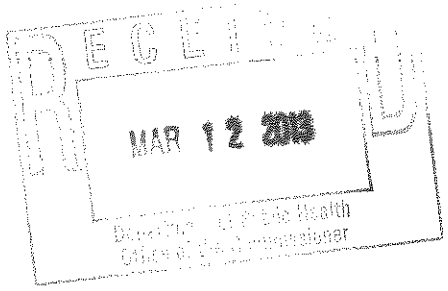
State of Connecticut
SENATE

SENATOR MICHAEL A. McLACHLAN
TWENTY-FOURTH SENATE DISTRICT
LEGISLATIVE OFFICE BUILDING
SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
DEPUTY MINORITY LEADER

RANKING MEMBER
GOVERNMENT ADMINISTRATION & ELECTIONS COMMITTEE
GENERAL BONDING SUB COMMITTEE
MEMBER
FINANCE, REVENUE, & BONDING COMMITTEE
JUDICIARY COMMITTEE
TRANSPORTATION COMMITTEE

March 11, 2013



Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

As State Senator for the 24th District of Connecticut, which includes the City of Danbury, I write to you today in support of the affiliation between Western Connecticut Health Network ("WCHN") and The Norwalk Hospital Corporation. These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of continuing best practices in health care delivery in order to enhance the health and well-being of residents within the geographic areas serviced by the two institutions.

I recognize that with the health care landscape changing rapidly, hospitals need to prepare for the future and position themselves to have the resources to deal with additional patients. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone. The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

Danbury Hospital has always put patients first, and WCHN has found a partner with the same philosophy. Both institutions strive to provide the highest quality of health care. Together they should be able to create strategies to serve more patients at the highest level of health care. I hope you agree.

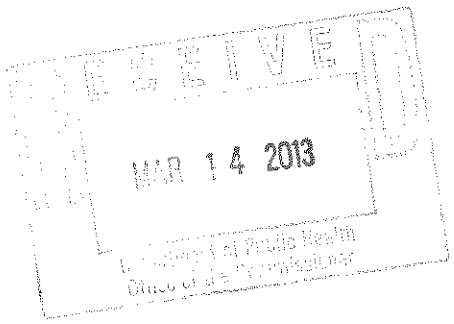
Sincerely Yours,

Michael A. McLachlan
State Senator – 24th District

United Way
of Western Connecticut

www.uwwesternct.org

March 11, 2013



Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am pleased to support the application for the proposed merger between Western Connecticut Health Network and the Norwalk Hospital Corporation. I believe the integration of these two health care systems and their affiliated entities has the potential to create a stronger health care system for the patients throughout western Connecticut. Our communities rely on the health care provided by these two applicants, and we are pleased that this affiliation will bring together two systems that each provide high quality health care. This affiliation will ensure that quality and accessibility of care will continue into the future.

In the economic times we are facing now, the United Way of Western Connecticut recognizes the need to pool resources together, end duplication where it is safe and responsible to do so, and work collaboratively so that resources are used to their best potential. Health care has many challenges ahead in the near future economically, even while it continues to make strong advances clinically. In order to serve additional patients, yet maintain the best practices available, health care providers have to use focus and ingenuity to plan ahead for the future.

We are pleased that each of these institutions has the foresight to plan ahead to maintain excellence in care through sharing of services and efficiencies. I believe that there will be greater health care by combining the resources that these two applicants embody.

We encourage you to approve this application.

Sincerely,

Kimberly Morgan
Chief Executive Officer
United Way of Western Connecticut

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

March 21, 2013

The Honorable Michael A. McLachlan
Senator – 24th District
State of Connecticut
Legislative Office Building, Room 3400
Hartford, CT 06106-1591

Re: Certificate of Need
Western Connecticut Health Network and The Norwalk Hospital Corporation
Affiliation between Western Connecticut Health Network and The Norwalk Hospital Corporation

Dear Senator McLachlan:

On March 12, 2013, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the Affiliation between Western Connecticut Health Network and The Norwalk Hospital Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of OHCA's formal record of the CON application docket once it is received. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http://www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone at (860) 418-7029.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

KRM:bko

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

NORWALK on the move!

OFFICE OF THE MAYOR

RICHARD A. MOCCIA

March 25, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT 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 for affiliation of WCHN and NHSC

Dear Deputy Commissioner Davis,

As Mayor of the City of Norwalk, I care very deeply about the health, safety and welfare of the individuals who live in our City. We are fortunate to have the Norwalk Health Services Corporation and its affiliates here in Norwalk. Since the Hospital's inception 120 years ago, there has been a longstanding commitment to this community and beyond. The Hospital's participation in the health and well being of the community, evidenced most recently through their leadership on the Initiative to end Homelessness as well as on the regional health care assessment and improvement plan, has been outstanding.

The services provided at the Hospital and through its affiliates are stellar. Norwalk Hospital is a national leader in health care quality and patient safety. The Hospital was awarded the HealthGrades Distinguished Hospital Award for Clinical Excellence in 2010, 2011 and 2012. HealthGrades also recognized Norwalk Hospital as ranking in the top five percent of all hospitals nationally for clinical excellence. Our community has benefits for the quality of care in the Hospital and the extension of that care through participation in community health outside the Hospital.

We all know that healthcare reimbursement is changing on both the federal and state levels, and hospitals will have to do more with less as they evolve to an environment which focuses even more on health and wellness while also caring for the sick. By affiliating with WCHN, the NHSC will have a partner whose values for providing care are similar to its own. Both entities seek excellence in the provision of care. Both entities see the possibility of being able to share some resources, and take advantage of some efficiencies of scale that will work to the benefit of both entities.

I applaud both entities for the vision they have and their planning for the future. I am confident that our community--our residents, employers, and visitors--will continue to receive outstanding quality healthcare and even stronger community health leadership going forward. I fully support and strongly endorse the affiliation between the Norwalk Health Services Corporation and Western Connecticut Health Network.

Sincerely,

Richard A. Moccia, Mayor

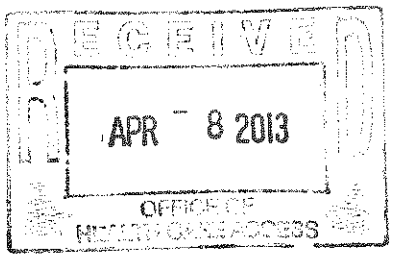
RECEIVED
MAR 28 2013
Department of Public Health
Office of the Commissioner

125 East Avenue • Post Office Box 5125 • Norwalk, CT 06856-5125 • Telephone 203-854-7701 • Fax 203-854-7939 • rmoccia@norwalkct.org

Norwalk Hospital

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

April 8, 2013



Via Hand Delivery

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: CON Application for the Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Dear Ms. Martone,

Enclosed please find the original CON application for the affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc., as well as four copies of the application and a CD with the full document.

We are pleased to be submitting this application to your office because it offers an outstanding opportunity for both entities to secure quality health care in the future for all of our patients. We anticipate that patients will have greater access to health care as we collaborate and share our resources. We also expect operational efficiencies in the new affiliated system that will benefit both entities by creating a secure financial base for the provision of health care in the future.

We look forward to any way that we may be useful in the process that lies ahead, and thank you, in advance, for your consideration of this application. If you have any questions, please do not hesitate to call either or both of us.

Respectfully submitted,

Norwalk Health Services Corporation

By: _____
Daniel J. DeBarba, Jr.
President and CEO, NHSC

Western Connecticut Health Network, Inc.

By: _____
John M. Murphy, MD.
President and CEO, WCHN

SENATOR MICHAEL A. McLACHLAN
TWENTY–FOURTH SENATE DISTRICT
LEGISLATIVE OFFICE BUILDING
SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
DEPUTY MINORITY LEADER

State of Connecticut

SENATE

RANKING MEMBER
GOVERNMENT ADMINISTRATION & ELECTIONS COMMITTEE
GENERAL BONDING SUB COMMITTEE

MEMBER
FINANCE, REVENUE, & BONDING COMMITTEE
JUDICIARY COMMITTEE
TRANSPORTATION COMMITTEE

March 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

As State Senator for the 24th District of Connecticut, which includes the City of Danbury, I write to you today in support of the affiliation between Western Connecticut Health Network ("WCHN") and The Norwalk Hospital Corporation. These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of continuing best practices in health care delivery in order to enhance the health and well-being of residents within the geographic areas serviced by the two institutions.

I recognize that with the health care landscape changing rapidly, hospitals need to prepare for the future and position themselves to have the resources to deal with additional patients. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone. The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

Danbury Hospital has always put patients first, and WCHN has found a partner with the same philosophy. Both institutions strive to provide the highest quality of health care. Together they should be able to create strategies to serve more patients at the highest level of health care. I hope you agree.

Sincerely Yours,

Michael A. McLachlan
State Senator – 24th District

State of Connecticut

SENATE

STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

SENATOR TONI BOUCHER
TWENTY-SIXTH SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 3701
HARTFORD, CT 06106-1591
CAPITOL: (860) 240-0485
TOLL FREE: (800) 842-1421
FAX: (860) 240-0036
E-mail: Toni.Boucher@cga.ct.gov

DEPUTY MINORITY LEADER

RANKING MEMBER
EDUCATION COMMITTEE
HIGHER EDUCATION COMMITTEE
TRANSPORTATION COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE

March 25, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I write to you today in support of the affiliation between Western Connecticut Health Network (WCHN) and The Norwalk Health Services Corporation (NH). These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of bringing best practices in health care delivery to enhance the health and well-being of residents within the geographic areas serviced by the two institutions.

I recognize that with the health care landscape changing rapidly, hospitals need to prepare for the future and position themselves to have the resources to deal with additional patients. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone. The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

Norwalk Hospital has always put patients first, and has found a partner in WCHN with the same philosophy and commitment to community. Both institutions strive to provide the highest quality of health care. Together they should be able to create strategies to serve patients at the highest level of health care. This is what we all want for Connecticut. On behalf of my constituents, I urge you to support this CON application.

Sincerely,

Toni

Toni Boucher
State Senator

Printed on recycled paper

State of Connecticut

SENATOR JOHN McKINNEY
SENATE MINORITY LEADER
28th DISTRICT

Suite 3400
Legislative Office Building
Hartford, Connecticut 06106-1591

Hartford: (860) 240-8800
Toll Free: 1-800-842-1421
Fax: (860) 240-8306

April 2, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis:

As the State Senate Minority Leader and the Senator representing the 28th district including the towns of Fairfield, Easton, Newtown, Weston and Westport, I write to urge approval of the affiliation between Western Connecticut Health Network (WCHN) and The Norwalk Health Services Corporation (NH). These institutions have signed a letter of agreement to affiliate for the purpose of bringing best practices in health care delivery to enhance the health and well-being of residents within the geographic areas serviced by the two institutions.

I recognize that with the health care landscape changing rapidly, hospitals need to prepare for the future and position themselves to have the resources to deal with additional patients. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone. The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

Norwalk Hospital has always put patients first, and has found a partner in WCHN with the same philosophy and commitment to community. Both institutions strive to provide the highest quality of health care. Together they should be able to create strategies to serve patients at the highest level of health care. This is what we all want for Connecticut.

Sincerely,

John McKinney
State Senator 28th District

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE DAVID ARCONTI
109TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4026
HARTFORD, CT 06106-1591

CAPITOL: 860-240-8585
FAX: 860-240-0206
E-MAIL: David.Arconti@cga.ct.gov

MEMBER
GENERAL LAW COMMITTEE
PUBLIC HEALTH COMMITTEE
PUBLIC SAFETY & SECURITY COMMITTEE

March 14th, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

As State Representative of the 109th District of Connecticut, which includes the City of Danbury, I write to you today in support of the affiliation between Western Connecticut Health Network ("WCHN") and The Norwalk Hospital Corporation. These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of continuing best practices in health care delivery in order to enhance the health and well-being of residents within the geographic areas serviced by the two institutions.

I recognize that with the health care landscape changing rapidly, hospitals need to prepare for the future and position themselves to have the resources to deal with additional patients. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone. The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

Danbury Hospital has always put patients first, and WCHN has found a partner with the same philosophy. Both institutions strive to provide the highest quality of health care. Together they should be able to create strategies to serve more patients at the highest level of health care. I hope you agree.

Yours truly,

David Arconti Jr.
State Representative, 109th District

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE CHRIS PERONE
137th ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4004
HARTFORD, CT 06106-1591
HOME: (203) 840-1643
CAPITOL: (860) 240-8585
TOLL FREE: 1 (800) 842-8267
FAX: (860) 240-0206
E-MAIL: Chris.Perone@cga.ct.gov

VICE CHAIRMAN
FINANCE, REVENUE AND BONDING COMMITTEE

MEMBER
COMMERCE COMMITTEE
TRANSPORTATION COMMITTEE

April 1, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT 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 for affiliation of WCHN and NHSC

Dear Deputy Commissioner Davis,

As State Representative for the 137th District of Connecticut, which includes the City of Norwalk, I write to you today in support of the affiliation between Western Connecticut Health Network (WCHN) and The Norwalk Health Services Corporation. These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of continuing best practices in health care delivery in order to enhance the health and well-being of residents within the geographic areas serviced by the two institutions.

I recognize that with the health care landscape changing rapidly, hospitals need to prepare for the future and position themselves to have the resources to deal with additional patients. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone. The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

Norwalk Hospital has always put patients first, and has found a partner with the same philosophy. Both institutions strive to provide the highest quality of health care. Together they should be able to create strategies to serve patients at the highest level of health care. I hope you agree.

Sincerely,

Chris Perone

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

April 3, 2013

Dear Deputy Commissioner Davis,

I ask you to endorse the affiliation between Western Connecticut Health Network (WCHN) and The Norwalk Health Services Corporation (NH). These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of bringing best practices in health care delivery to enhance the health and well-being of residents within their shared geographic service areas.

As a member of the legislature's M.O.R.E. Commission Regional Entities Committee, I'm dedicated to discovering appropriate ways to achieve regional efficiencies without compromising service quality. As the healthcare landscape continues to evolve, hospitals must prepare for the future by achieving the effective operational scale to handle a larger patient pool. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone.

The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

This fortified entity will be better positioned to serve patients at the highest level of health care. On behalf of my constituents, I urge you to support this CON application.

Sincerely,

Representative Jonathan Steinberg
136th District, Connecticut General Assembly

NORWALK on the move

OFFICE OF THE MAYOR

RICHARD A. MOCCIA

March 25, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT 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 for affiliation of WCHN and NHSC

Dear Deputy Commissioner Davis,

As Mayor of the City of Norwalk, I care very deeply about the health, safety and welfare of the individuals who live in our City. We are fortunate to have the Norwalk Health Services Corporation and its affiliates here in Norwalk. Since the Hospital's inception 120 years ago, there has been a longstanding commitment to this community and beyond. The Hospital's participation in the health and well being of the community, evidenced most recently through their leadership on the Initiative to end Homelessness as well as on the regional health care assessment and improvement plan, has been outstanding.

The services provided at the Hospital and through its affiliates are stellar. Norwalk Hospital is a national leader in health care quality and patient safety. The Hospital was awarded the HealthGrades Distinguished Hospital Award for Clinical Excellence in 2010, 2011 and 2012. HealthGrades also recognized Norwalk Hospital as ranking in the top five percent of all hospitals nationally for clinical excellence. Our community has benefits for the quality of care in the Hospital and the extension of that care through participation in community health outside the Hospital.

We all know that healthcare reimbursement is changing on both the federal and state levels, and hospitals will have to do more with less as they evolve to an environment which focuses even more on health and wellness while also caring for the sick. By affiliating with WCHN, the NHSC will have a partner whose values for providing care are similar to its own. Both entities seek excellence in the provision of care. Both entities see the possibility of being able to share some resources, and take advantage of some efficiencies of scale that will work to the benefit of both entities.

I applaud both entities for the vision they have and their planning for the future. I am confident that our community--our residents, employers, and visitors--will continue to receive outstanding quality healthcare and even stronger community health leadership going forward. I fully support and strongly endorse the affiliation between the Norwalk Health Services Corporation and Western Connecticut Health Network.

Sincerely,

Richard A. Moccia, Mayor

125 East Avenue • Post Office Box 5125 • Norwalk, CT 06856-5125 • Telephone 203-854-7701 • Fax 203-854-7939 • rmoccia@norwalkct.org

CITY OF DANBURY

OFFICE OF THE MAYOR
155 DEER HILL AVENUE
DANBURY, CONNECTICUT 06810

MARK D. BOUGHTON
MAYOR

(203) 797-4511
FAX (203) 796-1666
m.boughton@danbury-ct.gov

March 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

As Mayor of the City of Danbury, I care very deeply about the health, safety and welfare of the individuals who live in the City. I believe we are fortunate to have Danbury Hospital as our flagship hospital, as well as the many affiliates of the Hospital that are part of Western Connecticut Health Network ("WCHN") located in our community.

Danbury Hospital is a 371-bed regional medical center and university teaching hospital associated with Yale University School of Medicine, the UConn School of Medicine and the University of Vermont College of Medicine. It has centers of excellence in five areas: the Praxair Regional Heart and Vascular Center, the Praxir Cancer Center, the Center for Advanced Orthopedic and Spine Care, Radiology and Diagnostic Imaging, and Women's and Children's Services.

But for those of us who live in Danbury, and the towns surrounding Danbury, this is our local hospital. We know that patients come first, and that the Hospital always strives for excellence in every aspect of our health care. At Danbury Hospital, a person's health is considered their best investment, and the hospital emphasizes staying healthy through a range of wellness programs, education and preventative screenings. We are very fortunate to have a hospital with such outstanding leadership and excellent staff that works with us to stay well, but is there to treat us with excellent care when we are sick.

In recent years, health care reimbursement has changed on both the federal and state levels, with hospitals receiving less money as they attempt to treat more people. And technology has advanced in many ways, offering outstanding new treatments and administrative tools that are expensive for hospitals to purchase. The 2010 Patient Protection and Affordable Health Care Act may affect the provision of health care by

RECYCLED PAPER

putting more demands on all of our health care providers. As a result, hospitals are naturally considering affiliating with other health care organizations as a way to create efficiencies, and at the same time keep the quality of health care at an excellent level.

Western Connecticut health Network has worked diligently for over a year to determine whether The Norwalk Hospital Corporation would be a good match for an affiliation. The answer was a resounding "yes", and I respect the decision of the Board and administration of WCHN to reach out to Norwalk Hospital and do the necessary work to reach this point. The approval of the Office of Health Care Access is necessary before these two outstanding institutions can move forward to work together. I am pleased that the two organizations have reached this point, and hope that the State of Connecticut will agree.

I fully support the affiliation between the Norwalk Hospital Corporation and Western Connecticut Health Network.

Sincerely,

Mark D. Boughton
Mayor

RECYCLED PAPER

GREATER Norwalk CHAMBER OF COMMERCE

Mid-Fairfield County's Business Organization

EDWARD J. MUSANTE, JR.
PRESIDENT & CEO

March 25, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: CON application for affiliation of WCHN and NHS Corp.

Dear Deputy Commissioner Davis,

On behalf of the Greater Norwalk Chamber of Commerce, the largest business service organization in mid-Fairfield County, I am pleased to support the application for the proposed affiliation between Western Connecticut Health Network and the Norwalk Health Services Corp. Our businesses in and around Norwalk and their employees and their families rely on the health care provided by Norwalk Hospital. We are pleased that this affiliation will bring together two systems that each provide high quality health care and together the new system will strengthen that quality and improve accessibility and care for all of its patients.

In the economic times we are facing now, the Chamber recognizes the need to pool resources together, end duplication where it is safe and responsible to do so, and work collaboratively so that resources are used to their best potential. Health care has many financial challenges ahead while it continues to make outstanding advances clinically. In order to serve their patients, yet maintain the best practices available, health care providers have to use focus and ingenuity to plan for the future. We are pleased that each of these institutions has the foresight to plan ahead to maintain the excellence that each institution embodies today through sharing of serves and efficiencies that can be achieved. We believe that there will be greater health care strength by combining the resources that these two applicants embody.

We at the Greater Norwalk Chamber of Commerce strongly support this application and hope that you will consider approval at the earliest possible time.

Very truly yours,

Edward J. Musante, Jr.
President & CEO

101 East Avenue • Norwalk, Connecticut 06851
Tel: (203) 866-2521 • Fax: (203) 852-0583 • Email: emusante@norwalkchamberofcommerce.com
www.norwalkchamberofcommerce.com

GREATER danbury CHAMBER

April 2, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am pleased to support the application for the proposed merger between Western Connecticut Health Network and the Norwalk Hospital Corporation. This integration of these two health care systems and their affiliated entities has the potential to create a stronger health care system for businesses in both Danbury and Norwalk. Since our communities rely on the health care provided by these two applicants, we are pleased that this affiliation will bring together two systems that each provide high quality health care, and believe that this affiliation will guarantee that this quality and accessibility of care will continue into the future.

In the economic times we are facing now, the Greater Danbury Chamber of Commerce recognizes the need to pool resources together, end duplication where it is feasible to do so, and work collaboratively so that resources are used to their best potential. Health care has many challenges ahead in the near future economically, while it continues to make outstanding advances clinically. In order to serve additional patients, yet maintain the best practices available, health care providers have to use focus and ingenuity to plan ahead for the future. We are pleased that each of these institutions has the foresight to plan ahead to maintain the excellence that each institution embodies today through sharing of serves and efficiencies that can be achieved. I believe that there will be greater health care strength by combining the resources that these two applicants embody.

We support this application and encourage your approval.

Yours truly,

Stephen A. Bull
President

Greater Danbury Chamber of Commerce, Inc.
39 West Street • Danbury, Connecticut 06810 • 203-743-5565
Fax: 203-794-1439 email: info@danburychamber.com
Web: www.danburychamber.com

NORWALK on the move!
DEPARTMENT OF HEALTH

March 25, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

Dear Deputy Commissioner Davis,

For the past 20 years I've been charged with leading the development and implementation of policies and programs aimed at making Norwalk a place where people can be healthy. In the pursuit of this goal, my colleagues and I at the Health Department work closely with our counterparts at Norwalk Hospital. The Hospital Board of Trustees' and administration's commitment to serving the Norwalk community is exemplary.

The development of the Norwalk Community Health Center, a federally qualified health center serving the neediest members of our community and a recently completed community health assessment and community health improvement plan are just a few examples of our commitment to work together to improve community health. We are very fortunate to have a Hospital with outstanding leadership and excellent staff that works with us to prevent illnesses and is there to provide excellent care when we our people are sick.

Healthcare is changing and hospitals and systems must adapt if they are to continue to be there for their constituents. The affiliation with the Western Connecticut Health Network is a bold step toward building an even stronger commitment to continuing and improving community health. I fully support this venture and look forward to continuing to work with our valued partners.

Sincerely,

Tim Callahan

Tim Callahan
Director of Health

United Way
of Western Connecticut

www.uwwesternct.org

March 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am pleased to support the application for the proposed merger between Western Connecticut Health Network and the Norwalk Hospital Corporation. I believe the integration of these two health care systems and their affiliated entities has the potential to create a stronger health care system for the patients throughout western Connecticut. Our communities rely on the health care provided by these two applicants, and we are pleased that this affiliation will bring together two systems that each provide high quality health care. This affiliation will ensure that quality and accessibility of care will continue into the future.

In the economic times we are facing now, the United Way of Western Connecticut recognizes the need to pool resources together, end duplication where it is safe and responsible to do so, and work collaboratively so that resources are used to their best potential. Health care has many challenges ahead in the near future economically, even while it continues to make strong advances clinically. In order to serve additional patients, yet maintain the best practices available, health care providers have to use focus and ingenuity to plan ahead for the future.

We are pleased that each of these institutions has the foresight to plan ahead to maintain excellence in care through sharing of services and efficiencies. I believe that there will be greater health care by combining the resources that these two applicants embody.

We encourage you to approve this application.

Sincerely,

Kimberly Morgan
Chief Executive Officer
United Way of Western Connecticut

Certificate of Need Application

Norwalk Health Services Corporation

and

Western Connecticut Health Network, Inc.

Application to Form an Affiliated Entity

RECEIVED
APR 8 2013
OFFICE OF
HEALTH CARE ACCESS

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☒ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 13-31832-CON **Check No.:** 325963
OHCA Verified by: KR **Date:** 4-8-13

☒ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☒ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☒ **Attached are completed Financial Attachments I ~~and II~~.**

☒ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications (less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☒ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

THIS CHECK HAS A COLORED BACKGROUND AND CONTAINS MULTIPLE SECURITY FEATURES - SEE BACK FOR DETAILS

NORWALK HOSPITAL ASSOCIATION
24 Stevens St
Norwalk, CT 06856

WACHOVIA
637 West Avenue
Norwalk, CT 06859
51-110/211

325963

PAY ****FIVE HUNDRED AND XX / 100 DOLLAR****

Apr/04/2013 Date

$500.00*** Amount

Pay to the Order: **TREASURER STATE OF CONNECTICUT**
55 ELM ST #2
HARTFORD, CT 06106

HEAT SENSITIVE RUB AREA TO VERIFY

Daniel J. DeBonis Jr.
Authorized Signature

⑈325963⑈ ⑆021101108⑆ 2000014979549⑈

Check Date: Apr/04/2013 **Vendor Number:** 0000100963 **Check No.** 325963

Invoice Number	Invoice Date	Voucher ID	Gross Amount	Discount Taken	Late Charge	Paid Amount
04022013	Apr/02/2013	742679	500.00	0.00	0.00	500.00
FILING FEE CERTIFICATE OF NEED-AFFILIATION						

Check Number	Date	Total Gross Amount	Total Discounts	Total Late Charges	Total Paid Amount
325963	Apr/04/2013	$500.00	$0.00	$0.00	$500.00

PUBLISHER'S AFFIDAVIT

STATE OF CONNECTICUT)
ss. Norwalk
COUNTY OF FAIRFIELD)

I, JOCELYN A. BATTISTA, being duly sworn, dispose and say:

1. I am over the age of eighteen (18) and believe in the obligation of an oath;

2. I am the Classified Advertising Supervisor of The Hour Publishing Company, publisher of the following newspapers:

   1) The Hour, a daily newspaper, published in Norwalk, Connecticut;

   2) The Wilton Villager, a weekly newspaper, published in Norwalk, Connecticut; and

   3) The Stamford Times, a weekly newspaper, published in Norwalk, Connecticut.

3. On February 3, 2013, February 4, 2013 and February 5, 2013 an advertisement placed by Norwalk Hospital was published in The Hour.

LEGAL NOTICE

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and Norwalk Health Services Corporation (NHSC) will submit the following Certificate of Need application to the CT Office of Health Care Access:

Applicants: Western Connecticut Health Network, Inc. (WCHN) which includes The Danbury Hospital (DH) and New Milford Hospital, Inc. (NMH); and Norwalk Health Services Corporation (NHSC), which includes The Norwalk Hospital Association (NHA).

Addresses: NHSC and NHA are located at 34 Maple Street, Norwalk, CT. WCHN and DH are located at 20 Hospital Avenue, Danbury, CT. NMH is located at 21 Elm Street, New Milford, CT.

Proposal: This affiliation includes three hospitals, NHA, DH and NMH; the new organization will be governed by a single board of directors and a unified mission to promote the health and well being of people in the communities it serves. All 3 entities will remain at their current locations.

Capital Expenditure: $ 0

Jocelyn A. Battista, Classified Advertising Supervisor

Subscribed and sworn to before me this 6th day of February, 2013.

Brett L. Whitton
Commissioner of the Superior Court

Herlihy, Sally

Subject: FW: Request for placement asap

From: Rynn, Andrea J.
Sent: Friday, February 01, 2013 4:28 PM
To: DNTLegals
Cc: Herlihy, Sally; Johnson, Michelle
Subject: RE: Request for placement asap

Hi Diane,
Thank you for your help. This email confirms the ad will run for three consecutive days beginning Monday, 2/4/13 through Wednesday, 2/6/13 at a cost of $654.
Regards,
Andrea

From: DNTLegals [Legals@newstimes.com]
Sent: Friday, February 01, 2013 4:20 PM
To: Rynn, Andrea J.
Subject: RE: Request for placement asap

All set with the ad
Has to get in now for the deadline
Thank you

The News-Times

Classified

SOUTHERNCTJOBS.COM
monster®

Toll-Free: **877-542-6053** | classified@newstimes.com | Hours: 8:30 a.m. – 5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

Pursuant to section 19a-638 of Connecticut General Statutes, Western Connecticut Health Network (WCHN) and Norwalk Health Services Corporation (NHSC) will submit the following Certificate of Need application to the CT Office of Health Care Access:
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Proposal: This affiliation includes three hospitals, NHA, DH and NMH; the new organization will be governed by a single board of directors and a unified mission to promote the health and well being of people in the communities it serves. All 3 entities will remain at their current locations.
Capital Expenditure: $ 0.

STATE OF CONNECTICUT
COUNTY OF FAIRFIELD
CITY OF DANBURY

U-HAUL OF LOWER HUDSON VALLEY, 300 WINDSOR HIGHWAY, NEW WINDSOR, NY 12553, HEREBY GIVES NOTICE TO ALL INTERESTED PARTIES THAT THE CONTENTS OF STORAGE UNITS LOCATED 75 DIVISION ST, DANBURY, CT 06810, WILL BE SOLD TO THE HIGHEST BIDDER DUE TO THE NONPAYMENT OF RENT AS STATED IN THE RENTAL AGREEMENT. THE CONTENTS OF THESE UNITS CONSISTS OF FURNITURE, HOUSEHOLD GOODS, AND OTHER MISCELLANEOUS PROPERTY.

GENERAL HELP WANTED

RECRUITMENT ADVERTISING SALES CONSULTANTS

Hearst Media Services is looking for talented, highly motivated sales professionals with an interest in multi-media advertising to join our recruitment advertising team of digital media consultants.

If you love to sell and are knowledgeable about digital media, then we have the perfect opportunity for you to join us and help our customers to grow their businesses by meeting their hiring needs!

In addition to our 11 newspapers in greater Fairfield and Litchfield counties, and 16 web sites, we have partnerships with the biggest names in digital and social media, including monster.com.

With all this we can offer our advertisers unmatched reach and targeting capabilities - from the very local to the national scale.

Hearst Media Services prides itself

HEATING AND FIREWOOD

SEASONED FIREWOOD, $190/cord delivered, $165/cord pickup. Premium wood pellets. Dom's Garden Center 203-744-8755

MERCHANDISE FOR SALE

72" seven shelf bookshelf by Whalen. Excellent Condition. $95 obo -203-297-5889

ANTIQUE STAFFORDSHIRE DOGS pr. 13" high , 1875, glass eyes, $400. 203-261-5926

ANTIQUE CARRIAGE CLOCK 1895, USA, gilded frame, bev glass, $400. 203-261-5926

ARMCHAIR Contemp., brown leather on slender steel frame (on wheels). $25. 203-746-0460

BED Queen Pillowtop Mattress & Boxspring. Brand New. Still in Plastic. Sacrifice $250. 203-557-0949

BEDROOM CHERRY solid sleighbed, dresser, mirror, chest,

MERCHANDISE FOR SALE

DINING ROOM TABLE CHAIRS, 8, Oak. Excellent Cond. Please call, 203-743-3196. Part of Set.

FOLDING CART FOR GROCERIES, LAUNDRY ETC 18W15D27H $20.00 203-775-6118

FOSEBALL TABLE: Full-sized table, good cond. $100. 860-355-0357

HARLEY-DAVIDSON POWER WHEELS Ride-on Toy w/cord, needs batte, $70. 203-300-7797

HEATER/FAN 7X9" ADJ.SET. 1200W LOTS OF HEAT. $15. 203-775-6118

HENREDON OAK TABLE 44" md w/two 20" leafs, Bantry Bay, $450. 203-261-5925

HENREDON CAPTAIN CHAIRS 4, Oak, hob nail, cushioned, Bantry Bay, $499. 203-261-5925

HITACHI LCD TV w/matching stand, chrome w/glass shelves. 55" wide. $225. 203-746-0450. Great cond.

MERCHANDISE FOR SALE

ATTENTION

PLAYSTATION II with Controllers. $30. 203-746-0346

POOL TABLE. 8 ft Pro Style, 1 inch slate, solid wood, 6hr pockets. Brand new. Must Seel Cost $4500. Sacrifice $1500. Free Delivery. 203-247-9459

Red Sox Jersey Size 3XL also including six books/mags on Red Sox. $50 203-297-5889

REFRIGERATOR, GE 16 CU FT, Only 2 years old. Like new. Freezer on top. $350 BO. 203-470-5269

★★★

ROCKET DOG BOOTS. New w/ Tags. Size 10, Fur w/Pom Poms. $20. 203-746-0346

ROCKING CHAIR CONTEMP. MED COL WOOD OATMEAL COL CUSHION $75. 203-775-6118

04/05/2013
Affiliation CON-5

AFFIDAVIT

Applicants: Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Project Title: Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

I, Daniel J. DeBarba, Jr., President and Chief Executive Officer of Norwalk Health Services Corporation being duly sworn, depose and state that Norwalk Health Services Corporation's information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 4/4/13 Date

Subscribed and sworn to before me on April 4, 2013

Notary Public/Commissioner of Superior Court

My commission expires: 4/30/15

KRISTEN L. BRUNO
Notary Public-Connecticut
My Commission Expires
4/30/15

AFFIDAVIT

Applicants: Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Project Title: Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

I, John M. Murphy, M.D., President and Chief Executive Officer of Western Connecticut Health Network, Inc., being duly sworn, depose and state that Western Connecticut Health Network, Inc.'s information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 4/5/13 Date

Subscribed and sworn to before me on April 5, 2013

Carol Freeman

Notary Public/~~Commissioner of Superior~~ Court

My commission expires: 4-30-2014

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

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:

Docket Number	TBD	
Co-Applicants	Norwalk Heath Services Corporation	Western Connecticut Health Network, Inc.
Contact Person	Jeryl Topalian	Sally Herlihy
Contact Peron's Title	Executive Director Planning & Business Development	Vice President Planning
Contact Person's Address	34 Maple Street Norwalk, CT 06850	24 Hospital Avenue Danbury, CT 06810
Contact Person's Phone Number	203-852-2354	203-739-4903
Contact Person's Fax Number	203-852-1553	203-739-1974
Contact Person's Email Address	Jeryl.Topalian@norwalkhealth.org	Sally.Herlihy@wchn.org
Project Town	Norwalk, CT and Danbury, CT	
Project name	Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.	
Statute Reference	Section 19a-638, C.G.S.	
Estimated Total Capital expenditure	$0	

1. Project Description and Need: Change of Ownership or Control

a. Please provide a narrative detailing the proposal.

Norwalk Health Services Corporation (NHSC) and Western Connecticut Health Network, Inc. (WCHN) propose to affiliate to form a new integrated health care delivery system capable of bringing the best practices in health care delivery to enhance the quality of health and the well-being of residents within the geographic areas served by both organizations. This affiliation will join two health care provider organizations; NHSC, which includes Norwalk Hospital and its affiliated entities, and the current WCHN, which includes The Danbury Hospital, New Milford Hospital, Inc., and its affiliated entities. The newly formed entity will be referred to as "New WCHN" in this application.

Hospitals are facing many challenges including declining reimbursement and inpatient volume. Additional challenges include the health care reform mandates of the 2010 Patient Protection and Affordable Care Act (ACA), which require investment in quality assessment, physician integration, population health management and electronic health records (EHR). Affiliating with another hospital system is an opportunity to collaborate and cooperate in order to improve and enhance the quality of care provided to our patients and meet the increasing demands of the healthcare environment. These challenges we face require substantial human and financial resources which stand-alone hospitals are increasingly unable to meet. The proposed affiliation and integration of NHSC and WCHN is a responsible approach to meeting these costly and difficult challenges while strengthening the quality of, and access to health care in western Connecticut.

This affiliation proposal, if approved, will bring together the shared legacies and missions of three community hospitals and their affiliated entities across a not for profit, community-based network to achieve our shared vision of improving the community's health by delivering high quality, coordinated, and cost effective care across the continuum. The creation of the new WCHN will also result in efficient and streamlined operations, and enhanced education and research opportunities. The breadth and scope of the new WCHN will allow us to attract and retain talented individuals for the benefit of our collective communities.

New WCHN will be the sole corporate member of NHSC. A reconstituted 18-member single board of directors will govern the new organization. Eleven board members will be appointed from the current WCHN and 7 members will be appointed from the current NHSC.

New WCHN will have rights with regard to governance, operating and capital budgets, and strategic planning for NHSC, Danbury Hospital, New Milford Hospital and all other WCHN-related entities. (*See* Exhibit A, Affiliation Agreement By and Between NHSC and WCHN, Inc.)

New WCHN will be led by John M. Murphy, MD, currently President and CEO of WCHN who will become the CEO of New WCHN. Daniel DeBarba, Jr., currently President and CEO of NHSC, will become Executive Vice President of New WCHN and will remain as President and CEO of NHSC.

WCHN currently includes:

- Danbury Hospital, which was established in 1885, and is licensed for 345 beds and 26 bassinets is a teaching hospital located at 20 Hospital Avenue in Danbury, CT.
- New Milford Hospital, established 1921, which has 85 beds, is a community hospital located at 21 Elm Street in New Milford, CT.
- WCHN Affiliated entities (*See* Exhibit B, for a list of the non-hospital entities.)
- WCHN currently serves a population of approximately 440,000 in western CT and adjacent New York State.

NHSC includes:

- Norwalk Hospital, which was established 1892, is licensed for 328 beds and 38 bassinets. It is a teaching hospital located at 34 Maple Street in Norwalk, CT.
- NHSC affiliated entities (*See* Exhibit C, for a list of the non-hospital entities.)
- NHSC serves a population of 275,000 in lower Fairfield County, CT.

The affiliation of NHSC and WCHN into a new integrated healthcare delivery system will be realized with a collaborative and carefully planned approach to achieve operational efficiencies while preserving and seamlessly providing core clinical services to the communities we serve. For our patients, this affiliation will mean more treatment options; for our communities, it will result in a deeper commitment to provide the care that people need at locations they can easily access; for our staff, it will expand the scope of opportunities. Together, Norwalk, Danbury and New Milford Hospitals and their affiliates will promote the health and well-being of the people we serve.

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).

As healthcare reform moves from concept to reality there are increasing pressures on independent hospitals' resources and ultimate viability. In order for the hospitals involved in this affiliation to be able to continue to provide quality care for patients in their service areas now and in the future, efficiencies must be sought and realized. The CT Department of Public Health's Statewide Health Care Facilities and Services Plan ("the Plan") recognizes that hospitals are pursuing affiliations or mergers, *inter alia*, in response to growing financial pressures brought on by the increasing cost of providing healthcare, the decreasing federal and state reimbursement rates, the threat of government payers further reducing reimbursement, the need for access to capital, and the ability to develop economies of scale when purchasing supplies and services. (*See* Exhibit D, The Plan, p.7, Sec. 1.8.5).

NHSC Need

In November of 2008, the NHSC Board of Trustees and senior management explored the strategies and tactics that would be needed to ensure the long-term success of NHSC. Elements identified as essential to long-term viability included improved access to capital markets, support for physician recruitment/retention, clinical service development, and better use of scarce community resources.

In early 2009, Norwalk Hospital engaged Navigant Consulting, Inc. ("NCI") for an assessment of partnership options as one opportunity to ensure the continued strength and viability of the hospital. A Partnership Task Force, consisting of Board members and senior management, (the "Partnership Task Force") identified potential scenarios for further exploration and key drivers to be considered in a potential partner.

During this same time, NHSC was developing Vision 2015 – a strategic plan identifying the long-term strategic priorities for the hospital. These priorities included improving patient safety, satisfaction and quality outcomes, developing physician partnership and integration, and the continued growth and development of hospital facilities and programs. Working alongside NCI, NHSC recognized that selecting a partner was a critical element to achieving these priorities for the future.

The Partnership Task Force identified potential partners including several Connecticut and New York systems, as well as for-profit partners, and ruled out partnerships that did not materially address organizational needs. NHSC leadership entered into discussions with the remaining potential partners.

As a result of this process WCHN emerged as the most appropriate partner that would allow NHSC to achieve its goals. (See response to 1.c. below for the timeline forward). WCHN was selected for a multitude of reasons, including, without limitation demonstrated strong leadership, quality care, strong financial performance and a shared vision for the future. In addition, WCHN had experience in affiliation with another community hospital.

WCHN Need

Since the creation of the network in 2010, WCHN has continued to assess potential affiliate partners in order to build material scale. Later in 2010, the leadership of NHSC and WHCN initiated informal discussions about the possibility of a new alliance between their organizations. It was recognized that an affiliation with NHSC would allow for collaboration and development of a larger network to facilitate appropriate sharing of resources, services and technologies. More importantly, it would provide a stronger foundation for excellence in the delivery of health care services to residents in the western Connecticut region. Affiliating with a strong partner such as NHSC was viewed as an opportunity to share common goals of improving the quality of patient care between both programs and creating new synergies which focus on patient healthcare delivered at the right time and at the right place.

WCHN and NHSC Benefits

As a newly affiliated health care network, both entities (WCHN and NHSC) will be better able to continue to serve their communities with excellence over the long term. The Applicants share a common vision of improving the community's health by delivering coordinated, cost-effective care across the health care continuum.

Together WCHN and NHSC identified the benefits that could be achieved by an affiliation:

- Strengthen clinical programs to demonstrate quality outcomes and to improve access to health care, which can be done more economically with two cooperating systems rather than two stand-alone organizations.
- Enhance educational programs. This includes strengthened programs for medical students, residents and fellows in both organizations.
- Strengthen the physician platform for the delivery of care.
- Build competencies required for new reimbursement models, such as population health management, bundled payments, PHOs and ACOs.
- Integrate operations to achieve savings and create a unified operating model.
- Improve access to and/or reduce cost of capital due to system scale and performance.

WCHN and NHSC have much in common, including similar histories and missions, and local communities that hold each of them in high regard. If approved, the affiliation will create a sum greater than its individual parts, with the collective opportunity to affiliate and make improvements so our organizations can continue to serve our communities for the long term.

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?).

In 2009, NHSC, with the assistance of NCI began to identify possible partnership arrangements with other hospitals. In 2010 the respective CEOs of NHSC and WCHN initiated informal discussions about the possibility of a new alliance between their organizations. In the summer of 2011, the Boards of WCHN and NHSC authorized their respective CEO's to further explore the opportunity of an affiliation.

On September 16, 2011, NHSC and WCHN executed a Mutual Confidentiality Agreement. In the Fall of 2011, the Chartis Group, LLC was engaged through legal counsel to support the development and evaluation of a plan that provided the context and vision for the integration, as well as high-level financial estimates, to help determine if there was sufficient rationale to merit continued discussion. These discussions culminated with NHSC and WCHN executing a Letter of Intent (LOI) for corporate affiliation on April 3, 2012. (*See* Exhibit E)

Between April and December of 2012, NHSC and WCHN entered into due diligence, further evaluating the benefits of working together to create a new network of health care for their respective service areas. NHSC and WCHN executed a Summary of Terms, including elements of the Letter of Intent on September 18, 2012. (*See* Exhibit E) On January 18, 2013, the WCHN Board of Directors approved the Affiliation Agreement. (*See* Exhibit F) The NHSC Board of Trustees approved the Affiliation Agreement on January 21, 2013, (*See* Exhibit G) and the Agreement was signed by NHSC and WCHN on January 22, 2013. (*See* Exhibit A)

Subsequent discussions have been held with State of CT Attorney General's office, and the Hart-Scott-Rodino filing has been submitted to the Federal Trade Commission to initiate federal government approval of the transaction.

Integration planning is being organized, and the planning process will be initiated in mid-April, 2013. (Refer to Question 1f. for more information about the Transition Plan).

d. List any changes to the clinical services offered by the Applicants that result from this proposal, and provide an explanation.

Affiliation will enable WCHN and NHSC as a combined entity to build on their existing strengths and capabilities. No disruption to or curtailment of clinical services is anticipated at this time. The opportunities that will be created by this affiliation will be in the form of expansion of some services, where needed, and in shared service personnel so that both entities can continue to provide the wide range of services now being offered. However, in the future, changes may occur as opportunities to reduce duplication or inefficiencies in clinical service delivery are identified.

e. 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.

NHSC serves a large and diverse population of approximately 275,000 in its primary and secondary service areas. The primary service area is defined as Norwalk, Westport, New Canaan, Wilton and Weston. The secondary service area includes Darien, Fairfield, Redding and Ridgefield. (*See* Exhibit H for more detailed demographic information.)

WCHN's service area includes municipalities in both Connecticut and New York. The primary service area towns include: Bethel, Bridgewater, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, and Washington, CT, and Brewster, Dover Plains, Patterson, Pawling, and Wingdale, NY.

If the affiliation is approved, patients in the towns within the service area of both networks will have access to the same services as they have today. However, we believe that the services will be more accessible by having additional health care providers and locations available. It is also anticipated that many of the tertiary care services that are being provided today will be strengthened by the partnership of NHSC with WCHN.

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

The Applicants have jointly engaged PricewaterhouseCoopers, through legal counsel, to assist in developing a transition planning process to integrate their respective organizations. This involves a collaborative and carefully planned approach to achieve operational efficiencies while preserving and seamlessly providing core clinical services to the communities we serve. The transition plan is anticipated to evolve over a six-month period and will not disrupt continuity of patient care.

The approach will include establishing direction through identifying key integration initiatives and synergies for the merged entity, developing the framework and structure to accomplish the task, and a communications plan to keep the new organization and community informed of shared progress. It is also designed to capitalize on WCHN's experience bringing together its two hospitals (Danbury and New Milford) and affiliated entities two years ago.

To consolidate the activities into an executable plan, the integration project involves the following:

- An Integration Steering Committee to provide overall vision and direction, drive key decisions and commit and manage resources, drive change management behaviors and address obstacles
- An Integration Management Office to manage project objectives and milestones, provide tools, templates and protocols to facilitate activities, manage activities of functional teams and monitor results
- Integration teams focused on identifying synergy opportunities in key areas, developing work plans, resource needs and deliverables
- Change management and communication tools to foster ownership and support timely and consistent messaging.

This infrastructure will enable New WHCN to plan for its first day as a merged entity. Integration planning by the teams will be undertaken in the months prior to the close of the transaction to prepare for Day One as a combined entity, post deal close. Along with the Day One integration plan, New WCHN will have a plan for the first 100 days, including a communication plan and change-management resources. Longer-term integration items will be prioritized and documented in an overall integration strategy planning document.

g. 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.

The legal charts of the corporate structure are attached as <u>Exhibit I</u>. There are no new entities that will be created as a result of this affiliation.

ii. List of owners and the % ownership and shares of each.

There are no owners of either WCHN or the Norwalk Health Services Corporation. The Applicants are nonstock corporations that have no members. If the proposal is approved, WCHN would become the sole corporate member of Norwalk Health Services Corporation.

h. 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 Summary of Terms between NHSC and WCHN dated September 18, 2012 (included in Exhibit A) and the Affiliation Agreement executed January 22, 2013 (attached as Exhibit A). The final transaction agreement is expected to be finalized in the fall of 2013.

2. 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.

Both NHSC and WCHN have strong leadership at the management level based on a great deal of depth and experience in health care in general, and hospitals in particular. A copy of the CV's for each of the following leaders from NHSC and WCHN are attached in Exhibit J.

Norwalk Health Services Corporation	Western Connecticut Health Network
President & CEO Dan DeBarba, Jr.	President & CEO John Murphy, MD
Senior VP & COO Lisa Brady	Senior VP, COO, Danbury Hospital Michael Daglio
	Executive Director, Senior VP, New Milford Hospital, Deborah Weymouth
VP Finance, CFO Patrick Minicus	Senior VP, CFO & Treasurer Steve Rosenberg
VP Patient Care Services, CNO Renee Mauriello, RN	VP Patient Care Services, CNO Moreen Donahue, RN
VP, Chief Medical Officer Eric Mazur, MD	Chief Medical Officer Matt Miller, MD
VP, Human Resources Anthony Aceto	Senior VP, Human Resources Phyllis Zappala
Chief Legal Officer	General Counsel

Kristen Staikos	Carolyn McKenna
Chief Compliance Officer Jeannine Foran, RN, JD	Chief Risk & Compliance Officer Joe Campbell
Chief Medical Information Officer, Acting CIO Steve O'Mahony, MD	Chief Information Officer Kathy DeMatteo
Executive Director, Facilities Jim Haynes	VP, Facilities Morris Gross
Executive Director, Quality Joanne Svogun	VP, Quality & Patient Safety Dawn Myles
Executive Director, Planning & Business Development, Jeryl Topalian	VP, Planning Sally Herlihy
President NH Foundation, VP Public Affairs Mary Franco	Executive Director & VP Foundation Grace Linhard
President NHP&S, VP Business Development Michael Marks, MD	Executive Director, WCMG Tom Linhares

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

New WCHN will combine three quality hospitals, independent physician groups, outpatient facilities and other related providers in a manner that enhances access, quality and service excellence for patients.

As noted in Question 1b., several of the benefits achieved by affiliation will enhance the quality of health care delivery. The affiliation will:

- Strengthen clinical programs to demonstrate quality outcomes and to improve access to health care, which can be done more economically with two cooperating systems rather than two stand-alone organizations.
- Enhance educational programs. This includes strengthened programs for medical students, residents and fellows in both organizations.
- Strengthen the physician platform for the delivery of primary care and specialty services.
- Build competencies required for new reimbursement models, such as population health management, bundled payments, PHOs and ACOs.

<u>Strengthen Clinical Programs and Improve Access</u>

Integration will enable the combined entity to build on the existing strengths and capabilities of its hospital partners. The affiliation will work to improve clinical programs by strengthening the clinical platform so that physicians can succeed, and establishing quality standards to produce best practice outcomes across the single new network. In a larger network, it will be possible to attract the needed physicians in order to provide greater access to those requiring health care services. Access within one system of care for the residents living in the services area of the new network will provide patients with greater continuity of care.

Both organizations seek to develop and grow primary and subspecialty care in order to provide improved access to clinical services focused on quality and value. New WCHN will allow for improved access to primary care in outpatient facilities. Subspecialty care will be improved through collaboration and cooperation between the two organizations.

Enhance Educational Programs

Medical education and research capabilities will be enhanced with two teaching organizations developing a single, coordinated education program for tomorrow's workforce of physicians, nurses, technicians and others. A larger network will offer more opportunity for professional growth and development. The existing biomedical research laboratory at WCHN will be available to both organizations as we strive to answer questions about challenging diseases and tailor genomic therapies and unique solutions to medicine.

Both organizations offer select Graduate Medical Education (GME) programs with over 160 combined residents and fellows, and both maintain strategic educational relationships. Together our combined entity can achieve an educational platform with more breadth and depth than either organization can achieve on its own. Integration enhances the stature of the programs, and improves the quality of educational services throughout the system.

Strengthen Physician Platform

The proposed integration of the two systems creates a larger physician platform that positions the unified system to deepen its primary care base for improved patient access in addition to building specific clinical programs. Currently, both systems include physician groups that offer primary care, medical sub-specialty services and surgical sub-specialty services.

Independently each organization may consider some limited expansion in their respective communities but will do so gradually. The affiliation will provide the scale and resources to invest more quickly to expand primary care access. New WCHN will focus on areas that can be served through collaborative development of access/services. We will also be able to explore diverse care delivery models such as medical homes, open access primary care or urgent care. Affiliation of the two systems should allow New WCHN to more effectively recruit PCP's and specialists.

Build Competencies for New Reimbursement Models

Building competencies for managing care in a new reimbursement environment, and facilitating our movement toward value-based reimbursement models can be achieved collectively through integration. The investments and capabilities required for population health management can be shared. The new network values health education for patients, and will develop the infrastructure for population health management, focusing on wellness, prevention and management of chronic disease in the lowest cost, clinically

appropriate setting. This is an area that will benefit from collaboration to produce the most effective means of reaching patients.

In addition, combined scale and resources better positions the organization to participate in risk contracts, share infrastructure investments and operating costs. A larger managed population increases predictability of costs. A larger employee base allows the system to pilot new models of care.

Clinical integration requires joint hospital-physician infrastructure for new information technology ("IT"). This is the single most expensive and resource-intensive implementation required. However, this is a critical part of the plan to provide high quality care to patients, and also a way to avoid duplicative medical treatment, which will play a large role in reducing the cost of health care.

WCHN has been working for a number of years building a health information exchange ("HIE"), known as HealthLink, that allows digital information to flow from one provider to another. The patient is at the center of this multi-year, multi-million dollar endeavor that stores clinical information in a central repository. Upon the approval of this affiliation, NHSC will be able to combine their efforts with work already accomplished by WCHN, bringing new independent practitioners into the information exchange for the benefit of their patients, while reducing duplicative efforts.

3. Organizational and Financial Information

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

Both Applicants are corporations.

Does the Applicant have non-profit status?
☒ Yes (Provide documentation) ☐ No

Both Applicants are non profit tax-exempt entities. (*See* Exhibit K)

b. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

The hospital licenses are attached as Exhibit L.

c. 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.)**

NHSC and WCHN have filed their most recently completed fiscal year audited statements with OHCA.

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

Table 4: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$0
Imaging Equipment Purchase	$0
Non-Medical Equipment Purchase	$0
Land/Building Purchase *	$0
Construction/Renovation **	$0
Other Non-Construction (Specify)	$0
Total Capital Expenditure (TCE)	**$0**
Medical Equipment Lease (Fair Market Value) ***	$0
Imaging Equipment Lease (Fair Market Value) ***	$0
Non-Medical Equipment Lease (Fair Market Value) ***	$0
Fair Market Value of Space ***	N/A
Total Capital Cost (TCC)	**$0**
Total Project Cost (TCE + TCC)	**$0**
Capitalized Financing Costs (Informational Purpose Only)	$0
Total Capital Expenditure with Cap. Fin. Costs	$0

*** 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.

d. 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 and funds received to date; letter of interest or approval from a lending institution.

Not Applicable.

e. Demonstrate how this proposal will affect the financial strength of the state's health care system.

In an era of healthcare reform and diminishing resources, the NHSC-WCHN proposed affiliation is consistent with the goals of Department of Public Health's Statewide Health Care Facilities and Services Plan ("the Plan"). The guiding goal of the Plan is to "improve the health of Connecticut residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services". (*See* Exhibit D, The Plan, p. 2, Sec. 1.4).

This proposal will drive down the cost of delivery of healthcare through shared resources, volume purchasing and integrated operations. The goal is to provide the highest quality care at the lowest cost possible, in the most appropriate setting. As an affiliated system, it will achieve greater efficiencies in the delivery of health care due to savings from purchasing power of a larger network.

Integration will support strategic cost management by enabling the combined entity to centralize and standardize non-patient facing functions, and to more effectively use resources. Administrative functions will be centralized in select areas and the cost of IT development and implementation will be shared throughout the system.

WCHN has a proven record of success in achieving significant cost savings and clinical integration through its integration between Danbury and New Milford hospitals. In the affiliation decision (OHCA Final Decision, Docket No. 10-31560-CON, 9/29/19, p.21) OHCA found that "the affiliation would improve the quality, accessibility and cost effectiveness of the health care delivery in the region". In FY 2012, $7.05 M savings were realized through streamlined operational functions and implementation of processes supporting a single standard of care. Highlights include implementation of clinical practice standards across sites of care, organizational realignment of clinical and support departments (i.e. laboratory, radiology, infection control, IT, marketing, finance, foundation, compliance, coding, human resources, pharmacy, supply chain, volunteer services) and implementation of a common benefits platform and uniform Human Resource P&P.

Currently, WCHN and NHSC are each financially stable organizations. Together, both systems become stronger financially because their combined resources and efficiencies will provide improved operating performance.

The financial strength of the state's health care system is directly related to the strength of its providers. As the state and federal governments lower the rate of reimbursement for the large number of patients covered by government plans, it will be up to the providers to deliver quality, accessible, health care. Collaboration and affiliation between health networks to share resources and lower costs is one step closer toward to ensuring the financial strength of the state's health care system.

4. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 4a: WCHN Patient Population Mix

	Current FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Medicare*	44.9%	44.9%	44.9%	44.9%	44.9%
Medicaid*	16.6%	16.6%	16.6%	16.6%	16.6%
CHAMPUS & TriCare	0.2%	0.2%	0.2%	0.2%	0.2%
Total Government	**61.6%**	**61.6%**	**61.6%**	**61.6%**	**61.6%**
Commercial Insurers*	36.7%	36.7%	36.7%	36.7%	36.7%
Uninsured	1.2%	1.2%	1.2%	1.2%	1.2%
Workers Compensation	0.5%	0.5%	0.5%	0.5%	0.5%
Total Non-Government	**38.4%**	**38.4%**	**38.4%**	**38.4%**	**38.4%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

Table 4b: Norwalk Hospital Patient Population Mix

	Current FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Medicare*	41.0%	41.0%	41.0%	41.0%	41.0%
Medicaid*	20.0%	20.0%	20.0%	20.0%	20.0%
CHAMPUS & TriCare	0.1%	0.1%	0.1%	0.1%	0.1%
Total Government	**61.1%**	**61.1%**	**61.1%**	**61.1%**	**61.1%**
Commercial Insurers*	36.8%	36.8%	36.8%	36.8%	36.8%
Uninsured	1.8%	1.8%	1.8%	1.8%	1.8%
Workers Compensation	0.3%	0.3%	0.3%	0.3%	0.3%
Total Non-Government	**38.9%**	**38.9%**	**38.9%**	**38.9%**	**38.9%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

* Includes managed care activity.
** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 4c: With CON Consolidated WCHN Patient Population Mix

	FY 2014	FY 2015	FY 2016
Medicare*	43.3%	43.3%	43.3%
Medicaid*	18.0%	18.0%	18.0%
CHAMPUS & TriCare	0.2%	0.2%	0.2%
Total Government	**61.4%**	**61.4%**	**61.4%**
Commercial Insurers*	36.7%	36.7%	36.7%
Uninsured	1.4%	1.4%	1.4%
Workers Compensation	0.4%	0.4%	0.4%
Total Non-Government	**38.6%**	**38.6%**	**38.6%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**

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

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

The patient population mix is based on the inpatient volume at Norwalk Hospital and at WCHN (Danbury Hospital and New Milford Hospital). The consolidated entity would start in FY 2014. The patient population mix has been stable, so we do not expect the patient population mix to change as a result of the proposal.

5. 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 M for Financial Attachment I.

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

See Exhibit N for the assumptions used in Financial Attachment I.

c. Identify the entity that will be billing for the proposed service(s).

There will be no changes in billing as a result of this proposal. Each Applicant will continue to bill as a provider of current services.

d. 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 as a result of this proposal.

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

Not applicable.

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 are no losses associated with this proposal.

g. Describe how this proposal is cost effective

This proposal is cost effective because integration of WCHN and NHSC into a new organization will eliminate unnecessary duplication by enabling the combined entity to centralize and standardize non-patient functions to more effectively use the collective resources. Cost savings will be realized by:

- Centralization of roles and functions will enable cost savings primarily in non-clinical, administrative and managerial roles
- Standardization of policies and processes will create additional efficiencies even in some areas that remain hospital specific to reduce costs in local communities
- Scale provides the opportunity to achieve savings on purchased goods and services, including clinical and non-clinical supplies, physician preference items, drugs and external service contracts
- Scale supports more effective use of existing in-house resources, reducing reliance on external services

NHSC and WCHN recognize their continued viability rests, in part, on the vision that is developed today to provide for the health care needs of tomorrow. Our shared vision for the new WCHN is to improve the community's health by delivering cost-effective, coordinated care across the continuum.

Table of Exhibits

Exhibit	Description
A	Affiliation Agreement By and Between Norwalk Health Services Corporation and Western Connecticut Health Network, Inc., January 22, 2013
B	List of WCHN Affiliates
C	List of NHSC Affiliates
D	CT Department of Public Health, Office of Health Care Access, Statewide Health Care Facilities and Services Plan, October 2012, pages 2, 7
E	Letter of Intent for Corporate Affiliation Between Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation, April 3, 2012 and Summary of Terms dated September 18, 2012 (collectively "LOI")
F	Western Connecticut Health Network, Special Meeting of the Board of Directors, January 18, 2013
G	NHSC Board Minutes and Resolutions: January 8, 2013 and January 21, 2013
H	Norwalk Health Services Corporation Service Area Demographic Information
I	Corporate Organizational Structure for NHSC and WCHN Pre-Closing and Post-Closing
J	Curriculum Vitae for NHSC and WCHN
K	Letters Verifying Proof of Tax Exemption for NHSC and WCHN and Affiliated Entities
L	Hospital Licenses for Norwalk Hospital, Danbury Hospital and New Milford Hospital
M	Financial Attachment I
N	Financial Assumptions

Exhibit A

AFFILIATION AGREEMENT BY AND BETWEEN NORWALK HEALTH SERVICES CORPORATION AND WESTERN CONNECTICUT HEALTH NETWORK, INC.

This Affiliation Agreement (the "Agreement") is entered into as of this 22nd day of January, 2013 between Norwalk Health Services Corporation, a Connecticut nonprofit corporation ("NHSC") and Western Connecticut Health Network, Inc., a Connecticut nonprofit corporation ("WCHN"). Each of NHSC and WCHN 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 9.

WHEREAS, by entering into the proposed affiliation described in this Agreement (the "Affiliation"), the Parties intend to create an integrated health care delivery system (the "System") capable of bringing best practices in health care delivery to enhance the health and well-being of residents within the geographic areas served by the Parties;

WHEREAS, the Parties believe that the Affiliation will improve the health of the communities served by WCHN and NHSC by delivering coordinated, effective care;

WHEREAS, NHSC controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, The Norwalk Hospital Association ("NHA") and Norwalk Hospital Foundation, Inc. ("NHSCF") and other subsidiaries and affiliates listed on Schedule 1(a) (collectively, NHA, NHSCF and such other subsidiaries and affiliates of NHSC may be referred to herein as the "NHSC Affiliates" and the NHSC Affiliates, with NHSC, may be referred to herein as the "NHSC Entities");

WHEREAS, NHA owns and operates Norwalk Hospital;

WHEREAS, WCHN controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, The Danbury Hospital ("Danbury Hospital"), New Milford Hospital, Inc. ("New Milford Hospital"), Western Connecticut Home Care, Inc. and other subsidiaries and affiliates listed on Schedule 1(b) (collectively, Danbury Hospital, New Milford Hospital, Western Connecticut Home Care, Inc. and such other subsidiaries and affiliates of WCHN may be referred to herein as the "WCHN Affiliates" and the WCHN Affiliates, with WCHN, may be referred to herein as the "WCHN Entities" or the "WCHN System"); and

WHEREAS, on April 3, 2012, WCHN and NHSC executed a Letter of Intent for Corporate Affiliation (the "Letter of Intent") confirming their understanding with respect to a proposed affiliation and a Summary of Terms dated September 18, 2012 (the "Summary of Terms"), superseding the Letter of Intent in its entirety except with respect to Sections 5, 6 and 7 (the Letter of Intent and the Summary of Terms collectively referred to herein as the "Letter of Intent");

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.

(a) WCHN Actions. Prior to the execution of this Agreement, the board of directors of WCHN (the "WCHN Board") will have 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 4, an Amended and Restated Certificate of Incorporation of WCHN substantially in the form set forth in Exhibit A-1 and the Amended and Restated Bylaws of WCHN substantially in the form set forth in Exhibit B-1 (the "WCHN Restated Governing Documents"). At or prior to Closing, WCHN will cause Danbury Hospital and New Milford Hospital to amend and restate their governing documents to make them consistent with the terms of the Affiliation, in forms mutually agreeable to the Parties (such amended and restated governing documents may be referred to herein as the "Danbury and New Milford Restated Governing Documents").

(b) NHSC Actions. Prior to the execution of this Agreement, the board of trustees of NHSC (the "NHSC Board") will have 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 4, an Amended and Restated Certificate of Incorporation of NHSC substantially in the form set forth in Exhibit A-2 and Amended and Restated Bylaws of NHSC substantially in the form set forth in Exhibit B-2 (the "NHSC Restated Governing Documents"). At or prior to Closing, NHSC will cause all NHSC Affiliates to amend and restate their governing documents to make them consistent with the terms of the Affiliation, in forms mutually agreeable to the Parties (such amended and restated governing documents may be referred to herein as the "NHSC Affiliates Restated Governing Documents").

(c) NHA Actions. Prior to the execution of this Agreement, the board of trustees of NHA (the "NHA Board") and, to the extent required, the NHSC Board will have taken all necessary actions to approve and adopt, effective as of the Effective Date, an Amended and Restated Certificate of Incorporation of NHA substantially in the form set forth in Exhibit A-3 and Amended and Restated Bylaws of NHA substantially in the form set forth in Exhibit B-3 (the "NHA Restated Governing Documents").

(d) Organizational Charts. Attached as Exhibit C are schematics showing the relevant pre-Closing and post-Closing organizational structure of the Affiliation.

1.2 Closing Memorandum. Upon satisfaction or waiver of all of the conditions precedent set forth in Section 4 and unless this Agreement is earlier terminated pursuant to Section 5, the respective Presidents of WCHN and NHSC will execute a written memorandum (the "Closing Memorandum") which will 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, that the Closing will occur on such date ("Closing Date") and setting forth certain other matters as specified herein. The Closing will occur at Norwalk Hospital at 34 Maple Street Norwalk, Connecticut. 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").

2. **Initial Governance Structure**. Beginning at the Closing Date and ending upon the occurrence of one of the events set forth in Section 2.1(g) (the "Initial Period"), the governance structure of the Affiliation ("Initial Governance Structure") will be as follows, and as set forth in the WCHN Restated Governing Documents, NHSC Restated Governing Documents, NHA Restated Governing Documents, Danbury and New Milford Restated Governing Documents and the NHSC Affiliates Restated Governing Documents:

2.1 WCHN Board.

(a) WCHN Board Size. The WCHN Board will have eighteen (18) directors.

(b) WCHN Board Composition. At the Closing Date, the WCHN Board will include seven (7) voting members who were members of the NHSC Board immediately prior to the Closing Date (the "Initial NHSC Designees") and the remaining eleven (11) WCHN Board members will be individuals who served as members of the WCHN Board immediately prior to the Closing Date (the "Initial WCHN Designees"). Prior to the Closing Date, the Parties will mutually agree upon the individuals who will serve as the Initial NHSC Designees and Initial WCHN Designees (the "Initial WCHN Directors") and shall submit the names of such individuals to the members of WCHN for election of such slate of directors effective as of the Closing Date.

(i) The Initial WCHN Directors will serve for staggered terms as set forth in Section 3.3 of the Amended and Restated Bylaws of WCHN and as mutually agreed by the Parties prior to the Closing Date. The Initial WCHN Directors shall be subject to the term limits set forth in Section 3.4 of the Amended and Restated Bylaws of WCHN and as mutually agreed by the Parties prior to the Closing Date.

(ii) During the Initial Period, in the event of a vacancy among the Initial NHSC Designees or the Initial WCHN Designees, such vacancy will be filled by majority vote of the NHA Board (with respect to the Initial NHSC Designees) or the boards of directors of Danbury Hospital and New Milford Hospital (the "WCHN Hospital Boards") (with respect to the Initial WCHN Designees), subject in each case to approval by WCHN. In the event WCHN declines to elect any candidate, the NHA Board or WCHN Hospital Boards, as applicable, will designate one (1) or more new candidates until agreement is reached, provided, however, that if the Board declines to elect two (2) candidates proposed to fill the same vacancy, the Board may only decline to elect the third candidate proposed if the Board declines such candidate based on a Super-majority Vote (as defined below). The individuals serving as Initial WCHN Designees (together with such changes as may be made pursuant to this Section 2.1(b)(ii) with respect to vacancies) are referred to herein as the "WCHN Designees." The individuals serving as Initial NHSC Designees (together with such changes as may be made pursuant to this Section 2.1(b)(ii) with respect to vacancies) are referred to herein as the "NHSC Designees."

[redacted]

(c) WCHN Board Officers. Prior to the Closing Date, the Parties shall mutually agree on the officers of the WCHN Board to be effective as of the Closing Date. For the period beginning on the Closing Date and ending on the third annual meeting of the WCHN Board after the Closing Date (the "Third Annual Meeting"), the WCHN Board Chair will be an NHSC Designee elected by the WCHN Board and the WCHN Board Vice-Chair will be a WCHN Designee elected by the WCHN Board. For the following two-year term after the Third Annual Meeting date, the WCHN Board Chair will be a WCHN Designee elected by the WCHN Board and the WCHN Board Vice-Chair will be an NHSC Designee elected by the WCHN Board.

(d) Committees. During the Initial Period, any NHSC Board member serving on the NHSC Board immediately prior to the Closing Date who is not an Initial NHSC Designee to the WCHN Board will be provided an opportunity to serve on a WCHN Board committee or on the board of a WCHN Entity, and all such individuals will be eligible to become members of WCHN. To the extent permitted by applicable law, the same individuals will serve on board committees of WCHN, NHA, Danbury Hospital and New Milford Hospital; provided, however, that the medical staff, nominating and budget and finance committees will be maintained at the local level. [redacted] Committee assignments and chairmanships will be set forth on a schedule to the Closing Memorandum.

(e) Danbury Hospital and New Milford Hospital. At the Closing Date, the WCHN Hospital Boards will be comprised of those individuals serving as the Initial WCHN Designees. [redacted]

(f) Major WCHN Board Actions. As sole corporate member of NHSC, WCHN will have certain powers as set forth in the NHSC Restated Governing Documents and as set forth in the NHA Restated Governing Documents. In addition, during the Initial Period, certain WCHN Board actions (whether an affirmative power of the WCHN Board or a "Reserved Power" with respect to NHSC, as defined in the WCHN Restated Governing Documents and NHSC Restated Governing Documents) will require a super-majority vote of the WCHN Board, defined for this purpose as the affirmative votes of two-thirds of all of the WCHN Board members then serving (a "Super-majority Vote"). Thus, assuming eighteen (18) directors are currently serving, the vote of at least twelve (12) of the eighteen (18) directors (which would include at least one of the NHSC Designees) shall be required to satisfy the requirement for a Super-majority Vote. In the event of any vacancy of the NHSC Designees during the Initial Period, a Super-majority Vote will be deemed to require the affirmative vote of at least one of the NHSC Designees.

(g) Conclusion of the Initial Period. The Initial Governance Structure will continue in effect unless and until changed following the occurrence of any one of the following events:

[redacted]

(iv) NHSC Board. Except as expressly provided herein, the following provisions apply effective as of the Closing Date and shall continue through the Initial Period:

(h) WCHN as the Sole Member. Until modified in accordance with Section 6.7, WCHN will be the sole corporate member of NHSC and NHSC will continue as the sole corporate member of NHA.

(i) NHSC Board Composition. The NHSC Board will be initially comprised of the individuals serving in such capacity immediately prior to the Closing Date and shall include all of the NHSC Designees and thereafter will be comprised of individuals elected in accordance with the NHSC Restated Governing Documents. In addition, the WCHN President and Chief Executive Officer and at least one additional WCHN Designee will also become members of the NHSC Board commencing as of the Closing Date. The NHSC/NHA President and Chief Executive Officer and the NHSCF President and Chief Executive Officer will be *ex-officio* voting members of the NHSC Board. After the Closing, the NHSC Board will be elected by WCHN in accordance with the NHSC Restated Governing Documents.

(j) NHSC Board Powers. The NHSC Board, acting for NHSC as the sole corporate member of NHA, also shall have the powers set forth in the NHA Restated Governing Documents, subject to the Reserved Powers and compliance with WCHN System policies as set forth in Section 6.4(a). The NHSC Board will have all of the powers and authority granted to a board under the Act subject only to the Reserved Powers granted to its sole member, WCHN, pursuant to the NHSC Restated Governing Documents and WCHN System Policies as set forth in Section 6.4(a).

(k) Reserved Powers. Certain decisions, which will initially be made by the NHSC Board, shall be subject to approval by WCHN (the "Reserved Powers") as set forth in the NHSC Restated Governing Documents.

2.2 NHA Board. Except as expressly provided herein, the following provisions apply effective as of the Closing Date and shall continue through the Initial Period:

(a) NHSC as the Sole Member. Until modified in accordance with Section 6.7, NHSC will continue as the sole corporate member of NHA.

WCHN will exercise "reach through" rights, such that any NHA actions requiring member approval under the NHA Restated Governing Documents shall not be deemed approved until such time as NHA receives approval from both NHSC and WCHN, as the sole corporate member of NHSC.

(b) NHA Board Composition. The NHA Board will initially be comprised of the members of the NHSC Board in office immediately prior to the Closing Date. The NHSC/NHA President and Chief Executive Officer and the NHSCF President and Chief Executive Officer will be members of the NHA Board.

3. **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:

3.1 Commercially Reasonable, Good Faith Efforts. Each Party will 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 4 to be satisfied.

3.2 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 Material Transaction (without the approval of the other Party). Neither the WCHN Entities nor the NHSC Entities will amend or permit to be amended the certificates of incorporation or the bylaws of any of such entities, other than as described in Section 4.1.

3.3 Conduct of Business. Each Party will 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.

(a) Without limiting the generality of the foregoing, no NHSC Entity will take any of the following actions without the prior written consent of WCHN, which will 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. Without the prior approval of WCHN, the NHSC Entities will not transfer assets to any entity other than the NHSC Entities that is not in the usual, regular and ordinary course of business as set forth in the NHSC Entities' fiscal year 2013 capital and operating budgets and consistent with past practice.

(b) Without limiting the generality of the foregoing, no WCHN Entity will take any of the following actions without the prior written consent of NHSC, which will 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. Without the prior approval of NHSC, the WCHN Entities will not transfer assets to any entity other than the WCHN Entities that is not in the usual, regular and ordinary course of business as set forth in the WCHN Entities' fiscal year 2013 capital and operating budgets and consistent with past practice.

3.4 Public Statements. Except as may be required by applicable laws or as otherwise contemplated herein, none of the WCHN Entities or NHSC 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 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.

3.5 Communications with Government Officials. Unless the Parties otherwise agree in writing after the execution of this Agreement, the Parties will communicate jointly with government officials with respect to the Affiliation and will work together to develop a plan for coordinated communications by the Parties and by other WCHN Entities and other NHSC Entities. From the 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 WCHN Entities or the NHSC Entities will, 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, the WCHN Entities and the NHSC Entities will 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.

3.6 Additional Diligence Information. Pursuant to the Letter of Intent, WCHN and NHSC furnished each other with certain requested information in order to permit each of the Parties to perform a due diligence analysis of the Affiliation (the "Due Diligence Information"). From the date of this Agreement through the Effective Date, (i) each Party will disclose to the other Party any information known to the disclosing 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) NHSC will provide to WCHN, on a monthly basis, a financial information packet on the financial condition of the NHSC Entities in the same form provided to the NHSC Board and WCHN will provide to NHSC, on a monthly basis, a financial information packet on the financial condition of the WCHN Entities in the same form provided to the WCHN Board; (iii) NHSC will provide to WCHN a copy of each Medicare cost report filed by a NHSC Entity after the date hereof within five (5) days of such filing and WCHN will provide to NHSC a copy of each Medicare cost report filed by a WCHN Entity after

the date hereof within five (5) days of such filing; and (iv) NHSC will provide to WCHN and WCHN will provide to NHSC 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.

4. **Conditions Precedent**. The Affiliation will not occur until each of the following conditions is satisfied or waived by the Party it is intended to benefit:

4.1 Organizational Documents.

(a) WCHN. The WCHN Board (and if necessary, the members of WCHN) will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the WCHN Restated Governing Documents and caused Danbury Hospital and New Milford Hospital to approve and adopt the Danbury and New Milford Restated Governing Documents.

(b) NHSC. The NHSC Board will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the NHSC Restated Governing Documents and caused the NHSC Affiliates to approve and adopt the NHSC Affiliates Restated Governing Documents.

(c) NHA. The NHA Board (and, if necessary, NHSC) will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the NHA Restated Governing Documents.

4.2 Hart-Scott-Rodino. The applicable waiting period under the Hart-Scott-Rodino Act amendments to the Antitrust Improvement Act will 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 will have been resolved to the reasonable satisfaction of each of WCHN and NHSC.

4.3 Attorney General. The Attorney General of the State of Connecticut (the "Attorney General") will not have challenged the implementation of the Affiliation, or if the Attorney General initiates a challenge, the matter will have been resolved to the reasonable satisfaction of each of WCHN and NHSC.

4.4 Government Approvals and Filings. Each Party will have made the necessary filings with governmental or regulatory authorities and will have received the governmental permits, licenses, or other approvals in each case described on Schedule 4.4 (other than filings described on Schedule 4.4 as post-Closing filings), which will not be subject to any conditions, limitations or other terms not reasonably acceptable to the Parties.

4.5 Non-Governmental Consents. Each Party will have obtained and delivered to the other Party the consents from non-governmental third parties described on Schedule 4.5, which will not be subject to any conditions, limitations or other terms that would result or be reasonably likely to result in a NHSC Material Adverse Effect or WCHN Material Adverse Effect.

4.6 No Investigation or Enforcement Action. The implementation of the Affiliation will 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 will not be implemented without the agreement of each of WCHN and NHSC.

4.7 Compliance with Interim Covenants. Each Party will have determined in its sole discretion that the other Party has complied with the terms of Section 3.

4.8 No Material Adverse Effect. Unless waived by NHSC, between the date of this Agreement and the Closing Date, a WCHN Material Adverse Effect will not have occurred. Unless waived by WCHN, between the date of this Agreement and the Closing Date, an NHSC Material Adverse Effect will not have occurred.

4.9 Representations and Warranties. Unless waived by NHSC, all representations and warranties made by WCHN in Section 7 will be true, accurate, and complete in all material respects as of the Closing Date. Unless waived by WCHN, all representations and warranties made by NHSC in Section 7 will be true, accurate, and complete in all material respects as of the Closing Date.

[redacted]

4.11 WCHN Member Approval. The members of WCHN shall have approved the Initial NHSC Designees and Initial WCHN Designees.

4.12 Revisions to Restated Governing Documents. The Parties shall cause the WCHN Restated Governing Documents, the NHA Restated Governing Documents and the NHSC Restated Governing Documents to be revised substantially as described in Schedule 4.12 attached hereto and made a part hereof.

5. Termination Of Agreement.

5.1 Term. This Agreement will 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 September 30, 2013 absent mutual written consent by the Parties to extend the term. The term of the Agreement shall be perpetual unless terminated as provided herein.

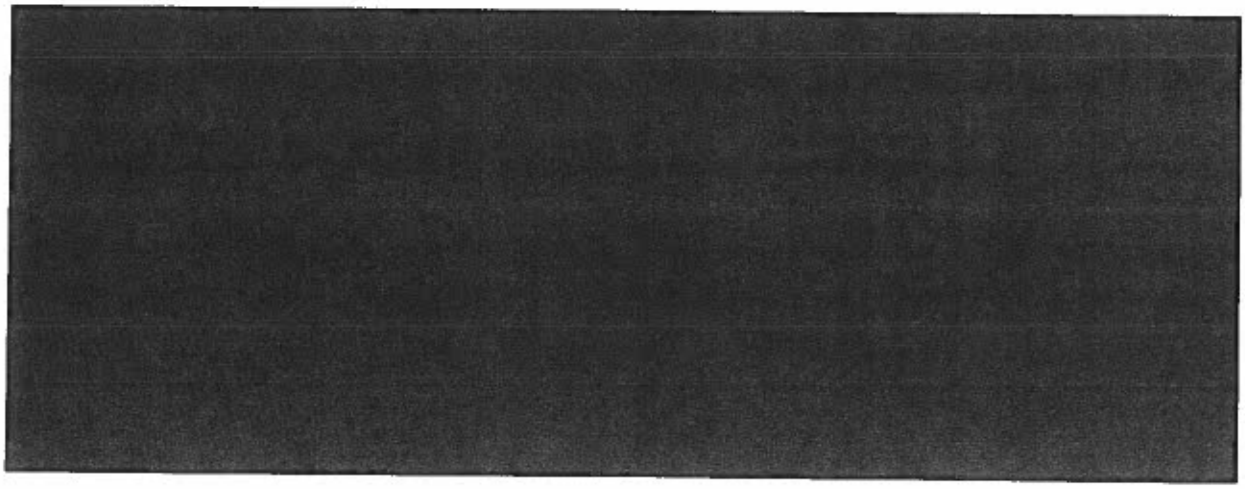
5.2 Termination by Mutual Written Consent. This Agreement may be terminated prior to the Closing Date by the mutual written consent of the Parties.

5.3 Termination by Material Adverse Event. This Agreement shall terminate on ten (10) days' prior written notice from WCHN or NHSC respectively in the event that an NHSC Material Adverse Event occurs that is not waived by WCHN or a WCHN Material Adverse Event occurs that is not waived by NHSC.

5.4 Survival. In the event of termination pursuant to Section 5.1, Section 5.2 or Section 5.3, all rights and obligations under the Agreement will cease and the terms and provisions of the Agreement will have no further effect, except that Section 3.4 [Public Statements] and Section 8.4 [Confidentiality] will 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 2 [Initial Governance Structure], Section 6 [Post-Closing Covenants] and Section 8 [Miscellaneous] will survive beyond the Closing Date. Protections provided under the Mutual Confidentiality Agreement by and between NHSC and WCHN dated as of September 16, 2011 with respect to communications and all information exchanged during the term of such Mutual Confidentiality Agreement will survive the termination of this Agreement.

6. **Post-Closing Covenants**. From and after the Closing Date, the Parties will take the following actions and observe the following covenants:

6.1 Oversight of Business. Immediately following the Closing Date, WCHN and NHSC will each retain full power and authority to oversee such Party's business; provided, however, that the authority to oversee the business of the NHSC Entities will be subject to the Reserved Powers of WCHN and further provided that each Party shall have the obligations, duties and requirements applicable to such Party after the Closing Date as set forth in this Agreement.

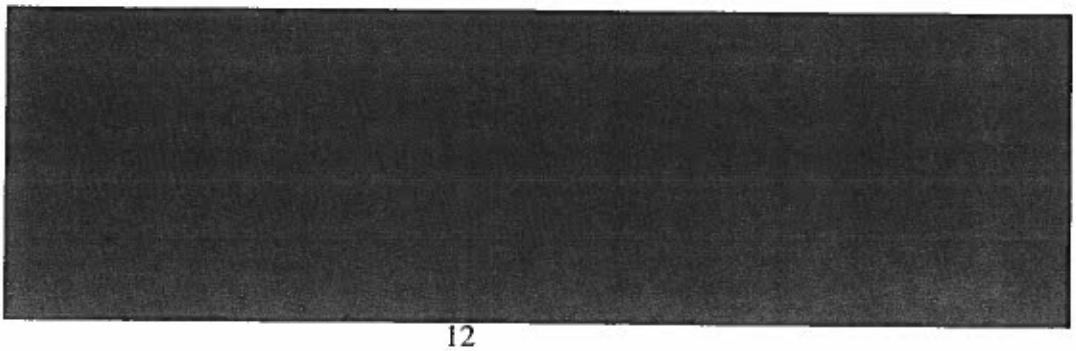


6.3 Executive Compensation. The WCHN Board Executive Compensation Committee, or such other committee as may be appointed by the WCHN Board, will review and establish executive compensation in accordance with applicable law.

6.4 Operation of NHSC Affiliates.

(a) Operation in Accordance with WCHN Policies. Subject to the provisions of this Agreement, the NHSC Restated Governing Documents, applicable law, and any terms and conditions of loan agreements, trust indentures, and any binding third party agreements existing prior to the Closing Date, the NHSC Entities will operate in accordance with the rights, obligations, duties, and requirements applicable to all WCHN Entities, as such rights, obligations, duties and requirements are from time to time established by WCHN, and applied from time to time to all WCHN Entities. Prior to the Closing Date, WCHN and NHSC shall agree on a schedule of policies, procedures and practices that will be binding on all parties ("System Policies") and other policies that may be maintained by any one or more of the Hospitals with such changes as may be adopted from time to time, and as are not inconsistent with the governance rights expressly set forth in the NHSC Restated Governing Documents and any new policies required by law or accrediting standards. It is understood that in the event any contract entered into by any of the WCHN Entities or the NHSC Entities after the Closing Date is in compliance with System Policies, but a subsequent change in System Policies is in conflict with such contract, the WCHN Entities or the NHSC Entities, as applicable, shall take commercially reasonable steps to unwind such non-compliant contract as soon as practicable. WCHN will have, in its sole discretion, the right to change or alter at any time the System Policies as applied to all WCHN Entities and NHSC Entities; provided that no System Policies adopted after the Closing Date that apply to any NHSC Entities shall be inconsistent with the governance rights expressly set forth in this Agreement and the NHSC Restated Governing Documents (unless required by law or accreditation standards).

(b) Medicare Form 855A. After the Closing Date, each NHSC Affiliate which is a participating provider in Medicare or Medicaid will submit a Form 855A change of information filing to its fiscal intermediary within the time frame required under applicable laws and regulations.



(d) Medical Staff. The Affiliation will not impact or change the medical staff appointment or clinical privileges of members of the medical staffs of Norwalk Hospital, Danbury Hospital or New Milford Hospital (each a "Hospital") as existing on the Closing Date. The Parties do not expect that execution of the Agreement will have any effect on the independent status of the medical staffs of any of the Hospitals. WCHN will work with the medical staffs of each Hospital 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.

6.5 Access to WCHN Insurance Programs. The NHSC Entities will have access to insurance programs offered by WCHN's insurance plans, subject to such entities' 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 such entities' eligibility for and acceptance by those programs.

[redacted]

7. **Representations and Warranties**.

7.1 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:

(a) Due Organization and Authority. The WCHN Entities and the NHSC Entities are corporations 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 each of the WCHN Entities and the NHSC Entities heretofore delivered to or made available for review by WCHN and NHSC are complete and correct, and no amendments thereto are pending or contemplated, other than as described in Section 1.1.

(b) 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 NHSC 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 A-3, Exhibit B-1, Exhibit B-2 and Exhibit B-3. No other corporate proceedings on the part of either WCHN or the NHSC 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 A-3, Exhibit B-1, Exhibit B-2 and Exhibit B-3. 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.

(c) Audited Financial Statements. WCHN has provided NHSC with the audited balance sheets and related statements of income and statements of cash flow of the WCHN Entities for the fiscal years ended September 30, 2009, 2010 and 2011, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of WCHN. NHSC has provided WCHN with the audited balance sheets and related statements of income and statements of cash flow of the NHSC Entities for the fiscal years ended September 30, 2009, 2010 and 2011, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of the NHSC 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 the WCHN Entities or the NHSC Entities, as the case may be, (ii) fairly present the financial condition and results of operations and cash flows for the WCHN Entities or the NHSC 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). None of the WCHN Entities nor any of the NHSC 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 the WCHN Entities or the NHSC 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.

(d) 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 any WCHN Entity or any NHSC Entity; (ii) result in acceleration in the time for performance of any obligation of any WCHN Entity or any NHSC Entity under any contractual obligation; (iii) result in the creation of any lien upon any asset of any WCHN Entity or any NHSC Entity; (iv) require any notice, consent, waiver or amendment to any contractual obligation; (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 WCHN Material Adverse Effect or a NHSC 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 4.4, 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 WCHN Material Adverse Effect or NHSC Material Adverse Effect, as the case may be, individually or in the aggregate, is required to be made or obtained by a WCHN Entity or a NHSC Entity, in connection with the execution, delivery or performance of this Agreement by a WCHN Entity or a NHSC Entity.

(e) Due Diligence. Each of the Parties has made due inquiry of all matters described in this Section 7 and has fully and completely disclosed to the other Party in Due Diligence Information all information relevant to such Party's representations in this Section 7.

7.2 Additional Representations and Warranties by WCHN. As a condition to NHSC's entry into this Agreement, WCHN as to itself and as to each of the WCHN Entities further

represents and warrants to NHSC that the statements set forth in this section are true and correct as of the date hereof:

(a) Legal Proceedings. Except as disclosed in Due Diligence Information:

(i) there is no potentially material incident report related to the operations or services of a WCHN 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 WCHN Entities, threatened against any WCHN Entity or against any WCHN Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such WCHN 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 WCHN Material Adverse Effect;

(ii) there is no litigation at law or in equity, or any proceeding before or, to the knowledge of a WCHN 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;

(iii) no WCHN 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 WCHN Material Adverse Effect, individually or in the aggregate;

(iv) 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 WCHN Entity; and

(v) the Due Diligence Information provided by WCHN 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 WCHN Entities, threatened against any WCHN Entity or against any WCHN Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such WCHN Entity.

(b) Compliance with Laws. Except as disclosed in Due Diligence Information,

(i) The business and operations of each WCHN 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 WCHN Material Adverse Effect, individually or in the aggregate.

(ii) 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 WCHN Entity is subject to any restriction of any kind or character, which may have a WCHN Material Adverse Effect on any WCHN Entity, individually or in the aggregate.

(iii) No WCHN 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 WCHN Material Adverse Effect.

(iv) The Due Diligence Information provided by WCHN contains complete and accurate information regarding (i) each WCHN 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 WCHN Entity or any of their respective properties.

(c) Insurance. Each WCHN 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 WCHN Entity as to amount and scope. No WCHN 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.

(d) Tax Exempt Status.

(i) Each WCHN Entity is an organization described in Section 501(c)(3) of 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.

(ii) Each WCHN 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 exist, to the extent necessary to support continued status as an organization described in Section 501(c)(3) of the Code.

(iii) No proceedings are pending with respect to which any WCHN 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.

(iv) No WCHN 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.

(v) The Due Diligence Information provided by WCHN 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 WCHN Entities.

(e) Titles, Leases, and Licenses. Except as disclosed in Due Diligence Information,

(i) Each WCHN 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 WCHN 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).

(ii) Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the WCHN Entities as now conducted. All such assets and properties, other than assets and properties in which the WCHN Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the WCHN Entities' Financial Statements or the footnotes thereto.

(iii) Each WCHN 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.

(iv) There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the WCHN Entities as now conducted that are licensed by the State of Connecticut Department of Public Health.

(f) Environmental Laws. Except as disclosed in Due Diligence Information,

(i) Each WCHN 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 WCHN Material Adverse Effect.

(ii) To the knowledge of the WCHN 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 WCHN Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs.

(iii) No WCHN 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, to the knowledge of the WCHN Entities, any investigation indicating that the WCHN 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.

(iv) No WCHN Entity has reason to believe that it will become subject to a matter identified in this Section 7.2(f); and no WCHN Entity has knowledge that any 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.

(v) No WCHN 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 WCHN Entity.

(g) Labor Unions and Collective Bargaining Agreements. Employees of WCHN Entities are currently represented only by the collective bargaining organizations listed on Schedule 7.2(g). Except in relation to the foregoing collective bargaining organizations, no WCHN 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 WCHN Entity, threatened with respect to any employees of any WCHN Entity.

(h) Employee Benefit Matters. Except as disclosed in Due Diligence Information,

(i) Multiemployer Plans. None of the WCHN Entities nor any other person that would be considered as a single employer with the WCHN 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.

(ii) Plan Qualification. Each employee benefit, welfare, pension or similar plans that any of the WCHN Entities sponsors or provides to its employees (each, a "WCHN Plan" and collectively, the "WCHN Plans") that is intended to be qualified under Section 401(a) of the Code is so qualified. Each WCHN 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 WCHN Plan that has subjected or reasonably could subject any of the WCHN Entities to any material penalty, excise tax or other material liability under ERISA or the Code.

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

(iv) Defined Benefit Pension Plans. In the case of each WCHN Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the WCHN 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 WCHN Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

(v) Claims. There is no pending or, to WCHN's knowledge, threatened action relating to a WCHN Plan, other than routine claims in the ordinary course of business for benefits provided for by the WCHN Plans. No WCHN 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.

(vi) Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no WCHN Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment (except for limited continued medical benefit coverage required to be provided under Section 4980B of the Code or as required by applicable state law).

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

(viii) Severance. The transactions contemplated by this Agreement will 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 WCHN Plan for the benefit of any current or former director, officer or employee of any of the WCHN Entities.

(ix) Diligence. Each of the WCHN Plans has been fully and completely described, with all applicable agreements and WCHN Plan documents, in the Due Diligence Information.

(i) Health Care Kickbacks. To the knowledge of WCHN after due inquiry, no WCHN 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.

(j) Prohibited Health Care Referrals. Except as disclosed in Due Diligence Information, to the knowledge of the WCHN Entities after due inquiry, no WCHN 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 who makes referrals to any WCHN Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. To the knowledge of the WCHN Entities after due inquiry, the Due Diligence Information provided by WCHN contains a complete and accurate list of all agreements between any of the WCHN Entities and referring physicians, physician organizations, other health care providers, and other referral sources. The Due Diligence Information provided by WCHN contains a full set of all such agreements between any of the WCHN Entities and referring physicians, physician organizations, other health care providers, and other referral sources which were requested by the NHSC Entities and their legal counsel. Except as disclosed in Due Diligence Information, to the knowledge of WCHN after due inquiry, none of the WCHN Entities has any arrangements with referring physicians, physician organizations, or other health care providers that are not memorialized in writing.

(k) Actions, Investigations, and Inquiries. Except as disclosed in Due Diligence Information,

(i) 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 WCHN 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 WCHN Material Adverse Effect or result in any material impairment to the right or ability of any WCHN Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs.

(ii) No WCHN 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.

(iii) The Due Diligence Information provided by WCHN 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 WCHN Entities, threatened, anticipated or contemplated against or affecting any WCHN 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).

(l) Permits.

(i) Each WCHN 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 WCHN Material Adverse Effect.

(ii) No WCHN Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of such Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of such Permits is pending or has been commenced or, to the knowledge of the WCHN Entities, threatened and no notification thereof has been received by any WCHN Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a WCHN Material Adverse Effect.

(iii) The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties will not limit, restrict, revoke, suspend or terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of such Permits.

(m) Medicare Cost Reports. The WCHN Entities have made available to NHSC true, correct and complete copies of their Medicare cost reports filed for the following years: 2009, 2010, and 2011. The status of all Medicare and

Medicaid cost reports of the WCHN Entities for the last two (2) cost-reporting years has been disclosed in the Due Diligence Information provided by WCHN, and there are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open such cost reports that would have a WCHN Material Adverse Effect.

7.3 Additional Representations and Warranties by NHSC. As a condition to WCHN's entry into this Agreement, NHSC as to itself and as to each of the NHSC Affiliates further represents and warrants to WCHN that the statements set forth in this section are true and correct as of the date hereof:

(a) Legal Proceedings. Except as disclosed in Due Diligence Information,

(i) There is no potentially material incident report related to the operations or services of a NHSC 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 NHSC Entities, threatened against any NHSC Entity or against any NHSC Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such NHSC 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 NHSC Material Adverse Effect.

(ii) There is no litigation at law or in equity, or any proceeding before or, to the knowledge of a NHSC 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.

(iii) No NHSC 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 NHSC Material Adverse Effect, individually or in the aggregate.

(iv) 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 NHSC Entity.

(v) The Due Diligence Information provided by NHSC 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 NHSC Entities, threatened against any NHSC Entity or against any NHSC Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such NHSC Entity.

(b) Compliance with Laws. Except as disclosed in Due Diligence Information,

(i) The business and operations of each NHSC 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 NHSC Material Adverse Effect, individually or in the aggregate.

(ii) 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 NHSC Entity is subject to any restriction of any kind or character, which may have a NHSC Material Adverse Effect on any NHSC Entity, individually or in the aggregate.

(iii) No NHSC 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 NHSC Material Adverse Effect.

(iv) The Due Diligence Information provided by NHSC contains complete and accurate information regarding (i) each NHSC 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 NHSC Entity or any of their respective properties.

(c) Insurance. Each NHSC 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 NHSC Entity as to amount and scope. No NHSC 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.

(d) Tax Exempt Status.

(i) Each NHSC 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.

(ii) Each NHSC 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 exist, to the extent necessary to support continued status as an organization described in Section 501(c)(3) of the Code.

(iii) No proceedings are pending with respect to which any NHSC 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.

(iv) No NHSC 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.

(v) The Due Diligence Information provided by NHSC 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 NHSC Entities.

(e) Titles, Leases, and Licenses. Except as disclosed in Due Diligence Information,

(i) Each NHSC 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 NHSC 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).

(ii) Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the NHSC Entities as now conducted. All such assets and properties, other than assets and properties in which the NHSC Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the NHSC Entities' Financial Statements or the footnotes thereto.

(iii) Each NHSC 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.

(iv) There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the NHSC Entities as now conducted that are licensed by the State of Connecticut Department of Public Health.

(f) Environmental Laws. Except as disclosed in Due Diligence Information,

(i) Each NHSC 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 NHSC Material Adverse Effect.

(ii) To the knowledge of the NHSC 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 NHSC Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs.

(iii) No NHSC 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, to the knowledge of the NHSC Entities, any investigation indicating that the NHSC 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.

(iv) No NHSC Entity has reason to believe that it will become subject to a matter identified in this Section 7.3(f); and no NHSC Entity has knowledge that any 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.

(v) No NHSC 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 NHSC Entity.

(g) Labor Unions and Collective Bargaining Agreements. Employees of NHSC Entities are currently represented only by the collective bargaining organizations listed on Schedule 7.3(g). Except in relation to the foregoing collective bargaining organizations, no NHSC 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. Except as set forth in Schedule 7.3(g), there is no strike or other work stoppage currently in effect or, to the knowledge of any NHSC Entity, threatened with respect to any employees of any NHSC Entity.

(h) Employee Benefit Matters. Except as disclosed in Due Diligence Information,

(i) Multiemployer Plans. None of the NHSC Entities nor any other person that would be considered as a single employer with the NHSC 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.

(ii) Plan Qualification. Each employee benefit, welfare, pension or similar plans that any of the NHSC Entities sponsors or provides to its employees (each, a "NHSC Plan" and collectively, the "NHSC Plans") that is intended to be qualified under Section 401(a) of the Code is so qualified. Each NHSC 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 NHSC Plan that has subjected or could subject any of the NHSC Entities to any material penalty, excise tax or other liability under ERISA or the Code.

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

(iv) Defined Benefit Pension Plans. In the case of each NHSC Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the NHSC 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 NHSC Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

(v) Claims. There is no pending or, to NHSC's knowledge, threatened action relating to a NHSC Plan, other than routine claims in the ordinary course of business for benefits provided for by the NHSC Plans. No NHSC 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.

(vi) Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no NHSC Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment (except for limited continued

medical benefit coverage required to be provided under Section 4980B of the Code or as required by applicable state law).

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

(viii) Severance. The transactions contemplated by this Agreement will 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 NHSC Plan for the benefit of any current or former director, officer or employee of any of the NHSC Entities.

(ix) Diligence. Each of the NHSC Plans has been fully and completely described, with all applicable agreements and NHSC Plan documents, in the Due Diligence Information.

(i) Health Care Kickbacks. To the knowledge of NHSC after due inquiry, no NHSC 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.

(j) Prohibited Health Care Referrals. Except as disclosed in Due Diligence Information, to the knowledge of the NHSC Entities after due inquiry, no NHSC 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 who makes referrals to any NHSC Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. To the knowledge of NHSC after due inquiry, the Due Diligence Information provided by NHSC contains a complete and accurate list of all agreements between any of the NHSC Entities and referring physicians, physician organizations, other health care providers, and other referral sources. The Due Diligence Information provided by NHSC contains a full set of all such agreements between any of the NHSC Entities and referring physicians, physician organizations, other health care providers, and other referral sources which were requested by the WCHN Entities and their legal counsel. Except as disclosed in Due Diligence Information, to the knowledge of NHSC after due inquiry none of the NHSC Entities has any arrangements with referring physicians, physician organizations, or other health care providers that are not memorialized in writing.

(k) Actions, Investigations, and Inquiries. Except as disclosed in Due Diligence Information,

(i) 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 NHSC 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 NHSC Material Adverse Effect or result in any material impairment to the right or ability of any NHSC Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs.

(ii) No NHSC 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.

(iii) The Due Diligence Information provided by NHSC 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 NHSC Entities, threatened, anticipated or contemplated against or affecting any NHSC 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).

(l) Permits.

(i) Each NHSC 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 NHSC Material Adverse Effect.

(ii) No NHSC Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of such Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of such Permits is pending or has been commenced or, to the knowledge of the NHSC Entities, threatened and no notification thereof has been received by any NHSC Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a NHSC Material Adverse Effect.

(iii) The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties will not limit, restrict, revoke, suspend or

terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of such Permits.

(m) Medicare Cost Reports. The NHSC Entities have made available to WCHN true, correct and complete copies of their Medicare cost reports filed for the following years: 2009, 2010, and 2011. There are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open Medicare and Medicaid cost reports of the NHSC Entities for the last two (2) cost-reporting years that would have a NHSC Material Adverse Effect.

8. **Miscellaneous**.

8.1 Governing Law. This Agreement will 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).

8.2 Successors; Assignment. This Agreement will inure to the benefit of, and will 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.

8.3 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 will 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 will be held to constitute a waiver of any other or subsequent breach.

8.4 Confidentiality.

(a) 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, trustees, 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, trustees, officers, employees, agents and advisors of the receiving Party or its affiliates with such a need to know. Each Party will require all members, directors, trustees, 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 will 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.

(b) 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.

(c) Excepted Information. The obligations of a Party as recipient of Confidential Information of the other Party under this Agreement will 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.

(d) Marking Confidential Information. Each disclosing Party will 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.

(e) Return and Destruction. Should this Agreement terminate prior to the Effective Date, each Party agrees (i) that it will promptly return to the disclosing Party or, with the permission of the disclosing Party, destroy all Confidential Information obtained from the disclosing 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 8.4(e), in no event will 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.

(f) Remedies. The Parties acknowledge and agree that any breach of the obligations under this Section 8.4 will result in irreparable injury to the Party whose Confidential Information is or is to be disclosed and that the Party so injured will have the right to specific enforcement of the restrictions of this Section 8.4 as well as all rights that it may have in accordance with the provisions of Section 8.9 hereof.

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

8.6 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" will be construed to have the same meaning and effect as the word "shall"; (vi) the word "any" will mean "any and all" unless otherwise indicated by context; (vii) the word "day" will mean calendar day, and days will 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 will 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.

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

8.8 Entire Agreement. This Agreement, together with the Exhibits and Schedules attached hereto, will 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 and that certain Mutual Confidentiality Agreement dated September 16, 2011.

8.9 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) except as

expressly set forth herein, and each of the Parties further agrees that each of the Parties will 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") will 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 will 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 will be entitled to recover its reasonable costs, expenses and attorneys' fees.

8.10 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 will 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.

8.11 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 will be deemed given when actually received.

If to NHSC:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Mr. Daniel J. DeBarba, Jr., President and Chief Executive Officer
Fax: (203) 852-1553

With a copy to:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Ms. Kristen Staikos, Chief Legal Officer
Fax: (203) 852-1553

If to WCHN:

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810
Attn: John M. Murphy, M.D. President and Chief Executive Officer
Fax: (203) 739-8751

With a copy to:

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810
Attn: Carolyn McKenna, General Counsel
Fax: (203) 739-8751

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

9. DEFINITIONS.

9.1 "Act" means the Connecticut Revised Non-Stock Corporation Act.

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

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

9.4 "Alleging Party" has the meaning set forth in Section 8.9.

9.5 "Attorney General" has the meaning set forth in Section 4.3.

9.6 "Closing" has the meaning set forth in Section 1.2.

9.7 "Closing Date" has the meaning set forth in Section 1.2.

9.8 "Closing Memorandum" has the meaning set forth in Section 1.2.

9.9 "Code" has the meaning set forth in Section 7.3(d).

9.10 "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.

9.11 "Defaulting Party" has the meaning set forth in Section 8.9.

9.12 "DOJ" has the meaning set forth in Section 4.2.

9.13 "Due Diligence Information" means the information disclosed by WCHN to NHSC and the information disclosed by NHSC to WCHN in writing as part of the due diligence process or in writing pursuant to Section 3.6.

9.14 "Effective Date" has the meaning set forth in Section 1.2.

9.15 "ERISA" means Title IV of the Employee Retirement Income Security Act of 1974, as amended.

9.16 "Financial Statement" has the meaning set forth in Section 7.1(c).

9.17 "FTC" has the meaning set forth in Section 4.2.

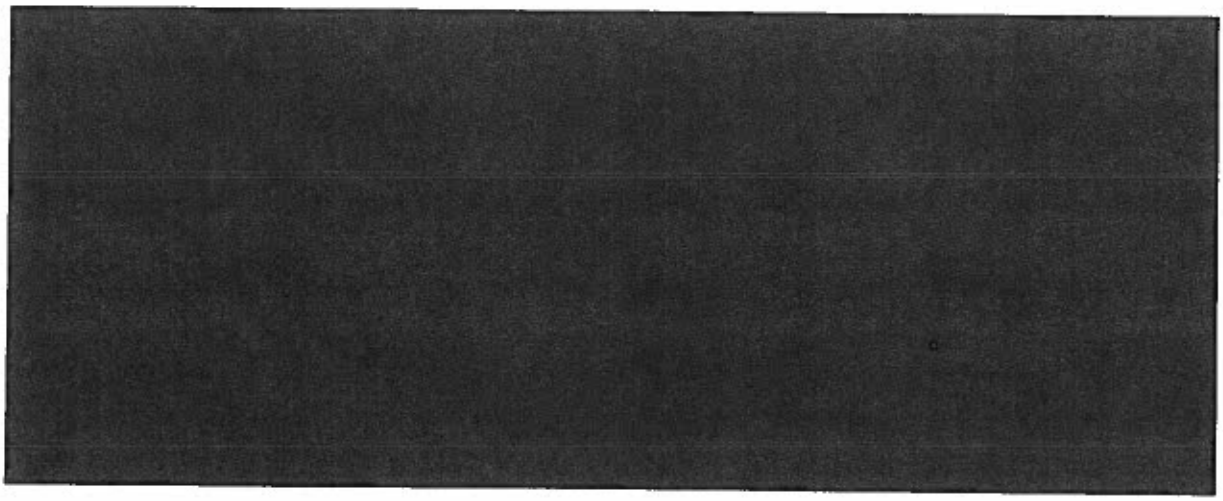
9.18 "Initial Governance Structure" has the meaning set forth in Section 2.

9.19 "Initial Period" has the meaning set forth in Section 2.

9.20 "Initial WCHN Directors" has the meaning set forth in Section 2.1(b).

9.21 "Interim Financial Statement" has the meaning set forth in Section 7.1(c).

9.22 "Letter of Intent" has the meaning set forth in the Preamble.



9.24 "NHA" has the meaning set forth in the Preamble.

9.25 "NHA Board" has the meaning set forth in Section 1.1(c).

9.26 "NHSC" has the meaning set forth in the Preamble.

9.27 "NHSC Board" has the meaning set forth in Section 1.1(b).

9.28 "NHSC Designee" has the meaning set forth in Section 2.1(b).

9.29 "NHSC Entities" has the meaning set forth in the Preamble.

9.30 "NHSC Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a NHSC Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to NHSC, including suspension, surrender, revocation or restriction in any manner of a NHSC 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 NHSC Entities considered as a single enterprise; or (iii) any change which would impair the ability of NHSC or any of the NHSC Entities to perform its obligations hereunder.

9.31 "NHSC Plan" has the meaning set forth in Section 7.3(h).

9.32 "Party" has the meaning set forth in the Preamble.

9.33 "Permit" has the meaning set forth in Section 7.3(l).

9.34 "Stark Law" has the meaning set forth in Section 7.3(j).

9.35 "Super-majority Vote" has the meaning set forth in Section 2.1(f).

9.36 "System Policies" has the meaning set forth in Section 6.4(a).

9.37 "WCHN" has the meaning set forth in the Preamble.

9.38 "WCHN Board" has the meaning set forth in Section 1.1(a).

9.39 "WCHN Designee" has the meaning set forth in Section 2.1(b).

9.40 "WCHN Entities" has the meaning set forth in the Preamble.

9.41 "WCHN Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a WCHN Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to WCHN, including suspension, surrender, revocation or

restriction in any manner of a WCHN 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 WCHN 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 WCHN Entities considered as a single enterprise; or (iii) any change which would impair the ability of WCHN or any of the WCHN Entities to perform its obligations hereunder.

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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

[*Name*] VICTOR LESS
[*Title*]

NORWALK HEALTH SERVICES CORPORATION

By: _____
Mr. Daniel J. DeBarba, Jr.
President and Chief Executive Officer

Witness

[*Name*]
[*Title*]

WESTERN CONNECTICUT HEALTH NETWORK, INC.

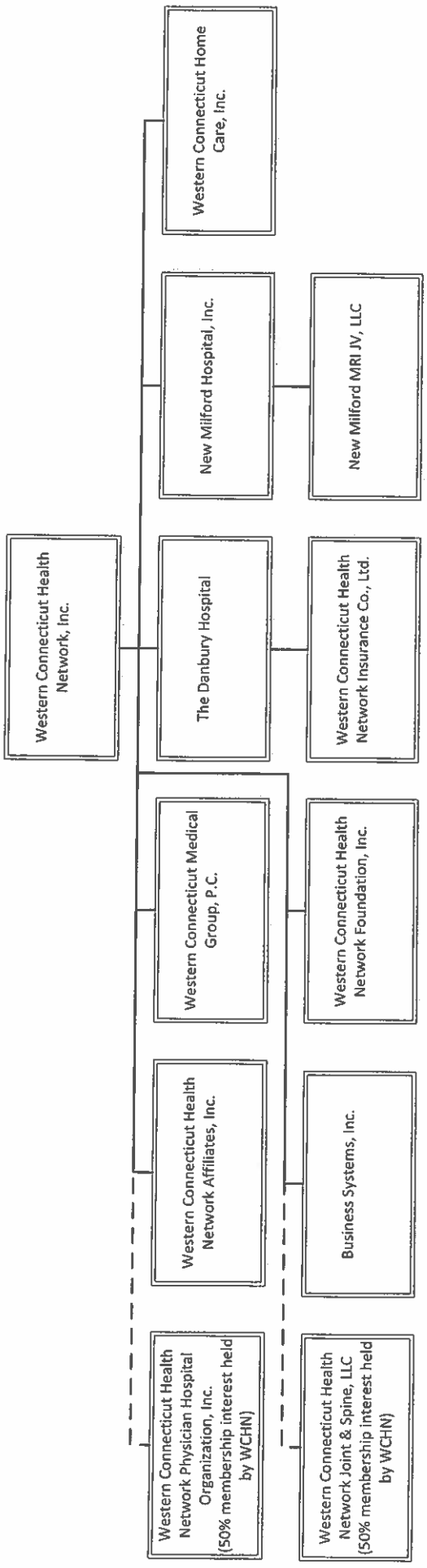
By: _____
John M. Murphy, M.D.
President and Chief Executive Officer

List of Exhibits and Schedules

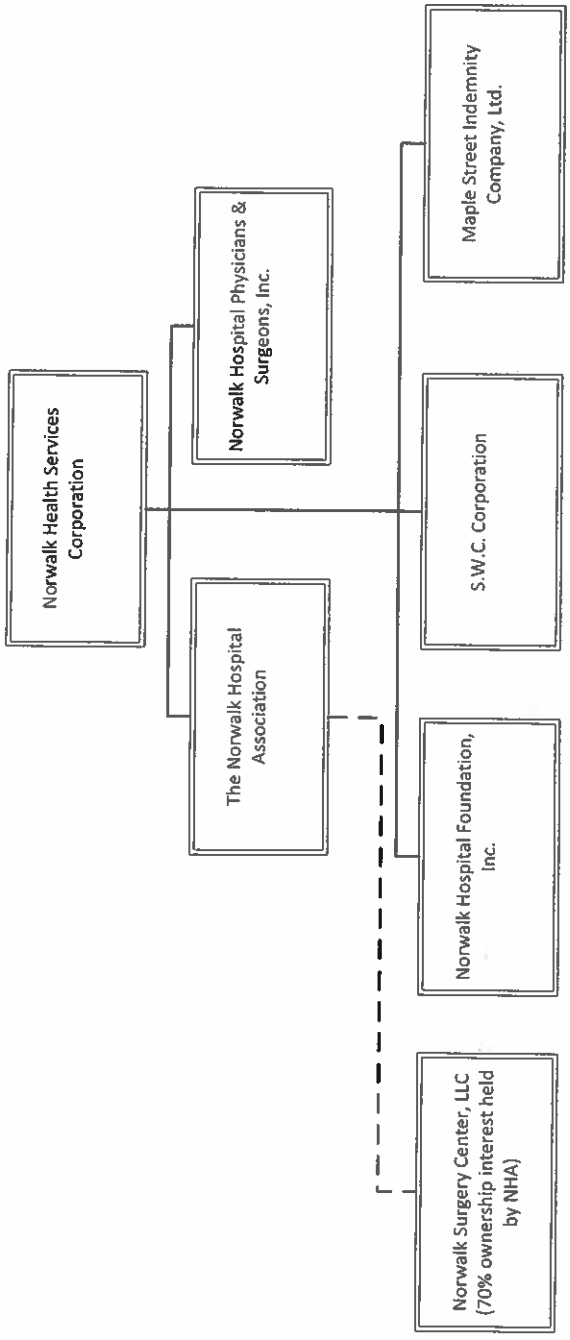
Exhibit A-1	WCHN Amended and Restated Certificate of Incorporation
Exhibit A-2	NHSC Amended and Restated Certificate of Incorporation
Exhibit A-3	NHA Amended and Restated Certificate of Incorporation
Exhibit B-1	WCHN Amended and Restated Bylaws
Exhibit B-2	NHSC Amended and Restated Bylaws
Exhibit B-3	NHA Amended and Restated Bylaws
Exhibit C	Pre-Closing and Post-Closing Organizational Structure
Schedule 1(a)	NHSC Affiliates
Schedule 1(b)	WCHN Entities
Schedule 4.4	Government Approvals
Schedule 4.5	Non-Governmental Consents
Schedule 4.12	Revisions to Restated Governing Documents
Schedule 7.2(g)	WCHN Labor Unions and Collective Bargaining Agreements
Schedule 7.3(g)	NHSC Labor Unions and Collective Bargaining Agreements

EXHIBIT C
Pre-Closing and Post-Closing Organizational Structure

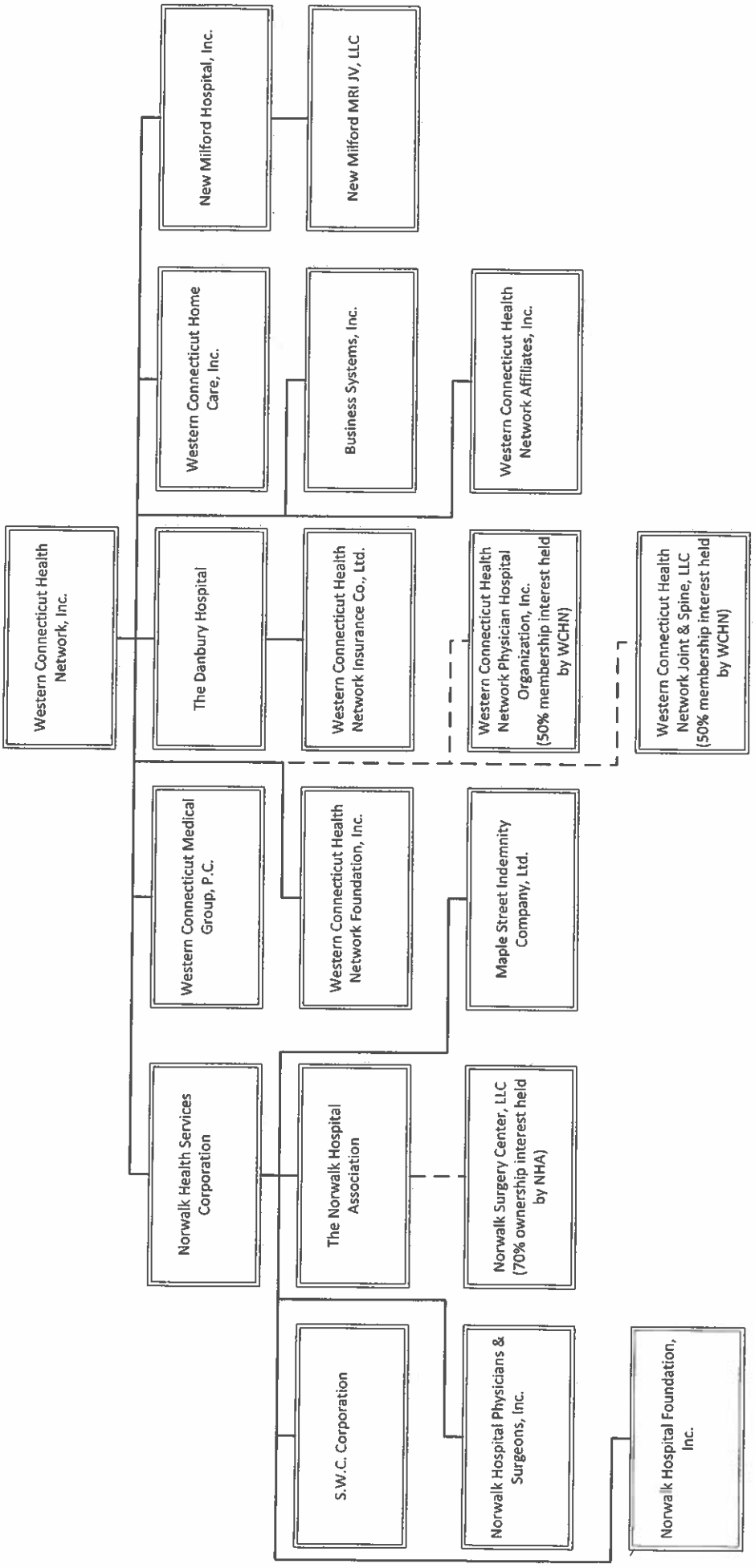
WCHN Pre-Closing



NHSC Pre-Closing



WCHN Post-Closing



SCHEDULE 1(a)
NHSC Affiliates

- Norwalk Health Services Corporation
- The Norwalk Hospital Association
- Norwalk Hospital Physicians & Surgeons, Inc.
- Norwalk Hospital Foundation, Inc.
- S.W.C. Corporation
- Maple Street Indemnity Company, Ltd.
- Norwalk Surgery Center, LLC [redacted]

SCHEDULE 1(b)
WCHN Affiliates

- Western Connecticut Health Network, Inc.
- The Danbury Hospital
- New Milford Hospital, Inc.
- Western Connecticut Health Network Affiliates, Inc.
- Western Connecticut Medical Group, P.C.
- Western Connecticut Home Care, Inc.
- Western Connecticut Health Network Foundation, Inc.
- Western Connecticut Health Network Insurance Co., Ltd.
- New Milford MRI JV, LLC
- Business Systems, Inc.
- Western Connecticut Health Network Physician Hospital Organization, Inc. [redacted]
- Western Connecticut Health Network Joint & Spine, LLC [redacted]

SCHEDULE 4.4
Government Filings and Approvals

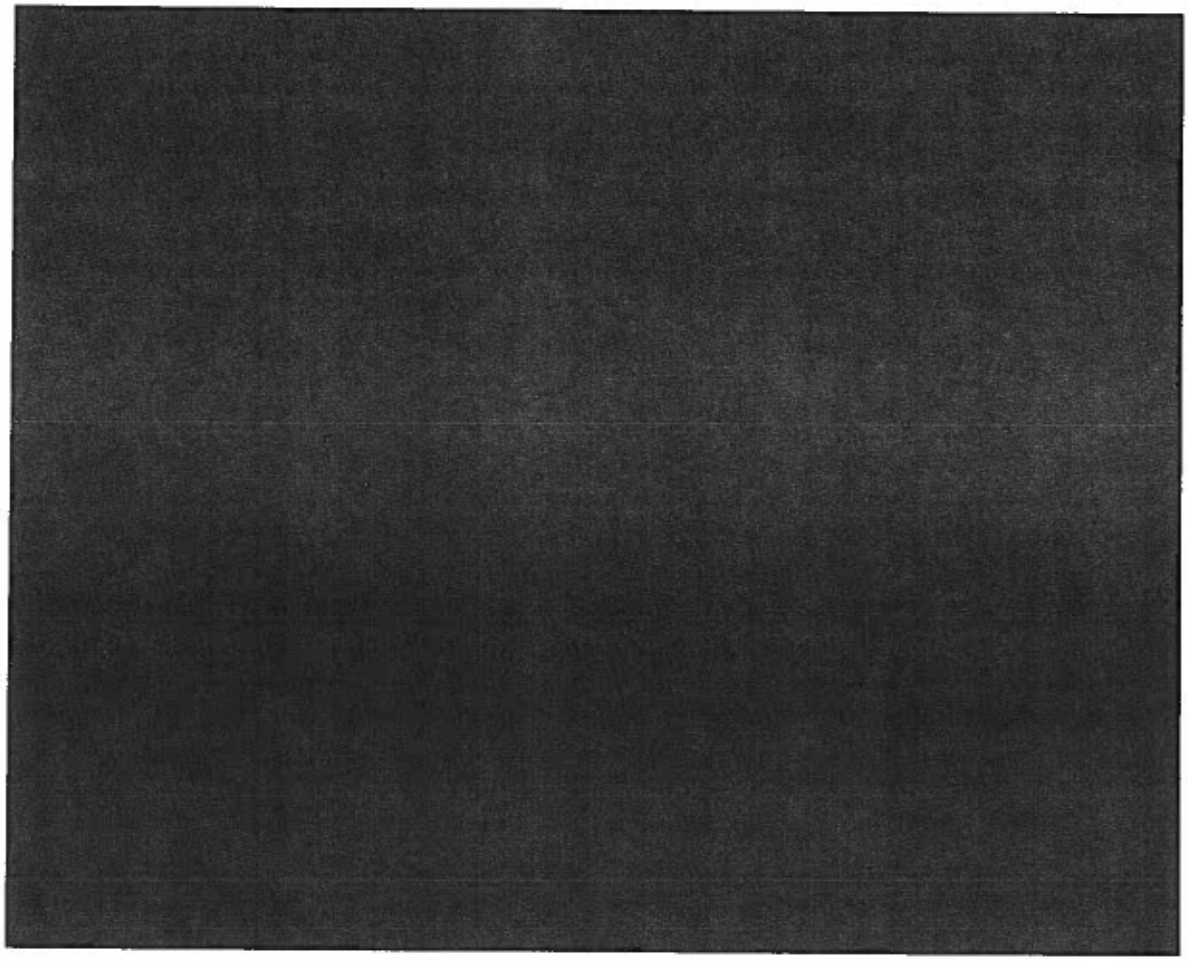
1. Hart-Scott-Rodino Pre-Merger Notification Filing with the U.S. Department of Justice and the U.S. Federal Trade Commission and subsequent clearance
2. State of Connecticut Office of Health Care Access Certificate of Need Application and approval
3. State of Connecticut Department of Public Health hospital license notice (post-closing)
4. Clinical Laboratory Improvements Act notice to State of Connecticut Department of Public Health
5. Change of Information Notice to the Centers for Medicare and Medicaid Services (post-closing)
6. Nuclear Regulatory Commission notice (post-closing)
7. Federal Drug Enforcement Agency notice (post-closing)
8. Registration number notice to State of Connecticut Department of Consumer Protection, Drug Control Division (post-closing)
9. State of Connecticut Office of Attorney General antitrust notice
10. Notice to Electronic Data Systems on behalf of Connecticut Department of Social Services (post-closing)
11. State of Connecticut Department of Environmental Protection Transfer Act form(s), as appropriate, with Norwalk as the certifying party, pursuant to Conn. Gen. Stat. §22a-134 et seq. (post-closing)

SCHEDULE 4.5
Non-Governmental Consents

None

SCHEDULE 4.12

Revisions to Restated Governing Documents



SCHEDULE 7.2(g)
WCHN Labor Agreements

[redacted]

SCHEDULE 7.3(g)
NHSC Labor Unions

[redacted]

Exhibit B

SCHEDULE 1(b)
WCHN Affiliates

- Western Connecticut Health Network, Inc.
- The Danbury Hospital
- New Milford Hospital, Inc.
- Western Connecticut Health Network Affiliates, Inc.
- Western Connecticut Medical Group, P.C.
- Western Connecticut Home Care, Inc.
- Western Connecticut Health Network Foundation, Inc.
- Western Connecticut Health Network Insurance Co., Ltd.
- New Milford MRI JV, LLC
- Business Systems, Inc.
- Western Connecticut Health Network Physician Hospital Organization, Inc. (50% membership interest held by WCHN)
- Western Connecticut Health Network Joint & Spine, LLC (50% membership interest held by WCHN)

Exhibit C

SCHEDULE 1(a)
NHSC Affiliates

- Norwalk Health Services Corporation
- The Norwalk Hospital Association
- Norwalk Hospital Physicians & Surgeons, Inc.
- Norwalk Hospital Foundation, Inc.
- S.W.C. Corporation
- Maple Street Indemnity Company, Ltd.
- Norwalk Surgery Center, LLC (70% ownership interest held by NHA)

Exhibit D

04/05/2013 Affected CON-81

Statewide Health Care Facilities and Services Plan

October 2012

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Connecticut Department Of Public Health
Office Of Health Care Access
410 Capitol Avenue • Hartford, CT 06134

1.3 ADVISORY BODY

In October 2010, the Office of Health Care Access invited representatives from a cross section of the health care industry and State government to participate in an advisory body that would be charged with providing guidance on the development of the Plan. Advisory Body members are listed in Appendix B. The advisory body met monthly beginning in November 2010. In May 2011, advisory body subcommittees were formed to conduct more in-depth work in the areas of Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care. Subcommittee members are listed in Appendix C.

Both advisory body and subcommittee members provided OHCA with guidance and expertise in the development of CON guidelines, standards, methodologies and analyses used in the Plan, including:

- Reviewing research conducted by OHCA on other states' facilities plans' standards, guidelines and methodologies and providing feedback and discussion regarding adaptation and applicability for Connecticut's Plan;
- Recommending authoritative professional organizations, published studies, industry-recognized standards/ guidelines/methodologies, etc., to be considered by OHCA in the development of its plan;
- Providing insight on industry best practices and evidenced based research;
- Recommending data sources; and
- Offering feedback on OHCA's use and interpretation of available data.

1.4 GUIDING PRINCIPLES

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage and support health education, promotion and prevention initiatives;
- Encourage collaboration among health care providers to develop health care delivery networks;
- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);
- Maintain and improve the quality of health care services offered to the state's residents;
- Promote planning that helps to contain the cost of delivering health care services to its residents;
- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state.

In November, 2010, the Department of Public Health, in accordance with Public Act 10-179, adopted interim Certificate of Need Policies and Procedures for Implementation of Public Act 10-179, §87, 89-93, which will be utilized by OHCA until official regulations are adopted by the General Assembly.

1.8.4 CERTIFICATE OF NEED AND HEALTH CARE REFORM

The 2010 Patient Protection and Affordable Care Act (PPACA) includes two provisions that may affect Connecticut's CON program: an increase in the insured population that will demand more services, which, in turn, may call for increased provider capacity; and provider payment reforms, which may restore some of the market constraints on prior health care system expansion. While it is unclear what the exact effect of these provisions will be, certain communities or regions may have adequate capacity to absorb increased demand, whereas those with a higher proportion of currently uninsured and less capacity may increase health care providers' reliance upon the CON program for health planning.[12]

1.8.5 MERGERS, ACQUISITIONS AND AFFILIATIONS

Even before health care reform has been fully implemented, the state's health care system has begun a transformation in response to and in anticipation of major changes in the way health care is financed and delivered. Many provisions of the PPACA favor integrated systems to create efficiencies and address quality. Hospital mergers and the acquisitions of imaging centers and physician practices are key issues surrounding Connecticut's CON process today.

Hospitals are pursuing affiliation arrangements and mergers in an effort to contend with growing financial pressures driven by such factors as providing uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients whose cost of care often exceeds federal and State reimbursement rates, the threat of reduced reimbursement by government payers and tough negotiations with health insurers over contract terms related to the cost of medical services. Financially struggling hospitals see mergers with stronger hospitals as a way to survive in the face of thin profits, gain access to capital to make needed facilities improvements or acquire technological equipment and contend with debt and liability issues. Affiliations help smaller hospitals share the cost of new technology, provide the opportunity to access specialists at larger hospitals and also offer patients a wider range of treatment and services.[13]

A growing number of Connecticut hospitals have become members of larger corporate health care systems. This trend may be the result of a variety of factors including: a weak economy, increased competition in the health care market, anticipation of changes due to federal health care reform, an attempt to gain leverage in payer contract negotiations, to develop economies of scale when purchasing supplies and services, and to improve access to capital. Additional hospitals are currently in discussion with other health care systems or have officially submitted applications for regulatory approval that would alter the current structure of Connecticut's existing hospitals. It should be noted that while every hospital is analyzing the advantages and disadvantages of pursuing affiliations and possible mergers, some hospitals are deciding that affiliating or merging is not the best route for their institutions or their communities. Table 1.1 represents general hospitals that are part of a larger health care system at the time this document was published.

[12]Yee, T., Stark, L.B., Bond, A. M. & Carrier, E. (2011). Health Care Certificate of Need Laws: Policy or Politics? National Institute for Health Care Reform. (Research Brief Number 4). 7. Retrieved from http://www.nihcr.org/CON_Laws.html
[13]Sturdevant, M. (2012, February 3). Hartford Hospital, Backus in Norwich Consider Joining Forces. *The Hartford Courant*. Retrieved from http://articles.courant.com/2012-02-03/business/hc-hartford-hospital-backus-20120203_1_hartford-healthcare-hartford-hospital-windham-hospital

Exhibit E

Letter of Intent for Corporate Affiliation Between Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation

This letter of intent (this "Letter") sets forth a non-binding agreement in principle between Western Connecticut Health Network, Inc., a Connecticut non-profit corporation ("WCHN"), and Norwalk Health Services Corporation, a Connecticut non-profit corporation ("NHSC" and together with WCHN, the "Health System"), covering certain of the terms and conditions of a proposed transaction (the "Proposed Transaction") pursuant to which WCHN and NHSC will affiliate by WCHN becoming the sole Member of NHSC and/or The Norwalk Hospital Association ("NHA") and remaining the sole member of Danbury Hospital and New Milford Hospital. The Proposed Transaction would occur pursuant to one or more definitive agreements (collectively, the "Definitive Agreements") consistent with the terms of this Letter. WCHN and NHSC may be referred to herein individually as a "Party" and collectively as the "Parties."

The Parties believe that the Proposed Transaction will, among other things, improve the community's health by delivering coordinated, effective care across the continuum. This goal will be accomplished through involving community leaders and engaging physicians in the Health System to build and maintain commitment; delivering a consistent, superior patient experience with respect to outcomes, service, and costs; assisting and advising management in the execution of the Health System's strategy; and achieving cost savings.

The objective of the discussions to be engaged in pursuant to this Letter will be the preparation, execution and consummation of mutually acceptable Definitive Agreements implementing the Proposed Transaction. Although it is expected that discussions regarding the Proposed Transaction will be fruitful, unless and until the Definitive Agreements are executed and delivered, there will be no legal and binding obligation of either Party except as set forth in paragraphs 5, 6, and 7 and neither Party shall be obligated to enter into the Proposed Transaction or any transaction.

Subject to performance of due diligence by both Parties and to the terms of the Definitive Agreements, certain of the principal terms and conditions of the Proposed Transaction are expected to be as follows:

1. **Structure of Proposed Transaction.** The Proposed Transaction will be structured and concluded in form and substance mutually agreeable to WCHN and NHSC and will result in WCHN becoming the sole Member of NHSC and/or NHA. The Parties intend that the current direct subsidiaries of NHSC will remain direct subsidiaries of NHSC if WCHN becomes the sole member of NHSC; will become direct subsidiaries of NHA if WCHN becomes the sole member of NHA or some of such subsidiaries may be consolidated pursuant to mutual agreement of the Parties. [redacted]

2. **Corporate Governance.**

   a. *WCHN Board Composition.* At the closing of the Proposed Transaction (the "Closing"), the WCHN Board will have a total of nineteen (19) members until January 2014, and thereafter no more than eighteen (18) members through the end of the five year period following the Closing (the "Initial Period"). At all times during the Initial

Period, seven (7) WCHN Board members shall be individuals who were NHSC Board members immediately prior to the Closing (the "Initial Period Trustees"). The Initial Period Trustees shall be selected by mutual agreement of the Chair of the NHSC Board in office as of the Closing and the Chair of the WCHN Board in office as of the Closing and elected by the boards of WCHN and NHSC. Any NHSC Board members serving on the NHSC Board immediately prior to the Closing who are not appointed to the WCHN Board will be provided the opportunity to serve on a WCHN Board committee or on the board of a WCHN subsidiary, and all such individuals will be eligible to become members of WCHN. For the first two years following the Closing, the Chair of the WCHN Board will be the individual serving as the NHSC Board Chair immediately prior to the Closing, and the Vice Chair of the WCHN Board will be the individual serving as the WCHN Board Chair immediately prior to the Closing. If WCHN becomes the sole member of NHSC, the NHSC Board and the NHA Board shall be comprised of the same individuals.

b. *WCHN Board Terms.* The terms of the seven Initial Period Trustees will be staggered in a manner to be defined by the Parties in the Definitive Agreements. During the Initial Period, if one of the Initial Period Trustees dies, resigns, is removed, or is disqualified, the resulting WCHN Board vacancy shall be filled by another individual who was serving on the NHSC Board immediately prior to the Closing (the "Replacement Initial Period Trustee"). The Replacement Initial Period Trustee shall be selected by mutual agreement of the Chair of the NHSC Board and the Chair of the WCHN Board and elected by the boards of WCHN and NHSC. Following the fifth anniversary of the Closing, all new WCHN Board members will be elected without regard to prior affiliation.

c. *Major WCHN Board Actions.* During the Initial Period, certain WCHN Board actions will require a super-majority vote of the WCHN Board, defined for this purpose as the affirmative votes of more than two-thirds of all of the WCHN Board members. Actions requiring a super-majority vote of the WCHN Board include the sale or other disposition of Norwalk Hospital to a third party, the closure of Norwalk Hospital, and such other actions as are agreed to by the Parties in the Definitive Agreements.

d. *NHSC Board Composition.* Upon Closing, the seven Initial Period Trustees will also serve on the NHSC Board and the NHA Board. The WCHN President/CEO and at least one additional WCHN Board member will become members of the NHSC Board and the NHA Board. The individual serving as the WCHN Board Chair immediately prior to the Closing will be the initial WCHN designee on the NHSC Board and the NHA Board. The remaining members of the NHSC Board and the NHA Board will be recommended by the NHSC Board for election by WCHN on an annual basis, or more frequently as necessary to fill vacancies.

For the three year period following the Closing, the Executive Vice President of WCHN/NHSC President and CEO will be the principal liaison to the NHSC Board and shall remain a member of the NHSC Board and the NHA Board. During such three year period, the WCHN Board will have the authority to direct the removal of a NHSC Board and NHA Board member by a super-majority vote if the WCHN Board determines that NHSC Board and NHA Board member is not acting in the best interests of NHSC. Upon completion of the three year period following the Closing,

the WCHN Board may remove NHSC Board and NHA Board members by majority vote.

If WCHN becomes the sole member of NHSC, during the three years following the Closing, the WCHN Board will review the need to maintain a NHSC Board. At the conclusion of such three-year period, and subject to the WCHN Board composition requirements set forth in paragraph 2.a, the WCHN Board may modify the composition of the NHSC Board and the NHA Board.

Subsequent to Closing, the Parties will work together to have the same individuals serving on Board Committees of NHSC, NHA and WCHN, to the extent permitted by law. The roles and responsibilities of the Boards of NHSC's affiliates will be determined in the Definitive Agreements.

e. *NHSC and NHA Board Responsibilities.* The NHSC Board and the NHA Board will have the following responsibilities:

- Review local quality and service goals and improvement programs within the context of Health System goals and programs and recommend changes to the WCHN Board;
- Review annual operating and capital budgets to ensure conformance with the strategy and objectives established by the Health System;
- Monitor local quality, service, and financial performance of the Health System;
- Approve medical staff bylaws and medical staff appointments based on standardized Health System applications and review processes;
- Participate in the search process for the President of Norwalk Hospital when the need arises;
- Participate in and support local communications with external audiences, including, but not limited to, local governments and the media;
- Support fundraising efforts conducted by the Norwalk Hospital Foundation in the local community;
- Oversee community benefit programs in the local community; and
- Such other responsibilities as may be set forth in the Definitive Agreements

f. *Management.* The current President/CEO of WCHN will remain the President/CEO of WCHN. The current President and CEO of NHSC will become the Executive Vice President of WCHN and will also remain the President and CEO of NHSC and NHA for a minimum period of three (3) years from Closing. There shall be an Office of the President which will be comprised of the President/CEO of WCHN and the President and CEO of NHSC and NHA. The current CFO of WCHN will report to the Office of the President.

3. **Consummation of the Proposed Transaction.**

a. *Due Diligence.* Following acceptance of this Letter, the Parties and their advisors will develop a due diligence plan and, consistent with such plan, 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. All inspections will only occur at times and in a manner as will not disrupt the delivery of care to patients.

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

c. *Time Line.* The Parties and their advisors will, following the execution of this Letter, agree upon a time for completion of major milestones necessary to expeditiously close the Proposed Transaction. Subject to receipt of all necessary governmental approvals, it is the Parties' intention to complete the Proposed Transaction by [January 1, 2013].

d. *Closing and Conditions.* WCHN and NHSC agree that the consummation of the Proposed Transaction is expressly conditioned upon customary closing conditions, including without limitation: (i) delivery of appropriate legal opinionsthe satisfactory completion of due diligence by both Parties; (ii) 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 Connecticut Office of Health Care Access, if applicable; (iii) the obtaining of all necessary board and member approvals, including the approvals of the Board and members of WCHN and the Board of NHSC in their sole discretion; and (iv) satisfaction of such other closing conditions as may be set forth in the Definitive Agreements.

4. **Term and Termination of Letter.**

a. *Term.* The term of this Letter will commence on the date of execution by both Parties, and continue until the earlier of: (i) the date on which the Definitive Agreements are executed and delivered; (ii) the date of termination pursuant to paragraph 4.b; or (iii) [January 1, 2013], which expiration date may be extended by mutual agreement of the Parties.

b. *Termination of Letter.* This Letter may be terminated in writing 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, and 7, which will survive termination.

5. **Confidentiality; Disclosure.** The Parties 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 who are bound by obligations of confidentiality regarding the Proposed Transaction, (b) any 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. Each of WCHN and NHSC acknowledges and agrees that the terms of the Mutual Confidentiality Agreement, dated as of September 16, 2011 (the "Confidentiality Agreement"), continue to apply to these negotiations and all matters relating to the Proposed Transaction.

6. **Public Announcement.** The Parties will 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 will 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, report, statement, or release from the other Party and such announcement, report, 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, report, statement, or release and will promptly furnish the other Party with a copy thereof.

7. **Exclusivity.** The exclusive dealing provision in paragraph 14 of the Confidentiality Agreement is hereby extended until this Agreement is terminated pursuant to paragraph 4.

8. **Non-binding Effect; No Contract.** It is expressly understood that this Letter, except for paragraphs 5, 6, and 7, which are binding on the Parties, is not a contract and that no Party will be entitled to any recourse, in the form of damages or otherwise, whether for expenses incurred or benefits conferred or otherwise 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 Agreements, except for paragraphs 5, 6, and 7.

9. **Miscellaneous.** The Parties recognize and agree that to the extent any provisions of this Letter are legally binding, such provisions will be governed by and enforced in accordance with the laws of the State of Connecticut, without regard to its conflict of law rules. No amendment of this Letter will be effective unless it is in writing and signed by the Parties. The Parties hereby acknowledge that the terms and language of this Letter were the result of negotiation between the Parties and, as a result, there will be no presumption that any ambiguities in this Letter will be resolved against any particular Party. Any controversy over construction of this Letter will be decided without regard to events of authorship or negotiation.

10. **Notice.** All notices, requests, demands, and other communications required or permitted by this Letter will be given to the respective Party by hand, by commercial overnight carrier service, by registered or certified mail, postage prepaid, or by facsimile, with a copy by electronic mail at the following addresses:

    a. Notices to WCHN will be addressed to:

    Western Connecticut Health Network, Inc.
    24 Hospital Avenue
    Danbury, CT 06810
    Attn: Dr. John M. Murphy, President & Chief Executive Officer
    Fax: (203) 739-8751
    Email: john.murphy@danhosp.org

    b. Notices to NHSC will be addressed to:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Mr. Daniel DeBarba, Jr., President & Chief Executive Officer
Fax: (203) 852-1553
Email: Dan.DeBarba@Norwalkhealth.org

IN WITNESS WHEREOF, the undersigned have executed this document as of the date of the last signature below.

WESTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____

Name: JOHN M. MURPHY, M.D.

Title: PRESIDENT & CEO

Date: 4/3/12

NORWALK HEALTH SERVICES CORPORATION

By: _____

Name: Daniel J. DeBarbs, Jr.

Title: President & CEO

Date: 4/3/12

CONFIDENTIAL *RG Draft 9/17/12*

WESTERN CONNECTICUT HEALTH NETWORK, INC.
AND
NORWALK HEALTH SERVICES CORPORATION

SUMMARY OF TERMS

This non-binding Summary of Terms (the "Term Sheet") serves to confirm the mutual intent of Western Connecticut Health Network, Inc. ("WCHN") and Norwalk Health Services Corporation ("NHSC") to amend and restate the terms of that certain Letter of Intent for Corporate Affiliation, dated April 3, 2012 between WCHN and NHSC (the "Letter of Intent") to achieve a full corporate affiliation (the "Proposed Transaction"). The date of the closing of the Proposed Transaction is referred to herein as the "Closing Date." Each of WCHN and NHSC is referred to herein as a "Party" and collectively as the "Parties."

For the avoidance of doubt, this Term Sheet supersedes the Letter of Intent in its entirety (provided that Sections 5 ["Confidentiality; Disclosure"], 6 ["Public Announcements"], and 7 ["Exclusivity"] of the Letter of Intent remain binding to the extent set forth in the Letter of Intent).

This Term Sheet is intended as an outline of certain material provisions to be included in one or more Definitive Agreements (the "Definitive Agreement") and does not address all matters upon which agreement must be reached and reflected in the Definitive Agreement in order for the respective Board's of the Parties to approve the Proposed Transaction. Although it is expected that discussions regarding the Proposed Transaction will be fruitful, unless and until the Definitive Agreement is executed and delivered, there will be no legal and binding obligation of either Party, except as set forth above.

Transaction Structure	WCHN will become the sole member of NHSC and/or the Norwalk Hospital Association ("NHA"). [redacted]
Corporate Governance	(1) WCHN Board Composition. The WHCN Board will have a total of eighteen (18) members. Seven (7) WCHN Board members shall be individuals who served as NHSC Board members immediately prior to the Closing (the "NHSC Designees"), and the remaining eleven (11) WCHN Board members shall be the individuals who served as WCHN board members immediately prior to the Closing (the "WCHN Designees"). The initial NHSC Designees and WCHN

	Designees will be set forth in the Definitive Agreement based on mutual agreement of the Board Chairs of the Parties. Members of the WCHN Board will be divided into three classes of equal size, with staggered terms, and will serve for a maximum of three, three-year terms. The Parties shall alternate the right to designate the Chair and Vice-Chair of the WCHN Board every two (2) years for the first four (4) years following the Closing Date. For the period beginning on the Closing Date and ending on the second anniversary of the Closing Date, the WCHN Board Chair shall be an NHSC Designee and the WCHN Board Vice-Chair shall be a WCHN Designee. For the period beginning on the second anniversary of the Closing Date and ending on the fourth anniversary of the Closing Date, the WCHN Board Chair shall be a WCHN Designee and the WCHN Board Vice-Chair shall be an NHSC Designee. The initial Chair and Vice-Chair of the WCHN Board and selection of the remainder of the WCHN Board officers shall be set forth in the Definitive Agreement. Any NHSC Board member serving on the NHSC Board immediately prior to the Closing Date who is not appointed to the WCHN Board will be provided an opportunity to serve on a WCHN Board committee or on the board of a WCHN subsidiary, and all such individuals will be eligible to become members of WCHN. To the extent consistent with applicable law, the same individuals will serve on board committees of WCHN, NHA and other hospital affiliates. [redacted] (2) NHSC Board Composition. At Closing, the NHSC Board shall be comprised of those persons serving in such capacity immediately prior to the Closing and shall include all of the NHSC Designees. The WCHN President/CEO and at least one additional WCHN Board member will become members of the NHSC Board. If WCHN becomes the sole member of NHSC through the Proposed Transaction, the NHSC Board and the NHA Board shall be comprised of the same individuals. During the Initial Period, the NHSC President and Chief Executive Officer will be a member of the NHSC Board and the NHA Board. In the event of a vacancy among the NHSC Designees or the WCHN Designees during the Initial Period, such individual shall be replaced by the Party that designated such NHSC or WCHN Designee, subject to approval by WCHN. In the event WCHN declines to elect any candidate, the Party that nominated the candidate will nominate one or more new candidates until agreement is reached. In the event WCHN becomes the sole Member of NHSC, the bylaws and charters of NHSC and NHA shall provide for "reach through" rights so that

	WCHN may exercise, directly or indirectly, the Super-majority Vote and Reserved Powers described below with respect to NHA in the same manner as with respect to Danbury and New Milford Hospitals. (3) Danbury Hospital and New Milford Hospital. At Closing, the Boards of Danbury Hospital and New Milford Hospital shall be comprised of those individuals serving as the WCHN Designees. (4) Potential Changes to WCHN Governance. Three (3) years after the Closing Date, the Governance Committee of WCHN shall review the corporate governance structure of WCHN and its affiliates and make such recommendations as may be appropriate. The representational Corporate Governance Structure and the Super-majority Vote provisions, as defined below (together, the "Transaction Governance Structure") will continue in effect until changed following the occurrence of any one of the events listed below: [redacted]
Major WCHN Board Actions	Certain WCHN Board actions (whether an affirmative power of the WCHN Board or a "Reserved Power" with respect to NHSC or NHA) will require a super-majority vote of the WCHN Board, defined for this purpose as the affirmative votes of two-thirds of all of the WCHN Board members (a "Super-majority Vote"). Thus, the vote of at least twelve (12) of the eighteen (18) trustees (which would include at least one of the NHSC Designees) is required to satisfy the requirement for a Super-majority Vote: Actions requiring a Super-majority Vote but that must be preceded by a vote of the NHSC or NHA Board are: (1) the sale or other disposition of NHA to a third party; (2) the closure of NHA or the closure or material diminution of a

	material program at NHA; and (3) approval of the NHA Capital Budget and Operating Budget. Other actions requiring a Super-majority Vote: (1) approval of the WCHN Strategic Plan; and (2) selection of the NHA CEO, except that such action shall require a Super-majority Vote for a period of one (1) year only after the Closing Date. After the first anniversary of the Closing Date, the WCHN Board shall not have the right to approve the NHA CEO, but the WCHN Board shall have input into such selection, which shall be under the direction of the WCHN CEO. (3) amendment of the bylaws or charter of WCHN, NHSC or NHA; (4) removal of an NHSC or NHA Board member; and (5) approval of the WCHN Capital Budget. All actions not requiring a Super-majority Vote shall be accomplished by majority vote.
Hospital Responsibilities	The management and Board of each Hospital will continue to operate and manage its facilities, programs, and services, subject to the Reserved Powers, as defined below, and including the following: (1) Review local quality and service goals and improvement programs within the context of the System's goals and programs and recommend changes to the WCHN Board; (2) Monitor local quality, service and financial performance of the System; (3) Approve medical staff bylaws and medical staff appointments based on standardized System applications and review processes; (4) Participate in the search process for the President of NHA, when the need arises; (5) Support management in making local communications with external audiences, including, but not limited to, local governments and the media; (6) Support fundraising efforts conducted by the Norwalk Hospital Foundation in the local community; (7) Oversee community benefit programs in the local community; and (8) such other responsibilities as may be set forth in the Definitive

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	Agreement. In addition, the following decisions, which shall initially be made by the NHSC Board (the "Reserved Powers"), are subject to approval by WCHN (subject to Super-majority Vote requirements as described above): (1) sale or other disposition of NHA to a third party; (2) the closure of NHA or the closure or material diminution of a material program at NHA; (3) appointment of an NHSC or NHA Board officer; and (4) approval of the NHA Capital Budget and Operating Budget.
Management	The current President/CEO of WCHN will remain the President/CEO of WCHN. The current President and CEO of NHSC will become Executive Vice President of WCHN, will report to the CEO of WCHN, and will also remain the President and CEO of NHSC and NHA. The Definitive Agreement shall specify a process for establishing and reviewing executive compensation.
Consummation of the Proposed Transaction	(1) Diligence. The Parties will develop a due diligence plan to complete due diligence investigations customary for transactions of this nature. (2) Definitive Agreement. The Parties will enter good faith negotiations to develop a mutually acceptable Definitive Agreement, embodying the terms herein, with terms normal and customary in a transaction similar to the Proposed Transaction. (3) Timing. The Parties will agree upon a time line for completion of regulatory filings to expeditiously close the Proposed Transaction. (4) Closing Conditions. The Parties agree that the consummation of the Transaction is subject to the following closing conditions, which shall be incorporated into the Definitive Agreement: (a) satisfactory completion of due diligence; (b) receipt of necessary third-party and other governmental approvals; (c) obtaining necessary approval by the governing boards of WCHN and NHSC, each in its or their sole discretion; (d) satisfaction of such other conditions as may be set forth in the Definitive Agreement.

[Signature Page Follows]

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IN WITNESS WHEREOF, the undersigned have executed this document as of the date set forth below.

WESTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name: JOHN M. MURPHY, MD
Title: PRESIDENT & CEO

NORWALK HEALTH SERVICES CORPORATION

By: _____
Name: Daniel J. DeBarba, Jr.
Title: President & CEO

Dated as of September 18, 2012

Exhibit F

WESTERN CONNECTICUT HEALTH NETWORK,
Special Meeting of the Board of Directors
January 18, 2013

A special meeting of the Board of Directors of Western Connecticut Health Network, was held via teleconference on Friday, January 18, 2013 at 12:00 p.m. Chairman of the Board Jim Kennedy presided.

PRESENT: A. Altorelli, M.D., D. Cyganowski, Neil Culligan, M.D. S Houldin, J. Kennedy, R. Jabara, D. Kramer, M.D. J. Murphy, MD, J. Patrick, J. Skrzypczak, B. White

ABSENT: A. Disney

ALSO PRESENT: C. McKenna, S. Rosenberg

CHAIRMAN'S REMARKS

Chairman Kennedy welcomed the directors and guests and noting that we had a quorum, began with the opening of the special meeting of the WCHN Board of Directors to approve the final documents and resolutions pertaining to our affiliation with Norwalk Hospital.

GENERAL/CONSENT

Approvals/Resolutions:

The Board reviewed the proposed amendments/resolutions pertaining to the Affiliation Agreement, Certificates of Incorporation and Bylaws of Western Connecticut Health Network, Norwalk Hospital Services Corporation and Norwalk Hospital Association **(attached).** There being no questions or issues raised at this time:

> A motion was made by J. Patrick and seconded by B. White and it was:
> **ACTION: VOTED to unanimously approve all amendments/resolutions as presented**

There being no further business, the meeting was adjourned at 12:15 p.m.

Respectfully submitted,

Fran Ratty, Recorder

James Kennedy
Chairman of the Board

Exhibit G

Board of Trustee Meeting Minutes
January 8, 2013

MINUTES OF THE MEETING OF
NORWALK HEALTH SERVICES CORPORATION

A meeting of the Board of Trustees of the Norwalk Health Services Corporation was held on Tuesday, January 8, 2013 at 8:00am in the Board Room at Norwalk Hospital.

Trustees present: Fred Afragola, Diane Allison, Thomas Ayoub, M.D., George Bauer, Barbara Butler, Dan DeBarba, Paul Gagne, M.D., Mark Gudis, Ed Kangas, David Lehn, Victor Liss, Joseph E. Mann, Gary Reiner, Andrew Whittingham Richard Zelkowitz, M.D.

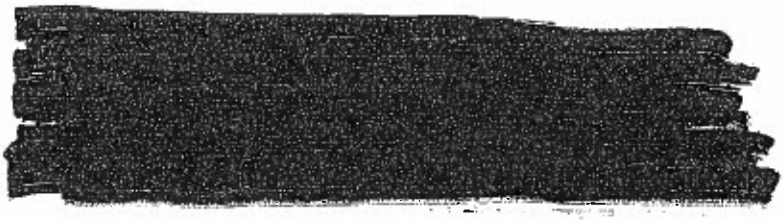
Trustees absent: Maria Borges-Lopes, David Komansky, Ed Mahony, Bob Ready

Attending by Invitation: Tony Aceto, Collin Barron, Gayle McGrath, Patrick Minicus, Erv Shames, Kristen Staikos, Howard Eison, MD., Amy Schafrann, Jeryl Topalian

Noting a quorum present, Diane Allison, Chairman of the Board, called the meeting to order at 8:00am.

Approval of the Minutes:
Diane Allison called for the approval of the minutes from the Norwalk Health Services Corporation Board of Trustees meeting held on November 27, 2012. The minutes of November 27, 2012 meeting were unanimously approved as submitted.

Report of the President:
Dan DeBarba, President and Chief Executive Officer, reminded the Board of Trustees that affiliation/partnership discussions started in May 2009 based on the recommendation of the Planning Committee. He further stated that a Task Force was formed in 2010 and spent one year analyzing, studying and discussing potential relationships with the following entities:



On June 28, 2011, a Board presentation was made by management and Navigant Consulting which highlighted all of the work that had been completed over the previous year. In addition, the presentation identified Danbury Hospital and Western Connecticut Health Network as the best partner for Norwalk Hospital.

Mr. DeBarba stated that shortly after this meeting, another Task Force was created to develop a business plan in support of the potential partnership. The Chartis Group was jointly hired by both Norwalk Hospital and Western Connecticut Health Network to develop a business plan. This business plan and a non-binding letter of intent was approved by the Board of Trustees on March 22, 2012.

Mr. DeBarba added that we are here today to review the results of the financial and legal due diligence reviews and to approve the definitive affiliation agreement. He also stated that the following:

Board of Trustee Meeting Minutes
January 8, 2013

1. Today we vote to take the next step in preserving a bright future for Norwalk Hospital during what will likely be extraordinarily difficult times for the health care industry;

2. The Federal Government has a massive deficit and health care (Medicare) will certainly be an area where spending cuts are made;

3. The State Government has a massive deficit and we expect to receive greater cuts in the future;

4. Employers can't absorb traditional increases in premiums any longer and with a slow economy – they can reduce benefits without losing valuable employees;

5. Physicians are looking for security and hospital employment is an attractive option if the hospital is deemed financially and operationally viable;

6. Both the Affiliation Task Force and the Finance Committee have approved this transaction with a few stipulations, which will be reviewed later in the meeting.

Mr. DeBarba thanked the Board of Trustees for their support to date and introduced Anthony Aceto, Vice President, Human Resources, and stated that Mr. Aceto will review the Due Diligence work.

Affiliation Due Diligence Summary:
Anthony Aceto, Vice President, Human Resources, presented the results of the legal and financial due diligence reviews.

(a copy of the presentation is attached)

Summary of Affiliation:
Collin Barron, Esq., of Pullman and Comley, LLC and Kristen Staikos, Chief Legal Council, presented a Summary of the Affiliation Agreement by and Between Norwalk Health Services Corporation ("NHSC") and Western Connecticut Health Network, Inc. ("WCHN").

(a copy of the presentation is attached)

Following a detailed discussion, the following two motions were proposed and seconded.

First Motion: The NHSC Board is concerned with the right of WCHN Members as they can have a significant effect on corporate governance and does not wish to proceed with the proposed affiliation between NHSC and WCHN until such rights are resolved to the satisfaction of the NHSC Board.

(a copy of the full motion is attached)

The first motion was approved by all Board members present except for [redacted] who voted against the motion.

Second Motion: The NHSC Board authorized the execution of the Affiliation Agreement between NHSC and WCHN subject to certain issues being resolved to the satisfaction of the NHSC Board.

(a copy of the full motion is attached)

The second motion was unanimously approved

Board of Trustee Meeting Minutes
January 8, 2013

Adjournment

With no further business to conduct, this meeting was adjourned at 10:45 AM.

The next scheduled meeting is January 21, 2013

_____

Diane Allison, Chairman

RESOLUTIONS ADOPTED BY
BOARD OF TRUSTEES
NORWALK HEALTH SERVICES CORPORATION

AFFILIATION WITH
WESTERN CONNECTICUT HEALTH NETWORK, INC.

JANUARY 8, 2013

WHEREAS, the Board of Trustees of Norwalk Health Services Corporation (the "Corporation") reviewed the proposed Affiliation Agreement between the Corporation and Western Connecticut Health Network, Inc. ("WCHN") and the Bylaws and Certificate of Incorporation of WCHN that detail the rights of Members of WCHN; and

WHEREAS, the Board is concerned with the rights of WCHN Members as they can have a significant effect on corporate governances; and

WHEREAS, the Board does not wish to proceed with the proposed affiliation between the Corporation and WCHN until such rights of WCHN Members are resolved to the satisfaction of the Board.

NOW, THEREFORE, IT IS HEREBY:

WHEREAS, that the following six issues must be resolved to the satisfaction of the Board before it will approve entering into a definitive Affiliation Agreement with WCHN:

1. Clarification that WCHN Member rights to vote on mergers, dissolutions and sales of assets not in the ordinary course apply only to WCHN and not to its affiliates.

2. Require that WCHN directors serve until their successors are elected and qualified.

3. Require that NHSC/NHA have the right to nominate and have elected the Elected Members equal in number to Elected Members nominated by WCHN.

4. Elimination of the right of the WCHN Board and Members to have an unlimited veto power with respect to NHSC/NHA nominees to the WCHN Board.

5. Require that there be a re-examination of whether WCHN should be a membership corporation within two years following the Closing.

6. Require that the seven (7) NHSC designees to the WCHN Board be approved by the WCHN Board and WCHN Members as a condition to the closing of the proposed affiliation.

RESOLUTIONS ADOPTED BY
BOARD OF TRUSTEES
NORWALK HEALTH SERVICES CORPORATION

AFFILIATION WITH
WESTERN CONNECTICUT HEALTH NETWORK, INC.

JANUARY 8, 2013

The Board of Trustees of Norwalk Health Services Corporation (the "Corporation") does hereby agree to and adopt the following resolutions:

WHEREAS, the Board of Trustees of the Corporation (the "Board") has determined that the Corporation's ability to continue to achieve its mission, including without limitation its mission in support of The Norwalk Hospital Association (the "Hospital"), relating to patient care, education, clinical research and community service, depends upon its ability to respond to and benefit from opportunities created by the rapidly changing health care marketplace; and

WHEREAS, the Board supports the Corporation's pursuit of a regional, integrated health care network development strategy; and

WHEREAS, the Board authorized the execution of a Summary of Terms between the Corporation and Western Connecticut Health Network ("WCHN"), the sole member of The Danbury Hospital and New Milford Hospital, Inc. which Summary of Terms sets forth the general principles of an affiliation between the Corporation and WCHN and their member hospitals; and

WHEREAS, a definitive Affiliation Agreement, attached hereto as Exhibit A has been negotiated with WCHN on terms consistent with the general principles set forth in the Summary of Terms; and

WHEREAS, the Board has had the opportunity to review and discuss the definitive Affiliation Agreement; and

WHEREAS, the officers of the Corporation (the "Officers"), in consultation with consultants and counsel to the Corporation, have (a) conducted legal and financial due diligence review of WCHN and its affiliates, (b) provided a written summary thereof to the Finance Committee and the Affiliation Task Force, and (c) summarized today to the Board the results of that review; and

WHEREAS, negotiations with WCHN have confirmed that certain changes will be required to the Certificate of Incorporation and Bylaws of the Corporation and its affiliates, including the Hospital, so as to permit WCHN to acquire actual or effective control of the Corporation and its affiliates while providing the Board a voice in the affairs of WCHN, the Corporation and its affiliates; and

WHEREAS, the Finance Committee and the Affiliation Task Force met on January 4, 2013, and after evaluating the legal and financial due diligence reports from NHSC's counsel and its financial advisers and reviewing a draft of the proposed definitive Affiliation Agreement recommended that this Board of Trustees approve the affiliation of NHSC and WCHN subject to certain conditions.

NOW, THEREFORE, IT IS HEREBY:

RESOLVED, that, subject to: (a) completion of due diligence review; (b) establishment of a WCHN committee structure, including chairmanships and memberships; and (c) completion of amended and restated certificates of incorporation and bylaws of NHSC and WCHN and their affiliates, all to the satisfaction of the Officers of NHSC, and subject to resolution of WCHN Member voting rights to the satisfaction of the Board, the Corporation enter into the Affiliation Agreement with WCHN, substantially in the form presented at this meeting, with such changes as may be deemed necessary, appropriate or desirable by any of the Officers in his or her discretion, and that the Officers be, and each of them hereby is, authorized to execute and deliver, for and on behalf of the Corporation, the Affiliation Agreement and such other documents, certificates, applications, filings and agreements with private or public entities or agencies as the Officers, in their sole discretion, deem necessary, appropriate or advisable to effect the transactions contemplated by the Affiliation Agreement, including without limitation filings pursuant to the Hart-Scott-Rodino Antitrust Improvements Act and applications for Certificates of Need from the Connecticut Office of Health Care Access, the execution and delivery thereof by such Officers to be conclusive evidence of authorization and approval hereunder; and

RESOLVED, that the Officers be, and each of them hereby is, authorized, empowered and directed to do and perform all other acts and things deemed by one or more of them necessary, appropriate or advisable to carry out the intent of the foregoing resolution; and

RESOLVED, that all actions heretofore taken by any Officer or agent of the Corporation in connection with any matter referred to or contemplated in the foregoing resolutions are hereby approved, ratified and confirmed in all respects.

Board of Trustee Meeting Minutes
January 21, 2013

MINUTES OF THE MEETING OF
NORWALK HEALTH SERVICE CORPORATION

A meeting of the Board of Trustees of the Norwalk Health Service Corporation was held on Tuesday, January 21, 2013 at 10:15am in the Board Room at Norwalk Hospital.

Trustees present: Fred Afragola, Diane Allison, Thomas Ayoub, M.D., George Bauer, Dan DeBarba, Mark Gudis, Ed Kangas, Victor Liss, Joseph E. Mann, Ed Mahony, Robert Ready, Richard Zelkowitz, M.D.

Trustees absent: Maria Borges-Lopez, Barbara Butler, Paul Gagne, M.D., David Komansky, David Lehn

Attending via phone conference: Gary Reiner, Amy Schafrann, Andrew Whittingham

Attending by Invitation: Tony Aceto, Collin Baron, Howard Eison, M.D., Gayle McGrath, Patrick Minicus, Erv Shames, Kristen Staikos, Jeryl Topalian, Frank Zullo

Noting a quorum present, Diane Allison, Chairman of the Board, called the meeting to order at 10:15am.

Approval of the Minutes:
Diane Allison called for the approval of the minutes from the Norwalk Health Service Corporation Board of Trustees meeting held on January 8, 2013. The minutes of January 8, 2013 meeting were unanimously approved as submitted.

Report of the Chairman:
Ms. Allison asked Dan DeBarba, President and Chief Executive Officer, to summarize the purpose and scope of today's meeting.

Report of the President:
Dan DeBarba, President and Chief Executive Officer, stated that the purpose of today's meeting is as follows:

1. To approve the affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. and to authorize officers of the Corporation to enter into a definitive Affiliation Agreement and to take all necessary steps to effectuate the affiliation;

2. To vote on proposed amendments to the Certificate of The Incorporation and Bylaws of the Norwalk Hospital Association;

3. To vote on the proposed amendments to the Certificate of Incorporation and Bylaws of the Norwalk Health Services Corporation; and

4. To review the Certificate of Incorporation and Bylaws of the Western Connecticut Health Network

Mr. DeBarba then asked Collin Baron and Kristen Staikos to review these documents with the Board in more detail.

Affiliation Agreement:
Collin Baron of Pullman Comley stated that during the January 8, 2013 meeting, the Norwalk Health Services Corporation adopted resolutions authorizing the execution of the Affiliation Agreement subject to 4 items.

Board of Trustee Meeting Minutes
January 21, 2013

Mr. Baron listed the four items at issue as follows:

1) Satisfactory Committee Structure and Composition;
2) Completion of Due Diligence;
3) Satisfactory resolution of Board conditions related to Western Connecticut Health Network Members' rights; and
4) Completion of revised Bylaws and Certificates of Incorporation for Norwalk Hospital and Norwalk Health Service Corporation.

Mr. Baron then facilitated the discussion regarding resolution of the four items at issue as follows:

Resolution of 1: Satisfactory Committee Structure and Composition:
Mr. DeBarba stated that it was agreed to that Committees will consist of 6 to 8 Board members for Finance, Governance and Compensation Committee. The remaining Committees may be larger than 8 members.

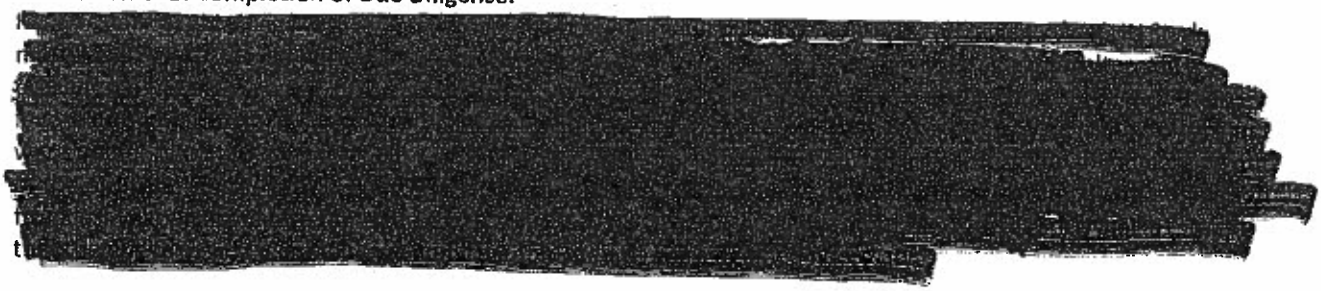
Mr. Shames added that it was agreed to that each Committee would be equitable by representatives of the two hospital systems and that the determination of how many total members will be left to the Committee Chairs. The final composition will be submitted to the Governance Committee for approval. He further stated that the Chairmen of the Committees will be as follows:

- Finance Committee, Chairman, Norwalk Hospital Board Member;
- Quality Committee, Chairman, WCHN Hospital Board Member;
- Governance Committee, Chairman, WCHN Hospital Board Member;
- Compensation Committee, Chairrman, Norwalk, Hospital Board Member;
- Strategic Planning Committee, Co-Chairmen, Norwalk and WCHN Hospital Board Members;
- Audit Committee, Chairman, WCHN Hospital Board Member

In addition, Mr. Shames discussed agreement on two sub-committees including:

- Investment Committee, a sub-committee of the Audit Committee, Chairman, WCHN Board Member
- Technology Management Committee, a sub-committee of the Strategic Planning Committee, Chairman, Norwalk Hospital Board Member

Resolution of 2: Completion of Due Diligence:



Resolution of 3: Western Connecticut Health Network Members' Rights:
Mr. Baron stated that at the NHSC Board meeting held on January 8, 2013, the Board adopted a resolution to the effect that the following six conditions that relate directly or indirectly to the voting rights of WCHN Members must be resolved to the Board's satisfaction. Mr. Baron presented a table showing the six requirements and how they were addressed. (see attached)

WCHN MEMBER RIGHTS

At the NHSC Board meeting held on January 8, 2013, the Board adopted a resolution to the effect that the following six conditions that relate directly or indirectly to the voting rights of WCHN Members must be resolved to the Board's satisfaction. Below is a table showing the six requirements and how they have been addressed:

Required by Board per 1/8/13 Meeting	Proposed Resolution of Issue
WCHN must provide a legal opinion that right of Members to vote on mergers, dissolutions and sale of assets applies only to WCHN and not to its subsidiaries, e.g. NHA.	The WCHN Certificate of Incorporation ("COI") will be amended to specify that Members have the right to vote only with respect to WCHN transactions.
Requirement that the Bylaws of WCHN specify that its directors shall serve until their successors are elected and qualified.	The requirement has been agreed to. In addition, the WCHN Bylaws will specify that the Members will vote on the entire slate of directors (including both NHSC and WCHN nominees) rather than on individual directors.
Requirement that NHSC/NHA will have the right to nominate and have elected WCHN Members in equal number to WCHN Members nominated by DH.	This requirement has been agreed to.
Requirement that the WCHN Board not have the right to an unlimited veto power over NHSC/NHA nominees to the WCHN Board.	A two strike rule has been agreed to with respect to nominees to the NHSC/NHA Board and the WCHN Board. If the WCHN Board rejects by majority vote two nominees for a NHSC/NHA or WCHN Board seat, the rejection of a third nominee would require a supermajority vote of the WCHN Board.
Require that the issue of whether WCHN should continue as a membership corporation be reviewed by the WCHN Board within two years following the Closing.	This has been agreed to but the timetable for the review of the WCHN/NHSC governance structure has been changed from three years to two years following Closing.
Require that the seven NHSC Designees to the WCHN Board be approved by the WCHN Board and Members as a condition to Closing.	This has been agreed to.

Board of Trustee Meeting Minutes
January 21, 2013

Resolution of 4: Completion of Bylaws and Certificates of Incorporation of Norwalk Hospital and Norwalk Health Services Corporation:
Mr. Baron highlighted a few minor changes to the previous version of the Norwalk Health Services Corporation and Norwalk Hospital Association Bylaws and Certificates. He noted that the Norwalk Hospital Association approved the Amendments to its Bylaws and Certificate at an earlier meeting.

Western Connecticut Health Network Amended and Restated Bylaws and Certificates:
Mr. Baron presented the WCHN Bylaws and Certificates to the Board of Trustees. In its review of the Bylaws of WCHN, the Board noted several provisions that are not consistent with discussions that have taken place between the respective Affiliation Task Forces and/or with the Summary of Terms. In particular, the Board determined that the following four additional revisions should be made to the WCHN Bylaws and that the Affiliation Agreement should be revised to require that these revisions be made a condition to the Closing;

(i) Non-Board members may be appointed to any WCHN Committee but without vote;

(ii) The Bylaws should explicitly require that there be an equitable distribution of Norwalk Directors and Danbury Directors on Board committees;

(iii) The Executive Compensation Committee should consist of not only the Chairman and the Vice Chairman but at least three other Directors; and

(iv) The Executive Compensation Committee should advise the Board not only on executive compensation strategies and policies but also executive benefit strategies and policies.

[redacted]

With no further discussion, the following resolutions were made, seconded and unanimously approved:

1. **AFFILIATION with WESTERN CONNECTICUT HEALTH NETWORK, INC.**
   (see attached resolution)

2. **BOARD OF DIRECTORS of WESTERN CONNECTICUT HEALTH NETWORK, INC.**
   (see attached resolution)

Adjournment
With no further business to conduct, the Norwalk Health Service Corporation meeting was adjourned at 11:30am.

The next scheduled meeting is February 26, 2013

_____

Diane Allison, Chairman

RESOLUTIONS OF
BOARD OF TRUSTEES
NORWALK HEALTH SERVICES CORPORATION

AFFILIATION WITH
WESTERN CONNECTICUT HEALTH NETWORK, INC.

JANUARY 21, 2013

The Board of Trustees of Norwalk Health Services Corporation (the "Corporation") does hereby agree to and adopt the following resolutions:

WHEREAS, the Board of Trustees of the Corporation (the "Board") has determined that the Corporation's ability to continue to achieve its mission, including without limitation its mission in support of The Norwalk Hospital Association (the "Hospital"), relating to patient care, education, clinical research and community service, depends upon its ability to respond to and benefit from opportunities created by the rapidly changing health care marketplace; and

WHEREAS, the Board supports the Corporation's pursuit of a regional, integrated health care network development strategy; and

WHEREAS, the Board authorized the execution of a Summary of Terms between the Corporation and Western Connecticut Health Network ("WCHN"), the sole member of The Danbury Hospital and New Milford Hospital, Inc. which Summary of Terms sets forth the general principles of an affiliation between the Corporation and WCHN and their member hospitals; and

WHEREAS, a definitive Affiliation Agreement, attached hereto as Exhibit A has been negotiated with WCHN on terms consistent with the general principles set forth in the Summary of Terms; and

WHEREAS, the Board has had the opportunity to review and discuss the definitive Affiliation Agreement; and

WHEREAS, the officers of the Corporation (the "Officers"), in consultation with consultants and counsel to the Corporation, have (a) conducted legal and financial due diligence review of WCHN and its affiliates, (b) provided a written report thereof to the Finance Committee and the Affiliation Task Force and the Board, and (c) reviewed with the Board these reviews; and

WHEREAS, negotiations with WCHN have confirmed that certain changes will be required to the Certificate of Incorporation and Bylaws of the Corporation and its affiliates, including the Hospital, so as to permit WCHN to acquire actual or effective control of the Corporation and its affiliates while providing the Board a voice in the affairs of WCHN, the Corporation and its affiliates; and

WHEREAS, the Finance Committee and the Affiliation Task Force met on January 4, 2013, and after evaluating the legal and financial due diligence reports from NHSC's counsel and its financial advisers and reviewing a draft of the proposed definitive Affiliation Agreement recommended that this Board of Trustees approve the affiliation of NHSC and WCHN subject to certain conditions; and

WHEREAS, the Board met and voted on January 8, 2013, to authorize the Officers to enter into a definitive Affiliation Agreement subject to (a) completion of due diligence review; (b) establishment of a WCHN committee structure, including chairmanships and memberships; and (c) completion of amended and restated certificates of incorporation and bylaws of NHSC and WCHN and their affiliates, all to the satisfaction of the Officers of WCHN and subject to resolution of WCHN Member voting rights to the satisfaction of the Board; and

WHEREAS, the Board has determined that all of the conditions contained in the January 8, 2013, resolutions of the Board, including the conditions relating to WCHN Member voting rights, have been satisfied.

NOW, THEREFORE, IT IS HEREBY:

RESOLVED, that the Corporation enter into the Affiliation Agreement with WCHN, substantially in the form presented at this meeting, but revised to include a condition to closing that the Bylaws of WCHN be further amended to address concerns raised at this meeting and such changes as may be deemed necessary, appropriate or desirable by any of the Officers in his or her discretion, and that the Officers be, and each of them hereby is, authorized to execute and deliver, for and on behalf of the Corporation, the Affiliation Agreement and such other documents, certificates, applications, filings and agreements with private or public entities or agencies as the Officers, in their sole discretion, deem necessary, appropriate or advisable to effect the transactions contemplated by the Affiliation Agreement, including without limitation filings pursuant to the Hart-Scott-Rodino Antitrust Improvements Act and applications for Certificates of Need from the Connecticut Office of Health Care Access, the execution and delivery thereof by such Officers to be conclusive evidence of authorization and approval hereunder; and

RESOLVED, that the Bylaws and Articles of Association of the Hospital and the Bylaws and Certification of Incorporation of the Corporation be amended in the form attached hereto effective on the consummation of the affiliation between the Corporation and WCHN pursuant to the Affiliation Agreement; and

RESOLVED, that the Officers be, and each of them hereby is, authorized, empowered and directed to do and perform all other acts and things deemed by one or more of them necessary, appropriate or advisable to carry out the intent of the foregoing resolutions; and

RESOLVED, that all actions heretofore taken by any Officer or agent of the Corporation in connection with any matter referred to or contemplated in the foregoing resolutions are hereby approved, ratified and confirmed in all respects.

RESOLUTION OF
BOARD OF TRUSTEES
NORWALK HEALTH SERVICES CORPORATION

BOARD OF DIRECTORS OF WCHN

JANUARY 21, 2013

The Board of Trustees of Norwalk Health Services Corporation (the "Corporation") does hereby agree to and adopt the following resolution:

WHEREAS, the Board of Trustees of the Corporation (the "Board") has adopted resolutions approving the execution of an Affiliation Agreement between the Corporation and Western Connecticut Health Network, Inc. ("WCHN") pursuant to which WCHN shall become the sole member of the Corporation ("Affiliation Agreement"); and

WHEREAS, pursuant to the Affiliation Agreement seven members of the Board shall be elected to the Board of Directors of WCHN; and

WHEREAS, the Board has determined that the selection of the seven Board members to serve on the Board of the Directors of WCHN shall be made by decision of the Board.

NOW, THEREFORE, IT IS HEREBY:

RESOLVED, that the Board shall determine the seven members of the Board who shall be put forward for election to the Board of Directors of WCHN as of the effective date of the proposed affiliation between the Corporation and WCHN.

Exhibit H

Norwalk Health Services Corporation
Service Area Demographic Information

Table 1: Service Area for Norwalk Hospital

Primary Service Area	Population estimated as of 2011
Norwalk	87,014
Westport	26,420
New Canaan	19,866
Wilton	18,641
Weston	10,224
Total PSA	**161,715**
Secondary Service Area	
Darien	19,777
Fairfield	59,625
Redding	9,181
Ridgefield	24,784
Total SSA	**113,67**
Total Service Area	**275,082**

Source: www.CERC, Town Profiles downloaded 3/20/2013

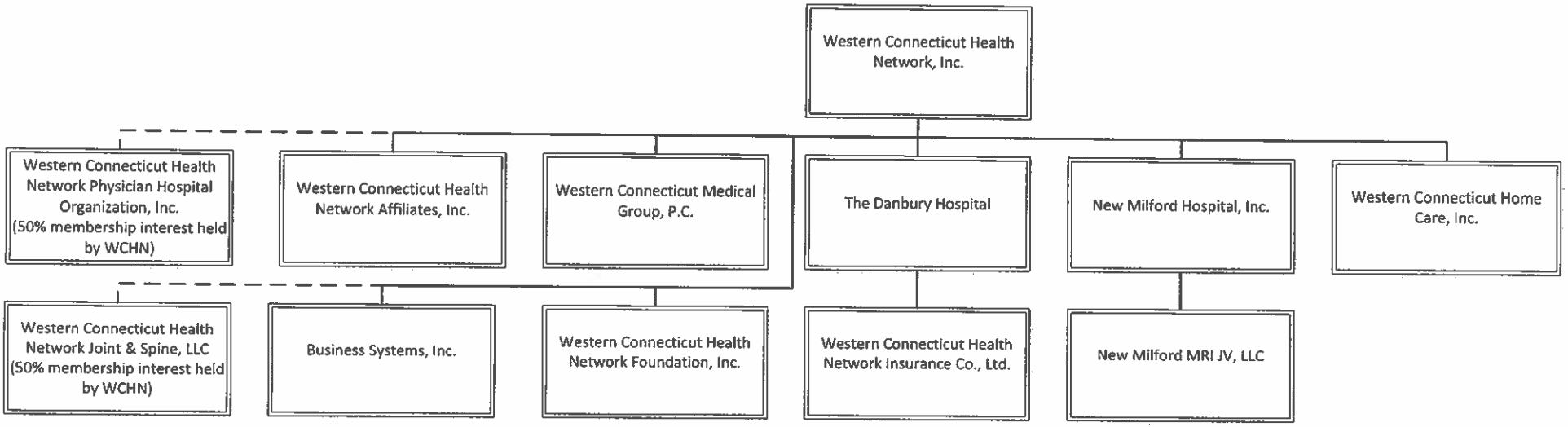
Table 2: Age and Gender Distribution

Primary Service Area	Male	Female	Total
0-17	21,096	19,769	40,865
18-24	7,549	6,980	14,529
25-29	26,207	26,700	52,907
50-65	14,865	16,092	30,957
65+	9,384	13,073	22,457
Total	79,101	82,614	161,715
Secondary Service Area	**Male**	**Female**	**Total**
0-17	15,147	13,924	29,071
18-24	5,233	5,199	10,432
25-29	17,975	19,300	37,275
50-65	10,239	10,697	20,936
65+	6,612	9,041	15,653
Total	55,206	58,161	113,367
Total Service Area	134,307	140,775	275,082

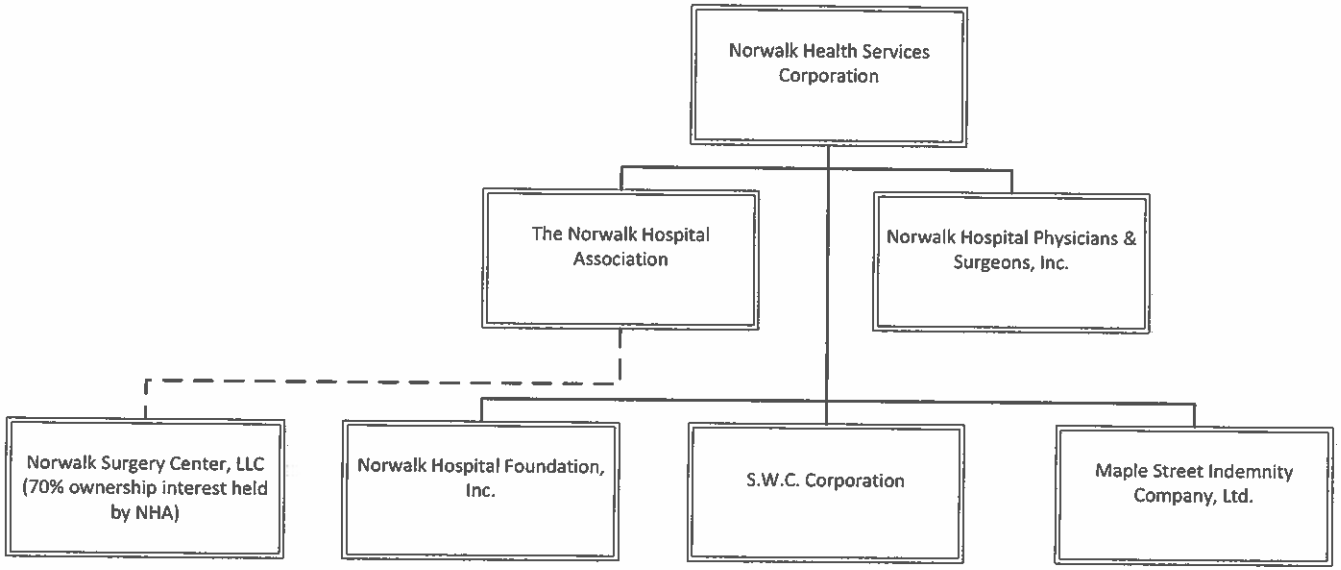
Source: www.CERC, Town Profiles downloaded 3/20/2013

Exhibit I

WCHN Pre-Closing



NHSC Pre-Closing



WCHN Post-Closing

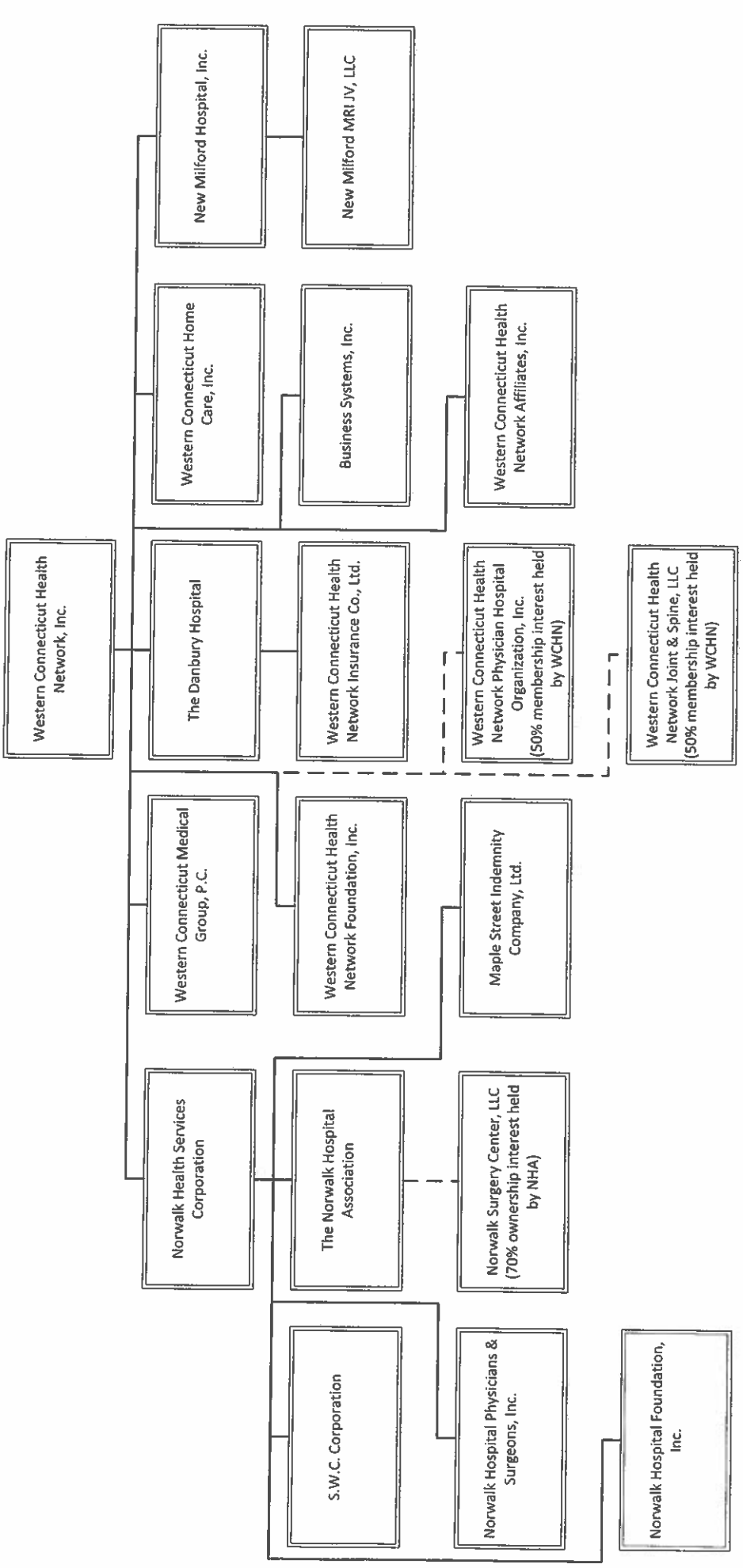


Exhibit J

Norwalk Health Services Corporation	Western Connecticut Health Network
President & CEO Dan DeBarba, Jr.	President & CEO John Murphy, MD
Senior VP & COO Lisa Brady	Senior VP, COO, Danbury Hospital Michael Daglio
	Executive Director, Senior VP, New Milford Hospital, Deborah Weymouth
VP Finance, CFO Patrick Minicus	Senior VP, CFO & Treasurer Steve Rosenberg
VP Patient Care Services, CNO Renee Mauriello, RN	VP Patient Care Services, CNO Moreen Donahue, RN
VP, Chief Medical Officer Eric Mazur, MD	Chief Medical Officer Matt Miller, MD
VP, Human Resources Anthony Aceto	Senior VP, Human Resources Phyllis Zappala
Chief Legal Officer Kristen Staikos	General Counsel Carolyn McKenna
Chief Compliance Officer Jeannine Foran, RN, JD	Chief Risk & Compliance Officer Joe Campbell
Chief Medical Information Officer, Acting CIO Steve O'Mahony, MD	Chief Information Officer Kathy DeMatteo
Executive Director, Facilities Jim Haynes	VP, Facilities Morris Gross
Executive Director, Quality Joanne Svogun	VP, Quality & Patient Safety Dawn Myles
Executive Director, Planning & Business Development, Jeryl Topalian	VP, Planning Sally Herlihy
President NH Foundation, VP Public Affairs Mary Franco	Executive Director & VP Foundation Grace Linhard
President NHP&S, VP Business Development Michael Marks, MD	Executive Director, WCMG Tom Linhares

Curriculum Vitae
Daniel J. DeBarba Jr.

Professional Experience:

Norwalk Hospital, Norwalk, CT
President and Chief Executive Officer 2010 to present
Mr. DeBarba was appointed President and Chief Executive Officer of Norwalk Hospital in 2010. In addition to managing senior leadership, his responsibilities include designing, implementing and sustaining an organizational and management structure that promotes the Hospital's mission, values, goals and objectives; planning and monitoring the financial, operational, capital and human resources of the Hospital; and providing leadership in developing and annually updating the Hospital's strategic, financial and human resources plans.

Vice President and Chief Operating Officer 2009 to 2010
Vice President and Chief Financial Officer 2007 to 2009
Since joining the Hospital in 2007, Mr. DeBarba has also served as Chief Operating Officer and Chief Financial Officer. Responsible for the day-to-day Hospital operations and worked with the Chief Executive Officer to provide strategic direction to the organization. Provided leadership and programmatic direction for the Hospital's clinical and non-clinical departments. Responsible for management and overall direction of finance division including accounting and financial reporting, budget and decision support, information technology, patient access, patient financial services, health information management, materials management, and treasury management. Also responsible for the direction and financial management of all health system subsidiaries including Honey Hill CareCenter and S.W.C. Corporation.

Saint Mary's Hospital, Waterbury, CT
Vice President and Chief Financial Officer 2005 to 2007
Managed and provided overall direction of finance division including accounting and financial reporting, budget and decision support, information technology, patient access, patient financial services, health information management, materials management, and treasury management. Also responsible for the direction and financial management of all health system subsidiaries including Diagnostic Imaging of Southbury, Naugatuck Valley Surgical Center, and several other physician groups and outpatient centers.

Yale New Haven Health System, New Haven, CT
Director of Financial Planning 2003 to 2005
Managed the budget and financial planning services of Yale New Haven Health System, a non-profit health care delivery system with three hospitals including Yale-New Haven, Bridgeport, and Greenwich Hospitals. With a $1.4 billion operating budget, the system included 1,400 inpatient beds and outpatient services including primary and specialty care clinics, ambulatory surgery centers, diagnostic radiology centers, and home care agencies.

Director of Finance, Bridgeport Hospital 2000 to 2003

PricewaterhouseCoopers LLP, Hartford, CT
Director, Health Care Consulting Practice 1997 to 2000
Manager, Health Care Consulting Practice 1996 to 1997
Senior Associate, Health Care Consulting Practice 1994 to 1996

Milford Hospital, Milford, CT
Budget and Reimbursement Analyst 1991 to 1994

Ernst & Young LLP, Hartford, CT
Senior Auditor 1990 to 1991
Staff Auditor 1988 to 1990

Military Service:
Connecticut Army National Guard, 1982 to 1988

Education:
University of Hartford, M.S. Accounting, 1988
University of Connecticut, B.A. English, 1986

Professional Certifications:
Certified Public Accountant

Professional Organizations:
American College of Healthcare Executives,
Healthcare Financial Management Association
American Institute of Certified Public Accountants

Other Areas of Interest:
Community Board Membership:
Greater Norwalk Chamber of Commerce

Curriculum Vitae
John M. Murphy, M.D.

Professional Experience

Western Connecticut Health Network (formerly DHS) **July 2010 - PRESENT**
President & Chief Executive Officer
Responsible for direction of core strategic programs, objectives and the enhancement of operational excellence, growth and financial performance of the $750M integrated delivery network. Work in collaboration with physician and nursing leadership to align operational areas to support quality care, patient safety and service excellence initiatives of Danbury Hospital, New Milford Hospital, Western Connecticut Medical Group, Western Connecticut Home Care and associated subsidiaries and the surrounding communities

Danbury Health Systems (DHS), Danbury, CT **July 2008 – June 2010**
Executive Vice President (President /CEO Designee)

Associated Neurologists, P.C., Danbury, CT **1989- 2008**
Clinical neurologist with a particular interest in stroke, multiple sclerosis, and neurodegenerative disorders. I was active both clinically as well as administratively serving as the president of the group for 18 years and actively expanded the group to include clinical research, neurophysiology, neuropsychology and infusion therapy. In addition I was active in clinical research and both undergraduate as well as graduate medical education

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

Professional Certifications

Fellow – American College of Physicians – Appointed 2012
Attending Neurologist – Danbury Hospital – 1989 – Present
Clinical Assistant Professor of Neurology – University of Vermont – 2010-Present
Fellow – American Academy of Neurology

Professional Organizations

American College of Healthcare Executives
Board of Directors – Voluntary Hospital Association (VHA)
Board of Trustees – Connecticut Hospital Association (CHA)
Board of Trustees – Union Savings Bank
Connecticut State Medical Society
Fairfield County Medical Society
Fairfield County Neurology Society
American Academy of Neurology

Curriculum Vitae
Lisa M. Brady

Professional Experience:

Norwalk Hospital, Norwalk, Connecticut, 2008 – Present
Senior Vice President and Chief Operating Officer, 2010 to present
Reporting to President/Chief Executive Officer
Responsibilities
- Overall Hospital operations
- Strategic direction to the organization
- Leadership and programmatic direction clinical and non-clinical departments

Vice President, Planning & Business Development, 2008-2010
Reporting to President/Chief Executive Officer
Responsibilities
- Strategic planning and business development
- Community physician practices
- Certificate of need development
- Marketing
- Community relations
- Cancer center
- Women's and children's services
- Occupational health services

Rush-Copley Medical Center, Aurora, Illinois
Senior Vice President, Strategy & Chief Strategy Officer, 2006-2008
Vice President, Planning & Business Development, 1998-2006
Reporting to President/Chief Executive Officer
Responsibilities
- Strategic planning and business development
- Institute strategic direction – product line oversight for 5 centers of excellence
- Neuroscience Institute
- Marketing communications
- Public relations
- Community relations
- Government relations
- Information services
- Rush-Copley Medical Group – 40+ providers and 200+ employees
- Heart Horizons, LLC Board member – joint venture with physicians for cardiac diagnostics
- River West Radiation Therapy Center, LLC Board member – joint venture with large multispecialty physician group

Premier, Inc., Westchester, Illinois
Vice President, 1995 – 1998
Senior Consultant, 1993 – 1995

Tiber Group, Chicago, Illinois
Senior Consultant and founding member, 1989 – 1993

Education:

Rush University, Chicago, Illinois
Master of Science, Health Systems Management, 1989

University of Illinois, Champaign-Urbana, Illinois
Bachelors of Science, Anatomical Sciences, 1987

Professional Organizations:

American College of Healthcare Executives
Rush University, Faculty, Course Director, Healthcare Marketing, 2001 – 2008
Montgomery Economic Development Corporation, Board of Directors, 2007 – 2008
YWCA, Board of Directors, 2002 – 2006
Sunnymere Retirement Center, Board of Directors, 1999 – 2004
United Way, Board of Directors, 1998 – 2003
Aurora Area Chamber of Commerce, Leadership Course Director, 2000

Curriculum Vitae
Michael J. Daglio

Professional Experience

Danbury Hospital, Danbury, CT **June 2004 –Present**

Senior Vice President and Chief Operating Officer ***October 2010 – present***

- Responsible for the following operational areas: Cardiovascular Service Line, Surgical Services, Cancer Center, Women's and Children's, Emergency Department, Radiology, Laboratory, Pharmacy, Facilities, Medical Education and Research.
- Provide senior level oversight of 7 direct reports and 1,400 indirect reports.
- Oversee Operating Budgets of $400,000,000 and manage capital budget of $30,000,000.
- Responsible for the post-merger integration of Danbury Hospital and New Milford Hospital operational and clinical departments.
- Developed a "Portfolio Review" process to identify cost reduction opportunities throughout the network. Achieved $18,000,000 in cost reduction in first twelve months of the program.
- Responsible for physician relations and physician acquisition strategy for key clinical services.
- Developed a "Staffing Management Council" to review all position requests for the Network. Reduced 140 positions through tighter controls, sharing of resources and more stringent approval process.

Vice President, Operations ***October 2007 – October 2010***

- Responsible for Medical Education and Research , the Cardiovascular, Radiology, Laboratory and Women's and Children's Service Lines, and The Emergency and Behavioral Health Departments
- Manage operating budget of $100,000,000 with gross revenues exceeding $350,000,000
- Manage average annual capital budget of $10,000,000 for service lines
- Provide senior level oversight of 10 Directors and a staff of 725 FTEs
- Leading $150,000,000 Hospital facility expansion project, including securing CON approval from the State
- Collaborate in partnerships with Chairmen and Physician Executives for the Service Lines
- Lead physician recruitment efforts and negotiate and execute physician contracts for service lines

Other Positions

- Danbury Hospital - Service Line Executive, Cardiovascular Services and Radiology Services- June 2004-October 2007
- Continuum Health Partners, New York, NY Director, Ambulatory Care - June 2001-June 2004
- Continuum Health Partners, New York, NY Assistant Director, Physician Initiatives Group– May 2000 – June 2001
- The George Washington University Hospital, Washington, DC Administrative Resident – May 1999-April 2000
- The George Washington University Hospital, Washington, DC Interim Administrative Director, Department of Medical Imaging – July 1998- May 1999
- The George Washington University Hospital, Washington, DC Project Coordinator, Department of Quality Management – July 1996 – July 1998

Education

The George Washington University – School of Business and Public Management, Washington, DC Masters of Health Administration May 2000

The University of Hartford – West Hartford, CT
Bachelor of Arts, Secondary Education and Allied Health May 1991

Professional Organizations

Danbury Hospital, Regional YMCA of Western Connecticut and the Pound Ridge Partnership – Pound Ridge, NY

Awards

2005 Recipient of the Fairfield County Business Journal's **"40 under 40"** award for extraordinary leadership qualities and outstanding professional accomplishments that have made a significant impact on my organization and Fairfield County, CT

Curriculum Vitae
Deborah Kinney Weymouth

Professional Experience

Executive Director, Senior Vice President, New Milford Hospital • New Milford, CT Western Connecticut Health Network, Danbury, CT	2011 – Present
Executive Vice President/Chief Operating Officer, Thompson Health • Canandaigua, NY	2009 – 2011
Chief Financial Officer/Senior Vice President, Thompson Health • Canandaigua, NY	2004 – 2009
Senior Vice President of Support Services, Thompson Health • Canandaigua, NY	1999 – 2004
Vice President of Operations, F.F. Thompson Continuing Care Center • Canandaigua, NY	1995 – 1999
Vice President, Key Bank of New York • Rochester, NY	1992 – 1994
Chief Operating Officer, Concierge Services of America • Washington, D.C.	1990 – 1992
Vice President, Citicorp NA/Citibank • Los Angeles, CA and Phoenix, AZ	1985 – 1990
Vice President of Operations, Great Western Bank • Phoenix, AZ	1984 – 1985

Education

Fellow, American College of Healthcare Executives (FACHE)	2007
Master in Business Administration - Master of International Management / Finance Thunderbird Global Management School • Phoenix, AZ	1984
Bachelor of Science - Education and Rehabilitation, Cum Laude Springfield College • Springfield, MA	1979

Professional Certifications

Examiner, Malcolm Baldrige National Quality Award Program	2010-2011
Institute of Healthcare Improvement (IHI) Executive Hospital Operations	2009
Graduate of Citibank Global Credit Training Program • New York, NY	1987

Professional Organizations

Member, New Milford Economic Development Corporation Board	2012 – Present
Member, DNS-Connecticut Hospital Association Fee-Based Services Board	2011 – Present
Member, United Way of Western Connecticut Board	2011 – Present
Chair, CFO Committee - Rochester Regional Healthcare Association	2009-11
Member, Finance Committee – Healthcare Association of NY	2008-11
Member, Information Technology Committee – Healthcare Association of NY	2009-11
Member, Board of Directors- Rochester Healthcare Financial Management Association	2010
Financial Executive of the Year - Rochester Business Journal	2008
Associate of the Year - Thompson Health Shining Star Award	2006
Athena Award, Outstanding Female Leadership - Canandaigua Chamber of Commerce	2002
Lifetime Achievement Award - Canandaigua Chamber of Commerce	1999
Employee of the Year - Great Western Bank	1984
8 Time NCAA All-American Swimmer	1975-79

Curriculum Vitae
Patrick Minicus

Professional Experience:

Norwalk Hospital, Norwalk, CT **October 2009 – present**
Vice President and Chief Financial Officer
Responsible for management and overall direction of finance division including accounting and financial reporting, budget decision support, information technology, patient access, patient financial services, health information management, materials management, and treasury management.

Bridgeport Hospital, Bridgeport, CT **December 2002 – October 2009**
Director of Finance/Accounting
Responsible for general ledger functions and all monthly financial statement reporting, commentary and analysis for Bridgeport Hospital & Healthcare Services, Inc. and Subsidiaries with consolidated operating revenues of $359 M.

Ernst & Young, LLP, New York NY **September 1997 – December 2002**
Manager – Health Sciences Practice
Served as auditor on several large academic medical centers and hospitals, including Bridgeport Hospital & Healthcare Services, Inc. and Subsidiaries, Mount Sinai-NYU Health and Memorial Sloan-Kettering Cancer Center

Education:
Siena College, Loudenville, NY
BBA Accounting

Professional Certifications:
Six Sigma Green Belt Certified
21st Century Leadership
Leadership Development institute Coach
Shared Governance Coordinating Council Member

Professional Organizations:
Fairfield County's 40 Under 40
Norwalk Hospital Physician & Surgeons Board Member
Ambulatory Surgery Center Board Member

Curriculum Vitae
Steven H. Rosenberg

Professional Experience

November 2010 – Present **Senior Vice President-Chief Financial Officer-Treasurer**
Western Connecticut Health Network

March 1987 – November 2010 **Senior Vice President and Chief Financial Officer**
Saint Francis Hospital and Medical Center - Hartford, CT

Steven H. Rosenberg is the Senior Vice President-Chief Financial Officer-Treasurer of Western Connecticut Health Network in Danbury, Connecticut. Mr. Rosenberg oversees all financial operations including patient accounting & billing, information technology, materials management, payor relations, contract management, general accounting and financial reporting, payroll, accounts payable, budget, reimbursement and decision support. Danbury Hospital is a 371-bed regional medical center and teaching hospital associated with Yale University, UConn and University of Vermont. The hospital's Centers of Excellence include: cardiovascular services, cancer, weight loss surgery, orthopedic and spine care, digestive disorders and radiology and employs approximately 2,400 FTEs.

Prior to his arrival at the Western Connecticut Health Network, Mr. Rosenberg was Senior Vice President and Chief Financial Officer for Saint Francis Hospital and Medical Center in Hartford, CT. Their health system included a hospital with 619 licensed beds; a 60-bed acute rehabilitation hospital; a faculty practice plan, (Woodland Physician Associates), which employed 110 physicians; a joint laboratory service with Bristol and St. Mary's Hospitals; and a very successful Physician Hospital Organization, which was jointly owned by physicians and the hospital.

Education

University of Connecticut
Storrs, CT
Accounting
BS 1975

University of New Haven
West Haven, CT
MBA 1980

Professional Organizations

Member, Connecticut Hospital Association Committee on Finance
Member, The Healthcare Financial Management Association

Curriculum Vitae
Renee Mauriello, RN, MSN

Professional Experience:

Vice President & Chief Nursing Officer,
Norwalk Hospital – 6/4/2012 to Present

With seasoned leadership and organizational skills, responsible for developing and directing the implementation of strategies to assure the provision of continuous patient care services characterized by the highest standards of quality, best clinical practice, efficient and cost effective systems, and total compliance with policies and regulatory requirements. Additionally, serves as a key member of the Hospital's senior leadership team providing management guidance, direction and values on a wide array of management and organizational matters including improvements to patient outcomes, quality measures and patient satisfaction.

Outstanding leadership skills demonstrated by results which include implementation of innovative clinical and management practices, methods that improve operational efficiency, and sustained exceptional performance in patient satisfaction. Strong organizational and interpersonal skills; including the ability to drive change, focus on results and develop and sustain collegial relationships with clinicians, staff, and other stakeholders in the Hospital as well as within the local community is required.

Vice President, Patient Care Services and Chief Nursing Officer, Catholic Health Services of Long Island, Inc. Mercy Medical Center, Rockville Centre, NY -2008 to 2012

Provided overall leadership and direction to 600 full time employees performing all aspects of clinical and administrative functions within the nursing department, patient relations and bed board. Her key responsibilities and accomplishments include:

- Achieved the ANCC Pathway to Excellence Designation in 2012.
- Implemented a nursing clinical ladder and ancillary clinical ladder.
- Improved patient satisfaction scores through the implementation of an ambassador program.
- Expanded an automated medication system throughout the hospital.
- Implemented a nursing summer internship program to aid in nurse recruitment, brought nursing orientation in-house and established a new orientee support group.
- Improved employee engagement and decreased nursing turnover from 25 percent in 2008 to 3 percent in 2011.
- Increased the percentage of nurses with baccalaureate degrees from 40 to 70 percent.
- Established hospital-wide nursing councils, along with nursing performance improvement, and nursing practice committees in preparation for the journey to "pathway to excellence".
- Completed successful joint commission and office of mental health surveys.
- Received the Cancer Care Award from American College of Surgeons.
- Reduced patient falls below the national benchmark on med/surg rehabilitation and psychiatry.
- Implemented house-wide lean initiatives to improve overall efficiency.
- Expanded a hospital-wide patient education program through "videos on demand.

Vice President, Patient Care Services & Chief Nursing Officer, Brooklyn Queens Hospital Corporation/Caritas, Brooklyn, NY - 1999 - 2008

Education: Herbert Lehman College, City University of New York, Bronx, NY
M.S., Nursing Administration, 1989
B.S., Nursing, 1977

Professional Certifications:

Registered Nurse, New York, Certified
Registered Nurse, Connecticut, Certified

Professional Organizations:

Connecticut Hospital Association, Wallingford, CT
NYONE
AONE

Curriculum Vitae
Moreen Donahue, DNP, RN, NEA-BC, FAAN

Professional Experience

Sr. Vice President, Patient Care Services & Chief Nursing Officer	Western Connecticut Health Network, Danbury, CT	2010 - Present
Sr. Vice President, Patient Care Services & Chief Nursing Officer	Danbury Hospital, Danbury, CT	2006 - 2010
Sr. Vice President, Patient Care Services & Chief Nursing Officer	Greenwich Hospital, Greenwich, CT	2000 – 2005
Director, Home Care & Hospice	Greenwich Hospital, Greenwich, CT	1997 - 2000
Vice President, Patient Care Services	United Home Care, Fairfield, CT	1990 - 1997

Professional History
Four decades of progressive administrative responsibilities in a variety of health care settings

Education

BS (Nursing)	Boston College, Boston, MA
MS (Education)	State University of New York, Cortland, NY
MSN	Case Western Reserve University Cleveland, OH
DNP	Case Western Reserve University Cleveland, OH

Professional 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)	Permanent Certification

Professional Organizations

American Academy of Nursing Fellowship	2011 – Present
American Organization of Nurse Executives	2007 – Present
American Organization of Nurse Executives – Connecticut	2007 - Present
Sigma Theta Tau International Honor Society of Nursing	2004 – Present
American College of Healthcare Executives	2002 - Present
American Nurses Association	2000 – Present
Connecticut Hospital Association Patient Care Executive Committee	2000 – Present
VHA Northeast CNO Network	2000 - Present

Other Areas of Interest
Nursing education, global collaboration, geriatric care, prevention of workplace violence

Curriculum Vitae

Eric Michael Mazur, MD

Professional Experience:

Vice President and Chief Medical Officer, Norwalk Hospital	May 2010 - present
Vice President of Clinical Integration Senior Management, Norwalk Hospital	2008 – May 2010
Chairman, Department of Medicine, Norwalk Hospital	1995 – May 2010

Summary of Professional History:

Dr. Mazur was appointed Vice President and Chief Medical Officer of Norwalk Hospital in 2010. In this role, he serves as a liaison between the medical staff and administration and is responsible for the daily management of patient care, patient safety, quality and graduate medical education. He also oversees the physician chairs of nine service lines and the operation of various inpatient and outpatient clinical services. After joining the Hospital in 1995, Dr. Mazur also served as Vice President of Clinical Integration and Chairman of the Department of Medicine. His professional memberships include the American College of Physicians and the American Society of Hematology. In 2012, he was elected a Master of the American College of Physicians. Dr. Mazur also serves as co-host of "Health Talk," a weekly local television show that provides health education for Fairfield County. He earned his undergraduate degree from Princeton University and his medical degree from Johns Hopkins University School of Medicine.

Education:

1967-1971	Princeton University Princeton, New Jersey - B.S.E. Summa Cum Laude Phi Beta Kappa
1971-1975	Johns Hopkins University School of Medicine Baltimore, Maryland - M.D. Alpha Omega Alpha
1975-1977	Categorical Internal Medicine Internship and Residency Strong Memorial Hospital, University of Rochester Rochester, New York
1977-1978	Postdoctoral Fellow in Hematology Yale University School of Medicine New Haven, Connecticut
1978-1979	Senior Internal Medicine Resident Yale-New Haven Hospital New Haven, Connecticut
1979-1981	Postdoctoral Fellow in Hematology and Oncology Department of Medicine, Yale University School of Medicine New Haven, Connecticut B.G. Forget and J.R. Bertino, Program Directors

Licenses and Board Certifications:

1979	Connecticut License
1981	New York License (Inactive)
1983	Rhode Island License (Inactive)
1988	Massachusetts License (Inactive)
July, 1976	National Board of Medical Examiners
Sept., 1978	American Board of Internal Medicine (active)
June, 1980	Subspecialty Board, Hematology (active)
Nov., 1981	Subspecialty Board, Oncology (active)

Professional Organizations:

American College of Physicians
- Fellow – January, 1992
- Connecticut Chapter Governor's Council - 1993-present
- Member, Health Care and Public Policy Committee - 1994-present
  - Leadership Day participant – 2003-2009
- Chairman, Annual Scientific Program Committee - 1994-1997, 2001-2004
- Laureate Award, (10/31/03)
- Governor-Elect, Connecticut Chapter (4/04 – 4/05)
- Governor, Connecticut Chapter (4/05 – 4/09)
- Top Ten Key Contact Special Recognition Award for 2004-2005 (Awarded May 17, 2005)
- Master, American College of Physicians (Awarded April 19, 2012)

American College of Physicians – Board of Governors
- Governor – Connecticut Chapter (Class of 2009), April, 2005- April, 2009
- Member – Medical Services Committee 2005-2007
- Abstract Review Board 2005 – 2008
- Resident Mentor 2005-2008

American Society of Hematology
American Society of Clinical Oncology (inactive)
American Cancer Society (inactive)
National Cancer Institute Investigator
Cancer and Acute Leukemia Group B (CALGB) - inactive

Curriculum Vitae
Matthew Alan Miller, MD

Professional Experience

1980-94	Director, Medical Intensive Care Unit, Danbury Hospital
1980-94	Chief, Pulmonary/Critical Care, 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

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

Licenses and Board Certifications

1975	Diplomat, American Board of Internal Medicine
1975	American Thoracic Society
1978	Diplomat, American Board of Internal Medicine in Pulmonary Disease
1981	Fellowship American College of Chest Physicians

Curriculum Vitae
Anthony R. Aceto III

Professional Experience:

Norwalk Hospital, Norwalk, CT January 2006- Present
Vice President Human Resources

Norwalk Hospital is a not for profit, community teaching hospital with 2,000 employees, 300 beds and $325 million in annual revenues. Reporting to the President and CEO, am responsible for directing a staff of 14 FTE's in all functions within Human Resources including Employee & Labor Relations, Compensation & Benefits, Staffing, Training & Organization Development.

Principal duties and responsibilities include:

- Establishment of Human Resource strategies and practices that support the organization's mission, values and business plans.
- Collaborate with the senior leadership team to identify opportunities for cost reductions, growth and improved operating efficiencies while maintaining the highest level of patient care, quality and customer satisfaction.
- Ensure that all Human Resources systems and practices facilitate the recruitment, retention and engagement of employees, with particular focus on high performers.
- Direct a comprehensive labor relations program to maintain effective relationship with Collective Bargaining agent for staff nurses. Directed highly successful negotiations resulting in three new Collective Bargaining Agreements.
- Ensure full compliance with all federal and state employment laws, regulations and requirements, and develop appropriate corrective action plans where needed.
- Conduct periodic market benchmarking to assure that HR practices, policies and programs are competitive.
- Establish a comprehensive training and development program for all employees to facilitate employee development, meet internal talent requirements, and to demonstrate the organization's investment in people.
- Plan and direct all Executive Compensation programs, and serve as staff member to Compensation Committee of Board of Trustees

Purdue Pharma L.P. Stamford, CT May 1999-December 2005
Executive Director, Human Resources January 2004–December 2005

Purdue Pharma L.P. is a privately held pharmaceutical company with 2005 sales of $1.8 billion and 2,500 employees in the U.S. Reported to the Senior Vice President of Human Resources, EHS and Administrative Services and was responsible for directing the effective planning and delivery of all HR services, operations and consultations in support of Purdue's Worldwide Research and Development group, Finance, IT, Corporate Procurement, General Counsel, Licensing and Business Development groups. Directed a department ranging in size from 12 to 6 HR professionals and support staff covering three locations in the U.S.

Key service offerings to clients included exempt and executive staffing and selection, employee relations, performance management, planning and administration of annual merit and bonus

programs, relocation and immigration, organizational development and meeting and program facilitation.

- Established and maintained HR as a key business partner through active participation and engagement with client operating and management committees. Provided direct facilitation, planning and guidance for all reorganizations and the application of appropriate internal OD resources and tools.
- Directed an employee relations program that provided equitable and consistent treatment of employees, discipline and conflict resolution while significantly reducing legal liability for the Company.
- In concert with the Senior V.P. HR, V.P. EEO Compliance and Office of the General Counsel, planned and successfully implemented multiple company restructurings and downsizings in a manner that was consistent with all state and federal laws and regulations and consistent with our company internal practices, procedures and core values.

Senior Director, Human Resources- Staffing & Headquarters Support 1999-2003
Reporting to the Vice President Human Resources, provided HR consultation and services to Purdue's Headquarters operations and directed a department of 6 HR professionals and support staff.

- Established a Center of Excellence for Staffing, directed a company-wide staffing plan in support of a 4 -year expansion program that resulted in the addition of more than 1,400 new colleagues.
- Successfully directed the external recruitment program for 10 new Vice Presidents in a variety of disciplines.
- Played a lead HR role in the acquisition and integration of CoCensys, a neurosciences company based in Irvine, California. Led HR role to consolidate existing and new resources into the new Research Center in Cranbury, New Jersey.
- Worked with Corporate Procurement to develop a formal RFP program for Preferred Providers of staffing services that resulted in an annual cost savings of $110K.
- Worked with HRIS group to lead the development of a new custom on line applicant flow and tracking system, a new on line Employee Referral Program, and a web based new hire offer and benchmarking approval system, all of which interfaced with PeopleSoft 8.5
- Developed an Interviewing and Selection skills toolkit for the HR Home page
- Directed the development and launch of a web based New Employee Orientation Program.
- Served on the Editorial Board of ***@Purdue***, the company internal quarterly news magazine.

SUMMARY
Human Resources Executive experienced in building collaborations with senior management to develop and implement human resources programs, provide guidance and consultation in organizational planning and employee development, and to assure that strategic and operational business objectives are achieved.

Education:
B.A., History, Boston College, Chestnut Hill, MA
MBA, University of New Haven, West Haven, CT

Professional Organizations:

Society for Human Resource Management (SHRM)

Curriculum Vitae
Phyllis F. Zappala

Professional Experience:
In her progressive career spanning over 25 years in general industry and healthcare, Phyllis has served in numerous HR leadership roles with increasing responsibility. Phyllis is known for her expertise in directing rapid growth and change in healthcare, services and manufacturing environments. She has successfully used HR strategies to help organizations achieve their business goals.

Western Connecticut Health Network, Danbury CT – 1998-Present
Senior Vice President Human Resources 2008 to date
Vice President Human Resources 1998 to 2007
Western Connecticut Health Network, consisting of Danbury and New Milford hospitals and numerous subsidiaries, is a leading regional health care provider located in western Connecticut with nearly 5000 employees including a 250 member physician practice subsidiary.

Staveley Industries plc, Norwalk, CT - 1988-1998
A UK based publically traded company with services and manufacturing holdings in 15 countries
Senior Vice President Human Resources, North America (1994-1998)
Vice President Human Resources (1988-1994)

The Penn Central Corporation – 1978-1988
Vice President of Human Resources and Corporate Communications (1978-1988); services and manufacturing businesses
HR Director (1981-1984)
HR Manager (1978-1981)

Education
Undergraduate: Bachelors Degree, St. John's University

Professional Certifications
Certificate from the New York School of Industrial Relations at Cornell University

Professional Organizations
American Society for Healthcare Human Resources Administrators (ASHHRA)
Connecticut Hospital Association (CHA)
The HR Investment Center, a program of the Health Care Advisory Board in Washington, D.C.

Curriculum Vitae
Kristen M. Staikos, Esq.

Professional Experience:

Norwalk Hospital, Norwalk, CT **March 2011 – present**
Chief Legal Officer
Responsible for management and direction of the planning, coordination and execution of all legal matters within the Hospital, including, without limitation, corporate transactions, labor and employment, real estate, litigation management, contracting, medical foundation and medical staff matters. Responsible to provide legal advice and counsel to senior management and the Board of Trustees of the Hospital on all matters related to Hospital operations.

Staff Counsel and Director, Employee Relations **November 2007 – March 2011**
Responsible for management and oversight of all matters related to the Hospital's Collective Bargaining Agreement. Directly managed all Hospital employment law matters with the EEOC, Connecticut Commission of Human Rights and Opportunities, and civil and federal employment matters. Provided day-to-day advice and counsel to the Hospital Human Resources Department and management.

Purdue Pharma L.P. **January 2001 –2007**
Assistant General Counsel
Supported multiple departments within the Company with respect to all legal issues, including human resources, corporate procurement, security and environmental. Assisted the legal department with the management and coordination of class action civil litigation and managed all employment litigation. Responsible for the management and oversight of the Company's Political Action Committee.

Education:
LeMoyne College, Syracuse, New York
B.S. Business Administration

Albany Law School of Union University, Albany, New York
Juris Doctorate

Professional Certifications:
Admitted to Connecticut and New York Bar

Professional Organizations:
Norwalk Hospital Physician & Surgeons Board Member, Secretary
Board Member, Saugatuck Child Care Services, Inc., Co-President,
Former Board Member, East Norwalk Library, Norwalk Public Library System
Former Board Member, Norwalk Public School System

Curriculum Vitae
Carolyn L. McKenna, Esq.

Professional Experience

Western Connecticut Health Network, Inc., Danbury, CT ***April, 2011 - Present***
General Counsel. Provide legal support for a two-hospital regional health system with home care services, a multi-specialty physician group, research and a multiple joint ventures. Support all corporate transactions, contracting, regulatory issues, litigation oversight, governance, risk and compliance. Provide management oversight responsibility for Western Connecticut Health Network Insurance Company, Ltd., an offshore captive insurance company. Participate in strategic development as a senior team member.

Eastern Connecticut Health Network, Inc., Manchester, CT	2003 - 2011
CIGNA Healthcare, Bloomfield, CT	2002 - 2003
YALE NEW HAVEN HEALTH SERVICES CORP., New Haven, CT	1998 - 2002
UNITED HEALTHCARE, INC., Hartford, CT Associate General Counsel	1995 - 1998
QUINNIPIAC UNIVERSITY SCHOOL OF LAW, Hamden, CT	1998 - 2001
U.S. DISTRICT COURT, District of Connecticut	1993 - 1995
U.S. COURT OF APPEALS FOR THE SECOND CIRCUIT	1992 - 1993

Education

UNIVERSITY OF BRIDGEPORT SCHOOL OF LAW, Bridgeport, CT
(Note: This is now Quinnipiac University School of Law, Hamden, CT)
J.D., May 1992 (Rank: Top 4%)
Honors: *magna cum laude*; Dean's Scholarship recipient
Activities: *University of Bridgeport Law Review*, Managing Editor; Phi Delta Phi Honors Fraternity

UNIVERSITY OF VERMONT, Burlington, VT
B.A. in English May 1985

Professional Certifications

Member of Connecticut and District of Connecticut Bars

Professional Organizations

American Health Lawyers In House Legal Counsel
Healthcare Roundtable
Association of Corporate Counsel
Connecticut Health Lawyers Association

Curriculum Vitae
Jeannine Foran

Professional Experience:

Norwalk Health Services Corporation, Norwalk, CT **November 2008 - present**
Chief Risk and Compliance Officer
Responsible for providing day-to-day leadership of the Hospital's Risk Management program, including oversight and monitoring of risk mitigation efforts. Oversees Corporate Compliance Program function at Hospital and affiliates, provide guidance on compliance matters to CEO, Senior Leadership Team and Trustees, provides oversight of third-party administrator for claims review and administration, supervises outside defense counsel in management of professional liability matters, and develops and implements policies aimed at risk reduction and mitigation.

Danbury Health Systems, Inc., Danbury, CT **May 2007 – November 2008**
Director of Risk Management and Legal Services
Coordinated risk management and legal services in conjunction with compliance program to identify and manage areas of exposure in order to reduce institutional ability and promote effective health care delivery.

Cambridge Integrated Services Group, Inc **October 2006 – May 2007**
Director of Professional Liability Claims/Risk Management
Administered claims management and litigation management for Norwalk Hospital and Danbury Health Systems, including review and analysis of professional and general liability claims and investigated and analyzed adverse events.

Education:
Villanova University School of Law
Juris Doctor; May 1992
University of Rhode Island
Bachelor of Science, Nursing; 1985

Licensure:
Registered Nurse, State of Connecticut (since 1988)

Bar Admissions:

Connecticut	1993	(State and Federal)
New York	1993	(State and Federal
Maryland	1992	

Curriculum Vitae
Joseph A. Campbell

Professional Experience

2001 to Present	Chief Risk & Compliance Officer – Western Connecticut Health Network
1989 – 2001	Chief Compliance Officer & Quality Executive – Greater Waterbury Health Network
1987 – 1989	Visiting Nurse Association of South Central Connecticut – Chief Financial Officer

Professional experience includes more than thirty years in the non-profit, healthcare industry in Connecticut; approximately ten years in Finance, ten years in Quality Management and fourteen years in Compliance.

Currently responsible for WCHN's Compliance Program that includes Regulatory Compliance, Revenue Compliance, Physician Coding Compliance, Internal Audit, Enterprise Risk and HIPAA Privacy.

The Chief Risk & Compliance Officer serves as a consultant to senior management in a matrix organization; is the key contact with outside regulators, i.e., DHHS Office of the Inspector General; U.S. Department of Justice; DHHS Office of Civil Rights; State of Connecticut Department of Social Services; and State of Connecticut Office of the Attorney General.

Education

B.S. Degree in Accounting/Business Administration
M.S. Degree in Healthcare Management
Rensselaer Polytechnic Institute

Professional Organizations

American College of Healthcare Executives
Health Care Compliance Association
Healthcare Financial Management Association
Institute of Internal Auditors

Professional Presentations

"The Role of Compliance in the Revenue Cycle"
Connecticut Chapter – Healthcare Financial Management Association, Uncasville, CT

"Retrospective Review of an OIG Self-disclosure"
American Health Lawyers Association/Healthcare Compliance Association, (AHLA/HCCA)
Fraud and Abuse Forum, Baltimore, MD

"Improving Internal Response to Audit & Compliance Situations"
Connecticut Hospital Association Annual Compliance Conference, Wallingford, CT

"Physician Responsibilities Under EMTALA"
National Association of Medical Staff Services, Las Vegas, NV

Curriculum Vitae
Stephen Paul O'Mahoney, MD, FACP

Professional Experience:

2010-Present

Chief Medical Information Officer
Interim CIO (2012)
Norwalk Hospital

Physician leader in charge of advancement, optimization and ongoing maintenance of clinical systems and technology to support the mission of Norwalk Hospital. Provides expertise and support in the use and development of technology to promote quality care, efficiency and patient safety. Reports to the President and CEO. Specific duties include:

- Comprehensive responsibility for IT including operations, management, clinical integration, and vision
- Chairman of IT Steering Committee
- Responsible for the development and implementation of the IT Strategic Plan
- Leader for Meaningful Use achievement to receive maximum ARRA funding for HIT – Completed Stage I attestation 6/12
- Leader in physician strategy for local and regional Health Information Exchange
- Leader in charge of ICD10 implementation
- Key member of ACO planning committee to ensure readiness for new payment models and population health management
- Provide education, leadership, and advocacy for the Medical Staff related to clinical information technology
- Support all departments in the development and maintenance of technology to improve patient care, efficiency, and outcomes
- Physician champion for maintenance and development of clinical IT infrastructure

2011-Present

Chief Quality Officer
Norwalk Hospital

Reports to the Vice President and Chief Medical Officer as the senior leader in charge of Quality at Norwalk Hospital. Responsible for promoting the mission of Norwalk Hospital through identification and mitigation of at risk systems and practices, promoting and supporting a just culture, optimizing clinical processes, developing a robust quality and safety infrastructure, implementing best practices, maintaining full compliance with regulatory bodies, and achieving highest performance in quality and safety outcomes. Specific duties include:

- Quality Strategic Plan
- Ownership of Measurable Quality
    - JCAHO Core Measures

  - CMS Alliance Measures
  - Value Based Purchasing
- Leader of Key Hospital Committees
  - Quality Committee of the Board of Trustees
  - Medical Staff Quality Committee
  - Patient Safety committee
  - Infection Control
  - Medication Safety
  - Electronic Security Task Force
- Member of Quality Leadership Council
- Regulatory Compliance
- Public Reporting

Key accomplishments include:

- Healthgrades Distinguished Hospital of Clinical Excellence recognized as top 5% nationally in clinical outcomes: 2010, 2011, 2012
- 2011 John D. Thompson award from the Connecticut Hospital Association for "Excellence in the Delivery of Healthcare through use of Data"

2005-Present **Chairman, Medical Staff Quality Committee**
Norwalk Hospital

Leading the peer review process in an effort to improve quality and safety at Norwalk Hospital. Duties include the establishment of peer review standards for the institution, leading quality of peer review, facilitating communication and distribution of best practice among all hospital departments, providing the institution with peer reviewed data to improve safety and quality, identifying both individual and system issues that need improvement, and ensuring proper resolution of issues.

