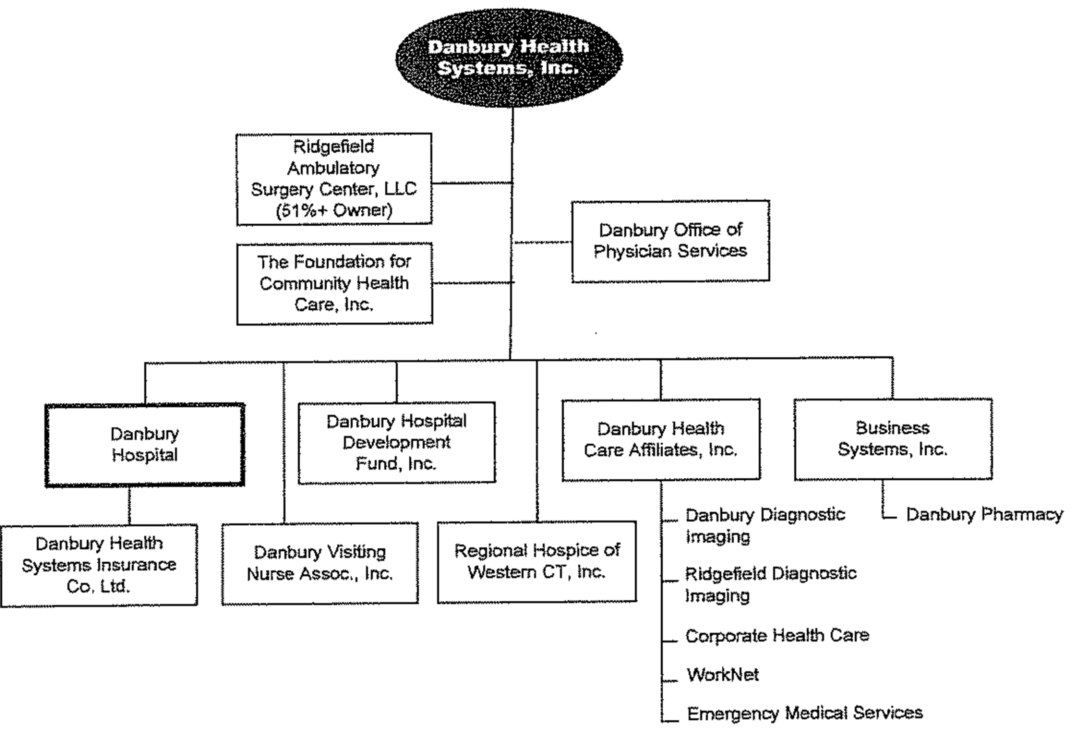
8. The Applicants provided a list of the fifteen (15) members of the board of directors of NEWCO including the four members from NMH's New Milford Community Board and the remaining eleven who are members of the Board of DH. *(June 9, 2010 Initial CON Application Exhibit 7, pages 85 & 91 and June 30, 2010 Completeness Response, page 327)*

9. Upon approval of this proposal by the appropriate regulatory authorities, NMH, DH and its affiliates will become wholly owned/controlled subsidiaries of NEWCO. *(June 9, 2010 Initial CON Application, page 2 and June 30, 2010 Completeness Response, page 327)*

10. NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses. *(June 9, 2010 Initial CON Application, page 2 and Exhibit 6 page 101)*

11. The organizational chart of DHS and its affiliates prior to the proposed affiliation with NMH is as follows:

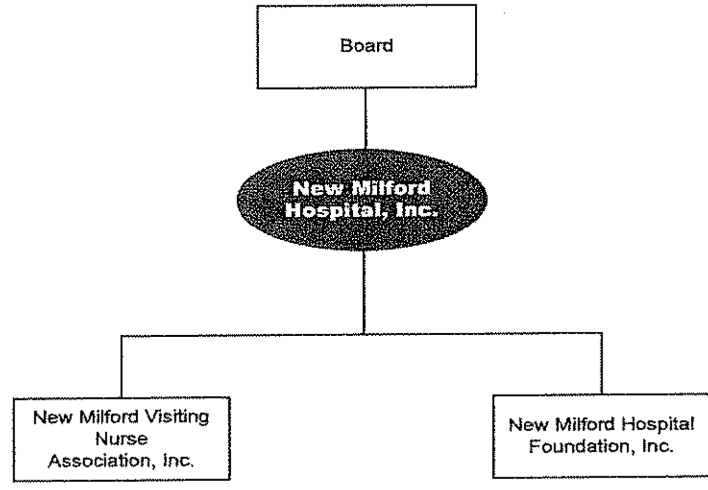
Chart One: DHS Organizational Chart Prior to the Proposed Affiliation



(*June 9, 2010 Initial CON Application Exhibit 6*)

12. The organizational chart of NMH and its affiliates prior to the proposed affiliation with DHS is as follows:

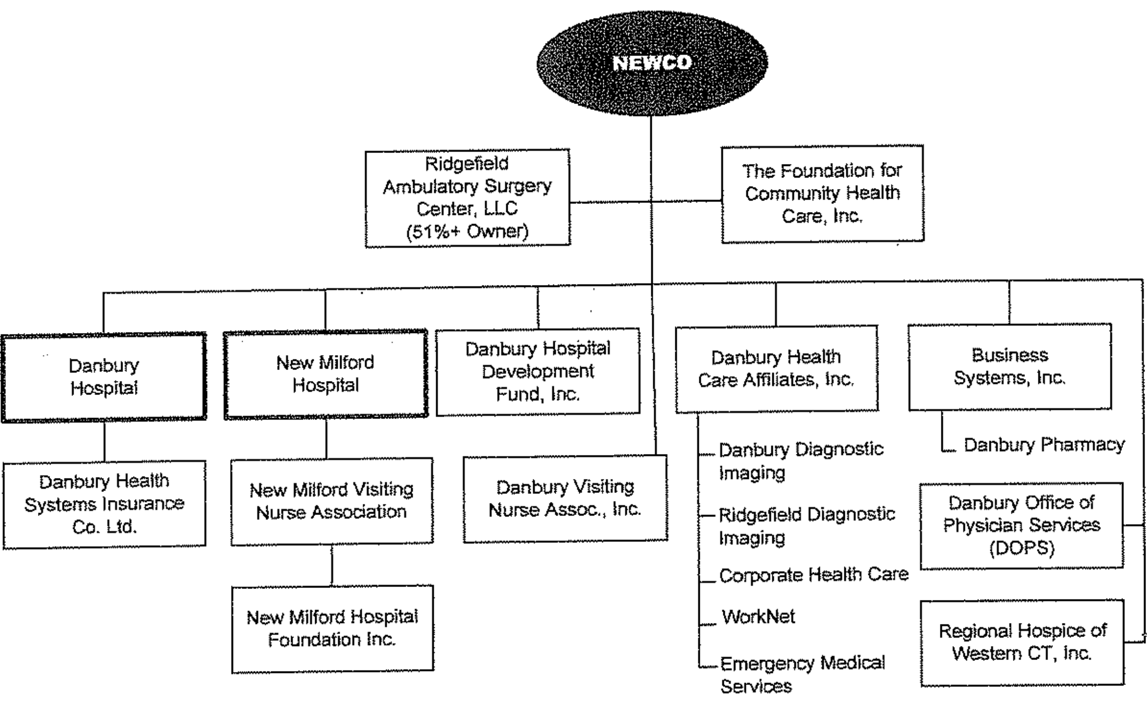
Chart Two: NMH Organizational Chart Prior to the Proposed Affiliation



(*June 9, 2010 Initial CON Application Exhibit 6*)

13. The proposed organizational chart of NEWCO and its affiliates after the proposed affiliation is as follows:

Chart Three: NEWCO Organizational Chart After the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

14. DHS has pursued a strategic plan to establish DH as a regional medical center, providing selected tertiary services to an ever greater number of people from a growing, broader geographic region. To that end, DHS has developed an operationally integrated health care delivery system comprised of health care entities that coordinate service along the health care continuum, enabling patients to receive care in the most appropriate systems. *(June 9, 2010, Initial CON Application, page 4)*

15. DH conducted an assessment of its service area during the strategic planning process, which established a direction for considering a relationship with other providers to engage in a more regional planning effort and to provide a more complete continuum of services. *(June 9, 2010, Initial CON Application, page 4)*

16. Following the closure of NMH's emergency angioplasty service, DH assisted in the transition and it became clear that both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. *(June 9, 2010, Initial CON Application, page 4)*

17. DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. *(June 9, 2010, Initial CON Application, page 5)*

18. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. *(June 9, 2010, Initial CON Application, pages 5, 93)*

19. DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. *(June 9, 2010 Initial CON Application, page 93)*

20. NMH expects that upon approval of this proposal, it will be well positioned to meet the challenges and demands of the health care industry, while remaining strong enough to sustain its commitment to offering access to high quality service to the communities it serves. *(June 9, 2010, Initial CON Application, page 5)*

21. NMH considered the following factors in its decision to pursue an affiliation with DHS:

    - Access to significant capital to maintain state-of-the-art treatment facilities as its physical plant and infrastructure ages and as it pursues replacement and expansion of its IT and telecommunications systems;
    - Access to the latest in diagnostic and therapeutic technologies, such as robotic surgery and the latest in genomic therapies:
    - Access to primary care and specialty services;
    - Physician recruitment/cross-coverage arrangements;
    - Quality improvement efforts;
    - Maximizing efficiencies and controlling costs; and
    - Investing in workforce development, retaining talent and attracting others to the institution to minimize vacancies.

    (June 9, 2010 Initial CON Application, pages 5-10)

22. The primary service area ("PSA") of DH is as follows:

Table 5: DH's Primary Service Area

PSA	Bethel
	Brookfield
	Danbury
	New Fairfield
	Newtown
	Redding
	Ridgefield

(June 9, 2010, Initial CON Application, page 15)

23. Based on inpatient discharges, OHCA finds that the towns of Danbury, Newtown, Bethel, Ridgefield, Brookfield, New Fairfield and Redding comprise 74% of DH's discharged patients.

Table 6: DH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
Danbury	39%	39%	93%
Newtown	8%	47%	72%
Bethel	8%	55%	90%
Ridgefield	7%	62%	77%
Brookfield	5%	67%	83%
New Fairfield	4%	72%	89%
Redding	2%	74%	59%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

24. NMH's primary service area ("PSA") is as follows:

Table 1: NMH's Primary Service Area

PSA	New Milford
	Kent
	Washington
	Brookfield
	Sherman
	Bridgewater
	Roxbury
	Warren

(June 9, 2010, Initial CON Application, page 17)

25. Based on inpatient discharges, OHCA finds that the towns of New Milford, Kent, Washington, Brookfield, Sherman, Bridgewater, Roxbury, Cornwall and Warren comprise 73% of NMH's discharged patients.

Table 2: NMH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
New Milford	49%	49%	52%
Kent	7%	56%	53%
Washington	5%	61%	52%
Brookfield	3%	64%	6%
Sherman	3%	67%	35%
Bridgewater	2%	69%	35%
Roxbury	2%	71%	35%
Cornwall+Warren	2%	73%	22%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

26. No changes in licensing of either hospital or affiliated home care agencies will result from this proposal. The Applicants intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions. *(June 9, 2010, Initial CON Application, page 2)*

27. Upon approval of the proposal, DH will serve as the primary provider of tertiary level inpatient and outpatient care to the Western CT region providing the following services:

Inpatient Services	Ancillary Services	Physician Services
Intensive & cardiovascular care Units	Level II Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
Adult & pediatric medical/surgical Units	Surgical services	
Obstetrical unit with NICU	Medical imaging	
High acuity rehabilitation Unit	Praxair Regional Heart and Vascular Center	
Behavioral health/psychiatry	Praxair Cancer Center	
	Center for Advanced Orthopedic & Spine Care	
	Women's and children's service	
	System-wide reference lab	

(June 9, 2010, Initial CON Application, page 3)

28. The following table illustrates the historical utilization by service category for DH:

Table 9: DH's Historical Utilization by Service Category

DH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	67,929	67,553	69,582	71,098
Ambulatory Surgery	13,092	12,277	11,668	11,204
Observation Patients	1,257	2,632	2,868	2,983
Extended Stay	-	-	-	504
Admissions				
Medical/ Surgical	14,420	14,486	14,894	14,916
Maternity	2,502	2,379	2,248	2,208
Newborn	2,272	2,127	1,956	1,944
Psychiatric	812	794	769	711
Pediatric	419	342	329	333
Rehabilitation	377	337	303	315
Total Admissions	**20,802**	**20,465**	**20,499**	**20,427**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12) (*June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)*

29. Inpatient discharges decreased from FY2008 through FY2010, from a significant shift in patients to an observation status and in FY2010, to extended stays.[1]

[1] Centers of Medicare and Medicaid Services and third party payers in seeking to eliminate unnecessary inpatient care allow "observation programs" for patients with selected medical conditions.

30. The following table represents the projected utilization by service category for DH:

Table 10: DH's Projected Utilization by Service Category

DH	FY 2011	FY 2012	FY 2013
ED visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411
Observation Patients	3,072	3,164	3,228
Extended Stay	554	610	653
Admissions			
Medical/ Surgical	15,217	15,437	15,656
Maternity	2,289	2,312	2,335
Newborn	1,947	1,967	1,986
Psychiatric	752	760	768
Pediatric	351	355	360
Rehabilitation	321	324	328
Total Admissions	**20,877**	**21,156**	**21,433**

Note: The Applicants made the following assumptions with respect to DH volumes as illustrated above:

i. Newborn, maternity, psychiatric and rehabilitation discharges will increase annually by 1%.
ii. Overall inpatient growth is attributed to growth in programs and services as well as a changing population.

(June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)

31. The Applicants expect inpatient medical/surgical and pediatrics discharges to grow 1.4% annually from a reduction in outmigration of medical/surgical cases through the affiliation. Approximately 80% of the increase is related to tertiary services as a result of lower outmigration or through improved access to primary care physicians and specialists in the NMH service area. *(June 30, 2010, Completeness Responses, page 333- 334)*

32. The Applicants anticipate that the majority of the transfers from NMH as well as other patients served by the added primary care physicians and specialists seeing patients in New Milford area will comprise the largest component of the projected inpatient volume increase. These assumptions are based on discussions with the NMH medical staff and early evidence of success in the field of cardiology. *(June 30, 2010, Completeness Responses, page 333)*

33. Following the closure of the NMH cardiac catheterization lab, DH has received 110 referrals from NMH physicians in FY 2010 YTD versus 51 referrals for the same time period in FY2009 – a 116% increase. *(June 30, 2010, Completeness questions, page 340)*

34. NMH will continue to provide the following inpatient and outpatient services to its service area:

Inpatient Services	Ancillary Services	Physician Services
Adult & pediatric medical/surgical unit ICU/stepdown/acuity adaptable unit Family birthing center Low acuity rehabilitation (pending space)	24-hour Emergency Department Surgical services Medical imaging Cardiovascular screening/diagnostics and clinics Regional Cancer Center OP Neurodiagnostics and other specialty clinics Expanded women's health and wellness programs Phase 1 Research Center office	Distributed locations of primary and specialty physicians (DOPS and independent)

(June 9, 2010, Initial CON Application, page 3)

35. The following table illustrates the historical utilization by service category for NMH:

Table 3: NMH's Historical Utilization by Service Category

NMH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	19,309	19,553	19,146	19,173
Ambulatory Surgery	2,414	2,335	2,461	2,787
Observation Patients	333	384	567	520
Admissions				
Newborn	294	342	296	264
Maternity	306	341	300	266
Psychiatric	-	-	-	-
Pediatric	68	58	47	15
Medical/Surgical	2,178	2,292	2,131	1,983
Rehabilitation	-	-	-	-
Total Admissions	**2,845**	**3,033**	**2,774**	**2,528**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12). *(June 9, 2010, Initial Con Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)*

36. Inpatient discharges decreased from FY2008 through FY2010, from a recent loss of market share and a significant shift in patients to an observation status.

37. The following table illustrates the projected utilization by service category for NMH:

Table 4: NMH's Projected Utilization by Service Category

NMH	FY 2011	FY 2012	FY 2013
ED visits	19,273	19,418	19,571
Ambulatory Surgery	2,704	2,732	2,761
Observation Patients	522	524	527
Admissions			
Newborn	250	248	246
Maternity	250	248	246
Psychiatric	-	-	-
Pediatric	24	24	24
Medical/Surgical	2,037	2,052	2,070
Rehabilitation	-	-	-
Total Admissions	**2,561**	**2,572**	**2,586**

Note: The Applicants made the following assumptions with respect to NMH volumes as illustrated above:

i. Inpatient medical discharges are expected to grow 0.9% to 1.0% annually and surgical at 0.4% to 0.5% from FY 2011.

ii. Inpatient Ob/Gyn discharges will grow annually at 0.8% while pediatrics volume will remain unchanged over the next three years.

ii. Newborn, maternity, psychiatric and rehabilitation discharges will remain unchanged over the next three years.

iv. Outpatient services will increase annually by 0.4% to 1.1%.

(June 9, 2010, Initial CON Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)

38. The incremental volumes attributable to the project are based upon a 1% growth in market share through reductions in out-migration from the affiliation. *(June 9, 2010, Initial CON Application, page 20)*

39. Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. *(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)*

40. Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Together, the two hospitals provided inpatient care to 81% of the discharges from the PSA; no other individual hospital accounts for more than 4% of acute care inpatient services to the area. The two PSAs are adjacent to each other with the town of Brookfield as the only overlapping town between the two.

Table 8: Significant Providers of Inpatient Services in New Milford Primary Service Area, FY 2009

	New Milford	Danbury	Sharon	Yale	Hartford	All Other*	Total
Percentage of NMH PSA	37%	44%	4%	4%	2%	9%	100%
% of Hospital Total	73%	12%	7%	0.4%	0.3%	0.2%	1%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

41. Excluding psychiatric referrals, in 2008, 196 patients were transferred from NMH PSA to other tertiary level providers.

Table 7: Number of Transfers from New Milford Hospital's Primary Service Area to Other Tertiary Providers, 2008

Connecticut Children's Medical Center	2
John Dempsey Hospital	2
Bridgeport Hospital	4
Waterbury Hospital	6
St. Francis Medical Center	9
Hospital of St. Raphael	10
Other Connecticut Hospitals	15
Other NY Hospitals	35
Hartford Hospital	36
NY Presbyterian	36
Yale-New Haven Hospital	41
Total	**196**

(June 30, 2010, Completeness Reponses, page 333)

42. Further, based on hospital inpatient discharge data, OHCA finds that compared to NMH, DH provides a higher percentage of specialty care including cardiac, neurological, women's health, general/other surgery, behavioral health and trauma care to NMH PSA residents.

Table 11: Providers of Inpatient Services to NMH Primary Service Area Residents, FY 2009

Service line	New Milford	Danbury	Sharon	Yale	Hartford	Other*	Total
Cardiac Care	38%	**42%**	3%	4%	5%	8%	100%
Cancer Care	32%	37%	3%	15%	3%	11%	100%
Neurological	32%	**47%**	5%	4%	3%	8%	100%
Renal or Urology	38%	38%	3%	5%	6%	10%	100%
Women's Health	40%	**50%**	2%	2%	1%	6%	100%
Orthopedics	42%	41%	3%	3%	1%	10%	100%
Respiratory	61%	30%	4%	1%	0%	3%	100%
Medicine	44%	42%	3%	4%	1%	6%	100%
General/other surgery	35%	**45%**	2%	8%	2%	7%	100%
Newborn	40%	52%	2%	1%	0%	5%	100%
Psychiatry	1%	**59%**	9%	2%	3%	26%	100%
Ophthalmology	40%	33%	0%	13%	0%	13%	100%
Trauma	19%	**47%**	3%	6%	10%	16%	100%
Dental	0%	25%	0%	50%	0%	25%	100%
Substance Abuse	15%	**35%**	25%	1%	0%	22%	100%
PSA Total	**39%**	**44%**	**3%**	**4%**	**2%**	**8%**	**100%**

(Office of Health Care Access' Connecticut Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

43. Based upon the foregoing data, OHCA finds that NMH has experienced significant out-migration in recent years and DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Additionally, DH provided a higher level of specialty care to NMH PSA residents.

44. In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. Therefore, increased availability of primary physicians will be beneficial to residents of the area.

Table 12: Percent of Primary Care Sensitive Preventable Hospitalizations[2] at NMH and DH, 2006-2008

Hospital	2006	2007	2008
New Milford	14%	12%	12%
Danbury	10%	10%	11%
CT	**12%**	**12%**	**11%**

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

45. NMH indicates, consistent with the above data in Findings 34 through 40, that one of the challenges it faces is a physician shortage in primary care and specialties. *(June 9, 2010, Initial CON Application, page 6)*

46. NMH has identified key specialties in which a need exists, such as endocrinology, neurology and selected surgical subspecialties. *(June 9, 2010, Initial CON Application, page 8)*

47. NMH has been unable to attract admissions and subspecialty care because of a documented shortage of both primary care physicians and sub-specialists. NEWCO will provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. *(June 30, 2010, Completeness questions, page 340)*

48. DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. *(June 9, 2010, Initial CON Application, page 8)*

49. DHS also houses Danbury Office of Physician Services ("DOPS"), a multispecialty faculty practice plan whose mission is to support DH in its objective of meeting the needs of all patients, including the underserved. DOPS has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. *(June 9, 2010, Initial CON Application, page 8)*

50. Another challenge for NMH is the growing need to address and upgrade the physical, clinical and technological infrastructure to meet community need. *(June 9, 2010, Initial CON Application, page 6)*

[2] OHCA utilized the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) software to identify preventable hospitalizations. AHRQ defines preventable hospitalizations as instances of inpatient hospital care for health conditions or illnesses typically treated or managed in outpatient settings. See http://www.ct.gov/ohca/lib/ohca/publications/2010/prev_hosp_report01-2010.pdf for more details.

51. An example of the larger capital expenses are: (a) information technology to support legacy systems as well as clinical applications; (b) implementation of an electronic medical record and other advanced clinical technologies designed to improve care, quality and efficiency; (c) enhanced PACS and voice dictation systems; (d) renovation and upgrades to patient care units; (e) facility improvements such as upgrading mechanicals and introducing green technologies; and (f) general plant maintenance associated with an aging facility. *(June 9, 2010, Initial CON Application page 7)*

52. Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. *(June 9, 2010, Initial CON Application, page 30)*

53. DHS currently operates an electronic health information exchange called HealthLink, which enables the hospital to link to other providers through a web-based architecture. NMH will obtain access to the IT expertise and systems currently in place at DH, accelerating its adoption of an EMR and creating seamless information access and connectivity among all entities for optimal clinical quality and operational efficiency. *(June 9, 2010, Initial CON Application, page 30)*

54. DH is engaged in various research initiatives, from basic science to translational research. DH Research Department provides infrastructure and coordinates all of the research and scholarly activities for the entire institution. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

55. In order to integrate the existing and future research and scholarly activities of NMH into the Department research activities and provide a seamless collaboration and coordination of the research efforts, DH will extend its research capabilities by developing a satellite research center at NMH. In addition, the programs at DH will be made available to NMH physicians and patients creating opportunities for greater involvement and collaboration. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

56. OHCA finds that both NMH's ability to recruit and retain high quality physicians will be enhanced through this affiliation due to greater access to technology and clinical research opportunities.

57. There is no capital cost associated with this proposal. *(June 9, 2010, Initial CON Application, page 24)*.

58. There will be no change in billing as a result of this proposal. *(June 9, 2010, Initial CON Application, page 26)*.

59. There will be no changes to existing reimbursement contracts between the Applicants and the payers. *(June 9, 2010, Initial CON Application, page 26)*.

60. This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of

approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. *(June 9, 2010, Initial CON Application, page 27).*

61. The proposed 2% (or $2,558,000) potential savings to NMH will be in two cost categories over the first three years of the affiliation. One category of potential cost savings is "salaries and benefits" through a reduction of eight (8) FTEs per year over three years in the back office area from retirements and elimination of management positions and normal attrition. The second area is "supplies and drugs."

Table 13: Potential Cost Savings for NMH

	FY 2011	FY 2012	FY 2013	3-YR TOTAL COST SAVINGS
Salaries & Benefits	$797,000	$855,000	$876,000	**$2,528,000**
Supplies & Drugs	$1,016,000	$1,057,000	$1,099,000	**$3,172,000**
Total	**$1,813,000**	**$1,912,000**	**$1,975,000**	**$5,700,000**

(June 30, 2010, Completeness Responses, pages 334-335)

62. The Applicants plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. *(June 9, 2010, Initial CON Application, page 27).*

63. The Applicants will also consider centralizing certain clinical functions, such as clinical laboratory and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. *(June 9, 2010, Initial CON Application, page 26).*

64. There are no plans to implement savings associated with the reduction, elimination, or combination of any clinical services in the short term. *(June 30, 2010, Completeness Responses, page 334).*

65. The cost efficiencies to be realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH. *(June 9, 2010, Initial CON Application, page 7).*

66. The potential bond rating of NEWCO would support an "A" rating and the strategic value of affiliating with another hospital would at least equal any dilutive financial impact in the short term. *(June 30, 2010, Completeness Responses, page 336)*

67. NMH's credit worthiness will be enhanced by the affiliation in that NMH will benefit from the guarantee of NEWCO, an organization whose numbers would support an "A" rating, which is better than NMH would be able to achieve on its own. *(June 30, 2010, Completeness Responses, page 336)*

68. The Applicants intend to improve productivity and contain costs by developing economies of scale in operations, establishing evidence-based quality decisions on services and care protocols, and developing an integrated plan that allows both organizations to address the needs in the greater region without the unnecessary duplication in services that has characterized the past. *(June 9, 2010, Initial CON Application, page 30).*

69. The projected incremental revenue from operations, total operating expense and gains from operations associated with the proposal are presented in the table below for the first three years with the proposed project:

Table 14: Combined Danbury and New Milford Hospital Financial Projections

Description	FY 2011	FY 2012	FY 2013
Incremental Revenue from Operations	$2,039,000	$2,820,000	$3,689,000
Incremental Total Operating Expense	($407,000)	($161,000)	$151,000
Incremental Gain from Operations	**$2,447,000**	**$2,981,000**	**$3,538,000**

(June 9, 2010, Initial CON Application, Financial Attachment I, page 320)

70. This proposal will also improve revenue through increased inpatient and outpatient volumes at NMH. *(June 30, 2010, Completeness Responses, page 336)*

71. DH's patient population mix is based on the FY 2010 budget, with no change in mix anticipated or projected. DH's current patient population mix and projected population mix with the CON proposal is as follows:

Table 15: Current and Three-Year Projected Population Mix with the CON Proposal

Danbury Hospital	Current FY Payer Mix	2011 Projected Payer Mix	2012 Projected Payer Mix	2013 Projected Payer Mix
Medicare	32.2%	32.2%	32.2%	32.2%
Medicaid	14.5%	14.5%	14.5%	14.5%
TRICARE and CHAMPUS	0.0%	0.0%	0.0%	0.0%
Total Government	**46.7%**	**46.7%**	**46.7%**	**46.7%**
Commercial Insurers	46.3%	46.3%	46.3%	46.3%
Uninsured	6.5%	6.5%	6.5%	6.5%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	**53.3%**	**53.3%**	**53.3%**	**53.3%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

(June 9, 2010, Initial CON Application, page 25)

72. NMH's patient mix is based on the FY 2010 budget, with no change in mix anticipated or projected. NMH's current population mix and projected population mix with the CON proposal is as follows:

Table 16: Current and Three-Year Projected Population Mix with the CON Proposal

New Milford Hospital	**Current FY Payer Mix**	**2011 Projected Payer Mix**	**2012 Projected Payer Mix**	**2013 Projected Payer Mix**
Medicare	45.8%	45.8%	45.8%	45.8%
Medicaid (includes other medical assistance)	10.0%	10.0%	10.0%	10.0%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	**55.9%**	**55.9%**	**55.9%**	**55.9%**
Commercial Insurers*	40.6%	40.6%	40.6%	40.6%
Uninsured	2.8%	2.8%	2.8%	2.8%
Workers Compensation	0.7%	0.7%	0.7%	0.7%
Total Non-Government	**44.1%**	**44.1%**	**44.1%**	**44.1%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

(June 9, 2010, Initial CON Application, page 25)

73. The Applicants provided resumes of its executive leadership team associated with this proposal demonstrating that they have sufficient managerial and financial experience in managing health care organizations to provide efficient and adequate service to the public. *(June 9, 2010, Initial CON Application, page 118)*

Rationale

OHCA approaches community and regional need for CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of DH in Danbury. NMH is a Connecticut non-stock 501 (c)(3) organization, located at 21 Elm Street, New Milford. DHS and NMH propose an affiliation, with no associated total capital expenditure. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. (Finding of Fact 18) DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. (Finding of Fact 19) The proposed affiliation is also intended to help strengthen access to capital, generate cost savings and leverage recruitment and retention of high quality physicians.

While DH views the affiliation as an opportunity to engage in a more regional planning effort and to provide a more complete continuum of services both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. (Findings of Fact 15-16) Additionally, DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. (Finding of Fact 17)

NMH also considered its need for access to significant capital to maintain state-of-the-art treatment facilities; access to the latest in diagnostic and therapeutic technologies; access to primary care and specialty services; physician recruitment/cross-coverage arrangements; quality improvement efforts; and maximizing efficiencies and controlling costs. (Finding of Fact 21) Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. (Finding of Fact 52) Additionally, NMH will now have access to DH's research capabilities as DH will establish a satellite research center at NMH and physicians and patients from NMH will be able to attend programs offered at DH. (Findings of Fact 54-55)

The affiliation will also provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. (Finding of Fact 47) DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. (Finding of Fact 48) DHS also houses DOPS, which has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. (Finding of Fact 49) Not only will NMH benefit from an increase in primary care physicians and specialists in the NMH service area, but DH also expects a modest increase in

inpatient utilization based upon the increases in referrals to DH's cardiac catheterization lab in 2010 following the closure of NMH's cardiac catheterization lab.

Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. (Finding of Fact 39) Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. (Finding of Fact 40) In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. (Finding of Fact 44) Specifically, 14% of NMH's hospitalizations were considered preventable compared to 12% for the state. (Finding of Fact 44) Thus, OHCA finds the ED utilization rate for NMH is higher than the statewide average. OHCA is concerned about the use of the ED for health care services that can be delivered in the community setting at a lower cost to the patient and the hospital. Accordingly, OHCA finds that proposed affiliation will improve the quality, accessibility and cost effectiveness of health care delivery in the region by increasing access to primary care and specialty physicians in the NMH service area.

This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. (Finding of Fact 60) The Applicants also plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. (Finding of Fact 62) The Applicants will also consider centralizing certain clinical functions, such as the clinical laboratories and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. (Finding of Fact 63) Additionally, the integrated IT system and EMR will provide significant cost savings for NMH. (Finding of Fact 52) The Applicants project operational gains of $2,447,000, $2,981,000 and $3,538,000 in the first three years of the proposal. (Finding of Fact 69) OHCA finds the financial projections and volumes upon which they are based appear to be reasonable and achievable. Accordingly, OHCA concludes that the proposal is financially feasible.

Based upon all of the foregoing, OHCA finds that the proposed affiliation will allow better access to capital and technology and will provide cost efficiencies for both Applicants to create a stronger health care system. Shared best practices, an integrated IT system and the ability to recruit and retain top-level physicians will enhance the Applicants' ability to respond to new federal health care reform initiatives that require health care providers to re-align all aspects of the delivery system and better coordinate those services around the patients' needs. In the absence of an affiliation with a larger tertiary hospital, NMH would probably find it difficult to meet future requirements and financial challenges. Accordingly, OHCA concludes that this proposal will create a larger and financially stronger health care delivery system that will better address these demands and continue to provide access to quality health care in the Applicants' service area.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Danbury Health System, Inc. and New Milford Hospital, Inc. for an affiliation, with no associated capital expenditure, is hereby **Approved,** subject to the following conditions:

1. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA, a full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of DHS and NMH has occurred.

2. If, in the future, there is any change in the ownership structure of DHS, NMH or its affiliates or any change in the affiliation agreement, the Applicants shall file a CON Determination Form with OHCA.

3. If, in the future, there is any change in NMH or NEWCO service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.

4. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA a comprehensive plan that includes the following:

   (i) The locations of current primary care providers in the NEWCO service area;

   (ii) A discussion of how the Applicants will recruit primary care physicians and specialists in the NEWCO service area;

   (iii) A discussion of how the Applicants will specifically address the need for additional primary care in the NEWCO service area, including, but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and

   (iv) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.

5. The Applicants shall schedule a meeting with OHCA to occur within 30 calendar days of the filing of the comprehensive plan to discuss the Applicants' provision of findings pursuant to Condition #4.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the

September 23, 2010
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner
Office of Health Care Access

** Transmit Conf. Report **

Sep 23 2010 8:47

Line Number:1 COMMISSIONER'S OFFICE Fax:8605097111

Fax/Phone Number	Mode	Start	Time	Page	Result	Note
912037398751	NORMAL	23, 8:47	7'26"	24	* O K	

410 Capitol Avenue, Hartford, CT 06106
• 860-509-7101
• 860-509-7111 Fax

State of Connecticut Department of Public Health

To: Dr. John Murphy, CEO From: Dr. Norma Gyle

Fax: 203-739-8751 Pages: 24

Phone: Date: 9/23/10

Re: CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Greer, Leslie

From: Herlihy, Sally <Sally.Herlihy@danhosp.org>
Sent: Tuesday, November 23, 2010 2:47 PM
To: Greer, Leslie
Subject: Western Connecticut Healthcare
Attachments: CON Affiliation Approval - Follow-up Reporting 11 22 10.pdf

Hi Leslie,
Please find attached a PDF of the correspondence from Western Connecticut Healthcare for Docket Number 10-31560-CON. The hard copy will follow by mail.
If you have any questions please do not hesitate to contact me.
Thank you for your assistance.
Sincerely,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning

24 Hospital Avenue, Danbury, CT 06810
Voice: (203) 739-4903
Fax: (203) 739-1974
Email: sally.herlihy@danhosp.org

New Milford Hospital

Western Connecticut Healthcare

Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810
(203) 739-7000
DanburyHospital.org

New Milford Hospital
21 Elm Street
New Milford, CT 06776
(860) 355-2611
NewMilfordHospital.org

Learn More About Western Connecticut Healthcare

A Video Message from John Murphy, M.D. | Western Connecticut Healthcare and its Subsidiaries

This transmittal is intended for a particular addressee(s). If it is not clear that you are the intended recipient, you are hereby notified that you have received this transmittal in error; any review, copying or distribution or dissemination is strictly prohibited. If you suspect that you have received this transmittal in error, please notify Danbury Health Systems immediately by email reply to the sender, and delete the transmittal and any attachments.

READER BEWARE: Internet e-mail is inherently insecure and occasionally unreliable. Please contact the sender if you wish to arrange for secure communication or to verify the contents of this message.

Western Connecticut Healthcare

RECEIVED
2010 NOV 23 P 3:58
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

November 22, 2010

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue MS # 13HCA
Hartford, CT 06134-0308

Re: **Docket Number 10-31560-CON**
Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Dear Ms. Martone:

This correspondence is a written response per the final decision executed on September 23, 2010 regarding approval for the affiliation of our two organizations – Danbury Health System, Inc. and New Milford Hospital, Inc. Specifically, conditions #1 and #4 of the Order request that information be filed with your office within 60 days of the completion of the affiliation. In addition, as stated in condition #5, we will be in contact with your office to schedule a meeting within 30 calendar days following the filing of this response to review provisions of findings pursuant to condition #4.

Should you have any questions please do not hesitate to contact me directly at 203-794-4903, or sally.herlihy@danhosp.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Healthcare

cc: Enclosure

Western Connecticut Healthcare

November 22, 2010

RECEIVED
2010 DEC -3 A 11:48
CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue MS # 13HCA
Hartford, CT 06134-0308

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Sincerely,

Sally F. Herlihy

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Healthcare

cc: Enclosure

Condition #1

Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA, full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of DHS and NMH has occurred.

RESPONSE:

A new corporate entity called Western Connecticut Healthcare (WCH) was formalized October 1, 2010, following OHCA approval received on September 23, 2010. Enclosed are the following:

Attachment I - The executed Affiliation Agreement

Attachment II - Certificate of Amendment for Danbury Health Systems, Inc. and New Milford Hospital, Inc.

Attachment III - Revised Bylaws for Danbury Health Systems, Inc. and New Milford Hospital, Inc.

Condition #4

Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA a comprehensive plan that includes the following:

- **(i) The location of current primary care providers in the NEWCO service area;**
- **(ii) A discussion of how the Applicants will recruit primary care physicians and specialists in the NEWCO service area;**
- **(iii) A discussion of how the Applicants will specifically address the need for additional primary care in the NEWCO service area, including but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and**
- **(iv) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.**

RESPONSE:

There are a total of 63 primary care practices representing 145 providers on the medical staff rosters of Danbury Hospital (DH) and New Milford Hospital (NMH) in the WCH service area. These physicians and their locations are identified and provided as follows:

Attachment IV – map with geographic distribution of primary care office locations

Attachment V – list of primary care physicians, addresses and hospital affiliation

The WCH physician alignment strategy is a multifaceted approach toward enhancing access to primary care service and subspecialty care that includes the following:

Physician employment – DH has invested in a physician network and practice management infrastructure in Danbury Office of Physician Services (DOPS). Physicians from the NMH medical staff have potential opportunities for employment and integration with this multi-specialty group practice. This offers a desirable option for physicians interested in employment, contributes to the delivery of effective care, and facilitates a common electronic medical record platform for exchange of patient information.

Increasing the number of providers across the service area – Recruitment is ongoing to achieve primary care alignment and growth through the addition of 40 new or aligned primary care physicians by 2015, including expansion in underserved markets and succession planning for physicians approaching retirement. In 2010, six primary care physicians joined four separate DOPS office locations in the WCH service area. Recruitment will continue at this pace for the next several years as needs are identified and appropriate candidates selected. A Family Physician has recently opened a new solo practice in Danbury and independent community physicians have expressed plans to recruit additional physicians to their practices in the service area.

Development of a Patient Centered Medical Home (PCMH) model of care – The PCMH focuses on changing the way medical care is delivered with coordination and partnership in managing patient health. It is an enhanced primary-care model that provides comprehensive and timely care and emphasizes teamwork by providers and engagement by those receiving the care. Principles of care include an ongoing relationship with a personal physician, collective responsibility for ongoing needs, coordination and integration of care across the health care system and patient's community, enhanced access, and delivery of quality and safe services. DOPS has the infrastructure to support this coordinated care model and efforts include:

- Two medical home pilots have been initiated in the Southbury and Brookfield, CT locations which have both achieved Level I designation (efforts in place to move to Level III designation in 2011) by the National Committee for Quality Assurance (NCQA). These are the first practices to receive such designation in the state of Connecticut.
- Additional DOPS primary care practices are targeted to achieve Level III designation during 2011 and once established, outreach efforts will be extended to assisting any independent physicians in developing this model in their practices.

- Achievement of Level I designation for DH's Seifert and Ford Medical Clinic located in Danbury during 2011.
- DH will have the first primary care residency program completely integrated into a PCMH and through partnership with the FQHC will help them move toward PCMH designation.

Training new providers and retention within the market – The Department of Medicine at DH offers a three-year medical residency program that includes a primary care track. It includes comprehensive preparation for the practice of general internal medicine. Previous graduates have stayed in the area and are on the staff at Danbury Hospital. Two current Chief Residents have been offered opportunities to join practices in 2011 (located in Brewster, NY and Southbury, CT) and an additional graduate has expressed interest in remaining in the greater Danbury area as a primary care physician.

DH is the recipient of two grants totaling $4.5 million that support the expansion and access to primary care physicians:

<table>
<tr><th>Grant</th><th>Description</th><th>Goal</th><th>Award</th><th>Term</th></tr>
<tr><td rowspan="2">Health Resources and Services Administration in the U.S Department of Health and Human Services under the Affordable Care Act</td><td>Innovative primary care residency program*</td><td>Focus on the patient-centered medical home and encourage primary care physicians to care for the underserved</td><td>$1.2 M</td><td rowspan="2">5-years: 2010 - 2015</td></tr>
<tr><td>Three-year medical residency program primary care track</td><td>Increase the number of medical residents who seek a career in primary care medicine (18 candidates with six graduating each year)</td><td>$3.3 M</td></tr>
</table>

* As part of the grant Danbury Hospital is partnering with the Greater Danbury Community Health Center, a federally funded community health center (FQHC) that provides medical services to people who lack health insurance and have limited financial resources. Primary care physicians training at Danbury Hospital will work at the Center during their final year.

Expanded coverage of specialty physicians within the New Milford service area – Where unfilled subspecialty recruitment need exists for NMH there is a concerted effort to help provide coverage for inpatient medicine. Currently Pulmonary Medicine specialists are available on-site at NMH Monday-Friday (8am-12 noon with 24/7 call capability). Additionally, through a time-share presence several Danbury-based specialty physicians are maintaining office hours in New Milford for outpatients (Pulmonary Docket

Medicine 1x/week and Renal Nephrology 1x/month) offering patient choice and ability for patients to remain in their own community for care.

Integrated Health IT platform – State of the art information technology that facilitates sharing of patient information amongst providers of care is a priority for the system. DH has taken a leadership role in the implementation of a regional health information exchange which is named HealthLink. The HealthLink exchange is a patient centric system that provides two way communications between all providers on the exchange including primary care physicians, specialists, clinics, home health agencies and other providers of care. It offers providers the ability to see a comprehensive "virtual health record" from all contributors and also offers physicians a cost effective electronic documentation system. In 2008, the first practices came on line exchanging orders and results and practices taking advantage of the e-prescribing features of HealthLink. The HealthLink user community continues to grow with over 700 authorized users accessing the systems to view current and prior records for the patients that they are treating. Twenty additional installations in physician practices in the New Milford region have come live in the past 90 days and plans are to expand the exchange to all practices in the region and all providers in the region.

A major focus of the efforts has been in increasing patient medication safety in the community and to date over 54% of the Danbury Hospital Medical staff are using a common e-prescribing platform to provide greater safety through alerts for medication contraindications. Additionally, through the primary care efforts we will be working with the providers to help assess their readiness for meaningful use and connecting them to the regional and national health information network.

Danbury is committed to using its expertise and technology to promoting state wide adoption of medical records through health information exchanges. The CIO was appointed to the Department of Public Health advisory board for health information has also been appointed to serve on the Board of Directors to the legislatively formed company to create and oversee the statewide exchange.

We believe collectively these initiatives support continued development of a strong primary care and specialty presence to meet the healthcare needs of the WCH communities.

Docket Number 10-31560-CON

Attachment I

- The executed Affiliation Agreement

EXECUTION COPY

AFFILIATION AGREEMENT BY AND BETWEEN DANBURY HEALTH SYSTEMS, INC. AND NEW MILFORD HOSPITAL, INC.

This Affiliation Agreement (the "Agreement") is entered into as of this first day of July, 2010 between Danbury Health Systems, Inc., a Connecticut nonprofit corporation ("Danbury") and New Milford Hospital, Inc., a Connecticut nonprofit corporation ("New Milford"). Each of Danbury and New Milford is referred to herein as a "Party" and collectively as the "Parties." All capitalized terms used herein and not defined upon initial use have the respective meanings set forth in Section 8.

