



**WESTERN CONNECTICUT
HEALTH NETWORK**

DANBURY HOSPITAL • NEW MILFORD HOSPITAL



24 Hospital Ave.
Danbury, CT 06810
203.739.4903

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

January 7, 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: Anticipated Certificate of Need Activity

Dear Ms. Martone:

This letter is to inform the Office of Health Care Access (OHCA) regarding potential future regulatory activities. The Danbury Hospital (DH), a subsidiary of Western Connecticut Health Network, Inc. (WCHN) will be publishing a Public Notice this week indicating intent to file a Certificate of Need for the transition of DH's Seifert & Ford Community Health Center programs and the Aftercare treatment at its Community Center for Behavioral Health (CCBH) to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center (GDCHC). GDCHC will occupy the current Seifert & Ford location at 70 Main Street and accommodate the CCBH Aftercare program currently at 152 West Street, Danbury, CT. The capital expenditure of this project is estimated to be under \$225,000. The formal CON filing will occur within the window identified by OHCA regulations.

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, MBA, FACHE
Vice President, Planning



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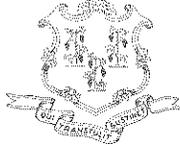
Sincerely,

A handwritten signature in cursive script that reads "Sally F. Herlihy".

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

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

January 16, 2015

The Honorable Bob Godfrey
Representative -110th Assembly District
House of Representatives
State Capitol
Hartford, CT 06106-1591

Re: Certificate of Need
Transition of Danbury Hospital's Seifert & Ford Family Community Health Center and
Community Center for Behavioral Health programs to the Connecticut Institute for
Communities, Inc.'s Greater Danbury Community Health Center.

Dear Representative Godfrey:

On January 15, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health outpatient primary health care programs to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) 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](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, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

A handwritten signature in cursive script that reads "Janet M. Brancifort".

Janet M. Brancifort, MPH
Deputy Commissioner

KRM:bko



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
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Hartford, Connecticut 06134-0308
www.ct.gov/dph

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State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE BOB GODFREY
ONE HUNDRED TENTH DISTRICT

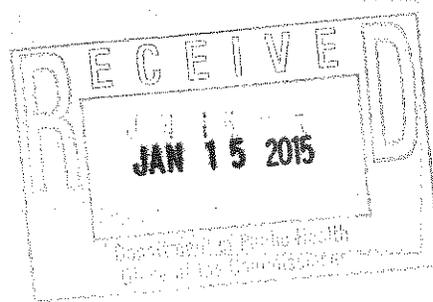
13 STILLMAN AVENUE
DANBURY, CONNECTICUT 06810-8007

DEPUTY SPEAKER

TELEPHONE
HOME: (203) 778-5127
CAPITOL: (860) 240-8500
TOLL FREE: 1-800-842-1902
EMAIL: BOB.GODFREY@CGA.CT.GOV

January 14, 2015

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



Dear Deputy Commissioner Davis,

This is written to support Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFC) Greater Danbury Community Health Center (GDCHC).

CIFC/GDCHC is a Federally Qualified Health Center (FQHC) serving Danbury and nine surrounding municipalities. The Health Center serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level (FPL), uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, CIFC/GDCHC provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach. In addition to the Health Center's principal site in downtown Danbury, CIFC/GDCHC operates five (5) Danbury area School Based Health Center (SBHC) sites; and sponsors the Region's WIC Program and SNAP enrollment services.

CIFC/GDCHC is recognized as a Level 3 Patient Centered Medical Home (the highest rating) by the National Committee for Quality Assurance (NCQA). In addition, CIFC/GDCHC provides a robust Graduate Medical Education (post-MD) Program for Residents to train and prepare for a career in Internal Medicine Primary Care. CIFC/GDCHC is accredited by the national Accreditation Council for Graduate Medical Education (ACGME); it is the first and only accredited Teaching Health Center in the State of Connecticut.

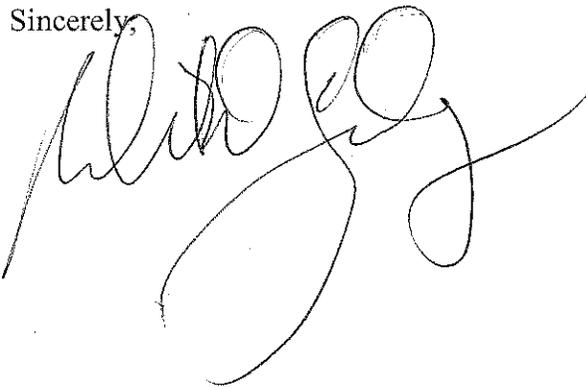
The proposed collaboration achieves a higher level of primary, dental, behavioral health and supportive care services that further strengthens the opportunities for underserved residents in the Greater Danbury area to secure a comprehensive medical home for their health needs. This proposed collaboration will: maximize this area's primary health care resources in a more coordinated, efficient manner; provide increased access including expanded hours of operation; and bring benefits that are not available through a hospital based clinic like Seifert and Ford, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

CIFC/GDCHC is a well-established and highly regarded Community Health Center whose mission complements that of Danbury Hospital and the Seifert and Ford clinic. By working together in this collaboration, Danbury Hospital and CIFC/GDCHC can reduce the cost of providing comprehensive primary health care throughout the region, while maintaining, expanding and enhancing the highest level of patient care.

FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to be "Michael J. [unclear]", written in a cursive style.

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

January 30, 2015

The Honorable David Arconti
Representative -109th Assembly District
House of Representatives
State Capitol, Room 4026
Hartford, CT 06106-1591

Re: Certificate of Need
Transition of Danbury Hospital's Seifert & Ford Family Community Health Center and
Community Center for Behavioral Health programs to the Connecticut Institute for
Communities, Inc.'s Greater Danbury Community Health Center.

Dear Representative Arconti:

On January 29, 2015, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health outpatient primary health care programs to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) 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, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

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Janet M. Brancifort, MPH
Deputy Commissioner



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

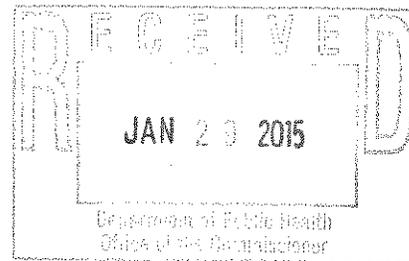
REPRESENTATIVE DAVID ARCONTI
ASSISTANT MAJORITY LEADER
109TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4026
HARTFORD, CT 06106-1591
CAPITOL: 860-240-8585
E-MAIL: David.Arconti@cga.ct.gov

MEMBER
ENVIRONMENT COMMITTEE (VICE-CHAIR)
GENERAL LAW COMMITTEE
HOUSING COMMITTEE
PUBLIC SAFETY & SECURITY COMMITTEE

January 14, 2015

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



Dear Deputy Commissioner Davis,

This is written to support Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFC) Greater Danbury Community Health Center (GDCHC).

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SERVING DANBURY

SERVING DANBURY

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FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

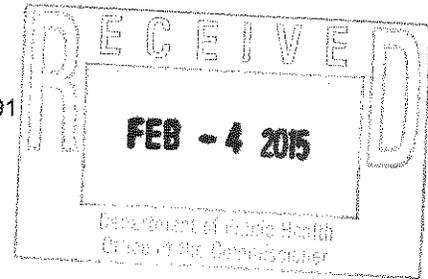
Thank you for your consideration.

Sincerely,


David Arcanti Jr.



State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591



1/30/15

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

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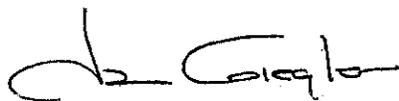
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Thank you for your consideration.

Sincerely,



Janice R. Giegler

State Representative, 138th District



Michael McLachlan

State Senator, 24th District

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

February 6, 2015

The Honorable Janice R. Giegler
Representative - 138th Assembly District
General Assembly
State Capitol
Hartford, CT 06106-1591

Re: Certificate of Need

Transition of Danbury Hospital's Seifert & Ford Family Community Health Center and
Community Center for Behavioral Health programs to the Connecticut Institute for
Communities, Inc.'s Greater Danbury Community Health Center.

Dear Representative Giegler:

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Sincerely,

A handwritten signature in cursive script that reads "Janet M. Brancifort".

Janet M. Brancifort, MPH
Deputy Commissioner



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Hartford, Connecticut 06134-0308
www.ct.gov/dph

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CITY OF DANBURY

HEALTH & HUMAN SERVICES DEPARTMENT
155 DEER HILL AVENUE, DANBURY, CONNECTICUT 06810

Central Health Office
Tel: (203) 797-4625
Fax: (203) 796-1596

Social Services Office
Tel: (203) 797-4569
Fax: (203) 797-4566

July 7, 2015

Office of Health Care Access
Department of Public Health
State of Connecticut

RE: Docket No.: 15-31978-CON

IN RE: PROPOSAL BY WESTERN
CONNECTICUT HEALTH NETWORK
TO TERMINATE AND TRANSFER
OWNERSHIP OF SEIFERT & FORD
FAMILY COMMUNITY HEALTH
CENTER AND COMMUNITY CENTER
FOR BEHAVIORIAL HEALTH PROGRAMS

Ladies and Gentlemen:

As Medical Advisor to the Department of Health and Human Services of the City of Danbury, this is written in support of the above referenced application by Western Connecticut Health Network.

As I am sure you are aware, best practices in primary health care now encourage the integration of all phases of primary care into a coordinated setting known as a "Patient Centered Medical Home." The proposal before you does exactly that, and in a manner that is very beneficial to the greater Danbury community, particularly residents with limited economic means who may be under-insured or without health insurance entirely.

Transitioning the existing primary care services of the Seifert & Ford Center (S&F) and the Danbury Hospital Community Center for Behavioral Health (CCBH) to the Greater Danbury Community Health Center has many, notable advantages:

- Greater Danbury Community Health Center (GDCHC) is a highly regarded health care organization, holding a level III (the highest) certification as a Patient Centered Medical Home from the National Committee for Quality Assurance.

All City Services 311
Eviction Prevention 203-797-4565
Information-Referral 203-797-4569

Dial 2-1-1 for all
Connecticut Services!

Emergency Shelter 203-796-1661
Emergency Shelter Fax 203-796-1660
WIC Program 203-797-4638

- Greater Danbury Community Health Center is governed by a non-profit Board of Directors, the majority of whom are patients of its Community Health Center services, which assure a vigorous, on-going community and patient focused voice in all GDCHC operations.
- Greater Danbury Community Health Center provides extended hours of service each week day, as well as on multiple Saturdays each month, well beyond the current hours of service of Seifert & Ford or CCBH, and GDCHC plans to still further extend its service hours after integrating S&F and CCBH into its operations.
- Patients of GDCHC have access to services not currently available to S&F or CCBH patients, such as the 340B Pharmacy discount program, which provides low cost prescriptions for the benefit of GDCHC patients and also provides direct discounts (in the range of 2/3rds off) for patients without pharmacy insurance.
- Finally, as alluded to above, this application is supportive of federal health care reform, and Connecticut's own state health plan, for the promotion of wellness, the expansion of preventative care, and the delivery of primary care in a medical home model.

I join Danbury Mayor Mark Boughton, who wrote to you in support of this proposal as previously submitted to your office, in asking you to approve the subject application, and afford GDCHC the opportunity to substantially enhance community health services to our area's residents, particularly those most in need.

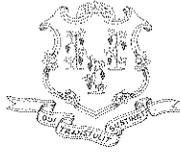
Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Thomas F. Draper". The signature is written in dark ink and is positioned above the printed name.

Dr. Thomas F. Draper, M.D.,
Medical Advisor

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner



Dannel P. Malloy
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February 6, 2015

The Honorable Michael McLachlan
Senator, 24th District
General Assembly
State Capitol
Hartford, CT 06106-1591

Re: Certificate of Need
Transition of Danbury Hospital's Seifert & Ford Family Community Health Center and
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Janet M. Brancifort, MPH
Deputy Commissioner



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February 10, 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 06134-038



Re: Western Connecticut Health Network, Inc. CON Request

Dear Ms. Martone,

Pursuant to Section 19a-638, C.G.S., please find enclosed a Certificate of Need for Western Connecticut Health Network, Inc. to transition Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center.

If you have any questions that the attached submission does not answer, please contact me so that we may provide whatever additional information you need in your deliberations. I can be reached directly at 203-739-4903, or sally.herlihy@wchn.org.

Sincerely,

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

WCHN CON Application

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.: 15-31978-CON Check No.: 871939
 OHCA Verified by: OC Date: _____

- 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 Attachment I.
- 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 signed 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 financial documents in MS Excel.

WCHN CON Application



**WESTERN CONNECTICUT
HEALTH NETWORK**

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Accounts Payable Telephone: 203-739-1169

Wachovia Bank of Delaware, NA
62-22/311

Check No. 871939

Check Date
02/09/2015

PAY *Five Hundred AND 00/100*

Check Amount (USD)
\$ *****500.00

TO THE ORDER OF
12337
TREASURER ST OF CT
55 ELM ST
SUITE 3
HARTFORD, CT 06106

John P. Murphy



AFFIDAVIT

Applicant: Western Connecticut Health Network, Inc.

Project Title: Transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center

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

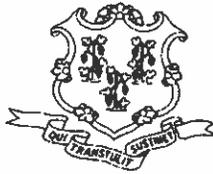
John M. Murphy
Signature

2/9/15
Date

Subscribed and sworn to before me on February 9, 2015

Alberta B. Riccardi





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. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number: TBD

Applicant: Western Connecticut Health Network, Inc.

Applicant’s Facility ID*: Danbury Hospital NPI for outpatient services is 1548293343
Danbury Hospital NPI for dental services is 1003835965

Contact Person: Sally Herlihy, MBA, FACHE

Contact Person’s Title: Vice President, Planning

Contact Person’s Address: 24 Hospital Avenue
Danbury, CT 06810

Contact Person’s Phone Number: 203-739-4903

Contact Person’s Fax Number: 203-739-1974

Contact Person’s Email Address: sally.herlihy@wchn.org

Project Town: Danbury, CT

Project Name: Transition of Danbury Hospital’s Seifert & Ford Family Community Health Center and Community Center for Behavioral Health programs to the Connecticut Institute For Communities, Inc.’s Greater Danbury Community Health Center (FQHC)

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: \$202,500

WCHN CON Application

1. Project Description: Service Termination

- a. For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.

Western Connecticut Health Network, Inc. ("WCHN") is an integrated delivery network comprised of The Danbury Hospital ("DH"), New Milford Hospital ("NMH"), Norwalk Hospital ("NH") and their affiliated entities. In October 2010, with Docket No. 10-1560-CON, DH and NMH became wholly owned subsidiaries of a newly formed entity, Western Connecticut Health Network, Inc. ("WCHN"). In December of 2013, with Docket No. 13-31832-CON, WCHN's corporate affiliation expanded to include NH. In June 2014, with Docket No. 13-31859-CON, WCHN received approval to terminate NMH's license and to add NMH's services and licensed beds to DH's license. NMH began operation as a campus of DH on October 1, 2014.

DH is a 456-bed acute care hospital with two campuses: Danbury Hospital located at 24 Hospital Avenue, Danbury, CT and NMH located at 21 Elm Street in New Milford, CT. DH's total licensed bed capacity includes 430 general hospital beds and 26 bassinets. NH is an acute care hospital located at 34 Maple Street, Norwalk, CT and its licensed bed capacity is 328 beds and 38 bassinets.

The Primary Service Area ("PSA") for the combined DH/NMH market includes nine towns (Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Ridgefield and Southbury, CT), and a Secondary Service Area ("SSA") with 14 towns (Bethlehem, Cornwall, Kent, Redding, Roxbury, Sherman, Washington, and Woodbury, CT and Brewster, Dover Plains, North Salem, Pawling, Wingdale, and Patterson, NY). This PSA/SSA has a combined population of 317,454 in 2010, and is estimated to increase 1.4% to 321,804 by 2015 (*Source: U.S. Census 2010 Population, 2015 projection; CT State data center, <http://ctsd.c.uconn.edu/projections.html>*). A map of the service area is included as Exhibit A.

DH operates the Seifert & Ford Family Community Health Center ("S&F") at 70 Main Street, Danbury, CT. S&F provides primary care services to the greater Danbury community through its Adult Medicine, Pediatric Medicine, Women's Services, and Dental Services programs (the "S&F Primary Care Services"). Its current hours of operation are Monday-Friday, 9am-5pm. The National Committee for Quality Assurance ("NCQA") has recognized the Adult Health Center at Seifert and Ford Family Community Health Center as a Level III Patient Centered Medical Home ("PCMH"). DH also operates the Community Center for Behavioral Health ("CCBH") located at 152 West Street, Danbury, CT which offers both intensive outpatient and adult behavioral/medication management services (the "Behavioral Health Clinic Services").

This proposal involves the transition of the S&F Primary Care Services and the CCBH Behavioral Health Clinic Services to the Greater Danbury Community Health Center ("GDCHC"), operated by the Connecticut Institute For Communities, Inc. ("CIFIC") over the course of a two (2) year transition period (the "Transition Period").

GDCHC is located at 57 North Street, in Danbury, CT. Its current hours of operation are Monday-Thursday: 8:30am-6:30pm; Friday: 8:30am-6pm; and Saturday: 9am-1:15pm. GDCHC serves a ten-town region including Danbury, Bethel, Bridgewater, Brookfield, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman. The CIFIC Business Office is located at 7 Old Sherman Turnpike, Suite 200, Danbury, CT, 06810.

GDCHC is a licensed federally qualified health center ("FQHC"), approved by the U.S. Department of Health and Human Services, Health Resources and Services Administration, and, offering a range of comprehensive primary care services, including, but not limited to medical, dental and mental health

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services. GDCHC provides these services on a sliding fee basis, to people of all ages and life cycles: prenatal, children, adolescents, adults and seniors, especially those who are medically underserved. Its mission is to ensure affordable, accessible, comprehensive, high quality health care to the residents of the greater Danbury area, regardless of their ability to pay or their insurance status.

An FQHC is a community-based and patient-directed organization that serves populations with limited or no access to health care and provides comprehensive preventive and primary medical care-related services.

Operated by private, non-profit or public agencies, FQHCs:

- Are located in or serve a high need community.
- Are governed by a community board composed of a majority (51% or more) of health center patients who represent the population served.
- Provide comprehensive primary health care services as well as supportive (enabling) services (education, translation and transportation, etc.) that promote access to health care.
- Provide services available to all with fees adjusted based on ability to pay.
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

Source: HRSA.gov

A map denoting the locations of the three entities (S&F, CCBH, and GDCHC) is included as Exhibit B. The proposed sites of care for delivery of the programs, if this CON is approved, are provided on Exhibit C.

- b. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.

S&F is located in downtown Danbury, CT and has been providing a wide range of outpatient healthcare services in one location since September 1, 1999. No CON was required to establish this service location. Through the proposed partnership between DH and GDCHC, WCHN will continue to provide specialty care clinics at S&F. DH's graduate medical education residents will perform clinical rotations under the supervision of GDCHC at S&F and GDCHC sites. GDCHC's existing infrastructure, performance and ability to expand services for the communities served by WCHN and GDCHC make GDCHC the strongest option to ensure long term primary care access for a growing population, and to expand access and availability.

- c. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.

Background

WCHN provides care to the underinsured and uninsured in its communities, including services provided through S&F and CCBH. Reimbursement for the services performed by S&F and CCBH is projected to decline in future fiscal years due to (i) reductions in Medicaid reimbursement, (ii) escalating costs of providing these services each year, and (iii) the increased costs of implementing and maintaining an electronic medical record for these clinics.

As a core tenet of WCHN's mission, and the primary reason each hospital within WCHN was founded, services are provided to individuals within the communities served regardless of their ability to pay for such services. Because of this mission, WCHN cannot eliminate these services in the community to reduce its losses in providing care to this population. Through partnering with another local entity, one which was founded on the same principles of providing healthcare to this very same population,

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regardless of their ability to pay, WCHN has an opportunity to expand access to services, enhance quality oversight of the healthcare provided, invest in technology and other infrastructure and expand our commitment to growing primary care providers, while concurrently reducing the costs of providing these services.

GDCHC is an established, federally-funded FQHC. The mission of FQHCs mirrors those of traditional hospital-based clinics in that they are community-based and patient-directed organizations that serve populations with limited access to health care. This includes low-income medically underserved and vulnerable populations; uninsured and limited English proficiency populations; migrant and seasonal farm workers; homeless populations, and those living on some form of public assistance.

It has been demonstrated across the country that a well-structured FQHC-hospital collaboration and linkages and collaborative arrangements with other community providers can help to maximize resources and efficiencies in service delivery systems and can produce benefits for both organizations. These benefits are the result of bringing additional, significant, outside funding into the local healthcare service area and reducing the redundant overhead that exists today with both organizations providing these services in the same community. As reimbursement for services continues to decline for the traditional hospital-based clinics and ambulatory care services, this collaboration will help improve the efficiency of the local healthcare delivery system in the current era of healthcare reform.

The FQHC program benefits that are not available to hospital-based clinics like S&F include:

- Malpractice cost savings due to coverage through the Federal Tort Claims Act;
- Enhanced reimbursement for Medicaid and Medicare services rendered to patients;
- Potential patient drug coverage through the 340B Drug Pricing Program;
- Vaccines for Children Program;
- Eligibility to receive federal, state, and private grants for recruitment and other costs associated with providing clinic patient services.

Benefits to FQHCs from Health System Collaboration

FQHCs have generally had limited administrative depth due to the need to focus their resources on providing patient care services. Health systems can provide administrative support services that are already in place in the health system physician division at minimal additional cost. Examples of potential support include:

- Recruitment assistance and coordination in the local service area;
- Support for the development or improvement of quality programs;
- Leadership and assistance with FQHC electronic medical record (EMR)/EHR development and integration effort;
- Improved care coordination for necessary specialty and hospital services;
- Assistance with board, physician, and administrative leadership education programs;
- Credentialing; and
- Other services based on FQHC needs and health system capabilities.

The transition of the S&F Primary Care Services and the Behavioral Health Clinic Services will have a positive impact on the provision of services and will expand access and availability of primary care services. By coming together in a partnership to provide services to the same medically underserved and vulnerable patient populations, WCHN and CIFC can significantly reduce the costs of providing this care through reduced overhead and elimination of duplication of services; increase the access and accessibility of services provided to this patient population through expanded service hours; increase the number of primary care providers and specialty providers; and expand collaborative programs to ensure

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this population is receiving the right care in the right place at the right time, regardless of the patient's ability to pay for the services.

Additional Supporting Rationale

On December 2013, Connecticut submitted its Healthcare Innovation Plan (the State's framework for health reform) to the federal Center for Medicare and Medicaid Innovation. The State's Innovation Model, ("SIM") is designed to thrust Connecticut "toward achievement of the triple aim: better health, better healthcare quality and reduction of costs".¹

The SIM report acknowledges that Connecticut's healthcare system "falls short," citing high emergency department utilization rates, especially for non-urgent conditions, and a relatively high rate of hospital readmissions.²

It is anticipated that the partnership between WCHN and CIFC will, over time, have a positive impact in emergency department diversion for several reasons:

- CIFC/GDCHC is recognized as a Level 3 PCMH by the NCQA. The PCMH methodology is designed to improve the quality, safety, efficiency, and effectiveness of patient health care by:
 - Delivering primary care that is oriented towards the whole person.
 - Empowering individuals to actively participate in their healthcare, and understand the importance of preventative healthcare.
 - Meeting the majority of a patient's physical and mental health care needs through a team-based approach to care.
 - Partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.
 - Coordinating patient care across all elements of the health care system, such as specialty care, hospitals, home health care, and community services, with an emphasis on efficient care transitions.³

When patients receive care in the setting of a PCMH they do not have to rely on a hospital's emergency department for primary healthcare services.

- The CIFC/GDCHC is also the only FQHC in the State to be accredited by the Accreditation Council for Graduate Medical Education ("ACGME") as a Teaching Health Center, sponsoring an innovative Primary Care Internal Medicine Residency Training Program based on the PCMH model of care. (At full capacity, they will be training 72 Primary Care Internal Medicine residents from GDCHC and DH).

Decision to Integrate Services

WCHN went through a multi-phased process in making the decision to partner with the CIFC/GDCHC in the provision of these services to this patient population and to transition the S&F Primary Care Services and the Behavioral Health Clinic Services to GDCHC:

- The two organizations first explored whether or not the model made sense in terms of a cultural fit relative to patient care provision, medical education, and ongoing collaborations to improve

¹ CT Health Care Innovation Plan, December 2013

² CT Health Care Innovation Plan, December 2013

³ PCMH Resource Center

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the access and quality of patient care to this patient population, and whether there was an opportunity to reduce costs in the provision of health care services.

- We then explored whether our missions were aligned in ensuring all community members would receive care regardless of their ability to pay for services.
- We next explored the quality programs that would be in place to ensure that the care provided to this patient population would be monitored, continuously improved, and transparent to all.
- We explored the ability to expand the provision of specialty care to this patient population.
- Once comfortable with the above due diligence, management teams from both organizations made proposals to their respective boards to move forward with this collaboration and the decision to cease the provision of S&F Primary Care Services and the Behavioral Health Clinic Services at WCHN.
- The Boards of WCHN and CIFC approved the proposed transactions.

Letters of Support for this proposed direction are provided in Exhibit D.

- d. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted on.

The proposed termination of the S&F Primary Care Services and the Behavioral Health Clinic Services at WCHN/DH and their transition to the CIFC required approval from the WCHN Board of Directors, and this occurred on May 22, 2014.

Minutes from WCHN Board meeting are enclosed as Exhibit E.

- e. Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

The 2010 Affordable Care Act (ACA) is challenging health systems to step up to a higher level of efficiency, improved integration of services, and to shift from a volume-based payment system to a value-based payment system. A major part of the service integration efforts in the reform legislation are focused on physician services, such as expansion of primary care services, development of electronic health records (EHRs), and improved patient transparency in healthcare delivery.

For WCHN this means embracing a strategy that supports increased access to primary care, growth in the recruitment of primary care providers, investment in costly information technology and improvements in quality outcomes and reporting, all while significantly reducing our costs for delivery of care. To continue to be true to our mission, WCHN must apply this strategy for each and every segment of the communities it serves, regardless of their ability to pay for such services.

The healthcare reform legislation for the ACA provides \$11 billion for community health centers ("CHC"), which are operated as FQHCs for Medicare and Medicaid purposes. The funding level represents a 500 percent increase in federal funding and is intended to be used to expand primary care services and support the FQHC mission of providing a "medical home" for underserved and uninsured patients. In addition, the Medicaid program administered through the states will be expanding to assist with coverage for the uninsured. These additional funding programs will provide resources to expand the FQHC network in many local healthcare communities, including those in Connecticut.

FQHCs are in the forefront of healthcare reform and will play a pivotal role in the revamping of the healthcare delivery and financing system. Clearly, FQHC providers are an integral component of the federal government's health care strategy. In recent years, non-FQHC health care organizations, such as hospitals, health systems, and health networks, have incurred economic losses on their ambulatory sites as a result of

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low Medicare and Medicaid reimbursements for health care services provided to patients with inadequate or no insurance. FQHCs, with their federal funding, by contrast, receive U.S. Public Health Service Section 330 grant funds to support services at new primary care access points and expand medical capacity. Additionally, FQHCs receive more favorable, enhanced Medicare and Medicaid payment rates and have the benefit of Federal Tort Claims Act (FTCA) coverage, which substitutes for traditional malpractice coverage at no cost to the FQHC.

WCHN and CIFC will partner on a delivery model that is not only sustainable for the greater Danbury community, but which will allow expansion of services beyond what is currently offered by either DH or GDCHC today. This partnership is necessary in order for both organizations to responsibly deliver the highest level of quality at the lowest cost.

2. Termination's Impact on Patients and Provider Community

- a. Identify the name and location (i.e. address, town and state), facility ID and hours of operation (as available) of existing providers in the towns listed above and in nearby towns;

TABLE 1
EXISTING SERVICE PROVIDERS

Facility Name	Facility ID*	Facility Address	Service	Days/Hours of Operation
Danbury Hospital - Seifert & Ford Family Community Health Center	NPI for outpatient services is #1548293343 NPI for dental services is #1003835965	70 Main Street, Danbury, CT 06810	Adult's & Ped's Women's Dental	Monday-Friday 8:00 AM-5:00 PM Monday-Thursday 8:00 AM-5:00 PM Monday, Tuesday, Thursday, Friday 8:00 AM-5:00 PM Wednesday 1:00 PM-8:00 PM
CCBH	NPI is #1548293343	152 West Street, Danbury CT 06810	OP Behavioral Health	Monday, Wednesday, Thursday, Friday 8:30 AM-5:00 PM Tuesday 8:30 AM-7:00 PM
GDCHC*	NPI is #1780918045	57 North Street, Danbury CT 06810	Primary Care	Monday, Tuesday, Wednesday, Thursday 8:00 AM-7:00 PM Friday 8:00AM-6:00 PM Saturday 8:30 AM-1:30 PM *stay as late as necessary to complete the final visit, and as provider availability allows may arrange early AM or PM as practicable
See <u>Exhibit F</u> for a listing of providers in the Danbury community obtained from the 2014 OHCA Statewide Healthcare Facilities and Services Inventory				

*Please provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label

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- b. For each provider to whom the Applicant proposes to transfer or refer clients, provide the facility ID, total capacity, current available capacity, as well as the utilization for the last completed year and for the current year.

TABLE 2
PROVIDERS ACCEPTING TRANSFERS/REFERRALS

Facility Name	Facility ID*	Facility Address	Total Capacity	Available Capacity at this location (visits per year)	Utilization FY 2014	Utilization Current 2014
Connecticut Institute for Communities, Inc./Greater Danbury Community Health Center	Medicare Billing # 071851	57 North Street, Danbury, CT	33,000	9,000	24,000	24,000

*Please provide either the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

**Fill in year and identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate. – The FY is January 1 – December 31

***For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

GDCHC will lease space at the S&F location to accommodate the S&F and CCBH volume.

- c. Identify any special populations that utilize the service(s) and explain how these populations will maintain access to the service following termination at the specific location; also, specifically address how the termination of this service will affect access to care for Medicaid recipients and indigent persons.

Uninsured, underinsured, and Medicaid patients are the predominant patient mix that utilizes the S&F and CCBH. The services this patient population receives at S&F and CCBH includes adult primary care, pediatric primary care, women's services (including prenatal care), dental services, behavioral health services and specific specialty services provided in a specialty clinic.

These patients will receive all of these same services through GDCHC at the S&F location. WCHN and the GDCHC will ensure all of these services will continue or are expanded, in the community through the provision of care that GDCHC offers and a community grant from WCHN to support these services going forward.

There will be no negative impact on the provision of care to Medicaid recipients or the indigent in this community.

GDCHC serves a ten-town region including Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman, all of which are in the area served by S&F and CCBH, with a population totaling 221,081. Of that, it is estimated that 29,960 residents live 200% below the poverty level (UDS Mapper). Danbury, Bethel and New Milford have the majority of low income residents, with Danbury as the urban hub, having the greatest concentration, approximately 18,634 who live 200% below the Federal Poverty Level. It is estimated that approximately 28,533 residents in GDCHC's ten-town region are without insurance and approximately 19.6% are under age 65. GDCHC will assume space at S&F

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for the provision of the services. S&F (and accordingly the new GDCHC site) is centrally located within easy access to public transportation to facilitate access to these populations.

Benefits associated with FQHCs for provision of care for Medicaid populations are highlighted in Exhibit G.

- d. What impact will the proposal have upon the cost effectiveness of providing access to services provided under the Medicaid program? If not applicable to the proposal, explain why it is not applicable.

By coming together in a partnership to provide services to the same patient population, WCHN and CIFIC can significantly reduce the costs of providing this care through reduced overhead and elimination of duplication of services in a more appropriate, FQHC ambulatory care setting.

Currently, both WCHN and CIFIC incur significant infrastructure costs in running separate clinics (S&F and GDCHC) that serve the same population of patients. Duplication exists in electronic medical record costs, quality programs oversight, staff productivity, medical education direction, legal fees, regulatory oversight, and management of the programs.

Exhibit H contains an article written by Susan Patton for HealthLeaders Media, April 16, 2010, titled "How Hospitals and Federally Qualified Health Centers Should Collaborate", recognizing the importance of developing collaborative arrangements that enhance community health care access as proposed in this CON proposal.

- e. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.

A Letter of Intent that sets forth a non-binding agreement in principle between the CIFIC d/b/a GDCHC and DH was executed on June 23, 2014 and is enclosed as Exhibit I.

- f. Describe how clients will be notified about the termination and transfer to other providers.

Communications will occur across several platforms, including notifications to current patients, the provider community, and on-site for future patients. A brief outline of the communications and outreach efforts is enclosed in Exhibit J.

3. Actual and Projected Volume

- a. Provide volumes for the most recently completed FY by town.

TABLE 3
UTILIZATION BY TOWN

Town	Utilization FY14 (Oct 1-Sept 30) # Visits
DANBURY, CT	37,619
BETHEL, CT	3,327
BROOKFIELD, CT	1,452
NEW MILFORD, CT	1,254
NEW FAIRFIELD, CT	1,177
RIDGEFIELD, CT	994
NEWTOWN, CT	875
SANDY HOOK, CT	603
REDDING, CT	357
WATERBURY, CT	238
SOUTHBURY, CT	190
WOODBURY, CT	113
WILTON, CT	89
HAWLEYVILLE, CT	84
MONROE, CT	75
SHERMAN, CT	70
ROXBURY, CT	57
NAUGATUCK, CT	49
OAKVILLE, CT	39
BREWSTER, NY	36
SOUTH MERIDEN, CT	36
WESTON, CT	32
REDDING RIDGE, CT	29
PLEASANT VALLEY, NY	27
GAYLORDSVILLE, CT	26
MIDDLEBURY, CT	25
14 towns with 10-24 each	219
66 towns with <10 each	223
TOTAL	49,324

*Fill in year and identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.). Label and provide the number of visits or discharges as appropriate.

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- b. Complete the following table for the past three fiscal years (“FY”) and current fiscal year (“CFY”), for the number of visits/discharges, as appropriate, by service.

The Table below shows the payor mix for the services provided at S&F and CCBH (as opposed to WCHN’s payor mix as a whole).

TABLE 4
HISTORICAL AND CURRENT VISITS/DISCHARGES

Service***	Actual Volume (last 3 completed FYs)			
	FY12	FY13	FY14	FY15, FPI-3
Adult Primary Care	12,537	11,784	10,018	2,555
TB / STD / HIV Clinics	1,423	1,153	1,396	324
Pediatric Primary Care	11,336	9,810	8,198	2,484
Women's Health	6,600	6,491	5,654	1,493
Behavioral Health	13,080	12,415	10,581	4,938
Dental	12,816	12,722	13,477	3,097
Totals	57,792	54,375	49,324	14,891

*For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

**Identify each service type and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

***Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g. July 1-June 30, calendar year, etc.).
FY is October 1 – September 30

- c. Explain any increases and/or decreases in volume seen in the table(s) above.
1. Adult Health: FY13 to FY14- Loss of full time internal medicine physician/preceptor.
 2. Pediatrics: FY12 to FY14- Loss of full time pediatric physician and APRN. Replaced with one APRN in FY14.
 3. Women’s: FY13 to FY14- Significant leave by full time provider; replaced by as needed physicians.
 4. Dental: FY13 to FY14- Increase in patient referrals, new and repeat visits.
- d. For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:
- i. Average daily census;
 - ii. Number of clients on the last day of the month;
 - iii. Number of clients admitted during the month; and
 - iv. Number of clients discharged during the month.
- i., iii., iv. – N/A
- ii. - CCBH services approximately 1,500 clients annually. These individuals are treated in the outpatient setting, which is partially funding from DMHAS.

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4. Projected Patient Population Mix:

- a. Provide the current and projected volume (and corresponding percentages) by patient population mix; including, but not limited to, access to services by Medicaid recipients and indigent persons for the proposed program.

The Table below shows the payor mix for the services provided at S&F and CCBH (as opposed to WCHN's payor mix as a whole).

TABLE 5
APPLICANT'S CURRENT & PROJECTED PAYER MIX

	Current		Projected					
	FY2014		FY2015		FY2016		FY2017 *	
	Vol	Pct	Vol	Pct	Vol	Pct	Vol	Pct
Medicare	7,482	15.2%	7,041	15.2%	3,827	20.3%	0	#DIV/0!
Medicaid	26,191	53.1%	24,105	52.0%	8,469	44.9%	0	#DIV/0!
Champus & TriCare	0	0.0%	0	0.0%	0	0.0%	0	#DIV/0!
Total Gov	33,673	68.3%	31,146	67.1%	12,296	65.2%	0	#DIV/0!
Commercial	2,258	4.6%	2,169	4.7%	1,421	7.5%	0	#DIV/0!
Uninsured	13,389	27.1%	13,060	28.2%	5,139	27.3%	0	#DIV/0!
Worker's Comp	5	0.0%	8	0.0%	0	0.0%	0	#DIV/0!
Total Non-Gov	15,651	31.7%	15,237	32.9%	6,559	34.8%	0	#DIV/0!
Total Payer Mix	49,324	100.0%	46,383	100.0%	18,855	100.0%	0	#DIV/0!

* Clinic volume transitioned successfully to FQHC

*Includes managed care activity.

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

Note: The patient population mix should be based on patient volumes, not patient revenues.

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

There is no growth assumption as, with CON approval, S&F will be transitioning its program to the GDCHC. The current patient population will continue to have access to the services. Through partnering with GDCHC, there will be efficiency in delivery of services, enhanced referral arrangements, co-location agreements for specialty care, and ED alternatives for urgent care as a lower cost modality. All patients without regard to their ability to pay for services or any other status (including citizenship or resident documentation) will be treated. As a designated FQHC, GDCHC offers a sliding fee schedule for all patients who qualify based on income, regardless of whether the patient carries health insurance coverage. The Financial Policy for the FQHC is enclosed in Exhibit K.

- c. For the Medicaid population only, provide the assumptions and actual calculation used to determine the projected patient volume.

No volume is projected following transition of services to GDCHC.

- d. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation for good cause for doing so. *Note: good cause shall not be demonstrated*

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solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

N/A, the services will remain intact with a new provider.

5. 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.

The Curriculum Vitae for the CIFC personnel are enclosed in Exhibit L.

- b. Explain how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, (1) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (2) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

Provision of primary care services to the community is core to WCHNs mission. Partnering with CIFC and fully transitioning the S&F Primary Care Services and the Behavioral Health Clinic Services will allow WCHN to maintain and expand health care services among underserved and uninsured populations. It will facilitate bridging the continuity of acute inpatient hospital and ambulatory (outpatient) primary care delivery systems within our community and ensure better access to health care and safety net services, enhance the amount, type and quality of services available, facilitate and improve continuum of care, and reduce duplication of certain outpatient primary care services. With its primary focus on primary care and preventative services, GDCHC will be in a position to improve and expand the services available to the community jointly served by WCHN and GDCHC.

The FQHC model is a proven model that allows for growing these services, innovation in providing the care to this patient population, investment in necessary infrastructure and collaboration with other community providers.

- c. Identify when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

S&F and CCBH are currently part of the DH license and reported as part of the hospital cost reports. The hospital license will remain in place as the specialty clinics located at S&F are not transitioning to CIFC.

Exhibit M contains the current Danbury Hospital license.

6. Organizational and Financial Information

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

WCHN is a Connecticut nonstock corporation.

- b. Does the Applicant have non-profit status?

Yes (Provide documentation) No

- c. Financial Statements

WCHN CON Application

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

The recent audited financial statements were filed with OHCA as part of the Hospital annual reporting packet.

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

TABLE 6
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging)	
Land/Building Purchase*	
Construction/Renovation**	202,500
Land/Building Purchase*	
Other (specify)	
Total Capital Expenditure (TCE)	202,500
Lease (Medical, Non-medical Imaging)***	0
Total Capital Cost (TCO)	0
Total Project Cost (TCE+TCO)	202,500

*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.

Overview of proposed construction activity:

- The 70 Main St. Danbury location includes various services noted on the plans with a total square footage of 23,862, of which 1,389 sf will continue to be used by DH for its specialty clinics. The building work includes modification of the negative pressure system to accommodate space changes relating to DH's Tuberculosis Clinic. In addition, we will perform an aesthetic upgrade to include painting, carpet, flooring, lighting, signage, cleaning to give the location a fresh look which is estimated to cost \$100,000. There are very few wall changes but no major construction. The timeline for 70 Main St. is approximately 1 year as the work has to be phased to prevent disruption of services.
- The 152 West St. Danbury location will house the outpatient Behavioral Health Services. Of the 10,500 sf currently used by DH, the GDCHC will utilize 4,010 sf. There will be a separation created between DH and GDCHC. The total overall work includes installation of automatic doors,

WCHN CON Application

wall changes, adding a reception desk, signage, and aesthetic upgrades (i.e. paint/ carpet) totaling \$102,500. The timeline to complete this area is 4 months.

Exhibit N contains a description of the facilities and associated square footage.

- e. 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.

The \$202,500 capital expense will be funded through cash flow.

- f. Demonstrate how this proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant.

The financial strength of the state's health care system is directly related to the strength of its providers. Providers must position their organizations to succeed in an uncertain and changing reimbursement environment. For WCHN, the ability to partner with the local FQHC while still meeting the needs of its community will enable WCHN to drive cost-efficiencies. This proposal to transition the S&F Primary Care Services and Behavioral Health Clinic Services to the GDCHC will ensure continued and expanded access to primary care services for the communities served by DH and CIFC/GDCHC.

7. Financial Attachments I

- 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 O – 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 P – Financial Assumptions

- c. Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

Yes, there has been reimbursement by third-party payers for these services. Yes, current reimbursement rates which are significantly less than operating costs contributed to this CON proposal. See response to 7.f. below for further rationale.

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

N/A

WCHN CON Application

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

N/A

- f. Describe how this proposal is cost effective.

The proposed transaction (described in detail in Question 1 above) achieves a collaboration of primary, dental, behavioral health and specialty care services strengthening the opportunities for the underserved in Greater Danbury and surrounding towns to seek and secure a medical home for their health care needs. This proposed transition of the S&F Primary Care Services and the Behavioral Health Clinic Services to the CIFC/GDCHC will create new efficiencies, reduce duplication of healthcare services, and realize cost savings. Patients will benefit from more access through expanded hours and more advanced technology available at the GDCHC. GDCHC is a FQHC and as such, receives a more sustainable level of reimbursement than the hospital-owned clinic is allowed to ensure access to this safety net in the future.

WCHN CON Application

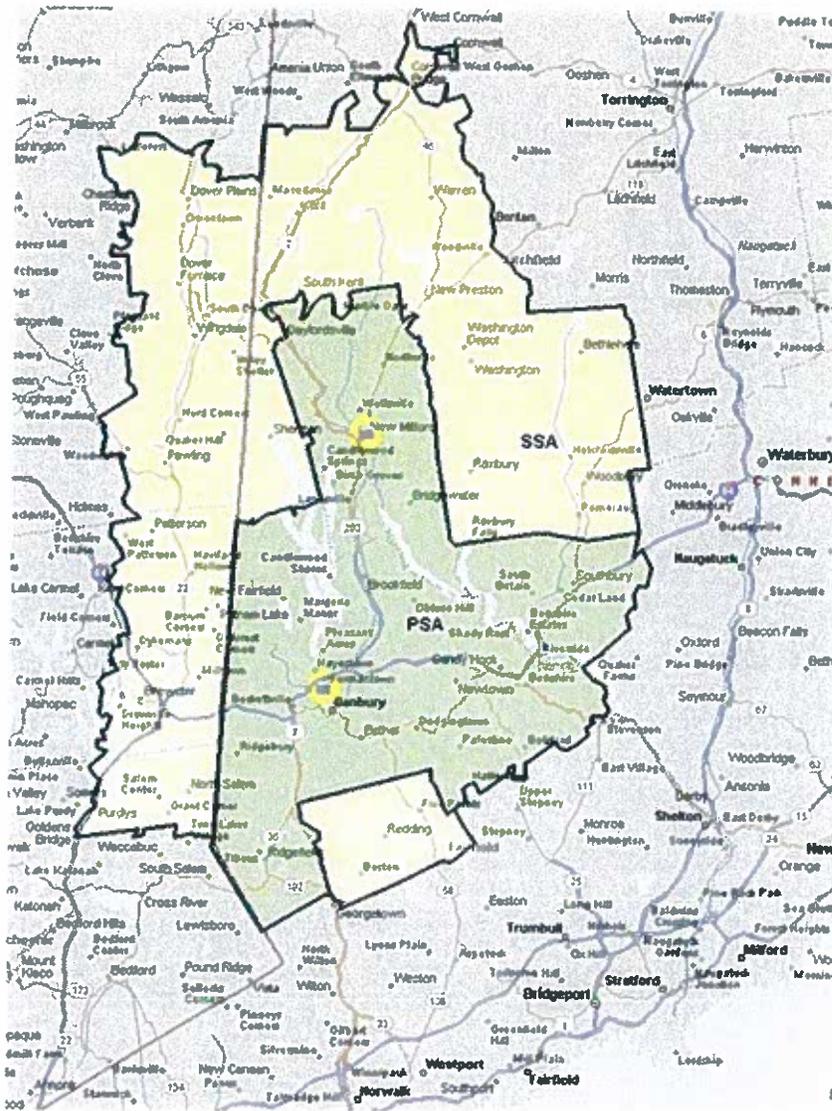
EXHIBITS

Number	Description
A	Map of Danbury/New Milford Hospital Service Area
B	Map of Facility Locations
C	Proposed Location Changes
D	Letters of Support
E	Minutes from WCHN Board
F	Excerpt of local providers identified in the 2014 OHCA Statewide Health Care Facilities and Services Inventory
G	Cherilyn G. Murer, JD, CRA, June 2011, "FQHCs: Saving the Medicaid Population in an Era of Health Reform" http://murer.com/pdfs/articles/FQHCs-June2011.pdf UPenn Blog, Janet Weiner, MPH, September 22, 2014, "Federally-Qualified Health Centers: Key Access Point to Primary Care for Expanded Medicaid Population" http://ldi.upenn.edu/voices/2014/09/22/federally-qualified-health-centers-key-access-point-to-primary-care-for-expanded-medicaid-population
H	HealthLeaders Media, Susan Patton, April 16, 2010, "How Hospitals and Federally Qualified Health Centers Should Collaborate"
I	Letter of Intent
J	Communications Outline
K	CIFC/GDCHC Financial Policy
L	CVs of Selected CIFC Personnel
M	Danbury Hospital Facility License
N	Facility Sites of Care
O	Financial Attachment I
P	Financial Assumptions

Exhibit A

Map of Danbury/New Milford Hospital Service Area

Danbury/New Milford Service Area



Total Primary (green) & Secondary (yellow) Service Areas Population:
2010 Population: 317,454
2015 Estimated Population: 321,804; 1.4% growth

Exhibit B

Locations:

Seifert & Ford Family Community Health Center – 70 Main Street, Danbury, CT

Community Center for Behavioral Health – 152 West Street, Danbury, CT

Greater Danbury Community Health Center – 57 North Street, Danbury, CT

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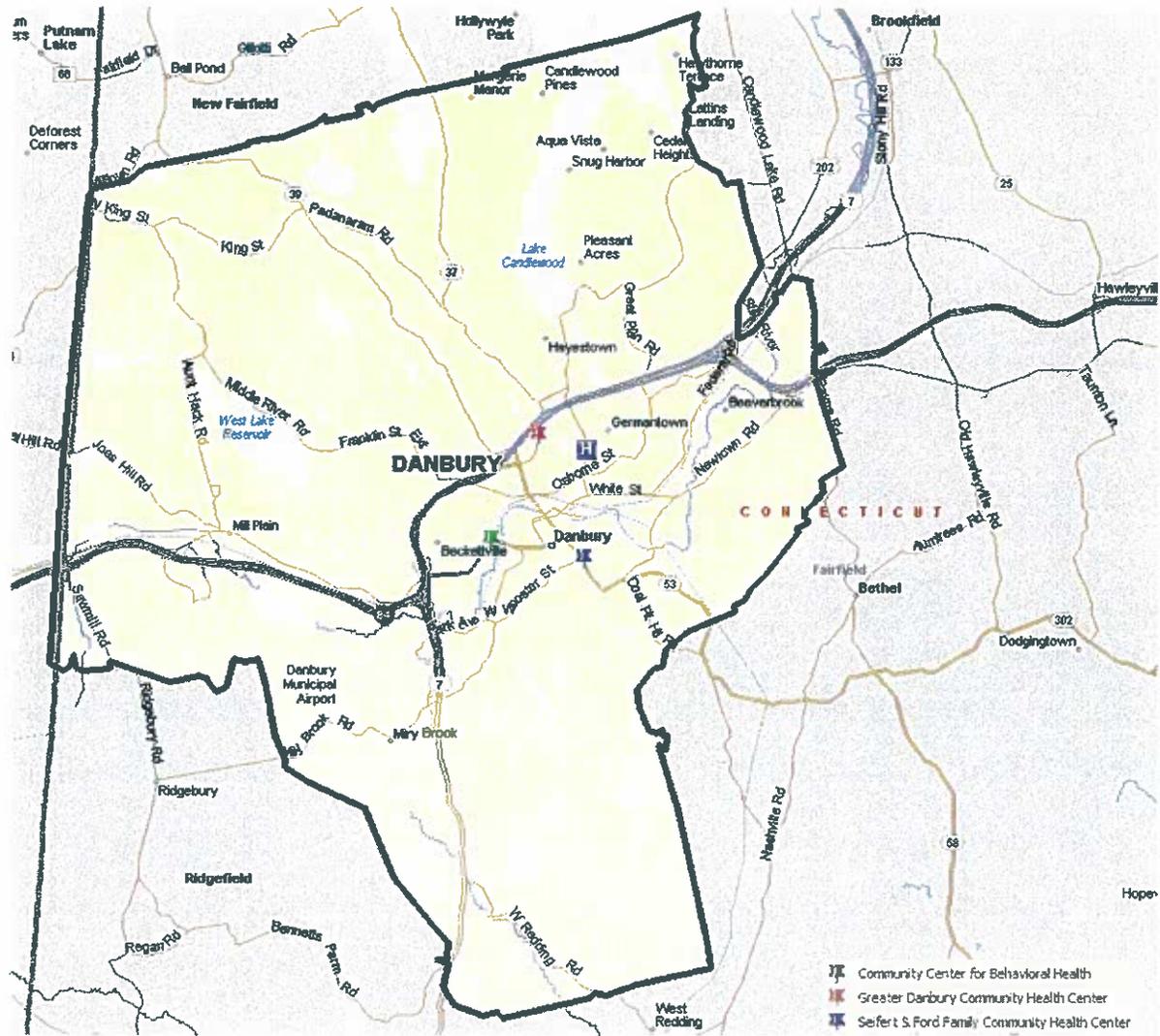


Exhibit C

Proposed Location Changes in Danbury

WCHN CON Application

Proposed Sites

Service	Current		Future		Estimated Date
	DH	CIFC	DH	CIFC	
Adult*, ***	70 Main St.	57 North St.		70 Main St.	7/1/2015
Pedi*	70 Main St.	57 North St.		57 North St.	7/1/2015
Women's/OB	70 Main St.			70 Main St.	7/1/2015
Dental**	70 Main St.			70 Main St.	7/1/2016
Behavioral Health**	152 West St.			152 West St.	7/1/2016

*A small portion of adult services will be available at 57 North and a small portion of Pedi services will be available at 70 Main Street

** Primary and specialty dental services and behavioral health services will move to CIFC in the second year of the transition period

*** TB/STD/HIV clinics will become part of CIFC, other specialty clinics will be provided by Danbury Hospital

Exhibit D

Letters of Support

WCHN CON Application



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

January 19, 2015

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

Dear Deputy Commissioner Davis,

This is written to support Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFIC) Greater Danbury Community Health Center (GDCHC).

CIFIC/GDCHC is a Federally Qualified Health Center (FQHC) serving Danbury and nine surrounding municipalities. The Health Center serves all age groups, from children to seniors; with their target population being people living below 200% of the Federal Poverty Level (FPL), uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, CIFIC/GDCHC provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach. In addition to the Health Center's principal site in downtown Danbury, CIFIC/GDCHC operates five Danbury area School Based Health Center (SBHC) sites, and sponsors the Region's WIC Program and SNAP enrollment services.

CIFIC/GDCHC is recognized as a Level 3 Patient Centered Medical Home (the highest rating) by the National Committee for Quality Assurance (NCQA). CIFIC/GDCHC also provides a robust Graduate Medical Education Program (post-MD) for residents to train and prepare for a career in Internal Medicine Primary Care. CIFIC/GDCHC is accredited by the national Accreditation Council for Graduate Medical Education (ACGME), and it is the first and only accredited Teaching Health Center in the State of Connecticut.

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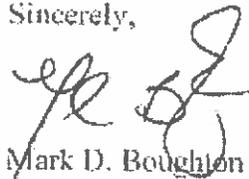
The proposed collaboration achieves a higher level of primary, dental, behavioral health and supportive care services, further strengthening the opportunities for underserved residents in the Greater Danbury area to secure a comprehensive medical home for their health needs. This proposed collaboration will: maximize this area's primary health care resources in a more coordinated, efficient manner; providing increased access including expanded hours of operation; and bringing benefits that are not available through a hospital based clinic like Seifert and Ford. There will be malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment, and other costs associated with providing patient services at an FQHC.

CIFC/GDCHC is a well-established and highly regarded Community Health Center whose mission complements that of Danbury Hospital and the Seifert and Ford clinic. By working together in this collaboration, Danbury Hospital and CIFC/GDCHC can reduce the cost of providing comprehensive primary health care throughout the region, while maintaining, expanding, and enhancing the highest level of patient care.

FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both the area's patients and our local communities.

Thank you for your consideration.

Sincerely,



Mark D. Boughton
Mayor



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

January 23, 2015

Dear Deputy Commissioner Davis:

I am pleased to support the application for transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH-aftercare only) programs to the Connecticut Institute For Communities, Inc.'s Greater Danbury Community Health Center (GDCHC). The GDCHC is a Federally Qualified Health center (FQHC) and as such, receives a more sustainable level of reimbursement than the hospital-owned clinic is allowed to ensure access to this safety net into the future.

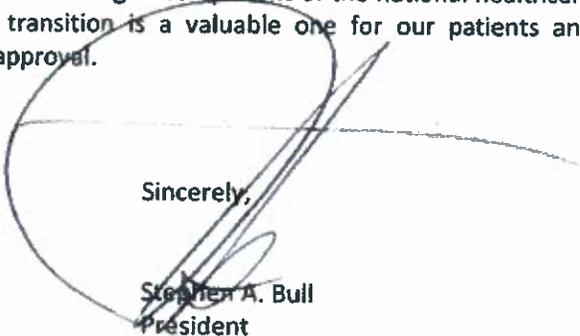
The proposed transfer achieves a collaboration of primary, dental, behavioral health and specialty care services strengthening the opportunities for the underserved in Greater Danbury and surrounding towns to seek and secure a medical home for their health needs. This proposed collaboration will create new efficiencies, reduce duplication of healthcare services, and realize cost savings. Patients will benefit from more access through expanded hours and more advanced technology available at the GDCHC.

The GDCHC is a well-established and highly reputable for providing high-quality primary care whose mission mirrors that of our Danbury Hospital and our clinic. We expect that together, we can best meet the needs of the low-income populations desperately needing our assistance. By coming together, in a partnership to provide services in a more coordinated way, we can significantly reduce the cost of providing this care, increase access to services, increase the number of primary and specialty care providers to ensure the patients are receiving the right care, in the right place at the right time.

FQHC's are at the forefront of healthcare reform and an integral component of the national healthcare strategy. It is our hope that you recognize this transition is a valuable one for our patients and community, and give it your full and unconditional approval.

Thank you for your consideration.

Sincerely,



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



AmeriCares Free Clinics, Inc.
88 Hamilton Avenue
Stamford, CT 06902

tel 203.658.9500
fax 203.658.9612

americaresfreeclinics.org

January 15, 2015

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

Dear Deputy Commissioner Davis,

The Boehringer Ingelheim AmeriCares Free Clinic of Danbury supports Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFC) Greater Danbury Community Health Center (GDCHC). CIFC/GDCHC is a Federally Qualified Health Center (FQHC) serving Danbury and nine surrounding municipalities. The Health Center serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level (FPL), uninsured area residents, low-income children and families, and other vulnerable groups. In addition to primary medical, behavioral and oral health care services, CIFC/GDCHC provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach. In addition to the Health Center's primary site in downtown Danbury, CIFC/GDCHC operates five Danbury area School Based Health Center (SBHC) sites; and sponsors the Region's WIC Program and SNAP enrollment services. CIFC/GDCHC is recognized as a Level 3 Patient Center Medical Home (the highest rating) by the National Committee for Quality Assurance (NCQA). In addition, CIFC/GDCHC provides a robust and unique Graduate Medical Education (post MD) Program for Residents to train and prepare for a career in Primary Care Internal Medicine. CIFC/GDCHC is accredited by the Accreditation Council for Graduate Medical Education (ACGME); it is the first and only Teaching Health Center in the State of Connecticut.