Education:

1988-1992	B.S.E. - Computer Engineering, University of Connecticut, *Valedictorian, Summa Cum Laude*
1992-1996	M.D., University of Connecticut School of Medicine
1996-1999	Post Graduate Training - New York Hospital - Cornell Medical Center, including Memorial Sloan Kettering Cancer Center
2009	Lean for Healthcare. Center for Executive Education of the College of Business Administration, University of Tennessee, Knoxville TN
2009	AAIM Executive Leadership Program. The Crimson Group, Cambridge MA.

Licenses and Board Certifications:

1999-Present	Board Certified in Internal Medicine (ABIM)
1999-Present	Connecticut State Medical License (#037765)
1997-1999	New York State Medical License (#208675)

Professional Organizations:

2011-Present	Connecticut Hospital Association
	Member of CIO Committee
	Member of the Committee on Patient Care Quality
2001 – Present	Governor's Council ACP, Member, Connecticut Chapter.
2003 - Present	American Medical Informatics Association
1998 - Present	American College of Physicians, Current Fellow
2000 - Present	Society of General Internal Medicine
2001 - Present	Society of Hospital Medicine

Other Areas of Interest:

Americares Free Clinic, Norwalk, CT, voluntary physician staff since 1999
St. Thomas Aquinas – School volunteer
Habitat for Humanity – assisted in building houses for the needy
Youth sports coach – soccer and basketball

Curriculum Vitae
Kathleen DeMatteo

Professional Experience

July 2011 – Present	Western Connecticut Health Network, Danbury, CT Chief Information Officer

Current responsibilities include oversight of all Information Technology for WCHN including clinical and financial systems, infrastructure, customer service, networking, telecommunications and health information management.

Recent accomplishments include the following:

- Developed an Information Technology Strategic Plan to align with the WCHN Strategic Plan.
- Implemented an IT governance structure to ensure alignment with business priorities.
- Established a strategy to centralize IT resources from Danbury Hospital and New Milford Hospital and standardize infrastructure and applications for the two hospitals.

2004 – 2007	Saint Francis Care, Hartford, CT Chief Information Officer
1999 - 2004	Saint Francis Care, Hartford, CT Director, Information Technology

Education

BS	Occupational Therapy University of New Hampshire, Durham NH
MPH	Healthcare Policy and Administration New York Medical College, Valhalla NY

Professional Organizations

College of Healthcare Information Management Executives (CHIME)
Health Information Management Systems Society (HIMSS)

Curriculum Vitae
James R. Haynes, CHFM

Professional Experience:

Executive Director, Facilities Operations, Norwalk Hospital	Feb 2006 - present
Director of Design & Construction, Norwalk Hospital	Sept 2004 – Feb 2006
Senior Project Manager, ARAMARK Facility Services, Norwalk Hospital	May 2002 – Sept 2004

Summary of Professional History:

Mr. Haynes joined Norwalk Hospital in 2004 and assumed the role of Executive Director Facilities Operations in 2006. In this role, he is responsible for the daily management of facilities, real estate and support services. He also oversees the current construction of a new 100,000 sf expansion that will be the new home of our Ambulatory Pavilion. Since joining the Hospital in 2004, Mr. Haynes has also served as Director of Design & Construction and Director of Facilities. Prior to joining Norwalk Hospital, Mr. Haynes worked for Aramark Facility Services supporting multiple hospitals across the United States. His professional memberships include American College of Healthcare Executives and American Society of Healthcare Engineers. He received his undergraduate degree from Widener University. Mr. Haynes is a Certified Healthcare Facility Manager.

Education:

Widener University, Chester, PA
B.S. Mechanical Engineering, 1996

Rensselaer Polytechnic Institute, Hartford, CT
Several credits towards Master's Business Administration

Professional Certifications:

Certified Healthcare Facility Manager [CHFM], 2010
ASHE - Certificate in Healthcare Construction, 2004
Certificate in Construction Management, 2001
Certified Facility Manager [CFM], 2000
30 Hour Training Course in General Industrial Safety & Health, 1998

Professional Organizations:

Member, American Society of Healthcare Engineers (ASHE)
Member, American College of Healthcare Executives (ACHE)

Curriculum Vitae
Morris Gross

Professional Experience
Danbury Hospital since 1975 in administration (38 years). During this time period has been responsible for almost all hospital departments, both clinical and support departments. Has held role of Vice President Facilities since 1992, and since October 2010 has been responsible for Facilities for Western Connecticut Health Network which includes both Danbury and New Milford Hospitals.

Since 1975, I have provided administrative support for all major construction projects including the Tower Project completed in 1979, the construction of the Stroock building, Cancer Center, Medical Arts Center building and Garage, and currently am responsible for the New North Tower project totaling 316,000 sq ft plus Blue Garage expansion. I am also responsible for the siting, development and ongoing facilities support for all offsite locations for Danbury and New Milford Hospitals as well as the development and implementation of the Master Facility Plan of both hospitals. In addition to construction and offsite development, I am currently administratively responsible for the Facilities division at Danbury and New Milford Hospitals including all plant operations, safety, security, environmental services, dietary, gift shops, and spiritual care.

Education
Undergraduate- University of Connecticut, Bachelors in Physical Therapy (1971)
Graduate- New York University, Masters in Health Administration within Graduate School of Public Administration (1975)

Professional Certifications
Licensed in Physical Therapy in Connecticut and New York
Fellow in the American College of Health Executives

Professional Organizations
Fellow in the American College of Healthcare Executives
Education Chairman for Connecticut for the American College of Healthcare Executives (since 1992)
On Board of Habitat for Humanity for Fairfield County

Other Areas of Interest
Member of Danbury Connecticut Lions Club since 1978

Curriculum Vitae

Joanne Svogun, RN, BSN, MHA, MSN, NEA-BC

Professional Experience:

Executive Director, Quality and Case Management, Norwalk Hospital	2012 – present
Director, Patient Care Service, Norwalk Hospital	2004 – 2012
Director, Nursing Honey Hill Care Center, Norwalk Hospital	2002 – 2004

Professional History:

Ms. Svogun joined Norwalk Hospital in 2002 as Director of Nursing Honey Hill Care Center and in 2004 she became the Director, Patient Care Service in Quality. In Ms. Svogun's current position as Executive Director, Quality and Case Management she is responsible for organizational quality, patient safety, infection control and regulatory compliance. She is leading the organization in developing High Reliability concepts and a just culture, and is improving processes to increase event reporting. Ms. Svogun is the Chair of Length of Stay committee, which decreased LOS by 3 days. She has developed a Triad Model for case management and in collaboration with physician leadership is building a Utilization Management Department, as well as a Readmission Collaborative for CHF. As Director of Patient Care Service, Ms. Svogun developed programs for education of all nursing staff, including a clinical expert program. She initiated MSN and BSN cohort program in collaboration with Sacred Heart University, maintained nursing competency, and monitored and reported Nursing Quality Indicators i.e. falls/skin/restraints. Ms. Svogun also initiated an outpatient ostomy program and ostomy support group, developed Professional Practice Model and collaborated to develop shared governance system, and is LEAN Certified.

Education:

Master in Nursing Administration Sacred Heart University, School of Nursing, Fairfield, CT	2011
Master of Health Care Administration Western Connecticut State University, School of Healthcare Administration, Danbury, CT	2008
Bachelor of Science in Nursing Sacred Heart University, School of Nursing, Fairfield, CT	2004
Associate in Nursing Misericordia College of Nursing, Bronx, NY	1997

Licenses and Board Certifications:

RN license State of Connecticut	Current
Certified Nurse Administrator Advanced (NEA-BC)	
Certification Nurse Executive Advanced, American Nurses Association	2011
Certification in Nursing College Teachers Preparation, Hartford Hospital	2009

Professional Organizations:

Connecticut Nurses Association
American Nurses Association

Other Areas of Interest:

Process Improvement
Advancing Nursing Education
Achieving Magnet Status

Curriculum Vitae
Dawn N. Myles

Professional Experience

12/08-Present — *Vice President, Quality and Patient Safety, Western Connecticut Health Network, Danbury, CT*
Direct the strategic planning and program implementation for quality improvement, patient safety/risk management, patient relations, volunteers, and infection control. Responsible for regulatory compliance programming and communication. Oversee initiatives with high impact on quality, patient safety, and efficiency.

10/97-12/08 — *Director of Performance Improvement/Chief Quality Officer, Danbury Hospital, Danbury CT*
Directed performance improvement, patient safety/risk management, patient relations, infection control, project management, and medical informatics functions. Responsible for clinical regulatory compliance functions. Oversaw participation in national quality programs, such as those sponsored by Leapfrog and the Institute for Healthcare Improvement

02/96-6/00 — *Director of Nursing & Quality Management, Behavioral Health, Danbury Hospital, Danbury, CT*
Supervised nursing practice in all inpatient and outpatient psychiatric and chemical dependency programs. Was directly responsible for daily operations on the inpatient psychiatric unit. Organized a system of orientation and cross training of service line nursing staff. Redesigned the Behavioral Health Quality Management program.

Education

01/95-09/96 — *M.S., Nursing, Clinical Nurse Specialist - Psychiatric/Mental Health Nursing, Pace University, Pleasantville, NY*

09/89-05/92 — *B.S., Nursing, Western Connecticut State University, Danbury, CT*

09/88-05/90 — *M.S., Counseling, Southern Connecticut State University, New Haven, CT*

09/84-05/88 — *B.A., Psychology/Communications, Western Connecticut State University, Danbury, CT*

Professional Certifications

Certified Professional in Healthcare Quality (CPHQ)
Certified Professional in Healthcare Risk Management (CPHRM)

Professional Organizations

American Society for Healthcare Risk Management
Connecticut Society for Healthcare Risk Management

Other Areas of Interest

Mentoring and Training

Curriculum Vitae
Jeryl Topalian, M.S., R.D.

Professional Experience:

Norwalk Hospital, Norwalk, Connecticut **3/86 – Present**

Executive Director, Planning & Business Development **7/10 – Present**

As a key member of Norwalk Hospital's leadership team, the Executive Director, Planning & Business Development is responsible for strategic planning, business planning and identifying growth opportunities. Works collaboratively with the senior management team, and relevant clinical leaders. Supports the Strategic Planning Committee of the Board of Trustees.

- Responsible service line business plans, physician development plan, CON and regulatory body process. Direct responsibility for marketing and communications departments through 2012, now oversee market research and service line marketing plans. Developed system Physician Liaison Program.

Director, Planning & Business Development **11/08-7/10**

Directs, leads and facilitates planning processes throughout the system, strategic and business. Responsible for market analysis. Provide internal consulting on business and strategic planning to leadership. Coordinates CON process. Leads development of annual strategic initiatives.

- Team leader for Master Facility Plan: Ambulatory Pavilion, a $110 M capital project
- Led strategic planning process to develop long-range strategic plan: Vision 2015

Director, Service Line Development, Women's & Children's Services **4/05 – 11/08**

Expanded Service Line operations responsibilities to include planning and business development. Developed strategic initiatives to meet quarterly growth targets identified in the hospital's strategic plan. Reported to VP Planning and Business Development.

Director, Women's & Children's Services **11/98–4/05**

Led the Women's and Children's Service Line. Developed strategic and operating plans, programs and services; marketing and public relations programs. Operational and financial responsibility for the departments of Obstetrics & Gynecology and Pediatrics, and four Fairfield County Medical Services (FCMS) group practices: Neonatology, Perinatology, OB/GYN & Midwifery, and Pediatrics. Worked collaboratively with two Chairmen, reported to COO.

Administrative Director: Departments of Surgery, Anesthesiology, Obstetrics & Gynecology, Pediatrics, and Food & Nutrition Services **4/95–11/98**

Responsible for 138 FTE's and an operating budget of over $9 million. Worked with five Department Chairmen/Vice President to provide leadership and direction for respective departments' administrative and operational activities. Reported to Chief Operating Officer.

Director, Food and Nutrition Services **3/86-4/95**

Responsibility for 79.5 FTE's and an operating budget of greater than $2 million. Administrative and clinical responsibility for programs, policies and procedures, and purchasing relating to nutrition and patient food services. Maintained department quality improvement program, resulting in three successful JCAHO site evaluations.

New York University Medical Center, New York, New York **5/84 - 3/86**
Senior Nutritionist, Cooperative Care Unit

Huntington Hospital, Huntington, New York **5/80 - 5/84**
Clinical Dietitian

Education:

Post-Graduate Certificate: Healthcare Administration, MBA Program
Sacred Heart University, Fairfield, Connecticut

M.S., Nutrition Education. Mass media/communications emphasis
Teachers College of Columbia University, New York, New York

Dietetic Internship
The New York Hospital-Cornell Medical Center, New York, New York

B.S., Dietetics, Magna cum Laude
Michigan State University, East Lansing, Michigan

Faye S. Kinder Award for Outstanding Dietetic Student, Michigan State University

Professional Certifications:

Registered Dietitian, R560191

Professional Organizations:

Omicron Nu Honor Society
American College of Healthcare Executives
Society for Healthcare Strategy and Market Development
New England Society for Healthcare Strategy

Curriculum Vitae
Sally F. Herlihy, MBA, FACHE

Professional Experience

2010 – Present — Western Connecticut Health Network, Danbury, CT
2010 – Present, VP, Planning
2011– Present, Interim VP, Marketing

Plans, organizes, directs and facilitates strategic planning processes, including creation of an overall WCHN Strategic Plan and monitoring implementation. Manages and coordinates planning across network entities, consults and informs leadership and service lines on business and strategic planning issues, including market share, market surveys, planning processes, future trends, and environmental assessments, and managing the CON process. Directs community needs assessments, oversees implementation of a public and government relations agenda, and collaborates in the strategic marketing planning for WCHN.

1985 – 2010 — New Milford Hospital, Inc. New Milford, CT
2007 – 2010 VP, Regulatory Compliance
1997 – 2007 VP, Planning and Marketing
1988 – 1997 VP, General Services
1985 – 1988 Corporate Project Planner

1980 – 1985 — The Seiler Corporation, Waltham, MA
1983-1985 Director, Food Services, New Milford Hospital, CT
1981-1983 Chief Dietitian, New Milford Hospital, CT
1980-1981 Clinical Dietitian, St. Elizabeth Hospital, Utica, NY

Education

1995 — University of New Haven, New Haven, CT
MBA (concentration in Health Care Management)

1980 — University of Connecticut, Storrs, CT
BS Degree, School of Allied Health (Clinical Dietetics)

Professional Certifications

1992 - Present — American College of Health Care Executives
Fellow Status – 2007, recertified - 2010
Diplomate – 1998, recertified - 2006
Member – 1992

American Dietetic Association
Registered Dietitian – 1980 - 2000

Curriculum Vitae
Mary G. Franco

Professional Experience:

2006-Present
President, Norwalk Hospital Foundation
Vice President, Public Affairs Norwalk Hospital:

Responsible for overall fundraising strategy and implementation including $30M capital campaign. Achieves $10.5M annual income and 81% ROI (three year average). Also responsible for government relations and advocacy, community strategy and governance for board of trustees, among other activities. Serves as community liaison.

1997-2006
Vice President Corporate Citizenship, GE Capital

Worked globally to build partnerships between company and local governments and non-government organizations to improve local communities and build brand. Managed charitable contributions and voluntary programs world-wide, as well as company's political action committee and employee giving campaigns. Franco was a leader in the GE Women's Network.

Prior to GE, Franco held leadership positions with the University of Connecticut where she played a key role in the creation of the University's Stamford campus, as well as the National Spinal Cord Injury Association and the Vermont Law School.

Education:
BA American Studies, Merrimack College, North Andover, MA 1981

Professional Organizations:
Trustee, Merrimack College
Board member, First County Bank
Board member, Norwalk Chamber of Commerce
Co Chair, Greater Norwalk Opening Doors Services Committee
Member, New Canaan Telehealth Committee
Former member, Governor's Early Childhood Research and Policy Council
Former regional board chair, National Conference for Community and Justice
Former board member, United Ways of Stamford, Norwalk and Wilton
Green Belt certified, Black Belt trained, Management development trained, GE

Curriculum Vitae
Grace Linhard

Professional Experience

Executive Director & Vice President, WCHN Foundation
2011-present

Vice President, Danbury Hospital Development Fund
2004-2011

Chief Development Officer, Waterbury Hospital
1998-2004

- Fundraising professional for 20 years
- Experience in United Way system (4 years) and healthcare philanthropy (16 years)
- Currently overseeing $50 million campaign for WCHN
- Manage $10+ million annual fundraising effort for WCHN's two hospitals
- Oversee fundraising department with 13 staff members
- Work closely with WCHN leadership team, physician leaders, Boards of Directors and other volunteer committees to maximize fundraising potential
- Develop and execute fundraising goals/plans

Education

Stonehill College
BA, Communication/Journalism

Professional Organizations

Association of Fundraising Professionals
New England Association of Healthcare Professionals
Planned Giving Society of Connecticut

Volunteer Affiliations

Board Chairman	- Jane Doe No More, Inc.
Alumni Class Agent	- Stonehill College
Volunteer	- Church of the Nativity, Bethlehem
Fundraising Consultant/Volunteer	- Clube Uniao Portuguesa

Awards / Recognitions

2010 Conference Speaker	- Int'l Assn of Fundraising Professionals
2009 Conference Speaker	- NE Assn of Healthcare Professionals
2008 Leadership Graduate	- Danbury Chamber of Commerce
2002 Leadership Graduate	- Greater Waterbury Chamber of Commerce
2002 Conference Chairman	- Assn of Fundraising Professionals

Curriculum Vitae
Michael R Marks, MD MBA

Professional Experience:

Vice-President Business Development — August 2010 – Present
President – Norwalk Hospital Physicians & Surgeons
Norwalk Hospital
Norwalk, CT 06856

- Reorganized the entire employed physician group management team and implemented the necessary changes to make it compliant with 2009 Connecticut Laws
- Implemented Cerner EMR in the practices to bring IT integration to the group
- Implemented new employment agreements that hold physicians accountable for financial performance and rewards quality, patient satisfaction and citizenship.
- Changed the culture of the employed physician group that they are not independent practices but an integral part of a larger organization
- Focused attention to improving the balance sheet within the limitations that prior agreements permitted
- Expanded the employed group geographically, and medical specialty
- Oversaw the consolidation of Rehabilitation and Occupational Health Services into one facility with a turnaround in financial performance of rehabilitation service
- Major reorganization of the Marketing Department with the hiring of a new Marketing & Sales Director and hiring of a new ad agency. Launch of new website with improved ability for analytics.
- Initiation of a physician liaison program to engage the medical staff in the services available at Norwalk Hospital

Coastal Orthopaedics, PC — August 1988 – December 2010
Norwalk, CT 06851

- Led the merger of two separate orthopaedic groups creating Coastal Orthopaedics in 2002
- As President, oversaw the expansion from 9 orthopaedist to 12 orthopaedist, 2 physiatrists, a physician assistant and hand therapist.
- Expanded services to include early morning hours and evening hours and expansion to 3 locations (Darien, Norwalk & Westport)
- Oversaw revenue grow to more than $12M

Education:

B.S. - Union College - Cum Laude
Schenectady, NY, June 1978

M.D. - George Washington University School of Medicine
Washington, D.C., May 1982

MBA - University of Tennessee, Physician's Executive
Knoxville, TN, December 2001

Post Graduate Training:

Fellow in Spine Surgery - August 1987 - July 1988
Cleveland Clinic Foundation, Cleveland, OH

Orthopedic Surgery Resident - July 1983 - June 1987
George Washington University Medical Center, Washington, D.C.

General Surgery Intern - July 1982 - June 1983
George Washington University Medical Center, Washington, D.C.

Licenses:

Connecticut - Since 1988
District of Columbia - 1984 - 1987
Massachusetts - 1994 – 2002

Board Certification:

Orthopaedic Surgery - July 1990
Orthopaedic Surgery Recertified – Thru 2010
Orthopaedic Surgery Recertified – Thru 2020

Professional Organizations:

American Academy of Orthopaedic Surgeons, 1986 – present
American College of Physician Executives, 2008 – present
American Medical Association, 1982-2008
American Spinal Injury Association, 1995-2008
Connecticut State Medical Society, 1988 – present
Connecticut Orthopaedic Society, 1988 – present
Fairfield County Medical Society, 1988 – present
Federation of Physicians & Dentists, 1998 – 2001
Medical Group Managers Association, 2011
National Osteoporosis Foundation, 1994 – present
Norwalk Medical Society, 1988 - 2010
North American Spine Society, 2001 – present
Phi Delta Epsilon, 1982

Other Areas of Interest:

Improving society through educational and communication endeavors

Curriculum Vitae
Thomas J. Linhares

Professional Experience

1/2012 – Present	Executive Director Western Connecticut Medical Group, P.C.
2005 – 12/2011	Vice President of Operations Lenox Hill Hospital, New York, NY
2004 – 2005	Associate Director Navigant Consulting

Mr. Linhares has over 30 years of experience in healthcare as a clinician, consultant and administrator with an emphasis on process re-engineering, software utilization, physician practice development and operations improvement. As current Executive Director of Western Connecticut Medical Group (WCMG), Mr. Linhares provides general enterprise oversight including supporting hospital group operational integration and coordinating hospital support services to the group. In addition, developing strategies for budgets, staffing plans, and investment programs to assure a medical enterprise that is increasingly competitive and responsive to the needs of the community and WCHN. Specific goals include improving communications; improve facility utilization; improve profitability and the profit model; develop the management team, grow the group and assure financial viability.

Education

Masters of Science, Nursing Administration (1989) – Villanova University
Bachelor of Science, Nursing (1985) – LaSalle University
Associate Degree, Nursing (1977) – Bristol Community College

Professional Certifications

Registered Nurse

Professional Organizations

American College of Healthcare Executives
Sigma Theta Tau International Honor Society of Nursing

Exhibit K

Person to Contact: Mr. Chasin
Telephone Number: (202) 566-3969

Refer Reply to:
OP:E:EO:R:2
Date:

14 APR 1986

Norwalk Hospital Development
Fund Inc.
24 Stevens Street
Norwalk, CT 06856

Legend:

M = Norwalk Hospital Association
N = Norwalk Health Services Corporation
O = Norwalk Hospital Development Fund, Inc.
P = Norwalk Health Care, Inc.
Q = S. W. C. Corporation

Dear Ladies and Gentlemen:

This is in reply to the ruling request of March 15, 1985, which was submitted on behalf of M, N, O, and P. These organizations have asked for a number of rulings regarding the income tax consequences of a corporate reorganization and the related transactions described below. This letter will rule on the ruling requests of all the entities.

M is a non-profit organization engaged in the operation of an acute care hospital. M is recognized as exempt from federal income taxes under section 501(c)(3) of the Internal Revenue Code and is classified as other than a private foundation under sections 509(a)(1) and 170(b)(1)(A)(iii) as an organization whose principal purpose or function is the provision of medical or hospital care.

In addition to its operation of the hosptial, M has significant operational and administrative responsibilities in areas not directly related to the provision of medical care to hospital patients. These responsibilities involve: fund-raising for the hospital and its related programs and investment management of an endowment fund; operating a broad educational program involving nursing education and continuing education for physicians; operating programs for the delivery of health care services to persons other than hospital patients through the use of certain clinics and community health education programs; and, supervising and coordinating all of M's programs on a daily basis and long range planning and policy making for these programs.

M represents it recently evaluated its corporate structure, programs, assets and possibile future plans for the hospital. As a result, M determined it was in the best interests of the hosptial to reorganize its corporate structure through the creation of several additional corporations to which existing assets and/or programs could be transferred and which could undertake new programs.

N is a nonstock corporation organized exclusively for charitable, scientific and educational purposes to serve as the parent

entity whose function it is to plan, develop, coordinate and direct the system of related and integrated health care entities. N's Certificate of Incorporation provides that its principal purpose is to benefit, perform the functions of, carry out the purposes of and uphold, promote and further the welfare, programs and activities of M by:

1. initiating, developing, recommending and carrying out for M goals and priorities for new and expanded programs for the benefit of the hospital;

2. continuously evaluating, re-evaluating, maintaining and revising a master plan for the programs and facilities of M;

3. considering and recommending the acquisition of properties or the construction of facilities by or for the use of M;

4. planning for the acquisition and placement of new facilities and equipment by or for the use of M;

5. assuming certain administrative operations not directly related to the medical and hospital care provided by M; and

6. performing public relations work on behalf of M, and soliciting and receiving subscriptions and gifts for the exclusively charitable purposes of M.

In addition, your submission of January 21, 1986, indicates that N will offer various types of health care education programs to the public, including TelMed, diabetic training, stop smoking clinic, arthritis exercise clinic program, sleep disorder laboratory and various other programs.

The original and current members of N are those persons who were members of M as of the date N's bylaws were adopted. N's bylaws also provide that a majority of its Directors must also be persons who are members of the Board of M. N is exempt from federal income tax under section 501(c)(3) of the Code and is classified as other than a private foundation under section 509(a)(2).

O was organized as a nonstock corporation, with N as its only member, for exclusively charitable, scientific and educational purposes. O's principal activity will be maintaining an endowment fund and soliciting and receiving contributions on behalf of M and other section 501(c)(3) organizations associated with N. O is recognized as tax exempt under section 501(c)(3) and is classified as other than a private foundation under sections 509(a)(1) and 170(b)(1)(A)(vi).

P was organized as a nonprofit stock corporation, with N as its only member, for exclusively charitable, scientific and educational purposes. O's activities will consist of the operation of community health programs which may or may not include neighborhood health centers, retirement centers, nursing homes, rehabilitation centers, industrial health facilities, health maintenance organizations, and surgicenters. In addition, P may maintain health education programs for physicians and nurses. P is recognized as tax exempt under section 501(c)(3) and is classified as other than a private foundation under section 509(a)(2).

Q is organized as a for-profit stock corporation with N as its sole shareholder. N's ownership of all of the stock of Q will assure that Q's after-tax profits which are available for distribution will be applied to M's exempt purposes or otherwise returned to the N group in the form of dividends. The primary purpose of Q is to render health care related services. It is not anticipated the M, N, O and P will provide any services to Q, but if services are provided, an arm's-length fee will be charged.

M represents the plan of reorganization was undertaken in order to: 1.) assure M's continued leadership role in the communtiy and continued capacity to provide patient care at a lower cost; 2.) facilitate compliance with governmental reporting requirements; 3.) segregate hospital assets from non-hospital assets so as to limit third party liability; 4.) separate regulated and non-regulated activities; 5.) isolate unrelated business activities from exempt activities; 6.) remove the management of non-hospital activities and assets from hospital management; 7.) increase investment opportunities; 8.) increase flexibility in undertaking capital expenditure projects; and 9.) facilitate long-range planning. All of the corporations in the N health care system will thereby be able to promote more efficient delivery of health care for the community.

M represents that in order to implement the corporate reorganization, it amended its Charter and Bylaws to designate N as its sole member. After the reorganization, M, N, O, and P, will, as a group, conduct the activities formerly conducted by M alone. M will continue to operate the general acute care hospital and provide medical and hospital care. O will provide fund-raising and investment management services for M. P may assume certain of the outpatient medical care programs or community health education programs previously performed by M. In addition, O may undertake outpatient programs unexplored by M. Q will provide those services which are related to hospital and medical care but which M has avoided since they constitute an unrelated business activity subject to taxation under section 511-514. N will function as the parent corproation in the structure and will provide overall direction and control to M, O, P, and Q.

M represents that sufficient cash to provide working capital will be transferred to N, O, and P by M at the consummation of the reorganization.

Norwalk Hospital Development
Fund Inc.

cash transfers among the exempt organizations depending, in part, upon their respective needs for additional funds. M states that a factor which will influence future transfers of cash is efficient management. Where assets owned by M are not directly related to its hospital activities, such assets may be transferred to N in order to allow the management of M to focus exclusively on hospital-related activities.

It is represented that as part of reorganization, M may transfer to O monies previously raised by M on the condition that O hold these dollars in a separate, segregated fund which will be used solely for the benefit of M.

After the reorganization, M, N, O, and P will share some assets, personnel and services in an effort to reduce, through economies of scale, the overall cost of providing health care services. A fee may or may not be charged for these shared services. To the extent there are transactions between the exempt organizations and S, such transactions will be conducted on an arm's-length basis and would be at fair market value.

Section 501(c)(3) of the Code provides, in part, for an exemption from federal income tax for a corporation organized and operated exclusively for charitable, scientific or educational purposes provided no part of the corporation's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "chartiable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. The promotion of health has long been recognized as a charitable purpose.

Section 509(a) of the Code provides that the term "private foundation" means an organization described in section 501(c)(3) other than -

(1) an organization described in section 170(b)(1)(4) (other than in classes (vii) and (viii)):

(2) an organization which -

(A) normally receives were than one-third of its support in such taxable year from any combination of -

(i) gifts, grants, contributions or membership fees, and

(ii) gross receipts from admissions, sales of merchandise performance of services, or furnishing of facilities in an activity that is not an unrelated trade or business (within the meaning of section 513), net including the extent such receipts excess the greater of $5,000.00 or one percent of the organization's support in such

taxable year.

from persons other than disqualified persons (as defined in section 4944 of the Code) with respect to the organization, or from organizations described in section 170(b)(1)(A) (other than in clauses (vii) and (viii)), and -

(a) normally receives net more than one third of its support in each taxable year from the sum of -

(i) gross investment income and

(ii) the excess of the amount of the unrelated business income taxable income over the amount of the tax imposed by section 511;

Section 170(b)(A)(1)(iii) of the Code describes an organization the principal purpose or functions of which are the providing of medical or hospital care, if the organization is a hospital.

Section 170(b)(1)(A)(vi) of the Code describe an organization which normally receives a substancial part of its support (exclusive of income received in the exercise or performance of its charitable purpose or (section) from direct or indirect contributions from the general public.

Section 511 of the Code imposes a tax on the unrelated business taxable income (as defined in section 513) of the organizations described in section 501(c).

Section 512 of the Code defines unrelated business taxable income as the gross income derived by an organization from any unrelated trade or business regularly carried on by it, less the allowable deductions which are directly connected with the carrying on of the trade or business, with certain modifications.

Section 513 of the Code defines "unrelated trade or business," for any organization subject to tax under section 501(c)(3), as any trade or business the conduct of which is not substantially related (aside from the need of the organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its charitable, educational or other purpose or function constituting the basis for its exemption under section 501.

Section 1.513-1(d)(2) of the regulations provides that a trade or business is "unrelated" to exempt purposes only where the conduct of the business activity has a causal relationship to the achievement of any exempt purpose, and is, "substantially related" for purposes of section 513, only if the causal relationship is a substantial one. Thus, for the conduct of trade or business from which a particular amount of gross income is derived to be substantially related to purposes for which exemption is granted, the production or distribution of goods or the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes.

Section 1.170A-9(e)(6) of the regulations provides that unusual grants may be excluded from both the numerator and denominator of the applicable support fraction if such contributions (1) are attracted by reason of the publicly supported nature of the organization, (b) are unusual or unexpected with respect to the amount thereof, and (c) would, by reason of their size, adversely affect the status of the organization as normally being publicly supported for the applicable period. The regulation states that no single factor will necessarily be determinative and refers to section 1.509(a)-3(c)(4) for some of the factors to be considered.

Section 1.509(a)-3(c)(4) of the regulations provides that whether a grant is considered "unusual" depends on the facts and circumstances. The regulation lists several factors that will be taken into consideration in making the determination.

Rev. Rul. 78-41, 1978-1 C.B. 148, described in a trust whose sole purpose was to accumulate and hold funds for use in satisfying malpractice claims against a hospital. The trust was determined to be an integral part of the hospital because it was controlled by the hospital and because it was performing a function that the hospital could do directly. The organization was ruled to be exempt under section 501(c)(3) of the Code.

Rev. Rul. 67-149, 1967-1 C.B. 133, described an organization that was formed for the purposes of providing financial assistance to several different types of organizations which were exempt from federal income tax under section 501(c)(3) of the Code. It carried on no operations other than receiving contributions and incidental investment income and making distributions of income to such exempt organizations at periodic intervals. The organization did not accumulate its investment income. The orgaization was ruled to be exempt under section 501(c)(3) of the Code.

Rev. Rul. 69-545, 1969-2 C.B. 117, provides that a non-profit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose if it meets the other requirements of section 501(c)(3) of the Code.

Norwalk Hospital Development
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Under the corporate restructuring, N, the parent entity, will operate for the benefit of its tax-exempt subsidiaries by providing them with financial, management and advisory support services. The reorganization will facilitate the realization of benefits discussed above by permitting more effective and efficient use of resources, as well as providing the ability to shift resources to meet the ever-changing community health needs. In addition, providing management services on an institution-by-institution basis can be expensive and the consolidation of these activities result in reduced health care costs and better utilization of available management talent. In essence, the corporate reorganization will enable the related and integrated health care providers to define operational responsibilities more clearly by separating management and planning, fund-raising, and taxable business activities from the operation of the hospital and the provision of health care services.

Because N can be considered an integral part of the integrated health care system within the meaning of Rev. Rul. 78-41, supra, and because it is performing functions which M could perform itself, the reorganization will not adversely affect the exempt status of N. Similarly, since O, and P will continue to engage solely in activities related to their exempt purposes as defined in section 501(c)(3), their exempt status will not be adversely affected by the reorganization and related transactions. Furthermore, because N, O, and P will continue to meet the requirements of sections 509(a)(1) and (2), the corporate restructuring will not adversely affect their non-private foundation classifications.

The purposes and activities of M will not be altered as part of the reorganization. It will continue to provide primary acute care and related medical services to the community on the same basis as in the past. Assitionally, M will continue to operate an emergency room and provide medical services to the needy irrespective of their ability to pay. Since M will continue to meet the requisite criteria so as to qualify as a hospital within the meaning of Rev. Rul. 69-545, supra, its exempt status will not be affected by the reorganzization or related transactions. Futhermore, the reorganization and related transactions contemplated will not change M's status as a hospital under sections 509(a)(1) and 170(b)(1)(A)(iii) of the Code.

In regard to the effect of N's ownership of all of the stock of Q, section 1.501(c)(3)-1(c) of the regulations provides that an organization may qualify for exemption only if it engages primarily in activities which accomplish one or more exempt purposes specified in section 501(c)(3). The information submitted indicates that N°s primary activity is the supervision and coordination of health care services. Accordingly, the ownership by N of the stock of Q will not affect N's tax-exempt status under section 501(c)(3) of the Code. Furthermore, section 1.509(a)-4 of the regulations does not circumscribe the holding of stock to taxable organizations but merely defines the uses to which income derived from such investments is to be put. N's ownership of all of Q's stock will

assure Q's after-tax profits are applied to M's exempt purposes and therefore, N's ownership will not jeopardize its public charity status under section 509(a)(2) of the Code, assuming it otherwise continues to meet the public support requirements.

When all the functions were originally accomplished by M, it was evident that M's resources were devoted to the achievement of its charitable purposes. It follows that the transfer of certain assets to various exempt members of the health care system will not adversely affect the exempt status of any of the organizations involved because the transferred assets will be put to the same charitable uses as they had been by M. The tax on unrelated business income imposed by section 511 of the Code will not be applicable because section 513(a) of the Code and section 1.513-1(d)(2) of the regulations exclude from the definition of unrelated trade or business any trade or business which contributes importantly to the accomplishment of an organization's exempt purpose. The ongoing asset transfers and provision of services among the related tax-exempt corporations will contribute importantly to the provision of health care to the commmunity because the health care system concept will provide the ability to shift resources to meet the ever-changing community health needs. Therefore, the transactions described above will not result in unrelated business income under sections 511 through 514 of the Code for any transferor or transferee except with respect to transactions involving Q, the for-profit subsidiary, to the extent, if any, calculated in accordance with section 512(b)(13) of the Code.

Additionally, the one-time transfer of endowment type funds from M to O will qualify as an unusual grant within the meaning of sections 1.170A-9(e)(6)(ii) and 1.509(a)-3(c)(4) of the regulations. The transfer is unusual in that it is a one-time divestiture of non-patient care funds and investments by M as part of a major hospital restructuring. The amounts being transferred were solicited by M from the general public and will be held by O as a separate, segrated endowment fund solely for the benefit of M.

Based on the information furnished, we rule that:

1.) The corporate reorganization described above will not adversely affect the tax-exempt status of M under section 501(c)(3) of the Code or its non-private foundation classification under sections 509(a)(1) and 170(b)(1)(A)(iii);

2.) The corporate reorganization will not jeopardize the tax-exempt status of N under section 501(c)(3) of the Code or its non-private foundation classification under section 509(a)(2);

3.) The corporate reorganization will not jeopardize the tax-exempt status of O under section 501(c)(3) of the Code or its public

charity classification under sections 509(a)(1) and 170(b)(1)(A)(vi);

4.) The corporate reorganization will not jeopardize the tax-exempt status of P or its non-private foundation classification under section 509(a)(2)

5.) N's ownership of 100 percent of the voting stock of Q and N's receipt of dividends from Q will not adversely affect N's status under sections 501(c)(3) and 509(a)(2), provided the requisite support tests are met. Additionally, the taxable income of Q will not be construed to be unrelated business income to N and any dividends received by N from Q will not be unrelated business income to N;

6.) The proposed transfers of cash and other assets and the sharing of personnel, services, facilities, and expense by and between M, N, O, and P will not (a) jeopardize the continued tax-exempt status of M, N, O, and P as organizations described in section 501(c)(3); (b) adversely affect M, N, O, and P's status as public charities under sections 509(a)(1) and 509(a)(2); or and (c) give rise to unrelated business taxable income under sections 511-514 to any of the involved exempt organizations.

7.) M's transfer of its philanthropic funds to O will qualify as an unusual grant under section 1.170A-9(e)(6)(ii) and 1.509(a)-3(c)(3) of the regulations and may be excluded from the calculation of public support under section 1.170A-9(e)(2) or 1.170A-9(e)(3)(i) of the regulations; and

8.) Contributions to M, N, O, and P will continue to be deductible by the donors as provided in section 170 of the Code.

9.) Transfers of funds from M and O to N will qualify as public support under the one-third public suppoet test of section 509(a)(2) provided M and O contintue to qualify as other than a private foundation under section 509(a)(1) 170(b)(1)(A)(iii), and 170(b)(1)(A)(vi), respectively.

In regard to this ruling it should be noted that any payments received by N from M, O, or P in the form of fees for services will be treated as public support only to the extent that they do not exceed the greater of $5,000 or one percent of N's support as provided by section 509(a)(2)(A)(ii) of the Code and section 1.509(a)-3(b)(1) of the regulations.

This ruling is directed only to the organization that requested it. Section 6110(j)(3) of the Code provides that it may not be used or cited as precedent.

Norwalk Hospital Development
Fund Inc.

We are informing your key District Director of this ruling. If

Because this letter could help resolve any future questions about your exempt status and unrelated trade or business activities, you should keep it for your permanent records.
you should have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,

Milton Cerny
Chief, Exempt Organizations
Rulings Branch

Internal Revenue Service
P.O. Box 2508
Cincinnati, OH 45201

Department of the Treasury

Date: SEP 25 2006

DANBURY HOSPITAL
% FLEET INV SERV
24 HOSPITAL AVE
DANBURY CT 06810-609

Person to Contact:
Tracy Garrigus #31-07307
Toll Free Telephone Number:
877-829-5500
Employer Identification Number:
06-0646597

Dear Sir or Madam:

This is in response to your request of August 8, 2006, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in October 1946 that recognized you as exempt from Federal income tax. Our records further indicate that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section 509(a)(1) and 170(b)(1)(A)(iii).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

Cindy Westcott

Cindy Westcott
Manager, Exempt Organizations
Determinations

Internal Revenue Service
P.O. Box 2508
Cincinnati, OH 45201

Department of the Treasury

Date:

DANBURY HEALTH SYSTEMS INC
95 LOCUST AVE
DANBURY CT 06810-6148

Person to Contact:
Tracy Garrigus #31-07307
Toll Free Telephone Number:
877-829-5500
Employer Identification Number:
22-2594977

Dear Sir or Madam:

This is in response to your request of August 8, 2006, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in August 1985 that recognized you as exempt from Federal income tax. Our records further indicate that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section 509(a)(3).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

Cindy Westcott
Manager, Exempt Organizations
Determinations

Internal Revenue Service
P.O. Box 2508
Cincinnati, OH 45201

Department of the Treasury

Date:

DANBURY HEALTH CARE AFFILIATES INC
24 HOSPITAL AVE
DANBURY CT 06810-6099

Person to Contact:
Tracy Garrigus #31-07307
Toll Free Telephone Number:
877-829-5500
Employer Identification Number:
22-2594968

Dear Sir or Madam:

This is in response to your request of August 8, 2006, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in August 1985 that recognized you as exempt from Federal income tax. Our records further indicate that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section 509(a)(2).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

Cindy Westcott
Manager, Exempt Organizations
Determinations

Internal Revenue Service

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Date: November 22, 2002

Danbury Office of Physicians Services P C
95 Locust Ave
Danbury, CT 06810-6010

Person to Contact:
Tonya Martin 31-07387
Customer Service Representative
Toll Free Telephone Number:
8:00 a.m. to 6:30 p.m. EST
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
06-1137531

Dear Sir or Madam:

This letter is in response to your telephone call requesting for a copy of your organization's determination letter. This letter will take the place of the copy you requested.

Our records indicate that a determination letter issued in March 1987, granting your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in section 509(a)(2).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Danbury Office of Physicians Services P C
06-1137531

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. You are also required to make available for public inspection a copy of your organization's exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of $20 a day for each day you do not make these documents available for public inspection (up to a maximum of $10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,

John E. Ricketts

John E. Ricketts, Director, TE/GE
Customer Account Services

U. S. TREASURY DEPARTMENT
INTERNAL REVENUE SERVICE

DISTRICT DIRECTOR
P. O. Box 2158
Hartford, Connecticut 06101

JUN 30 1966

HAR-EO-66-142
IN REPLY REFER TO
Form L-178
AU:R:EO
Call:244-3060

PURPOSE	
Charitable	
ADDRESS INQUIRIES & FILE RETURNS WITH DISTRICT DIRECTOR OF INTERNAL REVENUE	
Hartford, Connecticut	
FORM 990-A REQUIRED	ACCOUNTING PERIOD ENDING
☐ YES ☒ NO	December 31st

Danbury Visiting Nurse Association, Incorporated
21 Montgomery Street
Danbury, Connecticut 06910 06-0655138

Gentlemen:

On the basis of your stated purposes and the understanding that your operations will continue as evidenced to date or will conform to those proposed in your ruling application, we have concluded that you are exempt from Federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code. Any changes in operation from those described, or in your character or purposes, must be reported immediately to your District Director for consideration of their effect upon your exempt status. You must also report any change in your name or address.

You are not required to file Federal income tax returns so long as you retain an exempt status, unless you are subject to the tax on unrelated business income imposed by section 511 of the Code, in which event you are required to file Form 990-T. Our determination as to your liability for filing the annual information return, Form 990-A, is set forth above. That return, if required, must be filed on or before the 15th day of the fifth month after the close of your annual accounting period indicated above.

Contributions made to you are deductible by donors as provided in section 170 of the Code. Bequests, legacies, devises, transfers or gifts to or for your use are deductible for Federal estate and gift tax purposes under the provisions of section 2055, 2106 and 2522 of the Code.

You are not liable for the taxes imposed under the Federal Insurance Contributions Act (social security taxes) unless you file a waiver of exemption certificate as provided in such act. You are not liable for the tax imposed under the Federal Unemployment Tax Act. Inquiries about the waiver of exemption certificate for social security taxes should be addressed to this office, as should any questions concerning excise, employment or other Federal taxes.

This is a determination letter.

Very truly yours,

JOSEPH J. CONLEY, JR.
District Director

Internal Revenue Service
P.O. Box 2508
Cincinnati, OH 45201

Department of the Treasury

Date:

DANBURY HOSPITAL DEVELOPMENT FUND INC
24 HOSPITAL AVE
DANBURY CT 06810-6099

Person to Contact:
Tracy Garrigus #31-07307
Toll Free Telephone Number:
877-829-5500
Employer Identification Number:
23-7425557

Dear Sir or Madam:

This is in response to your request of August 8, 2006, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in May 1975 that recognized you as exempt from Federal income tax. Our records further indicate that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section 509(a)(1) and 170(b)(1)(A)(vi).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

Cindy Westcott
Manager, Exempt Organizations
Determinations

Internal Revenue Service
Director, Exempt Organizations
Rulings and Agreements

Department of the Treasury
P.O. Box 2508
Cincinnati, Ohio 45201

Date: JUN 19 2007

New Milford Hospital, Inc.
21 Elm Street
New Milford, CT 06776

Person to Contact - ID#:
Shari Kolnicki - 31-07853
Contact Telephone Numbers:
877-829-5500 Phone
Federal Identification Number:
06-0669121

Dear Sir or Madam:

By our determination dated September 30, 1944, you were held to be exempt from Federal Income Tax under the provisions of section 501(c)(3) of the Internal Revenue Code.

You recently furnished us information that the New Milford Hospital Holding Corporation, EIN 22-2531823, another 501(c)(3) entity, merged with New Milford Hospital, Incorporated, EIN 06-0669121 on January 31, 2007. Based on the information submitted, we have determined that the merger does not affect your exempt status. The organization will continue using Employer Identification Number 06-0669121.

Please let us know about any further changes in your character, purposes, method of operation, name or address.

If you have any questions regarding this matter, please contact the person whose name and telephone number appear in the heading of this letter.

Sincerely,

Robert Choi
Director, Exempt Organizations
Rulings and Agreements

Internal Revenue Service

Department of the Treasury

Affiliation CON-182

Washington, DC 20224

New Milford Hospital, Incorporated
21 Elm Street
New Milford, CT 06776

Person to Contact:
Harold N. Torpell
Telephone Number:
202-566-3712
Refer Reply to:
OP:E:EO:R:3EL
Date:
JUN 26 1984

Employer Identification Number: 06-0669121
Key District: 11

Legend

V = The New Milford Hospital, Incorporated
W = New Milford Hospital Holding Corporation
X = New Milford Hospital Foundation, Inc.
Y = New Milford Hospital Health Care, Inc.
Z = Twenty-One Elm Street Corporation

Dear Applicant:

We have received your accountant's 29 February 1984 request for rulings with respect to the effect of a proposed reorganization on your exempt and foundation statuses, unrelated trade or business activities, an unusual grant, and the effect on the holding company of ownership of all of the stock of a for-profit subsidiary.

V is a hospital located in the state of its incorporation. It was recognized exempt from federal income taxation under the predecessor of section 501(c)(3) of the Internal Revenue Code of 1954 on 30 September 1944 and classified as a hospital under sections 509(a)(1) and 170 (b)(1)(A)(iii).

W was incorporated on 6 February 1984 for exempt purposes and is organized and operated to benefit V. W has been recognized exempt from federal income taxation under section 501(c)(3) of the Code and classified as other than a private foundation under section 509(a)(3) in a letter of even date herewith.

X was incorporated on 6 February 1984 for exempt purposes under section 501(c)(3) and will maintain an endowment fund and solicit and receive contributions on behalf of V and W's other section 501(c)(3) subordinates. X has been recognized exempt from federal income taxation under section 501(c)(3) of the Code and classified as other than a private foundation because it is described in sections 509(a)(1) and 170(b)(1)(A)(vi) for an extended advance ruling period in a letter of even date herewith.

Copy from DRW/BEAR

New Milford Hospital, Incorporated

Y was incorporated on 6 February 1984 for exempt purposes under section 501(c)(3) of the Code in the state where it operates. It will provide medical care on an outpatient basis by maintaining community health programs. Such programs may include some or all of the following: neighborhood health centers, retirement centers, nursing homes, rehabilitation centers, industrial health facilities, health maintenance organizations, and surgicenters. Y may also maintain health education programs for physicians, nurses, and the public. Y has been recognized exempt from federal income taxation under section 501(c)(3) of the Code and classified as other than a private foundation because it is described in section 509(a)(2) for an advance ruling period in a letter of even date herewith.

Z was incorporated as a for-profit corporation under the laws of the state where it operates with W as its sole shareholder. W will, thus, receive any dividends paid by Z. Neither W, V, X, nor Y will provide any services to Z except at fair market value. Z will render health care related services, including management and personnel services, housekeeping, and food catering services.

V now proposes to continue to operate as a hospital but to spin off its fund-raising and investment management to X, its educational and certain clinical programs to Y, and overall coordination and supervision of all of V's and these other programs to W. W will become V's sole member as part of this reorganization and V's board, which represents a broad cross-section of the community and will continue to do so, will become the board of directors of W. W will also function as parent of X and Y. V will transfer sufficient cash to provide working capital to W, X, and Y. There will be further cash transfers among the exempt entities. There will be no consideration for such transfers. As part of the proposed reorganization V will transfer to X, V's endowment fund upon the condition that X hold this fund in a separate, segregated fund to be used solely for V's benefit.

After the reorganization V, W, X, and Y will share some assets, personnel, and services. A fee may be charged in some cases for the provision of these services. To the extent of transactions between any of the exempt organizations and Z, transactions will be at arm's-length, and charges will be at fair market value.

Copy from DRW REAP system

X, having requested unusual grant treatment, has represented that the transfer of V's endowment is a one-time occurrence and that X will not rely on any further unusual grants. The funds will not be used for current operating expenses. The size of the transfer would adversely affect X's foundation classification if the request for exclusion as an unusual grant were not granted. The governing body of X is representative of a broad cross-section of the community, and X will carry on an active program of public solicitation of funds. Only cash, marketable securities, and a small amount of land will be the subject of the unusual grant.

Section 501(c)(3) of the Code provides for the exemption of organizations that are organized and operated exclusively for religious, charitable, educational, scientific, or literary purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individuals.

Section 1.501(c)(3)-1(a)(1) of the Income Tax Regulations provides that in order to be exempt as an organization described in section 501 (c)(3) of the Code, an organization must be organized and operated exclusively for one or more of the purposes specified in such section. If an organization fails to meet either the organizational test or the operational test, it is not exempt.

Section 1.501(c)(3)-1(c) of the regulations provides that an organization is regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of exempt purposes.

Section 1.501(c)(3)-1(d)(1)(ii) of the regulations provides that an organization is not organized or operated exclusively for one or more exempt purposes unless it serves a public rather than a private interest. Thus, to meet the requirement of this subdivision, it is necessary for an organization to establish that it is not organized or operated for the benefit of private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests.

Section 509(a) of the Code provides, in relevant part, that a private foundation is an domestic organization described in section 501(c)(3) of the Code other than an organization described in section

Copy from DRW READ

170(b)(1)(A)(iii), a hospital, or section 170(b)(1)(A)(vi), a publicly supported organization receiving substantial support from the general public or from a governmental unit; or an organization which receives more than one-third of its support in any taxable year from any combination of gifts, grants, contributions, membership fees, or from gross receipts from sales subject to certain limits, and which normally receives not more than one-third of its support from gross investment income and unrelated trade or business; or an organization organized and operated exclusively to support or benefit one of the foregoing types of organizations.

Sections 1.170A-9(e)(6)(iii) and 1.509(a)-3(c)(4) of the regulations provide for unusual grants and indicate that each will be considered on its own facts and circumstances. One of those facts is that it will be a one-time occurrence. If the funds constitute an unusual grant, they will be excluded in computing support for section 509(a) purposes and thus will not adversely affect foundation status.

Section 511(a)(1) of the Code imposes a tax on the unrelated business taxable income of organizations described in section 501(c)(3). Under section 512(a)(1) the term "unrelated business taxable income" is defined as the gross income derived by an organization from any unrelated trade or business, as defined in section 513, regularly carried on by it, less certain deductions.

Section 512(a)(1) of the Code defines the term "unrelated business income" as gross income derived by an organization from any unrelated trade or business regularly carried on by it, less deductions which are directly connected with the carrying on of such trade or business.

Section 512(b)(1) of the Code excludes dividend income from the definition of unrelated trade or business taxable income.

Section 512(b)(3) of the Code provides that one of the modifications referred to in section 512(a)(1) is that there shall be excluded, with certain exceptions enumerated in section 512(b)(13), all rents from real property.

Section 512(b)(13) of the Code provides, in relevant part, that, notwithstanding section 512(b)(3)'s exclusion of rent from the definition of unrelated trade or business taxable income, rents derived from any controlled organization controlled by a controlling organization shall be included as an item of gross income in an amount which bears the same

ratio as the excess of the amount of taxable income of the controlled organization over the amount of such organization's taxable income of the controlled organization over the amount of such organization's taxable income which, if derived directly by the controlling organization, would be unrelated trade or business, bears to the taxable income of the controlled organization, compared without regard to amounts paid directly or indirectly to the controlling organization. There shall be allowed all deductions directly connected with amounts included in gross income under the preceding sentence.

Section 513(a) of the Code provides that the term "unrelated trade or business" means, in the case of any organization subject to the tax imposed by section 511, any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organizations of its charitable, educational or other purpose or function constituting the basis of its exemption under section 501.

Section 1.513-1(b) of the regulations states, in part, that for the purpose of section 513 the term "trade or business" generally includes any activity carried on for the production of income from the sale of goods or performance of services.

Section 1.513-1(d)(2) of the regulations provides that trade or business is "related" to exempt purposes in the relevant sense, only where the conduct of business activities has a causal relationship to the achievement of except purposes (other than through the production of income) and it is "substantially related", for the purposes of section 513 of the Code, only if the causal relationship is a substantial one. Thus, for the conduct of a trade or business from which a particular amount of gross income is derived to be substantially related to the purposes for which exemption is granted, the production or distribution of goods or the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes. Where the production or distribution of the goods or the performance of the services does not contribute importantly to the accomplishment of the exempt purposes of an organization, the income from the sale of goods or the performance of services does not derive from the conduct of related trade or business. Whether the activities productive of gross income contribute importantly to the accomplishment of any purpose for which an organization is granted exemption depends in each case upon the facts and circumstances involved.

Copy from DPW PEAP system

New Milford Hospital, Incorporated

Section 514(b) of the Code provides, in general, that the term "debt-financed property" means any property which is held to produce income and with respect to which there is an acquisition indebtedness (as defined in section 514(c) of the Code).

Section 1.514(b)-1(c)(2)(i) of the regulations provides that property owned by an exempt organization and used by a related exempt organization or by an exempt organization related to such related exempt organization shall not be treated as "debt-financed property" to the extent such property is used by either organization in furtherance of the purpose constituting the basis for its exemption under section 501.

Section 1.514(b)-1(c)(2)(ii)(b) of the regulations provides that two exempt organizations are related to each other if one organization has control of the other organization within the meaning of paragraph (1)(4) of section 1.512(b)-1.

Section 1.512(b)-1(1)(4)(i)(b) of the regulations provides, in relevant part, that in the case of a nonstock organization, the term "control" means that at least 80 percent of the directors or trustees of such organizations are representatives of an exempt organization. A trustee or director is a representative of an exempt organization if he is a trustee, director, agent, or employee of such exempt organization.

In Rev. Rul. 71-529, 1971-2 C.B. 234, exempt status was recognized for an organization formed to provide investment services below cost to related exempt organizations.

In Rev. Rul. 72-369, 1972-2 C.B. 245, the Service denied exempt status for an organization formed to provide management and consulting services at cost to unrelated exempt organizations.

Since, after the amendments to V's articles and by-laws, V's exempt purposes will not change and V will still operate as a hospital described in section 509(a)(1) and section 170(b)(1)(A)(vi) of the Code, neither V's exempt status nor its foundation status will be adversely affected by the reorganization. In the cases of W, X, and Y, each disclosed in its application for recognition of exemption that it was being organized as part of a reorganization of V. Accordingly, that reorganization was taken into account in recognizing each exempt from federal income taxation under section 501(c)(3) and classifying each as other than a private foundation under section 509(a). Thus, the exempt status and the foundation status of each will be unaffected by the reorganization. Since the

applicants' exempt status and foundation status will remain unchanged, contributions to each of them will continue to be deductible to donors as provided in section 170 in the same manner as before the reorganization.

An organization exempt under section 501(c)(3) of the Code may hold stock in a for-profit entity as an investment so long as payments to the exempt entity are for services rendered or as dividends and the exempt entity's primary purpose is not the operation of a for-profit business. Accordingly, W's ownership of all of the stock of Z as an investment and W's receipt of dividends therefrom will not have an adverse effect on W's exempt status under section 501(c)(3) nor on its foundation classification under section 509(a)(3). Furthermore, the receipt of dividends paid by one entity to a separate entity is not a business and is excluded from unrelated trade or business taxable income under section 512(b)(1). Accordingly, such payments are not unrelated trade or business taxable income to W.

Since V, W, X, and Y are all exempt entities under section 501(c)(3) of the Code, the transfer of cash and other assets and the sharing of personnel, services, facilities, and expenses will not jeopardize exempt status of any of the above entities under section 501(c)(3). Exempt organizations may give funds for exempt purposes or to other exempt organizations as a purpose of the giver. Assuming that the organizations otherwise meet all applicable support tests under sections 170(b)(1)(A)(vi) or 509(a)(2), as the case may be, such transfers and sharing will not adversely affect the foundation status of V, W, X, and Y. Since the transfer of assets and the sharing of services without a fee charged is not a business, such activity cannot be unrelated trade or business taxable income.

Intercorporate transfers of cash, etc., which are for the operating convenience of the related exempt organizations and facilitate their exempt activities promote the achievement of the purposes of each of the related organizations. Cf. Rev. Rul. 72-369, 1972-2 C.B. 245, where the entities were not related, with Rev. Rul. 71-529, 1971-2 C.B. 234, where the entities are related.

In view of the one-time nature of V's transfer of funds to X and its proposed active fund-raising campaign along with satisfaction of the other requisites of sections 1.170A-9(e)(6)(ii) and 1.509(a)-3(c)(3) of the regulations, such transfer constitutes an unusual grant which may be excluded from the computation in determining public support. Only cash, marketable securities, and land are excluded as being part of the unusual grant.

Copy from DPW PEAR system

New Milford Hospital Foundation, Inc.

Accordingly, based upon the facts as submitted and assuming that the transactions will occur in the manner described, we rule that:

1. After the amendment to the Certificate of Incorporation and Bylaws of V and the proposed reorganization, V will continue to qualify as an organization described in section 501(c)(3) and 170(b)(1)(A)(iii).

2. After the proposed reorganization, W will continue to qualify as an organization described in section 501(c)(3) and 509(a)(3).

3. After the proposed reorganization, X will continue to qualify as an organization described in section 501(c)(3) and, provided the requisite public support is received, sections 509(a)(1) and 170(b)(1)(A)(vi).

4. After the proposed reorganization, Y will continue to qualify as an organization described in sections 501(c)(3) and, provided it meets the support tests thereunder, 509(a)(2).

5. W's ownership of 100% of the issued and outstanding voting stock of Z and W's receipt of dividends from Z will have no adverse affect on W's status under sections 501(c)(3) and 509(a)(3) and the taxable income of Z will not be construed to be unrelated business income to W and any dividends received by W from Z will not be unrelated business income to W.

6. The proposed transfers of cash and other assets and the sharing of personnel, services, facilities and expenses by and between V, W, X and Y will not (a) jeopardize the continued tax-exempt status of V, W, X and Y as organizations described in sections 501(c)(3); (b) adversely affect V, W, X and Y's status as public charities under sections 509(a)(1), 509(a)(2) or 509(a)(3), provided any requisite public support tests are met; and (c) give rise to unrelated business taxable income under sections 511-514 to any of the involved exempt organizations. However, the transfer of property which is unrelated to exempt functions from one entity to another but subject to debt-financing will remain unrelated debt-financed property in the hands of the new holder.

Copy from DRWDEAD

New Milford Hospital, Incorporated

7. V's transfer of its philanthropic funds to X will qualify as an unusual grant under section 1.170A-9(e)(6)(ii) and 1.509(a)-3(c)(3) of the Income Tax Regulations and may be excluded from the calculation of public support under sections 1.170A-9(e)(2) or 1.170A-9(e)(3)(i) of the Income Tax Regulations.

8. After the amendments to the Certificate of Incorporation and Bylaws of V and the proposed reorganization, contributions to V, W, X and Y will be deductible by the donors as provided in section 170.

This ruling is directed only the the organization that requested it. Section 6110(j)(3) of the Code provides that it may not be used or cited as precedent.

Please continue to use your employer identification number on all returns which you file and in all correspondence with the Internal Revenue Service.

Because this letter could help resolve any future questions about your exempt status and unrelated trade or business activities, you should keep it in your permanent records.

We are informing your key District Director, Cincinnati, Ohio, of this ruling.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

(Signed) J. E. Griffith

J. E. Griffith
Chief, Exempt Organizations
Rulings Branch

Copy from DPW PEAP system

Exhibit L

STATE OF CONNECTICUT

Department of Public Health

License No. 0053

General Hospital

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

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

Norwalk Hospital is located at 34 Maple Street, Norwalk, CT 06856

The maximum number of beds shall not exceed at any time:
38 Bassinets
328 General Hospital beds

This license expires **June 30, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2011. RENEWAL.

Satellites
Norwalk Hospital Surgery Center, 40 Cross Street, Suite 120, Norwalk, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

Department of Public Health

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 The Danbury Hospital is hereby licensed to maintain and operate a General Hospital.

The Danbury Hospital 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, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. 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
Seifert & Ford Community Health Center, 70 Main Street, Danbury, CT
Ridgefield Surgical Center, 901 Ethan Allen Highway, Ridgefield, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

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, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2011. RENEWAL.

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

Jewel Mullen, MD, MPH, MPA
Commissioner

Exhibit M

Norwalk Health System - Stand Alone

Financial Attachment I

(Dollars are in thousands)

Total Facility: Description	FY 2012 * Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$219,894	227,152	-	$227,152	235,949		$235,949	241,666		$241,666	247,519		$247,519
Medicare	100,780	106,854	-	$106,854	108,267		$108,267	109,702		$109,702	111,158		$111,158
Medicaid and Other Medical Assistance	40,236	36,130	-	$36,130	36,287		$36,287	36,445		$36,445	36,606		$36,606
Other Government	-	-	-	-	-			-			-		
Total Net Patient Patient Revenue	$360,910	370,136	$0	$370,136	380,503	$0	$380,503	387,813	$0	$387,813	395,283	$0	$395,283
Other Operating Revenue	$23,548	$16,282	-	$16,282	$15,582	$0	$15,582	$14,782	$0	$14,782	$14,782	$0	$14,782
Revenue from Operations	$384,458	$386,418	$0	$386,418	$396,085	$0	$396,085	$402,595	$0	$402,595	$410,065	$0	$410,065
OPERATING EXPENSES													
Salaries and Fringe Benefits	$208,710	$215,148	-	$215,148	$221,545	(1,180)	$220,365	$227,084	(2,410)	$224,674	$231,568	(3,760)	$227,808
Professional / Contracted Services	48,511	49,481	-	49,481	50,471	-	50,471	51,480	-	51,480	52,510	-	52,510
Supplies and Drugs	57,903	59,640	-	59,640	61,429	(280)	61,149	63,272	(580)	62,692	65,170	(900)	64,270
Other Operating Expense	17,479	18,516	-	18,516	19,215	740	19,955	18,860	(430)	18,430	17,547	(1,930)	15,617
Subtotal	$332,603	$342,785	$0	$342,785	$352,660	($720)	$351,940	$360,696	($3,420)	$357,276	$366,795	($6,590)	$360,205
Depreciation/Amortization	20,511	21,793	-	21,793	22,716	-	22,716	24,869	-	24,869	26,671	-	26,671
Interest Expense	2,073	4,985	-	4,985	4,738	-	4,738	4,480	-	4,480	4,212	-	4,212
Lease Expense	9,171	9,354	-	9,354	9,542	-	9,542	9,732	-	9,732	9,927	-	9,927
Total Operating Expenses	$364,358	$378,917	$0	$378,917	$389,656	($720)	$388,936	$399,777	($3,420)	$396,357	$407,605	($6,590)	$401,015
Gain/(Loss) from Operations	$20,100	$7,501	$0	$7,501	$6,429	$720	$7,149	$2,818	$3,420	$6,238	$2,460	$6,590	$9,050
Plus: Non-Operating Income	$6,254	$5,989		$5,989	$6,128	$0	$6,128	$6,026	$0	$6,026	$5,887	$0	$5,887
Income before provision for income taxes	$26,354	$13,490	$0	$13,490	$12,557	$720	$13,277	$8,844	$3,420	$12,264	$8,347	$6,590	$14,937
Provision for income taxes	$0												
Revenue Over/(Under) Expense	$26,354	$13,490	$0	$13,490	$12,557	$720	$13,277	$8,844	$3,420	$12,264	$8,347	$6,590	$14,937
FTEs	1,837.0	1,839.0	-	1,839.0	1,840.0	(10.0)	1,830.0	1,842.0	(20.0)	1,822.0	1,844.0	(30.0)	1,814.0
*Volume Statistics:													
Inpatient Discharges	15,003	15,003	-	15,003	15,003	-	15,003	15,003	-	15,003	15,003	-	15,003
Outpatient Visits	363,378	367,012	-	367,012	370,682	-	370,682	374,389	-	374,389	378,133	-	378,133
Key Ratios:													
Op Margin	5.2%	1.9%		1.9%	1.6%		1.8%	0.7%		1.5%	0.6%		2.2%
Operating EBIDA Margin	11.1%	8.9%		8.9%	8.6%		8.7%	8.0%		8.8%	8.1%		9.7%
Excess Margin	6.9%	3.5%		3.5%	3.2%		3.4%	2.2%		3.0%	2.0%		3.6%

Net ASC JV profit reported as credit to other expense.

Western Connecticut Health Network - Stand Alone

Financial Attachment I

(Dollars are in thousands)

Total Facility: Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$435,339	449,156	-	$449,156	463,445		$463,445	478,246		$478,246	494,764		$494,764
Medicare	232,118	240,586	-	$240,586	242,562		$242,562	244,572		$244,572	247,898		$247,898
Medicaid and Other Medical Assistance	44,693	46,621	-	$46,621	46,657		$46,657	46,700		$46,700	46,937		$46,937
Other Government	-	-	-	-	-			-			-		
Total Net Patient Patient Revenue	$712,149	$736,363	$0	$736,363	$752,664	$0	$752,664	$769,518	$0	$769,518	$789,599	$0	$789,599
Other Operating Revenue	$29,907	$17,004	-	$17,004	$17,028	$0	$17,028	$15,893	$0	$15,893	$15,886	$0	$15,886
Revenue from Operations	$742,056	$753,367	$0	$753,367	$769,692	$0	$769,692	$785,411	$0	$785,411	$805,485	$0	$805,485
OPERATING EXPENSES													
Salaries and Fringe Benefits	$458,110	$468,522	-	$468,522	$479,582	(2,248)	$477,334	$490,914	(4,577)	$486,337	$503,535	(7,131)	$496,404
Professional / Contracted Services	6,171	6,294	-	6,294	6,420	-	6,420	6,549	-	6,549	6,680	-	6,680
Supplies and Drugs	92,857	95,646	-	95,646	98,515	(538)	97,978	101,471	(1,095)	100,376	104,515	(1,706)	102,809
Other Operating Expense	111,287	111,220	-	111,220	111,580	1,411	112,990	109,032	(811)	108,222	109,024	(3,671)	105,352
Subtotal	$668,426	$681,682	$0	$681,682	$696,097	($1,375)	$694,722	$707,966	($6,483)	$701,483	$723,753	($12,508)	$711,246
Depreciation/Amortization	39,029	39,452	-	39,452	43,002	-	43,002	49,852	-	49,852	55,208	-	55,208
Interest Expense	4,323	4,060	-	4,060	4,710	-	4,710	8,410	-	8,410	8,368	-	8,368
Lease Expense	11,914	12,153	-	12,153	12,396	-	12,396	12,644	-	12,644	12,897	-	12,897
Total Operating Expenses	$723,692	$737,347	$0	$737,347	$756,205	($1,375)	$754,830	$778,871	($6,483)	$772,388	$800,226	($12,508)	$787,718
Gain/(Loss) from Operations	$18,364	$16,020	$0	$16,020	$13,487	$1,375	$14,862	$6,540	$6,483	$13,023	$5,259	$12,508	$17,767
Plus: Non-Operating Income	$24,649	$9,924		$9,924	$10,742	$0	$10,742	$11,598	$0	$11,598	$12,243	$0	$12,243
Income before provision for income taxes	$43,013	$25,944	$0	$25,944	$24,229	$1,375	$25,604	$18,138	$6,483	$24,621	$17,502	$12,508	$30,010
Provision for income taxes	$501												
Revenue Over/(Under) Expense	$42,512	$25,944	$0	$25,944	$24,229	$1,375	$25,604	$18,138	$6,483	$24,621	$17,502	$12,508	$30,010
FTEs	3,736.0	3,733.8	-	3,733.8	3,728.9	(18.8)	3,710.1	3,726.5	(37.1)	3,689.4	3,729.0	(57.7)	3,671.3
*Volume Statistics:													
Inpatient Discharges	21,964	22,083	-	22,083	21,862	-	21,862	21,643	-	21,643	21,643	-	21,643
Outpatient Visits	1,130,467	1,135,428	-	1,135,428	1,140,438	-	1,140,438	1,145,498	-	1,145,498	1,150,609	-	1,150,609
Key Ratios:													
Op Margin	2.5%	2.1%		2.1%	1.8%		1.9%	0.8%		1.7%	0.7%		2.2%
Operating EBIDA Margin	8.3%	7.9%		7.9%	8.0%		8.1%	8.3%		9.1%	8.5%		10.1%
Excess Margin	5.8%	3.4%		3.4%	3.1%		3.3%	2.3%		3.1%	2.2%		3.7%

Western Connecticut Health Network - Consolidated

Financial Attachment I

(Dollars are in thousands)

Total Facility: Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$435,339	449,156	-	$449,156	463,445	235,949	$699,394	478,246	241,666	$719,912	494,764	247,519	$742,283
Medicare	232,118	240,586	-	$240,586	242,562	108,267	$350,829	244,572	109,702	$354,274	247,898	111,158	$359,056
Medicaid and Other Medical Assistance	44,693	46,621	-	$46,621	46,657	36,287	$82,944	46,700	36,445	$83,145	46,937	36,606	$83,543
Other Government	-	-	-	-	-			-			-		
Total Net Patient Patient Revenue	$712,149	736,363	$0	$736,363	752,664	$380,503	$1,133,167	769,518	$387,813	$1,157,331	789,599	$395,283	$1,184,882
Other Operating Revenue	$29,907	$17,004	-	$17,004	$17,028	$15,582	$32,610	$15,893	$14,782	$30,675	$15,886	$14,782	$30,668
Revenue from Operations	$742,056	$753,367	$0	$753,367	$769,692	$396,085	$1,165,777	$785,411	$402,595	$1,188,006	$805,485	$410,065	$1,215,550
OPERATING EXPENSES													
Salaries and Fringe Benefits	$458,110	$468,522	-	$468,522	$479,582	218,117	$697,699	$490,914	220,097	$711,011	$503,535	220,677	$724,212
Professional / Contracted Services	6,171	$6,294	-	6,294	$6,420	50,471	56,891	$6,549	51,480	58,029	$6,680	52,510	59,190
Supplies and Drugs	92,857	$95,646	-	95,646	$98,515	60,611	159,127	$101,471	61,597	163,068	$104,515	62,564	167,079
Other Operating Expense	111,287	$111,220	-	111,220	$111,580	21,366	132,945	$109,032	17,619	126,652	$109,024	11,946	120,969
Subtotal	$668,426	$681,682	$0	$681,682	$696,097	$350,565	$1,046,662	$707,966	$350,793	$1,058,759	$723,753	$347,697	$1,071,451
Depreciation/Amortization	39,029	39,452	-	39,452	43,002	22,716	65,718	49,852	24,869	74,721	55,208	26,671	81,879
Interest Expense	4,323	4,060	-	4,060	4,710	4,738	9,448	8,410	4,480	12,890	8,368	4,212	12,580
Lease Expense	11,914	12,153	-	12,153	12,396	9,542	21,938	12,644	9,732	22,376	12,897	9,927	22,823
Total Operating Expenses	$723,692	$737,347	$0	$737,347	$756,205	$387,561	$1,143,766	$778,871	$389,874	$1,168,745	$800,226	$388,507	$1,188,733
Gain/(Loss) from Operations	$18,364	$16,020	$0	$16,020	$13,487	$8,524	$22,011	$6,540	$12,721	$19,261	$5,259	$21,558	$26,817
Plus: Non-Operating Income	$24,649	$9,924		$9,924	$10,742	$6,128	$16,870	$11,598	$6,026	$17,624	$12,243	$5,887	$18,130
Income before provision for income taxes	$43,013	$25,944	$0	$25,944	$24,229	$14,652	$38,881	$18,138	$18,747	$36,885	$17,502	$27,445	$44,947
Provision for income taxes	$501												
Revenue Over/(Under) Expense	$42,512	$25,944	$0	$25,944	$24,229	$14,652	$38,881	$18,138	$18,747	$36,885	$17,502	$27,445	$44,947
FTEs	3,736.0	3,733.8	-	3,733.8	3,728.9	1,811.2	5,540.1	3,726.5	1,784.9	5,511.4	3,729.0	1,756.3	5,485.3
*Volume Statistics:													
Inpatient Discharges	21,964	22,083	-	22,083	21,862	15,003	36,865	21,643	15,003	36,646	21,643	15,003	36,646
Outpatient Visits	1,130,467	1,135,428	-	1,135,428	1,140,438	370,682	1,511,120	1,145,498	374,389	1,519,887	1,150,609	378,133	1,528,742
Key Ratios:													
Op Margin	2.5%	2.1%		2.1%	1.8%		1.9%	0.8%		1.6%	0.7%		2.2%
Operating EBIDA Margin	8.3%	7.9%		7.9%	8.0%		8.3%	8.3%		9.0%	8.5%		10.0%
Excess Margin	5.8%	3.4%		3.4%	3.1%		3.3%	2.3%		3.1%	2.2%		3.7%

Exhibit N

Financial Assumptions

Overview:

The Hospital(s) have assumed that any FY2013 reductions in the state uncompensated care pool will have to be met with severe expense adjustments such that the overall financials will not be impacted. Further significant future proposed pool payment reductions have also not been included in the following assumptions.

Western Connecticut Health Network - Without Project Assumptions:

		2013	2014	2015	2016
Rate Increase		5%	5%	5%	5%
Non-Government		0% - 3%	0% - 3%	0% - 3%	0% - 3%
Medicare		5%	1%	1%	1%
Medicaid		0%	0%	0%	0%
State DSH		0%	0%	0%	0%
Volume:					
	Inpatient	**-1%**	**-1%**	**0%**	**0%**
	Outpatient	**1%**	**1%**	**1%**	**1%**

Other Operating Revenue	Assumed flat, adjusted for declining meaningful use payments expected based on regulations
Salaries and Fringe Benefits	Includes 2.5% inflationary increase annually adjusted for changes in FTEs
Professional Services	Annual increase of 2% based on inflation
Supplies and Drugs	Based on 3.0% inflationary increases annually
Other Operating Expense	Assumed flat adjusted for improvements related to expense management initiatives
Depreciation/Amortization	Based on annual capital spend inclusive of new tower construction expected to be completed late FY2014
Interest Expense	Based on interest expense expected on existing debt
Lease Expense	Annual increase of 2% based on inflation
FTEs	Based on history adjusted for volume & continued productivity improvements

Norwalk Health Services Corporation - Without Project Assumptions:

		2013	2014	2015	2016
Rate Increase		5%	5%	5%	5%
Non-Government		0% - 3%	0% - 3%	0% - 3%	0% - 3%
Medicare		5%	1%	1%	1%
Medicaid		0%	0%	0%	0%
State DSH		0%	0%	0%	0%
Volume:					
	Inpatient	**-1%**	**-1%**	**0%**	**0%**
	Outpatient	**1%**	**1%**	**1%**	**1%**

Other Operating Revenue	Assumed flat, adjusted for declining meaningful use payments expected based on regulations. Reduced restricted fund transfers for FY 2012 v FY 2013.
Salaries and Fringe Benefits	Includes 3% inflationary increase annually decreasing to 2% by FY 2016.
Professional Services	Annual increase of 2% based on inflation
Supplies and Drugs	Based on 3.0% inflationary increases annually
Other Operating Expense	Assumed flat adjusted for improvements related to expense management initiatives
Depreciation/Amortization	Based on annual capital spend inclusive of depreciation associated with construction of a new Ambulatory Pavilion expected to be completed by FY 2015.
Interest Expense	Based on interest expense expected on existing debt
Lease Expense	Annual increase of 2% based on inflation
FTEs	Based on history adjusted for volume & continued productivity improvements

Incremental Assumptions – With Project:

Incremental synergies projected as a result of the project will provide both expense reductions through enhanced contract negotiations as well as overall increases in efficiency and productivity. These savings are offset by one time costs associated with legal, consulting and communication costs that will be incurred during the initial two years of the project. These expense synergies were allocated between WCHN and Norwalk Health System based on a percentage of total operating expense as the specific impact for each entity has not yet been identified. The allocation is 65% to WCHN and 35% to NHSC and is represented as the incremental impact with the proposal in Financial Attachment 1 for WCHN stand alone and NHSC stand alone.

Based on WCHN's experience with New Milford Hospital and Norwalk's relative size, these savings are anticipated.

Expense Impact (dollars shown in millions)

	FY 2014	**FY 2015**	**FY 2016**
Expense Synergies	$(4.7)	$(11.3)	$(19.1)
Legal Cost	$0.9	$0.4	
Consulting	$1.1	$0.6	
Communications	$0.6	$0.4	
Total	$(2.1)	$(9.9)	$(19.1)

A categorized breakout of the expense impact attributed to the proposal is summarized below.

Categorized Expense Impact for Consolidated WCHN

Expense Impact:	**FY 2014**	**FY 2015**	**FY 2016**
Salaries/Benefits	$(3.4)	$(7.0)	$(10.9)
Supplies/Drugs	$(0.8)	$(1.7)	$(2.6)
Other Costs*	$2.2	$(1.2)	$(5.6)
Total	$(2.1)	$(9.9)	$(19.1)
Gain/(Loss) Impact	$2.1	$9.9	$19.1

**Includes legal, consulting, communications*

Western Connecticut Health Network – Consolidated

The FY 2012 actual financial results and the financial projections without the CON for FY 2013–FY 2016 are for WCHN.

The projected incremental projections for FY 2014-FY 2016 consist of the incremental impact of the proposal on WCHN plus NHSC with the CON.

The financial projections with the CON for FY 2014-FY 2016 represent the impact of the CON on the consolidated WCHN.

Supplemental Information

Norwalk Health Services Corporation - Current Debt as of 9/30/2012:

Entity	Balance	Interest Rates
Norwalk Hospital Association		
CHEFA Series E	$8,560,000	4.625% - 5.00%*
CHEFA Series G	$23,860,000	5.12%
CHEFA Series H	$9,185,000	3.49%
CHEFA Series I	$10,790,000	3.40%
CHA Trust	$671,926	0.00%
CHEFA Lease	$4,703,893	4.38%
Total	**$57,770,819**	
Norwalk Surgery Center		
Term Loan - 7 Year The Bank of Fairfield	**$4,000,000**	4.875%

**CHEFA Series E Bonds were redeemed January 2013*

Note: On December 7, 2012 Norwalk Hospital issued $82,000,000 of additional bonds through a private placement as CHEFA Series J, with a synthetic fixed rate of 3.3343%.

Western Connecticut Health Network - Current Debt as of 9/30/2012:

Entity	Balance	Interest Rates	Description
Danbury Hospital			
Series H	$39,615,000	Mature from 2030-2036 @ avg rate of 4.425%	Fixed Rate
Western Connecticut Health Network			
Series K	$29,610,000	Serial maturities from 2011-2036/Final Maturity 2036 -	Variable Rate Direct Placement RBS Citizens
Series L	$96,000,000	Sinking fund installments 2015-2041	Variable Rate Direct Placement JP Morgan Chase
Series M	$46,030,000	Mature from 2031 to 2041 rates of 5.00%-5.75%	Fixed Rate
Series N	$39,880,000	Serial maturities from 2014-2019 rates of 3.0%-5.0%	Fixed Rate
New Milford Hospital			
Term loans	$466,426	4.63% (Finance construction of MRI JV)	Fixed Rate
Capital lease obligations	$1,042,429	4.80% (Linear Accelerator & CT Scanner)	Fixed Rate
WCHN Total	**$252,643,855**		

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

April 11, 2013

The Honorable Jonathan Steinberg
Representative, 136th District
Legislative Office Building
Room 4020
Hartford, CT 06106-1591

Re: Certificate of Need, Docket Number: 13-31832
Western Connecticut Health Network and the Norwalk Health Services Corporation
Affiliation between Western Connecticut Health Network and the Norwalk Health Services Corporation

Dear Representative Steinberg:

On April 8, 2013, the Department of Public Health received your letter concerning the Certificate of Need ("CON") for the affiliation between Western Connecticut Health Network and the Norwalk Health Services Corporation.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of OHCA's formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http://www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please contact Kimberly Martone, Director of Operations at the Office of Health Care Access at (860) 418-7029.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner, OHCA

LAD/KM/bko

Connecticut Department of Public Health

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REPRESENTATIVE JONATHAN STEINBERG
136TH ASSEMBLY DISTRICT

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VICE CHAIR
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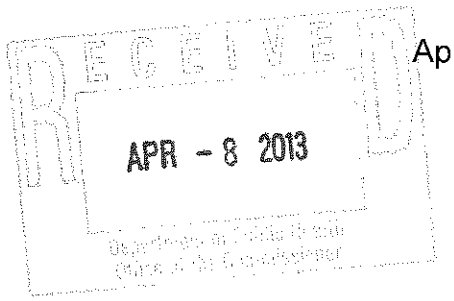
FINANCE, REVENUE AND BONDING COMMITTEE

April 3, 2013



Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I ask you to endorse the affiliation between Western Connecticut Health Network (WCHN) and The Norwalk Health Services Corporation (NH). These two institutions have signed a letter of agreement to affiliate their organizations for the purpose of bringing best practices in health care delivery to enhance the health and well-being of residents within their shared geographic service areas.

As a member of the legislature's M.O.R.E. Commission Regional Entities Committee, I'm dedicated to discovering appropriate ways to achieve regional efficiencies without compromising service quality. As the healthcare landscape continues to evolve, hospitals must prepare for the future by achieving the effective operational scale to handle a larger patient pool. When two outstanding health care organizations affiliate, they have the capability of creating efficiencies that neither could do alone.

The two institutions have taken a great deal of time and effort to create an agreement that will benefit my constituents. The process now needs the approval of your office.

This fortified entity will be better positioned to serve patients at the highest level of health care. On behalf of my constituents, I urge you to support this CON application.

Sincerely,

Representative Jonathan Steinberg
136th District, Connecticut General Assembly

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 7, 2013

VIA FAX ONLY

Jeryl Topalian
Executive Director, Planning & Business Development
Norwalk Health Services Corporation
34 Maple Street
Norwalk, CT 06850

Sally Herlihy
Vice President, Planning
Western Connecticut Health
Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Dear Mr. Topalian and Ms. Herlihy:

On April 8, 2013, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") application filing on behalf of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. (herein referred to as "Applicants") proposing the affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc., with no associated capital expenditure.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the submitted initial CON application.

General

1. Beginning on page 25 of the CON application, the Applicants submitted a redacted copy of the Affiliation Agreement and the related attachments between the parties. Specify the reason ("confidential" will not be accepted) and a general description of each redaction , so that OHCA can consider if a full open copy of the Affiliation Agreement will be required.

2. In reference to page 30, of the CON application, provide a list of "occurrences/events" that would change the Initial Governance Structure.

Need & Services

3. On page 11 of the CON application, the Applicants state that Norwalk Health Services Corporation ("NHSC"), through its Board of Trustees and senior management, explored strategies and tactics that would be needed for long-term success of NHSC. Furthermore, "[e]lements identified as essential to long-term viability included improved access to capital markets, support for physician recruitment/retention, clinical service development, and better use of scarce community resources." Regarding the aforementioned, please address the following questions:

    a. Provide a discussion on the methods/approaches utilized by NHSC's Board of Trustees and senior management to explore strategies and tactics for NHSC's long-term success.
    b. What specific strategies and tactics were developed to address and support the long-term success of NHSC?
    c. Was there a report developed by NHSC's Board of Trustees or senior management that chronicles the elements that were identified as essential to long-term viability of NHSC? If yes, please provide a copy. If no, please explain.

4. In 2009, Norwalk Hospital engaged Navigant Consulting, Inc. ("NCI") for an assessment of partnership options (page 11) Furthermore, a Partnership Task Force was created consisting of the Board of Trustees members and senior management. Please detail and discuss the outcome/findings of NCI's recommendations.

5. Did NCI produce a report for NHSC, regarding strategies, options and partners for Norwalk Hospital and NHSC? If so, please provide a copy.

6. Also on page 11, a reference is made that around the same time that the Partnership Task Force was created, NHSC developed "Vision 2015," a strategic plan identifying the long-term strategic priorities for the hospital. Please provide a copy of Vision 2015.

7. Did either of the Applicants perform a study or analysis that supports the benefits of this proposed affiliation (listed on page 12)?

    a. If yes, submit a copy to OHCA as evidence supporting the proposed benefits.
    b. If no, explain in detail, how the need and benefits for this proposal were developed and provide supporting evidence.
    c. Has either of the Applicants performed a Community Needs Assessment ("CNA")?
    d. Please provide copies of any CNA performed, draft or final.

8. On page 12, the application speaks to the benefits of affiliation for the WCHN and NHSC systems. Page 16 explains in very general terms how the proposal would improve health care delivery in the region by strengthening clinical programs and the physician platform, enhancing educational programs and building competencies. Please provide more specific

examples of how, within the first three years following affiliation, patient access and quality of services will be improved.

9. On page 13 of the CON application, the Applicants represent that at this time, no change in services will occur due to the proposal, however, in the future, changes may occur as opportunities to reduce duplication or inefficiencies in clinical service delivery are identified. Please address the following:

    a. Has either of the Applicants performed an analysis of the current services offered by each Applicant in its respective service area/region to determine if any services will be duplicated?
    b. At what point do the Applicants plan to perform an analysis of the demand for services in the respective service area/region to determine possible duplication of services or efficiencies that may be achieved by reconfiguring services. Provide a detailed discussion and timelines.
    c. Specifically, how will the proposed affiliation impact and improve NHSC and WCHN clinical programs and services?
    d. Provide a list of services that will be impacted as a result of this affiliation.

10. On page 13 of the CON application, the Applicants state that it is also anticipated that many of the tertiary care services that are being provided today will be strengthened by the partnership of NHSC with WCHN. Please explain and provide specific examples.

11. On page 11, the Applicants state that WCHN affiliating with a strong partner would, among other things, create new synergies which focus on patient healthcare delivered at the right time and at the right place. Explain the meaning of this statement and provide specific examples.

12. On page 12 of the CON application, the Applicants provide a list of benefits identified as a result of this proposal. Please provide an explanation of how each of these bulleted items would be achieved as a result of this affiliation and provide specific examples and cost savings related to each.

13. On page 14 of the CON application, the Applicants state that they have engaged PricewaterhouseCoopers to help develop a transition plan, which is anticipated to be completed over a six month period. Please address the following:

    a. Provide an update on the progress of this plan.
    b. Who will make up the proposed Integration Steering Committee?
    c. Who will the proposed Integration Steering Committee report to?

14. Page 17 of the application states that "New WCHN will allow for improved access to primary care in outpatient facilities." Have any areas in either WCHN or NHSC's service area been identified as needing additional primary care? Is there a plan to establish outpatient facilities dedicated to primary care as part of this proposal?

15. On page 18 of the CON application, the Applicants state that "[a] larger employee base allows the system to pilot new models of care." Provide examples and explain the function and benefits of such models.

16. Page 23, lists ways the affiliation will realize cost savings. Please further explain and quantify the second bullet: "Standardization of policies and processes will create additional efficiencies even in some areas that remain hospital specific to reduce costs in local communities." Bullet four states that scale will allow for the better use of in-house resources, reducing the reliance on external services. Provide examples of external services that could be reduced as a result of this proposed affiliation and quantify the savings.

Financial

17. On page 20 of the CON application, the Applicants state that this proposal will "drive down cost of delivery of healthcare through shared resources, volume purchasing and integrated operations." Please explain in detail, provide specific examples and projected cost savings for the first three years of this proposal and reconcile to Attachment I of the CON application.

18. In addition to the individual Financial Attachment I for NHSC and WCHN as presented in Exhibit M of the CON application, please provide the following:

    a. Separate Financial Attachment I for Norwalk Hospital, Danbury Hospital and New Milford Hospital that provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project.*
    b. The sources upon which the revenues and volume projection assumptions on pages 200-201 are based.
    c. Will the proposed WCHN be able to enhance private payer reimbursement more than if the two health systems operated separately? If so, please explain in detail as there is no mention of any changes in reimbursement in the financial assumptions.
    d. Has value based purchasing been considered in the financial assumptions? If so, please explain and quantify.

    *Note that the actual results for the fiscal year reported in the first column must agree with each Hospital's respective audited financial statements. The projections must include the first three <u>full</u> fiscal years of the project, FTE projections and utilization statistics by service.

19. In Financial Attachment I on pages 196 and 197, the incremental projections for NHSC (stand-alone) and WCHN (stand-alone) indicate that Other Operating Expenses will increase in FY 2014 and decrease in both FY 2015 and FY 2016. What is the rationale for these projections? Provide a more detailed breakdown of these Other Operating Expenses incremental to the affiliation.

20. Please answer the following with respect to each entity's interest expense in upcoming years:

    a. Explain why NHSC interest expense rises from $2.1 million in FY 2012 to almost $5 million in FY 2013.
    b. Explain why WCHN's interest expense rises from $4.7 million in FY 2014 to $8.4 million in FY 2015.

21. Regarding the three pages of financial projections on pages 196-198 of the application, please answer the following:

    a. Why do the operating gains for NHSC decrease from $20 million in FY 2012 to $7.5 million in FY 2013 and drop to $2.5 million in 2016?
    b. Why do the operating gains for WCHN decrease from $18.4 million in FY 2012 to $16 million in FY 2013 and decline further to just $5.3 million in 2016?
    c. How do the applicants plan to improve the operating margin of the new health system considering Gains from Operations decrease so dramatically over the next several years for each system and the total consolidated Gain from Operations for the consolidated system is less than the sum of the two systems in FY 2012?

22. On page 202, the Applicants provided details of the expected cost savings broken into the categories Salaries/Benefits, Supplies/Drugs and Other Costs. Respond to the following:

    a. Specific details of how these cost savings will be realized for each of the items indicated; including an itemized list of the category entitled "Other Costs."
    b. Reconcile the two charts of estimated cost savings, as Other Costs in chart 2 does not equal the sum of legal, consulting and communications from chart 1 as indicated in the footnote.
    c. Are these the same cost savings mentioned in the response to question 5(g) of the application? If so please quantify each of the four cost savings noted in the response provided.
    d. Will the proposed combined entity be able to use greater purchasing power as a cost savings mechanism? If so, please quantify and provide specific details, and reconcile or revise all Financial Attachment Is for all hospitals and both health systems.

23. In regard to the financial attachments and related assumptions on pages 200 & 201, the Applicants indicate that FTEs will be reduced if the two health systems are combined. Provide the following:

    a. Details of how the combined entities will reduce FTEs and which departments are expected to be affected.
    b. An explanation of the phrase "based on history adjusted for volume & continued productivity improvements" in the assumptions for FTE amounts.

24. If the consolidation of the two health systems was approved, please answer the following:

    a. Are there any areas where the hospitals will be able to achieve savings by the avoidance of a capital project? If so, please provide details of the projects(s) and the cost savings expected for each health system.
    b. Is WCHN committing any funding to Norwalk Hospital for any current or future projects or for any existing liabilities of the NHCS, such as pension funding or paying for NHCS's long term debt?

25. On page 203 of the application there are details regarding the individual health systems current debt levels as of September 30, 2012. Please respond to the following:

    a. Provide an update through March 31, 2013, of the existing debt levels for each of the current health systems.
    b. If the affiliation is approved, are there any plans to refinance any portion of the outstanding long term debt?
    c. If the new entity does plan to refinance the debt, provide specifics such as possible maturity dates and expected interest rates.
    d. Was any of the $82 million of CHEFA bonds issued in December of 2012 used to extinguish some of the existing long term debt amounts? If not, what were the funds used for? Also, please describe the meaning of a "synthetic" rate in regards to the rate of the CHEFA bonds.

26. Please provide evidence and elaborate on the benefits that WCHN and NHSC will receive and contribute in regards to capital infusion, pension obligations, capital avoidance, expense reduction and profitability with the proposed affiliation.

27. On page 12 of the CON application, the Applicants state that some of the benefits identified by WCHN and NHSC that could be achieved by the affiliation are to integrate operations to achieve and create a unified operating model and improve access to and/or reduce cost of capital due to system scale and performance. Provide further details how the Applicants will achieve the above benefits and quantify the reduction in cost of capital (provide all assumptions and calculations).

28. On page 20 of the CON application, the Applicants state that WCHN has a proven record of success in achieving significant cost savings and clinical integration through its integration between Danbury and New Milford hospitals. In FY 2012, $7.05 million savings were realized through streamlined operational functions and implementation of processes supporting a single standard of care. Please address the following:

    a) How were these annual savings quantified?
    b) File the following tables demonstrating actual cost savings (reductions in expenses) for Danbury and New Milford for FY 2010, FY 2011 and FY 2012 and projected cost savings (reductions in expenses) for Norwalk for FY 2013 - FY 2016. These categories are consistent with the current OHCA HRS Report 175.

Table1: Danbury Hospital and New Milford Hospital Cost Savings

Cost Savings	**FY 2010**	**FY 2011**	**FY2012**
Salaries & Wages			
Fringe Benefits			
Contractual Labor Fees			
Medical Supplies & Pharmaceutical			
Depreciation & Amortization			
Bad Debts			
Interest Expense			
Malpractice Expense			
Utilities			
Business Expenses & Other Operating Expenses			
TOTAL			

Table 2: Norwalk Hospital Projected Cost Savings

Projected Cost Savings	FY 2013	FY 2014	FY2015	FY 2016
Salaries & Wages				
Fringe Benefits				
Contractual Labor Fees				
Medical Supplies & Pharmaceutical				
Depreciation & Amortization				
Bad Debts				
Interest Expense				
Malpractice Expense				
Utilities				
Business Expenses & Other Operating Expenses				
TOTAL				

29. New Milford Hospital ("NMH") reported operating expense reductions totaling $4,956,957 or 5% from FY 2011 to FY 2012. Please address the following:

    a) Estimate how much of the reduction in operating expenses between FY 2011 and FY 2012 for NMH can be attributable to its affiliation with Danbury Hospital?
    b) How were these operating expense reductions achieved?

30. New Milford Hospital in FY 2011 and FY 2012 had loss from operations in the amount of $91,370 and $6,478,071, a 6990% change. Please address the following:

    a) Provide an explanation for the FY 2012 loss from operations of $6,478,071.
    b) Describe how the affiliation of New Milford Hospital and Danbury Hospital has financially benefitted New Milford Hospital, given that for the last two FYs New Milford has recorded losses from operations of approximately $6,569,441.

31. New Milford Hospital reported a decrease of $9,352,034 in Total Net Patient Revenue and a decrease of $1,991,624 in Other Operating Revenue from FY 2011 to FY 2012. Please address the following:

    a) Provide an explanation for the decrease in total net patient revenue and other operating revenue.

32. In regards to the proposed affiliation, the Applicants indicate the multiple benefits associated with the proposal. Will Norwalk Hospital take any steps to prevent any loss from operations for the next three FYs due to the proposed affiliation? Additionally, provide any current and proposed initiatives and efficiencies.

33. The Applicants provide discussion in the CON application related to the affiliation of New Milford Hospital with Danbury Hospital and the positive financial results of that affiliation. However, according to the most recent financial filings for New Milford Hospital with OHCA in the HRS process, New Milford Hospital has shown a loss from operations from FY 2011 to FY 2012, has had a decrease in days cash on hand and an increase in the average payment period. New Milford's total net assets, equity financing ratio and long term debt to capitalization ratio was negative over the period of FY 2011 to FY 2012.

    Please provide a discussion which shows in greater detail how the positive aspects of the New Milford Hospital affiliation that occurred with Danbury Hospital has led to a more positive financial positioning for that hospital in light of the FY 2011 to FY 2012 results reported to OHCA.

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 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 preceding it. Please begin your submission using Page 368 and reference "Docket Number: 13-31832-CON." Submit one (1) original and six (6) 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 Brian A Carney at (860) 418-7014 or me at (860) 418-7012.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

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*** TX REPORT ***
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TRANSMISSION OK

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

FAX SHEET

TO: Jeryl Topalian

FAX: (203) 852-1553

AGENCY:

FROM: Steven Lazarus

DATE: 5/7/13 TIME: 4:10

NUMBER OF PAGES: 10
(including transmittal sheet

Comments:

DN: 13-31832-CON Completion letter

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** 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 Laraia

DATE: 5/7/13 TIME: 4:10 pm

NUMBER OF PAGES: 10
(including transmittal sheet

Comments: DN: 13-31832-COA Completeness Letter

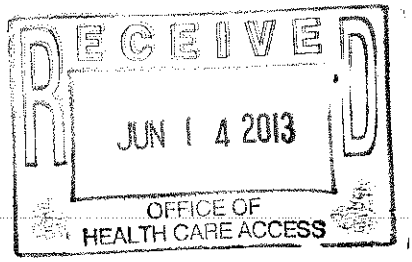
PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Norwalk Hospital

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

June 14, 2013

Via Hand Delivery



Steven W. Lazarus
Associate Health Care Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue: MS# 13HCA
P.O. Box 340308
Hartford CT 06134-0308

Re: Certificate of Need Application, Docket No. 13-31832-CON
Responses to OHCA CON Completeness Questions

Dear Mr. Lazarus,

Enclosed please find responses on behalf of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. to the Completeness Questions asked by OHCA in a letter dated May 7, 2013 in the above-captioned docket. Since the original filing, we have successfully completed our FTC review under the Hart-Scott-Rodino Act, including the Connecticut Attorney General's Office. While we are still in the planning process for integration, pending the approval of this proposal, our responses reflect the most current status of the integration process and projected impact on both operations and finances.

We have included the original and six hard copies of the Responses, as well as a CD with an Adobe format of the Responses.

Please contact me at 203-739-4903 or Jeryl Topalian, Executive Director, Planning & Business Development, Norwalk Hospital at 203-852-2354 if you have any questions regarding this submission.

Yours truly,

Sally F. Herlihy

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network, Inc.

Docket No.: 13-31832-CON Completeness Questions and Responses

General

1. Beginning on page 25 of the CON application, the Applicants submitted a redacted copy of the Affiliation Agreement and the related attachments between the parties. Specify the reason ("confidential" will not be accepted) and a general description of each redaction , so that OHCA can consider if a full open copy of the Affiliation Agreement will be required.

Please find attached as Exhibit A the un-redacted Affiliation Agreement in its entirety.

2. In reference to page 30, of the CON application, provide a list of "occurrences/events" that would change the Initial Governance Structure.

Please see the Affiliation Agreement provided in Exhibit A, Sec. 2.1, (g).

Need & Services

3. On page 11 of the CON application, the Applicants state that Norwalk Health Services Corporation ("NHSC"), through its Board of Trustees and senior management, explored strategies and tactics that would be needed for long-term success of NHSC. Furthermore, "[e]lements identified as essential to long-term viability included improved access to capital markets, support for physician recruitment/retention, clinical service development, and better use of scarce community resources." Regarding the aforementioned, please address the following questions:

    a. Provide a discussion on the methods/approaches utilized by NHSC's Board of Trustees and senior management to explore strategies and tactics for NHSC's long-term success.

The NHSC Board of Trustees and Senior Management held an off-site retreat, facilitated by Navigant Consulting, Inc. (NCI) in November of 2008. This was the initiation of the long-term strategic planning process, to develop a new plan for NHSC. The objectives were to:

- *Present a national perspective on the transformation of healthcare delivery which included growing hospital consolidation pressures, the rise of consumerism, new models of physician-hospital alignment, and the changing delivery of care*
- *Discuss observations on the Southern Connecticut market*
- *Evaluate Norwalk Hospital's (NH) positioning in light of national trends and regional market dynamics*
- *Review national, regional and local market implications to NH's planning for Vision 2015*
- *Identify key elements for NH to consider in its Vision 2015 as it relates to the national trends*

After NCI presented an extensive overview of the health care environment and analysis of healthcare trends, Board members and Senior Management broke out into groups, discussed the topics reviewed in the national trends section, and identified key considerations that NH would need to address within its Vision 2015 and long term plan. In addition, NHSC, with the

assistance of NCI undertook a physician resource planning process, and formed the Partnership Task Force to assess strategic partnership options.

This physician planning process kicked off in January, 2009 and was completed in March 2009. A steering committee consisting of NHSC Board members, physicians, and NH management and facilitated by NCI was the oversight body. Using a proprietary model which incorporates demographic trends, actuarial data, technology trends, physician utilization rates and work capacity, NCI developed an estimate of physician demand and benchmarked this against existing physician supply to determine community physician need. The resulting plan was endorsed by the Steering Committee and Board of Trustees in March, 2009 and utilized in the strategic planning process.

The Partnership Task Force, consisting of Board members and senior management, held a series of workshops facilitated by NCI in April and May of 2009. The process of the Partnership Task Force is discussed in detail in Completeness Question 4.

Vision 2015 was further developed by the Strategic Planning Committee of the Board of Trustees, at a series of meetings/workshops held beginning in March of 2009 and culminating in August 2009. The Strategic Planning Committee, comprised of NHSC Board members, members of the NH Medical Staff, key community members, and senior leadership of NH was supported by the Planning Department of NH.

b. What specific strategies and tactics were developed to address and support the long-term success of NHSC?

The specific strategies and tactics were developed and outlined in NHSC's long-range strategic plan: Vision 2015, which was developed by the Board of Trustees and the Strategic Planning Committee of NH, and approved by the Board of Trustees in August, 2009 (see Exhibit B).

c. Was there a report developed by NHSC's Board of Trustees or senior management that chronicles the elements that were identified as essential to long-term viability of NHSC? If yes, please provide a copy. If no, please explain.

The report developed was NHSC's long-range strategic plan: Vision 2015. It is attached as Exhibit B.

4. In 2009, Norwalk Hospital engaged Navigant Consulting, Inc. ("NCI") for an assessment of partnership options (page 11) Furthermore, a Partnership Task Force was created consisting of the Board of Trustees members and senior management. Please detail and discuss the outcome/findings of NCI's recommendations.

Navigant Consulting, Inc. (NCI) was engaged by NHSC to serve as both a content expert and a facilitator for the Partnership Task Force, and assisted the task force in working through strategic partnership options in a series of meetings held from April 2009 through May 2009.

NCI presented the Partnership Task Force with background on Healthcare Merger & Acquisition activity; both on a national and local level, and outlined the continuum of options – from remaining independent to full asset sale or merger, as well as the key drivers for independent hospitals to join/form a larger system.

Key Drivers for affiliation/partnership identified included:

- *Long term viability of the hospital (e.g., continuance of mission/services to the community)*
- *Improved access to capital markets and/or capital infusion*
- *Support for physician recruitment and retention*
- *Clinical service development, including the ability to provide more specialized services to the communities served*
- *Clinical, managerial, and technological talent and resources to reduce cost and improve quality*
- *Opportunity for collaboration*
- *Preserving community control and presence*
- *Quality improvement*
- *Better use of scarce community resources*
- *Improved care for the vulnerable and other community benefits*

The Partnership Task Force then discussed potential "triggering events" which could lead NHSC to initiate partnership discussions, broadly characterized as government forces, market forces, and internal forces. Each of these forces could potentially reduce reimbursement, decrease utilization of hospital services, or limit access to capital. NCI recommended that NH work through various partnership scenarios, in order to shape an informed opinion regarding potential partnership options before being forced to react to external events.

Seven potential partnership scenarios were developed and reviewed by the Partnership Task Force:

A. *Create a "Regional Health System" consisting of two or three independent facilities*
B. *Enter a joint operating agreement with a regional partner*
C. *Create the "Regional Health System" and enter into a joint operating agreement*
D. *Sell to a for-profit health system*
E. *Join an existing Connecticut health system*
F. *Join an academic New York health system*
G. *Become an affiliate hospital of a New York health system*

The advantages and draw-backs to each of these scenarios were explored against maintaining the status quo of NH remaining as an independent hospital. Scenarios D, F, and G were ruled out as options for NHSC, as the Partnership Task Force agreed that these scenarios would not materially address the key drivers identified to pursue a potential partnership. A framework was developed for NHSC to utilize in exploratory discussions with potential regional partners. NCI's engagement concluded in May, 2009. Key leaders from the Partnership Task Force held at least four meetings with each potential candidate between June of 2009 and May of 2011 to assess the best option for a future partnership.

In May, 2011 Senior Leadership and the Board of NHSC determined that the continued evolution of changes in the healthcare environment brought a new urgency to developing a partnership option. NCI was re-engaged to facilitate a special meeting of the NHSC Board of Trustees on June 28, 2011. The Senior Leadership of NH sought and obtained approval from the Board to initiate a feasibility study of a partnership with Western Connecticut Health Network, Inc. (WCHN).

5. Did NCI produce a report for NHSC, regarding strategies, options and partners for Norwalk Hospital and NHSC? If so, please provide a copy.

No report regarding strategies, options or partners was produced for NHSC by Navigant Consulting, Inc., as NCI was serving as a facilitator for the Partnership Task Force discussions. As noted in the response to Completeness Question 4, materials presented by NCI in the meetings included various case studies of organizational merger and acquisition strategies – and their success or failure, a situation assessment of the Southern Connecticut Healthcare landscape, sample vision and objectives for a potential collaboration, commonly cited rationale for consolidation, potential "triggering events" for initiating partnership talks and scenarios for potential partnership options.

6. Also on page 11, a reference is made that around the same time that the Partnership Task Force was created, NHSC developed "Vision 2015," a strategic plan identifying the long-term strategic priorities for the hospital. Please provide a copy of Vision 2015.

A copy of Vision 2015 is provided as Exhibit B.

7. Did either of the Applicants perform a study or analysis that supports the benefits of this proposed affiliation (listed on page 12)?

    a. If yes, submit a copy to OHCA as evidence supporting the proposed benefits.

After signing a Mutual Confidentiality Agreement on September 16, 2011, the Applicants, through legal counsel (Ropes & Gray), engaged The Chartis Group to perform a feasibility analysis of the strategic and financial benefits associated with affiliation, and develop a shared understanding of each organization's current position and the community landscape.

The Chartis Group, working through outside counsel, provided guidance to a small Joint Steering Committee comprised of representatives of NH and WCHN (CEOs, CFOs, CMOs, COOs, general counsel, strategic planning and medical staff leadership) for a three-month period in the winter of 2012. There were a series of informational discussions about the nature of the changing health care landscape and the Connecticut market in order to develop a context and vision for integration, as well as a high-level look at financials to determine if there was sufficient rationale to merit continued discussions. It also included the transforming economic model in health care with new payment models emerging and the shift toward increasing accountability for the costs and outcomes of care to providers, as they are best positioned to change care and operate under the new reimbursement models.

The report was presented to both the NHSC and WHCN Boards in March, 2012, and is attached as Exhibit C.

b. If no, explain in detail, how the need and benefits for this proposal were developed and provide supporting evidence.

Not applicable.

c. Has either of the Applicants performed a Community Needs Assessment ("CNA")?

The Greater Norwalk Area collaborative of NH and Norwalk Health Department led the community health planning process to assess the health of the community in the Greater Norwalk area in 2012. The health departments of New Canaan, Westport, Weston, Wilton, Darien, and Fairfield were also involved in this regional effort, which included a community health needs assessment (CHA) to identify the health-related needs and strengths of the Greater Norwalk Area, and a community health improvement plan (CHIP).

The WCHN approach to developing its community needs assessment has been a collaborative one with its local communities. A Steering Committee comprised of individuals from the Danbury and New Milford Departments of Public Health, WCHN, United Way and Western CT State University coordinated a data collection process that culminated in a Community Report Card in 2009. Those indicators and activities were updated and a new report card released in 2012. The Steering Committee has been guiding an interactive process with the following current activities underway:

- *May 2012 - Community Report Card - baseline of key demographic, socioeconomic, and health status indicators finalized and distributed*
- *September/October 2012 - Inventory and mapping of community assets and requests for services (utilizing 211 InfoLine database) completed*
- *October 2012 - Community Conversations held in Danbury and New Milford, with >50 participants participating in interactive discussions of priority health issues*
- *April 2013 - Stakeholders from diverse fields identified to assist with development of a community plan for action with shared responsibility and ownership*
- *June 2013 – Initiation of community action planning workgroups (going forward)*

d. Please provide copies of any CNA performed, draft or final.

The 2012 Greater Norwalk Area Community Health Assessment and Improvement Initiative is attached as Exhibit D.

The 2012 Community Report Card for Western Connecticut is attached as Exhibit E.

8. On page 12, the application speaks to the benefits of affiliation for the WCHN and NHSC systems. Page 16 explains in very general terms how the proposal would improve health care delivery in the region by strengthening clinical programs and the physician platform, enhancing educational programs and building competencies. Please provide more specific

examples of how, within the first three years following affiliation, patient access and quality of services will be improved.

An expanded physician base results from the proposed affiliation that can address community health needs of the contiguous communities serviced by the affiliated hospitals. WCHN has already begun collaboration between its two hospitals and its affiliated physicians. NHSC has also been working on physician alignment and integration. Working as partners allows WCHN and NHSC to leverage physician resources to the benefit of the communities served. The current distribution of employed physician providers within the NHSC and WCHN combined communities is shown in Exhibit F.

As stated on page 17 of the CON Application, the proposed integration of the two systems positions the unified system to deepen its primary care base for improved patient access in addition to building specific clinical programs. Independently, each organization might consider some limited expansion in their respective communities but would likely do so gradually. Together, where demand exists, the affiliation could provide scale and resources to more rapidly support investment in joint recruitment activities. It is anticipated that within the first three years following affiliation, patient access will be improved by the addition of more primary care doctors. Additionally, where demand warrants making investments, there could be improved access to primary care in outpatient facilities through extended hours of operation and varied locations.

WCHN has also begun implementing a system for better access, higher quality and lower cost services, using its employees as the participants. Emphasis is placed on preventive care as well as the right place for the right service. See response to Completeness Question 15 for an explanation of this new model, called eACO. NHSC, as affiliate of WCHN will be able to take advantage of the work that is underway at WCHN in terms of testing some of the new health care models without investing additional dollars for development or research. This highlights one of the key benefits of this affiliation: two organizations whose values and vision are similar, can benefit from the strengths and organizational competencies of each other (which can be adapted for the specific hospital's service area) once, rather than twice, for the benefit of two populations.

Specific examples that can be taken by the Applicants to provide enhanced patient care and access involve subspecialty care for head and neck surgery and cranial neurosurgery. These are areas where better access can be provided with improved quality and less expense in the first three years following affiliation.

<u>Example: Head and Neck Surgery</u>
Independent: Both organizations have small head and neck programs but significant room for growth

- *WCHN has one full-time head and neck surgeon who still has capacity and is eager to grow*
- *NH had a full-time head and neck surgeon but encountered volume and coverage issues. The physician has since left the area.*

Integrated: Combined, the hospitals can create a network-wide head and neck surgery program with a full range of services at both locations, improving the overall quality of the surgery program, better serving patients in their communities

Example: Cranial Neurosurgery

Independent: Both organizations have neurosurgery programs, but neither organization has advanced cranial neurosurgery capabilities

- *A common physician group practices at both organizations*
- *Over half of all neurosurgery cases leave the area for care, often for higher-acuity services, which neither hospital can provide*
- *Neither organization has the requisite scale to justify the investments required to expand this program*

Integrated: Together, the combined entity will have the patient volume necessary to make a network-wide investment to expand its shared neurosurgical capabilities, working with the physician group to recruit a subspecialist in cranial neurology. The new WCHN can deliver higher-acuity care to patients, who will be able to access these services closer to home

Integration also creates potential opportunities for the affiliated entity to build on existing strengths and capabilities, as is the case with Thoracic Surgery.

Example: Thoracic Surgery

Both organizations have small thoracic surgery programs but significant room for growth. Many thoracic surgery cases leave the community for care at a tertiary center. Together, the creation of a system-wide program would result in an expanded range and scale of thoracic surgery at NH and DH, supporting the pulmonary and cancer programs and improving the overall quality, better serving patients in the local communities.

Setting shared quality standards will produce best practice outcomes across the single new network. In a larger network, it will be possible to attract the needed physicians in order to provide greater access to those requiring health care services. Access within one system of care for the residents living in the services area of the new network will provide patients with greater continuity of care.

9. On page 13 of the CON application, the Applicants represent that at this time, no change in services will occur due to the proposal, however, in the future, changes may occur as opportunities to reduce duplication or inefficiencies in clinical service delivery are identified. Please address the following:

    a. Has either of the Applicants performed an analysis of the current services offered by each Applicant in its respective service area/region to determine if any services will be duplicated?

Neither Applicant performed an analysis of current services to determine if any services will be duplicated during the due diligence period due to anti-trust considerations. However, an analysis of the Applicants service area discharges was performed by Economists, Inc. as part of the Federal Trade Commission (FTC) Hart-Scott-Rodino (HSR) filing, and the resultant map is attached as Exhibit G. This analysis shows that the service areas of each of the Applicants have very little overlap and they provide health care services in contiguous markets. Based on this finding, the Applicants determined that current services offered by each Applicant would continue to be offered during the initial integration.

b. At what point do the Applicants plan to perform an analysis of the demand for services in the respective service area/region to determine possible duplication of services or efficiencies that may be achieved by reconfiguring services. Provide a detailed discussion and timelines.

The Applicants, individually, perform an analysis of the demand for services in their respective areas on at least an annual basis, as part of their respective strategic planning and business planning processes. Demand for and utilization of services is assessed at least quarterly, and is incorporated into service line business plans, community needs assessments, physician resources plans, and annual capital and operating budgets. It is important to note that the Applicants are separated by a distance of twenty-five miles, and that there is little overlap in their service areas. (See Exhibit G for a map demonstrating minimal overlap in respective Applicant service areas).

As part of the Integration planning, three clinical services lines have been identified as areas where collaboration may achieve greater access or efficiencies may be gained. These include Cardiovascular Services, Pediatrics, and Cancer Services. (See response to Completeness Question 13 for details of the integration planning process.)

Opportunities for efficiency may be achieved by being able to more fully attract, support and utilize specialists - (e.g. surgical oncologists in cancer services, pediatric specialists in pediatrics, interventional cardiologists and vascular surgeons in cardiac services) – who will be able to practice at network locations and cover a wider geographic service area. It is not anticipated that any of these services would be considered "duplication" as the distance would dictate that these services continue to be provided by each Applicant.

As strategic planning in the new WCHN will be performed at the network level, a new Board-level Strategic Planning Committee will be formed after the closing of this proposal. Developing a new strategic plan for the system will likely be undertaken by this body in the early part of 2014, and will include a regional analysis of service utilization as well as a projection of future needs and demands.

c. Specifically, how will the proposed affiliation impact and improve NHSC and WCHN clinical programs and services?

The affiliation will allow the administrators and clinical staff at two major organizations in the State to work together to develop and share the protocols for evidence-based, best practice medicine in every one of the areas where patient services are provided. Sharing personnel with

specific expertise will reduce duplication, while at the same time expand access to additional resources that neither organization may have presently. A few key areas of potential improvement were identified in response to Completeness Question 8.

d. Provide a list of services that will be impacted as a result of this affiliation.

We anticipate that, over time, and in response to transformations occurring within the health care delivery system that all services currently provided by the Applicants could potentially be impacted as a result of this affiliation. Initial areas of focus have been identified with our integration teams as explained in Completeness Question 13.

10. On page 13 of the CON application, the Applicants state that it is also anticipated that many of the tertiary care services that are being provided today will be strengthened by the partnership of NHSC with WCHN. Please explain and provide specific examples.

Both organizations are teaching hospitals offering fellowship programs and specific clinical areas of expertise at the tertiary level. WCHN has a fellowship in Cardiovascular Services, where NHSC has fellowships in Gastroenterology, Pulmonary, and Sleep Medicine. The affiliation will allow for sharing these resources, bringing the expertise to both service areas. Upon approval of this Application, these tertiary services will be examined to see whether there can be an expansion of these services. The two organizations will be able to collaborate with each other so that patient access to these resources is expanded. Please refer to Completeness Question 8 for examples.

11. On page 11, the Applicants state that WCHN affiliating with a strong partner would, among other things, create new synergies which focus on patient healthcare delivered at the right time and at the right place. Explain the meaning of this statement and provide specific examples.

Health care delivered at the right place at the right time refers to utilization of the integrated network of facilities for delivery of coordinated, effective patient care across the continuum. The goal being delivery of high quality care in the lowest cost setting appropriate. In a practical sense, it means that preventive care and chronic disease management can be performed by the primary care doctor in the office or in an outpatient setting that is accessible both in terms of location and hours of operation; that only acute and emergent interventions will occur at a hospital; and that post-operative, post-hospitalization rehabilitation will be undertaken at a skilled nursing facility or the hospital's own inpatient rehab unit, and that those patients will quickly transition to home care and out-patient rehabilitation services. The synergies achieved by affiliation will allow WCHN and NHSC in partnership with their affiliated physicians, to develop seamless transitions of care throughout the new system.

Specifically, for this proposed affiliation at this time it includes primary care and ambulatory care sites accessible to patients in key communities (multiple physician office sites; outpatient surgical centers in Norwalk and Ridgefield; diagnostic imaging facilities in Norwalk, New Canaan, Westport, Ridgefield and Danbury; regional cancer programs in New Milford, Danbury and Norwalk), support services offered through Western CT Homecare (greater Danbury

community), a community hospital in New Milford (NMH), and regional hospital referral centers located in Norwalk (NH) and Danbury (DH). Synergies in delivery of care to patients may result from centralized roles, sharing best practices where appropriate, health information exchange (HIE), and exploring cost-reduction through economies of scale.

12. On page 12 of the CON application, the Applicants provide a list of benefits identified as a result of this proposal. Please provide an explanation of how each of these bulleted items would be achieved as a result of this affiliation and provide specific examples and cost savings related to each.

The benefits listed on page 12 of the CON application were identified as part of the exploratory process the Applicants underwent to identify the strategic and financial benefits associated with affiliation. While it is the goal of the Applicants to achieve these benefits, they are projected opportunities, based in part on industry case studies of successful hospital affiliations applied to each organization's current position. For some of the anticipated benefits, it is not possible to provide specific examples or detailed cost-savings at this stage of the affiliation process.

Strengthen clinical programs – See response to Completeness Question 8 above. Both organizations seek to develop and grow primary and subspecialty care in order to provide improved access to clinical services focused on quality and value. The new network will allow for improved access to primary care in outpatient facilities that have extended hours of operation and varied locations. Subspecialty care will be improved through collaboration and cooperation between the two organizations. The new network values health education for patients, and will develop the infrastructure for population health management, focusing on wellness, prevention and management of chronic disease in the lowest cost clinically appropriate setting. This is an area that will benefit from collaboration to produce the most effective means of reaching patients. Cost-savings will be realized from the collaboration through recruitment and shared resources, but cannot be quantified at this stage of the integration process.

Enhance educational programs – Medical education and research capabilities will be enhanced with two teaching organizations developing a single, coordinated education program for tomorrow's workforce of physicians, nurses, technicians and others.[1] A larger network will offer more opportunity for professional growth and development. Additionally, the existing Biomedical Research Laboratory at WCHN will be available to both organizations as we strive to answer questions about challenging diseases and tailor genomic therapies and unique solutions to medicine.

The affiliated entity can achieve an educational platform with more breadth and scale than either organization can achieve on its own. Integration has the potential to improve the quality of medicine residents based on improved access to fellowships and expanded training opportunities across the system, reduce the need for and cost of external rotations, unified relationships with medical schools, and system-wide coordination for effective use of resources.

[1] Currently, WCHN offers residency programs in Internal Medicine, IM Primary Care, Obstetrics & Gynecology, Pathology, Surgery and Dentistry, as well as a fellowship in Cardiovascular Medicine at Danbury and New Milford Hospitals. NHSC offers residency programs in Internal Medicine and Radiology as well as fellowships in Gastroenterology, Pulmonary and Sleep Medicine at Norwalk Hospital.

The full scope of benefits of an enhanced educational program is difficult to quantify, however, by year three there is a potential opportunity to achieve a $650K financial benefit from a unified approach to GME and UGME academic affiliations.

Strengthen physician platform – In addition to the response to Completeness Question 14 below, there is an opportunity to bring together the employed physicians across the network into a large multi-specialty group practice. The proposed integration of the two systems creates a larger physician platform that positions the unified system to deepen its primary care base for improved patient access in addition to building specific clinical programs. Currently, both systems include physician groups that offer primary care, medical sub-specialty services and surgical sub-specialty services.

The new WCHN will focus on areas that can be served through collaborative development of opportunities to expand access/services. We will be able to explore diverse care delivery models such as medical homes, open access primary care or urgent care. The shared investment to develop a single practice management infrastructure could potentially result in operating cost savings from a consolidated management and administrative team and potential reductions in physician recruitment and retention costs. This could achieve a projected savings of $1M by year five.

Build competencies required for new reimbursement models – Building requirements for managing care in a new reimbursement environment, and facilitating our movement toward value-based reimbursement models can be achieved collectively through integration. New reimbursement models require new skills and new infrastructures. Integration will support strategic cost management by enabling the combined entity to centralize and standardize non-patient facing functions, to more effectively use resources.

The investments and capabilities required for population health management can be shared. Integration will enable identification and dissemination of best practices across the system, including adoption of evidence-based, consistent clinical protocols and care processes. Combined scale and resources will better position the organizations to participate in risk contracts. There is also an opportunity to develop a system-wide approach to promote communication and coordination in and between all sites of care. Costs savings resulting from these initiatives are not known at this time.

Integrate operations to achieve savings and create a unified operating model – Shared savings from a unified approach to operations and opportunities to centralize and standardize non-patient facing functions will result in more effective use of resources. This approach will preserve campus-specific clinical and support functions necessary to effectively serve patients and local communities, and reduce overhead by centralizing administrative functions. These can potentially result in an approximate 2.0% reduction on total combined expenses by year five. (Please see response to Completeness Question 17 for detail on these cost-saving opportunities).

Improve access to and/or reduce cost of capital to system scale and performance – In the long term, integration may allow WCHN and NH to benefit from shared investments and support continued financial health. Larger, multi-system health systems tend to have higher credit

ratings, which reduces cost of capital and improves access to capital. Future potential to avoid duplicative capital investment on equipment, facilities, IT and other infrastructure may result, but these opportunities are unknown at this time. An article from Moody's Investors Service identifying the importance of delivering value-based care by hospitals and its relationship to financial strength and credit ratings is attached as Exhibit H.

13. On page 14 of the CON application, the Applicants state that they have engaged PricewaterhouseCoopers to help develop a transition plan, which is anticipated to be completed over a six month period. Please address the following:

    a. Provide an update on the progress of this plan.

The Integration planning process kicked off in early April, with general orientation meetings held for staff at WCHN and NHSC. Subsequent to these meetings, twenty-two integration teams were formed, consisting of a senior leader sponsor (from either organization), two co-leads (one lead from each organization), and team members from both organizations. A list of the specific teams is attached as Exhibit I. Each team has been charged with development of a charter, designing a potential future state, and making recommendations to the Integration Steering Committee on how to proceed toward achievement of the future state and potential opportunity for efficiencies that could be realized through integration efforts. It is anticipated that initial recommendations will be endorsed by the end of July 2013 and the teams will then develop work plans in August and September 2013 that would commence on day one of the newly affiliated entity, if this CON is approved.

    b. Who will make up the proposed Integration Steering Committee?

The following individuals are participating on the Integration Steering Committee:

John Murphy, MD	*President & CEO, WCHN*
Dan DeBarba	*President & CEO, NHSC*
Lisa Brady	*COO, Norwalk Hospital*
Michael Daglio	*COO, Danbury Hospital*
Deborah Weymouth	*Executive VP, New Milford Hospital*
Steven Rosenberg	*CFO, WCHN*
Patrick Minicus	*CFO, Norwalk Hospital*
Renee Mauriello, RN	*CNO, Norwalk Hospital*
Moreen Donohue, RN	*CNO, WCHN*
Eric Mazur, MD	*CMO, Norwalk Hospital*
Matthew Miller, MD	*CMO, WCHN*
Sally Herlihy	*VP Planning, WCHN*
Rowena Rosenblum Bergmans	*Sr. Health Care Policy Advisor, NHSC*
Anthony Aceto	*VP Human Resources, Norwalk Hospital*
Phyllis Zappala	*Sr. VP Human Resources, WCHN*

c. Who will the proposed Integration Steering Committee report to?

The Integration Steering Committee will report to the Affiliation Task Force, comprised of members of the NHSC Board of Trustees and the WCHN Board of Directors.

14. Page 17 of the application states that "New WCHN will allow for improved access to primary care in outpatient facilities." Have any areas in either WCHN or NHSC's service area been identified as needing additional primary care? Is there a plan to establish outpatient facilities dedicated to primary care as part of this proposal?

In 2009 and again in 2012, NHSC conducted an analysis of the physician supply/demand in its Stark-defined service area, as well as secondary service areas. In both analyses, significant shortages in the supply of primary care physicians were identified. NHSC implemented their physician development plan to address these shortages, and has successfully recruited five new primary care providers to the service area over the past two years.

The WCH N physician alignment strategy is a multifaceted approach toward enhancing access to primary care service and subspecialty care that includes the following: physician employment, increasing the number of providers across the service area, development of a Patient Centered Medical Home (PCMH) model of care, training new providers and retention within the market.

The proposed affiliation between NH and WCHN creates a large physician platform with little service area overlap (see map in Exhibit G). This platform includes over 800 independent physicians and over 325 employed physicians that are geographically distributed to meet the needs of their respective service areas.

As was noted in the response to Completeness Question 8 and Completeness Question 12, independently, each organization would consider primary care expansion to meet the needs in their respective communities but would likely do so gradually. Together, the affiliation would provide scale and resources to more rapidly support investment in joint recruitment activities.

This proposal does not include a plan to establish outpatient facilities dedicated to primary care. One of the integration planning teams, the Primary Care Physician Distribution team is charged with evaluating the primary care physician supply in the service area towns of the new WCHN, and making recommendations to the Integration Steering Committee to address identified needs. At this stage of the integration planning, it has not been determined if additional outpatient facilities would be needed.

15. On page 18 of the CON application, the Applicants state that "[a] larger employee base allows the system to pilot new models of care." Provide examples and explain the function and benefits of such models.

Health systems and health plans are moving rapidly to establish accountable care organizations (ACOs), shifting the focus of care delivery from volume to outcomes. This is resulting in an increased emphasis on population health management (working to improve the health not just of one patient but one of a health system's entire populations) as a tool to move toward value-based

care delivery models. While the path toward ACO development is not defined for providers, there is support for developing smaller scale pilot programs to learn what might work and be adaptable on a larger scale. Employee populations offer an opportunity to create an employee accountable care organization (eACO) and WCHN is currently in the development stages of doing so. NHSC will be able to add their employee population to this effort, which provides a larger pool of enrollees to track outcomes and results.

Focusing programs on helping to reduce prevalent, chronic health diseases of individuals in the workforce, and addressing contributing factors for poor health will help reduce benefit costs. WCHN has implemented a Wellness Program and is developing an eACO. Success with these efforts will help inform development of sustainable healthcare delivery models. A description of WCHNs efforts is enclosed as Exhibit J. This presentation, "Managing Costs and Population Health Through an eACO Model" was co- presented to the Northeast Business Group on Health by WCHN and Towers Watson.

16. Page 23, lists ways the affiliation will realize cost savings. Please further explain and quantify the second bullet: "Standardization of policies and processes will create additional efficiencies even in some areas that remain hospital specific to reduce costs in local communities." Bullet four states that scale will allow for the better use of in-house resources, reducing the reliance on external services. Provide examples of external services that could be reduced as a result of this proposed affiliation and quantify the savings.

Efficiencies achieved through standardization of policies and processes assume that the new WCHN will identify best practices in each of the partners, and share these practices across the new organization. The integration teams are assessing these opportunities, and will have preliminary recommendations as described in Completeness Question 13. Examples of how potential expense reductions may be achieved include: automation of process(es) currently performed manually; consolidation of 3rd party contracts and data management systems; and reduction in the use of consultants or agencies that provide external subject matter expertise, or perform specific support functions. The total savings opportunity is not known at this point in time. (Also see response to Completeness Question 12 above.)

Financial

17. On page 202 of the CON application, the Applicants state that this proposal will "drive down cost of delivery of healthcare through shared resources, volume purchasing and integrated operations." Please explain in detail, provide specific examples and projected cost savings for the first three years of this proposal and reconcile to Attachment I of the CON application.

Through legal counsel, the Applicants engaged the Chartis Group to study possible synergies that could result from an affiliation. This review was completed by independently analyzing the overall cost structures within both organizations. Specific details of their computation were not shared with the two organizations because of antitrust concerns. The computed estimated possible synergies were then compared against publicly available sources of examples of

operational savings from affiliations to validate their reasonableness. The overall expense synergies were divided into several broad categories, allocated to various expense groupings and then included in financial Attachment I. The FY 2016 synergies represent less than 2.5 % of expenses of FY 2012 combined entity expenses. As indicated above, it should be noted that no specific reductions were identified and agreed to as part of this review process. NHSC and WCHN are currently in the early stages of integration planning and therefore it is not possible to identify at this time the specific expense synergies that will be implemented. However, Table A includes the system synergy categories and savings identified by the consultant and included in Attachment I.

Table A
Expense Synergies for FY 2014-2016 as projected by the Chartis Group:

Expense Synergies	Total System 2014	2015	2016	% of FY 16 Op. Exp
Admin Services	$ (2.2)	$ (5.1)	$ (7.8)	
Clinical Services	(2.0)	(4.0)	(6.9)	
Research and Ed	(0.0)	(0.1)	(0.1)	
Med Grp/Foundation/Pharm	(1.1)	(1.7)	(2.3)	
Education	(0.2)	(0.3)	(0.7)	
Support Services	(0.5)	(1.0)	(1.4)	
Other	(0.5)	(1.2)	(1.3)	
Severance	1.8	2.1	1.4	
Expense Syngergies	$ (4.7)	$ (11.3)	$ (19.1)	2.3%
FTE's	(19)	(37)	(58)	1.6%

Figures listed above are listed in millions.

Personnel savings can be achieved through centralization of roles and functions and through standardization of policies and procedures. Below is a description of synergies anticipated along with hypothetical examples:

Personnel Savings:
Centralization of roles and functions in non-clinical administrative and managerial roles offer the opportunity to eliminate duplicative labor costs. This is anticipated to occur in areas such Billing, Finance, Compliance, Planning, Marketing, Quality Management, Human Resources, Information Technology, Medical Education Coordination, and Clinical and Senior Leadership at the Hospital and Medical Group organizational level.
Standardization of policies and processes will create additional efficiencies even in areas that remain campus specific.

Savings on Purchased Goods and Services
Scale provides the opportunity to achieve savings on purchased goods and services including clinical and non clinical supplies, physician preference items, drugs, and external service agreements. In addition, scale supports more effective use of existing in-house resources,

reducing the reliance on external assistance required. Examples of the latter would include in-house management of construction projects, performance improvement projects, marketing and communications, and the system-wide implementation of a software program that simplifies and consolidates the valuation of revenues.

18. In addition to the individual Financial Attachment I for NHSC and WCHN as presented in Exhibit M of the CON application, please provide the following:

    a. Separate Financial Attachment I for Norwalk Hospital, Danbury Hospital and New Milford Hospital that provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project.*

See Exhibit K for stand-alone Norwalk Hospital, Danbury Hospital and New Milford Hospital Financial Attachment I.

    b. The sources upon which the revenues and volume projection assumptions on pages 200-201 are based.

NHSC and WCNH financial assumptions were developed by the management of the two entities based on their industry experience and in consideration of healthcare trends impacting volume and the future regulatory environment. These assumptions were reviewed and validated by outside consultants. As indicated in the assumptions, further proposed state pool payment reductions have not been included in the financials. Severe expense reductions will be necessary with the state budget approved for implementation July 1, 2013.

    c. Will the proposed WCHN be able to enhance private payer reimbursement more than if the two health systems operated separately? If so, please explain in detail as there is no mention of any changes in reimbursement in the financial assumptions.

Potential changes to private payer reimbursement are not known as contracting information has not been shared between the Applicants due to antitrust regulations. However, it is not a goal to enhance private payer reimbursement as a result of the proposed affiliation, and therefore, this was not factored into the financial assumptions.

    d. Has value based purchasing been considered in the financial assumptions? If so, please explain and quantify.

Value based purchasing was considered when projecting the overall Medicare rate increase assumption utilized to calculate Financial Attachment I. However, value based purchasing was one relatively small factor of many factors considered. For perspective, the value based purchasing adjustment impacted Medicare reimbursement by less than $100K in FY 2013 for NHSC and approximately $125K for WCHN in FY 2013 overall. It should also be noted that the applicants believe that the affiliation should result in improved clinical practices as a result of best practice implementation for the combined entity. Additionally, consolidating the Quality

Management departments should result in the potential for increased availability of quality management resources by eliminating duplicative services.

*Note that the actual results for the fiscal year reported in the first column must agree with each Hospital's respective audited financial statements. The projections must include the first three full fiscal years of the project, FTE projections and utilization statistics by service.

19. In Financial Attachment I on pages 196 and 197, the incremental projections for NHSC (stand-alone) and WCHN (stand-alone) indicate that Other Operating Expenses will increase in FY 2014 and decrease in both FY 2015 and FY 2016. What is the rationale for these projections? Provide a more detailed breakdown of these Other Operating Expenses incremental to the affiliation.

The reason for the increased other expenses in With Project FY 2014 is that expense synergies are expected to be offset by higher integration costs in the early phases of the integration of the two organizations. As shown in the table B below, other expense synergies are expected to ramp upwards as we move from FY 14 through FY 16 while integration costs are expected to decrease during the same period.

Table B provides a detailed breakdown of the other expense synergies from the affiliation. Our response to Completeness Question 17 outlines how these costs were computed. It is not possible to provide specific identified reductions at this time.

Table B

	2014	2015	2016
Expense Synergies			
Education	(0.2)	(0.3)	(0.7)
Admin Services	(0.6)	(1.4)	(2.1)
Clinical Services	(0.5)	(1.1)	(1.9)
Research and Ed	(0.0)	(0.0)	(0.0)
Med Grp/Foundation/Pharm	(0.3)	(0.5)	(0.6)
Support Services	(0.1)	(0.3)	(0.4)
Other	(0.7)	(1.5)	(2.0)
Total	$ (2.5)	$ (5.0)	$ (7.7)
Integration Costs			
Legal Cost	0.9	0.4	0.0
Consulting	1.3	0.9	0.7
Communications/Marketing	0.6	0.4	0.0
Severance	1.8	2.1	1.4
Total	$ 4.6	$ 3.8	$ 2.1
Total All Other	$ 2.2	$ (1.2)	$ (5.6)

20. Please answer the following with respect to each entity's interest expense in upcoming years:

    a. Explain why NHSC interest expense rises from $2.1 million in FY 2012 to almost $5 million in FY 2013.

NHSC interest expense increased due to the $82M tax exempt private placement financing through CHEFA completed in December 2012 (related to Docket No. 09-31492-CON, Master Facility Plan Ambulatory Pavilion. 7/13/10).

    b. Explain why WCHN's interest expense rises from $4.7 million in FY 2014 to $8.4 million in FY 2015.

WCHN interest expense increase is a direct result of the $125M financing related to the Tower Facility Project which is anticipated to be completed in late FY 2014. A full year of interest expense is reflected in FY 2015 (related to Docket No. 09-31490-CON, 8/24/10).

21. Regarding the three pages of financial projections on pages 196-198 of the application, please answer the following:

    a. Why do the operating gains for NHSC decrease from $20 million in FY 2012 to $7.5 million in FY 2013 and drop to $2.5 million in 2016?

Healthcare reform coupled with significant state and federal budget issues will place unprecedented financial pressures on healthcare providers. While the impact of specific components of healthcare reform and federal budget problems are not yet fully known, it is clear that hospitals will experience reduced payments for the foreseeable future. The Hospital's without project deteriorating projected financials is an acknowledgement that it is not possible to bend the cost curve sufficiently to fully offset reduced payment rates without significant organizational changes. This CON application is recognition that care delivery model paradigm is rapidly changing and without fundamental organizational restructuring possible through affiliations, deteriorating financial positions can be expected. (Refer to Exhibit L for the American Hospital Association article: The Fundamental Transformation of the Hospital Field.)

    b. Why do the operating gains for WCHN decrease from $18.4 million in FY 2012 to $16 million in FY 2013 and decline further to just $5.3 million in 2016?

Operating gains for WCHN continue to decline from FY 2013 through FY 2016 as a result of continued pressure anticipated on utilization of services, lower reimbursement, inflationary increases in expenses, and increases in expenses such as depreciation and interest associated with the completion of the Tower project.

    c. How do the applicants plan to improve the operating margin of the new health system considering Gains from Operations decrease so dramatically over the next several years for each system and the total consolidated Gain from Operations for the consolidated system is less than the sum of the two systems in FY 2012?

It is true that the operating margin of the new consolidated health system is less than the sum of the individual system's performance from FY 2012. This is an acknowledgement of the challenges the healthcare sectors continues to struggle with regarding utilization trends as well as reimbursement constraints. It is also an indication that the Applicants are strong in their belief that the affiliation will serve the community healthcare needs in the most cost effective manner possible. To do so requires achieving a reasonable operating margin which can only be attained through fundamental restructuring possible through an affiliation. Integration of the two systems will produce expense savings, labor efficiencies through centralization and purchasing opportunities as a result of scale.

22. On page 202, the Applicants provided details of the expected cost savings broken into the categories Salaries/Benefits, Supplies/Drugs and Other Costs. Respond to the following:

    a. Specific details of how these cost savings will be realized for each of the items indicated; including an itemized list of the category entitled "Other Costs."

Below is a detailed breakdown of the "Other Costs" synergies from the affiliation. Specific line item detailed is not yet available as integration teams are still completing their work plans. The reduction outlined is based upon both industry experience and WCHN's experience with the NMH integration.

Salary/Benefits – is anticipated to be achieved through the centralization of staffing along with alignment of benefits to a single platform

Supplies savings of approximately 1% is related to anticipated improvement in contract negotiations due to scale and standardization of vendors and product

"Other Costs"	WCHN			NHSC		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
Education	(130)	(195)	(455)	(70)	(105)	(245)
Legal Cost	585	260	-	315	140	-
Consulting	715	390	-	385	210	-
Communications/Marketing	390	260	-	210	140	-
Severance	1,170	1,365	910	630	735	490
Misc Nonsalary	(1,330)	(2,891)	(4,126)	(730)	(1,550)	(2,175)
Total	1,400	(811)	(3,671)	740	(430)	(1,930)

*Misc Nonsalary would apply to software maintenance, maintenance contracts, purchase service contracts, audit fees etc. Details by category have not yet been established.

    b. Reconcile the two charts of estimated cost savings, as Other Costs in chart 2 does not equal the sum of legal, consulting and communications from chart 1 as indicated in the footnote.

The chart 2 on page 202 provided is a summary of the expenses as categories. The footnote should have read : Other Costs" include legal, consulting, communications as well as other non salary savings which were categorized in the Expense Synergy section in Question 22.a. above.

c. Are these the same cost savings mentioned in the response to question 5(g) of the application? If so please quantify each of the four cost savings noted in the response provided.

Yes, these are the same cost savings mentioned in response 5(g) of the CON application. However, the expense synergies estimated by our consultant were not identified by type of reduction but rather by the functional area as shown in Table A provided in the Completeness Question 17 response.

d. Will the proposed combined entity be able to use greater purchasing power as a cost savings mechanism? If so, please quantify and provide specific details, and reconcile or revise all Financial Attachment Is for all hospitals and both health systems.

Yes, we expected the combined entities scale to provide the ability to negotiate lower prices on goods and services. We have not yet identified specific line item savings as previously outlined, however we expect these savings of approximately 1% to be realized in areas such as Med/Surg Supplies, Food Services, Wage Management, and Maintenance contracts for example.

23. In regard to the financial attachments and related assumptions on pages 200 & 201, the Applicants indicate that FTEs will be reduced if the two health systems are combined. Provide the following:

a. Details of how the combined entities will reduce FTEs and which departments are expected to be affected.

As discussed in response to Completeness Question 17, expense synergies for FY 2014-2016 were projected by the Chartis Group and we cannot provide specific details as to FTE reduction at this time. However, centralization of administrative and management roles and functions in areas such as Billing, Finance, Compliance, Planning, Marketing, Quality Management, Human Resources, Information Technology, Medical Education Coordination, Clinical and Senior Leadership at the Hospital and Medical Group organizational levels are expected to result in opportunities to reduce overall FTE's.

b. An explanation of the phrase "based on history adjusted for volume & continued productivity improvements" in the assumptions for FTE amounts.

Baseline FTEs are projected to remain flat with minimum adjustments for volume changes. Emphasis is on continued focus to achieve productivity improvements and workflow efficiency. FTEs savings associated with the project are expected to be realized in consolidation of overhead departments such as IT, Finance, Marketing, Human Resources and Administration. Details by department are not available at this time as integration teams are working through the planning process. Projections were based in part upon experience WCHN realized with the integration of NMH.

24. If the consolidation of the two health systems was approved, please answer the following:

    a. Are there any areas where the hospitals will be able to achieve savings by the avoidance of a capital project? If so, please provide details of the projects(s) and the cost savings expected for each health system.

We are not projecting any savings as a result of capital project avoidance at this time. The proposed new WCHN would be consolidating the capital planning function into a centralized function. The purpose would be to align the network's capital plans, access to capital markets, capital prioritization, and approvals to ensure the most efficient and effective use of capital spending.

    b. Is WCHN committing any funding to Norwalk Hospital for any current or future projects or for any existing liabilities of the NHCS, such as pension funding or paying for NHCS's long term debt?

No, WCHN is not committing any funding to NH related to projects, liabilities, debt or pension funding.

25. On page 203 of the application there are details regarding the individual health systems current debt levels as of September 30, 2012. Please respond to the following:

    a. Provide an update through March 31, 2013, of the existing debt levels for each of the current health systems.

Existing debt levels for NHSC and WCHN as of March 31, 2013 are attached as Exhibit M.

    b. If the affiliation is approved, are there any plans to refinance any portion of the outstanding long term debt?

There are no plans to refinance debt at this time.

    c. If the new entity does plan to refinance the debt, provide specifics such as possible maturity dates and expected interest rates.

Not Applicable

    d. Was any of the $82 million of CHEFA bonds issued in December of 2012 used to extinguish some of the existing long term debt amounts? If not, what were the funds used for? Also, please describe the meaning of a "synthetic" rate in regards to the rate of the CHEFA bonds.

As part of the December 2012 financing, NH extinguished approximately $8.6 M of the remaining 1999 Series E bonds issued by CHEFA.

The series E bonds are private placement bonds issued through CHEFA that include a variable rate component with a swap. The swap results in NH ultimately paying a fixed rate.

26. Please provide evidence and elaborate on the benefits that WCHN and NHSC will receive and contribute in regards to capital infusion, pension obligations, capital avoidance, expense reduction and profitability with the proposed affiliation.

The proposed affiliation will offer expense reductions, productivity efficiencies and enhanced purchasing opportunities which contribute to a lower cost of healthcare offered. Enclosed in Exhibit N is an article from the American Hospital Association, "Hospitals: The Changing Landscape is Good for Patients & Healthcare", which summarizes attributes of the rapid changes in health care and potentially positive impact on financial performance and consumer benefits. This application does not involve any capital infusion or pension obligations.

27. On page 12 of the CON application, the Applicants state that some of the benefits identified by WCHN and NHSC that could be achieved by the affiliation are to integrate operations to achieve and create a unified operating model and improve access to and/or reduce cost of capital due to system scale and performance. Provide further details how the Applicants will achieve the above benefits and quantify the reduction in cost of capital (provide all assumptions and calculations).

The opportunities afforded by the integration of operations, creating a unified operating model, and improving access to care have been documented in responses to previous questions. The applicants also believe that improved access to capital markets is also a significant benefit of the affiliation. Access to capital in today's rapidly changing technological and care model paradigm environment is critical for any healthcare providers' long term success. Larger, multi-system health systems tend to have higher credit ratings, which reduces the cost and improves the access to capital. Larger systems have higher credit ratings because they are able to better manage their cost structures for all the reasons documented in this application. Better managed cost structures should result in higher profitability and improved cash position and therefore the organization being viewed as more creditworthy than stand- alone facilities.

As an illustration of the financial impact, historical interest rate spreads between A vs. BBB credit rated organizations is approximately 50 basis points. Assuming a 25 year $100M debt, the difference in interest payments is in excess of $6M.

An article from AHA, "Fundamental Transformation of the Hospital Field", (included as Exhibit N) emphasizes current market trends that are transforming the health care field driving capital investments and economies of scale. Without the ability to merge, many hospitals ability to provide the kinds of services and care their patients and communities depend on would be deeply impacted.

28. On page 20 of the CON application, the Applicants state that WCHN has a proven record of success in achieving significant cost savings and clinical integration through its integration between Danbury and New Milford hospitals. In FY 2012, $7.05 million

savings were realized through streamlined operational functions and implementation of processes supporting a single standard of care. Please address the following:

a) How were these annual savings quantified?

Annual savings were quantified by individual integration teams. Savings span both salary and non salary expense categories and were the direct results of collaboration between the entities involved. These efforts focused on expense reduction, and identification of best practice results while maintaining outstanding quality. The integration did not occur until the start of FY 2011. FY 2011 savings realized were offset by one-time expense increases associated with integration costs. FY 2012 represents savings achieved as a result of the integration.

Details of New Milford Integration Savings $7M
(In thousands)

		FY 2012		
		Salary/Ben	Nonsalary	Total
Supply Chain	Product conversions and contract pricing	-	820	820
Revenue Cycle	Staff consolidation into corporate function	97	-	97
Quality	Insurance and staffing consolidation	178	300	478
Operations	Consolidation; staffing, elimination lab outsourcing	564	525	1,089
Nursing	Staff consolidation, pharmacy product standardization	538	225	763
Marketing	Staff consolidation into corporate function	50	-	50
Info Systems	Software maintenance		130	130
Human Resources	Staffing, centralized benefits, recruitment, pay practices	1,900	-	1,900
Finance	Staff consolidation into corporate function	374	-	374
Facilities	Consolidation; staffing, electricity contract, supplies	407	247	654
Dev Fund	Staffing consolidation and integration of software	560	140	700
		4,668	2,387	7,055

b) File the following tables demonstrating actual cost savings (reductions in expenses) for Danbury and New Milford for FY 2010, FY 2011 and FY 2012 and projected cost savings (reductions in expenses) for Norwalk for FY 2013 - FY 2016. These categories are consistent with the current OHCA HRS Report 175.

See completed Table 1 regarding DH and NMH Cost Savings. FY 2011 incurred an increase in cost associated with one time expenses associated with affiliation costs related to legal, marketing, branding, and consulting expenses. These one time costs were primarily offset with savings from supply contract renegotiations.

Table1: Danbury Hospital and New Milford Hospital Cost Savings

Cost Savings	FY 2010	FY 2011	FY2012
Salaries & Wages	-	189	2,378
Fringe Benefits	-	49	2,290
Contractual Labor Fees	-	-	-
Medical Supplies & Pharmaceutical	-	950	1,045
Depreciation & Amortization	-	-	
Bad Debts	-	-	

Interest Expense	-	-	
Malpractice Expense	-	300	300
Utilities	-	-	220
Business Expenses & Other Operating Expenses	-	(1,270)	822
TOTAL	**0**	**218**	**7,055**

Table 2: Norwalk Hospital Projected Cost Savings

Projected Cost Savings	FY 2013	FY 2014	FY2015	FY 2016
Salaries & Wages		(666)	(1,418)	(2,246)
Fringe Benefits		(343)	(730)	(1,157)
Contractual Labor Fees				
Medical Supplies & Pharmaceutical		(228)	(528)	(821)
Depreciation & Amortization				
Bad Debts				
Interest Expense				
Malpractice Expense				
Utilities				
Business Expenses & Other Operating Expenses		819	(299)	(1,773)
TOTAL		**(418)**	**(2,974)**	**(5,997)**

29. New Milford Hospital ("NMH") reported operating expense reductions totaling $4,956,957 or 5% from FY 2011 to FY 2012. Please address the following:

    a) Estimate how much of the reduction in operating expenses between FY 2011 and FY 2012 for NMH can be attributable to its affiliation with Danbury Hospital?

The expense reductions realized by NMH from FY 2011 to FY 2012 were directly associated with the integration with DH as outlined below.

    b) How were these operating expense reductions achieved?

Operating expense reductions were achieved as follows: standardization of supplies, consolidation of FTEs, expense reduction realized by shifting to a centralized benefit platform, improved contract rates on services and supplies, consolidation of debt, and malpractice expense reductions by shifting to centralized captive program.

30. New Milford Hospital in FY 2011 and FY 2012 had loss from operations in the amount of $91,370 and $6,478,071, a 6990% change. Please address the following:

a) Provide an explanation for the FY 2012 loss from operations of $6,478,071.

NMH's loss from operations in FY 2012 is the result of a drop in revenue of approx $11M attributed to a significant drop in both inpatient and outpatient volume offset partially by a $5M drop in expenses.

b) Describe how the affiliation of New Milford Hospital and Danbury Hospital has financially benefitted New Milford Hospital; given that for the last two FYs New Milford has recorded losses from operations of approximately $6,569,441.

See response to Question 33 below. The reduction in expenses achieved through affiliation synergies was not sufficient to offset volume declines and the associated decreases in reimbursement.

31. New Milford Hospital reported a decrease of $9,352,034 in Total Net Patient Revenue and a decrease of $1,991,624 in Other Operating Revenue from FY 2011 to FY 2012. Please address the following:

    a) Provide an explanation for the decrease in total net patient revenue and other operating revenue.

The decrease of approximately $9M in Total Net Patient Revenue from FY 2011 to FY 2012 was the result of the following:

- *Inpatient Patient Days and Discharges deceased by 9% due to lower inpatient surgeries, decrease in Maternity and Newborn due to anticipated closure of the unit, and the transfer of the Hospitalist professional billing to WCMG*
- *Outpatient Surgery cases decreased by 8%*
- *Other Outpatient services volume also declined overall, for example, Sleep Clinic cases decreased by 16% as well as CT Scans decreased by 6%*

The reduction in other operating income of $1,991,624 from FY 2011 to FY 2012 was directly associated with centralization of employed physicians to the Western Connecticut Medical Group and the shift of income from the physicians practices historically structured in NMH.

32. In regards to the proposed affiliation, the Applicants indicate the multiple benefits associated with the proposal. Will Norwalk Hospital take any steps to prevent any loss from operations for the next three FYs due to the proposed affiliation? Additionally, provide any current and proposed initiatives and efficiencies.

There will be no loss from operations at NH caused by the proposed affiliation. Any additional loss from that projected will be the result of volume, revenue, and expense changes caused by market conditions or the regulatory environment offset by management actions to address that changing environment.

While each affiliate of the two applicants will strive to prevent any loss from operations, it should be noted that from a financial perspective, the overall system financial performance will be more important to financial rating agencies than the individual affiliate's financials.

33. The Applicants provide discussion in the CON application related to the affiliation of New Milford Hospital with Danbury Hospital and the positive financial results of that affiliation. However, according to the most recent financial filings for New Milford Hospital with OHCA in the HRS process, New Milford Hospital has shown a loss from operations from FY 2011 to FY 2012, has had a decrease in days cash on hand and an increase in the average payment period. New Milford's total net assets, equity financing ratio and long term debt to capitalization ratio was negative over the period of FY 2011 to FY 2012.

    Please provide a discussion which shows in greater detail how the positive aspects of the New Milford Hospital affiliation that occurred with Danbury Hospital has led to a more positive financial positioning for that hospital in light of the FY 2011 to FY 2012 results reported to OHCA.

The affiliation of New Milford Hospital and Danbury Hospital to establish WCHN has resulted in cost savings to the system of approximately $7.05 million in FY 2012. These savings are the result of improved operational efficiencies, elimination of duplication of services and staff consolidation and are detailed in the response to Question 28.a, above. Of the $7.05 million in cost savings, approximately $5 million was realized at New Milford Hospital.

New Milford Hospital's financial performance for the period mentioned above was primarily attributable to a significant reduction in volume for FY 2012 which resulted in a loss of approximately $9 million in total net patient revenue. (See response to Question 31 for more detail.) A loss in other operating revenue of almost $2 million was the result of the centralization of physicians employed by New Milford Hospital to the WCMG.

The Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for FY 2011 (OHCA, September 2012) reports that New Milford Hospital had a negative total margin for FY 2008, 2009 and 2011 and a 5 year average total margin of -1.15% for the period of FY 2007-FY 2011(pp. 5-6). New Milford Hospital also experienced a decrease in inpatient days and discharges during the period of FY 2008 – FY 2011 (pp. 76-78). The decline in volume and revenue experienced in FY 2012 is a continuation of this trend. As emphasized in Exhibit L, the effective delivery of high-quality care depends on the hospital's ability to succeed in an increasingly competitive environment. Had the affiliation not occurred, New Milford Hospital would have experienced a greater loss from operations and have a weaker financial position. The reductions in revenue due to declining utilization would not have been offset by the significant cost-avoidance opportunities. Additionally, investments to New Milford Hospital that are necessary to support the greater New Milford community such as a new Emergency Department, implementation of IT upgrades for the NMH campus, financial system investments and other infrastructure enhancements would not be possible without Network investment. Had New Milford Hospital not become an affiliate, financial difficulties there would have been exacerbated.

The importance of approval of this CON application cannot be overstated. The Applicants' ability to respond to rapidly changing market forces, reduction in reimbursements, including the recently approved State of Connecticut funding cuts for hospitals (an estimated $30 M for WCHN and $24 M for NHSC over a two year period) will require achievement of scale. Achievement of operational efficiencies and development of new delivery care models to enable each organization to continue to provide the right care in the right place at the right time for their respective communities.

Exhibit	Description
A	Affiliation Agreement By and Between Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
B	Norwalk Hospital Long Range Strategic Plan: Vision 2015
C	Chartis Report to Board of Directors of NHSC and WCHN
D	2012 Greater Norwalk Area Health Plan
E	2012 Community Report Card for Western Connecticut
F	Distribution of Physicians Affiliated with NHSC and WCHN
G	Economist 's Inc. Map of NHSC and WCHN Service Areas
H	Moody's Investor Service Articles
I	Integration Teams at NHSC and WCHN
J	"Managing Costs and Population Health Through an eACO Model" by Western Connecticut Health Network, Inc.
K	Stand-alone Norwalk Hospital, Danbury Hospital and New Milford Hospital Financial Attachment I
L	"Fundamental Transformation of the Hospital Field" by the American Hospital Association.
M	Debt Schedule for NHSC and WCHN
N	"Hospitals, The Changing Landscape is Good for Patients & Healthcare" by the American Hospital Association

EXHIBIT A

AFFILIATION AGREEMENT BY AND BETWEEN NORWALK HEALTH SERVICES CORPORATION AND WESTERN CONNECTICUT HEALTH NETWORK, INC.

This Affiliation Agreement (the "Agreement") is entered into as of this 22nd day of January, 2013 between Norwalk Health Services Corporation, a Connecticut nonprofit corporation ("NHSC") and Western Connecticut Health Network, Inc., a Connecticut nonprofit corporation ("WCHN"). Each of NHSC and WCHN 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 9.

WHEREAS, by entering into the proposed affiliation described in this Agreement (the "Affiliation"), the Parties intend to create an integrated health care delivery system (the "System") capable of bringing best practices in health care delivery to enhance the health and well-being of residents within the geographic areas served by the Parties;

WHEREAS, the Parties believe that the Affiliation will improve the health of the communities served by WCHN and NHSC by delivering coordinated, effective care;

WHEREAS, NHSC controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, The Norwalk Hospital Association ("NHA") and Norwalk Hospital Foundation, Inc. ("NHSCF") and other subsidiaries and affiliates listed on Schedule 1(a) (collectively, NHA, NHSCF and such other subsidiaries and affiliates of NHSC may be referred to herein as the "NHSC Affiliates" and the NHSC Affiliates, with NHSC, may be referred to herein as the "NHSC Entities");

WHEREAS, NHA owns and operates Norwalk Hospital;

WHEREAS, WCHN controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, The Danbury Hospital ("Danbury Hospital"), New Milford Hospital, Inc. ("New Milford Hospital"), Western Connecticut Home Care, Inc. and other subsidiaries and affiliates listed on Schedule 1(b) (collectively, Danbury Hospital, New Milford Hospital, Western Connecticut Home Care, Inc. and such other subsidiaries and affiliates of WCHN may be referred to herein as the "WCHN Affiliates" and the WCHN Affiliates, with WCHN, may be referred to herein as the "WCHN Entities" or the "WCHN System"); and

WHEREAS, on April 3, 2012, WCHN and NHSC executed a Letter of Intent for Corporate Affiliation (the "Letter of Intent") confirming their understanding with respect to a proposed affiliation and a Summary of Terms dated September 18, 2012 (the "Summary of Terms"), superseding the Letter of Intent in its entirety except with respect to Sections 5, 6 and 7 (the Letter of Intent and the Summary of Terms collectively referred to herein as the "Letter of Intent");

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.

(a) WCHN Actions. Prior to the execution of this Agreement, the board of directors of WCHN (the "WCHN Board") will have 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 4, an Amended and Restated Certificate of Incorporation of WCHN substantially in the form set forth in Exhibit A-1 and the Amended and Restated Bylaws of WCHN substantially in the form set forth in Exhibit B-1 (the "WCHN Restated Governing Documents"). At or prior to Closing, WCHN will cause Danbury Hospital and New Milford Hospital to amend and restate their governing documents to make them consistent with the terms of the Affiliation, in forms mutually agreeable to the Parties (such amended and restated governing documents may be referred to herein as the "Danbury and New Milford Restated Governing Documents").

(b) NHSC Actions. Prior to the execution of this Agreement, the board of trustees of NHSC (the "NHSC Board") will have 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 4, an Amended and Restated Certificate of Incorporation of NHSC substantially in the form set forth in Exhibit A-2 and Amended and Restated Bylaws of NHSC substantially in the form set forth in Exhibit B-2 (the "NHSC Restated Governing Documents"). At or prior to Closing, NHSC will cause all NHSC Affiliates to amend and restate their governing documents to make them consistent with the terms of the Affiliation, in forms mutually agreeable to the Parties (such amended and restated governing documents may be referred to herein as the "NHSC Affiliates Restated Governing Documents").

(c) NHA Actions. Prior to the execution of this Agreement, the board of trustees of NHA (the "NHA Board") and, to the extent required, the NHSC Board will have taken all necessary actions to approve and adopt, effective as of the Effective Date, an Amended and Restated Certificate of Incorporation of NHA substantially in the form set forth in Exhibit A-3 and Amended and Restated Bylaws of NHA substantially in the form set forth in Exhibit B-3 (the "NHA Restated Governing Documents").

(d) Organizational Charts. Attached as Exhibit C are schematics showing the relevant pre-Closing and post-Closing organizational structure of the Affiliation.

1.2 Closing Memorandum. Upon satisfaction or waiver of all of the conditions precedent set forth in Section 4 and unless this Agreement is earlier terminated pursuant to Section 5, the respective Presidents of WCHN and NHSC will execute a written memorandum (the "Closing Memorandum") which will 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, that the Closing will occur on such date ("Closing Date") and setting forth certain other matters as specified herein. The Closing will occur at Norwalk Hospital at 34 Maple Street Norwalk, Connecticut. 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").

2. **Initial Governance Structure**. Beginning at the Closing Date and ending upon the occurrence of one of the events set forth in Section 2.1(g) (the "Initial Period"), the governance structure of the Affiliation ("Initial Governance Structure") will be as follows, and as set forth in the WCHN Restated Governing Documents, NHSC Restated Governing Documents, NHA Restated Governing Documents, Danbury and New Milford Restated Governing Documents and the NHSC Affiliates Restated Governing Documents:

2.1 WCHN Board.

(a) WCHN Board Size. The WCHN Board will have eighteen (18) directors.

(b) WCHN Board Composition. At the Closing Date, the WCHN Board will include seven (7) voting members who were members of the NHSC Board immediately prior to the Closing Date (the "Initial NHSC Designees") and the remaining eleven (11) WCHN Board members will be individuals who served as members of the WCHN Board immediately prior to the Closing Date (the "Initial WCHN Designees"). Prior to the Closing Date, the Parties will mutually agree upon the individuals who will serve as the Initial NHSC Designees and Initial WCHN Designees (the "Initial WCHN Directors") and shall submit the names of such individuals to the members of WCHN for election of such slate of directors effective as of the Closing Date.

(i) The Initial WCHN Directors will serve for staggered terms as set forth in Section 3.3 of the Amended and Restated Bylaws of WCHN and as mutually agreed by the Parties prior to the Closing Date. The Initial WCHN Directors shall be subject to the term limits set forth in Section 3.4 of the Amended and Restated Bylaws of WCHN and as mutually agreed by the Parties prior to the Closing Date.

(ii) During the Initial Period, in the event of a vacancy among the Initial NHSC Designees or the Initial WCHN Designees, such vacancy will be filled by majority vote of the NHA Board (with respect to the Initial NHSC Designees) or the boards of directors of Danbury Hospital and New Milford Hospital (the "WCHN Hospital Boards") (with respect to the Initial WCHN Designees), subject in each case to approval by WCHN. In the event WCHN declines to elect any candidate, the NHA Board or WCHN Hospital Boards, as applicable, will designate one (1) or more new candidates until agreement is reached, provided, however, that if the Board declines to elect two (2) candidates proposed to fill the same vacancy, the Board may only decline to elect the third candidate proposed if the Board declines such candidate based on a Super-majority Vote (as defined below). The individuals serving as Initial WCHN Designees (together with such changes as may be made pursuant to this Section 2.1(b)(ii) with respect to vacancies) are referred to herein as the "WCHN Designees." The individuals serving as Initial NHSC Designees (together with such changes as may be made pursuant to this Section 2.1(b)(ii) with respect to vacancies) are referred to herein as the "NHSC Designees."

(iii) Two (2) years after the Closing Date, the Governance Committee of WCHN will review the governance structure of WCHN and its affiliates, including consideration of whether WCHN should remain a membership corporation, and make such recommendations as may be appropriate.

(c) WCHN Board Officers. Prior to the Closing Date, the Parties shall mutually agree on the officers of the WCHN Board to be effective as of the Closing Date. For the period beginning on the Closing Date and ending on the third annual meeting of the WCHN Board after the Closing Date (the "Third Annual Meeting"), the WCHN Board Chair will be an NHSC Designee elected by the WCHN Board and the WCHN Board Vice-Chair will be a WCHN Designee elected by the WCHN Board. For the following two-year term after the Third Annual Meeting date, the WCHN Board Chair will be a WCHN Designee elected by the WCHN Board and the WCHN Board Vice-Chair will be an NHSC Designee elected by the WCHN Board.

(d) Committees. During the Initial Period, any NHSC Board member serving on the NHSC Board immediately prior to the Closing Date who is not an Initial NHSC Designee to the WCHN Board will be provided an opportunity to serve on a WCHN Board committee or on the board of a WCHN Entity, and all such individuals will be eligible to become members of WCHN. To the extent permitted by applicable law, the same individuals will serve on board committees of WCHN, NHA, Danbury Hospital and New Milford Hospital; provided, however, that the medical staff, nominating and budget and finance committees will be maintained at the local level. The Parties agree to be equitable with respect to the distribution of committee membership and chairmanships. Committee assignments and chairmanships will be set forth on a schedule to the Closing Memorandum.

(e) Danbury Hospital and New Milford Hospital. At the Closing Date, the WCHN Hospital Boards will be comprised of those individuals serving as the Initial WCHN Designees. At any time prior to or after the Closing Date, Danbury Hospital and New Milford Hospital may merge and hold one hospital license.

(f) Major WCHN Board Actions. As sole corporate member of NHSC, WCHN will have certain powers as set forth in the NHSC Restated Governing Documents and as set forth in the NHA Restated Governing Documents. In addition, during the Initial Period, certain WCHN Board actions (whether an affirmative power of the WCHN Board or a "Reserved Power" with respect to NHSC, as defined in the WCHN Restated Governing Documents and NHSC Restated Governing Documents) will require a super-majority vote of the WCHN Board, defined for this purpose as the affirmative votes of two-thirds of all of the WCHN Board members then serving (a "Super-majority Vote"). Thus, assuming eighteen (18) directors are currently serving, the vote of at least twelve (12) of the eighteen (18) directors (which would include at least one of the NHSC Designees) shall be required to satisfy the requirement for a Super-majority Vote. In the event of any vacancy of the NHSC Designees during the Initial Period, a Super-majority Vote will be deemed to require the affirmative vote of at least one of the NHSC Designees.

(g) Conclusion of the Initial Period. The Initial Governance Structure will continue in effect unless and until changed following the occurrence of any one of the following events:

(i) at any time (whether occurring prior to or after the two-year Governance Committee review set forth in Section 2.1(b)(iii)), the WCHN Board approves a different governance structure by a Super-majority Vote;

(ii) if WCHN becomes the sole member, sole shareholder or acquires substantially all of the assets, of an additional acute care hospital, and the WCHN Board approves a different governance structure by a simple majority vote; provided however, that prior to the earlier of (x) the fourth anniversary of the Closing Date, or (y) action taken pursuant to clause (i) above, the WCHN Board must approve a different governance structure by a Super-majority Vote; or

(iii) at any time after the date that is five (5) years after the Closing Date, twenty percent (20%) or more of the WCHN Board is comprised of directors who are "Independent" and the WCHN Board approves a new governance structure by majority vote. For purposes of this Section, an "Independent" director means any individual other than the following: (x) any current or former employee of any of the WCHN Entities or NHSC Entities and any immediate family members of such an employee; (y) any individual who served on the board of directors of NHA, Danbury Hospital or New Milford Hospital prior to or after the Closing Date and any immediate family member of such individual; provided, however, a director who is first

elected after the Closing to the board of directors of NHA, Danbury Hospital or New Milford Hospital and to the WCHN Board shall be considered Independent; and (z) any individual who is a member of the medical staff of Danbury Hospital, New Milford Hospital or NHA and any immediate family member of such individuals; provided, however, a director who is a member of the medical staffs of both (A) NHA and (B) Danbury Hospital and/or New Milford Hospital shall be considered Independent.

(iv) NHSC Board. Except as expressly provided herein, the following provisions apply effective as of the Closing Date and shall continue through the Initial Period:

(h) WCHN as the Sole Member. Until modified in accordance with Section 6.7, WCHN will be the sole corporate member of NHSC and NHSC will continue as the sole corporate member of NHA.

(i) NHSC Board Composition. The NHSC Board will be initially comprised of the individuals serving in such capacity immediately prior to the Closing Date and shall include all of the NHSC Designees and thereafter will be comprised of individuals elected in accordance with the NHSC Restated Governing Documents. In addition, the WCHN President and Chief Executive Officer and at least one additional WCHN Designee will also become members of the NHSC Board commencing as of the Closing Date. The NHSC/NHA President and Chief Executive Officer and the NHSCF President and Chief Executive Officer will be *ex-officio* voting members of the NHSC Board. After the Closing, the NHSC Board will be elected by WCHN in accordance with the NHSC Restated Governing Documents.

(j) NHSC Board Powers. The NHSC Board, acting for NHSC as the sole corporate member of NHA, also shall have the powers set forth in the NHA Restated Governing Documents, subject to the Reserved Powers and compliance with WCHN System policies as set forth in Section 6.4(a). The NHSC Board will have all of the powers and authority granted to a board under the Act subject only to the Reserved Powers granted to its sole member, WCHN, pursuant to the NHSC Restated Governing Documents and WCHN System Policies as set forth in Section 6.4(a).

(k) Reserved Powers. Certain decisions, which will initially be made by the NHSC Board, shall be subject to approval by WCHN (the "Reserved Powers") as set forth in the NHSC Restated Governing Documents.

2.2 NHA Board. Except as expressly provided herein, the following provisions apply effective as of the Closing Date and shall continue through the Initial Period:

(a) NHSC as the Sole Member. Until modified in accordance with Section 6.7, NHSC will continue as the sole corporate member of NHA.

WCHN will exercise "reach through" rights, such that any NHA actions requiring member approval under the NHA Restated Governing Documents shall not be deemed approved until such time as NHA receives approval from both NHSC and WCHN, as the sole corporate member of NHSC.

(b) NHA Board Composition. The NHA Board will initially be comprised of the members of the NHSC Board in office immediately prior to the Closing Date. The NHSC/NHA President and Chief Executive Officer and the NHSCF President and Chief Executive Officer will be members of the NHA Board.

3. **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:

3.1 Commercially Reasonable, Good Faith Efforts. Each Party will 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 4 to be satisfied.

3.2 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 Material Transaction (without the approval of the other Party). Neither the WCHN Entities nor the NHSC Entities will amend or permit to be amended the certificates of incorporation or the bylaws of any of such entities, other than as described in Section 4.1.

3.3 Conduct of Business. Each Party will 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.

(a) Without limiting the generality of the foregoing, no NHSC Entity will take any of the following actions without the prior written consent of WCHN, which will 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. Without the prior approval of WCHN, the NHSC Entities will not transfer assets to any entity other than the NHSC Entities that is not in the usual, regular and ordinary course of business as set forth in the NHSC Entities' fiscal year 2013 capital and operating budgets and consistent with past practice.

(b) Without limiting the generality of the foregoing, no WCHN Entity will take any of the following actions without the prior written consent of NHSC, which will 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. Without the prior approval of NHSC, the WCHN Entities will not transfer assets to any entity other than the WCHN Entities that is not in the usual, regular and ordinary course of business as set forth in the WCHN Entities' fiscal year 2013 capital and operating budgets and consistent with past practice.

3.4 Public Statements. Except as may be required by applicable laws or as otherwise contemplated herein, none of the WCHN Entities or NHSC 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 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.

3.5 Communications with Government Officials. Unless the Parties otherwise agree in writing after the execution of this Agreement, the Parties will communicate jointly with government officials with respect to the Affiliation and will work together to develop a plan for coordinated communications by the Parties and by other WCHN Entities and other NHSC Entities. From the 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 WCHN Entities or the NHSC Entities will, 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, the WCHN Entities and the NHSC Entities will 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.

3.6 Additional Diligence Information. Pursuant to the Letter of Intent, WCHN and NHSC furnished each other with certain requested information in order to permit each of the Parties to perform a due diligence analysis of the Affiliation (the "Due Diligence Information"). From the date of this Agreement through the Effective Date, (i) each Party will disclose to the other Party any information known to the disclosing 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) NHSC will provide to WCHN, on a monthly basis, a financial information packet on the financial condition of the NHSC Entities in the same form provided to the NHSC Board and WCHN will provide to NHSC, on a monthly basis, a financial information packet on the financial condition of the WCHN Entities in the same form provided to the WCHN Board; (iii) NHSC will provide to WCHN a copy of each Medicare cost report filed by a NHSC Entity after the date hereof within five (5) days of such filing and WCHN will provide to NHSC a copy of each Medicare cost report filed by a WCHN Entity after

the date hereof within five (5) days of such filing; and (iv) NHSC will provide to WCHN and WCHN will provide to NHSC 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.

4. **Conditions Precedent**. The Affiliation will not occur until each of the following conditions is satisfied or waived by the Party it is intended to benefit:

4.1 Organizational Documents.

(a) WCHN. The WCHN Board (and if necessary, the members of WCHN) will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the WCHN Restated Governing Documents and caused Danbury Hospital and New Milford Hospital to approve and adopt the Danbury and New Milford Restated Governing Documents.

(b) NHSC. The NHSC Board will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the NHSC Restated Governing Documents and caused the NHSC Affiliates to approve and adopt the NHSC Affiliates Restated Governing Documents.

(c) NHA. The NHA Board (and, if necessary, NHSC) will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the NHA Restated Governing Documents.

4.2 Hart-Scott-Rodino. The applicable waiting period under the Hart-Scott-Rodino Act amendments to the Antitrust Improvement Act will 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 will have been resolved to the reasonable satisfaction of each of WCHN and NHSC.

4.3 Attorney General. The Attorney General of the State of Connecticut (the "Attorney General") will not have challenged the implementation of the Affiliation, or if the Attorney General initiates a challenge, the matter will have been resolved to the reasonable satisfaction of each of WCHN and NHSC.

4.4 Government Approvals and Filings. Each Party will have made the necessary filings with governmental or regulatory authorities and will have received the governmental permits, licenses, or other approvals in each case described on Schedule 4.4 (other than filings described on Schedule 4.4 as post-Closing filings), which will not be subject to any conditions, limitations or other terms not reasonably acceptable to the Parties.

4.5 Non-Governmental Consents. Each Party will have obtained and delivered to the other Party the consents from non-governmental third parties described on Schedule 4.5, which will not be subject to any conditions, limitations or other terms that would result or be reasonably likely to result in a NHSC Material Adverse Effect or WCHN Material Adverse Effect.

4.6 No Investigation or Enforcement Action. The implementation of the Affiliation will 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 will not be implemented without the agreement of each of WCHN and NHSC.

4.7 Compliance with Interim Covenants. Each Party will have determined in its sole discretion that the other Party has complied with the terms of Section 3.

4.8 No Material Adverse Effect. Unless waived by NHSC, between the date of this Agreement and the Closing Date, a WCHN Material Adverse Effect will not have occurred. Unless waived by WCHN, between the date of this Agreement and the Closing Date, an NHSC Material Adverse Effect will not have occurred.

4.9 Representations and Warranties. Unless waived by NHSC, all representations and warranties made by WCHN in Section 7 will be true, accurate, and complete in all material respects as of the Closing Date. Unless waived by WCHN, all representations and warranties made by NHSC in Section 7 will be true, accurate, and complete in all material respects as of the Closing Date.

4.10 Employment Agreement. The individual serving as the President and Chief Executive Officer of NHSC/NHA on the Closing Date shall have entered into an employment agreement with WCHN which satisfies the requirements of Section 6.2 hereof (the "Executive VP Employment Agreement").

4.11 WCHN Member Approval. The members of WCHN shall have approved the Initial NHSC Designees and Initial WCHN Designees.

4.12 Revisions to Restated Governing Documents. The Parties shall cause the WCHN Restated Governing Documents, the NHA Restated Governing Documents and the NHSC Restated Governing Documents to be revised substantially as described in Schedule 4.12 attached hereto and made a part hereof.

5. Termination Of Agreement.

5.1 Term. This Agreement will 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 September 30, 2013 absent mutual written consent by the Parties to extend the term. The term of the Agreement shall be perpetual unless terminated as provided herein.

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

5.3 Termination by Material Adverse Event. This Agreement shall terminate on ten (10) days' prior written notice from WCHN or NHSC respectively in the event that an NHSC Material Adverse Event occurs that is not waived by WCHN or a WCHN Material Adverse Event occurs that is not waived by NHSC.

5.4 Survival. In the event of termination pursuant to Section 5.1, Section 5.2 or Section 5.3, all rights and obligations under the Agreement will cease and the terms and provisions of the Agreement will have no further effect, except that Section 3.4 [Public Statements] and Section 8.4 [Confidentiality] will 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 2 [Initial Governance Structure], Section 6 [Post-Closing Covenants] and Section 8 [Miscellaneous] will survive beyond the Closing Date. Protections provided under the Mutual Confidentiality Agreement by and between NHSC and WCHN dated as of September 16, 2011 with respect to communications and all information exchanged during the term of such Mutual Confidentiality Agreement will survive the termination of this Agreement.

6. **Post-Closing Covenants**. From and after the Closing Date, the Parties will take the following actions and observe the following covenants:

6.1 Oversight of Business. Immediately following the Closing Date, WCHN and NHSC will each retain full power and authority to oversee such Party's business; provided, however, that the authority to oversee the business of the NHSC Entities will be subject to the Reserved Powers of WCHN and further provided that each Party shall have the obligations, duties and requirements applicable to such Party after the Closing Date as set forth in this Agreement.

6.2 Management. Immediately following the Closing Date, the individual serving as President and Chief Executive Officer of WCHN on the Closing Date will remain the President and Chief Executive Officer of WCHN. Immediately following the Closing, the individual serving as President and Chief Executive Officer of NHA/NHSC on the Closing Date will be employed by WCHN as the Executive Vice President of WCHN, will report to the President and Chief Executive Officer of WCHN, and will continue to serve as the President and Chief Executive Officer of NHSC and NHA. After the first anniversary of the Closing Date, the individual then serving as the Executive Vice President of WCHN and President and Chief Executive Officer of NHSC and NHA shall serve at the pleasure of the President and Chief Executive Officer of WCHN subject to the terms of the Executive VP Employment Agreement; provided, however, that the NHA Board shall have input into the selection of such individual, who shall be under the direction of the President and Chief Executive Officer of WCHN.

6.3 Executive Compensation. The WCHN Board Executive Compensation Committee, or such other committee as may be appointed by the WCHN Board, will review and establish executive compensation in accordance with applicable law.

6.4 Operation of NHSC Affiliates.

(a) Operation in Accordance with WCHN Policies. Subject to the provisions of this Agreement, the NHSC Restated Governing Documents, applicable law, and any terms and conditions of loan agreements, trust indentures, and any binding third party agreements existing prior to the Closing Date, the NHSC Entities will operate in accordance with the rights, obligations, duties, and requirements applicable to all WCHN Entities, as such rights, obligations, duties and requirements are from time to time established by WCHN, and applied from time to time to all WCHN Entities. Prior to the Closing Date, WCHN and NHSC shall agree on a schedule of policies, procedures and practices that will be binding on all parties ("System Policies") and other policies that may be maintained by any one or more of the Hospitals with such changes as may be adopted from time to time, and as are not inconsistent with the governance rights expressly set forth in the NHSC Restated Governing Documents and any new policies required by law or accrediting standards. It is understood that in the event any contract entered into by any of the WCHN Entities or the NHSC Entities after the Closing Date is in compliance with System Policies, but a subsequent change in System Policies is in conflict with such contract, the WCHN Entities or the NHSC Entities, as applicable, shall take commercially reasonable steps to unwind such non-compliant contract as soon as practicable. WCHN will have, in its sole discretion, the right to change or alter at any time the System Policies as applied to all WCHN Entities and NHSC Entities; provided that no System Policies adopted after the Closing Date that apply to any NHSC Entities shall be inconsistent with the governance rights expressly set forth in this Agreement and the NHSC Restated Governing Documents (unless required by law or accreditation standards).

(b) Medicare Form 855A. After the Closing Date, each NHSC Affiliate which is a participating provider in Medicare or Medicaid will submit a Form 855A change of information filing to its fiscal intermediary within the time frame required under applicable laws and regulations.

(c) NHSC Employees. To the extent permitted by any applicable collective bargaining agreement, each employee of an NHSC Entity or WCHN Entity as of the Closing Date who becomes an employee of WCHN or any WCHN affiliate, in the case of a NHSC employee, or NHSC or any NHSC Entity, in the case of a WCHN employee, after the Closing Date will receive full recognition and credit for pre-Closing length of employment with any NHSC Entity, in the case of a WCHN employee, or WCHN Entity, in the case of an NHSC employee, including for purposes of seniority recognition, benefits eligibility and vesting of benefits.

(d) Medical Staff. The Affiliation will not impact or change the medical staff appointment or clinical privileges of members of the medical staffs of Norwalk Hospital, Danbury Hospital or New Milford Hospital (each a "Hospital") as existing on the Closing Date. The Parties do not expect that execution of the Agreement will have any effect on the independent status of the medical staffs of any of the Hospitals. WCHN will work with the medical staffs of each Hospital 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.

6.5 Access to WCHN Insurance Programs. The NHSC Entities will have access to insurance programs offered by WCHN's insurance plans, subject to such entities' 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 such entities' eligibility for and acceptance by those programs.

6.6 Obligated Group. As early as practicable after the Closing Date, the Parties will form a single obligated group.

6.7 NHSC Entities. WCHN will establish a leadership committee comprised of representatives from WCHN and NHSC to create a process and work plan for the merger or reorganization of NHSC and the NHSC Entities. As soon as practicable but no later than one (1) year from the Closing Date, NHSC will either be merged into NHA or restructured to become a sister affiliate of NHA. Upon the merger of NHSC into NHA or the restructuring of NHSC so that NHA becomes a direct subsidiary of WCHN, the NHA Bylaws will be amended and restated. For the avoidance of doubt, the approximately $30 million of unrestricted net assets of NHSC, reflected on the balance sheet of NHSC as of the date of this Agreement, will be restricted to use for NHSC Entities purposes. The Parties anticipate that NHSCF will remain a separately organized entity under the control of NHSC or NHA; provided, however, that nothing in this Agreement shall prohibit the merger or reorganization of NHSCF into, with or under another WCHN Entity or NHSC Entity in the future. All assets of NHSCF shall always be applied consistent with donor restrictions.

7. Representations and Warranties.

7.1 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:

(a) Due Organization and Authority. The WCHN Entities and the NHSC Entities are corporations 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 each of the WCHN Entities and the NHSC Entities heretofore delivered to or made available for review by WCHN and NHSC are complete and correct, and no amendments thereto are pending or contemplated, other than as described in Section 1.1.

(b) 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 NHSC 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 A-3, Exhibit B-1, Exhibit B-2 and Exhibit B-3. No other corporate proceedings on the part of either WCHN or the NHSC 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 A-3, Exhibit B-1, Exhibit B-2 and Exhibit B-3. 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.

(c) Audited Financial Statements. WCHN has provided NHSC with the audited balance sheets and related statements of income and statements of cash flow of the WCHN Entities for the fiscal years ended September 30, 2009, 2010 and 2011, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of WCHN. NHSC has provided WCHN with the audited balance sheets and related statements of income and statements of cash flow of the NHSC Entities for the fiscal years ended September 30, 2009, 2010 and 2011, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of the NHSC 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 the WCHN Entities or the NHSC Entities, as the case may be, (ii) fairly present the financial condition and results of operations and cash flows for the WCHN Entities or the NHSC 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). None of the WCHN Entities nor any of the NHSC 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 the WCHN Entities or the NHSC 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.

(d) 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 any WCHN Entity or any NHSC Entity; (ii) result in acceleration in the time for performance of any obligation of any WCHN Entity or any NHSC Entity under any contractual obligation; (iii) result in the creation of any lien upon any asset of any WCHN Entity or any NHSC Entity; (iv) require any notice, consent, waiver or amendment to any contractual obligation; (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 WCHN Material Adverse Effect or a NHSC 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 4.4, 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 WCHN Material Adverse Effect or NHSC Material Adverse Effect, as the case may be, individually or in the aggregate, is required to be made or obtained by a WCHN Entity or a NHSC Entity, in connection with the execution, delivery or performance of this Agreement by a WCHN Entity or a NHSC Entity.

(e) Due Diligence. Each of the Parties has made due inquiry of all matters described in this Section 7 and has fully and completely disclosed to the other Party in Due Diligence Information all information relevant to such Party's representations in this Section 7.

7.2 Additional Representations and Warranties by WCHN. As a condition to NHSC's entry into this Agreement, WCHN as to itself and as to each of the WCHN Entities further

represents and warrants to NHSC that the statements set forth in this section are true and correct as of the date hereof:

(a) Legal Proceedings. Except as disclosed in Due Diligence Information:

(i) there is no potentially material incident report related to the operations or services of a WCHN 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 WCHN Entities, threatened against any WCHN Entity or against any WCHN Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such WCHN 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 WCHN Material Adverse Effect;

(ii) there is no litigation at law or in equity, or any proceeding before or, to the knowledge of a WCHN 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;

(iii) no WCHN 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 WCHN Material Adverse Effect, individually or in the aggregate;

(iv) 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 WCHN Entity; and

(v) the Due Diligence Information provided by WCHN 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 WCHN Entities, threatened against any WCHN Entity or against any WCHN Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such WCHN Entity.

(b) Compliance with Laws. Except as disclosed in Due Diligence Information,

(i) The business and operations of each WCHN 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 WCHN Material Adverse Effect, individually or in the aggregate.

(ii) 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 WCHN Entity is subject to any restriction of any kind or character, which may have a WCHN Material Adverse Effect on any WCHN Entity, individually or in the aggregate.

(iii) No WCHN 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 WCHN Material Adverse Effect.

(iv) The Due Diligence Information provided by WCHN contains complete and accurate information regarding (i) each WCHN 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 WCHN Entity or any of their respective properties.

(c) Insurance. Each WCHN 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 WCHN Entity as to amount and scope. No WCHN 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.

(d) Tax Exempt Status.

(i) Each WCHN Entity is an organization described in Section 501(c)(3) of 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.

(ii) Each WCHN 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 exist, to the extent necessary to support continued status as an organization described in Section 501(c)(3) of the Code.

(iii) No proceedings are pending with respect to which any WCHN 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.

(iv) No WCHN 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.

(v) The Due Diligence Information provided by WCHN 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 WCHN Entities.

(e) Titles, Leases, and Licenses. Except as disclosed in Due Diligence Information,

(i) Each WCHN 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 WCHN 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).

(ii) Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the WCHN Entities as now conducted. All such assets and properties, other than assets and properties in which the WCHN Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the WCHN Entities' Financial Statements or the footnotes thereto.

(iii) Each WCHN 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.

(iv) There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the WCHN Entities as now conducted that are licensed by the State of Connecticut Department of Public Health.

(f) Environmental Laws. Except as disclosed in Due Diligence Information,

(i) Each WCHN 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 WCHN Material Adverse Effect.

(ii) To the knowledge of the WCHN 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 WCHN Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs.

(iii) No WCHN 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, to the knowledge of the WCHN Entities, any investigation indicating that the WCHN 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.

(iv) No WCHN Entity has reason to believe that it will become subject to a matter identified in this Section 7.2(f); and no WCHN Entity has knowledge that any 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.

(v) No WCHN 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 WCHN Entity.

(g) Labor Unions and Collective Bargaining Agreements. Employees of WCHN Entities are currently represented only by the collective bargaining organizations listed on Schedule 7.2(g). Except in relation to the foregoing collective bargaining organizations, no WCHN 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 WCHN Entity, threatened with respect to any employees of any WCHN Entity.

(h) Employee Benefit Matters. Except as disclosed in Due Diligence Information,

(i) Multiemployer Plans. None of the WCHN Entities nor any other person that would be considered as a single employer with the WCHN 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.

(ii) Plan Qualification. Each employee benefit, welfare, pension or similar plans that any of the WCHN Entities sponsors or provides to its employees (each, a "WCHN Plan" and collectively, the "WCHN Plans") that is intended to be qualified under Section 401(a) of the Code is so qualified. Each WCHN 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 WCHN Plan that has subjected or reasonably could subject any of the WCHN Entities to any material penalty, excise tax or other material liability under ERISA or the Code.

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

(iv) Defined Benefit Pension Plans. In the case of each WCHN Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the WCHN 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 WCHN Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

(v) Claims. There is no pending or, to WCHN's knowledge, threatened action relating to a WCHN Plan, other than routine claims in the ordinary course of business for benefits provided for by the WCHN Plans. No WCHN 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.

(vi) Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no WCHN Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment (except for limited continued medical benefit coverage required to be provided under Section 4980B of the Code or as required by applicable state law).

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

(viii) Severance. The transactions contemplated by this Agreement will 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 WCHN Plan for the benefit of any current or former director, officer or employee of any of the WCHN Entities.

(ix) Diligence. Each of the WCHN Plans has been fully and completely described, with all applicable agreements and WCHN Plan documents, in the Due Diligence Information.

(i) Health Care Kickbacks. To the knowledge of WCHN after due inquiry, no WCHN 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.

(j) Prohibited Health Care Referrals. Except as disclosed in Due Diligence Information, to the knowledge of the WCHN Entities after due inquiry, no WCHN 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 who makes referrals to any WCHN Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. To the knowledge of the WCHN Entities after due inquiry, the Due Diligence Information provided by WCHN contains a complete and accurate list of all agreements between any of the WCHN Entities and referring physicians, physician organizations, other health care providers, and other referral sources. The Due Diligence Information provided by WCHN contains a full set of all such agreements between any of the WCHN Entities and referring physicians, physician organizations, other health care providers, and other referral sources which were requested by the NHSC Entities and their legal counsel. Except as disclosed in Due Diligence Information, to the knowledge of WCHN after due inquiry, none of the WCHN Entities has any arrangements with referring physicians, physician organizations, or other health care providers that are not memorialized in writing.

(k) Actions, Investigations, and Inquiries. Except as disclosed in Due Diligence Information,

(i) 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 WCHN 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 WCHN Material Adverse Effect or result in any material impairment to the right or ability of any WCHN Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs.

(ii) No WCHN 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.

(iii) The Due Diligence Information provided by WCHN 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 WCHN Entities, threatened, anticipated or contemplated against or affecting any WCHN 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).

(l) Permits.

(i) Each WCHN 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 WCHN Material Adverse Effect.

(ii) No WCHN Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of such Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of such Permits is pending or has been commenced or, to the knowledge of the WCHN Entities, threatened and no notification thereof has been received by any WCHN Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a WCHN Material Adverse Effect.

(iii) The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties will not limit, restrict, revoke, suspend or terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of such Permits.

(m) Medicare Cost Reports. The WCHN Entities have made available to NHSC true, correct and complete copies of their Medicare cost reports filed for the following years: 2009, 2010, and 2011. The status of all Medicare and

Medicaid cost reports of the WCHN Entities for the last two (2) cost-reporting years has been disclosed in the Due Diligence Information provided by WCHN, and there are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open such cost reports that would have a WCHN Material Adverse Effect.

7.3 Additional Representations and Warranties by NHSC. As a condition to WCHN's entry into this Agreement, NHSC as to itself and as to each of the NHSC Affiliates further represents and warrants to WCHN that the statements set forth in this section are true and correct as of the date hereof:

(a) Legal Proceedings. Except as disclosed in Due Diligence Information,

(i) There is no potentially material incident report related to the operations or services of a NHSC 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 NHSC Entities, threatened against any NHSC Entity or against any NHSC Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such NHSC 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 NHSC Material Adverse Effect.

(ii) There is no litigation at law or in equity, or any proceeding before or, to the knowledge of a NHSC 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.

(iii) No NHSC 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 NHSC Material Adverse Effect, individually or in the aggregate.

(iv) 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 NHSC Entity.

(v) The Due Diligence Information provided by NHSC 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 NHSC Entities, threatened against any NHSC Entity or against any NHSC Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such NHSC Entity.

(b) Compliance with Laws. Except as disclosed in Due Diligence Information,

(i) The business and operations of each NHSC 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 NHSC Material Adverse Effect, individually or in the aggregate.

(ii) 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 NHSC Entity is subject to any restriction of any kind or character, which may have a NHSC Material Adverse Effect on any NHSC Entity, individually or in the aggregate.

(iii) No NHSC 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 NHSC Material Adverse Effect.

(iv) The Due Diligence Information provided by NHSC contains complete and accurate information regarding (i) each NHSC 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 NHSC Entity or any of their respective properties.

(c) Insurance. Each NHSC 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 NHSC Entity as to amount and scope. No NHSC 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.

(d) Tax Exempt Status.

(i) Each NHSC 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.

(ii) Each NHSC 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 exist, to the extent necessary to support continued status as an organization described in Section 501(c)(3) of the Code.

(iii) No proceedings are pending with respect to which any NHSC 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.

(iv) No NHSC 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.

(v) The Due Diligence Information provided by NHSC 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 NHSC Entities.

(e) Titles, Leases, and Licenses. Except as disclosed in Due Diligence Information,

(i) Each NHSC 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 NHSC 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).

(ii) Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the NHSC Entities as now conducted. All such assets and properties, other than assets and properties in which the NHSC Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the NHSC Entities' Financial Statements or the footnotes thereto.

(iii) Each NHSC 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.

(iv) There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the NHSC Entities as now conducted that are licensed by the State of Connecticut Department of Public Health.

(f) Environmental Laws. Except as disclosed in Due Diligence Information,

(i) Each NHSC 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 NHSC Material Adverse Effect.

(ii) To the knowledge of the NHSC 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 NHSC Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs.

(iii) No NHSC 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, to the knowledge of the NHSC Entities, any investigation indicating that the NHSC 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.

(iv) No NHSC Entity has reason to believe that it will become subject to a matter identified in this Section 7.3(f); and no NHSC Entity has knowledge that any 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.

(v) No NHSC 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 NHSC Entity.

(g) Labor Unions and Collective Bargaining Agreements. Employees of NHSC Entities are currently represented only by the collective bargaining organizations listed on Schedule 7.3(g). Except in relation to the foregoing collective bargaining organizations, no NHSC 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. Except as set forth in Schedule 7.3(g), there is no strike or other work stoppage currently in effect or, to the knowledge of any NHSC Entity, threatened with respect to any employees of any NHSC Entity.

(h) Employee Benefit Matters. Except as disclosed in Due Diligence Information,

(i) Multiemployer Plans. None of the NHSC Entities nor any other person that would be considered as a single employer with the NHSC 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.

(ii) Plan Qualification. Each employee benefit, welfare, pension or similar plans that any of the NHSC Entities sponsors or provides to its employees (each, a "NHSC Plan" and collectively, the "NHSC Plans") that is intended to be qualified under Section 401(a) of the Code is so qualified. Each NHSC 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 NHSC Plan that has subjected or could subject any of the NHSC Entities to any material penalty, excise tax or other liability under ERISA or the Code.

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

(iv) Defined Benefit Pension Plans. In the case of each NHSC Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the NHSC 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 NHSC Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

(v) Claims. There is no pending or, to NHSC's knowledge, threatened action relating to a NHSC Plan, other than routine claims in the ordinary course of business for benefits provided for by the NHSC Plans. No NHSC 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.

(vi) Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no NHSC Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment (except for limited continued

medical benefit coverage required to be provided under Section 4980B of the Code or as required by applicable state law).

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

(viii) Severance. The transactions contemplated by this Agreement will 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 NHSC Plan for the benefit of any current or former director, officer or employee of any of the NHSC Entities.

(ix) Diligence. Each of the NHSC Plans has been fully and completely described, with all applicable agreements and NHSC Plan documents, in the Due Diligence Information.

(i) Health Care Kickbacks. To the knowledge of NHSC after due inquiry, no NHSC 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.

(j) Prohibited Health Care Referrals. Except as disclosed in Due Diligence Information, to the knowledge of the NHSC Entities after due inquiry, no NHSC 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 who makes referrals to any NHSC Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. To the knowledge of NHSC after due inquiry, the Due Diligence Information provided by NHSC contains a complete and accurate list of all agreements between any of the NHSC Entities and referring physicians, physician organizations, other health care providers, and other referral sources. The Due Diligence Information provided by NHSC contains a full set of all such agreements between any of the NHSC Entities and referring physicians, physician organizations, other health care providers, and other referral sources which were requested by the WCHN Entities and their legal counsel. Except as disclosed in Due Diligence Information, to the knowledge of NHSC after due inquiry none of the NHSC Entities has any arrangements with referring physicians, physician organizations, or other health care providers that are not memorialized in writing.

(k) Actions, Investigations, and Inquiries. Except as disclosed in Due Diligence Information,

(i) 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 NHSC 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 NHSC Material Adverse Effect or result in any material impairment to the right or ability of any NHSC Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs.

(ii) No NHSC 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.

(iii) The Due Diligence Information provided by NHSC 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 NHSC Entities, threatened, anticipated or contemplated against or affecting any NHSC 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).

(l) Permits.

(i) Each NHSC 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 NHSC Material Adverse Effect.

(ii) No NHSC Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of such Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of such Permits is pending or has been commenced or, to the knowledge of the NHSC Entities, threatened and no notification thereof has been received by any NHSC Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a NHSC Material Adverse Effect.

(iii) The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties will not limit, restrict, revoke, suspend or

terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of such Permits.

(m) Medicare Cost Reports. The NHSC Entities have made available to WCHN true, correct and complete copies of their Medicare cost reports filed for the following years: 2009, 2010, and 2011. There are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open Medicare and Medicaid cost reports of the NHSC Entities for the last two (2) cost-reporting years that would have a NHSC Material Adverse Effect.

8. **Miscellaneous**.

8.1 Governing Law. This Agreement will 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).

8.2 Successors; Assignment. This Agreement will inure to the benefit of, and will 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.

8.3 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 will 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 will be held to constitute a waiver of any other or subsequent breach.

8.4 Confidentiality.

(a) 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, trustees, 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, trustees, officers, employees, agents and advisors of the receiving Party or its affiliates with such a need to know. Each Party will require all members, directors, trustees, 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 will 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.

(b) 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.

(c) Excepted Information. The obligations of a Party as recipient of Confidential Information of the other Party under this Agreement will 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.

(d) Marking Confidential Information. Each disclosing Party will 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.

(e) Return and Destruction. Should this Agreement terminate prior to the Effective Date, each Party agrees (i) that it will promptly return to the disclosing Party or, with the permission of the disclosing Party, destroy all Confidential Information obtained from the disclosing 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 8.4(e), in no event will 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.

(f) Remedies. The Parties acknowledge and agree that any breach of the obligations under this Section 8.4 will result in irreparable injury to the Party whose Confidential Information is or is to be disclosed and that the Party so injured will have the right to specific enforcement of the restrictions of this Section 8.4 as well as all rights that it may have in accordance with the provisions of Section 8.9 hereof.

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

8.6 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" will be construed to have the same meaning and effect as the word "shall"; (vi) the word "any" will mean "any and all" unless otherwise indicated by context; (vii) the word "day" will mean calendar day, and days will 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 will 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.

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

8.8 Entire Agreement. This Agreement, together with the Exhibits and Schedules attached hereto, will 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 and that certain Mutual Confidentiality Agreement dated September 16, 2011.

8.9 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) except as

expressly set forth herein, and each of the Parties further agrees that each of the Parties will 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") will 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 will 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 will be entitled to recover its reasonable costs, expenses and attorneys' fees.

8.10 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 will 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.

8.11 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 will be deemed given when actually received.

If to NHSC:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Mr. Daniel J. DeBarba, Jr., President and Chief Executive Officer
Fax: (203) 852-1553

With a copy to:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Ms. Kristen Staikos, Chief Legal Officer
Fax: (203) 852-1553

If to WCHN:

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810
Attn: John M. Murphy, M.D. President and Chief Executive Officer
Fax: (203) 739-8751

With a copy to:

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810
Attn: Carolyn McKenna, General Counsel
Fax: (203) 739-8751

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

9. DEFINITIONS.

9.1 "Act" means the Connecticut Revised Non-Stock Corporation Act.

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

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

9.4 "Alleging Party" has the meaning set forth in Section 8.9.

9.5 "Attorney General" has the meaning set forth in Section 4.3.

9.6 "Closing" has the meaning set forth in Section 1.2.

9.7 "Closing Date" has the meaning set forth in Section 1.2.

9.8 "Closing Memorandum" has the meaning set forth in Section 1.2.

9.9 "Code" has the meaning set forth in Section 7.3(d).

9.10 "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.

9.11 "Defaulting Party" has the meaning set forth in Section 8.9.

9.12 "DOJ" has the meaning set forth in Section 4.2.

9.13 "Due Diligence Information" means the information disclosed by WCHN to NHSC and the information disclosed by NHSC to WCHN in writing as part of the due diligence process or in writing pursuant to Section 3.6.

9.14 "Effective Date" has the meaning set forth in Section 1.2.

9.15 "ERISA" means Title IV of the Employee Retirement Income Security Act of 1974, as amended.

9.16 "Financial Statement" has the meaning set forth in Section 7.1(c).

9.17 "FTC" has the meaning set forth in Section 4.2.

9.18 "Initial Governance Structure" has the meaning set forth in Section 2.

9.19 "Initial Period" has the meaning set forth in Section 2.

9.20 "Initial WCHN Directors" has the meaning set forth in Section 2.1(b).

9.21 "Interim Financial Statement" has the meaning set forth in Section 7.1(c).

9.22 "Letter of Intent" has the meaning set forth in the Preamble.

9.23 "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 (i) has a term of one (1) year or greater and that requires any Party or Affiliate to make annual payments greater than One Million Dollars ($1,000,000), excluding therefrom ordinary course renewals on substantially the same terms of such agreements in effect as of the date of this Agreement; (ii) will restrict the ability of the WCHN System or the NHSC Entities or any component thereof to compete in any manner in any geographic area; (iii) that requires any Party to make any payments or disposition of assets in any year of greater than Two Million Dollars ($2,000,000); (iv) that includes an exclusive dealing, requirements, or output arrangement; or (v) that involves a payment in cash or in kind to or from any member of the governing body of any NHSC Entity or any WCHN Entity, or any immediate family member of the foregoing.

9.24 "NHA" has the meaning set forth in the Preamble.

9.25 "NHA Board" has the meaning set forth in Section 1.1(c).

9.26 "NHSC" has the meaning set forth in the Preamble.

9.27 "NHSC Board" has the meaning set forth in Section 1.1(b).

9.28 "NHSC Designee" has the meaning set forth in Section 2.1(b).

9.29 "NHSC Entities" has the meaning set forth in the Preamble.

9.30 "NHSC Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a NHSC Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to NHSC, including suspension, surrender, revocation or restriction in any manner of a NHSC 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 NHSC Entities considered as a single enterprise; or (iii) any change which would impair the ability of NHSC or any of the NHSC Entities to perform its obligations hereunder.

9.31 "NHSC Plan" has the meaning set forth in Section 7.3(h).

9.32 "Party" has the meaning set forth in the Preamble.

9.33 "Permit" has the meaning set forth in Section 7.3(l).

9.34 "Stark Law" has the meaning set forth in Section 7.3(j).

9.35 "Super-majority Vote" has the meaning set forth in Section 2.1(f).

9.36 "System Policies" has the meaning set forth in Section 6.4(a).

9.37 "WCHN" has the meaning set forth in the Preamble.

9.38 "WCHN Board" has the meaning set forth in Section 1.1(a).

9.39 "WCHN Designee" has the meaning set forth in Section 2.1(b).

9.40 "WCHN Entities" has the meaning set forth in the Preamble.

9.41 "WCHN Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a WCHN Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to WCHN, including suspension, surrender, revocation or

restriction in any manner of a WCHN 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 WCHN 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 WCHN Entities considered as a single enterprise; or (iii) any change which would impair the ability of WCHN or any of the WCHN Entities to perform its obligations hereunder.

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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

[*Name*] Vicki Liss
[*Title*]

NORWALK HEALTH SERVICES CORPORATION

By: _____
Mr. Daniel J. DeBarba, Jr.
President and Chief Executive Officer

Witness

[*Name*]
[*Title*]

WESTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
John M. Murphy, M.D.
President and Chief Executive Officer

List of Exhibits and Schedules

EXHIBIT A-1
WCHN Amended and Restated Certificate of Incorporation

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

OF

WESTERN CONNECTICUT HEALTH NETWORK, INC.

The board of directors of Western Connecticut Health Network, Inc. hereby amends and restates its certificate of incorporation pursuant to the Connecticut Revised Nonstock Corporation Act (the "Act"). References included in this certificate to provisions of the "Internal Revenue Code" shall be deemed to refer to provisions of the Internal Revenue Code of 1986, as amended, or to any corresponding provision of future federal law.

1. **Name**. The name of the corporation is Western Connecticut Health Network, Inc. (the "Corporation").

2. **Nonprofit Corporation**. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions except as otherwise provided in this certificate of incorporation or the bylaws of the Corporation or by applicable statute.

3. **Membership**. The Corporation is a membership corporation. The following three classes of individuals serve together as the members of the Corporation (the "Members"):

(a) Life Members. All persons listed in the corporate records of The Danbury Hospital as Life Members as of the thirtieth day of March, 2001, shall be Members of the Corporation until their death or resignation.

(b) Elected Members. Elected 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 to, or who has volunteered a substantial portion of time to the Corporation, any subsidiary or division thereof, or The Danbury Hospital, the New Milford Hospital, Inc., or The Norwalk Hospital Association (collectively, the "Hospitals"), or who has shown a willingness to commit a substantial portion of his or her time to the Corporation, or any subsidiary or division thereof, or the Hospitals, is eligible to be an Elected Member; provided that current employees of the Corporation, any

subsidiary or division thereof, or of the Hospitals, are not eligible for election as Elected Members.

(c) 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 New Milford Hospital, Inc., the President of the New Milford Hospital's Medical Staff, the President of The Norwalk Hospital Association, the President of The Norwalk Hospital Association's Medical Staff, the Mayor of the City of Danbury, the Mayor of New Milford, 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 of the Corporation (the "Board") shall have the power to add from time to time additional Ex-Officio Members without, in each instance, amending this certificate of incorporation.

4. **Registered Agent**. The Corporation's registered agent is on file with the Secretary of the State and shall be R&C Service Company, with a business office located at 280 Trumbull Street, Hartford, Connecticut 06103-3597.

5. **Purposes**. Subject to the restrictions set forth in Article 9 below, 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, and shall include the following:

(A) To benefit, perform the functions of, carry out the purposes of, and uphold, promote and further the welfare, programs and activities of the Hospitals:

(i) By initiating, developing, recommending and carrying out the Hospitals' goals and priorities for new or expanded programs for the benefit of the Hospitals;

(ii) By continuously re-evaluating, maintaining and revising a master plan for the programs and facilities of the Hospitals;

(iii) By considering and recommending the acquisition of properties or the construction of facilities by or for the use of the Hospitals;

(iv) By planning for the acquisition and placement of new facilities and equipment by or for the use of the Hospitals; and

(v) By performing public relations work on behalf of the Hospitals, and soliciting and receiving subscriptions and gifts exclusively for the charitable purposes of the Hospitals.

(B) To initiate, develop, operate and maintain, for the Hospitals and for other hospitals and health care facilities, programs directed toward improving the efficiency or utilization of health care facilities and services in the State of Connecticut, and in the service areas of the Hospitals in particular, and reducing the cost of health care to the public while maintaining a high quality of such care.

(C) To initiate, develop, operate and maintain educational programs for health professionals and for the public, including programs of nursing education, continuing medical education, residency training and community health education.

(D) To initiate, develop, operate and maintain, in cooperation with the Hospitals and with other hospitals and health care facilities, programs for the delivery of health care services to persons other than hospital patients; and to further this objective, the Corporation may operate, directly or through one or more separate corporations, one or more neighborhood health centers, retirement centers, nursing homes, rehabilitation and mental health centers, industrial health facilities, health maintenance organizations, home care agencies, surgical centers and similar programs and facilities.

(E) To acquire, improve, hold and lease to the Hospitals and to other hospitals and health care facilities any real or personal property useful to the accomplishment of the purposes of the Corporation, the Hospitals or such other hospitals or health care facilities.

(F) To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of the Corporation; and generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein.

(G) To engage in any lawful act or activity for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act, including without

limitation, the making of grants to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, or any corresponding provision of future federal law to promote the purposes of the Corporation.

6. **Board of Directors**. The activities, business, property and affairs of the Corporation shall be managed by a board of not less than three directors elected by the Members, as may be further provided in the Corporation's bylaws.

7. **Rights of Members**. Members shall elect directors of the Corporation and Elected Members in accordance with the Corporation's bylaws. The Members shall have the right to vote on those amendments to this certificate of incorporation or the bylaws of the Corporation that limit, reduce, or eliminate their existing rights. Any such amendment of this certificate of incorporation shall require approval of two-thirds of the Members voting thereon, a quorum as defined in the bylaws of the Corporation being present. Any such amendment of the bylaws shall require approval of the Members in accordance with the bylaws. The Members shall also have the right to approve any dissolution, merger, or sale of assets other than in the normal course of business, of the Corporation by a vote of two-thirds of the Members voting thereon, a quorum as defined in the bylaws being present. The Members may vote on such other matters as may be presented to them from time to time by the board of directors of the Corporation, but the Members shall not have the right to vote on any matter except as specified above or as expressly specified under the Act.

8. **Limitation on Liability of Directors**. The personal liability of a director to the Corporation or its Members for monetary damages for breach of duty as a director shall be limited to the amount of compensation, if any, received by the director for serving the Corporation during the year of the violation, so long as the breach was not of a sort for which such limitation of liability is not permitted by Section 33-1026(b)(4) of the Act.

Nothing contained in this Article 8 shall be construed to deny a director of the Corporation the benefit of Section 52-557m of the General Statutes of Connecticut, or of any other limitation of liability available to such director under law. Any repeal or modification of

this Article 8 shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification.

9. **Limitations**. Notwithstanding any other provision of this certificate of incorporation:

(a) The Corporation shall at all times be organized and operated exclusively for religious, charitable, scientific, literary, educational or other purpose within the meaning of Section 501(c)(3) of the Internal Revenue Code;

(b) No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's directors, officers or other private persons, provided that the Corporation may pay reasonable compensation for services actually rendered, may reimburse reasonable expenses actually incurred by any such persons, and may make payments and distributions, to the extent reasonable and necessary, in furtherance of the purpose set forth in Article 5 above;

(c) No substantial part of the activities of the Corporation shall include carrying on propaganda or otherwise attempting to influence legislation, and the Corporation shall not participate or intervene (including by the publication or distribution of statements) in any political campaign on behalf of or in opposition to any candidate for public office; and

(d) The Corporation shall not conduct any activities, nor exercise any power, not permitted to be conducted by a corporation exempt from taxation under Section 501(a) of the Internal Revenue Code as an organization described under Section 501(c)(3) of the Internal Revenue Code, or by a corporation the contributions to which are deductible by a contributor under Section 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Internal Revenue Code.

10. **Indemnification**. The Corporation shall indemnify and advance expenses to its directors to the fullest extent permitted by law. Without limiting the foregoing, the Corporation shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Act. In addition, the Corporation may indemnify and advance expenses to officers, employees and agents of the Corporation who are not directors to the same

extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Corporation and permitted by law. The Corporation may also procure insurance providing greater indemnification as provided by law.

11. **Dissolution**. The existence of the Corporation shall be perpetual unless sooner dissolved. If the Corporation is dissolved, all of its assets remaining for distribution after payment of obligations or provision for the same shall be distributed (subject to any restrictions imposed by any applicable will, trust, deed, agreement or other document) to one or more organizations organized and operated for religious, charitable, scientific, literary, educational or other purpose set forth in Section 501(c)(3) of the Internal Revenue Code, in such proportions as the board of directors (or if the board of directors fails to act a court of competent jurisdiction) may determine.

EXHIBIT A-2
NHSC Amended and Restated Certificate of Incorporation

AMENDED AND RESTATED

CERTIFICATE OF INCORPORATION

NORWALK HEALTH SERVICES CORPORATION

The board of directors of Norwalk Health Services Corporation hereby amends and restates its certificate of incorporation pursuant to the Connecticut Revised Nonstock Corporation Act (the "Act"). References included in this certificate to provisions of the "Code" shall be deemed to refer to provisions of the Internal Revenue Code of 1986, as amended, or to any corresponding provision of future federal law.

1. The name of the Corporation is and remains NORWALK HEALTH SERVICES CORPORATION (the "Corporation").

2. 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 Code and shall include the following:

A. To benefit, perform the functions of, carry out the purposes of, and uphold, promote and further the welfare, programs and activities of The Norwalk Hospital Association (the "Hospital"), and the Corporation's other subsidiaries:

1. by initiating, developing, recommending and carrying out the goals and priorities for new or expanded programs for the benefit of the Hospital and the Corporation's other subsidiaries;

2. by continuously evaluating, reevaluating, maintaining and revising a master plan for the programs and facilities of the Hospital and the Corporation's other subsidiaries;

3. by considering and recommending the acquisition of properties or the construction of facilities by or for the use of the Hospital and the Corporation's other subsidiaries;

4. by planning for the acquisition and placement of new facilities and equipment by or for the use of the Hospital and the Corporation's other subsidiaries; and

5. by performing public relations work on behalf of the Hospital and the Corporation's other subsidiaries, and by soliciting and receiving subscriptions and gifts for the exclusively charitable purposes of the Hospital and the Corporation's other tax-exempt subsidiaries.

B. To initiate, develop, operate and maintain for the Hospital, the Corporation's other subsidiaries, and other hospitals and health care facilities, programs directed toward improving the efficiency of utilization of health care facilities and services in the State of Connecticut, and in the Southwestern Connecticut area in particular, and reducing the cost of health care to the public while maintaining a high quality of such care.

C. To initiate, develop, operate and maintain educational programs for health professionals and for the public, including programs of nursing education, continuing medical education, residency training and community health education.

D. To initiate, develop, operate and maintain, in cooperation with the Hospital, the Corporation's other subsidiaries, and other hospitals and health care facilities, programs for the delivery of health care services to persons other than hospital patients, and to further this object, to operate, directly or through one or more separate corporations, such health centers, retirement centers, nursing homes, rehabilitation centers, industrial health facilities, health maintenance organizations, surgicenters and similar programs and facilities as the Board of the Corporation shall determine.

E. To acquire, improve, hold and lease to the Hospital, the Corporation's other subsidiaries, and other hospitals and health care facilities any real or personal property useful to the accomplishment of the purposes of this Corporation, the Hospital, the Corporation's other subsidiaries, or such other hospitals or health care facilities.

F. To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of this Corporation and its subsidiaries, and generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein.

G. To engage in any lawful act or activity for which a corporation may be organized under the Act, including without limitation, the making of grants to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code, or any corresponding provision of future federal law to promote the purposes of the Corporation.

3. The Corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

4. The Corporation shall have but one member, Western Connecticut Health Network, Inc., a corporation organized under the Act (the "Member"). Subject to and in accordance with this certificate of incorporation and the bylaws of the Corporation, the Member shall have the exclusive right: (i) to amend the bylaws of the Corporation, (ii) to elect the Corporation's directors, and (iii) to appoint individuals to fill vacancies on the board of directors of the Corporation (the "Board").

5. The activities, business, property and affairs of the Corporation shall be managed by a board of not less than three directors elected by the Member, as may be further provided in the Corporation's bylaws.

6. The Corporation is organized for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under said section. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, any private individual, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services actually rendered, may reimburse reasonable expenses actually incurred by any such persons, and may make payments and distributions, to the extent reasonable and necessary, in furtherance of its purposes. No substantial part of the activities of the Corporation shall include carrying on propaganda or otherwise attempting to influence legislation, and the Corporation shall not participate or intervene (including by the publication or distribution of statements) in any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on by any organization exempt from federal income tax under Section 501(a) and described in

Section 501(c)(3) of the Code, contributions to which are deductible under Section 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Code.

7. The personal liability of a director to the Corporation, or its Member, for monetary damages for breach of duty as a director shall be limited to the amount of compensation, if any, received by the director for serving the Corporation during the year of the violation, so long as the breach was not of a sort for which such limitation of liability is not permitted by Section 33-1026(b)(4) of the Act. Nothing contained in this Article 7 shall be construed to deny a director of the Corporation the benefit of Section 52-557m of the General Statutes of Connecticut, or of any other limitation of liability available to such director under law. Any repeal or modification of this Article 7 shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification.

8. The Corporation shall indemnify and advance expenses to its directors to the fullest extent permitted by law. Without limiting the foregoing, the Corporation shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Act. In addition, the Corporation may indemnify and advance expenses to officers, employees and agents of the Corporation who are not directors to the same extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Corporation and permitted by law. The Corporation may also procure insurance providing greater indemnification as provided by law.

9. The existence of the Corporation shall be perpetual unless sooner dissolved. If the Corporation is dissolved, all of its assets remaining for distribution after payment of

obligations or provision for the same shall be distributed (subject to any restrictions imposed by any applicable will, trust, deed, agreement or other document) to the Hospital, provided that the Hospital is at that time an organization exempt from taxation as an organization described under Section 501(c)(3) of the Code, and elects to accept such assets. If the Hospital is not so exempt, if it is not in existence at that time, or if it is unable or unwilling to accept such assets, then all of the Corporation's remaining assets shall be distributed for use restricted to purposes substantially similar to those set forth in this certificate of incorporation to one or more organizations organized and operated for religious, charitable, scientific, literary, educational or other purpose set forth in Section 501(c)(3) of the Code, in such proportions as the Board (or if the Board fails to act a court of competent jurisdiction) may determine.

EXHIBIT A-3
NHA Amended and Restated Certificate of Incorporation

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE NORWALK HOSPITAL ASSOCIATION

The board of directors of The Norwalk Hospital Association hereby amends and restates its certificate of incorporation pursuant to the Connecticut Revised Nonstock Corporation Act (the "Act"). References included in this certificate to provisions of the "Code" shall be deemed to refer to provisions of the Internal Revenue Code of 1986, as amended, or to any corresponding provision of future federal law.

ARTICLE I

The name of this Corporation is and remains THE NORWALK HOSPITAL ASSOCIATION (the "Hospital").

ARTICLE II

The specific purposes of the Hospital shall be:

(a) to establish, support, manage and furnish facilities, personnel and services to provide diagnosis, medical surgical and hospital care, extended care, outpatient care, home care and other medically related services to sick, injured or disabled persons without regard to race, color, sex or national origin;

(b) to carry on such activities related to rendering care to the sick or injured or the promotion of health which, in the opinion of the board of directors (the "Board") may be justified by the facilities, personnel, funds or other requirements that are or can be made available; and

(c) to engage in any and all activities consistent with or in furtherance of the above purposes.

ARTICLE III

The Hospital is located in the City of Norwalk, County of Fairfield, and State of Connecticut.

ARTICLE IV

The Hospital shall have but one member, Norwalk Health Services Corporation, a corporation organized under the Act (the "Member"). The Member shall have the exclusive right in accordance with this certificate of incorporation and the bylaws of the Corporation: (i) to amend the bylaws of the Corporation, (ii) to elect the Corporation's directors, and (iii) to appoint individuals to fill vacancies on the board of directors of the Corporation (the "Board").

ARTICLE V

The Hospital shall not have or issue shares of stock or pay dividends. The existence of the Hospital shall be perpetual unless sooner dissolved. If the Hospital is dissolved, all of its assets remaining for distribution after payment of obligations or provision for the same shall be distributed (subject to any restrictions imposed by any applicable will, trust, deed, agreement or other document) to the Member, provided that the Member is at that time an organization exempt from taxation as an organization described under Section 501(c)(3) of the Code, and elects to accept such assets. If the Member is not so exempt, if it is not in existence at that time, or if it is unable or unwilling to accept such assets, then all of the Hospital's remaining assets shall be distributed for use restricted to purposes substantially similar to those set forth in this certificate of incorporation to one or more organizations organized and operated for religious, charitable, scientific, literary, educational or other purpose set forth in Section 501(c)(3) of the Code, in such proportions as the Board (or if the Board fails to act a court of competent jurisdiction) may determine.

ARTICLE VI

The activities, business, property and affairs of the Hospital shall be managed by a board of not less than three directors elected by the Member, as may be further provided in the Hospital's bylaws.

ARTICLE VII

The Hospital is organized for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under said section. No part of the net earnings of the Hospital shall inure to the benefit of, or be distributable to, any private individual, except that the Hospital shall be authorized and empowered to pay reasonable compensation for services actually rendered, may reimburse reasonable expenses actually incurred by any such persons, and may make payments and distributions, to the extent reasonable and necessary, in furtherance of its purposes.

No substantial part of the activities of the Hospital shall include carrying on propaganda or otherwise attempting to influence legislation, and the Hospital shall not participate or intervene (including by the publication or distribution of statements) in any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provisions of this certificate of incorporation, the Hospital shall not carry on any other activities not permitted to be carried on by any organization exempt from federal income tax under Section 501(a) and described in Section 501(c)(3) of the Code, contributions to which are deductible under Section 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Code.

ARTICLE VIII

The personal liability of a director to the Hospital, or its Member, for monetary damages for breach of duty as a director shall be limited to the amount of compensation, if any, received by the director for serving the Hospital during the year of the violation, so long as the breach was

not of a sort for which such limitation of liability is not permitted by Section 33-1026(b)(4) of the Act.

Nothing contained in this Article VIII shall be construed to deny a director of the Hospital the benefit of Section 52-557m of the General Statutes of Connecticut, or of any other limitation of liability available to such director under law. Any repeal or modification of this Article VIII shall not adversely affect any right or protection of a director of the Hospital existing at the time of such repeal or modification.

ARTICLE IX

The Hospital shall indemnify and advance expenses to its directors to the fullest extent permitted by law. Without limiting the foregoing, the Hospital shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Act. In addition, the Hospital may indemnify and advance expenses to officers, employees and agents of the Hospital who are not directors to the same extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Hospital and permitted by law. The Hospital may also procure insurance providing greater indemnification as provided by law.

EXHIBIT B-1
WCHN Amended and Restated Bylaws

AMENDED AND RESTATED

BYLAWS OF

WESTERN CONNECTICUT HEALTH NETWORK, INC.

TABLE OF CONTENTS

AMENDED AND RESTATED

BYLAWS

of

WESTERN CONNECTICUT HEALTH NETWORK, INC.

ARTICLE I. GENERAL

1.1. Purpose. These bylaws supplement certain provisions of the certificate of incorporation of Western Connecticut Health Network, Inc. (the "Corporation") and the Connecticut Revised Nonstock Corporation Act, as amended from time to time (the "Act").

1.2. Offices of Corporation. The Corporation's board of directors (the "Board") shall have the power to determine the location of the registered office, in accordance with applicable law, from time to time, and to designate the principal office of the Corporation and such additional offices as it shall determine in its discretion.

ARTICLE II. MEMBERSHIP

2.1. Membership. The Corporation is a membership corporation. The members of the Corporation (the "Members") shall have only such rights, privileges and obligations conferred upon them by the Corporation's certificate of incorporation, these bylaws and the Act. Members shall have no other rights.

2.2. Number and Manner of Appointment of Members. The Members may be elected, serve for life, or serve ex-officio, as specified in the certificate of incorporation of the Corporation. The Corporation shall at all times have not less than fifty (50) Members. The board of directors of The Norwalk Hospital Association (the "NHA Board") may recommend to the Governance Committee individuals to serve as Members. From the individuals

recommended by the NHA Board, the Governance Committee shall nominate and include on a slate for election by the Members, a number of individuals to serve as Members that is equal to the aggregate number of (a) individuals proposed for Membership who were not nominated by the NHA Board; (b) individuals serving as Life Members; and (c) individuals serving as Ex-Officio Members other than the President of The Norwalk Hospital Association and the President of The Norwalk Hospital Association Medical Staff, unless the NHA Board consents to including a lesser number of NHA Board recommended Members on the slate. At their annual meeting, or any special meeting, the Members shall approve or disapprove a slate of individuals to serve as elected Members as proposed by the Governance Committee (or such other committee of the Board as may then be charged with nominating individuals to serve as elected Members). The number of Members presented for election may vary from year to year. All elected Members so appointed shall serve for a term of one year or until the next annual meeting.

2.3. **Member Vacancies**. If at any time the Corporation shall have less than fifty (50) Members, the remaining Members shall elect individuals to serve as elected Members as proposed by the Governance Committee in a number sufficient to bring the total membership of the Corporation to fifty (50) or more. 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 not be filled.

2.4. **Meetings of Members**. The annual meeting of the Corporation's Members shall be held on such day and at such hour and place as shall be designated by the Board, and as shall be set forth in the notice of the meeting. Special meetings of the Members may be called by the Board, Chair, or President and CEO, and shall be called within fifteen (15) days after receipt of

the written request of at least 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.

At each annual meeting or any special meeting called for such purpose, the Members shall (i) elect directors and Members in accordance with these bylaws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) conduct any other business relating to the affairs of the Corporation consistent with the rights of the Members.

2.5. Notice of Member Meetings. Notice of each meeting of the Members shall be given to each Member not less than ten (10) days nor more than sixty (60) days before the date of the meeting.

2.6. Member Quorum and Voting. Fifteen (15) Members 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 Corporation's membership, unless the act of a greater number is required by law, the certificate of incorporation or these bylaws.

ARTICLE III. BOARD OF DIRECTORS

3.1. Authority. All corporate powers shall be exercised by or under the authority of, and the activities, property and affairs of the Corporation shall be managed by or under the direction of, the Board, subject to any limitations set forth in the certificate of incorporation.