WHEREAS, Danbury is the parent of The Danbury Hospital ("Danbury Hospital"), a nonprofit regional medical center and university teaching hospital;

WHEREAS, Danbury controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, Danbury Hospital and The Danbury Visiting Nurse Association, Incorporated (collectively, with Danbury, the "Danbury Entities");

WHEREAS, New Milford is a nonprofit, full-service, community hospital;

WHEREAS, New Milford was recently affiliated with the New York-Presbyterian Healthcare System, Inc., and New Milford and the New York-Presbyterian Healthcare System, Inc. mutually agreed to terminate their affiliation effective as of June 30, 2010;

WHEREAS, New Milford controls, either directly or indirectly, certain subsidiaries and affiliates, including, as of the effective date of this Agreement, The New Milford Visiting Nurse Association, Incorporated ("New Milford Visiting Nurse Association") and New Milford Hospital Foundation, Inc. ("New Milford Foundation"), as such subsidiaries and affiliates may change from time to time (collectively, with New Milford, the "New Milford Entities");

WHEREAS, the current members (the "Current Members") of New Milford consist of certain persons or entities who have made contributions for the benefit of New Milford during New Milford's most recently concluded fiscal year;

WHEREAS, on February 8, 2010, Danbury and New Milford executed a Letter of Intent for Corporate Affiliation (the "Letter of Intent") confirming their understanding with respect to a proposed affiliation (the "Affiliation") between Danbury and New Milford whereby Danbury would be renamed to reflect the creation of a regional health care system (as so renamed, "Western Connecticut Healthcare"), the Current Members of New Milford would be replaced by Western Connecticut Healthcare, and Western Connecticut Healthcare would serve as the sole member of New Milford;

WHEREAS, by entering into the Affiliation, the Parties intend to create an integrated health care delivery system capable of bringing best practices in health care delivery to enhance the health and well being of residents within the region of western Connecticut and eastern New York State; and

WHEREAS, by entering into the Affiliation, the Parties intend to expand the availability of tertiary care services in the New Milford area, including endocrinology, nephrology, and certain surgical sub-specialties.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and in order to effectuate the Affiliation, the Parties agree as follows:

1. **AFFILIATION STEPS AND EFFECTIVE DATE.**

1.1 Effectuation of the Affiliation and Change of Ownership.

1.1.1 Danbury Actions. Prior to the execution of this Agreement, the board of directors of Danbury has taken all necessary actions to approve and adopt, effective as of the Effective Date and subject to the satisfaction or waiver of all the conditions to closing set forth in Section 3, an Amended and Restated Certificate of Incorporation substantially in the form set forth in Exhibit A-1 and the Amended and Restated Bylaws substantially in the form set forth in Exhibit B-1. Among other changes, the Amended and Restated Certificate of Incorporation as set forth in Exhibit A-1 and Amended and Restated Bylaws as set forth in Exhibit B-1 make the following changes: (i) the name of Danbury is changed from "Danbury Health Systems, Inc." to "Western Connecticut Healthcare, Inc.," (ii) the composition of the board of directors of Western Connecticut Healthcare is amended to include four (4) voting members from the New Milford Community Board (as defined in Section 1.1.2) as set forth on Schedule 1.1.1, and (iii) the composition of the Committee on Governance of the board of directors of Western Connecticut Healthcare is amended to include one (1) of the members of the New Milford Community Board who serves on the board of directors of Western Connecticut Healthcare as set forth on Schedule 1.1.1.

1.1.2 New Milford Actions. Prior to the execution of this Agreement, the board of directors of New Milford has taken all necessary actions to approve and adopt, effective as of the Effective Date and subject to the satisfaction or waiver of all the conditions to closing set forth in Section 3, an Amended and Restated Certificate of Incorporation substantially in the form set forth in Exhibit A-2 and Amended and Restated Bylaws substantially in the form set forth in Exhibit B-2. Among other changes, the Amended and Restated Certificate of Incorporation as set forth in Exhibit A-2 and Amended and Restated Bylaws as set forth in Exhibit B-2 make the following changes: (i) Current Members are replaced with Western Connecticut Healthcare serving as the sole member of New Milford; (ii) the board of directors of New Milford is replaced with those persons serving as the directors of Western Connecticut Healthcare; and (iii) a New Milford community board ("New Milford Community Board") is established.

1.1.3 New Milford Community Board. Three (3) years after the Closing Date and periodically thereafter, the Western Connecticut Healthcare board of directors

shall discuss and reach consensus on whether the New Milford Community Board is achieving its objectives and whether the New Milford Community Board should continue to exist. If the Western Connecticut Healthcare board of directors determines that the New Milford Community Board should not continue to exist, (i) the Western Connecticut Healthcare board of directors shall amend Western Connecticut Healthcare's Amended and Restated Bylaws to remove references to the New Milford Community Board, and (ii) Western Connecticut Healthcare, as the sole member of New Milford, shall amend New Milford's Amended and Restated Bylaws to remove the New Milford Community Board and references thereto.

1.2 Closing Memorandum. Upon satisfaction or waiver of all of the conditions precedent set forth in Section 3 and unless this Agreement is earlier terminated pursuant to Section 4, the respective Presidents of Danbury and New Milford shall execute a written memorandum (the "Closing Memorandum") which shall confirm their agreement, on behalf of their respective institutions, that all of the conditions precedent to the closing of the Affiliation (the "Closing") have been satisfied or waived as of the date of execution of the Closing Memorandum and that the Closing shall occur on such date ("Closing Date"). The Closing shall occur at New Milford at 21 Elm Street, New Milford, CT 06776. The Affiliation will be deemed to become effective as between the Parties as of 12:00:01 AM Eastern Time on the Closing Date (the "Effective Date").

1.3 New Milford Entities. Upon Closing, the New Milford Entities will retain ownership of their respective assets and will remain responsible for their respective operations and liabilities, except as otherwise stated in this Agreement.

2. **INTERIM COVENANTS.** The Parties agree that during the period from the date of execution of this Agreement to the earlier to occur of the Effective Date or the termination of this Agreement:

2.1 Commercially Reasonable, Good Faith Efforts. Each Party shall use commercially reasonable efforts and act in good faith to obtain all necessary regulatory, corporate and other approvals and to take all such other actions as may be necessary or appropriate to effectuate the Affiliation as described in this Agreement, including such actions as may be reasonably necessary or appropriate to cause the conditions to the Closing in Section 3 to be satisfied.

2.2 Standstill. Neither Party nor any of its respective affiliates will enter into discussions with any third party concerning a possible sale, conveyance, transfer, lease, membership substitution, merger, or other similar transaction involving the assets directly or indirectly owned or controlled by that Party or its affiliates (without the approval of the other Party) contemplated to be affected by this Agreement. Neither New Milford nor New Milford Foundation (including the current members thereof) shall amend the certificates of incorporation or the bylaws of New Milford or New Milford Foundation, other than as described in Sections 1.1.2 and 3.1.

2.3 Conduct of Business. Each New Milford Entity shall continue to operate in its usual, regular and ordinary manner consistent with past practices and to comply in all material respects with all applicable laws, rules and regulations. Without limiting the generality of the foregoing, no New Milford Entity will take any of the following actions without the prior written consent of Danbury, which shall not be unreasonably withheld or delayed: (i) enter into any Material Transaction or (ii) make any distributions of cash or other assets except in the ordinary course of its business and consistent with past practice. The New Milford Entities will provide Danbury ten (10) business days advance written notice of any transfer of assets to any entity other than the New Milford Entities that is not in the usual, regular and ordinary course of business as set forth in the New Milford Entities' Fiscal Year 2010 capital and operating budgets and consistent with past practice.

2.4 Public Statements. Except as may be required by applicable laws or as otherwise contemplated herein, none of the Danbury Entities or New Milford Entities will make any public statements or communications to the public, the press or any third party (other than to their respective affiliates and to their or their affiliates' respective officers, employees, accountants, attorneys, and agents who require access to such information in order to be able to perform necessary duties) regarding the existence or terms of the Affiliation or this Agreement without the other Party's prior written consent. Further, the Parties agree that in the event that the Affiliation described herein is not consummated for any reason, the Parties will mutually agree on a statement to that effect prior to any such disclosure to the public or the press.

2.5 Expenses. Danbury shall be responsible for seventy-five percent (75%) and New Milford shall be responsible for twenty-five percent (25%) of the combined legal, professional, and consulting fees incurred by the Parties in connection with the Affiliation, whether or not the Affiliation is consummated, including (i) expenses associated with any Hart-Scott-Rodino Act filing; (ii) expenses associated with obtaining other government approvals and making related filings, including any certificate of need, licensure, or change of ownership filings; and (iii) expenses of transaction counsel.

2.6 Communications with Government Officials. Unless the Parties agree otherwise after the effective date of this Agreement, the Parties shall communicate jointly with government officials with respect to the Affiliation and shall work together to develop a plan for coordinated communications by the Parties and by other Danbury Entities and other New Milford Entities. From the effective date of this Agreement until the earlier of the Effective Date or the date that this Agreement is terminated in accordance with its terms, none of the Danbury Entities or the New Milford Entities shall, except as required by applicable law, communicate separately with government officials regarding the Affiliation without the prior approval of the other Party. Notwithstanding the foregoing, (i) counsel to Danbury and/or counsel to New Milford may, with transaction counsel, communicate with representatives from the State of Connecticut Office of the Attorney General ("Attorney General"); and (ii) the Danbury Entities and the New Milford Entities shall be free, without prior approval of the other Party, to communicate with government officials in the ordinary course and with respect to matters unrelated to the Affiliation.

2.7 Additional Diligence Information. Pursuant to the Letter of Intent, Danbury and New Milford furnished each other with certain requested information in order to permit each of the Parties to perform a due diligence analysis of the Affiliation. From the date of this Agreement through the Closing Date, (i) each Party shall disclose to the other Party any information known to such first mentioned Party's senior management team that, if not disclosed, would make the Due Diligence Information provided to the other Party taken as a whole, in light of the circumstances under which such information was provided, materially incomplete, inaccurate or misleading in any material respect; (ii) New Milford shall provide to Danbury, on a monthly basis, a financial information packet on the financial condition of the New Milford Entities in the same form provided to the New Milford board of directors; (iii) New Milford shall provide to Danbury a copy of each Medicare cost report filed by a New Milford Entity after the date hereof within five (5) days of such filing; and (iv) New Milford shall provide to Danbury and Danbury shall provide to New Milford updates to any Schedules to this Agreement necessary to make such Schedules complete and accurate in all material respects as of the date on which the update is provided, including as of the Closing Date.

3. **CONDITIONS PRECEDENT**. The Affiliation shall not occur until each of the following conditions is satisfied or waived by the Party it is intended to benefit:

3.1 Organizational Documents.

3.1.1 Danbury. The board of directors of Danbury (and if necessary, the members of Danbury) shall have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, (i) an Amended and Restated Certificate of Incorporation in the form set forth in Exhibit A-1 and (ii) Amended and Restated Bylaws in the form set forth in Exhibit B-1.

3.1.2 New Milford. The Current Members and the board of directors of New Milford shall have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, (i) an Amended and Restated Certificate of Incorporation substantially in the form set forth in Exhibit A-2 and (ii) Amended and Restated Bylaws substantially in the form set forth in Exhibit B-2.

3.1.3 New Milford Entities. The member and the board of directors of New Milford Foundation shall have taken all necessary action (i) to approve and adopt, conditional on and effective as of the Effective Date, Amended and Restated Bylaws substantially in the form set forth in Exhibit B-3 and (ii) to replace the current members of the board of directors of New Milford Foundation with those individuals mutually agreed upon by the Parties. The Amended and Restated Bylaws substantially in the form set forth in Exhibit B-3 grant Western Connecticut Healthcare the authority to direct the New Milford Foundation to take certain actions in Western Connecticut Healthcare's discretion. The member and the board of directors of New Milford Visiting Nurse Association shall have taken all necessary action to approve and adopt, conditional on and effective as of the

Effective Date, Amended and Restated Bylaws in such form as the Parties may mutually agree. As of the date hereof, the Parties anticipate that Western Connecticut Healthcare will not hold the same reserved powers with respect to New Milford Visiting Nurse Association as it holds with respect to New Milford Foundation.

3.2 Hart-Scott-Rodino. In the event that a Hart-Scott-Rodino Act filing is required, the applicable waiting period under the Hart-Scott-Rodino Act amendments to the Antitrust Improvement Act shall have expired without any challenge by the Federal Trade Commission ("FTC") or the Department of Justice ("DOJ") to the implementation of the Affiliation, or in the event that the FTC or DOJ initiate a challenge, including through the issuance of a second request, the matter shall have been resolved to the reasonable satisfaction of each of Danbury and New Milford.

3.3 Attorney General. The Attorney General shall not have challenged the implementation of the Affiliation, or if the Attorney General initiates a challenge, the matter shall have been resolved to the reasonable satisfaction of each of Danbury and New Milford.

3.4 Government Approvals and Filings. Each Party shall have made the filings with governmental or regulatory authorities and shall have received the governmental permits, licenses, or other approvals in each case described on Schedule 3.4 (other than filings described on Schedule 3.4 as post-closing filings), which shall not be subject to any conditions, limitations or other terms not reasonably acceptable to the Parties.

3.5 Non-Governmental Consents. New Milford shall have obtained and delivered to Danbury the consents from non-governmental third parties described on Schedule 3.5, which shall not be subject to any conditions, limitations or other terms that would result or be reasonably likely to result in a New Milford Material Adverse Effect.

3.6 No Investigation or Enforcement Action. The implementation of the Affiliation shall not be the subject of any litigation or regulatory investigation or enforcement action; provided, however, that if the implementation of the Affiliation is subject to any litigation or regulatory investigation or enforcement action, the Affiliation shall not be implemented without the agreement of each of Danbury and New Milford.

3.7 Compliance with Interim Covenants. Each Party shall have determined in its sole discretion that the other Party has complied with the terms of Section 2.

3.8 Management Team. The Chief Executive Officer of Danbury shall have selected a management team to manage Western Connecticut Healthcare, Danbury Hospital, and the New Milford Entities after the Closing.

3.9 Opinions of Counsel. Each Party shall have received opinions of the other Party's counsel in customary form reasonably acceptable to the Parties.

3.10 No Material Adverse Effect. Unless waived by New Milford, between the date of this Agreement and the Closing Date, a Danbury Material Adverse Effect shall not have occurred. Unless waived by Danbury, between the date of this Agreement and the Closing Date, a New Milford Material Adverse Effect shall not have occurred.

3.11 Representations and Warranties. Unless waived by New Milford, all representations and warranties made by Danbury in Section 6 shall be true, accurate, and complete in all material respects as of the Closing Date. Unless waived by Danbury, all representations and warranties made by New Milford in Section 6 shall be true, accurate, and complete in all material respects as of the Closing Date.

3.12 Additional Conditions Related to Diligence Findings. Danbury shall have performed to New Milford's satisfaction all actions identified in Schedule 3.12.1, which actions are intended to address certain findings of New Milford during the due diligence process. New Milford shall have performed to Danbury's satisfaction all actions identified in Schedule 3.12.2, which actions are intended to address certain findings of Danbury during the due diligence process.

4. TERMINATION OF AGREEMENT.

4.1 Term. This Agreement shall become effective upon execution by the Parties and may be terminated by either Party by written notice to the other Party if the Closing has not occurred by December 31, 2010 absent a mutual written consent by the Parties to extend the term.

4.2 Termination by Mutual Written Consent. This Agreement may be terminated prior to the Closing Date by the mutual written consent of the Parties.

4.3 Survival. In the event of termination pursuant to Section 4.1 or Section 4.2, all rights and obligations under the Agreement shall cease and the terms and provisions of the Agreement will have no further effect, except that Section 2.4 [Public Statements], Section 2.5 [Expenses] and Section 7.4 [Confidentiality] shall survive termination of this Agreement in the event that the Affiliation is not consummated. In the event that the Affiliation is consummated, only the provisions of Section 5 [Post Closing Covenants] and Section 7 (not including Section 7.4) [Miscellaneous] shall survive beyond the Closing Date. Protections provided under the Mutual Confidentiality & Nondisclosure Agreement by and between New Milford Hospital, Danbury Hospital, and Danbury dated as of August 17, 2009, as amended by the First Amendment to the Mutual Confidentiality & Nondisclosure Agreement dated as of April 6, 2010, with respect to communications and all information exchanged during the term of such Mutual Confidentiality & Nondisclosure Agreement shall survive the termination of this Agreement.

5. **POST CLOSING COVENANTS**. From and after the Closing Date, the Parties shall take the following actions and observe the following covenants:

5.1 General Operation as Nonprofit Corporations. Western Connecticut Healthcare and New Milford shall continue in existence as Connecticut nonprofit corporations exempt from taxation under Section 501(c)(3) of the Code. Each Party shall retain full power and authority to govern and manage such Party's assets; provided, however, that New Milford's authority to govern and manage its assets shall be subject to the reserved powers of Western Connecticut Healthcare acting as New Milford's sole member.

5.2 Clinical Services. The clinical services to be provided by the Danbury Entities and the New Milford Entities immediately following the Closing are set forth on Schedule 5.2. Western Connecticut Healthcare is committed to assisting New Milford in maintaining the competitiveness of New Milford with respect to its clinical operations and physical infrastructure relative to other hospitals in its service area through the development of appropriate business plans for new and existing programs and initiatives.

5.3 Operation of New Milford Entities.

5.3.1 General. After the Closing Date, New Milford's operations will be overseen by its board of directors, which will consist of those persons serving from time to time as the directors of Western Connecticut Healthcare. To the extent practicable, after the Closing Date, the New Milford Entities shall operate in compliance with Western Connecticut Healthcare policies generally applicable to the Danbury Entities (e.g., with respect to choice of auditor, maintenance of and signatory authority with respect to bank accounts, etc.). It is understood and agreed that while the Parties may endeavor to harmonize policies relating to employees, benefits, etc., not all policies and practices will be completely integrated as of the Closing Date.

5.3.2 Operation in Accordance with Western Connecticut Healthcare Policies. The New Milford Entities shall operate in accordance with the rights, obligations, duties, and requirements applicable to all Danbury Entities, as such rights, obligations, duties and requirements are from time to time established by Western Connecticut Healthcare. The New Milford Entities shall comply with the all policies, procedures, practices and other requirements of Western Connecticut Healthcare as applied from time to time to all Danbury Entities, including those addressing governance and management, charity care, standards for just wage and benefits, and those requiring timely reporting and coordination with other Danbury Entities regarding aggregate liens and debt. Western Connecticut Healthcare shall have, in its sole discretion, the right to change or alter at any time the policies, procedures, practices, and other requirements of Western Connecticut Healthcare as applied to all Danbury Entities.

5.3.3 Medicare Form 855A. After the Closing Date, each New Milford Entity which is a participating provider in Medicare or Medicaid shall submit a Form 855A change of information filing to its fiscal intermediary within the time frame required under applicable laws and regulations.

5.3.4 New Milford Foundation. For a period of not less than ten (10) years following the Effective Date, New Milford Foundation shall continue to exist as a Connecticut nonprofit corporation that is exempt from federal income tax under Section 501(c)(3) of the Code and its corporate purposes shall remain to raise funds and make grants to support the inpatient, outpatient, and other hospital or community-based activities and projects of New Milford. The principal role and responsibilities of the New Milford Foundation board of directors shall be the local direction, supervision, and guidance of the New Milford Foundation's fundraising and support activities, the oversight and review of the New Milford Foundation's finances and operations, the review and approval of the New Milford Foundation's operating and capital budgets, and such other matters as may be related to the direction and supervision of the New Milford Foundation's fundraising and support activities. All grants or funds received by a New Milford Entity shall belong to or be the property of such New Milford Entity. Western Connecticut Healthcare shall provide support and counsel to the New Milford Foundation's operations and planned giving efforts.

5.3.5 New Milford Employees. To the extent permitted by any applicable collective bargaining agreement, each employee of a New Milford Entity as of the Closing Date who becomes an employee of Western Connecticut Healthcare or any Western Connecticut Healthcare affiliate after the Closing Date shall receive full recognition and credit for pre-Closing length of employment with any New Milford Entity, including for purposes of seniority recognition, benefits eligibility and accruals, and vesting of benefits.

5.3.6 Medical Staff. As of the Closing Date, the Affiliation shall not impact or change the medical staff appointment or clinical privileges of members of the medical staff of New Milford as existing on the Closing Date. The New Milford medical staff shall remain independent of the medical staff of Danbury Hospital immediately following the Closing Date. Subject to the approval of New Milford's medical staff, if necessary, New Milford's medical staff bylaws, rules and regulations, and policies will be amended to be consistent with Danbury Hospital's medical staff bylaws, rules and regulations, and policies and such amended bylaws, rules and regulations, and policies shall take effect upon the Closing or at such later date as the Parties may agree. Western Connecticut Healthcare and New Milford shall work with the medical staffs to evaluate and where feasible pursue opportunities for medical staff/clinical integration where doing so offers opportunities for advancement in quality and cost-effectiveness of care.

5.4 Access to Western Connecticut Healthcare Insurance Programs. New Milford may have access to insurance programs offered by Western Connecticut Healthcare's insurance plans, subject to New Milford's eligibility for and acceptance by those programs. Such insurance programs may or may not provide tail coverage, depending on the nature of the programs and New Milford's eligibility for and acceptance by those programs.

5.5 Annual Capital Allocation Process. Western Connecticut Healthcare will include the New Milford Entities in Western Connecticut Healthcare's annual capital allocation process for capital expenditures, which expenditures shall be governed by Western Connecticut Healthcare's normal capital allocation policy from time to time in effect for Western Connecticut Healthcare's affiliates. The Parties agree that one of the principle purposes of the Affiliation is to enhance capital access for both Parties so as to maintain the ability to offer medical care of the highest quality at all sites.

6. REPRESENTATIONS AND WARRANTIES.

6.1 By Each Party. As a condition to entry into this Agreement, each Party represents and warrants to the other Party that as to itself and as to each of its affiliates the statements set forth in this section are true and correct as of the date hereof:

6.1.1 Due Organization and Authority. Danbury and each of the New Milford Entities is a corporation duly organized and validly existing under the laws of the State of Connecticut. Each such corporation has all requisite corporate or other power and authority to own, lease, and operate its properties and to carry on its business as it is now being conducted. The copies of the certificates of incorporation and bylaws of Danbury and each of the New Milford Entities heretofore delivered to or made available for review by Danbury and New Milford are complete and correct, and no amendments thereto are pending or contemplated, other than the Amended and Restated Certificates of Incorporation and/or the Amended and Restated Bylaws of Danbury, New Milford, New Milford Foundation, and New Milford Visiting Nurse Association as described in Sections 1.1 and 3.1.3.

6.1.2 Corporate Power. Each of the Parties has full corporate power and authority to enter into and carry out the terms and provisions of this Agreement and the transactions contemplated hereby; all corporate proceedings have been duly called and conducted; and all corporate authorizations have been obtained by each of the Parties and the other New Milford Entities which are necessary to authorize the execution, delivery and performance of this Agreement and to adopt the Restated Certificates of Incorporation and Amended and Restated Bylaws in the respective forms set forth in Exhibit A-1, Exhibit A-2, Exhibit B-1, and Exhibit B-2. No other corporate proceedings on the part of either Danbury or the New Milford Entities are necessary to authorize such execution, delivery and performance of this Agreement or to adopt the Amended and Restated Certificates of Incorporation and Amended and Restated Bylaws in the respective forms set forth in Exhibit A-1, Exhibit A-2, Exhibit B-1, and Exhibit B-2. This Agreement is, and is intended to be, a legal, valid, and binding obligation of each of the Parties, enforceable in accordance with its terms; provided, however, that (i) such enforcement may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws currently now or hereafter in effect relating to creditors' rights generally; and (ii) the remedy of specific performance may be subject to equitable defenses and to the discretion of the court before which any proceeding therefor may be brought.

6.1.3 Audited Financial Statements. Danbury has provided New Milford with the audited balance sheets and related statements of income and statements of cash flow of Danbury for the fiscal years ended September 30, 2006, 2007, 2008 and 2009, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of Danbury. New Milford has provided Danbury with the audited balance sheets and related statements of income and statements of cash flow of the New Milford Entities for the fiscal years ended September 30, 2006, 2007, 2008 and 2009, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of the New Milford Entities. (Such audited balance sheets and related statements of income and statements of cash flow, including the notes thereto, are referred to herein as the "Financial Statements." Such unaudited balance sheets and related statements of income and statements of cash flow are referred to herein as the "Interim Financial Statements.") The Financial Statements (i) were prepared from the respective books and records of Danbury or the New Milford Entities, as the case may be, (ii) fairly present the financial condition and results of operations and cash flows for Danbury or the New Milford Entities, as the case may be, as of the dates and for the periods indicated, and (iii) were prepared in accordance with generally accepted accounting principles applied on a consistent basis (except as may be expressly indicated therein or in the notes thereto). Neither Danbury nor any of the New Milford Entities, as the case may be, have any material liabilities or obligations, whether contingent or absolute, direct or indirect, or matured or unmatured, which are not shown or provided for in the most recent of such Financial Statements or which have not otherwise been disclosed in writing to the other Party. The Interim Financial Statements were prepared from the respective books and records of Danbury or the New Milford Entities, as the case may be, consistent with the methods used to prepare the audited Financial Statements and any other adjustments expressly described therein or in the notes thereto.

6.1.4 Execution of Agreement. Neither the execution and delivery of this Agreement nor the consummation of any of the transactions contemplated hereby will (i) constitute a breach or a default under any contractual obligation of Danbury or any New Milford Entity; (ii) result in acceleration in the time for performance of any obligation of Danbury or any New Milford Entity under any contractual obligation; (iii) result in the creation of any lien upon any asset of Danbury or any New Milford Entity; (iv) require any notice, consent, waiver or amendment to any contractual obligation other than those set forth on Schedule 6.1.4.1 for Danbury or Schedule 6.1.4.2 for New Milford; (v) give rise to any severance payment, right of termination or any other right or cause of action under any contractual obligation; or (vi) violate or give rise to a default or any other right or cause of action under any law, except for the events or conditions described in clauses (i) through (vi) above which do not and would not be reasonably likely to, individually or in the aggregate, have a Danbury Material Adverse Effect or a New Milford Material Adverse Effect, as the case may be. Except for the

consents, waivers, approvals, and authorizations of, and the filings registrations, and qualifications with, governmental or regulatory authorities identified in Schedule 3.4, no consent, waiver, approval or authorization of, or filing, registration or qualification with, any governmental or regulatory authority which if not made or obtained could have a Danbury Material Adverse Effect or New Milford Material Adverse Effect, as the case may be, individually or in the aggregate, is required to be made or obtained by Danbury or a New Milford Entity, in connection with the execution, delivery or performance of this Agreement by Danbury or a New Milford Entity.

6.2 Additional Representations and Warranties by New Milford. As a condition to Danbury's entry into this Agreement, New Milford as to itself and as to each of the New Milford Entities further represents and warrants to Danbury that, except as disclosed in the Due Diligence Information, the statements set forth in this section are true and correct as of the date hereof:

6.2.1 Legal Proceedings. There is no potentially material incident report related to the operations or services of a New Milford Entity, and there is no litigation, at law or in equity, or any proceeding before or investigation by any foreign, federal, state or municipal board or other governmental or administrative agency or any arbitrator, or any fiscal intermediary or contractor pending or, to the knowledge of the New Milford Entities, threatened against any New Milford Entity or against any New Milford Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such New Milford Entity which would result or be reasonably likely to result in any uninsured loss, which, individually or in the aggregate, would result or be reasonably likely to result in any material liability, or which could otherwise, individually or in the aggregate, result or be reasonably likely to result in any New Milford Material Adverse Effect. There is no litigation at law or in equity, or any proceeding before or, to the knowledge of a New Milford Entity, any investigation by, any foreign, federal, state or municipal board or other governmental or administrative agency or any arbitrator pending which seeks rescission of, seeks to enjoin the consummation of, or which questions the validity of, this Agreement or any of the transactions contemplated hereby. No New Milford Entity has received notice of any judgment, decree or order of any foreign, federal, state or municipal court, board or other governmental or administrative agency or arbitrator, or any fiscal intermediary or contractor which has been issued against it or any of its members, trustees, directors, officers, or employees which would have or be likely to have a New Milford Material Adverse Effect, individually or in the aggregate. Neither (i) any attachments, or execution proceedings, nor (ii) any assignments for the benefit of creditors, insolvency, bankruptcy, reorganization or other similar proceedings are pending or threatened against any New Milford Entity. The New Milford Due Diligence Information contains a complete and accurate listing of all litigation, at law or in equity, or any proceeding before or investigation by any foreign, federal, state, or municipal board, other governmental or administrative

agency or arbitrator, or any fiscal intermediary or contractor pending or, to the knowledge of the New Milford Entities, threatened against any New Milford Entity or against any New Milford Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such New Milford Entity.

6.2.2 Compliance with Laws. The business and operations of each New Milford Entity have been and are being conducted in compliance with all material and applicable laws, ordinances, and rules and regulations of all authorities, and any non-compliance would not have a New Milford Material Adverse Effect, individually or in the aggregate. Except for federal and state laws and regulations that apply commonly to all hospitals in the State of Connecticut, and except for those matters, if any, expressly disclosed in the Financial Statements, no New Milford Entity is subject to any restriction of any kind or character, which may have a New Milford Material Adverse Effect on any New Milford Entity, individually or in the aggregate. No New Milford Entity is in receipt of any written notice of any violation of any law, statute, rule, regulation, judgment, order, decree, permit, concession, franchise or other governmental authorization or approval applicable to it or to any of its properties, except for violations which, individually or in the aggregate, would not have or result or be likely to have or result in a New Milford Material Adverse Effect. The New Milford Due Diligence Information provided by New Milford contains complete and accurate information regarding (i) each New Milford Entity's compliance with all applicable laws, ordinances, and rules and regulations of all authorities; and (ii) any written notice of any violation of any law, statute, rule, regulation, judgment, order, decree, permit, concession, franchise, or other governmental authorization or approval applicable to any New Milford Entity or any of their respective properties.

6.2.3 Insurance. Each New Milford Entity has insurance contracts in full force and effect, with financially sound and reputable insurers licensed to write insurance in the State of Connecticut, which insurance contracts provide for coverages that are usual and customary for the risks attending the operations of such New Milford Entity as to amount and scope. No New Milford Entity has received notice from any insurance carrier of, or has knowledge of, defects or inadequacies in its property or improvements or any other condition which if not corrected would result in termination of directors and officers, hazard, liability or other insurance coverage or increase in its cost.

6.2.4 Tax Exempt Status. Each New Milford Entity is an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), or corresponding provisions of prior law, as set forth in a determination letter issued by the Internal Revenue Service and no such letter has been modified, limited, or revoked. Each New Milford Entity is in material compliance with the terms, conditions, and limitations in such letter, and the facts and circumstances that form the basis of such letter as represented to the Internal Revenue Service continue to substantially exist. No proceedings are pending with respect to which

any New Milford Entity has been served or threatened in any way contesting or adversely affecting such entity's status as an organization described in Section 501(c)(3) of the Code or as an organization described in Sections 509(a)(1), (2) or (3) of the Code, or which would subject any income of such entity to federal income taxation to such an extent as would result in loss of such status. No New Milford Entity has knowledge of any challenge, investigation or inquiry that the Internal Revenue Service has made regarding its status as an organization described in Section 501(c)(3) of the Code or as an organization described in Section 509(a)(1), (2) or (3) of the Code. The New Milford Due Diligence Information provided by New Milford contains a complete and accurate set of all reports, filings, correspondence, or other documents to or from the Internal Revenue Service or the Connecticut Department of Revenue Services on any tax, compliance, or other issue related to any of the New Milford Entities.

6.2.5 Titles, Leases, and Licenses. Each New Milford Entity has good and marketable title to, or in the case of leased or licensed property, has valid leases or licenses under which it enjoys peaceful and undisturbed possession of, all of its properties and assets (whether real or tangible personal), including all properties and assets reflected in the Financial Statements and Interim Financial Statements of the New Milford Entities (except as sold or otherwise disposed of since the date of such Financial Statements or Interim Financial Statements in the ordinary course of business and consistent with past practice). Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the New Milford Entities as now conducted. All such assets and properties, other than assets and properties in which the New Milford Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the New Milford Entities' Financial Statements or the footnotes thereto. Each New Milford Entity has complied in all material respects under all leases to which it is a party and under which it is in occupancy, and all such leases are in full force and effect. There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the New Milford Entities as now conducted that are licensed by the State of Connecticut Department of Public Health other than those properties, assets, and facilities set forth in Schedule 6.2.5.

6.2.6 Environmental Laws. Each New Milford Entity has been and remains in compliance in all material respects with all applicable environmental laws, except for noncompliance that would not result in a New Milford Material Adverse Effect. To the knowledge of the New Milford Entities, there are no circumstances or conditions present at or arising out of the present or former assets, properties, leaseholds, businesses or operations of a New Milford Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs. No New Milford Entity nor any of its assets, properties, businesses, leaseholds or operations (i) has received or is subject to, or within the past three (3) years has received or been subject to, any order, decree, judgment, complaint, agreement, claim, citation, or notice or (ii) is subject to any

judicial or administrative proceeding or any investigation indicating that the New Milford Entity is or may be (a) in violation of any environmental law; (b) responsible for the on-site or off-site storage or release of any chemical substance; or (c) liable for any environmental liabilities and costs. No New Milford Entity has reason to believe that it will become subject to a matter identified in this Section 6.2.6; and no investigation or review with respect to such matters is pending or threatened, nor has any governmental authority or other third party indicated an intention to conduct the same. No New Milford Entity is subject to, or as a result of the transactions contemplated by this Agreement would be subject to, the requirements of any environmental laws that require notice, disclosure, cleanup or approval prior to or upon the Effective Date or which would impose liens on the assets or business of a New Milford Entity.

6.2.7 Labor Unions and Collective Bargaining Agreements. Employees of New Milford Entities are currently represented only by the collective bargaining organizations listed on Schedule 6.2.7. Except in relation to the foregoing collective bargaining organizations, no New Milford Entity is a party to any labor union or collective bargaining agreement with respect to its employees or has, within the previous three (3) years, been the subject of any organizing, petition or election with respect to the unionization of any of its employees. There is no strike or other work stoppage currently in effect or, to the knowledge of any New Milford Entity, threatened with respect to any employees of any New Milford Entity.

6.2.8 Employee Benefit Matters. Each of the employee benefit, welfare, pension or similar plans that any of the New Milford Entities sponsors or provides to its employees (each, a "Plan" and collectively, the "Plans") has been fully and completely described, with all applicable agreements and Plan documents, in the Due Diligence Information.

6.2.8.1. Multiemployer Plans. None of the New Milford Entities nor any other person that would be considered as a single employer with the New Milford Entities under the Code or ERISA has ever maintained, contributed to, or been required to contribute to any "multiemployer plan" within the meaning of Section 3(37) or Section 4001(a)(3) of ERISA.

6.2.8.2. Plan Qualification. Each Plan that is intended to be qualified under Section 401(a) of the Code is so qualified. Each Plan, including any associated trust or fund, has been administered in all material respects in accordance with its terms and with all applicable law, and nothing has occurred with respect to any Plan that has subjected or could subject any of the New Milford Entities to a penalty or other liability under ERISA or an excise tax under the Code.

6.2.8.3. All Contributions and Premiums Paid. All required contributions to and premium payments with respect to each Plan have been made on a

timely basis. No event has occurred that has resulted in or could subject any of the New Milford Entities to a tax under Section 4971 of the Code or its assets to a lien under Section 412(n) of the Code.

6.2.8.4. Defined Benefit Pension Plans. In the case of each Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the Plan equals or exceeds the present value of all benefit liabilities under the plan determined on a plan termination basis, and (ii) no "reportable event" (as defined in Section 4043 of ERISA) has occurred. No event has occurred that could subject any of the New Milford Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

6.2.8.5. Claims. There is no pending or, to New Milford's knowledge, threatened action relating to a Plan, other than routine claims in the ordinary course of business for benefits provided for by the Plans. No Plan is, or within the last six (6) years has been, the subject of an examination or audit by a governmental authority, is the subject of an application or filing under, or is a participant in, a government-sponsored amnesty, voluntary compliance, self-correction or similar program.

6.2.8.6. Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment.

6.2.8.7. No Restrictions On Termination. No provision of any Plan would result in any limitation on the ability of any of the New Milford Entities to terminate the Plan, and, in the case of any such Plan subject to Title IV of ERISA, to receive any excess assets after the satisfaction of all liabilities.

6.2.8.8. Severance. The transactions contemplated by this Agreement shall not, whether alone or upon the occurrence of any additional or subsequent event, result in any payment of severance or other compensation to, or acceleration, vesting or increase in benefits under any Plan for the benefit of any current or former director, officer or employee of any of the New Milford Entities.

6.2.9 Health Care Kickbacks. No New Milford Entity has engaged in any activity which is prohibited under the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, or the regulations promulgated thereunder, or related state or local fraud and abuse statutes or regulations.

6.2.10 Prohibited Health Care Referrals. No New Milford Entity has established or maintains a "financial relationship," as that term is defined by The Ethics in

Patient Referrals Act, 42 U.S.C. § 1395nn, and the regulations promulgated thereunder (the "Stark Law"), with any physician or with an immediate family member of any physician who makes referrals to any New Milford Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. The New Milford Due Diligence Information contains a complete and accurate set of all agreements between any of the New Milford Entities and referring physicians, immediate family members of referring physicians, physician organizations, other health care providers, and other referral sources. None of the New Milford Entities has any arrangements with referring physicians, immediate family members of referring physicians, physician organizations, or other health care providers that are not memorialized in a writing.

6.2.11 Actions, Investigations, and Inquiries. There are no actions, investigations, or inquiries pending (whether or not any formal written notification or any subpoena has been issued in connection therewith), threatened, anticipated or contemplated (nor is there any basis therefor) against or affecting any New Milford Entity, before or by any governmental authority or agency, accreditation body or third-party payor (including the Medicare and Medicaid programs and the Office of Inspector General of the United States Department of Health and Human Services) which relate to antitrust matters, billing practices, third-party relationships or any other matter: (i) which could prevent or hinder the consummation of the transactions contemplated by this Agreement or call into question the validity of any action taken or to be taken in connection with the transactions contemplated by this Agreement; or (ii) which in any single case or in the aggregate might have a New Milford Material Adverse Effect or result in any material impairment to the right or ability of any New Milford Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs. No New Milford Entity has received any warning or notice of decertification, revocation, suspension or termination, or of threatened or potential decertification, revocation, suspension or termination, with respect to the Medicare and Medicaid programs. The New Milford Due Diligence Information contains complete and accurate information regarding all actions, investigations, or inquiries pending (whether or not any formal written notification or any subpoena has been issued in connection therewith) or, to the knowledge of the New Milford Entities, threatened, anticipated or contemplated against or affecting any New Milford Entity before or by any governmental authority or agency, accreditation body, or third-party payor (including the Medicare and Medicaid programs and the Office of Inspector General of the United States Department of Health and Human Services).

6.2.12 Permits. Each New Milford Entity possesses all permits, licenses, franchises, easements, authorizations, certificates, accreditations, registrations, provider numbers, assignments, consents, rights and privileges necessary under laws applicable to the conduct of their business (collectively, the "Permits"), the non-

possession of which would have a New Milford Material Adverse Effect. No New Milford Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of the Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of the Permits is pending or has been commenced or, to the knowledge of the New Milford Entities, threatened and no notification thereof has been received by any New Milford Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a New Milford Material Adverse Effect. The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties shall not limit, restrict, revoke, suspend or terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of the Permits.

6.2.13 Medicare Cost Reports. New Milford and New Milford Visiting Nurse Association have made available to Danbury true, correct and complete copies of their Medicare cost reports filed for the following years: 2007, 2008, and 2009. The status of all Medicare and Medicaid cost reports of New Milford and New Milford Visiting Nurse Association for the last two (2) cost-reporting years has been disclosed in the New Milford Due Diligence Information, and there are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open such cost reports.

7. MISCELLANEOUS.

7.1 Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut (without reference to or application of any conflicts of laws principles).

7.2 Successors; Assignment. This Agreement shall inure to the benefit of, and shall be binding upon, the respective successors and permitted assignees of the Parties, including successors by merger or consolidation or any entity to which all or substantially all of the assets of any Party hereto may be transferred. Except as expressly provided in the preceding sentence, no Party may assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of the other Party.

7.3 Amendment. The provisions of this Agreement may be amended or waived only in writing by the Parties. The failure of either Party to enforce at any time any provision of this Agreement shall not be construed to be a waiver of such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any Party thereafter to enforce each and every provision. No waiver of any breach of this Agreement shall be held to constitute a waiver of any other or subsequent breach.

7.4 Confidentiality.

7.4.1 Prohibited Disclosures. Each Party, individually and on behalf of its affiliates, and their respective members, directors, officers, employees, and other agents, agrees to hold in confidence all Confidential Information of the other Party disclosed to it by the other Party and to limit disclosure of such Confidential Information to only those members, directors, officers, employees, agents and advisors of the receiving Party or of its affiliates who have a need to know such Confidential Information for purposes of implementing or carrying out the Affiliation. Each receiving Party will take reasonable measures to ensure that such Confidential Information is not distributed beyond the members, directors, officers, employees, agents and advisors of the receiving Party or its affiliates with such a need to know. Each Party shall require all members, directors, officers, employees, agents and advisors of the Party or its affiliates who have access to Confidential Information of the other Party to agree to confidentiality restrictions limiting their use and disclosure of such Confidential Information to purposes associated with the Affiliation and prohibiting them from disclosing such Confidential Information to third parties. No Party nor any of the Parties' affiliates shall disclose the Confidential Information of the other Party to any other person or entity (except as required by a facially valid judicial or governmental request, requirement or order) regardless of a pre-existing relationship or claim of interest in such Confidential Information.

7.4.2 Permitted Use. Each Party may use the Confidential Information of the other Party disclosed to it only for the purpose of implementing and carrying out the Affiliation and may not otherwise use the Confidential Information of the other Party for its own benefit (or for the benefit of another person or entity). If a receiving Party is requested or required in a judicial, administrative or governmental proceeding to disclose any Confidential Information of the other Party, it will notify the disclosing Party as promptly as practicable so that the disclosing Party may either seek an appropriate protective order or waive the provisions of this Agreement. If, in the absence of any protective order or waiver, the receiving Party is, in the written opinion of its counsel, required to disclose Confidential Information in any court or tribunal, or pursuant to compulsory process of a governmental agency, it may disclose such Confidential Information without liability hereunder.

7.4.3 Excepted Information. The obligations of a Party as recipient of Confidential Information of the other Party under this Agreement shall not apply to any such information (i) which is or becomes generally available to the public or otherwise in the public domain; (ii) which was or is otherwise available to or disclosed to the receiving Party on a non-confidential basis, other than by virtue of a breach of this Agreement; or (iii) which is approved for release by written authorization of an authorized officer of the Party whose Confidential Information is to be disclosed.

7.4.4 Marking Confidential Information. Each disclosing Party shall use reasonable efforts to mark all tangible materials that disclose or embody Confidential Information of such Party as "Confidential," "Proprietary" or the substantial equivalent thereof and to identify Confidential Information that is disclosed orally or visually as confidential at the time of disclosure.

7.4.5 Return and Destruction. Should this Agreement terminate prior to the Effective Date, each Party agrees (i) that it shall promptly return to the disclosing Party or, with the permission of the disclosing Party, destroy all Confidential Information obtained from the other Party and all notes, memoranda and other material which reflect, interpret, evaluate or are derived from such Confidential Information; and (ii) that it will not use such Confidential Information in its future decision-making. Notwithstanding the foregoing provisions of this Section 7.4.5, in no event shall any Party (or such Party's attorneys or other advisors) be required to return or destroy any due diligence analyses or attorney work product prepared in contemplation of the Affiliation.

7.4.6 Remedies. The Parties acknowledge and agree that any breach of the obligations under this Section 7.4 will result in irreparable injury to the Party whose Confidential Information is or is to be disclosed and that the Party so injured shall have the right to specific enforcement of the restrictions of this Section 7.4 as well as all rights that it may have in accordance with the provisions of Section 7.9 hereof.

7.5 Headings. The headings in this Agreement are for purposes of reference only and shall not limit or otherwise affect the meaning hereof. Each covenant contained herein shall be construed as being independent of each other covenant contained herein, so that compliance with any one covenant shall not be deemed to excuse compliance with any other covenant.

7.6 Interpretation. Except where expressly stated otherwise in this Agreement, the following rules of interpretation apply to this Agreement: (i) "include", "includes" and "including" are not limiting and mean include, includes and including, without limitation; (ii) definitions contained in this Agreement are applicable to the singular as well as the plural forms of such terms; (iii) references to an agreement, statute or instrument mean such agreement, statute or instrument as from time to time amended, modified or supplemented; (iv) references to an "Exhibit," "Section" or "Schedule" refer to a Section of, or any Exhibit or Schedule to, this Agreement unless otherwise indicated; (v) the word "will" shall be construed to have the same meaning and effect as the word "shall"; (vi) the word "any" shall mean "any and all" unless otherwise indicated by context; (vii) the word "day" shall mean calendar day, and days shall be counted by excluding the first and including the last day, provided that when the last day falls on a Saturday, Sunday, or holiday, the last day shall be the next day which is not a Saturday, Sunday, or holiday; and (viii) references to an hour of the day mean such hour of the day in Eastern Time.

7.7 Severability. In case any provision in this Agreement shall be determined by a court of competent jurisdiction to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

7.8 Entire Agreement. This Agreement, together with the Exhibits and Schedules attached hereto, shall be deemed for all purposes to constitute the entire agreement of the Parties pertaining to the subject matter hereof and supersedes and cancels all prior agreements, whether oral or written, pertaining to the subject matter hereof. Each Party confirms that it is not relying on any representations, warranties or covenants of the other Party except as specifically set out in this Agreement.