The proposed transfer achieves a higher level collaboration of primary, dental, behavioral health and specialty care services that further strengthens the opportunities for underserved residents in the Greater Danbury area to secure a comprehensive medical home for their health needs. This proposed collaboration will maximize primary health care resources in a more coordinated, efficient manner; provide increased access including expanded hours of operation; and bring benefits that are not available through a hospital based clinic like Seifert and Ford, specifically:

WCHN CON Application

malpractice cost savings due to coverage through the Federal Tort Claims Act; reduced costs for patients to purchase prescription drugs through the 340B drug program; and eligibility to receive federal, state, and private grants for recruitment and other costs associated with providing patient services as an FQHC.

CIFC/GDCHC is a well-established and highly reputable Health Center whose mission mirrors that of Danbury Hospital and the Seifert and Ford clinic. By working together in this collaboration, Danbury Hospital and CIFC/GDCHC can significantly reduce the cost of providing comprehensive primary health care throughout the region, while maintaining the highest level of patient care.

The mission of the Boehringer Ingelheim AmeriCares Free Clinic of Danbury (BI-AFC) is to provide free, quality health care to low-income, uninsured individuals. We partner with Danbury Hospital for lab and diagnostic testing, and we utilize a volunteer-based model composed of physicians and nurses who provide care at the clinic site, along with specialists in the community who are willing to see our patients at no charge in their offices. Our patients received specialty services free of charge at the Seifert and Ford clinic and will continue to do so after the transition. Since 1997 the BI-AFC has provided health care valued at over \$26 million.

FQHC's, along with free clinics are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. The AFC-BI urges you to unconditionally support this transition for the benefit of both our area's patients and our community.

Thank you for your consideration.

Sincerely,



Karen Gottlieb, RN, MBA
Executive Director

www.uvwesternct.org



January 30, 2015

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

Dear Deputy Commissioner Davis,

This is written to support Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFC) Greater Danbury Community Health Center (GDCHC).

CIFC/GDCHC is a Federally Qualified Health Center (FQHC) serving Danbury and nine surrounding municipalities. The Health Center serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level (FPL), uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, CIFC/GDCHC provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach. In addition to the Health Center's principal site in downtown Danbury, CIFC/GDCHC operates five (5) Danbury area School Based Health Center (SBHC) sites; and sponsors the Region's WIC Program and SNAP enrollment services.

CIFC/GDCHC is recognized as a Level 3 Patient Centered Medical Home (the highest rating) by the National Committee for Quality Assurance (NCQA). In addition, CIFC/GDCHC provides a robust Graduate Medical Education (post-MD) Program for Residents to train and prepare for a career in Internal Medicine Primary Care. CIFC/GDCHC is accredited by the national Accreditation Council for Graduate Medical Education (ACGME); it is the first and only accredited Teaching Health Center in the State of Connecticut.

The proposed collaboration achieves a higher level of primary, dental, behavioral health and supportive care services that further strengthens the opportunities for underserved residents in the

IMPROVING LIVES IN

Northern Fairfield County
85 West Street Danbury, CT 06810
Tel: 203.792.5330 Fax: 203.790.5182

Southern Litchfield County
21 Main Street, P.O. Box 29 New Milford, CT 06776
Tel: 860.354.8800 Fax: 860.350.1296

Stamford
1150 Summer Street Stamford, CT 06905
Tel: 203.348.7711 Fax: 203.967.9507

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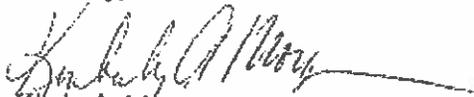
Greater Danbury area to secure a comprehensive medical home for their health needs. This proposed collaboration will: maximize this area's primary health care resources in a more coordinated, efficient manner; provide increased access including expanded hours of operation; and bring benefits that are not available through a hospital based clinic like Seifert and Ford, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

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FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

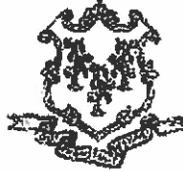
Thank you for your consideration.

Sincerely,



Kimberly Morgan

Chief Executive Officer



State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

1/30/15

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

Dear Deputy Commissioner Davis,

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WCHN CON Application

The proposed collaboration achieves a higher level of primary, dental, behavioral health and supportive care services that further strengthens the opportunities for underserved residents in the Greater Danbury area to secure a comprehensive medical home for their health needs. This proposed collaboration will: maximize this area's primary health care resources in a more coordinated, efficient manner; provide increased access including expanded hours of operation; and bring benefits that are not available through a hospital based clinic like Seifert and Ford, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

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FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Thank you for your consideration.

Sincerely,



Janice R. Giegler

State Representative, 138th District



Michael McLachlan

State Senator, 24th District

WCHN CON Application



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

REPRESENTATIVE BOB GODFREY
 ONE HUNDRED TENTH DISTRICT

15 STILLMAN AVENUE
 DANBURY CONNECTICUT 06810 8007

DEPUTY SPEAKER

TELEPHONE
 HOME (203) 778-5127
 CAPITOL (860) 240-8500
 TOLL FREE 1 800 842 1902
 EMAIL: BOB.GODFREY@CGA.CT.GOV

January 14, 2015

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

Dear Deputy Commissioner Davis,

This is written to support Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Foxd Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFC) Greater Danbury Community Health Center (GDCHC).

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WCHN CON Application

Accreditation Council for Graduate Medical Education (ACGME); it is the first and only accredited Teaching Health Center in the State of Connecticut.

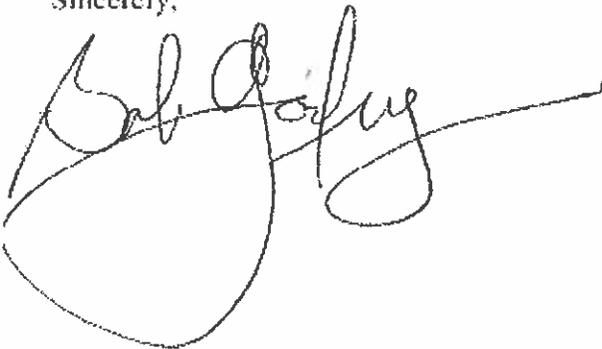
The proposed collaboration achieves a higher level of primary, dental, behavioral health and supportive care services that further strengthens the opportunities for underserved residents in the Greater Danbury area to secure a comprehensive medical home for their health needs. This proposed collaboration will: maximize this area's primary health care resources in a more coordinated, efficient manner; provide increased access including expanded hours of operation; and bring benefits that are not available through a hospital based clinic like Seifert and Ford, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

CIFC/GDCHC is a well-established and highly regarded Community Health Center whose mission complements that of Danbury Hospital and the Seifert and Ford clinic. By working together in this collaboration, Danbury Hospital and CIFC/GDCHC can reduce the cost of providing comprehensive primary health care throughout the region, while maintaining, expanding and enhancing the highest level of patient care.

FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Bob G. G. G.", with a long horizontal line extending to the right from the end of the signature.

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

REPRESENTATIVE DAVID ARCONTI

ASSISTANT MAJORITY LEADER
 109TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
 ROOM 4026
 HARTFORD, CT 06106-1591
 CAPITOL: 860-240-8585
 E-MAIL: David.Arconti@cga.ct.gov

MEMBER

ENVIRONMENT COMMITTEE (VICE-CHAIR)
 GENERAL LAW COMMITTEE
 HOUSING COMMITTEE
 PUBLIC SAFETY & SECURITY COMMITTEE

1/12/15

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

Dear Deputy Commissioner Davis,

This is written to support Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFIC) Greater Danbury Community Health Center (GDCHC).

CIFIC/GDCHC is a Federally Qualified Health Center (FQHC) serving Danbury and nine surrounding municipalities. The Health Center serves all age groups, from children to seniors, with their target population being people living below 200% of the Federal Poverty Level (FPL), uninsured area residents, low-income children and families, and other vulnerable groups. All patients receive services regardless of their insurance status or ability to pay. In addition to primary medical, behavioral and oral health care services, CIFIC/GDCHC provides prevention and education services, screenings, immunizations, case management, referrals, follow-up and community outreach. In addition to the Health Center's principal site in downtown Danbury, CIFIC/GDCHC operates five (5) Danbury area School Based Health Center (SBHC) sites; and sponsors the Region's WIC Program and SNAP enrollment services.

CIFIC/GDCHC is recognized as a Level 3 Patient Centered Medical Home (the highest rating) by the National Committee for Quality Assurance (NCQA). In addition, CIFIC/GDCHC provides a robust Graduate Medical Education (post-MD) Program for Residents to train and prepare for a career in Internal Medicine Primary Care. CIFIC/GDCHC is accredited by the national Accreditation Council for Graduate Medical Education (ACGME); it is the first and only accredited Teaching Health Center in the State of Connecticut.

The proposed collaboration achieves a higher level of primary, dental, behavioral health and supportive care services that further strengthens the opportunities for underserved residents in the Greater Danbury

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area to secure a comprehensive medical home for their health needs. This proposed collaboration will: maximize this area's primary health care resources in a more coordinated, efficient manner; provide increased access including expanded hours of operation; and bring benefits that are not available through a hospital based clinic like Seifert and Ford, including malpractice cost savings due to coverage through the Federal Tort Claims Act, reduced costs for patients to purchase prescription drugs through the FQHC Section 340B drug program, and eligibility for those primary care services to receive federal, state, and private grants for recruitment and other costs associated with providing patient services at an FQHC.

CIFC/GDCHC is a well-established and highly regarded Community Health Center whose mission complements that of Danbury Hospital and the Seifert and Ford clinic. By working together in this collaboration, Danbury Hospital and CIFC/GDCHC can reduce the cost of providing comprehensive primary health care throughout the region, while maintaining, expanding and enhancing the highest level of patient care.

FQHC's are at the forefront of healthcare reform and are an integral component of Connecticut's and the nation's healthcare strategy. I urge you to unconditionally support this transition for the benefit of both this area's patients and our local communities.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "David Arconti", with a long, sweeping flourish extending to the right.

Rep. David Arconti

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Exhibit E

Minutes from WCHN Board

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*Part of the May 22, 2014 WCHN BOD Meeting
Approved at the July 24th meeting of the WCHN BOD*

TOPIC: Federally Qualified Health Centers (FQHC)

DISCUSSION: A lengthy discussion ensued on the recommendation and resolutions regarding a potential transaction between Danbury Hospital and Connecticut Institute for Communities (CIFC), a Federally Qualified Health Center (FQHC), by fully transitioning certain DH clinics to CIFC and establishing a residency training program relationship. Michael Daglio, Chief Operating Officer, reported that our two organizations have a common mission and that this partnership would enable the expansion of health care services among the underserved and uninsured populations in our community.

It was noted that the relationship would facilitate the bridging of acute and primary care delivery systems within our community. This in turn would ensure better access to health care and safety net services and would increase the amount, type and quality of services available while also reducing duplication of certain outpatient services. In addition, this relationship would support the mission of our Medical Education Department and facilitate the expansion of primary care residents in our community, as well as the region, while providing significant savings with potential future opportunities for Behavioral Health expansion.

ACTION: VOTED to unanimously approve the FQHC Resolution, and requested that management develop a plan to address issues pertaining to the specialty clinics for presentation at a future board meeting.

Exhibit F

Excerpt of local providers identified in the
2014 OHCA Statewide Health Care Facilities and Services Inventory

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Facility Name	Provider Name	Facility Address	City	Zip code	Location Offers Primary Care Services	Location Offers Dental Services	Location Offers Well Child Services	Location Offers Mental Health Services
Americares Free Clinic of Danbury	Americares Free Clinic, Inc.	76 West Street	Danbury	06810	X			
Community Health Center of Danbury	Community Health Center, Inc.	8 DeLay Street	Danbury	06810	X			
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	60 Beaver Brook Road	Danbury	06810	X			
Greater Danbury Community Health Center	Connecticut Institute for Communities, Inc.	57 North Street	Danbury	06810	X			
Greater Danbury Community Health Center Mobile Health Unit	Connecticut Institute for Communities, Inc.	57 North Street	Danbury	06810	X			
Greater Danbury Community Health Center School Based Health Center at Broadview Middle School	Connecticut Institute for Communities, Inc.	72 Hospital Avenue	Danbury	06810	X	X		X
Greater Danbury Community Health Center School Based Health Center at Danbury High School	Connecticut Institute for Communities, Inc.	43 Clapboard Ridge Road	Danbury	06811	X	X		X
Greater Danbury Community Health Center School Based Health Center at Rogers Park Middle School	Connecticut Institute for Communities, Inc.	21 Memorial Drive	Danbury	06810	X	X		X
Greater Danbury Community Health Center School Based Health Clinic at Henry Abbott Technical High School	Connecticut Institute for Communities, Inc.	21 Hayestown Avenue	Danbury	06811	X			
Greater Danbury Community Health Center School Based Health Center at Danbury High School	Connecticut Institute for Communities, Inc.	43 Clapboard Ridge Road	Danbury	06811	X	X		X
Greater Danbury Community Health Center School Based Health Center at Rogers Park Middle School	Connecticut Institute for Communities, Inc.	21 Memorial Drive	Danbury	06810	X	X		X
Greater Danbury Community Health Center School Based Health Clinic at Henry Abbott Technical High School	Connecticut Institute for Communities, Inc.	21 Hayestown Avenue	Danbury	06811	X			
Samaritan Health Center	Samaritan Health Services, Inc.	13 Rose Street	Danbury	06810	X		X	

Table 23: Facilities Licensed as Outpatient Clinics and Table 24: Primary Care Clinics Operated by General Hospitals

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Facility Name	Provider Name	Facility Address	City	Zip code	Licensed Beds	CCF Group Home	OP Psychiatric Clinic for Children	Extended Day Treatment	CCF Safe Home
Danbury Youth Services, Inc. / OPCC	Danbury Youth & Family Counseling / OPCC	91 West Street	Danbury	06810			X		
Family and Children's Aid, Inc. / CGC / OPCC	FCA / CGC / OPCC	80 West Street	Danbury	06810			X		
Family and Children's Aid, Inc. / Danbury / SH	FCA / Danbury Star Shine Safe Home	79 West Street	Danbury	06810	8				X
Family and Children's Aid, Inc. / EDT	FCA / EDT	71 West Street	Danbury	06810	31			X	
Family and Children's Aid, Inc. / Ten Harmony / GH	FCA / Ten (10) Harmony TGH	10 Harmony Street	Danbury	06810	6	X			
Family and Children's Aid, Inc. / Three Harmony / GH	FCA / Three (3) Harmony TGH	3 Harmony Street	Danbury	06810	6	X			

Table 21: Health Care Facilities Licensed by the Department of Children and Families

Source: DCF licensure dataset provided to OHCA in February 2014. Above table does not include pending licenses at that time, only those with licensure status of Regular or Provisional.

CCF = Child Caring Facilities

Facility Name	Satellite Location Name ^a	Satellite Location Address	City	Zip Code
Danbury Hospital, The	Seifert and Ford Community Health Center	70 Main Street	Danbury	06810
Danbury Hospital, The	Pediatric Health Center, The	70 Main Street	Danbury	06810
Danbury Hospital, The	Center for Child and Adolescent Treatment Services	152 West Street	Danbury	06810
Danbury Hospital, The	Community Center for Behavioral Health (ADH-PHP)	152 West Street	Danbury	06810
Danbury Hospital, The	New Milford Hospital Behavioral Health Services	23 Poplar Street	New Milford	06776
Danbury Hospital, The	New Milford Hospital Campus	21 Elm Street	New Milford	06776
Danbury Hospital, The	Ridgefield Surgical Center	901 Ethan Allen Highway	Ridgefield	06877

Table 26: Satellite Locations for General, Children's and Specialty Hospitals

Exhibit F

Supporting Literature

FQHCs: Serving the Medicaid Population in an Era of Health Reform

By

CHERILYN G. MURER, JD, CRA

Amidst all the controversy surrounding the recently enacted Patient Protection and Affordable Care Act (PPACA) key provisions that will affect the Medicaid population went almost unnoticed. These provisions dealt with Federally Qualified Health Centers (FQHCs), a type of provider that is critical to helping the medically underserved and vulnerable. They present immense challenges for FQHCs in serving the Medicaid population. However, FQHCs are, by their very nature, well placed to successfully cope with these changes and thrive in an era of reform.

FQHCs Explained

FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act. They are nonprofit health centers which strive to provide high quality primary care in medically underserved regions regardless of patients' ability to pay. Patients at FQHCs include the uninsured, the underinsured, migrant farm workers, the homeless, and other low income groups.

Key features that distinguish FQHCs include a broad focus on primary care including dental, mental health, substance abuse, transportation necessary for adequate patient care, and hospital and specialty care. Additionally, FQHCs must meet certain performance and accountability requirements concerning administrative, clinical, and financial operations.

How the PPACA Affects FQHCs

There are provisions in the Act intended to help FQHCs by allowing them to treat a larger patient population, including those on Medicaid. In some cases, this should indeed prove beneficial. In other cases, the outcome is less certain.

Increased Funding

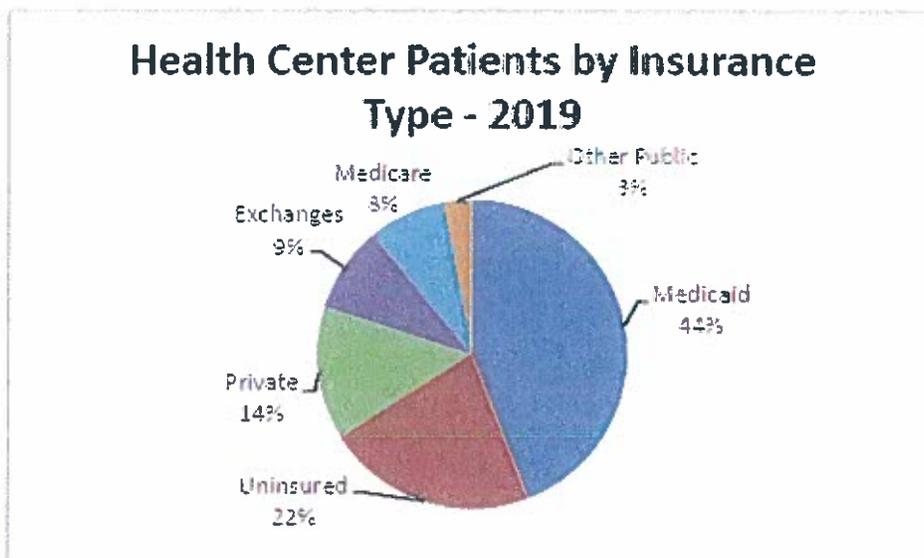
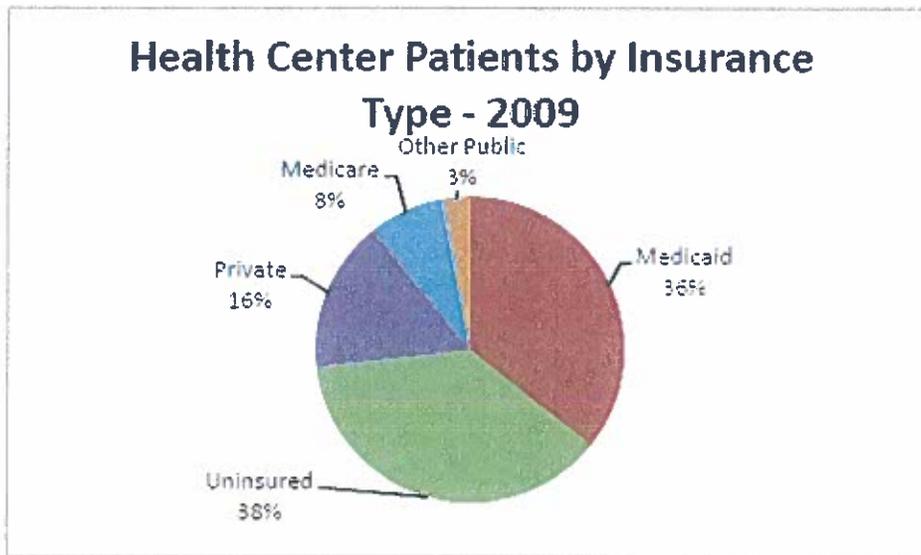
The PPACA allocates \$11 billion over the next five years in order to increase the number of patients that FQHCs can serve. This money will go to adding new centers as well as expanding and improving existing ones. The Act also appropriates \$1.5 billion to increase the number of primary care providers (including nurses, dentists, and allied health professionals) in communities where there is a shortage.

Insurance Expansion

Because insurance coverage will be expanded, a smaller proportion of FQHC patients will be uninsured, and the payor mix for FQHCs will change significantly. FQHCs will still serve primarily low income patients, but more of those patients will have some form of insurance. This means that a much lower proportion of services provided by FQHCs will go unreimbursed.

Under the PPACA, Medicaid will be extended to all children and adults with incomes below 133% of the Federal Poverty Line. This means many more FQHC patients will soon be eligible for the program. In fact, Medicaid will become by far the largest payor source for FQHCs. The PPACA also mandates the creation of insurance exchanges offering subsidized plans with essential health benefits (EHBs). Many services considered EHBs are already offered by FQHCs. This should result in increased insurance coverage and use of FQHC services among those who are not poor enough to qualify for Medicaid, but are still not able to afford private insurance on their own.

By 2019, the percentage of uninsured patients in FQHCs is expected to drop from 38% to 22%, primarily because many of these patients will obtain coverage through exchanges or Medicaid. The percentage of other payor sources will remain largely unchanged. This means a greater proportion of FQHC services will be reimbursed as illustrated in the table below.



Source: Ku, L., Richard, P., Dor, A., Tan, E., Shin, P. and S. Rosenbaum. June 30, 2010. "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform." Geiger Gibson/RCHN Community Health Foundation Research Collaborative Policy Research Brief No. 19.

Converging Payment Systems

FQHCs are reimbursed using a slightly different system from other providers. Until 2001, FQHC reimbursements from Medicare and Medicaid were both based on reasonable costs. At that time, Medicaid services became subject to a prospective payment system (PPS) described below, while Medicare reimbursement remained unaffected. This will change once again with the passage of the PPACA. There will be no direct effect as regards Medicaid since reimbursement under that program remains unaltered. However, Medicare reimbursement will change, and this could affect the overall financial health of many FQHCs.

Federal law requires Medicaid programs to make payments for FQHC services using a PPS. Reimbursement is on a per-visit basis equal to the reasonable cost of such services documented for a baseline period, with certain adjustments. This rate is specific to each provider. Individual states can use an alternative payment methodology as long as (1) FQHCs receive at least what they would under the PPS and (2) the FQHC in question agrees to the methodology.

Medicare reimbursement for FQHCs currently uses a different method. Under Medicare, FQHCs receive an all-inclusive payment based on reasonable costs, irrespective of the type, intensity, or duration of service. However, in 2014 the PPACA will change Medicare reimbursement for FQHCs to a PPS.

The specifics of the Medicare PPS have not yet been defined by the Department of Health and Human Services, and it is not known whether it will allow an alternative payment methodology as it does for Medicaid. What is known is that the new PPS will eliminate the all inclusive payment rate for FQHCs. Instead, the type of service will affect the level of reimbursement. Coding, therefore, becomes critical and FQHCs are now required to properly report all pertinent services provided when billing Medicare and list the appropriate code for each line item, along with revenue codes for each visit.

The Challenges Ahead

FQHCs will be treating an increased number of patients in the coming years, more of whom will depend on Medicaid. This presents its own challenge especially in light of the precarious nature of Federal funding. However, there are other issues that will affect the ability of FQHCs to serve Medicaid patients, even if only indirectly. All of these challenges revolve around one basic principle, however, maintaining access to Federal money.

Changing Reimbursement Methodology

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One challenge facing FQHCs' ability to serve their Medicaid population, albeit indirectly, is the fundamental change in its Medicare payment system. FQHCs have not previously been required to spend the time and money for coding Medicare claims, because there a PPS was not used.

As patient numbers are expected to increase, it is more important than ever that FQHCs maximize all forms of reimbursement. There are several reasons, however, that the changing Medicare payment system should not have a deleterious effect on FQHCs. First, Medicare is and will remain a relatively small proportion of FQHCs' payor mix, only 8%. Second, except for those using the alternative methodology, FQHCs already utilize a PPS for Medicaid claims. Third, the PPACA allows for time to adjust to the new Medicare PPS because it requires FQHCs to submit proper codes when billing Medicare now, even though the PPS will not come into effect until 2014. Therefore, the changes in the payment system are an important but by no means perilous challenge confronting FQHCs.

Complying with Quality Measures

Because of increased demand for their services, it will be more critical than ever that FQHCs meet the quality measures necessary to obtain Federal funding. These measures include:

- prompt availability and accessibility of services;
- maintaining collaborative relationships with other health care providers;
- having an ongoing quality improvement system;
- demonstration of financial responsibility by use of prescribed accounting procedures;
- maintenance of an arrangement for payment of the center's costs under Medicaid and SCHIP;
- proper efforts to collect reimbursement for its services;
- a schedule of fees adjusted for local rates and patients' ability to pay;
- a governing board, the majority of which represents the interests of patients served at the FQHC;
- responsiveness to the needs of those with a limited ability to speak English;
- maintenance of an ongoing referral relationship with other providers; and
- encouragement of patients to participate in public or private health programs for which they are eligible.

Meeting these quality measurements are already vitally important to FQHCs because they ensure access to Federal grant money, without which many could not operate. With the expected influx of patients, access to these funds will be more important than ever.

The Ticking Time Bomb of Funding

The principal challenge will be the uncertainty of the Federal funding necessary to provide the required level of services at FQHCs. There is no guarantee that Federal funding will remain at its current level, given strong push for budget cuts. In fact, in February of 2011, the House of Representatives passed a continuing resolution that would have cut funding to FQHCs by \$1.3 billion as part of Congress' ongoing budget battle. This proposal was ultimately voted down by

the Democratic-controlled Senate, but such cuts, or even larger ones, would be possible if and when Republicans gain control of Congress.

In order to continue to serve the Medicaid population, FQHCs must not only avoid a decrease in Federal funding but must also have a substantial increase year upon year. This happens under current law. Grant funding will increase by set amounts through 2015. Thereafter, it will be adjusted every year based on the number of patients treated and the costs incurred per patient. It is estimated that funding increases will allow FQHCs to serve 50 million people by 2019, more than double the current usage. This assumes, however, that future spending will match current budgets. This appears increasingly unlikely in today's political climate.

The increases necessary to sustain the level of services provided by FQHCs stem largely from the sheer size of the patient population that they will need to serve in the coming years. This increase is due to several factors. First, the country will have some level of overall population growth. Second, more people will be eligible for Medicaid or have insurance purchased through exchanges. Third, other providers are increasingly turning away Medicaid patients due to the program's low levels of reimbursement. These patients will be forced to rely on FQHCs which are obligated to not turn anyone away.

In essence, the Federal government has taken steps to permanently increase the demand for services at FQHCs by increasing access to Medicaid and insurance through exchanges. At the same time, due to budgetary and political pressures Congress can by no means guarantee the funding necessary to supply those services either in the short, medium, or long term. Therefore, it should be no surprise if, one day in the not too distant future, the demand for FQHC services greatly exceeds supply.

FQHCs Well Placed to Thrive in an Era of Reform

If FQHCs are able to meet the challenges outlined above, they can become the primary vehicle for serving the nation's Medicaid population in a manner consistent with the goals of health care reform. One of those goals of health care reform is to increase quality while lowering costs, especially for low income populations. Emphasis will be placed on integration and information sharing, often through enhanced use of information technology (IT). It is believed that these initiatives will provide better primary care and lower overall costs and will be tested through pilot programs funded by the federal government.

There are many reasons FQHCs are ideally suited to participate in these pilot programs. Indeed they are well positioned to achieve the overarching goals of health care reform.

First, they provide mostly primary and preventive care, the services on which health care reform places such great emphasis. This is because better primary and preventive care can help to avoid more serious (and more costly) conditions. In fact, FQHCs share many attributes with medical homes, a concept some regard as critical to achieving better outcomes at lower cost.

Second, FQHCs have experience in integration and information sharing by virtue of the formation of health center networks. For years, they have used IT in order to improve clinical outcomes, including utilization of electronic health records. They have also used networks to

coordinate the activities of member FQHCs for purposes of serving a patient population. This is a fundamental attribute of accountable care organizations (ACOs), which have received a great deal of emphasis in the health care reform bill.

The Medicaid population already depends heavily on services provided at FQHCs. This will only increase in the coming years. Fortunately, FQHCs have the structure in place to meet this challenge. Indeed they could prove to be the linchpin in the effort to serve the needs of America's Medicaid population in the coming years.

Summary

The American health care system can benefit greatly from increased utilization of FQHCs. As the system undergoes significant changes in an effort to improve outcomes while lowering costs, FQHCs will be increasingly relied upon by Medicaid and other low income patients. Given the structure and mission of these facilities, it is possible that precisely the right tool is available at precisely the right time for meeting the goals of health care reform. FQHCs are well placed to respond to the long term needs of the health care system by providing quality primary care to low income populations. However, the recent health care reform should also cause FQHCs to remain vigilant because with new ways of operating come new problems. Nevertheless, it is certain that FQHCs will remain a vital part of serving the nation's low income and Medicaid population now and in the future.

About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based healthcare management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on her web site: <http://www.murer.com>

Federally-Qualified Health Centers: Key Access Point to Primary Care for Expanded Medicaid Population

Monday, 22 September 2014

Janet Weiner, MPH @weinerja

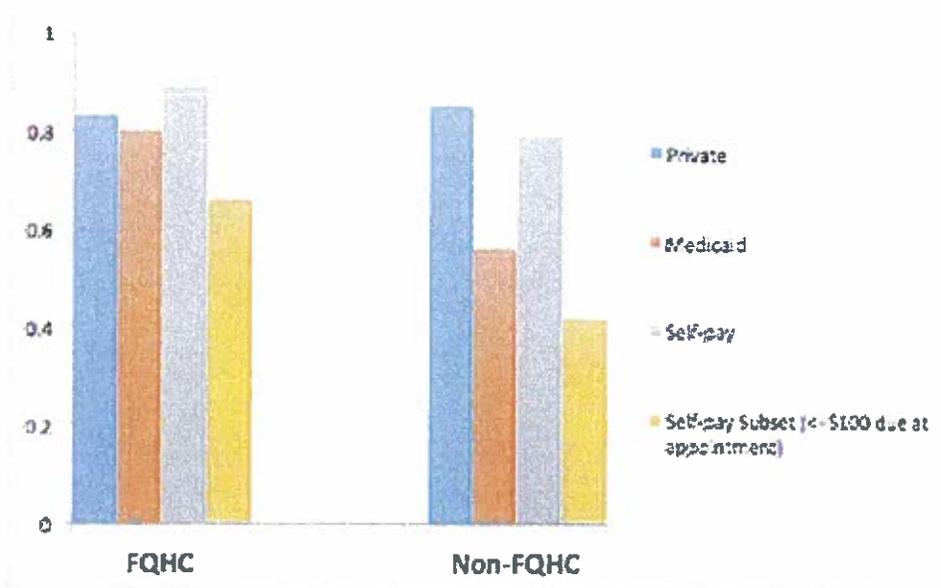
Associate Director for Health Policy, LDI

Pennsylvania recently became the 27th state to [expand](#) its Medicaid program, a move that will make nearly 300,000 uninsured adults newly eligible for coverage in 2015. As in other states, questions arise about the health system's ability to meet higher demands for primary care. A new [analysis](#) by LDI and Urban Institute Senior Fellows suggests that for these newly covered people, particularly those gaining Medicaid coverage, the best bet for getting a primary care appointment is to call a Federally-Qualified Health Center (FQHC).

'Secret shopper' study

Using data from a "secret shopper" study conducted in 2012-2013, Michael Richards and colleagues found that FQHCs granted appointments to Medicaid beneficiaries at much higher rates (80%) than non-FQHC providers (56%). In the [parent study](#), trained research assistants called a representative sample of providers in 10 states (including Pennsylvania), posing as patients requesting a new patient visit. The callers were randomized to say they had different insurance types (private, Medicaid, or self-pay). The design allowed the researchers to simulate the actual appointment availability for new patients seeking care, and to isolate the effect of insurance status from other factors that might influence appointment rates.

As shown below, FQHCs have very high appointment rates across all insurance types. Appointment rates for non-FQHC providers were lower for Medicaid, with larger disparities by insurance status, particularly between Medicaid and privately insured patients.



Appointment Rates by Caller Insurance Type, Primary Care Simulated Patient Study, 10 states, October 2012-March 2013

FQHCs differ from other providers in location and practice structure. FQHCs tend to be larger practices that include more non-physician professionals such as nurse practitioners. They are more often located in poorer areas with larger minority populations. But even after adjusting for demographic, geographic, and other contextual factors, the researchers found that Medicaid patients were 22 percentage points more likely

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to get an appointment at an FQHC than at other providers. Similarly, FQHCs added 8 percentage points to the probability of a self-pay caller getting an appointment. Reflecting the sliding scale nature of FQHC fees, self-pay patients were 30 percentage points more likely to be offered an appointment at \$100 or less at an FHCQ than at a non-FHCQ provider. Importantly, the greater acceptance rates of FQHCs did not mean that Medicaid and self-pay patients waited significantly longer for an appointment.

High-poverty vs. low-poverty areas

The researchers also explored whether these patterns changed when comparing high-poverty and low-poverty areas. FQHCs were more likely to offer an appointment than non-FQHCs in both high-poverty and low-poverty areas, and to the same degree. However, non-FQHC providers in low-poverty areas were less likely to offer a self-pay caller an appointment at \$100 or less than non-FQHCs in high-poverty areas. Thus, in low-poverty areas, FQHCs are still more likely to offer a cheaper visit, but the difference is less when compared with non-FQHCs in high-poverty areas.

FQHCs are community health clinics that receive federal grants to provide primary care access to underserved populations. Consistent with that mission, these data suggest that Medicaid patients seeking a new provider are likely to be more successful if they look to FQHCs, and that as of early 2013 FQHCs were able to accommodate the current Medicaid population. It also suggests that FQHCs are already seeing many uninsured patients that will gain access to Medicaid in 2015.

Recognizing the central role of community health centers, the Affordable Care Act includes \$11 billion in funding over five years to bolster the capacity of these centers to meet increased, and perhaps pent-up, demand for primary care services.

Pennsylvania's FQHCs

This is all good news for the newly eligible Medicaid population in Pennsylvania. According to the [Pennsylvania Association of Community Health Centers](#) (PACHC), there are more than 200 FQHCs in 45 of 67 counties providing care to about 700,000 Pennsylvanians. These health centers serve primarily low-income patients: 93% have incomes below 200% of poverty, and 68% have Medicaid or are uninsured.

The FQHCs will be key to the success of Pennsylvania's Medicaid expansion. All private plans covering this expansion population must include FQHCs as in-network providers. And last week, the PACHC received a federal [Navigator](#) grant of more than \$800,000 to provide in-person assistance to people enrolling on the Health Insurance Marketplace. Although the expansion population will not enroll in marketplace plans, these funds will enhance the centers' ability to implement a "one-stop shopping" approach to helping uninsured patients find their way to coverage and care.

Exhibit I

Letter of Intent

LETTER OF INTENT

This Letter of Intent sets forth a non-binding agreement in principle between the Connecticut Institute For Communities, Inc. d/b/a The Greater Danbury Community Health Center (the “**Health Center**”) and The Danbury Hospital (the “**Hospital**”). The Health Center and Hospital shall be referred to collectively herein as the “**Parties**” or individually as a “**Party**.”

1. **Proposed Arrangement.** The purpose of this Letter of Intent is to reflect the intention of the Parties diligently and in good faith to pursue and complete all legal, judicial, contractual, regulatory, financial and related actions and undertakings which may be necessary or appropriate to complete an arrangement (the “**Proposed Arrangement**”) between the Parties pursuant to which:

(a) Hospital will cease providing adult primary care, primary care obstetrics and gynecology, primary care pediatric services, and primary care dental services at the Seifert and Ford Family Community Health Center (the “**Clinic**”) and primary care behavioral health services at Hospital’s behavioral health facility at 152 West Street, Danbury, Connecticut (collectively, the “**Primary Care Services**”), over the course of two (2) years (the “**Transition Period**”) following satisfaction of the conditions precedent set forth in that certain Grant Agreement to be negotiated and entered into by the Parties, as described in Sections 1(b) and 1(c) below. The Parties shall agree upon deliverables, and a timeframe for accomplishing such deliverables, in order to facilitate the transition of the Primary Care Services to the Health Center.

(b) In the first year of the Transition Period (“**Year One**”), Hospital shall cease providing, and the Health Center will assume sole responsibility for the provision of, adult primary care services, primary care pediatric services, and primary care obstetrics and gynecology. Such adult primary care services and primary care obstetrics and gynecology services will generally be provided by the Health Center at the Clinic. The Health Center will generally provide the primary care pediatric services at the Health Center’s site at 57 North Street in Danbury, Connecticut. The remaining Primary Care Services will continue to be provided by Hospital during Year One.

(c) Beginning in the second year of the Transition Period (“**Year Two**”), or earlier, Hospital shall cease providing, and the Health Center will assume sole responsibility for the provision of, all Primary Care Services, which will be provided by the Health Center at Health Center locations, 152 West Street, Danbury, Connecticut and/or the Clinic, as agreed upon by the Parties.

(d) The Health Center will engage community physicians and physicians previously employed by the Hospital for such Primary Care Services in a number determined by the Health Center to be sufficient to meet the need for the Primary Care Services in the greater Danbury community.

(e) On an annual basis, Hospital will provide a grant to the Health Center to subsidize the Health Center's provision of the Primary Care Services for the following year. Such grant shall be in an amount agreed upon by the parties to cover a shortfall by the Health Center related to the provision of the Primary Care Services, and the activities contemplated in sub-paragraph (f) immediately below, conditioned upon the Health Center satisfying certain affirmative covenants agreed upon by the Parties.

(f) As Primary Care Services are transitioned to the Health Center, the Health Center will provide certain training to residents in Hospital's resident training programs in internal medicine, obstetrics and gynecology, and dentistry, as shall be agreed upon by the Parties, provided that the Health Center and Hospital comply with certain obligations regarding the operation of their respective facilities and graduate medical programs.

2. Definitive Agreements. The objective of the discussions between the Parties pursuant to this Letter of Intent will be the preparation, execution and consummation of a mutually acceptable definitive (i) Grant Agreement between the Parties, (ii) Residency Training Agreement between the Parties, (iii) Service Agreement between the Health Center and the Hospital, (iv) Sublease between Hospital and the Health Center regarding the use of all or part of the Clinic, and (v) Sublease between Hospital and the Health Center regarding the use of a portion of Hospital's location at 152 West Street in Danbury, Connecticut for the provision of agreed upon primary care behavioral health services (together, the "**Definitive Documents**"). To complete the Proposed Arrangement, the parties contemplate the execution of the Definitive Documents as described herein by no later than December 31, 2014. Although it is expected that discussions regarding the Proposed Arrangement will be fruitful, unless and until the Definitive Documents are executed and delivered, there will be no legal and binding obligation of any Party except as set forth in paragraphs 3 and 4 of this Letter of Intent (collectively, the "**Binding Provisions**") and no Party shall be obligated to enter into the Proposed Arrangement or any other agreement or arrangement. The Parties agree that any obligation of Hospital to provide a grant to the Health Center will be subject to the fulfillment of all conditions precedent to such grant, as agreed upon by the Parties and documented in the Grant Agreement, including but not limited to obtaining any necessary governmental approvals relating to (i) the termination of certain Primary Care Services by Hospital and (ii) the provision of such Primary Care Services by the Health Center.

3. Expenses. Each of the Parties will bear its own expenses relating to the Proposed Arrangement.

4. Confidentiality; Disclosure. Each of the Parties agrees not to disclose and to keep confidential this Letter of Intent and its contents and any information stamped "confidential" or identified in writing as such by the disclosing Party to the receiving Party 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 Arrangement (collectively "**Representatives**"), (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 Arrangement; provided that information shall not be deemed "confidential" if the receiving Party can demonstrate that it (i) is generally available to or known

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by the public other than as a result of improper disclosure by the receiving Party, (ii) is or was obtained by the receiving Party from a source other than the disclosing Party and such source was not bound by a duty of confidentiality to the disclosing Party or another party with respect to such information, or (iii) is released by mutual consent.

5. **Termination.** Either party may, with ten (10) days written notice to the other, terminate discussions regarding the Proposed Arrangement and this Letter of Intent.

6. **Non-binding Effect; No Contract.** It is expressly understood that this Letter of Intent, except for the Binding Provisions, 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 of Intent in the event that there is a failure, for any reason, of the parties to agree to the Definitive Documents. The Binding Provisions will automatically terminate upon the signing of the Definitive Documents and may be terminated earlier upon written notice by either Party to the other parties unilaterally, for any reason or no reason, with or without cause, at any time, provided, however, that the termination of the Binding Provisions will not affect the liability of a party for breach of any of the binding provisions prior to the termination.

7. **Miscellaneous.** The parties recognize and agree that to the extent any provisions of this Letter of Intent 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 of Intent 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 of Intent were the result of negotiation between the parties and, as a result, there will be no presumption that any ambiguities in this Letter of Intent will be resolved against any particular party. Any controversy over construction of this Letter of Intent will be decided without regard to events of authorship or negotiation.

8. **Notices.** Any notice required or permitted to be given under this Letter of Intent shall be sufficient if in writing, when delivered by hand, three (3) day after deposit with a nationally recognized overnight carrier for next day delivery or five (5) days after sent by Certified Mail, return receipt requested, to the parties at the addresses set forth below (unless another address as the addressee shall have specified by written notice):

If to Health Center: Connecticut Institute For Communities, Inc. d/b/a
The Greater Danbury Community Health Center
7 Old Sherman Tpke, Suite 200
Danbury, Connecticut 06810
Attn: Katie Curran, JD, COO & Deputy General Counsel

If to Hospital: The Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810
Attn: Carolyn L. McKenna, Sr. V.P. & General Counsel

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9. Counterparts. This Letter of Intent may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

10. Facsimile Signatures. Any party may execute this Letter of Intent by facsimile signature and the other parties shall be entitled to rely on such facsimile signature as evidence that this Letter has been duly executed by such Party.

11. Authority. Each undersigned entity hereby represents that the respective governing body of such entity has approved this Letter of Intent and authorized its execution by the undersigned.

IN WITNESS WHEREOF, the undersigned have executed this document as of June 23, 2014.

**CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.
d/b/a THE GREATER DANBURY COMMUNITY HEALTH
CENTER**

By: 
James H. Maloney, J.D.
President & Chief Executive Officer

THE DANBURY HOSPITAL

By: 
Name: Michael J. Duglio
Title: COO

Exhibit J

Communications Plan

Stakeholder Communications Document – working draft as of 12/19/14**Objectives:**

- Inform, educate and engage our community leaders and interested community-at-large to accept and endorse the consolidation
- Inform, educate and engage physicians/patients to readily accept the new provider organization understanding the benefits of doing so
- To communicate in support of a seamless transition of services

Target Audiences:

- Patients
- Employees-FQHC, S&F, CCBH, AFT/Union
- Physicians, allied health professionals-EMS, Pediatricians, PCP's, WCHN/Community, UVT (Residents/students)
- Regulatory agencies- Local, State, Federal- DPH/OHCA, DSS, DMHAS, HRSA, CMS, Joint Commission
- Community leaders and interested community-at-large
- Community clinics, agencies, Danbury VA
- Faith community-ARC Board, Parish Nurses, Pastoral Care
- Government

Key Messages/Benefits:

- We are considering the consolidation of the medical services currently offered at WCHN's Seifert and Ford Community Health Center, as well as the Community Center for Behavioral Health (CCBH) located on West Street in Danbury, with the Greater Danbury Community Health Center (GDCHC) which is sponsored by Connecticut Institute For Communities, Inc. (CIFIC).
- CIFIC's GDCHC is a Federally Qualified Health Center offering high-quality outpatient primary care services and resident teaching in Danbury. GDCHC is certified as a Level 3 (the highest possible) Patient Centered Medical Home by the National Committee for Quality Assurances. GDCHC's Internal Medicine Residency program is also accredited by the National Accreditation Council for Graduate Medical Education.
- As always patient care is top of mind. Should this transition go forward, benefits include:
 - Primary care medical home to best serve the personal care needs of each patient
 - Additional Primary Care Physicians on staff
 - Increased hours of operation for more convenient access
 - Pharmacy program providing discounted prescriptions
 - Electronic health records that follow the patient and create care efficiencies
 - Improved health outcomes associated with a teaching program
 - High quality programming with transparency
 - Convenient location for patients with ample parking and easy access to mass transit
 - A more fiscally sustainable model to serve the long-term needs of our community

EXHIBIT K

CIFC/GDCHC Financial Policy

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**Greater Danbury Community Health Center
Sliding Fee Schedule, Policy and Cost Schedule**

(1) Sliding Fee Discount for Health Services

Everyone deserves quality healthcare. The Greater Danbury Community Health Center (GDCHC) is a designated Federally Qualified Health Center and offers a sliding fee schedule for all patients who qualify based on income, regardless of whether the patient carries health insurance coverage. Any patient who indicates that she/he may be income eligible on their intake form will be screened by the GDCHC Office Coordinator or designee. Outreach Enrollment Specialists will be contacted to assist patients with enrollment in qualified health plans through Access Health CT and/or assist patients with Medicaid enrollment, which is also completed through the Access Health CT website.

Patients with verified income between 200% & 100% of the Federal Poverty Level (FPL) will be charged reduced fees in steps of 20% each, as shown on the attached Sliding Fee Scale, which is incorporated herein by reference.⁴ Patients above 200% of FPL are charged full fee. Patients below 100% of FPL will be charged only a nominal fee of \$20.00 per chargeable event, and for those patients below 50% of FPL, the nominal fee will be waived. To calculate what a patient will be charged, the total household gross income and family size is utilized (e.g., spouse, life partner, or any relative/non-relative contributing to the household income).

Adolescent patients seeking confidential care, which is that care to which they can consent to without a parent or guardian's consent, are exempt from the application process. Such services may be billed to Medicaid (HUSKY) if the adolescent has insurance coverage with Medicaid (HUSKY). Such services shall not be billed to private insurance where the primary person covered is someone other than the adolescent (e.g. a parent or guardian), but shall instead be billed to GDCHC's Child Care Fund. Under Connecticut law, confidential adolescent care includes but is not limited to treatment for alcohol or drug abuse, HIV testing, treatment for venereal disease, and certain kind and number of outpatient mental health treatment sessions.

Total household gross income for all patients other than adolescents seeking confidential care includes wages and salaries before deductions, and also includes: tips, social security, cash income from self-employment, retirement/pension, rental income, interest income, child support, alimony of all persons who occupy a housing unit (house or apartment) whether or not they are related to each other, and public assistance (excluding food stamps and housing assistance).

Individuals who are eligible for financial assistance must complete a brief sliding fee discount eligibility form and provide documentation as follows to verify income:

If the individual is paid wages, s/he is required to provide one of the following:

- (1) A most recent income tax return; OR
- (2) Most recent W2 Form; OR
- (3) 2 current, consecutive pay stubs.

If the individual is paid in cash, s/he is required to provide both:

- (1) A most recent income tax return, which includes a Schedule C form; AND
- (2) A letter from his/her employer, on the employer's letterhead, stating the employee's hours, days worked, and amount earned weekly.

If the individual is self-employed, s/he is required to provide the following:

⁴ For school or youth sports physicals provided on GDCHC's mobile health van, GDCHC does not bill insurance or otherwise charge patients. Instead, GDCHC has a suggested donation of \$30 for such school or youth sports physicals.

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- (1) A most recent income tax return, which includes a Schedule C form, AND a self-attestation letter indicating weekly or monthly income and/or profit and loss statement;
OR
- (2) Three (3) months worth of bank account statements AND a self-attestation letter indicating weekly or monthly income and/or profit and loss statement.

As applicable, these documents shall also serve to verify income in the case of unemployment or disability:

- (1) Social Security Income Statement;
- (2) SSI Supplemental Security Income Statement;
- (3) Disability Income Statement; or
- (4) Unemployment Income Statement.

If a patient has Medicaid health insurance with a required spend down amount, a "spend down letter" from the Department of Social Services (DSS) shall also serve as documentation to verify income.

If any of these situations apply to an individual, but the individual is unable to provide the documentation required, the individual should speak with the GDCHC Office Coordinator, who will review the case with the individual.

Patients will be instructed to bring this documentation prior to their first visit and meet with the GDCHC Office Coordinator or designee. While meeting with the patient, the GDCHC Office Coordinator or designee shall inform the patient of the amount due on the date of their first visit. If it is not possible for the patient to meet with the GDCHC Office Coordinator or designee prior to their first visit, the patient will be instructed to bring this documentation to their first visit. The documentation will be scanned into the patient record to document proof of income.

Payments due under the sliding scale policy and the related schedule shall be due on the date of service. If a patient is unable to meet with the GDCHC Office Coordinator or designee prior to his/her first visit, and is therefore unaware of the amount due for the first visit, the patient will be charged \$20 and will be billed for the remainder of the cost of his/her first visit under the Sliding Fee Schedule for which s/he has qualified. The patient should arrange to see the Office Coordinator or designee prior to or on the day of his/her second office visit if the patient did not meet with the Office Coordinator or designee prior to his/her first visit.

If a Patient does not bring any of the above documentation prior to or at their first visit, the Patient will be asked to complete the financial demographics and self-attestation financial form indicating their family size and annual income. This information will be entered into the Patient's record as self-attested, and, if applicable, a sliding discount will be applied to their first visit charges. For the discount to be maintained for future visits, however, the Patient must supply documentation prior to or at their next visit. If the documentation provided shows that the Patient was not eligible for the sliding fee at their first visit, full fees will be charged retroactively for that visit. **If documentation is not obtained for patients who return for subsequent visits, full fees will be charged for prior and subsequent visits until documentation is received.**⁵

If a Patient is unemployed without benefits, the Patient will be asked to complete the self-attestation form indicating such. This form will be scanned into the patient file as Proof of Income.

If a Patient's unemployed status is due to seasonal work, the GDCHC Office Coordinator shall determine whether additional information is needed to prove financial status.

⁵ If a patient received a sliding fee discount on their first visit without submitting supporting documentation, and never returns to the Health Center for a subsequent visit, the Health Center will allow the slide to apply to that first visit and shall not attempt to collect the full fee.

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The sliding fee discount is good for one year. Proof of income documentation must be updated annually so that the appropriate discount can be applied. **However, patients ARE REQUIRED to report any changes in income, address and/or contact information within ten (10) days of the change in order to continue to qualify for financial assistance.**

If, during this annual review of the patient's financial status, GDCHC is made aware of: (a) changes not reported within ten (10) days of the charge; or (b) incorrect information submitted, either of which impact the level of financial assistance that the patient received, the patient will be responsible for any additional charges due.

(2) Sliding Fee Discount for Prescriptions

In addition to offering discounted health care services, GDCHC participates in the 340B Pharmacy Discount Program. Currently, GDCHC has a contract with Walgreens to offer a prescription Sliding Fee Discount Schedule to low-income and uninsured patients at three (3) local Walgreens locations:

- Walgreens, 75 Main Street, Danbury, CT 06810
- Walgreens, 95 Locust Ave., #100, Danbury, CT 06810
- Walgreens, 101 Federal Road, Danbury, CT 06811

If a Patient is deemed eligible for GDCHC's Sliding Discount Program for health services, the Patient is also deemed eligible for the Sliding Fee Discount program for prescriptions. Upon determining that a Patient is eligible for GDCHC's Sliding Fee Discount Program, the GDCHC Office Coordinator or designee shall inform the Patient's provider and the front desk staff that the Patient is eligible for prescription discounts if one or more is written at the next visit. The Office Coordinator or designee shall also inform the Patient's provider and front desk staff where the Patient falls on the "pharmacy slide" listed below.

If a provider prescribes medication at the Patient's next visit, the provider will instruct the front desk staff at the conclusion of the visit to fill out a "GDCHC Pharmacy Voucher Card" in accordance with the pharmacy slide determination and provide the voucher card to the patient.

All GDCHC vouchers are valid for 90 days. They are only available for use at the three (3) Walgreens locations listed above. A Patient's eligibility for prescription discounts runs tandem with the Patient's eligibility for discounted health services. Thus, if a Patient fails to present documentation to provide eligibility for health services or is no longer eligible for such discounted services, they will also no longer be eligible for the discounted pharmacy program.

GDCHC Pharmacy Sliding Fee Scale

- G < 51%
- B 51 - 100% Pay \$20 flat fee
- C 101 - 125% Pay 20%
- D 126 - 150% Pay 40%
- E 151 - 175% Pay 60%
- F 176 - 200 % Pay 80%
- A Over 200% Pay 100%

EXHIBIT L

Curriculum Vitaes of Selected CIFC Personnel

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C.V.**Hon. James H. Maloney, J.D.**

15 Wooster Heights

Danbury, CT 06810

Tel: (203) 743-9760 x 202 Fax: (203) 743-3411

Email: JamesHMaloney@aol.com

SUMMARY: A highly accomplished leader of sophisticated, complex non-profit and public sector organizations and institutions.

PRINCIPAL SKILLS:

- Strategic Planning
- Institutional Development
- Fundraising
- Grant Writing
- Written Communications
- Oral Communications
- Program Management
- Government and Community Relations
- Economic Development
- Real Estate Development
- Non-Profit (Fund) Accounting
- Team Building
- Legal Analysis
- Press Relations
- Administrative Law and Regulatory Compliance
- Computer Literacy

EDUCATION :

- 1972 **Harvard University, B.A., with honors, in American History.**
- 1980 **Boston University School of Law, Juris Doctor (J.D.), with concentration in Administrative Law and the Law of Public Finance.**

PROFESSIONAL EXPERIENCE:

2003 – Present

**President / Chief Executive Officer and General Counsel
Connecticut Institute For Communities, Inc., Danbury, CT**

- Chief Executive Officer of comprehensive non-profit community development organization serving Northern and Western Connecticut.
- Founded organization; and developed multi-million dollar program in less than twenty-four months.
- Institute now operates six (10) major programs, with total revenue of approximately \$10 million per annum.

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- 2003 – 2008 Chief Operating Officer
Main Street Group, Ansonia, CT**
- Managed a network of non-profit housing, community and economic development organizations serving the Naugatuck Valley communities of Connecticut
 - Administered the activities and growth of the Main Street Development Corporation, the AHA Development Corporation, Curtisey Corporation, and the Naugatuck Valley Economic Growth Initiative, all non-profit organizations or projects serving the municipalities of Ansonia, Derby, Beacon Falls, Naugatuck, and Seymour, Connecticut and environs.
- 1997-2003 Member of Congress, United States House of Representatives
5th Congressional District of Connecticut**
- Member:
 - Financial Services Committee
 - Armed Service Committee
 - Education Task Force
 - Health Care Task Force.
 - Author/Co-Author: Significant legislation regarding education improvements, environmental protection, financial services modernization, health-care access, public safety advancements, and national security enhancement.
 - Secured multi-million dollar federal, state, local and private grants and funding resources.
 - Led strategic planning, fundraising, economic development, public relations, and public policy initiatives and programs.
 - Extensive expertise in government operations at all levels; developed and maintained wide-ranging corporate and organizational relationships; and managed constituent service, legislative research, and community outreach and public information programs.
- 1995 – 1997 Managing Partner and Attorney
Maloney, Leaphart & Knowles, P.C., Danbury, CT**
- Attorney and Counselor at Law
 - Practice concentrating in Administrative Law and Civil Litigation (including public agency representation, election law, and labor and employment law); real estate development and financing; public and municipal finance; non-profit organization law and taxation; commercial land use; business taxation; government relations; and related judicial proceedings and appeals.

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- 1995 – 1997 **Adjunct Faculty**
Western Connecticut State University
Department of Political Science, Danbury, CT
- American Government
 - State and Local Government
- 1987 – 1995 **State Senator**
Connecticut, 24th District (Greater Danbury)
- Senate Chair, Finance, Revenue & Bonding Committee
 - Assistant Majority Leader
 - Member, State Bond Commission
 - Past Senate Chair:
 - Labor & Public Employees Committee
 - Government Administration & Elections Committee
 - Extensive experience and leadership in public policy, organization, financing, economic development, and community and press relations.
- 1986 – 1995 **Principal and Attorney**
Dice, Maloney & Lenz, P.C., Danbury and Cheshire, CT
- Practice concentrating in commercial real estate, construction, and financing, and administrative agency representation, and related civil litigation and judicial appeals.
- 1980 – 1986 **Attorney**
Pinney, Payne, Van Lenten, Burrell, Wolfe and Dillman, P.C., Danbury, CT
- Commercial law practice, as above.
- 1978 – 1980 **Teacher**
St. Sebastian's School, Newton, Massachusetts
- American History
 - Advanced Placement American History
- 1974 – 1978 **Executive Director**
Community Action Committee of Danbury, Inc., Danbury, CT
- Chief Executive Officer of multi-million dollar human and social service agency.
 - Led development, fundraising and organizational efforts that produced 400% increase in agency budget and programs in a four year period.