3.2. Number and Composition. The Board shall consist of eighteen (18) directors. As of the Effective Date (as defined in Section 6.7 below), the Board shall be divided as follows: (i) eleven (11) directors will be individuals who were members of the Board immediately prior to the Effective Date (the "Initial DH/NMH Directors"); and (ii) seven (7) directors will be

individuals who were members of the board of directors of Norwalk Health Services Corporation ("NHSC") immediately prior to the Effective Date (the "Initial Norwalk Directors")(the Initial DH/NMH Directors and the Initial Norwalk Directors are referred to herein as the "Initial Directors"). Thereafter, the Board shall consist of (i) eleven (11) DH/NMH Directors (as defined in Section 3.3), and (ii) seven (7) Norwalk Directors (as defined in Section 3.3). The President and CEO of the Corporation shall serve as a DH/NMH Director, ex-officio, and shall be counted for purposes of quorum and shall have the right to vote. Until the date of the annual meeting of the Members held in January 2014 or, if none, the first such annual meeting held thereafter, four (4) of the DH/NMH Directors shall be members of the Community Board of New Milford Hospital, Inc. (the "Community Board Directors"). At all times the Board shall include two (2) individuals who also serve on each of the boards of directors of The Danbury Hospital and New Milford Hospital, Inc. (collectively, the "DH/NMH Boards") and the NHA Board.

3.3. **Nomination, Election and Terms of Office**. As of the Effective Date, the Initial DH/NMH Directors and the Initial Norwalk Directors shall be divided into three groups, so that an approximately equal number of directors have terms that expire during each year of the next three (3) years. At least annually thereafter, (i) the DH/NMH Boards collectively shall nominate individuals to succeed the eleven (11) Initial DH/NMH Directors and each of their successors (such Initial DH/NMH Directors and their successors being referred to herein collectively as "DH/NMH Directors" or individually as a "DH/NMH Director") whose terms are then expiring and (ii) the NHA Board shall nominate individuals to succeed the seven (7) Initial Norwalk Directors and each of their successors (such Initial Norwalk Directors and their successors being referred to herein collectively as "Norwalk Directors" or individually as a "Norwalk Director") whose terms are then expiring. The Board shall approve and submit to the Members, a slate of

candidates so nominated to succeed those directors whose terms are then expiring. In the event that the Board does not approve of an individual nominated to act as a DH/NMH Director or a Norwalk Director, the DH/NMH Boards or the NHA Board, as applicable, shall nominate another individual for the Board's approval until a candidate is approved: provided, however, if the Board declines to elect two (2) candidates proposed to fill the same directorship, the Board may only decline to elect the third candidate proposed if the Board declines such candidate based on a Super-majority Vote (as defined below). At their annual meeting, or any special meeting, the Members shall approve or disapprove such slate of candidates. Except for the Initial Directors, elected directors shall serve for a term of three (3) years and until their successors are elected and qualified.

3.4. **Term Limit**. As of the Effective Date, the Board shall set the year in which each of the Initial Directors' eligibility for reelection shall cease. Except for the Initial Directors and as provided in Section 5.1 of these bylaws, an elected director shall be eligible to serve three (3) consecutive terms on the Board and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed. A director elected to fill a vacancy in an unexpired term shall be deemed to have served one (1) three-year term for purposes of eligibility for reelection only if the director has served more than one (1) year of an unexpired term.

3.5. **Vacancies**. In the event of a vacancy among the DH/NMH Directors or the Norwalk Directors, such vacancy will be filled upon approval of, and election by, a majority vote of the Board with respect to a candidate nominated by the NHA Board (with respect to the Norwalk Directors) or the DH/NMH Boards (with respect to the DH/NMH Directors). In the event the Board declines to elect any candidate so proposed, the NHA Board or the DH/NMH Boards, as applicable, will designate one or more new candidates until agreement is reached,

provided, however, that if the Board declines to elect two (2) candidates proposed to fill the same vacancy, the Board may only decline to elect the third candidate proposed if the Board declines such candidate by a Super-majority Vote (as defined below).

3.6. **Meetings and Notices**. An annual meeting of the Board 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 shall elect or appoint, as appropriate, officers of the Corporation, and shall transact such other business relating to the affairs of the Corporation as may come before the meeting.

Regular meetings of the Board shall be held at such times as the Board shall from time to time determine. Special meetings of the Board may be called at any time by the Chair or the President and CEO, and shall be called by either of them within seven (7) days, and held within ten (10) days thereafter, after receipt of a written request of any three (3) directors. Meetings of the Board may be held within or without the State of Connecticut. No notice of regular meetings shall be required unless specifically directed by the President and CEO or the Chair. Except as otherwise provided in these bylaws, at least two (2) days' notice shall be given to each director of each special meeting of the Board, and such notice shall contain the date, time and place of such special meeting.

3.7. **Quorum and Action**. A majority of the directors then serving shall constitute a quorum for the transaction of business, and the act of a numerical majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the presence of or act of a greater number is specifically required by these bylaws, the Corporation's certificate of incorporation, or the Act. If a quorum shall not be present at any meeting of

directors, a majority of the directors present at such meeting may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.8. **Super-Majority Voting**. Certain actions undertaken by the Board shall be subject to additional voting requirements, as set forth below.

(a) The actions listed below require approval by a Super-majority Vote (as defined below), and may require approval of the Members as set forth in the Corporation's certificate of incorporation. A Super-majority Vote is defined for this purpose as the affirmative vote of two-thirds of the members of the Board then serving, provided that, in the event of any vacancy of the Norwalk Directors, the affirmative vote of at least one of the Norwalk Directors shall be required (a "Super-majority Vote"):

(i) approval of the Corporation's strategic plan;

(ii) subject to the rights of the Members as set forth in the certificate of incorporation of the Corporation, amendment of these bylaws or the Corporation's certificate of incorporation;

(iii) approval of the capital budget for the Corporation and for any affiliated entity controlled directly or indirectly by the Corporation (each an "Affiliate");

(iv) subject to the terms of any employment agreement with the Corporation, hiring or firing of the NHA/NHSC President and Chief Executive Officer; provided, however, that after the first anniversary of the Effective Date, the President/Chief Executive Officer of the Corporation shall have the unilateral authority to hire and fire the

NHA/NHSC President and Chief Executive Officer after obtaining input from the NHA Board;

(v) amendment of the bylaws of NHSC or removal of a member of the board of directors of NHSC;

(vi) amendment of the bylaws of The Danbury Hospital or the New Milford Hospital, Inc.

(b) The actions listed below (which must also be approved by the board of directors of NHSC (the "NHSC Board")) taken with respect to NHSC or by NHSC acting as a member or shareholder of any subsidiary of NHSC, including without limitation NHA (a "NHSC Subsidiary"), require a Super-majority Vote:

(i) the removal of a director of a NHSC Subsidiary;

(ii) the closure of Norwalk Hospital or the closure or material diminution of a material program at Norwalk Hospital;

(c) The actions listed below, if taken by the Corporation as the sole member or sole shareholder of any Affiliate (which must also be approved by the board of directors of the applicable Affiliate(s)) taken with respect to any Affiliate or a subsidiary for which the Affiliate acts as member or shareholder (an "Affiliate Subsidiary"), require a Super-majority Vote:

(i) Approval of all capital and operating budgets of Affiliates and Affiliate Subsidiaries;

(ii) Approval of any amendment or restatement of the (a) certificate of incorporation of Affiliates and any Affiliate Subsidiaries, and (b) bylaws

of Affiliates (other than The Danbury Hospital, New Milford Hospital, Inc. or NHSC) or of any Affiliate Subsidiary;

(iii) the sale, lease, exchange or other disposition of all or substantially all of the property or assets of the Affiliate or any Affiliate Subsidiary;

(iv) approval of the creation of any corporation of which the Affiliate or an Affiliate Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of the Affiliate or any Affiliate Subsidiary with another corporation; and the reorganization, liquidation or dissolution of the Affiliate or any Affiliate Subsidiary;

(v) approval of loans by the Affiliate or any Affiliate Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds two million dollars ($2.0 million) or which has a term longer than one year;

(vi) approval of policies relating to the control and supervision of the investment of the Affiliate's and any Affiliate Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of the Affiliate or the Affiliate Subsidiary;

(vii) approval of unbudgeted expenditures by the Affiliate or any Affiliate Subsidiary in excess of two million dollars ($2.0 million) or any increase in any previously approved annual operating or capital budget;

(viii) approval of any agreement or transaction of the Affiliate or any Affiliate Subsidiary involving an amount greater than two million dollars ($2.0 million) with another individual or entity;

(ix) approval of the affiliation of the Affiliate or any Affiliate Subsidiary with any other entities for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said organization or entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

(x) creation of any committee which shall have the authority to act on behalf of the Affiliate or on behalf of any Affiliate Subsidiary;

(xi) approval of any conveyance of, or the granting of mortgages, trusts, or on any real property assets of the Affiliate or of any Affiliate Subsidiary;

(xii) approval of any change to any employee pension or other employee benefit plans for or on behalf of the Affiliate or any Affiliate Subsidiary;

(xiii) approval of the adoption of or amendment to the policies and procedures governing indemnification of directors and officers of the Affiliate or any Affiliate Subsidiary; conflicts or dualities of interest; accounting and investment standards and practices; and such other policies as the Corporation may from time to time determine;

(xiv) approval of the strategic plan of the Affiliate and of any Affiliate Subsidiary;

(xv) approval of the engagement in managed care and other third party payor contracting on behalf of the Affiliate or any Affiliate Subsidiary;

(xvi) approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by the Affiliate or any Affiliate Subsidiary and approval of the filing of any application for a certificate of need by the Affiliate or any Affiliate Subsidiary;

(xvii) approval of system-wide quality, performance and credentialing standards and procedures to which the Affiliate or any Affiliate Subsidiary is expected to adhere; and

(xviii) approval of regulatory compliance and methodology for physician compensation arrangements.

3.9. **Action Without a Meeting**. Any action which may be taken at a meeting of the Board or of a committee of the Board may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors or all of the committee members entitled to vote with respect to the subject matter of such meeting. Such consent shall be filed with the minutes of the directors' or committee's meetings.

3.10. **Meeting by Conference Telephone**. A director or a member of a committee of the Board may participate in a meeting of the Board or of such committee by means of conference telephone or similar communications equipment enabling all directors or all

committee members participating in the meeting to hear one another, and participation in such a meeting shall constitute presence in person at such meeting.

3.11. Resignations. The resignation of any director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified, or at such later time as the resigning director may specify and the Corporation shall accept. Failure of a director to attend three (3) consecutive Board meetings without proper excuse may in the Chair's discretion be deemed a resignation.

3.12. Compensation. No director shall receive compensation for services rendered to the Corporation in such capacity, but directors shall be entitled to reimbursement for reasonable and necessary expenses actually incurred in connection with the performance of their duties in the manner and to the extent that the Board shall determine, and may receive reasonable compensation for services performed in other capacities for or on behalf of the Corporation.

ARTICLE IV. COMMITTEES OF THE BOARD

4.1. General. At least annually the Board, by the affirmative vote of a majority of all directors then serving shall appoint the members of a Governance Committee, an Executive Compensation Committee, an Audit Committee, a Finance Committee, a Planning Committee, and a Quality Committee, in accordance with these bylaws. Except as specifically authorized by a majority of all the directors then serving, all committees except the Executive Compensation Committee and the Audit Committee shall be advisory in nature and shall not have authority to act on behalf of the Corporation.

The Board may create such other committees as the Board from time to time may consider necessary or advisable. The Governance Committee shall recommend for approval by the Board a director to act as the chair of each committee. The membership, duties and authority

of each committee shall be recommended by the Governance Committee for approval by the Board. Any committee may invite such other persons to attend and present at its meetings as is necessary to complete its responsibilities. Non-board members may be appointed to any committee that does not have authority to act on behalf of the Corporation. All committee members shall be appointed for a term of one (1) year and until the next meeting at which the Board appoints committee members.

Notwithstanding authorization to act on behalf of the Board, no committee may: (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 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 of the Corporation; (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 the Corporation. Each committee shall meet with sufficient frequency to accomplish its assigned functions, reasonable notice thereof having been provided. Each committee shall report its actions, if any, to the Board at each Board meeting.

To the extent practicable and not inconsistent with law, accreditation requirements, or the bylaws of any Affiliate or Affiliate Subsidiary, all committees of the Corporation shall serve as so-called "matrix committees" and will serve to advise such Affiliates and Affiliate Subsidiaries regarding each committee's area of expertise.

4.2. **Quorum and Action**. At all committee meetings, a quorum for the transaction of business shall consist of a majority of members of the committee, and except to the extent

specifically set forth in these bylaws, the vote of a majority of those members present when a quorum is present shall constitute the act of the committee.

4.3. **Governance Committee**. The Governance Committee shall consist of the Chair, Vice Chair, and four other directors. The Governance Committee members shall include at least one (1) director who is a Norwalk Director. The Governance Committee shall report any actions and recommendations to the Board at each Board meeting.

The Governance Committee sets the agenda for meetings of the Board and coordinates board development and education. The Governance Committee's responsibilities include: (i) subject to the provision of Section 3.2 hereof, reviewing, developing and submitting recommendations, for approval by the Board and the Members, of individuals nominated by the NHA Board and the DH/NMH Board to serve on the Board; (ii) reviewing, developing and submitting to the Board nominations for all committee members and officers of the Corporation, (iii) reviewing, developing and submitting to the Board, for approval by the Board and the Members, a slate of individuals to serve as Members in accordance with Section 2.2 hereof; (iv) periodically reviewing the certificate of incorporation, these bylaws, and policies of the Corporation, and recommending amendments thereto to the Board, as appropriate, from time to time; (v) periodically reviewing the certificate of incorporation, bylaws and policies of the Affiliates and Affiliate Subsidiaries, and recommending amendments thereto to the Board, as appropriate, from time to time; and (vi) reviewing nominations for directors of the DH/NMH Boards and the NHA Board and recommending nominations to the Board for approval; provided, however, that any candidate proposed for consideration by the Governance Committee shall be forwarded to the Board for consideration unless such nomination is opposed by the majority of the members of the Governance Committee, including at least one (1) Norwalk Director.

4.4. **Executive Compensation Committee**. The Executive Compensation Committee shall consist of the Chair, the Vice Chair, and three (3) other directors. The Executive Compensation Committee shall advise the Board on compensation strategies and policies for the Corporation and its Affiliates and Affiliate Subsidiaries. The Executive Compensation Committee shall have authority to act for the Board with respect to (i) the approval of regulatory compliance and the methodology for physician compensation arrangements of the Corporation or of the Affiliates and Affiliate Subsidiaries and (ii) the evaluation and determination of compensation of the President and CEO and other officers of the Corporation as may be determined by the Board. In all other matters, the Executive Compensation Committee's role shall be advisory.

4.5. **Audit Committee**. The Audit Committee shall consist of no less than three (3) directors, each of whom shall be considered to be independent of the management of the Corporation. At least one (1) member of the Audit Committee shall have accounting and financial management expertise. The Audit Committee may investigate and advise the Board with respect to any matter reasonably related to the Corporation's annual financial statements. The Audit Committee may retain legal or other independent advice in completing its duties. The Audit Committee shall recommend annually the appointment of independent auditors to the Board and, when circumstances warrant, the discharge of such auditors. The Audit Committee shall oversee and recommend changes to the internal audit function of the Corporation, including the supervision of third party external auditors and management's response to audit findings. The Audit Committee shall assure the Board that financial statements and tax returns are fairly presented and, to the best of the committee members' knowledge, accurately reflect the Corporation's financial condition. In addition, the Audit Committee shall oversee the

compliance function of the Corporation and management of conflicts of interest.

4.6. **Finance Committee**. The Finance Committee shall consist of no less than three (3) directors. The Finance Committee shall advise the Board regarding its responsibilities on matters relating to finance and investments. The Finance Committee shall (i) review and recommend changes to accounting, banking and investment policies and practices; (ii) review and recommend adoption of operating and capital budgets; (iii) monitor return on investment of significant capital expenditures; (iv) review changes in the application of generally accepted accounting principles; (v) monitor compliance with bond covenants and reporting requirements in relation thereto; (vi) review pension and actuarial reports and recommend action by the Board as necessary, and (vii) monitor and recommend approval of equity transfers among the Corporation and its Affiliates.

4.7. **Planning Committee**. The Planning Committee shall consist of no less than two (2) directors. The Planning Committee shall advise the Board on matters relating to the Corporation's mission, strategic plan, community relations, technology strategy and technology infrastructure expenditures, organizational strategies, and community benefit strategies and status.

4.8. **Quality Committee**. The Quality Committee shall consist of no less than three (3) directors. The Quality Committee shall advise the Board on matters relating to the Corporation's medical and professional policies and quality of care issues. The Quality Committee shall: (i) review the policies and programs of the patient care centers at each Affiliate; (ii) assess and recommend changes to the reporting mechanisms of the medical staff committees of each Affiliate; (iii) review and recommend appointments and credentialing of medical staff; (iv) mediate and recommend action relating to any conflict regarding the medical

staff of each Affiliate; (v) assess compliance with clinical regulatory organizations and agencies and recommend changes as necessary; (vi) review and evaluate malpractice insurance coverage of each Affiliate and recommend changes as necessary; (vii) review and evaluate graduate medical education programs at each Affiliate and recommend changes as necessary; (viii) review and evaluate medical research programs at each Affiliate and recommend changes as necessary; and (ix) review and evaluate the functions and activities of the medical ethics committees at each Affiliate and recommend changes as necessary.

ARTICLE V. OFFICERS

5.1. **Officers, Appointment, Term and Vacancies**. The officers of the Corporation shall consist of a Chair, a Vice Chair, a Secretary and a Treasurer, each of whom shall be directors. There shall also be a President and CEO who, in accordance with these bylaws, shall serve as a director, ex-officio with vote. Except as provided in this Section 5.1, the directors shall elect each of the foregoing and may elect other officers, such as an Assistant Secretary or Assistant Treasurer, who need not be members of the Board. Any person may simultaneously hold multiple offices.

For the period beginning on the Effective Date and ending on the third annual meeting of the Board after the Effective Date (the "Third Annual Meeting"), the Chair shall be a Norwalk Director and the Vice-Chair will be a DH/NMH Director. For the following two-year term after the Third Annual Meeting date, the Chair will be a DH/NMH Director and the Vice-Chair will be a Norwalk Director.

Officers shall be elected at the annual meeting of the Board for a term extending until the next succeeding annual meeting of the Board and until his or her successor has been elected and qualified or his or her earlier death, resignation or removal, except that the Chair and the Vice

Chair shall each be elected to a term of two (2) years and until a successor is elected. Notwithstanding the provisions of Section 3.4 of these bylaws, a director whose term as Chair or Vice Chair will exceed that director's third full term as a director shall continue to serve as a director until expiration of his or her two-year term as Chair or Vice Chair, as applicable, and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed. Any vacancy or vacancies occurring in any office of the Corporation may be filled until the next annual meeting at which officers are elected by the affirmative vote of the remaining directors in office at any meeting of the Board, though such remaining directors are fewer than a quorum.

5.2. **Chair**. The Chair shall lead the Board in setting the mission and strategic direction of the Corporation, and overseeing the effective implementation thereof by management. The Chair shall work to ensure that the Board functions properly, meets its obligations and responsibilities, and fulfills its purpose and mission as set forth in the certificate of incorporation and these bylaws, and as otherwise determined from time to time by the Board. The Chair shall work to maintain an effective relationship between the Board and management and, in so doing, will be the liaison between the Board and management. The Chair shall, if present, preside over all meetings of the Board. The Chair shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board. The Chair shall also perform such other duties as may be assigned to him or her by the Board.

5.3. **Vice Chair**. The Vice Chair shall have such duties and responsibilities as the Chair or the Board of Directors shall from time to time determine. The Vice Chair shall assume the duties of the Chair in the absence or disability of the Chair.

5.4. **President and CEO**. The President and CEO shall be the chief executive officer of the Corporation, subject to the control and direction of the Board. The President and CEO

shall submit regular reports to the Chair and to the Board on the operations of the Corporation. The compensation and terms of employment of the President and CEO shall be reviewed and determined at least annually by the Governance Committee. The President and CEO shall perform such other duties as may be assigned to him or her by the Board.

5.5. **Secretary**. The Secretary shall issue or cause to be issued all notices required by law or these bylaws. The Secretary shall keep (or cause to be kept) minutes of the proceedings of the meetings of the Corporation and of the Board, and shall ensure that all records and reports of the Corporation and of the Board shall be retained. In addition, the Secretary shall perform such other duties as may be assigned to him or her by the Board or the Chair.

5.6. **Treasurer**. The Treasurer shall ensure that timely and accurate financial information is presented to the Board, and that financial records shall be available for inspection by any director of the Corporation. The Treasurer shall ensure that all reports and records required by law regarding the Corporation's financial status are submitted or retained as required. The Treasurer generally shall cause to be performed all acts incident to the office of Treasurer and shall oversee such further duties as may from time to time be assigned to him or her by the Board or the Chair.

5.7. **Removal of Officers**. Any officer of the Corporation may be removed at any time with or without cause by the affirmative vote of a majority of all directors then serving, but without prejudice to such officer's contract rights, if any, provided notice of such action shall have been transmitted to all directors at least seven (7) days before said meeting.

ARTICLE VI. GENERAL PROVISIONS

6.1. **Gender**. All references in these bylaws to the masculine, feminine or neuter gender shall be deemed to apply equally to one or more of such gender-specific references as may be appropriate.

6.2. **Subsidiaries**. The President and CEO shall receive notice of meetings on behalf of the Corporation in its capacity as member or shareholder of any Affiliate. The President and CEO, in his or her sole discretion, may waive notice of any such meeting; provided, however, the President and CEO shall report the circumstances of the waiver to the Board at its next meeting. Except as provided herein or as specifically authorized by the Board, the Corporation shall act in its capacity as member of any Affiliate by action of the Board.

6.3. **Fiscal Year**. The fiscal year of the Corporation shall be determined by the Board.

6.4. **Waiver of Notice**. Written waiver signed at any time by a Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any Member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the Member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

6.5. **Written Notice and Signature**. Any written notice required hereunder may, without limitation, be issued by regular mail, certified mail, hand delivery, electronic means or facsimile and shall be deemed given when sent. Any written signature required under these bylaws or the Corporation's certificate of incorporation or by Connecticut law may be evidenced

by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

6.6. **Amendment**. 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. The Board shall have the power to adopt, amend or repeal these bylaws as to those matters not so requiring the approval of the Members at any duly held regular or special meeting of the Board, provided notice of the proposed adoption, amendment or repeal shall have been given in the notice of the meeting, in accordance with the following:

(a) by a Super-Majority Vote at any time; or

(b) by the affirmative vote of a majority of the directors at such meeting, provided (i) the Corporation has become the sole or controlling member or sole or controlling shareholder, or has acquired substantially all of the assets of, an additional acute care hospital and such amendment to these bylaws is made after the fourth anniversary of the Effective Date; or (ii) such amendment is made after the fifth anniversary of the Effective Date and twenty percent (20%) or more of the Board is comprised of individuals who are "Independent." For purposes of this section, an "Independent" individual means any individual other than the following (x) an individual who has served at any time prior to or after the Effective Date on the Board or the board of any subsidiary for which the Corporation acts as a member or shareholder (each a "WCHN Subsidiary"), the board of directors of NHSC or the board of any subsidiary for which NHSC acts as member or shareholder (each a "NHSC Subsidiary") and any immediate family member of such individual;

provided, however, a director who is first elected after the Effective Date to the board of directors of NHA, The Danbury Hospital or New Milford Hospital and to the board of directors of the Corporation shall be considered Independent; (y) an individual who is a current or former employee of the Corporation, NHSC, a WCHN Subsidiary or a NHSC Subsidiary and any immediate family member of such current or former employees; or (z) an individual who is a member of the medical staff of The Danbury Hospital, New Milford Hospital or NHA and any immediate family member of such medical staff members; provided, however, a director who is a member of the medical staffs of (A) NHA and (B) The Danbury Hospital and/or New Milford Hospital shall be considered Independent.

6.7. **Effective Date**. The effective date of these bylaws (the "Effective Date") shall be the last to occur of the date upon which (i) these bylaws are approved by the Board, (ii) these bylaws are approved by the Members, and (iii) the "Closing Date" of that certain Affiliation Agreement, dated January 22, 2013, by and between the Corporation and NHSC (the "Affiliation Agreement") as the term is defined in Section 1.2 of the Affiliation Agreement.

The foregoing bylaws were adopted by the Board on _____, and by the Members on _____, and the Closing Date of the Affiliation Agreement was on _____. The effective date of these bylaws is, therefore, _____.

EXHIBIT B-2
NHSC Amended and Restated Bylaws

AMENDED AND RESTATED

BYLAWS

of

NORWALK HEALTH SERVICES CORPORATION

TABLE OF CONTENTS

AMENDED AND RESTATED

BYLAWS

of

NORWALK HEALTH SERVICES CORPORATION

ARTICLE I. GENERAL

1.1. **Purpose**. These bylaws supplement certain provisions of the certificate of incorporation of Norwalk Health Services Corporation (the "Corporation") and the Connecticut Revised Nonstock Corporation Act, as amended from time to time (the "Act").

1.2. **Offices of Corporation**. The Corporation's board of directors (the "Board") shall have the power to determine the location of the registered office, in accordance with applicable law, from time to time, and to designate the principal office of the Corporation and such additional offices as it shall determine in its discretion.

ARTICLE II. MEMBERSHIP

2.1. **Membership**. The Corporation is a membership corporation. The sole member of the Corporation is Western Connecticut Health Network, Inc. (the "Member"). The Member shall have only such rights, privileges and obligations conferred upon it by the Corporation's certificate of incorporation, these bylaws and the Act.

2.2. **Powers of the Member**. Subject to Section 7.6 of these bylaws, certain fundamental decisions to be undertaken by the Corporation require the approval of the Member as follows:

(a) The actions listed below, which do not require approval by the Board, are reserved solely to the Member and require a super-majority vote, as

defined in the bylaws of the Member (a "Super-majority Vote"), of the Member's board of directors (the "Member Board"):

(i) the amendment of these bylaws;

(ii) the removal of a director;

(iii) subject to the terms of any employment agreement with the Member, the hiring or firing of the President and Chief Executive Officer of the Corporation and of The Norwalk Hospital Association ("NHA"); provided, however, that after the first anniversary of the Effective Date of these bylaws, the President/Chief Executive Officer of the Member shall have the unilateral authority to hire and fire the President and Chief Executive Officer of the Corporation and of NHA after obtaining input on such action from the board of directors of NHA.

(b) The actions listed below, which do not require approval by the Board, are reserved solely to the Member and shall be taken by the Member in accordance with its bylaws and the process set forth in these bylaws:

(i) the election of a director.

(c) The actions listed below, which require prior approval of the Board, must also be approved by a Super-majority Vote of the Member Board:

(i) the removal of a director of a subsidiary for which the Corporation acts as a member or shareholder, including without limitation NHA (each a "NHSC Subsidiary");

(ii) the closure of Norwalk Hospital or the closure or material diminution of a material program at Norwalk Hospital;

(iii) approval of the capital budget and operating budget of the Corporation and of any NHSC Subsidiary;

(iv) amendment of the certificate of incorporation of the Corporation or any NHSC Subsidiary;

(v) amendment of the bylaws or operating agreement of any NHSC Subsidiary;

(vi) the sale, lease, exchange or other disposition of all or substantially all of the property or assets of the Corporation or any NHSC Subsidiary;

(vii) approval of the creation of any corporation of which the Corporation or an NHSC Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of the Corporation or any NHSC Subsidiary with another corporation; and the reorganization, liquidation or dissolution of the Corporation or any NHSC Subsidiary;

(viii) approval of loans by the Corporation or any NHSC Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds two million dollars ($2.0 million) or which has a term longer than one year;

(ix) approval of policies relating to the control and supervision of the investment of the Corporation's and any NHSC Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of the Corporation or the NHSC Subsidiary;

(x) approval of unbudgeted expenditures in excess of two million dollars ($2.0 million) or any increase in any approved annual operating or capital budget;

(xi) approval of any agreement or transaction of the Corporation or any NHSC Subsidiary involving an amount greater than two million dollars ($2.0 million) with another entity or individual;

(xii) approval of the affiliation of the Corporation or any NHSC Subsidiary with any other entity for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

(xiii) creation of any committee which shall have the authority to act on behalf of the Board or on behalf of any NHSC Subsidiary;

(xiv) approval of any conveyance of, or the granting of mortgages or trusts on any real property assets of the Corporation or of any NHSC Subsidiary;

(xv) approval of any change to any employee pension or other employee benefit plans of the Corporation or any NHSC Subsidiary;

(xvi) approval of the adoption of or amendment to the policies and procedures governing: (a) indemnification of directors and officers of the Corporation or any NHSC Subsidiary; (b) conflicts or dualities of interest; (c) accounting and investment standards and practices; and (d) such other policies as the Member may from time to time determine;

(xvii) approval of the strategic plan of the Corporation and of any NHSC Subsidiary;

(xviii) approval of the engagement in managed care and other third party payor contracting on behalf of the Corporation or any NHSC Subsidiary;

(xix) approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by the Corporation or any NHSC Subsidiary and approval of the filing of

any application for a certificate of need by the Corporation or any NHSC Subsidiary;

(xx) approval of system-wide quality, performance and credentialing standards and procedures to which the Corporation or any NHSC Subsidiary is expected to adhere; and

(xxi) approval of regulatory compliance and methodology for physician compensation arrangements.

(d) The actions listed below, which require prior approval by the Board, shall be approved by the Member in accordance with its bylaws:

(i) the election of a director of a NHSC Subsidiary; and

(ii) the election of any officer of the Corporation.

2.3. Meetings of the Member. The annual meeting of the Corporation's Member shall be held at such date, time and place as the Board shall determine, and as shall be set forth in the notice of the meeting. Notice of annual, regular or special meetings of the Member shall be provided to the Member no fewer than ten (10) nor more than sixty (60) days before the meeting date. Special meetings may be held at such dates, times and places, and for such specific purposes, as the Board shall determine, and as shall be set forth in the notice of the meeting. At each annual meeting or any special meeting called for such purpose, the Member shall (i) appoint directors in accordance with these bylaws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) conduct any other business relating to the affairs of the Corporation consistent with the rights of the Member.

ARTICLE III. BOARD OF DIRECTORS

3.1. **Authority**. All corporate powers not reserved to the Member shall be exercised by or under the authority of, and the activities, property and affairs of the Corporation shall be managed by or under the direction of, the Board, subject to any limitations set forth in the certificate of incorporation, including, but not limited to, the following:

(a) Review local quality and service goals and improvement programs within the context of the Member's goals and improvement programs and recommend changes thereto to the Member Board;

(b) Monitor local quality, service and financial performance;

(c) Support management in making local communications with external audiences, including, but not limited to, local governments and the media;

(d) Support fundraising efforts conducted by the Norwalk Hospital Foundation, Inc. in the local community; and

(e) Oversee community benefit programs in the local community.

3.2. **Number and Composition**. The Corporation shall have no less than twelve (12) and no more than twenty-five (25) voting directors. Of this number, the President and CEO of the Member, the President and CEO of the Corporation, and the President and CEO of Norwalk Hospital Foundation, Inc. shall serve as ex-officio directors, and shall be counted for purposes of quorum and shall have the right to vote. At least one director, other than the President and CEO of the Member, shall be an individual who also serves on the board of directors of each of the Member, The Danbury Hospital and the New Milford Hospital, Inc. All directors shall be individuals who also serve on the board of directors of NHA.

3.3. **Nomination, Election and Terms of Office**. As of the Effective Date, the Member shall divide the elected directors ("Initial Directors") into three (3) groups so that an

approximately equal number of directors have terms that expire each year and set the year in which each such director's eligibility for reelection shall cease. At each annual meeting of the Member thereafter, directors shall be elected by the Member in the manner set forth in these bylaws to succeed the directors in the class whose terms expire at that annual meeting. The Board shall nominate individuals to succeed those directors whose terms are then expiring. In the event that the Member does not approve an individual nominated for election as a director, the Board shall nominate another individual for the Member's approval until a candidate is approved; provided, however, that if the Member declines to elect two (2) candidates proposed to fill the same directorship, the Member may only decline to elect the third candidate by a Super-majority Vote. Other than the Initial Directors and directors elected to fill vacancies, elected directors shall serve for a term of three (3) years and until their successors are elected and qualified. Except for the Initial Directors and as provided in Section 6.1 of these bylaws, elected directors shall be eligible to serve three (3) consecutive terms on the Board and shall be eligible for reelection to the Board only after a one (1) year hiatus from service as a director. A director elected to fill a vacancy in an unexpired term shall be deemed to have served one (1) three-year term for purposes of eligibility for reelection only if the director has served more than one (1) year of an unexpired term.

3.4. **Vacancies**. Any vacancy or vacancies occurring on the Board shall be filled by action of the Member in accordance with Section 2.2(b) of these bylaws. The Board shall nominate candidates to fill a vacancy on the Board in accordance with the procedure set forth in Section 3.3. A vacancy that will occur at a specified later date, by reason of a resignation effective at a later date, may be filled before the vacancy occurs, but the new director may not take office until that vacancy occurs.

3.5. **Meetings and Notices**. Annual meetings of the Board shall be held at the principal offices of the Corporation unless otherwise specifically directed by the President and CEO. The Board or its Chair will specify an appropriate date and issue notice thereof as provided below, for the purpose of electing officers for the ensuing year, receiving reports from the Corporation's officers, agents and committees, and transacting such other business as may properly come before the meeting. Notice of the annual meeting of the Board shall be in writing and shall be sent to all directors at least seven (7) days before the annual meeting.

Regular meetings of the Board shall be held at such times as the Board shall from time to time determine or as requested by the Member. Special meetings of the Board may be called at any time by the Chair or the President and CEO, and shall be called by either of them within seven days after receipt of a written request of any three directors or the Member. Meetings of the Board may be held within or without the State of Connecticut. No notice of regular meetings shall be required unless specifically directed by the President and CEO or the Chair. Except as otherwise provided in these bylaws, at least two (2) days' written notice shall be given to each director of each special meeting of the Board, and such notice shall contain the date, time and place of such special meeting.

3.6. **Quorum, Action by Board of Directors and Adjournment**. A majority of the directors then serving shall constitute a quorum for the transaction of business, and the act of a numerical majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the presence of or act of a greater number is specifically required by these bylaws, the Corporation's certificate of incorporation, or the Act. If a quorum shall not be present at any meeting of directors, a majority of the directors present at such meeting

may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.7. **Action Without a Meeting**. Any action which may be taken at a meeting of the Board or of a committee of the Board may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors or all of the committee members entitled to vote with respect to the subject matter of such meeting. Such consent shall be filed with the minutes of the directors' or committee's meetings.

3.8. **Meeting by Conference Telephone**. A director or a member of a committee of the Board may participate in a meeting of the Board or of such committee by means of conference telephone or similar communications equipment enabling all directors or all committee members participating in the meeting to hear one another, and participation in such a meeting shall constitute presence in person at such meeting.

3.9. **Resignations**. The resignation of any director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified, or at such later time as the resigning director may specify and the Corporation shall accept. Failure of a director to attend three (3) consecutive Board meetings without proper excuse may, in the Chair's discretion, be deemed a resignation.

3.10. **Removal of Directors**. The Member may remove any director, with or without cause, by a Super-majority Vote.

3.11. **Compensation**. No director shall receive compensation for services rendered to the Corporation in such capacity, but directors shall be entitled to reimbursement for reasonable and necessary expenses actually incurred in connection with the performance of their duties in the manner and to the extent that the Board shall determine, and may receive

reasonable compensation for services performed in other capacities for or on behalf of the Corporation.

ARTICLE IV. COMMITTEES OF THE BOARD

4.1. General. At least annually the Board, by the affirmative vote of a majority of all directors then serving shall appoint the members of a Nominating Committee and a Budget and Finance Committee in accordance with these bylaws. In addition, to the extent permitted by law, the Corporation shall participate in the matrix committees established by the Member to provide advice to the Member and its affiliates. All committees of the Board shall be advisory and shall not have authority to act on behalf of the Board. The Board may create one or more additional ad-hoc advisory committees as the Board from time to time may consider necessary or advisable. The chairmanship and membership of each committee shall be recommended by the Nominating Committee and approved by the Board. The duties and authority of each committee shall be set forth and determined by the Board. The chair of each committee shall be a director. Non-board members may be appointed to any committee. Each committee shall report its activities and recommendations, if any, to the Board at each Board meeting.

4.2. Nominating Committee. The Nominating Committee shall consist of the Chair, the Vice Chair and at least three (3) directors elected by the Board. The Nominating Committee shall advise the Board on the nomination of individuals to serve as directors, members of the Member, and as members of the board of directors of the Member. The Nominating Committee shall review, develop, and submit to the Board nominations for election by the Member to service on the Board.

4.3. Budget and Finance Committee. The Budget and Finance Committee shall consist of no less than three (3) directors. The Budget and Finance Committee shall advise the

Board on matters relating to the management and expenditure of the Corporation's funds. The Budget and Finance Committee shall, in cooperation with the Finance Committee of the Member: (i) review and recommend for approval by the Board and the Member the operating and capital budgets of the Corporation and of the NHSC Subsidiaries; and (ii) review and recommend for approval by the Board and the Member the strategic plan of the Corporation and of the NHSC Subsidiaries.

4.4. Quorum and Action. At all committee meetings, a quorum for the transaction of business shall consist of a majority of the members of the committee, and the vote of a majority of those members present when a quorum is present shall constitute the act of the committee.

ARTICLE V. PRESIDENT AND CEO

The Corporation may contract with the Member for the services of a President and CEO. The President and CEO shall be the chief executive of the Corporation, and shall report to the Board. The President and CEO shall submit regular reports to the Chair and to the Board on the operations of the Corporation. The President and CEO, in accordance with these bylaws, shall serve as a director, ex-officio and shall have the right to vote. The President and CEO shall perform such other duties as may be assigned to him or her by the Board. The individual serving as President and CEO shall be the same individual serving as the President and CEO of NHA. Following the first anniversary of the Effective Date, the Member's President and CEO shall have the unilateral authority to hire or fire the President and CEO, subject to the terms of any employment agreement with the Member, after obtaining input on such action from the board of directors of NHA.

ARTICLE VI. OFFICERS

6.1. Officers, Appointment, Term and Vacancies. Subject to the approval of the Member, the directors shall elect all of the Corporation's officers. The officers of the Corporation shall consist of a Chair, a Vice Chair, a Secretary and a Treasurer, each of whom shall be directors. The Corporation may have such other officers, such as an Assistant Secretary or Assistant Treasurer, who need not be directors, as the Board may determine from time to time. Any person may simultaneously hold multiple offices.

Officers shall be elected at the annual meeting of the Board for a term extending until the next succeeding annual meeting of the Board and until his or her successor has been elected and qualified or his or her earlier death, resignation or removal, except that the Chair and the Vice Chair shall each be elected to a term of two (2) years and until a successor is elected. Notwithstanding the provisions of Section 3.3 of these bylaws, a director whose term as Chair or Vice Chair will exceed that director's third full term as a director shall continue to serve as a director until expiration of his or her two-year term as Chair or Vice Chair, as applicable, and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed.

Subject to the approval of the Member, any vacancy or vacancies occurring in any office of the Corporation may be filled until the next meeting at which officers are elected by the affirmative vote of the remaining directors in office at any meeting of the Board, though such remaining directors are fewer than a quorum.

6.2. Chair. The Chair shall work to ensure that the Board functions properly, meets its obligations and responsibilities, and fulfills its purpose and mission as set forth in the certificate of incorporation and these bylaws, and as otherwise determined from time to time by the Board. The Chair shall work to maintain an effective relationship between the Board and management and, in so doing, will be the liaison between the Board and management. The

Chair shall, if present, preside over all meetings of the Board. The Chair shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board. The Chair shall also perform such other duties as may be assigned to him or her by the Board.

6.3. **Vice Chair**. The Vice Chair shall serve a two-year term and shall have such duties and responsibilities as the Chair or the Board of Directors shall from time to time determine. The Vice Chair shall assume the duties of the Chair in the absence or disability of the Chair.

6.4. **Secretary**. The Secretary shall issue or cause to be issued all notices required by law or these bylaws. The Secretary shall keep (or cause to be kept) minutes of the proceedings of the meetings of the Corporation and of the Board, and shall ensure that all records and reports of the Corporation and of the Board shall be retained. In addition, the Secretary shall perform such other duties as may be assigned to him or her by the Board, the Chair, or the Member.

6.5. **Treasurer**. The Treasurer shall ensure that timely and accurate financial information is presented to the Board, and that financial records are maintained and available for inspection by any director or the Member of the Corporation. The Treasurer shall ensure that all reports and records required by law regarding the Corporation's financial status are submitted or retained as required. The Treasurer generally shall cause to be performed all acts incident to the office of Treasurer and shall oversee such further duties as may from time to time be assigned to him or her by the Board, the Chair, or the Member.

6.6. **Removal of Officers**. Subject to the approval of the Member, any officer of the Corporation (except the President and CEO) may be removed at any time with or without cause by the affirmative vote of a majority of all directors then serving, but without prejudice to such

officer's contract rights, if any, provided written notice of such action shall have been transmitted to all directors at least seven (7) days before said meeting.

ARTICLE VII. GENERAL PROVISIONS

7.1. **Gender**. All references in these bylaws to the masculine, feminine or neuter gender shall be deemed to apply equally to one or more of such gender-specific references as may be appropriate.

7.2. **Fiscal Year**. The fiscal year of the Corporation shall be determined by the Board.

7.3. **Waiver of Notice**. Written waiver signed at any time by the Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any Member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the Member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

7.4. **Written Notice and Signature**. Any written notice required hereunder may, without limitation, be issued by regular mail, certified mail, hand delivery, electronic means or facsimile and shall be deemed given when sent. Any written signature required under these bylaws or the Corporation's certificate of incorporation or by Connecticut law may be evidenced by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

7.5. **Conflict of Interest Policy**. The Corporation's officers and directors shall adhere to the conflict of interest policy adopted by the Member, as the same may be amended from time to time.

7.6. **Amendment**. The Member shall have the exclusive power to adopt, amend or repeal these bylaws at any duly held regular or special meeting of the Member Board, provided notice of the proposed adoption, amendment or repeal shall have been given in the notice of the meeting, in accordance with the following:

(a) by a Super-Majority Vote of the Member Board at any time; or

(b) by the affirmative vote of a majority of the directors of the Member at such meeting, provided (i) the Member has become the sole member, sole shareholder or has acquired substantially all of the assets, of an additional acute care hospital, and such amendment to these bylaws is made after the fourth anniversary of the Effective Date; or (ii) such amendment is made after the fifth anniversary of the Effective Date and twenty percent (20%) or more of the Member Board is comprised of individuals who are "Independent." For purposes of this section, an "Independent" individual means any individual other than the following (x) an individual who, has served at any time prior to or after the Effective Date on the Member Board, the board of any subsidiary for which the Member acts as a member or shareholder (each a "WCHN Subsidiary"), the Board, or the board of any NHSC Subsidiary and any immediate family member of such individual; provided, however, a director who is first elected after the Effective Date to the board of directors of NHA, The Danbury Hospital or New Milford Hospital and to the board of directors of the Member shall be considered Independent; (y) an individual who is a current or former employee of the Corporation, the Member, a WCHN Subsidiary or a

NHSC Subsidiary and any immediate family member of such current or former employees; or (z) an individual who is a member of the medical staff of The Danbury Hospital, New Milford Hospital or NHA and any immediate family member of such medical staff member; provided, however, a director who is a member of the medical staffs of (A) NHA and (B) The Danbury Hospital and/or New Milford Hospital shall be considered Independent.

7.7. **Effective Date**. The effective date of these bylaws (the "Effective Date") shall be the last to occur of the date upon which (i) these bylaws are approved by the Board, and (ii) the "Closing Date" of that certain Affiliation Agreement, dated January 22, 2013, by and between the Corporation and Western Connecticut Health Network, Inc. (the "Affiliation Agreement"), as the term is defined in Section 1.2 of the Affiliation Agreement.

EXHIBIT B-3
NHA Amended and Restated Bylaws

AMENDED AND RESTATED

BYLAWS

of

THE NORWALK HOSPITAL ASSOCIATION

TABLE OF CONTENTS

AMENDED AND RESTATED

BYLAWS

of

THE NORWALK HOSPITAL ASSOCIATION

ARTICLE I. GENERAL

1.1. Purpose. These bylaws supplement certain provisions of the certificate of incorporation of The Norwalk Hospital Association (the "Corporation") and the Connecticut Revised Nonstock Corporation Act, as amended from time to time (the "Act"). The Corporation is an affiliate of Western Connecticut Health Network, Inc., referred to herein as "WCHN."

1.2. Offices of Corporation. The Corporation's board of directors (the "Board") shall have the power to determine the location of the registered office, in accordance with applicable law, from time to time, and to designate the principal office of the Corporation and such additional offices as it shall determine in its discretion.

ARTICLE II. MEMBERSHIP

2.1. Membership. The Corporation is a membership corporation. Norwalk Health Services Corporation is the sole corporate member of the Corporation (the "Member"). WCHN is the sole corporate member of the Member. The Member shall have only such rights, privileges and obligations conferred upon it by the Corporation's certificate of incorporation, these bylaws and the Act.

2.2. Powers of the Member. Certain fundamental decisions to be undertaken by the Corporation require the approval of the Member. Any actions requiring Member approval under these bylaws shall not be deemed approved until such time that the Corporation receives

approval from the Member and, to the extent required under the bylaws of the Member, of WCHN.

(a) The actions listed below, which do not require approval by the Board, are reserved solely to the Member:

(i) The amendment of these bylaws; and

(ii) The election or removal of a director.

(b) The actions listed below, which require prior approval of the Board, must also be approved by the Member:

(i) The election and removal of a director of a subsidiary for which the Corporation acts as a member or shareholder ("NHA Subsidiary");

(ii) The election of the officers of the Corporation;

(iii) The closure of Norwalk Hospital or the closure or material diminution of a material program at Norwalk Hospital;

(iv) Approval of the capital budget and operating budget of the Corporation and of any NHA Subsidiary;

(v) Amendment of the certificate of incorporation of the Corporation or any NHA Subsidiary;

(vi) Amendment of the bylaws or operating agreement of any NHA Subsidiary;

(vii) The sale, lease, exchange or other disposition of all or substantially all of the property or assets of the Corporation or any NHA Subsidiary;

(viii) Approval of the creation of any corporation of which the Corporation or an NHA Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of the Corporation or any NHA Subsidiary with another corporation; and the reorganization, liquidation or dissolution of the Corporation or any NHA Subsidiary;

(ix) Approval of loans by the Corporation or any NHA Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds two million dollars ($2.0 million) or which has a term longer than one year;

(x) Approval of policies relating to the control and supervision of the investment of the Corporation's and any NHA Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of the Corporation or the NHA Subsidiary;

(xi) Approval of unbudgeted expenditures in excess of two million dollars ($2.0 million) or any increase in any approved annual operating or capital budget;

(xii) Approval of any agreement or transaction of the Corporation or any NHA Subsidiary involving an amount greater than two million dollars ($2.0 million) with another individual or entity;

(xiii) Approval of the affiliation of the Corporation or any NHA Subsidiary with any other entity for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

(xiv) Creation of any committee which shall have the authority to act on behalf of the Board or on behalf of any NHA Subsidiary;

(xv) Approval of any conveyance of, or the granting of mortgages or trusts on any real property assets of the Corporation or of any NHA Subsidiary;

(xvi) Approval of any change to any employee pension or other employee benefit plans of the Corporation or any NHA Subsidiary;

(xvii) Approval of the adoption of or amendment to the policies and procedures governing: (a) indemnification of directors and officers of the Corporation or any NHA Subsidiary; (b) conflicts or dualities of interest; (c) accounting and investment standards and practices; and (d) such other policies as the Member may from time to time determine;

(xviii) Approval of the strategic plan of the Corporation and of any NHA Subsidiary;

(xix) Approval of the engagement in managed care and other third party payor contracting on behalf of the Corporation or any NHA Subsidiary;

(xx) Approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by the Corporation or any NHA Subsidiary and approval of the filing of any application for a certificate of need by the Corporation or any NHA Subsidiary;

(xxi) Approval of system-wide quality, performance and credentialing standards and procedures to which the Corporation or any NHA Subsidiary is expected to adhere; and

(xxii) Approval of regulatory compliance and methodology for physician compensation arrangements.

2.3. **Meetings of the Member**. The annual meeting of the Corporation's Member shall be held at such date, time and place as the Board shall determine, and as shall be set forth in the notice of the meeting. Notice of annual, regular or special meetings of the Member shall be provided to the Member no fewer than ten (10) nor more than sixty (60) days before the meeting date. Special meetings may be held at such dates, times and places, and for such specific purposes, as the Board shall determine, and as shall be set forth in the notice of the meeting.

At each annual meeting or any special meeting called for such purpose, the Member shall (i) appoint directors in accordance with these bylaws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) conduct any other business relating to the affairs of the Corporation consistent with the rights of the Member.

ARTICLE III. BOARD OF DIRECTORS

3.1. Authority. All corporate powers not reserved to the Member shall be exercised by or under the authority of, and the activities, property and affairs of the Corporation shall be managed by or under the direction of, the Board, subject to any limitations set forth in the certificate of incorporation including, but not limited to the following:

(a) Review local quality and service goals and improvement programs within the context of the Member's goals and improvement programs and recommend changes thereto to the Member Board;

(b) Monitor local quality, service and financial performance;

(c) Support management in making local communications with external audiences, including, but not limited to, local governments and the media;

(d) Support fundraising efforts conducted by the Norwalk Hospital Foundation, Inc. in the local community;

(e) Oversee community benefit programs in the local community; and

(f) Approve medical staff bylaws and medical staff appointments based on standardized Member applications and review processes;

(g) Participate in the search process for the President and CEO of the Corporation when the need arises.

3.2. Number and Composition. The Corporation shall have no less than twelve (12) and not more than twenty-five (25) voting directors. Of this number, the President and CEO of

the Corporation, the President and CEO of WCHN, and the President and CEO of Norwalk Hospital Foundation, Inc., shall serve as ex-officio directors, and shall be counted for purposes of quorum and shall have the right to vote. At least one (1) director, other than the President and CEO of WCHN, shall be an individual who also serves on the board of each of WCHN, The Danbury Hospital and the New Milford Hospital, Inc. All directors shall be those individuals who serve on the board of the Corporation's Member.

3.3. **Appointment and Terms of Office**. As of the Effective Date, the Member shall divide the elected directors ("Initial Directors") into three (3) groups so that an approximately equal number of directors have terms that expire each year and set the year in which each such director's eligibility for reelection shall cease. At each annual meeting of the Member thereafter, directors shall be elected by the Member in the manner set forth in the bylaws of the Member to succeed the directors in the class whose terms expire at that annual meeting. Other than the Initial Directors and directors elected to fill vacancies, elected directors shall serve for a term of three (3) years and until their successors are elected and qualified. Except for the Initial Directors and as provided in Section 7.2 of these bylaws, directors shall be eligible to serve three (3) consecutive terms on the Board and shall be eligible for reelection to the Board only after a one (1) year hiatus from service as a director. A director elected to fill a vacancy in an unexpired term shall be deemed to have served one (1) three-year term for purposes of eligibility for reelection only if the director has served more than one (1) year of an unexpired term.

3.4. **Vacancies**. Any vacancy or vacancies occurring on the Board shall be filled by the Member in the manner set forth in the bylaws of the Member. A vacancy that will occur at a specified later date, by reason of a resignation effective at a later date, may be filled before the vacancy occurs, but the new director may not take office until that vacancy occurs.

3.5. **Meetings and Notices**. Annual meetings of the Board shall be held at the principal offices of the Corporation unless otherwise specifically directed by the President and CEO. The Board or its Chair will specify an appropriate date and issue notice thereof as provided below, for the purpose of electing officers for the ensuing year, receiving reports from the Corporation's officers, agents and committees, and transacting such other business as may properly come before the meeting. Notice of the annual meeting of the Board shall be in writing and shall be sent to all directors at least seven (7) days before the annual meeting.

Regular meetings of the Board shall be held at such times as the Board shall from time to time determine or as requested by the Member. Special meetings of the Board may be called at any time by the Chair or the President and CEO, and shall be called by either of them within seven (7) days after receipt of a written request of any three directors or the Member. Meetings of the Board may be held within or without the State of Connecticut. No notice of regular meetings shall be required unless specifically directed by the President and CEO or the Chair. Except as otherwise provided in these bylaws, at least two (2) days' written notice shall be given to each director of each special meeting of the Board, and such notice shall contain the date, time and place of such special meeting.

3.6. **Quorum, Action by Board of Directors and Adjournment**. A majority of the directors then serving shall constitute a quorum for the transaction of business, and the act of a numerical majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the presence of or act of a greater number is specifically required by these bylaws, the Corporation's certificate of incorporation, or the Act. If a quorum shall not be present at any meeting of directors, a majority of the directors present at such meeting may

adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.7. **Action Without a Meeting**. Any action which may be taken at a meeting of the Board or of a committee of the Board may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors or all of the committee members entitled to vote with respect to the subject matter of such meeting. Such consent shall be filed with the minutes of the directors' or committee's meetings.

3.8. **Meeting by Conference Telephone**. A director or a member of a committee of the Board may participate in a meeting of the Board or of such committee by means of conference telephone or similar communications equipment enabling all directors or all committee members participating in the meeting to hear one another, and participation in such a meeting shall constitute presence in person at such meeting.

3.9. **Resignations**. The resignation of any director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified, or at such later time as the resigning director may specify and the Corporation shall accept. Failure of a director to attend three (3) consecutive Board meetings without proper excuse may, in the Chair's discretion, be deemed a resignation.

3.10. **Removal of Directors**. The Member may remove any director, with or without cause.

3.11. **Compensation**. No director shall receive compensation for services rendered to the Corporation in such capacity, but directors shall be entitled to reimbursement for reasonable and necessary expenses actually incurred in connection with the performance of their duties in

the manner and to the extent that the Board shall determine, and may receive reasonable compensation for services performed in other capacities for or on behalf of the Corporation.

ARTICLE IV. MEDICAL STAFF

4.1. **General**. The Board shall appoint a medical staff operating in accordance with these bylaws and those bylaws, credentials or other medical staff policies, rules and regulations of the medical staff that are approved by the Board. The medical staff shall operate as an integral part of the Hospital and, through its department chairmen, committees and officers, shall be responsible and accountable to the Board for the discharge of those duties and responsibilities delegated to it by the Board from time to time. The Board has the ultimate authority over all decisions regarding the mission of the Corporation, its economic viability, organizational integrity and quality of care, and specifically reserves the authority to adopt such policies as the Board determines are necessary to facilitate its mission, protect its assets, further its economic viability, and to determine the most efficient manner in which to provide a Hospital service. Said policies may affect the eligibility of practitioners for (a) appointment or reappointment to the medical staff, (b) the exercise of clinical privileges, (c) service as a medical staff officer, committee member or department or section chief, (d) financial relationships with this Corporation or its affiliates, or (e) other benefits generally available to medical staff appointees. The Board shall have the authority to take any action that it deems appropriate with respect to any individual appointed to the medical staff or given clinical privileges or the right to practice in the Hospital.

4.2. **Medical Staff Bylaws, Rules and Regulations:**

(a) In recommending medical staff bylaws, rules and regulations, or policies, the medical staff shall follow the procedures set forth in the medical staff bylaws and Credentials Policy. Only such medical staff bylaws,

credentials or other medical staff policies, and rules and regulations as are adopted by the Board shall be effective.

(b) The medical staff may at any time recommend modifications of the medical staff bylaws, credentials or other medical staff policies, and rules and regulations to the Board. The Board shall act promptly on any such proposed amendments that are submitted by the medical staff.

(c) The Board reserves the right to rescind any authority or procedures delegated to the medical staff by bylaws, credentials or other medical staff policies, rules or regulations, or otherwise, and to amend the foregoing from time to time as it deems appropriate for the appropriate operation of the Hospital. In the event the Board believes there should be changes in the medical staff bylaws, credentials or other medical staff policies, rules or regulations, it shall submit such suggested changes to the medical staff. The medical staff shall promptly consider and submit to the Board its recommendations. If submissions by the medical staff in response to suggestions by the Board are not transmitted to the Board within a reasonable time as determined by the Board, then the Board may make such changes as are deemed necessary without the approval of the medical staff.

(d) In the event of a conflict between the provisions of the medical staff bylaws, credentials or other medical staff policies, or rules and regulations and these bylaws, the provisions of these bylaws shall be controlling.

4.3. **Medical Staff Appointment and Clinical Privileges:** The Board may appoint to the medical staff graduates of recognized professional schools meeting the personal and professional qualifications prescribed in the medical staff bylaws or the Corporation's Credentials Policy and may assign clinical privileges to them. Individuals so appointed shall have responsibility for the treatment of Hospital patients subject only to such limitations as the Board and its designees may impose, and to the medical staff bylaws, rules and regulations, or policies, including the Corporation's Credentials Policy. Appointments shall be provisional for the period described in, and are renewable in accordance with, the procedures set forth in the medical staff bylaws or the Corporation's Credentials Policy.

4.4. **Contracts for Clinical Services:**

(a) All individuals functioning pursuant to contracts or employment relationships with individuals, partnerships or corporations for the performance of certain health care services, including exclusive agreements and agreements for medical-administrative positions, who would be subject to the provisions of the medical staff bylaws, shall obtain and maintain staff appointment and/or clinical privileges, in accordance with the medical staff bylaws or the Corporation's Credentials Policy.

(b) Unless the service or employment contract provides otherwise, if a question arises concerning clinical competence that may affect such individual's staff appointment or clinical privileges during the term of the contract, that question may be processed in the same manner as would pertain to any other medical staff appointee. If a modification of privileges or appointment occurs that is sufficient to prevent the individual from

performing his contractual duties, the contract shall automatically terminate.

(c) Unless the service or employment contract provides otherwise, clinical privileges and medical staff appointment that are necessary to carry out the obligations of an exclusive contract or employment contract shall be valid only during the term of the contract. In the event that an exclusive contract expires or is terminated, then the medical staff appointment and clinical privileges of any individual who is employed by, or under contract with, the exclusive provider shall also expire. Similarly, in the event that an individual who is employed by, or under contract with, the exclusive provider is removed from service at the Hospital or terminates their employment by or contract with, the exclusive provider, then the medical staff appointment and clinical privileges of any such individual shall expire. Any such expiration of clinical privileges and medical staff appointment or the termination or expiration of the contract itself shall not entitle the individual to any hearing or appeal pursuant to the medical staff bylaws or Credentials Policy, unless there is a specific provision to the contrary in the contract. In the event that only a portion of the individual's clinical privileges are covered by the exclusive contract or employment contract, only that portion shall be affected by the expiration or termination of the exclusive contract or employment.

(d) Specific contractual or employment terms shall in all cases be controlling in the event that they conflict with provisions of the medical staff bylaws or the Corporation's Credentials Policy.

4.5. **Evaluating Professional Needs**: From time to time the Board, with the advice of the WCHN Planning Committee shall evaluate the number, age, admissions, and Hospital activities of medical staff appointees in various specialty areas so that a proper number of individuals in each specialty is determined maintained and revised as needed, in light of the strategic planning objectives and professional personnel requirements and limitations of the Hospital.

4.6. **Procedures for Board Actions Pertaining to Medical Staff Applicants or Appointees:**

(a) The Board retains the absolute discretion to take any action with respect to the Medical Staff it deems in the best interest of the Hospital and the decision of the Board shall be conclusive. At any time in its consideration of any recommendation involving a medical staff appointee, the Board may in its absolute discretion defer final determination by referring the matter to a committee of its choice for further consideration. Any such referral shall state the reasons therefor and shall set a time limit within which a subsequent recommendation to the Board shall be made. However, if the Board or a Board committee makes a recommendation that would entitle a medical staff appointee to a hearing, the Board shall, before taking final action, notify the affected individual of the hearing rights that are described in the Hospital's Credentials Policy. If a hearing

is requested, it shall be conducted in accordance with procedures outlined in the medical staff bylaws or the Credentials Policy.

(b) When the Board acts finally in the matter, it shall send notice of such decision through the President and CEO by certified mail, return receipt requested, to the applicant or appointee involved as well as to the Executive Committee of the Medical Staff and the chairman of the department affected.

(c) Notwithstanding the actions described in paragraph (a), a decision not to grant an application or a decision to defer the appointment of a qualified applicant, in accordance with the recommendations of the WCHN Planning Committee, does not entitle the applicant to the hearing and appeal rights outlined in the medical staff bylaws or the Corporation's Credentials Policy.

4.7. **Medical Staff Departments, Committees and Officers:**

(a) The chairmen of all medical staff departments, the chairmen and members of all medical staff committees, and the officers of the medical staff shall be elected or appointed in accordance with the provisions of the medical staff bylaws and the Credentials Policy and other medical staff policies and shall be subject to the approval of the Board prior to assuming their duties in those offices. Said individuals shall act for and on behalf of the Hospital when performing their duties under the bylaws and shall perform such additional duties as may be assigned from time to time by the Board or the President and CEO or his/her designee.

(b) All minutes, reports, recommendations, communications, and actions with respect to credentialing, peer review, quality assurance or related matters made or taken by the Board or its committees or by medical staff departments, committees and officers on behalf of the Hospital are deemed to be covered by the provisions of Connecticut or federal law or regulation providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to the medical staff bylaws or Credentials Policy or other medical staff policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

4.8. **Malpractice Insurance Coverage**: The Board shall require that all applicants and appointees of the Active, Consulting and Emeritus Staffs, and all applicants and appointees of the Allied Health Professional Staff, have and maintain malpractice insurance through a company approved by the Connecticut Insurance Department in an amount that the Board determines is commensurate with services provided by the practitioner in the Hospital to cover claims or suits arising from alleged malpractice in the Hospital. If at any time an appointee's malpractice insurance coverage lapses, is terminated, or otherwise is not in effect, the appointee's clinical privileges shall be deemed voluntarily relinquished as of that date until the matter is resolved and adequate malpractice insurance coverage is restored. Failure to restore adequate malpractice insurance coverage after six months from the relinquishment of privileges

shall constitute a voluntary relinquishment of clinical privileges and resignation from the Medical Staff. Compliance with this policy shall be evidenced by filing with the Chief Executive Officer a certificate of insurance from the carrier showing at least the minimum required insurance coverage.

ARTICLE V. COMMITTEES OF THE BOARD

5.1. General. At least annually the Board, by the affirmative vote of a majority of all directors then serving shall appoint a Nominating Committee and a Budget and Finance Committee in accordance with these bylaws. In addition, to the extent permitted by law, the Corporation shall participate in the matrix committees established by WCHN to provide advice to WCHN and its affiliates. The Board may create one or more additional ad-hoc advisory committees as the Board from time to time may consider necessary or advisable. All committees of the Board shall be advisory and shall not have authority to act on behalf of the Board. For the avoidance of doubt, the medical staff committees shall not be subject to participation on matrix committees of WCHN. The membership, duties and authority of each committee shall be set forth and determined by the Board. The chair of each committee shall be a director. Non-board members may be appointed to any committee. Each committee shall report its activities and recommendations, if any, to the Board at each Board meeting.

5.2. Nominating Committee. The Nominating Committee shall consist of the Chair, the Vice Chair and at least three (3) directors. The Nominating Committee shall advise the Board on the nomination of individuals to serve as directors, as members of WCHN and as members of the board of directors of the Member. The Nominating Committee shall review, develop, and submit to the Board nominations for election by the Member to service on the Board.

5.3. **Budget and Finance Committee**. The Budget and Finance Committee shall consist of no less than three (3) directors. The Budget and Finance Committee shall advise the Board on matters relating to the management and expenditure of the Corporation's funds. The Budget and Finance Committee shall, in cooperation with the Finance Committee of the Member: (i) review and recommend for approval by the Board and the Member the operating and capital budgets of the Corporation and of the NHSC Subsidiaries; and (ii) review and recommend for approval by the Board and the Member the strategic plan of the Corporation and of the NHSC Subsidiaries.

5.4. **Quorum and Action**. At all committee meetings, a quorum for the transaction of business shall consist of a majority of the members of the committee, and the vote of a majority of those members present when a quorum is present shall constitute the act of the committee.

ARTICLE VI. PRESIDENT AND CEO

The Corporation may contract with WCHN for the services of a President and CEO. The President and CEO shall be the chief executive of the Corporation, and shall report to the Board. The President and CEO shall submit regular reports to the Chair and to the Board on the operations of the Corporation. The President and CEO, in accordance with these bylaws, shall serve as a director, ex-officio and shall have the right to vote. The President and CEO shall perform such other duties as may be assigned to him or her by the Board. The individual serving as President and CEO shall be the same individual serving as the President and CEO of the Member. Following the first anniversary of the Effective Date, WCHN's President and CEO shall have the unilateral authority to hire or fire the President and CEO after obtaining input on such action from the Board, subject to the terms of any employment agreement between the

President and CEO and WCHN. Prior to that date, the hiring and firing of the President and CEO shall be done by WCHN in accordance with its bylaws.

ARTICLE VII. OFFICERS

7.1. **Officers, Appointment, Term and Vacancies**. Subject to the approval of the Member, the directors shall elect all of the Corporation's officers. The officers of the Corporation shall consist of a Chair, a Vice Chair, a Secretary and a Treasurer, each of whom shall be directors. The Corporation may have such other officers, such as an Assistant Secretary or Assistant Treasurer, who need not be directors, as the Board may determine from time to time. Any person may simultaneously hold multiple offices.

Officers shall be elected at the annual meeting of the Board for a term extending until the next succeeding annual meeting of the Board and until his or her successor has been elected and qualified or until his or her earlier death, resignation or removal, except that the Chair and the Vice Chair shall each be elected to a term of two (2) years and until a successor is elected. Notwithstanding the provisions of Section 3.3 of these bylaws, a director whose term as Chair or Vice Chair will exceed that director's third full term as a director shall continue to serve as a director until expiration of his or her two-year term as Chair or Vice Chair, as applicable, and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed. Subject to the approval of the Member, any vacancy or vacancies occurring in any office of the Corporation may be filled until the next meeting at which officers are elected by the affirmative vote of the remaining directors in office at any meeting of the Board, though such remaining directors are fewer than a quorum.

7.2. **Chair**. The Chair shall work to ensure that the Board functions properly, meets its obligations and responsibilities, and fulfills its purpose and mission as set forth in the certificate of incorporation and these bylaws, and as otherwise determined from time to time by

the Board. The Chair shall work to maintain an effective relationship between the Board and management and, in so doing, will be the liaison between the Board and management. The Chair shall, if present, preside over all meetings of the Board. The Chair shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board. The Chair shall also perform such other duties as may be assigned to him or her by the Board.

7.3. **Vice Chair**. The Vice Chair shall serve a two-year term and shall have such duties and responsibilities as the Chair or the Board of Directors shall from time to time determine. The Vice Chair shall assume the duties of the Chair in the absence or disability of the Chair.

7.4. **Secretary**. The Secretary shall issue or cause to be issued all notices required by law or these bylaws. The Secretary shall keep (or cause to be kept) minutes of the proceedings of the meetings of the Corporation and of the Board, and shall ensure that all records and reports of the Corporation and of the Board shall be retained. In addition, the Secretary shall perform such other duties as may be assigned to him or her by the Board, the Chair or the Member.

7.5. **Treasurer**. The Treasurer shall ensure that timely and accurate financial information is presented to the Board, and that financial records are maintained and available for inspection by any director or the Member of the Corporation. The Treasurer shall ensure that all reports and records required by law regarding the Corporation's financial status are submitted or retained as required. The Treasurer generally shall cause to be performed all acts incident to the office of Treasurer and shall oversee such further duties as may from time to time be assigned to him or her by the Board, the Chair, or the Member.

7.6. **Removal of Officers**. Subject to the approval of the Member, any officer of the Corporation may be removed at any time with or without cause by the affirmative vote of a

majority of all directors then serving, but without prejudice to such officer's contract rights, if any, provided written notice of such action shall have been sent to all directors at least seven (7) days before said meeting.

ARTICLE VIII. GENERAL PROVISIONS

8.1. **Gender**. All references in these bylaws to the masculine, feminine or neuter gender shall be deemed to apply equally to one or more of such gender-specific references as may be appropriate.

8.2. **Fiscal Year**. The fiscal year of the Corporation shall be determined by the Board.

8.3. **Waiver of Notice**. Written waiver signed at any time by the Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any Member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the Member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

8.4. **Written Notice and Signature**. Any written notice required hereunder may, without limitation, be issued by regular mail, certified mail, hand delivery, electronic means or facsimile and shall be deemed given when sent. Any written signature required under these bylaws or the Corporation's certificate of incorporation or by Connecticut law may be evidenced by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

8.5. **Conflict of Interest Policy**. The Corporation's officers and directors shall adhere to the conflict of interest policy adopted by the Member, as the same may be amended from time to time.

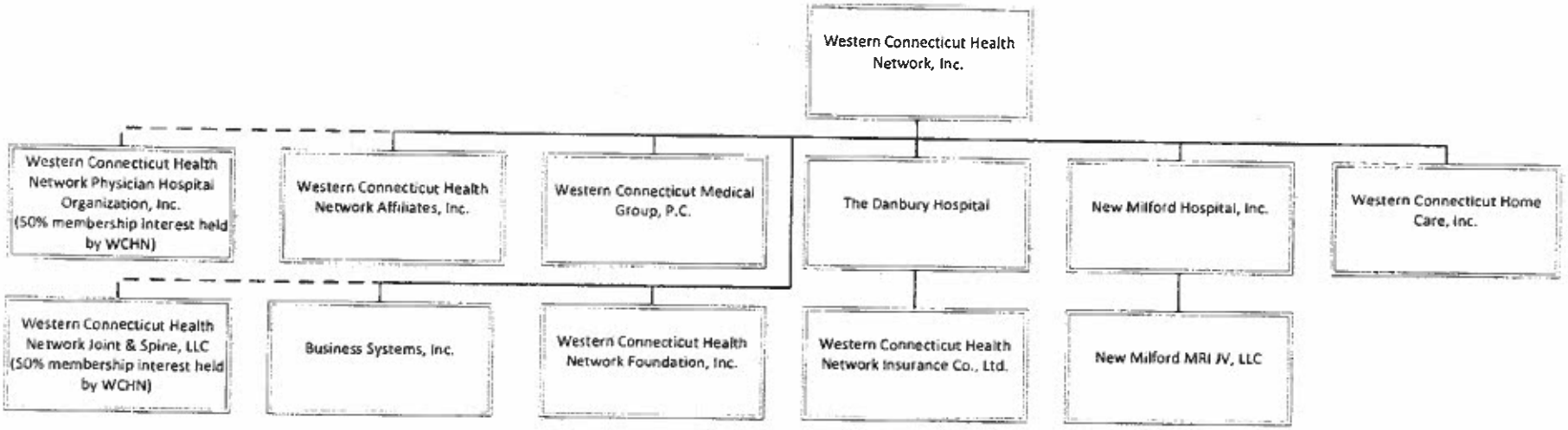
8.6. **Amendment**. These bylaws may be amended by the Member.

8.7. **Effective Date**. The effective date (the "Effective Date") of these bylaws shall be the last to occur of the date upon which (i) these bylaws are approved by the Board, (ii) these bylaws are approved by the Corporation's Member, and (ii) the "Closing Date" of that certain Affiliation Agreement, dated [ ], by and between the Corporation' Member and Western Connecticut Health Network, Inc. (the "Affiliation Agreement"), as the term is defined in Section 1.2 of the Affiliation Agreement.

Amended and restated as of _____ __, 2013.

EXHIBIT C
Pre-Closing and Post-Closing Organizational Structure

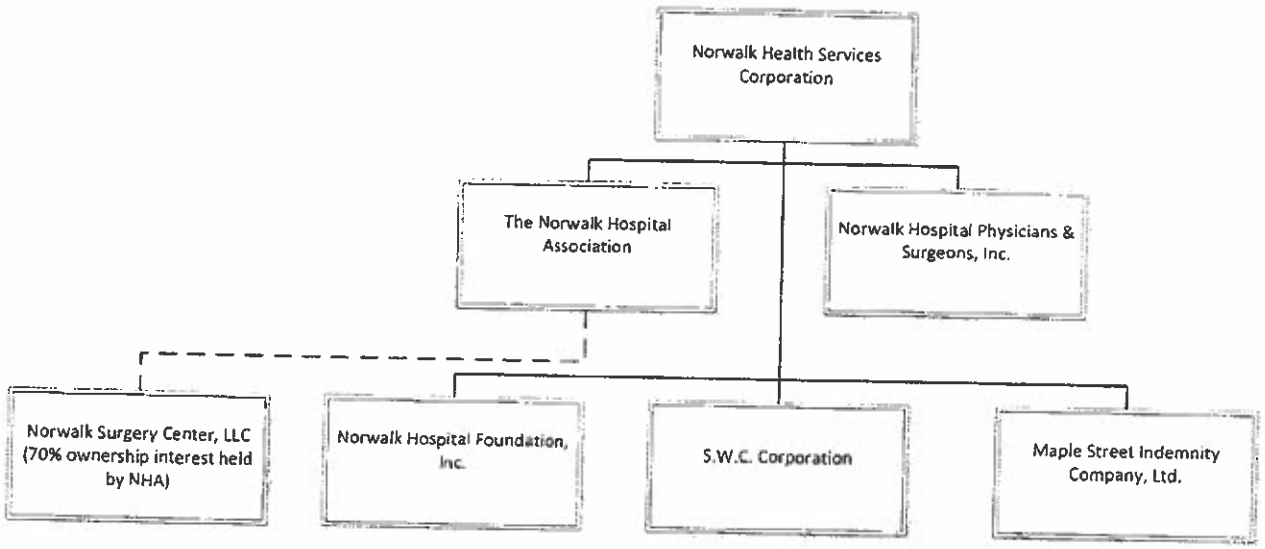
WCHN Pre-Closing



06/13/2013

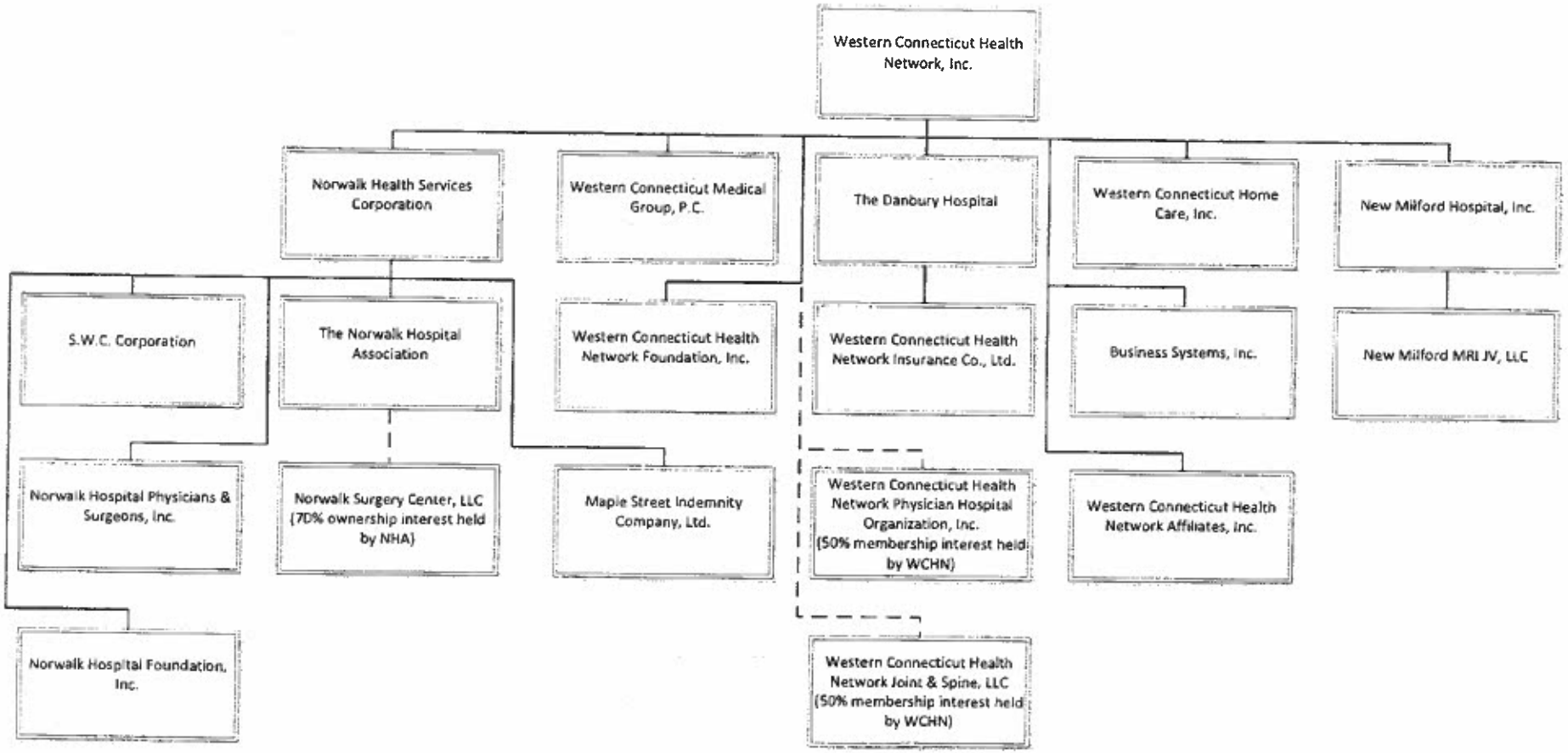
Affiliation CON-365

NHSC Pre-Closing



06/13/2013
Affiliation CON-366

WCHN Post-Closing



06/13/2013

Affiliation CON-367

SCHEDULE 1(a)
NHSC Affiliates

- Norwalk Health Services Corporation
- The Norwalk Hospital Association
- Norwalk Hospital Physicians & Surgeons, Inc.
- Norwalk Hospital Foundation, Inc.
- S.W.C. Corporation
- Maple Street Indemnity Company, Ltd.
- Norwalk Surgery Center, LLC (70% ownership interest held by NHA)

SCHEDULE 1(b)
WCHN Affiliates

- Western Connecticut Health Network, Inc.
- The Danbury Hospital
- New Milford Hospital, Inc.
- Western Connecticut Health Network Affiliates, Inc.
- Western Connecticut Medical Group, P.C.
- Western Connecticut Home Care, Inc.
- Western Connecticut Health Network Foundation, Inc.
- Western Connecticut Health Network Insurance Co., Ltd.
- New Milford MRI JV, LLC
- Business Systems, Inc.
- Western Connecticut Health Network Physician Hospital Organization, Inc. (50% membership interest held by WCHN)
- Western Connecticut Health Network Joint & Spine, LLC (50% membership interest held by WCHN)

SCHEDULE 4.4
Government Filings and Approvals

1. Hart-Scott-Rodino Pre-Merger Notification Filing with the U.S. Department of Justice and the U.S. Federal Trade Commission and subsequent clearance
2. State of Connecticut Office of Health Care Access Certificate of Need Application and approval
3. State of Connecticut Department of Public Health hospital license notice (post-closing)
4. Clinical Laboratory Improvements Act notice to State of Connecticut Department of Public Health
5. Change of Information Notice to the Centers for Medicare and Medicaid Services (post-closing)
6. Nuclear Regulatory Commission notice (post-closing)
7. Federal Drug Enforcement Agency notice (post-closing)
8. Registration number notice to State of Connecticut Department of Consumer Protection, Drug Control Division (post-closing)
9. State of Connecticut Office of Attorney General antitrust notice
10. Notice to Electronic Data Systems on behalf of Connecticut Department of Social Services (post-closing)
11. State of Connecticut Department of Environmental Protection Transfer Act form(s), as appropriate, with Norwalk as the certifying party, pursuant to Conn. Gen. Stat. §22a-134 et seq. (post-closing)

SCHEDULE 4.5
Non-Governmental Consents

None

SCHEDULE 4.12
Revisions to Restated Governing Documents

I. **Revision to NHSC Bylaws.** The reference in Section 3.2 to the President and CEO of Norwalk Hospital Foundation, Inc. shall be changed to the Chairman of the Board of Norwalk Hospital Foundation, Inc.

II. **Revision to NHA Bylaws.** The reference in Section 3.2 to the President and CEO of Norwalk Hospital Foundation, Inc. shall be changed to the Chairman of the Board of Norwalk Hospital Foundation, Inc.

III. **Revision to WCHN Bylaws.**

1. Section 4.1 shall be amended to provide that non-Board members may be appointed to any committee but without vote.

2. Section 4.1 shall be amended to provide that there shall be an equitable distribution of DH/NMH Directors (as defined in the WCHN Bylaws) and NHA Directors (as defined in the WCHN Bylaws) appointed to each of the six committees listed in Section 4.1

3. Section 4.4 shall be amended to provide that the Executive Compensation Committee shall consist of the Chair, Vice-Chair and at least three (3) other directors.

4. Section 4.4 shall be amended to reflect the fact that the Executive Compensation Committee shall advise the Board not only on executive compensation strategies and policies but also on executive benefit strategies and policies.

SCHEDULE 7.2(g)
WCHN Labor Agreements

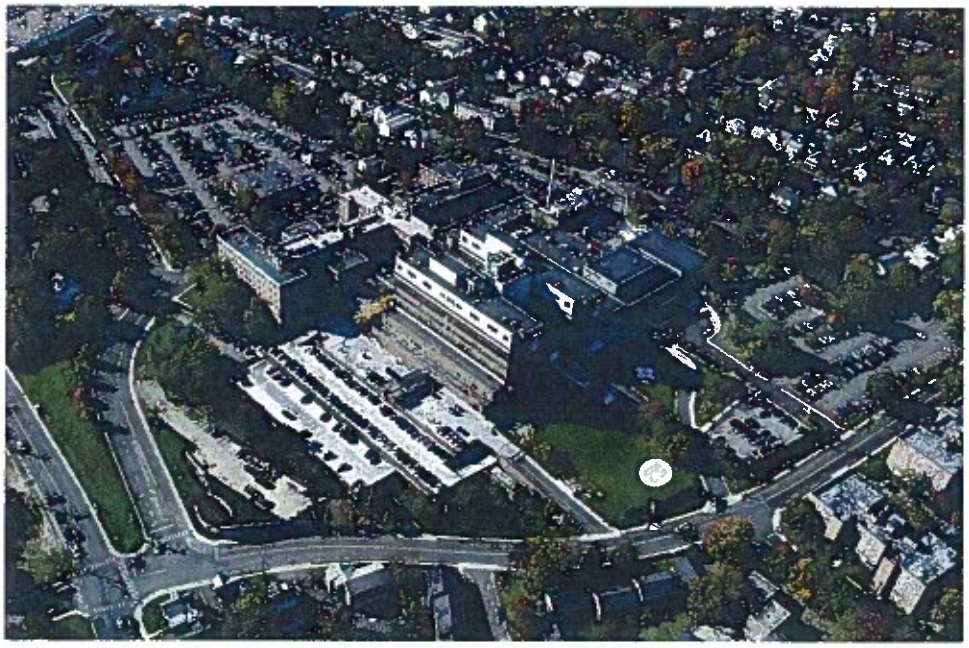
1. Agreement by and between The Danbury Hospital and Danbury Nurses Union Unit #47, Local #5047, AFTCT, AFT Healthcare, AFL-CIO, dated August 22, 2011.
2. Agreement by and between New Milford Hospital, Inc. and the New Milford Hospital Federation of Registered Nurses, AFT-Connecticut, AFT-Healthcare, American Federation of Teachers (AFT), AFL-CIO, dated January 1, 2012.

SCHEDULE 7.3(g)
NHSC Labor Unions

1. Collective Bargaining Agreement by and between The Norwalk Hospital Association and Registered Professional Nurses Local Unit #23, Connecticut Health Care Associates, National Union of Hospital & Health Care Employees, AFSCME, AFL-CIO, dated August 1, 2012

EXHIBIT B

Vision 2015



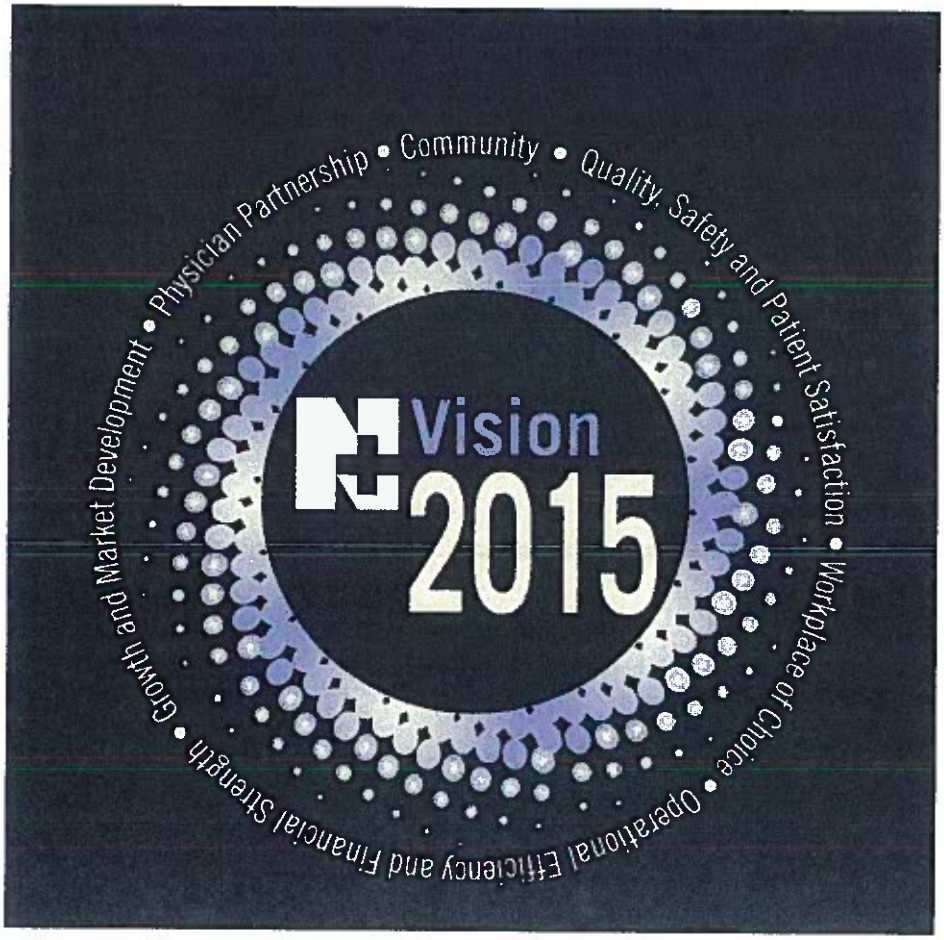
Norwalk Hospital Strategic Plan 2010-2015

APPROVED BY BOARD OF TRUSTEES
AUGUST 25, 2009

Norwalk Hospital
Compassion. Expertise. Results.

Norwalk Hospital
Strategic Plan: Vision 2015

Table of Contents **Page**



Approved by SPC August 5, 2009
Approved by BOT August 25, 2009

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Norwalk Hospital
Strategic Plan: Vision 2015

Introduction

Norwalk Hospital has a long history of meeting the healthcare needs of the residents of southern Fairfield County and surrounding communities. To continue the tradition of successfully providing quality, accessible healthcare services in a continuously changing environment, the leadership of the Hospital utilizes a strategic planning process that establishes a vision for the future, formulates strategies to achieve the vision, and measures and monitors outcomes to ensure progress in achieving defined goals.

The **Strategic Plan: Vision 2015** identifies the organization's strategic direction for 2010 through 2015. It builds upon the framework set forth in the Strategic Plan 2006-2009 and extends the organizational vision and goals further into the future. These high level goals will serve to guide Norwalk Hospital's strategic decisions and priorities.

Vision 2015 was formulated through a rigorous planning process guided by the Strategic Planning Committee of the Board of Trustees. With participation of the medical staff members, Board representatives and management, the Committee assessed the Hospital's competitive position as well as environmental factors influencing the future of healthcare to formulate strategic imperatives for the organization for the next five years.

The plan includes an update of the Hospital's statements of purpose, including the Mission Statement and Values, as well as an overarching aspirational goal for the organization in the Vision. Service line priorities are established in the articulation of Signature Services. The communities served by the Hospital have been defined in the Primary and Secondary Service Areas. In addition, areas of focus essential to achieving the vision have been identified as Strategic Imperatives.

Internal and external environmental conditions may lead to the refinement of Vision 2015 over time. However, the vision set forth in this plan will serve as a roadmap for organizational planning and prioritization. Through continued rigor and discipline, plans for Signature Services, community-specific plans, and annual strategic initiatives will be framed by the goals set forth in Vision 2015.

Norwalk Hospital
Strategic Plan: Vision 2015

Statements of Purpose

Mission

The mission of Norwalk Hospital is to provide uniquely excellent, innovative, and compassionate health care with exceptional outcomes.

Vision

Norwalk Hospital will be the hospital of choice for patients, physicians and healthcare professionals, recognized for delivering innovative clinical services with compassion.

Values

Norwalk Hospital is guided by these values:

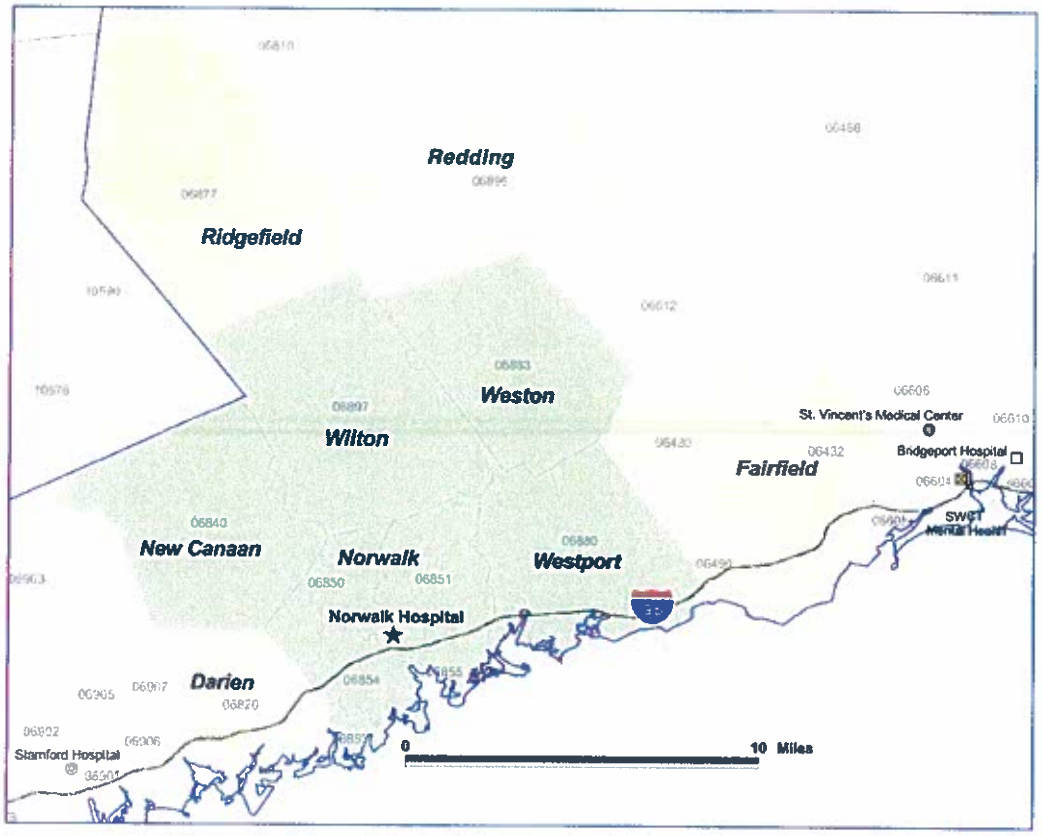
- **Patient-Centered** – honoring each individual's dignity, privacy and confidentiality; empowering patients and their families as partners in their care; facilitating simple, convenient ways for patients and their families to use our programs and services.
- **Excellence** – setting the highest standards for safety, clinical outcomes and personal service, and continuously measuring, monitoring and raising those standards.
- **Innovation** – continuously pioneering new and better ways to deliver care, research and prevention of illness.
- **Leadership** – attracting and developing throughout the organization, people who are recognized as exceptional leaders and who subscribe to these values.
- **Teamwork** – working together to achieve our mission and goals in a cooperative, respectful, open environment.
- **Trust and Fairness** – fostering a climate of openness in which all who work here treat one another with trust and fairness; supporting open communication to enhance this climate.
- **Education** – providing nationally recognized medical educational programs for future providers; participating in clinical research, and offering a range of educational programs to our patients and the community to enhance their health and well-being.
- **Financial Responsibility** – being accountable as financial stewards for constant improvement in the efficiency and effectiveness of service delivery; coordinating the services of Norwalk Hospital with those of other health, education and social services in the community (e.g. long-term care facilities, community outreach, health promotion/illness prevention organizations, etc) in order to optimize the availability of a full scope of services in a cost-effective manner.
- **Charity** – as a not-for-profit organization, providing needed medical care to all, including those who cannot pay for it.
- **Transparency** – Providing our community with reliable quality and cost information about our services, providers, and outcomes to empower informed decision making.

Norwalk Hospital
Strategic Plan: Vision 2015

Service Area

Norwalk Hospital serves a large and diverse population of approximately 272,000 in the primary and secondary service areas. The primary service area is defined as those communities in which Norwalk Hospital is a leader in market share and from which derive 80 percent of patient volume is derived. The secondary service area is a newly defined focus, and includes communities where the hospital has a noteworthy market or geographic presence, and opportunity to develop the market.

Primary Service Area (PSA)	
Community	Zip Codes
Norwalk	06850, 06851, 06852, 06853, 06854, 06855,06856,06857
Westport	06880, 06881
Weston	06883
Wilton	06897
New Canaan	06840, 06842
Secondary Service Area (SSA)	
Fairfield	06824, 06825, 06838, 06890
Ridgefield	06877
Darien	06820
Redding	06896, 06829, 06875, 06876



Approved by SPC August 5, 2009
Approved by BOT August 25, 2009

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Strategic Plan: Vision 2015

Signature Services

Service Line Priorities

Norwalk Hospital will continue to meet national standards for care in the full range of services expected from community hospitals, but will commit resources and priorities to developing a focus on key service lines which offer opportunities for market development and differentiation and are a hospital strength or patient point of entry.

Six service lines have been selected as the Signature Services of Norwalk Hospital:

- Cancer Services
- Cardiovascular Services
- Emergency Services
- Digestive Disease Services
- Ortho-Neuro-Spine Services
- Women's & Children's Services

Cancer Services and Cardiovascular Services demonstrate to the community the hospital's readiness and commitment to care for patients in life-altering and life-threatening situations. Emergency Services and Women's & Children's Services are key access points to the hospital – often a patient's first experience with hospitalization. And Ortho-Neuro-Spine Services and Digestive Disease Services will increasingly be in demand with the aging of the population in the communities served by Norwalk Hospital. These services also generate financial results that support other hospital services.

Norwalk Hospital
Strategic Plan: Vision 2015

Vision 2015 Strategic Imperatives

Intended to guide Norwalk Hospital for the next five years, the Strategic Imperatives identified in Vision 2015 build on those identified in the Strategic Plan 2006-2009 and expand into two new areas. Each year, these goals and strategies will be the basis for Strategic Initiatives crucial to the long-term success of Norwalk Hospital.

Vision 2015 Strategic Imperatives	
Quality, Safety and Patient Satisfaction	To achieve excellent medical outcomes, patient safety, and patient satisfaction.
Workplace of Choice	To attract and retain the "best of the best" health care professionals and hospital staff.
Operational Efficiency and Financial Strength	To achieve operational and financial results consistent with top hospital performers.
Growth and Market Development	To be the clear market leader in meeting the evolving healthcare needs of the community.
Care Integration	To be the hospital of choice for physicians by providing quality patient care in an efficient practice setting.
Community	To partner with the communities we serve to promote health and well-being through outreach in prevention, education, and screenings.

Norwalk Hospital
Strategic Plan: Vision 2015

Vision 2015 Strategic Imperatives and Goals

Quality, Safety, & Patient Satisfaction

- **To achieve excellent medical outcomes, patient safety, and patient satisfaction**
  - Achieve the highest level of results in national clinical quality measures and initiatives.
  - Continually assess methods for improving patient safety and implement those that result in superior patient outcomes.
  - Achieve 90th percentile in all areas of patient satisfaction surveyed.
  - Be a recognized leader in application of IT and other advanced quality technologies to ensure patient safety and adherence to evidence-driven patient care practices.
  - Achieve transparency and recognition in outcomes reporting.
  - Attain Magnet Hospital designation.

Operational Efficiency & Financial Strength

- **To achieve operational and financial results consistent with top hospital performers**
  - Attain operational outcomes consistent with top performance benchmarks.
  - Generate financial ratios and conditions consistent with A-minus rated or better healthcare organizations.
  - Attract significant philanthropic funds as a major source of support for program development and capital projects.
  - Be diligent in protecting and preserving the environment and in the application of "green" technologies as we move forward.
  - Assess emerging methods of health care delivery and implement those that benefit our mission.

Workplace of Choice

- To attract and retain the "best of the best" health care professionals and hospital staff
  - Provide education, training, and professional development programs to support patient care initiatives and hospital performance, and to attract and retain healthcare professionals.
  - Achieve employee engagement at the 90th percentile.
  - Achieve turnover rates, vacancy rates and other key metrics that exceed industry best practices.
  - Be recognized as a top employer by external experts.
  - Develop a sustained culture of service excellence which supports and values positive human interactions among staff and patients.
  - Demonstrate ethical behavior, corporate compliance and personal integrity in all organizational activities.

Norwalk Hospital
Strategic Plan: Vision 2015

Vision 2015 Strategic Imperatives and Goals

Growth & Market Development

- To be the clear market leader in meeting the evolving healthcare needs of the community
  - Provide healthcare services in state-of-the-art facilities that will meet the needs of our community.
    - Complete Phase I MFP – Ambulatory Pavilion.
    - Plan and develop the main Hospital campus.
    - Establish Ambulatory Services sites throughout the community.
  - Achieve consumer preference and be the recognized leader in market share in six Signature Services.*

Signature Service	Market Share Goal (%)	Consumer Preference Goal (%)
Cancer Services	65	35
Cardiovascular Services	70	25
Digestive Diseases	85	35
Emergency Services	85	45
Ortho-Neuro-Spine Service	75	35
Women's & Children's Services	70	35

*Targets are to be revisited as specific business plans are developed for Signature Service

  - Achieve improved patient access through enhanced technology and interactions.

Physician Partnership

- To be the hospital of choice for physicians by providing quality patient care in an efficient practice setting.
  - Coordinate the recruitment of physician resources sufficient to meet community needs and provide a range of practice options to appeal to a broad spectrum of physicians.
  - Strengthen the culture of respect and collaboration among the medical staff, and between the physicians and the hospital staff.
  - Achieve a seamless, integrated system of care which facilitates access for physicians and their patients.
  - Provide physicians with convenient access to health information needed to provide appropriate patient care.
  - Provide medical leadership which supports the Hospital's Signature Services.
  - Achieve physician satisfaction at the 90th percentile.

Norwalk Hospital
Strategic Plan: Vision 2015

Vision 2015 Strategic Imperatives and Goals

Community

- To partner with the communities we serve to promote health and well-being through outreach in prevention, education, and screenings
  - Serve as a key community source for health information by providing a wide range of educational, screening and illness prevention programs.
  - Collaborate with community leaders, government agencies, social service programs, and other healthcare organizations to provide needed healthcare services to the medically indigent residents of the community.
  - Develop tools to demonstrate the community benefit provided by the hospital services and programs.

EXHIBIT C

PROJECT ADVANCE

Board Discussion

March 27, 2012

THE CHARTIS GROUP
Management Consultants

Privileged and Confidential; Prepared for Counsel

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06/13/2013

Affiliation CON-387

Agenda

I. Context

II. Our Starting Point

III. Our Shared Vision and Key Initiatives to Achieve the Vision

IV. Financial Impact

V. Structure of the Proposed Relationship

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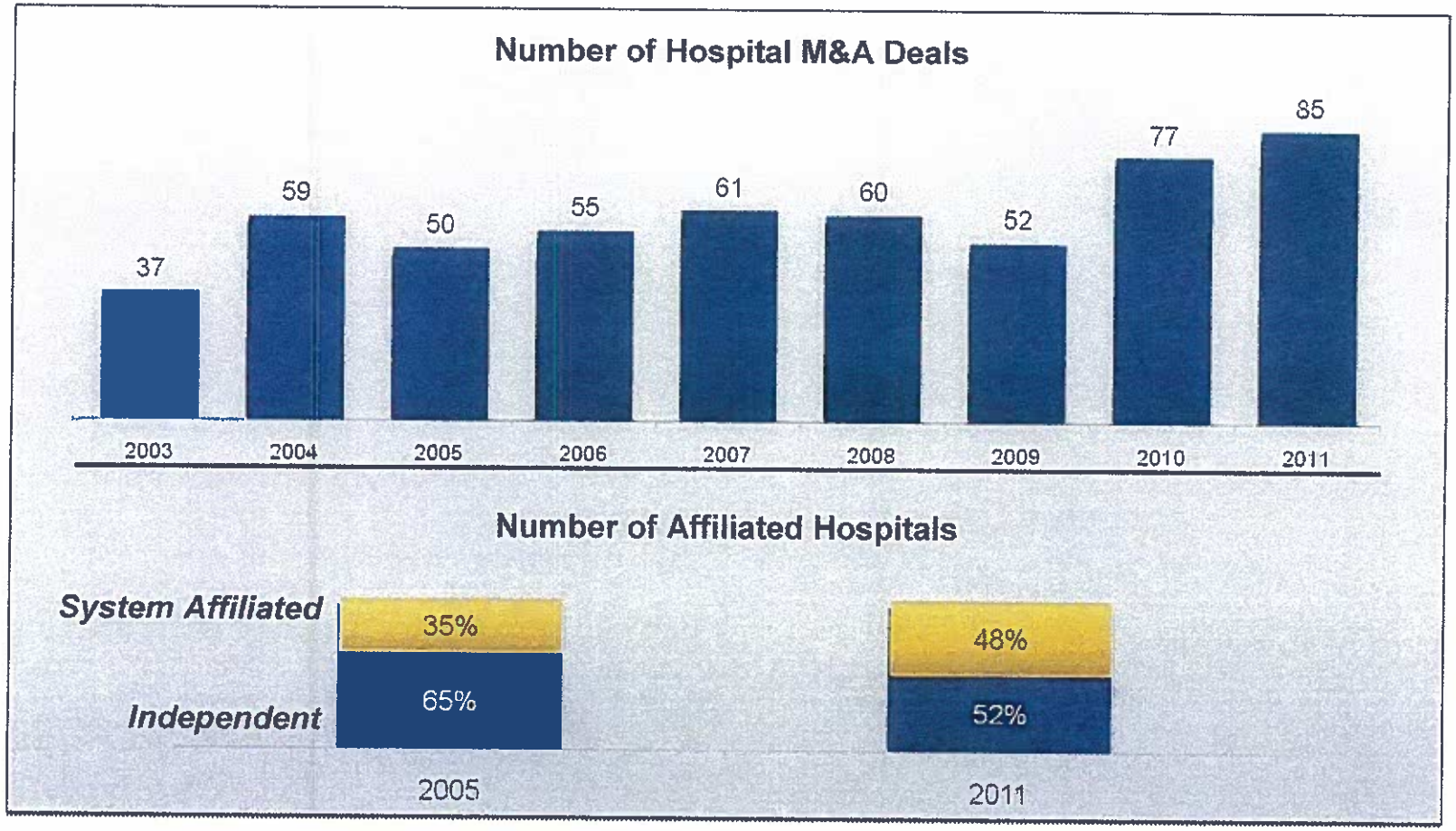
THE CHARTIS GROUP
Management Consultants

06/13/2013

Affiliation CON-388

I. Context: Hospital Consolidation is Occurring Rapidly

The health care industry is consolidating rapidly in response to a rapidly changing landscape.



Note: 2011 Figures are preliminary and will likely increase as annual filings are made.
Source: Medicare Cost Report Analysis, Irving Levin & Associates, The Healthcare M&A Monthly, January 2011, page 20.; Chartis Analysis.

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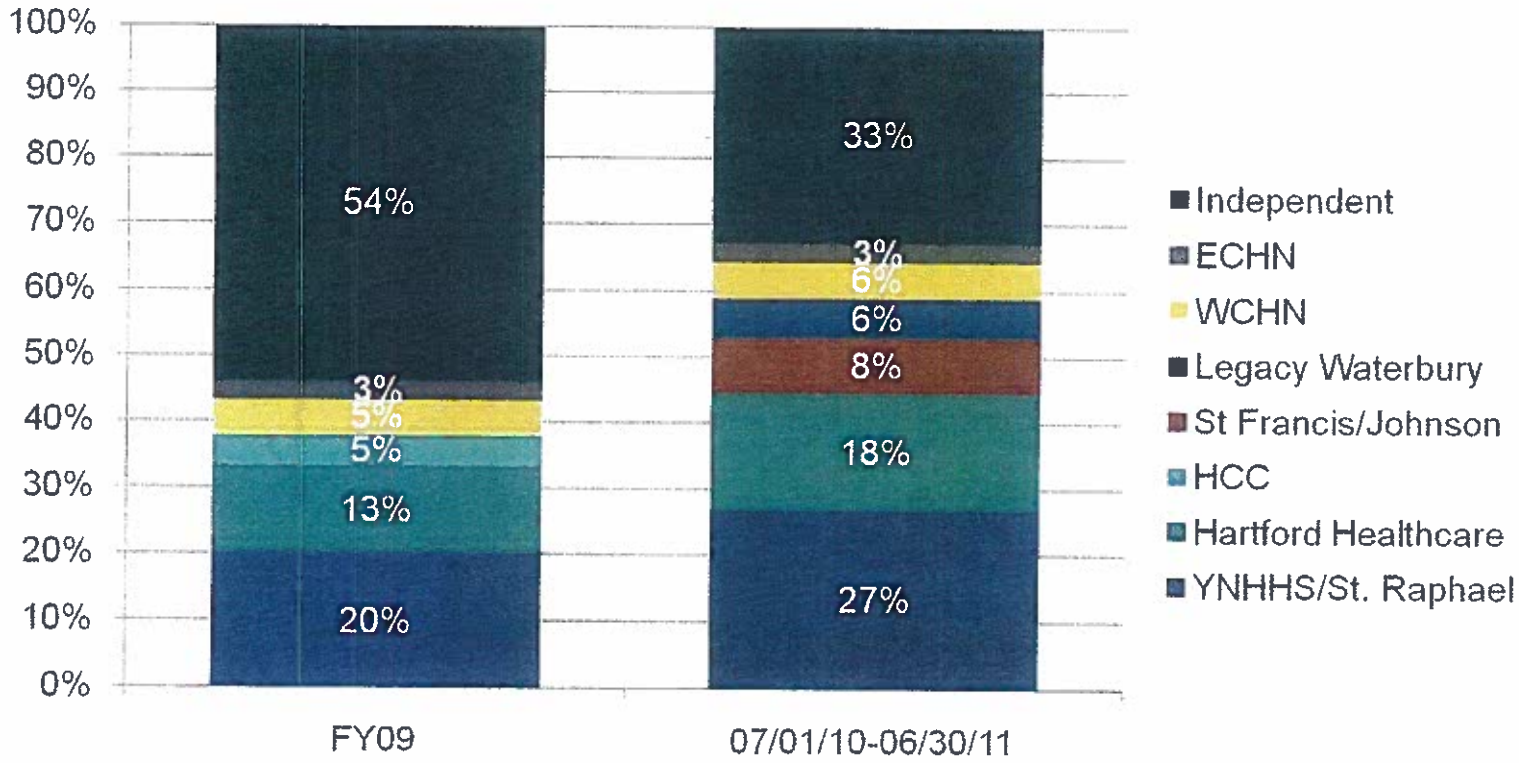
I. Context: Connecticut Provider Landscape Today

Further consolidation is likely as the remaining independent hospitals join systems and smaller systems combine.

Connecticut Discharges by System vs. Independent Hospital



Assumes the following pending relationships will be approved: St. Raphael's / YNHHS; St. Francis / Johnson Memorial; LHP acquisition of Waterbury/St. Mary's.

Source: Office of Connecticut Healthcare Access, Fiscal Year 2009; CHIME FY2010 Q3 – FY2011 Q2 (excl norm newborn).

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II. Overview: NHSC and WCHN Key Facilities

The combined entity accounts for 784 licensed beds, 35,428 discharges, and significant surgical capacity, with locations primarily along the Route 7 corridor…

Danbury Hospital
371 licensed beds
19,650 discharges,
92,953 days;
9 main ORs, 7 OP ORs,
9 procedure rooms

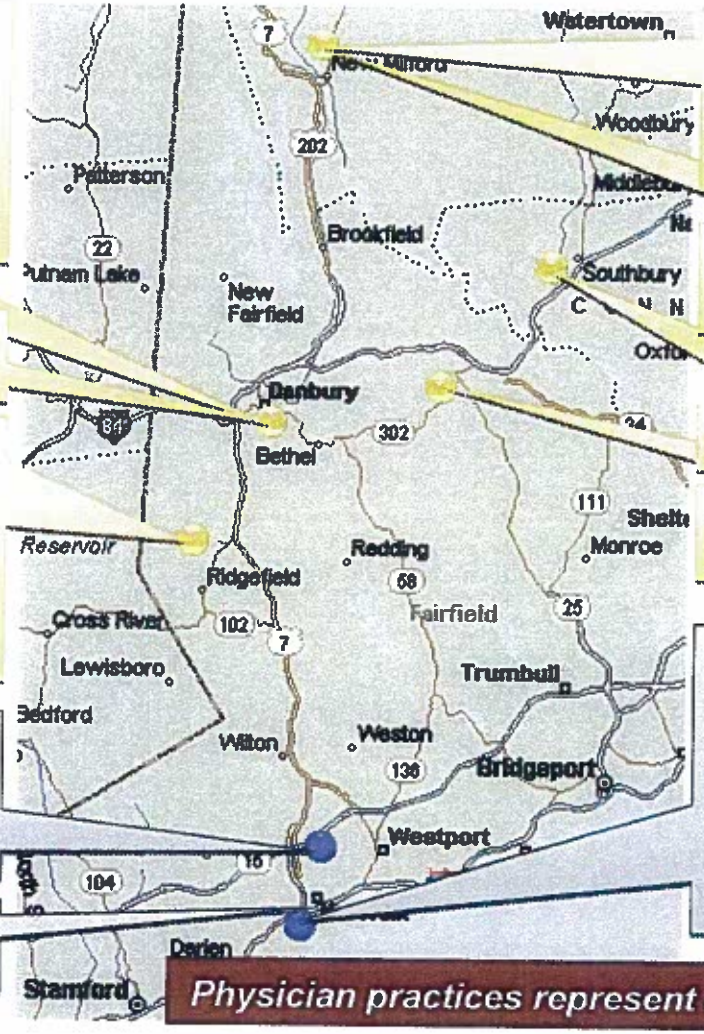
Danbury Diagnostic Imaging

Ridgefield Surgery Center
3 ORs, 1 procedure room (1 shell OR & 1 shell procedure room)

Ridgefield Diagnostic Imaging

Norwalk Surgery Center
(2 ORs; JV reopened 12/2011)

Norwalk Radiology and Mammography Center



New Milford Hospital
85 licensed beds
2,247 discharges, 8,630 days
4 ORs, 1 procedure room

New Milford Medical MRI (JV)

WCHN Sleep Lab

Newtown Diagnostic Imaging (under review)

Norwalk Hospital
328 licensed beds,
13,531 discharges,
65,690 days
10 ORs; 2 procedure rooms
Ambulatory Pavilion
(scheduled 2015)

Physician practices represent numerous additional sites.

Source: WCHN/NH Planning. CHIME FY2010 Q3 – FY2011 Q2 (excl norm newborn)

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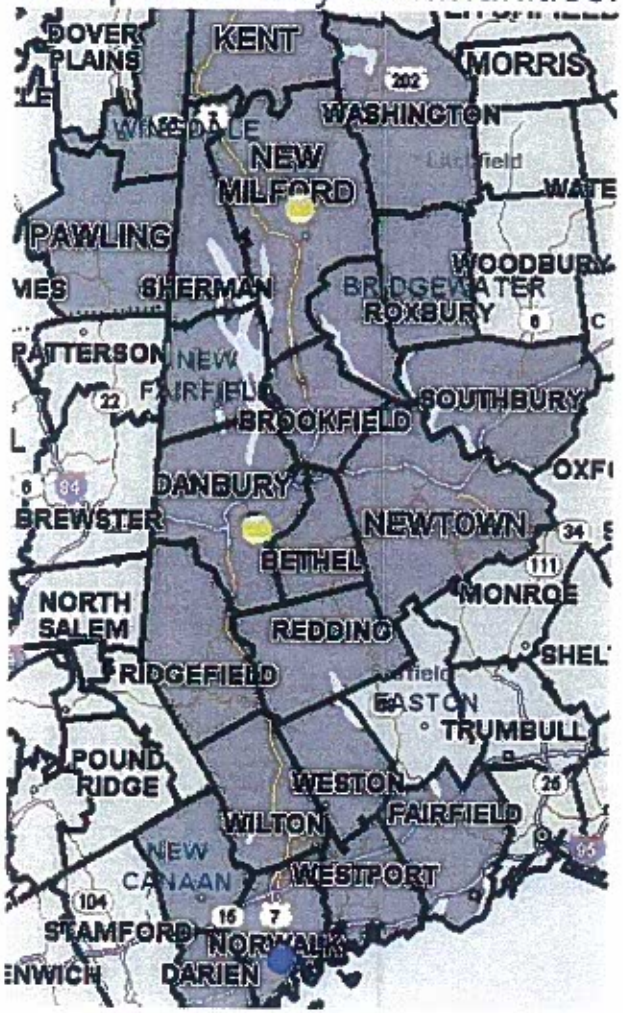
II. Overview: Community Overview

…and is positioned to serve complementary communities.



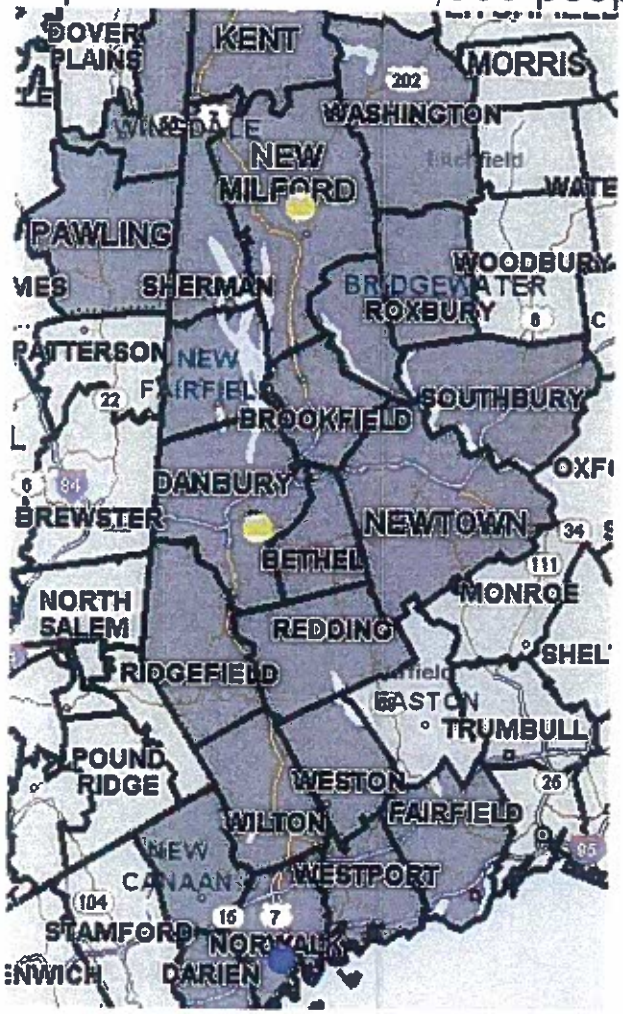
Town	WCHN Discharges	NH Discharges	WCHN + NH	Town Total Discharges
NORWALK	30	7440	7,470	9,730
DANBURY	7,441	32	7,473	7,844
FAIRFIELD	19	438	457	5,426
TRUMBULL	26	67	93	3,805
SOUTHBURY	1,171	9	1,180	2,505
NEW MILFORD	1,968	5	1,973	2,244
WESTPORT	13	1283	1,296	2,197
NEWTOWN	1,678	21	1,699	2,167
BETHEL	1,645	21	1,666	1,868
RIDGEFIELD	1,358	107	1,465	1,863
MONROE	42	38	80	1,473
BROOKFIELD	1,261	4	1,265	1,454
DARIEN	6	220	226	1,426
WILTON	60	913	973	1,410
NEW CANAAN	7	626	633	1,322
NEW FAIRFIELD	924	4	928	1,127
REDDING	517	159	676	861
PAWLING	169	1	170	733
WESTON	20	318	338	601
EASTON	3	28	31	529
WINGDALE	112		112	438
WASHINGTON	185	9	194	297
KENT	222		222	281
SHERMAN	179		179	237
ROXBURY	112		112	167
BRIDGEWATER	127	1	128	159
TOTAL	**19,295**	**11,744**	**31,039**	**52,164**

Source: CHIME, Hanys FY2010 Q3 – FY2011 Q2 (excl norm newborn); Claritas.
Note: Shaded areas represent 80% of discharges for 3 hospitals.

06/13/2013
Affiliation CON-392

II. Overview: Community Overview

The population of these communities represents over 540,000 people.



Town	2010 Population
NORWALK	82,688
DANBURY	79,076
FAIRFIELD	52,785
TRUMBULL	34,297
SOUTHBURY	20,255
NEW MILFORD	26,932
WESTPORT	27,544
NEWTOWN	15,568
BETHEL	18,227
RIDGEFIELD	24,384
MONROE	19,077
BROOKFIELD	17,148
DARIEN	20,523
WILTON	18,033
NEW CANAAN	20,178
NEW FAIRFIELD	14,154
REDDING	8,703
PAWLING	6,994
WESTON	10,405
EASTON	7,281
WINGDALE	4,559
WASHINGTON	2,995
KENT	2,966
SHERMAN	4,400
ROXBURY	2,311
BRIDGEWATER	1,924
TOTAL	**543,407**

Source: CHIME, Hanys FY2010 Q3 – FY2011 Q2 (excl norm newborn); Claritas.
Note: Shaded areas represent 80% of discharges for 3 hospitals.

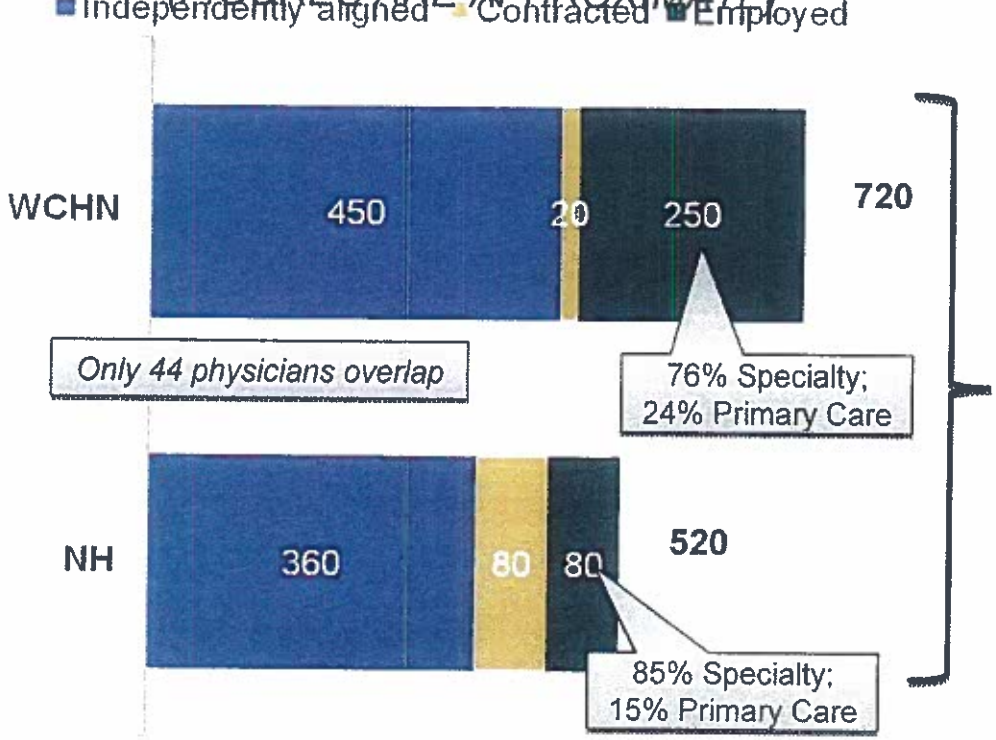
06/13/2013
Affiliation CON-393

II. Overview: WCHN and NHSC Physician Platforms

Integration creates a large physician platform with little overlap, including numerous independent physicians and a large employed medical group well-positioned to lead the region.

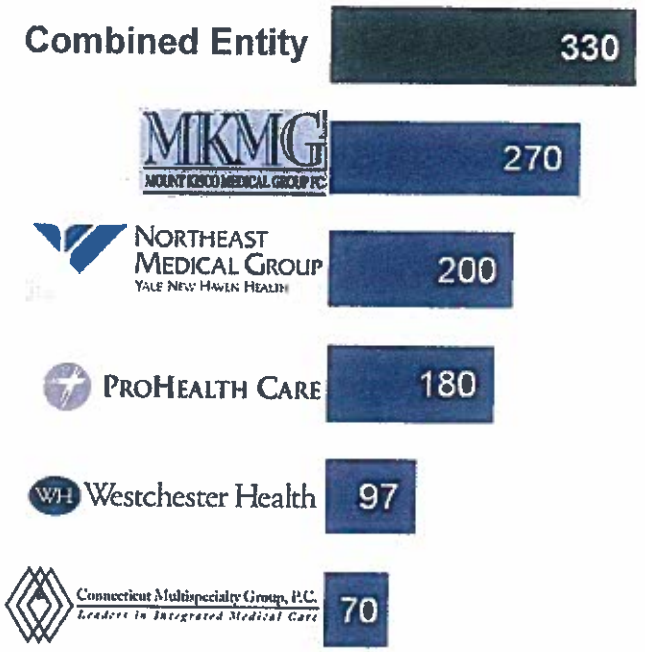
MEDICAL STAFF BY EMPLOYMENT STATUS

(FIGURES ARE APPROXIMATE)



MAJOR REGIONAL MEDICAL GROUPS

(FIGURES ARE APPROXIMATE)



Source: DH, NMH, and NH Medical Staff Rosters. Figures are approximate and represent number of physicians, not FTEs. Approximate size of other groups calculated off of medical group websites and Chartis research.

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Affiliation CON-394

II. Overview: WCHN and NHSC Education

Both organizations offer select GME programs, with over 160 combined residents and fellows, and maintain strategic educational relationships.

	Western Connecticut Health Network (Danbury Hospital · New Milford Hospital)	Norwalk Hospital (Compassion. Expertise. Results.)
Sponsored GME		
Residency Programs	Internal Medicine: 38 IM Primary Care: 11 filled (18 approved) Obstetrics & Gynecology: 12 Pathology (anatomic and clinical): 8 Surgery: 20 (15 + 2 preliminary + 3 in research year at UVM) Dentistry: 3	Internal Medicine (Yale affiliation): 46 Radiology- Diagnostic: 10
Fellowships	Cardiovascular Medicine: 6	Gastroenterology (Yale affiliation): 4 Pulmonary (Yale affiliation; Yale provides Critical Care training): 6 Sleep Medicine: 1 (2 approved)
Total Filled Positions	**98**	**67**
Other Programs		
Undergraduate Medical Education	University of Vermont College of Medicine, Ross	NY Medical College, St. George's, Rosalind Franklin (Chicago), University of Connecticut
Select Other Programs	Affiliate for NY Med College residency programs in Anesthesiology & Psychiatry	NH/Yale Surgical PA Program

© The Chartis Group, LLC Source: ACGME; Internal documents provided by Planning

06/13/2013

Affiliation CON-395

II. Overview: WCHN and NHSC Financial Metrics

The combined entity will have $1.1B in net revenue and $637.8M of net assets.

ORGANIZATIONAL FINANCIAL OUTLOOK

	WCHN*	NHSC	WCHN* + NHSC
Net Revenue[1]	$755.6M	$344.5M	$1,100.1M
Operating Margin[1]	3%	4%	**3%**
Total Margin[1]	4%	4%	**4%**
Net Assets[2]	$458.7M	$179.1M	**$637.8M**
Days Cash on Hand[2]	150	118	**140**
EBIDA[1]	$72.7M	$38.5M	**$111.2M**
Current Ratio[2]	3.7	2.5	**3.2**
Total Debt / Total Assets[2]	30%	15%	**25%**
Average Age of Plant[1,2]	9.2	13.4	**10.7**
Case Mix Index [3]	1.37	1.27	**1.33**
% Commercial[3]	38%	35%	**37%**

Sources:

(1) Income statements based on FY12 operating budgets

(2) Balance sheet for WCHN from audited FY2010 financial statements (adjusted for LT debt added in 2011) and unaudited FY 2011 NHSC financial statements.

(3) CMI and payer mix based on Connecticut CHIME data for 12 months ending June 30, 2011, excludes normal newborns.

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III. Vision for the Combined Organization

Our Shared Vision: Improve the community's health by delivering coordinated, effective care across the continuum

- **Consistently deliver the right care in the right place at the right time to achieve superior outcomes through a distributed, integrated network of facilities including:**
  - Regional referral centers at Norwalk Hospital and Danbury Hospital
  - Strong community hospitals, such as New Milford
  - Primary care and ambulatory care sites accessible to patients in key communities
- **Provide a consistent, seamless patient experience across all sites of care**
- **Engage and empower patients and their families as partners in their care**
- **Create an environment of continuous learning, discovery and innovation through medical education and research**
- **Engage leading physicians as partners in these efforts by:**
  - Building the region's leading multispecialty group practice with primary care and specialty sites accessible to patients in a broad geography
  - Aligning independent community-based primary and specialty care physicians
- **Be responsible stewards of the community's healthcare assets**

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III. Key Initiatives

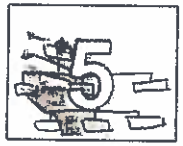
The key initiatives associated with integration are grouped into six primary areas.

Strengthen Clinical Programs and Improve Access

Enhance Educational Programs

Strengthen Physician Platform

Build Competencies Required for New Reimbursement Models



Integrate Operations to Achieve Savings and Create a Unified Operating Model

Improve Access to and/or Reduce Cost of Capital Due to System Scale and Performance

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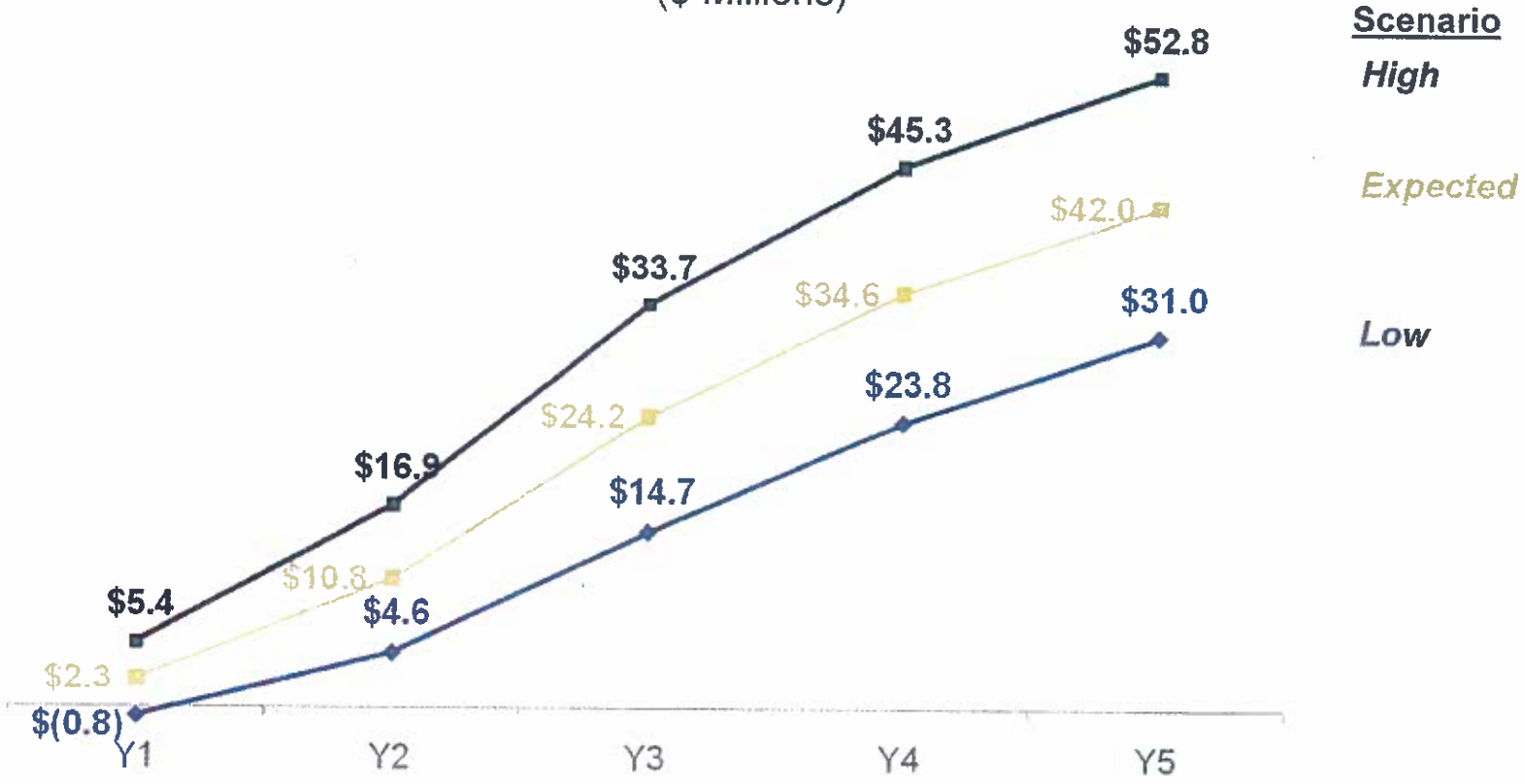
IV. Financial Impact of Integration

Together these initiatives represent an estimated $31 to $52.8 M in incremental improvements by year five, net of transaction and implementation costs.

Incremental Annual Net Impact: Low, Expected, High Scenarios
($ Millions)



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IV. Financial Impact of Integration

Projected Annual Impact of Integration, Expected Scenario ($ Millions)

Annual Financial Impact	Y1	Y2	Y3	Y4	Y5
Clinical Programs	$1.0	$2.0	$6.1	$10.0	$12.8
Education	$0.2	$0.3	$0.7	$0.7	$0.7
Operational Cost Savings (including Medical Group Administration)	$6.4	$13.3	$20.5	$25.2	$29.1
Net Operating Impact	**$7.6**	**$15.7**	**$27.3**	**$35.9**	**$42.5**
Costs associated with Integration	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**
Transaction Costs	($4.4)	($3.4)	($1.4)	($0.6)	($0.2)
IT Implementation	($0.9)	($1.5)	($1.7)	($0.7)	($0.4)
Cost of Integration	**($5.3)**	**($4.9)**	**($3.0)**	**($1.3)**	**($0.6)**
Net Impact	$2.3	$10.8	$24.2	$34.6	$42.0

Note: numbers may not add due to rounding

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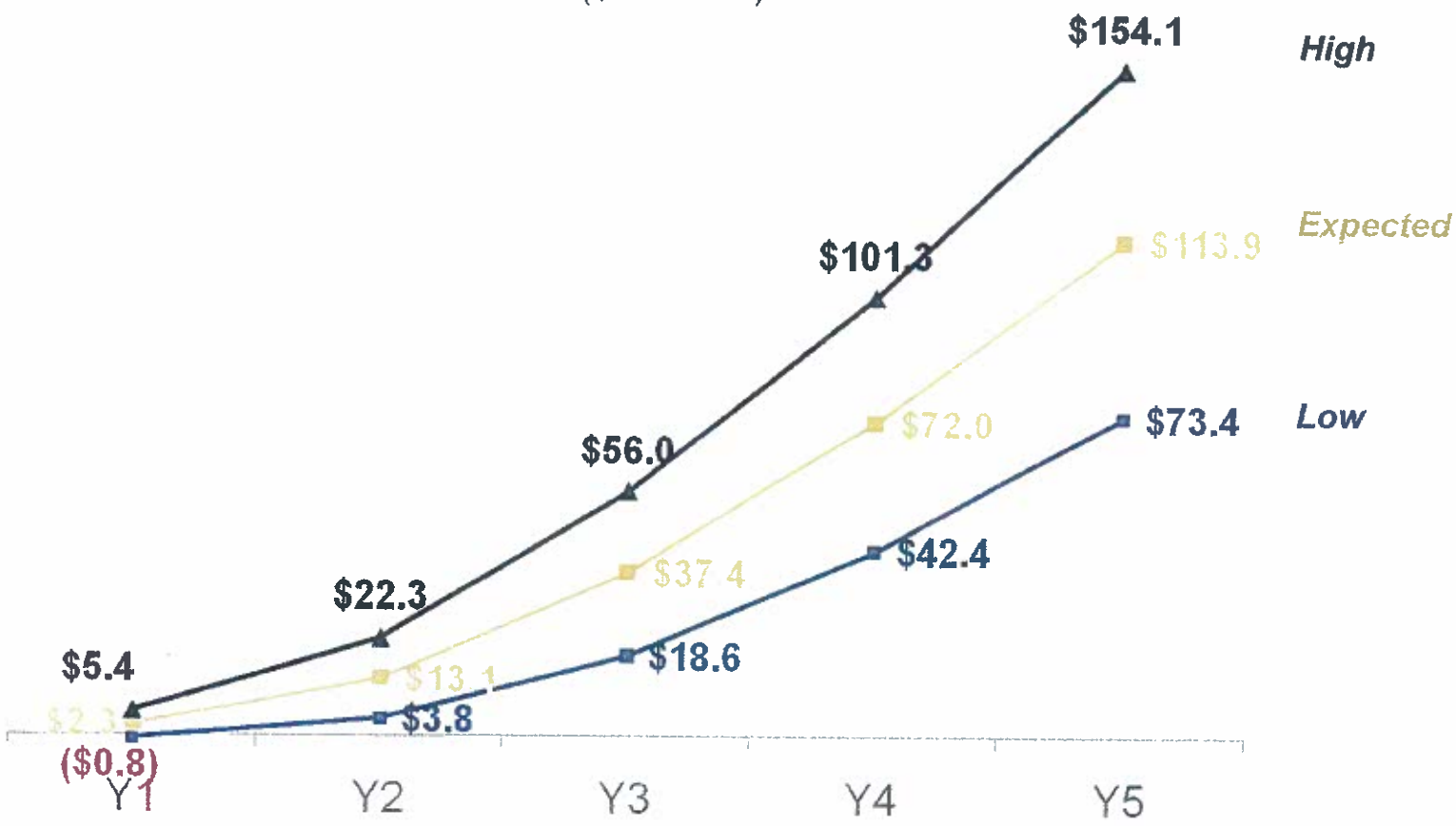
IV. Financial Impact of Integration

Cumulative net impact is projected to reach $73 to $154 M by the end of year five.

Cumulative Net Impact: Low, Expected, High Scenarios
($ Millions)



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IV. Key Initiatives: Improve Capital Access / Cost of Capital

The combined financial outlook suggests a stable to improved position in the near term, which should continue to improve as opportunities are achieved.

Our Performance vs. Fitch Median Ratios for Non-Profit Hospitals & Systems

* ***Combined Entity before revenue growth or savings***

Financial Metric	AA	AA-	A+	A	A-	BBB+	BBB	BBB-
Total Operating Revenue ($ Millions)	2245.3	1140.7	556.2	469.6	412.8	378.7	300.3	197.7
Operating Margin (%)	4.1	4.7	3.1	2.5	2.7	2.0	1.1	1.3
Days Cash on Hand	281.8	233.2	258.8	191.3	175.5	142.7	123.3	103.8
Debt to Capitalization (%)	31.9	36.3	34.7	35.6	49.7	50.2	44.9	50.8
Average Age of Plant (Years)	9.9	9.5	9.7	10.8	10.3	10.4	11.0	10.8

Source: Fitch 2011 Median Ratios for Non-Profit Hospitals and Health Systems

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Agenda

I. Context

II. Our Starting Point

III. Our Shared Vision and Key Initiatives to Achieve the Vision

IV. Financial Impact

V. Structure of the Proposed Relationship

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Affiliation CON-403

V. Governance Current State

Norwalk Health Services Corporation (Parent)

- *12-20-member board, including CEO and 2 med staff; actual=20*
- *Executive Committee=Chair, 2 Committee Chairs, Vice Chair, 1 at-large, CEO*
- *NHSC is corporate member of:*

Norwalk Hospital Association	• *Same as NHSC Board*
Maple Street Indemnity Company, Ltd. (Captive)	• *8 member Board: 3 NHSC, CEO, CFO, 1 physician, 2 Bermudian Representatives*
Norwalk Hospital Physicians & Surgeons	• *Medical Foundation: 8 member Board: 1 NHSC Board member, 5 physicians, NH CEO and CFO*
S.W.C. Corporation (2 Retail Pharmacies; taxable entity)	• *5 member Board: 4 NHSC, CEO*
Norwalk Hospital Foundation, Inc.	• *10-32 member Board of which 6 must be on NHSC Board including Chair & CEO*

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V. Governance Current State

Western Connecticut Health Network, Inc. (Parent)

- *50+ Members elect Board at annual meeting based on Governance Committee recommendations*
- *13-18 person board including at least 4 from NMH Community Board & WCHN CEO*
- *13 Board seats currently filled*
- *Requirement for 4 people from NMH Community Board until January 2014*
- *WCHN is corporate member of:*

New Milford Hospital, Inc.	• *10-18 person board; mirror board to parent* • *Community Board (no more than 12 members, includes member of the NMH Foundation; advisory)*
The Danbury Hospital	• *10-18 person board; mirror board to parent*
Western Connecticut Medical Group, P.C.	• *Transitioning to a Medical Foundation* • *Board will include physicians, executives, and WCHN Board members*
Business Systems, Inc. (1 Retail Pharmacy)	• 3 – 7 person board • 4 board seats currently filled (management board)
New Milford Hospital Foundation, Inc.	• Not less than 3 person board, 1 must be a director of WCHN • 5 board seats currently filled
Western Connecticut Health Network Foundation, Inc.	• Not less than 3 person board, 1 must be a director of WCHN • 15 board seats currently filled
Western Connecticut Health Affiliates, Inc.	• Not less than 3 person board, 1 must be a director of WCHN • 4 board seats currently filled
Western Connecticut Home Care, Inc.	• 10 – 18 person board, 1 must be a director of WCHN • 11 board seats currently filled

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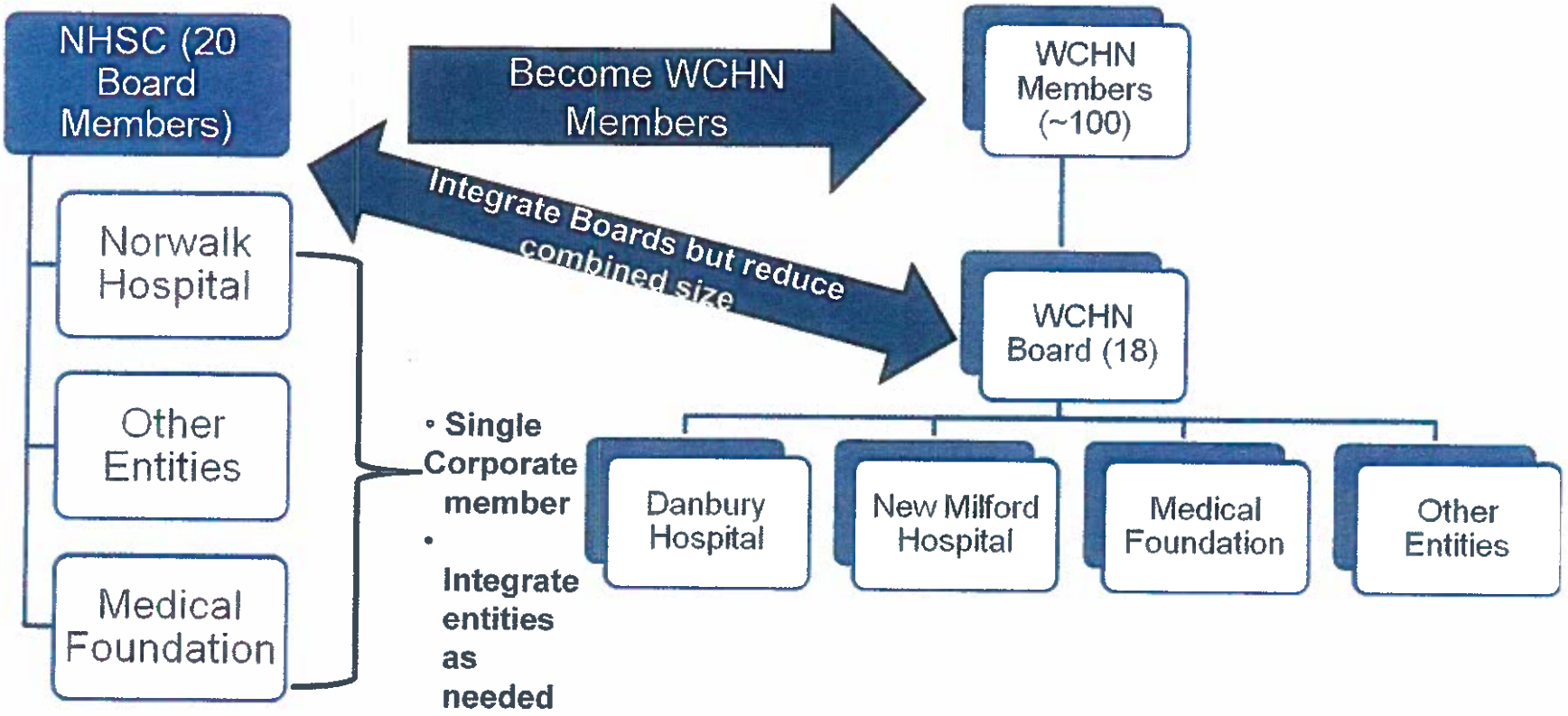
V. Potential Transaction Structure

All of the NHSC Board members could become WCHN 'members' and the WCHN and NHSC Boards would be integrated



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V. Key Transaction Elements

- Board Chair/Vice Chair
  - *The Chair of the Western Connecticut Health Network (WCHN) Board for the first two years after this transaction's closing will be the current Norwalk Health Services Corporation (NHSC) Board Chair*
  - *The Vice Chair of the WCHN Board will be the current WCHN Board Chair for the first two years*
- All members of the NHSC Board will be provided the opportunity to become members of the WCHN corporation
- Seven members of the NHSC Board will join the WCHN Board with the resulting WCHN Board composition summarized later in this document
- The terms of the seven NHSC Board members joining the WCHN Board will be staggered, but for the first ~~three~~ five years there will be at least 7 NHSC Board members on the WCHN Board
- Any existing NHSC Board member who is not on the WCHN Board will be provided the opportunity to be on a WCHN Board committee or on the Board of a WCHN subsidiary corporation
- The current CEO of WCHN will remain as WCHN CEO; the NSHC CEO will be the Executive Vice President of WCHN. The CFO will report to the Office of the President comprising the CEO and EVP

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V. Key Transaction Elements

- Certain WCHN decisions will require approval through a super-majority vote of the Board equal to 2/3 of the Board. This provision will last for the first five years after the closing of the transaction. Subjects requiring super-majority votes may include:
  - *Sale of Norwalk Hospital to a third party*
  - *Closure of Norwalk Hospital*
- Board representation by entity will be phased out within ~~three~~ five years of transaction closing; the goal in selecting future Board members will be to have a Board which represents the communities served by WCHN and has the skills required to govern an integrated health network
- The intention is for WCHN to form a single obligated group for debt purposes

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V. Key Transaction Elements

- There will continue to be a Norwalk Hospital Board as follows:
  - *The NH Board membership will include the 7 NHSC designees on the WCHN Board. The remaining members of the NH Board will be recommended by the NH Board members for approval by WCHN on an annual basis. The WCHN CEO and at least one additional WCHN Board member will be on the Norwalk Board. The current WCHN Board Chair will be the initial WCHN designee on the NH Board*
  - *The NH President will manage the NH Board.*
  - *The WCHN Board will have the authority to remove the NH Board members with a super-majority vote (defined as 2/3 of the WCHN Board) if it determines the NH Board is not functioning in the best interests of WCHN); after three years, the WCHN Board can remove NH Board members with a simple majority vote*
  - *In 3 years, the WCHN Board will review the need to maintain a Norwalk Hospital Board as described above. At that time, the WCHN Board can make itself the NH Board or modify the composition of the NH Board. The governance model selected for Norwalk at this time will be consistent across all WCHN hospitals*
- The Norwalk Hospital Board Committees will be integrated into the WCHN Board Committees

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V. System/Hospital Board Membership

The System/Hospital Boards will have the following composition assuming this transaction closes on or around January 2013

Organization	Current WCHN Board	January 2013 (or before)	January 2014
New Milford	4 (until Jan. 2014)	4	3
Danbury	8	7	7
CEO	1	1	1
Vacant	5	0	0
Norwalk		7	7
WCHN TOTAL	18	19	18

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Affiliation CON-410

V. Potential Roles of Norwalk Hospital Board

Norwalk Hospital Board Roles Delegated from WCHN Board

1. Review local quality and service goals and improvement programs within context of System goals and program and recommend changes to WCHN Board
2. Review annual operating and capital budgets to ensure conformance with strategy and objectives established by the Health System
3. Monitor local quality, service, and financial performance
4. Approve medical staff bylaws and medical staff appointments based on standardized System applications and review processes
5. Advise WCHN on search process for the Norwalk Hospital President at the time a new President needs to be found
6. Participate in and support local communications with external audiences, e.g., with local towns and media
7. Support fundraising efforts conducted by Foundation in local community
8. Oversee community benefit programs locally

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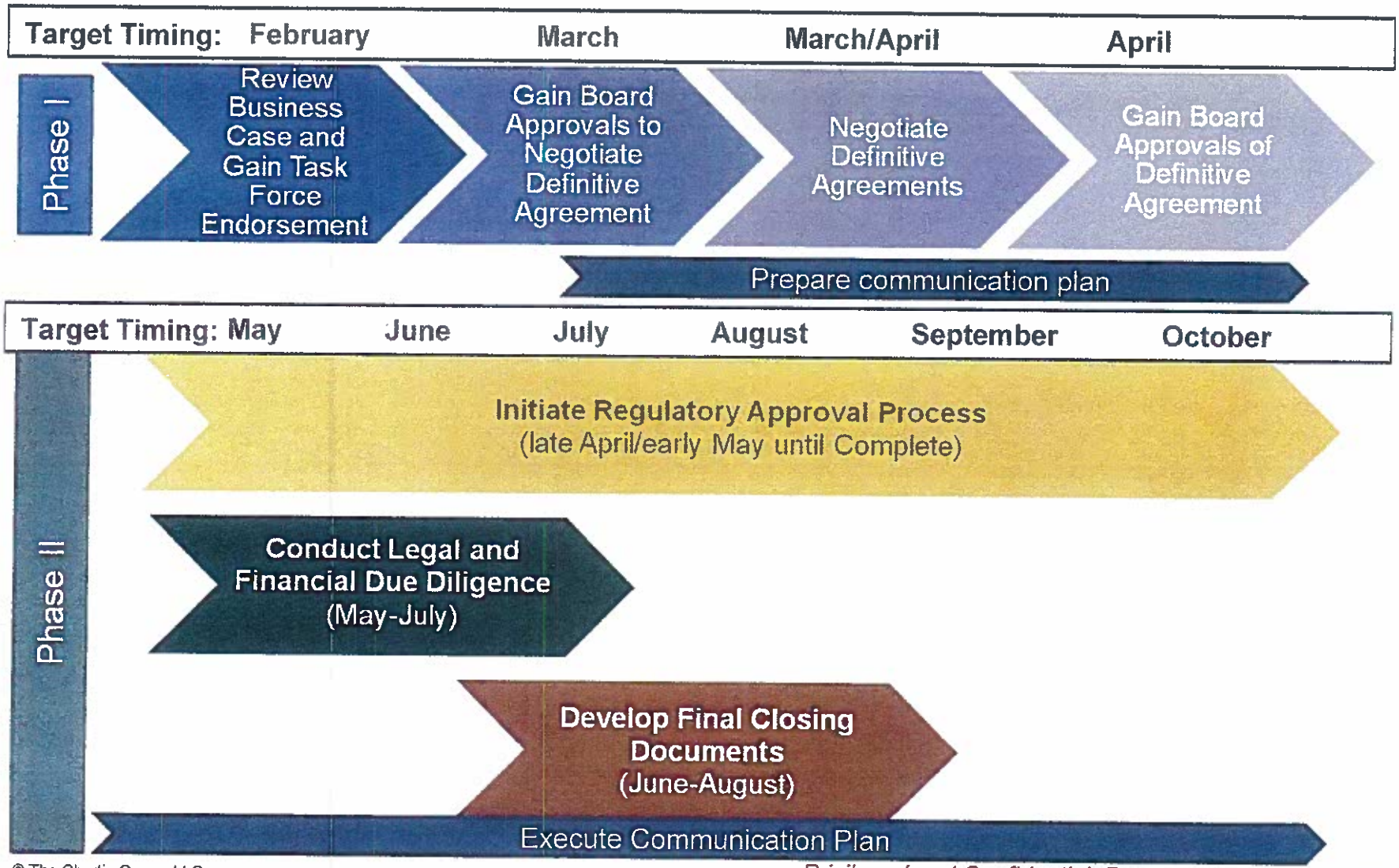
What might be the schedule and path forward from here?

Draft for Discussion: Process and Timeline



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Appendix: Alternative Board Models

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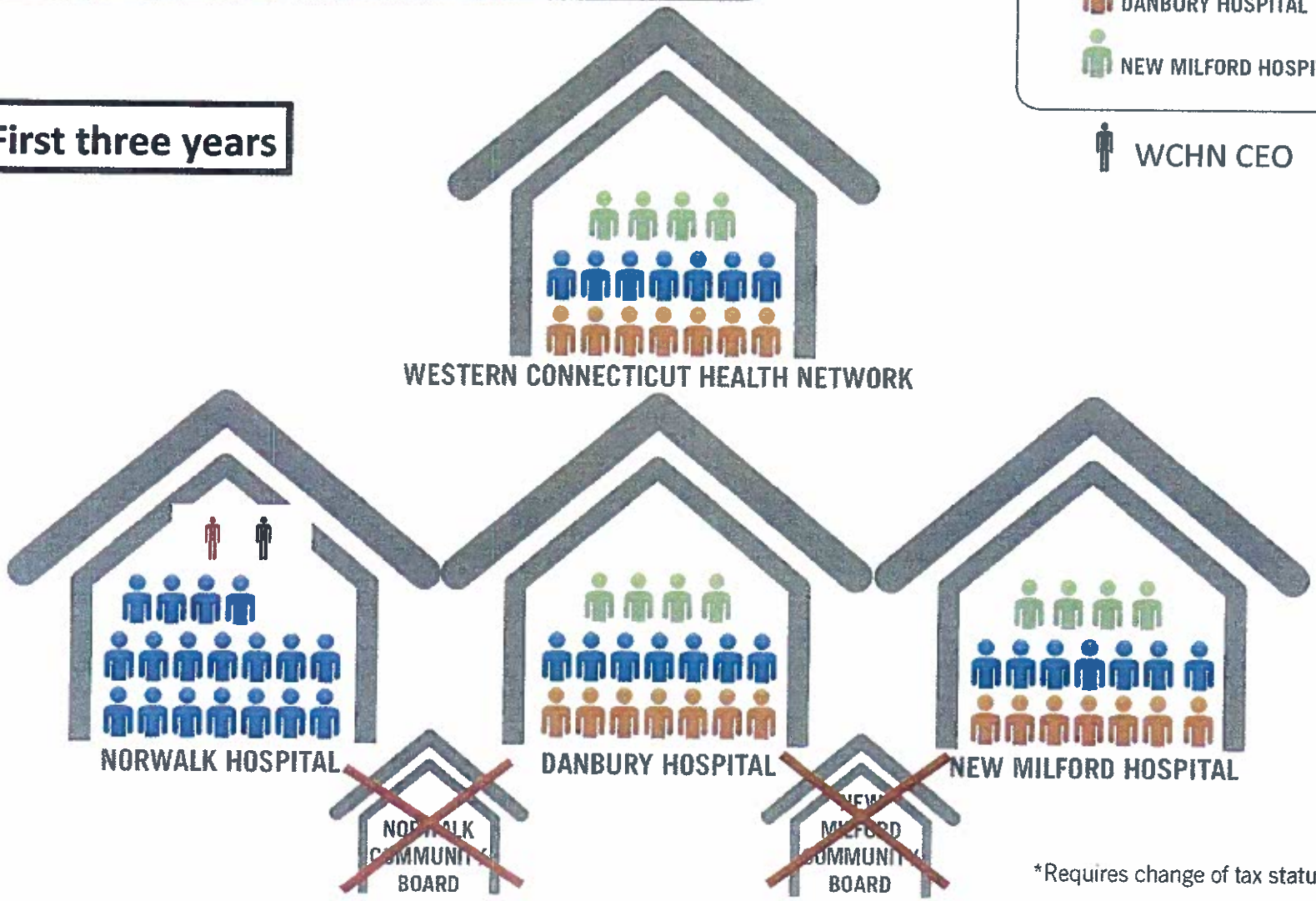
Governance Structure:
Norwalk Retains Its Board*

First three years



*Requires change of tax status.

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Affiliation CON-414

Governance Structure: **Mirror Boards**

Potential model year
4+

06/13/2013
Affiliation CON-415

EXHIBIT D

2012 Greater Norwalk Area Community Health Assessment and Improvement Initiative

December, 2012

Norwalk Hospital
Compassion. Expertise. Results.

Public Health
Prevent. Promote. Protect.
Norwalk Health Department

Table of Contents

GREATER NORWALK COMMUNITY HEALTH ASSESSMENT AND COMMUNITY HEALTH IMPROVEMENT PLAN

EXECUTIVE SUMMARY

Introduction

Improving the health of a community is essential to enhancing quality of life of residents in the region and supporting future social and economic well-being. The Greater Norwalk Area collaborative of Norwalk Hospital and Norwalk Health Department is leading a community health planning process to improve the health of residents in the Greater Norwalk Area. The health departments of New Canaan, Westport, Weston, Wilton, Darien, and Fairfield were also involved in this regional effort. This effort includes two phases: (1) a community health assessment (CHA) to identify the health-related needs and strengths of the Greater Norwalk Area and (2) a community health improvement plan (CHIP) to identify major health priorities, develop goals, and implement and coordinate strategies to address these priority issues across the region. This report provides an overview of key findings from the community health assessment and key elements of the community health improvement plan.

PART I: COMMUNITY HEALTH ASSESSMENT

Community Health Assessment Methods

The community health assessment was guided by a participatory, collaborative approach, which examined health in its broadest sense. This process included integrating existing data regarding social, economic, and health indicators in the region with qualitative information from 15 focus groups with community residents and service providers and 17 interviews with community stakeholders. Focus groups and interviews were conducted with individuals from the 7 municipalities that comprise the Greater Norwalk Area, with individuals representing youth; the Hispanic and African American communities; individuals receiving services from a federally-qualified health center; social service, health care, and mental health providers; businesses; housing; law enforcement; and the local government. This qualitative assessment process engaged over 200 individuals.

Key Findings

The following provides a brief overview of key findings that emerged from this assessment.

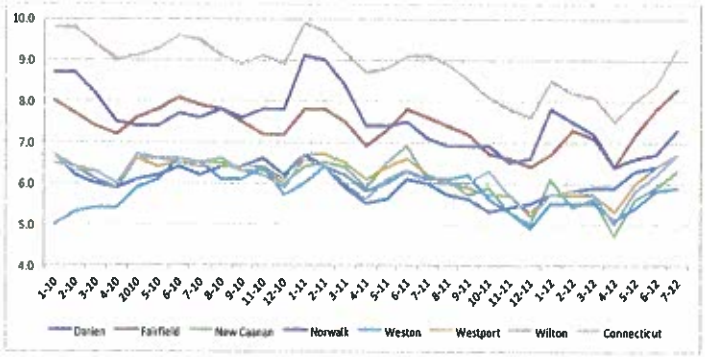
Who Lives in Norwalk?

- **Overall Population:** In 2010, the total population of the Greater Norwalk area was 240,109, an increase of 2.3% from 2000. While the region is located in Fairfield County, the state's largest county, the towns within the region vary by size, growth patterns, wealth, and composition of residents. Norwalk is the most populous town in the area, comprising 36% of the region's population in 2010. Overall, the Greater Norwalk Area has a higher proportion of families (71.5%) than the state as a whole (66.3%), with a greater concentration of families in Darien and Weston. Norwalk and Fairfield have a higher proportion of non-family households.
- **Age Distribution:** The age distribution for the region is similar to that of Connecticut, though the area has a slightly higher proportion of children under age 14 than the state as a whole. Across the 7 municipalities, there is variation in the age distribution and growth rates for each age group.
- **Racial and Ethnic Diversity:** Focus group and interview participants described the region's racial and ethnic diversity as a strength, though the municipalities in the Greater Norwalk Area varied in the levels and type of diversity of their population. While the region as a whole has less racial and ethnic

diversity than the state, Norwalk is 24% Hispanic and 14% African American. In the towns surrounding Norwalk, a greater proportion of racial and ethnic minorities are Asian or Hispanic.

- **Income, Poverty, and Employment:** The Greater Norwalk Area is characterized by substantial variation in income, with both very wealthy and less affluent households across the region and within municipalities. However, residents in the region as a whole struggled during the economic downturn. With the exception of Norwalk, all of the towns in the region have a median household income of greater than $100,000. The unemployment rate for the region and in all towns in the region was slightly lower than that for the state as a whole (7.6%). Unemployment rates were highest in Fairfield and Norwalk.
- **Educational Attainment:** Interview and focus group participants cited concern regarding educational achievement gaps and school budget cuts resulting from the economic downturn. Others expressed concern regarding educational achievement pressures for youth in the Greater Norwalk Region. While the majority of towns in the region have a highly educated population – approximately twice as many residents have a 4-year degree (70%) compared to the state (35%) – educational levels of adults in Norwalk and Fairfield were generally lower.

Figure 1: Monthly Unemployment, Connecticut Greater Norwalk, and Towns, 2010-2012



DATA SOURCE: Connecticut Department of Labor, Local Area Unemployment Statistics (LAUS)

Social and Physical Environment – What is the Norwalk Community Like?

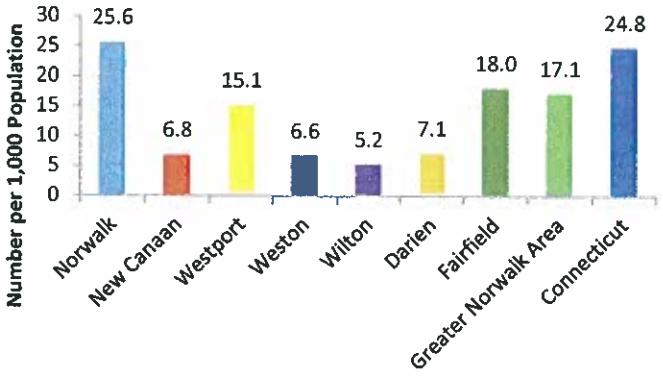
This section provides an overview of the larger environment around Norwalk to provide a greater context when discussing the community's health.

- **Housing:** As a generally affluent region, housing in the Greater Norwalk Area is fairly expensive, with median housing costs for monthly mortgages and rent exceeding that of the state. Focus group and interview participants identified the high cost of living in the region as a concern. Some respondents explained that housing constraints tied to high housing costs are evidenced by increased homelessness, strains on homeless services, and overcrowding in households.
- **Transportation:** Focus group participants described the transit system as a strength in the region. A greater proportion of residents in the region (13.0%) use public transportation to commute to work than the state as a whole (4.4%), perhaps attributable to persons who commute to New York City for work. A smaller percent of households in the region (4.6%) lack access to a vehicle than the state as a whole (8.6%), though there is variation by municipality, with 7.5% of Norwalk households lacking access to a vehicle.
- **Access to Healthy Foods and Recreation:** While the region has greater access to healthy food outlets relative to the state, several pockets of Norwalk have been identified by the U.S. Department of Agriculture as food desserts, with limited access to large supermarkets or grocery stores for low-income residents. While the Greater Norwalk Area (20 per 100,000 population) is also characterized by better access to recreational facilities than the state (14 per 100,000 population), several participants explained that these facilities may be less accessible to low-income residents, who may also have limited access to parks and green spaces.

> *"Transit system is a big plus as well."* – Focus group participant
>
> *"They took away the roller skating rink. They took away the ice skating rink. They took away teenage parties for kids that stayed out of the streets ... What is there for our children to do? There's nothing."* – Focus group participant

- **Environmental Quality:** Poor air quality is associated with negative health consequences, such as asthma and decreased lung function. While annual number of air quality days for Fairfield County (4 days) was the same as for the state as a whole, Fairfield County (14 days) had more ozone days than the state (6 days).
- **Crime and Violence:** Residents described higher rates of person-to-person violence and domestic violence as major concerns. While the crime rate is lower for the region (17.1 per 1,000 population) compared to the state (24.8 per 1,000 population), the crime rate in Norwalk (25.6 per 1,000) exceeds that of the state. While family violence rates are lower in the region than statewide, family violence has increased in the region since 2008.

Figure 2: Crime rate per 1,000 Population, Connecticut, Greater Norwalk and Towns, 2010



DATA SOURCE: Connecticut Uniform Crime Data, 2010

Risk and Protective Lifestyle Behaviors

This section examines lifestyle behaviors among Norwalk residents that may promote or hinder health.

- **Healthy Eating, Physical Activity, and Overweight/Obesity:** Similar to patterns nationwide, issues around overweight and obesity – particularly healthy eating and physical activity – emerged as key health concerns for focus group and interview participants. In the Greater Norwalk Area, childhood obesity is highest in Norwalk. In 2010, the prevalence of adult obesity in Fairfield County (16.6%) was lower than that of the state (23.0%) and country (27.6%). Diet, busy lifestyles, safety, and sedentary lifestyles were cited as factors contributing to the prevalence of overweight and obesity.
- **Substance Use and Abuse:** Participants described an increase in substance use and abuse as a key health concern for the region. Focus group and interview participants identified smoking, drinking and marijuana as substances that are easily accessible to youth and major issues for the health and well-being of youth. Use of illicit drugs was cited as a concern for residents of Norwalk. Quantitative data show that substance use rates for youth are slightly higher in Connecticut as compared to the nation. Among adults in Fairfield County, binge drinking has increased since 2006 and the percent of adults who binge drink is higher in Fairfield County than the State and nation.

"Gardens at all of the schools – a dynamic effort to introduce fruits and vegetables and influence families." – Interview Participant

"Folks who are more challenged economically are not going to have physical activity as a priority." – Focus Group Participant

"Norwalk probably has the most drug activity out of the communities—we have OD's, illicit drug sales everywhere. It is rampant. We've had at least three cases of bath salts. We have meth, heroin, crack, you name it, it's here." - Focus group participant

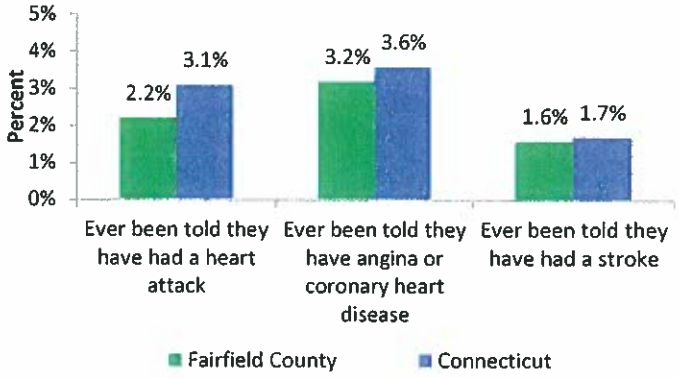
Health Outcomes

This section provides a quantitative overview of the leading health conditions in Norwalk, while also discussing concerns raised among residents and leaders during focus groups and in-depth interviews.

- **Overall Leading Causes of Death:** Quantitative data indicate that the top two causes of mortality in Norwalk, as in Connecticut, are cancer (162 per 100,000 population) and diseases of the heart (149 per 100,000 population).

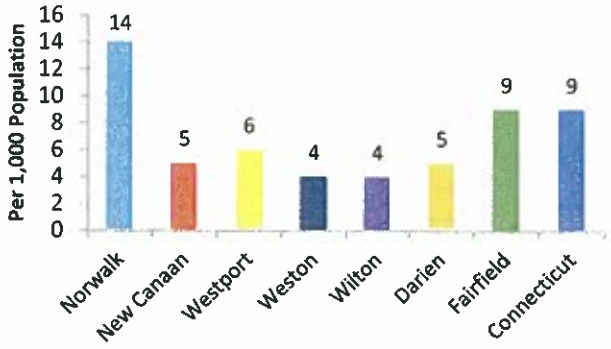
- **Overall Leading Causes of Hospitalization:** The leading causes of hospitalization varied by age group. Among the population under age 65, mental health and digestive issues are the leading causes of hospitalization. For persons aged 65 and over, leading causes of hospitalization are heart and respiratory conditions. Digestive and injury/poisoning issues are leading causes of hospitalization across all age groups.
- **Chronic Disease:** The prevalence of heart disease (3.2%), diabetes (6.0%) and asthma (8.3%) among adults in Fairfield County is lower than the state as a whole. Prevalence statistics for indicators of heart disease are presented in Figure 3.
- **Mental Health:** Mental health, particularly among youth, was a major health concern raised by participants. Focus group and interview participants cited pressures of academic achievement, stigma associated with seeking mental health care, and gaps in mental health services as factors that contribute to the high prevalence of poor mental health in the region. Mental health hospitalization rates are presented in Figure 4.
- **Maternal and Child Health:** While the prevalence of low birth weight (less than 2500 grams) in Fairfield County (7.0%) was below that for the state as a whole (8.1%), the prevalence varied across the Greater Norwalk Region and was highest in Wilton (13.0%). The teenage pregnancy rate was lower for Fairfield County (20.3 per 1,000 females) than for the state as a whole (23.9 per 1,000 females).
- **Oral Health:** In Fairfield County (83.1%), a greater proportion of residents saw a dentist in the past year than statewide (81.6%).

Figure 3: Percent of Adults Who Have Been Told They Have a Heart Related Chronic Condition, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS),

Figure 4: Mental Health Hospitalizations, Connecticut and Towns, 2005-2010



DATA SOURCE: CT Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health for years 2005-2010. For CT, DPH hospitalization data 2009; analysis by Norwalk Health Department

- **Communicable Diseases:** Several focus group and interview participants identified Lyme disease as a major concern. Many towns in the region have seen higher rates of Lyme disease compared to Fairfield County. While the HIV rate is lower in Fairfield County (366.4 per 100,000 population) than the state as a whole (372.6 per 100,000 population), the rate of new HIV cases is higher in Norwalk (15.2 per 100,000 population) than the region and state (11.5 per 100,000 population).

Health Care Access and Utilization

The following section provides a quantitative and qualitative overview of health care access and utilization in the region.

- **Resources and Use of Health Care Services:** Participants described health care resources in the region as a major strength, citing comprehensive services at hospitals and other resources throughout the community, including community health centers, school-based health centers, volunteer emergency responders, and food programs as important resources. The ratio of the

population to primary care physicians in Fairfield County (739 population per provider) is lower than that of the state (815 population per provider).

- **Challenges in Accessing Health Care Services:** When asked about access to health care services, participants cited a lack of health insurance, particularly for persons who lost a job during the economic downturn; higher co-pays; and long wait times as major barriers to accessing health care. The proportion of adults in Fairfield County who have health insurance coverage (89.8%) is similar to that of the state (88.4%). Gaps in mental health care and affordability of mental health services in the region emerged as major concerns cited by participants. Gaps in and affordability of dental services was another concern raised by participants. Other challenges to accessing services included transportation, bilingual services, and culturally competent care.

Community Strengths and Resources

When asked to identify assets and resources, participants in the surrounding communities pointed to high quality schools, strong civic mindedness, and philanthropy among residents. Those in Norwalk saw their strong and growing diversity as an asset. Additional assets and resources identified the Greater Norwalk Area included:

- **Health Care Services and Providers:** Participants described health care services and comprehensive care offered by the hospitals in the region as a major strength.
- **Strong Social Service Organizations:** Respondents characterized the region as largely rich in social services. They especially praised food access programs.
- **Facilities Promoting Healthy Behaviors:** According to participants, recreational activities, recreational facilities, parks and green spaces were important and accessible resources for youth and families in the region. This sentiment largely pertained to residents in more affluent communities outside of Norwalk.
- **Geography:** Proximity to New York City and access to the waterfront and recreational facilities were cited as major resources for employment opportunities and recreational activities.

Community Members' Perceptions of What is Needed

Focus group and interview participants were asked about what was needed to address health challenges in the region. The following key themes emerged:

- **Focus on Prevention:** Several participants described a need to change the health infrastructure to emphasize prevention. Providers explained that to reframe the health care focus on prevention, incentive structures would need reform. Additionally, a need for more substance use and mental health services was identified as a need.
- **Health Literacy:** Several focus group and interview participants noted that a lack of understanding of health (health literacy) and health care resources contributed to poor health and health behaviors in the region. While they reported that there were many health education programs in the region, they felt that more programs were needed, particularly around chronic disease prevention and stress management.
- **Centralized Resource Information:** A centralized listing of resources in the region was cited as an important tool needed for providers, medical staff, and discharge planners.
- **Parenting Support:** Additionally, the need to support parents in developing coping and problem-solving skills needed to raise children was a consistent theme throughout interviews.
- **Activities for Youth:** While numerous activities for youth and families were cited, participants noted a need for youth activities in less affluent areas, particularly as some recreational areas are closing.
- **Greater Cultural Competency:** Non-English speaking focus group participants noted the importance of enhanced cultural competency, or recognition of and respect for diverse cultural norms, attitudes, identities, and world views, in the health system. In addition, a need for interpreters and alternative medical practices was also expressed.

- **Enhanced Integration of Information across Health Systems**: The health provider community identified greater integration of health information across systems and incentives for health professionals to practice in the public sector as critical.
- **Greater Collaboration across Agencies:** While close collaboration was cited as a strength among health and social service systems, other participants noted that greater coordination was needed.

Key Overarching Themes and Conclusions:

Several overarching themes emerged from this synthesis of data, including:

- **There is wide variation in the Greater Norwalk Area's population composition and economic levels.** Compared to surrounding towns, Norwalk is more racially and ethnically diverse and has a higher proportion of households with lower median incomes. Participants described civic-minded residents, increasing diversity, a large proportion of highly educated residents, a child-oriented environment and strong business as strengths.
- **Mental health and substance abuse were considered growing, pressing concerns by focus group and interview participants, for which current services were not necessarily meeting community needs.** Stressors associated with the economic downturn and pressures on youth to succeed academically were cited by respondents as major factors contributing to mental health issues in the region. Respondents identified a paucity of mental health providers and services as well as the stigma around seeking mental health services as barriers to accessing mental health care.
- **As with the rest of the state and nation, healthy eating, physical activity and obesity were major issues cited by respondents, particularly as chronic diseases are the leading causes of morbidity and mortality.** A major concern was the substantial prevalence of childhood obesity in Norwalk. While recreational facilities, parks and grocery stores were described as prevalent in the region, participants described variation in access to and affordability of these resources in the region.
- **Currently, numerous services, resources and organizations are working to meet the health and social service needs of residents in the Greater Norwalk Area.** Participants praised the work of community-based organizations, regional organizations, Norwalk Hospital, Norwalk Community Health Center, local health departments and local service organizations in meeting the health needs in the region. However, several respondents described these services as fragmented and shared a vision for a more coordinated approach among these key players in working together to address priority health issues in the region.

PART II: COMMUNITY HEALTH IMPROVEMENT PLAN

Overview of the Community Health Improvement Plan

Norwalk's Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. The plan is critical to developing policies and defining actions to target efforts that promote health. Government agencies, including those related to health, human services, and education, as well as hospitals can use the CHIP in collaboration with other partners to set priorities and coordinate and target resources.

Development of the Greater Norwalk Area CHIP

To develop the CHIP, Norwalk Hospital and the Norwalk Health Department partnered to bring together over 100 community residents and leaders in health care, community organizations, education, housing, local government, business, mental and behavioral health, and social services to share the preliminary results of the Community Health Assessment (CHA) and identify priorities for the CHIP. Participants in the community meeting took part in a prioritization activity to identify the most important public health issues for Greater Norwalk from a list of seven major themes identified in the CHA. Based on the results

of the multi-voting exercise, participants agreed upon the following three health priority areas for the CHIP: 1) Mental Health, 2) Obesity, and 3) Substance Abuse.

Following the identification of the priority areas, the Norwalk Core Leadership Team engaged working groups based on interest and expertise that met to develop goals, objectives, strategies, output and outcome indicators, and key partners. Once the draft plan was complete, an online survey was administered to all community members who had been engaged in the assessment and planning process to solicit feedback on the components of the plan. As a result of suggestions made in the survey, the mental health and substance abuse priority areas were combined in to a single priority area.

Strategic Elements of the CHIP
Below are the final priority health issues, goals, and objectives that will be addressed in the CHIP:

Priority Area 1:	**Mental Health and Substance Abuse**
Goal 1:	Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.
Objective 1.1:	Increase providers' and community members' awareness and use of evidence-based mental health and substance abuse services and educational resources for prevention, intervention, treatment and recovery.
Objective 1.2:	Enhance local and regional partnerships to improve access to timely, comprehensive, and coordinated services for diverse populations across the life span by.
Objective 1.3:	Reduce financial barriers to treatment.
Priority Area 2:	**Obesity**
Goal 2:	Prevent and reduce obesity in the community by promoting healthy lifestyles
Objective 2.1:	Increase the number of children and adults who meet physical activity guidelines.
Objective 2.2:	Increase access to and consumption of healthy and affordable foods throughout the region.

Next Steps
The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. Members of the Core Leadership Team will revise and refine the suggested activities and timelines drafted by workgroup members to complete the action plans for the CHIP. Additionally, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in the Greater Norwalk Area.

INTRODUCTION

Understanding that health is affected by where we live, work, and play, in 2012, Norwalk Hospital and the Norwalk Health Department led a Community Health Assessment and Improvement Plan Initiative with the ultimate goal of creating a healthy community for the Greater Norwalk Area. The health departments of New Canaan, Westport/Weston, Wilton, Darien, and Fairfield, also joined this regional effort. Norwalk Hospital and the Norwalk Health Department contracted with Health Resources in Action (HRiA), a non-profit health consultancy organization in Boston, to assist with research and planning. The purpose and scope of this Initiative was to:

- Assess the health status and broader social, economic, and environmental conditions that impact health
- Recognize community health assets and strengths
- Identify priority issues for action to improve community health
- Develop and implement an improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

The approach to the CHA and CHIP was guided by the Association for Community Health Improvement (ACHI) framework of 1) establishing an assessment infrastructure, 2) defining the purpose and scope, 3) collecting and analyzing data, 4) selecting priorities, 5) documenting and communicating results, and 6) planning for action and monitoring progress.

The following report is divided into two parts. Part I, the 2012 Community Health Assessment, discusses the methodology and findings of the assessment. Part II, the Community Health Improvement Plan, discusses the methodology, goals, objectives, strategies, and indicators of the improvement plan.

Part I: Community Health Assessment

The following section includes the findings of the community health assessment, which was conducted from March through August 2012, using a collaborative, participatory approach. The 2012 Greater Norwalk Area Community Health Assessment (CHA) was designed to fulfill several overarching goals, specifically to:

- Gain a greater understanding of the health issues of residents of Norwalk, New Canaan, Westport, Weston, Wilton, Darien, and Fairfield
- Identify where and why we are healthy
- Identify where and what we need to do to improve the community's health

I. Community Health Assessment Methods

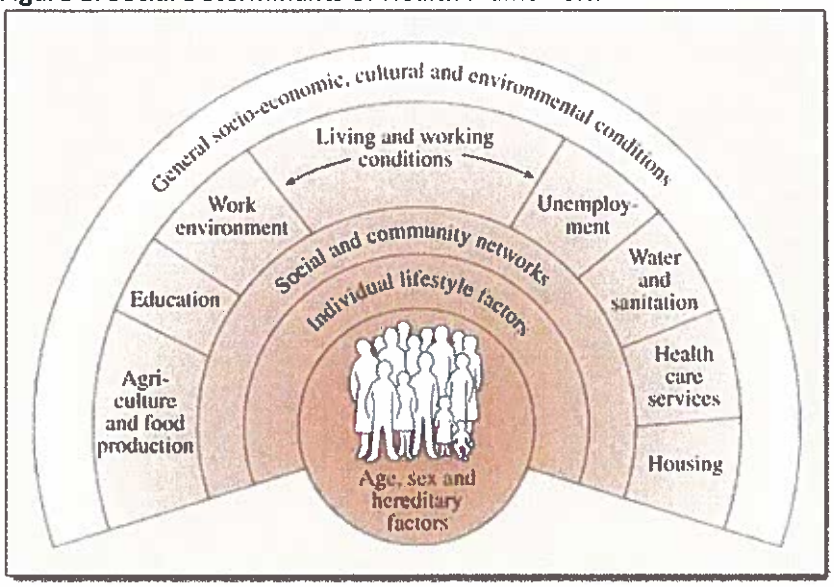
The following section details how the data for the CHA were compiled and analyzed, as well as the broader lens used to guide this process. Specifically, the CHA defines health in the broadest sense and recognizes that numerous factors at multiple levels— from lifestyle behaviors (e.g., diet and exercise), to clinical care (e.g., access to medical services), to social and economic factors (e.g., employment opportunities), to the physical environment (e.g., air quality)—have an impact on the community's health. The beginning discussion of this section describes the larger social determinants of health framework which helped to guide this process.

A. Social Determinants of Health Framework

It is important to recognize that multiple factors affect health, and there is a dynamic relationship between people and their environments. Where and how we live, work, play, and learn are interconnected factors that are critical to consider when assessing a community's health. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors (i.e., distal factors that influence health) such as employment status and quality of housing. The social determinants of health framework addresses the distribution of wellness and illness among a population—its patterns, origins, and implications. While the data to which we have access is often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are enabled and constrained by economic circumstances, social context, and government policies. Building on this framework, this assessment utilizes data to discuss which populations are healthiest and least healthy in the community as well as to examine the larger social and economic factors associated with good and poor health.

The following diagram in Figure 1 provides a visual representation of how individual lifestyle factors are influenced by more upstream factors.

Figure 1: Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on Social Determinants of Health. (2005)

B. Community Health Improvement Task Force

To provide feedback and guidance on the assessment, an advisory committee, named the Community Health Improvement Task Force, was formed. The group comprised of approximately 40 individuals from 30 key partner agencies and organizations were initially engaged to advise on the process, support data collection, and participate in the development and implementation of programs and policies to address priority issues. Engagement of community members and partners has expanded throughout the project to include over 200 individuals. Members of the Community Health Improvement Task Force included representatives from housing, transportation, education, business, local government, and neighboring health departments. The list of Community Health Improvement Task Force members may be found in Appendix A.

The Task Force met as a whole in March and July. Specifically, the Task Force was asked to provide existing quantitative and qualitative data; identify additional appropriate secondary data sources; provide input on primary data collection; motivate and recruit community members to participate in the assessment process; assist in organizing focus groups; provide technical assistance in their areas of expertise; identify priority issues for health improvement; and develop and implement programs and policies to address priority issues.

Throughout the process, information was provided to all Task Force members through email allowing participants to be informed on the progress of the project and the opportunities to share their expertise.

C. Secondary Data Collection

To provide a salient community health profile of the Greater Norwalk Area (Norwalk, New Canaan, Westport, Weston, Wilton, Darien, and Fairfield[1]), existing quantitative data drawn from national, state, and local sources were reviewed. This allowed the development of a portrait of these areas that discusses health, social, and economic characteristics. Data sources included but were not limited to U.S. Census, Centers for Disease Control, the Connecticut Department of Health, Norwalk Hospital, Norwalk Health Department, and County Health Rankings. Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS), as well as public health disease surveillance data, and vital statistics based on birth and death records. Additionally, data and analyses completed for the Connecticut Health Equity Index[2] were used to create the portrait and further the discussion of social determinants of health.

D. Qualitative Data Collection

Data collection in the form of focus groups and interviews occurred between June and July 2012. During this time, HRiA conducted qualitative research with hospital and health department staff, community stakeholders, and residents to gauge their perceptions of community strengths, needs, and health concerns, and the programming or services most needed to address these concerns. In total, 177 individuals were engaged across all seven communities through a series of 15 focus groups (with 160 individuals participating) and 17 interviews. For a list of participants, see Appendix B.

Key Informant Interviews

Following the review of secondary data, 17 key informant interviews were conducted with community stakeholders from community-based organizational staff, community leaders, and hospital and health department staff. Interviews explored their perspectives of their communities' health needs and strengths, challenges and successes of working in these communities; gaps in the current programming and servicing environment; and perceived opportunities to address these needs.

Key informant interviews were conducted with both leaders and front-line staff from a wide range of organizations in different sectors, such as education, housing, health care providers, local government, and social services, as well as community residents. Interviews were held either face-to-face or by telephone using a semi-structured interview guide and lasted approximately 30-60 minutes.

Focus Groups

In addition to key informant interviews, 15 focus groups were conducted with a total of 160 community members. The Task Force identified sectors of the community to target for the focus group phase of the data collection. These sectors included: business; housing; law enforcement; local government; education; health care providers; mental health providers;

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[1] For this report, all county wide data are labeled as Fairfield County. Data for the Town of Fairfield is labeled as Fairfield.

[2] The Health Equity Index is a community-based assessment that can be used to identify social, political, economic, and environmental conditions that are most strongly correlated with health outcomes. It is an initiative of the Health Equity Alliance and the Connecticut Association of Directors of Health. (index.healthequityalliance.us)

senior service providers; youth; members of the Hispanic and African American communities; and individuals receiving services from local federally qualified health centers. Focus group discussions examined community members' perceptions of the health assets and needs in their communities, as well as their suggestions on what types of services are needed in the community and how those can be best delivered. Discussions also explored the assets and resources they have identified as working well in their community as well as challenges that many residents currently face in seeking these services.

To engage Task Force members in the qualitative data collection and support the facilitation of the focus groups, a training of facilitators and notetakers was conducted in May for all interested Task Force members. Nine Task Force members were trained during this 90-minute session.

On average, each focus group had 8-13 participants, lasted approximately 60-90 minutes, and was moderated by an experienced HRiA, Norwalk Health Department, Norwalk Hospital, or a Task Force facilitator using a semi-structured guide. In addition to groups in English, two focus groups were conducted in Spanish. Participants in the community resident groups were provided a minimal stipend for their time. It was a priority to recruit participants for the focus groups from all sectors of the population, including traditionally under-served populations. Community Task Force members and community-based organizations served as key partners in recruitment.

Analyses

The collected qualitative information was coded and analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While community differences are noted where appropriate, analyses emphasized findings common across the Greater Norwalk Area. Selected paraphrased quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

E. Analyses and Limitations

The Greater Norwalk Community Health Assessment utilized a participatory, collaborative approach to look at health in its broadest context. As noted earlier, the assessment process included synthesizing existing (secondary) data on social, economic, and health indicators in the region as well as primary qualitative information from focus groups and interviews with community stakeholders from across the seven municipalities to create a health profile for the region. The qualitative data collection sought to elicit the perspectives and opinions of a range of people representing different audiences, including youth, parents, educational leaders, social service and health care providers, police, the faith community, and the general public. The information from these many, varied sources was used to identify priorities and opportunities for action.

As with all research efforts, there are several limitations related to the assessment's research methods that should be acknowledged. It should be noted that for the secondary data analyses, several sources did not provide current data stratified by race/ethnicity, gender, or age – thus, these data could only be analyzed for the total population. It is also important to note that there were geographic limitations to the BRFSS data, which are only available for Fairfield County as a whole and YRBS data, which are only available for the state as a whole.

There are some exceptions to the availability of the local behavioral health data for youth where data exists for the towns of Weston, Wilton, and Fairfield due to their involvement in a grant specific to these communities. Additionally, in many cases across all sources, some data were suppressed and not available because population counts were too small to report.

Likewise, data based on self-reports (i.e., BRFSS, YRBS) should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding of the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys here benefit from large sample sizes and repeated administrations, enabling comparison over time.

II. FINDINGS

"People love Norwalk; many were born and raised here. There's a commitment to help; a lot of foundations. The people are a great strength." – Interview participant

"We have the waterfront, we have the countryside, we have the amenities." – Focus group participant

"[There are] $4 million dollar homes on the water and public housing all in the same community." – Interview participant

"Norwalk just doesn't have the [financial] resources that the other communities do." – Focus group participant

"Each city or town is unique in our community." – Focus group participant

Located about 50 miles outside of New York City, the region covered by this community health assessment, Greater Norwalk, comprises the communities of Fairfield, Darien, New Canaan, Weston, Westport, and Wilton as well as Norwalk, Connecticut's sixth largest city. Focus group respondents and interviewees describe their region as one with substantial assets including proximity to New York and to the Long Island Sound; corporate headquarters of several companies; numerous amenities such as restaurants, beaches, parks, walking trails, and theaters; and excellent roads to get to these places. The area's population was described as a combination of long standing residents and newcomers, including recent immigrants. However, although residents described their region as largely affluent and resource rich, there were differences seen between the city of Norwalk and surrounding towns, and even among the surrounding towns. Furthermore, residents reported that the economic downturn has affected the region's residents and organizations that provide services to them. These factors have implications for community health and well-being.

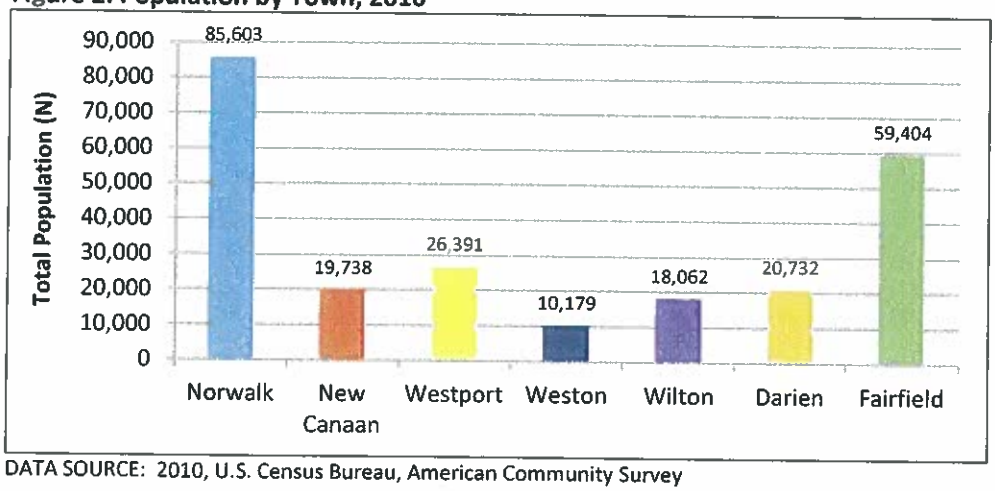
A. DEMOGRAPHICS

The health of a community is associated with numerous factors including the resources and services available (e.g., safe green space, access to healthy foods) as well as who lives in the community. That is to say that, who lives in a community is significantly related to the rates of health outcomes and behaviors of that area. For example, the distribution of age, gender, race, and ethnicity are important characteristics that have an impact on an individual's health by affecting the number and type of services and resources available. The section below provides an overview of the population of Greater Norwalk.

Population

The total population of the Greater Norwalk area was 240,109 in 2010, up 2.3% from 2000 (Figure 2). While the region is located in Fairfield County, the state's largest County, the towns within it vary in terms of size, growth patterns, wealth, and composition of residents. Norwalk, the state's 6th largest city, is the most populous town in the area, comprising 36% of the region's population in 2010. The town of Fairfield comprises another 25% of the defined area's population. The three smallest communities in terms of population size (New Canaan, Weston and Wilton) comprise a total of 20%. The smallest community in the region, Weston, comprises 4% of the region's total population.

Figure 2: Population by Town, 2010



DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

Greater Norwalk experienced a population increase of 2.3% from 2000 to 2010, a smaller rate of increase than for the state as a whole (4.9%) (Table 1). All towns within the region experienced a population increase between 2000 and 2010, with Darien experiencing that largest increase (5.7%).

Table 1: Population Change in Connecticut, Greater Norwalk, and Towns, 2000 and 2010

	2000 Population	2010 Population	% Change 2000 to 2010
Norwalk	82,951	85,603	3.2
New Canaan	19,395	19,738	1.8
Weston	10,037	10,179	1.4
Westport	25,749	26,391	2.5
Wilton	17,633	18,062	2.4
Darien	19,607	20,732	5.7
Fairfield	57,340	59,404	3.6
Greater Norwalk Area	232,712	240,109	2.3
Connecticut	3,405,565	3,574,097	4.9

DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

Overall, the region has a higher proportion of families (71.5%) than the state as a whole (66.3%) (Table 2). In the towns of Darien and Weston over 80% of households are families and a high proportion of these are families with children under the age of 18 (50.5% and 48.7%, respectively). Norwalk and Fairfield have a higher proportion of non-family households; slightly over a third of Norwalk households (36.3%) and close to 30% of Fairfield households (27.4%) are non-family households.

Table 2: Household and Families by Type in Connecticut, Greater Norwalk, and Towns, 2010[3]

	Number of Households	% of Families	% Families with Children <18	% Female householder, no husband present with Children <18	% Nonfamily households (single and unrelated)
Norwalk	33,217	63.7	29.2	6.7	36.3
New Canaan	7,010	77.0	43.2	4.1	23.0
Weston	3,379	84.5	48.7	3.7	15.5
Westport	9,573	75.6	41.2	4.4	24.4
Wilton	6,172	79.3	44.8	3.4	20.7
Darien	6,698	82.2	50.5	4.1	17.8
Fairfield	20,457	72.6	36.9	4.2	27.4
Greater Norwalk Area	86,506	71.5	37.0	5.1	28.5
Connecticut	1,371,087	66.3	30.0	7.1	33.7

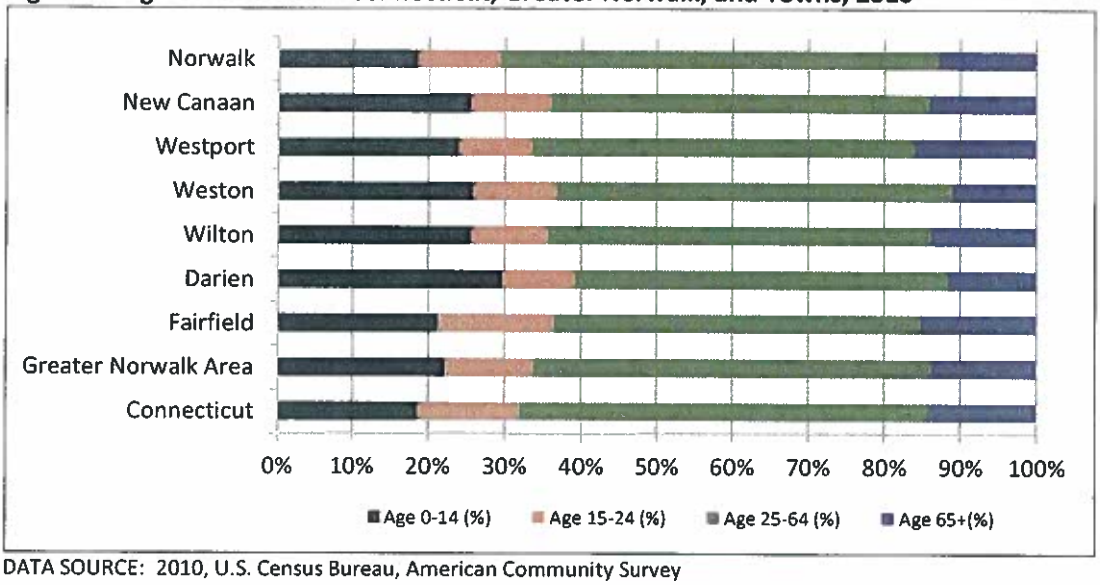
DATA SOURCE: Source: 2010, U.S. Census Bureau, American Community Survey

[3] Percentages are calculated as percent of all households. Households are broken into families (related) and non-families (singles and unrelated individuals). Families can be married couples with or without children, single parents with children, or groups of related adults. Female-headed families with children is a subset of all families and also a subset of families with children. Not all household types are presented. Therefore, the percentages do not add across the table.

Age Distribution

The Greater Norwalk area largely reflects a population age distribution consistent with that of the state: for every ten residents, approximately two residents are under 14 years old while one is 65 or over (see Figure 3). However, the area has a slightly higher proportion of children under age 14 (22.1%) than the state as a whole (18.6%). The age distribution varies somewhat across towns. Nearly 30% of Darien's population is under the age of 14; over 35% of the populations of Darien, Fairfield, Wilton, and Weston are under the age of 24. Norwalk, by contrast, has the smallest proportion of young people—less than 20% under the age of 14 and less than 30% under the age of 24. Norwalk has the largest proportion in the region of the population ages 25-64, however. The senior population comprises a higher proportion of the total population in the communities of Westport and Fairfield, slightly higher than the state average.

Figure 3: Age Distribution in Connecticut, Greater Norwalk, and Towns, 2010

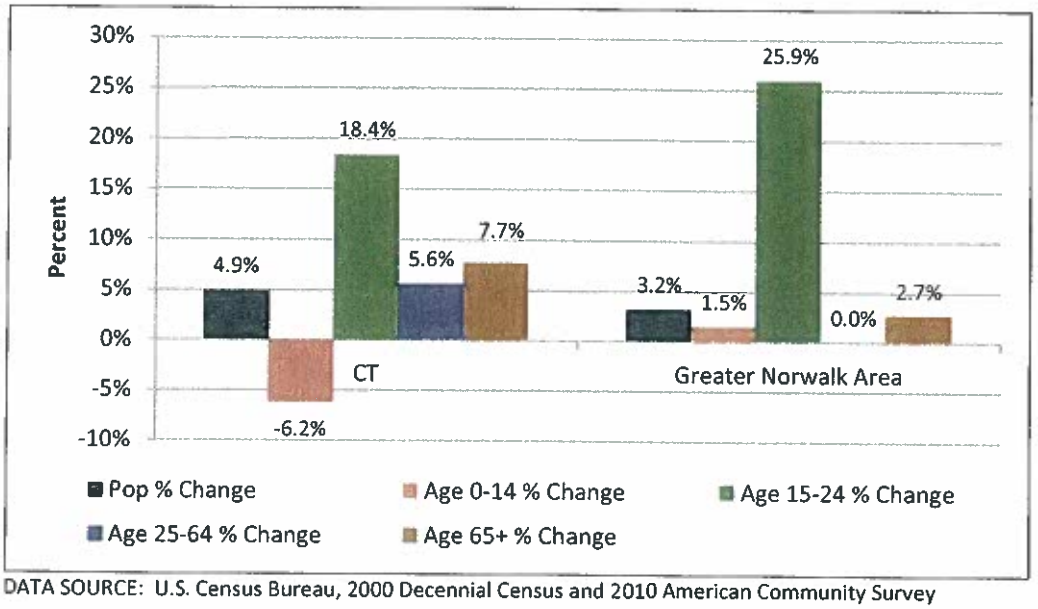


DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

A comparison of population growth rates between 2000 and 2010 reveals that Greater Norwalk's population of children ages 0-14 experienced an overall increase (1.5%) while the state's youth population in this age group declined substantially (-6.2%) during this decade (Figure 4). The region also experienced a higher rate of growth among those ages 15-24 (25.9%) than the state as a whole (18.4%). Conversely, the state's senior population grew substantially over this same time period (7.7%), while the growth rate of the senior population in the Greater Norwalk Area was lower, although still positive (2.7%).

Within the towns, there was substantial variation in the growth rates of different population groups between 2000 and 2010. Darien and Fairfield experienced the greatest increase across towns in populations under the age of 14 (8.4% and 7.1% growth, respectively) and negative growth in the population over age 65 (-2.4% and -4.6%, respectively). Conversely, the towns of Weston and Wilton experienced negative growth in populations under age 14 (-9.5% and -3.7%, respectively) and substantial growth in the population over age 65 during this ten-year period (15.1% and 16.1%, respectively). [Additional Data in Appendix E]

Figure 4: Population Change by Age Group in Connecticut and Greater Norwalk Area, 2000 and 2010



DATA SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

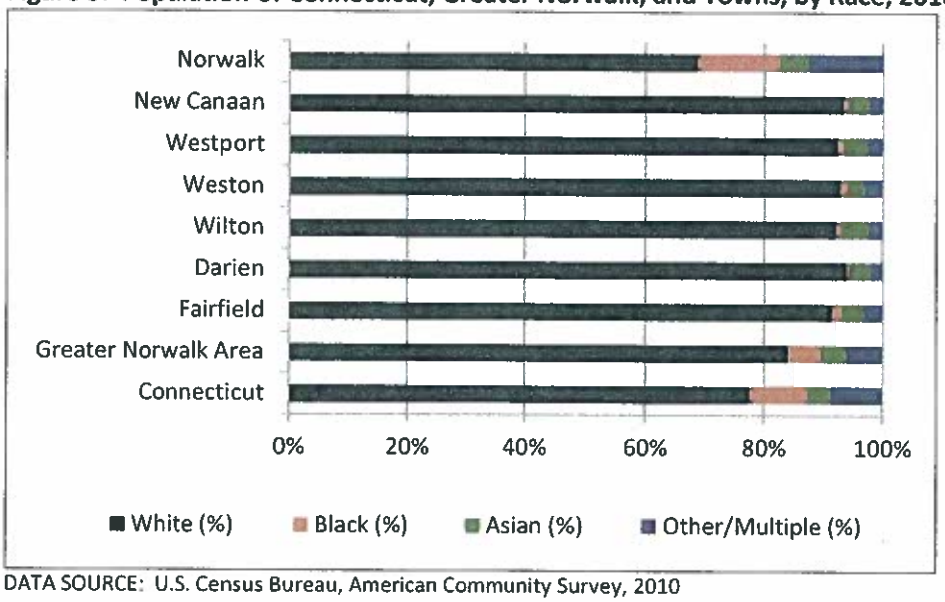
Racial and Ethnic Diversity

"It's a very, very diverse community which is one of the strong points and one of the more attractive aspects of being and working in Norwalk." – Focus group participant

The towns surrounding Norwalk were described by residents as largely white, affluent, English-speaking and highly educated. By contrast, respondents described the city of Norwalk as very diverse ethnically and racially as well as economically. Within Norwalk as well, there are differences in population composition according to focus group and interview participants. As one business focus group member explained, *"There are basically two Norwalks—the outer ring which looks and feels like whichever town they are adjacent to and then there's the inner ring...poverty at a much higher level."*

Quantitative data confirm the perceptions of focus group members and interviewees. While the city of Norwalk has substantial racial diversity, greater than Connecticut as a whole, the other communities are much less diverse—less than 8% of their populations are non-white (Figure 5). The Black/African American population (14.2%) also comprises a sizeable portion of Norwalk's population. In surrounding towns, the largest racial minority group is Asian, with a relatively low proportion of Black residents. The region overall has a smaller proportion of Blacks and people of multiple races than the state as a whole but has a slightly higher proportion of Asians (4.1%) than the state (3.8%).

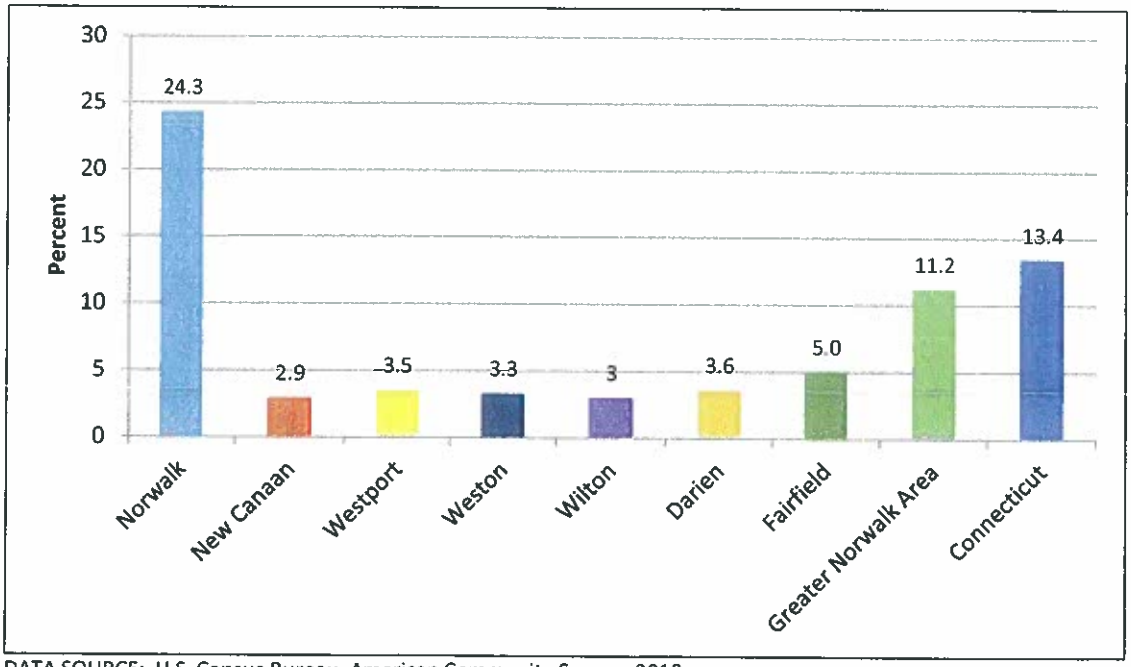
Figure 5: Population of Connecticut, Greater Norwalk, and Towns, by Race, 2010



DATA SOURCE: U.S. Census Bureau, American Community Survey, 2010

When considering the ethnicity, Norwalk has a significantly larger portion of its population who are Hispanic than the neighboring communities and the Connecticut as a whole. As shown in Figure 6, 24.3% of the population in Norwalk is Hispanic, while this population accounts for 13.4% of Connecticut. For other towns in the Greater Norwalk Area this percentage ranges from 2.9% in New Canaan to 5.0% in Fairfield.

Figure 6: Population of Connecticut, Greater Norwalk, and Towns, by Hispanic Ethnicity, 2010



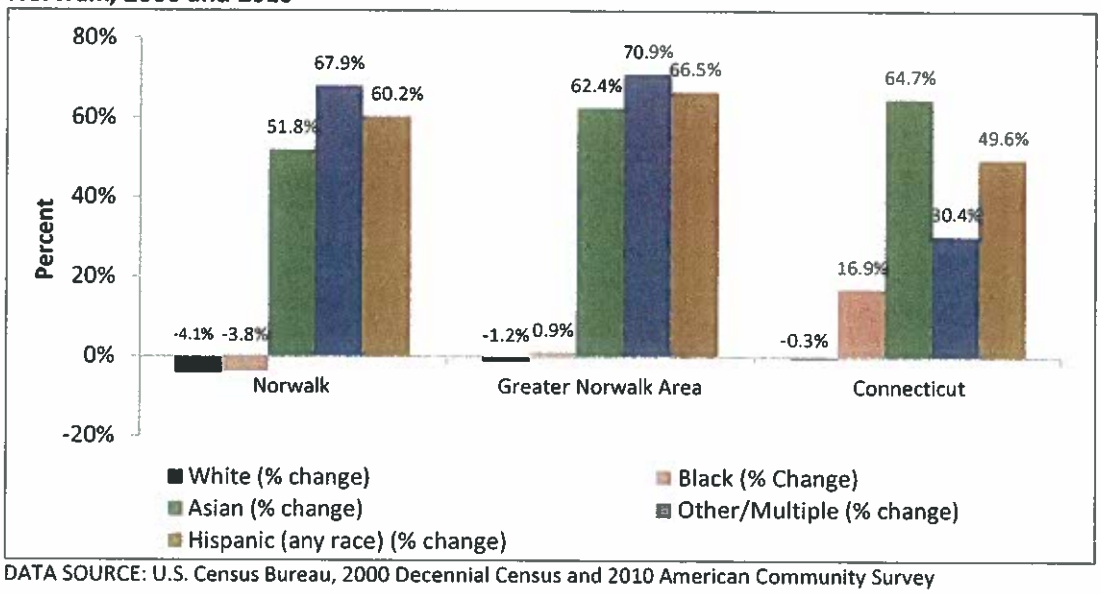
DATA SOURCE: U.S. Census Bureau, American Community Survey, 2010

A comparison of growth rates among diverse populations between 2000 and 2010 reveals a higher rate of growth among those identifying themselves as Hispanic and Other/Multiple Races in the Greater Norwalk Area (66.5% and 70.9%, respectively) than for the state as a

whole (49.6% and 30.4%, respectively) (Figure 7). Both the region and the state experienced a slight decline in the proportion of the White population (-1.2% and -0.3%, respectively). The growth in the Black population was substantially higher for the state (16.9%) than for the region (0.9%) over this time period. Those identifying as Asian grew across the region with a slightly higher rate for the state as a whole (64.7%) than the Greater Norwalk area (62.4%).

Quantitative data about changes in diversity across the towns in the region show that the towns of Fairfield and Wilton have seen the largest increase in those identifying themselves as Black (74.8% and 69.8% increase, respectively) and as Asian (88.1% and 74.5% increase, respectively). The White population decreased in all towns except Darien where it increased by 3.7%. Norwalk experienced the largest decrease in the White population between 2000 and 2010 (-4.1%). [Additional Data in Appendix E]

Figure 7: Population Change by Racial/Ethnic Group in Connecticut, Greater Norwalk, and Norwalk, 2000 and 2010



DATA SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

B. SOCIAL ENVIRONMENT

"It is a safe city .... There is good control (the police). There are no schools that don't rank well; it seems like a good level of education. Norwalk is a town that I would recommend. There is good work; there is a lot, if they do not work it's because they don't want to." – Focus group participant

"There are great things for the youth here, great for youth development- aquarium, library." – Focus group participant

"People really care about the community." – Interview participant

"There are many opportunities here in Norwalk." – Focus group participant

"It's a big asset to be living in this part of the country...there are opportunities for career choices, medical choices, entertainment. There are a wide range of interesting people." – Focus group participant

"It's a very, very diverse community which is one of the strong points and one of the more attractive aspects of being and working in Norwalk." – Focus group participant

The social environment as discussed in this report includes education, employment, poverty, and crime. These factors have all been shown to affect the health of individuals and groups living in communities. For example, additional years of formal education strongly correlate with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles. Poverty can result in reduced access to health services and negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, and poor health behaviors.

These social and economic factors were also recognized by community members as an important part of health. For example, jobs and local economic opportunities were mentioned by focus group participants as drivers of good health; they viewed health as the opportunity to earn a living in order to pay for daily essentials like food, medicine, and housing. In addition, residents noted the important relationship between social interaction and cohesion and health; several participants suggested that physical and mental health were improved by neighbors being together and being connected. As one focus group participant shared, *"People choose to be here and when you choose to be here, you're more invested in the community and its people."*

Focus group participants and interviewees pointed to substantial strengths and challenges of the region, although these differed by area. When asked about strengths, those in the surrounding communities pointed to high quality schools, strong civic mindedness, and philanthropic tendencies among residents, as well as a very strong "child-orientation," largely attributable to the large number of stay-at-home moms. Close proximity to shopping and the shore as well as New York City were also cited as assets of the region. Those in Norwalk saw their strong and growing diversity as a strength. Some saw greater opportunity in Norwalk than in other cities. As one focus group participant stated, *"It's easier to get a job, to be treated better—we are happy here."*

Educational Attainment

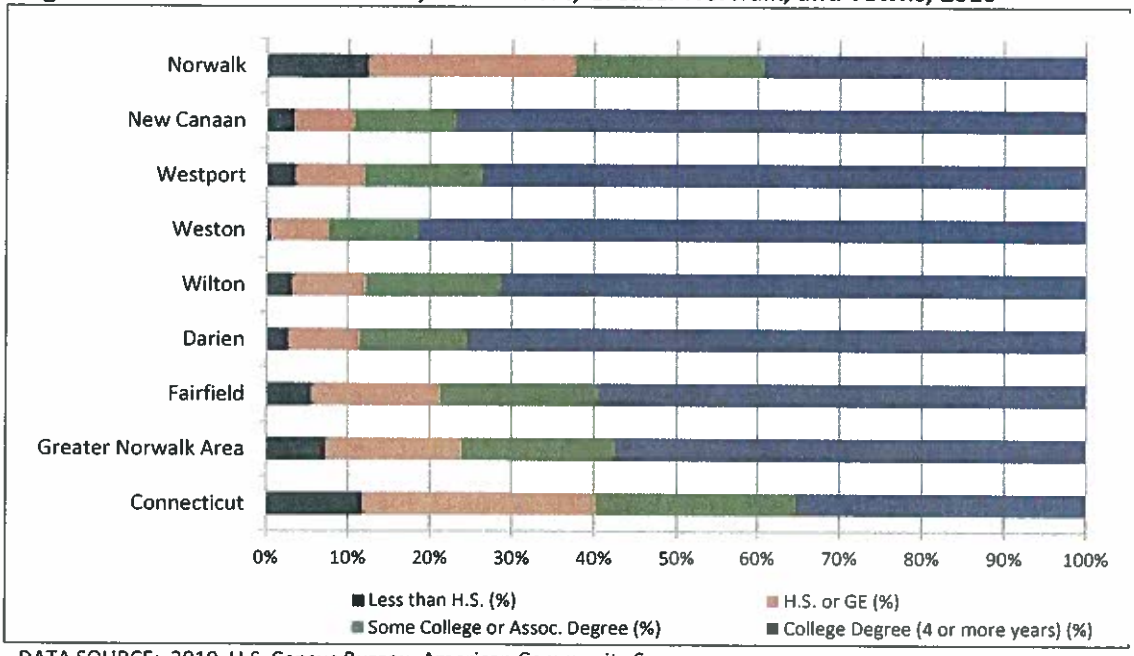
When asked about education in the region, respondents were mixed. Those from Norwalk expressed concern about the quality of education in the city. As one educator noted, *"[there are] dwindling resources and a major achievement gap."* Student focus group members also expressed concerns about school budget crises that have resulted in the loss of programs such as art, music and vocational classes; these losses make it more difficult for students wishing to pursue those fields or vocations. Those living in the surrounding areas expressed concern about the negative impact of the high achievement culture that characterizes those towns. They reported that there is substantial pressure on families, and especially students, to excel. As one focus group member stated, *"[there is] an expectation for excellence, starring in three sports, going to a big school."* The consequences of this, according to some, are higher rates of stress and anxiety, which can lead to mental health concerns and substance use.

Adults who complete college are more likely to live healthier lives. Quantitative results show high educational attainment among many of the area's communities, in general higher than the state average (Figure 8). A review of the literature for the Health Equity Index shows that, with higher education, adults are able to more easily find employment, earn a steady income,

and make better decisions[4]. These factors play a role in health outcomes, and studies have shown that college graduates live longer lives compared to individuals who do not complete high school[5].

Over 70% of adults in five of the towns (Darien, New Canaan, Weston, Westport, and Wilton) have a four-year degree or more, compared with 35% for the state as a whole. While the proportion of adults with less than a high school diploma is very low in most towns in the area, educational levels of adult residents are generally lower in Norwalk and Fairfield. Fairfield has fewer adults with a college degree or higher (59.3%) than many of the surrounding towns, but it still has a higher proportion than the state. Norwalk, however, has lower levels of educational attainment. The proportion of adults with a 4-year degree or higher (39.1%) is far lower than that of other towns in the area and much closer to the state average of 35.2%. The proportion of Norwalk adults with less than a high school diploma (12.3%) is slightly higher than the statewide average (11.7%) and far above the average for the Greater Norwalk area overall (7.2%).

Figure 8: Educational Attainment, Connecticut, Greater Norwalk, and Towns, 2010



DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

Income and Poverty

"There are pockets of Norwalk where people feel they have no way out." – Focus group participant

"Even the affluent are living on the edge." – Focus group participant

[4] California Newsreel, Nationality Minority Consortia, Joint Center Health Policy Institute. Unnatural Causes: Is Inequality Making Us Sick? http://www.unnaturalcauses.org/resources.php?topic_id=3

[5] Robert Wood Johnson Foundation Commission to Build a Healthier America. http://www.commissiononhealth.org/Education.aspx

The Health Equity Index points to the connection that income and poverty have to health outcomes. Higher incomes make it easier to buy medical insurance and medical care, nutritious foods, and better child care, and to live in a safe neighborhood with good schools and recreational facilities. Income levels have also been correlated to life expectancy, with lower income earners experiencing lower life expectancies[6]. It has been widely observed that poverty has been linked to ill health and vice versa, creating a cycle between income and health that can continue across lifetimes and generations[7]. Lower income communities have shown higher rates of asthma, obesity, diabetes, heart disease, and child poverty.

Focus group participants and interviewees identified several community concerns. The economic downturn has affected the region's residents and organizations that provide services to them. Poverty within Norwalk has increased. According to one interviewee, the proportion of Norwalk students eligible for free and reduced lunch has risen from 22% to 40%[8]. Other respondents from the city reported that residents are struggling to hold onto employment and sometimes work two or three low-wage jobs while at the same time struggling to pay for things like child care and health care. The economic downturn has affected the more affluent communities as well, as professional jobs have been lost and families struggle with adjusting to new lifestyles. Focus group participants from social service and health organizations reported that increased demand for their services and shrinking resources have challenged their ability to continue to meet needs effectively.

Quantitative data point to a region of substantial wealth. According to the Census Bureau, household median income in the Greater Norwalk area was more than $50,000 higher than that for Connecticut as a whole (Figure 9). With the exception of Norwalk, all of the towns in the region have a median household income of greater than $100,000, with the highest in Weston ($209,630). Norwalk's median household income in 2010 was $76,161, about $44,000 lower than that for the Greater Norwalk area as a whole.

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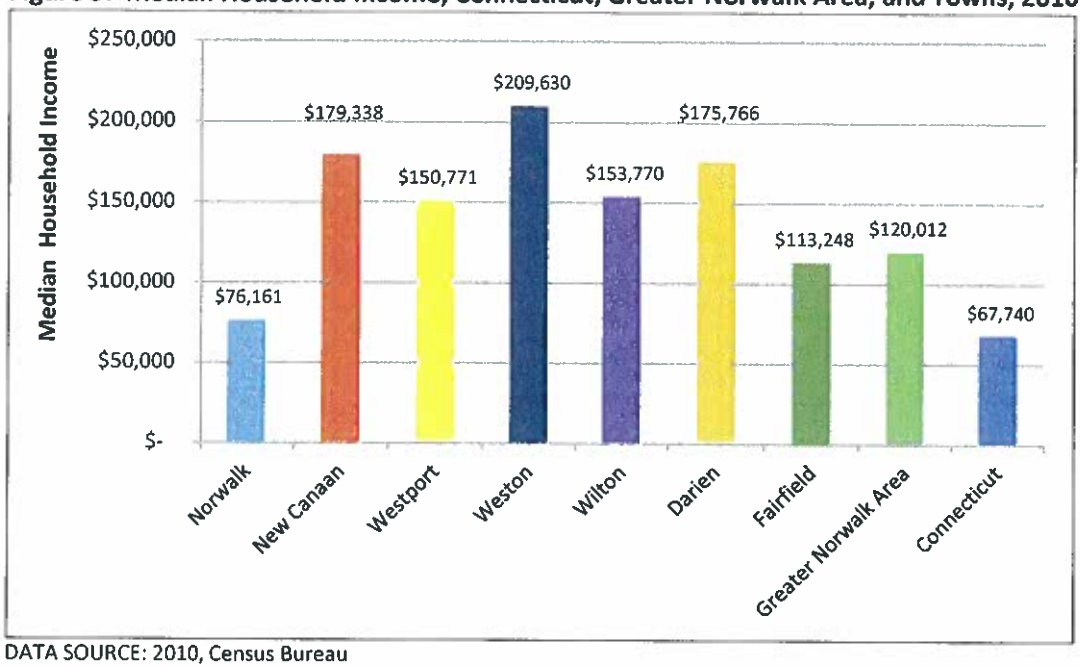
[6] California Newsreel, Nationality Minority Consortia, Joint Center Health Policy Institute. Unnatural Causes: Is Inequality Making Us Sick? http://www.unnaturalcauses.org/resources.php?topic_id=3

[7] Robert Wood Johnson Foundation Commission to Build a Healthier America. http://www.commissiononhealth.org/Education.aspx

[8] For the Fall semester of 2012, the percentage of students eligible free or reduced lunch in the Norwalk Public Schools was approximately 43%.

Figure 9: Median Household Income, Connecticut, Greater Norwalk Area, and Towns, 2010

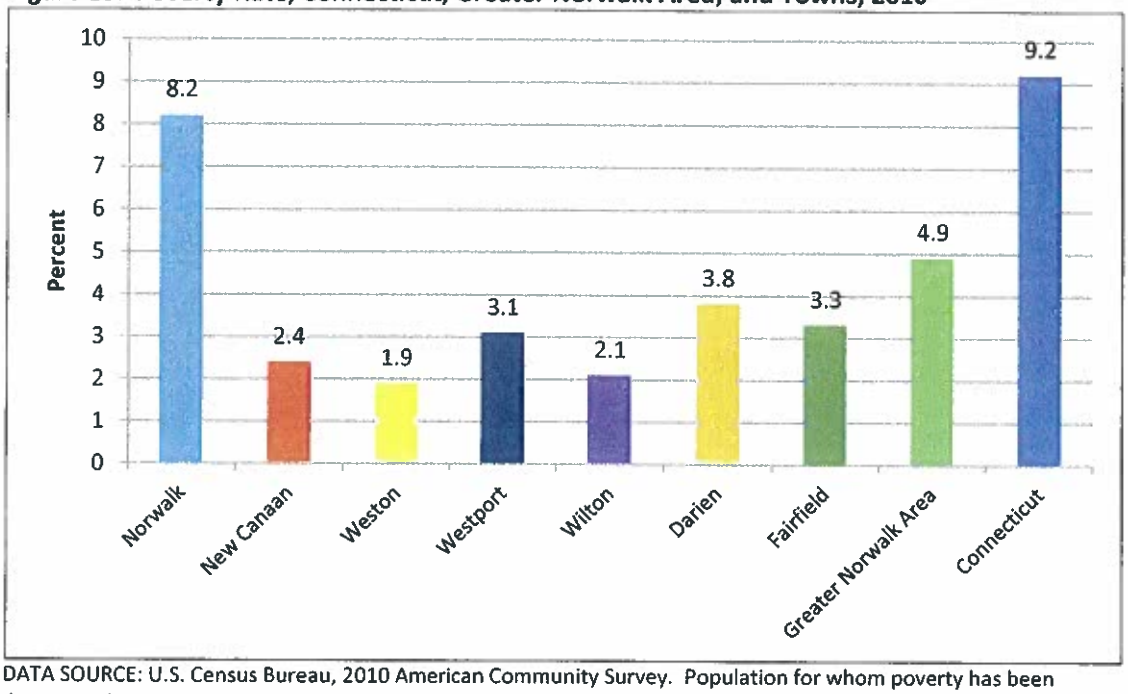


DATA SOURCE: 2010, Census Bureau

Poverty rates across much of the Greater Norwalk area are low. The poverty rate for the region was 4.9% in 2010, almost half the rate for the state (9.2%)

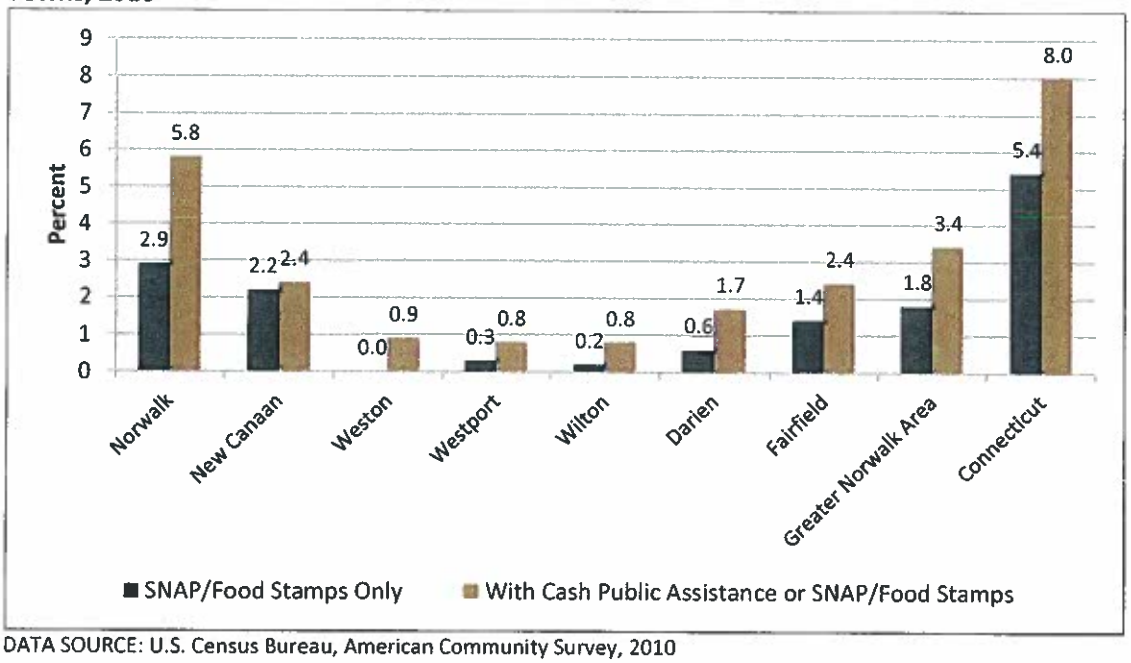
Figure 10 shows the poverty rate was less than 4% in most communities, with the exception of Norwalk where 8.2% of individuals were below poverty level according to the American Community Survey. Because of its larger population size, 61.3% of all persons in poverty (6,868) in the area in 2010 lived in Norwalk. Approximately 3.4% of Greater Norwalk households received cash public assistance or Food Stamps/SNAP in 2010, compared to 8.0% for the state as a whole (Figure 11). Twelve percent of persons in poverty in Norwalk are children under 18.

Figure 10: Poverty Rate, Connecticut, Greater Norwalk Area, and Towns, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey. Population for whom poverty has been determined.