7.9 Exclusive Remedies. The Parties hereto expressly waive and agree to forgo any and all rights to seek and obtain any form of monetary, economic or other damages (including actual, consequential, punitive and other forms of monetary or economic damages), and each of the Parties further agrees that each of the Parties shall be entitled to injunctive relief to prevent a violation of this Agreement and to obtain specific performance to require adherence to the obligations created by this Agreement. Before either Party brings legal action against the other Party (the "Defaulting Party") for failure to perform in any material respect any of its obligations under this Agreement, the entity alleging the breach (the "Alleging Party") shall first give the Defaulting Party written notice setting forth such failure in reasonable detail and stating that the Alleging Party requires such obligation to be performed, and shall give the Defaulting Party the opportunity to perform such obligation in all material respects within sixty (60) days of its receipt of such notice, or such longer period as is necessary if for reasons outside the control of the Defaulting Party such obligation cannot be performed within such sixty (60) day period, so long as the Defaulting Party is continuing in good faith to use its best efforts to perform such obligation. If any legal action relating to the enforcement of this Agreement is brought by a Party against the other Party, the prevailing Party shall be entitled to recover its reasonable costs, expenses and attorneys' fees.

7.10 No Third Party Beneficiaries. This Agreement is not intended to confer upon any person other than the Parties any rights or remedies hereunder. No person other than the Parties shall have any rights, interest or claims hereunder or be entitled to any benefits under or on account of this Agreement as a third-party beneficiary or otherwise.

7.11 Notices. Any notice hereunder may be given by facsimile transmission, with confirmation of transmission; by hand; by certified mail, return receipt requested; or by overnight delivery service, delivered to the Parties at their respective addresses or facsimile numbers set forth below, or to such other address or facsimile number as a Party may specify by notice to the other Party. Notices shall be deemed given when actually received.

If to Danbury/ Western Connecticut Healthcare:

John M. Murphy, M.D.
President and Chief Executive Officer
Danbury Health Systems, Inc.
24 Hospital Avenue
Danbury, CT 06810

with copies to:

Lisa M. Boyle
Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103

If to New Milford:

Richard J. Henley
Interim President/CEO
New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

with copies to:

David E. Daniels
Daniels and Porco, LLP
517 Route 22
P.O. Box 668
Pawling, NY 12564

7.12 Counterparts. This Agreement may be executed in any number of counterparts and by the Parties on separate counterparts, but all such counterparts shall together constitute but one and the same instrument.

8. **DEFINITIONS.**

8.1 "Affiliation" has the meaning set forth in the Preamble.

8.2 "Agreement" has the meaning set forth in the Preamble.

8.3 "Alleging Party" has the meaning set forth in Section 7.9.

8.4 "Attorney General" has the meaning set forth in Section 2.6.

8.5 "Closing" has the meaning set forth in Section 1.2.

8.6 "Closing Date" has the meaning set forth in Section 1.2.

8.7 "Closing Memorandum" has the meaning set forth in Section 1.2.

8.8 "Code" has the meaning set forth in Section 6.2.4.

8.9 "Confidential Information" means, with respect to a Party, all confidential or proprietary information concerning the business, finances or other affairs of such Party or of its affiliates disclosed in any manner, whether orally, visually or in written or other tangible form (including documents, devices and computer readable media) and all copies thereof, whether created by the discloser or recipient, by such Party or by its agents or employees to the other Party or its agents prior to, on or after the Effective Date.

8.10 "Current Members" has the meaning set forth in the Preamble.

8.11 "Danbury" has the meaning set forth in the Preamble.

8.12 "Danbury Entities" has the meaning set forth in the Preamble.

8.13 "Danbury Hospital" has the meaning set forth in the Preamble.

8.14 "Danbury Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a Danbury Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to Danbury, including suspension, surrender, revocation or restriction in any manner of a Danbury Entity's (a) participation in any government health care reimbursement program, including Medicare and Medicaid, or (b) license, registration, or certificate necessary to provide health care services; (ii) any adverse circumstance or change in or effect on a Danbury Entity's business, operations, assets, prospects or condition, financial or otherwise, which, when considered together with all other adverse changes and effects with respect to which such phrase is used in this Agreement, is material to the Danbury Entities considered as a single enterprise; or (iii) any change which would impair the ability of Danbury or any of the Danbury Entities to perform its obligations hereunder.

8.15 "Defaulting Party" has the meaning set forth in Section 7.9.

8.16 "DOJ" has the meaning set forth in Section 3.2.

8.17 "Due Diligence Information" means the information disclosed by Danbury to New Milford and the information disclosed by New Milford to Danbury in writing as part of the due diligence process or in writing pursuant to Section 2.7.

8.18 "Effective Date" has the meaning set forth in Section 1.2.

8.19 "ERISA" means Title IV of the Employee Retirement Income Security Act of 1974, as amended.

8.20 "Financial Statement" has the meaning set forth in Section 6.1.3.

8.21 "FTC" has the meaning set forth in Section 3.2.

8.22 "Interim Financial Statement" has the meaning set forth in Section 6.1.3.

8.23 "Letter of Intent" has the meaning set forth in the Preamble.

8.24 "Material Transaction" means the execution, amendment, or extension of an employment or consulting agreement for any Vice President or higher level executive; the incurrence of any indebtedness other than endorsement for deposit in the ordinary course of business; or entering into any contract, obligation, or other undertaking that has a term of a year or greater or that requires any New Milford Entity to make annual payments greater than $250,000, unless such New Milford Entity has a right to terminate without cause and without penalty on no more than thirty (30) days notice, excluding therefrom ordinary course renewals of the agreements listed on Schedule 8.24.

8.25 "New Milford" has the meaning set forth in the Preamble.

8.26 "New Milford Community Board" has the meaning set forth in Section 1.1.2.

8.27 "New Milford Due Diligence Information" means the information disclosed by New Milford to Danbury in writing as part of the due diligence process or disclosed by New Milford in writing pursuant to Section 2.7 as well as any reports on New Milford delivered to Danbury at the direction of New Milford.

8.28 "New Milford Entities" has the meaning set forth in the Preamble.

8.29 "New Milford Foundation" has the meaning set forth in the Preamble.

8.30 "New Milford Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a New Milford Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to New Milford, including suspension, surrender, revocation or restriction in any manner of a New Milford Entity's (a) participation in any government health care reimbursement program, including Medicare and Medicaid, or (b) license, registration, or certificate necessary to provide health care services; (ii) any adverse circumstance or change in or effect on its business, operations, assets, prospects or condition, financial or otherwise, which, when considered together with all other adverse changes and effects with respect to which such phrase is used in this Agreement, is material to the New Milford Entities considered as a single enterprise; or (iii) any change which would impair the ability of New Milford or any of the New Milford Entities to perform its obligations hereunder.

8.31 "New Milford Visiting Nurse Association" has the meaning set forth in the Preamble.

8.32 "Party" has the meaning set forth in the Preamble.

8.33 "Permit" has the meaning set forth in Section 6.2.12.

8.34 "Plan" has the meaning set forth in Section 6.2.8.

8.35 "Stark Law" has the meaning set forth in Section 6.2.10.

8.36 "Western Connecticut Healthcare" has the meaning set forth in the Preamble.

[Remainder of page intentionally left blank.]

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their respective, duly authorized officers as of the date first above written.

Witness	**DANBURY HEALTH SYSTEMS, INC.**
Judith Ward	By: [signature]
[*Name*]	[*Name*] John M. Murphy, M.D.
[*Title*] VP Planning and Marketing.	[*Title*] President and Chief Executive Officer

Witness	**NEW MILFORD HOSPITAL, INC.**
Sally F. Herlihy	By: [signature]
[*Name*]	[*Name*] Richard J. Henley
[*Title*] Vice President, Regulatory Compliance	[*Title*] Interim President/CEO

List of Schedules:

Schedule 1.1.1 – New Milford Community Board Members on Western Connecticut Healthcare Board of Directors
Schedule 3.4 Government Approvals and Filings
Schedule 3.5 – New Milford Non-Governmental Consents
Schedule 3.12.1 - Additional Actions to Be Completed by Danbury Based on Diligence Findings
Schedule 3.12.2 Additional Actions to Be Completed by New Milford Based on Diligence Findings
Schedule 5.2 – Clinical Services
Schedule 6.1.4.1 · Danbury Notices, Consents, Waivers and Amendments to Contractual Obligations
Schedule 6.1.4.2 - New Milford Notices, Consents, Waivers and Amendments to Contractual Obligations
Schedule 6.2.5 New Milford Facilities Licensed by the Department of Public Health
Schedule 6.2.7 – New Milford Collective Bargaining Organizations
Schedule 8.24 – New Milford Ordinary Course Renewals

Docket Number 10-31560-CON

Attachment II

- Certificate of Amendment for Danbury Health Systems, Inc. and New Milford Hospital, Inc.

CERTIFICATE OF AMENDMENT
NONSTOCK CORPORATION

Office of the Secretary of the State

MAILING ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
P.O. Box 150470
Hartford, CT 06115-0470
860-509-6003

DELIVERY ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
30 Trinity Street
Hartford, CT 06106
860-509-6003

FEE: $20.00

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FILING #0004248504 PG 01 OF 04 VOL B-01451
FILED 09/30/2010 11:00 AM PAGE 03412
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. NAME OF CORPORATION

DANBURY HEALTH SYSTEMS, INC.

2. THE CERTIFICATE OF INCORPORATION IS (check A, B or C)

_✓_ **A. AMENDED**

____ **B. RESTATED**

____ **C. AMENDED AND RESTATED**

The restated certificate consolidates all amendments into a single document.

3. TEXT OF EACH AMENDMENT / RESTATEMENT

See Attachment A.

(Please reference an 8 1/2 X 11 attachment if additional space is needed)

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FILED 09/30/2010 11:00 AM PAGE 03413
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

4. VOTE INFORMATION (check A, B or C.)

__✓__ A. **The Amendment was duly approved by the members in the manner required by sections 33-1140 to 33-1147 of the Connecticut General Statutes, and by the Certificate of Incorporation.**

_____ B. **The Amendment was duly approved by the incorporators and member approval was not required.**

_____ C. **The Amendment was duly approved by the board of directors and member approval was not required.**

5. EXECUTION

Dated this 30 day of September, 2010.

John M. Murphy	President and Chief Executive Officer	[signature]
Print or type name of signatory	**Capacity of signatory**	**Signature**

Revised 3/17/10

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FILED 09/30/2010 11:00 AM PAGE 03414
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

ATTACHMENT A

The Certificate of Incorporation of Danbury Health Systems, Inc. (the "Certificate") is hereby amended and changed as set forth below.

1. Section 1 of the Certificate is hereby amended and changed so as to read as follows: "The name of the corporation is Western Connecticut Healthcare, Inc."

2. Section 2.A of the Certificate is hereby amended and changed so as to read as follows:

   "2.A. The nature of the activities to be conducted, or the purposes to be promoted or carried out by the corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code ("the Code"), as the same may be amended from time to time, exclusively in support of and for the benefit of The Danbury Hospital ("the Danbury Hospital"), The Danbury Hospital Development Fund, Inc., Danbury Health Care Affiliates, Inc., New Milford Hospital, Inc. ("the New Milford Hospital"), New Milford Hospital Foundation, Inc. and The New Milford Visiting Nurse Association, Incorporated ("the supported organizations"), for so long as each such supported organization, respectively, (1) continues in existence as a functioning entity, and (2) continues to qualify for tax exemption under Section 501(c)(3) of the Code."

3. Section 2.D of the Certificate is hereby amended and changed so as to read as follows:

   "D. The corporation may engage in any lawful act or activity for which a corporation may be organized under the Nonstock Corporation Act of the State of Connecticut, provided any such act or activity is permitted to be carried on (1) by a corporation exempt from Federal Income Tax under Section 501(c)(3) of the Code, or (2) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code."

4. Section 5 of the Certificate is hereby amended and changed so as to read as follows:

   "5.A. There shall be the following classes of members:

   i. Life Members or Members for a Specified Term of Years. All persons listed in the corporate records of the Danbury Hospital as Life Members or Members for a Specified Term of Years as of the thirtieth day of March, 2001 shall be Members of the corporation for the period of time of their respective classification.

   ii. Regular Members. Regular Members of the corporation shall be nominated and elected to serve one (1) year terms in accordance with the provisions of the Bylaws of the corporation. Any person making a monetary contribution or who has volunteered a substantial portion of time to working for the corporation, or any subsidiaries or divisions thereof, or the Danbury Hospital or the New Milford Hospital, or who has shown a willingness to commit a

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FILED 09/30/2010 11:00 AM PAGE 03415
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

substantial portion of his or her time to the corporation, or any subsidiaries or divisions thereof, or the Danbury Hospital or the New Milford Hospital, is eligible to be a Regular Member.

iii. Ex Officio Members. The President of the corporation, the President of the Danbury Hospital, the President of the Danbury Hospital's Medical Staff, the President of the New Milford Hospital, the President of the New Milford Hospital's Medical Staff, the Mayor of the City of Danbury, and the First Selectman or Chief Executive Officer of the Towns of Bethel, Brookfield, New Fairfield, Newtown, Redding and Ridgefield shall be Ex-Officio Members of the Corporation. The Board of Directors shall have the power to add from time to time additional Ex-Officio Members without, in each instance, amending this Certificate of Incorporation. All such additions shall be by an affirmative vote held at a duly called Regular or Special Meeting of the Board of Directors."

5. Section 10 of the Certificate is hereby amended and changed so as to read as follows:

"10. References to sections of the Code shall be deemed references to the Internal Revenue Code of 1986, as the same may be amended from time to time, and to the corresponding provisions of any future United States Internal Revenue Law."

STATE OF CONNECTICUT
OFFICE OF THE SECRETARY OF THE STATE } SS. HARTFORD

I hereby certify that this is a true copy of record in this Office

In Testimony whereof, I have hereunto set my hand, and affixed the Seal of said State, at Hartford, this 30th day of September A.D. 20 10

Susan Bysiewicz

SECRETARY OF THE STATE

CERTIFICATE OF AMENDMENT
NONSTOCK CORPORATION

Office of the Secretary of the State

MAILING ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
P.O. Box 150470
Hartford, CT 06115-0470
860-509-6003

DELIVERY ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
30 Trinity Street
Hartford, CT 06106
860-509-6003

FEE: $20.00

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FILING #0004248508 PG 01 OF 07 VOL B-01451
FILED 09/30/2010 11:00 AM PAGE 03422
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. NAME OF CORPORATION

NEW MILFORD HOSPITAL, INC.

2. THE CERTIFICATE OF INCORPORATION IS (check A, B or C)

_____ **A. AMENDED**

_____ **B. RESTATED**

✓ **C. AMENDED AND RESTATED**

The restated certificate consolidates all amendments into a single document.

3. TEXT OF EACH AMENDMENT / RESTATEMENT

See Attachment A.

(Please reference an 8 1/2 X 11 attachment if additional space is needed)

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FILED 09/30/2010 11:00 AM PAGE 03423
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

4. VOTE INFORMATION (check A, B or C.)

✓ A. The Amendment was duly approved by the members in the manner required by sections 33-1140 to 33-1147 of the Connecticut General Statutes, and by the Certificate of Incorporation.

_____ B. The Amendment was duly approved by the incorporators and member approval was not required.

_____ C. The Amendment was duly approved by the board of directors and member approval was not required.

5. EXECUTION

Dated this 30 day of September, 2010.

Richard J. Henley	Interim President and Chief Executive Officer	[signature]
Print or type name of signatory	Capacity of signatory	Signature

Revised 3/17/10

ATTACHMENT A

AMENDMENT

The Certificate of Amendment to Certificate of Incorporation of The New Milford Hospital, Incorporated (the "Certificate") is hereby amended and changed as set forth below.

1. The title of the Certificate is hereby amended and changed so as to read as follows: "Amended and Restated Certificate of Incorporation of New Milford Hospital, Inc."

2. Section 4 of the Certificate is hereby amended and changed so as to read as follows:

"4. The classes, rights, privileges, qualifications, obligations, and the manner of election or appointment of the members are as follows: The sole member shall be specified in the Bylaws of the corporation (the "Sole Member"). The Sole Member shall have the right to vote and shall have all other rights, privileges, and obligations usually or by law accorded to the members of a non-stock, non-profit corporation and not conferred thereby or by the Certificate of Incorporation or Bylaws upon the Board of Directors of the corporation. The Sole Member shall have the right to approve all amendments to the Certificate of Incorporation and shall have the exclusive authority to amend or repeal the Bylaws.

The Bylaws of the corporation may provide that persons occupying certain positions within or without the corporation shall be ex-officio Directors who may vote and be counted in determining a quorum. As may be further provided in the Bylaws, the terms of elected Directors may be staggered by dividing the Directors into separate classes so that a specified number of Directors have terms that expire each year.

The personal liability of a Director to the corporation or its Sole Member for monetary damages for breach of duty as a Director shall be limited to the amount of compensation received by that Director for serving the corporation during the year of the violation if such breach did not:

A) involve a knowing and culpable violation of law by the Director;

B) enable the Director or an associate, as defined in Connecticut General Statutes, to receive an improper personal economic gain;

C) show a lack of good faith and a conscious disregard for the duty of the Director to the corporation under circumstances in which the Director was aware that his conduct or omission created an unjustifiable risk of serious injury to the corporation; or

D) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the corporation;

provided, however, that this provision shall not limit or preclude the liability of a Director for any act or omission occurring prior to its effective date."

3. Section 6 of the Certificate is hereby amended and changed so as to read as follows:

"6. Upon any dissolution or termination of the existence of the corporation, all of its property and assets shall, after payment of the lawful debts of the corporation and the expenses of its dissolution or termination, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to the Sole Member so long as it is at that time an organization that qualifies as an exempt organization under Section 501(c)(3) of the Code, or, if at the time of the dissolution or termination of existence of the corporation, the Sole Member is not in existence or does not qualify as an exempt organization under Section 501(c)(3) of the Code, to one or more charitable, scientific or educational organizations located in the State of Connecticut and qualified as exempt organizations under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Directors may determine."

[*The remainder of this page intentionally left blank.*]

Docket Number 10-31560-CON

Attachment III

- Revised Bylaws for Danbury Health Systems, Inc. and New Milford Hospital, Inc.

AMENDED AND RESTATED

BYLAWS

OF

WESTERN CONNECTICUT HEALTHCARE, INC.

ARTICLE I

Members

Section 1.01. Number of Members and Method of Election.

The Members of Western Connecticut Healthcare, Inc. (the "Corporation") shall not be less than fifty (50) in number, and all Members shall meet the qualification criteria specified in the Certificate of Incorporation. At any annual or special meeting of the Members, the Members shall elect the prospective Members proposed by the Committee on Governance (or such other committee of the Board as may then be charged with nominating individuals for election). The number of Members presented for election may vary from year to year. All Members elected shall serve for a term of one (1) year and until the next annual meeting.

Section 1.02. Vacancies. If at any time the Corporation shall have less than fifty (50) Members, the remaining Members may elect the additional prospective members proposed by the Committee on Governance in a number sufficient to bring the total membership to fifty (50). If the remaining Members constitute less than a quorum, the vote of a majority of the remaining Members shall nevertheless constitute action by the Members. Except as provided above, vacancies occurring in the membership between annual meetings shall be filled, if at all, at the next annual meeting.

Section 1.03. Annual Meetings. The annual meeting of the Members shall be held during the month of January in each year on such day and at such hour and place within the City of Danbury as shall be designated by the Board of Directors.

At the annual meeting the Members shall elect Directors in accordance with Section 2.01, shall elect new Members in accordance with Section 1.01, and shall transact such other business relating to the affairs of the Corporation as may come properly before the meeting.

Section 1.04. Special Meetings. Special meetings of the Members may be called by the Board of Directors, Chairman or President and shall be called within fifteen (15) days after receipt of the written request of twenty-five (25) Members of the Corporation. The call for a special meeting shall fix the time, day and place of the meeting and shall specify the general purpose or purposes for which the meeting is called.

Section 1.05. Notice of Meeting. Notice in writing of each meeting of the Members shall be given by or at the direction of the President or the Secretary or the officer or person calling the meeting to each Member by mailing a notice addressed to the Member at his or her last known post office address as last shown on the list of Members of the Corporation, postage prepaid, not less than ten (10) days nor more than sixty (60) days before the date of the meeting.

Section 1.06. Quorum and Voting. Fifteen (15) Members of the Corporation shall constitute a quorum for the transaction of business, and the act of a majority of Members present in person or

by proxy at any meeting at which a quorum is present at the time of the act shall be the act of the membership, unless the act of a greater number is required by law, the Certificate of Incorporation or these Bylaws.

ARTICLE II

Directors

Section 2.01. Election of Directors, Term of Office and Eligibility.

a. The Board of Directors shall consist of up to eighteen (18) Directors, no less than thirteen (13) of whom shall be Members of the Corporation. Up to thirteen (13) Directors shall be elected by the Members in accordance with Sections 2.01b and 2.01c. From the date of adoption of these Bylaws through the date of the annual meeting of the Members in January 2014, four (4) Directors (the "Community Board Directors") shall be members of the Community Board of New Milford Hospital, Inc. ("New Milford Hospital"). The President and Chief Executive Officer of the corporation shall be an ex-officio Director, who shall count towards a quorum and shall have the right to vote.

b. The elected Directors, excluding the Community Board Directors, shall be divided into three groups so that approximately an equal number of these Directors have terms that expire each year. At the first annual meeting of Members at which Directors are elected to serve such staggered terms, the Committee on Governance shall submit for election by the Members a slate of individuals approximately one-third of which shall be elected to one (1) year terms, approximately one-third of which shall be elected to two (2) year terms, and approximately one-third of which shall be elected to three (3) year terms. Thereafter, at each annual meeting of Members, the Committee on Governance shall submit for election by the Members a slate for

approximately one-third of the elected Directors, each to serve for a three (3) year term and until his successor is duly elected and qualified. The Committee on Governance may also submit for election by the Members at the annual meeting a slate of individuals to fill vacancies on the Board, including any vacancy in an unexpired term.

c. Except as provided in Section 3.01, an elected Director shall be eligible to serve three (3) consecutive terms on the Board of Directors and shall thereafter be eligible for reelection to the Board of Directors of the Corporation only after one year has elapsed. A Director elected to a one (1) year or two (2) year term at the first annual meeting of Members at which Directors are elected to three (3) year terms shall be deemed to have served a full three (3) year term for purposes of this Section. Thereafter, a Director elected to fill a vacancy in an unexpired term shall be deemed to have served a full three (3) year term for purposes of eligibility for reelection only if the Director has served more than one (1) year of the term.

Section 2.02. Duties and Responsibilities of the Board of Directors.

a. The final authority over the affairs, property and business of the Corporation is vested in the Board of Directors. The duties and responsibilities of the Board shall include, but not be limited to among others, the following:

- Formulate System Mission and Vision.
- Conduct strategic planning.
- Specify key goals/objectives to accomplish mission and vision.
- Establish key system-wide performance standards, objectives, and measurements.

- Approve mergers, acquisitions, joint ventures, affiliations, alliances and managed care relationships.
- Ensure executive management (CEO) performance.
- Approve operating and capital budgets.
- Allocate resources across organizational units; deploy capital.
- Manage investments.
- Ensure appropriate internal controls.
- Ensure an effective Human Resources program.
- Approve corporate charters.
- Conduct Board evaluation, recruitment.
- Ensure that the membership of the Board broadly represents the major geographic areas served by the Corporation's subsidiaries.
- Providing major support for all fund-raising, development and public relations efforts.

b. 1. Any duality of interest or possible conflict of interest, as determined under the Internal Revenue Code of 1986, as amended, or under the Connecticut Revised Nonstock Corporation Act (the "Act"), on the part of any Board member should be disclosed to the other members of the Board and made a matter of record. Following the annual meeting of the Board of Directors, and as may be provided in a conflict of interest policy adopted by the Board, each Director shall file a statement setting forth any potential duality or conflict of interest then known to or anticipated by such Director. Said statement shall become part of the permanent records of the Board. In addition, at any time when the subject of the duality or possible conflict becomes a matter of Board action, the Director shall restate for the record the possible conflict or duality.

2. Any Board member having a duality of interest or possible conflict of interest on any matter shall not vote or use his/her personal influence on the matter, and he/she shall not be counted in determining the quorum for the meeting, even where permitted by law. The minutes of the meeting shall reflect that the disclosure was made, the abstention from voting and the quorum situation.

3. The foregoing requirements should not be construed as preventing the Board member from briefly stating his/her position in the matter, or from answering pertinent questions of other Board members since his/her knowledge may be of great assistance.

4. The Board of Directors may adopt a policy on disclosure, duality of interest, and conflict of interest that supplements these provisions.

c. The members of the Board of the Corporation may also serve as members of the Boards of Directors of any of the Corporation's subsidiary organizations.

Section 2.03. Resignation. The resignation of a Director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified in such writing or at such later time as the resigning Director may specify and the Corporation shall accept.

Section 2.04. Vacancies. A vacancy shall be deemed to exist if the number of Directors in office is less than the maximum number permitted by these Bylaws. The existence of a vacancy

shall decrease the number of Directors in office for the purpose of determining a quorum. In case of any vacancy in the Board of Directors, the remaining Directors, though less than a quorum, by the concurring vote of a majority of such remaining Directors, may fill such vacancy until the next annual meeting of members, even though the number of Directors at the meeting is less than a quorum and even though such majority is less than a quorum; provided, however, that through the date of the annual meeting of the Members in January 2014, any vacancy with respect to a Community Board Director shall be filled by the remaining Directors from among the members of the Community Board of New Milford Hospital.

Section 2.05. Meetings, Voting, and Quorum.

a. Annual Meetings. An annual meeting of the Board of Directors shall be held as soon after the annual meeting of the Members as feasible, and such annual meeting may be held immediately after the adjournment of the annual meeting of the Members and at the same place, without notice. At such meeting the Board of Directors shall elect or appoint, as appropriate, the Chairman, the Vice Chairman, the President, one or more Executive, Senior and/or Vice Presidents, the Secretary, the Treasurer and such other officers of the Corporation as it deems desirable, and shall transact such other business relating to the affairs of the Corporation as may come before the meeting. The Chairman of the Corporation shall be elected from among the members of the Board of Directors.

b. Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman or the President and shall be called

by either of them within seven (7) days after receipt of a written request of any three (3) of the Directors. Meetings of the Board of Directors may be held within or without the State of Connecticut. No notice shall be given of regular meetings unless specifically directed by the President or the Chairman. Except as otherwise provided in these Bylaws, at least two (2) days written, oral or electronic notice shall be given to each Director of each special meeting of the Board of Directors, and such notice shall contain the date, time and place of such special meeting.

c. Quorum. A majority of the members of the Board of Directors in office immediately before a meeting of the Board begins shall constitute a quorum.

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

e. If all Directors, or all members of a committee of the Board of Directors, as the case may be, severally or collectively consent in writing to any action taken or to be taken, and the number of such Directors or members constitutes a quorum for such action, such action shall be as valid as though it had been authorized at a meeting of the Board of Directors or committee, as the case may be. The Secretary shall file such consents with the minutes of the meetings of the Board of Directors.

f. A Director or a member of a committee of the Board of Directors may participate in a meeting of the Board of Directors or of such committee by means of conference telephone or similar communications equipment enabling all Directors participating in the meeting to hear one another, and participation in a meeting pursuant to this subsection shall constitute presence in person at such meeting.

ARTICLE III

Officers

Section 3.01. Chairman of the Corporation. The Chairman shall serve a two (2) year term and shall have the responsibility and authority for assuring that the duties and responsibilities of the Board of Directors are properly performed. Notwithstanding the provisions of Section 2.01c to the contrary, a Director who is elected Chairman in the last year of the Director's third full term as a Director shall be eligible for election to a fourth term as a Director. His/her duties and responsibilities shall include but not be confined to:

a. Presiding at all meetings of the membership and the Board of Directors. In the absence of the Chairman, the Vice Chairman shall preside at any meeting. In the absence of both, any Director may be appointed by the Chairman or by the Directors present to preside at the meeting.

b. Deciding all rules of order at such meetings.

c. Acting as the principal advisor to the President and conferring regularly with him/her on recommendations for topics to be submitted to the Members and Directors.

d. Appointing any ad hoc committees of the Board in a manner consistent with these Bylaws.

e. Appointing Chairmen of standing, special and ad hoc committees except as otherwise noted in these Bylaws.

f. Approving recommendations on appointments to committees.

g. Developing the Board as a constructive force in the Corporation's affairs in insuring that its members are knowledgeable in the areas in which the Corporation operates and does business.

h. Keeping the membership advised of the business and affairs of the Corporation.

i. Signing, together with the President, reports to the membership.

j. Serving as an ex-officio member of all standing, special and ad hoc committees of the Board.

Section 3.02. Vice-Chairman of the Corporation. The Vice Chairman shall serve a two (2) year term and shall have such duties and responsibilities as the Chairman or the Board of Directors shall from time to time determine. The Vice Chairman shall assume the duties of the Chairman in the absence or disability of the Chairman.

Section 3.03. President. The President, as Chief Executive Officer of the Corporation, shall be responsible for its overall performance. He/she is accountable to the Board of Directors, through its Chairman, for planning, organizing, directing and controlling all corporate activities within approved budgets and under established policies, for execution of the Board's instructions and for achievement of the objectives agreed upon between him/her and the Board. He/she, or a representative designated by him/her, shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board, except the committee charged with reviewing his performance, or as otherwise provided in these Bylaws. His/her specific duties and responsibilities shall be as follows:

a. Proposing to the Board of Directors, for its approval, broad objectives and policies for the Corporation.

b. Developing, personally and by use of his/her executive team, the long-range plans for the Corporation consistent with approved objectives and submitting them to the Board for approval.

c. Assuring the timely preparation, personally and through use of his/her executive team, of the annual operating, cash flow and capital expenditure budgets, submitting them to the Board for approval and directing the organization toward achievement of the Board-approved budgets and objectives.

d. Determining, establishing and enforcing the general operating and administrative procedures required to implement basic policies established by the Board.

e. Preparing or directing the preparation of reports required by the Board and keeping it fully informed of important corporate activities and developments.

f. Presenting matters requiring Board decision, together with recommendations for appropriate action.

g. Assuring that a sound plan of organization is established, that the organizational functions are clearly defined and that competitive wage, salary and other compensation programs are developed, properly administered and maintained so that the Corporation will attract and hold competent, qualified employees.

h. Providing leadership for and directing the organizational units reporting to him/her and reviewing and evaluating their performance; insuring that such units are headed by qualified personnel and preparing a program for the development of these personnel.

i. Recommending to the Board of Directors, for approval, the appointment of officers, agents and consultants and their compensation.

j. Providing leadership, guidance and counsel to the Corporation's administrative unit.

k. Assuring, through the establishment and enforcement of proper controls and procedures, that all funds, physical assets and other property of the Corporation are safeguarded.

l. Assuring the timely preparation of a sound development and public relations program.

m. Representing the Corporation in contacts with industry, civic, educational, governmental and business groups and agencies.

n. Acting on behalf of the Corporation in its capacity as sole corporate member of any affiliated corporation or on behalf of the Corporation in exercising rights reserved to the Corporation in any subsidiaries of any affiliated corporation.

Section 3.04. Executive, Senior and Vice Presidents. The Board may elect or appoint one or more Executive, Senior and/or Vice Presidents of the Corporation, each of whom shall be accountable to the President. The specific duties and responsibilities of each Executive, Senior and/or Vice President shall be as determined by the President.

Section 3.05. Secretary. The Secretary shall serve a one (1) year term and shall act as secretary to the Corporation and the Board of Directors. The Secretary (or his/her designee) shall send appropriate notices, prepare agendas and records of minutes for all meetings of the Corporation and of the Board of Directors; shall act as custodian of all records and reports and shall be responsible for record keeping and maintaining adequate records.

Section 3.06. Treasurer. The Treasurer shall serve a one (1) year term and shall have the responsibility to determine that:

a. All funds, securities, notes, mortgages, deeds and other documents relating to the property of the Corporation are properly accounted for and all moneys are properly and promptly deposited.

b. The Board is informed of accounts that have been opened.

c. Financial statements accurately reflecting the financial status of the Corporation and its subsidiary organizations are reported to the Board.

d. Accounts are promptly paid consistent with corporate policy.

e. Resolutions as may be adopted by the Board relative to investments of funds are properly executed.

Section 3.07. Removal. The Board of Directors, by a vote of a majority of the Directors, may remove any officer of the Corporation from office at any time, regardless of the term for which such officer may have been elected or appointed.

Section 3.08. Additional officers. The Board of Directors, upon recommendation of the Committee on Governance or upon its own motion, may appoint such other officers of the Corporation, including a Controller, one or more Assistant Secretaries, or Assistant Treasurers,

as it finds necessary and appropriate. The Board shall prescribe the duties and responsibilities of all such appointed officers.

ARTICLE IV

Committees of the Board of Directors

Section 4.01. Committees. The Board of Directors, at the beginning of each year and as needed, will determine the number and type of committees required to support the Board in fulfilling its responsibilities and roles. The Board of Directors may create and constitute such committees with the purposes, powers, and duties as the Board may from time to time by resolution direct, and any such committee shall have been established pursuant to these written Bylaws.

a. Except as specifically authorized by a majority of the Directors, all committees shall be advisory in nature and shall not have authority to act on behalf of the Board of Directors. Committees authorized to act on behalf of the Board of Directors may not: (1) approve or recommend to the Members action that Sections 33-1000 to 33-1290 of the Act, inclusive, require to be approved by the Members; (2) fill vacancies on the Board of Directors or on any committee with the power to act on behalf of the Corporation; (3) adopt, amend or repeal these Bylaws; (4) approve a plan of merger; (5) approve a sale, lease, exchange or other disposition of all or substantially all of the property of the Corporation except as provided in Section 33-1101(e)(5) of the Act; or (6) approve a proposal to dissolve.

b. To the extent practicable and not inconsistent with law, accreditation requirements, or the bylaws of any affiliated entity controlled directly or indirectly by the Corporation ("Affiliates"), all committees of the Corporation shall serve as so-called "matrix committees" and will be

responsible for overseeing and coordinating the activities of the Affiliates within the scope of the purposes, powers, and duties of such committees as directed by the Board of Directors.

Section 4.02. Committee on Governance. In accordance with Section 4.01, the Board shall establish and maintain a committee to be charged with recommending individuals for election as Members, Directors, and Officers and with such other purposes, powers, and duties as the Board may direct. The committee shall be known as the Committee on Governance or by such other name as the Board shall determine.

ARTICLE V

Communications

The substance of all meetings of the Board of Directors and Board Committees shall be documented as minutes. All Directors shall receive the minutes of all meetings of the Board of Directors and Board Committees. Appropriate distribution of the minutes of the above meetings or dissemination of information contained therein to corporate personnel shall be the responsibility of the President.

ARTICLE VI

Amendments and Miscellaneous

Section 6.01. Amendment by Members. Any amendment of these Bylaws that limits, reduces, or eliminates the rights of Members shall require the affirmative vote of a majority of the Members voting thereon, a quorum being present. Notice of any such proposed amendment shall be included in the written notice of the meeting.

Section 6.02. Amendment by Directors. The Board of Directors shall have the power to adopt, amend or repeal these Bylaws as to those matters not specifically requiring the approval of the Members in accordance with Section 6.01 at any regular or special meeting of the Board by the affirmative vote of not less than a majority of the entire Board of Directors, provided notice of the proposed adoption, amendment or repeal shall have been given in the notice of the meeting.

Section 6.03. Seal. The seal of the Corporation shall be circular in form and shall bear the name of the Corporation around the circumference and shall be in such form as the Board of Directors may determine.

Section 6.04. Waivers of Notice. Whenever any notice of time, place, purpose, or any other matter, including any special notice or form of notice, is required or permitted to be given to any person by law or under the provisions of the Certificate of Incorporation or Bylaws of the Corporation, or of a resolution of Members or Directors, a written waiver of notice signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be equivalent to the giving of such notice. The Secretary of the Corporation shall cause any such waiver to be filed with or entered upon the records of the Corporation, or, in the case of a waiver of notice of a meeting, the records of the meeting. The attendance of any person at a meeting without protesting, prior to or at the commencement of the meeting, the lack of proper notice shall be deemed to be a waiver by such person of notice of such meeting.

Section 6.05. Indemnification of Corporation Members, Directors, Officers and Employees Against Judgments, Fines, and Penalties.

Present and past Members, Directors, Officers, employees and agents of the Corporation shall be entitled to, and this Corporation shall be obligated to provide, the indemnification benefits in accordance with the applicable provisions of the then current General Statutes of the State of Connecticut pertaining to nonstock Corporations.

Bylaws approved on September 30, 2010.

AMENDED AND RESTATED

BYLAWS

OF

NEW MILFORD HOSPITAL, INC.

(Changes adopted by the Directors on May 28, 2010)

DATED: SEPTEMBER 30, 2010

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ARTICLE I
Purposes

Section 1.1. General. The New Milford Hospital, Inc., a non-stock membership corporation (the "Corporation") and operator of the New Milford Hospital, was organized under Connecticut law on November 16, 1921, exclusively for charitable, scientific and educational purposes as a not-for-profit corporation. The purposes of the Corporation are to promote and further the financial welfare, programs, and activities of the New Milford Hospital (the "Hospital") and its affiliated entities. These purposes will be accomplished directly through the activities of the Corporation and by the delegation of specific responsibilities to affiliated entities of the Corporation. The Corporation is the sole member of The New Milford Visiting Nurse Association, Incorporated (the "Visiting Nurse Association") and the New Milford Hospital Foundation, Inc. (the "Foundation"). (The Foundation and the Visiting Nurse Association are referred to herein as the "Affiliated Entities.")

The Corporation shall be non-commercial, non-sectarian and non-partisan. It shall not endorse a commercial enterprise. The name of the Corporation shall not be used in connection with any commercial enterprise not appropriately related to promotion of the vision, mission, purposes or objectives of the Corporation.

Section 1.2. Affiliated Entities. The Affiliated Entities will act independently in order to accomplish their respective missions, while the Corporation will manage its own operations and will exercise its rights as sole member of the Affiliated Entities.

Section 1.3. Restrictions. The Corporation shall not, directly or indirectly, participate or intervene (in any way, including without limitation, the publishing or distributing of statements) in any political campaign on behalf of, or in opposition to, any candidate for public office; or devote more than an insubstantial part of its activities to attempting to influence legislation by propaganda or otherwise.

Section 1.4. Dissolution. In the event of the dissolution of the Corporation, its assets shall be distributed to one or more organizations in furtherance of one or more of the exempt purposes specified in Section 501(c)(3) and related Sections of the Internal Revenue Code of 1986, as from time to time amended.

ARTICLE II
Membership

Section 2.1. Member. The sole member of the Corporation shall be Western Connecticut Healthcare, Inc. (the "Sole Member"), a charitable corporation acting through its board of directors or by or through any person or persons designated by the board of directors of the Sole Member to act on behalf of the Sole Member.

Section 2.2. Duties and Responsibilities. The final authority over the affairs, property and business of the Corporation are vested in the Sole Member. The duties and responsibilities of the Sole Member shall include, among others, the following:

(a) Reviewing, making, and approving changes in these Bylaws;

(b) Insuring that the objectives, purposes, and goals of the Corporation as stated in these Bylaws are properly and effectively carried out by the Board of Directors;

(c) Approving, after presentment by the Board of Directors, the Corporation's annual operating and capital budgets and all fund raising programs proposed to be conducted by the Corporation;

(d) Selecting an independent auditor to examine the financial accounts of the Corporation at least annually;

(e) Approving, after presentment by the Board of Directors, significant programs and expenditures proposed to be undertaken by the Corporation, and, except where such action is in accordance with an approved operating or capital budget, the purchase or sale of significant capital or operating assets and the incurring of any indebtedness for borrowed money;

(f) Delegating, as appropriate, to the Board of Directors, policy-making functions, the supervision of the Hospital's operations, and the control over the Hospital's assets;

(g) Holding the exclusive power and authority to initiate any bankruptcy or insolvency action on behalf of the Corporation or to approve the initiation of any bankruptcy or insolvency action on behalf of any subsidiary of the Corporation, including, without limitation, the Foundation;

(h) Voting on all matters on which members are entitled to vote under the Connecticut Revised Nonstock Corporation Act upon recommendation of or approval from the Board of Directors; and

(i) Acting on any other matters on which action by the Sole Member is required or permitted by these Bylaws.

Section 2.3. Annual Meeting. The annual meeting of the Sole Member shall be held not less than 30 nor more than 135 days after the end of the Corporation's fiscal year, at such place and time as may be determined by the Board of Directors.

Section 2.4. Special Meetings. Special meetings of the Sole Member may be called by the Board of Directors or the Chairman of the Board of Directors and shall be called by the Chairman of the Board of Directors upon receipt of a written request of not less than 10 Directors. The notice for a special meeting shall fix the date, place and time of the meeting and the general purpose or purposes for which the meeting is called.

Section 2.5. Notice of Meeting. Notice of every meeting of the Sole Member shall be given by mailing a notice of the date, place and time of such meeting to the address of the Sole Member as the same appears on the records of the Corporation no fewer than 10 days and no greater than 60 days prior to the date of the meeting. Notice also may be provided to the Sole

Member by facsimile or e-mail to the facsimile or e-mail address of the Sole Member on record with the Corporation.

Section 2.6. Action Without Meeting. If the Sole Member consents in writing to any action taken or to be taken by the Corporation, the action shall be valid as though it had been authorized at a meeting of the Sole Member, and such written consent shall be filed in the corporate minute book.

ARTICLE III
Directors

Section 3.1. General Powers. The Board of Directors shall exercise the overall authority delegated to it by the Sole Member. The Board of Directors is responsible for ensuring the effectiveness and efficiency of the services and care provided at the Hospital and for continuous quality improvement, utilization, and risk management consistent with the goals and measures established by the Sole Member. The Board of Directors shall exercise the Corporation's rights as the sole member of the Affiliated Entities solely with the consent of, and at the direction of, the Sole Member. The Board of Directors will devote its efforts to the discharge of the following responsibilities, subject to the authority of the Sole Member:

(a) Formulate policies that ensure and enhance all aspects of the quality of care provided at the Hospital;

(b) Oversee the delivery of services in the region by monitoring quality of care and customer satisfaction;

(c) Recommend new services and opportunities based on community needs and advances in medical services;

(d) Monitor health status indicators and performance against quality goals established by the Corporation;

(e) Credential professional staff;

(f) Appoint and reappoint clinical privileges of members of the medical staff of the Hospital ("Medical Staff");

(g) Identify community needs;

(h) Conduct community outreach;

(i) Monitor community benefit activities;

(j) Advocate for the Corporation; and

(k) Review Medical Staff Bylaws and approve changes therein.

Section 3.2. Composition. The Board of Directors shall consist of those persons who serve from time to time as the directors of the Sole Member.

Section 3.3. Annual Meeting. The annual meeting of the Board of Directors shall be held immediately after the adjournment of the annual meeting of the Sole Member, and at the same place, without notice. At such meeting, the Board of Directors shall elect the officers of the Corporation, and shall transact such other business relating to the affairs of the Corporation as may come before the meeting.

Section 3.4. Regular Meetings. The Board of Directors shall meet for regular meetings not less frequently than quarterly (except for the quarter in which the annual meeting is held). Not less than two days notice by mail, telephone, facsimile or e-mail shall be given of each regular meeting of the Board of Directors. Each Director shall attend at least one-half of the regular meetings held during each year.

Section 3.5. Special Meetings. Special meetings of the Board of Directors may be called at any time by the Chairman and shall be called by him, or in the event of his absence or disability, the President, upon receipt of a written request of not less than four Directors. Not less than two days notice by mail, telephone, facsimile or e-mail shall be given of each special meeting of the Board of Directors, and such notice shall state the date, time and place of such special meeting.

Section 3.6. Quorum and Vote Required for Action. A majority of the Directors shall constitute a quorum for the transaction of business, and the act of a majority of the Directors present at a meeting and constituting a quorum thereat shall be the act of the Board of Directors, unless the act of a greater number is required by law, the Certificate of Incorporation, or these Bylaws. Directors comprising less than a quorum may adjourn the meeting to a future date.

Section 3.7. Action Without Meeting. If all the Directors unanimously consent in writing to any action taken or to be taken by the Corporation, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent shall be filed in the corporate minute book.

Section 3.8. Participation by Conference Telephone. A Director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communication equipment enabling all Directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 3.9. Self-Evaluation. On an annual basis, the Board of Directors shall conduct a self-evaluation and a summary report of the annual self-evaluation shall be maintained with the records of the Corporation.

Section 3.10. Compensation. The Directors shall not be paid any salary or other compensation for their services in such capacity; provided, however, that Directors may be reimbursed by the Corporation for their reasonable out-of-pocket expenses incurred in connection with their duties as Directors; and provided further, that nothing herein contained

shall be construed as prohibiting the payment to any person who is a Director of reasonable compensation for services rendered to the Corporation in any other capacity, subject in all events to the Corporation's Conflict of Interest Policy.