SELECTED AWARDS AND RECOGNITIONS:

- 2009 • Award for Outstanding Service to the Youth and Families in the Greater Danbury area, Danbury Youth Services, Inc.

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- 2002 • Certificate of Appreciation, National Education Association, Read Across America Program
- 2002 • Recognition Certificate, Safe Schools/Health Students Program, Waterbury, Connecticut
- 2002 • Humane Legislator Award, American Humane Association
- 2001 • Award of Appreciation, Association of Connecticut Library Boards
- 2001 • Legislator of the Year Award, American Society of Internal Medicine & American College of Physicians, Connecticut Chapter
- 2001 • Distinguished Public Service Award, American Association for Research in Otolaryngology
- 2001 • Legislator of the Year Award, Greater Waterbury Branch of the NAACP
- 2001 • Distinguished Service Award, Connecticut Chiropractic Association
- 2000 • Legislative Service Award, Northeastern Economic Developers Association
- 2000 • Martin Luther King Jr. Brotherhood Award, Naugatuck Valley Martin Luther King Ceremonial Awards Committee
- 2000 • Community Health "Super Hero" Award, National Association of Community Health Centers
- 2000 • Legislator of the Year Award, Connecticut College of Emergency Physicians
- 1999 • The Charles Dick Medal of Merit, from the National Guard Association of the United States
- 1999 • Leadership Award, Mid-Western Connecticut Council on Alcoholism
- 1999 • Man of the Year Award, Waterbury Neighborhood Council
- 1998 • Legislator of the Year, Connecticut Nurses Association
- 1995 • Who's Who in America, 49th and subsequent editions.
- 1993 • Special Recognition Award, The Jewish Home for the Elderly of Fairfield County, for efforts in support of Connecticut's senior citizens.
- 1992 • Legislator of the Year, Professional Insurance Agents of Connecticut, for leadership on workers compensation reform.

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- 1990 • Legislator of the Year, Caucus of Connecticut Democrats, for initiatives on election reform and freedom of information laws.
- 1990 • Community Service Award, Midwestern Connecticut Council on Alcoholism, for help in combating substance abuse.
- 1989 • Citation, Connecticut Library Association, for support of Connecticut Preservation Task Force and Connecticut's Historical Records.
- 1986 • Man of the Year, Danbury Jaycees for distinguished community service

CIVIC LEADERSHIP BACKGROUND:

- Member: United States Presidential Advisory Commission on Holocaust Assets in the United States
- Member: Connecticut Commission on Legal Ethics
- Founder: Danbury Community Endowment, Inc.
- Co-Founder: Fairfield County Community Foundation, Inc.
- Founder & Co-Chair: Housatonic Valley Economic Development Partnership
- Co-Founder: New Committee of One-Thousand (in successful support of \$40 million local school improvement and construction program)
- Chair: Danbury Area Unified Social Services, Inc. (DAUSS)
- Chair: Danbury Youth Services, Inc
- Vice-Chair and Board Member: United Way of Northern Fairfield County, Inc.
Chair: Strategic Planning Committee
- Board Member: Danbury Hospital, Inc.
Danbury Redevelopment Agency
Danbury Commission on Aging
- Member: American, Connecticut and Danbury Bar Associations

SELECTED PUBLICATIONS and WRITINGS:

- "Deploying Advanced U.S. Technology in the Pursuit of Peace", The Genocide Prevention Quarterly, Spring, 2002 (author).

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- “Charter School Facilities Financing Models”, prepared for the Democratic Education Task Force, United States House of Representatives, 2002 (author).
- “Northern Fairfield County/Southern Litchfield County Needs Assessment”, United Way of Northern Fairfield County, Inc., 1991 (co-author).
- “Dilemmas and Decisions: The DAUSS human services planning and coordination mandate; an historical analysis, status report and prospectus”, Danbury Youth Services, Inc., 1980 (author).
- “To Strike at Steel: Gary, Indiana, and the Steel Strike of 1919”, Honors Thesis, Harvard University, 1972 (author).
- Numerous grant applications, newspaper “Op-Eds”, position analyses, press releases, and related papers.

PERSONAL:

- Married, 3 children
- National Service: VISTA (Domestic Peace Corps), Gary, Indiana, 1968-1970

REFERENCES: Available upon request

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KATHERINE McKEON CURRAN

CurranKa@ct-institute.org

Bar Admission: Connecticut State Bar, November 2009**Certifications:** Certified in Health Care Compliance, Health Care Compliance Association, Sept. 2012
Completed Leadership Development Roundtable Program, March 2014**PROFESSIONAL EXPERIENCE****CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.**

Danbury, CT

Chief Operating Officer & Deputy General Counsel, March 2014-Present**COO Responsibilities:** Works directly with CEO on all operational matters, with the goal of transitioning all operational duties/responsibilities from CEO to COO by 2017.**Deputy General Counsel Responsibilities:** Oversees legal work and compliance for all programs of the Institute.**Staff Attorney & Compliance Officer**, August 2011-March 2014**Staff Attorney Responsibilities:** Drafted and reviewed legal documents, including all leases, grant agreements and other contracts. Conducted legal research on regulatory matters and advised President & CEO on legal matters related to contract, health, education, housing, employment law and related matters. Drafted and reviewed policies of the Institute across all programs. Provided executive level support for the Institute's President & CEO.**Compliance Responsibilities:** Oversaw compliance for all programs of the Institute, including the Institute's federally qualified health center (Greater Danbury Community Health Center), the Institute's Head Start/Early Head Start program, and the Beaver Street Apartments Cooperative, Inc. a low-income, multi-family housing cooperative managed by the Institute. Drafted the Institute's first formal compliance plan and began programmatic changes to implement the plan. Supervised housing site staff.**OFFICE OF LEGAL RESEARCH, STATE OF CONNECTICUT – SUPERIOR COURT****Law Clerk**, August 2009 – August 2011

Waterbury and Litchfield, CT

Provided legal research and wrote memoranda, including memoranda of decision, for judges of the Connecticut Superior Court. Briefed judges on the arguments of law scheduled for short calendar. Attended short calendar and other hearings to assist judges with subsequent research assignments. Edited, proof read and cite checked memoranda of decision to be consistent with the Connecticut Manual of Style. Work included all areas of law, with a focus on civil law. Memoranda included medical malpractice, insurance, family, tort, property, contract and employment cases, as well as criminal work.

QUINNIPIAC UNIVERSITY SCHOOL OF LAW, CIVIL CLINIC**Certified Legal Intern**, January 2009 – May 2009

Hamden, CT

Researched and wrote memoranda on special education, family and other civil law matters. Represented client in child support contempt and modification hearing. Interviewed, counseled and communicated with clients. Wrote and filed FOIA and other administrative requests with state agencies.

OFFICE OF THE GENERAL COUNSEL, CENTRAL CONNECTICUT STATE UNIVERSITY**Law Clerk**, May 2008 – May 2009

New Britain, CT

Assisted General Counsel to President with all legal matters. Performed legal research and wrote memoranda in the areas of employment, labor, tort, education, and constitutional law. Prepared draft interrogatory responses, admissions and discovery requests in federal employment discrimination case.

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STATE OF CONNECTICUT – SUPERIOR COURT New Haven and Waterbury, CT
Sappern Fellow, September 2007 – December 2007; *Legal Intern*, July 2007 – August 2007
 Assisted *pro se* parties in obtaining temporary restraining orders and divorces. Prepared memoranda for erasures, case status conferences and judicial pre-trials.

YALE UNIVERSITY CONSULTATION CENTER New Haven, CT
MAAY Facilitator (Maximizing Adolescent Academic Excellence), October 2006 – June 2007
 Taught a college awareness and social development curriculum to five classes of approximately thirty middle school students each at the Luis Munoz Marin School in Bridgeport, CT.

CONNECTICUT VOICES FOR CHILDREN New Haven, CT
Albert J. Solnit Policy Fellow, August 2004 – August 2006
 Researched issues on state agencies, economic development, tax and budget, juvenile justice and education as well as current policy trends and their relation to state law. Wrote memoranda and prepared fact sheets, presentations, and other materials for use during meetings with state and federal legislators. Testified before the Connecticut General Assembly's Commerce and Education Committees. Supervised student interns.

OFFICE OF U.S. SENATOR CHRISTOPHER DODD Washington, DC
Staff Assistant, July 2003 – August 2004
 Researched constituent issues and wrote constituent letters. Assisted legislative staff with committee hearing research and prepared questions for hearings. Handled constituent concerns on a daily basis. Wrote and designed constituent brochures detailing the Senator's legislative achievements.

EDUCATION

QUINNIPIAC UNIVERSITY SCHOOL OF LAW Hamden, CT
 Juris Doctor, *cum laude*, May 2009
 Concentration: Family Law, *with honors*
 Honors: Editor-in-Chief, Quinnipiac Health Law Journal, 2008-2009
 Publication: *Mental Health Screening in Schools: An Analysis of Recent Legislative Developments and the Legal Implications for Parents, Children and the State*
 Fannie & Samuel Glickstein Memorial Scholarship, Summer 2007
 Merit-based scholarship, 2006-2009
 Awards: ABA-BNA Award for Excellence in the Study of Health Law, May 2009
 Excellence in Clinical Work Award, Civil Clinic, May 2009
 Outstanding Legal Scholarship Award, May 2009
 Service to the Law School Award, May 2009
 Superior Classroom Performance Award, May 2009
 Distinguished Academic Achievement Award, Public Health Law, Fall 2008
 Distinguished Academic Achievement Award, Education Law, Spring 2008

HAMILTON COLLEGE Clinton, NY
 Bachelor of Arts, *cum laude*, Government, May 2003
 Honors: Department honors
 Pi Sigma Alpha National Political Science Honor Society
 Alexander Hamilton's List (Faculty recognition for achievement in writing given to less than 10% of the student body)
 Semester in Washington, D.C. program, Fall 2001. (Intern with the U.S. Senate Subcommittee on Employment Safety & Training and the Progressive Policy Institute)
 Activities: Varsity lacrosse, teaching assistant, volunteer in Utica public schools

David Savarese MD

Board Certified Pediatrician with 16 years of post-residency experience and 8 years of Medical Director experience. Position at Montefiore Medical Group for 10 years, hired as a pediatrician, promoted to Medical Director after 3 years. Position at Norwalk Community Health Center for 5 years, promoted to Medical Director after 2.5 years. Currently serving as Chairman of the Clinical Issues Committee for the Community Health Center Association of Connecticut

Professional Experience

Norwalk Community Health Center, Norwalk, CT

9/2006 to Present

Multispecialty Health Center offering Pediatrics, Ob/Gyn, Internal Medicine, Endocrinology, Infectious disease/HIV specialty care, and Mental Health/Social Services. There is on-site pharmacy and laboratory. Serves as a clinical teaching site for medical residents, PA students, and APRN Students.

Medical Director, 4/9-Present

- Responsible for the quality of medical care delivered at the health center
- Responsible for interviewing, hiring, and supervision of providers
- Worked with leadership team to improve organizational structure.
- Established peer review process
- Worked with Norwalk Hospital to improve inter-organization communication in relationship to Emergency Department, Inpatient units, Lab, Radiology, and Specialty Clinics.
- Worked with Norwalk Hospital lab to develop on-site lab at our health center.
- Transitioned health center from paper charts to electronic medical record.
- Restructured the Internal Medicine Department to meet the needs of the community
- Established and chaired Quality Improvement Committee.
- Responsible for development of the Emergency Preparedness Plan
- Instituted advanced access scheduling health center wide.
- Established and monitored committees developed to achieve specific goals
- Developed educational programs for patients both on site and in the community
- Assured good quality of care during expansion and move to a larger facility.

Lead Pediatrician, 9/06-4/09

Hired to redesign the pediatric department and to lead that department

- Trained staff in the principles of performance improve
- Improved efficiency, productivity, quality of care, patient and staff satisfaction
- Liaisoned with School Based Health Centers to improve communication
- Brought order to a previously chaotic department.
- Developed office protocols and practice standards.
- Instituted advanced access scheduling to the pediatric department.
- Established Group visit for asthma and newborn care.

WCHN CON Application



Montefiore Medical Center, Bronx, NY (Marble Hill Family Practice)

1/1996-8/2006

Hospital owned multispecialty group practice offering Internal Medicine, OB/Gyn, Pediatrics, Mental Health, and Dental Services. Serves as clinical teaching site for Medical Students

Medical Director, 5/99-8/06

- Utilized research based quality improvement techniques to improve efficiency.
- Responsible for the Quality of Care delivered at the practice.
- Responsible for the interviewing, hiring and evaluation of new providers and staff.
- Responsible for motivating staff and providers to improve their performance and productivity.
- Developed new provider orientation process and evaluation tool.

Pediatrician, 1/96-5/99

full time primary care including resident precepting, part time emergency department

New York State Department of Children and Family Services, Bronx, NY

8/2003-8/2006

Consultant Physician,

- Responsible for the oversight of medical care for incarcerated youth.
- Established clinical protocols for on-site medical office.

New City Pediatrics, New City, NY

7/1994-12/1996

Pediatrician, Private Group Practice

Education and Training

Long Island Jewish Medical Center, New Hyde Park, NY

7/1991-6/1994

Pediatric Residency

Albert Einstein College of Medicine, Bronx, NY

8/1987-6/1991

Medical Degree

Rutgers University, Newark, NJ
Bachelor of Arts (Zoology Major)

8/1984-6/1987

Languages: English and Spanish

WCHN CON Application

DIANA J. TRUMBLEY**EXPERIENCE:****OMNICARE PHARMACY OF CONNECTICUT****Value Health Care Services, Inc. Cheshire, CT***Central Billing Center Manager—7/08—11/09**Director of Reimbursement 4/01— 7/08**Controller 5/97 --4/01***Direct report to Unit General Manager, Regional Vice President and National Central Billing Center Director**

- Manage all facility and private pay billing aspects for long term care pharmacies in CT, RI, ME and VT (Massachusetts forthcoming Q4 2009)
- Involved in facility contract renegotiation.
- Address facility and private pay billing concerns.
- Review facility census compliance and work with facilities to better report demographic changes to reduce subsequent rebilling requests due to third party insurance filing limits.
- Coordinate Medicaid, third party insurance and internal audits, including Sarbanes Oxley.
- Review systems and processes to insure compliance with current policies and procedures.
- Review of Medicaid audit results with the Department of Social Services and work toward resolution of findings to reduce extrapolated findings.
- Insure compliance with third party audit requests for prescription, compound and delivery documentation
- Review IV charges, enter supply per diems/nursing starts and insure contract pricing compliance
- Compile monthly medical records and consulting charges
- Review monthly Medicare/PPS facility charges and evaluate per diem contracts including possible renegotiation of per diem rates based on actual experience.
- Involved in the collection of over \$25 million in facility and private pay accounts receivable.
- Oversee a billing/collections staff of 30.
- Involved in review of accounts payable and approval of patient refunds
- Responsible for maintaining pricing tables for facility and private pay billing to insure contract compliance.
- As controller, responsible for annual budget preparation and monthly comparison of actual results to budget and explaining variances

WCHN CON Application

Diann Trumbley Resume
Page 2

SUBURBAN HEALTH PLAN, INC.

Shelton, CT--*Controller 8/90-4/97*

Direct report to President/Executive Director.

- Managed all aspects of a rapidly growing HMO which tripled membership and staff over a 2 year period.
- Responsible for internal/external monthly financial reporting and quarterly/annual filings with regulatory agencies.
- Prepared demographic and financial projections for annual premium rate filings.
- Reviewed premium rate filings with outside actuaries and Department of Insurance.
- Approved rates quoted to groups and managed group and membership enrollment.
- Responsible for maintaining pricing tables in the billing system to insure contract compliance.
- Responsible for billing, collections, payables, payroll, general ledger, claim reserve/IBNR analysis and administrative budgeting.
- Prepared monthly marketing enrollment reports and calculated internal and broker commissions.
- Supervised staff of three.

BAILEY, MOORE, GLAZER, SCHAEFER AND PROTO

Woodbridge, CT--*Senior Accountant 8/89--8/90*

- Planned, supervised and performed certified audits for a diversified client base of real estate partnerships, insurance and manufacturing.
- Prepared financial statements and corporate, partnership and individual tax returns.

COOPERS & LYBRAND

Hartford, CT/Boston, MA--*Audit Supervisor 8/85--8/89*

- Planned, supervised and performed certified audits for a diversified client base consisting of higher education, insurance and manufacturing organizations.
- Prepared financial statements and special reports within specified deadlines.
- Proposed recommendations to management based upon client's financial position through financial analysis and operational review of existing systems.

EDUCATION:

Bentley College--Waltham, MA
Bachelor of Science, Accountancy--May 1985

ACHIEVEMENTS: Certified Public Accountant--Massachusetts (No longer active)

SOFTWARE: Excel Word Microsoft Access RESCOT

REFERENCES: Will be furnished upon request

EXHIBIT M

Danbury Hospital Facility License

STATE OF CONNECTICUT**Department of Public Health****LICENSE****License No. 0039****General Hospital**

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

The Danbury Hospital of Danbury, CT d/b/a 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:

26 Bassinets
430 General Hospital Beds

This license expires September 30, 2015 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2013.

Satellites:

*New Milford Hospital Campus, 21 Elm Street, New Milford, CT
*New Milford Hospital Behavioral Health Services, 23 Poplar Street, New Milford, CT
Center for Child and Adolescent Treatment Services, 152 West Street, Danbury, CT
Community Center for Behavioral 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

License revised to reflect:

*Added (2) satellites and increase of 85 General Beds because The Danbury Hospital merged and took over New Milford Hospital effective 10/1/14.



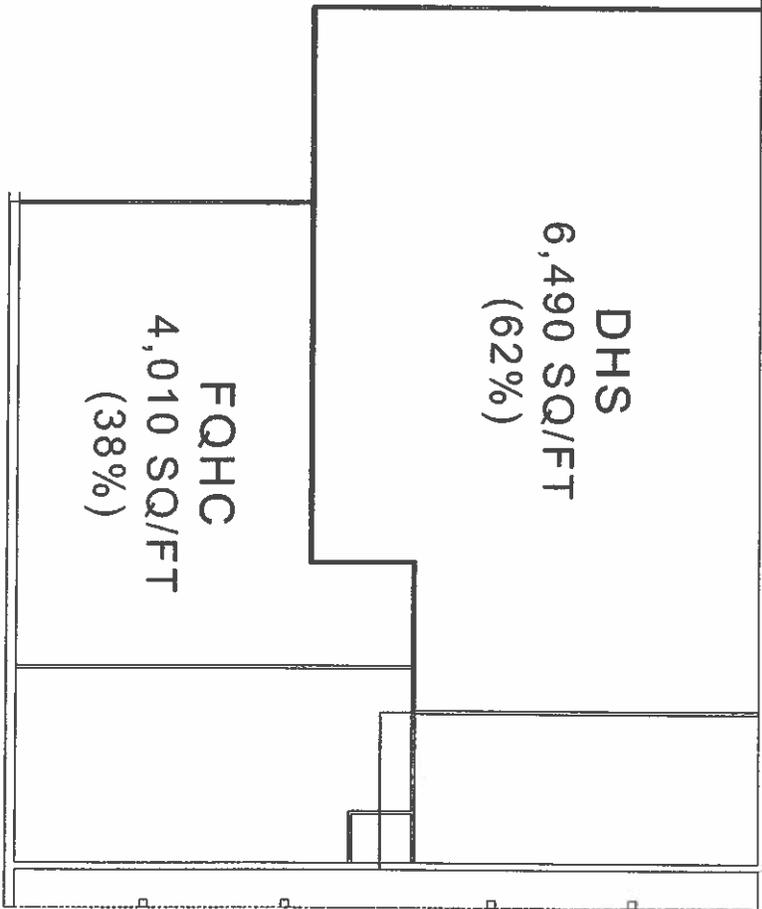
Handwritten signature of Jewel Mullen in black ink.

Jewel Mullen, MD, MPH, MPA
Commissioner

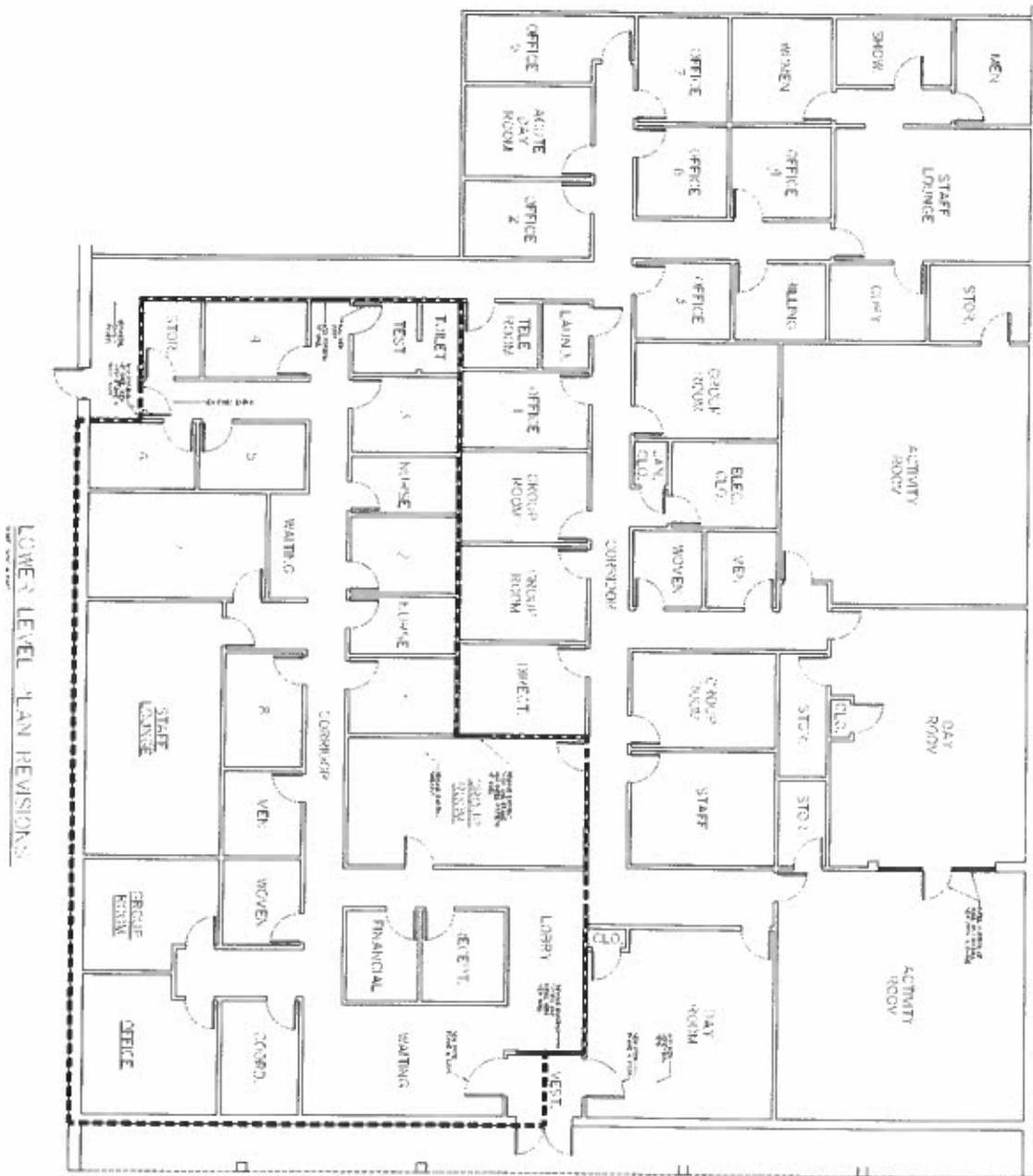
EXHIBIT N

Facility Sites of Care

TOTAL 10,500 SQ/FT
6,490 / 10,500 = 62%
4,010 / 10,500 = 38%

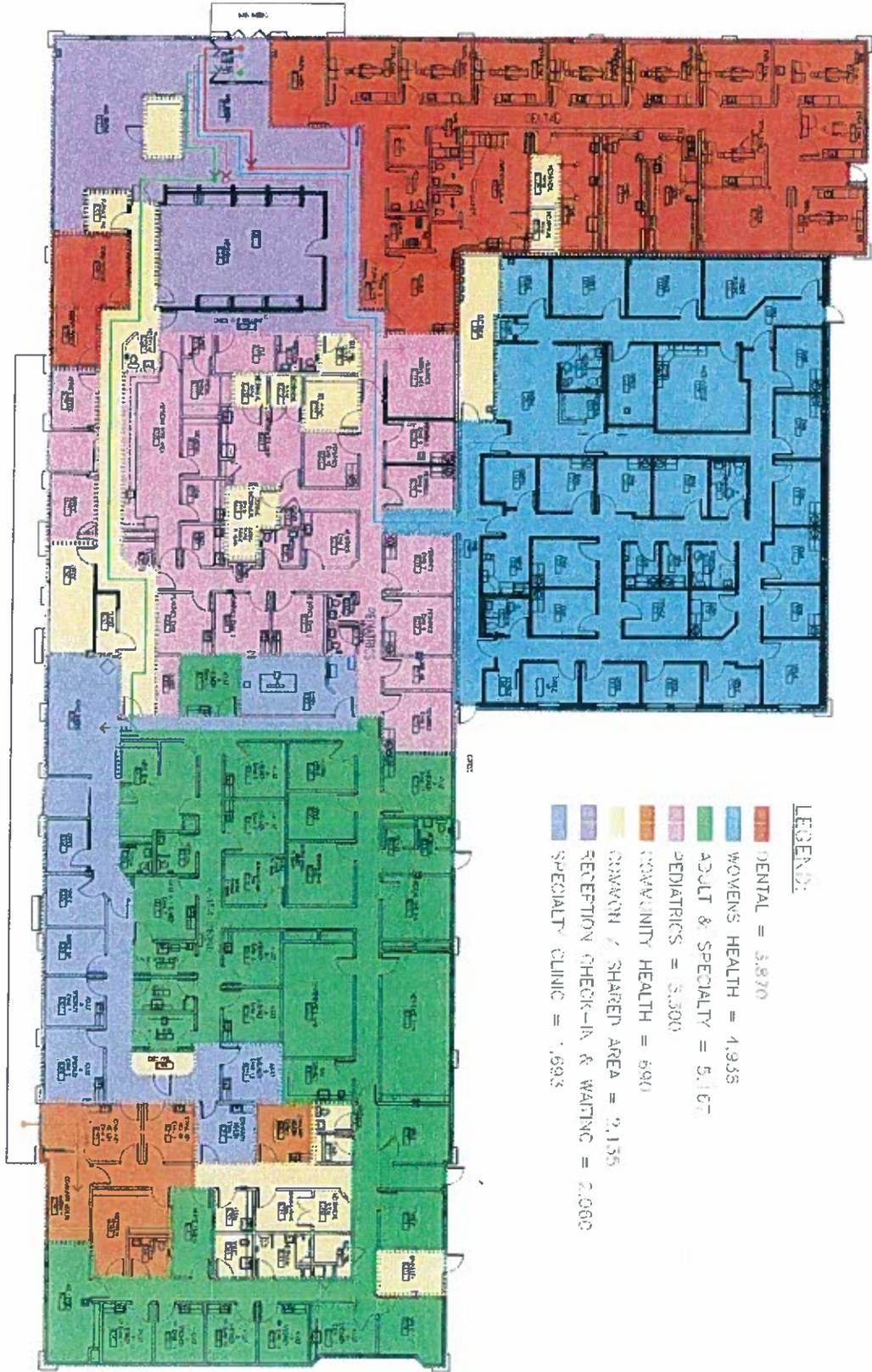


152 WEST STREET



LOWER LEVEL - PLAN REVISIONS

70 MAIN STREET DANBURY, CT - SPECIALTY CLINIC



LEGEND:

- DENTAL = 5,870
- WOMENS HEALTH = 4,935
- ADULT & SPECIALTY = 5,107
- PEDIATRICS = 5,300
- COMMUNITY HEALTH = 690
- CORRIDOR / SHARED AREA = 2,155
- RECEPTION CHECK-IN & WAITING = 2,000
- SPECIALTY CLINIC = 1,693

EXHIBIT O

Financial Attachment I

WCHN CON Application

Danbury Hospital - Clinic CON

Financial Attachment I

(Dollars are in thousands)

Total Facility:	FY2013	FY2014	FY2015	FY 2015	FY 2015	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018
Description	Actual Actuals	Actual Actuals	Projected Actuals	Projected Incremental	Projected With CON	Projected Actuals	Projected Incremental	Projected With CON	Projected Actuals	Projected Incremental	Projected With CON	Projected Actuals	Projected Incremental	Projected With CON	
NET PATIENT REVENUE															
Non-Government	296,229	296,863	333,642	(66)	331,577	340,316	(405)	339,911	347,123	(639)	346,284	354,067	(639)	353,227	
Medicare	175,171	182,492	209,862	(47)	209,835	209,961	(266)	209,575	209,840	(561)	208,259	209,819	(561)	209,239	
Medicaid and Other Medical Assistance	30,463	25,139	25,860	(265)	25,595	25,861	(1,210)	24,651	25,962	(1,666)	24,198	25,863	(1,666)	24,197	
Total Net Patient Revenue	501,863	504,493	569,364	(\$376)	566,008	576,038	(\$1,001)	574,137	592,825	(\$3,087)	579,739	589,749	(\$3,087)	586,662	
Other Operating Revenue	\$15,281	\$16,727	\$17,129	(20)	\$17,109	\$17,129	(192)	\$16,937	\$17,129	(528)	\$16,601	\$17,129	(528)	\$16,601	
Revenue from Operations	\$517,124	\$521,220	\$586,513	(\$396)	\$586,117	\$593,167	(\$2,093)	\$591,074	\$599,954	(\$3,615)	\$596,340	\$606,878	(\$3,615)	\$603,263	
OPERATING EXPENSES															
Salaries and Fringe Benefits	\$240,060	\$239,919	\$267,026	(235)	\$266,701	\$268,361	(1,345)	\$267,016	\$269,703	(2,689)	\$267,014	\$271,052	(3,074)	\$267,978	
Professional / Contracted Services	59,192	61,072	73,670	(242)	73,428	74,407	(1,142)	73,265	75,151	(1,659)	73,492	75,932	(1,665)	74,237	
Supplies and Drugs	79,427	82,494	93,292	(38)	93,244	96,080	(1,899)	95,892	98,963	(304)	98,659	101,932	(394)	101,628	
Other Operating Expense	68,732	72,654	78,154	63	78,217	78,936	213	79,148	79,725	(12)	79,713	80,522	(421)	80,101	
Subtotal	\$446,410	\$456,040	\$512,132	(\$452)	\$511,680	\$517,794	(2,494)	\$515,321	\$522,542	(4,664)	\$518,879	\$529,408	(6,464)	\$523,944	
Depreciation/Amortization	30,033	31,882	44,391	(14)	44,377	46,191	(69)	46,122	47,991	(110)	47,881	49,791	(110)	49,681	
Interest Expense	3,984	4,567	7,700	-	7,700	7,571	-	7,571	7,450	-	7,450	7,328	-	7,328	
Lease Expense	7,965	8,069	8,575	(118)	8,456	8,746	(533)	8,213	8,921	(709)	8,212	9,099	(709)	8,391	
Total Operating Expenses	\$488,392	\$500,348	\$572,798	(\$585)	\$572,213	\$580,293	(\$3,065)	\$577,227	\$587,903	(5,482)	\$582,421	\$595,626	(6,283)	\$589,344	
Gain/(Loss) from Operations	\$29,732	\$20,872	\$13,715	\$188	\$13,903	\$12,875	\$972	\$13,847	\$12,051	\$1,867	\$13,918	\$11,252	\$2,668	\$13,919	
Plus: Non-Operating Income	\$9,910	\$14,760	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500	
Income before provision for income taxes	\$38,642	\$35,632	\$22,215	\$188	\$22,403	\$21,375	\$972	\$22,347	\$20,551	\$1,867	\$22,418	\$19,752	\$2,688	\$22,419	
Provision for income taxes					\$0		\$0	\$0		\$0	\$0		\$0	\$0	
Revenue Over/(Under) Expense	\$38,642	\$35,632	\$22,215	\$188	\$22,403	\$21,375	\$972	\$22,347	\$20,551	\$1,867	\$22,418	\$19,752	\$2,688	\$22,419	
FTEs	2,362.3	2,351.8	2,624.9	(8.4)	2,616.5	2,598.7	(38.5)	2,560.2	2,572.7	(53.6)	2,519.0	2,548.9	(53.6)	2,493.3	
*Volume Statistics: Clinic Visits	54,375	49,324	53,464	(7,081)	46,383	53,464	(34,610)	18,855	53,464	(53,464)	-	53,464	(53,464)	-	

EXHIBIT P

Financial Assumptions

Danbury Hospital - Clinic CON**FINANCIAL ASSUMPTIONS****Net Patient Revenue:**

- Without Project: Determined using historical payment experience
- With Project: Reflects loss of net revenue associated with clinic encounters

Volume:

- Without Project: Assumes 1.0% annual decline in volume, based on historical trend
- With Project: Reflects loss of clinic volume

Other Operating Revenue:

- Without Project: Based on historical trend
- With Project: Reflects anticipated decrease in federal/state grant funding

Salaries and Fringe Benefits:

- Without Project: Includes 2.0% inflationary increase annually adjusted for productivity improvements ongoing.
- With Project: Reduction in workforce related to transition of services, plus anticipated retention & severance payments

Professional / Contracted Svcs:

- Without Project: Assumes 1.0% annual increase, based on projected trend
- With Project: Assumes professional services expenses transition to CIFC

Supplies and Drugs:

- Without Project: Assumes 3% annual increase, based on historical data combined with inflationary increases
- With Project: Reduction related to transition of clinic services

Other Op Expense:

- Without Project: Assumes 1.0% inflationary increase
- With Project: Reflects ongoing operating and teaching expenses in support of providing care to clinic patient:

Depreciation:

- Without Project: Based on historic trend inclusive of annual capital spend
- With Project: Reflects transfer of existing clinic equipment over to CIFC

Interest:

- Without Project: Based on current interest of existing debt rolled forward annually
- With Project: No Impact

Lease Expense:

- Without Project: Includes a 2% annual increase on expenses
- With Project: Reflects reduction in rent obligation for facilities at 70 Main St and 152 West St

FTEs:

- Without Project: Based on projected volume with continued productivity improvements
- With Project: Reduction in FTE based on proposed transition of services



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

March 13, 2014

VIA FAX ONLY

Sally F. Herlihy
Vice President, Planning
Western Connecticut Health Network, Inc.
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 15-31978-CON
Termination of the Seifert & Ford Family Community Health Center and Community
Center for Behavioral Health Programs

Dear Ms. Herlihy:

On February 11, 2015, the Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application on behalf Danbury Hospital, a subsidiary of Western Connecticut Health Network, Inc. ("Applicant" or "WCHN"). The proposal requests authorization to terminate the operation of primary care services at Seifert & Ford Family Health Center ("S&F") and behavioral health services at its Community Center for Behavioral Health ("CCBH"). Over the course of two years, the Applicant proposes transferring ownership of those services to the Greater Danbury Community Health Center ("GDCHC"), a licensed federally qualified health center which is operated by the Connecticut Institute for Communities, Inc ("CIFIC"). The associated capital expenditure is estimated to be \$202,500 for construction and renovation.

OHCA has reviewed the CON application and requests the following additional information pursuant to Connecticut General Statutes §19a-639a(c):

1. On pages 4 and 5 of the application are copies of a newspaper order confirmation and public notice. Please provide a more legible copy of each.
2. On page 16, Table 3, the Applicant provides utilization by town for FY14; resubmit that table with only one column of numbers.
3. Explain the methods by which you intend to convey your communications with patients, as outlined on page 64 of the application.

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

4. List the scholarly journals in which the literature on pages 50 and 56 were published.
5. Does CIFC/GDCHC have sufficient capacity at its 57 North Street, Danbury location to absorb WCHN's pediatric service patients? Please explain in detail.
6. Provide a copy of the grant agreement described in section 1(e) of the Letter of Intent. If you are unable to do so, please explain:
 - a) why the grant agreement cannot be provided;
 - b) whether the "community grant" mentioned on page 14 of the application and the "short fall" grant mentioned on page 60 are two separate grants;
 - c) whether there is a maximum amount of grant money the Applicant will provide GDCHC; and
 - d) whether there is a minimum and/or maximum number of years the Applicant will provide the grant(s) to GDCHC.
7. Please elaborate on the "opportunities for Behavioral Health expansion" mentioned during the WCHN Board of Directors minutes on page 45 of the application.
8. On page 18 of the application, the Applicant provides its current and projected payor mix in Table 5, showing a decrease in patient volume in 2016 and zero patient volume in 2017 as a result of the proposed CON. Please provide projected volumes without the proposed CON (i.e., if WCHN continued to operate S&F and CCBH).
9. Will current patients of CIFC have access to the specialty services at S&F?
10. Does WCHN/Danbury Hospital charge facility fees for services provided at S&F or CCBH? If yes, will facility fees be charged at S&F or CCBH once services are transferred to CIFC/GDCHC?
11. With respect to the proposal:
 - a. identify the target patient population to be served;
 - b. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit;
 - c. explain how access to care will be affected; and
 - d. discuss any alternative proposals that were considered.
12. On Financial Attachment I, page 89 of the application, the Applicant provided actual financial results for FY 2013 and projected results for fiscal years 2014 through 2018 for the entire Danbury Hospital. Please resubmit Financial Attachment I, reporting data from only S&F and CCBH.
13. On page 10 of the application, the Applicant references efficiencies in operations in the form of reduced overhead and reduced costs. Provide an itemization of anticipated cost savings

attributable to the proposal and incorporate those savings in the proposed S&F and CCBH Financial Attachment I.

14. On page 9 of the application, the Applicant states that WCHN will continue to provide specialty care clinics at S&F. What services are provided in these clinics?
15. On page 64 of the application, the Applicant mentions in its communication plan to stakeholders a “pharmacy program providing discounted prescriptions.” Explain the program in greater detail.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response. Information filed after the initial CON application submission (e.g., 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 91** and reference “Docket Number: 15-31978-CON.” Submit one (1) original and three (3) 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.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **May 12, 2015**, otherwise your application will be automatically considered withdrawn.

If you have any questions concerning this letter, please feel free to contact me or Olga Armah by email or at (860) 418-7001.

Sincerely,

Jessica Schaeffer-Helmecki
Program Analyst (CCT)
jessica.schaeffer-helmecki@ct.gov

* * * COMMUNICATION RESULT REPORT (MAR. 13. 2015 3:28PM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAR. 13. 2015 3:27PM
FILE MODE OPTION

ADDRESS

RESULT

PAGE

964 MEMORY TX

912037391974

OK

4/4

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-3) NO ANSWERE-2) BUSY
E-4) NO FACSIMILE CONNECTION

**STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS**

FAX SHEET

TO: MS. SALLY HERLIHY

FAX: (203) 739-1974

APPLICANT: WESTERN CONNECTICUT HEALTH NETWORK

FROM: OHCA

DATE: 3/13/2015 Time: _____

NUMBER OF PAGES: 4
(including transmittal sheet)

Comments:

Completeness Letter for Docket Number: 15-31978-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

*Phone: (860) 418-7001
Fax: (860) 418-7053*

*410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134*

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Thursday, March 19, 2015 2:45 PM
To: 'sally.herlihy@wchn.org'
Cc: Greer, Leslie; Armah, Olga; Riggott, Kaila; Hansted, Kevin
Subject: CON 15-31978: Motion to Intervene
Attachments: 31978_201503191343.pdf

Dear Ms. Herlihy,

Attached please find a Motion to Intervene in the matter of WCHN's CON application 15-31978 on behalf of Danbury Nurses Local 5047, AFT-CT, AFT, AFL-CIO and AFT-CT, received by OHCA on March 18, 2015.

Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134

(860) 509-8075

FERGUSON, DOYLE & CHESTER, P.C.

ATTORNEYS AT LAW
Telephone (860) 529-4762
Facsimile (860) 529-0339

James C. Ferguson
Brian A. Doyle
Eric W. Chester

35 Marshall Road
Rocky Hill, CT 06067
E-Mail: office@fdclawoffice.com

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

Re: Docket No. 31978

March 16, 2015

Dear Deputy Commissioner Davis:

This office represents the Danbury Nurses, Union Local 5047, Unit 47, AFT-CT, AFT, AFL-CIO and AFT-CT, as well as LPN's Technical employees employed by Danbury Hospital.

Enclosed please find a Motion to Intervene on behalf of our members in the matter of Western Connecticut Health Network's application for the transition of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health (CCBH) outpatient primary health care programs to the Connecticut Institute For Communities, Inc.'s (CIFIC) Greater Danbury Community Health Center (GDCHC).

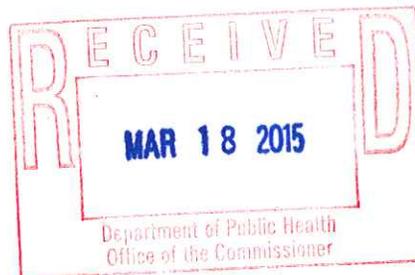
Please do not hesitate to contact me with any questions or concerns.

Sincerely,



Brian A. Doyle
FERGUSON, DOYLE & CHESTER, P.C.

BAD:jm



IN THE MATTER OF : **DOCKET NO. 31978**

WESTERN CONNECTICUT HEALTH NETWORK
APPLICATION FOR TRANSITION :

and :

DANBURY NURSES UNIT 47, AFT-CT, : **March 16, 2015**
AFT, AFL-CIO AND AFT-CT :

MOTION TO INTERVENE ON BEHALF OF DANBURY NURSES LOCAL 5047, AFT-CT, AFT, AFL-CIO AND AFT-CT

The Danbury Nurses, Local 5047, Unit 47, AFT-CT, AFT, AFL-CIO and AFT-CT moves the Office of Health Care Access to intervene as a party. The moveants have a substantial and direct interest in the subject matter.

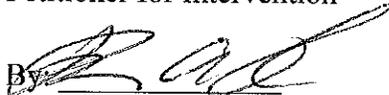
FERGUSON, DOYLE & CHESTER, P.C.
ATTORNEYS AT LAW

35 MARSHALL ROAD ~ ROCKY HILL, CT 06067 ~ TEL. (860) 529-4762 ~ FAX (860) 529-0339 ~ JURIS No. 401708



The moveant Danbury Nurses Union Local 47 represents registered nurses employed at Danbury Hospital and its satellite facilities. The moveant AFT-CT is the statewide affiliate and represents not only the before mentioned registered nurses as well as LPN's Technical employees employed by Danbury Hospital. The outcome of this matter will have a substantial impact on the moveants members. Therefore, AFT-CT, AFT, AFL-CIO respectfully requests that they be made a Party Defendant in this matter.

Respectfully submitted,
AFT Connecticut,
Petitioner for Intervention

By 

Brian A. Doyle
Ferguson, Doyle & Chester, P.C.
35 Marshall Rd.
Rocky Hill, CT 06067
(860) 529-4762
Their Attorney

FERGUSON, DOYLE & CHESTER, P.C.

ATTORNEYS AT LAW

35 MARSHALL ROAD ~ ROCKY HILL, CT 06067 ~ TEL. (860) 529-4762 ~ FAX (860) 529-0339 ~ JURIS No. 401708



Greer, Leslie

From: Martone, Kim
Sent: Monday, April 20, 2015 6:43 PM
To: Greer, Leslie; Riggott, Kaila
Subject: FW: Docket No. 15-31978-CON
Attachments: Docket No. 15-31978-CON S&F Completeness 04 20 2015.pdf

Importance: High

Sent using OWA for iPhone

From: Johnson, Michelle <Michelle.Johnson@wchn.org>
Sent: Monday, April 20, 2015 3:37:39 PM
To: Martone, Kim
Cc: Herlihy, Sally
Subject: Docket No. 15-31978-CON

Sent on behalf of Sally Herlihy, VP Planning, Western Connecticut Health Network:

Please find attached the CON Completeness Questions for the above noted docket. The original document, along with 3 copies will be sent to the OHCA offices by FedEx today.

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
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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24 Hospital Ave.
Danbury, CT 06810

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

April 20, 2015

Jessica Schaeffer-Helmecki, Program Analyst (CCT)
Department of Public Health
Office of Health Care Access
410 Capital Avenue: MS # 13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Responses to CON Completeness Questions, Docket No. 15-31978-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find Responses on behalf of The Danbury Hospital and Western Connecticut Health Network, Inc. to the Completeness Questions asked by OHCA in a letter dated March 13, 2015 in the above captioned docket. We have included the original and two hard copies of the responses, as well as a CD with an Adobe format (.pdf) of the Responses, and the Financial Attachments I (.xlsx).

Please contact me if you have any questions regarding this submission.

Sincerely,



Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosure

April 20, 2015

1. **On pages 4 and 5 of the application are copies of the newspaper order confirmation and public notice. Please provide a more legible copy of each.**

See Exhibit Q for requested documents

2. **On page 16, Table 3, the Applicant provides utilization by town for FY14; resubmit that table with only one column of numbers.**

See Exhibit R for Table 3

3. **Explain the methods by which you intend to convey your communications with patients, as outlined on page 64 of the application.**

We are implementing a comprehensive communications campaign over a period of several months to ensure a seamless transition for our patients. Our goal is to ensure our patients are informed and comfortable with all aspects of the proposed transition of services to GDCHC. Patients will receive information in English, Spanish and Portuguese face-to-face, over the phone, in writing, in media and via web-translation. See Exhibit S for a Frequently Asked Questions document that has been developed and is being shared with individuals regarding the proposed transition of services. The communications efforts are also designed to educate and engage key stakeholders such as community leaders, trusted health counselors (i.e. public health directors, other clinics), medical providers and Danbury Hospital employees.

4. **List the scholarly journals in which the literature on pages 50 and 56 were published.**

The June 2011 article titled "FQHCs: Saving the Medicaid Population in an Era of Health Reform" was obtained from Murer Consultants, Inc., a national legal-based health care management consulting firm. The company is comprised of consultants with legal backgrounds as well as varied experience in medicine, clinical services, finance and management.

The September 22, 2012 commentary titled "Federally-Qualified Health Centers: Key Access Point to Primary Care for Expanded Medicaid Population" was published in the University of Pennsylvania Leonard Davis Institute of Health Economics Voices Blog. The University of Pennsylvania established the Leonard Davis Institute of Health Economics in 1967, two years after Congress enacted Medicare. It was created to fill fundamental gaps in the evidence base that could inform policies critical to the financing and management of the nation's increasingly costly and complex health care system.

5. **Does CIFC/GDCHC have sufficient capacity at its 57 North Street, Danbury location to absorb WCHN's pediatric service patients? Please explain in detail.**

Yes. GDCHC will provide pediatric services in 3,500 square feet of space at 57 North Street. The parties are confident that GDCHC can provide access to its existing pediatric patients and the patients will be transferred from S&F in this space.

6. **Provide a copy of the grant agreement described in section 1(e) of the Letter of Intent. If you are unable to do so, please explain:**
 - a. **why the grant agreement cannot be provided**

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The grant agreement cannot be provided at this time because the parties are still finalizing the terms of the grant agreement.

b. whether the “community grant” mentioned on page 14 of the application and the “short fall” grant mentioned on page 60 are two separate grants;

The “community grant” and “short fall” grants referred to in the application are one and the same.

c. whether there is a maximum amount of grant money the Applicant will provide GDCHC; and

Yes, there is a maximum amount of grant money that the Applicant will provide to GDCHC in each year of the five (5) year grant term. The total grant to GDCHC will include (i) annual maximum cash amounts and (ii) the donation of certain equipment owned by the Applicant that will be necessary for GDCHC’s provision of services. The annual maximum cash amounts to be provided by the Applicant to GDCHC are as follows:

Year One: \$1,107,911
 Year Two: \$1,558,685
 Year Three: \$1,117,435
 Year Four: \$803,001
 Year Five: \$591,529

Each annual cash grant includes funds to reimburse GDCHC for expenses actually incurred by GDCHC for the provision of services previously provided by the Applicant. Components of the grant include (i) salary costs and benefits, (ii) costs of providing certain specialty dental services, and (iii) costs associated with electronic dental and medical records software, licenses and training and the converting paper records to electronic records; and (iv) a fixed amount of additional funds to reimburse GDCHC for additional costs associated with the transition of services to GDCHC but not anticipated by the parties, subject to the prior approval of the Applicant. Grant funds for each such component are subject to the annual cash cap above. An annual reconciliation of GDCHC’s actual costs and the grant payments made to GDCHC during the immediately preceding year will be performed.

d. whether there is a minimum and/or maximum number of years the Applicant will provide the grant(s) to GDCHC

There is no minimum number of years that the Applicant will provide the grant to GDCHC. Although the grant term has an initial five (5) year term, the grant agreement is subject to earlier termination in event of default or upon one (1) year’s prior notice by either party. Following the expiration of the initial term, the grant agreement will automatically renew for additional one (1) year terms unless a party provides notice of its intent to terminate the grant agreement. There is no maximum number of years that the Applicant will provide the grant to GDCHC.

7. Please elaborate on the “opportunities for Behavioral Health expansion” mentioned during the WCHN Board of Directors minutes on page 45 of the application.

Transitioning behavioral health services to GDCHC will increase access to care in the community because GDCHC will expand the hours during which behavioral health services are provided, by making behavioral health providers available during evening hours and on Saturdays. Additionally,

April 20, 2015

S&F patients' medical, dental and behavioral health records will be fully integrated into CIFIC's existing Electronic Health Record system, eClinicalWorks (eCW). The integrated health records system will provide a more coordinated system of care for patients requiring both medical and behavioral health services.

8. On page 18 of the application, the Applicant provides its current and projected payor mix in Table 5, showing a decrease in patient volume in 2016 and zero patient volume in 2017 as a result of the proposed CON. Please provide projected volumes without the proposed CON (i.e., if WCHN continued to operate S&F and CCBH).

Patient Population Mix without the proposed CON

(i.e. If WCHN continued to operate S&F and CCBH), with *FY2015 projected using FP1-5 actual

	Current		Projected					
	FY2014		FY2015 *		FY2016		FY2017	
	Vol	Pct	Vol	Pct	Vol	Pct	Vol	Pct
Medicare	179,389	35.4%	185,306	35.3%	185,306	35.3%	185,306	35.3%
Medicaid	93,071	18.4%	100,085	19.0%	100,085	19.0%	100,085	19.0%
CHAMPUS & TriCare	632	0.1%	607	0.1%	607	0.1%	607	0.1%
Total Government	273,092	53.9%	285,998	54.4%	285,998	54.4%	285,998	54.4%
Commercial	198,207	39.1%	204,017	38.8%	204,017	38.8%	204,017	38.8%
Uninsured	32,029	6.3%	32,513	6.2%	32,513	6.2%	32,513	6.2%
Worker's Comp	3,211	0.6%	2,998	0.6%	2,998	0.6%	2,998	0.6%
Total Non-Govt	233,447	46.1%	239,527	45.6%	239,527	45.6%	239,527	45.6%
Total Payer Mix	506,539	100.0%	525,526	100.0%	525,526	100.0%	525,526	100.0%

9. Will current patients of CIFIC have access to the specialty services at S&F?

Yes. All patients of CIFIC will have access to WCHN's specialty clinics which will continue to be located at S&F (80 Main Street).

10. Does WCHN/Danbury Hospital charge facility fees for services provided at S&F or CCBH? If yes, will facility fees be charged at S&F or CCBH once services are transferred to CIFIC/GDCHC?

Yes, WCHN/Danbury Hospital charges a facility fee for services provided at S&F and at CCBH. Following transition of services to CIFIC/GDCHC, WCHN will continue to charge a facility fee for *only* those specialty services that WCHN/Danbury Hospital will continue to provide at S&F. The primary care and behavioral health services to be provided by CIFIC/GDCHC will be billed by GDCHC and facility fees will not be charged for these services. Services provided by CIFIC/GDCHC will be subject to the fee limitations and required "sliding fee scale" of a FQHC.

11. With respect to the proposal:

- a. Identify the target patient population to be served;

The target population includes the current uninsured, underinsured and Medicaid patients receiving services at S&F, CCBH and CIFIC/GDCHC locations. GDCHC serves a ten-town region including Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman, with a population totaling 221,081. This region is also served by S&F and CCBH. Of this total population, it is estimated that 29,960 residents live 200% below the federal poverty level (UDS

April 20, 2015

Mapper). Danbury, Bethel and New Milford have the majority of low income residents in the region. Danbury alone has approximately 18,634 residents who live 200% below the federal poverty level. It is estimated that approximately 28,533 residents in GDCHC's ten-town region are without insurance and approximately 19.6% are also under age 65. These patients will receive all of these same services through GDCHC as currently provided at S&F. There will be no negative impact on the provision of care to Medicaid recipients or the indigent in this community.

b. Discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit;

The proposed transfer of services to GDCHC supports the continued delivery of health care services to the existing patient populations in the communities served by both S&F/CCBH and CIFIC/GDCH. GDCHC has experience in effectively and efficiently meeting the primary care needs of the population served by the parties. GDCHC's model of providing care as a community health center has been proven to increase access to services for uninsured and underinsured patients.

Included as Exhibit T is a March 2014 publication from the National Association of Community Health Centers titled "Access is the Answer: Community Health Centers, Primary Care and the Future of American Health Care", which highlights the valuable role that community health centers play in enhancing access to primary care services for an underserved population. As the publication states: "Health Centers' unique and comprehensive model of care complements broader insurance coverage while also filling in the gaps where insurance does not reach given limited provider availability, accessibility, or the complete lack of insurance. They stand as a proven solution for breaking down multiple barriers to care, and are ready to expand access to millions more in need, regardless of insurance status." The National Association of Community Health Centers (NACHC) was formed in 1971 by and for community-based health center programs and works closely with state primary care associations to fulfill the shared mission of delivering quality health care to those in need.

c. Explain how access to care will be affected; and

The proposed transition of the S&F primary care services and the behavioral health services from CCBH to CIFIC/GDCHC will have a positive impact on the provision of services and will expand access and availability of such services to a wider patient population. In addition, the transfer of these services to GDCHC will result in expanded service hours (beyond what is currently offered by either Danbury Hospital or GDCHC today) and an increase in the number of primary care providers and specialty providers.

d. Discuss any alternative proposals that were considered.

WCHN went through a multi-phase process in making the decision to transition the S&F Primary Care Services and the Behavioral Health Clinic Services to CIFIC/GDCHC. Alternative considerations included:

- Maintaining operations under the current hospital-based model and reducing expenses. After analysis of this option, WCHN leadership determined that this option is not economically sustainable given the capital investments required over the long term (such as electronic medical record costs), the rising expenses for staff and physician salaries and the declining Medicaid reimbursement rates for primary care and behavioral health services.

April 20, 2015

- Developing a federally qualified health center operated by Danbury Hospital. After analysis of this option, WCHN leadership determined that the difficult and lengthy process to establish a FQHC would require significant organizational focus and there is a significant risk that we would not receive federal approval for the establishment of the FQHC due to service area overlap with the existing FQHC.

12. On Financial Attachment I, page 89 of the application, the Applicant provided actual financial results for FY 2013 and projected results for fiscal years 2014 through 2018 for the entire Danbury Hospital. Please resubmit Financial Attachment I, reporting data from only S&F and CCBH.

Financial Attachment #1 limited to data for only S&F and CCBH is included as Exhibit U. In addition, we are including a revised version of Financial Attachment #1 for all of Danbury Hospital (attached as Exhibit V), to reflect the following:

- The most current version of the Grant Agreement between Danbury Hospital and CIFC
- A reallocation of some administrative expenses that were previously categorized as Other Operating Expenses
- A minor (\$16K) correction to the incremental Other Operating Income that was previously reported

13. On page 10 of the application, the Applicant references efficiencies in operations in the form of reduced overhead and reduced costs. Provide an itemization of anticipated cost savings attributable to the proposal and incorporate those savings in the proposed S&F and CCBH Financial Attachment I.

The net expense savings to the hospital are anticipated at \$5.5M by FY2017, the first full year after both phases of the transition. This figure is a combination of both salary and non-salary expenses, and consistent with the financial attachments, the breakdown is as follows:

(Dollars are in thousands)

	FY2017
Salaries & Fringe Benefits	3,451
Professional / Contracted Services	1,659
Supplies and Drugs	305
Other Operating Expense	-774
Depreciation / Amortization	110
Lease Expense	709
Total Expense Savings	5,460

14. On page 9 of the application, the Applicant states that WCHN will continue to provide specialty care clinics at S&F. What services are provided in these clinics?