Figure 11: Households with public assistance (cash) or food stamps (SNAP), Connecticut and Towns, 2010

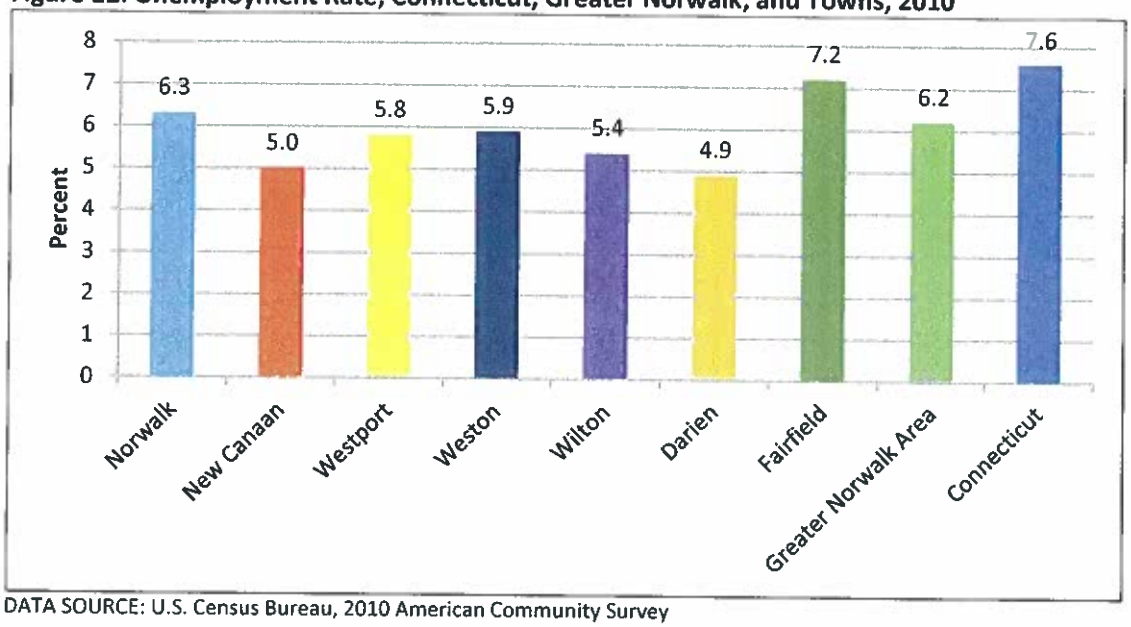


DATA SOURCE: U.S. Census Bureau, American Community Survey, 2010

Employment

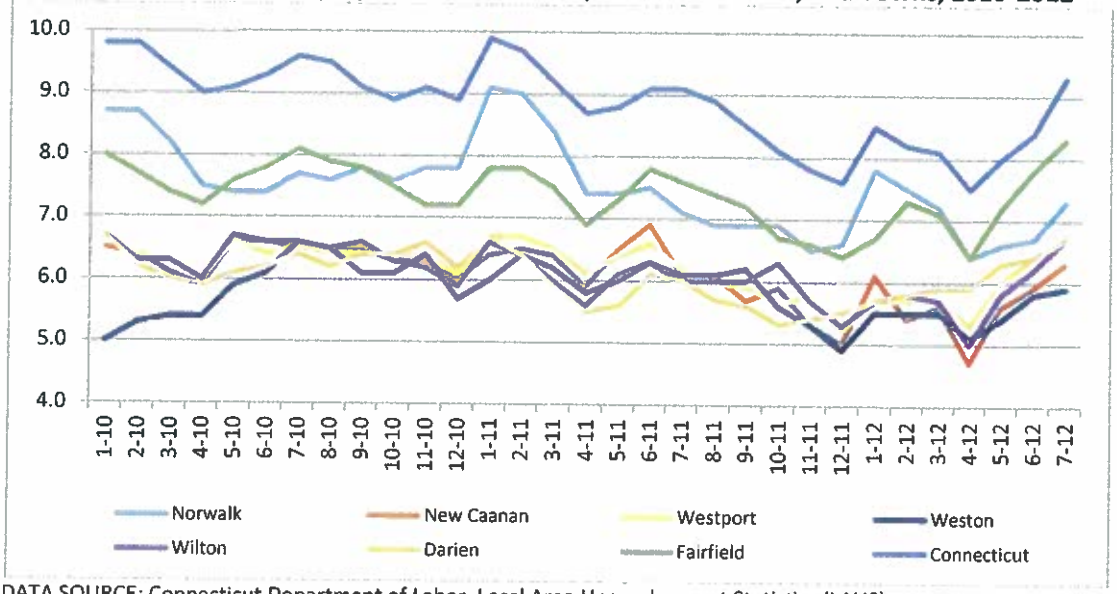
The 2010 unemployment rate for the Greater Norwalk Area was 6.2%, slightly lower than the rate for the state (7.6%) (Figure 12). Across most towns, the rate was between 5-6%. The highest unemployment rate in the area was in Fairfield (7.2%). Darien had the lowest unemployment rate, 4.9%. The unemployment rate in the region has fluctuated monthly since 2010 although over time, the rate for the towns has been less than for the state as a whole (Figure 13).

Figure 12: Unemployment Rate, Connecticut, Greater Norwalk, and Towns, 2010[9]



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

Figure 13: Monthly Unemployment, Connecticut, Greater Norwalk, and Towns, 2010-2012

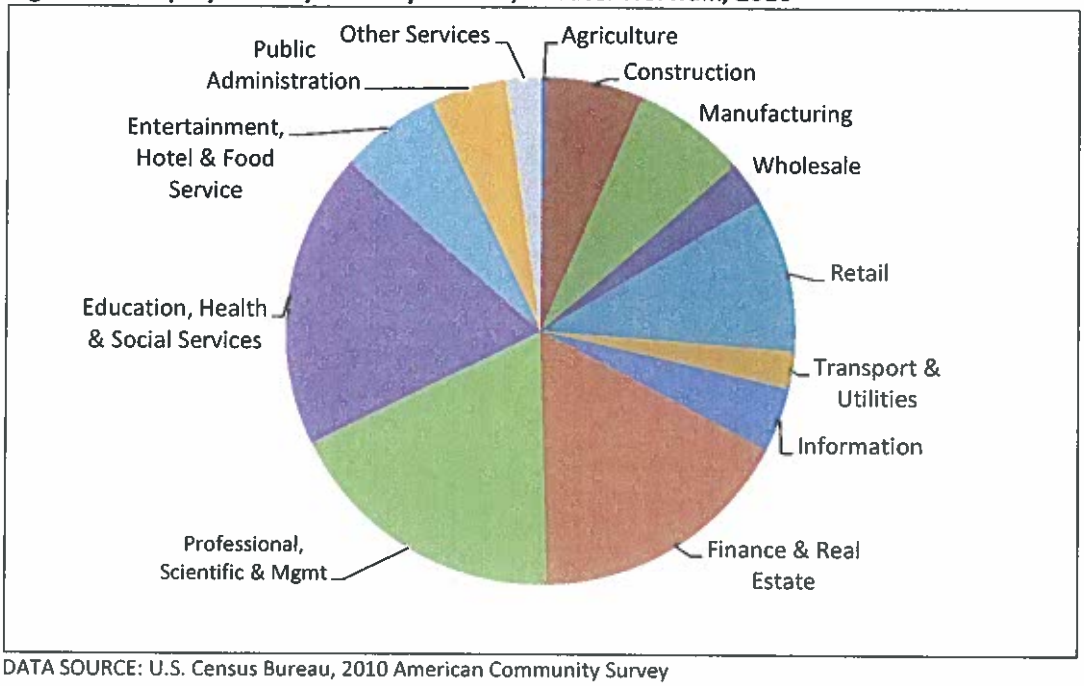


DATA SOURCE: Connecticut Department of Labor, Local Area Unemployment Statistics (LAUS)

[9] Civilian Labor Force, age 16 and above

As seen in Figure 14, the highest proportion of Greater Norwalk's workers are employed in Education, Health and Social services (18.8%), Professional, Scientific and Management (18.2%), and Finance and Real Estate (16.8%). Compared to the rest of the state, the region has a higher proportion of adults employed in Finance and Real Estate (16.8% compared to 9.5%) and Professional, Scientific, and Management positions (18.2% compared to 10.7%). [Additional Data in Appendix E]

Figure 14: Employment by Industry Sectors, Greater Norwalk, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

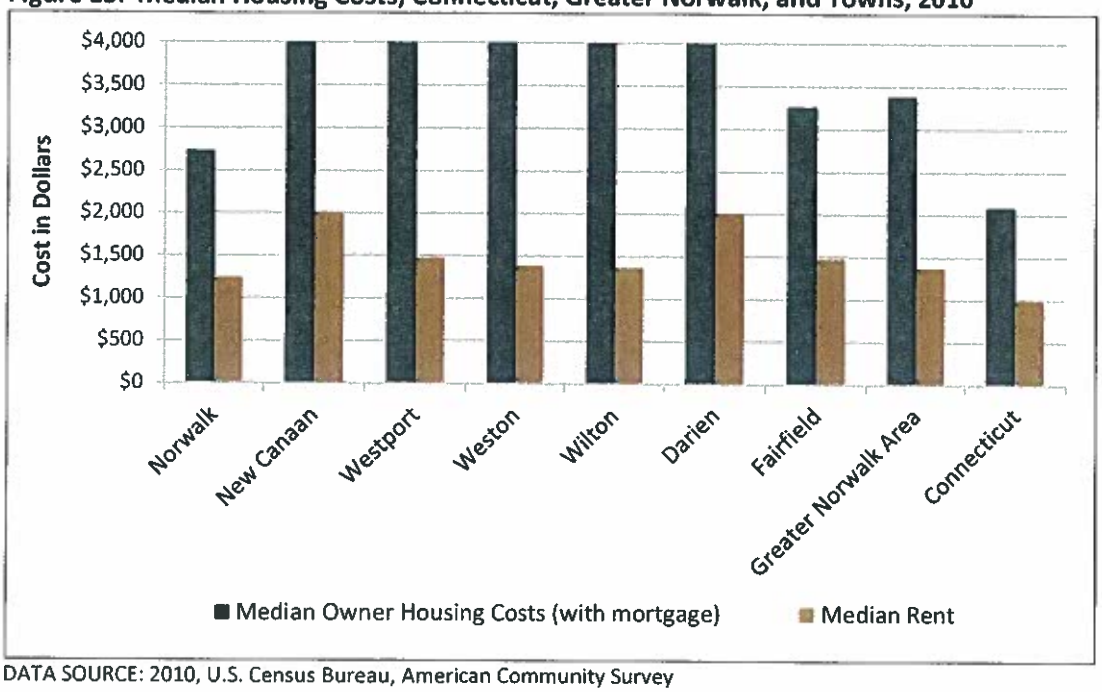
Housing

As a largely prosperous region, housing in the Greater Norwalk Area is expensive and many participants identified the high cost of housing throughout the region as a concern. For some individuals and families, after covering their housing costs, little is left to cover food and other items. Some pointed to rising homeless rates, over-burdened homeless services, and large numbers of people living in one residence/apartment as evidence of growing housing constraints, especially since the economic downturn. Others reported that it has become increasingly difficult for the elderly to afford to stay in their homes. Several focus group members from Norwalk reported that development in some areas of the city (SoNo) is forcing long-time residents out.

As shown in Figure 15, median monthly housing costs with a mortgage or monthly rental costs are higher in this region than for the state as a whole. Monthly mortgage costs range from $2,731/month in Norwalk to $4,000/month in the five communities of New Canaan, Westport, Weston, Wilton, and Darien. This compares to $2,082/month on average for the state. Monthly rental costs are also higher in the region than for the state as a whole. While Norwalk and Fairfield's rentals ($1,231/month and $1,464/month, respectively) are slightly higher than for the state as a whole ($982/month), in New Canaan and Darien, the monthly rental cost is twice as high. Housing in the region is very expensive; the median home sale price in the Greater Norwalk Area is three times higher than for the state as a whole

($631,808 versus $220,000). Data from the Connecticut Housing Finance Authority indicate the median sale price for a single family home in Darien and New Canaan was $1,250,000 in 2010. [Additional Data in Appendix E] Furthermore, the rate of foreclosure filings for the region (2.75 per 1,000 units) was lower than for the state (4.46 per 1,000 units). [Additional Data in Appendix E]

Figure 15: Median Housing Costs, Connecticut, Greater Norwalk, and Towns, 2010[10]



DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

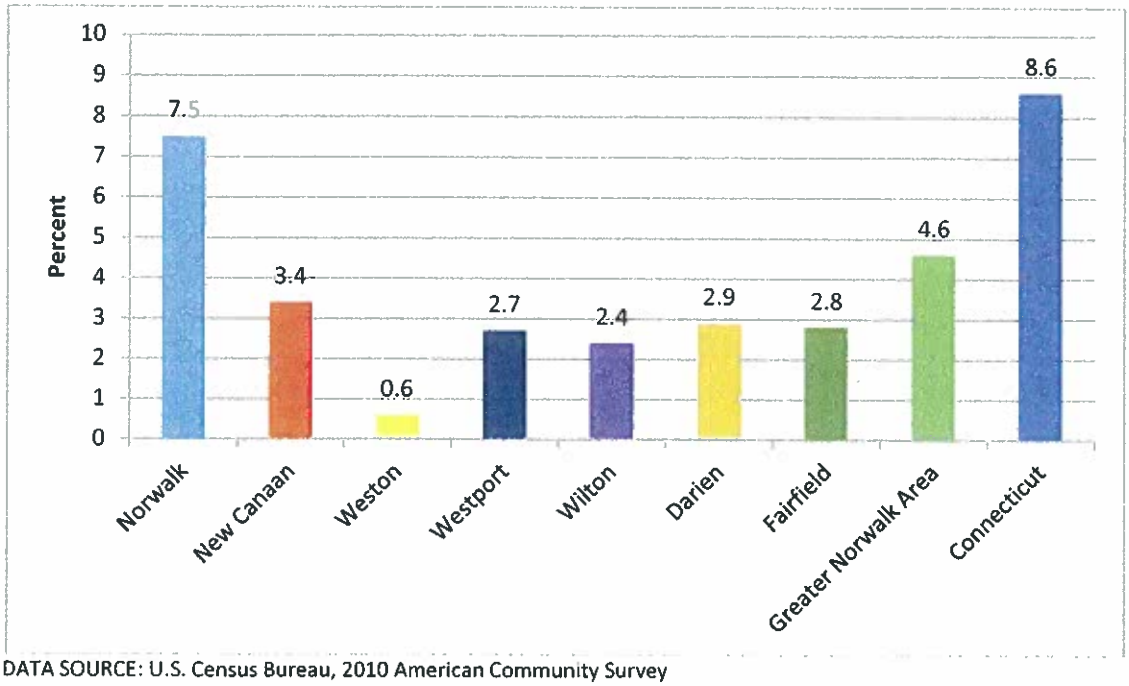
Transportation

"Transit system is a big plus as well." – Focus group participant

Quantitative data show that fewer Greater Norwalk residents (4.6%) than residents of the state as a whole (8.6%) lack access to a vehicle (Figure 16). While overall, residents in most of the towns have access to a vehicle, 7.5% of Norwalk's population does not have access to a vehicle. Further, a higher proportion of Greater Norwalk workers (13.0%) use public transportation to get to work than the state as a whole (4.4%) (
Figure 17). These findings may be attributable to the proportion of the population that commutes into New York City for work.

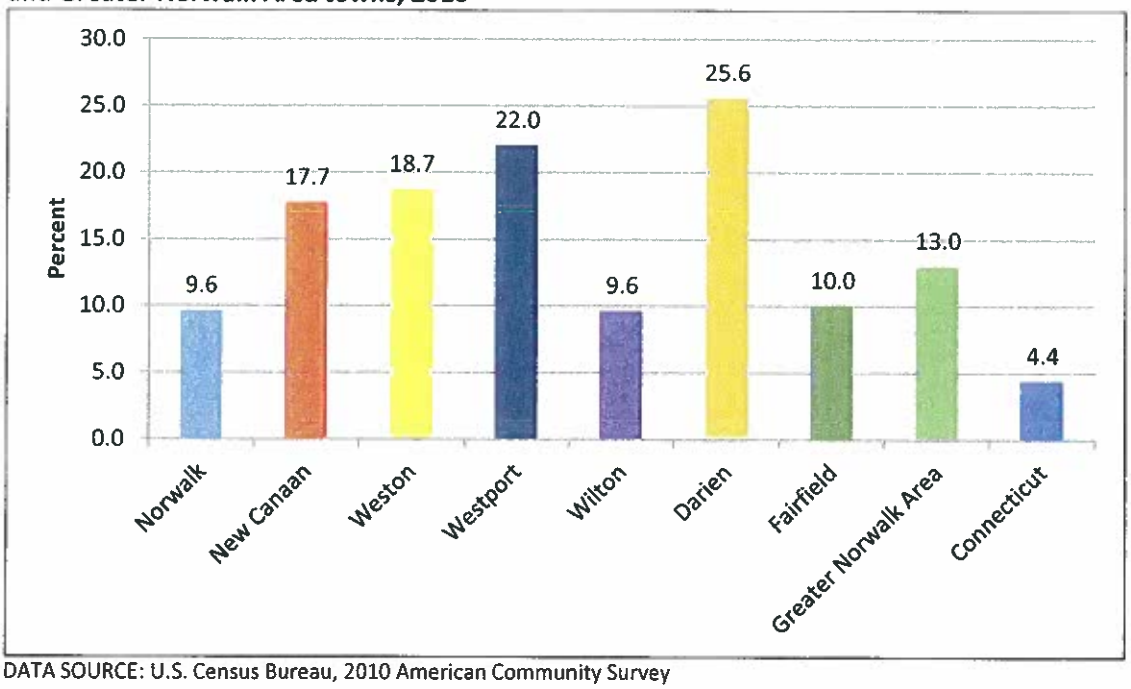
[10] Housing cost for owners includes mortgage (if there is one), taxes, insurance, and utilities. Rent does not include utilities unless they are included in the rent payment.

Figure 16: Households with no Vehicle Available, Connecticut, Greater Norwalk Area towns, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

Figure 17: Proportion of workers using public transportation to get to work, Connecticut and Greater Norwalk Area towns, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

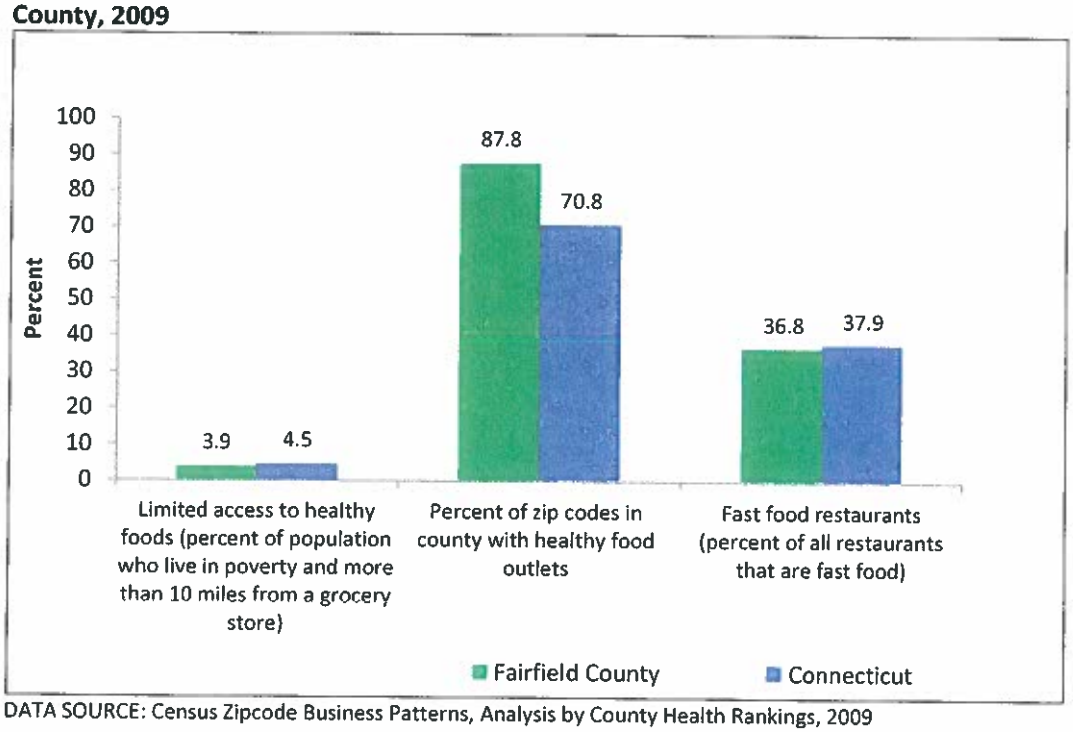
Access to Healthy Foods and Recreation

"Gyms are doing a healthy business – I am seeing full parking lots." – Focus group participant

"They took away the roller skating rink. They took away the ice skating rink. They took away teenage parties for kids that stayed out of the streets. They took away all of that. What is there for our children to do? There's nothing." – Focus group participant

Focus group respondents and interviewees reported concerns about rising obesity levels in the region, particularly among children. Closely related to obesity rates is the availability of healthy foods and opportunities for physical activity and recreation. As Figure 18 below shows, 87.8% of zip codes in Fairfield County have healthy food outlets (i.e., restaurants, grocery stores, convenience stores, farmers' markets, etc. where healthy foods are sold), higher than the rate for Connecticut as a whole (70.8%).[11] However, the proportion of restaurants in Fairfield County that are fast food establishments (36.8%) is similar to that of the state (37.9%). Access to healthy food is a concern in some areas of Norwalk where the U.S. Department of Agriculture has identified three census tracts south of Interstate as food deserts. This means that these areas are low income, and that a substantial number or share of residents has limited access to a supermarket or a large grocery store.

Figure 18: Percent of People with Access to Healthy Foods, Connecticut and Fairfield County, 2009



DATA SOURCE: Census Zipcode Business Patterns, Analysis by County Health Rankings, 2009

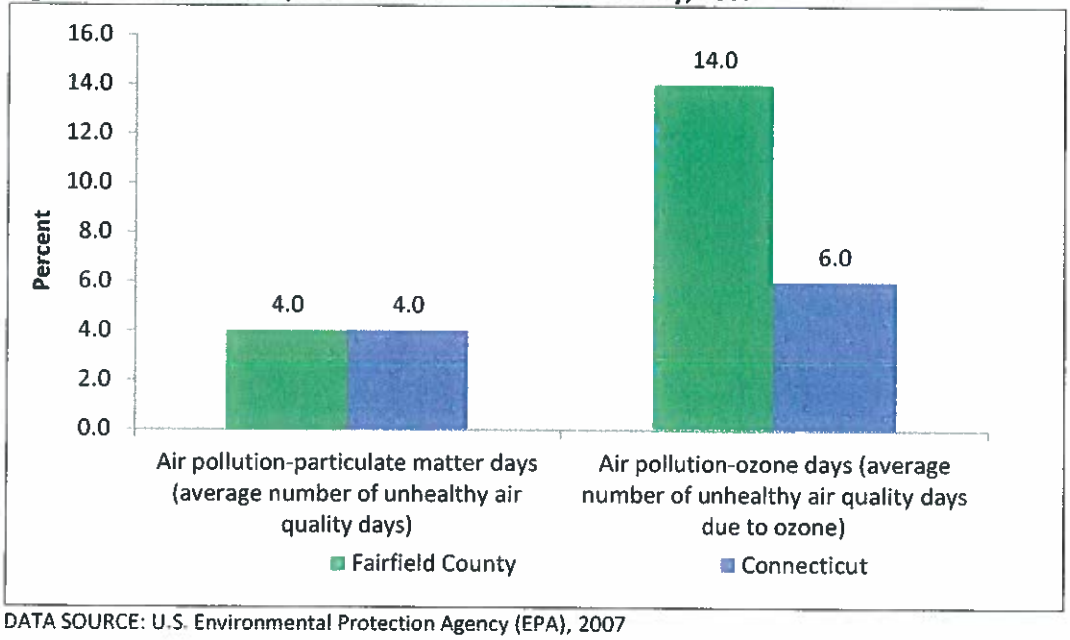
[11] Data specific to the Greater Norwalk Area are not available.

Overall, the region has substantial access to recreational facilities, defined by the County Health Rankings as establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports. There are 20 recreational facilities per 100,000 population in Fairfield County, which is higher than the state rate (14 per 100,000)[12]. However, the cost of using these facilities can be prohibitive to the less affluent, and some residents have less access to parks and green space than others.

Environmental Quality

The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. A review of the literature by the County Health Rankings indicates that the negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, and asthma, among other adverse pulmonary effects. The annual number of unhealthy air quality days due to fine particulate matter for Fairfield County was 4 in 2007, the same as for the state (Figure 19). However, Fairfield County had far higher (14) ozone days (days when air quality was unhealthy for sensitive populations due to ozone levels) than the state as a whole (6).

Figure 19: Air Pollution, Connecticut and Fairfield County, 2007



DATA SOURCE: U.S. Environmental Protection Agency (EPA), 2007

Crime and Safety

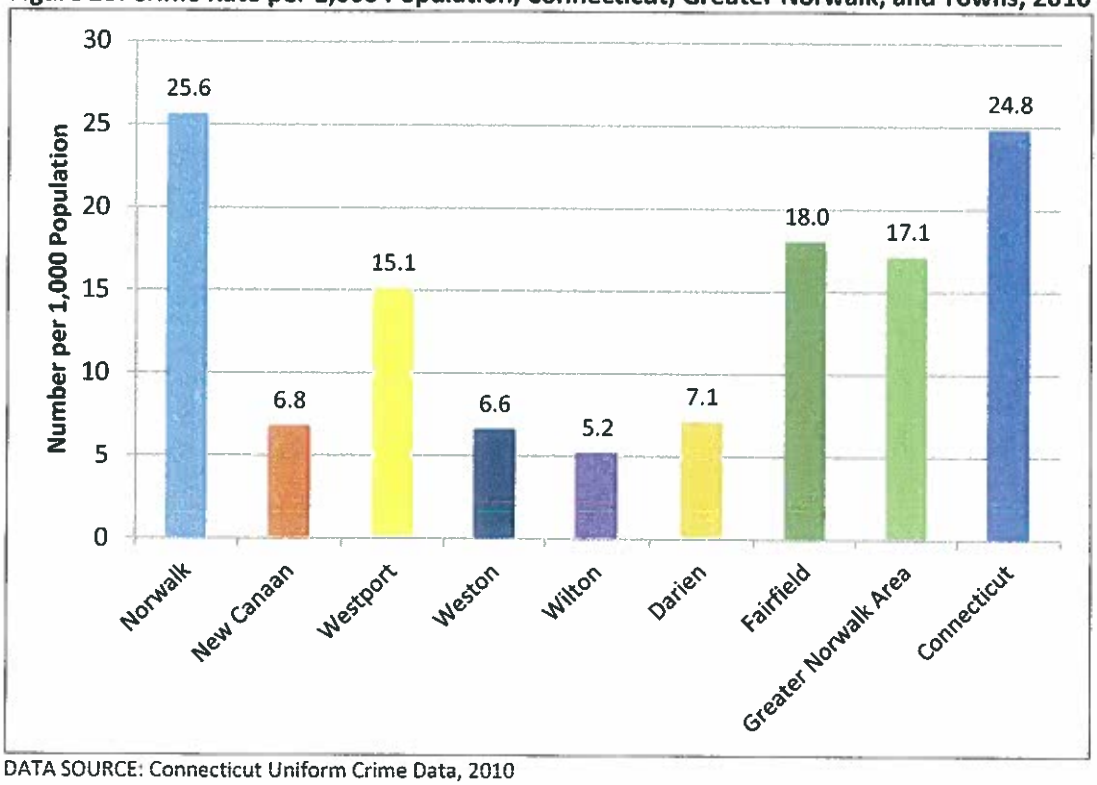
Focus group respondents and interviewees also reported growing rates of person-to-person violence. Within Norwalk, respondents expressed concern about rising crime. Law enforcement focus group members reported a rise in gun violence in the city. As one focus group member stated, *"on my street, in my neighborhood, I feel fine. But not in other places."*

[12] United States Department of Agriculture (USDA) Food Environment Atlas, analysis by County Health Rankings and Roadmaps, 2009

The crime rate (i.e., calculated below as the sum of crimes against persons and crimes against property per 1,000 population) is a widely used indicator to assess the level of safety in an area. Health Equity Index's literature review links crime rates to poorer health outcomes such as mental illness, drug and alcohol abuse, violence, and mortality rates[13]. High crime rates are also linked to other determinants such as income, education, stress, and race[14]. High crime rates contribute to poor physical, economic, and social environments and limits the amount of resources and services available to communities, which lead to poorer health outcomes[15].

Crime data show that, with the exception of Norwalk, the rate of crime is relatively low in the region. While Norwalk (25.6) exceeds the statewide rate of 24.8 crimes per 1,000 population, many of the surrounding communities have rates of less than 10 per 1,000 population. The crime rate in Fairfield and in Westport is also slightly higher than for the rest of the region. See Figure 20.

Figure 20: Crime Rate per 1,000 Population, Connecticut, Greater Norwalk, and Towns, 2010



DATA SOURCE: Connecticut Uniform Crime Data, 2010

Rising rates of domestic violence, within both wealthy and poorer populations, was also cited as a challenge by several respondents. Some attributed this trend to the stress and anxiety resulting from the economic downturn and noted that lack of reporting and/or action by victims is a challenge. As one focus group member noted, *"there are many women that stay*

[13] Dr Rüdiger Krech (Director, WHO Department of Ethics, Equity, Trade and Human Rights): Social Determinants of Health, May 17, 2010

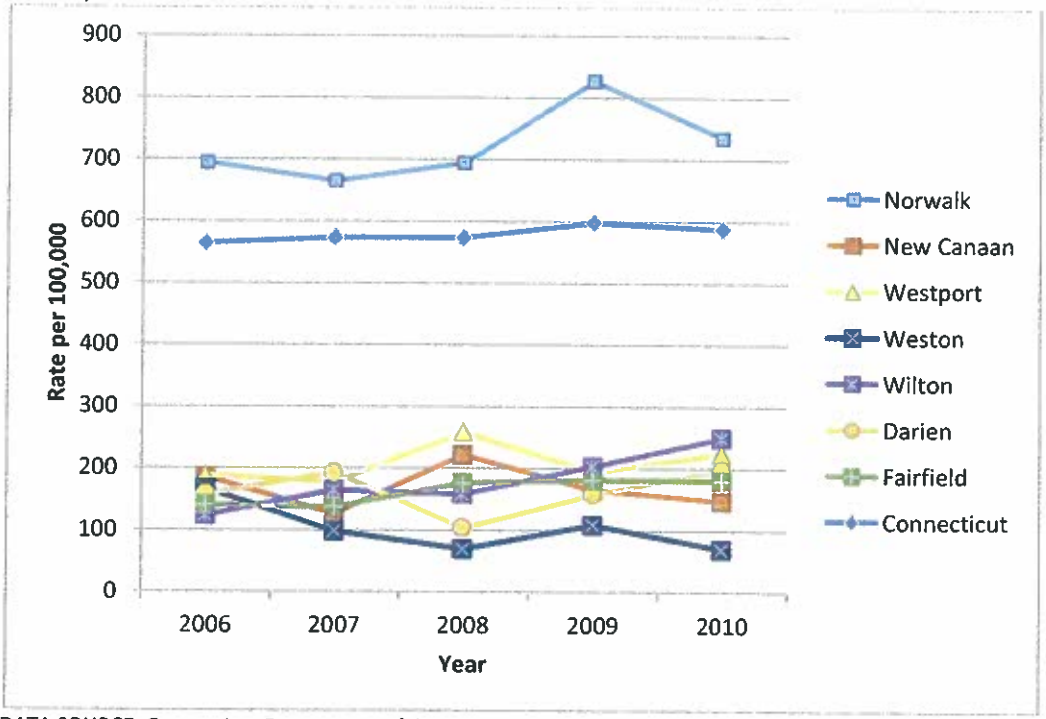
[14] http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2004/10/03/MNINFANTMO.DTL

[15] California Newsreel, Nationality Minority Consortia, Joint Center Health Policy Institute. Unnatural Causes: Is Inequality Making Us Sick? http://www.unnaturalcauses.org/resources.php?

quiet and don't say anything." A law enforcement focus group member shared the same perspective about more affluent women, *"there are going to be wealthy women who are too embarrassed to follow through with plans we help them put into place. They are dependent on their husbands."*

As focus group and interview participants noted that family and domestic violence are concerns in the region, quantitative data indicate that rates in Norwalk are much higher than what is seen statewide. As shown in Figure 21, while the rate of family violence incidence per 100,000 population has decreased in Norwalk from 2009 to 2010, it still remains much higher than the state (734 incidences per 100,000 population compared to 587 incidences per 100,000 population in 2010). Rates of family violence in the other communities are much less than what is seen statewide, yet the rates have been slightly increasing over time from 2008-2010 in Wilton and Darien.

Figure 21: Rate of Family Violence Incidences per 100,000 Population, Connecticut and Towns, 2006-2010



DATA SOURCE: Connecticut Department of Emergency Services and Public Protection

C. HEALTH BEHAVIORS

This section examines lifestyle behaviors among Greater Norwalk residents that support or hinder health. It examines several aspects of individuals' personal health behaviors and risk factors (including physical activity, nutrition, and alcohol and substance use) that result in the leading causes of morbidity and mortality among area residents. Included in this analysis are some measures that are tracked as part of the Healthy People 2020 (HP2020) Initiative, a 10-year agenda focused on improving the Nation's health. Where appropriate and available, Greater Norwalk area statistics are compared to the state as a whole as well as HP2020 targets. However, due to data constraints, most health behavior measures are available only for Fairfield County as a whole and in some cases, only state-level data are available.

Health was often defined by community residents as practicing healthy behaviors, such as physical activity and healthy eating. Focus group participants noted health as the ability to walk and experience natural spaces like the waterfront. For example, one focus group participant described, *"When we were little, people said, 'go outside and have a good time. I'll see you later.' That was a regular part of every day. Part of it is that there is so much that is organized, there are safety concerns, people feel that they have to keep their kids on a short leash. They are afraid."*

Community residents also recognized the importance of having a healthier food environment to maintain health. Several participants mentioned that school lunch programs have become healthier and that it would be advantageous to implement similar policies for the whole community. Additionally, several young community members noted that health means not using alcohol, tobacco or other drugs, as they have seen the negative consequences of these behaviors. The following section will elucidate further how these lifestyle behaviors affect the health of residents in the Greater Norwalk Area.

Healthy Eating, Physical Activity, and Overweight/Obesity

"There is a new bike path that has been established. Bike riding has become an apparent priority." – Focus group participant

"Gardens at all of the schools – a dynamic effort to introduce fruits and vegetables and influence families." – Interview participant

"There is a lot less physical activity [in schools] than there used to be." – Focus group participant

"Folks who are more challenged economically are not going to have physical activity as a priority." – Focus group participant

"As a culture, we've gotten to thinking these things are going to be quicker and easier than they are. It takes time to go to the farmer's market and cook things. Things you microwave aren't nutritious. It takes time to exercise. As a country, we don't spend time on these fundamental things." – Focus group participant

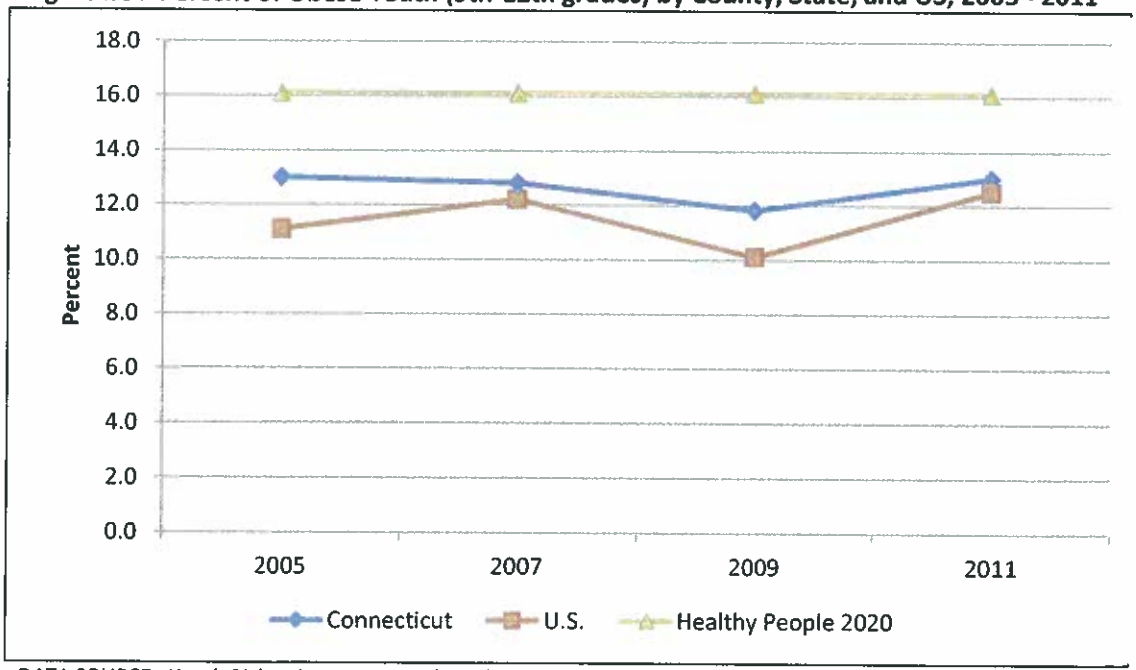
Similar to trends nationwide, issues around obesity—particularly healthy eating and physical activity—emerged as a concern among focus group and interview participants. Obesity was the health issue most frequently named by focus group respondents and interviewees, with a particular concern around childhood obesity. Participants saw that rates of obesity-related conditions such as diabetes and heart disease seemed to be rising.

Respondents offered several reasons for the rise in obesity especially among children, including a fast-paced and busy lifestyle that relies on fast food, concerns about safety, and the attraction of computers and texting that leads children to be more sedentary. Respondents suggested that among less affluent parents, the expense of healthy foods, gym memberships, and physical activity programs creates barriers to healthy eating and physical activity. Teens reported that gym classes in school do little to help or encourage students to stay in shape. Among more affluent parents, a focus on academics and educational activities reduces opportunities for physical activity. As one focus group member noted, "*kids don't even walk to the bus stop, they get picked up at their own houses*." Others noted that the old infrastructure in the region has made it difficult to make changes that encourage more physical activity such as adding bike lanes to roads. Several respondents expressed their opinions that the obesity epidemic stems from a lack of motivation among people to engage in healthy behaviors. As one focus group member observed, "*there are a lot of people who do not accept responsibility for taking care of themselves*."

Child and Youth Obesity

The obesity rate among high school students in Connecticut has changed little since 2005. In 2011, the rate (13.0%) as a whole was similar to that of the nation and lower than the Healthy People 2020 target of 16.1% (Figure 22). While little data are available about obesity rates specifically among Greater Norwalk's children, there are some data available for Norwalk from the 2011 Norwalk Body Mass Index (BMI) Data Report. Norwalk has youth obesity prevalence rates that are higher than the state average in many cases. For example, for 9th and 10th grade students, the rate is twice as high for Norwalk students than youth in the state of Connecticut overall (20% vs. 10%). Minority children are at higher risk of unhealthy weight than white children, as are children of all races from lower-income families.

Figure 22 : Percent of Obese Youth (9th-12th grades) by County, State, and US, 2005 - 2011

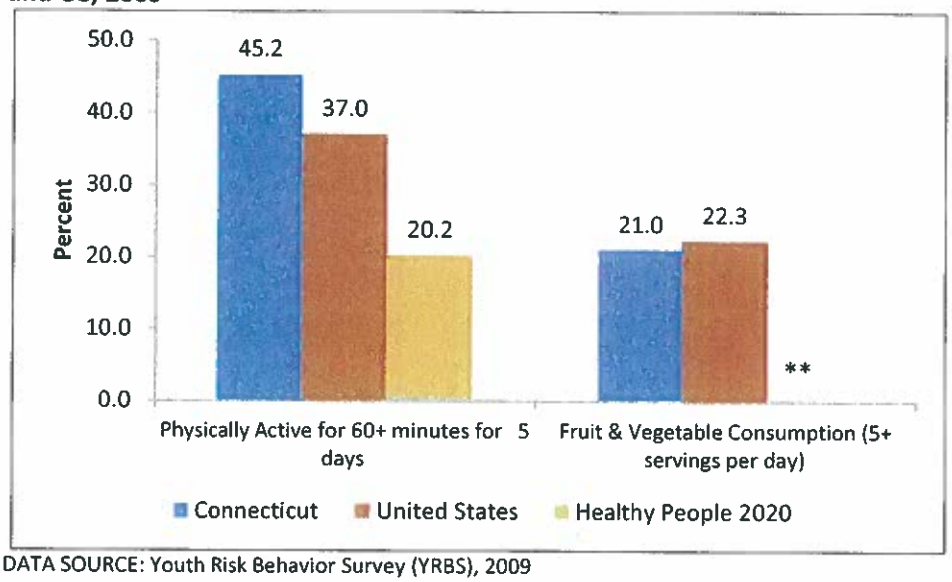


DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2005, 2007, 2009, 2011
**relevant Fairfield County data not available

Data collected through the Youth Risk Behavior Survey indicate that although higher than for the U.S. (37.0%) and the Healthy People 2020 Target (20.2%), less than half 45.2% of youth in

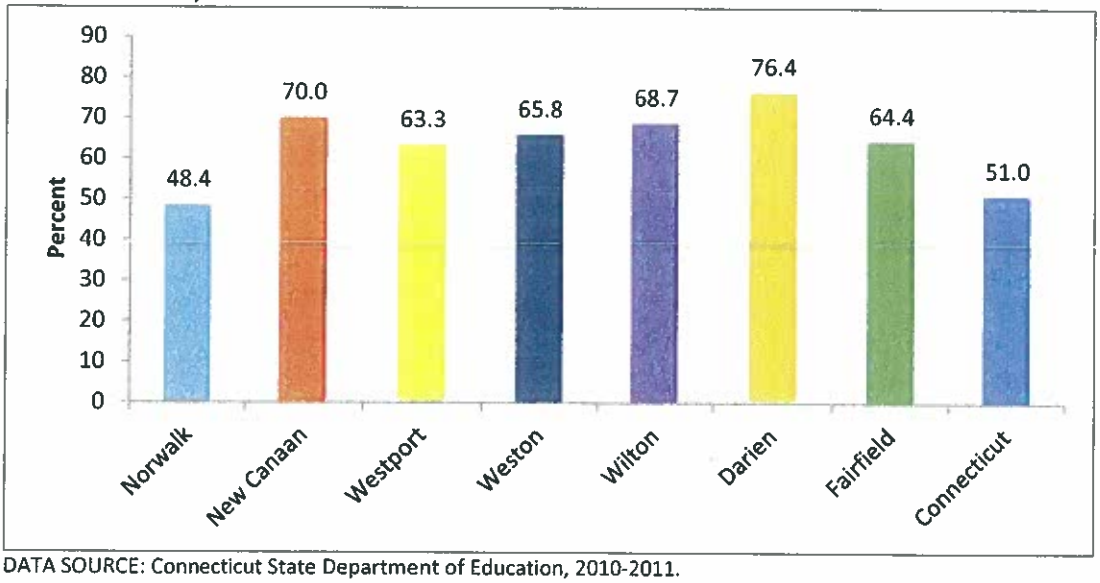
Connecticut are getting the recommended level of exercise per week (Figure 23). Less than one-quarter (21.0%) of youth in Connecticut were eating the recommended number of fruits and vegetables per day, roughly the same proportion for U.S. youth as a whole (22.3%). Town-level data on physical activity collected by the Connecticut Department of Education (Figure 24) indicate that most towns in the Greater Norwalk area exceed the state average for the percent of children meeting physical activity standards (averaging 63-76%). The exception is Norwalk, which had the lowest percentage of children meeting the standards (48.4%) among Greater Norwalk Area towns, and was below the state average (51.0%).

Figure 23: Physical Activity and Fruit and Vegetable Consumption among Youth by State and US, 2009



DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2009
*relevant Healthy People 2020 Target, not available

Figure 24: Percent of Children Meeting the Standard on All Four Physical Activity Tests* by Town and State, 2010-2011

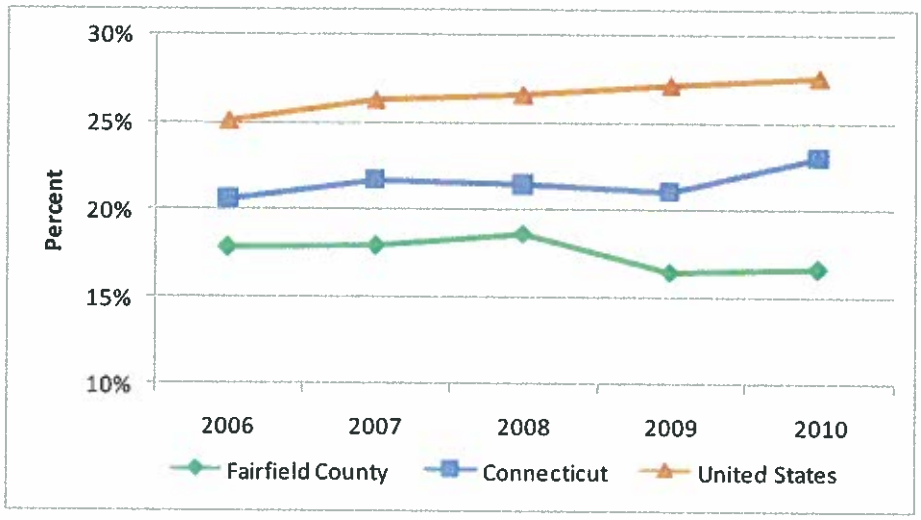


DATA SOURCE: Connecticut State Department of Education, 2010-2011.
*Four tests include: Aerobic endurance, upper body and abdominal strength and endurance and flexibility.

Adult Obesity

As seen in Figure 25, compared to the rest of the state and country, Fairfield County has a smaller prevalence of adult obesity (16.6%) in 2010, compared with the rest of the state (23.0%) and the country (27.6%), and is ranked as having the lowest obesity rate of all Connecticut counties. In addition, obesity in Fairfield County decreased slightly between 2006 and 2010, while rates for Connecticut and the U.S. have increased slightly. There are differences across racial and ethnic groups, however. The rates of adult obesity are highest for Blacks (43.5%), which is almost double the average for Whites (22.1%). [Additional Data in Appendix E]

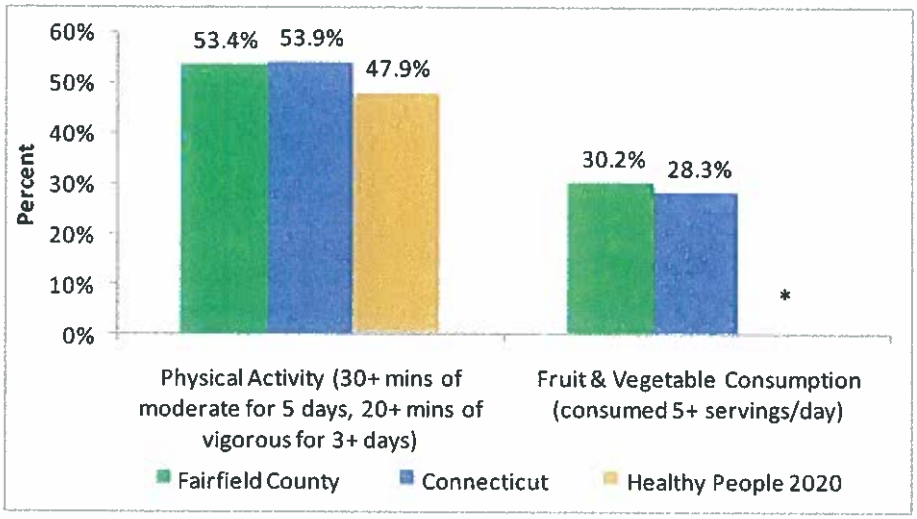
Figure 25: Percent of Obese Adults by County, State, and US, 2006-2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

As Figure 26 shows, rates of physical activity and fruit and vegetable consumption among Fairfield County adults are similar to the state as a whole. About one half (53.4%) of adults in Fairfield County are getting the recommended level of exercise per week, a rate similar to Connecticut as a whole (53.9%) and slightly exceeding the Healthy People 2020 goal of 47.9%. Roughly 30% of adults in Fairfield County are consuming the recommended number of fruits and vegetables per day, a rate comparable to that for the state (28.3%).

Figure 26: Physical Activity and Fruit and Vegetable Consumption among Adults in Fairfield County and Connecticut, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010
*relevant Healthy People 2020 Target, not available

Substance Use and Abuse (Alcohol, Tobacco, and Other Drugs)

"[Police bring on] average a drunk up to the ER every other day. [The ER] has limited resources and they release them after 4-5 hours. Within a week, we're grabbing the same person. [The ER staff should] send them for treatment, not back on the street." – Focus group participant

"[The system] is not always able to work together holistically to get people the longer term help they need." – Interview participant

"Norwalk probably has the most drug activity out of the communities—we have OD's, illicit drug sales everywhere. It is rampant. We've had at least three cases of bath salts. We have meth, heroin, crack, you name it, it's here." - Focus group participant

Substance abuse was the third most-frequently cited health concern in the region, especially in Norwalk, by focus group and interview participants.

Youth Substance Use

"High school kids are dealing with their families' heavy duty problems and this is reflected in their behaviors." – Focus group participant

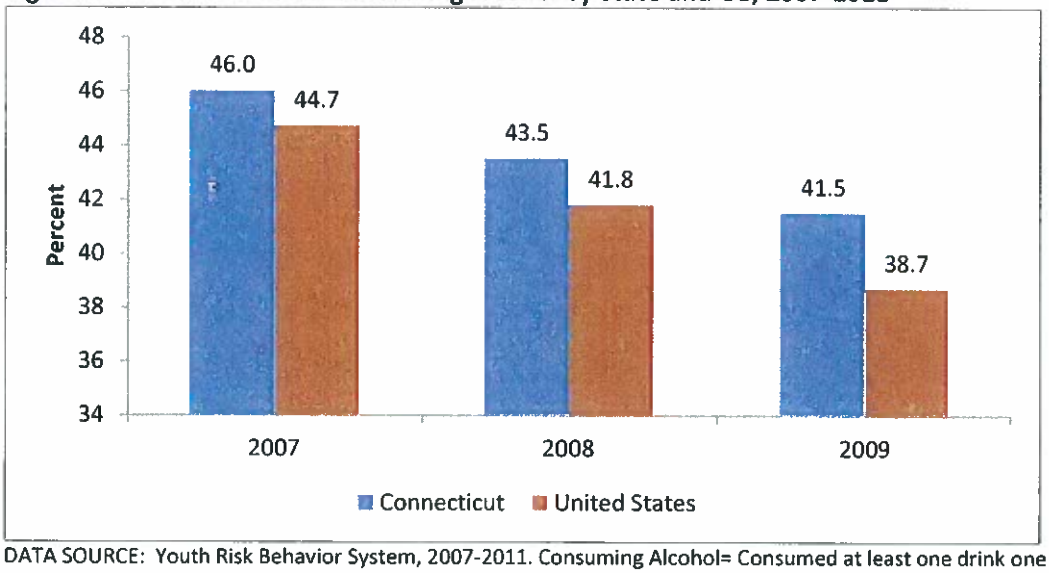
"Alcohol is a very big issue, probably the biggest." – Focus group participant

According to focus group participants and interviewees, among young people, drinking and marijuana is on the rise in both Norwalk and surrounding communities. Teen focus group members identified smoking, drinking, and drug use as a significant concern in their communities and noted that these substances are easily accessible to youth. An educator stated, *"there has been an increase in expulsions and suspensions due to use of marijuana."*

However, quantitative data indicate that drinking rates among youth in the region and the state have declined over time. Data from the Connecticut YRBS indicate that the proportion of youth consuming alcohol declined from 46.0% in 2007 to 41.5% in 2011 (Figure 27). This is similar to rates for the U.S., which had declined from 44.7% in 2007 to 38.7% in 2011.

Data show that the percentage of Connecticut youth consuming alcohol before the age of 13 has decreased from 21.3% in 2005 to 15.6% in 2011, a statistically significant decrease. Data collected by Positive Directions points to the average age of first consumption of alcohol in the region as about 13 years, which is similar to national numbers from the National Institute on Alcohol Abuse and Alcoholism, which identify 11 years old for boys and 13 years old for girls. Similarly, in Connecticut a higher percentage of males (18.2%) than females (12.7%) drank for the first time before 13 years of age. In addition, a higher percentage of Hispanic youth in Connecticut (20.7%) drinks alcohol before the age of 13 years than Black (16.7%) or White (13.8%) youth. These results are consistent with national trends. [Additional Data in Appendix E]

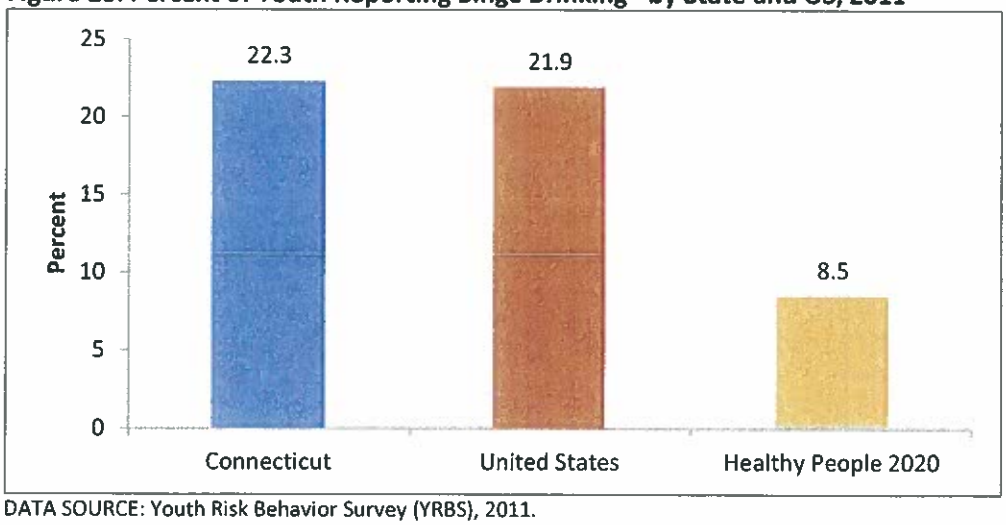
Figure 27: Percent of Youth Consuming Alcohol by State and US, 2007-2011



DATA SOURCE: Youth Risk Behavior System, 2007-2011. Consuming Alcohol= Consumed at least one drink one day in the last 30 days

Binge drinking rates[16] among Connecticut youth (22.3%) are similar to those for the nation as a whole (21.9%) and higher than the Healthy People 2020 target of 8.5% (Figure 28). As with age of first drink, Youth Risk Behavior Survey Data indicate that binge drinking among Connecticut youth has decreased from a rate of 27.8% in 2005 to 22.3% in 2011. This is a statistically significant decrease. The percentage of Connecticut male youth reporting binge drinking (25.4%) is higher than for Connecticut females (19.3%). In addition, a higher percentage of White youth in Connecticut (24.8%) had 5 or more drinks in a row within a couple hours on at least 1 day in the last month than Hispanic (21.1%) or Black (12.3%) youth. This differs from national trends that indicate higher binge drinking rates among Hispanic youth than Black or White youth. [Additional Data in Appendix E]

Figure 28: Percent of Youth Reporting Binge Drinking* by State and US, 2011

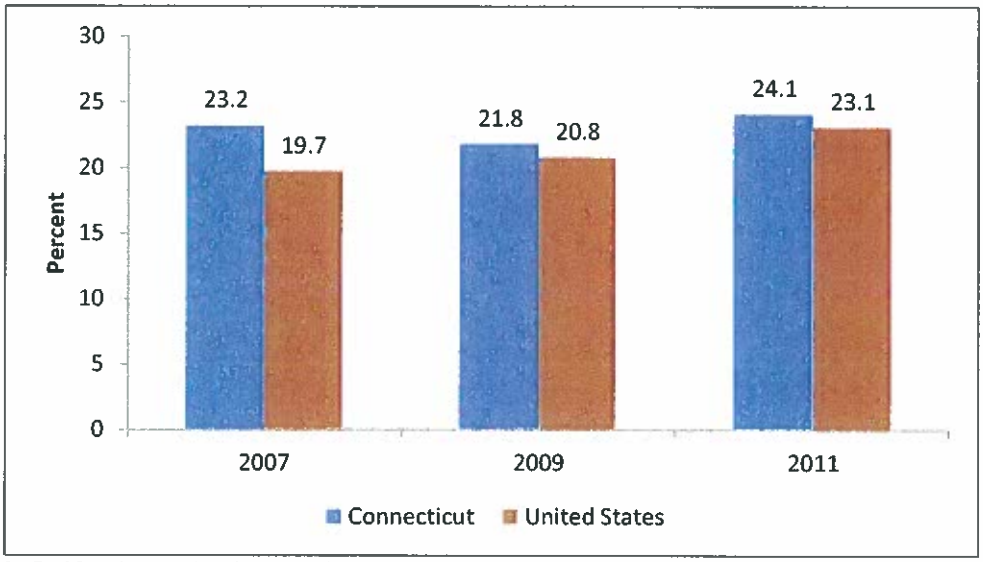


DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2011.
Binge drinking=*5 or more drinks in a row on 1 or more days

[16] Defined as 5+ drinks of alcohol in a row within a couple hours on at least one day in the last month

Marijuana use among Connecticut youth has remained relatively the same (roughly 24%) between 2007 and 2011, although it declined slightly in 2009 (see Figure 29). This rate is slightly higher than that of the U.S. According to 2011 YRBS data, only 6.3% of youth in Connecticut had tried marijuana for the first time before the age of 13, compared to 8.1% for the nation as a whole.

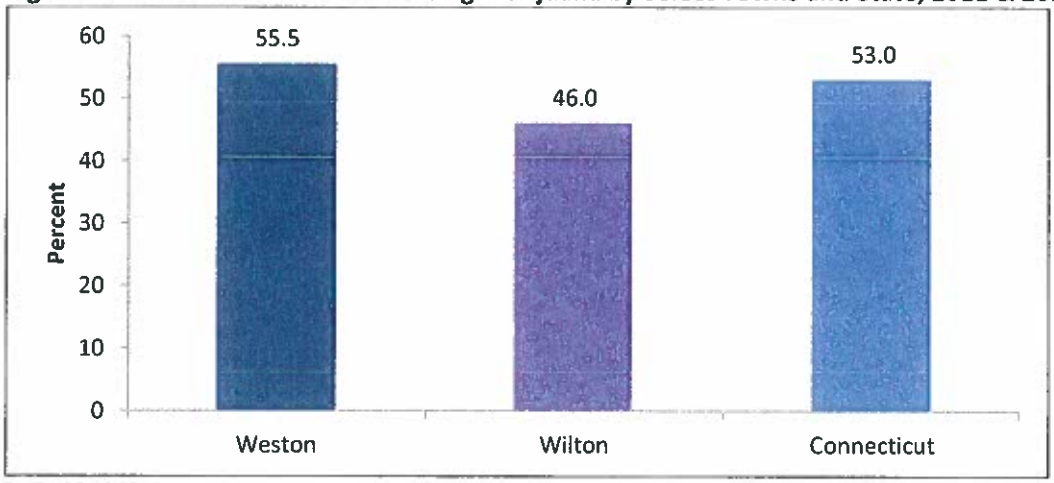
Figure 29: Percent of Youth Using Marijuana* in Previous 30 Days, by State and US, 2007-2011



DATA SOURCE: Youth Behavior Risk System, 2007-2011.
* Marijuana Use = Youth using marijuana at least once with the last 30 days

The proportion of 12th graders who have ever used marijuana in selected towns in the region is roughly the same as for the state as a whole (Figure 30). Data collected by Positive Directions points to the average age of first use of marijuana as between 14 and 15 in the region.

Figure 30: Percent of 12th Graders Using Marijuana by Select Towns and State, 2011 & 2012

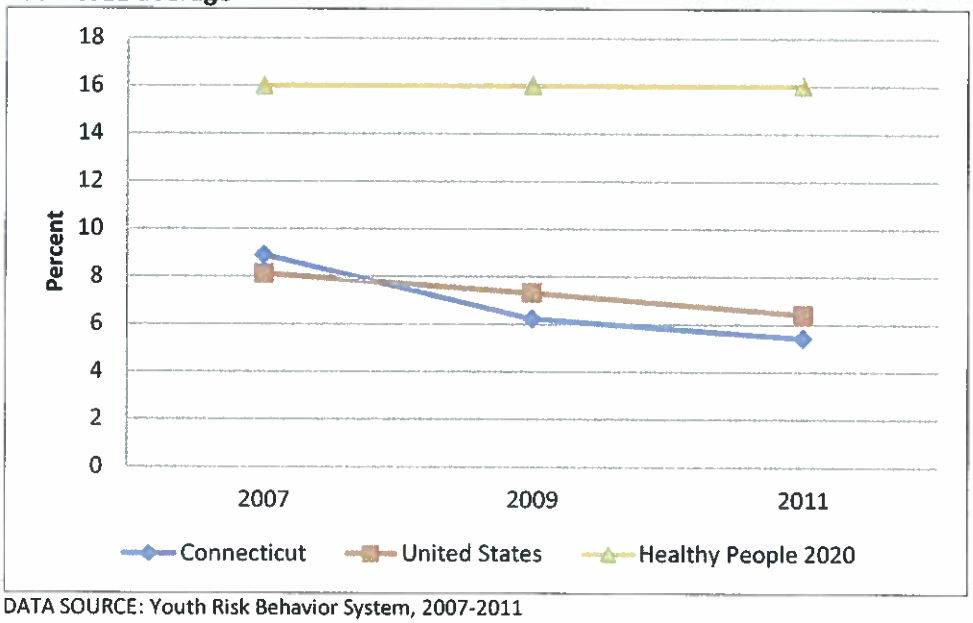


DATA SOURCE: Positive Directions, 2011 and Youth Risk Behavior System, 2011.
Weston & Wilton: % lifetime users of marijuana users among 12th graders. Source: Positive Directions, 2011.
Connecticut: %12 graders ever used marijuana Source: Youth Risk Behavior System, 2011

Participants in the July 24 Task Force meeting reported concerns about prescription drug abuse. Data collected by Positive Directions in Wilton reveals that 18.6% of senior high school students reported prescription drug abuse, slightly higher than the 16.8% of senior high school students in Connecticut. Nationwide 25.6% of 12th graders report taking prescription drugs without a doctor's prescription.

Quantitative data indicate that smoking rates among youth in the region and the state are low compared to the nation and have declined over time. The proportion of Connecticut youth who smoked heavily (20+ days of the prior month) in 2011 was 5.4% compared to 6.4% for the nation. This is substantially lower than the Healthy People 2020 target of 16% (Figure 31). Furthermore, data indicate that between 2007 and 2011 the proportion of youth smoking heavily decreased both nationally and in the state. In Connecticut, the percentage of youth who smoked heavily decreased from 8.9% in 2007 to 5.4% in 2011.

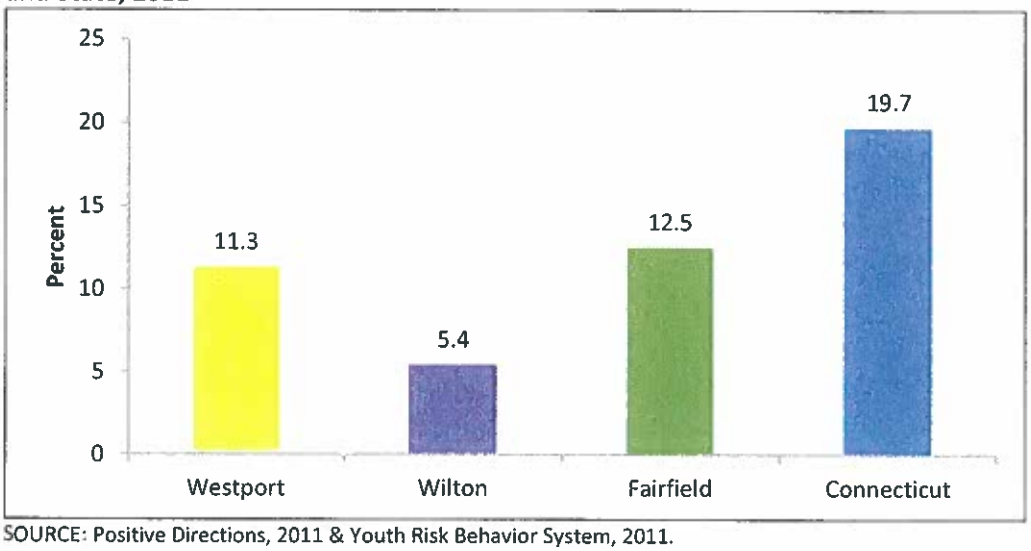
Figure 31: Percent of Youth Smoked Cigarettes on 20+ Days of Last 30 Days by State and US, 2007-2011 average



DATA SOURCE: Youth Risk Behavior System, 2007-2011

Quantitative data reveals that among youth in the three communities for which data are available, rates of youth smoking are lower than for the state as a whole. While 19.7% of 11th graders in Connecticut reported recently using cigarettes in 2011, slightly over 10% of youth in Westport and Fairfield and slightly over 5% of youth in Wilton reported recently using cigarettes (Figure 32).

Figure 32: Percent of 11th Graders Recently Used Cigarettes in Past 30 Days by Select Towns and State, 2011

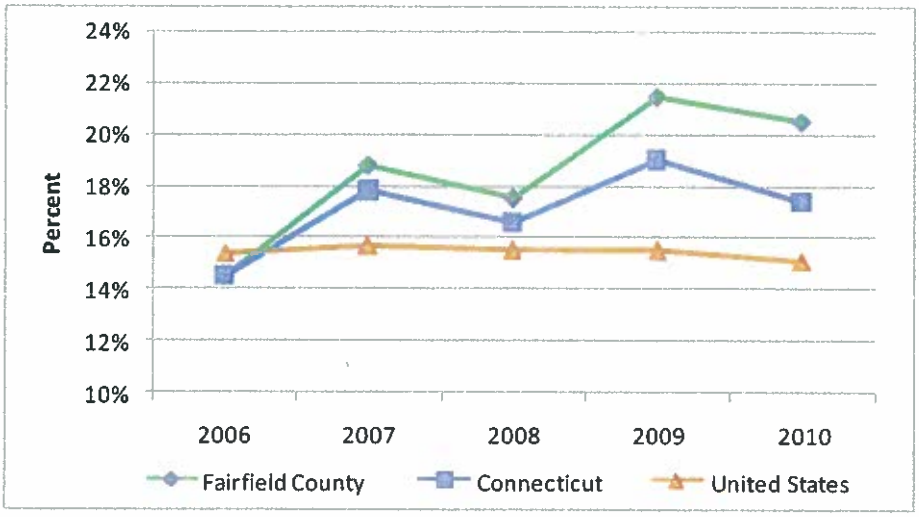


SOURCE: Positive Directions, 2011 & Youth Risk Behavior System, 2011.

Adult Substance Use

Alcohol use among adults is slightly higher among Fairfield County adults (19.7%) than for the state as a whole (18.4%). The percentage of adults who report heavy or binge drinking is higher in Fairfield County (20.5%) than for the Connecticut (17.4%) and the nation (15.1%) (Figure 33). Fairfield County is ranked 8th out of the 8 counties in Connecticut on binge drinking. The rate of binge drinking in Fairfield County and Connecticut has been increasing over the five-year period from 2006-2010, while the rate has been stable for the U.S.

Figure 33: Percentage of Adults Reporting Binge Drinking by County, State, and US, 2006 – 2010



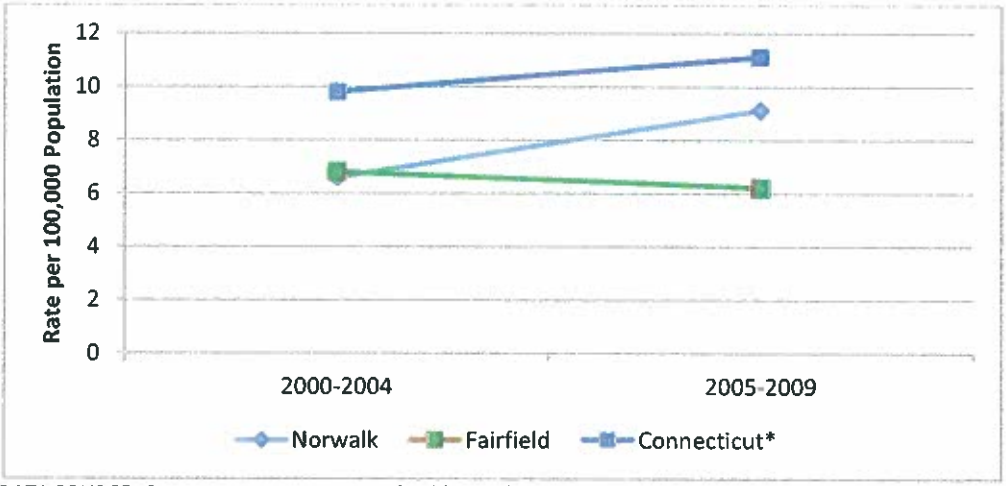
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS).

Young adults age 18-24 (35.4%) had the highest rate of binge drinking (almost double the state average), followed by adults age 25-34 (30.4%). [Additional Data in Appendix E] Binge drinking declines with increasing age until it is only 4.1% for persons over age 65. Males

(23.9%) have a binge drinking rate double that for females (11.5%). Blacks have a lower rate of binge drinking (6.1%) than Hispanics (22.6%) and whites (18.2%).

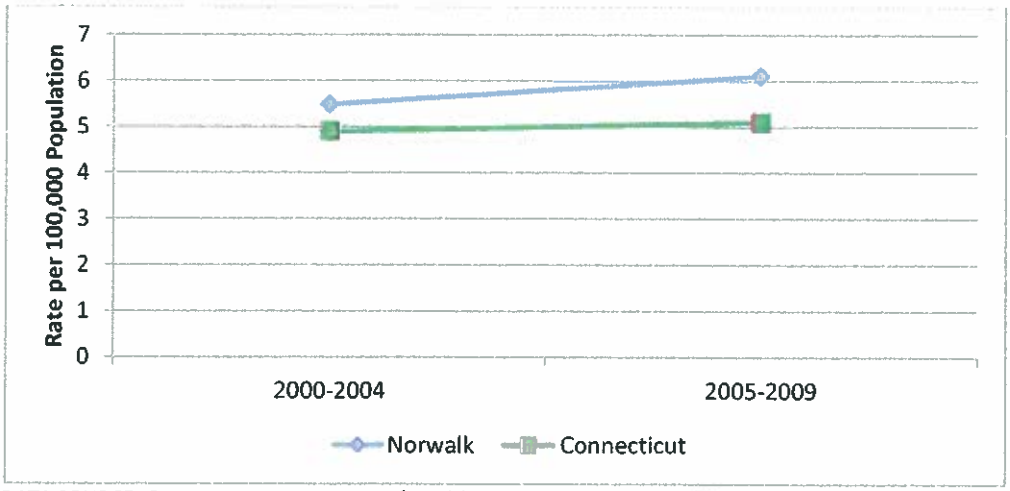
While little reliable data on drug use among adults were available for the region, drug and alcohol-induced deaths are available. In the Greater Norwalk area the highest rate of drug-induced deaths is in Norwalk (9.1 per 100,000 population) and Fairfield (6.1 per 100,000 population) with the other towns having counts that are too low to report. While both Norwalk and Fairfield have rates that are lower than the Connecticut average (11.1 per 100,000 population) (Figure 34), the rates in Norwalk and Connecticut have increased over a five-year period from 2005-2009. Data were also available for alcohol-induced deaths in Norwalk and Connecticut. Over the 2000 to 2009 time frame, the rate in Norwalk increased from 5.5 deaths per 100,000 population to 6.1 per 100,000. This rate was similar to that of Connecticut (5.1 per 100,000 population).

Figure 34: Drug -Induced Deaths per 100,000 Population by Select Towns, and State, 2000-2004 to 2005-2009



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics. * 2005-2009 AAMR is significantly different from 2000-2004 AAMR at p<0.05.

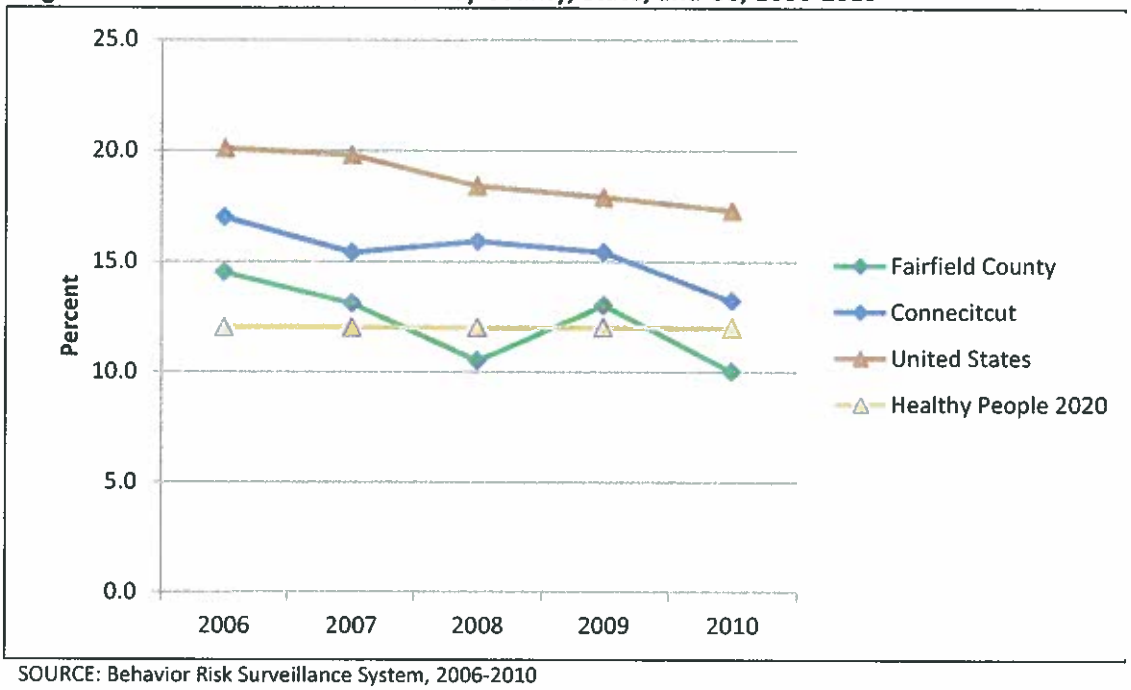
Figure 35: Alcohol-Induced Deaths per 100,000 Populations by Select Town and County, 2000-2004 to 2005-2009



DATA SOURCE: Connecticut Department of Health, Average Annual Mortality Rate (AAMR)

Cigarette use among Fairfield County adults (12.8%) is lower than use among Connecticut adults (15.9%) and below the Healthy People 2020 target (Figure 36). Smoking rates have generally remained steady in Fairfield County over the last several years, but have seen a slight decline from 2009 to 2010.

Figure 36: Percent of Adult Smokers by County, State, and US, 2006-2010



SOURCE: Behavior Risk Surveillance System, 2006-2010

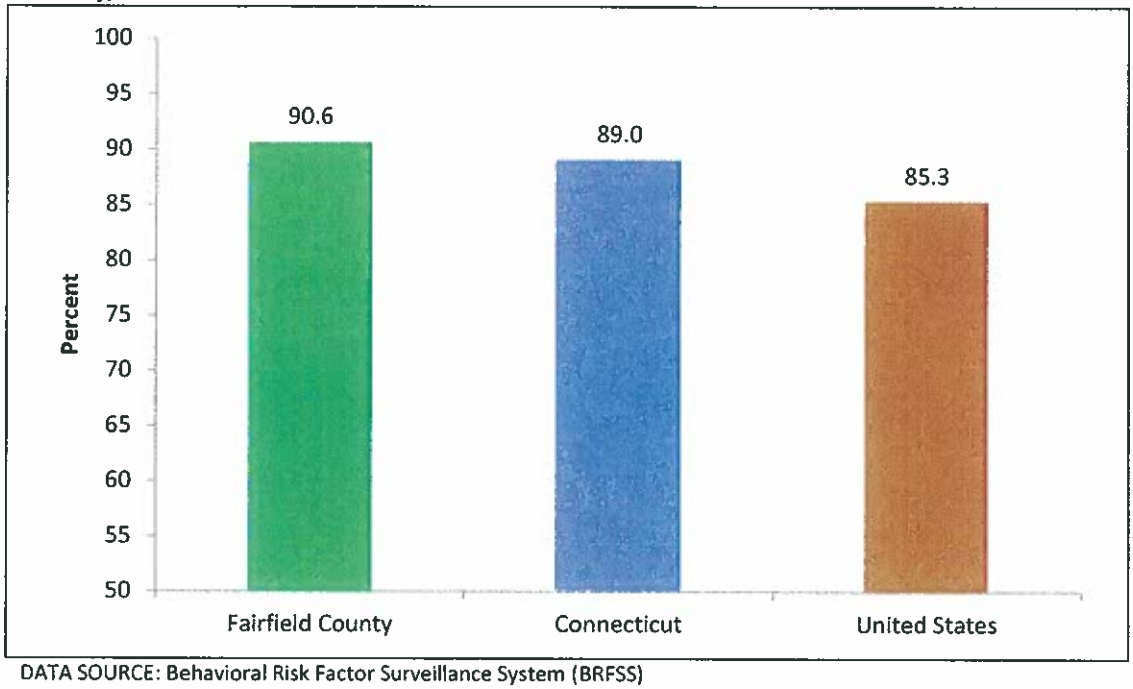
D. HEALTH OUTCOMES

This section of the report provides an overview of leading health conditions in the Greater Norwalk Area from an epidemiological perspective of examining incidence, hospitalization, and mortality data as well as discussing the pressing concerns that residents and leaders identified during in-depth conversations.

Perceived Health Status

As Figure 37 shows below, in Fairfield County, 90.6% of adults perceive their health to be "good" or "excellent," similar to the state as a whole (89%).[17]

Figure 37: Perceived Good or Excellent Health Status, Adults, Connecticut and Fairfield County, 2010



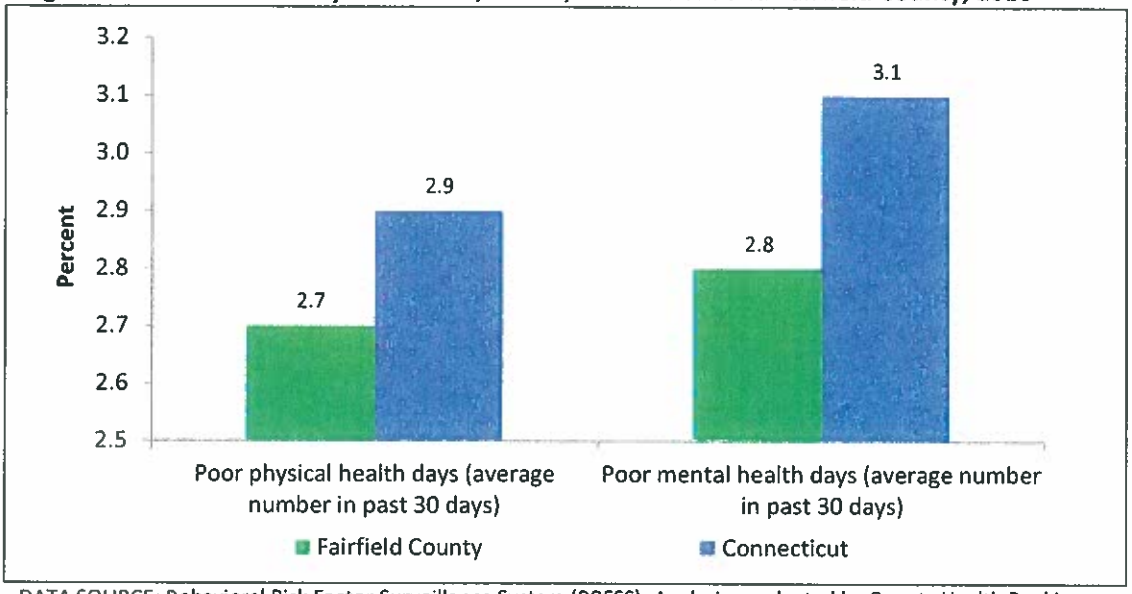
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

A strong association between self-reported health status and mortality has been well documented; thus it is a useful indicator of morbidity within a community[18]. Figure 38 shows that a lower proportion of Fairfield County adults than adults in the state as a whole report poor health. A smaller proportion of Fairfield County adult respondents reported poor physical health days (2.7%) and poor mental health days (2.8%) in the 30 days prior to the survey than respondents for the state as a whole (2.9% and 3.1%, respectively).

[17] Data for the Greater Norwalk area and towns not available.

[18] Centers for Disease Control and Prevention. Measuring Healthy Days: Population Assessment of Health-related Quality of Life. Atlanta, GA: Centers for Disease Control and Prevention; 2000.

Figure 38: Poor Health Days in Past 30, Adults, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS); Analysis conducted by County Health Rankings

Leading Causes of Hospitalization

In general, the Greater Norwalk Area's population is healthy. When considering reasons for going to the hospital when they are not healthy, a few themes are notable. As seen in Table 3, issues related to digestion and injury/poisoning are common across all age groups. Reasons for hospitalization related to mental health are most common in the under 65 population. Reasons related to health disease increase as individuals age.

Table 3: Leading Causes of Hospitalization by Age, 2009

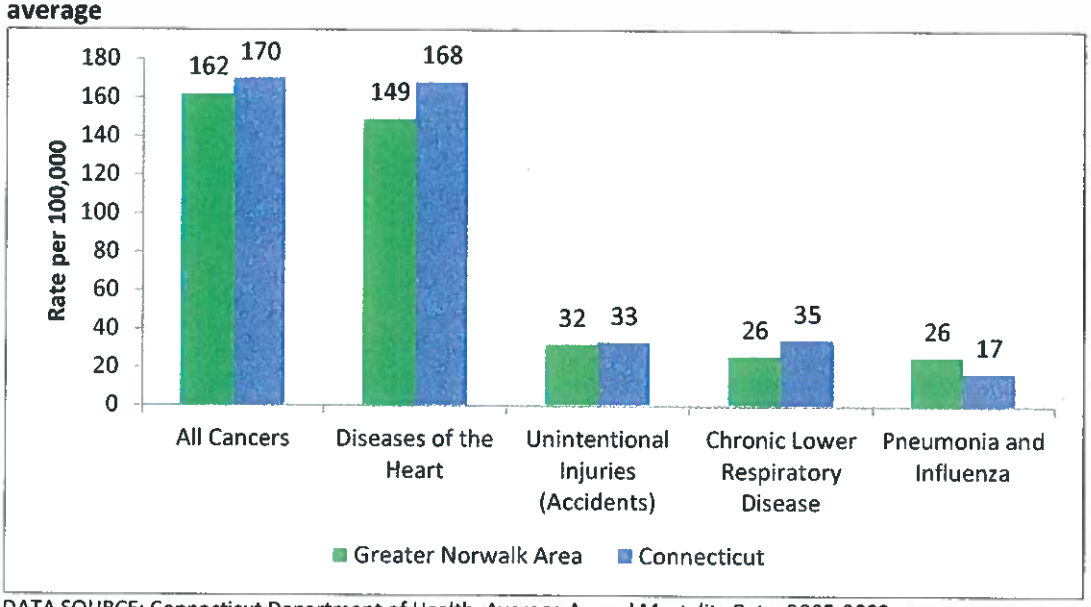
5 to 24 year olds	25 to 64 year olds	65 + year olds
1. Mental	1. Mental	1. Heart
2. Digestive	2. Digestive	2. Respiratory
3. Injury/Poisoning	3. Injury/Poisoning	3. Digestive
4. Respiratory	4. Heart	4. Injury/Poisoning
5. Endocrine	5. Musculoskeletal	5. Genitourinary

DATA SOURCE: Connecticut Office of Health Care Access, 2009

Leading Causes of Death

Quantitative data indicate that residents of the Greater Norwalk area are generally quite healthy. With the exception of pneumonia and influenza, death rates among Greater Norwalk residents from major diseases, illnesses, and injuries are lower than for the state as a whole (Figure 39). Quantitative data indicate that the leading causes of death in the Greater Norwalk area, as in the state, are cancer and heart disease. As seen in Figure 39, mortality rates for the Greater Norwalk area are slightly lower for these diseases (162 and 149 per 100,000 population, respectively) than for the state as a whole (170 and 168 per 100,000 population, respectively). Among the other leading causes of mortality, Greater Norwalk rates for mortality due to unintentional injuries and chronic lower respiratory diseases (i.e., emphysema, chronic bronchitis) are slightly lower than for the state. The death rate due to pneumonia and influenza in the region is higher than for the state (26 versus 17 per 100,000 population).

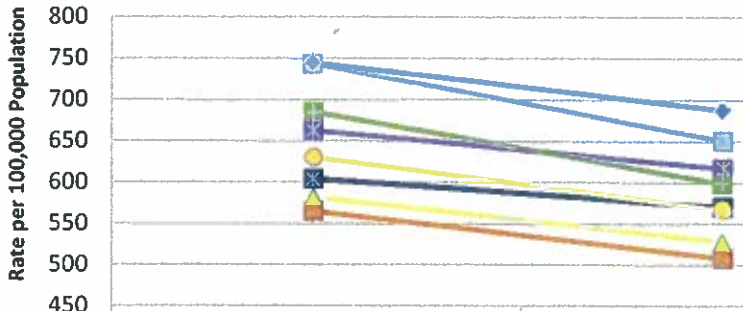
Figure 39: Age Adjusted Mortality Rates, Connecticut and Greater Norwalk, 2005-2009 average



DATA SOURCE: Connecticut Department of Health, Average Annual Mortality Rate, 2005-2009 average

A review of death rate data over time reveals that both the state and the region have had a decline in all causes of death between 2004 and 2009 (Figure 40). The city of Norwalk experienced the greatest decline, from 743.2 deaths per 100,000 population on average for 2000-2004 to 650.9 deaths per 100,000 population in 2005-2009. Norwalk, Darien and Fairfield all experienced a greater decline in their death rates over this time period than the state as a whole. The declines in Fairfield, Norwalk and the state are statistically significant. It should be noted that, per standard procedure by the original data source, mortality rates are aggregated for time periods to increase the sample sizes for comparison. [Additional Data in Appendix E]

Figure 40: Age-Adjusted Death Rates All Causes of Death, Connecticut and Towns, 2000-2004 to 2005-2009

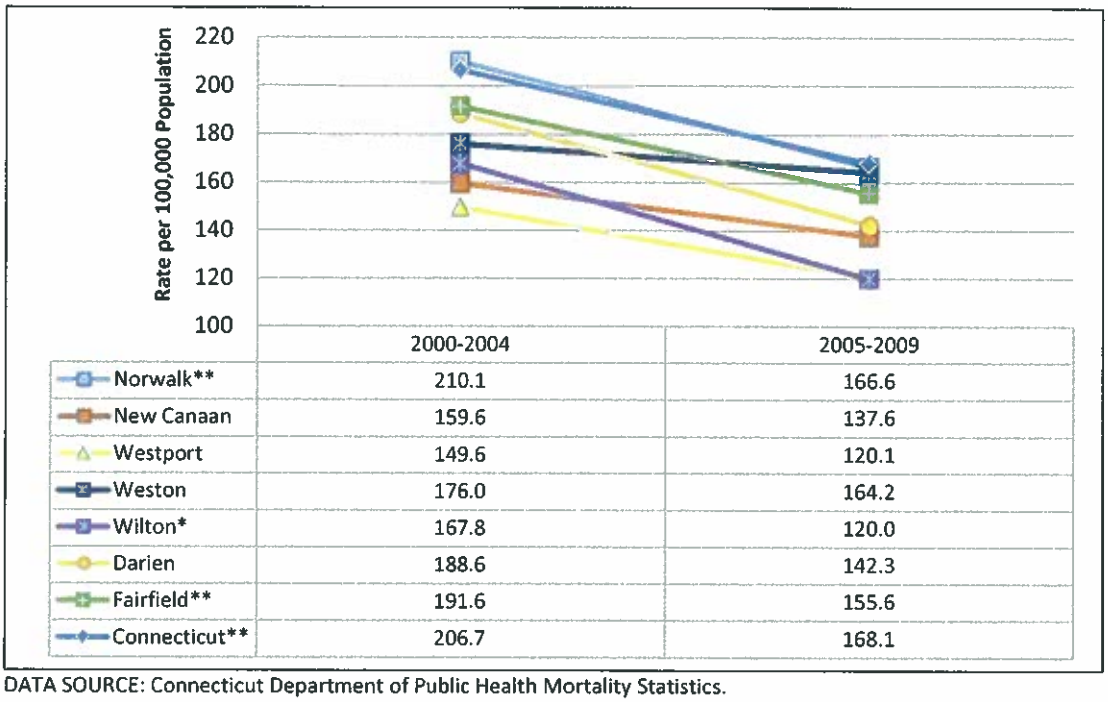


	2000-2004	2005-2009
Norwalk**	743.2	650.9
New Canaan	565.3	508.2
Westport	582.2	528.3
Weston	604.6	570.5
Wilton	663.1	617.4
Darien	630.5	567.0
Fairfield**	685.5	599.2
Connecticut**	744.7	687.6

DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.
** 2005-2009 AAMR is significantly different from 2000-2004 AAMR at p<0.01

As Figure 41 shows, age-adjusted death rates due to diseases of the heart have declined in Connecticut and all Greater Norwalk towns between 2000-2004 and 2005-2009. Significant decreases are noted in Fairfield, Norwalk, and Wilton, and the state as a whole. The largest decline, 47.8 deaths per 100,000 population, was seen in Wilton. [Additional data in Appendix E]

Figure 41: Age-Adjusted Death Rates to Diseases of the Heart, Connecticut and Towns, 2000-2004 to 2005-2009

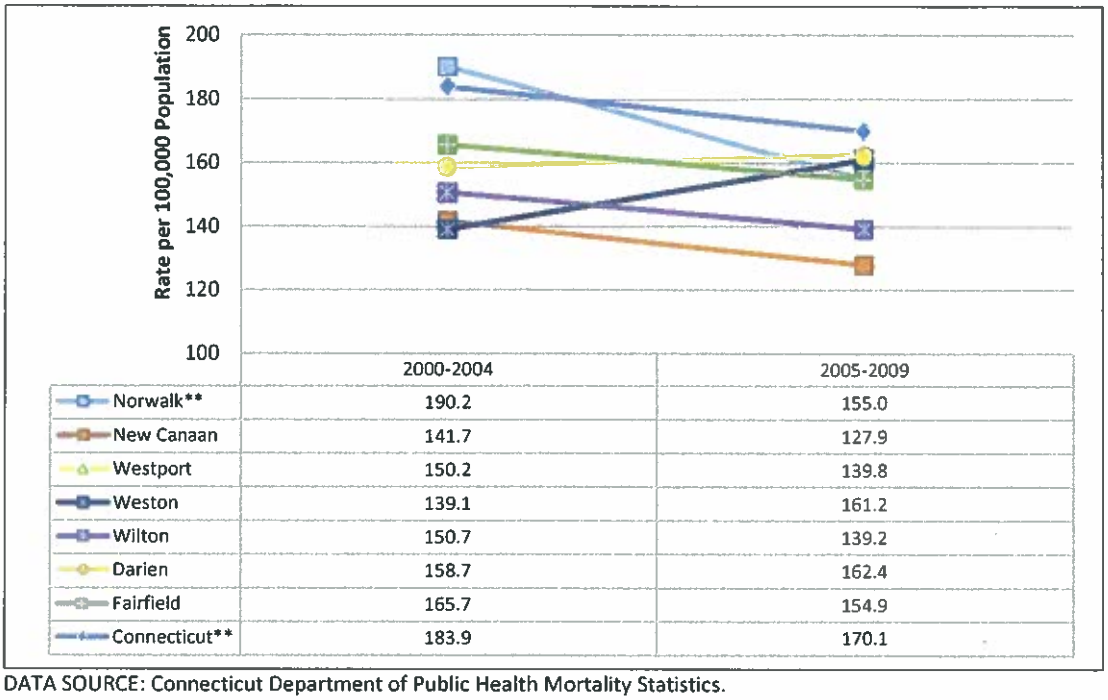


	2000-2004	2005-2009
Norwalk**	210.1	166.6
New Canaan	159.6	137.6
Westport	149.6	120.1
Weston	176.0	164.2
Wilton*	167.8	120.0
Darien	188.6	142.3
Fairfield**	191.6	155.6
Connecticut**	206.7	168.1

DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.
* 2005-2009 AAMR is significantly different from 2000-2004 AAMR at p<0.05.
** 2005-2009 AAMR is significantly different from 2000-2004 AAMR at p<0.01

Relative to cancer, there is variation across the area. In most Greater Norwalk towns and the state, cancer death rates have declined between 2000-2004 and 2005-2009 (Figure 42). The largest decline was seen in Norwalk (35.2 deaths per 100,000 population). However, Darien and Weston experienced increases in the cancer death rate over this time (by 3.7 and 22.1 deaths per 100,000 population, respectively). Although complete data about specific cancer death rates are not available at the town level, data about cancer deaths for Connecticut as a whole reveals that for many cancer types, death rates have gone down between 2000-2004 and 2005-2009 (Table 4). Exceptions are pancreatic cancer, uterine cancer, and bladder cancer, which have all increased slightly.

Figure 42: Age-Adjusted Death Rates from All Cancers, Connecticut and Towns, 2000-2004 to 2005-2009



	2000-2004	2005-2009
Norwalk**	190.2	155.0
New Canaan	141.7	127.9
Westport	150.2	139.8
Weston	139.1	161.2
Wilton	150.7	139.2
Darien	158.7	162.4
Fairfield	165.7	154.9
Connecticut**	183.9	170.1

DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.
** 2005-2009 AAMR is significantly different from 2000-2004 AAMR at p<0.01

Table 4: Age-Adjusted Death Rates Cancer, Connecticut, 2000-2004 to 2005-2009

	Deaths per 100,000 population	
	2000-2004	2005-2009
Trachea, bronchus & lung cancer	49.3	45.0
Prostate cancer	26.5	23.7
Female Breast cancer	25.1	22.2
Colorectal cancer	18.7	14.6
Pancreatic cancer	10.9	11.9
Ovarian cancer	8.5	8.0
Leukemia	7.1	6.7
Bladder cancer	4.5	4.8
Uterine cancer	4.0	4.5
Brain and central nervous system cancer	4.1	4.1

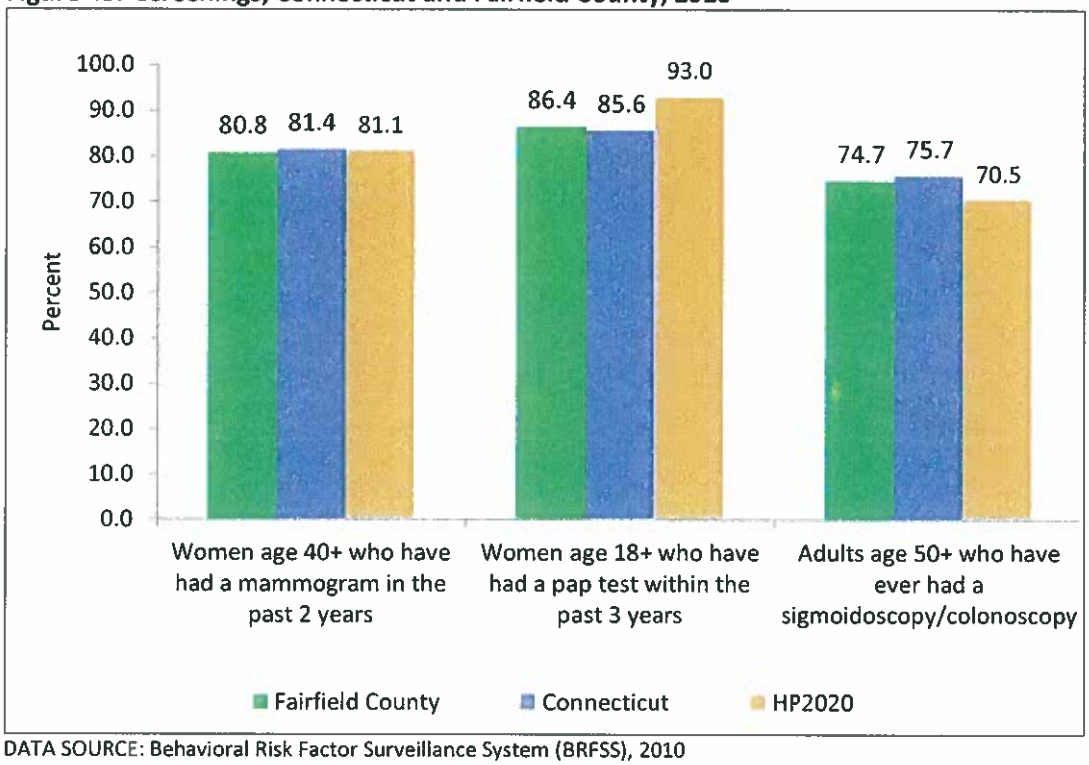
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.

Quantitative screening data indicate that screening rates among Fairfield County residents are similar to those for the state as a whole (Figure 43 and Figure 44).[19] Approximately 81% of women over the age of 40 in Fairfield County and the state have had a recent mammogram, nearly meeting the HP2020 target of 81.1%. The proportion of women over the age of 18 in

[19] Town-level data are unavailable.

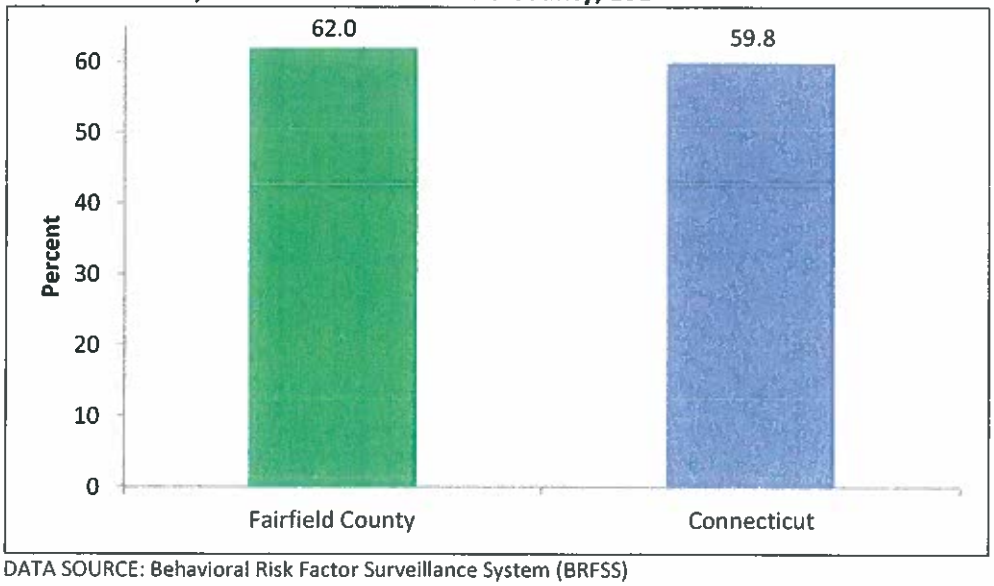
both Fairfield County and the state who have had a pap test is about 86%, lower than the HP2020 target of 93%. Conversely, about 75% of adults over age 50 in Fairfield County and the state have had a sigmoidoscopy/colonoscopy, higher than the HP2020 target of 70.5%. The PSA screening rate for men in Fairfield County (62%) is slightly higher than that for the state as a whole (59.8%).

Figure 43: Screenings, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

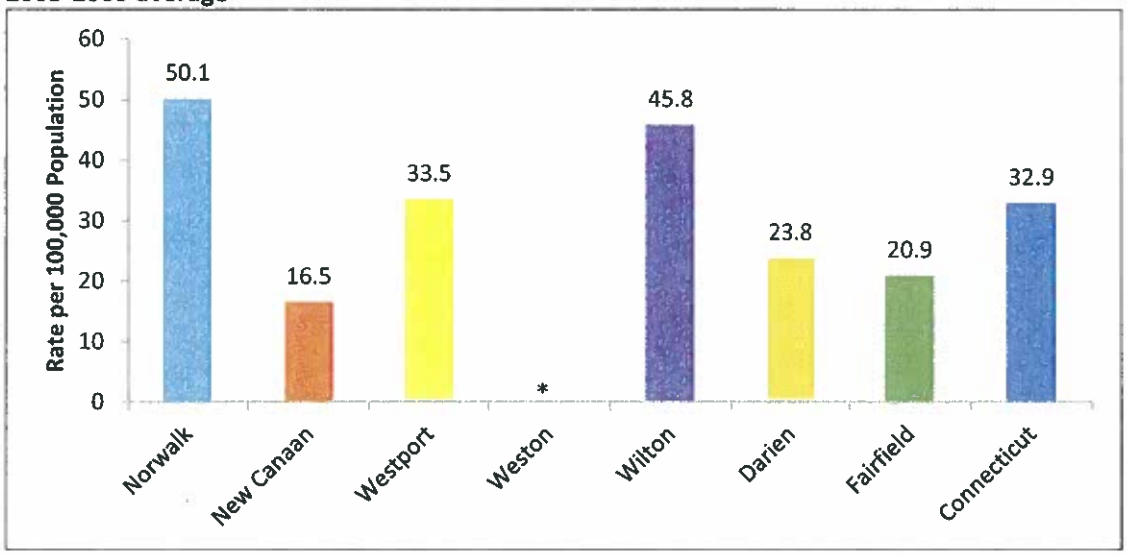
Figure 44: Percent of Men Age 40+ who have screened for Prostate Cancer (via a PSA Test) in the Past 2 Years, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

While not to the extent of heart disease and cancer, accidents (i.e., motor vehicle crashes, falls) are a leading cause of death in the Greater Norwalk Area. On a statewide basis, accidents, on average, take 32.9 lives per 100,000 population (Figure 45). Norwalk and Wilton have rates that are higher than the State of Connecticut at 50.1 and 45.8 per 100,000, respectively. Other towns in the area are similar to or lower than the State's rate.

Figure 45: Age-Adjusted Death Rate due Accidents per 100,000 Population by Town and State, 2005-2009 average

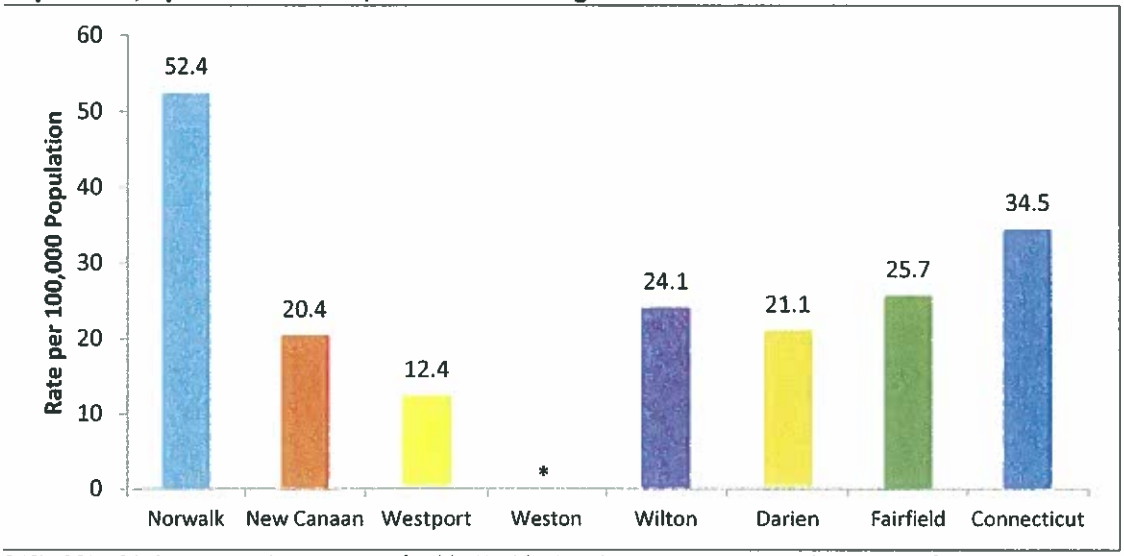


DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

*AAMRs are not reported for causes of death with <15 deaths.

Chronic lower respiratory disease is the fourth leading cause of death for the Greater Norwalk Area as a whole. Across the region the rates vary by town (see Figure 46). Norwalk has the highest rate among the towns at 52.4 per 100,000 population. The remaining six towns have rates that are lower than the State of Connecticut (34.5 per 100,000 population).

Figure 46: Age-Adjusted Death Rate due Chronic Lower Respiratory Disease per 100,000 Population, by Town and State, 2005-2009 average

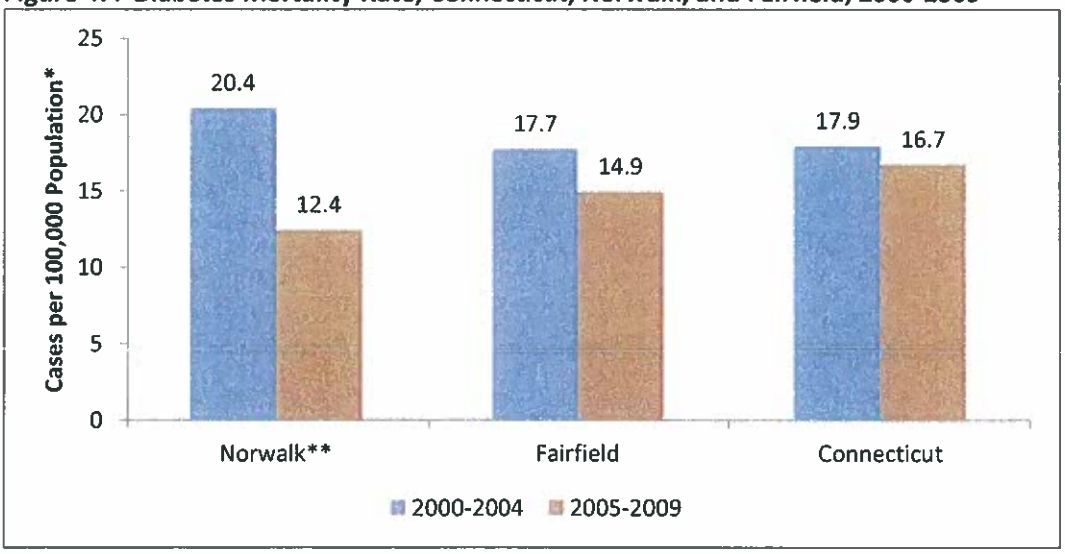


DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

*AAMRs are not reported for causes of death with <15 deaths.

The diabetes mortality rate has also declined in both the state and the Greater Norwalk area's two largest cities (Figure 47). The rate of decline from 2000-2004 through 2005-2009 in Norwalk, from 20.4 per 100,000 population to 12.4 per 100,000, was statistically significant. This decline mirrors the trend on a national level. The Centers for Disease Control attributes the decline in the diabetes mortality rate to improved medical care.

Figure 47: Diabetes Mortality Rate, Connecticut, Norwalk, and Fairfield, 2000-2009



DATA SOURCE: Department of Public Health, 2000-2009. * Age-Adjusted Mortality Rate

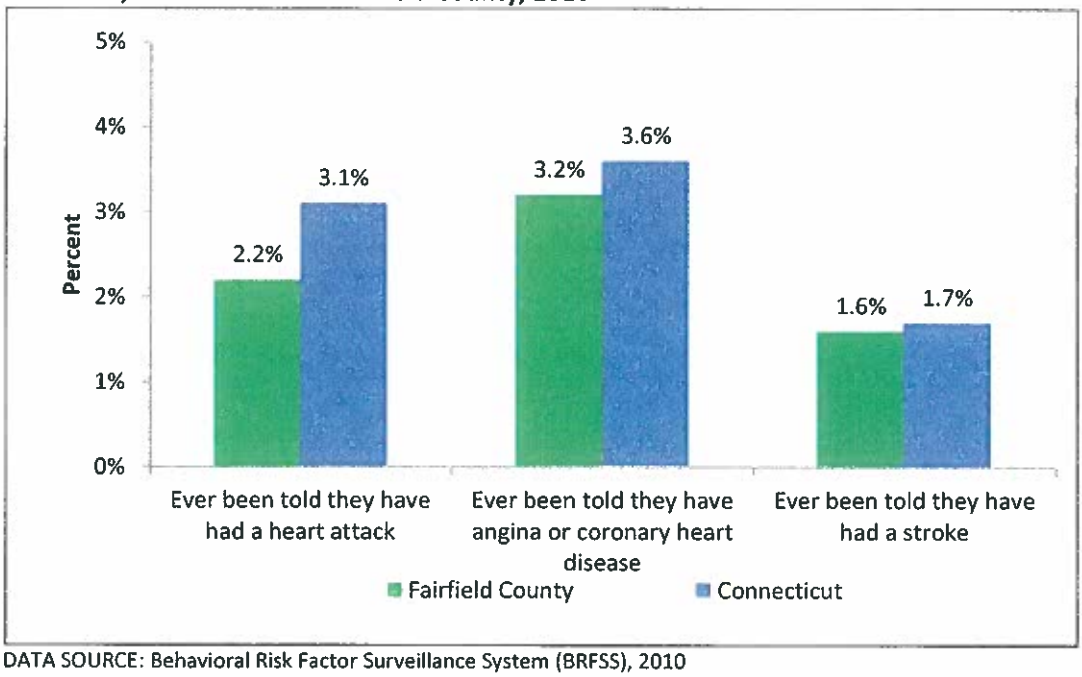
** Change from 2000-2004 to 2005-2009 is significantly different

E. HEALTH AREAS

Chronic Disease – Cardiovascular Disease

The Behavioral Risk Factor Surveillance Survey, a telephone survey of adults, asks respondents whether they ever had or currently have specific chronic conditions. Among survey respondents, heart disease and heart attacks were the most prevalent chronic conditions, with 3.2% and 2.2% of adults in Fairfield County reporting having been currently diagnosed with these diseases, respectively (Figure 48). Less than 2% of adult residents reported ever having a stroke or heart attack. Rates of chronic conditions among adults in Fairfield County are lower than for adults in the state overall.

Figure 48: Percent of Adults Who Have Been Told They Have a Heart Related Chronic Condition, Connecticut and Fairfield County, 2010



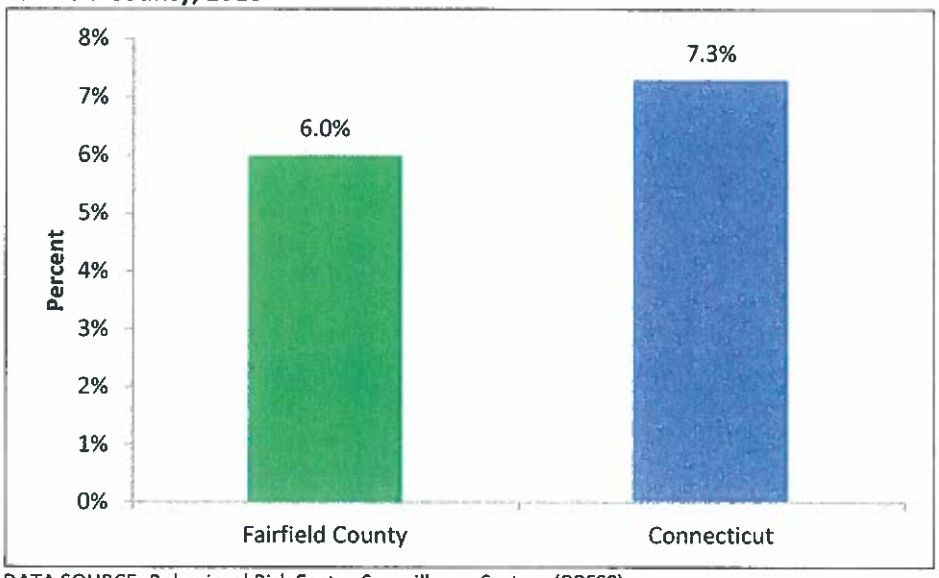
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

Chronic Disease – Diabetes

The diabetes mortality rate has declined in both the state and the Greater Norwalk area's two largest cities, as seen above (Figure 47). The rate of decline from 2000-2004 through in Norwalk, from 20.4 per 100,000 population to 12.4 per 100,000, was statistically significant.

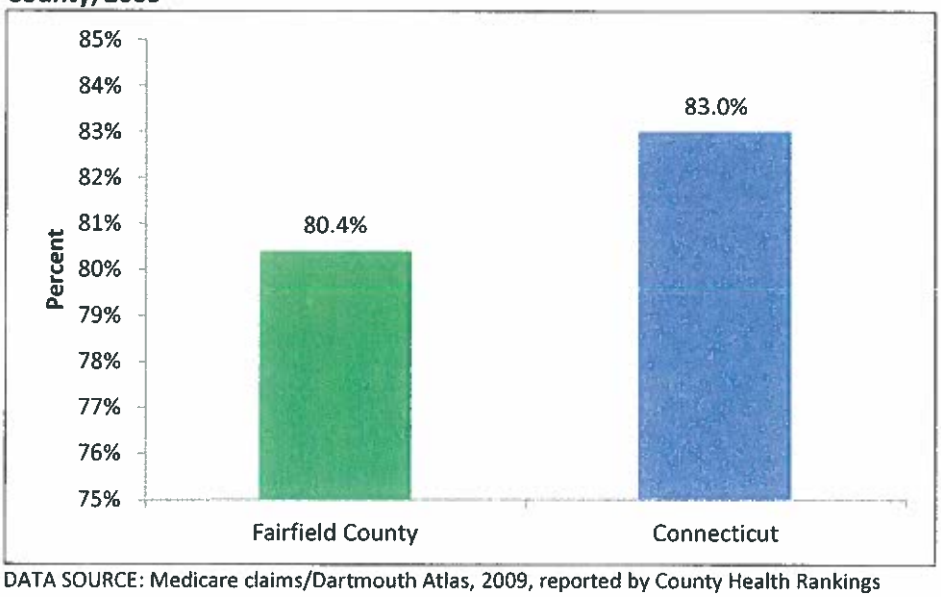
The proportion of adults who have ever been told they have diabetes is lower for Fairfield County (6.0%) than for the state (7.3%) (Figure 49). However, fewer Fairfield County adults with diabetes (80.4%) than Connecticut adults with diabetes (83.0%) received an HbA1c screening in 2009 (Figure 50). HbA1c is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well a person is controlling his or her diabetes.

Figure 49: Percent of Adults who have ever been told they have Diabetes, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 50: Percent of Diabetics that Receive HbA1c Screening, Connecticut and Fairfield County, 2009

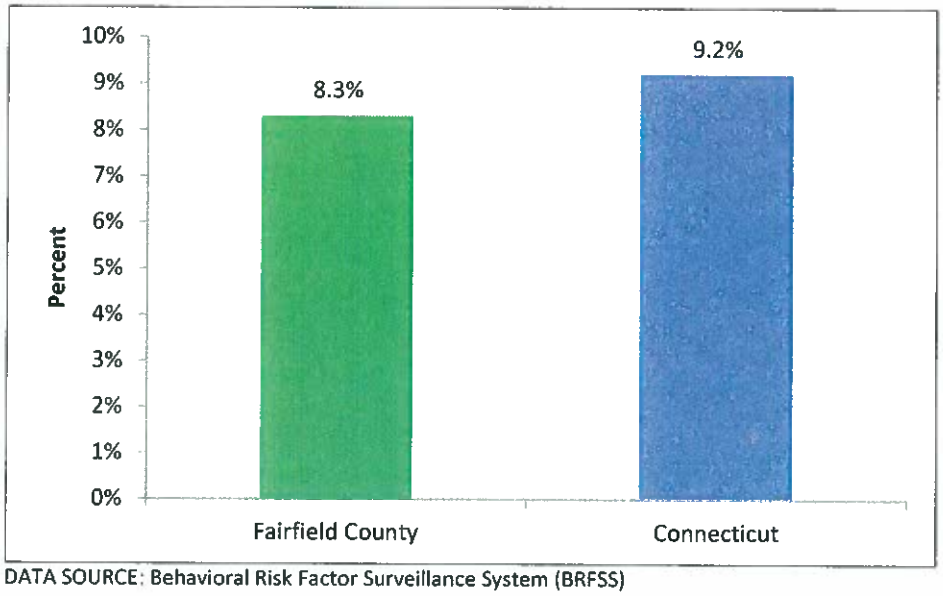


DATA SOURCE: Medicare claims/Dartmouth Atlas, 2009, reported by County Health Rankings

Chronic Disease – Asthma

Asthma rates among Fairfield County adults (8.3%) are slightly lower than for the state as a whole (9.2%) (Figure 51).

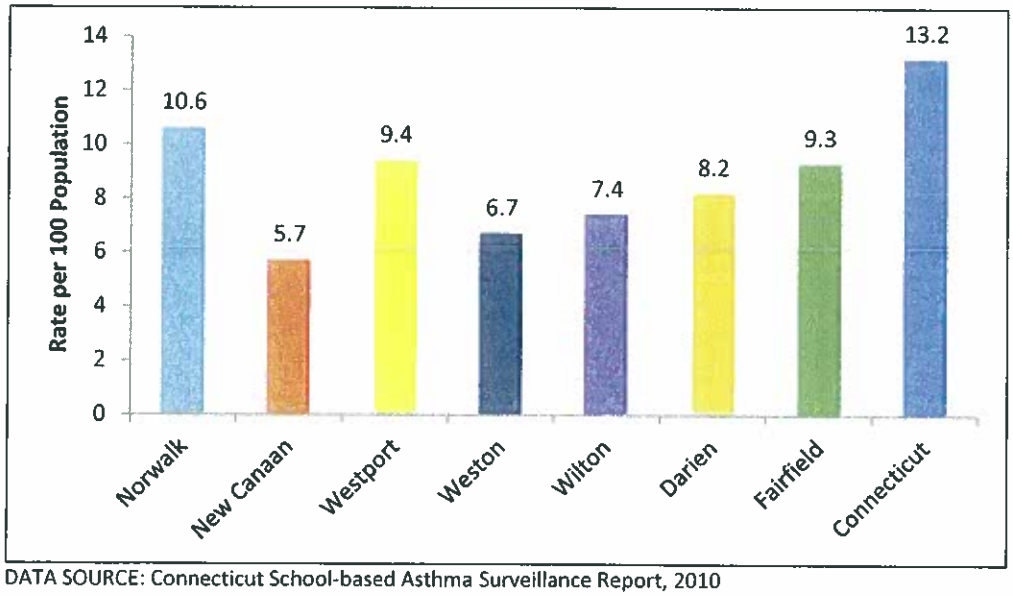
Figure 51: Percent of Adults Who Currently Have Asthma, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

Asthma rates among the region's students are lower overall than for the state (13.2 per 100,000 students) (Figure 52). Among the area's towns, asthma rates among students are highest in Norwalk (10.6 per 100,000 population), Westport (9.4 per 100,000 population) and Fairfield (9.3 per 100,000 population).

Figure 52: Asthma Prevalence Rates by School District for Public Schools, 2006-2009 Combined School Years



DATA SOURCE: Connecticut School-based Asthma Surveillance Report, 2010

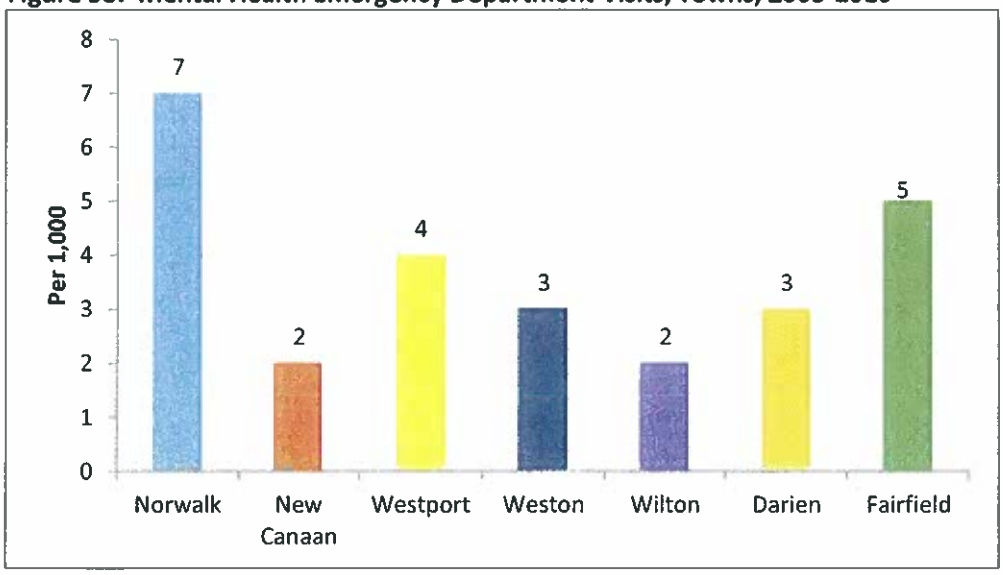
Mental and Behavioral Health

Mental health challenges were also cited as a substantial health concern in the region. Those working in health care, mental health care, and law enforcement in particular noted mental health is a significant concern. In surrounding communities, respondents noted the stress of living in the area and academic pressure felt by students and attributed the high use of alcohol and drugs, eating disorders, and recent suicides to these factors. One focus group respondent shared, "*kids are not allowed to fail. You're not allowed to try something and not be really good at it*." One of the teen focus groups observed that social media has affected young peoples' ability to effectively communicate their emotions leading to abuse of alcohol and drugs. As one teen focus group participant noted, "*people post suicidal tweets or Facebook posts and then you see them the next day and they act like nothing's wrong*."

A challenge in more affluent areas, according to participants, is that stigma prevents some from seeking services. Others reported that the rise in mental health issues also has to do with insufficient services to address these needs, especially for lower income individuals. According to focus group members from the hospital, the number of individuals with mental health needs appearing in the Emergency Room (ER) is increasing. Focus group participants from health care, mental health and law enforcement shared the increasing challenges each of these groups faces in meeting mental health needs. A mental health provider focus group member shared, "*there's a big gap between what in the past was covered by the police and criminal justice system that is now expected to be covered by the mental health system*." Law enforcement participants noted that they increasingly respond to calls that involve mental health issues.

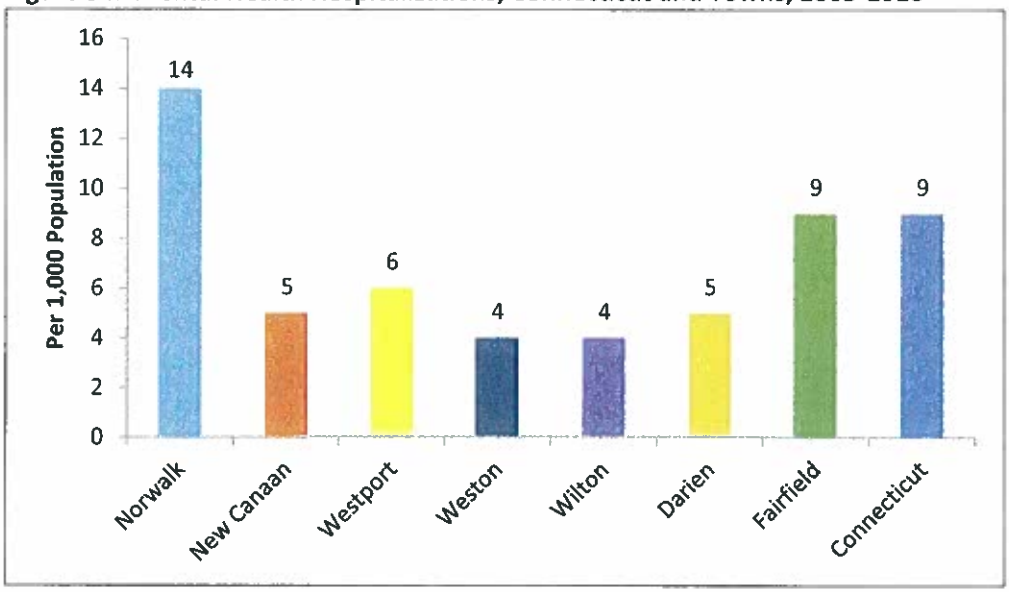
According to the BRFSS, Connecticut (3.1) and Fairfield County (2.8) residents report a higher number of days of poor mental health than the national average (2.3). Quantitative data about hospitalizations for mental health in the Greater Norwalk area show that rates are highest in Norwalk (7 per 1,000 population for emergency room visits and 14 per 1,000 population for hospitalizations). Rates are also relatively high in Fairfield (5 per 1,000 population for emergency room visits and 9 per 1,000 population for hospitalizations) (Figure 53 and Figure 54).

Figure 53: Mental Health Emergency Department Visits, Towns, 2005-2010



DATA SOURCE: Connecticut Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health for years 2005-2010

Figure 54: Mental Health Hospitalizations, Connecticut and Towns, 2005-2010



DATA SOURCE: Source: Source: CT Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health for years 2005-2010
Source: For CT, DPH hospitalization data 2009; analysis by Norwalk Health Department

Mental health issues among youth were cited as an area of particular concern in interviews and focus goups. Youth Risk Behavior Surveillance data indicate that 24.4% of Connecticut youth have reported feeling sad or hopeless almost every day for two or more weeks in a row [20]. Girls were significantly more likely than boys to have felt sad or hopeless (31% vs. 18%) and Hispanic students (33.5%) were more likely to have felt sad or hopeless than White students (22.4%) or Black students (21.2%). Data also indicate that 14.6% of Connecticut youth have seriously considered attempting suicide and 6.7% have attempted suicide one or more times. Girls were more likely than boys to have considered suicide (17.3% vs. 11.9%) and to have attempted suicide (8.2% vs. 5.2%). Hispanic students were more likely to have attempted suicide than White students. [Additional Data in Appendix E]

Bullying was also identified as a concern. According to the Youth Risk Behavior Survey, 21.6% of Connecticut youth reported having been bullied on school property and 16.3% reported having been electronically bullied. Boys were more likely to be bullied on school property than girls (22.3% vs. 20.6%) and girls were significantly more likely than boys to have been electronically bullied (20.1% vs. 12.5%). White and Hispanic students (23.2% and 22.3%) were significantly more likely to be bullied on school property than Black students (13.2%), and White and Hispanic students (17.6% and 17.2%) were significantly more likely to be bullied electronically than Black students (8.8%).

Although YRBS data are not available at a sub-state level, other data point to mental health concerns about youth in the region. For example, 42% of the visits to the Dr. Robert E. Appleby School Based Health Centers, which serve middle and high school students in Norwalk, are for mental health reasons. The top five mental health diagnoses at the centers

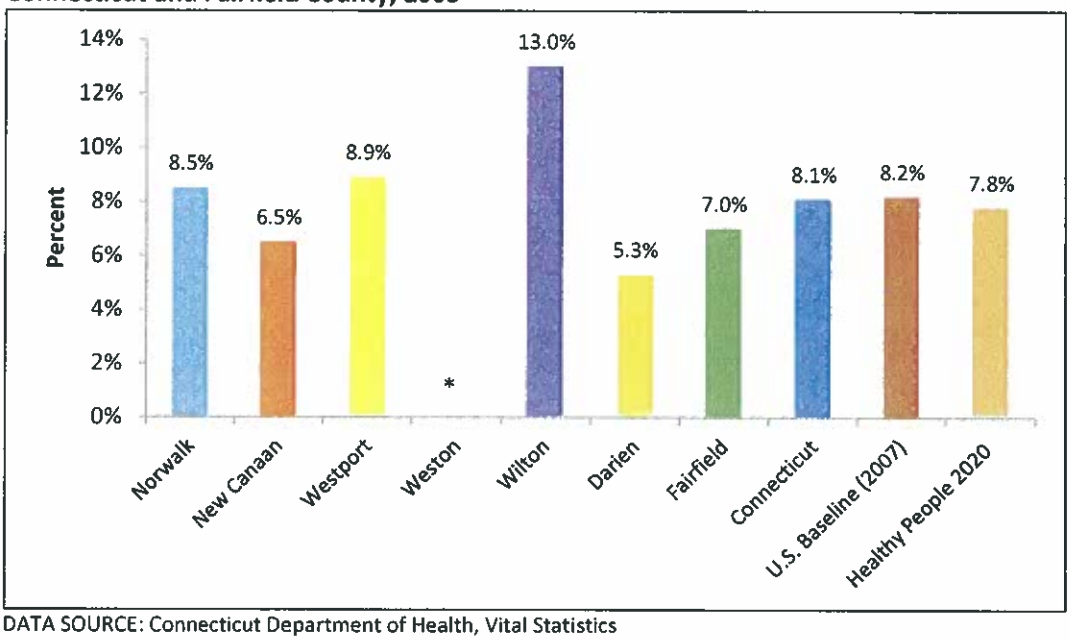
[20] YRBS data are not available at the County or town level.

are family circumstance, depression, adjustment disorder with depressed mood, relational problems, and academic maladjustment. The top presenting problems at the Mid-Fairfield Child Guidance Center Outpatient General Clinic were anxiety, disruptive behavior, family conflict, and depression.

Maternal and Child Health

Low birth weight outcomes (less than 2500 grams) in the Greater Norwalk area varied, see Figure 55. Wilton experienced the highest percentage of low birth weight babies in the region (13%), followed by Westport (8.9%). Focus group and interview participants noted that the high percentages of low birth weight babies may be due to multiple births as a result of in vitro fertilization (IVF).

Figure 55: Low Birth Weight (percent of live births with weight < 2500 grams), U.S., Connecticut and Fairfield County, 2009



DATA SOURCE: Connecticut Department of Health, Vital Statistics
*Data suppressed due to too few cases

For teenagers, having a child puts the mother and the child at risk. Research has shown that teenage mothers are less likely to complete high school and college[21]. Children born to teenage mothers are likely to have higher rates of low birth weight, develop chronic health problems, and drop out of school. Quantitative data indicate that the birth rate among Fairfield County teens (20.3 per 1,000 female population) is lower than for the state (23.9)

[21] Brown, S., & Eisenberg, L. (Eds.). (1995). *The best of intentions: Unintended pregnancy and the well-being of children and families*. Washington, DC: National Academy Press.

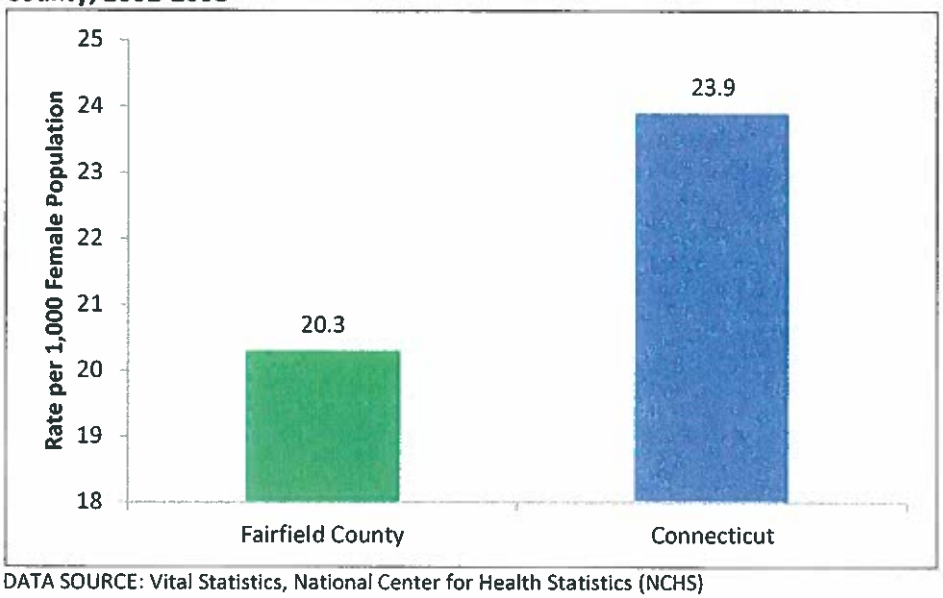
Bustan, M., & Coker, A. (1994). Maternal attitude toward pregnancy and the risk of neonatal death. *American Journal of Public Health, 84*(3), 411-414.

Gipson, J., Koenig, M., & Hindin, M. (2008). The effects of unintended pregnancy on infant, child, and parental health: A review of the literature. *Studies in Family Planning, 39*(1), 18-38.

Moore KA, Myers DE, Morrison DR, et al.Age at first childbirth and later poverty and later poverty. *J Res Adolesc* 1993;**3**:393–422.

(Figure 56). The proportion of teens giving birth is lower in both Norwalk (4.6%) and Fairfield County (4.9%) than the state (6.8%).

Figure 56: Teenage Birth Rate per 1,000 Females ages 15-19, Connecticut and Fairfield County, 2002-2008

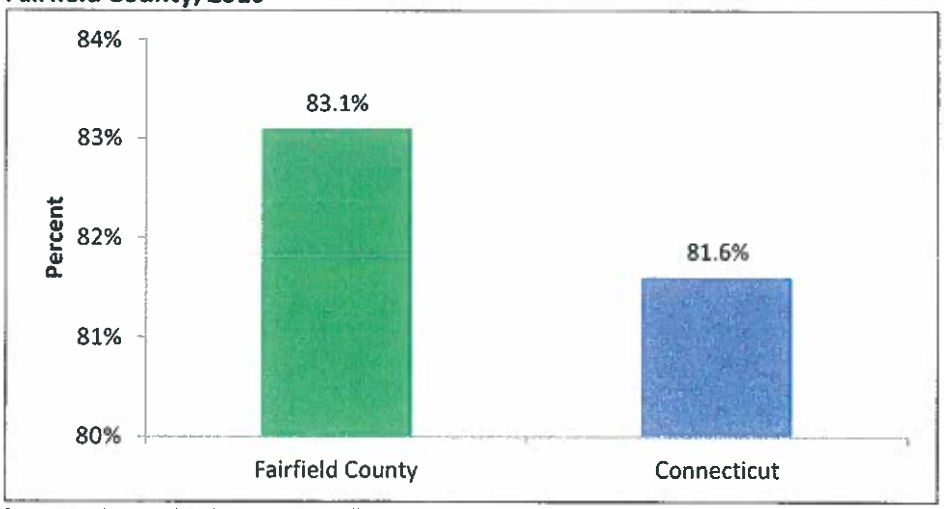


DATA SOURCE: Vital Statistics, National Center for Health Statistics (NCHS)

Oral Health

Quantitative data indicate that the proportion of adults in Fairfield County (83.1%) who have visited the dentist in the past year is higher than for the state (81.6%) (Figure 57).

Figure 57: Percent of Adults who have visited a Dentist in the Past Year, Connecticut and Fairfield County, 2010



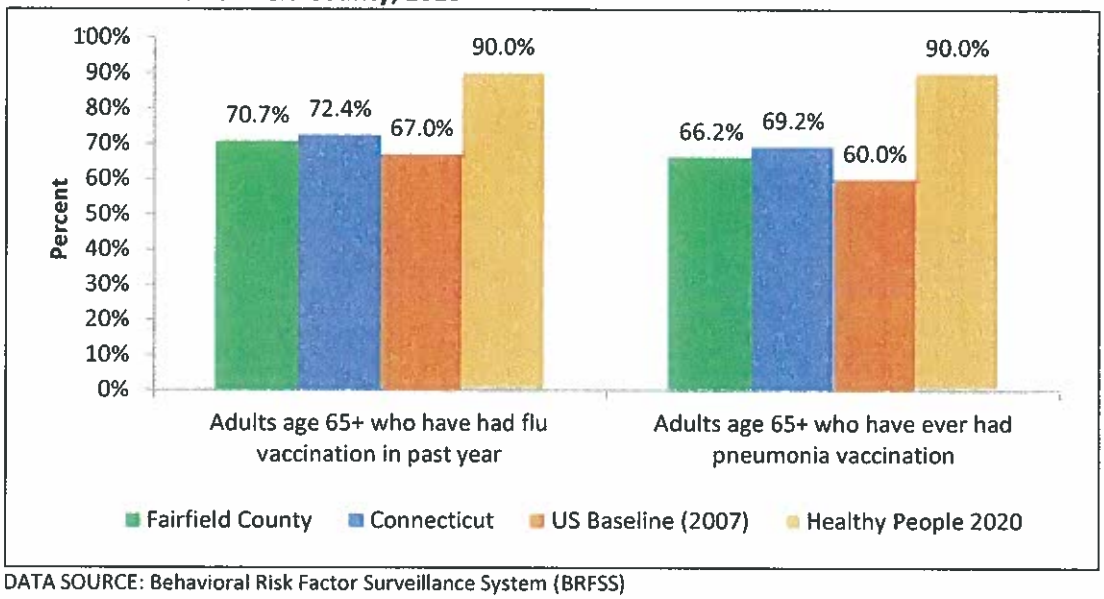
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Communicable Diseases

Vaccine-Preventable Diseases

In 2010, the percentage of adults aged 65 years and older who reported receiving the influenza and pneumococcal vaccines were lower in Fairfield County than for the state as a whole although higher than the nation (Figure 58).

Figure 58: Percent of Adults Age 65+ who have had Flu and Pneumonia Vaccination, U.S., Connecticut and Fairfield County, 2010

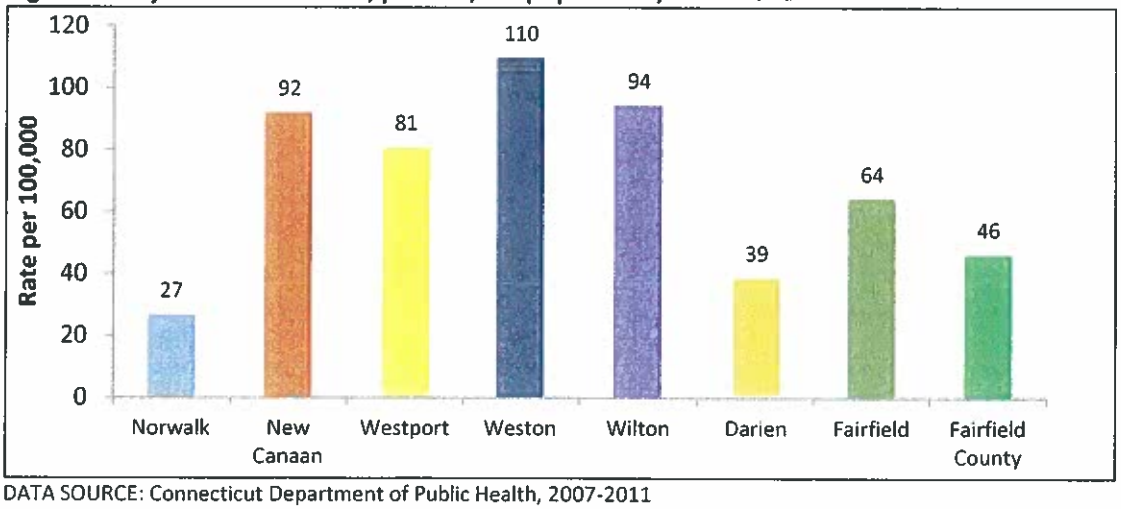


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

Lyme Disease

Several focus group participants and interviewees mentioned Lyme disease as a concern. As one local policymaker noted, "[it] feels like an epidemic proportion." Lyme disease rates in Connecticut are notably high and in many of the towns of Greater Norwalk, the rate per 100,000 population is higher than the rate for Fairfield County (Figure 59). Weston (110 per 100,000 population), Wilton (94 per 100,000 population), and New Canaan (92 per 100,000 population) experienced the highest rates of Lyme disease in the region.

Figure 59: Lyme Disease Rates, per 100,000 population, 2007-2011

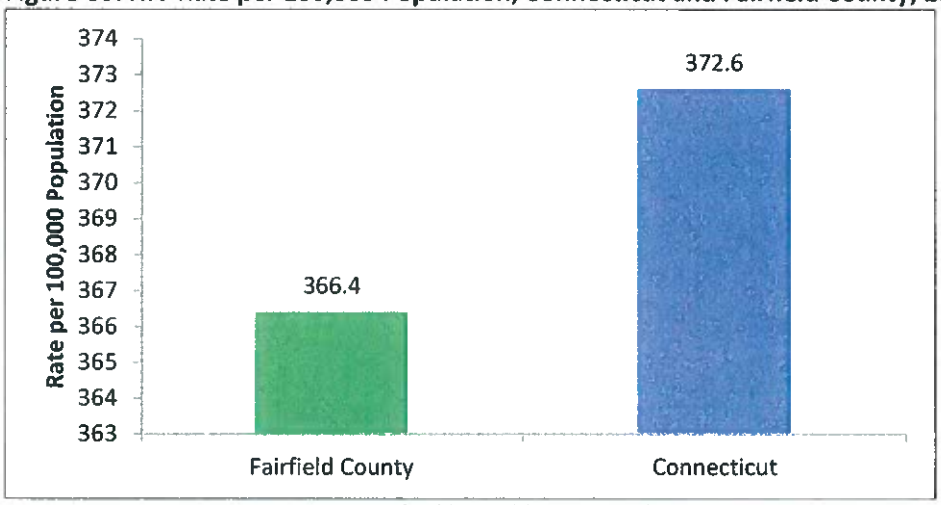


DATA SOURCE: Connecticut Department of Public Health, 2007-2011

HIV/AIDS

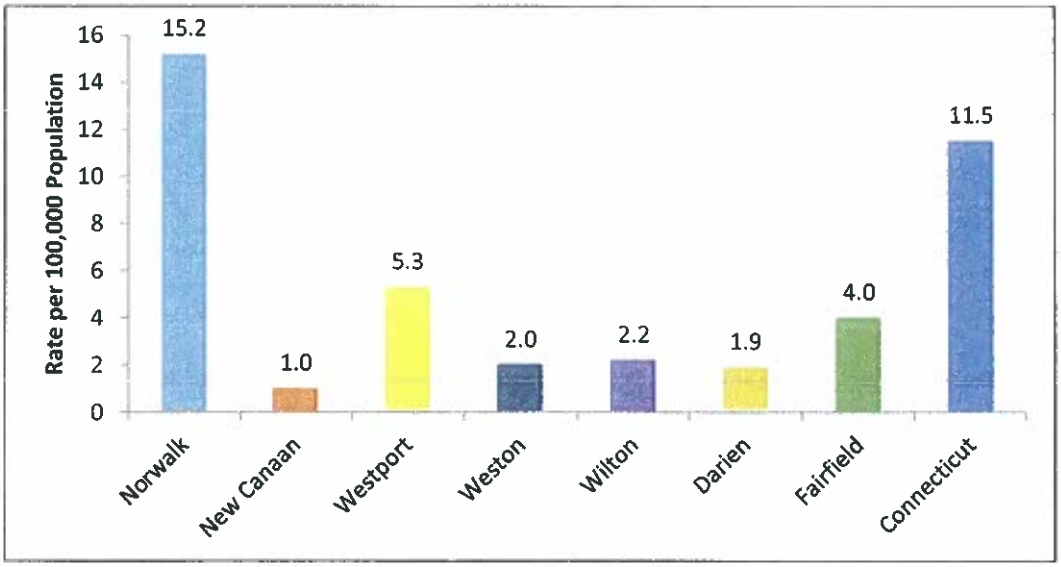
Quantitative data indicate that the rate of HIV is lower in Fairfield County (366.4) than the state (372.6) (Figure 60). The rate of new HIV cases is lower for most towns in the Greater Norwalk area than for the state (Figure 61). The notable exception is Norwalk, where the rate of new HIV cases per 100,000 population (15.2) is higher than for the state (11.5).

Figure 60: HIV Rate per 100,000 Population, Connecticut and Fairfield County, 2006-2010



DATA SOURCE: Connecticut Department of Public Health, HIV Surveillance Program

Figure 61: Rate of New HIV Cases per 100,000 Population, Connecticut and Towns, 2006-2010

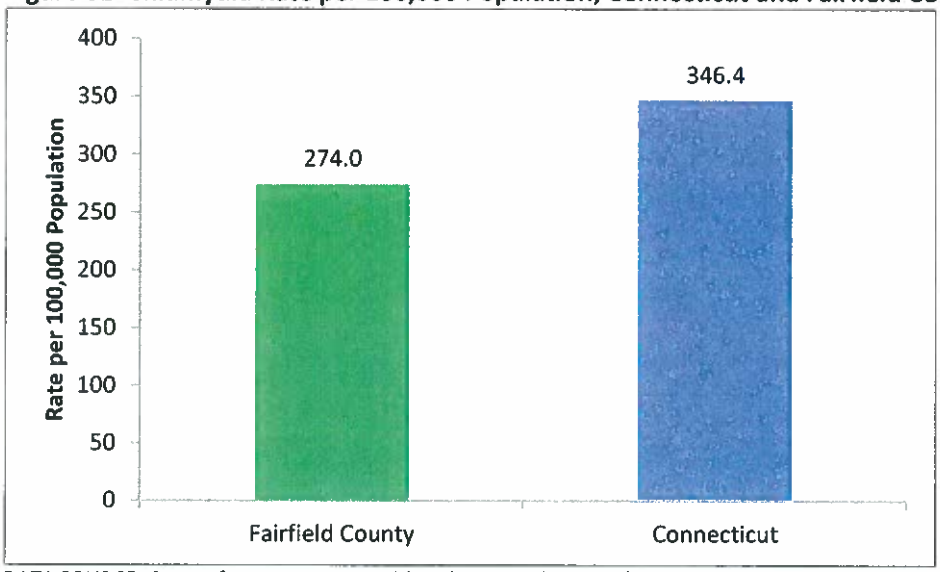


DATA SOURCE: Connecticut Department of Public Health, HIV Surveillance Program

Sexually-Transmitted Diseases

The rate of infection of Chlamydia is used as a proxy for the sexually transmitted diseases. In Fairfield County (274 per 100,000 population) the rate is lower than in the state (346.4 per 100,000 population) (Figure 62).

Figure 62: Chlamydia Rate per 100,000 Population, Connecticut and Fairfield County, 2009



DATA SOURCE: Center for Disease Control (CDC), National Center for Hepatitis, HIV, STD, and TB Prevention, as reported by County Health Rankings

F. HEALTH CARE ACCESS AND UTILIZATION

Resources and Use of Health Care Services

"Overall, I think this is a resource rich area. Just getting to know the other providers in the area, there is a high level of expertise across disciplines and different specialties even within mental health. There are a lot of experts in this county and in this town." – Focus group participant

"I love the clinic." –Focus group participant

"The hospital is a great help." – Focus group participant

"The community health centers are fantastic." – Focus group participant

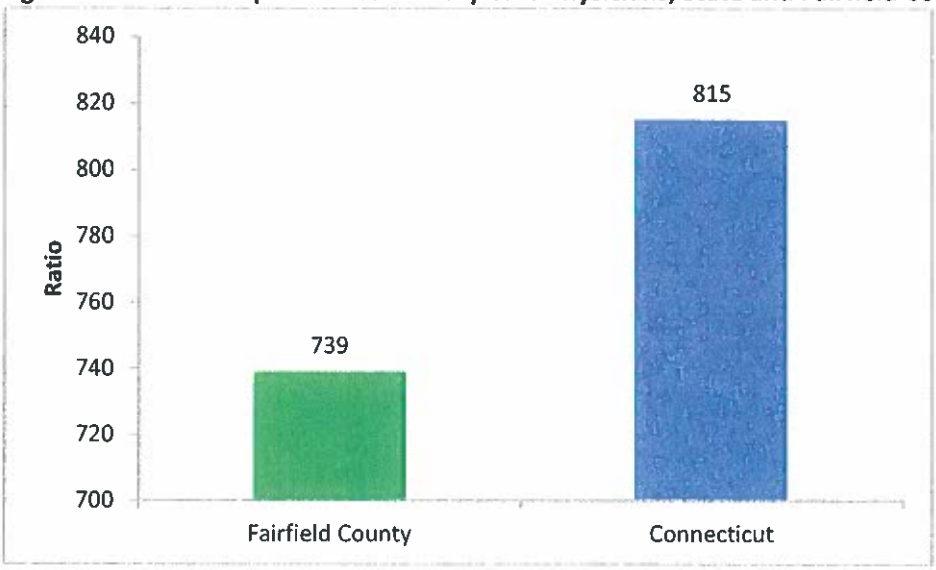
"The people from Norwalk Hospital and the health center follow through." – Focus group participant

Focus group respondents and interviewees noted that the region has substantial health resources and Norwalk Hospital and the Norwalk Community Health Center in particular were repeatedly cited as important assets. The Hospital was noted for its comprehensive services. Both were described as having excellent outreach, providing valuable community education, and serving a variety of people. As one physician noted, "[we serve] not only poor immigrants who don't speak the language but we serve some of the wealthiest people in the world and everyone in between."

Respondents pointed to several other health care assets in the region, including school-based health centers, school nurses, and volunteer emergency medical services in many communities. Local health departments play various roles including conducting screenings and immunizations and providing education in topics such as chronic disease and cooking classes. Respondents shared that there are a number of social service-related programs in the area which provide important services, including Meals on Wheels, Elder House (adult day care), senior centers, libraries and the 211 service line as well as programs such as the Norwalk Healthy Families Collaboration and the Pepperidge Farm initiative to combat childhood obesity.

As shown in Figure 63, the ratio of the population to primary care physicians is smaller in Fairfield County (739 population per primary care physician) than in the state (815). The national benchmark is 631 population per primary care physician.

Figure 63: Ratio of Population to Primary Care Physicians, State and Fairfield County, 2009



DATA SOURCE: Health Resources and Services Administration, Area Resource File (ARF), analysis by County Health Rankings, 2009

Challenges to Accessing Health Care Services

Community members viewed access to care as an essential part of health. One resident stated, *"We'd all like to see everybody have equal access to health care no matter how much money they have."* When asked about barriers to health care access and good health, focus group and interview participants identified insurance coverage, cost and long wait-times as interfering with receiving care and achieving optimal health. Lack of health insurance was noted as a concern by many and one that has become more challenging as people have lost their jobs in the economic downturn. For those with insurance, higher co-pays were noted as a concern. Providers at both Norwalk Community Health Center and Americares, another clinic, reported an increase in patients over the past few years in response to the decline in the economy and the subsequent loss of health insurance.

Lack of Insurance Coverage and Health Care Cost

"The first question they ask whenever I check in somewhere is whether I have insurance. I've walked right in because I've had that card when there were other people waiting." – Focus group participant

"They tell me let's take it [tooth] out and they gave me a payment plan but each appointment costs something and you have to go to the bank to get a loan." – Focus group participant

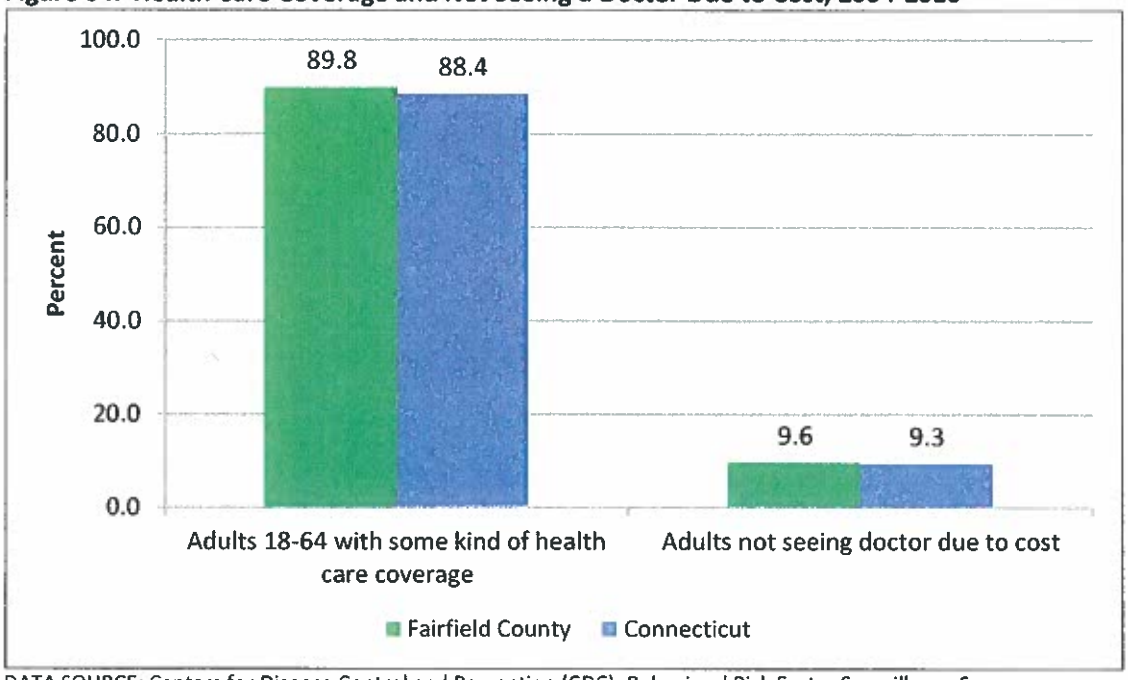
Lack of insurance and underinsurance was the most frequently cited barrier by focus group and interview participants to accessing health care. Focus group members and interviewees also reported that the cost of healthcare creates a barrier to access and often results in delays in seeking services. Several respondents reported a rise in "concierge" (pay ahead) health care. Others shared that they have been billed for services and tests after paying a co-pay. Although the Norwalk Community Health Center was noted as a substantial health asset in the community, some respondents reported surprise that services are discounted but not free.

Access to health care and long wait times for appointments were also named as a concern. Many residents reported that they have waited for long periods to get appointments while

others stated that they were not able to obtain appointments convenient for their work schedules. As one focus group member noted, *"making an appointment is the hardest part of getting health care."*

Quantitative data indicate that the proportion of Fairfield County adults (89.8%) with some kind of health care coverage is similar to that for the state (88.4%) (Figure 64). Likewise, in both Fairfield County and the state, less than 10% of adults reported not seeing a doctor due to cost.

Figure 64: Health Care Coverage and Not Seeing a Doctor Due to Cost, 2004-2010



DATA SOURCE: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance Survey (BRFSS) Data. Atlanta, Georgia: US department of Health and Human Services, Centers for Disease Control and Prevention

Gaps in Mental Health Delivery System

"There is no incentive for child and adolescent psychiatrists to come into the public sector." – Focus group participant

"Most people with mental health issues can't pay for visits and often drop out and are OK for a while and then become acute again." – Focus group participant

Gaps in the mental health care delivery system were cited as a particular concern for the region. Primary care providers reported treating more patients for depression and other mental health concerns, something they are not all comfortable doing. As one health department focus group member stated, *"this part of the system has so many barriers."* Among the barriers respondents cited were lack of providers, lack of parity in insurance and insurance coverage, and limited reimbursement. In regards to providers, the ratio of population to mental health providers is smaller in Fairfield County (1469 population per

primary care physician) than in the state (1493).[22] While respondents pointed to the success of the ChildFIRST program, they also noted that there is currently a waiting list for families to participate.[23] According to mental health providers, the region lacks skilled mental health providers in the schools, in-patient beds for children, and child psychiatrists, especially those willing to serve Medicaid children. As one focus group member noted, "*not only are they [child psychiatrists] not accessible, some of them aren't taking new patients because there is so much work.*" Services to help adults transition from acute mental health care to community-based care were also missing, according to respondents.

A 2010 assessment conducted by the Southwest Mental Health Board, Lower Fairfield county Regional Action Council, Mid-Fairfield Substance Abuse Coalition, and RYASAP, identified mental health and substance abuse service needs in the region. On the mental health side, the region has access to counseling services and crisis services, but lacks availability of respite services and inpatient services. In addition, related services such as group homes and supported education services are also less available. Similarly, identified substance abuse service needs included long term and intermediate residential services, intensive outpatient services and detox.

Gaps in Dental Services

Like mental health care, respondents noted gaps in dental services. The ratio of population to dentists in Fairfield County (1174) is slightly better than Connecticut at 1523. Low reimbursement rates by state programs have made it difficult to engage new providers to serve low-income people. In addition, as one dental provider interviewee noted, the state program does not provide for periodontal care and recently changed the frequency of cleanings covered from two per year to one. For patients, especially those with lower incomes, this has often meant forgoing needed treatment or going into debt for dental care. As one focus group member shared, "*I did not remove a molar because I did not have the money. Then it broke and I had to pay the money.*"

Transportation Barriers to Accessing Services

Transportation to health care was also raised as a barrier to access by some participants. One provider focus group member reported that use of 911 for transport to medical care has increased. However, several noted that the Norwalk Community Health Center has recently obtained a medical van that will help to address this need and to ensure greater access to health care for underserved populations.

Cultural Competency

Among non-English speakers, lack of cultural competency of providers and bi-lingual services were noted as concerns and create barriers to access. Immigrants and undocumented people were especially singled out as having difficulty accessing health care and other resources. Several respondents also mentioned concerns about health care for the elderly, noting that there is an insufficient number of physicians (geriatricians) able to care for the unique health needs of the aging population.

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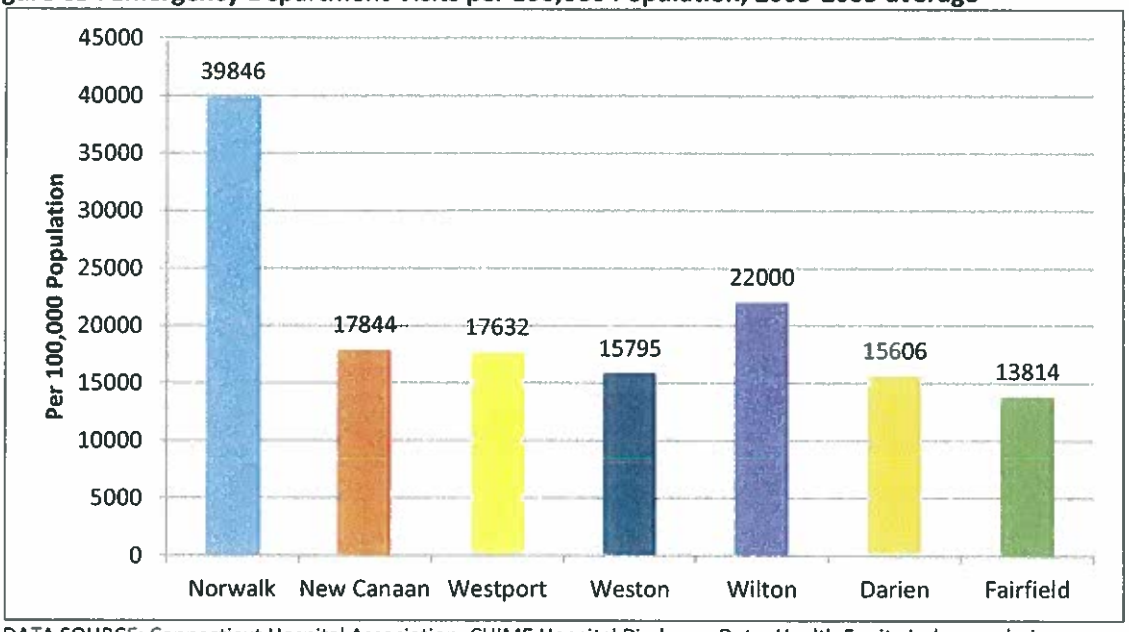
[22] United States Department of Agriculture (USDA) Food Environment Atlas, analysis by County Health Rankings and Roadmaps, 2009

[23] Child FIRST is a home-based early childhood intervention program that works to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and families.

Emergency Department as Primary Care

One key indicator of challenges in accessing health care is the pattern in the use of hospital emergency department (ED). The Health Equity Index uses the rate of emergency department visits as a proxy for a lack of access to health insurance and primary care services. Norwalk has the highest rate of emergency department visits per 100,000 population at 39,846. The other communities in the Greater Norwalk Area range from 13,814 per 100,000 population in Fairfield to 22,000 per 100,000 population in Wilton (see Figure 65). According to Greater Norwalk area respondents, these barriers to health care access as well as under capacity in some areas have led to greater use of the ED. The consequence, as one focus group member stated, is that "people using the ER for primary care bogs down the system." Lack of some services such as mental health and access issues for others means increased use of the ED for health services that could be addressed in other facilities. Others reported that problems with transportation and co-pays means that follow-up care after an ED visit does not always take place, resulting in hospital readmission rates and repeat visits to the ED.

Figure 65 : Emergency Department Visits per 100,000 Population, 2005-2009 average



DATA SOURCE: Connecticut Hospital Association, CHIME Hospital Discharge Data; Health Equity Index, analysis conducted by CT Association of Directors of Health, 2005-2009

G. COMMUNITY MEMBERS' PERCEPTIONS OF WHAT IS NEEDED

"How do we bring the community into a space where they are more accountable for themselves and interact differently with the health care system?" – Focus group participant

"Parents need to be better educated and engaged." – Focus group participant

"We tend to try to do too much. It would be great if we could agree on 1 to 2 things that we could collectively do and put our energy behind those things." – Interview participant

"Docs just don't know where to go to find help for their patients." – Interview participant

"You have patients with multiple needs and they can't navigate the system and there isn't anyone who is helping them." – Interview participant

Throughout the focus groups and interviews, participants were asked to identify assets and resources in the community that address the issues and needs they had identified. These programs and services were compiled with additional items from the development of the community health improvement plan into a list. [See Appendix F] Additionally, focus group members and interviewees were asked what was needed to address health challenges in the community. Many reported that they believed more money was needed for services but recognized that this would likely not be forthcoming until the economy improves. Several residents noted that the health centers needed more staff so that patients could "*see the doctor who knows their history*" to receive better personalized care. More staff were also needed to "reduce wait time" and "improve follow-through," both viewed by as important for resident respondents.

Those from housing noted the importance of more affordable housing. As one person stated, "*once people have their housing situated, it would free up resources for other things and reduce stress*." Others felt that the region could benefit from more educational support for young people and low wage earners, especially those who do not speak English well.

Focus on Prevention

Several respondents reported that they felt that fundamental change was needed in the health infrastructure to increase emphasis on prevention. As one health department focus group member stated, "*we focus on treating disease...we need a medical home that emphasizes prevention*." Providers talked about changing the incentive structure to emphasize prevention over treatment. More comprehensive substance use and mental health services were also named as a need, as these were two of the top three health concerns raised by community members.

Health Literacy

A number of focus group respondents and interviewees reported that they believed that a lack of awareness/understanding of health (health literacy) and health resources in the community were underlying causes of poor health and unhealthy behaviors in the region. Focus group respondents and interviewees frequently stated that there was a lack of understanding among many about how to take care of themselves. As one person summed up, "*we're reactive, not proactive. Even people with wonderful benefits aren't educated enough about prevention. They react only when there is something serious*." Another concurred, saying "*wellness care is foreign to us. Doing something before it turns into something doesn't happen*."

Although respondents reported that there already are many health education programs in the community, they felt more were needed. They suggested programs that educated about diabetes and other chronic diseases, how to eat better and the importance of physical activity, programs to help people manage stress. They cited the importance of reaching people who are busy, parents, and also those who do not speak English. As one Spanish-speaking focus group member stated, *"we need more groups where we talk about health."* One interviewee suggested that *"there should be a real marketing effort."* Several focus group participants noted that community conversations and events should be held "closer to where the people are" and that personal invitations would encourage them to attend.

Centralized Resource Information

A related need expressed by a number of focus group members and interviewees was a centralized listing of resources offered in the community. Provider focus group members noted that physicians as well as their office staff and discharge planners often do not know about resources offered in the community. Care coordinators are often relied on for such information and connection to services, and focus group members and interviewees who work with care coordinators praised their ability to connect patients to services. Several respondents suggested that a website or some other repository of such information that could be used by physicians and their staff would be helpful.

Support for Parents

The need for parenting support was a consistent theme in interviews and focus groups. Respondents stated that they thought more should be done to help parents model good coping skills for kids and to help them help their children learn about problem solving. As one mental health provider suggested, *"I think looking at how we provide services to families in terms of their ability to raise their children is critical."*

Activities for Youth

Both youth and adult respondents agreed that there were numerous community events and activities, such as family days and community centers, which existed in the area. Among youth, respondents reported a need for more activities, especially in less affluent areas. Several focus group participants mentioned that parks are closing and youth have nowhere to go. *"They took away the roller skating rink. They took away the ice skating rink. They took away teenage parties for kids that stayed out of the streets. They took away all of that. What is there for our children to do? There's nothing,"* stated one respondent. Respondents from these areas also felt that efforts to make healthy food more affordable and physical activity opportunities more accessible were important. Teens mentioned that additional clubs or intramural sports would be helpful for them to stay in shape and interact with each other face to face. As one youth said, *"there is too much social media, texting, tweeting, instead of talking. It's affecting kids' ability to communicate their emotions. Kids act differently in person than they do on social media."*

Despite the perceived lack of youth activities in lower income areas, among more affluent areas there was the perception that more attention was spent on youth activities than was necessary. As one respondent stated, "this is a very child-oriented area. There is a lot of pressure on young people to excel and achieve- emotionally, physically and academically." To support the development of youth, these areas were perceived as having many resources and activities. From EMT programs to youth asset building to dozens of sports teams and recreational facilities, the more affluent areas of the region have a wealth of resources

devoted to youth. Respondents in these areas remarked that the challenge was not access to resources and activities, but rather "balancing time, work, stress, exercise and eating healthy."

Greater Cultural Competency

Cultural competency can be defined many ways, but generally encompasses the ability to recognize and consider the diverse cultural norms, attitudes, identities and world views of all people with whom a person interacts. Organizations and people who strive towards maintaining a culturally competent practice engage in mindful cross-cultural interaction and carefully consider their own biases and expectations before making inferences about the identities and values of others. Enhancing cultural competency within the health system was an identified need by respondents, especially among non-English speaking focus group members. Suggestions included having more interpreters available in places like the ER, providing health information in other languages, offering alternative medicine practices, and ensuring that providers understood other cultures' health and social beliefs.

Enhanced Integration of Information Across Health Systems

Those in the health provider community reported that they would like to see greater integration of health information across systems and would like to see incentives for physicians, psychiatrists, and dental professionals to come into the public sector.

Greater Collaboration Across Agencies

Finally, although several respondents reported close collaboration across those in the health and social service systems, others felt greater coordination was needed. In Norwalk, an interviewee stated, "*people are stuck in an isolationist attitude*." As one interviewee noted, "*we have a lot of people working really hard doing a lot of stuff but what we don't do well is point the resources in the right direction...there is too much jumping in and doing because it just makes people feel better*."

III. CONCLUSION

Through a review of the secondary social, economic, and epidemiological data in the Greater Norwalk Area as well as discussion with community residents and leaders, this assessment report provides an overview of the social and economic environment of the area, the health conditions and behaviors that most affect the population, and the perceptions of strengths and gaps in the current public health and health care environment. Several overarching themes emerged from synthesizing these data points:

- **There is a variation within the Greater Norwalk Area in population composition and economic levels.** Norwalk differs from the surrounding towns in population size, diversity and number of households with lower median incomes. All of the communities bring strengths and resources to the area to support health improvement. Across the Greater Norwalk Area, focus group and interview participants noted strengths of civic-minded residents, growing diversity, highly educated residents, a child oriented environment, strong businesses, and access to the waterfront and recreational areas.

- **Mental Health and substance abuse were considered growing, pressing concerns by focus group and interview respondents, and one in which the current services were not necessarily addressing community needs.** Focus group and interview participants cited changes in the economy and pressures on adults and youth to succeed as significant reasons for an increased need for mental health and substance abuse services. A lack of accessible providers; a lack of needed services, such as inpatient and educational programs; and stigma around receiving services were expressed as barriers to care. While youth substance use appears to be on the decline, concerns were expressed related to alcohol, marijuana, and prescription drugs, among a range of residents, including parents, those who work with youth, and teens themselves. The social norm was that these substances are easily accessible.

- **As with the rest of the country and state, issues around physical activity, healthy eating, and obesity are issues for residents of the Greater Norwalk Area, especially as chronic conditions are the leading causes of morbidity and mortality.** The Greater Norwalk Area's rates related to physical activity, nutrition, and obesity are similar to or better than what is seen statewide or nationally, yet with heart disease, cancer, and diabetes as top issues in relation to morbidity and mortality, these issues are considered critical to address. Of particular concern was the evidence related to childhood obesity—an issue that will have even more severe health and cost repercussions in the future as the younger generation transitions to adulthood. This issue is more pronounced in the city of Norwalk. In general, although the Greater Norwalk Area residents have access to many grocery stores, parks, and recreational facilities, concerns were related to the accessibility and affordability of these outlets. While several facilities and programs around these issues exist, some interviewees and focus group participants commented that it was critical to address this issue through a comprehensive approach, in that multiple sectors, including health care, education, public works, transportation, local government, and the business community, needed to collaborate together to make an impact on current rates.

- **Numerous services, resources, and organizations are currently working to meet the health and social service needs of area residents.** Throughout the discussions, interview and focus group participants recognized the strong work related to health in which many community-based and regional organizations are involved. Local health departments, Norwalk Hospital and Norwalk Community Health Center, along with dozens of local health and social service organizations, were cited as key players in the community to meet current and future needs.

However, some interviewees commented that services in the area are fragmented, uncoordinated, and under-funded. There was strong interest for these issues to be addressed via a more strategic, coordinated approach with multiple organizations and agencies working together. Overall, participants were hopeful for the future and saw that the discussions occurring in the region would create momentum for moving forward with innovative, collaborative approaches towards health.

Part II: Community Health Improvement Plan

I. Overview of the Community Health Improvement Plan

A. What is a Community Health Improvement Plan?

A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.[24]

CHIPs are created through a community-wide planning process that engages residents and partners.

B. How to use a CHIP

A CHIP is developed to provide guidance to the health department, its partners, and its stakeholders, on improving the health of the population within the health department's jurisdiction.[25] The plan is critical to developing policies and defining actions to target efforts that promote health. Government agencies, including those related to health, human services, and education, as well as hospitals can use the CHIP in collaboration with community partners to set priorities and coordinate and target resources. A CHIP is designed to be a broad, strategic framework for community health that can be modified as conditions change. It is developed in a way that engages multiple perspectives so that any community member or organization can find a role in supporting the plan.

C. Methods

To develop the CHIP, Norwalk Hospital and the Norwalk Health Department partnered to bring together community residents and the area's influential leaders in healthcare, community organizations, education, housing, local government, business, mental and behavioral health, and social services. Following the guidelines of the Association for Community Health Improvement (ACHI), the Public Health Accreditation Board, and National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the current community health activities of many organizations in order to leverage existing resources for greater efficiency and impact. The assessment/planning/implementation/evaluation/reassessment process is a continuous cycle of improvement that seeks to "move the needle" on key health priorities over the course of time.

The next phase of the community health improvement process will involve broad implementation of the strategies and action plan developed from the CHIP, and monitoring/evaluation of the CHIP's output and outcome indicators.

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[24] (Adapted from: United States Department of Health and Human Services, Healthy People 2010. Washington, DC; Centers for Disease Control and Prevention, National Public Health Performance Standards Program, www.cdc.gov/nphpsp/FAQ.pdf).

[25] Public Health Accreditation Board (PHAB) Standards and Measures, Version 1.0: Standard 5.2.2. p. 127

II. DEVELOPMENT OF THE GREATER NORWALK AREA CHIP

A. Development of Data-Based Community Identified Health Priorities

After reviewing and discussing the data presented in the Community Health Assessment, members of the Core Leadership Team convened a two-hour community meeting on July 24, 2012 to share the preliminary results of the CHA and identify priorities for the CHIP. Over 100 community members and leaders attended this session, representing diverse perspectives and sectors from the community.

The following themes emerged most frequently from review of the available data and were used in the selection of the CHIP health priorities:

Mental Health
- Depression
- Stress and anxiety
- Stigma
- Access to services

Substance Abuse
- Tobacco
- Alcohol
- Marijuana
- Heroin
- Emerging Substances (i.e., bath salts)

Chronic Disease
- Cardiovascular Disease
- Cancer
- Diabetes
- Asthma
- HIV/AIDS

Obesity
- Healthy Eating
- Active Living

Health Literacy

After reviewing and discussing the CHA, community members suggested that Long Term Care and Access to Primary and Specialty Care be added to the list of major themes for priority selection.

Facilitators used a quality improvement multi-voting process to identify the three most important public health issues for Greater Norwalk from the list of seven major themes identified from the CHA. Each community participant received three dots to apply to their top three public health priorities, based on the following agreed-upon criteria:

- Political will exists to support change
- Community Values
  - Community cares about it
  - People, power and passion: Likely community mobilization
  - Important to community
- Key area of need (based on data)
  - Size: Many people affected
  - Trend: Getting worse
  - Seriousness: Deaths, hospitalizations, disabilities
  - Causes: Can identify root causes/social determinants
  - Research/evidence-based
- Achievable/doable
  - Feasible and realistic
- Resources available or likely
  - Builds on or enhances current work
- Measurable outcomes
- Can move the needle
  - Proven strategies to address multiple wins/catalytic actions
  - Easy short-term wins
- Population Based Strategies
  - Some groups affected more
  - Can focus on targeted population(s)

The results of the multi-voting process are as follows:

Key Health & Healthcare Themes from the CHA	Total # of Votes
Mental Health	**63**
Obesity	**39**
Substance Abuse	**36**
Access to Primary and Specialty Care	29
Chronic Disease	27
Long Term Care	22
Health Literacy	13

Based on the results of the multi-voting exercise, participants agreed upon the following three health priority areas for the CHIP:

1. Mental Health
2. Obesity
3. Substance Abuse

Task Force members engaged in three small table discussions around the priority areas. They recommended specific areas of focus for the priority areas, identified resources that might be needed and those that are already available to address the issues, and identified organizations and individuals that should be involved in workgroups to develop the CHIP. [See Appendix C for workgroup participants and affiliations]

B. Development of the CHIP Strategic Components

The Core Leadership Team convened two, three-hour work sessions on September 11 and September 25, 2012. Community members and partners were invited to participate in working groups based on interest and expertise in each of the three identified priority areas, as self-indicated on exit surveys from the community planning session. See Appendix C for a list of workgroup participants.

Two-person teams comprised of Core Leadership Team Members and HRiA staff facilitated the working groups on both days to develop draft goals, objectives, strategies, outcome indicators, and potential partners/resources for each of the three priority areas. As preparation for the planning sessions, Data Profiles were prepared for key demographic and social determinant data as well as each of the three priority areas selected from the CHA (Mental Health, Substance Abuse, and Obesity).These profiles were distributed to participants in advance and copies were also made available during the sessions to ensure that plan components were data-driven. Objectives and Outcome Indicators were aligned with Healthy People 2020 targets whenever possible. Finally, participants received samples of evidence-based strategies compiled from various sources, including County Health Rankings and The Community Guide, to inform this part of the planning.

In late October 2012, the Core Leadership Team and HRiA staff reviewed the draft plans developed at the planning sessions and edited the plan components for clarity and consistency. Once the draft plan was complete, an online survey was developed to solicit feedback on the components of the plan. From October 24 through November 7, the online survey was administered to all community members who had been engaged in the assessment and planning process (n=240).

Feedback from survey respondents (n=37) was incorporated into the final Community Health Improvement Plan. In general, the respondents agreed or strongly agreed on the importance of the identified strategies. As a result of suggestions made in the survey, the mental health and substance abuse priority areas were combined in to a single priority area. The CHIP was completed in December 2012.

C. Relationship between the CHIP and other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of the Greater Norwalk community.

At the national level, this CHIP has been aligned with the National Prevention Strategy, Healthy People 2020 and the Center for Disease Control's Winnable Battle-Nutrition, Physical Activity, and Obesity. At the state level, the Connecticut state-wide health improvement plan (SHIP) is currently in development, and the Connecticut Department of Public Health has been engaged in the community health improvement process for Norwalk to increase alignment between both plans. Finally, at the local level, participants in the CHIP development process identified potential partners and resources wherever possible rather than duplicating the recommendations and actions of existing frameworks and coalitions.

III. STRATEGIC ELEMENTS OF THE CHIP

Goals, Objectives, Strategies, Key Partners, and Output/Outcomes Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of where you would like to be, and a clear evaluation of whether your efforts are making a difference. The following pages outline the Goals, Objectives, Strategies, Potential Output and Outcomes Indicators, and Potential Partners/Resources for the three health priority areas outlined in the CHIP. See Appendix D for a glossary of terms used in the CHIP.

A. Priority One: Mental Health and Substance Abuse

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE ABUSE		
Goal 1:	**Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.**	
Objective 1.1:	**Increase providers' and community members' awareness and use of evidence-based mental health and substance abuse services and educational resources for prevention, intervention, treatment and recovery (by date).**	
Strategy 1.1.1:	Support collaborations among community-based and regional organizations to enhance and deliver training and other educational opportunities for community members on topics related to mental health and substance abuse.	***Examples of Partners or Sources of Information*** • Department of Mental Health and Addiction Services (DMHAS 101) • Southwest Regional Mental Health Board (SWRMHB) • Alanon • NAMI • Liberation Programs • Positive Directions • School Nurses • PTOs/PTAs
Strategy 1.1.2:	Build upon or expand existing training programs for providers at area educational institutions.	***Examples of Partners or Sources of Information*** • Department of Mental Health and Addiction Services (DMHAS 101 • Mid-Fairfield Substance Abuse Coalition • Local prevention councils • Connecticut Renaissance • Family and Children's Agency, Project Reward
Strategy 1.1.3:	Establish knowledgeable, well-trained, bi-lingual Patient Navigators and Community Health workers in key community based organizations.	***Examples of Partners or Sources of Information*** • Norwalk Community College School of Nursing • Norwalk Community Health Center • Public and private colleges and universities
Strategy 1.1.4:	Develop and disseminate a comprehensive, bilingual resource guide for programs and services that support mental health and prevent and treat substance use and abuse.	***Examples of Partners or Sources of Information*** • United Way • Connecticut Network of Care • Connecticut Behavioral Health Partnership • Norwalk, CT Resource Directory • Websites and social media as resources for distribution
Sample Output Indicators for 1.1: • Bilingual resource guide developed and disseminated • # of hard copies distributed by (DATE) • # of internet downloads • # trainings on adult and youth mental health service • # of educational opportunities related to substance abuse prevention, treatment and recovery • # Bilingual Patient Navigators and Community Health workers trained		

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE ABUSE		
Goal 1:	**Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.**	
Sample Outcome Indicators for 1.1: • Decreased inpatient rate of adolescents admissions • Decreased emergency department visits for mental illness • # calls for mental health services (211) • Increase in the # of referrals or use of programs • # people calling 211 speaking languages other than English • Increase in # of patients who stay in treatment • Increase in # of outpatient services for substance use and abuse • Increase in # of individuals receiving outpatient services from FQHC • Decrease in average # of mentally unhealthy days reported in past 30 days • Increase in # of patient navigators/community health workers who are assisting families with substance abuse services • Increase in # of culturally and linguistically competent services • Decrease the proportion of adults aged 18 and older who reported binge drinking during the past month *(NPS Indicator)* • Decrease the proportion of high school students who reported binge drinking during the past two weeks *(NPS Indicator)*		
Objective 1.2:	**Enhance local and regional partnerships to improve access to timely, comprehensive, and coordinated services for diverse populations across the life span by (date).**	
Strategy 1.2.1:	Conduct a regional assessment of the existing number of mental health care and substance abuse providers/resources currently available for adults and adolescents at each level of care as an initial step in the further development of collaboration and efficient use of resources among providers.	***Examples of Partners or Sources of Information*** • *(none provided)*
Strategy 1.2.2:	Identify and/or create 1 or 2 formalized, regional partnerships to address mental health and substance abuse service gaps and inefficiencies through collaborative planning, service delivery, and resource sharing.	***Examples of Partners or Sources of Information*** • *(none provided)*
Strategy 1.2.3:	Form an Alliance between local health care providers and community based services to provide accessible and financially viable outpatient services.	***Examples of Partners or Sources of Information*** • Norwalk Hospital • Norwalk Community Health Center • Local Providers • Community organizations • Payors

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE ABUSE

Goal 1: Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.

Sample Output Indicators for 1.2:

- Formal structure/local collaboration developed
- Local health care providers and community based service providers form Alliance to address access to treatment
- Increased representation of service types on regional partnerships
- Inpatient, outpatient, early childhood, social service providers, older adults, DCF, DMHAS

Sample Outcome Indicators for 1.2:

- Decreased inpatient rate of adolescents admissions
- Decreased ED visits for mental illness
- Increase in # people calling 211 speaking languages other than English
- Increase in # of clinics
- Increase in # of providers
- Increase in # of primary care facilities that provide mental health treatment services
- Increase in # of outpatient services for substance use and abuse
- Increase in # of individuals receiving outpatient services from FQHC
- Decrease in average # of mentally unhealthy days reported in past 30 days
- Increase in # of culturally and linguistically competent services
- Increase in # of patients who stay in treatment

Objective 1.3: Reduce financial barriers to treatment (by date).

Strategy 1.3.1: Convene payers in ACO/PHO (Accountable Care Organization/Physician Hospital Organization) to address reimbursement issues around mental health and substance abuse.	***Examples of Partners or Sources of Information*** • Norwalk Hospital • ACO/PHO's • Payors
Strategy 1.3.2: Work with local businesses to promote existing programs that address employees' substance abuse and mental health issues.	***Examples of Partners or Sources of Information*** • Federally Qualified Health Centers (FQHC's) • CT Business Partners on Health • Chamber of Commerce • United Way 211 • Employers/Employee Assistance Programs

Sample Output Indicators for 1.3:

- Payers come to the table

Sample Outcome Indicators for 1.3:

- One payer changes their reimbursement policy
- Increased use of existing programs that address employee substance abuse and mental health issues
- Decrease in employee absentees related to substance abuse and mental health issues

B. Priority Two: Obesity

PRIORITY AREA 2: OBESITY		
Goal 2:	**Prevent and reduce obesity in the community by promoting healthy lifestyles.**	
Objective 2.1:	**Increase the number of children and adults who meet physical activity guidelines by (date).**	
Strategy 2.1.1:	Increase opportunities for physical activity among school age children (Examples include instituting a walk school bus initiative, developing a physical activity "tool kit" for schools and community-based organizations, establishing or improving organizational policies to promote and support physical activity before, during and after the school day, exploring regional and local joint use agreements)	***Examples of Partners or Sources of Information*** • YMCA • Community Centers • Senior Centers • After-School Programs • Food Pantries • Local Supermarkets • Farmers • Parents • Parks and Recreation • ACHIEVE Grant (Norwalk Childhood Obesity Prevention Committee) • Public and private educational institutions – elementary, secondary, colleges and universities
Strategy 2.1.2:	Increase opportunities for physical activity among adults. (Examples include promoting "NorWALKER" walking routes, developing community "tool box" for community groups, conduct a community drive to collect exercise equipment and DVDs for distribution to groups with need, conducting a "Biggest Loser"– type community campaign for adults, establishing or improving organizational policies to promote and support physical activity, promote staff wellness programs, host free exercise classes, explore regional and local joint-use agreements.)	***Examples of Partners or Sources of Information*** • Parks and Recreation • Senior Centers • Work Sites/Local Businesses • Healthcare Providers • Community Clinics • Faith-based Organizations • Community Organizations • Public Libraries • Local Supermarkets • Community Centers • Transit Authority • Public and private educational institutions – elementary, secondary, colleges and universities

PRIORITY AREA 2: OBESITY		
Goal 2:	**Prevent and reduce obesity in the community by promoting healthy lifestyles.**	
Sample Output Indicators for 2.1: • 3-5 evidenced based strategies selected and implemented • New state mandate implemented • #of towns with joint use agreements		
Sample Outcome Indicators for 2.1: • # of minutes of physical activity in the school day • increased enrollment in physical activity in after school settings • increased number of people using walking routes • % of 9th graders at healthy weight • % of adults who meet physical activity guidelines (e.g., HSC survey; KAB survey; QOL survey; Healthy equity index)		
Objective 2.2:	**Increase access to and consumption of healthy and affordable foods throughout the region by (date).**	
Strategy 2.2.1:	Increase access to healthy foods through evidence-based initiatives such as mobile markets, healthy market projects, or healthy restaurant programs.	***Examples of Partners or Sources of Information*** • Local Supermarkets • Restaurants • Farmers • CT Department of Agriculture • Chamber of Commerce • Norwalk Health Department • CT Department of Public Health
Strategy 2.2.2:	Develop and implement an education campaign (programs, tools, and resources) to increase awareness about healthy eating.	***Examples of Partners or Sources of Information*** • ACHIEVE Grant (Norwalk Childhood Obesity Prevention Committee) • Local Media • Local Supermarkets • Worksites/Businesses • Faith-based Organizations • Community Centers • Public and private educational institutions – elementary, secondary, colleges and universities • Restaurants • Local Health Departments • CT Department of Public Health
Sample Output Indicators for 2.2: • Evidence-based initiatives to increase access to healthy foods implemented • # of educational programs, tools, and resources available to communities		
Sample Outcome Indicators for 2.2: • % of population with access to outlets selling healthy foods • # of people buying healthy foods • % of students who ate fruits and vegetables less than five times per day during the week before survey • % of high school students who are obese (>= 95th percentile for BMI by age and sex) • % of adults who are obese/increased proportion of adults at healthy weight		

IV. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. Members of the Core Leadership Team will meet with workgroup members to designate lead and supporting roles for partners to implement each strategy, starting in January 2013. They will further develop the strategies and provide more detailed timeframes.

Appendices

APPENDIX A: CORE LEADERSHIP TEAM AND TASK FORCE MEMBERS

One of the great successes of the process to develop the CHA and CHIP was the high level of cross-sector collaboration. This collaboration was led by Norwalk Health Department and Norwalk Hospital who met on a bi-weekly basis to discuss the each step of the process and review progress.

Hosts of CHA/CHIP Process

Norwalk Hospital
Norwalk Health Department

Core Leadership Team

Tim Callahan	Director of Health, Norwalk Health Department
Mary Franco	President, Norwalk Hospital Foundation Vice President, Public Affairs, Norwalk Hospital
Deanna D'Amore	Project Coordinator, Norwalk Health Department
Joyce D. Bretherton	Development Associate, Norwalk Hospital Foundation
Theresa Argondezzi	Health Educator, Norwalk Health Department

Consultants

Health Resources in Action, Inc., Boston, MA

Community Health Assessment and Improvement Task Force Members

Inta Adams	Assistant Director, Darien Social Services
Anthony Allison	Program Director, Norwalk Children's Foundation
Dr. Joe Andrews	Medical Director, Connecticut Hospice
Theresa Argondezzi	Health Educator, Norwalk Health Department
Richard Bangs	Norwalk Transit District
Charlene Barlow	Director, Community Outreach -- Home Care Family & Children's Agency
Carol Bauer	Community Advisory Board Member, Norwalk Hospital
Eva Beau	Community Outreach Coordinator, Norwalk Community Health Center
Rowena Bergmans	Consultant, Norwalk Hospital
Debi Boccanfuso	Principal, Darien Public Schools
Maria Borges-Lopez	Board of Trustees, Norwalk Hospital
Toni Boucher	State Senator, Connecticut
Adam Bovilsky	Director, Human Relations and Fair Rent Department, City of Norwalk
Carol Bower	Leading Planning Analyst, Connecticut Department of Public Health
Christine Bradley	Director, Norwalk Public Library
Sharon Bradley	President & CEO, Visiting Nurse and Hospice
Joyce Bretherton	Development Associate, Norwalk Hospital
Michele Bullock	Manager, Patient Access, St. Vincent's Health Services
Barbara Butler	Director, Westport Department of Human Services
Tim Callahan	Director of Health, Norwalk Health Department
Angelica Camacho	Behavioral Health Coordinator, Day Street Community Health Center
Rhonda Capuano	Director, Dr. Robert Appleby School Based Health Centers, Human Services Council
Patricia Carey	APRN, Communicable Disease Coordinator, Norwalk Health Department
Denise Cesareo	Executive Director, ElderHouse
Yohanna Cifuentes	Senior Bilingual Clinician, Mid-Fairfield Child Guidance Center
Sands Cleary	Director of Health, Fairfield Health Department

Tom Closter	Director of Environmental Services, Norwalk Health Department
Mark Cooper	Director of Health, Westport Weston Health District
Christina Crain	Southwestern Connecticut Agency on Aging
Larry Cross	Chief Executive Officer, Norwalk Community Health Center
Deanna D'Amore	Project Coordinator, Norwalk Health Department
Igor Dargery	CEO, Norwalk Medical Group
Dan DeBarba	President & CEO, Norwalk Hospital
Cathy DeCesare	Senior Vice President Strategic Initiatives, United Way of Coastal Fairfield County
Dr. Marvin Den	Norwalk Medical Group
Patricia DiPietro	Business Manager, Norwalk Health Department
Kathleen Dunn	Clinical Manager, Norwalk Hospital Behavioral Health
Izora Ebron	Acting Executive Director, Open Door Shelter
Dr. Marcia Eckerd	Psychologist, Norwalh Hospital Pediatric Development & Therapy Center
Dr. Howard Eison	Internal Medicine
Laura Epstein	Executive Director, Norwalk Senior Services
Mary Franco	President, Norwalk Hospital Foundation Vice President, Public Affairs, Norwalk Hospital
Carol Frank	Chair, Norwalk Human Relations Commission, City of Norwalk
Teresa Giegengack	Assistant Director, Client Services, Wesport Department of Human Services
Donna Glen	Senior Planning & Business Development Analyst, Norwalk Hospital
Kate Glidden	Senior Supervisory Clinician, Mid-Fairfield Child Guidance Center
Adele Gordon	Director of Fairfield County Sites, Community Health Centers, Inc.
Karen Gottlieb	Executive Director, AmeriCares
Marty Hauhuth	Executive Director, Positive Directions
Hope Hetherington	Chair, Interagency and Partnership Advisory Panel on Lupus
Darleen Hoffler	Supervisor of Clinical Services, Norwalk Health Department
Lauren Hughes	Coordinator Senior Services, Wilton Department of Social Services
Michele Jakob	Outreach Director, Norwalk Senior Center
Betty Karkut	Executive Director, Human Services Council
Dr. Janet Karpiak	Pediatrics, Norwalk Hospital, Norwalk Board of Health
David Knauf	Director of Health, Darien Health Department
Tom Kulhawik	Police Chief, Norwalk Police Department
Kimberly Kuta	Director of Research & Evaluation, Stepping Stones Museum
Ken Lalime	Member, Norwalk Board of Health
Molly Larson	Public Health Nurse, Darien Health Department
Dr. David Levinson	President, Norwalk Community College
Sarah Levy	Health Educator, Fairfield Health Department
Ana Lopez	Community Resident
Dr. Susan Marks	Superintendent, Norwalk Public Schools
Patricia Marsden-Kish	Planning Facilitator, Choice Neighborhoods, Norwalk Housing Authority
Allen Mathis	President & CEO, Liberation Programs, Inc.
Candace Mayer	Deputy Director, Norwalk Housing Authority
Dr. Eric Mazur	Vice President & Chief Medical Officer, Norwalk Hospital
Barbara McCabe	Clinic Director, AmeriCares
Barry McGovern	Associate Executive Director, Keystone House
Shaun Mee	Regional Manager, Mutual Security Credit Union
Dr. Katherine Michael	Chair, Department of Psychiatry, Norwalk Hospital
Richard Moccia	Mayor, City of Norwalk
Elayne Mordoff	Community Resident

Ed Musante	President and CEO, Greater Norwalk Chamber of Commerce
Jane Nyce	Executive Director, Staying Put, New Canaan
Kim O'Rielly	Executive Director, Southwest Regional Mental Health Board
Paul Palermo	Executive Director, Norwalk Senior Center
Christy Perone	Sales and Marketing Manager, Brookdale Place, Wilton
Susan Pfister	Director, Department of Human Services, Westport
Heather Porter	Director, Marketing and Business Development, Silver Hill Hospital
Judy Prager	Head Start Nutrition Manager, Norwalk Economic Opportunity Now
Terry Quell	Member, Norwalk Board of Health
Cesar Ramirez	Police Officer, Norwalk Police Department Chair, Housing Authority Board of Commissioners, City of Norwalk
Dr. David Reed	Director of Health, New Canaan Health Department Medical Advisor, Norwalk Health Department
Dr. Alan Richman	Radiology, Norwalk Hospital
Harry Rilling	Chief of Police, Norwalk Police Department
Milagros Rivera	Community Resident
Nicole Rivard	Community Resident
Maura Romaine	Director, Corporate Communications, Norwalk Hospital
Suzanne Schintzius	Stewardship Manager, Norwalk Hospital, Wilton Human Services, Town of Wilton
Libby Scott	Community Resident
Rose Sellers	Community Resident
Ervin Shames	Board Member, Norwalk Hospital Foundation
Sharon Simon	Community Relations Specialist, Norwalk Hospital
Kristen Sinatra	Director of Marketing, Waveny Care Network
Dr. Vicki Smetak	Chairman, Department of Pediatrics, Norwalk Hospital
Eileen Smith	Executive Director, Soundview Medical Associates
Jane Stickkel	Clinical Supervisor, Connecticut Hospice
Margaret Suib	Fair Housing Officer, City of Norwalk
Amy Taylor	Administrative Assistant to the Director, Day Street Community Health Center
Mary Ann Tessier	Professor and Chair of Nursing, Norwalk Community College
Jeryl Topalian	Executive Director, Planning and Business Development, Norwalk Hospital
Dr. Ed Tracey	Member, Board of Health, Norwalk
Terry Tumpane	Administrator, Waveny Home Health
Sarah Turbert	Director of Youth Development Services, Norwalk YMCA
Grace Vetter	Coordinator of School Health Services, Norwalk Public Schools
Ruthann Walsh	Director, Corporate Citizenship, Pepperidge Farm Corporation
Monica Wheeler	Director of Community Health, Westport Weston Health District
Valerie Williams	Executive Director, Keystone House
David Wrinn	Deputy Chief, Norwalk Police Department

APPENDIX B: FOCUS GROUP AND INTERVIEW PARTICIPANTS

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Marie Allen	Executive Director, Southwestern Connecticut Agency on Aging
Dr. Joe Andrews	Medical Director, Connecticut Hospice
Dilian Aquino	Community Resident
Vicki Ashy	Community Resident
Dr. Tom Ayoub	Obstetrics & Gynecology
Juliana Azor	Community Resident
Melanie Barnard	President, New Canaan Volunteer Ambulance Corp
Dr. Yoni Barnhard,	Chairman, Department of OB GYN, Norwalk Hospital
Katie Banzhaf	Executive Director, STAR
Rose L. Beau	Community Resident
Matt Bernhardt	Community Resident
Debi Boccanfuso	Principal, Middlesex Middle School, Darien Public Schools
Adam Bovilsky	Director, Human Relations and Fair Rent Department, City of Norwalk
Sharon Bradley	President & CEO, Visiting Nurse and Hospice
Bill Brennan	First Selectman, Town of Wilton
Ricky Bretherton	Community Resident
Matthew Brovender	Member, Norwalk Board of Health
Michelle Bullock	Manager of Patient Access, St. Vincent's Behavioral Health Services
Kathy Cahill	Head Teacher, Naramake Elementary School Family Resource Center
John Calka	Captain, Westport Police Department
Tim Callahan	Director of Health, Norwalk Health Department
Elizabeth Canales	Community Resident
Rhonda Capuano	Director, Dr. Robert Appleby School Based Health Centers, Human Services Council
Patricia Carey	APRN, Communicable Disease Coordinator, Norwalk Health Department
Dr. Michael Carius	Chairman, Department of Emergency Medicine, Norwalk Hospital
Nancy Carroll	Deputy Administrator, Norwalk Transit District
Gene Cederbaum	Fair Housing Agent, Town of Westport
Sands Cleary	Director of Health, Fairfield Health Department
Mark Cooper	Director of Health, Westport Weston Health District
Jason Cotaling	Community Resident
Bob Crosby	Deputy Chief, Wilton Police Department
Larry Cross	CEO, Norwalk Community Health Center
Dr. Peter Czuczka	Willows Pediatrics
Igor Dargery	CEO, Norwalk Medical Group
Dan DeBarba	President and CEO, Norwalk Hospital
Cathy DeCesare	Sr. Vice President Strategic Initiatives, United Way of Coastal Fairfield County
Dr. Marvin Den	Norwalk Medical Group
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Lloyd Dunbar	Community Resident
Raymond Dunlap	Community Resident
Izora Ebron	Acting Executive Director, Open Door Shelter
Dr. Mark Feigen	Director, Dental Services, Norwalk Hospital

Rita Ferri	Principal, Hindley Elementary School, Darien Public Schools
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Peter Fraboni	Associate Director, Earthplace Harbor Watch Program
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Angela Galbo	Community Resident
Mirna Garcia	Community Resident
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Art Goldblatt	Community Resident
Favian Gonzales	Community Resident
Zeronia Gordon	Community Resident
Karen Gottlieb	Executive Director, AmeriCares
Stuart Greenbaum	Executive Director, Mid-Fairfield Child Guidance Center
Kim Guinta	Rewards Manager, Diageo, Inc.
Henner Gutierrez	Community Resident
Sally Harding	Director of Client Services, ElderHouse
Dick Harris	Director of Harbor Watch, Earthplace Harbor Watch Program
Marty Hauhuth	Executive Director, Positive Directions
Hope Hetherington	Chair, Interagency and Partnership Advisory Panel on Lupus
Tyler Hiller	Community Resident
Laura Howell	Community Resident
Lauren Hughes	Coordinator Senior Services, Wilton Department of Social Services
Liz Inca	Community Resident
Michele Jakab	Outreach Director, Norwalk Senior Center
Damaris Jimenez	Community Resident
Giovanni Jimenez	Community Resident
Praveen John	Lieutenant, Norwalk Police Department
Lenore Jordan	Community Resident
Gordon Joseloff	First Selectman, Town of Westport
Bob Kalina	Vice President, Human Resources, Financial Accounting Foundation
Kayla Kessler	Community Resident
David Knauf	Director of Health, Darien Health Department
Anastasia Koskorelos	Community Resident
Tom Kulhawik	Police Chief, Norwalk Police Department
Ken Lalime	Member, Norwalk Board of Health
Janine Lane	Teacher, Fox Run Elementary School, Norwalk Public Schools
Molly Larson	Public Health Nurse, Darien Health Department
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M. Lawson	Community Resident
Jon Lawson	Community Resident
Barbara Lialios	School Nurse, Brien McMahon High School, Norwalk Public Schools
Stephanie Linton	Community Resident
Angelica M. Llanos	Community Resident
Ana P. Lopez	Community Resident

Maria Loya	Community Resident
Robert Mallozzi	First Selectman, Town of New Canaan
Rocio Marcelino	Community Resident
Abel Marcelino	Community Resident
Dr. Susan Marks	Superintendent, Norwalk Public Schools
Patricia Marsden-Kish	Planning Facilitator, Choice Neighborhoods, Norwalk Housing Authority
Graciela Martinez	Community Resident
Elda Mas-Portillo	Community Resident
Candace Mayer	Deputy Director, Norwalk Housing Authority
Dr. Eric Mazur	Vice President and Chief Medical Officer, Norwalk Hospital
Barbara McCabe	APRN, Clinic Director, AmeriCares
Bridget McCallum	Community Resident
David McCarthy	Councilman, Norwalk Common Council
Patricia McCrae	Community Resident
Carol McDonald	Director of Human Services, Town of New Canaan
Shawn Mee	Regional Manager, Mutual Security Credit Union
Dr. Katherine Michael	Chair, Department of Psychiatry, Norwalk Hospital
Richard Moccia	Mayor, City of Norwalk
Elayne Mordoff	Community Resident
Georgina Morgan	Community Resident
Ed Musante	President, Greater Norwalk Chamber of Commerce
Ed Nadriczny	Chief of Police, New Canaan Police Department
Jane Nyce	Executive Director, Staying Put, New Canaan
Brody O'Brien	Community Resident
Dr. Jason Orlinick	Hospitalist, NHPS
Lilian Ortega	Community Resident
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Mike Parlanti	Community Resident
Ricardo Partida	Community Resident
Veronica Partida	Community Resident
Merlin Perez	Community Resident
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Tia Perry	Community Resident
Susan Pfister	Director, Department of Human Services, Westport
Catherine Pierce	Municipal Agent, Wilton Department of Social Services
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Terry Quell	Member, Norwalk Board of Health
Jessica Reardon	Special Education Teacher, Darien Public Schools
David Reed	Director of Health, Town of New Canaan
Joseph Riker	Executive Director, CT Renaissance
Milagros Rivera	Community Resident
Francine Robert	Community Resident
Ramiro Rojo	Community Resident
Ellen Ryan	Director of School Health Services, Darien Public Schools
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Angelica Sanchez	Community Resident
Juana Sanchez	Community Resident
Maricela Sanchez	Community Resident

Rachel Satter	Teacher, Holmes Elementary School, Darien Public Schools
Mary Scalise	School Psychologist, Darien Public Schools
Brad Schmidt	Community Resident
Ed Schwartz	Officer, Norwalk Police Department
Libby Scott	Community Resident
Rose Sellers	Community Resident
Kristin Sinatra	Director of Marketing, Waveny Care Network
Yolanda Skinner	NAACP Health Chair
Dr. Vicki Smetak	Pediatric Chairman, Norwalk Hospital
Eileen Smith	Executive Director, Soundview Medical Associates
Yary Solano	Community Resident
Audrey Spellman	Special Educator, Family First Early Intervention Project
Jayme Stevenson	First Selectman, Town of Darien
Jane Stikkel	Clinical Supervisor, Connecticut Hospice
George Taube	Community Resident
Marcha Taube	Community Resident
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Rudean Thomas	Community Resident
Tanasia Ticking	Community Resident
Dr. Ed Tracey	Member, Norwalk Board of Health
Terry Tumpane	Administrator, Waveny Home Health
Sarah Turbert	Director of Youth Developmental Services, Norwalk YMCA
Chet Valiante	Publisher/COO, The Hour Publishing Company
Lynn VanDeusen	Community Resident
Aideen Vergara	Occupational Health Nurse Practitioner, GE Capital/Norwalk Hospital
Danielle Waddell	Community Resident
Denise Walsh	Chair, Fairfield Board of Health
Gayle Weinstein	First Selectman, Town of Weston
Ruthann Walsh	Director of Corporate Citizenship, Pepperidge Farm
Monica Wheeler	Director of Community Health, Westport Weston Health District
Valerie Williams	Executive Director, Keystone House
Shawn Wong Won	Community Police Lieutenant, Norwalk Police Department
Darlene Young	Mentoring Program Coordinator, City of Norwalk
Bethany Zaro	Public Health Nurse, New Canaan Health Department
Mariel Zeccola	APRN, Pediatric Development & Therapy Center, Norwalk Hospital

APPENDIX C: CHIP PLANNING SESSION WORKGROUP MEMBERS

Mental Health Work Group

Hollie Bentham-Rice	Disabilities and Mental Health Manager, NEON Child Development Program
Michele Bullock	Manager of Patient Access, St. Vincent's Behavioral Health
Angelica Camacho	Behavioral Health Coordinator, Day Street Community Health Center
Rhonda Capuano	Director, Dr. Robert E. Appleby School Based Health Centers, Human Services Council
Yohanna Cifuentes	Senior Bilingual Clinician, Mid-Fairfield Child Guidance Center
Larry Cross	Chief Executive Officer, Norwalk Community Health Center
Carol Frank	Chair, Norwalk Human Relations Commission
Jim Garland	COO /CFO, Norwalk YMCA
Shaun Mee	Regional Manager, Mutual Security Credit
Kim O'Rielly	Executive Director, Southwest Regional Mental Health Board
Toni Petrucci	Manager Hospitality Services, Norwalk Hospital
Ellen Rogan	Director, Department of Psychiatry, Norwalk Hospital
Valerie Williams	Executive Director, Keystone House
Mariel Zeccola	APRN, Norwalk Hospital, Pediatric Development & Therapy Center

Obesity Work Group

Theresa Argondezzi	Health Educator, Norwalk Health Department
Maria Borges-Lopez	Board of Trustees, Norwalk Hospital
Michael Case	CEO, Norwalk YMCA
Patricia DiPietro	Business Manager, Norwalk Health Department
Karen Gottlieb	Executive Director, AmeriCares
Darleen Hoffler	Clinical Supervisor, Norwalk Health Department
Jim Garland	COO/CFO, Norwalk YMCA
Dr. Janet Karpiak	Pediatrics, Norwalk Hospital & Norwalk Board of Health
Kimberly Kuta	Director of Research & Evaluation, Stepping Stones Museum for Children
Barbara McCabe	APRN, Clinic Director, AmeriCares
Barry McGovern	Associate Executive Director, Keystone House
Peter McKnight	Manager, Clinical Nutrition Services, Norwalk Hospital
Erin Moriarty	NEON Development Center
Judy Prager	Nutrition Consultant, NEON Child Development Program
Amy Taylor	Administrative Assistant to the Director, Day Street Community Health Center
Jeryl Topalian	Director of Planning & Business Development, Norwalk Hospital
Ruthann Walsh	Director, Corporate Citizenship, Pepperidge Farm
Monica Wheeler	Director of Community Health, Westport Weston Health District

CHIP Planning Session Workgroup Members - continued

Substance Abuse Work Group

Eva Beau	Community Outreach Coordinator, Norwalk Community Health Center
Rowena Bergmans	Consultant, Norwalk Hospital
Donna Glen	Senior Analyst, Planning & Business Development, Norwalk Hospital
Lauren Hughes	Coordinator, Senior Services, Wilton Department of Social Services
Alan Mathis	President & CEO, Liberation Programs, Inc.
Dr. Katherine Michael	Chairman, Department of Psychiatry, Norwalk Hospital
Linda Mosel	Chief Operating Officer of Outpatient Services, CT Renaissance
Coral Presti	Interim Director of Nursing and Allied Health, Norwalk Community College

APPENDIX D: GLOSSARY OF CHIP TERMS

Goals - identify in broad terms how the efforts will change things to solve identified problems

Objectives - measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals

Strategies - action-oriented phrases to describe how the objectives will be approached

Outcome Indicators - the changes that occur at the community level as a result of completion of the strategies and actions taken

Output Indicators - specific deliverables that are the result of the completion of the strategies and actions taken

Priority Areas - broad issues that pose problems for the community

APPENDIX E: ADDITIONAL DATA TABLES

DEMOGRAPHICS AND SOCIAL DETERMINANTS

Table A: Population Change by Age in Connecticut, Greater Norwalk Area, and Towns, 2000 and 2010

	Pop Change Number	Pop % Change	% Change Age 0-14	% Change Age 15-24	% Change Age 25-64	% Change Age 65+
Norwalk	2,652	3.2%	0.3%	11.2%	2.7%	3.3%
New Canaan	343	1.8%	-3.5%	40.9%	-2.5%	6.4%
Westport	642	2.5%	1.1%	52.8%	-4.6%	8.8%
Weston	142	1.4%	-9.5%	59.7%	-2.8%	15.1%
Wilton	429	2.4%	-3.7%	44.1%	-3.2%	16.1%
Darien	1,125	5.7%	8.4%	55.4%	0.0%	-2.4%
Fairfield	2,064	3.6%	7.1%	22.1%	0.0%	-4.6%
Greater Norwalk Area	7,397	3.2%	1.5%	25.9%	0.0%	2.7%
Connecticut	168,532	4.9%	-6.2%	18.4%	5.6%	7.7%

SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

Table B: Population Change by Racial/Ethnic Group in Connecticut, Greater Norwalk Area, and Towns, 2000 and 2010

	Pop Change Number	% Pop Change	White (% change)	Black (% Change)	Asian (% change)	Other/ Multiple (% change)	Hispanic (any race) (% change)
Norwalk	2,652	3.2%	-4.1%	-3.8%	51.8%	67.9%	60.2%
New Canaan	343	1.8%	0.0%	-2.0%	49.0%	46.0%	68.6%
Westport	642	2.5%	-0.3%	4.5%	67.5%	85.4%	54.8%
Weston	142	1.4%	-1.5%	48.9%	51.3%	101.4%	63.1%
Wilton	429	2.4%	-1.1%	69.8%	74.5%	89.8%	99.6%
Darien	1,125	5.7%	3.7%	16.9%	57.0%	64.9%	73.2%
Fairfield	2,064	3.6%	-0.4%	74.8%	88.1%	85.9%	123.8%
Greater Norwalk Area	7,397	3.2%	-1.2%	0.9%	62.4%	70.9%	66.5%
Connecticut	168,532	4.9%	-0.3%	16.9%	64.7%	30.4%	49.6%

SOUCRE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

Table C: Foreclosures, Connecticut, Greater Norwalk Area, and Towns, 2010

	Housing Units	# Foreclosure Filings	# Foreclosure Filings per 1,000 units
Norwalk	38,025	138	3.63
New Canaan	7,203	12	1.67
Westport	10,243	18	1.76
Weston	3,507	11	3.14
Wilton	6,197	11	1.78
Darien	7,051	14	1.99
Fairfield	20,537	51	2.48
Greater Norwalk Area	92,763	255	2.75
Connecticut	1,475,657	6,582	4.46

SOURCE: Connecticut Housing Finance Agency

Table D: Home Sales, Connecticut, Greater Norwalk Area, and Towns, 2010

	Housing Units	# Single-Family Home Sales	# Home Sales per 1,000 units	Median Sale Price	Town Sale Price as Percent of Connecticut Median
Norwalk	38,025	848	22.30	365,000	166
New Canaan	7,203	290	40.26	1,250,000	568
Westport	10,243	444	43.35	950,000	432
Weston	3,507	141	40.21	800,000	364
Wilton	6,197	221	35.66	729,000	331
Darien	7,051	291	41.27	1,250,000	568
Fairfield	20,537	793	38.61	480,000	518
Greater Norwalk Area	92,763	3,028	32.64	631,808	300
Connecticut	1,475,657	36,798	24.94	220,000	100

SOURCE: Connecticut Housing Finance Agency

Table E: Public Assistance and Food Stamps, Connecticut, Greater Norwalk Area, and Towns, 2010

	Households	With cash public assistance income (and FS if received) (%)	SNAP/Food Stamps Only (%)	With cash public assistance or Food Stamps/SNAP (%)
Norwalk	35,133	2.9	2.9	5.8
New Canaan	6,767	0.2	2.2	2.4
Westport	9,302	0.5	0.3	0.8
Weston	3,270	0.9	0.0	0.9
Wilton	5,994	0.6	0.2	0.8
Darien	6,713	1.1	0.6	1.7
Fairfield	19,220	1.0	1.4	2.4
Greater Norwalk Area	86,399	1.6	1.8	3.4
Connecticut	1,359,218	2.6	5.4	8.0

SOURCE: Source: U.S. Census Bureau, 2010 American Community Survey

Table F: Employment by Occupational Categories, Connecticut, Greater Norwalk Area, and Towns, 2010

	Management, Business, Science and Arts	Services	Sales and Office Occupations	Natural Resources	Production
Norwalk	40.2	16.2	27.0	9.6	7.1
New Canaan	59.7	7.3	28.6	3.0	1.4
Westport	64.7	6.4	24.8	2.7	1.5
Weston	71.0	4.8	18.6	2.8	2.8
Wilton	61.0	7.8	24.3	3.5	3.4
Darien	64.5	3.7	26.1	4.2	1.4
Fairfield	51.5	11.4	28.5	4.9	3.8
Greater Norwalk Area	51.1	11.5	26.7	6.2	4.5
Connecticut	40.0	16.8	25.0	8.0	10.2

SOURCE: U.S. Census Bureau, 2010 American Community Survey

Table G: Employment by Industry Sectors 2010 - Broad Classifications, Connecticut, Greater Norwalk Area, and Towns, 2010

	Norwalk	New Canaan	Westport	Weston	Wilton	Darien	Fairfield	Greater Norwalk Area	Connecticut
Agriculture	0.2	0.2	0	0	0.3	0.1	0.5	0.2	0.4
Construction	7.9	4.4	4	3.6	5	4.2	5.6	6.1	6.4
Manufacturing	8.4	4.5	5.6	3.8	8.2	6.1	7.7	7.3	11.8
Wholesale	2.8	2.7	3.2	3.3	1.7	2.4	2.6	2.7	2.7
Retail	11.9	8.6	8.4	7.4	8	6.1	9.7	9.9	11.1
Transport and Utilities	3.2	2	1	1.8	1.7	1.2	2.5	2.4	3.8
Information	3.7	4.5	3.3	6.5	4.5	4.9	4.1	4.1	2.6
Finance and Real Estate	11.3	25.4	22.8	20.1	21	34.9	14.1	16.8	9.5
Professional, Scientific and Management	16.8	20.7	22.5	22.4	22.9	18.7	15.7	18.2	10.7
Education, Health and Social Services	19.1	16.1	16.6	19	16.7	12.1	22.4	18.8	24.9
Entertainment, Hotel, Food Service	6.9	4.8	6.2	4.7	4.7	4.2	7.4	6.4	8
Public Administration	5.9	3.7	4.4	4	4	3.4	4.2	4.8	4.5
Other Services	1.8	2.4	2	3.3	1.3	1.7	3.4	2.3	3.8

SOURCE: U.S. Census Bureau, 2010 American Community Survey

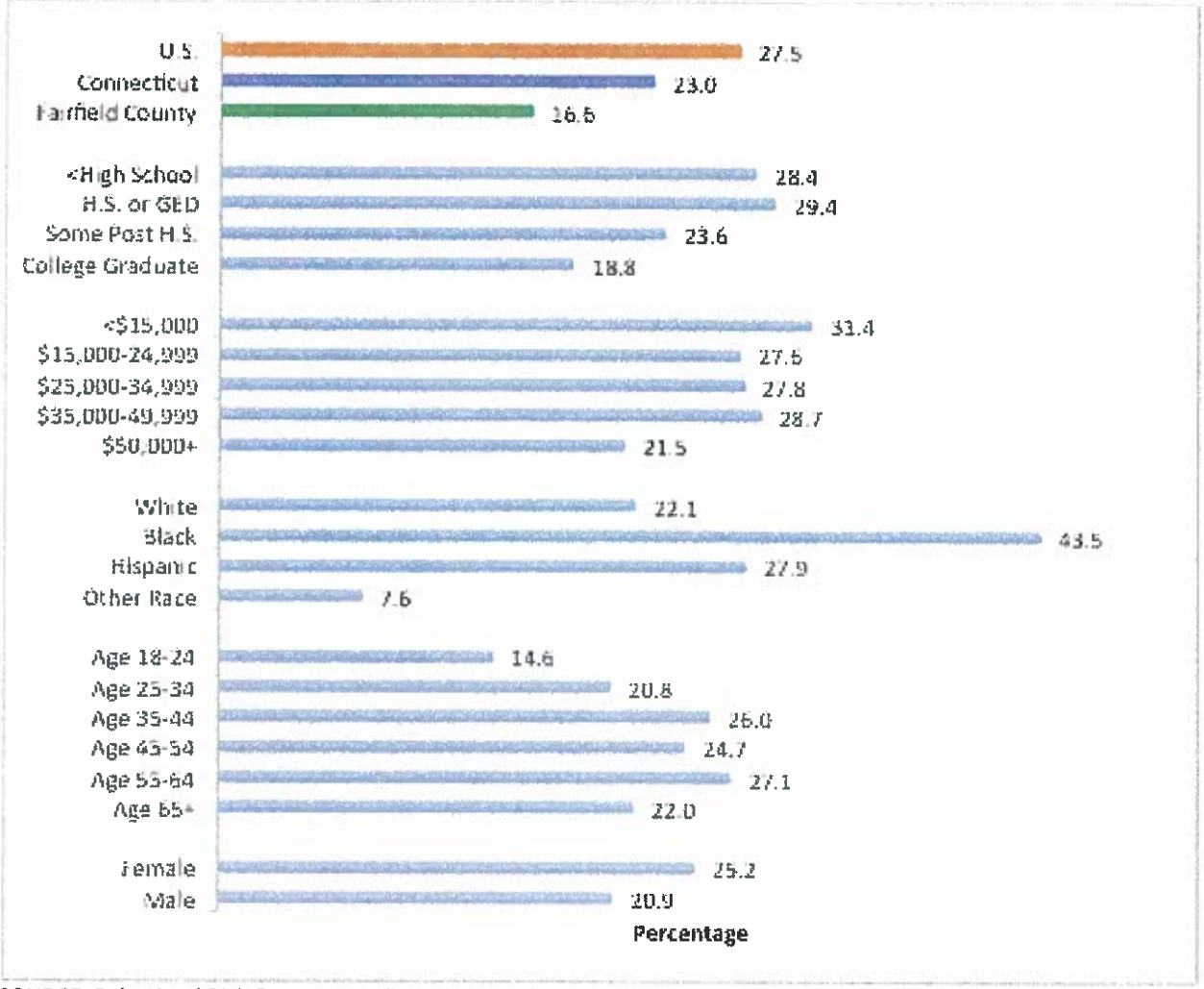
Table H: Crime Rate per 1,000 Population, Connecticut, Greater Norwalk Area, and Towns, 2010

	Crime Rate (# per 1,000)	Crimes Against Persons (# per 1,000)	Crimes Against Property (# per 1,000)
Norwalk	25.62	3.94	21.68
New Canaan	6.78	0.05	6.73
Westport	15.14	0.52	14.62
Weston	6.55	0.09	6.46
Wilton	5.24	0.00	5.24
Darien	7.10	0.05	7.05
Fairfield	18.00	0.60	17.40
Greater Norwalk Area	17.09	1.62	15.47
Connecticut	24.79	2.70	22.09

SOURCE: Source: Connecticut Uniform Crime Data retrieved 5-16-12 from http://www.dpsdata.ct.gov/dps/ucr/ucr.aspx Crimes against persons: murder, rape, robbery and aggravated assault. Crimes against property: burglary, larceny, and motor vehicle theft.