Section 3.11. Deportment. The Corporation shall maintain a Deportment Policy in order to promote professional and civil interaction between members of the Hospital community.

ARTICLE IV
Committees of the Board of Directors

Section 4.1. In General. Except where the Bylaws provide otherwise, the Board of Directors shall have the power to appoint chairmen and members of committees and subcommittees and to fill any vacancies on such committees or subcommittees.

A majority of the members of a committee shall constitute a quorum for the transaction of business, and the act of a majority of members of such committee present at a meeting and constituting a quorum thereat shall be the act of the committee. Members comprising less than a quorum may adjourn the meeting to a future date.

Members of committees need not be members of the Board of Directors. Except as specifically authorized by a majority of the entire Board of Directors, all committees shall be advisory and all actions and recommendations proposed by any committee to be taken on behalf of the Hospital shall be subject to the approval or disapproval of, or modification by, the Board of Directors.

To the extent practicable and not inconsistent with law or accreditation requirements, committees of the Corporation shall be established as so-called "matrix committees" pursuant to which the applicable committee of the Sole Member shall also serve as the corresponding committee of the Corporation (e.g., the finance committee of the Sole Member shall serve as the finance committee of the Corporation). A matrix committee may take action on behalf of the Board of Directors only if the Board of Directors approves the creation of and appointment of directors to such matrix committee and all members of such matrix committee are Directors.

Section 4.2. Medical Affairs Committee. The Board of Directors shall establish and maintain, among other committees, a Medical Affairs Committee responsible to the Board of Directors for medical and professional policies, assuring quality care at the Hospital and peer review. The Medical Affairs Committee shall be charged with any matters relative to the professional qualifications and activities of the Medical Staff or applicants (including appointments, privileges, disciplinary action and/or reappointment for physicians and dentists referred to the committee by the Board of Directors) and shall act, through an appropriate subcommittee, as the Joint Conference Committee pursuant to the Public Health Code. The Medical Affairs Committee may, on behalf of the Board of Directors, review and approve amendments to the Medical Staff Bylaws, rules and regulations, and policies. The Medical Affairs Committee also may act on behalf of the Board of Directors in matters of appointment,

reappointment, or renewal or modification of clinical privileges, provided that the Board of Directors shall consider and, if appropriate, ratify all positive Medical Affairs Committee decisions at its next regularly scheduled meeting, and provided further that the Medical Affairs Committee shall not act if any of the following conditions exist: (1) the applicant has submitted an incomplete application; (2) the Executive Committee of the Medical Staff has made a final recommendation that is adverse or limits privileges; (3) there is a current challenge or a previously successful challenge to the applicant's license or registration; (4) the applicant's medical staff membership at another organization has been involuntarily terminated; (5) the applicant's clinical privileges have been involuntary limited, reduced, denied, or removed; or (6) there has been a final judgment adverse to the applicant in a professional liability action. If the Medical Affairs Committee's decision is adverse to an applicant, the decision shall be considered a decision of the Board of Directors and the matter shall be subject to further proceedings in accordance with the Medical Staff Bylaws, rules and regulations, and policies.

ARTICLE V
Officers

Section 5.1. Number and Title. The officers of the Corporation shall be a Chairman, a Vice Chairman, a President, a Secretary, a Treasurer and such other officers as the Board of Directors may from time to time deem necessary.

Section 5.2. Election, Term of Office and Vacancies. The officers of the Corporation shall be elected by the Board of Directors at its annual meeting. Vacancies or new offices may be filled at any meeting of the Board of Directors. Paid employees who are designated as officers of the Corporation shall be appointed by the Board of Directors, shall carry out their duties under the direction of the President, and shall hold office at the pleasure of the Board of Directors.

Section 5.3. Duties and Powers. The duties of the officers shall be as follows:

(a) Chairman. The Chairman shall serve a two (2) year term and, as directed by and representing the Board of Directors, shall have the responsibility and authority for assuring that the duties and responsibilities of the Board of Directors are properly performed. A Director who is elected Chairman in the last year of the Director's third full term as a Director shall be eligible for election to a fourth term as a Director. His/her duties and responsibilities shall include but not be confined to:

(i) Presiding at all meetings of the Board of Directors. In the absence of the Chairman, the Vice Chairman shall preside at any meeting. In the absence of both, any Director may be appointed by the Chairman or by the Directors present to preside at the meeting.

(ii) Deciding all rules of order at such meetings.

(iii) Acting as the principal advisor to the President of the Hospital and conferring regularly with him on recommendations for topics to be submitted for consideration by the Directors.

(iv) Appointing any ad hoc committees of the Board of Directors in a manner consistent with these Bylaws.

(v) Appointing Chairmen of standing and special committees except as otherwise provided in these Bylaws.

(vi) Approving recommendations on appointments to committees, and reviewing and monitoring the performance of the committees of the Board of Directors.

(vii) Developing the Board of Directors as a constructive force in the Hospital's affairs by insuring that its members are knowledgeable in medical and administrative matters in the areas in which the Hospital operates or where expansion is contemplated.

(viii) Keeping the Sole Member promptly and fully advised of the business and affairs of the Hospital.

(ix) Signing, together with the President, reports to the Sole Member.

(x) Serving as an ex-officio member of all standing and special committees of the Board of Directors and of the Medical Staff.

(b) Vice Chairman. The Vice Chairman shall serve a two (2) year term and shall have such duties and responsibilities as the Chairman or the Board of Directors shall from time to time determine. The Vice Chairman shall assume the duties of the Chairman in the absence or disability of the Chairman.

(c) President. The President is the Chief Executive Officer of the Hospital and shall be responsible for its overall performance. He shall be qualified for his responsibilities through education and experience. He is accountable to the Board of Directors, through its Chairman, for planning, organizing, directing and controlling all Hospital activities within approved budgets and under established policies; for execution of the Board of Directors' instructions and for achievement of the objectives agreed upon between him and the Board of Directors. He is a member of the Board of Directors. He shall be an ex-officio member of all standing, special and ad hoc committees of the Board of Directors and the Medical Staff. His specific duties and responsibilities shall include the following:

(i) Proposing to the Board of Directors, for its approval, broad Hospital objectives and policies.

(ii) Developing strategic and long-range plans for the Hospital consistent with approved objectives and submitting them to the Board of Directors for approval.

(iii) Assuring the timely preparation of the annual operating, cash flow and capital expenditure budgets, submitting them to the Board of

Directors for approval and directing the organization toward achievement of the Board of Directors approved budgets and objectives.

(iv) Determining, establishing and enforcing the general operating and administrative procedures required to implement basic policies established by the Board of Directors.

(v) Preparing or directing the preparation of reports required by the Board of Directors and keeping it fully informed of important Hospital activities and developments.

(vi) Presenting matters requiring decision by the Board of Directors, together with recommendations for appropriate action.

(vii) Assuring that a sound plan of organization is established, that the organizational functions are clearly defined and that competitive wage, salary and other compensation programs are developed, properly administered and maintained so that the Hospital will attract and hold competent, qualified employees.

(viii) Providing leadership for and directing the organizational units reporting to him and evaluating their performance; insuring that such units are headed by qualified personnel and preparing a program for the development of these personnel.

(ix) Recommending to the Board of Directors, for approval, the appointment of officers, agents and consultants and their compensation.

(x) Providing leadership, guidance and counsel to the Hospital's administrative, medical and operating units.

(xi) Assuring, through the establishment and enforcement of proper controls and procedures, that all funds, physical assets and other property of the Hospital are safeguarded.

(xii) Assuring the timely preparation of a sound development and public relations program.

(xiii) Representing the Hospital, in contacts with industry, civic, educational, governmental and business groups and agencies.

(xiv) Serving or delegating representatives to serve as members ex-officio of all standing committees.

(d) Executive, Senior and Vice Presidents. The Executive, Senior and Vice Presidents, if any, shall perform those functions delegated to them by the President.

(e) Treasurer. The Treasurer shall serve a one year term and shall be responsible for determining that:

(i) All funds, securities, notes, mortgages, deeds, and other documents relating to the property of the Corporation are properly accounted for.

(ii) The Board of Directors is informed of accounts that have been opened and is assured that moneys are properly and promptly deposited.

(iii) Financial statements accurately reflecting the financial status are reported to the Board of Directors.

(iv) Accounts are promptly paid consistent with Hospital policy.

(v) Resolutions as may be adopted by the Board of Directors relative to investments of funds are properly executed.

(f) Secretary. The Secretary shall serve a one year term and shall act as Secretary to the Corporation and the Board of Directors. The Secretary (or his designee) shall send appropriate notices, prepare agendas and record minutes for all meetings of the Board of Directors; shall act as custodian of all records and reports; and shall be responsible for the keeping of adequate records of the actions of the Board of Directors.

Section 5.4. Other Officers. The Board of Directors may elect a Controller and one or more Assistant Secretaries or Assistant Treasurers, who need not be members of the Board of Directors.

Section 5.5. Removal. The Board of Directors, by the affirmative vote of a majority of Directors present at a meeting and constituting a quorum thereat, may remove any officer of the Corporation from office at any time, and with or without cause, regardless of the term for which such officer may have been elected or appointed.

ARTICLE VI
Community Board

Section 6.1. General. The Directors shall organize and appoint a community board of advisors ("Community Board") that shall operate as a unit of the Corporation and not as a separate legal entity.

Section 6.2. Composition. The Community Board shall include no more than 12 members. The members of the Community Board shall include a representative of the Visiting Nurse Association and a representative of the Foundation. The Chief Executive Officer of the

Sole Member may attend meetings of the Community Board in his discretion. The Directors may appoint one or more members of the Community Board to serve as Chairman or as Co-Chairman of the Community Board.

Section 6.3. Qualifications of Members. Members of the Community Board shall possess the following qualifications:

(a) Members should demonstrate an interest in contributing to the betterment of the community;

(b) Members should demonstrate the capacity to bring sound judgment and thinking to the issues before the Community Board;

(c) Members should have a business, professional, or volunteer background that provides expertise in one or more of the following areas: finance, management, quality assurance, health care, marketing, human resources, or planning;

(d) Members should have one residence within the Hospital's primary or secondary service area;

(e) Members should be committed to the mission of the Hospital and its subsidiaries and be informed about the Hospital's mission, services, policies, and programs;

(f) Members should serve in good faith and in a manner reasonably believed to be in the best interests of the Hospital and community and should understand that the role of any good Community Board member is to be a team player;

(g) Members should be persons who can be trusted to keep information in confidence as appropriate with regard to Community Board matters, follow conflict of interest and confidentiality policies, and assist the Board of Directors in carrying out its fiduciary responsibilities;

(h) Members should consistently attend Community Board meetings;

(i) Members may be asked to serve on a committee of the board of directors of the Sole Member;

(j) Members may be encouraged to participate in both external and internal functions for the Hospital and advocate and inform others about the Hospital;

(k) Members should demonstrate the ability to listen, analyze, think clearly and creatively, and work well with people individually and in a group;

(l) Members should be willing to (i) commit time for preparation and evaluation of agenda and supporting materials, issues, and data related to the Community Board's responsibility in ensuring Hospital policy, (ii) ask questions, (iii) offer constructive

comments, (iv) take responsibility and follow through on a given assignment, (v) open doors in the community, and (vi) evaluate oneself; and

(m) Members should possess honesty; sensitivity to and tolerance of differing views; a friendly, responsive, and patient approach; community-building skills; personal integrity; a developed sense of values; and concern for the Hospital's development.

Section 6.4. Term. Members of the Community Board shall ordinarily be elected to terms of three years. Members of the Community Board shall be divided into three groups so that approximately an equal number of members of the Community Board have terms that expire each year.

Section 6.5. Duties. The Community Board shall fulfill the following duties:

(a) Respond to requests from the Board of Directors for input on strategic direction, changes in service, community relations, and philanthropy;

(b) Upon request from the Board of Directors, provide advice with respect to the Hospital's facilities, maintenance, staff, programs, services, and policies;

(c) Represent the unique interests of the Hospital's service area and constituencies by identifying, advising and championing new projects, services, and outreach efforts of particular interest to residents of the Hospital's service area;

(d) Serve as ambassadors for the Hospital with local community groups and constituents;

(e) Support and promote philanthropy efforts by assisting in identifying prospective donors and upon request, participating in efforts to secure additional donations, including at special events in support of the Foundation;

(f) Participate in educational sessions concerning the Hospital's strategic plan and needs; and

(g) Carry out other responsibilities as requested by the Board of Directors.

Section 6.6. Meetings. The Community Board shall meet at least quarterly at such times as may be determined by the Co-Chairman of the Community Board.

Section 6.7. Periodic Review. The Board of Directors shall periodically review the duties and activities of the Community Board to determine whether the Community Board is achieving its objectives and whether the Community Board should continue to exist.

ARTICLE VII
Medical Staff

Section 7.1. Regulatory Standards. The Standards of the Joint Commission, Healthcare Facilities Accreditation Program and other regulatory bodies shall serve as guidelines in establishing the qualifications, powers and duties of the Medical Staff.

Section 7.2. Membership. The Board of Directors shall delegate to the Medical Staff the authority to evaluate the professional competence of staff members and applicants for staff privileges. It shall hold the Medical Staff responsible for making annual and interim recommendations to the Board of Directors concerning initial staff appointments, re-appointments, and the assignment or curtailment of privileges.

The Board of Directors has the authority and the responsibility for appointing members of the Medical Staff. The Board of Directors shall establish a procedure for processing and evaluating the applications for Medical Staff membership, and for granting of clinical privileges. This procedure shall involve the Corporation's administration, the Medical Staff, and the Board of Directors. The appointment and re-appointment of Medical Staff members should be based upon well-defined and written criteria related to the goals and standards of the Corporation as set forth in the Medical Staff Bylaws, rules and regulations, and policies. The Board of Directors shall utilize the advice of the Medical Staff in granting and defining the scope of clinical privileges to individuals, commensurate with their qualifications, experience, and present capabilities. No applicant shall be denied Medical Staff membership and/or clinical privileges on the basis of sex, race, creed, color, or national origin or on the basis of any other criterion lacking professional justification.

In holding the Medical Staff responsible for making recommendations to the Board of Directors concerning staff appointments and re-appointments, as well as the granting, curtailment, suspension, or revocation of clinical privileges, the Board of Directors shall require that the Medical Staff Bylaws, rules and regulations, and policies include a mechanism for review of decisions, including the right to be heard at each step of the process, when requested by the particular practitioner. The final decision must be rendered by the Board of Directors within a stated period of time.

Whenever the Board of Directors does not concur in a Medical Staff recommendation relative to clinical privileges, there shall be a review of the recommendations by the Medical Affairs Committee before a final decision is reached by the Board of Directors.

Practitioners applying for Medical Staff membership and/or for clinical privileges must sign an agreement to abide by the Hospital rules and regulations and the Medical Staff Bylaws, rules and regulations, and policies. The Board of Directors should inform applicants of the disposition of their application for Medical Staff membership and/or clinical privileges within a reasonable period of time after their application has been submitted.

Section 7.3. Bylaws, Rules and Regulations, and Policies. The Medical Staff Bylaws, rules and regulations, and policies shall be subject to the approval of the Board of Directors,

which approval shall not be unreasonably withheld. Such Bylaws, rules and regulations, and policies shall include an effective formal means for the Medical Staff to participate in the development of Corporation policy relative to hospital management and patient care. The Medical Staff Bylaws, rules and regulations, and policies, including subsequent amendments, shall state the policies under which the Medical Staff shall regulate itself, and shall become effective when approved by the Board of Directors. Effective communication between the Board of Directors and the Medical Staff shall be established by the Medical Affairs Committee and through appointment of individual Medical Staff members to appropriate committees of the Board of Directors.

Section 7.4. Standards, Ethics and Policies. The Board of Directors shall require that the Medical Staff establish methods that are designed to ensure the achievement and maintenance of high standards of professional ethical practices.

Policies shall be established by the Board of Directors that ensure that only members of the Medical Staff shall admit patients to the Hospital. Further policies shall ensure that a physician member of the Medical Staff is responsible for the medical aspects of each hospitalized patient's care.

The Board of Directors shall ensure that the Medical Staff is provided with the necessary administrative assistance to facilitate regular comprehensive peer analysis of the clinical practice and to facilitate utilization review activities within the Hospital. The Board of Directors must be kept advised of recommendations ensuing from Medical Staff activity.

The Board of Directors shall require that each member of the Medical Staff observe all the ethical principles of his or her profession, and the Board of Directors and the Medical Staff shall take all reasonable steps to ensure adherence to such ethical principles. Upon termination of medical/administrative personnel, physicians shall have the right to the same procedures as provided for other members of Medical Staff, unless otherwise provided by contract.

ARTICLE VIII
Signing of Contracts, Checks, Etc.

Section 8.1. Contracts. All contracts for the sale or purchase of real property or other capital assets, and all deeds, leases, mortgages, releases and other instruments of conveyance relative to the sale, lease or mortgage of the property of the Corporation, shall be executed on behalf of the Corporation, by the Chairman of the Board of Directors or, in his absence or disability, as may be provided by the Board of Directors by resolution duly adopted. Notwithstanding the foregoing, the President shall have the authority to make expenditures in such amounts as do not exceed the budget approved by the Board of Directors budget during any one year. With respect to the sale or purchase of non-real estate capital assets, the Board of Directors may adopt a policy that includes pre-approved authority for certain officers of the Corporation.

Section 8.2. Checks, Etc. All checks or demands for monies and notes of the Corporation shall be signed by such officer or officers, or such other person or persons as the Board of Directors may from time to time designate.

ARTICLE IX
Indemnification

Section 9.1. Indemnification of the Member, Directors, Etc. The Corporation shall indemnify its Sole Member, Directors, officers, employees and agents against any and all judgments, fines, amounts paid in settlement and expenses, including attorneys' fees, arising out of or relating to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, and to which such persons are or may be made parties by reason of their affiliation with the Corporation, to the fullest extent possible under Connecticut law.

ARTICLE X
Conflict of Interest, Confidentiality and Fidelity Policies

Section 10.1. Conflict of Interest. The Corporation shall maintain a Conflict of Interest Policy in accordance with generally accepted standards and practices of tax-exempt hospitals and health care organizations, nonprofit corporations and/or applicable law.

Section 10.2. Confidentiality Policy. No director, committee member, officer, or senior manager of the Corporation (each of which for purposes of this Article X shall be hereinafter referred to as a "Recipient(s) of Information") shall discuss with or otherwise disclose to third parties confidential information regarding the operations or, generally, the affairs of the Corporation, except when engaged in the conduct of the proper business of the Corporation. For purposes of this Article, all information that is not a matter of public record, or not otherwise authorized by the Board of Directors or the President to be disclosed to the public, or furnished in the proper business of the Corporation, shall be considered strictly confidential. In furtherance, and not in limitation, of this policy, the Board of Directors shall use its best efforts to ensure that the following shall apply to all Recipients of Information:

(a) The operations and affairs of the Corporation, including without limitation, the deliberations of the Board of Directors and committees, subcommittees staff or the deliberations of other meetings of the Corporation, shall not be discussed with or otherwise disclosed to third parties. In addition, the resolutions, decisions and other business of the Board of Directors, officers committees, or subcommittees with powers delegated by the Board of Directors shall not be disclosed to third parties without the prior authorization of the Board of Directors or the President.

(b) The Corporation's operations and general affairs, including its books and records (including all documents, reports, records, data, financial statements, membership lists, minutes and related materials) shall not be discussed or otherwise disclosed to third parties. In furtherance of this non-disclosure policy, information regarding donors, donations, pending grants, investments, ownership rights, contracts and agreements entered into by the Corporation,

policies of the Corporation, financial information and business records of the Corporation shall be treated as strictly confidential by all Recipients of Information.

(c) A Recipient of Information shall not sell, trade or exchange information about the Corporation's donors or potential donors.

(d) A Recipient of Information shall not disclose information regarding a donor or potential donor or a donation or potential donation without the prior, written approval of the Board of Directors and such donor or potential donor.

Section 10.3. Fidelity Policy. In addition to his or her fiduciary obligations under applicable law, each director, committee member, officer and senior manager shall have the affirmative duty of loyalty to the Corporation. Each Recipient of Information shall refrain from taking any action that would be detrimental to the interests of the Corporation.

Section 10.4. Annual Affirmations. Each Recipient of Information annually shall sign a statement which affirms such person:

(a) has received a copy of the Corporation's Conflict of Interest Policy;

(b) has received a copy of the Confidentiality and Fidelity Policies set forth above in Sections 10.2 and 10.3;

(c) has read and understands each such Policy;

(d) has made disclosures when necessary and agreed to comply, has complied, and is in compliance with the Corporation's Conflict of Interest Policy, Confidentiality Policy and Fidelity Policy; and

(e) shall disclose to the Board of Directors his or her service as a member of the board of directors, or as an officer, employee or independent contractor of any other hospital or other charitable organization with similar purposes, whether within or without the State of Connecticut.

Section 10.5. Survival of Duties, Etc. The duties, obligations and responsibilities with respect to confidentiality as set forth in this Article shall survive the resignation, removal or expiration of the term of any person subject thereto.

ARTICLE XI
Amendment and Miscellaneous

Section 11.1. Amendment. These Bylaws may be altered, amended or repealed by the Sole Member at any annual or special meeting of the Sole Member.

Section 11.2. No Discrimination. It shall be the policy of the Corporation to fully support and comply with state and federal laws related to equal opportunity. The Board of Directors, Committees of the Corporation and their members shall not engage in discrimination

against any person because of race, color, national origin, religion, disability, sexual orientation, age, or any other class or status protected by state or federal law.

Section 11.3. Fiscal Year. The fiscal year of the Corporation shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 11.4. Principal Office. The principal office of the Corporation shall be located in New Milford, Connecticut. The Corporation may have other offices within or without the State of Connecticut as the Board of Directors may from time to time determine.

Section 11.5. Seal. The seal of the Corporation shall be circular in form and shall bear the name of the Corporation around the circumference and shall be in such form as the Board of Directors may determine.

Section 11.6. Waivers of Notice. Whenever any notice of time, place, purpose or any other matter, including any special notice or form of notice, is required or permitted to be given to any person by law or under the provisions of the Certificate of Incorporation or Bylaws of the Corporation, or of a resolution of the Sole Member or Directors, a written waiver of notice signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be equivalent to the giving of such notice. The Secretary of the Corporation shall cause any such waiver to be filed with or entered upon the records of the Corporation or, in the case of a waiver of notice of a meeting, the records of the meeting. The attendance of any person at a meeting without protesting, prior to or at the commencement of the meeting, the lack of proper notice shall be deemed to be a waiver of such person of notice of such meeting.

Section 11.7. Gender. Any office of the Corporation may be held by either a man or woman and, whenever such office is held by a woman, the words "he" or "him" contained in these Bylaws shall be read "she" and "her".

Section 11.8. Severance and Construction. Should any provision of these Bylaws be invalid under law, then such provision shall be deemed stricken from these Bylaws and the remainder shall be unaffected thereby. Should any provision be invalid due to its scope or breadth, then it shall be construed to be valid to the scope or breadth permitted by law.

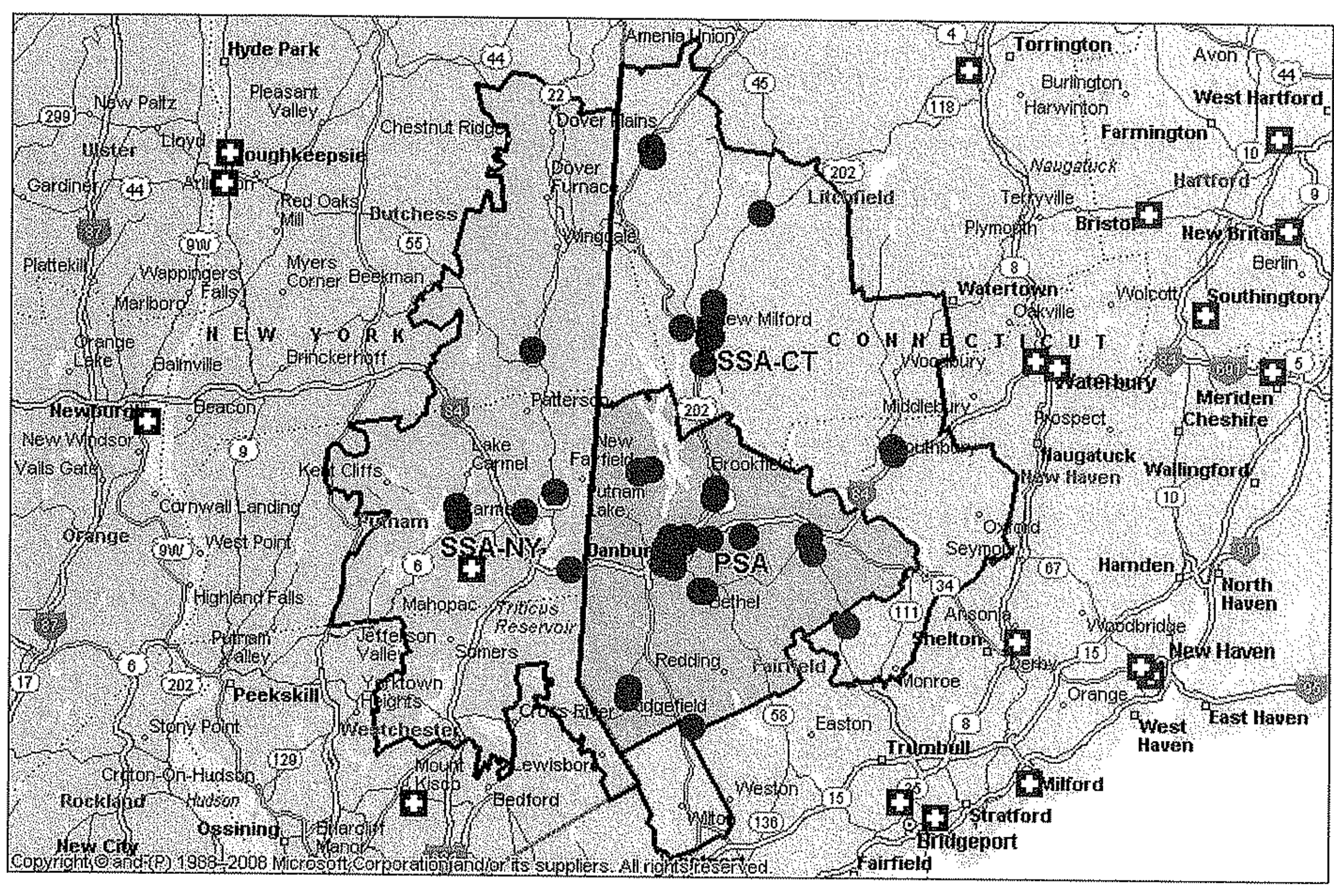
Bylaws approved on September 30, 2010.

Docket Number 10-31560-CON

Attachment IV

- Western Connecticut Healthcare Map of Primary Care Office Locations

Location of Western Connecticut Healthcare Primary Care Practices



Docket Number 10-31560-CON

- Western Connecticut Healthcare Listing of Primary Care Physicians

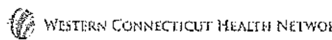
WESTERN CONNECTICUT HEALTHCARE PRIMARY CARE PHYSICIAN OFFICES

Bethel Medical Group, PC	David Shapiro, MD	155 Greenwood Avenue	Bethel, CT	DH
Bethel Medical Group, PC	Edward Volpintesta, MD	155 Greenwood Avenue	Bethel, CT	DH
Village Square Internal Medicine	James Finnerty, MD	2 Elizabeth Street	Bethel, CT	DH
Village Square Internal Medicine	Michelle Lentner-Foye, MD	2 Elizabeth Street	Bethel, CT	DH
Village Square Internal Medicine	Sean Mcgrade, MD	2 Elizabeth Street	Bethel, CT	DH
Village Square Internal Medicine	Robert Wenick, MD	2 Elizabeth Street	Bethel, CT	DH
Village Square Internal Medicine	Thomas Whelan, MD	2 Elizabeth Street	Bethel, CT	DH
--	Robert Fitton, MD	246 Federal Road	Brookfield, CT	NMH
--	Ivette Diaz, MD	304 Federal Road	Brookfield, CT	DH
--	Frederick Kayal, MD	300 Federal Road	Brookfield, CT	DH
--	Irene Moreira, MD	246 Federal Road	Brookfield, CT	DH
Brookfield Family Medicine	Matthew Amara, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Julia Auerbach, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Matthew Farrell, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Jolanta Fragoso, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Rob Mascia, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Kumkum Modwel, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Martha Moulton, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Brookfield Family Medicine	Kenneth Pellegrino, MD	60 Old New Milford Road	Brookfield, CT	DH - DOPS
Free Pediatrics	Claire Free, MD	2 Old New Milford Road	Brookfield, CT	DH
Landmark Healthcare	Robert Jarrett, MD	2 Old New Milford Road	Brookfield, CT	DH
--	Cristina Blejan, MD	93 West Street	Danbury, CT	NMH
--	Charles Cahn, MD	16 Hospital Avenue	Danbury, CT	DH
--	Howard Kaplan, MD	2 Glen Hill Road	Danbury, CT	DH
--	Sargur Jyothi, MD	57 North Street	Danbury, CT	DH
Advanced Internal Medicine	Michael Taweh, MD	16 Hospital Avenue	Danbury, CT	DH
Advanced Internal Medicine	Walter Curtice, MD	16 Hospital Avenue	Danbury, CT	DH
Danbury Medical Group	Karen Coblens, MD	132 Main Street	Danbury, CT	DH
Danbury Medical Group	Kenneth Litwin, MD	132 Main Street	Danbury, CT	DH
Danbury Medical Group	Jeffrey Metzger, MD	132 Main Street	Danbury, CT	DH
Danbury Medical Group	Madalina Raut, MD	132 Main Street	Danbury, CT	DH
Danbury Medical Group	Svetlana Tikhomirova, MD	132 Main Street	Danbury, CT	DH
Danbury Medical Group	Diane Wenick, MD	132 Main Street	Danbury, CT	DH
Danbury Medical Group	Martin Williams, MD	132 Main Street	Danbury, CT	DH
Danbury Primary Care	Craig Curry, MD	41 Germantown Road	Danbury, CT	DH - DOPS
Danbury Primary Care	Aida Dervisevic, MD	41 Germantown Road	Danbury, CT	DH - DOPS
Danbury Primary Care	Joseph Franceschina, MD	41 Germantown Road	Danbury, CT	DH - DOPS
Danbury Primary Care	Jay Weiner, MD	41 Germantown Road	Danbury, CT	DH - DOPS
Danbury Primary Care	Gary Yacono, MD	41 Germantown Road	Danbury, CT	DH - DOPS
Magavi & Magavi Internal Medicine	Nimi Magavi, MD	57 North Street	Danbury, CT	DH
Magavi & Magavi Internal Medicine	Shiv Magavi, MD	57 North Street	Danbury, CT	DH
Martha Severino, MD, PLLC	Martha Severino, MD	67 Sand Pit Road	Danbury, CT	DH
Medical Associates of Danbury	Mary Blackman, MD	79 Sand Pit Road	Danbury, CT	DH - DOPS
Medical Associates of Danbury	Kenneth Osnoss, MD	79 Sand Pit Road	Danbury, CT	DH - DOPS
Medical Associates of Danbury	Byron Thomas, MD	79 Sand Pit Road	Danbury, CT	DH - DOPS
Medical Associates of Danbury	Vadim Tikhomirov, MD	79 Sand Pit Road	Danbury, CT	DH - DOPS
Medical Associates of Danbury	David Weinshel, MD	79 Sand Pit Road	Danbury, CT	DH - DOPS
Pediatric Associates of Western Connecticut	Jamie Alon, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	Kevin Ferguson, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	Leon Baczeski, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	Bruce Cohen, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	John Ertl, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	David Gropper, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	Rachel Rothschild, MD	41 Germantown Road	Danbury, CT	DH
Pediatric Associates of Western Connecticut	Janessa Peralta, MD	41 Germantown Road	Danbury, CT	DH
Samaritan Health Center	Pamela Paulhus, MD	13 Rose Street	Danbury, CT	DH
Seifert & Ford Family Community Health Center	William Delaney, MD	70 Main Street	Danbury, CT	DH
Seifert & Ford Family Community Health Center	Dino Messina, MD	70 Main Street	Danbury, CT	DH
Seifert & Ford Family Community Health Center	Maria Moroldo, MD	70 Main Street	Danbury, CT	DH
Seifert & Ford Family Community Health Center	Sujata Prasad, MD	70 Main Street	Danbury, CT	DH
Seifert & Ford Family Community Health Center	Veronica Ron-Priola, MD	70 Main Street	Danbury, CT	DH

Seifert & Ford Family Community Health Center	Ralph Tremaglio, MD	70 Main Street	Danbury, CT	DH
Western Connecticut	Allen Davis, MD	105A Newtown Road	Danbury, CT	DH
--	Eric Einstein, MD	73 Redding Road	Georgetown, CT	DH
Kent Med/Peds, LLC	Christie Garb, MD	38 North Main Street	Kent, CT	NMH
Kent Med/Peds, LLC	David McIntosh, MD	38 North Main Street	Kent, CT	NMH
Kent Primary Care, LLC	Suzanne Lefebvre, MD	64 Maple Street	Kent, CT	NMH
Family Medical Center of Monroe, LLC	Naga Chirunomula, MD	765 Main Street	Monroe, CT	DH
Family Medical Center of Monroe, LLC	Sekhar Chirunomula, MD	765 Main Street	Monroe, CT	DH
--	Roger Karlin, MD	88 State Route 27	New Fairfield, CT	DH
--	Peter Rostenberg, MD	71 Route 39	New Fairfield, CT	DH
New Fairfield Family Practice	William Biles, MD	96 Route 37	New Fairfield, CT	DH - DOPS
New Fairfield Family Practice	Dana Buchanan, MD	96 Route 37	New Fairfield, CT	DH - DOPS
New Fairfield Family Practice	Yu-Fang Lin, MD	96 Route 37	New Fairfield, CT	DH - DOPS
New Fairfield Family Practice	Christine Metz, MD	96 Route 37	New Fairfield, CT	DH - DOPS
Associated Family Physicians	Henry Allen, MD	146 Danbury Road	New Milford, CT	NMH
Associated Family Physicians	George Barth, MD	146 Danbury Road	New Milford, CT	NMH
Candlewood Pediatrics	Matthew Abel, MD	120 Park Lane	New Milford, CT	NMH
Candlewood Pediatrics	Kristi Beck, MD	120 Park Lane	New Milford, CT	NMH
Candlewood Pediatrics	Wendy Drost, MD	120 Park Lane	New Milford, CT	NMH
Candlewood Pediatrics	Frank Fanella, MD	120 Park Lane	New Milford, CT	NMH
Candlewood Pediatrics	Evan Hack, MD	120 Park Lane	New Milford, CT	NMH
Family Medicine on the Green	Jonathan Beck, MD	50 Bridge Street	New Milford, CT	NMH
Housatonic Medicine & Pediatrics	Cornelius Ferreira, MD	219 Kent Road	New Milford, CT	DH - DOPS
Housatonic Medicine & Pediatrics	Abra Mabasa, MD	219 Kent Road	New Milford, CT	DH - DOPS
Housatonic Medicine & Pediatrics	Karen Tarbell, MD	219 Kent Road	New Milford, CT	DH - DOPS
New Milford Family Practice	Peter Anderson, MD	1 Old Park Lane	New Milford, CT	NMH
New Milford Internal Medicine Associates	Kenneth Marici, MD	11 Grove Street	New Milford, CT	NMH
New Milford Medical Group	Harold Kamm, MD	11 Old Park Lane	New Milford, CT	NMH
New Milford Medical Group	Doreen Konick, MD	11 Old Park Lane	New Milford, CT	NMH
New Milford Medical Group	Christian Leonardi, DO	11 Old Park Lane	New Milford, CT	NMH
New Milford Medical Group	Pacey Pet, MD	11 Old Park Lane	New Milford, CT	NMH
New Milford Medical Group	Jeffrey Tyler, MD	11 Old Park Lane	New Milford, CT	NMH
Pediatrics, PC	Roman Alder, MD	41 South Main Street	New Milford, CT	NMH
Pediatrics, PC	Josef Burton, MD	41 South Main Street	New Milford, CT	NMH
--	Alphonse Altorelli, MD	125 New Milford Turnpike	New Preston, CT	NMH
--	Jennifer Holloway, MD	172 Mt Pleasant Road	Newtown, CT	DH
--	Paul Fitch, MD	184 Mt. Pleasant Road	Newtown, CT	DH
--	Francis Forno, Jr, DO	172 Mt. Pleasant Road	Newtown, CT	DH
Community Health Associates	Jeffrey Friedman, MD	54 South Main Street	Newtown, CT	
Family Health Care Center, LLC	Alexander Isgut, MD	19 Church Hill Road	Newtown, CT	DH
Family Health Care Center, LLC	Alireza Afshar, MD	19 Church Hill Road	Newtown, CT	DH
Newtown Center Pediatrics, LLC	Richard Auerbach, MD	10 Queen Street	Newtown, CT	DH
Newtown Center Pediatrics, LLC	Laura Nowacki, MD	10 Queen Street	Newtown, CT	DH
Newtown Pediatrics	Lalaine Mortera, MD	172 Mt Pleasant Road	Newtown, CT	DH - DOPS
Newtown Pediatrics	Corinna Balanon Soriano, MD	172 Mt Pleasant Road	Newtown, CT	DH - DOPS
	Peter Licht, MD	172 Mt Pleasant Road	Newtown, CT	DH
--	Gregory Brucato, MD	38B Grove Street	Ridgefield, CT	DH
--	Edward Berman, MD	30 Prospect Street	Ridgefield, CT	DH
--	Robert Ruxin, MD	30 Prospect Street	Ridgefield, CT	DH
--	Lynne Savino, MD	96 Danbury Road	Ridgefield, CT	DH
Ahern, Cigno & Galban	James Ahern, MD	77 Danbury Road	Ridgefield, CT	DH
Ahern, Cigno & Galban	Thomas Cigno, MD	77 Danbury Road	Ridgefield, CT	DH
Ahern, Cigno & Galban	Carol-Ann Galban, MD	77 Danbury Road	Ridgefield, CT	DH
Ahern, Cigno & Galban	JoAnn Thompson, MD	77 Danbury Road	Ridgefield, CT	DH
Family Medical Associates	Wendy Maki, MD	96 Danbury Road	Ridgefield, CT	DH
Family Medical Associates	David Pazer, MD	96 Danbury Road	Ridgefield, CT	DH
Family Medical Associates	Cynthia Vanson, MD	96 Danbury Road	Ridgefield, CT	DH
Ridgefield Pediatrics	Anil Britto, MD	36B Grove Street	Ridgefield, CT	DH
Ridgefield Pediatrics	Susan Leib, MD	36B Grove Street	Ridgefield, CT	DH
Ridgefield Pediatrics	Natasha Tzagaloff, MD	36B Grove Street	Ridgefield, CT	DH
Ridgefield Pediatrics	Christine Verna, MD	36B Grove Street	Ridgefield, CT	DH
Ridgefield Primary Care	Jay D'Orso, MD	21 South Street	Ridgefield, CT	DH - DOPS
Ridgefield Primary Care	Lawrence Leibowitz, MD	21 South Street	Ridgefield, CT	DH - DOPS
Ridgefield Primary Care	Nathalie Michaud, MD	21 South Street	Ridgefield, CT	DH - DOPS
Ridgefield Primary Care	Simon O'Regan, MD	21 South Street	Ridgefield, CT	DH - DOPS
Ridgefield Primary Care	Weiming Seo, MD	21 South Street	Ridgefield, CT	DH - DOPS
	Serafima Glouzqal, MD	38B Grove Street	Ridgefield, CT	DH
--	Michael Trager, MD	365 Main Street	Southbury, CT	DH

--	Swapna Omraju, MD	385 Main Street	Southbury, CT	DH
Southbury Pediatrics	Marina Arena, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
Southbury Pediatrics	Susan Beris, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
Southbury Primary Care	Ramin Ahmadi, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
Southbury Primary Care	Sarah Balfour, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
Southbury Primary Care	Robert Carr, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
Southbury Primary Care	David Hoenicke, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
Southbury Primary Care	Casey Ott, MD	22 Old Waterbury Road	Southbury, CT	DH - DOPS
--	Lynne Miller, MD	509 Route 312	Brewster, NY	DH
Brewster Medical Group	Frank Kessler, MD	3423 Danbury Road	Brewster, NY	DH - DOPS
Brewster Medical Group	Jeff Michaelis, MD	3423 Danbury Road	Brewster, NY	DH - DOPS
Mt. Kisco Medical Group	Gary Wenick, MD	2050 Route 22	Brewster, NY	DH
Mt. Kisco Medical Group	Nilo Herrera, Jr, MD	2050 Route 22	Brewster, NY	DH
--	Carolyn Couture, MD	150 Route 52	Carmel, NY	DH
	Michael Bank, MD	91 Gleneida Avenue	Carmel, NY	DH
--	Laurie Schedgick-Davis, DO	36 Charles Colman Boulevard	Pawling, NY	NMH

Source: Medical Staff Office Rosters - Danbury and New Milford Hospitals (November 1, 2010)



DANBURY HOSPITAL

24 Hospital Ave
Danbury, CT 06810
203.739.4903
DanburyHosptial.org

RECEIVED
MAR 19 2013
OFFICE OF HEALTH CARE ACCESS

From:	Sally Herlihy Vice President, Planning		
To:	Kimberly Martone		
Fax:	860-418-7053	No. of Pages:	33
Phone:	860-418-7001	Date:	March 18, 2013
RE:	CON Docket 10-31560-CON	CC:	

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Fax

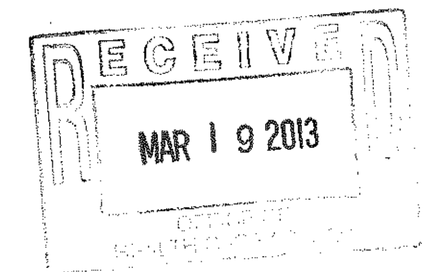
The original letter will be mailed to your office.

Thank you.

CONFIDENTIALITY
The document accompanying this transmission contains information from Danbury Hospital, which is confidential and/or legally privileged. The information is intended only for use by the individual or entity named on the transmission sheet.

If you are not the intended recipient, you are hereby notified that using, disclosing, copying, distributing or taking any action in reliance on the contents of the transmitted information is strictly prohibited and that the document should be immediately returned to Danbury Hospital.

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need



All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner
Full legal name	Western Connecticut Health Network, Inc.
Doing Business As	The Danbury Hospital and New Milford Hospital, Inc.
Name of Parent Corporation	Western Connecticut Health Network, Inc.
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	24 Hospital Avenue, Danbury, CT 06810
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP
Name of Contact person, including title	Sally F. Herlihy, MBA, FACHE Vice President, Planning
Contact person's street mailing address	24 Hospital Avenue, Danbury, CT 06810
Contact person's phone, fax and e-mail address	Phone: (203) 739-4903 Fax: (203) 739-1974 Email: sally.herlihy@wchn.org

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):

Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc. - Docket No. 10-31560-CON

b. Location of proposal (Town including street address):

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

☒ Other – Describe: Change in Findings of Fact #10, and #26 in OHCA Final Decision, Docket No. 10-31560-CON (*See* Attachment A).
Note: The Final Decision in this docket did not require that there be separate licenses, nor did it prohibit a single license.

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

The request for change is to modify Findings of Facts #10 and #26 in Docket No. 10-31560-CON, to enable a single license for The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH"), affiliates of Western Connecticut Health Network, Inc. ("WCHN").

In Docket No. 10-31560-CON, DH and NMH as well as their affiliated entities became wholly owned subsidiaries of a newly formed entity, now known as WCHN. The purpose of the affiliation 2 ½ years ago was to develop a regional health care delivery system. (*OHCA Final Decision, 9/23/10, Docket No. 10, p.3*). In its decision, OHCA also found that "the affiliation would improve the quality, accessibility and cost effectiveness of the health care delivery in the region". (*OHCA Final Decision, Docket No. 10-31560-CON, 9/39/19, p.21*).

At the time of affiliation, the direction was to maintain two separate licenses for the individual hospitals. (*OHCA Final Decision, Finding of Fact #10, p 3).* However, since the affiliation in October 2010 the two hospitals have begun to integrate operations to create stronger quality and more cost effective delivery of care. The leadership of NMH is provided by Deborah Weymouth, Executive Director of NMH and Senior VP of WCHN, who reports to WCHN's President & CEO, John M. Murphy, MD. Additionally, a matrix organizational structure, which includes a service line executive and physician director, has been developed across service lines. This ensures provision of a single standard of care for our patients, supported by ongoing alignment of policies and procedures and practices.