The specialty clinics at S&F include the following specialties: orthopedics, spine, podiatry, urology, neurology, allergy, rheumatology, and tuberculosis

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15. On page 64 of the application, the Applicant mentions in its communication plan to stakeholders a “pharmacy program providing discounted prescriptions.” Explain the program in greater detail.

As a federally qualified health center (FQHC), CIFIC/GDCHC participates in the USD/HHS 340B Program, which is administered by the Health Resources and Services Administration (HRSA). The 340B Program allows FQHCs to purchase pharmaceuticals at deeply discounted prices and then dispense such pharmaceuticals to patients through either contract pharmacies or in-house pharmacies. At the present time, CIFIC GDCHC has a contract pharmacy relationship with Walgreens. For those CIFIC/GDCHC patients with private third party insurance, there is no change in the cost of their prescriptions (e.g. they still owe their scheduled co-payment). However, Medicaid, Medicare and self-pay patients whose prescriptions are not reimbursable by a private third party insurer, which is approximately 78% of the FQHC’s total patient population, are eligible to purchase the deeply discounted 340B prescription drugs from Walgreens. Walgreens dispenses prescription pharmaceuticals to eligible CIFIC/GDCHC patients at three locations in Danbury, including the Walgreens store at 75 Main Street, which is diagonally across the street from the current S&F Clinic. According to HRSA, “[s]tudies show that entities participating in the 340B Program are able to expand the type and volume of care they provide to the most vulnerable patient populations as a result of access to these lower cost medications.” (See: www.hrsa.gov/opa/update.html).

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EXHIBITS

Number	Description
Q	Copy of newspaper order confirmation and public notice
R	Table 3- Utilization by Town
S	Patient Communication
T	<i>"Access is the Answer: Community Health Centers, Primary Care and the Future of American Health Care"</i> , March 2014, National Association of Community Health Centers
U	Financial Attachment I, S&F and CCBH only
V	Revised Financial Attachment I, Danbury Hospital

April 20, 2015

Exhibit Q

Order Confirmation

Ad Order Number 0002048297	Customer DANB HOSP WEST CT HEALT	Print Customer DANB HOSP WEST CT HEALT
Sales Rep. dsctiani	Customer Account 197666	Print Account 197666
Order Taker dsctiani	Customer Address 24 HOSPITAL AVENUE, Ann Nichols Johnson DANBURY CT 06810 USA	Print Address 24 HOSPITAL AVENUE, Ann Nichols Johnson DANBURY CT 06810 USA
Ordered By MICHELLE JOHNSON	Customer Phone 203-739-7919	Print Phone 203-739-7919
Order Source E-mail	Customer Fax 203-739-1589	Customer Email Michelle.Johnson@wchc.org

Ad Content Front

The Danbury Hospital (DH), a subsidiary of Western Connecticut Health Network, Inc. (WCHN) is offering a Certificate of Need with the Office of Health Care Access for the transfer of CH's Senior & First Community Health Center programs and the Afternoon treatment at its Community Center for Behavioral Health (CCBH) to the Connecticut Institute for Community Health Center (CICHC). CICHC will occupy the current Senior & First location at 70 Main Street and accommodate the CCBH Afternoon program currently at 122 West Street, Danbury, CT. The total expenditure of this project is estimated to be under \$225,000.

Line Starts	Proofs	Articles	Special Pricing	Printed Type
0	0	0	None	

Order Notes:
Invoice Test:

Blind Box	Materials	Payment Method		
Net Amount	Tax Amount	Total Amount	Payment Amt	Amount Due
\$440.55	\$0.00	\$440.55	\$0.00	\$440.55

Ad Number	Ad Type	Ad Size	Rich Media Number
0002048297-01	Legal Lines	10X23 LI	

External Ad #	Ad Rejected	Ad Allotment
	No	

Color	Production Method	Production Notes
<NONE>	AdBooker	

Product	Placement Class	\$ Inserts	Cost
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Run Dates:
Sort Test:
Run Schedule Invoice Test

Danbury News-Times	Public Notices	3	\$410.25
1/8/2015 - 1/9/2015, 1/10/2015			
THE DANBURY HOSPITAL HAS SUBSIDIARY OF WESTERN CONNECTICUT HEALTH NETWORK INC The Danbury Hospital (DH), a subsidiary of Western Connecticut H			
news1mes.com:	Public Notices	3	\$30.60
1/8/2015 - 1/8/2015, 1/10/2015			
THE DANBURY HOSPITAL HAS SUBSIDIARY OF WESTERN CONNECTICUT HEALTH NETWORK INC The Danbury Hospital (DH), a subsidiary of Western Connecticut H			

PUBLIC NOTICES

LEGAL NOTICE PUBLIC HEARING

The Newtown Water and Sewer Authority hereby gives notice of a public hearing to be held on Thursday, January 8, 2015 at 7:00 p.m. at the Wastewater Treatment Facility, Commerce Road, Newtown, CT to consider the following:

Proposed amendments to the Sewer Use Regulations dated 8/11/11 and to the Water pollution Control Plan dated 8/13/2009.

A copy of the proposed changes are available for review at the Town Clerks Office in the Municipal Building, 3 Primrose Street, Newtown, CT.

If you plan to attend this meeting and require assisted hearing devices or an interpreter, please contact the Office of the First Selectman (203-270-4201) at least forty-eight hours prior to meeting.

Water and Sewer Authority
Marianne Brown, Chairman

The Danbury Hospital (DH), a subsidiary of Western Connecticut Health Network, Inc. (WCHN) is filing a Certificate of Need with the Office of Health Care Access for the transition of DH's Seifert & Ford Community Health Center programs and the Aftercare treatment at its Community Center for Behavioral Health (CCBH) to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center (GDCHC). GDCHC will occupy the current Seifert & Ford location at 70 Main Street and accommodate the CCBH Aftercare program currently at 152 West Street, Danbury, CT. The capital expenditure of this project is estimated to be under \$225,000.

GENERAL HELP WANTED

ASSISTANT FOR PUBLISHER

located in Danbury: customer service, administrative duties, light book-keeping. Must know MS Word, Quick Books, Excel, Power Point. Full time with benefits.

Fax resume: 203-938-7088

AUTO BODY FRAME TECH

needed for collision repair shop. Exp & own tools. Comp sal. Call 203-748-0579/ fdcash@comcast.net

CASHIER- Part -Time

Hilario's Super Variety
Evenings & Weekends. M-F
6pm-10pm, Sat 4pm-10pm,
Sun 8am-4pm. Responsibilities: Gas
Attendent, Deli clerk. Must be
motivated. Fax resume, 203-270-8211

DAYCARE- Danbury area Daycare seeks loving, patient, energetic & reliable FT & PT daycare Teacher's Asst. Serious inquiries only. Contact Kathy or Trish (203)-791-9000.

Framers Needed

Call 203-240-6219

MAINTENANCE PERSONAL/PORTERS

Greentree Toyota is the immediate need of maintenance personal/porters, entry level & experienced technicians & office staff. Responsibilities for porters include everything from cleaning and maintaining building to assisting staff with our customers. Office staff will answer phones, scan documents, make appointments, complete the daily deposit & assist management. We offer a 40 hour work week, 401k, health/dental Insurance, & uniforms.

All interested candidates should go to greentreemomotr.com, click on the information link then employment, & fill out the on line application. Please call (203) 775-6221 ask to speak to Chris Morgado to arrange an interview.

OFFICE MANAGER with experience in managing & motivating staff. Homecare agency exp. a

GENERAL HELP

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and Fall) and a 16U C
and Fall). These are p
Please forward your qu
any questions to penm

HEALTHCARE EMPLOYMENT

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Billing & Coder & S
for busy multi office su
Experience rec
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email mellissa@aol

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ATTENT

The advertiser
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service

CAREGIVER COMPANION

I am a CNA with our
references. Well know
local & NYC doctors

April 20, 2015

Exhibit R

TABLE 3
FY 2014 Utilization by Town
(October 1, 2013 – September 30, 2014)

TOWN	Utilization FY14 # Visits
Danbury, CT	37,619
Bethel, CT	3,327
Brookfield, CT	1,452
New Milford, CT	1,254
New Fairfield, CT	1,177
Ridgefield, CT	994
Newtown, CT	875
Sandy Hook, CT	603
Redding, CT	357
Waterbury, CT	238
Southbury, CT	190
Woodbury, CT	113
Wilton, CT	89
Hawleyville, CT	84
Monroe, CT	75
Sherman, CT	70
Roxbury, CT	57
Naugatuck, CT	49
Oakville, CT	39
Brewster, NY	36
South Meriden, CT	36
Weston, CT	32
Redding Ridge, CT	29
Pleasant Valley, NY	27
Gaylordsville, CT	26
Middlebury, CT	25
14 towns with 10-24 each	219
66 towns with <10 each	223
TOTAL	49,324

April 20, 2015

Exhibit S



DANBURY HOSPITAL

Frequently Asked Questions- Seifert and Ford Community Health Center Transition

- **What is happening at Seifert & Ford?** Danbury Hospital is planning to transition the primary care medical services currently offered at WCHN's Seifert and Ford Community Health Center (S&F), as well as the Community Center for Behavioral Health (CCBH) located on West Street in Danbury, to the Greater Danbury Community Health Center (GDCHC) which is sponsored by Connecticut Institute For Communities, Inc. (CIFC). The GDCHC is well known and highly respected in Danbury currently seeing patients at 57 North Street - right down the street.
- **What services will transition?** Primary care (adult, women's, pediatric), dental care and outpatient behavioral health – including our doctors who provide these services – would transition as part of this plan. We are working closely with the GDCHC to retain existing staff, or where we can, find placements for staff in other areas within our health network.
- **Why is this plan a good idea?** The transition of these services to CIFC will ensure that patients at S&F and CCBH continue to have local access to high-quality medical and behavioral health care, as well as a primary care medical home, expanded service hours, access to discounted prescriptions, and an enhanced electronic health record.
- **When do you expect this to take place?** While we have filed an application for this change with the State, it could take many months for an approval. We are still in the planning stage – working out details to ensure patients have uninterrupted access to the care they need. Timing should become clearer over the next several months.
- **What does this mean for me and my family?** At some point in the future, and after we receive necessary approvals, patients will benefit from more convenient access to care, evening and weekend hours, access to more physicians and staff, and pharmacy discounts to help with prescription costs.
- **When will more details be available?** It is our intent to keep you updated whenever we have news to share; however, that may not be for weeks or even months.
- **What if I have questions?** Please ask us during your visit or send us an email: 70mainstreet@wchn.org.

2/24/15

April 20, 2015



DANBURY HOSPITAL

Perguntas frequentes - Transferência do Centro Comunitário de Saúde Seifert and Ford

- **O que está acontecendo no Seifert & Ford?** O Danbury Hospital planeja transferir os serviços médicos oferecidos atualmente no Centro Comunitário de Saúde Seifert and Ford (S&F) da WCHN, assim como o Centro Comunitário de Saúde Comportamental (CCBH, Community Center for Behavioral Health), localizados na West Street em Danbury, para o Centro de Saúde Comunitária da Grande Danbury (GDCHC, Greater Danbury Community Health Center), que é mantido pelo Connecticut Institute For Communities, Inc. (CIFIC). O GDCHC é conhecido e altamente respeitado em Danbury, e atualmente atende a seus pacientes na 57 North Street, próxima ao S&F.
- **Quais serviços serão transferidos?** Atendimento básico (adulto, ginecológico e pediátrico), assistência odontológica e atendimento ambulatorial de saúde comportamental seriam transferidos como parte desse plano, incluindo os médicos que prestam esses serviços. Estamos trabalhando com o GDCHC para manter a equipe existente ou, quando possível, encontrar vagas para a equipe em outras áreas de nossa rede de saúde.
- **Por que esse plano é uma boa ideia?** A transferência desses serviços para o CIFIC garantirá que os pacientes do S&F e do CCBH continuem a ter acesso local a atendimento médico e de saúde comportamental de alta qualidade, assim como a cuidados médicos básicos contínuos e a um registro eletrônico de saúde aprimorado.
- **Quando isso acontecerá?** Apesar de já termos solicitado a mudança ao Estado de Connecticut, pode levar muitos meses até que ela seja aprovada. Ainda estamos na fase de planejamento, pensando nos detalhes para garantir que os pacientes tenham acesso ininterrupto ao atendimento necessário. Nos próximos meses, os prazos deverão estar mais definidos.
- **O que isso significa para mim e para minha família?** No futuro, após o recebimento das aprovações necessárias, os pacientes serão beneficiados com um acesso mais conveniente ao atendimento, horários noturnos e nos fins de semana, acesso a mais médicos e equipes, além de descontos em farmácias para ajudar nos gastos com medicamentos prescritos.
- **Quando terei acesso a mais detalhes?** Nossa intenção é informá-lo assim que tivermos novidades, mas pode ser que isso não ocorra nas próximas semanas ou meses.
- **E se eu tiver mais dúvidas?** Você pode tirar suas dúvidas quando vier ao hospital ou pelo e-mail: 70mainstreet@wchn.org.

2/24/15

April 20, 2015



DANBURY HOSPITAL

Preguntas frecuentes: Transición del Seifert and Ford Community Health Center

- **¿Qué está sucediendo en Seifert & Ford?** Danbury Hospital está planeando trasladar los servicios médicos que actualmente se ofrecen en Seifert and Ford Community Health Center (S&F) de WCHN, así como también Community Center for Behavioral Health (CCBH) ubicado en West Street en Danbury, a Greater Danbury Community Health Center (GDCHC), el cual es patrocinado por Connecticut Institute For Communities, Inc. (CIFIC). El GDCHC es conocido y altamente respetado en Danbury que actualmente atiende a los pacientes en 57 North Street que está en la misma calle.
- **¿Qué servicios entrarán en transición?** Los cuidados primarios (para adultos, mujeres, pediátricos), cuidado dental y salud mental ambulatoria – así como también nuestros doctores que proporcionan estos servicios – entrarán en transición como parte del plan. Estamos trabajando conjuntamente con el GDCHC para conservar al personal existente, o donde podamos, reubicarlos en otras áreas dentro de nuestra red de salud.
- **¿Por qué este plan es una buena idea?** Las transición de estos servicios a CIFIC garantizará que los pacientes de S&F y CCBH continúen teniendo acceso local a cuidados de la salud mental y médicos de alta calidad como también un centro médico de cuidados primarios y un historial médico electrónico mejorado.
- **¿Cuándo espera que esto suceda?** Hemos presentado una solicitud al Estado para realizar este cambio, lo que podría tomar varios meses para que sea autorizada. Todavía estamos en la fase de planificación; estamos trabajando en los detalles para asegurarnos de que los pacientes tengan un acceso interrumpido a los cuidados que necesiten. Las fechas deberían definirse claramente en los próximos meses.
- **¿Qué significa esto para mí y mi familia?** En algún punto en el futuro, y después de que hayamos recibido las autorizaciones necesarias, los pacientes se beneficiarán de un acceso más conveniente a la atención médica, en horas de la noche y de los fines de semana, acceso a más médicos y al personal y descuentos de farmacia para ayudarles con los costos de las recetas.
- **¿Cuándo nos brindarán mayor información al respecto?** Tenemos la intención de mantenerlos informados en cuanto tengamos noticias que compartir; sin embargo, esto podría no darse en semanas o incluso en meses.
- **¿A quién puedo dirigirme si tengo alguna pregunta?** Por favor consúltenos durante su visita o envíenos un correo electrónico a: 70mainstreet@wchn.org.

April 20, 2015

Exhibit T



NATIONAL ASSOCIATION OF
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MARCH
2014

Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care

This year, millions of Americans will gain insurance coverage, many or most for the first time in years, if ever. That accomplishment, though historic, misses a key point: expanding health care coverage without addressing the need to provide access to high-quality preventive and primary care services addresses only part of the health care equation. **Access is more than just having an insurance card. It is more than getting care in an emergency room.** Access is having a regular, reliable source of quality preventive and primary health care. Unfortunately, too many uninsured – and even insured – Americans have inadequate access to primary care.

People can experience barriers to high-quality, comprehensive primary and preventive care in many forms, including the **availability** of providers where health care resources are scarce, the **affordability** of care regardless of insurance status, or the **accessibility** of providers who understand the culture, language, transportation challenges, and preferences of the surrounding community. Even among people who have an insurance card access may be out of reach because of who they are and where they live.

Our new research uncovers that **62 million people nationwide have no or inadequate access to primary care given local shortages of such physicians**— one important indicator of unmet health needs (Figure 1). Our research, conducted with the Robert Graham Center, also finds that this population represents U.S. residents from all walks of life:

- 43% are low-income, 28% live in rural areas, and 38% are racial/ethnic minorities.
- The vast majority actually have insurance (22% have Medicaid, 58% have other insurance, and 21% are uninsured). However, the uninsured are more affected by the shortage of primary care, with 30% of all uninsured Americans affected compared to 21% of all insured.¹

The impact of improving access to primary care on our nation's health care system cannot be overstated. Research shows that having a usual source of care improves health more effectively than having insurance alone.² When people have access to primary care, health problems are detected and treated before they can become serious and require hospitalization. Extensive evidence documents that access to primary care results in better health outcomes, reduced health disparities, and lower health care expenditures.³ Yet primary care remains off limits to many, including some with chronic illness.

Clearly, **Access is the Answer** to what plagues the American health care system. Expanding access to primary and preventive care improves health and lowers costs, and is the foundation for driving higher quality care.⁴ The good news is that a proven solution exists to expand access to care.

Our research demonstrates that **if it were not for Community Health Centers, 21 million more people could experience the barrier of primary care provider shortages** (Figure 2).

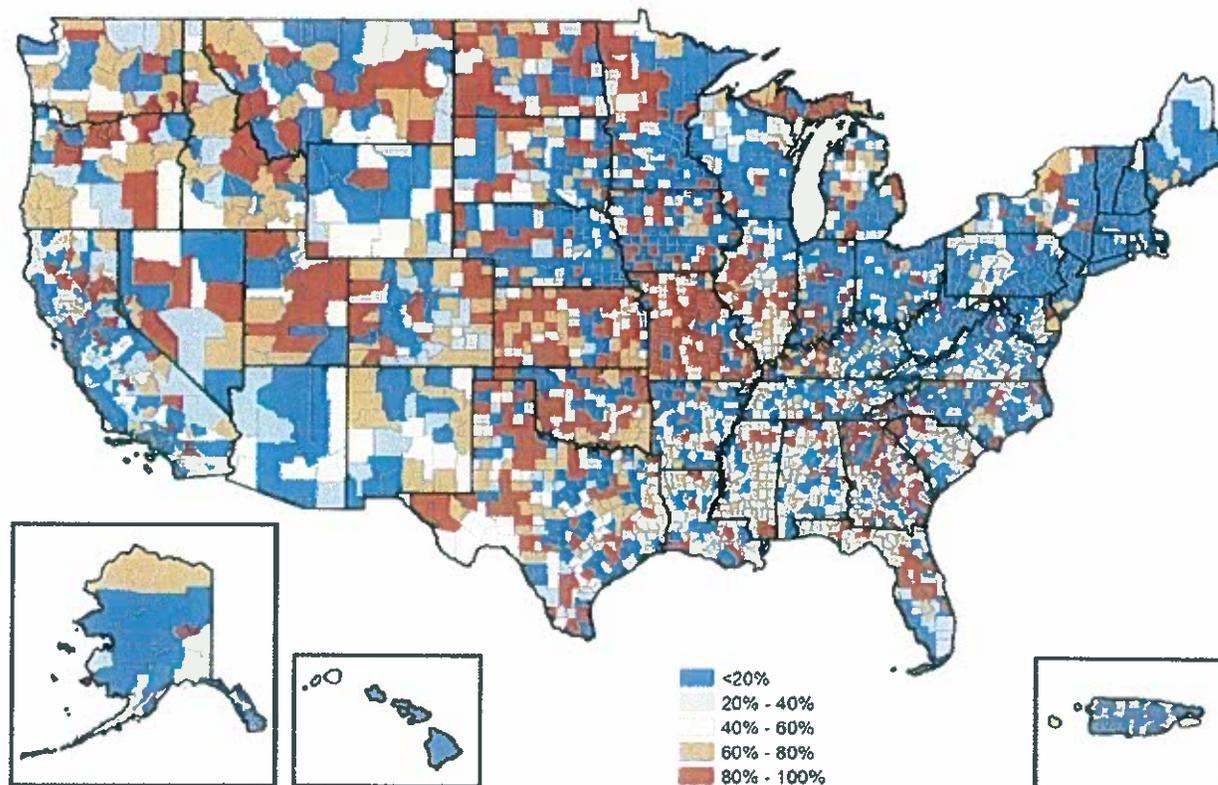
The federal Health Center Program has nearly 50 years of experience in breaking down the many complex barriers to care that people often confront. They provide high-quality, cost-effective primary and preventive care to traditionally underserved communities across America (Figure 3). Currently, Health Centers serve over 22 million people through over 9,000 urban, suburban and rural locations in every state and territory. Research demonstrates their ability to improve access to a regular source of care while holding down emergency room visits and overall health care costs. **Today, demand for Health Centers is escalating under health reform, and they stand ready to apply their proven model in more medically disenfranchised communities across the nation.**



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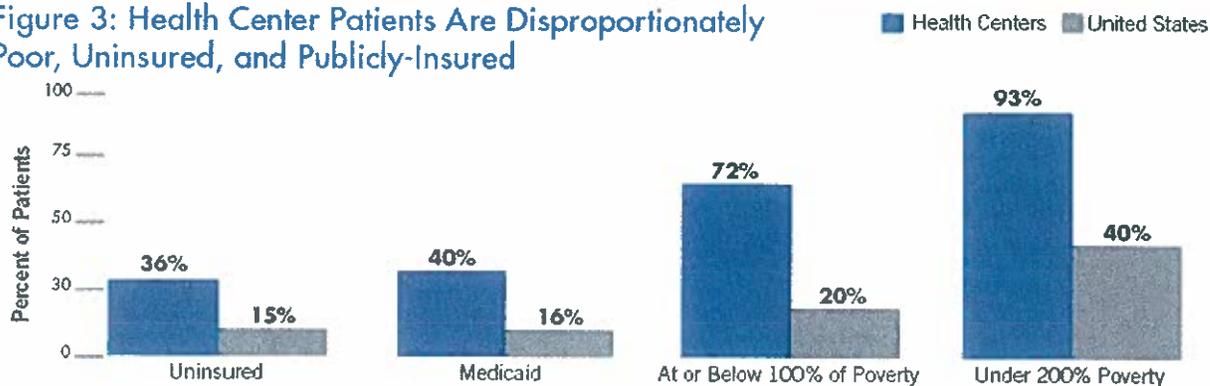
ACCESS IS THE ANSWER

Figure 1: Estimated Percent of County Residents Experiencing Shortages of Primary Physicians, 2013



Source: Created by The Robert Graham Center (2014). US Census 2010; HRSA Data Warehouse 2014 HPSA and MUA/P shapefiles; AMA Masterfile 2013; UDS Mapper 2014.

Figure 3: Health Center Patients Are Disproportionately Poor, Uninsured, and Publicly-Insured



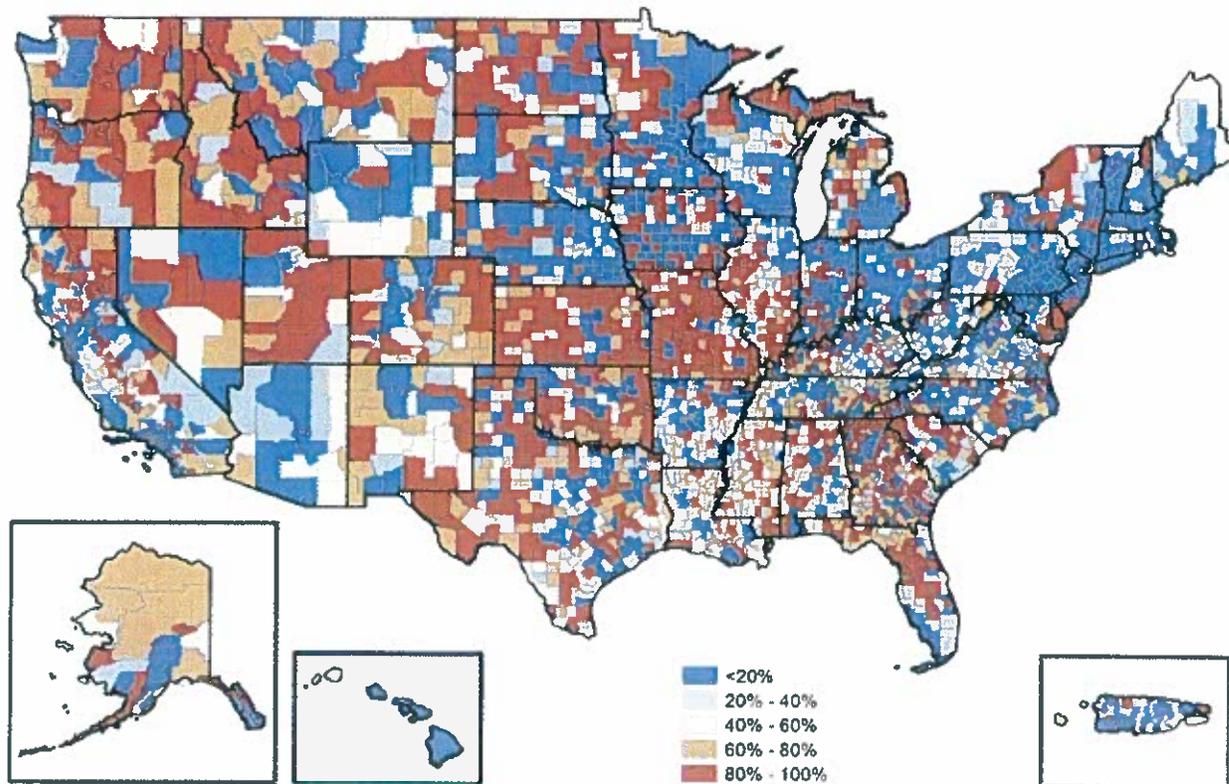
Source: Health Centers data: Based on Bureau of Primary Health Care, HRSA, DHHS, 2012 Uniform Data System. Source for Health Coverage and Poverty data: U.S., Kaiser Family Foundation, State Health Facts Online, www.statehealthfacts.org. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).



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Figure 2: Without Community Health Centers: Estimated Percent of County Residents Experiencing Shortage of Primary Care Physicians, 2013



Source: Created by The Robert Graham Center (2014). US Census 2010; HRSA Data Warehouse 2014 HPSA and MUA/P shapefiles; AMA Masterfile 2013; UDS Mapper 2014.

HEALTH CENTERS AND HEALTH CENTER EXPANSION ARE THE KEY TO ACCESS

The federal Health Center Program is made up of Community, Migrant, Homeless, and Public Housing Health Centers, often collectively known as Community Health Centers or Health Centers. Each Health Center has a federal mandate to improve access to regular, primary and preventive care for populations that would otherwise go without. Strengthening and expanding Health Centers nationwide makes sense as a pragmatic approach that will alleviate the nation's primary care access challenges, especially as insurance coverage expansions roll forward. **Health Centers have a proven record of reaching people and communities most in**

need, delivering high-quality care, and saving the health care system \$24 billion a year.

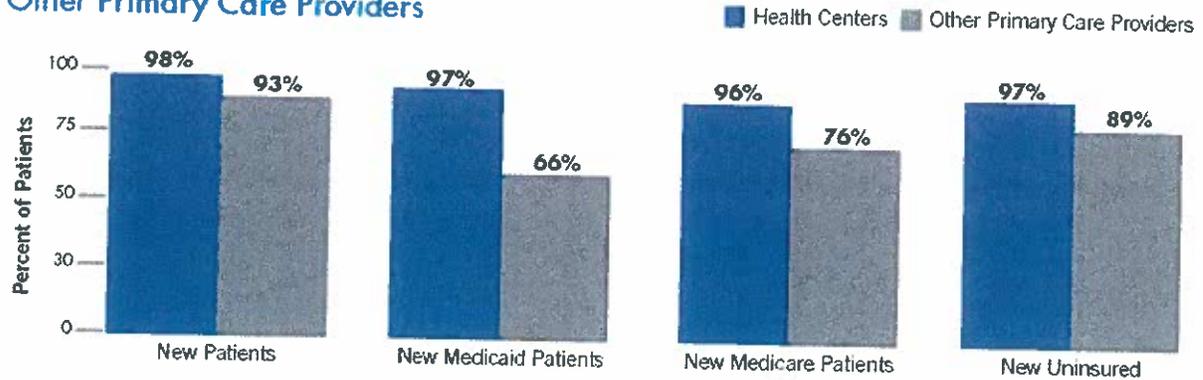
Improving Access is the Health Center Model

Health Centers are not only *in* the communities they serve but are largely made up of the communities in which they thrive. Federal law requires that they operate under the direction of patient-majority governing boards, and that they serve underserved communities and populations where care is needed but scarce. They are mandated to accept all patients no matter their ability to pay and to tailor their services to fit the special needs and priorities of their diverse communities.



ACCESS IS THE ANSWER.

Figure 4: Health Centers Have Higher Rates of Accepting New Patients Compared to Other Primary Care Providers



Source: Hing E, Hooker RS, Ashman JJ. Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. J Community Health. 2010 Nov 3 published.

Evidence shows that patients choose Health Centers because they are convenient, culturally competent, affordable, and offer a range of services under one roof,⁵ making it easier for patients to access and use care regularly – the first step in staying healthy and productive. In fact, **low-income communities with greater federal Health Center funding have better access to care** than communities with less federal Health Center funding.⁶

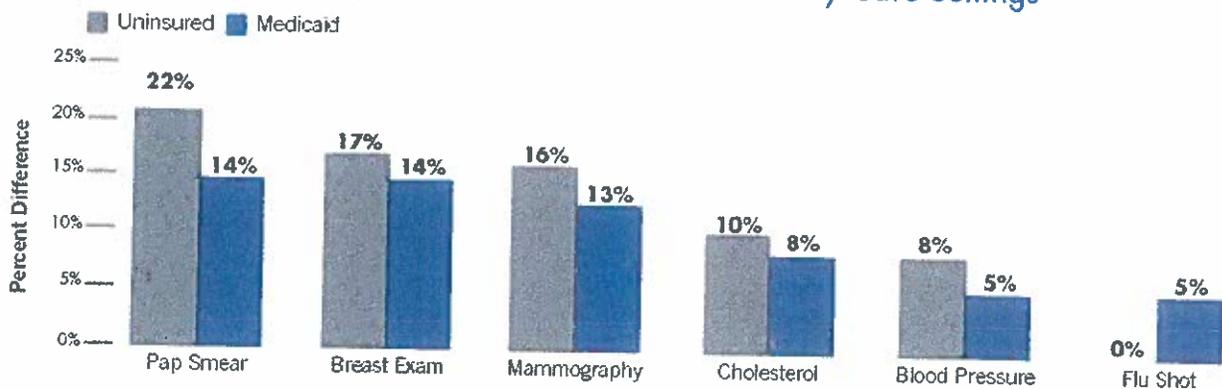
of preventive care services not typically seen in other primary care settings, such as dental, mental health and substance abuse, vision, and pharmacy services.

Health Centers Provide High-Quality Care

Despite serving traditionally underserved patient populations, Health Centers have established an impressive record of delivering high-quality care. Research has shown that Health Centers provide better or equal care compared to other primary care providers, all while serving communities with more chronic illness and socioeconomic complexity.⁸ And their patients receive more preventive services, such as immunizations, health education,

Compared to other primary care providers, Health Centers are more likely to accept new patients (Figure 4), and to offer evening or weekend hours.⁷ Health Centers' comprehensive model reaches beyond the traditional scope of primary care to provide a full range

Figure 5: Uninsured and Medicaid Health Center Patients Receive More Selected Preventive Services Compared to Patients at Other Primary Care Settings



Source: Cox, A., Pylpchuck, Y., Shin, P., and Rosenbaum, S. Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers. Gelger Gibson/RCHN Community Health Foundation Research Brief #4. August 2008.



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mammograms, pap smears, and other screenings, than patients of other providers (Figure 5).⁹

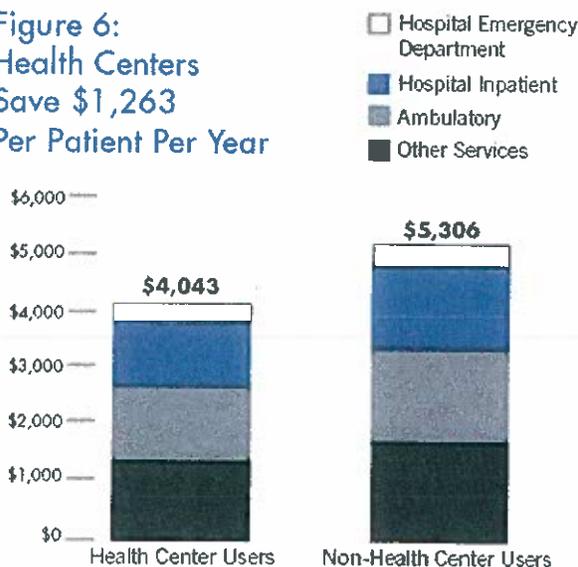
Moreover, their care leads to positive results for their high-risk patients. Nearly all Health Centers outperform the average Medicaid Managed Care Organization performance benchmark for diabetes control, hypertension control, and receipt of a Pap test.¹⁰ They also consistently perform better than the national average for low birth weight and narrow racial and ethnic disparities in low birth weight babies.¹¹

Patients recognize these quality achievements. In fact, Health Center patients report higher rates of satisfaction with hours of operation and overall care received than the general U.S. patient population.¹²

Health Centers Save the Health System Money

The American health care system struggles with ballooning costs because the current care delivery system is fragmented and patients rely too heavily on costly, inefficient settings – like hospital emergency departments – to receive even routine services or care that could have been avoided through timely prevention. Greater federal Health Center funding and capacity have been shown to lower emergency department utilization among populations that historically experience access challenges, including the low-income, Medicaid-enrolled, uninsured, and rural communities.¹³

Figure 6:
Health Centers
Save \$1,263
Per Patient Per Year



Source: NACHC analysis based on Ku L et al. Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs. GWU Department of Health Policy. Policy Research Brief No. 14. September 2009.

Health Centers save **\$1,263 per person per year** because their care is timely, appropriate for the patient and efficient. As a result, costs are lowered across the delivery system from ambulatory care settings to the emergency department to hospital stays (Figure 6). **Not only is their cost of care low, they also generate savings of \$24 billion a year for the entire health system**, including \$6.7 billion in savings for the federal share of the Medicaid program.¹⁴

HEALTH REFORM WILL MEAN MORE DEMAND FOR HEALTH CENTERS

Now and into tomorrow Health Centers will remain a key source of primary care for the uninsured and underinsured, who will rely on Health Centers more heavily for their care needs even after health reform expansion winds down. Although Health Centers will serve more Medicaid and privately insured patients, approximately 40% of Health Centers' currently uninsured patients could remain without insurance coverage,¹⁵ and new uninsured patients will turn to Health Centers as their best option for care.

Demand for Health Center services will continue to climb. This was the case in Massachusetts after the Commonwealth launched health reform in 2006. In 2005, prior to reform, 36% of Massachusetts Health Center patients were uninsured. This dropped to 20% by 2009 as more patients were covered by Medicaid and Commonwealth Care. Yet Health Centers continued to serve a disproportionate share of the Commonwealth's total uninsured residents – rising from 22% of all Massachusetts uninsured residents in 2006 to 38% in 2009. Many of these patients could not find care elsewhere, and many were adults with complex and unmanaged chronic conditions, including mental illness.¹⁶

As more Americans realize the promise of insurance coverage, they are also likely to experience the realities of accessing care. **Expanding the reach of Health Centers will be a crucial tool in meeting demand, and with appropriate support, Health Centers stand ready to expand access today and into the future.**



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ACCESS IS THE ANSWER

THE ROAD AHEAD: OVERCOMING CHALLENGES TO FACILITATE EXPANDED ACCESS TO CARE

In order to turn the vision of Community Health Center expansion into reality, there must be an ongoing, multi-faceted effort to assure that Health Centers are equipped with adequate resources. Adequate resources are necessary for maintaining the Health Center Program's current reach of 22 million medically vulnerable patients, as well as extending their reach into the vast medically disenfranchised and underserved communities across the nation.

Strengthening Federal Health Center Funding and Fixing the Primary Care Cliff

The Affordable Care Act (ACA) created the mandatory Health Center Trust Fund to grow the program over existing discretionary funding levels, but the full potential of this fund was never realized. In FY2011, Congress cut funding for the Health Center Program's discretionary base by \$600 million annually, slashing the Trust Fund's impact by approximately \$3 billion over 5 years. Additionally, sequestration has further eroded the ACA's investment in Health Centers.

Under current law, the Health Center Trust Fund is slated to expire by FY2016, leaving only discretionary funding to cover the program's operations. Even assuming no further reductions (including no further sequestration cuts), **current law would lead to a 70% funding reduction for all existing Health Centers** (Figure 7). This reduction would be catastrophic for centers, forcing them to close sites, lay off staff, and reduce services at the very time their

primary care capacity is needed most. Similarly, crucial primary care workforce development programs are also facing expiring mandatory funds.

In order to secure and expand access to care for millions, **Congress should reauthorize the mandatory Health Center Trust Fund for FYs 2016-2020** with sufficient funding for Health Centers to serve 35 million patients by 2020. Additionally, Congress should continue funding for the vitally important National Health Service Corps and Teaching Health Center primary care workforce programs.

Ensuring Fair and Adequate Medicaid Reimbursement

As many current and future Health Center patients become eligible for Medicaid, adequate Medicaid payments become even more essential for Health Centers' sustainability. Medicaid is the largest insurer of Health Center patients and represents 38% of total revenue – Health Centers' largest source of financing and directly proportional to the percent of patients with Medicaid. Over the years, Medicaid reimbursement has fallen notably below costs at a time when Health Centers serve more Medicaid patients (Figure 8). The expected increase in patient volume will not make up for per-patient revenue losses.

Health Centers' Medicaid payments are intended to cover their comprehensive services, including dental, mental health, and pharmacy services. This payment structure also ensures that Health Center grant revenues can be dedicated to care for the uninsured rather than subsidizing care for Medicaid patients.

Figure 7: Health Center Funding Under Current Law
Community Health Center Funding: FY 2010 – FY 2016

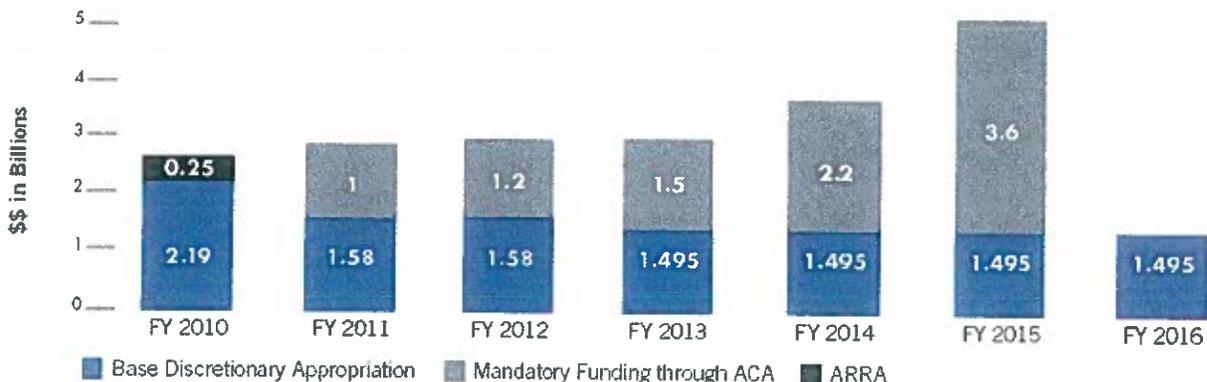
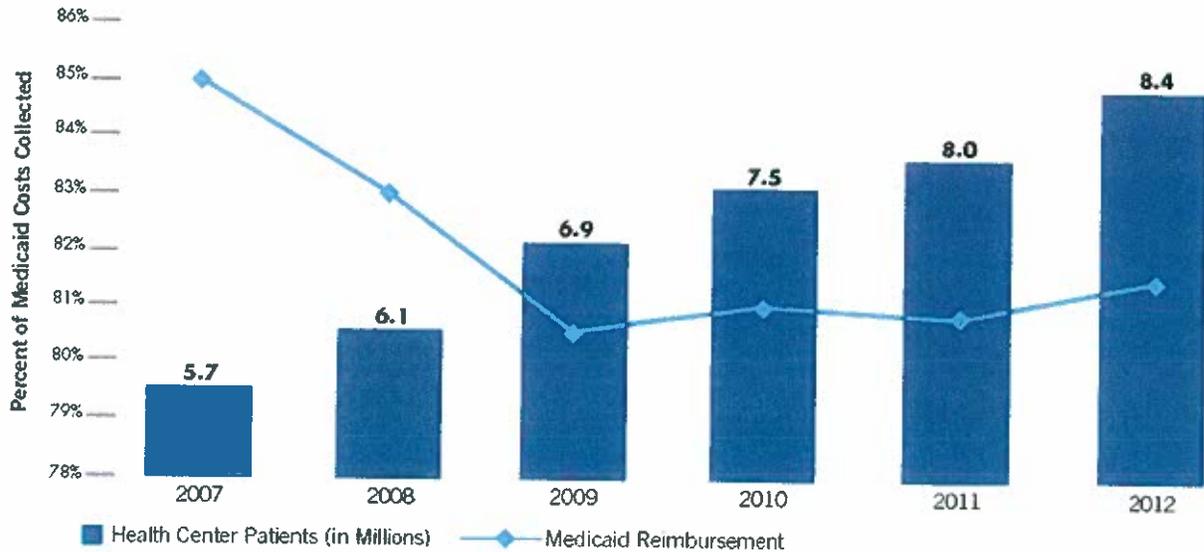


Figure 8: Medicaid Reimbursement Rate Has Declined as Health Center Medicaid Patients Have Increased



Since this reimbursement requirement went into effect, Health Centers were able to apply their freed-up grant funds to double the number of uninsured patients they serve.

As states examine varying options for expanding and reforming Medicaid, and as Congress examines the future viability of the program, **policymakers must ensure that Health Centers continue to receive Medicaid payment under their current Federally-Qualified Health Center prospective payment system (PPS).**

ACCESS IS THE ANSWER: MAKING MEANINGFUL CARE A REALITY FOR ALL

Although having insurance overcomes many fiscal barriers to accessing health care, it is not enough to guarantee access to an accessible, high-quality usual source of primary and preventive care, including dental, behavioral health, and pharmacy care that are also critically important for improving health.

Health Centers' unique and comprehensive model of care complements broader insurance coverage while also filling in the gaps where insurance does not reach given limited provider availability, accessibility, or the complete lack of insurance. They stand as a proven solution for breaking down multiple barriers to care, and are ready to expand access to millions more in need, regardless of insurance status.

In order to turn this vision into reality, increased federal funding and adequate reimbursement from third-party payers are the first steps in assuring that Health Centers have the resources, staffing, and facilities necessary to serve as a true health home to all Americans in need.



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Seifert & Ford Clinic CON - Docket No. 15-31978-CON

Completeness Question #12. Financial Attachment I for S&F & CCBH Only

(Dollars are in thousands)

Description	FY2013 Actual Actuals	FY2014 Actual Actuals	FY2015 Projected Actuals	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected Actuals	FY2016 Projected Incremental	FY2016 Projected With CON	FY2017 Projected Actuals	FY2017 Projected Incremental	FY2017 Projected With CON	FY2018 Projected Actuals	FY2018 Projected Incremental	FY2018 Projected With CON
NET PATIENT REVENUE														
Non-Government	822	842	842	(65)	777	842	(405)	437	842	(839)	3	842	(839)	3
Medicare	683	608	608	(47)	561	608	(286)	323	608	(581)	27	608	(581)	27
Medicaid and Other Medical Assistance	1,779	1,834	1,834	(265)	1,569	1,834	(1,210)	624	1,834	(1,666)	168	1,834	(1,666)	168
Total Net Patient Revenue	3,284	3,284	3,284	(\$376)	2,908	3,284	(\$1,901)	1,383	3,284	(\$3,087)	\$197	3,284	(\$3,087)	197
Other Operating Revenue	\$519	\$544	\$544	(24)	\$520	\$544	(208)	\$336	\$544	(544)	\$0	\$544	(544)	\$0
Revenue from Operations	\$3,803	\$3,828	\$3,828	(\$401)	\$3,428	\$3,828	(\$2,109)	\$1,719	\$3,828	(\$3,631)	\$197	\$3,828	(\$3,631)	\$197
OPERATING EXPENSES														
Salaries and Fringe Benefits	\$4,480	\$4,182	\$4,182	(381)	\$3,800	\$4,182	(1,975)	\$2,207	\$4,182	(3,451)	\$731	\$4,182	(3,836)	\$346
Professional / Contracted Services	2,414	2,367	2,367	(242)	2,125	2,367	(1,142)	1,225	2,367	(1,659)	708	2,367	(1,665)	702
Supplies and Drugs	305	320	320	(38)	282	320	(190)	130	320	(305)	14	320	(305)	14
Other Operating Expense	620	699	699	215	914	699	865	1,565	699	774	1,473	699	364	1,063
Subtotal	\$7,819	\$7,568	\$7,568	(\$447)	\$7,121	\$7,568	(2,442)	\$5,128	\$7,568	(4,642)	\$2,926	\$7,568	(5,442)	\$2,126
Depreciation/Amortization	101	112	112	(14)	98	112	(69)	43	112	(110)	3	112	(110)	3
Interest Expense	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lease Expense	795	757	757	(118)	639	757	(533)	225	757	(709)	49	757	(709)	49
Total Operating Expenses	\$8,714	\$8,438	\$8,438	(\$579)	\$7,858	\$8,438	(\$3,043)	\$5,394	\$8,438	(5,460)	\$2,978	\$8,438	(6,261)	\$2,177
Gain/(Loss) from Operations	(\$4,911)	(\$4,609)	(\$4,609)	\$179	(\$4,430)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$1,829	(\$2,780)	(\$4,609)	\$2,630	(\$1,980)
Plus: Non-Operating Income	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Income before provision for income taxes	(\$4,911)	(\$4,609)	(\$4,609)	\$179	(\$4,430)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$1,829	(\$2,780)	(\$4,609)	\$2,630	(\$1,980)
Provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Revenue Over/(Under) Expense	(\$4,911)	(\$4,609)	(\$4,609)	\$179	(\$4,430)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$1,829	(\$2,780)	(\$4,609)	\$2,630	(\$1,980)
FTEs	59.9	56.1	56.1	(8.4)	47.7	56.1	(38.5)	17.6	56.1	(53.6)	2.5	56.1	(53.6)	2.5
*Volume Statistics: Clinic Visits	56,695	51,744	55,924	(7,081)	48,843	55,924	(34,610)	21,314	55,924	(53,464)	2,460	55,924	(53,464)	2,460

** Baseline financials w/o CON held constant pending decision on FQ Business Proposal

Exhibit V

Seifert & Ford Clinic CON - Docket No. 15-31978-CON

**Question 7a. Financial Attachment I
REVISED**

(Dollars are in thousands)
Total Facility:

Description	FY 2013 Actual	FY 2014 Actual	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	FY 2017 Projected Actuals	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected Actuals	FY 2018 Projected Incremental	FY 2018 Projected With CON
NET PATIENT REVENUE														
Non-Government	296,229	296,863	333,642	(65)	333,577	340,316	(405)	339,911	347,123	(839)	346,284	354,067	(839)	353,227
Medicare	175,171	182,492	209,882	(47)	209,835	209,861	(286)	209,575	209,840	(581)	209,259	209,819	(581)	209,238
Medicaid and Other Medical Assistance	30,463	25,138	25,960	(265)	25,995	25,861	(1,210)	24,651	25,862	(1,666)	24,196	25,863	(1,666)	24,197
Total Net Patient Revenue	501,863	504,493	569,384	(\$376)	569,408	576,038	(\$1,901)	574,137	582,825	(\$3,087)	579,739	589,749	(\$3,087)	586,662
Other Operating Revenue	\$15,261	\$16,727	\$17,129	(24)	\$17,105	\$17,129	(208)	\$16,921	\$17,129	(544)	\$16,585	\$17,129	(544)	\$16,585
Revenue from Operations	\$517,124	\$521,220	\$586,513	(\$401)	\$586,113	\$593,167	(\$2,109)	\$591,058	\$599,954	(\$3,631)	\$596,323	\$606,876	(\$3,631)	\$603,247
OPERATING EXPENSES														
Salaries and Fringe Benefits	\$240,060	\$239,819	\$267,026	(381)	\$266,645	\$268,361	(1,975)	\$266,386	\$269,703	(3,451)	\$266,252	\$271,052	(3,836)	\$267,216
Professional / Contracted Services	58,192	61,072	73,670	(242)	73,428	74,407	(1,142)	73,265	75,151	(1,659)	73,492	75,902	(1,685)	74,237
Supplies and Drugs	79,427	82,494	93,282	(38)	93,244	96,080	(190)	95,890	98,963	(305)	98,658	101,932	(305)	101,627
Other Operating Expense	68,732	72,654	78,154	215	78,369	78,936	865	79,801	79,725	774	80,499	80,522	364	80,886
Subtotal	\$446,410	\$456,040	\$512,132	(\$447)	\$511,685	\$517,784	(2,442)	\$515,343	\$523,542	(4,642)	\$518,900	\$529,408	(5,442)	\$523,966
Depreciation/Amortization	30,033	31,682	44,391	(14)	44,377	46,191	(69)	46,122	47,991	(110)	47,881	49,791	(110)	49,681
Interest Expense	3,984	4,557	7,700	-	7,700	7,571	-	7,571	7,450	-	7,450	7,328	-	7,328
Lease Expense	7,965	8,069	8,575	(118)	8,456	8,746	(533)	8,213	8,921	(709)	8,212	9,099	(709)	8,391
Total Operating Expenses	\$488,382	\$500,348	\$572,798	(\$579)	\$572,219	\$580,293	(\$3,043)	\$577,249	\$587,903	(5,460)	\$582,443	\$595,626	(6,261)	\$589,366
Gain/(Loss) from Operations	\$28,732	\$20,872	\$13,715	\$179	\$13,894	\$12,875	\$934	\$13,809	\$12,051	\$1,829	\$13,880	\$11,252	\$2,630	\$13,881
Plus: Non-Operating Income	\$9,910	\$14,760	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500
Income before provision for income taxes	\$38,642	\$35,632	\$22,215	\$179	\$22,394	\$21,375	\$934	\$22,309	\$20,551	\$1,829	\$22,380	\$19,752	\$2,630	\$22,381
Provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Revenue Over/(Under) Expense	\$38,642	\$35,632	\$22,215	\$179	\$22,394	\$21,375	\$934	\$22,309	\$20,551	\$1,829	\$22,380	\$19,752	\$2,630	\$22,381
FTEs	2,362.3	2,351.8	2,624.9	(8.4)	2,616.5	2,598.7	(38.5)	2,560.2	2,572.7	(53.6)	2,519.0	2,546.9	(53.6)	2,493.3
*Volume Statistics: Clinic Visits	54,375	49,324	53,464	(7,081)	46,383	53,464	(34,610)	18,855	53,464	(53,464)	53,464	53,464	(53,464)	53,464

Seifert & Ford Clinic CON - Docket No. 15-31978-CON**Question 7b. FINANCIAL ASSUMPTIONS****Net Patient Revenue:**

Without Project: Determined using historical payment experience
 With Project: Reflects loss of net revenue associated with clinic encounters

Volume:

Without Project: Assumes 1.0% annual decline in volume, based on historical trend
 With Project: Reflects loss of clinic volume

Other Operating Revenue:

Without Project: Based on historical trend
 With Project: Reflects anticipated decrease in federal/state grant funding

Salaries and Fringe Benefits:

Without Project: Includes 2.0% inflationary increase annually adjusted for productivity improvements ongoing.
 With Project: Reduction in workforce related to transition of services, plus anticipated retention & severance payments

Professional / Contracted Svcs:

Without Project: Assumes 1.0% annual increase, based on projected trend
 With Project: Assumes professional services expenses transition to CIFC

Supplies and Drugs:

Without Project: Assumes 3% annual increase, based on historical data combined with inflationary increases
 With Project: Reduction related to transition of clinic services

Other Op Expense:

Without Project: Assumes 1.0% inflationary increase
 With Project: Reflects ongoing operating and teaching expenses in support of providing care to clinic patients

Depreciation:

Without Project: Based on historic trend inclusive of annual capital spend
 With Project: Reflects transfer of existing clinic equipment over to CIFC

Interest:

Without Project: Based on current interest of existing debt rolled forward annually
 With Project: No Impact

Lease Expense:

Without Project: Includes a 2% annual increase on expenses
 With Project: Reflects reduction in rent obligation for facilities at 70 Main St and 152 West St

FTEs:

Without Project: Based on projected volume with continued productivity improvements
 With Project: Reduction in FTE based on proposed transition of services



WESTERN CONNECTICUT
HEALTH NETWORK

DANBURY HOSPITAL • NEW MILFORD HOSPITAL



24 Hospital Ave.
Danbury, CT 06810

WesternConnecticutHealthNetwork.org
DanburyHospital.org
NewMilfordHospital.org

April 20, 2015

Jessica Schaeffer-Helmecki, Program Analyst (CCT)
Department of Public Health
Office of Health Care Access
410 Capital Avenue: MS # 13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Responses to CON Completeness Questions, Docket No. 15-31978-CON

Dear Ms. Schaeffer-Helmecki,

Enclosed please find Responses on behalf of The Danbury Hospital and Western Connecticut Health Network, Inc. to the Completeness Questions asked by OHCA in a letter dated March 13, 2015 in the above captioned docket. We have included the original and two hard copies of the responses, as well as a CD with an Adobe format (.pdf) of the Responses, and the Financial Attachments I (.xlsx).

Please contact me if you have any questions regarding this submission.

Sincerely,

Sally F. Herlihy, MBA, FACHE
Vice President, Planning

Enclosure

April 20, 2015

1. **On pages 4 and 5 of the application are copies of the newspaper order confirmation and public notice. Please provide a more legible copy of each.**

See Exhibit Q for requested documents

2. **On page 16, Table 3, the Applicant provides utilization by town for FY14; resubmit that table with only one column of numbers.**

See Exhibit R for Table 3

3. **Explain the methods by which you intend to convey your communications with patients, as outlined on page 64 of the application.**

We are implementing a comprehensive communications campaign over a period of several months to ensure a seamless transition for our patients. Our goal is to ensure our patients are informed and comfortable with all aspects of the proposed transition of services to GDCHC. Patients will receive information in English, Spanish and Portuguese face-to-face, over the phone, in writing, in media and via web-translation. See Exhibit S for a Frequently Asked Questions document that has been developed and is being shared with individuals regarding the proposed transition of services. The communications efforts are also designed to educate and engage key stakeholders such as community leaders, trusted health counselors (i.e. public health directors, other clinics), medical providers and Danbury Hospital employees.

4. **List the scholarly journals in which the literature on pages 50 and 56 were published.**

The June 2011 article titled "FQHCs: Saving the Medicaid Population in an Era of Health Reform" was obtained from Murer Consultants, Inc., a national legal-based health care management consulting firm. The company is comprised of consultants with legal backgrounds as well as varied experience in medicine, clinical services, finance and management.

The September 22, 2012 commentary titled "Federally-Qualified Health Centers: Key Access Point to Primary Care for Expanded Medicaid Population" was published in the University of Pennsylvania Leonard Davis Institute of Health Economics Voices Blog. The University of Pennsylvania established the Leonard Davis Institute of Health Economics in 1967, two years after Congress enacted Medicare. It was created to fill fundamental gaps in the evidence base that could inform policies critical to the financing and management of the nation's increasingly costly and complex health care system.

5. **Does CIFC/GDCHC have sufficient capacity at its 57 North Street, Danbury location to absorb WCHN's pediatric service patients? Please explain in detail.**

Yes. GDCHC will provide pediatric services in 3,500 square feet of space at 57 North Street. The parties are confident that GDCHC can provide access to its existing pediatric patients and the patients will be transferred from S&F in this space.

6. **Provide a copy of the grant agreement described in section 1(e) of the Letter of Intent. If you are unable to do so, please explain:**
 - a. **why the grant agreement cannot be provided**

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The grant agreement cannot be provided at this time because the parties are still finalizing the terms of the grant agreement.

b. whether the “community grant” mentioned on page 14 of the application and the “short fall” grant mentioned on page 60 are two separate grants;

The “community grant” and “short fall” grants referred to in the application are one and the same.

c. whether there is a maximum amount of grant money the Applicant will provide GDCHC; and

Yes, there is a maximum amount of grant money that the Applicant will provide to GDCHC in each year of the five (5) year grant term. The total grant to GDCHC will include (i) annual maximum cash amounts and (ii) the donation of certain equipment owned by the Applicant that will be necessary for GDCHC’s provision of services. The annual maximum cash amounts to be provided by the Applicant to GDCHC are as follows:

Year One: \$1,107,911
 Year Two: \$1,558,685
 Year Three: \$1,117,435
 Year Four: \$803,001
 Year Five: \$591,529

Each annual cash grant includes funds to reimburse GDCHC for expenses actually incurred by GDCHC for the provision of services previously provided by the Applicant. Components of the grant include (i) salary costs and benefits, (ii) costs of providing certain specialty dental services, and (iii) costs associated with electronic dental and medical records software, licenses and training and the converting paper records to electronic records; and (iv) a fixed amount of additional funds to reimburse GDCHC for additional costs associated with the transition of services to GDCHC but not anticipated by the parties, subject to the prior approval of the Applicant. Grant funds for each such component are subject to the annual cash cap above. An annual reconciliation of GDCHC’s actual costs and the grant payments made to GDCHC during the immediately preceding year will be performed.

d. whether there is a minimum and/or maximum number of years the Applicant will provide the grant(s) to GDCHC

There is no minimum number of years that the Applicant will provide the grant to GDCHC. Although the grant term has an initial five (5) year term, the grant agreement is subject to earlier termination in event of default or upon one (1) year’s prior notice by either party. Following the expiration of the initial term, the grant agreement will automatically renew for additional one (1) year terms unless a party provides notice of its intent to terminate the grant agreement. There is no maximum number of years that the Applicant will provide the grant to GDCHC.

7. Please elaborate on the “opportunities for Behavioral Health expansion” mentioned during the WCHN Board of Directors minutes on page 45 of the application.

Transitioning behavioral health services to GDCHC will increase access to care in the community because GDCHC will expand the hours during which behavioral health services are provided, by making behavioral health providers available during evening hours and on Saturdays. Additionally,

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S&F patients' medical, dental and behavioral health records will be fully integrated into CIFIC's existing Electronic Health Record system, eClinicalWorks (eCW). The integrated health records system will provide a more coordinated system of care for patients requiring both medical and behavioral health services.

8. On page 18 of the application, the Applicant provides its current and projected payor mix in Table 5, showing a decrease in patient volume in 2016 and zero patient volume in 2017 as a result of the proposed CON. Please provide projected volumes without the proposed CON (i.e., if WCHN continued to operate S&F and CCBH).

Patient Population Mix without the proposed CON

(i.e. If WCHN continued to operate S&F and CCBH), with *FY2015 projected using FP1-5 actual

	Current		Projected					
	FY2014		FY2015 *		FY2016		FY2017	
	Vol	Pct	Vol	Pct	Vol	Pct	Vol	Pct
Medicare	179,389	35.4%	185,306	35.3%	185,306	35.3%	185,306	35.3%
Medicaid	93,071	18.4%	100,085	19.0%	100,085	19.0%	100,085	19.0%
CHAMPUS & TriCare	632	0.1%	607	0.1%	607	0.1%	607	0.1%
Total Government	273,092	53.9%	285,998	54.4%	285,998	54.4%	285,998	54.4%
Commercial	198,207	39.1%	204,017	38.8%	204,017	38.8%	204,017	38.8%
Uninsured	32,029	6.3%	32,513	6.2%	32,513	6.2%	32,513	6.2%
Worker's Comp	3,211	0.6%	2,998	0.6%	2,998	0.6%	2,998	0.6%
Total Non-Govt	233,447	46.1%	239,527	45.6%	239,527	45.6%	239,527	45.6%
Total Payer Mix	506,539	100.0%	525,526	100.0%	525,526	100.0%	525,526	100.0%

9. Will current patients of CIFIC have access to the specialty services at S&F?

Yes. All patients of CIFIC will have access to WCHN's specialty clinics which will continue to be located at S&F (80 Main Street).

10. Does WCHN/Danbury Hospital charge facility fees for services provided at S&F or CCBH? If yes, will facility fees be charged at S&F or CCBH once services are transferred to CIFIC/GDCHC?

Yes, WCHN/Danbury Hospital charges a facility fee for services provided at S&F and at CCBH. Following transition of services to CIFIC/GDCHC, WCHN will continue to charge a facility fee for *only* those specialty services that WCHN/Danbury Hospital will continue to provide at S&F. The primary care and behavioral health services to be provided by CIFIC/GDCHC will be billed by GDCHC and facility fees will not be charged for these services. Services provided by CIFIC/GDCHC will be subject to the fee limitations and required "sliding fee scale" of a FQHC.

11. With respect to the proposal:

- a. Identify the target patient population to be served;

The target population includes the current uninsured, underinsured and Medicaid patients receiving services at S&F, CCBH and CIFIC/GDCHC locations. GDCHC serves a ten-town region including Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman, with a population totaling 221,081. This region is also served by S&F and CCBH. Of this total population, it is estimated that 29,960 residents live 200% below the federal poverty level (UDS

April 20, 2015

Mapper). Danbury, Bethel and New Milford have the majority of low income residents in the region. Danbury alone has approximately 18,634 residents who live 200% below the federal poverty level. It is estimated that approximately 28,533 residents in GDCHC's ten-town region are without insurance and approximately 19.6% are also under age 65. These patients will receive all of these same services through GDCHC as currently provided at S&F. There will be no negative impact on the provision of care to Medicaid recipients or the indigent in this community.

b. Discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit;

The proposed transfer of services to GDCHC supports the continued delivery of health care services to the existing patient populations in the communities served by both S&F/CCBH and CIFC/GDCH. GDCHC has experience in effectively and efficiently meeting the primary care needs of the population served by the parties. GDCHC's model of providing care as a community health center has been proven to increase access to services for uninsured and underinsured patients.

Included as Exhibit T is a March 2014 publication from the National Association of Community Health Centers titled "Access is the Answer: Community Health Centers, Primary Care and the Future of American Health Care", which highlights the valuable role that community health centers play in enhancing access to primary care services for an underserved population. As the publication states: "Health Centers' unique and comprehensive model of care complements broader insurance coverage while also filling in the gaps where insurance does not reach given limited provider availability, accessibility, or the complete lack of insurance. They stand as a proven solution for breaking down multiple barriers to care, and are ready to expand access to millions more in need, regardless of insurance status." The National Association of Community Health Centers (NACHC) was formed in 1971 by and for community-based health center programs and works closely with state primary care associations to fulfill the shared mission of delivering quality health care to those in need.

c. Explain how access to care will be affected; and

The proposed transition of the S&F primary care services and the behavioral health services from CCBH to CIFC/GDCHC will have a positive impact on the provision of services and will expand access and availability of such services to a wider patient population. In addition, the transfer of these services to GDCHC will result in expanded service hours (beyond what is currently offered by either Danbury Hospital or GDCHC today) and an increase in the number of primary care providers and specialty providers.

d. Discuss any alternative proposals that were considered.

WCHN went through a multi-phase process in making the decision to transition the S&F Primary Care Services and the Behavioral Health Clinic Services to CIFC/GDCHC. Alternative considerations included:

- Maintaining operations under the current hospital-based model and reducing expenses. After analysis of this option, WCHN leadership determined that this option is not economically sustainable given the capital investments required over the long term (such as electronic medical record costs), the rising expenses for staff and physician salaries and the declining Medicaid reimbursement rates for primary care and behavioral health services.

April 20, 2015

- Developing a federally qualified health center operated by Danbury Hospital. After analysis of this option, WCHN leadership determined that the difficult and lengthy process to establish a FQHC would require significant organizational focus and there is a significant risk that we would not receive federal approval for the establishment of the FQHC due to service area overlap with the existing FQHC.

12. On Financial Attachment I, page 89 of the application, the Applicant provided actual financial results for FY 2013 and projected results for fiscal years 2014 through 2018 for the entire Danbury Hospital. Please resubmit Financial Attachment I, reporting data from only S&F and CCBH.

Financial Attachment #1 limited to data for only S&F and CCBH is included as Exhibit U. In addition, we are including a revised version of Financial Attachment #1 for all of Danbury Hospital (attached as Exhibit V), to reflect the following:

- The most current version of the Grant Agreement between Danbury Hospital and CFC
- A reallocation of some administrative expenses that were previously categorized as Other Operating Expenses
- A minor (\$16K) correction to the incremental Other Operating Income that was previously reported

13. On page 10 of the application, the Applicant references efficiencies in operations in the form of reduced overhead and reduced costs. Provide an itemization of anticipated cost savings attributable to the proposal and incorporate those savings in the proposed S&F and CCBH Financial Attachment I.

The net expense savings to the hospital are anticipated at \$5.5M by FY2017, the first full year after both phases of the transition. This figure is a combination of both salary and non-salary expenses, and consistent with the financial attachments, the breakdown is as follows:

(Dollars are in thousands)

	FY2017
Salaries & Fringe Benefits	3,451
Professional / Contracted Services	1,659
Supplies and Drugs	305
Other Operating Expense	-774
Depreciation / Amortization	110
Lease Expense	709
Total Expense Savings	5,460

14. On page 9 of the application, the Applicant states that WCHN will continue to provide specialty care clinics at S&F. What services are provided in these clinics?

The specialty clinics at S&F include the following specialties: orthopedics, spine, podiatry, urology, neurology, allergy, rheumatology, and tuberculosis

April 20, 2015

15. On page 64 of the application, the Applicant mentions in its communication plan to stakeholders a “pharmacy program providing discounted prescriptions.” Explain the program in greater detail.

As a federally qualified health center (FQHC), CIFC/GDCHC participates in the USD/HHS 340B Program, which is administered by the Health Resources and Services Administration (HRSA). The 340B Program allows FQHCs to purchase pharmaceuticals at deeply discounted prices and then dispense such pharmaceuticals to patients through either contract pharmacies or in-house pharmacies. At the present time, CIFC GDCHC has a contract pharmacy relationship with Walgreens. For those CIFC/GDCHC patients with private third party insurance, there is no change in the cost of their prescriptions (e.g. they still owe their scheduled co-payment). However, Medicaid, Medicare and self-pay patients whose prescriptions are not reimbursable by a private third party insurer, which is approximately 78% of the FQHC’s total patient population, are eligible to purchase the deeply discounted 340B prescription drugs from Walgreens. Walgreens dispenses prescription pharmaceuticals to eligible CIFC/GDCHC patients at three locations in Danbury, including the Walgreens store at 75 Main Street, which is diagonally across the street from the current S&F Clinic. According to HRSA, “[s]tudies show that entities participating in the 340B Program are able to expand the type and volume of care they provide to the most vulnerable patient populations as a result of access to these lower cost medications.” (See: www.hrsa.gov/opa/update.html).

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EXHIBITS

Number	Description
Q	Copy of newspaper order confirmation and public notice
R	Table 3- Utilization by Town
S	Patient Communication
T	<i>"Access is the Answer: Community Health Centers, Primary Care and the Future of American Health Care"</i> , March 2014, National Association of Community Health Centers
U	Financial Attachment I, S&F and CCBH only
V	Revised Financial Attachment I, Danbury Hospital

PUBLIC NOTICES**LEGAL NOTICE
PUBLIC HEARING**

The Newtown Water and Sewer Authority hereby gives notice of a public hearing to be held on Thursday, January 8, 2015 at 7:00 p.m. at the Wastewater Treatment Facility, Commerce Road, Newtown, CT to consider the following:

Proposed amendments to the Sewer Use Regulations dated 8/11/11 and to the Water pollution Control Plan dated 8/13/2009.

A copy of the proposed changes are available for review at the Town Clerks Office in the Municipal Building, 3 Primrose Street, Newtown, CT.

If you plan to attend this meeting and require assisted hearing devices or an interpreter, please contact the Office of the First Selectman (203-270-4201) at least forty-eight hours prior to meeting.

Water and Sewer Authority
Marianne Brown, Chairman

The Danbury Hospital (DH), a subsidiary of Western Connecticut Health Network, Inc. (WCHN) is filing a Certificate of Need with the Office of Health Care Access for the transition of DH's Seifert & Ford Community Health Center programs and the Aftercare treatment at its Community Center for Behavioral Health (CCBH) to the Connecticut Institute for Communities, Inc.'s Greater Danbury Community Health Center (GDCHC). GDCHC will occupy the current Seifert & Ford location at 70 Main Street and accommodate the CCBH Aftercare program currently at 152 West Street, Danbury, CT. The capital expenditure of this project is estimated to be under \$225,000.

GENERAL HELP WANTED**ASSISTANT FOR PUBLISHER**

located in Danbury: customer service, administrative duties, light book-keeping. Must know MS Word, Quick Books, Excel, Power Point. Full time with benefits.

Fax resume: 203-938-7088

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needed for collision repair shop. Exp & own tools. Comp sal. Call 203-748-0579/ fdcrash@comcast.net

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DAYCARE- Danbury area Daycare seeks loving, patient, energetic & reliable FT & PT daycare Teacher's Asst. Serious inquiries only. Contact Kathy or Trish (203)-791-9000.

Framers Needed

Call 203-240-6219

**MAINTENANCE
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Greentree Toyota is the immediate need of maintenance personal/porters, entry level & experienced technicians & office staff. Responsibilities for porters include everything from cleaning and maintaining building to assisting staff with our customers. Office staff will answer phones, scan documents, make appointments, complete the daily deposit & assist management. We offer a 40 hour work week, 401k, health/dental Insurance, & uniforms.

All interested candidates should go to greentreemomotr.com, click on the information link then employment & fill out the on line application. Please call (203) 775-6221 ask to speak to Chris Morgado to arrange an interview.

OFFICE MANAGER with experience in managing & motivating staff. Homecare agency exp. a

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any questions to penms

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email melissa@aol

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April 20, 2015

Exhibit R

TABLE 3
FY 2014 Utilization by Town
(October 1, 2013 – September 30, 2014)

TOWN	Utilization FY14 # Visits
Danbury, CT	37,619
Bethel, CT	3,327
Brookfield, CT	1,452
New Milford, CT	1,254
New Fairfield, CT	1,177
Ridgefield, CT	994
Newtown, CT	875
Sandy Hook, CT	603
Redding, CT	357
Waterbury, CT	238
Southbury, CT	190
Woodbury, CT	113
Wilton, CT	89
Hawleyville, CT	84
Monroe, CT	75
Sherman, CT	70
Roxbury, CT	57
Naugatuck, CT	49
Oakville, CT	39
Brewster, NY	36
South Meriden, CT	36
Weston, CT	32
Redding Ridge, CT	29
Pleasant Valley, NY	27
Gaylordsville, CT	26
Middlebury, CT	25
14 towns with 10-24 each	219
66 towns with <10 each	223
TOTAL	49,324

April 20, 2015

Exhibit S



DANBURY HOSPITAL

Frequently Asked Questions- Seifert and Ford Community Health Center Transition

- **What is happening at Seifert & Ford?** Danbury Hospital is planning to transition the primary care medical services currently offered at WCHN's Seifert and Ford Community Health Center (S&F), as well as the Community Center for Behavioral Health (CCBH) located on West Street in Danbury, to the Greater Danbury Community Health Center (GDCHC) which is sponsored by Connecticut Institute For Communities, Inc. (CIFC). The GDCHC is well known and highly respected in Danbury currently seeing patients at 57 North Street - right down the street.
- **What services will transition?** Primary care (adult, women's, pediatric), dental care and outpatient behavioral health – including our doctors who provide these services – would transition as part of this plan. We are working closely with the GDCHC to retain existing staff, or where we can, find placements for staff in other areas within our health network.
- **Why is this plan a good idea?** The transition of these services to CIFC will ensure that patients at S&F and CCBH continue to have local access to high-quality medical and behavioral health care, as well as a primary care medical home, expanded service hours, access to discounted prescriptions, and an enhanced electronic health record.
- **When do you expect this to take place?** While we have filed an application for this change with the State, it could take many months for an approval. We are still in the planning stage – working out details to ensure patients have uninterrupted access to the care they need. Timing should become clearer over the next several months.
- **What does this mean for me and my family?** At some point in the future, and after we receive necessary approvals, patients will benefit from more convenient access to care, evening and weekend hours, access to more physicians and staff, and pharmacy discounts to help with prescription costs.
- **When will more details be available?** It is our intent to keep you updated whenever we have news to share; however, that may not be for weeks or even months.
- **What if I have questions?** Please ask us during your visit or send us an email: 70mainstreet@wchn.org.

2/24/15

April 20, 2015



Perguntas frequentes - Transferência do Centro Comunitário de Saúde Seifert and Ford

- **O que está acontecendo no Seifert & Ford?** O Danbury Hospital planeja transferir os serviços médicos oferecidos atualmente no Centro Comunitário de Saúde Seifert and Ford (S&F) da WCHN, assim como o Centro Comunitário de Saúde Comportamental (CCBH, Community Center for Behavioral Health), localizados na West Street em Danbury, para o Centro de Saúde Comunitária da Grande Danbury (GDCHC, Greater Danbury Community Health Center), que é mantido pelo Connecticut Institute For Communities, Inc. (CIFIC). O GDCHC é conhecido e altamente respeitado em Danbury, e atualmente atende a seus pacientes na 57 North Street, próxima ao S&F.
- **Quais serviços serão transferidos?** Atendimento básico (adulto, ginecológico e pediátrico), assistência odontológica e atendimento ambulatorial de saúde comportamental seriam transferidos como parte desse plano, incluindo os médicos que prestam esses serviços. Estamos trabalhando com o GDCHC para manter a equipe existente ou, quando possível, encontrar vagas para a equipe em outras áreas de nossa rede de saúde.
- **Por que esse plano é uma boa ideia?** A transferência desses serviços para o CIFIC garantirá que os pacientes do S&F e do CCBH continuem a ter acesso local a atendimento médico e de saúde comportamental de alta qualidade, assim como a cuidados médicos básicos contínuos e a um registro eletrônico de saúde aprimorado.
- **Quando isso acontecerá?** Apesar de já termos solicitado a mudança ao Estado de Connecticut, pode levar muitos meses até que ela seja aprovada. Ainda estamos na fase de planejamento, pensando nos detalhes para garantir que os pacientes tenham acesso ininterrupto ao atendimento necessário. Nos próximos meses, os prazos deverão estar mais definidos.
- **O que isso significa para mim e para minha família?** No futuro, após o recebimento das aprovações necessárias, os pacientes serão beneficiados com um acesso mais conveniente ao atendimento, horários noturnos e nos fins de semana, acesso a mais médicos e equipes, além de descontos em farmácias para ajudar nos gastos com medicamentos prescritos.
- **Quando terei acesso a mais detalhes?** Nossa intenção é informá-lo assim que tivermos novidades, mas pode ser que isso não ocorra nas próximas semanas ou meses.
- **E se eu tiver mais dúvidas?** Você pode tirar suas dúvidas quando vier ao hospital ou pelo e-mail: 70mainstreet@wchn.org.

2/24/15

April 20, 2015



DANBURY HOSPITAL

Preguntas frecuentes: Transición del Seifert and Ford Community Health Center

- **¿Qué está sucediendo en Seifert & Ford?** Danbury Hospital está planeando trasladar los servicios médicos que actualmente se ofrecen en Seifert and Ford Community Health Center (S&F) de WCHN, así como también Community Center for Behavioral Health (CCBH) ubicado en West Street en Danbury, a Greater Danbury Community Health Center (GDCHC), el cual es patrocinado por Connecticut Institute For Communities, Inc. (CIFIC). El GDCHC es conocido y altamente respetado en Danbury que actualmente atiende a los pacientes en 57 North Street que está en la misma calle.
- **¿Qué servicios entrarán en transición?** Los cuidados primarios (para adultos, mujeres, pediátricos), cuidado dental y salud mental ambulatoria – así como también nuestros doctores que proporcionan estos servicios – entrarán en transición como parte del plan. Estamos trabajando conjuntamente con el GDCHC para conservar al personal existente, o donde podamos, reubicarlos en otras áreas dentro de nuestra red de salud.
- **¿Por qué este plan es una buena idea?** Las transición de estos servicios a CIFIC garantizará que los pacientes de S&F y CCBH continúen teniendo acceso local a cuidados de la salud mental y médicos de alta calidad como también un centro médico de cuidados primarios y un historial médico electrónico mejorado.
- **¿Cuándo espera que esto suceda?** Hemos presentado una solicitud al Estado para realizar este cambio, lo que podría tomar varios meses para que sea autorizada. Todavía estamos en la fase de planificación; estamos trabajando en los detalles para asegurarnos de que los pacientes tengan un acceso interrumpido a los cuidados que necesiten. Las fechas deberían definirse claramente en los próximos meses.
- **¿Qué significa esto para mí y mi familia?** En algún punto en el futuro, y después de que hayamos recibido las autorizaciones necesarias, los pacientes se beneficiarán de un acceso más conveniente a la atención médica, en horas de la noche y de los fines de semana, acceso a más médicos y al personal y descuentos de farmacia para ayudarles con los costos de las recetas.
- **¿Cuándo nos brindarán mayor información al respecto?** Tenemos la intención de mantenerlos informados en cuanto tengamos noticias que compartir; sin embargo, esto podría no darse en semanas o incluso en meses.
- **¿A quién puedo dirigirme si tengo alguna pregunta?** Por favor consúltenos durante su visita o envíenos un correo electrónico a: 70mainstreet@wchn.org.

April 20, 2015

Exhibit T



NATIONAL ASSOCIATION OF
Community Health Centers

MARCH
2014

Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care

This year, millions of Americans will gain insurance coverage, many or most for the first time in years, if ever. That accomplishment, though historic, misses a key point: expanding health care coverage without addressing the need to provide access to high-quality preventive and primary care services addresses only part of the health care equation. **Access is more than just having an insurance card. It is more than getting care in an emergency room.** Access is having a regular, reliable source of quality preventive and primary health care. Unfortunately, too many uninsured – and even insured – Americans have inadequate access to primary care.

People can experience barriers to high-quality, comprehensive primary and preventive care in many forms, including the **availability** of providers where health care resources are scarce, the **affordability** of care regardless of insurance status, or the **accessibility** of providers who understand the culture, language, transportation challenges, and preferences of the surrounding community. Even among people who have an insurance card access may be out of reach because of who they are and where they live.

Our new research uncovers that **62 million people nationwide have no or inadequate access to primary care given local shortages of such physicians** – one important indicator of unmet health needs (Figure 1). Our research, conducted with the Robert Graham Center, also finds that this population represents U.S. residents from all walks of life:

- 43% are low-income, 28% live in rural areas, and 38% are racial/ethnic minorities.
- The vast majority actually have insurance (22% have Medicaid, 58% have other insurance, and 21% are uninsured). However, the uninsured are more affected by the shortage of primary care, with 30% of all uninsured Americans affected compared to 21% of all insured.¹

The impact of improving access to primary care on our nation's health care system cannot be overstated. Research shows that having a usual source of care improves health more effectively than having insurance alone.² When people have access to primary care, health problems are detected and treated before they can become serious and require hospitalization. Extensive evidence documents that access to primary care results in better health outcomes, reduced health disparities, and lower health care expenditures.³ Yet primary care remains off limits to many, including some with chronic illness.

Clearly, **Access is the Answer** to what plagues the American health care system. Expanding access to primary and preventive care improves health and lowers costs, and is the foundation for driving higher quality care.⁴ The good news is that a proven solution exists to expand access to care.

Our research demonstrates that **if it were not for Community Health Centers, 21 million more people could experience the barrier of primary care provider shortages** (Figure 2).

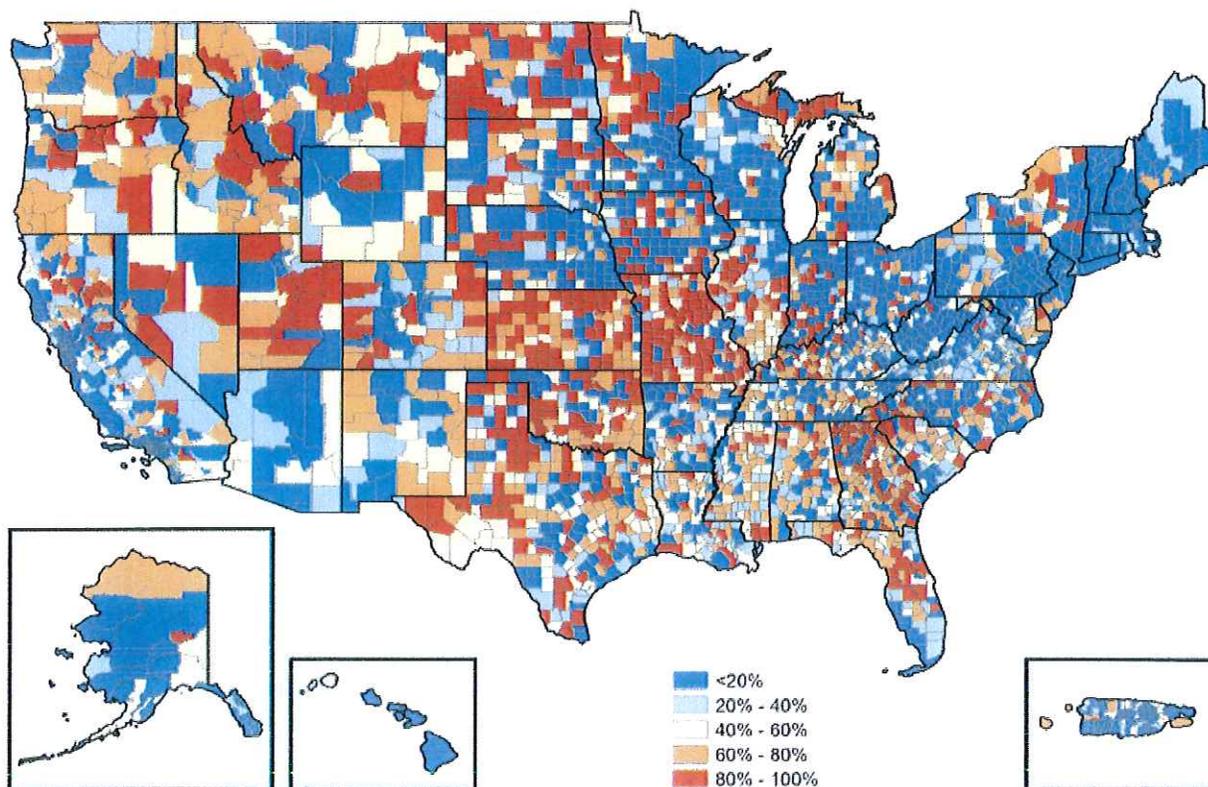
The federal Health Center Program has nearly 50 years of experience in breaking down the many complex barriers to care that people often confront. They provide high-quality, cost-effective primary and preventive care to traditionally underserved communities across America (Figure 3). Currently, Health Centers serve over 22 million people through over 9,000 urban, suburban and rural locations in every state and territory. Research demonstrates their ability to improve access to a regular source of care while holding down emergency room visits and overall health care costs. **Today, demand for Health Centers is escalating under health reform, and they stand ready to apply their proven model in more medically disenfranchised communities across the nation.**



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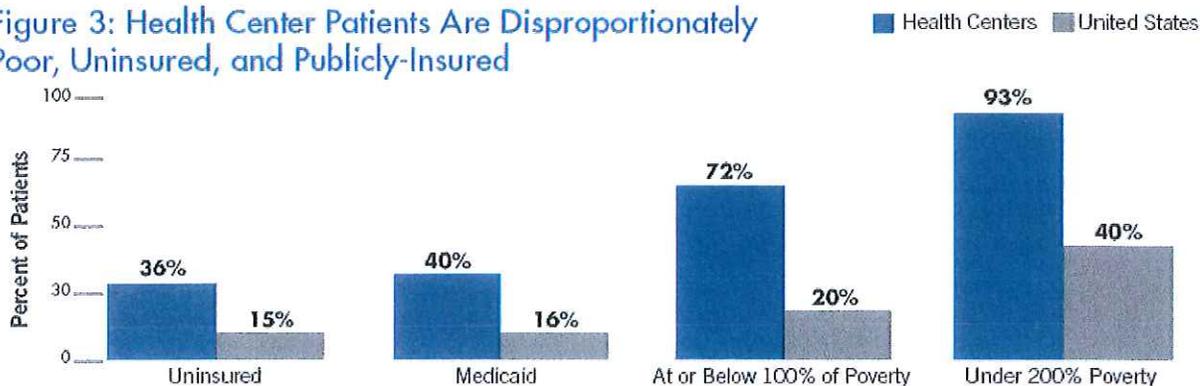
ACCESS IS THE ANSWER:

Figure 1: Estimated Percent of County Residents Experiencing Shortages of Primary Physicians, 2013



Source: Created by The Robert Graham Center (2014). US Census 2010; HRSA Data Warehouse 2014 HPSA and MUA/P shapefiles; AMA Masterfile 2013; UDS Mapper 2014.

Figure 3: Health Center Patients Are Disproportionately Poor, Uninsured, and Publicly-Insured



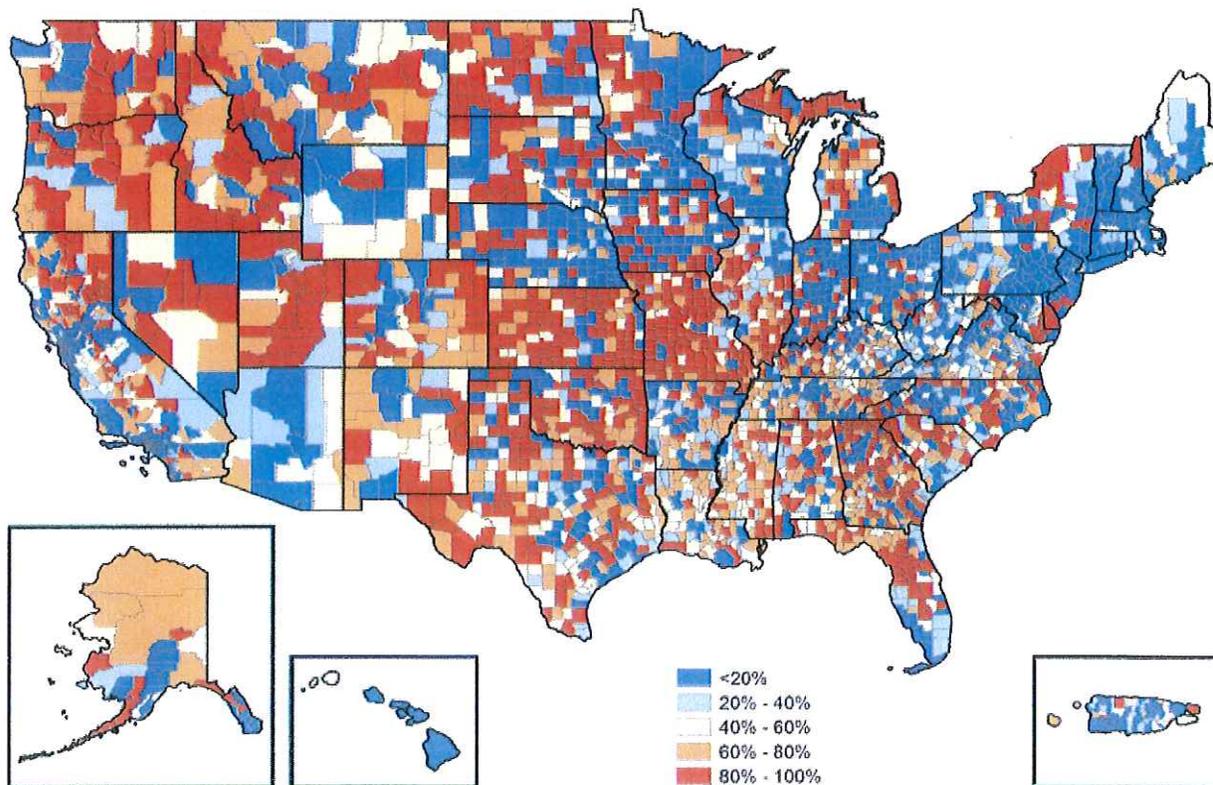
Source: Health Centers data: Based on Bureau of Primary Health Care, HRSA, DHHS, 2012 Uniform Data System. Source for Health Coverage and Poverty data: U.S.: Kaiser Family Foundation, State Health Facts Online, www.statehealthfacts.org. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).



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Figure 2: Without Community Health Centers: Estimated Percent of County Residents Experiencing Shortage of Primary Care Physicians, 2013



Source: Created by The Robert Graham Center (2014). US Census 2010; HRSA Data Warehouse 2014 HPSA and MUA/P shapefiles; AMA Masterfile 2013; UDS Mapper 2014.

HEALTH CENTERS AND HEALTH CENTER EXPANSION ARE THE KEY TO ACCESS

The federal Health Center Program is made up of Community, Migrant, Homeless, and Public Housing Health Centers, often collectively known as Community Health Centers or Health Centers. Each Health Center has a federal mandate to improve access to regular, primary and preventive care for populations that would otherwise go without. Strengthening and expanding Health Centers nationwide makes sense as a pragmatic approach that will alleviate the nation's primary care access challenges, especially as insurance coverage expansions roll forward. **Health Centers have a proven record of reaching people and communities most in**

need, delivering high-quality care, and saving the health care system \$24 billion a year.

Improving Access is the Health Center Model

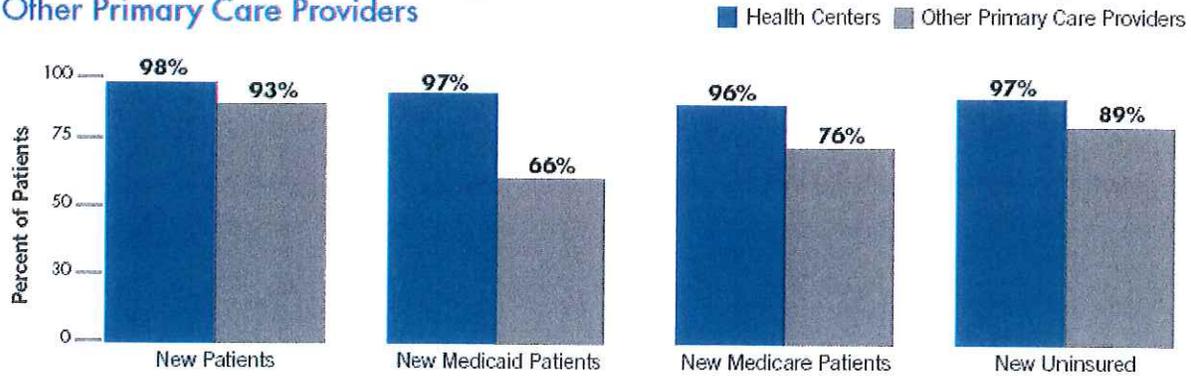
Health Centers are not only *in* the communities they serve but are largely made up *of* the communities in which they thrive. Federal law requires that they operate under the direction of patient-majority governing boards, and that they serve underserved communities and populations where care is needed but scarce. They are mandated to accept all patients no matter their ability to pay and to tailor their services to fit the special needs and priorities of their diverse communities.



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ACCESS IS THE ANSWER:

Figure 4: Health Centers Have Higher Rates of Accepting New Patients Compared to Other Primary Care Providers



Source: Hing E, Hooker RS, Ashman JJ. Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. J Community Health. 2010 Nov 3 published.

Evidence shows that patients choose Health Centers because they are convenient, culturally competent, affordable, and offer a range of services under one roof,⁵ making it easier for patients to access and use care regularly – the first step in staying healthy and productive. In fact, **low-income communities with greater federal Health Center funding have better access to care** than communities with less federal Health Center funding.⁵

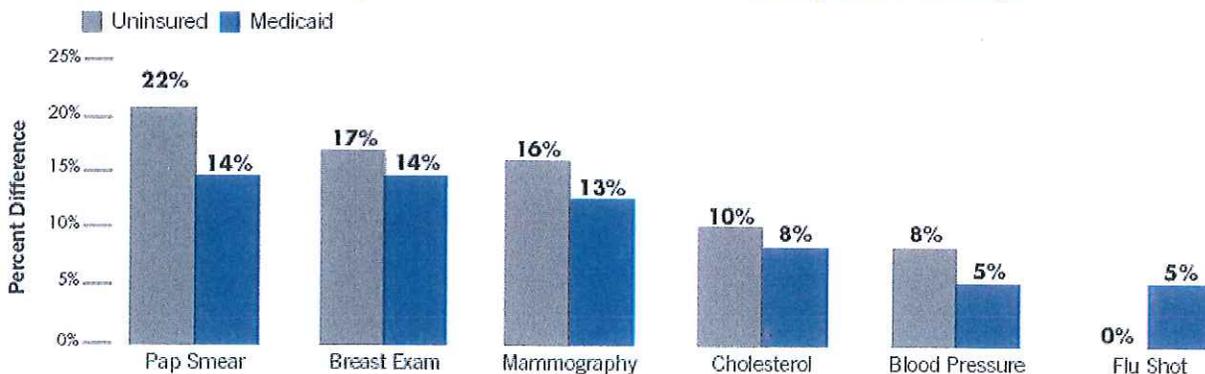
Compared to other primary care providers, Health Centers are more likely to accept new patients (Figure 4), and to offer evening or weekend hours.⁷ Health Centers' comprehensive model reaches beyond the traditional scope of primary care to provide a full range

of preventive care services not typically seen in other primary care settings, such as dental, mental health and substance abuse, vision, and pharmacy services.

Health Centers Provide High-Quality Care

Despite serving traditionally underserved patient populations, Health Centers have established an impressive record of delivering high-quality care. Research has shown that Health Centers provide better or equal care compared to other primary care providers, all while serving communities with more chronic illness and socioeconomic complexity.⁸ And their patients receive more preventive services, such as immunizations, health education,

Figure 5: Uninsured and Medicaid Health Center Patients Receive More Selected Preventive Services Compared to Patients at Other Primary Care Settings



Source: Dor, A., Pylypchuck, Y., Shin, P., and Rosenbaum, S. Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers. Gelger Gibson/RCHN Community Health Foundation Research Brief #4. August 2008.



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mammograms, pap smears, and other screenings, than patients of other providers (Figure 5).⁹

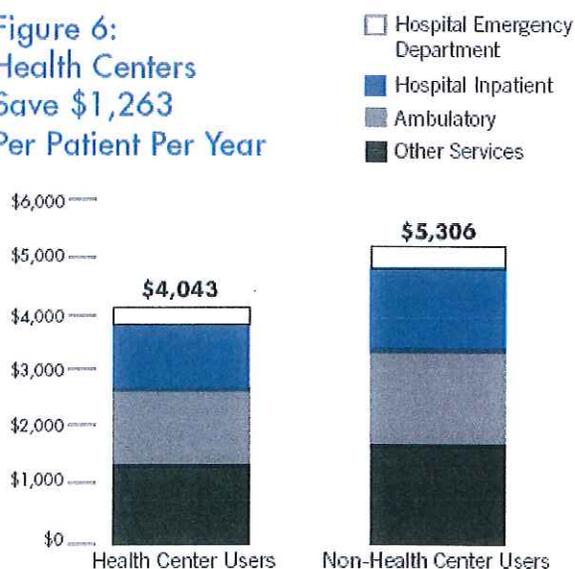
Moreover, their care leads to positive results for their high-risk patients. Nearly all Health Centers outperform the average Medicaid Managed Care Organization performance benchmark for diabetes control, hypertension control, and receipt of a Pap test.¹⁰ They also consistently perform better than the national average for low birth weight and narrow racial and ethnic disparities in low birth weight babies.¹¹

Patients recognize these quality achievements. In fact, Health Center patients report higher rates of satisfaction with hours of operation and overall care received than the general U.S. patient population.¹²

Health Centers Save the Health System Money

The American health care system struggles with ballooning costs because the current care delivery system is fragmented and patients rely too heavily on costly, inefficient settings – like hospital emergency departments – to receive even routine services or care that could have been avoided through timely prevention. Greater federal Health Center funding and capacity have been shown to lower emergency department utilization among populations that historically experience access challenges, including the low-income, Medicaid-enrolled, uninsured, and rural communities.¹³

Figure 6:
Health Centers
Save \$1,263
Per Patient Per Year



Source: NACHC analysis based on Ku L et al. Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs. GWU Department of Health Policy, Policy Research Brief No. 14, September 2009.

Health Centers save **\$1,263 per person per year** because their care is timely, appropriate for the patient and efficient. As a result, costs are lowered across the delivery system from ambulatory care settings to the emergency department to hospital stays (Figure 6). **Not only is their cost of care low, they also generate savings of \$24 billion a year for the entire health system**, including \$6.7 billion in savings for the federal share of the Medicaid program.¹⁴

HEALTH REFORM WILL MEAN MORE DEMAND FOR HEALTH CENTERS

Now and into tomorrow Health Centers will remain a key source of primary care for the uninsured and underinsured, who will rely on Health Centers more heavily for their care needs even after health reform expansion winds down. Although Health Centers will serve more Medicaid and privately insured patients, approximately 40% of Health Centers' currently uninsured patients could remain without insurance coverage,¹⁵ and new uninsured patients will turn to Health Centers as their best option for care.

Demand for Health Center services will continue to climb. This was the case in Massachusetts after the Commonwealth launched health reform in 2006. In 2005, prior to reform, 36% of Massachusetts Health Center patients were uninsured. This dropped to 20% by 2009 as more patients were covered by Medicaid and Commonwealth Care. Yet Health Centers continued to serve a disproportionate share of the Commonwealth's total uninsured residents – rising from 22% of all Massachusetts uninsured residents in 2006 to 38% in 2009. Many of these patients could not find care elsewhere, and many were adults with complex and unmanaged chronic conditions, including mental illness.¹⁶

As more Americans realize the promise of insurance coverage, they are also likely to experience the realities of accessing care. **Expanding the reach of Health Centers will be a crucial tool in meeting demand, and with appropriate support, Health Centers stand ready to expand access today and into the future.**



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ACCESS IS THE ANSWER:

THE ROAD AHEAD: OVERCOMING CHALLENGES TO FACILITATE EXPANDED ACCESS TO CARE

In order to turn the vision of Community Health Center expansion into reality, there must be an ongoing, multi-faceted effort to assure that Health Centers are equipped with adequate resources. Adequate resources are necessary for maintaining the Health Center Program's current reach of 22 million medically vulnerable patients, as well as extending their reach into the vast medically disenfranchised and underserved communities across the nation.

Strengthening Federal Health Center Funding and Fixing the Primary Care Cliff

The Affordable Care Act (ACA) created the mandatory Health Center Trust Fund to grow the program over existing discretionary funding levels, but the full potential of this fund was never realized. In FY2011, Congress cut funding for the Health Center Program's discretionary base by \$600 million annually, slashing the Trust Fund's impact by approximately \$3 billion over 5 years. Additionally, sequestration has further eroded the ACA's investment in Health Centers.

Under current law, the Health Center Trust Fund is slated to expire by FY2016, leaving only discretionary funding to cover the program's operations. Even assuming no further reductions (including no further sequestration cuts), **current law would lead to a 70% funding reduction for all existing Health Centers** (Figure 7). This reduction would be catastrophic for centers, forcing them to close sites, lay off staff, and reduce services at the very time their

primary care capacity is needed most. Similarly, crucial primary care workforce development programs are also facing expiring mandatory funds.

In order to secure and expand access to care for millions, **Congress should reauthorize the mandatory Health Center Trust Fund for FYs 2016-2020** with sufficient funding for Health Centers to serve 35 million patients by 2020. Additionally, Congress should continue funding for the vitally important National Health Service Corps and Teaching Health Center primary care workforce programs.

Ensuring Fair and Adequate Medicaid Reimbursement

As many current and future Health Center patients become eligible for Medicaid, adequate Medicaid payments become even more essential for Health Centers' sustainability. Medicaid is the largest insurer of Health Center patients and represents 38% of total revenue – Health Centers' largest source of financing and directly proportional to the percent of patients with Medicaid. Over the years, Medicaid reimbursement has fallen notably below costs at a time when Health Centers serve more Medicaid patients (Figure 8). The expected increase in patient volume will not make up for per-patient revenue losses.

Health Centers' Medicaid payments are intended to cover their comprehensive services, including dental, mental health, and pharmacy services. This payment structure also ensures that Health Center grant revenues can be dedicated to care for the uninsured rather than subsidizing care for Medicaid patients.

Figure 7: Health Center Funding Under Current Law

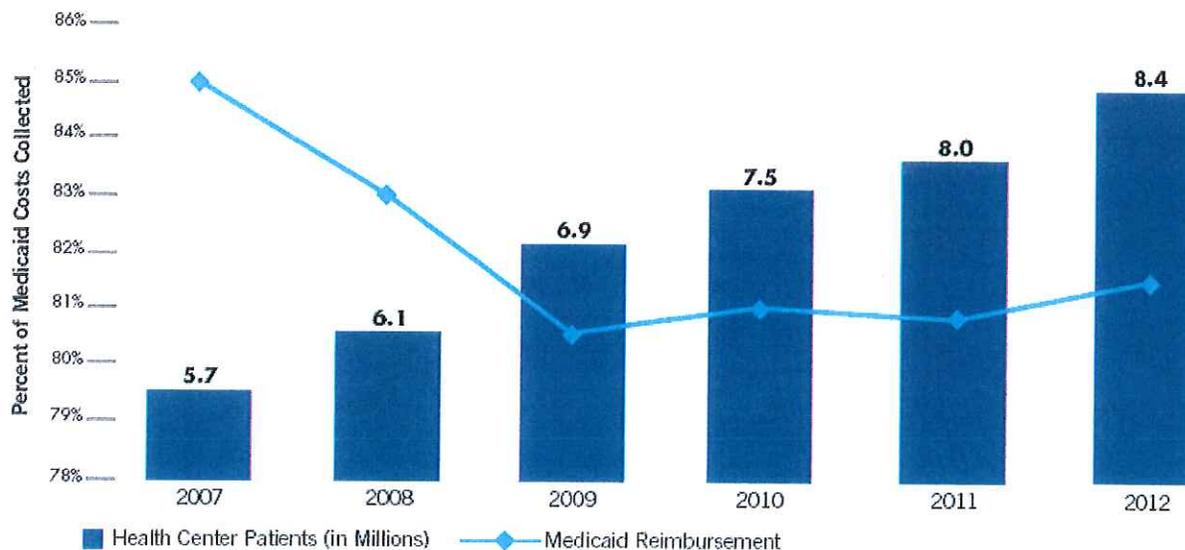
Community Health Center Funding: FY 2010 – FY 2016



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COMMUNITY HEALTH CENTERS, PRIMARY CARE & THE FUTURE OF AMERICAN HEALTH CARE

Figure 8: Medicaid Reimbursement Rate Has Declined as Health Center Medicaid Patients Have Increased



Since this reimbursement requirement went into effect, Health Centers were able to apply their freed-up grant funds to double the number of uninsured patients they serve.

As states examine varying options for expanding and reforming Medicaid, and as Congress examines the future viability of the program, **policymakers must ensure that Health Centers continue to receive Medicaid payment under their current Federally-Qualified Health Center prospective payment system (PPS).**

ACCESS IS THE ANSWER: MAKING MEANINGFUL CARE A REALITY FOR ALL

Although having insurance overcomes many fiscal barriers to accessing health care, it is not enough to guarantee access to an accessible, high-quality usual source of primary and preventive care, including dental, behavioral health, and pharmacy care that are also critically important for improving health.

Health Centers' unique and comprehensive model of care complements broader insurance coverage while also filling in the gaps where insurance does not reach given limited provider availability, accessibility, or the complete lack of insurance. They stand as a proven solution for breaking down multiple barriers to care, and are ready to expand access to millions more in need, regardless of insurance status.

In order to turn this vision into reality, increased federal funding and adequate reimbursement from third-party payers are the first steps in assuring that Health Centers have the resources, staffing, and facilities necessary to serve as a true health home to all Americans in need.



April 20, 2015

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NATIONAL ASSOCIATION OF
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Exhibit U

Seifert & Ford Clinic CON - Docket No. 15-31978-CON

Completeness Question #12. Financial Attachment I for S&F & CCBH Only

(Dollars are in thousands)

Description	FY2013 Actual		FY2014 Actual		FY2015 Projected Actuals		FY2015 Projected Incremental		FY2015 Projected With CON		FY2016 Projected Actuals		FY2016 Projected Incremental		FY2016 Projected With CON		FY2017 Projected Actuals		FY2017 Projected Incremental		FY2017 Projected With CON		FY2018 Projected Actuals		FY2018 Projected Incremental		FY2018 Projected With CON								
NET PATIENT REVENUE																																			
Non-Government	822	842	842	777	842	(65)	777	842	(405)	437	842	(405)	437	842	(839)	842	(839)	842	(839)	842	(839)	842	(839)	842	(839)	842	(839)	842	(839)	842	(839)				
Medicare	683	608	608	561	608	(47)	561	608	(286)	323	608	(286)	323	608	(581)	608	(581)	608	(581)	608	(581)	608	(581)	608	(581)	608	(581)	608	(581)	608	(581)				
Medicaid and Other Medical Assistance	1,779	1,834	1,834	1,569	1,834	(265)	1,569	1,834	(1,210)	624	1,834	(1,210)	624	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)	1,834	(1,666)				
Total Net Patient Revenue	3,284	3,284	3,284	2,908	3,284	(\$376)	2,908	3,284	(\$1,901)	1,383	3,284	(\$1,901)	1,383	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)	3,284	(\$3,087)				
Other Operating Revenue	\$519	\$544	\$544	\$520	\$544	(24)	\$520	\$544	(208)	\$336	\$544	(208)	\$336	\$544	(544)	\$544	(544)	\$544	(544)	\$544	(544)	\$544	(544)	\$544	(544)	\$544	(544)	\$544	(544)	\$544	(544)				
Revenue from Operations	\$3,803	\$3,828	\$3,828	\$3,428	\$3,828	(\$401)	\$3,428	\$3,828	(\$2,109)	\$1,719	\$3,828	(\$2,109)	\$1,719	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)	\$3,828	(\$3,631)				
OPERATING EXPENSES																																			
Salaries and Fringe Benefits	\$4,480	\$4,182	\$4,182	\$3,800	\$4,182	(381)	\$3,800	\$4,182	(1,975)	\$2,207	\$4,182	(1,975)	\$2,207	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)	\$4,182	(3,451)		
Professional / Contracted Services	2,414	2,367	2,367	2,125	2,367	(242)	2,125	2,367	(1,142)	1,225	2,367	(1,142)	1,225	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)	2,367	(1,659)		
Supplies and Drugs	305	320	320	282	320	(38)	282	320	(190)	130	320	(190)	130	320	(305)	320	(305)	320	(305)	320	(305)	320	(305)	320	(305)	320	(305)	320	(305)	320	(305)	320	(305)		
Other Operating Expense	620	699	699	914	699	215	914	699	865	1,568	699	865	1,568	699	774	699	774	699	774	699	774	699	774	699	774	699	774	699	774	699	774	699			
Subtotal	\$7,819	\$7,568	\$7,568	\$7,121	\$7,568	(\$447)	\$7,121	\$7,568	(2,442)	\$5,126	\$7,568	(2,442)	\$5,126	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)	\$7,568	(4,642)		
Depreciation/Amortization	101	112	112	98	112	(14)	98	112	(69)	43	112	(69)	43	112	(110)	112	(110)	112	(110)	112	(110)	112	(110)	112	(110)	112	(110)	112	(110)	112	(110)	112	(110)		
Interest Expense	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
Lease Expense	795	757	757	639	757	(118)	639	757	(533)	225	757	(533)	225	757	(709)	757	(709)	757	(709)	757	(709)	757	(709)	757	(709)	757	(709)	757	(709)	757	(709)	757	(709)		
Total Operating Expenses	\$8,714	\$8,438	\$8,438	\$7,858	\$8,438	(\$579)	\$7,858	\$8,438	(\$3,043)	\$5,394	\$8,438	(\$3,043)	\$5,394	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)	\$8,438	(5,460)		
Gain/(Loss) from Operations	(\$4,911)	(\$4,609)	(\$4,609)	(\$4,430)	(\$4,609)	\$179	(\$4,430)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)		
Plus: Non-Operating Income	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
Income before provision for income taxes	(\$4,911)	(\$4,609)	(\$4,609)	(\$4,430)	(\$4,609)	\$179	(\$4,430)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)		
Provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		
Revenue Over/(Under) Expense	(\$4,911)	(\$4,609)	(\$4,609)	(\$4,430)	(\$4,609)	\$179	(\$4,430)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$934	(\$3,675)	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)	(\$4,609)	\$1,829	(\$4,609)		
FTEs	59.9	56.1	56.1	47.7	56.1	(8.4)	47.7	56.1	(38.5)	17.6	56.1	(38.5)	17.6	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)	56.1	(53.6)		
*Volume Statistics: Clinic Visits	56,695	51,744	51,744	48,843	55,924	(7,081)	48,843	55,924	(34,610)	21,314	55,924	(34,610)	21,314	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)	55,924	(53,464)

** Baseline financials w/o CON held constant pending decision on FQ Business Proposal

Exhibit V

Seifert & Ford Clinic CON - Docket No. 15-31978-CON

Question 7a. Financial Attachment I
****REVISED****

(Dollars are in thousands)

Description	FY2013 Actual		FY2014 Actual		FY2015 Projected Actuals		FY2016 Projected Actuals		FY2017 Projected Actuals		FY2018 Projected Actuals		FY2019 Projected Actuals	
	Actual	Actual	Actual	Actual	Actual	Incremental								
NET PATIENT REVENUE														
Non-Government	296,229	296,863	333,642	333,577	340,316	(405)	347,123	(839)	346,284	354,067	(839)	353,227	353,227	(839)
Medicare	175,171	182,492	209,862	209,835	209,861	(286)	209,861	(286)	209,861	209,819	(581)	209,238	209,238	(581)
Medicaid and Other Medical Assistance	30,463	25,138	25,860	25,595	25,861	(1,210)	25,862	(1,210)	24,196	25,863	(1,666)	24,197	24,197	(1,666)
Total Net Patient Revenue	501,863	504,493	569,364	569,008	576,038	(\$1,901)	582,825	(\$1,901)	\$579,739	589,749	(\$3,087)	\$586,662	\$586,662	(\$3,087)
Other Operating Revenue	\$15,261	\$16,727	\$17,129	\$17,105	\$17,129	(208)	\$17,129	(208)	\$16,585	\$17,129	(544)	\$16,585	\$16,585	(544)
Revenue from Operations	\$517,124	\$521,220	\$586,513	\$586,113	\$593,167	(\$2,109)	\$599,954	(\$2,109)	\$596,323	\$606,878	(\$3,631)	\$603,247	\$603,247	(\$3,631)
OPERATING EXPENSES														
Salaries and Fringe Benefits	\$240,060	\$239,819	\$267,026	\$266,645	\$268,361	(1,975)	\$269,703	(1,975)	\$266,252	\$271,052	(3,836)	\$267,216	\$267,216	(3,836)
Professional / Contracted Services	58,192	61,072	73,670	73,428	74,407	(1,142)	75,151	(1,142)	73,492	75,902	(1,665)	74,237	74,237	(1,665)
Supplies and Drugs	79,427	82,494	93,282	93,244	96,080	(190)	98,963	(190)	98,658	101,932	(305)	101,627	101,627	(305)
Other Operating Expense	68,732	72,654	78,154	78,369	78,936	865	79,725	865	80,499	80,522	364	80,886	80,886	364
Subtotal	\$446,410	\$456,040	\$512,132	\$511,685	\$517,784	(2,442)	\$523,542	(2,442)	\$518,900	\$529,408	(5,442)	\$523,966	\$523,966	(5,442)
Depreciation/Amortization	30,033	31,682	44,391	44,377	46,191	(69)	47,991	(69)	47,881	49,791	(110)	49,681	49,681	(110)
Interest Expense	3,984	4,587	7,700	7,700	7,571	-	7,450	-	7,450	7,328	-	7,328	7,328	-
Lease Expense	7,965	8,069	8,575	8,456	8,746	(533)	8,921	(533)	8,212	9,099	(709)	8,391	8,391	(709)
Total Operating Expenses	\$488,392	\$500,348	\$572,798	\$572,219	\$580,293	(\$3,043)	\$587,903	(\$3,043)	\$582,443	\$595,626	(6,261)	\$589,366	\$589,366	(6,261)
Gain/(Loss) from Operations	\$28,732	\$20,872	\$13,715	\$13,894	\$12,875	\$934	\$12,051	\$934	\$13,880	\$11,252	\$2,630	\$13,881	\$13,881	\$2,630
Plus: Non-Operating Income	\$9,910	\$14,760	\$8,500	\$8,500	\$8,500	\$0	\$8,500	\$0	\$8,500	\$8,500	\$0	\$8,500	\$8,500	\$0
Income before provision for income taxes	\$38,642	\$35,632	\$22,215	\$22,394	\$21,375	\$934	\$20,551	\$934	\$22,380	\$19,752	\$2,630	\$22,381	\$22,381	\$2,630
Provision for income taxes	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Revenue Over/(Under) Expense	\$38,642	\$35,632	\$22,215	\$22,394	\$21,375	\$934	\$20,551	\$934	\$22,380	\$19,752	\$2,630	\$22,381	\$22,381	\$2,630
FTEs	2,362.3	2,351.8	2,624.9	2,616.5	2,598.7	(38.5)	2,572.7	(38.5)	2,519.0	2,546.9	(53.6)	2,493.3	2,493.3	(53.6)
*Volume Statistics: Clinic Visits	54,375	49,324	53,464	46,383	53,464	(34,610)	53,464	(34,610)	18,855	53,464	(53,464)	53,464	53,464	(53,464)

Seifert & Ford Clinic CON - Docket No. 15-31978-CON**Question 7b. FINANCIAL ASSUMPTIONS**

Net Patient Revenue:

Without Project: Determined using historical payment experience
 With Project: Reflects loss of net revenue associated with clinic encounters

Volume:

Without Project: Assumes 1.0% annual decline in volume, based on historical trend
 With Project: Reflects loss of clinic volume

Other Operating Revenue:

Without Project: Based on historical trend
 With Project: Reflects anticipated decrease in federal/state grant funding

Salaries and Fringe Benefits:

Without Project: Includes 2.0% inflationary increase annually adjusted for productivity improvements ongoing.
 With Project: Reduction in workforce related to transition of services, plus anticipated retention & severance payments

Professional / Contracted Svcs:

Without Project: Assumes 1.0% annual increase, based on projected trend
 With Project: Assumes professional services expenses transition to CIFC

Supplies and Drugs:

Without Project: Assumes 3% annual increase, based on historical data combined with inflationary increases
 With Project: Reduction related to transition of clinic services

Other Op Expense:

Without Project: Assumes 1.0% inflationary increase
 With Project: Reflects ongoing operating and teaching expenses in support of providing care to clinic patients

Depreciation:

Without Project: Based on historic trend inclusive of annual capital spend
 With Project: Reflects transfer of existing clinic equipment over to CIFC

Interest:

Without Project: Based on current interest of existing debt rolled forward annually
 With Project: No Impact

Lease Expense:

Without Project: Includes a 2% annual increase on expenses
 With Project: Reflects reduction in rent obligation for facilities at 70 Main St and 152 West St

FTEs:

Without Project: Based on projected volume with continued productivity improvements
 With Project: Reduction in FTE based on proposed transition of services

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Tuesday, May 19, 2015 4:44 PM
To: Greer, Leslie
Subject: FW: CON 15-31978 Completeness Follow-up Questions

Leslie, would you please add this to the record? Thanks!

From: Schaeffer-Helmecki, Jessica
Sent: Tuesday, May 19, 2015 4:20 PM
To: 'sally.herlihy@wchn.org'
Subject: CON 15-31978 Completeness Follow-up Questions

Sally—

As discussed, we've received your completeness response for the above-referenced application. We did need clarification on several points, though. If you could respond by Thursday, May 21, 2015 it would be helpful and we can hopefully avoid a second completeness letter.

1. On page 113, the volume statistics/clinic visits for FYs 2013 and 2014 do not match the volume statistics provided on pages 17 and 18 of your original application. Please explain the discrepancy.
2. The table on page 94 shows the current and projected payor mix. Do these estimates include all of Danbury Hospital? If so, please show the payor mix for just S&F and CCBH?

Please let me know if you have any questions.

Thank you,

Jessica Schaeffer-Helmecki
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134

(860) 509-8075

Olejarz, Barbara

Subject: FW: CON 15-31978 Completeness Follow-up Questions

From: Schaeffer-Helmecki, Jessica
Sent: Thursday, May 21, 2015 3:51 PM
To: 'Herlihy, Sally'
Subject: RE: CON 15-31978 Completeness Follow-up Questions

Hi Sally—fyi I have received your responses and faxed you completeness correspondence.

From: Herlihy, Sally [<mailto:Sally.Herlihy@wchn.org>]
Sent: Thursday, May 21, 2015 3:26 PM
To: Schaeffer-Helmecki, Jessica
Cc: Herlihy, Sally
Subject: RE: CON 15-31978 Completeness Follow-up Questions

Hi Jessica,

- 1. On page 113, the volume statistics/clinic visits for FYs 2013 and 2014 do not match the volume statistics provided on pages 17 and 18 of your original application. Please explain the discrepancy.**

Response: The FY2013 & FY2014 volume statistics included on pages 17 and 18 of the original application are specific to services that we intend to transition over to the FQHC. In contrast, the FY2013 & FY2014 volume statistics contained on page 113 from our completeness response are inclusive of ALL services provided at S&F and CCBH, including the specialty care clinics which WCHN plans to retain.

- 2. The table on page 94 shows the current and projected payor mix. Do these estimates include all of Danbury Hospital? If so, please show the payor mix for just S&F and CCBH?**

Response: Yes, the current and projected payor mix included on page 94 is representative of all of Danbury Hospital. The payor mix specific to S&F and CCBH was provided on page 18 of our original application, and is included below for reference.

	Current		Projected					
	FY2014		FY2015		FY2016		FY2017 *	
PAYOR	Vol	Pct	Vol	Pct	Vol	Pct	Vol	Pct
Medicare	7,482	15.20%	7,041	15.20%	3,827	20.30%	0	#DIV/0!
Medicaid	26,191	53.10%	24,105	52.00%	8,469	44.90%	0	#DIV/0!
Champus & TriCare	0	0.00%	0	0.00%	0	0.00%	0	#DIV/0!
Total Govt	33,673	68.30%	31,146	67.10%	12,296	65.20%	0	#DIV/0!
Commercial	2,258	4.60%	2,169	4.70%	1,421	7.50%	0	#DIV/0!
Uninsured	13,389	27.10%	13,060	28.20%	5,139	27.30%	0	#DIV/0!
Worker's Comp	5	0.00%	8	0.00%	0	0.00%	0	#DIV/0!
Total Non-Govt	15,651	31.70%	15,237	32.90%	6,559	34.80%	0	#DIV/0!
Total Payer Mix	49,324	100.00%	46,383	100.00%	18,855	100.00%	0	#DIV/0!

* Clinic volume transitioned successfully to FQHC

Please let me know if you have any further questions.

Regards,
Sally

Sally F. Herlihy, FACHE
Vice President, Planning
Western Connecticut Health Network

203-739-4903

From: Schaeffer-Helmecki, Jessica [<mailto:Jessica.Schaeffer-Helmecki@ct.gov>]
Sent: Tuesday, May 19, 2015 4:20 PM
To: Herlihy, Sally
Subject: CON 15-31978 Completeness Follow-up Questions

Sally—

As discussed, we've received your completeness response for the above-referenced application. We did need clarification on several points, though. If you could respond by Thursday, May 21, 2015 it would be helpful and we can hopefully avoid a second completeness letter.

1. On page 113, the volume statistics/clinic visits for FYs 2013 and 2014 do not match the volume statistics provided on pages 17 and 18 of your original application. Please explain the discrepancy.
2. The table on page 94 shows the current and projected payor mix. Do these estimates include all of Danbury Hospital? If so, please show the payor mix for just S&F and CCBH?

Please let me know if you have any questions.

Thank you,

Jessica Schaeffer-Helmecki

Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134

(860) 509-8075



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

VIA FACSIMILE ONLY

May 21, 2015

Sally M. Hearlihy
Western Connecticut Health Network, Inc.
24 Hospital Ave.
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 15-31978-CON
Western Connecticut Health Network
Termination/transfer of Danbury Hospital's Seifert & Ford Family Community Health
Center and Community Center for Behavioral Health Programs to Connecticut Institute
for Communities, Inc's Greater Danbury Health Center

Dear Ms. Hearlihy:

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 March 21, 2015.

If you have any questions regarding this matter, please feel free to contact me at (860) 509-8075.

Sincerely,

Jessica Schaeffer-Helmecki
Planning Analyst

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

* * * COMMUNICATION RESULT REPORT (MAY. 21. 2015 3:42PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FILE MODE	MAY. 21. 2015 3:42PM OPTION	ADDRESS	RESULT	PAGE
078	MEMORY TX	912037391974	OK	2/2

REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



**STATE OF CONNECTICUT
 OFFICE OF HEALTH CARE ACCESS**

FAX SHEET

TO: SALLY M. HEARLIHY

FAX: (203) 739-1974

APPLICANT: WCHN

FROM: OHCA

DATE: 5/21/2015 **Time:** _____

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments:

DN 15-31978 deemed complete

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

*Phone: (860) 418-7001
 Fax: (860) 418-7053*

*410 Capitol Ave., MS#13HCA
 P.O.Box 340308
 Hartford, CT 06134*



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 22, 2015

Sally Herlihy, MBA, FACHE
Western Connecticut Health Network
Vice President, Planning
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application, Docket Number 15-31978-CON
Western Connecticut Health Network
Proposal to Terminate and Transfer Ownership of Seifert & Ford Family
Community Health Center and Community Center for Behavioral Health
Programs

Dear Ms. Herlihy,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Western Connecticut Health Network ("Applicant") on May 21, 2015, 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: Western Connecticut Health Network

Docket Number: 15-31978-CON

Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford
Family Community Health Center and Community Center for
Behavioral Health Programs

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: July 7, 2015
Time: 4:00 p.m.
Place: Broadview Middle School - Auditorium
72 Hospital Avenue
Danbury, CT 06810

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *New Haven Register* pursuant to General Statutes § 19a-639a (f).

Sincerely,

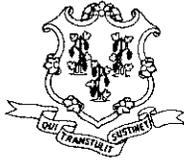


Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
William Gerrish, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: SWL:PF:img



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 22, 2015

Requisition #49128

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

Gentlemen/Ladies:

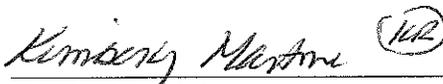
Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Tuesday, June 23, 2015**. Please provide the following **within 30 days** of publication:

- 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:JSH:OA:img

New Haven Register
Notice of Public Hearing, Docket Number 15-31978-CON

June 22, 2015

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference: 19a-638
Applicant: Western Connecticut Health Network
Town: Danbury
Docket Number: 15-31978-CON
Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford
Family Community Health Center and Community Center for
Behavioral Health Programs
Date: July 7, 2015
Time: 4:00 p.m.
Place: Broadview Middle School – Auditorium
72 Hospital Avenue
Danbury, CT 06810

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 2, 2015 (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.

* * * COMMUNICATION RESULT REPORT (JUN. 22. 2015 4:13PM) * * *

FAX HEADER:

TRANSMITTED/STORED FILE MODE	: JUN. 22. 2015 4:11PM OPTION	ADDRESS	RESULT	PAGE
127	MEMORY TX	912037391974	OK	5/5

REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



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

FAX SHEET

TO: SALLY HERLIHY, MBA, FACHE

FAX: (203) 739-1974

AGENCY: WESTERN CT HEALTH NETWORK

FROM: OHCA

DATE: 6/22/15

NUMBER OF PAGES: 5
(including transmittal sheet)

Comments: DN: 15-31987-CON Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

**410 Capitol Ave., MS#13HCA
 P.O.Box 340308
 Hartford, CT 06134**

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Monday, June 22, 2015 11:35 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

Good day!

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

*Consider adding a **Priority Job Upgrade** to your **HigherJobs** listing.*

PLEASE NOTE: New Department of Labor guidelines allow web based 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.

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

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
<http://www.graystoneadv.com/>

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, June 22, 2015 11:32 AM
To: ads <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: Hearing Notice DN: 15-31978-CON

Please run the attached hearing notice in the New Haven Register by 6/23/15. For billing purposes, please refer to requisition 49128. In addition, please forward me a "proof of publication" when it becomes available.

Thanks,

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: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Monday, June 22, 2015 3:55 PM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

Hi Leslie,

The notice will be published tomorrow.
\$420.42

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Mon, 22 Jun 2015 19:42:20 +0000
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: Hearing Notice DN: 15-31978-CON

Hi Robert,
Please confirm that the ad will run on 6/23/15 as requested.
Thanks,
Leslie Greer

From: ADS [<mailto:ADS@graystoneadv.com>]
Sent: Monday, June 22, 2015 11:35 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

Good day!

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

*Consider adding a **Priority Job Upgrade** to your **Higheredjobs listing**.*

PLEASE NOTE: New Department of Labor guidelines allow web based 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.

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

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
<http://www.graystoneadv.com/>

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, June 22, 2015 11:32 AM
To: ads <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: Hearing Notice DN: 15-31978-CON

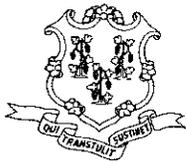
Please run the attached hearing notice in the New Haven Register by 6/23/15. For billing purposes, please refer to requisition 49128. In addition, please forward me a "proof of publication" when it becomes available.

Thanks,

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



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 23, 2015

Sally Herlihy, MBA, FACHE
Western Connecticut Health Network
Vice President, Planning
24 Hospital Avenue
Danbury, CT 06810

REVISED

RE: Certificate of Need Application, Docket Number 15-31978-CON
Western Connecticut Health Network
Proposal to Terminate and Transfer Ownership of Seifert & Ford Family
Community Health Center and Community Center for Behavioral Health
Programs

Dear Ms. Herlihy,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Western Connecticut Health Network ("Applicant") on May 21, 2015, 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: Western Connecticut Health Network

Docket Number: 15-31978-CON

Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: July 7, 2015

Time: 4:00 p.m.

Place: Broadview Middle School - Auditorium
72 Hospital Avenue
Danbury, CT 06810

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Danbury News Times* pursuant to General Statutes § 19a-639a (f).

Sincerely,

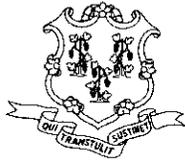
Handwritten signature of Kimberly R. Martone in cursive, with a circled 'RM' monogram to the right.

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
William Gerrish, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:JSH:OA:lmg



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 23, 2015

Requisition #49128

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 **Wednesday, June 24, 2015**. 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:JSH:OA:img

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference: 19a-638
Applicant: Western Connecticut Health Network
Town: Danbury
Docket Number: 15-31978-CON
Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford
Family Community Health Center and Community Center for
Behavioral Health Programs
Date: July 7, 2015
Time: 4:00 p.m.
Place: Broadview Middle School – Auditorium
72 Hospital Avenue
Danbury, CT 06810

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 2, 2015 (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.

* * * COMMUNICATION RESULT REPORT (JUN. 23. 2015 1:50PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 23. 2015 1:49PM
FILE MODE OPTION

ADDRESS

RESULT

PAGE

130 MEMORY TX

912037391974

OK

5/5

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-3) NO ANSWERE-2) BUSY
E-4) NO FACSIMILE CONNECTION

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

FAX SHEETTO: SALLY HERLIHYFAX: (203) 739-1974AGENCY: WESTERN CONNECTICUT HEALTH NETWORKFROM: OHCADATE: 6/23/15NUMBER OF PAGES: 5*(including transmittal sheet)*

Comments: Revised Hearing Notice for DN: 15-31978-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Office of Health Care Access Public Hearing

Source: Hearst Media Services

Category: Events & Notices » Legal & Public Notices

<http://hearstmediaservices.kaango.com/ads/viewad?adid=23988941>

Ad Details:

Ad ID:	23988941
Location:	Danbury, CT
Created:	Jun 23, 2015
Expires:	Jul 1, 2015
Member:	CTOHCA

Office of Health Care Access Public Hearing Statute Reference: 19a-638 Applicant: Western Connecticut Health Network Town: Danbury Docket Number: 15-31978-CON Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs Date: July 7, 2015 Time: 4:00 p.m. Place: Broadview Middle School – Auditorium 72 Hospital Avenue Danbury, CT 06810 Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 2, 2015 (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: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Tuesday, June 23, 2015 3:33 PM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

Leslie,

The notice is set to publish tomorrow.
\$391.93

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Tue, 23 Jun 2015 15:19:51 +0000
To: RTaylor <rtaylor@graystoneadv.com>
Subject: RE: Hearing Notice DN: 15-31978-CON

Yes, please run the revised notice tomorrow. Thanks

From: Robert Taylor [<mailto:RTaylor@graystoneadv.com>]
Sent: Tuesday, June 23, 2015 11:03 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

The next issue is tomorrow. Wednesday, 6/24. Should I proceed?

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Tue, 23 Jun 2015 14:54:47 +0000
To: RTaylor <rtaylor@graystoneadv.com>
Subject: RE: Hearing Notice DN: 15-31978-CON

Just to clarify nothing can be done today???

From: Robert Taylor [<mailto:RTaylor@graystoneadv.com>]
Sent: Tuesday, June 23, 2015 10:50 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON
Importance: High

Hi Leslie,

It can be published tomorrow in the News-Times.

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Tue, 23 Jun 2015 14:43:41 +0000
To: RTaylor <rtaylor@graystoneadv.com>
Subject: RE: Hearing Notice DN: 15-31978-CON

Hi Robert,

I have an emergency issue. We made a mistake, the newspaper notice I sent should have been published in the Danbury Times instead of the New Haven Register. What are the chances of getting it published in the Newstimes ASAP?
Leslie

From: Robert Taylor [<mailto:RTaylor@graystoneadv.com>]
Sent: Monday, June 22, 2015 3:55 PM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

Hi Leslie,

The notice will be published tomorrow.
\$420.42

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Mon, 22 Jun 2015 19:42:20 +0000

To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: Hearing Notice DN: 15-31978-CON

Hi Robert,
Please confirm that the ad will run on 6/23/15 as requested.
Thanks,
Leslie Greer

From: ADS [<mailto:ADS@graystoneadv.com>]
Sent: Monday, June 22, 2015 11:35 AM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 15-31978-CON

Good day!

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

*Consider adding a **Priority Job Upgrade** to your **HigherJobs** listing.*

PLEASE NOTE: New Department of Labor guidelines allow web based 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.

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

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
<http://www.graystoneadv.com/>

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Monday, June 22, 2015 11:32 AM
To: ads <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: Hearing Notice DN: 15-31978-CON

Please run the attached hearing notice in the New Haven Register by 6/23/15. For billing purposes, please refer to requisition 49128. In addition, please forward me a "proof of publication" when it becomes available.

Thanks,

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

HELP WANTED FULL TIME

DISTRICT MANAGER NEWSPAPER (New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a District Manager for a new site launch in New Haven area...

Duties include:

- Distributing 100-125K weekly newspapers are timely and professionally
- Recruit, contract, and administer Independent Contractor Delivery (IC) force
- Understand warehouse operating procedures and staging
- Ensure site staff are qualified, trained and QA product delivery
- Possess excellent client and customer service skills
- Experience with newspaper circulation and marketing/distribution industry must

Salary:\$35-38K

Please email resumes to ATTN: HR at cwandrey@cipsmarketing.com

RESTAURANT FOOD SERVICE

Exp. SHORT ORDER COOKS & WAITSTAFF \$15-\$17 per hour

Apply at: Country Corner Diner, 756 Amity Rd. (Rt. 63), Bethany. 203-393-1489

EITHER BUYING, selling, or trading, a classified is a good investment.

LEGAL NOTICE

CITY OF ANSONIA WATER POLLUTION CONTROL AUTHORITY NOTICE OF PUBLIC HEARING

Notice is hereby given that in accordance with C.G.S. Section 7-255, the Water Pollution Control Authority will hold a PUBLIC HEARING on July 1, 2015 at 6:45P.M. in Ansonia City Hall 253 Main St. Ansonia, CT. in the Erlingheuser Room, second floor, to set the rate for the sewer use fee for the period of July 1, 2015 to June 30, 2016. The proposed rate is \$2.75 Per 100 cubic feet of water usage plus a \$50.00 capital fee.

For those sewer users with wells the proposed flat charge is \$237.00 per year plus a \$50.00 capital fee.

A copy of the proposed sewer rates is on file in the City Clerk's office and available for inspection by the public.

Nunzio Parente, WPCA Chairman
Attest: Elizabeth S. Lynch, Town and City Clerk

A HOME OF YOUR OWN

*The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale "Buried Treasure"*

Find these and more in the **New Haven Register Classifieds.**

CALL TOLL-FREE
1-800-922-7066
TO PLACE YOUR CLASSIFIED AD

LEGAL NOTICE

LIQUOR PERMIT

Notice of Application

This is to give notice that I, ANDREA CORAZZINI 33 BEECHWOOD LN NEW HAVEN, CT 06511-1205

Have filed an application placarded 06/16/2015 with the Department of Consumer Protection for a RESTAURANT LIQUOR PERMIT for the sale of alcoholic liquor on the premises at 135 ORANGE ST #141 NEW HAVEN, CT 06510-3111

The business will be owned by: G CAFE BAKERY LLC

Entertainment will consist of: Acoustics (Not Amplified)

Objections must be filed by: 07/28/2015

ANDREA CORAZZINI

The Inland Wetlands Commission, Town of Hamden, will hold a Regular Meeting on Wednesday, July 1, 2015 at 7:00 p.m. in the Legislative Council Chambers, Memorial Town Hall, 2372 Whitney Avenue, Hamden, CT and the following items will be reviewed:

15-1210 560 Newhall St-construct multi-family dwelling units, Mutual Housing Association of SC CT, Inc. Applicant; Submitted by: Stacy Shellard, Commission Clerk

YOU GET QUICK action at a low cost when you advertise in the Insider classifieds.

LEGAL NOTICE

ORANGE TPZC NOTICE OF DECISION

Notice is hereby given that at a meeting held on Tuesday, June 16, 2015 the Orange Town Plan and Zoning Commission took action on the following:

SUBDIVISION APPLICATION - "Subdivision of Assessor's Lot 7 and Portion of Assessor's Lot 8". Submitted by property owner Racebrook Estates, LLC. Location 846 Racebrook Road (Assessor's Map 90-1-7) and portion of lot 8. To subdivide 8.3 acres of RES Residential land into 2 lots. APPROVED.

RE-SUBDIVISION APPLICATION - 831 Derby Milford Road. Submitted by Walter M. & Mary Ellen K. Bespuda Living Trust, for property known as 831 Derby Milford Road. The proposal is to create 2 lots from 34.6 acres. Zoned Residential RES. APPROVED.

A copy of this notice has been filed with the Orange Town Clerk. Dated in Orange, CT this 17th day of June, 2015.

Oscar Parente
Secretary
T.P.Z.C.

CLASSIFIED IS OPEN

8:00 AM - 5:00 PM
MON-FRI
Call 1.800.922.7066
or email:
CLASSIFIEDS@NHREGISTER.COM

Office of Health Care Access Public Hearing

Statute Reference: 19a-638
Applicant: Western Connecticut Health Network
Town: Danbury
Docket Number: 15-31978-CON
Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs
Date: July 7, 2015
Time: 4:00 p.m.
Place: Broadview Middle School - Auditorium 72 Hospital Avenue Danbury, CT 06810

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 2, 2015 (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.

STATE OF CONNECTICUT

RETURN DATE: JULY 21, 2015 :SUPERIOR COURT

FIRST NIAGARA BANK, NATIONAL ASSOCIATION :JUDICIAL DISTRICT OF NEW HAVEN

V. :AT NEW HAVEN

MARK J. BORSE, ET AL. :MAY 27, 2015

NOTICE TO THE WIDOWER, HEIRS, AND/OR CREDITORS OF THE ESTATE OF JUDITH A. BORSE A/K/A JUDITH A. SELLONG 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 has named as a Defendant, THE WIDOWER, HEIRS, AND/OR CREDITORS OF THE ESTATE OF JUDITH A. SELLONG, 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 can be vested or contingent, if not living, as a party defendant(s) in the complaint which it is bringing to the above-named Court seeking a foreclosure of its mortgage upon premises known as 468 CHURCH STREET, WALLINGFORD, CT 06492.

The Plaintiff has represented to said Court, by means of an affidavit annexed to the Complaint, that, despite all reasonable efforts to ascertain such information, it has been unable to determine the identity and/or whereabouts of THE WIDOWER, HEIRS, AND/OR CREDITORS OF THE ESTATE OF JUDITH A. BORSE A/K/A JUDITH A. SELLONG, 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 can be vested or contingent, if not living.

Now, Therefore, it is hereby ORDERED that notice of the institution of this action be given to said THE WIDOWER, HEIRS, AND/OR CREDITORS OF THE ESTATE OF JUDITH A. BORSE A/K/A JUDITH A. SELLONG 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 can be vested or contingent, by some proper officer causing a true and attested copy of this Order of Notice to be published in the New Haven Register, once a week for two successive weeks, commencing on or before July 1, 2015, and that return of such service be made to this Court.

BY THE COURT
By: Ecker J.
June 2, 2015

A TRUE COPY ATTEST:
Edward DiLieto - State Marshal
New Haven County

Notice of Intent to Issue General Permits Notice of Public Informational Meetings

In accordance with Connecticut General Statutes ("CGS") § 22a-361(d)(2) and CGS § 22a-378a, the Department of Energy and Environmental Protection ("DEEP") hereby gives notice of intent to issue General Permits ("GPs") for certain coastal activities undertaken waterward of the coastal jurisdiction line in the tidal, coastal or navigable waters of the State of Connecticut and in tidal wetlands. In addition to authorizing new activities, the proposed GPs would also consolidate the activities currently authorized in existing GPs #DEEP-LIS-GP-001 through #DEEP-LIS-GP-015. Therefore, such existing authorizations would be superseded upon adoption of the proposed GPs.

The activities proposed to be authorized under these GPs include:

DEEP-OLISP-GP-2015-01 (Minor Coastal Structures): 4/40 docks; non-harbor moorings; osprey platforms and perch poles; buoys and navigational markers; harbor moorings; swim floats; pump-out facilities; experimental activities and scientific monitoring devices.

DEEP-OLISP-GP-2015-02 (Coastal Maintenance): marina reconfigurations; remedial activities; modification of residential structures to meet FEMA standards; reconstruction of coastal structures; certain Department of Transportation maintenance activities; beach grading; removal of a derelict structures; placement of culch; minor seawall repairs; catch basin cleaning; repairs of backflow structures on discharge pipes; certain coastal restoration activities; temporary construction access; and certain DEEP boat launch repairs.

DEEP-OLISP-GP-2015-03 (Coastal Storm Response): certain coastal storm-preparation activities and post-storm recovery and repair activities.

Interested parties are encouraged to review the full text and a summary overview of these proposed GPs at: www.ct.gov/deep/publicnotices.

A general permit is a permit issued to authorize a specific category of activities, rather than an individual activity. The proposed GPs would allow persons to conduct the covered activities provided that such activities conform to the specific authorization requirements set forth in each of the GPs including consistency with CGS § 22a-361(d)(1) and § 22a-92; protection of coastal resources including endangered and threatened species and essential habitats, fish, shellfish, and wildlife; natural sedimentation and erosion processes; shellfishing; and maintenance of safe navigation.

DEEP has made a tentative determination that the activities proposed to be authorized through these GPs will: (A) cause minimal environmental effects when conducted separately, (B) cause only minimal cumulative environmental effects, (C) be consistent with the considerations and the public policy set forth in CGS § 22a-28 to 22a-35, inclusive, and § 22a-359, as applicable, (D) be consistent with the policies of the Coastal Management Act, and (E) constitute an acceptable encroachment into public lands and waters.

DEEP will hold two public informational sessions on the proposed GPs as follows:

Tuesday July 21st, 10:00AM - 11:30AM
DEEP Russell Hearing Room, 3rd Floor
79 Elm Street, Hartford, CT 06106-5127

Wednesday July 22nd, 7:00PM - 8:30PM
DEEP Marine HQ Auditorium Bldg. #3
333 Ferry Road, Old Lyme, CT 06371

Written comments on the proposed GPs may be submitted at the public informational sessions or can be sent to Peter B. Francis, DEEP/Office of Long Island Sound Programs, 79 Elm Street, Hartford, CT 06106-5127 or to peter.francis@ct.gov. Prior to making a decision to approve, deny or modify any of these proposed General Permits, the Commissioner shall consider all comments provided during the public comment period. **Any comments on the proposed GPs must be submitted no later than July 27, 2015.**

The Commissioner also gives notice that DEEP shall hold an adjudicatory hearing upon receipt of a petition signed by twenty-five or more persons pursuant to CGS § 22a-361(d)(2) and CGS § 22a-378a(b). Petitions for a hearing should include the GP number noted above and also identify a contact person to receive notifications. Petitions may also identify a person who is authorized to engage in discussions regarding the hearing request and, if resolution is reached, withdraw the petition. Original petitions must be mailed or delivered within the comment period noted above to: DEEP Office of Adjudications, 79 Elm Street, 3rd floor, Hartford, 06106-5127. Petitions cannot be sent by fax or email. For additional information visit www.ct.gov/deep/adjudications. **Any petitions for hearing on the proposed General Permits must be submitted no later than July 23, 2015.**

DEEP is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 418-5910 or deep.accommodations@ct.gov.

Approved by: Michael Sullivan
Deputy Commissioner

Date: June 23, 2015

Notice of Intent to Issue General Permits Notice of Public Informational Meetings

In accordance with Connecticut General Statutes ("CGS") § 22a-361(d)(2) and CGS § 22a-378a, the Department of Energy and Environmental Protection ("DEEP") hereby gives notice of intent to issue General Permits ("GPs") for certain coastal activities undertaken waterward of the coastal jurisdiction line in the tidal, coastal or navigable waters of the State of Connecticut and in tidal wetlands. In addition to authorizing new activities, the proposed GPs would also consolidate the activities currently authorized in existing GPs #DEEP-LIS-GP-001 through #DEEP-LIS-GP-015. Therefore, such existing authorizations would be superseded upon adoption of the proposed GPs.

The activities proposed to be authorized under these GPs include:

DEEP-OLISP-GP-2015-01 (Minor Coastal Structures): 4/40 docks; non-harbor moorings; osprey platforms and perch poles; buoys and navigational markers; harbor moorings; swim floats; pump-out facilities; experimental activities and scientific monitoring devices.

DEEP-OLISP-GP-2015-02 (Coastal Maintenance): marina reconfigurations; remedial activities; modification of residential structures to meet FEMA standards; reconstruction of coastal structures; certain Department of Transportation maintenance activities; beach grading; removal of a derelict structures; placement of culch; minor seawall repairs; catch basin cleaning; repairs of backflow structures on discharge pipes; certain coastal restoration activities; temporary construction access; and certain DEEP boat launch repairs.

DEEP-OLISP-GP-2015-03 (Coastal Storm Response): certain coastal storm-preparation activities and post-storm recovery and repair activities.

Interested parties are encouraged to review the full text and a summary overview of these proposed GPs at: www.ct.gov/deep/publicnotices.

A general permit is a permit issued to authorize a specific category of activities, rather than an individual activity. The proposed GPs would allow persons to conduct the covered activities provided that such activities conform to the specific authorization requirements set forth in each of the GPs including consistency with CGS § 22a-361(d)(1) and § 22a-92; protection of coastal resources including endangered and threatened species and essential habitats, fish, shellfish, and wildlife; natural sedimentation and erosion processes; shellfishing; and maintenance of safe navigation.

DEEP has made a tentative determination that the activities proposed to be authorized through these GPs will: (A) cause minimal environmental effects when conducted separately, (B) cause only minimal cumulative environmental effects, (C) be consistent with the considerations and the public policy set forth in CGS § 22a-28 to 22a-35, inclusive, and § 22a-359, as applicable, (D) be consistent with the policies of the Coastal Management Act, and (E) constitute an acceptable encroachment into public lands and waters.

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Approved by: Michael Sullivan
Deputy Commissioner

Date: June 23, 2015

WE HAVE IMMEDIATE OPENINGS!

SEEKING FULL & PART TIME SALES PROFESSIONALS

EARNING POTENTIAL \$100 - \$200/DAY

Sales Reps Required!

We are growing, and we want YOU to be a part of our Sales Team!

Opportunity to market a product that everyone recognizes. Set your own hours with a flexible schedule.

An excellent pay plan with unlimited earning potential is just one of the many benefits.

Applicants should be outgoing and self-motivated with strong desire to succeed.

INTERESTED CANDIDATES SHOULD CONTACT US AT 800-313-1135 OR EMAIL AT: info@actionconsumermarketing.com

Healthy Adults Needed for Brain Imaging Study

If you are a medically healthy, drug-free, nonsmoker between the ages of 25 and 85 years of age, you can participate in a study to help us understand how people learn and make decisions at different ages by imaging dopamine receptors in the brain.

The study will involve 3-5 visits over a 4 to 6 week period. Your visits may include blood draw, urine drug test, EKG, MRI, and PET scan.

Compensation up to \$680 for ages 25-50 or up to \$410 for ages 51-85.

If you are interested in participating and to complete eligibility screening questions, please contact us at:

(203) 432-1150
All calls are confidential

Yale University School of Medicine
HIC# 1308012544

THE NEWS-TIMES

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SOUTHERN CT JOBS

203-330-6556 | classified@newstimes.com | Hours: 8:30 a.m.-5:30 p.m., M-F | Major Credit Cards Accepted

PUBLIC NOTICES

Office of Health Care Access Public Hearing

Statute Reference: 19a-638
 Applicant: Western Connecticut Health Network
 Town: Danbury
 Docket Number: 15-31978-CON
 Proposal: Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs
 Date: July 7, 2015
 Time: 4:00 p.m.
 Place: Broadview Middle School - Auditorium
 72 Hospital Avenue
 Danbury, CT 06810

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 2, 2015 (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.

LIQUOR PERMITS

LIQUOR PERMIT

Notice of Application

This is to give notice that I

CRAIG C. RICHARDSON
 78 SPRING LAKE ROAD
 SHERMAN CT 06784-1215

Have filed an application placarded 06/10/2015 with the Department of Consumer Protection for a CAFE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at

21 BANK ST.
 NEW MILFORD, CT 06776-2701

The business will be owned by:

AMERICAN COMFORT FOOD LLC

Entertainment will consist of:
 NONE

Objections must be filed by:
 07/22/2015

CRAIG RICHARDSON

PUBLIC NOTICES

ATTENTION SPECIAL SERVICE RECORDS TO BE DESTROYED

In keeping with state and federal regulations on confidentiality, school officials plan to destroy special service records and Section 504 records of students born in the year 1987, who attended the New Fairfield Public Schools. Confidential records are destroyed six years after they become irrelevant to the provision of educational services or after graduation. The destruction is scheduled to take place on July 22, 2014.

Anyone interested in receiving his or her records or those of their children should make the request in writing to: Director of Pupil Personnel Services, New Fairfield High School, 54 Gillotti Road, New Fairfield, CT 06812.

GENERAL HELP WANTED

DRIVER/WAREHOUSE F/T

Driver for deliveries in Tri-state area and warehouse duties. CDL Class B with hazmat endorsement necessary. Benefits package including full medical, dental, optical, 401K. Call 914-273-4400 for appointment.

GENERAL HELP WANTED

Automotive

Greentree Toyota Service Center is looking for Experienced **SERVICE ADVISORS, ASE & CERTIFIED TECHNICIANS**.

We offer a \$250.00 sign on bonus. 40 hour work week. 401k. Health Insurance, and Uniforms. All interested candidates should go on-line to greentreamotors.com. Click on the information link then employment. Fill out the on line application to arrange an interview. Or call Chris Morgado @ 203775-6221. ext114

GENERAL HELP WANTED

Automotive-Mechanic, FT

Mahopac, NY. Own tools, transportation & Exp. necessary. Ref's a Must! Call Joan, 845-628-3060

GENERAL HELP WANTED

CARPENTER/PAINTERS - FT

Experienced only. Must have own transportation. Danbury area. Call 203-790-5615

GENERAL HELP WANTED

CHAUFFEURS - PT/FT

EXPERIENCED "stretch" limo Driver Knowledge of Fairfield & NY Metro area. Call Chuck 203-762-7780

GENERAL HELP WANTED

COOK

Line Cook PT/FT. Breakfast experience a plus. American Pie Co., Sherman, CT 860-350-0662

GENERAL HELP WANTED

COUNTER PERSON - F/T-P/T

for Colonial Cleaners in Ridgefield. Must be detail oriented, friendly & enjoy working w/customers. Speak & read English. Call 203-431-6397

GENERAL HELP WANTED

CUSTOMER SERVICE

Call Center-Danbury area. Full & Part time, afternoon & evening shifts. Must be able to work weekends and have a clean criminal background. \$12-\$12.50/hr to start. Immediate openings! Call HCB- (203) 456-1800

GENERAL HELP WANTED

DELIVERY DRIVER - LP GAS

Class B CDL w/Tanker, Hazmat & clear driving history req'd. Exc. comp., 401k, profit sharing & health benefits. Secure year round position. MUST reside w/in 20 miles of Bethel CT. Fax resume 203-730-8623/E-mail hr@newenglandpropane.com

GENERAL HELP WANTED

DIESEL MECHANIC (Heavy Truck)

Experience Necessary! for garbage/recycling co in Westchester City, NY. Mostly Macks, Union, health ins, pension t: 914-873-8233, f: 914-698-0364, joriando@suburbancarting.com

GENERAL HELP WANTED

DRIVER P/T Mon & Wed. 9am-2pm to drive non-drivers car on various errands. Danbury/Ridgefield area. Requires: female & valid CT drivers license. Call 203-746-2121

SCHOOLS & JOB TRAINING

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CLASSES AVAILABLE TO LEARN

- NEW PATIENT CARE TECHNICIAN IN 10 WEEKS
- NEW CNA'S TO PATIENT CARE TECH IN 7 WEEKS
- CERTIFIED NURSING AIDE IN 4 WEEKS
- DENTAL ASSISTING IN 4 WEEKS
- PHLEBOTOMY
- EKG

NEW Bridgeport Location: 4637 Main Street
 The Brookside Professional Bldg.
 91 Shraffts Dr., Waterbury
 203-378-2210 • 1-800-886-8773

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 EASY PAYMENT PLANS • AS LITTLE AS \$150 DOWN

GENERAL HELP WANTED

HANDY MAN/ CARPENTER

Looking for sub-contractors that have experience in painting and dry-wall repairs, interior/exterior trim and siding work, deck repairs, & gutters. The sub-contractor will carry their own business insurance and be required to use their own vehicle. The sub-contractors position will pay up to \$25/ hour depending on experience. This will be for year round work. Send resume or letter of interest to dezmond54@aol.com

JOB FAIR

Career Opportunities

FULL/PART TIME - ALL SHIFTS
 DIRECT CARE POSITIONS

STAR, Inc. is located in Norwalk and supports individuals with intellectual and developmental disabilities in the surrounding towns in all aspects of life including housing, employment, and recreation. If you are looking for a rewarding career supporting adults with disabilities, please join us. Great benefits with opportunities for advancement.

Date: Thursday, June 25, 2015
4:00 p.m. - 6:00 p.m.
STAR, Inc.
182 Wolfpit Avenue
Norwalk, CT 06851

Goodwill

JOIN US FOR A RETAIL HIRING EVENT

Friday, June 26, 2015
 9:00 A.M. TO 3:00 P.M.
 New Milford Goodwill store
 141-143 Danbury Rd New Milford

- Managers
- Shift Supervisors
- Retail Associates
- Donation Center Attendants

Goodwill offers competitive salaries & excellent benefits package.

For Immediate Consideration stop in the New Milford Store 141-143 Danbury Rd, New Milford CT to fill out an application. EOE M/F/D/V

GENERAL HELP WANTED

LITIGATION PARALEGAL

Cramer & Anderson LLP is seeking a litigation paralegal, full or part time hours will be considered for our Litchfield office. Candidate must have 3-5 years minimum experience in drafting documents, filing pleadings with court, able to work independently, possess strong communication and client contact skills, clerical and secretarial duties required. Competitive salary and benefits offered.

Please email resume to gfredlund@crameranderson.com

GENERAL HELP WANTED

***** OPEN HOUSE *****

Saturday - 6/27
 9:00am - 1:00pm
ECA

10 Mountain View Drive
 Shelton, CT

Job openings include:

- Sheet Metal Fabricators: press brake, welders, finishing, CNC
- Assemblers-skilled bench
- Shipping/Receiving/Packaging

1st & 2nd shifts

Please bring resumes
All TEMP to PERM Positions

For more information contact H.C. of Milford
203-882-5025

GENERAL HELP WANTED

PROFESSIONAL CORPORATE DRIVERS NEEDED

For Large Transportation Company in Southern CT. Starts Immediately - Competitive Pay.

Daily M-F Scheduled Routes (SUV's Vans, Shuttle Buses) 1st and 2nd shifts available "E" Endorsement required

Experienced Coach Drivers also needed

For more information or to schedule a meeting call 203-665-6922 M-F before 5pm

GENERAL HELP WANTED

RESTAURANT The Iron Rail, a new restaurant opening on 10 Railroad St, New Milford. Looking for exp'd Bartenders & Dishwashers FT/PT. Contact 860-248-9655

GENERAL HELP WANTED

RESTAURANT DISHWASHER / GRILL PERSON for Diner in Ridgefield. Call 203-438-5338

SCHOOLS & JOB TRAINING

\$\$\$ EARN CASH \$\$\$

Be a Newspaper Carrier

7-day early morning independent contractor routes available in

- Ridgefield
- Bethel
- Brookfield
- New Fairfield

Please reply by calling:
203-731-3474

and include: Name, email, phone, town you live in, type of vehicle, newspaper delivery experience. A Route Manager will contact you.

* We prefer to match routes with people who live close to the towns where routes are located.

GENERAL HELP WANTED

Restaurant

EXPERIENCED SHORT ORDER COOK, GRILL PERSON, SERVERS. SAUTE BROILER PERSON

F/T Breakfast, Lunch & Dinner.
 Pay \$15-\$18/HR
 Apply in person
COUNTRY CORNER DINER
 756 Amity Rd, Bethany
 203-393-1489

GENERAL HELP WANTED

RESTORATION- Masons & Roofers

Experienced commercial. New England Masonry 203-729-2266 AA/EOE

GENERAL HELP WANTED

SALES ASSOCIATE

for CT's Largest Volume Used Car Dealership. Excellent appearance, verbal & written communication skills. Aggressive Pay. Valid driver's lic. Call Kam or Mike @ 203-720-5600.

GENERAL HELP WANTED

SALON ASSISTANT Part-Time
 Tues, Wed, & Fri. Bethel.
 Call 203-798-2789

GENERAL HELP WANTED

SERVER

Full & part time positions available for premier senior living community Great hourly rate, full benefits package for FT. Please apply in person Ridgefield Crossings, 640 Danbury Rd, Ridgefield, CT 06877. No phone calls please

GENERAL HELP WANTED

STORE FRONT INSTALLER

Glass work exp a bonus. Must be able to use power tools and a tape measure. Fluent in english & good driving record. Stamford. Fax res. 203-327-9698 or Call 203-327-5730. Email: ctglassmirror@aol.com

GENERAL HELP WANTED

WAREHOUSE STOCK PERSON

If you are good with numbers, are passionate, & have a great attitude, we have a job for you. Full & Part Time overnight positions available. Fax resume 203-731-3085, Email: jeff@levineauto.com www.levineauto.com

GENERAL HELP WANTED

HEALTHCARE & EMPLOYMENT OPS

DENTAL ASSISTANT - FT

Reliable- Will train!
 Career Minded
 Benefits.
 Please call 203-792-2264

GENERAL HELP WANTED

THE CITY OF STAMFORD

is recruiting for the following healthcare positions at the Smith House Health and Rehabilitation Center:

Assistant Director of Nursing \$79,590 - \$102,256
Recreation Facilitator \$18.35 - \$21.68/hour
MDS Coordinator \$88,626.79
Staff Nurse - RN \$29.82 - \$40.58/hour
RN Care Manager \$92,603

Applications can be obtained at www.stamfordct.gov

SITUATIONS WANTED

ATTENTION

The advertisers in this classification are providing a service.

ABSOLUTELY FREE

FILE CABINET, metal, 5 drawer, vertical, 15"W x 59"H x 28.5"D, FREE. 203-746-7060

LOCK RIDING LAWN MOWER (sit down). Does not work. FREE. Call 203-733-8894.

TWIN BED, blue race car frame, FREE. 203-775-8243 leave message

MERCHANDISE FOR SALE

2009 CUB CADET LTX1040 42in tractor, 2009 cub cadet LTX1040 42in tractor runs, best for parts, 200 call 203-482-1985

3 Blizzak tires on 18" Ford wheels with hubcaps, Tires like new. \$100. 203-470-5269.

A1 Cond. Cocker Spaniel Sandicats status. Var. Colors. Lg. size. pups/adults \$25ea 203-743-7751

MERCHANDISE FOR SALE

ADDING MACHINE SHARP, 12 DIG-IT W/PRINTOUT, \$35. 203-746-5046

ADIRONDACK CHAIRS, Stacking white chair 4 for \$20. 203-426-2437

MERCHANDISE FOR SALE

ADIRONDACK FURNITURE 2 rocking chairs, 2 high chairs w/stand up table, 2 dbl chairs w/table between, futon end tables & queen bed frame, call for prices. 203-970-0028

AIR CONDITIONER, Friedrich 12,000 BTU \$125. 860-354-7278

AIR CONDITIONER GE 9900 BTU, W/REMOTE EXCELLENT CONDITION, \$125. 203-746-5046

MERCHANDISE FOR SALE

AMERICAN TOURISTER, 5 piece luggage set, \$30 firm. 203-573-0820

ANTIQUE LIMOGES by Macys china. 92 pieces (12 place settings), exc cond for age. \$275. 203-748-2774

ANTIQUE LINENS, assorted small linens. \$3 each. 203-748-2774

MERCHANDISE FOR SALE

BEDROOM SET, Stanley 6 piece, Excellent condition. \$899. 203-746-4467

BEDROOM SET Scrubbed pine, Sleigh bed, 2 dressers, lingerie cabinet, \$1500 obo; Bedroom Set Ethan Allen cherry \$3500; Piano \$75. (203)262-6084

MERCHANDISE FOR SALE

BRAND NEW Queen Pillow-top Mattress, still in plastic, \$100. Call Bob 860-402-8007

BRAND NEW King Size Mattress, still in plastic, \$200. call Bob 860-402-8007

MERCHANDISE FOR SALE

BUMPERS 1 front, Black 1 rear, chrome with brackets for 1953 - 56 PU. \$100/ea. 203-743-6163

CARPET SWEEPER HANDY MANUAL, FULLER BRUSH, \$20. 203-746-5046

MERCHANDISE FOR SALE

C CLAMP TOOL for removing and replacing universal in drive shafts on cars. All sizes. \$25. 203-743-6163

CHAIR, Solid wooden chair dark color, kitchen, office, cut out back, exc cond, \$30.00 203-268-9170

MERCHANDISE FOR SALE

CHINA, 88 piece Sango-Charlemagne #3659, perfect cond, \$95. 203-743-0542

CIRCULAR HAND SAW, Black & Decker, aluminum, 110 volts, extra blades, \$20. 203-743-6163

MERCHANDISE FOR SALE

DINING ROOM table with bench, brown, 65" x 36" Bassett laminated top, truss legs, \$200. 203-743-6163

ENTRY DOOR 36" steel door/frame, 6 pane arch win. 2x6 wall Exc cond. \$60. 203-743-4064

MERCHANDISE FOR SALE

ETHAN ALLEN CHAIRS, 2, excellent condition \$849. 203-746-4467

FRANCONIA QUADRILL CHINA new, 8 pl. Settings +, \$125. 203-743-7751

MERCHANDISE FOR SALE

GENERATOR HUSKY 3750, brand new, never used, \$325. 203-970-0028

GOLF CART w/charger. \$1200.00 Call (860)799-0850

HOUSE JACKS, 2 large, cast iron, \$15. 203-746-2113

MERCHANDISE FOR SALE

JENN-AIR GRILL, stainless steel with electric rottisseri, 7"W, \$425. 203-970-0028

KITCHEN CAHIRS (4) oak \$40.00 china closet, oak, beveled glass 47X80X20 \$115.00 203-746-1711

MERCHANDISE FOR SALE

LADDER EXT. 28' wood exc. cond. \$10.00 Rug dq. quality round 7' \$25.00, Old pedal Singer sewing mach. \$140.00 203-746-1711

LIVING ROOM FURNITURE, 2 pc futon sofa & chair, both open to full & single bed, fall like colors. Very good cond, \$450. Call 203-746-1706

MERCHANDISE FOR SALE

MICROWAVE, Emerson .7 cubic feet very clean and works great, \$20. 203-240-5910

MURRAY FEISS 3 light oil rubbed bronze Chandelier with matching Pendant light never used \$325. 203-746-4467

MERCHANDISE FOR SALE

NAIL GUN, Remington nail gun \$35. 203-746-2113

Nissan Frontier alloy wheels and tires, will fit 2005-14. Excellent shape. \$400. 203-470-5269.

MERCHANDISE FOR SALE

Nissan Frontier Crew Cab BakFlip hard tonneau cover, weather proof, solid, like new. \$350. 203-470-5269.

OAK TABLE, 5x3, old library tgable, \$300. 203-970-0028

MERCHANDISE FOR SALE

PERENNIALS for sale. Many to choose from. Most deer resist. Call for comp. list. \$3& up 203-748-2774

PORCELIN DOLL collection each doll approx 16" tall, included 5'H mahogany curio cabinet, cost \$1800, asking \$300. 203-743-0542

MERCHANDISE FOR SALE

RACING SCANNER receiver with 72 headphones, \$75 BO. 203-426-2635

ROYAL DALTON & Hummel Collection, 1950's & 1960's vintage, all for \$450. 203-743-0542

MERCHANDISE FOR SALE

SAW HORSES, (2), \$10. 203-746-2113

SHOES DESIGNER TORY BURCH
 Brand new Size 5 1/2 Cheetah Coconut #215 Jess flat
 Leather Style 32138468
ORIGINAL PRICE \$265.00
\$100.00 OBO 203-775-6925

MERCHANDISE FOR SALE

SNAP ON socket set, 3/4" drive, 3/4" to 1 13/16" sockets in box, ratchet head, sliding & handle head, extension lock button, adaptors to 1/2" drive, \$150. 203-743-6163

SNOW TIRES Honda Fit, Four snow tires for Honda Fit - Viking 195/55 R15, 85H M.S. \$200 OBO. 917-365-3400

MERCHANDISE FOR SALE

SOFA, 72" beige, flower design, \$75. 203-746-2113

SOFTOPPER for 2005 - 12 Toyota Tacoma for double cab short bed. \$100. 203-470-5269.

MERCHANDISE FOR SALE

S.S. PORTER "Young Mother" 1906 print. \$85. 203-573-0820

STORAGE/ENTERTAINMENT, 48lx38Hx19W, \$85. 203-746-5046

MERCHANDISE FOR SALE

STORM DOOR, 36" wnt. hvy duty 3/4 glass screen \$50. 203-743-4064

TABLE FAN, 18 inch, Sanyo, \$18. 203-746-2113

MERCHANDISE FOR SALE

TEA CART, glass/walnut/brass, \$15. 203-573-0820

THOMAS ORGAN, exc cond, full keyboard & base pedals, electric, \$499. 203-426-2635 lv msg

MERCHANDISE FOR SALE

TIRES & RIMS, call for details. 203-981-4878

Toyota Tacoma full set of steel wheels and tires for 1998-2004. Tires are great. \$125. 203-470-5269.

MERCHANDISE FOR SALE

TV/ARMOIRE OAK 43X84X32 \$100.00, Victorian sofa/2arm chairs exc. cond. \$400.00 203-746-7111

WAGON WHEELS, one small, \$50 & 1 large, \$75. 203-970-0028

MERCHANDISE FOR SALE

WATER SKIS, O'Brien 68 inches, one slalom, one regular ski, exc cond, \$45. 203-797-9695

WICKER SHELF UNIT, natural color, \$15. 203-573-0820

DOMESTIC ANIMALS



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by
Western Connecticut Health Network

Docket Number: 15-31978-CON

Notice to Petitioner re: Request for Status

RULING ON A PETITION TO BE DESIGNATED AS A PARTY

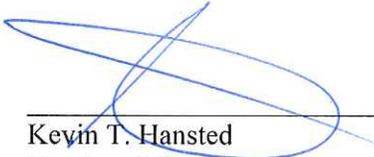
By petition dated March 16, 2015, The Danbury Nurses, Local 5047, Unit 47, AFT-CT, AFT, AFL-CIO and AFT-CT ("Petitioner") requested party status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of Western Connecticut Health Network ("Applicant") filed under Docket Number: 15-31978-CON.

Pursuant to Connecticut General Statutes § 4-177a(b), the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for July 7, 2015, 4:00 p.m., at Broadview Middle School – Auditorium, 72 Hospital Avenue, Danbury, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 15-31978-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant. Pursuant to § 19a-9-29 (e) of the Regulations of Connecticut State Agencies, 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. The Petitioner must submit prefiled testimony to OHCA no later than 12:00 p.m. on July 2, 2015.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

6/23/15
Date


Kevin T. Hansted
Hearing Officer

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

June 23, 2015

Ms. Sally F. Herlihy
Vice President, Planning
Western Connecticut Health Network
24 Hospital Avenue
Danbury, CT 06810

RE: Certificate of Need Application; Docket Number: 15-31978-CON
Western Connecticut Health Network
Termination and Transfer of Ownership of Seifert & Ford Family Community Health Center
("S&F") and Community Center for Behavioral Health Programs ("CCBH")

Dear Ms. Herlihy:

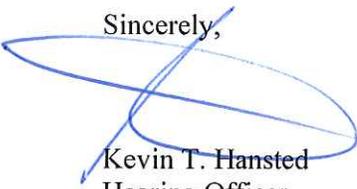
The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on July 7, 2015. The hearing will be held at 4:00 p.m. in the auditorium of Broadview Middle School, 72 Hospital Avenue, Danbury. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any 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. Western Connecticut Health Network must submit prefiled testimony to OHCA no later than 12:00 p.m. on July 2, 2015.

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 Jessica Schaeffer-Helmecki at (860) 509-8075 or Olga Armah at (860) 418-7070, if you have any questions concerning this request.

Sincerely,



Kevin T. Hansted
Hearing Officer

cc. Brian A. Doyle, Esq.
Attachment

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

Issues

Certificate of Need Application; Docket Number: 15-31978-CON

Western Connecticut Health Network (“WCHN”)

Termination and Transfer of Ownership of Seifert & Ford Family Community Health Center (“S&F”) and Community Center for Behavioral Health Programs (“CCBH”)

The Applicant should be prepared to present and discuss supporting evidence on the following issues:

1. Any changes to services currently provided by the Applicant that will now be provided by Greater Danbury Community Health Center (“GDCHC”)
2. The financial ability of GDCHC to maintain the levels of services currently provided by the Applicant

* * * COMMUNICATION RESULT REPORT (JUN. 23. 2015 3:21PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 23. 2015 3:19PM

FILE MODE	OPTION	ADDRESS	RESULT	PAGE
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REASON FOR ERROR
 E-1) HANG UP OR LINE FAIL
 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



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

FAX SHEET

TO: Brian A. Doyle, Esq.

FAX: (860) 529 0339

AGENCY: Ferguson, Doyle & Chester, P.C.

FROM: Jessica Schaeffer-Helmecki/Olga Armah

DATE: 6/23/2015 **TIME:** _____

NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: 15-31978 -CON Termination and Transfer of Ownership of S& F and CCBH
 Ruling on Petition for Party Status and Hearing Issues

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001

Fax: (860) 418-7053

**410 Capitol Ave., MS#13HCA
 P.O.Box 340308
 Hartford, CT 06134**

* * * COMMUNICATION RESULT REPORT (JUN. 23. 2015 3:19PM) * * *

FAX HEADER:

TRANSMITTED/STORED : JUN. 23. 2015 3:18PM	FILE MODE	OPTION	ADDRESS	RESULT	PAGE
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 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



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

FAX SHEET

TO: Sally F. Herlihy
Vice President, Planning

FAX: (203) 739 1974

AGENCY: Western Connecticut Health Network

FROM: Jessica Schaeffer-Helmecki/Olga Armah

DATE: 6/23/2015 **TIME:** _____

NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: 15-31978 -CON Termination and Transfer of Ownership of
 S& F and CCBH
 Hearing Issues and Ruling on Petition for Party Status

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

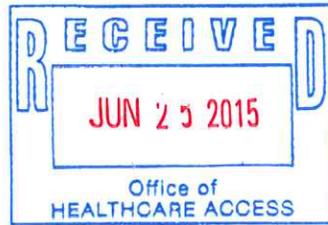
Phone: (860) 418-7001

Fax: (860) 418-7053

**410 Capitol Ave., MS#13HCA
 P.O.Box 340308
 Hartford, CT 06134**

THEODORE J. TUCCI

280 Trumbull Street
Hartford, CT 06103-3597
Main (860) 275-8200
Fax (860) 275-8299
ttucci@rc.com
Direct (860) 275-8210



Via Hand Delivery

June 25, 2015

Kimberly R. Martone
Director of Operations
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134

Re: Certificate of Need Application
Docket Number: 15-31978-CON
Western Connecticut Health Network
Proposal to Terminate and Transfer Ownership of
Seifert & Ford Family Community Health Center and
Community Center for Behavioral Health Programs

Dear Ms. Martone:

On behalf of Western Connecticut Health Network ("WCHN"), enclosed please find my appearance, along with two copies, on behalf of WCHN in connection with the above referenced CON proceeding. I also enclose a copy of my appearance for purposes of date stamping and returning to me.

Thank you for your attention to this matter.

Very truly yours,

Theodore J. Tucci

TJT/seh
Enclosure

CERTIFICATION

This is to certify that a copy of the foregoing was sent by first class mail, postage prepaid,
on June 25, 2015 to Intervenor's counsel:

Brian A. Doyle, Esq.
Ferguson, Doyle & Chester, P.C.
35 Marshall Road
Rocky Hill, CT 06068


Theodore J. Tucci

Greer, Leslie

From: Armah, Olga
Sent: Monday, June 29, 2015 4:07 PM
To: Sally Herlihy (Sally.Herlihy@wcthealthnetwork.org)
Cc: Schaeffer-Helmecki, Jessica; Greer, Leslie
Subject: Docket No. 15-31978 CON WCHN Hearing Designation
Attachments: 31978_201506291358.pdf

Attached is the notice of hearing officer designation for your records.

Olga Armah, M. Phil
Associate Research Analyst
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Phone: 860 418 7070
Fax: 860 418 7053
mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner 

DATE: June 29, 2015

RE: Certificate of Need Application; Docket Number: 15-31978-CON
Western Connecticut Health Network
Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community
Health Center and Community Center for Behavioral Health Programs

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.



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

* * * COMMUNICATION RESULT REPORT (JUN. 29. 2015 4:06PM) * * *

FAX HEADER:

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REASON FOR ERROR
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 E-3) NO ANSWER

E-2) BUSY
 E-4) NO FACSIMILE CONNECTION



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

FAX SHEET

TO: Brian A. Doyle, Esq.

FAX: (860) 529 0339

AGENCY: Ferguson, Doyle & Chester, P.C.

FROM: Jessica Schaeffer-Helmecki/Olga Armah

DATE: 6/29/2015 **TIME:** _____

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments: 15-31978 -CON Termination and Transfer of Ownership of S& F and CCBH Hearing Officer Designation

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 Fax: (860) 418-7053
410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

THEODORE J. TUCCI

280 Trumbull Street
Hartford, CT 06103-3597
Main (860) 275-8200
Fax (860) 275-8299
ttucci@rc.com
Direct (860) 275-8210

Via Hand Delivery

July 2, 2015



Kimberly R. Martone
Director of Operations
State of Connecticut
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134

Re: Certificate of Need Application
Docket Number: 15-31978-CON
Western Connecticut Health Network
Proposal to Terminate and Transfer Ownership of
Seifert & Ford Family Community Health Center and
Community Center for Behavioral Health Programs

Dear Ms. Martone:

In accordance with Hearing Officer Hansted's ruling dated June 23, 2015, and pursuant to Section 19a-9-29(e) of the Regulations of Connecticut State Agencies, enclosed for filing in the above-captioned Docket are the original and two copies of the Prefiled Testimony of Michael Daglio, President of Norwalk Hospital and Senior Vice President of Western Connecticut Health Network, Inc.

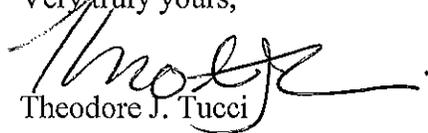
13900906-v1

Robinson + Cole

Kimberly R. Martone
July 2, 2015
Page 2

Thank you for your attention to this matter.

Very truly yours,



Theodore J. Tucci

TJT/she
Enclosure

Copy to: Brian A. Doyle, Esq. (w/encl.)

Background

A core tenet of WCHN's mission is to provide healthcare services to the communities we serve regardless of any individual's ability to pay. Historically, WCHN has advanced that goal, in part, through services offered at S&F and CCBH. The realities of today's healthcare reimbursement system have created a situation in which providing these services to underinsured and uninsured patients in a hospital-based clinic setting is economically unsustainable. After careful consideration of multiple options, WCHN determined that the optimal strategy for continuing to ensure access to quality primary care to the medically underserved would be to terminate its provision of certain services and to establish a collaborative relationship with GDCHC which, as a FQHC, mirrors the mission of S&F and CCBH. GDCHC currently operates in Danbury, and offers a wide range of comprehensive primary care services, including medical, dental, and mental health. GDCHC provides such services to medically underserved residents of all ages in the greater Danbury area. Its mission is to ensure affordable, high quality comprehensive health care to maintain and promote wellness. WCHN seeks to come together with GDCHC to form a well-structured hospital/FQHC collaboration. In formulating this proposal, WCHN is following successful models in the State of Connecticut and around the country that have been demonstrated to maximize resources available to deliver community-based care, increase the financial stability of organizations delivering this care, and reduce unnecessary duplication of services in the local healthcare delivery system.

Proposal to Transition and Collaborate

The collaboration between WCHN and GDCHC is multi-faceted. It will involve transitioning primary care and behavioral services to CIFC/GDCHC, recognized as a Level 3 patient centered medical home ("PCMH") by the NCQA. At the same time, Danbury Hospital will continue providing specialty care clinics at the existing S&F and CCBH locations. It is important to note that, going forward, Danbury Hospital will be actively collaborate with GDCHC through an agreement to provide specialty services that include: orthopedics, spine, podiatry, urology, neurology, allergy, rheumatology, and tuberculosis. In the first year of the transition plan, GDCHC will assume responsibility for provision of adult primary care, pediatric services and primary care obstetrics (which does not include childbirth). WCHN will maintain responsibility for behavioral and dental services, which will not be transitioned to GDCHC until year two.

We have learned, after months of working together to craft this collaboration, the depth of similarity between our two organizations in terms of shared mission and promoting access to quality care for patients who might not otherwise have the resources to pay. Our target population includes the current uninsured, underinsured and Medicaid patients receiving services at the S&F, CCBH and CIFC locations. S&F, CCBH and CIFC service patients in the same geographic region. The proposed transfer of services supports the continued seamless delivery of health care to the existing patients of S&F and CCBH, but also the expansion of access to such services in the communities served by both organizations.

Consistent with goals of federal health care reform under the Affordable Care Act, this proposal is not simply a transfer of existing primary care service responsibility to a FQHC, but the establishment of an ongoing collaboration between WCHN and GDCHC. Coordination of the full range of primary and specialty services to the medically underserved will be enhanced by strategic initiatives to improve the quality of healthcare and promote overall wellness of our patients. In addition, WCHN and GDCHC will work together on accountable care initiatives intended to efficiently manage health care for their patient population. Accountable care efforts will include use of quality measures and the formulation for a Quality Committee with joint representation from S&F and GDCHC. We will also work together on a residency training program for primary care physicians intended to increase the number of physicians providing primary care, the coordination of primary and specialty care for patients through shared electronic health records, and other administrative and supportive functions that WCHN can provide. As demonstrated in our CON submission, this proposal is reflective of the implementation of a new model for community-based healthcare delivery for patients, especially those who may be uninsured or underinsured.

The benefits that will result from approval of this proposed are spelled out in detail at pages 10-12 of our CON application, and include:

- By coming together in a partnership to provide services to the same medically underserved and vulnerable patient populations, WCHN and CIFIC can significantly reduce the costs of providing this care through reduced infrastructure cost and elimination of duplication of services
- Increase the access and accessibility of services provided to this patient population through expanded service hours
- Increase the number of primary care providers and specialty providers; and
- Expand collaborative programs to ensure this population is receiving the right care in the right place at the right time, regardless of the patient's ability to pay for the services.
- Taking advantage of reimbursement mechanisms and funding sources that would not otherwise be available to S&F, which will enhance GDCHC's financial ability to continue to provide community based primary care.

These goals for the patients in our service area cannot be achieved if this proposal is not approved.

Benefit to Patients

Upon approval of this application, WCHN and CIFIC will begin to move forward immediately to ensure a seamless transition of care over time – from what patients will experience, to what physicians will access, to how our communities will participate. The benefits to the patients we serve will be significant. Our collaboration will result in increased access to care through expanded hours, reduction in drug costs for patients due to availability of

340B drug pricing, improved coordination of primary and specialty care, and greater future stability in the system for delivery of primary care due to financial and reimbursement advantages available to GDCHC as a FQHC.

State Health Care Policy

I come to you to share my strong confidence in the future of community health that our collaboration with the Connecticut Institute for Communities, Inc.'s (CIFIC) will bring to the people located in our local communities. In an era of health care reform, and diminishing resources, this proposal furthers 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.

This application also furthers the aims of Connecticut's Healthcare Innovation Plan (the State's framework for health reform) through the State Innovation Model ("SIM"), Connecticut seeks to achieve the "triple aim: better health, better healthcare quality and reduction of costs". The SIM report acknowledges that Connecticut's healthcare system "falls short," citing high emergency department utilization rates, especially for non-urgent conditions, and a relatively high rate of hospital readmissions. (CT Health Care Innovation Plan, December 2013). As explained above, we have put forth a proposal that will enhance the quality of primary care and the economic viability of the model for delving that care for years to come. I ask that you approve our application for the transition of services to and collaboration with CIFIC.

Respectfully submitted,



Michael Daglio

Healthcare Experience

Western Connecticut Health Network, Danbury CT – January 2014 – Present

President, Norwalk Hospital, Sr. Vice President, Western Connecticut Health Network

- Oversee the day-to-day responsibilities of Norwalk Hospital
- Responsible for the outcomes in Quality, Patient Experience, Patient Safety, Employee Engagement, Physician Alignment and Financial Performance of Norwalk Hospital.
- Continue to perform functions as Sr. Vice President for the Network as outlined below.

Senior Vice President and Chief Operating Officer

- Responsible for operational oversight of the three hospitals within the Network – Danbury Hospital, Norwalk Hospital, New Milford Hospital.
- Developed and executing strategies to integrate major service lines, programs, departments and all facilities across the Network.
- Direct the operations for all major service lines across the Network including Cancer, Cardiovascular, Surgery, Medicine, Women's and Children's, Behavioral Health, Emergency Medicine, and Emergency Preparedness.
- Direct all ancillary services for the Network including Pathology, Radiology, Pharmacy and Employee and Corporate Health.
- Direct all facilities and Real Estate functions for the Network including master facility planning and real estate strategies.
- Oversee the operational needs for Medical Education and the Research Institute for the Network.
- Oversee operating budget of \$600,000,000 and a capital budget of \$55,000,000
- Provide Senior level oversight of 8 direct reports and 2,700 indirect reports.

Danbury Hospital, Danbury, CT- June 2004 –December 2013

Senior Vice President and Chief Operating Officer – October 2010 – December 2013

- 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
- Participate on Finance, Planning, and Technology Committees of the Hospital Board
- Serve on Hospital's Executive Compliance and Performance Improvement (Quality) Committees

Michael J. Daglio ~~Responsible for~~ physician practice operations for Service Lines' practices

- ~~Lead physician recruitment efforts and negotiate and execute physician contracts for service lines~~
 - Lead management team in operational and productivity improvements through Lean/Six Sigma and DMAIC methodology
- Service Line Executive, Cardiovascular Services and Radiology Services- June 2004-October 2007

- Provide Executive oversight of
 - Cardiac Surgery
 - Interventional Cardiology
 - Cardiovascular diagnostic Laboratories
 - Catheterization Laboratories
 - Vascular Surgery
 - Cardiac Telemetry
 - Diagnostic imaging centers on the main campus and three outpatient centers.
- Developed Service Line model to align the goals and objectives of all cardiovascular services, staff, and Physicians.
- Provide senior level leadership to 8 Directors and a staff of 325 FTEs
- Manage over \$222 million in patient revenue.
- Manage all operating and capital budgets for both service lines

Continuum Health Partners, New York, NY - May 2000 – June 2004

Director, Ambulatory Care - June 2001-June 2004

- Manage the operations of thirteen Multi-Specialty physician practices in Westchester County, NY and the Bronx, NY for the Beth Israel Medical Center, with a combined volume of approximately 230,000 annual visits.
- Responsible for the performance and development of 10 Practice Managers, 1 Facility Manager and 185 total FTEs.
- Prepare and manage annual operating budget of \$33 million.
- Collaborate with Medical Director to develop new physician business opportunities.
- Collaborate with the Medical Directors of the Orthopedic and Cardiology Service Lines to implement new services and expand patient access in the thirteen practices.
- Develop business plans and process improvement initiatives to identify cost reduction and revenue enhancement opportunities.
- Responsible for all day-to-day maintenance and capital improvements for the facilities
- Negotiate and contract with vendors for capital equipment and facility services.

Assistant Director, Physician Initiatives Group– May 2000 – June 2001

- Served as internal consultant for the seven-hospital system on its Musculoskeletal, Cancer, and Cardiac service lines
- Responsible for improving operations, consolidation, and business development across the service lines
- Developed Osteoporosis Institute for New York Bone and Joint and Musculoskeletal service line
- Responsible for implementing corporate health initiatives.
- Participated with physician recruitment and new program development

The George Washington University Hospital, Washington, DC - July 1996-April 2000

Administrative Resident – May 1999-April 2000

- Trained under the Chief Executive Officer in senior level hospital administration including finance, strategic planning, service line development and physician relations
- Served as Acting Associate Administrator for Operations in the first eight months of the residency. Responsible for senior management oversight of Security Services, Medical Imaging, Dietary Services, Plant Operations, Housekeeping and Biomedical Electronics
- Supported the Chief Operating Officer and Associate Administrators in evaluating operational issues and developing cost reduction and service improvement strategies
- Developed the hospital's 2000 business plan and contributed to the development of the 2000 capital and operating budgets
- Developed and marketed a new International Patient Services Department
- Served as an active member of the Disaster and Safety Committees
- Negotiated with service vendors for outsourcing dietary, radiation safety, biomedical electronics, and laboratory services for the hospital

Michael J. Daglio

Interim Administrative Director, Department of Medical Imaging – July 1998- May 1999

- Managed inpatient, hospital-based medical imaging services including MRI, CT Scan, ultrasound, special procedures, nuclear medicine, and general diagnostics, as well as an outpatient clinic that included general diagnostics and mammography services

- Responsible for operating and capital budgets
- Responsible for a staff of 45 FTEs, including modality supervisors, techs, and film room clerks, and front office reception.
- Reorganized the department to increase staffing efficiency and reduced staff by 10 FTEs
- Collaborated with the medical director of the department to address patient flow and process improvements throughout the department
- Managed the upgrade of the PACS system to increase the department's filmless capabilities
- Developed a capital equipment strategy and purchased new capital equipment for department

Project Coordinator, Department of Quality Management – July 1996 – July 1998

- Assisted the director of Quality Management and Regulatory Compliance in quality improvement initiatives throughout the hospital using the PDCA CQI improvement model
- Developed improvement projects including restraint reduction, patient flow, and development of a hospital report card
- Developed, organized, and conducted a JCAHO mock survey of various hospital departments to assure quality patient care, a safe environment of care, and regulatory compliance
- Prepared the hospital for a successful Joint Commission Survey

Other Experience

The George Washington University Career Center, Washington, DC

Executive Coordinator - April 1995-July 1996

- Managed the business operations for the University's Career Center
- Responsible for Department's operating and grants budgets
- Supervised a staff of four clerical staff and twenty student employees

Equinox Fitness Club, New York, NY

Operations Manager - July 1993-April 1995

- Managed the day-to-day operations of the club
- Responsible for the performance of twenty employees and all front desk functions
- Ensured the facility was clean and equipment was functional at all times

Summit Park Apartments, Philadelphia, PA

Operations Manager - August 1991-July 1993

- Managed the apartment complex's fitness center, restaurant, and outdoor facilities
- Responsible for the facility's staff and oversight of the contracted landscaping company
- Performed accounting of all income received at the facilities for deposit

Education

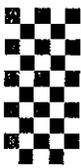
- **The George Washington University** – School of Business and Public Management, Washington, DC May 2000
Masters of Health Administration
- **The University of Hartford** – West Hartford, CT May 1991
Bachelor of Arts, Secondary Education and Allied Health

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.

Board Affiliations

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



FERGUSON, DOYLE & CHESTER, P.C.
35 Marshall Road
Rocky Hill, CT 06067

JAMES C. FERGUSON
BRIAN A. DOYLE
ERIC W. CHESTER

TEL: (860) 529-4762
FAX: (860) 529-0339

FAX TRANSMITTAL SHEET

TO: Kevin Hansted, Hearing Officer (860) 418-7053

FROM: Brian A. Doyle, Esq.

DATE: July 6, 2015

NUMBER OF PAGE(S) INCLUDING COVER SHEET: 2

SPECIAL INSTRUCTIONS/ADDITIONAL COMMENTS:

Re: Case No. 15-31978

CONFIDENTIALITY NOTICE

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FERGUSON, DOYLE & CHESTER, P.C.

ATTORNEYS AT LAW
Telephone (860) 529-4762
Facsimile (860) 529-0339

James C. Ferguson
Brian A. Doyle
Eric W. Chester

35 Marshall Road
Rocky Hill, CT 06067
E-Mail: office@fdclawoffice.com

Kevin Hansted
Hearing Officer
CT Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13 HCA
PO Box 340308
Hartford, CT 06134-0308

SENT VIA FACSIMILE (860) 418-7053



Re: Docket No. 15-31978, Certificate of Need Application
Western Connecticut Health Network

July 6, 2015

Dear Hearing Officer Hansted:

This office represents the Danbury Nurses, Union Local 5047, Unit 47, AFT-CT, AFT, AFL-CIO and AFT-CT, as well as LPN's Technical employees employed by Danbury Hospital. I will be appearing at the hearing scheduled for tomorrow, July 7, 2015.

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

Brian A. Doyle
FERGUSON, DOYLE & CHESTER, P.C.

BAD:jm



FERGUSON, DOYLE & CHESTER, P.C.
35 Marshall Road
Rocky Hill, CT 06067

JAMES C. FERGUSON
BRIAN A. DOYLE
ERIC W. CHESTER

TEL: (860) 529-4762
FAX: (860) 529-0339

FAX TRANSMITTAL SHEET

TO: Kevin Hansted, Hearing Officer (860)418-7053

FROM: Brian Doyle, Esq.

DATE: July 6, 2015

NUMBER OF PAGE(S) INCLUDING COVER SHEET: 4



SPECIAL INSTRUCTIONS/ADDITIONAL COMMENTS:

Re: Case No. 15-31978

CONFIDENTIALITY NOTICE

This facsimile contains privileged and confidential information intended only for the use of the addressee named above. If you are not the intended recipient of the facsimile or the recipient, you are hereby notified that any dissemination or copying of this facsimile is strictly prohibited. If you have received this facsimile in error, please immediately contact us by telephone and return the original message to our office.

IN THE MATTER OF : DOCKET NO. 15-31978

WESTERN CONNECTICUT HEALTH NETWORK
APPLICATION FOR TRANSITION :

and :

DANBURY NURSES UNIT 47, AFT-CT, : July 6, 2015
AFT, AFL-CIO :



**MOTION TO WITHDRAW APPEARANCE AND INTERVENOR STATUS ON
BEHALF OF DANBURY NURSES LOCAL 5047,
AFT-CT, AFT, AFL-CIO**

The Petitioner, Danbury Nurses, Local 5047, AFT-CT, AFT, AFL-CIO hereby requests that counsel's notification of appearance regarding the Certificate of Need Application of Western Connecticut Health Network filed under Docket No. 15-31978 be withdrawn.

Additionally, the Petitioner's Intervenor status, as granted on June 23, 2015 is respectfully requested to be withdrawn.

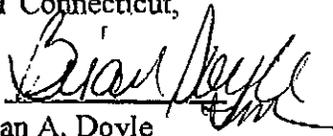
FERGUSON, DOYLE & CHESTER, P.C.

ATTORNEYS AT LAW

35 MARSHALL ROAD ~ ROCKY HILL, CT 06067 ~ TEL. (860) 529-4762 ~ FAX (860) 529-0339 ~ JURIS NO. 401708



Respectfully submitted,
AFT Connecticut,

By: 

Brian A. Doyle

Ferguson, Doyle & Chester, P.C.
35 Marshall Rd.
Rocky Hill, CT 06067
(860) 529-4762
Their Attorney

FERGUSON, DOYLE & CHESTER, P.C.
ATTORNEYS AT LAW

35 MARSHALL ROAD ~ ROCKY HILL, CT 06067 ~ TEL. (860) 529-4762 ~ FAX (860) 529-0339 ~ JURIS No. 401708



CERTIFICATION

This is to certify that on this date, July 6, 2015 a copy of the attached Motion to Withdraw Appearance and Intervenor Status was sent via facsimile and electronic mail to:

Sally F. Herlihy
Vice President of Planning
Western Connecticut Health Network
24 Hospital Ave.
Danbury, CT 06810
Fax No. (203) 739-1974
sally.herlihy@wchn.org

Theodore J. Tucci
Robinson & Cole
280 Trumbull St.
Hartford, CT 06103-3597
(860) 275-8200
ttucci@rc.com

FERGUSON, DOYLE & CHESTER, P.C.

ATTORNEYS AT LAW

35 MARSHALL ROAD ~ ROCKY HILL, CT 06067 ~ TEL. (860) 529-4762 ~ FAX (860) 529-0339 ~ JURIS No. 401708



GRANT AGREEMENT

This GRANT AGREEMENT (the "Agreement") is entered into as of June 4, 2015, (the "Execution Date"), but effective as of the Commencement Date as defined herein by and between The Connecticut Institute For Communities, Inc. d/b/a The Greater Danbury Community Health Center (the "Health Center") and The Danbury Hospital ("Hospital").

RECITALS:

The following recitals are hereby incorporated into this Agreement:

WHEREAS, the Hospital operates the Seifert and Ford Family Community Health Center at 70 Main Street, Danbury Connecticut (the "Clinic"), where it provides certain primary care and subspecialty services, including, but not limited to: (1) internal medicine (adult primary care); (2) obstetrics and gynecology; (3) pediatrics; (4) dental; and (5) other specified services, and the Community Center for Behavioral Health located at 152 West Street, Danbury, Connecticut, where it provides, inter alia, behavioral health services (collectively, the "Clinic Services") as well as certain specialty services to residents of the greater Danbury community (the "Service Area");

WHEREAS, the Hospital has determined that the most efficient and effective way to ensure individuals and families in the Service Area have increased access to such primary care Clinic Services is to work with a provider with proven experience in providing primary care medical and other services to medically underserved populations, which is capable of assuming the responsibility of providing primary care Clinic Services to individuals and families in the Service Area;

WHEREAS, the Health Center is a Federally Qualified Health Center ("FQHC") that receives federal grant support from the Health Resources and Services Administration within the United States Department of Health and Human Services pursuant to Section 330 of the Public Health Service Act, to provide, or arrange for the provision of, high quality, cost-effective, community-based comprehensive primary and preventive health care and related services (including, but not limited to, ancillary and enabling services) to medically underserved communities in the Service Area, regardless of the individual's or family's ability to pay for such services;

WHEREAS, the Health Center has determined that there is a growing need by residents in the Service Area to have access to primary health care and that it may be in the best interest of those residents for the Health Center to provide the Clinic Services;

WHEREAS, in light of the foregoing, and taking into consideration the best interest of residents in the Service Area, the parties desire to enter into an arrangement pursuant to which (a) the Hospital will cease providing said Clinic Services, and (b) the Health Center will assume the provision of the Clinic Services over the course of two (2) years (the "Transition Period"), conditioned upon the satisfaction of the conditions precedent set forth in this Agreement, such Clinic Services to be provided at the Health Center locations in Danbury, Connecticut (the "Health Center Facilities"), as described in this Agreement;

WHEREAS, in order to provide the Clinic Services, the Health Center will be required to engage additional staff to provide such services;

WHEREAS, the Service Area contains medically underserved areas which are in great need of expanded primary health care services with a focus on care to the indigent and uninsured;

WHEREAS, the Hospital desires to further its charitable mission to ensure the availability of health care services for underserved persons by granting a sum of money to the Health Center to be used in the provision of Clinic Services by the Health Center;

WHEREAS, the Hospital acknowledges that without the grant, the Health Center may incur losses from the provision of Clinic Services;

WHEREAS, the Health Center desires to further its charitable mission to ensure the availability of health care services for underserved persons and reasonably expects the grant to enhance such availability;

WHEREAS, 42 U.S.C. 1320a-7b(b)(3)(I) contains a statutory safe harbor relating to agreements with FQHCs and 42 C.F.R. 1001.952 contains a regulatory safe harbor relating to grants to FQHCs (collectively the "Safe Harbors");

WHEREAS, the parties have structured this Agreement to comply with the Safe Harbors;

WHEREAS, in furtherance of the charitable missions of the Hospital and the Health Center and recognizing the interest of Service Area residents and governmental agencies in having a comprehensive primary care health center provide health care services in the Service Area, the Hospital intends to make a grant to the Health Center, and the Health Center intends to accept such grant, in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the covenants contained herein and other good and valuable consideration, it is mutually agreed as follows:

ARTICLE I

THE GRANT

SECTION 1.01 Recitals. The recitals set forth above are incorporated herein as if fully set forth below.

SECTION 1.02 Commencement Date; Term and Termination Without Cause.

(a) **Term**. The parties agree that the Hospital's obligations to make the Grant and the Health Center's obligations to provide the Clinic Services shall not be effective until satisfaction of the conditions precedent set forth in Article II (the "Commencement Date"). The term of this Agreement shall commence as of the Commencement Date and shall continue thereafter until the date which is five (5) years from the Commencement Date. This Agreement shall automatically

renew for additional one (1) year terms, on the same terms and conditions then in effect, unless a party provides the other party written notice of its intent not to renew the Agreement by December 31st of any calendar year, which termination shall be effective as of July 1st of the subsequent calendar year, unless terminated sooner as permitted hereunder.

(b) Termination Without Cause. This Agreement may be terminated as of July 1st of any calendar year by either party without cause upon at least one (1) year's prior written notice by either Party.

SECTION 1.03 Grant. Subject to the terms and conditions of this Agreement, the parties agree that the Hospital shall make a grant to the Health Center (collectively, the "Grant") as follows:

(a) Grant Budget. The parties acknowledge that the Hospital desires to provide a grant to the Health Center to subsidize the Health Center's direct provision of the Clinic Services (the "Permitted Purpose"). The parties agree that in each year of the term of this Agreement, the Hospital shall provide an annual Grant to the Health Center consisting of the Grant Components (as defined below) described below in Section 1.03(b) and described in Exhibit A, attached hereto and made a part hereof:

(i) Definitions.

(1) "Year One" shall mean the period commencing on the Commencement Date and expiring twelve (12) months thereafter.

(2) "Year Two" shall mean the period commencing on the first anniversary of the Commencement Date and expiring twelve (12) months thereafter.

(3) "Year Three" shall mean the period commencing on the second anniversary of the Commencement Date and expiring twelve (12) months thereafter.

(4) "Year Four" shall mean the period commencing on the third anniversary of the Commencement Date and expiring twelve (12) months thereafter.

(5) "Year Five" shall mean the period commencing on the fourth anniversary of the Commencement Date and expiring twelve (12) months thereafter.

(6) Each of Year One, Year Two, Year Three, Year Four and Year Five shall be referred to as a "Grant Period."

(7) The Grant to be made by the Hospital during each Grant Period shall be referred to as an "Annual Grant Amount". At no time shall any Annual Grant Amount exceed the total grant amounts described in Exhibit A, unless otherwise agreed to by the parties or subject to the reconciliations set forth herein.

(8) "Grant Components" shall include the specific areas of funding provided by the Hospital, as described below.

(b) Grant Components. As described in Exhibit A, each Annual Grant Amount includes funding for all or some of the following Grant Components to support the Permitted Purpose. During the term of the Agreement, the Grant Components shall include the following:

(i) Salary Variance Component. Prior to the Commencement of Year One, the Health Center shall hire eleven (11) physicians, including three (3) physician "Site Directors," who will be employees of the Health Center and who provided the Clinic Services on behalf of the Hospital immediately prior to the Commencement Date, as listed in Exhibit B hereto (the "Clinic Physicians"). For (a) a period of three (3) years following the commencement of employment of any Clinic Physician who is not a Site Director and (b) the remainder of the term of this Agreement following the commencement of employment of any Clinic Physician who is a Site Director or a pediatrician, the Hospital shall pay to the Health Center the difference between (x) each Clinic Physician's prior salary as an employee of the Hospital (or a Hospital affiliate), as listed on Exhibit B and (y) the salary the Clinic Physician would otherwise receive as an employee of the Health Center (a "Salary Variance"), plus an additional ten percent (10%) of each Clinic Physician's annual salary to cover the incremental increased costs of fringe benefits for the Clinic Physicians (collectively, the "Salary Variance Component"). The parties agree that, as of the Commencement Date, Clinic Physicians employed by the Health Center who are not Site Directors would otherwise be eligible to earn an annual salary equal to [REDACTED] and Site Directors employed by the Health Center would otherwise be eligible to earn an annual salary equal to [REDACTED]

[REDACTED] In no event shall the Salary Variance Component payments to be made by the Hospital exceed the amounts described in Exhibit A as a "Salary Variance Component Annual Cap," unless otherwise agreed to by the parties. In the event that any Clinic Physician's employment with the Health Center is terminated for any reason, the applicable Salary Variance Component Annual Cap and the Annual Maximum Grant Amount for such Grant Period shall be reduced by the amount equal to the Salary Variance for such Clinic Physician. The Salary Variance Component shall be paid to Health Center by Hospital within thirty (30) days from the start of each calendar quarter in equal installments, subject to annual reconciliation of the actual Salary Variance for the Clinic Physicians and the Salary Variance Component payments received by the Health Center. In the event that the Hospital's Salary Variance Component payments during any Grant Period exceed the actual Salary Variance for the Clinic Physicians employed by the Health Center during such Grant Period, the excess funds shall be returned to the Hospital within sixty (60) days following the close of such Grant Period. In the event that the Hospital's Salary Variance Component payments during any Grant Period are less than the actual Salary Variance for the Clinic Physicians employed by the Health Center during such Grant Period, the Hospital shall pay that difference to the Health Center within sixty (60) days following the close of such Grant Period. It is understood by all parties that, in addition to the Salary Variance Component set forth herein, the Hospital shall be responsible for entering into a severance agreement with each physician described herein, if applicable, to compensate them for any accrued benefits or other differences in benefits previously earned, or heretofore anticipated to be earned, with the Hospital.

(ii) Dental Clinic Component. The Hospital shall provide on-going grant funding to support the dental services to be provided by the Health Center, which is anticipated to commence in Year Two, at the Clinic (the "Dental Clinic Component") as follows:

(1) Beginning in Year Two and for the remainder of the term, the Hospital shall subsidize the Health Center's provision of certain high-cost, specialty dental services ("Specialty Dental Services") in an amount equal to the difference between the (a) actual cost to the Health Center of such procedures and (b) the amounts actually received by the Health Center from any third-party payor for such Specialty Dental Services (the "Specialty Dental Services Variance"), which Specialty Dental Services Variance shall be paid to Health Center quarterly, provided that such Specialty Dental Services Variance shall not exceed [REDACTED] on an annual basis, unless otherwise agreed to by the parties.. The Health Center agrees to (i) document all Health Center costs associated with, and reimbursements actually collected by the Health Center for, such Specialty Dental Services and (ii) to provide such documentation to the Hospital within thirty (30) days following the close of each calendar quarter during the term of this Agreement. The Hospital shall pay Health Center an amount equal to the actual Specialty Dental Services Variance for the immediately preceding calendar quarter within thirty (30) days of Hospital's receipt of such documentation. The Health Center agrees to perform an annual reconciliation of the Specialty Dental Services Variance realized by the Health Center prior to the Hospital's final payment for any Grant Period. In the event that the Specialty Dental Services Variance during such Grant Period is less than the payments received from the Hospital for such Grant Period, the excess funds shall be returned to the Hospital within thirty (30) days following the close of such Grant Period.

(2) In Year Two, the Hospital shall reimburse the Health Center in an amount not to exceed [REDACTED] for software, training and implementation costs of the software licenses associated with providing dentists, hygienists and Hospital Residents who will provide dental services on behalf of the Health Center with access to the Health Center's dental services electronic medical records software, Dental EHR (collectively, the "Dental EHR Conversion Costs"), or the equivalent. The Dental EHR Conversion Costs are one (1) time expenses to the Health Center and shall be paid by the Hospital not less than thirty (30) days following the Hospital's receipt of invoices from the Health Center detailing the Dental EHR Conversion Costs incurred by the Health Center.

(iii) eClinical Conversion Component. The Hospital shall reimburse the Health Center's for the costs actually incurred by the Health Center for (a) Health Center's electronic health record software license fees for the Clinic Physicians listed on Exhibit B and all Hospital Residents performing Clinic Services under the supervision of the Health Center for Health Center patients during each Grant Period, (b) practitioner training in the eClinical software ("eClinical Training") in Year One and (c) the costs of converting Clinic patient records to the eClinical software during each of Year One and Year Two, plus fifteen percent (15%) of the clinical conversion costs to convert paper medical records (collectively, the "eClinical Conversion Costs"), provided that the costs for the eClinical Training shall not exceed [REDACTED] unless otherwise agreed to by the parties. Reimbursement of the eClinical Conversion Costs incurred by the Health Center shall be made on a quarterly basis following Hospital's receipt of an invoice from the Health Center detailing the eClinical Conversion Costs actually incurred by the Health Center during the immediately preceding quarter and subject to an annual reconciliation of the eClinical Conversion Costs actually incurred by the Health Center during the applicable Grant Period (the "eClinical Conversion Component"). In the event that the Hospital's eClinical Conversion Component quarterly

payments to the Health Center during any Grant Period exceed the Health Center's actual eClinical Conversion Costs for such Grant Period, the excess amounts shall be returned to the Hospital within thirty (30) days following the close of such Grant Period. In the event that the Hospital's eClinical Conversion Component quarterly payments to the Health Center during any Grant Period are less than the eClinical Conversion Costs actually incurred by the Health Center during such Grant Period, the Hospital shall pay the difference to the Health Center within thirty (30) days following the close of such Grant Period, provided that in no event shall the total amount of Hospital's eClinical Conversion Component payments to the Health Center exceed [REDACTED] in the aggregate, unless otherwise agreed to by the parties.

(iv) Equipment Grant Component. Prior to the commencement of Year One, the Hospital shall donate to the Health Center the equipment for adult medicine, pediatrics and OBGYN listed in Section I of Exhibit C, which shall be added to this Agreement not later than the Commencement Date. Prior to the commencement of Year Two, the Hospital shall donate to the Health Center the equipment for dental and behavioral health listed in Section II of Exhibit C, which shall be added to this Agreement not less than six (6) months prior to the commencement of Year Two (collectively, all of the equipment listed on Exhibit C to be donated by Hospital is referred to as the "Equipment"). The fair market value of the Equipment shall be determined six (6) months prior to donation by a valuation consultant engaged by the Hospital and documented as Exhibit C-1 of this Agreement. In the event either party terminates this Agreement as set forth herein, the equipment shall remain the property of the Health Center.

(v) Additional Transition Costs Component. In each of Year One, Year Two and Year Three, the Hospital shall reserve additional funds equal to the amounts described in Exhibit A to reimburse the Health Center for additional costs not specifically anticipated by the parties but actually incurred by the Health Center that are directly related to the Hospital's transition of the Clinic Services to the Health Center ("Additional Transition Costs"), provided that all Additional Transition Costs are subject to the prior approval of the Hospital, which may not be unreasonably withheld. For example only, such Additional Transition Costs may include additional staffing to assist in electronic health record conversion and scanning Clinic patient charts, and necessary renovations to the Health Center Facilities.

(vi) Documentation of all Grant Components. The Hospital reserves the right to reasonably request from the Health Center copies of all Health Center documents and/or records related to the Grant Components. Upon request from the Hospital for such documentation, the Health Center shall produce such documentation in a timely manner.

SECTION 1.04 No Repayment or Interest. The Health Center shall have no obligation to repay, and interest will not accrue on, the Grant, provided however that the Health Center shall repay any excess amounts paid by Hospital following any reconciliation of Health Center costs described above.

SECTION 1.05 Use of Proceeds. The Health Center will use the Grant only for the Permitted Purpose and for no other purpose.

SECTION 1.06 Terms of Grant. Subject to the terms and conditions set forth herein, in each Grant Period, the Hospital will pay the costs associated with the applicable Grant Components for such Grant Period. The requirement to pay the Grant hereunder shall be subject to the Health Center providing to the Hospital an executed certification, in the form of Exhibit D hereto, within thirty (30) days of the annual anniversary of the Commencement Date and each annual anniversary thereafter. The parties agree that the Grant Components and Annual Grant Amount shall be subject to modification in the event that certain Residency Training Agreement between the parties is terminated, which modification is limited only to reflect changes for items that may no longer be incurred by the Health Center as a result of the termination of that certain Residency Training Agreement between the parties.

SECTION 1.07 Evaluation of Grant. On an annual basis, the parties shall meet to review the Grant and the scope and availability of services provided by the Health Center in the Service Area and to evaluate the impact of the Grant on the Health Center's operations (an "Evaluation") in accordance with Section 3.01(e)(iv) below; provided however, that the parties may conduct an Evaluation more frequently than annually upon a reasonable request by the Hospital. Such Evaluation shall be documented in writing by the parties.

ARTICLE II

CONDITIONS PRECEDENT

SECTION 2.01 Conditions Precedent to Grant. In addition to any procedures set forth in Section 1.06 hereof, the obligation of the Hospital to make the Grant and/or any Payment is subject to the fulfillment of each of the following conditions precedent:

(a) **Representations, Warranties and Covenants; No Event of Default.** The representations and warranties contained in Section 3.01 of this Agreement shall be correct on and as of the date of each Payment as though made on and as of such date; the Health Center shall have complied with the covenants set forth in Article IV hereof; and no Event of Default or event which, with the giving of notice or the lapse of time or both, would constitute an Event of Default shall have occurred and be continuing on the date of each Payment or would result from the making of the Payment.

(b) **Legality.** The making of the Grant shall not contravene any federal, state or local law, rule or regulation applicable to the Hospital or the Health Center.

(c) **Government Approvals.** The parties have obtained any necessary governmental approvals relating to (i) the termination of the Clinic Services by the Hospital, including but not limited to, approval of the Certificate of Need from the Connecticut Office of Health Care Access of the Connecticut Department of Public Health, (ii) the provision of such Clinic Services by the Health Center, including but not limited to, all required approvals from the United States Department of Health and Human Services Health Resources and Services Administration ("HRSA"), including the Changes in Scope for the activities described herein, and (iii) appropriate licensure from the Connecticut State Department of Public Health, including an operating license issued to the Health Center for the services to be provided at 70 Main Street, Danbury, CT.

(d) Delivery of Documents.

(i) The Hospital shall have received, on or before the commencement of Year One, the following, each in form and substance satisfactory to the Hospital: (i) such approvals, opinions and other documents as the Hospital may reasonably request, including, without limitation, the Certificate of Incorporation and Bylaws of the Health Center, and any amendments thereto and (ii) resolutions of the Board of Directors of the Health Center, as appropriate, approving the Grant and the execution and delivery of this Agreement.

(ii) The Health Center shall have received, on or before the commencement of Year One, the following, each in form and substance satisfactory to the Health Center: (i) such approvals, opinions and other documents as the Health Center may reasonably request, including, without limitation, the Certificate of Incorporation and Bylaws of the Hospital, and any amendments thereto and (ii) resolutions of the Board of Directors of the Hospital, as appropriate, approving the Grant and the execution and delivery of this Agreement.

(iii) The parties agree that this Agreement is executed in contemplation of the execution of other agreements related to the transition of the Clinic Services to the Health Center and the operation of certain of the Hospital's residency programs (e.g., a Residency Training Agreement, a Hospital Services Agreement, a 70 Main Street Sublease Agreement, and a 152 West Street Sublease Agreement). In the event that the negotiation of such related agreements results in terms that are inconsistent with this Agreement, the terms of this Agreement shall be amended by the Parties as may be necessary.

(e) Proceedings: Receipt of Documents. All proceedings in connection with the making of the Grant and the other transactions contemplated by this Agreement, and all documents incidental thereto, shall be reasonably satisfactory to the Hospital.

(f) Medicaid Eligibility. The Health Center using reasonable efforts to determine patient eligibility for the Medicaid Program and to assist patients in obtaining Medicaid coverage.

(g) Collections from Patients. The Health Center making reasonable efforts to collect payment from patients for services, within the limits of HRSA rules for FQHCs and the Health Center's then existing Collections Policy and Procedures, as shall be provided to the Hospital upon request.

(h) Residency Programs. The Health Center shall maintain, for the duration of the term of this Agreement, accreditation by the American College of Graduate Medical Education of the Health Center's graduate medical education programs and any other applicable accrediting entity, including, but not limited to, the American Board of Obstetrics and Gynecology and the Commission on Dental Accreditation.

ARTICLE III

REPRESENTATIONS AND WARRANTIES

SECTION 3.01 Representations and Warranties of the Health Center. The Health Center represents and warrants as follows:

(a) Organization, Good Standing, Etc. The Health Center (i) is a nonprofit corporation, validly existing and in good standing under the laws of the State of Connecticut, and (ii) has all requisite power and authority to conduct its business as now conducted and as presently contemplated, and to accept the Grant hereunder.

(b) Authorization, Etc. The execution, delivery and performance by the Health Center of this Agreement (i) have been duly authorized by all necessary corporate actions, (ii) do not and will not contravene its Certificate of Incorporation or Bylaws, any law, rule or regulation or any contractual restriction binding on or otherwise affecting it or any of its properties, and (iii) do not and will not result in any suspension, revocation, impairment, forfeiture or nonrenewal of any permit, license, authorization or approval applicable to its operations or any of its properties.

(c) Governmental Approvals. No authorization or approval or other action by, and no notice to or filing with, any governmental authority or other regulatory body is required in connection with the due execution, delivery and performance by the Health Center of this Agreement or the operation of its business, except such as have been obtained or as otherwise set forth herein.

(d) Enforceability of Agreement. This Agreement, when executed and delivered hereunder, will be a legal, valid and binding obligation of the Health Center, enforceable against it in accordance with its terms.

(e) Compliance With Safe Harbors. The Health Center represents that (1) it has determined that this Agreement currently complies with all of the provisions of the Safe Harbors, and (2) the Health Center and this Agreement will continue to comply with all of the provisions of the Safe Harbors. In furtherance thereof, the Health Center agrees that, without limiting its obligations pursuant to the Safe Harbors, it:

(i) will provide its patients with notice of their freedom to choose any willing provider or supplier;

(ii) will disclose in a timely manner the existence and nature of this Agreement to any patient who inquires about this Agreement;

(iii) has documented its determination that this arrangement is reasonably expected to contribute meaningfully to the Health Center's ability to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the Health Center; and

(iv) will on an annual basis and upon any renewals of this Agreement, review this arrangement to ensure that the Health Center expects the arrangement to continue satisfying

the conditions of Section 3.01(e)(iii) above, and document such determination on a contemporaneous basis.

SECTION 3.02 Representations and Warranties of the Hospital. The Hospital represents and warrants as follows:

(a) **Organization, Good Standing; Etc.** The Hospital (i) is a nonprofit corporation, validly existing and in good standing under the laws of the State of Connecticut, and (ii) has all requisite power and authority to conduct its business as now conducted and as presently contemplated, and to provide the Grant hereunder.

(b) **Authorization. Etc.** The execution, delivery and performance by the Hospital of this Agreement (i) have been duly authorized by all necessary corporate actions, (ii) do not and will not contravene its Certificate of Incorporation or Bylaws, any law, rule or regulation or any contractual restriction binding on or otherwise affecting it or any of its properties, and (iii) do not and will not result in any suspension, revocation, impairment, forfeiture or nonrenewal of any permit, license, authorization or approval applicable to its operations or any of its properties.

(c) **Governmental Approvals.** No authorization or approval or other action by, and no notice to or filing with, any governmental authority or other regulatory body is required in connection with the due execution, delivery and performance by the Hospital of this Agreement or the operation of its business, except such as have been obtained or as otherwise set forth herein.

(d) **Enforceability of Agreement.** This Agreement, when executed and delivered hereunder, will be a legal, valid and binding obligation of the Hospital, enforceable against it in accordance with its terms.

ARTICLE IV

COVENANTS OF THE HEALTH CENTER

SECTION 4.01 Affirmative Covenants. The Health Center shall, unless the Hospital otherwise consents in writing:

(a) **Reporting Requirements.** Furnish to the Hospital quarterly unaudited financial statements within sixty (60) days after the end of each quarter, as well as any, when due, annual audited financial statements, documents or reports the Health Center is required to file with any federal agencies relating to its FQHC status, costs or reimbursement and such other quarterly financial statements, reports, instruments and documents as the Hospital shall reasonably request from time to time. In addition, the Health Center shall furnish to the Hospital, promptly after the commencement thereof, notice of each action, suit, or proceeding before any court or other governmental authority or other regulatory body or any arbitrator in which the Health Center is a party, which may adversely affect its condition or operations, financial or otherwise.

(b) **Maintenance of Permits.** Maintain all permits, licenses, authorizations and approvals required for the lawful operation of its business, including, without limitation,

approval as an FQHC, and all such licenses and approvals as required under federal and state law.

(c) Conduct of Business/Insurance. Conduct its business in a commercially reasonable manner in accordance with all applicable laws, rules and regulations and maintain such insurance policies as are standard for a like organization located in the Service Area.

SECTION 4.02 Services to be Provided by the Health Center and the Hospital.

(a) Clinic Services. At all times during the Term of this Agreement, subject to the scheduled transition of services from the Hospital to the Health Center, the Health Center shall provide the following services to all residents of the Service Area, regardless of ability to pay: in Year One of the Agreement, (i) adult primary care, (ii) pediatric primary care, and (iii) primary care obstetrics and gynecology, including prenatal health services; and starting in Year Two of the Agreement, (iv) behavioral health services, and (v) dental services.

(b) Specialty Services. The Hospital shall continue to provide "Adult Specialty Services" at the Clinic, including podiatry, allergy, endocrinology, neurology, orthopedics, rheumatology, urology, and spine.

SECTION 4.03 Transition of Clinic Services to the Health Center. During the Transition Period, the Hospital shall cease providing the Clinic Services at the Clinic and the Health Center shall assume the provision of such Clinic Services in accordance with the schedule set forth below.

(a) Year One. In Year One, the Hospital shall cease providing, and the Health Center shall assume sole responsibility for the provision of, adult primary care services, pediatric services and primary care obstetrics and gynecology, but not including childbirth deliveries.

(b) Year Two. Beginning in Year Two, the Hospital shall cease providing, and the Health Center shall assume sole responsibility for the provision of behavioral and dental services, or all Clinic Services, which shall be provided by the Health Center at Health Center Facilities.

SECTION 4.04 Hospital Strategic Initiatives. The Health Center agrees to be a collaborative participant with the Hospital in all of the Hospital's strategic initiatives that may be impacted by the Health Center's patients, including, but not limited to the following:

(a) Utilization Initiatives. Hospital readmission, utilization of the Hospital's Emergency Department for primary care-related services, appropriate access to care initiatives and such other initiatives as may be undertaken by the Hospital or a WCHN affiliate from time to time.

(b) Accountable Care Initiatives. WCHN's accountable care efforts to more effectively manage the health of the Service Area's population. The parties agree that the Health Center will cooperate with such efforts, but is not bound to be a member of WCHN's accountable care organization ("ACO"), rather the Health Center reserves the right to be a member of another ACO.

SECTION 4.05 Quality of Care. In furtherance of the Hospital's and the Health Center's commitment to provide quality health services to residents of the Service Area, the Health Center agrees to the following:

(a) Pediatric Quality Measures. In accordance with a reporting schedule to be agreed upon by the parties, which shall be no more than quarterly, the Health Center agrees to measure and report the following pediatric care quality measures: (i) immunization rates, (ii) screening for tobacco exposure, (iii) early referral to a dental home, (iv) screening for signs of autism spectrum disorders, (v) body mass index measurements to identify overweight or obese pediatric patients, (vi) lead screening, and (vii) psychosocial evaluations of teenaged pediatric patients.

(b) NCQA Designation. The Health Center agrees that, for the term of this Agreement, it shall (i) maintain the highest level of National Committee for Quality Assurance ("NCQA") Patient-Centered Medical Home Recognition status, and (ii) implement all patient care strategies required in NCQA's guidelines for the Patient-Centered Medical Home Recognition programs, including, but not limited to, appropriate levels of care navigators.

(c) Health Center Quality Committee. The Health Center agrees that, for the term of this Agreement, it shall appoint two (2) professionals from the Hospital's clinical staff annually, who shall be mutually agreeable to the Hospital and the Health Center, to the Health Center's Institute Quality Assurance Committee. The Health Center's Institute Quality Assurance Committee shall submit to the Hospital the Health Center's quality reports and/or quality scorecards as they are regularly produced. In addition, the Health Center agrees to work collaboratively with the Hospital and use its best efforts to maintain, and as appropriate, enhance the quality of care provided by the Health Center.

(d) Access to Quality Data. From time to time, the Health Center shall provide to the Hospital, upon reasonable request from the Hospital, patient data, subject to the Health Center's privacy policies, to inform any performance initiatives that the Hospital plans to undertake. The parties shall enter into a business associate agreement in the form attached hereto as Exhibit E.

(e) Development of Service Level Standards. The Health Center shall comply with HRSA service level standards to ensure that the Health Center provides appropriate and timely access to primary care and specified services in the Service Area. The parties shall collaborate to minimize barriers to access to health care services in the Service Area. The Health Center shall provide quarterly reports to the Hospital regarding access to services and quality of such services as part of the Hospital's participation on the Health Center's Institute Quality Assurance Committee.

ARTICLE V

EVENTS OF DEFAULT OR NONCOMPLIANCE

SECTION 5.01 Events of Default. The following shall constitute Events of Default:

(a) Breach by the Health Center. (i) A default shall occur under, or the Health Center shall fail to perform or observe any term, covenant or agreement contained in, this Agreement and such default or failure shall remain unremedied for thirty (30) days after notice of such

failure has been given by the Hospital in writing to the Health Center; (ii) the Health Center is debarred, excluded, suspended or otherwise determined to be ineligible to participate in any federal health care program; (iii) the Health Center fails to maintain all licenses, permits, registrations and certifications required for it to provide Clinic Services to patients without restriction; or (iv) the Health Center loses its FQHC status at any time;

(b) Breach by the Hospital. (i) The Hospital shall fail to pay any Payments when required hereunder or shall otherwise fail to perform or observe any term, covenant or agreement contained in this Agreement and such default or failure shall remain unremedied for thirty (30) days after notice of such failure has been given in writing by the Health Center to the Hospital; or (ii) the Hospital is debarred, excluded, suspended or otherwise determined to be ineligible to participate in any federal health care program;

(c) Bankruptcy. Any proceeding shall be instituted by or against the Health Center seeking to adjudicate it bankrupt or insolvent, or seeking dissolution, liquidation, winding up, reorganization, arrangement, adjustment, protection, relief or composition of it or its debts under any law relating to bankruptcy, insolvency or reorganization or relief of debtors, or seeking the entry of an order for relief or the appointment of a receiver, trustee, custodian or other similar official for the Health Center or for any substantial part of its property, and such proceeding shall not be stayed or dismissed within ninety (90) days;

(d) Cessation of Operations. The Health Center shall cease to operate an outpatient clinic and an FQHC at any time during the term hereof;

(e) Change of Control. Any of the following shall occur: (i) the Health Center shall merge or consolidate with another entity, including, but not limited to, another FQHC or FQHC Look-Alike; (ii) the Health Center shall become affiliated with, or sponsored by, another entity, including, but not limited to, another FQHC or FQHC Look-Alike; (iii) the Health Center shall sell, or dispose of all or substantially all of its assets; or (iv) any entity shall have the authority to, directly or indirectly, manage or control the management, operations or governance of the Health Center, including, but not limited to, the ability to appoint any members of the Board of Directors; or

(f) Cross Default. (i) Any written agreement between the Hospital and the Health Center, including, without limitation, the Residency Training Agreement between the parties, expires, is not renewed or is terminated for any reason by any party (collectively, a "Termination"); or (ii) there is a default under any written agreement between the Hospital and the Health Center.

SECTION 5.02 Remedies. If an Event of Default shall occur and be continuing, then:

(a) In the event of a default by the Health Center under Section 5.01 (a), (c), (d), (e) or (f), the Hospital shall have the option to terminate this Agreement, subject to the Notice provision in Article VII, Section 7.01 of this Agreement, and the Hospital shall not be under any obligation to make further Payments, except that the Hospital shall be obligated to pay for costs incurred by the Health Center that are included in the Grant Components and not the subject of dispute as of the execution date of termination of this Agreement.

(b) In the event of a default by the Hospital under Section 5.01(b), 5.01(c) or Section 5.01 (f), the Health Center shall have the option to terminate this Agreement, subject to the Notice provision in Article VII, Section 7.01 of this Agreement, and neither party shall have any obligations for periods following termination.

ARTICLE VI

NO REFERRALS, TREATMENT OF PATIENTS

SECTION 6.01 No Referrals. None of the terms of this Agreement, the Grant, nor any Payment shall be determined in a manner that varies with, or otherwise takes into account in any way, the volume or value of any referrals or other Federal health care program business generated between the parties. In addition, neither party is obligated to make any referrals to the other party.

SECTION 6.02 Patient Services. Each party shall use its best efforts to serve all patients referred to it by the other party, regardless of the patients' ability to pay.

SECTION 6.03 Freedom of Choice. Each party agrees that all patients will be advised of their freedom to choose any willing provider (subject to valid restrictions imposed by the patient's managed care plan, if any).

ARTICLE VII

MISCELLANEOUS

SECTION 7.01 Notices. Any notice required or permitted to be given under this Agreement, including but not limited to change of address, shall be sufficient if in writing, when delivered by hand, three (3) days after deposit with a nationally recognized overnight carrier for next day delivery or five (5) days after sent by Certified Mail, return receipt requested, to the parties at the addresses as follows:

If to Health Center: Connecticut Institute For Communities, Inc.
7 Old Sherman Tpke, Suite 200
Danbury, Connecticut 06810
Attn: President & CEO

If to Hospital: The Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810
Attn: Chief Operating Officer

SECTION 7.02 Amendments. No amendment of any provision of this Agreement shall be effective unless it is in writing and signed by the Health Center and the Hospital, and no waiver of any provision of this Agreement, nor consent to any departure by the Health Center or the Hospital therefrom, shall be effective unless it is in writing and signed by the Parties, and then

such waiver or consent shall be effective only in the specific instance and for the specific purpose for which given.

SECTION 7.03 Autonomy of Each Institution. The parties of this Agreement shall remain in exclusive control of their respective policies, management, assets and affairs. Neither party shall, by virtue of this Agreement, assume any liability or obligation of the other. Neither party shall have the authority to act to bind the other party, or act as an agent or representative of the other party.

SECTION 7.04 No Waiver; Remedies. No failure on the part of the Hospital or the Health Center to exercise, and no delay in exercising, any right hereunder shall operate as a waiver thereof; nor shall any single or partial exercise of any right under this Agreement preclude any other or further exercise thereof or the exercise of any other right. The rights and remedies of the Hospital and the Health Center provided herein are cumulative and are in addition to, and not exclusive of, any rights or remedies provided by law or in equity.

SECTION 7.05 Severability. If any provision of this Agreement, or the application of any provision hereto to any person or circumstance, is held to be legally invalid, inoperative or unenforceable, then the remainder of this Agreement shall not be affected unless the invalid provision substantially impairs the benefit of the remaining portions of this Agreement to all of the parties.

SECTION 7.06 Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the Health Center and the Hospital and their respective successors and assigns, except that neither the Health Center nor the Hospital may assign its rights hereunder or any interest herein without the prior written consent of the other party, which consent cannot be unreasonably withheld.

SECTION 7.07 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which taken together shall constitute one and the same agreement.

SECTION 7.08 Headings. Section and article headings herein are included for convenience of reference only and shall not constitute a part of this Agreement for any other purpose.

SECTION 7.09 Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Connecticut. Venue shall be in Danbury, Connecticut.

SECTION 7.10 Legislative Changes. The parties understand that their relationship pursuant to this Agreement and the Residency Training Agreement has been structured with the expectation that reimbursement and federal grants to FQHCs will continue to be available in substantially similar amounts as are currently provided. Moreover, the parties understand that their relationship under this Agreement has been created in accordance with the Safe Harbors relating to grants to FQHCs. The parties agree that in the event the Safe Harbors are terminated or modified or there is any other change in applicable law which impacts on the grant amount or methodology set forth herein (a "Materially Adverse Event"), the parties shall use good faith efforts to renegotiate this Agreement to comply with such regulations or applicable law. In the event the parties cannot agree on a new grant amount or methodology within one hundred twenty

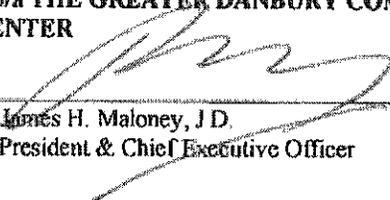
(120) days of such change, either party may terminate this Agreement on thirty (30) days prior written notice.

SECTION 7.11 Coordination with Other Agreements. Hospital maintains centrally and updates a master list of contracts that includes all contracts between Hospital and Health Center which list is available for review by the Secretary of Health and Human Services upon request and is maintained in a manner that preserves the historical record of such contracts. The parties agree to amend the master list to reflect any additional agreements or arrangements between the parties at the time such agreements or arrangements are made.

[Signatures on next page]

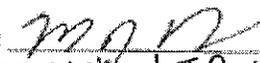
IN WITNESS WHEREOF, the parties hereto have caused this Grant Agreement to be executed by their respective officers or other representatives thereunto duly authorized, as of the date first above written,

**CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.
d/b/a THE GREATER DANBURY COMMUNITY HEALTH
CENTER**

By: 

James H. Maloney, J.D.
President & Chief Executive Officer

THE DANBURY HOSPITAL

By: 

Name: Michael J. Deglio

Title: SVP Western Health Network


SVP & Chief Financial Officer

EXHIBIT A
GRANT BUDGET

FQHC - Grant Components

Component	DH	CFC	Variance	Years				
				1	2	3	4	5
<u>Physician Salary Variance Annual Cap</u>								
Physician's Phase I (Adult/Pedi/Womens)								
Physician's Phase II (Dental/BehHealth)								
<u>Fringe Benefits (401k subsidy)</u>								
<u>Dental Clinic Component</u>								
Specialty Dental Services Variance								
Detrix Software (IT Interface)								
Detrix - New License								
<u>eClinical Conversion Component</u>								
New practioner licenses (FT: \$5K/each; PT: \$2.5K/each; Residents: \$500/each)								
eClinical Training								
eClinical Conversion Costs								
<u>Equipment</u>								
<u>Additional Transition Costs</u>								
TOTAL Grant								

EXHIBIT B
CLINIC PHYSICIANS

<u>Name</u>	<u>FTE</u>	<u>Position</u>	<u>Salary</u>
[REDACTED]	1.00	Site Director, Dental	
[REDACTED]	1.00	Site Director, Internal Med	
[REDACTED]	0.80	Site, Director, Ob/Gyn	
[REDACTED]	1.00	Pediatrics	
[REDACTED]	0.80	Internal Med	
[REDACTED]	0.35	Internal Med	
[REDACTED]	1.00	Internal Med	
[REDACTED]	0.80	Ob/Gyn	
[REDACTED]	0.80	Psychiatry	
[REDACTED]	0.80	Psychiatry	

EXHIBIT C

EQUIPMENT

Section I (adult medicine, pediatrics and OBGYN)

[To be specified not later than the Commencement Date]

Section II (dental and behavioral health equipment)

[To be specified not less than six (6) months prior to commencement of Year Two]

EXHIBIT C-1

EQUIPMENT VALUATION

Section I (adult medicine, pediatrics and OBGYN)

[To be specified not later than the Commencement Date]]

Section II (dental and behavioral health equipment)

[To be specified not less than six (6) months prior to commencement of Year Two]

EXHIBIT D

FORM OF CERTIFICATION

Date: _____

Connecticut Institute For Communities, Inc. d/b/a The Greater Danbury Community Health Center (the "Health Center") hereby certifies, pursuant to the terms and conditions of the Grant Agreement (the "Agreement"), dated as of _____, 201__, by and between the Health Center and The Danbury Hospital, that:

1. The Health Center hereby confirms that all payments for the Grant received were used only for Permitted Purposes (as such terms are defined in the Agreement) in accordance with the terms of the Agreement.
2. The Health Center hereby confirms that the representations and warranties contained in the Agreement are true and correct as of the date hereof and that all conditions precedent to the making of a Payment and covenants set forth in the Agreement have been satisfied.
3. THE UNDERSIGNED IS DULY AUTHORIZED TO MAKE THIS CERTIFICATION ON BEHALF OF.

Connecticut Institute For Communities, Inc.

By: _____
James H. Maloney, J.D.
President & Chief Executive Officer

EXHIBIT E

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of June 4, 2015 (the "Execution Date"), by and between The Connecticut Institute For Communities, Inc. d/b/a The Greater Danbury Community Health Center (the "Covered Entity") and The Danbury Hospital ("Business Associate").

RECITALS:

WHEREAS, the Business Associate and the Covered Entity have entered into that certain Grant Agreement dated June 4, 2015 (the "Agreement") under which the Business Associate performs or assists the Covered Entity with a function or activity involving the use or disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which privacy regulations are codified at 45 C.F.R. parts 160 and 164 and which security regulations are codified at 45 C.F.R. part 160, 162 and 164, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") and as such regulations may be amended from time to time (collectively referred to herein as the "HIPAA Standards");

WHEREAS, the Covered Entity and the Business Associate acknowledge and agree that capitalized terms used, but not otherwise defined, herein are as defined in the HIPAA Standards;

WHEREAS, the HIPAA Standards require that the Covered Entity obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information used or disclosed by the Business Associate in the course of performing services pursuant to the Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the Parties agree as follows:

1. **Obligations and Activities of Business Associate**
 - a) Business Associate shall not use or further disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as required by law.
 - b) Business Associate shall use appropriate safeguards to prevent use or disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

- c) Business Associate shall immediately report to the Covered Entity any use or disclosure of Protected Health Information or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information and any Security Incident involving the Protected Health Information or an Individual's information of which the Business Associate becomes aware. Business Associate shall take any action necessary or requested by the Covered Entity to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Security Incident or use or disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information by Business Associate in violation of the requirements of this Business Associate Agreement. In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate's notice to the Covered Entity of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed by the Business Associate, to have been, accessed, acquired, or disclosed during such Breach. Business Associate shall also provide Covered Entity any other available information that the Covered Entity are required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any action necessary as requested by the Covered Entity to assist the Covered Entity in complying with any applicable Breach notification requirements.
- d) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of, the Covered Entity agrees to the same restrictions and conditions that apply through this Business Associate Agreement to Business Associate with respect to such information.
- e) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:
 - (1) provide access, at the request of the Covered Entity, and in the time and manner designated by the Covered Entity, to Protected Health Information in a Designated Record Set, to the Covered Entity or, as directed by the Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524; and
 - (2) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity direct or agree to pursuant to 45 C.F.R. § 164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity.
- f) Business Associate shall make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, the Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the

Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the HIPAA Standards.

- g) Business Associate shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Covered Entity or Business Associate to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.
- h) Business Associate shall provide to the Covered Entity, in a time and manner designated by the Covered Entity, information pertaining to disclosures of Protected Health Information by Business Associate to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of disclosures of Protected Health Information made by Business Associate, including, effective January 1, 2011 or a later date as provided by the HIPAA Standards, any request for an accounting of disclosures of Protected Health Information made from a Covered Entity's electronic health record for treatment, payment, or health care operation purposes during the three (3) years prior to the date of such request, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.
- i) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is used or disclosed only as authorized under the HIPAA Standards and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Standards that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Standards. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Standards and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper use and/or disclosure of an Individual's information.
- j) Business Associate shall, in the performance of its duties under this Business Associate Agreement and the Agreement, comply with all applicable state and federal laws, regulations and rules (including, without limitation, the HIPAA Standards).
- k) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that the Covered Entity would be subject to if such Covered Entity violated the same requirements.

2. Permitted Uses and Disclosures by Business Associate

- a) Except as otherwise limited in this Business Associate Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate the HIPAA Standards if done by the Covered Entity.
- b) Except as otherwise limited in this Business Associate Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- c) Except as otherwise limited in this Business Associate Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- d) Except as otherwise permitted by the HIPAA Standards, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request. When guidance to be issued by the Secretary as to what constitutes the "minimum necessary" becomes effective, Business Associate shall comply with such guidance when using, disclosing and requesting Protected Health Information.
- e) Except as otherwise permitted by the HIPAA Standards, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless the Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section 2(e) and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.
- f) Except as otherwise permitted by the HIPAA Standards, Business Associate agrees that it will not use or disclose Protected Health Information in connection with any fundraising and/or marketing communication for or on behalf of a Covered Entity unless such Covered Entity has obtained a valid authorization from each Individual who will be a recipient of any such communication.

- g) If an Individual requests that Business Associate restrict the disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

3. Obligations of the Covered Entity

- a) Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produce in accordance with 45 C.F.R. § 164.520, as well as any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.
- b) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.
- c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity have agreed to in accordance with 45 C.F.R. § 164.522.
- d) Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the HIPAA Standards if done by Covered Entity.

4. Term and Termination

- a) Term. The Term of this Business Associate Agreement shall be effective as of the Execution Date and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.
- b) Termination for Cause. Upon the Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, the Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation, and the Covered Entity shall terminate the Agreement if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity, or immediately terminate the Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in their reasonable discretion.

c) Effect of Termination.

- (1) Except as provided in subparagraph (2) of this subsection (c), upon termination of the Agreement or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of the Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
- (2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.
- (3) The Parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entity and the Business Associate. The Parties further agree that the Covered Entity would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entity shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

5. Miscellaneous

- a) Survival. The respective rights and obligations of Business Associate under Section 4(c) and the obligations of Business Associate under Section 5(i) of this Business Associate Agreement shall survive the termination of this Business Associate Agreement.
- b) Interpretation. Any ambiguity in this Business Associate Agreement shall be resolved in favor of a meaning that permits the Parties to comply with the HIPAA Standards.
- c) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the Parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.
- d) Amendment. In the event that any law or regulation is enacted or promulgated regarding the protection of health information that is in any way inconsistent with

the terms of this Business Associate Agreement or that interferes with either Party's obligations with respect to the protection of health information so as to warrant a modification to this Business Associate Agreement or in the event any HIPAA Standard is amended or modified, either Party shall have the right to amend this Business Associate Agreement so as to bring it into compliance with any such change by providing written notice thereof to the other Party but without having to obtain the other Party's consent thereto. Except as set forth above in this Section 5(d), this Business Associate Agreement shall only be amended or modified upon written consent of the Parties.

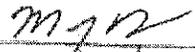
- e) Application of State Law. Where any applicable provision of State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Standards, the Parties shall comply with the applicable provisions of State law.
- f) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.
- g) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The Parties agree that venue shall lie in Federal and State courts in the State of Connecticut, without regard to its conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.
- h) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the address set forth above and shall be considered given upon delivery.
- i) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement, Business Associate shall indemnify, hold harmless and defend the Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any use or disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by the Covered Entity in providing required breach notifications.

IN WITNESS WHEREOF, the Parties hereto have executed this Business Associate Agreement as of the Execution Date.

CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.
d/b/a THE GREATER DANBURY COMMUNITY HEALTH
CENTER

By: 
James H. Maloney, J.D.
President & Chief Executive Officer

THE DANBURY HOSPITAL

By: 
Name: Michael J. Duglio
Title: SVP, Western Connecticut Health Network



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

TENTATIVE AGENDA

HEARING

Docket Number: 15-31978

Western Connecticut Health Network

**Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community
Health Center and Community Center for Behavioral Health Programs**

July 7, 2015 at 4:00 p.m.

- I. Convening of the Public Hearing
- II. Applicant's Direct Testimony
- III. OHCA's Questions-Applicant
- 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

* * * COMMUNICATION RESULT REPORT (JUL. 6.2015 3:26PM) * * *

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 DEPARTMENT OF PUBLIC HEALTH
 OFFICE OF HEALTH CARE ACCESS**

FAX SHEET

TO: Sally F. Herlihy
Vice President, Planning

FAX: (203) 739 1974

AGENCY: Western Connecticut Health Network

FROM: OHCA

DATE: 7/6/15 **TIME:** _____

NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: 15-31978 -CON Termination and Transfer of Ownership of S& F and CCBH
 Informatin regarding tomorrows hearing

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FAX SHEET

TO: THEODORE J. TUCCI
FAX: 860 275-8299
AGENCY: Robinson & Cole LLP
FROM: OHCA
DATE: 7/6/15 TIME: _____
NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: 15-31978 -CON Termination and Transfer of Ownership of S& F and CCBH
Hearing Information for tomorrow's hearing

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Fax: (860) 418-7053

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P.O.Box 340308
Hartford, CT 06134

**PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET**

July 7, 2015
4:00 p.m.

Docket Number: 15-31978-CON

Western Connecticut Health Network

Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs

PRINT NAME	Representing Self or Organization
<i>Liz Murray</i>	<i>Committee Institute for Grants</i>
Katie curran	Dr. Thomas Draper, ^{City of Danbury} Dept. of Health
<i>Kim Morgan</i>	<i>United Way of Western CT</i>

**PUBLIC HEARING
APPLICANT
SIGN UP SHEET**

July 7, 2015
4:00 p.m.

Docket Number: 15-31978-CON

Western Connecticut Health Network

Proposal to Terminate and Transfer Ownership of Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs

PRINT NAME	Phone	Fax	Representing Organization
Andrea Rynn	203 739 7919	203 739 1689	WCHN
Sally Herlihy	203-739-4903		WCHN
Maryalice Cullen	203-739-6157		WCHN
Kelli Stock	203-739-7714		WCHN
Carolyn McKenna	203-739-6868		WCHN

Western Connecticut Health Network

PRINT NAME	Phone	Fax	Representing Organization
William DeLuve	203 791 5000	203 791 5000	WCHN
Thomas Gross	203-739-7161		WCHN
Carla Fyles	203 791-5034		WCHN
Anabella Rodriguez	203 994-0270		WCHN
Deborah Henriquez	203 312 6901		WCHN
Shannon Ritchie	203 470 6321		WCHN
Michael Daglio	203-852-2353		WCHN

ORIGINAL

1

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



WESTERN CONNECTICUT HEALTH NETWORK

PROPOSAL TO TERMINATE AND TRANSFER OWNERSHIP OF
SEIFERT & FORD FAMILY COMMUNITY HEALTH CENTER AND
COMMUNITY CENTER FOR BEHAVIORAL HEALTH PROGRAMS

DOCKET NO. 15-31978-CON

JULY 7, 2015

4:00 P.M.

72 HOSPITAL AVENUE
DANBURY, CONNECTICUT

POST REPORTING SERVICE
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RE: WESTERN CONNECTICUT HEALTH NETWORK
JULY 7, 2015

1 . . .Verbatim proceedings of a hearing
2 before the State of Connecticut, Department of Public
3 Health, Office of Health Care Access, in the matter of
4 Western Connecticut Health Network, proposal to terminate
5 and transfer ownership of Seifert & Ford Family Community
6 Health Center and Community Center for Behavioral Health
7 Programs, held at 72 Hospital Avenue, Danbury,
8 Connecticut, on July 7, 2015 at 4:00 p.m. . . .

9
10
11
12 HEARING OFFICER KEVIN HANSTED: Good
13 afternoon, everyone. We're going to get started here.
14 This public hearing before the Office of Health Care
15 Access, identified by Docket No. 15-31978-CON, is being
16 held on July 7, 2015 to consider Western Connecticut
17 Health Network, Inc.'s application to terminate and
18 transfer ownership of Seifert & Ford Family Community
19 Health Center and Community Center for Behavioral Health
20 Programs.

21 This public hearing is being held pursuant
22 to Connecticut General Statute, Section 19a-639a, and
23 will be conducted as a contested case, in accordance with
24 the provisions of Chapter 54 of the Connecticut General

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1 Statutes.

2 My name is Kevin Hansted, and I have been
3 designated by Commissioner Jewel Mullen of the Department
4 of Public Health to serve as the Hearing Officer for this
5 matter.

6 The staff members assigned to this case
7 are Kaila Riggott, Jessica Schaeffer-Helmecki and Olga
8 Armah. The hearing is being recorded by Post Reporting
9 Services.

10 In making its decision, OHCA will consider
11 and make written findings concerning the principles and
12 guidelines set forth in Section 19a-639 of the
13 Connecticut General Statutes.

14 Western Connecticut Health Network, Inc.
15 has been designated as a party in this proceeding.

16 At this time, I will ask staff to read
17 into the record those documents already appearing in
18 OHCA's Table of the Record in this matter.

19 All documents have been identified in the
20 Table of the Record for reference purposes. Jessica?

21 MS. JESSICA SCHAEFFER-HELMECKI: Good
22 evening. My name is Jessica Schaeffer-Helmecki, and, on
23 behalf of OHCA, I'd like to request that Exhibits A
24 through Q be entered into the record.

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1 HEARING OFFICER HANSTED: Thank you. And
2 are there any objections to the exhibits?

3 MR. THEODORE TUCCI: Good afternoon,
4 Hearing Officer Hansted.

5 HEARING OFFICER HANSTED: You need to turn
6 on your microphone.

7 MR. TUCCI: Good afternoon, Hearing
8 Officer Hansted. No objection to the entry of the
9 exhibits, as noted on the record. Just one comment,
10 question for staff.

11 With regard to Exhibit O, which is
12 described as a letter from the Applicant enclosing pre-
13 filed testimony, the record designation indicates 160
14 pages. My guess is that may be a typographical error,
15 and I just wanted to note that.

16 HEARING OFFICER HANSTED: Thank you.
17 We'll revise that, so that you have the proper amount of
18 pages.

19 MR. TUCCI: Thank you.

20 HEARING OFFICER HANSTED: This evening, we
21 will first hear from the Applicant for an overview of the
22 project, and then OHCA will ask some questions. After
23 that, that's referred to as the technical portion, we
24 will then turn it over to the public portion, whereby the

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1 public will have an opportunity to comment on the
2 application pending before the Office of Health Care
3 Access.

4 At this time, I would ask anyone, who is
5 going to testify here this evening on behalf of the
6 Applicant, to please stand, raise your right hand, and
7 have the court reporter swear you in.

8 (Whereupon, the parties were duly sworn
9 in.)

10 HEARING OFFICER HANSTED: Thank you,
11 everyone. And just as a reminder, for those of you, who
12 have pre-filed testimony, when you first testify this
13 evening, adopt the pre-filed testimony for the record.

14 And for those of you, who have not pre-
15 filed testimony, I would appreciate if you would just
16 identify yourself on the record, just so the court
17 reporter knows who you are.

18 We will proceed with the technical
19 portion, and the Applicant may start.

20 MR. TUCCI: Thank you, Hearing Officer
21 Hansted, and good afternoon to you and to members of the
22 Office of Health Care Access. Good afternoon to you and
23 to members of the Office of Health Care Access staff.

24 My name is Theodore Tucci, and I represent

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1 the Applicant in this Certificate of Need proceeding,
2 Western Connecticut Health Network.

3 The title of the CON application refers to
4 a termination and transfer of ownership of certain
5 primary care and behavioral health services, which
6 obviously is technically correct.

7 I'd just comment that I think it might be
8 more apt for OHCA to look at this request as one for a
9 transfer and continuation of vital services in the
10 Greater Danbury community, which actually reflects what
11 we believe are the goals and realities of the health care
12 delivery in the environment of health care reform that we
13 face today.

14 It's my pleasure to introduce to the
15 Hearing Officer and to OHCA staff Mr. Daglio, who will
16 present his pre-filed testimony and the remarks on behalf
17 of the Applicant.

18 MR. MICHAEL DAGLIO: Can you hear that
19 okay? Good afternoon, Hearing Officer Hansted and Office
20 of Health Care Access staff. My name is Mike Daglio. I
21 am the President of Norwalk Hospital and the Senior Vice
22 President of Western Connecticut Health Network, and I
23 hereby adopt my pre-filed testimony.

24 The project proposal before you today is a

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1 response to the ever-changing health care economics, in
2 which hospital organizations, like Western Connecticut
3 Health Network, are being challenged to become health
4 care managers of a given population and to produce higher
5 quality outcomes at a lower cost.

6 Western Connecticut Health Network
7 subscribes to this new model of accountable care, and,
8 over the past few years, we've been transforming
9 ourselves from a legacy hospital system that once
10 measured success on inpatient discharges into a health
11 care system that is now focused on keeping our population
12 well in the outpatient setting.

13 Hospitals are being incentivized by payers
14 to perform better on clinical indicators with an
15 increasing focus on the care we provide to patients
16 outside of the hospital, including improved management of
17 chronic conditions to reduce unnecessary admissions to
18 the hospital, improved transition of care plans to avoid
19 unnecessary readmissions of patients once they are
20 discharged from a hospital stay, expanded community care
21 team strategies to reduce inappropriate emergency room
22 utilization, and adherence to evidence-based best
23 practice care management plans to reduce unnecessary
24 utilization of diagnostic testing.

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1 And while the payers continue to move
2 towards these quality-based incentive and reimbursement
3 models that have significantly reduced utilization of
4 hospital-based services, they are also placing
5 significant downward pressures on the pricing of these
6 services.

7 This confluence of lower utilization of
8 hospital services and downward pressure on pricing has
9 caused Western Connecticut Health Network to seriously
10 examine its current operating model of providing health
11 care services to its community.

12 We recognize that the current structure in
13 place -- excuse me. Too much rain. The current
14 structure in place was built on a legacy fee for service
15 reimbursement system that will not be sustainable in the
16 future of accountable care systems.

17 We must look for innovative and sometimes
18 disruptive models of care to sustain services on a going
19 forward basis. We are faced with not only the question
20 of how to provide certain services in the future, but
21 whether we can afford to provide certain services under
22 the new economic realities.

23 In no area does that question loom larger
24 than with our provision of Community Health Care Services

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1 in our Seifert & Ford and CCBH clinics, where we provide
2 adult health, pediatrics, women's dental and behavioral
3 health services to the uninsured and the Medicaid
4 patients in our community.

5 In recent years, the increasing costs of
6 running the clinics under the new requirements of value-
7 based reimbursement and the significant reductions in
8 Medicaid reimbursements in the State of Connecticut over
9 the past few years has made running these clinics under a
10 hospital-based model unsustainable.

11 In 2014, Danbury Hospital lost 4.6 million
12 dollars in the provision of clinic services in Seifert &
13 Ford and CCBH clinic under Medicaid reimbursement and
14 free care.

15 So we face the dilemma how can we continue
16 to meet our mission to provide health care to all of our
17 community members, regardless of their ability to pay,
18 but be able to do so in a sustainable way?

19 In many of the circumstances where we have
20 addressed these types of issues, developing new
21 partnerships with other organizations have proven to be a
22 good model for us to refer to.

23 In this circumstance and for the many
24 reasons outlined in our CON application, partnering with

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1 the Connecticut Institute for Communities, which is a
2 federally-qualified health care center, is the optimum
3 model for us to pursue, in order to continue to support
4 access to high-quality health care services to our
5 neediest population while, at the same time, reducing
6 costs.

7 I would like to say that we are proposing
8 an innovative model to address our dilemma, but hospitals
9 and FQHCs across the country and, specifically, here in
10 the State of Connecticut have been partnering in the
11 provision of these community services for a number of
12 years. In fact, our sister hospital, Norwalk Hospital,
13 implemented this same model in 1999.

14 I would like to thank OHCA for considering
15 our application and hearing from us on this matter today.
16 I'm confident that with your support on this proposal
17 Western Connecticut Health Network and CIFC will build a
18 sustainable model of high-quality health care to the
19 Greater Danbury community for many years to come, so
20 thank you.

21 HEARING OFFICER HANSTED: Counsel, do you
22 have any other witnesses, who would like to testify?

23 MR. TUCCI: No. That concludes our
24 presentation. Thank you.

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1 HEARING OFFICER HANSTED: Okay. Thank
2 you, counsel. And, at this point, OHCA has some
3 questions for you.

4 MS. SCHAEFFER-HELMECKI: Now in your
5 testimony just now and in your application, you mentioned
6 that the new models of Patient-Centered Medical Home
7 system is one of the benefits to the proposal. Will all
8 new patients be treated using the PCMH model?

9 MR. DAGLIO: I think that might be a
10 question better answered by CFC, but it's our
11 understanding they are a level three Patient-Centered
12 Medical Home accredited by the NCQA, and, so, their model
13 is Patient-Centered Medical Home, and they will be
14 providing that care to all patients, who come through
15 their clinic.

16 MS. SCHAEFFER-HELMECKI: And I just have a
17 couple of financial questions. Firstly, how did WCHN
18 determine the year one and year five grant amounts to
19 cover the shortfall?

20 MR. DAGLIO: Sure. So you'll see in the
21 years, as they go forward, the grant amount becomes less.
22 The initial costs of transitioning the programs, the
23 clinics into each other, have a lot of upfront startup
24 costs, so moving all of our clinic patients, the Seifert

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1 & Ford and CCBH and the dental patients all over to the
2 FQHC's or the CIFC's practice, where they have electronic
3 medical records, there's a lot of licensing costs, there
4 are a lot of startup costs from infrastructure, a lot of
5 provision of hardware that need to be rolled out, so the
6 upfront costs over the first two years are greater, and
7 then the support going forward is less in subsequent
8 years.

9 MS. SCHAEFFER-HELMECKI: And now if that
10 grant amount does turn out to be insufficient in any of
11 the years to cover the operating cost, will the Greater
12 Danbury Community Health Center be able to continue
13 providing the same level of services that they currently
14 do?

15 MR. DAGLIO: Again, I think that's a good
16 question for the CIFC, but the way the grant model works
17 is that we have contingency dollars built into the grant
18 model, so if there are unforeseen expenses that arise, so
19 we have a very detailed listing of things that we are
20 supporting, items that we are supporting from a financial
21 standpoint, but then we also have built in contingencies
22 for those unforeseen expenses that may arise during this
23 transition, so we have built in for some of that and to
24 have some padding, I guess, if you will, for those things

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1 that we're not aware of today.

2 MS. SCHAEFFER-HELMECKI: You said that you
3 have a list of very specific costs that the grant dollars
4 can cover. Is that in the agreement that you had
5 mentioned?

6 HEARING OFFICER HANSTED: The grant
7 agreement?

8 MS. SCHAEFFER-HELMECKI: The grant
9 agreement, so this may be in 2014?

10 MR. DAGLIO: Yeah. There's a grant
11 agreement, and there's an exhibit in the grant agreement
12 with that detail.

13 HEARING OFFICER HANSTED: I just want
14 follow-up. Now the grant agreement, it's our
15 understanding from your responses to OHCA's completeness
16 questions, that has not been finalized? Is that
17 accurate?

18 MR. DAGLIO: At the time of answering the
19 questions of the completeness, it was not signed. It has
20 recently been signed.

21 HEARING OFFICER HANSTED: Okay. Can you
22 provide OHCA with a copy of that agreement?

23 MR. DAGLIO: Sure. We can do that.

24 HEARING OFFICER HANSTED: Okay and I'll

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1 order that as Late File No. 1. By July 21st, does that
2 give you enough time? That's two weeks.

3 MR. TUCCI: Actually, if I can comment on
4 that, Hearing Officer Hansted?

5 HEARING OFFICER HANSTED: Sure.

6 MR. TUCCI: We anticipated that OHCA might
7 make a request for the grant agreement, and we actually
8 are prepared today to submit into the record a copy of
9 the grant agreement.

10 I just wanted to note for the record that
11 there are certain proprietary information and
12 confidential information that's obviously contained in
13 this agreement between the two parties that is different
14 than the financial information that Mr. Daglio referred
15 to, which remains in the agreement.

16 The agreement that we're prepared to
17 submit today has redacted certain confidential
18 proprietary information, but I believe the information
19 that OHCA is interested in reviewing is in the agreement,
20 and, with your permission, we can submit it today.

21 HEARING OFFICER HANSTED: That would be
22 fine, if you want to submit the redacted version tonight,
23 however, we will hold open our option to request the
24 unredacted version if we feel that the redacted version

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1 is not sufficient, so if you want to submit that, that
2 will be, let's see, that will end up being Exhibit S.

3 And, while we're at it, just to clarify
4 the record, Exhibit R will be a motion to withdraw
5 appearance and intervener status on behalf of Danbury
6 Nurses Local 5047, AFT-CTAFTAFL-CIO, dated July 6, 2015.

7 MR. TUCCI: All right and, if I can
8 approach, I have a copy of the --

9 HEARING OFFICER HANSTED: Absolutely.

10 MR. TUCCI: -- agreement.

11 HEARING OFFICER HANSTED: And just to
12 clarify, the grant agreement, which Attorney Tucci just
13 handed me, will be Exhibit R. I had mistakenly thought
14 that the motion to withdraw appearance and intervener
15 status had not been recorded yet, but that has been
16 recorded as Exhibit Q, so, again, the grant agreement
17 will be Exhibit R.

18 MS. SCHAEFFER-HELMECKI: I have a couple
19 more questions before I pass around the microphone. So
20 is there any contingency plan that you're aware of in
21 case the GDCHC cannot continue providing any services for
22 any reason?

23 MR. DAGLIO: Yeah. We talked about that,
24 and we talked about it with our Board, as well, that if

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1 they were to go out of business or to default on this, we
2 would have to take the services back. As a hospital with
3 a mission to support our community, that is something we
4 would do, is to take those services back and reopen, if
5 you will, a clinic to support these patients.

6 MS. SCHAEFFER-HELMECKI: And do you have a
7 time frame for that contingency plan?

8 MR. DAGLIO: In terms of?

9 MS. SCHAEFFER-HELMECKI: Going forward, is
10 there a definite period that, if there's a default in the
11 next two years, three years, five years, do you have any
12 --

13 MR. DAGLIO: It would have to be in
14 perpetuity. We would have to start those services up
15 again. It's our mission to care for these patients, so
16 the hope would be enough warning in advance that we would
17 have to convert it back to a hospital-based service, but
18 that's something we're prepared to do.

19 MS. SCHAEFFER-HELMECKI: Okay, thank you.

20 MS. KAILA RIGGOTT: I just have a couple
21 of questions, additional questions. Kaila Riggott. I
22 have a couple of additional questions. Kaila Riggott,
23 OHCA staff.

24 Is the 57 North Street location, the

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1 proposed location for pediatric services, as accessible
2 as the current location with respect to public
3 transportation?

4 MR. DAGLIO: I believe they are. I'd have
5 to defer to somebody. I believe they're all in the same
6 location. How would I do that?

7 HEARING OFFICER HANSTED: Is there an
8 individual here that can testify, as to that answer?

9 MR. TUCCI: If we could just have a
10 moment?

11 HEARING OFFICER HANSTED: Absolutely.

12 MR. MORRIS GROSS: Morris Gross, Vice
13 President of Facilities. There are buses running along
14 North Street in that area, as far as the current location
15 you're talking about, but, certainly, at the new
16 location, if that's really what you're focused on,
17 there's a bus stop right in front of the building at 70
18 Main Street.

19 MR. DAGLIO: She's talking about 57.

20 MR. GROSS: At 57, I know there's a bus
21 that runs on North Street there, as far as that, and
22 there are many patients, who go there now.

23 MS. RIGGOTT: Thank you. And one further
24 question. In the application, you mentioned the

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1 anticipated expansion of services, specifically, on pages
2 13 and 45. Can you discuss those and elaborate, please?

3 MR. DAGLIO: Sure. The first thing we
4 talked about was the hours of operation, so there are
5 expanded hours of operation currently being run by CIFC,
6 and we would adopt those new hours of operation for all
7 the patients, who would convert and transition over to
8 the CIFC, so there's expanded access right there.

9 We're also building a program with
10 residents in a PCP training program that would allow for
11 greater access for patients to see physicians, as well,
12 and then the other thing we're doing is we're taking some
13 of the savings that we'll achieve.

14 There's an investing in growth in
15 specialty clinics that we have at the clinic, as well,
16 and, so, we will be able to take some of that funding to
17 apply towards greater access of specialty services.

18 MS. OLGA ARMAH: My name is Olga Armah,
19 OHCA staff. You talked about specialty services. What
20 are the specific specialty services you'll be providing
21 there?

22 MR. DAGLIO: It's in the response
23 questions. Let me just look it up. So on our response
24 questions or response to the questions on page looks like

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1 it's page 96 of the packet, it's question 14 on page nine
2 of the application. The Applicant states that WCHN will
3 continue to provide specialty care clinics at Seifert &
4 Ford and what services are provided in these clinics, so
5 it's orthopedic, spine, podiatry, urology, neurology,
6 allergy, rheumatology and TB services.

7 MS. ARMAH: So these would be at the S & F
8 location and not at the hospital, so that patients will
9 not have to go to the hospital. They'll just come to S &
10 F?

11 MR. DAGLIO: That's correct. They're
12 currently at Seifert & Ford, and they will remain there,
13 as well, and they would still be run as hospital
14 services.

15 MS. ARMAH: Okay.

16 MS. RIGGOTT: So, just to clarify, then,
17 the expansion of services it's basically the hours of
18 operation and the residence program, correct?

19 MR. DAGLIO: And the expansion of clinic
20 service, yeah, the specialty clinics. The specialty
21 clinics typically have a longer wait time than some of
22 the primary care, because it's hard to get the
23 specialists to come over to the clinic more regularly, so
24 what we're trying to do is create more days and more

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1 sessions of specialty clinics to reduce that backlog of
2 specialty visits for the patients.

3 MS. RIGGOTT: Okay, thank you.

4 MR. DAGLIO: Sure.

5 MS. ARMAH: Where are the patients
6 receiving the services right now?

7 HEARING OFFICER HANSTED: Hold on.

8 MS. ARMAH: It's on. Where are the
9 patients receiving the services, specialty services,
10 currently?

11 MR. DAGLIO: At the Seifert & Ford clinic
12 on Main Street.

13 MS. ARMAH: Okay.

14 MR. DAGLIO: There's a separate clinic for
15 specialty services.

16 HEARING OFFICER HANSTED: All set?

17 MS. ARMAH: All set.

18 HEARING OFFICER HANSTED: Okay.

19 MS. ARMAH: Thank you.

20 HEARING OFFICER HANSTED: Jessica, all
21 set? Kaila, all set?

22 MS. RIGGOTT: Yes.

23 HEARING OFFICER HANSTED: Okay, thank you
24 for answering those questions. The only question I had

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1 was with respect to the grant agreement, which you've
2 submitted as an exhibit, so I'll review that. That
3 concludes the technical portion for OHCA.

4 I had one matter of housekeeping, which
5 I'll just do on the record, with respect to Exhibit Q,
6 which is the motion to withdraw appearance and intervener
7 status on behalf of the Union. That motion is hereby
8 granted.

9 At this point, we'll take a brief break,
10 about five minutes. We just want to get the public sign-
11 in sheet and take care of that. Thank you.

12 (Off the record)

13 HEARING OFFICER HANSTED: Okay, we're back
14 on the record. I just wanted to clarify one thing with
15 respect to the grant agreement.

16 We took a quick review of it during the
17 break, and Ms. Armah has one follow-up question.

18 MS. ARMAH: Yes. This has to do with the
19 specialty services. The services listed in the grant
20 agreement is a little different from what was in the pre-
21 file.

22 The pre-file does not include
23 endocrinology and TB, so are those services that will
24 continue to be provided at the facility?

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1 MR. TUCCI: If I could just ask a
2 clarifying question? Do you have a specific page
3 reference?

4 MS. ARMAH: I'm sorry. Page 11 of the
5 grant agreement and page two of the pre-file.

6 HEARING OFFICER HANSTED: So in the grant
7 agreement, it's Section 4.02b under specialty services,
8 and, in the pre-filed testimony, it's on page two, the
9 second paragraph down, under proposal to transition and
10 collaborate.

11 MR. DAGLIO: So the question is they don't
12 match?

13 MS. ARMAH: Yes.

14 MR. DAGLIO: You said pre-filed testimony.
15 Do you mean the questions?

16 MS. ARMAH: No. The testimony, itself.

17 MR. DAGLIO: The testimony, itself.

18 MS. ARMAH: Itself, yes.

19 MR. DAGLIO: Okay. I think it just may
20 have been an omission. We plan to provide all the same
21 services we provide today, so, if that helps clarify, we
22 can send you a listing of those exact. I think it might
23 have just been an omission of a service.

24 MS. ARMAH: Okay, thank you.

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1 MR. DAGLIO: But we're not reducing any
2 services in specialty.

3 MS. ARMAH: Not reducing services, okay.
4 Thank you.

5 HEARING OFFICER HANSTED: So that includes
6 endocrinology and tuberculosis?

7 MR. DAGLIO: That's right.

8 HEARING OFFICER HANSTED: Okay, thank you.

9 MR. TUCCI: And I would just note for the
10 record that Exhibit R that was submitted is a signed
11 agreement between the two parties, so I believe that
12 would govern.

13 HEARING OFFICER HANSTED: Yes, absolutely.
14 I just wanted to clarify the testimony.

15 (Whereupon, the hearing adjourned.)

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CERTIFICATE

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

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

In witness whereof I have hereunto set my hand and do so attest to the above, this 9th day of July, 2015.



Paul Landman
President

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Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Tuesday, July 21, 2015 2:36 PM
To: 'Herlihy, Sally'
Cc: 'Tucci, Theodore'; Armah, Olga; Riggott, Kaila; Greer, Leslie
Subject: Public Hearing: WCHN 15-31978-CON
Attachments: 31978 Public Hearing Closed.pdf

Sally,

Attached please find a public hearing closure notification for docket number 15-31978.

Thank you,

Jessica

Jessica Schaeffer-Helmecki

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134

P: (860) 509-8075 | F: (860) 418-7053 | E: jessica.schaeffer-helmecki@ct.gov





STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

July 21, 2015

VIA E-MAIL ONLY

Sally F. Herlihy
Western Connecticut Health Network, Inc.
24 Hospital Ave
Danbury, CT 06810

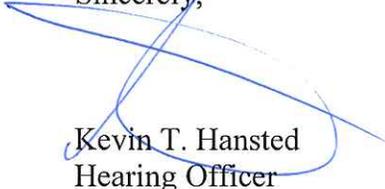
RE: Certificate of Need Application; Docket Number: 15-31978-CON
Termination/transfer of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs to Connecticut Institute For Communities, Inc.'s Greater Danbury Community Health Center
Closure of Public Hearing

Dear Ms. Herlihy:

Please be advised, by way of this letter, the public hearing held on July 7, 2015, in the above referenced matter is hereby closed as of July 21, 2015. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Jessica Schaeffer-Helmecki at (860) 509-8075 or Olga Armah at (860) 418-7070.

Sincerely,



Kevin T. Hansted
Hearing Officer

KTH:jsh

Cc: Theodore J. Tucci, Esq.

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

August 24, 2015

IN THE MATTER OF:

An Application for a Certificate of Need
filed Pursuant to Section 19a-638, C.G.S.
by:

Western Connecticut Health Network

Notice of Decision
Office of Health Care Access
Docket Number: 15-31978-CON

Termination of Danbury Hospital's Seifert &
Ford Family Community Health Center and
Community Center for Behavioral Health
Programs to Connecticut Institute For
Communities, Inc.'s Greater Danbury
Community Health Center

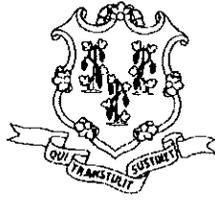
To: Sally Herlihy, MBA, FACHE
Western Connecticut Health Network, Inc
24 Hospital Avenue
Danbury, CT 06810

Dear Ms. Herlihy:

Enclosed please find a copy of the decision issued in the above-referenced matter pursuant to Connecticut General Statutes § 19a-639a on August 24, 2015.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:jssh



**Department of Public Health
Office of Health Care Access
Certificate of Need Application**

Final Decision

Applicants: Western Connecticut Health Network, Inc.
24 Hospital Avenue, Danbury, CT 06810

Docket Number: 15-31978-CON

Project Title: Termination of Danbury Hospital's Seifert & Ford Family Community Health Center and Community Center for Behavioral Health Programs to Connecticut Institute For Communities, Inc.'s Greater Danbury Community Health Center

Project Description: Western Connecticut Health Network, Inc. ("Applicant") seeks authorization to terminate Danbury Hospital's Seifert & Ford Family Community Health Center primary care services and Community Center for Behavioral Health programs to the Connecticut Institute for Communities, Inc. d/b/a Greater Danbury Community Health Center, at a capital expenditure of \$202,500.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The News Times* on January 8, 9 and 10 of 2015. On February 11, 2015, the Office of Health Care Access ("OHCA") received the initial CON application from the Applicant for the above-referenced project. OHCA deemed the application complete on March 21, 2015.

By petition dated March 28, 2015, Nurses Union Local 5947, AFT-CT, AFT, AFL-CIO and AFT-CT and LPN's Technical employees of Danbury Hospital requested intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated the petitioner as an intervenor with full rights of cross-examination. The intervenor filed a motion to withdraw on July 6, 2015, which was granted.

On June 23, 2015, the Applicant and intervenor were notified of the date, time, and place of the public hearing. On June 23 and 24, 2015, a notice to the public announcing the hearing was published in *The News-Times* (Danbury). Thereafter, pursuant to Connecticut General Statutes (“Conn. Gen. Stat.”) § 19a-639a(e), a public hearing regarding the CON application was held on July 7, 2015.

Commissioner Jewel Mullen designated Attorney Kevin T. 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 Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(e). The public hearing record was closed on July 21, 2015. Deputy Commissioner Brancifort considered the entire record in this matter.

Findings of Fact and Conclusions of Law

1. Western Connecticut Health Network, Inc. (“Applicant” or “WCHN”), an integrated delivery network, comprises Danbury Hospital (“DH”), Norwalk Hospital, New Milford Hospital and their affiliates. Ex. A, p. 8
2. DH is a 430-bed not-for-profit hospital with its primary location at 24 Hospital Avenue, Danbury, CT. Ex. A, p. 8.
3. DH operates the Seifert & Ford Family Community Health Center (“S&F”) which provides adult and pediatric medicine, women’s/obstetrics and dental services (“S&F primary care services”), TB/STD/HIV clinics and specialty care services at 70 Main Street, Danbury CT. Ex. A, pp. 8 & 17.
4. DH also operates the Community Center for Behavioral Health (“CCBH”) which provides intensive outpatient and adult behavioral and medication management services (“behavioral health clinic services”) at 152 West Street, Danbury, CT. Ex. A, p. 8.
5. The Applicant is seeking to terminate ownership and operation of S&F primary care services and CCBH behavioral health clinic services and transfer operations and sole responsibility of both clinics to Greater Danbury Community Health Center (“GDCHC”) over the course of two years beginning in 2016. Ex. A, pp. 8 & 59.
6. GDCHC is a federally qualified health center (“FQHC”) located at 57 North Street, Danbury and operated by the Connecticut Institute For Communities, Inc. (“CIFC”). Ex. A, p. 9.
7. CIFC is recognized by the National Committee for Quality Assurance as a Level 3 Patient Centered Medical Home and is the only FQHC in Connecticut accredited by the Accreditation Council for Graduate Medical Education as a teaching health center. Ex. A, pp. 8-9, 11.
8. Benefits of the proposal to patients include:
 - a. Continued operation as a patient centered medical home to help ensure coordinated patient care;
 - b. Additional primary care physicians on staff;
 - c. Increased hours of operation for more convenient access, including evening and Saturday appointments for the behavioral health services;
 - d. Pharmacy program providing deeply discounted prescriptions, particularly for Medicaid, Medicare and self-pay patients; and
 - e. Electronic health records that follow the patient.Ex. A, pp. 60, 64; Ex. C, p. 93-94, 97.

9. DH will, in accordance with the grant agreement dated June 4, 2015, provide a multi-year grant to CIFIC/GDCHC to subsidize:
- a. A shortfall by CIFIC/GDCHC in the provision of the primary care and behavioral health services;
 - b. Subleases between CIFIC/GDCHC and DH for use of all or part of S&F at 70 Main St, Danbury, CT and CCBH at 152 West St, Danbury, CT;
 - c. DH's graduate medical education residents' clinical rotations in internal medicine, obstetrics and gynecology and dentistry under the supervision of GDCHC at S&F and GDCHC sites;
 - d. Salary costs and benefits;
 - e. Costs of providing certain dental services;
 - f. Costs associated with electronic dental and medical records software, licenses and training and converting paper records to electronic records; and
 - g. A fixed amount for additional costs associated with the transition of services to GDCHC but not anticipated by either party.

Ex. A, pp. 60, 93.

10. There is no maximum number of years for which the Applicant will provide the grant and it will automatically renew, barring default or one-year notification of discontinuation by either party. The five-year annual maximum cash amounts the Applicant will provide to GDCHC are as follows:

TABLE 1
MAXIMUM GRANT AMOUNT BY YEAR

Year	Max Amount
1	\$1,107,911
2	\$1,558,685
3	\$1,117,435
4	\$803,001
5	\$591,529

Ex. C, p. 93.

11. If CIFIC/GDCHC cannot, due to a default of the grant agreement's terms or GDCHC ceases to exist, continue to provide the S&F primary care services or behavioral health clinic services at any time in the future, the Applicant will reassume provision of those services to the community. Ex. S, Transcript of public hearing testimony, Michael Daglio, President, Norwalk Hospital, Senior Vice President, WCHN, pp. 15-16.
12. In FY 2014, 76% of S&F's and CCBH's patient visits originated from the city of Danbury. Utilization by residents of DH's primary service area towns are indicated in the table below:

TABLE 2
PRIMARY CARE AND BEHAVIORAL HEALTH
PATIENT VISITS (FY 2014)

PRIMARY SERVICE AREA TOWNS	VISITS	PERCENT
Danbury	37,619	76%
Bethel	3,327	7%
Brookfield	1,252	3%
New Milford	1,254	3%
New Fairfield	1,177	2%
Newtown	875	2%
Ridgefield	994	2%
Redding	325	1%
Southbury	190	<1%
Sub-Total	47,013	95%
All other	2,311	5%
Total	49,324	100%

Ex. A, p.16.

13. The Applicant's historical utilization for S&F primary care, CCBH and TB/STD/HIV clinic services are as follows:

TABLE 3
APPLICANT'S HISTORICAL UTILIZATION
FISCAL YEARS 2012-2015

SERVICE	FY 2012	FY 2013	FY 2014*	FY 2015**	CHANGE FY 2012-2014
Adult primary care	12,537	11,784	10,018	2,555	-20%
TB/STD/HIV Clinics	1,423	1,153	1,396	324	-2%
Pediatric primary care	11,336	9,810	8,198	2,484	-28%
Women's health	6,660	6,491	5,654	1,493	-15%
Behavioral health	13,080	12,415	10,581	4,938	-19%
Dental	12,816	12,722	13,477	3,097	5%
Total	57,792	54,375	49,324	14,891	-15%

*Decrease in adult primary care due to loss of a full time internal medicine physician/preceptor.
 Decrease in pediatric visits due to loss of full time pediatric physician and APRN and replaced with one APRN.
 Decrease in women's health visits due to a significant leave by full time provider and replaced by "as needed" physicians.
 Increase in dental visits due to increase in patient referrals, new and repeat visits.

**Year to date

Ex. A, p. 17.

14. CIFC/GDCHC will engage community physicians and physicians previously employed by DH to provide primary care services at S&F and behavioral health services at CCBH, in a number determined by CIFC/GDCHC to be sufficient to meet such services needs of the greater Danbury community. Ex. A, p. 59.
15. CIFC/GDCHC will lease space at the S&F location to accommodate the S&F primary care and CCBH volumes. Ex. A, p. 14.
16. Except for S&F pediatric medicine services which will be moved to 57 North Street, GDCHC will continue to provide the remaining S&F and CCBH services at the current locations as follows:

TABLE 4
 CURRENT AND PROPOSED SITES
 AND TRANSITION DATES

SERVICE	CURRENT		PROPOSED		ESTIMATED TRANSITION DATES
	DH	CIFC/ GDCHC	DH	CIFC/ GDCHC	
Primary Care					
Adult	70 Main St	57 North St.	-	70 Main St.	7/1/2015
Pediatric	70 Main St	57 North St	-	57 North St.	7/1/2015
Women's/OB	70 Main St	-	-	70 Main St.	7/1/2015
Dental	70 Main St	-	-	70 Main St.	7/1/2016
Behavioral Health	152 West St	-	-	152 West St	7/1/2016

Ex. C, p. 29.

17. The 57 Main Street location, where pediatric services will be moved, is accessible by public bus. Ex. S, Public Hearing Testimony of Morris Gross, Vice President of Operations, WCHN, p. 18.
18. WCHN will continue to provide specialty clinics services that include orthopedics, spine, podiatry, urology, neurology, allergy, rheumatology and tuberculosis at the S&F location. Ex. A, pp. 9 & 60. Ex. O, Prefile Testimony of Michael Daglio, President, Norwalk Hospital, Senior Vice President, WCHN, p. 18.
19. The proposal will reduce overhead costs of providing primary care services at S&F and behavioral health services at CCBH by combining duplicative services. The Applicant anticipates reduced costs of electronic medical records, program quality oversight, legal fees and costs associated with regulatory oversight. Ex. A, p. 15.
20. Under GDCHC, S&F and CCBH's hours of operation would be extended and services will start being provided on Saturdays, as well. Ex. A, p. 13; Ex. S, Daglio Testimony, p. 18.
21. DH will provide a capital expenditure of \$202,500 from its existing cash reserve to renovate the current spaces at 70 Main St., Danbury and 152 West St. Danbury. Ex. A, p. 20.
22. Uninsured, underinsured and Medicaid patients are the predominant patient mix that utilizes S&F primary care and specialty services and CCBH. The Applicant's current and projected payer mix are as follows:

TABLE 5
APPLICANT'S CURRENT AND PROJECTED PAYER MIX

Payer	CURRENT		PROJECTED				
	FY 2014		FY 2015		FY 2016		FY 2017*
Medicare	7,482	15%	7,041	15%	3,827	20%	0
Medicaid	29,191	53%	24,105	52%	8,469	45%	0
Total Government	33,673	68%	31,146	67%	12,296	65%	0
Commercial Insurers	2,258	5%	2,169	5%	1,421	8%	0
Uninsured	13,389	27%	13,060	28%	5,139	27%	0
Worker's Comp.	5	0%	8	0%	0	0%	0
Total Non-Government	15,651	32%	15,237	33%	6,559	35%	0
Total Payer Mix	49,324	100%	46,383	100%	18,855	100%	0

*Clinic volume transitioned to CIFIC/GDCHC
 Ex. A, pp. 14, -18.

23. GDCHC provides primary care services on a sliding fee basis to people of all ages regardless of patients' ability to pay or insurance status. Due to GDCHC's status as a FQHC, the proposal will allow for enhanced Medicaid and Medicare reimbursement for services rendered. Ex. A, pp. 9-10, 15.

24. The proposal will result in continued and increasing operating gains for the Applicant in each of the next three fiscal years as indicated in the table below.

TABLE 6
DH'S PROJECTED INCREMENTAL REVENUES AND EXPENSES
FY 2015 – FY 2018

	FY 2015	FY 2016	FY 2017	FY 2018
Revenue from Operations	(\$401,000)	(\$2,109,000)	(\$3,087,000)	(\$3,087,000)
Total Operating Expense	(\$579,000)	(\$3,043,000)	(\$5,460,000)	(\$6,261,000)
Gain/Loss from Operations	\$179,000	\$934,000	\$1,829,000	\$2,630,000

*DH fiscal year (October 1-September 30)

Ex. A, p. 113.

25. The Applicant currently services Medicaid and indigent patients and GDCHC will continue to do so once it takes over the proposed programs and services. Ex. A, pp. 14, 18-19.
26. GDCHC is a FQHC and, as such, would receive increased Medicaid reimbursement comparative to the Applicant's current reimbursement levels. Ex. A, p. 22.
27. 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 regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).
28. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))
29. The Applicant has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).
30. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).
31. The Applicant has satisfactorily demonstrated that access to services and cost effectiveness and quality of health care delivery will be improved. (Conn. Gen. Stat. § 19a-639(a)(5))
32. The Applicant has satisfactorily demonstrated that there will be no change of services to the relevant populations and payer mix, including Medicaid patients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))
33. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).

34. The Applicant's historical utilization in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).
35. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).
36. The Applicant has satisfactorily demonstrated that this proposal would improve access to services for Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).
37. The Applicant has satisfactorily demonstrated that the proposal will not result in a negative impact on the diversity of health care providers in the area. (Conn. Gen. Stat. § 19a-639(a)(11)).
38. The Applicant has satisfactorily demonstrated that its proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)).

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 § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727 (2013).

The Applicant, Western Connecticut Health Network, Inc. (“WCHN” or “Applicant”) is an integrated delivery network comprised of the Danbury Hospital (“DH”) and Norwalk Hospital (“NH”) and their affiliate entities. *FF1*. DH operates the Seifert & Ford Family Community Health Center (“S&F”) which provides adult and pediatric medicine, women’s/obstetrics and dental services (“S&F primary care services”) and specialty care services at 70 Main Street, Danbury CT. *FF3*. It also operates the Community Center for Behavioral Health (“CCBH”), which provides intensive outpatient and adult behavioral and medication management services (“behavioral health clinic services”) at 152 West Street, Danbury, CT. *FF4*.

The Applicant proposes terminating S&F and CCBH services and transferring operation of and sole responsibility for both clinics to Greater Danbury Community Health Center (“GDCHC”) over a two-year period beginning in 2016. *FF5*. GDCHC is a federally qualified health center (“FQHC”) located at 57 North Street, Danbury operated by the Connecticut Institute For Communities, Inc. (“CIFC”). It provides primary care services on a sliding fee basis to people of all ages regardless of patients’ ability to pay or insurance coverage. *FF23*.

The Applicant has satisfactorily demonstrated that access to all existing services will be improved. There will be no change to the provision of women’s, dental and behavioral health services, and they will continue to be provided at their current locations. GDCHC’s and the Applicant’s adult primary care services will be provided at 70 Main Street, GDCHC’s current adult services location. *FF16*. Likewise, GDCHC’s and the Applicant’s pediatric primary care services will be combined and offered at 57 North Street, the Applicant’s current pediatric location. *FF16*. The two locations are 1.4 miles apart and are accessible by public bus, ensuring current patients will not be unduly inconvenienced by the relocation of the Applicant’s adult and GDCHC’s pediatric services. *FF17*. Additionally, this proposal will reduce the overhead costs associated with providing duplicative health care services at two different locations. *FF19*.

The proposal will result in increased hours including evening and Saturday appointments for behavioral health services. Patients of S&F’s primary care services will also benefit from additional primary care physicians on staff and electronic health records that will follow the patient to other GDCHC services. Additionally, as an FQHC, GDCHC will be able to offer deeply discounted prescriptions for Medicaid, Medicare and self-pay patients. Patients with commercial insurance would not experience any change in their prescription costs. GDCHC will continue operating S&F and CCBH as a patient centered medical home to coordinate patient’s medical care across a spectrum of services. *FF8*.

The Applicant currently provides specialty clinic services including orthopedics, spine, podiatry, urology, neurology, allergy, rheumatology and tuberculosis in the same building occupied by

S&F. Following implementation of the proposal, the Applicant will continue to provide those specialty services and will continue to accept patients once GDCHC assumes responsibility for primary care services. *FF18*.

Furthermore, an agreement between the Applicant and GDCHC stipulates that the Applicant will provide, subject to conditions, grants capped at predetermined amounts to cover any short-falls GDCHC experiences as a result of its assuming S&F and CCBH services. *FF9*. The Applicant has agreed to provide up to \$1,107,911 during the first year to cover salary costs, costs of providing certain specialty dental services, records software and related licenses and unanticipated costs resulting from the transition. *FF9, 10*. By year five, the maximum grant amount will be reduced to \$591,529. *FF10*. There is no maximum number of years for which the Applicant will provide the grant and it will automatically renew, barring default or one-year notification of discontinuation by either party. *FF10*. Additionally, should GDCHC discontinue operation of S&F or CCBH for any reason at any time, the Applicant will reassume responsibility for S&F and CCBH. *FF11*.

Uninsured and Medicaid patients are historically the predominant patient mix of S&F and CCBH. *FF22*. GDCHC will continue to provide services to Medicaid and indigent persons upon assuming control of S&F and CCBH. *FF24*. As an FQHC, GDCHC's comparatively higher Medicaid reimbursement rate will help ensure access to care for Medicaid patients will be maintained. *FF26*.

As a result of the proposal, the Applicant projects incremental gains from FY15 through FY18 and a capital expenditure of \$202,500 for renovations. *FF21, 24*. Thus, the Applicant has demonstrated it is financially feasible.

The proposal will result in the continuation of primary care and behavioral health services in the Danbury area. It will ensure Medicaid and indigent persons in the community have access to those services. Moreover the Applicant has demonstrated that the proposal is consistent with the goals of the Statewide Health Care Facilities and Services Plan given the focus on the interrelation of mental health and primary care services.

Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application of Western Connecticut Health Network, Inc. to terminate and transfer Danbury Hospital's Seifert & Ford Family Community Health Center primary care services and Community Center for Behavioral Health Programs to Connecticut Institute For Communities, Inc.'s Greater Danbury Community Health Center in Danbury, Connecticut, is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

August 21, 2015
Date

Janet M. Brancifort
Janet M. Brancifort, MPH, RRT
Deputy Commissioner

* * * COMMUNICATION RESULT REPORT (AUG. 24. 2015 1:50PM) * * *

FAX HEADER:

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E-3) NO ANSWER

E-2) BUSY
E-4) NO FACSIMILE CONNECTION



STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: SALLY HEARLIHY

FAX: (203) 739-1974

APPLICANT: WESTERN CONNECTICUT HEALTH NETWORK

FROM: OHCA

DATE: 8/24/2015 Time: _____

NUMBER OF PAGES: 14
(including transmittal sheet)

Comments:

Final decision for docket number 15-31978

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

Phone: (860) 418-7001
Fax: (860) 418-7053

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134