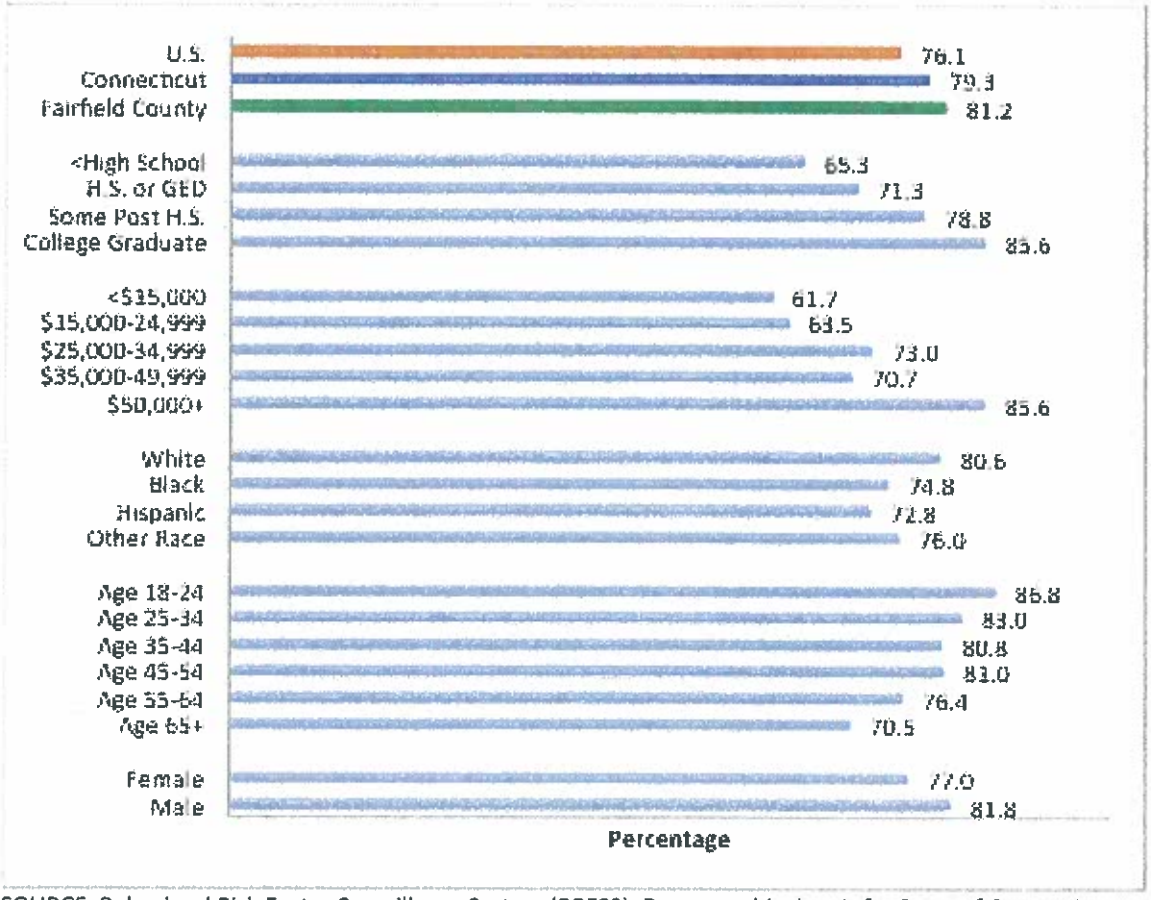
HEALTH BEHAVIORS – ADULTS

Figure A: Percentage of Obese Adults by County, State, and US, 2010



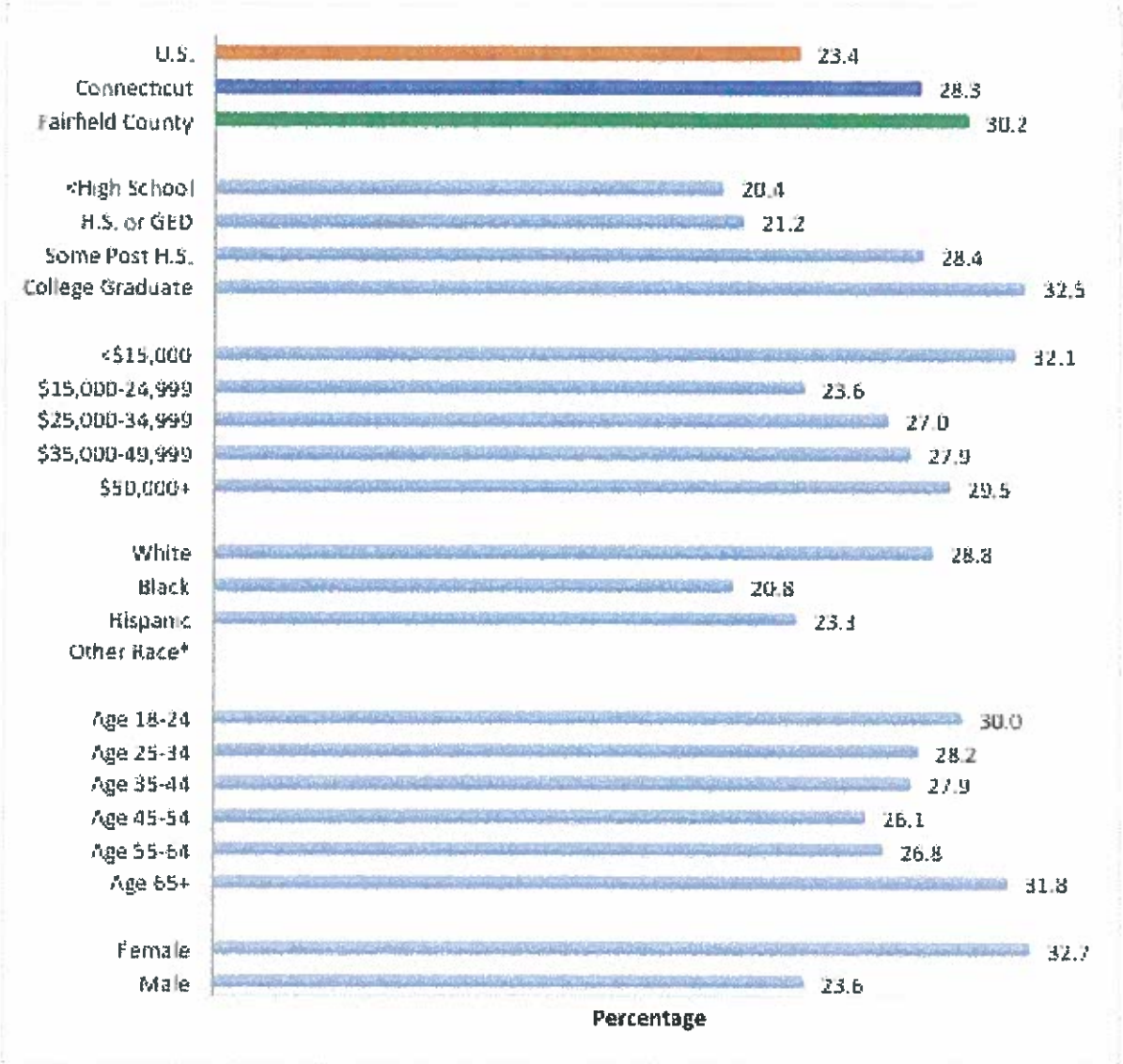
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Weight classification by Body Mass Index (BMI) – Obese defined as BMI of 30.0 - 99.8. Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure B: Percentage of Adults Reporting Physical Activity in the Past Month by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

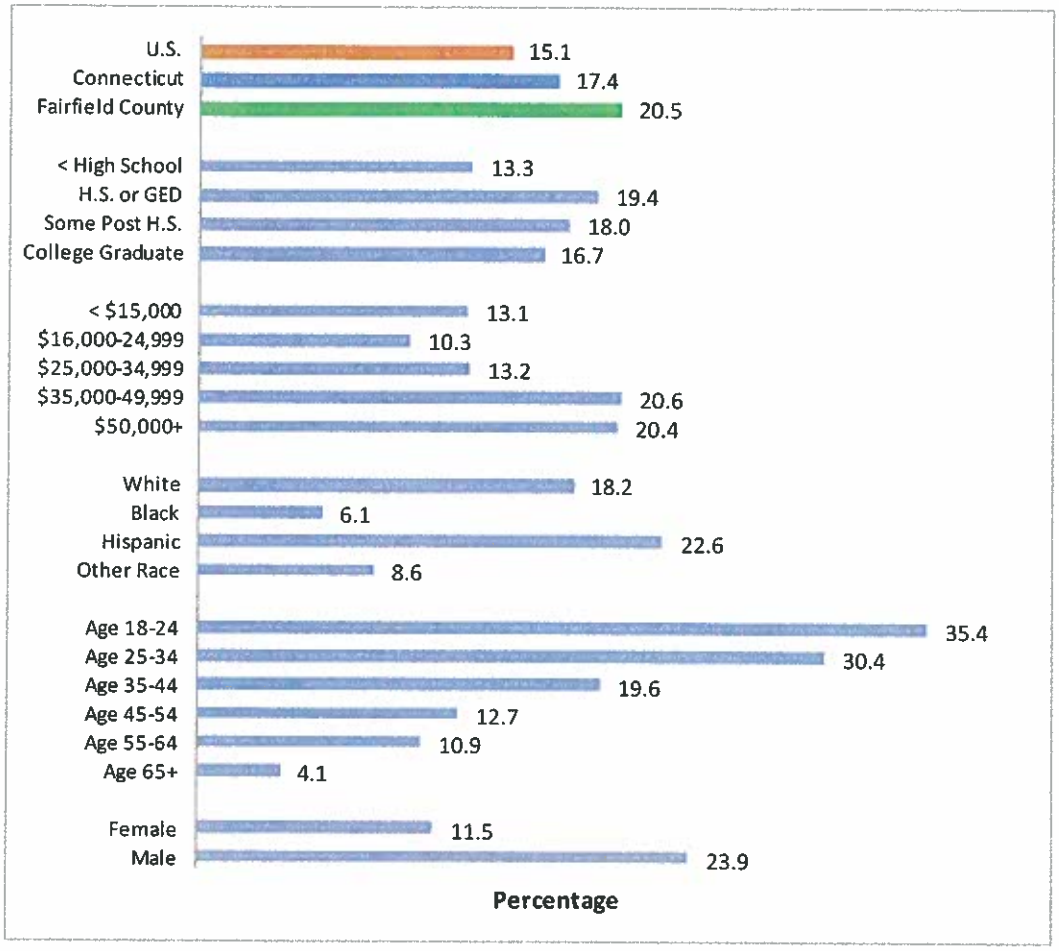
Figure C: Percentage of Adults Reporting Recommended Daily Fruit and Vegetable Consumption by County, State, and US, 2009



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Recommended daily fruit and vegetable consumption for adults is defined as consuming fruits and vegetables five or more times per day. Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

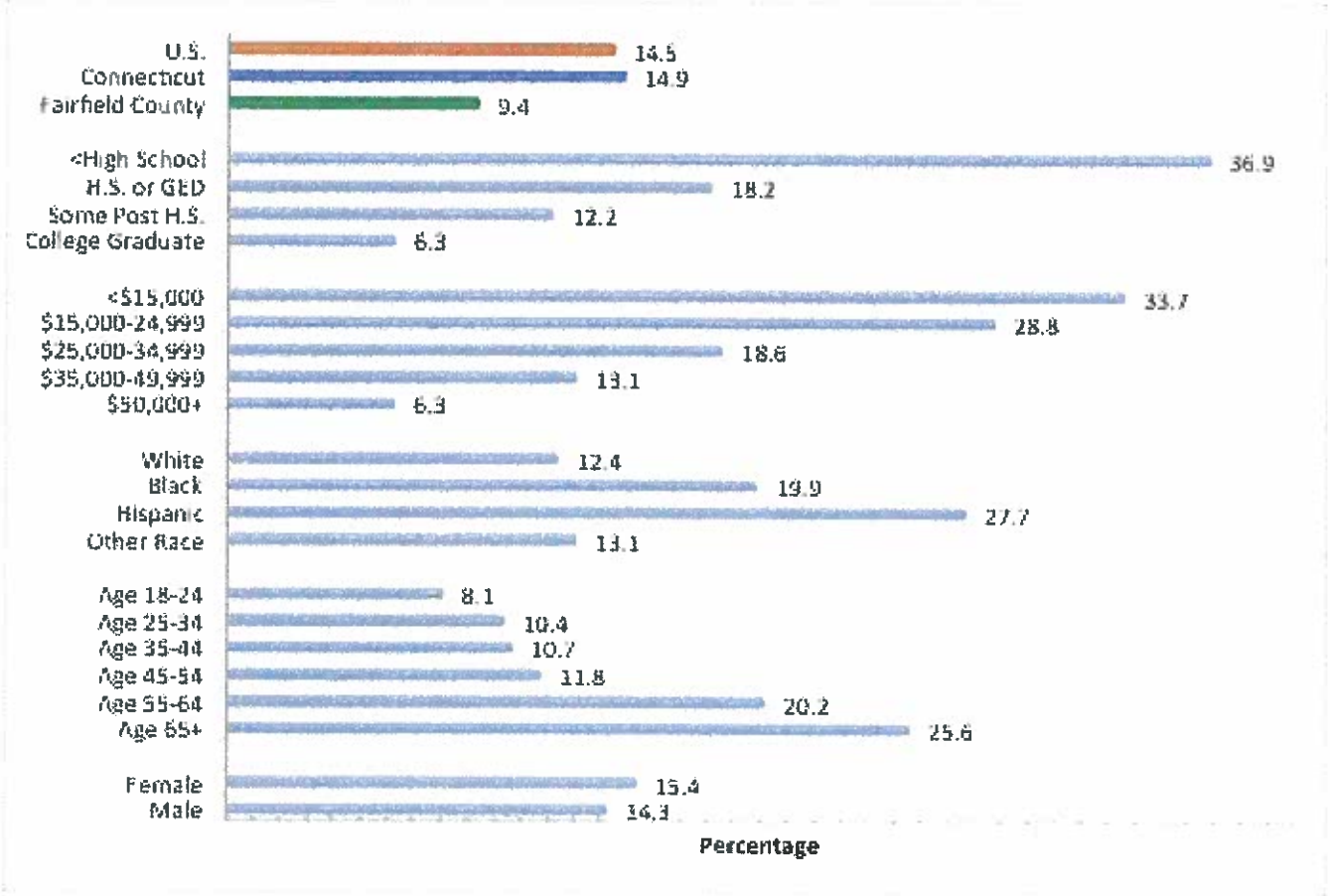
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure D: Percentage of Adults Reporting Binge Drinking by County, State, and US, 2010



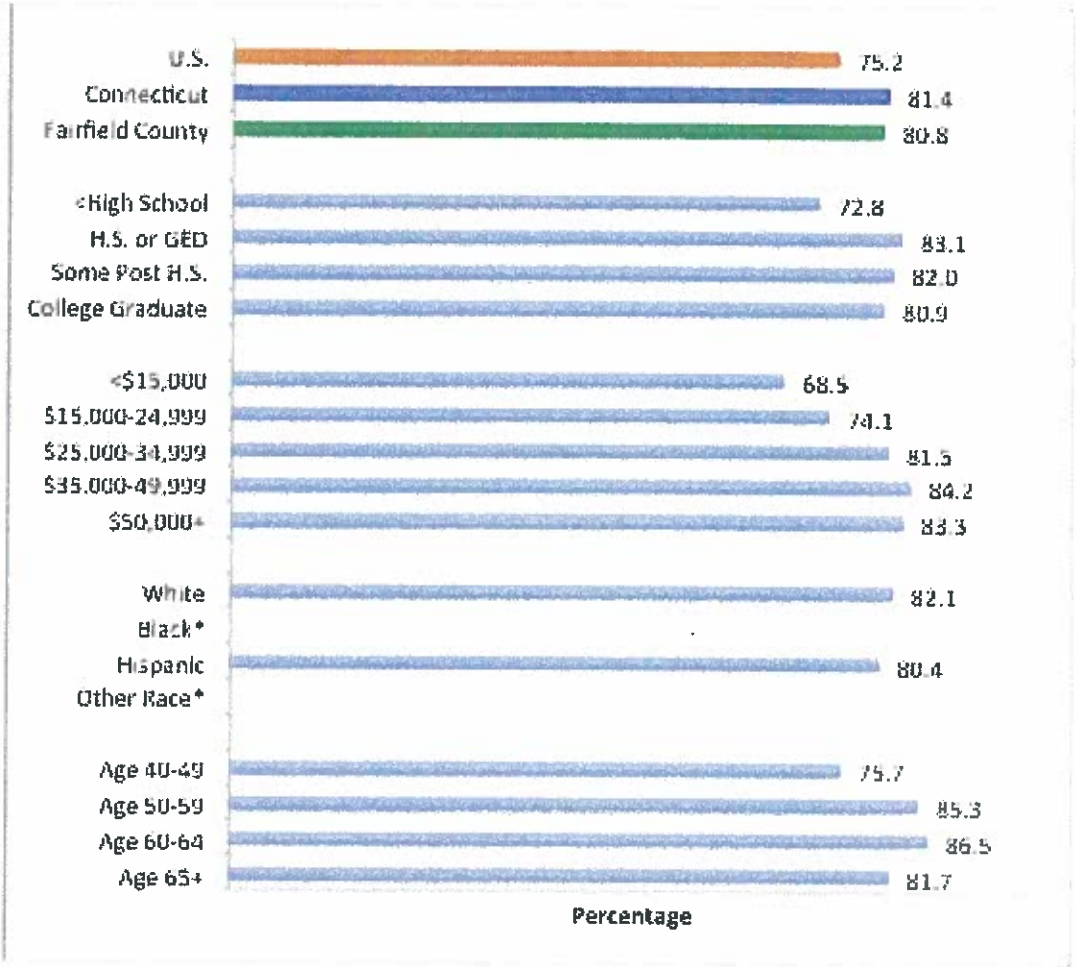
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion) Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure E: Percentage of Adults Reporting Fair or Poor Health by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

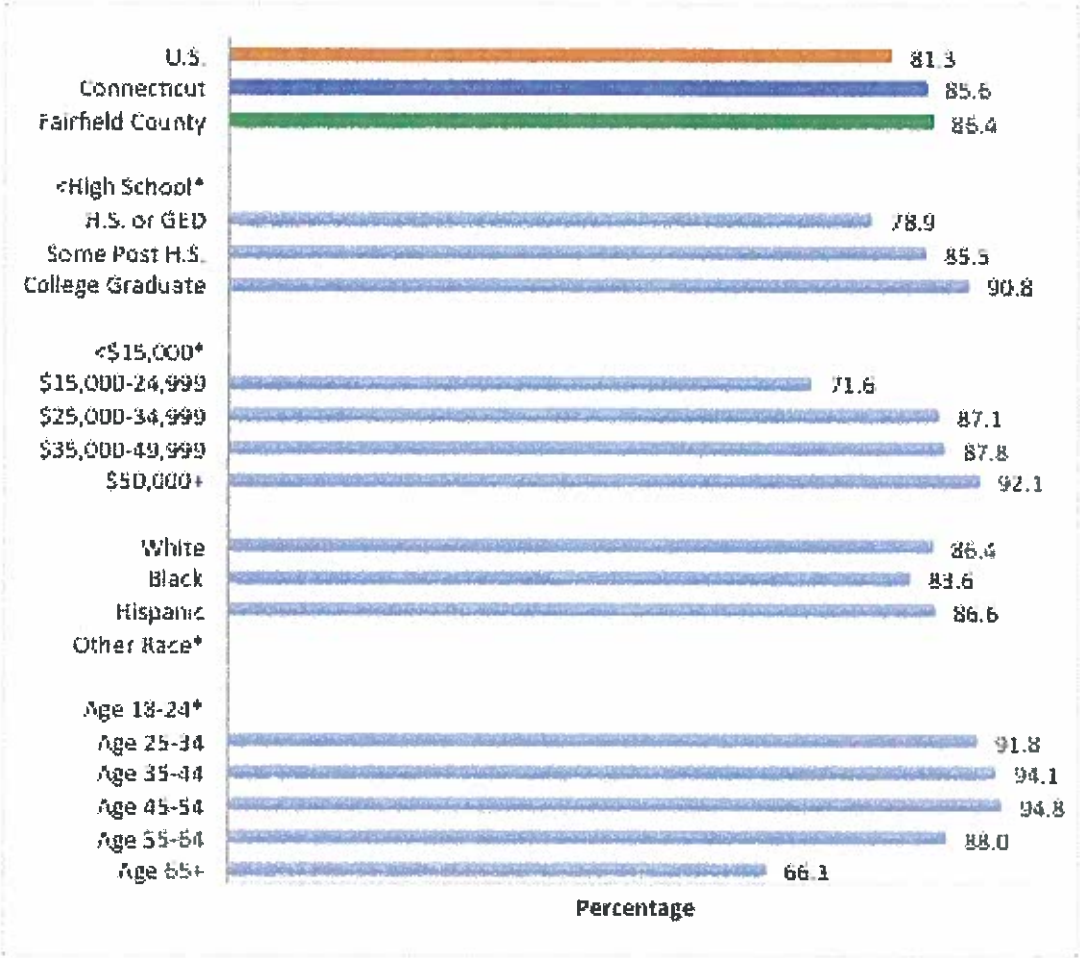
Figure F: Percentage of Women Aged 40+ whom Reported Having a Mammogram in Past 2 Years by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

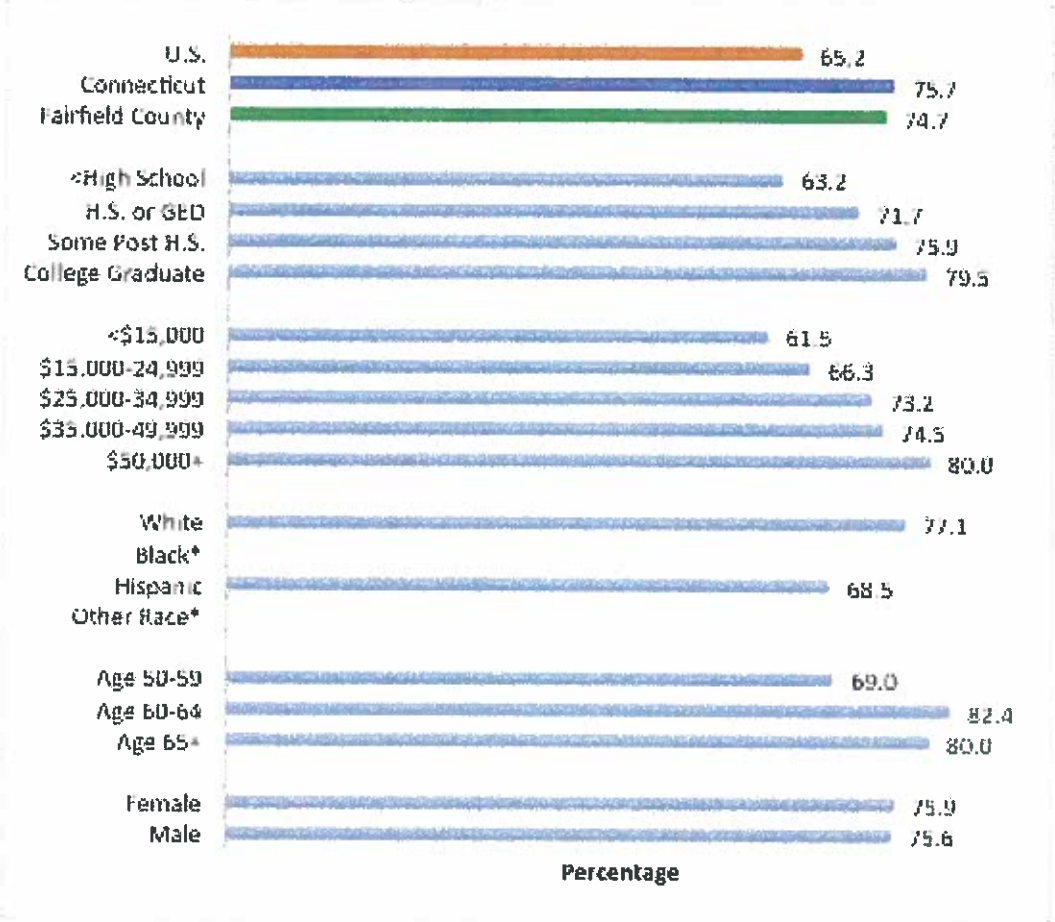
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure G: Percentage of Women Aged 18+ whom Reported Having a Pap test in Past 3 Years by County, State, and US, 2010



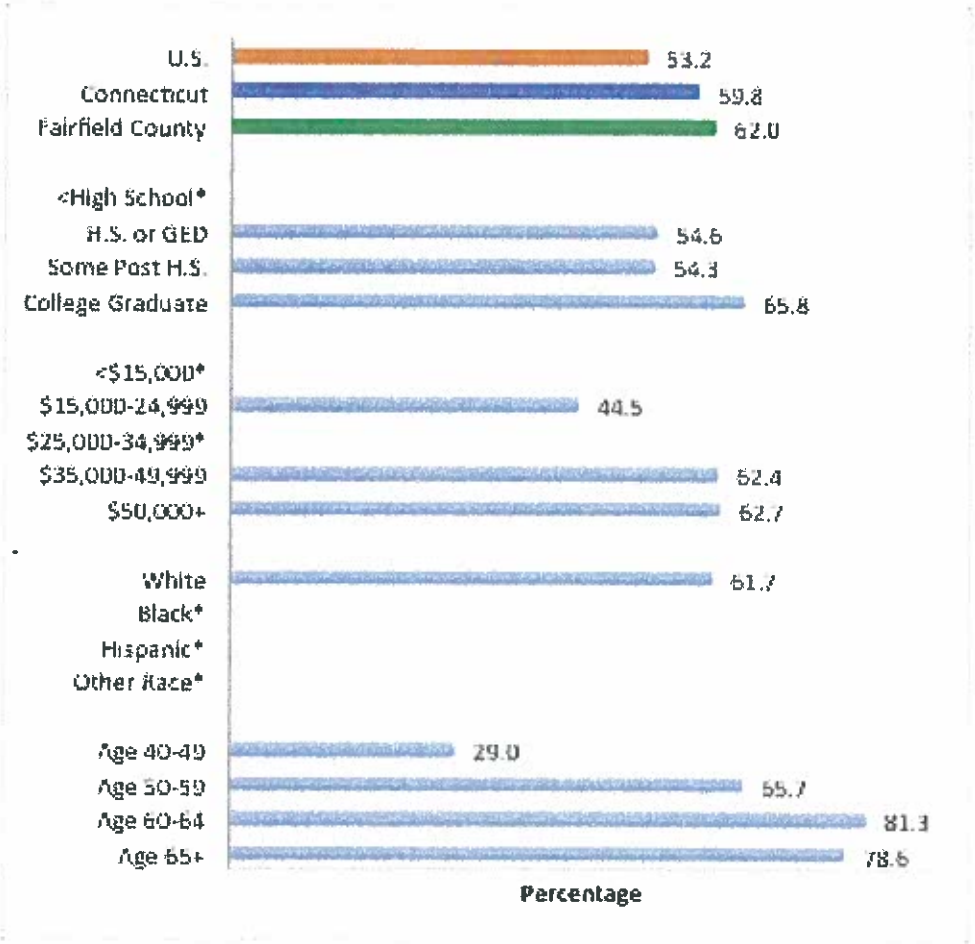
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure H: Percentage of Adults Aged 50+ whom Reported Having Ever had a Colonoscopy or Sigmoidoscopy by County, State, and US, 2010



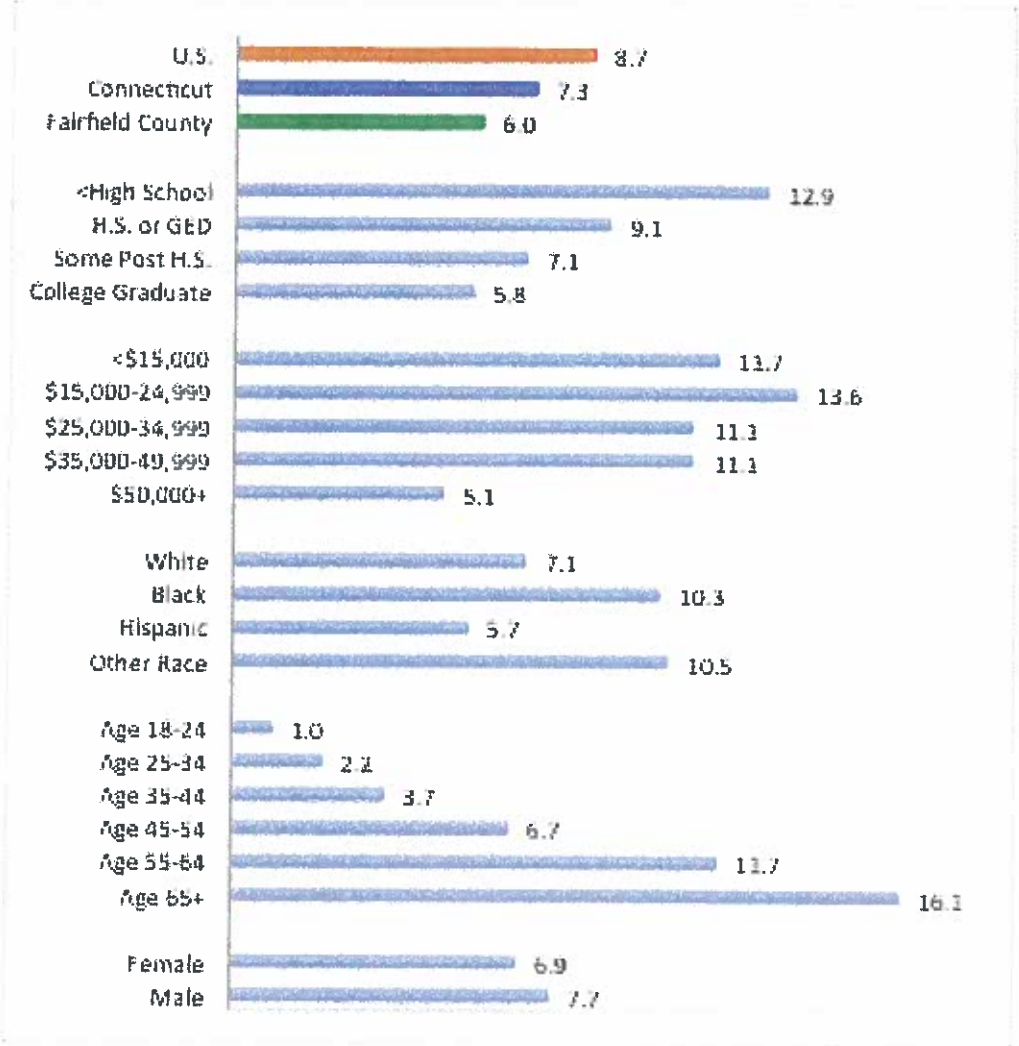
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure I: Percentage of Men Aged 40+ whom Reported Having a PSA Test in the Past 2 Years by County, State, and US, 2010



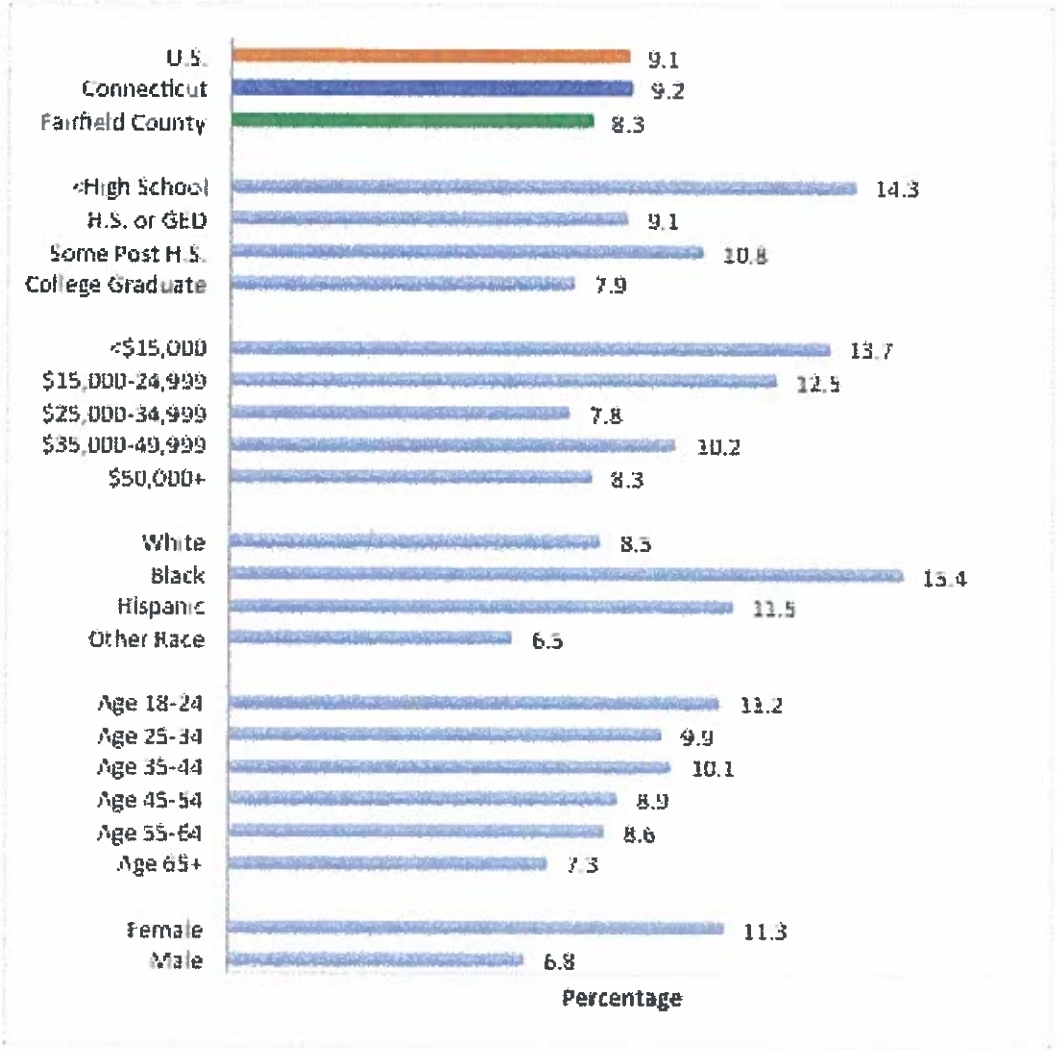
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure J: Percentage of Adults Who Have Ever Been Told They Have Diabetes by County, State, and US, 2010



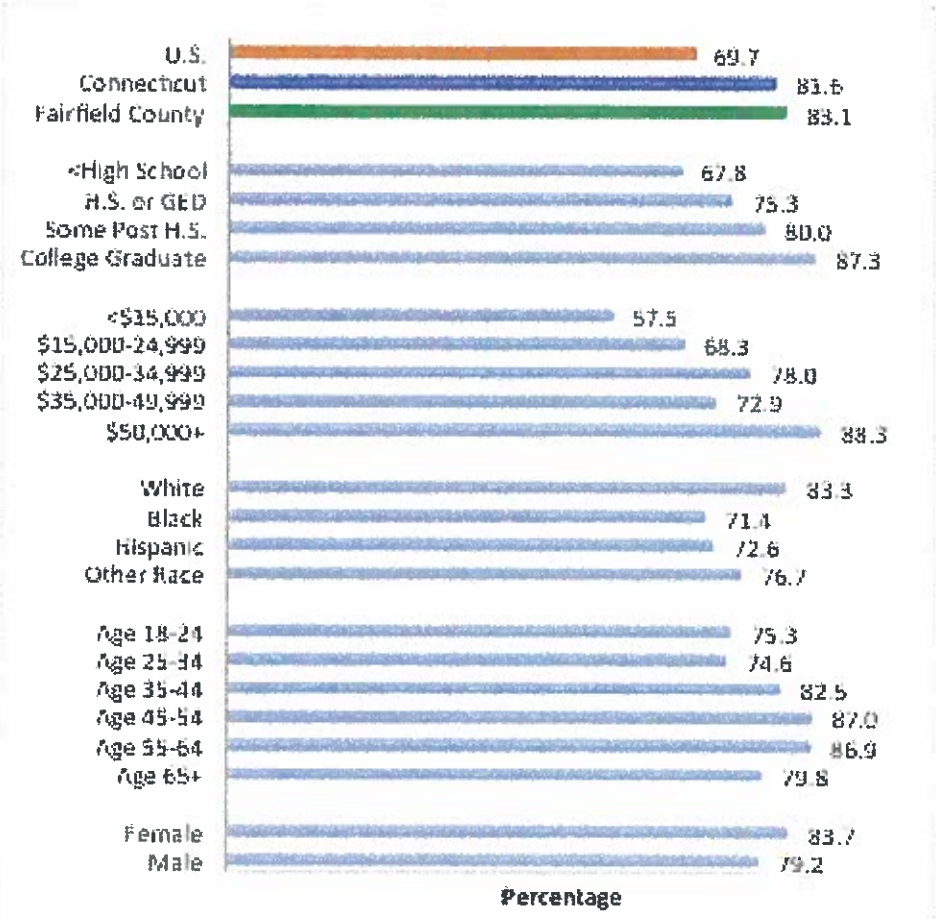
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure K: Percentage of Adults Who Reported Being told they Currently have Asthma by County, State, and US, 2010



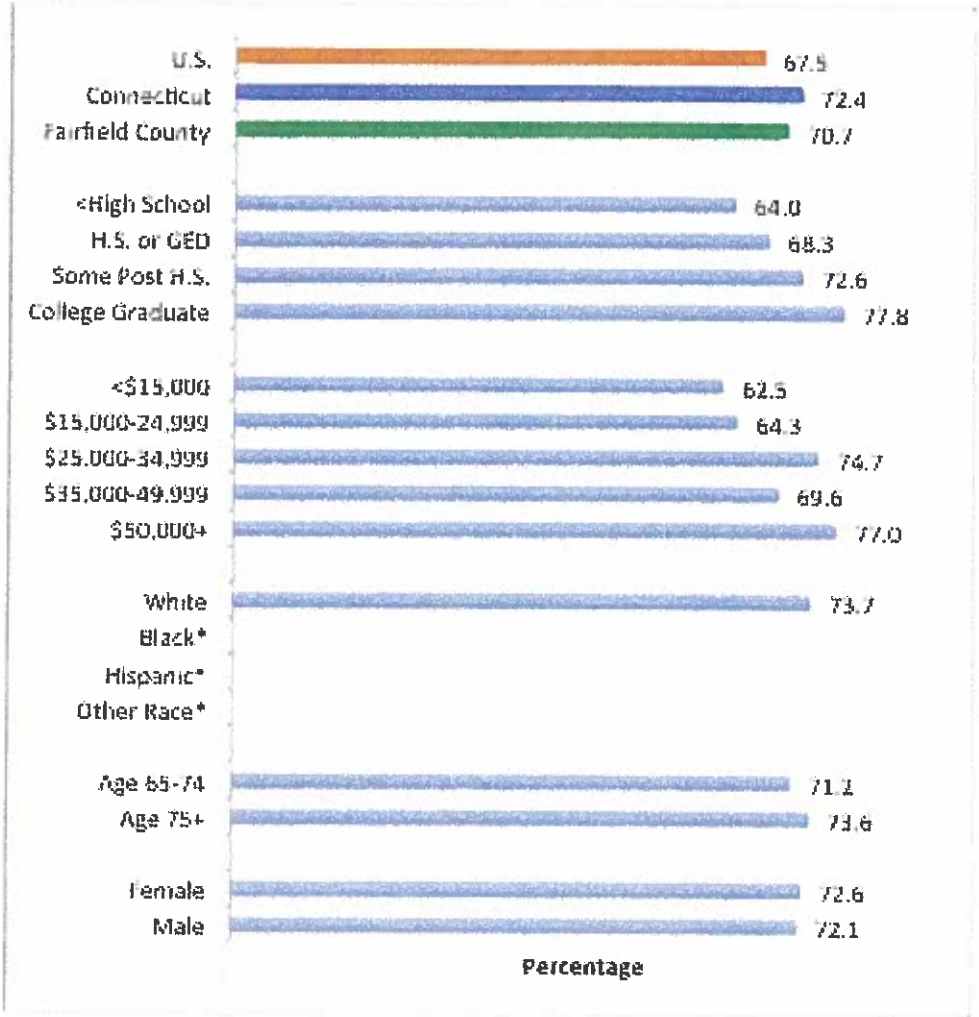
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure L: Percentage of Adults Who Reported Visiting a Dentist in the Past Year by County, State, and US, 2010



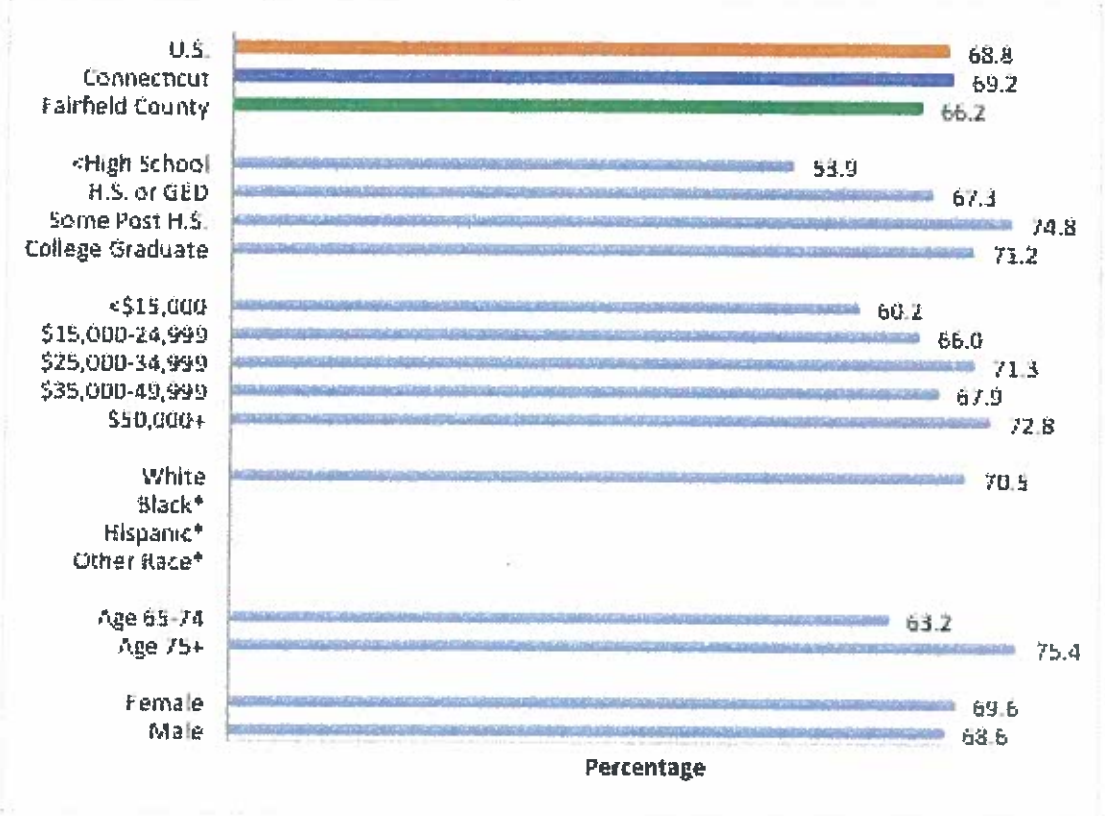
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure M: Percentage of Adults Aged 65+ Who Reported Having a Flu Shot in the Past Year by County, State, and US, 2010



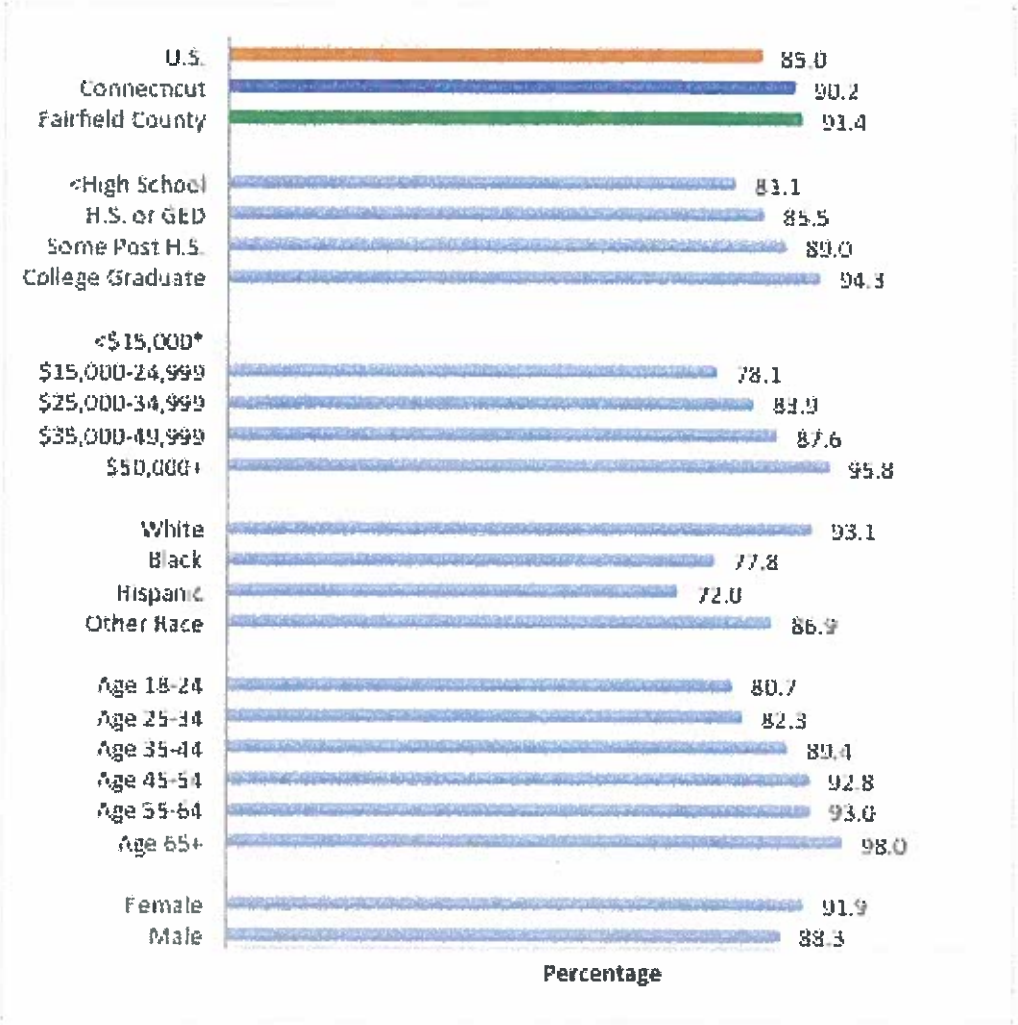
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure N: Percentage of Adults Aged 65+ Who Reported Having a Pneumonia Vaccination in the Past Year by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

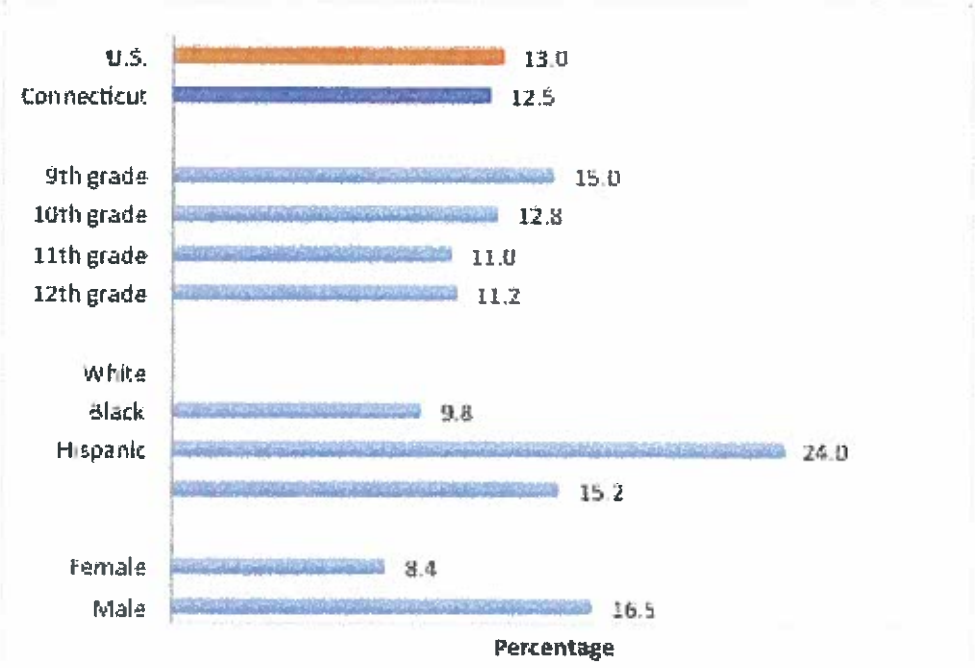
Figure O: Percentage of Adults Who Reported Currently Having Any Kind of Health Care Coverage by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

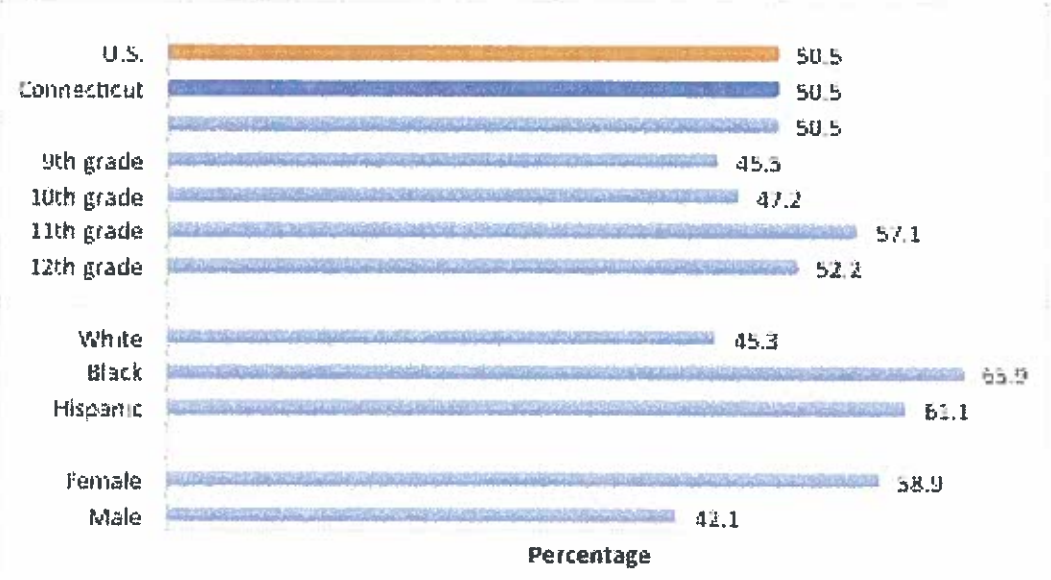
HEALTH BEHAVIORS – YOUTH

Figure P: Percentage of Obese Students by State and US, 2011



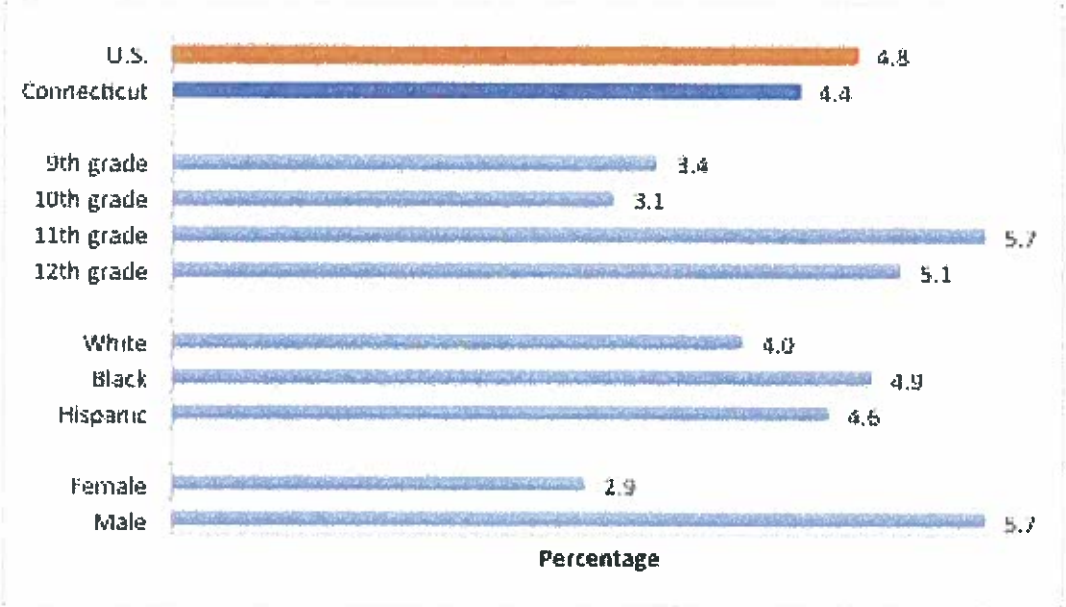
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Demographic data is for State of Connecticut.

Figure Q: Percentage of Students Reporting Physical Activity by State and US, 2011



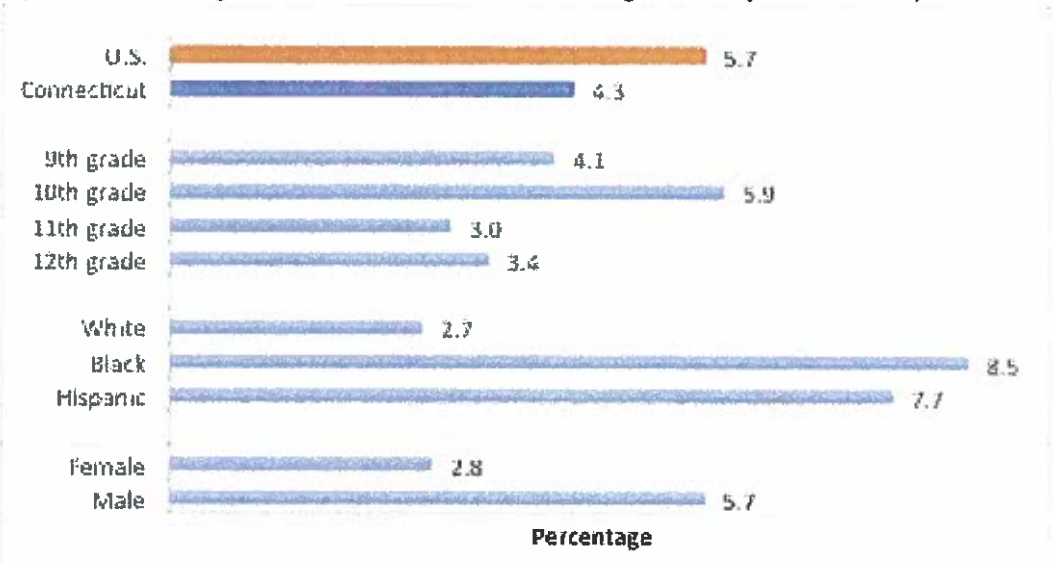
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Physically active defined as at least 60 minutes of physical activity per day for 5 days. Demographic data is for State of Connecticut.

Figure R: Percentage of Students Who Did Not Eat Fruit by State and US, 2011



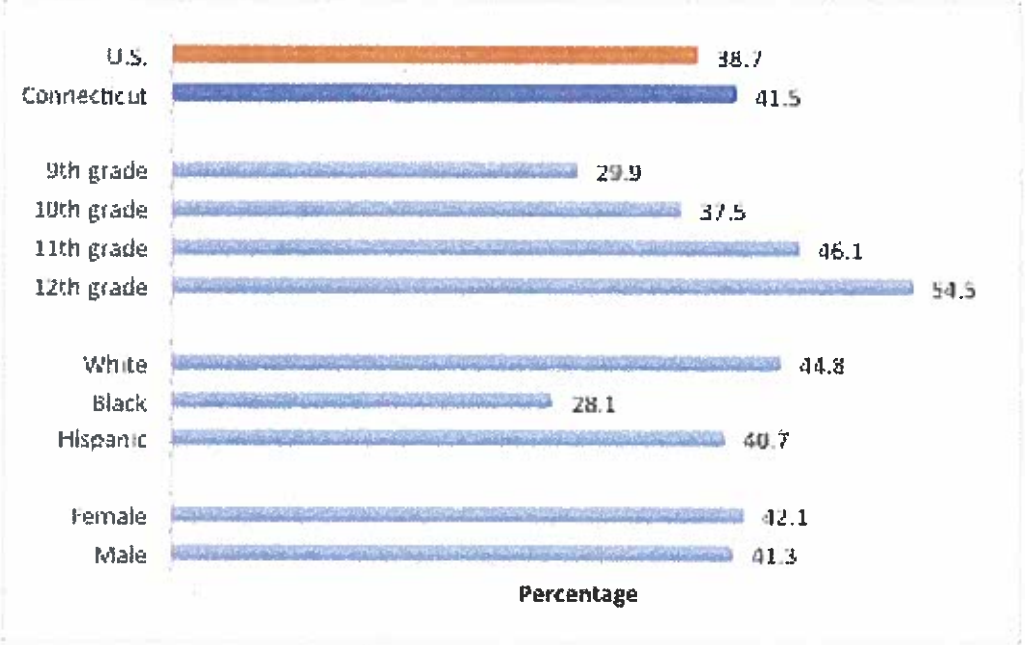
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who did not eat fruit in the seven days prior to the survey. Demographic data is for State of Connecticut.

Figure S: Percentage of Students Who Did Not Eat Vegetables by State and US, 2011



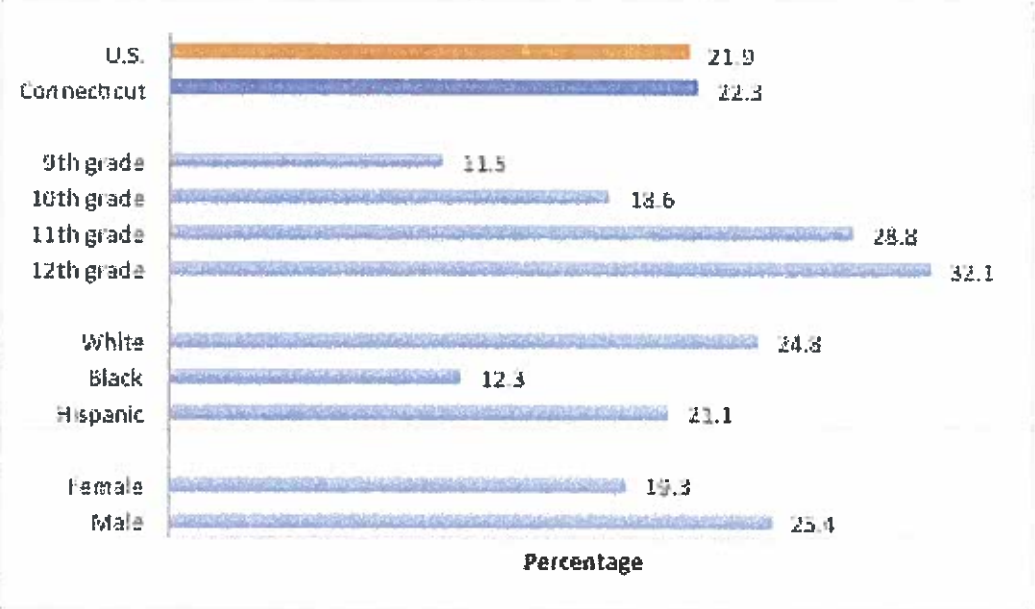
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who did not eat vegetables in the seven days prior to the survey. Demographic data is for State of Connecticut.

Figure T: Percentage of Students Who Report Current Alcohol Use by State and US, 2011



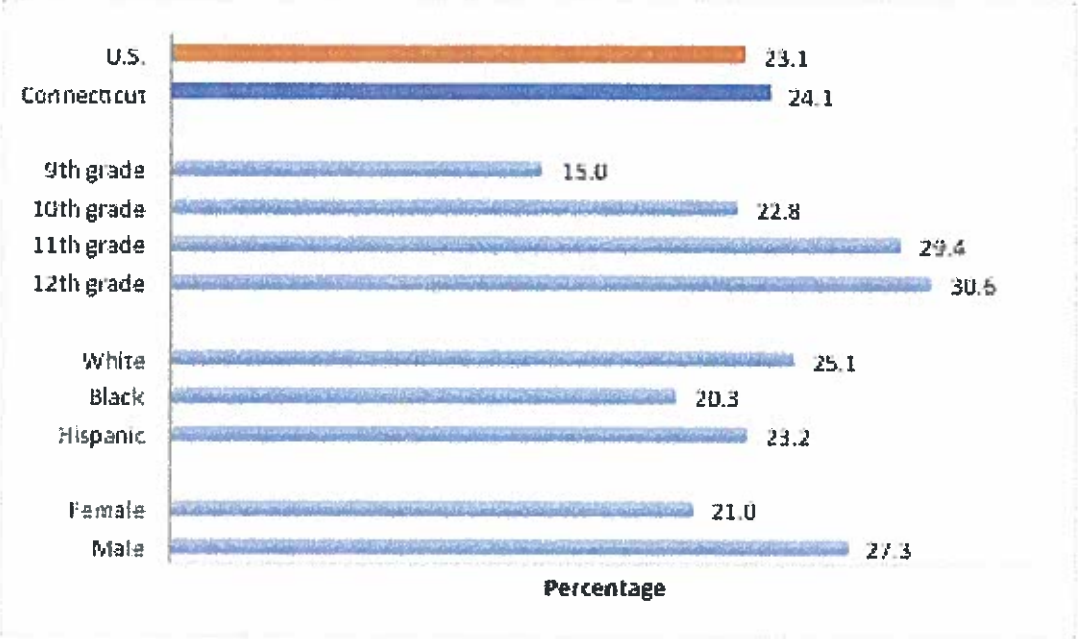
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who had one drink of alcohol on one day during the seven days prior to the survey. Demographic data is for State of Connecticut.

Figure U: Percentage of Students Who Report Binge Drinking by State and US, 2011



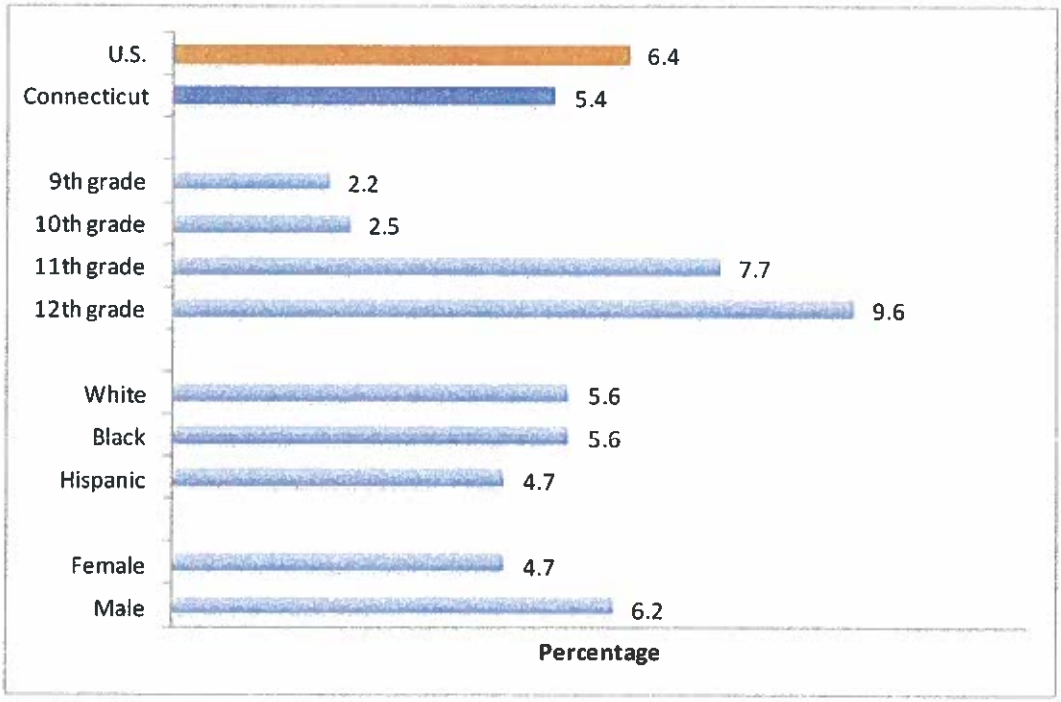
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the 30 days before the survey. Demographic data is for State of Connecticut.

Figure V: Percentage of Students Who Report Current Marijuana Use by State and US, 2011



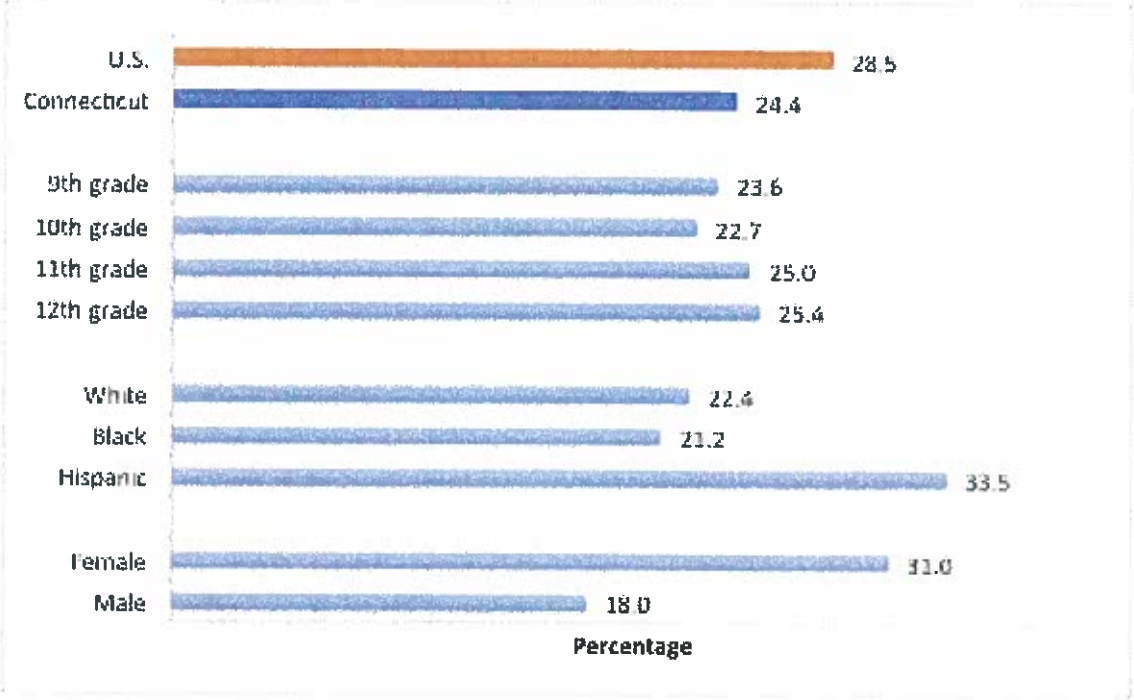
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who used marijuana one or more times during the 30 days before the survey. Demographic data is for State of Connecticut.

Figure W: Percentage of Students Who Report Frequent Cigarette Use by State and US, 2011



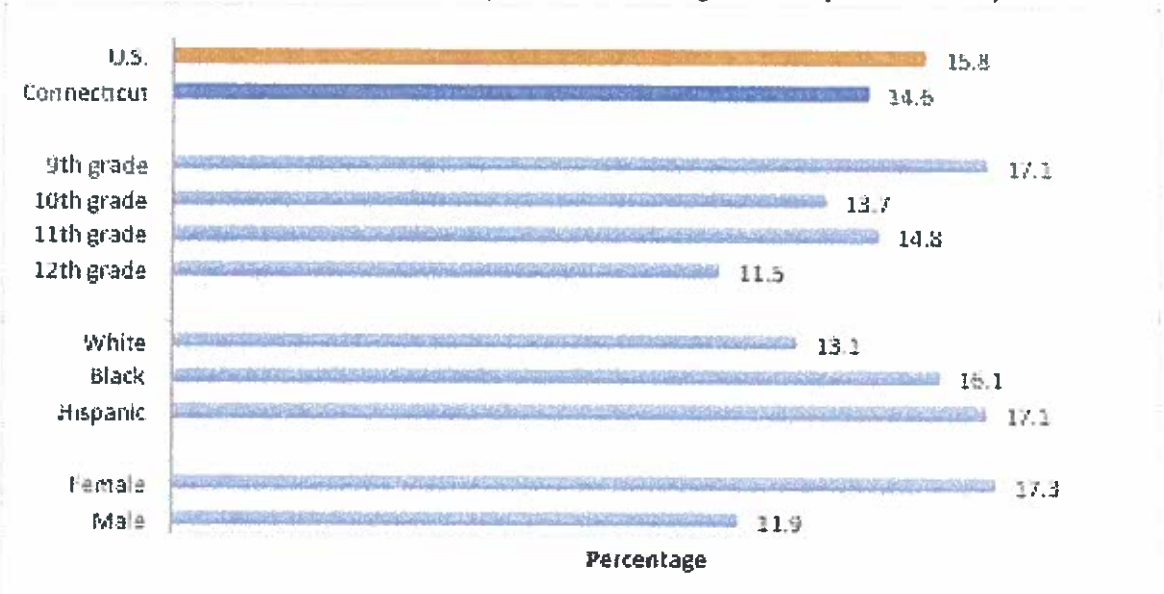
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who smoked cigarettes on 20 or more days during the 30 days before the survey. Demographic data is for State of Connecticut.

Figure X: Percentage of Students Who Reported Feeling Sad or Hopeless by State and US, 2011



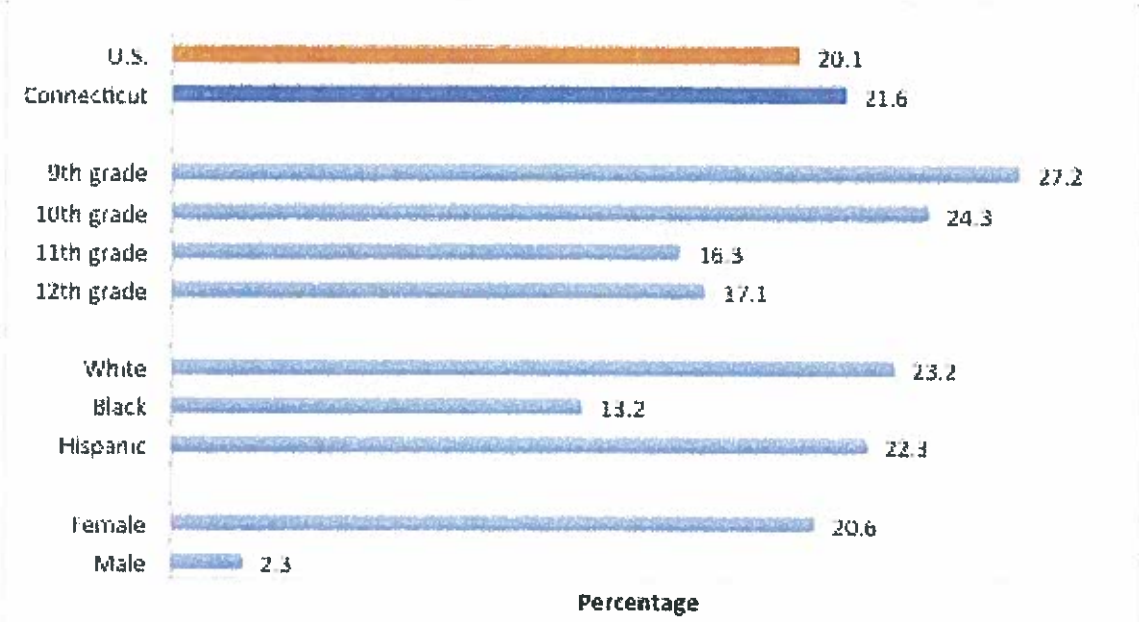
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey. Demographic data is for State of Connecticut.

Figure Y: Percentage of Students Who Reported Considering Suicide by State and US, 2011



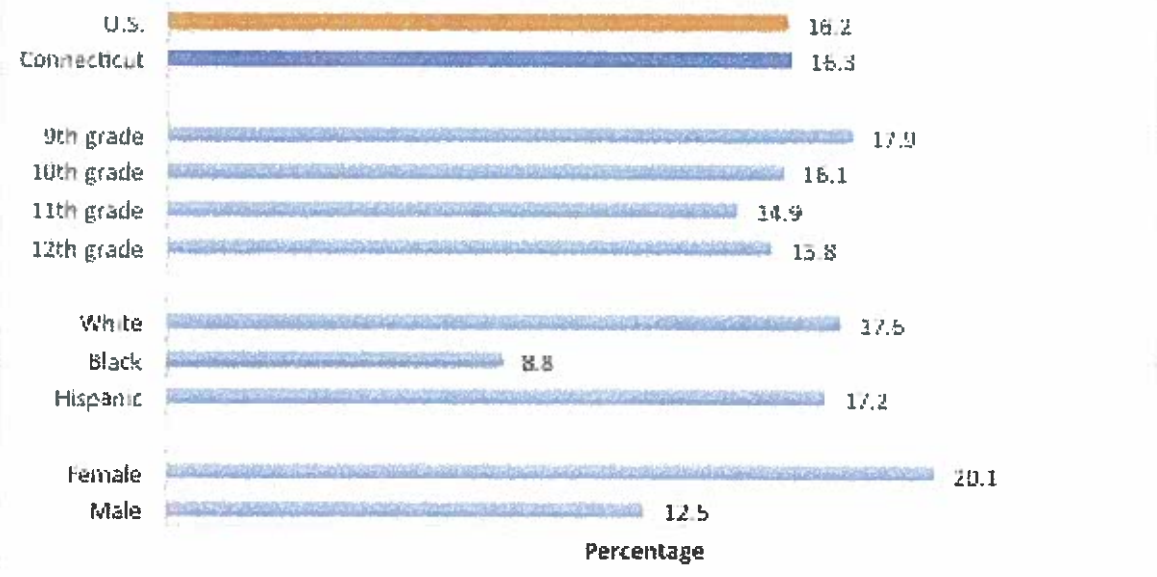
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who seriously considered attempting suicide during the 12 months before the survey. Demographic data is for State of Connecticut.

Figure Z: Percentage of Students Who Reported Being Bullied on School Property by State and US, 2011



SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who reported being bullied on school property during the 12 months before the survey. Demographic data is for State of Connecticut.

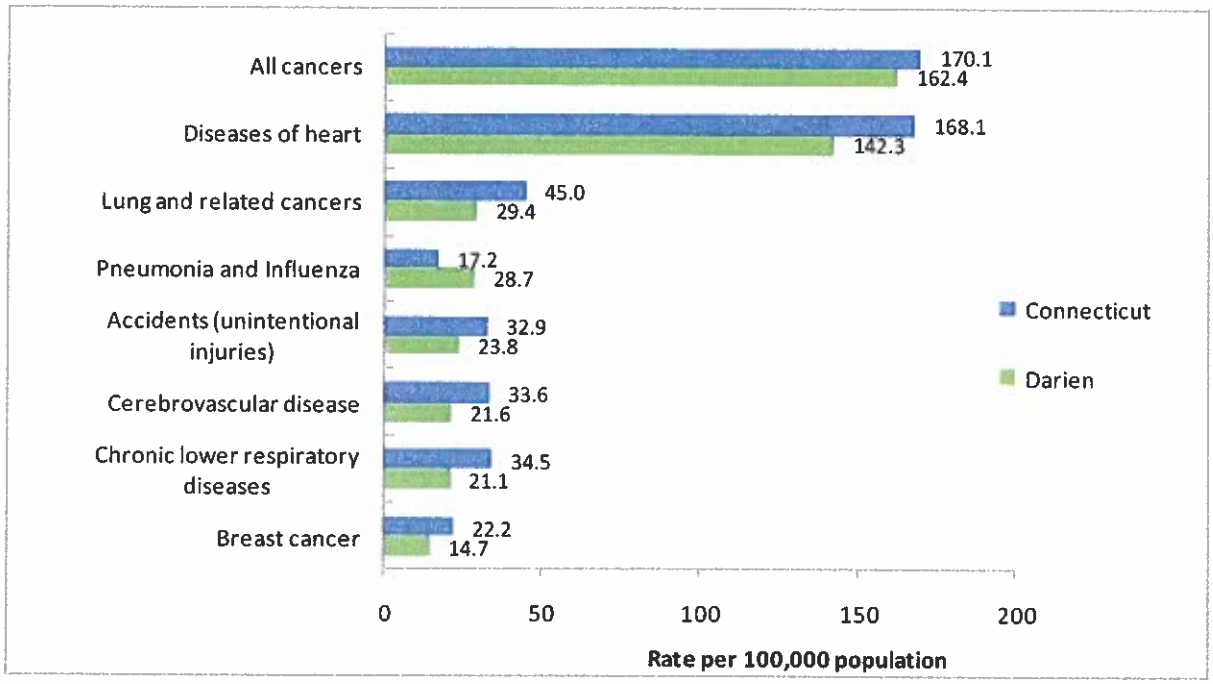
Figure AA: Percentage of Students Who Reported Being Electronically Bullied by State and US, 2011



SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who reported even being electronically bullied including through e-mail, chat rooms, instant messaging, web sites, or texting during the 12 months before the survey. Demographic data is for State of Connecticut.

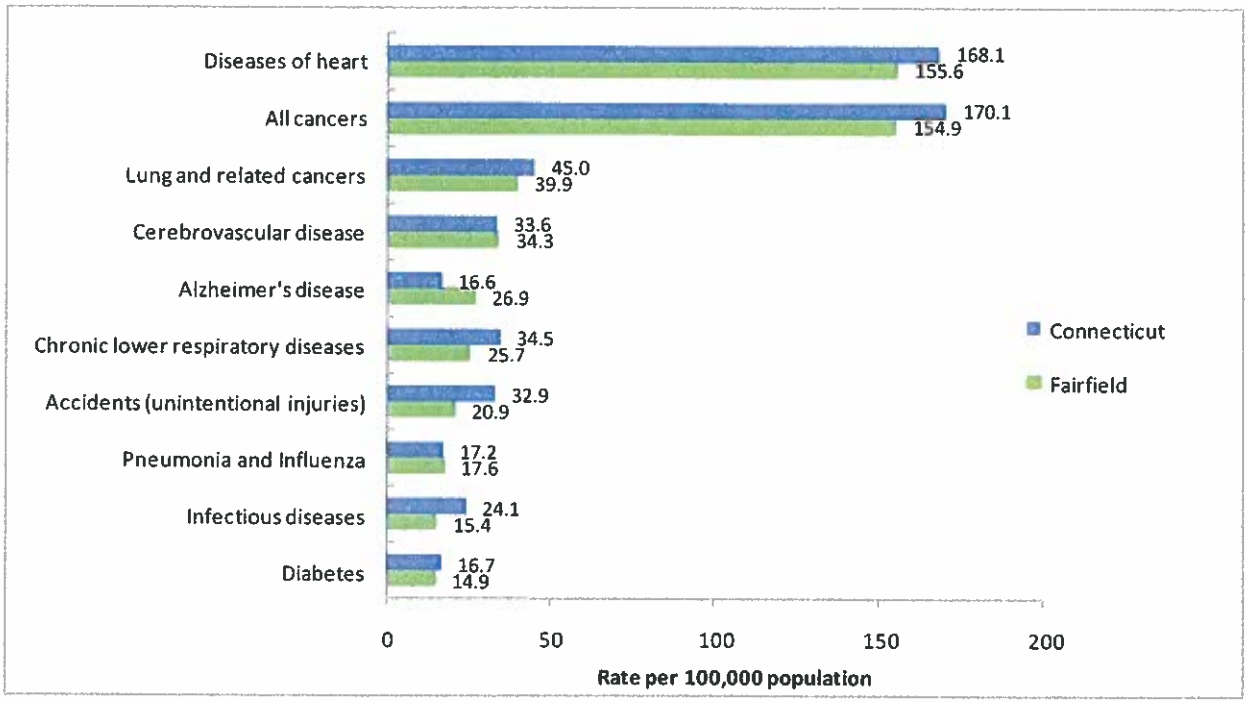
HEALTH OUTCOMES

Figure AB: Age-Adjusted Death Rate per 100,000 Population in Darien and Connecticut, 2005-2009 average



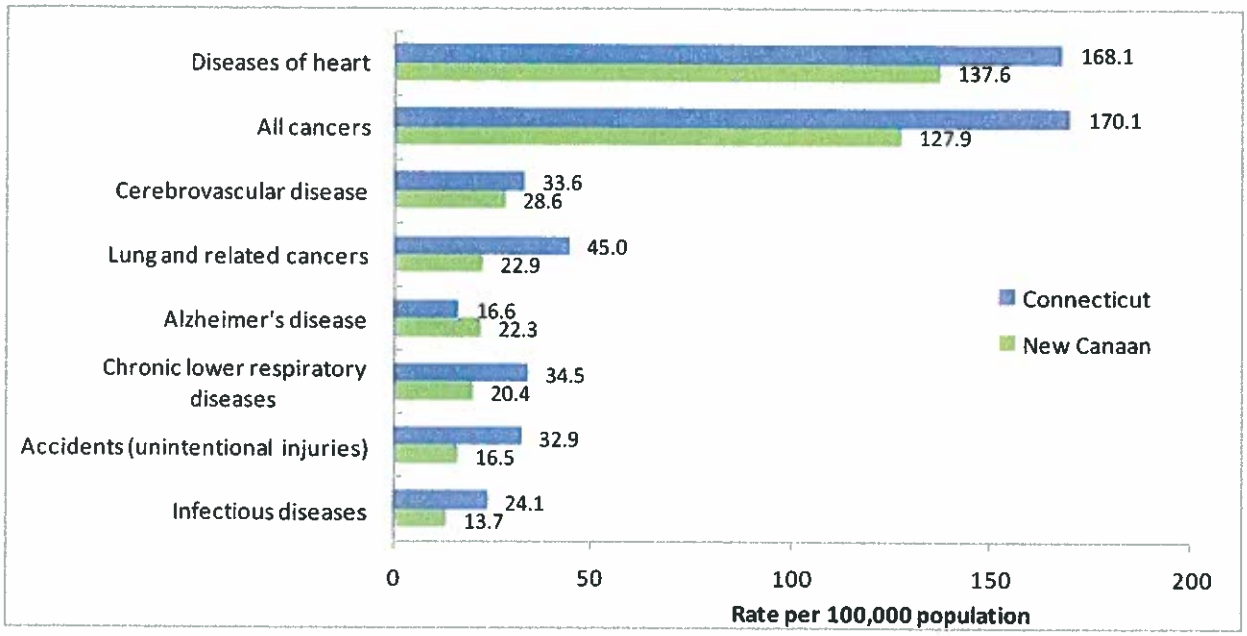
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

Figure AC: Age-Adjusted Death Rate per 100,000 Population in Fairfield and Connecticut, 2005-2009 average



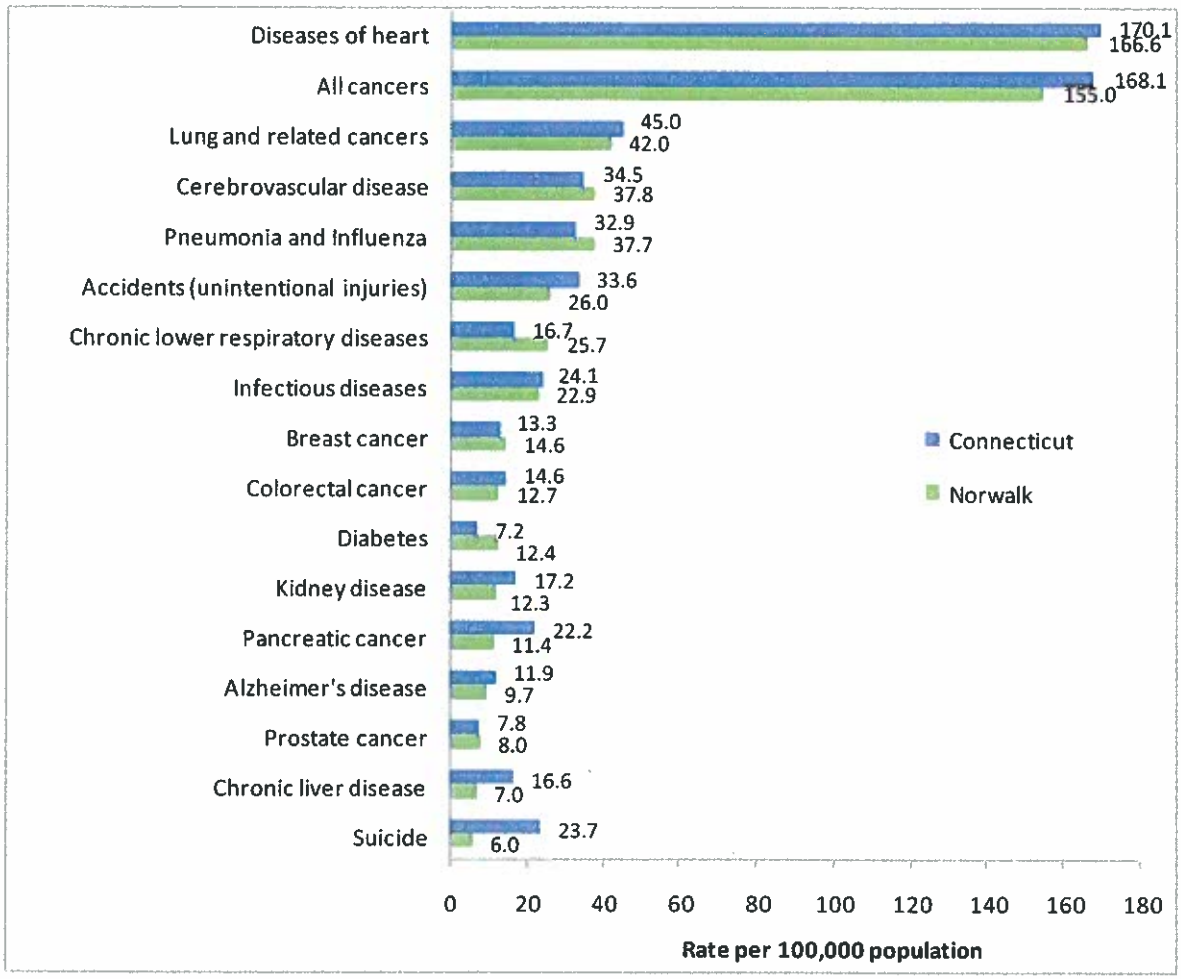
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

Figure AD: Age-Adjusted Death Rate per 100,000 Population in New Canaan and Connecticut, 2005-2009 average



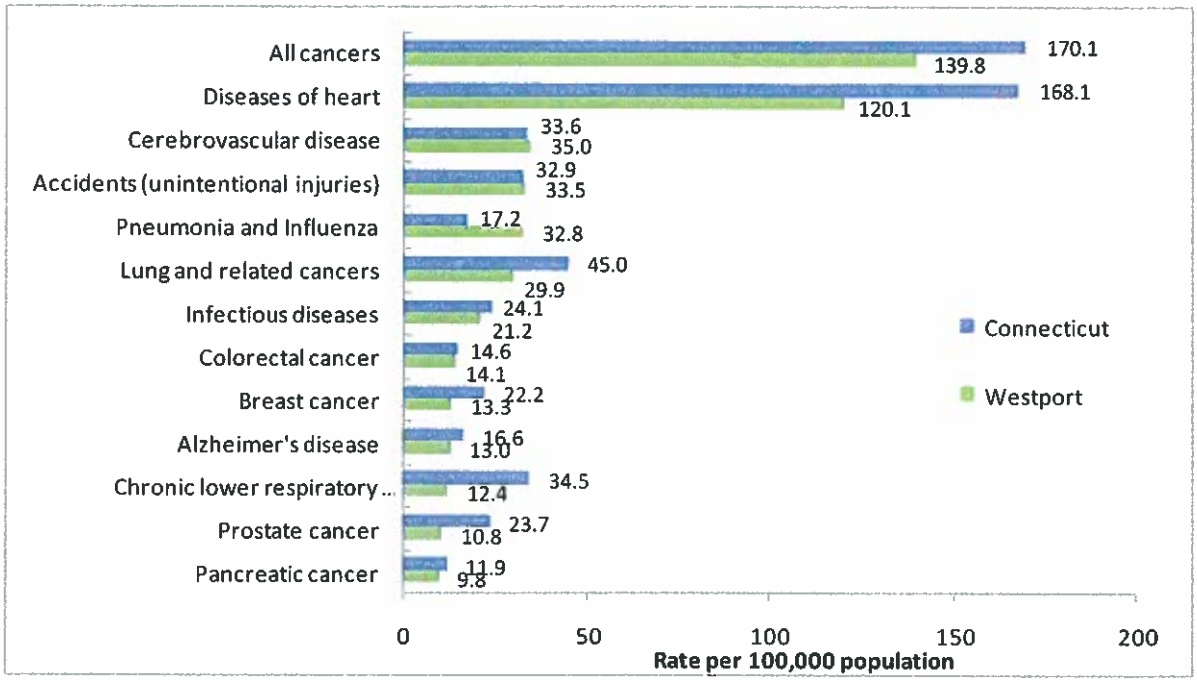
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

Figure AE: Age-Adjusted Death Rate per 100,000 Population in Norwalk and Connecticut, 2005-2009 average



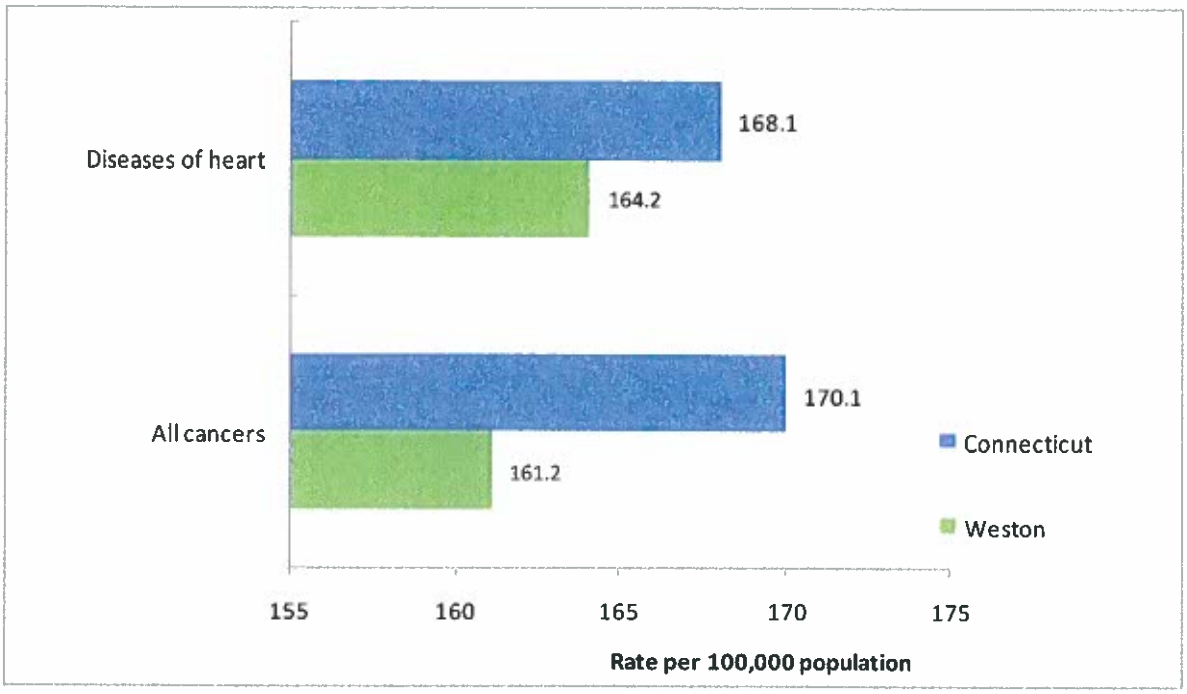
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

Figure AF: Age-Adjusted Death Rate per 100,000 Population in Westport and Connecticut, 2005-2009 average



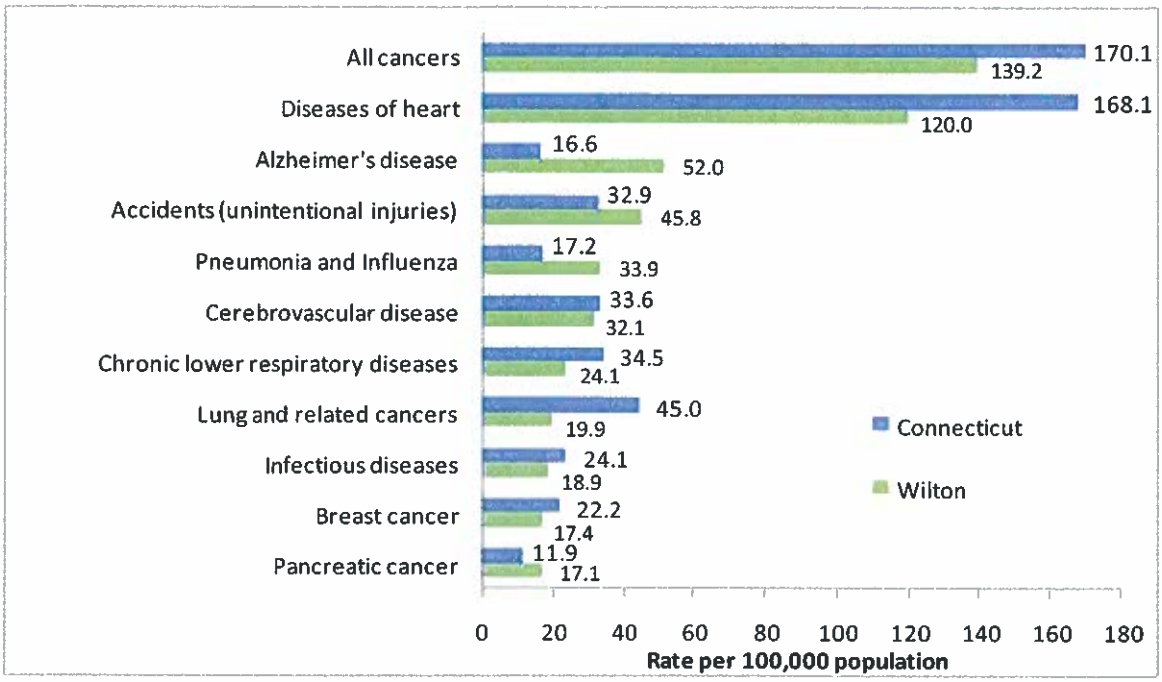
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

Figure AG: Age-Adjusted Death Rate per 100,000 Population in Weston and Connecticut, 2005-2009 average



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

Figure AH: Age-Adjusted Death Rate per 100,000 Population in Wilton and Connecticut, 2005-2009 average



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432

APPENDIX F: HEALTH RELATED ASSETS AND RESOURCES

List of Health Related Assets and Resources Identified by Community Members through the Community Health Assessment

GENERAL ASSETS AND RESOURCES

Assets

- Collaborations focusing on promoting health, healthy eating and active living. Collaborators include:
    - Norwalk Health Department
    - Local high schools
    - Health fairs
- Commitment to helping others and sense of collective responsibility amongst residents
- Federally qualified health centers are well positioned to get federal funding
- Green space, parks, beaches
- Intellectual capital represented by large number of highly educated residents in the town and region
- Investment of families in addressing social and health concerns of their children
- Perceived low rates of crime and a general sense of safety in most areas
- Presence of both public and private-funded programs and initiatives
- Proximity to New York City for:
    - Employment opportunities
    - Medical resources
- Socioeconomic and racial and ethnic diversity of community
- Quantity of physicians in the region (but not all accept insurance or federally-funded insurance)
- Robust volunteer corps addressing health issues
- Transportation
    - Public transportation
    - Highways
    - Trains
- Value given to education of youth in community; Well-rated schools

Resources

- 211
- Americares
- Christian Community Action- non-profit that offers food and financial assistance (covers same towns as Norwalk CHA)
- Darien Community Association
- Darien Library
- G.E. initiative called Health Ahead
- Local health departments
- Local schools
    - School based services for students
        - Skilled teachers and tutors
        - Behavioral and special needs specialists

        - Availability of social worker within the school
        - Well-trained nurses
        - School-based health centers
    - Facilities – buildings, athletic venues, playgrounds
- Local social service departments
- NEON (energy assistance for low-income residents)
- Norwalk Community Healthcare Center
- Norwalk healthy families collaboration - Consortium of health care non-profits that are truly interested in working together to understand needs in an organized way
- Norwalk Hospital
- Operation Fuel- heating and utility assistance (income cut-off is 60% of area median income)

OBESITY AND CHRONIC DISEASE

Assets

- Dedication of parents to health and social issues facing their family
- Gardens at Norwalk schools – a dynamic effort to introduce fruits and vegetables and influence families
- Green space, parks, beaches
- Local initiative between Norwalk Hospital and Jefferson Elementary School targeting better nutrition and increased physical activity to lower BMI
- Local school systems
- Proactive health department, which is open to new ideas and collaborations

Resources

- Accountable Care collaboration between Norwalk Hospital, NCHC and large private practices
- ACHIEVE grant, which is trying to implement policy change (effort led by Norwalk Health Department)
- Beaches, parks, walking trails, rowing clubs, municipal golf course
- Boy & Girls Clubs
- Catholic Family (Senior meal program)
- Cooking program at housing developments
- Day Street Community Health Center
- Farmer's market coupons for eligible low-income residents
- Fitness clubs/gyms
- Food rescue organizations
- Headstart program
- Live Well (Chronic Disease Self-Management) program
    - Evidenced-based program, delivered in a number of communities for free to assist adults with the problems commonly shared by those with chronic conditions, no matter the cause. Developed for people over 55, age for participation is now 18 and older.
- Local city and town planners
- Local health departments
- Lower Fairfield County Food Bank
- Local Schools
    - School-based health centers
    - physical education department
    - Board of Education

    - Principals
    - Teachers
    - Those who decide on/manage food choices
- Meals on Wheels
- Medicare obesity program (counseling program)
- Norwalk Chamber of Commerce
- Norwalk Early Childhood Coalition
- Norwalk Health Department
- Norwalk Hospital
- Parks and Recreation Departments in all towns
- Project Lean
- RWJ grant supported development of jogging and fitness stations
- Senior Centers: Nutrition classes, exercise classes
- Stew Leonard's
- US Department of Agriculture
- WIC
- Wilton Family YMCA - 16-week CDC program addressing pre-diabetes
- YMCA

SUBSTANCE ABUSE

Assets
- Many police officers have Crisis Intervention Training (CIT)
- Private, non-hospital based psychologists and psychiatrists
- Schools

Resources
- 211
- 24-Hour Crisis Intervention Services (for adults through Dubois Center; for children through Child Guidance of Southern CT)
- Alcoholics Anonymous or other self help programs
- Americares
- CT Community for Addiction Recovery
- CT Counseling Centers, Inc
- CT Department of Mental Health and Addiction Services
    - DMHAS Prevention Unit "Regional Drug Profile Priority" - Collaborative process lead by the Regional Action Councils in each region
- CT Renaissance
- DARE programs in schools
- Day Street Community Health Center
- EMS
- Faith-based organizations
- Family & Children's Agency (Project Reward)
- Fire Departments
- Law enforcement with Crisis Intervention Training (CIT)
- Liberation Programs – Family and Youth Options

- Local faith and clergy members
- Local social service departments
- Mid-Fairfield County Regional Action Council
- Mid-Fairfield Substance Abuse Coalition
- Norwalk Hospital
- Positive Directions (in Westport)
- Silver Hill Hospital (in New Canaan)
- St. Vincent's Behavioral Health Services

MENTAL HEALTH

Assets

- Advocacy amongst parents of children with disabilities at the state and national level
- Collaborations among towns and executive offices around mental health
- Community is very accepting about behavioral issues
- Counseling agencies already exist
- Extra-curricular activities for youth
- federally qualified health care centers
- Green space, parks, beaches
- Police have been understanding of behavioral issues and proper treatment (e.g., connect persons with behavioral issues mental health services rather than criminalizing behavioral issues)
- Positive youth development collaboration with Wilton, Weston, Westport and Fairfield
- Private counseling services
- Social service directors in suburban towns who meet together regularly

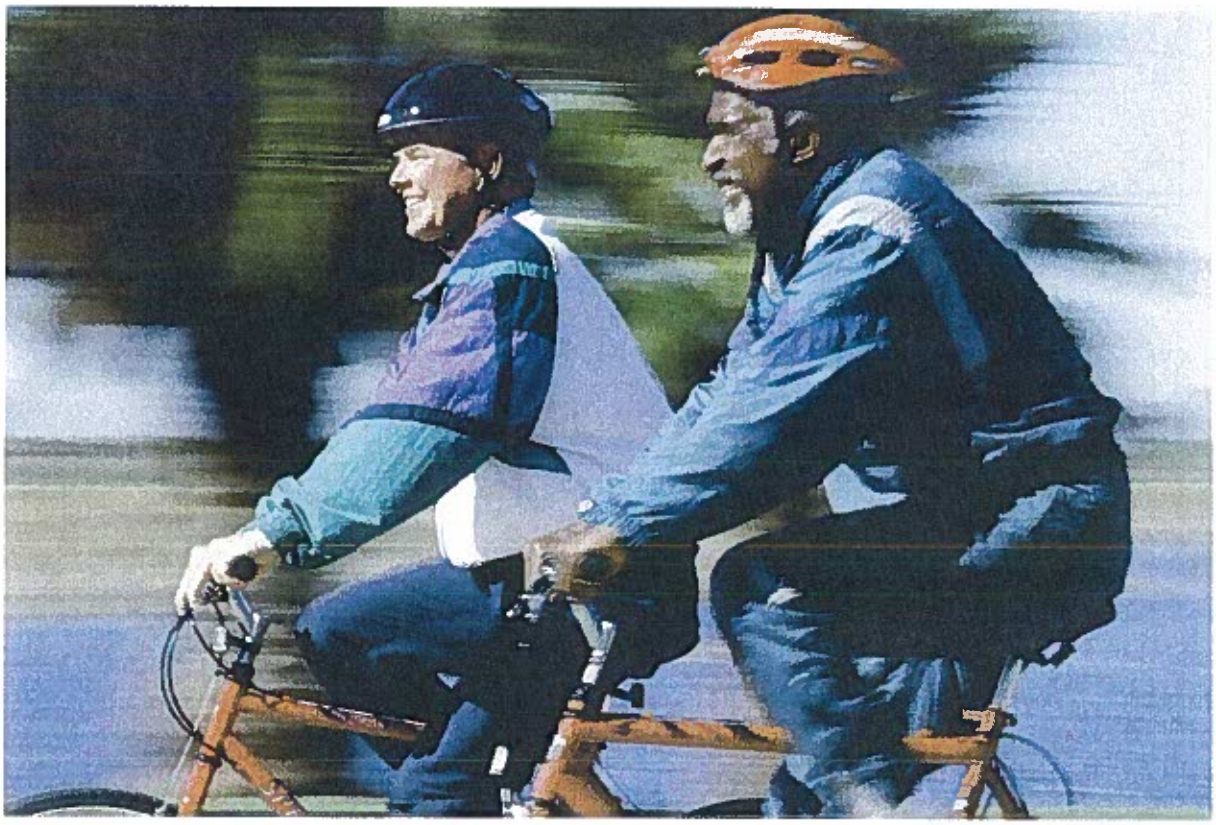
Resources

- 211
- 24-hour Crisis Intervention Services
- Beaches, parks, walking trails, rowing clubs, municipal golf course
- Catholic Charities
- Center for Hope - Program for boys 8-11 to work on esteem
- Child Guidance of Southern CT
- CT Counseling Service
- CT Council of Family Service Agencies
- CT Department of Children and Families
- CT Department of Mental Health and Addiction Services
- CT Renaissance
- Day Street Community Health Center
- Department of Children and Families Regional Advocacy Council
- Department of Mental Health and Addiction Services (DMHAS) (2)
- Domestic Violence Crisis Center
- Fairfield County Medical Association (for lists of mental health physicians by specialty)
- Families United for Children's Mental Health
- Family & Children's Agency
- Family Centers, Inc.
- Human Services Council's Mentor Program
- Human Services Council's School Based Health Centers – medical/mental health

- Jewish Family Services
- Keystone House
- Law enforcement with CIT (Crisis Intervention Training)
- Local faith and clergy leaders
- Local schools
    - School-based health centers
    - School nurses
    - Guidance counselors
    - Special education teachers
- Local social service departments
- Mid-Fairfield County Child Guidance
- NAMI
- Network of Care for Behavioral Health
- Norwalk Child Guidance Center
- Norwalk Community Healthcare Center
- Norwalk Hospital - Ambulatory psychiatric care
- Positive Directions
- Shelter
- Silver Hill
- Southwest Regional Mental Health Board
- St. Vincent's Behavioral Health Services
- Warm Line
- Water Street Clinic
- YWCA - Parent awareness programs, guest speakers

EXHIBIT E

Community Report Card for Western Connecticut



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Introduction

The first release of the *Community Report Card for Western Connecticut* in 2009 established a baseline profile of community health in the Housatonic Valley Region (HVR) by assessing key demographic, socioeconomic, and health status indicators. The HVR is comprised of ten distinct municipalities (herein referred to as the "community") including: Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman. The *2009 Community Report Card* focused on indicators in the following areas:

- *Economic Stability*
- *Education*
- *Health Status*
- *Health and Lifestyle Behaviors and Risk Factors*
- *Diseases*

The *2012 Community Report Card for Western Connecticut* contains an update of the original key indicators, and integrates relevant findings from selected national and state health assessments and surveys, and the U.S. Census. Comparison of trends for the same indicators over time permits health, human services, and community leaders to measure improvements, identify disparities, and establish priorities to improve the health-related quality of life and well-being of residents throughout the region. This includes collaboration among health and community leaders to identify opportunities to improve access to health-related services, cost-effectiveness of services, and service quality.

This report was commissioned by the City of Danbury Health and Human Services Department, Western CT Health Network/ Danbury Hospital-New Milford Hospital, United Way of Western Connecticut, and Western Connecticut State University (WCSU). The collective thoughts, opinions, and expertise of a regional Steering Committee – including health care providers, educational institutions, community-based providers, and local government agencies – guided the development of this report. The Community Report Card represents a collaborative effort of community members, leaders, and organizations whose mission is to identify priority health needs in the region and mobilize resources to address those needs.

This update was prepared by a team of WCSU experts, led by Dr. Robyn Housemann, Associate Professor and Co-Chair of WCSU's Department of Health Promotion & Exercise Science. Final editing and updating, focus group planning and administration, and survey analysis and reporting were conducted by Mary Bevan, M.P.H and Mhora Lorentson Ph.D., of *The Center for Healthy Schools & Communities at EDUCATION CONNECTION.*

Funding for this report was provided by Aetna Foundation, the CT Department of Public Health, Western CT Health Network/ Danbury Hospital-New Milford Hospital, the Peter and Carmen Lucia Buck Foundation, Inc., Savings Bank of Danbury, Union Savings Bank, and United Way of Western Connecticut with in-kind support from Western Connecticut State University.

Objectives

The major objectives of the *2012 Community Report Card for Western Connecticut* are to:

1. Provide a narrative and statistical update of key indicators in the areas of economic stability, education, health status, behavioral risk factors, and diseases for HVR residents.
2. Provide current recommendations on how provider and community partnerships could improve the health and well-being of HVR residents.
3. Provide more in-depth insight on the health and social needs of older adults living in our community.

Methods

The *Report Card* combines narrative information and statistical data (tables, charts, and graphs) drawn from local, state, and federal sources. The report is intended to be descriptive and not analytical; therefore data is presented for general reference and, in most instances, has not been analyzed for statistical significance. Whenever possible, indicators are presented at the municipal (town or city) level. In the case of certain indicators, the statistical data is not available for lesser populated towns. In addition, health data is not published at the town level when there are a very small number of events, due to validity and confidentiality concerns. State and federal statistics are also included for certain indicators to provide a perspective on how the Housatonic Valley Region compares to the state and nation. The process of how the indicators were selected is described in the initial version of the Report Card (2009). For this Report, the data was obtained from the original sources when available. If the data was no longer available from the original source then searches were conducted and the new source is noted. There are some indicators where the data was collected in a different manner; in these instances an explanation is included to describe the changes and any implications.

With the growth in the population ages 65 and over in the region, the 2012 version of the Community Report Card contains a section specifically dedicated to the health of older adults. "Seniors in our communities are healthy and thrive" is the vision statement crafted by the Steering Committee for the older adult component of the *2012 Community Report Card*. Four topics were identified to enable public health, hospitals, human service providers, and the general public to better assess if older adults in the region exemplify this vision statement:

- *Housing.* This includes availability of housing options, skilled nursing, assisted living, and hospice facilities.
- *Support Services.* This includes services which promote access to health care and human services, such as public transportation, fuel assistance, Meals on Wheels, senior centers, etc.
- *Quality of Life.* This includes demographics, socioeconomic status, social supports, recreation, and spirituality.
- *Physical and Mental Health.* This includes risk factors, disease (morbidity) and death (mortality) rates.

Methods, cont'd.

The survey design team at WCSU reviewed published senior health report cards to select indicators for an Older Adult Health Survey. These included the Naugatuck Valley 2007 *Senior Needs Assessment* http://www.valleyunitedway.org/2007/SeniorNeedsExecutiveSummary.pdf, *Seniors in Canada 2006 Report Card* http://dsp-psd.pwgsc.gc.ca/Collection/HP30-1-2006E.pdf, and *Improving Health Literary for Older Adults, 2009* http://www.cdc.gov/healthmarketing/healthliteracy/reports/olderadults.pdf.

After selection of relevant indicators, Senior Center and Social Services Directors from HVR municipalities reviewed both the topics and the indicators and commented on the usefulness of compiling information on these indicators. Feedback confirmed that the needs of older adults are covered by the four topics and the indicators were then finalized.

Older Adult Health surveys were developed by the project team at WCSU from validated survey instruments for completion by older adults throughout the region. Long and short versions were developed for a general health and a general health plus dental survey. An effort was made to distribute surveys equally across all 10 HVR municipalities based on the population ages 65 and older. The target population was older adults who had the ability to complete the survey and also had an understanding of the needs in their community. Ninety-one sites were identified for survey administration. Although many sites were interested in receiving the results of the survey, permission to conduct the surveys was obtained from only 20 of these sites and completed surveys were received from only 10 sites. A total of 123 surveys were received. The majority of these surveys were collected at a regional volunteer recognition luncheon. Although this is not a representative sample of the older adult population in the HVR, as community volunteers, survey respondents are potentially more aware of available services and service gaps. Survey results are presented in The Older Adult Health Survey and Focus Group Summary section of this report.

Health: A Definition

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (http://www.who.int/governance/eb/who_constitution_en.pdf)

The phrase "health status" refers to the current condition of wellness and illness in our community, which is defined by measures of both positive and harmful behaviors, the existence of symptoms and conditions of illness and wellness, and the prevalence of specific diseases.

Findings and Recommendations

The findings and recommendations presented in this report are designed to promote discussion among all stakeholders on the health and well-being of the community as well as access and quality of health delivery systems in the region. The overarching intent is to identify priority needs for health improvement within the Housatonic Valley Region and provide a starting point for a more comprehensive health assessment in the future.

Looking Back

In April 2011, health care provider agencies and community members were asked to participate in a brief questionnaire as past recipients of the *2009 Community Report Card for Western Connecticut*. This survey was designed to capture perspectives on the value of the Report Card, i.e., how its content was used to support grant requests and funding, foster alignment of programs and services and partnerships, and advance a particular community health improvement initiative. Assessment of progress towards the five key consensus recommendations of community stakeholders presented in the *2009 Community Report Card* was also part of the survey. A 29% response rate was achieved (133 distributed surveys with 38 completed) and respondents included health care providers, community agencies, and community members.

The majority of respondents (63%; 24 individuals) indicated that they had received a copy of the *2009 Community Report Card for Western Connecticut*. Of the individuals who indicated they did not receive a copy, nearly half noted they had heard of the Report Card. An overwhelming majority (97%) indicated they would like to receive a future version of the Report Card. A summary of all survey respondent findings, including reported progress towards the 2009 Report Card's consensus recommendations, follows.

1. Use of the Community Report Card

More than half of the respondents (54%) indicated they had utilized information provided in the Report Card during the past two years. The primary use was for discussion purposes, followed by facilitation of program development/ implementation and funding requests, and education about community needs.

2. Five Key Recommendations

Recommendation # 1 - The community should capitalize on existing collaborations, initiatives, partnerships and programs to develop and embrace educational strategies across a broad continuum of providers that will expand and strengthen the focus on prevention, particularly targeting childhood obesity, heart disease, cancer, diabetes, and tick-borne illness.

Twenty-two (22) respondents indicated they had developed or partnered with another entity to address one of the recommended programs: Childhood Obesity (18), Diabetes (9), Heart Disease (8), Tick-borne Illness (8) and Cancer (7).

Highlights of programs and/or partnerships cited include the United Way Obesity initiative; HVCEO Tick Illness Prevention Task Force; Ridgefield BLAST Lyme program; WCSU Health Service "biggest loser" program; Connecticut Institute for Communities, Inc. colorectal cancer screening and establishment of a

Looking Back, cont'd.

Federally Qualified Community Health Center; Danbury Public Schools School-Based Health Centers and American Heart Association and American Cancer Society's awareness activities targeting the school age population; Ann's Place partnership with the Hispanic Center to address the needs of Hispanic/Latino cancer survivors; Americas Free Clinic emphasis on outreach and care for uninsured diabetics; Town of New Milford Walking Project; Town of Bethel 2-1-1 referral program; Regional YMCA of Western Connecticut Coalition for Healthy Kids and Diabetes Self-Management Education program with Danbury Hospital; and Danbury Hospital's Healthy Heart screening and education initiatives.

Recommendation # 2 – Data indicates the Greater Danbury area generally is very healthy across many indicators, including the 10 leading causes of death. Public health, hospitals and human services providers should be recognized for their efforts toward preventive, interceptive and ongoing care and supports for our community. They should also continue to strive for ways to maintain existing and pertinent programs and to find new and creative solutions to address emerging needs.

Nearly two-thirds (65%) of respondents indicated they implemented ways to maintain existing and pertinent programs. Seventeen (17) individuals indicated they found solutions to address emerging needs.

Recommendation # 3 – While indicators show the community has fairly substantial access to care in our region, lacking health insurance should not be a barrier to receiving care. The community should continue to work toward ensuring access to quality, affordable care for residents. The community should make the public better aware of state health insurance initiatives such as HUSKY and Charter Oak in a continuing effort to bridge barriers to care.

The majority of respondents (72%) indicated they have undertaken efforts to make the community more aware of health insurance initiatives.

Activities identified include evaluating clients for eligibility for public assistance and increasing awareness of state insurance initiatives. Specifics cited include Newtown's parent awareness of HUSKY programs as part of Free and Reduced Lunch programs; Danbury Department of Health and Human Services TB clinic referrals to Danbury Hospital's Financial Counseling; Danbury Housing Partnership educating the public on housing and homeless issues; the 3Rs collaborative and Danbury Children First's dissemination of information about HUSKY and pediatric clinics at events and through their Parent to Parent Newsletter; Women's Center of Greater Danbury referrals for resources; Boys & Girls Club of Ridgefield newsletter link to the no-cost and anonymous screener: www.qualify4care.com; Town of Bethel referral to 2-1-1 if the health department does not have the specific referral information sought; and Danbury Hospital's Families Network at Children's Day.

Recommendation # 4 - The community should develop a plan to better promote 2-1-1 (United Way Info Line) as a source for available services for the general provider populations.

Approximately 75% of respondents have not yet developed a plan to promote Info Line. Ten (10) individuals noted they provided

Looking Back, cont'd.

specific presentations at networking meetings, written identification in communications such as program directories, workplace campaigns, electronic communication, newsletters and annual reports, Development of referral procedures for handling information requests and a reference directory of current health information, subject matter experts and agency information to provide residents/others to assure they receive the information they need to help themselves was also noted.

Recommendation # 5 - The Community Report Card for Western Connecticut should be used as a source of information and a forum for education that spurs discussion and moves all stakeholders into action, and it should be revised biennially.

An overwhelming majority indicated support for ALL of the initiatives for helping the community prepare for future reports. These include collecting community-specific data where there is none; determining "target" populations and collecting relevant data for these populations; conducting focus groups with target populations; prioritizing needs; conducting a Resource Assessment (scan of what resources are available) and identifying unmet needs and creating a plan to address them; identifying evidence-based strategies/programs to meet the needs and evaluating programs and monitoring indicators.

Respondents noted that while all of the activities are possible and desirable, sufficient human and financial resources and the right leadership are needed to implement and sustain these activities. Highlights include:

- *Success is dependent on key stakeholders being on board and adequate resources being available.*
- *This requires organization, motivation and support.*
- *Collaborative, facilitated community conversations can lead to prioritization of needs, joint data gathering exercises, and resource assessments.*
- *There are many services in our area but there are many who are not aware of them. Efforts should be made to broaden awareness and utilize many of the individual agency efforts as a starting point.*
- *The community should and can prepare for future reports, by expanding the Steering Committee (in numbers and scope) and build on the foundation of the first Community Report Card.*
- *To improve health disparities, it is important to collect more in-depth data especially through focus groups to better align community resources with gaps identified by the community.*
- *The Community Health Committee representing the towns and cities should use a community health linkages model to obtain data and support to refine what the area health problems are and the priority list with a targeted plan of action.*

Moving Forward

Connecticut Health Rankings

According to the United Health Foundation, in 2011 Connecticut ranks third in health status in the country overall, a continued positive trend from the 2009 seventh rank and 2010 fourth rank. Strengths include low rates of smoking, a lower prevalence of obesity when compared to other states in the nation, a low percentage of children in poverty, a low rate of uninsured population, high immunization coverage, and relatively high proportion of primary care physicians. Areas where improvement is needed include a high prevalence of binge drinking and moderate levels of air pollution. The report indicates that Connecticut has demonstrated success in reducing deaths from cardiovascular disease and cancer and, in the past ten years, smoking prevalence has decreased dramatically. Although Connecticut has a relatively low rate of uninsured, the percent uninsured has increased from 9.7% in 2009 to 11.1% in 2011. Highlights include:

- While Connecticut has one of the lowest obesity rates in the U.S., 634,000 adults in Connecticut are obese, an increase of 188,000 individuals in the past 10 years.
- In the past year, smoking decreased from 15.4 percent to 13.2 percent of adults. There are 364,000 adults in Connecticut who still smoke.
- In the past year, diabetes increased from 6.6 percent to 7.3 percent of adults. There are 201,000 adults in Connecticut who have diabetes.
- Compared to other health measures, the rate of preventable hospitalizations remains high in Connecticut at 63.1 discharges per 1,000 Medicare enrollees.
- Health Disparities - In Connecticut, obesity is more prevalent among non-Hispanic blacks at 39.5 % than non-Hispanic whites at 20.8 %. Diabetes also varies by race and ethnicity in the state; 11.5 % of non-Hispanic blacks have diabetes compared to 6.7 % of non-Hispanic whites.

Source: United Health Foundation (2011) *"America's Health Rankings®: A Call to Action for Individuals and Their Communities" 22nd edition* http://www.americashealthrankings.org/CT/2011, *accessed 1/12/12).*

Healthy People 2010 and 2020

Any report of community health indicators should include *Healthy People 2010* and *Healthy People 2020*. This comprehensive set of national disease prevention and health promotion goals for the nation targets measureable health objectives in 28 focus areas. The final Healthy People 2010 report and the newly released objectives for Healthy People 2020 can be accessed at http://www.healthypeople.gov.

The overarching goal of *Healthy People 2020* is to increase both the quality and years of healthy life, and eliminate health disparities. A report on statewide progress towards achievement of *Healthy People 2010* targets was compiled by the CT Department of Public Health in June 2010. Findings from this report, *Healthy Connecticut 2010*, are incorporated into the Report Card sections as relevant. The entire report is available at: http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf.

Our Community

Population

The Housatonic Valley Region (HVR) comprises ten municipalities in western Connecticut in close proximity to the New York metropolitan area.

Data from the United States Census Bureau shows that as of 2010, the population of this region was 224,616, an increase of 12,368 since Census 2000. The HVR has grown at a faster rate than any other region in Connecticut. In the 1950s these 10 communities represented only 2.9% of Connecticut's population; in 2000 they represented 6.2% of the state population. This growth trend continued through 2010 at which time they represented 6.6% of the state population. By 2030, the HVR is projected to be at 7.1% of the state population. Table 1 outlines projections to the year 2030 compiled by the Connecticut State Data Center. It is important to note that these projected population numbers are derived from historical patterns of population change and that there is no guarantee that past patterns will hold constant in the future.

Table 1: Population Projections for HVR Municipalities, 2015-2030

Town	Census 2010 Population	2015	2020	2025	2030
Bethel	18,584	22,486	24,223	25,779	26,878
Bridgewater	1,727	2,057	2,134	2,216	2,271
Brookfield	16,452	17,756	18,424	19,065	19,644
Danbury	80,893	79,403	81,665	83,813	85,754
New Fairfield	13,881	15,196	15,624	16,012	16,249
New Milford	28,142	31,156	32,562	33,953	35,173
Newtown	27,560	30,147	32,242	34,242	36,161
Redding	9,158	8,092	7,721	7,436	7,225
Ridgefield	24,638	25,676	26,483	27,142	27,729
Sherman	3,581	4,430	4,586	4,724	4,823
HVR Totals	224,616	236,399	245,664	254,382	261,907
Connecticut	3,408,029	3,573,885	3,622,774	3,669,990	3,702,400

Source: Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html, accessed 5/28/2011

Our Community cont'd.

Demographic Profile

Ethnicity and Race

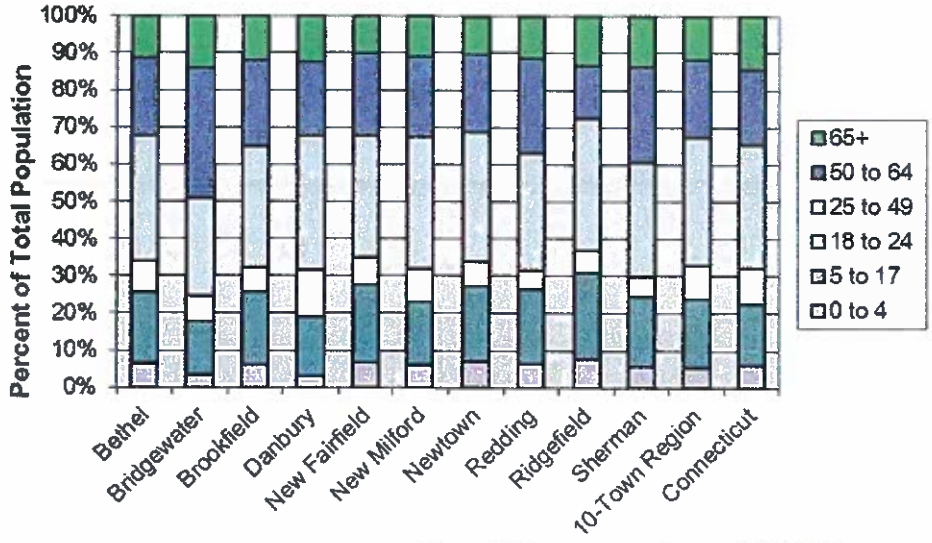
The Housatonic Valley Region has become much more ethnically diverse in recent years. From 2000 to 2010, the Black/African American population in the region increased from 6,527 to 7,671, or 17.5% of the total population. In 2010, 75.6% of the region's Black/African American population resided in Danbury. The Hispanic/Latino population in the region nearly doubled from 2000 to 2010, and currently comprises 12% of the region's population. Three-fourths of the Hispanic/Latino population in the region resides in Danbury. In 2000, Hispanic/Latino residents in the region represented many nationalities; the groups with the largest populations in the region are Puerto Rican (19% of the total Hispanic/Latino population), Ecuadorian (15%), Dominican (14%), and Mexican (12%). The region also had a substantial population of residents of Irish, Italian, German, and Polish ancestry in 2000 – 23%, 20%, 17%, and 6% respectively. (Source: Housatonic Valley Council of Elected Officials, http://hvceo.org/tables/TABLE_P18.php http://hvceo.org/tables/TABLE_P20.php Accessed 8/7/11.)

Note: At the time of publication, Census 2010 data on ancestry was not yet available, so no comparisons of growth in specific nationalities are available.

Age

The population distribution among age groups in the region is similar to the distribution in the state and in the nation. However, four communities in our region have a larger percentage of adults in the 50 and over range than either the state (34.4%) or the nation (33.3%). Bridgewater has the highest percentage of adults over the age of 50 with 49.1% of the population in this category, followed by Sherman (39.4%), Redding (36.8%), and Brookfield (35.3%). As expected, the median age in these communities is also higher than the state average. Communities with older populations usually have a greater demand for health care services, in the present and in the future. The proportion of each HVR municipality population by age range in 2010 is shown graphically below:

Figure 1: HVR Municipality Population by Age, 2010

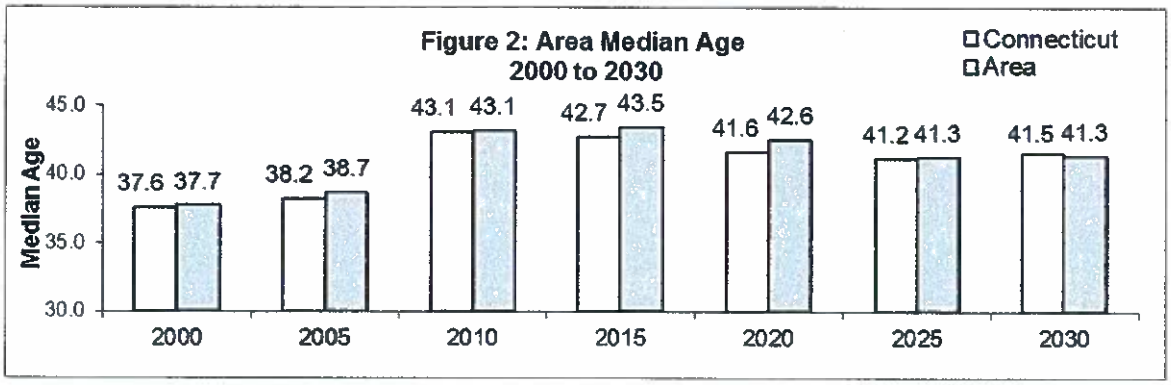


Source: Connecticut Economic Resource Center http://www.cerc.com/townprofiles/ accessed 4/11/2011

Our Community cont'd.

Age, cont'd.

Median age projections for the HVR as compiled by the CT Data Center for 2000-2030 show an overall increasing trend through 2015, influenced by factors such as aging in the "baby boomer" generation and the state's declining birth rate.



Population Trends

Careful examination of changes in population statistics over time, or temporal trends, is an important component of community health assessment and planning. A summary of population trends in HVR municipalities over the past decade by race/ethnicity follows.

Table 2: HVR Municipality Census 2000 and 2010 Population Counts by Race/Ethnicity

Municipality	Total Census Population*		White Population		Black/African American Population		Asian Population		Hispanic/Latino Population	
	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
Bethel	18,067	18,584	16,692	16,504	228	343	641	833	669	1,419
Brookfield	15,664	16,452	14,926	15,285	119	177	388	598	372	710
Danbury	74,848	80,893	56,853	55,202	5,060	5,803	4,082	5,474	11,791	20,185
New Fairfield	13,953	13,881	13,511	13,161	54	149	177	232	393	611
Newtown	25,031	27,560	23,815	25,914	437	444	351	648	590	1,033
Redding	8,270	9,158	7,952	8,693	62	63	147	200	122	237
Ridgefield	23,643	24,683	22,726	23,147	146	179	492	788	465	941
Sherman	3,827	3,581	3,726	3,469	21	15	26	35	66	76
Bridgewater	1,824	1,727	1,779	1,681	17	14	13	16	9	26
New Milford	27,121	28,142	25,583	25,809	383	484	518	779	751	1,693
HVR Total	212,248	224,661	187,563	188,865	6,527	7,671	6,835	9,603	14,477	26,931

Source: CT State Data Center, University of Connecticut, http:// ctsdc.uconn.edu/.../2010_2000_PL_Census_data_comparison_towns, accessed 1/12/12

** Note - subgroup population numbers do not equal the total population numbers as ethnic/racial subgroups with fewer than 10 residents for one or more municipalities and "other" were not included.*

Our Community, cont'd.

Population Trends, cont'd.

In interpreting the significance of the percentage change in population by racial/ethnic subgroup, it is important to also reference the absolute change in population numbers from 2000 to 2010 to gain perspective. Even small numeric changes in events with fewer occurrences may result in large percentage changes. This is referred to as small numbers effect or phenomenon. For example, a numeric increase of 10 from 10 to 20 represents a 100% increase, as does a numeric increase of 1,000 from 1,000 to 2,000.

Table 3: HVR Municipality Census 2000 and 2010 Number and Percentage Population Change

Municipality	Total Population		White Population		Black/African American Population		Asian Population		Hispanic/ Latino Population	
	Number Change	% Change	Number Change	% Change	Number Change	% Change	Number Change	% Change	Number Change	% Change
Bethel	517	2.9	-188	-1.1	115	50.4	192	30.0	750	112.1
Brookfield	788	5.0	359	2.4	58	48.7	210	54.1	338	90.9
Danbury	6,045	8.1	-1,651	-2.9	743	14.7	1,392	34.1	8,394	71.2
New Fairfield	-72	-0.5	-35	-2.6	95	175.9	55	31.1	218	55.5
Newtown	2,529	10.1	2,099	8.8	7	1.6	297	84.6	443	75.1
Redding	888	10.7	741	9.3	1	1.6	53	36.1	115	94.3
Ridgefield	995	4.2	421	1.9	33	22.6	296	60.2	476	102.4
Sherman	-246	-6.4	-257	-6.9	-6	-28.6	9	34.6	10	15.2
Bridgewater	-97	-5.3	-98	-5.5	-3	-17.7	3	23.1	17	188.9
New Milford	1,021	3.8	226	0.9	101	26.7	261	50.4	942	125.4
HVR Total	12,413	5.9	1,302	0.7	1,144	17.5	2,768	40.5	12,454	86.0

Source: CT State Data Center, University of Connecticut, http://ctsdc.uconn.edu/.../2010_2000_PL_Census_data_comparison_towns, accessed 1/12/12

Overall, review of population changes from 2000 to 2010 indicate that there is considerable variation in population growth rates among HVR municipalities as well as increasing ethnic and racial diversity throughout the region. The most consistent population growth in the region has occurred in Asian and Hispanic/Latino subgroups. In addition, the population growth rate for the region has slowed over the past decade at 5.8% compared with 13% from 1990 to 2000. Additional population statistics for the region are available at http://www.hvceo.org/areainfo.php.

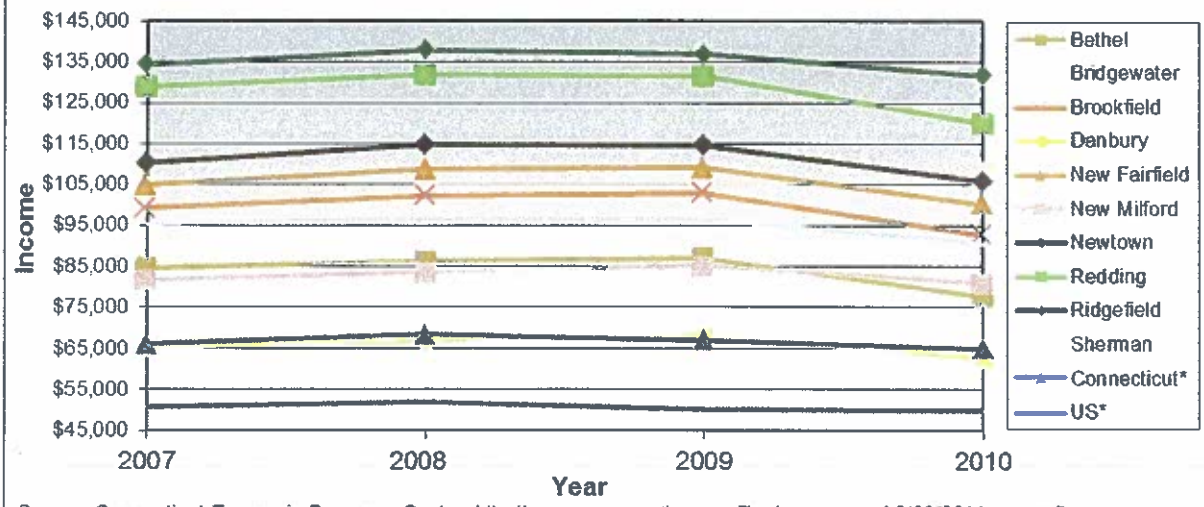
Economic Stability: Indicators and Findings

It is well documented that persons of higher socioeconomic status are more likely to have health insurance, participate in health screenings and regular health care, obtain a higher level of education, reside in safer neighborhoods, and exhibit healthier personal lifestyle habits. In sharp contrast, persons living in poverty tend to have fragmented health care; low educational attainment; live in substandard housing and unsafe neighborhoods; and experience higher rates of unemployment, crime, tobacco use, substance abuse, mental illness, and certain chronic health conditions such as obesity and diabetes. *Healthy People 2010 and 2020* both emphasize the inseparable connections among individual health status and the social factors and physical conditions in the environment in which people are born, live, learn, play, work, and age.

Income and Poverty

The median household income in the region varies widely. In 2010, the annual household median income in HVR municipalities ranged from a low of $62,582 in Danbury to a high of $131,677 in Ridgefield. All municipalities except Danbury have median household incomes well above the state and national average. As indicated in Figure 3, since 2009 there has been a decline in the median household income in all HVR communities with the exception of Bridgewater. Danbury and New Milford experienced the smallest decline.

Figure 3: Median Household Income, 2007 - 2010



Source: Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 3/23/2011 + e-mail communication from Dale Shannon, Senior Economist CERC 6/6/2011
* United States Census Bureau Median Household Income 1-year Estimates http://www.census.gov/did/www/saipe/county.html accessed 6/9/2011

Economic Stability: Indicators and Findings, cont'd.

Income and Poverty, cont'd.

In 2012, the official U.S. federal poverty level for a family of four was set at an annual income of $23,050 or less. (Source: US Department of Health and Human Services http://aspe.hhs.gov/ poverty/ 12poverty.shtml, accessed 1/27/2012). In geographic areas with a high cost of living such as our region, even persons living above 200% of the poverty level struggle to make ends meet. The federal poverty guidelines, or percentage multiples of them (such as 130 percent, 150 percent, or 185 percent), are used to determine eligibility for a number of federal and state assistance programs, including the National School Lunch Program, Supplemental Nutrition Assistance Program (formerly the Food Stamp Program), the Temporary Assistance for Needy Families Program, and the WIC Program.

With the current economic downturn, a growing number of individuals and families in the region are entering the ranks of the "working poor." These individuals, underemployed and/or employed in low wage jobs, earn too much money to qualify for federal or state assistance programs, but not enough money to experience a decent quality of life or meet many of their basic needs. The working poor are also more likely to not receive health insurance benefits through their employers.

According to the U.S. Census Bureau, 42.9 million Americans (14.3% of the US population) lived in poverty in 2009 (Source: US Census Bureau, "Poverty: 2008 and 2009, American Community Survey Briefs" http://www.census.gov/ prod/ 2010pubs/acsbr09-1.pdf accessed 8/12/2011). The proportion of Americans living in poverty has increased over the past decade. Table 4 shows that our community poverty rates fall below both the state and national rates. Danbury's level of poverty is considerably higher than the other municipalities in the region and comparable to the state. It should be noted that throughout the state and region, significant disparities exist with minority populations disproportionately living in poverty.

Table 4: Economic Characteristics of HVR Municipalities

Town	Median Household Income in 2010 ($)	Poverty Rate in 2009 (percent)
Bethel	$77,625	4.8%
Bridgewater	$107,934	2.9%
Brookfield	$92,731	2.4%
Danbury	$62,582	8.5%
New Fairfield	$100,202	2.9%
New Milford	$80,887	2.1%
Newtown	$105,744	2.2%
Redding	$119,788	1.6%
Ridgefield	$131,677	1.8%
Sherman	$90,638	2.2%
Connecticut*	$64,851	8.7%
United States*	$49,777	14.3%

Source: Connecticut Economic Resource Center, Inc. Town Profiles 2011 www.cerc.org accessed 8/17/2011
* United States Census Bureau Median Household Income 1-year Estimates http://www.census.gov/did/www/saipe/county.html accessed 6/9/2011

Economic Stability: Indicators and Findings, cont'd.

Employment Status

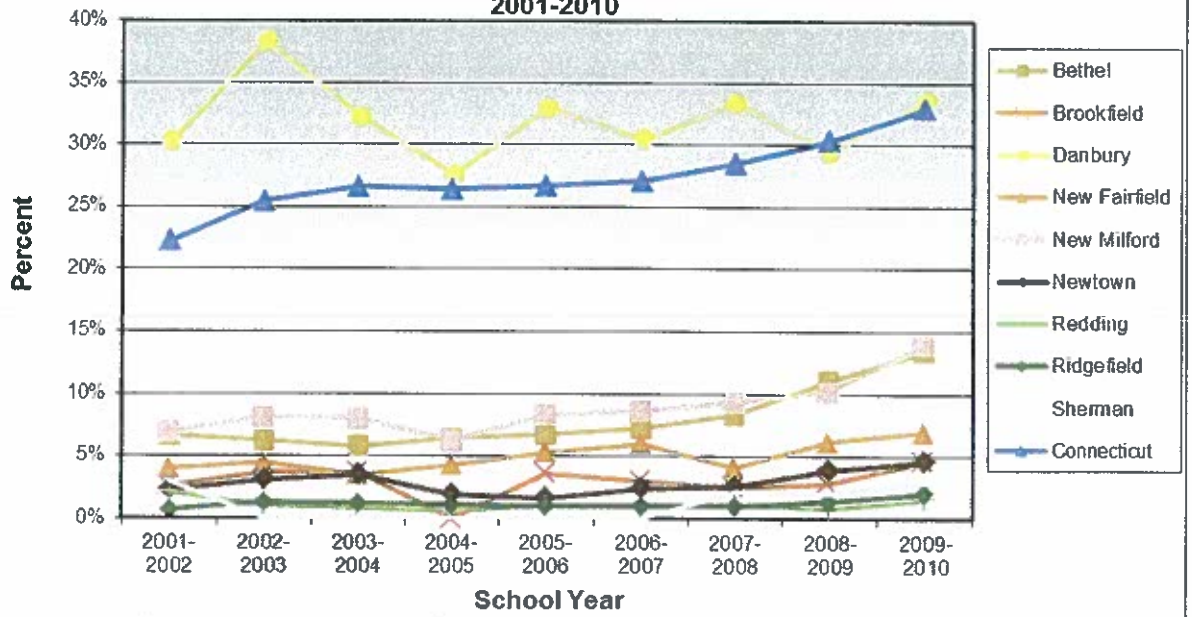
According to State Department of Labor data reports, Connecticut and the HVR municipalities have recently experienced a decline in the unemployment rate. The state's unemployment rate in July 2011 was 9.1%, and as of December 2011 this had declined to 7.6%, below the national unemployment rate of 8.5%. In December 2011, unemployment rates in the region ranged from a low of 4.4% in Bridgewater to a high of 6.4% in Sherman. (Source: Connecticut Department of Labor, http://www.ctdol.state.ct.us/ accessed 8/18/2011 & 1/27/12).

Free and Reduced Price School Meals

Free or reduced price school meals are available for all children attending public schools whose families are income eligible. The income eligibility for free meals is 130% or below the federal poverty level; for reduced meals it is more than 130% up to 185% of the federal poverty level. The percentage of children receiving free or reduced price school meals is a highly useful indicator of the extent of poverty and economic stability in our community.

Since 2000, data indicate that the region tends to fall below the statewide average for free or reduced price meal eligibility. This is consistent with the region's overall higher average median household income. Danbury is the exception with the percentage of students eligible for free/reduced price meals generally exceeding the state average. In 2009-2010, one out of every three Danbury children was eligible to receive free/reduced price meals. The Danbury Promise for Children Partnership's *2011 Community Report Card on Danbury's Young Children* states this had increased to 46% in 2010-2011. It is notable that over the past two years, there has been an increase in the number of eligible children in all HVR communities.

Figure 4: Percent of Students Eligible for Free/Reduced Price Meals, 2001-2010



Source: Connecticut State Department of Education, Student Need Data http://sdeportal.ct.gov/Cedar/WEB/ct_report/StudentNeedDT.aspx accessed 3/23/2011

Economic Stability: Indicators and Findings, cont'd.

Homelessness

The National Alliance to End Homelessness defines homelessness as a complex problem with a simple solution - housing. People become homeless when they cannot find housing that they can afford. It is estimated that there are 643,067 people experiencing homelessness on any given night in the United States with 238,110 people in families, and 404,957 individuals. These numbers are from point-in-time counts conducted in communities throughout the country on a single night in January every other year. (Source: The National Alliance to End Homelessness, Snapshot of Homelessness, http://www.endhomelessness.org/section/about_homelessness/snapshot_of_homelessness accessed 8/29/2011).

Homelessness results from many factors. Economics is a major driver of homelessness across the nation. In Connecticut, the economic pressures are particularly acute with the relatively high cost of living and scarcity of low cost housing. In the Danbury metropolitan area, the estimated 2011 living wage to afford a one bedroom apartment was $24.27 per hour; the minimum wage in 2012 is only $8.25 per hour. (Source: Fiscal Year 2011 Final Fair Market Rents for Existing Housing, http://www.universallivingwage.org, accessed 1/30/12).

The data in Table 5 indicates that 4,451 people were homeless in Connecticut on January 27, 2011. Table 5 shows the Point-in-Time Count of homeless in the Greater Danbury area and Connecticut from January 2008 through January 2011.

Table 5: Homelessness Point-in-Time Counts for Connecticut and Greater Danbury, 2008-2011

		January 30, 2008		January 30, 2009		January 27, 2010		January 27, 2011		Total Percent Change from 2008 to 2011	
		Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide
Total	Total	123	3,444	103	2,824	127	3,829	158	4,451	28.5%	29.2%
	Single Adults	115	2,847	91	2,414	96	2,508	130	3,064		
	Families	10	482	12	423	11	521	11	533		
	Unaccompanied Youth	0	119	0	17	0	18	0	0		
	Children in Families	16	873	23	793	20	782	17	854		

Note: an unsheltered homeless person resides in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street, and a sheltered homeless person resides in an emergency shelter or transitional housing for homeless persons who originally came from the streets or emergency shelters.

Source: CT Coalition to End Homelessness http://www.cceh.org/publications/, 2010-2011 data update accessed 1/27/12.

Economic Stability: Indicators and Findings, cont'd.

Homelessness, cont'd.

In 2005 Danbury Mayor Mark D. Boughton commissioned a Task Force to develop a comprehensive and detailed plan to end homelessness in Danbury within 10 years. The plan was unveiled in February 2006 with four objectives:

1. Increase the supply of permanent housing units to meet the projected need of homeless persons.
2. Keep people housed and reduce the number of people becoming homeless and specifically reduce the number of people being discharged into homelessness by state and local institutions and agencies.
3. Ensure that there are adequate, appropriate and sufficient services to assist homeless or at-risk persons in accessing and retaining housing.
4. Develop a strategy to ensure that the plan is both implemented and monitored to completion.

The Task Force's report stresses urgency in ending homelessness. The cost of long-term homelessness is "most acutely felt by the health and mental health systems. A recent study found that hospitalized homeless people stay an average of more than four days longer than other inpatients and that almost half of medical hospitalizations of homeless people were directly attributable to their homeless condition and therefore preventable." Homeless individuals "are three times more likely to use hospital emergency rooms than the general population, and are at higher risk for emergency department services because of their poor health." The American Academy of Pediatrics has found that homeless children are more likely than other children to experience trauma-related injuries, developmental delays, chronic disease, and poor academic achievement. (Source: The Mayor's Task Force to End Homelessness, www.ci.danbury.ct.us, accessed 11/9/08.)

The Greater Danbury Continuum of Care and the Danbury Housing Partnership are working with a broad range of partners throughout the region to address the multifaceted needs of the homeless population. The Partnership website can be accessed at: www.danbury housing partnership.org.

Education: Indicators and Findings

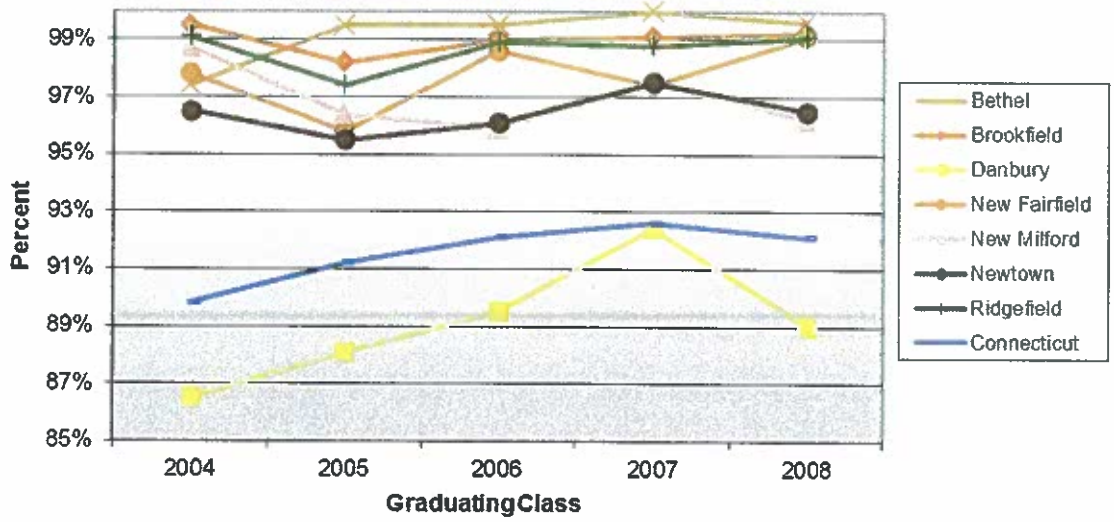
According to the National Center for Education Statistics (NCES), an individual's level of education is highly correlated with specific socioeconomic outcomes. For example, a high school graduate tends to achieve more stable employment and a higher income level than a high school dropout. According to the NCES, students who do not graduate from high school are more likely to rely on public assistance and have poorer physical health than individuals who completed graduation requirements. Data also indicates that the socioeconomic and quality of life benefits of education continue with further advances in educational attainment. Higher education is strongly associated with improved health status, access to health care, increased income, and job opportunities. Persons with higher educational attainment are more likely to live in safe neighborhoods, be employed in higher paying jobs with health benefits, and practice healthy lifestyle habits.

The Connecticut State Department of Education has established three priorities in their 2006 – 2011 Comprehensive Plan for Education to address gaps in educational achievement.

1. High-quality preschool education for all students.
2. High academic achievement for all students in reading, writing, mathematics and science.
3. High school reform so that all students graduate and are prepared for lifelong learning and careers in a competitive global economy.

The ability to achieve these priorities within our local schools will have a direct impact on the future quality-of-life for our students and the economic well-being of our communities.

Figure 5: High School Graduation Rate, 2004-2008



Source: Connecticut State Department of Education, CEDAR, http://sdeportal.ct.gov/Cedar/WEB/ct_report/GraduationDT.aspx accessed 3/24/2011
Note: Bridgewater, Redding, and Sherman are excluded as their students attend high schools located in other towns.

Education: Indicators and Findings

High School Graduation and Higher Educational Attainment

As indicated in Figure 5, the graduation rate for most HVR municipalities is well above the state rate. Danbury, a priority school district, is the exception with a graduation rate consistently below the state average. According to the NCES, the national graduation rate in 2008-2009 was 75.5%, compared with Connecticut's rate of 92%. This rate varies greatly by race/ethnicity and was highest for Asian/Pacific Islanders at 91.8%, followed by White students at 82%, Hispanic students at 65.9%, Native American students at 64.8% and African-American students at 63.5%. (Source: National Center for Education Statistics, www.nces.ed.gov, accessed 8/16/2011).

Four-year cumulative data for the 2009 cohort of high school students in Connecticut shows an overall decline in graduation rates and considerable disparities in these rates by socio-demographic group: Hispanic/Latino (58.1%), African American/Black (66.2%), low income (59.9%), limited English proficiency (53.4%), and special education students (53.4%) compared with (86.8%) for White students. (Source: Connecticut Department of Education. Commissioner Calls for Action. *"New Formula, Unique Student Data Produce More Accurate State Graduation Rates"*, Press Release. March 23, 2010).

Table 6 summarizes existing data relating to the level of educational attainment by HVR residents age 25 and over in the last decade. During this period of time, the overall level of education has consistently increased. With the exception of Danbury, residents ages 25 and over throughout the region were more likely to graduate from high school and to receive advanced degrees than the average Connecticut resident. Residents in eight out of ten HVR municipalities exceeded the state average for attainment of a bachelor's degree or higher.

Table 6: Educational Attainment in HVR Residents Ages 25 and Over, Census 2000 and 2010

Municipality	High School Graduate or Higher		Bachelor's Degree or Higher	
	Census 2000	Census 2010	Census 2000	Census 2010
Bethel	89%	91%	37%	40%
Bridgewater	93%	96%	48%	52%
Brookfield	93%	94%	44%	46%
Danbury	77%	84%	27%	33%
New Fairfield	94%	96%	41%	44%
New Milford	91%	95%	31%	35%
Newtown	93%	95%	50%	53%
Redding	97%	98%	63%	65%
Ridgefield	96%	97%	66%	67%
Sherman	94%	95%	42%	45%
State (CT)	84%	89%	31%	35%

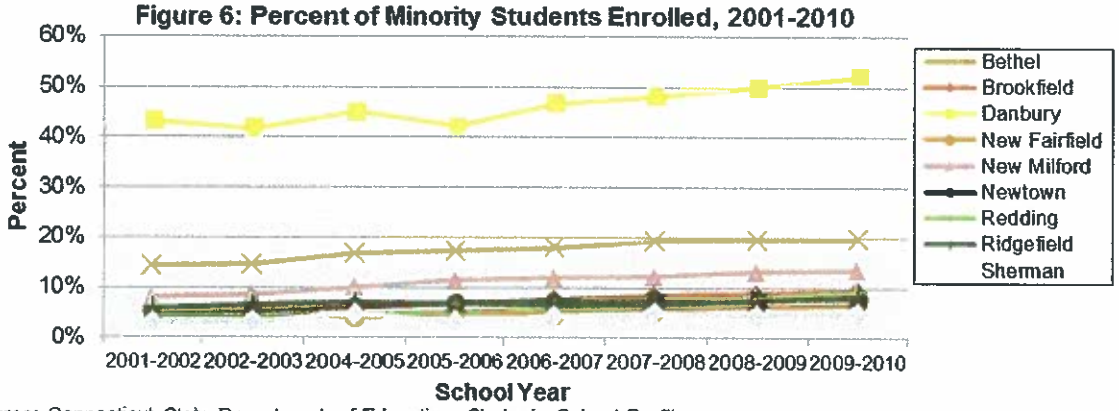
Sources: CERC 2011 Town Profiles and Census 2000: Summary Social, Economic and Housing Characteristics (Table 4).

Education: Indicators and Findings, cont'd.

High School Graduation and Higher Educational Attainment, cont'd.

Among the public school districts in our region, in 2009-2010 Danbury had the highest concentration of racial/ethnic diversity with over half of the students enrolled being minority (52%), followed by Bethel at 19.7%. Figure 6 shows the percentage of minority students from 2001-2002 through the 2009–2010 school years. This growth trend in the proportion of minority students in public schools is consistent across all HVR municipalities.

Figure 6: Percent of Minority Students Enrolled, 2001-2010

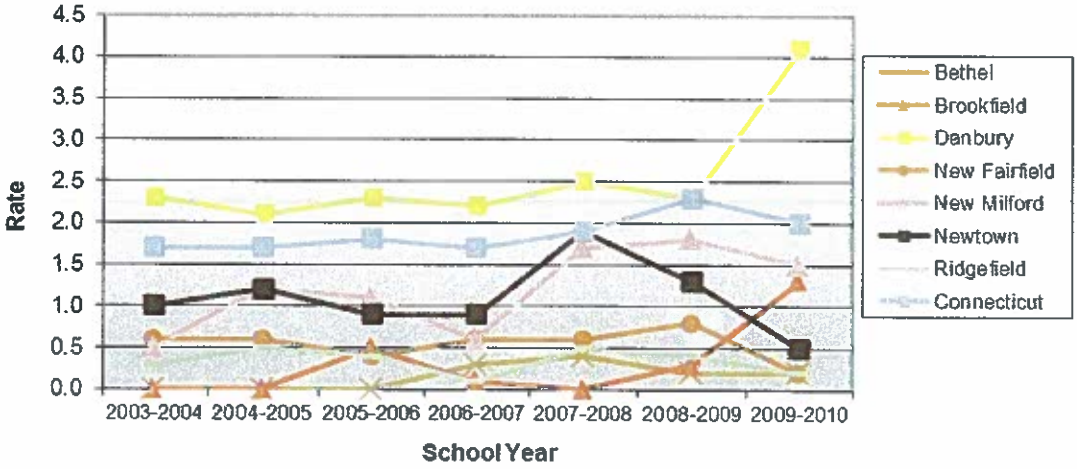


Source: Connecticut State Department of Education, Strategic School Profiles, http://sdeportal.ct.gov/Cedar/WEB/ResearchandReports/SSPReports.aspx accessed 5/31/2011
Note: Bridgewater is included in the Region 12 School District.

High School Dropout Rate

As shown in Figure 7, many municipalities in the region have on average maintained a low dropout rate with the exception of Brookfield, Danbury, and New Milford where the dropout rates remain above the regional average (and exceed the state average in the case of Danbury).

Figure 7: High School Dropout Rate, Grades 9 - 12, 2003-2010



Source: Connecticut State Department of Education, Dropout Rate http://sdeportal.ct.gov/Cedar/WEB/ct_report/DropoutDT.aspx accessed 3/24/2011
Note: Bridgewater is included in the Region 12 District

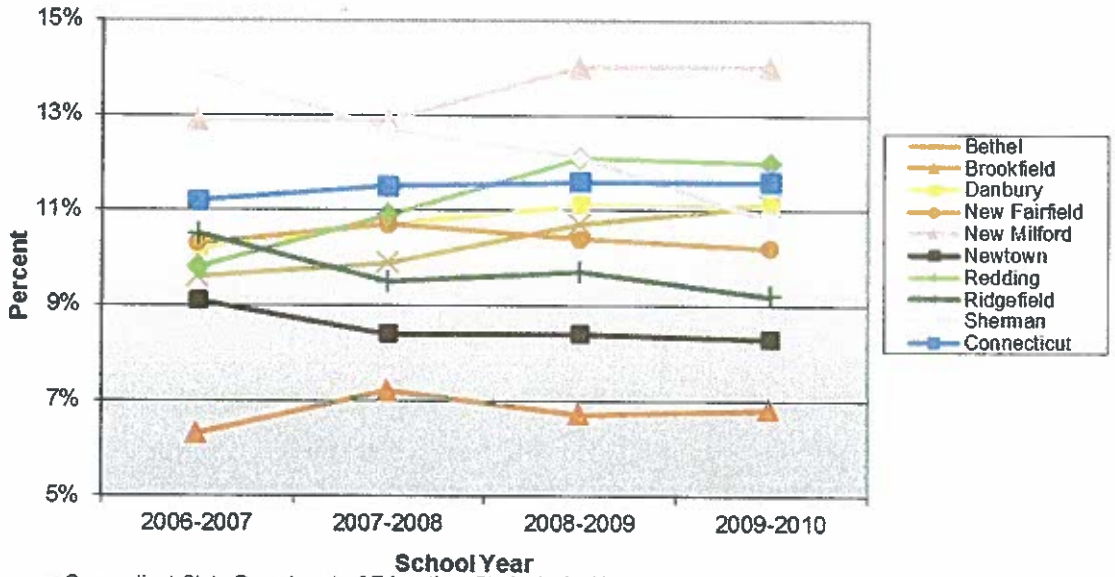
Education: Indicators and Findings, cont'd.

Special Education and Students with Disabilities

Special education involves the provision of individualized educational services for students with a wide range of disabilities. Special education is provided to a child with an identified disability who needs specially designed instruction to meet his/her unique needs and to enable the child to access the general curriculum of the school district. A child who is eligible for special education services is entitled by federal law to receive a free appropriate public education (FAPE). FAPE ensures that all students with disabilities receive an appropriate public education at no cost to the family.

The percentage of K-12 students with disabilities by HVR municipality is presented in Figure 8. This percentage has held fairly constant for many municipalities over the past four years. Sherman has experienced a steady decline in the percent of students with disabilities and there has been an overall increase in the percent of students with disabilities in New Milford, Danbury, and Redding.

Figure 8: Prevalence Rate Students with Disabilities*, 2006-2010



Source: Connecticut State Department of Education, Students for Whom District is Fiscally Responsible, http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationResourseDT.aspx Accessed 3/23/2011
* Past reports used title "Percent of Students with Disabilities for Whom the District is Fiscally Responsible"

Education: Indicators and Findings, cont'd.

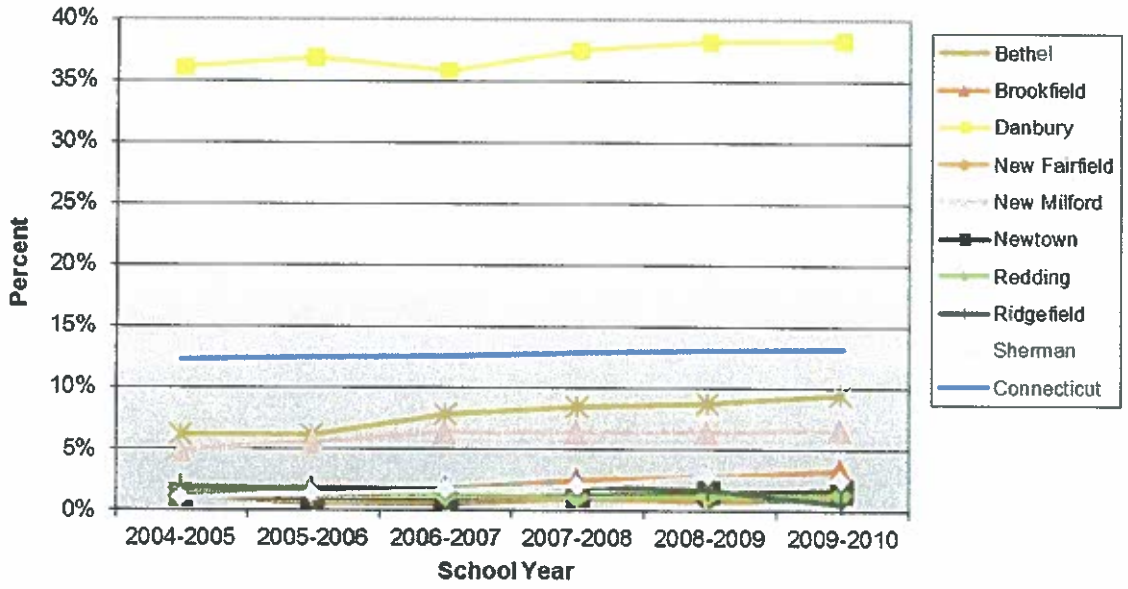
English as a Second Language (ESL)

There are frequently socioeconomic disparities between ESL residents and residents whose primary language is English. Disparities are seen in both children and adults and are reflected in many of the other issues examined within this report.

Students with limited English proficiency, or English Language Learners, tend to have poorer academic performance than children who are fluent in English. Children residing in ESL homes are also less likely to have health insurance and more likely to be living in poverty.

Although the percent of students with a non-English home language is increasing in the majority of municipalities in our region, it is clearly impacting Danbury to a far greater degree. As presented in Figure 9, Danbury's level is considerably higher than the state, while all other municipalities fall below the state percentage.

Figure 9: K-12 Students with a Non-English Home Language, 2004-2010



Source: Connecticut State Department of Education. Students for Whom District is Fiscally Responsible, http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationResourseDT.aspx Accessed 3/23/2011
* Past reports used title "Percent of Students with Disabilities for Whom the District is Fiscally Responsible"

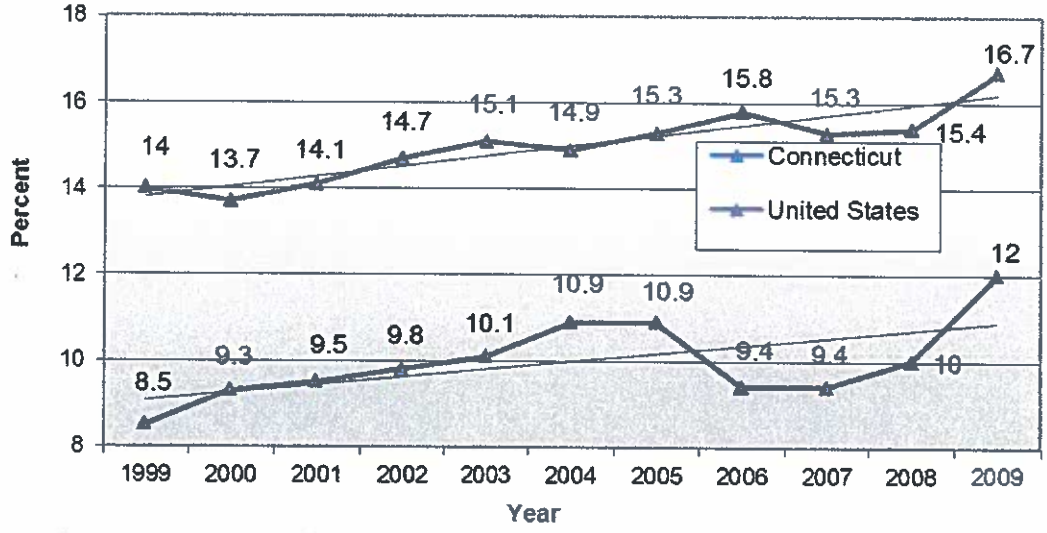
Health Status: Indicators and Findings

Health Insurance Coverage

Having public or private health insurance coverage is a potent predictor of both access to and regular use of all types of health care services - preventive, screening, and diagnostic and treatment.

Studies demonstrate that individuals without health insurance are far more likely to receive fragmented health care and experience delayed access to health screenings and treatment for disease. In addition to the negative impact of delayed access to care on individual health, the economic costs to society are high. Research has shown that delayed access to care results in overuse of costly emergency department services and premature death and disability. As shown in Figure 10, Connecticut falls well below the national average in the percentage of residents who are uninsured. During the past few years, however, this percentage has been increasing at a faster rate in CT than in the U.S. as a whole.

Figure 10: CT and U.S. Percent Uninsured Population, 1999-2009



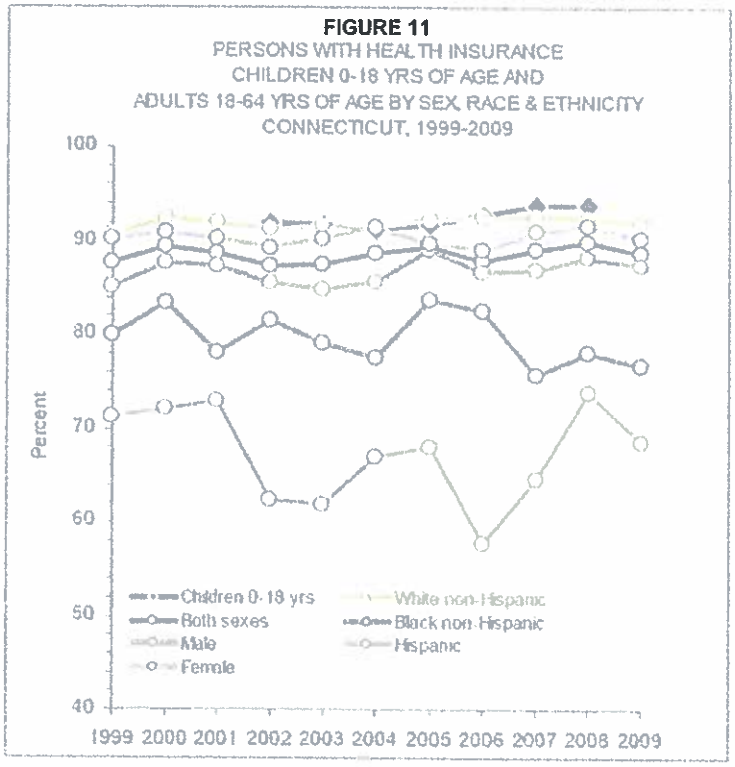
Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 3/24/2011
Note: Population as of March of the following year.

Health Status: Indicators and Findings, cont'd.

Health Insurance Coverage, cont'd.

According to the CT Department of Public Health's report, *Healthy Connecticut 2010*, the likelihood of being insured in our state varies considerably for different population subgroups. As shown in Figure 11, children in Connecticut are more likely than adults to have health insurance, females are more likely than males, and white non-Hispanic residents are significantly more likely than non-Hispanic Black and Hispanic residents to have health insurance coverage.

FIGURE 11
PERSONS WITH HEALTH INSURANCE
CHILDREN 0-18 YRS OF AGE AND
ADULTS 18-64 YRS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System as cited in *Healthy Connecticut 2010*
Note: Data for children 0-18 years of age not available until 2002.

Factors Influencing Insurance Status

There are several key reasons why individuals and families may or may not be insured, most notably employment status and availability of employer-sponsored health insurance, eligibility for public health insurance, and affordability of insurance for persons who are self-insured.

HUSKY Health is Connecticut's comprehensive public health insurance program for children, parents, relative caregivers, senior citizens, individuals with disabilities, adults without children and pregnant women who meet income and citizenship eligibility guidelines. HUSKY Health is designed to reduce the number of uninsured families in Connecticut and increase access to preventive care and diagnostic and treatment services. It is important to note that our region has a growing number of undocumented residents. These individuals are categorically ineligible for public health insurance programs, such as Medicaid, which require proof of citizenship (natural-born citizen,

Health Status: Indicators and Findings, cont'd.

Factors Influencing Insurance Status, cont'd.

naturalized citizen, or U.S. national).

HUSKY A (Medicaid) provides benefits to CT children under the age of 19 and their parents or a relative caregiver with incomes at or below 185% of the federal poverty level and low income pregnant women. HUSKY B, also known as the Children's Health Insurance Program or CHIP, provides benefits to children under the age of 19 who are not eligible for HUSKY A and live in households with incomes between 185-300% of the poverty level. HUSKY A provides free health care coverage for children under the age of 19 and parents or relative caregivers who live with a child under the age of 19. HUSKY B plans include co-payments and/or premiums based on family composition and income.

Both plans cover comprehensive preventive and illness-related health care, including physician visits, emergency and hospital care, immunizations, prescriptions, and vision care. Dental care is provided through the Dental Health Partnership. Children with mental health and substance abuse concerns are served through the Connecticut Behavioral Health Partnership. For children with special physical health needs, the program provides coverage for additional services.

HUSKY C, formerly known as Title 19, or Medicaid for the for the Aged/Disabled, provides coverage to income-eligible CT residents ages 65 or older, and ages 18 to 64 who are blind or have another qualifying disability. HUSKY D, formerly known as Medicaid for Low Income Adults, provides coverage for persons ages 19-64 who do not qualify for HUSKY A and do not receive Supplemental Security Income or Medicare. (Sources: United Way of CT 2-1-1 HUSKY Health Plans, http://infoline.org, and www.huskyhealth.com, accessed 1/31/12).

In 2009, 10% of Connecticut's population was uninsured, which is considerably below the U.S. average at 16.7%. Data for individual municipalities in the HVR region are not available, however according to the U.S. Census Bureau, Fairfield County's uninsured population was 10.8% in 2007 for persons under the age of 65 (Source: U.S. Census Bureau, Small Area Health Insurance Estimates, http://www.census.gov/did/www/sahie/index.html accessed 7/7/2011). Interestingly, from 2008-2009 there was a reported decrease in the percent of persons covered by public insurance in the state in contrast to an increase in the country.

Table 7: Health Insurance Coverage by Type, Percent of Total Population, 2007 - 2009

	Connecticut			United States		
Type	2007	2008	2009	2007	2008	2009
Covered by Private or Government	90.6%	90.0%	88.0%	84.7%	84.6%	83.3%
Private	76.3%	74.9%	75.3%	67.5%	66.7%	63.9%
Employment-based	68.0%	65.7%	66.3%	59.3%	58.5%	55.8%
Direct Purchase	9.4%	9.4%	9.6%	8.9%	8.9%	8.9%
Government	25.8%	27.0%	24.7%	27.8%	29.0%	30.6%
Medicaid	11.2%	11.8%	9.6%	13.2%	14.1%	15.7%
Medicare	14.3%	14.9%	14.7%	13.8%	14.3%	14.3%
Military Health Care	1.9%	2.1%	2.2%	3.7%	3.8%	4.1%

Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 3/24/2011

Note: Population as of March of the following year.

Health Status: Indicators and Findings, cont'd.

Factors Influencing Insurance Status, cont'd.

Overall enrollment of CT children in the HUSKY A and B Plans has increased from 2010 to 2011, holding relatively constant during 2011. The data in Table 8 shows the number of children enrolled in the region and in the state for January 2009, January 2010 and for January and December 2011. Seven of the ten HVR municipalities experienced an increase in HUSKY A child enrollment in 2011; five experienced an increase in HUSKY B enrollment.

Table 8: Number of Children Enrolled in HUSKY A and B Comparison, 2009 - 2011

	January 1, 2009		January 1, 2010		January 1, 2011		December 1, 2011	
	Husky A	Husky B	Husky A	Husky B	Husky A	Husky B	Husky A	Husky B
Bethel	584	120	695	127	777	130	792	123
Bridgewater	27	<5	32	6	35	*	30	*
Brookfield	277	52	295	93	395	61	400	70
Danbury	5,620	542	6,348	561	7,174	499	7,426	518
New Fairfield	266	73	354	63	397	63	408	67
New Milford	915	167	1,121	188	1,237	181	1,220	182
Newtown	383	81	494	154	619	93	604	99
Redding	80	18	99	42	130	27	139	22
Ridgefield	37	31	203	36	224	39	242	32
Sherman	76	17	97	19	112	24	115	18
Connecticut	331,519	13,654	239,531	15,657	256,808	14,874	256,052	14,874

Source: State of Connecticut Department of Social Services, Healthcare for UninSured Kids and Youth (HUSKY), http://www.ct.gov/hh/ and http://www.huskyhealth.com/hh/lib/hh/pdf/Reports/HUSKYBEnrollment0110.pdf, accessed 3/24/2011 and 1/31/12
* indicates < 5

Findings: Although publicly-funded insurance programs are in place in the region and state to serve low income children and adults, they are not available for persons who do not meet income or citizenship eligibility requirements. Income thresholds for HUSKY are also more stringent for non-pregnant adults without children, and access to providers is limited in some areas. In addition, the enrollment process may be challenging for those with language and/or literacy barriers. Ongoing enrollment assistance at such sites as community and faith-based organizations, social and human services offices, community health centers, hospitals, and WIC offices would help encourage enrollment by eligible adults and children.

Emergency Department Visits

When individuals have health insurance they are more likely to access either a private health provider's office or a primary care clinic when they or their children are ill. Without insurance, the alternatives are community-based health centers with a sliding fee schedule for self-pay patients based on income, and hospital emergency departments. Tracking the frequency of emergency department visits for non-emergent conditions is one way to evaluate if hospitals are inappropriately being used for primary care. Frequent use of the emergency department services for primary care indicates that a community may have an insufficient quantity of primary care providers or health providers serving the uninsured population

Health Status: Indicators and Findings, cont'd.

Emergency Department Visits, cont'd.

such as Federally Qualified Community Health Centers.

Table 9 provides the number of emergency department visits for community residents at Western CT Health System's Danbury and New Milford Hospitals and emergency department visits at all Connecticut hospitals for Connecticut residents only. The number of emergency department visits as a percent of the total population (2010 Census data) for each municipality was calculated for comparative purposes. It should be noted these percentages are a rough approximation, as the visit counts are not unduplicated, i.e., one individual may have multiple visits, and the percentages do not capture hospital visits occurring outside of the state. The proportion of emergency visits by resident population varies greatly across the region, and is highest in Danbury (41.7%) and lowest in Ridgefield at 14.2%. In 2007, all HVR municipalities were below the state percentage (41.5%). Some factors that may explain the variance include: resident geographic proximity to the hospital (percentages are highest in Danbury and New Milford where the hospitals are physically located), the proportion of residents who are uninsured, and the proportion of residents seeking care outside CT.

Table 9: Emergency Visits by Municipality[1] compared to statewide data (2007) [3], FY 2010

	Inpatient (Admitted from Emergency Department)	Outpatient (Discharged from Emergency Department)	Total	Population Census 2010[2]	Emergency Department visits as % of population
Bethel	1,046	4,705	5,751	18,584	30.9%
Bridgewater	78	425	503	1,727	29.1%
Brookfield	725	3,345	4,070	16,452	24.7%
Danbury	4,652	29,069	33,721	80,893	41.7%
New Fairfield	545	2,768	3,313	13,881	23.9%
New Milford	1,149	9,936	11,085	28,142	39.4%
Newtown	1,108	3,654	4,762	27,560	17.3%
Redding	316	1,067	1,383	9,158	15.1%
Ridgefield	857	2,643	3,500	24,638	14.2%
Sherman	102	870	972	3,581	27.1%
HVR Total	10,578	58,482	69,060	224,616	30.7%
Connecticut[3]	1,223,641	230,244	1,453,885	3,502,309	41.5%

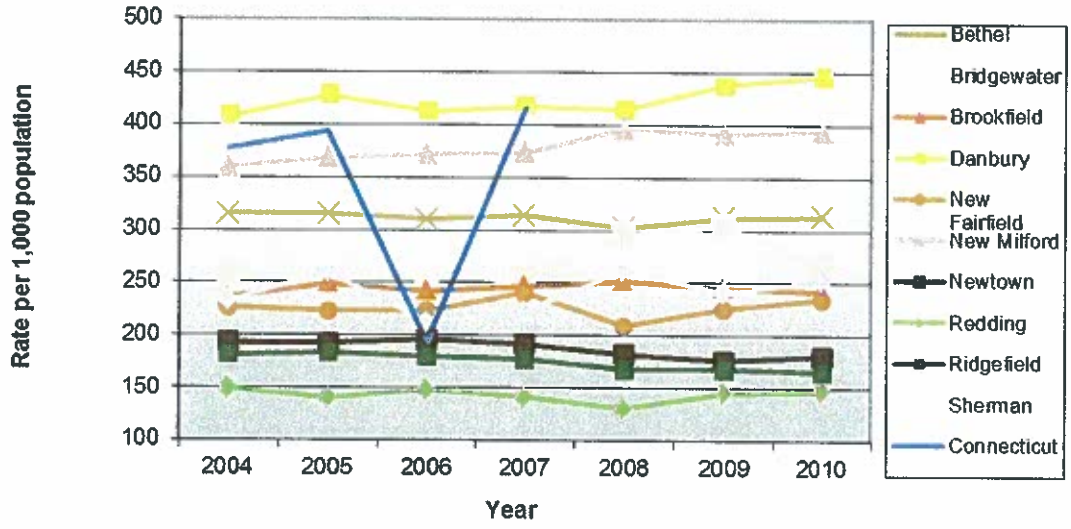
Sources:
[1] Danbury and New Milford Hospital, data received July 31, 2008 and August 26, 2008
[2] Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html, accessed 5/28/2011.
[3] CHIME (Connecticut Health Information and Management Exchange) data received from Danbury Hospital 1/8/2009

Health Status: Indicators and Findings, cont'd.

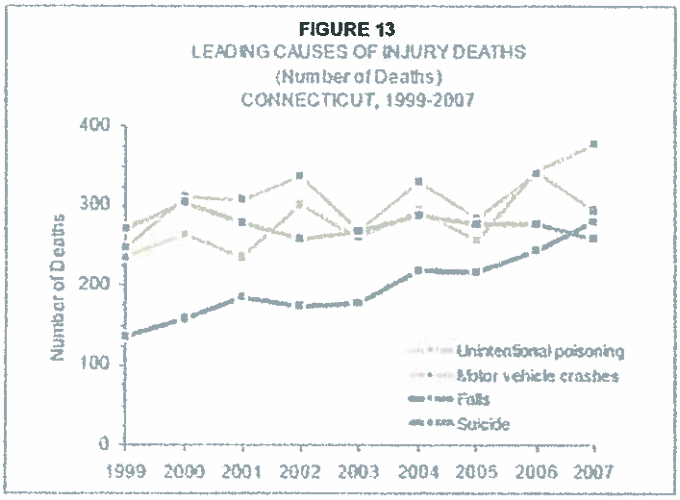
Emergency Department Visits, cont'd.

The trend data in Figure 12 show the rate of emergency room visits per 1,000 population (based on 2010 Census data) from 2004 to 2010. Local trends have remained fairly constant. Danbury has the highest rate, followed by New Milford.

Figure 12: Emergency Visits per 1,000 population*, FY 2004-2010



Sources: Source: Danbury and New Milford Hospital. data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population - Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011. Data for CT available only through 2007.



Source: Connecticut Death Registry (Registration Reports) as cited in *Healthy Connecticut 2010*

Emergency department visits for intentional and unintentional injuries are additional important indicators of community health. The most prevalent unintentional injuries vary by age group and include: accidental poisonings in infants and children, motor vehicle accidents in adolescents and young adults (many of which are alcohol-related), and falls in the elderly. Intentional injuries include those that are self-inflicted such as suicide attempts. As shown in Figure 13, the leading causes of injury-related deaths in the state include unintentional poisoning, motor vehicle accidents, falls, and suicide.

Health Status: Indicators and Findings, cont'd.

Mental or Behavioral Health

The World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." Furthermore, as noted in *Healthy Connecticut 2010*, WHO reports that mental health disorders, including substance use/abuse, anxiety disorders, impulse-control disorders, and mood disorders account for more disability than other chronic diseases, such as heart disease and cancer.

Access to appropriate counseling and treatment for mental health concerns and disorders is critical to a community's overall well-being. High rates of crime, homelessness, suicide, and substance abuse are all distress signals. Behavioral health is often overlooked as a priority community health issue and there is a lack of current and comprehensive community level assessment data in this area. Figures 14 and 15 provide insight on the prevalence of two mental health disorders - serious psychological distress in CT adults and major depressive episodes in CT residents ages 12 and older - from 2005-2007, respectively.

Serious psychological distress is defined by mental health experts as having a score of 13 or higher on The Kessler 6 (K6) screening scale. Major depressive episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of symptoms for depression as described in the DSM-IV. Overall, there has been a downward trend in the prevalence of these disorders in CT adolescents and adults for the three year period shown. More recent data was not available for inclusion in this report.

FIGURE 14
SERIOUS PSYCHOLOGICAL DISTRESS
ADULTS 18+ YEARS OF AGE
CONNECTICUT 2005-2007

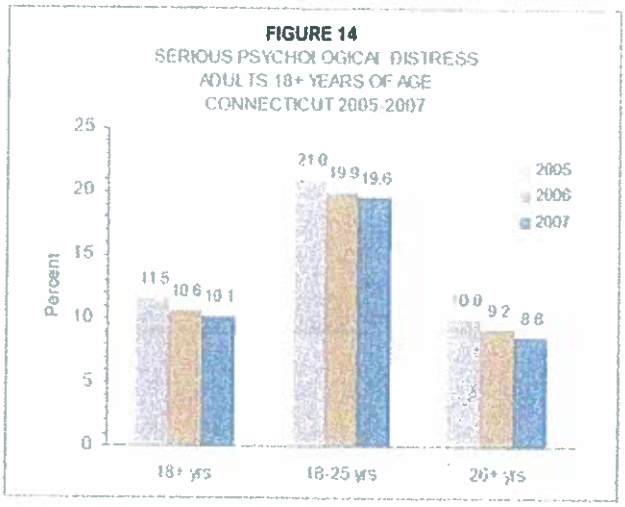
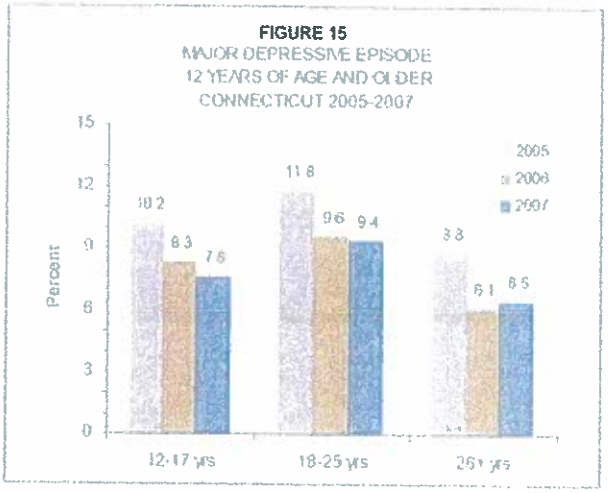


FIGURE 15
MAJOR DEPRESSIVE EPISODE
12 YEARS OF AGE AND OLDER
CONNECTICUT 2005-2007



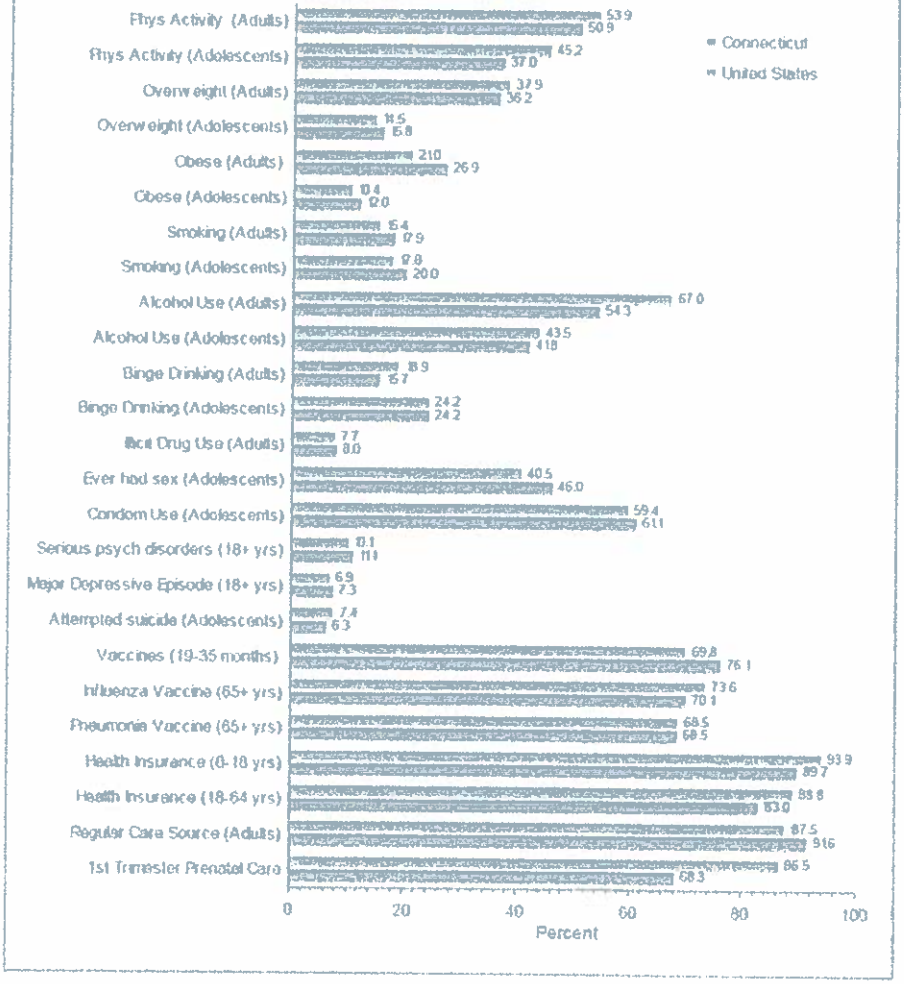
Source: SAMHSA National Survey on Drug Use and Health as cited in *Healthy Connecticut 2010*

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings

Leading Health Indicator Behavioral Risk Overview

A comparison of outcomes in U.S. and CT residents for selected behavioral health objectives related to the *Healthy People 2010* leading health indicators – physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care – are presented in Figure 16. Behavioral risk factor data is only available at the state level, due to the sampling framework used for the Behavioral Risk Factor Surveillance Survey, or BRFSS.

FIGURE 16
COMPARISON OF OUTCOMES FOR SELECTED BEHAVIORAL HEALTH OBJECTIVES FOR LEADING HEALTH INDICATORS
CONNECTICUT AND UNITED STATES (See "Note" for years)



Sources: Behavioral Risk Factor Surveillance System, Connecticut School Health Survey, Youth Risk Behavior Survey, National Immunization Survey, National Survey on Drug Use and Health

Notes: Data years: Physical Activity, Overweight, Obese, Smoking, Alcohol Use, Binge Drinking (Adults 2009, Adolescents 2009), Illicit Drug Use, Serious Psychological Disorders, Major Depressive Episode (2006-2007), Sex, Condom Use (during last sexual intercourse), Attempted Suicide (2009), Vaccines (2009), Health Insurance (Children 2007-2008, Adults 18-64 yrs 2009)

Source: Healthy Connecticut 2010

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Leading Health Indicator Behavioral Risk Overview, cont'd.

As shown in Figure 16, compared to the U.S. as a whole, Connecticut had a lower prevalence of most risk factors. CT residents under the age of 65 were more likely to have health insurance coverage and have a regular source of health care; pregnant women were more likely to receive early prenatal care; adults and teens were more likely to be physically active, not be obese, and not smoke. Negative findings include the higher prevalence of alcohol use in CT adults and teens and binge drinking in CT adults than in the U.S. as a whole.

Childhood and Adolescent Obesity

According to the Centers for Disease Control and Prevention, the prevalence of childhood obesity has more than tripled in the past 30 years. The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 20% in 2008. Over this same time period, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18%. In 2008, more than one-third of children and adolescents were overweight or obese. (Source: Centers for Disease Control and Prevention, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/facts.htm, accessed 2/20/12).

Although not representative of the general pediatric population, the 2010 Pediatric Nutrition Surveillance System (PedNSS) assesses weight status of children from low-income families participating in the Special Supplemental Food Program for Women, Infants and Children (WIC). PedNSS reports that 30.5% of low-income children ages 2 to 5 years are overweight or obese nationwide.
(Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System, http://www.cdc.gov/pednss/ accessed 8/9/2011).

The long-term health implications of childhood and adolescent obesity are serious. Youth who are obese are more likely to experience social and psychological problems due to poor self-esteem. They are more likely to be overweight adults, and consequently at a greater risk for developing heart disease, hypertension, type 2 diabetes, stroke, osteoarthritis, and certain types of cancer. (Source: Centers for Disease Control and Prevention, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/facts.htm, accessed 2/20/12).

According to the National Survey of Children's Health:

- Approximately 95,000 Connecticut children ages 10-17 years (25.7%) are considered overweight or obese according to Body Mass Index (BMI) for age standards.
- Hispanic/Latino (40.4%) and Black/African American (38.1%) children in Connecticut are almost two times more likely than white children (21.8%) to be overweight or obese.
- CT children are more likely than their counterparts nationwide to be physically active for at least four days per week (36.2% versus 34.4%), and less likely to spend one hour or more a day in front of a television or computer screen (42.7% versus 50.1%).

More information on obesity and other health issues for CT children are available at: www.nschdata.org.

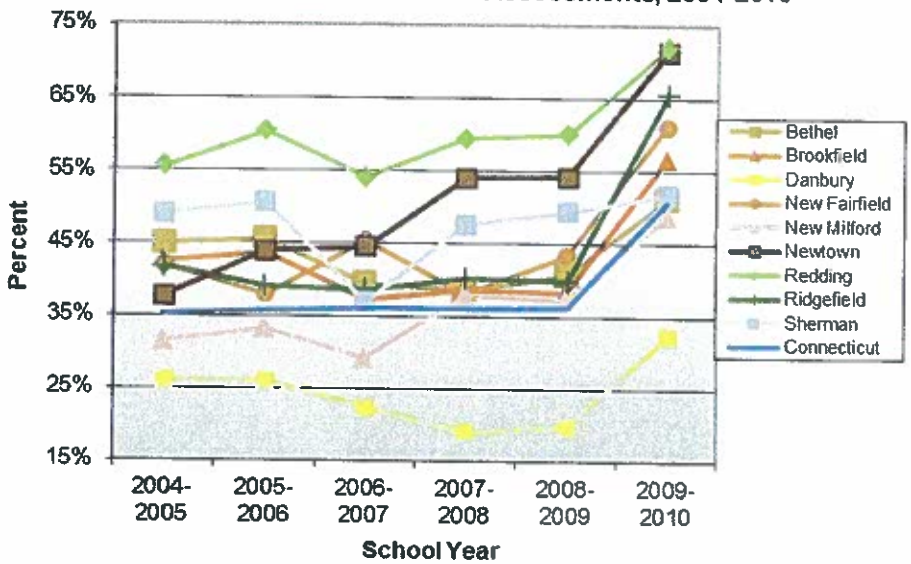
Lack of physical activity is a major contributing factor to overweight and obesity. Figure 17 provides information about the percentage of school age children in our community who have passed the state physical fitness test. Students are tested according to the standards presented in Figure 18. In the past, students were tested in

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

all four areas of fitness: aerobic endurance, flexibility, muscular strength and endurance, and body composition. In the 2009-2010 school year, the requirement for testing body composition was removed. This has likely resulted in a falsely elevated number of students meeting the requirements.

Figure 17: Percent of CT Public School Students Meeting State Standards on All Four Fitness Assessments, 2004-2010



Source: Connecticut State Department of Education, Physical Fitness Assessment, http://sdeportal.ct.gov/Cedar/WEB/ct_report/PhysicalFitnessDT.aspx Accessed 4/5/2011
*Previous title was Percent of Students Passing the Fitness Test
Note: 2nd Generation Test 2002-2009 3rd Generation Test 2009-2010
Bridgewater students attend the Region 12 school district.

Figure 18: Physical Fitness Assessment Guidelines

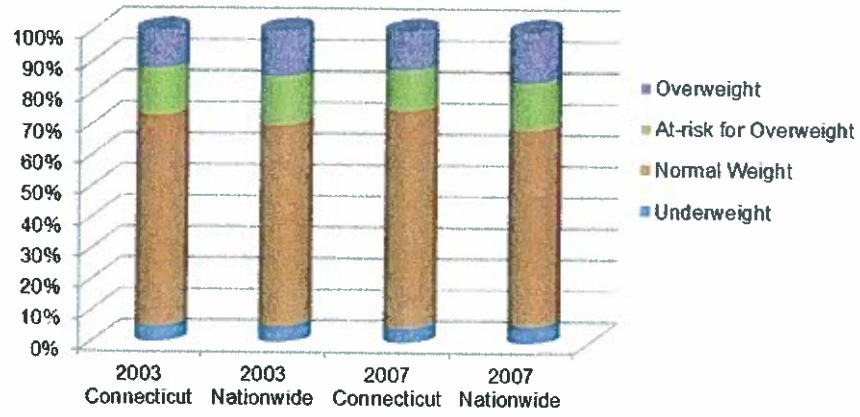
Health-related Component	2nd Generation (1999)	3rd Generation (2009)	Change
• Flexibility	• Back-saver sit-and-reach	• Back-saver sit-and-reach (improved version) • Shoulder stretch (optional)	• Adjusted for lower back • Addition of shoulder flexibility check
• Upper body muscle • Strength and endurance	• Right-angle push- up	• 90° push-up	• None • Name changed for consistency with research and literature
• Abdominal muscle strength and endurance	• Curl-up	• Curl-up • (improved version)	• Adjusted for limb length and neck comfort
• Aerobic endurance	• Mile run	• Mile run or P.A.C.E.R.	• District option, focus on v0$_2$max
• Body composition	• BMI		• BMI not included

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

Figure 19 provides information on the weight status of children in CT and the U.S. for 2003 and 2007. Children are classified as underweight, normal weight, at-risk for overweight or overweight based on the Body Mass Index (BMI) for their age. BMI is a proxy measure for body composition that is calculated based on the child's height and weight. Overall, more children in CT were reported to be of a healthy weight than the national average.

Figure 19: Weight Status of Children/Youth Ages 10-17 based on Body Mass Index for Age, 2003 and 2007



Source: Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. http://www.nschdata.org/Content/07ObesityReportCards.aspx Accessed 1/19/2010.

According to the 2007 National Survey of Children's Health, Connecticut ranks fifth in the nation for overweight or obese children (first is best). This is an improvement from the 2003 rank of 17th. This report indicates only 58.3% of Connecticut children ages 6-17 engage in 4 or more days of vigorous activity per week. This percentage is slightly lower than the national average of 64.3%. However, Connecticut children engage in less screen time (includes TV, video games, etc.) per week when compared to the national average. Overall, 10.7% of children ages 1 to 5 and 8.5% of children ages 6 to 17 engage in 4 or more hours per weekday compared to the national averages of 12.8% and 10.8%, respectively. It is interesting to note that children with public health insurance were considerably more likely to be overweight or obese than children with private health insurance at both the state and national level (Connecticut: 35.1% versus 21.9%; U.S.: 43.2% versus 27.3%). (Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/, accessed 1/19/2010).

As reported in *Healthy Connecticut 2010*, adolescent obesity prevalence data for 2005-2009 from the Youth Risk Behavior Survey also show a favorable decline in obesity for teens in grades 9-12. Analysis of 2009 data shows a higher prevalence of obesity in males and in Hispanic/ Latino teens.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

Findings: As shown in Figure 19, the prevalence of overweight and obesity increased across the U.S. from 2003-2007. It is notable that, during this same period of time, the prevalence of overweight *decreased* in CT. Specifically, the proportion of overweight and obese children 10-17 years of age in CT decreased from 27.3% in 2003 to 25.7% in 2007. Unfortunately, there is no representative data on weight status of children or adolescents at the municipal level. As noted previously, BMI is no longer included in the standard physical fitness assessment measures for public school children in CT, and there is no BMI surveillance system in place in CT. Three potential BMI surveillance methods include school-based, registry-based, and hybrid (de-identified extraction of height and weight measurements from school health record forms). (Source: Altarum Institute, Registry-Based BMI Surveillance: A Guide to System Preparation, Design, and Implementation, http://www.altarum.org, accessed 2/14/12) BMI surveillance methodologies should be further evaluated to advance the quality and representativeness of overweight and obesity prevalence data available in CT.

Preventive Dental Care

The Pew Charitable Trusts issued a report in 2011 which assessed each state's ability to serve insured children. In this report, states were graded on eight benchmarks assessing dental health policies. The report states that tooth decay is the most common disease of childhood; it is five times more common than asthma. In spite of this, most children do not have dental insurance. There are three times as many children without dental insurance compared to those without medical insurance. (Source: Pew Charitable Trusts, The State of Children's Dental Health http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=85899359680 accessed 8/25/2011).

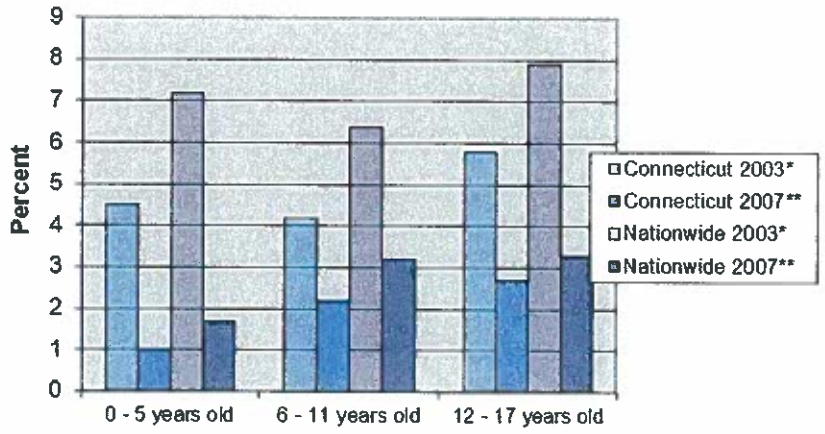
Connecticut is one of seven states that received an "A" in 2011 by meeting six of the eight policy benchmarks for strengthening children's dental health. This is the result of a concerted, joint effort of a number of entities to improve the status of dental care in Connecticut and increase access to oral health care services. The full report can be accessed on the Pew website listed above; the Connecticut Fact Sheet can be accessed at: http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Initiatives/Childrens_Dental_Health/048_11_DENT_50_State_Factsheets_Connecticut_052311_web.pdf.

Figure 20 shows state and national levels of children by age group who did not receive needed preventive dental care during the past 12 months in 2003 and 2007. Data are not available at the community level. Overall, children in Connecticut are more likely to receive dental care than the general U.S. population.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Preventive Dental Care, cont'd.

Figure 20: Percent of Children/Youth Ages 1-17 Needing Dental Care in the past 12 months and Did Not Receive It, Connecticut vs. Nationwide, 2003 and 2007



Sources. *Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Accessed [06/27/2008] from www.nschdata.org
**Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health. Data Resource Center for Child and Adolescent Health website. www.nschdata.org accessed 4/6/2011

Findings: There has been a marked improvement in Connecticut and the nation in the proportion of children who received required dental care in 2003 and 2007. Connecticut has experienced a 50% or more reduction in those who needed care but did not receive it across all age groups. These findings provide support for the effectiveness of statewide initiatives to improve children's access to and utilization of dental health services.

Teen Births

The teen birth rate is an important health indicator as teen mothers are more likely to have poor birth outcomes such as low birth weight and prematurity. Infants of teen mothers are also at risk of be raised in an economically unstable environment, since teen mothers have a greater likelihood of being a single parent and not completing high school. Their children tend to exhibit poorer health, are more likely to be abused, and more likely to become single parents themselves. Often the infant is born into poverty and from that stems a cycle of dependence for both mother and child in addition to many other socioeconomic challenges. (Source: March of Dimes Medical Resources - Teenage Pregnancy. http://www.marchofdimes.com/professionals/medicalresources_teenpregnancy.html accessed 2/20/12.)

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Teen Births, cont'd.

Table 10: Teen Births Ages 15 -17, 2004, 2006, and 2008

	2004		2006		2008	
	Number	Rate	Number	Rate	Number	Rate
Bethel	3	*	1	*	0	0
Bridgewater	0	0	0	0	0	0
Brookfield	1	*	1	*	1	*
Danbury	18	14.4	13	10.2	12	9.5
New Fairfield	2	*	2	*	0	0
New Milford	3	*	2	*	2	*
Newtown	0	0	1	*	0	0
Redding	0	0	0	0	0	0
Ridgefield	0	0	1	*	0	0
Sherman	0	0	0	0	0	0
Connecticut	917	13.8	912	13.7	846	12.8
United States	133,980	22.0	133,943	22.0	135,664	22.0

Sources: Connecticut Association for Human Services Connecticut Kids Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011

Rate is number of births to females ages 15-17 per 1,000 females for that age group in a town
* Rates for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers.

Births to teen mothers and teen pregnancy also create serious financial consequences. Statistics compiled from the National Campaign to Prevent Teen Pregnancy show that teen pregnancy cost Connecticut taxpayers about $137 million in 2008 up from $98 million in 2004. This number covers public health costs, public welfare, loss of income, and incarceration. On a positive note, the teen birth rate in Connecticut has declined 43% between 1991 and 2008, a savings to Connecticut taxpayers of approximately of $162 million in 2008. (Source: The National Campaign to Prevent Teen Pregnancy, http://www.thenationalcampaign.org/, accessed 8/19/2011).

Findings: The teen birth rates in our region are well below the state and national rate, with a positive downward trend.

Prenatal Care

Adequate and timely prenatal care can significantly impact the quality of a woman's pregnancy and birth outcomes. The detrimental effects of late or no prenatal care to both maternal and infant health are well documented. Table 11 indicates that the rates of late or no prenatal care in most HVR municipalities are lower than the state average but higher than the national average. As reported in *Healthy Connecticut 2010*, statewide, non-Hispanic white females are most likely to begin prenatal care early; Black non-Hispanic and Hispanic females were the least likely.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Prenatal Care, cont'd.

Findings: The rates for delayed or lack of prenatal care in Danbury for 2008 are higher than in other HVR communities however, Danbury rates have shown a favorable decline from those in 2004 and 2006. Danbury is considerably more ethnically diverse than the other communities, with the highest proportion of undocumented immigrants who may not receive timely prenatal care due to cultural, health insurance, and deportation issues.

Table 11: Late Or No Prenatal Care, 2004, 2006, and 2008

	2004		2006		2008	
	Number	Percent	Number	Percent	Number	Percent
Bethel	12	6.2%	25	11.9%	18	9.5%
Bridgewater	2	*	0	0.0%	0	0.0%
Brookfield	17	9.6%	19	11.6%	8	5.8%
Danbury	193	19.0%	233	19.6%	182	14.8%
New Fairfield	10	6.1%	5	3.9%	6	5.0%
New Milford	24	6.6%	22	6.8%	24	7.8%
Newtown	14	5.1%	17	7.1%	20	10.0%
Redding	3	*	2	*	7	11.1%
Ridgefield	20	7.8%	18	7.7%	12	6.6%
Sherman	1	*	4	*	1	*
Connecticut	5,302	12.8%	5,858	14.0%	4,947	12.4%
United States	114,916	3.6%	97,420	4.0%	51,889	4.0%

Sources: Connecticut Association for Human Services Connecticut Kids Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011
Percent of All Live Births
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

Low Birth Weight

Low birth weight is a term used for infants who are born weighing less than 2,500 grams or 5½ pounds. Low birth weight is a major risk factor for infant mortality and long term disability. Prevention of low birth weight is a major focus of public health and prenatal care programs. As defined in the Institute of Medicine's report, *Preventing Low Birthweight*, risk factors for LBW include: low socioeconomic status, low education level, non-white race (particularly Black/African American), childbearing at extremes of age, inadequate weight gain, smoking, substance abuse, absent or inadequate prenatal care, and preterm delivery or multiple pregnancies. Low birth weight infants are at increased risk for complications and related health care costs are escalated due to the need for highly specialized care, including neonatal intensive care units. The rates of low birth weight for HVR municipalities are presented in Table 12.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Low Birth Weight, cont'd.

Table 12: Low Birth Weight, 2004, 2006, and 2008

	2004		2006		2008	
	Number	Percent	Number	Percent	Number	Percent
Bethel	9	4.6%	14	6.7%	13	6.8%
Bridgewater	2	*	0	0%	0	0%
Brookfield	7	3.9%	12	7.3%	13	9.4%
Danbury	69	6.8%	78	6.6%	77	6.3%
New Fairfield	8	4.9%	5	3.9%	7	5.7%
New Milford	21	5.8%	20	6.2%	22	7.1%
Newtown	10	3.6%	11	4.6%	9	4.5%
Redding	5	5.9%	0	0%	3	*
Ridgefield	13	5.1%	18	7.7%	7	3.8%
Sherman	1	*	6	18.2%	0	0%
Connecticut	3,078	8.0%	3,389	8.1%	3,004	8.1%
United States	331,772	8.1%	351,974	8.3%	347,209	8.2%

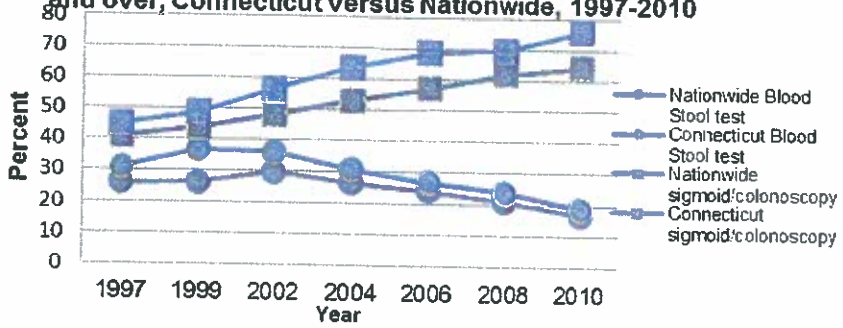
Source: Connecticut Association for Human Services Connecticut Kid Count http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
Percent of All Live Births
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

Findings: The data for 2004-2008 in Table 9 shows the rates for low birth weight in all HVR municipalities except Danbury remained lower than the state and national rates.

Colorectal Cancer Screening

Colorectal cancer occurs most frequently in men and women over the age of 50. It is the third leading cause of cancer death among both genders. Early detection is the best defense in overcoming this disease. The American Cancer Society (http://www.cancer.org) and National Cancer Institute (http://cancer.gov) recommend first screening at age 50 if there are no risk factors other than age; an individual with family history of colorectal cancer, polyps or other risk factors should begin screening at an earlier age.

Figure 21: Colorectal Cancer Screening Among Adult Ages 50 and over, Connecticut versus Nationwide, 1997-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, accessed 6/9/2011

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Colorectal Cancer Screening, cont'd.

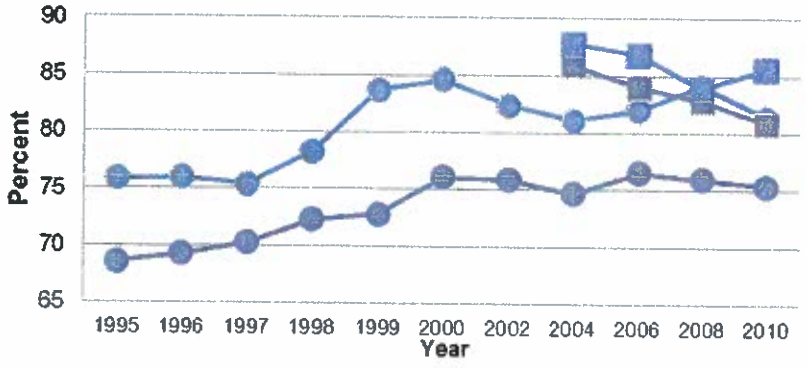
Findings: Early detection and treatment are key to reducing deaths from colorectal cancer. The data in Figure 21 indicates that Connecticut has been consistently above the national average in the rate of colorectal screening for adults age 50 and older across all testing methods. There has been a positive upward trend in the sigmoid/colonoscopy screening rate, and the *Healthy People 2020* goal of 70.5% was achieved in 2010. The steady decline in reported blood stool test screening is likely due to many physicians now using colonoscopy/sigmoidoscopy as the primary screening method for colorectal cancer.

Mammography Screening and Papanicolaou Smear

Early detection of breast and cervical cancer improves the likelihood that these cancers are diagnosed at an early stage and treated successfully. The American Cancer Society and National Cancer Institute recommend routine mammography screening for early detection of breast cancer among women ages 40 and over. One of the risk factors for cervical cancer is the Human Papilloma Virus (HPV), which can be detected with a Papanicolaou Smear (Pap test). Recent data show a highly favorable decrease in both incidence (declined from 146.7 cases per 100,000 residents in 1998 to 136.5 cases per 100,000 residents in 2008) and mortality (declined from 29 deaths per 100,000 residents in 1997 to 21.7 deaths per 100,000 residents in 2007) for breast cancer in Connecticut. Similar trends are seen for cervical cancer and both are in line with national trends. (Source: National Cancer Institute, State Cancer Profiles Historical Trend Data, http://statecancerprofiles.cancer.gov/ accessed 8/5/2011).

Findings: Figure 22 shows that Connecticut exceeds the national average for participation in each of these cancer screening procedures. It is noteworthy that there has been a consistent downward trend in the percent of women reporting they had a Pap test in the past three years. This may be related to changes in the routine screening periodicity recommendations to every two to three years.

Figure 22: Mammography Screening and Papanicolou Smear Prevalence Among Women, Connecticut Versus Nationwide, 1995-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

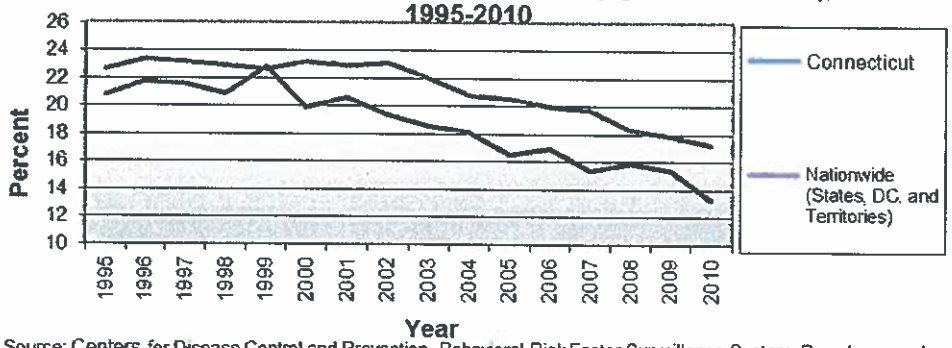
Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs

Cardiovascular disease, cancer and diseases of the lung are among the most common causes of death and can be directly attributed to unhealthy behaviors, most notably tobacco use. Alcohol and drug abuse are major factors in premature death and disability. While drug abuse often receives a great deal of media attention, the impact of alcohol and tobacco on morbidity and mortality far exceed all other drugs and accidents combined. Other chronic conditions such as diseases of the lungs, liver and kidneys, as well as intentional and unintentional injuries, are related to tobacco, alcohol and/or drug abuse.

Tobacco Use

Figure 23: Current Smokers, CT Adults (ages 18 and over), 1995-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence and Trends Data, http://apps.nccd.cdc.gov/BRFSS/index.asp, accessed 4/6/2011

Figure 23 shows that adult tobacco use has been declining in Connecticut and nationwide; Figure 24 indicates a slight decrease in smoking among youth. In 2010, the prevalence of use among adults was much lower in Connecticut (13.2%) when compared to the national average (17.2%). Highlights from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) and the 2009 Youth Risk Behavior Survey (YRBS) for Connecticut include:

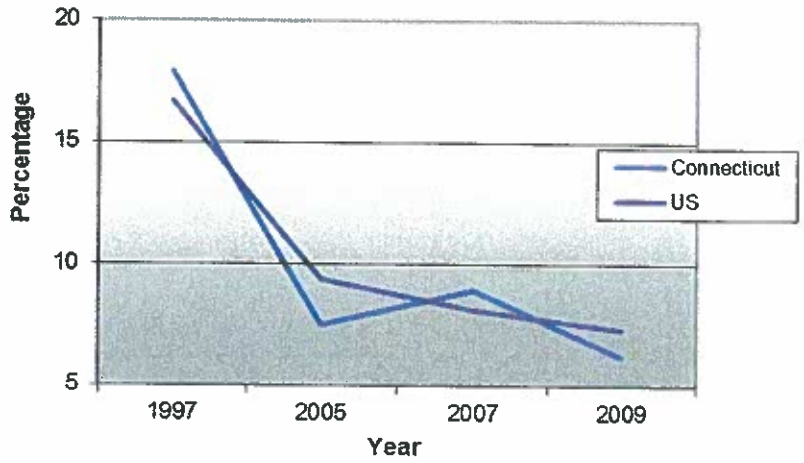
- Men are slightly more likely to smoke than women (15.4% versus 11.1%).
- Younger adults, age 18-24 (20.4%), are much more likely to smoke than older adults (25-34 years: 18.5%, 35-44 years: 13.0%, 45-54 years: 12.5%, 55-64 years: 13.2%, and 65+ years: 5.0%).
- Hispanic/Latinos (14.0%) are more likely to smoke than whites or Black/African-Americans (13.4% and 9.9% respectively). The percent of Black/African-American smokers decreased dramatically from 21.7% in 2007 to 9.9% in 2010.
- People with lower incomes are much more likely to smoke than those with higher incomes (< $15,000: 23.7%, $15,000-24,999: 24.2%, $25,000-34,999: 17.8%, $35,000-49,999: 20.5%, and >$50,000: 9.4%).
- Adults with a lower education are much more likely to smoke than those with more education (< high school: 24.2%, high school or GED: 19.3%, some post high school: 16.6%, and college graduate: 6.9%).
- Among female high school students in the 12th grade, whites are more likely to smoke.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Tobacco Use, cont'd.

Figure 24: Percentage of students in grades 9 - 12 who smoked cigarettes on 20 or more days during the 30 days before the survey, 1997-2009



Source: Centers for Disease Control and Prevention Youth Risk Behavior Surveillance System, http://apps.nccd.cdc.gov/yrbss, accessed 4/7/2011

Findings: Although tobacco use has been declining in Connecticut, use among youth is just slightly below the national average. Data indicate a need for interventions targeted toward younger, less-educated, and lower-income adult audiences and teenage girls.

Alcohol Use

A major issue with alcohol use is binge drinking. Binge drinking — drinking to get drunk — is defined as consuming five or more drinks in a row for males and four or more drinks in a row for females. Binge drinking is especially a problem for young drinkers and can result in unintentional injuries and death. The drinker may be unable to make rational decisions, may be more likely to engage in acts of violence or be a victim, and more likely to be in a motor vehicle accident.

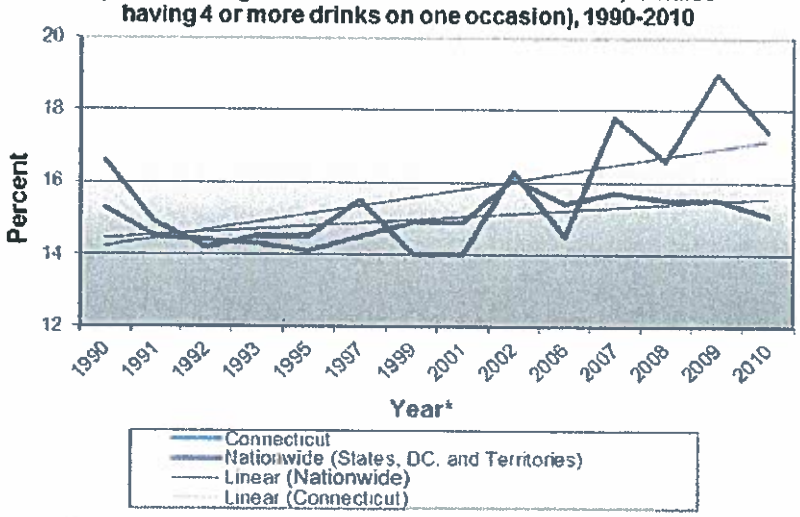
Although alcohol use is decreasing, binge drinking is increasing. The rate of binge drinking spiked in 2002 and in 2007, and reached almost 20% in 2009. The Connecticut Legislature changed the underage drinking laws in 2006 to include prosecution for underage drinking on private property in addition to public places specifically to address this problem. When compared with the nation, Connecticut has been close to the national average. In 2007, the percentage of binge drinking increased in Connecticut, surpassing the national average and it has since continued to be above the national average. People with an income of $30,000 or more and those with a high school degree or some college are likely to participate in binge drinking. Males are twice as likely as females (23.9% versus 11.5%); young adults (age 18-24) are twice as likely as 25-34 year olds and 9 times more likely than those over age 65; and Hispanic/Latinos are more likely to binge drink. Binge drinking interventions should focus on college students and younger adults in the work force.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Alcohol Use, cont'd.

Figure 25: Binge Drinkers (males having 5 or more drinks on one occasion, females having 4 or more drinks on one occasion), 1990-2010



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, Accessed 6/9/2011
* Data were not available for all years

Alcohol-related hospitalizations, whether into the emergency department for acute intoxication or into the inpatient unit for alcohol withdrawal and alcohol-related consequences, have risen slightly or are leveling off in most communities as Figure 26 illustrates. The exception to this is the rise in alcohol-related hospitalizations in Danbury in 2008 and in Bethel in 2010. The Danbury numbers remained high for 2009 and 2010.

Missing from alcohol-related hospitalizations is data on the lengths of stay and readmission rates, which would reveal a more important story regarding both the severity of those with alcohol-related problems and the success or lack thereof regarding access and response to treatment for those problems upon discharge.

Findings: Certain community characteristics could help to explain the higher rates of alcohol-related hospitalizations in Danbury and Bethel. When compared to the other towns, Danbury and Bethel have the lowest median incomes, have school districts in lower District Reference Groups (DRGs), and, in 2006, had higher numbers of liquor permits per square mile. (Sources: Connecticut State Department of Education, http://www.sde.ct.gov/sde/LIB/sde/PDF/dgm/report1/cpse2006/appndxa.pdf and University of Connecticut Health Center, Department of Mental Health and Addiction Services, http://www.commed.uchc.edu/healthservices/sew/files/SI_MAP_Compendium.pdf accessed 9/2/2011).

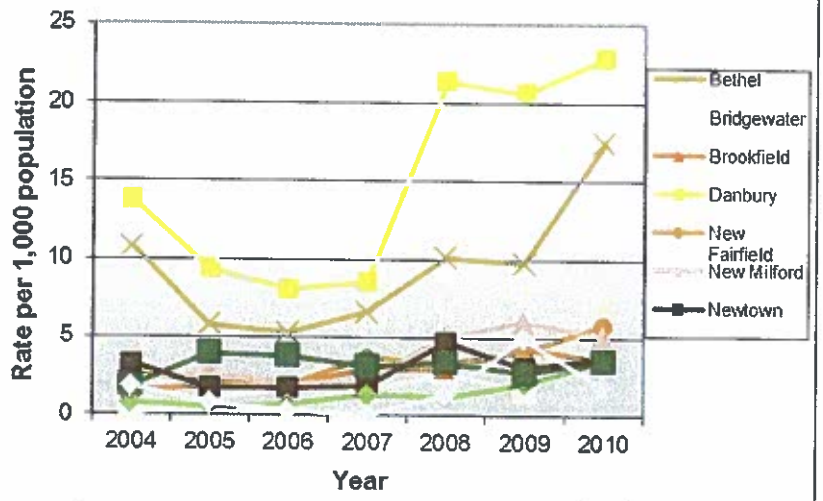
Changes in the underage drinking laws could be a catalyst for increased use of emergency department services for intoxication. In addition, Danbury Hospital closed its detoxification center in 2008 and Midwestern Connecticut Council on Alcoholism (MCCA) opened an outpatient center in Danbury and transitional centers (one in Bethel and one in Danbury). The increased use of the hospital emergency department could potentially be a result of transports from the MCCA facilities to the hospital. (Source: Sharon Guck, Director CHOICES Program, WCSU, personal communication 9/1/2011).

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Alcohol Use, cont'd.

Figure 26: Alcohol-related Hospitalizations per 1,000 population*, FY 2004-2010

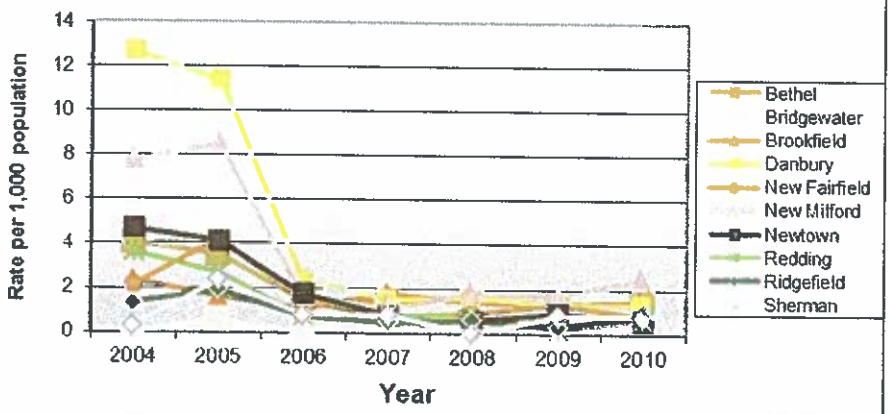


Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Drug Use

Figure 27 indicates a decline in drug-related hospitalizations for Danbury residents and a slight decline or leveling for the other HVR communities.

Figure 27: Drug-Related Hospitalizations per 1,000 Population*, FY 2004-2010



Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Findings: As Figure 27 demonstrates, overall there has been a substantial decline in drug-related hospitalizations for residents in the region from 2004-2006; with trends remaining relatively stable since 2007.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse

Although child abuse is not a lifestyle behavior or risk, it may be the outcome of other health and lifestyle factors, such as substance abuse. The term "child abuse" encompasses definitions categorized by two headings: abuse and neglect. The Connecticut Department of Children and Families (DCF) defines abuse as a non-accidental injury to a child that, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care. This abuse primarily includes physical and sexual abuse. Neglect is the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education. A child is defined as anyone younger than 18. Table 13 presents the 2010 Census tally of children aged 18 and under in each town, the state of Connecticut, and the nation.

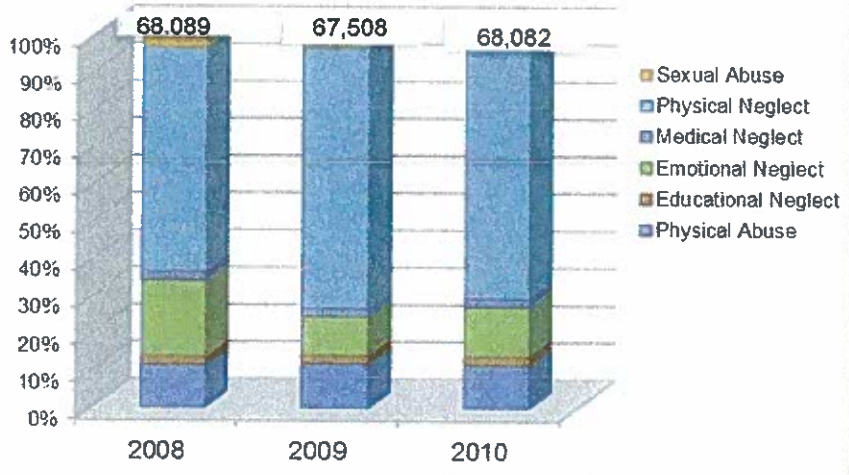
Table 13: Percent of Total Population Aged 18 and Under, 2010

Town	Percentage	Town	Percentage
Bethel	25.70%	New Milford	23.07%
Bridgewater	17.83%	Newtown	27.28%
Brookfield	25.47%	Redding	26.52%
Danbury	19.09%	Ridgefield	30.93%
New Fairfield	27.65%	Sherman	24.68%
Connecticut	22.74%	U.S.	23.69%

Source: Calculated based on data retrieved from Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Figure 28 shows statewide data on child abuse for 2008 through 2010 and presents the number of substantiated child abuse allegations per type of abuse for the state.

Figure 28: Number of Statewide Allegations to DCF, 2008-2010



Source: State of Connecticut Department of Children and Families, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf accessed 4/3/2011

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Our community's statistics indicate that, for the most part, HVR municipalities fall below the state's average for the percent of children with substantiated allegations of child abuse. According to Childhelp®, the national average on a yearly basis of substantiated child abuse reports is 12.3 per thousand children. This mirrors the child abuse rates in our community. It is important to note that both local and national statistics reflect only child abuse cases that are reported. Experts estimate that the actual number of child abuse cases is three times higher than those reported. (Source: ChildHelp®, National Child Abuse Statistics, http://www.childhelp.org/pages/statistics accessed 8/6/2011).

Table 14 provides local data for child abuse claims for the community for 2009-2010. The table indicates the total child abuse allegations, the substantiated allegations, and the substantiation rate for the entire state. This data is not available for all towns each year.

Table 14: Child Abuse Cases Reported to Department of Children and Families, 2009 - 2010

Community	Total	Substantiated	Number of Children Substantiated	Substantiation Rate	Percent of Children[1]
2009					
Bethel	146	26	19	18.0%	0.10%
Bridgewater					0.00%
Brookfield	77	22	13	29.0%	0.08%
Danbury	1,134	262	180	23.0%	0.23%
New Fairfield	81	20	12	25.0%	0.09%
New Milford	358	80	44	22.0%	0.15%
Newtown	117	20	14	17.0%	0.05%
Redding					0.00%
Ridgefield	104	24	16	23.0%	0.07%
Sherman	9	--	--	--	--
Connecticut	67,508	19,495	9,828	29%	0.28%
2010					
Bethel	183	56	40	31.0%	0.22%
Bridgewater					0.00%
Brookfield	89	16	11	18.0%	0.07%
Danbury	1,038	291	197	28.0%	0.25%
New Fairfield	98	35	23	36.0%	0.16%
New Milford	344	77	42	22.0%	0.15%
Newtown	125	34	21	27.0%	0.08%
Redding					0.00%
Ridgefield	120	18	14	15.0%	0.06%
Sherman					0.00%
Connecticut	68,082	19,315	9,873	28%	0.28%

Source: CT Department of Children and Families town pages, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf accessed 4/3/2011
Notes: For confidentiality reasons, data for towns with 10 or less Children Substantiated as Abuse/Neglect/Uncared For will not be reported as an individual town
Data are reported for Department of Children and Family's Fiscal Year (July 1 - June 30)
[1]Based on 2007 population estimates from Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/Projections.html, accessed 1/9/2009

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Findings: While there should be zero tolerance for any incident of child abuse, the data indicates that local substantiation rates (the number of reported incidents substantiated) are in line or better and the rate of substantiated is lower for our region than for Connecticut as a whole.

Diseases: Indicators and Findings

The incidence and prevalence of infectious and chronic diseases are major indicators of personal and community health. The 2009 Community Report Card for Western CT identified selected infectious diseases of high interest in our region including: Tuberculosis (TB), HIV/AIDS, Sexually Transmitted Diseases (STDs), and tick-borne illnesses. Chronic diseases identified as high interest include: asthma, diabetes, cancer, and cardiovascular disease. Although this is not an exhaustive list of diseases of concern to our community, it represents selected conditions of high interest to monitor improvements in health over time.

The data and narrative which follow provide an update of the impact of these diseases in the community – including such factors as hospitalization rates, incidence, prevalence, and mortality (death) rates. The results of disease-specific surveillance reports for the state and municipalities in our region are also included as relevant to these selected diseases. Examination of the diseases most impacting health is important to determining methods to minimize premature illness and death by enhancing primary, secondary, and tertiary prevention efforts targeted to priority health concerns.

Chronic Diseases

Cardiovascular Disease, Cancer, and Diabetes

These three chronic diseases are leading causes of death in the country, state, and region. Risk for developing these diseases can be greatly reduced through healthy lifestyle choices.

Table 15: Number of Deaths per 100,000 Population, 2005-2007

	2005			2006			2007		
	Diabetes[1]	Heart Disease[2]	Cancer[3]	Diabetes[1]	Heart Disease[2]	Cancer[3]	Diabetes[1]	Heart Disease[2]	Cancer[3]
Connecticut	20	173	179	19.2	177.3	177.8	15.8	171	170.7
United States	25	211	184	23.3	200.2	180.7	22.5	190.9	178.4

Source: Data were retrieved from : http://statehealthfacts.org/ accessed 4/1/2011, the following were the primary sources for these data:
[1] Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 2005, Series 20 No. 2K, 2008.
[2] Source: The Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 56, Number 10, April 24, 2008, Table 29. Available at http://www.cdc.gov/nchs/pro Note: Cerebrovascular disease or stroke deaths are not included in Heart Disease rates.
[3] Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 1999-2005, CDC WONDER On-line Database

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Cardiovascular Disease, Cancer, and Diabetes, cont'd.

Cardiovascular diseases (CVD) are the leading cause of death in the United States and world-wide. Cardiovascular diseases include coronary heart disease (CHD), cerebrovascular disease (stroke), and heart failure. CVD is the leading cause of death in Connecticut, accounting for about one-third of all Connecticut resident deaths. More than half (55%) of these deaths are among females. Risk factors for CVD may be modifiable or non-modifiable. Modifiable risk factors include high blood pressure, high blood cholesterol, smoking, diabetes, obesity, and physical inactivity. Non-modifiable risk factors include increasing age and family history of heart disease and stroke. The age adjusted mortality rates for CVD declined significantly for CT residents from 1999-2008. There are considerable disparities in mortality from CVD, with Black/African American residents having the highest age-adjusted mortality rates. (Source: State of Connecticut, Department of Public Health, the Burden of Cardiovascular Disease in Connecticut, 2010 Surveillance Report, http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf accessed 8/21/2011).

The second leading cause of death in the United States and Connecticut is cancer. The death rate and the annual rate of new cancer cases have been decreasing. This is the result of increased primary prevention efforts, earlier detection (secondary prevention) and improved treatment options. (Source: State of Connecticut, Department of Public Health, Connecticut Comprehensive Cancer Control Program, Connecticut Cancer Plan 2009-2013, http://www.ct.gov/dph/lib/dph/comp_cancer/pdf_files/ctcancerplan_2009_2013_cdversion.pdf accessed 8/21/2011).

In 2008, the age-adjusted cancer incidence rate in Connecticut was estimated at 499.8 per 100,000 people, a decrease from the 2007 rate of 502.5 per 100,000 people. (Source: National Cancer Institute, State Cancer Profiles, http://statecancerprofiles.cancer.gov/ accessed 8/21/2011). As noted in the CT DPH *2009 Connecticut Health Disparities Report*, Black/African American residents have the highest cancer mortality rate, followed by white residents. Hispanic/Latino and Asian/Pacific Islander residents have the lowest cancer mortality rates.

In 2008, diabetes was the eighth leading cause of death in Connecticut. In Connecticut (2007-2009 data), an estimated 6.9% or approximately 186,000 adults aged 18 and older reported being diagnosed with diabetes. An additional 93,000 adults are estimated to have undiagnosed diabetes. The prevalence of type 2 diabetes in Connecticut and in the nation has increased significantly. This is the most common form of diabetes and was previously known as adult onset diabetes. Type 2 diabetes typically develops later in life and is strongly linked to overweight and obesity. In type 2 diabetes, either the body does not produce enough insulin or the cells ignore the insulin. In contrast, type 1 diabetes is usually diagnosed in children and young adults, and was previously known as juvenile onset diabetes. Type 1 diabetes, the body does not produce insulin.

Risk factors for diabetes are both modifiable with primary prevention (physical activity and healthy eating) and non-modifiable (genetic). In addition to practicing healthy lifestyle behaviors, persons with insulin-dependent diabetes must control their diabetes with medication. The impact of diabetes on a person's health can be minimized with regular medical care and self-monitoring of blood glucose levels. (Source: State of Connecticut, Department of Public Health, the Burden of Diabetes in Connecticut, 2010 Surveillance Report, http://ct.gov/dph/lib/dph/hisr/pdf/2010diabetesburden_final.pdf accessed 8/21/2011).

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Cardiovascular Disease, Cancer, and Diabetes, cont'd.

As stated in the *2009 Connecticut Health Disparities Report*, lower income and Hispanic/Latino and Black/African American residents have a higher prevalence of diabetes and a higher mortality rate from this disease.

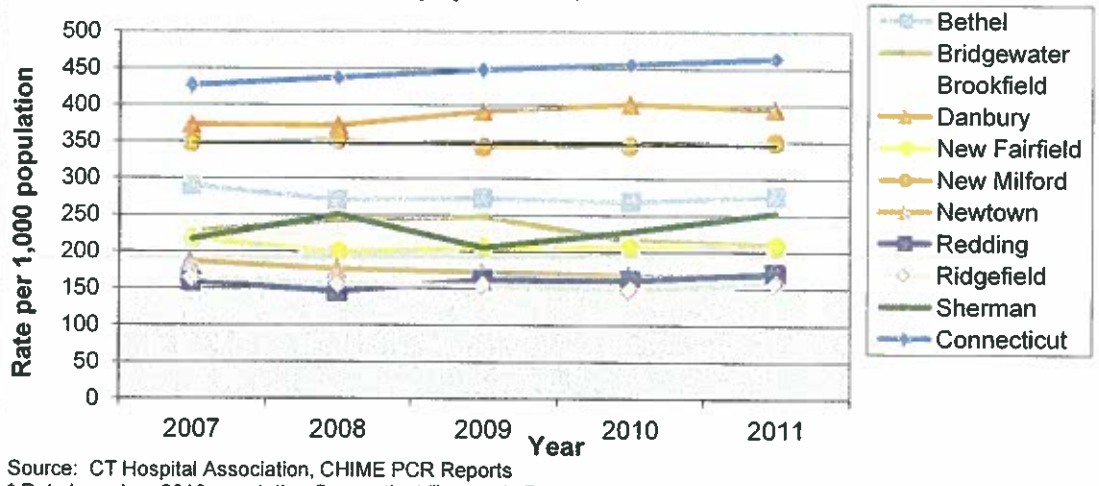
Findings: CT age-adjusted rates for Heart Disease, Cancer, and Diabetes compare favorably with those for the U.S. as a whole, however the rates for Cancer and Heart Disease remain above *Healthy People 2020* targets. Due to their prevalence, these conditions are major causes of premature disability and death, and result in significant health care costs. Disparities in disease prevalence and mortality rates by racial/ethnic group and socioeconomic status are also evident.

Asthma

Asthma is a chronic respiratory condition that inflames the airways which restricts the flow of air in and out of the lungs. Asthma is one of the most common chronic diseases in children, and a major cause of school absenteeism. Asthma is associated with exposure to allergens, indoor pollutants (such as tobacco smoke), and ambient air pollutants. Asthma is more common in persons living in poverty. These individuals are generally less likely to receive regular or specialized medical care, and are more likely to smoke and live in substandard housing, therefore experiencing greater exposure to asthma irritants. (Source: American Lung Association. http://www.lung.org/lung-disease/asthma/, accessed 2/20/12).

Figure 29 provides local data for asthma-related hospital emergency department visit rates for the years 2007 to 2011. The rates have remained relatively consistent over time. The rates in Danbury and New Milford are higher than those for other HVR municipalities, however all HVR rates fall below those for the state.

Figure 29: Asthma-Related Emergency Department Visits per 1,000 population*, 2007-2011



Source: CT Hospital Association, CHIME PCR Reports
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Asthma, cont'd.

As reported by CT DPH in the *Connecticut School-based Asthma Surveillance Report for 2010*, asthma prevalence rates among Connecticut public school students have remained fairly constant since 2006, measured most recently at 13.1% for school year 2008-2009. Asthma prevalence rates during this time were higher among students in grade PK or K than for students in either grades 6-7 or grades 9-11 and higher among male students than female students. For example, during the school year 2008-2009, the asthma rates were 14.5% among male students and 11.6% among female students.

Students from racial and ethnic subgroups experienced different rates of asthma during this same time period. Hispanic/Latino students had the highest rates of asthma followed by Black/African American students, other race/ethnicity students, and white students. Specifically, during 2008-2009, the asthma rates were 16.9% among Hispanic/Latino students, 14.8% among Black/African American students, 12.2% among students of other race/ethnicity, and 10.6% among white students. In general, asthma rates increased with decreasing socioeconomic status as measured by school District Reference Group or DRG. Asthma prevalence rates by public school district for HVR communities are provided in Table 16.

Table 16: Asthma Prevalence Rates by School District, 2006-2009 Average

Town	Percentage	Town	Percentage
Bethel	12.4%	Newtown	10.4%
Brookfield	9.7%	Redding	8.5%
Danbury	11.2%	Ridgefield	6.8%
New Fairfield	9.4%	Sherman	13.5%
New Milford	15.2%	Connecticut	13.2%

Source: CT DPH Connecticut School-based Asthma Surveillance Report 2010 http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/schoo_base_asthma_surveillance_report_2010.pdf, assessed 2/20/12 Note: Bridgewater is included in Region 12.

Findings: Asthma tends to be more prevalent in urban areas, so it is expected that Danbury and New Milford would have the highest emergency department visit rate in our region. The rates for all HVR municipalities are consistently lower than the rate for the state.

Asthma prevalence in school children is higher than the state three year average in two HVR communities – New Milford and Sherman. As Sherman is a rural and relatively affluent K-8 district, this higher rate may reflect the younger age distribution of students in the district.

Diseases: Indicators and Findings, cont'd.

Infectious Diseases

Tuberculosis

Tuberculosis (TB) is a disease caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, however TB bacteria can attack any part of the body. Tuberculosis remerged as a public health issue in the 1980's, peaking in 1992. In 2010, 60% of reported TB cases in the United States occurred in foreign-born persons. There are a number of foreign countries which are endemic for Tuberculosis, most notably in sub-Saharan Africa and Asia. The case rate among foreign-born persons (18.1 cases per 100,000) in 2010 was approximately 11 times higher than among U.S.-born persons (1.6 cases per 100,000). In 2010, both the number of TB cases reported and the case rate decreased compared to 2009. In 2010, the number of reported TB cases in 2010 was the lowest recorded since national reporting began in 1953. CT's TB case rate ranked 24th out of the 50 states in 2010. (Sources: Centers for Disease Control and Prevention. Reported Tuberculosis in the United States, 2010 http://www.cdc.gov/tb/statistics/reports/210/table20.htm and Trends in Tuberculosis, 2010 http://wwwcdc.gov/tb/publications/factsheets/statistics/TBTrends.htm, accessed 2/21/12.)

Tuberculosis is associated with poverty and substandard, crowded living conditions. The bacteria are released into the air when a person with active TB coughs or sneezes. Co-infection in persons with human immunodeficiency virus (HIV) infection is also a concern as the condition thrives in individuals with compromised immune systems.

Table 17: Annual TB Incidence by City and Year, 2005 - 2010

	2005	2006	2007	2008	2009	2010*
Bethel	0	0	0	0	1	1
Bridgewater	0	0	0	0	0	0
Brookfield	0	0	0	0	0	0
Danbury	6	6	11	4	4	7
New Fairfield	0	0	1	0	0	0
New Milford	0	0	1	0	0	0
Newtown	0	0	0	0	1	0
Redding	0	0	0	0	0	0
Ridgefield	0	0	0	0	0	0
Sherman	0	0	0	0	0	0
State	95	89	108	98	95	85

Sources: Connecticut Department of Public Health. http://www.ct.gov/dph/lib/dph/CityByYear2000_2009.pdf. accessed 4/3/2011 and CDC Reported Tuberculosis in the United States, 2010 http://www.cdc.gov/tb/statistics/reports/2010/table20.htm, accessed 12/20/12

* Local TB clinic data received from Maureen Singer, R.N., City of Danbury TB Clinic. Personal communication with Andrea Rynn 5/11/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tuberculosis, cont'd.

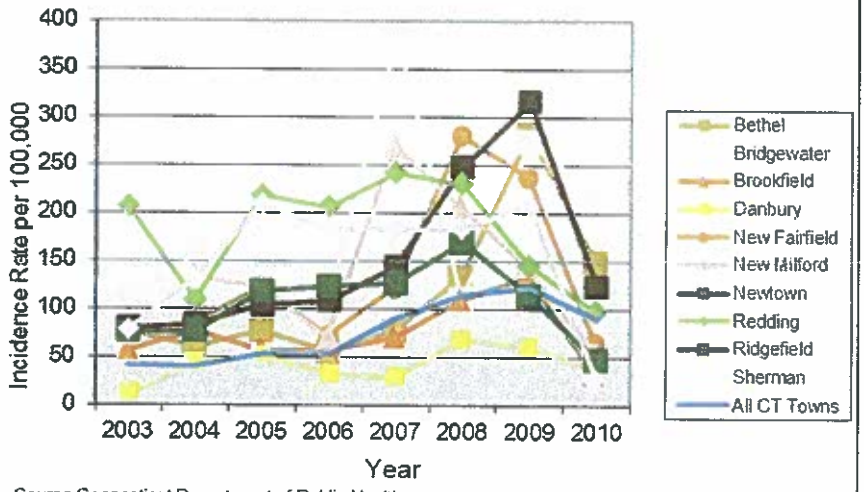
Findings: It appears that tuberculosis is not a major health issue in the HVR except in Danbury. "Danbury continues to have a higher incidence of tuberculosis than either the state as a whole or the nation at large. Most of the Danbury cases have occurred in persons born in Latin America or Asia who acquired a latent infection while resident in their home country which then reactivated some time after arrival in the U.S. Because there are large populations in Danbury from Brazil, Ecuador and Indochina at risk of reactivation TB as they age, the community is likely to continue to experience TB cases well into the future. This problem may well be augmented by travel and visitation to the home countries where the disease remains prevalent." (Source: Scott LeRoy, Director of Health, Danbury Health and Human Services Department, email communication received August 16, 2011).

Tick-Borne Illness

Our region has a higher rate of tick-borne illness than most other geographic areas in the nation. There are also extremely high rates reported in neighboring Hudson Valley New York counties. There are many varieties of tick-borne diseases but this report will focus on three: Lyme disease, Ehrlichiosis, and Babesiosis. The positive news is that effective precautions can significantly reduce the risk of contracting these illnesses.

According to CDC, Lyme disease is caused by the bacterium *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks. In Ehrlichiosis is also transmitted to humans by the bite of an infected tick. The lone star tick (Amblyomma americanum) is the primary vector of both *Ehrlichia chaffeensis* and *Ehrlichia ewingii* in the United States. Babesiosis is carried by blacklegged ticks infected with the *Babesia* parasite.

Figure 30: Lyme Disease Rates per 100,000 Population, 2003-2010



Source Connecticut Department of Public Health http://www.ct.gov/dph/cwp/view.asp?a=3136&Q=399694&dphPNavCtr=|46973|#48999 Accessed 4/3/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tick-Borne Illness, cont'd.

Untreated Lyme disease can potentially result in extremely serious health consequences. Some people infected with Ehrlichiosis may have symptoms so mild that they never seek medical attention, and the body fights off the illness on its own. But untreated Ehrlichiosis with persistent symptoms can result in serious illness as well. Most patients recover from Babesiosis with few, if any, lasting effects.

The Housatonic Valley Council of Elected Officials (HVCEO) has endorsed the tick-borne disease prevention program called "BLAST" in all 10 HVCEO municipalities. The Ridgefield Health Department received a grant from the Connecticut Department of Public Health to create this unique health education program in 2008. BLAST stands for the five most important things families can do to stay safe from tick-borne illness (Bathe within two hours of outdoor activity, Look for ticks and rashes daily, Apply repellents to skin and clothing, Spray the yard perimeter for ticks, and Treat pets with veterinarian recommended products). The BLAST Program includes printed materials, age-appropriate power point presentations and health fair display materials in both English and Spanish. Trained community volunteers are available year round to staff community and corporate wellness events. Complete information about the program is available on the Town of Ridgefield website: www.ridgefieldct.org.

In addition, Western Connecticut State University is the setting for an annual Spring Lyme disease patient seminar and health fair coordinated by area task forces and Rotary Clubs. The event recognizes May as Lyme Awareness month and features practitioners and resources that may be helpful to this patient population. Lyme patients are also served by the Ridgefield Visiting Nurse Association's Lyme, Chronic Fatigue and Fibromyalgia Support Group. This free drop-in group, which is open to all area residents, meets at noon on the second Thursday of each month. Details can be found at www.ridgefieldvna.org under Community Wellness. A complete listing of local tick-borne disease related events, support services and resources can be found on the HVCEO Tick-Borne Illness Prevention Center website at www.hvceo.org/lymemain.php.
(Source: Jennifer Reid, BLAST Program Coordinator, e-mail communication received 8/31/2011).

The Western Connecticut Health Network's Biomedical Research Institute currently operates the state's only Lyme Disease Registry. The purpose of the Registry is to create a comprehensive database of Lyme disease patients to support multidisciplinary research leading to a better understanding of: 1) the course of disease and how people are affected; 2) causes of persistent symptoms; and 3) improved diagnosis and treatment. The Registry is seeking persons ages 5 and older who have been diagnosed with Lyme by a health care provider. Participants are asked to answer questions about their symptoms and treatment and provide a blood sample. Participation is free, voluntary, and strictly confidential. Only one visit is required; all follow-up is conducted by mail or email. For more information or to participate, contact the Registry at 203-739-8383 or by mail: lymeregistry@danhosp.org.

Findings: The data in Figure 30 show that Lyme disease is a prevalent health concern in the region; preventive health education initiatives are underway. Figure 31 graphically depicts the number of new Lyme disease cases reported across the country. It is evident that Lyme disease remains a priority health issue in our region.

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tick-Borne Illness, cont'd.

Figure 31
Reported Cases of Lyme Disease -- United States, 2010

Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs)

These conditions are preventable through education and safe sex practices. Injection drug use and risky sexual practices, including prostitution, are contributing factors in many HIV and STD cases. STD cases are on the rise nationally among high school students.

At a national level, the estimated number of HIV cases in 2009 as reported in 40 states with confidential name-based HIV infection reporting was 42,011 (rate of 17.4 per 100,000 population). This represents a slight increase from 2008 (42,005 cases). During the same year, the estimated number of cases of AIDS in the United States and dependent areas was 34,247 (rate of 11.2 per 100,000 population), a decrease from 2008 (34,755 cases). (Source: Centers for Disease Control and Prevention, HIV/AIDS Statistics and Surveillance, http://www.cdc.gov/hiv/topics/surveillance/index.htm accessed 8/13/2011). As shown in Table 18, Danbury has the largest number of residents living with HIV/AIDS in the region.

Table 18: HIV/AIDS Surveillance Program HIV and AIDS Cases Reported by City/Town of Residence 2009 and cumulative from 1980 through December 31, 2009*

	HIV/AIDS			
	Incidence[1] 2009	1980-2009	Living with 2009 [2]	Living with 2008 [2]
Bethel	1	29	21	20
Bridgewater	0	2	1	1
Brookfield	1	21	11	10
Danbury	9	407	215	224
New Fairfield	1	13	4	6
New Milford	0	54	24	29
Newtown	0	4	3	12
Redding	1	19	8	10
Ridgefield	0	22	13	13
Sherman	0	6	1	1
ALL CT Towns	538	19,473	10,574	10,860

*HIV and AIDS data are combined for 2009. The data were reported separately in previous years
[1]Current year data are new cases for the year.
[2]This number includes all cases from 1980 to current year still living.
Source: Connecticut Department of Public Health.
http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/city_and_county/ct_hivaids_town_currentyear_table_new.pdf, Accessed 4/3/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs), cont'd.

According to CDC, Chlamydia is the most commonly reported sexually transmitted disease in the United States with 1,244,180 cases in 2009 (409.2 per 100,000 people), increased 3% from 2008 and 19% from 2006. Gonorrhea is the second-most commonly reported STD with 301,174 cases in 2009 (99.1 cases per 100,000 people). Nationally, Gonorrhea rates declined 10% since 2008 and are at the lowest level since tracking began in 1941. Although the number of cases of primary and secondary syphilis is much lower (13,997 in 2009), the rate has been increasing. The national rate per 100,000 people is 4.6 for 2009, an increase of 5% from 2008 and 39% since 2006. (Source: Centers for Disease Control and Prevention, STD Surveillance, 2009 http://www.cdc.gov/std/stats09/default.htm accessed 8/13/2011).

Table 19 shows the cases of Chlamydia, Gonorrhea, and Syphilis as reported by the Connecticut STD Control Program for 2007 and 2009. The largest increase in the number of Chlamydia cases was reported in Danbury residents; the largest increase in Gonorrhea cases was reported in Bethel residents. Fortunately, there were no Syphilis cases reported in the region in 2009.

Table 19: Chlamydia, Gonorrhea, and Primary and Secondary Syphilis Cases by HVR Municipality and CT, 2007 and 2009

	2007				2009			
	Chlamydia cases	Gonorrhea cases	Syphilis cases	Total Cases	Chlamydia cases	Gonorrhea cases	Syphilis cases	Total Cases
Bethel	22	0	0	22	19	20	0	39
Bridgewater	0	0	0	0	0	0	0	0
Brookfield	10	1	0	11	8	1	0	9
Danbury	131	17	0	148	197	9	0	206
New Fairfield	10	0	1	11	11	2	0	13
New Milford	20	1	0	21	37	3	0	40
Newtown	6	3	1	10	17	1	0	20
Redding	4	0	0	4	6	0	0	6
Ridgefield	9	1	0	10	9	1	0	10
Sherman	0	0	0	0	3	3	0	6
State Total	11,512	2,332	39	13,883	12,136	2,554	65	14,755

Source: CT Department of Public Health. http://www.ct.gov/dph/lib/dph/infectious_diseases/std/std_city.pdf, Accessed 4/1/2011

Findings: Six of the 10 HVR municipalities have experienced an increase in the number of STD cases; Danbury has seen the largest increase in absolute numbers.

Diseases: Indicators and Findings, cont'd.

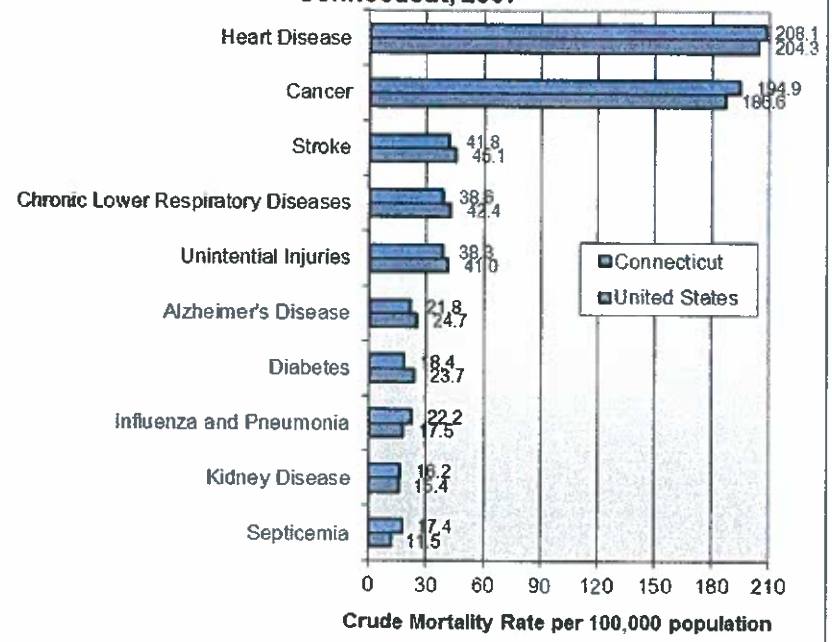
Leading Causes of Death and Mortality Rates

Examination of the leading causes of death and other mortality data is essential to assessing and monitoring the health of a community. This information is also critical to identify priority needs for programs and services to prevent or reduce premature death and disability from chronic diseases and injury.

Figure 32 presents the leading causes of death in the United States and Connecticut for 2007. Table 20 shows the leading causes of death in our community and Connecticut for 2005-2009.

Although the 10 causes of death are not in the same rank order for each community, the underlying causes of death are chronic conditions which are related to behavioral risk factors. Efforts should be focused on supporting health-promoting behaviors along with awareness education and skill-building. This is especially true of physical activity; healthy eating; avoiding tobacco use, alcohol abuse, and illicit drugs; managing stress; and other preventive lifestyle behaviors.

Figure 32: Leading Causes of Death United States and Connecticut, 2007



Source: Centers for Disease Control and Prevention, National Center for Health Statistics http://www.cdc.gov/nchs/data/dvs/LCWK9_2007.pdf, accessed 4/3/2011

Updated data from the National Center for Health Statistics for the 10 leading causes of death in CT residents reveal that the rank order (from first to last) in 2009 was the same as that shown in Figure 32 with the exception of kidney disease now ranked as the 9th leading cause and septicemia as the 10th leading cause. It is noteworthy that there are differences in the rank order of the leading causes of death by gender and race/ethnicity. For example, the leading cause of death for males of all races/ethnicities in CT is cancer and for females it is heart disease. For both White males and females, the leading cause of death in 2009 was heart disease, followed by cancer. For

Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates, cont'd.

Black/African American and Hispanic/Latinos residents, the leading cause of death was cancer for both genders, followed by heart disease. (Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe, accessed 2/23/12.)

Table 20: Leading Causes of Death, 2005-2009 Average Crude Rate[1]

Community	Heart Disease	Cancer	Stroke	Chronic Lower Respiratory Diseases	Unintentional Injuries	Alzheimer's Disease	Diabetes	Influenza and Pneumonia	Kidney Disease	Septicemia	Suicide	Chronic Liver Disease and Cirrhosis
Bethel	169.2	158.3	28.2	45.6	29.3	9.8	13.0	17.4	9.8	14.1	7.6	4.3
Bridgewater	157.8	218.4	12.1	36.4	-	12.1	48.5	-	36.4	24.3	-	24.3
Brookfield	162.5	163.7	25.7	36.6	22.0	15.9	14.7	8.6	9.8	13.4	7.3	7.3
Danbury	166.7	154.0	24.6	32.3	26.4	13.0	16.8	12.5	9.1	14.5	8.6	7.6
New Fairfield	121.1	122.5	18.5	21.4	31.3	17.1	11.2	15.7	4.3	19.6	8.5	7.1
New Milford	235.6	156.8	28.8	37.3	30.9	28.1	11.3	19.0	8.4	16.2	7.7	10.5
Newtown	141.7	165.7	28.5	29.2	28.5	12.0	9.0	13.5	11.2	10.5	7.5	1.5
Redding	210.1	210.1	59.4	34.3	36.5	36.5	2.3	20.6	9.1	18.3	11.4	9.1
Ridgefield	134.7	135.5	29.3	23.4	20.9	14.2	10.9	12.5	10.9	9.2	5.0	2.5
Sherman	107.7	142.0	29.4	14.7	14.7	19.6	9.8	4.9	4.9	9.8	14.7	9.8
Connecticut	209.0	195.7	42.0	41.1	36.0	22.1	19.8	22.2	16.3	16.8	8.1	8.1

Source: Connecticut Department of Public Health Epidemiology Program, email communication 2/24/12
[2] Crude mortality rates were used for this table since the age-adjusted mortality rates were not available for all causes of death

It is important to note that Figure 32 and Table 20 reflect crude mortality rates, which have not been age-adjusted. Crude mortality rates are useful to assess the magnitude of the number of deaths in a community, however they do not account for differences in rates that are attributable to differences in the age composition of the resident population. For example, communities with a higher proportion of older residents, such as Bridgewater, would be expected to have higher mortality rates from chronic diseases, as the incidence and prevalence of these diseases increase with age. Age-adjusted mortality rates (AAMR) correct for differences in age distribution of communities, and therefore give an accurate representation of excess disease mortality. In 2008, CTDPH published two reports of age-adjusted town-state comparisons for the ten leading causes of death in CT residents for the time period 2002-2006. These reports can be accessed at www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/pdf/aamr_comparisons_2002_2006.pdf and www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/pdf/lcod_2002-2006_aamr.pdf.

Statistically significant findings from 2002-2006 of relevance to HVR municipalities include:

- Bethel, Brookfield, New Milford, and Newtown had a *higher AAMR from all causes* for both genders combined compared with the state as a whole.
- Bethel and Newtown had a *higher AAMR for all causes for males* compared with males in the state as a whole.

Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates, cont'd.

- Bethel had a *higher AAMR for Major Cardiovascular Diseases and Diseases of the Heart for males* compared with males in the state as a whole.
- Danbury had a *higher AAMR for Coronary Heart Disease for both genders* combined compared with the state as a whole.
- Danbury had a *lower AAMR for Congestive Heart Failure for both genders* combined and for females compared with the state as a whole.
- New Milford had a *lower AAMR for Diseases of the Heart for both genders* combined compared with the state as a whole.

Updated age-adjusted mortality data provided by CTDPH for all causes of death by municipality for the five-year period 2005-2009 shows that the overall AAMR is *lower* than the state AAMR for the majority of HVR communities. The AAMR for all causes of death was lower than the state rate at statistically significant levels in Bethel, Bridgewater, Danbury, New Fairfield, Redding, and Ridgefield, and statistically higher than the state rate in New Milford.

Findings: When examining the leading causes of death in Connecticut and the U.S., data show HVR municipalities overall compare favorably, with some exceptions. Since 2000-2004, there has been a decline in the mortality rates for many the leading causes of death in the nation, state, and our region. However, the high prevalence of these conditions in the population warrants ongoing prevention efforts. Table 20 reflects crude death rates, which are statistically invalid for comparisons across communities. However, it is interesting to note that, based on crude mortality rates, Sherman, which has the second highest proportion of persons ages 50 and over in the region, had the lowest rates for heart disease, chronic lower respiratory diseases, unintentional injuries, and influenza/pneumonia. Data for 2005-2009 provided by CT DPH reflect a lower AAMR from all causes of death compared with the state in the majority of HVR municipalities.

Infant Mortality

Infant mortality is commonly used as an indicator of a community's health. The infant mortality rate typically varies from year to year in communities such as the HVR where there are a small number of infant deaths per year. Table 21 shows the number of infant deaths and rate of infant mortality in HVR communities from 2004 to 2006 and 2006 to 2008.

Diseases: Indicators and Findings, cont'd.

Infant Mortality, cont'd.

Table 21: Infant Mortality Rates in HVR Municipalities, 2004-2008

	2004-2006		2006-2008	
	Number	Rate	Number	Rate
Bethel	4	*	5	8.0
Bridgewater	0	0.0	0	0.0
Brookfield	1	*	1	*
Danbury	15	4.4	19	5.2
New Fairfield	2	*	2	*
New Milford	7	6.7	5	5.3
Newtown	0	0.0	0	0.0
Redding	0	0.0	0	0.0
Ridgefield	1	*	1	*
Sherman	2	*	0	0.0
Connecticut	717	5.7	753	6.2
United States (2006 & 2007)	28,527	6.7	29,138	6.8

Sources: Connecticut Association for Human Services Connecticut Kid Count http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011
Rate is per 1,000 live births
* Rates are not calculated for cases of less than 5 events

Findings: In general, the infant mortality rate in Connecticut has increased but is still lower than the national average. With the small number of events in our communities, the rates vary considerably, with no consistent trend.

Suicide Mortality

Suicide can have a profound effect on a community. At times, especially in the suicide of a young person, an entire community suffers from feelings of guilt over what might have been done to prevent it. The sense of community is equally jarred when an adult commits suicide. A community's behavioral health resources should be fully engaged in the healing and recovery process and in ongoing prevention efforts.

Key findings from a special report issued by CT DPH and previously summarized in the *2009 Community Report Card* are provided for reference.

- Suicide was the second leading cause of injury death in Connecticut accounting for 18.1% of all injury-related deaths between 2000–2004, with 1,396 suicide deaths, for an average of 279 suicides a year.
- The cities and towns with the highest number of suicide deaths among residents were Hartford (60), New Haven (51), Bridgeport (45), Waterbury (40), Meriden (34), New Britain (34), Bristol (31), Stamford (29), East Hartford (28), Danbury (27), and Fairfield (25).
- Overall, males completed suicide at a rate of four times

Diseases: Indicators and Findings, cont'd.

Suicide Mortality, cont'd.

higher than females and up to 11 times higher among the 65–69 age group reaching a peak rate of 30.2 per 100,000 males 85 years or older. Females experienced their highest suicide death rate between 45–49 years.

- Suicide rates were roughly twice as high among non-Hispanic Whites (8.7 per 100,000 population) as compared to either Hispanics (4.6 per 100,000 population) or non-Hispanic Blacks (3.9 per 100,000 population).

Prevention of suicide in youth and young adults remains a key health priority in CT. As stated in a 2009 CT Department of Mental Health and Addiction Services Report, *Youth Suicide: A Public Health Problem in CT*, suicide was the second leading cause of death for ages 10-14 and the third among people aged 15 to 24; however, it ranks second for college students. The 2007 CT Youth Risk Behavior Survey found that 15.1% (U.S =16.9%) of students seriously considered attempting suicide during the past 12 months; 13.8 % (U.S.=13.0%) of students made a plan about how they would attempt suicide during the past 12 months; and 12.1 % (U.S.=8.4%; statistically significant difference) of students actually attempted suicide one or more times during the past 12 months. (Source: Youth Suicide: A Public Health Problem in CT, http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/YouthSuicideCT.pdf, assessed 2/23/12).

More recent mortality data from the National Center for Injury Prevention and Control indicate that in 2009, suicide was the second leading cause of death both in youth ages 15-19 (15 deaths; 16%) and in young adults ages 20-24 (27 deaths; 15.7%). (Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe, accessed 2/23/12.)

Older Adult Health: Survey and Focus Group Findings

As previously noted in the Introduction Section, a key objective of the 2012 Report Card was to provide more in-depth insight on the health and social needs of older adult residents in our region. The Report Card Steering Committee identified four broad topics to enable public health, hospitals, human service providers, and the general public to better assess how older adults in the region exemplify the vision statement "Seniors in our communities are healthy and thrive".

- *Housing.* This includes availability of housing options, skilled nursing, assisted living, and hospice facilities.
- *Support Services.* This includes services which promote access to health care and human services, such as public transportation, fuel assistance, meals on wheels, senior centers, etc.
- *Quality of Life.* This includes demographics, socioeconomic status, social supports, recreation, and spirituality.
- *Physical and Mental Health.* This includes risk factors, disease (morbidity) and death (mortality) rates.

Assessment of older adult health and social needs in the region was accomplished through three methods – health surveys administered to senior volunteers, focus groups with older adults conducted at area senior centers, and a focus group with providers of services to older adults in the region. Key focus group questions were developed by Mhora Lorentson, Ph.D., and Mary Bevan, M.P.H, of *The Center for Healthy Schools and Communities at EDUCATION CONNECTION*, in consultation with Steering Committee leadership. The consumer and provider focus group sessions were professionally facilitated by Dr. Lorentson.

Older Adult Health Surveys

The health survey design team at WCSU reviewed published senior health report cards to select indicators for an Older Adult Health Survey. As previously mentioned, these included the Naugatuck Valley 2007 *Senior Needs Assessment*, *Seniors in Canada 2006 Report Card* and *Improving Health Literary for Older Adults, 2009.*

After selection of relevant indicators, Senior Center and Social Services Directors from HVR municipalities reviewed both the topics and the indicators. Feedback confirmed that key needs of older adults were covered satisfactorily within the four topic areas and the indicators were then finalized.

During the spring of 2011, the Older Adult Health Survey was administered to senior volunteers in the region to gain insight on current health needs and the availability of local services to meet these needs. Dr. Lorentson completed the analysis of survey data. Survey questions targeted key indicators of older adult health-related needs in each topic area. Four surveys were developed and administered and included both long and short versions, with and without questions relating to dental health. All questions on the short survey

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Health Surveys, cont'd.

versions were included on the long versions.

Survey administration occurred through a comprehensive process in which 91 locations for survey distribution were identified across the region. Twenty of these identified sites provided permission to administer the survey and completed surveys were received from only 10 sites. A total of 123 surveys were received with the majority of these surveys being completed by participants at a regional volunteer recognition luncheon. Although this is not a representative sample of the older adult population in the HVR, as community volunteers, survey respondents are potentially more aware of available services and service gaps.

Key Findings

Overall, data suggest that survey respondents are experiencing a variety of successes, needs and challenges related to their existing housing, support services, quality of life and physical and mental health. It is noted that, due to the limited and relatively homogenous sample, data cannot be assumed to be representative of older adults in the region. However, data provide a good understanding of the experiences of the 123 respondents and can serve as a baseline from which to further explore and examine the health-related needs of our older adult population, design and administer more representative health surveys and, in conjunction with other data summarized in the Community Report Card for Western CT, to further develop strategies to identify and address the priority health needs of our community.

Housing

Data suggest that the majority of respondents live alone or with a spouse or partner. The majority of respondents own their home, pay no mortgage payments, perceive their financial resources to be sufficient to pay for housing and living expenses all or most of the time, and feel very safe in their communities. It is noted that, due to the small and relatively homogeneous sample, these results are skewed in the direction of highly active, non-minority older adults who are involved in their communities. It is of particular note that, even given this homogeneous sample, there was a subgroup of respondents who still pay a mortgage or rent and experience financial challenges most or some of the time. Additionally, of the sample, almost one-third expressed that they feel only somewhat safe in their communities.

Older Adult Health: Survey and Focus Group Findings, cont'd.

Key Findings, cont'd.

Support Services

The majority of respondents appeared to have a social support network in place to at least some extent. Overall, participants were most likely to report the availability of emotional support and less likely to express the availability of physical support in the sense of the presence of a person who could help them to do things they could not do for themselves. Individuals generally perceived their neighborhood to be a positive and friendly place to live. It is noted however, that even in the small sample expected to be healthier and more active than the majority of the community, there are generally eight to sixteen percent of individuals who do not perceive their neighborhoods to be a highly positive place to live.

The majority of respondents owned a car and drive themselves when necessary. Very few were dependent on others or on public transportation.

Quality of Life

As expected given the relatively small, homogeneous sample, survey results indicate that the majority of respondents are at least somewhat active in their communities with attendance at religious services being the most common activity reported. One-third of respondents attended religious services more than twice to six times per month. Respondents were less likely to have friends over to their home and more likely to attend clubs or organizational meetings or to volunteer.

Respondents were most likely to communicate using a cellular phone for voice applications or to use a computer for e-mail and communication and generally less likely to text for communication or to use computers to pay bills or manage money.

Even with the considerable bias of the sample toward healthier, active older adults in the community, respondents reported a range of physical and emotional health limitations with almost half expressing limitations in the area of moderate daily activities. Results indicate that respondents also experience challenges in the area of mental health with half or more of respondents expressing issues with anxiety and frequently not feeling happy.

Physical and Mental Health

When asked to complete a rating scale, the majority of respondents self-reported good to excellent mental and physical health and relatively healthy nutritional habits. However, it is noted that the majority of individuals also report not participating in any physical activity during the past month and 8% have only two meals a day on most days of the week. In addition, the majority of respondents consume less than the recommended number of servings of fruits and vegetables per day.

Chronic health conditions including diabetes, cancer, and angina were reported by 2 to 21% of respondents. Cancer was the chronic health condition most commonly faced by both respondents (21%) and their families (45%).

The majority of respondents stated that they understood their medications and were under the care of at least one health provider. Use of prescription medications was common (87% of respondents). A considerable proportion of respondents had never participated in recommended health screenings. Compliance was lowest for mammograms by women and for sigmoid/colonoscopy by both genders.

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups

Dr. Lorentson completed five focus group interviews with older adults and one focus group interview with providers of services to older adults in the region. Older adult focus group interviews were hosted by senior centers within the region. The focus group with providers of services to older adults was held at the Danbury City Hall. A total of 42 seniors participated in focus groups. Participants represented primarily the towns of Bethel, Brookfield, Danbury and New Milford with a few individuals attending from other area towns. The majority of respondents were women. Additionally, four providers of services to seniors participated in the provider focus group. These individuals worked in New Milford and Danbury and included representatives from a hospital, a visiting nurse association, a specialized care settings and an organization targeting the medical and non-medical needs of seniors.

Focus group interview questions were developed to identify key indicators within each topic area and were designed to assess current health needs, satisfaction with current health-related services and to identify recommendations for service improvement as appropriate.

Conceptual analysis of responses was used to analyze focus group interview results. Overall, the results of focus group interviews suggest a number of key themes.

Overall Perceptions

Participants are generally satisfied with the level of services provided for older adults in the ten town region. Most individuals "*love it*" and state that they "*get all kinds of help*". Participants expressed enthusiasm in a number of areas including the availability of senior centers and high quality healthcare. Participants describe available programs and services as providing motivation and support to keep moving forward.

Participants expressed satisfaction with the existence of SweetHART buses; opportunities for socialization provided by senior centers and area religious organizations; availability of a variety of high-quality medical services; support provided by area social services and hospitals; available living opportunities for low-income and high-income senior adults; and the interpersonal support provided to each other by senior adults. Respondents were particularly enthusiastic about the interest shown in the welfare of seniors as evidenced by the inclusion of focus groups and surveys to collect supplementary information related to Older Adult health needs as a component of the Community Report Card.

Participants expressed concerns related to the lack of transportation and limited availability of SweetHART buses; lack of sidewalks and places for seniors to walk; shortage of low-income and medium-income housing, in particular a lack of availability of housing on one floor; the need for opportunities for socialization and interpersonal interaction of homebound seniors; the need for increased availability of delivery services for food and pharmaceuticals; the need for dental services that accept Medicaid; the need for behavioral health services and support for seniors and their caregivers; the need for inexpensive in-home non-medical support for seniors; and the need for support for the "*very old*". All participants emphasized the importance of education for seniors to help them understand how to

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Overall Perceptions, cont'd.

take care of themselves medically and to increase their utilization of available services. All participants expressed interest in continuing to strengthen and expand senior center activities and the availability of services for older adults in the ten town region.

Housing and Living Environment

Respondents described the living situations of older adults as generally safe and comfortable with older adults described as living in condominiums or low-income/ medium-income housing or with family or friends. Housing was typically considered to be relatively safe and comfortable with adequate availability of low-income housing throughout the ten town region. Service providers however emphasized that the safety and security of individuals varies by income level. These individuals described some of the seniors they interacted with as living "*in extremely poor conditions*". A number of participants emphasized that the availability of low-income housing varies by town with shortages described as existing in some towns. A number of participants also described shortages of medium-income housing throughout the area.

Although generally satisfied with the overall living conditions in the region, participants expressed a number of concerns. Specifically, large gaps were identified in the availability of housing with only one floor, suitable for individuals with mobility concerns and in the availability of housing in which one senior can live with another senior to share costs and support personal safety. Participants stated that many seniors live alone and that living alone is often a risk itself for personal safety. Senior participants stated that a number of housing situations prohibit non-family members from living together.

Additionally, participants identified a number of safety issues for individuals living alone. Specifically, the high cost of "*safety buttons*" such as Life Alert was described as a barrier for many senior adults who were unable to purchase security systems. A number of individuals discussed the importance of "*senior-to-senior*" or other networks to just "*check in*" and make sure someone who is living alone is "*okay*".

Participants expressed significant concerns related to the isolation of individuals with medical issues living alone in any type of housing situation and emphasized that, in the current culture and work setting, many seniors do not live close to either family or friends. It was also emphasized that, when older adults do live in proximity to family, family members are often described as "*busy with their own lives*" and not easily available to address the needs of their senior relatives. Lastly, a number of participants expressed a need for support in cleaning and maintaining a household. Participants described situations in which isolation and medical limitations make it difficult for some seniors to clean their own homes and maintain a safe and sanitary living environment. These individuals described a service that used to be, but is no longer, available in which social service representatives went to senior households to help to clean and

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Housing and Living Environment, cont'd.

organize the house. This service was described as very important to seniors facing physical or emotional limitations that make it difficult to maintain a safe and sanitary household.

The majority of participants expressed that the financial impact of housing varies by individual. Participants generally described Connecticut as a very expensive state to live in for seniors. However, many of the towns in the region were described as providing a number of options for low-income seniors to support the cost of housing, including tax breaks and vouchers. Senior centers and social service agencies were identified as providing seniors with educational opportunities to learn about available financial assistance.

Quality of Life

Respondents identified a number of key indicators of quality of life for seniors including the need for socialization and communication on a consistent basis. Respondents were generally very satisfied with the number of opportunities available for socialization in the region and identified the senior centers as the hub for most social activities. Senior centers were described as critical to seniors to find support from their peers; participate in clubs and activities such as dancing, singing and yoga; to receive educational guidance related to issues of importance to seniors such as use of technology, financial planning and support services available, including tax services. In addition to senior centers, area religious and social service organizations were identified as sources of socialization and support for many seniors.

Challenges cited by participants include ongoing difficulties with transportation due to a lack of adequate availability of SweetHART buses, a lack of sidewalks or other venues seniors can use to walk to social events, a lack of opportunities to provide social activities for homebound seniors, and a lack of services to address the needs of "the oldest of the old." Additionally, the majority of participants described a lack of adequate funding for senior centers in recent years has resulted in decreased space for participants, decreased availability of "day trips" and decreased opportunities for a variety of activities.

Respondents described a wide variety of use of technology by seniors to support quality of life. Specifically, the majority of senior participants described themselves as using cell phones and computers for communication on a consistent basis. Approximately half of participants also used computers for games, to track finances, and to conduct Internet searches on topics of interest.

Participants described quality of life as dependent on the availability of support services to help older adults to cope with existing physical limitations. Participants described needs such as *"how to fix a light bulb"*, *"cook dinner"*, *"get groceries"*, *"clean the house"* and *"obtain medications"* as issues commonly faced by the senior population. This area was described for many as a *"tough"* area with the majority of participants being *"unsatisfied"* with support available in this area. A number of participants stated a belief that senior citizens often get *"taken advantage of"* when these needs have to be addressed. Seniors described a situation in which individuals with close and supportive family and neighbors were able to address many of these needs. However, for individuals

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Quality of Life, cont'd.

without close family, support in these areas was described as typically coming *"at a cost"* and requiring consistent efforts to find and identify trustworthy individuals to help.

Similarly, participants described a need for increased availability of support for emotional or mental health challenges faced by seniors. Senior participants emphasized a need for free or low-cost counseling services, increased support for seniors within the home setting, and support groups to provide emotional and interpersonal support.

Social Support

The majority of participants described social support as critical to the emotional and physical health of seniors. As one individual stated, *"We need laughter to keep moving forward...that is what we need."* Social support was generally described as being provided by family members who live in the area and the senior centers. Additionally, individuals residing in condominiums or other shared living situations often described a positive network of support within these communities.

As in other areas, transportation was described as a significantly limiting factor to obtaining social support. Some seniors stated that they still *"drove themselves"* or *"were picked up by other seniors"* to attend events. The need for increased availability of SweetHART buses, or similar door-to-door transportation services, was emphasized by participants throughout all focus groups. Participants described some availability of volunteer drivers for senior adults through local religious organizations.

Physical and Mental Health

All participants perceived the availability of high-quality medical care to be excellent within the area. However, large gaps in ability of individuals to access this care were identified. Specifically, participants emphasized that medical care for low-income individuals was generally highly supported through social services and high-income individuals could pay for care that was necessary. However, the middle-income population was consistently described as not having the ability to support the continuum of care required and, particularly, the long-term expense of home care when that became necessary. Additionally, access to dental care, behavioral healthcare and vision and hearing support were described as minimal due to lack of insurance coverage. Older adults from New Milford expressed concerns that the recent merger of Danbury and New Milford Hospitals might lead to a shortage of medical services in the New Milford area.

Individuals described challenges faced by older adults in practicing good health habits such as being physically active, eating nutritious meals, drinking plenty of water, participating in health screenings, not smoking and not drinking alcohol in excess. Seniors described a low degree of motivation for individuals living by themselves to cook nutritious meals or to *"get out and move."* Although all participants described a high availability of fitness centers and sports clubs with sliding fee scales or low-cost opportunities for seniors, transportation difficulties were described as making it challenging for seniors to use these services. Additionally, the physical layout of many of the ten

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Physical and Mental Health, cont'd.

municipalities in the region was described as having few sidewalks or walking paths and therefore creating a challenge for seniors to experience ongoing physical activities.

All participants described the ability to understand and have the energy to follow-up and practice medical recommendations as a challenge for seniors with stamina or cognitive issues. Participants expressed a need for ongoing education and follow-up support to assist seniors to follow medical recommendations and practice good health habits. This need was described as particularly acute for seniors with chronic health conditions such as asthma, high blood pressure, or heart disease as these individuals need to be especially diligent in practicing positive health habits.

Representative Focus Group Quotes

Older Adults

"Transportation is a big issue...many of us don't drive. There aren't enough SweetHART buses. And...for those with physical limitations, the buses only pick you up at the bottom of the driveway—you have to get there. Often there are hills, or slippery, it is tough."

"We have great healthcare resources out there—a lot of them and they are qualified. But, to use them you need Medicare plus supplemental—then you are fine."

"Senior centers are so important for seniors. Many senior volunteer services have often been cut back. It would be nice if the towns could do more—not depend so much on the senior centers."

"We have physical limitations...not at all satisfied with the support provided by communities to address these. A lot of people can't get out—there are no structures in place for friendly visits to the home, support for home-bound people. There are often no more neighborhoods so neighbors aren't there—have to go to the senior centers and that is often not possible."

"The gaps we face? We really need transportation, help for the "oldest of the old", and support for socialization needs—especially of home-bound adults. The senior centers are critical—we need a comfortable place to go."

"There is often not enough low or middle income housing—some towns have them but generally not enough. There are huge waiting lists. Especially, you need to have housing all on one floor—we need a lot more of that. And...many places don't let non-relatives live together, so you can't share expenses"

"Great housing options for the lower and high income brackets—very little middle income housing."

Older Adult Health: Survey and Focus Group Findings, cont'd.

Representative Focus Group Quotes, cont'd.

Health Care Providers

"How do older adults get support to meet their day-to-day needs? This is a huge portion of healthcare. Wealthy people can pay for it, there are a lot of options for low income people. Middle of the road people have nothing—they try to pull in family and friends to do this...a huge issue. There is very little support out there for caregivers either."

"The three major priorities we see to improve the health services for older adults are: 1) education—help them see and understand what they need to do to take care of themselves; 2) Transportation to get them out and where they need to go; and 3) Address the needs of middle-income older adults. They are hurting the most."

The complete Older Adult Health Survey and Focus Group Reports can be accessed at the United Way of Western CT website: http://www.uwwesternct.org.

Conclusions

Overall, survey and focus group data indicates that the region continues to be relatively successful at meeting a number of health and social needs of senior adults. The region was generally described as having high quality medical care, excellent housing options for low and high income seniors, and active and supportive senior centers. However, focus group data indicates that a number of gaps in service and opportunities for improvement also exist. Specifically, data suggests significant improvements are needed in the areas of health education for older adults, financial and social support for middle-income senior adults, and in the availability of more flexible housing and transportation options.

Recommendations for Future Data Collection

- Future older adult health surveys should be developed to be less complex and be validated prior to administration.
- Future data collection efforts should consider the use of a random sample for survey distribution or the use of targeted survey distribution directed toward key informants to increase the generalizability of findings. An individual trained in survey administration should be present to review surveys for completion and obvious errors prior to collection.
- It is highly recommended that future assessments include strategies to assess the needs of less active, less mobile, less affluent and minority senior adults who were not well-represented in the current survey and focus group information.
- Future provider focus groups should include broader representation of health and social service providers, both geographically and by area of specialty.

Conclusions and Recommendations

The leading health concerns in our community, as in the state and the nation, result from a number of interconnected factors, many of which can be controlled or modified. Harmful lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, tobacco use, substance abuse, and unsafe sexual practices have major impacts on individual health. Lack of health insurance, limited English proficiency, and cultural factors present barriers to access and utilization of medical care and preventive health services. Income, employment status, educational attainment, housing, and transportation are social factors which impact health or access to care. Uncontrollable factors, including inherited health conditions or increased susceptibility to disease, also significantly influence health.

In spite of the favorable health status enjoyed by most HVR residents, health disparities exist and are concentrated in the uninsured and low income population groups. Families and individuals who live in poverty or are uninsured are more likely to have poor health status. Poverty underlies many of the social factors that contribute to poor health. Differences for many health indicators are also apparent by gender, race/ethnicity, age, and place of residence. This information should be used to determine subgroups in the population in need of further assessment, as well as to guide the development of programs and services to meet identified health needs. Expanded joint planning and coordination of programs and services among health partners in the community can reduce health disparities and improve the health of all area residents.

Effective strategies to improve community health involve active collaboration and commitment among providers, health agencies, educators, and community-based organizations and groups, and the public they serve. Developing a plan for health improvement in the community involves collective action and sharing of expertise and resources across agencies and organizations in both the public and private sectors.

With this in mind, the following key recommendations are proposed by the Community Report Card Steering Committee Leadership to guide future Community Report Card health assessment activities:

- *Broaden the CRC Steering Committee membership to assure active participation by community agencies providing services to and community groups most affected by health disparities in the region.*
- *Use a strategic health planning process to identify gaps in qualitative and quantitative data needed to determine priority health needs, and to begin to develop a comprehensive action plan for community health improvement.*
- *Collect more in-depth data, through surveys, focus groups, and key informant interviews, to better inform the determination of priority health needs and to better align community resources with these needs.*
- *Conduct a scan of available health-related data and assessments to refine the key health indicators for the region for inclusion in future editions of the Community Report Card.*

EXHIBIT F

Distribution of Norwalk Hospital and WCHN Employed Physicians

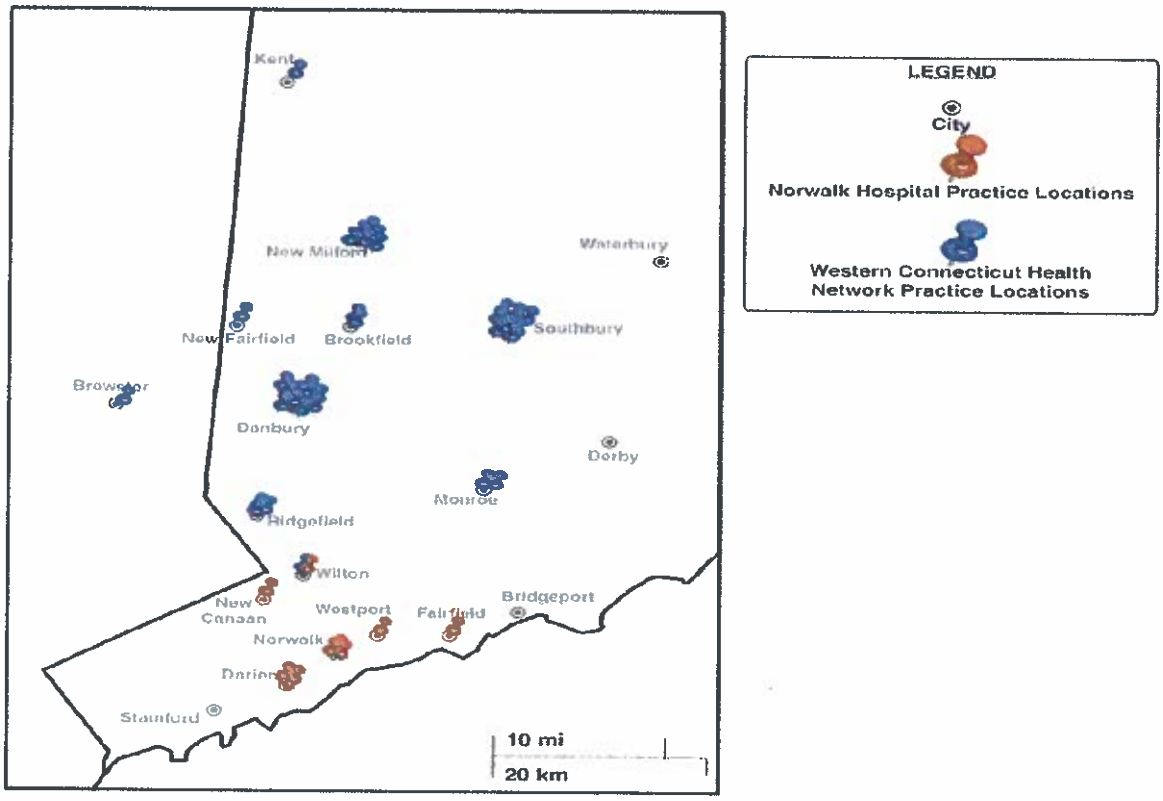


EXHIBIT G

Economist Map, February 27, 2013

WCHN's 75% Service Area and Norwalk 75% Service Area Do Not Overlap

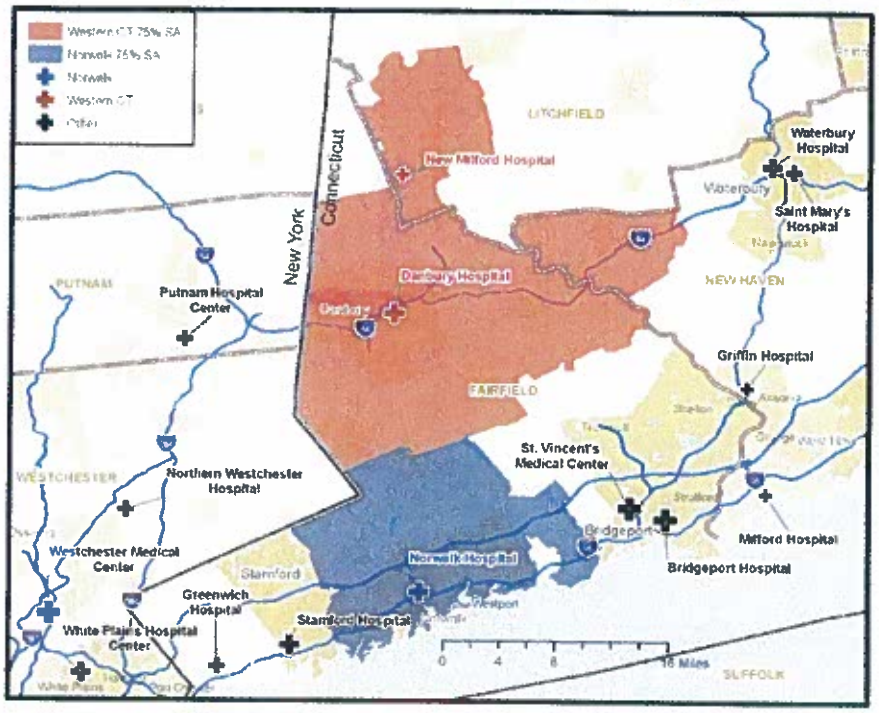


EXHIBIT H

PRINT

Moody's: Value-Based Care Paramount for Hospitals' Future Credit, Finances

Written by Bob Herman | May 08, 2013

For non-profit hospitals, providing quality, affordable healthcare will be instrumental in their credit ratings and financial strength in the future as the healthcare sector gradually shifts from fee-for-service and to value-based reimbursement, according to a report from Moody's Investors Service.

Medicare, Medicaid and private payors are all shifting their reimbursement strategies to risk-based contracting, which creates financial incentives and/or penalizes hospitals for not meeting certain quality and cost targets.

MOODY'S INVESTORS SERVICE

Moody's will start measuring the evolving payment and care models through new hospital indicators in order to "publish forward-looking, anticipatory ratings and research that look beyond the near term," according to the report. For example, the indicators will focus on both demand, such as employed physicians, and reimbursement risk, such as Medicare readmission rate.

"After decades of following volume-based incentives, measuring and proving value will become necessary for healthcare systems to maintain operating stability and distinguish themselves as market leaders," said Lisa Goldstein, Moody's associate managing director and author of the report.

More Articles on Moody's Reports:

Moody's: Small Hospitals Bear Brunt of 1Q Downgrades
Moody's: Sequestration Worsens Challenging Hospital Environment
Moody's: Hospitals Getting Innovative to Cope With Reform

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MOODY'S
INVESTORS SERVICE

Announcement: Moody's: Financial focus for US not-for-profit hospitals shifts toward healthcare value

Global Credit Research - 08 May 2013

New York, May 08, 2013 -- The ability to deliver quality care at an affordable cost is becoming increasingly important to the financial strength and credit quality of a not-for-profit hospital, says Moody's Investors Service in a new report, as reimbursements shifts toward rewarding value in healthcare.

"After decades of following volume-based incentives, measuring and proving value will become necessary for healthcare systems to maintain operating stability and distinguish themselves as market leaders," says Moody's Associate Managing Director Lisa Goldstein in her report "Not for-Profit Hospitals: The Pursuit of Value."

Long-term trends such as excessive cost inflation and the near-term reforms in government policies are driving the shift toward a new quality-based business model, says Moody's.

Moody's details four specific objectives hospital managers are pursuing as they respond to the shift in business model. These are achieving breakeven performance with Medicare rates, building scale through non-traditional methods, improved patient experience, and cultivating informed leadership.

The sector is facing reimbursement reductions and incentive changes embedded in The Patient Protection and Affordability Act (ACA), in addition to cuts associated with federal deficit reduction, says Moody's.

In response to the shift, Moody's recently added several new indicators that measure a hospital's quality and demand for services. These include number of unique patients, covered lives, employed physicians, Medicare readmission rates, all payer readmission rates, and risk-based revenues.

Private and government payers are also increasing their emphasis on value by introducing risk-based contracts that create incentives for hospitals to achieve certain quality and cost targets or, in some cases, face financial penalties.

"Individuals and businesses have become more discerning in their healthcare purchases since the recession," says Moody's Goldstein. "Both payers and purchasers will accelerate their demand for high value healthcare products with the start of mandated insurance exchanges in 2014."

For more information, Moody's research subscribers can access this report at http://www.moodys.com/research/Not-for-Profit-Hospitals-The-Pursuit-of-Value--PBM_PBM153434.

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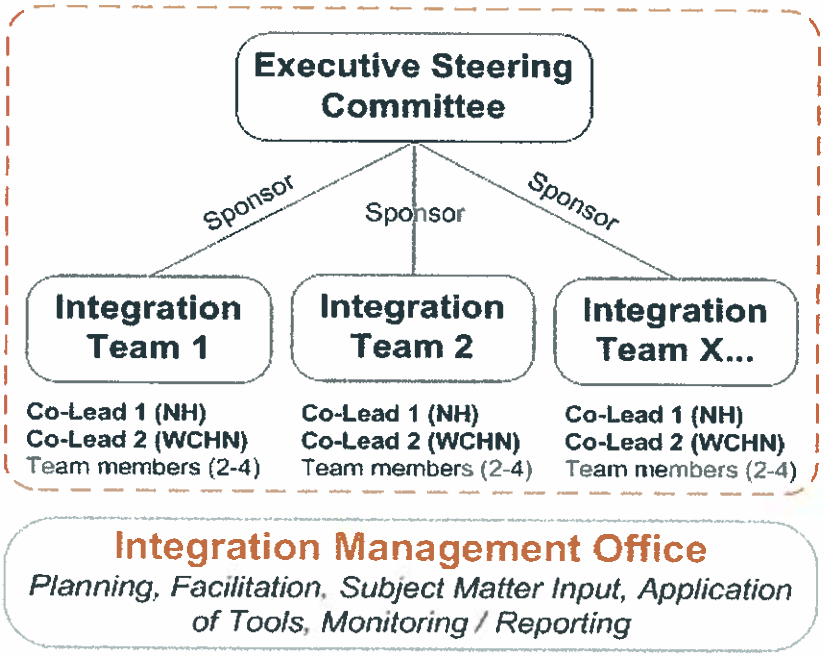
EXHIBIT I

Integration Teams



- Cardiovascular Services
- Laboratory and Pathology Services
- Cancer Services (includes Hematology)
- Finance
- Pediatric Services
- Physician Organization
- Primary Care Physician Distribution
- Medical Education
- Quality/Safety
- Compliance
- Risk Management
- IT Shared Services
- HR and Benefits
- HR Operations
- Revenue Cycle
- Supply Chain
- Foundations/Development
- PHO/ACO
- Care Coordination/UM
- Marketing, Communication & Planning
- Pharmacy (non-supply chain)
- Facilities Mgmt/Real Estate

EXHIBIT J

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

Managing Costs and Population Health through an eACO Model

April 24, 2013

your wellness. your rewards!

WESTERN CONNECTICUT HEALTH NETWORK
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Western Connecticut Health Network

Who we are

Western Connecticut Health Network is the region's premier patient-centered system of care dedicated **to improving the health and well-being of those we serve in western Connecticut and adjacent areas of New York.**

- An organized network of providers, services and locations
- Formed in 2010 by the merger of Danbury Hospital and New Milford Hospital and their affiliated organizations

Our Vision

Our physicians, nurses and other professionals are collaborating through a shared vision to engage and empower patients and families as partners in their care.

WESTERN CONNECTICUT HEALTH NETWORK
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Accountable Care Strategy

Employee ACO Pilot

- WCHN is taking the critical steps required for continued success amid the new demands of health care reform and health care cost and quality controls
- Embarked on an Accountable Care Strategy, partnering with Aetna to become an Accountable Care Organization
- Using the employee health plan as a pilot for a commercial ACO product to be offered to the community

As an organization whose vision is to **engage and empower patients to be actively involved in their own health, we recognized that we needed to start with the health of our own employees and their families**

WESTERN CONNECTICUT HEALTH NETWORK
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Employee Wellness: Mission and Goals

Mission

Provide employees with a comprehensive worksite wellness program that offers health promotion and resources, so that we may create a culture of healthy living, and model a healthy lifestyle for patients and the community.

Goals

Improve the health and wellness of employees in order to:

- Limit risk exposure for employees to chronic diseases
- Reduce health care injury and claim costs for the Network
- Explore and illustrate the potential of an **accountable care environment** in a defined population
- Develop wellness best practices that are transferable to the community

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Phase I: Your Wellness. Your Rewards!

- **Program branding/recognition (Your Wellness. Your Rewards!)**
  - "Umbrella" brand that includes existing and new initiatives
- **Educate/Inform/Communicate**
  - HealthStream modules
  - Monthly themed offerings (e.g. Heart Health, Nutrition, Stress Awareness)
  - Informational presentations (live and online)
  - Vital Signs Online and Quarterly; flatscreen monitors; posters/flyers and email
- **Introduction of core elements**
  - Virgin HealthMiles program to inspire/incent for more activity
  - Health Risk Assessments
  - Biometric Assessments
  - Nutrition support and incentives ("Rate your Plate")
  - Special programs (massage, meditation, therapeutic touch, music, etc.)

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Participation in Virgin HealthMiles

- **3,807 Employees Eligible to Participate**
- 2,772 enrolled = 73% (far surpassing Virgin's benchmark)
- Of those enrolled in Virgin HealthMiles:
  - 40% (1,117) are using the GoZone (pedometer upload)
  - 40% (1,006) are using the LifeZone (Virgin's online resource center)
  - 26% (610) are submitting verified biometrics monthly (March data)
  - 33% (928) completed a Health Risk Assessment

Employees have taken 5,445,629,310 steps since July 2011 – that's 109 times around the globe!

FY 2013 Vital Sign: Skilled and Motivated Workforce

Performance versus Targets:

Improve the wellness of our workforce by further encouraging wellness behavior through expanding the VHM program	**5% increase** in employee participation in Health Zone and biometric activities by end of FY 2013 **10% increase** in HRA participation (600 FY 2012)	**610 users – Progress toward target** **55% increase – above target (928 completed an HRA)**
	Maintain 60% enrollment of eligible ees	**73% enrolled – above target**
	Program ROI target: $200,000	**FY 2013 health care costs are $3.5M better than budget**

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WESTERN CONNECTICUT HEALTH NETWORK
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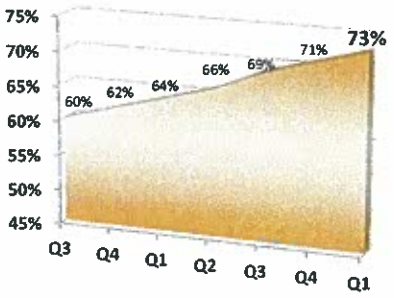
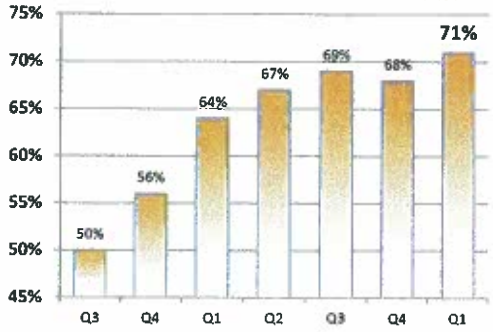
Employee Wellness – Virgin HealthMiles

- Enrollment in Virgin HealthMiles has increased steadily since 2011
  - 73% of eligible employees in March 2013
- An increasing number of participants are meeting the program's physical activity targets

HealthMiles Enrollment



Met Physical Activity Targets



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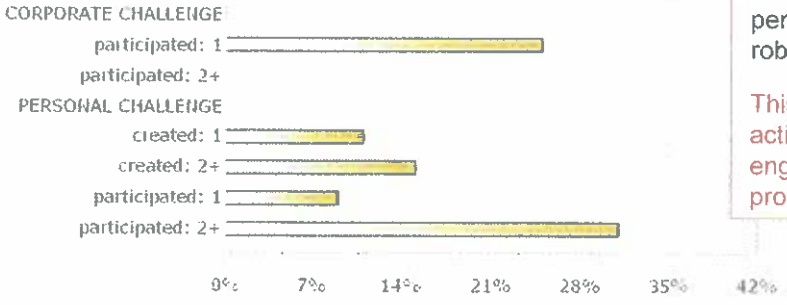
Early Results: Challenge Participation Robust!

Challenge Participation

Percentage breakdown of corporate challenge participation and personal challenge creation/participation during the selected date range



Participation in HealthMiles personal challenges is robust at 31%.

This is an indicator of active employee engagement in the program

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WCHN Employee Risk Profile vs. Nat'l Benchmarks*

A study of WCHN's employee population by Towers Watson indicated our employees have significant health care needs

Category	Finding
Overall health risk of population	Risk score is 53% higher than overall database.
Chronic conditions	18% more prevalent and 31% more costly than benchmark. Individuals with chronic conditions represent 22% of members and 44% of cost.
Lifestyle risks	Higher prevalence of obesity, tobacco use, noncontrolled lipids and noncontrolled hypertension than benchmark

* Benchmarks: 2010 U.S. Total Norms from Thomson Healthcare's MarketScan normative database, age/gender adjusted.

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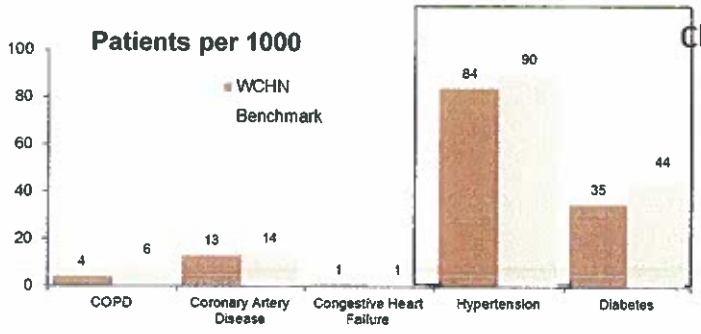
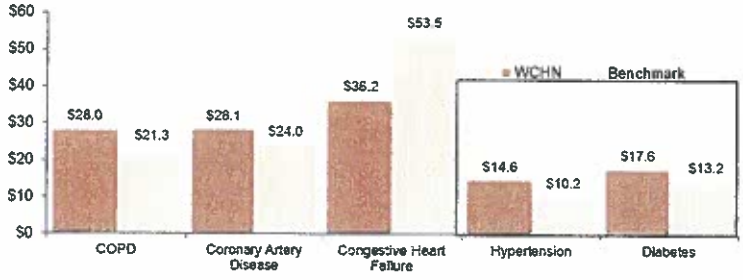


Chronic Conditions prevalence and costs compared to benchmarks

- Members with chronic conditions cost $12,357 per patient compared to $4,641 per member without chronic conditions
- Higher costs per patient for most conditions



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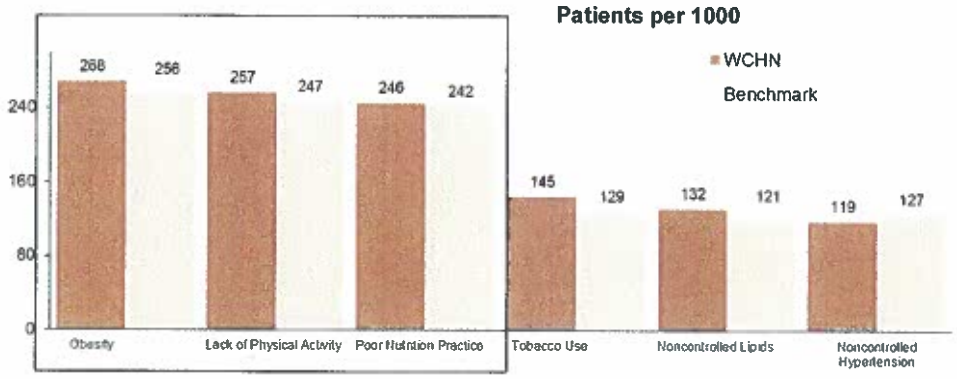
Employee Risk Data Indicates Opportunity



- WCHN lifestyle conditions shown above may be understated – many members with these conditions do not have active diagnoses or claims data that can be directly linked to a specific lifestyle condition

Benchmarks: Rates are benchmarked against the 2010 US Total Norms from Thomson Healthcare's MarketScan normative database. All benchmarks are age/gender adjusted

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Employee Risk Data Indicates Opportunity

BMI

	#	%
Underweight	17	1
Ideal	513	36
Overweight	479	34
Obesity 1	228	16
Obesity 2	96	7
Obesity 3	75	5

Blood Pressure

	#	%
Ideal	874	60
Pre-Hypertension	510	35
Hypertension 1	52	4
Hypertension 2	12	1

62% of employees (878) reporting biometrics are overweight to obese based on BMI

30% of employees who did the Aetna HRA are smokers*

44% of HRA respondents get <u>inadequate</u> exercise*

40% of VHM-participating employees (about 574) reporting biometrics are pre-hypertensive or already hypertensive

*HRA data from 2012

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eACO strategy reflects population health risks

Based on WCHN's employee risk factors / population health needs, the eACO plan design focuses on 5 target conditions and lifestyle risks

- Diabetes
- Hypertension
- Hyperlipidemia
- Smoking
- Obesity

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Enhanced Benefits for HealthSmart Participants for 2013

Value based prescription drug benefit for target conditions

Diabetes

- No cost generic drugs for diabetic medications
- 100% coverage for diabetes education
- 100% coverage for nutritional counseling

Hypertension

- No cost generic drugs for hypertensive medications

Hyperlipidemia

- No cost generic drugs for hyperlipidemia

Obesity

- Bonus HealthMiles for reaching weight loss milestones

Tobacco Use

- No cost generic smoking cessation drugs
- 100% coverage for 6-week WCHN smoking cessation program

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Employee Accountable Care Organization (eACO)

- Of the 4,755 employees and spouses participating in our medical plans, 369 are in the Health Smart Program (8%). All participants completed a Health Risk Assessment via Aetna Navigator and were awarded bonus miles through Virgin HealthMiles
- 58% of PCPs/Specialists managing HealthSmart participants are in our PHO
- Clinical expectations for participants were established on 4/8/13 based on disease categories
- Aetna's Infomatics Department will perform a cohort study providing us with baseline data

Disease/Condition	Employees in Program	Spouses in program
Hypertension	105	72
Hyperlipidemia	98	74
Diabetes Mellitus	35	27
Obesity	17	3

Number of Conditions	Employees in Program	Spouses in program
1	40	21
2	42	21
3	37	11
4 or more	77	53

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Goal: Implement an eACO to improve cost and quality outcomes

Objectives	Process	Metric
2013: Implement an eACO program as an overlay to the existing WCHN medical plans to improve cost and quality outcomes **2014: Ensure that the eACO program is more fully developed in time for open enrollment** **Work with eACO team to develop care management and attendant metrics**	Identify implementation/ design team, Assign roles	Design team includes major stakeholders
	Determine eligibility requirements for eACO participation	Set rigorous expectations for participating employees Refine future eligibility based on HealthSmart participants' PCP utilization and condition management engagement levels
	Provide input to the eACO team relative to WCHN's expectations for eACO providers	Require adherence to evidence based medicine protocols and collaboration with Aetna's disease management program

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Goal: Implement an eACO to improve cost and quality outcomes

Objectives	Process	Metric
2013: Implement an eACO program as an overlay to the existing WCHN medical plans	Assess Aetna's capability to administer the eACO	Seamless administration Robust reporting capability
2014: Ensure that the eACO program is more fully developed in time for open enrollment **Work with eACO team to develop care management and attendant metrics**	Finalize plan design including pricing and providers	Market competitive and affordable program
	Present recommendations to WCHN leadership	Approval for 2013 / 2014 program enhancements; allocation of resources for successful implementation
	Develop and execute supporting communications	Create communications that are complete and engaging
	Roll out plan in time for Open Enrollment	Update HRIS / Onboarding software for the new plan

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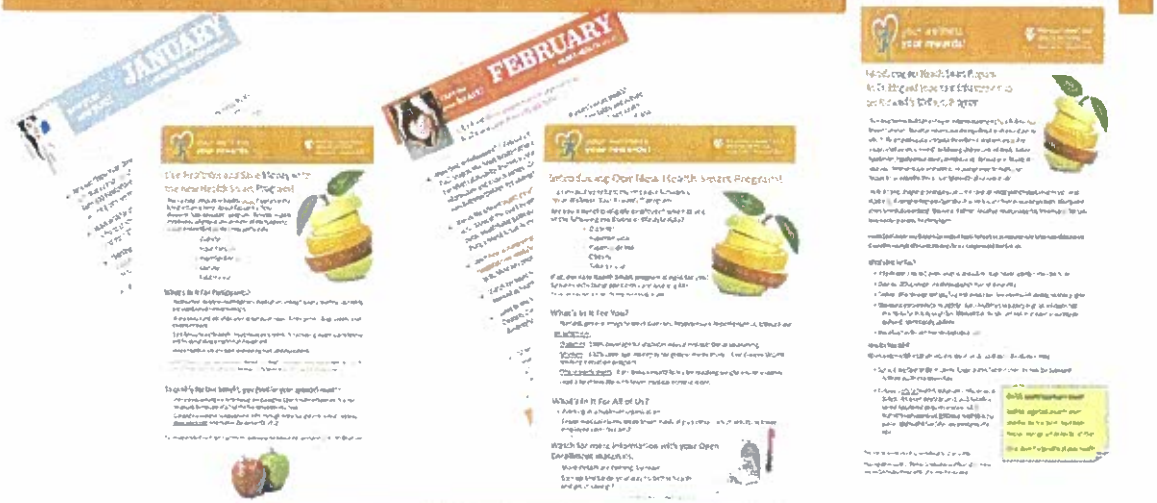
Ongoing communication keeps message fresh



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Employee Wellness – Online Learning

- Participation in HealthStream wellness modules is increasing

	HealthStream Program	Participants
October 2012	Keys to Cancer Prevention	195
November 2012	Be Smart – Make the Right Choices	88
December 2012	[No Course offered]	n/a
January 2013	Setting Reasonable Resolutions	225
February 2013	Take Care of Your Heart	293
March 2013	SuperFoods for your Health	335

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eACO – Plan Design Considerations for 2014

Design features will incentivize wellness behavior

- Reduced co-pay for visiting PCP/Specialist in ACO Network ($0)
- One wellness exam annually with $0 co-pay (vs. every 24 months)
- More cross linking to Wellness Program:
  - —Integration with Your Wellness Your Rewards
  - —Enhanced incentives

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Enhanced Protocols for HealthSmart Participants for 2014

Wellness Exam Annually for all Conditions

Diabetes

- Had two (2) hemoglobin A 1C levels in one year
- Attended diabetes education classes
- Received nutritional counseling
- Had an eye exam
- Had a foot exam
- Had a lab test for LDL
- Blood pressure reading
- Filling related medications

Hypertension

- Filling related medications
- Has blood pressure checked to reach 140/90 goal

Hyperlipidemia

- Filled related medications
- Measure lipid profile

Obesity

- Measurement of circumference
- Documentation from a qualified source of percentage of body weight loss
- Had measurement of lipid profile
- Filled related medications

Tobacco Use

- Filled related medications
- Attended smoking cessation classes

EXHIBIT K

NORWALK HOSPITAL - Stand Alone

12. C (i).

(000's ommitted)	Hosp Excl JV FY 2012 Actual Results	Hosp Excl JV FY 2013 Projected	Hosp Excl JV FY 2013 Projected Incremental	Hosp Excl JV FY 2013 Projected With CON	Hosp Excl JV FY 2014 Projected W/out CON	Hosp Excl JV FY 2014 Projected Incremental	Hosp Excl JV FY 2014 Projected With CON	Hosp Excl JV FY 2015 Projected W/out CON	Hosp Excl JV FY 2015 Projected Incremental	Hosp Excl JV FY 2015 Projected With CON	Hosp Excl JV FY 2016 Projected W/out CON	Hosp Excl JV FY 2016 Projected Incremental	Hosp Excl JV FY 2016 Projected With CON
Total Facility:													
Description													
NET PATIENT REVENUE													
Non-Government	$206,483	$213,299		$213,299	$221,559		$221,559	$226,926		$226,926	$232,423		$232,423
Medicare	97,675	$103,562		$103,562	$104,932		$104,932	$106,322		$106,322	$107,734		$107,734
Medicaid and Other Medical Assistance	35,580	$31,949		$31,949	$32,088		$32,088	$32,228		$32,228	$32,370		$32,370
Other Government													
Total Net Patient Patient Revenue	339,738	$348,809		$348,809	$358,578		$358,578	$365,477		$365,477	$372,527		$372,527
Other Operating Revenue	20,311	$14,044		$14,044	$13,440		$13,440	$12,750		$12,750	$12,750		$12,750
Revenue from Operations	360,049	$362,853		$362,853	$372,018		$372,018	$378,227		$378,227	$385,277		$385,277
OPERATING EXPENSES													
Salaries and Fringe Benefits	181,353	$186,947		$186,947	$192,506	($1,009)	$191,326	$197,159	($2,148)	$195,012	$200,996	($3,403)	$197,593
Professional / Contracted Services	70,286	71,692		$71,692	$73,126		$73,126	$74,588		$74,588	$76,080		$76,080
Supplies and Drugs	31,420	32,363		$32,363	$33,334	($228)	$33,054	$34,334	($528)	$33,806	$35,364	($821)	$34,542
Bad Debts	0			$0			$0						
Other Operating Expense	23,785	25,198		$25,198	$26,147	$819	$26,887	$25,664	($299)	$25,365	$23,877	($1,773)	$22,104
Subtotal	306,844	$316,200		$316,200	$325,112	($418)	$324,392	$331,744	($2,974)	$328,770	$336,316	($5,997)	$330,319
Depreciation/Amortizat	20,380	$21,654		$21,654	$22,571		$22,571	$24,710		$24,710	$26,501		$26,501
Interest Expense	2,026	$4,873		$4,873	$4,631		$4,631	$4,379		$4,379	$4,117		$4,117
Lease Expense	9,171	$9,354		$9,354	$9,542		$9,542	$9,732		$9,732	$9,927		$9,927
Total Operating Expense	$338,421	$352,080		$352,080	$361,855	($418)	$361,135	$370,566	($2,974)	$367,592	$376,861	($5,997)	$370,864
Gain/(Loss) from Operations	$21,628	$10,773		$10,773	$10,163	$418	$10,883	$7,662	$2,974	$10,635	$8,416	$5,997	$14,413
Plus: Non-Operating Revenue	$7,930	$7,593		$7,593	$7,770		$7,770	$7,640		$7,640	$7,464		$7,464
Revenue Over/(Under) Expense	$29,558	$18,367		$18,367	$17,933		$18,653	$15,302		$18,276	$15,880		$21,877
FTEs	1,699	1,701		1,701	1,699	(9)	1,690	1,701	(18)	1,719	1,739	(27)	1,767
*Volume Statistics													
Inpatient Discharges	15,003	15,003		15,003	15,003		15,003	15,003		15,003	15,003		15,003
Outpatient Visits	265,235	267,887		267,887	270,566		270,566	273,272		273,272	276,005		276,005
Key Ratio's													
Op Margin	6.0%	3.0%		3.0%	2.7%		2.9%	2.0%		2.8%	2.2%		3.7%
Operating EBIDA	12.2%	10.3%		10.3%	10.0%		10.2%	9.7%		10.5%	10.1%		11.7%
Excess Margin	8.2%	5.1%		5.1%	4.8%		5.0%	4.0%		4.8%	4.1%		5.7%

DANBURY HOSPITAL - Stand Alone

Financial Attachment I

(Dollars are in thousands)

Total Facility: Description	FY2012 Actual Actuals	FY2013 Projected Actuals	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected Actuals	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected Actuals	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected Actuals	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$295,602	296,980	-	296,980	$306,428	-	306,428	$316,214	-	316,214	$327,136	-	327,136
Medicare	170,634	172,306	-	172,306	173,721	-	173,721	175,161	-	175,161	177,543	-	177,543
Medicaid and Other Medical Assistance	35,821	37,362	-	37,362	37,391	-	37,391	37,425	-	37,425	37,615	-	37,615
Other Government	366	325	-	325	325		325	325		325	325		325
Total Net Patient Patient Revenue	$502,423	506,973	$0	506,973	517,865	$0	517,865	529,125	$0	$529,125	542,619	$0	542,619
Other Operating Revenue	$22,127	$11,393	-	$11,393	$11,409	$0	$11,409	$10,649	$0	$10,649	$10,644	$0	$10,644
Revenue from Operations	$524,549	$518,366	$0	$518,366	$529,274	$0	$529,274	$539,774	$0	$539,774	$553,263	$0	$553,263
OPERATING EXPENSES													
Salaries and Fringe Benefits	$258,694	$254,095	-	$254,095	$260,093	(1,929)	$258,164	$266,239	(4,084)	$262,154	$273,083	(6,465)	$266,619
Professional / Contracted Services	55,287	55,938	-	55,938	57,057	-	57,057	58,198	-	58,198	59,362	-	59,362
Supplies and Drugs	77,291	80,299	-	80,299	82,708	(462)	82,246	85,189	(977)	84,212	87,745	(1,547)	86,198
Other Operating Expense	61,088	61,267	-	61,267	61,465	1,556	63,021	60,062	(586)	59,476	60,057	(3,367)	56,690
Subtotal	$452,359	$451,599	$0	$451,599	$461,324	(835)	$460,488	$469,688	(5,647)	$464,041	$480,248	(11,379)	$468,869
Depreciation/Amortization	31,663	31,876	-	31,876	35,126	-	35,126	40,976	-	40,976	45,332	-	45,332
Interest Expense	4,156	3,987	-	3,987	4,637	-	4,637	8,337	-	8,337	8,295	-	8,295
Lease Expense	7,206	7,472	-	7,472	7,621	-	7,621	7,773	-	7,773	7,929	-	7,929
Total Operating Expenses	$495,384	$494,933	$0	$494,933	$508,707	($835)	$507,872	$526,774	($5,647)	$521,127	$541,804	($11,379)	$530,425
Gain/(Loss) from Operations	$29,165	$23,433	$0	$23,433	$20,567	$835	$21,402	$13,000	$5,647	$18,647	$11,460	$11,379	$22,838
Plus: Non-Operating Income	$24,211	$14,627		$14,627	$14,481	$0	$14,481	$14,336	$0	$14,336	$14,193	$0	$14,193
Income before provision for income taxes	$53,376	$38,060	$0	$38,060	$35,048	$835	$35,883	$27,336	$5,647	$32,983	$25,652	$11,379	$37,031
Provision for income taxes			-	$0			$0			$0			$0
Revenue Over/(Under) Expense	$53,376	$38,060	$0	$38,060	$35,048	$835	$35,883	$27,336	$5,647	$32,983	$25,652	$11,379	$37,031
FTEs	2,405.1	2,376.5	-	2,376.5	2,371.6	(16.6)	2,355.0	2,369.2	(33.8)	2,335.4	2,371.7	(53.3)	2,318.4
*Volume Statistics: Inpatient Discharges	19,676	18,681		18,681	18,494		18,494	18,309		18,309	18,126		18,126
Outpatient Visits	430,495	434,236	-	434,236	435,973	-	435,973	437,717	-	437,717	439,468	-	439,468
Key Ratios:													
Op Margin	5.6%	4.5%		4.5%	3.9%		4.0%	2.4%		3.5%	2.1%		4.1%
Operating EBIDA Margin	12.4%	11.4%		11.4%	11.4%		11.6%	11.5%		12.6%	11.8%		13.8%
Excess Margin	10.2%	7.3%		7.3%	6.6%		6.8%	5.1%		6.1%	4.6%		6.7%

NEW MILFORD HOSPITAL - Stand Alone

Financial Attachment I

(Dollars are in thousands)

Total Facility: Description	FY 2012 Actual Results	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$48,136	45,592	-	$45,592	47,042	-	47,042	48,544	-	48,544	50,221	-	50,221
Medicare	24,242	19,229	-	$19,229	18,687	-	$18,687	18,842	-	$18,842	19,098	-	$19,098
Medicaid and Other Medical Assistance	5,632	5,340	-	$5,340	5,344	-	$5,344	5,349	-	$5,349	5,376	-	$5,376
Other Government	101	85	-	-	85		$85	85		$85	85		$85
Total Net Patient Patient Revenue	$78,111	$70,245	$0	$70,160	$71,157	$0	$71,157	$72,820	$0	$72,820	74,780	$0	$74,780
Other Operating Revenue	$1,101	$980	-	$980	$980	$0	$980	$980	$0	$980	$980	$0	$980
Revenue from Operations	$79,212	$71,225	$0	$71,140	$72,137	$0	$72,137	$73,799	$0	$73,799	$75,759	$0	$75,759
OPERATING EXPENSES													
Salaries and Fringe Benefits	$45,235	$40,419	-	$40,419	$41,329	-	$41,329	$42,259	-	$42,259	$43,209	-	$43,209
Professional / Contracted Services	12,196	8,713	-	8,713	8,887	-	8,887	9,065	-	9,065	9,246	-	9,246
Supplies and Drugs	10,418	9,589	-	9,589	9,876	-	9,876	10,173	-	10,173	10,478	-	10,478
Other Operating Expense	10,942	10,360	-	10,360	10,360	-	10,360	10,360	-	10,360	10,360	-	10,360
Subtotal	$78,792	$69,081	$0	$69,081	$70,452	$0	$70,452	$71,856	$0	$71,856	$73,294	$0	$73,294
Depreciation/Amortization	5,527	5,862	-	5,862	6,162	-	6,162	7,162	-	7,162	8,162	-	8,162
Interest Expense	419	268	-	268	268	-	268	268	-	268	268	-	268
Lease Expense	447	824	-	824	832	-	832	841	-	841	849	-	849
Total Operating Expenses	$85,184	$76,035	$0	$76,035	$77,715	$0	$77,715	$80,127	$0	$80,127	$82,573	$0	$82,573
Gain/(Loss) from Operations	($5,972)	($4,810)	$0	($4,895)	($5,578)	$0	($5,578)	($6,328)	$0	($6,328)	($6,813)	$0	($6,813)
Plus: Non-Operating Income	$772	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income before provision for income taxes	($5,200)	($4,810)	$0	($4,895)	($5,578)	$0	($5,578)	($6,328)	$0	($6,328)	($6,813)	$0	($6,813)
Provision for income taxes			-	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense	($5,200)	($4,810)	$0	($4,895)	($5,578)	$0	($5,578)	($6,328)	$0	($6,328)	($6,813)	$0	($6,813)
FTEs	420.0	375.0	-	375.0	375.0	-	375.0	375.0	-	375.0	375.0	-	375.0
*Volume Statistics: Inpatient Discharges	2,288	1,922		1,922	1,903		1,903	1,884		1,884	1,865		1,865
Outpatient Visits	61,244	47,458	-	47,458	47,648	-	47,648	47,838	-	47,838	48,030	-	48,030
Key Ratios:													
Op Margin	-7.5%	-6.8%		-6.9%	-7.7%		-7.7%	-8.6%		-8.6%	-9.0%		-9.0%
Operating EBIDA Margin	0.0%	1.9%		1.7%	1.2%		1.2%	1.5%		1.5%	2.1%		2.1%
Excess Margin	-6.6%	-6.8%		-6.9%	-7.7%		-7.7%	-8.6%		-8.6%	-9.0%		-9.0%

EXHIBIT L

Debt Schedules as of March 31, 2013

Norwalk Health Services Corporation

Norwalk Hospital Association		
CHEFA Series G	$	22,650,000
CHEFA Series H		8,300,000
CHEFA Series I		9,750,000
CHEFA Series J		82,000,000
CHA Trust		537,140
CHEFA Lease		4,240,370
Total		127,477,510
Norwalk Surgery Center		
Term Loan - 7 Year The Bank of Fairfield		3,678,715
Total	$	131,156,225

Western Connecticut Health Network

Danbury Hospital		
Series H	$	39,615,000
Western Connecticut Health Network		
Series K		28,860,000
Series L		96,000,000
Series M		46,030,000
Series N		39,880,000
New Milford Hospital		
Term loans		405,105
Capital lease obligations		860,375
Total	$	251,650,480

EXHIBIT M

Hospitals: The Changing Landscape is Good for Patients & Health Care

American Hospital Association.

Hospitals: Care Integration for the Right Reasons

Coming on the heels of the recession, hospital merger/acquisition activity began to accelerate. Hospitals began acquiring other hospitals and hiring medical staff in an effort to provide the leadership needed to reform a siloed health care system that nearly everyone from Institute of Medicine to the Medicare Payment Advisory Commission (MedPAC) has singled out as one of the main culprits in higher cost, lower quality health care.

Both government and the private sector are creating incentives that are driving hospitals toward one another and toward their medical staffs with new global and fixed payments; new incentives for meeting quality, efficiency, and patient satisfaction goals (and penalties for failing to do so); and rescinding payments for certain readmissions.

Both Moody's and Standard & Poor's report a negative financial outlook for hospitals, attributable in large part, to the fact that "[t]he healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed."

—Moody's Outlook 2012

"[H]ospitals that successfully improve operating efficiencies, engage in growth strategies, and align more closely with physicians will be better poised to adapt to ongoing challenges."

—Moody's Special Comment 2012

Meeting these myriad challenges requires building a continuum of care that includes healthier, leaner hospitals and closely aligned medical staff.

"The ability to demonstrate lower costs while providing higher quality care will be the key driver in governmental and commercial reimbursement going forward."

—Moody's New Forces 2012

To achieve these worthy goals, mergers may be the only recourse, as decades old regulatory barriers can keep hospitals and doctors from working closely together to improve care and reduce costs unless they are under the same ownership umbrella. Gainsharing demonstration projects in New Jersey, for example, show care and cost improvements from closer collaboration, yet the barriers remain.

"We believe physician employment … will continue to grow because of the expected incentives … call for tighter care coordination to manage services that are bundled together … or simply to better manage patients with chronic conditions."

—Standard & Poor's 2012

Hospitals: Antitrust Watchdogs Prevent Anticompetitive Mergers

Hospitals have been under the watchful eyes of the federal antitrust authorities for decades. When the Federal Trade Commission (FTC) believes a hospital merger threatens competition, the agency has not hesitated to step up.

The FTC alone investigated a dozen completed hospital mergers and challenged or threatened to challenge at least that many proposed mergers in recent years.

New care models, like accountable care organizations (ACOs), will continue to get the FTC's closest scrutiny. In response to a question about ACOs, the FTC's chairman said:

"We're not going to roll over and play dead and allow a lot of health-care consolidation."

Not so for insurance companies. Over the past decade, no merger between major insurance companies has been completely rejected by the federal antitrust authorities. Indeed, as well documented annually by the American Medical Association and observed by others:

"[I]t appears that consolidation has resulted in the possession and exercise of health insurer *monopoly* power ... instead of passing any benefits of consolidation such as lower premiums from efficiency gains on to consumers .... [T]he majority of health insurance markets in the United States are highly concentrated."

—Competition in Health Insurance 2012

"Payers have consolidated over the past several years … providing greater negotiating leverage for the payer."

"In most markets dominated by large payers, hospital commercial reimbursement rates are lower than average."

—Moody's 2012

Some payers tend to blame hospital mergers for high insurance premiums. *Two* economic consulting firms examined charges that hospital mergers in the 1990s drove up prices. They said:

"There is no valid empirical basis for [that] conclusion."

—Competition Policy Associates and Economists Incorporated 2003.

That is still true today.

—Continued

American Hospital Association.

Hospitals: The Changing Landscape is Good for Patients & Health Care

Continued

Hospitals: Consumer Preference Matters

Like firms in every other sector of our economy, hospitals are not all the same. Some hospitals with high-level or more costly services, like burn or high-level trauma units or other highly specialized care, have higher costs and may charge higher prices. These may also be the very hospitals that consumers most want to go to when they are seriously ill or badly injured.

Pundits often confuse such consumer preferences with market power – they are wrong to do so.

> "Even the FTC acknowledges that for hospitals, different prices are "neither necessary nor sufficient to demonstrate … market power."
>
> —*FTC Working Paper 2009*

Hospitals compete to be the best and invest the resources needed to maintain consumer trust and loyalty.

—*Compass Lexecon 2010*

In a radio interview, small business owners in California said they were willing to pay more for the hospitals their employees believed were the best.

—*KQED, November 20, 2010*

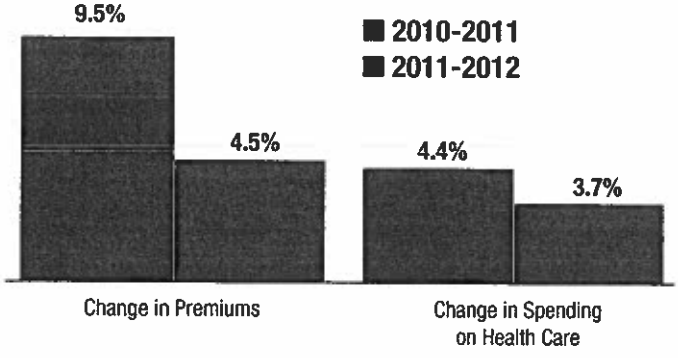
Hospitals: Price Growth is at Historic Lows

Despite renewed merger activity, the growth in spending on hospital care is at historic lows.

—*Altarum 2012*

It is *not* hospital prices that are driving the rise in insurance premiums. The growth in insurance costs from 2010 to 2011 was more than double that of the underlying health care costs, including hospitals. From 2011 to 2012, premiums began to reflect the lower spending growth, but still outpaced it by nearly 14%.

Percent Change in Premium Levels vs. National Spending on Health Care, 2010 to 2011 and 2011 to 2012



Source: The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits Survey.* Data released 2011. Link: http://ehbs.kff.org/pdf/2011/8225.pdf. Altarum Institute, Insights from Monthly National Health Expenditure Estimates through December 2011. Link: http://www.altarum.org/reasearch-initiatives-health-systems-health-care/altarum-center-for-studying-health-spending/health-indicator-reports.

Insurance companies are expected to drive hospital rate increases even lower, according to Moody's, "continuing a multi-year trend."

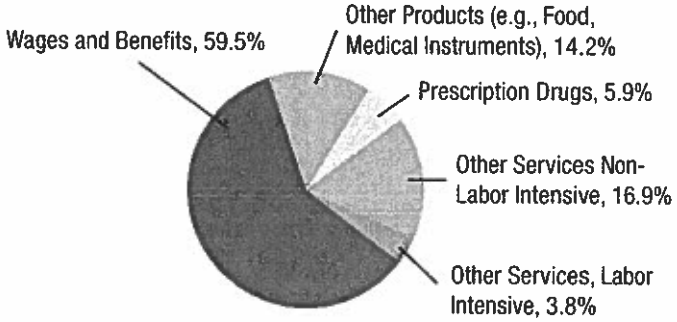
> "[T]he opportunities to gain leverage and higher rates from commercial payors are quickly dissipating...."
>
> —*Moody's New Forces 2012*

> "We expect commercial payers to remain highly aggressive in negotiating lower reimbursement rates with hospitals in 2012."
>
> —*Moody's 2012*

Unlike other health care sectors, study after study has shown that hospital prices are directly related to the cost of caring for patients. Funds needed to hire and retain doctors, nurses and other medical and support staff with the right qualifications and training are the single largest cost for hospitals – they account for two-thirds of total expenses.

About two-thirds of hospital costs go to the wages and benefits of caregivers and other staff.

Percent of Hospital Costs' by Type of Expense, 4Q09



Source: IHS Global Insight, Quarterly Index Levels in the CMS Prospective Payment System (IPPS) Hospital Input Price Index, 2009 Q3.

—Continued

American Hospital Association.

Hospitals: The Changing Landscape is Good for Patients & Health Care Continued

Hospitals: Investing in Technology and Upgraded Facilities

Other significant outlays for hospitals involve IT. Every hospital is expected to meet new standards for having and using electronic medical records for its patients or face penalties in 2015.

Meeting that requirement safely will cost as much as $50 million for a midsize hospital.

—National Journal 2012

Moody's lists "[i]ncreased need for capital relating to plant modernization and IT systems" as one of the top reasons for its negative outlook for hospitals in 2012.

—Moody's 2012

Getting and making this new technology work for patients and meeting new and far-reaching government and private-sector requirements (coming from employers and payers) is a major investment for all hospitals. For cash-strapped hospitals it may be beyond their reach without merging with another hospital that can provide those funds.

These same hospitals may not be able to borrow to do so because of depreciation rules.

"Independent hospitals tend to have narrower margins, meaning they can't simply fork over the cash … to digitize their records."

—National Journal 2012

Doctors must meet similar requirements, yet regulatory barriers make that difficult or impossible to do so in collaboration with a hospital without being in its employ.

"Investment in IT systems was indicated as the most important area of capital spending."

—Fitch Special Report 2012

Hospitals: Essential Capital is in Short Supply

There is no doubt that limited access to capital for IT and other investments essential to providing high-quality care at lower costs is driving mergers.

"The changing healthcare operating environment has led most hospitals to invest in an array of initiatives including IT, physician alignment, inpatient and outpatient facilities and expanding clinical access points in the community."

—Fitch Special Report 2012

Capital markets for not-for-profit hospitals have still not fully recovered from the recent financial meltdown. Three temporary federal financing options that helped ease the credit crunch expired in 2010. For many hospitals, particularly those with lower bond ratings, the best and perhaps only strategy to remaining viable in their community is merging with another hospital that has the financial resources it lacks.

"Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner."

—Moody's New Forces 2012

The Michigan Attorney General recently approved a hospital deal citing access to capital as its primary benefit. The AG said that lack of capital made it impossible for the hospital to "perform necessary renovations, improvements, and expansion of its aging structures and equipment …." The deal, the AG said, "offers hope that the [community] will continue to be well served … for a long time to come."

Hospitals: Need to be Healthy to Provide the Most Value

"Of all the transformations reshaping American healthcare, none is more profound than the shift toward value."

—Value through Partnership 2012

Quality outcomes, affordability, and patient satisfaction are rapidly becoming the touchstones employers, payers, government and, most importantly, patients expect and demand. Meeting these challenges requires reshaping the hospital field, sometimes through mergers, alliances, partnerships or other innovative relationships.

This transformation will require time, patience and capital investment to build a continuum of care that accommodates 21st century technology and standards of medical care. When mergers are needed to help financially, geographically or otherwise challenged hospitals avoid "closure, bankruptcy, or payment default," or to become stronger and more efficient to meet current challenges and fulfill community needs, that should be a welcome development.

References available at *www.aha.org*, updated 12/12

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EXHIBIT N

Fundamental Transformation of the Hospital Field

At a time when hospital revenues already are strained, hospitals must respond to rapidly changing market forces, including: (1) reimbursement reductions and changes; (2) an increasing necessity to implement robust electronic health records (EHR) systems; and (3) limited access to capital. These market forces are driving an urgent need for hospitals to make significant capital investments and achieve greater economies of scale, both of which are critical to hospitals' future ability to compete.

> *"The healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed."*
>
> Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012

Effective delivery of high-quality care to a community depends on the hospital's ability to succeed in an increasingly competitive environment. For many hospitals – particularly stand-alone hospitals – merging with another hospital or system may be the only hope for remaining competitive. Indeed, changes in the field are prompting a "national explosion of consolidation" in the health care sector (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). Without the ability to merge, many hospitals' ability to provide the kinds of services and care their patients and community depend on would be deeply impacted.

Current Market Trends are Transforming the Health Care Field, Driving an Urgent Need for Capital Investments and Economies of Scale

In the health care field, "actual market realities" demonstrate that hospitals' past performance often reveals little about their future ability to compete. Many hospitals are struggling to make ends meet, and three major trends have created further pressure: reimbursement reductions and changes, EHR requirements and difficulty accessing capital. To remain competitive, hospitals must have the capability to adapt to these trends by making significant capital investments and achieving economies of scale.

Reimbursement Reductions and Changes are Constraining Revenues and Will Require Hospitals to Alter Methods of Delivering Care.

In light of the challenges facing hospitals and the uncertainty surrounding the future of health care, analysts have reported an "unequivocally negative" outlook for hospitals "for at least the next several years" (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative* for 2012, Jan. 25, 2012). Hospital reimbursement rates have declined in recent years, and they are expected to undergo further cuts. Meanwhile, commercial and government payers have implemented dramatic reimbursement changes that will fundamentally alter the manner in which hospitals provide care. Together, these changes will require hospitals to make significant investments in technology, as well as develop greater economies of scale.

Recent Reimbursement Pressures. Hospital reimbursements are declining, resulting in an "unprecedented threat to revenues." According to industry analysts, "the median hospital revenue growth rate is the lowest in two decades" at 4.0 percent (Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow*, Aug. 10, 2011). Revenue is expected to continue to decline in 2012 and "reach a low point in 2013" (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011).

Hospital reimbursement rates under Medicare and Medicaid – which account for more than half of hospital revenues – have been constrained, and these revenue sources are very likely to suffer deeper cuts (Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow*, Aug. 10, 2011). Medicare payment rates increased every year from 1999 to 2010, but rates were effectively cut in federal fiscal year 2011. Changes in reimbursement methods will not only transform the way in which hospitals deliver care, but will also lead to cuts of $150 billion in Medicare payments over the next 10 years. And further Medicare cuts are likely as legislators struggle to reduce the federal deficit (Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow*, Aug. 10, 2011).

Medicaid reimbursement rates also are under fire. Financially strapped states have cut Medicaid reimbursement rates in an effort to balance their budgets. Currently, average Medicaid rates are only 72 percent of Medicare rates. Deeper Medicaid cuts loom: Over the next five years, $14 billion dollars will be cut from Medicaid Disproportionate Share Hospital payments, which provide additional assistance to hospitals caring for a high number of Medicaid and uninsured patients. These cuts will be felt acutely by hospitals in states that elect not to expand Medicaid coverage under the *Patient Protection and Affordable Care Act* because they will not be offset by revenues from newly eligible Medicaid patients.

These reimbursement pressures are compounded by a decrease in inpatient admissions and a shift toward outpatient treatment. This shift is significant because reimbursement for observation stays and same-day visits "is much lower than for a comparable inpatient day" (Standard & Poor's, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012).

Hospitals have implemented "aggressive cost reduction strategies across the board" to match decreased revenues with decreased costs, including by cutting salaries and benefits (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011). But these cost-cutting measures only go so far. "While managing costs is an effective near- to medium-term strategy, . . . its effectiveness is limited in the long term as it is hard to find new cost-cutting initiatives year after year, unless the broader business model also changes" (Standard & Poor's, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012). "[A]s many providers are forced to hold down or lower costs year after year to maintain operating margins" in the face of reimbursement pressure, "it remains unclear how hospitals can come up with additional reductions." As a result, "[a]dditional expense reductions will now involve deeper and more difficult strategies in order to both gain efficiencies and fundamentally change how hospitals deliver care" (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011).

Changes in Reimbursement Methods Threaten Revenues and Alter the Metrics for Success, Requiring Hospitals to Reduce Costs as They Improve Quality.

As hospitals struggle to reduce costs in line with reimbursement reductions, they also must adapt to groundbreaking changes in reimbursement methods. To maximize value, hospitals must improve the quality of care while finding new ways to gain efficiencies.

The Shift from Volume to Value. "Of the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value." Both government and private payers are moving away from the traditional fee-for-service model, which assigns a reimbursement amount for each particular service. Instead, payers are implementing "value-based" reimbursement, which ties payment to the quality and cost-effectiveness of care.

Value-based programs – sometimes called "pay-for-performance" programs – take on various forms. Some commercial insurers tie hospital payments to performance goals such as clinical outcomes and cost per case. Other programs incorporate additional measures of value, including adoption of information technology (IT) and patient satisfaction. Even Medicare has joined the trend toward value-based reimbursement; the Hospital Value-Based Purchasing Program marks "the beginning of an historic change in how Medicare pays health care providers." The program will withhold a portion of Medicare reimbursement each year and redistribute it as "incentive" payments based on hospitals' achievement of various quality outcomes.

Payers are also measuring hospital "readmission" rates, the rates at which patients are readmitted to a hospital after initial discharge. For example, hospitals now face penalties for having disproportionately high readmission rates, which could cost a hospital up to 3 percent of its total Medicare reimbursements.

Bundled payment systems also illustrate this shift. Under a new pilot program, the government will make a flat (bundled) payment for a package of services, which may include hospital, physician and post-acute care costs. Bundled payment systems "are currently being more widely tested by commercial payers" (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012), and they "driv[e] the need for greater efficiencies" (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012).

Adapting to Reimbursement Changes Requires Investments in IT and Economies of Scale. The focus on value is "driving a fundamental reorientation of the healthcare system" to maximize quality and cost-effectiveness. As the health care field evolves, hospitals' relevant "success factors" "will change from what we know today." In a value-based field, these "success" factors include making immediate capital investments in IT and achieving economies of scale.

Investments in IT. Value-based reimbursement methods demand that hospitals make significant investments in IT to achieve a variety of performance-based goals. Enhanced IT is "essential if providers are to comply with new quality standards and pay-for-performance initiatives being imposed by Medicare and private insurers." To qualify for value-based payments, providers must have IT that permits them to "[a]ccurately and consistently report data on appropriate metrics," share information throughout the organization, and measure quality results against benchmarks to monitor progress. Such systems enable providers to "link quality and financial metrics to quantify the value of care provided." IT also may help hospitals improve quality of care by developing clinical protocols to promote consistent practices (Fitch Ratings, *Capital Expenditure Trends Among Nonprofit Hospitals*, May 16, 2012). Moreover, IT will enable providers to "improve processes and allocate resources in a highly efficient way, resulting in an efficient cost structure." These systems require large upfront investments, which may be particularly difficult for smaller providers with limited resources.

Economies of Scale. Another "success factor" is the ability of hospitals to gain "sufficient size to achieve economies of scale in all their operations." Economies of scale allow providers to reduce costs, as well as provide comprehensive care for a community or population "by deploying the right resources in the appropriate setting." More comprehensive care is likely to result in better clinical outcomes and fewer readmissions, which in turn lead to higher value-based payments.

To Remain Competitive In The Future, Hospitals Must Adopt Electronic Health Records.

Another trend transforming the health care field is the movement toward electronic health records (EHRs). Not only are EHRs necessary for hospitals to succeed in a value-based reimbursement model, but a portion of Medicare and Medicaid reimbursements are now conditioned on hospitals' adoption of EHRs that meet various objectives. The costs of HER systems are staggering, however, making it difficult for already-struggling hospitals to keep up.

EHRs have the potential to improve efficiency and clinical outcomes – both of which are essential in value-based purchasing. Federal "meaningful use" requirements encourage hospitals to reap these benefits by awarding Medicare and Medicaid "incentive payments" to hospitals that are "meaningful users" of EHRs. A hospital is deemed a "meaningful user" if it implements certified technology that meets various standards – for example, the technology must have the ability to conduct drug-drug and drug-allergy interaction checks. Hospitals that have not achieved targeted "meaningful use" standards by 2013 or early 2014 will face penalties in the form of decreased Medicare reimbursements. To maintain revenues, it is imperative that hospitals implement certified EHRs that pass muster under "meaningful use" requirements.

Despite this imperative, hospitals' overall rate of EHR adoption remains low, with a long way to go before they reach full implementation. Indeed, more than 80 percent of hospitals have not met the government's "meaningful use" Criteria. In the meantime, the digital divide is widening. Large, urban teaching hospitals are more likely to adopt EHR systems than their smaller, rural nonacademic counterparts. Smaller hospitals may continue to fall further behind as other hospitals reap the eventual cost-saving benefits of EHRs.

Hospitals that have not adopted EHRs cite financial concerns – including capital and maintenance costs – as the primary barrier to implementation. EHR systems require significant "upfront costs to initiate" the technology. In addition to evaluating and purchasing the technology itself, a hospital may need to hire additional staff or outsource the conversion of paper charts to electronic charts; train its staff members on the systems; and adapt the hospital infrastructure to house the technology. EHRs also require ongoing maintenance costs, such as implementing system updates. One expert estimates that implementing EHRs will cost between $20 million and $200 million, depending on the size of the hospital. Even those hospitals that already have EHRs may face high costs – $10 million in one hospital's estimate – to upgrade their systems to meet federal requirements. Although hospitals eventually will receive "incentive payments," those payments are available only *after* hospitals have made significant investments. Hospitals' ability to make these investments is an important measure of their future ability to compete.

The Capital Crisis: Despite Hospitals' Need For Significant Capital Investments, They Continue To Suffer From Limited Access To Capital.

Despite hospitals' strong need to invest in EHRs and other technology, it is increasingly difficult for hospitals to access the capital necessary to do so. A hospital's ability to access capital is a critical "indicator[] of future ability to compete" in the changing field of health care.

The Need for Capital. Hospitals' need for capital is greater now than ever. The trend toward value-based purchasing will require hospitals to adopt sophisticated IT, including EHRs, to compete in the health care market. Meanwhile, hospitals must continue to update their plant, property and equipment to maintain quality care.

"Hospitals are very capital intensive. Hospitals must spend money on capital to maintain their equipment, to provide new systems, and to avoid decline." Hospitals that do not consistently invest in buildings, equipment and IT cannot effectively compete in the future market of health care. "Years of thin or deferred capital spending can place hospitals at a significant competitive disadvantage with patients, payers, physicians, and employees." Hospital quality – and, as a result, patients' clinical outcomes – could suffer.

The Process of Accessing Capital. Hospitals rely on various sources of capital, including investment income, philanthropy and tax-exempt bonds. For not-for-profit hospitals, tax-exempt bonds are the traditional and primary means of financing future projects. A hospital's ability to finance projects through tax-exempt bonds depends primarily on its credit rating, which is shorthand for its ability to access capital and the price at which it can borrow money. Ratings agencies, including Moody's and Standard and Poor's, evaluate and rate the creditworthiness of hospitals. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on the bonds. In other words, the higher the bond rating, the lower the cost of capital. Even the slightest drop in a bond rating – resulting in a slightly higher interest rate – may cost a hospital significantly more over the lifetime of a bond issue.

Hospitals' Difficulties Accessing Capital. The health care sector "is becoming increasingly bifurcated into 'haves' and 'have nots'" (HFMA, *How Are Hospitals Financing the Future?: The Future of Capital Access*, May 2004). The "haves" are those hospitals with broad access to capital, while the "have-nots" suffer from limited access. In 2009, 88 percent of hospitals reported that it was "more difficult or impossible to access capital from tax-exempt bonds" since the 2008 recession.

Difficulties obtaining access to tax-exempt bonds have led hospitals to "quickly scale[] back" their capital projects. "In order to preserve liquidity, some healthcare systems delayed major projects that were not already started, halted projects already begun, postponed new equipment purchases and/or re-prioritized projects" (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012). The median growth rate of capital investment has declined for two consecutive years. And the median average age of plant has increased for three straight years, indicating that hospitals are delaying capital spending, and that they will have an even greater need for capital spending in the future.

Without capital expenditures, hospitals are unable to invest in new technology and equipment that benefit patients, and hospitals may find it more difficult to recruit top physicians. Continued deferment of capital expenditures is not sustainable. "[G]iven the pace of change in the industry . . . , hospitals may not be able to reign in capital expenditures and remain competitive." As a result, consolidation activity has continued "as resource strapped hospitals seek partners to help them invest in these areas."

To the extent that hospitals have made capital expenditures, they are increasingly funding projects with cash holdings, as opposed to debt borrowings. "While this strategy protects current debt service coverage requirements, it reduces the balance sheet cushion and may reduce liquidity, weakening cash to debt measures" (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012).

The Downward Spiral. Because a hospital's access to capital is closely tied to its financial health and ability to invest in the future, trends in capital spending reveal "the potential for a downward spiral." The spiral involves the following sequence:

- "Hospitals increasingly struggle with their financial health…
- [T]heir deteriorating financial health makes them less creditworthy…
- [T]heir ability to access capital becomes limited…
- [T]hey must devote a larger proportion of their capital to keeping up with the demands of today…
- [T]hey are decreasingly able to invest in the future…
- [A]s a result, their financial health drops significantly."

As "[s]truggling hospitals" experience this "very slow downward spiral," they become "unable to meet consumer and competitive needs." The outlook can be particularly bleak for smaller hospitals that enter the spiral with lower credit ratings and less access to capital (see Moody's Investors Service, U.S. *Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011).

Unless hospitals short-circuit the downward spiral by improving their access to capital, they will continue to fall behind and may never regain their footing. "[E]ventually, if they are not acquired, they wind down and close." As a result, "more hospital closures are likely."

The results could be devastating for both patients and the community. The financial unraveling of a hospital has the potential to impact the community more profoundly than the unplanned closure of nearly any other institution. Patients will suffer as hospitals struggle to survive and slowly deteriorate. Prices will rise, equipment will wear down without being replaced, and physicians will leave for greener pastures. Ultimately, the health of the community will suffer. Furthermore, closure may result in reduced specialty services and overcrowding in other hospital emergency departments, while patients may delay treatment due to confusion regarding where to obtain appropriate care.

The Impact of these Trends Impact the Likely Competitive Effects of a Merger. These three trends – reimbursement reductions and changes, EHRs and limited access to capital – are changing the landscape of health care, and they speak "directly to the question of whether future lessening of competition [i]s probable." Hospitals' past performance is no longer a "conclusive indicator[] of anticompetitive effects." Rather, hospitals' ability to compete turns on their ability to keep pace with these trends, which requires significant capital investments and economies of scale.

Mergers are Critical to Hospitals' Future Ability to Compete in the Changing Field of Health Care

Current market forces "have ignited the national explosion of consolidation" in the health care field. Moody's Consolidation Report at 1. For a field that has a depressed ratings outlook, consolidation often offers a glimmer of hope (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012). Mergers arm hospitals with two critical "success factors" that will enable them to adapt to recent health care trends: economies of scale and improved access to capital.

Mergers Enable Hospitals to Become More Competitive Through Economies of Scale. Even the most vigilant cost-cutting efforts cannot carry already-struggling hospitals through this period of transformation. Mergers present hospitals with a unique opportunity to achieve deeper cost reductions and greater economies of scale with the promise of becoming more competitive.

Now more than ever, "size and scale are . . . a more important means to gaining greater efficiencies and driving waste and costs out of the delivery systems" (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). Through consolidation, hospitals can gain the "size and scale" necessary to diversify their revenue sources, spread costs over a larger base, and "allocat[e] . . . resources to better withstand likely future reductions in funding" (Fitch Ratings, *US Hospital M&A Generally Positive for Bondholders*, July 6, 2012).

For example, mergers allow hospitals to reduce excess capacity, the number of available hospital beds that go unoccupied. Unused beds – as well as the staff and buildings necessary to maintain those beds – "represent fixed costs that must still be paid and thus spread over a dwindling number of patients and . . . over all other services at that particular facility." Reducing excess capacity results in significant cost savings, which can then be captured and reinvested to fill community needs, such as a pro-competitive expansion of services.

Mergers also allow hospitals to eliminate duplicative services and technology, which "could save money without compromising access to care." Eliminating these expenses may result in lower prices. **Consolidation efforts short of a merger do not typically result in the same degree of success in eliminating excess capacity and duplicative resources.** By establishing common ownership of facilities and equipment, mergers allow hospitals a clearer path to achieve these critical improvements, which are relevant to the "probable anticompetitive effect of the merger."

Mergers Provide Hospitals with Greater Access to Capital, Allowing them to Make Necessary Investments to Remain Competitive in the Future. Access to capital is critical to hospitals' ability to make capital investments – and to effectively compete in the future. Mergers allow hospitals to improve their access to capital by increasing their size and, in many cases, by joining a hospital system.

Hospital size is closely tied to a hospital's bond rating; larger hospitals tend to have higher bond ratings, in part due to their greater "scope and acuity of services" and "ability to gain greater efficiencies" (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011). Smaller providers, on the other hand, are subject to greater ratings pressure. By increasing size, hospitals may improve their ability to access capital.

Through a merger, the acquired hospital frequently joins a larger hospital system, which provides even greater access to capital. In general, hospitals that are part of systems tend to have better access to capital. Rating agencies may allow systems to achieve higher credit ratings with some lower thresholds – such as days cash on hand – because they generally see less risk in a system than a stand-alone hospital. A hospital system disperses risk among a variety of facilities, services, and even geographic locations. In addition, hospitals frequently obtain "[g]reater synergies as a larger system with critical mass, particularly if in same or adjacent markets" (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). Furthermore, hospitals that become part of a system may also join that system's obligated group, which is a group of organizations that act as a single entity for credit purposes and that are obligated on the collective debt of the group. Membership in an obligated group will increase the security of the acquired hospital's debt and likely lead to higher credit ratings.

In light of the benefits of size and system membership, it is unsurprising that hospital mergers have a positive impact on a hospital's credit – and corresponding ability to access capital (see Standard & Poor's, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012, Jan. 25, 2012*, discussing "two multinotch upgrades" that occurred as a result of mergers). "Access to capital . . . almost certainly will improve as a result of consolidation." Greater access to capital allows hospitals to make critical capital expenditures.

Particularly for Stand-Alone Hospitals, Mergers may be the only Means of Remaining Competitive in the Future. In the rapidly changing field of health care, many stand-alone hospitals – those hospitals that are not part of a system – are facing a crossroads: Will they merge with a partner hospital to ensure that they remain competitive, or will they remain independent and hope to find other means to weather the storms? As analysts have recognized, "[l]ong term structural change in the sector has favored a minority of larger, well managed hospitals and systems, while creating ever tighter competitive conditions for the majority of smaller, *especially freestanding*, hospitals" (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012).

Stand-alone hospitals are particularly vulnerable to the threat of the downward spiral. There is a "longstanding credit quality gap between . . . systems and stand-alone providers," and market changes threaten to widen the gap (Standard & Poors, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012). Recent downgrades in hospital credit ratings "were disproportionately weighted toward stand-alone hospitals." In the future, stand-alone hospitals "with weaker ratings will be greatly constrained in obtaining the capital they need for facility improvements, product line development, IT improvements, or physician alignment strategies." This pressure "may push them over the edge to seek a merger partner or acquisition."

Indeed, experts are advising the boards and management of stand-alone hospitals to consider consolidation. "[Given the ever-growing pressures [facing hospitals,] it is imperative that each hospital be willing to perform a candid, objective assessment of its ability to continue to go it alone." Although many not-for-profit boards and CEOs "have a bias toward independence," they are advised to carefully consider "whether independence continues to be in the hospital's best interest," Various indicators – "[a] weakening in key financial metrics, a softening market share, or an inability to keep pace with facility and technology upgrades" – "may point to the need for affiliation or merger." Many stand-alone hospitals have followed this advice; in 2009, 85 percent of hospital mergers and acquisitions involved stand-alone hospitals.

Hospitals that are "left out of consolidations, especially smaller stand-alone hospitals . . . , will face greater negative rating pressure going forward" (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). This pressure will make it harder for hospitals to access capital and to remain competitive. Those hospitals that do survive are likely to "evaluate their service offerings [and] may downsize their footprints," which will further reduce competition. Therefore, many acquisitions of stand-alone hospitals will result in more competition, rather than less.

Policy Makers Should Consider these Market Realities when Assessing the Probable Effect of Hospital Mergers. During this period of rapid market transformation, many smaller hospitals – especially stand-alone hospitals – will struggle to remain competitive unless they find a partner that can help improve their access to capital and provide greater economies of scale. This "market realit[y]," is highly relevant to any "assessment of what will likely happen if a merger proceeds as compared to what will likely happen if it does not."

Hospitals should not be forced to wait to merge until they are in imminent danger of closing their doors. If hospitals must tumble through the downward spiral, both patients and the community will suffer from disruptions in the quality and consistency of care as hospital services slowly deteriorate. . In many cases, "the public interest would best be served by allowing the hospitals to proceed with the merger."

This paper has been adapted from an AHA amicus brief filed on Sept. 24, 2012 in the Sixth Circuit Court of Appeals. For a complete list of references, go to: http://www.aha.org/advocacy-issues/legal/legal-amicus-briefs.shtml.

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 15, 2013 FAX ONLY

Jeryl Topalian
Executive Director, Planning & Business Development
Norwalk Health Services Corporation
34 Maple Street
Norwalk, CT 06850

Sally Herlihy
Vice President, Planning
Western Connecticut Health
Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc
CON Application Deemed Complete

Dear Mr. Topalian and Ms. Herlihy:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of July 15, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7001.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

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*** TX REPORT ***
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FAX SHEET

TO: Sally Herlihy

FAX: (203) 739-1974

AGENCY:

FROM: Steven Lazarus

DATE: 7/15/13 **TIME:** 3:50 pm

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Comments: Letter re: 13-31832 Enclosed

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FAX SHEET

TO: Jerry Topalian

FAX: (203) 852-1553

AGENCY:

FROM: Steven Lazarus

DATE: 7/15/13 TIME: 3:50 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Letter re: 13-31832 Enclosed

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

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: August 5, 2013

RE: Certificate of Need Application; Docket Number: 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

August 23, 2013

Jeryl Topalian
Executive Director & Business Development
Norwalk Health Services Corporation
34 Maple Street
Norwalk, CT 06850

Sally Herilihy
Vice President Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Dear Mr. Topalian and Ms. Herlihy:

With the receipt of the completed Certificate of Need ("CON") application information submitted by Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. ("Applicants") on July 15, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s):	Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Docket Number:	13-31832-CON
Proposal:	Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. with no associated capital expenditure

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: September 10, 2013

Time: 3:00 p.m.

Place: The Norwalk Inn and Conference Center
99 East Avenue – Mariner Ball Room
Norwalk, CT

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in *The Hour* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Steven Lazarus, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: SWL:PF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

August 23, 2013 Requisition # 43054

The Hour
P.O. Box 790
Norwalk, CT 06852-0790

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 **Monday, August 26, 2013**. 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 Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:PF:lmg

The Hour **August 23, 2013**
Notice of Public Hearing, Docket Number 13-31832-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant(s):	Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Town:	Norwalk
Docket Number:	13-31832-CON
Proposal:	Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. with no associated capital expenditure
Date:	September 10, 2013
Time:	3:00 p.m.
Place:	The Norwalk Inn and Conference Center 99 East Avenue – Mariner Ball Room Norwalk, CT

Any person who wishes to request status in the above listed public hearing may file a written petition no later than September 5, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

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TO: SALLY HERL HY

FAX: (203) 739-1974

AGENCY: WESTERN CO NNECTICUT HEALTH NETWORK, INC.

FROM: STEVEN LAZ RUS

DATE: 8/23/13 **TIME:**

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Phone: (8 0) 418-7001 ***Fax: (860) 418-7053***

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ST. TE OF CONNECTICUT
DEPAR MENT OF PUBLIC HEALTH
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FAX SHEET

TO: JERYL TOPAI IAN

FAX: (203) 852-2354

AGENCY: NORWALK HI ALTH SERVICES CORPORATION

FROM: STEVEN LAZA RUS

DATE: 8/23/13 **TIME:**

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Comments: DN: 13-31852- ON Hearing Notice

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Phone: (8 0) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, August 23, 2013 10:24 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 13-31832-CON

Good day!

Thanks so much for your ad submission.
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If you have any questions or concerns, please don't hesitate to contact us at the number below.

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From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, August 23, 2013 8:55 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31832-CON

Please run the attached hearing notice in The Hour by 8/26/13. For billing purposes, refer to requisition 43054. In addition, please submit a "proof of publication" for my records when available.

Thank you,

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

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Friday, August 23, 2013 3:55 PM
To: Greer, Leslie
Subject: FW: Hearing Notice DN: 13-31832-CON
Attachments: 13-31832np Hour.doc

Your legal notice is all set to run as follows:

Norwalk Hour, 8/26 issue - $182.96

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, August 23, 2013 8:55 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31832-CON

Please run the attached hearing notice in The Hour by 8/26/13. For billing purposes, refer to requisition 43054. In addition, please submit a "proof of publication" for my records when available.

Thank you,

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 28, 2013 Via Fax Only

Jeryl Topalian
Executive Director & Business Development
Norwalk Health Services Corporation
34 Maple Street
Norwalk, CT 06850

Sally Herilihy
Vice President Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Request for Prefile Testimony and Issues

Dear Mr. Topalian and Ms. Herlihy:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on September 10, 2013. The hearing is at 3:00 p.m. at The Norwalk Inn and Conference Center, 99 East Avenue – Mariner Ball Room, in Norwalk. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. ("Applicants") submit prefiled testimony by 12:00 p.m. on September 5, 2013.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues outlining the topics that will be discussed at the hearing.

Please contact Steven W. Lazarus at (860) 418-7012, if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

Attachment

Issues

Certificate of Need Application, Docket Number: 13-31832-CON

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

The Applicants should be prepared to discuss and present supporting evidence on the following issues:

1. The clear public need for the proposed affiliation.
2. The financial and other benefits of the proposed affiliation.
3. The effect of the proposed affiliation on the following:
    a) the residents of the region;
    b) existing healthcare providers,
    c) healthcare services in the region; and
    d) elimination/consolidation of duplication of services.
4. Whether this proposal is consistent with the overall goals of the Hospitals' Community Needs Assessments and the Department of Public Health's Statewide Facilities and Services Plan.

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

TRANSMISSION OK

TX/RX NO	3662
RECIPIENT ADDRESS	912038521553
DESTINATION ID	
ST. TIME	08/28 13:37
TIME USE	00'35
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: Jeryl Topalian

FAX: (203) 852-1553

AGENCY:

FROM: Steven Lazarus

DATE: 8/28/13 **TIME:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: DN: 13-31832 - Request for Prof h + Issu

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

****
*** ERROR TX REPORT ***
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TX FUNCTION WAS NOT COMPLETED

TX/RX NO	3661
RECIPIENT ADDRESS	912037361974
DESTINATION ID	
ST. TIME	08/28 13:40
TIME USE	00'36
PAGES SENT	0
RESULT	NG #0018 BUSY/NO SIGNAL

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

FAX SHEET

TO: Sally Herlihy

FAX: (203) 739-1974

AGENCY:

FROM: Steve - Lazaro

DATE: 8/28/13 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
DN: 13-37832 Request for Profile + Usage

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Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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

TRANSMISSION OK

TX/RX NO	3663
RECIPIENT ADDRESS	912037391974
DESTINATION ID	
ST. TIME	08/28 13:43
TIME USE	01'03
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: Sally Herlihy

FAX: (203) 739-1974

AGENCY:

FROM: Steve - Lazarus

DATE: 8/28/13 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
DN: 13-37832 Request for Profile + Usage

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

August 28, 2013 Requisition # 43079

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 **Thursday, August 29, 2013**. 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 Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:PF:lmg

The News Times **August 28, 2013**
Notice of Public Hearing, Docket Number 13-31832-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant(s):	Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Town:	Norwalk
Docket Number:	13-31832-CON
Proposal:	Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. with no associated capital expenditure
Date:	September 10, 2013
Time:	3:00 p.m.
Place:	The Norwalk Inn and Conference Center 99 East Avenue – Mariner Ball Room Norwalk, CT

Any person who wishes to request status in the above listed public hearing may file a written petition no later than September 5, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Wednesday, August 28, 2013 10:47 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 13-31832-CON

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.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

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Fax: 203-549-0061

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http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Wednesday, August 28, 2013 9:40 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31832-CON

Please run the attached hearing notice in The News Times by 8/29/13. For billing purposes, refer to requisition 43079. In addition, please submit a "proof of publication" when available for my records.

Thank you,

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

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Wednesday, August 28, 2013 4:33 PM
To: Greer, Leslie
Subject: FW: Hearing Notice DN: 13-31832-CON
Attachments: 13-31832np Newstimes.doc

Your legal notice is all set to run as follows:

Danbury News, 8/29 issue - $405.02

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Wednesday, August 28, 2013 9:40 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31832-CON

Please run the attached hearing notice in The News Times by 8/29/13. For billing purposes, refer to requisition 43079. In addition, please submit a "proof of publication" when available for my records.

Thank you,

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

The Law Office of Patricia A. Gerner, LLC
240 Ramstein Road P.O. Box 209
New Hartford, CT 06057
Phone: (860) 794-1907 Fax: (860) 489-9380

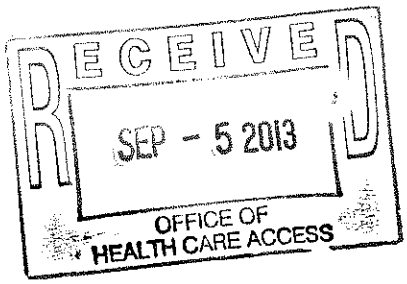
Facsimile Transmittal

Date: SEPT. 5, 2013

To: OFFICE OF HEALTH CARE ACCESS
ATT: STEVEN LAZARUS

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)

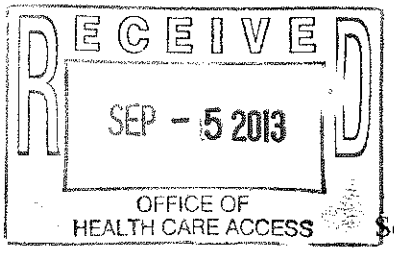
Message:

RE: DOCKET NO: 13-31832-CON

The document(s) accompanying this facsimile transmission cover page are privileged and contain confidential information intended only for the use of the individual(s) or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution use or copying of this communication is prohibited. If you have received this communication in error, kindly immediately notify us by telephone so that we can arrange for the retrieval of the facsimile transmission at no cost to you. Thank you

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

Docket No.: 13-31832-CON
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.



September 5, 2013

APPEARANCE

Please enter my appearance in Docket No. 13-31832-CON on behalf of the Applicants, Norwalk Health Services Corporation ("NHSC") and Western Connecticut Health Network ("WCHN").

I plan to attend the hearing on Tuesday, September 10, 2013 on behalf of my clients.

Patricia A. Gerner

9/5/13
Date

Patricia A. Gerner
The Law Office of Patricia A. Gerner, LLC
240 Ramstein Road: P.O. Box 209
New Hartford, CT 06059
Phone: (860) 794-1907
Fax: (860) 489-9380
Email: KLG1@aol.com

Greer, Leslie

From: Herlihy, Sally <Sally.Herlihy@wchn.org>
Sent: Thursday, September 05, 2013 12:05 PM
To: Lazarus, Steven; Greer, Leslie
Cc: Jeryl.Topalian@Norwalkhealth.org
Subject: WCHN-NHSC Prefile Testimony Docekt No. 13-31832-CON
Attachments: WCHN NHSC Pre-file Testimony.pdf

Hi Steven,
Please find attached the required document for Docket No. 13-31832-CON.
The original copy with signatures will be sent to the OHCA office via Federal Express.
Thank you,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

Executive Assistant: Michelle Johnson
Voice: (203) 739-4935
Email: michelle.johnson@wchn.org

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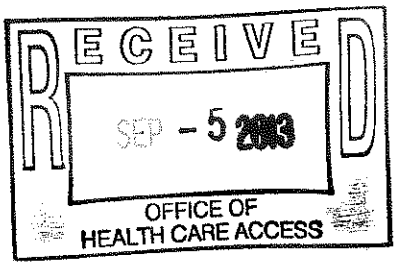
WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.7503

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org



September 5, 2013

Lisa A. Davis, MBA, BFN, R.N.
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: Certificate of Need Application: Docket Number: 13-31832-CON
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Dear Deputy Commissioner Davis,

Attached please find the Prefile Testimony being submitted on behalf of the Applicants, Norwalk Health Services Corporation and Western Connecticut Heath Network, Inc. The individuals submitting prefile testimony will be present at the hearing on September 10, 2013, and will be available for questioning by the Office of Health Care Access.

Please let me know us there is anything else you need prior to the hearing. I can be reached at (203) 739 4903. Jeryl Topalian, Executive Director for Planning and Business Development at Norwalk Health Services Corporation can be reached at (203) 852-2354.

Respectfully submitted,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

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

Affiliation of NHSC and WCHN, Inc.
Docket No. 13-31832-CON

September 5, 2013

PRE-FILED TESTIMONY OF DANIEL J. DEBARBA, JR., PRESIDENT & CEO
NORWALK HEALTH SERVICES CORPORATION

Good afternoon DPH and OHCA staff. My name is Dan DeBarba, and I am the President and CEO of Norwalk Health Services Corporation. I appreciate the fact that you have come to our community to hold this hearing, and welcome the opportunity to share my thoughts on the benefits of the proposed affiliation.

I am here today to request your approval of the proposed affiliation between Norwalk Health Services Corporation and Western Connecticut Health Network. As you are probably aware, the transformation of the health care delivery system, which is occurring at an unprecedented rate, has placed increasing pressures on hospitals to consolidate. The Office of Health Care Access ("OHCA") recognizes the many reasons that hospitals are thinking about affiliations and mergers in Chapter 1 of the CT Department of Public Health's Statewide Health Care Facilities and Services Plan, ("the Plan") published in 2012. (*See* Application, Exhibit D, The Plan, p.7, Sec. 1.8.5).

We selected Western Connecticut Health Network as our partner because we believe they are the best fit for us for an affiliation. We share similar values and have common goals for the

future: successfully providing high quality and accessible healthcare services to our communities, maintaining patient safety and satisfaction, monitoring and improving patient outcomes, providing more care to the underserved, increasing access to primary care and preventive health programs; and recruiting more outstanding physicians, hospital staff and other experts with the skills we need to be successful in the future. We are happy to be here today with a great deal of work already accomplished, and an integration planning process underway.

Norwalk Health Services Corporation began our search for the best way to meet future health care demands in our service area in 2008. Our goals and the plan to achieve these goals are set forth in "Vision 2015: Norwalk Hospital Strategic Plan 2010-2015", which was approved by our Board in August of 2009. (*See* Completeness Answers, Exhibit B, pp. 376-385). At about the same time, NHSC formed the Partnership Task force to assess the continuum of strategic partnership options and drivers that could initiate partnership discussions. (*See* Completeness Answers, p.206). The transforming economic model in health care, with new payment models emerging and the shift toward increasing accountability for the costs and outcomes to providers, was one such driver.

Healthcare is moving from fee-for-service to value-based reimbursement. Reimbursement strategies in the future for Medicare, Medicaid and private payors are expected to shift to risk-based contracting which involves financial incentives for meeting certain quality and cost targets, and penalties for those who do not meet these goals. We want to be able to meet these goals. WCHN has already created a model accountable care organization ("eACO")

with its own employees through Aetna. The eACO has given WCHN the kind of experience we would like to be able to learn from in order to develop an ACO model in the future. With the talent and experience that exists at all three hospitals, we anticipate collaborating on best practices and proven protocols to improve quality and outcomes, at Norwalk, Danbury and New Milford Hospitals.

The federal Patient Protection and Affordable Care Act of 2010 ("ACA"), was a second driver. The new federal law requires investment in quality assessment, physician integration, population health management and electronic health records. We need to be able to make investments in clinical technology in order to be able to demonstrate high quality outcomes, while providing cost-effective care. If this affiliation is approved, we plan to develop an interface between the electronic medical record systems now in use at WCHN and NHSC, to improve continuity of care for patients across the network. The clinical integration of these electronic records with our affiliated physicians' practices will bring a higher level of excellence to the patient through the adoption of evidence-based clinical protocols and processes, while reducing the cost of the care provided. Systems such as these cost millions of dollars. However, investments in this technology are more cost-effective when shared across a larger network, such as the combined NHSC and WCHN.

As a result of the ACA implementation, the expansion of Medicaid, and the development of Health Insurance Exchanges (HIEs), we expect to see a greater demand for health care services beginning in fiscal 2014. Our service area population is stable, but aging, and we anticipate increased numbers of Medicaid patients. With the implementation of the ACA and

value-based payments, we also expect to see reduced reimbursement for Medicare and Medicaid patients. In addition, hospitals have just experienced significant reimbursement cuts from the State and Federal government. With more patients and less reimbursement, the strain on our financial resources will quickly be outpaced by the demands for quality care and better outcomes. Both Norwalk Health Services Corporation and Western Connecticut Health Network are financially strong institutions now, and we have taken measures to remain that way. But we are facing enormous challenges as health care is changing. The sharing of existing resources and the opportunity to collaborate on programs will strengthen all three hospitals and their affiliates. Partnering with WCHN - another large, stable health care institution - is needed so that we can continue to provide health care services long into the future.

In addition to the drivers toward affiliation, I would like to focus on the benefits achieved through this partnership; beginning with improving patient access to services, and improving the quality of those services.

Access to Services

Norwalk Health Services Corporation has conducted a physician resources assessment in its Stark-defined service area, most recently in 2012, which identified significant shortages in primary care providers. (*See* Completeness Answers, p.216). NHSC implemented a physician development plan, and has recruited new primary care practitioners to the service area. Western Connecticut has also made significant investment in physician integration, by developing a physician-hospital organization ("PHO"). By affiliating, we will have the scale

and resources to more rapidly invest in developing the primary care infrastructure in each service area. We anticipate expanding access to primary care services in the community with extended hours and varied locations as needed. The enhancement of access to primary care will provide a cost effective alternative to urgent care, much of which is currently provided in the Emergency Department at a great expense.

The proposed affiliation creates a physician platform that includes over 800 independent physicians and over 300 employed physicians distributed over the contiguous geographic areas served by each organization. There is no plan to curtail any of the clinical services that are currently offered at either institution at this time. Cost savings and accessibility improvements will occur by sharing some services that aren't fully utilized by any of the three hospitals, but could be shared between the three. This is especially true for highly trained specialists who are critical when needed, but are not fully utilized at one location. Opportunities for efficiency may be achieved by the ability to develop specialists who will be able to practice at network locations, covering a wider geographic area.

Improved Quality

The affiliation will allow the administrators and clinical staff of NHSC and WCHN to work together to develop and share the protocols for evidence-based, best practice medicine in every area where patient services are provided (*See* Completeness Answers, p. 211). The synergies achieved by affiliation will allow WCHN and NHSC, in partnership with their affiliated physicians, to develop seamless transitions of care throughout the system, with the goal of providing high quality care in the lowest cost clinical setting appropriate.

Financial Benefits

The affiliation of the two systems results in a more effective cost management program and a stronger financial position. As discussed earlier, healthcare reform coupled with significant state and federal reimbursement reductions have placed unprecedented financial pressures on healthcare providers. It is clear that providers will face downward pressures on reimbursement and utilization for the foreseeable future. Without significant organizational changes, such as affiliations and partnerships, hospitals will be unable to flatten the cost curve sufficiently to offset reduced payment rates. (*See* Completeness Answers, Exhibit L for the AHA article: The Fundamental Transformation of the Hospital Field).

The proposed integration will produce expense savings and labor efficiencies through centralization of non-patient support functions and purchasing opportunities as a result of scale. Financial opportunities and cost-savings measures are outlined in the Application pp. 20-21, 23 and in the Completeness Answers pp. 213-215. I would like to highlight a few areas where we expect to achieve synergies across the network:

- Automation of process(es) currently performed manually
- Consolidation of the third-party contracts and data management systems
- Reductions in the use of consultants or agencies that provide external subject matter expertise, or perform specific support functions
- Centralization of administrative roles and functions through standardization of policies and procedures
- Savings on purchased goods and services achieved through economies of scale

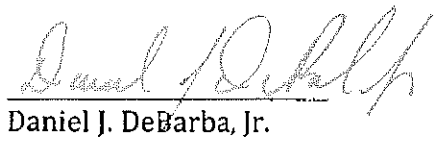
These expense synergies will be achieved over time in the first few years of the integration process, so that by 2016 we expect a 2.5% reduction in the combined entity expenses. (*See* Completeness Answers p. 218 Table A for details of these expense synergies).

With the scale we will have as the new WCHN, we expect to continue to have access to capital and lower rates for borrowing. Larger health systems tend to have better credit ratings, and greater financial strength. A recent article from Moody's Investors Services, included in the Completeness Answers as Exhibit H, details the importance of the ability of hospitals and health systems to deliver value-based care. We anticipate that the affiliation will help us to move along this path as we collaborate to develop the infrastructure for population health management, focusing on maintaining the health of our community through prevention and management of chronic disease, in the lowest cost clinically appropriate setting.

The proposed affiliation will offer expense reductions, productivity efficiencies and enhanced purchasing opportunities which contribute to cost reductions while allowing us to continue to provide high quality health care services to our community.

This is the expectation for the affiliation that we have at Norwalk Hospital. We respectfully request approval of this project. I am happy to answer any questions.

Thank you for your time and attention, and I hereby adopt this pre-filed testimony as my own.



Daniel J. DeBarba, Jr.
President & CEO
Norwalk Health Services Corporation

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

Affiliation of NHSC and WCHN, Inc.
Docket No. 13-31832-CON September 5, 2013

PRE-FILED TESTIMONY OF JOHN MURPHY, MD, PRESIDENT & CEO
WESTERN CONNECTICUT HEALTH NETWORK, INC.

Good afternoon Hearing Officer Hansted and OHCA staff. My name is John Murphy and I am the President and CEO of Western Connecticut Health Network, Inc.

I come to you to share my strong confidence in the future of community health that our affiliation with Norwalk Hospital will bring to the people of Fairfield and Litchfield counties. In an era of health care reform, and diminishing resources, we clearly see how this affiliation can help the State achieve its objectives outlined in the *Statewide Health Care Facilities and Services Plan,* specifically to improve the health of Connecticut residents, increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services. (Executive Summary, p. ix).

Background

A few years ago, when we took a fresh look at the landscape of health care in Western Connecticut, we saw a disturbing future for not-for-profit, community-based care. We feared the new realities of health care cost and reform might jeopardize the long-term viability of a

community-based hospital committed to provide care to all dimensions of a population. Because we didn't like that picture, we decided to create our own.

We focused, at Danbury Hospital, on strengthening our expertise in critical areas to become a destination for quality care. We began to develop a network approach to provide community access to care, from the primary care physician to the lab, clinic, specialist and hospital, as well as to the home and hospice, to address patient needs at every stage of life, for every generation. We opened a state-of-the-art research facility where we don't leave the discoveries in the lab; we use them at the bedside in patient care. And we formed, with New Milford Hospital, the beginnings of a network designed to provide the right care in the right place at the right time. Together, we see a day when we help communities manage the health of populations by providing patient-centered care in a medical home.

We have learned a lot from our work. We have learned how consumer views of health care needs have changed as well as what they expect from providers. We have experienced a shift from care that primarily occurs inside the hospital to care in outpatient settings for many services, at the same time consumers demand higher levels of experience when hospitalized. We have seen an ever-growing need for state-of-the-art, technology-driven emergency care. And we have learned; again, that *community* is at the heart of what we deliver.

I strongly believe in the contribution this affiliation will make to our state. We have learned, over the months, how similar these two organizations are in what we believe, how we work, and what we want to achieve. Neither of us could find a better partner for the future. We have learned that,

as different as our relative geographies may be in terrain, the needs of the people we serve are similar and, together, our collaborative service lines can provide a range and depth of quality care, each in its own service area. And we have learned that, with all the change in health care funding, the efficiencies we can create through affiliation with Norwalk Health Services Corporation will assure that we have the financial resources to invest in the facilities, technology and people that will make a real difference.

With this clear picture of what we can provide, as well as a realistic view of what resources we need, we began, in 2010, to consider what our two organizations could achieve together. In June of 2011, the respective Boards gave us the authority to officially pursue an affiliation. That fall, we engaged outside consultants to help us look at what we could accomplish and, in April 2012, convinced of the merits, we signed a non-binding Letter of Intent to continue the official exploration.

At the same time, a steering committee from the Danbury and New Milford Departments of Public Health, WCHN, the United Way, Regional YMCA and Western Connecticut State University continued a community needs assessment that began with a Community Report Card first developed in 2009. This process expanded to include community conversations to discuss priority health issues, a community plan for action to reach a diverse range of stakeholders, and initiation of community action planning work groups. This work is detailed in the Completeness Answers, Exhibit E, pages 552 through 623. As you will see, Recommendation Two of this report states, "Data indicated that the greater Danbury area is very healthy across many indicators, including the 10 leading causes of death. Public health, hospitals and human service

providers should be recognized for their efforts toward preventive, interceptive and ongoing care and supports for our community. They should also continue to strive for ways to maintain existing and pertinent programs and to find new and creative solutions to address emerging needs."

Benefits of Affiliation

These results reconfirm that our mission is sound, our strategy is relevant, and our affiliation with Norwalk Health Services Corporation has merit. WCHN has, for example, already begun collaboration between our hospitals in Danbury and New Milford, and our affiliated physicians. Norwalk Hospital has also been working on physician alignment and integration. Working as affiliates will enable our two organizations to leverage physician resources to the benefit of the communities we serve.

As we signed when we signed the definitive Affiliation Agreement with Norwalk Hospital on January 22, 2013, "we each bring strong legacies in not-for-profit, community-based care to our shared goal to be a beacon of quality care in an ever-changing health care landscape. Together we will build an integrated network of health services for our communities to redefine what a health care organization can offer." Today, after all the work we have done in the past months, we are more convinced of the value our affiliation will create when two organizations work together to achieve more while carefully managing their resources.

For example, when we look beyond physician alignment, we see patients who need to us to carefully evaluate what they actually need, if we see them in a doctor's office or an outpatient

setting. To ensure better outcomes, we reserve inpatient care for patients who actually need to be treated in the hospital, for emergency or tertiary care that is not available elsewhere. Because the affiliation will enable us to expand and deepen the care we can offer, we can work to reduce the rate of recidivism to reduce unnecessary re-admissions. That's what we mean when we say the right care in the right place at the right time.

We spell out the specific benefits of affiliation, and why we believe the affiliation is needed, on page 12 of our application for the Certificate of Need. These benefits include:

- Efficiently strengthening clinical programs to improve access to quality care and, in turn, improve outcomes
- Enhancing our educational programs for the health care providers of tomorrow including medical students, residents and fellows
- Strengthening the physician platform for the delivery of care
- Building competencies for new reimbursement models including population health management, bundled payments, PHOs and ACOs
- Integrating operations to stretch the dollars we spend in a unified operating model, and
- Improving access and reduce the cost of capital because of the efficiencies of scale of a larger organization. We, behind the scenes of the affiliation, operational opportunities to create real value.

Without this affiliation, neither organization will be able to adequately reach these goals.

It is all about stretching the dollars we spend as we strengthen the care we deliver. Information technology, for example, is a huge need in health care and a significant expense for any health

care organization. The benefits of affiliation, when it comes to IT, may be significant, as we look at the efficiencies of coordinating platforms and software. New IT record keeping can vastly improve how all care givers can access patient records, which will save time and money as well as strengthen the continuity of care. The ease of access to a patient's past medical history will enable a physician to make a more accurate diagnosis before treatment begins. Electronic health records, as well, will help us manage the health of various populations as well as reduce unnecessary duplication.

At WCHN, we have already started down this road of electronic health records by working on a health information exchange known as Health Link that allows digital information to flow from one provider to another. The patient is at the center of a multi-million dollar system that stores patient information in a central repository. Today, we are adding New Milford Hospital patients to the core system at Danbury Hospital, and, once our application for affiliation is approved, we will begin to connect Norwalk Hospital to the system as well.

As good as this sounds, however, all this technology costs a lot of money. The more patients and communities we can serve through a single investment can significantly stretch the dollars we must invest. This is the role that a larger scale plays. With our combined organizations, we can borrow money at a lower cost, we can create efficiencies that spread over all three hospitals in purchasing and in doing so, we have more money for patient care. Fortunately, our two organizations come to this affiliation with solid financial positions and we are well experienced, at WCHN, from our work with New Milford Hospital. The integration of Danbury and New Milford Hospitals that started in fiscal year 2011, for example, yielded a $7 million reduction in

expenses in fiscal year 2012, of which $5 million was at New Milford Hospital. While working to align the budgets, WCHN has also invested in renovating the emergency department at New Milford. Integration accomplishments have also included implementation of clinical practice standards across sites of care, organizational re-alignment of clinical and support departments including; laboratory, radiology, infection control, IT, marketing, finance, foundation compliance, coding, human resources, pharmacy, supply chain, volunteer services, and implementation of a common benefits platform.

To be clear, as much as we have learned from our work with New Milford Hospital, our affiliation with Norwalk is different. With New Milford, our service areas overlap, and we have looked for ways to consolidate services to broaden the community's access to quality care. Norwalk is a major urban hospital in a service area that is contiguous to WCHN's. With Norwalk, we will together explore ways to expand our complementary services to broaden community access.

As a hospital CEO and business leader, I certainly see the strengths of the affiliation, and look forward to stretching the dollars so we can strengthen the care. But it's John Murphy the physician that gets the most excited about what this affiliation can be. Like my colleagues at all three hospitals, I went into medicine because I want to help people get and stay well. With all the challenges we face in health care today, this affiliation will make this organization the best possible place for physicians like me to practice medicine. The "new picture of health" we are creating for our communities will make it easier for people to access the care they need at a price tag our patients, hospitals and providers can afford.

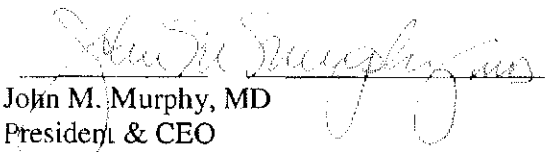
Transition to Implementation

If our application is approved, we will begin to work out many of the details that will begin on that "day one," from what patients will experience, to what physicians will access, to how communities will participate. During this transition, we won't simply talk with ourselves, as we reach out to community leaders, donors, patients and families, and our staff, to learn what it takes to be the health care organization people choose for care, contributions and careers. We each bring strong legacies in not-for-profit, community-based care to our shared goal to be a beacon of quality in an ever-changing health care landscape. The new organization will have greater access to capital, technology and purchasing power; more opportunity to achieve cost efficiencies; and a stronger ability to attract and retain top-notch specialists.

We believe in this affiliation, we know what we will bring to the communities we serve, and we know our approach to health care is essential. By looking ahead with clarity, and managing today with discipline, we assure the long life of this new organization as we redefine ourselves, and what we deliver, over the next several months. And so, years from now, we will look back with pride at a year when we imagined the possible and dared to make it come true. We officially ask for you to approve our application for the affiliation of Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation.

I welcome your questions.

Thank you for your time and attention today and I hereby adopt this pre-filed testimony as my own.



John M. Murphy, MD
President & CEO
Western Connecticut Health Network, Inc.

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

Affiliation of NHSC and WCHN, Inc.
Docket No. 13-31832-CON

September 5, 2013

PRE-FILED TESTIMONY OF ERVIN SHAMES, BOARD MEMBER
NORWALK HEALTH SERVICES CORPORATION

Good afternoon DPH and OHCA staff. My name is Erv Shames, and I am the past Chair of the Norwalk Health Services Corporation Board of Trustees, and the future Chair of the Board of the new Western Connecticut Health Network. I am pleased to welcome you to the community served by Norwalk Hospital, and appreciate that you have traveled to Norwalk to conduct this public hearing.

I am here today to ask that you approve the affiliation between Norwalk Health Services Corporation and Western Connecticut Health Network. In late 2008, the Board of Trustees and Senior Management of Norwalk Health Services Corporation began exploring the best ways to position Norwalk Hospital and its affiliates to meet future health care demands and the needs of the communities we serve. In the five years since then, assessment and evaluation have continued through the Strategic Planning Committee, and the Partnership Task Force of the Board of Trustees in collaboration with the Senior Leadership and the Medical Staff of Norwalk Hospital, as well as through the counsel and insight of industry experts. A great deal of work has been accomplished, from the development of Vision 2015, our long-range strategic plan (*See* Completeness Answers, Exhibit B, pp. 376-385) to our current proposal to affiliate with Western Connecticut Health Network. The guiding

principle of the Board of Trustees, as responsible stewards of valuable community resources, was to ensure that the people of the communities we served continued to have access to high-quality healthcare services.

We did not initially begin with the idea of affiliating with Western Connecticut Health Network. With the help of outside consultants beginning in 2009, we looked at all models, including not-for-profit and for-profit institutions, in-state and out-of-state institutions, and a myriad of legal arrangements from asset purchase to merger or affiliation. We also considered our option to remain a stand-alone hospital. We were looking for the arrangement that would be most beneficial for the health and well-being of the residents of the geographic area served by Norwalk Hospital. As the health care system began to transform to meet the mandates of the Patient Protection and Affordable Care Act ("ACA"), we came to the realization that remaining a stand-alone hospital would become increasingly unsustainable.

By 2010, the Partnership Task Force had identified key drivers for Norwalk Hospital and its affiliates to seek a strategic partnership option. These included:

- Long term viability of Norwalk Hospital – the continuance of mission/services to the community
- Improved access to capital markets and/or capital infusion
- Support for physician recruitment and retention
- Clinical service development, including the ability to provide more specialized services to the communities served

- Clinical, managerial, and technological talent and resources to reduce cost and improve quality
- Opportunity for collaboration
- Preserving community control and presence
- Quality improvement
- Better use of scarce community resources
- Improved care for the vulnerable and other community benefits.

In the meantime, Western Connecticut Health Network was assessing potential partners in order to build a network that has sufficient volume to effectively share resources, services and technologies. By the end of 2010, WCHN and NHSC had begun informal discussions about the potential for an affiliation, and in June of 2011 the respective Boards approved the initiation of a feasibility study for a partnership between NHSC and WCHN.

After a painstaking process and careful evaluation of potential arrangements Norwalk Health Services Corporation selected Western Connecticut Health Network as our partner because we believe their institution is the best fit for us for an affiliation and would allow our institution to achieve the goals set forth above. The history and mission of these two organizations is very similar, both not-for-profit, community hospitals, founded over 100 years ago – in the case of Danbury Hospital and Norwalk Hospital and almost 100 years ago in the case of New Milford Hospital. We share similar values and have common goals for the future: delivering high-quality, coordinated, and cost-effective care across the continuum.

While five years ago, there was no immediate public need for us to affiliate in order to maintain excellent health care for the patients in our service area we did, however, foresee a long-term need. As anticipated, hospitals today face many challenges including declining reimbursement, and changes in the health care delivery model. Beginning in 2014, we expect that more people in our service area will begin to demand access to health care services, as they will now have health insurance through Health Insurance Exchanges (HIEs) and the expansion of Medicaid under the mandates of the ACA.

Norwalk Hospital and its health system serve approximately 275,000 people in its primary and secondary service areas. Danbury Hospital and New Milford Hospital serve approximately 440,000 people in their combined service areas. Although our service area population is projected to have very little overall growth the demographics show a projected growth in the number of people ages 65 and older. We also expect an increased utilization of health care services as the population ages. So while we expect to care for greater numbers of newly insured patients, and of both Medicare and Medicaid patients, we have seen and continue to expect reductions in the reimbursement for service provided to these patients. With the talent and knowledge that exists at all three hospitals, we anticipate collaborating on best practices and protocols to provide quality care in the most appropriate clinical setting.

In 2012, Norwalk Hospital and the Norwalk Health Department published the "2012 Greater Norwalk Area Community Health Assessment and Improvement Initiative" (*See* Completeness Answers, Exhibit D, pp. 417-550) which gave us a very detailed look at what the community needed. This report integrated existing data regarding social, economic, and

health indicators in the region with qualitative information from 15 focus groups made up of community residents and service providers, and 17 interviews with community stakeholders. Interviews were held with individuals representing youth; the Hispanic and African American communities; individuals receiving services from a federally-qualified health centers; social services, health care and mental health providers; businesses; housing; law enforcement; and the local government.

This very detailed report examined all sectors of the community NHSC serves, and listened to their voices. We found that the community is concerned about the issues of chronic disease resulting from being overweight and obese – and concerned about the limited services for treatment of substance abuse as well as mental health services. The Executive Summary, beginning on page 420, gives an excellent outline of the depth of this report. The message from all who participated in the assessment was clear: that there is a public need for more health care services and better access to services. Leading the list of what is needed to address health challenges in the community was a focus on preventive health care, which will require changes to the health care delivery infrastructure.

A similar community needs assessment process was undertaken by a steering committee comprised of individuals from the Danbury and New Milford Departments of Public Health, Western Connecticut Health Network, the United Way, and Western CT State University. This collaborative created a Community Report Card (See Completeness Answers, Exhibit E, pp.552-623). This group also recommended that the health care providers in their area should "continue to strive for ways to maintain existing and pertinent programs and to find

new and creative solutions to address emerging needs." (See Completeness Answers, Exhibit E, p. 560).

We anticipate that the affiliation will respond to these identified community needs by expanding accessibility to health care services in the community, and emphasizing the focus on preventive care. By affiliating, we will have the scale and resources to invest in the expansion of primary care in each service area. And residents of our region will also find better specialized and tertiary level care near home, due to collaborative efforts of all three hospitals. Sharing existing resources and the opportunity to collaborate on programs will strengthen all three hospitals and their affiliates. We will be able to explore diverse care models such as medical homes, open access primary care and immediate/urgent care facilities. The enhancement of access to primary care will provide a cost effective alternative to fragmented care, much of which is currently provided in the emergency department at great expense.

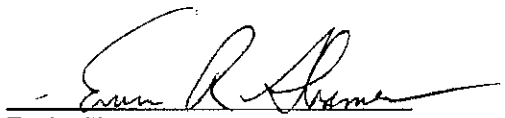
As noted in the Executive Summary of the Statewide Health Care Facilities and Services Plan, "Many provisions of the 2010 Patient Protection and Affordable Care Act (PPACA) favor integrated systems to create efficiencies and address quality." (p. ix). The goals of the ACA are aligned with the goals we have had at Norwalk Health Services Corporation and to the recommendations of the Community Health Assessment and Improvement Initiative; successfully providing high quality and accessible healthcare services, maintaining patient safety and satisfaction, providing more care to the underserved, increasing primary care and prevention programs to better manage health issues for our patients; monitoring and

improving patient outcomes and recruiting more outstanding physicians, hospital staff and other experts with the skills we need. Our goals and the plan to achieve these goals are set forth in "Vision 2015: Norwalk Hospital Strategic Plan 2010-2015", which was approved by our Board in August of 2009. (*See* Completeness Answers, Exhibit B, pp. 376-385) and in the "2012 Greater Norwalk Area Community Health Assessment and Improvement Initiative" (*See* Completeness Answers, Exhibit D, pp. 417-550).

Norwalk Health Services Corporation is a strong institution now, and through careful leadership and planning has been able to respond to the rapid transformation in the health care environment. But we are facing enormous challenges as the health care system continues to evolve at an unprecedented rate. With the expectation of more patients and less reimbursement, the strain on our financial resources will quickly be outpaced by the demands for quality care and better outcomes. We recognize that as responsible stewards of the health care resources for our community, it would be wise to position ourselves so that we are not only ready to meet the challenges ahead – but that we can thrive and flourish in meeting the health care needs of the patients in our service area in the future.

Through this affiliation, we will be able to meet these challenges: to expand services, rather than reduce services, to share in the cost of new technology that is necessary for the new models of care, to provide the opportunity for our communities to access primary care physician and specialists associated with each hospital, and to continue to meet the needs of our community. We hope that OHCA agrees, and request approval of this application. I am happy to answer any questions.

Thank you for your time and attention today and I adopt this pre-filed testimony as my own.



Ervin Shames
Norwalk Health Service Corporation Board of Trustees

PUBLIC NOTICES

LEGAL NOTICE
THREE CONDOMINIUM SEWER PROJECT
BROOKFIELD WATER POLLUTION CONTROL AU THORITY
Notice is hereby given that the Brookfield Water Pollution Control Authority, on July 24, 2013, modified the installment payment plan in effect with respect to benefit assessments levied in connection with the Three Condominium Sewer Project.

The Authority extended the payment plan by one year to 2029 and modified the manner in which the assessment is amortized:

1) For properties for which the assessment was current as of the December 1, 2012 installment, the remaining principal balance of the benefit assessment, together with interest at the rate of 2.0% per annum compounded annually and payable in arrears, may be paid in 17 equal annual installments of principal and interest commencing December 1, 2013 and continuing each year thereafter until December 1, 2029. Each payment made shall be applied first to interest accrued and then to principal.

2. For properties for which the assessment was subject to Elderly Deferral as of the December 1, 2012 installment, the balance of the deferred benefit assessment and deferred interest, together with interest on the deferred benefit assessment at the rate of 2.0% per annum compounded annually and payable in arrears, may be paid in 17 equal annual installments of principal and interest commencing December 1, 2013 and continuing each year thereafter until December 1, 2029. Such payment plan, however, remains subject to the provisions of the Elderly-Disabled Deferral Policy.

3) For properties for which the assessment was delinquent as of the December 1, 2012 installment, the existing payment plan (16 remaining installments) shall remain in effect until such delinquency is brought current.

The properties affected by the foregoing are located at: # 1, 2, 4 and 6 Sand Cut Road, including units #1 through #10 at 2 Sand Cut Road and Units #1 through #10 at 4 Sand Cut Road; #1 Old Grays Bridge Road; #20, 29, 36, 37, 53, 56, 58, 60, 63, 65, 77, 93, 107 and 124 Vale Road; #12A and #15 West Whisconier Road; #1 through # 32 Cedarbrook Townhouses; #1 through 41 Whisconier Village Condominiums; and at #1 through #34 Acorn Lane, #83 through #162 Heatherwood Drive, #1 through #16 Locust Lane, #1 through #10 Nutmeg Lane, #1 through #8 Tulip Tree Circle and #1 through #14 Walnut Lane in Stony Hill Village Condominiums.

A copy of the resolution effecting such modification is attached to the July 24, 2013 minutes of the Brookfield Water Pollution Control Authority on file and available for public examination at the office of the Brookfield Town Clerk and on the Brookfield WPCA website at http://www.brookfieldwpca.com/index.php?id=54 .

Dated at Brookfield, Connecticut this 29th day of August, 2013 and this 26th day of September, 2013.

BROOKFIELD WATER POLLUTION CONTROL AUTHORITY
BY: Nelson Malwitz, Chairman

DOCKET NO.DBD-CV-12-60110229-2 : SUPERIOR COURT

WELLS FARGO BANK : JUDICIAL DISTRICT OF DANBURY

V : AT DANBURY

SEALUND, NANCY R., ET AL : AUGUST 6, 2013

STATE OF CONNECTICUT

NOTICE TO: JEAN LEA JOHNSON, HER WIDOWER, HEIRS, AND CREDITORS AND ALL UNKNOWN PERSONS CLAIMING OR WHO MAY CLAIM ANY RIGHTS, TITLE, INTEREST OR ESTATE IN OR LIEN OR ENCUMBRANCE UPON THE PROPERTY DESCRIBED IN THIS COMPLAINT, ADVERSE TO THE PLAINTIFF, WHETHER SUCH CLAIM OR POSSIBLE CLAIM BE VESTED OR CONTINGENT

The Plaintiff One West Bank, FSB, has named Jean Lea Johnson, if living or not living, and her WIDOWER, HEIRS AND /OR CREDITORS as party defendant in the complaint which it is bringing to this Honorable court seeking a foreclosure of its mortgage upon premises known as 45 Dodgington Road, Newtown, CT. This complaint is returnable to court on July 22, 2013, and will be pending therein after that date.

The subscribing authority finds that the residance of the above-named Defendant, if living, and the identity and whereabouts of her widower and heirs, if not living, is unknown to the plaintiff, who represents that all reasonable efforts have been made to ascertain the same and have failed.

Now, Therefore, it is hereby ordered that notice of the institution of this action be given to each such defendant by some proper officer causing a true and attested copy of this order be published in the News-Times, once a week for 2 consecutive weeks, commencing on or before September 12, 2013 and that return of service be made to the Court.

BY: Vanessa S. Fertaly, Clerk Assistant Superior Court
Judicial District of Danbury
THIS IS A TRUE COPY OF THE ORIGINAL ORDER OF NOTICE IN MY HANDS FOR SERVICE BY PUBLICATION
ATTEST: MARK A PESIRI, STATE MARSHAL

PUBLIC NOTICE
Office of Health Care Access Public Hearing

Statute Reference: 19a-639
Applicant(s): Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Town: Norwalk
Docket Number: 13-31832-CON
Proposal: Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. with no associated capital expenditure
Date: September 10, 2013
Time: 3:00 p.m.
Place: The Norwalk Inn and Conference Center, 99 East Avenue - Mariner Ball Room, Norwalk, CT

Any person who wishes to request status in the above listed public hearing may file a written petition no later than September 5, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

LOST AND FOUND

LOST, ONE 3 YR. OLD BLACK CAT; small, short hair female. Answers to the name of "Loki". If found please call 203-797-0905

ABSOLUTELY FREE

BEDDING & DAY BED 1 Laura Ashley Caroline twin comforter, 1 quilt, 4 valances, 1 bed skirt and 2 decorative pillows. 1 Laura Ashley Prescott twin comforter and 1 quilt. 1 brass day bed, trundle and 2 mattresses. $500. 203-794-9469

BRASS/GLASS CHANDELIERS (3) Foyer, Kitchen, Dining Room. Good Condition. FREE 203-798-7375

FREE FIREWOOD Very large oak tree cut down in late spring. Lots offirewood (unsplit) for free, as long as you have a truck to take it away. Located on the Weston/Redding border. Call 203-300-3582.

WEIGHT MACHINE -DT Universal weight machine, 20 different exercises. You pick up for free in Danbury. Call 203-746-2202

WOOD RACK, round, metal 45" high, 41" wide, in Brookfield. Call 203-775-1567 9:00 AM to 8:00 PM

HEATING AND FIREWOOD

SEASONEED FIREWOOD You pick up by the cord, New Milford, CT. Split cord $100. Blocks 12-18" $75. Logs 12-15' $55. Local business for the last 45 yrs. 860-354-6931

Seasoned Firewood Only the best hardwood. Split and delivered. 3 or more at $185 per cord.. Guaranteed full cord. Call Rod Fitch 860-355-9876

MERCHANDISE FOR SALE

4 LAWN or BEACH CHAIRS webbed - call 203 743 3297 $16

5 # ANKLE WEIGHTS for use while exercising. Call 203-743-3297 $14

ACCENT LIVING ROOM TABLE dark wood 23" round 19" high $25. 203-775-4070

ACETYLENE TORCH SET, tank, hose, regulator, tips, SS sticks, $140. 203-748-7818

AIR CONDITIONER, Brand new 10,000 BTU GE remote controlled used only 1 month. $150. 203-748-0723

AIR CONDITIONER, Brand new 10,000 BTU GE remote controlled air conditioner used only 2 months. $175.00 203-748-0723

MERCHANDISE FOR SALE

★★★

AIR CONDITIONER, GE WINDOW A.C. 14,100 BTU. Remote & cover included. $100. 860-355-5868.

ANTIQUE LINENS, box of 12 assorted small linens. $25. 203-748-2774

ANTIQUE TABLETOP wood pinball game w/orig. 18 steel balls and stick, not mech., $100. 203-748-2774

ANTIQUE DESK CHAIR solid wood swivel chair with casters $40.00 203 775-4070

★★★

ARMOIRE Four door TV cabinet distressed look Solid Oak finish, fits a 40 TV, new in excellant condition. $399.860-355-9255/ kathleenksg@aol.com

mint-see

ARMOIRE, Solid Oak distressed Armoire Beautiful new four door Armoire will fit 40 inch TV, bottom cabinet for stereo and storage. $399.00 860-355-9255/kathleenksg@aol.com

ATT CORDED PHONE Trim Line - new in box, 4 months old-never used $8.00 203-748-7818

AWL & SPLITTER for use in splitting large sections of wood, $19. call 203-743-3297

AXES for chopping and splitting wood, $16. call 203-743-3297

BAKING TINS (3) for cheese cakes, etc. 3 different sizes - non-stick, $15. call 203-743-3297

★★★

BASKETBALL CARD SET '90-91 NBA Hoops Series full Set #1-336, incl. Jordan $29. 203-570-8427

★★★

BASKETBALL CARD SET '90-91 NBA Hoops Series full Set #1-336, incl. Jordan $29. 203-570-8427

BED Queen Pillowtop Mattress & Boxspring. Brand New. Still in Plastic. Sacrifice $250. 203-557-0949

BEDROOM SET grey formica, 2 night stands, 8 drawer dresser, large armoire, pics online $475. 203-291-4893

PROBATE NOTICES

STATE OF CONNECTICUT
COURT OF PROBATE
DANBURY PROBATE DISTRICT

NOTICE TO CREDITORS

ESTATE OF
KENNETH E. STILSON
AKA Kenneth Stilson
AKA Kenneth E. Stilson, Sr.
(13-0453)

The Hon. Dianne E. Yamin, Judge of the Court of Probate, Danbury Probate District, by decree dated August 26, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Jessica E. Regan, Assistant Clerk

The fiduciary is:

Devin T. Stilson, 25 Cornwall Drive, Goshen, CT 06756.

STATE OF CONNECTICUT
COURT OF PROBATE
DANBURY PROBATE DISTRICT

NOTICE TO CREDITORS

ESTATE OF
CHRISTINE M. PANE
(13-0449)

The Hon. Dianne E. Yamin, Judge of the Court of Probate, Danbury Probate District, by decree dated August 22, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Jessica E. Regan, Assistant Clerk

The fiduciary is:

Philip A. Pane, Jr.
c/o Paula Boa Sousa, Esq., Collins, Hannafin, Garamella, Jaber & Tuozzolo, 148 Deer Hill Avenue, Danbury, CT 06810.

MERCHANDISE FOR SALE

★★★

BEDROOM SET grey formica, 2 night stands, 8 dr. dreser, large armoire, pics online $475. 203-291-4893

BEDROOM CHERRY solid sleigh bed, dresser, mirror, chest, night stand. Cost $2500. Sacrifice $850. 203-557-0949

BENCHES Two, upholstered waterfall styled. Like new condition. $195. Call 203-258-9531.

BICYCLE, 20" Girls Bicycle. Good condition. Quality bulit by Diamond Back. $50. 203-733-5875

BICYCLE, 20" Boys Bicycle - Good Condition - Quality built by Diamond Back . Danbury - $50. 203-733-5875

BIKE RACK for minivan carries 2 bikes, $38. call 203-743-3297

NEW ADD

BOOKS Romance, Self Help, Comedy, Mystery. Over 100 Books .50/Soft, $1.00/Hard. 203-746-0346

BOOTS, BRAND NEW Code West Black Leather Western Boots Size 7 M, $50. Call or text 860-488-0338

BRASS TORCHIERE w/ glass disc shaped lighted top. $95. Call 203-258-9531.

BUNK BED SET, solid wood, never used, 65x42x81, can deliver, $300. 203-233-3493

CABINETS Glazed Maple. New, Never Installed. All Wood. Dovetail. Can add or subtract to Fit Kitchen, Cost $9000, sell $2500. Can Deliver. 203-247-9459.

LOOK HERE

CANNING MASON JARS (7) with wax & lids. Asking $7. 203-746-0346

CANON IMAGE CLASS 2200 Series Copier + stand (wheels) slots for letter/legal $400 Neg. 203-948-3081

CAR DOORS 1993 PLY VOYAGER driver & passenger $150 OBO. 203-731-1224

LOOK HERE

CASSETTES 600 total Metal and Hard Rock A-Z, $120. 203-306-6766

CAST IRON FRY PAN Griswold 10" ex cond great for home & grill! $25. 203-426-5767

CERAMIC WINE COOLER for use to chill wine at dinner table, $13. call 203-743-3297

CERAMIC TILES (33) 8x8 GLAZED, COVERS 15 SQ FT, BONE COLOR, $15. 203-746-5046

CHERRY DINING room table, 6 chairs and hutch. Pennsylvana house. Cherry wood. 203-743-0727

CHILD'S ROCKER Black wood. Exc w/cushion. $25. 860-354-1732

CHINA #G1026 Mikasa Trousseau service for 10-12. Blue and White Flowers, $225. 203-650-0366

CHINA CABINET, Danish Modern $475. Call 203-744-1950.

CHINA CABINET, Oak Call 203-743 3196. Part of Set.

CHINA #G1026 Mikasa Trousseau service for ten. Blue and White Flowers, $225. 203-650-0366

COAT, New Genuine Leather Coat with Genuine FOX Collar, Fits like a Med. Large call 203-743-3196

Coffee Table Real wood,light water marks. 203-746-8488 before 8PM. $25

COINS SILVER PROOF SETS 2000-2006 $66 each. 203-746-5046

COINS BICENTENNIAL SILVER UNCIRCULATED SET 1776-1976 $24. 203-746-5046

COMFORTER light weight for twin bed, $15. call 203-743-3297

COMFORTERS King set, shams bedskirt. 2 val $65 Gr only Queen Comf. $40. 203-661-4462.

COMPUTER DESK ALMOST NEW, ANTIQUE WOOD, $45. (203) 426-6476

CONSOLE/SOFA TABLE Black lacquer w/ frosted glass insert top, very unique $295. Call 203-258-9531.

PUBLIC NOTICES

LEGAL NOTICE
This publication is to give notice to Elizabeth Sierra, formerly of 01 Fairfield Avenue, Unit B4, Danbury, CT., that there is a civil case, Docket #SCC-487439, pending in small claims court at the Superior Court at 146 White St., Danbury, CT 06810.

The Plaintiff, Tall Oaks LLC has filed for money damages pursuant to a lease between the parties.

The defendant is hereby requested to contact the Superior Court at 146 White St., Danbury, CT 06810 or the Plaintiff, Tall Oaks LLC at 01 Corporate Dr., Danbury, CT 06810, regarding this matter.

Legal Notice
Invitation to Bid
The Town of New Fairfield/New Fairfield Volunteer Fire Co. invites all interested parties to submit sealed proposals for a new ambulance. To be considered, proposals must be received no later than 4:00 PM on Monday, September 30, 2013, at 3 Brush Hill Road, Purchasing Department. Proposal shall be in a sealed envelope clearly marked **"Town of New Fairfield/ Volunteer Fire Company, Ambulance Replacement," "Bid Number 2013-14-FD1"** with the bidder's name on the exterior of the envelope.
Terms and conditions as well as the description of the Ambulance are stated in the specifications. Specifications may be obtained from the information above or at www.newfairfield.org under Invitations to Bid. Bids received later than the date and time stated above will be rejected. For further information, please call Patty Mota 203-312-5653.
The Town of New Fairfield is an equal opportunity and affirmative action purchaser, and bids from all vendors, including those from enterprises owned by minorities and women, are encouraged.
Dated August 27, 2013

MERCHANDISE FOR SALE

CONSOLE STEINWAY PIANO, walnut, good condition. $1,800. 52" round marble table with pedestal and Lazy Susan. 4 padded cane chairs. Lighted china cabinet, glass doors and shelves, Black formica, new condition, 74"Wx74"Hx17½"D. Matching bar 41"Wx82"Hx19"D. Queen platform bed, drawers under, with matching triple dresser, high cabinet, quiet Peach formica. Home Sold - must empty - also many other pieces. Call 203-775-6681

CORNER TABLE, Black lacquer w/ drawer. $95. Call 203-258-9531.

CRAFT SUPPLIES Flowers,baskets vases, containers, crafting tools $800.ValueSale $250. 203-743-5084

ATTENTION

CREDENZA all-wood medium color finish with sliding front doors $75 call 203-775-4719

DESIGNER PURSES & SHOES women's shoes & clothing, from $20 & up. excellent condition. 203-794-0082

DESK, WOODEN has glass cover, 3 drawers, lite ash color, $65. 203-748-7818

DESK/WORKSTATION 4 cabinets, 4 lg drawers, bulletin board. $150. 203-417-4393 photos

DINING ROOM SET table, leaves, 8 chairs, hutch, buffet, $290. 203-261-6480

DINING ROOM TABLE Oak. Top Inlay, Call 203-743-3196 Part of Set.

DINING ROOM TABLE CHAIRS (6) Oak. Call 203-743-3196. Part of Set.

DINING ROOM SERVER, Oak. Call 203-743-3196. Part of Set.

DINING ROOM accessory 5 tier corner free standing shelf $25. 203-775 4070

DISPLAY CABINET 24W X 19H X 4D WITH LOCK/KEY, $25. 203-746-5046

DIVING MASKS - Silicone w/resistant glass lens. 2 DACOR DIVING masks. Professional. $15.00 each. 203-733-5875

DOG SUPPLIES, medium size sweaters, rain coat, matching harness & lead, also misc, all brand new, $20. 203-264-7111

DRUM SET with hardware and cymbals excellent condition, $250. 203-866-4879

DVD/CD NEW BOX 50 PLASTIC CASES, $12. 203-746-5046

ELECTRIC HEDGE TRIMMERS for easy shrub pruning, $16. call 203 743-3297

END LAMP TABLE NEW, SHELVES. $25. (203) 426-6476

END TABLES TWO, EXCELLENT, IDEAL FURNITURE, $25 EACH. 203-426-6476

END TABLE, Black lacquer w/ cut out detail & frosted glass insert top. beautiful. $195. Call 203-258-9531.

ENTERTAINMENT CENTER Solid oak w/ lighted glass door cabinet, 2 storage cabinets below fits 32" TV. $150. Call 203-241-2641

MERCHANDISE FOR SALE

EVAN PICONE MISSES RAIN-COAT tan, longer length w tie belt, remov liner. ex cond. like new. $35. 203-292-3307

FILE CABINET 2 drawer lateral file cabinet $100. 5 drawer $150. 203-417 4393

FINE QUALITY, Beautiful green fabric, excellent condition, no wear at all, hardly ever used. $45.00 203-733-5875

FIRE ESCAPE ROPE & plastic ladder, 2nd floor, folding, new, $25. 203-264-7111

FISHER XP-7B SPEAKERS (2) Four-Way Speaker System, Solid Walnut , 24"x14"x12" $50. 203-733-5875

FISH TANK 53 gallon with filter, heater & oak stand, $100. 203-470-8732

FISH TANK, 53 gallon Fish Tank with filter, heater & oak stand, $100. 203-470-8732

mint-see

FLOOR PILLOWS (2) Large, Oversized Brown; Great for Kids Room or Dog Bed $10 for both. 203-746-0346

FLORENTINE PLAQUES (2) HANDPAINTED ON SILK, $40. 203-746-5046

FOR SALE EVERYTHING EXCEPT BED & COMPUTER, $500. 203-778 8077

FREEZER, Kenmore 14.1 CF upright freezer. New defroster timer and ther-mostat. $150. 203-748-0723

FURNITURE FOR SALE Dark green hand painted armoire for sale. $200.00 Double size brass bed -mattress included $150.00 Kids desk gas en-gine $250.00 call 860-355-4900

GIRL'S BEDROOM SET Very nice, quality, excellent, 5 piece set. $400. 203-733-5875

GOLF 3 OLD WOODS, wood head Steel Shaft #1 & 3 Wilson, #1 Titleist fair cond, $55. 203-426-5767

GOLF 3 OLD WOODS, wood head Steel shaft, #3,4,5, Northeastern Golf good Cond, $55. 203-426-5767

GOLF 4 CLUBS CHILDREN'S PUTTER, 9/P Cleveland, 7 Jr-pro, 5 Austad's, $45. 203-426-5767

GOLF 4 CLUBS WOOD Shaft Driver twine wood DaveHunter, Chipper forged, Iron 2p-sart forged, fair, $55. 203-426-5767

GOLF CLUB SETS Various woods and irons $50. 203-224-8122

LOOK HERE

GOTHIC & HALLOWEEN COSTUMES dragon mirror, lamp, decor. $100.00 203-748-6803

GPS, used only 1 hour, loaded with data and extra features, paid $200, asking $75. 203-748-5340

GRANITE PEDESTAL TABLE round beige brown table, exc condition $200. 203-261-6480

ATTENTION

HAIR DRESSER KIT w/ Bag, Cape, Spray Bottle, Scissors, Clips. From Salon Store, $10. 203-746-0346

HALLOWEEN DECORATION & COSTUME for house and trick or treating, $17. call 203-743-3297

HESS TRUCKS 1987-2003 $15-$35 ea. 203-746-1700

HOT TUB: 2013 Model, 5/6 Pers, 40 Jets, all opt w/Cover. New in Pkg, never used. Full wrty. Orig. Cost $7000 sacrifice $2950. Can Deliver. 203-232-8778

***Hutch lt oak, 6 sh 2 doors. 36x76x12 $50. 860-350-8857

★★★

ICE BOX Oak Ice Box. $399. 860-355-9255/kathleenksg@aol.com

IKEA COAT, HAT & STORAGE RACK dark oak. Moving sale. $30. Call/text 860-488-0338

mint-see

IKEA RATTAN CHAIR w/Cushioned Pad. Excellent Condition $25. 203-746-0346

KAYAK Inflatable 2 person new in box, $100. 860-350-3020 Jerry

KAYAK Inflatable 2 person new in box, $100. 860-350-3020 Jerry

KENMORE 14.1 CF upright freezer. New defroster timer and ther-mostat. $150. 203-748-0723

KENWOOD/BOSTON Acoustic Unity DVD Home theater Sys Awesome $125. Mike 203-994-0683

KENWOOD/BOSTON Acoustic Unity DVD Home theater Sys Awesome $125. Mike 203-994-0683

LOOK HERE

KID'S STUFF Water bottles, toys, backpack. $20.00. 203-746-6803

LARGE CHINA cabinet, fruit wood, old. 203-743-0727

MERCHANDISE FOR SALE

LARGE GLASS PUNCH BOWL w/glass cups & ladle for serving, $29. call 203-743-3297

LATCH HOOK WOOL, 6.5 lbs., many colors, ready to make a colorful rug, $30. 203-748-2774

mint-see

LOVELLY ASIAN OAK DINING TABLE. Seats 6 closed. Has hidden leaf system in table which can easily seat 10 when fully opened. Comes with 4 side chairs and two arm chairs. $400. 203-770-9301

MATTRESS & Boxspring. King size Pillowtop set, brand new, still in plastic. Sacrifice $399. 203-557-0949

MEDIA CENTER 48Lx38Hx19W glass doors, shelves TV access, $75. 203-746-5046

ATTENTION

MEN'S SHOES, Nunn & Bush Brown Casual Leather Shoes. Size 13, Worn Twice, $15. 203-746-0346

mint-see

MEN'S THONG Size 13 (Gotcha Name Brand), Never Worn. $8. 203-746-0346

★★★

MEN'S THONG SANDALS Never Worn, Size 13, Brown (Gotcha Name Brand). $8. 203-746-0346

METAL BADMINTON RACQUETS 4 in exc shape, $13. 203-743 3297

MIRROR Black lacquer, tear drop shaped. Exc cond. $95. Call 203-258-9531.

MODEM & PHONES WITH ANSWER MACHINE. $5-10. 203-426-6476

MONITOR 17" A plasma flat screen works great, $25. 203-748-7818

MOTORCYCLE PARTS Harley Davidson chrome mufflers. Fits early bikes. $150 BO. Call 203-746-4679

NIKKOR 35-105 No haze/fungus. Includes lens and rear lens cap. $110. Call/Text 860-488-0338

NIKON NIKKOR 18-70 AF-S, Rear lens cap & Nikon HB-32 lens hood. $110. 860-488-0338 Call/Text

NOKIA LUMIA 900 - 1/2" scratch on screen, scratches on back. $100. 860-488-0338 Call/Text

NORMAN ROCKWELL SHIP-BUILDER PLATE, $25. 203-746-5046

★★★

NUNN & BUSH LEATHER SHOES Brown Lace Up. Worn Twice, Cost $70 will sell for $15. 203-746-0346

OCTAGON MIRROR 18x24 hanging mirror $15. 203-775-4070

OFFICE DESK includes CPU area, storage, drawers, $140. 203-746-0747

OUTDOOR FURNITURE, assorted bridge chairs, tables, best offer. 203-775-3876

PATIO SET table 66x40, 6 recline stack chairs, 2 ottomans, sm. table $400 neg. 203-270-0485

PERENNIALS for sale. Many varieties to choose from. Call for complete list. $3 & up. 203-748-2774

PLOW AND MOWER DECKS. Massey fergeson plow $100, mower decks $100. Call 203-791-0145

PLOW AND MOWER DECKS. Massey fergeson plow $100, mower decks $100. Call 203-791-0145

POOL TABLE, $100. 203-744-1838

POOL TABLE. 8 ft Pro Style, 1 inch slate, solid wood, 1fhr pockets. Brand new. Must See! Cost $4500. Sacrifice $1500. Free Delivery. 203-247-9459

POWER SPRAY PAINTER 7.2 GALLONS 2 SPEED BRAND NEW, $99. 203-746-5046

★

PROJECTION TV 51 HD, Black with speakers, $50. 860-355-9255/ kathleenksg@aol.com

RAWLINGS BASEBALL GLOVE in good shape for great catches Ccall 203-743-3297 $9

ROCKING CHAIR Solid wood excellent condition $45.00 203-775-4070

SAMSONITE 2 piece luggage set. Excellent. $25. 860-354-1732

SAMSUNG CELL PHONE M60, CHARGER, MANUAL, ABSOLUTELY FREE. (203) 426-6476

SCHWINN CHILD'S BICYCLE Training Wheels . $10. 203-733-5875

SCUBA TANKS, 100 cu.ft., HP steel w/DIN fittings. $225 ea. or both w/Sher. racks $450. 203-748-2774

Set of 12 WINE GLASSES long stemmed - call 203 743 3297 $45

SEWING MACHINE Completely serviced, Ready to sew, $85.00. 203-426-2662

SIDE CHAIR Black lacquer w/ paradise designed chair back & upholstered seat. Beautiful accent piece. $150. Call 203-258-9531.

SIDE TABLE DRAWER, TILE TOP & SHELF, $50. 203-746-5046

Service Directory

ATTIC, BASEMENT, YARDS AND DUMP RUNS

ANYTHING HAULED Big or Small- ...Com'l Resid'l...Willie & Sean (203)797-8124

ELECTRICAL SERVICES

TIGER ELECTRIC Complete Electrical Services. Service calls, repairs, new work, generators. Call (203)798-1012

HOME IMPROVEMENT / REPAIR

A-1 HANDYMAN LLC Carpentry, tile, sheetrock, doors/ molding, cabinets, shelving, painting & more. #573143. Ins'd. Call 203-746-8833 A1handymanllc.com

SEAL COATING Fill cracks & seal blacktop driveways & walkways. Free Estimates! Call Benny & Emilio. 203-748-4049 or 203-482-8581

LAWN & GARDEN SERVICES

HUGO TREE SERVICES Clean up Pruning, gardening, lawn care Firewood for sale 203-942-6001

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LUNO MASONRY All aspects of masonry. Stone, brick walls, all re - pairs, etc. Lic & insur. 203-770-9273

The News-Times Service Directory ads run for 30 days in The News-Times, 4 weeks in our 2 weekly papers (The Greater New Milford Spectrum and Stuff) and every day on our website www.newstimes.com

Place an ad in The News-Times Service Directory today… and have new business tomorrow!

Call (203) 797-1414 or stop by our office at 333 Main Street, Danbury, CT

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31832-CON

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc

Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

September 10, 2013 at 3:00 p.m.

I. **Convening of the Public Hearing**

II. **Applicants' Direct Testimony (10 minutes each)**

III. **OHCA's Questions**

IV. **Public Comment**

V. **Closing Remarks**

VI. **Public Hearing Adjourned**

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.**

DOCKET NUMBER: **13-31832-CON**

PUBLIC HEARING: **September 10, 2013 at 3:00 p.m.**

PLACE: **The Norwalk Inn and Conference Center**
99 East Avenue
Norwalk, CT

EXHIBIT	DESCRIPTION
A	Letter from Norwalk Health Services Corporation and Western Connecticut Health Networks, Inc. ("Applicants") dated April 5, 2013, enclosing Certificate of Need forms for the affiliation between Western Connecticut Health Nework and The Norwalk Health Services Corporation received by the Office of Health Care Access ("OHCA") on April 8, 2013.
B	Letters received from Representative Jonathan Steinberg and Mayor Richard A. Moccia and OHCA's responses to the letters in the matter of the CON applicaton under Docket Number 13-31832. (4 pages)
C	OHCA's letter to the Applicants dated May 7, 2013, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31832.(9 pages)
D	Applicants' responses to OHCA's letter of May 7, 2013, dated June 14, 2013, in the matter of the CON application under Docket Number 13-31832, received by OHCA on June 14, 2013. (462 pages)
E	OHCA's letter to the Applicants dated July 15, 2013 deeming the application complete in the matter of the CON application under Docket Number 13-31832. (1 page)
F	Designation letter dated August 5, 2013 of Hearing Officer in the matter of the CON application under Docket Number 13-31832. (1 page)

G	OHCA's request for legal notification in *The Hour* and OHCA's Notice to the Applicants of the public hearing scheduled for September 10, 2013, in the matter of the CON application under Docket Number 13-31832, dated August 23, 2013. (4 pages)
H	OHCA's letter to the Applicants dated August 28, 2013, requesting prefile testimony in the matter of the CON application under Docket Number 13-31832.(2 pages)
I	OHCA's request for legal notification in *The News Time* of the public hearing scheduled for September 10, 2013, in the matter of the CON application under Docket Number 13-31832, dated August 28, 2013. (2 pages)
J	Letter from the Law Office of Patricia A. Gerner, LLC dated September 5, 2013 entering her notice of appearance on behalf of the Applicants in the matter of the CON application under Docket Number 13-31832, received by OHCA on September 5, 2013. (1 page)
K	Letter from the Applicants enclosing Prefile Testimony dated September 5, 2013 in the matter of the CON application under Docket Number 13-31832, received by OHCA on September 5, 2013.(26 pages)

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FAX SHEET

TO: **PAT GERNER**

FAX: **(860) 489-9380**

AGENCY: **LAW OFFICE OF PATRICIA A. GERNER, LLC**

FROM: **STEVEN LAZ. RUS**

DATE: **9/9/13** **TIME:**

NUMBER OF PAGES: **4**
(in luding transmittal sheet

Comments: DN: 13-3183 -CON Hearing packet

PLEASE PHONE IF T. IERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (. 60) 418-7001 ***Fax: (860) 418-7053***

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ST ATE OF CONNECTICUT
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OFFIC OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HERL HY

FAX: (203) 739-1974

AGENCY: WESTERN C HEALTH NETWORK, INC.

FROM: STEVEN LAZ RUS

DATE: 9/9/13 **TIME:**

NUMBER OF PAGES: 4
(in luding transmittal sheet

Comments: DN: 13-3183 -CON Hearing packet

PLEASE PHONE IF T HERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (60) 418-7001 ***Fax: (860) 418-7053***

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

RECEIVED
SEP - 6 2013
Department of Public Health
Office of the Commissioner

September 5, 2013

Lisa A. Davis, MBA, BFN, R.N.
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: Certificate of Need Application: Docket Number: 13-31832-CON
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Dear Deputy Commissioner Davis,

Attached please find the Prefile Testimony being submitted on behalf of the Applicants, Norwalk Health Services Corporation and Western Connecticut Heath Network, Inc. The individuals submitting prefile testimony will be present at the hearing on September 10, 2013, and will be available for questioning by the Office of Health Care Access.

Please let me know us there is anything else you need prior to the hearing. I can be reached at (203) 739-4903. Jeryl Topalian, Executive Director for Planning and Business Development at Norwalk Health Services Corporation can be reached at (203) 852-2354.

Respectfully submitted,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

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

Affiliation of NHSC and WCHN, Inc.
Docket No. 13-31832-CON

September 5, 2013

PRE-FILED TESTIMONY OF DANIEL J. DEBARBA, JR., PRESIDENT & CEO
NORWALK HEALTH SERVICES CORPORATION

Good afternoon DPH and OHCA staff. My name is Dan DeBarba, and I am the President and CEO of Norwalk Health Services Corporation. I appreciate the fact that you have come to our community to hold this hearing, and welcome the opportunity to share my thoughts on the benefits of the proposed affiliation.

I am here today to request your approval of the proposed affiliation between Norwalk Health Services Corporation and Western Connecticut Health Network. As you are probably aware, the transformation of the health care delivery system, which is occurring at an unprecedented rate, has placed increasing pressures on hospitals to consolidate. The Office of Health Care Access ("OHCA") recognizes the many reasons that hospitals are thinking about affiliations and mergers in Chapter 1 of the CT Department of Public Health's Statewide Health Care Facilities and Services Plan, ("the Plan") published in 2012. (*See* Application, Exhibit D, The Plan, p.7, Sec. 1.8.5).

We selected Western Connecticut Health Network as our partner because we believe they are the best fit for us for an affiliation. We share similar values and have common goals for the

future: successfully providing high quality and accessible healthcare services to our communities, maintaining patient safety and satisfaction, monitoring and improving patient outcomes, providing more care to the underserved, increasing access to primary care and preventive health programs; and recruiting more outstanding physicians, hospital staff and other experts with the skills we need to be successful in the future. We are happy to be here today with a great deal of work already accomplished, and an integration planning process underway.

Norwalk Health Services Corporation began our search for the best way to meet future health care demands in our service area in 2008. Our goals and the plan to achieve these goals are set forth in "Vision 2015: Norwalk Hospital Strategic Plan 2010-2015", which was approved by our Board in August of 2009. (*See* Completeness Answers, Exhibit B, pp. 376-385). At about the same time, NHSC formed the Partnership Task force to assess the continuum of strategic partnership options and drivers that could initiate partnership discussions. (*See* Completeness Answers, p.206). The transforming economic model in health care, with new payment models emerging and the shift toward increasing accountability for the costs and outcomes to providers, was one such driver.

Healthcare is moving from fee-for-service to value-based reimbursement. Reimbursement strategies in the future for Medicare, Medicaid and private payors are expected to shift to risk-based contracting which involves financial incentives for meeting certain quality and cost targets, and penalties for those who do not meet these goals. We want to be able to meet these goals. WCHN has already created a model accountable care organization ("eACO")

with its own employees through Aetna. The eACO has given WCHN the kind of experience we would like to be able to learn from in order to develop an ACO model in the future. With the talent and experience that exists at all three hospitals, we anticipate collaborating on best practices and proven protocols to improve quality and outcomes, at Norwalk, Danbury and New Milford Hospitals.

The federal Patient Protection and Affordable Care Act of 2010 ("ACA"), was a second driver. The new federal law requires investment in quality assessment, physician integration, population health management and electronic health records. We need to be able to make investments in clinical technology in order to be able to demonstrate high quality outcomes, while providing cost-effective care. If this affiliation is approved, we plan to develop an interface between the electronic medical record systems now in use at WCHN and NHSC, to improve continuity of care for patients across the network. The clinical integration of these electronic records with our affiliated physicians' practices will bring a higher level of excellence to the patient through the adoption of evidence-based clinical protocols and processes, while reducing the cost of the care provided. Systems such as these cost millions of dollars. However, investments in this technology are more cost-effective when shared across a larger network, such as the combined NHSC and WCHN.

As a result of the ACA implementation, the expansion of Medicaid, and the development of Health Insurance Exchanges (HIEs), we expect to see a greater demand for health care services beginning in fiscal 2014. Our service area population is stable, but aging, and we anticipate increased numbers of Medicaid patients. With the implementation of the ACA and

value-based payments, we also expect to see reduced reimbursement for Medicare and Medicaid patients. In addition, hospitals have just experienced significant reimbursement cuts from the State and Federal government. With more patients and less reimbursement, the strain on our financial resources will quickly be outpaced by the demands for quality care and better outcomes. Both Norwalk Health Services Corporation and Western Connecticut Health Network are financially strong institutions now, and we have taken measures to remain that way. But we are facing enormous challenges as health care is changing. The sharing of existing resources and the opportunity to collaborate on programs will strengthen all three hospitals and their affiliates. Partnering with WCHN - another large, stable health care institution - is needed so that we can continue to provide health care services long into the future.

In addition to the drivers toward affiliation, I would like to focus on the benefits achieved through this partnership; beginning with improving patient access to services, and improving the quality of those services.

Access to Services

Norwalk Health Services Corporation has conducted a physician resources assessment in its Stark-defined service area, most recently in 2012, which identified significant shortages in primary care providers. (*See* Completeness Answers, p.216). NHSC implemented a physician development plan, and has recruited new primary care practitioners to the service area. Western Connecticut has also made significant investment in physician integration, by developing a physician-hospital organization ("PHO"). By affiliating, we will have the scale

and resources to more rapidly invest in developing the primary care infrastructure in each service area. We anticipate expanding access to primary care services in the community with extended hours and varied locations as needed. The enhancement of access to primary care will provide a cost effective alternative to urgent care, much of which is currently provided in the Emergency Department at a great expense.

The proposed affiliation creates a physician platform that includes over 800 independent physicians and over 300 employed physicians distributed over the contiguous geographic areas served by each organization. There is no plan to curtail any of the clinical services that are currently offered at either institution at this time. Cost savings and accessibility improvements will occur by sharing some services that aren't fully utilized by any of the three hospitals, but could be shared between the three. This is especially true for highly trained specialists who are critical when needed, but are not fully utilized at one location. Opportunities for efficiency may be achieved by the ability to develop specialists who will be able to practice at network locations, covering a wider geographic area.

Improved Quality

The affiliation will allow the administrators and clinical staff of NHSC and WCHN to work together to develop and share the protocols for evidence-based, best practice medicine in every area where patient services are provided (*See* Completeness Answers, p. 211). The synergies achieved by affiliation will allow WCHN and NHSC, in partnership with their affiliated physicians, to develop seamless transitions of care throughout the system, with the goal of providing high quality care in the lowest cost clinical setting appropriate.

Financial Benefits

The affiliation of the two systems results in a more effective cost management program and a stronger financial position. As discussed earlier, healthcare reform coupled with significant state and federal reimbursement reductions have placed unprecedented financial pressures on healthcare providers. It is clear that providers will face downward pressures on reimbursement and utilization for the foreseeable future. Without significant organizational changes, such as affiliations and partnerships, hospitals will be unable to flatten the cost curve sufficiently to offset reduced payment rates. (*See* Completeness Answers, Exhibit L for the AHA article: The Fundamental Transformation of the Hospital Field).

The proposed integration will produce expense savings and labor efficiencies through centralization of non-patient support functions and purchasing opportunities as a result of scale. Financial opportunities and cost-savings measures are outlined in the Application pp. 20-21, 23 and in the Completeness Answers pp. 213-215. I would like to highlight a few areas where we expect to achieve synergies across the network:

- Automation of process(es) currently performed manually
- Consolidation of the third-party contracts and data management systems
- Reductions in the use of consultants or agencies that provide external subject matter expertise, or perform specific support functions
- Centralization of administrative roles and functions through standardization of policies and procedures
- Savings on purchased goods and services achieved through economies of scale

These expense synergies will be achieved over time in the first few years of the integration process, so that by 2016 we expect a 2.5% reduction in the combined entity expenses. (*See* Completeness Answers p. 218 Table A for details of these expense synergies).

With the scale we will have as the new WCHN, we expect to continue to have access to capital and lower rates for borrowing. Larger health systems tend to have better credit ratings, and greater financial strength. A recent article from Moody's Investors Services, included in the Completeness Answers as Exhibit H, details the importance of the ability of hospitals and health systems to deliver value-based care. We anticipate that the affiliation will help us to move along this path as we collaborate to develop the infrastructure for population health management, focusing on maintaining the health of our community through prevention and management of chronic disease, in the lowest cost clinically appropriate setting.

The proposed affiliation will offer expense reductions, productivity efficiencies and enhanced purchasing opportunities which contribute to cost reductions while allowing us to continue to provide high quality health care services to our community.

This is the expectation for the affiliation that we have at Norwalk Hospital. We respectfully request approval of this project. I am happy to answer any questions.

Thank you for your time and attention, and I hereby adopt this pre-filed testimony as my own.

Daniel J. DeBarba, Jr.
President & CEO
Norwalk Health Services Corporation

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

Affiliation of NHSC and WCHN, Inc.
Docket No. 13-31832-CON

September 5, 2013

PRE-FILED TESTIMONY OF JOHN MURPHY, MD, PRESIDENT & CEO
WESTERN CONNECTICUT HEALTH NETWORK, INC.

Good afternoon Hearing Officer Hansted and OHCA staff. My name is John Murphy and I am the President and CEO of Western Connecticut Health Network, Inc.

I come to you to share my strong confidence in the future of community health that our affiliation with Norwalk Hospital will bring to the people of Fairfield and Litchfield counties. In an era of health care reform, and diminishing resources, we clearly see how this affiliation can help the State achieve its objectives outlined in the *Statewide Health Care Facilities and Services Plan,* specifically to improve the health of Connecticut residents, increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services. (Executive Summary, p. ix).

Background

A few years ago, when we took a fresh look at the landscape of health care in Western Connecticut, we saw a disturbing future for not-for-profit, community-based care. We feared the new realities of health care cost and reform might jeopardize the long-term viability of a

community-based hospital committed to provide care to all dimensions of a population. Because we didn't like that picture, we decided to create our own.

We focused, at Danbury Hospital, on strengthening our expertise in critical areas to become a destination for quality care. We began to develop a network approach to provide community access to care, from the primary care physician to the lab, clinic, specialist and hospital, as well as to the home and hospice, to address patient needs at every stage of life, for every generation. We opened a state-of-the-art research facility where we don't leave the discoveries in the lab; we use them at the bedside in patient care. And we formed, with New Milford Hospital, the beginnings of a network designed to provide the right care in the right place at the right time. Together, we see a day when we help communities manage the health of populations by providing patient-centered care in a medical home.

We have learned a lot from our work. We have learned how consumer views of health care needs have changed as well as what they expect from providers. We have experienced a shift from care that primarily occurs inside the hospital to care in outpatient settings for many services, at the same time consumers demand higher levels of experience when hospitalized. We have seen an ever-growing need for state-of-the-art, technology-driven emergency care. And we have learned; again, that *community* is at the heart of what we deliver.

I strongly believe in the contribution this affiliation will make to our state. We have learned, over the months, how similar these two organizations are in what we believe, how we work, and what we want to achieve. Neither of us could find a better partner for the future. We have learned that,

as different as our relative geographies may be in terrain, the needs of the people we serve are similar and, together, our collaborative service lines can provide a range and depth of quality care, each in its own service area. And we have learned that, with all the change in health care funding, the efficiencies we can create through affiliation with Norwalk Health Services Corporation will assure that we have the financial resources to invest in the facilities, technology and people that will make a real difference.

With this clear picture of what we can provide, as well as a realistic view of what resources we need, we began, in 2010, to consider what our two organizations could achieve together. In June of 2011, the respective Boards gave us the authority to officially pursue an affiliation. That fall, we engaged outside consultants to help us look at what we could accomplish and, in April 2012, convinced of the merits, we signed a non-binding Letter of Intent to continue the official exploration.

At the same time, a steering committee from the Danbury and New Milford Departments of Public Health, WCHN, the United Way, Regional YMCA and Western Connecticut State University continued a community needs assessment that began with a Community Report Card first developed in 2009. This process expanded to include community conversations to discuss priority health issues, a community plan for action to reach a diverse range of stakeholders, and initiation of community action planning work groups. This work is detailed in the Completeness Answers, Exhibit E, pages 552 through 623. As you will see, Recommendation Two of this report states, "Data indicated that the greater Danbury area is very healthy across many indicators, including the 10 leading causes of death. Public health, hospitals and human service

providers should be recognized for their efforts toward preventive, interceptive and ongoing care and supports for our community. They should also continue to strive for ways to maintain existing and pertinent programs and to find new and creative solutions to address emerging needs."

Benefits of Affiliation

These results reconfirm that our mission is sound, our strategy is relevant, and our affiliation with Norwalk Health Services Corporation has merit. WCHN has, for example, already begun collaboration between our hospitals in Danbury and New Milford, and our affiliated physicians. Norwalk Hospital has also been working on physician alignment and integration. Working as affiliates will enable our two organizations to leverage physician resources to the benefit of the communities we serve.

As we signed when we signed the definitive Affiliation Agreement with Norwalk Hospital on January 22, 2013, "we each bring strong legacies in not-for-profit, community-based care to our shared goal to be a beacon of quality care in an ever-changing health care landscape. Together we will build an integrated network of health services for our communities to redefine what a health care organization can offer." Today, after all the work we have done in the past months, we are more convinced of the value our affiliation will create when two organizations work together to achieve more while carefully managing their resources.

For example, when we look beyond physician alignment, we see patients who need to us to carefully evaluate what they actually need, if we see them in a doctor's office or an outpatient

setting. To ensure better outcomes, we reserve inpatient care for patients who actually need to be treated in the hospital, for emergency or tertiary care that is not available elsewhere. Because the affiliation will enable us to expand and deepen the care we can offer, we can work to reduce the rate of recidivism to reduce unnecessary re-admissions. That's what we mean when we say the right care in the right place at the right time.

We spell out the specific benefits of affiliation, and why we believe the affiliation is needed, on page 12 of our application for the Certificate of Need. These benefits include:

- Efficiently strengthening clinical programs to improve access to quality care and, in turn, improve outcomes
- Enhancing our educational programs for the health care providers of tomorrow including medical students, residents and fellows
- Strengthening the physician platform for the delivery of care
- Building competencies for new reimbursement models including population health management, bundled payments, PHOs and ACOs
- Integrating operations to stretch the dollars we spend in a unified operating model, and
- Improving access and reduce the cost of capital because of the efficiencies of scale of a larger organization. We, behind the scenes of the affiliation, operational opportunities to create real value.

Without this affiliation, neither organization will be able to adequately reach these goals.

It is all about stretching the dollars we spend as we strengthen the care we deliver. Information technology, for example, is a huge need in health care and a significant expense for any health

care organization. The benefits of affiliation, when it comes to IT, may be significant, as we look at the efficiencies of coordinating platforms and software. New IT record keeping can vastly improve how all care givers can access patient records, which will save time and money as well as strengthen the continuity of care. The ease of access to a patient's past medical history will enable a physician to make a more accurate diagnosis before treatment begins. Electronic health records, as well, will help us manage the health of various populations as well as reduce unnecessary duplication.

At WCHN, we have already started down this road of electronic health records by working on a health information exchange known as Health Link that allows digital information to flow from one provider to another. The patient is at the center of a multi-million dollar system that stores patient information in a central repository. Today, we are adding New Milford Hospital patients to the core system at Danbury Hospital, and, once our application for affiliation is approved, we will begin to connect Norwalk Hospital to the system as well.

As good as this sounds, however, all this technology costs a lot of money. The more patients and communities we can serve through a single investment can significantly stretch the dollars we must invest. This is the role that a larger scale plays. With our combined organizations, we can borrow money at a lower cost, we can create efficiencies that spread over all three hospitals in purchasing and in doing so, we have more money for patient care. Fortunately, our two organizations come to this affiliation with solid financial positions and we are well experienced, at WCHN, from our work with New Milford Hospital. The integration of Danbury and New Milford Hospitals that started in fiscal year 2011, for example, yielded a $7 million reduction in

expenses in fiscal year 2012, of which $5 million was at New Milford Hospital. While working to align the budgets, WCHN has also invested in renovating the emergency department at New Milford. Integration accomplishments have also included implementation of clinical practice standards across sites of care, organizational re-alignment of clinical and support departments including; laboratory, radiology, infection control, IT, marketing, finance, foundation compliance, coding, human resources, pharmacy, supply chain, volunteer services, and implementation of a common benefits platform.

To be clear, as much as we have learned from our work with New Milford Hospital, our affiliation with Norwalk is different. With New Milford, our service areas overlap, and we have looked for ways to consolidate services to broaden the community's access to quality care. Norwalk is a major urban hospital in a service area that is contiguous to WCHN's. With Norwalk, we will together explore ways to expand our complementary services to broaden community access.

As a hospital CEO and business leader, I certainly see the strengths of the affiliation, and look forward to stretching the dollars so we can strengthen the care. But it's John Murphy the physician that gets the most excited about what this affiliation can be. Like my colleagues at all three hospitals, I went into medicine because I want to help people get and stay well. With all the challenges we face in health care today, this affiliation will make this organization the best possible place for physicians like me to practice medicine. The "new picture of health" we are creating for our communities will make it easier for people to access the care they need at a price tag our patients, hospitals and providers can afford.

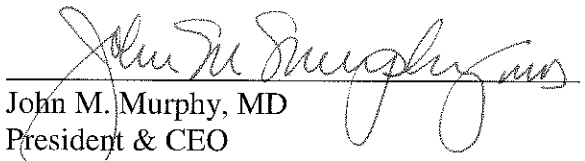
Transition to Implementation

If our application is approved, we will begin to work out many of the details that will begin on that "day one," from what patients will experience, to what physicians will access, to how communities will participate. During this transition, we won't simply talk with ourselves, as we reach out to community leaders, donors, patients and families, and our staff, to learn what it takes to be the health care organization people choose for care, contributions and careers. We each bring strong legacies in not-for-profit, community-based care to our shared goal to be a beacon of quality in an ever-changing health care landscape. The new organization will have greater access to capital, technology and purchasing power; more opportunity to achieve cost efficiencies; and a stronger ability to attract and retain top-notch specialists.

We believe in this affiliation, we know what we will bring to the communities we serve, and we know our approach to health care is essential. By looking ahead with clarity, and managing today with discipline, we assure the long life of this new organization as we redefine ourselves, and what we deliver, over the next several months. And so, years from now, we will look back with pride at a year when we imagined the possible and dared to make it come true. We officially ask for you to approve our application for the affiliation of Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation.

I welcome your questions.

Thank you for your time and attention today and I hereby adopt this pre-filed testimony as my own.



John M. Murphy, MD
President & CEO
Western Connecticut Health Network, Inc.

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

Affiliation of NHSC and WCHN, Inc.
Docket No. 13-31832-CON

September 5, 2013

PRE-FILED TESTIMONY OF ERVIN SHAMES, BOARD MEMBER
NORWALK HEALTH SERVICES CORPORATION

Good afternoon DPH and OHCA staff. My name is Erv Shames, and I am the past Chair of the Norwalk Health Services Corporation Board of Trustees, and the future Chair of the Board of the new Western Connecticut Health Network. I am pleased to welcome you to the community served by Norwalk Hospital, and appreciate that you have traveled to Norwalk to conduct this public hearing.

I am here today to ask that you approve the affiliation between Norwalk Health Services Corporation and Western Connecticut Health Network. In late 2008, the Board of Trustees and Senior Management of Norwalk Health Services Corporation began exploring the best ways to position Norwalk Hospital and its affiliates to meet future health care demands and the needs of the communities we serve. In the five years since then, assessment and evaluation have continued through the Strategic Planning Committee, and the Partnership Task Force of the Board of Trustees in collaboration with the Senior Leadership and the Medical Staff of Norwalk Hospital, as well as through the counsel and insight of industry experts. A great deal of work has been accomplished, from the development of Vision 2015, our long-range strategic plan (*See* Completeness Answers, Exhibit B, pp. 376-385) to our current proposal to affiliate with Western Connecticut Health Network. The guiding

principle of the Board of Trustees, as responsible stewards of valuable community resources, was to ensure that the people of the communities we served continued to have access to high-quality healthcare services.

We did not initially begin with the idea of affiliating with Western Connecticut Health Network. With the help of outside consultants beginning in 2009, we looked at all models, including not-for-profit and for-profit institutions, in-state and out-of-state institutions, and a myriad of legal arrangements from asset purchase to merger or affiliation. We also considered our option to remain a stand-alone hospital. We were looking for the arrangement that would be most beneficial for the health and well-being of the residents of the geographic area served by Norwalk Hospital. As the health care system began to transform to meet the mandates of the Patient Protection and Affordable Care Act ("ACA"), we came to the realization that remaining a stand-alone hospital would become increasingly unsustainable.

By 2010, the Partnership Task Force had identified key drivers for Norwalk Hospital and its affiliates to seek a strategic partnership option. These included:

- Long term viability of Norwalk Hospital – the continuance of mission/services to the community
- Improved access to capital markets and/or capital infusion
- Support for physician recruitment and retention
- Clinical service development, including the ability to provide more specialized services to the communities served

- Clinical, managerial, and technological talent and resources to reduce cost and improve quality
- Opportunity for collaboration
- Preserving community control and presence
- Quality improvement
- Better use of scarce community resources
- Improved care for the vulnerable and other community benefits.

In the meantime, Western Connecticut Health Network was assessing potential partners in order to build a network that has sufficient volume to effectively share resources, services and technologies. By the end of 2010, WCHN and NHSC had begun informal discussions about the potential for an affiliation, and in June of 2011 the respective Boards approved the initiation of a feasibility study for a partnership between NHSC and WCHN.

After a painstaking process and careful evaluation of potential arrangements Norwalk Health Services Corporation selected Western Connecticut Health Network as our partner because we believe their institution is the best fit for us for an affiliation and would allow our institution to achieve the goals set forth above. The history and mission of these two organizations is very similar, both not-for-profit, community hospitals, founded over 100 years ago – in the case of Danbury Hospital and Norwalk Hospital and almost 100 years ago in the case of New Milford Hospital. We share similar values and have common goals for the future: delivering high-quality, coordinated, and cost-effective care across the continuum.

While five years ago, there was no immediate public need for us to affiliate in order to maintain excellent health care for the patients in our service area we did, however, foresee a long-term need. As anticipated, hospitals today face many challenges including declining reimbursement, and changes in the health care delivery model. Beginning in 2014, we expect that more people in our service area will begin to demand access to health care services, as they will now have health insurance through Health Insurance Exchanges (HIEs) and the expansion of Medicaid under the mandates of the ACA.

Norwalk Hospital and its health system serve approximately 275,000 people in its primary and secondary service areas. Danbury Hospital and New Milford Hospital serve approximately 440,000 people in their combined service areas. Although our service area population is projected to have very little overall growth the demographics show a projected growth in the number of people ages 65 and older. We also expect an increased utilization of health care services as the population ages. So while we expect to care for greater numbers of newly insured patients, and of both Medicare and Medicaid patients, we have seen and continue to expect reductions in the reimbursement for service provided to these patients. With the talent and knowledge that exists at all three hospitals, we anticipate collaborating on best practices and protocols to provide quality care in the most appropriate clinical setting.

In 2012, Norwalk Hospital and the Norwalk Health Department published the "2012 Greater Norwalk Area Community Health Assessment and Improvement Initiative" (*See* Completeness Answers, Exhibit D, pp. 417-550) which gave us a very detailed look at what the community needed. This report integrated existing data regarding social, economic, and

health indicators in the region with qualitative information from 15 focus groups made up of community residents and service providers, and 17 interviews with community stakeholders. Interviews were held with individuals representing youth; the Hispanic and African American communities; individuals receiving services from a federally-qualified health centers; social services, health care and mental health providers; businesses; housing; law enforcement; and the local government.

This very detailed report examined all sectors of the community NHSC serves, and listened to their voices. We found that the community is concerned about the issues of chronic disease resulting from being overweight and obese – and concerned about the limited services for treatment of substance abuse as well as mental health services. The Executive Summary, beginning on page 420, gives an excellent outline of the depth of this report. The message from all who participated in the assessment was clear: that there is a public need for more health care services and better access to services. Leading the list of what is needed to address health challenges in the community was a focus on preventive health care, which will require changes to the health care delivery infrastructure.

A similar community needs assessment process was undertaken by a steering committee comprised of individuals from the Danbury and New Milford Departments of Public Health, Western Connecticut Health Network, the United Way, and Western CT State University. This collaborative created a Community Report Card (See Completeness Answers, Exhibit E, pp.552-623). This group also recommended that the health care providers in their area should "continue to strive for ways to maintain existing and pertinent programs and to find

new and creative solutions to address emerging needs." (See Completeness Answers, Exhibit E, p. 560).

We anticipate that the affiliation will respond to these identified community needs by expanding accessibility to health care services in the community, and emphasizing the focus on preventive care. By affiliating, we will have the scale and resources to invest in the expansion of primary care in each service area. And residents of our region will also find better specialized and tertiary level care near home, due to collaborative efforts of all three hospitals. Sharing existing resources and the opportunity to collaborate on programs will strengthen all three hospitals and their affiliates. We will be able to explore diverse care models such as medical homes, open access primary care and immediate/urgent care facilities. The enhancement of access to primary care will provide a cost effective alternative to fragmented care, much of which is currently provided in the emergency department at great expense.

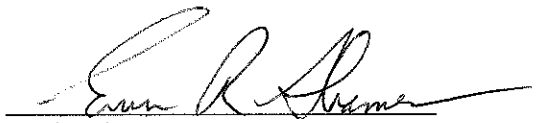
As noted in the Executive Summary of the Statewide Health Care Facilities and Services Plan, "Many provisions of the 2010 Patient Protection and Affordable Care Act (PPACA) favor integrated systems to create efficiencies and address quality." (p. ix). The goals of the ACA are aligned with the goals we have had at Norwalk Health Services Corporation and to the recommendations of the Community Health Assessment and Improvement Initiative; successfully providing high quality and accessible healthcare services, maintaining patient safety and satisfaction, providing more care to the underserved, increasing primary care and prevention programs to better manage health issues for our patients; monitoring and

improving patient outcomes and recruiting more outstanding physicians, hospital staff and other experts with the skills we need. Our goals and the plan to achieve these goals are set forth in "Vision 2015: Norwalk Hospital Strategic Plan 2010-2015", which was approved by our Board in August of 2009. (*See* Completeness Answers, Exhibit B, pp. 376-385) and in the "2012 Greater Norwalk Area Community Health Assessment and Improvement Initiative" (*See* Completeness Answers, Exhibit D, pp. 417-550).

Norwalk Health Services Corporation is a strong institution now, and through careful leadership and planning has been able to respond to the rapid transformation in the health care environment. But we are facing enormous challenges as the health care system continues to evolve at an unprecedented rate. With the expectation of more patients and less reimbursement, the strain on our financial resources will quickly be outpaced by the demands for quality care and better outcomes. We recognize that as responsible stewards of the health care resources for our community, it would be wise to position ourselves so that we are not only ready to meet the challenges ahead – but that we can thrive and flourish in meeting the health care needs of the patients in our service area in the future.

Through this affiliation, we will be able to meet these challenges: to expand services, rather than reduce services, to share in the cost of new technology that is necessary for the new models of care, to provide the opportunity for our communities to access primary care physician and specialists associated with each hospital, and to continue to meet the needs of our community. We hope that OHCA agrees, and request approval of this application. I am happy to answer any questions.

Thank you for your time and attention today and I adopt this pre-filed testimony as my own.



Ervin Shames
Norwalk Health Service Corporation Board of Trustees

User, OHCA

From: Lynn Taborsak <ltaborsak@gmail.com>
Sent: Tuesday, September 10, 2013 10:55 AM
To: User, OHCA
Subject: Testimony for Docket #13-31832-CON
Attachments: WCHN Hearing_91013.docx

Please include this statement in the record for Docket #13-31832-CON.

Public Hearing on
Proposed Affiliation between Norwalk Hospital and
Western Connecticut Health Network
Docket# 13-31832-CON
September 10, 2013

Good afternoon. My name is Lynn Taborsak and I am here to express my concerns as a consumer about the proposed affiliation of Western Connecticut Health Network with Norwalk Hospital. I want health care for myself and members of my community to be provided at a local community hospital. This is especially important if trauma care is needed for a life-threatening injury, or critical care is needed for an unexpected heart attack, or palliative care is needed at the end of life.

This summer my elderly neighbor contracted pneumonia. She has stage four lung cancer. She was hospitalized at Danbury Hospital for eight days. I was able to visit her three times a day to raise her spirits, offer comfort and give encouragement. She has no family members living in Connecticut. I am sure that Norwalk Hospital provides excellent care for patients with pneumonia but it would be a hardship for Danbury residents to visit a hospitalized family member there.

Just as parents prefer the familiarity of local neighborhood schools for their children, consumers prefer the familiarity of their local community hospital for their health care needs. It's a familiar place in the community. We know how to get there. We know where to park. We know where the coffee shop is. When a family member is hospitalized, we don't need the added stress of dealing with a foreign environment.

I appreciate the economies of scale that can help reduce costs for the proposed network that will serve a population of about 620,000. In many ways the network will be a health care monopoly for the region. The care for patients in the region must not be Balkanized or geographically divided; each community must offer cancer care, cardiac care, trauma care, renal dialysis and palliative care in a familiar community setting.

Submitted by
Lynn Taborsak
110 Hayestown Road
Danbury, CT 06811

Greer, Leslie

From: Greer, Leslie
Sent: Tuesday, September 10, 2013 11:21 AM
To: klg1@aol.com
Cc: Lazarus, Steven
Subject: Testimony for Docket #13-31832-CON

Tracking:

Recipient	Delivery
klg1@aol.com	
Lazarus, Steven	Delivered: 9/10/2013 11:21 AM

Pat,
The following is correspondence received for today's hearing.
Leslie Greer

From: User, OHCA
Sent: Tuesday, September 10, 2013 11:05 AM
To: Lazarus, Steven; Fiducia, Paolo; Ciesones, Ron; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: FW: Testimony for Docket #13-31832-CON

Forwarded from OHCA email.

From: Lynn Taborsak [mailto:ltaborsak@gmail.com]
Sent: Tuesday, September 10, 2013 10:55 AM
To: User, OHCA
Subject: Testimony for Docket #13-31832-CON

Please include this statement in the record for Docket #13-31832-CON.

Public Hearing on
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Submitted by
Lynn Taborsak
110 Hayestown Road
Danbury, CT 06811

Greer, Leslie

From: Greer, Leslie
Sent: Tuesday, September 10, 2013 3:41 PM
To: klg1@aol.com
Subject: Norwalk Hearing
Attachments: 31832-6.pdf

Pat,
Attached are additional letters received for today's hearing.

Leslie M. Greer
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Office of Health Care Access
410 Capitol Avenue, MS#13HCA
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Phone: (860) 418-7013
Fax: (860) 418-7053
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Danbury Nurses Union Unit #47,
AFT LCOAL 5047, AFT Connecticut, AFL-CIO
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FAX TRANSMITTAL COVER SHEET

TO: Lisa Davis, OCHA Commissioner FAX #: 860-418-7053

FROM: Mary Consoli President Danbury Nurses Union

DATE: 9/10/2013

PAGES INCLUDING Cover: 3

NOTATIONS:

This testimony is being sent by FAX because I am not able to attend public hearing being held today 9/10/13 at 3:00pm in Norwalk, Ct.

Sincerely,
Mary Consoli

Danbury Nurses' Union Unit #47 Local 5047
AFT-CT, AFT Healthcare, AFL- CIO
18 Great Plain Road, Danbury, CT 06810 (203) 748-4774
FAX (203) 748-2988 E-mail aft5047unit47@gmail.com
http://ct.aft.org/unit47

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Office of Health Care Access Public Hearing Docket # 13-31832
Proposed Affiliation between Norwalk Hospital and
Western Connecticut Health Network
September 10, 2013

Good afternoon. My name is Mary Consoli. I am President of the Danbury Nurses' Union Unit #47 and a community member who utilizes Danbury Hospital for my healthcare needs. I want to express my concerns regarding the affiliation of Western Connecticut Health Network with Norwalk Hospital. My concerns are not only as president of this union representing 620 registered nurses, but also as a resident of Danbury, Connecticut.

In August 2011, Danbury Hospital contracted their Neonatology Intensive Care medical care coverage, to a third party staffing organization, Onsite Neonatal Partners, as a cost saving measure. Dr. Edward James, a local Neonatologist, was named Director and was responsible for the transition of care for the Neonatal Intensive Care Unit. In June of 2013 Dr. Meltem Seli, from Onsite and Norwalk Hospital was named Interim Director. Towards the end of June 2013 when the NICU census was high, and there were some staffing issues, Dr. Seli suggested that we send the babies born at Danbury Hospital to Norwalk Hospital. Fortunately the Danbury Hospital Director of Pediatrics and the Nursing Director of Maternal and Child Care did not let this happen. My concern is that this will be the plan for the future.

The decisions about admissions, transfers, surgery and tests should be made by the treating physician weighing the acuteness of the patient's condition. Patient care at Danbury Hospital should not be allowed to be based on third party administrator's decisions, or on the availability of beds in the network. There will always be fluctuations in patient census and we must be creative in responding to both high and low numbers? Nurses already adjust to demands of patient care. They should not have to float or be assigned to work at other network facilities as part of their job requirement.

As a Danbury resident, I want to be treated at my community hospital. I want to be there for my family and friends if they need emotional support for a serious illness or injury, whether it is on a beautiful fall day or in the middle of a snow storm. If I need end of life care, I want familiar faces to be at my bedside along with my family. Families, should not have to travel 25 miles in either direction on Route 7 for care or to visit loved ones.

I acknowledge the challenges in today's health care environment and understand the positives of "buying in bulk" and other cost reduction measures. However, the community hospital should put patient care above hospital profit margins.

Submitted by

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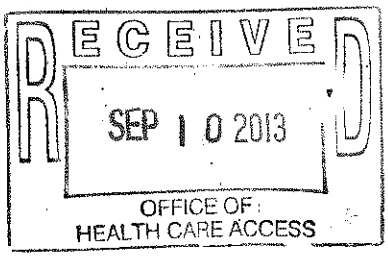

facsimile transmittal

To:	**Lisa Davis**	Fax:	**860-418-7053**
	OHCA		
From:	**Lynn Tabersak**	Date:	**9/10/2013**
Re:	**Docket #13-31832-CON**	Pages:	**2**

☐ Urgent ☐ For review ☐ Please comment ☐ Please reply ☐ Please recycle

Please include this statement in the matter of Docket #13-31832-CON which is being heard today in Norwalk.

RECEIVED
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Public Hearing on
Proposed Affiliation between Norwalk Hospital and
Western Connecticut Health Network
Docket# 13-31832-CON
September 10, 2013

Good afternoon. My name is Lynn Taborsak and I am here to express my concerns as a consumer about the proposed affiliation of Western Connecticut Health Network with Norwalk Hospital. I want health care for myself and members of my community to be provided at a local community hospital. This is especially important if trauma care is needed for a life-threatening injury, or critical care is needed for an unexpected heart attack, or palliative care is needed at the end of life.

This summer my elderly neighbor contracted pneumonia. She has stage four lung cancer. She was hospitalized at Danbury Hospital for eight days. I was able to visit her three times a day to raise her spirits, offer comfort and give encouragement. She has no family members living in Connecticut. I am sure that Norwalk Hospital provides excellent care for patients with pneumonia but it would be a hardship for Danbury residents to visit a hospitalized family member there.

Just as parents prefer the familiarity of local neighborhood schools for their children, consumers prefer the familiarity of their local community hospital for their health care needs. It's a familiar place in the community. We know how to get there. We know where to park. We know where the coffee shop is. When a family member is hospitalized, we don't need the added stress of dealing with a foreign environment.

I appreciate the economies of scale that can help reduce costs for the proposed network that will serve a population of about 620,000. In many ways the network will be a health care monopoly for the region. The care for patients in the region must not be Balkanized or geographically divided; each community must offer cancer care, cardiac care, trauma care, renal dialysis and palliative care in a familiar community setting.

Submitted by
Lynn Taborsak
110 Hayestown Road
Danbury, CT 06811

SEP-10-2013 10:27 AM LYNN TABORSAK 203 790 6042 P.02

Applicants Exhibit 1

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Norwalk Hospital

Physician Resource Planning

May 16, 2012

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DISPUTES & INVESTIGATIONS • ECONOMICS • FINANCIAL ADVISORY • MANAGEMENT CONSULTING

Today's Agenda

Section 1 » Project Overview

Section 2 » NCI's Physician Resource Planning Methodology

Section 3 » Service Area & Norwalk Profile

Section 4 » Physician Resource Planning Output

Section 5 » Appendix

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Section 1. Project Overview

Objectives for Physician Resource Planning

» A comprehensive Physician Resource Plan should address a variety of important strategic issues:

- Community need by specialty for compliance with prevailing federal guidelines (IRS and OIG)
- Geographic areas of strength and opportunity by specialty and location
- Assessment of immediate and/or pending succession needs and other medical staff demographics
- Unique characteristics and/or needs of the service area

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Project Workplan

January					February				March				April					May	
1/2	1/9	1/16	1/23	1/30	2/6	2/13	2/20	2/27	3/5	3/12	3/19	3/26	4/2	4/9	4/16	4/23	4/30	5/7	5/14

On-site

Phase I: Project Mobilization & Internal Assessment

Phase II: External Assessment – Data Collection and Synthesis

Phase III: Surplus/(Deficit) Analysis and Development of Strategic Conclusions

Activities

1. Identify system project liaison to coordinate all activities involving the planning process
2. Work with project liaison to confirm service area and key specialties

Deliverables

- Comprehensive data request

Activities

1. Coordinate data needs/collection with system liaison
2. Collect and verify community physician demographic data
3. Apply NCI's actuarially based model to determine the community physician need

Deliverables

- Confirmation of key planning assumptions
- Community physician supply roster

Activities

1. Identify community physician surplus/deficit projections by specialty and geographic location
2. Complete on-site interviews with physicians and administration

Deliverables

- Community Surplus/(Deficit) tables
- Strategic conclusions relative to community need

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List of Interviewees

- Dr. Altbaum, Internal Medicine
- Dr. Thomas Ayoub, Chief of Staff
- Ms. Lisa Brady, COO
- Dr. Michael Carius, Chair of ED
- Mr. Dan DeBarba, CEO
- Dr. Klaus Thaler, Chair of Surgery
- Dr. Marvin Den, Internal Medicine/Private Practice
- Dr. Eric Mazur, VP & CMO
- Dr. T. Michaels, Chair of Psychiatry
- Mr. Patrick Minicus, CFO
- Dr. J. Orlinick, Associate Chair, Dept. of Medicine
- Dr. Papaharis, Internal Medicine
- Dr. V. Smetak, Chair of Pediatrics
- Dr. Michael Marks, President NHP&S, VP Business Development
- Dr. Berman, Chair Department of Medicine
- Dr. Yoni Barnhard, Chair Department of OB/GYN

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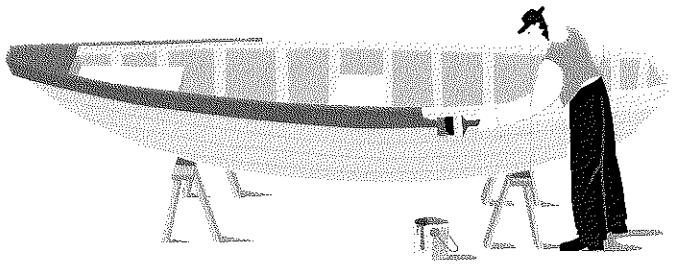
Section 2. Physician Resource Planning Methodology



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Conceptual Overview of the Physician Resource Model

Navigant has developed a physician resource planning model that includes demand and supply for a client-defined geography. Community physician demand is calculated based on a number of factors, shown below.

Current Physician Demand

Based on:

- Demographic Profile
- Insurance Enrollment by Type
- Historical Utilization
  (ambulatory and surgical encounters)
- Physician Work Capacity
  (set at MGMA survey medians unless otherwise indicated, see appendix)

Future Physician Demand

Also takes into account:

- Population Growth and Aging
- Changes in Insurance Coverage Due to Healthcare Reform
- Increasing Care Coordination
- Impact of the Economy

Current Physician Supply

- Current FTE Count by Specialty

Future Physician Supply

Also takes into account:

- Retirements (at age 65 years)

Notes: See the following pages for further detail on demand factors. Physician demand is calculated at an age/gender cohort and insurance status specific level for each specialty

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Physician Requirements Model Overview

Physician specialty specific use rates are segmented by insurance types (commercial, Medicare, Medicaid, and uninsured) and risk (managed care and fee for service) and applied to the community population which is also segmented into those seven categories (in addition to the usual age and gender cohorts).

Segmented use rates are applied to the population statistics within the service area:

Physician Specialty Use Rates x **Population (by age cohorts and gender)** = **Physician Demand (# of anticipated physician encounters, i.e., office visits)**

Adjustments

- Urban vs. rural
- Insurance type
- Risk vs. traditional fee for service
- Projected changes to purchasing power

Insurance Segments

- Commercial Risk
- Commercial Non-Risk
- Medicare Risk
- Medicare Non-Risk
- Medicaid Risk
- Medicaid Non-Risk
- Uninsured

The resulting Physician Demand is then applied to the specific office capacity for a given specialty to calculate Physician Community Need

Demand (# of anticipated physician encounters) **Work Capacity (average # of annual patients seen per MGMA benchmarks)** = **Community Physician Need (FTEs)**

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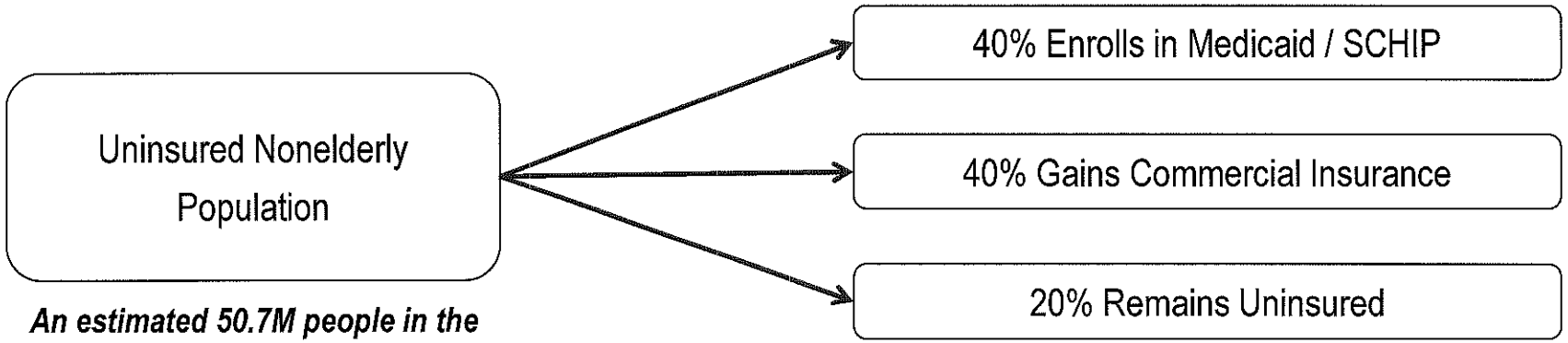
Changes in Insurance Status Due to Reform

» The Congressional Budget Office and Joint Committee on Taxation estimate that by 2019, the effect of healthcare reform would reduce the percentage nonelderly in the US without health insurance from 17% to just 6%

- Half of the newly insured would gain coverage through Medicaid or the State Children's Health Insurance Program ("SCHIP")
- Half would shift to private insurance, purchased through the new insurance exchanges, the individual insurance market outside of the exchanges, or through employer based coverage



An estimated 50.7M people in the US are uninsured

Sources: Thomson Reuters & HealthLeaders, "FactFile: Healthcare Reform: Utilization" (December 2010); Congressional Budget Office, "Cost estimate for the amendment in the nature of a substitute for H.R. 4872, incorporating a proposed manager's amendment" (made public on 3/20/2010) ; Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey.

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Future Physician Demand: Key Drivers

Population Growth and Aging

- Over 127,000 people live in the Norwalk Hospital Stark II Service Area
- While the overall population base is only expected to grow by +0.8% over the next five years, the 65+ age cohort, which drives a significant portion of physician utilization, is the fastest growing segment, projected to increase by 12.6% by 2017

Changes in Health Insurance Coverage Due to Reform

- Currently about 10% of non-elderly adults in Southern Connecticut are uninsured
- As healthcare reform is implemented, 40% of the uninsured population is expected to gain coverage through expanded Medicaid access and eligibility and another 40% is expected to enroll in some type of commercial product

Increasing Care Coordination

- Managed care penetration in the Southern Connecticut area is moderate, though likely to increase as physician practice and access patterns evolve due to health care reform and pressures to control costs
  - Among those eligible for Medicare in Southern Connecticut, 19% are enrolled in a Medicare Advantage plan
  - 26% of the Southern Connecticut commercially insured population is enrolled in HMO plans
  - Managed Medicaid encompasses 82% of all Medicaid enrollees in Southern Connecticut
- Physician utilization within care coordination models varies—upward 5% to 10% for certain primary care and downward 0% to 10% for select medical and surgical specialties

Impact of the Economy

- Prolonged recessions may also erode physician demand; however, the impact in the Norwalk Region will not be as dramatic as the local economy is expected to fare relatively well in the near future

Sources: Claritas; HealthLeaders Market Overview, Southern Connecticut, 2011.

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Other Factors Affecting Calculated Physician Demand

» **Use of Mid-Level Providers**

- Reliable data on mid level provider utilization is not currently available
- Given the shortage of primary care providers, it is known that in a reform environment, mid level providers will play a larger role in the provision of healthcare
- The demand model applies a standard 15% adjustment to office visit demand for family practitioners, internists and pediatricians to account for the use of mid levels

» **Variations in Physician Productivity**

- The current model uses the specialty specific median physician productivity numbers reported by the MGMA survey, with the ability to adjust these figures in markets where the physicians may deviate from these benchmarks
- The model can also accommodate client-customized physician productivity benchmarks when available

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Physician Supply Methodology

Norwalk's service area physician supply was constructed using the following steps:

1) Integrated current Norwalk hospital physician roster with AMI physician data

2) Supplemented this data set with an audit of nearby hospital competitor website information, local payer rosters and Medicare enrollee physician lists

3) Contacted physician offices by telephone to verify:
   - Practice status – full/part-time
   - Practice location
   - Other providers in office
   - Physician specialty

4) Provided fully-verified roster to Norwalk for multiple reviews and comment

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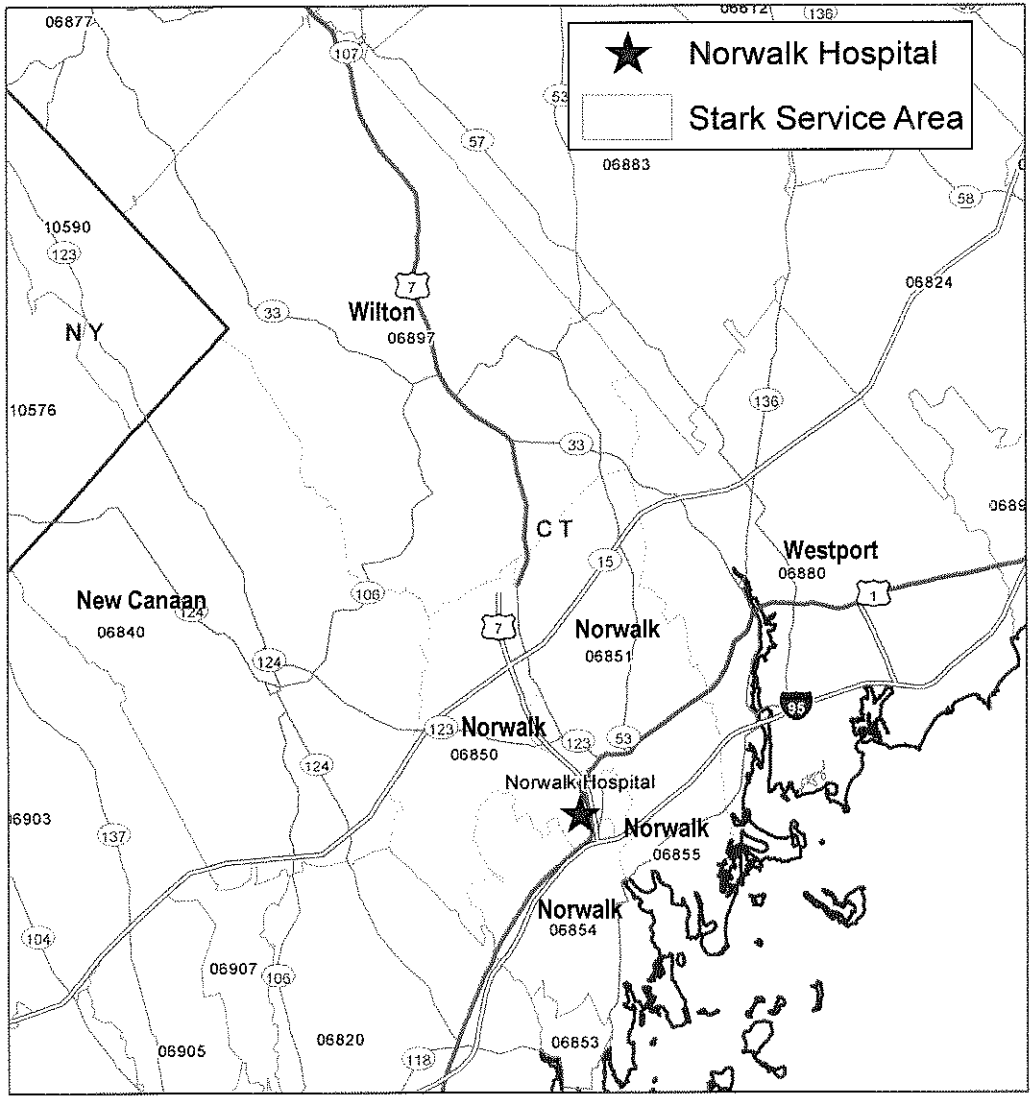
Section 3. Service Area & Norwalk Profile

Stark Defined Primary Service Area



In order to justify recruitment assistance, a community deficit must exist in a particular specialty, within a certain geographic area as specifically defined by Stark Laws. The Stark Law-defined service area (Stark Service Area) is defined as the lowest number of contiguous zip codes that accounts for 75% of a hospital's inpatient admissions.

Note: Stark service area is used (and must be used per federal guidelines) to demonstrate a community need if hospital is providing income guarantee or other financial support for physician recruitment. Hospitals are not bound by the Stark service area if pursuing employment of physicians.

Source: Norwalk Hospital internal discharge data

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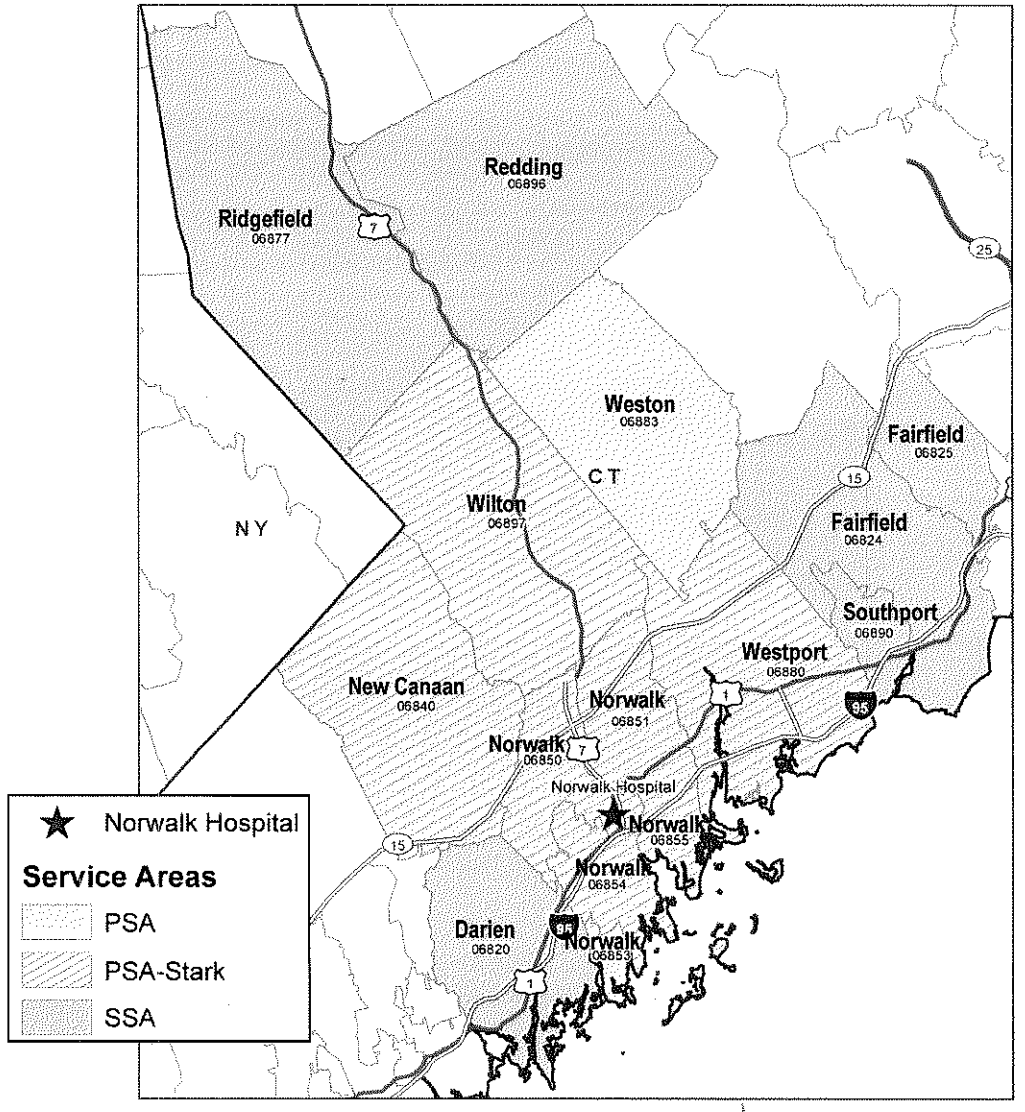
Service Area Definition

NH Service Area	Zip	2012 Pop	2017 Pop	CAGR ('12-'17)
Primary-Stark	06851	26,272	26,663	0.3%
	06854	29,131	29,514	0.3%
	06850	18,522	18,553	0.0%
	06880	27,071	27,147	0.1%
	06897	18,045	18,122	0.1%
	06855	7,963	7,989	0.1%
	06840	19,666	19,755	**0.1%**
Primary-Stark Total:		**146,670**	**147,743**	**0.1%**
Primary-Other	06883	10,124	10,260	**0.3%**
	06853	3,634	3,700	**0.4%**
Primary-Other Total:		**13,758**	**13,960**	**0.3%**
Secondary	06824	33,997	34,356	0.2%
	06820	21,055	21,374	0.3%
	06896	9,279	9,665	0.8%
	06877	24,857	25,436	0.5%
	06825	20,935	21,061	0.1%
	06890	4,362	4,407	0.2%
Secondary Total:		**114,485**	**116,299**	**0.3%**
Grand Total:		**274,913**	**278,002**	**0.2%**



Sources: Claritas, Norwalk Hospital.

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Stark PSA Service Area Demographic Profile

Norwalk Hospital Service Area, 5-Year Projected Population (2012 - 2017) and Average Household Income

NAH Service Area Region	2012 Population	2017 Population	% Change	CAGR (2012-2017)	Average Household Income (2012)
PSA-Stark	146,670	147,743	0.7%	0.1%	$142,422
PSA-Other	13,758	13,960	1.5%	0.3%	$219,444
SSA	114,485	116,299	1.6%	0.3%	$166,088
Total Service Area:	**274,913**	**278,002**	**1.1%**	**0.2%**	**$155,614**
Connecticut	**3,588,886**	**3,632,955**	**1.2%**	**0.2%**	**$87,886**
United States	**313,095,504**	**325,256,783**	**3.9%**	**0.8%**	**$67,314**

NH Stark PSA Service Area Population and Distribution by Age Group (2012 - 2017)

Age Group	2012 Population	2017 Population	% Change	CAGR (2012-2017)	US CAGR (2012-2017)	2012 % Distrib.
Under 18	73,707	72,051	(2.2%)	(0.5%)	0.5%	26.8%
18 to 44	83,552	82,470	(1.3%)	(0.3%)	0.0%	30.4%
45 to 64	80,381	81,578	1.5%	0.3%	1.0%	29.2%
65 to 84	31,654	35,462	12.0%	2.3%	2.9%	11.5%
85+	5,619	6,441	14.6%	2.8%	2.9%	2.0%
Total:	**274,913**	**278,002**	**1.1%**	**0.2%**	**0.8%**	**100%**

Observations

- The Norwalk Stark PSA service area population is forecast to grow +0.7% over the next 5 years.
- However, the population is rapidly aging, with the 65+ population expected to grow from 13.2% of the total in 2012, to 14.8% in 2017.

Sources: Claritas, Norwalk Hospital.

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Norwalk Medical Staff Age Analysis

Specialty	Total Count	Count of NH Physicians					% Age
		<40	40-49	50-54	55-59	60+	60+
Family/General Practice	7	2	1	1	1	2	29%
Internal Medicine	64	7	21	7	8	21	33%
Hospitalists	36	18	14	2	1	1	3%
Pediatrics	48	7	23	5	6	7	15%
Obstetrics / Gynecology	29	9	7	5	6	2	7%
Primary Care	**184**	**43**	**66**	**20**	**22**	**33**	**18%**
Allergy/Immunology	9	2	1	3	1	2	22%
Cardiology	29	3	7	8	3	8	28%
Dermatology	10	2	2	1	1	4	40%
Endocrinology	13	3	7	2	1	0	0%
Gastroenterology	16	3	3	1	4	5	31%
Hematology/Oncology	9	0	4	2	1	2	22%
Infectious Disease	3	2	0	0	1	0	0%
Nephrology	5	1	0	0	0	4	80%
Neonatology	9	1	4	3	1	0	0%
Neurology	8	1	1	2	0	4	50%
Perinatology	15	7	5	3	0	0	0%
Pulmonary Medicine	8	1	2	1	3	1	13%
Radiation Therapy	11	4	4	2	0	1	9%
Rheumatology	5	1	1	0	1	2	40%
Medical Subspecialties	**150**	**31**	**41**	**28**	**17**	**33**	**22%**
CT Surgery	2	0	1	0	0	1	50%
Vascular Surgery	8	2	4	2	0	0	0%
Colorectal Surgery	4	0	2	0	1	1	25%
General Surgery	11	1	3	3	3	1	9%
Neurosurgery	4	1	0	0	1	2	50%
Ophthalmology	11	2	1	5	0	3	27%
Orthopedics	17	2	4	1	5	5	29%
ENT	6	0	4	0	1	1	17%
Plastic Surgery	17	4	7	0	2	4	24%
Urology	7	0	4	0	0	3	43%
Subsurgical Specialties	**87**	**12**	**30**	**11**	**13**	**21**	**24%**
Anesthesia & Pain Management	24	4	12	1	5	2	8%
Emergency Medicine	21	3	8	5	2	3	14%
Pathology	5	1	0	1	0	3	60%
Physical Medicine/Rehab	7	1	1	2	2	1	14%
Psychiatry	14	2	1	0	2	9	64%
Radiology - Diagnostic	16	3	5	1	2	5	31%
TOTAL	**508**	**100**	**164**	**69**	**65**	**110**	**22%**

Observations

- Of the 508 Norwalk staff physicians identified within these specialties, 110 (or 22%) are older than age 60
- Nephrology is the only specialty that requires immediate succession planning – 80% of Norwalk's nephrologists are over the age of 60
- Five specialties have 50% or more of their active physicians over the age of 60 – Neurology, CT Surgery, Neurosurgery, Pathology, and Psychiatry
- Norwalk may not have significant succession planning issues over the next five years given that age 60+ physicians account for only 22% of the medical staff. However, physicians in the 50 – 59 age cohort represent approximately one-quarter of the medical staff indicating that in ten years, Norwalk may have some significant succession planning hurdles to overcome.

Note: All physician status categories are included in this analysis.
Source: Norwalk physician roster (Jan. 2012)

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Section 4. Physician Resource Planning Output

Stark Primary Service Area

Primary (Stark) Service Area – 2012 Community Surplus/(Deficit)

Specialty	Demand	Supply	Surplus (Deficit)
Family/General Practice	35.4	13.9	(21.5)
Internal Medicine	56.5	40.5	(16.0)
Pediatrics	22.0	32.3	10.3
Obstetrics / Gynecology	15.6	20.2	4.6
Primary Care	**129.5**	**106.9**	**(22.7)**
Allergy/Immunology	3.2	5.3	2.1
Cardiology	8.8	8.1	(0.7)
Dermatology	6.5	11.3	4.8
Endocrinology	2.4	3.2	0.8
Gastroenterology	7.3	11.5	4.2
Hematology/Oncology	3.5	4.5	1.0
Infectious Disease	4.4	2.3	(2.1)
Nephrology	3.1	3.0	(0.1)
Neurology	4.7	5.0	0.3
Pulmonary Medicine	4.1	5.6	1.5
Radiation Therapy	2.5	1.4	(1.1)
Rheumatology	2.5	3.3	0.8
Medical Subspecialties	**53.0**	**64.5**	**11.5**
CT Surgery - Cardiac	2.5	-	(2.5)
CT Surgery - Thoracic	1.2	0.2	(1.0)
Vascular Surgery	2.0	1.0	(1.0)
Colorectal Surgery	0.5	1.5	1.0
Oncology Surgery	0.2	0.2	0.0
General Surgery	2.9	9.0	6.1
Breast Surgery	1.7	2.0	0.3
Bariatric Surgery	0.2	0.5	0.3
Neurosurgery	3.3	2.5	(0.8)
Ophthalmology	8.9	9.4	0.5
Orthopedics	9.8	11.8	1.9
ENT	5.8	2.5	(3.3)
Plastic Surgery	2.4	11.0	8.6
Urology	5.1	5.5	0.4
Subsurgical Specialties	**46.5**	**57.1**	**10.6**
TOTAL	**229.0**	**228.5**	**(0.5)**

Observations

- The primary care specialties currently exhibit deficits, in contrast to the majority of medical and surgical specialties, which are currently experiencing surpluses
- To some degree, a portion of the primary care deficits are most likely being met by other community resources (ED, urgent care, midlevel use); some of the Family Practice deficit may be fulfilled through the surpluses in Pediatrics and OB/Gyn, while some of the Internal Medicine deficit could be satisfied by medical specialists (Gastroenterology, Pulmonology, Endocrinology, etc.)
- There are currently pockets of need in addition to FP and IM, most notable are:
  - Infectious Disease = 2.1
  - CT Surgery - Thoracic = 1.0
  - ENT = 3.3

Source: Navigant Consulting Physician Resource Planning Model

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Primary (Stark) Service Area – 2017 Community Surplus/(Deficit)

Specialty	Demand	Supply	Surplus (Deficit)
Family/General Practice	36.4	11.1	(25.3)
Internal Medicine	59.5	31.1	(28.4)
Pediatrics	21.3	26.8	5.5
Obstetrics / Gynecology	15.7	18.4	2.7
Primary Care	**132.9**	**87.4**	**(45.5)**
Allergy/Immunology	3.1	3.5	0.4
Cardiology	9.5	4.9	(4.6)
Dermatology	6.5	7.1	0.6
Endocrinology	2.4	3.2	0.8
Gastroenterology	7.6	9.1	1.5
Hematology/Oncology	3.7	3.0	(0.7)
Infectious Disease	4.7	2.2	(2.5)
Nephrology	3.4	0.9	(2.5)
Neurology	4.8	5.0	0.2
Pulmonary Medicine	4.3	4.7	0.4
Radiation Therapy	2.7	0.4	(2.3)
Rheumatology	2.6	1.9	(0.7)
Medical Subspecialties	**55.3**	**45.9**	**(9.4)**
CT Surgery - Cardiac	2.8	-	(2.8)
CT Surgery - Thoracic	1.3	-	(1.3)
Vascular Surgery	2.2	1.0	(1.2)
Colorectal Surgery	0.5	1.0	0.5
Oncology Surgery	0.2	0.2	0.0
General Surgery	2.9	7.5	4.6
Breast Surgery	1.8	2.0	0.2
Bariatric Surgery	0.2	0.5	0.3
Neurosurgery	3.6	1.4	(2.2)
Ophthalmology	9.3	7.1	(2.2)
Orthopedics	10.0	6.6	(3.4)
ENT	5.9	1.5	(4.4)
Plastic Surgery	2.5	8.3	5.8
Urology	5.3	3.9	(1.4)
Subsurgical Specialties	**48.5**	**41.0**	**(7.5)**
TOTAL	**236.7**	**174.3**	**(62.4)**

Observations

- By 2017, the service area deficit is projected to widen from a 0.5 FTE deficit to 67.4 FTEs primarily due to physician retirements and an aging population which drives higher utilization
- Approximately 74% of the community demand will be met by 2017
- Medical specialties will shift to a deficit by 2017 with most specialties exhibiting a need except for the following:
  - Allergy/Immunology
  - Dermatology
  - Endocrinology
  - Gastroenterology
  - Neurology
- Overall surgical specialties will also shift to a deficit by 2017, with needs in all specialties except:
  - Colorectal Surgery
  - Oncology Surgery
  - General Surgery
  - Breast Surgery
  - Bariatric Surgery
  - Plastic Surgery

Source: Navigant Consulting Physician Resource Planning Model

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Strategic Primary Service Area

Strategic Primary Service Area – 2012 Community Surplus/(Deficit)

Specialty	Demand	Supply	Surplus (Deficit)
Family/General Practice	38.8	13.9	(24.9)
Internal Medicine	61.8	40.5	(21.3)
Pediatrics	24.4	32.3	7.9
Obstetrics / Gynecology	17.0	20.2	3.2
Primary Care	**142.0**	**106.9**	**(35.1)**
Allergy/Immunology	3.5	5.3	1.8
Cardiology	9.6	8.1	(1.5)
Dermatology	7.2	11.3	4.1
Endocrinology	2.6	3.2	0.6
Gastroenterology	8.0	11.5	3.5
Hematology/Oncology	3.9	4.5	0.6
Infectious Disease	4.9	2.3	(2.6)
Nephrology	3.4	3.0	(0.4)
Neurology	5.2	5.0	(0.2)
Pulmonary Medicine	4.5	5.6	1.1
Radiation Therapy	2.7	1.4	(1.3)
Rheumatology	2.7	3.3	0.6
Medical Subspecialties	**58.2**	**64.5**	**6.3**
CT Surgery - Cardiac	2.7	-	(2.7)
CT Surgery - Thoracic	1.3	0.2	(1.1)
Vascular Surgery	2.2	1.0	(1.2)
Colorectal Surgery	0.6	1.5	0.9
Oncology Surgery	0.2	0.2	0.0
General Surgery	3.1	9.0	5.9
Breast Surgery	1.9	2.0	0.1
Bariatric Surgery	0.3	0.5	0.2
Neurosurgery	3.7	2.5	(1.2)
Ophthalmology	9.7	9.4	(0.3)
Orthopedics	10.7	11.8	1.0
ENT	6.4	2.5	(3.9)
Plastic Surgery	2.7	11.0	8.3
Urology	5.5	5.5	0.0
Subsurgical Specialties	**51.0**	**57.1**	**6.1**
TOTAL	**251.2**	**228.5**	**(22.7)**

Observations

- Primary Care exhibits a deficit within the community, while most of the medical and surgical specialties are currently experiencing surpluses
- As is the case in the Stark service area, some of the primary care deficits are likely being met by both other resources within the community, and other specialists
- However, currently there are pockets of need in addition to Family Practice and Internal Medicine, most notable are:
  - Infectious Disease = 2.6
  - CT Surgery - Thoracic = 1.1
  - Vascular Surgery = 1.2
  - Neurosurgery = 1.2
  - ENT = 3.9

Source: Navigant Consulting Physician Resource Planning Model

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Strategic Primary Service Area – 2017 Community Surplus/(Deficit)

Specialty	Demand	Supply	Surplus (Deficit)
Family/General Practice	39.9	11.1	(28.8)
Internal Medicine	65.0	31.1	(34.0)
Pediatrics	23.7	26.8	3.2
Obstetrics / Gynecology	17.1	18.4	1.3
Primary Care	**145.7**	**87.4**	**(58.3)**
Allergy/Immunology	3.4	3.5	0.1
Cardiology	10.3	4.9	(5.4)
Dermatology	7.1	7.1	0.0
Endocrinology	2.7	3.2	0.5
Gastroenterology	8.3	9.1	0.8
Hematology/Oncology	4.0	3.0	(1.0)
Infectious Disease	5.1	2.2	(2.9)
Nephrology	3.7	0.9	(2.8)
Neurology	5.3	5.0	(0.3)
Pulmonary Medicine	4.7	4.7	0.0
Radiation Therapy	2.9	0.4	(2.5)
Rheumatology	2.8	1.9	(1.0)
Medical Subspecialties	**60.3**	**45.9**	**(14.4)**
CT Surgery - Cardiac	3.0	-	(3.0)
CT Surgery - Thoracic	1.5	-	(1.5)
Vascular Surgery	2.4	1.0	(1.4)
Colorectal Surgery	0.6	1.0	0.4
Oncology Surgery	0.2	0.2	0.0
General Surgery	3.2	7.5	4.3
Breast Surgery	2.0	2.0	0.0
Bariatric Surgery	0.3	0.5	0.2
Neurosurgery	4.0	1.4	(2.6)
Ophthalmology	10.2	7.1	(3.1)
Orthopedics	11.0	6.6	(4.4)
ENT	6.4	1.5	(4.9)
Plastic Surgery	2.7	8.3	5.6
Urology	5.8	3.9	(1.9)
Subsurgical Specialties	**53.3**	**41.0**	**(12.3)**
TOTAL	**259.3**	**174.3**	**(85.0)**

Observations

- By 2017, the service area is projected to increase in overall deficit from a 22.7 FTE deficit to a deficit of 85.0 FTEs primarily due to physician retirements and an aging population which drives higher utilization
- Approximately 67% of the community demand will be met by 2017
- Medical specialties will shift to a deficit by 2017 with most specialties exhibiting a need except for the following:
  - Allergy/Immunology
  - Dermatology
  - Endocrinology
  - Gastroenterology
- Overall surgical specialties will experience deficits in 2017, with needs in all specialties except:
  - Colorectal Surgery
  - Oncology Surgery
  - General Surgery
  - Breast Surgery
  - Bariatric Surgery
  - Plastic Surgery

Source: Navigant Consulting Physician Resource Planning Model

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Strategic Secondary Service Area

Strategic Secondary Service Area – 2012 Community Surplus/(Deficit)

Specialty	Demand	Supply	Surplus (Deficit)
Family/General Practice	27.8	11.0	(16.8)
Internal Medicine	45.1	45.8	0.7
Pediatrics	18.2	41.6	23.4
Obstetrics / Gynecology	11.9	19.9	8.0
Primary Care	**103.0**	**118.3**	**15.3**
Allergy/Immunology	2.5	6.6	4.1
Cardiology	7.1	6.9	(0.2)
Dermatology	5.1	4.2	(0.9)
Endocrinology	1.9	2.2	0.3
Gastroenterology	5.8	8.5	2.7
Hematology/Oncology	2.8	6.0	3.2
Infectious Disease	3.6	2.4	(1.2)
Nephrology	2.6	0.3	(2.3)
Neurology	3.8	8.2	4.4
Pulmonary Medicine	3.3	3.2	(0.1)
Radiation Therapy	2.0	0.0	(2.0)
Rheumatology	2.0	0.5	(1.5)
Medical Subspecialties	**42.5**	**49.0**	**6.5**
CT Surgery - Cardiac	2.0	0.0	(2.0)
CT Surgery - Thoracic	1.0	2.5	1.5
Vascular Surgery	1.6	8.5	6.9
Colorectal Surgery	0.4	1.0	0.6
Oncology Surgery	0.2	0.2	0.0
General Surgery	2.3	8.1	5.8
Breast Surgery	1.4	0.0	(1.4)
Bariatric Surgery	0.2	0.5	0.3
Neurosurgery	2.6	1.0	(1.6)
Ophthalmology	7.1	8.9	1.8
Orthopedics	7.8	21.0	13.2
ENT	4.6	4.8	0.2
Plastic Surgery	1.9	9.3	7.4
Urology	4.1	9.0	4.9
Subsurgical Specialties	**37.2**	**74.8**	**37.6**
TOTAL	**182.7**	**242.1**	**59.4**

Observations

- Primary Care exhibits a surplus in the SSA, along with surpluses in both medical and surgical subspecialties
- The surpluses in primary care observed within the SSA could be satisfying some of the unmet need within the primary service area as people travel outside of the primary service area for care
- However, some pockets of need still exist, most notable are:
  - Family/General Practice = 16.8
  - Nephrology = 2.3
  - Radiation Therapy = 2.0
  - Rheumatology = 1.5
  - Neurosurgery = 1.6

Source: Navigant Consulting Physician Resource Planning Model

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Strategic Secondary Service Area – 2017 Community Surplus/(Deficit)

Specialty	Demand	Supply	Surplus (Deficit)
Family/General Practice	28.7	10.5	(18.2)
Internal Medicine	47.5	33.1	(14.4)
Pediatrics	18.0	37.1	19.1
Obstetrics / Gynecology	12.1	17.0	4.9
Primary Care	**106.3**	**97.7**	**(8.6)**
Allergy/Immunology	2.4	5.8	3.4
Cardiology	7.6	6.2	(1.4)
Dermatology	5.1	3.7	(1.4)
Endocrinology	1.9	1.5	(0.4)
Gastroenterology	6.0	6.1	0.1
Hematology/Oncology	3.0	4.5	1.5
Infectious Disease	3.8	2.2	(1.6)
Nephrology	2.8	0.3	(2.5)
Neurology	3.9	5.8	1.9
Pulmonary Medicine	3.5	2.5	(1.0)
Radiation Therapy	2.2	-	(2.2)
Rheumatology	2.1	0.4	(1.7)
Medical Subspecialties	**44.3**	**39.0**	**(5.3)**
CT Surgery - Cardiac	2.3	-	(2.3)
CT Surgery - Thoracic	1.1	2.3	1.2
Vascular Surgery	1.8	8.2	6.4
Colorectal Surgery	0.4	1.0	0.5
Oncology Surgery	0.2	0.2	0.0
General Surgery	2.3	7.4	5.1
Breast Surgery	1.5	0.0	(1.5)
Bariatric Surgery	0.2	0.5	0.3
Neurosurgery	2.8	0.9	(1.9)
Ophthalmology	7.4	7.4	(0.0)
Orthopedics	8.0	15.7	7.7
ENT	4.6	4.5	(0.1)
Plastic Surgery	2.0	7.9	5.9
Urology	4.3	6.6	2.3
Subsurgical Specialties	**38.9**	**62.6**	**23.7**
TOTAL	**189.5**	**199.3**	**9.8**

Observations

- By 2017, the surplus will decline from 59.4 FTEs to only 9.8 surplus FTEs primarily due to physician retirements and an aging population which drives higher utilization
- Medical specialties will shift to a deficit by 2017 with most specialties exhibiting a need except for the following:
  - Allergy/Immunology
  - Gastroenterology
  - Hematology/Oncology
  - Neurology
- Overall surgical specialties will still see a surplus by 2017, with specific needs in the following specialties:
  - Breast Surgery = 1.5
  - Neurosurgery = 1.9

Source: Navigant Consulting Physician Resource Planning Model

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Strategic Secondary Service Area (by Town)
2012 & 2017 PCP Community Surplus/(Deficit)

Darien, 2012	Demand	Supply	Surplus (Deficit)
Family/General Practice	5.1	1.8	(3.3)
Internal Medicine	7.8	12.0	4.1
Pediatrics	4.0	18.9	14.9
Obstetrics / Gynecology	2.2	5.5	3.3
Primary Care	**19.1**	**38.1**	**19.1**

Darien, 2017	Demand	Supply	Surplus (Deficit)
Family/General Practice	5.2	1.6	(3.6)
Internal Medicine	8.2	6.6	(1.6)
Pediatrics	4.0	17.3	13.2
Obstetrics / Gynecology	2.2	4.6	2.5
Primary Care	**19.6**	**30.1**	**10.5**

Fairfield, 2012	Demand	Supply	Surplus (Deficit)
Family/General Practice	14.3	3.6	(10.7)
Internal Medicine	24.1	28.8	4.7
Pediatrics	8.6	13.1	4.5
Obstetrics / Gynecology	6.2	13.1	7.0
Primary Care	**53.2**	**58.6**	**5.4**

Fairfield, 2017	Demand	Supply	Surplus (Deficit)
Family/General Practice	14.7	3.5	(11.2)
Internal Medicine	25.3	21.8	(3.5)
Pediatrics	8.4	11.2	2.7
Obstetrics / Gynecology	6.3	11.2	4.9
Primary Care	**54.7**	**47.6**	**(7.1)**

Redding , 2012	Demand	Supply	Surplus (Deficit)
Family/General Practice	2.3	0.0	(2.3)
Internal Medicine	3.6	0.7	(2.9)
Pediatrics	1.4	0.0	(1.4)
Obstetrics / Gynecology	1.0	0.0	(1.0)
Primary Care	**8.3**	**0.7**	**(7.6)**

Redding , 2017	Demand	Supply	Surplus (Deficit)
Family/General Practice	2.4	0.0	(2.4)
Internal Medicine	3.9	0.7	(3.2)
Pediatrics	1.4	0.0	(1.4)
Obstetrics / Gynecology	1.0	0.0	(1.0)
Primary Care	**8.7**	**0.7**	**(8.0)**

Ridgefield , 2012	Demand	Supply	Surplus (Deficit)
Family/General Practice	6.1	5.6	(0.5)
Internal Medicine	9.6	4.4	(5.2)
Pediatrics	4.1	9.5	5.4
Obstetrics / Gynecology	2.6	1.3	(1.3)
Primary Care	**22.4**	**20.8**	**(1.6)**

Ridgefield , 2017	Demand	Supply	Surplus (Deficit)
Family/General Practice	6.3	5.4	(0.9)
Internal Medicine	10.2	4.0	(6.2)
Pediatrics	4.1	8.6	4.5
Obstetrics / Gynecology	2.6	1.2	(1.4)
Primary Care	**23.3**	**19.3**	**(4.0)**

Note: Fairfield includes Southport (06890)
Source: Navigant Consulting Physician Resource Planning Model

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Conclusions

- The Norwalk Hospital Stark Primary Service Area is currently experiencing a significant deficit in adult primary care (Family Practice and Internal Medicine), which is likely only partially satisfied by other providers and the existing surplus within the secondary service area
- This deficit may represent an opportunity for Norwalk to expand its aligned primary care base within the PSA and some of the underserved towns within the SSA (note: within the SSA, recruitment assistance to independent practices is not an option, and Norwalk would have to pursue employment or redirection of existing physicians in order to actively expand its primary care presence)
- Although the Stark Primary Service Area is currently relatively well-supplied with medical and surgical specialists, there are a few key areas of need, specifically ENT and Thoracic Surgery
- When considering how best to address specific deficits, Norwalk should look at the entire service area to see if there are specialties with deficits in both the PSA and SSA (i.e. Thoracic Surgery) where new resources could be used to gain volume in both areas, or if the reverse is true – a deficit in one area and a surplus in another (i.e. adult primary care) where redirection of existing resources could be used to effectively address the needs of the community

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APPENDIX

Increasing Care Coordination

»In order to attempt to quantify the impact coordinated care has on physician utilization, Navigant drew upon a wide range of established resources and publications, as well as its own experience and expertise. Key sources included:

- The National Physician Workforce Study published by the US Department of Health & Human Services Bureau of Health Professions ("BHPr") which benchmarks physician utilization rates across different insurance coverage models
- A comprehensive literature review which encompassed a number of studies analyzing and opining on the impact of managed care on medical expenditures and utilization
- The knowledge of Navigant's internal industry experts, as well as experience and proprietary information originating from prior work with major health systems and national insurance companies

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Increasing Care Coordination: Continuum of Coordination

Increasing maturity of care coordination impacts physician demand over time

Care Coordination Level	Uncoordinated	Loosely Coordinated	Moderately Coordinated	Well Coordinated	Super-Tightly Coordinated
	FFS/PPO markets with no management	*PPO markets with some UM*	*Current state of many HMO markets*	*Significant bundling and incentive programs*	*Fully-functioning mature "ACO-like" entity*
Est. Admits/ 1000	▪ 95+ Admits/1000	▪ 75-95 Admits/1000	▪ 65-75 Admits/1000	▪ 55-65 Admits/1000	▪ 45-55 Admits/1000
Additional Description of Coordination Level	**Current modeled coordination levels are Uncoordinated vs. Moderately Coordinated Population**	▪ Payment decline for many specialty services, including cardiac care ▪ Limits on revenue opportunities from ancillaries and physician-owned services	▪ Designated provider or team provides comprehensive healthcare management and patient navigation ▪ Better coordination of care for patients with multiple healthcare needs	▪ Providers receive a single payment for an "episode of care" defined as the typical inpatient stay plus required post-discharge care ▪ No later than 2013, Medicare will begin bundled payment pilot programs for episodes of care through 30 days post-discharge; Medicaid programs may begin bundled payment demonstration payments	▪ Organized groups of providers accountable for the overall health of a population of Medicare beneficiaries; ACOs manage all the healthcare needs for a defined, per-capita payment ▪ If ACOs realize cost savings through more efficient care, the ACO will be eligible to keep a portion of these savings

Note: Admits/1000 estimates are blended indicators based on Navigant's market experience in different markets and intended to demonstrate the concepts underlying medical management levels rather than precise number

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Increasing Care Coordination: National Physician Workforce Study

Per Capita Index for Use of Physician Services (relative to fee-for-service)

Specialty	Fee-for-Service	Exclusive Network HMO	Other Managed Care*	Uninsured
Primary Care Specialties				
General / Family Practice	1.00	0.87	0.99	0.60
Internal Medicine	1.00	1.03	1.18	0.25
Obstetrics / Gynecology	1.00	0.83	0.95	0.30
Pediatrics	1.00	1.00	1.00	0.62
Medical Specialties				
Cardiovascular Disease	1.00	0.92	1.00	0.18
Internal Medicine Subspecialties	1.00	0.90	1.00	0.24
Surgical Specialties				
General Surgery	1.00	0.86	0.98	0.33
General Surgery Subspecialties	1.00	0.86	0.98	0.33
Ophthalmology	1.00	1.00	1.00	0.67
Orthopedic Surgery	1.00	0.78	0.90	0.22
Otolaryngology	1.00	0.66	0.76	0.45
Urology	1.00	0.94	1.00	0.21
Hospital-Based Specialties				
Anesthesiology	1.00	0.86	0.98	0.29
Emergency Medicine	1.00	0.41	0.47	0.78
Pathology	1.00	0.86	0.98	0.27
Other Specialties				
Psychiatry	1.00	0.65	0.75	1.00
Radiology	1.00	0.86	0.98	0.22
All Other Specialties	1.00	0.59	0.68	0.32

While Milliman has actuarial data to show the variations in utilization among the commercially insured, Medicare, and Medicaid population, it is also known that there are variations within the commercially insured population based on the type of coverage and network made available to enrollees.

*This category of insurance includes PPOs, POS plans organized as open-ended HMO, non-HMO POS, and other HMO/managed care plans.
Notes: Table is based on data from 2003 as analyzed by the Bureau of Health Professions.
Source: US HHS Health Resources and Services Administration Bureau of Health Professions, "The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand (December 2008).

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Increasing Care Coordination: Navigant's Physician Utilization Coordinated Care Adjustments

Physician Demand per Capita with Coordinated Care

Relative to insurance plans with no care coordination

Physician Specialty	Moderate Impact	High Impact
Primary Care		
Family/General Practice	10%	15%
Internal Medicine	10%	15%
OB/Gyn	0%	0%
Medical Subspecialties		
Allergy/Immunology	0%	(5%)
Cardiology	0%	(5%)
Dermatology	0%	(5%)
Endocrinology	(5%)	(10%)
Gastroenterology	0%	(5%)
Hematology/Oncology	(2%)	(4%)
Infectious Disease	0%	(5%)
Nephrology	0%	(5%)
Neurology	(5%)	(10%)
Perinatology	(5%)	(9%)
Pulmonary Medicine	(5%)	(10%)
Radiation Therapy	0%	0%
Rheumatology	0%	(5%)

Physician Specialty	Moderate Impact	High Impact
Surgical Subspecialties		
CT Surgery	(2%)	(6%)
Vascular Surgery	(2%)	(14%)
General Surgery	0%	(4%)
Neurosurgery	(2%)	(14%)
Ophthalmology	0%	0%
Orthopedics	(5%)	(20%)
ENT	(5%)	(10%)
Plastic Surgery	0%	0%
Urology	0%	(6%)
Other Subspecialties		
Psychiatry	0%	0%
Physical Medicine/Rehab	0%	(5%)
Radiology	(5%)	(15%)
Hospital-Based Specialties		
Hospitalist (PCP Only)	(5%)	(10%)
Critical Care/Intensivist	(5%)	(10%)

Navigant's Strategic Physician Requirements Model segments a percentage of the commercially insured, Medicare and Medicaid populations into plans with care coordination

- The model's payer- and specialty-specific utilization rates for those segmented into coordinated care categories are adjusted using these factors
- This coordinated care percentage by payer class can be adjusted over the projection horizon

Source: Navigant research and analysis.

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Impact of the Economy: Early Reports of Declines in Physician Utilization

THE WALL STREET JOURNAL.

July 29, 2010

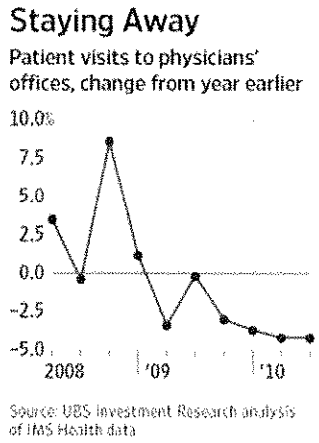
Americans Cut Back on Visits to Doctor

Insured Americans are using fewer medical services, raising questions about whether patients are consuming less health care as they pick up a greater share of the costs.

The drop in usage is showing up as health-care companies report financial results. Insurers, lab-testing companies, hospitals and doctor-billing concerns say that patient visits, drug prescriptions and procedures were down in the second quarter from year-ago levels...

Utilization has ticked down in previous recessions, and tends to take a year or two to change because of how far in advance employers and insurers design their health plans, said Carl McDonald, an analyst at Citigroup Investment Research. He said the last time he saw utilization fall off was in 2003, adding that usage also dipped in the early 1990s. But he added the drop is bigger this time than in previous recessions...

Physician visits and hospital admissions are dropping this year, according to Thomson Reuters' healthcare business, which surveys doctors and hospitals. Doctor visits have declined each month this year, including a 7.6% drop in May 2010 from May 2009. Likewise, hospital admissions dropped in three of the first four months of this year compared to those months last year, including being down 2.3% in April 2010 from April 2009.



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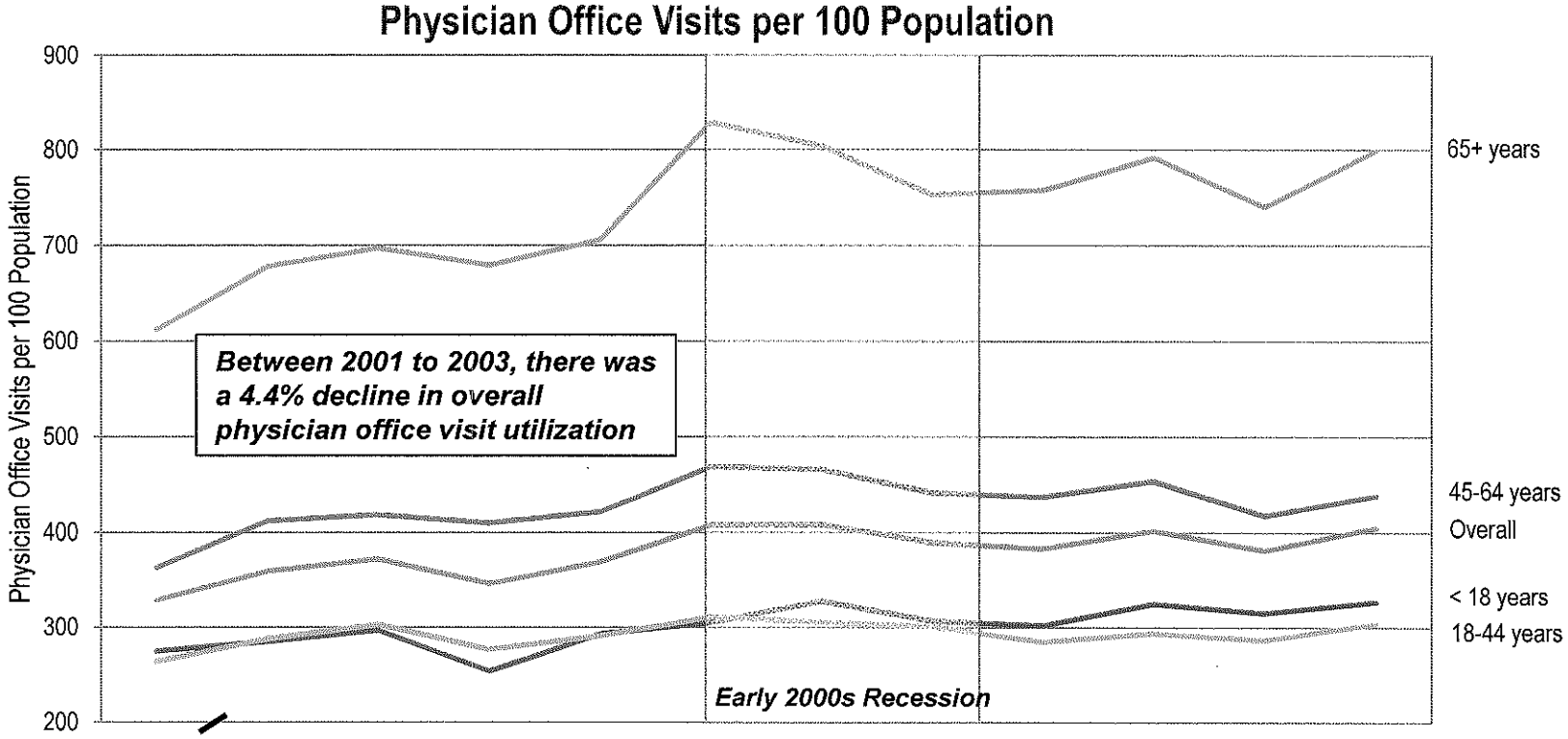
Impact of the Economy: Historical Trend in Physician Office Utilization & the Early 2000s Recession



Office Visits per 100 Population	1995	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Overall	**329**	**360**	**373**	**347**	**370**	**408**	**409**	**390**	**384**	**402**	**382**	**405**
Under 18 years	275	285	297	254	293	305	328	307	302	325	315	327
18-44 years	264	288	303	277	291	311	306	301	285	294	287	304
45-64 years	364	412	419	410	422	469	466	442	438	454	418	439
65 years +	612	678	697	679	706	829	804	753	758	792	740	799
Total Physician Office Visits (thousands)	697,082	787,372	829,280	756,734	823,542	951,214	964,304	906,023	910,857	963,617	901,954	994,321

Source: National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey.

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APPLICANT ✓
SIGN UP SHEET

September 10, 2013
3:00 p.m.

Docket Number: 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

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PUBLIC HEARING
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September 10, 2013
3:00 p.m.

Docket Number: 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

PRINT NAME	Phone	Fax	Representing
(1) Mayor Richard Moccia			City of Norwalk

PUBLIC OFFICIAL

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc

PRINT NAME	Phone	Fax	Representing Organization
(2) Tim Callahan			City of Norwalk Health Department

Public appeal

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc

PRINT NAME	Representing
(3) Rep. David Scribner	CT Legislature

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

September 10, 2013
3:00 p.m.

Docket Number: 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

	PRINT NAME	Representing
1	(2) Joseph F Andrews Jr MD / (1) Michael Eugene MACIOLEK	CONN Hospice Inc
(3)	Frederick M. Lione, Jr.	NHV

GENERAL PUBLIC

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc

PRINT NAME	Representing
Kim Morgan	United Way of Western CT

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc

PRINT NAME	Phone	Fax	Representing Organization
Edward J. Musante Jr.	203-866-2521		Greater Norwalk Chamber of Commerce

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

DN: 13-31832-CON

Hearing Date: September 10, 2013

Time: 3:00 p.m.

Proposal: Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

OHCA Exhibit #	Description
1	
2	
3	
4	
5	

Applicant Exhibit #	Description
1	Physician Resource Plan
2	
3	
4	
5	

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.**

DOCKET NUMBER: **13-31832-CON**

PUBLIC HEARING: **September 10, 2013 at 3:00 p.m.**

PLACE: **The Norwalk Inn and Conference Center**
99 East Avenue
Norwalk, CT

EXHIBIT	DESCRIPTION
A	Letter from Norwalk Health Services Corporation and Western Connecticut Health Networks, Inc. ("Applicants") dated April 5, 2013, enclosing Certificate of Need forms for the affiliation between Western Connecticut Health Nework and The Norwalk Health Services Corporation received by the Office of Health Care Access ("OHCA") on April 8, 2013.
B	Letters received from Representative Jonathan Steinberg and Mayor Richard A. Moccia and OHCA's responses to the letters in the matter of the CON applicaton under Docket Number 13-31832. (4 pages)
C	OHCA's letter to the Applicants dated May 7, 2013, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31832.(9 pages)
D	Applicants' responses to OHCA's letter of May 7, 2013, dated June 14, 2013, in the matter of the CON application under Docket Number 13-31832, received by OHCA on June 14, 2013. (462 pages)
E	OHCA's letter to the Applicants dated July 15, 2013 deeming the application complete in the matter of the CON application under Docket Number 13-31832. (1 page)
F	Designation letter dated August 5, 2013 of Hearing Officer in the matter of the CON application under Docket Number 13-31832. (1 page)

G	OHCA's request for legal notification in *The Hour* and OHCA's Notice to the Applicants of the public hearing scheduled for September 10, 2013, in the matter of the CON application under Docket Number 13-31832, dated August 23, 2013. (4 pages)
H	OHCA's letter to the Applicants dated August 28, 2013, requesting prefile testimony in the matter of the CON application under Docket Number 13-31832.(2 pages)
I	OHCA's request for legal notification in *The News Time* of the public hearing scheduled for September 10, 2013, in the matter of the CON application under Docket Number 13-31832, dated August 28, 2013. (2 pages)
J	Letter from the Law Office of Patricia A. Gerner, LLC dated September 5, 2013 entering her notice of appearance on behalf of the Applicants in the matter of the CON application under Docket Number 13-31832, received by OHCA on September 5, 2013. (1 page)
K	Letter from the Applicants enclosing Prefile Testimony dated September 5, 2013 in the matter of the CON application under Docket Number 13-31832, received by OHCA on September 5, 2013.(26 pages)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

SEPTEMBER 10, 2013
PUBLIC COMMENT

NORWALK HEALTH SERVICES CORPORATION AND WESTERN CONNECTICUT HEALTH NETWORK, INC

AFFILIATION OF NORWALK HEALTH SERVICES CORPORATION AND WESTERN CONNECTICUT HEALTH NETWORK, INC.

INFORMATIONAL SHEET FOR PERSONS SIGNING UP TO SPEAK FROM THE GENERAL PUBLIC

Any and all persons are welcome to make a comment on the record at the public hearing for Docket Number: 13-31832-CON. All those who wish to speak must sign up prior to speaking.

- Please make sure you have signed up on OHCA's Sign-Up Sheet for the General Public.
- Please only sign up for yourself.
- Individuals who have signed up to speak will be called in the order they appear on the sign-up sheet.
- Your comments should be your own personal opinion.
- Your comments should be limited to **three (3) minutes** or less.
- If you do not wish to speak on the record and would instead like to submit a written comment by mail please do so at your earliest convenience. Such written comments are part of OHCA's administrative record in this matter and have the same weight as all verbal comments made at the hearing. Please address your comments to:

Kimberly R. Martone
Director of Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capitol Avenue, MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

- **Agenda for this Proceeding**:
  - Convening of the Proceeding
  - Applicants' Direct Testimony
  - OHCA Questions
  - Comments from the Public Officials and General Public
  - Closing Comments
  - Public Hearing Adjourned

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31832-CON

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc

Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

September 10, 2013 at 3:00 p.m.

I. **Convening of the Public Hearing**

II. **Applicants' Direct Testimony (10 minutes each)**

III. **OHCA's Questions**

IV. **Public Comment**

V. **Closing Remarks**

VI. **Public Hearing Adjourned**

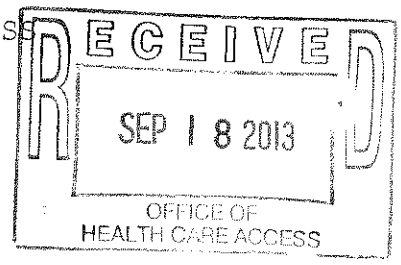
An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



NORWALK HEALTH SERVICES CORPORATION AND
WESTERN CONNECTICUT HEALTH NETWORK, INC.

AFFILIATION OF NORWALK HEALTH SERVICES
CORPORATION AND WESTERN CONNECTICUT
HEALTH NETWORK, INC.

DOCKET NO. 13-31832-CON

SEPTEMBER 10, 2013

3:00 P.M.

NORWALK INN AND CONFERENCE CENTER
MARINER III BALLROOM
99 EAST AVENUE
NORWALK, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

HEARING RE: NORWALK HEALTH SERVICES CORPORATION
SEPTEMBER 10, 2013

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc., held at Norwalk Inn and Conference Center, Mariner III Ballroom, 99 East Avenue, Norwalk, Connecticut, on September 10, 2013 at 3:00 p.m.

. . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. Before we begin, I would just ask that everyone please turn off your cell phones, with the exception of any doctors we may have in the room. Please feel free to keep those on for emergency purposes.

Can everyone in the back of the room hear me? Everything is okay?

This public hearing before the Office of Health Care Access, identified by Docket No. 13-31832-CON, is being held on September 10, 2013 to consider the application of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. for the

affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, the Uniform and Administrative Procedures Act.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to act as the Hearing Officer for this matter this evening.

Assisting me today with the public hearing are Kaila Riggott and Steven Lazarus. The hearing is being recorded by Post Reporting Services.

The way that we will proceed this afternoon is to first hear from each of the Applicants for a brief 10-minute overview of the project, followed by OHCA's questions.

Out of deference to public officials, and I understand we have a couple here this evening, we will call them first, and then we will go to the public portion of the sign-up sheets.

Each person, who wishes to speak, should write his or her name on the sign-up sheets, which have

been provided. I have a couple up here, but there should still be one in the back, if anyone has not signed up yet.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record. All documents have been identified in the Table of Record for reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus, OHCA staff. I would like to enter into the record Exhibits A through I. I apologize. Exhibits A through K, and, also, we'd like to add two additional exhibits, which would be an e-mail correspondence from Lynn Taborsak, as Exhibit L, and a fax correspondence from Mary Consoli on behalf of Danbury Nurse's Union, Unit No. 47. That would be Exhibit M.

HEARING OFFICER HANSTED: Do the Applicants have any objections to those exhibits? Attorney Gerner?

MS. PATRICIA GERNER: I have no objection to the exhibits.

HEARING OFFICER HANSTED: Thank you.

COURT REPORTER: I didn't hear who answered.

MS. GERNER: I'm sorry. Patricia Gerner.

HEARING OFFICER HANSTED: The Applicants, Norwalk Health Services Corporation and Western Connecticut Health Network, Inc., have been designated as parties in this proceeding.

At this time, I would like all the individuals, who are going to testify on behalf of the Applicants, to please stand, raise your right hand, and be sworn in.

(Whereupon, the parties were sworn.)

HEARING OFFICER HANSTED: Thank you, everyone. And, at this time, the Applicants may proceed.

MR. ERV SHAMES: Thank you.

HEARING OFFICER HANSTED: You're welcome.

MR. SHAMES: Good afternoon. My name is Erv Shames. I am the past Chair of the Board of --

COURT REPORTER: Excuse me, sir. Could you move the mike closer to you?

MR. SHAMES: This one?

HEARING OFFICER HANSTED: No, the one in front of you. Is that okay?

COURT REPORTER: That one.

MR. SHAMES: I am the past Chair of the Board of Trustees of Norwalk Health Services Corporation,

which, for brevity sake, I'd like to call Norwalk, and the designated Chair of the Board of the new Western Connecticut Health Network, which I would appreciate referring to as WCHN.

We are pleased to welcome you to Norwalk and appreciate that you traveled here to conduct the public hearing, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. SHAMES: The Board of Trustees of Norwalk enthusiastically endorses and asks that you approve the affiliation between Norwalk and WCHN.

In 2008, the Board and the senior management of Norwalk initiated an extensive process to explore the best strategies to insure that Norwalk continues to meet the future health care needs of the communities that we serve.

Since then, evaluation and assessment have continued, utilizing the Board's strategic planning committee and its partnership task force, working in collaboration with the hospital's senior leadership and its medical staff.

Consultations were held with industry experts, physicians and community leaders. As part of this effort, the Board looked at many strategic

partnerships, including not-for-profit and for-profit institutions, in-state and out-of-state institutions, and a myriad of legal arrangements, from asset purchase merger to affiliation.

We also considered an option to stay as a standalone hospital. By 2010, the partnership task force had identified the key drivers involved for Norwalk if we were to seek a strategic partnership. A complete list of these drivers are on pages two to three of my pre-filed testimony.

Throughout this work, the Board's guiding principle as responsible stewards under valuable community resources was to insure that the people of the communities that we serve continue to have access to high-quality health care services.

After a painstaking process and careful evaluation of the strategic alternatives and, then, the potential affiliation options, the Board decided that affiliation was the best alternative and that WCHN was the best potential partner.

The history and mission of these two organizations are very similar. Both are not-for-profit community hospitals founded over 100 years ago. We share similar values and have common goals, which are to

deliver high-quality, coordinated and cost-effective health care to the communities that we serve.

Five years ago, there was no immediate pressing need for us to affiliate in order to maintain excellent health care for the patients in our service area, but, as the health care system began to transform to meet the requirements and mandates of the Affordable Care Act, we realized that remaining a standalone hospital would become increasingly unsustainable.

Beginning in 2014, we expect that more people in our service area will begin to access health care services, as, under the mandates of the ACA, it will obtain health insurance through the Health Insurance Exchanges and the expansion of Medicaid.

In addition, our service area population is aging, resulting in anticipated increases in utilization of health care services; bottom line being that we expect to care for greater numbers of patients while experiencing reductions in the reimbursements for the services provided of those patients.

In 2012, we formed a collaborative with the Norwalk Health Department and others to assess our community's health needs. The resulting report, entitled 2012 Greater Norwalk Area Community Health Assessment and

Improvements Initiative, gives us a very detailed look at the health needs of our Greater Norwalk community.

We found that the community is concerned about the issue of chronic disease resulting from being overweight and obese and concerned about the limited services for treatment of substance abuse, as well as mental health services.

The message we received was clear, that there is a public need for more health care services, better access to services, and a focus on preventative care, all of which will require changes to how health care is delivered.

We anticipate that the proposed affiliation will respond to the needs identified for the Greater Norwalk Community, as well as those found for WCHN's communities, by expanding accessibility to health care services in these communities and emphasizing the focus on preventative care.

By affiliating, we will have the scale and resources to invest in primary care in both service areas. We will be able to explore diverse care models, such as medical homes, open access primary care, and immediate urgent care facilities.

Enhanced access to primary care will

provide a cost-effective alternative to fragmented care, much of which is currently provided in emergency departments at great expense.

Residents of our region will also find better specialty and tertiary level care near home, due to the collaborative efforts of these three hospitals.

The goals of the ACA and the statewide health care facilities and services plan are aligned with the goals of the proposed affiliation to successfully provide greater access, quality and efficiency in the delivery of health care to our communities.

Norwalk and WCHN today are strong institutions, which, through leadership and careful planning, have successfully responded to the rapid transformations to date in the health care environment, but we are facing enormous challenges as the health care system continues to evolve at an unprecedented rate.

We recognize that, as responsible stewards for the health care resources for our communities, we must position ourselves, so that we not only meet these challenges, but that we thrive and flourish and being the future needs of our communities, and that is what this affiliation will accomplish.

We hope that OHCA agrees, and we request

approval of this application. I'll be happy to answer any questions, but, if not, I'll turn the microphone over to Dan DeBarba.

HEARING OFFICER HANSTED: Thank you. We'll leave the questions for after everyone has spoken. Thank you.

MR. DANIEL DeBARBA: Good afternoon. My name is Dan DeBarba, and I'm the President of Norwalk Hospital and Norwalk Health Services Corporation, and I hereby adopt my pre-filed testimony.

I want to thank you and tell you how much we appreciate the fact you have come to our community to hold this hearing. I also appreciate the opportunity to share my thoughts on the proposed affiliation and the rationale supporting it.

The transformation of our nation's health care system is both dramatic and unprecedented, and, of course, this transformation has placed significant and increasing pressure on hospitals to consolidate and to find new ways to conduct business and care for patients.

The Office of Health Care Access highlighted this fact in Chapter One of the Department of Public Health's statewide health care facilities and services plan.

Norwalk selected WCHN as a partner, because we believe that they are absolutely the best fit for our institution, our physicians and this community.

As not-for-profit hospitals with rich histories and deep roots in our respective communities, we share similar values and common goals for the future, most significant of which is to collaborate on which -- on the delivery of high-quality, cost-effective and compassionate care to our patients and their families.

Several years ago, Norwalk formed a partnership task force to assess the major trends impacting the health care industry and the strategic options for dealing with these trends.

The task force members identified both the new payment models emerging and the impact of health care reform as the two most important trends that we need to contend with.

They believed then and based on more recent events believed even more strongly today that an affiliation between Norwalk and WCHN best prepares us for an uncertain future.

As I previously stated, the trend of new payment models emerging was identified by the task force as one of the great concerns. As the industry moves from

fee-for-service to value-based reimbursement, Medicare, Medicaid and private payers are all expected to shift, at least in part, to risk-based contracting.

We fully expect pay arrangements and financial incentives for meeting certain quality and cost targets and penalties if we fail to meet these goals.

To deal with this trend, WCHN has already begun a process to create expertise in the development of an accountable care organization, and we at Norwalk look forward to collaborating with them on best practices and proven protocols to improve quality and outcomes for patients across the continuum.

Regarding the second critical trend identified by the task force, the impact of health care reform, the Federal Patient Protection and Affordable Care Act of 2010 cannot go without mention.

This new federal law requires significant investments in quality management, physician integration models, population health management tools and electronic health records.

All hospitals will need to make significant investments in these clinical technologies in order to be able to produce and demonstrate high-quality outcomes and cost-effective care.

These investments will undoubtedly be substantial, yet they're much more feasible and cost-effective when shared across a larger network. As we look ahead to the future, scale really does matter.

Both Norwalk and WCHN are institutions with strong financial positions, and we've worked very hard to remain that way in the face of enormous challenge, but with the impact of the Affordable Care Act, with the expansion of Medicaid, and with the development of Health Insurance Exchanges, we surely expect a growing demand for health care services, but we also expect very unpredictable payment and reimbursement models.

Who would have anticipated a year or two ago the magnitude of cuts from the State and Federal governments that Connecticut Hospitals would be contending with today?

With more patients and less reimbursement, our financial strength may quickly be undermined without this proposed affiliation.

The benefits that Norwalk and WCHN will achieve through this affiliation are both numerous and significant. I'd like to briefly focus on three of these benefits; access to care, quality of care, and cost of

care.

In 2012, Norwalk conducted a physician resources assessment, which identified significant shortages of primary care providers in our service area.

As a result, they implemented a physician recruitment and integration plan and added several new practitioners to the service area.

For its part, WCHN has also made significant investments in physician recruitment and integration, including the development of a Physician Hospital Organization, PHO.

With the approval of this affiliation, Norwalk and its physicians will be able to join the PHO, and the resulting network will have more scale and resources to invest in developing our primary care infrastructure, thereby increasing access.

The proposed affiliation will also create a network-wide physician platform that includes over 800 independent and over 300 employed physicians.

While there's no plan to curtail any of these clinical services currently offered, improvement in access will occur by sharing across the system services and highly-trained specialists that are currently being utilized fully at any one location.

In addition, greater access may also be achieved by developing a new network, new network-wide specialties that neither of the institutions have today.

The affiliation will allow us to improve the already high-quality care that both Norwalk and WCHN currently provide. By working together to develop and share protocols for evidence-based best practice medicine, all of our patients will benefit.

Norwalk and WCHN, in partnership with their affiliated physicians, will have the opportunity to develop seamless transitions of care across the continuum, with the goal of providing the highest quality care available.

And, finally, the affiliation of Norwalk and WCHN will result in a more cost-effective management program and a stronger financial position.

As I mentioned earlier, health care reform, coupled with significant State and Federal payment reductions, have placed unprecedented financial pressures on hospitals.

Without significant organizational change, hospitals will be unable to reduce costs at the rate that payments are reduced.

The proposed integration will produce

expense savings and labor efficiencies through centralization of administrative and support functions and through savings and purchasing from our economies of scale.

Through our current integration planning process, we are confident that cost savings will be achieved from the very beginning and grow over time, so that, by 2016, a two and a half percent reduction in the combined entities cost is expected.

With the scale achieved through the Norwalk WCHN affiliation, we expect to have greater access to capital and lower borrowing rates. It is certainly a known fact that larger health systems tend to have better credit ratings, due to greater financial diversity and strength.

A recent article from Moody's that we've included in our answers to the completeness questions details the importance of scale and the ability of hospitals and health systems to deliver value-based care both now and in the future.

So let me conclude by saying that this affiliation will strengthen the three hospitals, our dedicated physicians, and all the affiliates of Norwalk and WCHN, and insure that high-quality, community-based

and compassionate health care services will be provided long into the future.

This is certainly the expectation for the affiliation that we have at Norwalk, and we respectfully request that you approve the Certificate of Need and protect the health and well-being of our respective communities. Thank you, and I will turn it over to Dr. John Murphy.

HEARING OFFICER HANSTED: Thank you.

DR. JOHN MURPHY: Good afternoon, Hearing Officer Hansted and other members of the OHCA staff.

HEARING OFFICER HANSTED: Good afternoon.

DR. MURPHY: My name is John Murphy, and I'm the President and CEO of Western Connecticut Health Network, and I hereby adopt my pre-filed testimony.

I come to you today to share my strong belief that our affiliation with Norwalk Hospital will improve the health of the communities we serve in Fairfield and in Litchfield Counties.

In this era of health care reform and the associated transformation that is already underway, we clearly see how this affiliation can help the State achieve the objectives outlined in the statewide health care facilities and services plan, specifically, to

improve the health of Connecticut residents, increase the accessibility, continuity and quality of health services, prevent unnecessary duplication of health resources, and provide financial stability and cost containment of health care services.

A few years ago, when we took a fresh look at the landscape of health care in Western Connecticut, we saw an uncertain future for not-for-profit community-based care.

We worried that the new realities of health care reform, with all of its demands for increasing access to care, coupled with the imperatives to reduce the cost of that care, could jeopardize the long-term viability of community-based hospitals committed to providing care to all who need it, including those with little or no financial resources.

Because we didn't like that picture, we decided to create our own. At Danbury Hospital, we focused on strengthening our expertise in critical areas to become a destination for quality care.

We began to develop a network approach to provide the community with improved access to care from the primary care physicians in the community committed to keeping people well to the Emergency Department staff, as

well as our highly-talented specialists, and the hospital's inpatient providers, all of whom are available around the clock to those in need 365 days a year.

In addition, we reaffirmed our commitment to providing care in the home and through Hospice to address patients' needs at every stage of life and for every generation.

We also opened a state-of-the-art translational research facility, where we have been pursuing tomorrow's cures, with a promise that we won't leave those discoveries in the lab. We will bring them to the bedside.

And we formed with New Milford Hospital the beginnings of a network designed to provide the right care in the right place at the right time.

Together, we see a day when we will manage the health of our population by providing care in a variety of settings. Much of that care will be anchored by our patient-centered medical homes.

We've learned a great deal from this work. We have learned how consumers' views of health care have changed, not only in terms of what they need, given the increasing burdens of chronic illness, but also in terms of what they expect in this era of increasing access to

information, a growing need for transparency, and a stronger focus on accountability.

We've experienced the shift from care that primarily occurs inside the hospital to more and more care being provided in the outpatient setting.

We've also seen an ever-growing need for state-of-the-art emergency care, with all of the sophisticated technology that modern medicine can offer, and we've learned, again, that community is at the hearth of what we deliver.

I strongly believe in the contribution this affiliation will make to our state. We've learned over many months how similar Western Connecticut Health Network and Norwalk Hospital are in what we believe, and how we work, and what we want to achieve.

Neither of us could find a better partner for the future. We've learned that, as different as our relative geographies may be, in terms of terrain, the needs of the people we serve are, indeed, very similar, and, together, our collaborative service lines can provide a more comprehensive range of high-quality care offerings, each in its own service area.

And we've learned that with all the changes in health care funding, the efficiencies we can

create through this affiliation will insure that we have the financial resources to invest in the facilities, technology and people that will make a difference in the lives of our communities.

In 2010, with a realistic and shared view of the future, we began to explore what our two organizations might accomplish by coming together.

In June of 2011, the respective Boards gave us the authority to officially examine the possibility of an affiliation in more detail.

That fall, we engaged independent experts from the health care industry to study the pros and cons of such a transaction, and, in April of 2012, convinced of the merits, we signed a non-binding letter of intent to proceed with the necessary due diligence.

At the same time, a steering committee from the Danbury and New Milford Departments of Public Health, WCHN, the United Way, the Regional Y, and Western Connecticut State University updated a community needs assessment that began with a community report card first developed in 2009.

This process included community conversations, discussing priority health issues, a community plan for action to reach a diverse range of

stakeholders, and the initiation of community action planning workgroups.

This report states that, quote, "The Greater Danbury area is very healthy across many indicators, including the 10 leading causes of death. Public health, hospitals and human service providers should be recognized for their efforts toward preventive, interceptive and ongoing care and supports for our community. They should also continue to strive for ways to maintain existing and pertinent programs and to find new and creative solutions to address emerging needs," end quote.

These findings confirm that our mission is sound, our strategy is relevant, and our affiliation has merit. When we signed the definitive affiliation agreement with Norwalk Hospital on January 22nd of this year, we said we each bring strong legacies in not-for-profit community-based cares to our shared goal of being a beacon of quality in an ever-changing health care landscape.

Together, we will build an integrated network of health services for our communities to redefine what a health care organization can offer.

Today, after all the work we have done in

recent months, we are even more convinced of the value our affiliation will create when our organizations come together to improve the quality and availability of care while carefully managing our finite resources.

WCHN has, for example, already begun collaboration between our hospitals and our affiliated physicians. Norwalk Hospital has also been working on physician alignment and integration.

Working together as a larger network, we'll enable our two organizations to improve and extend our physician resources for the benefit of the communities we serve.

When we look beyond physician alignment to the range of services we intend to offer, we see patients, who are living longer and with a broader range of chronic illnesses.

How, when and where to treat these patients is an evolving challenge. To insure better outcomes, we reserve inpatient care for patients, who actually need to be treated in the hospital, while simultaneously enhancing our outpatient capabilities, where we can better coordinate and expedite care.

Because the affiliation will enable us to expand and deepen the care we can offer, I'm confident we

will eventually reduce inpatient utilization, including the much talked about rate of readmissions. That's what we mean when we say the right care in the right place at the right time.

As we have provided in our application for the Certificate of Need, the affiliation will enable us to efficiently strengthen clinical programs to improve access to quality care and, in turn, improve outcomes, enhance our educational programs for the health care providers of tomorrow, including medical students, residents and fellows, strengthen the physician platform for the delivery of care, build competencies for new reimbursement models, including population health management, bundled payments, PHOs and ACOs, integrate operations to manage our limited resources in a unified operating model, and improve access and reduce the cost of capital as a result of the economies of scale that come with being a larger organization.

With this affiliation, we will stretch the dollars we spend as we strengthen the care we deliver. A practical example of the benefits of this affiliation is in our approach to information technology, that, as you know, is a critical element of the provision of coordinated health care, yet it also represents a

significant expense.

Sophisticated IT systems can vastly improve how caregivers access patient information in ways that save both time and money, as well as strengthen the continuity of care.

The ease of access to a patient's complete medical history will enable physicians to make more accurate diagnoses before treatment begins. Electronic medical records will help us manage the health of various populations, as well as reduce unnecessary duplication of services.

At WCHN, we are well along the path of adopting electronic health records and are now working to connect that distributed and at times fragmented information by creating a Health Information Exchange, known as Health Link, that enables vital information to flow seamlessly from one provider to another wherever or whenever it is needed.

The patient is at the center of this multi-million-dollar, multi-year investment that securely stores and shares patient information in a system specifically designed to improve the quality and safety of the care we provide.

We have already added New Milford Hospital

patients to this system, along with those of Danbury Hospital and our affiliated medical practices. When this application for affiliation is approved, we will begin to connect Norwalk Hospital to the system in the very same fashion.

But all of this technology is expensive. The more patients and communities we can serve to a single-shared investment the better we can stretch the dollars we must invest.

With our affiliated organizations, we can borrow money at a lower cost, create efficiencies that benefit all three hospitals in purchasing supplies, and have more money left for patient care.

Fortunately, our two organizations come to this affiliation with solid financial positions and experience. The integration of Danbury and New Milford Hospitals that started in fiscal year 2011 yielded a seven-million-dollar reduction in expenses in fiscal year 2012, of which five million was at New Milford Hospital.

WCHN has also made significant investments in renovating and modernizing the Emergency Department at New Milford Hospital. Other integration accomplishments include implementing the very same clinical practice standards across sites of care, realigning the

organization of clinical and support departments, including laboratory, radiology, infection control, IT, marketing, finance, the foundation, compliance, coding, Human Resources, pharmacy supply chain and volunteer services. We've also implemented a common benefits platform.

As a hospital CEO and business leader, I see the strengths of this affiliation clearly, and I look forward to finding ways to invest the dollars we have available, so that we can strengthen the care we provide, but it is John Murphy, the physician, who feels most deeply about the value of this affiliation.

Like all physicians, I went into medicine, because I wanted to advance one or more of the goals that I believe lie at the heart of all medical care; to relieve suffering, to prevent future suffering, or to prolong life.

With all the challenges we face in health care today, this affiliation will make this organization the best possible place for physicians like me to practice medicine.

This new picture of health that we will create for our communities will make it easier for people to access care and not just any care. We intend to

provide effective, high-quality care that is accessible, coordinated, patient-centered and affordable.

If our application is approved, we will begin to work on the details of day one, from what patients will experience, to what physicians will expect, to how communities will participate.

During this transition, we won't simply talk with ourselves. We will reach out to community leaders, donors, patients and families and our staff as we continue to learn what it takes to be the health care organization people choose for their care, their contributions, or their careers.

Our new organization will have greater access to capital, technology and purchasing power, more opportunity to achieve cost efficiencies, and a stronger ability to attract and retain top-notch talent.

We each bring a strong legacy in not-for-profit community-based care to our shared goal of being a trusted beacon of quality in an ever-changing health care landscape.

We believe in this affiliation. We know what we will bring to the communities we serve, and we know our approach to health care is essential.

By looking ahead with clarity and managing

today with discipline, we assure the long life of this new organization as we redefine ourselves and what we deliver over the coming months.

And, so, years from now, we will look back with pride at a year, when we imagined the possible and dared to make it come true.

We officially ask you to approve our application for the affiliation of Western Connecticut Health Network and Norwalk Health Services Corporation. Thank you and I welcome questions.

HEARING OFFICER HANSTED: Okay. OHCA has some questions at this point.

MR. LAZARUS: Good afternoon. Steven Lazarus, OHCA staff.

COURT REPORTER: Excuse me. Can you move the mike closer?

MR. LAZARUS: Sure.

COURT REPORTER: Thank you.

MR. LAZARUS: Steven Lazarus, OHCA staff. I'll start with Mr. DeBarba. I just have a couple of questions. On page two of your pre-filed testimony, you state that transforming the economic model in health care with new payment models emerging and the shift towards increasing accountability for costs in health care to

providers was one such drive.

Can you please explain what you mean by that statement? How, specifically, will this proposal benefit that?

MR. DeBARBA: Where was the quote again? I'm sorry.

MR. LAZARUS: Page two. Go to your testimony.

MR. DeBARBA: Oh, the transforming economic model in health care?

MR. LAZARUS: Yes.

MR. DeBARBA: Well I think it's basically what I just tried to point out in my pre-filed, my revised, I guess, pre-filed testimony or testimony.

The way we get paid is going to change. We move from fee-for-service to a risk-based contract, and a hospital needs Human Resources skills that we don't have today, ability to manage risk, ability to assess risk, scale.

If you look at the size of the population we serve and you think about how one might spread risk over that population, certainly it enhances our opportunity to spread that risk if the population is much larger.

So I think, you know, there's many, many answers to that question, but, certainly, the payment model, moving from fee-for-serve to risk-based, is truly one of the main drivers behind the affiliation here.

MR. LAZARUS: Okay, thank you. On page four of your testimony, you state that you've conducted a physician resources assessment?

MR. DeBARBA: Yes.

MR. LAZARUS: Which identified the shortages in the primary care providers, etcetera. Can you provide OHCA a copy of that physician resource assessment as evidence?

MR. DeBARBA: Absolutely.

HEARING OFFICER HANSTED: Okay. I'll order that as Late File No. 1.

MR. LAZARUS: I think that's the only specific questions I have for you. Thank you.

Dr. Murphy, you stated on your testimony on page one prevent unnecessary duplication of health resources and provide financial stability and cost containment of health care services.

Do you see any clinical services, such as inpatient/outpatient, that may also be addressed regarding the duplication that might help financial or

cost containment?

DR. MURPHY: I think, certainly, if you look at, for instance, the introduction of a common IT platform, to the extent that any provider has access to laboratory testing or imaging that's already been done in an outpatient setting that may be invisible to a provider on the inpatient setting, if we could implement a technology solution that shares that information, I think we actually could reduce utilization of those tests, for instance, be it on the inpatient side or on the outpatient side, as long as the physician has access to wherever that test was done previously, so, yes, I do think there are opportunities to reduce utilization of both inpatient and outpatient services in at least that regard.

MR. LAZARUS: Okay. You stated on page three of your testimony that you engaged outside consultants to help look at the cost to help what could be accomplished, and that was back in April 2012, and convinced on those merits, you signed a non-binding letter of intent.

Do you have a copy of the report that you might be able to provide OHCA as evidence?

DR. MURPHY: Yes. We submitted. That's

the Chartis(phonetic) report.

MR. LAZARUS: Oh, that is the Chartis report that you were referring to?

DR. MURPHY: Yes.

MR. LAZARUS: Okay. Thank you. On page eight, you state we will begin to work out many of the details that will begin on day one, and you also testified again today from what patients will experience to what patients will have access to and how communities will participate.

Have the Applicants conducted a study that aided in moving forward with its proposal that lays out what and how the Applicants or what the Applicants' expectations related to the patients' physician community as a result of this proposal would be?

DR. MURPHY: Can you -- I didn't catch the tail end of the question.

MR. LAZARUS: Basically, I'm trying to figure out have you conducted some sort of a study that will sort of help you, as to which expectations would -- how they would be realized?

DR. MURPHY: I don't think necessarily we've conducted a study, per se. What we have tried to address, and I think that we have submitted some

information in this regard in our answers to some of the questions you had posed, is we did deploy a number of integration work teams that have spent the last several months contemplating what we would want to look like once this affiliation is approved to try to create a picture of what those expectations will be and how we were going to meet them, and we've taken them really, I think, as far as we can go, up until the point when the, hopefully, the affiliation is approved.

We can, then, process them further and actually develop specific work plans.

MR. LAZARUS: All right, thank you. Mr. Shames, on page two of your pre-filed testimony, it states that, with the help of outside consultants beginning in 2009, you looked at various models, from non-profit to for-profit models, and, additionally, I had stated that, by 2010, the task force, partnership task force, had identified key drivers.

Is there a report that was generated or that aided your decision-making?

COURT REPORTER: Excuse me. I didn't hear your answer. I can't have you speak not on a microphone.

HEARING OFFICER HANSTED: Why don't you come up to the table and please identify yourself?

MS. JERYL TOPALIAN: I'm Jeryl Topalian, the Executive Director of Planning and Business Development.

COURT REPORTER: Could you spell your last name, please?

MS. TOPALIAN: It's T-O-P-A-L-I-A-N.

COURT REPORTER: Thank you.

MS. TOPALIAN: The completeness questions detail that information, and that was from the series of meetings that was held with the partnership task force, and the information from those meetings was detailed in our completeness answers, but there was no report.

MR. LAZARUS: All right, thank you. Also in your testimony, you had listed a few of the benefits, and one of those things you had stated was preserving community control and presence, and we were wondering what you meant by that, if you could elaborate a little bit on that?

MR. SHAMES: Yes. I want to make sure that the needs of our community are recognized and residents input the services that we're going to provide as a result of this affiliation, and the bylaws were carefully crafted to accomplish two things.

Number one, to achieve the success of the

affiliation along the lines we've heard, in terms of the benefits, but, number two, is to protect the rightful vital interests of our community, in terms of services that they will receive and how they'll receive it.

MR. LAZARUS: Okay. I just have a couple of general questions. On page 497 of completeness responses, I believe that's a community needs assessment, and the Applicants emphasized that two key components or the focus of the community need was the substance abuse and obesity, and they were the top two priorities.

Please discuss how this proposal will support those two priorities, and if you could provide some sort of specific examples?

COURT REPORTER: One moment, please.

MR. DeBARBA: Steve?

MR. LAZARUS: Yes.

MR. DeBARBA: Remind me what page.

MR. LAZARUS: 497.

COURT REPORTER: You don't have a microphone.

MR. DeBARBA: What section, Steve?

HEARING OFFICER HANSTED: Let's go off the record.

(Off the record)

HEARING OFFICER HANSTED: Back on the record.

DR. MURPHY: I think that, certainly, obesity and substance abuse or mental health issues are prevalent issues for any community, and Norwalk certainly isn't unique in that respect.

I think, for us to move forward and effectively improve the health of our communities, we do have to address both of them.

First, with respect to obesity, I can tell you that one of the small pilots that we've already begun at WCHN, which we would certainly expand upon, is start really with our own employees first, and, by that, I mean we've encouraged those individuals, who work for us, as well as their family members, to complete a health risk assessment, and, actually, we've encouraged them to wear these pedometers to try to incent them to get active again.

And, actually, we provide financial rewards to our employees if they achieve a certain level of activity, and I think through that, as well as encouraging through waiving co-pays for patients, who self-identify with certain chronic conditions, we want to improve their access to their primary care physicians.

At the same time, we want to try to convert our primary care practices from standalone practices, where it's a single provider, try and be all things to all people, to patient-centered medical homes, which are really a constellation of providers, which include social workers, mental health professionals, nurse practitioners, PAs, as well as care navigators.

And, so, it's really through this team-based approach that I think we will have more time to deal with some of these complex issues, be it obesity, if it really requires not just what happens in the patient-centered medical home, but we've also learned that these are enormous social problems that are best going to be solved through collaboratives in partnership with other members of the community, be it the school system, where an education about proper nutrition can be afforded, whether it's through community churches, whether it's through business partnerships, as well as the municipalities, themselves, who have to help us by building sidewalks.

These are complex issues, and I think that certainly from our end we have to demonstrate a willingness to partner with other members of the community.

We have to, I think, convert to a more team-based approached to care, and, certainly, with respect to substance abuse, I think the same is true. We have to de-stigmatize some issues around mental health, and we certainly have -- I think this affiliation will allow us to attract actually more health, mental health providers, because we are such a large or will be such a large organization.

We found this in our own community. A fair number of mental health providers are opting out of some of these managed care contracts, so trying to get access to care for people, who are poor, has become a challenge, but through our employed model, we've been able to attract and retain not only highly-talented nurse practitioners, but, also, psychiatrists, and mobilize teams that can actually go out into the community instead of waiting for members to come to us.

So I do think that some of the lessons that we have learned, some of the pilots that we've initiated, some of the strategies that we've adopted will certainly be made available to the Norwalk community, but I don't think that their problems are unique in any way.

HEARING OFFICER HANSTED: I just want to follow-up on that. Doctor, can you go into more detail,

in terms of the teams you mentioned, who will be going out into the public, in the community? I can have her sworn in. Come on up.

(Whereupon, Mary Franco was sworn.)

COURT REPORTER: Please state your name and spell your last name.

MS. MARY FRANCO: My name is Mary Franco, and that's F-R-A-N-C-O.

COURT REPORTER: Thank you.

MS. FRANCO: So one of the -- we've done a couple of things, in terms of meeting the needs of the community needs assessment. We've put together a community health improvement plan, and that includes at the moment three projects.

One project establishes a community care team, which is made up of the hospital and some 20-plus other entities in the community, and the purpose of the community care team is to get together on a regular basis, a weekly basis, to look at substance abusers and people with behavioral health issues to try to provide wraparound services for this community to decrease inpatient and outpatient admissions to the hospital and to provide better care for this community, so saving costs and providing better care for this, these members

of the community.

A second project is an obesity project, which is looking at some similar things that Danbury is looking at. Walking to school. We have a project that is taking off in October this year, that encourages students in the community to walk to school and gets families involved.

There is a school partnership that is looking at body mass index and how to decrease body mass index among school-age children in our most diverse school, and that project may or may not go to other schools, but that's what we're looking at now.

We're also looking at in-depth information from the hospital side, as well as from the community side, on substance abuse and mental health patients and what services are missing in the local community to help keep those individuals from coming to the hospital, and the Chairman of our Emergency Department is Chairing that group.

We also have a Community Health Committee that we've established of the Board of Trustees.

HEARING OFFICER HANSTED: Okay, thank you. And if this proposal were to be approved, would that program be expanded to all of the service areas for the

three hospitals?

DR. MURPHY: I think that, if I could try to answer a piece of what I heard --

COURT REPORTER: Doctor, excuse me. Could you move the silver mike?

DR. MURPHY: In terms of how are we addressing the mobility of the response, we do have circumstances. We had one this week, actually, where there was a young adult male with mental illness and substance abuse in a home, where a violent episode had taken place.

The parents called us and said we can't get him to seek help. We actually sent a team out and with assistance from the police were able to address the issue and bring him in, but we actually sent a team out.

We did the very same thing in December, where we sent multiple teams out to the tragedy in Newtown, where we went to the schools. We are still in the schools providing routine access to mental health services.

We don't even ask people to tell us their names at this point. If they want care, they have immediate access. That, as you can imagine, isn't easy to pull off, but we have done it, and we will continue to

do it.

And I think, to answer your question to Mary, what we would like to do is really examine whose got the best plan, what seems to work well, what isn't working well, how do we find resources to fund these things, because they're all expensive, and the funding is not what we wish it could be.

We would examine it, but we would certainly try to replicate it in all of the communities where it's been successful.

HEARING OFFICER HANSTED: Okay, thank you, Doctor. At this point, just before you go on, Steve, I want to break from OHCA's questioning. I understand we have some public officials here that need to leave, so I want to give them an opportunity to speak today.

Attorney Gerner, can you introduce them for me, please?

MS. GERNER: I know the Mayor of Norwalk. There's one individual, who --

COURT REPORTER: I can't hear you.

MAYOR RICHARD MOCCIA: Thank you very much. I appreciate the opportunity --

COURT REPORTER: Excuse me, Mayor. I'm not picking you up at all.

MAYOR MOCCIA: Okay.

COURT REPORTER: Thank you.

MAYOR MOCCIA: Right. Thank you, again, for the opportunity. I do apologize for coming up. The Governor is having the 9/11 service in Sherwood Island and memorial service, and I do want to get there. I think it's important.

You know, it's interesting. There's no way that I can improve on the great testimony presented by the three individuals up here today, the depth of their knowledge, but I think, even more importantly, the depth of their commitment to provide health care for a wide area.

I know, in talking to Mayor Bouton from Danbury, the excellent reputation that WCHN has up there. I have a son, a daughter-in-law and two grandchildren that live in Danbury, and I know the services they provide there, but I'm here to talk about Norwalk and the commitment that the Norwalk Hospital has made to this alignment and the commitment they've made to the people of Norwalk.

There is a bond and a trust that the residents of this city have with the Norwalk Hospital. And in talking with the residents, not hundreds, but

numerous ones that have read about the merger, they believe in this hospital, and they believe that the merger is going to be in the best interest to provide the most important thing that I think Dr. Murphy talked about, and that is service to the people that need it.

And in talking about some of the issues that were raised, childhood obesity, we work very closely with them in our health -- my Health Director, Mr. Callahan, will be up later to talk about our programs, but we have worked very hard on the obesity and the addiction problem.

And the Norwalk Hospital was one of the first participants in the committee that I put together several years ago, the 10-year plan to end homelessness, the Continuum of Care Committees that we put together, that breaks down the silos of information going from non-profits to hospitals, their involvement at the homeless shelter with the outreach program to try and assist these people in the two areas particularly that you mentioned, the obesity and they mentioned the drug.

It's a continued commitment, and it's a continued understanding of the needs of this community. Norwalk is the sixth largest city in the state. Danbury is the seventh.

We both have the same economic problems, and we also have the same demographics, so, from a population point of view and from a demographic point of view, it seems like a perfect merger.

Dave talked about the uncertainty of what's going to happen with the Affordable Health Care Plan, but one of the certainties that I know, that the residents of this city and I, as Mayor, know is that this merger will deal with those uncertainties and continue to provide the best possible care that hospitals can provide.

Both hospitals and associations are rated very highly across the country. The stats are all there. But, again, speaking as Mayor of the City, I can tell you that our residents believe, trust, and I even believe that this merger is for the best interest of everyone.

And just really, if I may, on a personal note, we all have read about the unfortunate accident that happened over the weekend with the ride collapse, and the professionalism of the EMS people on site and the handling of the patients that went to the Norwalk Hospital was second to none.

And, again, all the reports, everybody, thank you to the Norwalk Hospital for providing such

immediate and comprehensive care and comforting the parents, who obviously, despite there were no serious injuries, certainly were traumatized by it.

So, as Mayor, I support this affiliation. I believe in it, because I believe in both hospitals. Thank you.

HEARING OFFICER HANSTED: Thank you, Mayor. Attorney Gerner, are there any other public officials here you'd like to -- I'm sorry?

MS. GERNER: Attorney Gerner. The only individual that I know, who requested to speak earlier, because he had another commitment, was the Mayor of Norwalk. I believe you have the list of other dignitaries, so unless someone would want to tell you of a pressing need to leave early, I think it's your call, certainly, as to whether you want to continue the questioning, or have some of those people speak now.

HEARING OFFICER HANSTED: No. Since there's only one other public official, I'll give the same deference to Mr. Callahan.

MS. GERNER: Okay. Thank you very much.

HEARING OFFICER HANSTED: You're welcome. Just one moment, sir. Let's go off the record.

(Off the record)

HEARING OFFICER HANSTED: Mr. Callahan, you may proceed. After that, we'll have Mr. Scribner. Thank you.

MR. TIM CALLAHAN: Thank you for the opportunity to speak today. Norwalk Hospital has served this community for over 100 years.

Dr. William Tracy, one of the founders of the hospital back at the turn of the -- from the 1800s to 1900s was actually one of the first Health Directors in the City.

His grandson, Ed Tracy, who is a physician, who served Norwalk for many years, is just completing his 37th year on the Board of Health, so, from the beginning, the City and the Norwalk Health Department have been linked.

Most recently, though, the Health Department and the hospital led a process through a community health assessment and a community health improvement plan.

Those two activities are required by the IRS for the hospital to maintain its non-profit status. And across the country, there are many approaches to completing those two, which can be pretty involved processes.

Norwalk has taken it to the max. We've put together a community health assessment and improvement plan that has become a national model for hospitals and Health Departments working together. Along the way, we involved more than 100 members of the Greater Norwalk community in completing that project.

To assure that the improvement plan that we've developed is implemented, the Hospital Board of Trustees established a community Board, and we've expanded the membership on that Board to include representatives from all segments of the community of Norwalk and the surrounding towns, so the Town of Darien, New Canaan, Weston, Westport and Wilton all have people serving on that Board, and the improvement plan that we've established takes into account those communities, in addition to Norwalk.

In these very challenging and dynamic times, it is imperative to us that the project that we put together continues, and I believe that, by these two organizations affiliating, we will better utilize the precious dollars that we need to make projects like this continue to exist, so I'm very much in support of this merger, and speaking on behalf of the participants in the community assessment and improvement project, we all feel

the same way.

I think this is a step in the right direction. Thank you.

HEARING OFFICER HANSTED: Thank you. Representative?

MR. DAVID SCRIBNER: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. SCRIBNER: And thank you. I'd like to --

COURT REPORTER: Sir, excuse me. Please identify yourself for the record.

MR. SCRIBNER: I will. I am State Representative David Scribner, whose district covers Bethel, Brookfield and Danbury, Connecticut.

I am an Assistant Minority Leader and currently serve as ranking member of the legislature's Transportation Committee, ranking member of the Transportation Bonding Committee, member of the Finance, Revenue and Bonding Committee, the General Bonding Committee and, perhaps most importantly, the Public Health Committee.

I've been a resident of Brookfield for my entire life and know the region's needs well. I happen to have been blessed to be born at New Milford Hospital.

My mother was a nurse at New Milford Hospital for many years, and my wife and I chose to have each of our three children born there.

My family and I utilize both the Danbury and New Milford Hospitals for our own health needs, and all of the constituents that I represent use each of those two hospitals.

I'm here today to give a strong endorsement to the planned affiliation between Norwalk Hospital and the Danbury and New Milford Hospitals that are part of the Western Connecticut Health Network.

I have watched the affiliation of Danbury and New Milford Hospitals with great interest and continue to be impressed as Western Connecticut Health Network navigates the challenging economic environment, mandated reforms, and the ever-changing community needs with thoughtful sensitivity, fiscal responsibility, and the management skills required for a sustainable health care operation today.

One of the highlights of my 15-year legislative career was the opportunity to work closely with Danbury Hospital officials as they applied through the Office of Health Care Access to establish a cardiac care center a number of years ago.

The unwavering commitment of hospital officials and professionals was not only impressive, it ultimately secured an approval and led to the establishment of one of the State's top comprehensive cardiac care surgical providers.

The professionalism, focus and thorough approach developed the finest level of care to its patients, secured my greatest respect to confidence and faith in the hospital.

As a longtime public servant, I am aware of the challenging times that face our State. Health care funding is limited and, as witnessed this past session, at risk and challenged constantly.

The need for hospitals to plan for and realize efficiencies and how they are able to operate is critical. It is also critical to the way that they will be able to serve the needs of our residents for years to come.

These organizations before you today are not-for-profit, mission-driven organizations, with a proven track record of serving the needs of the uninsured and the underinsured.

I believe this affiliation will sustain their collective mission, so those community needs can

continue to be met.

I have great confidence that this affiliation can help improve the accessibility, the continuity and quality of health services and, ultimately, the health of Connecticut residents.

I encourage you to approve this application, so these hospitals are available and actively serving the broad needs of residents of all of Western Connecticut.

Thank you for your time and consideration.

HEARING OFFICER HANSTED: Thank you. Okay, at this time, we're going to go back to OHCA's questions. I apologize for the disjointedness there. Mr. Lazarus?

MR. LAZARUS: Before I move on, Ms. Franco had mentioned the Community Health Improvement Plan. Is it possible for OHCA to get a copy of that for evidence?

HEARING OFFICER HANSTED: Exhibit E. Thank you.

MS. TOPALIAN: Exhibit D.

HEARING OFFICER HANSTED: D, as in David? Thank you.

MR. LAZARUS: Do you envision that certain hospitals within the WCHN will offer certain distinct

services by hospital location?

DR. MURPHY: I think the answer to that question is time will tell. There are circumstances, where I could envision, for instance, highly-specialized care.

For instance, if we had a hepatobiliary surgeon, who was interested in resecting tumors from the liver that required a very complex team, as well as very expensive equipment and the procedures are done infrequently, I could see where we would want to collectively address and decide where best should we do this, such that we can provide the care efficiently, we can determine that it will be of high quality, and that the teams practice it often enough that they can insure a consistent outcome.

But notwithstanding those exceptional circumstances, I think that we want to provide immediate access for all routine care wherever we can, and, certainly, that would include Norwalk Hospital being what it is today, and we have not identified or contemplated eliminating any of the services that they provide at this time.

MS. KAILA RIGGOTT: Kaila Riggott, Office of Health Care Access. My question is for Mr. Shames.

On page three of your pre-filed testimony, you talk about key drivers behind the affiliation, one of them being improved care for the vulnerable, and, on page six, you - -

COURT REPORTER: Excuse me. Could you move your microphone closer? The silver one.

MS. RIGGOTT: This one?

COURT REPORTER: Yeah.

MS. RIGGOTT: And, on page six, you reference OHCA's Statewide Facilities and Services Plan, the alignment of the proposal's goals with the ACA and one of them being providing more care to the underserved.

Can you please elaborate on how this proposal will accomplish improved care for vulnerable populations and the underserved?

MR. SHAMES: I think the key here is to be able to reach out into the community and to tie into other agencies in the community, so that we don't wait for the underserved necessarily to come to us, but we go to them on a preventative basis and on an integrated basis.

I believe, as you heard, we believe that this will give us the capability and the financial wherewithal to expand those services and accessibility.

HEARING OFFICER HANSTED: Why wouldn't you have the capability without the affiliation?

MR. SHAMES: It's a matter of financial pressures. The bottom line here is we're going to be trying to give higher access at lower reimbursement, and we're under tremendous pressure, and, so, those are the kinds of things that get prioritized.

And, so, this gives us greater financial wherewithal. The two and a half percent savings is significant.

HEARING OFFICER HANSTED: Okay, thank you. Sorry.

MS. RIGGOTT: That's okay. That's all I have.

HEARING OFFICER HANSTED: That's all you have? Okay. I just have a couple of questions. In terms of the assets of the Norwalk Hospital, who would retain control of the assets or ownership, I should say?

MR. DeBARBA: The Norwalk Hospital, itself, remains a member. Well, actually, the Norwalk Health Service Corporation remains the sole member of Norwalk Hospital, and the WCHN becomes the sole member of Norwalk Health Services Corporation, so the assets of Norwalk Hospital would remain within Norwalk Hospital.

There may be a time when we move to a consolidated debt offering and secure that debt with the assets of the entire health system, and we may do that in the very near future, but, as of this moment, those assets stay separate within Norwalk Hospital, which has a Board, as Mr. Shames pointed out earlier, with, you know, a limited, but robust set of responsibilities.

HEARING OFFICER HANSTED: Okay, thank you. I think you answered both of my questions within that same answer, so thank you for that. Okay, that's all I had, in terms of questions, and that completes OHCA's question portion of this hearing.

At this time, I'd like to just take a 15-minute break, just to give everyone some time to stretch their legs, and we'll start off again in 15 minutes. We'll go off the record. Thank you.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're going to start the public portion of this afternoon's hearing now, and each person, who wishes to speak, should have written their name on the sign-up sheet that was provided in the back of the room.

We will be calling the names of those individuals, who have signed up to speak, in order in

which they have signed up.

I ask that you keep your comments limited to three minutes each, just because we have a lot of people here, and I want to make sure everyone has an opportunity to speak this evening.

For those of you, who do not wish to speak or were not able to speak today, keep in mind that you can submit written testimony.

We will accept all written testimony until the closing date of the hearing process. The mailing address is listed on the information sheet that's also in the back of the room on the table.

You do not have to identify your street name or telephone number if you are submitting written testimony.

Okay, we'll start with the first individual, first two people, I believe, signed up. Joseph Andrews and Eugene -- I apologize. If you can please state your name?

MR. EUGENE MICHAEL: Yes. Thank you. My name is Eugene Michael, and I'm pleased to be here representing the Connecticut Hospice, which is based in Branford, but which also has a home care patient service office right across the street on Park Street here in

Norwalk.

I'm here, basically, to say we approve, or we're not in the approval business, but we like the idea of the merger, and we are certainly in favor of the merger between Danbury and Norwalk Hospitals.

Our association is a little bit more personal with Norwalk Hospital. By virtue of history, about 30 years ago, an oncologist from Norwalk Hospital asked us to consider opening a patient office for home care services here in Norwalk, and we did that, and we've been here for the past 30 years, working closely with community agencies, serving patients, and we have patients in home care and in Hospice home care as we speak here in Norwalk.

We have affiliations with most of the hospitals in Connecticut, but we've been able to have a special relationship, I guess, with Norwalk. Dr. Joseph Andrews, who is following me, he's our Medical Director. He used to be here at Norwalk Hospital.

Dr. Andrea Peterson has joined us most recently. She was formerly a physician here at Norwalk Hospital, and she's on the medical staff.

And, so, I'm sorry, Dr. Murphy, that we haven't been able to steal some physicians from Danbury,

but maybe, as a result of this merger, you know, we can do some more business. (Laughter)

I was telling Dr. Murphy earlier that I was born at Danbury Hospital some years ago, before his time, and grew up there, and, so, I'm quite familiar with Danbury, but we certainly think this merger is a good idea, and that's basically all I have to say today.

HEARING OFFICER HANSTED: Okay, thank you.

DR. JOSEPH ANDREWS: My name is Joe Andrews, A-N-D-R-E-W-S, and I'm currently the Medical Director at the Connecticut Hospice, but, for many years, from 1974 until 2007, I practiced primary care internal medicine in Norwalk and have a long, happy affiliation with the hospital.

My initial response when I heard about the affiliation was to question it and look more carefully at it. Having done so, I think it's a terrific idea.

I think that the hospitals and the patients that they care for will greatly benefit from the combined forces of not only economies of scale, but, as Dr. Murphy was saying, an ability to work together to provide the right care for the right patient and family in the right setting at the right time.

We're going to have much less money, and

we're going to have to get better results. This is going to mean, also, for our point of view, as a Hospice and palliative care hospital up in Branford, who also has a home care agency and a Hospice license, that we can help get the patients to the right level of care at the right time.

Currently, the Connecticut Hospice has been following 121 patients with a diagnosis of congestive heart failure. The readmission rate on these patients has been 1.75 percent.

We've really be able to care for them in a very efficient way in home settings with what we would say low-tech, high-touch care.

All of our patients are managed by an interdisciplinary team. We've been doing that for 30 odd years, with social workers, nurse practitioners, physicians, chaplains, artists and musicians, volunteers, bringing together at the bedside all of the things that will fit into this new culture that I think is going to evolve fairly rapidly among New Milford, Danbury and Norwalk.

We can also provide some education for residents and fellows. We do grant CMEs. We are licensed to do that through 2019, and we've been a

renowned provider of the initial Hospice services in the United States, so we're proud of our corporate culture and our not-for-profit setup.

I think endorsing this is a good thing for all the patients, who are going to be involved in the catchment area, and we would love to be helpful as an independent cooperating institution to help get that culture into the acute hospital setting.

The purpose of everything we do is to cure often, always to be of comfort, and provide symptomatic relief along a long constellation.

In closing, I'd just like to say that the palliative care consult in the United States occurs about 32 to 30 days before the patient's death.

We think that needs to be acculturated in medicine and nursing, so that the palliative care and Hospice services can be started much earlier on, maybe up to six or seven months.

And I think it will make an immense difference in reducing over-utilization, duplication of services, and inappropriate high-tech care when it's no longer indicated.

So I'm here as an old Norwalk hand to endorse this affiliation enthusiastically and with no

reservations at all. Thank you.

HEARING OFFICER HANSTED: Thank you, Doctor. Can we have Mr. Frederick Lione, Jr. step up, please?

MR. FREDERIC LIONE: My name is Fred Lione, L-I-O-N-E. I'm President of the Norwalk Hospital Volunteers. I'm a member of the Community Health Committee, but, per your instructions, I'm here speaking as an individual.

Norwalk Hospital is my community hospital. Twice in the last two decades it's brought me back from a myocardial infarction and sepsis, so, personally, I'm delighted with their care.

I realize, like everybody does and everybody has talked about here, that the world is changing, that they need more down stroke, as they say, that the economies of scale are necessary, in order to make them retain their community hospital abilities and yet have the ability to take advantage of the technology that's out there and the health care, the Affordable Health Care Act is providing.

That's all I have. Thank you very much.

HEARING OFFICER HANSTED: Thank you. Kim Morgan.

MS. KIM MORGAN: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MS. MORGAN: My name is Kim Morgan, and I am the President and CEO of United Way of Western Connecticut, which has a geographic service area throughout Western Connecticut and covers up to New Milford.

I am here today to endorse the planned affiliation between Norwalk Hospital and Danbury and New Milford Hospitals that are part of the Western Connecticut Health Network.

There is an old adage that states, alone, we can do so little, but, together, we can do so much. In 2007, my own organization demonstrated a very similar vision to affiliate to sustain our mission, but improve our cost efficiencies, our regional planning for optimal health, and our outcomes for the people of Western Connecticut.

Additionally, the United Way of Coastal Fairfield County, who partners with Norwalk Hospital, has also gone through similar mergers for the same exact reasons.

And, so, the challenge that we face is most likely similar for what these hospitals are facing,

to remain a local provider, in tune with the local needs, but to leverage your capacity regionally.

You spoke earlier about the community outreach and an interest in the community outreach plans, and I can wholeheartedly attest that, in Danbury, the community plan is driven by Danbury Hospital, and that we are all around the table working together on how we're going to improve the health for our community.

I think change can be difficult to implement, but I know firsthand that affiliations of this nature can bridge communities in very positive ways. They create efficiencies in how our organizations are able to operate, and they best leverage those limited resources for the greater good.

My own organization is living proof that not only are affiliations, such as this, absolutely necessary and productive, but they can lead to new practices that help communities thrive as a result.

As we see health care reforms are implemented and environment of diminishing resources, it is abundantly clear that this affiliation can help improve the accessibility, continuity and quality of health services and, ultimately, the health of our residents.

When we look to improve health outcomes, there needs to be a view of the whole person in that continuity of care, and having a system of hospitals and doctors that have specialties, but yet are connected as one organism, can only improve patient outcomes.

I believe this is a visionary move that will bring the collective strength of those two organizations together for a stronger, healthier future for our region.

I encourage you to approve the application and allow it go forward to benefit the residents of the community that I live in and work in.

I think that United Way can only be successful in meeting our mission if we have strong partners, and we have a strong partner in this hospital system, so I thank you for your consideration.

HEARING OFFICER HANSTED: Thank you. Edward Musante, Jr.?

COURT REPORTER: One moment, please.

(Off the record)

COURT REPORTER: Please spell your last name for the record.

MR. EDWARD MUSANTE: Sure. My name is Edward J. Musante, Jr. It's M-U-S-A-N-T-E. I'm the

President and CEO of the Greater Norwalk Chamber of Commerce. I'm here representing our Board of Directors. Our Chamber represents about 800 member companies in Greater Norwalk.

I have a little bit of a different angle to discuss with you this afternoon. I'd like to kind of approach this from the business perspective.

Norwalk Hospital is the largest employer, not only in Norwalk, but in Central Fairfield County, or Greater Norwalk, as we like to call it, which include the towns of Darien, New Canaan, Norwalk, Wilton, Westport and Weston.

Health care is one of only a few industry groups that's expected to grow at a significant rate, providing not just jobs, but careers for lots of people, particularly here in Fairfield County, where, actually, in Connecticut, the average -- the demographics show that the average age is higher than that of the United States as a whole, and Fairfield County has a higher age, average age than the State of Connecticut, so we are a population getting older here in Fairfield County, and certainly in need of significant health care resources.

And if you take a look at that from the business perspective, that means jobs, that means careers

for people, it means opportunities for people that may presently not have those opportunities.

Norwalk is host to about 50,000 to 60,000 employees each work day, and if you take a look at all of Greater Norwalk, the Central Fairfield County area, that swells to about 80,000 people working here during the week.

Norwalk Hospital would be and is the first provider of emergency care during the workday for that entire population, regardless of where they live.

And if you know anything about the employment in Fairfield County, you know that people are coming here from further and further away. It's not uncommon to find people from the Naugatuck Valley, from Milford and beyond traveling here, and any of you that have traveled the highways in the morning know that that is the case.

As an economic driver and as the provider of emergency health services for approximately 80,000 workday residents, we need not only a stable, but a very strong health network to service our growing workforce.

Future attraction of jobs here is not based on lower personnel or operating costs. Fairfield County is not a low-cost area. Fairfield County is a

high-cost area, and if someone's business is based on lower cost, they often times would not choose Fairfield County to be their location.

However, clearly, our region is that high-cost area. It is, however, based on having the highest quality of life, and that's why companies move here, and that's how we attract employees.

So we believe that the proposed affiliation with the Western Connecticut Health Network will provide the best opportunity to achieve all of these things, not only for the short-term, but for the longer term, in order to create stability within the industry and, also, stability for our businesses.

The one thing that businesses crave more than anything else is certainty, and we believe that this affiliation provides a significant certainty for enhanced health care in our region for all, including the business community, therefore, the Board of Directors has asked me to come here and ask for your approval of the Certificate of Need at your earliest convenience. Thank you very much.

HEARING OFFICER HANSTED: Thank you.

MR. LAZARUS: I believe that's the last name I had on the list. Is there anybody else in here

from the general public, who wishes to speak at the moment?

MS. FRANCO: There are two legislative representatives moved to the 9/11 event, because they wouldn't be able to get here and then get there on time, so they're not going to be here.

HEARING OFFICER HANSTED: Okay.

MS. FRANCO: They're going to submit letters to you.

HEARING OFFICER HANSTED: Okay, thank you. If anyone wishes to submit written testimony, rather than speaking here this afternoon, please do so by September 24th, and, as I stated earlier, the address is on the information sheet, which is in the back of the room.

At this point, I'm going to just take another break. I want to make sure anyone that wishes to attend this evening from the public has an opportunity to get here from work, so we'll be here until at least 6:00 p.m., and, at this point, we'll go off the record.

(Off the record)

HEARING OFFICER HANSTED: Okay. We're going to get started again. Attorney Gerner, I understand you wanted to have something put on the record, a late file?

MS. GERNER: Yes.

HEARING OFFICER HANSTED: Did you want to do that now?

MS. GERNER: Pat Gerner, the attorney for both the Applicants. Jeryl Topalian from Norwalk Health Care System would like to submit the document that you requested during the hearing, so if you would allow her to approach and give you that document?

HEARING OFFICER HANSTED: Absolutely. It's Late File No. 1.

MS. GERNER: Very good. Thank you.

MR. LAZARUS: We'll label that as Applicant Exhibit 1, instead of Late File, because we received it during the hearing.

HEARING OFFICER HANSTED: Okay and, just for the record, are there any other members of the public here this evening, who would like to give a statement on this application? Let the record reflect that there are none, and if the Applicants would like to give a closing statement, you're welcome to do so at this time.

DR. MURPHY: We'd like to. On behalf of my colleagues, I want to personally thank the OHCA staff for conducting such a thorough study of the potential benefits of this affiliation between our organizations.

We sincerely appreciate the care and precision with which you do your work and for the opportunity today to share our vision for the new picture of health we hope to create for the communities we serve.

As we have described, embracing the challenges of health care in these communities is a complex task. There are no easy answers. There is no crystal ball.

The best any of us can do, the hospitals, their Boards, our medical staffs, our employees, who are our community, is to work with people we trust to create the best possible team to confront the challenges, embrace the possibilities, and listen to the people we serve.

We believe, with the affiliation of our organizations, we have the best possible team to redefine what personalized access to health care services can mean for the people in our communities.

As we've outlined today and in the detailed material provided in this process, we approach this task with the belief in the parallel missions we pursue, an understanding of the realities we face, and a firm conviction to do what is needed to improve the health of the people in our combined service areas.

While we cannot claim to have all of the answers today, we can assure you that we will bring the best people in our business to deliver the care that people need.

We will strengthen the care, enhance the access, and carefully manage the dollars, so people can continue to access the right care in the right place at the right time.

All of us in this room are committed to improve the health of the people in our state. That's why we entered the health care profession in the first place.

The environment we first practiced in has significantly changed in recent years. Few of us could have imagined the challenges we now face on a daily basis.

No matter what may change in the realities we confront, what remains steadfast is our commitment to manage the details of the business, so we can continue to deliver the mission.

That's at the heart of how we work every day. That's at the core of why we all believe so strongly in the potential of this affiliation.

Throughout this application process,

including today's session, we've heard many worthwhile observations, questions, concerns and ideas. We commit to you that we will continue to listen.

Effective health care doesn't happen by accident. It's the product of how we listen, how we absorb, how we think, how we work. Ultimately, it's about how we serve our communities, one patient at a time.

That's why we come to work every day. That's how we will continue to work; together, as the new Western Connecticut Health Network.

Again, thank you for your time, focus and thought. We will be better, because of the care you bring to this process.

HEARING OFFICER HANSTED: Thank you, Doctor. Any other statements? No? With that, I thank you, all, and I'll adjourn this hearing.

(Whereupon, the hearing adjourned at 5:56 p.m.)

HEARING RE: NORWALK HEALTH SERVICES CORPORATION
SEPTEMBER 10, 2013

AGENDA

CERTIFICATE

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

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

In witness whereof I have hereunto set my hand and do so attest to the above, this 16th day of September, 2013.

Paul Landman
President

Post Reporting Service
1-800-262-4102

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

September 25, 2013 VIA FAX ONLY

Jeryl Topalian
Executive Director & Business Development
Norwalk Health Services Corporation
34 Maple Street
Norwalk, CT 06850

Sally Herlihy
Vice President Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application; Docket Number: 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Closure of Public Hearing

Dear Ms. Topalian and Ms. Herlihy:

On September 10, 2013, the Office of Health Care Access ("OHCA") held a public hearing in this matter and kept the hearing record open to allow for additional public comments through September 24, 2013. Please be advised, by way of this letter, the public hearing is closed and OHCA has received no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Steven W. Lazarus at (860) 418-7012.

Sincerely,

Kevin T. Hansted
Hearing Officer

KH:swl

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3714
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DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Pat Gerner

FAX: (860) 489-9380

AGENCY:

FROM: Steven Lazarus

DATE: 9/25/13 **TIME:** 12:45p 1pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Close of Hearing Letter, DN: 13-31832-Con

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TIME USE	00'45
PAGES SENT	2
RESULT	OK

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DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Ms. Sally Herlihy

FAX: (205) 739-1974

AGENCY:

FROM: Steven Logan

DATE: 9/25/13 **TIME:** ~~12:45 pm~~ 1 pm

NUMBER OF PAGES: 2
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PAGES SENT	2
RESULT	OK

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DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Ms. Jaryl Topalian

FAX: (203) 852-1553

AGENCY:

FROM: Steven Lazarus

DATE: 9/25/13 **TIME:** 12:45 pm 1pm

NUMBER OF PAGES: 2
(including transmittal sheet)

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PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: Hansted, Kevin
Sent: Tuesday, December 31, 2013 9:21 AM
To: Greer, Leslie
Subject: FW: Norwalk/Danbury Affiliation

Leslie, please add the below email to the Danbury/Norwalk affiliation file.

Thank you.

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

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-----Original Message-----
From: Nichols, Brian D. [mailto:bnichols@rc.com]
Sent: Thursday, December 26, 2013 11:22 AM
To: Hansted, Kevin
Cc: Boyle, Lisa M; klg1@aol.com; McKenna, Carolyn (Carolyn.McKenna@wchn.org)
Subject: RE: Norwalk/Danbury Affiliation

Kevin,
Our client has already provided signed signature pages on December 24th. By this email, I am authorizing you to attach the signature pages already provided by our client to the revised order that does not reflect the requested language. Please let me know when I can pick up the fully executed order or if you have any questions. Thanks.

Brian

Brian D. Nichols

Robinson & Cole LLP
280 Trumbull Street
Hartford, CT 06103
Direct 860-275-8354 | Fax 860-275-8299
bnichols@rc.com | www.rc.com

Boston Providence Hartford New London

Stamford New York Albany Los Angeles Sarasota

-----Original Message-----
From: Hansted, Kevin [mailto:Kevin.Hansted@ct.gov]
Sent: Thursday, December 26, 2013 11:09 AM
To: Nichols, Brian D.
Subject: FW: Norwalk/Danbury Affiliation

Brian,

I received your voice mail. Please see below.

Thank you.

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

_____

From: Hansted, Kevin
Sent: Thursday, December 26, 2013 9:16 AM
To: klg1@aol.com
Cc: Horn, Marianne; Martone, Kim
Subject: Norwalk/Danbury Affiliation

Good morning Pat,

I hope you had a wonderful holiday.

Attached please find a revised agreed settlement for execution. After further consideration, OHCA has decided that it does not want to include the additional language as proposed by your client regarding the merger between Norwalk Hospital and Norwalk Health Services Corp. Please note this was the only change made to the document signed by your client earlier this week. At this point the attached document is not negotiable. Please have your client execute two originals and return it overnight to my attention. Upon my receipt, I will ensure that the documents are signed expeditiously.

Thank you for your understanding.

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

_____
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_____

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 26, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Agreed Settlement Office of Health Care Access Docket Number: 13-31832-CON
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.	**Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.**

To: Patricia A. Gerner, Esq.
The Law Office of Patricia A. Gerner
240 Ramstein Road
New Hartford, CT 06057

Dear Attorney Gerner:

This letter will serve as notice of the approved Certificate of Need Application in the above-referenced matter. On December 26, 2013, the Agreed Settlement, attached hereto, was adopted and issued as an Order by the Department of Public Health, Office of Health Care Access.

Karen Roberts for Kimberly Martone

Kimberly R. Martone
Director of Operations

Enclosure
KRM:swl

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants: **Norwalk Health Services Corporation**
34 Maple Street, Norwalk, CT 06850

Western Connecticut Health Network, Inc.
24 Hospital Avenue, Danbury, CT 06810

Docket Number: **13-31832-CON**

Project Title: **Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.**

Project Description: Western Connecticut Health Network, Inc. ("WCHN") and Norwalk Health Services Corporation ("NHSC") (herein referred to as "Applicants") propose that WCHN become NHSC's sole corporate member for the purpose of establishing a corporate affiliation, with no associated capital expenditure.

Procedural History: The Applicants published notice of their intent to file a CON application in The News Times (Danbury) on February 4, 5 and 6, 2013. On April 8, 2013, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicants for the above-referenced project. On July 15, 2013, OHCA deemed the application complete.

On August 23, 2013, the Applicants were notified of the date, time, and place of the public hearing. On August 29, 2013, a notice to the public announcing the hearing was published in The Hour (Norwalk). Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on September 10, 2013.

Commissioner Jewel Mullen designated Attorney Kevin Hansted as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) and Conn. Gen. Stat. § 19a-

639a. The public hearing record was closed on September 25, 2013. Deputy Commissioner Davis considered the entire record in this matter.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

Findings of Fact

1. Western Connecticut Health Network, Inc. ("WCHN") is the parent corporation of Danbury Hospital, New Milford Hospital and other affiliated entities. Ex. A, p. 9.

2. Norwalk Health Services Corporation ("NHSC") is the parent corporation of Norwalk Hospital and other affiliated entities. Ex. A, p. 9.

3. Danbury Hospital, located at 20 Hospital Avenue in Danbury, is licensed for 345 beds and 26 bassinets. New Milford Hospital, located at 21 Elm Street in New Milford, is licensed for 85 beds. Ex. A, p. 10.

4. Norwalk Hospital is licensed for 328 beds and 38 bassinets. Ex. A, p. 10.

5. Under this proposal, WCHN will join NHSC for the purpose of effectuating a corporate affiliation and a new entity, New WCHN, will be formed. Ex. A, p. 9.

6. New WCHN will be the sole corporate member of NHSC. A reconstituted 18-member single board of directors will govern the new organization. Eleven board members will be appointed from the current WCHN and seven members will be appointed from the current NHSC. Ex. A, p. 9.

7. New WCHN will have rights with regard to governance, operating and capital budgets and strategic planning for NHSC, Danbury Hospital, New Milford Hospital and all other WCHN related entities. Ex. A, p. 9

8. NHSC's primary service area includes Norwalk, Westport, New Canaan, Wilton and Weston. The secondary service area includes the towns of Darien, Fairfield, Redding and Ridgefield. Ex. A, p. 13.

9. WCHN's primary service area includes the towns of Bethel, Bridgewater, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman and Washington, and the New York towns of Brewster, Dover Plains, Patterson, Pawling, and Wingdale. Ex. A, p. 13.

10. The Applicants represented that they are facing multiple challenges including declining reimbursement and inpatient volume, and the mandates of the 2010 Patient Protection and Affordable Care Act ("ACA"), requiring investments in quality assessment, physician integration, population health management and electronic health records. Ex. A, p. 9.

11. Affiliating with another hospital system will allow the Applicants an opportunity to collaborate and cooperate in order to improve and enhance the quality of care provided to the patients and meet the increasing demands of the health care environment. Ex. A, p. 9.

12. According to the Applicants, as the health care system transforms to meet the requirements and mandates of the ACA, remaining a stand-alone hospital will become unsustainable. Hearing Transcript, p. 8, Mr. Erv Shames, Chairman of the Board of Trustees of Norwalk Health Services

13. In November 2008, the NHSC Board of Trustees and senior management began exploring the strategies and tactics that would be needed to ensure the long-term success of NHSC. Elements identified as essential to long-term viability included improved access to capital markets, support for physician recruitment/retention, clinical service development and better use of scarce community resources. Ex. A, p. 11.

14. In early 2009, Norwalk Hospital engaged Navigant Consulting, Inc. for an assessment of partnership options as one opportunity to ensure the continued strength and viability of the hospital. A Partnership Task Force consisting of Board members and senior management (the "Partnership Task Force") identified potential scenarios for further exploration and key drivers to be considered in a potential partner. Ex. A, p. 11.

15. During the same period, NHSC was developing Vision 2015, a strategic plan identifying the long-term strategic priorities for the Hospital. These priorities included improving patient safety, satisfaction and quality outcomes, developing physician partnerships and integration, and the continued growth and development of hospital facilities and programs. Ex. A, p. 11.

16. As a result of this process, WCHN emerged as the most appropriate partner that would allow NHSC to achieve its goals. Ex. A, p. 11.

17. The Partnership Task Force identified new emerging payment models as an area of great concern. WCHN has already begun a process to create expertise in the development of an accountable care organization ("ACO"), and will collaborate on best practices and proven protocols to improve quality and outcomes for patients across the continuum. Hearing Transcript, pp. 12-13, Mr. Daniel DeBarba, President of Norwalk Hospital and Norwalk Health Services

18. The proposed affiliation of NHSC and WCHN is intended to meet these costly and difficult challenges while strengthening the quality of, and access to health care in western Connecticut. Ex. A, p. 9.

19. The creation of New WCHN is expected to result in efficient and streamlined operations, and enhanced education and research opportunities. Ex. A, p. 9.

20. A 2012 Greater Norwalk Area Community Health Assessment and Improvements Initiative examined the health needs of the Greater Norwalk community and found that the Norwalk community is concerned about the issues of chronic disease resulting from being overweight and obese and the limited services for treatment of substance abuse, as well as mental health services. Hearing Transcript, p. 8, Mr. Erv Shames, Chairman of the Board of Trustees of Norwalk Health Services

21. Norwalk Hospital has a community care team that meets weekly to evaluate the community substance abuse and behavioral health issues and attempts to provide a wraparound service to decrease inpatient/outpatient admissions to the Hospital. Another Norwalk Hospital initiative involves working with local community schools to encourage physical activities such as walking to school and gets the children's families to help decrease body mass index among school-age children. Hearing Transcript, pp. 41-42, Ms. Mary Franco, Vice President of Public Affairs, Norwalk Hospital

22. The Applicants provided examples of WCHN's responsiveness to community needs, where Danbury Hospital sent a team out to address an individual's urgent behavioral health needs rather than waiting for the patient to be admitted first. The Applicants state they would examine what outreach efforts are most successful and try to replicate them in the communities they serve. Hearing Transcript, p. 43, Dr. John Murphy, President and CEO of Western Connecticut Health Network

23. The Applicants identified the following as benefits of the proposed affiliation:

    a) Strengthening clinical programs to demonstrate quality outcomes and to improve access to health care, which can be done more economically with two cooperating systems rather than two stand-alone organizations;
    b) Enhancing educational programs, including strengthened programs for medical students, residents and fellows in both organizations;
    c) Strengthening the physician platform for delivery of care;
    d) Building competencies required for new reimbursement models, such as population health management, bundled payments, Physician Hospital Organization ("PHO") and ACOs;
    e) Integrating operations to achieve savings and create a unified operating model; and
    f) Improving access to and/or reducing cost of capital due to system scale and performance. Hearing Transcript, pp. 14-15, Mr. Daniel DeBarba, President of Norwalk Hospital and Norwalk Health Services Corporation, Ex. A, p. 12

24. According to the Applicants, the affiliation will improve health care services by strengthening the clinical platforms so that physicians can succeed, and establishing quality standards to produce best practice outcomes across the single new network. It will then be possible to attract the needed physicians in order to provide greater access to

those requiring health care services. Access within one system of care for the residents living in the service area of the new network will provide patients with greater continuity of care. Ex. A, p. 16.

25. The proposed affiliation will create a larger physician platform that will allow the unified system to deepen its primary care base for improved patient access, in addition to building specific clinical programs, and allow WCHN to more effectively recruit primary care physicians and specialists. Ex. A, p. 17.

26. In 2012, Norwalk Hospital conducted a physician resources assessment, which identified significant shortages of primary care providers in its service area. As a result, they implemented a physician recruitment and integration plan and added several new practitioners to the service area. Hearing Transcript, p. 15, Mr. Daniel DeBarba, President of Norwalk Hospital and Norwalk Health Services Corporation.

27. WCHN has made significant investments in physician recruitment and integration, including the development of a PHO. With the approval of this affiliation, Norwalk Hospital and its physicians will be able to join the PHO, and the resulting network will have more scale and resources to invest in developing the primary care infrastructure, thereby increasing access. Hearing Transcript, p. 15, Mr. Daniel DeBarba, President of Norwalk Hospital and Norwalk Health Services Corporation.

28. The proposed affiliation will create a network-wide physician platform that includes over 800 independent and over 300 employed physicians. Hearing Transcript, p. 15, Mr. Daniel DeBarba, President of Norwalk Hospital and Norwalk Health Services Corporation.

29. No disruption to or curtailment of clinical services is anticipated. The opportunities created by this affiliation will be in the form of expansion of some services, where needed, and in shared service personnel so that both entities can continue to provide the wide range of services now being offered. Ex. A, p. 13.

30. NHSC revenues have exceeded expenses in each of the last four fiscal years. WCHN has reported revenues in excess of expenses in three of the last four fiscal years.

Table 1: Applicants' Actual Excess/(Deficiency) of Revenue Over Expenses

Description	FY 2009	FY 2010	FY 2011	FY 2012
Norwalk Health Services Corp.	$12,643,049	$1,777,613	$11,598,207	$26,355,112
Western Connecticut Health Network, Inc.	$38,139,570	$38,758,693	($2,807,169)	$42,512,453

Source: Hospital Reporting System Report 385 – Parent Corporation Consolidated Financial Data Analysis for FYs 2009-2012, respectively.

31. NHSC reported unrestricted assets of $147.6 million in FY 2012; WCHN reported $277.1 million.

Table 2: Applicants' Unrestricted Net Assets

Description	FY 2009	FY 2010	FY 2011	FY 2012
Norwalk Health Services Corp.	$145,071,590	$138,968,662	$126,940,368	$147,589,726
Western Connecticut Health Network, Inc.	$183,488,285	$244,887,741	$286,369,831	$277,089,185

Source: Hospital Reporting System Report 385 – Parent Corporation Consolidated Financial Data Analysis for FYs 2009-2012, respectively.

32. As a result of the proposal's cost savings, NHSC projects revenues in excess of expenses of approximately $720,000 in FY 2014, $3.4 million ("M") in FY 2015 and $6.6M in FY 2016. WCHN projects revenues in excess of expenses of approximately $1.4M in FY 2014, $6.5M in FY 2015, and $12.5M in FY 2016.

Table 3: Financial Projections Incremental to the Proposal for NHSC

Description	FY 2013	FY 2014	FY 2015	FY 2016
Incremental Op. Revenue	$0	$0	$0	$0
Incremental Op. Expenses	$0	($720,000)	($3,420,000)	($6,590,000)
Incremental Gain (Loss)	$0	$720,000	$3,420,000	$6,590,000
Incremental Non-Op. Revenue	$0	$0	$0	$0
Rev. Over/(Under) Expense	$0	$720,000	$3,420,000	$6,590,000

Assumes that the proposed affiliation will occur in the last quarter of FY 2013.
Fiscal years 2014 through 2016 represent the first three full years of the proposed affiliation.
Financial Attachment I; p. 196

Table 4: Financial Projections Incremental to the Proposal for WCHN

Description	FY 2013	FY 2014	FY 2015	FY 2016
Incremental Revenue	$0	$0	$0	$0
Incremental Expenses	$0	($1,375,000)	($6,483,000)	($12,508,000)
Incremental Gain (Loss)	$0	$1,375,000	$6,483,000	$12,508,000
Incremental Non-Op. Revenue	$0	$0	$0	$0
Rev. Over/(Under) Expense	$0	$1,375,000	$6,483,000	$12,508,000

Assumes that the proposed affiliation will occur in the last quarter of FY 2013.
Fiscal years 2014 through 2016 represent the first three full years of the proposed affiliation.
Financial Attachment I; p. 197

33. Assumptions made for NHSC and WHCN's financial projections were developed by the management of the two entities based on their industry experience which were validated by outside consultants and are as follows:
    a. Salaries and fringe benefits include 3% annual inflation increases decreasing to 2% by FY 2016 for Norwalk Hospital while Danbury Hospital includes 2.5% inflation increases adjusted for changes in FTE's;
    b. Supplies and drugs will have a 3% annual increase;

c. Professional services increase 2% a year based on inflation;
d. Lease expense will have a 2% annual inflation increase;
e. Interest expense is the interest on existing debt;
f. Depreciation and amortization is based on annual capital expenditures inclusive of a new tower at Danbury Hospital and Ambulatory Care Pavilion at Norwalk Hospital; and
g. Other operating expenses were assumed to be flat but were adjusted for improvements related to expense management initiatives.
Exhibit, A. pp. 200, 201 and 219

34. No change in WCHN's payor/population mix is projected as a result of this proposal. WCHN's current payor/population mix and three year projected population mix with the CON proposal is as follows:

Table 5: Current and Three-Year Projected Population Mix with the CON Proposal

WCHN	2012 Current Payer Mix	2013 Projected Payer Mix	2014 Projected Payer Mix	2015 Projected Payer Mix
Medicare	44.8%	44.8%	44.8%	44.8%
Medicaid	16.6%	16.6%	16.6%	16.6%
TRICARE and CHAMPUS	0.2%	0.2%	0.2%	0.2%
Total Government	**61.6%**	**61.6%**	**61.6%**	**61.6%**
Commercial Insurers	36.7%	36.7%	36.7%	36.7%
Uninsured	1.2%	1.2%	1.2%	1.2%
Workers Compensation	0.5%	0.5%	0.5%	0.5%
Total Non-Government	**38.4%**	**38.4%**	**38.4%**	**38.4%**
Total Population Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 5 represents inpatient discharges from Danbury Hospital and New Milford Hospital. Ex. A. p. 20.

35. No change in the NHSC's payor/population mix is projected as a result of this proposal. NHSC's current payor/population mix and three year projected population mix with the CON proposal is as follows:

Table 6: Current and Three-Year Projected Population Mix with the CON Proposal

NHSC	2012 Current Payer Mix	2013 Projected Payer Mix	2014 Projected Payer Mix	2015 Projected Payer Mix
Medicare	41.0%	41.0%	41.0%	41.0%
Medicaid	20.0%	20.0%	20.0%	20.0%
TRICARE and CHAMPUS	0.1%	0.1%	0.1%	0.1%
Total Government	**61.1%**	**61.1%**	**61.1%**	**61.1%**
Commercial Insurers	36.8%	36.8%	36.8%	36.8%
Uninsured	1.8%	1.8%	1.8%	1.8%
Workers Compensation	0.3%	0.3%	0.3%	0.3%
Total Non-Government	**38.9%**	**38.9%**	**38.9%**	**38.9%**
Total Population Mix	**100.0%**	**100.0%**	**100.0%**	**100.0 %**

Table 6 represents inpatient discharges from Norwalk Hospital. Ex. A, p. 20.

36. Norwalk Hospital's net revenue is not expected to increase as a result of this proposal. Norwalk Hospital's expenses are expected to decrease in FYs 2014-2016. These savings are largely due to decreases in salaries and wages ($4.3M), fringe benefits ($2.2M) and supply and drug costs ($1.6M).

Table 7: Norwalk Hospital's Projected Cost Savings

Area	FY 2014	FY 2015	FY 2016
Net Revenue	$0	$0	$0
Salaries & Wages	$666,000	$1,418,000	$2,246,000
Fringe Benefits	$343,000	$730,000	$1,157,000
Supplies & Drugs	$228,000	$528,000	$821,000
Business Exp & Other Operating	$(819,000)	$299,000	$1,773,000
Net Total Savings	**$418,000**	**$2,974,000**	**$5,997,000**

Ex. A, p. 227.

37. Danbury Hospital's net revenue is not expected to increase as a result of this proposal. Danbury Hospital's expenses are expected to decrease in FYs 2014-2016. These savings are largely due to decreases in salaries and fringe benefits ($12.4M) and supply and drug costs ($3.0M).

Table 8: Danbury Hospital's Projected Cost Savings

Area	FY 2014	FY 2015	FY 2016
Net Revenue	$0	$0	$0
Salaries & Fringe Benefits	$1,929,000	$4,084,000	$6,465,000
Supplies & Drugs	$462,000	$977,000	$1,547,000
Business Exp & Other Operating	$(1,556,000)	$586,000	$3,367,000
Net Total Savings	**$835,000**	**$5,647,000**	**$11,379,000**

Ex. A, p. 649.

38. The Applicants are expecting the following savings for NHSC and WCHN:

Table 9: Forecasted Expense Savings

	FY 2014	FY 2015	FY 2016
Salaries and Fringe Benefits	$3,428,000	$6,987,000	$10,891,000
Supplies and Drugs	$818,000	$1,675,000	$2,606,000
Other Operating Expense (Costs)*	($2,151,000)	$1,241,000	$5,601,000
Total Savings	**$2,095,000**	**$9,903,000**	**$19,098,000**

*Other operating expenses are costs associated with the affiliation for items such as legal fees, consulting and marketing.
Financial Attachment I, pp. 196 and 197

39. The Applicants expect the combined entities' scale will provide the ability to negotiate lower prices on goods and services. The specific line item savings have not been identified but savings are expected in the following areas: med/surg supplies, food services, waste management and maintenance contracts. Ex. A, p. 223

40. The Chartis Group, a consulting firm engaged by the Applicants, expects that FTEs can be reduced and personnel savings can be achieved through centralization of roles and functions and through standardization of policies and procedures. Ex. A, pp. 218;223

41. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

42. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

43. The Applicants have established that there is a clear public need for their proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

44. The Applicants have satisfactorily demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

45. The Applicants have satisfactorily demonstrated that the proposal would improve quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5))

46. The Applicants have shown that there would be no significant change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

47. The Applicants have satisfactorily identified the population to be served by the proposal, and have satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

48. The historical utilization of health care facilities and services in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

49. The Applicants have satisfactorily demonstrated that the proposal would not result in an unnecessary duplication of existing health care facilities or services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

Norwalk Health Services Corporation ("NHSC"), the parent corporation of Norwalk Hospital ("the Hospital") is proposing to have Western Connecticut Health Network ("WCHN"), the parent corporation of Danbury Hospital and New Milford Hospital, join NHSC for the purpose of establishing a corporate affiliation and a new entity, New WCHN, will be formed. New WCHN will be the sole corporate member of NHSC. A reconstituted 18-member single board of directors will govern the new organization. Eleven board members will be appointed from the current WCHN and seven members will be appointed from the current NHSC. *Finding of Fact (FF)1-6.* New WCHN will have rights with respect to Norwalk Hospital's governance, financial matters and strategic planning. *FF7* The proposal is aimed at increasing access to care, improving the quality of care and controlling costs. The proposal is the result of NHSC's identified need for a partnership, essential to the strength and long term viability of the Hospital. *FF10-18*

NHSC's primary and secondary service areas include the towns of Norwalk, Westport, New Canaan, Wilton, Weston, Darien, Fairfield, Redding and Ridgefield. *FF8* WCHN's primary service area includes the Connecticut towns of Bethel, Bridgewater, Brookfield, Danbury, Kent, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman and Washington as well as five New York towns. *FF9* This proposal will not adversely affect these towns' populations, as no changes to clinical services are anticipated. *FF29* Rather, the proposal will strengthen the ability of Norwalk Hospital to better serve these residents in the future. Opportunities will be created by this affiliation in the form of expansion of some services, where needed, and in shared service personnel so that both entities can continue to provide the wide range of series now being offered. There will be no change to the patient payor mix. *FF34-35*

The Applicants view the proposed affiliation as an opportunity to collaborate and cooperate in order to strengthen clinical programs and improve and enhance the quality of care provided to patients. *FF 18, 25, 28-29* The affiliation is expected to result in enhanced education and research opportunities for medical students, residents and fellows. It is also anticipated that the breadth and scope of the affiliation will improve the ability to attract and retain an adequate workforce, including needed primary care and specialty physicians, thus strengthening the delivery of care and providing greater access to and continuity of care within one system. *FF23* This proposal will allow Norwalk Hospital's physicians to join WCHN's existing Physician Hospital Organization (PHO), and the resulting network will have more scale and resources to invest in developing the primary care infrastructure, thereby increasing access. The proposed affiliation will also create a network-wide physician platform that includes over 800 independent and over 300 employed physicians. *FF27-28.*

Furthermore, the Applicants indicate that the proposed affiliation will assist them in meeting the increasing demands of the current health care environment by building competencies necessary for new reimbursement models. *FF11, 24* WCHN has already begun a process to create expertise in the development of an accountable care organization (ACO), and is exploring collaboration on best practices and protocols to improve quality and outcomes for patients across the continuum. *FF17* The affiliation is also expected to result in more efficient, streamlined operations. *FF19*

Both NHSC and WCHN have developed community health needs assessments in collaboration with their respective communities and provide outreach directly in the community. For example, NHSC has a program in place through the hospital, in partnership with 20 plus other entities in the Norwalk area, which involves a community care team to regularly provide wraparound behavioral health and substance abuse services. *FF20-22* WCHN has provided similar individualized behavioral health outreach in the community. The Applicants will examine what is most successful and try to replicate it in the communities they serve. *FF22*

Neither WCHN nor Norwalk Hospital's net revenue is expected to change after the affiliation. However, Norwalk Hospital's expenses are expected to decrease $720,000 in FY 2014, $3.4 million in FY 2015 and $6.6 million in FY 2016. These savings are largely due to decreases in salaries and benefits ($7.4m) and supply and drug costs ($1.8m). The Applicants are projecting combined expense savings of $2.1 million in 2014, $9.9 million in 2015 and $19.1 million in 2016. *FF36-40*

Based on the foregoing, OHCA finds that the proposal will improve access to and the quality of health care services in the Applicants' service areas through an enhanced workforce, broadened physician platform, strengthened clinical programs, shared best practices and protocols, improved continuity of care and more efficient integrated operations through shared resources and economies of scale. This will be accomplished by having two relatively financially strong health systems collaborate at both the clinical and administrative level. The Applicants have demonstrated that there is a need for the proposed affiliation as the quality, accessibility and cost effectiveness of health care delivery in the Applicants' service areas will be improved.

As the Applicants have represented that specific service integration and cost savings will occur as a result of the proposed affiliation, OHCA has set forth certain conditions in the attached Order.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA"), Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation (Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation are herein collectively referred to as the "Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to establish an affiliation as follows:

1. The request of the Applicants to have Western Connecticut Health Network, Inc. join Norwalk Health Services Corporation for the purpose of establishing a corporate affiliation is hereby approved.

2. Within sixty (60) days of the closing date, the Applicants shall file with OHCA a complete, non-redacted copy of any and all signed, dated and completed final affiliation agreement documents, including attachments. The non-redacted documents will be entered as part of the permanent record in this proceeding.

3. On an annual basis, for two (2) years from the date of execution of this Agreed Settlement, the Applicants must report to OHCA how the benefits/cost savings enumerated in Findings of Fact 23 and 36-38 have been achieved and within sixty (60) days of all the benefits/savings having been accounted for, the Applicants shall provide a final summary enumerating all aforementioned benefits/cost savings.

4. The Applicants agree to submit to OHCA, no later than March 31, 2014, a detailed and comprehensive document showing the plan to integrate the operations of both parent corporations and attain the cost savings stated within the CON Application. At a minimum, the submission shall address anticipated cost savings, staffing and quality improvements. Subsequent to the submission of the plan, the Applicants shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years for both NHSC and its affiliate, Norwalk Hospital. For purposes of the Order, semi-annual periods are October 1–March 31 and April 1–September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31, 2014, November 30, 2014, May 31, 2015, November 30, 2015, May 31, 2016, and November 30, 2016. The Applicants shall submit the following on a semi-annual basis:

    a. The Applicants agree to file narrative updates on the progress of the implementation of the plan.

    b. The Applicants shall report cost saving totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital, for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major

operating expense categories (Categories A,B,C,D,E,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. Norwalk Health Services Corporation shall also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. The Applicants shall file a completed Statement of Operations for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital. The format shall be consistent with HRS Reports 350/150, or successor reports.

d. The Applicants shall file a completed Balance Sheet for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital. The format shall be consistent with HRS Reports 300/100, or successor reports.

5. The Applicants shall obtain CON authorization prior to any merger of Norwalk Hospital with any entities controlled by Western Connecticut Health Network.

6. The Applicants shall obtain CON authorization prior to terminating any inpatient or outpatient services at Norwalk Hospital.

7. OHCA and the Applicants agree that this Agreed Settlement represents a final agreement between OHCA and the Applicants with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes that may have been raised by the Applicants with regard to Docket Number: 13-31832-CON.

8. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 at the Applicants' expense if the Applicants fail to comply with its terms.

9. This Agreed Settlement shall inure to the benefit of and be binding upon the Office of Health Care Access and the Applicants, and their successors and assigns.

Signed by Daniel J. DeBarba, President & CEO
(Print name) (Title)

12/23/13
Date

Duly Authorized for
Norwalk Health Services Corporation

Signed by John M. Murphy M.D., President & CEO
(Print name) (Title)

12/23/13
Date

Duly Authorized for
Western Connecticut Health Network

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on 12/24/13.

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

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PUBLIC NOTICE
Office of Health Care Access
Public Hearing

Statute Reference:
19a-639
Applicant(s):
Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Town:
Norwalk
Docket Number:
13-31832-CON
Proposal:
Affiliation of Norwalk Health Services Corporation and Western Connecticut Health Net-
work, Inc. with no associated capital expenditure
Date:
September 10, 2013
Time:
3:00 p.m.
Place:
The Norwalk Inn and Conference Center, 99 East Avenue - Mariner Ball Room Norwalk, CT

Any person who wishes to request status in the above listed public hearing may file a written petition no later than September 5, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

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$1250/mo. + utilities.
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1 BR
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Heat/HW, parking.& storage included.
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WESTPORT
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Call 203-227-9227.

garage for rent 665

2 CAR GARAGE FOR RENT
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Call 203-966-7229.

home sale norwalk 675

TWO-FAMILY HOUSE FOR SALE
$350,000
Conveniently located Colonial w/3 bedrooms, 2 baths. Close to bus line, courthouse, restaurants, theater, etc. Gas heat, city utilities.
Contact: Marc Romano
Marr & Caruso Realty Group
203-223-3576

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As part of our team, you are responsible for collaborating with small business owners in the Greater Norwalk area to design an effective ad campaign in both print and digital media.

RESPONSIBILITIES INCLUDE:
Identifying target list of advertisers
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Desire to continue to develop business skills
Achieve monthly sales goals
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QUALIFICATIONS:
Highly ambitious self-starter
Excellent communications skills
Reliable transportation
Basic computer competency
Business advertising
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We offer a competitive commission plan, auto reimbursement & ongoing training in a supportive working environment.

High-energy, motivated sellers who crave challenge and the freedom to succeed are encouraged to apply! Please submit a letter of interest, a current resume and salary history to jbrosz@thehour.com

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203-450-1550

clean up/ hauling 3205

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Comm'l & Residential
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jkmcleaningservice.com

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masonry contracting 3530

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overhead doors 3590

NORWALK OVERHEAD DOOR COMPANY
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norwalkoverheaddoorcompany.com

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Removal of all types of trees, stump grinding, bucket tree service.
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CITY OF NORWALK
BIDS INVITED
RFP #3329
Fork Lift TruckConstruction.
Deadline for the submissions of bids is 2:00pm, Tuesday, September 10, 2013.

Bid information is available via the Internet. The City's website site is located at http://www.norwalkct.org. Information about doing business with the City of Norwalk can be found within the "Business" tab listed on the main page of the website. The document number will be the same as the project number indicated above. Additional information is also available by contacting the Purchasing Department, Norwalk City Hall, 125 East Ave., P.O. Box 5125, Norwalk, Connecticut 06856-5125, Tel - (203) 854-7712, Fax - (203) 854-7817

SOLUTION:

9	5	6	8	3	2	7	1	4
7	2	4	5	9	1	3	8	6
8	1	3	6	4	7	2	5	9
2	8	1	7	6	9	5	4	3
5	4	9	1	2	3	6	7	8
3	6	7	4	8	5	9	2	1
6	9	2	1	5	4	8	3	7
1	7	8	3	9	6	4	5	2
4	3	5	9	7	8	1	6	9

8/26

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UNIVERSAL Sudoku Puzzle

Complete the grid so that every row, column and 3x3 box contains every digit from 1 to 9 inclusively.

2	6						3	4
	9		6	2		8	7	
	3		4			2		
	2		5			7		
				1				
		5			7		8	
		2			6		1	
	8	3		9	5		2	
4	1						5	9

8/26

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DIFFICULTY RATING: ★☆☆☆☆

Los Angeles Times Daily Crossword Puzzle

Edited by Rich Norris and Joyce Nichols Lewis

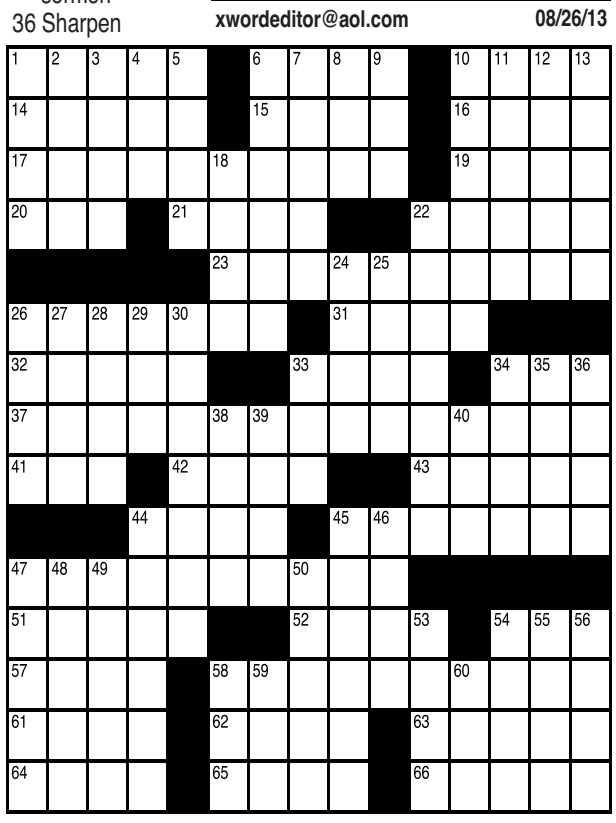
ACROSS
1 "Pay attention!"
6 Taj Mahal city
10 __ of Arc
14 Tokyo automaker with a liar named Joe in its old ads
15 Forehead
16 Neutral shade
17 Home country
19 Amble
20 Add blonde highlights to, say
21 Whole bunch
22 Free-for-all
23 Out of touch with reality
26 Musical with nightclub scenes
31 Men of the future?
32 Take to the soapbox
33 Disco brothers' name
34 Church seat
37 Get one's head out of the clouds
41 Tooth tender's org.
42 Trim, as a photo
43 Any one of New England's six
44 Fly alone
45 So far
47 Strike it rich
51 Stave off
52 March Madness org.
54 Performing pair
57 Missing
58 Position of moral superiority
61 Bear in the sky
62 Clarinet cousin
63 "Rubber Duckie" Muppet
64 Checked out
65 911 responders: Abbr.
66 Helps, as a perp

DOWN
1 Discover
2 Anthem start
3 Just darling
4 Israeli weapon
5 Honda Pilot and Ford Explorer, briefly
6 Not there
7 Watchdog's warning
8 "Vive le __!"
9 Piercing tool
10 Tiara sparklers
11 Central Florida city
12 Specter formerly of the Senate
13 Microwaved
18 "Night" author Wiesel
22 "It's possible"
24 Slightly
25 Gray wolf
26 __-Cola
27 Longtime infield partner of Jeter, familiarly
28 Ole Miss rival
29 Downed
30 Minuteman enemy
33 Econ. yardstick
34 Seek guidance in a 34-Across
35 Suffix with sermon
36 Sharpen
38 Air France destination
39 Lumber
40 DOJ division
44 Butter or mayo
45 McDonald's golden symbol
46 Without a date
47 World Court site, with "The"
48 Old white-key material
49 Anxious
50 Gold bar
53 Geometry calculation
54 Sandy slope
55 Military squad
56 Keats works
58 Whack weeds the old-fashioned way
59 "Big Blue"
60 Sphere

ANSWER TO PREVIOUS PUZZLE:

S	Q	U	E	A	K	T	O	Y		A	S	S	A	D
O	U	T	S	M	A	R	T	S		L	I	E	T	O
D	I	E	S	E	L	O	I	L		S	Z	E	L	L
A	P	P		N	I	T	S		H	A	Z	M	A	T
			F	I	N	S		W	I	T	L	E	S	S
E	C	A	R	T	E		J	A	N	I	E			
D	A	V	E	Y		J	U	X	T	A	P	O	S	E
A	L	O	E		G	E	N	E	S		L	O	A	D
M	I	N	T	M	A	R	K	S		S	A	R	G	E
			H	A	N	K	Y		M	I	T	T	E	N
S	T	R	I	N	G	Y		W	A	L	E			
T	H	O	N	G	S		R	O	L	E		T	O	G
R	O	Y	K	O		L	E	M	O	N	L	I	M	E
E	M	C	E	E		I	D	E	N	T	I	K	I	T
P	E	E	R	S		Z	O	N	E	B	L	I	T	Z

xwordeditor@aol.com 08/26/13



By Billie Truitt
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08/26/13

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, February 28, 2014 11:58 AM
To: Greer, Leslie
Cc: Roberts, Karen; Huber, Jack; Martone, Kim; Hansted, Kevin; Riggott, Kaila
Subject: FW: Docket Number 13-31832-CON
Attachments: WCHN NHSC Documents for OHCA.ZIP; OHCA Letter Order Number Two 2 28 2014.pdf

Leslie,

Please place in the appropriate record.

Thank you,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Herlihy, Sally [mailto:Sally.Herlihy@wchn.org]
Sent: Friday, February 28, 2014 8:07 AM
To: Lazarus, Steven
Cc: Jeryl.Topalian@Norwalkhealth.org
Subject: Docket Number 13-31832-CON

Hi Steven,

Please find attached correspondence related to Order Number Two of the corporate affiliation between WCHN/NHSC and the request for Closing documents. This email will be followed up with a copy of the materials sent via Federal Express to the OHCA office. If you have any questions please do not hesitate to contact me.

Sincerely,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

Executive Assistant: Michelle Johnson
Voice: (203) 739-4935
Email: michelle.johnson@wchn.org

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WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

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Office of
HEALTHCARE ACCESS

February 28, 2014

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone:

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Heath Services Corporation - Order Number Two requests that within sixty (60) days of the closing date, the Applicants shall file with OHCA a complete, non-redacted copy of any and all signed, dated and completed final affiliation agreement documents, including attachments to be entered as part of the permanent record.

Please find enclosed the following:

- Attachment I – Closing Memorandum
- Attachment II – Executed Affiliation Agreement

Should you have any questions please do not hesitate to contact me directly at 203-794-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally. F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

cc: Lisa Brady, SVP Strategy & Market Development
Carolyn McKenna, Esq. General Counsel

AFFILIATION AGREEMENT BY AND BETWEEN NORWALK HEALTH SERVICES CORPORATION AND WESTERN CONNECTICUT HEALTH NETWORK, INC.

This Affiliation Agreement (the "Agreement") is entered into as of this 22nd day of January, 2013 between Norwalk Health Services Corporation, a Connecticut nonprofit corporation ("NHSC") and Western Connecticut Health Network, Inc., a Connecticut nonprofit corporation ("WCHN"). Each of NHSC and WCHN 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 9.

WHEREAS, by entering into the proposed affiliation described in this Agreement (the "Affiliation"), the Parties intend to create an integrated health care delivery system (the "System") capable of bringing best practices in health care delivery to enhance the health and well-being of residents within the geographic areas served by the Parties;

WHEREAS, the Parties believe that the Affiliation will improve the health of the communities served by WCHN and NHSC by delivering coordinated, effective care;

WHEREAS, NHSC controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, The Norwalk Hospital Association ("NHA") and Norwalk Hospital Foundation, Inc. ("NHSCF") and other subsidiaries and affiliates listed on Schedule 1(a) (collectively, NHA, NHSCF and such other subsidiaries and affiliates of NHSC may be referred to herein as the "NHSC Affiliates" and the NHSC Affiliates, with NHSC, may be referred to herein as the "NHSC Entities");

WHEREAS, NHA owns and operates Norwalk Hospital;

WHEREAS, WCHN controls, either directly or indirectly, certain subsidiaries and affiliates, including, without limitation, The Danbury Hospital ("Danbury Hospital"), New Milford Hospital, Inc. ("New Milford Hospital"), Western Connecticut Home Care, Inc. and other subsidiaries and affiliates listed on Schedule 1(b) (collectively, Danbury Hospital, New Milford Hospital, Western Connecticut Home Care, Inc. and such other subsidiaries and affiliates of WCHN may be referred to herein as the "WCHN Affiliates" and the WCHN Affiliates, with WCHN, may be referred to herein as the "WCHN Entities" or the "WCHN System"); and

WHEREAS, on April 3, 2012, WCHN and NHSC executed a Letter of Intent for Corporate Affiliation (the "Letter of Intent") confirming their understanding with respect to a proposed affiliation and a Summary of Terms dated September 18, 2012 (the "Summary of Terms"), superseding the Letter of Intent in its entirety except with respect to Sections 5, 6 and 7 (the Letter of Intent and the Summary of Terms collectively referred to herein as the "Letter of Intent");

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.

(a) WCHN Actions. Prior to the execution of this Agreement, the board of directors of WCHN (the "WCHN Board") will have 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 4, an Amended and Restated Certificate of Incorporation of WCHN substantially in the form set forth in Exhibit A-1 and the Amended and Restated Bylaws of WCHN substantially in the form set forth in Exhibit B-1 (the "WCHN Restated Governing Documents"). At or prior to Closing, WCHN will cause Danbury Hospital and New Milford Hospital to amend and restate their governing documents to make them consistent with the terms of the Affiliation, in forms mutually agreeable to the Parties (such amended and restated governing documents may be referred to herein as the "Danbury and New Milford Restated Governing Documents").

(b) NHSC Actions. Prior to the execution of this Agreement, the board of trustees of NHSC (the "NHSC Board") will have 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 4, an Amended and Restated Certificate of Incorporation of NHSC substantially in the form set forth in Exhibit A-2 and Amended and Restated Bylaws of NHSC substantially in the form set forth in Exhibit B-2 (the "NHSC Restated Governing Documents"). At or prior to Closing, NHSC will cause all NHSC Affiliates to amend and restate their governing documents to make them consistent with the terms of the Affiliation, in forms mutually agreeable to the Parties (such amended and restated governing documents may be referred to herein as the "NHSC Affiliates Restated Governing Documents").

(c) NHA Actions. Prior to the execution of this Agreement, the board of trustees of NHA (the "NHA Board") and, to the extent required, the NHSC Board will have taken all necessary actions to approve and adopt, effective as of the Effective Date, an Amended and Restated Certificate of Incorporation of NHA substantially in the form set forth in Exhibit A-3 and Amended and Restated Bylaws of NHA substantially in the form set forth in Exhibit B-3 (the "NHA Restated Governing Documents").

(d) Organizational Charts. Attached as Exhibit C are schematics showing the relevant pre-Closing and post-Closing organizational structure of the Affiliation.

1.2 Closing Memorandum. Upon satisfaction or waiver of all of the conditions precedent set forth in Section 4 and unless this Agreement is earlier terminated pursuant to Section 5, the respective Presidents of WCHN and NHSC will execute a written memorandum (the "Closing Memorandum") which will 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, that the Closing will occur on such date ("Closing Date") and setting forth certain other matters as specified herein. The Closing will occur at Norwalk Hospital at 34 Maple Street Norwalk, Connecticut. 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").

2. **Initial Governance Structure**. Beginning at the Closing Date and ending upon the occurrence of one of the events set forth in Section 2.1(g) (the "Initial Period"), the governance structure of the Affiliation ("Initial Governance Structure") will be as follows, and as set forth in the WCHN Restated Governing Documents, NHSC Restated Governing Documents, NHA Restated Governing Documents, Danbury and New Milford Restated Governing Documents and the NHSC Affiliates Restated Governing Documents:

2.1 WCHN Board.

(a) WCHN Board Size. The WCHN Board will have eighteen (18) directors.

(b) WCHN Board Composition. At the Closing Date, the WCHN Board will include seven (7) voting members who were members of the NHSC Board immediately prior to the Closing Date (the "Initial NHSC Designees") and the remaining eleven (11) WCHN Board members will be individuals who served as members of the WCHN Board immediately prior to the Closing Date (the "Initial WCHN Designees"). Prior to the Closing Date, the Parties will mutually agree upon the individuals who will serve as the Initial NHSC Designees and Initial WCHN Designees (the "Initial WCHN Directors") and shall submit the names of such individuals to the members of WCHN for election of such slate of directors effective as of the Closing Date.

(i) The Initial WCHN Directors will serve for staggered terms as set forth in Section 3.3 of the Amended and Restated Bylaws of WCHN and as mutually agreed by the Parties prior to the Closing Date. The Initial WCHN Directors shall be subject to the term limits set forth in Section 3.4 of the Amended and Restated Bylaws of WCHN and as mutually agreed by the Parties prior to the Closing Date.

(ii) During the Initial Period, in the event of a vacancy among the Initial NHSC Designees or the Initial WCHN Designees, such vacancy will be filled by majority vote of the NHA Board (with respect to the Initial NHSC Designees) or the boards of directors of Danbury Hospital and New Milford Hospital (the "WCHN Hospital Boards") (with respect to the Initial WCHN Designees), subject in each case to approval by WCHN. In the event WCHN declines to elect any candidate, the NHA Board or WCHN Hospital Boards, as applicable, will designate one (1) or more new candidates until agreement is reached, provided, however, that if the Board declines to elect two (2) candidates proposed to fill the same vacancy, the Board may only decline to elect the third candidate proposed if the Board declines such candidate based on a Super-majority Vote (as defined below). The individuals serving as Initial WCHN Designees (together with such changes as may be made pursuant to this Section 2.1(b)(ii) with respect to vacancies) are referred to herein as the "WCHN Designees." The individuals serving as Initial NHSC Designees (together with such changes as may be made pursuant to this Section 2.1(b)(ii) with respect to vacancies) are referred to herein as the "NHSC Designees."

(iii) Two (2) years after the Closing Date, the Governance Committee of WCHN will review the governance structure of WCHN and its affiliates, including consideration of whether WCHN should remain a membership corporation, and make such recommendations as may be appropriate.

(c) WCHN Board Officers. Prior to the Closing Date, the Parties shall mutually agree on the officers of the WCHN Board to be effective as of the Closing Date. For the period beginning on the Closing Date and ending on the third annual meeting of the WCHN Board after the Closing Date (the "Third Annual Meeting"), the WCHN Board Chair will be an NHSC Designee elected by the WCHN Board and the WCHN Board Vice-Chair will be a WCHN Designee elected by the WCHN Board. For the following two-year term after the Third Annual Meeting date, the WCHN Board Chair will be a WCHN Designee elected by the WCHN Board and the WCHN Board Vice-Chair will be an NHSC Designee elected by the WCHN Board.

(d) Committees. During the Initial Period, any NHSC Board member serving on the NHSC Board immediately prior to the Closing Date who is not an Initial NHSC Designee to the WCHN Board will be provided an opportunity to serve on a WCHN Board committee or on the board of a WCHN Entity, and all such individuals will be eligible to become members of WCHN. To the extent permitted by applicable law, the same individuals will serve on board committees of WCHN, NHA, Danbury Hospital and New Milford Hospital; provided, however, that the medical staff, nominating and budget and finance committees will be maintained at the local level. The Parties agree to be equitable with respect to the distribution of committee membership and chairmanships. Committee assignments and chairmanships will be set forth on a schedule to the Closing Memorandum.

(e) Danbury Hospital and New Milford Hospital. At the Closing Date, the WCHN Hospital Boards will be comprised of those individuals serving as the Initial WCHN Designees. At any time prior to or after the Closing Date, Danbury Hospital and New Milford Hospital may merge and hold one hospital license.

(f) Major WCHN Board Actions. As sole corporate member of NHSC, WCHN will have certain powers as set forth in the NHSC Restated Governing Documents and as set forth in the NHA Restated Governing Documents. In addition, during the Initial Period, certain WCHN Board actions (whether an affirmative power of the WCHN Board or a "Reserved Power" with respect to NHSC, as defined in the WCHN Restated Governing Documents and NHSC Restated Governing Documents) will require a super-majority vote of the WCHN Board, defined for this purpose as the affirmative votes of two-thirds of all of the WCHN Board members then serving (a "Super-majority Vote"). Thus, assuming eighteen (18) directors are currently serving, the vote of at least twelve (12) of the eighteen (18) directors (which would include at least one of the NHSC Designees) shall be required to satisfy the requirement for a Super-majority Vote. In the event of any vacancy of the NHSC Designees during the Initial Period, a Super-majority Vote will be deemed to require the affirmative vote of at least one of the NHSC Designees.

(g) Conclusion of the Initial Period. The Initial Governance Structure will continue in effect unless and until changed following the occurrence of any one of the following events:

(i) at any time (whether occurring prior to or after the two-year Governance Committee review set forth in Section 2.1(b)(iii)), the WCHN Board approves a different governance structure by a Super-majority Vote;

(ii) if WCHN becomes the sole member, sole shareholder or acquires substantially all of the assets, of an additional acute care hospital, and the WCHN Board approves a different governance structure by a simple majority vote; provided however, that prior to the earlier of (x) the fourth anniversary of the Closing Date, or (y) action taken pursuant to clause (i) above, the WCHN Board must approve a different governance structure by a Super-majority Vote; or

(iii) at any time after the date that is five (5) years after the Closing Date, twenty percent (20%) or more of the WCHN Board is comprised of directors who are "Independent" and the WCHN Board approves a new governance structure by majority vote. For purposes of this Section, an "Independent" director means any individual other than the following: (x) any current or former employee of any of the WCHN Entities or NHSC Entities and any immediate family members of such an employee; (y) any individual who served on the board of directors of NHA, Danbury Hospital or New Milford Hospital prior to or after the Closing Date and any immediate family member of such individual; provided, however, a director who is first

elected after the Closing to the board of directors of NHA, Danbury Hospital or New Milford Hospital and to the WCHN Board shall be considered Independent; and (z) any individual who is a member of the medical staff of Danbury Hospital, New Milford Hospital or NHA and any immediate family member of such individuals; provided, however, a director who is a member of the medical staffs of both (A) NHA and (B) Danbury Hospital and/or New Milford Hospital shall be considered Independent.

(iv) NHSC Board. Except as expressly provided herein, the following provisions apply effective as of the Closing Date and shall continue through the Initial Period:

(h) WCHN as the Sole Member. Until modified in accordance with Section 6.7, WCHN will be the sole corporate member of NHSC and NHSC will continue as the sole corporate member of NHA.

(i) NHSC Board Composition. The NHSC Board will be initially comprised of the individuals serving in such capacity immediately prior to the Closing Date and shall include all of the NHSC Designees and thereafter will be comprised of individuals elected in accordance with the NHSC Restated Governing Documents. In addition, the WCHN President and Chief Executive Officer and at least one additional WCHN Designee will also become members of the NHSC Board commencing as of the Closing Date. The NHSC/NHA President and Chief Executive Officer and the NHSCF President and Chief Executive Officer will be *ex-officio* voting members of the NHSC Board. After the Closing, the NHSC Board will be elected by WCHN in accordance with the NHSC Restated Governing Documents.

(j) NHSC Board Powers. The NHSC Board, acting for NHSC as the sole corporate member of NHA, also shall have the powers set forth in the NHA Restated Governing Documents, subject to the Reserved Powers and compliance with WCHN System policies as set forth in Section 6.4(a). The NHSC Board will have all of the powers and authority granted to a board under the Act subject only to the Reserved Powers granted to its sole member, WCHN, pursuant to the NHSC Restated Governing Documents and WCHN System Policies as set forth in Section 6.4(a).

(k) Reserved Powers. Certain decisions, which will initially be made by the NHSC Board, shall be subject to approval by WCHN (the "Reserved Powers") as set forth in the NHSC Restated Governing Documents.

2.2 NHA Board. Except as expressly provided herein, the following provisions apply effective as of the Closing Date and shall continue through the Initial Period:

(a) NHSC as the Sole Member. Until modified in accordance with Section 6.7, NHSC will continue as the sole corporate member of NHA.

WCHN will exercise "reach through" rights, such that any NHA actions requiring member approval under the NHA Restated Governing Documents shall not be deemed approved until such time as NHA receives approval from both NHSC and WCHN, as the sole corporate member of NHSC.

(b) NHA Board Composition. The NHA Board will initially be comprised of the members of the NHSC Board in office immediately prior to the Closing Date. The NHSC/NHA President and Chief Executive Officer and the NHSCF President and Chief Executive Officer will be members of the NHA Board.

3. **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:

3.1 Commercially Reasonable, Good Faith Efforts. Each Party will 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 4 to be satisfied.

3.2 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 Material Transaction (without the approval of the other Party). Neither the WCHN Entities nor the NHSC Entities will amend or permit to be amended the certificates of incorporation or the bylaws of any of such entities, other than as described in Section 4.1.

3.3 Conduct of Business. Each Party will 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.

(a) Without limiting the generality of the foregoing, no NHSC Entity will take any of the following actions without the prior written consent of WCHN, which will 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. Without the prior approval of WCHN, the NHSC Entities will not transfer assets to any entity other than the NHSC Entities that is not in the usual, regular and ordinary course of business as set forth in the NHSC Entities' fiscal year 2013 capital and operating budgets and consistent with past practice.

(b) Without limiting the generality of the foregoing, no WCHN Entity will take any of the following actions without the prior written consent of NHSC, which will 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. Without the prior approval of NHSC, the WCHN Entities will not transfer assets to any entity other than the WCHN Entities that is not in the usual, regular and ordinary course of business as set forth in the WCHN Entities' fiscal year 2013 capital and operating budgets and consistent with past practice.

3.4 Public Statements. Except as may be required by applicable laws or as otherwise contemplated herein, none of the WCHN Entities or NHSC 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 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.

3.5 Communications with Government Officials. Unless the Parties otherwise agree in writing after the execution of this Agreement, the Parties will communicate jointly with government officials with respect to the Affiliation and will work together to develop a plan for coordinated communications by the Parties and by other WCHN Entities and other NHSC Entities. From the 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 WCHN Entities or the NHSC Entities will, 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, the WCHN Entities and the NHSC Entities will 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.

3.6 Additional Diligence Information. Pursuant to the Letter of Intent, WCHN and NHSC furnished each other with certain requested information in order to permit each of the Parties to perform a due diligence analysis of the Affiliation (the "Due Diligence Information"). From the date of this Agreement through the Effective Date, (i) each Party will disclose to the other Party any information known to the disclosing 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) NHSC will provide to WCHN, on a monthly basis, a financial information packet on the financial condition of the NHSC Entities in the same form provided to the NHSC Board and WCHN will provide to NHSC, on a monthly basis, a financial information packet on the financial condition of the WCHN Entities in the same form provided to the WCHN Board; (iii) NHSC will provide to WCHN a copy of each Medicare cost report filed by a NHSC Entity after the date hereof within five (5) days of such filing and WCHN will provide to NHSC a copy of each Medicare cost report filed by a WCHN Entity after

the date hereof within five (5) days of such filing; and (iv) NHSC will provide to WCHN and WCHN will provide to NHSC 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.

4. **Conditions Precedent**. The Affiliation will not occur until each of the following conditions is satisfied or waived by the Party it is intended to benefit:

4.1 Organizational Documents.

(a) WCHN. The WCHN Board (and if necessary, the members of WCHN) will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the WCHN Restated Governing Documents and caused Danbury Hospital and New Milford Hospital to approve and adopt the Danbury and New Milford Restated Governing Documents.

(b) NHSC. The NHSC Board will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the NHSC Restated Governing Documents and caused the NHSC Affiliates to approve and adopt the NHSC Affiliates Restated Governing Documents.

(c) NHA. The NHA Board (and, if necessary, NHSC) will have taken all additional action (if any) necessary to approve and adopt, conditional on and effective as of the Effective Date, the NHA Restated Governing Documents.

4.2 Hart-Scott-Rodino. The applicable waiting period under the Hart-Scott-Rodino Act amendments to the Antitrust Improvement Act will 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 will have been resolved to the reasonable satisfaction of each of WCHN and NHSC.

4.3 Attorney General. The Attorney General of the State of Connecticut (the "Attorney General") will not have challenged the implementation of the Affiliation, or if the Attorney General initiates a challenge, the matter will have been resolved to the reasonable satisfaction of each of WCHN and NHSC.

4.4 Government Approvals and Filings. Each Party will have made the necessary filings with governmental or regulatory authorities and will have received the governmental permits, licenses, or other approvals in each case described on Schedule 4.4 (other than filings described on Schedule 4.4 as post-Closing filings), which will not be subject to any conditions, limitations or other terms not reasonably acceptable to the Parties.

4.5 Non-Governmental Consents. Each Party will have obtained and delivered to the other Party the consents from non-governmental third parties described on Schedule 4.5, which will not be subject to any conditions, limitations or other terms that would result or be reasonably likely to result in a NHSC Material Adverse Effect or WCHN Material Adverse Effect.

4.6 No Investigation or Enforcement Action. The implementation of the Affiliation will 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 will not be implemented without the agreement of each of WCHN and NHSC.

4.7 Compliance with Interim Covenants. Each Party will have determined in its sole discretion that the other Party has complied with the terms of Section 3.

4.8 No Material Adverse Effect. Unless waived by NHSC, between the date of this Agreement and the Closing Date, a WCHN Material Adverse Effect will not have occurred. Unless waived by WCHN, between the date of this Agreement and the Closing Date, an NHSC Material Adverse Effect will not have occurred.

4.9 Representations and Warranties. Unless waived by NHSC, all representations and warranties made by WCHN in Section 7 will be true, accurate, and complete in all material respects as of the Closing Date. Unless waived by WCHN, all representations and warranties made by NHSC in Section 7 will be true, accurate, and complete in all material respects as of the Closing Date.

4.10 Employment Agreement. The individual serving as the President and Chief Executive Officer of NHSC/NHA on the Closing Date shall have entered into an employment agreement with WCHN which satisfies the requirements of Section 6.2 hereof (the "Executive VP Employment Agreement").

4.11 WCHN Member Approval. The members of WCHN shall have approved the Initial NHSC Designees and Initial WCHN Designees.

4.12 Revisions to Restated Governing Documents. The Parties shall cause the WCHN Restated Governing Documents, the NHA Restated Governing Documents and the NHSC Restated Governing Documents to be revised substantially as described in Schedule 4.12 attached hereto and made a part hereof.

5. **Termination Of Agreement**.

5.1 Term. This Agreement will 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 September 30, 2013 absent mutual written consent by the Parties to extend the term. The term of the Agreement shall be perpetual unless terminated as provided herein.

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

5.3 Termination by Material Adverse Event. This Agreement shall terminate on ten (10) days' prior written notice from WCHN or NHSC respectively in the event that an NHSC Material Adverse Event occurs that is not waived by WCHN or a WCHN Material Adverse Event occurs that is not waived by NHSC.

5.4 Survival. In the event of termination pursuant to Section 5.1, Section 5.2 or Section 5.3, all rights and obligations under the Agreement will cease and the terms and provisions of the Agreement will have no further effect, except that Section 3.4 [Public Statements] and Section 8.4 [Confidentiality] will 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 2 [Initial Governance Structure], Section 6 [Post-Closing Covenants] and Section 8 [Miscellaneous] will survive beyond the Closing Date. Protections provided under the Mutual Confidentiality Agreement by and between NHSC and WCHN dated as of September 16, 2011 with respect to communications and all information exchanged during the term of such Mutual Confidentiality Agreement will survive the termination of this Agreement.

6. **Post-Closing Covenants**. From and after the Closing Date, the Parties will take the following actions and observe the following covenants:

6.1 Oversight of Business. Immediately following the Closing Date, WCHN and NHSC will each retain full power and authority to oversee such Party's business; provided, however, that the authority to oversee the business of the NHSC Entities will be subject to the Reserved Powers of WCHN and further provided that each Party shall have the obligations, duties and requirements applicable to such Party after the Closing Date as set forth in this Agreement.

6.2 Management. Immediately following the Closing Date, the individual serving as President and Chief Executive Officer of WCHN on the Closing Date will remain the President and Chief Executive Officer of WCHN. Immediately following the Closing, the individual serving as President and Chief Executive Officer of NHA/NHSC on the Closing Date will be employed by WCHN as the Executive Vice President of WCHN, will report to the President and Chief Executive Officer of WCHN, and will continue to serve as the President and Chief Executive Officer of NHSC and NHA. After the first anniversary of the Closing Date, the individual then serving as the Executive Vice President of WCHN and President and Chief Executive Officer of NHSC and NHA shall serve at the pleasure of the President and Chief Executive Officer of WCHN subject to the terms of the Executive VP Employment Agreement; provided, however, that the NHA Board shall have input into the selection of such individual, who shall be under the direction of the President and Chief Executive Officer of WCHN.

6.3 Executive Compensation. The WCHN Board Executive Compensation Committee, or such other committee as may be appointed by the WCHN Board, will review and establish executive compensation in accordance with applicable law.

6.4 Operation of NHSC Affiliates.

(a) Operation in Accordance with WCHN Policies. Subject to the provisions of this Agreement, the NHSC Restated Governing Documents, applicable law, and any terms and conditions of loan agreements, trust indentures, and any binding third party agreements existing prior to the Closing Date, the NHSC Entities will operate in accordance with the rights, obligations, duties, and requirements applicable to all WCHN Entities, as such rights, obligations, duties and requirements are from time to time established by WCHN, and applied from time to time to all WCHN Entities. Prior to the Closing Date, WCHN and NHSC shall agree on a schedule of policies, procedures and practices that will be binding on all parties ("System Policies") and other policies that may be maintained by any one or more of the Hospitals with such changes as may be adopted from time to time, and as are not inconsistent with the governance rights expressly set forth in the NHSC Restated Governing Documents and any new policies required by law or accrediting standards. It is understood that in the event any contract entered into by any of the WCHN Entities or the NHSC Entities after the Closing Date is in compliance with System Policies, but a subsequent change in System Policies is in conflict with such contract, the WCHN Entities or the NHSC Entities, as applicable, shall take commercially reasonable steps to unwind such non-compliant contract as soon as practicable. WCHN will have, in its sole discretion, the right to change or alter at any time the System Policies as applied to all WCHN Entities and NHSC Entities; provided that no System Policies adopted after the Closing Date that apply to any NHSC Entities shall be inconsistent with the governance rights expressly set forth in this Agreement and the NHSC Restated Governing Documents (unless required by law or accreditation standards).

(b) Medicare Form 855A. After the Closing Date, each NHSC Affiliate which is a participating provider in Medicare or Medicaid will submit a Form 855A change of information filing to its fiscal intermediary within the time frame required under applicable laws and regulations.

(c) NHSC Employees. To the extent permitted by any applicable collective bargaining agreement, each employee of an NHSC Entity or WCHN Entity as of the Closing Date who becomes an employee of WCHN or any WCHN affiliate, in the case of a NHSC employee, or NHSC or any NHSC Entity, in the case of a WCHN employee, after the Closing Date will receive full recognition and credit for pre-Closing length of employment with any NHSC Entity, in the case of a WCHN employee, or WCHN Entity, in the case of an NHSC employee, including for purposes of seniority recognition, benefits eligibility and vesting of benefits.

(d) Medical Staff. The Affiliation will not impact or change the medical staff appointment or clinical privileges of members of the medical staffs of Norwalk Hospital, Danbury Hospital or New Milford Hospital (each a "Hospital") as existing on the Closing Date. The Parties do not expect that execution of the Agreement will have any effect on the independent status of the medical staffs of any of the Hospitals. WCHN will work with the medical staffs of each Hospital 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.

6.5 Access to WCHN Insurance Programs. The NHSC Entities will have access to insurance programs offered by WCHN's insurance plans, subject to such entities' 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 such entities' eligibility for and acceptance by those programs.

6.6 Obligated Group. As early as practicable after the Closing Date, the Parties will form a single obligated group.

6.7 NHSC Entities. WCHN will establish a leadership committee comprised of representatives from WCHN and NHSC to create a process and work plan for the merger or reorganization of NHSC and the NHSC Entities. As soon as practicable but no later than one (1) year from the Closing Date, NHSC will either be merged into NHA or restructured to become a sister affiliate of NHA. Upon the merger of NHSC into NHA or the restructuring of NHSC so that NHA becomes a direct subsidiary of WCHN, the NHA Bylaws will be amended and restated. For the avoidance of doubt, the approximately $30 million of unrestricted net assets of NHSC, reflected on the balance sheet of NHSC as of the date of this Agreement, will be restricted to use for NHSC Entities purposes. The Parties anticipate that NHSCF will remain a separately organized entity under the control of NHSC or NHA; provided, however, that nothing in this Agreement shall prohibit the merger or reorganization of NHSCF into, with or under another WCHN Entity or NHSC Entity in the future. All assets of NHSCF shall always be applied consistent with donor restrictions.

7. **Representations and Warranties**.

7.1 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:

(a) Due Organization and Authority. The WCHN Entities and the NHSC Entities are corporations 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 each of the WCHN Entities and the NHSC Entities heretofore delivered to or made available for review by WCHN and NHSC are complete and correct, and no amendments thereto are pending or contemplated, other than as described in Section 1.1.

(b) 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 NHSC 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 A-3, Exhibit B-1, Exhibit B-2 and Exhibit B-3. No other corporate proceedings on the part of either WCHN or the NHSC 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 A-3, Exhibit B-1, Exhibit B-2 and Exhibit B-3. 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.

(c) Audited Financial Statements. WCHN has provided NHSC with the audited balance sheets and related statements of income and statements of cash flow of the WCHN Entities for the fiscal years ended September 30, 2009, 2010 and 2011, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of WCHN. NHSC has provided WCHN with the audited balance sheets and related statements of income and statements of cash flow of the NHSC Entities for the fiscal years ended September 30, 2009, 2010 and 2011, including the notes thereto, together with the most recent unaudited balance sheets and related statements of income and statements of cash flow of the NHSC 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 the WCHN Entities or the NHSC Entities, as the case may be, (ii) fairly present the financial condition and results of operations and cash flows for the WCHN Entities or the NHSC 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). None of the WCHN Entities nor any of the NHSC 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 the WCHN Entities or the NHSC 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.

(d) 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 any WCHN Entity or any NHSC Entity; (ii) result in acceleration in the time for performance of any obligation of any WCHN Entity or any NHSC Entity under any contractual obligation; (iii) result in the creation of any lien upon any asset of any WCHN Entity or any NHSC Entity; (iv) require any notice, consent, waiver or amendment to any contractual obligation; (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 WCHN Material Adverse Effect or a NHSC 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 4.4, 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 WCHN Material Adverse Effect or NHSC Material Adverse Effect, as the case may be, individually or in the aggregate, is required to be made or obtained by a WCHN Entity or a NHSC Entity, in connection with the execution, delivery or performance of this Agreement by a WCHN Entity or a NHSC Entity.

(e) Due Diligence. Each of the Parties has made due inquiry of all matters described in this Section 7 and has fully and completely disclosed to the other Party in Due Diligence Information all information relevant to such Party's representations in this Section 7.

7.2 Additional Representations and Warranties by WCHN. As a condition to NHSC's entry into this Agreement, WCHN as to itself and as to each of the WCHN Entities further

represents and warrants to NHSC that the statements set forth in this section are true and correct as of the date hereof:

(a) Legal Proceedings. Except as disclosed in Due Diligence Information:

(i) there is no potentially material incident report related to the operations or services of a WCHN 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 WCHN Entities, threatened against any WCHN Entity or against any WCHN Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such WCHN 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 WCHN Material Adverse Effect;

(ii) there is no litigation at law or in equity, or any proceeding before or, to the knowledge of a WCHN 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;

(iii) no WCHN 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 WCHN Material Adverse Effect, individually or in the aggregate;

(iv) 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 WCHN Entity; and

(v) the Due Diligence Information provided by WCHN 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 WCHN Entities, threatened against any WCHN Entity or against any WCHN Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such WCHN Entity.

(b) Compliance with Laws. Except as disclosed in Due Diligence Information,

(i) The business and operations of each WCHN 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 WCHN Material Adverse Effect, individually or in the aggregate.

(ii) 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 WCHN Entity is subject to any restriction of any kind or character, which may have a WCHN Material Adverse Effect on any WCHN Entity, individually or in the aggregate.

(iii) No WCHN 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 WCHN Material Adverse Effect.

(iv) The Due Diligence Information provided by WCHN contains complete and accurate information regarding (i) each WCHN 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 WCHN Entity or any of their respective properties.

(c) Insurance. Each WCHN 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 WCHN Entity as to amount and scope. No WCHN 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.

(d) Tax Exempt Status.

(i) Each WCHN Entity is an organization described in Section 501(c)(3) of 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.

(ii) Each WCHN 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 exist, to the extent necessary to support continued status as an organization described in Section 501(c)(3) of the Code.

(iii) No proceedings are pending with respect to which any WCHN 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.

(iv) No WCHN 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.

(v) The Due Diligence Information provided by WCHN 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 WCHN Entities.

(e) Titles, Leases, and Licenses. Except as disclosed in Due Diligence Information,

(i) Each WCHN 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 WCHN 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).

(ii) Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the WCHN Entities as now conducted. All such assets and properties, other than assets and properties in which the WCHN Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the WCHN Entities' Financial Statements or the footnotes thereto.

(iii) Each WCHN 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.

(iv) There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the WCHN Entities as now conducted that are licensed by the State of Connecticut Department of Public Health.

(f) Environmental Laws. Except as disclosed in Due Diligence Information,

(i) Each WCHN 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 WCHN Material Adverse Effect.

(ii) To the knowledge of the WCHN 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 WCHN Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs.

(iii) No WCHN 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, to the knowledge of the WCHN Entities, any investigation indicating that the WCHN 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.

(iv) No WCHN Entity has reason to believe that it will become subject to a matter identified in this Section 7.2(f); and no WCHN Entity has knowledge that any 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.

(v) No WCHN 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 WCHN Entity.

(g) Labor Unions and Collective Bargaining Agreements. Employees of WCHN Entities are currently represented only by the collective bargaining organizations listed on Schedule 7.2(g). Except in relation to the foregoing collective bargaining organizations, no WCHN 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 WCHN Entity, threatened with respect to any employees of any WCHN Entity.

(h) Employee Benefit Matters. Except as disclosed in Due Diligence Information,

(i) Multiemployer Plans. None of the WCHN Entities nor any other person that would be considered as a single employer with the WCHN 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.

(ii) Plan Qualification. Each employee benefit, welfare, pension or similar plans that any of the WCHN Entities sponsors or provides to its employees (each, a "WCHN Plan" and collectively, the "WCHN Plans") that is intended to be qualified under Section 401(a) of the Code is so qualified. Each WCHN 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 WCHN Plan that has subjected or reasonably could subject any of the WCHN Entities to any material penalty, excise tax or other material liability under ERISA or the Code.

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

(iv) Defined Benefit Pension Plans. In the case of each WCHN Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the WCHN 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 WCHN Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

(v) Claims. There is no pending or, to WCHN's knowledge, threatened action relating to a WCHN Plan, other than routine claims in the ordinary course of business for benefits provided for by the WCHN Plans. No WCHN 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.

(vi) Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no WCHN Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment (except for limited continued medical benefit coverage required to be provided under Section 4980B of the Code or as required by applicable state law).

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

(viii) Severance. The transactions contemplated by this Agreement will 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 WCHN Plan for the benefit of any current or former director, officer or employee of any of the WCHN Entities.

(ix) Diligence. Each of the WCHN Plans has been fully and completely described, with all applicable agreements and WCHN Plan documents, in the Due Diligence Information.

(i) Health Care Kickbacks. To the knowledge of WCHN after due inquiry, no WCHN 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.

(j) Prohibited Health Care Referrals. Except as disclosed in Due Diligence Information, to the knowledge of the WCHN Entities after due inquiry, no WCHN 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 who makes referrals to any WCHN Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. To the knowledge of the WCHN Entities after due inquiry, the Due Diligence Information provided by WCHN contains a complete and accurate list of all agreements between any of the WCHN Entities and referring physicians, physician organizations, other health care providers, and other referral sources. The Due Diligence Information provided by WCHN contains a full set of all such agreements between any of the WCHN Entities and referring physicians, physician organizations, other health care providers, and other referral sources which were requested by the NHSC Entities and their legal counsel. Except as disclosed in Due Diligence Information, to the knowledge of WCHN after due inquiry, none of the WCHN Entities has any arrangements with referring physicians, physician organizations, or other health care providers that are not memorialized in writing.

(k) Actions, Investigations, and Inquiries. Except as disclosed in Due Diligence Information,

(i) 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 WCHN 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 WCHN Material Adverse Effect or result in any material impairment to the right or ability of any WCHN Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs.

(ii) No WCHN 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.

(iii) The Due Diligence Information provided by WCHN 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 WCHN Entities, threatened, anticipated or contemplated against or affecting any WCHN 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).

(l) Permits.

(i) Each WCHN 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 WCHN Material Adverse Effect.

(ii) No WCHN Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of such Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of such Permits is pending or has been commenced or, to the knowledge of the WCHN Entities, threatened and no notification thereof has been received by any WCHN Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a WCHN Material Adverse Effect.

(iii) The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties will not limit, restrict, revoke, suspend or terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of such Permits.

(m) Medicare Cost Reports. The WCHN Entities have made available to NHSC true, correct and complete copies of their Medicare cost reports filed for the following years: 2009, 2010, and 2011. The status of all Medicare and

Medicaid cost reports of the WCHN Entities for the last two (2) cost-reporting years has been disclosed in the Due Diligence Information provided by WCHN, and there are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open such cost reports that would have a WCHN Material Adverse Effect.

7.3 Additional Representations and Warranties by NHSC. As a condition to WCHN's entry into this Agreement, NHSC as to itself and as to each of the NHSC Affiliates further represents and warrants to WCHN that the statements set forth in this section are true and correct as of the date hereof:

(a) Legal Proceedings. Except as disclosed in Due Diligence Information,

(i) There is no potentially material incident report related to the operations or services of a NHSC 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 NHSC Entities, threatened against any NHSC Entity or against any NHSC Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents or employees of such NHSC 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 NHSC Material Adverse Effect.

(ii) There is no litigation at law or in equity, or any proceeding before or, to the knowledge of a NHSC 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.

(iii) No NHSC 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 NHSC Material Adverse Effect, individually or in the aggregate.

(iv) 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 NHSC Entity.

(v) The Due Diligence Information provided by NHSC 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 NHSC Entities, threatened against any NHSC Entity or against any NHSC Entity's directors, officers, agents, or employees in their capacities as directors, officers, agents, or employees of such NHSC Entity.

(b) Compliance with Laws. Except as disclosed in Due Diligence Information,

(i) The business and operations of each NHSC 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 NHSC Material Adverse Effect, individually or in the aggregate.

(ii) 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 NHSC Entity is subject to any restriction of any kind or character, which may have a NHSC Material Adverse Effect on any NHSC Entity, individually or in the aggregate.

(iii) No NHSC 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 NHSC Material Adverse Effect.

(iv) The Due Diligence Information provided by NHSC contains complete and accurate information regarding (i) each NHSC 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 NHSC Entity or any of their respective properties.

(c) Insurance. Each NHSC 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 NHSC Entity as to amount and scope. No NHSC 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.

(d) Tax Exempt Status.

(i) Each NHSC 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.

(ii) Each NHSC 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 exist, to the extent necessary to support continued status as an organization described in Section 501(c)(3) of the Code.

(iii) No proceedings are pending with respect to which any NHSC 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.

(iv) No NHSC 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.

(v) The Due Diligence Information provided by NHSC 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 NHSC Entities.

(e) Titles, Leases, and Licenses. Except as disclosed in Due Diligence Information,

(i) Each NHSC 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 NHSC 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).

(ii) Such properties and assets include all material properties and assets used, or necessary for the conduct of, the business of the NHSC Entities as now conducted. All such assets and properties, other than assets and properties in which the NHSC Entities have leasehold interests from unrelated parties, are free and clear of all liens, except as specifically described in the NHSC Entities' Financial Statements or the footnotes thereto.

(iii) Each NHSC 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.

(iv) There are no properties, assets, or facilities used, or necessary for the conduct of, the business of the NHSC Entities as now conducted that are licensed by the State of Connecticut Department of Public Health.

(f) Environmental Laws. Except as disclosed in Due Diligence Information,

(i) Each NHSC 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 NHSC Material Adverse Effect.

(ii) To the knowledge of the NHSC 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 NHSC Entity, including on-site or off-site storage or release of a chemical substance, that may give rise to any environmental liabilities and costs.

(iii) No NHSC 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, to the knowledge of the NHSC Entities, any investigation indicating that the NHSC 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.

(iv) No NHSC Entity has reason to believe that it will become subject to a matter identified in this Section 7.3(f); and no NHSC Entity has knowledge that any 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.

(v) No NHSC 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 NHSC Entity.

(g) Labor Unions and Collective Bargaining Agreements. Employees of NHSC Entities are currently represented only by the collective bargaining organizations listed on Schedule 7.3(g). Except in relation to the foregoing collective bargaining organizations, no NHSC 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. Except as set forth in Schedule 7.3(g), there is no strike or other work stoppage currently in effect or, to the knowledge of any NHSC Entity, threatened with respect to any employees of any NHSC Entity.

(h) Employee Benefit Matters. Except as disclosed in Due Diligence Information,

(i) Multiemployer Plans. None of the NHSC Entities nor any other person that would be considered as a single employer with the NHSC 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.

(ii) Plan Qualification. Each employee benefit, welfare, pension or similar plans that any of the NHSC Entities sponsors or provides to its employees (each, a "NHSC Plan" and collectively, the "NHSC Plans") that is intended to be qualified under Section 401(a) of the Code is so qualified. Each NHSC 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 NHSC Plan that has subjected or could subject any of the NHSC Entities to any material penalty, excise tax or other liability under ERISA or the Code.

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

(iv) Defined Benefit Pension Plans. In the case of each NHSC Plan subject to Title IV of ERISA, (i) the current fair market value of the assets of the NHSC 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 NHSC Entities to liability under Sections 4062, 4063 or 4064 of ERISA.

(v) Claims. There is no pending or, to NHSC's knowledge, threatened action relating to a NHSC Plan, other than routine claims in the ordinary course of business for benefits provided for by the NHSC Plans. No NHSC 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.

(vi) Retiree Benefits. Except as required under Section 601 et seq. of ERISA, no NHSC Plan provides benefits or coverage in the nature of health, life or disability insurance following retirement or other termination of employment (except for limited continued

medical benefit coverage required to be provided under Section 4980B of the Code or as required by applicable state law).

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

(viii) Severance. The transactions contemplated by this Agreement will 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 NHSC Plan for the benefit of any current or former director, officer or employee of any of the NHSC Entities.

(ix) Diligence. Each of the NHSC Plans has been fully and completely described, with all applicable agreements and NHSC Plan documents, in the Due Diligence Information.

(i) Health Care Kickbacks. To the knowledge of NHSC after due inquiry, no NHSC 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.

(j) Prohibited Health Care Referrals. Except as disclosed in Due Diligence Information, to the knowledge of the NHSC Entities after due inquiry, no NHSC 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 who makes referrals to any NHSC Entity for "designated health services," as that term is used in the Stark Law, that fails to meet an exception to the Stark Law. To the knowledge of NHSC after due inquiry, the Due Diligence Information provided by NHSC contains a complete and accurate list of all agreements between any of the NHSC Entities and referring physicians, physician organizations, other health care providers, and other referral sources. The Due Diligence Information provided by NHSC contains a full set of all such agreements between any of the NHSC Entities and referring physicians, physician organizations, other health care providers, and other referral sources which were requested by the WCHN Entities and their legal counsel. Except as disclosed in Due Diligence Information, to the knowledge of NHSC after due inquiry none of the NHSC Entities has any arrangements with referring physicians, physician organizations, or other health care providers that are not memorialized in writing.

(k) Actions, Investigations, and Inquiries. Except as disclosed in Due Diligence Information,

(i) 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 NHSC 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 NHSC Material Adverse Effect or result in any material impairment to the right or ability of any NHSC Entity to carry on its operations, activities or business as now conducted, including participation in the Medicare and Medicaid programs.

(ii) No NHSC 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.

(iii) The Due Diligence Information provided by NHSC 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 NHSC Entities, threatened, anticipated or contemplated against or affecting any NHSC 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).

(l) Permits.

(i) Each NHSC 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 NHSC Material Adverse Effect.

(ii) No NHSC Entity has engaged in any activity which would cause the loss, limitation, restriction, revocation or suspension of any of such Permits; and no action, proceeding, claim or notification with respect to any loss, limitation, restriction, revocation or suspension of any of such Permits is pending or has been commenced or, to the knowledge of the NHSC Entities, threatened and no notification thereof has been received by any NHSC Entity, except in each case where such loss, limitation, restriction, revocation or suspension would not, alone or in the aggregate, result in a NHSC Material Adverse Effect.

(iii) The execution and delivery of this Agreement and the consummation of the Affiliation by the Parties will not limit, restrict, revoke, suspend or

terminate, or result in the limitation, loss, restriction, revocation, suspension or termination of, any of such Permits.

(m) Medicare Cost Reports. The NHSC Entities have made available to WCHN true, correct and complete copies of their Medicare cost reports filed for the following years: 2009, 2010, and 2011. There are no pending appeals, adjustments, challenges, audits, litigation, or notices of intent to reopen or open Medicare and Medicaid cost reports of the NHSC Entities for the last two (2) cost-reporting years that would have a NHSC Material Adverse Effect.

8. **Miscellaneous**.

8.1 Governing Law. This Agreement will 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).

8.2 Successors; Assignment. This Agreement will inure to the benefit of, and will 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.

8.3 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 will 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 will be held to constitute a waiver of any other or subsequent breach.

8.4 Confidentiality.

(a) 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, trustees, 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, trustees, officers, employees, agents and advisors of the receiving Party or its affiliates with such a need to know. Each Party will require all members, directors, trustees, 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 will 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.

(b) 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.

(c) Excepted Information. The obligations of a Party as recipient of Confidential Information of the other Party under this Agreement will 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.

(d) Marking Confidential Information. Each disclosing Party will 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.

(e) Return and Destruction. Should this Agreement terminate prior to the Effective Date, each Party agrees (i) that it will promptly return to the disclosing Party or, with the permission of the disclosing Party, destroy all Confidential Information obtained from the disclosing 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 8.4(e), in no event will 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.

(f) Remedies. The Parties acknowledge and agree that any breach of the obligations under this Section 8.4 will result in irreparable injury to the Party whose Confidential Information is or is to be disclosed and that the Party so injured will have the right to specific enforcement of the restrictions of this Section 8.4 as well as all rights that it may have in accordance with the provisions of Section 8.9 hereof.

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

8.6 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" will be construed to have the same meaning and effect as the word "shall"; (vi) the word "any" will mean "any and all" unless otherwise indicated by context; (vii) the word "day" will mean calendar day, and days will 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 will 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.

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

8.8 Entire Agreement. This Agreement, together with the Exhibits and Schedules attached hereto, will 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 and that certain Mutual Confidentiality Agreement dated September 16, 2011.

8.9 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) except as

expressly set forth herein, and each of the Parties further agrees that each of the Parties will 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") will 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 will 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 will be entitled to recover its reasonable costs, expenses and attorneys' fees.

8.10 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 will 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.

8.11 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 will be deemed given when actually received.

If to NHSC:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Mr. Daniel J. DeBarba, Jr., President and Chief Executive Officer
Fax: (203) 852-1553

With a copy to:

Norwalk Health Services Corporation
c/o Norwalk Hospital
34 Maple Street
Norwalk, CT 06850
Attn: Ms. Kristen Staikos, Chief Legal Officer
Fax: (203) 852-1553

If to WCHN:

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810
Attn: John M. Murphy, M.D. President and Chief Executive Officer
Fax: (203) 739-8751

With a copy to:

Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810
Attn: Carolyn McKenna, General Counsel
Fax: (203) 739-8751

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

9. DEFINITIONS.

9.1 "Act" means the Connecticut Revised Non-Stock Corporation Act.

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

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

9.4 "Alleging Party" has the meaning set forth in Section 8.9.

9.5 "Attorney General" has the meaning set forth in Section 4.3.

9.6 "Closing" has the meaning set forth in Section 1.2.

9.7 "Closing Date" has the meaning set forth in Section 1.2.

9.8 "Closing Memorandum" has the meaning set forth in Section 1.2.

9.9 "Code" has the meaning set forth in Section 7.3(d).

9.10 "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.

9.11 "Defaulting Party" has the meaning set forth in Section 8.9.

9.12 "DOJ" has the meaning set forth in Section 4.2.

9.13 "Due Diligence Information" means the information disclosed by WCHN to NHSC and the information disclosed by NHSC to WCHN in writing as part of the due diligence process or in writing pursuant to Section 3.6.

9.14 "Effective Date" has the meaning set forth in Section 1.2.

9.15 "ERISA" means Title IV of the Employee Retirement Income Security Act of 1974, as amended.

9.16 "Financial Statement" has the meaning set forth in Section 7.1(c).

9.17 "FTC" has the meaning set forth in Section 4.2.

9.18 "Initial Governance Structure" has the meaning set forth in Section 2.

9.19 "Initial Period" has the meaning set forth in Section 2.

9.20 "Initial WCHN Directors" has the meaning set forth in Section 2.1(b).

9.21 "Interim Financial Statement" has the meaning set forth in Section 7.1(c).

9.22 "Letter of Intent" has the meaning set forth in the Preamble.

9.23 "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 (i) has a term of one (1) year or greater and that requires any Party or Affiliate to make annual payments greater than One Million Dollars ($1,000,000), excluding therefrom ordinary course renewals on substantially the same terms of such agreements in effect as of the date of this Agreement; (ii) will restrict the ability of the WCHN System or the NHSC Entities or any component thereof to compete in any manner in any geographic area; (iii) that requires any Party to make any payments or disposition of assets in any year of greater than Two Million Dollars ($2,000,000); (iv) that includes an exclusive dealing, requirements, or output arrangement; or (v) that involves a payment in cash or in kind to or from any member of the governing body of any NHSC Entity or any WCHN Entity, or any immediate family member of the foregoing.

9.24 "NHA" has the meaning set forth in the Preamble.

9.25 "NHA Board" has the meaning set forth in Section 1.1(c).

9.26 "NHSC" has the meaning set forth in the Preamble.

9.27 "NHSC Board" has the meaning set forth in Section 1.1(b).

9.28 "NHSC Designee" has the meaning set forth in Section 2.1(b).

9.29 "NHSC Entities" has the meaning set forth in the Preamble.

9.30 "NHSC Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a NHSC Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to NHSC, including suspension, surrender, revocation or restriction in any manner of a NHSC 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 NHSC Entities considered as a single enterprise; or (iii) any change which would impair the ability of NHSC or any of the NHSC Entities to perform its obligations hereunder.

9.31 "NHSC Plan" has the meaning set forth in Section 7.3(h).

9.32 "Party" has the meaning set forth in the Preamble.

9.33 "Permit" has the meaning set forth in Section 7.3(l).

9.34 "Stark Law" has the meaning set forth in Section 7.3(j).

9.35 "Super-majority Vote" has the meaning set forth in Section 2.1(f).

9.36 "System Policies" has the meaning set forth in Section 6.4(a).

9.37 "WCHN" has the meaning set forth in the Preamble.

9.38 "WCHN Board" has the meaning set forth in Section 1.1(a).

9.39 "WCHN Designee" has the meaning set forth in Section 2.1(b).

9.40 "WCHN Entities" has the meaning set forth in the Preamble.

9.41 "WCHN Material Adverse Effect" means (i) any adverse circumstance or change in or effect on a WCHN Entity's business, operations, assets, liabilities, prospects or condition, financial or otherwise, which is material to WCHN, including suspension, surrender, revocation or

restriction in any manner of a WCHN 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 WCHN 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 WCHN Entities considered as a single enterprise; or (iii) any change which would impair the ability of WCHN or any of the WCHN Entities to perform its obligations hereunder.

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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

[*Name*] VICTOR LESS
[*Title*]

NORWALK HEALTH SERVICES CORPORATION

By: _____
Mr. Daniel J. DeBarba, Jr.
President and Chief Executive Officer

Witness

[*Name*]
[*Title*]

WESTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
John M. Murphy, M.D.
President and Chief Executive Officer

List of Exhibits and Schedules

EXHIBIT A-1
WCHN Amended and Restated Certificate of Incorporation

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

OF

WESTERN CONNECTICUT HEALTH NETWORK, INC.

The board of directors of Western Connecticut Health Network, Inc. hereby amends and restates its certificate of incorporation pursuant to the Connecticut Revised Nonstock Corporation Act (the "Act"). References included in this certificate to provisions of the "Internal Revenue Code" shall be deemed to refer to provisions of the Internal Revenue Code of 1986, as amended, or to any corresponding provision of future federal law.

1. **Name**. The name of the corporation is Western Connecticut Health Network, Inc. (the "Corporation").

2. **Nonprofit Corporation**. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions except as otherwise provided in this certificate of incorporation or the bylaws of the Corporation or by applicable statute.

3. **Membership**. The Corporation is a membership corporation. The following three classes of individuals serve together as the members of the Corporation (the "Members"):

(a) Life Members. All persons listed in the corporate records of The Danbury Hospital as Life Members as of the thirtieth day of March, 2001, shall be Members of the Corporation until their death or resignation.

(b) Elected Members. Elected 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 to, or who has volunteered a substantial portion of time to the Corporation, any subsidiary or division thereof, or The Danbury Hospital, the New Milford Hospital, Inc., or The Norwalk Hospital Association (collectively, the "Hospitals"), or who has shown a willingness to commit a substantial portion of his or her time to the Corporation, or any subsidiary or division thereof, or the Hospitals, is eligible to be an Elected Member; provided that current employees of the Corporation, any

subsidiary or division thereof, or of the Hospitals, are not eligible for election as Elected Members.

(c) 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 New Milford Hospital, Inc., the President of the New Milford Hospital's Medical Staff, the President of The Norwalk Hospital Association, the President of The Norwalk Hospital Association's Medical Staff, the Mayor of the City of Danbury, the Mayor of New Milford, 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 of the Corporation (the "Board") shall have the power to add from time to time additional Ex-Officio Members without, in each instance, amending this certificate of incorporation.

4. **Registered Agent**. The Corporation's registered agent is on file with the Secretary of the State and shall be R&C Service Company, with a business office located at 280 Trumbull Street, Hartford, Connecticut 06103-3597.

5. **Purposes**. Subject to the restrictions set forth in Article 9 below, 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, and shall include the following:

(A) To benefit, perform the functions of, carry out the purposes of, and uphold, promote and further the welfare, programs and activities of the Hospitals:

(i) By initiating, developing, recommending and carrying out the Hospitals' goals and priorities for new or expanded programs for the benefit of the Hospitals;

(ii) By continuously re-evaluating, maintaining and revising a master plan for the programs and facilities of the Hospitals;

(iii) By considering and recommending the acquisition of properties or the construction of facilities by or for the use of the Hospitals;

(iv) By planning for the acquisition and placement of new facilities and equipment by or for the use of the Hospitals; and

(v) By performing public relations work on behalf of the Hospitals, and soliciting and receiving subscriptions and gifts exclusively for the charitable purposes of the Hospitals.

(B) To initiate, develop, operate and maintain, for the Hospitals and for other hospitals and health care facilities, programs directed toward improving the efficiency or utilization of health care facilities and services in the State of Connecticut, and in the service areas of the Hospitals in particular, and reducing the cost of health care to the public while maintaining a high quality of such care.

(C) To initiate, develop, operate and maintain educational programs for health professionals and for the public, including programs of nursing education, continuing medical education, residency training and community health education.

(D) To initiate, develop, operate and maintain, in cooperation with the Hospitals and with other hospitals and health care facilities, programs for the delivery of health care services to persons other than hospital patients; and to further this objective, the Corporation may operate, directly or through one or more separate corporations, one or more neighborhood health centers, retirement centers, nursing homes, rehabilitation and mental health centers, industrial health facilities, health maintenance organizations, home care agencies, surgical centers and similar programs and facilities.

(E) To acquire, improve, hold and lease to the Hospitals and to other hospitals and health care facilities any real or personal property useful to the accomplishment of the purposes of the Corporation, the Hospitals or such other hospitals or health care facilities.

(F) To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of the Corporation; and generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein.

(G) To engage in any lawful act or activity for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act, including without

limitation, the making of grants to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, or any corresponding provision of future federal law to promote the purposes of the Corporation.

6. **Board of Directors**. The activities, business, property and affairs of the Corporation shall be managed by a board of not less than three directors elected by the Members, as may be further provided in the Corporation's bylaws.

7. **Rights of Members**. Members shall elect directors of the Corporation and Elected Members in accordance with the Corporation's bylaws. The Members shall have the right to vote on those amendments to this certificate of incorporation or the bylaws of the Corporation that limit, reduce, or eliminate their existing rights. Any such amendment of this certificate of incorporation shall require approval of two-thirds of the Members voting thereon, a quorum as defined in the bylaws of the Corporation being present. Any such amendment of the bylaws shall require approval of the Members in accordance with the bylaws. The Members shall also have the right to approve any dissolution, merger, or sale of assets other than in the normal course of business, of the Corporation by a vote of two-thirds of the Members voting thereon, a quorum as defined in the bylaws being present. The Members may vote on such other matters as may be presented to them from time to time by the board of directors of the Corporation, but the Members shall not have the right to vote on any matter except as specified above or as expressly specified under the Act.

8. **Limitation on Liability of Directors**. The personal liability of a director to the Corporation or its Members for monetary damages for breach of duty as a director shall be limited to the amount of compensation, if any, received by the director for serving the Corporation during the year of the violation, so long as the breach was not of a sort for which such limitation of liability is not permitted by Section 33-1026(b)(4) of the Act.

Nothing contained in this Article 8 shall be construed to deny a director of the Corporation the benefit of Section 52-557m of the General Statutes of Connecticut, or of any other limitation of liability available to such director under law. Any repeal or modification of

this Article 8 shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification.

9. **Limitations**. Notwithstanding any other provision of this certificate of incorporation:

(a) The Corporation shall at all times be organized and operated exclusively for religious, charitable, scientific, literary, educational or other purpose within the meaning of Section 501(c)(3) of the Internal Revenue Code;

(b) No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's directors, officers or other private persons, provided that the Corporation may pay reasonable compensation for services actually rendered, may reimburse reasonable expenses actually incurred by any such persons, and may make payments and distributions, to the extent reasonable and necessary, in furtherance of the purpose set forth in Article 5 above;

(c) No substantial part of the activities of the Corporation shall include carrying on propaganda or otherwise attempting to influence legislation, and the Corporation shall not participate or intervene (including by the publication or distribution of statements) in any political campaign on behalf of or in opposition to any candidate for public office; and

(d) The Corporation shall not conduct any activities, nor exercise any power, not permitted to be conducted by a corporation exempt from taxation under Section 501(a) of the Internal Revenue Code as an organization described under Section 501(c)(3) of the Internal Revenue Code, or by a corporation the contributions to which are deductible by a contributor under Section 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Internal Revenue Code.

10. **Indemnification**. The Corporation shall indemnify and advance expenses to its directors to the fullest extent permitted by law. Without limiting the foregoing, the Corporation shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Act. In addition, the Corporation may indemnify and advance expenses to officers, employees and agents of the Corporation who are not directors to the same

extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Corporation and permitted by law. The Corporation may also procure insurance providing greater indemnification as provided by law.

11. **Dissolution**. The existence of the Corporation shall be perpetual unless sooner dissolved. If the Corporation is dissolved, all of its assets remaining for distribution after payment of obligations or provision for the same shall be distributed (subject to any restrictions imposed by any applicable will, trust, deed, agreement or other document) to one or more organizations organized and operated for religious, charitable, scientific, literary, educational or other purpose set forth in Section 501(c)(3) of the Internal Revenue Code, in such proportions as the board of directors (or if the board of directors fails to act a court of competent jurisdiction) may determine.

EXHIBIT A-2
NHSC Amended and Restated Certificate of Incorporation

AMENDED AND RESTATED

CERTIFICATE OF INCORPORATION

NORWALK HEALTH SERVICES CORPORATION

The board of directors of Norwalk Health Services Corporation hereby amends and restates its certificate of incorporation pursuant to the Connecticut Revised Nonstock Corporation Act (the "Act"). References included in this certificate to provisions of the "Code" shall be deemed to refer to provisions of the Internal Revenue Code of 1986, as amended, or to any corresponding provision of future federal law.

1. The name of the Corporation is and remains NORWALK HEALTH SERVICES CORPORATION (the "Corporation").

2. 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 Code and shall include the following:

A. To benefit, perform the functions of, carry out the purposes of, and uphold, promote and further the welfare, programs and activities of The Norwalk Hospital Association (the "Hospital"), and the Corporation's other subsidiaries:

1. by initiating, developing, recommending and carrying out the goals and priorities for new or expanded programs for the benefit of the Hospital and the Corporation's other subsidiaries;

2. by continuously evaluating, reevaluating, maintaining and revising a master plan for the programs and facilities of the Hospital and the Corporation's other subsidiaries;

3. by considering and recommending the acquisition of properties or the construction of facilities by or for the use of the Hospital and the Corporation's other subsidiaries;

4. by planning for the acquisition and placement of new facilities and equipment by or for the use of the Hospital and the Corporation's other subsidiaries; and

5. by performing public relations work on behalf of the Hospital and the Corporation's other subsidiaries, and by soliciting and receiving subscriptions and gifts for the exclusively charitable purposes of the Hospital and the Corporation's other tax-exempt subsidiaries.

B. To initiate, develop, operate and maintain for the Hospital, the Corporation's other subsidiaries, and other hospitals and health care facilities, programs directed toward improving the efficiency of utilization of health care facilities and services in the State of Connecticut, and in the Southwestern Connecticut area in particular, and reducing the cost of health care to the public while maintaining a high quality of such care.

C. To initiate, develop, operate and maintain educational programs for health professionals and for the public, including programs of nursing education, continuing medical education, residency training and community health education.

D. To initiate, develop, operate and maintain, in cooperation with the Hospital, the Corporation's other subsidiaries, and other hospitals and health care facilities, programs for the delivery of health care services to persons other than hospital patients, and to further this object, to operate, directly or through one or more separate corporations, such health centers, retirement centers, nursing homes, rehabilitation centers, industrial health facilities, health maintenance organizations, surgicenters and similar programs and facilities as the Board of the Corporation shall determine.

E. To acquire, improve, hold and lease to the Hospital, the Corporation's other subsidiaries, and other hospitals and health care facilities any real or personal property useful to the accomplishment of the purposes of this Corporation, the Hospital, the Corporation's other subsidiaries, or such other hospitals or health care facilities.

F. To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of this Corporation and its subsidiaries, and generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein.

G. To engage in any lawful act or activity for which a corporation may be organized under the Act, including without limitation, the making of grants to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code, or any corresponding provision of future federal law to promote the purposes of the Corporation.

3. The Corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

4. The Corporation shall have but one member, Western Connecticut Health Network, Inc., a corporation organized under the Act (the "Member"). Subject to and in accordance with this certificate of incorporation and the bylaws of the Corporation, the Member shall have the exclusive right: (i) to amend the bylaws of the Corporation, (ii) to elect the Corporation's directors, and (iii) to appoint individuals to fill vacancies on the board of directors of the Corporation (the "Board").

5. The activities, business, property and affairs of the Corporation shall be managed by a board of not less than three directors elected by the Member, as may be further provided in the Corporation's bylaws.

6. The Corporation is organized for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under said section. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, any private individual, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services actually rendered, may reimburse reasonable expenses actually incurred by any such persons, and may make payments and distributions, to the extent reasonable and necessary, in furtherance of its purposes. No substantial part of the activities of the Corporation shall include carrying on propaganda or otherwise attempting to influence legislation, and the Corporation shall not participate or intervene (including by the publication or distribution of statements) in any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provisions of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on by any organization exempt from federal income tax under Section 501(a) and described in

Section 501(c)(3) of the Code, contributions to which are deductible under Section 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Code.

7. The personal liability of a director to the Corporation, or its Member, for monetary damages for breach of duty as a director shall be limited to the amount of compensation, if any, received by the director for serving the Corporation during the year of the violation, so long as the breach was not of a sort for which such limitation of liability is not permitted by Section 33-1026(b)(4) of the Act. Nothing contained in this Article 7 shall be construed to deny a director of the Corporation the benefit of Section 52-557m of the General Statutes of Connecticut, or of any other limitation of liability available to such director under law. Any repeal or modification of this Article 7 shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification.

8. The Corporation shall indemnify and advance expenses to its directors to the fullest extent permitted by law. Without limiting the foregoing, the Corporation shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Act. In addition, the Corporation may indemnify and advance expenses to officers, employees and agents of the Corporation who are not directors to the same extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Corporation and permitted by law. The Corporation may also procure insurance providing greater indemnification as provided by law.

9. The existence of the Corporation shall be perpetual unless sooner dissolved. If the Corporation is dissolved, all of its assets remaining for distribution after payment of

obligations or provision for the same shall be distributed (subject to any restrictions imposed by any applicable will, trust, deed, agreement or other document) to the Hospital, provided that the Hospital is at that time an organization exempt from taxation as an organization described under Section 501(c)(3) of the Code, and elects to accept such assets. If the Hospital is not so exempt, if it is not in existence at that time, or if it is unable or unwilling to accept such assets, then all of the Corporation's remaining assets shall be distributed for use restricted to purposes substantially similar to those set forth in this certificate of incorporation to one or more organizations organized and operated for religious, charitable, scientific, literary, educational or other purpose set forth in Section 501(c)(3) of the Code, in such proportions as the Board (or if the Board fails to act a court of competent jurisdiction) may determine.

EXHIBIT A-3
NHA Amended and Restated Certificate of Incorporation

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE NORWALK HOSPITAL ASSOCIATION

The board of directors of The Norwalk Hospital Association hereby amends and restates its certificate of incorporation pursuant to the Connecticut Revised Nonstock Corporation Act (the "Act"). References included in this certificate to provisions of the "Code" shall be deemed to refer to provisions of the Internal Revenue Code of 1986, as amended, or to any corresponding provision of future federal law.

ARTICLE I

The name of this Corporation is and remains THE NORWALK HOSPITAL ASSOCIATION (the "Hospital").

ARTICLE II

The specific purposes of the Hospital shall be:

(a) to establish, support, manage and furnish facilities, personnel and services to provide diagnosis, medical surgical and hospital care, extended care, outpatient care, home care and other medically related services to sick, injured or disabled persons without regard to race, color, sex or national origin;

(b) to carry on such activities related to rendering care to the sick or injured or the promotion of health which, in the opinion of the board of directors (the "Board") may be justified by the facilities, personnel, funds or other requirements that are or can be made available; and

(c) to engage in any and all activities consistent with or in furtherance of the above purposes.

ARTICLE III

The Hospital is located in the City of Norwalk, County of Fairfield, and State of Connecticut.

ARTICLE IV

The Hospital shall have but one member, Norwalk Health Services Corporation, a corporation organized under the Act (the "Member"). The Member shall have the exclusive right in accordance with this certificate of incorporation and the bylaws of the Corporation: (i) to amend the bylaws of the Corporation, (ii) to elect the Corporation's directors, and (iii) to appoint individuals to fill vacancies on the board of directors of the Corporation (the "Board").

ARTICLE V

The Hospital shall not have or issue shares of stock or pay dividends. The existence of the Hospital shall be perpetual unless sooner dissolved. If the Hospital is dissolved, all of its assets remaining for distribution after payment of obligations or provision for the same shall be distributed (subject to any restrictions imposed by any applicable will, trust, deed, agreement or other document) to the Member, provided that the Member is at that time an organization exempt from taxation as an organization described under Section 501(c)(3) of the Code, and elects to accept such assets. If the Member is not so exempt, if it is not in existence at that time, or if it is unable or unwilling to accept such assets, then all of the Hospital's remaining assets shall be distributed for use restricted to purposes substantially similar to those set forth in this certificate of incorporation to one or more organizations organized and operated for religious, charitable, scientific, literary, educational or other purpose set forth in Section 501(c)(3) of the Code, in such proportions as the Board (or if the Board fails to act a court of competent jurisdiction) may determine.

ARTICLE VI

The activities, business, property and affairs of the Hospital shall be managed by a board of not less than three directors elected by the Member, as may be further provided in the Hospital's bylaws.

ARTICLE VII

The Hospital is organized for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under said section. No part of the net earnings of the Hospital shall inure to the benefit of, or be distributable to, any private individual, except that the Hospital shall be authorized and empowered to pay reasonable compensation for services actually rendered, may reimburse reasonable expenses actually incurred by any such persons, and may make payments and distributions, to the extent reasonable and necessary, in furtherance of its purposes.

No substantial part of the activities of the Hospital shall include carrying on propaganda or otherwise attempting to influence legislation, and the Hospital shall not participate or intervene (including by the publication or distribution of statements) in any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provisions of this certificate of incorporation, the Hospital shall not carry on any other activities not permitted to be carried on by any organization exempt from federal income tax under Section 501(a) and described in Section 501(c)(3) of the Code, contributions to which are deductible under Section 170(c)(2), 2055(a)(2) or 2522(a)(2) of the Code.

ARTICLE VIII

The personal liability of a director to the Hospital, or its Member, for monetary damages for breach of duty as a director shall be limited to the amount of compensation, if any, received by the director for serving the Hospital during the year of the violation, so long as the breach was

not of a sort for which such limitation of liability is not permitted by Section 33-1026(b)(4) of the Act.

Nothing contained in this Article VIII shall be construed to deny a director of the Hospital the benefit of Section 52-557m of the General Statutes of Connecticut, or of any other limitation of liability available to such director under law. Any repeal or modification of this Article VIII shall not adversely affect any right or protection of a director of the Hospital existing at the time of such repeal or modification.

ARTICLE IX

The Hospital shall indemnify and advance expenses to its directors to the fullest extent permitted by law. Without limiting the foregoing, the Hospital shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Act. In addition, the Hospital may indemnify and advance expenses to officers, employees and agents of the Hospital who are not directors to the same extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Hospital and permitted by law. The Hospital may also procure insurance providing greater indemnification as provided by law.

EXHIBIT B-1
WCHN Amended and Restated Bylaws

AMENDED AND RESTATED

BYLAWS OF

WESTERN CONNECTICUT HEALTH NETWORK, INC.

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AMENDED AND RESTATED

BYLAWS

of

WESTERN CONNECTICUT HEALTH NETWORK, INC.

ARTICLE I. GENERAL

1.1. Purpose. These bylaws supplement certain provisions of the certificate of incorporation of Western Connecticut Health Network, Inc. (the "Corporation") and the Connecticut Revised Nonstock Corporation Act, as amended from time to time (the "Act").

1.2. Offices of Corporation. The Corporation's board of directors (the "Board") shall have the power to determine the location of the registered office, in accordance with applicable law, from time to time, and to designate the principal office of the Corporation and such additional offices as it shall determine in its discretion.

ARTICLE II. MEMBERSHIP

2.1. Membership. The Corporation is a membership corporation. The members of the Corporation (the "Members") shall have only such rights, privileges and obligations conferred upon them by the Corporation's certificate of incorporation, these bylaws and the Act. Members shall have no other rights.

2.2. Number and Manner of Appointment of Members. The Members may be elected, serve for life, or serve ex-officio, as specified in the certificate of incorporation of the Corporation. The Corporation shall at all times have not less than fifty (50) Members. The board of directors of The Norwalk Hospital Association (the "NHA Board") may recommend to the Governance Committee individuals to serve as Members. From the individuals

recommended by the NHA Board, the Governance Committee shall nominate and include on a slate for election by the Members, a number of individuals to serve as Members that is equal to the aggregate number of (a) individuals proposed for Membership who were not nominated by the NHA Board; (b) individuals serving as Life Members; and (c) individuals serving as Ex-Officio Members other than the President of The Norwalk Hospital Association and the President of The Norwalk Hospital Association Medical Staff, unless the NHA Board consents to including a lesser number of NHA Board recommended Members on the slate. At their annual meeting, or any special meeting, the Members shall approve or disapprove a slate of individuals to serve as elected Members as proposed by the Governance Committee (or such other committee of the Board as may then be charged with nominating individuals to serve as elected Members). The number of Members presented for election may vary from year to year. All elected Members so appointed shall serve for a term of one year or until the next annual meeting.

2.3. Member Vacancies. If at any time the Corporation shall have less than fifty (50) Members, the remaining Members shall elect individuals to serve as elected Members as proposed by the Governance Committee in a number sufficient to bring the total membership of the Corporation to fifty (50) or more. 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 not be filled.

2.4. Meetings of Members. The annual meeting of the Corporation's Members shall be held on such day and at such hour and place as shall be designated by the Board, and as shall be set forth in the notice of the meeting. Special meetings of the Members may be called by the Board, Chair, or President and CEO, and shall be called within fifteen (15) days after receipt of

the written request of at least 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.

At each annual meeting or any special meeting called for such purpose, the Members shall (i) elect directors and Members in accordance with these bylaws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) conduct any other business relating to the affairs of the Corporation consistent with the rights of the Members.

2.5. Notice of Member Meetings. Notice of each meeting of the Members shall be given to each Member not less than ten (10) days nor more than sixty (60) days before the date of the meeting.

2.6. Member Quorum and Voting. Fifteen (15) Members 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 Corporation's membership, unless the act of a greater number is required by law, the certificate of incorporation or these bylaws.

ARTICLE III. BOARD OF DIRECTORS

3.1. Authority. All corporate powers shall be exercised by or under the authority of, and the activities, property and affairs of the Corporation shall be managed by or under the direction of, the Board, subject to any limitations set forth in the certificate of incorporation.

3.2. Number and Composition. The Board shall consist of eighteen (18) directors. As of the Effective Date (as defined in Section 6.7 below), the Board shall be divided as follows: (i) eleven (11) directors will be individuals who were members of the Board immediately prior to the Effective Date (the "Initial DH/NMH Directors"); and (ii) seven (7) directors will be

individuals who were members of the board of directors of Norwalk Health Services Corporation ("NHSC") immediately prior to the Effective Date (the "Initial Norwalk Directors")(the Initial DH/NMH Directors and the Initial Norwalk Directors are referred to herein as the "Initial Directors"). Thereafter, the Board shall consist of (i) eleven (11) DH/NMH Directors (as defined in Section 3.3), and (ii) seven (7) Norwalk Directors (as defined in Section 3.3). The President and CEO of the Corporation shall serve as a DH/NMH Director, ex-officio, and shall be counted for purposes of quorum and shall have the right to vote. Until the date of the annual meeting of the Members held in January 2014 or, if none, the first such annual meeting held thereafter, four (4) of the DH/NMH Directors shall be members of the Community Board of New Milford Hospital, Inc. (the "Community Board Directors"). At all times the Board shall include two (2) individuals who also serve on each of the boards of directors of The Danbury Hospital and New Milford Hospital, Inc. (collectively, the "DH/NMH Boards") and the NHA Board.

3.3. Nomination, Election and Terms of Office. As of the Effective Date, the Initial DH/NMH Directors and the Initial Norwalk Directors shall be divided into three groups, so that an approximately equal number of directors have terms that expire during each year of the next three (3) years. At least annually thereafter, (i) the DH/NMH Boards collectively shall nominate individuals to succeed the eleven (11) Initial DH/NMH Directors and each of their successors (such Initial DH/NMH Directors and their successors being referred to herein collectively as "DH/NMH Directors" or individually as a "DH/NMH Director") whose terms are then expiring and (ii) the NHA Board shall nominate individuals to succeed the seven (7) Initial Norwalk Directors and each of their successors (such Initial Norwalk Directors and their successors being referred to herein collectively as "Norwalk Directors" or individually as a "Norwalk Director") whose terms are then expiring. The Board shall approve and submit to the Members, a slate of

candidates so nominated to succeed those directors whose terms are then expiring. In the event that the Board does not approve of an individual nominated to act as a DH/NMH Director or a Norwalk Director, the DH/NMH Boards or the NHA Board, as applicable, shall nominate another individual for the Board's approval until a candidate is approved: provided, however, if the Board declines to elect two (2) candidates proposed to fill the same directorship, the Board may only decline to elect the third candidate proposed if the Board declines such candidate based on a Super-majority Vote (as defined below). At their annual meeting, or any special meeting, the Members shall approve or disapprove such slate of candidates. Except for the Initial Directors, elected directors shall serve for a term of three (3) years and until their successors are elected and qualified.

3.4. Term Limit. As of the Effective Date, the Board shall set the year in which each of the Initial Directors' eligibility for reelection shall cease. Except for the Initial Directors and as provided in Section 5.1 of these bylaws, an elected director shall be eligible to serve three (3) consecutive terms on the Board and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed. A director elected to fill a vacancy in an unexpired term shall be deemed to have served one (1) three-year term for purposes of eligibility for reelection only if the director has served more than one (1) year of an unexpired term.

3.5. Vacancies. In the event of a vacancy among the DH/NMH Directors or the Norwalk Directors, such vacancy will be filled upon approval of, and election by, a majority vote of the Board with respect to a candidate nominated by the NHA Board (with respect to the Norwalk Directors) or the DH/NMH Boards (with respect to the DH/NMH Directors). In the event the Board declines to elect any candidate so proposed, the NHA Board or the DH/NMH Boards, as applicable, will designate one or more new candidates until agreement is reached,

provided, however, that if the Board declines to elect two (2) candidates proposed to fill the same vacancy, the Board may only decline to elect the third candidate proposed if the Board declines such candidate by a Super-majority Vote (as defined below).

3.6. Meetings and Notices. An annual meeting of the Board 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 shall elect or appoint, as appropriate, officers of the Corporation, and shall transact such other business relating to the affairs of the Corporation as may come before the meeting.

Regular meetings of the Board shall be held at such times as the Board shall from time to time determine. Special meetings of the Board may be called at any time by the Chair or the President and CEO, and shall be called by either of them within seven (7) days, and held within ten (10) days thereafter, after receipt of a written request of any three (3) directors. Meetings of the Board may be held within or without the State of Connecticut. No notice of regular meetings shall be required unless specifically directed by the President and CEO or the Chair. Except as otherwise provided in these bylaws, at least two (2) days' notice shall be given to each director of each special meeting of the Board, and such notice shall contain the date, time and place of such special meeting.

3.7. Quorum and Action. A majority of the directors then serving shall constitute a quorum for the transaction of business, and the act of a numerical majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the presence of or act of a greater number is specifically required by these bylaws, the Corporation's certificate of incorporation, or the Act. If a quorum shall not be present at any meeting of

directors, a majority of the directors present at such meeting may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.8. Super-Majority Voting. Certain actions undertaken by the Board shall be subject to additional voting requirements, as set forth below.

(a) The actions listed below require approval by a Super-majority Vote (as defined below), and may require approval of the Members as set forth in the Corporation's certificate of incorporation. A Super-majority Vote is defined for this purpose as the affirmative vote of two-thirds of the members of the Board then serving, provided that, in the event of any vacancy of the Norwalk Directors, the affirmative vote of at least one of the Norwalk Directors shall be required (a "Super-majority Vote"):

(i) approval of the Corporation's strategic plan;

(ii) subject to the rights of the Members as set forth in the certificate of incorporation of the Corporation, amendment of these bylaws or the Corporation's certificate of incorporation;

(iii) approval of the capital budget for the Corporation and for any affiliated entity controlled directly or indirectly by the Corporation (each an "Affiliate");

(iv) subject to the terms of any employment agreement with the Corporation, hiring or firing of the NHA/NHSC President and Chief Executive Officer; provided, however, that after the first anniversary of the Effective Date, the President/Chief Executive Officer of the Corporation shall have the unilateral authority to hire and fire the

NHA/NHSC President and Chief Executive Officer after obtaining input from the NHA Board;

(v) amendment of the bylaws of NHSC or removal of a member of the board of directors of NHSC;

(vi) amendment of the bylaws of The Danbury Hospital or the New Milford Hospital, Inc.

(b) The actions listed below (which must also be approved by the board of directors of NHSC (the "NHSC Board")) taken with respect to NHSC or by NHSC acting as a member or shareholder of any subsidiary of NHSC, including without limitation NHA (a "NHSC Subsidiary"), require a Super-majority Vote:

(i) the removal of a director of a NHSC Subsidiary;

(ii) the closure of Norwalk Hospital or the closure or material diminution of a material program at Norwalk Hospital;

(c) The actions listed below, if taken by the Corporation as the sole member or sole shareholder of any Affiliate (which must also be approved by the board of directors of the applicable Affiliate(s)) taken with respect to any Affiliate or a subsidiary for which the Affiliate acts as member or shareholder (an "Affiliate Subsidiary"), require a Super-majority Vote:

(i) Approval of all capital and operating budgets of Affiliates and Affiliate Subsidiaries;

(ii) Approval of any amendment or restatement of the (a) certificate of incorporation of Affiliates and any Affiliate Subsidiaries, and (b) bylaws

of Affiliates (other than The Danbury Hospital, New Milford Hospital, Inc. or NHSC) or of any Affiliate Subsidiary;

(iii) the sale, lease, exchange or other disposition of all or substantially all of the property or assets of the Affiliate or any Affiliate Subsidiary;

(iv) approval of the creation of any corporation of which the Affiliate or an Affiliate Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of the Affiliate or any Affiliate Subsidiary with another corporation; and the reorganization, liquidation or dissolution of the Affiliate or any Affiliate Subsidiary;

(v) approval of loans by the Affiliate or any Affiliate Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds two million dollars ($2.0 million) or which has a term longer than one year;

(vi) approval of policies relating to the control and supervision of the investment of the Affiliate's and any Affiliate Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of the Affiliate or the Affiliate Subsidiary;

(vii) approval of unbudgeted expenditures by the Affiliate or any Affiliate Subsidiary in excess of two million dollars ($2.0 million) or any increase in any previously approved annual operating or capital budget;

(viii) approval of any agreement or transaction of the Affiliate or any Affiliate Subsidiary involving an amount greater than two million dollars ($2.0 million) with another individual or entity;

(ix) approval of the affiliation of the Affiliate or any Affiliate Subsidiary with any other entities for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said organization or entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

(x) creation of any committee which shall have the authority to act on behalf of the Affiliate or on behalf of any Affiliate Subsidiary;

(xi) approval of any conveyance of, or the granting of mortgages, trusts, or on any real property assets of the Affiliate or of any Affiliate Subsidiary;

(xii) approval of any change to any employee pension or other employee benefit plans for or on behalf of the Affiliate or any Affiliate Subsidiary;

(xiii) approval of the adoption of or amendment to the policies and procedures governing indemnification of directors and officers of the Affiliate or any Affiliate Subsidiary; conflicts or dualities of interest; accounting and investment standards and practices; and such other policies as the Corporation may from time to time determine;

(xiv) approval of the strategic plan of the Affiliate and of any Affiliate Subsidiary;

(xv) approval of the engagement in managed care and other third party payor contracting on behalf of the Affiliate or any Affiliate Subsidiary;

(xvi) approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by the Affiliate or any Affiliate Subsidiary and approval of the filing of any application for a certificate of need by the Affiliate or any Affiliate Subsidiary;

(xvii) approval of system-wide quality, performance and credentialing standards and procedures to which the Affiliate or any Affiliate Subsidiary is expected to adhere; and

(xviii) approval of regulatory compliance and methodology for physician compensation arrangements.

3.9. Action Without a Meeting. Any action which may be taken at a meeting of the Board or of a committee of the Board may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors or all of the committee members entitled to vote with respect to the subject matter of such meeting. Such consent shall be filed with the minutes of the directors' or committee's meetings.

3.10. Meeting by Conference Telephone. A director or a member of a committee of the Board may participate in a meeting of the Board or of such committee by means of conference telephone or similar communications equipment enabling all directors or all

committee members participating in the meeting to hear one another, and participation in such a meeting shall constitute presence in person at such meeting.

3.11. Resignations. The resignation of any director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified, or at such later time as the resigning director may specify and the Corporation shall accept. Failure of a director to attend three (3) consecutive Board meetings without proper excuse may in the Chair's discretion be deemed a resignation.

3.12. Compensation. No director shall receive compensation for services rendered to the Corporation in such capacity, but directors shall be entitled to reimbursement for reasonable and necessary expenses actually incurred in connection with the performance of their duties in the manner and to the extent that the Board shall determine, and may receive reasonable compensation for services performed in other capacities for or on behalf of the Corporation.

ARTICLE IV. COMMITTEES OF THE BOARD

4.1. General. At least annually the Board, by the affirmative vote of a majority of all directors then serving shall appoint the members of a Governance Committee, an Executive Compensation Committee, an Audit Committee, a Finance Committee, a Planning Committee, and a Quality Committee, in accordance with these bylaws. Except as specifically authorized by a majority of all the directors then serving, all committees except the Executive Compensation Committee and the Audit Committee shall be advisory in nature and shall not have authority to act on behalf of the Corporation.

The Board may create such other committees as the Board from time to time may consider necessary or advisable. The Governance Committee shall recommend for approval by the Board a director to act as the chair of each committee. The membership, duties and authority

of each committee shall be recommended by the Governance Committee for approval by the Board. Any committee may invite such other persons to attend and present at its meetings as is necessary to complete its responsibilities. Non-board members may be appointed to any committee that does not have authority to act on behalf of the Corporation. All committee members shall be appointed for a term of one (1) year and until the next meeting at which the Board appoints committee members.

Notwithstanding authorization to act on behalf of the Board, no committee may: (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 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 of the Corporation; (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 the Corporation. Each committee shall meet with sufficient frequency to accomplish its assigned functions, reasonable notice thereof having been provided. Each committee shall report its actions, if any, to the Board at each Board meeting.

To the extent practicable and not inconsistent with law, accreditation requirements, or the bylaws of any Affiliate or Affiliate Subsidiary, all committees of the Corporation shall serve as so-called "matrix committees" and will serve to advise such Affiliates and Affiliate Subsidiaries regarding each committee's area of expertise.

4.2. Quorum and Action. At all committee meetings, a quorum for the transaction of business shall consist of a majority of members of the committee, and except to the extent

specifically set forth in these bylaws, the vote of a majority of those members present when a quorum is present shall constitute the act of the committee.

4.3. Governance Committee. The Governance Committee shall consist of the Chair, Vice Chair, and four other directors. The Governance Committee members shall include at least one (1) director who is a Norwalk Director. The Governance Committee shall report any actions and recommendations to the Board at each Board meeting.

The Governance Committee sets the agenda for meetings of the Board and coordinates board development and education. The Governance Committee's responsibilities include: (i) subject to the provision of Section 3.2 hereof, reviewing, developing and submitting recommendations, for approval by the Board and the Members, of individuals nominated by the NHA Board and the DH/NMH Board to serve on the Board; (ii) reviewing, developing and submitting to the Board nominations for all committee members and officers of the Corporation, (iii) reviewing, developing and submitting to the Board, for approval by the Board and the Members, a slate of individuals to serve as Members in accordance with Section 2.2 hereof; (iv) periodically reviewing the certificate of incorporation, these bylaws, and policies of the Corporation, and recommending amendments thereto to the Board, as appropriate, from time to time; (v) periodically reviewing the certificate of incorporation, bylaws and policies of the Affiliates and Affiliate Subsidiaries, and recommending amendments thereto to the Board, as appropriate, from time to time; and (vi) reviewing nominations for directors of the DH/NMH Boards and the NHA Board and recommending nominations to the Board for approval; provided, however, that any candidate proposed for consideration by the Governance Committee shall be forwarded to the Board for consideration unless such nomination is opposed by the majority of the members of the Governance Committee, including at least one (1) Norwalk Director.

4.4. Executive Compensation Committee. The Executive Compensation Committee shall consist of the Chair, the Vice Chair, and three (3) other directors. The Executive Compensation Committee shall advise the Board on compensation strategies and policies for the Corporation and its Affiliates and Affiliate Subsidiaries. The Executive Compensation Committee shall have authority to act for the Board with respect to (i) the approval of regulatory compliance and the methodology for physician compensation arrangements of the Corporation or of the Affiliates and Affiliate Subsidiaries and (ii) the evaluation and determination of compensation of the President and CEO and other officers of the Corporation as may be determined by the Board. In all other matters, the Executive Compensation Committee's role shall be advisory.

4.5. Audit Committee. The Audit Committee shall consist of no less than three (3) directors, each of whom shall be considered to be independent of the management of the Corporation. At least one (1) member of the Audit Committee shall have accounting and financial management expertise. The Audit Committee may investigate and advise the Board with respect to any matter reasonably related to the Corporation's annual financial statements. The Audit Committee may retain legal or other independent advice in completing its duties. The Audit Committee shall recommend annually the appointment of independent auditors to the Board and, when circumstances warrant, the discharge of such auditors. The Audit Committee shall oversee and recommend changes to the internal audit function of the Corporation, including the supervision of third party external auditors and management's response to audit findings. The Audit Committee shall assure the Board that financial statements and tax returns are fairly presented and, to the best of the committee members' knowledge, accurately reflect the Corporation's financial condition. In addition, the Audit Committee shall oversee the

compliance function of the Corporation and management of conflicts of interest.

4.6. Finance Committee. The Finance Committee shall consist of no less than three (3) directors. The Finance Committee shall advise the Board regarding its responsibilities on matters relating to finance and investments. The Finance Committee shall (i) review and recommend changes to accounting, banking and investment policies and practices; (ii) review and recommend adoption of operating and capital budgets; (iii) monitor return on investment of significant capital expenditures; (iv) review changes in the application of generally accepted accounting principles; (v) monitor compliance with bond covenants and reporting requirements in relation thereto; (vi) review pension and actuarial reports and recommend action by the Board as necessary, and (vii) monitor and recommend approval of equity transfers among the Corporation and its Affiliates.

4.7. Planning Committee. The Planning Committee shall consist of no less than two (2) directors. The Planning Committee shall advise the Board on matters relating to the Corporation's mission, strategic plan, community relations, technology strategy and technology infrastructure expenditures, organizational strategies, and community benefit strategies and status.

4.8. Quality Committee. The Quality Committee shall consist of no less than three (3) directors. The Quality Committee shall advise the Board on matters relating to the Corporation's medical and professional policies and quality of care issues. The Quality Committee shall: (i) review the policies and programs of the patient care centers at each Affiliate; (ii) assess and recommend changes to the reporting mechanisms of the medical staff committees of each Affiliate; (iii) review and recommend appointments and credentialing of medical staff; (iv) mediate and recommend action relating to any conflict regarding the medical

staff of each Affiliate; (v) assess compliance with clinical regulatory organizations and agencies and recommend changes as necessary; (vi) review and evaluate malpractice insurance coverage of each Affiliate and recommend changes as necessary; (vii) review and evaluate graduate medical education programs at each Affiliate and recommend changes as necessary; (viii) review and evaluate medical research programs at each Affiliate and recommend changes as necessary; and (ix) review and evaluate the functions and activities of the medical ethics committees at each Affiliate and recommend changes as necessary.

ARTICLE V. OFFICERS

5.1. Officers, Appointment, Term and Vacancies. The officers of the Corporation shall consist of a Chair, a Vice Chair, a Secretary and a Treasurer, each of whom shall be directors. There shall also be a President and CEO who, in accordance with these bylaws, shall serve as a director, ex-officio with vote. Except as provided in this Section 5.1, the directors shall elect each of the foregoing and may elect other officers, such as an Assistant Secretary or Assistant Treasurer, who need not be members of the Board. Any person may simultaneously hold multiple offices.

For the period beginning on the Effective Date and ending on the third annual meeting of the Board after the Effective Date (the "Third Annual Meeting"), the Chair shall be a Norwalk Director and the Vice-Chair will be a DH/NMH Director. For the following two-year term after the Third Annual Meeting date, the Chair will be a DH/NMH Director and the Vice-Chair will be a Norwalk Director.

Officers shall be elected at the annual meeting of the Board for a term extending until the next succeeding annual meeting of the Board and until his or her successor has been elected and qualified or his or her earlier death, resignation or removal, except that the Chair and the Vice

Chair shall each be elected to a term of two (2) years and until a successor is elected. Notwithstanding the provisions of Section 3.4 of these bylaws, a director whose term as Chair or Vice Chair will exceed that director's third full term as a director shall continue to serve as a director until expiration of his or her two-year term as Chair or Vice Chair, as applicable, and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed. Any vacancy or vacancies occurring in any office of the Corporation may be filled until the next annual meeting at which officers are elected by the affirmative vote of the remaining directors in office at any meeting of the Board, though such remaining directors are fewer than a quorum.

5.2. Chair. The Chair shall lead the Board in setting the mission and strategic direction of the Corporation, and overseeing the effective implementation thereof by management. The Chair shall work to ensure that the Board functions properly, meets its obligations and responsibilities, and fulfills its purpose and mission as set forth in the certificate of incorporation and these bylaws, and as otherwise determined from time to time by the Board. The Chair shall work to maintain an effective relationship between the Board and management and, in so doing, will be the liaison between the Board and management. The Chair shall, if present, preside over all meetings of the Board. The Chair shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board. The Chair shall also perform such other duties as may be assigned to him or her by the Board.

5.3. Vice Chair. The Vice Chair shall have such duties and responsibilities as the Chair or the Board of Directors shall from time to time determine. The Vice Chair shall assume the duties of the Chair in the absence or disability of the Chair.

5.4. President and CEO. The President and CEO shall be the chief executive officer of the Corporation, subject to the control and direction of the Board. The President and CEO

shall submit regular reports to the Chair and to the Board on the operations of the Corporation. The compensation and terms of employment of the President and CEO shall be reviewed and determined at least annually by the Governance Committee. The President and CEO shall perform such other duties as may be assigned to him or her by the Board.

5.5. Secretary. The Secretary shall issue or cause to be issued all notices required by law or these bylaws. The Secretary shall keep (or cause to be kept) minutes of the proceedings of the meetings of the Corporation and of the Board, and shall ensure that all records and reports of the Corporation and of the Board shall be retained. In addition, the Secretary shall perform such other duties as may be assigned to him or her by the Board or the Chair.

5.6. Treasurer. The Treasurer shall ensure that timely and accurate financial information is presented to the Board, and that financial records shall be available for inspection by any director of the Corporation. The Treasurer shall ensure that all reports and records required by law regarding the Corporation's financial status are submitted or retained as required. The Treasurer generally shall cause to be performed all acts incident to the office of Treasurer and shall oversee such further duties as may from time to time be assigned to him or her by the Board or the Chair.

5.7. Removal of Officers. Any officer of the Corporation may be removed at any time with or without cause by the affirmative vote of a majority of all directors then serving, but without prejudice to such officer's contract rights, if any, provided notice of such action shall have been transmitted to all directors at least seven (7) days before said meeting.

ARTICLE VI. GENERAL PROVISIONS

6.1. **Gender**. All references in these bylaws to the masculine, feminine or neuter gender shall be deemed to apply equally to one or more of such gender-specific references as may be appropriate.

6.2. **Subsidiaries**. The President and CEO shall receive notice of meetings on behalf of the Corporation in its capacity as member or shareholder of any Affiliate. The President and CEO, in his or her sole discretion, may waive notice of any such meeting; provided, however, the President and CEO shall report the circumstances of the waiver to the Board at its next meeting. Except as provided herein or as specifically authorized by the Board, the Corporation shall act in its capacity as member of any Affiliate by action of the Board.

6.3. **Fiscal Year**. The fiscal year of the Corporation shall be determined by the Board.

6.4. **Waiver of Notice**. Written waiver signed at any time by a Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any Member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the Member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

6.5. **Written Notice and Signature**. Any written notice required hereunder may, without limitation, be issued by regular mail, certified mail, hand delivery, electronic means or facsimile and shall be deemed given when sent. Any written signature required under these bylaws or the Corporation's certificate of incorporation or by Connecticut law may be evidenced

by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

6.6. Amendment. 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. The Board shall have the power to adopt, amend or repeal these bylaws as to those matters not so requiring the approval of the Members at any duly held regular or special meeting of the Board, provided notice of the proposed adoption, amendment or repeal shall have been given in the notice of the meeting, in accordance with the following:

(a) by a Super-Majority Vote at any time; or

(b) by the affirmative vote of a majority of the directors at such meeting, provided (i) the Corporation has become the sole or controlling member or sole or controlling shareholder, or has acquired substantially all of the assets of, an additional acute care hospital and such amendment to these bylaws is made after the fourth anniversary of the Effective Date; or (ii) such amendment is made after the fifth anniversary of the Effective Date and twenty percent (20%) or more of the Board is comprised of individuals who are "Independent." For purposes of this section, an "Independent" individual means any individual other than the following (x) an individual who has served at any time prior to or after the Effective Date on the Board or the board of any subsidiary for which the Corporation acts as a member or shareholder (each a "WCHN Subsidiary"), the board of directors of NHSC or the board of any subsidiary for which NHSC acts as member or shareholder (each a "NHSC Subsidiary") and any immediate family member of such individual;

provided, however, a director who is first elected after the Effective Date to the board of directors of NHA, The Danbury Hospital or New Milford Hospital and to the board of directors of the Corporation shall be considered Independent; (y) an individual who is a current or former employee of the Corporation, NHSC, a WCHN Subsidiary or a NHSC Subsidiary and any immediate family member of such current or former employees; or (z) an individual who is a member of the medical staff of The Danbury Hospital, New Milford Hospital or NHA and any immediate family member of such medical staff members; provided, however, a director who is a member of the medical staffs of (A) NHA and (B) The Danbury Hospital and/or New Milford Hospital shall be considered Independent.

6.7. Effective Date. The effective date of these bylaws (the "Effective Date") shall be the last to occur of the date upon which (i) these bylaws are approved by the Board, (ii) these bylaws are approved by the Members, and (iii) the "Closing Date" of that certain Affiliation Agreement, dated January 22, 2013, by and between the Corporation and NHSC (the "Affiliation Agreement") as the term is defined in Section 1.2 of the Affiliation Agreement.

The foregoing bylaws were adopted by the Board on _____, and by the Members on _____, and the Closing Date of the Affiliation Agreement was on _____. The effective date of these bylaws is, therefore, _____.

EXHIBIT B-2
NHSC Amended and Restated Bylaws

AMENDED AND RESTATED

BYLAWS

of

NORWALK HEALTH SERVICES CORPORATION

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AMENDED AND RESTATED

BYLAWS

of

NORWALK HEALTH SERVICES CORPORATION

ARTICLE I. GENERAL

1.1. Purpose. These bylaws supplement certain provisions of the certificate of incorporation of Norwalk Health Services Corporation (the "Corporation") and the Connecticut Revised Nonstock Corporation Act, as amended from time to time (the "Act").

1.2. Offices of Corporation. The Corporation's board of directors (the "Board") shall have the power to determine the location of the registered office, in accordance with applicable law, from time to time, and to designate the principal office of the Corporation and such additional offices as it shall determine in its discretion.

ARTICLE II. MEMBERSHIP

2.1. Membership. The Corporation is a membership corporation. The sole member of the Corporation is Western Connecticut Health Network, Inc. (the "Member"). The Member shall have only such rights, privileges and obligations conferred upon it by the Corporation's certificate of incorporation, these bylaws and the Act.

2.2. Powers of the Member. Subject to Section 7.6 of these bylaws, certain fundamental decisions to be undertaken by the Corporation require the approval of the Member as follows:

(a) The actions listed below, which do not require approval by the Board, are reserved solely to the Member and require a super-majority vote, as

defined in the bylaws of the Member (a "Super-majority Vote"), of the Member's board of directors (the "Member Board"):

(i) the amendment of these bylaws;

(ii) the removal of a director;

(iii) subject to the terms of any employment agreement with the Member, the hiring or firing of the President and Chief Executive Officer of the Corporation and of The Norwalk Hospital Association ("NHA"); provided, however, that after the first anniversary of the Effective Date of these bylaws, the President/Chief Executive Officer of the Member shall have the unilateral authority to hire and fire the President and Chief Executive Officer of the Corporation and of NHA after obtaining input on such action from the board of directors of NHA.

(b) The actions listed below, which do not require approval by the Board, are reserved solely to the Member and shall be taken by the Member in accordance with its bylaws and the process set forth in these bylaws:

(i) the election of a director.

(c) The actions listed below, which require prior approval of the Board, must also be approved by a Super-majority Vote of the Member Board:

(i) the removal of a director of a subsidiary for which the Corporation acts as a member or shareholder, including without limitation NHA (each a "NHSC Subsidiary");

(ii) the closure of Norwalk Hospital or the closure or material diminution of a material program at Norwalk Hospital;

(iii) approval of the capital budget and operating budget of the Corporation and of any NHSC Subsidiary;

(iv) amendment of the certificate of incorporation of the Corporation or any NHSC Subsidiary;

(v) amendment of the bylaws or operating agreement of any NHSC Subsidiary;

(vi) the sale, lease, exchange or other disposition of all or substantially all of the property or assets of the Corporation or any NHSC Subsidiary;

(vii) approval of the creation of any corporation of which the Corporation or an NHSC Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of the Corporation or any NHSC Subsidiary with another corporation; and the reorganization, liquidation or dissolution of the Corporation or any NHSC Subsidiary;

(viii) approval of loans by the Corporation or any NHSC Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds two million dollars ($2.0 million) or which has a term longer than one year;

(ix) approval of policies relating to the control and supervision of the investment of the Corporation's and any NHSC Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of the Corporation or the NHSC Subsidiary;

(x) approval of unbudgeted expenditures in excess of two million dollars ($2.0 million) or any increase in any approved annual operating or capital budget;

(xi) approval of any agreement or transaction of the Corporation or any NHSC Subsidiary involving an amount greater than two million dollars ($2.0 million) with another entity or individual;

(xii) approval of the affiliation of the Corporation or any NHSC Subsidiary with any other entity for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

(xiii) creation of any committee which shall have the authority to act on behalf of the Board or on behalf of any NHSC Subsidiary;

(xiv) approval of any conveyance of, or the granting of mortgages or trusts on any real property assets of the Corporation or of any NHSC Subsidiary;

(xv) approval of any change to any employee pension or other employee benefit plans of the Corporation or any NHSC Subsidiary;

(xvi) approval of the adoption of or amendment to the policies and procedures governing: (a) indemnification of directors and officers of the Corporation or any NHSC Subsidiary; (b) conflicts or dualities of interest; (c) accounting and investment standards and practices; and (d) such other policies as the Member may from time to time determine;

(xvii) approval of the strategic plan of the Corporation and of any NHSC Subsidiary;

(xviii) approval of the engagement in managed care and other third party payor contracting on behalf of the Corporation or any NHSC Subsidiary;

(xix) approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by the Corporation or any NHSC Subsidiary and approval of the filing of

any application for a certificate of need by the Corporation or any NHSC Subsidiary;

(xx) approval of system-wide quality, performance and credentialing standards and procedures to which the Corporation or any NHSC Subsidiary is expected to adhere; and

(xxi) approval of regulatory compliance and methodology for physician compensation arrangements.

(d) The actions listed below, which require prior approval by the Board, shall be approved by the Member in accordance with its bylaws:

(i) the election of a director of a NHSC Subsidiary; and

(ii) the election of any officer of the Corporation.

2.3. Meetings of the Member. The annual meeting of the Corporation's Member shall be held at such date, time and place as the Board shall determine, and as shall be set forth in the notice of the meeting. Notice of annual, regular or special meetings of the Member shall be provided to the Member no fewer than ten (10) nor more than sixty (60) days before the meeting date. Special meetings may be held at such dates, times and places, and for such specific purposes, as the Board shall determine, and as shall be set forth in the notice of the meeting. At each annual meeting or any special meeting called for such purpose, the Member shall (i) appoint directors in accordance with these bylaws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) conduct any other business relating to the affairs of the Corporation consistent with the rights of the Member.

ARTICLE III. BOARD OF DIRECTORS

3.1. Authority. All corporate powers not reserved to the Member shall be exercised by or under the authority of, and the activities, property and affairs of the Corporation shall be managed by or under the direction of, the Board, subject to any limitations set forth in the certificate of incorporation, including, but not limited to, the following:

(a) Review local quality and service goals and improvement programs within the context of the Member's goals and improvement programs and recommend changes thereto to the Member Board;

(b) Monitor local quality, service and financial performance;

(c) Support management in making local communications with external audiences, including, but not limited to, local governments and the media;

(d) Support fundraising efforts conducted by the Norwalk Hospital Foundation, Inc. in the local community; and

(e) Oversee community benefit programs in the local community.

3.2. Number and Composition. The Corporation shall have no less than twelve (12) and no more than twenty-five (25) voting directors. Of this number, the President and CEO of the Member, the President and CEO of the Corporation, and the President and CEO of Norwalk Hospital Foundation, Inc. shall serve as ex-officio directors, and shall be counted for purposes of quorum and shall have the right to vote. At least one director, other than the President and CEO of the Member, shall be an individual who also serves on the board of directors of each of the Member, The Danbury Hospital and the New Milford Hospital, Inc. All directors shall be individuals who also serve on the board of directors of NHA.

3.3. Nomination, Election and Terms of Office. As of the Effective Date, the Member shall divide the elected directors ("Initial Directors") into three (3) groups so that an

approximately equal number of directors have terms that expire each year and set the year in which each such director's eligibility for reelection shall cease. At each annual meeting of the Member thereafter, directors shall be elected by the Member in the manner set forth in these bylaws to succeed the directors in the class whose terms expire at that annual meeting. The Board shall nominate individuals to succeed those directors whose terms are then expiring. In the event that the Member does not approve an individual nominated for election as a director, the Board shall nominate another individual for the Member's approval until a candidate is approved; provided, however, that if the Member declines to elect two (2) candidates proposed to fill the same directorship, the Member may only decline to elect the third candidate by a Super-majority Vote. Other than the Initial Directors and directors elected to fill vacancies, elected directors shall serve for a term of three (3) years and until their successors are elected and qualified. Except for the Initial Directors and as provided in Section 6.1 of these bylaws, elected directors shall be eligible to serve three (3) consecutive terms on the Board and shall be eligible for reelection to the Board only after a one (1) year hiatus from service as a director. A director elected to fill a vacancy in an unexpired term shall be deemed to have served one (1) three-year term for purposes of eligibility for reelection only if the director has served more than one (1) year of an unexpired term.

3.4. Vacancies. Any vacancy or vacancies occurring on the Board shall be filled by action of the Member in accordance with Section 2.2(b) of these bylaws. The Board shall nominate candidates to fill a vacancy on the Board in accordance with the procedure set forth in Section 3.3. A vacancy that will occur at a specified later date, by reason of a resignation effective at a later date, may be filled before the vacancy occurs, but the new director may not take office until that vacancy occurs.

3.5. Meetings and Notices. Annual meetings of the Board shall be held at the principal offices of the Corporation unless otherwise specifically directed by the President and CEO. The Board or its Chair will specify an appropriate date and issue notice thereof as provided below, for the purpose of electing officers for the ensuing year, receiving reports from the Corporation's officers, agents and committees, and transacting such other business as may properly come before the meeting. Notice of the annual meeting of the Board shall be in writing and shall be sent to all directors at least seven (7) days before the annual meeting.

Regular meetings of the Board shall be held at such times as the Board shall from time to time determine or as requested by the Member. Special meetings of the Board may be called at any time by the Chair or the President and CEO, and shall be called by either of them within seven days after receipt of a written request of any three directors or the Member. Meetings of the Board may be held within or without the State of Connecticut. No notice of regular meetings shall be required unless specifically directed by the President and CEO or the Chair. Except as otherwise provided in these bylaws, at least two (2) days' written notice shall be given to each director of each special meeting of the Board, and such notice shall contain the date, time and place of such special meeting.

3.6. Quorum, Action by Board of Directors and Adjournment. A majority of the directors then serving shall constitute a quorum for the transaction of business, and the act of a numerical majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the presence of or act of a greater number is specifically required by these bylaws, the Corporation's certificate of incorporation, or the Act. If a quorum shall not be present at any meeting of directors, a majority of the directors present at such meeting

may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.7. Action Without a Meeting. Any action which may be taken at a meeting of the Board or of a committee of the Board may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors or all of the committee members entitled to vote with respect to the subject matter of such meeting. Such consent shall be filed with the minutes of the directors' or committee's meetings.

3.8. Meeting by Conference Telephone. A director or a member of a committee of the Board may participate in a meeting of the Board or of such committee by means of conference telephone or similar communications equipment enabling all directors or all committee members participating in the meeting to hear one another, and participation in such a meeting shall constitute presence in person at such meeting.

3.9. Resignations. The resignation of any director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified, or at such later time as the resigning director may specify and the Corporation shall accept. Failure of a director to attend three (3) consecutive Board meetings without proper excuse may, in the Chair's discretion, be deemed a resignation.

3.10. Removal of Directors. The Member may remove any director, with or without cause, by a Super-majority Vote.

3.11. Compensation. No director shall receive compensation for services rendered to the Corporation in such capacity, but directors shall be entitled to reimbursement for reasonable and necessary expenses actually incurred in connection with the performance of their duties in the manner and to the extent that the Board shall determine, and may receive

reasonable compensation for services performed in other capacities for or on behalf of the Corporation.

ARTICLE IV. COMMITTEES OF THE BOARD

4.1. General. At least annually the Board, by the affirmative vote of a majority of all directors then serving shall appoint the members of a Nominating Committee and a Budget and Finance Committee in accordance with these bylaws. In addition, to the extent permitted by law, the Corporation shall participate in the matrix committees established by the Member to provide advice to the Member and its affiliates. All committees of the Board shall be advisory and shall not have authority to act on behalf of the Board. The Board may create one or more additional ad-hoc advisory committees as the Board from time to time may consider necessary or advisable. The chairmanship and membership of each committee shall be recommended by the Nominating Committee and approved by the Board. The duties and authority of each committee shall be set forth and determined by the Board. The chair of each committee shall be a director. Non-board members may be appointed to any committee. Each committee shall report its activities and recommendations, if any, to the Board at each Board meeting.

4.2. Nominating Committee. The Nominating Committee shall consist of the Chair, the Vice Chair and at least three (3) directors elected by the Board. The Nominating Committee shall advise the Board on the nomination of individuals to serve as directors, members of the Member, and as members of the board of directors of the Member. The Nominating Committee shall review, develop, and submit to the Board nominations for election by the Member to service on the Board.

4.3. Budget and Finance Committee. The Budget and Finance Committee shall consist of no less than three (3) directors. The Budget and Finance Committee shall advise the

Board on matters relating to the management and expenditure of the Corporation's funds. The Budget and Finance Committee shall, in cooperation with the Finance Committee of the Member: (i) review and recommend for approval by the Board and the Member the operating and capital budgets of the Corporation and of the NHSC Subsidiaries; and (ii) review and recommend for approval by the Board and the Member the strategic plan of the Corporation and of the NHSC Subsidiaries.

4.4. Quorum and Action. At all committee meetings, a quorum for the transaction of business shall consist of a majority of the members of the committee, and the vote of a majority of those members present when a quorum is present shall constitute the act of the committee.

ARTICLE V. PRESIDENT AND CEO

The Corporation may contract with the Member for the services of a President and CEO. The President and CEO shall be the chief executive of the Corporation, and shall report to the Board. The President and CEO shall submit regular reports to the Chair and to the Board on the operations of the Corporation. The President and CEO, in accordance with these bylaws, shall serve as a director, ex-officio and shall have the right to vote. The President and CEO shall perform such other duties as may be assigned to him or her by the Board. The individual serving as President and CEO shall be the same individual serving as the President and CEO of NHA. Following the first anniversary of the Effective Date, the Member's President and CEO shall have the unilateral authority to hire or fire the President and CEO, subject to the terms of any employment agreement with the Member, after obtaining input on such action from the board of directors of NHA.

ARTICLE VI. OFFICERS

6.1. Officers, Appointment, Term and Vacancies. Subject to the approval of the Member, the directors shall elect all of the Corporation's officers. The officers of the Corporation shall consist of a Chair, a Vice Chair, a Secretary and a Treasurer, each of whom shall be directors. The Corporation may have such other officers, such as an Assistant Secretary or Assistant Treasurer, who need not be directors, as the Board may determine from time to time. Any person may simultaneously hold multiple offices.

Officers shall be elected at the annual meeting of the Board for a term extending until the next succeeding annual meeting of the Board and until his or her successor has been elected and qualified or his or her earlier death, resignation or removal, except that the Chair and the Vice Chair shall each be elected to a term of two (2) years and until a successor is elected. Notwithstanding the provisions of Section 3.3 of these bylaws, a director whose term as Chair or Vice Chair will exceed that director's third full term as a director shall continue to serve as a director until expiration of his or her two-year term as Chair or Vice Chair, as applicable, and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed.

Subject to the approval of the Member, any vacancy or vacancies occurring in any office of the Corporation may be filled until the next meeting at which officers are elected by the affirmative vote of the remaining directors in office at any meeting of the Board, though such remaining directors are fewer than a quorum.

6.2. Chair. The Chair shall work to ensure that the Board functions properly, meets its obligations and responsibilities, and fulfills its purpose and mission as set forth in the certificate of incorporation and these bylaws, and as otherwise determined from time to time by the Board. The Chair shall work to maintain an effective relationship between the Board and management and, in so doing, will be the liaison between the Board and management. The

Chair shall, if present, preside over all meetings of the Board. The Chair shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board. The Chair shall also perform such other duties as may be assigned to him or her by the Board.

6.3. Vice Chair. The Vice Chair shall serve a two-year term and shall have such duties and responsibilities as the Chair or the Board of Directors shall from time to time determine. The Vice Chair shall assume the duties of the Chair in the absence or disability of the Chair.

6.4. Secretary. The Secretary shall issue or cause to be issued all notices required by law or these bylaws. The Secretary shall keep (or cause to be kept) minutes of the proceedings of the meetings of the Corporation and of the Board, and shall ensure that all records and reports of the Corporation and of the Board shall be retained. In addition, the Secretary shall perform such other duties as may be assigned to him or her by the Board, the Chair, or the Member.

6.5. Treasurer. The Treasurer shall ensure that timely and accurate financial information is presented to the Board, and that financial records are maintained and available for inspection by any director or the Member of the Corporation. The Treasurer shall ensure that all reports and records required by law regarding the Corporation's financial status are submitted or retained as required. The Treasurer generally shall cause to be performed all acts incident to the office of Treasurer and shall oversee such further duties as may from time to time be assigned to him or her by the Board, the Chair, or the Member.

6.6. Removal of Officers. Subject to the approval of the Member, any officer of the Corporation (except the President and CEO) may be removed at any time with or without cause by the affirmative vote of a majority of all directors then serving, but without prejudice to such

officer's contract rights, if any, provided written notice of such action shall have been transmitted to all directors at least seven (7) days before said meeting.

ARTICLE VII. GENERAL PROVISIONS

7.1. Gender. All references in these bylaws to the masculine, feminine or neuter gender shall be deemed to apply equally to one or more of such gender-specific references as may be appropriate.

7.2. Fiscal Year. The fiscal year of the Corporation shall be determined by the Board.

7.3. Waiver of Notice. Written waiver signed at any time by the Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any Member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the Member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

7.4. Written Notice and Signature. Any written notice required hereunder may, without limitation, be issued by regular mail, certified mail, hand delivery, electronic means or facsimile and shall be deemed given when sent. Any written signature required under these bylaws or the Corporation's certificate of incorporation or by Connecticut law may be evidenced by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

7.5. Conflict of Interest Policy. The Corporation's officers and directors shall adhere to the conflict of interest policy adopted by the Member, as the same may be amended from time to time.

7.6. Amendment. The Member shall have the exclusive power to adopt, amend or repeal these bylaws at any duly held regular or special meeting of the Member Board, provided notice of the proposed adoption, amendment or repeal shall have been given in the notice of the meeting, in accordance with the following:

(a) by a Super-Majority Vote of the Member Board at any time; or

(b) by the affirmative vote of a majority of the directors of the Member at such meeting, provided (i) the Member has become the sole member, sole shareholder or has acquired substantially all of the assets, of an additional acute care hospital, and such amendment to these bylaws is made after the fourth anniversary of the Effective Date; or (ii) such amendment is made after the fifth anniversary of the Effective Date and twenty percent (20%) or more of the Member Board is comprised of individuals who are "Independent." For purposes of this section, an "Independent" individual means any individual other than the following (x) an individual who, has served at any time prior to or after the Effective Date on the Member Board, the board of any subsidiary for which the Member acts as a member or shareholder (each a "WCHN Subsidiary"), the Board, or the board of any NHSC Subsidiary and any immediate family member of such individual; provided, however, a director who is first elected after the Effective Date to the board of directors of NHA, The Danbury Hospital or New Milford Hospital and to the board of directors of the Member shall be considered Independent; (y) an individual who is a current or former employee of the Corporation, the Member, a WCHN Subsidiary or a

NHSC Subsidiary and any immediate family member of such current or former employees; or (z) an individual who is a member of the medical staff of The Danbury Hospital, New Milford Hospital or NHA and any immediate family member of such medical staff member; provided, however, a director who is a member of the medical staffs of (A) NHA and (B) The Danbury Hospital and/or New Milford Hospital shall be considered Independent.

7.7. Effective Date. The effective date of these bylaws (the "Effective Date") shall be the last to occur of the date upon which (i) these bylaws are approved by the Board, and (ii) the "Closing Date" of that certain Affiliation Agreement, dated January 22, 2013, by and between the Corporation and Western Connecticut Health Network, Inc. (the "Affiliation Agreement"), as the term is defined in Section 1.2 of the Affiliation Agreement.

EXHIBIT B-3
NHA Amended and Restated Bylaws

AMENDED AND RESTATED

BYLAWS

of

THE NORWALK HOSPITAL ASSOCIATION

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AMENDED AND RESTATED

BYLAWS

of

THE NORWALK HOSPITAL ASSOCIATION

ARTICLE I. GENERAL

1.1. Purpose. These bylaws supplement certain provisions of the certificate of incorporation of The Norwalk Hospital Association (the "Corporation") and the Connecticut Revised Nonstock Corporation Act, as amended from time to time (the "Act"). The Corporation is an affiliate of Western Connecticut Health Network, Inc., referred to herein as "WCHN."

1.2. Offices of Corporation. The Corporation's board of directors (the "Board") shall have the power to determine the location of the registered office, in accordance with applicable law, from time to time, and to designate the principal office of the Corporation and such additional offices as it shall determine in its discretion.

ARTICLE II. MEMBERSHIP

2.1. Membership. The Corporation is a membership corporation. Norwalk Health Services Corporation is the sole corporate member of the Corporation (the "Member"). WCHN is the sole corporate member of the Member. The Member shall have only such rights, privileges and obligations conferred upon it by the Corporation's certificate of incorporation, these bylaws and the Act.

2.2. Powers of the Member. Certain fundamental decisions to be undertaken by the Corporation require the approval of the Member. Any actions requiring Member approval under these bylaws shall not be deemed approved until such time that the Corporation receives

approval from the Member and, to the extent required under the bylaws of the Member, of WCHN.

(a) The actions listed below, which do not require approval by the Board, are reserved solely to the Member:

(i) The amendment of these bylaws; and

(ii) The election or removal of a director.

(b) The actions listed below, which require prior approval of the Board, must also be approved by the Member:

(i) The election and removal of a director of a subsidiary for which the Corporation acts as a member or shareholder ("NHA Subsidiary");

(ii) The election of the officers of the Corporation;

(iii) The closure of Norwalk Hospital or the closure or material diminution of a material program at Norwalk Hospital;

(iv) Approval of the capital budget and operating budget of the Corporation and of any NHA Subsidiary;

(v) Amendment of the certificate of incorporation of the Corporation or any NHA Subsidiary;

(vi) Amendment of the bylaws or operating agreement of any NHA Subsidiary;

(vii) The sale, lease, exchange or other disposition of all or substantially all of the property or assets of the Corporation or any NHA Subsidiary;

(viii) Approval of the creation of any corporation of which the Corporation or an NHA Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of the Corporation or any NHA Subsidiary with another corporation; and the reorganization, liquidation or dissolution of the Corporation or any NHA Subsidiary;

(ix) Approval of loans by the Corporation or any NHA Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds two million dollars ($2.0 million) or which has a term longer than one year;

(x) Approval of policies relating to the control and supervision of the investment of the Corporation's and any NHA Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of the Corporation or the NHA Subsidiary;

(xi) Approval of unbudgeted expenditures in excess of two million dollars ($2.0 million) or any increase in any approved annual operating or capital budget;

(xii) Approval of any agreement or transaction of the Corporation or any NHA Subsidiary involving an amount greater than two million dollars ($2.0 million) with another individual or entity;

(xiii) Approval of the affiliation of the Corporation or any NHA Subsidiary with any other entity for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

(xiv) Creation of any committee which shall have the authority to act on behalf of the Board or on behalf of any NHA Subsidiary;

(xv) Approval of any conveyance of, or the granting of mortgages or trusts on any real property assets of the Corporation or of any NHA Subsidiary;

(xvi) Approval of any change to any employee pension or other employee benefit plans of the Corporation or any NHA Subsidiary;

(xvii) Approval of the adoption of or amendment to the policies and procedures governing: (a) indemnification of directors and officers of the Corporation or any NHA Subsidiary; (b) conflicts or dualities of interest; (c) accounting and investment standards and practices; and (d) such other policies as the Member may from time to time determine;

(xviii) Approval of the strategic plan of the Corporation and of any NHA Subsidiary;

(xix) Approval of the engagement in managed care and other third party payor contracting on behalf of the Corporation or any NHA Subsidiary;

(xx) Approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by the Corporation or any NHA Subsidiary and approval of the filing of any application for a certificate of need by the Corporation or any NHA Subsidiary;

(xxi) Approval of system-wide quality, performance and credentialing standards and procedures to which the Corporation or any NHA Subsidiary is expected to adhere; and

(xxii) Approval of regulatory compliance and methodology for physician compensation arrangements.

2.3. Meetings of the Member. The annual meeting of the Corporation's Member shall be held at such date, time and place as the Board shall determine, and as shall be set forth in the notice of the meeting. Notice of annual, regular or special meetings of the Member shall be provided to the Member no fewer than ten (10) nor more than sixty (60) days before the meeting date. Special meetings may be held at such dates, times and places, and for such specific purposes, as the Board shall determine, and as shall be set forth in the notice of the meeting.

At each annual meeting or any special meeting called for such purpose, the Member shall (i) appoint directors in accordance with these bylaws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) conduct any other business relating to the affairs of the Corporation consistent with the rights of the Member.

ARTICLE III. BOARD OF DIRECTORS

3.1. Authority. All corporate powers not reserved to the Member shall be exercised by or under the authority of, and the activities, property and affairs of the Corporation shall be managed by or under the direction of, the Board, subject to any limitations set forth in the certificate of incorporation including, but not limited to the following:

(a) Review local quality and service goals and improvement programs within the context of the Member's goals and improvement programs and recommend changes thereto to the Member Board;

(b) Monitor local quality, service and financial performance;

(c) Support management in making local communications with external audiences, including, but not limited to, local governments and the media;

(d) Support fundraising efforts conducted by the Norwalk Hospital Foundation, Inc. in the local community;

(e) Oversee community benefit programs in the local community; and

(f) Approve medical staff bylaws and medical staff appointments based on standardized Member applications and review processes;

(g) Participate in the search process for the President and CEO of the Corporation when the need arises.

3.2. Number and Composition. The Corporation shall have no less than twelve (12) and not more than twenty-five (25) voting directors. Of this number, the President and CEO of

the Corporation, the President and CEO of WCHN, and the President and CEO of Norwalk Hospital Foundation, Inc., shall serve as ex-officio directors, and shall be counted for purposes of quorum and shall have the right to vote. At least one (1) director, other than the President and CEO of WCHN, shall be an individual who also serves on the board of each of WCHN, The Danbury Hospital and the New Milford Hospital, Inc. All directors shall be those individuals who serve on the board of the Corporation's Member.

3.3. Appointment and Terms of Office. As of the Effective Date, the Member shall divide the elected directors ("Initial Directors") into three (3) groups so that an approximately equal number of directors have terms that expire each year and set the year in which each such director's eligibility for reelection shall cease. At each annual meeting of the Member thereafter, directors shall be elected by the Member in the manner set forth in the bylaws of the Member to succeed the directors in the class whose terms expire at that annual meeting. Other than the Initial Directors and directors elected to fill vacancies, elected directors shall serve for a term of three (3) years and until their successors are elected and qualified. Except for the Initial Directors and as provided in Section 7.2 of these bylaws, directors shall be eligible to serve three (3) consecutive terms on the Board and shall be eligible for reelection to the Board only after a one (1) year hiatus from service as a director. A director elected to fill a vacancy in an unexpired term shall be deemed to have served one (1) three-year term for purposes of eligibility for reelection only if the director has served more than one (1) year of an unexpired term.

3.4. Vacancies. Any vacancy or vacancies occurring on the Board shall be filled by the Member in the manner set forth in the bylaws of the Member. A vacancy that will occur at a specified later date, by reason of a resignation effective at a later date, may be filled before the vacancy occurs, but the new director may not take office until that vacancy occurs.

3.5. Meetings and Notices. Annual meetings of the Board shall be held at the principal offices of the Corporation unless otherwise specifically directed by the President and CEO. The Board or its Chair will specify an appropriate date and issue notice thereof as provided below, for the purpose of electing officers for the ensuing year, receiving reports from the Corporation's officers, agents and committees, and transacting such other business as may properly come before the meeting. Notice of the annual meeting of the Board shall be in writing and shall be sent to all directors at least seven (7) days before the annual meeting.

Regular meetings of the Board shall be held at such times as the Board shall from time to time determine or as requested by the Member. Special meetings of the Board may be called at any time by the Chair or the President and CEO, and shall be called by either of them within seven (7) days after receipt of a written request of any three directors or the Member. Meetings of the Board may be held within or without the State of Connecticut. No notice of regular meetings shall be required unless specifically directed by the President and CEO or the Chair. Except as otherwise provided in these bylaws, at least two (2) days' written notice shall be given to each director of each special meeting of the Board, and such notice shall contain the date, time and place of such special meeting.

3.6. Quorum, Action by Board of Directors and Adjournment. A majority of the directors then serving shall constitute a quorum for the transaction of business, and the act of a numerical majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the presence of or act of a greater number is specifically required by these bylaws, the Corporation's certificate of incorporation, or the Act. If a quorum shall not be present at any meeting of directors, a majority of the directors present at such meeting may

adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

3.7. Action Without a Meeting. Any action which may be taken at a meeting of the Board or of a committee of the Board may be taken without a meeting if a consent in writing, setting forth the action so taken, or to be taken, shall be signed by all of the directors or all of the committee members entitled to vote with respect to the subject matter of such meeting. Such consent shall be filed with the minutes of the directors' or committee's meetings.

3.8. Meeting by Conference Telephone. A director or a member of a committee of the Board may participate in a meeting of the Board or of such committee by means of conference telephone or similar communications equipment enabling all directors or all committee members participating in the meeting to hear one another, and participation in such a meeting shall constitute presence in person at such meeting.

3.9. Resignations. The resignation of any director shall be in writing and shall be effective immediately upon receipt by the Corporation if no time is specified, or at such later time as the resigning director may specify and the Corporation shall accept. Failure of a director to attend three (3) consecutive Board meetings without proper excuse may, in the Chair's discretion, be deemed a resignation.

3.10. Removal of Directors. The Member may remove any director, with or without cause.

3.11. Compensation. No director shall receive compensation for services rendered to the Corporation in such capacity, but directors shall be entitled to reimbursement for reasonable and necessary expenses actually incurred in connection with the performance of their duties in

the manner and to the extent that the Board shall determine, and may receive reasonable compensation for services performed in other capacities for or on behalf of the Corporation.

ARTICLE IV. MEDICAL STAFF

4.1. General. The Board shall appoint a medical staff operating in accordance with these bylaws and those bylaws, credentials or other medical staff policies, rules and regulations of the medical staff that are approved by the Board. The medical staff shall operate as an integral part of the Hospital and, through its department chairmen, committees and officers, shall be responsible and accountable to the Board for the discharge of those duties and responsibilities delegated to it by the Board from time to time. The Board has the ultimate authority over all decisions regarding the mission of the Corporation, its economic viability, organizational integrity and quality of care, and specifically reserves the authority to adopt such policies as the Board determines are necessary to facilitate its mission, protect its assets, further its economic viability, and to determine the most efficient manner in which to provide a Hospital service. Said policies may affect the eligibility of practitioners for (a) appointment or reappointment to the medical staff, (b) the exercise of clinical privileges, (c) service as a medical staff officer, committee member or department or section chief, (d) financial relationships with this Corporation or its affiliates, or (e) other benefits generally available to medical staff appointees. The Board shall have the authority to take any action that it deems appropriate with respect to any individual appointed to the medical staff or given clinical privileges or the right to practice in the Hospital.

4.2. Medical Staff Bylaws, Rules and Regulations:

(a) In recommending medical staff bylaws, rules and regulations, or policies, the medical staff shall follow the procedures set forth in the medical staff bylaws and Credentials Policy. Only such medical staff bylaws,

credentials or other medical staff policies, and rules and regulations as are adopted by the Board shall be effective.

(b) The medical staff may at any time recommend modifications of the medical staff bylaws, credentials or other medical staff policies, and rules and regulations to the Board. The Board shall act promptly on any such proposed amendments that are submitted by the medical staff.

(c) The Board reserves the right to rescind any authority or procedures delegated to the medical staff by bylaws, credentials or other medical staff policies, rules or regulations, or otherwise, and to amend the foregoing from time to time as it deems appropriate for the appropriate operation of the Hospital. In the event the Board believes there should be changes in the medical staff bylaws, credentials or other medical staff policies, rules or regulations, it shall submit such suggested changes to the medical staff. The medical staff shall promptly consider and submit to the Board its recommendations. If submissions by the medical staff in response to suggestions by the Board are not transmitted to the Board within a reasonable time as determined by the Board, then the Board may make such changes as are deemed necessary without the approval of the medical staff.

(d) In the event of a conflict between the provisions of the medical staff bylaws, credentials or other medical staff policies, or rules and regulations and these bylaws, the provisions of these bylaws shall be controlling.

4.3. **Medical Staff Appointment and Clinical Privileges:** The Board may appoint to the medical staff graduates of recognized professional schools meeting the personal and professional qualifications prescribed in the medical staff bylaws or the Corporation's Credentials Policy and may assign clinical privileges to them. Individuals so appointed shall have responsibility for the treatment of Hospital patients subject only to such limitations as the Board and its designees may impose, and to the medical staff bylaws, rules and regulations, or policies, including the Corporation's Credentials Policy. Appointments shall be provisional for the period described in, and are renewable in accordance with, the procedures set forth in the medical staff bylaws or the Corporation's Credentials Policy.

4.4. **Contracts for Clinical Services**:

(a) All individuals functioning pursuant to contracts or employment relationships with individuals, partnerships or corporations for the performance of certain health care services, including exclusive agreements and agreements for medical-administrative positions, who would be subject to the provisions of the medical staff bylaws, shall obtain and maintain staff appointment and/or clinical privileges, in accordance with the medical staff bylaws or the Corporation's Credentials Policy.

(b) Unless the service or employment contract provides otherwise, if a question arises concerning clinical competence that may affect such individual's staff appointment or clinical privileges during the term of the contract, that question may be processed in the same manner as would pertain to any other medical staff appointee. If a modification of privileges or appointment occurs that is sufficient to prevent the individual from

performing his contractual duties, the contract shall automatically terminate.

(c) Unless the service or employment contract provides otherwise, clinical privileges and medical staff appointment that are necessary to carry out the obligations of an exclusive contract or employment contract shall be valid only during the term of the contract. In the event that an exclusive contract expires or is terminated, then the medical staff appointment and clinical privileges of any individual who is employed by, or under contract with, the exclusive provider shall also expire. Similarly, in the event that an individual who is employed by, or under contract with, the exclusive provider is removed from service at the Hospital or terminates their employment by or contract with, the exclusive provider, then the medical staff appointment and clinical privileges of any such individual shall expire. Any such expiration of clinical privileges and medical staff appointment or the termination or expiration of the contract itself shall not entitle the individual to any hearing or appeal pursuant to the medical staff bylaws or Credentials Policy, unless there is a specific provision to the contrary in the contract. In the event that only a portion of the individual's clinical privileges are covered by the exclusive contract or employment contract, only that portion shall be affected by the expiration or termination of the exclusive contract or employment.

(d) Specific contractual or employment terms shall in all cases be controlling in the event that they conflict with provisions of the medical staff bylaws or the Corporation's Credentials Policy.

4.5. Evaluating Professional Needs: From time to time the Board, with the advice of the WCHN Planning Committee shall evaluate the number, age, admissions, and Hospital activities of medical staff appointees in various specialty areas so that a proper number of individuals in each specialty is determined maintained and revised as needed, in light of the strategic planning objectives and professional personnel requirements and limitations of the Hospital.

4.6. Procedures for Board Actions Pertaining to Medical Staff Applicants or Appointees:

(a) The Board retains the absolute discretion to take any action with respect to the Medical Staff it deems in the best interest of the Hospital and the decision of the Board shall be conclusive. At any time in its consideration of any recommendation involving a medical staff appointee, the Board may in its absolute discretion defer final determination by referring the matter to a committee of its choice for further consideration. Any such referral shall state the reasons therefor and shall set a time limit within which a subsequent recommendation to the Board shall be made. However, if the Board or a Board committee makes a recommendation that would entitle a medical staff appointee to a hearing, the Board shall, before taking final action, notify the affected individual of the hearing rights that are described in the Hospital's Credentials Policy. If a hearing

is requested, it shall be conducted in accordance with procedures outlined in the medical staff bylaws or the Credentials Policy.

(b) When the Board acts finally in the matter, it shall send notice of such decision through the President and CEO by certified mail, return receipt requested, to the applicant or appointee involved as well as to the Executive Committee of the Medical Staff and the chairman of the department affected.

(c) Notwithstanding the actions described in paragraph (a), a decision not to grant an application or a decision to defer the appointment of a qualified applicant, in accordance with the recommendations of the WCHN Planning Committee, does not entitle the applicant to the hearing and appeal rights outlined in the medical staff bylaws or the Corporation's Credentials Policy.

4.7. <u>Medical Staff Departments, Committees and Officers</u>:

(a) The chairmen of all medical staff departments, the chairmen and members of all medical staff committees, and the officers of the medical staff shall be elected or appointed in accordance with the provisions of the medical staff bylaws and the Credentials Policy and other medical staff policies and shall be subject to the approval of the Board prior to assuming their duties in those offices. Said individuals shall act for and on behalf of the Hospital when performing their duties under the bylaws and shall perform such additional duties as may be assigned from time to time by the Board or the President and CEO or his/her designee.

(b) All minutes, reports, recommendations, communications, and actions with respect to credentialing, peer review, quality assurance or related matters made or taken by the Board or its committees or by medical staff departments, committees and officers on behalf of the Hospital are deemed to be covered by the provisions of Connecticut or federal law or regulation providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to the medical staff bylaws or Credentials Policy or other medical staff policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

4.8. **Malpractice Insurance Coverage**: The Board shall require that all applicants and appointees of the Active, Consulting and Emeritus Staffs, and all applicants and appointees of the Allied Health Professional Staff, have and maintain malpractice insurance through a company approved by the Connecticut Insurance Department in an amount that the Board determines is commensurate with services provided by the practitioner in the Hospital to cover claims or suits arising from alleged malpractice in the Hospital. If at any time an appointee's malpractice insurance coverage lapses, is terminated, or otherwise is not in effect, the appointee's clinical privileges shall be deemed voluntarily relinquished as of that date until the matter is resolved and adequate malpractice insurance coverage is restored. Failure to restore adequate malpractice insurance coverage after six months from the relinquishment of privileges

shall constitute a voluntary relinquishment of clinical privileges and resignation from the Medical Staff. Compliance with this policy shall be evidenced by filing with the Chief Executive Officer a certificate of insurance from the carrier showing at least the minimum required insurance coverage.

ARTICLE V. COMMITTEES OF THE BOARD

5.1. General. At least annually the Board, by the affirmative vote of a majority of all directors then serving shall appoint a Nominating Committee and a Budget and Finance Committee in accordance with these bylaws. In addition, to the extent permitted by law, the Corporation shall participate in the matrix committees established by WCHN to provide advice to WCHN and its affiliates. The Board may create one or more additional ad-hoc advisory committees as the Board from time to time may consider necessary or advisable. All committees of the Board shall be advisory and shall not have authority to act on behalf of the Board. For the avoidance of doubt, the medical staff committees shall not be subject to participation on matrix committees of WCHN. The membership, duties and authority of each committee shall be set forth and determined by the Board. The chair of each committee shall be a director. Non-board members may be appointed to any committee. Each committee shall report its activities and recommendations, if any, to the Board at each Board meeting.

5.2. Nominating Committee. The Nominating Committee shall consist of the Chair, the Vice Chair and at least three (3) directors. The Nominating Committee shall advise the Board on the nomination of individuals to serve as directors, as members of WCHN and as members of the board of directors of the Member. The Nominating Committee shall review, develop, and submit to the Board nominations for election by the Member to service on the Board.

5.3. Budget and Finance Committee. The Budget and Finance Committee shall consist of no less than three (3) directors. The Budget and Finance Committee shall advise the Board on matters relating to the management and expenditure of the Corporation's funds. The Budget and Finance Committee shall, in cooperation with the Finance Committee of the Member: (i) review and recommend for approval by the Board and the Member the operating and capital budgets of the Corporation and of the NHSC Subsidiaries; and (ii) review and recommend for approval by the Board and the Member the strategic plan of the Corporation and of the NHSC Subsidiaries.

5.4. Quorum and Action. At all committee meetings, a quorum for the transaction of business shall consist of a majority of the members of the committee, and the vote of a majority of those members present when a quorum is present shall constitute the act of the committee.

ARTICLE VI. PRESIDENT AND CEO

The Corporation may contract with WCHN for the services of a President and CEO. The President and CEO shall be the chief executive of the Corporation, and shall report to the Board. The President and CEO shall submit regular reports to the Chair and to the Board on the operations of the Corporation. The President and CEO, in accordance with these bylaws, shall serve as a director, ex-officio and shall have the right to vote. The President and CEO shall perform such other duties as may be assigned to him or her by the Board. The individual serving as President and CEO shall be the same individual serving as the President and CEO of the Member. Following the first anniversary of the Effective Date, WCHN's President and CEO shall have the unilateral authority to hire or fire the President and CEO after obtaining input on such action from the Board, subject to the terms of any employment agreement between the

President and CEO and WCHN. Prior to that date, the hiring and firing of the President and CEO shall be done by WCHN in accordance with its bylaws.

ARTICLE VII. OFFICERS

7.1. Officers, Appointment, Term and Vacancies. Subject to the approval of the Member, the directors shall elect all of the Corporation's officers. The officers of the Corporation shall consist of a Chair, a Vice Chair, a Secretary and a Treasurer, each of whom shall be directors. The Corporation may have such other officers, such as an Assistant Secretary or Assistant Treasurer, who need not be directors, as the Board may determine from time to time. Any person may simultaneously hold multiple offices.

Officers shall be elected at the annual meeting of the Board for a term extending until the next succeeding annual meeting of the Board and until his or her successor has been elected and qualified or until his or her earlier death, resignation or removal, except that the Chair and the Vice Chair shall each be elected to a term of two (2) years and until a successor is elected. Notwithstanding the provisions of Section 3.3 of these bylaws, a director whose term as Chair or Vice Chair will exceed that director's third full term as a director shall continue to serve as a director until expiration of his or her two-year term as Chair or Vice Chair, as applicable, and shall thereafter be eligible for reelection to the Board only after one (1) year has elapsed. Subject to the approval of the Member, any vacancy or vacancies occurring in any office of the Corporation may be filled until the next meeting at which officers are elected by the affirmative vote of the remaining directors in office at any meeting of the Board, though such remaining directors are fewer than a quorum.

7.2. Chair. The Chair shall work to ensure that the Board functions properly, meets its obligations and responsibilities, and fulfills its purpose and mission as set forth in the certificate of incorporation and these bylaws, and as otherwise determined from time to time by

the Board. The Chair shall work to maintain an effective relationship between the Board and management and, in so doing, will be the liaison between the Board and management. The Chair shall, if present, preside over all meetings of the Board. The Chair shall serve as an ex-officio member of all standing, special and ad hoc committees of the Board. The Chair shall also perform such other duties as may be assigned to him or her by the Board.

7.3. Vice Chair. The Vice Chair shall serve a two-year term and shall have such duties and responsibilities as the Chair or the Board of Directors shall from time to time determine. The Vice Chair shall assume the duties of the Chair in the absence or disability of the Chair.

7.4. Secretary. The Secretary shall issue or cause to be issued all notices required by law or these bylaws. The Secretary shall keep (or cause to be kept) minutes of the proceedings of the meetings of the Corporation and of the Board, and shall ensure that all records and reports of the Corporation and of the Board shall be retained. In addition, the Secretary shall perform such other duties as may be assigned to him or her by the Board, the Chair or the Member.

7.5. Treasurer. The Treasurer shall ensure that timely and accurate financial information is presented to the Board, and that financial records are maintained and available for inspection by any director or the Member of the Corporation. The Treasurer shall ensure that all reports and records required by law regarding the Corporation's financial status are submitted or retained as required. The Treasurer generally shall cause to be performed all acts incident to the office of Treasurer and shall oversee such further duties as may from time to time be assigned to him or her by the Board, the Chair, or the Member.

7.6. Removal of Officers. Subject to the approval of the Member, any officer of the Corporation may be removed at any time with or without cause by the affirmative vote of a

majority of all directors then serving, but without prejudice to such officer's contract rights, if any, provided written notice of such action shall have been sent to all directors at least seven (7) days before said meeting.

ARTICLE VIII. GENERAL PROVISIONS

8.1. **Gender**. All references in these bylaws to the masculine, feminine or neuter gender shall be deemed to apply equally to one or more of such gender-specific references as may be appropriate.

8.2. **Fiscal Year**. The fiscal year of the Corporation shall be determined by the Board.

8.3. **Waiver of Notice**. Written waiver signed at any time by the Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any Member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the Member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

8.4. **Written Notice and Signature**. Any written notice required hereunder may, without limitation, be issued by regular mail, certified mail, hand delivery, electronic means or facsimile and shall be deemed given when sent. Any written signature required under these bylaws or the Corporation's certificate of incorporation or by Connecticut law may be evidenced by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

8.5. **Conflict of Interest Policy**. The Corporation's officers and directors shall adhere to the conflict of interest policy adopted by the Member, as the same may be amended from time to time.

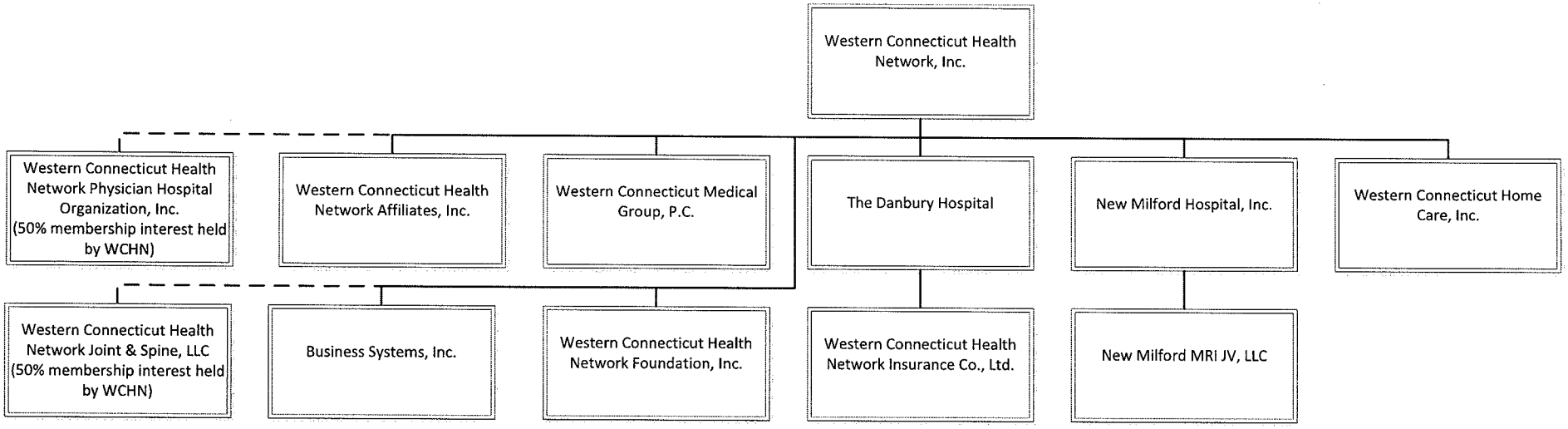
8.6. **Amendment**. These bylaws may be amended by the Member.

8.7. **Effective Date**. The effective date (the "Effective Date") of these bylaws shall be the last to occur of the date upon which (i) these bylaws are approved by the Board, (ii) these bylaws are approved by the Corporation's Member, and (ii) the "Closing Date" of that certain Affiliation Agreement, dated [ ], by and between the Corporation' Member and Western Connecticut Health Network, Inc. (the "Affiliation Agreement"), as the term is defined in Section 1.2 of the Affiliation Agreement.

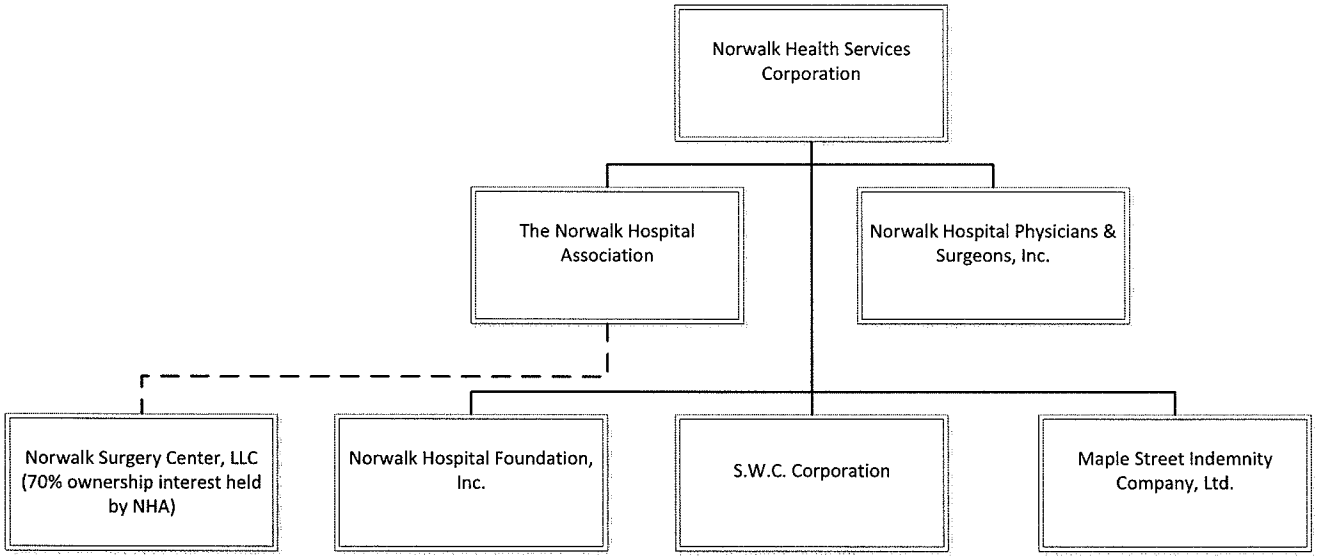
Amended and restated as of _____ __, 2013.

EXHIBIT C
Pre-Closing and Post-Closing Organizational Structure

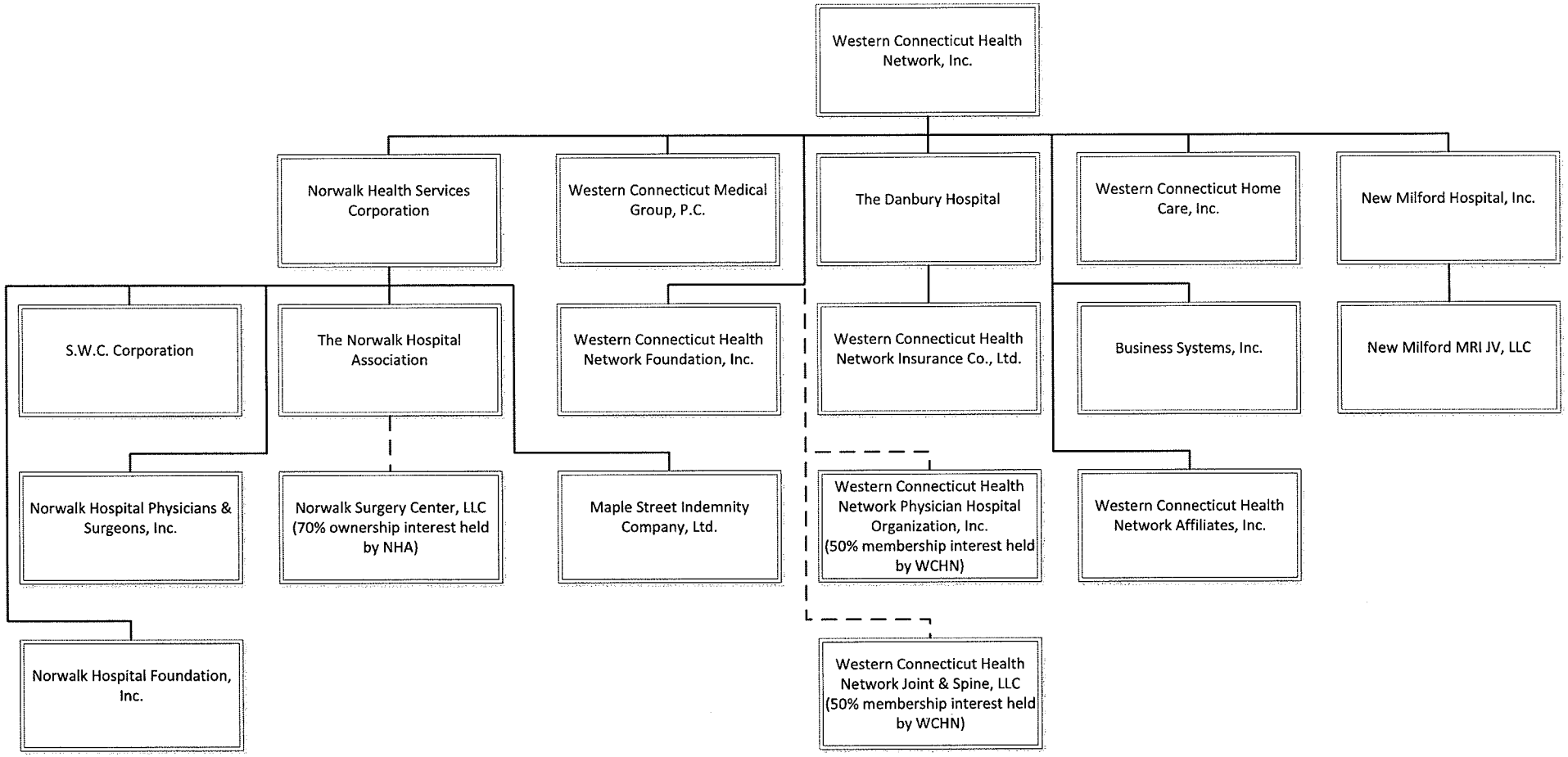
WCHN Pre-Closing



NHSC Pre-Closing



WCHN Post-Closing



SCHEDULE 1(a)
NHSC Affiliates

- Norwalk Health Services Corporation
- The Norwalk Hospital Association
- Norwalk Hospital Physicians & Surgeons, Inc.
- Norwalk Hospital Foundation, Inc.
- S.W.C. Corporation
- Maple Street Indemnity Company, Ltd.
- Norwalk Surgery Center, LLC (70% ownership interest held by NHA)

SCHEDULE 1(b)
WCHN Affiliates

- Western Connecticut Health Network, Inc.
- The Danbury Hospital
- New Milford Hospital, Inc.
- Western Connecticut Health Network Affiliates, Inc.
- Western Connecticut Medical Group, P.C.
- Western Connecticut Home Care, Inc.
- Western Connecticut Health Network Foundation, Inc.
- Western Connecticut Health Network Insurance Co., Ltd.
- New Milford MRI JV, LLC
- Business Systems, Inc.
- Western Connecticut Health Network Physician Hospital Organization, Inc. (50% membership interest held by WCHN)
- Western Connecticut Health Network Joint & Spine, LLC (50% membership interest held by WCHN)

SCHEDULE 4.4
Government Filings and Approvals

1. Hart-Scott-Rodino Pre-Merger Notification Filing with the U.S. Department of Justice and the U.S. Federal Trade Commission and subsequent clearance
2. State of Connecticut Office of Health Care Access Certificate of Need Application and approval
3. State of Connecticut Department of Public Health hospital license notice (post-closing)
4. Clinical Laboratory Improvements Act notice to State of Connecticut Department of Public Health
5. Change of Information Notice to the Centers for Medicare and Medicaid Services (post-closing)
6. Nuclear Regulatory Commission notice (post-closing)
7. Federal Drug Enforcement Agency notice (post-closing)
8. Registration number notice to State of Connecticut Department of Consumer Protection, Drug Control Division (post-closing)
9. State of Connecticut Office of Attorney General antitrust notice
10. Notice to Electronic Data Systems on behalf of Connecticut Department of Social Services (post-closing)
11. State of Connecticut Department of Environmental Protection Transfer Act form(s), as appropriate, with Norwalk as the certifying party, pursuant to Conn. Gen. Stat. §22a-134 et seq. (post-closing)

SCHEDULE 4.5
Non-Governmental Consents

None

SCHEDULE 4.12

Revisions to Restated Governing Documents

I. **Revision to NHSC Bylaws.** The reference in Section 3.2 to the President and CEO of Norwalk Hospital Foundation, Inc. shall be changed to the Chairman of the Board of Norwalk Hospital Foundation, Inc.

II. **Revision to NHA Bylaws.** The reference in Section 3.2 to the President and CEO of Norwalk Hospital Foundation, Inc. shall be changed to the Chairman of the Board of Norwalk Hospital Foundation, Inc.

III. **Revision to WCHN Bylaws.**

1. Section 4.1 shall be amended to provide that non-Board members may be appointed to any committee but without vote.

2. Section 4.1 shall be amended to provide that there shall be an equitable distribution of DH/NMH Directors (as defined in the WCHN Bylaws) and NHA Directors (as defined in the WCHN Bylaws) appointed to each of the six committees listed in Section 4.1

3. Section 4.4 shall be amended to provide that the Executive Compensation Committee shall consist of the Chair, Vice-Chair and at least three (3) other directors.

4. Section 4.4 shall be amended to reflect the fact that the Executive Compensation Committee shall advise the Board not only on executive compensation strategies and policies but also on executive benefit strategies and policies.

SCHEDULE 7.2(g)
WCHN Labor Agreements

1. Agreement by and between The Danbury Hospital and Danbury Nurses Union Unit #47, Local #5047, AFTCT, AFT Healthcare, AFL-CIO, dated August 22, 2011.
2. Agreement by and between New Milford Hospital, Inc. and the New Milford Hospital Federation of Registered Nurses, AFT-Connecticut, AFT-Healthcare, American Federation of Teachers (AFT), AFL-CIO, dated January 1, 2012.

SCHEDULE 7.3(g)
NHSC Labor Unions

1. Collective Bargaining Agreement by and between The Norwalk Hospital Association and Registered Professional Nurses Local Unit #23, Connecticut Health Care Associates, National Union of Hospital & Health Care Employees, AFSCME, AFL-CIO, dated August 1, 2012

CLOSING MEMORANDUM
OF
NORWALK HEALTH SERVICES CORPORATION
AND
WESTERN CONNECTICUT HEALTH NETWORK, INC.

This Closing Memorandum is being delivered as of this 23rd day of December, 2013 pursuant to Section 1.2 of that certain Affiliation Agreement by and between Norwalk Health Services Corporation ("NHSC") and Western Connecticut Health Network, Inc. ("WCHN"), dated as of January 22, 2013 (the "Affiliation Agreement"). NHSC and WCHN may be referred to herein singly as a "Party" and collectively as the "Parties."

Each of the undersigned individuals, acting solely in his capacity as the President and Chief Executive Officer of NHSC or WCHN, as applicable, pursuant to all requisite approval of the Board of Directors of NHSC or WCHN, as applicable, hereby agrees the Closing (as such term is defined in the Affiliation Agreement) will occur on January 1, 2014 and certifies the following with respect to NHSC or WCHN, as applicable:

1. Except as previously disclosed to the other Party in compliance with the interim disclosure requirements set forth in the Affiliation Agreement, each of the representations and warranties of NHSC or WCHN, as applicable, set forth in Section 7 of the Affiliation Agreement is true, accurate and complete in all material respects as of the date hereof; and

2. All conditions precedent to the Closing set forth in Section 4 of the Affiliation Agreement have been satisfied or are hereby waived.

In addition, each of the undersigned individuals agree, on behalf of NHSC or WCHN, as applicable, that, subject to and effective as of the Closing, the membership of each standing committee of WCHN named in the Bylaws of WCHN shall be as set forth in **Exhibit A** attached hereto and made a part hereof.

[SIGNATURES ON NEXT PAGE]

IN WITNESS HEREOF, the undersigned individuals have executed this Closing Memorandum as of the date first above written.

WESTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name: John M. Murphy, M.D.
Title: President and Chief Executive Officer

NORWALK HEALTH SERVICES CORPORATION

By: _____
Name: Daniel J. DeBarba, Jr.
Title: President and Chief Executive Officer

EXHIBIT A
WCHN Committee Appointments

Quality	
Post-Affiliation	
Directors	Non-Directors
Richard Jabara – Chair	Thomas Ayoub, M.D.
David Kramer, M.D.	Robert Ready
Neil Culligan, M.D.	Howard Eison, M.D.
Spencer M. Houldin	
Paul Gagne, M.D.	William Begg, M.D.
Diane M. Allison	John Chronakos, M.D.
Barbara Butler	Mark Booth

Finance	
Post-Affiliation	
Directors	Non-Directors
Diane M. Allison – Chair	Mark Gudis
Joseph D. Skrzypczak	Patricia S. Bam
Victor Liss	Karleen C. Strayer
George Bauer	Martin Serrins, M.D.
David Cyganowski	Bruce Dresner
Brian C. White	

Planning	
Post-Affiliation	
Directors	Non-Directors
Anthea Disney – Co-Chair	Amy Schafrann
Ervin R. Shames – Co-Chair	Gary Reiner
James A. Kennedy	Frank Zullo
Paul Gagne, M.D.	
Joseph D. Skrzypczak	Gregory D. Smith
Andrew Whittingham	Deborah Seidel
	Clemens Taeuber

Technology subcommittee	
Post-Affiliation	
Directors	Non-Directors
James A. Kennedy	Gary Reiner - Chair
Andrew Whittingham	Richard Zelkowitz
	Clemens Taeuber
	William Hennessy, M.D.
	Dale Kutnick
	Victor Abraham
	Paul McGuire, M.D.

Governance	
Post-Affiliation	
Directors	Non-Directors
James A. Kennedy - Chair	
David Cyganowski	
Anthea Disney	
Diane M. Allison	
George Bauer	
Barbara Butler	

Compensation	
Post-Affiliation	
Directors	Non-Voting Appointees
Ervin R. Shames - Chair	David Komansky
David Cyganowski	
Joseph D. Skrzypczak	
George Bauer	
Diane M. Allison	
James A. Kennedy	

Audit	
Post-Affiliation	
Directors	Non-Voting Appointees
Brian C. White - Chair	Fred R. Afragola
Joseph D. Skrzypczak	Ed Mahony
Victor Liss	David Lehn

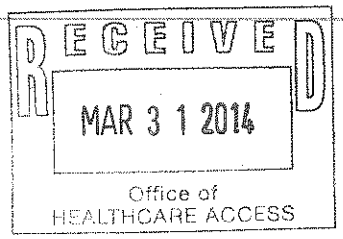
Investment Subcommittee	
Post-Affiliation	
Directors	Non-Directors
Andrew Whittingham	Bruce Dresner - Chair
George Bauer	Mark Gudis
	David Lehn
Joseph D. Skrzypczak	Fred R. Afragola
	Patricia S. Bam
	Robert McDonald

Huber, Jack

From: Roberts, Karen
Sent: Monday, March 31, 2014 8:31 AM
To: Huber, Jack
Cc: Ciesones, Ron
Subject: FW: Docket Number 13-31832-CON
Attachments: OHCA Docket #13-31832-CON Reporting 3 28 2014.pdf

FYI related to the Norwalk affiliation. Karen

From: Herlihy, Sally [mailto:Sally.Herlihy@wchn.org]
Sent: Friday, March 28, 2014 5:00 PM
To: Roberts, Karen
Cc: Jeryl.Topalian@Norwalkhealth.org
Subject: Docket Number 13-31832-CON



Hi Karen,

Please find attached correspondence related to Order Number Four of the corporate affiliation between WCHN/NHSC and the request for integration plans. This email will be followed up with a copy of the materials sent via Federal Express to the OHCA office. If you have any questions please do not hesitate to contact me.

Sincerely,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

Executive Assistant: Michelle Johnson
Voice: (203) 739-4935
Email: michelle.johnson@wchn.org

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

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 Western Connecticut Health Network immediately by email reply to the sender, and delete the transmittal and any attachments.

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Office of
HEALTHCARE ACCESS

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

March 28, 2014

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone:

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation - Order Number Four requests that we submit no later than March 31, 2014, a detailed and comprehensive document showing the plan to integrate the operations of both parent corporations and attain the cost savings stated within the CON Application.

Please find enclosed the following:

- A summary plan to implement integration efforts and realize the benefits of the affiliation.
- A summary of the anticipated financial savings as outlined during the CON process.

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally. F. Herlihy

Sally. F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Lisa Brady, SVP Strategy & Market Development
Carolyn McKenna, Esq. General Counsel

Docket # 13-31832-CON

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

I. Integration Planning

The affiliation between Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. provides an opportunity to collaborate and cooperate in order to improve and enhance the quality of care provided to our patients and meet the increasing demands of the health care environment. The key initiatives identified through our integration efforts are designed to bring together both organizations and support the following affiliation goals:

- Strengthen clinical programs to demonstrate quality outcomes and to improve access to health care;
- Strengthen physician platform for delivery of care;
- Build competencies required for new reimbursement models, such as population health management, bundled payments, PHO and ACOs;
- Enhance educational programs, including programs for medical students, residents and fellows;
- Integrate certain operations to achieve savings and create a unified operating model;
- Improve access to and/or reduce cost of capital due to system scale and performance.

Infrastructure and Functions

The structure to integrate our operations and attain the costs savings stated within the CON application include a Steering Committee which is comprised of members of senior leadership; dedicated staff in an Integration Management Office, including performance improvement; and individual teams focused on core areas to realize our affiliation goals.

The functions of each of these structures are:

Steering Committee

- Provide overall vision and direction
- Drive key decisions
- Commit and manage resourcing
- Eliminate obstacles
- Spearhead change management behaviors

Integration Management Office (IMO)

- Manage project objectives and milestones
- Manage activities of functional teams
- Assess overall resourcing
- Provide tools, templates and protocols
- Monitor results and report appropriately

Integration Teams

- Identify synergy opportunities
- Assign resources and team roles
- Develop consensus and buy-in
- Develop work plans, resource needs and deliverables
- Provide regular progress reports to the IMO

Timeline & Task Details

Day 1 of the affiliation commenced January 1, 2014.

Key Areas of Focus:

The integration teams are categorized within four areas: Clinical Programs, Education Programs, Operations, and Physician Platform. Each team has been charged with development of a charter, designing a potential future state, making recommendations on how to proceed and potential efficiencies that could be realized through integration efforts. Consideration has also been focused toward addressing the leadership and organization structure, assessing resource capacity and requirements, monitoring and addressing dependencies, developing a plan consistent with core business, and prioritizing with other initiatives.

A summary of the tactical integration projects is identified below. The potential impact of these initiatives includes cost savings (C), efficiencies through staffing and operations (E), and quality outcomes and access (Q).

Clinical Programs		
Teams	*Value Statement*	*Description of Initiatives*
Cardiovascular Services	Leverage the full resources of our system to better serve the patients in our expanded catchment area. Potential impact: C, E, Q	1. Clinical Steering and Advisory Committee 2. Clinical quality guidelines 3. Clinical integration
Cancer Services	Leverage the enhanced oncology service line to increase physician engagement and broaden patient services to strengthen the program. Potential impact: C, E, Q	1. Organizational structure 2. Disease site programs 3. Accreditations 4. Data management
Care Coordination	Develop a standardized approach to appropriate utilization of resources across the patient care continuum assuring that patients are consistently treated at the right place, with the right care. Potential impact: C, E, Q	1. Delivery model 2. Standardization through admission, stay and discharge 3. Utilization review
Laboratory and Pathology	Determine an enhanced laboratory service delivery model to most effectively and efficiently serve both inpatient and outpatient needs. Potential impact: C, E, Q	1. Reference testing 2. Automation 3. Centralized approach
Pediatrics	Establish a service line across the health system to fully support the inpatient and surgical services for the pediatric patients in our population. Potential impact: C, E, Q	1. Primary and subspecialty needs 2. Medical education

Teams	*Value Statement*	*Description of Initiatives*
Pharmacy	Determine an enhanced pharmacy service delivery model to most effectively and efficiently serve both inpatient and outpatient needs. Potential impact: C, E, Q	1. P&T Structure 2. Medication formularies 3. Standardization 4. Group purchasing
Primary Care	Evaluate geographical, specialty and volume considerations and implications to best serve patients in line with the system's new approach to delivery of medical services. Potential impact: C, E, Q	1. Alignment 2. Patient-centered medical homes 3. Primary care infrastructure
Quality and Safety	Integrated departments, processes, policies and procedures to create a consistent approach to "quality" across the system. Potential impact: C, E, Q	1. Organizational structure 2. Quality & Patient Safety Committee 3. Level 3 HRO
Education Programs		
Teams	*Value Statement*	*Description of Initiatives*
Medical Education	Evaluate synergies and opportunities to integrate, extend, and create medical education and research programs. Potential impact: C, E, Q	1. Organizational structure 2. Residency and fellowship programs
Operations		
Teams	*Value Statement*	*Description of Initiatives*
Compliance	Integrate and standardize the approach to the broad spectrum of compliance functions to ensure consistency, clarity and effectiveness across the system. Potential impact: C, E, Q	1. Internal audit 2. Compliance and Privacy programs 3. Revenue compliance
Facilities	Integrate facilities management and real estate functions across entities to create a responsive and efficient service. Potential impact: C, E, Q	1. Project management 2. Utilities management 3. Maintenance and service contracts 4. Policies and procedures
Finance	Optimize processes to reduce duplication and create efficiencies. Potential impact: C, E, Q	1. Corporate office and function 2. Accounting & Finance information systems 3. Payroll processes 4. Accounts payable processes 5. Productivity and benchmarking 6. Audit processes

Teams	*Value Statement*	*Description of Initiatives*
Foundations	Identify opportunities for combined development activity and Foundation structure and synergies. Potential impact: C, E, Q	1. Leadership structure 2. Databases and systems 3. Event calendar 4. Communications 5. Fundraising priorities and goals 6. Donor recognition
Human Resources	Evaluate and identify areas to standardize policies and procedures to optimize employee engagement, retain high performing talent, and define the optimal structure, functions and processes of HR operations. Potential impact: C, E, Q	1. Centralized approach 2. Operations 3. Benefits platform
Information Technology	Develop, prioritize and optimize the systems, technology and information intelligence necessary to achieve the mission of our new system. Potential impact: C, E, Q	1. Enterprise approach and guiding principles 2. IT Governance structure 3. Decision/prioritization model 4. Transformation roadmaps
Marketing & Planning	Develop a standardized and centralized approach to support the business and brand across marketing, communications and planning to enable the health system to effectively deliver these functions and project a consistent image. Potential impact: C, E, Q	1. Organizational structure 2. Market intelligence 3. Geographic distribution 4. Business development 5. "Virtual" community
Revenue Cycle	Standardize processes to enhance services, reduce duplication and create efficiencies. Potential impact: C, E, Q	1. Organizational structure 2. Patient financial services 3. Patient access 4. Revenue integrity 5. Revenue cycle 6. Coding, HIM and clinical documentation integrity 7. Outsourced functions
Risk Management	Integrate and standardize approach to risk management across the system. Potential impact: C, E, Q	1. Leadership structure 2. Insurance programs
Supply Chain	Integrate and standardize processes, reduce duplication and create efficiencies. Potential impact: C, E, Q	1. Organizational structure 2. Guiding processes, policies and procedures 3. Strategic sourcing 4. Contracts and capital management processes 5. Distribution processes

Physician Platform		
Teams	*Value Statement*	*Description of Initiatives*
PHO/ACO	Identify opportunities to expand the PHO and ACO strategies to best serve all of the expanded system entities. Potential impact: C, E, Q	1. Governance structure 2. Integrated care management 3. Population health management 4. Pilot ACO 5. Network management
Physician Organization	Create consistent organizational alignment, compensation structure and philosophy to properly align incentives and motivate physicians to execute against the strategic vision of the new enterprise. Potential impact: C, E, Q	1. Governance structure 2. Standardization and alignment 3. EHR systems

Monitoring

An ongoing process of oversight and progress reporting is coordinated by the IMO:

- The Steering Committee, comprised of key leadership, meets on a routine basis to assess activities and progress of the plan, including:
  - Key accomplishments and observations
  - Major issues and decisions needed
  - Action plans and focused activities for next status report
  - Cross work stream dependencies and collaborations
  - Key performance indicators
- The Integration Steering Committee reports activities to the WCHN Board of Directors.

Narrative updates on the progress of implementation plans will be submitted to OHCA on a semi-annual basis for three years, including how the benefits/cost savings enumerated in the CON have been accounted for.

II. Anticipated Financial Savings

The semi-annual financial reporting requirements will also include the specifics of the cost savings for major operating expense categories. These categories include Salaries and Wages, Fringe Benefits, Contracted Labor Fees, Medical Supplies and Pharmaceutical Costs, Deprecation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expense and Other Operating Expenses.

Forecasted Expense Savings (as outlined in the CON)

	Year 1*	Year 2	Year 3
Salaries and Fringe Benefits	$3,428,000	$6,987,000	$10,891,000
Supplies and Drugs	$818,000	$1,675,000	$2,606,000
Other Operating Expense (Costs)**	($2,151,000)	$1,241,000	$5,601,000
Total Savings	$2,095,000	$9,903,000	$19,098,000

* Year 1 commenced January 1, 2014

**Other operating expenses are costs associated with the affiliation such as legal fees, consulting, and marketing

Source: Financial Attachment I, CON pages 196 and 197

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Source: Financial Attachment I, CON pages 196 and 197

Roberts, Karen

From: Herlihy, Sally <Sally.Herlihy@wchn.org>
Sent: Friday, May 30, 2014 4:06 PM
To: Roberts, Karen
Cc: lisa.brady@norwalkhealth.org; McKenna, Carolyn
Subject: OHCA Docket #13-31832 CON Reporting
Attachments: OHCA Docket #13-31832 CON Reporting 5 30 2014.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Karen,

Please find attached correspondence related to Order Number Four of the corporate affiliation between WCHN/NHSC and the request for a narrative update and financial information. This email will be followed up with a copy of the materials mailed to the OHCA office. If you have any questions please do not hesitate to contact me.

Sincerely,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

Executive Assistant: Michelle Johnson
Voice: (203) 739-4935
Email: michelle.johnson@wchn.org

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL + NEW MILFORD HOSPITAL

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DANBURY HOSPITAL • NEW MILFORD HOSPITAL

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JUN - 5 2014
Office of HEALTHCARE ACCESS

24 Hospital Ave.
Danbury, CT 06810
203.739.7000

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DanburyHospital.org
NewMilfordHospital.org

May 30, 2014

Kimberly R. Martone, Director of Operations
Department of Public Health
Office of Health Care Access
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P.O. Box 340308
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Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
d. Balance Sheet for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital

Please find enclosed our responses.

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Lisa Brady, SVP Strategy & Market Development
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Progress Report: January-March 2014

Our Integration Steering Committee has met monthly since the affiliation date of January 1, 2014 for the purpose of reviewing progress of our implementation plan activities, addressing resource requirements and ensuring coordination and communication of activities across our hospital campuses is in place.

Our Integration Management Office (IMO) is managing the project objectives and monitoring implementation activities. Integration Teams continue to assess current and future resource requirements, develop work plans and provide progress reports to the IMO. Each Integration team has been assigned an IMO staff person to provide resources and tools as integration activities become operational.

A Resource Management Council (RMC) has been developed from two pre-existing staffing committees that existed at the separate hospitals and managed FTE requests and job postings. The RMC meets weekly to review requests for resources of all three hospitals, including filling staff vacancies, assessing new positions, identifying space needs, and reviewing productivity metrics. A RMC Intake form has been developed and implemented that standardizes the review of these requests.

Information technology (IT) requests abound across our individual hospitals, and a similar assessment process has been established to evaluate specific IT needs. Multiple teams have met to set expectations, gather requirements and investigate current solutions in place. Some activities are identified as requiring a business case for execution, with decisions pending potential future determination, some are interim decisions influenced by the IT platforms in place, and others are more likely to just be implemented as the IT staff can address them. An IT Strategy Council provides governance oversight to the process.

A summary of our integration activities is noted below:

CLINICAL PROGRAMS

A priority focus has been placed on the staff at both legacy organizations getting to know each other, with awareness to current and potential future organizational structures and alignment. A number of ad hoc work groups and committees have been established to facilitate these efforts.

Both the Cancer and Cardiology services have identified a diad leadership structure that includes a physician executive and administrative leader. A number of team meetings have been held to engage staff and review campus priorities. Clinical Steering Committees have been developed to provide oversight to these clinical programs.

An organizational structure to support a system Care Coordination function has been identified and a Director of Care Coordination appointed. An FTE analysis to support a new delivery model is underway.

A review of the reference Laboratories utilized by the hospitals has been undertaken to assess best quality outcomes and evaluate pricing structures to achieve savings.

A single organizational structure has been established for the Quality & Safety function and commitment to High Reliability Organization (HRO) training. A review of job responsibilities is ongoing along with assessment of policies, procedures and processes to align activities is a priority. Our network continues on its HRO/Patient Safety journey and a required safety training class entitled "Safety Starts with Me" is being taught by WCHN managers and senior leaders. Our goal is to have all staff trained by 12/31/14, with classes being offered several times a week through the end of December on all 3 hospital campuses to facilitate implementation.

An outline for system level and local level Pharmacy and Therapeutics Committee (medication use approval) has been developed, along with a recommended timeline for medication/formulary alignment for the hospitals. Formulary changes will result in annualized cost savings across the network.

EDUCATION

Communication about the affiliation and our ongoing activities is a priority for the organization. A series of Leadership and Manager Alignment workshops were held in February to provide an overview of the affiliation and address opportunities to inform and engage the entire workforce and stakeholder communities. A new employee portal has also been implemented to share activities and facilitate employee inquiries about our progress.

A system-wide Education and Development Office has been formed, and several programs on managing change and leading change will be offered to supervisory staff at both the Norwalk Hospital and Danbury Hospital locations in Q3.

Work has been initiated to evaluate potential synergies and opportunities to integrate, extend, and create medical education and research programs across the hospitals.

OPERATIONS

A new Compliance Committee structure has been approved to have one committee for all the hospitals and one committee for the medical group. An integrated work plan is under development that will guide policies and procedures, assessment, education and implementation of priorities. An audit function formally performed by a contract agency will now been done by compliance staff resulting in some operational savings.

An assessment of all our Facilities across the network is in process, along with development of a recommendation for a future real estate management program. Ongoing construction activities at all three hospital campuses are being actively managed through a centralized function. Proposed renovations at Norwalk Hospital will now be self-managed, instead of hiring an "Owner's Representative" firm, and the project will be re-bid based on this new model with cost-savings anticipated over the long term.

An organizational structure encompassing the Finance functions across the network has been developed, with implementation staged over the coming months. A capital policy and guidance for the capital budget planning cycle has been developed. A review of the service line definitions and alignment of reporting across the hospitals has been launched. A goal to centralize staff to a single location to achieve economies of scale is a work in progress.

Revenue Cycle and Supply Chain infrastructures are under active evaluation. Policies and procedures are being assessed, with processes identified that need to be changed or enhanced. Contract approval, capital management, and purchasing processes are being reviewed, modified and introduced as needed.

The staff of the two individual Foundations is being combined and a contract to merge the databases has been approved.

An integrated team of HR specialists from Norwalk and WCHN are working together to support the departments. They are evaluating existing and newly created jobs resulting from the integration work, as well as conducting ongoing recruitment as identified through the work of the RMC. A key focus is to understand the disparate record keeping systems and develop a recommendation for a future platform to bring all the work together. Recognizing the importance of the employee engagement and access, a decision has been made relative to the HR team to have an "on-site" presence at each major location in the network.

An overall centralized organizational structure for the Marketing & Communications, Planning, and Business Development functions has been approved. An account executive model has been implemented to support service lines and various other key stakeholder groups. A web consolidation project has been launched.

Risk Management activities include a review of the individual insurance programs and opportunities for consolidation at a future point in time. IT support for the steps necessary with current systems to enable a common platform for occurrence reporting is in progress.

PHYSICIAN COMMUNITY

A Physician Strategy Council has been formed to serve as a steering group for physician-related business development functions. The group will review specific issues in order to respond to the market's demand for integrated, quality, and effective care across the continuum, including projected requirements for primary care physicians.

Efforts of the PHO are centered on its structure and broadening recruitment activities to include the Norwalk-based physician community. A Practice Managers Advisory Committee has been formed and a pilot ACO program with a provider for their Medicare Advantage enrollees is in development.

4.b.
NHSC/Norwalk Hospital Expense Savings From Affiliation

January 1 - March 31, 2014

	NHSC	Norwalk Hospital
OPERATING EXPENSES		
Salaries and Wages	$8,453	$8,453
Fringe Benefits	3,623	3,623
Contracted Labor Fees		
Medical Supplies and Pharmaceutical Costs	62,736	62,736
Bad Debts		
Depreciation/Amortization		
Interest Expense		
Malpractice		
Utilities		
Business Expenses	8,750	8,750
Other Operating Expense		
Total Savings	$83,562	$83,562

4.c.

NORWALK HOSPITAL

FISCAL YEAR 2013- 6 Months FY 2014

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(4)	(4)
LINE	DESCRIPTION	FY 2013 ACTUAL	FY 2014 - 6 Months ACTUAL
A.	**Operating Revenue:**		
1	Total Gross Patient Revenue	$913,394,783	$445,448,390
2	Less: Allowances	$543,154,825	$264,028,970
3	Less: Charity Care	$18,272,000	$9,176,231
4	Less: Other Deductions	$0	$0
	Total Net Patient Revenue	**$351,967,958**	**$172,243,189**
5	Provision for Bad Debts	$17,836,044	$8,969,083
	Net Patient Service Revenue less provision for bad debts	**$334,131,914**	**$163,274,105**
6	Other Operating Revenue	$16,843,048	$7,662,686
7	Net Assets Released from Restrictions	$0	$0
	Total Operating Revenue	**$350,974,962**	**$170,936,792**
B.	**Operating Expenses:**		
1	Salaries and Wages	$138,382,600	$66,473,699
2	Fringe Benefits	$51,686,620	$20,518,682
3	Physicians Fees	$7,455,185	$3,734,039
4	Supplies and Drugs	$30,741,799	$16,107,133
5	Depreciation and Amortization	$18,635,476	$9,965,037
6	Bad Debts	$0	$0
7	Interest Expense	$2,529,391	$1,230,251
8	Malpractice Insurance Cost	$5,816,594	$1,918,513
9	Other Operating Expenses	$83,733,460	$42,216,660
	Total Operating Expenses	**$338,981,125**	**$162,164,013**
	Income/(Loss) From Operations	**$11,993,837**	**$8,772,779**
C.	**Non-Operating Revenue:**		
1	Income from Investments	$2,302,857	$1,188,994
2	Gifts, Contributions and Donations	$0	$0
3	Other Non-Operating Gains/(Losses)	$0	$1,476,370
	Total Non-Operating Revenue	**$2,302,857**	**$2,665,364**

NORWALK HOSPITAL

FISCAL YEAR 2013- 6 Months FY 2014

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(4)	(4)
LINE	DESCRIPTION	FY 2013 ACTUAL	FY 2014 - 6 Months ACTUAL
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$14,296,694**	**$11,438,143**
	Other Adjustments:		
	Unrealized Gains/(Losses)	$7,760,507	$5,093,251
	All Other Adjustments	$0	$0
	Total Other Adjustments	**$7,760,507**	**$5,093,251**
	Excess/(Deficiency) of Revenue Over Expenses	**$22,057,201**	**$16,531,394**
	Principal Payments	$12,900,862	$3,985,746

NORWALK HEALTH SERVICES CORPORATION

FISCAL YEAR 2013 - 6 Months FY 2014

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(4)	(4)
LINE	DESCRIPTION	FY 2013 ACTUAL	FY 2014 - 6 Months ACTUAL
A.	**Operating Revenue:**		
1	Total Gross Patient Revenue	$979,538,787	$466,834,526
2	Less: Allowances	$577,711,522	$273,420,149
3	Less: Charity Care	$18,272,000	$9,176,231
4	Less: Other Deductions	$0	$0
	Total Net Patient Revenue	**$383,555,265**	**$184,238,146**
5	Provision for Bad Debts	$18,754,828	$9,446,303
	Net Patient Service Revenue less provision for bad debts	**$364,800,437**	**$174,791,843**
6	Other Operating Revenue	$15,543,696	$7,329,850
7	Net Assets Released from Restrictions	$3,450,936	$187,549
	Total Operating Revenue	**$383,795,069**	**$182,309,242**
B.	**Operating Expenses:**		
1	Salaries and Wages	$164,801,605	$79,347,983
2	Fringe Benefits	$56,875,510	$22,892,260
3	Physicians Fees	$8,321,347	$4,377,181
4	Supplies and Drugs	$39,003,388	$19,883,446
5	Depreciation and Amortization	$19,123,385	$10,038,026
6	Bad Debts	$0	$0
7	Interest Expense	$2,695,815	$1,230,251
8	Malpractice Insurance Cost	$7,265,774	$1,918,513
9	Other Operating Expenses	$71,673,327	$38,396,828
	Total Operating Expenses	**$369,760,151**	**$178,084,488**
	Income/(Loss) From Operations	**$14,034,918**	**$4,224,754**
C.	**Non-Operating Revenue:**		
1	Income from Investments	$2,307,725	$1,675,018
2	Gifts, Contributions and Donations	$0	
3	Other Non-Operating Gains/(Losses)	($246,698)	$2,302,720
	Total Non-Operating Revenue	**$2,061,027**	**$3,977,738**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$16,095,945**	**$8,202,492**

NORWALK HEALTH SERVICES CORPORATION

FISCAL YEAR 2013 - 6 Months FY 2014

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(4)	(4)
LINE	DESCRIPTION	FY 2013 ACTUAL	FY 2014 - 6 Months ACTUAL
	Other Adjustments:		
	Unrealized Gains/(Losses)	$10,016,229	$8,106,331
	All Other Adjustments	($1,345,837)	($826,350)
	Total Other Adjustments	**$8,670,392**	**$7,279,981**
	Excess/(Deficiency) of Revenue Over Expenses	**$24,766,337**	**$15,482,473**

4.d.

NORWALK HOSPITAL

FISCAL YEAR 2013 - 6 Months FY 2014

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(4)	(4)
LINE	DESCRIPTION	FY 2013 ACTUAL	FY 2014 - 6 Months ACTUAL
I.	**ASSETS**		
A.	**Current Assets:**		
1	Cash and Cash Equivalents	$73,750,817	$66,993,539
2	Short Term Investments	$8,738,868	$8,738,868
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$26,795,462	$32,097,217
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0
5	Due From Affiliates	$1,346,260	$941,366
6	Due From Third Party Payers	$0	$0
7	Inventories of Supplies	$1,845,044	$1,881,191
8	Prepaid Expenses	$1,589,839	$1,353,250
9	Other Current Assets	$3,410,889	$1,023,761
	Total Current Assets	**$117,477,179**	**$113,029,192**
B.	**Noncurrent Assets Whose Use is Limited:**		
1	Held by Trustee	$59,708,986	$50,870,129
2	Board Designated for Capital Acquisition	$0	$0
3	Funds Held in Escrow	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$327	$327
	Total Noncurrent Assets Whose Use is Limited:	**$59,709,313**	**$50,870,456**
5	Interest in Net Assets of Foundation	$45,162,957	$47,550,619
6	Long Term Investments	$80,922,925	$87,172,038
7	Other Noncurrent Assets	$77,286,903	$31,015,194
C.	**Net Fixed Assets:**		
1	Property, Plant and Equipment	$436,266,355	$438,691,135
2	Less: Accumulated Depreciation	$310,387,551	$319,957,750
	Property, Plant and Equipment, Net	**$125,878,804**	**$118,733,385**
3	Construction in Progress	$34,252,962	$50,988,000
	Total Net Fixed Assets	**$160,131,766**	**$169,721,385**
	Total Assets	**$540,691,043**	**$499,358,884**

NORWALK HOSPITAL

FISCAL YEAR 2013 - 6 Months FY 2014

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1) LINE	(2) DESCRIPTION	(4) FY 2013 ACTUAL	(4) FY 2014 - 6 Months ACTUAL
II.	**LIABILITIES AND NET ASSETS**		
A.	**Current Liabilities:**		
1	Accounts Payable and Accrued Expenses	$29,302,635	$25,979,732
2	Salaries, Wages and Payroll Taxes	$22,048,375	$17,171,463
3	Due To Third Party Payers	$4,893,626	$36,922,182
4	Due To Affiliates	$851,758	$176,610
5	Current Portion of Long Term Debt	$3,265,000	$3,400,000
6	Current Portion of Notes Payable	$1,243,589	$1,266,295
7	Other Current Liabilities	$818,694	$738,157
	Total Current Liabilities	**$62,423,677**	**$85,654,439**
		$62,423,677	$85,654,439
B.	**Long Term Debt:**	$ -	$ -
1	Bonds Payable (Net of Current Portion)	$119,435,000	$116,035,000
2	Notes Payable (Net of Current Portion)	$2,926,397	$2,182,916
	Total Long Term Debt	**$122,361,397**	**$118,217,916**
3	Accrued Pension Liability	$13,061,730	$9,678,419
4	Other Long Term Liabilities	$95,631,123	$20,389,950
	Total Long Term Liabilities	**$231,054,250**	**$148,286,285**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0
C.	**Net Assets:**		
1	Unrestricted Net Assets or Equity	$207,578,029	$223,395,411
2	Temporarily Restricted Net Assets	$30,180,235	$32,561,097
3	Permanently Restricted Net Assets	$9,454,852	$9,461,652
	Total Net Assets	**$247,213,116**	**$265,418,160**
	Total Liabilities and Net Assets	**$540,691,043**	**$499,358,884**

NORWALK HEALTH SERVICES CORPORATION

FISCAL YEAR 2013 - 6 Months FY 2014

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1) LINE	(2) DESCRIPTION	(4) FY 2013 ACTUAL	(4) FY 2014 - 6 Months ACTUAL
I.	**ASSETS**		
A.	**Current Assets:**		
1	Cash and Cash Equivalents	$82,407,195	$76,157,231
2	Short Term Investments	$33,656,759	$28,595,102
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$28,873,592	$33,541,137
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0
5	Due From Affiliates	$0	$0
6	Due From Third Party Payers	$0	$0
7	Inventories of Supplies	$2,717,050	$2,293,850
8	Prepaid Expenses	$1,589,839	$1,560,950
9	Other Current Assets	$6,865,383	$2,348,955
	Total Current Assets	**$156,109,818**	**$144,497,225**
B.	**Noncurrent Assets Whose Use is Limited:**		
1	Held by Trustee	$59,708,986	$36,961,483
2	Board Designated for Capital Acquisition	$0	$0
3	Funds Held in Escrow	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$327	$327
	Total Noncurrent Assets Whose Use is Limited:	**$59,709,313**	**$36,961,810**
5	Interest in Net Assets of Foundation	$0	$0
6	Long Term Investments	$158,419,428	$179,271,248
7	Other Noncurrent Assets	$59,228,366	$58,452,609
C.	**Net Fixed Assets:**		
1	Property, Plant and Equipment	$440,926,532	$441,153,184
2	Less: Accumulated Depreciation	$312,199,270	$321,188,346
	Property, Plant and Equipment, Net	**$128,727,262**	**$119,964,838**
3	Construction in Progress	$34,252,962	$50,988,000
	Total Net Fixed Assets	**$162,980,224**	**$170,952,838**
	Total Assets	**$596,447,149**	**$590,135,730**
		$ 596,447,149	$ 590,135,730

NORWALK HEALTH SERVICES CORPORATION

FISCAL YEAR 2013 - 6 Months FY 2014

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(4)	(4)
LINE	DESCRIPTION	FY 2013 ACTUAL	FY 2014 - 6 Months ACTUAL
		$ -	$ 0
II.	**LIABILITIES AND NET ASSETS**		
A.	**Current Liabilities:**		
1	Accounts Payable and Accrued Expenses	$31,050,734	$28,275,554
2	Salaries, Wages and Payroll Taxes	$26,011,309	$20,704,761
3	Due To Third Party Payers	$5,008,734	$37,037,290
4	Due To Affiliates	$0	$362,336
5	Current Portion of Long Term Debt	$3,265,000	$3,400,000
6	Current Portion of Notes Payable	$1,925,534	$1,266,295
7	Other Current Liabilities	$1,101,735	$738,157
	Total Current Liabilities	**$68,363,046**	**$91,784,393**
B.	**Long Term Debt:**		
1	Bonds Payable (Net of Current Portion)	$119,435,000	$116,035,000
2	Notes Payable (Net of Current Portion)	$5,595,298	$2,182,916
	Total Long Term Debt	**$125,030,298**	**$118,217,916**
3	Accrued Pension Liability	$13,061,730	$9,678,419
4	Other Long Term Liabilities	$97,627,328	$56,642,522
	Total Long Term Liabilities	**$235,719,356**	**$184,538,857**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0
C.	**Net Assets:**		
1	Unrestricted Net Assets or Equity	$239,539,585	$257,472,215
2	Temporarily Restricted Net Assets	$43,370,310	$46,878,613
3	Permanently Restricted Net Assets	$9,454,852	$9,461,652
	Total Net Assets	**$292,364,747**	**$313,812,480**
	Total Liabilities and Net Assets	**$596,447,149**	**$590,135,730**

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.7000

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

RECEIVED
DEC - 9 2014
Office of
HEALTHCARE ACCESS

December 1, 2014

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
d. Balance Sheet for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital

Please find enclosed our responses for the time period April 1, 2014-September 30, 2014.

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Lisa Brady, SVP Strategy & Market Development
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Progress Report: April-September 2014

Our Integration Steering Committee continues to meet on a monthly basis for the purpose of reviewing progress of our implementation plan activities, and our Integration Management Office (IMO) monitors the activities of our integration teams.

A summary of our integration activities is noted below:

CLINICAL PROGRAMS

The Cancer and Cardiovascular Services each have appointed network service line directors, assistant medical directors, and implemented supporting organizational structures. There are network Clinical Steering Committees in place focused on oversight to these clinical programs. A Cancer Center retreat was hosted for over 35 physicians from the network and a clinical research structure to support activities has been developed. Quality dashboards have been developed for both service lines.

Nurse navigators have been transitioned into the Care Coordination function for discharge planning, and engaged in dialogue with community skilled nursing facilities and home care agencies for collaboration.

A network director was appointed and the supporting organization structure for Laboratory & Pathology services was implemented. The consolidation of specialty laboratory services continues to be explored. An IT solution was identified to allow for certain reference testing to be performed and resulted within the network.

The Quality and Safety function and our commitment to become a high-reliability organization (HRO) continues. Over 2,000 employees have been trained to date. Daily safety huddles have been initiated at each hospital campus.

A system Pharmacy and Therapeutics Committee for the network was created and a standardized committee functions locally on each hospital campus. Several medications were approved and standardized to align formularies.

EDUCATION

Communication about the affiliation continues as a priority for the organization, and we have implemented vehicles to provide regular integration related communications which are distributed across the network. These vehicles are frequently updated with news about our integration activities.

Our Education and Development Office held several workshops, at locations across the network, for managers about leading and managing change.

Discussion continues on defining potential opportunities to integrate, extend, and create medical education and research programs across the network.

OPERATIONS

In the Compliance arena we have completed an internal review and comparison of HIPAA privacy policies for all hospitals and affiliated entities to ensure consistency.

Our Facilities team managed renovations of various building space to accommodate relocation and consolidation of staff and have also initiated a project to identify synergies in real estate management for the network.

The centralization of Finance staff to a single location to achieve economies of scale was accomplished and work was completed to support the development of the FY2015 budget at each hospital campus. The Revenue Cycle staff was also centralized to one location to streamline operations. The Supply Chain team designed and developed a Clinical Quality & Value Analysis process across the network and has begun implementation of support software.

The Human Resource specialists continue to support the work of each integration team in the implementation of new organizational structures. Standardization of HR practices such as uniform salary ranges for positions, common background check for employment, onboarding of new employees, and benefit plan design for the coming year have received priority focus.

The staff consolidation of Marketing & Communications, Planning, and Business Development functions has been finalized with relocation plans for both campuses in process. Proposed strategic initiatives and a physician manpower assessment have been undertaken.

A network Claims Committee has been established to support the Risk Management function and the two captive insurance programs have been merged.

PHYSICIAN COMMUNITY

A Physician Strategy Council has been formed to serve as a steering group for physician-related business development functions. Primary Care Councils with designated medical leadership have been established at the Danbury and Norwalk campuses to operationalize integration team recommendations.

Our Physician Hospital Organization (PHO) structure continues to evolve with development of Clinical Pathways and Population Health Management Committees representing independent community practices and employed physicians. An application was submitted to participate in Medicare's Shared Savings program (MSSP) for 2015.

4.b.

NHSC/Norwalk Hospital Expense Savings From Affiliation

April 1 – September 30, 2014

	NHSC	Norwalk Hospital
OPERATING EXPENSES		
Salaries and Wages	$79,181	$6,637
Fringe Benefits	23,754	1,992
Contracted Labor Fees		
Med. Supplies and Pharmaceutical Costs		130,352
Bad Debts		
Depreciation/Amortization		
Interest Expense		
Malpractice		
Utilities		
Business Expenses		26,000
Other Operating Expense	29,270	286,260
Total Savings	$132,206	$451,241

4.c.

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2014-12 Months FY 2014

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)
LINE	DESCRIPTION	FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
A.	**Operating Revenue:**		
1	Total Gross Patient Revenue	$445,448,390	$454,817,110
2	Less: Allowances	$264,028,970	$271,600,572
3	Less: Charity Care	$9,176,231	$7,625,371
4	Less: Other Deductions	$0	$0
	Total Net Patient Revenue	**$172,243,189**	**$175,591,167**
5	Provision for Bad Debts	$8,969,083	$16,550,100
	Net Patient Service Revenue less provision for bad debts	**$163,274,105**	**$159,041,068**
6	Other Operating Revenue	$7,662,686	$12,716,815
7	Net Assets Released from Restrictions	$0	$0
	Total Operating Revenue	**$170,936,792**	**$171,757,882**
B.	**Operating Expenses:**		
1	Salaries and Wages	$66,473,699	$66,548,362
2	Fringe Benefits	$20,518,682	$13,045,698
3	Physicians Fees	$3,734,039	$3,928,347
4	Supplies and Drugs	$16,107,133	$16,127,250
5	Depreciation and Amortization	$9,965,037	$8,672,769
6	Bad Debts	$0	$0
7	Interest Expense	$1,230,251	$1,226,474
8	Malpractice Insurance Cost	$1,918,513	$1,517,614
9	Other Operating Expenses	$42,216,660	$37,086,074
	Total Operating Expenses	**$162,164,013**	**$148,152,589**

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2014-12 Months FY 2014

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)
LINE	DESCRIPTION	FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
	Income/(Loss) From Operations	**$8,772,779**	**$23,605,293**
C.	**Non-Operating Revenue:**		
1	Income from Investments	$1,188,994	$1,069,625
2	Gifts, Contributions and Donations	$0	$0
3	Other Non-Operating Gains/(Losses)	$1,476,370	($3,786,738)
	Total Non-Operating Revenue	**$2,665,364**	**($2,717,113)**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$11,438,143**	**$20,888,180**
	Other Adjustments:		
	Unrealized Gains/(Losses)	$5,093,251	$1,246,174
	All Other Adjustments	$0	$0
	Total Other Adjustments	**$5,093,251**	**$1,246,174**
	Excess/(Deficiency) of Revenue Over Expenses	**$16,531,394**	**$22,134,354**
	Principal Payments	$3,985,746	$522,843

NORWALK HEALTH SERVICES CORPORATION

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)
LINE	DESCRIPTION	FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
A.	**Operating Revenue:**		
1	Total Gross Patient Revenue	$466,834,526	$479,305,479
2	Less: Allowances	$273,420,149	$291,055,166
3	Less: Charity Care	$9,176,231	$7,627,686
4	Less: Other Deductions	$0	$0
	Total Net Patient Revenue	**$184,238,146**	**$180,622,627**
5	Provision for Bad Debts	$9,446,303	$8,079,799
	Net Patient Service Revenue less provision for bad debts	**$174,791,843**	**$172,542,828**
6	Other Operating Revenue	$7,329,850	$11,893,495
7	Net Assets Released from Restrictions	$187,549	($187,549)
	Total Operating Revenue	**$182,309,242**	**$184,248,774**
B.	**Operating Expenses:**		
1	Salaries and Wages	$79,347,983	$80,382,633
2	Fringe Benefits	$22,892,260	$15,527,478
3	Physicians Fees	$4,377,181	$5,378,387
4	Supplies and Drugs	$19,883,446	$20,710,131
5	Depreciation and Amortization	$10,038,026	$8,842,511
6	Bad Debts	$0	$0
7	Interest Expense	$1,230,251	$1,226,475
8	Malpractice Insurance Cost	$1,918,513	$1,517,614
9	Other Operating Expenses	$38,396,828	$31,337,029
	Total Operating Expenses	**$178,084,488**	**$164,922,258**
	Income/(Loss) From Operations	**$4,224,754**	**$19,326,516**
C.	**Non-Operating Revenue:**		
1	Income from Investments	$1,675,018	($1,675,018)
2	Gifts, Contributions and Donations		$4,831,662
3	Other Non-Operating Gains/(Losses	$2,302,720	$129,697
	Total Non-Operating Revenue	**$3,977,738**	**$3,286,341**
	Over Expenses (Before Other Adjustments)	**$8,202,492**	**$22,612,857**
	Other Adjustments:		
	Unrealized Gains/(Losses)	$8,106,331	$1,540,337
	All Other Adjustments	($826,350)	($2,526,052)
	Total Other Adjustments	**$7,279,981**	**($985,715)**

NORWALK HEALTH SERVICES CORPORATION			
DRAFT (unaudited)			
FISCAL YEAR 2014 - 12 Months FY 2014			
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION			
(1)	(2)	(3)	(4)
LINE	DESCRIPTION	FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
	Excess/(Deficiency) of Revenue Over Expenses	$15,482,473	$21,627,142

4.d.

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3) FY 2014 - 6 Months Ending 03/31/2014	(4) FY 2014 - 6 Months Ending 09/30/2014
LINE	DESCRIPTION	ACTUAL	ACTUAL
I.	**ASSETS**		
A.	**Current Assets:**		
1	Cash and Cash Equivalents	$66,993,539	$74,550,518
2	Short Term Investments	$8,738,868	$8,764,927
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$32,097,217	$40,426,872
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0
5	Due From Affiliates	$941,366	$359,163
6	Due From Third Party Payers	$0	$0
7	Inventories of Supplies	$1,881,191	$1,774,961
8	Prepaid Expenses	$1,353,250	$1,172,206
9	Other Current Assets	$1,023,761	$1,782,124
	Total Current Assets	**$113,029,192**	**$128,830,771**
B.	**Noncurrent Assets Whose Use is Limited:**		
1	Held by Trustee	$50,870,129	$23,405,407
2	Board Designated for Capital Acquisition	$0	$0
3	Funds Held in Escrow	$0	$0
4	Other Noncurrent Assets Whose Use is Limited	$327	$327
	Total Noncurrent Assets Whose Use is Limited:	**$50,870,456**	**$23,405,734**
5	Interest in Net Assets of Foundation	$47,550,619	$47,837,445
6	Long Term Investments	$87,172,038	$116,845,100
7	Other Noncurrent Assets	$31,015,194	$9,540,310
C.	**Net Fixed Assets:**		
1	Property, Plant and Equipment	$438,691,135	$499,341,781
2	Less: Accumulated Depreciation	$319,957,750	$327,851,270
	Property, Plant and Equipment, Net	**$118,733,385**	**$171,490,511**
3	Construction in Progress	$50,988,000	$73,526,813
	Total Net Fixed Assets	**$169,721,385**	**$245,017,324**

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3) FY 2014 - 6 Months Ending 03/31/2014	(4) FY 2014 - 6 Months Ending 09/30/2014
LINE	DESCRIPTION	ACTUAL	ACTUAL
	Total Assets	$499,358,884	$571,476,684

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3) FY 2014 - 6 Months Ending 03/31/2014	(4) FY 2014 - 6 Months Ending 09/30/2014
LINE	DESCRIPTION	ACTUAL	ACTUAL
II.	**LIABILITIES AND NET ASSETS**		
A.	**Current Liabilities:**		
1	Accounts Payable and Accrued Expenses	$25,979,732	$39,622,141
2	Salaries, Wages and Payroll Taxes	$17,171,463	$18,445,669
3	Due To Third Party Payers	$36,922,182	$36,793,995
4	Due To Affiliates	$176,610	$28,975,095
5	Current Portion of Long Term Debt	$3,400,000	$3,400,000
6	Current Portion of Notes Payable	$1,266,295	$1,146,051
7	Other Current Liabilities	$738,157	$778,518
	Total Current Liabilities	**$85,654,439**	**$129,161,469**
		$85,654,439	$129,161,469
B.	**Long Term Debt:**	$ -	$ -
1	Bonds Payable (Net of Current Portion)	$116,035,000	$119,993,971
2	Notes Payable (Net of Current Portion)	$2,182,916	$1,780,316
	Total Long Term Debt	**$118,217,916**	**$121,774,287**
3	Accrued Pension Liability	$9,678,419	$20,983,507
4	Other Long Term Liabilities	$20,389,950	$17,759,638
	Total Long Term Liabilities	**$148,286,285**	**$160,517,432**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0
C.	**Net Assets:**		
1	Unrestricted Net Assets or Equity	$223,395,411	$242,613,565
2	Temporarily Restricted Net Assets	$32,561,097	$29,722,566
3	Permanently Restricted Net Assets	$9,461,652	$9,461,652
	Total Net Assets	**$265,418,160**	**$281,797,783**
	Total Liabilities and Net Assets	**$499,358,884**	**$571,476,684**

NORWALK HEALTH SERVICES CORPORATION

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1) LINE	(2) DESCRIPTION	(3) FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	(4) FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
6	Long Term Investments	$179,271,248	$157,872,131
7	Other Noncurrent Assets	$58,452,609	$57,441,714
C.	**Net Fixed Assets:**		
1	Property, Plant and Equipment	$441,153,184	$498,392,071
2	Less: Accumulated Depreciation	$321,188,346	$330,053,165
	Property, Plant and Equipment, Net	**$119,964,838**	**$168,338,906**
3	Construction in Progress	$50,988,000	$78,197,483
	Total Net Fixed Assets	**$170,952,838**	**$246,536,389**
	Total Assets	**$590,135,730**	**$621,906,426**
		$ 590,135,730	

NORWALK HEALTH SERVICES CORPORATION

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1) LINE	(2) DESCRIPTION	(3) FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	(4) FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
		$ 0.25	
II.	**LIABILITIES AND NET ASSETS**		
A.	**Current Liabilities:**		
1	Accounts Payable and Accrued Expenses	$28,275,554	$42,007,757
2	Salaries, Wages and Payroll Taxes	$20,704,761	$22,250,707
3	Due To Third Party Payers	$37,037,290	$36,909,103
4	Due To Affiliates	$362,336	$1,042,611
5	Current Portion of Long Term Debt	$3,400,000	$4,546,051
6	Current Portion of Notes Payable	$1,266,295	$778,518
7	Other Current Liabilities	$738,157	$0
	Total Current Liabilities	**$91,784,393**	**$107,534,747**
B.	**Long Term Debt:**		
1	Bonds Payable (Net of Current Portion)	$116,035,000	$119,993,971
2	Notes Payable (Net of Current Portion)	$2,182,916	$1,780,316
	Total Long Term Debt	**$118,217,916**	**$121,774,287**
3	Accrued Pension Liability	$9,678,419	$20,983,507
4	Other Long Term Liabilities	$56,642,522	$52,531,110
	Total Long Term Liabilities	**$184,538,857**	**$195,288,904**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0

NORWALK HEALTH SERVICES CORPORATION

DRAFT (unaudited)

FISCAL YEAR 2014 - 12 Months FY 2014

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)
LINE	DESCRIPTION	FY 2014 - 6 Months Ending 03/31/2014 ACTUAL	FY 2014 - 6 Months Ending 09/30/2014 ACTUAL
C.	**Net Assets:**		
1	Unrestricted Net Assets or Equity	$257,472,215	$263,077,279
2	Temporarily Restricted Net Assets	$46,878,613	$46,543,844
3	Permanently Restricted Net Assets	$9,461,652	$9,461,652
	Total Net Assets	**$313,812,480**	**$319,082,775**
	Total Liabilities and Net Assets	**$590,135,730**	**$621,906,426**

Greer, Leslie

From: Martone, Kim
Sent: Sunday, February 08, 2015 4:32 PM
To: Greer, Leslie; Riggott, Kaila
Subject: Fw: OHCA - Docket # 13-31832-CON
Attachments: #13-31832-CON OHCA First Annual Report of Accomplishments- 6th draft.pdf

Importance: High

From: Johnson, Michelle [mailto:Michelle.Johnson@wchn.org]
Sent: Friday, February 06, 2015 04:04 PM
To: Martone, Kim
Cc: McKenna, Carolyn <Carolyn.McKenna@wchn.org>; DeBarba, Daniel <Daniel.DeBarba@wchn.org>; Roberts, Karen; Herlihy, Sally <Sally.Herlihy@wchn.org>
Subject: OHCA - Docket # 13-31832-CON

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached documentation for Docket Number 13-31832-CON on behalf of Western Connecticut Health Network. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson
Executive Assistant to Senior Administrators
Western Connecticut Health Network

203-739-4935

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

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WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL · NEW MILFORD HOSPITAL

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Office of
HEALTHCARE ACCESS

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

February 06, 2015

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Three requests that we will submit the following:

On an annual basis, for two (2) years from the date of execution of the Agreed Settlement, the applicants must report to OHCA how the benefits/cost savings enumerated in Findings of Fact 23 and 36-38 have been achieved and within sixty (60) days of all the benefits/savings having been accounted for, the Applicants shall provide a final summary enumerating all aforementioned benefits/cost savings.

Please find enclosed our first annual response.

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Dan DeBarba, Executive VP, WCHN
Carolyn McKenna, Esq. General Counsel

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Year 1 Progress Report

OVERVIEW

On January 1, 2014 the affiliation between Norwalk Health Services Corporation and Western Connecticut Health Network, Inc. was formally executed. The infrastructure to integrate operations of the organizations was developed that includes an Integration Steering Committee, Integration Management Office and individual teams focused on core areas to realize our affiliation goals.

The following were identified as benefits of the affiliation:

a) Strengthening clinical programs to demonstrate quality outcomes and to improve access to health care;
b) Enhancing educational programs, including strengthened programs for medical students, residents, and fellows in both organizations;
c) Strengthening the physician platform for delivery of care;
d) Building competencies required for new reimbursement models, such as population health management, bundled payments, Physician-Hospital Organization (PHO), and ACOs;
e) Integrating operations to achieve savings and create a unified operating model; and
f) Improving access to and/or reducing cost of capital due to system scale and performance.

A summary of our progress in achieving these benefits is noted below.

STRENGTHENING CLINICAL PROGRAMS

A priority goal with our affiliation is clinical integration that ensures the provision of ongoing care in a consistent manner across network clinical services. As noted in previous reports, Cancer and Cardiovascular services have been identified as network service lines, and each has appointed network service line directors and supporting organizational structures. There are network Clinical Steering Committees in place focused on oversight to these clinical programs and performance dashboards have been developed for both service lines. A physician director has been recruited to oversee the three network Cancer Centers, and a network cancer registry has been created. A physician director has also been appointed to oversee the network cardiovascular services. Danbury Hospital Interventional Cardiologists obtained privileges at Norwalk Hospital, and have performed cases at the Norwalk campus that would have otherwise been transferred.

Medicine, Surgery, Women's & Children's, Behavioral Health, Radiology, Laboratory, Pharmacy, and Corporate & Occupational Health each have network administrative directors appointed and are building the supporting infrastructure.

Expanded network clinical advancements include the transcatheter aortic valve replacement (without open heart surgery), radioactive seed localization (more precise localization of breast mass in cancer treatment), fenestrated endovascular abdominal aortic repair (advancements in aneurysm management), robotically-assisted total hip replacement using the MAKO robot, LINQ insertable cardiac monitors (smallest devoice available) and LINX reflux management system (reducing need for medications).

ENHANCING QUALITY & PATIENT SAFETY

Development of the Quality and Safety infrastructure and our commitment to become a high-reliability organization (HRO) continues. In our first year, 50 leaders have been certified as HRO trainers and we have trained over 7,000 employees and members of our medical staff across the network in HRO principles. New employees are now receiving HRO training as part of their orientation process. We believe that this training is critical to ensuring a solid foundation to build upon, as we continue to strengthen our HRO culture. Daily Safety Huddles have been initiated at each hospital campus and we are reintroducing a consistent approach to Leadership Rounding across the campuses.

We have established a Network Quality Department that includes Quality, Patient Safety, Regulatory Compliance, Patient Relations, Risk Management and Infection Control. We are standardizing nursing care and implementing best practices to minimize falls, infections and pressure ulcers. Nurse navigators have been transitioned into the Care Coordination function for discharge planning, and engaged in dialogue with community skilled nursing facilities and home care agencies for collaboration.

EDUCATION

Communication about the affiliation continues as a priority for the organization, and we have implemented vehicles to provide regular integration related communications which are distributed across the network. These vehicles are updated frequently with news about our integration activities. Our Education and Development Office held several workshops, at locations across the network, for managers about leading and managing change.

Discussion continues on defining potential opportunities to integrate, extend, and create medical education and research programs across the network. The Obstetrics & Gynecology residency has been expanded to the Norwalk campus.

BROADENING THE PHYSICIAN PLATFORM

A Physician Strategy Council has been formed to serve as a steering group for physician-related business development functions. A physician manpower assessment was completed in October, and the community need for primary care and specialty care physicians has been identified across the network. Plans are being developed to prioritize recruitment efforts by geography and specialty to address community needs.

We have expanded hepatobiliary surgery, colorectal surgery, thoracic surgery, gynecologic surgery and gastroenterology services. Thirty-eight new physicians, 29 advance practice professionals and 4 practices have been recruited to expand access to care across the network. A unified organizational structure was implemented for management of the medical groups; Western Connecticut Medical Group (WCMG), and Norwalk Hospital Physicians and Surgeons (NHP&S).

NEW REIMBURSEMENT MODELS

Our network commitment to build the necessary competencies and infrastructure to position the network's successful progression from volume to value reimbursement models continues. Our Physician Hospital Organization (PHO) structure is evolving with development of Clinical Pathways and Population Health Management Committees representing independent community practices and employed physicians. Thirty-five (35) independent community practices agreed to participate in the WCHN ACO, along with the network

hospitals and medical group. An application was submitted to participate in Medicare's Shared Savings program (MSSP) for 2015, and we received notification in December, 2014 that the network was selected for participation. In addition, an agreement was finalized to participate in Aetna's pilot accountable care program. A data warehousing system was selected for the PHO and ACO.

CREATING AN INTEGRATED OPERATING MODEL

We have implemented a network-wide organizational structure and management team. As noted in previous progress reporting, work continues with 22 integration teams identifying synergy opportunities, developing priorities and work plans and implementing tactical changes.

Of note employee benefits (health & retirement) have been consolidated to a single platform across the system. The Human Resource specialists continue to support the work of each integration team in the implementation of new organizational structures. Standardization of HR practices such as uniform salary ranges for positions, common background check for employment, onboarding of new employees, and benefit plan design for the coming year received priority focus.

Work supporting the centralization of Finance staff to a single location to achieve economies of scale was accomplished; the Revenue Cycle staff was also centralized to one location to streamline operations. We have transitioned Danbury and New Milford to a single license, and implemented a new financial system across the two campuses.

A network chief information officer was appointed and a supporting organizational structure was implemented. High-speed network connection was established between Norwalk and legacy WCHN campuses. An integrated information technology strategy was developed, with a network level IT Strategy Council to guide all strategic IT initiatives. IT project support was prioritized for integration team activities. IT Strategy Council approval was obtained for recommendations for IT system selections for financial budgeting, cost accounting, decision support system, reference lab integration, web strategy, and analytics. An initial evaluation of incumbent vendors was completed in preparation for network selection of ERP strategy.

A network Claims Committee has been established to support the Risk Management function and the two captive insurance programs have been merged.

Network mission, vision and values have been identified, along with a new Strategic Plan and fiscal year 2015 strategic objectives approved by the Board in December.

FINANCIAL STRENGTH AND ACCESS TO CAPITAL

Implementation of the integration work plan has resulted in $ 2,761,917 savings and no large capital projects were initiated during the period.

PROJECTED COST SAVINGS
October 1, 2013 – September 30, 2014

Norwalk Hospital

Category	Impact	
Salaries & Wages	$	501,611
Fringe Benefits	$	3,610,364
Med Supplies/Rx Costs	$	161,387
Business & Other Op Expenses	$	(418,615)
Total:	**$**	**3,854,747**

Danbury/New Milford Hospital

Category	Impact	
Salaries & Wages	$	390,716
Fringe Benefits	$	158,429
Med Supplies/Rx Costs	$	1,268,273
Business & Other Op Expenses	$	(2,736,228)
Total:	**$**	**(918,810)**

Total Network (NHSC & WCHN)

Category	Impact	
Salaries & Wages	$	786,181
Fringe Benefits	$	3,736,949
Med Supplies/Rx Costs	$	1,429,660
Business & Other Op Expenses	$	(3,190,873)
Total:	**$**	**2,761,917**

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

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24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHeatlhNetwork.org
DanburyHospital.org
NewMilfordHospital.org

February 06, 2015

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

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Please find enclosed our first annual response.

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Dan DeBarba, Executive VP, WCHN
Carolyn McKenna, Esq. General Counsel

Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.
Year 1 Progress Report

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c) Strengthening the physician platform for delivery of care;
d) Building competencies required for new reimbursement models, such as population health management, bundled payments, Physician-Hospital Organization (PHO), and ACOs;
e) Integrating operations to achieve savings and create a unified operating model; and
f) Improving access to and/or reducing cost of capital due to system scale and performance.

A summary of our progress in achieving these benefits is noted below.

STRENGTHENING CLINICAL PROGRAMS

A priority goal with our affiliation is clinical integration that ensures the provision of ongoing care in a consistent manner across network clinical services. As noted in previous reports, Cancer and Cardiovascular services have been identified as network service lines, and each has appointed network service line directors and supporting organizational structures. There are network Clinical Steering Committees in place focused on oversight to these clinical programs and performance dashboards have been developed for both service lines. A physician director has been recruited to oversee the three network Cancer Centers, and a network cancer registry has been created. A physician director has also been appointed to oversee the network cardiovascular services. Danbury Hospital Interventional Cardiologists obtained privileges at Norwalk Hospital, and have performed cases at the Norwalk campus that would have otherwise been transferred.

Medicine, Surgery, Women's & Children's, Behavioral Health, Radiology, Laboratory, Pharmacy, and Corporate & Occupational Health each have network administrative directors appointed and are building the supporting infrastructure.

Expanded network clinical advancements include the transcatheter aortic valve replacement (without open heart surgery), radioactive seed localization (more precise localization of breast mass in cancer treatment), fenestrated endovascular abdominal aortic repair (advancements in aneurysm management), robotically-assisted total hip replacement using the MAKO robot, LINQ insertable cardiac monitors (smallest devoice available) and LINX reflux management system (reducing need for medications).

ENHANCING QUALITY & PATIENT SAFETY

Development of the Quality and Safety infrastructure and our commitment to become a high-reliability organization (HRO) continues. In our first year, 50 leaders have been certified as HRO trainers and we have trained over 7,000 employees and members of our medical staff across the network in HRO principles. New employees are now receiving HRO training as part of their orientation process. We believe that this training is critical to ensuring a solid foundation to build upon, as we continue to strengthen our HRO culture. Daily Safety Huddles have been initiated at each hospital campus and we are reintroducing a consistent approach to Leadership Rounding across the campuses.

We have established a Network Quality Department that includes Quality, Patient Safety, Regulatory Compliance, Patient Relations, Risk Management and Infection Control. We are standardizing nursing care and implementing best practices to minimize falls, infections and pressure ulcers. Nurse navigators have been transitioned into the Care Coordination function for discharge planning, and engaged in dialogue with community skilled nursing facilities and home care agencies for collaboration.

EDUCATION

Communication about the affiliation continues as a priority for the organization, and we have implemented vehicles to provide regular integration related communications which are distributed across the network. These vehicles are updated frequently with news about our integration activities. Our Education and Development Office held several workshops, at locations across the network, for managers about leading and managing change.

Discussion continues on defining potential opportunities to integrate, extend, and create medical education and research programs across the network. The Obstetrics & Gynecology residency has been expanded to the Norwalk campus.

BROADENING THE PHYSICIAN PLATFORM

A Physician Strategy Council has been formed to serve as a steering group for physician-related business development functions. A physician manpower assessment was completed in October, and the community need for primary care and specialty care physicians has been identified across the network. Plans are being developed to prioritize recruitment efforts by geography and specialty to address community needs.

We have expanded hepatobiliary surgery, colorectal surgery, thoracic surgery, gynecologic surgery and gastroenterology services. Thirty-eight new physicians, 29 advance practice professionals and 4 practices have been recruited to expand access to care across the network. A unified organizational structure was implemented for management of the medical groups; Western Connecticut Medical Group (WCMG), and Norwalk Hospital Physicians and Surgeons (NHP&S).

NEW REIMBURSEMENT MODELS

Our network commitment to build the necessary competencies and infrastructure to position the network's successful progression from volume to value reimbursement models continues. Our Physician Hospital Organization (PHO) structure is evolving with development of Clinical Pathways and Population Health Management Committees representing independent community practices and employed physicians. Thirty-five (35) independent community practices agreed to participate in the WCHN ACO, along with the network

hospitals and medical group. An application was submitted to participate in Medicare's Shared Savings program (MSSP) for 2015, and we received notification in December, 2014 that the network was selected for participation. In addition, an agreement was finalized to participate in Aetna's pilot accountable care program. A data warehousing system was selected for the PHO and ACO.

CREATING AN INTEGRATED OPERATING MODEL

We have implemented a network-wide organizational structure and management team. As noted in previous progress reporting, work continues with 22 integration teams identifying synergy opportunities, developing priorities and work plans and implementing tactical changes.

Of note employee benefits (health & retirement) have been consolidated to a single platform across the system. The Human Resource specialists continue to support the work of each integration team in the implementation of new organizational structures. Standardization of HR practices such as uniform salary ranges for positions, common background check for employment, onboarding of new employees, and benefit plan design for the coming year received priority focus.

Work supporting the centralization of Finance staff to a single location to achieve economies of scale was accomplished; the Revenue Cycle staff was also centralized to one location to streamline operations. We have transitioned Danbury and New Milford to a single license, and implemented a new financial system across the two campuses.

A network chief information officer was appointed and a supporting organizational structure was implemented. High-speed network connection was established between Norwalk and legacy WCHN campuses. An integrated information technology strategy was developed, with a network level IT Strategy Council to guide all strategic IT initiatives. IT project support was prioritized for integration team activities. IT Strategy Council approval was obtained for recommendations for IT system selections for financial budgeting, cost accounting, decision support system, reference lab integration, web strategy, and analytics. An initial evaluation of incumbent vendors was completed in preparation for network selection of ERP strategy.

A network Claims Committee has been established to support the Risk Management function and the two captive insurance programs have been merged.

Network mission, vision and values have been identified, along with a new Strategic Plan and fiscal year 2015 strategic objectives approved by the Board in December.

FINANCIAL STRENGTH AND ACCESS TO CAPITAL

Implementation of the integration work plan has resulted in $ 2,761,917 savings and no large capital projects were initiated during the period.

PROJECTED COST SAVINGS
October 1, 2013 – September 30, 2014

Norwalk Hospital

Category	Impact	
Salaries & Wages	$	501,611
Fringe Benefits	$	3,610,364
Med Supplies/Rx Costs	$	161,387
Business & Other Op Expenses	$	(418,615)
Total:	**$**	**3,854,747**

Danbury/New Milford Hospital

Category	Impact	
Salaries & Wages	$	390,716
Fringe Benefits	$	158,429
Med Supplies/Rx Costs	$	1,268,273
Business & Other Op Expenses	$	(2,736,228)
Total:	**$**	**(918,810)**

Total Network (NHSC & WCHN)

Category	Impact	
Salaries & Wages	$	786,181
Fringe Benefits	$	3,736,949
Med Supplies/Rx Costs	$	1,429,660
Business & Other Op Expenses	$	(3,190,873)
Total:	**$**	**2,761,917**

Greer, Leslie

Subject: FW: Docket Number 13-31832-CON Reporting
Attachments: Docket 13-31832 CON Reporting 05 31 2015.pdf

Importance: High

From: Johnson, Michelle [mailto:Michelle.Johnson@wchn.org]
Sent: Monday, June 01, 2015 4:15 PM
To: Martone, Kim
Cc: Roberts, Karen; McKenna, Carolyn; Herlihy, Sally; Topalian, Jeryl
Subject: Docket Number 13-31832-CON Reporting
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached documentation for Docket Number 13-31832-CON. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson
Executive Assistant to Senior Administrators
Western Connecticut Health Network

203-739-4935

WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

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WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

RECEIVED
JUN - 1 2015
Office of
HEALTHCARE ACCESS

May 31, 2015

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
d. Balance Sheet for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital

Please find enclosed our responses for the time period October 1, 2014 – March 31, 2015. Of note, Reports 300 and 350 are no longer provided as NHSC was terminated as of Sept. 29, 2014 (CON Determination Report Number 14-31930-DTR).

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Semi-annual Progress Report #3: October 2014 – March 2015

Progress with our implementation plan is reviewed on a quarterly basis by the WCHN Integration Steering Committee. Many of the core integration teams have accomplished their initial priorities within the first year (by January 2015) and their scope is evolving to incorporate routine operation activities. Highlighted achievements from October 2014 – March 2015 are summarized below:

CLINICAL PROGRAMS

The Cancer and Cardiovascular service lines are fully operational as network departments. Cancer Services recruited a physician director and a network Research Office was established. Planning for a joint IRB and contracting is underway so that the same trials could open at both sites. Disease site programs for GI, Lung and GYN Oncology are being developed across the network. The cardiovascular services Clinical Steering Committee is focused on standardizing STEMI and NSTEMI protocols across campuses; DVT management protocol; cardiac surgery quality metrics; and a quarterly lecture series. Capital funds have been allocated to support an Echo PACS upgrade at NH this calendar year.

Care Coordination recommendations are operational and evolving. Care coordinators are focusing on education and follow-up for high risk patients in 5 diagnoses (AMI, COPD, CHF, Pneumonia, Stroke) to reduce readmissions. Preferred partner agreements have been signed with community skilled nursing facilities and home care agencies for collaboration.

All areas identified in the Laboratory & Pathology plan have been integrated with standardization of clinical pathology procedures initiated. The transition of reference testing to the Danbury location is 85% complete. New courier support was implemented across the network. Planning for laboratory automation has begun.

Pharmacy operations have been integrated and efforts continue to progress to align the formulary across the network and evaluate clinical programs at each hospital. A RFP for a system wholesaler is being finalized, and work has begun on implementing an electronic invoice payment system.

Initial work of the Pediatrics Integration Team has been refocused toward standardizing staffing models and call coverage.

All Quality and Safety recommendations are fully implemented. High-reliability organization (HRO) training was completed network-wide with over 7000 employees trained.

EDUCATION

The Education and Development Office launched the Network Leadership Development Curriculum and held several programs across the network. The network New Hire Orientation was redesigned to include the new network Mission, Vision and Values as well as a HRO Training component.

Discussion continues on defining potential opportunities to integrate, extend, and create medical education and research programs across the network. A workgroup was convened to develop a network strategic plan for Medical Education.

OPERATIONS

Compliance and Privacy policies have been reviewed, revised, consolidated and posted across the network. Compliance staff now rotates between hospital campuses. Compliance training was added to Norwalk Hospital New Employee Orientation to ensure consistency across the network.

Facilities completed the integration of the management team across the network, and now function as a single unit supporting all 3 campuses. Real Estate management has also been consolidated.

The Finance staff and functions continue to centralize to achieve economies of scale. A corporate payroll was implemented for all WCHN corporate staff. A revenue cycle work team involving all clinical department directors and Compliance was created and network-wide Key Performance Indicators (KPIs) were developed. EPSI implementation was begun for Norwalk, which will allow a single network system for budget/financial reporting. Supply chain standardization continues with a focus on equipment maintenance contracts across the network.

The Human Resource specialists continue to support the work of each integration team in the implementation of new organizational structures. Standardization of HR practices such as the annual review and goal setting processes were accomplished, as well as consolidation of retirement and benefit plans.

All Marketing, Planning & Communications recommendations have been addressed. The network Strategic Plan, and FY Strategic Initiatives were developed and approved by the Board. The development of a digital marketing strategy and a Communications Committee are underway.

A network Claims Committee has been established to support the risk management function and the two captive insurance programs have been merged. All integration plan initiatives have been implemented.

PHYSICIAN COMMUNITY

The Physician Strategy Council endorsed a prioritization of primary care needs in each community. Primary Care Councils continue to evolve at the Danbury and Norwalk campuses; additional physician representative from employed and private medical groups are being identified. Integration of NHP&S with WCMG continues with the implementation of a unified billing system and completion of the EMR and operational assessments.

The Physician Hospital Organization (PHO) was invited to participate in the Value Care Alliance (VCA) provider network, which has an Accountable Care Agreement with Aetna. Highline was selected as the data warehouse system for the ACO. WCHN's application to participate in Medicare's Shared Savings program (MSSP) for 2015 was accepted by CMS.

4.b.
NHSC/Norwalk Hospital Expense Savings From Affiliation
April 1 – September 30, 2014

	Norwalk Hospital
OPERATING EXPENSES	
Salaries and Wages	436,838
Fringe Benefits	1,833,151
Contracted Labor Fees	
Med. Supplies/Pharmaceutical Costs	284,677
Bad Debts	
Depreciation/Amortization	
Interest Expense	
Malpractice	
Utilities	79,490
Business Expenses	12,000
Other Operating Expense	925,125
Total Savings	$3,571,282

4.c

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2015-6 Months FY 2015

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)
LINE	**DESCRIPTION**	**FY 2015 - 6 Months Ending 03/31/2015 ACTUAL**
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$460,079,334
2	Less: Allowances	$279,070,398
3	Less: Charity Care	$7,788,882
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$173,220,054**
5	Provision for Bad Debts	$9,615,407
	Net Patient Service Revenue less provision for bad debts	**$163,604,647**
6	Other Operating Revenue	$8,336,509
7	Net Assets Released from Restrictions	$0
	Total Operating Revenue	**$171,941,156**
B.	**Operating Expenses:**	
1	Salaries and Wages	$68,578,429
2	Fringe Benefits	$19,450,638
3	Physicians Fees	$4,173,971
4	Supplies and Drugs	$16,440,290
5	Depreciation and Amortization	$10,767,876
6	Bad Debts	$0
7	Interest Expense	$1,601,555
8	Malpractice Insurance Cost	$4,155,851
9	Other Operating Expenses	$30,956,620
	Total Operating Expenses	**$156,125,230**

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2015-6 Months FY 2015

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)
LINE	**DESCRIPTION**	**FY 2015 - 6 Months Ending 03/31/2015 ACTUAL**
	Income/(Loss) From Operations	**$15,815,926**
C.	**Non-Operating Revenue:**	
1	Income from Investments	$1,646,314
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	$56,352
	Total Non-Operating Revenue	**$1,702,666**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$17,518,592**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	$0
	Total Other Adjustments	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**$17,518,592**
	Principal Payments	$4,744,415

4.d

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2015 - 6 Months FY 2015

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3) FY 2015 - 6 Months Ending 03/31/2015
LINE	**DESCRIPTION**	**ACTUAL**
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$67,935,148
2	Short Term Investments	$8,778,669
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$38,228,739
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$2,813,108
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$1,864,031
8	Prepaid Expenses	$705,801
9	Other Current Assets	$1,138,937
	Total Current Assets	**$121,464,433**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$16,750,192
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$327
	Total Noncurrent Assets Whose Use is Limited:	**$16,750,519**
5	Interest in Net Assets of Foundation	$77,950,423
6	Long Term Investments	$124,195,868
7	Other Noncurrent Assets	$6,700,208
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$499,988,280
2	Less: Accumulated Depreciation	$339,749,301
	Property, Plant and Equipment, Net	**$160,238,979**
3	Construction in Progress	$97,068,462
	Total Net Fixed Assets	**$257,307,441**

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2015 - 6 Months FY 2015

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3) FY 2015 - 6 Months Ending 03/31/2015
LINE	DESCRIPTION	ACTUAL
	Total Assets	$604,368,892

NORWALK HOSPITAL

DRAFT (unaudited)

FISCAL YEAR 2015 - 6 Months FY 2015

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3) FY 2015 - 6 Months Ending 03/31/2015
LINE	**DESCRIPTION**	**ACTUAL**
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$38,804,479
2	Salaries, Wages and Payroll Taxes	$12,500,536
3	Due To Third Party Payers	$33,550,197
4	Due To Affiliates	$8,966,482
5	Current Portion of Long Term Debt	$6,508,948
6	Current Portion of Notes Payable	$941,348
7	Other Current Liabilities	$322,983
	Total Current Liabilities	**$101,594,973**
B.	**Long Term Debt:**	$ -
1	Bonds Payable (Net of Current Portion)	$113,598,970
2	Notes Payable (Net of Current Portion)	$1,258,474
	Total Long Term Debt	**$114,857,444**
3	Accrued Pension Liability	$14,575,277
4	Other Long Term Liabilities	$17,941,423
	Total Long Term Liabilities	**$147,374,144**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	$305,207,954
2	Temporarily Restricted Net Assets	$40,723,369
3	Permanently Restricted Net Assets	$9,468,452
	Total Net Assets	**$355,399,775**
	Total Liabilities and Net Assets	**$604,368,892**

Greer, Leslie

From: Roberts, Karen
Sent: Tuesday, December 01, 2015 8:13 AM
To: Huber, Jack; Greer, Leslie
Cc: Martone, Kim
Subject: FW: OHCA Notification
Attachments: Docket 13-31832 CON OHCA Reporting 11 30 2015.pdf

Importance: High

From: Johnson, Michelle [mailto:Michelle.Johnson@wchn.org]
Sent: Monday, November 30, 2015 4:59 PM
To: Martone, Kim
Cc: Herlihy, Sally; McKenna, Carolyn; Roberts, Karen
Subject: OHCA Notification
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached an OHCA notification for Docket Number 13-31832-CON. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson
Executive Assistant to Senior Administrators
Western Connecticut Health Network

203-739-4935

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WESTERN CONNECTICUT HEALTH NETWORK
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WesternConnecticutHeatlhNetwork.org
DanburyHospital.org
NewMilfordHospital.org

November 30, 2015

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for Norwalk Hospital
d. Balance Sheet for Norwalk Hospital

Please find enclosed our fourth response for the time period April 1, 2015 – September 30, 2015. Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures
cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health services Corporation and Western Connecticut Health Network, Inc.

Semi-annual Progress Report #4: April 1, 2015 – September 30, 2015

Highlighted achievements include the following:

CLINICAL PROGRAMS

As noted in our last report, our Cancer and Cardiovascular programs are fully operational as network service lines. As such, the centralized leadership continues to focus on program developments and service enhancements to address patient need. In the Cancer program, the disease site programs for GI, Lung and GYN oncology continue to evolve, and a network IRB for cancer clinical trials became operational. In the Cardiology program, collaboration between campuses is underway to enhance the outpatient cardiovascular program at Norwalk Hospital. Previous plans for cardiovascular-specific information system integration have been halted in order to focus on vetting the cardiovascular offerings available through Cerner, the IT platform to be implemented network-wide during 2016.

Care coordination teams are being enhanced to include an RN discharge planner, RN utilization reviewer, social worker, and case management assistant to proactively address patient care needs. A bundled payment program was initiated on July 1, 2015 and care coordination staff was educated and are utilizing a new software system to identify patients in bundles and proactively ensure information is provided to the next care partner.

Pharmacy operations is continuing the network formulary alignment, wholesaler conversion and implementing a centralized Pharmacy & Therapeutic Committee structure. Laboratory & Pathology services continue their standardization work with integration of laboratory flow cytometry, immunology, immunohistochemistry completed, and microbiology progressing.

EDUCATION

The Education and Development Office continued its focus on enhancing our learning and discovery. During the past 6 months there were 85 active users of a Harvard Mentor manager program and 459 participants in onsite education seminars. The participants represented individuals across the network and >90% agreed on overall relevance and value of the curriculum and intent to apply learning to the job.
In concert with the organization's Vision 2020, the strategic direction for both the Medical Education and Research & Innovation programs have been developed.

OPERATIONS

The Finance team successfully implemented a single patient registration/revenue cycle platform (EPSi) in time for the FY2016 budget development across the network. The team has been working on standardization of reporting structure definitions, development of the new system, and training for operational efficiencies. The September 2015 month-end system was run live with parallel processing for several cycles to ensure accuracy.

PHYSICIAN COMMUNITY

The integration of community-based NHP&S and WCMG providers is complete and a transition of IT hardware was also completed, resulting in enhanced network connectivity for physician practices.

4.b. NHSC/Norwalk Hospital Expense Savings from Affiliation: April 1, 2015 - September 30, 2015

OHCA Category	**Norwalk Hospital (Total)**	
Business Expenses	$	3,000
Capital Expense	$	-
Fringe Benefits	$	1,858,912
Med Supplies/Rx Costs	$	327,482
Operating Expense	$	-
Other Operating Exp.	$	656,144
Revenue Improvement	$	-
Salaries & Wages	$	517,711
Utilities	$	83,490
Grand Total	$	3,446,739

4.c.

NORWALK HOSPITAL						
DRAFT						
FISCAL YEAR 2015-12 Months FY 2015						
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION						
(1)	(2)	(3)	(4)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2015 - 6 Months Ending 03/31/2015 ACTUAL	FY 2015 - 6 Months Ending 09/30/2015 ACTUAL	FY 2015 - 12 Months Ending 09/30/2015 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**					
1	Total Gross Patient Revenue	$460,079,334	$484,987,892	$945,067,226	$24,908,558	5%
2	Less: Allowances	$279,070,398	$296,297,369	$575,367,767	$17,226,971	6%
3	Less: Charity Care	$7,788,882	$7,930,679	$15,719,561	$141,797	2%
4	Less: Other Deductions	$0	$0	$0	$0	0%
	Total Net Patient Revenue	**$173,220,054**	**$180,759,844**	**$353,979,898**	**$7,539,790**	**4%**
5	Provision for Bad Debts	$9,615,407	$3,497,961	$13,113,368	($6,117,446)	-64%
	Net Patient Service Revenue less provision for bad debts	**$163,604,647**	**$177,261,883**	**$340,866,530**	**$13,657,236**	**8%**
6	Other Operating Revenue	$8,336,509	$16,044,104	$24,380,613	$7,707,595	92%
7	Net Assets Released from Restrictions	$0	$0	$0	$0	0%
	Total Operating Revenue	**$171,941,156**	**$193,305,987**	**$365,247,143**	**$21,364,831**	**12%**
B.	**Operating Expenses:**					
1	Salaries and Wages	$68,578,429	$67,143,931	$135,722,360	($1,434,498)	-2%
2	Fringe Benefits	$19,450,638	$19,752,134	$39,202,772	$301,496	2%
3	Physicians Fees	$4,173,971	$3,929,401	$8,103,372	($244,570)	-6%
4	Supplies and Drugs	$16,440,290	$22,880,126	$39,320,416	$6,439,836	39%
5	Depreciation and Amortization	$10,767,876	$9,496,277	$20,264,153	($1,271,599)	-12%
6	Bad Debts	$0	$0	$0	$0	0%
7	Interest Expense	$1,601,555	$1,631,904	$3,233,459	$30,349	2%
8	Malpractice Insurance Cost	$4,155,851	$2,616,155	$6,772,006	($1,539,696)	-37%
9	Other Operating Expenses	$30,956,620	$60,504,586	$91,461,206	$29,547,966	95%
	Total Operating Expenses	**$156,125,230**	**$187,954,514**	**$344,079,744**	**$31,829,284**	**20%**
	Income/(Loss) From Operations	**$15,815,926**	**$5,351,473**	**$21,167,399**	**($10,464,453)**	**-66%**
C.	**Non-Operating Revenue:**					
1	Income from Investments	$1,646,314	$1,453,608	$3,099,922	($192,706)	-12%
2	Gifts, Contributions and Donations	$0	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$56,352	$45,709	$102,061	($10,643)	-19%
	Total Non-Operating Revenue	**$1,702,666**	**$1,499,317**	**$3,201,983**	**($203,349)**	**-12%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$17,518,592**	**$6,850,790**	**$24,369,382**	**($10,667,802)**	**-61%**
	Other Adjustments:					
	Unrealized Gains/(Losses)	$0	($4,976,964)	($4,976,964)	($4,976,964)	0%
	All Other Adjustments	$0	($1,967,738)	($1,967,738)	($1,967,738)	0%
	Total Other Adjustments	**$0**	**($6,944,702)**	**($6,944,702)**	**($6,944,702)**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$17,518,592**	**($93,912)**	**$17,424,680**	**($17,612,504)**	**-101%**
	Principal Payments		$6,316,051	$6,316,051	$6,316,051	0%

NORWALK HOSPITAL					
DRAFT					
FISCAL YEAR 2015 -12 Months FY 2015					
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3) FY 2015 - 6 Months Ending 03/31/2015	(4) FY 2015 - 6 Months Ending 09/30/2015	(5) AMOUNT	(6) %
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$67,935,148	$43,246,447	($24,688,701)	-36%
2	Short Term Investments	$8,778,669	$8,795,652	$16,983	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$38,228,739	$44,269,944	$6,041,205	16%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$2,813,108	$994,031	($1,819,077)	-65%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,864,031	$2,725,505	$861,474	46%
8	Prepaid Expenses	$705,801	$1,488,811	$783,010	111%
9	Other Current Assets	$1,136,937	$2,348,091	$1,209,154	106%
	Total Current Assets	**$121,464,433**	**$103,868,481**	**($17,595,952)**	**-14%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$16,750,192	$16,298,580	($451,612)	-3%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$327	$327	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$16,750,519**	**$16,298,907**	**($451,612)**	**-3%**
5	Interest in Net Assets of Foundation	$77,950,423	$98,322,402	$20,371,979	26%
6	Long Term Investments	$124,195,868	$120,410,769	($3,785,099)	-3%
7	Other Noncurrent Assets	$6,700,208	$5,852,227	($847,981)	-13%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$499,988,280	$514,398,602	$14,410,322	3%
2	Less: Accumulated Depreciation	$339,749,301	$349,245,364	$9,496,063	3%
	Property, Plant and Equipment, Net	**$160,238,979**	**$165,153,238**	**$4,914,259**	**3%**
3	Construction in Progress	$97,068,462	$103,097,325	$6,028,863	6%
	Total Net Fixed Assets	**$257,307,441**	**$268,250,563**	**$10,943,122**	**4%**
	Total Assets	**$604,368,892**	**$613,003,349**	**$8,634,457**	**1%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$38,804,479	$33,120,984	($5,683,495)	-15%
2	Salaries, Wages and Payroll Taxes	$12,500,536	$15,029,084	$2,528,548	20%
3	Due To Third Party Payers	$33,550,197	$27,998,660	($5,551,537)	-17%
4	Due To Affiliates	$8,966,482	$8,140,448	($826,034)	-9%
5	Current Portion of Long Term Debt	$6,508,948	$6,364,481	($144,467)	-2%
6	Current Portion of Notes Payable	$941,348	$1,054,094	$112,746	12%
7	Other Current Liabilities	$322,983	$292,611	($30,372)	-9%
	Total Current Liabilities	**$101,594,973**	**$92,000,362**	**($9,594,611)**	**-9%**
B.	**Long Term Debt:**	$ -			

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Danbury, CT 06810
203.739.4903

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November 30, 2015

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for Norwalk Hospital
d. Balance Sheet for Norwalk Hospital

Please find enclosed our fourth response for the time period April 1, 2015 – September 30, 2015. Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures
cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health services Corporation and Western Connecticut Health Network, Inc.

Semi-annual Progress Report #4: April 1, 2015 – September 30, 2015

Highlighted achievements include the following:

CLINICAL PROGRAMS

As noted in our last report, our Cancer and Cardiovascular programs are fully operational as network service lines. As such, the centralized leadership continues to focus on program developments and service enhancements to address patient need. In the Cancer program, the disease site programs for GI, Lung and GYN oncology continue to evolve, and a network IRB for cancer clinical trials became operational. In the Cardiology program, collaboration between campuses is underway to enhance the outpatient cardiovascular program at Norwalk Hospital. Previous plans for cardiovascular-specific information system integration have been halted in order to focus on vetting the cardiovascular offerings available through Cerner, the IT platform to be implemented network-wide during 2016.

Care coordination teams are being enhanced to include an RN discharge planner, RN utilization reviewer, social worker, and case management assistant to proactively address patient care needs. A bundled payment program was initiated on July 1, 2015 and care coordination staff was educated and are utilizing a new software system to identify patients in bundles and proactively ensure information is provided to the next care partner.

Pharmacy operations is continuing the network formulary alignment, wholesaler conversion and implementing a centralized Pharmacy & Therapeutic Committee structure. Laboratory & Pathology services continue their standardization work with integration of laboratory flow cytometry, immunology, immunohistochemistry completed, and microbiology progressing.

EDUCATION

The Education and Development Office continued its focus on enhancing our learning and discovery. During the past 6 months there were 85 active users of a Harvard Mentor manager program and 459 participants in onsite education seminars. The participants represented individuals across the network and >90% agreed on overall relevance and value of the curriculum and intent to apply learning to the job. In concert with the organization's Vision 2020, the strategic direction for both the Medical Education and Research & Innovation programs have been developed.

OPERATIONS

The Finance team successfully implemented a single patient registration/revenue cycle platform (EPSi) in time for the FY2016 budget development across the network. The team has been working on standardization of reporting structure definitions, development of the new system, and training for operational efficiencies. The September 2015 month-end system was run live with parallel processing for several cycles to ensure accuracy.

PHYSICIAN COMMUNITY

The integration of community-based NHP&S and WCMG providers is complete and a transition of IT hardware was also completed, resulting in enhanced network connectivity for physician practices.

4.b. NHSC/Norwalk Hospital Expense Savings from Affiliation: April 1, 2015 - September 30, 2015

OHCA Category	**Norwalk Hospital (Total)**	
Business Expenses	$	3,000
Capital Expense	$	-
Fringe Benefits	$	1,858,912
Med Supplies/Rx Costs	$	327,482
Operating Expense	$	-
Other Operating Exp.	$	656,144
Revenue Improvement	$	-
Salaries & Wages	$	517,711
Utilities	$	83,490
Grand Total	$	3,446,739

4.c.

NORWALK HOSPITAL						
DRAFT						
FISCAL YEAR 2015-12 Months FY 2015						
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION						
(1)	(2)	(3)	(4)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2015 - 6 Months Ending 03/31/2015 ACTUAL	FY 2015 - 6 Months Ending 09/30/2015 ACTUAL	FY 2015 - 12 Months Ending 09/30/2015 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**					
1	Total Gross Patient Revenue	$460,079,334	$484,987,892	$945,067,226	$24,908,558	5%
2	Less: Allowances	$279,070,398	$296,297,369	$575,367,767	$17,226,971	6%
3	Less: Charity Care	$7,788,882	$7,930,679	$15,719,561	$141,797	2%
4	Less: Other Deductions	$0	$0	$0	$0	0%
	Total Net Patient Revenue	**$173,220,054**	**$180,759,844**	**$353,979,898**	**$7,539,790**	**4%**
5	Provision for Bad Debts	$9,615,407	$3,497,961	$13,113,368	($6,117,446)	-64%
	Net Patient Service Revenue less provision for bad debts	**$163,604,647**	**$177,261,883**	**$340,866,530**	**$13,657,236**	**8%**
6	Other Operating Revenue	$8,336,509	$16,044,104	$24,380,613	$7,707,595	92%
7	Net Assets Released from Restrictions	$0	$0	$0	$0	0%
	Total Operating Revenue	**$171,941,156**	**$193,305,987**	**$365,247,143**	**$21,364,831**	**12%**
B.	**Operating Expenses:**					
1	Salaries and Wages	$68,578,429	$67,143,931	$135,722,360	($1,434,498)	-2%
2	Fringe Benefits	$19,450,638	$19,752,134	$39,202,772	$301,496	2%
3	Physicians Fees	$4,173,971	$3,929,401	$8,103,372	($244,570)	-6%
4	Supplies and Drugs	$16,440,290	$22,880,126	$39,320,416	$6,439,836	39%
5	Depreciation and Amortization	$10,767,876	$9,496,277	$20,264,153	($1,271,599)	-12%
6	Bad Debts	$0	$0	$0	$0	0%
7	Interest Expense	$1,601,555	$1,631,904	$3,233,459	$30,349	2%
8	Malpractice Insurance Cost	$4,155,851	$2,616,155	$6,772,006	($1,539,696)	-37%
9	Other Operating Expenses	$30,956,620	$60,504,586	$91,461,206	$29,547,966	95%
	Total Operating Expenses	**$156,125,230**	**$187,954,514**	**$344,079,744**	**$31,829,284**	**20%**
	Income/(Loss) From Operations	**$15,815,926**	**$5,351,473**	**$21,167,399**	**($10,464,453)**	**-66%**
C.	**Non-Operating Revenue:**					
1	Income from Investments	$1,646,314	$1,453,608	$3,099,922	($192,706)	-12%
2	Gifts, Contributions and Donations	$0	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$56,352	$45,709	$102,061	($10,643)	-19%
	Total Non-Operating Revenue	**$1,702,666**	**$1,499,317**	**$3,201,983**	**($203,349)**	**-12%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$17,518,592**	**$6,850,790**	**$24,369,382**	**($10,667,802)**	**-61%**
	Other Adjustments:					
	Unrealized Gains/(Losses)	$0	($4,976,964)	($4,976,964)	($4,976,964)	0%
	All Other Adjustments	$0	($1,967,738)	($1,967,738)	($1,967,738)	0%
	Total Other Adjustments	**$0**	**($6,944,702)**	**($6,944,702)**	**($6,944,702)**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$17,518,592**	**($93,912)**	**$17,424,680**	**($17,612,504)**	**-101%**
	Principal Payments		$6,316,051	$6,316,051	$6,316,051	0%

NORWALK HOSPITAL					
DRAFT					
FISCAL YEAR 2015 -12 Months FY 2015					
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3) FY 2015 - 6 Months Ending 03/31/2015	(4) FY 2015 - 6 Months Ending 09/30/2015	(5) AMOUNT	(6) %
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$67,935,148	$43,246,447	($24,688,701)	-36%
2	Short Term Investments	$8,778,669	$8,795,652	$16,983	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$38,228,739	$44,269,944	$6,041,205	16%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$2,813,108	$994,031	($1,819,077)	-65%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$1,864,031	$2,725,505	$861,474	46%
8	Prepaid Expenses	$705,801	$1,488,811	$783,010	111%
9	Other Current Assets	$1,138,937	$2,348,091	$1,209,154	106%
	Total Current Assets	**$121,464,433**	**$103,868,481**	**($17,595,952)**	**-14%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$16,750,192	$16,298,580	($451,612)	-3%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$327	$327	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$16,750,519**	**$16,298,907**	**($451,612)**	**-3%**
5	Interest in Net Assets of Foundation	$77,950,423	$98,322,402	$20,371,979	26%
6	Long Term Investments	$124,195,868	$120,410,769	($3,785,099)	-3%
7	Other Noncurrent Assets	$6,700,208	$5,852,227	($847,981)	-13%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$499,988,280	$514,398,602	$14,410,322	3%
2	Less: Accumulated Depreciation	$339,749,301	$349,245,364	$9,496,063	3%
	Property, Plant and Equipment, Net	**$160,238,979**	**$165,153,238**	**$4,914,259**	**3%**
3	Construction in Progress	$97,068,462	$103,097,325	$6,028,863	6%
	Total Net Fixed Assets	**$257,307,441**	**$268,250,563**	**$10,943,122**	**4%**
	Total Assets	**$604,368,892**	**$613,003,349**	**$8,634,457**	**1%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$38,804,479	$33,120,984	($5,683,495)	-15%
2	Salaries, Wages and Payroll Taxes	$12,500,536	$15,029,084	$2,528,548	20%
3	Due To Third Party Payers	$33,550,197	$27,998,660	($5,551,537)	-17%
4	Due To Affiliates	$8,966,482	$8,140,448	($826,034)	-9%
5	Current Portion of Long Term Debt	$6,508,948	$6,364,481	($144,467)	-2%
6	Current Portion of Notes Payable	$941,348	$1,054,094	$112,746	12%
7	Other Current Liabilities	$322,983	$292,611	($30,372)	-9%
	Total Current Liabilities	**$101,594,973**	**$92,000,362**	**($9,594,611)**	**-9%**
B.	**Long Term Debt:**	$ -			

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WesternConnecticutHeatlhNetwork.org
DanburyHospital.org
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January 29, 2016

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Three requests that we will submit the following:

On an annual basis, for two (2) years from the date of execution of the Agreed Settlement, the applicants must report to OHCA how the benefits/cost savings enumerated in Findings of Fact 23 and 36-38 have been achieved and within sixty (60) days of all the benefits/savings having been accounted for, the Applicants shall provide a final summary enumerating all aforementioned benefits/cost savings.

Please find enclosed our second annual response.

Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning
Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Dan DeBarba, Executive VP, WCHN
Carolyn McKenna, Esq. General Counsel

Western Connecticut Health Network, Inc.

Year 2 Progress Report

OVERVIEW

The affiliation between Norwalk Health Services Corporation (NHSC) and Western Connecticut Health Network, Inc. (WCHN) was formally executed on January 1, 2014 and this summary reflects WCHN's integration progress for October 1, 2014 through September 30, 2015. As previously reported, NHSC was terminated as of September 29, 2014 (CON Determination Report Number 14-31930-DTR) and this progress report focuses on areas of synergy that were addressed in FY2015 to realize our affiliation goals.

STRENGTHENING CLINICAL PROGRAMS

Clinical integration continued with the Cancer and Cardiovascular services becoming fully operational as network service lines, reinforced by organizational leadership and infrastructures advancing the delivery of care in a consistent manner across the network.

In the Cancer program, there is now one group of unified medical oncology providers with tumor-site specific programs supporting a sophisticated care delivery model and innovative research programs. A network-wide Institutional Review Board for cancer clinical trials was established. There was growth in gynecologic cancer diagnosis and treatment with recruitment of a renowned surgeon leading the program across all hospitals. During this year our cancer programs (The Danbury Hospital Praxair Cancer Center, New Milford Hospital Diebold Cancer Center and Norwalk Hospital Whittingham Cancer Center) all achieved national accreditation "with commendation" as Comprehensive Care Programs by the American College of Surgeons (ACS) which recognizes cancer programs that strive for excellence in providing comprehensive, multidisciplinary quality care to cancer patients..

Our Cardiology program has experienced growth and greater medical staff coverage across the campuses, including collaboration to enhance the outpatient cardiovascular program at Norwalk Hospital. The cardiovascular services Clinical Steering Committee focused on standardizing STEMI and NSTEMI protocols across campuses; DVT management protocol; cardiac surgery quality metrics; and implemented a quarterly lecture series. Danbury Hospital and Norwalk Hospital each earned The Joint Commission's Gold Seal of Approval and the American Heart Association/American Stroke Association's Heart-Check mark for Advanced Certification for Primary Stroke Centers.

Pharmacy operations continued their alignment and standardization of formularies. Wholesaler conversion and a unified Pharmacy & Therapeutic Committee structure will become fully operational in February 2016.

ENHANCING QUALITY & PATIENT SAFETY

A priority emphasis on building a high-reliability organization (HRO) continued with ongoing training in HRO principles. Our network focus to reduce the incidence of preventable harm resulted in a 70% reduction from FY14 performance. This achievement has been supported by implementation of daily safety huddles at each campus to ensure continued efforts are focused on having zero preventable harm events. All events undergo causal analysis and are routed through the local Quality Committees, with lessons learned shared through Network Quality Committees. Safety Coach and Senior Leader rounding programs were also implemented during the year.

As noted previously, our Network Quality Department integrated the Quality, Patient Safety, Regulatory Compliance, Patient Relations, Risk Management and Infection Control functions across the organizations. We continue to standardize patient care protocols and implement best practices to minimize falls, infections and pressure ulcers. Our performance on ICU CAUTI and CLABSI rates across the network placed us near the top 25th percentile nationally. These accomplishments are supported by clinical practice changes and prevention efforts led by CAUTI/CLABSI teams.

Nurse navigators have been transitioned into the Care Coordination function for discharge planning, and engage in dialogue with community skilled nursing facilities and home care agencies for collaboration. The Care Coordination model is flexible and supports our growing need to manage care across the continuum, bridging the gap between the acute care setting and community providers to ensure continuity of services and quality care. In the post-acute care setting our preferred providers achieved a decrease of 10% in our aggregate readmissions rate.

The Community Care Team (CCT) concept introduced at Norwalk Hospital a year ago continues to be successful and was expanded to the Danbury campus during the second quarter of this year. On the Norwalk campus we achieved a 32% decrease in ED usage among identified subgroups (mental health issues, homeless or at risk, over users of chronic pain medication). On the Danbury campus we achieved a 30% decrease in ED utilization for the same high risk populations. The approach in New Milford did not warrant a full CCT team, however we are addressing inappropriate high utilization through medical psychiatric interventions and are involving social services when needed.

EDUCATION

We continued our commitment to educational programs this year. The Education and Development Office launched a network leadership development curriculum and held several programs to educate and build the skills necessary for the workforce for tomorrow. Managers continued involvement in on-site and on-line learning opportunities with 41 programs and 88 sessions/workshops that reached 1,573 participants.

This year the network also developed a Nurse Leadership program for the identification and implementation of leading edge and innovative nursing education standards and practices to ensure that our nurses and patient care services are benchmarked to "best in industry". Nurse leader programs included topics such as Core Competencies, Leading through the Reform Storm, Elevating the Impact of the Frontline Nurse, and Managing Conflict without Confrontation. Over 100 nurses and 80 patient care technicians were selected for participation in the nursing education program in the coming year.

Aligning with our network strategic plan, Vision 2020, work progressed on defining the medical education and research strategic direction for the network.

BROADENING THE PHYSICIAN PLATFORM

The integration of community-based Norwalk Hospital Physicians & Surgeons (NHP&S) and Western Connecticut Medical Group (WCMG) providers is complete and a transition of IT equipment was also completed with an associated expense of $1.4M, resulting in enhanced network connectivity for physician practices. Access to care is enhanced by a group of 376 physicians and 154 advanced practice providers in 63 locations across 17 cities/towns in the WCHN service area.

Our Physician Hospital Organization (PHO) has grown to include over 900 providers.

WCMG's thirteen Danbury-area primary care practices each received NCQA Patient-Centered Medical Home (PCMH) Recognition for using evidence-based, patient-centered processes that focus on highly coordinated care and long-term, participative relationships. Each practice is recognized at Level 3, the highest level awarded by NCQA.

NEW REIMBURSEMENT MODELS

Commitment to build the necessary competencies and infrastructure to position the network's successful progression from volume to value reimbursement models continues. Our Physician Hospital Organization (PHO) structure is evolving with development of Clinical Pathways and Population Health Management Committees representing independent community practices and employed physicians.

Thirty-five (35) independent community practices agreed to participate in the WCHN ACO, along with the network hospitals and medical group. An application was submitted to participate in Medicare's Shared Savings program (MSSP), and the network was selected as one of 89 new Medicare Shared Savings ACOs. In addition, the PHO participated in Aetna's pilot accountable care program, and entered into a value-based contract with Anthem. A data warehousing system for the PHO and ACO was utilized to collect and analyze data on the 87,000 lives covered under these contracts, with the goal of improving quality of care.

A bundled payment program was initiated on July 1, 2015 and care coordination staff is utilizing a new software system to identify patients in bundles and proactively ensure information is provided to the next care partner.

WCHN, a founding member of the Value Care Alliance (VCA), entered into a new tiered insurance product with other VCA members and Aetna.

CREATING AN INTEGRATED OPERATING MODEL

The network-wide organizational structure and management team has been fully implemented. Many of the core integration teams have accomplished their initial priorities and ongoing activities have been incorporated into routine operations. These include Care Coordination, Compliance, Facilities, Finance,

Human Resources, Information Technology, Marketing & Communications, Planning, Quality, Revenue Cycle, and Risk Management.

Employee benefits (health & retirement) have been consolidated to a single platform across the system. Danbury and New Milford Hospitals transitioned to a single license on October 1, 2015, and implemented a new financial system across the two campuses. A network Claims Committee supports the Risk Management function and the two captive insurance programs have been merged. The network achieved an A Stable rating from a rating agency, reducing the cost of capital and allowing network debt to be refinanced under a single obligated group.

An integrated information technology strategy has been developed, with a network level IT Strategy Council to guide all strategic IT initiatives. Hospitals & Health Networks named two hospitals within WCHN - Danbury Hospital and Norwalk Hospital - to its 2015 list of the nation's "Most Wired" Hospitals and Health Systems.

FINANCIAL STRENGTH AND ACCESS TO CAPITAL

PROJECTED COST SAVINGS October 1, 2014 – September 30, 2015

Norwalk Hospital

Category	Impact
Salaries & Wages	$875,368
Fringe Benefits	$3,668,309
Med Supplies/Rx Costs	$748,159
Business & Other Op Expenses	$1,714,249
Total:	**$7,006,085**

Danbury/New Milford Hospital

Category	Impact
Salaries & Wages	($777,039)
Fringe Benefits	($216,333)
Med Supplies/Rx Costs	$4,346,874
Business & Other Op Expenses	$1,357,306
Total:	**$4,710,509**

Total Network (NHSC & WCHN)

Category	Impact
Salaries & Wages	($705,814)
Fringe Benefits	$3,211,240
Med Supplies/Rx Costs	$5,095,033
Business & Other Op Expenses	$3,144,555
Total:	**$10,745,014**

Greer, Leslie

From: Roberts, Karen
Sent: Tuesday, May 31, 2016 1:42 PM
To: Greer, Leslie
Cc: Martone, Kim
Subject: FW: OHCA Notification- Docket 13-31832-CON
Attachments: Docket 13-31832-CON Reporting 05 31 2016.pdf

Importance: High

FYI – compliance for #31832. Karen

From: Johnson, Michelle [mailto:Michelle.Johnson@wchn.org]
Sent: Tuesday, May 31, 2016 1:41 PM
To: Martone, Kim
Cc: Herlihy, Sally; Roberts, Karen; McKenna, Carolyn
Subject: OHCA Notification- Docket 13-31832-CON
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached an OHCA notification for Docket Number 13-31832-CON. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson | Executive Assistant to Senior Administrators
Western Connecticut Health Network | wchn.org
tel: 203-739-4935

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 Western Connecticut Health Network immediately by email reply to the sender, and delete the transmittal and any attachments.

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Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

May 31, 2016

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for Norwalk Hospital
d. Balance Sheet for Norwalk Hospital

Please find enclosed our fifth response for the time period October 1 2015 – March 31, 2016. Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health services Corporation and Western Connecticut Health Network, Inc.

Semi-annual Progress Report #5: October 1, 2015 – March 31, 2016

All twenty-two integration teams that were identified in the WCHN Integration Plan are now focused on operations. Highlighted achievements include the following:

The Cancer and Cardiovascular services lines are fully integrated across the network. Our centralized leadership continues to focus on program developments and service enhancements to address patient need.

In the Cancer program we have implemented new treatments (HIPEC- heated intraperitoneal chemotherapy) for GYN oncology and GI oncology cases, focused at Danbury Hospital (DH). A network initiative on utilization of chemotherapeutic drugs is underway, supported by a network-wide subcommittee of the Pharmacy & Therapeutics Committee and enhanced clinical trials under one Institutional Review Board. We continue to implement the Oncology care delivery model across the continuum of care, including plans for integration of outpatient palliative care in the medical oncology practices, development of an urgent care structure for symptom management to reduce ED visits and admissions, and exploration of the oncology medical home model. Medical and surgical oncology physician recruitments continue based on identified community and program needs. Efforts are also moving forward with implementation of the network's Cerner Millennium clinical information systems to achieve optimal patient outcomes through standardized order sets and chemotherapeutic regimens and integration of oncology, ambulatory and financial information.

In the Cardiovascular program we are developing programs in minimally invasive and robotic cardiac surgery, as well as advanced techniques for mitral valve repair. WCHN's first cryoablation procedure for treating atrial fibrillation took place in February at DH, further expanding our portfolio of electrophysiology (EP) services. The NH Cardiovascular Services completed a successful Phase 2 upgrade to our MUSE EKG system. Phase 2 enables physicians to read EKGs on screen rather than having them printed. We expect improved physician satisfaction from this enhancement. Planning continues to develop the NH Outpatient Cardiovascular Center that will offer general cardiology, EP, interventional cardiology, and cardiothoracic surgery consults.

The Care Coordination teams' role and staff functions continue to evolve with staffing to meet demand at each hospital campus. Staff are participating in continuing education, mentoring and coaching as care coordination is an integral component of the network strategic objectives (including a reduction in length of stay, readmissions, skilled nursing episodes and bundled payments). An interdisciplinary complex discharge team has been developed at NH to develop individualized care plans for high-risk patients, recidivists and multifactorial complex patients.

4.b. NHSC/Norwalk Hospital Expense Savings from Affiliation:

October 1, 2015 – March 31, 2016

OHCA Category	NH
Business Expenses	(16,250)
Fringe Benefits	1,869,375
Med Supplies/Rx Costs	1,031,438
Other Operating Exp.	904,530
Salaries & Wages	552,031
Utilities	83,490
Grand Total Savings	4,424,614

4.c.

NORWALK HOSPITAL		
FISCAL YEAR 2016 - 6 Months FY 2016		
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	(3)
LINE	DESCRIPTION	FY 2016 - 6 Months Ending 03/31/2016 ACTUAL
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$514,890,508
2	Less: Allowances	$319,490,035
3	Less: Charity Care	$9,653,648
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$185,746,825**
5	Provision for Bad Debts	$6,133,201
	Net Patient Service Revenue less provision for bad debts	**$179,613,624**
6	Other Operating Revenue	$9,418,758
7	Net Assets Released from Restrictions	$0
	Total Operating Revenue	**$189,032,382**
B.	**Operating Expenses:**	
1	Salaries and Wages	$70,639,324
2	Fringe Benefits	$21,839,817
3	Physicians Fees	$7,428,228
4	Supplies and Drugs	$25,194,476
5	Depreciation and Amortization	$12,009,273
6	Bad Debts	$0
7	Interest Expense	$1,476,841
8	Malpractice Insurance Cost	$797,078
9	Other Operating Expenses	$55,843,453
	Total Operating Expenses	**$195,228,490**
	Income/(Loss) From Operations	**($6,196,108)**
C.	**Non-Operating Revenue:**	
1	Income from Investments	$3,604,884
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	$90,708
	Total Non-Operating Revenue	**$3,695,592**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($2,500,516)**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$1,865,948
	All Other Adjustments	($883,860)
	Total Other Adjustments	**$982,088**
	Excess/(Deficiency) of Revenue Over Expenses	**($1,518,428)**
	Principal Payments	$5,146,842

NORWALK HOSPITAL		
FISCAL YEAR 2016 - 6 Months FY 2016		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3) FY 2016 - 6 Months Ending 03/31/2016
LINE	DESCRIPTION	ACTUAL
I.	ASSETS	
A.	Current Assets:	
1	Cash and Cash Equivalents	$44,946,183
2	Short Term Investments	$785,478
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$43,402,247
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$71,445
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$3,207,180
8	Prepaid Expenses	$2,872,922
9	Other Current Assets	$2,030,506
	Total Current Assets	**$97,315,961**
B.	Noncurrent Assets Whose Use is Limited:	
1	Held by Trustee	$7,555,786
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$327
	Total Noncurrent Assets Whose Use is Limited:	**$7,556,113**
5	Interest in Net Assets of Foundation	$91,203,242
6	Long Term Investments	$127,135,744
7	Other Noncurrent Assets	$7,833,139
C.	Net Fixed Assets:	
1	Property, Plant and Equipment	$520,798,537
2	Less: Accumulated Depreciation	$361,254,503
	Property, Plant and Equipment, Net	**$159,544,034**
3	Construction in Progress	$109,768,192
	Total Net Fixed Assets	**$269,312,226**
	Total Assets	**$600,356,425**
II.	LIABILITIES AND NET ASSETS	
A.	Current Liabilities:	
1	Accounts Payable and Accrued Expenses	$34,784,680
2	Salaries, Wages and Payroll Taxes	$8,194,598
3	Due To Third Party Payers	$17,214,551
4	Due To Affiliates	$19,612,670
5	Current Portion of Long Term Debt	$6,449,794
6	Current Portion of Notes Payable	$982,991
7	Other Current Liabilities	$305,252
	Total Current Liabilities	**$87,544,536**
B.	Long Term Debt:	$ -
1	Bonds Payable (Net of Current Portion)	$104,754,264
2	Notes Payable (Net of Current Portion)	$183,352
	Total Long Term Debt	**$104,937,616**
3	Accrued Pension Liability	$34,963,249
4	Other Long Term Liabilities	$17,854,458
	Total Long Term Liabilities	**$157,755,323**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	Net Assets:	
1	Unrestricted Net Assets or Equity	$304,537,449
2	Temporarily Restricted Net Assets	$41,050,665
3	Permanently Restricted Net Assets	$9,468,452
	Total Net Assets	**$355,056,566**
	Total Liabilities and Net Assets	**$600,356,425**

Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

May 31, 2016

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for Norwalk Hospital
d. Balance Sheet for Norwalk Hospital

Please find enclosed our fifth response for the time period October 1 2015 – March 31, 2016. Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health services Corporation and Western Connecticut Health Network, Inc.

Semi-annual Progress Report #5: October 1, 2015 – March 31, 2016

All twenty-two integration teams that were identified in the WCHN Integration Plan are now focused on operations. Highlighted achievements include the following:

The Cancer and Cardiovascular services lines are fully integrated across the network. Our centralized leadership continues to focus on program developments and service enhancements to address patient need.

In the Cancer program we have implemented new treatments (HIPEC- heated intraperitoneal chemotherapy) for GYN oncology and GI oncology cases, focused at Danbury Hospital (DH). A network initiative on utilization of chemotherapeutic drugs is underway, supported by a network-wide subcommittee of the Pharmacy & Therapeutics Committee and enhanced clinical trials under one Institutional Review Board. We continue to implement the Oncology care delivery model across the continuum of care, including plans for integration of outpatient palliative care in the medical oncology practices, development of an urgent care structure for symptom management to reduce ED visits and admissions, and exploration of the oncology medical home model. Medical and surgical oncology physician recruitments continue based on identified community and program needs. Efforts are also moving forward with implementation of the network's Cerner Millennium clinical information systems to achieve optimal patient outcomes through standardized order sets and chemotherapeutic regimens and integration of oncology, ambulatory and financial information.

In the Cardiovascular program we are developing programs in minimally invasive and robotic cardiac surgery, as well as advanced techniques for mitral valve repair. WCHN's first cryoablation procedure for treating atrial fibrillation took place in February at DH, further expanding our portfolio of electrophysiology (EP) services. The NH Cardiovascular Services completed a successful Phase 2 upgrade to our MUSE EKG system. Phase 2 enables physicians to read EKGs on screen rather than having them printed. We expect improved physician satisfaction from this enhancement. Planning continues to develop the NH Outpatient Cardiovascular Center that will offer general cardiology, EP, interventional cardiology, and cardiothoracic surgery consults.

The Care Coordination teams' role and staff functions continue to evolve with staffing to meet demand at each hospital campus. Staff are participating in continuing education, mentoring and coaching as care coordination is an integral component of the network strategic objectives (including a reduction in length of stay, readmissions, skilled nursing episodes and bundled payments). An interdisciplinary complex discharge team has been developed at NH to develop individualized care plans for high-risk patients, recidivists and multifactorial complex patients.

4.b. NHSC/Norwalk Hospital Expense Savings from Affiliation:

October 1, 2015 – March 31, 2016

OHCA Category	NH
Business Expenses	(16,250)
Fringe Benefits	1,869,375
Med Supplies/Rx Costs	1,031,438
Other Operating Exp.	904,530
Salaries & Wages	552,031
Utilities	83,490
Grand Total Savings	4,424,614

4.c.

NORWALK HOSPITAL		
FISCAL YEAR 2016 - 6 Months FY 2016		
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	(3)
LINE	DESCRIPTION	FY 2016 - 6 Months Ending 03/31/2016 ACTUAL
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$514,890,508
2	Less: Allowances	$319,490,035
3	Less: Charity Care	$9,653,648
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$185,746,825**
5	Provision for Bad Debts	$6,133,201
	Net Patient Service Revenue less provision for bad debts	**$179,613,624**
6	Other Operating Revenue	$9,418,758
7	Net Assets Released from Restrictions	$0
	Total Operating Revenue	**$189,032,382**
B.	**Operating Expenses:**	
1	Salaries and Wages	$70,639,324
2	Fringe Benefits	$21,839,817
3	Physicians Fees	$7,428,228
4	Supplies and Drugs	$25,194,476
5	Depreciation and Amortization	$12,009,273
6	Bad Debts	$0
7	Interest Expense	$1,476,841
8	Malpractice Insurance Cost	$797,078
9	Other Operating Expenses	$55,843,453
	Total Operating Expenses	**$195,228,490**
	Income/(Loss) From Operations	**($6,196,108)**
C.	**Non-Operating Revenue:**	
1	Income from Investments	$3,604,884
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	$90,708
	Total Non-Operating Revenue	**$3,695,592**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($2,500,516)**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$1,865,948
	All Other Adjustments	($883,860)
	Total Other Adjustments	**$982,088**
	Excess/(Deficiency) of Revenue Over Expenses	**($1,518,428)**
	Principal Payments	$5,146,842

NORWALK HOSPITAL		
FISCAL YEAR 2016 - 6 Months FY 2016		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		FY 2016 - 6 Months Ending 03/31/2016
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$44,946,183
2	Short Term Investments	$785,478
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$43,402,247
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$71,445
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$3,207,180
8	Prepaid Expenses	$2,872,922
9	Other Current Assets	$2,030,506
	Total Current Assets	**$97,315,961**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$7,555,786
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$327
	Total Noncurrent Assets Whose Use is Limited:	**$7,556,113**
5	Interest in Net Assets of Foundation	$91,203,242
6	Long Term Investments	$127,135,744
7	Other Noncurrent Assets	$7,833,139
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$520,798,537
2	Less: Accumulated Depreciation	$361,254,503
	Property, Plant and Equipment, Net	**$159,544,034**
3	Construction In Progress	$109,768,192
	Total Net Fixed Assets	**$269,312,226**
	Total Assets	**$600,356,425**
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$34,784,680
2	Salaries, Wages and Payroll Taxes	$8,194,598
3	Due To Third Party Payers	$17,214,551
4	Due To Affiliates	$19,612,670
5	Current Portion of Long Term Debt	$6,449,794
6	Current Portion of Notes Payable	$982,991
7	Other Current Liabilities	$305,252
	Total Current Liabilities	**$87,544,536**
B.	**Long Term Debt:**	$ -
1	Bonds Payable (Net of Current Portion)	$104,754,264
2	Notes Payable (Net of Current Portion)	$183,352
	Total Long Term Debt	**$104,937,616**
3	Accrued Pension Liability	$34,963,249
4	Other Long Term Liabilities	$17,854,458
	Total Long Term Liabilities	**$157,755,323**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	$304,537,449
2	Temporarily Restricted Net Assets	$41,050,665
3	Permanently Restricted Net Assets	$9,468,452
	Total Net Assets	**$355,056,566**
	Total Liabilities and Net Assets	**$600,356,425**

Greer, Leslie

From: Roberts, Karen
Sent: Friday, December 02, 2016 3:05 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: OHCA Notification- Docket Number 13-31832-CON
Attachments: Docket 13-31832 CON OHCA Reporting 11 30 2016 v5.pdf

Importance: High

For record #31832. Karen

From: Johnson, Michelle [mailto:Michelle.Johnson@wchn.org]
Sent: Friday, December 02, 2016 2:54 PM
To: Martone, Kim
Cc: Roberts, Karen; Herlihy, Sally; McKenna, Carolyn
Subject: OHCA Notification- Docket Number 13-31832-CON
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached an OHCA notification for Docket Number 13-31832-CON. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

The original document will be sent to the OHCA offices by mail.

Thank you.

Michelle Johnson | Executive Assistant to Senior Administrators
Western Connecticut Health Network | wchn.org
tel: 203-739-4935

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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 Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

December 2, 2016

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Four requests that we will submit the following:

a. Narrative update on the progress of the implementation of the integration plan
b. Cost savings totals of the affiliation for both Norwalk Health Services Corporation and its affiliate, Norwalk Hospital
c. Statement of Operations for Norwalk Hospital
d. Balance Sheet for Norwalk Hospital

Please find enclosed our sixth and final response for the time period April 1, 2016 – September 30, 2016. Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures

cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

4.a. Norwalk Health Services Corporation and Western Connecticut Health Network, Inc.

Semi-annual Progress Report #6: April 1, 2016 – September 30, 2016

At the close of FY2016, opportunities identified in the integration work plan have all been addressed; however, new synergies continue to be implemented. Tracking of integration savings per the plan are no longer separately measurable as network roles and functions are now fully integrated into operations.

A key pillar of our clinical integration is ongoing evolution of network service lines to improve coordination of care across the continuum. The cancer and cardiovascular service lines are more mature and major activities focus on program development and service enhancements to address patient need. Highlights of our accomplishments include:

Under the direction of our network Cancer Medical Director and service line leader, we have standardized treatments for radiation oncology, established a network oncology Palliative Care program, created a GI Network Disease Management program, and enhanced our research activities. We have successfully recruited new providers based on identified community and program needs including a surgical oncologist, colorectal surgeon, and gynecologic oncology surgeon. New treatments and services include improved treatment and diagnosis of urological malignancies, and expanded services for GYN malignancies. The Danbury Hospital Praxair Cancer Center received full Joint Commission Cancer Accreditation and was awarded the Outstanding Achievement Award.

Under the direction of our network Cardiovascular Medical Director and service line leader we have expanded programs in the clinical cardiology, electrophysiology, vascular surgery and interventional cardiology areas. A new Network Chair of Cardiovascular Surgery has also joined the network.

In care coordination efforts our three "care transitions" work teams addressed the challenges of point of entry, inpatient care, and post-acute care, with established charters, goals and metrics. Included in post-acute will be improved coordination with skilled nursing facilities (SNF), home care and physician offices, particularly PCPs. Our partnership with selected SNFs in the region has led to documented better outcomes, including reduced readmission rates from these SNFs, and lower SNF length of stay.

4.b. NHSC/Norwalk Hospital Expense Savings from Affiliation:

April 1, 2016 – September 30, 2016

OHCA Category	NH
Business Expenses	(16,250)
Fringe Benefits	1,990,834
Med Supplies/Rx Costs	1,031,438
Other Operating Exp.	904,530
Salaries & Wages	1,037,866
Utilities	83,490
Grand Total Savings	$5,031,907

4.c. Norwalk Hospital Statement of Operations

NORWALK HOSPITAL						
DRAFT						
FISCAL YEAR 2015-12 Months FY 2016						
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION						
(1)	(2)	(3)	(4)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2016 - 6 Months Ending 03/31/2016 ACTUAL	FY 2016 - 6 Months Ending 09/30/2016 ACTUAL	FY 2016 - 12 Months Ending 09/30/2016 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**					
1	Total Gross Patient Revenue	$514,890,508	$499,516,758	$1,014,407,266	($15,373,750)	-3%
2	Less: Allowances	$319,490,035	$291,866,032	$611,356,067	($27,624,003)	-9%
3	Less: Charity Care	$9,653,648	$8,935,075	$18,588,723	($718,573)	-7%
4	Less: Other Deductions	$0	$0	$0	$0	0%
	Total Net Patient Revenue	**$185,746,825**	**$198,715,651**	**$384,462,476**	**$12,968,826**	**7%**
5	Provision for Bad Debts	$6,133,201	$10,123,601	$16,256,802	$3,990,400	65%
	Net Patient Service Revenue less provision for bad debts	**$179,613,624**	**$188,592,050**	**$368,205,674**	**$8,978,426**	**5%**
6	Other Operating Revenue	$9,418,758	$10,018,574	$19,437,332	$599,816	6%
7	Net Assets Released from Restrictions	$0	$0	$0	$0	0%
	Total Operating Revenue	**$189,032,382**	**$198,610,624**	**$387,643,006**	**$9,578,242**	**5%**
B.	**Operating Expenses:**					
1	Salaries and Wages	$70,639,324	$69,271,882	$139,911,206	($1,367,442)	-2%
2	Fringe Benefits	$21,839,817	$16,986,830	$38,826,647	($4,852,987)	-22%
3	Physicians Fees	$7,428,228	$7,093,831	$14,522,059	($334,397)	-5%
4	Supplies and Drugs	$25,194,476	$25,321,606	$50,516,082	$127,130	1%
5	Depreciation and Amortization	$12,009,273	$10,940,537	$22,949,810	($1,068,736)	-9%
6	Bad Debts	$0	$0	$0	$0	0%
7	Interest Expense	$1,476,841	$1,189,540	$2,666,381	($287,301)	-19%
8	Malpractice Insurance Cost	$797,078	$798,950	$1,596,028	$1,872	0%
9	Other Operating Expenses	$55,843,453	$57,037,344	$112,880,797	$1,193,891	2%
	Total Operating Expenses	**$195,228,490**	**$188,640,520**	**$383,869,010**	**($6,587,970)**	**-3%**
	Income/(Loss) From Operations	**($6,196,108)**	**$9,970,104**	**$3,773,996**	**$16,166,212**	**-261%**
C.	**Non-Operating Revenue:**					
1	Income from Investments	$3,604,884	$1,156,666	$4,761,550	($2,448,218)	-68%
2	Gifts, Contributions and Donations	$0	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$90,708	($1,851,067)	($1,760,359)	($1,941,775)	-2141%
	Total Non-Operating Revenue	**$3,695,592**	**($694,401)**	**$3,001,191**	**($4,389,993)**	**-119%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($2,500,516)**	**$9,275,703**	**$6,775,187**	**$11,776,219**	**-471%**
	Other Adjustments:					
	Unrealized Gains/(Losses)	$1,865,948	$5,446,801	$7,312,749	$3,580,853	192%
	All Other Adjustments	($883,860)	($1,135,526)	($2,019,386)	($251,666)	28%
	Total Other Adjustments	**$982,088**	**$4,311,275**	**$5,293,363**	**$3,329,187**	**339%**
	Excess/(Deficiency) of Revenue Over Expenses	**($1,518,428)**	**$13,586,978**	**$12,068,550**	**$15,105,406**	**-995%**
	Principal Payments	$5,146,842	$1,622,252	$6,769,094	($3,524,590)	-68%

4.d. Norwalk Hospital Balance Sheet

NORWALK HOSPITAL DRAFT FISCAL YEAR 2015 -12 Months FY 2016 REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION					
(1)	(2)	(3) FY 2016 - 6 Months Ending 03/31/2016	(4) FY 2015 - 6 Months Ending 09/30/2016	(5) AMOUNT	(6) %
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$44,946,183	$29,721,657	($15,224,526)	-34%
2	Short Term Investments	$785,478	$787,047	$1,569	0%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$43,402,247	$43,516,152	$113,905	0%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$71,445	$126,691	$55,246	77%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$3,207,180	$3,163,878	($43,302)	-1%
8	Prepaid Expenses	$2,872,922	$731,341	($2,141,581)	-75%
9	Other Current Assets	$2,030,506	$1,725,144	($305,362)	-15%
	Total Current Assets	**$97,315,961**	**$79,771,910**	**($17,544,051)**	**-18%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$7,555,786	$7,895,307	$339,521	4%
2	Board Designated for Capital Acquisition	$0	$0	$0	0%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$327	$327	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$7,556,113**	**$7,895,634**	**$339,521**	**4%**
5	Interest in Net Assets of Foundation	$91,203,242	$100,887,641	$9,684,399	11%
6	Long Term Investments	$127,135,744	$143,647,499	$16,511,755	13%
7	Other Noncurrent Assets	$7,833,139	$14,908,737	$7,075,598	90%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$520,798,537	$535,985,115	$15,186,578	3%
2	Less: Accumulated Depreciation	$361,254,503	$372,195,174	$10,940,671	3%
	Property, Plant and Equipment, Net	**$159,544,034**	**$163,789,941**	**$4,245,907**	**3%**
3	Construction in Progress	$109,768,192	$108,187,023	($1,581,169)	-1%
	Total Net Fixed Assets	**$269,312,226**	**$271,976,964**	**$2,664,738**	**1%**
	Total Assets	**$600,356,425**	**$619,088,385**	**$18,731,960**	**3%**

II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$34,784,680	$33,881,164	($903,516)	-3%
2	Salaries, Wages and Payroll Taxes	$8,194,598	$12,103,153	$3,908,555	48%
3	Due To Third Party Payers	$17,214,551	$14,593,559	($2,620,992)	-15%
4	Due To Affiliates	$19,612,670	$11,372,416	($8,240,254)	-42%
5	Current Portion of Long Term Debt	$6,449,794	$6,542,782	$92,988	1%
6	Current Portion of Notes Payable	$982,991	$726,222	($256,769)	-26%
7	Other Current Liabilities	$305,252	$301,249	($4,003)	-1%
	Total Current Liabilities	**$87,544,636**	**$79,520,545**	**($8,023,991)**	**-9%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$104,754,264	$103,521,514	($1,232,750)	-1%
2	Notes Payable (Net of Current Portion)	$183,352	$0	($183,352)	-100%
	Total Long Term Debt	**$104,937,616**	**$103,521,514**	**($1,416,102)**	**-1%**
3	Accrued Pension Liability	$34,963,249	$0	($34,963,249)	-100%
4	Other Long Term Liabilities	$17,854,458	$20,074,458	$2,220,000	12%
	Total Long Term Liabilities	**$157,755,323**	**$123,595,972**	**($34,159,351)**	**-22%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$304,537,449	$368,847,626	$64,310,177	21%
2	Temporarily Restricted Net Assets	$41,050,665	$37,534,755	($3,515,910)	-9%
3	Permanently Restricted Net Assets	$9,468,452	$9,589,487	$121,035	1%
	Total Net Assets	**$355,056,566**	**$415,971,868**	**$60,915,302**	**17%**
	Total Liabilities and Net Assets	**$600,356,425**	**$619,088,385**	**$18,731,960**	**3%**

User, OHCA

From: Roberts, Karen
Sent: Friday, April 13, 2018 2:31 PM
To: User, OHCA
Subject: FW: OHCA Notification
Attachments: Norwalk Health Services Docket 13-31832-CON 04 13 2018.pdf

Importance: High

From: Johnson, Michelle [mailto:Michelle.Johnson@wchn.org]
Sent: Friday, April 13, 2018 2:30 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>
Cc: Herlihy, Sally <Sally.Herlihy@wchn.org>; McKenna, Carolyn <Carolyn.McKenna@wchn.org>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: OHCA Notification
Importance: High

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached an OHCA notification for Docket Number 13-31832-CON. If you have any questions please contact Sally Herlihy, VP Planning at 203-739-4903, or sally.herlihy@wchn.org.

Thank you.

Michelle Johnson | Executive Assistant to Senior Administrators
Western Connecticut Health Network | wchn.org
tel: 203-739-4935

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Western Connecticut Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

April 12, 2018

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 Number 13-31832-CON
Affiliation of Norwalk Health Services Corporation with Western Connecticut Health Network, Inc.

Dear Ms. Martone,

As stipulated in the Agreed Settlement executed on December 26, 2013 regarding approval for the corporate affiliation of our two organizations – Western Connecticut Health Network, Inc. and Norwalk Health Services Corporation – Order Number Three requests that we will submit the following:

On an annual basis, for two (2) years from the date of execution of the Agreed Settlement, the Applicants must report to OHCA how the benefits/costs savings enumerated in Findings of Fact 23 and 36-38 have been achieved and within sixty (60) days of all benefits/savings having been accounted for, the Applicants shall provide a final summary enumerating all aforementioned benefits/cost savings.

Please find enclosed our final savings report. Should you have any questions please do not hesitate to contact me directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosures
cc: Karen Roberts, Compliance Officer, OHCA
Carolyn McKenna, Esq. General Counsel

Western Connecticut Health Network, Inc. Summary

On January 1, 2014, the affiliation between Norwalk Health Services Corporation[1] and Western Connecticut Health Network (WCHN) was formally executed. The affiliation provided the opportunity for three community hospitals to collaborate and cooperate in order to improve and enhance the quality of care provided to our collective patients and meet the increasing demands of the health care environment. The infrastructure to integrate operations of the organizations was developed that included an Integration Steering Committee, Integration Management Office and individual teams focused on core areas to realize our affiliation goals.

The following were identified as benefits of the affiliation:

a) Strengthening clinical programs to demonstrate quality outcomes and to improve access to health care;
b) Enhancing educational programs, including strengthened programs for medical students, residents, and fellows in both organizations;
c) Strengthening the physician platform for delivery of care;
d) Building competencies required for new reimbursement models, such as population health management, bundled payments, Physician-Hospital Organization (PHO), and ACOs;
e) Integrating operations to achieve savings and create a unified operating model; and
f) Improving access to and/or reducing cost of capital due to system scale and performance.

WCHN's strategic plan, Vision 2020, was approved by its Board of Directors on December 4, 2014 and serves as a guide to the strategic direction of WCHN for the five-year horizon from 2015 through 2020.

A high priority goal with our affiliation is clinical integration that ensures the provision of ongoing care in a consistent manner across the network; specifically wherever care is provided, and for any condition, that care should look and feel the same to us and to our patients.

[1] Effective October 1, 2014, NHSC was merged into WCHN (CON Determination Report Number 14-31930-DTR).

Our Cancer, Cardiovascular, Musculoskeletal and Primary Care programs operate as network service lines, reinforced by organizational leadership and infrastructures advancing the delivery of care in a consistent manner. Synergies have been developed during the three years of the affiliation through recruitment of network physician directors to oversee these programs, establishment of clinical steering committees focusing on oversight, including development of performance dashboards, and recruitment of new specialty physicians with privileges across campuses.

As an organization, we have focused on safety practices that make us highly reliable and reduce the incidence of preventable harm to our patients. This commitment to become a high-reliability organization (HRO) has been supported by a Quality & Safety infrastructure with over 50 leaders certified as HRO trainers and over 7,000 employees and members of our medical staff across the network trained in HRO principles. New employees receive HRO training as part of their orientation process.

As a learning organization we have supported our commitment to develop and offer educational programs across our workforce. The Education and Development Office manages a curriculum that includes leading and managing change and building the skills necessary for the workforce for tomorrow. Specific clinical Nurse Leadership programs focus on the identification and implementation of leading edge and innovative nursing education standards and practices to ensure that our nurses and patient care services are benchmarked to "best in industry".

Aligning with our network strategic plan, Vision 2020, our WCHN medical education achievements include the steps necessary to create a Clinical Branch Campus with the University of Vermont College of Medicine (UVM). All the GME programs maintain full accreditation status. The Danbury Hospital-based Simulation Center expanded its program offerings and work is underway to build a Center for Active Learning at Norwalk Hospital to host simulation training, library, and team learning activities in a highly conducive space.

The WCHN network now comprises over 1,500 Medical Staff members. The Medical Staff credentialing and peer review structures is standardized, with one electronic platform for Medical Staff appointment, and the hospital bylaws for the hospitals are now consistent and complementary. A physician manpower assessment was completed during our second year of the affiliation, the community need for primary

care and specialty care physicians was identified, and primary care recruitment has been prioritized by geography to address community needs. We integrated our employed community-based physicians by transitioning physicians formerly employed by Norwalk Hospital Physicians & Surgeons (NHP&S) to Western Connecticut Medical Group (WCMG). Access to care by this group has been enhanced to include nearly 500 primary care and multispecialty care providers located in over 60 locations across 17 cities/towns in the WCHN service area.

As an organization, WCHN is focused on delivery transformation, and building the necessary competencies required to take increased quality and utilization risk under value based payment reform. Our Physician Hospital Organization (PHO) structure is evolving with development of Clinical Pathways and Population Health Management Committees representing independent community practices and employed physicians. The Centers for Medicare and Medicaid Services ("CMS") awarded Danbury Hospital a five year, $4.5 million grant to establish the CMS Accountable Health Communities Model, which aims to address health-related social needs of Medicare and Medicaid beneficiaries. The grant funds screening programs for individuals for social determinants of health and then connects them to appropriate services.

Danbury and New Milford Hospitals transitioned to a single license on October 1, 2015, thereby facilitating operation of both hospitals with one standard of care under one license and one electronic health record platform. A network-wide organizational structure and management team was implemented and a determination was made as a network (although not identified in our original implementation planning) to pursue a single, integrated electronic medical record platform across the WCHN system. All WCHN campuses (including Norwalk, New Milford, and Danbury) and network facilities, including WCMG, are operating on a single platform across inpatient and outpatient settings as of March 3, 2018. This multiyear project to consolidate our clinical and patient financial systems onto one electronic health record with the Cerner system is a key part of WCHN's strategic growth and transformation and helps ensure coordination and delivery of a seamless patient care experience across multiple care settings.

The network maintained its A Stable rating from the rating agencies throughout this reporting period.

Financial Savings

Specific cost savings for major operating expense categories include Salaries and Wages, Fringe Benefits, Contracted Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expense and Other Operating Expenses (costs associated with the affiliation such as legal fees, consulting, and marketing).

Forecasted Expense Savings (as outlined in the CON):

	Year 1 (2014)*	Year 2 (2015)	Year 3 (2016)
Salaries and Fringe Benefits	$3,428,000	$6,987,000	$10,891,000
Supplies and Drugs	$818,000	$1,675,000	$2,606,000
Other Operating Expense (Costs)**	($2,151,000)	$1,241,000	$5,601,000
Total Savings	$2,095,000	$9,903,000	$19,098,000

* Year 1 commenced January 1, 2014
**Other operating expenses are costs associated with the affiliation such as legal fees, consulting, and marketing
Source: Financial Attachment I, CON pages 196 and 197

Actual Final Cost Savings Achieved:

Category	FY14 Impact	FY15 Impact	FY16 Impact
Salaries & Wages	786,181	(705,814)	(766,456)
Fringe Benefits	3,736,949	3,211,240	3,366,385
Med Supplies/Rx Costs	1,429,660	5,095,033	8,322,364
Business & Other Op Expenses	(3,190,873)	3,144,555	3,683,058
Total:	**2,761,917**	**10,745,014**	**14,605,352**

During FY2017 we realized an additional final management restructuring savings of $4,428,082, bringing the final total of financial savings resulting from the affiliation to **$32,540,364**.