The goal is to enhance the quality of care that is provided, while delivering it as efficiently as possible. NMH is a small, community hospital in close proximity to DH, which currently has a tremendous burden to provide all of the services of any acute care hospital. Operating with one license would be beneficial and supports consistency and quality in the programs and continued alignment together where it makes sense to do so. A single license also enables savings to be achieved through economies of scale, thus reducing the cost of health care (such as single approach to accreditation processes, Medical Staff credentialing and peer review, Medicare Cost Reporting, and annual auditing). This affiliation is meant to strengthen both hospitals by working together to provide the best care available for the residents of the NMH service area.

The WCHN Board of Directors is comprised of members from the former DH and members from the former NMH. The Board Members support this modification request as a natural evolution of the plan to provide the best services possible at the most reasonable cost for the patients in the WCHN service area. See Attachment B for the Board of Directors meeting minutes of December 6, 2012 endorsing a resolution to authorize the operational activities necessary to develop a plan of merger and single licensure for DH and NMH.

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

N/A

a. Certificate of Need expiration date per CON Final Decision:

____

b. Requested revised CON expiration date:

____

c. Rationale for increased time to fully complete and implement the authorized project:

____

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION

(other than extension of the CON expiration date)

N/A

a. Identify the CON Condition that you are requesting to be revised or vacated.

____

b. Provide the rationale for such requested change:

____

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

The Affidavit follows, and is part of, this request.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

This request for modification is to change Finding of Fact #10 on p. 3 which states that "NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses" and Finding of Fact #26 on p. 8 which also states that "[n]o changes in licensing at either hospital . . . will result from this proposal".

c. Identify what has been accomplished to date in terms of full project implementation.

The affiliation has been fully implemented as planned in Docket No. 10-31560-CON.

CON MODIFICATION AFFIDAVIT

Applicant: Western Connecticut Health Network

Project Title: Modification of WCHN Affiliation Agreement

I, John M. Murphy, M.D., President & CEO of Western Connecticut Health Network, Inc. being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature: [signature] Date: 3/18/13

Subscribed and sworn to before me on March 18, 2013

Carol Freeman

Notary Public/~~Commissioner of Superior Court~~

My commission expires:

4-30-2014

Attachment A

Docket No. 10-31560-CON
Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

September 23, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 10-31560-CON
Danbury Health System, Inc. and New Milford Hospital, Inc.	Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

To:

John Murphy	Sally Herlihy
CEO	VP, Regulatory Compliance
Danbury Health Systems, Inc.	New Milford Hospital, Inc.
24 Hospital Avenue	21 Elm Street
Danbury, CT 06810	New Milford, CT 06776

Dear Mr. Murphy and Ms. Herlihy:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Sections 19a-638, C.G.S. On September 23, 2010, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:pf

An Equal Opportunity Employer
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688
Fax: (860) 418-7053

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	Danbury Health System, Inc. and New Milford Hospital, Inc.
Docket Number:	10-31560-CON
Project Title:	Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Project Description: Danbury Health System, Inc. ("DHS") and New Milford Hospital, Inc. ("NMH") propose an affiliation, with no associated total capital expenditure.

Nature of Proceedings: On June 30, 2010, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") for the above-referenced project. DHS and NMH (collectively known as the "Applicants") are considered health care facilities pursuant to Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent ("LOI") was published on March 8, 2010 in *The News Times* pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S). OHCA received no responses from the public concerning the Applicants' LOI.

Pursuant to Section 19a-638, C.G.S. three individuals or an individual representing an entity with five or more people had until July 21, 2010, the twenty-first calendar day following the filing of the CON application, to request that OHCA hold a public hearing on the Applicants' proposal. OHCA received no hearing requests from the public by July 21, 2010.

OHCA's authority to review and approve, modify or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of The Danbury Hospital ("DH"), in Danbury. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

2. DH is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury, and is licensed by the Connecticut Department of Public Health for 345 general hospital beds and 26 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

3. NMH is a Connecticut non-stock 501(c)(3) organization, located at 21 Elm Street, New Milford, and is licensed by the Connecticut Department of Public Health for 85 general hospital beds and 10 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

4. On February 8, 2010, DHS and NMH executed an LOI for a Corporate Affiliation confirming their understanding with respect to a proposed affiliation between DHS and NMH whereby DHS will be renamed to reflect the creation of a regional health care system. *(June 9, 2010 Applicants' Initial CON Application, 10-31560-CON Exhibit 8 page 93)*

5. With respect to the proposed affiliation, the Applicants state the following:

   i. Summer 2008 – Senior management and representatives from both Applicants' Boards met to discuss if there was sufficient interest to pursue discussion of a possible affiliation.

   ii. August 17, 2009 – Applicants entered into a Confidentiality Agreement.

   iii. Fall 2009 – Applicants each appointed a Board Affiliation team and jointly engaged a facilitator with a preliminary "due diligence" process, to determine the opportunities to realize through a potential strategic partnership, and met on a monthly basis from October 2009 to January 2010.

   iv. Winter to Spring 2010 – Senior management from both hospitals met with medical and hospital staff to discuss the Letter of Intent for Corporate Affiliate as contemplated. Due diligence was completed and the Letter of Intent between the two parties was approved and signed by both Applicants' Boards on February 15, 2010. Detailed "Phase two due diligence" was conducted by both Applicants.

   v. Spring 2010 – Multiple meetings with constituencies held.

   vi. Spring to Summer 2010 – Definitive Affiliation Agreement was negotiated and approved by each Board and will be signed by Applicants at the completion of the due diligence process to be finalized in summer of 2010. Ongoing dialogue was held with DH and NMH medical staff, employees, volunteers, Board of Directors and community

education regarding the potential affiliation and opportunities to develop a regional health care delivery system and benefits.
(June 9, 2010 Initial CON Application Exhibit 8, pages 12-13)

6. Under the proposed affiliation, DHS will become the sole corporate member of NMH and will change its name from "Danbury Health Systems, Inc." to a name mutually agreeable to both applicants prior to the effective date of the affiliation. The proposed new entity was temporarily named NEWCO for this application. *(June 9, 2010 Initial CON Application Exhibit 8, page 93)*

7. The draft affiliation agreement requires NMH to replace its current four-member board of directors with a "New Milford Community Board" who shall also serve as members of the board of directors of NEWCO with voting rights. *(June 9, 2010 Initial CON Application Exhibit, page 94)*

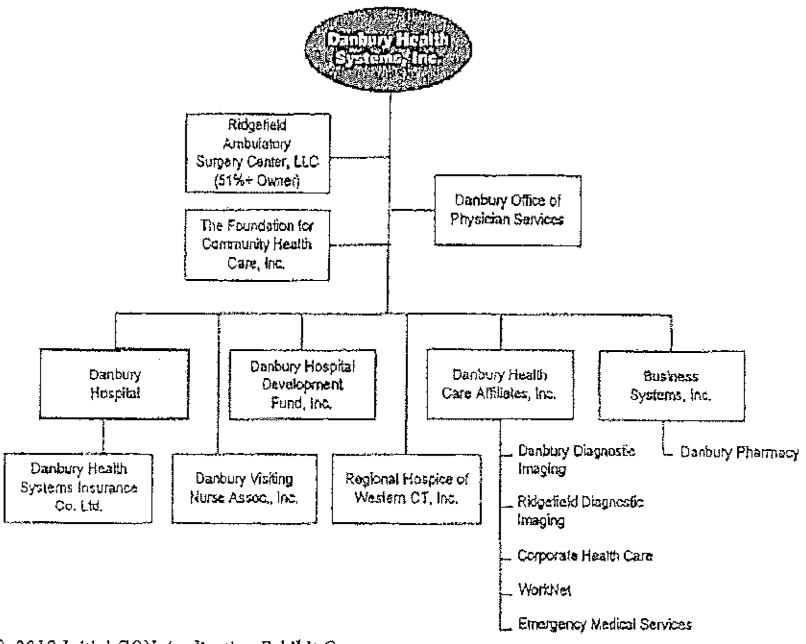
8. The Applicants provided a list of the fifteen (15) members of the board of directors of NEWCO including the four members from NMH's New Milford Community Board and the remaining eleven who are members of the Board of DH. *(June 9, 2010 Initial CON Application Exhibit 7, pages 85 & 91 and June 30, 2010 Completeness Response, page 327)*

9. Upon approval of this proposal by the appropriate regulatory authorities, NMH, DH and its affiliates will become wholly owned/controlled subsidiaries of NEWCO. *(June 9, 2010 Initial CON Application, page 2 and June 30, 2010 Completeness Response, page 327)*

10. NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses. *(June 9, 2010 Initial CON Application, page 2 and Exhibit 6 page 101)*

11. The organizational chart of DHS and its affiliates prior to the proposed affiliation with NMH is as follows:

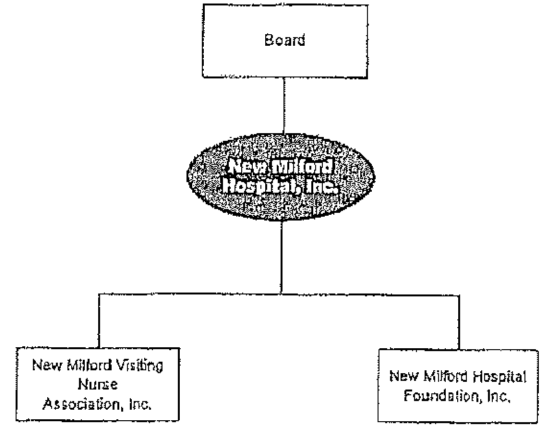
Chart One: DHS Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

12. The organizational chart of NMH and its affiliates prior to the proposed affiliation with DHS is as follows:

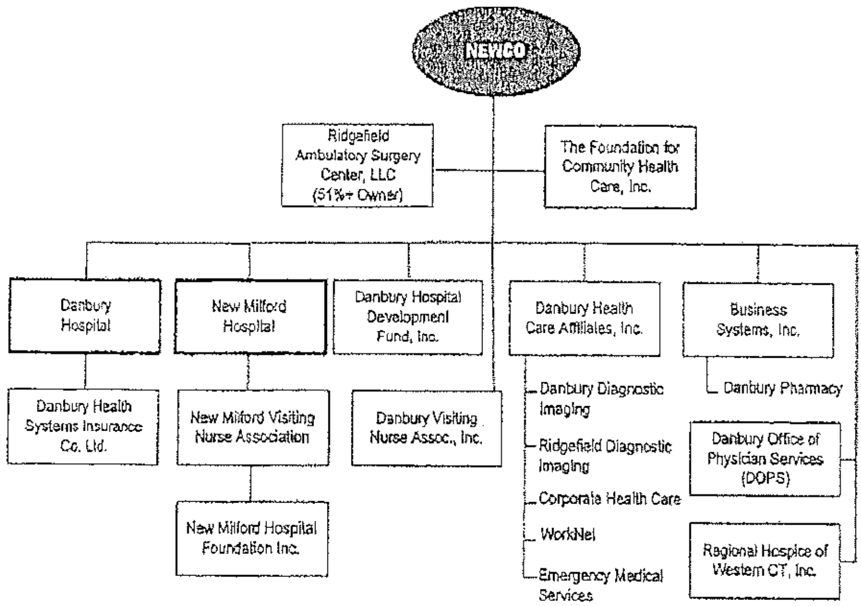
Chart Two: NMH Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

13. The proposed organizational chart of NEWCO and its affiliates after the proposed affiliation is as follows:

Chart Three: NEWCO Organizational Chart After the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

14. DHS has pursued a strategic plan to establish DH as a regional medical center, providing selected tertiary services to an ever greater number of people from a growing, broader geographic region. To that end, DHS has developed an operationally integrated health care delivery system comprised of health care entities that coordinate service along the health care continuum, enabling patients to receive care in the most appropriate systems. *(June 9, 2010, Initial CON Application, page 4)*

15. DH conducted an assessment of its service area during the strategic planning process, which established a direction for considering a relationship with other providers to engage in a more regional planning effort and to provide a more complete continuum of services. *(June 9, 2010, Initial CON Application, page 4)*

16. Following the closure of NMH's emergency angioplasty service, DH assisted in the transition and it became clear that both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. *(June 9, 2010, Initial CON Application, page 4)*

17. DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. *(June 9, 2010, Initial CON Application, page 5)*

18. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. *(June 9, 2010, Initial CON Application, pages 5, 93)*

19. DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. *(June 9, 2010 Initial CON Application, page 93)*

20. NMH expects that upon approval of this proposal, it will be well positioned to meet the challenges and demands of the health care industry, while remaining strong enough to sustain its commitment to offering access to high quality service to the communities it serves. *(June 9, 2010, Initial CON Application, page 5)*

21. NMH considered the following factors in its decision to pursue an affiliation with DHS:

   - Access to significant capital to maintain state-of-the-art treatment facilities as its physical plant and infrastructure ages and as it pursues replacement and expansion of its IT and telecommunications systems;
   - Access to the latest in diagnostic and therapeutic technologies, such as robotic surgery and the latest in genomic therapies:
   - Access to primary care and specialty services;
   - Physician recruitment/cross-coverage arrangements;
   - Quality improvement efforts;
   - Maximizing efficiencies and controlling costs; and
   - Investing in workforce development, retaining talent and attracting others to the institution to minimize vacancies.

   (June 9, 2010 Initial CON Application, pages 5-10)

22. The primary service area ("PSA") of DH is as follows:

Table 5: DH's Primary Service Area

PSA	Bethel
	Brookfield
	Danbury
	New Fairfield
	Newtown
	Redding
	Ridgefield

(June 9, 2010, Initial CON Application, page 15)

23. Based on inpatient discharges, OHCA finds that the towns of Danbury, Newtown, Bethel, Ridgefield, Brookfield, New Fairfield and Redding comprise 74% of DH's discharged patients.

Table 6: DH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
Danbury	39%	39%	93%
Newtown	8%	47%	72%
Bethel	8%	55%	90%
Ridgefield	7%	62%	77%
Brookfield	5%	67%	83%
New Fairfield	4%	72%	89%
Redding	2%	74%	59%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

24. NMH's primary service area ("PSA") is as follows:

Table 1: NMH's Primary Service Area

PSA	New Milford
	Kent
	Washington
	Brookfield
	Sherman
	Bridgewater
	Roxbury
	Warren

(June 9, 2010, Initial CON Application, page 17)

25. Based on inpatient discharges, OHCA finds that the towns of New Milford, Kent, Washington, Brookfield, Sherman, Bridgewater, Roxbury, Cornwall and Warren comprise 73% of NMH's discharged patients.

Table 2: NMH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
New Milford	49%	49%	52%
Kent	7%	56%	53%
Washington	5%	61%	52%
Brookfield	3%	64%	6%
Sherman	3%	67%	35%
Bridgewater	2%	69%	35%
Roxbury	2%	71%	35%
Cornwall+Warren	2%	73%	22%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

26. No changes in licensing of either hospital or affiliated home care agencies will result from this proposal. The Applicants intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions. *(June 9, 2010, Initial CON Application, page 2)*

27. Upon approval of the proposal, DH will serve as the primary provider of tertiary level inpatient and outpatient care to the Western CT region providing the following services:

Inpatient Services	Ancillary Services	Physician Services
Intensive & cardiovascular care Units	Level II Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
Adult & pediatric medical/surgical Units	Surgical services	
Obstetrical unit with NICU	Medical imaging	
High acuity rehabilitation Unit	Praxair Regional Heart and Vascular Center	
Behavioral health/psychiatry	Praxair Cancer Center	
	Center for Advanced Orthopedic & Spine Care	
	Women's and children's service	
	System-wide reference lab	

(June 9, 2010, Initial CON Application, page 3)

28. The following table illustrates the historical utilization by service category for DH:

Table 9: DH's Historical Utilization by Service Category

DH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	67,929	67,553	69,582	71,098
Ambulatory Surgery	13,092	12,277	11,668	11,204
Observation Patients	1,257	2,632	2,868	2,983
Extended Stay	-	-	-	504
Admissions				
Medical/ Surgical	14,420	14,486	14,894	14,916
Maternity	2,502	2,379	2,248	2,208
Newborn	2,272	2,127	1,956	1,944
Psychiatric	812	794	769	711
Pediatric	419	342	329	333
Rehabilitation	377	337	303	315
Total Admissions	20,802	20,465	20,499	20,427

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12) *(June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)*

29. Inpatient discharges decreased from FY2008 through FY2010, from a significant shift in patients to an observation status and in FY2010, to extended stays.[1]

[1] Centers of Medicare and Medicaid Services and third party payers in seeking to eliminate unnecessary inpatient care allow "observation programs" for patients with selected medical conditions.

30. The following table represents the projected utilization by service category for DH:

Table 10: DH's Projected Utilization by Service Category

DH	FY 2011	FY 2012	FY 2013
ED visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411
Observation Patients	3,072	3,164	3,228
Extended Stay	554	610	653
Admissions			
Medical/ Surgical	15,217	15,437	15,656
Maternity	2,289	2,312	2,335
Newborn	1,947	1,967	1,986
Psychiatric	752	760	768
Pediatric	351	355	360
Rehabilitation	321	324	328
Total Admissions	20,877	21,156	21,433

Note: The Applicants made the following assumptions with respect to DH volumes as illustrated above:

i. Newborn, maternity, psychiatric and rehabilitation discharges will increase annually by 1%.

ii. Overall inpatient growth is attributed to growth in programs and services as well as a changing population.

(June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)

31. The Applicants expect inpatient medical/surgical and pediatrics discharges to grow 1.4% annually from a reduction in outmigration of medical/surgical cases through the affiliation. Approximately 80% of the increase is related to tertiary services as a result of lower outmigration or through improved access to primary care physicians and specialists in the NMH service area. *(June 30, 2010, Completeness Responses, page 333- 334)*

32. The Applicants anticipate that the majority of the transfers from NMH as well as other patients served by the added primary care physicians and specialists seeing patients in New Milford area will comprise the largest component of the projected inpatient volume increase. These assumptions are based on discussions with the NMH medical staff and early evidence of success in the field of cardiology. *(June 30, 2010, Completeness Responses, page 333)*

33. Following the closure of the NMH cardiac catheterization lab, DH has received 110 referrals from NMH physicians in FY 2010 YTD versus 51 referrals for the same time period in FY2009 – a 116% increase. *(June 30, 2010, Completeness questions, page 340)*

34. NMH will continue to provide the following inpatient and outpatient services to its service area:

Inpatient Services	Ancillary Services	Physician Services
Adult & pediatric medical/surgical unit	24-hour Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
ICU/stepdown/acuity adaptable unit	Surgical services	
Family birthing center	Medical imaging	
Low acuity rehabilitation (pending space)	Cardiovascular screening/diagnostics and clinics	
	Regional Cancer Center	
	OP Neurodiagnostics and other specialty clinics	
	Expanded women's health and wellness programs	
	Phase 1 Research Center office	

(June 9, 2010, Initial CON Application, page 3)

35. The following table illustrates the historical utilization by service category for NMH:

Table 3: NMH's Historical Utilization by Service Category

NMH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	19,309	19,553	19,146	19,173
Ambulatory Surgery	2,414	2,335	2,461	2,787
Observation Patients	333	384	567	520
Admissions				
Newborn	294	342	296	264
Maternity	306	341	300	266
Psychiatric	-	-	-	-
Pediatric	68	58	47	15
Medical/Surgical	2,178	2,292	2,131	1,983
Rehabilitation	-	-	-	-
Total Admissions	2,845	3,033	2,774	2,528

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12). *(June 9, 2010, Initial Con Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)*

36. Inpatient discharges decreased from FY2008 through FY2010, from a recent loss of market share and a significant shift in patients to an observation status.

37. The following table illustrates the projected utilization by service category for NMH:

Table 4: NMH's Projected Utilization by Service Category

NMH	FY 2011	FY 2012	FY 2013
ED visits	19,273	19,418	19,571
Ambulatory Surgery	2,704	2,732	2,761
Observation Patients	522	524	527
Admissions			
Newborn	250	248	246
Maternity	250	248	246
Psychiatric	-	-	-
Pediatric	24	24	24
Medical/Surgical	2,037	2,052	2,070
Rehabilitation	-	-	-
Total Admissions	2,561	2,572	2,586

Note: The Applicants made the following assumptions with respect to NMH volumes as illustrated above:

i. Inpatient medical discharges are expected to grow 0.9% to 1.0% annually and surgical at 0.4% to 0.5% from FY 2011.

ii. Inpatient Ob/Gyn discharges will grow annually at 0.8% while pediatrics volume will remain unchanged over the next three years.

ii. Newborn, maternity, psychiatric and rehabilitation discharges will remain unchanged over the next three years.

iv. Outpatient services will increase annually by 0.4% to 1.1%.

(June 9, 2010, Initial CON Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)

38. The incremental volumes attributable to the project are based upon a 1% growth in market share through reductions in out-migration from the affiliation. *(June 9, 2010, Initial CON Application, page 20)*

39. Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. *(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)*

40. Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Together, the two hospitals provided inpatient care to 81% of the discharges from the PSA; no other individual hospital accounts for more than 4% of acute care inpatient services to the area. The two PSAs are adjacent to each other with the town of Brookfield as the only overlapping town between the two.

Table 8: Significant Providers of Inpatient Services in New Milford Primary Service Area, FY 2009

	New Milford	Danbury	Sharon	Yale	Hartford	All Other*	Total
Percentage of NMH PSA	37%	44%	4%	4%	2%	9%	100%
% of Hospital Total	73%	12%	7%	0.4%	0.3%	0.2%	1%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

41. Excluding psychiatric referrals, in 2008, 196 patients were transferred from NMH PSA to other tertiary level providers.

Table 7: Number of Transfers from New Milford Hospital's Primary Service Area to Other Tertiary Providers, 2008

Connecticut Children's Medical Center	2
John Dempsey Hospital	2
Bridgeport Hospital	4
Waterbury Hospital	6
St. Francis Medical Center	9
Hospital of St. Raphael	10
Other Connecticut Hospitals	15
Other NY Hospitals	35
Hartford Hospital	36
NY Presbyterian	36
Yale-New Haven Hospital	41
Total	196

(June 30, 2010, Completeness Reponses, page 333)

42. Further, based on hospital inpatient discharge data, OHCA finds that compared to NMH, DH provides a higher percentage of specialty care including cardiac, neurological, women's health, general/other surgery, behavioral health and trauma care to NMH PSA residents.

Table 11: Providers of Inpatient Services to NMH Primary Service Area Residents, FY 2009

Service line	New Milford	Danbury	Sharon	Yale	Hartford	Other*	Total
Cardiac Care	38%	42%	3%	4%	5%	8%	100%
Cancer Care	32%	37%	3%	15%	3%	11%	100%
Neurological	32%	47%	5%	4%	3%	8%	100%
Renal or Urology	38%	38%	3%	5%	6%	10%	100%
Women's Health	40%	50%	2%	2%	1%	6%	100%
Orthopedics	42%	41%	3%	3%	1%	10%	100%
Respiratory	61%	30%	4%	1%	0%	3%	100%
Medicine	44%	42%	3%	4%	1%	6%	100%
General/other surgery	35%	45%	2%	8%	2%	7%	100%
Newborn	40%	52%	2%	1%	0%	5%	100%
Psychiatry	1%	59%	9%	2%	3%	26%	100%
Ophthalmology	40%	33%	0%	13%	0%	13%	100%
Trauma	19%	47%	3%	6%	10%	16%	100%
Dental	0%	25%	0%	50%	0%	25%	100%
Substance Abuse	15%	35%	25%	1%	0%	22%	100%
PSA Total	39%	44%	3%	4%	2%	8%	100%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

43. Based upon the foregoing data, OHCA finds that NMH has experienced significant out-migration in recent years and DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Additionally, DH provided a higher level of specialty care to NMH PSA residents.

44. In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. Therefore, increased availability of primary physicians will be beneficial to residents of the area.

Table 12: Percent of Primary Care Sensitive Preventable Hospitalizations[2] at NMH and DH, 2006-2008

Hospital	2006	2007	2008
New Milford	14%	12%	12%
Danbury	10%	10%	11%
CT	12%	12%	11%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

45. NMH indicates, consistent with the above data in Findings 34 through 40, that one of the challenges it faces is a physician shortage in primary care and specialties. *(June 9, 2010, Initial CON Application, page 6)*

46. NMH has identified key specialties in which a need exists, such as endocrinology, neurology and selected surgical subspecialties. *(June 9, 2010, Initial CON Application, page 8)*

47. NMH has been unable to attract admissions and subspecialty care because of a documented shortage of both primary care physicians and sub-specialists. NEWCO will provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. *(June 30, 2010, Completeness questions, page 340)*

48. DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. *(June 9, 2010, Initial CON Application, page 8)*

49. DHS also houses Danbury Office of Physician Services ("DOPS"), a multispecialty faculty practice plan whose mission is to support DH in its objective of meeting the needs of all patients, including the underserved. DOPS has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. *(June 9, 2010, Initial CON Application, page 8)*

50. Another challenge for NMH is the growing need to address and upgrade the physical, clinical and technological infrastructure to meet community need. *(June 9, 2010, Initial CON Application, page 6)*

[2] OHCA utilized the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) software to identify preventable hospitalizations. AHRQ defines preventable hospitalizations as instances of inpatient hospital care for health conditions or illnesses typically treated or managed in outpatient settings. See http://www.ct.gov/ohca/lib/ohca/publications/2010/prev_hosp_report01-2010.pdf for more details.

51. An example of the larger capital expenses are: (a) information technology to support legacy systems as well as clinical applications; (b) implementation of an electronic medical record and other advanced clinical technologies designed to improve care, quality and efficiency; (c) enhanced PACS and voice dictation systems; (d) renovation and upgrades to patient care units; (e) facility improvements such as upgrading mechanicals and introducing green technologies; and (f) general plant maintenance associated with an aging facility. *(June 9, 2010, Initial CON Application page 7)*

52. Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. *(June 9, 2010, Initial CON Application, page 30)*

53. DHS currently operates an electronic health information exchange called HealthLink, which enables the hospital to link to other providers through a web-based architecture. NMH will obtain access to the IT expertise and systems currently in place at DH, accelerating its adoption of an EMR and creating seamless information access and connectivity among all entities for optimal clinical quality and operational efficiency. *(June 9, 2010, Initial CON Application, page 30)*

54. DH is engaged in various research initiatives, from basic science to translational research. DH Research Department provides infrastructure and coordinates all of the research and scholarly activities for the entire institution. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

55. In order to integrate the existing and future research and scholarly activities of NMH into the Department research activities and provide a seamless collaboration and coordination of the research efforts, DH will extend its research capabilities by developing a satellite research center at NMH. In addition, the programs at DH will be made available to NMH physicians and patients creating opportunities for greater involvement and collaboration. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

56. OHCA finds that both NMH's ability to recruit and retain high quality physicians will be enhanced through this affiliation due to greater access to technology and clinical research opportunities.

57. There is no capital cost associated with this proposal. *(June 9, 2010, Initial CON Application, page 24)*.

58. There will be no change in billing as a result of this proposal. *(June 9, 2010, Initial CON Application, page 26)*.

59. There will be no changes to existing reimbursement contracts between the Applicants and the payers. *(June 9, 2010, Initial CON Application, page 26)*.

60. This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of

approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. *(June 9, 2010, Initial CON Application, page 27).*

61. The proposed 2% (or $2,558,000) potential savings to NMH will be in two cost categories over the first three years of the affiliation. One category of potential cost savings is "salaries and benefits" through a reduction of eight (8) FTEs per year over three years in the back office area from retirements and elimination of management positions and normal attrition. The second area is "supplies and drugs."

Table 13: Potential Cost Savings for NMH

	FY 2011	FY 2012	FY 2013	3-YR TOTAL COST SAVINGS
Salaries & Benefits	$797,000	$855,000	$876,000	$2,528,000
Supplies & Drugs	$1,016,000	$1,057,000	$1,099,000	$3,172,000
Total	$1,813,000	$1,912,000	$1,975,000	$5,700,000

(June 30, 2010, Completeness Responses, pages 334-335)

62. The Applicants plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. *(June 9, 2010, Initial CON Application, page 27).*

63. The Applicants will also consider centralizing certain clinical functions, such as clinical laboratory and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. *(June 9, 2010, Initial CON Application, page 26).*

64. There are no plans to implement savings associated with the reduction, elimination, or combination of any clinical services in the short term. *(June 30, 2010, Completeness Responses, page 334).*

65. The cost efficiencies to be realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH. *(June 9, 2010, Initial CON Application, page 7).*

66. The potential bond rating of NEWCO would support an "A" rating and the strategic value of affiliating with another hospital would at least equal any dilutive financial impact in the short term. *(June 30, 2010, Completeness Responses, page 336)*

67. NMH's credit worthiness will be enhanced by the affiliation in that NMH will benefit from the guarantee of NEWCO, an organization whose numbers would support an "A" rating, which is better than NMH would be able to achieve on its own. *(June 30, 2010, Completeness Responses, page 336)*

68. The Applicants intend to improve productivity and contain costs by developing economies of scale in operations, establishing evidence-based quality decisions on services and care protocols, and developing an integrated plan that allows both organizations to address the needs in the greater region without the unnecessary duplication in services that has characterized the past. *(June 9, 2010, Initial CON Application, page 30).*

69. The projected incremental revenue from operations, total operating expense and gains from operations associated with the proposal are presented in the table below for the first three years with the proposed project:

Table 14: Combined Danbury and New Milford Hospital Financial Projections

Description	FY 2011	FY 2012	FY 2013
Incremental Revenue from Operations	$2,039,000	$2,820,000	$3,689,000
Incremental Total Operating Expense	($407,000)	($161,000)	$151,000
Incremental Gain from Operations	$2,447,000	$2,981,000	$3,538,000

(June 9, 2010, Initial CON Application, Financial Attachment I, page 320)

70. This proposal will also improve revenue through increased inpatient and outpatient volumes at NMH. *(June 30, 2010, Completeness Responses, page 336)*

71. DH's patient population mix is based on the FY 2010 budget, with no change in mix anticipated or projected. DH's current patient population mix and projected population mix with the CON proposal is as follows:

Table 15: Current and Three-Year Projected Population Mix with the CON Proposal

Danbury Hospital	Current FY Payer Mix	2011 Projected Payer Mix	2012 Projected Payer Mix	2013 Projected Payer Mix
Medicare	32.2%	32.2%	32.2%	32.2%
Medicaid	14.5%	14.5%	14.5%	14.5%
TRICARE and CHAMPUS	0.0%	0.0%	0.0%	0.0%
Total Government	46.7%	46.7%	46.7%	46.7%
Commercial Insurers	46.3%	46.3%	46.3%	46.3%
Uninsured	6.5%	6.5%	6.5%	6.5%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	53.3%	53.3%	53.3%	53.3%
Total Population Mix	100%	100%	100%	100%

(June 9, 2010, Initial CON Application, page 25)

72. NMH's patient mix is based on the FY 2010 budget, with no change in mix anticipated or projected. NMH's current population mix and projected population mix with the CON proposal is as follows:

Table 16: Current and Three-Year Projected Population Mix with the CON Proposal

New Milford Hospital	Current FY Payer Mix	2011 Projected Payer Mix	2012 Projected Payer Mix	2013 Projected Payer Mix
Medicare	45.8%	45.8%	45.8%	45.8%
Medicaid (includes other medical assistance)	10.0%	10.0%	10.0%	10.0%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	55.9%	55.9%	55.9%	55.9%
Commercial Insurers*	40.6%	40.6%	40.6%	40.6%
Uninsured	2.8%	2.8%	2.8%	2.8%
Workers Compensation	0.7%	0.7%	0.7%	0.7%
Total Non-Government	44.1%	44.1%	44.1%	44.1%
Total Population Mix	100%	100%	100%	100%

(June 9, 2010, Initial CON Application, page 25)

73. The Applicants provided resumes of its executive leadership team associated with this proposal demonstrating that they have sufficient managerial and financial experience in managing health care organizations to provide efficient and adequate service to the public. *(June 9, 2010, Initial CON Application, page 118)*

Rationale

OHCA approaches community and regional need for CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of DH in Danbury. NMH is a Connecticut non-stock 501 (c)(3) organization, located at 21 Elm Street, New Milford. DHS and NMH propose an affiliation, with no associated total capital expenditure. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. (Finding of Fact 18) DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. (Finding of Fact 19) The proposed affiliation is also intended to help strengthen access to capital, generate cost savings and leverage recruitment and retention of high quality physicians.

While DH views the affiliation as an opportunity to engage in a more regional planning effort and to provide a more complete continuum of services both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. (Findings of Fact 15-16) Additionally, DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. (Finding of Fact 17)

NMH also considered its need for access to significant capital to maintain state-of-the-art treatment facilities; access to the latest in diagnostic and therapeutic technologies; access to primary care and specialty services; physician recruitment/cross-coverage arrangements; quality improvement efforts; and maximizing efficiencies and controlling costs. (Finding of Fact 21) Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. (Finding of Fact 52) Additionally, NMH will now have access to DH's research capabilities as DH will establish a satellite research center at NMH and physicians and patients from NMH will be able to attend programs offered at DH. (Findings of Fact 54-55)

The affiliation will also provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. (Finding of Fact 47) DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. (Finding of Fact 48) DHS also houses DOPS, which has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. (Finding of Fact 49) Not only will NMH benefit from an increase in primary care physicians and specialists in the NMH service area, but DH also expects a modest increase in

inpatient utilization based upon the increases in referrals to DH's cardiac catheterization lab in 2010 following the closure of NMH's cardiac catheterization lab.

Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. (Finding of Fact 39) Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. (Finding of Fact 40) In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. (Finding of Fact 44) Specifically, 14% of NMH's hospitalizations were considered preventable compared to 12% for the state. (Finding of Fact 44) Thus, OHCA finds the ED utilization rate for NMH is higher than the statewide average. OHCA is concerned about the use of the ED for health care services that can be delivered in the community setting at a lower cost to the patient and the hospital. Accordingly, OHCA finds that proposed affiliation will improve the quality, accessibility and cost effectiveness of health care delivery in the region by increasing access to primary care and specialty physicians in the NMH service area.

This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. (Finding of Fact 60) The Applicants also plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. (Finding of Fact 62) The Applicants will also consider centralizing certain clinical functions, such as the clinical laboratories and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. (Finding of Fact 63) Additionally, the integrated IT system and EMR will provide significant cost savings for NMH. (Finding of Fact 52) The Applicants project operational gains of $2,447,000, $2,981,000 and $3,538,000 in the first three years of the proposal. (Finding of Fact 69) OHCA finds the financial projections and volumes upon which they are based appear to be reasonable and achievable. Accordingly, OHCA concludes that the proposal is financially feasible.

Based upon all of the foregoing, OHCA finds that the proposed affiliation will allow better access to capital and technology and will provide cost efficiencies for both Applicants to create a stronger health care system. Shared best practices, an integrated IT system and the ability to recruit and retain top-level physicians will enhance the Applicants' ability to respond to new federal health care reform initiatives that require health care providers to re-align all aspects of the delivery system and better coordinate those services around the patients' needs. In the absence of an affiliation with a larger tertiary hospital, NMH would probably find it difficult to meet future requirements and financial challenges. Accordingly, OHCA concludes that this proposal will create a larger and financially stronger health care delivery system that will better address these demands and continue to provide access to quality health care in the Applicants' service area.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Danbury Health System, Inc. and New Milford Hospital, Inc. for an affiliation, with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA, a full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of DHS and NMH has occurred.

2. If, in the future, there is any change in the ownership structure of DHS, NMH or its affiliates or any change in the affiliation agreement, the Applicants shall file a CON Determination Form with OHCA.

3. If, in the future, there is any change in NMH or NEWCO service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.

4. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA a comprehensive plan that includes the following:

   (i) The locations of current primary care providers in the NEWCO service area;

   (ii) A discussion of how the Applicants will recruit primary care physicians and specialists in the NEWCO service area;

   (iii) A discussion of how the Applicants will specifically address the need for additional primary care in the NEWCO service area, including, but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and

   (iv) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.

5. The Applicants shall schedule a meeting with OHCA to occur within 30 calendar days of the filing of the comprehensive plan to discuss the Applicants' provision of findings pursuant to Condition #4.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the

September 23, 2010
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner
Office of Health Care Access

Attachment B

WESTERN CONNECTICUT HEALTH NETWORK
BOARD OF DIRECTORS
December 6, 2012

Draft

A meeting of the Board of Directors of Western Connecticut Health Network, New Milford Hospital and Danbury Hospital was held on Thursday, December 6, 2012 at 8:00 a.m. in the Robison Conference Room at New Milford Hospital. Chairman of the Board Jim Kennedy presided.

PRESENT:	A. Altorelli, M.D, A. Disney, S. Houldin, J. Kennedy, J. Murphy, MD., J. Patrick, J. Skrzypczak, B White
VIA TELECONFERENCE:	D. Cyganowski, N. Culligan, and M.D. D. Kramer, M.D.
ABSENT:	R. Jabara,
GUESTS:	Lisa Boyle, Esq. – Robinson & Cole Bruce Barth, Esq. – Robinson & Cole (via teleconference)
ALSO PRESENT:	M. Daglio, C. McKenna, S. Rosenberg, D. Weymouth

CHAIRMAN'S REMARKS

Chairman Kennedy welcomed the directors and guests and noting that we had a quorum, began with the opening of the meeting of the WCHN Board of Directors to review the status of due diligence work being done towards the possible affiliation with Norwalk Hospital.

NEW MILFORD HOSPITAL

GENERAL/CONSENT

Approvals/Resolutions (attachments):

a. Licensure – New Milford

A motion was made by J. Patrick and seconded by Dr. A. Altorelli and it was:
ACTION: VOTED to unanimously approve resolutions as presented

RESOLUTIONS TO BE CONSIDERED
FOR ADOPTION
AT THE MEETING OF THE GOVERNANCE COMMITTEE OF THE
BOARD OF DIRECTORS
OF
WESTERN CONNECTICUT HEALTH NETWORK, INC.

December 6, 2012

Licensure

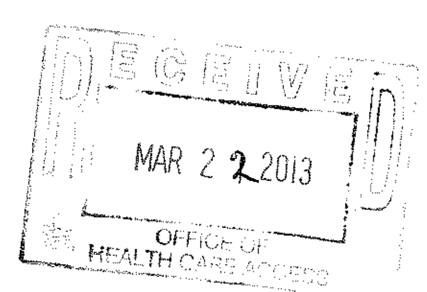
WHEREAS, Western Connecticut Health Network, Inc. ("WCHN") is the sole member of The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH");

WHEREAS, the DH and NMH each operate separately licensed hospitals (the "Hospitals"); and

WHEREAS, the DH and NMH desire to authorize the operational activities necessary to present the board of directors of each entity with a plan to merge the two entities and operate the Hospitals as one licensed facility with two campuses,

NOW, THEREFORE, BE IT:

RESOLVED, that, WCHN, as the sole member of each of DH and NMH, hereby authorizes and directs the proper officers of DH and NMH, on behalf of each entity, to take all necessary and appropriate actions to develop a plan of merger and single licensure for DH and NMH, including without limitation engaging consultants and authorizing communications with the Connecticut Department of Health, the Centers for Medicare and Medicaid Services, and the Joint Commission, the taking of such action to be conclusive evidence of the necessity, appropriateness or desirability thereof.



State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner
Full legal name	Western Connecticut Health Network, Inc.
Doing Business As	The Danbury Hospital and New Milford Hospital, Inc.
Name of Parent Corporation	Western Connecticut Health Network, Inc.
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	24 Hospital Avenue, Danbury, CT 06810
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP
Name of Contact person, including title	Sally F. Herlihy, MBA, FACHE Vice President, Planning
Contact person's street mailing address	24 Hospital Avenue, Danbury, CT 06810
Contact person's phone, fax and e-mail address	Phone: (203) 739-4903 Fax: (203) 739-1974 Email: sally.herlihy@wchn.org

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):

Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc. - Docket No. 10-31560-CON

b. Location of proposal (Town including street address):

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

☒ Other – Describe: Change in Findings of Fact #10, and #26 in OHCA Final Decision, Docket No. 10-31560-CON (*See* Attachment A).
Note: The Final Decision in this docket did not require that there be separate licenses, nor did it prohibit a single license.

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

The request for change is to modify Findings of Facts #10 and #26 in Docket No. 10-31560-CON, to enable a single license for The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH"), affiliates of Western Connecticut Health Network, Inc. ("WCHN").

In Docket No. 10-31560-CON, DH and NMH as well as their affiliated entities became wholly owned subsidiaries of a newly formed entity, now known as WCHN. The purpose of the affiliation 2 ½ years ago was to develop a regional health care delivery system. (*OHCA Final Decision, 9/23/10, Docket No. 10, p.3*). In its decision, OHCA also found that "the affiliation would improve the quality, accessibility and cost effectiveness of the health care delivery in the region". (*OHCA Final Decision, Docket No. 10-31560-CON, 9/39/19, p.21*).

At the time of affiliation, the direction was to maintain two separate licenses for the individual hospitals. *(OHCA Final Decision, Finding of Fact #10, p 3).* However, since the affiliation in October 2010 the two hospitals have begun to integrate operations to create stronger quality and more cost effective delivery of care. The leadership of NMH is provided by Deborah Weymouth, Executive Director of NMH and Senior VP of WCHN, who reports to WCHN's President & CEO, John M. Murphy, MD. Additionally, a matrix organizational structure, which includes a service line executive and physician director, has been developed across service lines. This ensures provision of a single standard of care for our patients, supported by ongoing alignment of policies and procedures and practices.

The goal is to enhance the quality of care that is provided, while delivering it as efficiently as possible. NMH is a small, community hospital in close proximity to DH, which currently has a tremendous burden to provide all of the services of any acute care hospital. Operating with one license would be beneficial and supports consistency and quality in the programs and continued alignment together where it makes sense to do so. A single license also enables savings to be achieved through economies of scale, thus reducing the cost of health care (such as single approach to accreditation processes, Medical Staff credentialing and peer review, Medicare Cost Reporting, and annual auditing). This affiliation is meant to strengthen both hospitals by working together to provide the best care available for the residents of the NMH service area.

The WCHN Board of Directors is comprised of members from the former DH and members from the former NMH. The Board Members support this modification request as a natural evolution of the plan to provide the best services possible at the most reasonable cost for the patients in the WCHN service area. See Attachment B for the Board of Directors meeting minutes of December 6, 2012 endorsing a resolution to authorize the operational activities necessary to develop a plan of merger and single licensure for DH and NMH.

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

N/A

a. Certificate of Need expiration date per CON Final Decision:

____

b. Requested revised CON expiration date:

____

c. Rationale for increased time to fully complete and implement the authorized project:

____

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION

(other than extension of the CON expiration date)

N/A

a. Identify the CON Condition that you are requesting to be revised or vacated.

____

b. Provide the rationale for such requested change:

____

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

The Affidavit follows, and is part of, this request.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

This request for modification is to change Finding of Fact #10 on p. 3 which states that "NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses" and Finding of Fact #26 on p. 8 which also states that "[n]o changes in licensing at either hospital . . . will result from this proposal".

c. Identify what has been accomplished to date in terms of full project implementation.

The affiliation has been fully implemented as planned in Docket No. 10-31560-CON.

CON MODIFICATION AFFIDAVIT

Applicant: Western Connecticut Health Network

Project Title: Modification of WCHN Affiliation Agreement

I, John M. Murphy, M.D., President & CEO of Western Connecticut Health Network, Inc. being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature [signature] Date 3/18/13

Subscribed and sworn to before me on March 18, 2013

Carol Freeman
Notary Public/~~Commissioner of Superior Court~~

My commission expires:

4-30-2014

Attachment A

Docket No. 10-31560-CON
Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

September 23, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:

Danbury Health System, Inc. and New Milford Hospital, Inc.

Notice of Final Decision
Office of Health Care Access
Docket Number: 10-31560-CON

Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

To:

John Murphy
CEO
Danbury Health Systems, Inc.
24 Hospital Avenue
Danbury, CT 06810

Sally Herlihy
VP, Regulatory Compliance
New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

Dear Mr. Murphy and Ms. Herlihy:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter, as provided by Sections 19a-638, C.G.S. On September 23, 2010, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:pf

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	**Danbury Health System, Inc. and New Milford Hospital, Inc.**
Docket Number:	**10-31560-CON**
Project Title:	**Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.**

Project Description: Danbury Health System, Inc. ("DHS") and New Milford Hospital, Inc. ("NMH") propose an affiliation, with no associated total capital expenditure.

Nature of Proceedings: On June 30, 2010, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") for the above-referenced project. DHS and NMH (collectively known as the "Applicants") are considered health care facilities pursuant to Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent ("LOI") was published on March 8, 2010 in *The News Times* pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S). OHCA received no responses from the public concerning the Applicants' LOI.

Pursuant to Section 19a-638, C.G.S. three individuals or an individual representing an entity with five or more people had until July 21, 2010, the twenty-first calendar day following the filing of the CON application, to request that OHCA hold a public hearing on the Applicants' proposal. OHCA received no hearing requests from the public by July 21, 2010.

OHCA's authority to review and approve, modify or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of The Danbury Hospital ("DH"), in Danbury. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

2. DH is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury, and is licensed by the Connecticut Department of Public Health for 345 general hospital beds and 26 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

3. NMH is a Connecticut non-stock 501(c)(3) organization, located at 21 Elm Street, New Milford, and is licensed by the Connecticut Department of Public Health for 85 general hospital beds and 10 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

4. On February 8, 2010, DHS and NMH executed an LOI for a Corporate Affiliation confirming their understanding with respect to a proposed affiliation between DHS and NMH whereby DHS will be renamed to reflect the creation of a regional health care system. *(June 9, 2010 Applicants' Initial CON Application, 10-31560-CON Exhibit 8 page 93)*

5. With respect to the proposed affiliation, the Applicants state the following:

   i. Summer 2008 – Senior management and representatives from both Applicants' Boards met to discuss if there was sufficient interest to pursue discussion of a possible affiliation.

   ii. August 17, 2009 – Applicants entered into a Confidentiality Agreement.

   iii. Fall 2009 – Applicants each appointed a Board Affiliation team and jointly engaged a facilitator with a preliminary "due diligence" process, to determine the opportunities to realize through a potential strategic partnership, and met on a monthly basis from October 2009 to January 2010.

   iv. Winter to Spring 2010 – Senior management from both hospitals met with medical and hospital staff to discuss the Letter of Intent for Corporate Affiliate as contemplated. Due diligence was completed and the Letter of Intent between the two parties was approved and signed by both Applicants' Boards on February 15, 2010. Detailed "Phase two due diligence" was conducted by both Applicants.

   v. Spring 2010 – Multiple meetings with constituencies held.

   vi. Spring to Summer 2010 – Definitive Affiliation Agreement was negotiated and approved by each Board and will be signed by Applicants at the completion of the due diligence process to be finalized in summer of 2010. Ongoing dialogue was held with DH and NMH medical staff, employees, volunteers, Board of Directors and community

education regarding the potential affiliation and opportunities to develop a regional health care delivery system and benefits.
(June 9, 2010 Initial CON Application Exhibit 8, pages 12-13)

6. Under the proposed affiliation, DHS will become the sole corporate member of NMH and will change its name from "Danbury Health Systems, Inc." to a name mutually agreeable to both applicants prior to the effective date of the affiliation. The proposed new entity was temporarily named NEWCO for this application. *(June 9, 2010 Initial CON Application Exhibit 8, page 93)*

7. The draft affiliation agreement requires NMH to replace its current four-member board of directors with a "New Milford Community Board" who shall also serve as members of the board of directors of NEWCO with voting rights. *(June 9, 2010 Initial CON Application Exhibit, page 94)*

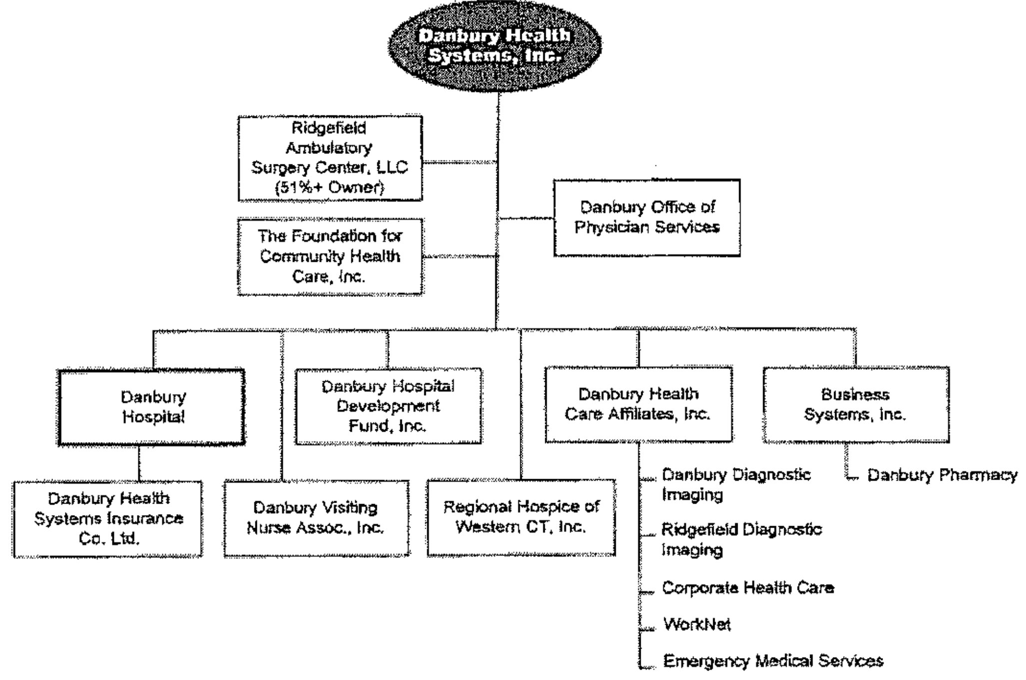
8. The Applicants provided a list of the fifteen (15) members of the board of directors of NEWCO including the four members from NMH's New Milford Community Board and the remaining eleven who are members of the Board of DH. *(June 9, 2010 Initial CON Application Exhibit 7, pages 85 & 91 and June 30, 2010 Completeness Response, page 327)*

9. Upon approval of this proposal by the appropriate regulatory authorities, NMH, DH and its affiliates will become wholly owned/controlled subsidiaries of NEWCO. *(June 9, 2010 Initial CON Application, page 2 and June 30, 2010 Completeness Response, page 327)*

10. NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses. *(June 9, 2010 Initial CON Application, page 2 and Exhibit 6 page 101)*

11. The organizational chart of DHS and its affiliates prior to the proposed affiliation with NMH is as follows:

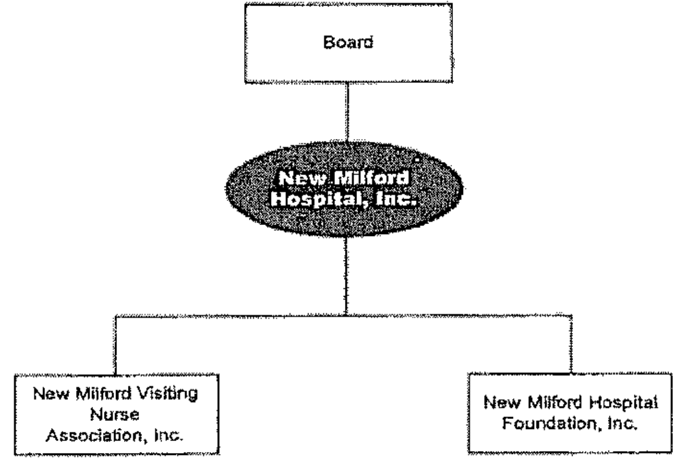
Chart One: DHS Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

12. The organizational chart of NMH and its affiliates prior to the proposed affiliation with DHS is as follows:

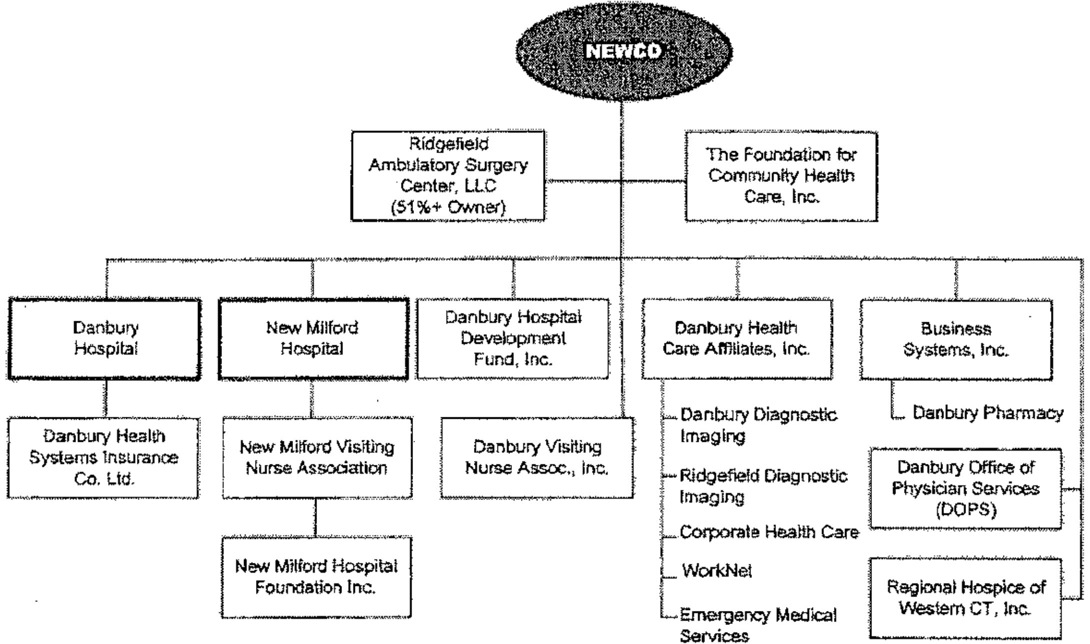
Chart Two: NMH Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

13. The proposed organizational chart of NEWCO and its affiliates after the proposed affiliation is as follows:

Chart Three: NEWCO Organizational Chart After the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

14. DHS has pursued a strategic plan to establish DH as a regional medical center, providing selected tertiary services to an ever greater number of people from a growing, broader geographic region. To that end, DHS has developed an operationally integrated health care delivery system comprised of health care entities that coordinate service along the health care continuum, enabling patients to receive care in the most appropriate systems. *(June 9, 2010, Initial CON Application, page 4)*

15. DH conducted an assessment of its service area during the strategic planning process, which established a direction for considering a relationship with other providers to engage in a more regional planning effort and to provide a more complete continuum of services. *(June 9, 2010, Initial CON Application, page 4)*

16. Following the closure of NMH's emergency angioplasty service, DH assisted in the transition and it became clear that both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. *(June 9, 2010, Initial CON Application, page 4)*

17. DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. *(June 9, 2010, Initial CON Application, page 5)*

18. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. *(June 9, 2010, Initial CON Application, pages 5, 93)*

19. DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. *(June 9, 2010 Initial CON Application, page 93)*

20. NMH expects that upon approval of this proposal, it will be well positioned to meet the challenges and demands of the health care industry, while remaining strong enough to sustain its commitment to offering access to high quality service to the communities it serves. *(June 9, 2010, Initial CON Application, page 5)*

21. NMH considered the following factors in its decision to pursue an affiliation with DHS:

    - Access to significant capital to maintain state-of-the-art treatment facilities as its physical plant and infrastructure ages and as it pursues replacement and expansion of its IT and telecommunications systems;
    - Access to the latest in diagnostic and therapeutic technologies, such as robotic surgery and the latest in genomic therapies:
    - Access to primary care and specialty services;
    - Physician recruitment/cross-coverage arrangements;
    - Quality improvement efforts;
    - Maximizing efficiencies and controlling costs; and
    - Investing in workforce development, retaining talent and attracting others to the institution to minimize vacancies.

    (June 9, 2010 Initial CON Application, pages 5-10)

22. The primary service area ("PSA") of DH is as follows:

Table 5: DH's Primary Service Area

PSA	Bethel
	Brookfield
	Danbury
	New Fairfield
	Newtown
	Redding
	Ridgefield

(June 9, 2010, Initial CON Application, page 15)

23. Based on inpatient discharges, OHCA finds that the towns of Danbury, Newtown, Bethel, Ridgefield, Brookfield, New Fairfield and Redding comprise 74% of DH's discharged patients.

Table 6: DH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
Danbury	39%	39%	93%
Newtown	8%	47%	72%
Bethel	8%	55%	90%
Ridgefield	7%	62%	77%
Brookfield	5%	67%	83%
New Fairfield	4%	72%	89%
Redding	2%	74%	59%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

24. NMH's primary service area ("PSA") is as follows:

Table 1: NMH's Primary Service Area

PSA	New Milford
	Kent
	Washington
	Brookfield
	Sherman
	Bridgewater
	Roxbury
	Warren

(June 9, 2010, Initial CON Application, page 17)

25. Based on inpatient discharges, OHCA finds that the towns of New Milford, Kent, Washington, Brookfield, Sherman, Bridgewater, Roxbury, Cornwall and Warren comprise 73% of NMH's discharged patients.

Table 2: NMH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
New Milford	49%	49%	52%
Kent	7%	56%	53%
Washington	5%	61%	52%
Brookfield	3%	64%	6%
Sherman	3%	67%	35%
Bridgewater	2%	69%	35%
Roxbury	2%	71%	35%
Cornwall+Warren	2%	73%	22%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

26. No changes in licensing of either hospital or affiliated home care agencies will result from this proposal. The Applicants intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions. *(June 9, 2010, Initial CON Application, page 2)*

27. Upon approval of the proposal, DH will serve as the primary provider of tertiary level inpatient and outpatient care to the Western CT region providing the following services:

Inpatient Services	Ancillary Services	Physician Services
Intensive & cardiovascular care Units	Level II Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
Adult & pediatric medical/surgical Units	Surgical services	
Obstetrical unit with NICU	Medical imaging	
High acuity rehabilitation Unit	Praxair Regional Heart and Vascular Center	
Behavioral health/psychiatry	Praxair Cancer Center	
	Center for Advanced Orthopedic & Spine Care	
	Women's and children's service	
	System-wide reference lab	

(June 9, 2010, Initial CON Application, page 3)

28. The following table illustrates the historical utilization by service category for DH:

Table 9: DH's Historical Utilization by Service Category

DH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	67,929	67,553	69,582	71,098
Ambulatory Surgery	13,092	12,277	11,668	11,204
Observation Patients	1,257	2,632	2,868	2,983
Extended Stay	-	-	-	504
Admissions				
Medical/ Surgical	14,420	14,486	14,894	14,916
Maternity	2,502	2,379	2,248	2,208
Newborn	2,272	2,127	1,956	1,944
Psychiatric	812	794	769	711
Pediatric	419	342	329	333
Rehabilitation	377	337	303	315
Total Admissions	**20,802**	**20,465**	**20,499**	**20,427**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12) (*June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)*

29. Inpatient discharges decreased from FY2008 through FY2010, from a significant shift in patients to an observation status and in FY2010, to extended stays.[1]

[1] Centers of Medicare and Medicaid Services and third party payers in seeking to eliminate unnecessary inpatient care allow "observation programs" for patients with selected medical conditions.

30. The following table represents the projected utilization by service category for DH:

Table 10: DH's Projected Utilization by Service Category

DH	FY 2011	FY 2012	FY 2013
ED visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411
Observation Patients	3,072	3,164	3,228
Extended Stay	554	610	653
Admissions			
Medical/ Surgical	15,217	15,437	15,656
Maternity	2,289	2,312	2,335
Newborn	1,947	1,967	1,986
Psychiatric	752	760	768
Pediatric	351	355	360
Rehabilitation	321	324	328
Total Admissions	**20,877**	**21,156**	**21,433**

Note: The Applicants made the following assumptions with respect to DH volumes as illustrated above:

i. Newborn, maternity, psychiatric and rehabilitation discharges will increase annually by 1%.

ii. Overall inpatient growth is attributed to growth in programs and services as well as a changing population.

(June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)

31. The Applicants expect inpatient medical/surgical and pediatrics discharges to grow 1.4% annually from a reduction in outmigration of medical/surgical cases through the affiliation. Approximately 80% of the increase is related to tertiary services as a result of lower outmigration or through improved access to primary care physicians and specialists in the NMH service area. *(June 30, 2010, Completeness Responses, page 333- 334)*

32. The Applicants anticipate that the majority of the transfers from NMH as well as other patients served by the added primary care physicians and specialists seeing patients in New Milford area will comprise the largest component of the projected inpatient volume increase. These assumptions are based on discussions with the NMH medical staff and early evidence of success in the field of cardiology. *(June 30, 2010, Completeness Responses, page 333)*

33. Following the closure of the NMH cardiac catheterization lab, DH has received 110 referrals from NMH physicians in FY 2010 YTD versus 51 referrals for the same time period in FY2009 – a 116% increase. *(June 30, 2010, Completeness questions, page 340)*

34. NMH will continue to provide the following inpatient and outpatient services to its service area:

Inpatient Services	Ancillary Services	Physician Services
Adult & pediatric medical/surgical unit	24-hour Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
ICU/stepdown/acuity adaptable unit	Surgical services	
Family birthing center	Medical imaging	
Low acuity rehabilitation (pending space)	Cardiovascular screening/diagnostics and clinics	
	Regional Cancer Center	
	OP Neurodiagnostics and other specialty clinics	
	Expanded women's health and wellness programs	
	Phase 1 Research Center office	

(June 9, 2010, Initial CON Application, page 3)

35. The following table illustrates the historical utilization by service category for NMH:

Table 3: NMH's Historical Utilization by Service Category

NMH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	19,309	19,553	19,146	19,173
Ambulatory Surgery	2,414	2,335	2,461	2,787
Observation Patients	333	384	567	520
Admissions				
Newborn	294	342	296	264
Maternity	306	341	300	266
Psychiatric	-	-	-	-
Pediatric	68	58	47	15
Medical/Surgical	2,178	2,292	2,131	1,983
Rehabilitation	-	-	-	-
Total Admissions	**2,845**	**3,033**	**2,774**	**2,528**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12). *(June 9, 2010, Initial Con Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)*

36. Inpatient discharges decreased from FY2008 through FY2010, from a recent loss of market share and a significant shift in patients to an observation status.

37. The following table illustrates the projected utilization by service category for NMH:

Table 4: NMH's Projected Utilization by Service Category

NMH	FY 2011	FY 2012	FY 2013
ED visits	19,273	19,418	19,571
Ambulatory Surgery	2,704	2,732	2,761
Observation Patients	522	524	527
Admissions			
Newborn	250	248	246
Maternity	250	248	246
Psychiatric	-	-	-
Pediatric	24	24	24
Medical/Surgical	2,037	2,052	2,070
Rehabilitation	-	-	-
Total Admissions	**2,561**	**2,572**	**2,586**

Note: The Applicants made the following assumptions with respect to NMH volumes as illustrated above:

i. Inpatient medical discharges are expected to grow 0.9% to 1.0% annually and surgical at 0.4% to 0.5% from FY 2011.

ii. Inpatient Ob/Gyn discharges will grow annually at 0.8% while pediatrics volume will remain unchanged over the next three years.

ii. Newborn, maternity, psychiatric and rehabilitation discharges will remain unchanged over the next three years.

iv. Outpatient services will increase annually by 0.4% to 1.1%.

(June 9, 2010, Initial CON Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)

38. The incremental volumes attributable to the project are based upon a 1% growth in market share through reductions in out-migration from the affiliation. *(June 9, 2010, Initial CON Application, page 20)*

39. Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. *(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)*

40. Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Together, the two hospitals provided inpatient care to 81% of the discharges from the PSA; no other individual hospital accounts for more than 4% of acute care inpatient services to the area. The two PSAs are adjacent to each other with the town of Brookfield as the only overlapping town between the two.

Table 8: Significant Providers of Inpatient Services in New Milford Primary Service Area, FY 2009

	New Milford	Danbury	Sharon	Yale	Hartford	All Other*	Total
Percentage of NMH PSA	37%	44%	4%	4%	2%	9%	100%
% of Hospital Total	73%	12%	7%	0.4%	0.3%	0.2%	1%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

41. Excluding psychiatric referrals, in 2008, 196 patients were transferred from NMH PSA to other tertiary level providers.

Table 7: Number of Transfers from New Milford Hospital's Primary Service Area to Other Tertiary Providers, 2008	
Connecticut Children's Medical Center	2
John Dempsey Hospital	2
Bridgeport Hospital	4
Waterbury Hospital	6
St. Francis Medical Center	9
Hospital of St. Raphael	10
Other Connecticut Hospitals	15
Other NY Hospitals	35
Hartford Hospital	36
NY Presbyterian	36
Yale-New Haven Hospital	41
Total	**196**

(June 30, 2010, Completeness Reponses, page 333)

42. Further, based on hospital inpatient discharge data, OHCA finds that compared to NMH, DH provides a higher percentage of specialty care including cardiac, neurological, women's health, general/other surgery, behavioral health and trauma care to NMH PSA residents.

Table 11: Providers of Inpatient Services to NMH Primary Service Area Residents, FY 2009

Service line	New Milford	Danbury	Sharon	Yale	Hartford	Other*	Total
Cardiac Care	38%	**42%**	3%	4%	5%	8%	100%
Cancer Care	32%	37%	3%	15%	3%	11%	100%
Neurological	32%	**47%**	5%	4%	3%	8%	100%
Renal or Urology	38%	38%	3%	5%	6%	10%	100%
Women's Health	40%	**50%**	2%	2%	1%	6%	100%
Orthopedics	42%	41%	3%	3%	1%	10%	100%
Respiratory	61%	30%	4%	1%	0%	3%	100%
Medicine	44%	42%	3%	4%	1%	6%	100%
General/other surgery	35%	**45%**	2%	8%	2%	7%	100%
Newborn	40%	52%	2%	1%	0%	5%	100%
Psychiatry	1%	**59%**	9%	2%	3%	26%	100%
Ophthalmology	40%	33%	0%	13%	0%	13%	100%
Trauma	19%	**47%**	3%	6%	10%	16%	100%
Dental	0%	25%	0%	50%	0%	25%	100%
Substance Abuse	15%	**35%**	25%	1%	0%	22%	100%
PSA Total	**39%**	**44%**	**3%**	**4%**	**2%**	**8%**	**100%**

(Office of Health Care Access' Connecticut Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

43. Based upon the foregoing data, OHCA finds that NMH has experienced significant out-migration in recent years and DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Additionally, DH provided a higher level of specialty care to NMH PSA residents.

44. In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. Therefore, increased availability of primary physicians will be beneficial to residents of the area.

Table 12: Percent of Primary Care Sensitive Preventable Hospitalizations[2] at NMH and DH, 2006-2008

Hospital	2006	2007	2008
New Milford	14%	12%	12%
Danbury	10%	10%	11%
CT	**12%**	**12%**	**11%**

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

45. NMH indicates, consistent with the above data in Findings 34 through 40, that one of the challenges it faces is a physician shortage in primary care and specialties. *(June 9, 2010, Initial CON Application, page 6)*

46. NMH has identified key specialties in which a need exists, such as endocrinology, neurology and selected surgical subspecialties. *(June 9, 2010, Initial CON Application, page 8)*

47. NMH has been unable to attract admissions and subspecialty care because of a documented shortage of both primary care physicians and sub-specialists. NEWCO will provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. *(June 30, 2010, Completeness questions, page 340)*

48. DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. *(June 9, 2010, Initial CON Application, page 8)*

49. DHS also houses Danbury Office of Physician Services ("DOPS"), a multispecialty faculty practice plan whose mission is to support DH in its objective of meeting the needs of all patients, including the underserved. DOPS has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. *(June 9, 2010, Initial CON Application, page 8)*

50. Another challenge for NMH is the growing need to address and upgrade the physical, clinical and technological infrastructure to meet community need. *(June 9, 2010, Initial CON Application, page 6)*

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[2] OHCA utilized the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) software to identify preventable hospitalizations. AHRQ defines preventable hospitalizations as instances of inpatient hospital care for health conditions or illnesses typically treated or managed in outpatient settings. See http://www.ct.gov/ohca/lib/ohca/publications/2010/prev_hosp_report01-2010.pdf for more details.

51. An example of the larger capital expenses are: (a) information technology to support legacy systems as well as clinical applications; (b) implementation of an electronic medical record and other advanced clinical technologies designed to improve care, quality and efficiency; (c) enhanced PACS and voice dictation systems; (d) renovation and upgrades to patient care units; (e) facility improvements such as upgrading mechanicals and introducing green technologies; and (f) general plant maintenance associated with an aging facility. *(June 9, 2010, Initial CON Application page 7)*

52. Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. *(June 9, 2010, Initial CON Application, page 30)*

53. DHS currently operates an electronic health information exchange called HealthLink, which enables the hospital to link to other providers through a web-based architecture. NMH will obtain access to the IT expertise and systems currently in place at DH, accelerating its adoption of an EMR and creating seamless information access and connectivity among all entities for optimal clinical quality and operational efficiency. *(June 9, 2010, Initial CON Application, page 30)*

54. DH is engaged in various research initiatives, from basic science to translational research. DH Research Department provides infrastructure and coordinates all of the research and scholarly activities for the entire institution. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

55. In order to integrate the existing and future research and scholarly activities of NMH into the Department research activities and provide a seamless collaboration and coordination of the research efforts, DH will extend its research capabilities by developing a satellite research center at NMH. In addition, the programs at DH will be made available to NMH physicians and patients creating opportunities for greater involvement and collaboration. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

56. OHCA finds that both NMH's ability to recruit and retain high quality physicians will be enhanced through this affiliation due to greater access to technology and clinical research opportunities.

57. There is no capital cost associated with this proposal. *(June 9, 2010, Initial CON Application, page 24).*

58. There will be no change in billing as a result of this proposal. *(June 9, 2010, Initial CON Application, page 26).*

59. There will be no changes to existing reimbursement contracts between the Applicants and the payers. *(June 9, 2010, Initial CON Application, page 26).*

60. This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of

approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. *(June 9, 2010, Initial CON Application, page 27).*

61. The proposed 2% (or $2,558,000) potential savings to NMH will be in two cost categories over the first three years of the affiliation. One category of potential cost savings is "salaries and benefits" through a reduction of eight (8) FTEs per year over three years in the back office area from retirements and elimination of management positions and normal attrition. The second area is "supplies and drugs."

Table 13: Potential Cost Savings for NMH

	FY 2011	FY 2012	FY 2013	3-YR TOTAL COST SAVINGS
Salaries & Benefits	$797,000	$855,000	$876,000	**$2,528,000**
Supplies & Drugs	$1,016,000	$1,057,000	$1,099,000	**$3,172,000**
Total	**$1,813,000**	**$1,912,000**	**$1,975,000**	**$5,700,000**

(June 30, 2010, Completeness Responses, pages 334-335)

62. The Applicants plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. *(June 9, 2010, Initial CON Application, page 27).*

63. The Applicants will also consider centralizing certain clinical functions, such as clinical laboratory and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. *(June 9, 2010, Initial CON Application, page 26).*

64. There are no plans to implement savings associated with the reduction, elimination, or combination of any clinical services in the short term. *(June 30, 2010, Completeness Responses, page 334).*

65. The cost efficiencies to be realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH. *(June 9, 2010, Initial CON Application, page 7).*

66. The potential bond rating of NEWCO would support an "A" rating and the strategic value of affiliating with another hospital would at least equal any dilutive financial impact in the short term. *(June 30, 2010, Completeness Responses, page 336)*

67. NMH's credit worthiness will be enhanced by the affiliation in that NMH will benefit from the guarantee of NEWCO, an organization whose numbers would support an "A" rating, which is better than NMH would be able to achieve on its own. *(June 30, 2010, Completeness Responses, page 336)*

68. The Applicants intend to improve productivity and contain costs by developing economies of scale in operations, establishing evidence-based quality decisions on services and care protocols, and developing an integrated plan that allows both organizations to address the needs in the greater region without the unnecessary duplication in services that has characterized the past. *(June 9, 2010, Initial CON Application, page 30).*

69. The projected incremental revenue from operations, total operating expense and gains from operations associated with the proposal are presented in the table below for the first three years with the proposed project:

Table 14: Combined Danbury and New Milford Hospital Financial Projections

Description	FY 2011	FY 2012	FY 2013
Incremental Revenue from Operations	$2,039,000	$2,820,000	$3,689,000
Incremental Total Operating Expense	($407,000)	($161,000)	$151,000
Incremental Gain from Operations	**$2,447,000**	**$2,981,000**	**$3,538,000**

(June 9, 2010, Initial CON Application, Financial Attachment I, page 320)

70. This proposal will also improve revenue through increased inpatient and outpatient volumes at NMH. *(June 30, 2010, Completeness Responses, page 336)*

71. DH's patient population mix is based on the FY 2010 budget, with no change in mix anticipated or projected. DH's current patient population mix and projected population mix with the CON proposal is as follows:

Table 15: Current and Three-Year Projected Population Mix with the CON Proposal

Danbury Hospital	**Current FY Payer Mix**	**2011 Projected Payer Mix**	**2012 Projected Payer Mix**	**2013 Projected Payer Mix**
Medicare	32.2%	32.2%	32.2%	32.2%
Medicaid	14.5%	14.5%	14.5%	14.5%
TRICARE and CHAMPUS	0.0%	0.0%	0.0%	0.0%
Total Government	**46.7%**	**46.7%**	**46.7%**	**46.7%**
Commercial Insurers	46.3%	46.3%	46.3%	46.3%
Uninsured	6.5%	6.5%	6.5%	6.5%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	**53.3%**	**53.3%**	**53.3%**	**53.3%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

(June 9, 2010, Initial CON Application, page 25)

72. NMH's patient mix is based on the FY 2010 budget, with no change in mix anticipated or projected. NMH's current population mix and projected population mix with the CON proposal is as follows:

Table 16: Current and Three-Year Projected Population Mix with the CON Proposal

New Milford Hospital	**Current FY Payer Mix**	**2011 Projected Payer Mix**	**2012 Projected Payer Mix**	**2013 Projected Payer Mix**
Medicare	45.8%	45.8%	45.8%	45.8%
Medicaid (includes other medical assistance)	10.0%	10.0%	10.0%	10.0%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	**55.9%**	**55.9%**	**55.9%**	**55.9%**
Commercial Insurers*	40.6%	40.6%	40.6%	40.6%
Uninsured	2.8%	2.8%	2.8%	2.8%
Workers Compensation	0.7%	0.7%	0.7%	0.7%
Total Non-Government	**44.1%**	**44.1%**	**44.1%**	**44.1%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

(June 9, 2010, Initial CON Application, page 25)

73. The Applicants provided resumes of its executive leadership team associated with this proposal demonstrating that they have sufficient managerial and financial experience in managing health care organizations to provide efficient and adequate service to the public. *(June 9, 2010, Initial CON Application, page 118)*

Rationale

OHCA approaches community and regional need for CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of DH in Danbury. NMH is a Connecticut non-stock 501 (c)(3) organization, located at 21 Elm Street, New Milford. DHS and NMH propose an affiliation, with no associated total capital expenditure. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. (Finding of Fact 18) DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. (Finding of Fact 19) The proposed affiliation is also intended to help strengthen access to capital, generate cost savings and leverage recruitment and retention of high quality physicians.

While DH views the affiliation as an opportunity to engage in a more regional planning effort and to provide a more complete continuum of services both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. (Findings of Fact 15-16) Additionally, DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. (Finding of Fact 17)

NMH also considered its need for access to significant capital to maintain state-of-the-art treatment facilities; access to the latest in diagnostic and therapeutic technologies; access to primary care and specialty services; physician recruitment/cross-coverage arrangements; quality improvement efforts; and maximizing efficiencies and controlling costs. (Finding of Fact 21) Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. (Finding of Fact 52) Additionally, NMH will now have access to DH's research capabilities as DH will establish a satellite research center at NMH and physicians and patients from NMH will be able to attend programs offered at DH. (Findings of Fact 54-55)

The affiliation will also provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. (Finding of Fact 47) DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. (Finding of Fact 48) DHS also houses DOPS, which has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. (Finding of Fact 49) Not only will NMH benefit from an increase in primary care physicians and specialists in the NMH service area, but DH also expects a modest increase in

inpatient utilization based upon the increases in referrals to DH's cardiac catheterization lab in 2010 following the closure of NMH's cardiac catheterization lab.

Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. (Finding of Fact 39) Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. (Finding of Fact 40) In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. (Finding of Fact 44) Specifically, 14% of NMH's hospitalizations were considered preventable compared to 12% for the state. (Finding of Fact 44) Thus, OHCA finds the ED utilization rate for NMH is higher than the statewide average. OHCA is concerned about the use of the ED for health care services that can be delivered in the community setting at a lower cost to the patient and the hospital. Accordingly, OHCA finds that proposed affiliation will improve the quality, accessibility and cost effectiveness of health care delivery in the region by increasing access to primary care and specialty physicians in the NMH service area.

This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. (Finding of Fact 60) The Applicants also plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. (Finding of Fact 62) The Applicants will also consider centralizing certain clinical functions, such as the clinical laboratories and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. (Finding of Fact 63) Additionally, the integrated IT system and EMR will provide significant cost savings for NMH. (Finding of Fact 52) The Applicants project operational gains of $2,447,000, $2,981,000 and $3,538,000 in the first three years of the proposal. (Finding of Fact 69) OHCA finds the financial projections and volumes upon which they are based appear to be reasonable and achievable. Accordingly, OHCA concludes that the proposal is financially feasible.

Based upon all of the foregoing, OHCA finds that the proposed affiliation will allow better access to capital and technology and will provide cost efficiencies for both Applicants to create a stronger health care system. Shared best practices, an integrated IT system and the ability to recruit and retain top-level physicians will enhance the Applicants' ability to respond to new federal health care reform initiatives that require health care providers to re-align all aspects of the delivery system and better coordinate those services around the patients' needs. In the absence of an affiliation with a larger tertiary hospital, NMH would probably find it difficult to meet future requirements and financial challenges. Accordingly, OHCA concludes that this proposal will create a larger and financially stronger health care delivery system that will better address these demands and continue to provide access to quality health care in the Applicants' service area.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Danbury Health System, Inc. and New Milford Hospital, Inc. for an affiliation, with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA, a full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of DHS and NMH has occurred.

2. If, in the future, there is any change in the ownership structure of DHS, NMH or its affiliates or any change in the affiliation agreement, the Applicants shall file a CON Determination Form with OHCA.

3. If, in the future, there is any change in NMH or NEWCO service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.

4. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA a comprehensive plan that includes the following:

   (i) The locations of current primary care providers in the NEWCO service area;

   (ii) A discussion of how the Applicants will recruit primary care physicians and specialists in the NEWCO service area;

   (iii) A discussion of how the Applicants will specifically address the need for additional primary care in the NEWCO service area, including, but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and

   (iv) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.

5. The Applicants shall schedule a meeting with OHCA to occur within 30 calendar days of the filing of the comprehensive plan to discuss the Applicants' provision of findings pursuant to Condition #4.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the

September 23, 2010
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner
Office of Health Care Access

Attachment B

WESTERN CONNECTICUT HEALTH NETWORK
BOARD OF DIRECTORS
December 6, 2012

Draft

A meeting of the Board of Directors of Western Connecticut Health Network, New Milford Hospital and Danbury Hospital was held on Thursday, December 6, 2012 at 8:00 a.m. in the Robison Conference Room at New Milford Hospital. Chairman of the Board Jim Kennedy presided.

PRESENT:	A. Altorelli, M.D, A. Disney, S. Houldin, J. Kennedy, J. Murphy, MD., J. Patrick, J. Skrzypczak, B. White
VIA TELECONFERENCE:	D. Cyganowski, N. Culligan, and M.D. D. Kramer, M.D.
ABSENT:	R. Jabara,
GUESTS:	Lisa Boyle, Esq. – Robinson & Cole Bruce Barth, Esq. – Robinson & Cole (via teleconference)
ALSO PRESENT:	M. Daglio, C. McKenna, S. Rosenberg, D. Weymouth

CHAIRMAN'S REMARKS

Chairman Kennedy welcomed the directors and guests and noting that we had a quorum, began with the opening of the meeting of the WCHN Board of Directors to review the status of due diligence work being done towards the possible affiliation with Norwalk Hospital.

NEW MILFORD HOSPITAL

GENERAL/CONSENT

Approvals/Resolutions (attachments):

a. Licensure – New Milford

A motion was made by J. Patrick and seconded by Dr. A. Altorelli and it was:
ACTION: VOTED to unanimously approve resolutions as presented

RESOLUTIONS TO BE CONSIDERED FOR ADOPTION AT THE MEETING OF THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF WESTERN CONNECTICUT HEALTH NETWORK, INC.

December 6, 2012

Licensure

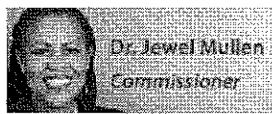
WHEREAS, Western Connecticut Health Network, Inc. ("WCHN") is the sole member of The Danbury Hospital ("DH") and New Milford Hospital, Inc. ("NMH");

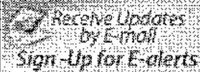
WHEREAS, the DH and NMH each operate separately licensed hospitals (the "Hospitals"); and

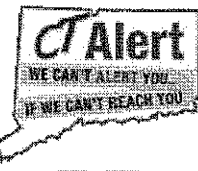
WHEREAS, the DH and NMH desire to authorize the operational activities necessary to present the board of directors of each entity with a plan to merge the two entities and operate the Hospitals as one licensed facility with two campuses.

NOW, THEREFORE, BE IT:

RESOLVED, that, WCHN, as the sole member of each of DH and NMH, hereby authorizes and directs the proper officers of DH and NMH, on behalf of each entity, to take all necessary and appropriate actions to develop a plan of merger and single licensure for DH and NMH, including without limitation engaging consultants and authorizing communications with the Connecticut Department of Health, the Centers for Medicare and Medicaid Services, and the Joint Commission, the taking of such action to be conclusive evidence of the necessity, appropriateness or desirability thereof.







Welcome to the Office of Health Care Access. Our Mission is to ensure that the citizens of Connecticut have access to a quality health care delivery system.

CT State-Wide Health Care Facilities and Services Plan Advisory Body

Outpatient Data Work Group

Latest CON Deemed Complete:

On April 10, 2013, the Certificate of Need Application of Blue Sky Behavioral Health, LLC for the establishment of a mental health residential living center in Danbury was deemed complete. This CON application was filed under Docket No. 12-31811-CON.

On March 25, 2013, the Certificate of Need Application of for the acquisition of a portable multi-Slice CT scanner by Yale-New Haven Hospital was deemed complete. This CON application was filed under Docket No. 12-31815-CON.

On March 15, 2013, the Certificate of Need Application of for the for the acquisition of 3.0 Tesla MRI for the Yale-New Haven's Children's Hospital was deemed complete. This CON application was filed under Docket No. 12-31810-CON.

Upcoming Public Hearing Notices:

Date	Reference
Tuesday, March 26, 2013	Docket # 12-31788-CON
Wednesday, April 10, 2013	Docket # 12-31793-CON

Click on '*Check the Calendar*' on the left navigation bar for details.

News:

- NEW !!! On April 12, 2013, OHCA received the Certificate of Need application of Tolland Imaging Center, LLC for the continuation of comprehensive imaging services in Tolland through the permanent acquisition of an Open MRI and a CT Scanner. This CON application was filed under Docket No: 13-31833-CON.
- NEW!!! On March 25, 2013, OHCA received the Certificate of Need Application for the Retreat at South Connecticut for the Establishment of a 105 Bed Substance Abuse Treatment Facility in New Haven. This CON application was filed under Docket No. 13-31828-CON.
- NEW!!! Statement of Operations data for Connecticut's 30 Short Term Acute Care Hospitals for Fiscal Year 2012. This document provides a summary of revenues and expenses for each acute care

hospital and on a cumulative statewide basis for the fiscal year ending September 30, 2012.

- NEW !!! On March 19, 2013, OHCA received a Request for Modification from Western Connecticut Health Network, Inc. d/b/a The Danbury Hospital and New Milford Hospital to modify OHCA's Final Decision rendered under Docket No.: 10-31560-CON. Anyone wishing to submit any comments or request a hearing regarding this matter should contact OHCA and refer to Docket No.: 13-31560-MDF by April 18, 2013.

- NEW !!! On February 13, 2013, OHCA received the Certificate of Need application of The Next Right Thing, LLC, to establish an intensive outpatient behavioral health treatment program in West Hartford. This CON application was filed under Docket No. 13-31822-CON.

- OHCA's newest fact sheet entitled Acute Care Hospital Expenses for FY 2011 is now available. This fact sheet provides data on 11 different categories of hospital expenses and includes some trends that have been occurring over the years FY 2008 – FY 2011 in hospital operating expenses.

Important Feature E-Alerts! Register on our Website to receive email notification when new information is posted regarding:

CON Decisions, Determinations, CON Status Reports
Health Care Facilities and Services Plan Advisory Body
New Issue Briefs and Reports
Press Releases

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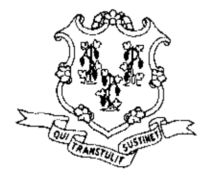

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 17, 2013 VIA FAX ONLY

Sally Herlihy, MBA, FACHE
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31560-CON
Western Connecticut Health Network, Inc.
Request for Modification of Final Decision rendered under Docket Number 10-31560.

Dear Ms. Herlihy:

On March 19, 2013, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") Modification Request on behalf of Western Connecticut Health Network, Inc. to modify Findings of Facts numbers 10 and 26, to enable one license for The Danbury Hospital and New Milford Hospital, Inc., with no associated capital expenditure.

OHCA has reviewed the CON Modification Request and requests the following additional information.

1. Will there be an impact or change in the governance or controlling body of New Milford Hospital, Inc. or The Danbury Hospital?

2. Will there be a sale or transfer of net assets of New Milford Hospital, Inc. or The Danbury Hospital?

3. Please provide a copy of the plan of merger and copies of all agreements that describe the merger and operation and control of The Danbury Hospital and New Milford Hospital, Inc. and their assets.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response. Submit one (1) original and four (4) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

****
*** TX REPORT ***
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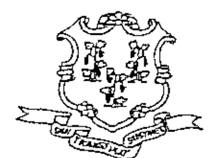

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Sally Herlihy

FAX: (203) 739-1974

AGENCY:

FROM: Steven Lazarus

DATE: 5/20/13 TIME:

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
Comp. Letter re: DN-13-31560-CON

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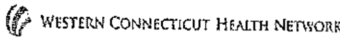
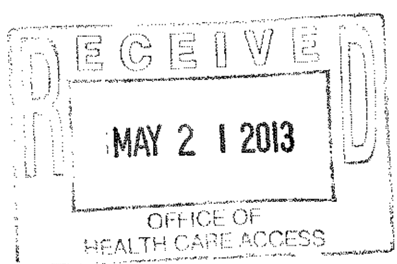


DANBURY HOSPITAL



24 Hospital Ave
Danbury, CT 06810
203.739.4903
DanburyHosptial.org

From: Sally Herlihy
Vice President, Planning

To: Kimberly Martone

Fax: 860-418-7053 No. of Pages: 28

Phone: 860-418-7029 Date: May 21, 2013

RE: Docket No. 10-31560-CON CC:

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Fax

The original letter will be mailed to your office.

Thank you.

Sally

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DanburyHospital.org
NewMilfordHospital.org

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May 21, 2013

Via Fax and First-Class Mail

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Docket No. 13-31560-CON
Western Connecticut Health Network, Inc.
Request for Modification of Final Decision in Docket No. 10-31560

Dear Ms. Martone,

Enclosed please find answers from Western Connecticut Health Network, Inc. to the Completeness Questions from OHCA dated May 17, 2013.

The request before the Office of Health Care Access ("OHCA") seeks a modification of the decision granted in September of 2010 in which both hospitals (The Danbury Hospital and New Milford Hospital, Inc.) retained individual licenses. We are requesting OHCA's approval in order to approach DPH for a single hospital license for both hospitals within our system.

If you have any questions, please do not hesitate to contact me.

Respectfully submitted,

Sally F. Herlihy

Sally F. Herlihy
Vice President, Planning

cc: Kaila Riggott, Planning Specialist
Steven Lazarus, Staff Analyst

Western Connecticut Health Network, Inc.

Docket No. 13-31560

Completeness Answers

The following answers are in response to the Completeness Questions dated May 17, 2013 regarding the Applicant's request for a single license for Danbury Hospital and New Milford Hospital:

1. Will there be an impact or change in the governance or controlling body of New Milford Hospital, Inc. or The Danbury Hospital?

No. There will be no impact or change in the governance or controlling body of New Milford Hospital, Inc. ("NMH") or The Danbury Hospital ("DH") as a result of this request for a modification to allow both hospitals to operate under a single license. Both hospitals are controlled and operated by Western Connecticut Health Network, Inc. ("WCHN") as a result of the affiliation which occurred through OHCA Docket No. 10-31560. Operationally, the Executive Directors of NMH and DH each report directly to the President & CEO of WCHN.

The proposed and current organizational charts after the affiliation of DH and NMH are attached as Exhibit A. There are no changes to the organizational structure proposed with operating under a single license.

2. Will there be a sale or transfer of net assets of New Milford Hospital, Inc. or The Danbury Hospital?

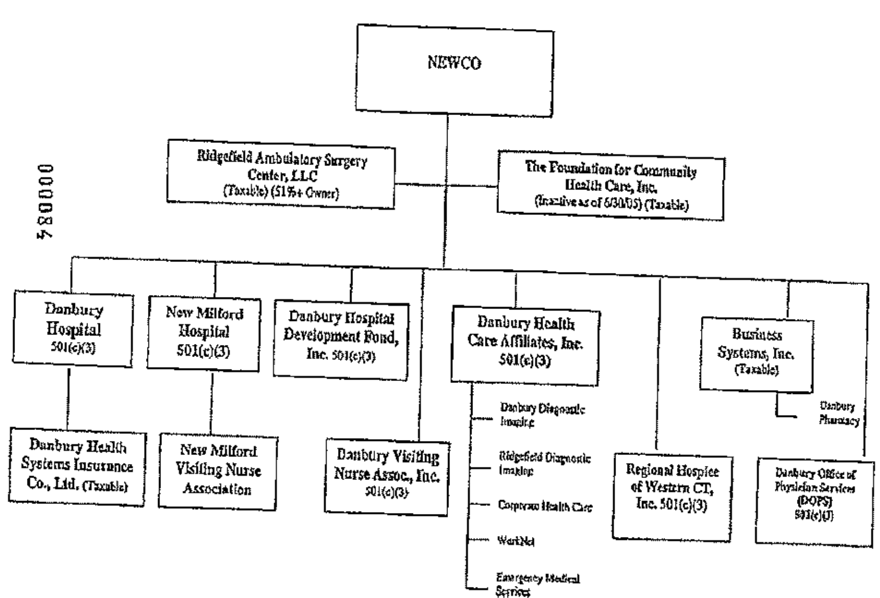
No. The requested modification is to allow the two above-named hospitals to operate under a single license, and the assets will continue to be controlled by WCHN.

3. Please provide a copy of the plan of merger and copies of all agreements that describe the merger and operation and control of The Danbury Hospital and New Milford Hospital, Inc. and their assets.

Please see the full application on file in OHCA Docket No. 10-31560, which contains all of the plans of the operation and control of DH and NMH, and their assets. For reference, the Notice of Final Decision of September 23, 2010 is attached as Exhibit B. DH and NMH have been operating more and more as a unified entity, and additional efficiencies can be realized if there is a single license, including a single audit, IT conversion and single charge master. Consolidated accreditation surveys will reduce further the duplication of work and positively benefit the cost of delivery of health care in the community. Activities supporting achievement of a single license have been explored (i.e. single medical staff structure, Medicare Conditions of Participation), and will be pursued with the licensing division of DPH and the federal government upon approval from OHCA.

Exhibit A

Proposed Organization after Affiliation – 2010



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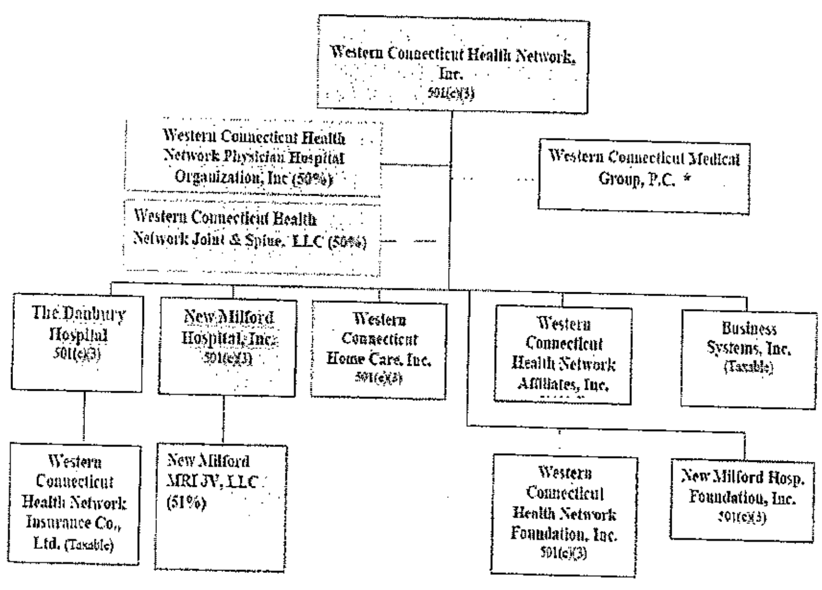
Current Western Connecticut Health Network, Inc – 2013



* Controlled entity via management agreement

WCHN Org Chart 6-2012

Exhibit B

Notice of Final Decision – Docket No. 10-31560-CON

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants: Danbury Health System, Inc. and New Milford Hospital, Inc.

Docket Number: 10-31560-CON

Project Title: Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Project Description: Danbury Health System, Inc. ("DHS") and New Milford Hospital, Inc. ("NMH") propose an affiliation, with no associated total capital expenditure.

Nature of Proceedings: On June 30, 2010, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") for the above-referenced project. DHS and NMH (collectively known as the "Applicants") are considered health care facilities pursuant to Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent ("LOI") was published on March 8, 2010 in *The News Times* pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S). OHCA received no responses from the public concerning the Applicants' LOI.

Pursuant to Section 19a-638, C.G.S. three individuals or an individual representing an entity with five or more people had until July 21, 2010, the twenty-first calendar day following the filing of the CON application, to request that OHCA hold a public hearing on the Applicants' proposal. OHCA received no hearing requests from the public by July 21, 2010.

OHCA's authority to review and approve, modify or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of The Danbury Hospital ("DH"), in Danbury. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

2. DH is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury, and is licensed by the Connecticut Department of Public Health for 345 general hospital beds and 26 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

3. NMH is a Connecticut non-stock 501(c)(3) organization, located at 21 Elm Street, New Milford, and is licensed by the Connecticut Department of Public Health for 85 general hospital beds and 10 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

4. On February 8, 2010, DHS and NMH executed an LOI for a Corporate Affiliation confirming their understanding with respect to a proposed affiliation between DHS and NMH whereby DHS will be renamed to reflect the creation of a regional health care system. *(June 9, 2010 Applicants' Initial CON Application, 10-31560-CON Exhibit 8 page 93)*

5. With respect to the proposed affiliation, the Applicants state the following:

   i. Summer 2008 – Senior management and representatives from both Applicants' Boards met to discuss if there was sufficient interest to pursue discussion of a possible affiliation.

   ii. August 17, 2009 – Applicants entered into a Confidentiality Agreement.

   iii. Fall 2009 – Applicants each appointed a Board Affiliation team and jointly engaged a facilitator with a preliminary "due diligence" process, to determine the opportunities to realize through a potential strategic partnership, and met on a monthly basis from October 2009 to January 2010.

   iv. Winter to Spring 2010 – Senior management from both hospitals met with medical and hospital staff to discuss the Letter of Intent for Corporate Affiliate as contemplated. Due diligence was completed and the Letter of Intent between the two parties was approved and signed by both Applicants' Boards on February 15, 2010. Detailed "Phase two due diligence" was conducted by both Applicants.

   v. Spring 2010 – Multiple meetings with constituencies held.

   vi. Spring to Summer 2010 – Definitive Affiliation Agreement was negotiated and approved by each Board and will be signed by Applicants at the completion of the due diligence process to be finalized in summer of 2010. Ongoing dialogue was held with DH and NMH medical staff, employees, volunteers, Board of Directors and community

education regarding the potential affiliation and opportunities to develop a regional health care delivery system and benefits.
(June 9, 2010 Initial CON Application Exhibit 8, pages 12-13)

6. Under the proposed affiliation, DHS will become the sole corporate member of NMH and will change its name from "Danbury Health Systems, Inc." to a name mutually agreeable to both applicants prior to the effective date of the affiliation. The proposed new entity was temporarily named NEWCO for this application. *(June 9, 2010 Initial CON Application Exhibit 8, page 93)*

7. The draft affiliation agreement requires NMH to replace its current four-member board of directors with a "New Milford Community Board" who shall also serve as members of the board of directors of NEWCO with voting rights. *(June 9, 2010 Initial CON Application Exhibit, page 94)*

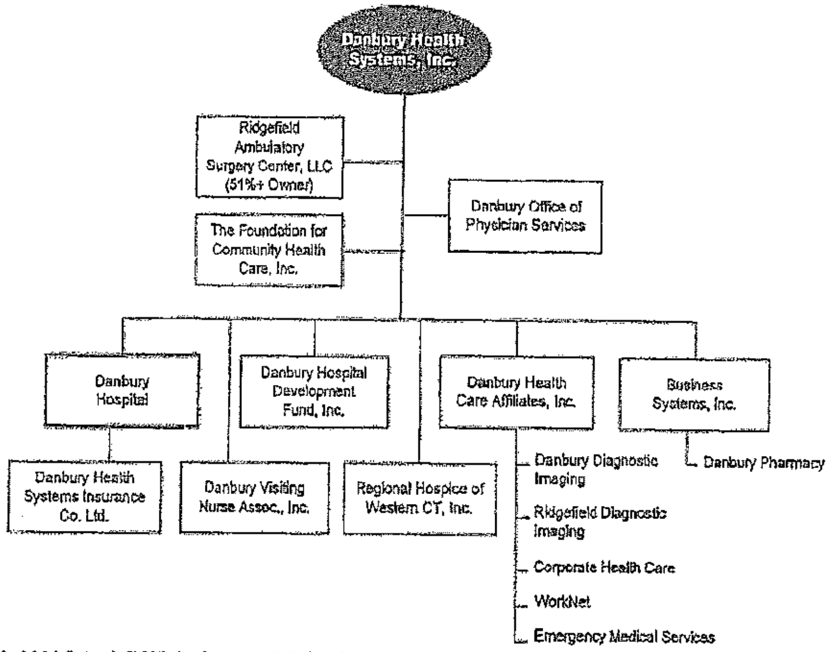
8. The Applicants provided a list of the fifteen (15) members of the board of directors of NEWCO including the four members from NMH's New Milford Community Board and the remaining eleven who are members of the Board of DH. *(June 9, 2010 Initial CON Application Exhibit 7, pages 85 & 91 and June 30, 2010 Completeness Response, page 327)*

9. Upon approval of this proposal by the appropriate regulatory authorities, NMH, DH and its affiliates will become wholly owned/controlled subsidiaries of NEWCO. *(June 9, 2010 Initial CON Application, page 2 and June 30, 2010 Completeness Response, page 327)*

10. NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses. *(June 9, 2010 Initial CON Application, page 2 and Exhibit 6 page 101)*

11. The organizational chart of DHS and its affiliates prior to the proposed affiliation with NMH is as follows:

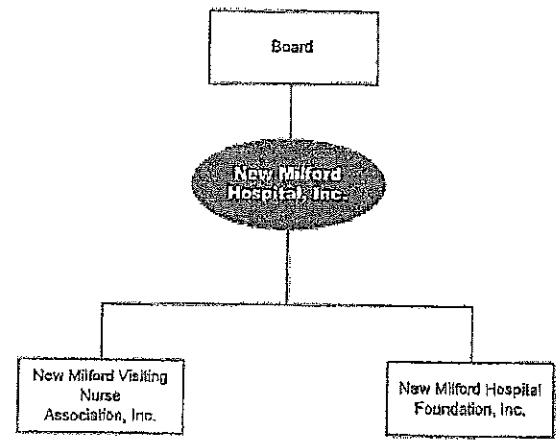
Chart One: DHS Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

12. The organizational chart of NMH and its affiliates prior to the proposed affiliation with DHS is as follows:

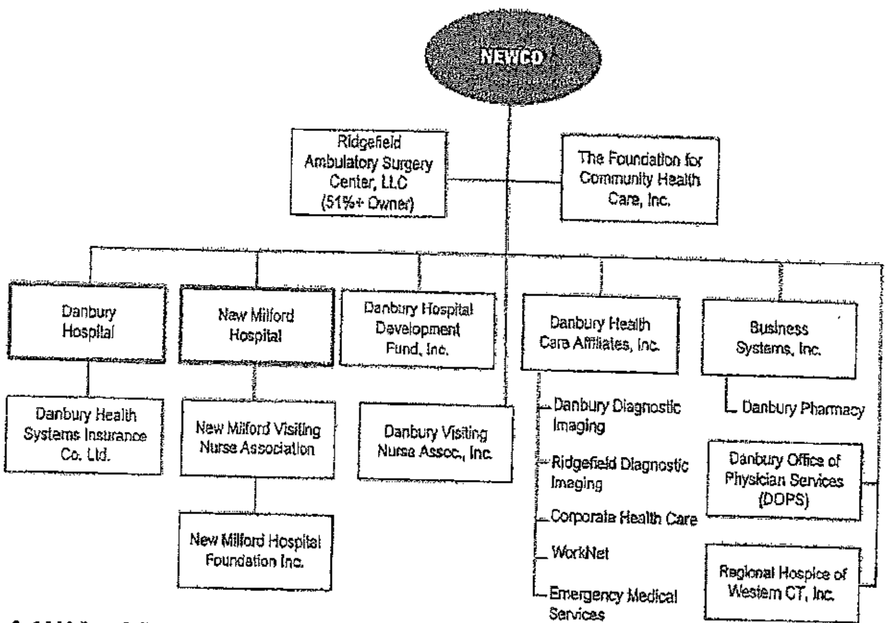
Chart Two: NMH Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

13. The proposed organizational chart of NEWCO and its affiliates after the proposed affiliation is as follows:

Chart Three: NEWCO Organizational Chart After the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

14. DHS has pursued a strategic plan to establish DH as a regional medical center, providing selected tertiary services to an ever greater number of people from a growing, broader geographic region. To that end, DHS has developed an operationally integrated health care delivery system comprised of health care entities that coordinate service along the health care continuum, enabling patients to receive care in the most appropriate systems. *(June 9, 2010, Initial CON Application, page 4)*

15. DH conducted an assessment of its service area during the strategic planning process, which established a direction for considering a relationship with other providers to engage in a more regional planning effort and to provide a more complete continuum of services. *(June 9, 2010, Initial CON Application, page 4)*

16. Following the closure of NMH's emergency angioplasty service, DH assisted in the transition and it became clear that both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. *(June 9, 2010, Initial CON Application, page 4)*

17. DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. *(June 9, 2010, Initial CON Application, page 5)*

18. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. *(June 9, 2010, Initial CON Application, pages 5, 93)*

19. DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. *(June 9, 2010 Initial CON Application, page 93)*

20. NMH expects that upon approval of this proposal, it will be well positioned to meet the challenges and demands of the health care industry, while remaining strong enough to sustain its commitment to offering access to high quality service to the communities it serves. *(June 9, 2010, Initial CON Application, page 5)*

21. NMH considered the following factors in its decision to pursue an affiliation with DHS:

    - Access to significant capital to maintain state-of-the-art treatment facilities as its physical plant and infrastructure ages and as it pursues replacement and expansion of its IT and telecommunications systems;
    - Access to the latest in diagnostic and therapeutic technologies, such as robotic surgery and the latest in genomic therapies:
    - Access to primary care and specialty services;
    - Physician recruitment/cross-coverage arrangements;
    - Quality improvement efforts;
    - Maximizing efficiencies and controlling costs; and
    - Investing in workforce development, retaining talent and attracting others to the institution to minimize vacancies.

    (June 9, 2010 Initial CON Application, pages 5-10)

22. The primary service area ("PSA") of DH is as follows:

Table 5: DH's Primary Service Area

PSA	Bethel
	Brookfield
	Danbury
	New Fairfield
	Newtown
	Redding
	Ridgefield

(June 9, 2010, Initial CON Application, page 15)

23. Based on inpatient discharges, OHCA finds that the towns of Danbury, Newtown, Bethel, Ridgefield, Brookfield, New Fairfield and Redding comprise 74% of DH's discharged patients.

Table 6: DH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
Danbury	39%	39%	93%
Newtown	8%	47%	72%
Bethel	8%	55%	90%
Ridgefield	7%	62%	77%
Brookfield	5%	67%	83%
New Fairfield	4%	72%	89%
Redding	2%	74%	59%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

24. NMH's primary service area ("PSA") is as follows:

Table 1: NMH's Primary Service Area

PSA	New Milford
	Kent
	Washington
	Brookfield
	Sherman
	Bridgewater
	Roxbury
	Warren

(June 9, 2010, Initial CON Application, page 17)

25. Based on inpatient discharges, OHCA finds that the towns of New Milford, Kent, Washington, Brookfield, Sherman, Bridgewater, Roxbury, Cornwall and Warren comprise 73% of NMH's discharged patients.

Table 2: NMH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
New Milford	49%	49%	52%
Kent	7%	56%	53%
Washington	5%	61%	52%
Brookfield	3%	64%	6%
Sherman	3%	67%	35%
Bridgewater	2%	69%	35%
Roxbury	2%	71%	35%
Cornwall+Warren	2%	73%	22%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

26. No changes in licensing of either hospital or affiliated home care agencies will result from this proposal. The Applicants intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions. *(June 9, 2010, Initial CON Application, page 2)*

27. Upon approval of the proposal, DH will serve as the primary provider of tertiary level inpatient and outpatient care to the Western CT region providing the following services:

Inpatient Services	Ancillary Services	Physician Services
Intensive & cardiovascular care Units	Level II Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
Adult & pediatric medical/surgical Units	Surgical services	
Obstetrical unit with NICU	Medical imaging	
High acuity rehabilitation Unit	Praxair Regional Heart and Vascular Center	
Behavioral health/psychiatry	Praxair Cancer Center	
	Center for Advanced Orthopedic & Spine Care	
	Women's and children's service	
	System-wide reference lab	

(June 9, 2010, Initial CON Application, page 3)

28. The following table illustrates the historical utilization by service category for DH:

Table 9: DH's Historical Utilization by Service Category

DH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	67,929	67,553	69,582	71,098
Ambulatory Surgery	13,092	12,277	11,668	11,204
Observation Patients	1,257	2,632	2,868	2,983
Extended Stay	-	-	-	504
Admissions				
Medical/ Surgical	14,420	14,486	14,894	14,916
Maternity	2,502	2,379	2,248	2,208
Newborn	2,272	2,127	1,956	1,944
Psychiatric	812	794	769	711
Pediatric	419	342	329	333
Rehabilitation	377	337	303	315
Total Admissions	**20,802**	**20,465**	**20,499**	**20,427**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12) (*June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)*

29. Inpatient discharges decreased from FY2008 through FY2010, from a significant shift in patients to an observation status and in FY2010, to extended stays.[1]

[1] Centers of Medicare and Medicaid Services and third party payers in seeking to eliminate unnecessary inpatient care allow "observation programs" for patients with selected medical conditions.

30. The following table represents the projected utilization by service category for DH:

Table 10: DH's Projected Utilization by Service Category

DH	FY 2011	FY 2012	FY 2013
ED visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411
Observation Patients	3,072	3,164	3,228
Extended Stay	554	610	653
Admissions			
Medical/ Surgical	15,217	15,437	15,656
Maternity	2,289	2,312	2,335
Newborn	1,947	1,967	1,986
Psychiatric	752	760	768
Pediatric	351	355	360
Rehabilitation	321	324	328
Total Admissions	**20,877**	**21,156**	**21,433**

Note: The Applicants made the following assumptions with respect to DH volumes as illustrated above:

i. Newborn, maternity, psychiatric and rehabilitation discharges will increase annually by 1%.

ii. Overall inpatient growth is attributed to growth in programs and services as well as a changing population.

(June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)

31. The Applicants expect inpatient medical/surgical and pediatrics discharges to grow 1.4% annually from a reduction in outmigration of medical/surgical cases through the affiliation. Approximately 80% of the increase is related to tertiary services as a result of lower outmigration or through improved access to primary care physicians and specialists in the NMH service area. *(June 30, 2010, Completeness Responses, page 333- 334)*

32. The Applicants anticipate that the majority of the transfers from NMH as well as other patients served by the added primary care physicians and specialists seeing patients in New Milford area will comprise the largest component of the projected inpatient volume increase. These assumptions are based on discussions with the NMH medical staff and early evidence of success in the field of cardiology. *(June 30, 2010, Completeness Responses, page 333)*

33. Following the closure of the NMH cardiac catheterization lab, DH has received 110 referrals from NMH physicians in FY 2010 YTD versus 51 referrals for the same time period in FY2009 – a 116% increase. *(June 30, 2010, Completeness questions, page 340)*

34. NMH will continue to provide the following inpatient and outpatient services to its service area:

Inpatient Services	Ancillary Services	Physician Services
Adult & pediatric medical/surgical unit	24-hour Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
ICU/stepdown/acuity adaptable unit	Surgical services	
Family birthing center	Medical imaging	
Low acuity rehabilitation (pending space)	Cardiovascular screening/diagnostics and clinics	
	Regional Cancer Center	
	OP Neurodiagnostics and other specialty clinics	
	Expanded women's health and wellness programs	
	Phase 1 Research Center office	

(June 9, 2010, Initial CON Application, page 3)

35. The following table illustrates the historical utilization by service category for NMH:

Table 3: NMH's Historical Utilization by Service Category

NMH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	19,309	19,553	19,146	19,173
Ambulatory Surgery	2,414	2,335	2,461	2,787
Observation Patients	333	384	567	520
Admissions				
Newborn	294	342	296	264
Maternity	306	341	300	266
Psychiatric	-	-	-	-
Pediatric	68	58	47	15
Medical/Surgical	2,178	2,292	2,131	1,983
Rehabilitation	-	-	-	-
Total Admissions	2,845	3,033	2,774	2,528

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12). *(June 9, 2010, Initial Con Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)*

36. Inpatient discharges decreased from FY2008 through FY2010, from a recent loss of market share and a significant shift in patients to an observation status.

37. The following table illustrates the projected utilization by service category for NMH:

Table 4: NMH's Projected Utilization by Service Category

NMH	FY 2011	FY 2012	FY 2013
ED visits	19,273	19,418	19,571
Ambulatory Surgery	2,704	2,732	2,761
Observation Patients	522	524	527
Admissions			
Newborn	250	248	246
Maternity	250	248	246
Psychiatric	-	-	-
Pediatric	24	24	24
Medical/Surgical	2,037	2,052	2,070
Rehabilitation	-	-	-
Total Admissions	**2,561**	**2,572**	**2,586**

Note: The Applicants made the following assumptions with respect to NMH volumes as illustrated above:

i. Inpatient medical discharges are expected to grow 0.9% to 1.0% annually and surgical at 0.4% to 0.5% from FY 2011.

ii. Inpatient Ob/Gyn discharges will grow annually at 0.8% while pediatrics volume will remain unchanged over the next three years.

ii. Newborn, maternity, psychiatric and rehabilitation discharges will remain unchanged over the next three years.

iv. Outpatient services will increase annually by 0.4% to 1.1%.

(June 9, 2010, Initial CON Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)

38. The incremental volumes attributable to the project are based upon a 1% growth in market share through reductions in out-migration from the affiliation. *(June 9, 2010, Initial CON Application, page 20)*

39. Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. *(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)*

40. Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Together, the two hospitals provided inpatient care to 81% of the discharges from the PSA; no other individual hospital accounts for more than 4% of acute care inpatient services to the area. The two PSAs are adjacent to each other with the town of Brookfield as the only overlapping town between the two.

Table 8: Significant Providers of Inpatient Services in New Milford Primary Service Area, FY 2009

	New Milford	Danbury	Sharon	Yale	Hartford	All Other*	Total
Percentage of NMH PSA	37%	44%	4%	4%	2%	9%	100%
% of Hospital Total	73%	12%	7%	0.4%	0.3%	0.2%	1%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

41. Excluding psychiatric referrals, in 2008, 196 patients were transferred from NMH PSA to other tertiary level providers.

Table 7: Number of Transfers from New Milford Hospital's Primary Service Area to Other Tertiary Providers, 2008	
Connecticut Children's Medical Center	2
John Dempsey Hospital	2
Bridgeport Hospital	4
Waterbury Hospital	6
St. Francis Medical Center	9
Hospital of St. Raphael	10
Other Connecticut Hospitals	15
Other NY Hospitals	35
Hartford Hospital	36
NY Presbyterian	36
Yale-New Haven Hospital	41
Total	196

(June 30, 2010, Completeness Reponses, page 333)

42. Further, based on hospital inpatient discharge data, OHCA finds that compared to NMH, DH provides a higher percentage of specialty care including cardiac, neurological, women's health, general/other surgery, behavioral health and trauma care to NMH PSA residents.

Table 11: Providers of Inpatient Services to NMH Primary Service Area Residents, FY 2009

Service line	New Milford	Danbury	Sharon	Yale	Hartford	Other*	Total
Cardiac Care	38%	**42%**	3%	4%	5%	8%	100%
Cancer Care	32%	37%	3%	15%	3%	11%	100%
Neurological	32%	**47%**	5%	4%	3%	8%	100%
Renal or Urology	38%	38%	3%	5%	6%	10%	100%
Women's Health	40%	**50%**	2%	2%	1%	6%	100%
Orthopedics	42%	41%	3%	3%	1%	10%	100%
Respiratory	61%	30%	4%	1%	0%	3%	100%
Medicine	44%	42%	3%	4%	1%	6%	100%
General/other surgery	35%	**45%**	2%	8%	2%	7%	100%
Newborn	40%	52%	2%	1%	0%	5%	100%
Psychiatry	1%	**59%**	9%	2%	3%	26%	100%
Ophthalmology	40%	33%	0%	13%	0%	13%	100%
Trauma	19%	47%	3%	6%	10%	16%	100%
Dental	0%	25%	0%	50%	0%	25%	100%
Substance Abuse	15%	**35%**	25%	1%	0%	22%	100%
PSA Total	**39%**	**44%**	**3%**	**4%**	**2%**	**8%**	**100%**

(Office of Health Care Access' Connecticut Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

43. Based upon the foregoing data, OHCA finds that NMH has experienced significant out-migration in recent years and DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Additionally, DH provided a higher level of specialty care to NMH PSA residents.

44. In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. Therefore, increased availability of primary physicians will be beneficial to residents of the area.

Table 12: Percent of Primary Care Sensitive Preventable Hospitalizations[2] at NMH and DH, 2006-2008

Hospital	2006	2007	2008
New Milford	14%	12%	12%
Danbury	10%	10%	11%
CT	12%	12%	11%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

45. NMH indicates, consistent with the above data in Findings 34 through 40, that one of the challenges it faces is a physician shortage in primary care and specialties. *(June 9, 2010, Initial CON Application, page 6)*

46. NMH has identified key specialties in which a need exists, such as endocrinology, neurology and selected surgical subspecialties. *(June 9, 2010, Initial CON Application, page 8)*

47. NMH has been unable to attract admissions and subspecialty care because of a documented shortage of both primary care physicians and sub-specialists. NEWCO will provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. *(June 30, 2010, Completeness questions, page 340)*

48. DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. *(June 9, 2010, Initial CON Application, page 8)*

49. DHS also houses Danbury Office of Physician Services ("DOPS"), a multispecialty faculty practice plan whose mission is to support DH in its objective of meeting the needs of all patients, including the underserved. DOPS has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. *(June 9, 2010, Initial CON Application, page 8)*

50. Another challenge for NMH is the growing need to address and upgrade the physical, clinical and technological infrastructure to meet community need. *(June 9, 2010, Initial CON Application, page 6)*

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[2] OHCA utilized the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) software to identify preventable hospitalizations. AHRQ defines preventable hospitalizations as instances of inpatient hospital care for health conditions or illnesses typically treated or managed in outpatient settings. See http://www.ct.gov/ohca/lib/ohca/publications/2010/prev_hosp_report01-2010.pdf for more details.

51. An example of the larger capital expenses are: (a) information technology to support legacy systems as well as clinical applications; (b) implementation of an electronic medical record and other advanced clinical technologies designed to improve care, quality and efficiency; (c) enhanced PACS and voice dictation systems; (d) renovation and upgrades to patient care units; (e) facility improvements such as upgrading mechanicals and introducing green technologies; and (f) general plant maintenance associated with an aging facility. *(June 9, 2010, Initial CON Application page 7)*

52. Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. *(June 9, 2010, Initial CON Application, page 30)*

53. DHS currently operates an electronic health information exchange called HealthLink, which enables the hospital to link to other providers through a web-based architecture. NMH will obtain access to the IT expertise and systems currently in place at DH, accelerating its adoption of an EMR and creating seamless information access and connectivity among all entities for optimal clinical quality and operational efficiency. *(June 9, 2010, Initial CON Application, page 30)*

54. DH is engaged in various research initiatives, from basic science to translational research. DH Research Department provides infrastructure and coordinates all of the research and scholarly activities for the entire institution. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

55. In order to integrate the existing and future research and scholarly activities of NMH into the Department research activities and provide a seamless collaboration and coordination of the research efforts, DH will extend its research capabilities by developing a satellite research center at NMH. In addition, the programs at DH will be made available to NMH physicians and patients creating opportunities for greater involvement and collaboration. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

56. OHCA finds that both NMH's ability to recruit and retain high quality physicians will be enhanced through this affiliation due to greater access to technology and clinical research opportunities.

57. There is no capital cost associated with this proposal. *(June 9, 2010, Initial CON Application, page 24).*

58. There will be no change in billing as a result of this proposal. *(June 9, 2010, Initial CON Application, page 26).*

59. There will be no changes to existing reimbursement contracts between the Applicants and the payers. *(June 9, 2010, Initial CON Application, page 26).*

60. This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of

approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. *(June 9, 2010, Initial CON Application, page 27).*

61. The proposed 2% (or $2,558,000) potential savings to NMH will be in two cost categories over the first three years of the affiliation. One category of potential cost savings is "salaries and benefits" through a reduction of eight (8) FTEs per year over three years in the back office area from retirements and elimination of management positions and normal attrition. The second area is "supplies and drugs."

Table 13: Potential Cost Savings for NMH

	FY 2011	FY 2012	FY 2013	3-YR TOTAL COST SAVINGS
Salaries & Benefits	$797,000	$855,000	$876,000	$2,528,000
Supplies & Drugs	$1,016,000	$1,057,000	$1,099,000	$3,172,000
Total	$1,813,000	$1,912,000	$1,975,000	$5,700,000

(June 30, 2010, Completeness Responses, pages 334-335)

62. The Applicants plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. *(June 9, 2010, Initial CON Application, page 27).*

63. The Applicants will also consider centralizing certain clinical functions, such as clinical laboratory and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. *(June 9, 2010, Initial CON Application, page 26).*

64. There are no plans to implement savings associated with the reduction, elimination, or combination of any clinical services in the short term. *(June 30, 2010, Completeness Responses, page 334).*

65. The cost efficiencies to be realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH. *(June 9, 2010, Initial CON Application, page 7).*

66. The potential bond rating of NEWCO would support an "A" rating and the strategic value of affiliating with another hospital would at least equal any dilutive financial impact in the short term. *(June 30, 2010, Completeness Responses, page 336)*

67. NMH's credit worthiness will be enhanced by the affiliation in that NMH will benefit from the guarantee of NEWCO, an organization whose numbers would support an "A" rating, which is better than NMH would be able to achieve on its own. *(June 30, 2010, Completeness Responses, page 336)*

68. The Applicants intend to improve productivity and contain costs by developing economies of scale in operations, establishing evidence-based quality decisions on services and care protocols, and developing an integrated plan that allows both organizations to address the needs in the greater region without the unnecessary duplication in services that has characterized the past. *(June 9, 2010, Initial CON Application, page 30).*

69. The projected incremental revenue from operations, total operating expense and gains from operations associated with the proposal are presented in the table below for the first three years with the proposed project:

Table 14: Combined Danbury and New Milford Hospital Financial Projections

Description	FY 2011	FY 2012	FY 2013
Incremental Revenue from Operations	$2,039,000	$2,820,000	$3,689,000
Incremental Total Operating Expense	($407,000)	($161,000)	$151,000
Incremental Gain from Operations	$2,447,000	$2,981,000	$3,538,000

(June 9, 2010, Initial CON Application, Financial Attachment I, page 320)

70. This proposal will also improve revenue through increased inpatient and outpatient volumes at NMH. *(June 30, 2010, Completeness Responses, page 336)*

71. DH's patient population mix is based on the FY 2010 budget, with no change in mix anticipated or projected. DH's current patient population mix and projected population mix with the CON proposal is as follows:

Table 15: Current and Three-Year Projected Population Mix with the CON Proposal

Danbury Hospital	Current FY Payer Mix	2011 Projected Payer Mix	2012 Projected Payer Mix	2013 Projected Payer Mix
Medicare	32.2%	32.2%	32.2%	32.2%
Medicaid	14.5%	14.5%	14.5%	14.5%
TRICARE and CHAMPUS	0.0%	0.0%	0.0%	0.0%
Total Government	46.7%	46.7%	46.7%	46.7%
Commercial Insurers	46.3%	46.3%	46.3%	46.3%
Uninsured	6.5%	6.5%	6.5%	6.5%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	53.3%	53.3%	53.3%	53.3%
Total Population Mix	100%	100%	100%	100%

(June 9, 2010, Initial CON Application, page 25)

72. NMH's patient mix is based on the FY 2010 budget, with no change in mix anticipated or projected. NMH's current population mix and projected population mix with the CON proposal is as follows:

Table 16: Current and Three-Year Projected Population Mix with the CON Proposal

New Milford Hospital	Current FY Payer Mix	2011 Projected Payer Mix	2012 Projected Payer Mix	2013 Projected Payer Mix
Medicare	45.8%	45.8%	45.8%	45.8%
Medicaid (includes other medical assistance)	10.0%	10.0%	10.0%	10.0%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	55.9%	55.9%	55.9%	55.9%
Commercial Insurers*	40.6%	40.6%	40.6%	40.6%
Uninsured	2.8%	2.8%	2.8%	2.8%
Workers Compensation	0.7%	0.7%	0.7%	0.7%
Total Non-Government	44.1%	44.1%	44.1%	44.1%
Total Population Mix	100%	100%	100%	100%

(June 9, 2010, Initial CON Application, page 25)

73. The Applicants provided resumes of its executive leadership team associated with this proposal demonstrating that they have sufficient managerial and financial experience in managing health care organizations to provide efficient and adequate service to the public. *(June 9, 2010, Initial CON Application, page 118)*

Rationale

OHCA approaches community and regional need for CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of DH in Danbury. NMH is a Connecticut non-stock 501 (c)(3) organization, located at 21 Elm Street, New Milford. DHS and NMH propose an affiliation, with no associated total capital expenditure. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. (Finding of Fact 18) DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. (Finding of Fact 19) The proposed affiliation is also intended to help strengthen access to capital, generate cost savings and leverage recruitment and retention of high quality physicians.

While DH views the affiliation as an opportunity to engage in a more regional planning effort and to provide a more complete continuum of services both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. (Findings of Fact 15-16) Additionally, DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. (Finding of Fact 17)

NMH also considered its need for access to significant capital to maintain state-of-the-art treatment facilities; access to the latest in diagnostic and therapeutic technologies; access to primary care and specialty services; physician recruitment/cross-coverage arrangements; quality improvement efforts; and maximizing efficiencies and controlling costs. (Finding of Fact 21) Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. (Finding of Fact 52) Additionally, NMH will now have access to DH's research capabilities as DH will establish a satellite research center at NMH and physicians and patients from NMH will be able to attend programs offered at DH. (Findings of Fact 54-55)

The affiliation will also provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. (Finding of Fact 47) DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. (Finding of Fact 48) DHS also houses DOPS, which has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. (Finding of Fact 49) Not only will NMH benefit from an increase in primary care physicians and specialists in the NMH service area, but DH also expects a modest increase in

inpatient utilization based upon the increases in referrals to DH's cardiac catheterization lab in 2010 following the closure of NMH's cardiac catheterization lab.

Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. (Finding of Fact 39) Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. (Finding of Fact 40) In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. (Finding of Fact 44) Specifically, 14% of NMH's hospitalizations were considered preventable compared to 12% for the state. (Finding of Fact 44) Thus, OHCA finds the ED utilization rate for NMH is higher than the statewide average. OHCA is concerned about the use of the ED for health care services that can be delivered in the community setting at a lower cost to the patient and the hospital. Accordingly, OHCA finds that proposed affiliation will improve the quality, accessibility and cost effectiveness of health care delivery in the region by increasing access to primary care and specialty physicians in the NMH service area.

This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. (Finding of Fact 60) The Applicants also plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. (Finding of Fact 62) The Applicants will also consider centralizing certain clinical functions, such as the clinical laboratories and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. (Finding of Fact 63) Additionally, the integrated IT system and EMR will provide significant cost savings for NMH. (Finding of Fact 52) The Applicants project operational gains of $2,447,000, $2,981,000 and $3,538,000 in the first three years of the proposal. (Finding of Fact 69) OHCA finds the financial projections and volumes upon which they are based appear to be reasonable and achievable. Accordingly, OHCA concludes that the proposal is financially feasible.

Based upon all of the foregoing, OHCA finds that the proposed affiliation will allow better access to capital and technology and will provide cost efficiencies for both Applicants to create a stronger health care system. Shared best practices, an integrated IT system and the ability to recruit and retain top-level physicians will enhance the Applicants' ability to respond to new federal health care reform initiatives that require health care providers to re-align all aspects of the delivery system and better coordinate those services around the patients' needs. In the absence of an affiliation with a larger tertiary hospital, NMH would probably find it difficult to meet future requirements and financial challenges. Accordingly, OHCA concludes that this proposal will create a larger and financially stronger health care delivery system that will better address these demands and continue to provide access to quality health care in the Applicants' service area.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Danbury Health System, Inc. and New Milford Hospital, Inc. for an affiliation, with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA, a full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of DHS and NMH has occurred.

2. If, in the future, there is any change in the ownership structure of DHS, NMH or its affiliates or any change in the affiliation agreement, the Applicants shall file a CON Determination Form with OHCA.

3. If, in the future, there is any change in NMH or NEWCO service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.

4. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA a comprehensive plan that includes the following:

    (i) The locations of current primary care providers in the NEWCO service area;

    (ii) A discussion of how the Applicants will recruit primary care physicians and specialists in the NEWCO service area;

    (iii) A discussion of how the Applicants will specifically address the need for additional primary care in the NEWCO service area, including, but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and

    (iv) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.

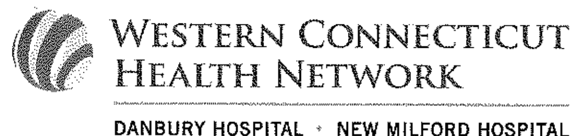
5. The Applicants shall schedule a meeting with OHCA to occur within 30 calendar days of the filing of the comprehensive plan to discuss the Applicants' provision of findings pursuant to Condition #4.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the

September 23, 2010
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner
Office of Health Care Access



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WesternConnecticutHeatlhNetwork.org
DanburyHospital.org
NewMilfordHospital.org

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HEALTH CARE ACCESS

May 21, 2013

Via Fax and First-Class Mail

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Docket No. 13-31560-CON
Western Connecticut Health Network, Inc.
Request for Modification of Final Decision in Docket No. 10-31560

Dear Ms. Martone,

Enclosed please find answers from Western Connecticut Health Network, Inc. to the Completeness Questions from OHCA dated May 17, 2013.

The request before the Office of Health Care Access ("OHCA") seeks a modification of the decision granted in September of 2010 in which both hospitals (The Danbury Hospital and New Milford Hospital, Inc.) retained individual licenses. We are requesting OHCA's approval in order to approach DPH for a single hospital license for both hospitals within our system.

If you have any questions, please do not hesitate to contact me.

Respectfully submitted,

Sally F. Herlihy

Sally F. Herlihy
Vice President, Planning

cc: Kaila Riggott, Planning Specialist
Steven Lazarus, Staff Analyst

Western Connecticut Health Network, Inc.

Docket No. 13-31560

Completeness Answers

The following answers are in response to the Completeness Questions dated May 17, 2013 regarding the Applicant's request for a single license for Danbury Hospital and New Milford Hospital:

1. Will there be an impact or change in the governance or controlling body of New Milford Hospital, Inc. or The Danbury Hospital?

No. There will be no impact or change in the governance or controlling body of New Milford Hospital, Inc. ("NMH") or The Danbury Hospital ("DH") as a result of this request for a modification to allow both hospitals to operate under a single license. Both hospitals are controlled and operated by Western Connecticut Health Network, Inc. ("WCHN") as a result of the affiliation which occurred through OHCA Docket No. 10-31560. Operationally, the Executive Directors of NMH and DH each report directly to the President & CEO of WCHN.

The proposed and current organizational charts after the affiliation of DH and NMH are attached as Exhibit A. There are no changes to the organizational structure proposed with operating under a single license.

2. Will there be a sale or transfer of net assets of New Milford Hospital, Inc. or The Danbury Hospital?

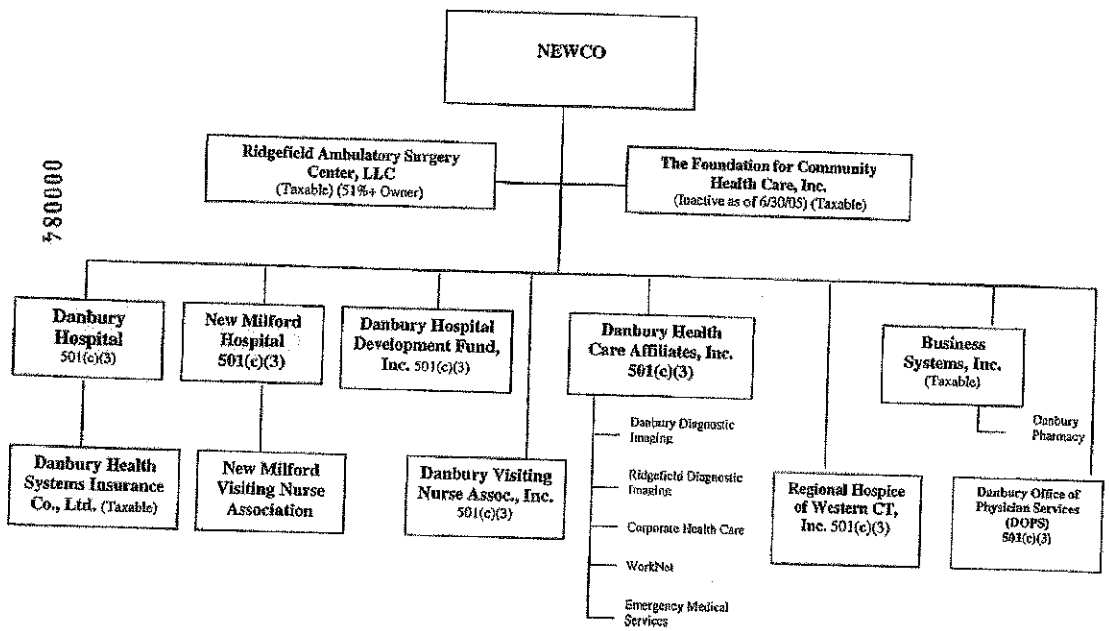
No. The requested modification is to allow the two above-named hospitals to operate under a single license, and the assets will continue to be controlled by WCHN.

3. Please provide a copy of the plan of merger and copies of all agreements that describe the merger and operation and control of The Danbury Hospital and New Milford Hospital, Inc. and their assets.

Please see the full application on file in OHCA Docket No. 10-31560, which contains all of the plans of the operation and control of DH and NMH, and their assets. For reference, the Notice of Final Decision of September 23, 2010 is attached as Exhibit B. DH and NMH have been operating more and more as a unified entity, and additional efficiencies can be realized if there is a single license, including a single audit, IT conversion and single charge master. Consolidated accreditation surveys will reduce further the duplication of work and positively benefit the cost of delivery of health care in the community. Activities supporting achievement of a single license have been explored (i.e. single medical staff structure, Medicare Conditions of Participation), and will be pursued with the licensing division of DPH and the federal government upon approval from OHCA.

Exhibit A

Proposed Organization after Affiliation – 2010



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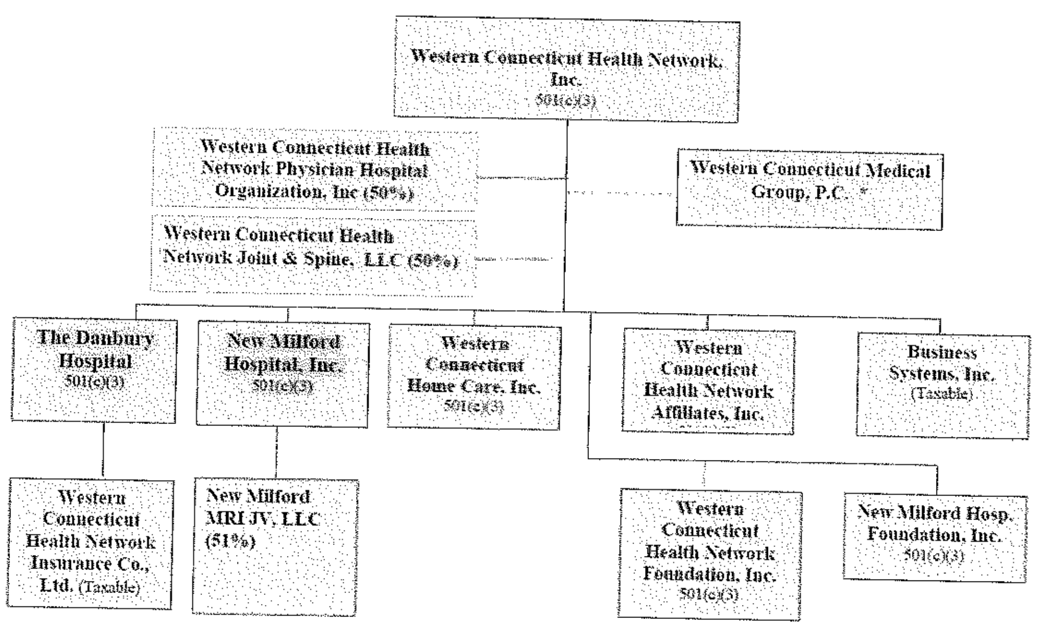
Current Western Connecticut Health Network, Inc – 2013



*Controlled entity via management agreement

WCHN Org Chart 6-2012

Exhibit B

Notice of Final Decision – Docket No. 10-31560-CON

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	**Danbury Health System, Inc. and New Milford Hospital, Inc.**
Docket Number:	**10-31560-CON**
Project Title:	**Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.**

Project Description: Danbury Health System, Inc. ("DHS") and New Milford Hospital, Inc. ("NMH") propose an affiliation, with no associated total capital expenditure.

Nature of Proceedings: On June 30, 2010, the Office of Health Care Access ("OHCA") received the completed Certificate of Need ("CON") for the above-referenced project. DHS and NMH (collectively known as the "Applicants") are considered health care facilities pursuant to Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent ("LOI") was published on March 8, 2010 in *The News Times* pursuant to Section 19a-638 of the Connecticut General Statutes ("C.G.S). OHCA received no responses from the public concerning the Applicants' LOI.

Pursuant to Section 19a-638, C.G.S. three individuals or an individual representing an entity with five or more people had until July 21, 2010, the twenty-first calendar day following the filing of the CON application, to request that OHCA hold a public hearing on the Applicants' proposal. OHCA received no hearing requests from the public by July 21, 2010.

OHCA's authority to review and approve, modify or deny this proposal is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

1. DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of The Danbury Hospital ("DH"), in Danbury. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

2. DH is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury, and is licensed by the Connecticut Department of Public Health for 345 general hospital beds and 26 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

3. NMH is a Connecticut non-stock 501(c)(3) organization, located at 21 Elm Street, New Milford, and is licensed by the Connecticut Department of Public Health for 85 general hospital beds and 10 bassinets. *(Applicants' LOI and Initial CON Application, 10-31560-CON)*

4. On February 8, 2010, DHS and NMH executed an LOI for a Corporate Affiliation confirming their understanding with respect to a proposed affiliation between DHS and NMH whereby DHS will be renamed to reflect the creation of a regional health care system. *(June 9, 2010 Applicants' Initial CON Application, 10-31560-CON Exhibit 8 page 93)*

5. With respect to the proposed affiliation, the Applicants state the following:

   i. Summer 2008 – Senior management and representatives from both Applicants' Boards met to discuss if there was sufficient interest to pursue discussion of a possible affiliation.

   ii. August 17, 2009 – Applicants entered into a Confidentiality Agreement.

   iii. Fall 2009 – Applicants each appointed a Board Affiliation team and jointly engaged a facilitator with a preliminary "due diligence" process, to determine the opportunities to realize through a potential strategic partnership, and met on a monthly basis from October 2009 to January 2010.

   iv. Winter to Spring 2010 – Senior management from both hospitals met with medical and hospital staff to discuss the Letter of Intent for Corporate Affiliate as contemplated. Due diligence was completed and the Letter of Intent between the two parties was approved and signed by both Applicants' Boards on February 15, 2010. Detailed "Phase two due diligence" was conducted by both Applicants.

   v. Spring 2010 – Multiple meetings with constituencies held.

   vi. Spring to Summer 2010 – Definitive Affiliation Agreement was negotiated and approved by each Board and will be signed by Applicants at the completion of the due diligence process to be finalized in summer of 2010. Ongoing dialogue was held with DH and NMH medical staff, employees, volunteers, Board of Directors and community

education regarding the potential affiliation and opportunities to develop a regional health care delivery system and benefits.
(June 9, 2010 Initial CON Application Exhibit 8, pages 12-13)

6. Under the proposed affiliation, DHS will become the sole corporate member of NMH and will change its name from "Danbury Health Systems, Inc." to a name mutually agreeable to both applicants prior to the effective date of the affiliation. The proposed new entity was temporarily named NEWCO for this application. *(June 9, 2010 Initial CON Application Exhibit 8, page 93)*

7. The draft affiliation agreement requires NMH to replace its current four-member board of directors with a "New Milford Community Board" who shall also serve as members of the board of directors of NEWCO with voting rights. *(June 9, 2010 Initial CON Application Exhibit, page 94)*

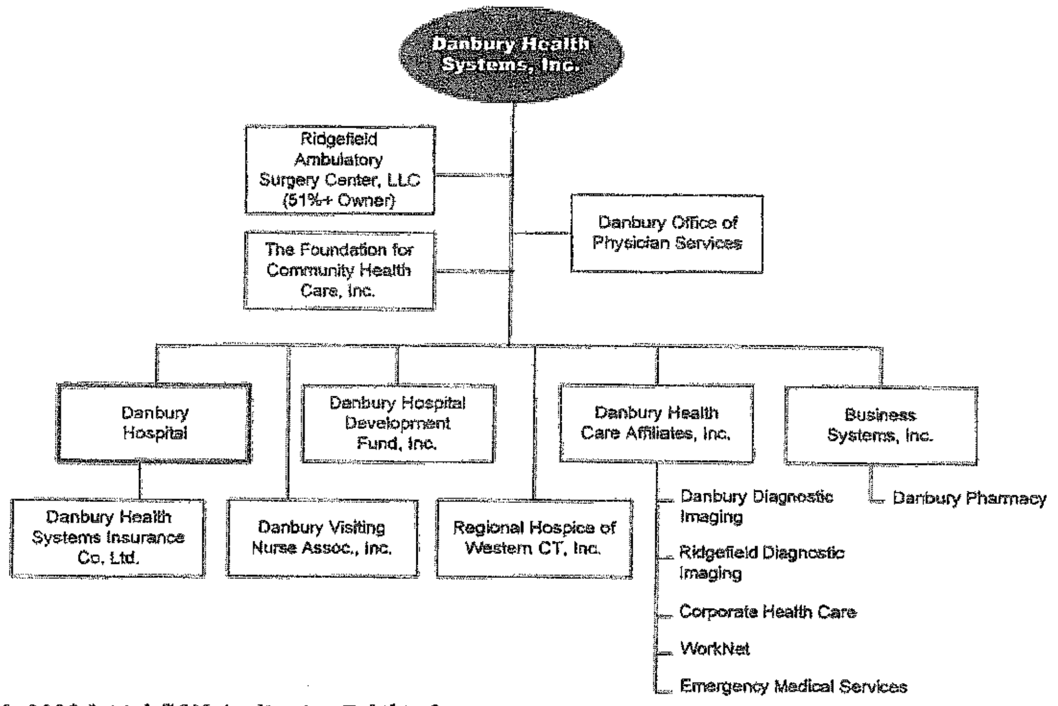
8. The Applicants provided a list of the fifteen (15) members of the board of directors of NEWCO including the four members from NMH's New Milford Community Board and the remaining eleven who are members of the Board of DH. *(June 9, 2010 Initial CON Application Exhibit 7, pages 85 & 91 and June 30, 2010 Completeness Response, page 327)*

9. Upon approval of this proposal by the appropriate regulatory authorities, NMH, DH and its affiliates will become wholly owned/controlled subsidiaries of NEWCO. *(June 9, 2010 Initial CON Application, page 2 and June 30, 2010 Completeness Response, page 327)*

10. NMH and DH will remain separate and legal entities, with independent medical staffs and hospital licenses. *(June 9, 2010 Initial CON Application, page 2 and Exhibit 6 page 101)*

11. The organizational chart of DHS and its affiliates prior to the proposed affiliation with NMH is as follows:

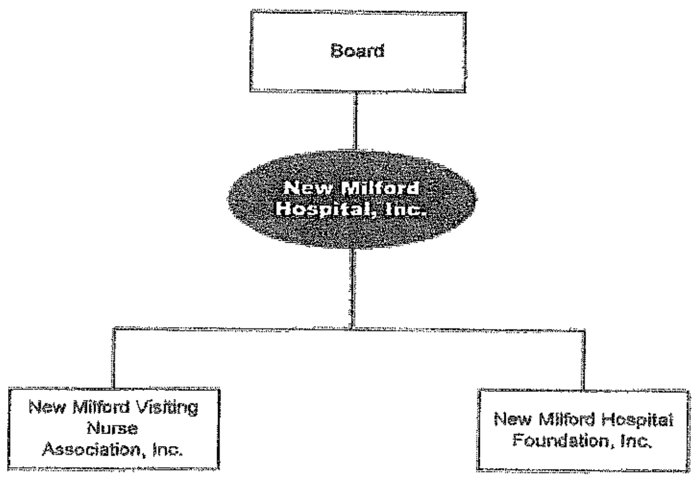
Chart One: DHS Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

12. The organizational chart of NMH and its affiliates prior to the proposed affiliation with DHS is as follows:

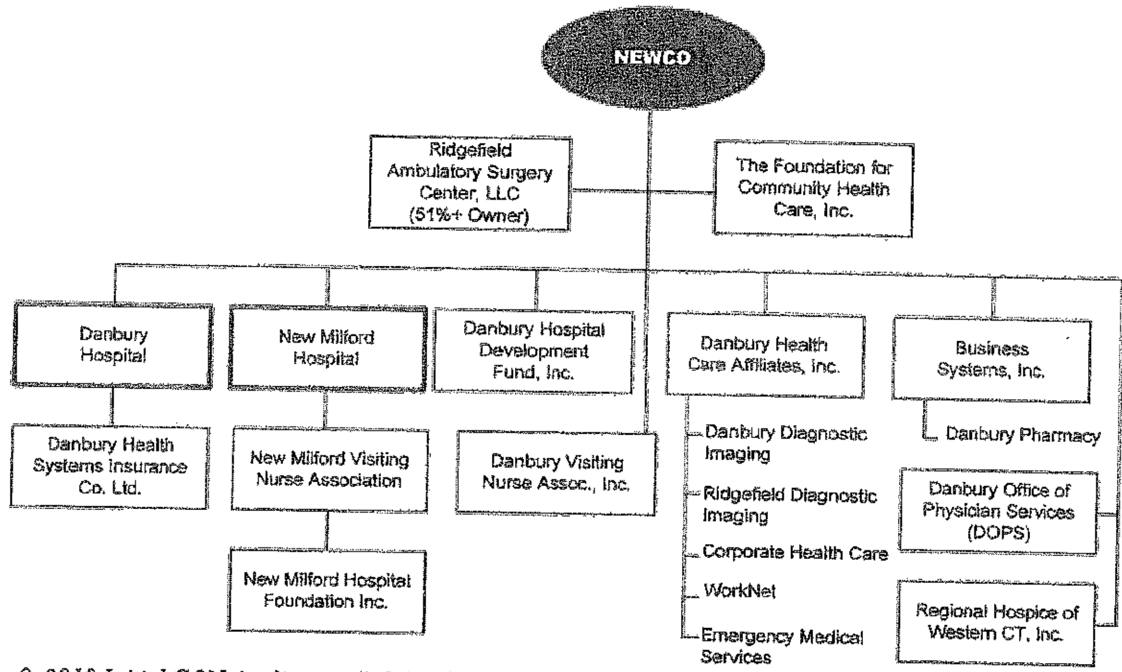
Chart Two: NMH Organizational Chart Prior to the Proposed Affiliation



(June 9, 2010 Initial CON Application Exhibit 6)

13. The proposed organizational chart of NEWCO and its affiliates after the proposed affiliation is as follows:

Chart Three: NEWCO Organizational Chart After the Proposed Affiliation



(*June 9, 2010 Initial CON Application Exhibit 6*)

14. DHS has pursued a strategic plan to establish DH as a regional medical center, providing selected tertiary services to an ever greater number of people from a growing, broader geographic region. To that end, DHS has developed an operationally integrated health care delivery system comprised of health care entities that coordinate service along the health care continuum, enabling patients to receive care in the most appropriate systems. (*June 9, 2010, Initial CON Application, page 4)*

15. DH conducted an assessment of its service area during the strategic planning process, which established a direction for considering a relationship with other providers to engage in a more regional planning effort and to provide a more complete continuum of services. (*June 9, 2010, Initial CON Application, page 4)*

16. Following the closure of NMH's emergency angioplasty service, DH assisted in the transition and it became clear that both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. (*June 9, 2010, Initial CON Application, page 4)*

17. DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. (*June 9, 2010, Initial CON Application, page 5)*

18. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. *(June 9, 2010, Initial CON Application, pages 5, 93)*

19. DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. *(June 9, 2010 Initial CON Application, page 93)*

20. NMH expects that upon approval of this proposal, it will be well positioned to meet the challenges and demands of the health care industry, while remaining strong enough to sustain its commitment to offering access to high quality service to the communities it serves. *(June 9, 2010, Initial CON Application, page 5)*

21. NMH considered the following factors in its decision to pursue an affiliation with DHS:

    - Access to significant capital to maintain state-of-the-art treatment facilities as its physical plant and infrastructure ages and as it pursues replacement and expansion of its IT and telecommunications systems;
    - Access to the latest in diagnostic and therapeutic technologies, such as robotic surgery and the latest in genomic therapies:
    - Access to primary care and specialty services;
    - Physician recruitment/cross-coverage arrangements;
    - Quality improvement efforts;
    - Maximizing efficiencies and controlling costs; and
    - Investing in workforce development, retaining talent and attracting others to the institution to minimize vacancies.

    (June 9, 2010 Initial CON Application, pages 5-10)

22. The primary service area ("PSA") of DH is as follows:

Table 5: DH's Primary Service Area

PSA	Bethel
	Brookfield
	Danbury
	New Fairfield
	Newtown
	Redding
	Ridgefield

(June 9, 2010, Initial CON Application, page 15)

23. Based on inpatient discharges, OHCA finds that the towns of Danbury, Newtown, Bethel, Ridgefield, Brookfield, New Fairfield and Redding comprise 74% of DH's discharged patients.

Table 6: DH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
Danbury	39%	39%	93%
Newtown	8%	47%	72%
Bethel	8%	55%	90%
Ridgefield	7%	62%	77%
Brookfield	5%	67%	83%
New Fairfield	4%	72%	89%
Redding	2%	74%	59%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

24. NMH's primary service area ("PSA") is as follows:

Table 1: NMH's Primary Service Area

PSA	New Milford
	Kent
	Washington
	Brookfield
	Sherman
	Bridgewater
	Roxbury
	Warren

(June 9, 2010, Initial CON Application, page 17)

25. Based on inpatient discharges, OHCA finds that the towns of New Milford, Kent, Washington, Brookfield, Sherman, Bridgewater, Roxbury, Cornwall and Warren comprise 73% of NMH's discharged patients.

Table 2: NMH's Discharge Total and Market Share by Town for FY 2009

PSA Towns	Percentage of Hospital Total	Cumulative Hospital Total	Percentage of Town Market Share
New Milford	49%	49%	52%
Kent	7%	56%	53%
Washington	5%	61%	52%
Brookfield	3%	64%	6%
Sherman	3%	67%	35%
Bridgewater	2%	69%	35%
Roxbury	2%	71%	35%
Cornwall+Warren	2%	73%	22%

(Office of Health Care Access' Connecticut Inpatient Discharge Database)

26. No changes in licensing of either hospital or affiliated home care agencies will result from this proposal. The Applicants intend to maintain DH's and NMH's standing as acute care hospitals and to maintain the current services available at both institutions. *(June 9, 2010, Initial CON Application, page 2)*

27. Upon approval of the proposal, DH will serve as the primary provider of tertiary level inpatient and outpatient care to the Western CT region providing the following services:

Inpatient Services	Ancillary Services	Physician Services
Intensive & cardiovascular care Units	Level II Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
Adult & pediatric medical/surgical Units	Surgical services	
Obstetrical unit with NICU	Medical imaging	
High acuity rehabilitation Unit	Praxair Regional Heart and Vascular Center	
Behavioral health/psychiatry	Praxair Cancer Center	
	Center for Advanced Orthopedic & Spine Care	
	Women's and children's service	
	System-wide reference lab	

(June 9, 2010, Initial CON Application, page 3)

28. The following table illustrates the historical utilization by service category for DH:

Table 9: DH's Historical Utilization by Service Category

DH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	67,929	67,553	69,582	71,098
Ambulatory Surgery	13,092	12,277	11,668	11,204
Observation Patients	1,257	2,632	2,868	2,983
Extended Stay	-	-	-	504
Admissions				
Medical/ Surgical	14,420	14,486	14,894	14,916
Maternity	2,502	2,379	2,248	2,208
Newborn	2,272	2,127	1,956	1,944
Psychiatric	812	794	769	711
Pediatric	419	342	329	333
Rehabilitation	377	337	303	315
Total Admissions	**20,802**	**20,465**	**20,499**	**20,427**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12) (*June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)*

29. Inpatient discharges decreased from FY2008 through FY2010, from a significant shift in patients to an observation status and in FY2010, to extended stays.[1]

[1] Centers of Medicare and Medicaid Services and third party payers in seeking to eliminate unnecessary inpatient care allow "observation programs" for patients with selected medical conditions.

30. The following table represents the projected utilization by service category for DH:

Table 10: DH's Projected Utilization by Service Category

DH	FY 2011	FY 2012	FY 2013
ED visits	70,560	71,053	71,551
Ambulatory Surgery	12,047	12,228	12,411
Observation Patients	3,072	3,164	3,228
Extended Stay	554	610	653
Admissions			
Medical/ Surgical	15,217	15,437	15,656
Maternity	2,289	2,312	2,335
Newborn	1,947	1,967	1,986
Psychiatric	752	760	768
Pediatric	351	355	360
Rehabilitation	321	324	328
Total Admissions	**20,877**	**21,156**	**21,433**

Note: The Applicants made the following assumptions with respect to DH volumes as illustrated above:
i. Newborn, maternity, psychiatric and rehabilitation discharges will increase annually by 1%.
ii. Overall inpatient growth is attributed to growth in programs and services as well as a changing population.

(June 9, 2010, Initial Con Application, pages 18-19 and June 30, 2010, Completeness Responses, page 328, 330 & 334)

31. The Applicants expect inpatient medical/surgical and pediatrics discharges to grow 1.4% annually from a reduction in outmigration of medical/surgical cases through the affiliation. Approximately 80% of the increase is related to tertiary services as a result of lower outmigration or through improved access to primary care physicians and specialists in the NMH service area. *(June 30, 2010, Completeness Responses, page 333- 334)*

32. The Applicants anticipate that the majority of the transfers from NMH as well as other patients served by the added primary care physicians and specialists seeing patients in New Milford area will comprise the largest component of the projected inpatient volume increase. These assumptions are based on discussions with the NMH medical staff and early evidence of success in the field of cardiology. *(June 30, 2010, Completeness Responses, page 333)*

33. Following the closure of the NMH cardiac catheterization lab, DH has received 110 referrals from NMH physicians in FY 2010 YTD versus 51 referrals for the same time period in FY2009 – a 116% increase. *(June 30, 2010, Completeness questions, page 340)*

34. NMH will continue to provide the following inpatient and outpatient services to its service area:

Inpatient Services	Ancillary Services	Physician Services
Adult & pediatric medical/surgical unit	24-hour Emergency Department	Distributed locations of primary and specialty physicians (DOPS and independent)
ICU/stepdown/acuity adaptable unit	Surgical services	
Family birthing center	Medical imaging	
Low acuity rehabilitation (pending space)	Cardiovascular screening/diagnostics and clinics	
	Regional Cancer Center	
	OP Neurodiagnostics and other specialty clinics	
	Expanded women's health and wellness programs	
	Phase 1 Research Center office	

(June 9, 2010, Initial CON Application, page 3)

35. The following table illustrates the historical utilization by service category for NMH:

Table 3: NMH's Historical Utilization by Service Category

NMH	FY 2007	FY 2008	FY 2009	FY 2010*
ED visits	19,309	19,553	19,146	19,173
Ambulatory Surgery	2,414	2,335	2,461	2,787
Observation Patients	333	384	567	520
Admissions				
Newborn	294	342	296	264
Maternity	306	341	300	266
Psychiatric	-	-	-	-
Pediatric	68	58	47	15
Medical/Surgical	2,178	2,292	2,131	1,983
Rehabilitation	-	-	-	-
Total Admissions	**2,845**	**3,033**	**2,774**	**2,528**

*Annualized based on data provided for October 1, 2009 through May 31, 2010 (May YTD divided by 8 times 12). *(June 9, 2010, Initial Con Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)*

36. Inpatient discharges decreased from FY2008 through FY2010, from a recent loss of market share and a significant shift in patients to an observation status.

37. The following table illustrates the projected utilization by service category for NMH:

Table 4: NMH's Projected Utilization by Service Category

NMH	FY 2011	FY 2012	FY 2013
ED visits	19,273	19,418	19,571
Ambulatory Surgery	2,704	2,732	2,761
Observation Patients	522	524	527
Admissions			
Newborn	250	248	246
Maternity	250	248	246
Psychiatric	-	-	-
Pediatric	24	24	24
Medical/Surgical	2,037	2,052	2,070
Rehabilitation	-	-	-
Total Admissions	**2,561**	**2,572**	**2,586**

Note: The Applicants made the following assumptions with respect to NMH volumes as illustrated above:

i. Inpatient medical discharges are expected to grow 0.9% to 1.0% annually and surgical at 0.4% to 0.5% from FY 2011.

ii. Inpatient Ob/Gyn discharges will grow annually at 0.8% while pediatrics volume will remain unchanged over the next three years.

ii. Newborn, maternity, psychiatric and rehabilitation discharges will remain unchanged over the next three years.

iv. Outpatient services will increase annually by 0.4% to 1.1%.

(June 9, 2010, Initial CON Application, page 18 & 19 and June 30, 2010 Completeness Response, pages 329 & 330)

38. The incremental volumes attributable to the project are based upon a 1% growth in market share through reductions in out-migration from the affiliation. *(June 9, 2010, Initial CON Application, page 20)*

39. Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. *(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)*

40. Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Together, the two hospitals provided inpatient care to 81% of the discharges from the PSA; no other individual hospital accounts for more than 4% of acute care inpatient services to the area. The two PSAs are adjacent to each other with the town of Brookfield as the only overlapping town between the two.

Table 8: Significant Providers of Inpatient Services in New Milford Primary Service Area, FY 2009

	New Milford	Danbury	Sharon	Yale	Hartford	All Other*	Total
Percentage of NMH PSA	37%	44%	4%	4%	2%	9%	100%
% of Hospital Total	73%	12%	7%	0.4%	0.3%	0.2%	1%

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

41. Excluding psychiatric referrals, in 2008, 196 patients were transferred from NMH PSA to other tertiary level providers.

Table 7: Number of Transfers from New Milford Hospital's Primary Service Area to Other Tertiary Providers, 2008	
Connecticut Children's Medical Center	2
John Dempsey Hospital	2
Bridgeport Hospital	4
Waterbury Hospital	6
St. Francis Medical Center	9
Hospital of St. Raphael	10
Other Connecticut Hospitals	15
Other NY Hospitals	35
Hartford Hospital	36
NY Presbyterian	36
Yale-New Haven Hospital	41
Total	**196**

(June 30, 2010, Completeness Reponses, page 333)

42. Further, based on hospital inpatient discharge data, OHCA finds that compared to NMH, DH provides a higher percentage of specialty care including cardiac, neurological, women's health, general/other surgery, behavioral health and trauma care to NMH PSA residents.

Table 11: Providers of Inpatient Services to NMH Primary Service Area Residents, FY 2009

Service line	New Milford	Danbury	Sharon	Yale	Hartford	Other*	Total
Cardiac Care	38%	**42%**	3%	4%	5%	8%	100%
Cancer Care	32%	37%	3%	15%	3%	11%	100%
Neurological	32%	**47%**	5%	4%	3%	8%	100%
Renal or Urology	38%	38%	3%	5%	6%	10%	100%
Women's Health	40%	**50%**	2%	2%	1%	6%	100%
Orthopedics	42%	41%	3%	3%	1%	10%	100%
Respiratory	61%	30%	4%	1%	0%	3%	100%
Medicine	44%	42%	3%	4%	1%	6%	100%
General/other surgery	35%	**45%**	2%	8%	2%	7%	100%
Newborn	40%	52%	2%	1%	0%	5%	100%
Psychiatry	1%	**59%**	9%	2%	3%	26%	100%
Ophthalmology	40%	33%	0%	13%	0%	13%	100%
Trauma	19%	**47%**	3%	6%	10%	16%	100%
Dental	0%	25%	0%	50%	0%	25%	100%
Substance Abuse	15%	**35%**	25%	1%	0%	22%	100%
PSA Total	**39%**	**44%**	**3%**	**4%**	**2%**	**8%**	**100%**

(Office of Health Care Access' Connecticut Inpatient Discharge Database)
*Hospitals included are Bridgeport, Charlotte Hungerford, John Dempsey, Griffin, William W. Backus, Milford, St. Mary's, St. Francis, Lawrence & Memorial, Bristol, Norwalk, Middlesex, St. Raphael, Waterbury, Greenwich, Central CT, Stamford, St. Vincent's, Manchester and CT Children's.

43. Based upon the foregoing data, OHCA finds that NMH has experienced significant out-migration in recent years and DH was the provider of inpatient care for 44% of discharges from NMH's PSA. Additionally, DH provided a higher level of specialty care to NMH PSA residents.

44. In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. Therefore, increased availability of primary physicians will be beneficial to residents of the area.

Table 12: Percent of Primary Care Sensitive Preventable Hospitalizations[2] at NMH and DH, 2006-2008

Hospital	2006	2007	2008
New Milford	14%	12%	12%
Danbury	10%	10%	11%
CT	**12%**	**12%**	**11%**

(Office of Health Care Access' Connecticut Hospital Inpatient Discharge Database)

45. NMH indicates, consistent with the above data in Findings 34 through 40, that one of the challenges it faces is a physician shortage in primary care and specialties. *(June 9, 2010, Initial CON Application, page 6)*

46. NMH has identified key specialties in which a need exists, such as endocrinology, neurology and selected surgical subspecialties. *(June 9, 2010, Initial CON Application, page 8)*

47. NMH has been unable to attract admissions and subspecialty care because of a documented shortage of both primary care physicians and sub-specialists. NEWCO will provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. *(June 30, 2010, Completeness questions, page 340)*

48. DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. *(June 9, 2010, Initial CON Application, page 8)*

49. DHS also houses Danbury Office of Physician Services ("DOPS"), a multispecialty faculty practice plan whose mission is to support DH in its objective of meeting the needs of all patients, including the underserved. DOPS has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. *(June 9, 2010, Initial CON Application, page 8)*

50. Another challenge for NMH is the growing need to address and upgrade the physical, clinical and technological infrastructure to meet community need. *(June 9, 2010, Initial CON Application, page 6)*

[2] OHCA utilized the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) software to identify preventable hospitalizations. AHRQ defines preventable hospitalizations as instances of inpatient hospital care for health conditions or illnesses typically treated or managed in outpatient settings. See http://www.ct.gov/ohca/lib/ohca/publications/2010/prev_hosp_report01-2010.pdf for more details.

51. An example of the larger capital expenses are: (a) information technology to support legacy systems as well as clinical applications; (b) implementation of an electronic medical record and other advanced clinical technologies designed to improve care, quality and efficiency; (c) enhanced PACS and voice dictation systems; (d) renovation and upgrades to patient care units; (e) facility improvements such as upgrading mechanicals and introducing green technologies; and (f) general plant maintenance associated with an aging facility. *(June 9, 2010, Initial CON Application page 7)*

52. Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. *(June 9, 2010, Initial CON Application, page 30)*

53. DHS currently operates an electronic health information exchange called HealthLink, which enables the hospital to link to other providers through a web-based architecture. NMH will obtain access to the IT expertise and systems currently in place at DH, accelerating its adoption of an EMR and creating seamless information access and connectivity among all entities for optimal clinical quality and operational efficiency. *(June 9, 2010, Initial CON Application, page 30)*

54. DH is engaged in various research initiatives, from basic science to translational research. DH Research Department provides infrastructure and coordinates all of the research and scholarly activities for the entire institution. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

55. In order to integrate the existing and future research and scholarly activities of NMH into the Department research activities and provide a seamless collaboration and coordination of the research efforts, DH will extend its research capabilities by developing a satellite research center at NMH. In addition, the programs at DH will be made available to NMH physicians and patients creating opportunities for greater involvement and collaboration. *(June 9, 2010, Initial CON Application, page 30 and June 30, 2010, Completeness Responses, page 336)*

56. OHCA finds that both NMH's ability to recruit and retain high quality physicians will be enhanced through this affiliation due to greater access to technology and clinical research opportunities.

57. There is no capital cost associated with this proposal. *(June 9, 2010, Initial CON Application, page 24)*.

58. There will be no change in billing as a result of this proposal. *(June 9, 2010, Initial CON Application, page 26)*.

59. There will be no changes to existing reimbursement contracts between the Applicants and the payers. *(June 9, 2010, Initial CON Application, page 26)*.

60. This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of

approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. *(June 9, 2010, Initial CON Application, page 27).*

61. The proposed 2% (or $2,558,000) potential savings to NMH will be in two cost categories over the first three years of the affiliation. One category of potential cost savings is "salaries and benefits" through a reduction of eight (8) FTEs per year over three years in the back office area from retirements and elimination of management positions and normal attrition. The second area is "supplies and drugs."

Table 13: Potential Cost Savings for NMH

	FY 2011	FY 2012	FY 2013	3-YR TOTAL COST SAVINGS
Salaries & Benefits	$797,000	$855,000	$876,000	$2,528,000
Supplies & Drugs	$1,016,000	$1,057,000	$1,099,000	$3,172,000
Total	$1,813,000	$1,912,000	$1,975,000	$5,700,000

(June 30, 2010, Completeness Responses, pages 334-335)

62. The Applicants plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. *(June 9, 2010, Initial CON Application, page 27).*

63. The Applicants will also consider centralizing certain clinical functions, such as clinical laboratory and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. *(June 9, 2010, Initial CON Application, page 26).*

64. There are no plans to implement savings associated with the reduction, elimination, or combination of any clinical services in the short term. *(June 30, 2010, Completeness Responses, page 334).*

65. The cost efficiencies to be realized through integration, including improved operating performance and evaluating capital expenditures, will allow NEWCO, as a whole, to secure needed financing on favorable terms thereby enhancing the financial strength of the entire System which will serve to enhance the credit worthiness of NMH. *(June 9, 2010, Initial CON Application, page 7).*

66. The potential bond rating of NEWCO would support an "A" rating and the strategic value of affiliating with another hospital would at least equal any dilutive financial impact in the short term. *(June 30, 2010, Completeness Responses, page 336)*

67. NMH's credit worthiness will be enhanced by the affiliation in that NMH will benefit from the guarantee of NEWCO, an organization whose numbers would support an "A" rating, which is better than NMH would be able to achieve on its own. *(June 30, 2010, Completeness Responses, page 336)*

68. The Applicants intend to improve productivity and contain costs by developing economies of scale in operations, establishing evidence-based quality decisions on services and care protocols, and developing an integrated plan that allows both organizations to address the needs in the greater region without the unnecessary duplication in services that has characterized the past. *(June 9, 2010, Initial CON Application, page 30).*

69. The projected incremental revenue from operations, total operating expense and gains from operations associated with the proposal are presented in the table below for the first three years with the proposed project:

Table 14: Combined Danbury and New Milford Hospital Financial Projections

Description	FY 2011	FY 2012	FY 2013
Incremental Revenue from Operations	$2,039,000	$2,820,000	$3,689,000
Incremental Total Operating Expense	($407,000)	($161,000)	$151,000
Incremental Gain from Operations	**$2,447,000**	**$2,981,000**	**$3,538,000**

(June 9, 2010, Initial CON Application, Financial Attachment I, page 320)

70. This proposal will also improve revenue through increased inpatient and outpatient volumes at NMH. *(June 30, 2010, Completeness Responses, page 336)*

71. DH's patient population mix is based on the FY 2010 budget, with no change in mix anticipated or projected. DH's current patient population mix and projected population mix with the CON proposal is as follows:

Table 15: Current and Three-Year Projected Population Mix with the CON Proposal

Danbury Hospital	Current FY Payer Mix	2011 Projected Payer Mix	2012 Projected Payer Mix	2013 Projected Payer Mix
Medicare	32.2%	32.2%	32.2%	32.2%
Medicaid	14.5%	14.5%	14.5%	14.5%
TRICARE and CHAMPUS	0.0%	0.0%	0.0%	0.0%
Total Government	**46.7%**	**46.7%**	**46.7%**	**46.7%**
Commercial Insurers	46.3%	46.3%	46.3%	46.3%
Uninsured	6.5%	6.5%	6.5%	6.5%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	**53.3%**	**53.3%**	**53.3%**	**53.3%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

(June 9, 2010, Initial CON Application, page 25)

72. NMH's patient mix is based on the FY 2010 budget, with no change in mix anticipated or projected. NMH's current population mix and projected population mix with the CON proposal is as follows:

Table 16: Current and Three-Year Projected Population Mix with the CON Proposal

New Milford Hospital	**Current FY Payer Mix**	**2011 Projected Payer Mix**	**2012 Projected Payer Mix**	**2013 Projected Payer Mix**
Medicare	45.8%	45.8%	45.8%	45.8%
Medicaid (includes other medical assistance)	10.0%	10.0%	10.0%	10.0%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	**55.9%**	**55.9%**	**55.9%**	**55.9%**
Commercial Insurers*	40.6%	40.6%	40.6%	40.6%
Uninsured	2.8%	2.8%	2.8%	2.8%
Workers Compensation	0.7%	0.7%	0.7%	0.7%
Total Non-Government	**44.1%**	**44.1%**	**44.1%**	**44.1%**
Total Population Mix	**100%**	**100%**	**100%**	**100%**

(June 9, 2010, Initial CON Application, page 25)

73. The Applicants provided resumes of its executive leadership team associated with this proposal demonstrating that they have sufficient managerial and financial experience in managing health care organizations to provide efficient and adequate service to the public. *(June 9, 2010, Initial CON Application, page 118)*

Rationale

OHCA approaches community and regional need for CON proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

DHS is a Connecticut non-stock 501(c)(3) organization, located at 24 Hospital Avenue, Danbury. DHS is the parent corporation of DH in Danbury. NMH is a Connecticut non-stock 501 (c)(3) organization, located at 21 Elm Street, New Milford. DHS and NMH propose an affiliation, with no associated total capital expenditure. Through the affiliation, DHS and NMH intend to create an integrated health care system capable of bringing best practices in health care delivery to enhance the health and well being of residents in western Connecticut and Eastern New York State. (Finding of Fact 18) DHS and NMH also intend to expand availability of tertiary care in the NMH area, including in endocrinology, nephrology and certain surgical sub-specialties. (Finding of Fact 19) The proposed affiliation is also intended to help strengthen access to capital, generate cost savings and leverage recruitment and retention of high quality physicians.

While DH views the affiliation as an opportunity to engage in a more regional planning effort and to provide a more complete continuum of services both DH and NMH board members saw the potential value in establishing a broader more integrated relationship. (Findings of Fact 15-16) Additionally, DH and NMH share a common vision and core values for the establishment of an innovative and collaborative community based health care delivery system. (Finding of Fact 17)

NMH also considered its need for access to significant capital to maintain state-of-the-art treatment facilities; access to the latest in diagnostic and therapeutic technologies; access to primary care and specialty services; physician recruitment/cross-coverage arrangements; quality improvement efforts; and maximizing efficiencies and controlling costs. (Finding of Fact 21) Upon approval of the proposal, NMH will be integrated into DH's IT system for creating an integrated electronic medical record ("EMR") at a much lower cost than NMH could achieve on its own. (Finding of Fact 52) Additionally, NMH will now have access to DH's research capabilities as DH will establish a satellite research center at NMH and physicians and patients from NMH will be able to attend programs offered at DH. (Findings of Fact 54-55)

The affiliation will also provide increased availability of specialists to the existing physicians and patients, thereby reducing the need for people to leave the community or be referred out of the community. (Finding of Fact 47) DH currently has a medical residency program and has been approved for a primary care track that will increase the number of medical residents who seek a career in primary care medicine. (Finding of Fact 48) DHS also houses DOPS, which has the infrastructure to support the expansion of a stronger primary care network within the NMH service area. (Finding of Fact 49) Not only will NMH benefit from an increase in primary care physicians and specialists in the NMH service area, but DH also expects a modest increase in

inpatient utilization based upon the increases in referrals to DH's cardiac catheterization lab in 2010 following the closure of NMH's cardiac catheterization lab.

Currently, 63% percent of discharges from NMH's PSA out-migrate to obtain inpatient care from other hospitals. (Finding of Fact 39) Moreover, DH was the provider of inpatient care for 44% of discharges from NMH's PSA. (Finding of Fact 40) In addition to out-migration, NMH has a larger ratio of hospitalizations that may have been prevented with timely and appropriate care in non-hospital settings compared to the state, overall. (Finding of Fact 44) Specifically, 14% of NMH's hospitalizations were considered preventable compared to 12% for the state. (Finding of Fact 44) Thus, OHCA finds the ED utilization rate for NMH is higher than the statewide average. OHCA is concerned about the use of the ED for health care services that can be delivered in the community setting at a lower cost to the patient and the hospital. Accordingly, OHCA finds that proposed affiliation will improve the quality, accessibility and cost effectiveness of health care delivery in the region by increasing access to primary care and specialty physicians in the NMH service area.

This proposal is cost effective for each Applicant on the basis that DHS anticipates an increase in patient volume of tertiary care services, and NMH will have overall savings of approximately 2% through savings in productivity via economies of scale and supply savings from changes in group purchasing. (Finding of Fact 60) The Applicants also plan to centralize certain back-office administrative functions so that they may reduce redundancies and associated overhead costs, such as, facilities and materials management, risk and claim management, finance, legal, compliance, accounting, and human resources. (Finding of Fact 62) The Applicants will also consider centralizing certain clinical functions, such as the clinical laboratories and to develop system-wide service lines, such as in the areas of diabetic care, oncology, cardiology, neurology (e.g. stroke management) and behavioral health. (Finding of Fact 63) Additionally, the integrated IT system and EMR will provide significant cost savings for NMH. (Finding of Fact 52) The Applicants project operational gains of $2,447,000, $2,981,000 and $3,538,000 in the first three years of the proposal. (Finding of Fact 69) OHCA finds the financial projections and volumes upon which they are based appear to be reasonable and achievable. Accordingly, OHCA concludes that the proposal is financially feasible.

Based upon all of the foregoing, OHCA finds that the proposed affiliation will allow better access to capital and technology and will provide cost efficiencies for both Applicants to create a stronger health care system. Shared best practices, an integrated IT system and the ability to recruit and retain top-level physicians will enhance the Applicants' ability to respond to new federal health care reform initiatives that require health care providers to re-align all aspects of the delivery system and better coordinate those services around the patients' needs. In the absence of an affiliation with a larger tertiary hospital, NMH would probably find it difficult to meet future requirements and financial challenges. Accordingly, OHCA concludes that this proposal will create a larger and financially stronger health care delivery system that will better address these demands and continue to provide access to quality health care in the Applicants' service area.

ORDER

Based on the foregoing Findings and Rationale, the Certificate of Need application of Danbury Health System, Inc. and New Milford Hospital, Inc. for an affiliation, with no associated capital expenditure, is hereby **Approved**, subject to the following conditions:

1. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA, a full copy of any and all signed, dated and completed final affiliation agreements, including attachments indicating the affiliation of DHS and NMH has occurred.

2. If, in the future, there is any change in the ownership structure of DHS, NMH or its affiliates or any change in the affiliation agreement, the Applicants shall file a CON Determination Form with OHCA.

3. If, in the future, there is any change in NMH or NEWCO service availability as a direct result of this proposal, the Applicants shall file a CON Determination Form with OHCA.

4. Within 60 days of the completion of the affiliation between DHS and NMH, the Applicants shall file with OHCA a comprehensive plan that includes the following:

    (i) The locations of current primary care providers in the NEWCO service area;

    (ii) A discussion of how the Applicants will recruit primary care physicians and specialists in the NEWCO service area;

    (iii) A discussion of how the Applicants will specifically address the need for additional primary care in the NEWCO service area, including, but not limited to, increasing existing primary care staff and/or hours, implementing new or expanding current primary care services; and

    (iv) A discussion of any plans the Applicant has to pursue 2010 Patient Protection and Affordable Care Act federal funding opportunities related to primary care.

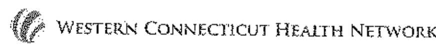
5. The Applicants shall schedule a meeting with OHCA to occur within 30 calendar days of the filing of the comprehensive plan to discuss the Applicants' provision of findings pursuant to Condition #4.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the

September 23, 2010
Date

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner
Office of Health Care Access



DANBURY HOSPITAL

24 Hospital Ave
Danbury, CT 06810
203.739.4903
DanburyHosptial.org

From: Sally Herlihy
Vice President, Planning

To: Kimberly Martone

Fax: 860-418-7053 No. of Pages: 28

Phone: 860-418-7029 Date: May 21, 2013

RE: Docket No. 10-31560-CON CC:

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The original letter will be mailed to your office.

Thank you.

Sally

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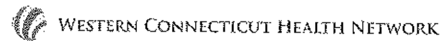

DANBURY HOSPITAL

24 Hospital Ave
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DanburyHosptial.org

From:	Sally Herlihy Vice President, Planning		
To:	Steven Lazarus		
Fax:	860-418-7053	No. of Pages:	28
Phone:	860-418-7012	Date:	May 21, 2013
RE:	Docket No. 10-31560-CON	CC:	

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Thank you

Sally

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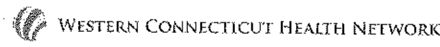
WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL

24 Hospital Ave
Danbury, CT 06810
203.739.4903
DanburyHosptial.org

From: Sally Herlihy
Vice President, Planning

To: Kaila Riggott

Fax: 860-418-7053 No. of Pages: 28

Phone: 860-418-7037 Date: May 21, 2013

RE: Docket No. 10-31560-CON CC:

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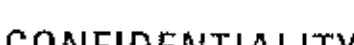
Thank you

Sally



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Total Pages	28	Status	1 of 1 successful
Billing Info	prn131		

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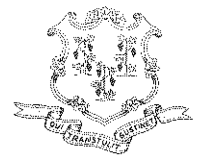
STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

May 31, 2013

Sally F. Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Docket Number 13-31560-MDF; A modification of a CON under Docket No. 10-31560-CON Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

Dear Ms. Herlihy:

On March 19, 2013, the Office of Health Care Access ("OHCA") received a request from Western Connecticut Health Network, Inc. ("Hospital") to modify the Certificate of Need ("CON") authorized by OHCA under Docket Number 10-31560-CON. The CON allows for the affiliation of the Danbury Hospital and New Milford Hospital, Inc. with the maintenance of separate hospital licenses. The Hospital has requested modification of the original CON authorization to modify Findings of Facts #10 and #26 in order to enable The Danbury Hospital and New Milford Hospital, Inc. to operate under a single hospital license.

OHCA has reviewed the Hospital's request for a modification and finds that the Hospital's proposal would result in the termination of one hospital license, thereby resulting in a termination of services under that license. Therefore, a CON is required for the Hospital to effectuate the termination of services under the license to be terminated. Based on OHCA's review of this matter, OHCA hereby denies the Hospital's request for a modification of the CON issued under Docket No. 10-31560-CON.

The Hospital will need to seek appropriate OHCA approval pursuant to Section 19a-639 of the Connecticut General Statutes related to the termination of services.

Sincerely,

Lisa A. Davis

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

Connecticut Department of Public Health

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

FAX SHEET

TO: **SALLY HERLIHY**

FAX: **203 739-1974**

AGENCY: **WESTERN CONNECTICUT HEALTH NETWORK, INC.**

FROM: **OHCA**

DATE: **5/31/13** **Time:** ***1:40 pm***

NUMBER OF PAGES: **2**
(including transmittal sheet)

Comments:

Modification for Docket Number 13-31560, Affiliation of Danbury Health System, Inc. and New Milford Hospital, Inc.

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION