SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: 860-251-5104
Fax: 860-251-5211
jfeldman@goodwin.com

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September 24, 2012

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OFFICE OF
HEALTH CARE ACCESS

Kimberly 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: Affiliation of Backus Corporation with Hartford HealthCare Corporation

Dear Ms. Martone:

On behalf of Hartford HealthCare Corporation and Backus Corporation, enclosed please find a Certificate of Need Application for the affiliation of Backus Corporation with Hartford HealthCare Corporation. As requested, I have included 1 original and 4 hard copies of the Certificate of Need Application in 3-ring binders and a CD with the electronic version of the enclosed documents and materials. Also attached to this letter is a check for the $500.00 filing fee.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

Joan W. Feldman, Esq.

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SEP 2 4 2012
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HEALTH CARE ACCESS

Application Checklist

Instructions:

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

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

For OHCA Use Only:

Docket No.: 12-31788-CON **Check No.:** _____
OHCA Verified by: SD **Date:** 9/24/12

☒ **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) 428-7053, at the time of the publication)***

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

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

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

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

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

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

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

HARTFORD HEALTHCARE CORPORATION
ATTN: ACCOUNTS PAYABLE
PO BOX 5037
HARTFORD, CT 06102-5037

51-57
119

Check Number
4304
FLEET BANK

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

hundred and 00/100 Dollars

the order of

TREASURER STATE OF CONNECTICUT
LICENSE FEES & REGISTRATION
BUSINESS OFFICE
79 ELM ST
HARTFORD, CT 06106

Date	Payment Amount
08/28/2012	******$500.00

VOID AFTER 90 DAYS

THE BACK OF THIS DOCUMENT CONTAINS LAID LINES AND AN ARTIFICIAL WATERMARK. HOLD AT AN ANGLE TO VIEW.

⑈004304⑈ ⑆011900571⑆ 00018 55212⑈

TREASURER STATE OF CONNECTICUT
LICENSE FEES & REGISTRATION
BUSINESS OFFICE
79 ELM ST
HARTFORD, CT 06106

Entity	Vendor ID / Location	Check Number
0001	08112 035	4304

HARTFORD HEALTHCARE CORPORATION

Invoice Number	Invoice Date	Gross Amount	Discount Amount	Withholding Amount	Net Amount
NSULTING	08/15/2012	500.00			500.00
N TO CHRIS EDWARD FINANCE					

PUBLISHER'S CERTIFICATE

LEGAL NOTICE

Hartford HealthCare Corporation ("HHC") and Backus Corporation ("BC") are jointly filing an application for a Certificate of Need under section 19a-638(a)(2) of the Connecticut General Statutes. In the forthcoming Certificate of Need Application, HHC and BC will request the Office of Health Care Access's approval for BC to affiliate with HHC, which will result in the William W. Backus Hospital joining and becoming a part of the HHC integrated healthcare system. William W. Backus Hospital's current location, which will not change as a result of this project, is 326 Washington Street, Norwich, Connecticut 06360. There is no capital expenditure associated with this project.

State of Connecticut,

ss. Norwich

County of New London,

On this **9th** day of **July** **2012**

personally appeared before the undersigned, a Notary Public, within and for said County and State

Erin M. Lewis, Proof of Publication

of the "THE BULLETIN" a daily newspaper published at Norwich, County of New London, State of Connecticut, who, being duly sworn, states on oath that

LEGAL NOTICE

HARTFORD HEALTHCARE CORPORATION ("HHC") AND BACKUS CORPORATION ("BC") ARE JOINTLY FILING AN APPLICATION FOR A CERTIFICATE OF NEED UNDER SECTION 19A-638(A)(2) OF APPLICATION, HHC AND BC WILL REQUEST THE OFFICE OF HEALTH

a true copy of which is hereto annexed, was published in said newspaper in its issue of the

6th day of **July** **2012**

7th day of **July** **2012**

8th day of **July** **2012**

Subscribed and sworn to before me this 9th day of July A.D. 2012

Kathleen A. Sullivan

Notary Public

My Commission Expires 8/31/2016

AFFIDAVIT

Applicant: Hartford HealthCare Corporation

Project Title: Affiliation of Backus Corporation with Hartford HealthCare Corporation

I, Elliot T. Joseph, President and CEO of Hartford HealthCare Corporation being duly sworn, depose and state that Hartford HealthCare Corporation's information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

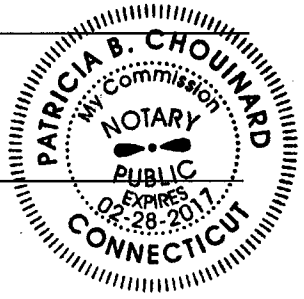
Signature

August 21, 2012
Date

Subscribed and sworn to before me on August 21, 2012

Notary Public/~~Commissioner of Superior Court~~

My commission expires: _____



AFFIDAVIT

Applicant: Backus Corporation

Project Title: Affiliation of Backus Corporation with Hartford HealthCare Corporation

I, David A. Whitehead, President and CEO of Backus Corporation being duly sworn, depose and state that Backus Corporation's information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature

09/24/12
Date

Subscribed and sworn to before me on September 24, 2012

Donna M. Carter

Notary Public/Commissioner of Superior Court

My commission expires: September 30, 2015

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

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

Docket Number:		
Applicant:	**Applicant One** Hartford HealthCare Corporation	**Applicant Two** Backus Corporation
Contact Person:	Karen Goyette	Keith Fontaine
Contact Person's Title:	Vice President Strategic Planning and Business Development	Vice President and Chief Administrative Officer
Contact Person's Address:	One State Street Suite 19 Hartford, CT 06103	326 Washington Street Norwich, CT 06360
Contact Person's Phone Number:	860-263-4157	860-889-6539
Contact Person's Fax Number:	860-263-4125	860-892-8964
Contact Person's Email Address:	Karen.Goyette@HHChealth.org	Kfontaine@wwbh.org
Project Town:	Norwich	Norwich
Project Name:	Affiliation of Backus Corporation with Hartford HealthCare Corporation	Affiliation of Backus Corporation with Hartford HealthCare Corporation
Statute Reference:	Section 19a-638, C.G.S.	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$0	$0

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

a. Please provide a narrative detailing the proposal.

BACKGROUND:

Backus Corporation, the parent organization of The William W. Backus Hospital ("Backus Hospital"), proposes to have Hartford HealthCare Corporation ("HHC") become its sole corporate member for the purpose of effectuating a corporate affiliation between Backus Corporation and HHC (the "Proposal"). The Proposal, if approved, will expand HHC's integrated healthcare delivery system which will allow it to further enhance quality, performance, and access to health services for patients in Eastern Connecticut.

Backus Corporation reached its decision to affiliate with HHC after careful analysis and consultation with national healthcare experts. Once Backus Corporation considered its options, it decided to pursue an affiliation with a strong and effective integrated health care delivery system. To consider its options, Backus Corporation engaged an independent advisor to solicit and review proposals from potential partners. Several systems, both within and outside of the State, responded and each proposal was evaluated by a board-designated Strategic Alignment Subcommittee. Based upon the subcommittee's review, HHC's integrated health care delivery system (the "System") was selected as the Backus Corporation partner of choice for the following reasons:

i. Backus Corporation and the System share a common mission, vision and values;[1]
ii. Backus Corporation and HHC share common short and long-term strategic objectives including, but not limited to, providing strong local, primary, secondary and tertiary care services and enhanced patient access to the most advanced technologies and service lines;
iii. Backus Corporation and HHC are both committed to providing high value healthcare services in the Eastern Connecticut Region through the development of a collaborative strategic plan;[2] and
iv. HHC has a demonstrated track record for successfully integrating with and adding value to its affiliated System members.[3]

The integration of Backus Corporation into the System, at a corporate level, will involve HHC becoming the sole corporate member of Backus Corporation. As the sole corporate member of Backus Corporation, HHC will have rights with respect to Backus Corporation's governance, financial matters and strategic planning. See Exhibit 1 attached hereto for the

[1] Both recognize that the development of a truly integrated healthcare delivery system will further support their missions and respective community roles.
[2] Consistent with HHC's value-driven geared approach, a strategic plan for acute and ambulatory care for the Eastern Connecticut Region will be developed by Backus Corporation, HHC and other System members serving the Eastern Connecticut Region.
[3] The System's approach, as demonstrated through the successful integration of Windham Community Memorial Hospital and The Hospital of Central Connecticut, is to fundamentally reinvent the way community-based organizations deliver and deploy clinical care along the entire spectrum of care.

proposed Backus Corporation Certificate of Incorporation and Bylaws. These reserved HHC powers will mirror those that HHC has established with its other System member hospitals, all of which are designed to allow the System to respond to market forces in a timely, coordinated and efficient manner. See Exhibit 2 attached hereto for an explanation of HHC's "Value-Driven Geared Model" approach.

The operational integration of the Backus Corporation will be realized with a disciplined and collaborative approach by and between Backus Corporation and the System. HHC's experience with the integration of its other hospital members into the System will serve as the template for the Backus Corporation integration, resulting in a more seamless and timely integration of Backus Corporation with the System. As of the effective date of the proposed affiliation, a team of qualified individuals will be engaged to implement, *ab initio*, the steps and processes necessary to achieve and maximize efficiencies in accordance with explicit timelines. See the Hartford HealthCare Integration Playbook attached hereto as Exhibit 3.

AFFILIATION RATIONALE:

The continued viability of Backus Corporation depends, in large part, on its strategic positioning and ability to respond to the demands of the healthcare marketplace.[4] Physician alignment, care coordination, development of innovative care delivery models, translational research and new information technologies are all essential in a reformed healthcare delivery system. However, each of the foregoing comes at considerable cost. While a standalone community hospital may be able to fund several of these initiatives, it is unlikely that a standalone community hospital can afford to do all that it needs to do on its own. Accordingly, this Proposal is developed to allow Backus Corporation to collaborate with the System in responsible decision-making, appropriate sharing of resources, services and technologies so that it may maintain its stability and continue its legacy of excellence in the delivery of health care in the Eastern Connecticut Region.

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

BACKUS CORPORATION'S DETERMINATION OF NEED:

In 2010, Backus Corporation engaged Kaufman, Hall & Associates, Inc., a national health care consulting firm, to assist Backus Corporation in evaluating its current and future market position. Backus Corporation identified its primary objective as providing the Eastern Connecticut Region with a sustainable, high-value, fully integrated healthcare delivery system. Taking into consideration national trends of shrinking reimbursement levels, lower investment returns, and the need to make substantial investments in advanced information and medical technologies, Backus Corporation determined that it must strategically reposition itself for the future. Specifically, Backus Corporation realized that for it to

[4] Even before the Patient Protection and Affordable Care Act was upheld as constitutional by the United States Supreme Court, there was ample evidence that both private and governmental payors were moving away from the fee-for-service model to value-based purchasing.

successfully respond to the market demands associated with a fully reformed healthcare delivery system and, in particular, to thrive in a value-based purchasing environment, it would need affiliation with a strong integrated healthcare delivery system to secure:

i. Greater debt capacity and access to capital on more favorable terms;
ii. Opportunities for capital avoidance;
iii. Economies of scale to reduce costs;
iv. Standardization and process redesign;
v. Improved care coordination along clinical service lines;
vi. Sufficient scale to attract highly qualified clinical talent;
vii. Innovative care delivery models;
viii. Rational service distribution systems ensuring patient access across the continuum, including pre-acute, acute and post-acute settings; and
ix. Information systems that support clinical decision making, information management, and quality improvement.

After considering the proposals it solicited, Backus Corporation determined that HHC was the most appropriate partner for maximizing the effectiveness of health care delivery in the Eastern Connecticut Region.

GENERAL BENEFITS TO BACKUS CORPORATION AND THE EASTERN CONNECTICUT REGION:

The following benefits have been identified as being immediately available to Backus Corporation and the Eastern Connecticut Region if this Proposal is approved[5]:

i. Expansion and enhancement of clinical programs and services available in the Eastern Connecticut Region, including but not limited to, providing access to care delivery models that will allow Backus Corporation to align its physicians with HHC for the purpose of collaboratively improving quality, gaining efficiencies and sharing risk (e.g. clinical integration, accountable care organizations, medical foundation practice model, and patient-centered medical homes);
ii. Access to clinical care protocols and other care management tools that will further improve quality, ensure best practices and reduce healthcare delivery costs;
iii. Access to software and information technologies that allow monitoring and real time measurement from both a quality and cost perspective;
iv. Access to clinical and management expertise to more accurately assess utilization and cost by provider and service line;
v. Coordination with System providers to enhance patient flow processes;
vi. Access to capital on more favorable terms as a member of a System-wide obligated group;
vii. Avoidance of service redundancies in the Eastern Connecticut Region through coordinated strategic planning[6];

[5] Not all of the benefits can be immediately identified. There are likely to be significantly more benefits over time with further integration.

viii. Capacity to direct care to the lowest cost setting without compromising quality or access for the patient;
ix. Ability to participate in supply chain management and supply choice standardization; and
x. Access to translational research.

SPECIFIC BENEFITS TO BACKUS CORPORATION AND THE EASTERN CONNECTICUT REGION:

The following are more specific benefits that Backus Corporation and the Eastern Connecticut Region will realize if the Proposal is approved:

i. System-level commitment of two hundred million dollars ($200,000,000) over a ten (10) year-period to implement clinical programs and services in accordance with the strategic plan for the Eastern Connecticut Region;
ii. Funding for physician recruitment up to three million dollars ($3,000,000) over a (3) three-year period;
iii. Establishment of an extensive primary care and ambulatory care network based on patient-centered medical homes as certified by the National Committee on Quality Assurance;
iv. Development of an ambulatory surgery network within the Eastern Connecticut Region;
v. Creation of a Preventative Medicine Institute at Backus Hospital[7];
vi. Increased access to patient data, informatics and reporting systems for cost and quality management;
vii. Development of a peripheral vascular program at Backus Hospital and for the Eastern Connecticut Region;
viii. Enhancement of cardiology services with local specialists, to include primary and elective angioplasty, integrated congestive heart failure programs and on-site electrophysiology;
ix. Participation in Clinical Collaboratives relating to becoming a "High Reliability Organization", readmission reduction, patient experience, reduction of hospital-acquired infections and fall reduction;
x. Organization and development of a cancer services network with local specialists for the Eastern Connecticut Region;
xi. Development of a behavioral health network for the Eastern Connecticut Region;
xii. Maintenance of a Trauma Program (Level 3 at a minimum) along with a commitment to maintain LIFE STAR on the Backus Hospital campus;
xiii. Enhancement of current neonatology coverage;

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[6] HHC and Backus Corporation will develop a strategic plan for the Eastern Connecticut Region through a collaborative planning process among Backus Corporation's executive management team and board, HHC's executive management team, and other System leadership and boards in the Eastern Connecticut Region.
[7] The Robert J. Wood Foundation study showed that Windham County had the highest obesity rate in the State at 28%.

xiv. Expanded access to post-acute care (e.g., home care, skilled nursing and outpatient rehabilitation);
xv. Participation in System Clinical Councils (Hospitalist Medicine, Emergency Medicine, Pharmacy/Therapeutics, Infectious Disease/Epidemiology, Anesthesiology, Oncology, and Cardiovascular Diseases) for the implementation of evidence-based medicine and prevention (e.g., Antibiotic Stewardship Program);
xvi. Cost reduction programs through standardization of physician preference items[8];
xvii. Access to the System Center of Education, Simulation and Innovation;
xviii. Access to regional physician coverage arrangements;
xix. Opportunities for sharing of new technologies;
xx. Participation in extensive quality and patient safety infrastructure focused on process redesign, data warehousing, internal and external benchmarking and best practices;
xxi. Participation in risk-based reimbursement initiatives and the formation of new, System-sponsored risk-based organizations and programs;
xxii. Participation in the System captive insurance program at both the Backus Hospital and physician level;
xxiii. Shared clinical information systems (i.e., a System-wide health information exchange, centralized scheduling, and consistent patient financial assistance counseling);
xxiv. Guarantee by HHC of Backus Corporation's pension obligations; and
xxv. System-level board designated fund to finance and support community benefit activities in the Eastern Connecticut Region.

HHC'S PROVEN TRACK RECORD:

HHC has a proven track record of being able to integrate hospital systems and achieve cost reductions while enhancing access to care. The following sets forth a description of those benefits realized by both Windham Community Memorial Hospital, a 144 - bed community hospital in Eastern Connecticut ("Windham Hospital") and The Hospital of Central Connecticut, a 349 - bed community hospital in New Britain and Southington, Connecticut ("HOCC"), the two hospitals that have most recently affiliated with the System.

In 2008, when HHC proposed its affiliation with Windham Hospital to OHCA, the System was at its nascent stage with respect to System-level clinical and operational integration. See Docket # 08-31178-CON. Since such time, there has been tremendous progress and success with respect to the integration of Windham Hospital. The following are some of the examples of the benefits Windham Hospital has received since affiliating with the System:

i. Savings relating to risk management and professional liability coverage;
ii. More effective investment management expertise at lower cost;
iii. Savings relating to third-party consultant services;

[8] Specific projections with respect to cost reduction and capital avoidance will be discussed in Question 5.g. of this Application.

iv. Development of a primary care network and integration of certain of its primary care physicians with Hartford Medical Group[9];
v. Savings relating to human resource and employee benefit management;
vi. Capital avoidance;
vii. More favorable debt financing as a member of a System-wide obligated group facilitating the investment in an MRI, PACS, a medical office building and ambulatory clinic;
viii. Senior management services (e.g., CEO and CFO);
ix. Marketing, legal and governmental relations services;
x. Centralization of business functions - integrating the billing and collection functions (i.e., $1,400,000 in annual savings);
xi. Savings resulting from a more effective GPO;
xii. Physician recruitment success from System GME training programs;
xiii. Clinical integration in oncology, gynecology and obstetrics (e.g., protocols for breast cancer patients improving patient experience and clinical outcomes);
xiv. Tumor registry services;
xv. Access to interventional radiology services;
xvi. Information technology, hardware, software and management expertise (e.g., EMR and CPOE);
xvii. Biomedical engineering services (i.e., annual savings of approximately $40,000);
xviii. Savings relating to more cost-effective reference laboratories (i.e., $50,000 in annual savings);
xix. Participation in Clinical Councils (e.g., readmission reduction, patient experience, and reduction in hospital acquired infections); and
xx. Enhanced access to specialty clinical care.

All of the integration initiatives described above have saved Windham Hospital at least three and one half million dollars ($3,500,000) on an annual recurring basis. More importantly, Windham Hospital has received additional immeasurable value by having access to a breadth of management and clinical expertise that it previously did not have as a standalone community hospital. See Exhibit 4 for a breakdown of the Windham Hospital savings and efficiencies. Both the System and Windham Hospital believe that Windham Hospital is stronger now than it was four (4) years ago.

In 2009, about the time that the System was making great strides towards clinical and operational integration with Windham Hospital, the System proposed to OHCA that the Central Connecticut Health Alliance ("CCHA"), the parent organization of HOCC, affiliate with the System. See Docket No. 09-31441-CON. Since such affiliation was approved by OHCA, tremendous success and progress has been realized with respect to the clinical and operational integration of CCHA with the System.

From a financial perspective, to date, HOCC has realized more than twelve million dollars ($12,000,000) in cost savings as a direct result of its System affiliation. It is projected that HOCC will experience a total of approximately forty-nine million dollars ($49,000,000) in

[9] HHC has significant internal expertise in planning, designing and launching primary care and ambulatory facilities.

cost savings by FY 2015 and thereafter, realize approximately fifty million dollars ($50,000,000) in annual reoccurring cost savings as a direct result of its System affiliation. Savings have resulted from approximately ninety (90) unique initiatives distributed across twenty (20) departments. See the summary of the targeted and actual savings relating to the CCHA affiliation with the System attached hereto as Exhibit 5. Please note that not included in Exhibit 5 are at least fifteen million dollars ($15,000,000) of present value savings associated with the planned construction of HOCC's Cancer Center.[10]

With respect to clinical integration, some of the benefits realized by HOCC are in the following areas:

i. Shared services for the Chief of Cardiology and the establishment of a new Heart Failure Clinic;[11]
ii. Newly coordinated programs in fetal medicine, gynecological oncology and robotic surgery[12];
iii. Improved access to vascular and colorectal surgeons;
iv. Shared services for emergency department neurology coverage between HOCC and MidState Medical Center ("MidState");
v. HOCC/Hartford Hospital-ICU/ Surgical Clinical Care Partnership in Central Connecticut. Region[13];
vi. Centralization of inpatient behavioral health services on the HOCC campus, subject to OHCA's approval;
vii. Management of outpatient rehabilitation services through the Eastern Rehabilitation Network;
viii. Enhanced planning and marketing support;
ix. Enhanced primary care infrastructure, access and recruitment;[14] and
x. Consolidation of a failing CCHA home care agency with the System's home care division to ensure continued home care services in Central Connecticut.

All of the clinical integration described above has enhanced the clinical services offered to the patient population served by HOCC. In sum, the System's ability to recruit high-caliber talent has benefitted HOCC.

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[10] It is currently projected that there will be at least fifteen million dollars ($15,000,000) of additional cost reductions (when compared to CCHA's cost projections made by it prior to its System affiliation) all of which are directly related to the System's financial management and debt capacity.[10]

[11] Dr. Jason Lundbye, formerly with Hartford Hospital, has now become the full-time HOCC Chief of Cardiology and CHF patients are being seen within four (4) days of discharge resulting in reductions in CHF readmissions.

[12] Without this additional clinical support, HOCC would not have been able to continue to see the uninsured patients that it was previously seeing, especially with respect to high-risk pregnancies.

[13] Needed physician coverage is provided to HOCC by Hartford Hospital's critical care physicians.

[14] Since the affiliation with CCHA, the System has formed a medical foundation which will integrate HOCC employed primary care physicians with other System primary care practices for a more efficient and accessible health care delivery system model. In addition, HOCC employed primary care physicians will jointly form an accountable care organization and apply to CMS for participation in the Medicare Shared Savings Program, and designation as a patient-centered medical home. Finally, the System has actively assisted in the recruitment of ten (10) additional primary care physicians to the HOCC service area.

Some of the benefits HOCC has realized with respect to operational integration are as follows:

i. Group purchasing savings in the first 6 months (i.e., $2,000,000);
ii. Reduction in HOCC's information technology costs as a result of it becoming the System's main data hub;
iii. Annual savings from using the System's reference laboratory (i.e., $400,000);
iv. Annual savings from preferred system pricing for pharmacy (i.e., $250,000);
v. Shared Chief Financial Officer with MidState Medical Center;
vi. Cost-effective investment management; and
vii. Savings resulting from a Central Business Office.

The foregoing benefits are similar to those expected to be realized by Backus Corporation. Therefore, if this Proposal is approved, Backus Corporation will be positioned to achieve greater economies of scale, enhance its access to management and clinical expertise, and participate in the creation of innovative delivery models that it would otherwise not have access to as a standalone community hospital system.

HHC'S DETERMINATION OF NEED AND THE BENEFITS TO THE SYSTEM:

HHC has a long-established presence in the Eastern Connecticut Region with Windham Hospital and Natchaug Hospital. Both hospitals have received enormous benefits from their affiliation with the System. However, HHC believes that additional benefits could be realized for the Eastern Connecticut Region if Backus Corporation affiliated with the System. Given Backus Corporation's reputation for providing high-quality health care programs and services, along with its commitment to collaboration, coordination and transformation, HHC believes that Backus Corporation is the ideal partner to serve as the administrative and managerial nucleus for a more integrated and efficient component delivery system in the Eastern Connecticut Region.[15]

More specifically, through collaborative planning, responsible decision-making and appropriate sharing of services, resources and technologies, Windham and Backus Hospitals will be better positioned to improve the quality, performance and efficiency of services and clinical programs available to the Eastern Connecticut Region than they would otherwise be capable of achieving if this Proposal is not approved.[16] In summary, this Proposal will allow Backus Corporation, as part of the System, to create an innovative healthcare delivery system for the Eastern Connecticut Region while retaining its identity and commitment to communities in its service areas.

[15] Executive management for Windham Hospital and Backus Hospital would be centralized to achieve certain operating efficiencies.

[16] Both Windham Hospital and Natchaug Hospital (one a community hospital and the other a psychiatric hospital) are located in the Eastern Region of Connecticut. See Exhibit 6 for a map showing the geographic proximity of Windham Hospital and Backus Hospital.

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

i. Backus Corporation conducted sustainability assessment: (Summer/Fall 2010);
ii. Backus Corporation engaged in strategic options process: (December 2010);
iii. Backus Corporation authorized evaluation of partnership opportunities: (March 2011);
iv. Backus Corporation solicited Requests for Proposals from potential partners: (June 2011);
v. Backus Corporation began evaluation of potential partners: (September 2011);
vi. Backus Corporation signed Letter of Intent with HHC: (February 2012);
vii. Backus Corporation and HHC signed a Memorandum of Understanding: (May 2012);
viii Huron Healthcare reported to the Applicants with respect to the potential efficiencies that could be achieved as a result of the proposed affiliation (June 2012); and
ix. HHC and Backus Corporation signed an Affiliation Agreement (August 2012).[17]

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

There will be no changes in clinical services by virtue of the affiliation alone. However, as described herein, should redundancies or inefficiencies exist, or opportunities for new services are identified, changes in services may be considered.

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

Backus Hospital receives 75% of its patients from the following areas identified by zip code: 06360, 06351, 06382, 06374, 06415, 06365, 06331, 06380, 06370, 06330, 06354, 06339 and 06384. These zip codes include Norwich and the surrounding towns in New London County, as well as the towns of Plainfield and Canterbury.

This Proposal will not impact these populations. Rather, this Proposal strengthens the ability of Backus Hospital to serve these populations long into the future.

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

There will be no interruption in services. Integration will be timely and seamless. See Exhibit 3 for Hartford HealthCare Integration Playbook.

[17] Please note that all agreements between HHC and Backus Corporation are subject to regulatory approvals including, OHCA's approval of this Proposal.

g. **For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:**

i. **Legal chart of corporate or entity structure including all affiliates.**

See Exhibit 7 attached hereto for the requested organizational charts.

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

There are no equity owners because the Applicants are nonstock corporations. Both HHC and Backus Corporation have no members. If the Proposal is approved, HHC would become the sole corporate member of Backus Corporation.

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

See Exhibits 8 and 9 for the Memorandum of Understanding and the Affiliation Agreement between HHC and Backus Corporation.

2. **Quality Measures**

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

HHC:
Elliot Joseph, President and Chief Executive Officer
Thomas Marchozzi, Executive Vice President and Chief Financial Officer
Rocco Orlando, M.D., Chief Medical Officer

Backus Corporation:
David Whitehead, President and Chief Executive Officer
Daniel Lohr, Senior Vice President and Chief Financial Officer
Peter Shea, M.D., Senior Vice President and Chief Medical Officer

See Curriculum Vitae attached hereto as Exhibit 10.

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

This entire Proposal is focused on improving the access and quality of health care delivered in the Eastern Connecticut Region. In particular, it creates a culture and organizational structure in which clinical care, education and research are supported so that patients and local communities benefit from the latest technology, innovation and clinical excellence. The philosophy of the System is premised upon the creation and support of innovative and

collaborative community-based organizations that acknowledges the critical fact that health care is best delivered close to home. Through systematic sharing of intellectual, human and financial capital, there is unlimited opportunity for the sharing of innovative clinical and business processes focused upon improving quality and containing costs. The System believes strongly that by reducing variability across the care continuum, patients will realize more effective and efficient healthcare services at the local level.

With respect to the System's commitment to quality, all improvement initiatives are coordinated across the System using common informatics tools/analytics, definitions and reporting systems. System-wide Clinical Councils disseminate and share the best practices and provide forums for organizing approaches to coordinated care in the Eastern Connecticut Region.[18] Attached is a document describing the organizational structure for quality at the System level. See Exhibit 11 attached hereto. Core quality initiatives begin at the System board level and transcend down to all System members.[19] The System is fully committed to making the necessary investments in the infrastructure needed to achieve top performance and, if this Proposal is approved, Backus Corporation will become an important component of the quality and safety infrastructure, ultimately advancing quality in the Eastern Connecticut Region.

3. Organizational and Financial Information

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

Backus Corporation and HHC are both Connecticut nonstock corporations.

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

See Exhibit 12 for Backus Corporation's and HHC's respective IRS Determination Letters evidencing their tax-exempt status.

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

Neither Backus Corporation nor HHC are DPH-licensed entities.

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[18] HHC's clinical quality initiatives are organized under the direction of the Chief Medical Officer ("CMO") and the System Quality Council. Specifically, HHC has established 5 Clinical Collaboratives. These groups will operate at a System level and draw together experts from all the System members looking at evidence-based best practices and work to define the care pathways that will propel superior quality standards.

[19] In particular, at the System level, an Office of Clinical Quality and Safety was created to coordinate quality and safety activities across the System. The HHC CMO and Quality Director are responsible for coordinating informatics and improvements with each System member's quality data.

d. Financial Statements

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

The Applicants are not Connecticut licensed hospitals.

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

Both Backus Corporation and HHC have filed their Audited Financial Statements for FY 2011 with OHCA.

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

Table 2: Proposed Capital Expenditures/Costs

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

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

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

No funding or financing is necessary for the Proposal.

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

As stated above, it is imperative for hospitals to find ways to further reduce their costs and remain sustainable to perform their mission in the future.[20] However, most standalone community hospitals have maximized their opportunities for cost reductions. Given the inevitability of future reimbursement reductions and the costs associated with health care reform, Backus Corporation will strengthen its financial position by aligning with the System for all the reasons discussed herein. Both HOCC and Windham Hospital are recent examples of the beneficial cost savings and improvements that have been realized through affiliation with the System. Section 5.g. below will further describe how this Proposal is cost-effective. In particular, the cost-effectiveness of this Proposal, the access to enhanced primary, tertiary and quaternary care services, and enhanced quality in a value-based purchasing environment, will undoubtedly add value to the quality of services provided and ultimately enhance the financial strength of Backus Corporation.

4. Patient Population Mix: Current and Projected

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

See Exhibit 13 for Table 3, which reflects the patient population mix for Backus Corporation and HHC (without and with the approval of this Proposal).

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

Table 3 represents inpatient volumes at the HHC System hospitals (i.e. Windham Hospital, MidState, Hartford Hospital and HOCC) and Backus Hospital. Because the patient population mix for both the HHC and Backus Corporation affiliated hospitals has been stable over the last few years, and the Applicants do not expect the patient population mix to change as a result of this Proposal.

[20] Many standalone hospitals have been reducing their costs over the last decade as reimbursement has continued to decrease. At this point, there are limited opportunities for further reduction without increasing scale and maximizing efficiencies across a larger healthcare delivery system.

5. **Financial Attachments I & II**

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

      See Exhibit 14 for HHC's and Backus Corporation's 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.).**

      The Applicants have assumed annual revenue growth of approximately five percent (5%). These assumptions are based on what each Applicant and their affiliated hospitals have historically experienced. Expense reduction will occur as a result of operational cost savings and capital avoidance. The expense reductions benefit both Applicants and are reflected in "Operating Expenses" under the "Projected Incremental" column in Financial Attachment I. The financial analysis presented here assumes that this proposed affiliation will occur in the first quarter of FY 2012. FYs 2013-2016 are shown because these are the first three full years of operations.

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

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

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

      There will be no immediate changes. Future effects are not predictable at this time. Neither Applicant has seen the others' reimbursement rates.

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

      Not applicable.

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

      There are no losses associated with this Proposal.

g. Describe how this proposal is cost effective.

This Proposal is intended to integrate Backus Corporation with the System on both clinical and operational/administrative levels in order to maximize efficiencies and deliver high quality services in a pay for performance environment. At the same time, this Proposal is intended to improve access to primary, specialty and tertiary care services in the Eastern Connecticut Region. By having Backus Corporation as the administrative and managerial nucleus for the Eastern Connecticut Region, it is projected that the System will be able to deliver more cost-effective care and gain efficiencies beyond those already achieved. The specific projections relating to how this Proposal will be more cost-effective for health care delivery in the Eastern Connecticut Region are set forth in Table 4 below.[21] The projections were made by Huron Healthcare, an independent consultant engaged by the Applicants.

TABLE 4

Area	2013	2014	2015	2016	Anticipated
Non-Labor: Savings due to asset management and insurance, pharmacy, laboratory and clinical supplies	$2,364,000	$2,957,000	$2,957,000	$2,957,000	
Revenue Cycle: Savings due to vendor cost reductions, consolidated staffing, new processes	$1,480,000	$2,665,000	$2,665,000	$2,665,000	
Clinical Operations: Savings due to Transfer Center, Care Coordination, Bed Management, and other Best Practices	$675,000	$1,037,500	$1,037,500	$1,037,500	
Human Resources: Savings from employee benefits, absence management, premium pay, purchased services	$1,000,000	$1,146,500	$1,146,500	$1,146,500	
Labor: Savings from revenue cycle, fiscal services and Central Business Office, supply chain and administrative	$5,530,000	$7,240,000	$7,240,000	$7,240,000	
Capital Avoidance: Avoidance of duplication with respect to the development of urgent care and primary care centers in the Eastern Connecticut Region, one ambulance service versus two, shared Information Technology Services					$28,600,000
Estimated Total Savings	$11,049,000	$15,046,000	$15,046,000	$15,046,000	$28,600,000

It is the full hope and expectation of the Applicants that these projections will be far exceeded. These savings, along with other tangible and intangible benefits discussed herein, will wisely position Backus Corporation for the future. See the Standard & Poor's Ratings Direct "U.S.

[21] Please also note that Windham Hospital will save at least $700,000 per year in senior management salaries if the Proposal is approved by OHCA.

Not-For-Profit Health Care System Ratios: Stability in 2011 Gives Providers a Firm Foundation to Face Industry Changes" (August 13, 2012), www.standardandpoors.com/ratingsdirect wherein the analysts predict that hospital systems will fare much better than standalone hospitals with the expected changes in health care delivery and financing over the next few years. Specifically,

> "[c]ompared with stand-alone hospitals, we believe many larger systems remain well positioned to withstand operating and market pressures for now due to their revenue and geographic diversity as well as large revenue bases. Furthermore, we believe health care systems at the top of the credit spectrum will likely continue to hold significant advantages over lower-rated peers because of their strong business positions, generally excellent balance sheets, overall scale, including the ability to attract and retain physicians, managers, and resources, and preferred access to capital."

Id. at page 2-3.

For all of the foregoing reasons, the Applicants respectfully request that this Proposal to allow Backus Corporation to affiliate with HHC be approved by OHCA.

Table of Exhibits

Exhibit	Description
1	Backus Corporation: Certificate of Incorporation (proposed); Bylaws (proposed)
2	HHC Value-Driven Geared Model Approach
3	Hartford HealthCare Integration Playbook
4	Windham Hospital Savings and Efficiencies
5	CCHA Affiliation Savings
6	Map
7	Organizational Charts
8	Memorandum of Understanding
9	Affiliation Agreement
10	Curriculum Vitae For: HHC and Backus Corporation
11	Organizational Quality Structure
12	HHC & Backus Corporation IRS Determination Letters
13	Table 3 (Patient Population Mix)
14	Financial Attachment I for Backus Corporation & HHC

Exhibit 1

Backus Corporation:

Certificate of Incorporation (proposed)

Bylaws (proposed)

AMENDED AND RESTATED
CERTIFICATE OF INCORPORATION

OF

BACKUS CORPORATION

1. The name of the corporation is **Backus Corporation** (the "Corporation").

2. The Corporation is organized and shall be operated exclusively for charitable, scientific, literary and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall be operated as a component part of the integrated health care delivery system (the "System") of which the parent is Hartford HealthCare Corporation. The nature and activities to be conducted, or the purposes to be promoted or carried out by the Corporation are as follows:

(a) to promote the delivery of quality and cost-effective health care services in the Eastern Connecticut region as a constituent part of the System, and to foster the accountability of the Corporation's affiliates to the strategic objectives developed by the System; and

(b) otherwise to engage in any lawful act or activity consistent with the foregoing for which corporations may be formed under the Connecticut Revised Nonstock Corporation Act (the "Act").

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions or dividends.

4. The Corporation shall have a single member, namely, Hartford HealthCare Corporation, a Connecticut nonstock corporation (the "Member"). The Member shall have the power to elect directors of the Corporation ("Directors") and to remove Directors with or without cause, shall have the power to adopt and amend the Bylaws of the Corporation (the "Bylaws"), and shall have such other rights, powers and responsibilities as are accorded to members under the Act, this Certificate of Incorporation or the Bylaws.

5. The Corporation shall operate under the management of its Board of Directors (the "Board"), and the Directors who shall be elected by the Member as provided in the Bylaws of the Corporation. The corporate powers of the Board, and any applicable limitations thereon, shall be as set forth in the Bylaws as in effect from time to time. The Bylaws shall prescribe the number, qualifications and manner of election of Directors. In the event a Director ceases to be in office, the Board shall fill the vacancy caused thereby until the next annual meeting of the Member of the Corporation held for the purpose of electing Directors. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio Directors of the Board who may vote and be counted in determining a quorum. As may be

further provided in the Bylaws, the terms of elected Directors of the Board may be staggered by dividing the Directors into up to three (3) groups so that approximately an equal number of such Directors have terms that expire each year.

6. Notwithstanding any other provision of this Amended and Restated Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on: (a) by an organization exempt from federal income tax under Section 501(a) of the Code as an organization described in Section 501(c)(3) of the Code; or (b) by an organization, contributions to which are deductible under Section 170(c)(2) of the Code.

7. The net earnings of the Corporation or any part thereof may not be distributed to or inure to the benefit of any private individual or a Director or officer of the Corporation. However, nothing herein shall restrict the right of the Corporation to reasonably compensate any officer, Director or other individual for services rendered to the Corporation or to reimburse any officer, Director or other individual for expenses, disbursements or liabilities properly made or incurred, on account of that individual's service to the Corporation.

8. A substantial part of the activities of the Corporation shall not consist of carrying on propaganda or attempting to influence legislation. The Corporation may not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

9. Upon dissolution of the Corporation, the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the purposes of the Corporation, to the Member exclusively for its charitable, scientific, literary or educational purposes, provided the Member shall be then exempt from federal taxation as an organization described in Section 501(c)(3) of the Code. If the Member shall not be so qualified as an organization described in Section 501(c)(3) of the Code, then the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the charitable, scientific, literary or educational purposes of the Corporation, to one or more organizations as shall be then exempt from federal taxation as an organization or organizations described in Section 501(c)(3) of the Code, in such proportions and amounts and in such manner as the Board shall determine. No part of the Corporation's assets shall ever be distributed to its Directors or officers, or inure to the benefit of any private individual.

10. The personal liability of a Director of the Corporation to the Corporation for monetary damages for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act or any other applicable laws presently or hereafter in effect. Without limiting the effect of the preceding sentence, no Director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of duty as a Director of the Corporation in an amount greater than the compensation received by the Director for serving the Corporation during the year of the violation if such breach did not: (i) involve a knowing and culpable violation of law by the Director; (ii) enable the Director, or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain; (iii) show a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constitute a

sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. No amendment to, or modification or repeal of, this Article 10 shall adversely affect any right or protection of a Director of the Corporation existing hereunder with respect to any act or omission occurring prior to such amendment, modification or repeal. Nothing contained in this Article 10 shall be construed to deny to the Directors of the Corporation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation.

11. The Corporation shall indemnify a Director for a liability, as defined in Section 33-1116(5) of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that: (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including reasonable attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both: (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Article 10 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Article 11. Such expenses (including reasonable attorneys' fees) incurred by other employees and agents may be so paid upon such terms and conditions, if any, as the Board deems appropriate. The indemnification and advancement of expenses provided by, or granted pursuant to, this Article 11 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

12. References in this Amended and Restated Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act, and references to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or as the same may hereafter be amended from time to time.

AMENDED AND RESTATED BYLAWS

OF

BACKUS CORPORATION

* * * * * * *

ARTICLE 1

NAME; PURPOSE; DEFINITIONS

1.1 Name. The name of the corporation is Backus Corporation (the "Corporation").

1.2 Purpose. The Corporation is organized and shall be operated for the purposes set forth in the Certificate of Incorporation.

1.3 Definitions. The following terms used in these Bylaws shall have the following

(a) "Act" shall mean the Connecticut Revised Nonstock Corporation Act, as amended from time to time.

(b) "Affiliation Agreement" shall mean the agreement effectuating the full corporate affiliation between the Member and the Corporation, executed as of [redacted] and effective on the Closing Date.

(c) "Backus Hospital" shall mean The William W. Backus Hospital.

(d) "Certificate of Incorporation" shall mean the Corporation's certificate of incorporation, as the same may be amended from time to time.

(e) "Closing Date" shall mean the date on which the affiliation between the Member and the Corporation is fully consummated in accordance with the terms of the Affiliation Agreement.

(f) "Corporation's President and CEO" shall mean the President and Chief Executive Officer of the Corporation.

(g) "Member" shall mean Hartford HealthCare Corporation, a Connecticut nonstock corporation.

(h) "Subsidiary" or "Subsidiaries" shall mean any entity directly or indirectly controlled by the Corporation. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of an entity, whether through the ability to exercise voting power by contract or otherwise. "Controlled" or

"Controlling" have correlative meanings. Without limiting the foregoing, each of the following entities shall be considered a Subsidiary: Backus Hospital; Backus Medical Center Condominium Association, Inc.; Community Medical Partners, Inc.; Backus Health Care, Inc.; CONNCare, Inc.; Backus Physician Services, LLC; WWB Corporation; Omni Home Health Services of Eastern Connecticut, LLC; and MedConn Collection Agency, LLC.

(i) "System" shall mean the comprehensive and integrated health care delivery system operated by the Member.

(j) "Transitional Period" shall mean a period of three years commencing on the Closing Date.

ARTICLE 2

MEMBERSHIP

2.1 Members. The Corporation shall have a single Member, namely, Hartford HealthCare Corporation.

2.2 Member's Rights and Powers. In addition to any other rights and powers which the Member may have under law, under these Bylaws or under the Certificate of Incorporation, the Member shall have the right and power to:

(a) Approve the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation and its Subsidiaries, including but not limited to approving capital and operating budgets;

(b) Approve the mission of the Corporation and its Subsidiaries;

(c) Approve the vision of the Corporation and its Subsidiaries;

(d) Approve the formation or acquisition by the Corporation or any Subsidiary of any direct or indirect subsidiaries, joint ventures or affiliations;

(e) Approve the Certificate of Incorporation and Bylaws of the Corporation and each Subsidiary, and any amendments thereto or restatements thereof; provided, however, the Member: (i) will not, during the Transitional Period, impose any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that are inconsistent with the terms of the Affiliation Agreement; (ii) will consult with the Corporation Board prior to implementing any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that are related to the Member's system-wide changes; and (iii) will, during the Transitional Period, obtain the approval of the Corporation Board prior to imposing any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that only apply to the Corporation and Backus Hospital and are not related to System-wide changes;

(f) Approve the governance documents of the Corporation and each Subsidiary, and any amendments thereto or restatements thereof;

(g) Appoint and remove with or without cause all directors ("Directors") and officers for the Corporation and determine the committee structure for the Corporation, including but not limited to appointing individuals to fill vacancies on the Corporation's Board of Directors ("Board"), subject to the provisions of Sections 3.2(c) and 3.6 of these Bylaws;

(h) Approve all core competencies and qualifications required for selection of the Board;

(i) Approve any guidelines for centralized accounting or debt management programs for the System, establish any debt limits under such programs, and approve any variances from such guidelines and set specific limits for the Corporation and its Subsidiaries;

(j) Approve the Corporation's borrowing of any sum in excess of one million dollars which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's or Backus Hospital's real property or by a security interest in the Corporation's or Backus Hospital's assets or revenues;

(k) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation and its Subsidiaries, subject to any established guidelines;

(l) Approve the spectrum of services offered by the Subsidiaries and approve the introduction or termination of any service, including without limitation the filing of any application for a certificate of need with the State of Connecticut; provided, however, that during the Transitional Period, any decision to reduce or terminate a material clinical service that Backus Hospital provided as of the Execution Date of the Affiliation Agreement shall occur only after prior consultation with, and the consent of, the Corporation Board;

(m) Approve the sale, transfer or substantial change in the use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation or change in corporate membership or ownership, or corporate reorganization of the Corporation or any Subsidiary of the Corporation;

(n) Approve the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(o) Approve the Corporation's filing of a voluntary petition for bankruptcy;

(p) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal government authorities;

(q) Accept evaluations submitted by the Board, with respect to the performance of the Board, the chair of the Board (the "Chair") and the vice chair of the Board (the "Vice Chair");

(r) Delegate to the Member's President and Chief Executive Officer (the "Member's President and CEO") the Member's powers of review or approval of actions on matters related to

the Corporation to the extent permitted by law, the Certificate of Incorporation and these Bylaws; and

(s) Take such other actions and steps as maybe necessary to maintain the long-range financial strength and viability of the Corporation.

2.3 System Parent Rights. In addition to the Member's rights and powers set forth above, in the event that the Corporation has the right to give or withhold its approval, vote or consent as a member, partner, shareholder or other owner of a Subsidiary or other organization where such approval, vote or consent is required by statute, regulation, the certificate or articles of incorporation, bylaws, partnership certificate or agreement, operating agreement, voting or shareholders agreement or other similar organizational or organic document of such other organization, the Corporation shall only give or withhold such approval, vote or consent as directed by the Member.

2.4 Manner of Acting. In the exercise of its powers, the Member may act through the Member's President and CEO or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws. All action of the Member may be taken by written consent in lieu of a meeting, including in lieu of the annual meeting of the Member for the election of Directors.

ARTICLE 3

BOARD OF DIRECTORS

3.1 Powers and Duties, Functions. The property and affairs of the Corporation shall be managed and conducted by the Board which may authorize and direct the Corporation to exercise all such powers and do all such things as may be exercised or done by the Corporation but subject nevertheless to the provisions of the Corporation's Certificate of Incorporation, these Bylaws, the laws of the State of Connecticut and the laws of the United States of America, and subject to the powers and rights of the Member. In exercising any of its powers of review or approval of actions or matters relating to any Subsidiary, to the extent permitted by law, the Certificate of Incorporation and these Bylaws, the Board may delegate such powers to the Corporation's President and CEO.

3.2 Election, Number, Term of Office, Class and Term Limits.

(a) Election. The Board may recommend to the Member individuals who meet the core competencies and qualifications recommended by the Member to serve as Directors and officers of the Corporation. The Member shall annually appoint individuals to the Board of Directors from among candidates recommended by the Member's Nominating and Governance Committee. The Member may elect Directors to serve on the Corporation's Board at other

special or regular meetings of the Corporation for the purpose of increasing the size of the Board or to fill vacancies on the Board.

(b) Number. Following the Transitional Period, the Board shall be comprised of fifteen (15) Directors. Twelve (12) of the Directors (the "Elected Directors") shall be elected from individuals recommended by the Governance Committee as members of the community served by the Hospital, chosen for their leadership, experience, expertise, voluntary service and philanthropic inclination, and one of whom shall be a member of the Hospital's Medical Staff (the "Elected Director from the Medical Staff"). The Elected Director from the Medical Staff shall be chosen from a list of no more than three (3) members in good standing of the Hospital's Medical Staff provided to the Governance Committee of the Board by the Hospital's Medical Staff; provided, however, that: (i) the Governance Committee may request that the Hospital's Medical Staff recommend for election as the Elected Director from the Medical Staff members in good standing of the Hospital's Medical Staff in addition to those identified on the initial list provided to the Governance Committee; and (ii) if a list of candidates for the Elected Director from the Medical Staff is not provided by the Hospital's Medical Staff to the Governance Committee within thirty (30) days of a written request for such list (or additional list(s)), the Governance Committee may nominate any member in good standing of the Medical Staff of the Hospital for election as the Elected Director from the Medical Staff. The remaining three (3) Directors (the "Ex-Officio Directors") shall be the Chief Executive Officer, the President of the Hospital's Medical Staff and the Vice President of the Hospital's Medical Staff. The Elected Directors and the Ex-Officio Directors shall each have a vote and shall be counted for quorum purposes. Notwithstanding the foregoing, during the Transitional Period, the Board shall be comprised of seventeen (17) Directors, which shall include fifteen (15) directors described above and the two (2) HHC-Appointed Directors (defined below).

(c) Transitional Period. Notwithstanding anything to the contrary contained in these Bylaws, the Directors serving on the Corporation Board on the day prior to the Closing Date will continue to serve as Directors during the Transitional Period (the "Legacy Directors"). The Member shall appoint two (2) representatives to serve as Directors during the Transitional Period (the "HHC-Appointed Directors"). During the Transitional Period, additional Directors may be nominated and elected in accordance with these Bylaws.

(d) Classes; Manner of Election; Term of Office. With respect to all Directors other than the Legacy Directors and the HHC-Appointed Directors, the Board shall be divided into three (3) classes, comprised of as equal a number of Directors per class as possible. Each class of Directors shall serve for term of three (3) years, with terms staggered so that approximately one-third (1/3) of the Directors shall be elected by the Member annually. The Directors so elected annually shall hold their offices for a term to expire at the third (3rd) annual meeting after their election and until others shall be elected or appointed in their places. A Director elected at any other meeting or time to fill a vacancy shall hold office only for the unexpired term, unless elected to continue to fill additional terms. In the event that a Director is filling an unexpired term created by a Board vacancy, such Director may not serve on the Board for more than nine (9) consecutive years, including any terms preceding or subsequent to such Director's term during which they are filling a vacancy.

(e) Term Limits. There shall be a limit of three (3) consecutive full terms which an individual may serve as a Director. Any Director who shall serve for three (3) consecutive full terms shall not be eligible for appointment to a further term or terms until the annual meeting of the Board immediately following the expiration of such third successive full term. For purposes of this limitation, a partial term served as the result of filling a vacancy shall not be counted as a "full term". The Board may waive the above term limit to permit a Director to serve as Board Chair and/or Board Vice Chair, provided such waiver shall be for not more than one (1) additional year to an existing term. Notwithstanding the foregoing, (i) a Director's term shall end upon his or her death, resignation, or removal as provided in these Bylaws; and (ii) a Director of the Corporation who has served for three (3) consecutive full terms will be immediately eligible for appointment to the board of any one of the health care entities which comprise the System.

(f) Director Restrictions. No Director of the Corporation shall serve simultaneously on the Board of Directors of the Corporation and on the board of directors of the Member; provided, however, pursuant to the Affiliation Agreement, during the Transitional Period, the Corporation may nominate, and the Member shall approve, two individuals from the Corporation Board to serve as directors of the Member. The foregoing restrictions shall not apply to the HHC-Appointed Directors or any executive of the Corporation who serves on the board of directors of any non-hospital Subsidiary in an ex-officio capacity.

(g) Ex-Officio Directors. Each Ex-Officio Director shall cease to be a Director immediately and automatically upon ceasing to hold the office from which his or her ex-officio status derives, without the need for any action by the Member, the Corporation or its Directors. There shall be no other ex-officio members on the Board.

(h) Board Competencies and Qualifications. The Corporation shall have a written policy approved by the Member with respect to the qualifications and core competencies for the selection of the persons appointed to the Board.

(i) Special Requirements for Board. The Board shall ensure that the Member's President and CEO is at all times an invited guest at the Board meetings, with attendance at such Board meetings to be left to the sole discretion of the Member's President and CEO.

(j) Honorary Roles. The Board may grant honorary roles, such as the role of Director Emeritus, for individuals who have ceased to serve as Directors. Such roles shall be without any governance responsibilities, including but not limited to voting rights or the right to attend, receive material from, or participate in meetings of the Board.

3.3 Board Meetings. The Board shall hold a maximum of six (6) regular meetings each year, one of which shall also serve as its annual meeting. All meetings, annual, regular or special, shall be held at such place or places within or without the State of Connecticut as the Board may from time to time by resolution determine or as shall be specified or fixed in the notice or waiver of notice thereof.

(a) Annual Meetings. An annual meeting of the Board for the transaction of such business as may properly come before the Board shall be held following the annual meeting of

the Member of the Corporation in each year, at such time and place as shall be determined by the Board.

(b) Regular Meetings. Regular meetings of the Board shall be held at such times as shall be specified in a resolution adopted by the Board then in effect, or if there shall not be any such resolution then in effect, as shall be specified in a notice of such meeting.

(c) Special Meetings. Special meetings of the Board shall be held whenever called by the Board Chair, by the Corporation's President and CEO, by the Member, or by at least two (2) of the Directors then in office.

(d) Notice. At least two (2) days' written, oral or electronic notice of each special meeting stating the time and place of the meeting shall be given to each Director by the Corporation's President and CEO or by the Secretary, or in the case of a special meeting that has been called by the Directors, by the Directors calling the meeting. Except as otherwise provided in these Bylaws or as otherwise required by law, neither the business to be transacted at, nor the purpose of any special meeting of the Board, need be specified in the notice or waiver of notice of such meeting.

(e) Waiver of Notice. The attendance of a Director at any meeting without protesting prior to the commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him or her of notice of such meeting.

(f) Telephonic Participation at a Board Meeting. Directors may participate in a meeting of the Board by use of a conference telephone or similar communications equipment which allows all persons participating in the meeting to simultaneously hear each other and to communicate with one another.

(g) Quorum. A majority of the number of Directors then in office shall constitute a quorum for the transaction of business.

(h) Adjournment. A majority of the Directors present at any meeting of the Board, including a meeting at which a quorum is not present, thereat may adjourn the meeting to another time and place. Notice of any adjourned meeting need not be given unless the meeting shall have been adjourned for more than three (3) days.

3.4 Vote Required for Action. The act of a majority of the Directors present at any meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the vote of a greater or lesser proportion is otherwise required by law. If all the Directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, such action shall be the act of the Board with the same force and effect as though it had been authorized at a duly called and held meeting of the Board.

3.5 Resignation. Any Director of the Corporation may resign at any time by giving written notice to the Corporation's President and CEO. In the event of a resignation of a Director without written notice, the Corporation's President and CEO shall confirm such resignation in writing. Such resignation shall take effect at the time specified therein. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it

effective. A vacancy on the Board thereby created shall be filled as provided in Section 3.7 hereof.

3.6 Removal. Any Director may be removed from the Board of Directors with or without cause by the Member. Such action may be taken at any annual meeting, any regular meeting or any special meeting, provided that due notice of the proposed removal shall have been duly given to the subject Director. Notwithstanding the foregoing, during the Transitional Period the Member shall only exercise its power to remove a Legacy Director if such removal is for cause and after prior consultation with the Chair of the Backus Board.

3.7 Vacancies. In the event a Director ceases to be in office, the Member shall have the power to fill the vacancy caused thereby, and the person elected to fill such vacancy shall hold office for the unexpired portion of the term of his or her predecessor

ARTICLE 4

COMMITTEES

4.1 Committees. The Board may designate two (2) or more Directors, plus such additional individuals, to constitute a committee, which may be standing or ad hoc. The Member may designate one or more of the Corporation's Directors to chair a committee. Committees shall have and may exercise all such authority of the Board as shall be provided in resolutions of appointment, except that no such committee shall have any power or authority prohibited by law or as to the following:

(a) filling of vacancies in the Board or any of its committees;

(b) amending the Certificate of Incorporation;

(c) adopting, amending or repealing these Bylaws;

(d) amending or repealing of any resolution of the Board;

(e) approving a plan of merger, a sale, lease, exchange or other disposition of all or substantially all of the property of the Corporation or of a proposal to dissolve the Corporation;

(f) acting on matters committed by these Bylaws or a resolution of the Board to the Member, or to another committee of the Board.

Except as provided in these Bylaws, members of committees and their respective chairpersons shall be appointed by the Board at the annual meeting of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

4.2 Standing Committees. There shall be a Board Governance Committee, a Fundraising Committee, and such additional standing committees as the Member may from time to time establish. Except as set forth in these Bylaws, members of committees need not be

Directors of the Corporation. All chairpersons of a committee shall be Directors of the Corporation.

4.3 Board Governance Committee. The Board Governance Committee shall identify qualified candidates and recommend nominations for Directors, and officers of the Corporation to the Member's Nominating and Governance Committee. The Board Governance Committee shall also oversee any Board self-evaluation process; evaluating the Chair and Vice Chair, and consulting with the Member's President and CEO on any annual performance objectives, performance and compensation of the Corporation's President and CEO. The Board Governance Committee shall also advise the Board on matters related to governance of the Corporation, Director performance evaluation and oversight of any Director conflict of interest matters. The Board Governance Committee shall have the responsibilities and shall follow the procedures set forth in the Board Governance Committee Charter as adopted by the Board.

4.4 Fundraising Committee. The Fundraising Committee shall assist the management of the Corporation in fund development matters, shall participate in the formulation of plans and programs to enhance the Corporation's ability to generate financial support from public and private sources, and shall make recommendations and reports to the Board from time to time as it may deem appropriate and as may be consistent with the System's overall fundraising and development objectives. The Fundraising Committee shall have the responsibilities and shall follow the procedures set forth in the Fundraising Committee Charter as adopted by the Board.

4.5 Procedures, Actions by Committee. Subject to any charter adopted by the Board for the governance of any committee, each committee of the Board shall act in accordance with the following procedures: Each committee shall adopt a schedule of regular meetings and shall hold additional special meetings on the call of the committee chair or any two committee members. Notice of each such meeting shall be given to all committee members in the manner provided for notice of regular meetings of the Board. All members of a committee shall be entitled to participate in committee activities and shall have full voting rights on actions taken by such committee. A majority of voting members of the committee shall constitute a quorum for all business. The act of a majority of voting members of the committee present at any meeting duly held at which a quorum is present at the time of the act shall be the act of the committee; and if less than a quorum is present at any committee meeting, a majority of the voting members of the committee present may adjourn such meeting from time to time without notice. Each committee shall keep a record of its proceedings and shall report to the Board as requested. The term of office of a committee member shall be determined by the Board. Members of a committee may be removed at any time by the Board with or without cause.

ARTICLE 5

OFFICERS

5.1 Term and Election of Officers. The Member shall elect the Corporation's Chair and a Vice Chair of the Board. The Secretary and Treasurer of the Corporation shall be appointed by the Board at the annual meeting of the Corporation upon recommendation of the

Corporation's President and CEO. The Member's President and CEO shall appoint the Corporation's President and CEO. Each officer shall hold office for the term for which he or she is elected and until his or her successor shall have been duly elected and qualified. Unless otherwise provided in a resolution electing an officer, his or her term of office shall extend to and expire on the date of the next annual meeting of the Board following his or her election. However if earlier, an officer's term shall end upon his or her death, resignation or removal as provided in these Bylaws.

5.2 Chair. The Chair shall preside at all meetings of the Board and shall have such powers and duties as from time to time may be determined by the Board. The Board shall recommend to the Member an individual from among the Directors to serve as Chair.

5.3 Vice Chair. The Vice Chair shall perform the duties of the Chair in the event of the Chair's absence or disability and shall assist the Chair in such duties as the Chair may from time to time assign to the Vice Chair. The Vice Chair shall not automatically succeed to the position of Chair. The Board shall recommend to the Member an individual from among the Directors to serve as Vice Chair.

5.4 The Corporation's President and CEO. The Member's President and CEO shall appoint the Corporation's President and CEO and shall establish the objectives, evaluate the performance and determine the compensation for the Corporation's President and CEO. The removal of the Corporation's President and CEO shall be at the discretion of the Member's President and CEO; provided, however, that during the Transitional Period, any removal of the Corporation's President and CEO shall be made only after consultation with the Corporation's Board. The Corporation's President and CEO shall be the chief executive officer of the Corporation. Subject to the powers expressly reserved to the Board or the Corporation's Member, the Corporation's President and CEO shall, in general, supervise and control all the business and affairs of the Corporation and shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair or Vice Chair has been appointed or in the absence of the Chair or Vice Chair, the Corporation's President and CEO shall preside at each meeting of the Board. The Corporation's President and CEO shall see that all orders and resolutions of the Board and of the committees of the Board are carried into effect. In general, he or she shall perform all duties incident to the office of President and CEO and such other duties as may from time to time be assigned to the Corporation's President and CEO by these Bylaws, by the Board, or by the Member's President and CEO.

Without limiting the foregoing, the Corporation's President and CEO shall have the power to:

(a) Be responsible for coordinating the business affairs of the Corporation within overall System guidelines;

(b) Recommend the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation and its Subsidiaries, including but not limited to capital and operating budgets, to the Member upon consultation with the Board;

(c) Recommend to the Member the vision of the Corporation and of its Subsidiaries;

(d) Recommend to the Board any incurrence or assumption of debt by the Corporation or its Subsidiaries in accordance with the guidelines established by the Member for the System's centralized debt management program;

(e) Identify the need for the Corporation's formation of any new legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, and/or disposition of assets closures, mergers, consolidations or changes in corporate membership or ownership of the Corporation or any Subsidiary of the Corporation; and

(f) Recommend to the Member the need for the introduction or termination of any service and the filing of any application for a certificate of need with the State of Connecticut.

5.5 Treasurer. The Treasurer shall have charge and custody of and be responsible for all the funds and securities of the Corporation; he or she shall keep full and accurate accounts of assets, liabilities, receipts and disbursements and other transactions of the Corporation in books belonging to the Corporation; and he or she shall see that all moneys and other valuable effects of the Corporation are deposited or invested in the name of and to the credit of the Corporation in such banks or other financial institutions as may be designated by the Board. The Treasurer shall disburse or oversee the disbursement of the funds of the Corporation as may be ordered by the Board, taking proper vouchers for disbursements, and shall render to the Corporation's President and CEO and to the Directors at the meetings of the Board, or whenever they may require it, a statement of all his or her transactions as Treasurer and an account of the financial condition of the Corporation. In general, he or she shall perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Board or by the Corporation's President and CEO.

5.6 Secretary. The Secretary shall serve all notices for the Corporation that have been authorized by the Board; keep the minutes of the meetings of the Board and the Member; be the custodian of the corporate records and of the seal of the Corporation; and in general, perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the Board or the Corporation's President and CEO.

5.7 Other Officers. The Board may from time to time appoint such other Board officers as may be deemed necessary or advisable for the efficient operation of the Corporation's affairs, each of whom shall hold office for such period, have such authority and perform such duties as the Member may from time to time determine.

5.8 Removal of Officers. Irrespective of term of office, but subject to any written contract rights or any other provisions in these Bylaws, any officer of the Board may be removed with or without cause at any time by the Member.

5.9 Vacancies. Except as otherwise provided in these Bylaws, if the office of the President and Chief Executive Officer, the Chair, Vice Chair, or any other officer appointed by the Member becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by the Member. If the office of Treasurer, Secretary, Assistant

Secretary, or any other officer appointed by the Board becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by the Board.

5.10 Resignations. Any officer of the Corporation may resign his or her office at any time by giving written notice thereof to the Corporation's President and CEO or to the Board. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

ARTICLE 6

CONFLICT OF INTEREST

All Directors and officers of the Corporation shall be subject to and abide by the terms of the Corporation's Conflict of Interest Policy maintained on record by the Corporation, a copy of which has been provided to all Directors and officers.

ARTICLE 7

INDEMNIFICATION

7.1 Limitation of Liability. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act, or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability (as defined in Section 33-1116 of the Act) to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director, (ii) enabled the Director or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal gain, (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

7.2 Indemnification of Directors and Officers. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect.

7.3 Expenses. Expenses incurred by a Director or officer in defending a civil or criminal action, suit or proceeding shall be paid for or reimbursed by the Corporation to the fullest extent permitted by law in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such Director or officer of his or her

good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under the Certificate of Incorporation or these Bylaws and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall be ultimately determined that such director or officer is not entitled to be indemnified by the Corporation. Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon the terms and conditions, if any, as the Board of Directors deems appropriate.

7.4 Non-exclusivity. The indemnification and advancement of expenses provided for herein shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a Director or officer and shall inure to the benefit of the heirs, executors and administrators of such a person. Notwithstanding the foregoing, the Corporation shall not provide such indemnification or advancement for expenses to the extent that such indemnification or advancement would constitute self-dealing within the meaning of section 4941(d) of the Internal Revenue Code of 1986, as amended.

7.5 Amendment or Repeal. No amendment to or repeal of this Article 7 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

ARTICLE 8

MISCELLANEOUS PROVISIONS

8.1 Notice. Any notice required or permitted to be given under these Bylaws in writing shall be deemed to have been delivered if delivered in person or if sent by United States mail, overnight delivery, telegraph (charges prepaid), telex, facsimile, fax or email and addressed to such person at the address shown on the records of the Corporation or the address supplied by him or her to the Corporation for the purpose of notice. If such notice is sent by mail, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail.

8.2 Amendment. The Member shall have the exclusive power to make, amend or repeal the Corporation's Certificate of Incorporation or these Bylaws, subject to the limitations set forth in Section 2.2(e).

8.3 Execution of Contracts. The Board may authorize any officer or officers and any agent or agents to enter into any contract or execute any instrument in the name of, and on behalf of, the Corporation, and such authority may be general or limited to specified instances. No officer, agent or employee shall have any power or authority to bind or obligate the Corporation

by any commitment, contract or engagement, or to pledge its credit or render it liable for any purpose or in any amount unless duly authorized by the Board.

8.4 Compensation for Services. The Corporation may reimburse any Director for expenses incurred in connection with fulfilling his or her duties as a member of the Board, provided that the amount of such reimbursement is reasonable and not excessive.

8.5 Consistency with Affiliation Agreement. In the event of a conflict between any provision of these Bylaws and the terms of the Affiliation Agreement, the provisions of the Affiliation Agreement shall control.

Exhibit 2

HHC Value-Driven Geared Model Approach

Value-Driven Geared Model

The hallmark of our integrated system approach is embodied in our **"Value-Driven Geared Model"** (see Fig. 1) and is premised on the creation of an innovative and collaborative community-based organization that appreciates the critical fact that **health care is best delivered close to home.** The Value-Driven Geared Model recognizes the important role each participant organization has in providing services to its community. It fosters the systematic sharing of intellectual, human and financial capital and it enables the unlimited sharing and implementation of innovative business and clinical processes.

In short, our approach to system formation recognizes "the whole as being greater than the sum of the parts." Our goal is to create an innovative organizational structure capable of delivering at the local level, through collaboration and interdependence, well-coordinated, high-quality patient care. And we do that **by strengthening the capabilities of local institutions**. We have developed a culture and organizational structure in which clinical care, education and research are supported so that patients and local communities benefit from the latest technology, clinical excellence and innovation.

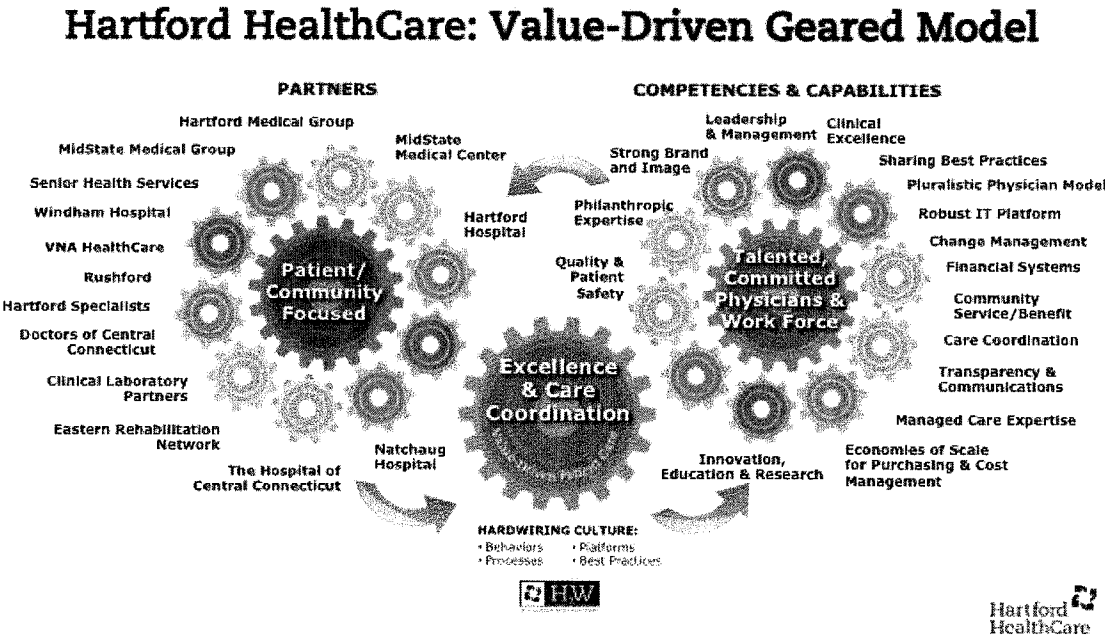

Exhibit 3

Hartford HealthCare Integration Playbook

Hartford HealthCare

INTEGRATION PLAYBOOK

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Integration Playbook Contents

- Overall guiding principles
- Best practice lessons learned
- Integration program structure and timeline
- Synergies
- Appendix – tools and templates

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Overall Guiding Principles

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Affiliation Guiding Principles

- Open, factual, honest and timely communications to all employees, physicians, the community and other key stakeholders
- Enhance the culture of excellence in safety, quality and service by promoting best clinical practices across the organization
- Improve patient access, including the underserved population, to a full continuum of care services
- Improve the organization's ability to invest in new technology and services by leveraging economies of scale and best administrative practices
- Provide additional development and growth opportunities for staff
- H3W will be used to enable the affiliation program

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The Playbook supports the Hartford HealthCare vision

Nationally respected for excellence in patient care and most trusted for personalized coordinated care.

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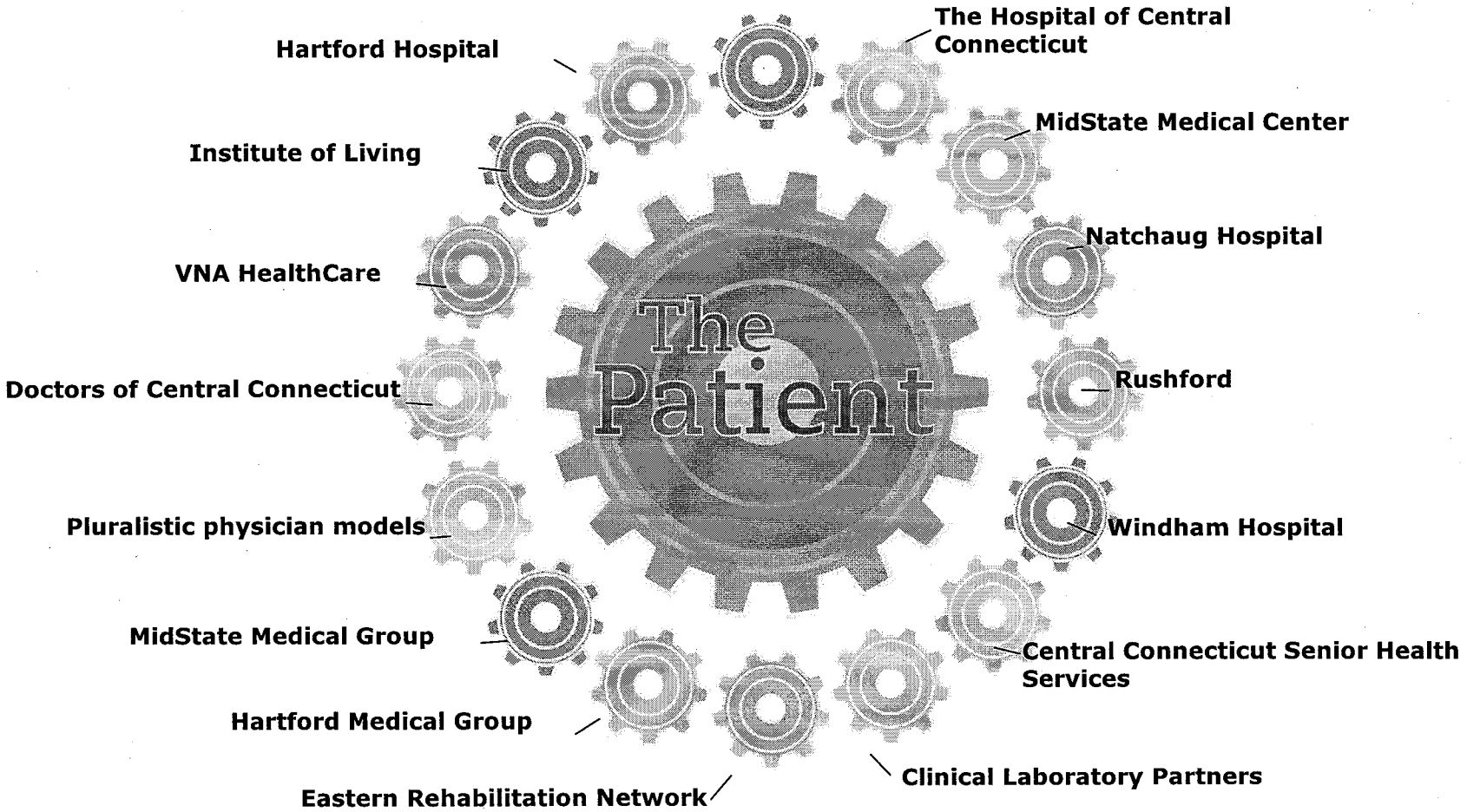
… and is consistent with the Geared Model



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Affiliation Best Practice and Lessons Learned

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Best Practices

Value

Put the patient at the center of everything we do

Focus on Clinical Best Practices – as well as the administrative efficiencies

People

Resolve people issues quickly – clarify reporting relationships quickly after the approval announcement

Introduce H3W, Values and Leadership Principles quickly – culture really does matter

Win the "hearts and minds" of employees – communicate a passionate vision of the system's future

Process

Utilize a structured affiliation process – use simple process tools

Focus most of the organization on running the business, not affiliation – excellence, integrity, caring and safety are what it is all about

Have effective decision making process involving the right people – be clear about decision making

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There are several lessons learned from prior affiliation work

- While most leaders will be anxious to speak with their peers in the new organization, carefully orchestrate the initial communications to ensure consistent messaging and objectives and to help build trust
- Kick off the programs with the highest value to the organization and least controversy to generate early wins (e.g., purchasing)
- Appoint the right people to lead the key program activities
  - Some of the operational leaders may not have the necessary skills to drive the affiliation activities
- Clearly message and reinforce that best practices can come from any organization.
- Outline a clear process for resolving conflicts and making decisions
  - Ambiguity and delays in making decisions can be harmful to relationships and building trust

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Affiliation Program Structure and Timeline

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Affiliation Program Goals

- To build and manage the collaborative processes that yield the desired benefits of the affiliation, including:
  - Implementation of quality initiatives, including shared clinical best practices
  - Recruitment and retention of world-class medical talent
  - Additional opportunities for clinical research and teaching
  - Volume purchasing
  - Best practice implementation and optimization of certain administration services
  - Opportunities for deployment of technologies throughout the system

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Proposed Affiliation Program Approach

Structured Affiliation Process

- Co-chaired by Senior Leadership at each organization empowered to make decsions
- Key areas of both organizations represented
- Function as the single point of contact for all affiliation activities

Steering Committee

- Representative leaders from key functional areas
- Regularly scheduled periodic meetings
- Structured agenda
- Accountable for obtaining qualitative and synergy goals

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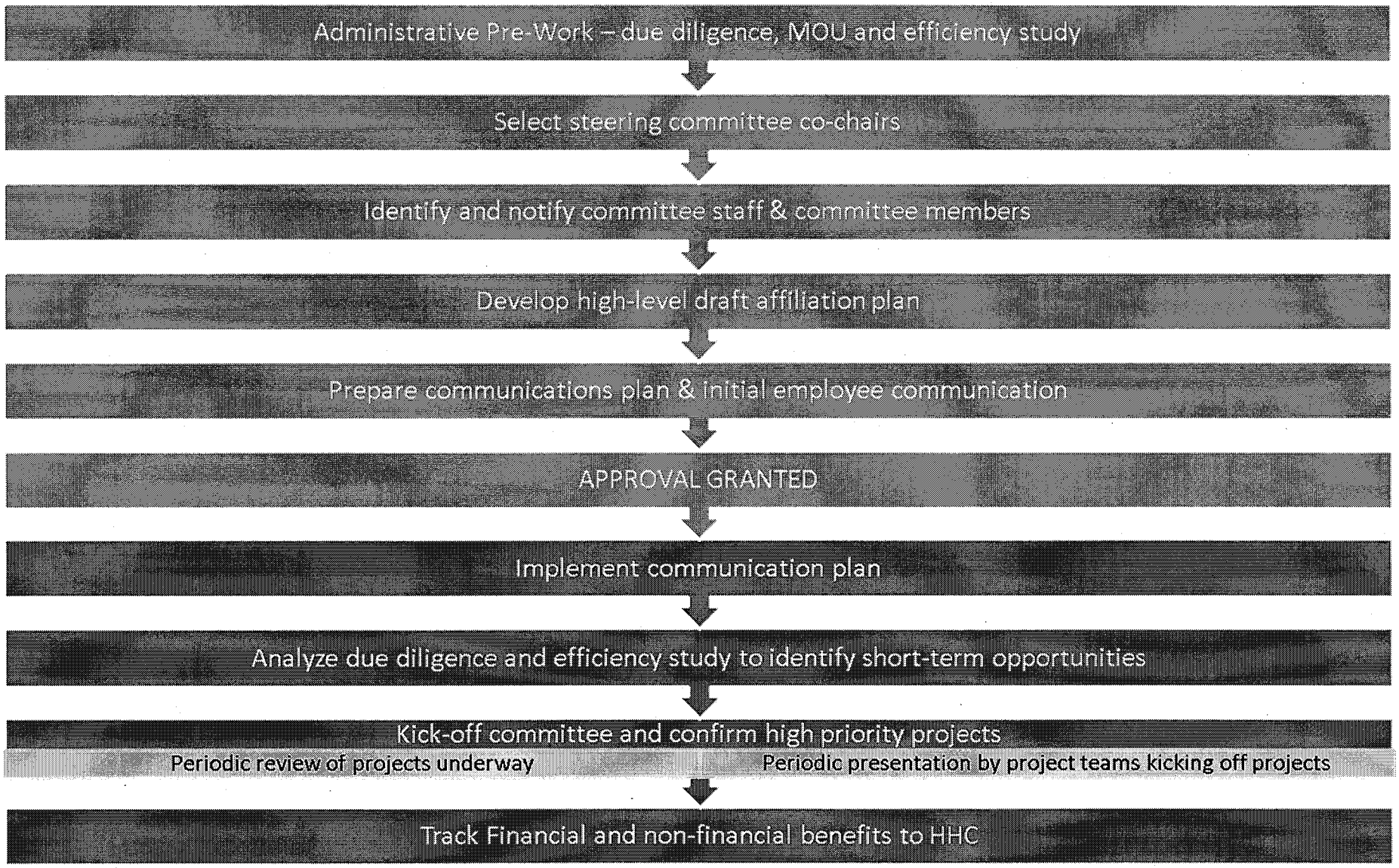
Overall Affiliation Program Timeline



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Proposed Action Items

Immediate Post-Approval Actions

Timeline: 0 – 90 Days

Item	Examples
Communications Plan	employees, physicians, community, key politicians
Create Transition Team	Select chairs, staff & members
Governance	By-laws, board member appointments, governance cycle
H3W	Training plan
Balanced Scorecard	Sharing of key priorities
Finance	FMV, financial reporting, budget/forecast, treasury/obligated group, capital planning
Clinical Councils	Expanded to include affiliate representation
Leadership Cycle	Sharing of processes
Compliance	Evaluate consistency of policies

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Proposed Action Items

High Priority Value Creators

Timeline: 30 – 120 Days

Item
Physician Recruitment
Service Enhancements
Laboratory
Materials Management & Purchased Goods
Managed Care Contracting
Information Technology
Medical Foundation
Revenue Cycle
Malpractice Captive
Practice Central

Other Opportunities

Timeline: TBD (typically 30 – 270

Item
Rehabilitation Services
Visiting Nurses Association
Behavioral Health
Human Resources
Facilities Management / Real Estate
Long-Term Care / Seniors
Pharmacy
Other items identified during due diligence

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Sample: Action Plans

Timeline: 0 – 90 Days

Item	Examples	Prior to Approval	0-30 Days	31-60 Days	61-90 Days
Communications Plan	employees, physicians, community, key politicians	Develop draft plan	Kick off communications plan activities	Ongoing communication activities	Ongoing communication activities
Create Transition Team	Select chairs, staff & members	Identify leader from each organization and membership	Initial kick off meeting, identification of key programs and development of project plans	Oversight of program plans	Oversight of program plans
Governance	By-laws, board member appointments, governance cycle	Identification of board members for respective boards	Bring board members through governance process		
H3W	Training plan	Education of Backus leadership regarding H3W	Development of H3W implementation plans		
Balanced Scorecard	Sharing of key priorities		Sharing of respective balanced score cards		

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Sample: Action Plans

Timeline: 0 – 90 Days

Item	Examples	Prior to Approval	0-30 Days	31-60 Days	61-90 Days
Finance	FMV, financial reporting, budget/forecast, treasury/obligated group, capital planning		Engage actuary for pension evaluation & FMV assessment; determine legal structure; incorporate into financial reporting	Determine status of all tax returns; plan integration of obligated group debt; begin risk management/insurance discussions	Develop accounting policies and procedures; decision support, budget, grant accounting and financial system discussions begin
Clinical Councils	Expanded to include affiliate representation		Incorporate individuals in key clinical councils		
Leadership Cycle	Sharing of processes		Include Backus leadership in key leadership meetings	Expand calendars to incorporate Backus meetings	
Compliance	Evaluate consistency of policies		Meeting of compliance leaders to share plans		

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Rules for synergy identification

Agree to a baseline	• Budget or actual and what fiscal year
Should be integration related	• For previously identified projects, whenever possible, try to determine incremental savings
Synergies must be measurable	• Focus on higher value but do not exclude some "quick wins" to build momentum • Priority set by workgroups
Avoided cost can be counted in certain circumstances determined by committee chairs	• Should be based on need (savings included) versus wants (savings not included)
Synergies can be recurring or one-timers	

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Affiliation Tools

- Sample tool box includes:

Communications	Affiliation Committee	Work Teams
• Internal and external communications plan • Executive dashboard • Weekly dashboard reporting	• Agenda templates • Prioritization grid • Financial tracking • Non-financial tracking • Project lists	• Project charters • Action plans • Contact lists • Presentation templates

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See appendix for sample documents from previous affiliation efforts

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Appendix

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Sample Executive Summary

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Executive Summary for HHC and CCHA Affiliation

Hartford HealthCare

UPDATED: 4/3/12	Financial Savings		
	Prorated FY11	Projected FY12	Projected FY13
Clinical			
Administrative			
Finance - Acct/Rpt			
Finance - RevCycle			
Human Resources			
Information Technology			
Support Services			
Other Operations			
Total Savings (Cummulative)			
Target Savings (Cummulative)			
Variance from Target			

00065

Exhibit 4

Windham Hospital
Savings & Efficiencies

HHC – Backus Affiliation

DEMONSTRATED SUCCESS – HHC-WINDHAM AFFILIATION FINANCIAL BENEFIT

Huron Healthcare

Improvements in system physician and coding reviews and the centralization of staff have resulted in annual, recurring savings of more than $3.5 million.

Area	Benefit
Streamlined System Coding and Document Review	**$ 1,300,000**
Centralization of Revenue Cycle Staff	**$ 1,100,000**
Refinancing – Reduced Existing Interest Costs	**$ 600,000**
Group Purchasing – Blood Products, Lab Reference Testing, Implants, Pacemakers, Waste Management	**$ 300,000**
Malpractice Captive and Other Insurance Savings	**$ 250,000**
Annualized Total	**$ 3,550,000**

00067

Exhibit 5

CCHA Affiliation Savings

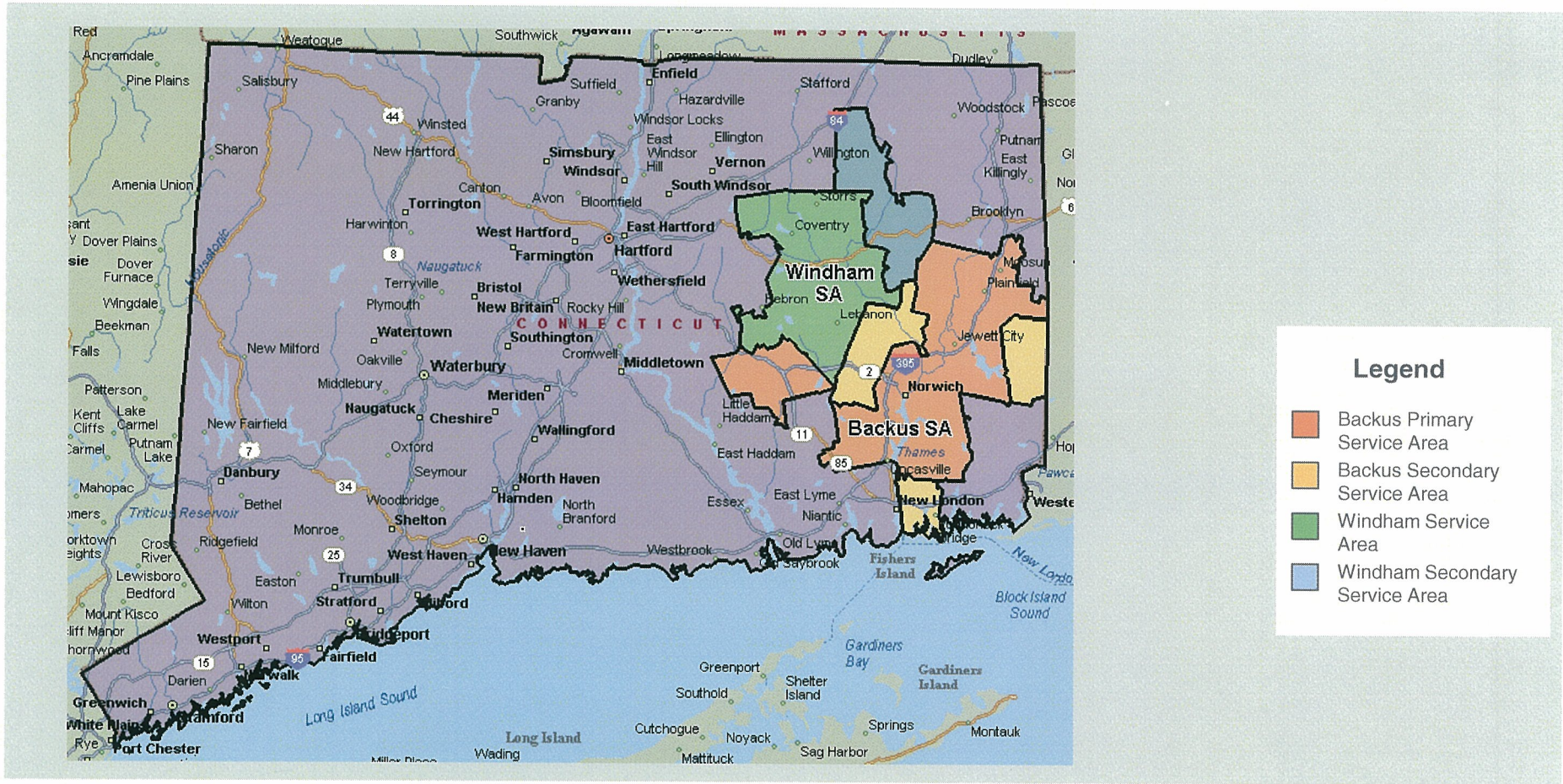
HOCC cost savings

	Cumulative Figures																	
	Target FY2011	Actual FY2011		Target FY2012	Actual FY2012		Target FY2013	Actual FY2013		Target FY2014	Actual FY2014		Target FY2015	Actual FY2015		Target Total	Actual Total	
Administration	1,413,970	1,852,630		2,662,491	2,825,375	-	2,853,436		-	3,014,827		-	1,251,275		-	11,195,999	4,678,005	
Clinical Opportunities	-	-		517,715	-	-	436,505	-		3,106,291		-	2,030,256		-	6,090,767	-	
Purchased Goods and Services	983,566	1,083,990		5,164,693	5,571,256	-	9,355,659		-	7,374,142		-	2,094,018		-	24,972,078	6,655,246	
Revenue Cycle	87,681	278,795		182,213	407,494	-	460,332	-		359,287		-	71,553		-	1,161,066	686,289	
Improve Bad Debt & Denials	300,000	-		1,100,000	-	-	1,800,000	-		2,000,000		-	800,000		-	6,000,000	-	
	2,785,217	3,215,415		9,627,112	8,804,126	-	14,905,932			15,854,547		-	6,247,102		-	49,419,910	12,019,540	

69000

Exhibit 6

Map

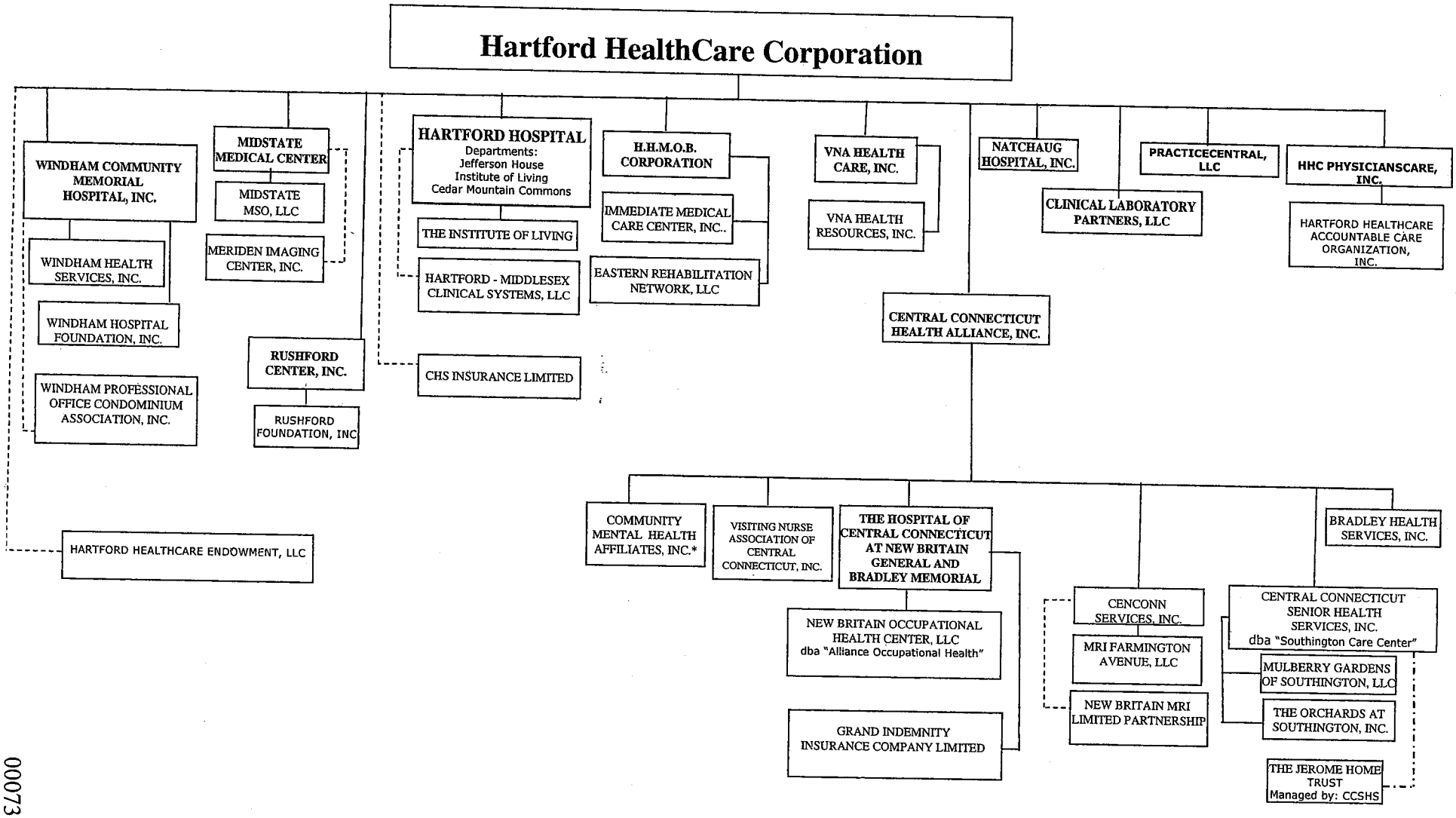


Hartford HealthCare

Exhibit 7

Organizational Charts

CORPORATE ORGANIZATION CHART
Hartford HealthCare Corporation
(Without Backus Corporation)



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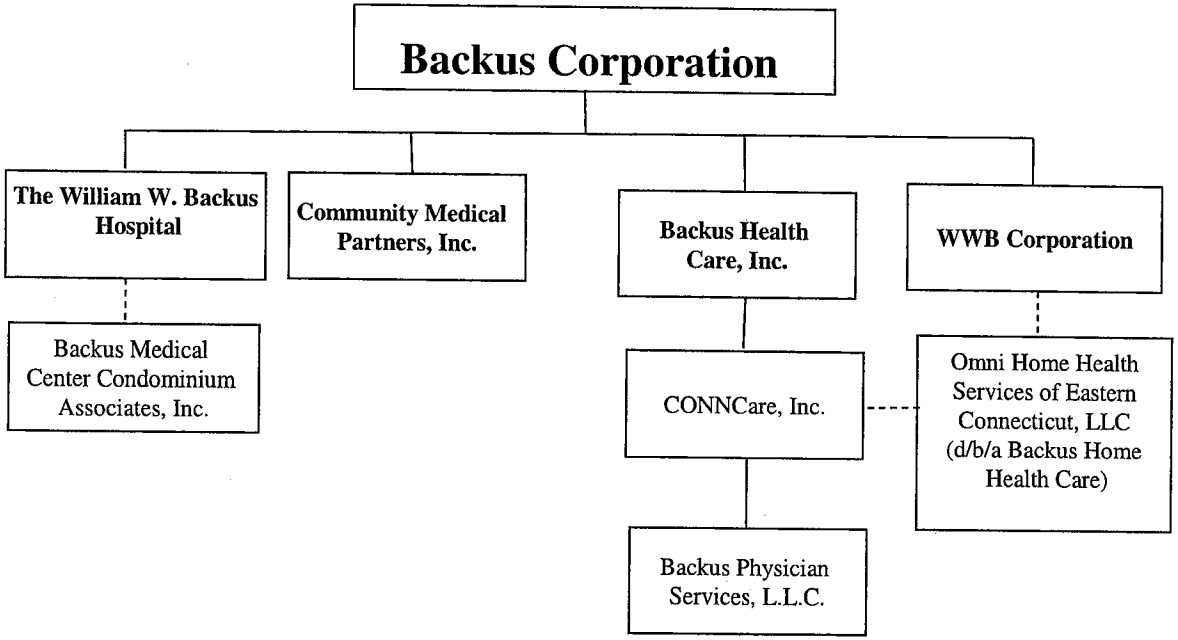
*A CON Application has been filed (see Docket #12-31750-CON) to sever the affiliation between Community mental Health Affiliates and Central Connecticut Health Alliance.

2448522 V.2

CORPORATE ORGANIZATION CHART

Backus Corporation
(Without Hartford HealthCare Corporation)



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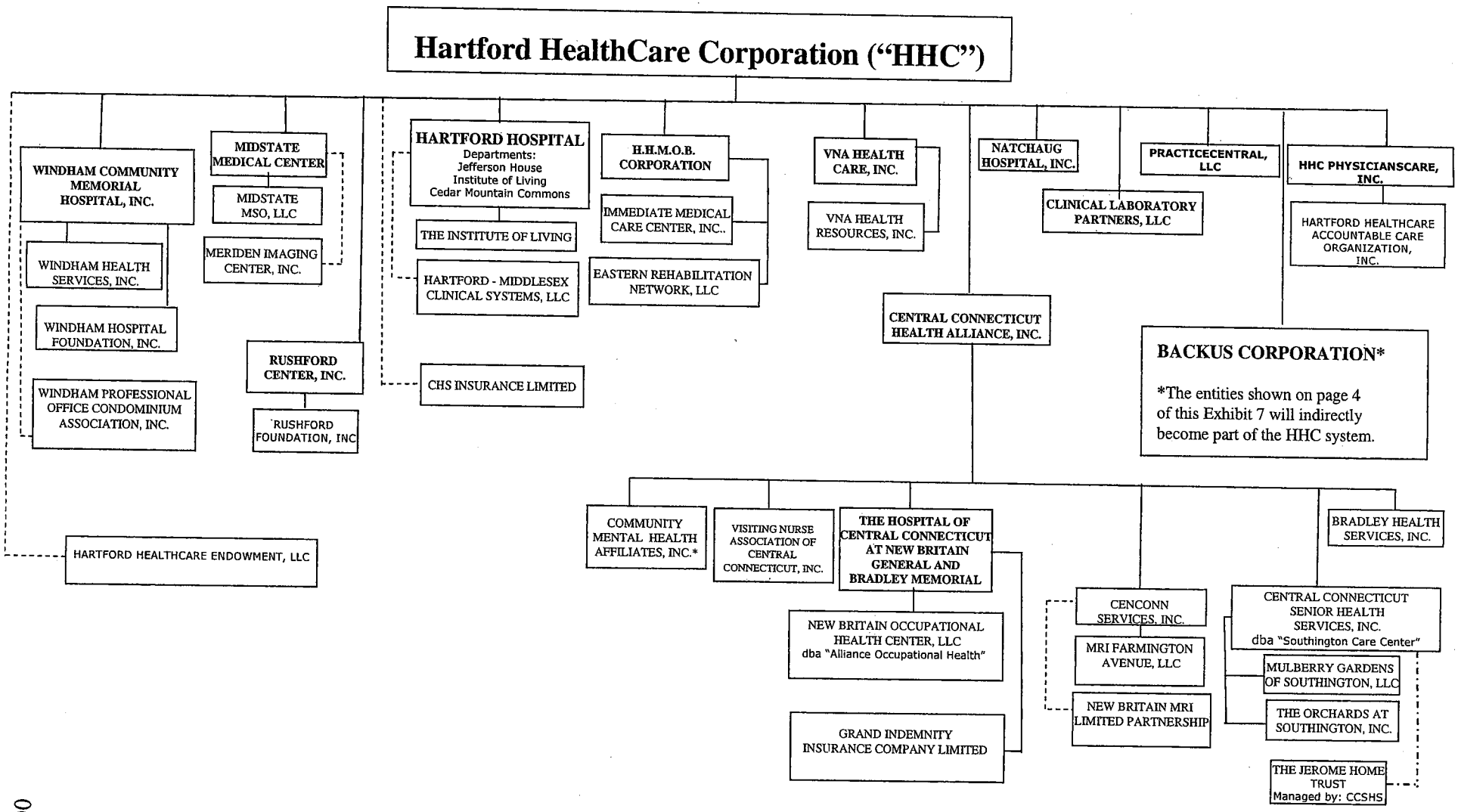
CORPORATE ORGANIZATION CHART

Hartford HealthCare Corporation
(With Backus Corporation)



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*A CON Application has been filed (see Docket #12-31750-CON) to sever the affiliation between Community mental Health Affiliates and Central Connecticut Health Alliance.

Backus Corporation
As Part of Harford HealthCare Corporation

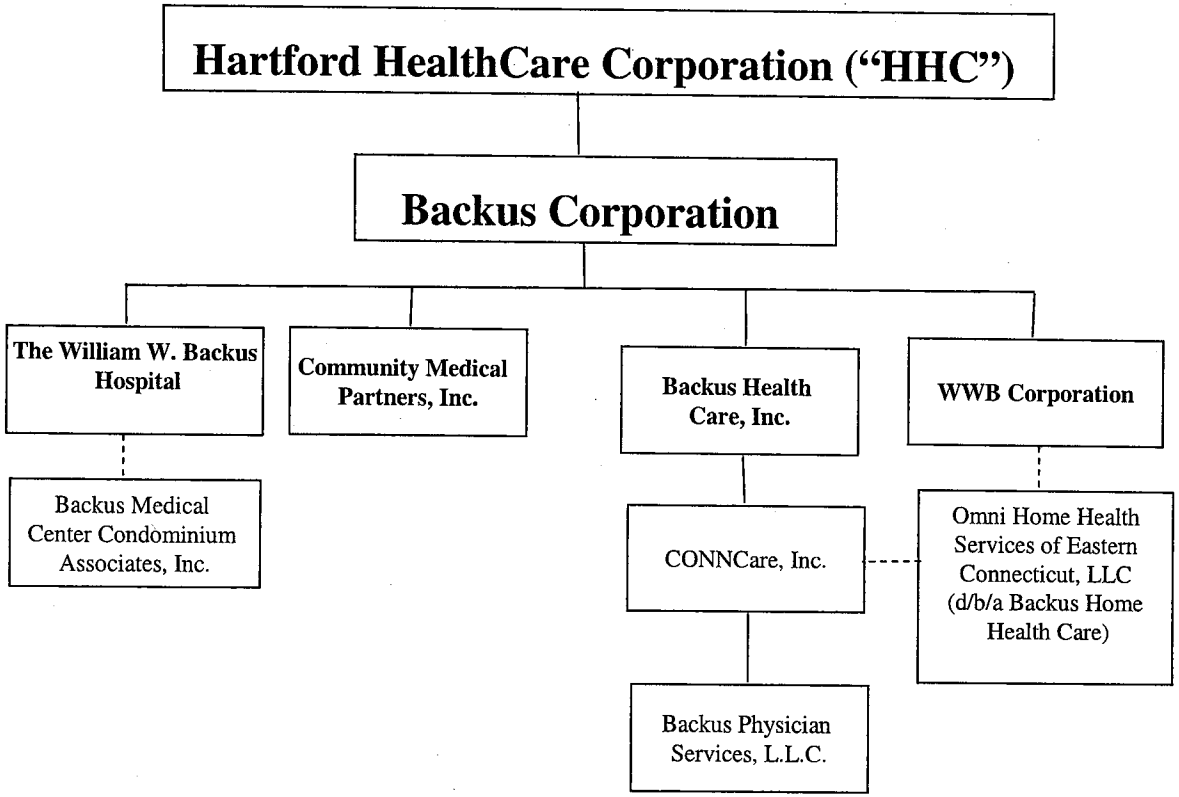

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Exhibit 8

Memorandum of Understanding

BACKUS CORPORATION
AND
HARTFORD HEALTHCARE CORPORATION

MEMORANDUM OF UNDERSTANDING
AND
SUMMARY OF TERMS
May 25, 2012

This Memorandum of Understanding (this "MOU") serves to confirm the mutual intent of Backus Corporation ("Backus") and Hartford HealthCare Corporation ("Hartford HealthCare") to achieve a full corporate affiliation (the "Transaction"). The Transaction will occur pursuant to one or more definitive agreements, including an affiliation agreement (collectively, the "Definitive Agreements") consistent with the terms of this MOU. The date of the closing of the Transaction is referred to herein as the "Effective Date." Each of Backus and Hartford HealthCare is referred to herein as a "Party" and collectively as the "Parties."

I. OVERVIEW

Backus, a Connecticut non-stock 501(c)(3) organization, is the sole corporate member of The William W. Backus Hospital, a Connecticut non-stock 501(c)(3) organization ("Backus Hospital") and various other affiliates (the "Backus Affiliates").

Hartford HealthCare, a Connecticut non-stock 501(c)(3) organization, which is the sole corporate member of Hartford Hospital, MidState Medical Center, Natchaug Hospital, Windham Hospital, The Hospital of Central Connecticut, and other providers of health care, is the planning and integrating body for that system of health care entities (the "Hartford System"). The members of the Hartford System are referred to herein as the "Hartford System Members."

The Parties intend to prepare and execute mutually acceptable Definitive Agreements by July 1, 2012 to achieve a full corporate affiliation between Backus and Hartford HealthCare, consistent with the terms set forth herein.

This MOU is intended as an outline of certain material provisions to be included in the Definitive Agreements and does not address all matters upon which agreement must be reached and reflected in the Definitive Agreements in order for the respective Board's of the Parties to approve the Transaction. Although it is expected that discussions regarding the Transaction will be fruitful, unless and until the Definitive Agreements are executed and delivered, there will be no legal and binding obligation of either Party, except as otherwise set forth in that certain Letter of Intent, as described below.

Each of Backus and Hartford HealthCare acknowledges and agrees that the terms of confidentiality and exclusivity extended by that certain letter agreement related to confidentiality and non-disclosure, dated as of July 20, 2011 continue to apply to these negotiations and all matters related to the Transaction. The Parties further agree that the terms of that certain Letter of Intent, dated as of February 2, 2012, continue to apply to these negotiations and all matters related to the Transaction.

II. DILIGENCE PERIOD

Upon the execution of this MOU, the Parties shall enter into a diligence period during which (i) each Party will perform a due diligence investigation of the other Party, (ii) the Parties will negotiate in good faith the terms of the Definitive Agreements, (iii) the Parties will agree upon a timeline for any regulatory filings required by the Transaction and will assign responsibility for such regulatory filings, and (iv) the Parties will further develop their analysis of synergies and opportunities for cost savings and efficiencies to be included in the Definitive Agreements.

III. GUIDING PRINCIPLES

Backus and Hartford HealthCare share a mutual commitment to support an integrated delivery system with expanded geographic coverage, a full continuum of care, strong local primary, secondary and tertiary care services, the highest standards of clinical care, enhanced patient access, including for underserved populations, and the most advanced technologies and service lines. The Parties recognize that the development of a truly integrated healthcare delivery system will further enhance their ability and the ability of their affiliated physicians and other health care providers to support their missions, identity and respective community roles.

IV. VISION

The Parties desire to expand Hartford HealthCare's integrated health care delivery system to achieve a higher level of quality, performance and efficiency. Central to this goal is the development of an Eastern Connecticut region consisting of Windham and New London counties (the "Eastern CT Region") utilizing Backus as its clinical nucleus. The Eastern CT Region will be integrated within the Hartford System and will expand and enhance the clinical programs and services available to those communities within the Eastern CT Region. Consistent with Hartford HealthCare's collaborative, value-driven geared approach, a strategic plan for acute and ambulatory care for the Eastern CT Region (the "Strategic Plan") will be developed by Backus, Hartford HealthCare and other Hartford System Members serving the Eastern CT Region in a manner consistent with the overall strategic plan for the Hartford System and implemented by Backus as further described below.

Through collaborative planning to meet the challenging needs of the Eastern CT Region, including responsible decision-making and appropriate sharing of services, resources and technologies, Hartford HealthCare and Backus expect to achieve certain economies of scale that will benefit the communities they serve, including, but not limited to, additional opportunities for clinical research, teaching, implementation of quality initiatives, including sharing of best practices, volume purchasing, consolidation of certain

administrative services, opportunities for deployment of expensive technologies throughout the Hartford System and the spreading of risk.

V. SUMMARY OF TERMS

The Parties' agreement with respect to a number of structural and governance aspects of the Transaction are set forth below, which shall be confirmed in the Definitive Agreements.

Transaction Structure	Hartford HealthCare will become the sole corporate member of Backus. Backus will continue as the parent of Backus Hospital. This will be accomplished by amending and restating the Certificate of Incorporation and Bylaws of Backus, Backus Hospital and the Backus Affiliates to make them consistent with those of the other Hartford System Members. As described below, Backus Hospital will remain a separate legal entity, with a separate medical staff and separate hospital license.
Community Considerations	Hartford HealthCare and Backus are committed to addressing the critical health care needs of the communities they serve, facilitating the continuation of community benefit programs and reinvestment in the Eastern CT Region, and ensuring the provision of care at the highest level of quality and patient safety delivered in an efficient manner. To demonstrate Hartford HealthCare's commitment to responding to the health needs of the Hartford System Members' communities, Hartford HealthCare will establish a system-level, board-designated fund to finance and support community benefit activities in the Eastern CT Region and other communities served by the Hartford System. The fund will assure continuation of the current levels of support provided by Backus Hospital for community benefit activities and serve as a spring board for expanded efforts to include communities throughout the Eastern CT Region. Backus Hospital will maintain charity and indigent care policies to implement this commitment that are consistent with Hartford HealthCare's charity and indigent care policies. To support an integrated delivery system with expanded geographic coverage, a full continuum of care and strong local primary, secondary and tertiary care services, the Parties agree to work cooperatively to encourage the return of patients originating within the Eastern CT Region back to the originating facility and its physicians for local and specialty care following treatment at any other Hartford System Member facility.
Employees	Hartford HealthCare will guarantee all pension obligations of existing Backus employees. Prior credit for length of service will be provided for any benefit plan consolidation.

	The Backus Chief Executive Officer ("CEO") will become an employee of Hartford HealthCare or its designee. On the Effective Date, all other employees of Backus and its affiliates will continue to be employed by their current employers.
Board Structure	Backus and Backus Hospital Boards: The current Backus and Backus Hospital Board membership will be retained for a period of three (3) years after the Effective Date (the "Transitional Period"), subject to the provisions of the revised Backus and Backus Hospital Bylaws adopted as of the Effective Date. During the Transitional Period, new members of the Backus and Backus Hospital Boards will be nominated and appointed in accordance with such Bylaws and the Bylaws of Hartford HealthCare. Hartford HealthCare shall appoint two individuals who shall each serve on both the Backus and Backus Hospital Boards as of the Effective Date and through the Transitional Period. During the Transitional Period, without limiting Hartford HealthCare's authority, prior to the removal of any Backus or Backus Hospital director, the Chair of the Hartford HealthCare Board shall consult with the Chair of the Backus Board regarding such proposed action; provided, however, that during the Transitional Period, Hartford HealthCare shall only exercise its powers to remove a Backus or Backus Hospital director if such removal is for cause. Hartford HealthCare Board: After the Effective Date, the Hartford HealthCare Board will be increased during the Transitional Period by two (2) additional members nominated by Backus and approved by Hartford HealthCare. During the Transitional Period, consistent with Hartford HealthCare's Bylaws, Hartford HealthCare will appoint representatives from the Backus Board to serve on Hartford HealthCare's Board Committees.
Management and Governance	The management and Board of Backus Hospital will continue to operate and manage its facilities, programs, and services on a day-to-day basis, subject to the Reserved Powers, as defined below. As part of the integration of Backus and Hartford HealthCare, the Backus CEO will report to the Hartford HealthCare CEO and the Backus and Backus Hospital Boards. The following decisions are subject to Hartford HealthCare's approval as the Sole Corporate Member (the "Reserved Powers"): – Approval of annual operating and capital budgets as developed by Backus, consistent with Hartford HealthCare's strategic plan; – Approval and removal of Board members, subject to the limitations set forth in the section regarding Board Structure above; – Amendments to the Articles or Bylaws of Backus or Backus Hospital in

	effect as of the Effective Date; provided, however, that Hartford HealthCare: (i) may not impose any changes during the Transitional Period to the Articles or Bylaws of Backus or Backus Hospital that are inconsistent with the terms of the Definitive Agreements; (ii) will consult with the Backus Board prior to implementing any changes to the Articles or Bylaws of Backus or Backus Hospital that are related to Hartford System-wide changes; and (iii) during the Transitional Period will obtain the prior approval of the Backus Board prior to imposing any changes to the Articles or Bylaws of Backus or Backus Hospital that only apply to Backus and Backus Hospital and are not related to Hartford System-wide changes; – Mergers, consolidations, divestitures, acquisitions, restructurings; – Sale, pledge, lease, transfer or other disposition of all or substantially all of the assets of Backus or Backus Hospital; – Borrowing of any sum in excess of one million dollars which has a stated term greater than one year or which is secured by a mortgage of all or any portion of Backus' or Backus Hospital's real property or by a security interest in Backus' or Backus Hospital's assets or revenues; – Dissolution or liquidation of Backus or Backus Hospital; – Filing of voluntary petition for bankruptcy; and – Any other matter that requires member approval under Connecticut law or pursuant to the Articles or Bylaws of Hartford HealthCare, Backus or Backus Hospital following the Effective Date. Notwithstanding the foregoing, Hartford HealthCare agrees that in exercising its Reserved Powers the following provisions shall apply: – During the Transitional Period, any decision to reduce or terminate any material clinical service or program that Backus Hospital provided at the time of the execution of the Definitive Agreements shall occur only after prior consultation with and consent of the Backus Hospital Board; – During the Transitional Period, any change of the Backus CEO shall be effectuated only after consultation with the Backus Board; – Until such time as Backus joins Hartford HealthCare's obligated group (as provided below), no transfer of cash will be made from Backus or any of the Backus Affiliates to Hartford HealthCare except for fair market value in the ordinary course of business or as permitted under applicable bond

	documents; – During the Transitional Period, Hartford HealthCare will maintain Backus Hospital as a separately incorporated acute care hospital and will not transfer ownership of Backus or Backus Hospital; – For a period of ten (10) years after the Effective Date, prior to initiation of any action, including merger, dissolution, consolidation or sale of Backus or Backus Hospital, or amendments to Backus or Backus Hospital's Certificate of Incorporation or Bylaws that would result in (i) the cessation of Backus Hospital as a licensed acute care hospital, or (ii) a change in Backus Hospital's corporate existence or tax-exempt status, Hartford HealthCare shall consult with the Backus Board regarding such proposed action; – During the Transitional period, in the event the actions described in (i) or (ii) are contemplated by Hartford HealthCare solely with respect to Backus, Hartford HealthCare will first present an affiliation unwind option to Backus for consideration and the Parties will engage in good faith discussion regarding the unwind of the Transaction. The provisions relating to the unwind will be described in the Definitive Agreements but will include a fair and reasonable transition period (e.g., two (2) years) for continuation at fair market value of Information Technology ("IT") and other support services that cannot practicably be transferred sooner; – In exercising its Reserved Powers Hartford HealthCare, as sole corporate member of Backus, will act in a manner it reasonably believes is in the best interests of the communities served by Backus and Hartford HealthCare; and – During the term of this MOU and until such time as the Definitive Agreements are executed, in the event Hartford HealthCare enters into a similar affiliation arrangement with another community acute care hospital or health system, Hartford HealthCare shall provide a copy to Backus of the agreements relating to such arrangement within fifteen (15) days of Hartford HealthCare entering into a binding agreement with such entity. If Backus determines in good faith that the terms of such arrangement are more favorable to such entity than the terms applicable to Backus hereunder or under the Definitive Agreements, Backus shall provide written notice to Hartford HealthCare within fifteen (15) days of receipt of the binding agreements. Within forty-five (45) days of Backus's delivery of such notice, Hartford HealthCare and Backus agree to amend the terms of this MOU or the Definitive Agreements, as applicable, to incorporate for the benefit of Backus such more favorable terms.

Capital Allocation Strategy	In addition to the capital commitments described in the section regarding Capital Commitments below, Backus will be treated in the same manner as all other Hartford System Members for purposes of capital allocation approvals and in accordance with the Hartford HealthCare Corporate Treasury Operating Guidelines. It is further understood that expenditures required to satisfy state or federal life safety requirements or to maintain licensure will be authorized outside of the normal budgetary process. Backus will provide Hartford HealthCare as much advance notice as possible with respect to the necessity to make such expenditures.
Strategic Planning and Synergies	Consistent with the Parties' vision described above, the Parties desire to create an integrated health system that expands and enhances the clinical programs and services available to the communities of the Eastern CT Region. The development of the Strategic Plan and the subsequent operation of the Eastern CT Region shall be a collaborative process consistent with the Hartford System's integrated-geared model. Process: The Parties shall develop the Strategic Plan through a collaborative process among Backus' executive management team and Board, Hartford HealthCare's executive management team, and other Hartford System leadership and boards in the Eastern CT Region. The Strategic Plan shall be coordinated with Hartford System's strategic plan and shall be presented to the Hartford HealthCare Board (which shall include two directors appointed by Backus as discussed above) for approval. Once approved, managerial and administrative oversight for the effective implementation of the Strategic Plan for the Eastern CT Region will reside with Backus' executive management with guidance and input from Hartford HealthCare and other Hartford System leadership and boards in the Eastern CT Region, and will be consistent and integrated with the strategic process and plan for the Hartford System. The Strategic Plan will be developed within 120 days after the Effective Date and shall include a comprehensive assessment and formal implementation plan for the Eastern CT Region, which will include, but not be limited to, the development of an ambulatory network. The Strategic Plan will include a projected capital budget and an estimated timeline for capital expenditures to be made in furtherance of the plan. The Hartford HealthCare Strategic Planning Committee will review progress under the Strategic Plan at least annually during the term of the capital commitment (described below). Within 90 days of the end of each year under the Strategic Plan, Hartford HealthCare will provide a report to the Backus Board on progress in meeting Plan objectives. In addition, the Annual Community Report issued by Backus and/or Hartford HealthCare shall contain detailed information regarding the current status of the implementation of each component of the Strategic Plan in a format suitable for distribution to the Eastern CT Region communities. It is the intention of the

	Parties that the Strategic Plan be developed in a collaborative manner, as described above, and implemented in a transparent manner designed to make Hartford HealthCare and Backus fully and continuously accountable to the communities served by the Eastern CT Region for the implementation of the Plan. If, during the Transitional Period, the Backus Board determines the Strategic Plan is not being implemented in a manner consistent with the provisions of the Definitive Agreement, including the requisite expenditure of capital funds sufficient to implement the Strategic Plan, after first consulting with the President of Hartford HealthCare, the Chairman of the Board of Backus may require that such matter be placed on the agenda of a meeting of the Board of Directors of Hartford HealthCare within sixty (60) days of such consultation. At such meeting, the Chairman will be given the opportunity to make a presentation setting forth the concerns of the Backus Board. The Hartford HealthCare Board will carefully consider such presentation and, within sixty (60) days of such meeting, will provide the Backus Board with its plan for addressing these concerns.
Capital Commitment	In consideration for completing the corporate member substitution and consistent with Backus becoming a full Hartford System Member, Hartford HealthCare will agree as a binding contractual obligation (and not as voluntary cash transfers), to the following minimum capital commitments: – $200 million in capital expenditures over ten (10) years to enhance and support clinical and operational capabilities, services and programs in the Eastern CT Region consistent with the Strategic Plan; – $25-50 million of such $200 million in capital expenditures shall be spent during an initial period specified in the Strategic Plan and shall be used to implement Eastern CT Regional programs and services including, but not limited to, operationalizing a comprehensive ambulatory network; and – $3 million, in addition to the $200 million described above, shall be available as of the Effective Date and shall be used to establish a Hartford HealthCare designated fund which will be replenished by Hartford HealthCare over a three (3)-year period, to support medical staff development and recruitment efforts for Backus and the Eastern CT Region.
Obligated Group	On the earliest date that is economically feasible following the Effective Date, unless Hartford HealthCare determines that the Hartford System would be better served by selecting a later date, Backus and Backus Hospital will join Hartford

	HealthCare's obligated group.
Programs/Services	As part of completing the corporate member substitution and consistent with Backus becoming a full Hartford System Member, and in developing the integrated health care system contemplated by the Parties, the following services and programs shall be maintained and/or considered for implementation along with any other items identified in the Strategic Plan, as well as programs and services identified from time to time as part of Hartford System-wide planning activities: – Establishment of an extensive primary care and ambulatory care network based on Patient-Centered Medical Homes, as certified by the National Committee for Quality Assurance; – Development of an ambulatory surgery network within the Eastern CT Region; – Creation of a Preventive Medicine Institute at Backus; – Enhancement of the delivery of cardiac care at Backus and for the Eastern CT Region with local specialists to include at least primary and an elective angioplasty and integrated congestive heart failure programs and on-site electrophysiology; – Development of a peripheral vascular program at Backus and for the Eastern CT Region in partnership with local providers; – Organization and development of a cancer services network for the Eastern CT Region in coordination with statewide programs developed by Hartford HealthCare; – Organization and development of a behavioral health network for the Eastern CT Region in coordination with statewide programs developed by Hartford HealthCare; – Maintain a trauma program verification of at least Level 3; – Ensure that a LIFE STAR air ambulance will be permanently based at the Backus Hospital campus in Norwich, Connecticut; and – Enhancement of current neonatology coverage of the nursery at Backus Hospital to 24/7 coverage. Backus representation will also be included on the Hartford HealthCare Quality

	Council and applicable focused clinical councils.
Medical Staff	Backus Hospital will maintain its current Medical Staff Bylaws; provided, however, that the Parties will work to ensure a cooperative privileging process. Backus Hospital will maintain an open medical staff with no restrictions on a physician's ability to refer patients. Backus Hospital physicians will have access to clinical research activities being conducted throughout the Hartford System, use of the Center for Education, Simulation and Innovation, and access to existing regional coverage arrangements. Backus and Hartford HealthCare will have access to the physician recruitment infrastructure and MSO functions of the organizations. Backus Hospital and its physicians will not be required to terminate any existing clinical affiliations.
Information Technology	As part of an integrated information system that will promote patient access, and enhance the quality of services throughout the system, the Parties will share IT system resources and develop new and expanded capabilities as part of a consistent information system. Hartford HealthCare will assist Backus Hospital in electronic medical record ("EMR") development and develop cost accounting or financial planning systems to assist in assessing variability of utilization costs by physician and service line. To facilitate this integrated system, the Parties agree to examine the Backus Business and Technology Center to serve as an information system data center for the Hartford System. As part of the diligence and negotiation of the Definitive Agreements, the Parties will perform a joint comprehensive IT assessment to identify synergies and opportunities to integrate the existing Backus EMR technology into the Hartford HealthCare IT system, and the Parties agree to integrate the existing Backus ambulatory clinical IT platforms into the Hartford HealthCare IT system. Notwithstanding the foregoing, following the Effective Date and during the Transitional Period, Hartford HealthCare will consult with Backus prior to effecting any change in Backus' clinical, financial or management IT platform(s).
Management Services	Central support service charges will be allocated to Backus on a basis consistent with other Hartford System Members.
Risk Management/Insurance	Backus and its employed physicians will participate in Hartford HealthCare's captive insurance program and private physicians affiliated with Backus will be eligible to participate in the captive insurance program, subject to customary underwriting requirements.

Miscellaneous	Except as otherwise set forth herein, the Parties acknowledge and agree that each Party will honor all of its donor restrictions and outstanding debt obligations, consistent with the terms of such instruments, and that nothing in the Definitive Agreements will interfere with such obligations. All permanently restricted contributions donated to Backus by third parties shall be utilized in accordance with donor intent. Major disputes, as further specified in the Definitive Agreements, will be settled by binding arbitration.

VI. CLOSING CONDITIONS

In addition to the conditions set forth above, consummation of the Transaction contemplated herein is subject to the following, which terms shall be incorporated into the Definitive Agreements:

(i) satisfactory completion of due diligence by each Party in its sole discretion;

(ii) the negotiation, execution and delivery by Hartford HealthCare and Backus of mutually satisfactory Definitive Agreements, which will contain all of the terms and conditions of Transaction;

(iii) satisfactory compliance with the requirements of, and receipt of satisfactory approvals from all governmental authorities, including, without limitation, Hart-Scott-Rodino approval, if required, and approval of the Connecticut Department of Public Health, and any other regulatory or governmental body necessary to consummate the Transaction; and

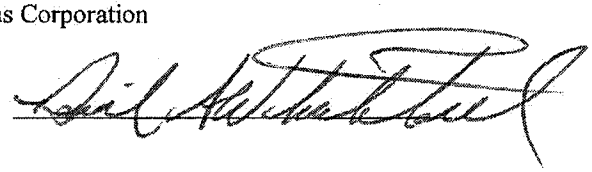
(iv) approval of the proposed Transaction by the governing boards of Hartford HealthCare and Backus, each in its or their sole discretion.

[Signature Page Follows]

If the foregoing accurately reflects your understanding of our discussions, please indicate your acceptance of this MOU by signing where indicated below on the enclosed copy of this letter and then returning that signed copy to the undersigned.

Very truly yours,

Backus Corporation

By: 

Acknowledged and Agreed:

Hartford HealthCare Corporation

By:

Exhibit 9

Affiliation Agreement

CONFIDENTIAL

AFFILIATION AGREEMENT

BY AND BETWEEN

HARTFORD HEALTHCARE CORPORATION

AND

BACKUS CORPORATION

August 17, 2012

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AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (the "**Agreement**") is made and entered into as of August 17, 2012 (the "**Execution Date**"), to be effective as of the Effective Time by and between Backus Corporation ("**Backus**") and Hartford HealthCare Corporation ("**Hartford HealthCare**"). Backus and Hartford HealthCare are each referred to herein as a "**Party**" and, collectively, as the "**Parties**" to this Agreement. ARTICLE 21 contains a glossary of all capitalized terms used in this Agreement.

RECITALS

WHEREAS, Hartford HealthCare, a Connecticut nonstock corporation exempt from federal income tax under 501(c)(3) of the Internal Revenue Code (the "**Code**"), is the sole corporate member of Hartford Hospital, MidState Medical Center, Natchaug Hospital, Windham Hospital, The Hospital of Central Connecticut, and other providers of health care services, and is the planning and integrating body for that system of health care entities (the "**Hartford System**"). The members of the Hartford System are collectively referred to herein as the "**Hartford System Members**."

WHEREAS, Backus, a Connecticut nonstock corporation exempt from federal income tax under 501(c)(3) of the Code, is the sole corporate member of The William W. Backus Hospital, a Connecticut nonstock corporation exempt from federal income tax under 501(c)(3) of the Internal Revenue Code ("**Backus Hospital**") and other Affiliates listed on Schedule 1. Each of Backus, Backus Hospital and the Affiliates of Backus is referred to herein as a "**Backus Entity**" and are collectively referred to herein as the "**Backus Entities**."

WHEREAS, Backus and Hartford HealthCare share a mutual commitment to develop an integrated delivery system with: expanded geographic coverage; a full continuum of care; strong local primary, secondary and tertiary care services; the highest standards of clinical care, enhanced patient access, including for underserved populations; and the most advanced technologies and service lines. The Parties recognize that the development of a truly integrated healthcare delivery system will further enhance their ability and the ability of their affiliated physicians and other health care providers to support their missions, identity and respective community roles.

WHEREAS, the Parties desire to expand Hartford HealthCare's integrated health care delivery system to achieve a higher level of quality, performance and efficiency. Central to this goal is the development of an Eastern Connecticut region consisting of Windham and New London counties (the "**Eastern CT Region**") utilizing Backus as its clinical nucleus. The Eastern CT Region will be integrated within the Hartford System and will expand and enhance the clinical programs and services available to those communities within the Eastern CT Region. Consistent with Hartford HealthCare's collaborative, value-driven geared approach, a strategic plan for acute and ambulatory care for the Eastern CT Region (the "**Strategic Plan**") will be developed by Backus, Hartford HealthCare and other Hartford System Members serving the Eastern CT Region in a manner consistent with the overall strategic plan for the Hartford System and will be implemented by Backus as further described herein.

WHEREAS, through collaborative planning to meet the challenging needs of the Eastern CT Region, including responsible decision-making and appropriate sharing of services, resources and technologies, Hartford HealthCare and Backus expect to achieve certain economies of scale that will benefit the communities they serve, including, but not limited to, additional opportunities for clinical research, teaching, implementation of quality initiatives (including sharing of best practices and clinical and process innovations), volume purchasing, consolidation of certain administrative services, opportunities for deployment of expensive technologies throughout the Hartford System, and the spreading of risk under risk-based payor contracts.

WHEREAS, pursuant to a Memorandum of Understanding dated May 25, 2012 (the "**MOU**"), the Parties agreed that the Backus Entities would become part of the Hartford System as of the Closing Date upon the terms and conditions set forth in the MOU.

WHEREAS, as contemplated by the MOU, the Parties wish to set forth the full and complete terms of their agreement with respect to the foregoing matters.

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which are forever acknowledged and confessed, the Parties agree as follows:

ARTICLE 1

CHANGE OF CORPORATE STRUCTURE

1.1 **Change of Membership**. Effective as of 12:00:01 a.m. (the "**Effective Time**") on the day after the Closing Date, as defined in Section 15.1, (the "**Closing**") of the transaction contemplated hereby (the "**Contemplated Transaction**"), Backus shall amend and restate its Governing Documents to provide that Hartford HealthCare shall be its sole corporate member, and to otherwise fulfill the terms and conditions of this Agreement. Backus will continue as the sole corporate member of Backus Hospital. Backus shall cause Backus Hospital and the other Backus Entities to amend and restate their Governing Documents to make them consistent with those of the other Hartford System Members. The amended and restated Governing Documents of Backus, Backus Hospital and the other Backus Entities shall be effective as of the Effective Time and are attached as Exhibit 1.1.

1.2 **Assets and Liabilities**. Except as otherwise set forth in this Agreement, the Contemplated Transaction shall not result in the transfer or conveyance as of the Closing Date of any asset or liability of either Party or any affiliate of either Party.

1.3 **Schematics**. Attached as Exhibit 1.3 are schematics showing the relevant pre-Closing and post-Closing organizational structure of the Parties.

ARTICLE 2

GOVERNANCE

2.1 Boards of Directors.

2.1.1 Composition. As of the Effective Time, the board of directors of each of Backus, Backus Hospital, and Hartford HealthCare (each a "**Board**") shall be structured and consist of directors ("**Directors**") as further described in this Section 2.1.

2.1.2 Post Closing-Date Board Structures.

(a) The pre-Closing Date Backus and Backus Hospital Board membership will be retained for a period of not less than three years after the Closing Date (the "**Transitional Period**"), subject to the provisions of the revised Backus and Backus Hospital Governing Documents adopted as of the Effective Time. During the Transitional Period, Directors of the Backus and Backus Hospital Boards will be nominated and appointed in accordance with such Governing Documents and the bylaws of Hartford HealthCare. The two individuals who are listed on Schedule 2.1.2(a)(i) shall be appointed by Hartford HealthCare as of the Effective Time to each serve on both the Backus and Backus Hospital Boards (the "**Hartford-Appointed Directors**"). The Hartford-Appointed Directors, or their replacements as appointed by Hartford HealthCare, shall serve on the Backus and Backus Hospital Boards throughout the Transitional Period. During the Transitional Period, without limiting Hartford HealthCare's authority, prior to the removal of any Backus or Backus Hospital Director, the Chair of the Hartford HealthCare Board shall consult with the Chair of the Backus Board regarding such proposed removal; provided, however, that during the Transitional Period, Hartford HealthCare shall only exercise its powers to remove a Backus or Backus Hospital Director if such removal is for cause. The names of the initial post-Closing Backus and Backus Hospital Directors are set forth on Schedule 2.1.2(a)(ii).

(b) The two individuals who are listed on Schedule 2.1.2(b)(i) shall be nominated by Backus and approved by Hartford HealthCare as of the Effective Time to serve on the Hartford HealthCare Board (the "**Backus-Appointed Directors**"). The Backus-Appointed Directors, or their replacements as nominated by Backus and approved by Hartford HealthCare, shall serve on the Hartford HealthCare Board throughout the Transitional Period. During the Transitional Period, consistent with Hartford HealthCare's bylaws, Hartford HealthCare will appoint members of the Backus Board to serve on the Hartford HealthCare Board committees listed on Schedule 2.1.2(b)(ii).

2.2 Reserved Powers. As the sole corporate member of Backus, Hartford HealthCare shall have the reserved powers (the "**Reserved Powers**") set forth in the amended and restated Governing Documents of Backus, Backus Hospital and the other Backus Entities, attached hereto as Exhibit 1.1 and as amended from time to time. Notwithstanding the foregoing, Hartford HealthCare agrees that in exercising its Reserved Powers the following provisions contained in this Section 2.2 shall apply.

2.2.1 During the Transitional Period, any decision to reduce or terminate any material clinical service listed on Schedule 2.2.1 that Backus Hospital provided as of the Execution Date shall occur only after prior consultation with, and the consent of, the Backus Hospital Board.

2.2.2 During the Transitional Period, any removal of the Backus Chief Executive Officer (the "**Backus CEO**") shall be made only after consultation with the Backus Board.

2.2.3 Until such time as Backus joins Hartford HealthCare's obligated group, no transfer of cash will be made from any Backus Entity to Hartford HealthCare, except for fair-market-value transfers occurring in the ordinary course of business or as otherwise permitted under applicable bond documents.

2.2.4 During the Transitional Period, Hartford HealthCare will maintain Backus Hospital as a separately-incorporated acute care hospital and will not transfer ownership of Backus or Backus Hospital.

2.2.5 For a period of ten years after the Closing Date, prior to initiating any action, including merger, dissolution, consolidation or sale of Backus or Backus Hospital, or amendments to Backus or Backus Hospital's Governing Documents that would result in: (a) Backus Hospital ceasing to operate its licensed acute care hospital; or (b) change of Backus Hospital's corporate existence or tax-exempt status, Hartford HealthCare shall consult with the Backus Board regarding such proposed action. During the Transitional Period, in the event the actions described in (a) or (b) are contemplated by Hartford HealthCare solely with respect to Backus, Backus shall first have an option to initiate an unwind process (the "**Unwind**") of the Contemplated Transaction by providing written notice to Hartford HealthCare. Upon receiving such notice, the Parties shall meet in good faith to establish a written plan that will describe the processes by which the Unwind shall be accomplished and the time frame in which the Unwind shall be accomplished; provided, however, that, among other items, the Unwind will include a fair and reasonable transaction period (e.g., two years) for continuation at fair market value of information technology and other support services that cannot practicably be transferred sooner.

2.2.6 In exercising its Reserved Powers, Hartford HealthCare, as sole corporate member of Backus, will act in a manner it reasonably believes is in the best interests of the communities served by Backus and Hartford HealthCare.

ARTICLE 3

STRATEGIC PLAN

3.1 Strategic Plan. Consistent with the Parties' vision as described in the Recitals, the Parties desire to create an integrated health system that expands and enhances the clinical programs and services available to the communities of the Eastern CT Region. The development

of the Strategic Plan and the subsequent operation of the Eastern CT Region shall be a collaborative process consistent with the Hartford System's integrated geared model.

3.2 **Process**. The Parties shall develop the Strategic Plan through a collaborative process among Backus' executive management team and Board, Hartford HealthCare's executive management team, and other Hartford System leadership and boards in the Eastern CT Region. The Strategic Plan shall be coordinated with the Hartford System's strategic plan and shall be presented to the Hartford HealthCare Board (which shall include two Directors appointed by Backus as described in Section 2.1.2(b)) for approval. The Strategic Plan shall be developed within 120 days after the Closing Date and shall include: (a) a projected capital budget and an estimated timeline for capital expenditures to be made in furtherance of the Strategic Plan in accordance with the capital commitments set forth in Section 16.1 and the program commitments set forth in Section 4.6; and (b) a comprehensive assessment and formal implementation plan for the Eastern CT Region, which will include, but not be limited to, the development of an ambulatory network.

3.3 **Implementation**.

3.3.1 Once approved by the Hartford HealthCare Board, responsibility for the effective implementation of the Strategic Plan for the Eastern CT Region will: (a) reside with the Backus CEO, under the direction of Hartford HealthCare with input from Hartford System leadership and boards in the Eastern CT Region; and (b) will be coordinated and integrated with the strategic process and plan for the Hartford System; provided, however, that the implementation and accountability for certain service line elements/components of the Strategic Plan will reside with applicable Hartford System management. The Hartford HealthCare Strategic Planning Committee will review progress under the Strategic Plan at least annually during the term of the capital commitments described in Section 16.1 and the applicable program/service line commitments set forth in Section 4.6.

3.3.2 Within 90 days of the end of each year under the Strategic Plan, Hartford HealthCare will provide a report to the Backus Board on progress in meeting Strategic Plan objectives. In addition, the Annual Community Report issued by Backus and/or Hartford HealthCare shall contain detailed information regarding the current status of the implementation of each component of the Strategic Plan in a format suitable for distribution to the Eastern CT Region communities. It is the intention of the Parties that the Strategic Plan be developed in a collaborative manner, as described above, and implemented in a transparent manner designed to make Hartford HealthCare and Backus fully and continuously accountable to the communities served by the Eastern CT Region for the implementation of the Strategic Plan.

3.3.3 If, during the Transitional Period, the Backus Board determines the Strategic Plan is not being implemented in a manner consistent with the provisions of this Agreement, including the requisite expenditure of capital funds sufficient to implement the Strategic Plan, after first consulting with the President of Hartford HealthCare, the Chairman of the Backus Board may require that such matter be placed

on the agenda of a meeting of the Hartford HealthCare Board within 60 days of such consultation. At such meeting, the Chairman of the Backus Board will be given the opportunity to make a presentation setting forth the concerns of the Backus Board. The Hartford HealthCare Board will carefully consider such presentation and, within 60 days of such meeting, will provide the Backus Board with a plan for addressing such concerns.

3.3.4 To further assure the timely implementation of the Strategic Plan, in the event that during the Transitional Period, Hartford HealthCare does not spend, or is not otherwise legally obligated to spend, at least $25 million on items specifically identified in the Strategic Plan, then an amount equal to the difference between the amount actually spent or otherwise legally committed by Hartford HealthCare on items specifically identified in the Strategic Plan and $25 million, (the "**Shortfall**"), shall be promptly deposited into an account to be used to implement the elements of the approved Strategic Plan. For purposes of determining whether a Shortfall exists, amounts which have been authorized by Hartford HealthCare but not actually expended, due to delays in receiving regulatory approvals, shall be counted towards satisfaction of Hartford HealthCare's commitment under the Strategic Plan (i.e., shall decrease the amount of the Shortfall).

ARTICLE 4

POST-CLOSING OPERATIONS OF BACKUS

4.1 Governance Generally. Following the Closing Date, the management and Board of Backus Hospital will continue to operate and manage Backus Hospital's facilities, programs, and services on a day-to-day basis in accordance with Hartford HealthCare policies and procedures in effect from time to time and subject to the Reserved Powers set forth in Section 2.2.

4.2 Hospital Name. From and after the Closing Date and in accordance with Hartford HealthCare policies and procedures in effect from time to time, the Backus Entities shall add a reference to their affiliation with Hartford HealthCare when using their respective names and to their signage, stationery and marketing materials.

4.3 Donor-Restricted Funds. Following the Closing Date, all bequests, gifts and endowments restricted as to use or manner of investment shall continue to be so restricted, and the Parties shall honor the donors' intent with respect thereto. All grants or funds received at any time by a Backus Entity and restricted by the donor to use by or at such entity, shall be the property of such Backus Entity.

4.4 Medical Staff.

4.4.1 The Closing shall not affect or otherwise change: (a) the medical staff privileges held by members of the medical staff of Backus Hospital on the Closing Date; or (b) the medical staff bylaws, rules and regulations, or credentialing procedures of Backus Hospital in effect on the Closing Date; provided, however, that the

Parties shall work to facilitate a cooperative Hartford system-wide privileging process and, where feasible, pursue opportunities for medical staff/clinical integration where doing so offers opportunities for advancement in quality of care.

4.4.2 Subject to generally-applicable Hartford HealthCare policies and procedures in effect from time to time, physicians on the medical staff of Backus Hospital shall have access to clinical research activities being conducted throughout the Hartford System, use of the Center for Education, Simulation and Innovation, and have access to regional coverage arrangements on the same basis as similarly-situated physicians on the medical staffs of other Hartford System Members. Backus shall have access to the physician recruitment infrastructure and management services organization functions of Hartford HealthCare. Backus Hospital and its physicians will not be required to terminate any existing clinical affiliations as of the Effective Time as a result of the Contemplated Transaction.

4.5 Risk Management/Insurance. Backus and its employed physicians shall participate in Hartford HealthCare's captive insurance program and private physicians affiliated with Backus shall be eligible to participate in the captive insurance program, subject to customary underwriting requirements.

4.6 Post-Closing Programs and Services. As part of completing the corporate member substitution and consistent with Backus becoming a Hartford System Member, and in developing the integrated health care system contemplated by the Parties, the services and programs described in this Section 4.6 shall be maintained and/or considered for implementation, as well as any other items identified in the Strategic Plan and programs and services identified from time to time as part of Hartford System-wide planning activities. Backus nominees will also be included on the Hartford HealthCare Quality Council and applicable focused clinical councils. The following programs, or enhancements to programs, shall be maintained or considered for implementation in the Strategic Plan as part of the Contemplated Transaction:

(a) Maintenance, at current levels and consistent with applicable health and safety requirements, a trauma program verification of at least Level 3 at Backus Hospital.

(b) Maintenance, on a permanent basis, of a LIFE STAR air ambulance at the Backus Hospital campus in Norwich, Connecticut.

(c) Establishment of an extensive primary care and ambulatory care network based on Patient-Centered Medical Homes, as certified by the National Committee for Quality Assurance.

(d) Development of an ambulatory surgery network within the Eastern CT Region.

(e) Creation of a Preventive Medicine Institute at Backus Hospital.

(f) Enhancement of the delivery of cardiac care at Backus Hospital and for the Eastern CT Region, with local specialists to include at least primary and an elective angioplasty, a congestive heart failure program integrated with existing programs in the Hartford System and on-site electrophysiology capability.

(g) Development of a peripheral vascular program at Backus Hospital serving the Eastern CT Region in partnership with local providers.

(h) Organization and development of a cancer services network for the Eastern CT Region with local specialist participation in coordination with statewide programs developed by Hartford HealthCare.

(i) Organization and development of a behavioral health network for the Eastern CT Region in coordination with statewide programs developed by Hartford HealthCare.

(j) Enhancement of current neonatology coverage at Backus Hospital to enable 24/7 coverage.

4.7 **Central Support Services**. The Parties anticipate that Hartford HealthCare will provide certain management, administrative or other services to the Backus Entities. Hartford HealthCare shall allocate a portion of the cost of such services to Backus based upon a reasonable allocation methodology determined by Hartford HealthCare that is consistent with the allocation methodology used for other Hartford System Members.

ARTICLE 5

EMPLOYEES

5.1 **Employment of Chief Executive Officer of Backus**. The Backus CEO will become an employee of Hartford HealthCare or its designee, effective as of the Effective Time. Such employment will be accomplished by the assignment of the Backus CEO's existing employment agreement with Backus to Hartford HealthCare. As part of the integration of Backus and Hartford HealthCare, the Backus CEO will report to the Hartford HealthCare Chief Executive Officer and the Backus and Backus Hospital Boards.

5.2 **Employment of other Backus Employees**. The Parties agree that the employees of the Backus Entities in good standing as of the Closing Date, other than the CEO of Backus described in Section 5.1 (the "**Employees**"), shall continue to be employed as of the Effective Time by the same Backus Entity in the same position and location at the same pay rates and with the same employee benefits and seniority as such Employees have on the Closing Date. No Employee shall be terminated from employment as a result of the Closing; provided, however, that nothing herein is intended to restrict the right of a Backus Entity to terminate, discipline, or change the duties of any Employee, or to engage in staff reductions or consolidations, prior to or after the Closing Date (to the extent such actions are consistent with the then-current applicable policies and procedures, any collective bargaining agreements, any employment agreements, and Applicable Law). All current Employee policies, promises, commitments and Benefit Plans

described in Schedule 17.15.1, including but not limited to policies regarding at-will employment, shall remain in effect after the Closing Date until the same are amended, modified, replaced or terminated and Employees shall retain credit for current employment experience and service with the applicable Backus Entity under the Contemplated Transaction for purposes of seniority recognition, benefits eligibility and accruals and vesting of benefits, in accordance with the provisions of those policies, promises, commitments, and Benefit Plans in effect from time to time and as governed by Applicable Law.

5.3 **Backus Pension Obligations**. Hartford HealthCare will guarantee all pension obligations of existing Backus Employees as of the Closing Date.

ARTICLE 6

COMMUNITY CONSIDERATIONS

6.1 **Community Benefit Activities Fund**. The Parties are committed to addressing the critical health care needs of the communities they serve, facilitating the continuation of community benefit programs and reinvestment in the Eastern CT Region, and ensuring the provision of care at the highest level of quality and patient safety delivered in an efficient manner. To demonstrate Hartford HealthCare's commitment to responding to the health care needs of the Hartford System Members' communities, Hartford HealthCare shall establish a Hartford System-level, Hartford HealthCare Board-designated fund to support community benefit activities in the Eastern CT Region and other communities served by the Hartford System. The fund will assure the continuation of the provision of community benefits through various programs and services provided from time to time by Backus Hospital and Hartford HealthCare and serve as a catalyst for expanded efforts to serve communities throughout the Eastern CT Region.

6.2 **Backus Hospital Charity and Indigent Care Policies**. To further the implementation of the Parties' commitment to responding to the health care needs of the Hartford System Members' communities, Backus Hospital shall maintain charity and indigent care policies that are consistent with Hartford HealthCare's charity and indigent care policies.

6.3 **Local Care Delivery**. To support an integrated delivery system with expanded geographic coverage, a full continuum of care and strong local primary, secondary and tertiary care services, the Parties agree to work cooperatively to encourage the return of patients originating within the Eastern CT Region back to the originating facility and its physicians for local and specialty care following treatment at any other Hartford System Member facility.

ARTICLE 7

INFORMATION TECHNOLOGY

7.1 **Integrated Information System**. As part of an integrated information system that will promote patient access and enhance the quality of services throughout the Hartford System, the Parties shall share information technology ("**IT**") system resources and develop new and expanded capabilities as part of a consistent information system. Hartford HealthCare shall assist

Backus Hospital in developing an integration plan for electronic medical record system ("**EMR**") and shall develop an integration plan for cost accounting or financial planning systems to assist Backus in assessing variability of utilization costs by physician and service line.

7.2 **Assessment of IT Synergies and Opportunities**. To facilitate the development of this integrated information system, the Parties shall undertake a comprehensive assessment to determine the capacity and feasibility of the Backus Business and Technology Center serving as an information system data center for the Hartford System. The Parties have performed an initial joint comprehensive IT assessment to identify synergies and opportunities to integrate the existing Backus EMR technology into Hartford HealthCare IT system. The Parties shall integrate the existing Backus ambulatory clinical IT platforms into the Hartford HealthCare IT system. Notwithstanding the foregoing, following the Closing Date and during the Transitional Period, Hartford HealthCare will consult with Backus prior to affecting any change in Backus' clinical, financial or management IT platform(s).

ARTICLE 8

EXECUTION OF THIS AGREEMENT

8.1 **Execution Date Deliveries**. The execution of this Agreement by the Parties shall be subject to receipt of the items specified in Sections 8.1.1, 8.1.2 and 8.1.3. No Party shall be deemed to have executed this Agreement until it has received or waived all required deliveries.

8.1.1 Hartford HealthCare Board Resolutions. On the Execution Date, Hartford HealthCare shall deliver to Backus a copy of resolutions of the Hartford HealthCare Board, certified by the Secretary of Hartford HealthCare as having been duly adopted and still in effect as of the Execution Date, authorizing and approving the execution of this Agreement, the performance of all actions to be taken on behalf of Hartford HealthCare pursuant to this Agreement, and the completion of all transactions contemplated herein.

8.1.2 Backus Board Resolutions. On the Execution Date, Backus shall deliver to Hartford HealthCare a copy of resolutions of the Backus Board, certified by the Secretary of Backus as having been duly adopted and still in effect as of the Execution Date, authorizing and approving the execution of this Agreement, the performance of all actions to be taken on behalf of the Backus Entities pursuant to this Agreement, and the completion of all transactions contemplated herein.

8.1.3 Exhibits and Schedules. On the Execution Date, each of Backus and Hartford HealthCare shall deliver to the other the Exhibits and Schedules that it is obligated to provide in accordance with Section 13.7 or Section 14.7, as applicable.

ARTICLE 9

TERMINATION

9.1 Termination of Agreement. This Agreement may be terminated prior to the Closing as set forth in this Section 9.1.

9.1.1 Termination by Hartford HealthCare or Backus. Either Hartford HealthCare or Backus may terminate this Agreement upon the occurrence of any of the following:

(a) the Closing shall not have occurred by 4:00 p.m. Eastern time on July 31, 2013 (the "**Termination Date**"); provided, however, that if the Closing shall not have occurred on or before the Termination Date due to a material breach of any representations, warranties, covenants or agreements contained in this Agreement by Hartford HealthCare or Backus, then the breaching Party may not terminate this Agreement pursuant to this Section 9.1.1(a) and the non-breaching Party may not terminate this Agreement until any applicable cure period required pursuant to Section 9.1.3(b) or 9.1.4(b) has ended. Notwithstanding the foregoing, if, despite having pursued with due diligence and timely submitted any and all applications or other filings required to obtain the regulatory approvals described in Sections 13.1 and 14.1, the Parties have not obtained all such regulatory approvals but are otherwise in compliance with their obligations under this Agreement, then either Party shall have the right to delay the Closing by 30 days by delivering to the other Party a written notice of its exercise of this right by not later than five business days prior to the earlier of the Termination Date or the date upon which the Parties have agreed the Closing is otherwise scheduled to occur; or

(b) there shall be in effect a final, non-appealable order of a court or other decision by a governmental body of competent jurisdiction restraining, enjoining, failing to issue a required consent or approval for, or otherwise prohibiting the consummation of the Contemplated Transaction.

9.1.2 Termination by Mutual Written Consent. This Agreement may be terminated at any time by the mutual written consent of Backus and Hartford HealthCare.

9.1.3 Termination by Hartford HealthCare. Hartford HealthCare may terminate this Agreement upon the occurrence of any of the following:

(a) if any of the conditions to the obligations of Hartford HealthCare set forth in ARTICLE 14 shall have become incapable of fulfillment, other than as a result of a breach by Hartford HealthCare of any covenant or agreement contained in this Agreement, and such condition is not waived by Hartford HealthCare; or

(b) if there shall be a material breach by Backus of any representation or warranty, or any covenant or agreement contained in this Agreement, which breach would provide Hartford HealthCare the right not to close the Contemplated Transaction pursuant to Sections 14.2 or 14.3 and which breach cannot be cured or has not been cured by the later of 20

business days after the giving of written notice by Hartford HealthCare to Backus of such breach or the Termination Date;

9.1.4 Termination by Backus. Backus may terminate this Agreement upon the occurrence of any of the following:

(a) if any of the conditions to the obligations of Backus set forth in ARTICLE 13, shall have become incapable of fulfillment, other than as a result of a breach by Backus of any covenant or agreement contained in this Agreement, and such condition is not waived by Backus; or

(b) if there shall be a material breach by Hartford HealthCare of any representation or warranty, or any covenant or agreement contained in this Agreement that would provide Backus the right not to close the Contemplated Transaction pursuant to Sections 13.2 or 13.3 and which breach cannot be cured or has not been cured by the later of 20 business days after the giving of written notice by Backus to Hartford HealthCare of such breach or the Termination Date.

9.1.5 Procedure For Termination. In the event of termination of this Agreement by Hartford HealthCare or Backus, or both, pursuant to Section 9.1, written notice thereof shall forthwith be given to the other Party, and upon the giving of such notice (or at such time as specified in the particular termination right set forth in Section 9.1) the Contemplated Transaction shall be abandoned and this Agreement shall terminate to the extent and with the effect provided by Section 9.1.6, without further action by Hartford HealthCare or Backus.

9.1.6 Effect of Termination.

(a) In the event that this Agreement is validly terminated as provided herein so that the Closing contemplated hereunder does not occur, then: (i) each of the Parties shall be relieved of its duties and obligations arising under this Agreement after the date of such termination; provided, however, that the obligations of the Parties set forth in the Confidentiality Agreement and those obligations specifically identified in this Agreement as surviving termination, shall survive any such termination and shall be enforceable in accordance with their terms; and (ii) each Party shall upon request return as soon as practicable any or all documents, work papers and other material of any other Party relating to its business or affairs or the Contemplated Transaction, whether obtained before or after the execution hereof, to the Party furnishing the same, other than any material that is, or has become, publicly available other than as a result of the breach of this Agreement.

(b) In the event that this Agreement is terminated pursuant to Section 9.1, all further obligations of the Parties under this Agreement shall terminate without further liability of either Party to the other, other than as provided in Section 9.1.1; provided, however, that nothing in this Section 9.1.6 shall relieve Backus or Hartford HealthCare of any liability for an intentional breach of any covenant in this Agreement prior to the date of termination.

ARTICLE 10

PRE-CLOSING COVENANTS OF BACKUS

Backus hereby agrees to keep, perform and fully discharge, or to cause to be kept, performed and fully discharged, as applicable, the following covenants and agreements, as applicable:

10.1 Interim Conduct of Business. From the Execution Date to the Closing Date:

10.1.1 Each Backus Entity shall:

(a) use commercially reasonable efforts to preserve, protect and maintain its business, properties and assets;

(b) operate its businesses as a going concern, consistent with prior practices and not other than in the ordinary course of business;

(c) use commercially reasonable efforts to preserve the goodwill of all individuals having business or other relations with it, including, without limitation, physicians, employees, patients, customers and suppliers; and

(d) obtain all documents called for by this Agreement and required to facilitate the consummation of the Contemplated Transaction.

10.1.2 Backus shall provide Hartford HealthCare with interim financial statements of the Backus Entities, as referenced in Section 17.4.1, as soon as practicable.

10.1.3 Unless the prior approval of Hartford HealthCare has been obtained, none of the Backus Entities shall:

(a) make any material changes, or permit any such changes to be made, in the Governing Documents of the Backus Entities, except for changes expressly authorized by this Agreement; or

(b) except as disclosed on Schedule 10.1.3(b), enter into any transaction which could constitute a Material Adverse Change with respect to the businesses of the Backus Entities, except for transactions expressly authorized by this Agreement.

10.2 Preserve Accuracy of Representations and Warranties. From the Execution Date to the Closing Date:

10.2.1 The Backus Entities shall take no action which would render any representation or warranty contained in ARTICLE 17 inaccurate or untrue as of the Closing Date.

10.2.2 Backus shall promptly notify Hartford HealthCare of any material lawsuits, claims, administrative actions or other proceedings asserted or commenced against any of the Backus Entities or their respective officers, directors or members, or materially affecting the businesses, properties or assets of the Backus Entities, or of the Real Property.

10.2.3 Backus shall promptly notify Hartford HealthCare of any facts or circumstances which come to its attention and which cause, or through the passage of time may cause, any of the representations and warranties made by Backus and contained in ARTICLE 17 to be untrue or misleading at any time from the Execution Date to the Closing Date.

10.3 Access to Information.

10.3.1 From the Execution Date to the Closing Date, each of the Backus Entities shall give to Hartford HealthCare and to its representatives full and free access, during normal business hours, to all properties, books, records and contracts and other materials pertaining to the businesses, properties and assets of the Backus Entities, as may be reasonably requested, and in accordance with guidelines approved by the Parties' antitrust counsel, subject to reasonable advance notice and provided that Hartford HealthCare shall not exercise such rights of access in such manner as would unduly interfere with the operations of the Backus Entities' personnel or the activities of patients or guests.

10.3.2 Backus shall cooperate in keeping Hartford HealthCare fully informed and shall promptly notify Hartford HealthCare of any Material Adverse Change in the normal course of business or prospects of the Backus Entities.

10.4 Maintain Books and Accounting Practices. From the Execution Date to the Closing Date, the Backus Entities shall maintain the books of account of the Backus Entities in the usual, regular and ordinary manner in accordance with generally accepted accounting principles ("**GAAP**") consistently applied and on a basis consistent with prior years, including, without limitation, the consistent use of assumptions, practices, procedures and terminology, and except as otherwise required by GAAP, the Backus Entities shall not make or cause to be made any material changes in the accounting methods or practices of the Backus Entities.

10.5 Compliance with Laws; Consents. From the Execution Date to the Closing Date, Backus shall use commercially reasonable efforts to, and to cause each of the other Backus Entities to:

10.5.1 comply with all Applicable Laws;

10.5.2 keep, hold and maintain all certificates, certificates of need, certificates of exemption, accreditation, licenses and other permits necessary for the conduct and operation of the Backus Entities; and

10.5.3 obtain expeditiously and, as applicable, cooperate fully with Hartford HealthCare in its efforts to obtain, all consents, approvals, exemptions and authorizations of third parties, whether governmental or private, make all filings, and give all notices which may be necessary or appropriate under all Applicable Laws and under all contracts, agreements and commitments to which the Backus Entity is a party or is bound in order to consummate the Contemplated Transaction and to the extent necessary for the valid execution, delivery and performance of this Agreement by Backus.

10.6 No Merger or Consolidation. From the Execution Date to the Closing Date, no Backus Entity shall merge or consolidate with any other entity, except with another Backus Entity, and the Backus Entities shall not acquire (except in the ordinary course) any of the assets of any other corporation, business or person, except as may first be agreed to in writing by Hartford HealthCare.

ARTICLE 11

PRE-CLOSING COVENANTS OF HARTFORD HEALTHCARE

Hartford HealthCare hereby agrees to keep, perform and fully discharge the following covenants and agreements:

11.1 Interim Conduct of Business. From the Execution Date to the Closing Date, Hartford HealthCare shall provide Backus with interim financial statements as soon as practicable.

11.2 Preserve Accuracy of Representations and Warranties. From the Execution Date to the Closing Date:

11.2.1 Hartford HealthCare shall take no action which would render any representation or warranty contained in ARTICLE 18 inaccurate or untrue as of the Closing Date.

11.2.2 Hartford HealthCare shall promptly notify Backus of any lawsuits, claims, administrative actions or other proceedings asserted or commenced against Hartford HealthCare, or its officers, directors or member involving in any material way the ability of Hartford HealthCare to consummate the Contemplated Transaction, or materially affecting Hartford HealthCare's business properties or its assets.

11.2.3 Hartford HealthCare shall promptly notify Backus in writing of any facts or circumstances which come to Hartford HealthCare's attention and which cause, or through the passage of time may cause, any of the representations and warranties contained in ARTICLE 18 to be untrue or misleading at any time from the Execution Date to the Closing Date.

11.3 No Merger or Consolidation; Similar Affiliation Arrangement. From the Execution Date to the Closing Date, Hartford HealthCare shall not merge into or consolidate with any other corporation, in a transaction in which Hartford Healthcare is not the surviving corporation, or sell or transfer substantially all its assets to any other entity. In addition, from the Execution Date until the Closing Date, in the event Hartford HealthCare enters into a similar affiliation arrangement with another community acute care hospital or health system, Hartford HealthCare shall provide a copy to Backus of the agreements relating to such arrangement within fifteen (15) days of Hartford HealthCare entering into a binding agreement with such entity. If Backus determines in good faith that the terms of such arrangement are more favorable to such entity than the terms applicable to Backus hereunder, Backus shall provide written notice to Hartford HealthCare within fifteen (15) days of receipt of the binding agreements. Within forty-five (45) days of Backus's delivery of such notice, Hartford HealthCare and Backus agree to amend the terms of this Agreement, as applicable, to incorporate for the benefit of Backus such more favorable terms.

11.4 Access to Information.

11.4.1 From the Execution Date to the Closing Date, Hartford HealthCare shall give Backus and its representatives full and free access, during normal business hours, to all properties, books, records and contracts and other materials pertaining to the businesses, properties and assets of Hartford HealthCare, as may be reasonably requested, and in accordance with guidelines approved by the Parties' antitrust counsel, subject to reasonable advance notice and provided that Backus shall not exercise such rights of access in such manner as would unduly interfere with the operations of Hartford Healthcare or the work of Hartford HealthCare personnel.

11.4.2 Hartford HealthCare shall cooperate in keeping Backus fully informed and shall promptly notify Backus of any Material Adverse Change in the normal course of business or prospects of Hartford HealthCare.

11.5 Compliance with Laws; Consents. From the Execution Date to the Closing Date, Hartford HealthCare shall:

11.5.1 comply with all Applicable Laws;

11.5.2 keep, hold and maintain all certificates, certificates of need, certificates of exemption, accreditation, licenses and other permits necessary for the conduct and operation of Hartford HealthCare; and

11.5.3 use commercially reasonable efforts to obtain and, as applicable, cooperate fully with Backus in its efforts to obtain, all consents, approvals, exemptions and authorizations of third parties, whether governmental or private, make all filings, and give all notices which may be necessary or appropriate under all Applicable Laws and under all contracts, agreements and commitments to which Hartford HealthCare is a party or is bound in order to consummate the Contemplated Transaction and to the extent necessary for the valid execution, delivery and performance of this Agreement by Backus.

11.6 **Third Party Authorizations**. From the Execution Date to the Closing Date, Hartford HealthCare shall cooperate fully with Backus in its efforts to obtain all consents, approvals, exemptions and authorizations of third parties, whether governmental or private, and to make all filings, necessary in order to consummate the Contemplated Transaction.

ARTICLE 12

PRE-CLOSING COVENANTS OF THE PARTIES

12.1 **Publicity**. No Party shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the Contemplated Transaction without the prior consent of the other Party, except for information and filings reasonably necessary to be directed to governmental agencies to effect fully and lawfully the Contemplated Transaction or required by Applicable Law; provided, however, that a Party shall notify the other prior to making any such filing with a governmental agency and provide the other Party with an opportunity to review such filing in accordance with guidance from its antitrust counsel.

12.2 **Consummation of Transactions**. Each Party shall use its commercially reasonable efforts to: (a) take all actions necessary or appropriate to consummate the Contemplated Transaction; and (b) cause the fulfillment at the earliest practicable date of all of the conditions to their respective obligations to consummate the Contemplated Transaction. Neither Party shall deliberately take any action or deliberately fail to take any action not permitted by this Agreement with the Knowledge and intention that such action or failure to take action would result in: (y) any of the representations and warranties of Backus or Hartford HealthCare, as the case may be, set forth in this Agreement becoming untrue; or (z) any of the conditions to the obligations of Backus or Hartford HealthCare, as the case may be, to close the Contemplated Transaction not being satisfied.

ARTICLE 13

CONDITIONS PRECEDENT TO OBLIGATIONS OF BACKUS

The obligation of Backus to consummate the Contemplated Transaction are subject to the fulfillment, prior to or on the Closing Date, of each of the following conditions contained in this ARTICLE 13 (any or all of which may be waived by Backus in whole or in part to the extent permitted by applicable Law).

13.1 **Regulatory Approvals**. All regulatory consents and approvals required for the consummation of the Contemplated Transaction shall have been obtained on or before the Closing Date, including, without limitation:

13.1.1 Hart-Scott-Rodino. The Parties shall have submitted their respective filings under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the rules and regulations thereunder (collectively, "**HSR Act**"), and all required waiting periods under the HSR Act shall have expired.

13.1.2 Health Planning. The Parties shall have obtained a certificate of need from the Connecticut Department of Public Health to consummate the Contemplated Transaction.

13.2 Accuracy of Representations and Warranties. The representations and warranties of Hartford HealthCare contained in ARTICLE 18, subject to any qualification as to materiality, shall be true and correct in all material respects at and as of the Closing Date as though made on the Closing Date, except to the extent such representations and warranties relate to an earlier date (in which case such representations and warranties shall be true and correct in all material respects on and as of such earlier date), and Backus shall have received a certificate signed by an authorized officer of Hartford HealthCare, dated the Closing Date, to the foregoing effect.

13.3 Performance of Covenants. Hartford HealthCare shall have performed all of the obligations and complied with each and all of the covenants, agreements and conditions required to be performed or complied with by it on or prior to the Closing Date.

13.4 No Pending Action. No action or proceeding before any court or governmental body shall be pending or threatened wherein an unfavorable judgment, decree or order would prevent the carrying out of this Agreement or the Contemplated Transaction, declare unlawful the Contemplated Transaction or cause such transactions to be rescinded.

13.5 No Bankruptcy. Hartford HealthCare shall not: (a) be in receivership or dissolution; (b) have made any assignment for the benefit of creditors; (c) have admitted in writing its inability to pay its debts as they mature; (d) have been adjudicated bankrupt; or (e) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Hartford HealthCare.

13.6 Consents. All consents, approvals and authorizations of third parties required for the consummation of the Contemplated Transaction or required by this Agreement shall have been obtained on or before the Closing Date.

13.7 Exhibits, Schedules and Statements. On the Execution Date, Hartford HealthCare shall deliver to Backus all Exhibits and Schedules required to be completed and delivered by Hartford HealthCare under this Agreement. Subsequent to the Execution Date, Hartford HealthCare may only revise any such Exhibits or Schedules upon the written consent of Backus.

13.8 Delivery of Hartford HealthCare Closing Documents. Hartford HealthCare shall have delivered, on or before the Closing Date, the Hartford HealthCare Closing Documents.

13.9 Delivery of Other Agreements. Hartford HealthCare shall have executed and delivered all other agreements reasonably determined by the Parties to be necessary or appropriate to be entered into as of the Closing Date, relating to the Contemplated Transaction.

13.10 No Catastrophic Losses or Liabilities. Following the Execution Date, Hartford HealthCare shall not have suffered or incurred any uninsured liabilities outside of the ordinary course of their businesses or uninsured casualty losses exceeding $200,000,000 in the aggregate.

13.11 Due Diligence. Backus shall have completed its due diligence investigation of Hartford HealthCare, and the resulting information from such investigation shall have been acceptable to Backus in its sole discretion; provided,howev er, that the Parties agree to have each completed their due diligence investigation of the other as of the Execution Date.

ARTICLE 14

CONDITIONS PRECEDENT TO OBLIGATIONS OF HARTFORD HEALTHCARE

The obligations of Hartford HealthCare to consummate the Contemplated Transaction are, at the option of Hartford HealthCare, subject to the satisfaction, on or prior to the Closing Date, of the following conditions:

14.1 Regulatory Approvals. All regulatory consents and approvals required for the consummation of the Contemplated Transaction shall have been obtained on or before the Closing Date, including, without limitation:

14.1.1 Hart-Scott-Rodino. The Parties shall have submitted their respective filings under HSR Act, and all required waiting periods under the HSR Act shall have expired.

14.1.2 Health Planning. The Parties shall have obtained a certificate of need from the Connecticut Department of Public Health to consummate the Contemplated Transaction.

14.2 Accuracy of Representations and Warranties. The representations and warranties of Backus contained in ARTICLE 17), subject to any qualification for materiality, shall be true and correct in all material respects at and as of the Closing, except to the extent such representations and warranties expressly relate to an earlier date (in which case such representations and warranties shall be true and correct in all material respects on and as of such earlier date) and Hartford HealthCare shall have received a certificate signed by an authorized officer of Backus, dated the Closing Date, to the foregoing effect; provided, however, that in the event any such representation or warranty has been breached the condition set forth in this Section 14.2 shall nevertheless be deemed satisfied unless the effect of all such breaches of representations and warranties taken together result in a Material Adverse Effect.

14.3 Performance of Covenants. Backus shall have performed all of the obligations and complied with each and all of the covenants, agreements and conditions required to be performed or complied with by it on or prior to the Closing Date.

14.4 No Pending Action. No action or proceeding before any court or governmental body shall be pending or threatened wherein an unfavorable judgment, decree or order would

prevent the carrying out of this Agreement or the Contemplated Transaction, declare unlawful the Contemplated Transaction or cause such transactions to be rescinded.

14.5 No Bankruptcy. No Backus Entity shall: (a) be in receivership or dissolution; (b) have made any assignment for the benefit of creditors; (c) have admitted in writing its inability to pay its debts as they mature; (d) have been adjudicated bankrupt; or (e) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against any Backus Entity.

14.6 Consents. All consents, approvals and authorizations of third parties, required for the consummation of the Contemplated Transaction shall have been obtained on or before the Closing Date.

14.7 Exhibits, Schedules and Statements. On the Execution Date, Backus shall deliver to Hartford HealthCare all Exhibits and Schedules required to be completed and delivered by Backus under this Agreement. Subsequent to the Execution Date, Backus may only revise any such Exhibits or Schedules upon the written consent of Hartford HealthCare.

14.8 Delivery of Closing Documents. Backus shall have delivered on or before the Closing Date the Backus Closing Documents.

14.9 Delivery of Other Agreements. The Backus shall have executed and delivered all other agreements reasonably determined by the Parties to be necessary or appropriate to be entered into as of the Closing Date, relating to the Contemplated Transaction.

14.10 No Catastrophic Losses or Liabilities. Followin g the Execution Date, no Backus Entity shall have suffered or incurred any uninsured liabilities outside of the ordinary course of their businesses or uninsured casualty losses exceeding $5,000,000 in the aggregate.

14.11 Due Diligence. Hartford HealthCare shall have completed its due diligence investigation of the Backus Entities, and the resulting information from such investigation shall have been acceptable to Hartford HealthCare in its sole discretion; provided, however, that the Parties agree to have each completed their due diligence investigation of the other as of the Execution Date.

ARTICLE 15

CLOSING

15.1 Closing Date; Closing. The Parties shall mutually agree upon a Closing Date that is as soon as practicable after the satisfaction or waiver by the appropriate Party of all of the conditions precedent to the Closing specified in ARTICLE 13, ARTICLE 14 and ARTICLE 15 (the "Closing Date"). Upon successful completion of the Closing pursuant to this Agreement, the Contemplated Transaction shall be effective as of the Effective Time.

15.2 Pre-Closing Actions. Prior to the Closing, the Parties shall take and cause to be taken all actions necessary or appropriate on their respective parts to implement the Contemplated Transaction on the Closing Date, including the following:

15.2.1 Actions by Hartford HealthCare: Prior to the Closing Date, the Hartford HealthCare Board shall approve the execution on behalf of Hartford HealthCare of any and all agreements and other documents and the taking of any and all other actions contemplated or required by this Agreement to be executed or taken by Hartford HealthCare on or before the Closing Date.

15.2.2 Actions by Backus: Prior to the Closing Date, the Backus Board shall approve the execution on behalf of Backus of any and all agreements and other documents, and the taking of any and all other actions contemplated or required by this Agreement to be executed or taken by Backus and the other Backus Entities on or before the Closing Date, including, without limitation, the following:

(a) approve the amended and restated Governing Documents of the Backus Entities, in substantially the forms attached as Exhibits 1.1, to become effective at the Effective Time; and

(b) take or approve the taking of any and all such other actions as are necessary or appropriate to consummate the Contemplated Transaction.

15.2.3 Actions by Backus Entities. Prior to the Closing Date, the Boards of the Backus Entities (other than Backus), as applicable, shall approve the execution on behalf of the applicable Backus Entity of any and all agreements and other documents, and the taking of any and all other actions contemplated or required by this Agreement to be executed or taken by such Backus Entity on or before the Closing Date, including, without limitation, the following:

(a) approve the amended and restated Governing Documents of the applicable Backus Entity, in substantially the forms attached as Exhibits 1.1, to become effective at the Effective Time; and

(b) take or approve the taking of any and all such other actions as are necessary or appropriate to consummate the Contemplated Transaction.

15.3 Closing Document Deliveries. At the Closing, the Parties shall deliver the documents described below.

15.3.1 Hartford HealthCare. At the Closing, Hartford HealthCare shall deliver the following documents (the "**Hartford HealthCare Closing Documents**"):

(a) a certificate of an authorized officer of Hartford HealthCare, dated as of the Closing Date, certifying as to the continued accuracy and completeness of Hartford HealthCare's representations and warranties, and its performance of the covenants and conditions precedent, set forth in this Agreement;

(b) a certificate of an authorized officer of Hartford HealthCare, dated as of the Closing Date, certifying as to the continued accuracy and completeness of the Exhibits and Schedules delivered by Hartford HealthCare in accordance with Section 13.7;

(c) a certificate of the Secretary of Hartford HealthCare, dated as of the Closing Date, certifying as to the due adoption and continued effectiveness of, and attaching a copy of, the resolutions of the Hartford HealthCare Board approving, with respect to Hartford HealthCare, the actions and transactions required or contemplated by this Agreement; and

(d) such other instruments and documents as may be reasonably necessary to carry out the Contemplated Transaction and to comply with the terms hereof.

15.3.2 Backus. At the Closing, Backus shall deliver the following documents (the "**Backus Closing Documents**"):

(a) a certificate of an authorized officer of Backus, dated as of the Closing Date, certifying as to the continued accuracy and completeness of representations and warranties of the Backus Entities and their respective performance of the covenants and conditions precedent, set forth in this Agreement;

(b) a certificate of an authorized officer of Backus, dated as of the Closing Date, certifying as to the continued accuracy and completeness of the Exhibits and Schedules delivered by Backus in accordance with Section 14.7;

(c) a certificate of the Chief Financial Officer of Backus, dated as of the Closing Date, certifying to the Knowledge of such officer as of the date thereof, as to the accuracy of the financial representations and warranties relating to the Backus Entities set forth at Sections 17.4 and 17.5;

(d) a certificate of the Secretary of Backus, dated as of the Closing Date, certifying as to the due adoption and continued effectiveness of, and attaching a copy of: (i) the resolutions of the Backus Board approving the Contemplated Transaction, including the amended and restated Governing Documents of the Backus Entities; (ii) the resolutions of the other Backus Entities approving amended Governing Documents for those Backus Entities and any transactions contemplated hereunder which are required, pursuant to the Backus Governing Documents in effect as of the Execution Date, to be approved by Backus; and (iii) the amended and restated Governing Documents of the Backus Entities;

(e) a certificate of the Secretary of Backus Hospital, dated as of the Closing Date, certifying as to the due adoption and continued effectiveness of, and attaching a copy of the resolutions of the Backus Hospital Board approving the Contemplated Transaction, including the amended and restated Governing Documents of the Backus Hospital set forth in Exhibit 1.1;

(f) a copy of the amended and restated applicable Governing Documents of the Backus Entities certified as of a recent date by the Secretary of State of the state of formation; and

(g) such other instruments and documents as may be reasonably necessary to carry out the transactions contemplated or required by this Agreement and to comply with the terms hereof.

ARTICLE 16

POST-CLOSING COVENANTS

16.1 Capital Commitments. In consideration for the carrying out of the Contemplated Transaction and consistent with Backus becoming a Hartford System Member, Hartford HealthCare hereby makes the following binding capital commitments, which shall be expended consistent with the Strategic Plan and pursuant to applicable Hartford HealthCare policies and procedures in effect from time to time, including its capital allocation policies and procedures:

16.1.1 Hartford HealthCare commits to spend $200 million in capital expenditures over a period of 10 years commencing on the Closing Date to enhance and support clinical and operational capabilities, services and programs in the Eastern CT Region in a manner consistent with the Strategic Plan; provided, however, that $25–$50 million of such $200 million shall be spent during an initial period specified in the Strategic Plan and shall be used to implement Eastern CT Regional programs and services including, but not limited to, operationalizing a comprehensive ambulatory network; and

16.1.2 Hartford HealthCare commits (in addition to the $200 million described in Section 16.1.1 above) to establish a $3 million Hartford HealthCare Board designated fund to support medical staff development and recruitment efforts for Backus and the Eastern CT Region (the "**Medical Staff Development Fund**"). The Medical Staff Development Fund shall be available as of the Effective Time and, at the end of each of the three succeeding years following the Closing, to the extent that the amount of the Medical Staff Development Fund is less than $3 million, Hartford HealthCare will deposit an amount into the Medical Staff Development Fund to bring the total amount available in the such fund to $3 million.

16.2 Capital Allocation. In addition to the capital commitments described above in Section 16.1, Backus will be treated in the same manner as all other Hartford System Members for purposes of capital allocation approvals, and in accordance with the Hartford HealthCare Corporate Treasury Operating Guidelines, and any other applicable policies and procedures, in effect from time to time. Expenditures required to satisfy state or federal life safety requirements or to maintain the licensure status of Backus Entities will be authorized outside of the normal budgetary process. Backus shall provide Hartford HealthCare as much advance notice as possible with respect to the necessity to make such expenditures.

16.3 Obligated Group. On the earliest date that is economically feasible, as determined by Hartford HealthCare, following the Closing, unless Hartford HealthCare determines that the Hartford System would be better served by selecting a later date, Backus and Backus Hospital shall join Hartford HealthCare's obligated group. Backus shall, and shall cause

Backus Hospital to, take such actions as are necessary to cause Backus and Backus Hospital to join Hartford HealthCare's obligated group.

ARTICLE 17

REPRESENTATIONS AND WARRANTIES OF BACKUS

Backus gives, as of the Execution Date, the following representations and warranties to Hartford HealthCare:

17.1 Due Organization; Legal Existence; Power. Each of the Backus Entities is duly formed and is validly existing under the laws of the respective states of formation, and has the corporate power and authority to own, operate or hold under lease its properties and assets and to carry on its business and operations as presently conducted. Each of the Backus Entities has registered with the proper governmental authorities all assumed names under which each of the Backus Entities operates its businesses, and continuously maintained all such filings in good standing.

17.2 Corporate Authorization.

17.2.1 Backus has the full corporate power and authority to enter into and to perform its obligations under this Agreement.

17.2.2 The execution, delivery and performance of this Agreement by Backus has been duly and properly authorized by all necessary corporate action in accordance with its Governing Documents.

17.2.3 This Agreement constitutes the valid and legally binding obligation of Backus, enforceable against it in accordance with its terms, except as enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium or other laws of general application now or hereafter in effect relating to or affecting the enforcement of creditors' rights generally.

17.3 No Violation; Approvals.

17.3.1 Except to the extent specified in Schedule 17.3.1, the execution, delivery and performance of this Agreement shall not result in the creation of any lien, charge, or encumbrance of any kind or the termination or acceleration of any indebtedness or other obligation of any Backus Entity, and is not prohibited by, does not violate or conflict with any provision of, and does not constitute a default under or breach of any Material Contract to which any Backus Entity is a party or is subject or by which any such corporation is bound, or any Applicable Law.

17.3.2 Except to the extent specified in Schedule 17.3.2, no approval, authorization, registration, consent, order or other action of or filing that has not occurred or been obtained with or from any person, including any court, administrative agency or other governmental authority, is required for the execution and delivery by

Backus of this Agreement or the consummation by Backus of the Contemplated Transaction, except for filings required pursuant to the HSR Act and the Connecticut certificate of need statute and regulations.

17.4 Financial Statements.

17.4.1 Attached as Schedule 17.4.1 are true and correct copies of: (a) audited, where available, financial statements of each of the Backus Entities for the three years ended September 30, 2009, September 30, 2010 and September 30, 2011; (b) audited consolidated financial statements of the Backus Entities for the three years ended September 30, 2009, September 30, 2010 and September 30, 2011; and (c) unaudited financial statements of the Backus Entities for the interim period from October 1, 2011, through the most recent month-end date for which financial statements were available prior to the Execution Date. From the Execution Date to the Closing Date, by the fifteenth day of the following month, Backus shall provide Hartford HealthCare with monthly unaudited financial statements for the immediately preceding month. (The financial statements referred to in this Section 17.4.1 shall collectively be referred to herein as the "**Backus Financial Statements**").

17.4.2 The Backus Financial Statements are complete and present fairly in all material respects the financial position of the Backus Entities, respectively, and the results of the respective operations of the Backus Entities at the dates and for the periods indicated, in conformity with GAAP (except as otherwise disclosed on Schedule 17.4.2), applied consistently for the periods specified, including the consistent use of assumptions, practices, procedures and terminology, except that the interim financial statements need not contain any of the footnotes required to comply with GAAP.

17.4.3 From and after October 1, 2011, (except as set forth in Schedule 17.4.3), the Backus Entities have not made any material changes to their accounting methods or practices, including methods or practices used to:

(a) establish reserves on any patient and notes and accounts receivable;

(b) establish estimates of any third-party settlements; and

(c) determine the value of any other accounts which require subjective determinations.

17.4.4 Except as disclosed on Schedule 17.4.4, to the Knowledge of Backus, the Backus Entities have no liabilities or obligations of any kind, whether contingent or absolute, direct or indirect, or matured or unmatured, which are not shown or provided for in the Backus Financial Statements provided to Hartford HealthCare prior to the Execution Date, other than claims covered by insurance and any individual liability or other obligation of less than $100,000, provided such liabilities and obligations in the aggregate do not exceed $1 million.

17.4.5 Except as disclosed on Schedule 17.4.5, none of the assets of the Backus Entities is subject to restrictions imposed by the donors of specific funds or other assets.

17.4.6 Set forth on Schedule 17.4.6 is an accurate and complete list of all of the accounts in which funds of or attributable to employee pension plans of all Backus Entities are invested or otherwise held. No Backus Entity has taken, or caused or permitted to be taken any action which would change the legal or beneficial ownership status of such funds prior to the Closing Date.

17.5 Interim Changes. Except for matters expressly permitted or authorized by this Agreement and except as set forth on Schedule 17.5, there has not been, after the date of the most recent interim financial statements provided for the Backus Entities on Schedule 17.4.1:

17.5.1 to the Knowledge of Backus, any change in the financial condition, assets, liabilities, properties or results of operation of the Backus Entities which has had or could have, in the aggregate, a materially adverse effect on the Backus Entities;

17.5.2 any damage, destruction or loss, whether or not covered by insurance, which has had or could have, in the aggregate, a Materially Adverse Effect on the Backus Entities;

17.5.3 any disposition by the Backus Entities of any property, rights or other assets owned by or employed in the Backus Entities, except for dispositions in the usual and ordinary course of the business;

17.5.4 any change to the make-up or composition of the Backus Board; and

17.5.5 any amendment or termination of any Material Contract which has had or could have, in the aggregate, a materially adverse effect on the Backus Entities.

17.6 Legal Proceedings. Except as disclosed on Schedule 17.6, none of the Backus Entities is a defendant in, or, to the Knowledge of Backus, threatened with any action, suit, proceeding, complaint, charge, hearing or arbitration which may materially and adversely affect their respective businesses or financial conditions or the ability of any of such corporations to perform hereunder. Except as disclosed on Schedule 17.6, none of the Backus Entities has received notice of any investigation or threatened investigation by any Federal, state or local governmental or regulatory agency, including those involving its business practices and policies, which could have, in the aggregate, a materially adverse effect on the Backus Entities.

17.7 Licenses and Permits.

17.7.1 To the Knowledge of Backus, each of the Backus Entities holds and is in compliance with all material and applicable governmental licenses, permits,

certificates, consents and approvals, noncompliance with which would have a material effect on its business and operations (the "**Licenses and Permits**"). The Licenses and Permits, each of which is listed on Schedule 17.7.1, are current, unrestricted and valid.

17.7.2 To the Knowledge of Backus, no statement of deficiencies, survey report, inspection report, notice of audit, audit results, complaint or other notice of noncompliance with the requirements, standards or other conditions of any revocation, termination, suspension or limitation of any of the Licenses and Permits has been issued, received, proposed or threatened, for which any actual or potential payment or other obligation exists, nor does Backus have any Knowledge of a material basis for any such action.

17.8 No Material Omissions.

17.8.1 Backus has responded in all material respects to all requests for information and documentation made by Hartford HealthCare in connection with its due diligence review of the business, operations, assets and liabilities of the Backus Entities. Backus has not knowingly omitted any material information relating to the businesses, operations, assets or liabilities of the Backus Entities in their respective responses to Hartford HealthCare's requests. Since the delivery of such responses to Hartford HealthCare, none of the Backus Entities has received and not disclosed any information which would render untrue or misleading in any material respect any information previously disclosed to Hartford HealthCare in response to their requests for information.

17.8.2 To the Knowledge of Backus, the representations and warranties of Backus contained in this Agreement, and each Exhibit, Schedule, certificate or other written statement delivered at Closing by Backus and Backus Hospital pursuant to this Agreement, are accurate, correct and complete in all material respects, do not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements and information contained therein not misleading.

17.9 Compliance with Law. Except as otherwise disclosed on Schedule 17.9, to the Knowledge of Backus, each of the Backus Entities is in compliance with all Applicable Laws, including without limitation all Health Care Laws, noncompliance with which would have a material effect on its business and operations.

17.10 Title to Real Property and Other Assets.

17.10.1 Schedule 17.10 lists all real property owned by any Backus Entity by common address, legal description and property identification number (the "**Owned Real Property**"). Except as set forth on Schedule 17.10, one or more of the Backus Entities is the sole and exclusive owner of all right, title and interest in and has good, marketable, and insurable fee simple title to the Owned Real Property free and clear of all liens, mortgages, security interests, options, pledges, charges, covenants, conditions, restrictions and other encumbrances and claims of any kind or character

whatsoever, other than covenants, restrictions and easements listed on Schedule 17.10 hereto. No Backus Entity knows of any unrecorded or undisclosed legal or equitable interest in any Real Property. Schedule 17.10 lists each lease or agreement to which any Backus Entity is a party under which it is a lessee or a lessor of any real property (together with any amendments thereto or other agreements affecting same, the "**Leases**", and the real property subject to such Leases, the "**Leased Real Property**", which together with the Owned Real Property is referred to as the "**Real Property**"). Each Lease is a valid agreement, duly authorized and entered into, without any default of any Backus Entity under such Lease and, to the Knowledge of the Backus Entities, without any default under such Lease of any other party to such Lease. With respect to each Lease, all insurance required to be obtained thereunder has been obtained and is currently in force and effect. The Backus Entities have not received or given a notice of default under the Leases other than notices with respect to defaults which have either been cured or waived. Except as set forth in Schedule 17.10, the Backus Entities have not assigned, transferred, conveyed, mortgaged, deeded in trust, or encumbered any interest in any leasehold or subleasehold under any Lease. All facilities leased or subleased under any Lease are supplied with utilities and other services to the extent reasonably necessary for the present operation of the facilities. Except as set forth in Schedule 17.10, no Backus Entity has leased or otherwise granted to any person or entity the right to use any Real Property or any portion thereof.

There are no outstanding options, right of first refusal, rights of first offer, or other rights to purchase any Real Property or any portion thereof or interest therein. The Real Property is accurately described in Schedule 17.10 and includes all real estate owned by the Backus Entities and used in connection with their current operations. Except as described on Schedule 17.10, with respect to the Real Property:

(a) No Backus Entity has received during the past three years notice of a violation of any Applicable Law;

(b) The Real Property and its operation are in compliance with, or has proper variances from, all applicable zoning, land use, public health, fire safety, building code or other similar ordinances, and the consummation of the Contemplated Transaction will not result in a violation of any ordinance or the termination of any such variance now existing;

(c) The Real Property is subject to no easements, restrictions, ordinances or such other limitations on title which restrict or impair its current use, except those which would have only an immaterial effect on such impacted Real Property, or the operation of the facilities thereon;

(d) There are no tenants or other persons or entities occupying any space in the Real Property, or claiming any possession, adverse or not, to any portion of the Real Property, other than pursuant to tenant leases described in Schedule 17.10, and no tenants have paid rent in advance for more than one month and no improvement credit or other tenant allowance of any nature is owed to any tenant, nor is any landlord improvement work required;

(e) As set forth in Schedule 17.10, each parcel of Real Property is either: (i) exempt from real property or ad valorem taxation pursuant to CONN. GEN. STAT. § 12-81(7) and the Backus Entities have received no notice and have no Knowledge that the status of such Real Property will change from exempt to taxable; or (ii) separately assessed for real estate tax purposes (with all imposed real estate taxes and assessment having been paid through the date hereof) and is not combined with any land or real estate which is not a part of the Real Property for real estate tax assessment purposes and the Backus Entities have not received any notice of change in assessed value which is not reflected in real property tax bills;

(f) No Backus Entity has received any notice of any existing, proposed or contemplated plans or contemplated eminent domain proceeding that would result in the taking of all or any part of the Real Property or that would adversely affect the current use of any part of the Real Property;

(g) To the Knowledge of Backus, all permanent certificates of occupancy and all other licenses, permits, authorizations, consents, certificates and approvals required by all governmental authorities having jurisdiction and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions) have been issued for the Real Property (and all individual items constituting the Real Property), have been paid for, are in full force and effect, are assignable by the Backus Entities, and will not be invalidated, violated or otherwise adversely affected by the assignment thereof or by any transfer of the Real Property to a Hartford System Member or by any change of Control of any Backus Entity;

(h) Water, sanitary sewer, storm sewer, drainage, electric, telephone, gas, fuel, oil, cable television and other public utility systems and lines serve the Real Property with capacity and in a manner adequate for the present use of the Real Property and are directly connected to the lines and/or other facilities of the respective public authorities or utility companies providing such services or accepting such discharge, either adjacent to the Real Property (in public ways abutting same) or through easements or rights-of-way appurtenant to and forming a part of the Real Property; and, to the Knowledge of the Backus Entities, such easements or rights-of-way have been fully granted, and all charges therefore have been fully paid by the Backus Entities and all charges for such utility systems and the connection of the Real Property to such systems, including, without limitation, connections fees, "tie-in" charges and other charges now or hereafter to become due and payable, have been fully paid by the Backus Entities; and the water and sanitary sewer service described above is supplied by public authority;

(i) None of the Real Property is served by a septic tank, and To the Knowledge of Backus Entities, there are no septic tanks located on any Real Property;

(j) The existing improvements located upon the Real Property do not encroach upon adjacent premises or upon existing utility company easements of record and existing restrictions of record on the applicable Real Property are not violated by the improvements located on the Real Property;

(k) All buildings, structures, fixtures, building systems and equipment on the Real Property and all components thereof are in sufficient repair and condition for the operation of the Backus Entities as currently conducted, reasonable wear and tear excepted. No Backus Entity knows of any latent or other defects in the Real Property, including but not limited to, roofs, electrical, plumbing, drainage, sewerage and HVAC and other mechanical systems at or serving the Real Property which have not been specifically reveal to Hartford Healthcare in writing prior to the date hereof.

(l) The Real Property is subject to no conditions, restrictions, ordinances, or other limitations that would make such property unusable for its current use or the title to such property unmarketable, which materially restrict or impair the current use or operation of the business in a manner consistent with the current use, or which would require the removal of any improvements, except which individually would not materially impair the value of or the continued use and operation by the Backus Entities.

17.10.2 Each of the Backus Entities has good and defensible title to all of its personal property of every kind, character and description, whether tangible or intangible, used in connection with the operation of the businesses of the Backus Entities, free and clear of all liens, mortgages, security interests, options, pledges, charges, covenants, conditions, restrictions and other encumbrances and claims of any kind or character whatsoever.

17.10.3 Except as set forth on Schedule 17.10.3: (a) to the Knowledge of Backus, the Real Property is in compliance, in all material respects, with all Environmental Laws; (b) the Backus Entities have not received any notice from the federal, state, or local government within the past three years alleging or asserting either a violation of any Environmental Law or a legal obligation to investigate, assess, remove, or remediate any part or all of the Real Property under or pursuant to any Environmental Law, nor have the Backus Entities received such notice from any other party within that time period alleging or asserting either a material violation of any Environmental Law or a legal obligation to investigate, assess, remove, or remediate any part or all of the Real Property under or pursuant to any Environmental Law; (c) the Backus Entities have not possessed, managed, processed, released, handled or disposed of or discharged Hazardous Substances at, on, or from the Real Property (including groundwater), except in compliance in all material respects with applicable Environmental Law; (d) the Backus Entities have no Knowledge that any prior owners, operators or occupants of the Real Property have caused or allowed any Hazardous Substances to be discharged, possessed, managed, processed, released, or otherwise handled on the Real Property in violation of any Environmental Law; (e) to the Knowledge of Backus, the Backus Entities are complying and, for the previous 3 years, have complied in all material respects with all applicable Environmental Law; (f) to the Knowledge of the Backus Entities, the Real Property does not contain asbestos-containing material in such form or condition for which abatement, repair or removal is required by applicable Environmental Law; and (g) there are no, nor to the Knowledge of the Backus Entities, have there ever been any, dumps, pits, landfills, or surface impoundments located on the Real Property for the disposal or containment of

Hazardous Substances. Backus shall promptly notify Hartford HealthCare should the Backus Entities obtain Knowledge, prior to the Closing Date, of any lien, written notice, litigation, or threat of litigation relating to any alleged or actual unauthorized release of any Hazardous Substance with respect to any part of the Real Property. Except as set forth on Schedule 17.10.3, to the Knowledge of the Backus Entities, none of the Backus Entities has sent, arranged for disposal or treatment, arranged with a transporter for transport for disposal or treatment, transported, or accepted for transport any Hazardous Substances, to a facility, site or location, which, pursuant to federal, state, or local law: (i) has been placed or has been publicly proposed by authorities having jurisdiction to be placed, on the National Priorities List or its state equivalent; or (ii) is subject to a claim, administrative order or other demand to take removal or remedial action by any person having jurisdiction and authority in the matter. Without limiting the generality of the foregoing, (x) all current or former underground storage tanks located on the Real Property of which the Backus Entities have Knowledge and all information in Backus Entities' possession relating to the capacity, uses, dates of installation and contents of such underground storage tanks located on the Real Property are identified in Schedule 17.10.3; and (y) all existing above ground and underground storage tanks used by the Backus Entities to store Hazardous Substances are in compliance in all materials respects with applicable Environmental Law.

17.11 Affiliates and Subsidiaries. Schedule 1 sets forth an accurate and complete list of all Backus Entities.

17.12 Tax-Exempt Status. Except as set forth on Schedule 17.12, each of the Backus Entities is exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code and is not a "private foundation" within the meaning of Section 509(a) of the Code. The IRS has not taken, or, to the Knowledge of the Backus Entities, proposed to take, any action to revoke the tax-exemption of any of the tax-exempt Backus Entities. Except as set forth on Schedule 17.12, the IRS has not determined in writing or, to the Knowledge of the Backus Entities, proposed to announce, that any of the Backus Entities is a "private foundation" within the meaning of Section 509(a) of the Code. Except as set forth on Schedule 17.12, none of the Backus Entities has Knowledge of any change in the organization or operation of any of the tax-exempt Backus Entities that would result in a loss of the Backus Entity's status as an organization described in Section 501(c)(3) of the Code or which could cause the Backus Entity to be treated as a "private foundation" within the meaning of Section 509(a) of the Code.

17.13 Insurance. Schedule 17.13 sets forth an accurate, correct and complete list (including the name of the insurer, coverage, premium and expiration date) of all binders and policies of insurance (collectively, the "**Insurance Policies**") maintained by the Backus Entities in which a Backus Entity is a named insured; or which otherwise insure assets used primarily in connection with the operation of the Backus Entities. Except as set forth on Schedule 17.13, the Insurance Policies are in full force and effect and shall remain in full force and effect through the Closing Date. Further, Backus' professional liability trust is solvent and actuarially sound.

17.14 Taxes. Backus Entities have filed, or shall file, all returns, declarations, and reports and all information returns and statements required to be filed or sent with respect to all Taxes for all periods ending on or within the six-year period preceding the Execution Date (collectively, the "**Returns**"). Except as set forth on Schedule 17.14, as of the time of filing, the Returns correctly reflected, and Returns prepared or being prepared but not yet filed as of the Execution Date, shall correctly reflect, the income, business, assets, operations, activities and status of the Backus Entities and any other information required to be shown therein. The Backus Entities have timely paid or made provision for all Taxes shown as due and payable on its Returns required to be filed or sent prior to the Execution Date and has made provision for timely payment of all Taxes that shall be shown as due and payable on its Returns required to be filed or sent by it after the Execution Date and relating to any period prior to the Closing Date.

17.15 Employee Benefits.

17.15.1 Schedule 17.15.1 sets forth an accurate, correct and complete list of all "employee welfare benefit plans" (as defined in Section 3(1) of ERISA), "employee pension benefit plans" (as defined in Section 3(2) of ERISA), and all other employee benefit plan agreements and arrangements and employee benefit policies, whether funded or unfunded, qualified or nonqualified, written or unwritten, subject to ERISA or not, maintained or contributed to (or required to be contributed to) by Backus Entities for the benefit of any of its officers, employees or other persons (all the foregoing being herein referred to as "**Benefit Plans**"). Backus Entities have delivered to Hartford HealthCare accurate, correct and complete copies of:

(a) Each Benefit Plan and all amendments thereto.

(b) The three most recent annual reports on Form 5500, if required, filed with the IRS or the Department of Labor with respect to any Benefit Plan, including all schedules and attachments.

(c) Each trust agreement, group annuity contract, insurance contract or other funding vehicle relating to any Benefit Plan and any amendments thereto.

(d) The three most recent certified financial statements relating to each Benefit Plan, as applicable, and the three most recent actuarial reports for any Benefit Plan which is a tax-qualified defined benefit pension plan.

(e) The summary plan description and all summaries of material modifications for each Benefit Plan.

(f) All collective bargaining agreements or other such contracts, including any riders or amendments thereto.

(g) Each determination letter, ruling letter or any outstanding ruling request on the tax-exempt status of any qualified Benefit Plan or any voluntary employees' beneficiary association implementing a Benefit Plan.

(h) A complete copy of any and all notices that were given by the IRS, the PBGC, or the Department of Labor to Backus Entities or its affiliates or any Benefit Plan within the three (3) years preceding the date of this Agreement (e.g., IRS audit requests, etc.).

(i) Complete copies of any and all notices that were given by Backus Entities or any Affiliate or any Benefit Plan to the IRS, the PBGC, the Department of Labor or any participant or beneficiary, pursuant to statute, within the three (3) years preceding the date of this Agreement, including notices that are expressly mentioned elsewhere in this Agreement.

(j) Complete copies of any voluntary correction filings made with respect to any Benefit Plan to the IRS or Department of Labor regarding any qualification or operational failure under such Benefit Plan whether submitting in writing to the governmental entity or pursued through self-correction methodologies.

(k) Each sample correspondence to employees giving notice of their rights under Section 4980B of the Code and any other documents indicating compliance with said Section 4980B, if applicable.

(l) The three most recent annual PBGC-1 forms, if required, filed with the PBGC with respect to any Benefit Plan, including all schedules and attachments.

17.15.2 To the Knowledge of the Backus Entities, the following statements with respect to the Benefit Plans are true in all material respects:

(a) Each such Benefit Plan listed on Schedule 17.15.1 is legally valid and binding as of the date of this Agreement and in full force and effect.

(b) All contributions to, and payments from, the Benefit Plans required to be made in accordance with the terms of the Benefit Plans and Applicable Law have been timely made. Except for those Benefit Plans disclosed on Schedule 17.15.1, no Benefit Plan is subject to the funding rules of Section 302 of ERISA or Section 412 of the Code.

(c) All Benefit Plans (and all related trust agreements or annuity contracts or any funding instruments) have been administered in accordance with their terms and comply currently, and have complied in the past, both as to form and operation, with the provisions of applicable tax laws, the Code and Applicable Law. To the extent that any Benefit Plan is a tax-qualified retirement plan, it has been maintained and administered in accordance with its terms and the provisions of applicable tax laws and the Code, where required for the Benefit Plan to be tax-qualified under Sections 401(a) and 501(a) of the Code, and all other Applicable Laws (including Code Section 403(b), if applicable), rules and regulations. The Benefit Plans that are pension benefit plans have received determination letters or private letter rulings from the IRS to the effect that such Benefit Plans are qualified and exempt from Federal income taxes under Sections 401(a) and 501(a), respectively, of the Code, or are church plans as defined in Code Section 414(e), and no such determination letter or private letter ruling has been revoked nor, to the Knowledge of any Backus Entity, has revocation been threatened, nor has any such Benefit Plan been amended or experienced any change in facts or circumstances since

the date of its most recent determination letter or private letter ruling or application therefor in any respect which would adversely affect its qualification or materially increase its cost.

(d) All reports, returns and similar documents with respect to the Benefit Plans required to be filed with any government agency or distributed to any Benefit Plan participant have been, or will be, duly and timely filed or distributed. To the Knowledge of the Backus Entities, there are no threatened or pending investigations by any governmental agency, termination proceedings or other claims (except claims for benefits payable in the normal operation of the Benefit Plans), suits or proceedings against or involving any Benefit Plan or asserting any rights or claims to benefits under any Benefit Plan that could give rise to any material liability, nor are there any facts that could give rise to any material liability in the event of any such investigation, claim, suit or proceeding.

(e) No "prohibited transaction" (as defined in Section 4975 of the Code or Section 406 of ERISA) has occurred which involves the assets of any Benefit Plan and which could subject any of the Backus Entities, or any of their respective Employees, or a trustee, administrator or other fiduciary of any trust created under any Benefit Plan, to the tax or penalty on prohibited transactions imposed by Section 4975 of the Code or the sanctions imposed under Title I of ERISA. No Benefit Plan which has been terminated has or may cause liability to any of the Backus Entities.

(f) Backus Entities has made appropriate entries in its financial records and statements for all obligations and liabilities under such Benefit Plans that have accrued but are not due.

(g) Neither Backus Entities nor any Affiliate has made any voluntary correction program submission to either the IRS or the Department of Labor with respect to any compliance failure or operational failure as relates to any Benefit Plan listed in Schedule 17.15.1.

(h) No statement, either written or oral, has been made by Backus Entities to any person with regard to any Benefit Plan that was not in accordance with the Benefit Plan and that could have an adverse economic consequence to Backus Entities or to Hartford.

(i) Each Benefit Plan contains authority to terminate providing Backus with the ability to terminate such Benefit Plan in the future, subject to Applicable Law.

(j) Neither Backus Entities nor any affiliate has filed a notice of intent to terminate any Benefit Plan or has adopted any amendment to treat a Benefit Plan as terminated. The PBGC has not instituted proceedings to treat any Benefit Plan as terminated. No event has occurred or circumstance exists that may constitute grounds under ERISA § 4042 for the termination of, or the appointment of a trustee to administer, any Benefit Plan.

(k) With respect to any defined benefit pension plan, Backus Entities has paid, if applicable, all amounts due to the PBGC pursuant to ERISA Section 4007. Further, no amendment has been made, or is reasonably expected to be made, to any Benefit Plan that has required or could require the provision of security under Code Section 401(a)(29). The actuarial

report for any pension plan pursuant to which Backus Entities or any affiliate participated, fairly presents the financial condition and the results of operations of each such pension plan in accordance with GAAP. Since the last valuation date for each pension plan pursuant to which Backus Entities or any affiliate participated, no event has occurred or circumstance exists that would increase the amount of benefits under any such pension plan or that would cause the excess of pension plan assets over benefit liabilities (as defined in ERISA Section 4001) to decrease, or the amount by which benefit liabilities exceed assets to increase, other than the normal market fluctuation of the investments from time to time. No reportable event (as defined in ERISA Section 4043 and in regulations issued thereunder) has occurred. There is no fact or circumstance that may give rise to any liability of Backus Entities or Hartford HealthCare to the PBGC under Title IV of ERISA.

(l) With respect to any health and welfare plan, no event has occurred or circumstance exist that could result in an increase in premium costs of Benefit Plans that are insured, or an increase in benefit costs of such Benefit Plans that are self-insured, other than any such increase that has not had and is not reasonably likely to have a Material Adverse Effect. Further, neither Backus Entities nor any affiliate has established, maintained, or contributed to, or had any obligation to establish, maintain or contribute to: (I) a multiple employer welfare arrangement within the meaning of ERISA Section 3(40)(A), or (II) a voluntary employees' beneficiary association under Code Section 501(c)(9). Neither Backus Entities nor any other affiliate has any obligation to provide any medical, life or similar benefits to current or future retired or terminated employees, their spouses or dependents following termination of employment except as required in ERISA Section 601. Backus Entities has complied with the provisions of ERISA Section 601 et seq. and IRC Section 4980B.

(m) With respect to any executive compensation related matters, the consummation of the contemplated transactions will not: (I) entitle any current or former employee, officer, director or independent contractor of Backus Entities to severance pay, unemployment compensation or any other payment, (II) accelerate the time or payment or vesting, or increase the amount of payments or compensation due any such individual, or (III) result in any prohibited transaction described in ERISA Section 406 or IRC Section 4975 for which an exemption is not available. No payment that is owed or may become due to any director, officer, employee, or agent of Backus Entities or any affiliate will be non-deductible to Backus Entities or subject to tax under IRC Section 280G or Section 4999; nor will Backus Entities or any affiliate be required to "gross up" or otherwise compensate any such person because of the imposition of any excise tax on a payment to such person. Each Benefit Plan that is a "nonqualified deferred compensation plan" (as defined in Code Section 409A(d)(1)) has been operated since January 1, 2005 in good faith compliance with Code Section 409A and the underlying IRS guidance and Department of Treasury regulations.

17.16 Payment Programs. The Backus Entities listed on Schedule 17.16 are participating providers in the private, commercial and governmental payment and procurement programs (including, without limitation, Medicare and Medicaid) set forth on Schedule 17.16, which includes a complete and accurate list of all such Payment Programs in which the Backus Entities currently participate or with which they contract (the "**Payment Programs**"). Except as set forth on Schedule 17.16:

17.16.1 to the Knowledge of Backus, no Backus Entity is engaged in termination proceedings as to its respective participation in any Payment Program, nor has any Backus Entity received notice that its current participation in any Payment Program is subject to any contest, termination or suspension as a result of alleged violations or any noncompliance with participation requirements;

17.16.2 to the Knowledge of Backus, no Backus Entity has taken or committed to any action, entered into any agreement, contract or undertaking, or taken or omitted to take any other action of any nature whatsoever that was or is in violation of any applicable Payment Program condition of participation, contract, standard, policy, rule, regulation, procedure or other requirement, that individually or in the aggregate would be material;

17.16.3 and except as disclosed on the Backus Financial Statements, all billing and collection practices of each Backus Entity and, of any billing and/or collection agent acting on behalf of any Backus Entity, have been in compliance with all Health Care Laws and the conditions for participation, contracts, standards, policies, rules, regulations, manuals, procedures and requirements of all Payment Programs, noncompliance with which would have a material effect on its business and operations;

17.16.4 and except as disclosed on the Backus Financial Statements, to the Knowledge of Backus, all cost reports and cost statements submitted by the Backus Entities to any Payment Program are true, accurate and complete in all material respects and have been prepared and submitted in accordance with cost and accounting principles consistently applied that comply with all applicable Payment Program conditions for participation, contracts, standards, policies, rules, regulations, manuals, procedures and requirements, including, without limitation, Payment Program interpretations and guidance;

17.16.5 no cost reports or cost statements are open and unresolved;

17.16.6 and except as disclosed on the Backus Financial Statements, to the Knowledge of Backus, no Backus Entity has taken any of the following actions: submitted to any Payment Program any false, fraudulent, abusive or improper claim for payment, billed any Payment Program for any service not rendered or not rendered as claimed, or received and retained any payment or reimbursement from any Payment Program in excess of the proper amount allowed by Applicable Law and applicable contracts or agreements with the Payment Programs;

17.16.7 to the Knowledge of the Backus Entities, there is no audit, investigation, adverse action, or civil, administrative, or criminal proceeding threatened or pending relating to participation in any Payment Program by any Backus Entity; and with respect to the matters disclosed on Schedule 17.16, to the Knowledge of the Backus Entities, there is no basis for any such adverse action by the Payment Program against any Backus Entity;

17.16.8 to the Knowledge of the Backus Entities, no Payment Program has requested or threatened any recoupment, refund, or set-off from any Backus Entity, or imposed any fine, penalty or other sanction on any Backus Entity; and

17.16.9 the Backus Entities have complied, or will comply, in a timely manner with any notice, approval, application, submission, filing or other requirements of the Payment Programs with respect to the Contemplated Transaction, including, without limitation, any transfer or change of ownership requirements.

17.17 Accreditation. The Backus Entities listed on Schedule 17.17 are accredited by the organizations as are listed on Schedule 17.17 (collectively, the "**Accreditations**"). Except as set forth on Schedule 17.17; (a) the Accreditations have been duly obtained and are held by the Backus Entities, are current and valid, and are in full force and effect; (b) to the Knowledge of Backus, no event has occurred or other fact exists with respect to the Accreditations that allows, or after notice or lapse of time or both would allow, revocation, suspension, restriction, limitation or termination of any of the Accreditations or would result in any other impairment of the rights of the holder of any of the Accreditations that individually or in the aggregate would be material; (c) no notice from any accreditation organization in respect to the revocation, suspension, restriction, limitation or termination of any Accreditations has been issued, received or, to the Knowledge of Backus, proposed or threatened; and (d) no statement of deficiencies, survey report, inspection report, notice of audit, audit results, complaint or other notice of noncompliance with the requirements, standards or other conditions of any Accreditation has been issued, received or, to the Knowledge of Backus, proposed or threatened by any accreditation organization, for which any actual or potential payment or other obligation exists.

17.18 No Defaults. Except as listed on Schedule 17.18, to the Knowledge of Backus, no Backus Entity is in breach or default in any material respect under any term or provision of any Material Contract.

17.19 Exclusion from Health Care Programs. Except as listed on Schedule 17.19, neither any Backus Entity nor any of their respective officers, directors, agents or managing employees (as such term is defined in 42 U.S.C. §1320a-5(b)) nor any other employee, agent or independent contractor of any Backus Entity has been: (a) excluded from participating in any Federal Health Care Program (as defined in 42 U.S.C. § 1320a-7b(f)); (b) subject to sanction or been indicted or convicted of a crime, or pled *nolo contendere* or to sufficient facts, in connection with any allegation of violation of any Federal Health Care Program requirement or Health Care Law; (c) debarred or suspended from any federal or state procurement or nonprocurement program by any government agency; or (d) designated a Specially Designated National or Blocked Person by the Office of Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE 18

REPRESENTATIONS AND WARRANTIES OF HARTFORD HEALTHCARE

Hartford HealthCare gives as of the Execution Date the following representations and warranties to Backus:

18.1 Due Organization; Legal Existence; Power. Hartford HealthCare is an Connecticut nonstock corporation, exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code and is not a "private foundation" within the meaning of Section 509(a) of the Code. Hartford HealthCare is duly formed and is validly existing under the laws of the State of Connecticut and has the corporate power and authority to own, operate or hold under lease its properties and assets and to carry on its business and operations as presently conducted.

18.2 Corporate Authorization.

18.2.1 Hartford HealthCare has the full corporate power and authority to enter into and to perform their obligations under this Agreement.

18.2.2 The execution, delivery and performance of this Agreement by Hartford HealthCare has been duly and properly authorized by all necessary corporate action in accordance with its respective Governing Documents.

18.2.3 This Agreement constitutes the valid and legally binding obligation of Hartford HealthCare, enforceable against it in accordance with its terms, except as enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium or other laws of general application now or hereafter in effect relating to or affecting the enforcement of creditors' rights generally.

18.3 No Violation; Approvals.

18.3.1 Except to the extent specified in this Agreement or in Schedule 18.3.1, the execution, delivery and performance of this Agreement shall not result in the creation of any lien, charge, or encumbrance of any kind or the termination or acceleration of any indebtedness or other obligation of Hartford HealthCare, and is not prohibited by, does not violate or conflict with any provision of, and does not constitute a default under or breach of any Material Contract to which Hartford HealthCare is a party or is subject or by which any such corporation is bound, or any Applicable Law.

18.3.2 Except to the extent specified in Schedule 18.3.2, no approval, authorization, registration, consent, order or other action of or filing that has not occurred or been obtained with or from any person, including any court, administrative agency or other governmental authority, is required for the execution and delivery by Hartford HealthCare of this Agreement or the consummation by Hartford HealthCare of

the Contemplated Transaction, except for filings required pursuant to the HSR Act and the Connecticut certificate of need statute and regulations.

18.4 No Material Omissions.

18.4.1 Hartford HealthCare has responded in all material respects to all requests for information and documentation made by Backus in connection with its due diligence review of the business, operations, assets and liabilities of Hartford HealthCare. Hartford HealthCare has not knowingly omitted any material information relating to the businesses, operations, assets or liabilities of Hartford HealthCare or any of the Hartford System Members in it responses to Backus' requests. Since the delivery of such responses to Backus, Hartford HealthCare has not received and not disclosed any information which would render untrue or misleading in any material respect any information previously disclosed to Backus in response to their requests for information.

18.4.2 To the Knowledge of Hartford HealthCare, the representations and warranties of Hartford HealthCare contained in this Agreement, and each Exhibit, Schedule, certificate or other written statement delivered at Closing by Hartford HealthCare pursuant to this Agreement, are accurate, correct and complete in all material respects, do not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements and information contained therein not misleading.

18.5 Compliance with Law. To the Knowledge of Hartford HealthCare, except as set forth on Schedule 18.5, each of the Hartford System Members is in compliance with all Applicable Laws which are material to Hartford HealthCare's business and operations, taken as a whole.

18.6 Tax Exempt Status. Hartford HealthCare is exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code and is not a "private foundation" within the meaning of Section 509(a) of the Code. The IRS has not taken, or, to the Knowledge of Hartford HealthCare, proposed to take, any action to revoke the tax-exemption of Hartford HealthCare, and has not determined in writing or, to the Knowledge of Hartford HealthCare, proposed to announce, that Hartford HealthCare is a "private foundation" within the meaning of Section 509(a) of the Code. Hartford HealthCare does not have Knowledge of any change in its the organization or operation that would result in a loss of its status as an organization described in Section 501(c)(3) of the Code or which could cause it to be treated as a "private foundation" within the meaning of Section 509(a) of the Code.

18.7 Legal Proceedings. Except as disclosed on Schedule 18.7, none of the Hartford System Members is a defendant in, or, to the Knowledge of Hartford HealthCare, threatened with any action, suit, proceeding, complaint, charge, hearing, arbitration or state or federal governmental investigation which would materially and adversely affect the ability of Hartford HealthCare to perform its obligations under this Agreement. Except as disclosed on Schedule 18.7, Hartford HealthCare has not received notice of any investigation or threatened investigation by any Federal, state or local governmental or regulatory agency, including those

involving its business practices and policies, which could have, in the aggregate, a materially adverse effect on Hartford HealthCare.

ARTICLE 19

DISPUTE RESOLUTION

19.1 Dispute Resolution Procedures.

19.1.1 Meet and Confer. In the event of a dispute between Hartford HealthCare and Backus prior to the Closing or during the Transitional Period either may give notice to the other setting forth the nature of such dispute and requesting that the Parties meet and confer to discuss the dispute (the "**Meet and Confer Request**"). Not later than 30 days after receipt of a Meet and Confer Request, the Dispute Representatives shall meet and confer to discuss the dispute in good faith in an attempt to resolve the dispute. The Dispute Representatives shall meet at such dates and times as are mutually convenient to the Dispute Representatives within such 30-day period. For purposes of this ARTICLE 19:

(a) "**Dispute Representatives**" shall mean the Hartford HealthCare Dispute Representatives and the Backus Dispute Representatives.

(b) "**Hartford HealthCare Dispute Representatives**" shall mean the Hartford HealthCare Chief Executive Officer and his or her designee.

(c) "**Backus Dispute Representatives**" shall mean the Backus Chief Executive Officer and his or her designee.

19.1.2 Binding Arbitration. All Material Disputes shall be decided through a binding arbitration process. A "Material Dispute" shall mean any dispute related to the limitations on Hartford HealthCare's Reserved Powers described in Sections 2.2.1 through 2.2.5 and with respect to the removal of a Backus or Backus Hospital Board Director pursuant to Section 2.1.2. Either Party shall provide notice of such Party's intention to submit the Material Dispute to the binding arbitration process pursuant to this Section 19.1.2.

(a) Not later than 30 days after such notice, the Parties shall jointly select an arbitrator. Arbitration proceedings shall be conducted in Hartford, Connecticut, in accordance with the American Health Lawyers' Association ("**AHLA**") Alternative Resolution Service arbitration rules, except as modified herein.

(b) Not later than 60 days after the date on which the arbitrator is selected, the arbitrator shall conduct a formal hearing into the Material Dispute in accordance with the applicable rules for arbitration of the AHLA then in effect.

(c) The arbitrator shall not have the authority to order the termination or rescission of this Agreement unless Hartford HealthCare and Backus otherwise agree in writing prior to the commencement of the formal hearing.

(d) The arbitrator's decision shall be final and binding upon the Parties and shall be enforceable in accordance with its terms under Connecticut law.

(e) The Parties shall share equally in the cost of arbitration, including the arbitrator's fees, but each Party shall bear its own legal and other expenses incurred by it in connection with the arbitration.

ARTICLE 20

GENERAL PROVISIONS

20.1 Confidentiality. The Parties agree that the Confidential Information provided to each other in connection with this Agreement and the consummation of the Contemplated Transaction is subject to the terms of the Confidentiality and Non-Disclosure Agreement entered into between the Parties and dated July 20, 2011 (the "**Confidentiality Agreement**"), the terms of which are incorporated herein by reference and, to the extent applicable, supersede any conflicting or inconsistent provisions contained in this Agreement. For purposes of this Section 20.1, "**Confidential Information**" means any confidential information with respect to, including, methods of operation, customers, customer lists, prices, fees, costs, technology, inventions, trade secrets, know-how, software, marketing methods, plans, personnel, suppliers, competitors, markets or other specialized information or proprietary matters.

20.2 Notices. All notices, requests, demands and other communications under this Agreement shall be in writing and shall be deemed to have been duly given or made as follows: (a) if sent by registered or certified mail in the United States return receipt requested, upon receipt; (b) if sent designated for overnight delivery by nationally recognized overnight air courier (such as Federal Express, UPS or DHL), one business day after mailing; (c) if sent by facsimile transmission or electronic mail before 5:00 p.m. (sender's time), when transmitted and receipt is confirmed through a delivery report; (d) if sent by facsimile transmission or electronic mail after 5:00 p.m. (sender's time) and receipt is confirmed through a delivery report, on the following business day; and (e) if otherwise actually personally delivered, when delivered, provided that such notices, requests, demands and other communications are delivered to the address set forth below, or to such other address as either Party shall provide by like notice to the other Parties:

Hartford HealthCare: One State Street
Suite 19
Hartford, CT 06103
Attn: President and CEO

With a simultaneous copy to:	One State Street Suite 19 Hartford, CT 06103 Attn: General Counsel
Backus:	Backus Corporation 326 Washington Street, Norwich, Connecticut 06360 Attn: President and CEO
With a simultaneous copy to:	Ropes & Gray LLP Prudential Tower, 800 Boylston Street Boston, MA 02199-3600 Attn: Anne P. Ogilby

20.3 **Expenses**. Except as otherwise provided in this Agreement, the Parties shall each pay their own fees and expenses and those of their respective agents, advisors, consultants, attorneys and accountants with respect to the transactions described in this Agreement, their respective due diligence investigations, and the negotiation of the Agreement and the Closing. Notwithstanding anything to the contrary, Hartford HealthCare and Backus shall share equally in the cost of any fees charged by any government agency in connection with notices or other filings as may be required under the HSR Act.

20.4 **No Brokerage**. The Parties represent to each other that no broker has in any way been contacted in connection with the Contemplated Transaction. Each Party agrees to indemnify the other Parties from and against all loss, cost, damage or expense arising out of claims for fees or commissions of brokers employed or alleged to have been employed by such indemnifying Party.

20.5 **Entire Agreement; Amendment**. This Agreement, including all Schedules, Exhibits and statements required hereunder, supersedes all previous agreements, oral or written, and constitutes the entire agreement among the Parties respecting the subject matter of this Agreement, and no Party shall be entitled to benefits other than those specified herein. Each Exhibit, Schedule and statement referenced in this Agreement shall be considered a part hereof as if set forth herein in full. As among the Parties, oral statements or prior written material which are not specifically incorporated herein shall not be of any force and effect. The Parties specifically acknowledge that in entering into and executing this Agreement, the Parties rely solely upon the representations and agreements contained in this Agreement and no others. This Agreement may be amended or modified only by an agreement in writing signed by all the Parties.

20.6 **Non-Assignment**. This Agreement shall be binding upon and inure to the benefit of the Parties and their respective permitted successors, assigns and legal representatives, but no Party may assign its rights in this Agreement or delegate its duties under this Agreement to a third party by any means without first obtaining the prior written consent of the other Party.

20.7 No Third-Party Beneficiaries. Except as expressly set forth herein, this Agreement shall not confer any rights or remedies upon any person or other third party other than the Parties and their respective successors and permitted assigns.

20.8 Third Party Authorizations. From the Execution Date to the Effective Time, each of the Parties shall use its reasonable best efforts to obtain expeditiously all consents, authorizations and other approvals of third parties necessary for the valid execution, delivery and performance of this Agreement by the Party.

20.9 Consents, Approvals and Discretion. Except as herein expressly provided to the contrary, whenever this Agreement requires any consent or approval to be given by a Party or a Party must or may exercise discretion, the Parties agree that such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

20.10 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable, in whole or in part, for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice or disturb the validity of any remaining provision of this Agreement, which shall be and remain in full force and effect, and binding and enforceable in accordance with its terms.

20.11 Applicable Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Connecticut; provided, however, that the conflicts of law principles of the State of Connecticut shall not apply to the extent they would operate to apply the laws of another state. The Parties hereby consent to the jurisdiction of Connecticut courts over all matters relating to this Agreement.

20.12 Headings; Cross References. Headings of Articles and Sections in this Agreement and the table of contents hereof are solely for convenience or reference, do not constitute a part hereof and shall not affect the meaning, construction or effect hereof. Unless indicated otherwise, references in this Agreement to Articles, Sections, Schedules and Exhibits are to articles, sections, schedules and exhibits of this Agreement.

20.13 Construction. Each Party has engaged separate independent legal counsel and independent advisors to provide advice and guidance to such Party. This Agreement and all documents or instruments delivered pursuant hereto shall be construed without regard to the identity of the person who drafted the various provisions of the same. Each and every provision of this Agreement and such other documents and instruments shall be construed as though the Parties participated equally in the drafting of the same. Consequently, the Parties acknowledge and agree that any rule of construction that a document is to be construed against the drafting Party shall not be applicable to this Agreement.

20.14 Waiver of Terms. The failure of either Party to insist, in any one or more instances, on performance of any of the terms, covenants and conditions of this Agreement shall not be construed as a waiver or relinquishment of any rights granted hereunder or thereunder or of the future performance of any such term, covenant or condition, but the obligations of the Parties with respect thereto shall continue in full force and effect. A waiver by one Party of the performance of any covenant, condition, representation or warranty of the other Party shall not

invalidate this Agreement, nor shall such waiver be construed as a waiver of any other covenant, condition, representation or warranty. A waiver by either Party of the time for performing any act shall not constitute a waiver of the time for performing any other act or the time for performing an identical act required to be performed at a later time.

20.15 Counterparts; Facsimile and pdf Signatures. The Parties agree that this Agreement may be executed in multiple originals, each of which shall be considered an original for all purposes and, collectively, shall be considered to constitute this Agreement. The Parties further agree that signatures transmitted by facsimile or in Portable Document Format (pdf) may be considered an original for all purposes, including, without limitation, the execution of this Agreement and enforcement of this Agreement.

20.16 Time is of the Essence. Time is hereby expressly made of the essence with respect to each and every term and provision of this Agreement and any other agreements determined by the Parties to be necessary or appropriate to be entered into in connection with the Contemplated Transaction.

20.17 Force Majeure. If either Party is rendered unable to perform its duties under this Agreement, in whole or in part, by reason of any event that is not reasonably under its control (including, but not limited to, Acts of God, fires, floods, earthquakes, accidents, strikes, riots, national emergencies, changes of law or regulations and other such *force majeure* events), then any duty so impacted will be suspended during such event. The Party rendered unable to perform due to *force majeure* must promptly notify the other Party and use reasonable efforts to overcome the *force majeure* event, and neither Party shall be responsible to the other Party for any losses resulting from such force majeure.

ARTICLE 21

GLOSSARY

21.1 Glossary. For convenience, set forth below is a glossary of defined terms used in this Agreement:

21.1.1 "**Accreditations**" shall have the meaning set forth in Section 17.17.

21.1.2 "**Affiliate**" means any entity which is under the Control of, or which is under common Control with, the subject entity.

21.1.3 "**Agreement**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.4 "**AHLA**" shall have the meaning set forth in Section 19.1.2(a).

21.1.5 "**Applicable Law**" shall mean all applicable federal, state and local laws, statutes, ordinances, rules, regulations, codes and any judgment, decree, order, writ or injunction of any court or regulatory authority.

21.1.6 "**Backus**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.7 **"Backus-Appointed Directors"**shall have the meaning set forth in Section 2.1.2(b).

21.1.8 "**Backus CEO**" shall have the meaning set forth in Section 2.2.2

21.1.9 **"Backus Closing Documents"** shall have the meaning set forth in Section 15.3.2.

21.1.10 "**Backus Dispute Representative**" shall have the meaning set forth in Section 19.1.1(c).

21.1.11 "**Backus Entity**" or "**Backus Entities**" shall have the meaning set forth in the Recitals.

21.1.12 "**Backus Financial Statements**" shall have the meaning set forth in Section 17.4.1.

21.1.13 "**Backus Hospital**" shall have the meaning set forth in the Recitals.

21.1.14 "**Backus Hospital Board**" means the Board of Directors of Backus Hospital.

21.1.15 "**Benefit Plans**" shall have the meaning set forth in Section 17.15.1.

21.1.16 "**Board**" shall have the meaning set forth in Section 2.1.1.

21.1.17 "**Closing**" shall have the meaning set forth in Section 1.1.

21.1.18 "**Closing Date**" shall have the meaning set forth in Section 15.1.

21.1.19 "**Code**" shall have the meaning set forth in the Recitals.

21.1.20 "**Confidential Information**" shall have the meaning set forth in Section 20.1.

21.1.21 "**Confidentiality Agreement**" shall have the meaning set forth in Section 20.1.

21.1.22 "**Contemplated Transaction**" shall have the meaning set forth in Section 1.1.

21.1.23 **"Control"** means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity whether through ownership of voting securities, by contract or otherwise.

21.1.24 "**Directors**" shall have the meaning set forth in Section 2.1.1.

21.1.25 "**Dispute Representatives**" shall have the meaning set forth in Section 19.1.1(a).

21.1.26 "**Eastern CT Region**" shall have the meaning set forth in the Recitals.

21.1.27 "**Effective Time**" shall have the meaning set forth in Section 1.1.

21.1.28 "**Employees**" shall have the meaning set forth in Section 5.2.

21.1.29 "**EMR**" has the meaning set forth in Section 7.1.

21.1.30 "**Environmental Law**" shall mean federal, state or local statutes and ordinances, and all rules and regulations promulgated thereunder, common law, orders, consent decrees, permits, and binding judicial and administrative interpretations thereof, pertaining or relating to: (a) natural resources and the environment, (b) public and worker health and safety; and (c) the identification, reporting, generation, manufacture, processing, distribution, use, treatment, storage, disposal, emission, discharge, release, transport or other handling of any Hazardous Substances, including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act, as amended ("CERCLA"), and the Resource Conservation and Recovery Act, as amended ("RCRA").

21.1.31 "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

21.1.32 "**Excluded Matter**" means any one or more of the following: (i) any action taken by Hartford HealthCare with respect to the Contemplated Transaction; (ii) any matter that has already been disclosed in writing (including via posting in any electronic data room established by or on behalf of Backus for purposes of due diligence or otherwise in conjunction with the Contemplated Transaction) to Hartford HealthCare by Backus on or before the Execution Date; (iii) the public announcement of this Agreement, compliance with terms of this Agreement or the consummation of the Contemplated Transaction; (iv) any fact, circumstance, event, change, effect, condition or occurrence, or series of such items, to the extent affecting (A) global or national or regional economic, business, regulatory, market or political conditions or national or global financial markets, including changes in interest or exchange rates, (B) the healthcare industry generally or such industry in Connecticut, or (C) the long-term acute care hospital business generally or in Connecticut; (v) any changes or any proposed changes in law after the Execution Date that are not directed at

Backus or Hartford HealthCare, in each instance to the exclusion of others; (vi) any changes in government programs or the implementation of the Patient Protection and Affordable Care Act; (vii) any variability in the financial or operating performance of Backus in the ordinary course of business; (viii) any increase in competitive activity by other health care providers in Backus' service area; (ix) any activities related to efforts to unionize any of the employees of the Backus Entities, (x) any delay in the Closing of the Contemplated Transaction due to circumstances beyond the Control of Backus; (xi) any action taken by Backus at the direction of, or with the written consent of, Hartford HealthCare; or (xii) any changes or any proposed changes in GAAP after the Execution Date.

21.1.33 "**Execution Date**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.34 "**Exhibit**" shall mean any exhibit required under this Agreement.

21.1.35 "**GAAP**" shall have the meaning set forth in Section 10.4.

21.1.36 "**Governing Documents**" shall mean the articles of incorporation, certificate of incorporation, bylaws, partnership agreement, operating agreement or other documents by and through which a business organization is formed and governed.

21.1.37 "**Hartford-Appointed Directors**" shall have the meaning set forth in Section 2.1.2(a).

21.1.38 "**Hartford HealthCare**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.39 "**Hartford HealthCare Board**" means the Board of Directors of Hartford HealthCare.

21.1.40 "**Hartford HealthCare Closing Documents**" shall have the meaning set forth in Section 15.3.1.

21.1.41 "**Hartford HealthCare Dispute Representatives**" shall have the meaning set forth in Section 19.1.1(b).

21.1.42 "**Hartford System**" shall have the meaning set forth in the Recitals.

21.1.43 "**Hartford System Member**" and "**Hartford System Members**" shall have the meanings set forth in the Recitals.

21.1.44 "**Hart-Scott-Rodino Act**" or "**HSR Act**" shall have the meaning set forth in Section 13.1.1.

21.1.45 "**Hazardous Substances**" shall mean petroleum or petroleum products, polychlorinated biphenyls, asbestos-containing materials, lead-based paint, radioactive materials, toxic mold or fungus of any kind or species, medical wastes, and any substances, materials, chemicals, pollutants, constituents, or wastes regulated by any Environmental Law due to their actual or potentially hazardous, toxic, noxious, dangerous, or polluting properties or effects.

21.1.46 "**Health Care Laws**" shall mean all federal, state and local laws, statutes, rules, regulations, ordinances and codes applicable to health care providers and facilities; federal and state health care program conditions of participation, standards, policies, rules, procedures and other requirements; and accreditation standards of any applicable accrediting organization. Health Care Laws include, without limitation, the following laws: the federal (Title XIX of the Social Security Act) and state Medicaid programs and their implementing regulations, the Medicare Program (Title XVIII of the Social Security Act) and its implementing regulations, the federal False Claims Act (31 U.S.C. §§3729 et seq.), the Federal Health Care Program Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)), the Federal Physician Self-Referral Law (42 U.S.C. §1395nn), the Federal Administrative False Claims Law (42 U.S.C. §1320a-7b(a)), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rule, the HIPAA Security Rule and the HIPAA Standards for Transactions and Code Sets (42 U.S.C. 1320d-1329d-8; 45 CFR Parts 160 and 164), the federal Confidentiality of Alcohol and Drug Abuse Patient Records Act (42 U.S.C. 290ee-3), the Rehabilitation Act, the Americans with Disabilities Act, the Occupational Safety and Health Administration statutes and regulations for blood borne pathogens and workplace risks, and any state and local laws that address the same or similar subject matter. Health Care Laws also include federal, state and local laws applicable to health care providers and facilities, including, without limitation, laws related to: federal and state health care program billing, cost reporting, revenue reporting, payment and reimbursement; federal and state health care program fraud, abuse, theft or embezzlement; procurement of health care services, human and social services, and other health related services; employee background checks and credentialing of employees; credentialing and licensure of facilities or providers of such services; zoning, maintenance, safety and operations of group homes, residential facilities and day programs, and other building health and safety codes and ordinances; certificate of need laws; state law restrictions on the corporate practice of medicine (or the corporate practice of any other health related profession); eligibility for federal and state health care program contracting, including any requirements limiting contracting to nonprofit or tax-exempt entities; patient information and medical record confidentiality, including psychotherapy and mental health records; splitting of health care fees; patient brokering, patient solicitation, patient capping, and/or payment of inducements to recommend or refer, or to arrange for the recommendation or referral of, patients to health care providers or facilities; standards of care, quality assurance, risk management, utilization review, peer review, and/or mandated reporting of incidents, occurrences, diseases and events; advertising or marketing of health care services; and the enforceability of restrictive covenants on health care providers.

21.1.47 "**Insurance Policies**" shall have the meaning set forth in Section 17.13.

21.1.48 "**IRS**" means the Internal Revenue Service.

21.1.49 "**IT**" shall have the meaning set forth in Section 7.1.

21.1.50 "**Joint Commission**" shall mean The Joint Commission.

21.1.51 "**Knowledge**", "**known**", "**knowingly**", "**to the knowledge of**" **or any variant thereof shall, when qualifying** any representation, warranty or other statement in this Agreement, means as of the Execution Date the actual knowledge of any member of the applicable Party's senior officers (after making reasonable inquiry of department or clinical service heads including the person responsible for environmental compliance, as applicable) actually and materially involved in any of the Contemplated Transaction.

21.1.52 **"Leased Real Property"** shall have the meaning set forth in Section 17.10.

21.1.53 "**Leases**" shall have the meaning set forth in Section 17.10.

21.1.54 "**Licenses and Permits**" shall have the meaning set forth in Section 17.7.1.

21.1.55 "**Material Adverse Change**" means any change, or event that could reasonably be expected to result in a change during any rolling 12-month period, in the assets, results of operation or the financial condition of a Party taken as a whole: (a) as to any reduction in the total net assets of the entity in an amount in the aggregate greater than ten percent of the Party's total net assets as reflected on the Party's interim unaudited balance sheet for the initial month of the 12-month period; (b) as to any change in the financial condition of the Party, has resulted in or is reasonably likely to result, on a normalized basis (i.e., after taking into account whether the effects of such change or event are reasonably likely to continue over such period), in a reduction in earnings before deductions for interest, taxes, depreciation and amortization of the Party ("EBITDA") and/or Net Revenue over the 12-month period ending in the month in which the change or event occurs, in an amount greater than ten percent of the Party's total net assets (as reflected on the Party's interim unaudited balance sheets for the initial month of that 12-month period); or (c) as to any capital expenditures greater than $5 million in the aggregate, other than the capital expenditures set forth on Schedule 21.1.55(c). Notwithstanding anything to the contrary, "Material Adverse Change" shall not include: (i) changes in the financial or operating performance of the Party due to or caused by the announcement of the Contemplated Transaction; (ii) changes or proposed changes to any law, reimbursement rates or policies of governmental agencies or bodies that are generally applicable to hospitals or healthcare facilities; or (iii) requirements, reimbursement rates, policies or procedures of third party payors or accreditation

commissions or organizations that are generally applicable to hospitals or healthcare facilities.

21.1.56 "**Material Adverse Effect**" means any fact, circumstance, event, change, effect, condition or occurrence that, individually or in the aggregate, has had or is reasonably likely to have a material adverse effect: (i) on the property or the condition of the asset owned as of the Closing Date by the Backus Entities; or (ii) on the ability of Backus to consummate the Contemplated Transaction or to perform its obligations under this Agreement, other than an effect resulting from one or more Excluded Matters.

21.1.57 "**Material Contracts**" shall mean the following: all contracts, leases (capital and operating), and other agreements entered into by or on behalf of any one or more of the Backus Entities or Hartford HealthCare, which are in effect as of the Execution Date and involve a material aspect of the operations of such entity, including, without limitation, the following, as applicable:

(a) any management contracts whereby Backus or Backus Hospital, or any of their officers or employees provide management services to other hospitals, educational, or other healthcare institutions and involving payment of more than $250,000 in the aggregate per year;

(b) all management or consulting agreements involving payment of more than $250,000 in the aggregate per year;

(c) all service contracts, shared service agreements, joint purchasing agreements, or similar agreements involving payment of more than $250,000 in the aggregate;

(d) all leases of space and/or equipment involving payment of more than $250,000 in the aggregate;

(e) all agreements for the sale or acquisition of capital assets involving payment of more than $250,000 in the aggregate;

(f) all service agreements and warranties with respect to assets of Backus Hospital involving payment of more than $250,000 in the aggregate;

(g) all installment payment agreements involving payment of more than $250,000 in the aggregate;

(h) all membership or other agreements with groups or entities, which engage in quality review or rate review procedures, involving payment of more than $250,000 in the aggregate;

(i) all agreements with third-party administrators involving payment of more than $250,000 in the aggregate;

(j) all membership or other agreements with groups formed to coordinate facilities or services planning involving payment of more than $250,000 in the aggregate;

(k) all affiliation and transfer agreements or contracts with educational institutions, other health care facilities, and government agencies involving payment of more than $250,000 in the aggregate;

(l) all supply agreements involving payment of more than $250,000 in the aggregate;

(m) all brokers' or finders' agreements involving payment of more than $250,000 in the aggregate;

(n) all agreements pursuant to which any department of a Backus Entity is operated under a lease arrangement;

(o) all joint venture agreements or shareholder agreements to which a Backus Entity is a party;

(p) all agreements or commitments related to physician hospital organizations (PHOs), medical services organizations (MSOs), physician networks, community care networks, integrated delivery networks, or other health care delivery systems or networks;

(q) all indemnity arrangements for officers, directors, members, shareholders, or advisory board members of Backus Hospital; and

(r) license and sublicense agreements with respect to any computer software and involving payment of more than $250,000 in the aggregate.

21.1.58 **"Material Dispute"** has the meaning set forth in Section 19.1.2.

21.1.59 **"Medical Staff Development Fund"** shall have the meaning set forth in Section 16.1.2.

21.1.60 "**Meet and Confer Request**" shall have the meaning set forth in Section 19.1.1.

21.1.61 "**MOU**" shall have the meaning set forth in the Recitals.

21.1.62 "**Owned Real Property**" shall have the meaning set forth in Section 17.10.

21.1.63 **"PBGC"** means the Pension Benefit Guaranty Corporation.

21.1.64 "**Party**" and "**Parties**" shall have the meanings set forth in the introductory paragraph of this Agreement.

21.1.65 "**Payment Programs**" shall have the meaning set forth in Section 17.16.

21.1.66 "**Real Property**" shall have the meaning set forth in Section 17.10.

21.1.67 "**Reserved Powers**" shall have the meaning set forth in Section 2.2.

21.1.68 "**Returns**" shall have the meaning set forth in Section 17.14.

21.1.69 "**Schedule**" shall mean any schedule required under this Agreement.

21.1.70 "**Shortfall**" shall have the meaning set forth in Section 3.3.4.

21.1.71 "**Strategic Plan**" shall have the meaning set forth in the Recitals.

21.1.72 "**Taxes**" means all federal, state, county, local and other taxes of every kind.

21.1.73 "**Termination Date**" shall have the meaning set forth in Section 9.1.1(a).

21.1.74 "**Transitional Period**" shall have the meaning set forth in Section 2.1.2(a).

21.1.75 "**Unwind**" shall have the meaning set forth in Section 2.2.5.

[signatures attached]

IN WITNESS WHEREOF, the Parties, acting through their duly authorized representatives, have executed this Affiliation Agreement as of the Execution Date.

HARTFORD HEALTHCARE CORPORATION

By: _____
Elliot Joseph
President and CEO

BACKUS CORPORATION

By: _____
Dave Whitehead
President and CEO

Signature Page to Affiliation Agreement

IN WITNESS WHEREOF, the Parties, acting through their duly authorized representatives, have executed this Affiliation Agreement as of the Execution Date.

HARTFORD HEALTHCARE CORPORATION

By: _____
Elliot Joseph
President and CEO

BACKUS CORPORATION

By: _____
Dave Whitehead
President and CEO
08/17/12

Signature Page to Affiliation Agreement

LIST OF SCHEDULES & EXHIBITS

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Schedule 2.1.2(a)(ii)	Post-Closing Backus and Backus Hospital Directors
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Schedule 2.1.2(b)(ii)	Hartford HealthCare Board Committees
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Schedule 10.1.3(b)	Backus Transactions Potentially Constituting a Material Adverse Change
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Schedule 17.17	Backus Accreditations
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Exhibit 1.1	Backus Amended and Restated Governing Documents
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1 Backus Entities

The William W. Backus Hospital
Backus Corporation
WWB Corporation
Backus Health Care, Inc.
CONNCare, Inc.
Backus Physician Services, LLC
Backus Medical Center Condominium Associates
Community Medical Partners, Inc.
Omni Home Health Services of Eastern Connecticut, LLC (d/b/a Backus Home Health Care)

Schedule 2.1.2(a)(i)

Hartford-Appointed Directors

To be determined prior to Closing.

2.1.2(a)(ii) Post-Closing Backus and Backus Hospital Directors*

BACKUS CORPORATION
and
THE WILLIAM W. BACKUS HOSPITAL

2011 - 2012

Officers

Chairman	Vacated
Vice Chairman	Anthony A. Joyce (2010)
President	David A. Whitehead
Secretary	Joseph A. Fatone (2007)
Treasurer	Robert T. Ramsdell (2010)

Board of Directors / Trustees

Term Expiring 2014	Term Expiring 2013	Term Expiring 2012
Stephen T. Briggs, M.D. (2011)	Elizabeth Conway (2005)	Vacated
Anthony Joyce (2008)	Joseph A. Fatone (1997)	John F. Bilda (2010)
Peter Wm. Maneri, Jr. (2010)	Lynne Quintal-Hill (2010)	Deborah Monahan (2010)
Paul C. Maxfield (2011)	Donna Romito, D.O. (2011)	Robert T. Ramsdell (2005)

Ex-officio: Bert A. Coppotelli, M.D. – President, Medical Staff
Mark Tramontozzi, M.D. – Vice President, Medical Staff
David A. Whitehead – President and CEO, Backus Corporation and WWBH

*This represents the current Backus and Backus Hospital Board of Directors/Trustees, but this is subject to change based on timing of the Closing.

Schedule 2.1.2(b)(i)

Backus-Appointed Directors

To be determined prior to Closing.

Schedule 2.1.2(b)(ii)

Hartford HealthCare Board Committees

1. Nominating and Governance (must be Backus-Appointed Director(s))
2. Audit and Compliance (must be the Backus-Appointed Director(s))
3. Finance
4. Quality and Safety
5. Investments
6. Pension
7. Strategic Planning & Community Benefit

2.2.1 Backus Material Clinical Services

Anesthesia
Backus Health Centers
Bariatrics
CardiologyCHF program
Critical Care Unit (CCU)
Dentistry
Dermatology
Diagnostic Imaging
Dialysis — Acute and Chronic
Emergency Department
Endocrinology
Family Medicine
Gastroenterology/Endoscopy
Home Health Care
Hospitalist Program
Internal Medicine
Interventional Radiology
Laboratory Services
LIFESTAR
Medical Foundation
Nephrology
Neurology
Newborn Nursery
Obstetrics/Gynecology
Occupational Medicine
Oncology
Opthalmology
Otolaryngology
Pain Management Clinic
Palliative Care
Pathology
Pediatrics
Pharmacy
Psychiatry
    Inpatient
    Partial Hospitalization Program
    Mental Health Center
Pulmonology
Radiation Therapy
Rehabilitation Services
Rheumatology
Stroke Center
Surgical Services
    General
    Bariatric
    Orthopaedic
    Plastic
    Neurologic
    Robotic
Trauma Center Level III
Urology
Wound Care/Hyperbaric Oxygen Therapy

10.1.3(b) Backus Transactions Potentially Constituting a Material Adverse Change

None.

17.3.1 Backus Third Party Approvals

Approval from Ambac Assurance Corporation, Assured Guarantee (FSA) and the Connecticut Health and Educational Facilities Authority is still pending.

17.3.2 Backus Governmental Approvals and Filings

None.

17.4.1 Backus Financial Statements

Attached are true and correct copies of the following financial statements:

17.4.1 (a)
The William W. Backus Hospital

Statement	Attachment Name
Audited statements for September 30, 2009	Item 17.4.1a Hospital Financials 2009
Audited statements for September 30, 2010	Item 17.4.1a Hospital Financials 2010
Audited statements for September 30, 2011	Item 17.4.1a Hospital Financials 2011

17.4.1 (a)
Backus Home Health Care

Statement	Attachment Name
Audited statements for September 30, 2011	Item 17.4.1a Backus Home Health Care Financials 2011
Audited statements for September 30, 2010	Item 17.4.1a Backus Home Health Care Financials 2010
Audited statements for September 30, 2009	Item 17.4.1a Backus Home Health Care Financials 2009

17.4.1 (b)
Backus Corporation and Subsidiaries

Statement	Attachment Name
Audited statements for September 30, 2009	Item 17.4.1b Consolidated Financials 2009
Audited statements for September 30, 2010	Item 17.4.1b Consolidated Financials 2010
Audited statements for September 30, 2011	Item 17.4.1b Consolidated Financials 2011

17.4.1 (c)
Backus Corporation and Subsidiaries

Statement	Attachment Name
The William W. Backus Hospital-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Condominium Assoc-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Corporation-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Health Care Inc-unaudited July 2012	Item 17.4.1c Entities July 2012
ConnCare Inc.-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Physician Services LLC-unaudited July 2012	Item 17.4.1c Entities July 2012
WWB Corp-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Home Health Care-unaudited July 2012	Item 17.4.1c Entities July 2012

AUDITED FINANCIAL STATEMENTS AND OTHER FINANCIAL INFORMATION

The William W. Backus Hospital
Years Ended September 30, 2009 and 2008
With Report of Independent Auditors

The William W. Backus Hospital

Audited Financial Statements
and Other Financial Information

Years Ended September 30, 2009 and 2008

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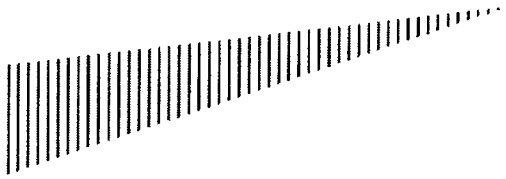

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors

The Board of Trustees
The William W. Backus Hospital

We have audited the accompanying balance sheets of The William W. Backus Hospital (the Hospital) as of September 30, 2009 and 2008, and the related statements of operations, changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Hospital's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The William W. Backus Hospital as of September 30, 2009 and 2008, and the results of its operations, changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst + Young LLP

December 1, 2009

The William W. Backus Hospital

Balance Sheets

	September 30 2009	2008
Assets		
Current assets:		
Cash and cash equivalents	**$ 57,570,735**	$ 46,717,416
Assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
Accounts receivable, less allowance for uncollectible accounts (2009 – $20,629,000; 2008 – $15,610,000)	**36,111,295**	33,683,248
Due from affiliates	**3,901,924**	3,388,030
Inventories of supplies	**3,252,641**	1,923,318
Prepaid expenses and other	**925,340**	1,779,906
Total current assets	**109,002,747**	94,140,105
Assets whose use is limited:		
Board-designated investments	**44,500,233**	43,002,912
Held by trustee	**22,743,662**	18,156,456
Total assets whose use is limited	**67,243,895**	61,159,368
Less assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
	60,003,083	54,511,181
Interest in Foundation	**41,147,474**	39,032,937
Property, plant, and equipment, net	**98,131,132**	95,130,673
Deferred financing costs	**2,025,397**	2,118,397
Other assets	**1,801,751**	3,788,338
Total assets	**$ 312,111,584**	$ 288,721,631

	September 30	
	2009	2008
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,508,835**	$ 9,994,419
Salaries and wages, payroll taxes, and taxes withheld from payroll	**8,205,022**	6,787,976
Other accrued liabilities	**6,325,794**	5,843,160
Due to third-party reimbursement agencies	**1,831,013**	1,270,638
Interest payable	**864,418**	880,518
Current portion of long-term debt	**1,825,000**	1,755,000
Total current liabilities	**29,560,082**	26,531,711
Other liabilities:		
Long-term debt – State of Connecticut Health and Educational Facilities Authority Revenue Bonds, less current portion	**63,931,536**	65,808,169
Employee related obligations	**84,442,697**	39,209,762
Self-insured professional liability	**10,580,762**	11,939,205
Due to third-party reimbursement agencies	**10,307,215**	3,892,438
Other	**667,654**	534,191
	169,929,864	121,383,765
Net assets:		
Unrestricted	**102,312,376**	132,409,920
Temporarily restricted	**3,447,432**	2,475,427
Permanently restricted	**6,861,830**	5,920,808
Total net assets	**112,621,638**	140,806,155
Total liabilities and net assets	**$ 312,111,584**	$ 288,721,631

See accompanying notes.

The William W. Backus Hospital

Statements of Operations

	Year Ended September 30	
	2009	**2008**
Operating revenues:		
Net patient service revenue	**$ 259,652,271**	$ 242,131,827
Other operating revenues	**4,213,341**	4,727,859
	263,865,612	246,859,686
Operating expenses:		
Salaries, wages, and professional fees	**112,184,033**	102,256,348
Payroll taxes and other fringe benefits	**27,425,902**	23,695,796
Supplies, insurance, and other	**74,547,698**	78,669,671
Provision for uncollectible accounts	**16,898,318**	14,162,003
Depreciation and amortization	**16,939,369**	16,453,137
Interest	**3,091,298**	3,003,005
	251,086,618	238,239,960
Operating income	**12,778,994**	8,619,726
Nonoperating gains and (losses):		
Income (loss) from investments	**2,799,208**	(4,802,633)
Change in value of swap		(843,514)
Other	**(366,280)**	201,183
Change in equity interest in net assets of Foundation	**(3,735,563)**	(167,456)
Excess of revenues over expenses	**$ 11,476,359**	$ 3,007,306

See accompanying notes.

The William W. Backus Hospital

Statements of Changes in Net Assets

	Total	Unrestricted	Temporarily Restricted	Permanently Restricted
Net assets, October 1, 2007	$ 163,733,063	$ 154,458,390	$ 2,945,255	$ 6,329,418
Excess of revenues over expenses	3,007,306	3,007,306		
Investment income	2,550		2,550	
Change in pension funding and postretirement obligation	(14,558,507)	(14,558,507)		
Change in equity interest in net unrealized losses of Foundation	(10,497,269)	(10,497,269)		
Change in equity interest in net assets of Foundation	(880,988)		(472,378)	(408,610)
Decrease in net assets	(22,926,908)	(22,048,470)	(469,828)	(408,610)
Net assets, September 30, 2008	140,806,155	132,409,920	2,475,427	5,920,808
Excess of revenues over expenses	**11,476,359**	**11,476,359**		
Investment income	**1,350**		**1,350**	
Effect of early measurement date elimination	**(1,762,428)**	**(1,762,428)**		
Change in pension funding and postretirement obligation	**(43,749,898)**	**(43,749,898)**		
Changes in equity interest in net unrealized gains of Foundation	**3,938,423**	**3,938,423**		
Change in equity interest in net assets of Foundation	**1,911,677**		**970,655**	**941,022**
(Decrease) increase in net assets	**(28,184,517)**	**(30,097,544)**	**972,005**	**941,022**
Net assets, September 30, 2009	**$ 112,621,638**	**$ 102,312,376**	**$ 3,447,432**	**$ 6,861,830**

See accompanying notes.

The William W. Backus Hospital

Statements of Cash Flows

	Year Ended September 30	
	2009	**2008**
Operating activities		
Decrease in net assets	**$ (28,184,517)**	$ (22,926,908)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**16,939,369**	16,453,137
Provision for uncollectible accounts	**16,898,318**	14,162,003
Effect of early measurement date elimination	**1,762,428**	
Change in pension funding and postretirement obligation	**43,749,898**	14,558,507
(Purchase) proceeds from sale of investments – board designated, net	**(1,497,321)**	1,409,265
Change in equity interest in net assets of Foundation	**(2,114,537)**	13,542,282
Changes in operating assets and liabilities *(Note 15)*	**(12,446,239)**	(17,206,997)
Net cash provided by operating activities	**35,107,399**	19,991,289
Investing activities		
Purchase of investments – held in trust, net	**(4,587,206)**	(1,279,461)
Net additions to property, plant, and equipment	**(18,720,156)**	(15,818,207)
Decrease (increase) in other assets	**859,915**	(504,083)
Net cash used in investing activities	**(22,447,447)**	(17,601,751)
Financing activities		
Principal payments on long-term debt	**(1,755,000)**	(815,000)
Change in deferred financing costs and amortization of bond premium	**(51,633)**	(127,164)
Net cash used in financing activities	**(1,806,633)**	(942,164)
Net increase in cash and cash equivalents	**10,853,319**	1,447,374
Cash and cash equivalents at beginning of year	**46,717,416**	45,270,042
Cash and cash equivalents at end of year	**$ 57,570,735**	$ 46,717,416

See accompanying notes.

The William W. Backus Hospital

Notes to Financial Statements

September 30, 2009

1. Significant Accounting Policies

Organization

The William W. Backus Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Backus Corporation (the sole member). The Board of Directors of Backus Corporation elects a Board of Trustees that has control of the operations of the Hospital. Refer to Note 7 for further discussion of related party transactions.

The financial statements include the operations of Backus Medical Center Condominium Association, Inc. (the Association). All intercompany transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

Cash Equivalents

The Hospital considers all highly liquid time deposits, commercial paper, and money market mutual funds purchased with a maturity at date of acquisition of three months or less to be cash equivalents.

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman, or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements of the Hospital. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority), as more fully explained in Note 6. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenues over expenses unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method), or market.

Property, Plant, and Equipment

Property, plant, and equipment are stated on the basis of cost. The Hospital provides for depreciation using the straight-line method in amounts sufficient to depreciate the cost of its assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

1. Significant Accounting Policies (continued)

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds, and changes in the equity interest in net assets of Backus Foundation, Inc. (the Foundation).

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions, which is included in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying financial statements.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for 2009 and for 2008. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues Over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in equity interest in net unrealized gains of Foundation, change in equity interest in net assets of Foundation, the change in pension funding and postretirement obligation changes in the fair value of the interest rate swap, and the effect of early measurement date elimination.

1. Significant Accounting Policies (continued)

Interest in Foundation

The interest in Foundation represents the Hospital's interest in the net assets of the Foundation. This investment is accounted for in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-20, *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises or Holds Contributions for Others.*

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Association is a taxable entity; however, any taxes are immaterial to the financial statements of the Hospital taken as a whole.

ASC 740-10, *Uncertain Tax Positions*, prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the financial statements is not significant.

Adoption of New Authoritative Pronouncements

In June 2009, FASB issued FASB ASC 105, *Generally Accepted Accounting Principles* (ASC 105), which establishes the FASB Accounting Standards Codification as the sole source of authoritative generally accepted accounting principles. Pursuant to the provisions of ASC 105, the Hospital has updated references to GAAP in its financial statements for the year ended September 30, 2009. The adoption of ASC 105 did not impact the Hospital's financial position or results of operations.

Effective 2009, the Hospital adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with GAAP, and expands disclosure about fair value measurements.

In 2009, the Hospital adopted ASC 825-10, *Fair Value Option*, which permits companies to choose to measure certain financial instruments and other items at fair value that are not currently required to be measured at fair value. The Hospital did not elect fair value accounting for any asset or liability not currently required to be measured at fair value.

1. Significant Accounting Policies (continued)

In June 2009, the Hospital adopted the provisions of ASC 855-10, *Subsequent Events*, which establishes standards of accounting for disclosure of events or transactions that occur after the balance sheet date, but before the financial statements are issued or available to be issued. ASC 855-10 is effective on a prospective basis for financial periods ended after June 15, 2009. The Hospital evaluated the impact of subsequent events through December 1, 2009, representing the date at which the financial statements were available to be issued. The adoption of ASC 855-10 in 2009 did not impact the Hospital's financial position or results of operations. Management evaluated subsequent events through December 1, 2009, the date the financial statements were available to be issued.

2. Revenues from Services to Patients and Charity Care

Net patient service revenue for the years ended September 30, 2009 and 2008 consists of the following:

	Year Ended September 30	
	2009	**2008**
Gross patient service revenue	**$ 560,641,054**	$ 512,314,357
Deductions:		
Allowances	**(294,073,379)**	(263,580,702)
Charity care (at charges)	**(6,915,404)**	(6,601,828)
	(300,988,783)	(270,182,530)
	$ 259,652,271	$ 242,131,827

Patient accounts receivable and revenues are recorded when patient services are performed. Differences between amounts received from most third-party payors and the established billing rates of the Hospital are accounted for as allowances.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $671,000 and $3,600 in 2009 and 2008, respectively.

2. Revenues from Services to Patients and Charity Care (continued)

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 7%, respectively, of the Hospital's net patient service revenue for the year ended September 30, 2009 and 30% and 6% for the year ended September 30, 2008. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

3. Charity Care

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Hospital does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Hospital's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,915,404**	**$ 3,042,778**
Bad debt	**16,898,318**	**7,435,260**
Total uncompensated care, September 30, 2009	**$ 23,813,722**	**$ 10,478,038**
Charity care	$ 6,601,828	$ 3,016,131
Bad debt	14,162,003	6,470,095
Total uncompensated care, September 30, 2008	$ 20,763,831	$ 9,486,226

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2009 and 2008:

	Year Ended September 30	
	2009	**2008**
Realized and unrealized gains (losses) on investments	**$ 1,621,546**	$ (5,689,835)
Interest and dividend income	**1,331,067**	1,352,412
Other investment income (loss)	**14,767**	(222,664)
Investment fees	**(168,172)**	(242,546)
	$ 2,799,208	$ (4,802,633)

The market value of assets whose use is limited at September 30 is set forth in the following table:

	2009	**2008**
Board designated:		
Cash and cash equivalents	**$ 16,508,452**	$ 16,123,886
Common stocks	**13,153,726**	11,361,170
Government bonds	**9,679,063**	12,538,088
Corporate bonds	**5,158,992**	2,979,768
	$ 44,500,233	$ 43,002,912
Held by trustee:		
Mutual funds	**$ 17,496,461**	$ 9,613,200
Cash and cash equivalents	**4,804,214**	8,096,731
Government bonds	**442,987**	446,525
	$ 22,743,662	$ 18,156,456

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which, among other things, provides guidance on the net asset classification of donor-restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

4. Investments (continued)

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift at the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Hospital's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Hospital's inflation-adjusted value over time. The Hospital's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The Investment Committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider expenditures based on need and current market conditions as well as long-term investment goals.

4. Investments (continued)

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets. The activity for the year ended September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$ 3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$ 4,841,631	$ 4,976,846

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2009	2008
Capital projects	**$ 1,548,434**	$ 933,829
Preventive care	**763,501**	778,537
Health care services	**414,281**	340,180
Other	**358,416**	66,956
Laboratory	**184,552**	181,410
Extraordinary nursing care	**97,635**	96,765
Nursing education	**70,948**	68,085
Free beds	**9,665**	9,665
	$ 3,447,432	$ 2,475,427

5. Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets at September 30 are restricted to the following:

	2009	2008
Income to be used:		
For general uses and purposes	**$ 6,018,245**	$ 5,077,223
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 6,861,830	$ 5,920,808

6. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2009	2008
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,630,000) from 2010 to 2012, with interest rates ranging from 4.60% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 9,145,000**	$ 9,640,000
Series F, serial maturities ($7,300,000) from 2010 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**29,425,000**	30,100,000
Series G, serial maturities ($18,960,000) from 2010 to 2026, with interest rates of 3.25% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5%	**26,380,000**	26,965,000
	64,950,000	66,705,000
Add net unamortized bond premium	**806,536**	858,169
Less current portion	**(1,825,000)**	(1,755,000)
Long-term debt	**$ 63,931,536**	$ 65,808,169

6. Long-Term Debt (continued)

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital, and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets, and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principal and interest on the Series E, Series F and Series G bonds.

Series E bonds maturing on or after July 1, 2008 are subject to redemption prior to maturity. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015 are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015 are subject to optional redemption prior to maturity.

Future minimum principal payments during each of the next five fiscal years, and in the aggregate, are as follows:

2010	$ 1,825,000
2011	1,895,000
2012	1,965,000
2013	2,045,000
2014	2,120,000
Aggregate thereafter	55,100,000
	64,950,000
Less current portion	1,825,000
Add net unamortized bond premium	806,536
	$ 63,931,536

The Hospital paid interest of $3,158,024 and $2,706,703 in 2009 and 2008, respectively. Interest incurred in 2009 and 2008 was $3,091,298 and $3,003,005, respectively.

In June 2008 the Hospital remarketed its Series F bonds, converting them from a variable auction rate to a fixed rate. As a result, the swap associated with the original bond issue, which was intended to effectively fix the interest rate paid on the bonds, was terminated. The change in the value of the swap presented in the statement of operations at September 30, 2008 of $(843,514) reflects the change in the fair value of the swap plus the reclassification of prior deferrals.

7. Related Party Transactions

Amounts due from affiliates at September 30, 2009 and 2008 includes advances to Backus Properties of approximately $1,720,000 and $1,883,000 for building improvements and property acquisitions during 2009 and 2008, respectively. Amounts due from the Foundation include monies in support of charity care and Hospital programs of approximately $43,000 and $93,000 for 2009 and 2008, respectively. In addition, the Hospital processes payroll and disbursements for several of its affiliated entities for which it is reimbursed. Reimbursements due to the Hospital at September 30, 2009 and 2008 were approximately $668,000 and $760,000, respectively.

The Hospital has unconditionally guaranteed full and prompt payment and performance of all liabilities of an affiliate organization to the lessor for a term of twenty years. The maximum potential amount of future payments includes lease payments for the first ten years of $2,095,890. Payments over the remaining term of the lease are based on a future interest rate that is not yet determinable. There are no recourse provisions available to the Hospital upon breach of contract by the affiliate.

Subsequent to year end, Backus Foundation Inc. and Backus Properties Inc. (Properties) will cease to exist as separate entities and all assets, liabilities, equity and operations will merge into the Hospital. The merger of the Foundation will not impact net assets as it is currently accounted for under ASC 958-20 as described in Note 1. The merger of Properties will result in an increase in unrestricted net assets of approximately $1,400,000.

8. Retirement Benefit Plans

The Hospital maintains a noncontributory defined benefit pension plan covering substantially all of its employees. The Hospital also provides noncontributory postretirement health care benefits to eligible retirees and eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsors a nonqualified pension benefit program. Included in long-term liabilities at September 30, 2009 and 2008 is approximately $3,600,000 and $850,000, respectively, related to the future obligation for the nonqualified benefits.

Effective January 1, 2010, the Hospital will amend its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants. Management anticipates that the change in the pension plan will result in a reduction of the unfunded liability of approximately $35 million. It is the Hospital's intention to establish a defined contribution plan concurrent with the amendment of the defined benefit plan.

8. Retirement Benefit Plans (continued)

Effective October 1, 2008, the Hospital adopted ASC 715-20, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, which requires elimination of the early measurement date of the plans.

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2009	**2008**	**2009**	**2008**
	(In thousands)			
Unrecognized actuarial (loss) gain	**$ (67,240)**	$ (26,335)	**$ 1,249**	$ 2,223
Unrecognized prior service cost	**(15)**	(19)		
Unrecognized transition obligation			**(1,213)**	(1,617)
	$ (67,255)	$ (26,354)	**$ 36**	$ 606

The prior service cost, actuarial (loss) gain and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2010 are $3,323, $5,129,108 and $323,491, respectively.

At September 30, 2008, the unfunded status of the pension plan is included in long-term liabilities in the amount of $30,206,752. The unfunded status of the postretirement benefits is $5,045,761, with $479,175 included in short-term liabilities, and the remainder of $4,566,586 included in long-term liabilities. At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities.

8. Retirement Benefit Plans (continued)

The following table sets forth the funded status of the plans as of the measurement date of September 30 in 2009 and June 30 in 2008 for each plan and amounts recognized in the Hospital's balance sheets at September 30. In 2008, contributions made subsequent to the measurement date, but prior to September 30, reduced the accrued benefit liability.

	Pension Benefits		Postretirement Benefits	
	2009	**2008**	**2009**	**2008**
	(In thousands)			
Change in projected benefit obligation				
Benefit obligation at beginning of year	**$ (133,189)**	$ (124,809)	**$ (5,156)**	$ (5,524)
Service cost	**(4,484)**	(4,620)	**(22)**	(30)
Interest cost	**(9,002)**	(7,986)	**(338)**	(334)
Change in assumptions	**(38,217)**	5,256	**(558)**	134
Actuarial (loss) gain	**(2,156)**	(4,249)	**382**	199
Effect of early measurement date elimination	**11,740**		**295**	
Benefits paid	**3,477**	3,219	**428**	399
Benefit obligation at end of year	**$ (171,831)**	$ (133,189)	**$ (4,969)**	$ (5,156)
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,957**	$ 102,625		
Actual return on plan assets	**2,662**	(7,224)		
Effect of early measurement date elimination	**(8,097)**			
Contributions	**8,100**	8,775	**$ 428**	$ 399
Benefits paid	**(3,477)**	(3,219)	**(428)**	(399)
Fair value of plan assets at end of year	**$ 100,145**	$ 100,957	**$**	$
Reconciliation of underfunded status				
Underfunded status	**$ (71,686)**	$ (32,232)	**$ (4,969)**	$ (5,156)
Contribution subsequent to measurement date		2,025		111
Accrued benefit liability recognized in the balance sheets	**$ (71,686)**	$ (30,207)	**$ (4,969)**	$ (5,045)
Components of net periodic benefit cost				
Service cost	**$ 4,484**	$ 4,620	**$ 22**	$ 30
Interest cost	**9,002**	7,986	**338**	334
Expected return on plan assets	**(7,605)**	(8,417)		
Net amortization and deferral	**1,129**	3	**(541)**	(260)
Net periodic benefit cost	**$ 7,010**	$ 4,192	**$ (181)**	$ 104

8. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2009	2008	2009	2008
	(In thousands)			
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.60%**	6.50%	**5.60%**	6.50%
Rate of compensation increase	**5.00**	5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**7.25**	6.25	**7.25**	6.25
Expected long-term rate of return on plan assets	**8.00**	8.00		
Rate of compensation increase	**5.00**	5.00		

The expected long-term rate of return on plan assets was determined by the expected return on each asset class based on a model that considers historical and expected future performance.

The accumulated benefit obligation at September 30, 2009 and 2008 was $137,279,286 and $107,697,366, respectively.

The asset allocations for the retirement plan at the end of 2009 and 2008 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	Minimum	Maximum	2009	2008
US Equity Large Cap	35%	45%	**27%**	34%
US Equity Small Cap		10	**4**	5
International Equity	17	27	**17**	19
Core Fixed Income	25	35	**52**	42
Real estate		6		
Total			**100%**	100%

8. Retirement Benefit Plans (continued)

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2010	$ 8,100,000	$ 462,097
Estimated future benefit payments:		
2010	4,462,917	462,097
2011	4,982,416	464,756
2012	5,495,548	472,761
2013	6,025,576	481,792
2014	6,719,521	481,673
2015-2019	46,736,124	2,066,165

Assumed healthcare cost trend rates for 2009 are as follows:	
Health care trend rate assumed for next year	8.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 2	$ (2)
Effect on postretirement benefit obligation	$ 26	$ (22)

9. Property, Plant, and Equipment

Property, plant, and equipment at September 30 consist of the following:

	2009	2008
Land and land improvements	**$ 2,408,486**	$ 2,373,312
Buildings and leasehold improvements	**109,893,844**	102,370,729
Equipment	**95,975,645**	86,262,740
Construction in process (2009 estimated cost to complete $6,900,000)	**4,251,661**	4,429,799
Less accumulated depreciation	**(114,398,504)**	(100,305,907)
	$ 98,131,132	$ 95,130,673

Included in construction in progress at September 30, 2009 are $1,280,000 of internally developed software costs. The Hospital wrote off approximately $1,426,000 of fully depreciated assets in 2009.

In 2004, the Hospital began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2009 and 2008 was $705,436 and $667,384, respectively.

The Hospital leases various types of equipment with annual payments ranging from $103 to $119,064. Expenses as a result of these leases were approximately $478,000 and $928,000 for the years ended September 30, 2009 and 2008, respectively.

The Hospital also leases various properties from a related party. Rent expense for those leases totaled approximately $644,000 and $610,000 for the years ended September 30, 2009 and 2008, respectively. As described in Note 7, the related party will be merged with the Hospital for years beginning in 2010. As a result, no lease payments to that related party are included in the future minimum payments listed below. However, leases between the related party and unrelated lessors are included.

9. Property, Plant, and Equipment (continued)

Future minimum lease payments under the above leases during each of the next five years were as follows:

2010	$ 1,233,982
2011	1,042,391
2012	775,265
2013	748,603
2014	145,161
Aggregate thereafter	1,102,588
	$ 5,047,990

10. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of accounts receivable, net of contractual allowances, from patients and third-party payors at September 30 is as follows:

	2009	%	2008	%
Medicare	**$ 14,223,122**	**25%**	$ 12,265,855	25%
Medicaid	**4,685,984**	**8**	3,166,368	6
Anthem Blue Cross/Blue Shield	**7,989,343**	**14**	8,128,274	16
Health Maintenance Organizations	**9,452,755**	**17**	7,671,571	16
Commercial	**2,776,338**	**5**	3,140,618	6
Self pay	**13,430,756**	**24**	11,688,493	24
Other state agencies	**4,182,234**	**7**	3,231,784	7
	56,740,532	**100%**	49,292,963	100%
Less allowance for uncollectible accounts	**20,629,237**		15,609,715	
	$ 36,111,295		$ 33,683,248	

11. Contingencies

There have been malpractice claims that fall within the Hospital's partially self-insured program (see Note 1) which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2009 that may result in the assertion of claims. Hospital management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

11. Contingencies (continued)

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position or results of operations.

12. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2009	**2008**
Cafeteria sales	**$ 1,049,650**	$ 989,415
Grants	**642,728**	630,810
Rental income	**568,148**	482,704
Interest	**476,907**	1,505,928
Condominium income	**440,047**	306,803
Miscellaneous	**424,282**	326,336
Child care	**336,700**	350,051
Purchase discounts	**274,879**	135,812
	$ 4,213,341	$ 4,727,859

13. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2009	**2008**
Health care services	**$ 188,561,536**	$ 180,224,412
General and administrative	**62,525,082**	58,015,548
	$ 251,086,618	$ 238,239,960

Costs for interest and insurance are included in general and administrative expenses. Malpractice insurance is included in health care services.

14. Fair Value of Financial Instruments

On October 1, 2008, the Hospital adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Financial assets as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 57,570,735			$ 57,570,735
Assets whose use is limited	67,243,895			67,243,895

The carrying amount of certain of the Hospital's financial instruments, including cash and cash equivalents, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at fiscal year end. The fair value of long-term debt is $68,087,973 and $65,336,934 at September 30, 2009 and 2008, respectively.

15. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2009	2008
Increase in assets:		
Accounts receivable	**$ (19,326,365)**	$ (17,003,287)
Due from affiliates	**(513,894)**	(1,144,405)
Inventories of supplies, prepaid expenses, and other	**(474,757)**	(25,215)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**6,975,152**	2,676,010
Accounts payable	**514,416**	(3,105,471)
Employee related obligations	**(279,391)**	(3,431,132)
Interest payable and other accrued liabilities	**466,534**	(15,500)
Salaries and wages, payroll taxes, and taxes withheld from payroll	**1,417,046**	1,264,820
Self-insured professional liability	**(1,358,443)**	3,297,056
Other liabilities	**133,463**	280,127
Changes in operating assets and liabilities	**$ (12,446,239)**	$ (17,206,997)

Other Financial Information

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Trustees
The William W. Backus Hospital

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Ernst & Young LLP

December 1, 2009

The William W. Backus Hospital

Consolidating Balance Sheet

September 30, 2009

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 57,570,735			$ 57,570,735
Assets whose use is limited – required for current liabilities	7,240,812			7,240,812
Accounts receivable, less allowance for uncollectible accounts	36,111,295			36,111,295
Due from affiliates	3,901,924			3,901,924
Inventories of supplies	3,252,641			3,252,641
Prepaid expenses and other	905,576	$ 19,764		925,340
Total current assets	108,982,983	19,764		109,002,747
Assets whose use is limited:				
Board-designated investments	44,500,233			44,500,233
Held by trustee	22,743,662			22,743,662
Total assets whose use is limited	67,243,895			67,243,895
Less assets whose use is limited – required for current liabilities	7,240,812			7,240,812
	60,003,083			60,003,083
Interest in Foundation	41,147,474			41,147,474
Property, plant, and equipment, net	98,131,132			98,131,132
Deferred financing costs	2,025,397			2,025,397
Other assets	1,801,751			1,801,751
Total assets	$ 312,091,820	$ 19,764		$ 312,111,584

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The William W. Backus Hospital

Consolidating Balance Sheet (continued)

September 30, 2009

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable – trade	$ 10,508,835			$ 10,508,835
Salaries and wages, payroll taxes, and taxes withheld from payroll	8,205,022			8,205,022
Other accrued liabilities	6,324,099	$ 1,695		6,325,794
Due to third-party reimbursement agencies	1,831,013			1,831,013
Interest payable	864,418			864,418
Current portion of long-term debt	1,825,000			1,825,000
Total current liabilities	29,558,387	1,695		29,560,082
Other liabilities:				
Long-term debt, less current portion	63,931,536			63,931,536
Employee related obligations	84,442,697			84,442,697
Self-insured professional liability	10,580,762			10,580,762
Due to third-party reimbursement agencies	10,307,215			10,307,215
Other	667,654			667,654
	169,929,864			169,929,864
Net assets:				
Unrestricted	102,294,307	18,069		102,312,376
Temporarily restricted	3,447,432			3,447,432
Permanently restricted	6,861,830			6,861,830
Total net assets	112,603,569	18,069		112,621,638
Total liabilities and net assets	$ 312,091,820	$ 19,764		$ 312,111,584

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The William W. Backus Hospital

Consolidating Statement of Operations

Year Ended September 30, 2009

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Operating revenues:				
Net patient service revenue	$ 259,652,271			$ 259,652,271
Other operating revenues	3,773,294	$ 482,183	$ (42,136)	4,213,341
	263,425,565	482,183	(42,136)	263,865,612
Operating expenses:				
Salaries, wages, and professional fees	112,184,033			112,184,033
Payroll taxes and other fringe benefits	27,425,902			27,425,902
Supplies, insurance, and other	74,107,651	482,183	(42,136)	74,547,698
Provision for uncollectible accounts	16,898,318			16,898,318
Depreciation and amortization	16,939,369			16,939,369
Interest	3,091,298			3,091,298
	250,646,571	482,183	(42,136)	251,086,618
Operating income	12,778,994			12,778,994
Nonoperating gains and (losses):				
Income from investments	2,799,208			2,799,208
Other	(366,280)			(366,280)
Change in equity interest in net assets of Foundation	(3,735,563)			(3,735,563)
Excess of revenues over expenses	$ 11,476,359			$ 11,476,359

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Audited Financial Statements and Other Financial Information

The William W. Backus Hospital
Years Ended September 30, 2010 and 2009
With Report of Independent Auditors

The William W. Backus Hospital

Audited Financial Statements
and Other Financial Information

Years Ended September 30, 2010 and 2009

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
The William W. Backus Hospital

We have audited the accompanying balance sheets of The William W. Backus Hospital (the Hospital) as of September 30, 2010 and 2009, and the related statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Hospital's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The William W. Backus Hospital as of September 30, 2010 and 2009, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Balance Sheets

	September 30 2010	2009
Assets		
Current assets:		
Cash and cash equivalents	**$ 72,131,779**	$ 57,570,735
Assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
Accounts receivable, less allowance for uncollectible accounts (2010 – $20,081,000; 2009 – $20,629,000)	**30,758,941**	36,111,295
Pledges receivable	**185,866**	
Due from affiliates	**661,088**	3,901,924
Inventories of supplies	**3,799,896**	3,252,641
Prepaid expenses and other	**1,277,144**	925,340
Total current assets	**116,746,304**	109,002,747
Assets whose use is limited:		
Board-designated investments	**96,626,409**	44,500,233
Held by trustee	**26,988,802**	22,743,662
Total assets whose use is limited	**123,615,211**	67,243,895
Less assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
	115,683,621	60,003,083
Interest in Foundation		41,147,474
Property, plant, and equipment, net	**99,122,387**	98,131,132
Deferred financing costs	**1,933,364**	2,025,397
Other assets	**1,603,864**	1,801,751
Total assets	**$ 335,089,540**	$ 312,111,584

	September 30 2010	2009
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,129,146**	$ 10,508,835
Salaries and wages, payroll taxes, and taxes withheld from payroll	**6,206,054**	8,205,022
Other accrued liabilities	**8,213,638**	6,325,794
Due to third-party reimbursement agencies	**2,614,222**	1,831,013
Interest payable	**754,026**	864,418
Current portion of long-term debt	**2,032,691**	1,825,000
Total current liabilities	**29,949,777**	29,560,082
Other liabilities:		
Long-term debt	**64,591,831**	63,931,536
Employee related obligations	**57,973,203**	84,442,697
Self-insured professional liability	**10,514,332**	10,580,762
Due to third-party reimbursement agencies	**12,767,632**	10,307,215
Other	**349,678**	667,654
	146,196,676	169,929,864
Net assets:		
Unrestricted	**147,366,124**	102,312,376
Temporarily restricted	**4,101,543**	3,447,432
Permanently restricted	**7,475,420**	6,861,830
Total net assets	**158,943,087**	112,621,638
Total liabilities and net assets	**$ 335,089,540**	$ 312,111,584

See accompanying notes.

The William W. Backus Hospital

Statements of Operations

	Year Ended September 30	
	2010	**2009**
Operating revenues:		
Net patient service revenue	**$ 270,048,715**	$ 259,652,271
Other operating revenues	**4,673,356**	4,213,341
Net assets released from restriction	**91,211**	
	274,813,282	263,865,612
Operating expenses:		
Salaries, wages, and professional fees	**109,179,026**	112,184,033
Payroll taxes and other fringe benefits	**27,181,443**	27,425,902
Supplies, insurance, and other	**91,056,415**	74,547,698
Provision for uncollectible accounts	**14,409,876**	16,898,318
Depreciation and amortization	**17,480,126**	16,939,369
Interest	**3,185,038**	3,091,298
	262,491,924	251,086,618
Operating income	**12,321,358**	12,778,994
Nonoperating gains and (losses):		
Income from investments	**6,218,347**	2,799,208
Contributions	**328,840**	
Other	**(116,761)**	(366,280)
Change in equity interest in net assets of Foundation		(3,735,563)
Excess of revenues over expenses	**$ 18,751,784**	$ 11,476,359

See accompanying notes.

The William W. Backus Hospital

Statements of Changes in Net Assets

	Total	Unrestricted	Temporarily Restricted	Permanently Restricted
Net assets, September 30, 2008	$ 140,806,155	$ 132,409,920	$ 2,475,427	$ 5,920,808
Excess of revenues over expenses	11,476,359	11,476,359		
Investment income	1,350		1,350	
Effect of early measurement date elimination	(1,762,428)	(1,762,428)		
Change in pension funding and postretirement obligation	(43,749,898)	(43,749,898)		
Changes in equity interest in net unrealized gains of Foundation	3,938,423	3,938,423		
Change in equity interest in net assets of Foundation	1,911,677		970,655	941,022
(Decrease) increase in net assets	(28,184,517)	(30,097,544)	972,005	941,022
Net assets, September 30, 2009	112,621,638	102,312,376	3,447,432	6,861,830
Excess of revenues over expenses	**18,751,784**	**18,751,784**		
Investment income	**739,782**		**618,691**	**121,091**
Curtailment gain	**34,536,288**	**34,536,288**		
Change in pension funding and postretirement obligation	**(9,564,206)**	**(9,564,206)**		
Transfer to affiliates	**(73,056)**	**(73,056)**		
Merger of Properties	**1,402,938**	**1,402,938**		
Contributions	**484,695**		**126,631**	**358,064**
Change in net assets held in trust	**134,435**			**134,435**
Net assets released from restriction	**(91,211)**		**(91,211)**	
Increase in net assets	**46,321,449**	**45,053,748**	**654,111**	**613,590**
Net assets, September 30, 2010	**$ 158,943,087**	**$ 147,366,124**	**$ 4,101,543**	**$ 7,475,420**

See accompanying notes.

The William W. Backus Hospital

Statements of Cash Flows

	Year Ended September 30 2010	2009
Operating activities		
Increase (decrease) in net assets	**$ 46,321,449**	$ (28,184,517)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,480,126**	16,939,369
Provision for uncollectible accounts	**14,409,876**	16,898,318
Curtailment gain	**(34,536,288)**	
Effect of early measurement date elimination		1,762,428
Change in pension funding and postretirement obligation	**9,564,206**	43,749,898
Transfer to affiliates	**73,056**	
Merger of Properties	**(1,402,938)**	
Purchase of investments – board designated, net	**(15,613,572)**	(1,497,321)
Permanently restricted contributions and income	**(613,590)**	
Change in equity interest in net assets of Foundation		(2,114,537)
Changes in operating assets and liabilities *(Note 16)*	**(9,177,820)**	(12,446,239)
Net cash provided by operating activities	**26,504,505**	35,107,399
Investing activities		
Purchase of investments – held in trust, net	**(1,917,827)**	(4,587,206)
Net additions to property, plant, and equipment	**(12,056,041)**	(18,720,156)
(Increase) decrease in other assets	**(72,956)**	859,915
Cash transfer from merger	**2,226,244**	
Net cash used in investing activities	**(11,820,580)**	(22,447,447)
Financing activities		
Proceeds from loan	**1,250,000**	
Principal payments on long-term debt and capital lease obligations	**(1,863,950)**	(1,755,000)
Change in deferred financing costs and amortization of bond premium	**(49,465)**	(51,633)
Permanently restricted contributions and income	**613,590**	
Transfer to affiliates	**(73,056)**	
Net cash used in financing activities	**(122,881)**	(1,806,633)
Net increase in cash and cash equivalents	**14,561,044**	10,853,319
Cash and cash equivalents at beginning of year	**57,570,735**	46,717,416
Cash and cash equivalents at end of year	**$ 72,131,779**	$ 57,570,735

See accompanying notes.

The William W. Backus Hospital

Notes to Financial Statements

September 30, 2010

1. Significant Accounting Policies

Organization

The William W. Backus Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Backus Corporation (the sole member). The Board of Directors of Backus Corporation elects a Board of Trustees that has control of the operations of the Hospital. Refer to Note 9 for further discussion of related party transactions.

The financial statements include the operations of Backus Medical Center Condominium Association, Inc. (the Association). All intercompany transactions have been eliminated in consolidation.

Merger

Effective November 1, 2009, Backus Foundation, Inc. and Backus Properties Inc. were merged into the Hospital. The merger was accounted for as a "pooling of interests". The accompanying financial statements reflect the consolidated assets, liabilities and net assets of the three entities at September 30, 2010 and the revenue, expenses and changes in net assets for the entire fiscal year. The merger of the Foundation had no impact on net assets because the Foundation was previously accounted for in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-20, *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises of Holds Contributions for Others* and as such, the 2009 presentation would not be materially different. The merger of Properties increased unrestricted net assets by approximately $1,400,000 in 2010.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Cash Equivalents

The Hospital considers all highly liquid time deposits, commercial paper, and money market mutual funds purchased with a maturity at date of acquisition of three months or less to be cash equivalents.

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman, or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements of the Hospital. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority), as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenues over expenses unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method), or market.

Property, Plant, and Equipment

Property, plant, and equipment are stated on the basis of cost. The Hospital provides for depreciation using the straight-line method in amounts sufficient to depreciate the cost of its assets over their estimated useful lives.

1. Significant Accounting Policies (continued)

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions, which is included in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying financial statements.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for both 2010 and for 2009. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues Over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include pension curtailment gains, equity transfers from affiliates, both temporarily and permanently restricted donations and investment income, changes in perpetual trust arrangements, changes in equity interest in net unrealized gains of Foundation, change in equity interest in net assets of Foundation, the change in pension funding and postretirement obligation and the effect of early measurement date elimination.

1. Significant Accounting Policies (continued)

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Association is a taxable entity; however, any taxes are immaterial to the financial statements of the Hospital taken as a whole.

ASC 740-10, *Uncertain Tax Positions*, prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the financial statements is not significant.

Adoption of New Authoritative Pronouncements

Effective 2010, the Hospital adopted ASC 715-20, *Retirement Benefits*, which requires additional disclosures relating to defined benefit pension plans, including additional fair value disclosures for pension assets.

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which is delayed until 2011, the guidance in ASU 2010-06 becomes effective for reporting periods beginning after December 15, 2009. Management is currently evaluating the effect that the provisions of ASU 2010-06 will have on the consolidated financial statements.

1. Significant Accounting Policies (continued)

Reclassifications

Certain reclassifications were made to the 2009 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Net patient service revenue for the years ended September 30, 2010 and 2009 consists of the following:

	Year Ended September 30	
	2010	**2009**
Gross patient service revenue	**$ 585,390,725**	$ 560,641,054
Deductions:		
Allowances	**(308,845,388)**	(294,073,379)
Charity care (at charges)	**(6,496,622)**	(6,915,404)
	(315,342,010)	(300,988,783)
	$ 270,048,715	$ 259,652,271

Patient accounts receivable and revenues are recorded when patient services are performed. Differences between amounts received from most third-party payors and the established billing rates of the Hospital are accounted for as allowances.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates had no impact on net patient service revenue for 2010, and increased net patient service revenue by approximately $671,000 in 2009.

2. Revenues from Services to Patients and Charity Care (continued)

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 8%, respectively, of the Hospital's net patient service revenue for the year ended September 30, 2010 and 28% and 7% for the year ended September 30, 2009. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

3. Charity Care

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Hospital does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Hospital's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,496,622**	**$ 2,858,514**
Bad debt	**14,409,876**	**6,340,345**
Total uncompensated care, September 30, 2010	**$ 20,906,498**	**$ 9,198,859**
Charity care	$ 6,915,404	$ 3,042,778
Bad debt	16,898,318	7,435,260
Total uncompensated care, September 30, 2009	$ 23,813,722	$ 10,478,038

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2010
BackusCare campaign	$ 185,114
Other	7,077
Unconditional promises to give before unamortized discount	192,191
Less unamortized discount and allowance	(6,325)
	$ 185,866
Amounts due in:	
Less than one year	$ 133,366
One to five years	52,500
Total	$ 185,866

5. Investments

Investment income and gains are comprised of the following for the years ended September 30:

	2010	2009
Realized and unrealized gains on investments	**$ 4,574,175**	$ 1,621,546
Interest and dividend income	**1,813,339**	1,331,067
Other investment income	**11,600**	14,767
Investment fees	**(180,767)**	(168,172)
	$ 6,218,347	$ 2,799,208

5. Investments (continued)

The market value of assets whose use is limited at September 30 is set forth in the following table:

	2010	2009
Board designated:		
Mutual funds	**$ 38,540,722**	$ -
Cash and cash equivalents	**33,837,100**	16,508,452
Common stocks	**13,327,371**	13,153,726
Government bonds	**8,462,882**	9,679,063
Corporate bonds	**2,458,334**	5,158,992
	$ 96,626,409	$ 44,500,233
Held by trustee:		
Mutual funds	**$ 22,211,515**	$ 17,496,461
Cash and cash equivalents	**4,430,958**	4,804,214
Common stock	**287,581**	
Real estate	**58,748**	
Government bonds		442,987
	$ 26,988,802	$ 22,743,662

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which, among other things, provides guidance on the net asset classification of donor-restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift at the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

5. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Hospital's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Hospital's inflation-adjusted value over time. The Hospital's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The Investment Committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets.

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

5. Investments (continued)

The activity for the year ended September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$ 3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$ 4,841,631	$ 4,976,846

6. Fair Value of Financial Instruments

On October 1, 2008, the Hospital adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 75,157,255	$ 2,738		$ 75,159,993
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)			$ 58,751	58,751
Total	$ 160,542,096	$ 35,146,143	$ 58,751	$ 195,746,990

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Real Estate (REIT)
Beginning balance	-
Purchases	$ 54,286
Unrealized gains	4,465
Total	$ 58,751

Financial assets as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 57,578,855			$ 57,578,855
Certificates of deposit		$ 4,815,074		4,815,074
Money market funds	14,207,293			14,207,293
US government obligations	9,075,929			9,075,929
Corporate bonds		8,487,292		8,487,292
Equity securities	13,153,726			13,153,726
Mutual funds	17,496,461			17,496,461
Total	$ 111,512,264	$ 13,302,366		$ 124,814,630

6. Fair Value of Financial Instruments (continued)

The carrying amount of certain of the Hospital's financial instruments, including cash and cash equivalents and pledge receivables approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Hospital's fiscal year end. The fair value of long-term debt is $69,437,056 and $68,087,973 at September 30, 2010 and 2009, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2010	2009
Capital projects	**$ 1,733,950**	$ 1,548,434
Preventive care	**792,377**	763,501
Other	**626,772**	358,416
Health care services	**499,200**	414,281
Laboratory	**228,659**	184,552
Extraordinary nursing care	**109,852**	97,635
Nursing education	**84,912**	70,948
Free beds	**25,821**	9,665
	$ 4,101,543	$ 3,447,432

Permanently restricted net assets at September 30 are restricted to the following:

	2010	2009
Income to be used:		
For general uses and purposes	**$ 6,631,835**	$ 6,018,245
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,475,420	$ 6,861,830

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2010	2009
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,110,000) from 2011 to 2012, with interest rates ranging from 4.75% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,625,000**	$ 9,145,000
Series F, serial maturities ($6,600,000) from 2011 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,725,000**	29,425,000
Series G, serial maturities ($18,355,000) from 2011 to 2026, with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5%	**25,775,000**	26,380,000
Other long-term debt:		
Mortgage, maturing May 1, 2025 with a fixed interest rate of 6.125%	**1,236,586**	
Obligations under capital leases	**1,505,864**	
	65,867,450	64,950,000
Add net unamortized bond premium	**757,072**	806,536
Less current portion	**(2,032,691)**	(1,825,000)
Long-term debt	**$ 64,591,831**	$ 63,931,536

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital, and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets, and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principal and interest on the Series E, Series F and Series G bonds.

8. Long-term Debt (continued)

Series E bonds maturing on or after July 1, 2008 are subject to redemption prior to maturity. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015 are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015 are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years, and in the aggregate, are as follows:

	Long-Term Debt	Capital Leases
2011	$ 1,948,410	$ 386,104
2012	2,021,619	386,104
2013	2,105,440	386,104
2014	2,184,302	386,104
2015	2,303,411	355,554
Aggregate thereafter	53,798,404	2,375,136
	64,361,586	4,275,106
Add net unamortized bond premium	757,072	
Less interest		(2,769,242)
	$ 65,118,658	$ 1,505,864

The Hospital paid interest of $3,323,608 and $3,158,024 in 2010 and 2009, respectively. Interest incurred in 2010 and 2009 was $3,185,038 and $3,091,298, respectively.

In 2010 the Hospital entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

In 2010 the Hospital also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2010 was $441,720. Under the terms of the lease, the Hospital has the option to renew for five periods for five years each.

Deferred financing costs are amortized over a period consistent with the life of the bonds.

9. Related Party Transactions

The Hospital processes payroll and disbursements for several of its affiliated entities for which it is reimbursed. Reimbursements due to the Hospital at September 30, 2010 and 2009 were approximately $647,000 and $668,000, respectively. Amounts due from affiliates at September 30, 2009 include advances to Backus Properties of approximately $1,720,000 for building improvements and property acquisitions during 2009. Amounts due from the Foundation include monies in support of charity care and Hospital programs of approximately $43,000 for 2009. Amounts due the Hospital from Backus Properties and the Foundation were eliminated upon the merger of those entities as described in Note 1.

10. Retirement Benefit Plans

Effective January 1, 2010, the Hospital amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Hospital will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Hospital will also make a non-elective transition contribution equal to 3% of employee's eligible earnings for all employees who meet the transition participant criteria. The Hospital may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the year ended September 30, 2010 is $3,589,500.

The Hospital also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsored a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2010 and 2009 is approximately $2,600,000 and $3,600,000, respectively, related to the future obligation for the nonqualified benefits.

10. Retirement Benefit Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2010	2009	2010	2009
	(In thousands)			
Unrecognized actuarial (loss) gain	**$ (43,157)**	$ (67,240)	**$ 1,734**	$ 1,249
Unrecognized prior service cost		(15)		
Unrecognized transition obligation			**(889)**	(1,213)
	$ (43,157)	$ (67,255)	**$ 845**	$ 36

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2011 are $2,743,736 and $323,491, respectively.

At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities. At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities.

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2010 and 2009.

	Pension Benefits		Postretirement Benefits	
	2010	2009	2010	2009
		(In thousands)		
Change in projected benefit obligation				
Benefit obligation at beginning of year	**$ (171,831)**	$ (133,189)	**$ (4,969)**	$ (5,156)
Service cost	**(1,836)**	(4,484)	**(15)**	(22)
Interest cost	**(7,684)**	(9,002)	**(267)**	(338)
Change in assumptions	**(11,951)**	(38,217)	**387**	(558)
Actuarial (loss) gain	**(3,598)**	(2,156)	**154**	382
Effect of curtailment	**34,551**			
Effect of early measurement date elimination		11,740		295
Benefits paid	**4,083**	3,477	**444**	428
Benefit obligation at end of year	**$ (158,266)**	$ (171,831)	**$ (4,266)**	$ (4,969)

10. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2010	2009	2010	2009
		(In thousands)		
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,145**	$ 100,957		
Actual return on plan assets	**10,017**	2,662		
Effect of early measurement date elimination		(8,097)		
Contributions	**8,124**	8,100	**$ 444**	$ 428
Benefits paid	**(4,083)**	(3,477)	**(444)**	(428)
Fair value of plan assets at end of year	**$ 114,203**	$ 100,145	**$**	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	**$ (44,063)**	$ (71,686)	**$ (4,266)**	$ (4,969)
Components of net periodic benefit cost				
Service cost	**$ 1,836**	$ 4,484	**$ 15**	$ 22
Interest cost	**7,684**	9,002	**267**	338
Expected return on plan assets	**(6,901)**	(7,605)		
Net amortization and deferral	**1,964**	1,129	**269**	(541)
Net periodic benefit cost	**$ 4,583**	$ 7,010	**$ 551**	$ (181)
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.10%**	5.60%	**5.10%**	5.60%
Rate of compensation increase		5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.60**	7.25	**5.60**	7.25
Expected long-term rate of return on plan assets	**6.75**	8.00		
Rate of compensation increase	**5.00**	5.00		

The accumulated benefit obligation at September 30, 2010 and 2009 was $158,266,226 and $137,279,286, respectively.

10. Retirement Benefit Plans (continued)

The asset allocations for the retirement plan at the end of 2010 and 2009 and the target allocation by asset category are as follows:

Asset Category	Target Allocation		Percentage of Plan Assets	
	Minimum	Maximum	2010	2009
US Equity Large Cap	20%	50%	**31%**	27%
US Equity Small Cap		15	**5**	4
International Equity	10	30	**17**	17
Core Fixed Income	20	60	**47**	52
Total			**100%**	100%

The following table presents the Hospital Plan's fair value hierarchy for those assets measured at fair value as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity(b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category invests primarily in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital by investing at least 80% in international equity securities.
(c) This category seeks maximum current income by investing primarily in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

10. Retirement Benefit Plans (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ -	$ -	$ -
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

The Hospital Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Hospital Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2011	$ 8,100,000	$ 452,466
Estimated future benefit payments:		
2011	5,057,112	452,466
2012	5,586,022	439,761
2013	6,060,768	433,204
2014	6,598,072	424,838
2015	7,158,748	401,741
2016-2020	43,816,630	1,669,284

10. Retirement Benefit Plans (continued)

Assumed healthcare cost trend rates for 2010 are as follows:	
Health care trend rate assumed for next year	8.00%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (2)
Effect on postretirement benefit obligation	$ 9	$ (7)

11. Property, Plant, and Equipment

Property, plant, and equipment at September 30 consist of the following:

	2010	2009
Land and land improvements	**$ 4,889,512**	$ 2,408,486
Buildings and leasehold improvements	**125,274,358**	109,893,844
Equipment	**101,055,036**	95,975,645
Construction in process (2010 estimated cost to complete $4,601,400)	**630,806**	4,251,661
Less accumulated depreciation	**(132,727,325)**	(114,398,504)
	$ 99,122,387	$ 98,131,132

Unamortized internally developed software costs totaled $968,970 and $1,280,233 at September 30, 2010 and 2009, respectively. Amortization expense for the years ended September 30, 2010 and 2009 was $591,171 and $213,372, respectively.

The Hospital wrote off approximately $853,000 of fully depreciated assets in 2010.

11. Property, Plant, and Equipment (continued)

In 2004, the Hospital began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2010 and 2009 was $640,018 and $705,436, respectively.

The Hospital leases various types of equipment with annual payments ranging from $103 to $55,600. Expenses as a result of these leases were approximately $375,000 and $478,000 for the years ended September 30, 2010 and 2009, respectively.

Prior to the merger described in Note 1, the Hospital leased various properties from a related party. Rent expense for those leases totaled approximately $644,000 for the year ended September 30, 2009. Leases with unrelated parties previously held by the related party were assumed by the Hospital.

Future minimum lease payments under the above leases during each of the next five years were as follows:

2011	$ 935,358
2012	726,417
2013	718,648
2014	137,725
2015	65,380
	$ 2,583,528

12. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross accounts receivable from patients and third-party payors at September 30 is as follows:

	2010	2009
Medicare	**27%**	25%
Self pay	**24**	24
Health Maintenance Organizations	**15**	17
Anthem Blue Cross/Blue Shield	**14**	14
Medicaid	**10**	8
Commercial	**5**	5
Other state agencies	**5**	7
	100%	100%

13. Contingencies

There have been malpractice claims that fall within the Hospital's partially self-insured program (see Note 1) which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2010 that may result in the assertion of claims. Hospital management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position or results of operations.

14. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2010	**2009**
Rental income	**$ 1,222,133**	$ 568,148
Cafeteria sales	**1,063,020**	1,049,650
Grants	**733,844**	642,728
Condominium income	**389,640**	440,047
Miscellaneous	**361,626**	424,282
Child care	**355,497**	336,700
Purchase discounts	**351,343**	274,879
Interest	**196,253**	476,907
	$ 4,673,356	$ 4,213,341

15. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2010	**2009**
Health care services	**$ 213,627,999**	$ 202,673,597
General and administrative	**48,673,060**	48,413,021
Fundraising	**190,865**	
	$ 262,491,924	$ 251,086,618

Costs for interest and insurance are included in general and administrative expenses. Malpractice insurance is included in health care services.

16. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2010	2009
(Increase) decrease in assets:		
Accounts receivable	**$ (9,057,522)**	$ (19,326,365)
Collection on pledges	**348,127**	
Due from affiliates	**(141,929)**	(513,894)
Inventories of supplies, prepaid expenses, and other	**(783,378)**	(474,757)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**3,243,626**	6,975,152
Accounts payable	**(421,931)**	514,416
Employee related obligations	**(1,497,412)**	(279,391)
Interest payable and other accrued liabilities	**1,523,472**	466,534
Salaries and wages, payroll taxes, and taxes withheld from payroll	**(1,998,968)**	1,417,046
Self-insured professional liability	**(66,430)**	(1,358,443)
Other liabilities	**(325,475)**	133,463
Changes in operating assets and liabilities	**$ (9,177,820)**	$ (12,446,239)

Noncash investing and financing activities include the following:

Trusts acquired in merger of Foundation	$ 2,327,313
Net property acquired in merger of Properties	$ 5,593,682
Capital lease acquired in merger of Properties	$ 1,072,619
Capital lease	$ 458,781

17. Subsequent Events

Management evaluated subsequent events through December 2, 2010, the date the financial statements were issued.

Other Financial Information

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Trustees
The William W. Backus Hospital

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Consolidating Balance Sheet

September 30, 2010

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 72,131,779			$ 72,131,779
Assets whose use is limited – required for current liabilities	7,931,590			7,931,590
Accounts receivable, less allowance for uncollectible accounts	30,758,941			30,758,941
Pledges receivable	185,866			185,866
Due from affiliates	647,255	$ 13,833		661,088
Inventories of supplies	3,799,896			3,799,896
Prepaid expenses and other	1,271,686	5,458		1,277,144
Total current assets	116,727,013	19,291		116,746,304
Assets whose use is limited:				
Board-designated investments	96,626,409			96,626,409
Held by trustee	26,988,802			26,988,802
Total assets whose use is limited	123,615,211			123,615,211
Less assets whose use is limited – required for current liabilities	7,931,590			7,931,590
	115,683,621			115,683,621
Property, plant, and equipment, net	99,122,387			99,122,387
Deferred financing costs	1,933,364			1,933,364
Other assets	1,603,864			1,603,864
Total assets	$ 335,070,249	$ 19,291		$ 335,089,540

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The William W. Backus Hospital

Consolidating Balance Sheet (continued)

September 30, 2010

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable – trade	$ 10,129,146			$ 10,129,146
Salaries and wages, payroll taxes, and taxes withheld from payroll	6,206,054			6,206,054
Other accrued liabilities	8,212,416	$ 1,222		8,213,638
Due to third-party reimbursement agencies	2,614,222			2,614,222
Interest payable	754,026			754,026
Current portion of long-term debt	2,032,691			2,032,691
Total current liabilities	29,948,555	1,222		29,949,777
Other liabilities:				
Long-term debt, less current portion	64,591,831			64,591,831
Employee related obligations	57,973,203			57,973,203
Self-insured professional liability	10,514,332			10,514,332
Due to third-party reimbursement agencies	12,767,632			12,767,632
Other	349,678			349,678
	146,196,676			146,196,676
Net assets:				
Unrestricted	147,348,055	18,069		147,366,124
Temporarily restricted	4,101,543			4,101,543
Permanently restricted	7,475,420			7,475,420
Total net assets	158,925,018	18,069		158,943,087
Total liabilities and net assets	$ 335,070,249	$ 19,291		$ 335,089,540

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The William W. Backus Hospital

Consolidating Statement of Operations

Year Ended September 30, 2010

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Operating revenues:				
Net patient service revenue	$ 270,048,715			$ 270,048,715
Other operating revenues	4,283,716	$ 414,529	$ (24,889)	4,673,356
Net assets released from restriction	91,211			91,211
	274,423,642	414,529	(24,889)	274,813,282
Operating expenses:				
Salaries, wages, and professional fees	109,179,026			109,179,026
Payroll taxes and other fringe benefits	27,181,443			27,181,443
Supplies, insurance, and other	90,666,775	414,529	(24,889)	91,056,415
Provision for uncollectible accounts	14,409,876			14,409,876
Depreciation and amortization	17,480,126			17,480,126
Interest	3,185,038			3,185,038
	262,102,284	414,529	(24,889)	262,491,924
Operating income	12,321,358			12,321,358
Nonoperating gains and (losses):				
Income from investments	6,218,347			6,218,347
Contributions	328,840			328,840
Other	(116,761)			(116,761)
Excess of revenues over expenses	$ 18,751,784			$ 18,751,784

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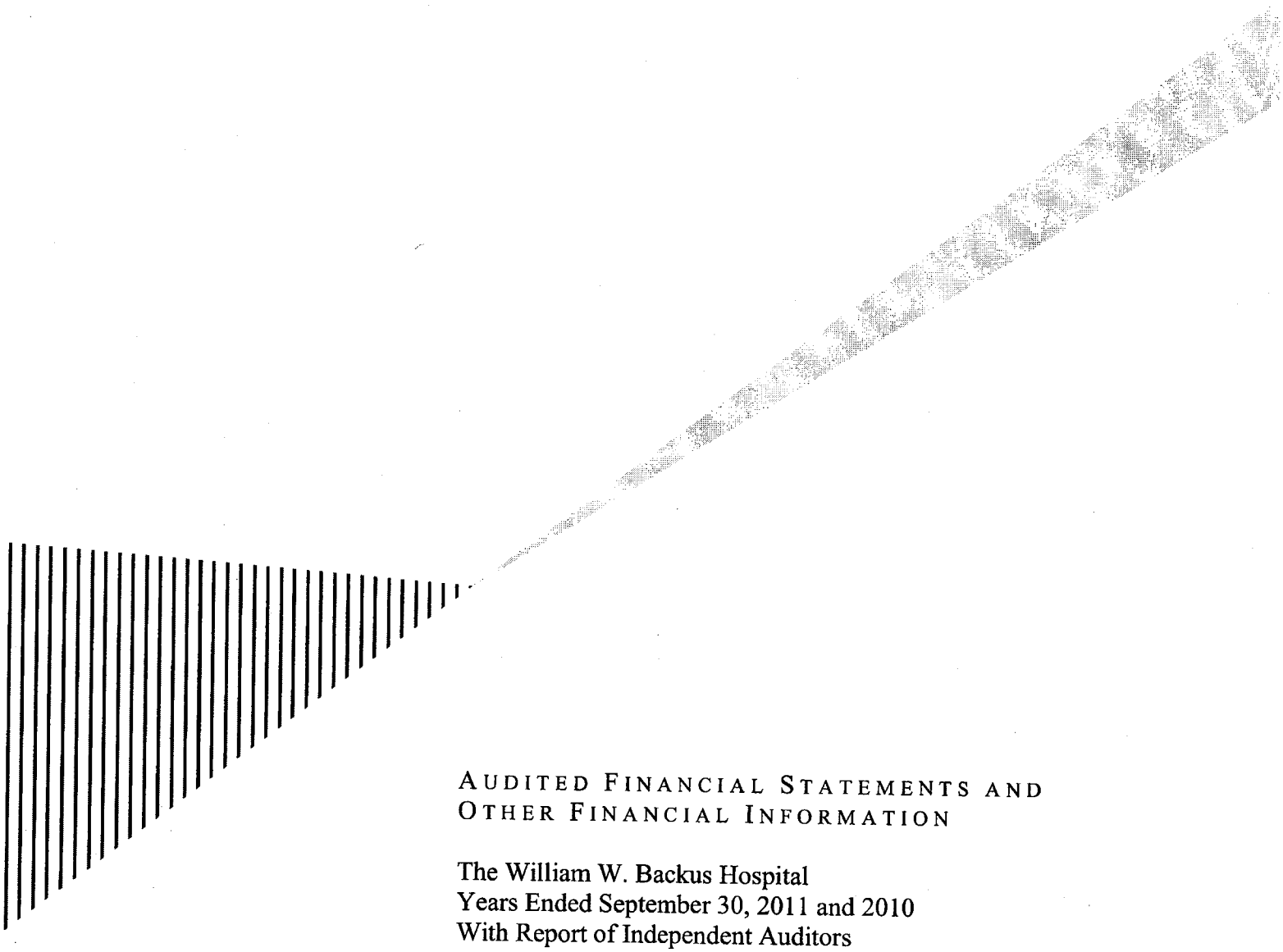

Audited Financial Statements and Other Financial Information

The William W. Backus Hospital
Years Ended September 30, 2011 and 2010
With Report of Independent Auditors

Ernst & Young LLP

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The William W. Backus Hospital

Audited Financial Statements
and Other Financial Information

Years Ended September 30, 2011 and 2010

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
The William W. Backus Hospital

We have audited the accompanying balance sheets of The William W. Backus Hospital (the Hospital) as of September 30, 2011 and 2010, and the related statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Hospital's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The William W. Backus Hospital as of September 30, 2011 and 2010, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst + Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Balance Sheets

	September 30 2011	2010
Assets		
Current assets:		
Cash and cash equivalents	**$ 93,136,217**	$ 72,131,779
Assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
Accounts receivable, less allowance for uncollectible accounts (2011 – $21,200,000; 2010 – $20,081,000)	**32,373,122**	30,758,941
Pledges receivable	**101,211**	185,866
Due from affiliates	**164,147**	661,088
Inventories of supplies	**3,704,067**	3,799,896
Prepaid expenses and other	**1,624,606**	1,277,144
Total current assets	**136,988,852**	116,746,304
Assets whose use is limited:		
Board-designated investments	**105,438,402**	96,626,409
Held by trustee	**28,078,427**	26,988,802
Total assets whose use is limited	**133,516,829**	123,615,211
Less assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
	127,631,347	115,683,621
Property, plant, and equipment, net	**89,983,664**	99,122,387
Deferred financing costs	**1,842,330**	1,933,364
Other assets	**1,542,292**	1,603,864
Total assets	**$ 357,988,485**	$ 335,089,540

	September 30	
	2011	2010
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 9,918,459**	$ 10,129,146
Salaries and wages, payroll taxes, and taxes withheld from payroll	**6,666,138**	6,206,054
Other accrued liabilities	**4,999,447**	8,213,638
Employee related obligations	**3,942,900**	3,589,500
Due to third-party reimbursement agencies	**4,683,178**	2,614,222
Interest payable	**734,838**	754,026
Current portion of long-term debt	**2,115,360**	2,032,691
Total current liabilities	**33,060,320**	33,539,277
Other liabilities:		
Long-term debt	**62,389,713**	64,591,831
Employee related obligations	**69,884,879**	54,383,703
Self-insured professional liability	**10,853,762**	10,514,332
Due to third-party reimbursement agencies	**19,162,526**	12,767,632
Other	**443,183**	349,678
	162,734,063	142,607,176
Net assets:		
Unrestricted	**153,345,431**	147,366,124
Temporarily restricted	**1,399,547**	4,101,543
Permanently restricted	**7,449,124**	7,475,420
Total net assets	**162,194,102**	158,943,087
Total liabilities and net assets	**$ 357,988,485**	$ 335,089,540

See accompanying notes.

The William W. Backus Hospital

Statements of Operations

	Year Ended September 30	
	2011	**2010**
Operating revenues:		
Net patient service revenue	**$ 271,933,218**	$ 270,048,715
Other operating revenues	**4,848,198**	4,673,356
Net assets released from restriction	**673,194**	91,211
	277,454,610	274,813,282
Operating expenses:		
Salaries, wages, and professional fees	**110,169,857**	109,179,026
Payroll taxes and other fringe benefits	**25,655,346**	27,181,443
Supplies, insurance, and other	**83,918,758**	91,056,415
Provision for uncollectible accounts	**12,522,978**	14,409,876
Depreciation and amortization	**16,971,187**	17,480,126
Interest	**3,247,715**	3,185,038
	252,485,841	262,491,924
Operating income	**24,968,769**	12,321,358
Nonoperating gains and (losses):		
Income from investments	**581,947**	6,218,347
Contributions	**158,300**	328,840
Other	**(565,873)**	(116,761)
Excess of revenues over expenses	**$ 25,143,143**	$ 18,751,784

See accompanying notes.

The William W. Backus Hospital

Statements of Changes in Net Assets

	Total	Unrestricted	Temporarily Restricted	Permanently Restricted
Net assets, September 30, 2009	$ 112,621,638	$ 102,312,376	$ 3,447,432	$ 6,861,830
Excess of revenues over expenses	18,751,784	18,751,784		
Investment income	739,782		618,691	121,091
Curtailment gain	34,536,288	34,536,288		
Change in pension funding and postretirement obligation	(9,564,206)	(9,564,206)		
Transfer to affiliates	(73,056)	(73,056)		
Merger of Properties	1,402,938	1,402,938		
Contributions	484,695		126,631	358,064
Change in net assets held in trust	134,435			134,435
Net assets released from restriction	(91,211)		(91,211)	
Increase in net assets	46,321,449	45,053,748	654,111	613,590
Net assets, September 30, 2010	158,943,087	147,366,124	4,101,543	7,475,420
Excess of revenues over expenses	**25,143,143**	**25,143,143**		
Investment (loss) income	**(275,296)**		**(346,369)**	**71,073**
Change in pension funding and postretirement obligation	**(21,176,691)**	**(21,176,691)**		
Transfer to affiliates	**(245,005)**	**(245,005)**		
Contributions	**580,427**		**575,427**	**5,000**
Change in net assets held in trust	**(102,369)**			**(102,369)**
Net assets released from restriction used for purchase of equipment	**2,257,860**	**2,257,860**		
Net assets released from restriction	**(2,931,054)**		**(2,931,054)**	
Increase (decrease) in net assets	**3,251,015**	**5,979,307**	**(2,701,996)**	**(26,296)**
Net assets, September 30, 2011	**$ 162,194,102**	**$ 153,345,431**	**$ 1,399,547**	**$ 7,449,124**

See accompanying notes.

The William W. Backus Hospital

Statements of Cash Flows

	Year Ended September 30 2011	2010
Operating activities		
Increase in net assets	**$ 3,251,015**	$ 46,321,449
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**16,971,187**	17,480,126
Provision for uncollectible accounts	**12,522,978**	14,409,876
Curtailment gain		(34,536,288)
Change in pension funding and postretirement obligation	**21,176,691**	9,564,206
Transfer to affiliates	**245,005**	73,056
Merger of Properties		(1,402,938)
Purchase of investments – board designated, net	**(8,811,993)**	(15,613,572)
Permanently restricted contributions and income	**26,296**	(613,590)
Changes in operating assets and liabilities *(Note 16)*	**(13,216,508)**	(9,177,820)
Net cash provided by operating activities	**32,164,671**	26,504,505
Investing activities		
Purchase of investments – held in trust, net	**(1,089,625)**	(1,917,827)
Net additions to property, plant, and equipment	**(7,741,430)**	(12,056,041)
Decrease (increase) in other assets	**61,572**	(72,956)
Cash transfer from merger		2,226,244
Net cash used in investing activities	**(8,769,483)**	(11,820,580)
Financing activities		
Proceeds from loan		1,250,000
Principal payments on long-term debt and capital lease obligations	**(2,074,347)**	(1,863,950)
Change in deferred financing costs and amortization of bond premium	**(45,102)**	(49,465)
Permanently restricted contributions and income	**(26,296)**	613,590
Transfer to affiliates	**(245,005)**	(73,056)
Net cash used in financing activities	**(2,390,750)**	(122,881)
Net increase in cash and cash equivalents	**21,004,438**	14,561,044
Cash and cash equivalents at beginning of year	**72,131,779**	57,570,735
Cash and cash equivalents at end of year	**$ 93,136,217**	$ 72,131,779

See accompanying notes.

The William W. Backus Hospital

Notes to Financial Statements

September 30, 2011

1. Significant Accounting Policies

Organization

The William W. Backus Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Backus Corporation (the sole member). The Board of Directors of Backus Corporation elects a Board of Trustees that has control of the operations of the Hospital. Refer to Note 9 for further discussion of related party transactions.

The financial statements include the operations of Backus Medical Center Condominium Association, Inc. (the Association). All intercompany transactions have been eliminated in consolidation.

Merger

Effective November 1, 2009, Backus Foundation, Inc. and Backus Properties Inc. were merged into the Hospital. The merger was accounted for as a "pooling of interests". The merger of the Foundation had no impact on net assets because the Foundation was previously accounted for in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-20, *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises of Holds Contributions for Others* . The merger of Properties increased unrestricted net assets by approximately $1,400,000 in 2010.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Department of Public Health, Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Cash Equivalents

The Hospital considers all highly liquid time deposits, commercial paper, and money market mutual funds purchased with a maturity at date of acquisition of three months or less to be cash equivalents.

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman, or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements of the Hospital. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority), as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenues over expenses unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method), or market.

Property, Plant, and Equipment

Property, plant, and equipment are stated on the basis of cost. The Hospital provides for depreciation using the straight-line method in amounts sufficient to depreciate the cost of its assets over their estimated useful lives.

1. Significant Accounting Policies (continued)

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions, which is included in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying financial statements.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $5,000,000 annually for 2011 and $4,000,000 for 2010. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues Over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include pension curtailment gains, equity transfers from affiliates, both temporarily and permanently restricted donations and investment income, changes in perpetual trust arrangements and the change in pension funding and postretirement obligations.

1. Significant Accounting Policies (continued)

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Association is a taxable entity; however, any taxes are immaterial to the financial statements of the Hospital taken as a whole.

Adoption of New Authoritative Pronouncements

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which will be effective for the Hospital's fiscal 2012, the guidance in ASU 2010-06 became effective for the Hospital's fiscal 2011. The adoption of the provisions of ASU 2010-06 did not impact the Hospital's consolidated financial statements.

In January 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions*, (ASU 2010-07), which establishes accounting and disclosure requirements for how a not-for-profit entity determines whether a combination is a merger or an acquisition, how to account for each, and the required disclosures. In addition, ASU 2010-07 included amendments to FASB's Accounting Standards Codification (the Codification, or ASC) Topic 350, *Intangibles – Goodwill and Other*, (ASC Topic 350), and Topic 810, *Consolidation*, (ASC Topic 810) to make both applicable to not-for-profit entities. ASC Topic 350 clarifies the accounting for goodwill and indefinite-lived identifiable intangible assets recognized in a not-for-profit entity's acquisition of a business or nonprofit activity. Such assets are not amortized and are tested for impairment at least annually. The Hospital adopted the guidance relative to ASU 2010-07 as of October 1, 2010.

1. Significant Accounting Policies (continued)

In August 2010, the FASB issued Accounting Standards Codification ("ASC") 954-605, *Measuring Charity Care for Disclosure.* ASC 954-605 requires that the level of charity care provided be presented based on the direct and indirect costs of the charity services provided. ASC 954-605 also requires separate disclosure of the amount of any cash reimbursements received for providing charity care. ASC 954-605 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Hospital is evaluating the effect of ASC 954-605 on its consolidated financial statements.

In August 2010, the FASB also issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries.* Under ASU 2010-24, anticipated insurance recoveries and estimated liabilities for medical malpractice claims or similar contingent liabilities will be presented separately on the balance sheet. The guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Hospital is evaluating the effect of ASU 2010-24 on its consolidated financial statements.

In July 2011, FASB issued new guidance, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts.* The guidance requires certain health care entities to present the bad debt expense associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense. The guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. The Hospital is evaluating the effect of the new guidance on its consolidated financial statements.

Reclassifications

Certain reclassifications were made to the 2010 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Net patient service revenue for the years ended September 30, 2011 and 2010 consists of the following:

	Year Ended September 30	
	2011	**2010**
Gross patient service revenue	**$ 604,060,585**	$ 585,390,725
Deductions:		
Allowances	**(327,123,232)**	(308,845,388)
Charity care (at charges)	**(5,004,135)**	(6,496,622)
	(332,127,367)	(315,342,010)
	$ 271,933,218	$ 270,048,715

Patient accounts receivable and revenues are recorded when patient services are performed. Differences between amounts received from most third-party payors and the established billing rates of the Hospital are accounted for as allowances.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $2,065,000 in 2011 and had no impact on net patient service revenue for 2010.

Revenues from the Medicare and Medicaid programs accounted for approximately 27.5% and 9.5%, respectively, of the Hospital's net patient service revenue for the year ended September 30, 2011 and 28% and 8% for the year ended September 30, 2010. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations, except as noted in Note 13. While no regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

3. Charity Care

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Hospital does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Hospital's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following table summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 5,004,135**	**$ 2,201,819**
Bad debt	**12,522,978**	**5,510,110**
Total uncompensated care, September 30, 2011	**$ 17,527,113**	**$ 7,711,929**
Charity care	$ 6,496,622	$ 2,858,514
Bad debt	14,409,876	6,340,345
Total uncompensated care, September 30, 2010	$ 20,906,498	$ 9,198,859

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2011	2010
BackusCare campaign	$ 45,546	$ 185,114
Other	57,077	7,077
Unconditional promises to give before unamortized discount	102,623	192,191
Less unamortized discount and allowance	(1,412)	(6,325)
	$ 101,211	$ 185,866
Amounts due in:		
Less than one year	$ 96,211	$ 133,366
One to five years	5,000	52,500
Total	$ 101,211	$ 185,866

5. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30:

	2011	2010
Realized and unrealized (losses) gains on investments	$ (1,163,661)	$ 4,574,175
Interest and dividend income	1,959,569	1,813,339
Other investment income	12,600	11,600
Investment fees	(226,561)	(180,767)
	$ 581,947	$ 6,218,347

5. Investments (continued)

The market value of assets whose use is limited at September 30 is set forth in the following table:

	2011	2010
Board designated:		
Cash and cash equivalents	**$ 41,525,574**	$ 33,837,100
Mutual funds	**37,251,516**	38,540,722
Common stocks	**12,925,056**	13,327,371
Government bonds	**12,811,596**	8,462,882
Corporate bonds	**924,660**	2,458,334
	$105,438,402	$ 96,626,409
Held by trustee:		
Cash and cash equivalents	**$ 24,668,758**	$ 4,430,958
Mutual funds	**2,327,261**	22,211,515
Government bonds	**731,506**	
Common stock	**292,470**	287,581
Real estate	**58,432**	58,748
	$ 28,078,427	$ 26,988,802

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) provides guidance on investment decisions and endowment expenditures for nonprofit organizations. The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift at the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

5. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Hospital's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Hospital's inflation-adjusted value over time. The Hospital's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The Investment Committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets. Any deficits are funded with available temporarily restricted or unrestricted funds so as to maintain the corpus. Subsequent positive market returns replace the deficits.

The activity for the year ended September 30, 2011 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 513,486	$ 5,320,786	$ 5,834,272
Investment return:			
Investment income		151,536	151,536
Net depreciation (realized and unrealized)		(176,945)	(176,945)
Earnings reclassified	(96,482)	96,482	
Total investment (loss) return	(96,482)	71,073	(25,409)
Contributions		5,000	5,000
Endowment net assets at end of year	$ 417,004	$ 5,396,859	$ 5,813,863

5. Investments (continued)

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

6. Fair Value of Financial Instruments

For assets and liabilities required to be measured at fair value, the Hospital measures fair value based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are applied based on the unit of account from the Hospital's perspective. The unit of account determines what is being measured by reference to the level at which the asset or liability is aggregated (or disaggregated) for purposes of applying other accounting pronouncements.

The Hospital follows a valuation hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad categories. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Fair value for Level 2 assets are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers. Level 3 assets consist of asset backed and mortgage backed obligations held by the defined benefit plan which are priced using model-based valuations using market information that best represents the value at which the security could be sold.

6. Fair Value of Financial Instruments (continued)

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Hospital uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

Financial assets as of September 30, 2011 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 95,941,634	$ 852,014		$ 96,793,648
Certificates of deposit		24,901,139		24,901,139
Money market funds	37,571,306	64,456		37,635,762
US government obligations (a)	10,833,829	2,709,273		13,543,102
Corporate bonds (b)	249,858	674,802		924,660
Equity securities	13,217,526			13,217,526
Mutual funds-equities (c)	8,773,825	9,707,473		18,481,298
Mutual funds-international equities (d)	8,140,798	219,147		8,359,945
Mutual funds-fixed income (e)	12,062,082	675,452		12,737,534
Real estate (REIT)		58,432		58,432
Total	$ 186,790,858	$ 39,862,188	–	$ 226,653,046

(a) Includes both Treasury bonds and Treasury stripped bonds.
(b) Includes both foreign and domestic corporate bonds.
(c) This category primarily represents investments in common stock or similar securities of high-quality, financially secure companies listed on principal exchanges.
(d) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(e) This category seeks maximum current income primarily thorough investments in fixed income securities of varying maturities.

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 75,157,255	$ 2,738		$ 75,159,993
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)		58,751		58,751
Total	$ 160,542,096	$ 35,204,894	–	$ 195,746,990

The following table presents the Hospital's fair value hierarchy for defined benefit plan assets as of September 30, 2011. At September 30, 2011, Level 3 assets comprise approximately 0.2% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 10,173,248			$ 10,173,248
Mutual funds-equity (a)	23,965,541	$ 25,514,446		49,479,987
Mutual funds-international equity(b)	22,103,407			22,103,407
Mutual funds-fixed income (c)	9,739,453	38,850		9,778,303
US Government obligations(d)	6,277,919	319,903		6,597,822
Corporate bonds (e)		9,553,768		9,553,768
Mortgage backed obligations		7,777,727	$180,660	7,958,387
Total	$ 72,259,568	$ 43,204,694	$ 180,660	$ 115,644,922

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily thorough investments in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

6. Fair Value of Financial Instruments (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2010 to September 30, 2011.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ 250,065	$ 88,920	$ 338,985
Purchases		99,500	99,500
Unrealized gains (losses)	716	(7,760)	(7,044)
Sales	(250,781)		(250,781)
Total	$ –	$180,660	$ 180,660

The following table presents the Hospital's fair value hierarchy for defined benefit plan assets as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity(b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily through investments in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

6. Fair Value of Financial Instruments (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ –	$ –	$ –
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

The carrying amount of certain of the Hospital's financial instruments, including cash and cash equivalents and pledge receivables approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Hospital's fiscal year end. The fair value of long-term debt is $70,878,867 and $69,437,056 at September 30, 2011 and 2010, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2011	2010
Health care services	**$ 789,466**	$ 499,200
Preventative care	**193,861**	792,377
Extraordinary nursing care	**105,444**	109,852
Nursing education	**87,446**	84,912
Laboratory	**8,522**	228,659
Free beds	**8,066**	25,821
Capital projects		1,733,950
Other	**206,742**	626,772
	$ 1,399,547	$ 4,101,543

7. Temporarily and Permanently Restricted Net Assets (continued)

Income generated by permanently restricted net assets at September 30 is restricted to the following purposes:

	2011	2010
Income to be used:		
For general uses and purposes	**$ 6,605,539**	$ 6,631,835
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,449,124	$ 7,475,420

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2011	2010
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($565,000) to 2012, with an interest rate of 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,080,000**	$ 8,625,000
Series F, serial maturities ($5,875,000) from 2012 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,000,000**	28,725,000
Series G, serial maturities ($17,730,000) from 2012 to 2026, with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5%	**25,150,000**	25,775,000
Other long-term debt:		
Mortgage, maturing May 1, 2025 with a fixed interest rate of 6.125%	**1,183,176**	1,236,586
Obligations under capital leases	**1,379,926**	1,505,864
	63,793,102	65,867,450
Add net unamortized bond premium	**711,971**	757,072
Less current portion	**(2,115,360)**	(2,032,691)
Long-term debt	**$ 62,389,713**	$ 64,591,831

8. Long-term Debt (continued)

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital, and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets, and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principal and interest on the Series E, Series F and Series G bonds.

Series E bonds are subject to redemption prior to maturity. Series F bonds are subject to optional redemption prior to maturity. Series G bonds maturing after July 1, 2015 are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years, and in the aggregate, are as follows:

	Long-Term Debt	Capital Leases
2012	$ 2,021,619	$ 361,204
2013	2,105,440	361,204
2014	2,184,302	361,204
2015	2,303,411	336,859
2016	2,387,624	263,904
Aggregate thereafter	51,410,780	2,111,232
	62,413,176	3,795,607
Add net unamortized bond premium	711,971	
Less interest		(2,415,681)
	$ 63,125,147	$ 1,379,926

The Hospital paid interest of $3,312,005 and $3,323,608 in 2011 and 2010, respectively. Interest incurred in 2011 and 2010 was $3,247,715 and $3,185,038, respectively.

In 2010 the Hospital entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

8. Long-term Debt (continued)

In 2010 the Hospital also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2011 was $326,520. Under the terms of the lease, the Hospital has the option to renew for five periods of five years each.

Deferred financing costs are amortized over the life of the bonds.

9. Related Party Transactions

The Hospital processes payroll and disbursements for several of its affiliated entities for which it is reimbursed. Reimbursements due to the Hospital at September 30, 2011 and 2010 were approximately $165,000 and $647,000, respectively.

10. Retirement Benefit Plans

Effective January 1, 2010, the Hospital amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Hospital will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Hospital will also make a non-elective transition contribution equal to 3% of employee's eligible earnings for all employees who meet the transition participant criteria. The Hospital may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the years ended September 30, 2011 and 2010 was $5,206,397 and $3,589,500, respectively.

The Hospital also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the cost based on years of service. In addition, the Hospital sponsors a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2011 and 2010 is approximately $2,600,000 related to the future obligation for the nonqualified benefits.

10. Retirement Benefit Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
	(In thousands)			
Unrecognized actuarial (loss) gain	**$ (64,522)**	$ (43,157)	**$ 1,600**	$ 1,734
Unrecognized transition obligation			**(565)**	(889)
	$ (64,522)	$ (43,157)	**$ 1,035**	$ 845

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2012 are $4,557,386 and $323,491, respectively.

At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities. At September 30, 2011, the unfunded status of the pension plan is included in long-term liabilities in the amount of $60,301,776. The unfunded status of the postretirement benefits is $4,083,669, with $435,510 included in short-term liabilities, and the remainder of $3,648,159 included in long-term liabilities.

10. Retirement Benefit Plans (continued)

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2011 and 2010.

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
	(In thousands)			
Change in projected benefit obligation				
Benefit obligation at beginning of year	$ (158,266)	$ (171,831)	$ (4,266)	$ (4,969)
Service cost		(1,836)	(4)	(15)
Interest cost	(7,963)	(7,684)	(207)	(267)
Change in assumptions	(12,536)	(11,951)	(147)	387
Actuarial (loss) gain	(2,006)	(3,598)	113	154
Effect of curtailment		34,551		
Benefits paid	4,825	4,083	428	444
Benefit obligation at end of year	$ (175,946)	$ (158,266)	$ (4,083)	$ (4,266)
Change in plan assets				
Fair value of plan assets at beginning of year	$ 114,203	$ 100,145		
Actual return on plan assets	(1,834)	10,017		
Contributions	8,100	8,124	$ 428	$ 444
Benefits paid	(4,825)	(4,083)	(428)	(444)
Fair value of plan assets at end of year	$ 115,644	$ 114,203	$	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	$ (60,302)	$ (44,063)	$ (4,083)	$ (4,266)
Components of net periodic benefit cost				
Service cost		$ 1,836	$ 4	$ 15
Interest cost	$ 7,963	7,684	207	267
Expected return on plan assets	(7,832)	(6,901)		
Net amortization and deferral	2,843	1,964	224	269
Net periodic benefit cost	$ 2,974	$ 4,583	$ 435	$ 551
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	4.60%	5.10%	4.60%	5.10%
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	5.10	5.60	5.10	5.60
Expected long-term rate of return on plan assets	6.75	6.75		

10. Retirement Benefit Plans (continued)

The accumulated benefit obligation at September 30, 2011 and 2010 was $175,946,699 and $158,266,226, respectively.

The asset allocations for the retirement plan at the end of 2011 and 2010 and the target allocation by asset category are as follows:

Asset Category	Target Allocation		Percentage of Plan Assets	
	Minimum	Maximum	2011	2010
US Equity Large Cap	20%	50%	**34%**	31%
US Equity Small Cap		15	**5**	5
International Equity	10	30	**15**	17
Core Fixed Income	20	60	**46**	47
Total			**100%**	100%

The Hospital Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Hospital Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2012	$ 8,100,000	$ 435,510
Estimated future benefit payments:		
2012	5,621,240	435,510
2013	6,120,026	423,489
2014	6,721,770	414,800
2015	7,280,102	392,976
2016	7,768,999	370,874
2017-2021	47,330,022	1,533,884

10. Retirement Benefit Plans (continued)

Assumed healthcare cost trend rates for 2011 are as follows:	
Health care trend rate assumed for next year	7.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2015

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (1)
Effect on postretirement benefit obligation	$ 6	$ (5)

11. Property, Plant, and Equipment

Property, plant, and equipment at September 30 consist of the following:

	2011	2010
Land and land improvements	**$ 4,862,121**	$ 4,889,512
Buildings and leasehold improvements	**125,984,685**	125,274,358
Equipment	**98,557,288**	101,055,036
Construction in process (2012 estimated cost to complete $5,995,000)	**1,365,773**	630,806
Less accumulated depreciation	**(140,786,203)**	(132,727,325)
	$ 89,983,664	$ 99,122,387

The net unamortized value of internally developed software was $388,314 and $968,970 at September 30, 2011 and 2010, respectively. Amortization expense for the years ended September 30, 2011 and 2010 was $596,429 and $591,171, respectively.

The Hospital wrote off approximately $7,299,000 of fully depreciated assets in 2011.

11. Property, Plant, and Equipment (continued)

The Hospital leases space to be used for patient services. Two years remain on the initial term, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2011 and 2010 was $655,574 and $640,018, respectively.

The Hospital leases various types of equipment with annual payments ranging from $103 to $39,000. Expenses as a result of these leases were approximately $362,000 and $375,000 for the years ended September 30, 2011 and 2010, respectively

Future minimum lease payments under the above leases during each of the next five years were as follows:

2012	$ 907,327
2013	831,624
2014	173,838
2015	118,349
2016	11,378
	$ 2,042,516

12. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross accounts receivable from patients and third-party payors at September 30 is as follows:

	2011	2010
Medicare	**26%**	27%
Self pay	**23**	24
Health Maintenance Organizations	**17**	15
Anthem Blue Cross/Blue Shield	**15**	14
Medicaid	**10**	10
Commercial	**5**	5
Other state agencies	**4**	5
	100%	100%

13. Contingencies

There have been malpractice claims that fall within the Hospital's partially self-insured program (see Note 1) which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2011, that may result in the assertion of claims. Hospital management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

Hospital management believes that it may not have conformed to all applicable laws and regulations regarding certain arrangements with outside parties. An internal investigation is underway and management has estimated and accrued a liability related to this matter. Except for this matter, Hospital management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of any potential wrongdoing.

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position or results of operations.

14. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2011	**2010**
Rental income	**$ 1,336,398**	$ 1,222,133
Cafeteria sales	**1,102,713**	1,063,020
Miscellaneous	**590,792**	361,626
Grants	**578,977**	733,844
Condominium income	**412,106**	389,640
Child care	**391,976**	355,497
Purchase discounts	**269,594**	351,343
Interest	**165,642**	196,253
	$ 4,848,198	$ 4,673,356

15. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2011	**2010**
Health care services	**$ 200,530,936**	$ 213,627,999
General and administrative	**51,760,982**	48,673,060
Fundraising	**193,923**	190,865
	$ 252,485,841	$ 262,491,924

Costs for interest and insurance are included in general and administrative expenses. Malpractice insurance is included in health care services.

16. Cash Flows

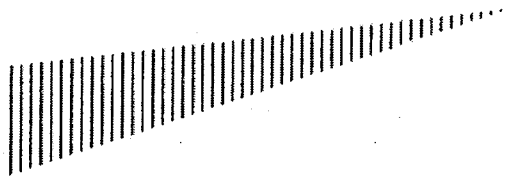
Changes in operating assets and liabilities at September 30 include the following:

	2011	**2010**
(Increase) decrease in assets:		
Accounts receivable	**$ (14,137,159)**	$ (9,057,522)
Pledges receivable	**84,655**	348,127
Due from affiliates	**496,941**	(141,929)
Inventories of supplies, prepaid expenses, and other	**(251,633)**	(783,378)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**8,463,850**	3,243,626
Accounts payable	**(210,687)**	(421,931)
Employee related obligations	**(5,322,115)**	(1,497,412)
Interest payable and other accrued liabilities	**(3,233,379)**	1,523,472
Salaries and wages, payroll taxes, and taxes withheld from payroll	**460,084**	(1,998,968)
Self-insured professional liability	**339,430**	(66,430)
Other liabilities	**93,505**	(325,475)
Changes in operating assets and liabilities	**$ (13,216,508)**	$ (9,177,820)

17. Subsequent Events

The Hospital evaluates the impact of subsequent events, which are events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date for the year ended September 30, 2011. The Hospital evaluated subsequent events through January 27, 2012, which is the date the financial statements were issued. No events occurred that require disclosure or adjustment to the combined financial statements.

Other Financial Information



Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Trustees
The William W. Backus Hospital

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Ernst + Young LLP

January 27, 2012

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The William W. Backus Hospital

Consolidating Balance Sheet

September 30, 2011

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 93,136,217			$ 93,136,217
Assets whose use is limited – required for current liabilities	5,885,482			5,885,482
Accounts receivable, less allowance for uncollectible accounts	32,373,122			32,373,122
Pledges receivable	101,211			101,211
Due from affiliates	161,210	$ 2,937		164,147
Inventories of supplies	3,704,067			3,704,067
Prepaid expenses and other	1,608,996	15,610		1,624,606
Total current assets	136,970,305	18,547		136,988,852
Assets whose use is limited:				
Board-designated investments	105,438,402			105,438,402
Held by trustee	28,078,427			28,078,427
Total assets whose use is limited	133,516,829			133,516,829
Less assets whose use is limited – required for current liabilities	5,885,482			5,885,482
	127,631,347			127,631,347
Property, plant, and equipment, net	89,983,664			89,983,664
Deferred financing costs	1,842,330			1,842,330
Other assets	1,542,292			1,542,292
Total assets	$ 357,969,938	$ 18,547		$ 357,988,485

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The William W. Backus Hospital

Consolidating Balance Sheet (continued)

September 30, 2011

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable – trade	$ 9,918,459			$ 9,918,459
Salaries and wages, payroll taxes, and taxes withheld from payroll	6,666,138			6,666,138
Other accrued liabilities	4,998,969	$ 478		4,999,447
Employee related obligations	3,942,900			3,942,900
Due to third-party reimbursement agencies	4,683,178			4,683,178
Interest payable	734,838			734,838
Current portion of long-term debt	2,115,360			2,115,360
Total current liabilities	33,059,842	478		33,060,320
Other liabilities:				
Long-term debt, less current portion	62,389,713			62,389,713
Employee related obligations	69,884,879			69,884,879
Self-insured professional liability	10,853,762			10,853,762
Due to third-party reimbursement agencies	19,162,526			19,162,526
Other	443,183			443,183
	162,734,063			162,734,063
Net assets:				
Unrestricted	153,327,362	18,069		153,345,431
Temporarily restricted	1,399,547			1,399,547
Permanently restricted	7,449,124			7,449,124
Total net assets	162,176,033	18,069		162,194,102
Total liabilities and net assets	$ 357,969,938	$ 18,547		$ 357,988,485

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The William W. Backus Hospital

Consolidating Statement of Operations

Year Ended September 30, 2011

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Operating revenues:				
Net patient service revenue	$ 271,933,218			$ 271,933,218
Other operating revenues	4,436,092	$ 440,909	$ (28,803)	4,848,198
Net assets released from restriction	673,194			673,194
	277,042,504	440,909	(28,803)	277,454,610
Operating expenses:				
Salaries, wages, and professional fees	110,169,857			110,169,857
Payroll taxes and other fringe benefits	25,655,346			25,655,346
Supplies, insurance, and other	83,506,652	440,909	(28,803)	83,918,758
Provision for uncollectible accounts	12,522,978			12,522,978
Depreciation and amortization	16,971,187			16,971,187
Interest	3,247,715			3,247,715
	252,073,735	440,909	(28,803)	252,485,841
Operating income	24,968,769			24,968,769
Nonoperating gains and (losses):				
Income from investments	581,947			581,947
Contributions	158,300			158,300
Other	(565,873)			(565,873)
Excess of revenues over expenses	$ 25,143,143			$ 25,143,143

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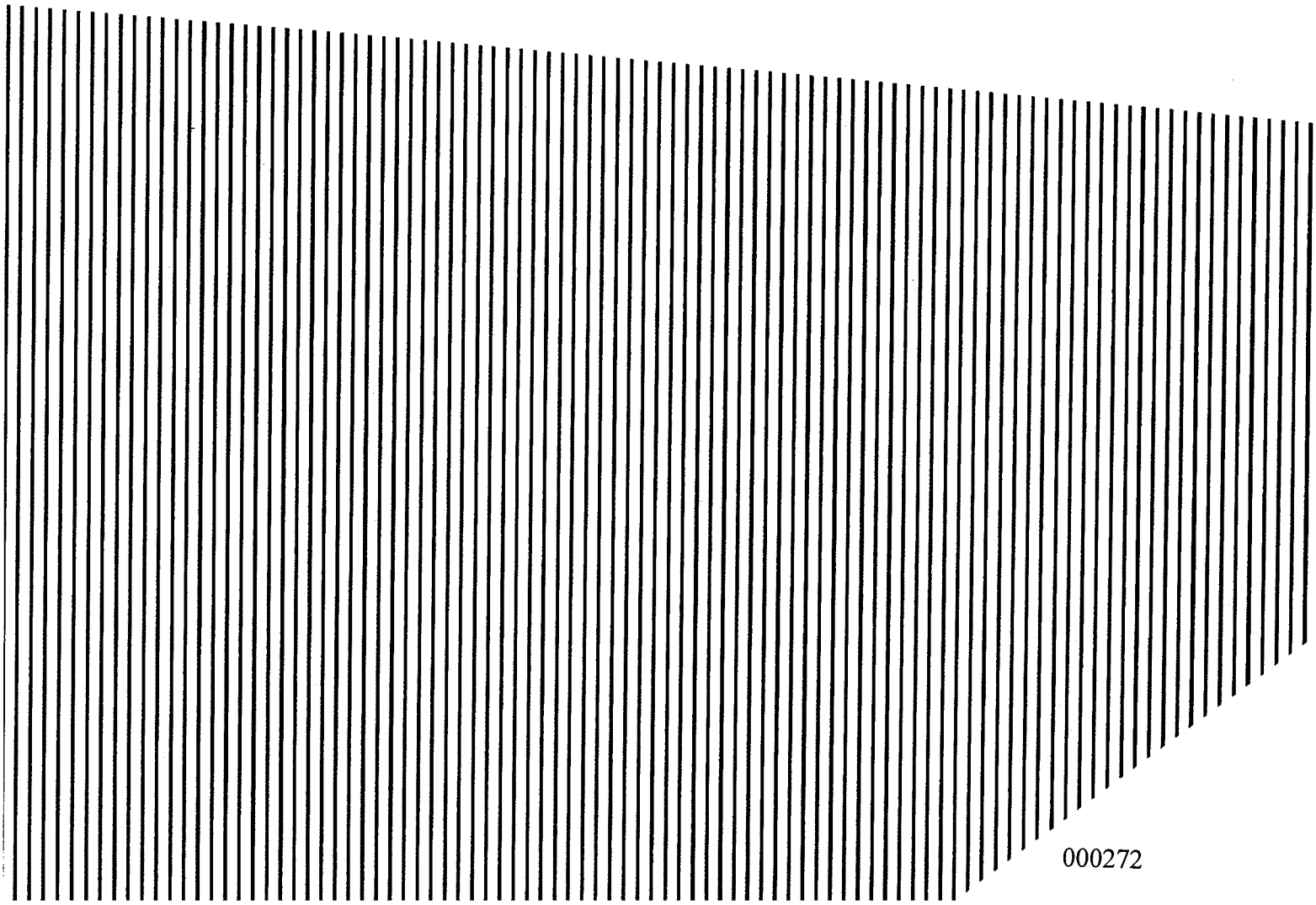

Audited Consolidated Financial Statements and Other Financial Information

Backus Corporation and Subsidiaries
Years Ended September 30, 2009 and 2008
With Report of Independent Auditors

Backus Corporation and Subsidiaries

Audited Consolidated Financial Statements
and Other Financial Information

Years Ended September 30, 2009 and 2008

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors

The Board of Trustees
Backus Corporation and Subsidiaries

We have audited the accompanying consolidated balance sheets of Backus Corporation and Subsidiaries (the Corporation) as of September 30, 2009 and 2008, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Corporation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Backus Corporation and Subsidiaries as of September 30, 2009 and 2008, and the consolidated results of its operations, changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 1, 2009

Backus Corporation and Subsidiaries

Consolidated Balance Sheets

	September 30 2009	2008
Assets		
Current assets:		
Cash and cash equivalents	**$ 62,155,067**	$ 50,429,864
Assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
Accounts receivable, less allowance for uncollectible accounts (2009 – $21,206,000; 2008 – $16,169,000)	**38,032,269**	35,783,224
Pledges receivable	**533,993**	1,103,017
Inventories of supplies	**3,367,607**	2,004,317
Prepaid expenses and other	**1,023,236**	1,871,894
Total current assets	**112,352,984**	97,840,503
Assets whose use is limited:		
Board-designated and donor restricted	**81,012,837**	77,540,189
Held by trustee	**25,070,975**	20,554,290
Total assets whose use is limited	**106,083,812**	98,094,479
Less assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
	98,843,000	91,446,292
Property, plant and equipment, net	**103,839,068**	100,690,508
Deferred financing costs	**2,025,397**	2,118,397
Other assets	**2,837,828**	4,325,328
Total assets	**$ 319,898,277**	$ 296,421,028

	September 30	
	2009	**2008**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 11,143,511**	$ 10,146,787
Salaries and wages, payroll taxes and taxes withheld from payroll	**8,955,228**	7,358,943
Other accrued liabilities	**9,568,027**	7,548,447
Due to third-party reimbursement agencies	**2,310,804**	1,750,429
Current portion of long-term debt	**1,833,475**	1,810,232
Total current liabilities	**33,811,045**	28,614,838
Other liabilities:		
Long-term debt, less current portion	**64,995,680**	67,121,518
Employee related obligations	**84,442,697**	39,209,762
Self-insured professional liability	**10,580,762**	11,939,205
Due to third-party reimbursement agencies	**10,307,215**	3,892,438
Other	**675,153**	541,666
	171,001,507	122,704,589
Net assets:		
Unrestricted	**104,776,463**	136,705,366
Temporarily restricted	**3,447,432**	2,475,427
Permanently restricted	**6,861,830**	5,920,808
Total net assets	**115,085,725**	145,101,601
Total liabilities and net assets	**$ 319,898,277**	$ 296,421,028

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Operations

	Years Ended September 30	
	2009	**2008**
Operating revenues:		
Net patient service revenue	**$ 271,765,388**	$ 251,767,293
Other operating revenue	**4,412,193**	4,930,976
Net assets released from restrictions	**86,494**	72,396
	276,264,075	256,770,665
Operating expenses:		
Salaries, wages and professional fees	**120,907,812**	109,220,049
Payroll taxes and other fringe benefits	**29,445,026**	25,284,879
Supplies, insurance and other	**80,131,898**	82,630,439
Provision for uncollectible accounts	**17,106,501**	14,689,011
Depreciation and amortization	**17,335,024**	16,814,826
Interest	**3,361,670**	3,277,607
	268,287,931	251,916,811
Operating income	**7,976,144**	4,853,854
Nonoperating gains and (losses)		
Contributions and donations	**429,646**	384,478
Investment income	**5,177,633**	(12,766,293)
	5,607,279	(12,381,815)
Excess (deficiency) of revenues over expenses	**$ 13,583,423**	$ (7,527,961)

Backus Corporation and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Total	Unrestricted	Restricted	Permanently Restricted
Net assets, October 1, 2007	$168,392,530	$ 159,117,857	$ 2,945,255	$ 6,329,418
Excess of revenues over expenses	(7,527,961)	(7,527,961)		
Contributions	797,210		792,190	5,020
Investment income	(715,227)		(715,227)	
Net assets released from restriction	(546,791)		(546,791)	
Change in pension funding and postretirement obligation	(14,558,507)	(14,558,507)		
Current year acquisition	(326,023)	(326,023)		
Change in net assets held in trust	(413,630)			(413,630)
Increase in net assets	(23,290,929)	(22,412,491)	(469,828)	(408,610)
Net assets, September 30, 2008	145,101,601	136,705,366	2,475,427	5,920,808
Contributions	**1,712,752**		**742,752**	**970,000**
Investment income	**315,747**		**315,747**	
Excess of revenues over expenses	**13,583,423**	**13,583,423**		
Net assets released from restriction	**(86,494)**		**(86,494)**	
Effect of early measurement date elimination	**(1,762,428)**	**(1,762,428)**		
Change in pension funding and postretirement obligation	**(43,749,898)**	**(43,749,898)**		
Change in net assets held in trust	**(28,978)**			**(28,978)**
(Decrease) increase in net assets	**(30,015,876)**	**(31,928,903)**	**972,005**	**941,022**
Net assets, September 30, 2009	**$115,085,725**	**$ 104,776,463**	**$ 3,447,432**	**$ 6,861,830**

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	Years Ended September 30	
	2009	**2008**
Operating activities		
Decrease in net assets	**$ (30,015,876)**	$ (23,290,929)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,335,024**	16,814,826
Provision for uncollectible accounts	**17,106,501**	14,689,011
Effect of early measurement date elimination	**1,762,428**	
Change in pension funding and postretirement obligation	**43,749,898**	14,558,507
(Purchase) proceeds from sale of investments-board designated, net	**(3,472,648)**	14,928,912
Changes in operating assets and liabilities:		
Accounts receivable and pledge receivable	**(18,786,522)**	(18,499,304)
Inventories of supplies, prepaid expenses and other	**(514,632)**	170,941
Accounts payable	**996,724**	(3,026,456)
Employee related obligations	**(279,391)**	(3,431,132)
Other accrued liabilities	**2,019,580**	456,030
Salaries and wages, payroll taxes and taxes withheld from payroll	**1,596,285**	1,605,186
Due to third-party reimbursement agencies	**6,975,152**	3,155,801
Self-insured professional liability	**(1,358,443)**	3,297,056
Other liabilities	**133,487**	280,127
Net cash provided by operating activities	**37,247,567**	21,708,576
Investing activities		
Purchase of investments-held in trust, net	**(4,516,685)**	(810,209)
Net additions to property, plant and equipment	**(19,263,913)**	(16,728,230)
Decrease in other assets	**360,829**	99,522
Net cash used in investing activities	**(23,419,769)**	(17,438,917)
Financing activities		
Principal payments on long-term debt	**(2,050,962)**	(900,485)
Change in deferred financing costs and amortization of bond premium	**(51,633)**	(127,164)
Net cash used in financing activities	**(2,102,595)**	(1,027,649)
Net increase in cash and cash equivalents	**11,725,203**	3,242,010
Cash and cash equivalents at beginning of year	**50,429,864**	47,187,854
Cash and cash equivalents at end of year	**$ 62,155,067**	$ 50,429,864

See accompanying notes.

Backus Corporation and Subsidiaries

Notes to Consolidated Financial Statements

September 30, 2009

1. Significant Accounting Policies

Organization

Backus Corporation (Corporation) is a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation provides overall direction and control for The William W. Backus Hospital (the Hospital), Backus Foundation, Inc. (Foundation) and Backus Health Care, Inc. Backus Properties, Inc. (Properties), a not-for-profit organization, holds and manages certain nonpatient related properties for the Corporation. WWB Corporation conducts the related for-profit activities of the Corporation, its sole shareholder. Omni Home Health Services of Eastern Connecticut LLC dba Backus Home Health Services provides continual home care to patients. Backus Physician Services, LLC provides surgical services. The accompanying consolidated statements of operations include the excess (deficiency) of revenue over expenses as the performance indicator. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenues and expenses; peripheral or incidental transactions are reported as nonoperating items. All intercompany transactions have been eliminated in consolidation. Subsequent to year end, Backus Foundation Inc. and Backus Properties Inc. will cease to exist as separate entities and all assets, liabilities, equity and operations will merge into the Hospital. The merger will not impact the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority) as more fully explained in Note 6. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities, with readily determinable fair values, are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenue over expense unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

Property, Plant and Equipment

Property, plant and equipment are stated on the basis of cost. The Corporation and its subsidiaries provide for depreciation using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

1. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying consolidated financial statements.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in nonoperating gains and losses. Conditional promises to give are not included as support until the conditions are substantially met.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for 2009 and 2008. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in pension funding and postretirement obligation, changes in the fair value of the interest rate swap current year acquisitions, and the effect of early measurement date elimination.

Cash Equivalents

The Corporation considers all highly liquid time deposits, commercial paper and money market mutual funds purchased with a maturity date at acquisition of three months or less to be cash equivalents.

1. Significant Accounting Policies (continued)

Income Taxes

The Corporation, the Hospital, the Foundation, and Backus Health Care, Inc. are not-for-profit organizations exempt from federal income taxes on related income under Section 501(c)(3); Backus Properties, Inc. is a not-for-profit title holding corporation exempt from federal income taxes under Section 501(c)(2); WWB Corporation is a taxable stock corporation; CONNCare Inc., a subsidiary of Backus Health Care, is a taxable, nonstock corporation. Backus Home Health Services is a partnership taxable to its members and Backus Physician Services, LLC is a taxable, nonstock corporation.

Accounting Standards Codification (ASC) 740-10, *Uncertain Tax Positions*, (ASC 740-10), prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the consolidated financial statements is not significant.

CONNCare, Inc. has a net operating loss carry-forward of $5,390,745. This net operating loss results in a potential deferred tax asset in the amount of approximately $2,200,000. WWB Corporation, Inc. has a net operating loss carry-forward of $459,599. This net operating loss results in a potential deferred tax asset in the amount of approximately $184,000. Neither asset has been recorded as these assets are offset by valuation allowances of the same amounts.

Adoption of New Authoritative Pronouncements

In June 2009, the Financial Accounting Standards Board (FASB) issued FASB ASC 105, *Generally Accepted Accounting Principles* (ASC 105), which establishes the FASB Accounting Standards Codification as the sole source of authoritative GAAP. Pursuant to the provisions of ASC 105, the Corporation has updated references to GAAP in its financial statements for the year ended September 30, 2009. The adoption of ASC 105 did not impact the Corporation's consolidated financial position or results of operations.

Effective 2009, the Corporation adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with GAAP, and expands disclosure about fair value measurements.

1. Significant Accounting Policies (continued)

In 2009, the Corporation adopted ASC 825-10, *Fair Value Option*, which permits companies to choose to measure certain financial instruments and other items at fair value that are not currently required to be measured at fair value. The Corporation did not elect fair value accounting for any asset or liability not currently required to be measured at fair value.

In June 2009, the Corporation adopted provisions of ASC 855-10, *Subsequent Events*, which establishes standards of accounting for disclosure of events or transactions that occur after the balance sheet date, but before the financial statements are issued or available to be issued. ASC 855-10 is effective on a prospective basis for financial periods ended after June 15, 2009. The adoption of ASC 855-10 in 2009 did not impact the Corporation's consolidated financial position or results of operations. Management evaluated subsequent events through December 1, 2009, the date the consolidated financial statements were available to be issued.

2. Revenues from Services to Patients and Charity Care

Patient accounts receivable and revenues are recorded when patient services are performed.

For 2009 and 2008, Hospital revenue accounted for 96% of net patient service revenue. The following summarizes net patient service revenue:

	Year Ended September 30	
	2009	**2008**
Gross patient service revenue	**$ 578,445,014**	$ 524,204,277
Deductions:		
Allowances	**(299,764,222)**	(265,835,156)
Charity care (at charges)	**(6,915,404)**	(6,601,828)
	(306,679,626)	(272,436,984)
Net patient service revenue	**$ 271,765,388**	$ 251,767,293

2. Revenues from Services to Patients and Charity Care (continued)

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $671,000 and $3,600 in 2009 and 2008, respectively.

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 7%, respectively, of the Corporation's net patient service revenue for the year ended September 30, 2009 and 30% and 6% for the year ended September 30, 2008. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Corporation.

3. Charity Care

The Corporation provides services without charge or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Corporation does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Corporation's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

3. Charity Care (continued)

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,915,404**	**$ 3,042,778**
Bad debt	**17,106,501**	**7,526,860**
Total uncompensated care, September 30, 2009	**$ 24,021,905**	**$ 10,569,638**
Charity care	$ 6,601,828	$ 3,016,131
Bad debt	14,689,011	6,710,866
Total uncompensated care, September 30, 2008	$ 21,290,839	$ 9,726,997

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2009 and 2008:

	Year Ended September 30 2009	2008
Realized and unrealized gains (losses) on investments	**$ 1,229,304**	$ (15,367,123)
Interest and dividend income	**2,015,679**	2,420,054
Investment in joint ventures	**2,420,701**	1,306,303
Other investment losses	**(269,976)**	(809,893)
Investment fees	**(218,075)**	(315,634)
	$ 5,177,633	$ (12,766,293)

4. Investments (continued)

The market value of assets whose use is limited at September 30, is set forth in the following table:

	2009	2008
Board designated:		
Cash and cash equivalents	**$ 18,129,468**	$ 16,123,886
Common stock	**13,153,726**	15,281,005
Corporate bonds	**9,815,901**	6,875,227
Government bonds	**15,780,860**	17,695,487
Mutual funds	**24,132,882**	21,564,584
	$ 81,012,837	$ 77,540,189
Held by trustee:		
Cash and cash equivalents	**$ 4,804,214**	$ 8,096,731
Mutual funds	**17,496,461**	9,613,200
Government bonds	**442,987**	446,525
Other marketable securities	**2,327,313**	2,397,834
	$ 25,070,975	$ 20,554,290

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which provides guidance on the net asset classification of donor restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

4. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Corporation's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Corporation's inflation-adjusted value over time. The Corporation's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The investment committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider expenditures based on need and current market conditions as well as long-term investment goals.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets. The activity for year end September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$4,841,631	$ 4,976,846

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2009	2008
Capital Projects	**$ 1,548,434**	$ 933,829
Preventative care	**763,501**	778,537
Health care services	**414,281**	340,180
Other	**358,416**	66,956
Laboratory	**184,552**	181,410
Extraordinary nursing care	**97,635**	96,765
Nursing education	**70,948**	68,085
Free beds	**9,665**	9,665
	$ 3,447,432	$ 2,475,427

Permanently restricted net assets at September 30 are restricted to the following:

	2009	2008
Income to be used:		
For general purposes	**$ 6,018,245**	$ 5,077,223
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 6,861,830	$ 5,920,808

6. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2009	2008
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,630,000) from 2010 to 2012 with interest rates ranging from 4.60% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 9,145,000**	$ 9,640,000
Series F, serial maturities ($7,300,000) from 2010 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**29,425,000**	30,100,000
Series G, serial maturities ($18,960,000) from 2010 to 2026 with interest rates of 3.25% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5.00%	**26,380,000**	26,965,000
Other long-term debt:		
Mortgage paid in full August 2009		289,273
Obligation under capital lease	**1,072,619**	1,079,308
	66,022,619	68,073,581
Add net unamortized bond premium	**806,536**	858,169
Less current portion	**(1,833,475)**	(1,810,232)
Long-term debt	**$ 64,995,680**	$ 67,121,518

The Master Indenture related to the tax-exempt Hospital revenue bonds, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. The mortgages are secured by a warehouse and by certain leasehold improvements. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principle and interest on the Series E, Series F, and Series G bonds.

6. Long-term Debt (continued)

Bonds maturing on or after July 1, 2008, are subject to redemption prior to maturity commencing July 1, 2008. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015, are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015, are subject to optional redemption prior to maturity.

Future minimum principal payments during each of the next five fiscal years and in the aggregate are as follows:

	Hospital	Backus Properties	Total
2010	$ 1,825,000	$ 8,475	$ 1,833,475
2011	1,895,000	10,738	1,905,738
2012	1,965,000	13,604	1,978,604
2013	2,045,000	17,235	2,062,235
2014	2,120,000	21,836	2,141,836
Aggregate thereafter	55,100,000	1,000,731	56,100,731
	64,950,000	1,072,619	66,022,619
Less current portion	1,825,000	8,475	1,833,475
Add net unamortized bond premium	806,536		806,536
	$ 63,931,536	$ 1,064,144	$ 64,995,680

The Corporation paid interest of $3,428,396 and $2,981,305 in 2009 and 2008, respectively. Interest incurred in 2009 and 2008 was $3,361,670 and $3,277,607, respectively.

In June 2008 the Hospital remarketed its Series F bonds, converting them from a variable auction rate to a fixed rate. As a result, the swap associated with the original bond issue, which was intended to effectively fix the interest rate paid on the bonds, was terminated. The change in the value of the swap presented in the statement of operations at September 30, 2008 of $(843,514) reflects the change in the fair value of the swap plus the reclassification of prior deferrals.

7. Retirement Benefit Plans

The Corporation maintains a noncontributory defined benefit pension plan covering substantially all of its employees. The Corporation also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsored a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2009 and 2008 is approximately 3,600,000 and 850,000 respectively, related to the future obligation for the nonqualified benefits.

Effective January 1, 2010, the Corporation will amend its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants. Management anticipates that the change in the pension plan will result in a reduction of the unfunded liability of approximately $35 million. It is the Corporation's intention to establish a defined contribution plan concurrent with the amendment of the defined benefit plan.

Effective October 1, 2008, the Corporation adopted ASC 715-20, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, which requires elimination of the early measurement date of the plans.

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2009	**2008**	**2009**	**2008**
	(In Thousands)			
Unrecognized actuarial (loss) gain	**$ (67,240)**	$ (26,335)	**$ 1,249**	$ 2,223
Unrecognized prior service cost	**(15)**	(19)		
Unrecognized transition obligation			**(1,213)**	(1,617)
	$ (67,255)	$ (26,354)	**$ 36**	$ 606

The prior service cost, actuarial (loss) gain and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2010 are $3,323, $5,129,108 and $323,491, respectively.

7. Retirement Benefit Plans (continued)

At September 30, 2008, the unfunded status of the pension plan is included in long-term liabilities in the amount of $30,206,752. The unfunded status of the postretirement benefits is $5,045,761, with $479,175 included in short-term liabilities, and the remainder of $4,566,586 included in long-term liabilities. At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities.

The following table sets forth the funded status of the plans as of the measurement date of September 30 in 2009 and June 30 in 2008 for each plan and amounts recognized in the Corporation's consolidated balance sheets at September 30. In 2008, contributions made subsequent to the measurement date, but prior to September 30, reduced the accrued benefit liability.

	Pension Benefits		Postretirement Benefits	
	2009	**2008**	**2009**	**2008**
		(In Thousands)		
Change in benefit obligations				
Benefit obligations at beginning of year	**$ (133,189)**	$ (124,809)	**$ (5,156)**	$ (5,524)
Service cost	**(4,484)**	(4,620)	**(22)**	(30)
Interest cost	**(9,002)**	(7,986)	**(338)**	(334)
Change in assumptions	**(38,217)**	5,256	**(557)**	134
Actuarial (loss) gain	**(2,156)**	(4,249)	**383**	199
Effect of early measurement date elimination	**11,740**		**295**	
Benefits paid	**3,477**	3,219	**428**	399
Benefit obligations at end of year	**$ (171,831)**	$ (133,189)	**$ (4,967)**	$ (5,156)
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,957**	$ 102,625		
Actual return on plan assets	**2,662**	(7,224)		
Effect of early measurement date elimination	**(8,097)**			
Contributions	**8,100**	8,775	**$ 428**	$ 399
Benefits paid	**(3,477)**	(3,219)	**(428)**	(399)
Fair value of plan assets at end of year	**$ 100,145**	$ 100,957	**$**	$
Reconciliation of underfunded status				
Underfunded status	**$ (71,686)**	$ (32,232)	**$ (4,969)**	$ (5,156)
Contribution subsequent to measurement date		2,025		111
Accrued benefit liability recognized in the balance sheets	**$ (71,686)**	$ (30,207)	**$ (4,969)**	$ (5,045)

7. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2009	2008	2009	2008
	(in thousands)			
Components of net periodic benefit cost				
Service cost	**$ 4,484**	$ 4,620	**$ 22**	$ 30
Interest cost	**9,002**	7,986	**338**	334
Expected return on plan assets	**(7,605)**	(8,417)		
Net amortization and deferral	**1,129**	3	**(541)**	(260)
Net periodic benefit cost	**$ 7,010**	$ 4,192	**$ (181)**	$ 104
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.60%**	6.50%	**5.60%**	6.50%
Rate of compensation increase	**5.00**	5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**7.25**	6.25	**7.25**	6.25
Expected long-term rate of return on plan assets	**8.00**	8.00		
Rate of compensation increase	**5.00**	5.00		

The expected long-term rate of return on plan assets was determined by the expected return on each asset class based on a model that considers historical and expected future performance.

The accumulated benefit obligation at September 30, 2009 and 2008 was $137,279,286 and $107,697,366, respectively.

The asset allocation for the retirement plan at the end of 2009 and 2008 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	**Minimum**	**Maximum**	**2009**	**2008**
US Equity Large Cap	35%	45%	**27%**	34%
US Equity Small Cap		10	**4**	5
International Equity	17	27	**17**	19
Core Fixed Income	25	35	**52**	42
Real estate		6		
Total			**100%**	100%

7. Retirement Benefit Plans (continued)

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2010	$ 8,100,000	$ 462,097
Estimated future benefit payments:		
2010	4,462,917	462,097
2011	4,982,416	464,756
2012	5,495,548	472,761
2013	6,025,576	481,792
2014	6,719,521	481,673
2015-2019	46,736,124	2,066,165

Assumed healthcare cost trend rates for 2009 are as follows:	
Health care trend rate assumed for next year	8.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 2	$ (2)
Effect on postretirement benefit obligation	$ 26	$(22)

8. Contingencies

There have been malpractice claims that fall within the Corporation's partially self-insured program (see Note 1, Organization and Accounting Policies) which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2009 that may result in the assertion of claims. Corporation management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

The Corporation is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Corporation's financial position.

9. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2009	2008
BackusCare campaign	**$ 553,353**	$ 1,163,035
Other	**7,077**	7,077
Unconditional promises to give before unamortized discount	**560,430**	1,170,112
Less unamortized discount and allowance	**(26,437)**	(67,095)
	$ 533,993	$ 1,103,017
Amounts due in:		
Less than one year	**$ 414,993**	$ 490,504
One to five years	**119,000**	612,513
Total	**$ 533,993**	$ 1,103,017

10. Property, Plant and Equipment

Property, plant and equipment at September 30 consist of the following:

	2009	2008
Land and land improvements	**$ 4,905,192**	$ 4,741,682
Buildings and leasehold improvements	**115,686,063**	107,777,362
Equipment	**96,886,734**	87,154,025
Construction in process (2009 estimated cost to complete $6,900,000)	**4,251,661**	4,438,532
Less accumulated depreciation	**(117,890,582)**	(103,421,093)
	$ 103,839,068	$ 100,690,508

Included in construction in progress at September 30, 2009 are $1,280,000 of internally developed software costs. The Corporation wrote off approximately $1,426,000 of fully depreciated assets in 2009.

In 2004, the Corporation began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2009 and 2008 was $705,436 and $667,384, respectively.

The Corporation leases various types of equipment with annual payments ranging from $103 to $119,064. Expenses as a result of these leases were approximately $478,000 and $928,000 for the years ended September 30, 2009 and 2008, respectively.

Future minimum lease payments under the above leases during each of the next five years were as follows:

2010	$ 1,257,360
2011	1,042,391
2012	775,265
2013	748,603
2014	145,161
Aggregate thereafter	1,102,588
	$ 5,071,368

11. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2009	**2008**
Cafeteria sales	**$ 1,049,650**	$ 989,415
Grants	**642,728**	630,810
Rental income	**663,647**	630,448
Interest	**476,907**	1,505,928
Condominium income	**440,047**	306,803
Miscellaneous	**527,635**	381,709
Child care	**336,700**	350,051
Purchase discounts	**274,879**	135,812
	$ 4,412,193	$ 4,930,976

12. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2009	**2008**
Health care services	**$ 200,628,303**	$ 189,364,177
General and administrative	**67,467,717**	62,248,517
Fundraising	**191,911**	304,117
	$ 268,287,931	$ 251,916,811

13. Concentrations of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. For 2009 and 2008, Hospital receivables accounted for 95% and 94%, respectively. The mix of accounts receivable, net of contractual allowances, from patients and third-party payors at September 30 is as follows:

	2009	%	2008	%
Medicare	**$ 14,223,122**	**25%**	$ 12,265,855	25%
Medicaid	**4,685,984**	**8**	3,166,368	6
Anthem Blue Cross/Blue Shield	**7,989,343**	**14**	8,128,274	16
Health Maintenance Organizations	**9,452,755**	**17**	7,671,571	16
Commercial	**2,776,338**	**5**	3,140,618	6
Self pay	**13,430,756**	**24**	11,688,493	24
Other state agencies	**4,182,234**	**7**	3,231,784	7
	56,740,532	**100%**	49,292,963	100%
Less allowance for uncollectible accounts	**20,629,237**		15,609,715	
	$36,111,295		$ 33,683,248	

14. Fair Value of Financial Instruments

On October 1, 2008, the Corporation adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

14. Fair Value of Financial Instruments (continued)

Financial assets and liabilities as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 62,155,067		$	$ 62,155,067
Assets whose use is limited	106,083,812			106,083,812
Pledges receivable	533,993			533,993

The carrying amount of certain of the Corporation's financial instruments, including cash and cash equivalents and pledges receivable, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at fiscal year end. The fair value of fixed rate debt is $68,087,973 and $65,336,934 at September 30, 2009 and 2008, respectively.

Other Financial Information

ERNST & YOUNG

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Directors
Backus Corporation and Subsidiaries

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Ernst + Young LLP

December 1, 2009

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 45,846	$ 57,570,735	$ 2,085,506	$ 1,108,911	$ 140,738	$ 1,203,331		$ 62,155,067
Assets whose use is limited – required for current liabilities		7,240,812						7,240,812
Accounts receivable, less allowance for uncollectible accounts		36,111,295		839,709	30,125	1,051,140		38,032,269
Pledges receivable			533,993					533,993
Inventories of supplies		3,252,641		114,966				3,367,607
Prepaid expenses and other		925,340		9,671	85,556	2,669		1,023,236
Due from affiliates	27,582	3,901,924					$ (3,929,506)	
Total current assets	73,428	109,002,747	2,619,499	2,073,257	256,419	2,257,140	(3,929,506)	112,352,984
Assets whose use is limited:								
Board-designated and donor restricted		44,500,233	36,512,604					81,012,837
Held by trustee		22,743,662	2,327,313					25,070,975
Total assets whose use is limited		67,243,895	38,839,917					106,083,812
Less assets whose use is limited – required for current liabilities		7,240,812						7,240,812
		60,003,083	38,839,917					98,843,000
Interest in Foundation		41,147,474					(41,147,474)	
Property, plant, and equipment, net		98,131,132		90,657	5,593,682	23,597		103,839,068
Deferred financing costs		2,025,397						2,025,397
Other assets	1,000	1,801,751		966,810		85,112	(16,845)	2,837,828
	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

000304

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable-trade		$ 10,508,835	$ 11,448	$ 394,244	$ 30,263	$ 198,721		$ 11,143,511
Salaries and wages, payroll taxes and taxes withheld from payroll		8,205,022	531	369,819		379,856		8,955,228
Due to affiliates	$284,800		45,983	118,309	3,336,782	143,632	$ (3,929,506)	
Other accrued liabilities		7,190,212	253,980	1,801,202		322,633		9,568,027
Due to third-party reimbursement agencies		1,831,013				479,791		2,310,804
Current portion of long-term debt		1,825,000			8,475			1,833,475
Total current liabilities	284,800	29,560,082	311,942	2,683,574	3,375,520	1,524,633	(3,929,506)	33,811,045
Other liabilities:								
Long-term debt, less current portion		63,931,536			1,064,144			64,995,680
Employee related obligations		84,442,697						84,442,697
Self-insured professional liability		10,580,762						10,580,762
Due to third-party reimbursement agencies		10,307,215						10,307,215
Other		667,654			7,499			675,153
		169,929,864			1,071,643			171,001,507
Net assets:								
Common stock						1,000	(1,000)	
Unrestricted	(210,372)	102,312,376		447,150	1,402,938	840,216	(15,845)	104,776,463
Temporarily restricted		3,447,432	34,308,847				(34,308,847)	3,447,432
Permanently restricted		6,861,830	6,838,627				(6,838,627)	6,861,830
Total net assets	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Total liabilities and net assets	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

000305

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 259,652,271		$ 5,073,240		$ 7,128,542	$ (88,665)	$ 271,765,388
Other operating revenue	$ 125,004	4,213,341		81,199	$ 1,099,706	22,154	(1,129,211)	4,412,193
Net assets released from restrictions			$ 547,411				(460,917)	86,494
	125,004	263,865,612	547,411	5,154,439	1,099,706	7,150,696	(1,678,793)	276,264,075
Operating expenses:								
Salaries, wages and professional fees	256,742	112,184,033	155,336	4,348,579	24,755	3,938,367		120,907,812
Payroll taxes and other fringe benefits	35,218	27,425,902	40,414	969,731	3,238	970,523		29,445,026
Supplies, insurance and other	18,420	74,547,698	351,661	3,963,600	741,108	1,727,287	(1,217,876)	80,131,898
Provision for uncollectible accounts		16,898,318		74,663		133,520		17,106,501
Depreciation and amortization		16,939,369		28,162	352,257	15,236		17,335,024
Interest		3,091,298			270,372			3,361,670
	310,380	251,086,618	547,411	9,384,735	1,391,730	6,784,933	(1,217,876)	268,287,931
Operating (loss) income	(185,376)	12,778,994		(4,230,296)	(292,024)	365,763	(460,917)	7,976,144
Nonoperating gains and (losses):								
Contributions and donations							429,646	429,646
Change in equity interest in net assets of the Foundation		(3,735,563)					3,735,563	
Investment income	92	2,432,928		2,347,772	(2,049)	164,759	234,131	5,177,633
	92	(1,302,635)		2,347,772	(2,049)	164,759	4,399,340	5,607,279
Excess (deficiency) of revenues over expenses	$ (185,284)	$ 11,476,359	$	$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423

* Includes Backus Condominium Association

000306

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ (185,284)	$ 11,476,359		$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423
Change in equity interest in net assets of the Foundation		3,938,423					(3,938,423)	
Change in pension funding obligation		(45,512,326)						(45,512,326)
Increase (decrease) in unrestricted net assets	(185,284)	(30,097,544)		(1,882,524)	(294,073)	530,522		(31,928,903)
Temporarily restricted net assets:								
Contributions			$ 1,172,398				(429,646)	742,752
Income from investments		1,350	548,528				(234,131)	315,747
Change in equity interest in net assets of the Foundation		970,655					(970,655)	
Net assets released from restrictions			(547,411)				460,917	(86,494)
Increase (decrease) in temporarily restricted net assets		972,005	1,173,515				(1,173,515)	972,005
Permanently restricted net assets								
Contributions			970,000					970,000
Change in net assets held in trust			(28,978)					(28,978)
Change in equity interest in net assets of the Foundation		941,022					(941,022)	
Increase in permanently restricted net assets		941,022	941,022				(941,022)	941,022
Increase (decrease)in net assets	(185,284)	(28,184,517)	2,114,537	(1,882,524)	(294,073)	530,522	(2,114,537)	(30,015,876)
Net assets (deficit) at beginning of year	(25,088)	140,806,155	39,032,937	2,329,674	1,697,011	310,694	(39,049,782)	145,101,601
Net assets (deficit) at end of year	$ (210,372)	$ 112,621,638	$ 41,147,474	$ 447,150	$ 1,402,938	$ 841,216	$ (41,164,319)	$ 115,085,725

* Includes Backus Condominium Association

000307

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,457	$ 834,815	$ 262,639		$ 1,108,911
Accounts receivable, less allowance for uncollectible accounts		511,479	328,230		839,709
Inventories of supplies		114,966			114,966
Prepaid expenses		9,113	558		9,671
Due from affiliates	24,624	749,606		$ (774,230)	
Total current assets	36,081	2,219,979	591,427	(774,230)	2,073,257
Property, plant and equipment:					
Buildings and leasehold improvements		59,768			59,768
Equipment		268,112	48,323		316,435
Accumulated depreciation		(270,306)	(15,240)		(285,546)
		57,574	33,083		90,657
Other assets		966,810			966,810
	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 13,318	$ 380,926		$ 394,244
Salaries and wages, payroll taxes and taxes withheld from payroll		270,617	99,202		369,819
Other accrued liabilities		1,801,202			1,801,202
Due to affiliates	$ 28,334	114,599	749,606	$ (774,230)	118,309
Total current liabilities	28,334	2,199,736	1,229,734	(774,230)	2,683,574
Net assets (deficit)	7,747	1,044,627	(605,224)		447,150
Total liabilities and net assets	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724

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Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,943,958	$ 1,129,282		$ 5,073,240
Other operating revenue	$ 36,936	67,042	14,157	$ (36,936)	81,199
Total revenues	36,936	4,011,000	1,143,439	(36,936)	5,154,439
Expenses:					
Salaries and wages		2,870,703	1,477,876		4,348,579
Payroll taxes and fringe benefits		805,491	164,240		969,731
Supplies and other	38,486	3,098,692	863,358	(36,936)	3,963,600
Provision for uncollectible accounts		4,057	70,606		74,663
Depreciation and amortization		17,434	10,728		28,162
Total expenses	38,486	6,796,377	2,586,808	(36,936)	9,384,735
Operating loss	(1,550)	(2,785,377)	(1,443,369)		(4,230,296)
Nonoperating gains:					
Investment income	20	2,347,630	122		2,347,772
Deficiency of revenue over expenses	(1,530)	(437,747)	(1,443,247)		(1,882,524)
Net assets at beginning of year	9,277	1,482,374	838,023		2,329,674
Net assets (deficit) at end of year	$ 7,747	$ 1,044,627	$ (605,224)	$	$ 447,150

000309

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2009

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,061,007	$ 142,324		$ 1,203,331
Accounts receivable, less allowance for uncollectible accounts		1,051,140		1,051,140
Prepaid expenses and other		2,669		2,669
Due from affiliates	184,628		$ (184,628)	
Total current assets	1,245,635	1,196,133	(184,628)	2,257,140
Property, plant and equipment:				
Lease improvements		3,872		3,872
Equipment		350,608		350,608
Accumulated depreciation		(330,883)		(330,883)
		23,597		23,597
Other assets	81,312	3,800		85,112
	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 198,721		$ 198,721
Salaries and wages, payroll taxes and taxes withheld from payroll		379,856		379,856
Other accrued liabilities		322,633		322,633
Due to third party reimbursement agencies		479,791		479,791
Due to affiliates	$ 143,632	184,628	$ (184,628)	143,632
Total current liabilities	143,632	1,565,629	(184,628)	1,524,633
Common stock	1,000			1,000
Retained earnings (deficit)	1,182,315	(342,099)		840,216
Total liabilities and net assets	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849

000310

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,128,542		$ 7,128,542
Other operating revenue		22,154		22,154
Total revenues		7,150,696		7,150,696
Expenses:				
Salaries and wages		3,938,367		3,938,367
Payroll taxes and fringe benefits		970,523		970,523
Supplies and other	$ 80,645	1,646,642		1,727,287
Provision for uncollectible accounts		133,520		133,520
Depreciation and amortization		15,236		15,236
Total expenses	80,645	6,704,288		6,784,933
Operating (loss) income	(80,645)	446,408		365,763
Nonoperating gains:				
Investment income	164,599	160		164,759
Excess of revenue over expenses	83,954	446,568		530,522
Net assets (deficit) at beginning of year	1,098,361	(788,667)		309,694
Net assets (deficit) at end of year	$ 1,182,315	$ (342,099)	$	$ 840,216

000311

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 63,252	$ 46,717,416	$ 1,409,496	$ 961,177	$ 93,566	$ 1,184,957		$ 50,429,864
Assets whose use is limited – required for current liabilities		6,648,187						6,648,187
Accounts receivable, less allowance for uncollectible accounts		33,683,248		1,218,969	35,643	845,364		35,783,224
Pledges receivable			1,103,017					1,103,017
Inventories of supplies		1,923,318		80,999				2,004,317
Prepaid expenses and other		1,779,906			65,646	26,342		1,871,894
Due from affiliates	133,816	3,388,030					$ (3,521,846)	
Total current assets	197,068	94,140,105	2,512,513	2,261,145	194,855	2,056,663	(3,521,846)	97,840,503
Assets whose use is limited:								
Board-designated and donor restricted		43,002,912	34,537,277					77,540,189
Held by trustee		18,156,456	2,397,834					20,554,290
Total assets whose use is limited		61,159,368	36,935,111					98,094,479
Less assets whose use is limited – required for current liabilities		6,648,187						6,648,187
		54,511,181	36,935,111					91,446,292
Interest in Foundation		39,032,937					(39,032,937)	
Property, plant, and equipment, net		95,130,673		104,554	5,420,321	34,960		100,690,508
Deferred financing costs		2,118,397						2,118,397
Other assets	1,000	3,788,338		486,913		65,922	(16,845)	4,325,328
	$198,068	$ 288,721,631	$ 39,447,624	$ 2,852,612	$ 5,615,176	$ 2,157,545	$ (42,571,628)	$ 296,421,028

* Includes Backus Condominium Association

000312

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable-trade		$ 9,994,419	$ 10,792	$ 24,535	$ 6,699	$ 110,342		$ 10,146,787
Salaries and wages, payroll taxes and taxes withheld from payroll		6,787,976	12,401	264,014		294,552		7,358,943
Due to affiliates	$221,061		95,972	185,987	2,535,410	483,416	$ (3,521,846)	
Other accrued liabilities	2,095	6,723,678	295,522	48,402		478,750		7,548,447
Due to third-party reimbursement agencies		1,270,638				479,791		1,750,429
Current portion of long-term debt		1,755,000			55,232			1,810,232
Total current liabilities	223,156	26,531,711	414,687	522,938	2,597,341	1,846,851	(3,521,846)	28,614,838
Other liabilities:								
Long-term debt, less current portion		65,808,169			1,313,349			67,121,518
Accrued pension and other retirement costs		35,623,338						35,623,338
Self-insured professional liability		11,939,205						11,939,205
Due to third-party reimbursement agencies		3,892,438						3,892,438
Other		4,120,615			7,475			4,128,090
		121,383,765			1,320,824			122,704,589
Net assets:								
Common stock						1,000	(1,000)	
Unrestricted (deficit)	(25,088)	132,409,920		2,329,674	1,697,011	309,694	(15,845)	136,705,366
Temporarily restricted		2,475,427	33,135,332				(33,135,332)	2,475,427
Permanently restricted		5,920,808	5,897,605				(5,897,605)	5,920,808
Total net assets	(25,088)	140,806,155	39,032,937	2,329,674	1,697,011	310,694	(39,049,782)	145,101,601
Total liabilities and net assets	$198,068	$ 288,721,631	$ 39,447,624	$ 2,852,612	$ 5,615,176	$ 2,157,545	$ (42,571,628)	$ 296,421,028

* Includes Backus Condominium Association

000313

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 242,131,827		$ 4,787,746		$ 5,014,824	$ (167,104)	$ 251,767,293
Other operating revenue	$125,004	4,727,859		53,348	$ 1,066,064	2,025	(1,043,324)	4,930,976
Net assets released from restrictions			$ 1,432,392				(1,359,996)	72,396
	125,004	246,859,686	1,432,392	4,841,094	1,066,064	5,016,849	(2,570,424)	256,770,665
Operating expenses:								
Salaries, wages and professional fees	173,816	102,256,348	158,918	3,328,371	21,133	3,281,463		109,220,049
Payroll taxes and other fringe benefits	23,870	23,695,796	37,862	765,249	2,868	759,234		25,284,879
Supplies, insurance and other	26,550	78,669,671	1,235,612	1,726,009	645,645	1,537,380	(1,210,428)	82,630,439
Provision for uncollectible accounts		14,162,003		55,644		(17,098)	488,462	14,689,011
Depreciation and amortization		16,453,137		26,072	318,021	17,596		16,814,826
Interest		3,003,005			274,602			3,277,607
	224,236	238,239,960	1,432,392	5,901,345	1,262,269	5,578,575	(721,966)	251,916,811
Operating (loss) income	(99,232)	8,619,726		(1,060,251)	(196,205)	(561,726)	(1,848,458)	4,853,854
Nonoperating gains and (losses):								
Contributions and donations							384,478	384,478
Change in equity interest in net assets of the Foundation		(167,456)					167,456	
Investment income	63	(5,444,964)		1,207,007		160,808	(8,689,207)	(12,766,293)
	63	(5,612,420)		1,207,007		160,808	(8,137,273)	(12,381,815)
(Deficiency) excess of revenues over expenses	$ (99,169)	$ 3,007,306	$	$ 146,756	$ (196,205)	$ (400,918)	$ (9,985,731)	$ (7,527,961)

* Includes Backus Condominium Association

000314

Backus Corporation and Subsidiaries

Consolidating Statement of Operations Changes in Net Assets (continued)

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess of revenues over expenses (continued)	$ (99,169)	$ 3,007,306		$ 146,756	$ (196,205)	$ (400,918)	$ (9,985,731)	$ (7,527,961)
Change in equity interest in net assets of the Foundation		(10,497,269)					10,497,269	
Change in pension funding obligation		(14,558,507)						(14,558,507)
Current year acquisition						(326,023)		(326,023)
Equity contribution				6,148,491			(6,148,491)	
Transfer to affiliates				1,000,000			(1,000,000)	
(Decrease) increase in unrestricted net assets	(99,169)	(22,048,470)		7,295,247	(196,205)	(726,941)	(6,636,953)	(22,412,491)
Temporarily restricted net assets:								
Contributions			$ 702,273				89,917	792,190
Income from investments		2,550	(9,406,984)				8,689,207	(715,227)
Change in equity interest in net assets of the Foundation		(472,378)					472,378	
Net assets released from restrictions			(1,432,392)				885,601	(546,791)
Transfers to (from) affiliates			(2,996,569)				2,996,569	
(Decrease) increase in temporarily restricted net assets		(469,828)	(13,133,672)				13,133,672	(469,828)
Permanently restricted net assets								
Contributions			5,020					5,020
Change in net assets held in trust			(413,630)					(413,630)
Change in equity interest in net assets of the Foundation		(408,610)					408,610	
Decrease in permanently restricted net assets		(408,610)	(408,610)				408,610	(408,610)
Increase (decrease) in net assets	(99,169)	(22,926,908)	(13,542,282)	7,295,247	(196,205)	(726,941)	6,905,329	(23,290,929)
Net assets (deficit) at beginning of year	74,081	163,733,063	52,575,219	(4,965,573)	1,893,216	1,037,635	(45,955,111)	168,392,530
Net assets (deficit) at end of year	$ (25,088)	$ 140,806,155	$ 39,032,937	$ 2,329,674	$ 1,697,011	$ 310,694	$ (39,049,782)	$ 145,101,601

* Includes Backus Condominium Association

000315

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2008

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,437	$ 477,609	$ 472,131		$ 961,177
Accounts receivable, less allowance for uncollectible accounts		830,900	388,069		1,218,969
Inventories of supplies		80,999			80,999
Due from affiliates	129,276			$ (129,276)	
Total current assets	140,713	1,389,508	860,200	(129,276)	2,261,145
Property, plant and equipment:					
Buildings and leasehold improvements		59,768			59,768
Equipment		265,246	39,799		305,045
Accumulated depreciation		(255,105)	(5,154)		(260,259)
		69,909	34,645		104,554
Other assets		486,913			486,913
	$ 140,713	$ 1,946,330	$ 894,845	$ (129,276)	$ 2,852,612
Liabilities and net assets					
Current liabilities:					
Accounts payable		$ 7,477	$ 17,058		$ 24,535
Salaries and wages, payroll taxes and taxes withheld from payroll		224,250	39,764		264,014
Other accrued liabilities		48,402			48,402
Due to affiliates	$ 131,436	183,827		$ (129,276)	185,987
Total current liabilities	131,436	463,956	56,822	(129,276)	522,938
Net assets (deficit)	9,277	1,482,374	838,023		2,329,674
Total liabilities and net assets	$ 140,713	$ 1,946,330	$ 894,845	$ (129,276)	$ 2,852,612

000316

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2008

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 4,370,665	$ 417,081		$ 4,787,746
Other operating revenue	$ 36,936	53,348		$ (36,936)	53,348
Total revenues	36,936	4,424,013	417,081	(36,936)	4,841,094
Expenses:					
Salaries and wages		2,948,686	379,685		3,328,371
Payroll taxes and fringe benefits		733,842	31,407		765,249
Supplies and other	38,186	1,562,087	162,672	(36,936)	1,726,009
Provision for uncollectible accounts		55,504	140		55,644
Depreciation and amortization		20,918	5,154		26,072
Total expenses	38,186	5,321,037	579,058	(36,936)	5,901,345
Operating loss	(1,250)	(897,024)	(161,977)		(1,060,251)
Nonoperating gains:					
Investment income	38	1,206,969			1,207,007
(Deficiency) excess of revenue over expenses	(1,212)	309,945	(161,977)		146,756
Net assets (deficit) at beginning of year	10,489	(4,976,062)			(4,965,573)
Contributions		6,148,491	1,000,000		7,148,491
Net assets (deficit) at end of year	$ 9,277	$ 1,482,374	$ 838,023	$	$ 2,329,674

000317

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2008

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 976,620	$ 208,337		$ 1,184,957
Accounts receivable, less allowance for uncollectible accounts		845,364		845,364
Prepaid expenses and other	17,405	8,937		26,342
Due from affiliates	522,830		$ (522,830)	
Total current assets	1,516,855	1,062,638	(522,830)	2,056,663
Property, plant and equipment:				
Equipment		350,608		350,608
Accumulated depreciation		(315,648)		(315,648)
		34,960		34,960
Other assets	65,922			65,922
	$ 1,582,777	$ 1,097,598	$ (522,830)	$ 2,157,545
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 110,342		$ 110,342
Salaries and wages, payroll taxes and taxes withheld from payroll		294,552		294,552
Other accrued liabilities		478,750		478,750
Due to third party reimbursement agencies		479,791		479,791
Due to affiliates	$ 483,416	522,830	$ (522,830)	483,416
Total current liabilities	483,416	1,886,265	(522,830)	1,846,851
Common stock	1,000			1,000
Retained earnings	1,098,361	(788,667)		309,694
Total liabilities and net assets	$ 1,582,777	$ 1,097,598	$ (522,830)	$ 2,157,545

000318

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2008

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 5,014,824		$ 5,014,824
Other operating revenue		2,025		2,025
Total revenues		5,016,849		5,016,849
Expenses:				
Salaries and wages		3,281,463		3,281,463
Payroll taxes and fringe benefits		759,234		759,234
Supplies and other	$ 96,626	1,440,754		1,537,380
Provision for uncollectible accounts		(17,098)		(17,098)
Depreciation and amortization		17,596		17,596
Total expenses	96,626	5,481,949		5,578,575
Operating loss	(96,626)	(465,100)		(561,726)
Nonoperating gains:				
Investment income	158,352	2,456		160,808
(Deficiency) excess of revenue over expenses	61,726	(462,644)		(400,918)
Net assets (deficit) at beginning of year	1,037,635			1,037,635
Current year acquisition		(326,023)		(326,023)
Net assets (deficit) at end of year	$ 1,099,361	$ (788,667)	$ –	$ 310,694

000319

AUDITED CONSOLIDATED FINANCIAL STATEMENTS AND OTHER FINANCIAL INFORMATION

Backus Corporation and Subsidiaries
Years Ended September 30, 2010 and 2009
With Report of Independent Auditors

Backus Corporation and Subsidiaries

Audited Consolidated Financial Statements
and Other Financial Information

Years Ended September 30, 2010 and 2009

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
Backus Corporation and Subsidiaries

We have audited the accompanying consolidated balance sheets of Backus Corporation and Subsidiaries (the Corporation) as of September 30, 2010 and 2009, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Corporation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Backus Corporation and Subsidiaries as of September 30, 2010 and 2009, and the consolidated results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidated Balance Sheets

	September 30 2010	2009
Assets		
Current assets:		
Cash and cash equivalents	**$ 74,929,624**	$ 62,155,067
Assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
Accounts receivable, less allowance for uncollectible accounts (2010 – $20,574,000; 2009 – $21,206,000)	**32,546,895**	38,032,269
Pledges receivable	**185,866**	533,993
Inventories of supplies	**3,885,317**	3,367,607
Prepaid expenses and other	**1,303,628**	1,023,236
Total current assets	**120,782,920**	112,352,984
Assets whose use is limited:		
Board-designated and donor restricted	**96,626,409**	81,012,837
Held by trustee	**26,988,802**	25,070,975
Total assets whose use is limited	**123,615,211**	106,083,812
Less assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
	115,683,621	98,843,000
Property, plant and equipment, net	**99,769,244**	103,839,068
Deferred financing costs	**1,933,364**	2,025,397
Other assets	**2,413,877**	2,837,828
Total assets	**$ 340,583,026**	$ 319,898,277

	September 30	
	2010	**2009**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,942,326**	$ 11,143,511
Salaries and wages, payroll taxes and taxes withheld from payroll	**6,905,328**	8,955,228
Other accrued liabilities	**10,711,877**	9,568,027
Due to third-party reimbursement agencies	**2,963,415**	2,310,804
Current portion of long-term debt	**2,032,691**	1,833,475
Total current liabilities	**33,555,637**	33,811,045
Other liabilities:		
Long-term debt, less current portion	**64,591,831**	64,995,680
Employee related obligations	**57,973,203**	84,442,697
Self-insured professional liability	**10,514,332**	10,580,762
Due to third-party reimbursement agencies	**12,767,632**	10,307,215
Other	**349,678**	675,153
	146,196,676	171,001,507
Net assets:		
Unrestricted	**149,253,750**	104,776,463
Temporarily restricted	**4,101,543**	3,447,432
Permanently restricted	**7,475,420**	6,861,830
Total net assets	**160,830,713**	115,085,725
Total liabilities and net assets	**$ 340,583,026**	$ 319,898,277

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Operations

	Years Ended September 30	
	2010	**2009**
Operating revenues:		
Net patient service revenue	**$ 282,901,504**	$ 271,765,388
Other operating revenue	**4,357,277**	4,412,193
Net assets released from restrictions	**91,211**	86,494
	287,349,992	276,264,075
Operating expenses:		
Salaries, wages and professional fees	**117,710,320**	120,907,812
Payroll taxes and other fringe benefits	**29,622,058**	29,445,026
Supplies, insurance and other	**94,223,260**	80,131,898
Provision for uncollectible accounts	**14,462,163**	17,106,501
Depreciation and amortization	**17,534,609**	17,335,024
Interest	**3,185,038**	3,361,670
	276,737,448	268,287,931
Operating income	**10,612,544**	7,976,144
Nonoperating gains:		
Contributions and donations	**328,840**	429,646
Investment income	**8,486,755**	5,177,633
Other	**77,066**	
	8,892,661	5,607,279
Excess of revenues over expenses	**$ 19,505,205**	$ 13,583,423

Backus Corporation and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Total	Unrestricted	Restricted	Permanently Restricted
Net assets, September 30, 2008	$145,101,601	$ 136,705,366	$ 2,475,427	$ 5,920,808
Contributions	1,712,752		742,752	970,000
Investment income	315,747		315,747	
Excess of revenues over expenses	13,583,423	13,583,423		
Net assets released from restriction	(86,494)		(86,494)	
Effect of early measurement date elimination	(1,762,428)	(1,762,428)		
Change in pension funding and postretirement obligation	(43,749,898)	(43,749,898)		
Change in net assets held in trust	(28,978)			(28,978)
(Decrease) increase in net assets	(30,015,876)	(31,928,903)	972,005	941,022
Net assets, September 30, 2009	115,085,725	104,776,463	3,447,432	6,861,830
Contributions	**484,695**		**126,631**	**358,064**
Investment income	**739,782**		**618,691**	**121,091**
Excess of revenues over expenses	**19,505,205**	**19,505,205**		
Net assets released from restriction	**(91,211)**		**(91,211)**	
Curtailment gain	**34,536,288**	**34,536,288**		
Change in pension funding and postretirement obligation	**(9,564,206)**	**(9,564,206)**		
Change in net assets held in trust	**134,435**			**134,435**
Increase in net assets	**45,744,988**	**44,477,287**	**654,111**	**613,590**
Net assets, September 30, 2010	**$160,830,713**	**$ 149,253,750**	**$ 4,101,543**	**$ 7,475,420**

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	Years Ended September 30	
	2010	**2009**
Operating activities		
Increase (decrease) in net assets	**$ 45,744,988**	$(30,015,876)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,534,609**	17,335,024
Provision for uncollectible accounts	**14,462,163**	17,106,501
Curtailment gain	**(34,536,288)**	
Effect of early measurement date elimination		1,762,428
Change in pension funding and postretirement obligation	**9,564,206**	43,749,898
Purchase of investments-board designated, net	**(15,613,572)**	(3,472,648)
Permanently restricted contributions and income	**(613,590)**	
Changes in operating assets and liabilities *(Note 15)*	**(9,310,288)**	(9,217,760)
Net cash provided by operating activities	**27,232,228**	37,247,567
Investing activities		
Purchase of investments-held in trust, net	**(1,917,827)**	(4,516,685)
Net additions to property, plant and equipment	**(12,643,127)**	(19,263,913)
Decrease in other assets	**153,108**	360,829
Net cash used in investing activities	**(14,407,846)**	(23,419,769)
Financing activities		
Proceeds from loan	**1,250,000**	
Principal payments on long-term debt and capital lease obligations	**(1,863,950)**	(2,050,962)
Change in deferred financing costs and amortization of bond premium	**(49,465)**	(51,633)
Permanently restricted contributions and income	**613,590**	
Net cash used in financing activities	**(49,825)**	(2,102,595)
Net increase in cash and cash equivalents	**12,774,557**	11,725,203
Cash and cash equivalents at beginning of year	**62,155,067**	50,429,864
Cash and cash equivalents at end of year	**$ 74,929,624**	$ 62,155,067

See accompanying notes.

1. Significant Accounting Policies

Organization

Backus Corporation (Corporation) is a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation provides overall direction and control for The William W. Backus Hospital (the Hospital), Backus Foundation, Inc. (Foundation) and Backus Health Care, Inc. Backus Properties, Inc. (Properties), a not-for-profit organization, holds and manages certain nonpatient related properties for the Corporation. WWB Corporation conducts the related for-profit activities of the Corporation, its sole shareholder. Omni Home Health Services of Eastern Connecticut LLC dba Backus Home Health Services provides continual home care to patients. Backus Physician Services, LLC provides surgical services. The accompanying consolidated statements of operations include the excess (deficiency) of revenue over expenses as the performance indicator. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenues and expenses; peripheral or incidental transactions are reported as nonoperating items. All intercompany transactions have been eliminated in consolidation. Effective November 1, 2009, the Foundation and Properties were merged into the Hospital. The merger did not impact the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority) as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities, with readily determinable fair values, are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenue over expense unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

Property, Plant and Equipment

Property, plant and equipment are stated on the basis of cost. The Corporation and its subsidiaries provide for depreciation using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

1. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying consolidated financial statements.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in nonoperating gains and losses. Conditional promises to give are not included as support until the conditions are substantially met.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for both 2010 and 2009. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in pension funding and postretirement obligation, pension curtailment gains, both temporarily and permanently restricted donations and investment income ,changes in trust arrangements , and the effect of early measurement date elimination.

1. Significant Accounting Policies (continued)

Cash Equivalents

The Corporation considers all highly liquid time deposits, commercial paper and money market mutual funds purchased with a maturity date at acquisition of three months or less to be cash equivalents.

Income Taxes

The Corporation, the Hospital, the Foundation, and Backus Health Care, Inc. are not-for-profit organizations exempt from federal income taxes on related income under Section 501(c)(3); Backus Properties, Inc. is a not-for-profit title holding corporation exempt from federal income taxes under Section 501(c)(2); WWB Corporation is a taxable stock corporation; CONNCare Inc., a subsidiary of Backus Health Care, is a taxable, nonstock corporation. Backus Home Health Services is a partnership taxable to its members and Backus Physician Services, LLC is a taxable, nonstock corporation.

Accounting Standards Codification (ASC) 740-10, *Uncertain Tax Positions*, (ASC 740-10), prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the consolidated financial statements is not significant.

CONNCare, Inc. has a net operating loss carry-forward of $5,947,728. This net operating loss results in a potential deferred tax asset in the amount of approximately $2,400,000. No asset has been recorded as these assets are offset by valuation allowances of the same amounts.

Adoption of New Authoritative Pronouncements

Effective 2010, the Hospital adopted ASC 715-20, *Retirement Benefits*, which requires additional disclosures relating to defined benefit pension plans, including additional fair value disclosures for pension assets.

1. Significant Accounting Policies (continued)

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which is delayed until 2011, the guidance in ASU 2010-06 becomes effective for reporting periods beginning after December 15, 2009. Management is currently evaluating the effect that the provisions of ASU 2010-06 will have on the consolidated financial statements.

Reclassifications

Certain reclassifications were made to the 2009 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Patient accounts receivable and revenues are recorded when patient services are performed.

Hospital revenue accounted for 95% and 96% of net patient service revenue, respectively for the years ended September 30, 2010 and 2009. The following summarizes net patient service revenue:

	Year Ended September 30	
	2010	**2009**
Gross patient service revenue	**$ 604,461,491**	$ 578,445,014
Deductions:		
Allowances	**(315,063,365)**	(299,764,222)
Charity care (at charges)	**(6,496,622)**	(6,915,404)
	(321,559,987)	(306,679,626)
Net patient service revenue	**$ 282,901,504**	$ 271,765,388

2. Revenues from Services to Patients and Charity Care (continued)

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates had no impact on net patient service revenue for 2010, and increased net patient service revenue by approximately $671,000 in 2009.

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 8%, respectively, of the Corporation's net patient service revenue for the year ended September 30, 2010 and 28% and 7% for the year ended September 30, 2009. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Corporation.

3. Charity Care

The Corporation provides services without charge or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Corporation does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Corporation's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

3. Charity Care (continued)

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,496,622**	**$ 2,858,514**
Bad debt	**14,462,163**	**6,363,352**
Total uncompensated care, September 30, 2010	**$ 20,958,785**	**$ 9,221,866**
Charity care	$ 6,915,404	$ 3,042,778
Bad debt	17,106,501	7,526,860
Total uncompensated care, September 30, 2009	$ 24,021,905	$ 10,569,638

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2010	2009
BackusCare campaign	**$ 185,114**	$ 553,353
Other	**7,077**	7,077
Unconditional promises to give before unamortized discount	**192,191**	560,430
Less unamortized discount and allowance	**(6,325)**	(26,437)
	$ 185,866	$ 533,993
Amounts due in:		
Less than one year	**$ 133,366**	$ 414,993
One to five years	**52,500**	119,000
Total	**$ 185,866**	$ 533,993

5. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2010 and 2009:

	Year Ended September 30	
	2010	**2009**
Realized and unrealized gains on investments	**$ 4,574,175**	$ 1,229,304
Interest and dividend income	**1,819,741**	2,015,679
Investment in joint ventures	**2,262,006**	2,420,701
Other investment losses	**11,600**	(269,976)
Investment fees	**(180,767)**	(218,075)
	$ 8,486,755	$ 5,177,633

The market value of assets whose use is limited at September 30, is set forth in the following table:

	2010	**2009**
Board designated:		
Mutual funds	**$ 38,540,722**	$ 24,132,882
Cash and cash equivalents	**33,837,100**	18,129,468
Common stocks	**13,327,371**	13,153,726
Government bonds	**8,462,882**	15,780,860
Corporate bonds	**2,458,334**	9,815,901
	$ 96,626,409	$ 81,012,837
Held by trustee:		
Mutual funds	**$ 22,211,515**	$ 19,516,650
Cash and cash equivalents	**4,430,958**	4,804,214
Common stock	**287,581**	307,124
Real estate	**58,748**	
Government bonds		442,987
	$ 26,988,802	$ 25,070,975

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which provides guidance on the net asset classification of donor restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

5. Investments (continued)

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Corporation's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Corporation's inflation-adjusted value over time. The Corporation's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The investment committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets.

5. Investments (continued)

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

The activity for year end September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$4,841,631	$ 4,976,846

6. Fair Value of Financial Instruments

On October 1, 2008, the Corporation adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

6. Fair Value of Financial Instruments (continued)

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 77,955,100	$ 2,738		$ 77,957,838
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)			$ 58,751	58,751
Total	$ 163,339,941	$ 35,146,143	$ 58,751	$ 198,544,835

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Real Estate (REIT)
Beginning balance	-
Purchases	$ 54,286
Unrealized gains	4,465
Total	$ 58,751

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 63,823,514	$ 2,142		$ 63,825,656
Certificates of deposit		4,815,074		4,815,074
Money market funds	14,248,373	50,247		14,298,620
US government obligations	9,075,929			9,075,929
Corporate bonds		8,487,292		8,487,292
Equity securities	13,412,497			13,412,497
Mutual funds	39,000,401	15,323,410		54,323,811
Total	$ 139,560,714	$ 28,678,165		$ 168,238,879

The carrying amount of certain of the Corporation's financial instruments, including cash and cash equivalents, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Corporation's fiscal year end. The fair value of long-term debt is $69,437,056 and $68,087,973 at September 30, 2010 and 2009, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2010	2009
Capital Projects	**$ 1,733,950**	$ 1,548,434
Preventative care	**792,377**	763,501
Other	**626,772**	358,416
Health care services	**499,200**	414,281
Laboratory	**228,659**	184,552
Extraordinary nursing care	**109,852**	97,635
Nursing education	**84,912**	70,948
Free beds	**25,821**	9,665
	$ 4,101,543	$ 3,447,432

7. Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets at September 30 are restricted to the following:

	2010	2009
Income to be used:		
For general purposes	**$ 6,631,835**	$ 6,018,245
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,475,420	$ 6,861,830

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2010	2009
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,110,000) from 2011 to 2012 with interest rates ranging from 4.75% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,625,000**	$ 9,145,000
Series F, serial maturities ($6,600,000) from 2011 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,725,000**	29,425,000
Series G, serial maturities ($18,355,000) from 2011 to 2026 with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5.00%	**25,775,000**	26,380,000
Other long-term debt:		
Mortgage, maturing May 1,2025 with a fixed rate of 6.125%	**1,236,586**	
Obligation under capital leases	**1,505,864**	1,072,619
	65,867,450	66,022,619
Add net unamortized bond premium	**757,072**	806,536
Less current portion	**(2,032,691)**	(1,833,475)
Long-term debt	**$ 64,591,831**	$ 64,995,680

8. Long-term Debt (continued)

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. The mortgages are secured by a warehouse and by certain leasehold improvements. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principle and interest on the Series E, Series F, and Series G bonds.

Bonds maturing on or after July 1, 2008, are subject to redemption prior to maturity commencing July 1, 2008. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015, are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015, are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years and in the aggregate are as follows:

	Long-Term Debt	Capital Leases
2011	$ 1,948,410	$ 386,104
2012	2,021,619	386,104
2013	2,105,440	386,104
2014	2,184,302	386,104
2015	2,303,411	355,554
Aggregate thereafter	53,798,404	2,375,136
	64,361,586	4,275,106
Add net unamortized bond premium	757,072	
Less interest		(2,769,242)
	$ 65,118,658	$ 1,505,864

The Corporation paid interest of $3,323,608 and $3,428,396 in 2010 and 2009, respectively. Interest incurred in 2010 and 2009 was $3,185,038 and $3,361,670, respectively.

In 2010 the Corporation entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

8. Long-term Debt (continued)

In 2010 the Corporation also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2010 was $441,720. Under the terms of the lease, the Hospital has the option to renew for five periods for five years each.

Deferred financing costs are amortized over a period consistent with the life of the bonds.

9. Retirement Benefit Plans

Effective January 1, 2010, the Corporation amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Corporation will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Corporation will also make a non-elective transition contribution equal to 3% for all employees who meet the transition participant criteria. The Corporation may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the year ended September 30, 2010 is $3,589,500.

The Corporation also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsored a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2010 and 2009 is approximately $2,600,000 and $3,600,000, respectively, related to the future obligation for the nonqualified benefits.

9. Retirement Benefit Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
	(In Thousands)			
Unrecognized actuarial (loss) gain	**$ (43,157)**	$ (67,240)	**$ 1,734**	$ 1,249
Unrecognized prior service cost		(15)		
Unrecognized transition obligation			**(889)**	(1,213)
	$ (43,157)	$ (67,255)	**$ 845**	$ 36

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2011 are $2,743,736 and $323,491, respectively.

At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities. At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities.

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2010 and 2009.

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
	(In Thousands)			
Change in benefit obligations				
Benefit obligations at beginning of year	**$ (171,831)**	$ (133,189)	**$ (4,969)**	$ (5,156)
Service cost	**(1,836)**	(4,484)	**(15)**	(22)
Interest cost	**(7,684)**	(9,002)	**(267)**	(338)
Change in assumptions	**(11,951)**	(38,217)	**387**	(558)
Actuarial (loss) gain	**(3,598)**	(2,156)	**154**	382
Effect of curtailment	**34,551**			
Effect of early measurement date elimination		11,740		295
Benefits paid	**4,083**	3,477	**444**	428
Benefit obligations at end of year	**$ (158,266)**	$ (171,831)	**$ (4,266)**	$ (4,969)

9. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
		(In Thousands)		
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,145**	$ 100,957		
Actual return on plan assets	**10,017**	2,662		
Effect of early measurement date elimination		(8,097)		
Contributions	**8,124**	8,100	**$ 444**	$ 428
Benefits paid	**(4,083)**	(3,477)	**(444)**	(428)
Fair value of plan assets at end of year	**$ 114,203**	$ 100,145	**$**	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	**$ (44,063)**	$ (71,686)	**$ (4,266)**	$ (4,969)
Components of net periodic benefit cost				
Service cost	**$ 1,836**	$ 4,484	**$ 15**	$ 22
Interest cost	**7,684**	9,002	**267**	338
Expected return on plan assets	**(6,901)**	(7,605)		
Net amortization and deferral	**1,964**	1,129	**269**	(541)
Net periodic benefit cost	**$ 4,583**	$ 7,010	**$ 551**	$ (181)
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.10%**	5.60%	**5.10%**	5.60%
Rate of compensation increase		5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.60**	7.25	**5.60**	7.25
Expected long-term rate of return on plan assets	**6.75**	8.00		
Rate of compensation increase	**5.00**	5.00		

The accumulated benefit obligation at September 30, 2010 and 2009 was $158,266,226 and $137,279,286, respectively.

9. Retirement Benefit Plans (continued)

The asset allocation for the retirement plan at the end of 2010 and 2009 and the target allocation by asset category are as follows:

Asset Category	Target Allocation		Percentage of Plan Assets	
	Minimum	Maximum	2010	2009
US Equity Large Cap	20%	50%	**31%**	27%
US Equity Small Cap		15	**5**	4
International Equity	10	30	**17**	17
Core Fixed Income	20	60	**47**	52
Total			**100%**	100%

The following table presents the Hospital Plan's fair value hierarchy for those assets measured at fair value as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity (b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category invests primarily in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital by investing at least 80% in international equity securities.
(c) This category seeks maximum current income by investing primarily in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

9. Retirement Benefit Plans (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ -	$ -	$ -
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

The Hospital Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Hospital Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2011	$ 8,100,000	$ 452,466
Estimated future benefit payments:		
2011	5,057,112	452,466
2012	5,586,022	439,761
2013	6,060,768	433,204
2014	6,598,072	424,838
2015	7,158,748	401,741
2016-2020	43,816,630	1,669,284

Assumed healthcare cost trend rates for 2010 are as follows:	
Health care trend rate assumed for next year	8.00%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

9. Retirement Benefit Plans (continued)

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (2)
Effect on postretirement benefit obligation	$ 9	$ (7)

10. Contingencies

There have been malpractice claims that fall within the Corporation's partially self-insured program (see Note 1, Organization and Accounting Policies) which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2010 that may result in the assertion of claims. Corporation management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

The Corporation is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Corporation's financial position.

11. Property, Plant and Equipment

Property, plant and equipment at September 30 consist of the following:

	2010	2009
Land and land improvements	**$ 4,889,512**	$ 4,905,192
Buildings and leasehold improvements	**125,739,952**	115,686,063
Equipment	**101,463,454**	96,886,734
Construction in process (2010 estimated cost to complete $4,601,400)	**630,806**	4,251,661
Less accumulated depreciation	**(132,954,480)**	(117,890,582)
	$ 99,769,244	$ 103,839,068

Unamortized internally developed software costs totaled $968,970 and $1,280,233 at September 30, 2010 and 2009, respectively. Amortization expense for the years ended September 30, 2010 and 2009 was $591,171 and $213,372, respectively.

11. Property, Plant and Equipment (continued)

The Corporation wrote off approximately $853,000 of fully depreciated assets in 2010.

In 2004, the Corporation began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2010 and 2009 was $640,018 and $705,436, respectively.

The Corporation leases various types of equipment with annual payments ranging from $103 to $55,600. Expenses as a result of these leases were approximately $375,000 and $478,000 for the years ended September 30, 2010 and 2009, respectively.

Future minimum lease payments under the above leases during each of the next five years were as follows:

2011	$ 935,358
2012	726,417
2013	718,648
2014	137,725
2015	65,380
	$ 2,583,528

12. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2010	**2009**
Cafeteria sales	**$ 1,063,020**	$ 1,049,650
Rental income	**812,182**	663,647
Grants	**733,844**	642,728
Miscellaneous	**455,498**	527,635
Condominium income	**389,640**	440,047
Child care	**355,497**	336,700
Purchase discounts	**351,343**	274,879
Interest	**196,253**	476,907
	$ 4,357,277	$ 4,412,193

13. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2010	**2009**
Health care services	**$ 224,821,690**	$ 214,740,364
General and administrative	**51,724,893**	53,355,656
Fundraising	**190,865**	191,911
	$ 276,737,448	$ 268,287,931

14. Concentrations of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. For 2010 and 2009, Hospital receivables accounted for 96% and 95%, respectively. The mix of gross accounts receivable, net of contractual allowances, from patients and third-party payors at September 30 is as follows:

	2010	**2009**
Medicare	**27%**	25%
Self pay	**24**	24
Health Maintenance Organizations	**15**	17
Anthem Blue Cross/Blue Shield	**13**	14
Medicaid	**11**	8
Commercial	**5**	5
Other state agencies	**5**	7
	100%	100%

15. Cash Flows

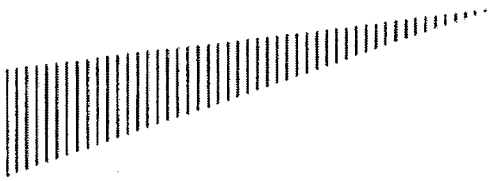
Changes in operating assets and liabilities at September 30 include the following:

	2010	2009
(Increase) decrease in assets:		
Accounts receivable	**$ (8,976,789)**	$ (19,355,546)
Collection on pledges	**348,127**	569,024
Inventories of supplies, prepaid expenses, and other	**(798,102)**	(514,632)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**3,113,028**	6,975,152
Accounts payable	**(201,185)**	996,724
Employee related obligations	**(1,497,412)**	(279,391)
Interest payable and other accrued liabilities	**1,143,850**	2,019,580
Salaries and wages, payroll taxes, and taxes withheld from payroll	**(2,049,900)**	1,596,285
Self-insured professional liability	**(66,430)**	(1,358,443)
Other liabilities	**(325,475)**	133,487
Changes in operating assets and liabilities	**$ (9,310,288)**	$ (9,217,760)

16. Subsequent Events

Management evaluated subsequent events through December 2, 2010, the date the financial statements were issued.

Other Financial Information



Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Directors
Backus Corporation and Subsidiaries

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Ernst + Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 63,324	$ 72,131,779	$ 1,612,700	$ 1,121,821		$ 74,929,624
Assets whose use is limited – required for current liabilities		7,931,590				7,931,590
Accounts receivable, less allowance for uncollectible accounts		30,758,941	838,941	949,013		32,546,895
Pledges receivable		185,866				185,866
Inventories of supplies		3,799,896	85,421			3,885,317
Prepaid expenses and other		1,277,144	20,282	6,202		1,303,628
Due from affiliates	63,142	661,088			$ (724,230)	
Total current assets	126,466	116,746,304	2,557,344	2,077,036	(724,230)	120,782,920
Assets whose use is limited:						
Board-designated and donor restricted		96,626,409				96,626,409
Held by trustee		26,988,802				26,988,802
Total assets whose use is limited		123,615,211				123,615,211
Less assets whose use is limited – required for current liabilities		7,931,590				7,931,590
		115,683,621				115,683,621
Property, plant, and equipment, net		99,122,387	145,235	501,622		99,769,244
Deferred financing costs		1,933,364				1,933,364
Other assets	1,000	1,603,864	782,197	43,661	(16,845)	2,413,877
	$ 127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

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Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable-trade		$ 10,129,146	$ 625,229	$ 187,951		$ 10,942,326
Salaries and wages, payroll taxes and taxes withheld from payroll		6,206,054	309,223	390,051		6,905,328
Due to affiliates			203,033	521,197	$ (724,230)	
Other accrued liabilities		8,967,664	1,281,437	462,776		10,711,877
Due to third-party reimbursement agencies		2,614,222		349,193		2,963,415
Current portion of long-term debt		2,032,691				2,032,691
Total current liabilities		29,949,777	2,418,922	1,911,168	(724,230)	33,555,637
Other liabilities:						
Long-term debt, less current portion		64,591,831				64,591,831
Employee related obligations		57,973,203				57,973,203
Self-insured professional liability		10,514,332				10,514,332
Due to third-party reimbursement agencies		12,767,632				12,767,632
Other		349,678				349,678
		146,196,676				146,196,676
Net assets:						
Common stock				1,000	(1,000)	
Unrestricted	$127,466	147,366,124	1,065,854	710,151	(15,845)	149,253,750
Temporarily restricted		4,101,543				4,101,543
Permanently restricted		7,475,420				7,475,420
Total net assets	127,466	158,943,087	1,065,854	711,151	(16,845)	160,830,713
Total liabilities and net assets	$127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

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Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 270,048,715		$ 5,497,679		$ 7,378,559	$ (23,449)	$ 282,901,504
Other operating revenue	$ 593,530	4,673,356		87,120		6,752	(1,003,481)	4,357,277
Net assets released from restrictions		91,211						91,211
	593,530	274,813,282		5,584,799		7,385,311	(1,026,930)	287,349,992
Operating expenses:								
Salaries, wages and professional fees	174,812	109,179,026		4,740,065		4,148,270	(531,853)	117,710,320
Payroll taxes and other fringe benefits	55,510	27,181,443		978,613		1,406,492		29,622,058
Supplies, insurance and other	25,447	91,056,415		1,716,164		1,920,311	(495,077)	94,223,260
Provision for uncollectible accounts		14,409,876		(11,974)		64,261		14,462,163
Depreciation and amortization		17,480,126		27,483		27,000		17,534,609
Interest		3,185,038						3,185,038
	255,769	262,491,924		7,450,351		7,566,334	(1,026,930)	276,737,448
Operating (loss) income	337,761	12,321,358		(1,865,552)		(181,023)		10,612,544
Nonoperating gains and (losses):								
Contributions and donations		328,840						328,840
Investment income	77	6,218,347		2,213,811		54,520		8,486,755
Other		(116,761)		197,389		(3,562)		77,066
	77	6,430,426		2,411,200		50,958		8,892,661
Excess (deficiency) of revenues over expenses	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205

* Includes Backus Condominium Association

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Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205
Merger of Properties		1,402,938			$(1,402,938)			
Intercompany transfer		(73,056)		73,056				
Pension curtailment		34,536,288						34,536,288
Change in pension funding obligation		(9,564,206)						(9,564,206)
Increase (decrease) in unrestricted net assets	337,838	45,053,748		618,704	(1,402,938)	(130,065)		44,477,287
Temporarily restricted net assets:								
Contributions		126,631						126,631
Income from investments		618,691						618,691
Merger of Foundation			$(34,308,847)				34,308,847	
Net assets released from restrictions		(91,211)						(91,211)
Increase (decrease) in temporarily restricted net assets		654,111	(34,308,847)				34,308,847	654,111
Permanently restricted net assets								
Contributions		358,064						358,064
Income from investments		121,091						121,091
Merger of Foundation			(6,838,627)				6,838,627	
Change in net assets held in trust		134,435						134,435
Increase (decrease) in permanently restricted net assets		613,590	(6,838,627)				6,838,627	613,590
Increase (decrease)in net assets	337,838	46,321,449	(41,147,474)	618,704	(1,402,938)	(130,065)	41,147,474	45,744,988
Net assets (deficit) at beginning of year	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Net assets at end of year	$ 127,466	$ 158,943,087	$	$ 1,065,854	$	$ 711,151	$ (16,845)	$ 160,830,713

* Includes Backus Condominium Association

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Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,463	$ 1,228,148	$ 373,089		$ 1,612,700
Accounts receivable, less allowance for uncollectible accounts		369,242	469,699		838,941
Inventories of supplies		85,421			85,421
Prepaid expenses		9,376	10,906		20,282
Due from affiliates	61,560	2,340,589		$(2,402,149)	
Total current assets	73,023	4,032,776	853,694	(2,402,149)	2,557,344
Property, plant and equipment:					
Buildings and leasehold improvements		19,619			19,619
Equipment		244,681	61,648		306,329
Accumulated depreciation		(152,895)	(27,818)		(180,713)
		111,405	33,830		145,235
Other assets		782,197			782,197
	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 10,233	$ 614,996		$ 625,229
Salaries and wages, payroll taxes and taxes withheld from payroll		246,716	62,507		309,223
Other accrued liabilities		1,281,437			1,281,437
Due to affiliates	$ 67,520	197,073	2,340,589	$ (2,402,149)	203,033
Total current liabilities	67,520	1,735,459	3,018,092	(2,402,149)	2,418,922
Net assets (deficit)	5,503	3,190,919	(2,130,568)		1,065,854
Total liabilities and net assets	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776

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Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,608,723	$ 1,888,956		$ 5,497,679
Other operating revenue	$ 36,936	68,042	19,078	$ (36,936)	87,120
Total revenues	36,936	3,676,765	1,908,034	(36,936)	5,584,799
Expenses:					
Salaries and wages		2,634,018	2,106,047		4,740,065
Payroll taxes and fringe benefits		719,574	259,039		978,613
Supplies and other	39,186	714,272	999,642	(36,936)	1,716,164
Provision for uncollectible accounts		(69,754)	57,780		(11,974)
Depreciation and amortization		14,905	12,578		27,483
Total expenses	39,186	4,013,015	3,435,086	(36,936)	7,450,351
Operating loss	(2,250)	(336,250)	(1,527,052)		(1,865,552)
Nonoperating gains:					
Investment income	6	2,213,805			2,213,811
Other		197,389			197,389
(Deficiency) excess of revenue over expenses	(2,244)	2,074,944	(1,527,052)		545,648
Net assets (deficit) at beginning of year	7,747	1,044,627	(605,224)		447,150
Intercompany transfer		71,348	1,708		73,056
Net assets (deficit) at end of year	$ 5,503	$ 3,190,919	$(2,130,568)	$	$ 1,065,854

000358

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2010

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,087,166	$ 34,655		$ 1,121,821
Accounts receivable, less allowance for uncollectible accounts		949,013		949,013
Prepaid expenses and other		6,202		6,202
Due from affiliates	563,194		$(563,194)	
Total current assets	1,650,360	989,870	(563,194)	2,077,036
Property, plant and equipment:				
Buildings and leasehold improvements		445,975		445,975
Equipment		102,089		102,089
Accumulated depreciation		(46,442)		(46,442)
		501,622		501,622
Other assets	39,861	3,800		43,661
	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 187,951		$ 187,951
Salaries and wages, payroll taxes and taxes withheld from payroll		390,051		390,051
Other accrued liabilities		462,776		462,776
Due to third party reimbursement agencies		349,193		349,193
Due to affiliates	$ 521,197	563,194	$ (563,194)	521,197
Total current liabilities	521,197	1,953,165	(563,194)	1,911,168
Common stock	1,000			1,000
Retained earnings (deficit)	1,168,024	(457,873)		710,151
Total liabilities and net assets	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319

000359

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,378,559		$ 7,378,559
Other operating revenue		6,752		6,752
Total revenues		7,385,311		7,385,311
Expenses:				
Salaries and wages		4,148,270		4,148,270
Payroll taxes and fringe benefits		1,406,492		1,406,492
Supplies and other	$ 67,510	1,852,801		1,920,311
Provision for uncollectible accounts		64,261		64,261
Depreciation and amortization		27,000		27,000
Total expenses	67,510	7,498,824		7,566,334
Operating (loss) income	(67,510)	(113,513)		(181,023)
Nonoperating gains:				
Investment income	53,219	1,301		54,520
Other		(3,562)		(3,562)
Excess of revenue over expenses	(14,291)	(115,774)		(130,065)
Net assets (deficit) at beginning of year	1,182,315	(342,099)		840,216
Net assets (deficit) at end of year	$ 1,168,024	$ (457,873)	$	$ 710,151

000360

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 45,846	$ 57,570,735	$ 2,085,506	$ 1,108,911	$ 140,738	$ 1,203,331		$ 62,155,067
Assets whose use is limited – required for current liabilities		7,240,812						7,240,812
Accounts receivable, less allowance for uncollectible accounts		36,111,295		839,709	30,125	1,051,140		38,032,269
Pledges receivable			533,993					533,993
Inventories of supplies		3,252,641		114,966				3,367,607
Prepaid expenses and other		925,340		9,671	85,556	2,669		1,023,236
Due from affiliates	27,582	3,901,924					$ (3,929,506)	
Total current assets	73,428	109,002,747	2,619,499	2,073,257	256,419	2,257,140	(3,929,506)	112,352,984
Assets whose use is limited:								
Board-designated and donor restricted		44,500,233	36,512,604					81,012,837
Held by trustee		22,743,662	2,327,313					25,070,975
Total assets whose use is limited		67,243,895	38,839,917					106,083,812
Less assets whose use is limited – required for current liabilities		7,240,812						7,240,812
		60,003,083	38,839,917					98,843,000
Interest in Foundation		41,147,474					(41,147,474)	
Property, plant, and equipment, net		98,131,132		90,657	5,593,682	23,597		103,839,068
Deferred financing costs		2,025,397						2,025,397
Other assets	1,000	1,801,751		966,810		85,112	(16,845)	2,837,828
	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

000361

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable-trade		$ 10,508,835	$ 11,448	$ 394,244	$ 30,263	$ 198,721		$ 11,143,511
Salaries and wages, payroll taxes and taxes withheld from payroll		8,205,022	531	369,819		379,856		8,955,228
Due to affiliates	$284,800		45,983	118,309	3,336,782	143,632	$ (3,929,506)	
Other accrued liabilities		7,190,212	253,980	1,801,202		322,633		9,568,027
Due to third-party reimbursement agencies		1,831,013				479,791		2,310,804
Current portion of long-term debt		1,825,000			8,475			1,833,475
Total current liabilities	284,800	29,560,082	311,942	2,683,574	3,375,520	1,524,633	(3,929,506)	33,811,045
Other liabilities:								
Long-term debt, less current portion		63,931,536			1,064,144			64,995,680
Employee related obligations		84,442,697						84,442,697
Self-insured professional liability		10,580,762						10,580,762
Due to third-party reimbursement agencies		10,307,215						10,307,215
Other		667,654			7,499			675,153
		169,929,864			1,071,643			171,001,507
Net assets:								
Common stock						1,000	(1,000)	
Unrestricted	(210,372)	102,312,376		447,150	1,402,938	840,216	(15,845)	104,776,463
Temporarily restricted		3,447,432	34,308,847				(34,308,847)	3,447,432
Permanently restricted		6,861,830	6,838,627				(6,838,627)	6,861,830
Total net assets	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Total liabilities and net assets	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

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Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 259,652,271		$ 5,073,240		$ 7,128,542	$ (88,665)	$ 271,765,388
Other operating revenue	$ 125,004	4,213,341		81,199	$ 1,099,706	22,154	(1,129,211)	4,412,193
Net assets released from restrictions			$ 547,411				(460,917)	86,494
	125,004	263,865,612	547,411	5,154,439	1,099,706	7,150,696	(1,678,793)	276,264,075
Operating expenses:								
Salaries, wages and professional fees	256,742	112,184,033	155,336	4,348,579	24,755	3,938,367		120,907,812
Payroll taxes and other fringe benefits	35,218	27,425,902	40,414	969,731	3,238	970,523		29,445,026
Supplies, insurance and other	18,420	74,547,698	351,661	3,963,600	741,108	1,727,287	(1,217,876)	80,131,898
Provision for uncollectible accounts		16,898,318		74,663		133,520		17,106,501
Depreciation and amortization		16,939,369		28,162	352,257	15,236		17,335,024
Interest		3,091,298			270,372			3,361,670
	310,380	251,086,618	547,411	9,384,735	1,391,730	6,784,933	(1,217,876)	268,287,931
Operating (loss) income	(185,376)	12,778,994		(4,230,296)	(292,024)	365,763	(460,917)	7,976,144
Nonoperating gains and (losses):								
Contributions and donations							429,646	429,646
Change in equity interest in net assets of the Foundation		(3,735,563)					3,735,563	
Investment income	92	2,432,928		2,347,772	(2,049)	164,759	234,131	5,177,633
	92	(1,302,635)		2,347,772	(2,049)	164,759	4,399,340	5,607,279
Excess (deficiency) of revenues over expenses	$ (185,284)	$ 11,476,359	$	$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423

* Includes Backus Condominium Association

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Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ (185,284)	$ 11,476,359		$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423
Change in equity interest in net assets of the Foundation		3,938,423					(3,938,423)	
Change in pension funding obligation		(45,512,326)						(45,512,326)
Increase (decrease) in unrestricted net assets	(185,284)	(30,097,544)		(1,882,524)	(294,073)	530,522		(31,928,903)
Temporarily restricted net assets:								
Contributions			$ 1,172,398				(429,646)	742,752
Income from investments		1,350	548,528				(234,131)	315,747
Change in equity interest in net assets of the Foundation		970,655					(970,655)	
Net assets released from restrictions			(547,411)				460,917	(86,494)
Increase (decrease) in temporarily restricted net assets		972,005	1,173,515				(1,173,515)	972,005
Permanently restricted net assets								
Contributions			970,000					970,000
Change in net assets held in trust			(28,978)					(28,978)
Change in equity interest in net assets of the Foundation		941,022					(941,022)	
Increase in permanently restricted net assets		941,022	941,022				(941,022)	941,022
Increase (decrease)in net assets	(185,284)	(28,184,517)	2,114,537	(1,882,524)	(294,073)	530,522	(2,114,537)	(30,015,876)
Net assets (deficit) at beginning of year	(25,088)	140,806,155	39,032,937	2,329,674	1,697,011	310,694	(39,049,782)	145,101,601
Net assets (deficit) at end of year	$ (210,372)	$ 112,621,638	$ 41,147,474	$ 447,150	$ 1,402,938	$ 841,216	$ (41,164,319)	$ 115,085,725

000364

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,457	$ 834,815	$ 262,639		$ 1,108,911
Accounts receivable, less allowance for uncollectible accounts		511,479	328,230		839,709
Inventories of supplies		114,966			114,966
Prepaid expenses		9,113	558		9,671
Due from affiliates	24,624	749,606		$ (774,230)	
Total current assets	36,081	2,219,979	591,427	(774,230)	2,073,257
Property, plant and equipment:					
Buildings and leasehold improvements		59,768			59,768
Equipment		268,112	48,323		316,435
Accumulated depreciation		(270,306)	(15,240)		(285,546)
		57,574	33,083		90,657
Other assets		966,810			966,810
	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 13,318	$ 380,926		$ 394,244
Salaries and wages, payroll taxes and taxes withheld from payroll		270,617	99,202		369,819
Other accrued liabilities		1,801,202			1,801,202
Due to affiliates	$ 28,334	114,599	749,606	$ (774,230)	118,309
Total current liabilities	28,334	2,199,736	1,229,734	(774,230)	2,683,574
Net assets (deficit)	7,747	1,044,627	(605,224)		447,150
Total liabilities and net assets	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724

000365

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,943,958	$ 1,129,282		$ 5,073,240
Other operating revenue	$ 36,936	67,042	14,157	$ (36,936)	81,199
Total revenues	36,936	4,011,000	1,143,439	(36,936)	5,154,439
Expenses:					
Salaries and wages		2,870,703	1,477,876		4,348,579
Payroll taxes and fringe benefits		805,491	164,240		969,731
Supplies and other	38,486	3,098,692	863,358	(36,936)	3,963,600
Provision for uncollectible accounts		4,057	70,606		74,663
Depreciation and amortization		17,434	10,728		28,162
Total expenses	38,486	6,796,377	2,586,808	(36,936)	9,384,735
Operating loss	(1,550)	(2,785,377)	(1,443,369)		(4,230,296)
Nonoperating gains:					
Investment income	20	2,347,630	122		2,347,772
Deficiency of revenue over expenses	(1,530)	(437,747)	(1,443,247)		(1,882,524)
Net assets at beginning of year	9,277	1,482,374	838,023		2,329,674
Net assets (deficit) at end of year	$ 7,747	$ 1,044,627	$ (605,224)	$	$ 447,150

000396

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2009

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,061,007	$ 142,324		$ 1,203,331
Accounts receivable, less allowance for uncollectible accounts		1,051,140		1,051,140
Prepaid expenses and other		2,669		2,669
Due from affiliates	184,628		$ (184,628)	
Total current assets	1,245,635	1,196,133	(184,628)	2,257,140
Property, plant and equipment:				
Lease improvements		3,872		3,872
Equipment		350,608		350,608
Accumulated depreciation		(330,883)		(330,883)
		23,597		23,597
Other assets	81,312	3,800		85,112
	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 198,721		$ 198,721
Salaries and wages, payroll taxes and taxes withheld from payroll		379,856		379,856
Other accrued liabilities		322,633		322,633
Due to third party reimbursement agencies		479,791		479,791
Due to affiliates	$ 143,632	184,628	$ (184,628)	143,632
Total current liabilities	143,632	1,565,629	(184,628)	1,524,633
Common stock	1,000			1,000
Retained earnings (deficit)	1,182,315	(342,099)		840,216
Total liabilities and net assets	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849

000367

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,128,542		$ 7,128,542
Other operating revenue		22,154		22,154
Total revenues		7,150,696		7,150,696
Expenses:				
Salaries and wages		3,938,367		3,938,367
Payroll taxes and fringe benefits		970,523		970,523
Supplies and other	$ 80,645	1,646,642		1,727,287
Provision for uncollectible accounts		133,520		133,520
Depreciation and amortization		15,236		15,236
Total expenses	80,645	6,704,288		6,784,933
Operating (loss) income	(80,645)	446,408		365,763
Nonoperating gains:				
Investment income	164,599	160		164,759
Excess of revenue over expenses	83,954	446,568		530,522
Net assets (deficit) at beginning of year	1,098,361	(788,667)		309,694
Net assets (deficit) at end of year	$ 1,182,315	$ (342,099)	$	$ 840,216

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Audited Consolidated Financial Statements and Other Financial Information

Backus Corporation and Subsidiaries
Years Ended September 30, 2011 and 2010
With Report of Independent Auditors

Ernst & Young LLP

Ernst & Young

Backus Corporation and Subsidiaries

Audited Consolidated Financial Statements
and Other Financial Information

Years Ended September 30, 2011 and 2010

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
Backus Corporation and Subsidiaries

We have audited the accompanying consolidated balance sheets of Backus Corporation and Subsidiaries (the Corporation) as of September 30, 2011 and 2010, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Corporation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Backus Corporation and Subsidiaries as of September 30, 2011 and 2010, and the consolidated results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidated Balance Sheets

	September 30 2011	2010
Assets		
Current assets:		
Cash and cash equivalents	**$ 95,434,551**	$ 74,929,624
Assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
Accounts receivable, less allowance for uncollectible accounts (2011 – $21,442,000; 2010 – $20,574,000)	**34,428,013**	32,546,895
Pledges receivable	**101,211**	185,866
Inventories of supplies	**3,704,067**	3,885,317
Prepaid expenses and other	**1,634,141**	1,303,628
Total current assets	**141,187,465**	120,782,920
Assets whose use is limited:		
Board-designated and donor restricted	**105,438,402**	96,626,409
Held by trustee	**28,078,427**	26,988,802
Total assets whose use is limited	**133,516,829**	123,615,211
Less assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
	127,631,347	115,683,621
Property, plant and equipment, net	**90,635,773**	99,769,244
Deferred financing costs	**1,842,330**	1,933,364
Other assets	**2,137,224**	2,413,877
Total assets	**$ 363,434,139**	$ 340,583,026

	September 30 2011	2010
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,347,081**	$ 10,342,325
Salaries and wages, payroll taxes and taxes withheld from payroll	**7,383,760**	6,905,328
Other accrued liabilities	**5,957,134**	9,430,440
Employee related obligations	**3,942,900**	3,589,500
Due to third-party reimbursement agencies	**5,023,840**	2,963,415
Current portion of long-term debt	**2,115,360**	2,032,691
Total current liabilities	**34,770,075**	35,263,699
Other liabilities:		
Long-term debt, less current portion	**62,389,713**	64,591,831
Employee related obligations	**69,884,879**	54,383,703
Self-insured professional liability	**14,021,149**	12,395,770
Due to third-party reimbursement agencies	**19,162,526**	12,767,632
Other	**443,183**	349,678
	165,901,450	144,488,614
Net assets:		
Unrestricted	**153,913,943**	149,253,750
Temporarily restricted	**1,399,547**	4,101,543
Permanently restricted	**7,449,124**	7,475,420
Total net assets	**162,762,614**	160,830,713
Total liabilities and net assets	**$ 363,434,139**	$ 340,583,026

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Operations

	Years Ended September 30	
	2011	**2010**
Operating revenues:		
Net patient service revenue	**$ 285,207,565**	$ 282,901,504
Other operating revenue	**4,307,817**	4,357,277
Net assets released from restrictions	**673,194**	91,211
	290,188,576	287,349,992
Operating expenses:		
Salaries, wages and professional fees	**119,644,775**	117,710,320
Payroll taxes and other fringe benefits	**27,854,316**	29,622,058
Supplies, insurance and other	**88,087,439**	94,223,260
Provision for uncollectible accounts	**12,767,930**	14,462,163
Depreciation and amortization	**17,045,582**	17,534,609
Interest	**3,247,715**	3,185,038
	268,647,757	276,737,448
Operating income	**21,540,819**	10,612,544
Nonoperating gains (losses):		
Contributions and donations	**158,300**	328,840
Investment income	**2,445,778**	8,486,755
Other	**(565,873)**	77,066
	2,038,205	8,892,661
Excess of revenues over expenses	**$ 23,579,024**	$ 19,505,205

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Total	Unrestricted	Restricted	Permanently Restricted
Net assets, September 30, 2009	$115,085,725	$ 104,776,463	$ 3,447,432	$ 6,861,830
Excess of revenues over expenses	19,505,205	19,505,205		
Contributions	484,695		126,631	358,064
Investment income	739,782		618,691	121,091
Curtailment gain	34,536,288	34,536,288		
Change in pension funding and postretirement obligation	(9,564,206)	(9,564,206)		
Change in net assets held in trust	134,435			134,435
Net assets released from restriction	(91,211)		(91,211)	
Increase in net assets	45,744,988	44,477,287	654,111	613,590
Net assets, September 30, 2010	160,830,713	149,253,750	4,101,543	7,475,420
Excess of revenues over expenses	**23,579,024**	**23,579,024**		
Contributions	**580,427**		**575,427**	**5,000**
Investment (loss) income	**(275,296)**		**(346,369)**	**71,073**
Change in pension funding and postretirement obligation	**(21,176,691)**	**(21,176,691)**		
Change in net assets held in trust	**(102,369)**			**(102,369)**
Net assets released from restriction used for purchase of equipment	**2,257,860**	**2,257,860**		
Net assets released from restriction	**(2,931,054)**		**(2,931,054)**	
Increase (decrease) in net assets	**1,931,901**	**4,660,193**	**(2,701,996)**	**(26,296)**
Net assets, September 30, 2011	**$162,762,614**	**$ 153,913,943**	**$ 1,399,547**	**$ 7,449,124**

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	Years Ended September 30	
	2011	**2010**
Operating activities		
Increase in net assets	**$ 1,931,901**	$ 45,744,988
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,045,582**	17,534,609
Provision for uncollectible accounts	**12,767,930**	14,462,163
Curtailment gain		(34,536,288)
Change in pension funding and postretirement obligation	**21,176,691**	9,564,206
Purchase of investments-board designated, net	**(8,811,993)**	(15,613,572)
Permanently restricted contributions and income	**26,296**	(613,590)
Changes in operating assets and liabilities *(Note 15)*	**(12,851,686)**	(9,310,288)
Net cash provided by operating activities	**31,284,721**	27,232,228
Investing activities		
Purchase of investments-held in trust, net	**(1,089,625)**	(1,917,827)
Net additions to property, plant and equipment	**(7,821,077)**	(12,643,127)
Decrease in other assets	**276,653**	153,108
Net cash used in investing activities	**(8,634,049)**	(14,407,846)
Financing activities		
Proceeds from loan		1,250,000
Principal payments on long-term debt and capital lease obligations	**(2,074,347)**	(1,863,950)
Change in deferred financing costs and amortization of bond premium	**(45,102)**	(49,465)
Permanently restricted contributions and income	**(26,296)**	613,590
Net cash used in financing activities	**(2,145,745)**	(49,825)
Net increase in cash and cash equivalents	**20,504,927**	12,774,557
Cash and cash equivalents at beginning of year	**74,929,624**	62,155,067
Cash and cash equivalents at end of year	**$ 95,434,551**	$ 74,929,624

See accompanying notes.

Backus Corporation and Subsidiaries

Notes to Consolidated Financial Statements

September 30, 2011

1. Significant Accounting Policies

Organization

Backus Corporation (Corporation) is a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation provides overall direction and control for The William W. Backus Hospital (the Hospital) and Backus Health Care, Inc. WWB Corporation conducts the related for-profit activities of the Corporation, its sole shareholder. Omni Home Health Services of Eastern Connecticut LLC dba Backus Home Health Services provides continual home care to patients. Backus Physician Services, LLC provides surgical services. The accompanying consolidated statements of operations include the excess (deficiency) of revenue over expenses as the performance indicator. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenues and expenses; peripheral or incidental transactions are reported as nonoperating items. All intercompany transactions have been eliminated in consolidation. Effective November 1, 2009, the Foundation and Properties were merged into the Hospital. The merger did not impact the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Department of Public Health, Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority) as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities, with readily determinable fair values, are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenue over expense unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

Property, Plant and Equipment

Property, plant and equipment are stated on the basis of cost. The Corporation and its subsidiaries provide for depreciation using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

1. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying consolidated financial statements.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in nonoperating gains and losses. Conditional promises to give are not included as support until the conditions are substantially met.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $5,000,000 annually for 2011 and $4,000,000 for 2010. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in pension funding and postretirement obligation, pension curtailment gains, both temporarily and permanently restricted donations and investment income and changes in trust arrangements.

1. Significant Accounting Policies (continued)

Cash Equivalents

The Corporation considers all highly liquid time deposits, commercial paper and money market mutual funds purchased with a maturity date at acquisition of three months or less to be cash equivalents.

Income Taxes

The Corporation, the Hospital, and Backus Health Care, Inc. are not-for-profit organizations exempt from federal income taxes on related income under Section 501(c)(3); WWB Corporation is a taxable stock corporation; CONNCare Inc., a subsidiary of Backus Health Care, is a taxable, nonstock corporation. Backus Home Health Services is a partnership taxable to its members and Backus Physician Services, LLC is a taxable, nonstock corporation.

CONNCare, Inc. has a net operating loss carry-forward of $5,755,000. This net operating loss results in a potential deferred tax asset in the amount of approximately $2,300,000. No asset has been recorded as these assets are offset by valuation allowances of the same amounts.

Adoption of New Authoritative Pronouncements

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which will be effective for the Hospital's fiscal 2012, the guidance in ASU 2010-06 became effective for the Hospital's fiscal 2011. The adoption of the provisions of ASU 2010-06 did not impact the Corporation's financial statements.

1. Significant Accounting Policies (continued)

In January 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions*, (ASU 2010-07), which establishes accounting and disclosure requirements for how a not-for-profit entity determines whether a combination is a merger or an acquisition, how to account for each, and the required disclosures. In addition, ASU 2010-07 included amendments to FASB's Accounting Standards Codification (the Codification, or ASC) Topic 350, *Intangibles – Goodwill and Other*, (ASC Topic 350), and Topic 810, *Consolidation*, (ASC Topic 810) to make both applicable to not-for-profit entities. ASC Topic 350 clarifies the accounting for goodwill and indefinite-lived identifiable intangible assets recognized in a not-for-profit entity's acquisition of a business or nonprofit activity. Such assets are not amortized and are tested for impairment at least annually. The Corporation adopted the guidance relative to ASU 2010-07 as of October 1, 2010.

In August 2010, the FASB issued Accounting Standards Codification ("ASC") 954-605, *Measuring Charity Care for Disclosure*. ASC 954-605 requires that the level of charity care provided be presented based on the direct and indirect costs of the charity services provided. ASC 954-605 also requires separate disclosure of the amount of any cash reimbursements received for providing charity care. ASC 954-605 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Corporation is evaluating the effect of ASC 954-605 on its consolidated financial statements.

In August 2010, the FASB also issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*. Under ASU 2010-24, anticipated insurance recoveries and estimated liabilities for medical malpractice claims or similar contingent liabilities will be presented separately on the balance sheet. The guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Corporation is evaluating the effect of ASU 2010-24 on its consolidated financial statements.

In July 2011, FASB issued new guidance, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*. The guidance requires certain health care entities to present the bad debt expense associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense. The guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. The Corporation is evaluating the effect of the new guidance on its consolidated financial statements.

1. Significant Accounting Policies (continued)

Reclassifications

Certain reclassifications were made to the 2010 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Patient accounts receivable and revenues are recorded when patient services are performed.

Hospital revenue accounted for 95% of net patient service revenue for the years ended September 30, 2011 and 2010. The following summarizes net patient service revenue:

	Year Ended September 30	
	2011	**2010**
Gross patient service revenue	**$ 624,460,853**	$ 604,461,491
Deductions:		
Allowances	**(334,249,153)**	(315,063,365)
Charity care (at charges)	**(5,004,135)**	(6,496,622)
	(339,253,288)	(321,559,987)
Net patient service revenue	**$ 285,207,565**	$ 282,901,504

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $2,065,000 in 2011 and had no impact on net patient service revenue for 2010.

2. Revenues from Services to Patients and Charity Care (continued)

Revenues from the Medicare and Medicaid programs accounted for approximately 27.5% and 9.5%, respectively, of the Corporation's net patient service revenue for the year ended September 30, 2011 and 28% and 8% for the year ended September 30, 2010. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations, except as described in Note 10. While no regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Corporation.

3. Charity Care

The Corporation provides services without charge or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Corporation does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Corporation's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 5,004,135**	**$ 2,201,819**
Bad debt	**12,767,930**	**5,617,889**
Total uncompensated care, September 30, 2011	**$ 17,772,065**	**$ 7,819,708**
Charity care	$ 6,496,622	$ 2,858,514
Bad debt	14,462,163	6,363,352
Total uncompensated care, September 30, 2010	$ 20,958,785	$ 9,221,866

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2011	2010
BackusCare campaign	**$ 45,546**	$ 185,114
Other	**57,077**	7,077
Unconditional promises to give before unamortized discount	**102,623**	192,191
Less unamortized discount and allowance	**(1,412)**	(6,325)
	$ 101,211	$ 185,866
Amounts due in:		
Less than one year	**$ 96,211**	$ 133,366
One to five years	**5,000**	52,500
Total	**$ 101,211**	$ 185,866

5. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2011 and 2010:

	Year Ended September 30	
	2011	**2010**
Realized and unrealized (losses) gains on investments	**$(1,163,661)**	$ 4,574,175
Interest and dividend income	**1,962,447**	1,819,741
Investment in joint ventures	**1,860,953**	2,262,006
Other investment losses	**12,600**	11,600
Investment fees	**(226,561)**	(180,767)
	$ 2,445,778	$ 8,486,755

5. Investments (continued)

The market value of assets whose use is limited at September 30, is set forth in the following table:

	2011	2010
Board designated:		
Cash and cash equivalents	**$ 41,525,574**	$ 33,837,100
Mutual funds	**37,251,516**	38,540,722
Common stocks	**12,925,056**	13,327,371
Government bonds	**12,811,596**	8,462,882
Corporate bonds	**924,660**	2,458,334
	$105,438,402	$ 96,626,409
Held by trustee:		
Cash and cash equivalents	**$ 24,668,758**	$ 4,430,958
Mutual funds	**2,327,261**	22,211,515
Government bonds	**731,506**	
Common stock	**292,470**	287,581
Real estate	**58,432**	58,748
	$ 28,078,427	$ 26,988,802

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) provides guidance on investment decisions and endowment expenditures for nonprofit organizations. The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

5. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Corporation's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Corporation's inflation-adjusted value over time. The Corporation's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The investment committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Corporation and are included in permanently restricted net assets. Any deficits are funded with available temporarily restricted or unrestricted funds so as to maintain the corpus. Subsequent positive market returns replace the deficits.

5. Investments (continued)

The activity for the year ended September 30, 2011 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 513,486	$ 5,320,786	$ 5,834,272
Investment return:			
Investment income		151,536	151,536
Net depreciation (realized and unrealized)		(176,945)	(176,945)
Earnings reclassified	(96,482)	96,482	
Total investment (loss) return	(96,482)	71,073	(25,409)
Contributions		5,000	5,000
Endowment net assets at end of year	$ 417,004	$ 5,396,859	$ 5,813,863

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

6. Fair Value of Financial Instruments

For assets and liabilities required to be measured at fair value, the Corporation measures fair value based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are applied based on the unit of account from the Corporation's perspective. The unit of account determines what is being measured by reference to the level at which the asset or liability is aggregated (or disaggregated) for purposes of applying other accounting pronouncements.

6. Fair Value of Financial Instruments (continued)

The Corporation follows a valuation hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad categories. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Fair value for Level 2 assets are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers. Level 3 assets consist of asset backed and mortgage backed obligations held by the defined benefit plan which are priced using model-based valuations using market information that best represents the value at which the security could be sold.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Corporation uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2011 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 98,239,968	$ 852,014		$ 99,091,982
Certificates of deposit		24,901,139		24,901,139
Money market funds	37,571,306	64,456		37,635,762
US government obligations (a)	10,833,829	2,709,273		13,543,102
Corporate bonds (b)	249,858	674,802		924,660
Equity securities	13,217,526			13,217,526
Mutual funds-equities (c)	8,773,825	9,707,473		18,481,298
Mutual funds-international equities (d)	8,140,798	219,147		8,359,945
Mutual funds-fixed income (e)	12,062,082	675,452		12,737,534
Real estate (REIT)		58,432		58,432
Total	$ 189,089,192	$ 39,862,188	–	$ 228,951,380

(a) Includes both Treasury bonds and Treasury stripped bonds.
(b) Includes both foreign and domestic corporate bonds.
(c) This category primarily represents investments in common stock or similar securities of high-quality, financially secure companies listed on principal exchanges.
(d) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(e) This category seeks maximum current income primarily thorough investments in fixed income securities of varying maturities.

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 77,955,100	$ 2,738		$ 77,957,838
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)		58,751		58,751
Total	$ 163,339,941	$ 35,204,894	–	$ 198,544,835

6. Fair Value of Financial Instruments (continued)

The following table presents the Corporation's fair value hierarchy for defined benefit plan assets as of September 30, 2011. At September 30, 2011, Level 3 assets comprise approximately 0.2% of the Corporation Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 10,173,248			$ 10,173,248
Mutual funds-equity (a)	23,965,541	$ 25,514,446		49,479,987
Mutual funds-international equity(b)	22,103,407			22,103,407
Mutual funds-fixed income (c)	9,739,453	38,850		9,778,303
US Government obligations(d)	6,277,919	319,903		6,597,822
Corporate bonds (e)		9,553,768		9,553,768
Mortgage backed obligations		7,777,727	$180,660	7,958,387
Total	$ 72,259,568	$ 43,204,694	$ 180,660	$ 115,644,922

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily through investment in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2010 to September 30, 2011.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ 250,065	$ 88,920	$ 338,985
Purchases		99,500	99,500
Unrealized gains (losses)	716	(7,760)	(7,044)
Sales	(250,781)		(250,781)
Total	$ –	$ 180,660	$ 180,660

6. Fair Value of Financial Instruments (continued)

The following table presents the Corporation's fair value hierarchy for defined benefit plan assets as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Corporation Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity(b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily through investments in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ –	$ –	$ –
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

6. Fair Value of Financial Instruments (continued)

The carrying amount of certain of the Corporation's financial instruments, including cash and cash equivalents, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Corporation's fiscal year end. The fair value of long-term debt is $70,878,867 and $69,437,056 at September 30, 2011 and 2010, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2011	2010
Health care services	**$ 789,466**	$ 499,200
Preventative care	**193,861**	792,377
Extraordinary nursing care	**105,444**	109,852
Nursing education	**87,446**	84,912
Laboratory	**8,522**	228,659
Free beds	**8,066**	25,821
Capital projects		1,733,950
Other	**206,742**	626,772
	$ 1,399,547	$ 4,101,543

Permanently restricted net assets at September 30 are restricted to the following:

	2011	2010
Income to be used:		
For general purposes	**$ 6,605,539**	$ 6,631,835
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,449,124	$ 7,475,420

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2011	2010
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($565,000) to 2012 with an interest rate of 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,080,000**	$ 8,625,000
Series F, serial maturities ($5,875,000) from 2012 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,000,000**	28,725,000
Series G, serial maturities ($17,730,000) from 2012 to 2026 with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5.00%	**25,150,000**	25,775,000
Other long-term debt:		
Mortgage, maturing May 1,2025 with a fixed rate of 6.125%	**1,183,176**	1,236,586
Obligation under capital leases	**1,379,926**	1,505,864
	63,793,102	65,867,450
Add net unamortized bond premium	**711,971**	757,072
Less current portion	**(2,115,360)**	(2,032,691)
Long-term debt	**$ 62,389,713**	$ 64,591,831

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. The mortgages are secured by a warehouse and by certain leasehold improvements. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principle and interest on the Series E, Series F, and Series G bonds.

8. Long-term Debt (continued)

Series E bonds are subject to redemption prior to maturity. Series F bonds are subject to optional redemption prior to maturity. Series G bonds maturing after July 1, 2015, are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years and in the aggregate are as follows:

	Long-Term Debt	Capital Leases
2012	$ 2,021,619	$ 361,204
2013	2,105,440	361,204
2014	2,184,302	361,204
2015	2,303,411	336,859
2016	2,387,624	263,904
Aggregate thereafter	51,410,780	2,111,232
	62,413,176	3,795,607
Add net unamortized bond premium	711,971	
Less interest		(2,415,681)
	$ 63,125,147	$ 1,379,926

The Corporation paid interest of $3,312,005 and $3,323,608 in 2011 and 2010, respectively. Interest incurred in 2011 and 2010 was $3,247,715 and $3,185,038, respectively.

In 2010 the Corporation entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

In 2010 the Corporation also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2011 was $326,520. Under the terms of the lease, the Hospital has the option to renew for five periods of five years each.

Deferred financing costs are amortized over the life of the bonds.

9. Retirement Benefit Plans

Effective January 1, 2010, the Corporation amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Corporation will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Corporation will also make a non-elective transition contribution equal to 3% for all employees who meet the transition participant criteria. The Corporation may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the years ended September 30, 2011 and 2010 was $5,206,397 and $3,589,500, respectively.

The Corporation also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the cost based on years of service. In addition, the Hospital sponsors a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2011 and 2010 is approximately $2,600,000, related to the future obligation for the nonqualified benefits.

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2011	**2010**	**2011**	**2010**
	(In Thousands)			
Unrecognized actuarial (loss) gain	**$ (64,522)**	$ (43,157)	**$ 1,600**	$ 1,734
Unrecognized transition obligation			**(565)**	(889)
	$ (64,522)	$ (43,157)	**$ 1,035**	$ 845

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2011 are $4,557,386 and $323,491, respectively.

9. Retirement Benefit Plans (continued)

At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities. At September 30, 2011, the unfunded status of the pension plan is included in long-term liabilities in the amount of $60,301,776. The unfunded status of the postretirement benefits is $4,083,669, with $435,510 included in short-term liabilities, and the remainder of $3,648,159 included in long-term liabilities

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2011 and 2010.

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
		(In Thousands)		
Change in benefit obligations				
Benefit obligations at beginning of year	$ (158,266)	$ (171,831)	$ (4,266)	$ (4,969)
Service cost		(1,836)	(4)	(15)
Interest cost	(7,963)	(7,684)	(207)	(267)
Change in assumptions	(12,536)	(11,951)	(147)	387
Actuarial (loss) gain	(2,006)	(3,598)	113	154
Effect of curtailment		34,551		
Benefits paid	4,825	4,083	428	444
Benefit obligations at end of year	$ (175,946)	$ (158,266)	$ (4,083)	$ (4,266)
Change in plan assets				
Fair value of plan assets at beginning of year	$ 114,203	$ 100,145		
Actual return on plan assets	(1,834)	10,017		
Contributions	8,100	8,124	$ 428	$ 444
Benefits paid	(4,825)	(4,083)	(428)	(444)
Fair value of plan assets at end of year	$ 115,644	$ 114,203	$	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	$ (60,302)	$ (44,063)	$ (4,083)	$ (4,266)
Components of net periodic benefit cost				
Service cost		$ 1,836	$ 4	$ 15
Interest cost	$ 7,963	7,684	207	267
Expected return on plan assets	(7,832)	(6,901)		
Net amortization and deferral	2,843	1,964	224	269
Net periodic benefit cost	$ 2,974	$ 4,583	$ 435	$ 551

9. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
	(In Thousands)			
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**4.60%**	5.10%	**4.60%**	5.10%
Rate of compensation increase				
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.10**	5.60	**5.10**	5.60
Expected long-term rate of return on plan assets	**6.75**	6.75		

The accumulated benefit obligation at September 30, 2011 and 2010 was $175,946,699 and $158,266,226, respectively.

The asset allocation for the retirement plan at the end of 2011 and 2010 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	Minimum	Maximum	2011	2010
US Equity Large Cap	20%	50%	**34%**	31%
US Equity Small Cap		15	**5**	5
International Equity	10	30	**15**	17
Core Fixed Income	20	60	**46**	47
Total			**100%**	100%

The Corporation Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Corporation Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

9. Retirement Benefit Plans (continued)

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2012	$ 8,100,000	$ 435,510
Estimated future benefit payments:		
2012	5,621,240	435,510
2013	6,120,026	423,489
2014	6,721,770	414,800
2015	7,280,102	392,976
2016	7,768,999	370,874
2017-2021	47,330,022	1,533,884

Assumed healthcare cost trend rates for 2011 are as follows:

Health care trend rate assumed for next year	7.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2015

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (1)
Effect on postretirement benefit obligation	$ 6	$ (5)

10. Contingencies

There have been malpractice claims that fall within the Corporation's partially self-insured program (see Note 1, Organization and Accounting Policies) which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2011, that may result in the assertion of claims. Corporation management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

10. Contingencies (continued)

The Corporation's management believes that it may not have conformed to all applicable laws and regulations regarding certain arrangements with outside parties. An internal investigation is underway and management has estimated and accrued a liability related to this matter. Except for this matter, the Corporation's management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of any potential wrongdoing.

The Corporation is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Corporation's financial position.

11. Property, Plant and Equipment

Property, plant and equipment at September 30 consist of the following:

	2011	2010
Land and land improvements	**$ 4,862,121**	$ 4,889,512
Buildings and leasehold improvements	**126,459,709**	125,739,952
Equipment	**99,035,255**	101,463,454
Construction in process (2012 estimated cost to complete $5,995,000)	**1,365,773**	630,806
Less accumulated depreciation	**(141,087,085)**	(132,954,480)
	$ 90,635,773	$ 99,769,244

The net unamortized value of internally developed software was $388,314 and $968,970 at September 30, 2011 and 2010, respectively. Amortization expense for the years ended September 30, 2011 and 2010 was $596,429 and $591,171, respectively.

The Corporation wrote off approximately $7,299,000 of fully depreciated assets in 2011.

The Corporation leases space to be used for patient services. Two years remain on the initial term, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2011 and 2010 was $655,574 and $640,018, respectively.

The Corporation leases various types of equipment with annual payments ranging from $103 to $39,000. Expenses as a result of these leases were approximately $362,000 and $375,000 for the years ended September 30, 2011 and 2010, respectively.

11. Property, Plant and Equipment (continued)

Future minimum lease payments under the above leases during each of the next five years were as follows:

2012	$ 907,327
2013	831,624
2014	173,838
2015	118,349
2016	11,378
	$ 2,042,516

12. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2011	**2010**
Cafeteria sales	**$ 1,102,713**	$ 1,063,020
Rental income	**698,837**	812,182
Miscellaneous	**687,972**	455,498
Grants	**578,977**	733,844
Condominium income	**412,106**	389,640
Child care	**391,976**	355,497
Purchase discounts	**269,594**	351,343
Interest	**165,642**	196,253
	$ 4,307,817	$ 4,357,277

13. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2011	**2010**
Health care services	**$ 212,969,557**	$ 224,821,690
General and administrative	**55,484,277**	51,724,893
Fundraising	**193,923**	190,865
	$ 268,647,757	$ 276,737,448

14. Concentrations of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. For 2011 and 2010, Hospital receivables accounted for 95% and 96%, respectively. The mix of gross accounts receivables from patients and third-party payors at September 30 is as follows:

	2011	**2010**
Medicare	**26%**	27%
Self pay	**23**	24
Health Maintenance Organizations	**16**	15
Anthem Blue Cross/Blue Shield	**14**	13
Medicaid	**11**	11
Commercial	**5**	5
Other state agencies	**5**	5
	100%	100%

15. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2011	2010
(Increase) decrease in assets:		
Accounts receivable	**$ (14,649,048)**	$ (8,976,789)
Pledge receivable	**84,655**	348,127
Inventories of supplies, prepaid expenses, and other	**(149,263)**	(798,102)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**8,455,319**	3,113,028
Accounts payable	**4,756**	(201,185)
Employee related obligations	**(5,322,115)**	(1,497,412)
Interest payable and other accrued liabilities	**(3,473,306)**	1,143,850
Salaries and wages, payroll taxes, and taxes withheld from payroll	**478,432**	(2,049,900)
Self-insured professional liability	**1,625,379**	(66,430)
Other liabilities	**93,505**	(325,475)
Changes in operating assets and liabilities	**$ (12,851,686)**	$ (9,310,288)

16. Subsequent Events

The Hospital evaluates the impact of subsequent events, which are events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date for the year ended September 30, 2011. The Hospital evaluated subsequent events through January 27, 2012, which is the date the financial statements were issued. No events occurred that require disclosure or adjustment to the combined financial statements.

Other Financial Information

ERNST & YOUNG

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Directors
Backus Corporation and Subsidiaries

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Ernst + Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 83,986	$ 93,136,217	$ 1,681,599	$ 532,749		$ 95,434,551
Assets whose use is limited – required for current liabilities		5,885,482				5,885,482
Accounts receivable, less allowance for uncollectible accounts		32,373,122	1,040,962	1,013,929		34,428,013
Pledges receivable		101,211				101,211
Inventories of supplies		3,704,067				3,704,067
Prepaid expenses and other		1,624,606		9,535		1,634,141
Due from affiliates	98,496	164,147			$ (262,643)	
Total current assets	182,482	136,988,852	2,722,561	1,556,213	(262,643)	141,187,465
Assets whose use is limited:						
Board-designated and donor restricted		105,438,402				105,438,402
Held by trustee		28,078,427				28,078,427
Total assets whose use is limited		133,516,829				133,516,829
Less assets whose use is limited – required for current liabilities		5,885,482				5,885,482
		127,631,347				127,631,347
Property, plant, and equipment, net		89,983,664	162,224	489,885		90,635,773
Deferred financing costs		1,842,330				1,842,330
Other assets	1,000	1,542,292	512,931	97,846	(16,845)	2,137,224
	$ 183,482	$ 357,988,485	$ 3,397,716	$ 2,143,944	$ (279,488)	$ 363,434,139

* Includes Backus Condominium Association

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Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable-trade		$ 9,918,459	$ 26,928	$ 401,694		$ 10,347,081
Salaries and wages, payroll taxes and taxes withheld from payroll		6,666,138	394,468	323,154		7,383,760
Due to affiliates			226,021	36,622	$ (262,643)	
Other accrued liabilities		5,734,285	777	222,072		5,957,134
Employee related obligations		3,942,900				3,942,900
Due to third-party reimbursement agencies		4,683,178		340,662		5,023,840
Current portion of long-term debt		2,115,360				2,115,360
Total current liabilities		33,060,320	648,194	1,324,204	(262,643)	34,770,075
Other liabilities:						
Long-term debt, less current portion		62,389,713				62,389,713
Employee related obligations		69,884,879				69,884,879
Self-insured professional liability		10,853,762	3,167,387			14,021,149
Due to third-party reimbursement agencies		19,162,526				19,162,526
Other		443,183				443,183
		162,734,063	3,167,387			165,901,450
Net assets:						
Common stock				1,000	(1,000)	
Unrestricted	183,482	153,345,431	(417,865)	818,740	(15,845)	153,913,943
Temporarily restricted		1,399,547				1,399,547
Permanently restricted		7,449,124				7,449,124
Total net assets	183,482	162,194,102	(417,865)	819,740	(16,845)	162,762,614
Total liabilities and net assets	$ 183,482	$ 357,988,485	$ 3,397,716	$ 2,143,944	$ (279,488)	$ 363,434,139

* Includes Backus Condominium Association

000406

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:						
Net patient service revenue		$ 271,933,218	$ 5,513,552	$ 7,769,219	$ (8,424)	$ 285,207,565
Other operating revenue	$ 55,920	4,848,198	95,365	1,815	(693,481)	4,307,817
Net assets released from restrictions		673,194				673,194
	55,920	277,454,610	5,608,917	7,771,034	(701,905)	290,188,576
Operating expenses:						
Salaries, wages and professional fees	186,263	110,169,857	4,542,201	4,746,454		119,644,775
Payroll taxes and other fringe benefits	58,738	25,655,346	890,706	1,249,526		27,854,316
Supplies, insurance and other	3	83,918,758	3,326,153	1,544,430	(701,905)	88,087,439
Provision for uncollectible accounts		12,522,978	102,603	142,349		12,767,930
Depreciation and amortization		16,971,187	34,004	40,391		17,045,582
Interest		3,247,715				3,247,715
	245,004	252,485,841	8,895,667	7,723,150	(701,905)	268,647,757
Operating (loss) income	(189,084)	24,968,769	(3,286,750)	47,884		21,540,819
Nonoperating gains and (losses):						
Contributions and donations		158,300				158,300
Investment income	95	581,947	1,803,031	60,705		2,445,778
Other		(565,873)				(565,873)
	95	174,374	1,803,031	60,705		2,038,205
Excess (deficiency) of revenues over expenses	$ (188,989)	$ 25,143,143	$ (1,483,719)	$ 108,589		$ 23,579,024

* Includes Backus Condominium Association

000407

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:						
Excess (deficiency) of revenues over expenses (continued)	$ (188,989)	$ 25,143,143	$ (1,483,719)	$ 108,589		$ 23,579,024
Change in pension funding obligation		(21,176,691)				(21,176,691)
Intercompany transfer	245,005	(245,005)				
Assets released from restriction used for purchase of equipment		2,257,860				2,257,860
Increase (decrease) in unrestricted net assets	56,016	5,979,307	(1,483,719)	108,589		4,660,193
Temporarily restricted net assets:						
Contributions		575,427				575,427
Income from investments		(346,369)				(346,369)
Net assets released from restrictions		(2,931,054)				(2,931,054)
Decrease in temporarily restricted net assets		(2,701,996)				(2,701,996)
Permanently restricted net assets						
Contributions		5,000				5,000
Income from investments		71,073				71,073
Change in net assets held in trust		(102,369)				(102,369)
Decrease in permanently restricted net assets		(26,296)				(26,296)
Increase (decrease)in net assets	56,016	3,251,015	(1,483,719)	108,589		1,931,901
Net assets at beginning of year	127,466	158,943,087	1,065,854	711,151	$ (16,845)	160,830,713
Net assets (deficit) at end of year	$ 183,482	$ 162,194,102	$ (417,865)	$ 819,740	$ (16,845)	$ 162,762,614

* Includes Backus Condominium Association

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Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2011

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,469	$ 1,654,736	$ 15,394		$ 1,681,599
Accounts receivable, less allowance for uncollectible accounts		424,360	616,602		1,040,962
Due from affiliates	98,496	3,091,170		$ (3,189,666)	
Total current assets	109,965	5,170,266	631,996	(3,189,666)	2,722,561
Property, plant and equipment:					
Buildings and leasehold improvements		19,619			19,619
Equipment		295,006	61,648		356,654
Accumulated depreciation		(176,106)	(37,943)		(214,049)
		138,519	23,705		162,224
Other assets		512,931			512,931
	$ 109,965	$ 5,821,716	$ 655,701	$ (3,189,666)	$ 3,397,716
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 22,003	$ 4,925		$ 26,928
Salaries and wages, payroll taxes and taxes withheld from payroll		228,385	166,083		394,468
Other accrued liabilities			777		777
Self-insured professional liability		1,161,387	2,006,000		3,167,387
Due to affiliates	$ 108,925	215,592	3,091,170	(3,189,666)	226,021
Total current liabilities	108,925	1,627,367	5,268,955	(3,189,666)	3,815,581
Net assets (deficit)	1,040	4,194,349	(4,613,254)		(417,865)
Total liabilities and net assets	$ 109,965	$ 5,821,716	$ 655,701	$ (3,189,666)	$ 3,397,716

000409

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2011

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,077,468	$ 2,436,084		$ 5,513,552
Other operating revenue	$ 36,936	90,102	5,263	$ (36,936)	95,365
Total revenues	36,936	3,167,570	2,441,347	(36,936)	5,608,917
Expenses:					
Salaries and wages		2,168,572	2,373,629		4,542,201
Payroll taxes and fringe benefits		560,111	330,595		890,706
Supplies and other	41,405	1,158,068	2,163,616	(36,936)	3,326,153
Provision for uncollectible accounts		56,527	46,076		102,603
Depreciation and amortization		23,879	10,125		34,004
Total expenses	41,405	3,967,157	4,924,041	(36,936)	8,895,667
Operating loss	(4,469)	(799,587)	(2,482,694)		(3,286,750)
Nonoperating gains:					
Investment income	6	1,803,017	8		1,803,031
(Deficiency) excess of revenue over expenses	(4,463)	1,003,430	(2,482,686)		(1,483,719)
Net assets (deficit) at beginning of year	5,503	3,190,919	(2,130,568)		1,065,854
Net assets (deficit) at end of year	$ 1,040	$ 4,194,349	$ (4,613,254)	$	$ (417,865)

000410

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2011

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 345,033	$ 187,716		$ 532,749
Accounts receivable, less allowance for uncollectible accounts		1,013,929		1,013,929
Prepaid expenses and other		9,535		9,535
Due from affiliates	789,464		$ (789,464)	
Total current assets	1,134,497	1,211,180	(789,464)	1,556,213
Property, plant and equipment:				
Buildings and leasehold improvements		455,405		455,405
Equipment		121,313		121,313
Accumulated depreciation		(86,833)		(86,833)
		489,885		489,885
Other assets	97,846			97,846
	$ 1,232,343	$ 1,701,065	$ (789,464)	$ 2,143,944
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 401,694		$ 401,694
Salaries and wages, payroll taxes and taxes withheld from payroll		323,154		323,154
Other accrued liabilities		222,072		222,072
Due to third party reimbursement agencies		340,662		340,662
Due to affiliates	$ 36,622	789,464	$ (789,464)	36,622
Total current liabilities	36,622	2,077,046	(789,464)	1,324,204
Common stock	1,000			1,000
Retained earnings (deficit)	1,194,721	(375,981)		818,740
Total liabilities and net assets	$ 1,232,343	$ 1,701,065	$ (789,464)	$ 2,143,944

000411

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2011

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,769,219		$ 7,769,219
Other operating revenue		1,815		1,815
Total revenues		7,771,034		7,771,034
Expenses:				
Salaries and wages		4,746,454		4,746,454
Payroll taxes and fringe benefits		1,249,526		1,249,526
Supplies and other	$ 33,989	1,510,441		1,544,430
Provision for uncollectible accounts		142,349		142,349
Depreciation and amortization		40,391		40,391
Total expenses	33,989	7,689,161		7,723,150
Operating (loss) income	(33,989)	81,873		47,884
Nonoperating gains:				
Investment income	60,686	19		60,705
Excess of revenue over expenses	26,697	81,892		108,589
Net assets (deficit) at beginning of year	1,168,024	(457,873)		710,151
Net assets (deficit) at end of year	$ 1,194,721	$ (375,981)	$	$ 818,740

000412

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 63,324	$ 72,131,779	$ 1,612,700	$ 1,121,821		$ 74,929,624
Assets whose use is limited – required for current liabilities		7,931,590				7,931,590
Accounts receivable, less allowance for uncollectible accounts		30,758,941	838,941	949,013		32,546,895
Pledges receivable		185,866				185,866
Inventories of supplies		3,799,896	85,421			3,885,317
Prepaid expenses and other		1,277,144	20,282	6,202		1,303,628
Due from affiliates	63,142	661,088			$ (724,230)	
Total current assets	126,466	116,746,304	2,557,344	2,077,036	(724,230)	120,782,920
Assets whose use is limited:						
Board-designated and donor restricted		96,626,409				96,626,409
Held by trustee		26,988,802				26,988,802
Total assets whose use is limited		123,615,211				123,615,211
Less assets whose use is limited – required for current liabilities		7,931,590				7,931,590
		115,683,621				115,683,621
Property, plant, and equipment, net		99,122,387	145,235	501,622		99,769,244
Deferred financing costs		1,933,364				1,933,364
Other assets	1,000	1,603,864	782,197	43,661	(16,845)	2,413,877
	$ 127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

000413

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable-trade		$ 10,129,146	$ 25,228	$ 187,951		$ 10,342,325
Salaries and wages, payroll taxes and taxes withheld from payroll		6,206,054	309,223	390,051		6,905,328
Due to affiliates			203,033	521,197	$ (724,230)	-
Other accrued liabilities		8,967,664		462,776		9,430,440
Employee related obligations		3,589,500				3,589,500
Due to third-party reimbursement agencies		2,614,222		349,193		2,963,415
Current portion of long-term debt		2,032,691				2,032,691
Total current liabilities		33,539,277	537,484	1,911,168	(724,230)	35,263,699
Other liabilities:						
Long-term debt, less current portion		64,591,831				64,591,831
Employee related obligations		54,383,703				54,383,703
Self-insured professional liability		10,514,332	1,881,438			12,395,770
Due to third-party reimbursement agencies		12,767,632				12,767,632
Other		349,678				349,678
		142,607,176	1,881,438			144,488,614
Net assets:						
Common stock				1,000	(1,000)	
Unrestricted	$ 127,466	147,366,124	1,065,854	710,151	(15,845)	149,253,750
Temporarily restricted		4,101,543				4,101,543
Permanently restricted		7,475,420				7,475,420
Total net assets	127,466	158,943,087	1,065,854	711,151	(16,845)	160,830,713
Total liabilities and net assets	$ 127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

000414

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 270,048,715		$ 5,497,679		$ 7,378,559	$ (23,449)	$ 282,901,504
Other operating revenue	$ 593,530	4,673,356		87,120		6,752	(1,003,481)	4,357,277
Net assets released from restrictions		91,211						91,211
	593,530	274,813,282		5,584,799		7,385,311	(1,026,930)	287,349,992
Operating expenses:								
Salaries, wages and professional fees	174,812	109,179,026		4,740,065		4,148,270	(531,853)	117,710,320
Payroll taxes and other fringe benefits	55,510	27,181,443		978,613		1,406,492		29,622,058
Supplies, insurance and other	25,447	91,056,415		1,716,164		1,920,311	(495,077)	94,223,260
Provision for uncollectible accounts		14,409,876		(11,974)		64,261		14,462,163
Depreciation and amortization		17,480,126		27,483		27,000		17,534,609
Interest		3,185,038						3,185,038
	255,769	262,491,924		7,450,351		7,566,334	(1,026,930)	276,737,448
Operating income (loss)	337,761	12,321,358		(1,865,552)		(181,023)		10,612,544
Nonoperating gains and (losses):								
Contributions and donations		328,840						328,840
Investment income	77	6,218,347		2,213,811		54,520		8,486,755
Other		(116,761)		197,389		(3,562)		77,066
	77	6,430,426		2,411,200		50,958		8,892,661
Excess (deficiency) of revenues over expenses	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205

* Includes Backus Condominium Association

000415

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205
Merger of Properties		1,402,938			$ (1,402,938)			
Intercompany transfer		(73,056)		73,056				
Pension curtailment		34,536,288						34,536,288
Change in pension funding obligation		(9,564,206)						(9,564,206)
Increase (decrease) in unrestricted net assets	337,838	45,053,748		618,704	(1,402,938)	(130,065)		44,477,287
Temporarily restricted net assets:								
Contributions		126,631						126,631
Income from investments		618,691						618,691
Merger of Foundation			$ (34,308,847)				34,308,847	
Net assets released from restrictions		(91,211)						(91,211)
Increase (decrease) in temporarily restricted net assets		654,111	(34,308,847)				34,308,847	654,111
Permanently restricted net assets								
Contributions		358,064						358,064
Income from investments		121,091						121,091
Merger of Foundation			(6,838,627)				6,838,627	
Change in net assets held in trust		134,435						134,435
Increase (decrease) in permanently restricted net assets		613,590	(6,838,627)				6,838,627	613,590
Increase (decrease)in net assets	337,838	46,321,449	(41,147,474)	618,704	(1,402,938)	(130,065)	41,147,474	45,744,988
Net assets (deficit) at beginning of year	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Net assets at end of year	$ 127,466	$ 158,943,087	$	$ 1,065,854	$	$ 711,151	$ (16,845)	$ 160,830,713

* Includes Backus Condominium Association

000416

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,463	$ 1,228,148	$ 373,089		$ 1,612,700
Accounts receivable, less allowance for uncollectible accounts		369,242	469,699		838,941
Inventories of supplies		85,421			85,421
Prepaid expenses		9,376	10,906		20,282
Due from affiliates	61,560	2,340,589		$ (2,402,149)	
Total current assets	73,023	4,032,776	853,694	(2,402,149)	2,557,344
Property, plant and equipment:					
Buildings and leasehold improvements		19,619			19,619
Equipment		244,681	61,648		306,329
Accumulated depreciation		(152,895)	(27,818)		(180,713)
		111,405	33,830		145,235
Other assets		782,197			782,197
	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 10,233	$ 14,995		$ 25,228
Salaries and wages, payroll taxes and taxes withheld from payroll		246,716	62,507		309,223
Self-insured professional liability		1,281,437	600,001		1,881,438
Due to affiliates	$ 67,520	197,073	2,340,589	$ (2,402,149)	203,033
Total current liabilities	67,520	1,735,459	3,018,092	(2,402,149)	2,418,922
Net assets (deficit)	5,503	3,190,919	(2,130,568)		1,065,854
Total liabilities and net assets	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776

000417

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,608,723	$ 1,888,956		$ 5,497,679
Other operating revenue	$ 36,936	68,042	19,078	$ (36,936)	87,120
Total revenues	36,936	3,676,765	1,908,034	(36,936)	5,584,799
Expenses:					
Salaries and wages		2,634,018	2,106,047		4,740,065
Payroll taxes and fringe benefits		719,574	259,039		978,613
Supplies and other	39,186	714,272	999,642	(36,936)	1,716,164
Provision for uncollectible accounts		(69,754)	57,780		(11,974)
Depreciation and amortization		14,905	12,578		27,483
Total expenses	39,186	4,013,015	3,435,086	(36,936)	7,450,351
Operating loss	(2,250)	(336,250)	(1,527,052)		(1,865,552)
Nonoperating gains:					
Investment income	6	2,213,805			2,213,811
Other		197,389			197,389
(Deficiency) excess of revenue over expenses	(2,244)	2,074,944	(1,527,052)		545,648
Net assets (deficit) at beginning of year	7,747	1,044,627	(605,224)		447,150
Intercompany transfer		71,348	1,708		73,056
Net assets (deficit) at end of year	$ 5,503	$ 3,190,919	$ (2,130,568)	$	$ 1,065,854

000418

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2010

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,087,166	$ 34,655		$ 1,121,821
Accounts receivable, less allowance for uncollectible accounts		949,013		949,013
Prepaid expenses and other		6,202		6,202
Due from affiliates	563,194		$ (563,194)	
Total current assets	1,650,360	989,870	(563,194)	2,077,036
Property, plant and equipment:				
Buildings and leasehold improvements		445,975		445,975
Equipment		102,089		102,089
Accumulated depreciation		(46,442)		(46,442)
		501,622		501,622
Other assets	39,861	3,800		43,661
	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 187,951		$ 187,951
Salaries and wages, payroll taxes and taxes withheld from payroll		390,051		390,051
Other accrued liabilities		462,776		462,776
Due to third party reimbursement agencies		349,193		349,193
Due to affiliates	$ 521,197	563,194	$ (563,194)	521,197
Total current liabilities	521,197	1,953,165	(563,194)	1,911,168
Common stock	1,000			1,000
Retained earnings (deficit)	1,168,024	(457,873)		710,151
Total liabilities and net assets	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319

000419

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,378,559		$ 7,378,559
Other operating revenue		6,752		6,752
Total revenues		7,385,311		7,385,311
Expenses:				
Salaries and wages		4,148,270		4,148,270
Payroll taxes and fringe benefits		1,406,492		1,406,492
Supplies and other	$ 67,510	1,852,801		1,920,311
Provision for uncollectible accounts		64,261		64,261
Depreciation and amortization		27,000		27,000
Total expenses	67,510	7,498,824		7,566,334
Operating (loss) income	(67,510)	(113,513)		(181,023)
Nonoperating gains:				
Investment income	53,219	1,301		54,520
Other		(3,562)		(3,562)
Excess of revenue over expenses	(14,291)	(115,774)		(130,065)
Net assets (deficit) at beginning of year	1,182,315	(342,099)		840,216
Net assets (deficit) at end of year	$ 1,168,024	$ (457,873)	$	$ 710,151

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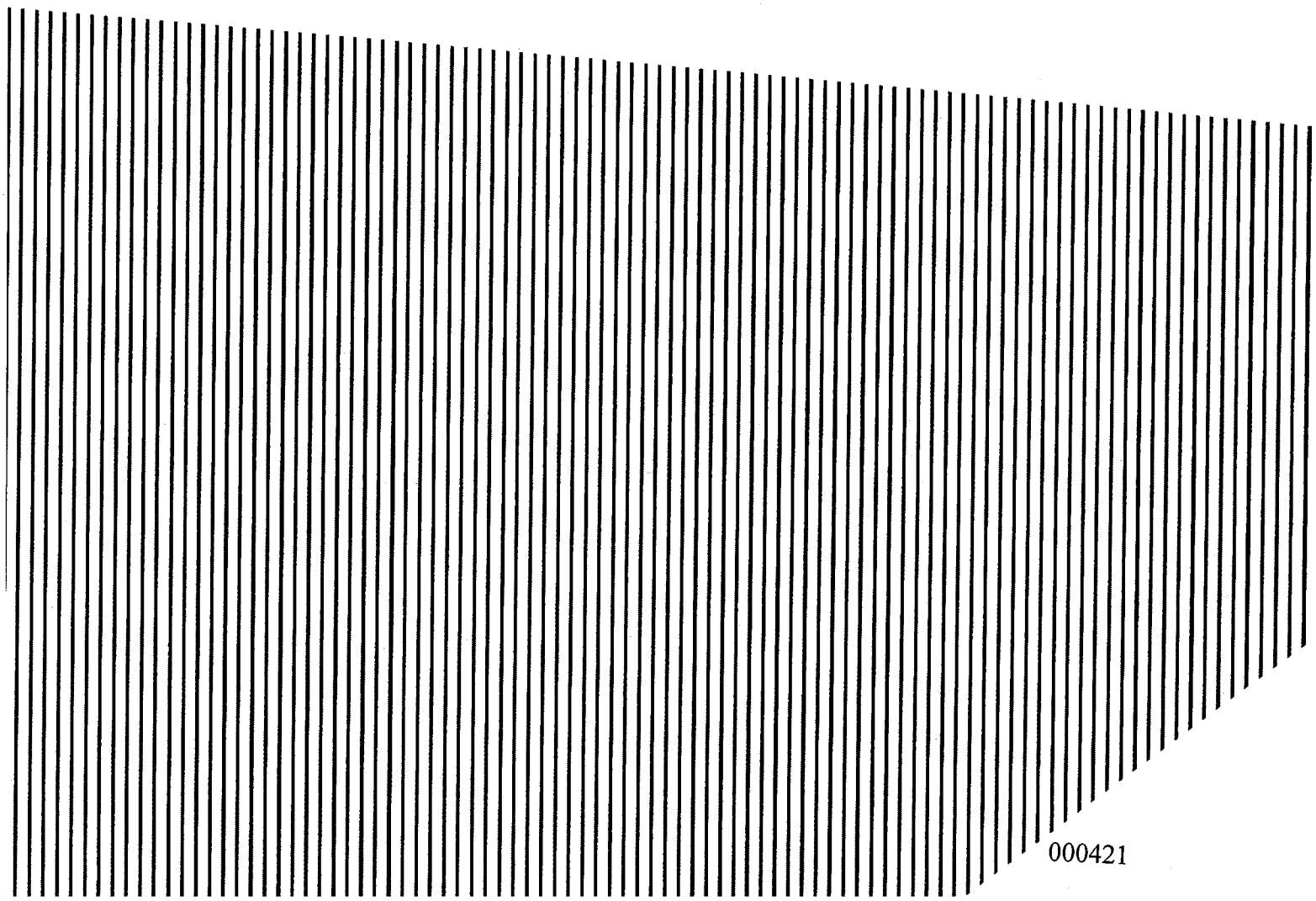
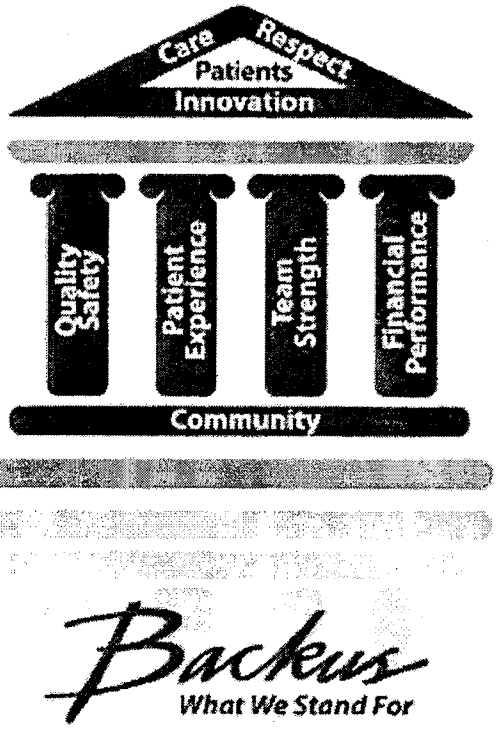


Backus

Year-To-Date Financial Report
June 30, 2012



Backus
What We Stand For

Appendix A: Consolidated Financial Statements

Unaudited Financial Statements of the Backus Corporation and Subsidiaries

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
June 30,2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Assets						
Current assets:						
Cash and cash equivalents	$ 84,070	$ 105,809,659	$ 653,991	$ 423,400		$ 106,971,120
Assets whose use is limited-required for current liabilities		7,155,095				7,155,095
Accounts receivable, less allowance		27,622,168	1,058,997	885,893	-	29,567,058
Pledges receivable		31,004				31,004
Inventories of supplies		3,813,399				3,813,399
Prepaid expenses		1,842,942	63,507	19,924		1,926,373
Due from affiliates	140,436	630,561			$ (770,997)	-
Total current assets	224,506	146,904,828	1,776,495	1,329,217	(770,997)	149,464,049
Assets whose use is limited:						
Board designated and donor restricted		113,246,171				113,246,171
Held by trustee		31,469,316				31,469,316
Total assets whose use is limited	-	144,715,487	-	-	-	144,715,487
Less assets whose use is limited-required for current liabilities		7,155,095				7,155,095
	-	137,560,392	-	-	-	137,560,392
Other assets:						
Deferred financing costs		1,774,640				1,774,640
Other assets, less allowance	1,000	1,520,170	597,038	71,074	(16,845)	2,172,437
Total other assets	1,000	3,294,810	597,038	71,074	(16,845)	3,947,077
Property, plant and equipment						
Land and land improvements		4,862,121				4,862,121
Buildings and leasehold improvements		125,830,703	19,619	455,405		126,305,727
Equipment		96,825,571	372,755	127,894		97,326,220
Construction in progress		18,244,176				18,244,176
Accumulated depreciation		(151,422,853)	(234,016)	(114,193)		(151,771,062)
	-	94,339,718	158,358	469,106	-	94,967,182
	$ 225,506	$ 382,099,748	$ 2,531,891	$ 1,869,397	$ (787,842)	$ 385,938,700

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Backus Corporation and Subsidiaries
Consolidating Balance Sheets
June 30,2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Liabilities and Net Assets						
Current liabilities						
Accounts payable-trade		$ 10,598,148	$ 232,965	$ 268,735	-	$ 11,099,848
Salaries and wages, payroll taxes and taxes withheld from payroll		4,075,460	367,907	304,219	-	4,747,586
Due to affiliates	$ 110,976		390,523	269,498	$ (770,997)	-
Other accrued liabilities		7,628,468	1,817	176,631		7,806,916
Employee related obligations		2,706,450				2,706,450
Due to third parties		6,518,622		299,953		6,818,575
Current portion of long-term debt		2,031,354				2,031,354
Total current liabilities	110,976	33,558,502	993,212	1,319,036	(770,997)	35,210,729
Other Liabilities:						
Long-term debt, less current portion		67,414,405				67,414,405
Employee related obligations		66,732,298				66,732,298
Self-insured professional liability		10,200,336	2,509,957			12,710,293
Due to third parties		19,262,893				19,262,893
Other		590,717			-	590,717
	-	164,200,649	2,509,957	-	-	166,710,606
Net Assets:						
Common stock				1,000	(1,000)	-
Unrestricted net assets	114,530	174,065,995	(971,278)	549,361	(15,845)	173,742,763
Temporarily restricted net assets		2,519,764				2,519,764
Permanently restricted net assets		7,754,838				7,754,838
	114,530	184,340,597	(971,278)	550,361	(16,845)	184,017,365
	$ 225,506	$ 382,099,748	$ 2,531,891	$ 1,869,397	$ (787,842)	$ 385,938,700

*includes Backus Condominium Association

000425

Backus Corporation and Subsidiaries
Consolidating Statement of Operations and Change in Net Assets
June 30, 2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Revenues:						
Net patient service revenue		$ 205,983,824	$ 4,451,761	$ 6,018,261	$ (4,995)	$ 216,448,851
Provision for bad debt		$ (10,016,639)	$ (67,590)	$ (78,899)		(10,163,128)
Other operating revenue	$ 41,940	3,714,027	95,354	8,245	(496,996)	3,362,570
Net assets released from restrictions		146,347			-	146,347
	41,940	199,827,559	4,479,525	5,947,607	(501,991)	209,794,640
Expenses:						
Salaries and wages	110,976	82,926,178	4,118,831	3,440,432		90,596,417
Payroll taxes and fringe benefits		23,539,669	859,354	1,102,962		25,501,985
Supplies and expenses		65,602,005	973,974	1,690,119	(501,991)	67,764,107
Depreciation and amortization		13,097,011	27,167	27,360		13,151,538
Interest		2,419,633			-	2,419,633
	110,976	187,584,496	5,979,326	6,260,873	(501,991)	199,433,680
Operating income (loss)	(69,036)	12,243,063	(1,499,801)	(313,266)	-	10,360,960
Nonoperating gains and (losses)						
Contributions and donations		114,120			-	114,120
Investment income	84	8,225,045	942,917	24,280	-	9,192,326
Other		125,693		19,607		145,300
Excess (deficiency) of revenue over expenses	(68,952)	20,707,921	(556,884)	(269,379)	-	19,812,706
Unrestricted net assets:						
Excess of revenue over expenses	(68,952)	20,707,921	(556,884)	(269,379)	-	19,812,706
Assets released from restriction-pp&e		16,114				16,114
Intercompany transfer		(3,471)	3,471			-
Increase (decrease) in unrestricted net assets	(68,952)	20,720,564	(553,413)	(269,379)	-	19,828,820
Temporarily restricted net assets:						
Contributions		367,053				367,053
Income from investments		915,624				915,624
Net assets released from restrictions		(162,460)				(162,460)
Increase (decrease) in temp restricted net assets		1,120,217	-	-	-	1,120,217
Permanently restricted net assets						
Change in net assets held in trust		305,714				305,714
Increase (decrease) in perm restricted net assets	-	305,714	-	-	-	305,714
Increase (decrease) in net assets	(68,952)	22,146,495	(553,413)	(269,379)	-	21,254,751
Net assets (deficit) at beginning of year	183,482	162,194,102	(417,865)	819,740	(16,845)	162,762,614
Net assets (deficit) at end of year	$ 114,530	$ 184,340,597	$ (971,278)	$ 550,361	$ (16,845)	$ 184,017,365

Appendix B: Hospital Financial Statements

Unaudited Financial Statements of the Backus Hospital

The William W. Backus Hospital

Statements of Financial Position

Assets	June 2012	September 2011
Current assets:		
Cash and cash equivalents	$ 105,809,659	$ 93,136,217
Assets whose use is limited-required for current liabilities	7,155,095	5,885,482
Accounts receivable, less allowance for uncollectible accounts (2012-$22,475,942 2011-$21,200,088)	27,622,168	32,373,122
Pledge receivable	31,004	101,211
Due from affiliates, less allowance	954,380	165,240
Inventories of supplies	3,813,399	3,704,067
Prepaid expenses and other	1,820,835	1,604,965
Total Current Assets	147,206,540	136,970,304
Assets whose use is limited:		
Board designated	113,246,171	105,438,550
Held by trustee	2,667,551	2,356,916
Malpractice reserve	22,268,273	21,536,349
Debt service reserve fund	2,512,745	2,516,792
Debt service fund	4,020,746	1,668,222
Total assets whose use is limited	144,715,486	133,516,829
Less assets whose use is limited-required for current liabilities	(7,155,095)	(5,885,482)
	137,560,391	127,631,347
Property, plant and equipment:		
Land and land improvements	4,862,121	4,862,121
Buildings	125,830,703	125,984,685
Equipment	96,825,571	98,557,288
Construction in process	18,244,175	1,365,774
Accumulated depreciation (deduction)	(151,422,853)	(140,786,203)
	94,339,717	89,983,665
Deferred financing costs	1,774,642	1,842,329
Other assets	1,520,171	1,542,292
	$ 382,401,461	$ 357,969,937

Statements of Financial Position (con't)

	June 2012	September 2011
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 10,598,148	$ 9,918,459
Salaries and wages, payroll taxes and taxes witheld from payrolls	4,075,460	6,666,138
Other accrued liabilities	6,158,791	4,998,968
Employee related obligations	2,706,450	3,942,900
Due to third parties	6,898,893	4,683,178
Interest payable	1,469,677	734,838
Current portion of long-term debt	2,031,354	2,115,359
Total current liabilities	33,938,773	33,059,840
Other liabilities:		
Long-term debt	67,414,405	62,389,713
Accrued pension and other retirement costs	66,732,299	69,884,880
Self-insured professsional liability	10,200,336	10,853,762
Due to third-party reimbursement agencies	19,262,893	19,162,526
Other	590,717	443,182
	164,200,650	162,734,063
Net assets:		
Unrestricted	173,987,436	153,327,362
Temporarily restricted	2,519,764	1,399,547
Permanently restricted	7,754,838	7,449,125
	184,262,038	162,176,034
	$ 382,401,461	$ 357,969,937

The William W. Backus Hospital

Statements of Operations

	Nine months ended June	
	2012	2011
Operating revenues:		
Net revenues from services to patients	$ 205,983,824	$ 205,422,944
Bad debt	(10,016,639)	(11,786,625)
Other operating revenues	3,327,259	3,087,647
Net assets released from restriction	146,347	256,367
	199,440,791	196,980,333
Operating expenses:		
Salaries, wages and professional fees	82,926,178	79,904,734
Payroll taxes and other fringe benefits	23,539,669	21,691,809
Supplies and expenses	65,275,726	62,186,084
Provision for depreciation and amortization	13,097,011	14,029,097
Interest	2,419,633	2,450,228
	187,258,217	180,261,952
Operating Income	12,182,574	16,718,381
Non-operating gains and (losses):		
Income from investments	8,225,044	8,677,160
Contributions and Donations	114,120	107,858
Other	125,693	(508,004)
Excess of revenues over expenses	$ 20,647,431	$ 24,995,395

The William W. Backus Hospital

Statement of Changes in Net Assets

	Nine months ended June 2012	2011
Unrestricted net assets:		
Excess of revenues over expenses	$ 20,647,431	$ 24,995,395
Intercompany Transfers	(3,471)	-
Assets released from restriction-PPE	16,114	1,997,872
Increase in unrestricted assets	20,660,074	26,993,267
Temporarily restricted net assets:		
Income from investments	915,624	703,344
Contributions and Donations	367,053	490,347
Net assets released from restriction	(162,460)	(2,254,239)
Increase (decrease) in temporarily restricted net assets	1,120,217	(1,060,548)
Permanently restricted net assets:		
Income from investments	-	71,073
Contributions and Donations	-	5,000
Change in net assets held in trust	305,714	207,243
Increase in permanently restricted net assets	305,714	283,316
Increase in net assets	22,086,005	26,216,035
Net assets at beginning of period	162,176,033	158,925,018
Net assets at end of period	$ 184,262,038	$ 185,141,052

The William W. Backus Hospital

Statement of Cash Flows

	Nine Months ended June 2012	2011
Operating activities		
Increase in net assets	$ 22,086,005	$ 26,216,035
Adjustments to reconcile increase(decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	13,097,011	14,029,097
Provision for uncollectible accounts	10,016,639	11,788,663
Transfers to affiliates	3,471	-
Purchase of investments-board designated, net	(6,662,540)	(18,776,558)
Changes in operating assets and liabilities:		
Accounts receivable	(5,265,686)	(10,652,200)
Collection on pledges	70,207	58,709
Due to affiliates	(789,140)	(394,366)
Inventories of supplies, prepaid expenses and other	(325,201)	(512,612)
Accounts payable	679,689	(274,623)
Employee related obligations	(4,389,031)	(5,079,117)
Interest payable and other accrued liabilities	1,894,662	(99,360)
Salaries and wages, payroll taxes and taxes withheld from payrolls	(2,590,678)	(1,814,374)
Self-insured professional liability	(653,426)	2,266,099
Due to third parties and taxes payable	2,316,082	2,636,285
Other liabilities	147,535	66,974
Net cash provided by operating activities	29,635,599	19,458,652
Investing activities		
Purchases of investments-held in trust, net	(4,536,118)	(3,038,577)
Net additions to property, plant and equipment	(12,277,361)	(5,619,897)
Decrease in other assets	22,122	730,608
Net cash used in investing activities	(16,791,357)	(7,927,866)
Financing activities		
Principal payments and capital lease obligations	(133,839)	(117,690)
Change in deferred financing and amortization of bond premuim	(33,490)	(18,855)
Transfers to affiliates	(3,471)	-
Net cash used in financing activities	(170,800)	(136,545)
Increase in cash and cash equivalents	12,673,442	11,394,241
Cash and cash equivalents at beginning of period	93,136,217	72,131,779
Cash and cash equivalents at end of period	$ 105,809,659	$ 83,526,020

THE WILLIAM W. BACKUS HOSPITAL
REVENUE AND EXPENSES
JUNE 2012

	Current Month		Prior Year	Year-to-Date		Prior Year
	Actual	Budget	Actual	Actual	Budget	Actual
Patient Revenue						
Patient revenue-inpatient	$18,583	$20,248	$19,834	$177,606	$183,621	$184,143
Patient revenue-outpatient	30,726	28,687	30,831	280,010	266,170	267,962
Gross patient revenue	49,309	48,935	50,665	457,616	449,791	452,105
Deductions from Patient Revenue						
Contractual discounts	26,555	26,732	27,310	251,632	243,719	246,682
Provisions for bad debts	965	1,147	1,342	10,017	10,501	11,787
Total deductions from revenue	27,520	27,879	28,652	261,649	254,220	258,469
Net patient revenue	21,789	21,056	22,013	195,967	195,571	193,636
Other operating revenue	336	267	312	3,327	2,872	3,088
Net assets released from restriction	4	2	7	147	65	256
Total operating revenue	22,129	21,325	22,332	199,441	198,508	196,980
Operating Expenses						
Salary & wages	8,817	8,818	8,689	81,583	79,628	78,623
Fringe benefits	1,909	2,662	2,092	23,540	23,868	21,692
Medical fees	167	134	138	1,343	1,270	1,282
Medical & general supplies/drugs	3,279	3,383	3,326	31,473	31,307	31,151
Purchased services	1,251	1,216	1,091	10,362	9,829	8,791
Depreciation	1,427	1,410	1,486	13,097	13,337	14,029
Interest	300	264	272	2,419	2,379	2,450
Ins, food & other operating expenses	3,783	2,872	2,820	23,441	24,273	22,244
Net operating expenses	20,933	20,759	19,914	187,258	185,891	180,262
Excess of revenue over expenses	1,196	566	2,418	12,183	12,617	16,718
Nonoperating Revenue						
Investment income	1,939	247	(805)	8,225	6,706	8,677
Contributions and donations	10	19	21	114	85	108
Other	105		9	125		(508)
Net non-operating revenue	2,054	266	(775)	8,464	6,791	8,277
Excess of revenue over expense	$3,250	$832	$1,643	$20,647	$19,408	$24,995

THE WILLIAM W. BACKUS HOSPITAL
REVENUE AND EXPENSES
JUNE 2012

	Quarter-to-Date		Prior Year	Year-to-Date		Prior Year
	Actual	Budget	Actual	Actual	Budget	Actual
Patient Revenue						
Patient revenue-inpatient	$57,117	$60,920	$60,222	$177,606	$183,621	$184,143
Patient revenue-outpatient	94,579	87,986	91,242	280,010	266,170	267,962
Gross patient revenue	151,696	148,906	151,464	457,616	449,791	452,105
Deductions from Patient Revenue						
Contractual discounts	85,507	82,886	86,203	251,632	243,719	246,682
Provisions for bad debts	1,551	1,667	1,584	10,017	10,501	11,787
Total deductions from revenue	87,058	84,553	87,787	261,649	254,220	258,469
Net patient revenue	64,638	64,353	63,677	195,967	195,571	193,636
Other operating revenue	969	869	1,011	3,327	2,872	3,088
Net assets released from restriction	25	42	168	147	65	256
Total operating revenue	65,632	65,264	64,856	199,441	198,508	196,980
Operating Expenses						
Salary & wages	26,693	26,568	26,378	81,583	79,628	78,623
Fringe Benefits	7,653	8,198	7,005	23,540	23,868	21,692
Medical fees	456	416	432	1,343	1,270	1,282
Medical & general supplies/drugs	10,294	10,165	10,065	31,473	31,307	31,151
Purchased services	3,848	3,335	3,335	10,362	9,829	8,791
Depreciation	4,014	4,254	4,516	13,097	13,337	14,029
Interest	829	793	817	2,419	2,379	2,450
Ins, food & other operating expenses	8,222	8,375	7,784	23,441	24,273	22,244
Net operating expenses	62,009	62,104	60,332	187,258	185,891	180,262
Excess of revenue over expenses	3,623	3,160	4,524	12,183	12,617	16,718
Nonoperating Revenue						
Investment income	($1,868)	1,930	1,288	8,225	6,706	8,677
Contributions and donations	$57	56	60	114	85	108
Other	$163		(479)	125		(508)
Net non-operating revenue	(1,648)	1,986	869	8,464	6,791	8,277
Excess of revenue over expense	$1,975	$5,146	$5,393	$20,647	$19,408	$24,995

THE WILLIAM W. BACKUS HOSPITAL
SELECTED OPERATING AND FINANCIAL STATISTICS

OPERATING STATISTICS	Jun-12	May-12	Apr-12	Mar-12	Feb-12	Jan-12	Dec-11	Nov-11	Oct-11	FY 11
Med/Surg/ICU Patient Days	3,296	3,370	3,195	3,604	3,621	3,570	3,290	3,179	3,476	40,731
Med/Surg/ICU Discharges	768	779	732	849	808	818	816	825	798	9,471
Med/Surg/ICU Occupancy Rate	72.8%	72.0%	70.5%	77.0%	82.7%	76.3%	70.3%	70.2%	74.3%	73.9%
Med/Surg /ICU Average Length of Stay	4.3	4.3	4.4	4.2	4.5	4.4	4.0	3.9	4.4	4.3
Case Mix Index (exclude IP Psych)	1.2511	1.3506	1.2294	1.2711	1.2618	1.3414	1.3023	1.2307	1.2607	1.3034
Case Mix Index Medicare	1.3924	1.4784	1.3500	1.3237	1.4294	1.4289	1.3837	1.3628	1.3860	1.4654
Case Mix Index Other Gov't	0.9333	1.1244	0.9685	1.0470	0.9476	1.1566	1.0107	0.9284	0.9541	1.0040
Case Mix Index Non Gov't	1.2581	1.2909	1.2106	1.3235	1.2306	1.3208	1.3469	1.2399	1.2462	1.2691
Total Equivalent Discharges	2,600	2,543	2,518	2,673	2,466	2,499	2,621	2,679	2,581	29,683
Full Time Equivalents (FTEs)	1,548	1,521	1,510	1,519	1,526	1,533	1,536	1,542	1,543	1,501
FTE Per Adj Average Daily Census	4.3	4.4	4.4	4.3	4.2	4.5	4.6	4.6	4.5	4.6
Salary Per FTE (Annualized)	69,280	71,272	69,855	70,093	71,840	70,616	71,061	69,846	69,387	72,220
Gross Revenue Per Equivalent Discrg	18,962	21,214	19,237	19,473	20,720	20,501	19,031	18,978	19,686	20,350
Net Revenue Per Equivalent Dischrg	8,510	9,056	8,563	8,596	9,618	9,450	8,892	8,744	9,189	9,161
Contractuals as a % of Gross Revenue excluding Bad Debt	53.9%	56.1%	56.1%	56.8%	54.3%	55.0%	53.8%	54.5%	54.3%	55.0%
Net Expense Per Equivalent Dischrg	8,050	8,174	8,490	8,335	9,098	8,877	8,474	8,085	8,303	8,492
FINANCIAL STATISTICS										
Current Ratio	4.3	5.2	4.8	4.5	4.3	4.1	4.2	4.8	4.4	4.1
Gross Days in Accounts Receivable	69.4	71.0	69.7	70.2	71.3	71.8	67.0	71.4	74.7	74.1
Operating Profit Margin	5.5%	9.9%	0.9%	3.1%	5.5%	6.2%	4.8%	7.6%	9.8%	12.8%
Days Cash on Hand > **75**	313.3	300.9	304.6	304.7	305.7	298.8	300.6	305.8	307.0	286.9
Debt Service Coverage > **1.25**	6.71	7.24	7.03	7.41	7.76	7.83	8.09	8.60	8.90	9.44
Capitalization < **.60**	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Liquidity > **2.0**	34.0	35.2	35.7	35.7	35.8	34.3	34.4	34.7	34.1	32.3

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
July 31,2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Assets						
Current assets:						
Cash and cash equivalents	$ 84,081	$ 102,501,960	$ 356,608	$ 499,852		$ 103,442,501
Assets whose use is limited-required for current liabilities		6,053,832				6,053,832
Accounts receivable, less allowance		29,119,093	1,242,774	964,366	-	31,326,233
Pledges receivable		49,776				49,776
Inventories of supplies		3,836,806				3,836,806
Prepaid expenses		1,678,614	46,106	16,551		1,741,271
Due from affiliates	145,096	392,597			$ (537,693)	-
Total current assets	229,177	143,632,678	1,645,488	1,480,769	(537,693)	146,450,419
Assets whose use is limited:						
Board designated and donor restricted		114,132,492				114,132,492
Held by trustee		28,378,990				28,378,990
Total assets whose use is limited	-	142,511,482	-	-	-	142,511,482
Less assets whose use is limited-required for current liabilities		6,053,832				6,053,832
	-	136,457,650	-	-	-	136,457,650
Other assets:						
Deferred financing costs		1,766,921				1,766,921
Other assets, less allowance	1,000	1,519,918	509,293	80,457	(16,845)	2,093,823
Total other assets	1,000	3,286,839	509,293	80,457	(16,845)	3,860,744
Property, plant and equipment						
Land and land improvements		4,862,121				4,862,121
Buildings and leasehold improvements		125,830,703	19,619	455,405		126,305,727
Equipment		96,403,124	372,755	127,894		96,903,773
Construction in progress		19,400,489				19,400,489
Accumulated depreciation		(152,582,935)	(236,617)	(117,126)		(152,936,678)
	-	93,913,502	155,757	466,173	-	94,535,432
	$ 230,177	$ 377,290,669	$ 2,310,538	$ 2,027,399	$ (554,538)	$ 381,304,245

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	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Liabilities and Net Assets						
Current liabilities						
Accounts payable-trade		$ 8,480,999	$ 233,490	$ 487,121	-	$ 9,201,610
Salaries and wages, payroll taxes and taxes withheld from payroll		6,433,558	408,405	354,244	-	7,196,207
Due to affiliates	$ 121,527		(58,407)	474,573	$ (537,693)	-
Other accrued liabilities		6,641,322	2,173	190,408		6,833,903
Employee related obligations		2,962,820				2,962,820
Due to third parties		4,040,032		293,390		4,333,422
Current portion of long-term debt		2,092,342				2,092,342
Total current liabilities	121,527	30,651,073	585,661	1,799,736	(537,693)	32,620,304
Other Liabilities:						
Long-term debt, less current portion		65,365,670				65,365,670
Employee related obligations		65,906,439				65,906,439
Self-insured professional liability		7,000,490	1,787,984			8,788,474
Due to third parties		19,331,656				19,331,656
Other		600,814			-	600,814
	-	158,205,069	1,787,984	-	-	159,993,053
Net Assets:						
Common stock				1,000	(1,000)	-
Unrestricted net assets	108,650	178,207,297	(63,107)	226,663	(15,845)	178,463,658
Temporarily restricted net assets		2,557,409				2,557,409
Permanently restricted net assets		7,669,821				7,669,821
	108,650	188,434,527	(63,107)	227,663	(16,845)	188,690,888
	$ 230,177	$ 377,290,669	$ 2,310,538	$ 2,027,399	$ (554,538)	$ 381,304,245

*includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Statement of Operations and Change in Net Assets
July 31, 2012

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	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Revenues:						
Net patient service revenue		$ 228,719,505	$ 5,646,573	$ 6,707,095	$ (4,995)	$ 241,068,178
Provision for bad debt		(9,471,130)	(539,927)	(91,757)		(10,102,814)
Other operating revenue	$ 46,600	4,965,072	112,170	8,247	(552,353)	4,579,736
Net assets released from restrictions		150,086			-	150,086
	46,600	224,363,533	5,218,816	6,623,585	(557,348)	235,695,186
Expenses:						
Salaries and wages	121,527	94,036,472	4,615,831	3,846,992		102,620,822
Payroll taxes and fringe benefits		26,751,310	950,048	1,484,434		29,185,792
Supplies and expenses		71,527,325	421,010	1,907,313	(557,348)	73,298,300
Depreciation and amortization		14,253,545	30,269	30,293		14,314,107
Interest		2,708,250			-	2,708,250
	121,527	209,276,902	6,017,158	7,269,032	(557,348)	222,127,271
Operating income (loss)	(74,927)	15,086,631	(798,342)	(645,447)	-	13,567,915
Nonoperating gains and (losses)						
Contributions and donations		130,766			-	130,766
Investment income	95	9,426,235	1,149,629	33,763	-	10,609,722
Other		125,693		19,607		145,300
Excess (deficiency) of revenue over expenses	(74,832)	24,769,325	351,287	(592,077)	-	24,453,703

Backus Corporation and Subsidiaries
Consolidating Statement of Operations and Change in Net Assets
July 31, 2012

000439

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Unrestricted net assets:						
Excess of revenue over expenses	(74,832)	24,769,325	351,287	(592,077)	-	24,453,703
Assets released from restriction-pp&e		96,014				96,014
Intercompany transfer		(3,471)	3,471			-
Increase (decrease) in unrestricted net assets	(74,832)	24,861,868	354,758	(592,077)	-	24,549,717
Temporarily restricted net assets:						
Contributions		409,214				409,214
Income from investments		994,748				994,748
Net assets released from restrictions		(246,100)				(246,100)
Increase (decrease) in temp restricted net assets		1,157,862	-	-	-	1,157,862
Permanently restricted net assets						
Change in net assets held in trust		220,695				220,695
Increase (decrease) in perm restricted net assets	-	220,695	-	-	-	220,695
Increase (decrease) in net assets	(74,832)	26,240,425	354,758	(592,077)	-	25,928,274
Net assets (deficit) at beginning of year	183,482	162,194,102	(417,865)	819,740	(16,845)	162,762,614
Net assets (deficit) at end of year	$ 108,650	$ 188,434,527	$ (63,107)	$ 227,663	$ (16,845)	$ 188,690,888

Backus Health Care and Subsidiaries
Consolidating Balance Sheet
July 31,2012

	Backus Health Care Unconsolidated	ConnCare	Backus Physician Services LLC	Eliminations	Combined Backus Health Care
Assets					
Current assets:					
Cash and cash equivalents	$ 11,472	$ 127,224	$ 217,912		$ 356,608
Accounts receivable, less allowance		429,002	813,772		1,242,774
Prepaid expenses		870	45,236		46,106
Due from affiliates	129,276	4,399,857		$ (4,529,133)	-
Total current assets	140,748	4,956,953	1,076,920	(4,529,133)	1,645,488
Other assets:					
Covenant not to compete		31,000			31,000
Net investment in Davita-Norwich		-			-
Net investment in Davita-New London		478,293			478,293
Total other assets		509,293			509,293
Property, plant and equipment					
Buildings and leasehold improvements		19,619			19,619
Equipment		307,636	65,119		372,755
Accumulated depreciation		(192,837)	(43,780)		(236,617)
		134,418	21,339		155,757
	140,748	5,600,664	1,098,259	(4,529,133)	2,310,538
Liabilities and Net Assets					
Current liabilities					
Accounts payable-trade		144,632	88,858		233,490
Salaries and wages, payroll taxes and taxes withheld from payroll		273,684	134,721		408,405
Due to affiliates	142,280	(71,411)	4,399,857	(4,529,133)	(58,407)
Other accrued liabilities		1,080,984	709,173		1,790,157
Total current liabilities	142,280	1,427,889	5,332,609	(4,529,133)	2,373,645
Net Assets:					
Fund Balance	(1,532)	4,172,775	(4,234,350)		(63,107)
Total Liabilities and Capital	$ 140,748	$ 5,600,664	$ 1,098,259	$ (4,529,133)	$ 2,310,538

Backus Health Care and Subsidiaries
Consolidating Income Statement
July 31,2012

	Backus Health Care Unconsolidated	ConnCare	Backus Physician Services LLC	Eliminations	Combined Backus Health Care
Revenues:					
Net patient service revenue		$ 2,832,561	$ 2,814,012		$ 5,646,573
Provision for bad debt		(188,844)	(351,083)		(539,927)
Other operating revenue	$ 30,780	93,137	19,033	$ (30,780)	112,170
Total Revenues	30,780	2,736,854	2,481,962	(30,780)	5,218,816
Expenses:					
Salaries and wages		2,315,814	2,300,017		4,615,831
Payroll taxes and fringe benefits		523,826	426,222		950,048
Supplies and expenses	33,355	1,043,902	(625,467)	(30,780)	421,010
Depreciation and amortization		24,431	5,838		30,269
	33,355	3,907,973	2,106,610	(30,780)	6,017,158
Net income	(2,575)	(1,171,119)	375,352	-	(798,342)
Nonoperating gains (losses):					
Investment income	3	1,149,545	81		1,149,629
Deficiency of revenue over expenses	(2,572)	(21,574)	375,433	-	351,287
Fund Balance (deficit) at beginning of year	1,040	4,194,349	(4,613,254)		(417,865)
Intercompany transfer			3,471		3,471
Fund Balance (deficit) at end of year	$ (1,532)	$ 4,172,775	$ (4,234,350)	$ -	$ (63,107)

WWB Corporation
Consolidating Balance Sheet
July 31, 2012

	WWB Corp.	BHHC	Eliminations	Consolidated
Assets				
Current Assets:				
Cash and cash equivalents	$415,741	$84,111		$499,852
Net Accounts Receivable		964,366		964,366
Due from affiliates	1,181,198		$ (1,181,198)	-
Prepaid Expenses		16,551		16,551
Total Current Assets	1,596,939	1,065,028	(1,181,198)	1,480,769
Property, Plant, & Equipment		466,173		466,173
Other assets	80,457	-		80,457
Total Investments	80,457	-	-	80,457
Total Assets	1,677,396	1,531,201	(1,181,198)	2,027,399
Liabilities and Stockholder's Equity				
Current Liabilities:				
Accounts Payable & Accrued Expenses		487,121		487,121
Due to affiliates	474,573	1,181,198	(1,181,198)	474,573
Due to third parties		293,390		293,390
Other Accrued Expenses		190,408		190,408
Accrued Payroll & Related Taxes		354,244		354,244
Total Current Liabilities	474,573	2,506,361	(1,181,198)	1,799,736
Stockholder's Equity:				
Common Stock issued and outstanding	1,000			1,000
Retained Earnings/Equity	1,201,823	(975,160)		226,663
	1,202,823	(975,160)	-	227,663
Total Liabilities and Stockholder's Equity	$1,677,396	$1,531,201	($1,181,198)	$2,027,399

WWB Corporation
Consolidating Income Statement
July 31,2012

	WWB Corp.	BHHC	Eliminations	Consolidated
Operating revenue:				
Net patient service revenue		$6,707,095		$6,707,095
Provision for bad debt		($91,757)		($91,757)
Other operating revenue		8,247		8,247
Total operating revenue	-	6,623,585	-	6,623,585
Operating expenses:				
Salaries and wages		3,846,992		3,846,992
Payroll taxes and fringe benefits		1,484,434		1,484,434
Supplies and other	$ 46,218	1,861,095		1,907,313
Depreciation		30,293		30,293
Total operating expenses	46,218	7,222,814	-	7,269,032
Operating (loss) income	(46,218)	(599,229)		(645,447)
Nonoperating gains				
Investment income	33,713	50		33,763
Other	19,607			19,607
Net Income (Loss)	7,102	(599,179)	-	(592,077)
Retained Earnings beginning of the period	1,194,721	(375,981)		818,740
Retained Earnings end of Period	$1,201,823	($975,160)		$226,663

BACKUS MEDICAL CONDOMINIUM ASSOCIATION
BALANCE SHEET
JUN 2012

	CURRENT YTD	PRIOR FISCAL YEAR END
ASSETS		
CASH	0	0
TENANT AR	22,105	15,610
DUE FROM WWBH	380,272	0
TOTAL ASSETS	402,377	15,610
LIABILITIES AND FUND BALANCE		
LIABILITIES		
MM/AP GROSS ACCRUAL	0	477
DUE TO WWBH	323,818	(2,937)
TOTAL LIABILITIES	323,818	(2,460)
FUND BALANCE	78,559	18,069
TOTAL LIABILITIES AND FUND BALANCE	402,377	15,610

BACKUS MEDICAL CONDOMINIUM ASSOCIATION
OPERATING STATEMENT
JUN 2012

	CURRENT YTD	PRIOR FISCAL YEAR END
CAM REVENUE	386,768	440,909
ALLOCATED EXPENSES		
REPAIRS & MAINT	63,485	120,701
UTILS-ELECTRICITY	186,787	260,311
UTILS-WATER/SEWER	23,131	33,583
UTILS-CABLE EXP	449	784
MAINTENANCE CONTRACTS	2,479	3,690
OFFICE SUPPLIES	166	418
OTHER SUPPLIES	146	0
LEGAL SERVICES	495	32
AUDITING FEES	1,061	464
PURCHASED SERVICE EXP	5,740	1,080
PROPERTY TAXES	42,290	83,367
SIGNAGE	0	5,455
WWBH SERVICES	50	(68,976)
TOTAL ALLOCATED EXPENSES	326,278	440,909
OTHER INCOME	0	0
NET INCOME(LOSS)	60,490	1

17.4.2 Backus Financial Statement Disclosures

None.

17.4.3 Backus Accounting Disclosures

None.

17.4.4 Backus Liabilities

None.

17.4.5 Backus Donor-Restricted Funds

See attached.

Removed Donor names.

Donor restricted Funds

Temporarily Restricted Funds

Balance @ 7/31/12	Restricted purpose
13,613	health care services
(1,699)	laboratory
124,821	extraordinary nursing care
6,252	trauma
222,562	preventative care
65,209	laboratory
19,867	general use
88,735	nursing education
52,463	free bed
23,991	free bed
71,866	equipment or cap construction
2,624	cardiology
23,145	general use
701,838	general use
125,899	general use
990,958	various uses
15,600	nursing education
9,665	free bed
2,557,409	

Permanently Restricted Funds

29,153	general use
100,000	general use
231,389	general use
174,218	laboratory
25,000	extraordinary nursing care
993,711	general use
5,000	general use
1,703,879	general use
300,000	free bed
83,964	laboratory
100,000	general use
34,374	general use
10,140	nursing education
47,500	general use
227,060	free bed
100,000	general use
1,148,248	general use
50,000	general use
10,020	general use
1,128,826	general use
238,154	general use
905,982	general use
23,203	extraordinary nursing care
7,669,821	

Removed Trustee names and Account numbers.

17.4.6 Backus Pension Funds

The William W. Backus Hospital

Plan Type	Trustee	Account Number
Defined Benefit Plan		
403B		
457[1]		

CONNCare, Inc, Backus Home Health Care, Backus Physician Services, LLC

Plan Type	Trustee	Account Number
401K Plan		

[1] Note, these are voluntarily segregated funds for this non-qualified plan. There is no requirement to fund this plan.

17.5 Backus Interim Changes

17.5.3: The Backus Entities may record acquisitions or dispositions of assets to or from other Backus Entities, including the acquisition of certain assets of CONNCare, Inc. and Backus Physician Services, LLC by Community Medical Partners, Inc.

17.6 Backus Legal Proceedings

A lawsuit pending in Connecticut Superior Court (#KNL-cv-10-600425-S) as described in the letter to R. Edwards of Ernst & Young dated October 25, 2010.

17.7.1 Backus Licenses and Permits

The following Backus Entities hold licenses, permits, certificates, consents, or approvals as listed below:

The William W. Backus Hospital	
Name	Issuing Body
Hospital License	State of Connecticut Department of Public Health (DPH)
Pharmacy – State Controlled Substance Registration CSP.0003826	State of Connecticut Dept of Consumer Protection
Pharmacy – DEA Number AT155642	US Drug Enforcement Administration
Plainfield Emergency Department - Controlled Substance Registration CSP.0038215	State of Connecticut Dept of Consumer Protection
Plainfield Emergency Department – DEA Number FS3199646	US Drug Enforcement Administration
Mary Allen Ross Child Care Center License	State of Connecticut Department of Public Health
Mary Allen Ross Child Care Center Food Service License	Uncas Health District
Diagnostic and Therapeutic X-ray Device Registration	Connecticut Department of Energy and Environmental Protection, Bureau of Air Management Radiation Division
Radioactive Material and Industrial X-ray Device Registration	Connecticut Department of Energy and Environmental Protection, Bureau of Air Management Radiation Division
NRC	United States Nuclear Regulatory Commission
MQSA – Mammography Quality Standards Act	United States Food & Drug Administration
Clinical Laboratory Improvement Amendments (CLIA) License- Main Lab	Centers for Medicare & Medicaid Services (CMS)
CLIA License- Nursing	CMS
CLIA License- STD Clinic	CMS
CT Lab License- Main Lab	State of Connecticut DPH
CT Lab License- Blood Bank	State of Connecticut DPH
CT Lab License- STD	State of Connecticut DPH
Industrial Alcohol User Permit	Department of the Treasury, Bureau of Alcohol, Tobacco, and Firearms

17.7.1 Backus Licenses and Permits

The William W. Backus Hospital	
Name	Issuing Body
Blood Collection Facility Certification-MOB	State CT DPH
Blood Collection Facility Certification-Colchester	State CT DPH
Blood Collection Facility Certification-BOCC	State CT DPH
Blood Collection Facility Certification-Montville	State CT DPH
Blood Collection Facility Certification-Jewett City	State CT DPH
Blood Collection Facility Certification-Plainfield	State CT DPH
Air Management General Permit to Limit the Potential to Emit	State of Connecticut (CT) Department of Energy and Environmental Protection (DEEP)
Flood Plain Parking Permit	CT DEEP
Photographic Wastewater Discharge Permit	CT DEEP
Permit for Discharge of Minor Boiler Blowdown Wastewater	CT DEEP
Food Preparation Wastewater	CT DEEP
Vehicle Maintenance Wastewater Registration	CT DEEP
General Permit for Miscellaneous Discharges of Sewer Compatible (MISC) Wastewater and Domestic Sewerage Registration	CT DEEP
Underground Oil Tank Registrations UST I.D. Numbers, A1R1, B2R2, B3R1, C3	CT DEEP
8/8/88 Oil Spill Monitoring	CT DEEP
Certificate #3 Boiler	CT Dept. of Public Safety
Certificate #2 Boiler	CT Dept. Public Safety
Certificate #1 Boiler	CT Dept. Public Safety
Lo Pres. Water heater certificate #082262	CT Dept. Public Safety
Low Pres. Water Heater certificate #082295	CT Dept. Public Safety
Low Pres. Water Heater cert. # 08299	CT Dept. Public Safety
Low Pres. Water heater cert. #098399	CT Dept. Public Safety
Low pres. Cast iron boiler #033250 315 Wash. St.	CT Dept. Public Safety
Lo Pres. Cast Iron boiler #045668	CT Dept. Public Safety
Lo Pres. Cast Iron Boiler #045666	Ct Dept. Public Safety

17.7.1 Backus Licenses and Permits

The William W. Backus Hospital	
Name	Issuing Body
Lo Pres. Cast iron boiler	CT Dept. Public Safety
Lo Pres. CI Boiler	CT Dept. Public Safety
Lo Pres Firetube Boiler #045673	CT Dept. Public Safety
Lo Pres Firetube Boiler#080613	CT Dept. Public Safety
Lo pres. Cast iron boiler #045672	CT Dept. Public Safety
Lo pres. Cast Iron boiler #045671	CT Dept. Public Safety
Elevator 104-0247	CT Bureau of Elevators
Elevator 104-0246	CT Bureau of Elevators
Elev. 104-0278	CT Bureau of Elev.
Dumbwaiter 104-0202	CT Bureau of Elev.
Dumbwaiter 104-0118	CT Bureau of Elev.
Elev. 104-0228	CT Bureau of Elev.
Elev. 104-0227	CT Bureau of Elev.
Elev. 104-0193	CT Bureau of Elev.
Elev. 104-0123	CT Bureau of Elev.
Class 4 Food Service License	Uncas Health District (local health department)
Special Permit Authorization DOT-SP 13556	State of Connecticut Department of Transportation
State of Connecticut Department of Energy and Environmental Protection Hazardous Waste Transport Permit (Veolia)	State of CT/Veolia for chemo waste
Airport License	State of Connecticut Department of Transportation
WMTS Coordination Certificate (Cardiac Rehab certificate)	The American Society for Healthcare Engineering of the American Hospital Association, WMTS Frequency Coordinator
WMTS Coordination Certificate (facility-wide telemetry)	The American Society for Healthcare Engineering of the American Hospital Association, WMTS Frequency Coordinator
WMTS Coordination Certificate (portable monitoring)	The American Society for Healthcare Engineering of the American Hospital Association, WMTS Frequency Coordinator

Backus Home Health Care	
Name	**Issuing Body**
Home Health Care Agency License	State of CT Department of Public Health
Clinical Laboratory Improvements Amendment Certificate of Waiver	State of CT Department of Public Health

CONNCare, Inc.	
Name	**Issuing Body**
Colchester Outpatient Clinic License	State of Connecticut (CT) Department of Public Health (DPH)
Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver – Colchester Outpatient Clinic	Centers for Medicare & Medicaid Services (CMS)
Foxwoods Industrial Health Facility License	State of Connecticut Department of Public Health
Ledyard Outpatient Clinic License	State of CT DPH
CLIA Certificate of Waiver – Ledyard Outpatient Clinic	CMS
Montville Outpatient Clinic License	State of CT DPH
CLIA Certificate of Waiver – Montville Outpatient Clinic	CMS
Plainfield Outpatient Clinic License	State of CT DPH
CLIA Certificate of Waiver – Plainfield Outpatient Clinic	CMS

Removed one description of a compliance issue.

17.9 Backus Compliance with Law

17.10 Backus Real Property

The William W. Backus Hospital - Owned Real Property

Section 17.10.1 Address	Section 17.10.1 Legal Description (attached)	Section 17.10.1 Property ID	Section 17.10.1 Encumbrances/ Liens	Section 17.10.1 Leases	Section 17.10.1 (c) Easements, etc.	Section 17.10.1 (e) Tax Exempt	Section 17.10.1 (j) Encroachments
326 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule A	n/a	17.10.1 Attachment Schedule A		17.10.1 Attachment Schedule A	Exempt	
330 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule B	2010010012509	17.10.1 Attachment Schedule B	17.10.1 Attachment Schedule B	17.10.1 Attachment Schedule B	Flr 1 Exempt Flrs 2-5 Not Exempt	
303 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule C	2010010012517	17.10.1 Attachment Schedule C	17.10.1 Attachment Schedule C		Not Exempt	
304 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule D	n/a	17.10.1 Attachment Schedule D		17.10.1 Attachment Schedule D	Exempt	17.10.1 Attachmen Schedule D
305 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule e	2010010012520	17.10.1 Attachment Schedule e			Not Exempt	
315 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule F	2010010012512	17.10.1 Attachment Schedule F	17.10.1 Attachment Schedule F	17.10.1 Attachment Schedule F	Not Exempt	
321 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule G	2010010012513	17.10.1 Attachment Schedule G	17.10.1 Attachment Schedule G	17.10.1 Attachment Schedule G	Not Exempt	
323 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule H	2010010012511	17.10.1 Attachment Schedule H	17.10.1 Attachment Schedule H	17.10.1 Attachment Schedule H	Not Exempt	
99 Lafayette Street Norwich, CT 06360	17.10.1 Attachment Schedule I	2010010012514	17.10.1 Attachment Schedule I			Not Exempt	
107 Lafayette Street Norwich, CT 06360	17.10.1 Attachment Schedule J	n/a	17.10.1 Attachment Schedule J		17.10.1 Attachment Schedule J	Exempt	
121 Lafayette Street Norwich, CT 06360	17.10.1 Attachment Schedule K	n/a	17.10.1 Attachment Schedule K	17.10.1 Attachment Schedule K	17.10.1 Attachment Schedule K	Exempt	
1-4 Matlack Drive Norwich, CT 06360	17.10.1 Attachment Schedules L & M	2010010012518	17.10.1 Attachment Schedules L & M			Lot 1 Not Exempt Lot 4 Exempt	
12 Case Street, Suite 101 Norwich, CT 06360	17.10.1 Attachment Schedule N		17.10.1 Attachment Schedule N		17.10.1 Attachment Schedule N	Exempt	
12 Case Street, Suite 313 Norwich, CT 06360	17.10.1 Attachment Schedule N	2010010012515	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	Not Exempt	
12 Case Street, Suites 314/315 Norwich, CT 06360	17.10.1 Attachment Schedule N	2010010012515	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	Not Exempt	
12 Case Street, Suite 303 Norwich, CT 06360	17.10.1 Attachment Schedule N	2010010012519	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	Not Exempt	
11 & 11A Stott Avenue Norwich, CT 06360	17.10.1 Attachment Schedules P & Q	2010010012508	17.10.1 Attachment Schedules P & Q		17.10.1 Attachment Schedules P & Q	Exempt	
11 Murphy Road Franklin, CT 06254	17.10.1 Attachment Schedule R	2010010000068	17.10.1 Attachment Schedule R		17.10.1 Attachment Schedule R	Exempt	
120-122 Plainfield Road Moosup, CT 06354	17.10.1 Attachment Schedule S	2010010005874	17.10.1 Attachment Schedule S	17.10.1 Attachment Schedule S	17.10.1 Attachment Schedule S	Exempt	

17.10 Backus Real Property

The William W. Backus Hospital
Leased Real Property

Section 17.10.1 **Leased Property Address**	Section 17.10.1 (i) **Septic**	Section 17.10.1 **Lessee**
Owner: John Grillo 112 Lafayette Street Norwich, CT 06360		Pain & Palliative Care CONNCare Billing BPS Billing
Owner: J. Leland Lichtenstein, DDS 105 Lafayette Street Norwich, CT 06360		n/a
Owner: Plaza Enterprises 113 Salem Turnpike Norwich, CT 06360		Advanced Dermatology
Owner: PC 80 LLC 80 Norwich New London Tpke Uncasville, CT 06382		CONNCare, Inc.
Owner: UCFS 76 Main Street Jewett City, CT 06351		n/a
Owner: BRG Interests 123 Broadway Colchester, CT 06415		Pulmonary Physicians
Owner: Paradise Agency 163 Broadway Colchester, CT 06415		CONNCare, Inc.
Owner: Mark Rachwal 743 Colonel Ledyard Highway Ledyard, CT 06339	Served by Septic	CONNCare, Inc.
Owner: OR&L Construction 582 Norwich Road Plainfield, CT 06374		n/a

Backus Home Health Care

000460

17.10 Backus Real Property

Owned Real Property

Section 17.10.1 **Address**	Section 17.10.1 **Legal Description (attached)**	Section 17.10.1 **Property ID**	Section 17.10.1 **Encumbrances/ Liens**	Section 17.10.1 c **Easements, etc.**	Section 17.10.1 (e) **Tax Exempt**
12 Case Street, Suites 316/317 Norwich, CT 06360	17.10.1 Attachment Schedule O	2010010008818 2010020041198	17.10.1 Attachment Schedule O	17.10.1 Attachment Schedule O	Not Exempt

Backus Home Health Care
Leased Real Property

Leased Property Address
Owner: Norwich Orthopedic Group 82 New Park Avenue Franklin, CT 06254

Backus Physician Services, LLC
Leased Real Property

Section 17.10.1 **Leased Property Address**	Section 17.10.1 **Lessee**
Owner: John Grillo 112 Lafayette Street Norwich	Pain & Palliative Care CONNCare Billing BPS Billing
Owner: WWBH 330 Washington Street Norwich	n/a

17.10 Backus Real Property

CONNCare, Inc.
Leased Real Property

Section 17.10.1	Section 17.10 (i)
Leased Property Address	**Septic**
Owner: John Grillo 112 Lafayette Street Norwich	
Owner: PC 80 LLC 80 Norwich New London Tpke Uncasville	
Owner: Paradise Agency 163 Broadway Colchester	
Owner: Mark Rachwal 743 Colonel Ledyard Highway Ledyard	Served by Septic

The 17.10.1 Attachment file contains the Tax Code Citation, a Note regarding Encroachments, Disclosure of Right of First Refusal, and Disclosure of Option Agreement.

000492

17.10.1 Attachment

SCHEDULE A TO SCHEDULE 17.10

Entity	**Address**
William W. Backus Hospital	326 Washington Street, Norwich

Exceptions: See Schedule A-1 attached.

Description: See Schedule A-2

See also 330 Washington Street

SCHEDULE A-1

. Taxes to the City of Norwich on the Grand List of October 1, 2004 not yet due and payable.

:. Water and sewer use charges to the City of Norwich, payments of which are current.

). Riparian rights of others in and to the waters of the Yantic River, and any watercourses abutting or flowing through the premises.

). Terms and provisions set forth in an Indenture by an between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records; as affected by an Indenture by and among William C. Reynolds, Reginald Reynolds, Louise R. Greene, Albert L. Reynolds, John M. Reynolds, The William W. Backus Hospital, and Margaret V. Del Carlo dated January 16, 1915 and recorded in Volume 145 at Page 131 of the said Land Records.

;. Covenants and agreements set forth in a Warranty Deed from George W. Guard to Thomas M. Connor dated May 31, 1919 and recorded in Volume 156 at Page 37 of the Norwich Land Records.

). Rights in favor of the State of Connecticut as set forth in an Instrument dated March 30, 1940 and recorded in Volume 218 at Page 1 of the Norwich Land Records.

'. Building restrictions as more particularly set forth in a Warranty Deed from The William W. Backus Hospital to Norwich Medical Center, Incorporated dated September 4, 1959 and recorded in Volume 302 at Page 652 of the Norwich Land Records.

). Terms and conditions set forth in Lease from The William W. Backus Hospital to City of Norwich dated December 8, 1964, and recorded in Volume 330 at Page 806 of the Norwich Land Records.

9. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an Instrument dated February 11, 1969 and recorded in Volume 352 at Page 754 of the Norwich Land Records.

10. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an Instrument dated February 11, 1969 and recorded in Volume 352 at Page 756 of the Norwich Land Records.

11. Possible gas line and drainage easements as referenced in a Warranty Deed from Norwich Medical Center, Incorporated to The William W. Backus Hospital, Inc. dated June 12, 1969 and recorded in Volume 354 at Page 59 of the Norwich Land Records.

12. Sewer easements in favor of the City of Norwich as more particularly set forth in Certificates of Taking dated March 18, 1970 and April 9, 1970 and recorded in Volume 358 at Pages 12 and 218, respectively, of the Norwich Land Records.

13. Permanent easement and right of way in favor of the City of Norwich as more particularly set forth in a Quitclaim Deed dated January 9, 1974 and recorded in Volume 398 at Page 192 of the Norwich Land Records.

14. Maintenance obligations as set forth in a Grant of Easement from the City of Norwich to The William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

15. Maintenance obligations as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

16. Easements in favor of Norwich Medical Center, Incorporated as more particularly described in an Easement dated December 12, 1986 and recorded in Volume 753 at Page 81 of the Norwich Land Records.

17. Conditions and obligations as more particularly set forth in a Grant of Easement from Norwich Medical Center Condominium Association to The William W. Backus Hospital dated March 25, 1992 and recorded in Volume 1053 at Page 121 of the Norwich Land Records.

18. Right of way and easement in favor of Norwich Medical Center Condominium Association dated March 19, 1992 and recorded in Volume 1053 at Page 126 of the Norwich Land Records.

19. Denial of access rights to and from Routes 2 and 32 as more particularly set forth in a Quit-Claim Deed from the State of Connecticut to The William W. Backus Hospital, Inc. dated September 28, 1995 and recorded in Volume 1246 at Page 148 of the Norwich Land Records.

SCHEDULE A (LEGAL DESCRIPTION)

All that certain place or parcel of land, with the buildings and improvements thereon, being shown on a plan entitled "Plan Made for The William W. Backus Hospital Property at Lafayette Street & Washington Streets - Norwich, CT. Scale: 1" = 80' Chandler, Palmer & King Norwich, Connecticut January 8, 1988 Additions: November 6, 1985 Additions 6/7/91 Revised 7/31/92 Additions: Sept. 18, 1992", further revised to 9/31/97. Said premises are more particularly bounded and described as follows:

Beginning at a point at the intersection of the southwesterly line of Washington Street with the northwesterly line of Lafayette Street and running thence South 25° 43' 10" West, 64.67 feet along the said northwesterly line of Lafayette Street to a drill hole; thence South 28° 05' 22" West, 40.00 feet along said street line to a drill hole at land of the Norwich Medical Center, Inc.; thence North 88° 51' 29" West, 242.12 feet to a point; thence South 01° 08' 31" West, 39.20 feet to a point; thence North 87° 17' 04" West, 51.04 feet to a point; thence South 02° 45' 26" West, 36.21 feet to a point; thence North 88° 35' 23" West, 30.05 feet to a point; thence South 02° 45' 44" West, 155.55 feet to a spike; thence South 65° 32' 16" East, 123.00 feet to a spike in the pavement on the said northwesterly line of Lafayette Street, these last seven lines abutting southerly, easterly and northeasterly on said land now or formerly of the Norwich Medical Center, Inc.; thence South 51° 26' 53" West, 38.94 feet along said street line to an iron pipe; thence North 65° 17' 55" West, 102.78 feet to a drill hole; thence North 66° 57' 56" West, 64.07 feet along the face of a retaining wall to a point, these last two lines abutting southwesterly on land now or formerly of Santo J. Grillo; thence North 66° 05' 56" West, 83.15 feet to a point; thence North 81° 47' 49" West, 104.01 feet to a fence post, these last two lines abutting southwesterly on land of S. John Grillo; thence South 11° 52' 14" West, 171.96 feet along a fence to a fence post, abutting easterly on land now or formerly of S. John Grillo and on land of Robert L. Degler and D. Robert Pannone; thence North 82° 35' 07" West, 628.13 feet along a fence line to a fence post; thence South 44° 25' 50 seconds West, 90.13 feet along a fence to an iron pipe; thence South 19° 14' 16" West, 190.18 feet along a fence to a drill hole; thence South 02° 50' 00" West, 114.91 feet along a fence to an iron pipe; thence South 02° 37' 50" East, 84.94 feet along a fence to a fence post; thence South 31° 43' 27" West, 88.70 feet along a fence to a point; thence South 35° 28' 33" West, 202.41 feet to an iron pipe; thence continuing along the extension of the last course about 28 feet to the easterly shore line of the Yantic River, these last seven lines abutting southwesterly, southeasterly, easterly and southeasterly on land of the City of Norwich (Yantic Cemetery); thence running northerly and northeasterly along the shore line of the Yantic River about 1,600 feet to land now or formerly of the State of Connecticut; thence North 84° 05' 59" East, about 20 feet to an iron pin; thence continuing North 84° 05' 59" East, 106.50 feet to a point; thence North 00° 25' 41" East, 94.05 feet to a Connecticut Highway Department Monument; thence South 89° 33' 20" East, 500.00 feet to a Connecticut Highway Department Monument; thence South 85° 21' 11" East, 208.95 feet to a Connecticut Highway Department Monument; thence South 40° 22' 20" East, 71.56 feet to a monument on said southwesterly line of Washington Street, the last five lines abutting northerly, westerly, northerly and northeasterly on land now or formerly of the State of Connecticut; thence along said southwesterly line of Washington Street, South 24° 15' 50" East, 460.31 feet to the point of beginning.

Together with rights granted under a certain indenture by and between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records.

Together with the rights and easement as more particularly set forth in a Grant of Easement from the City of Norwich to the William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

Together with the rights and easements as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

Excepting therefrom the Backus Medical Center Condominium

All those certain condominium units, located in the Town of Norwich, County of New London and State of Connecticut, known as Units 210, 220, 230, 310, 320, 330, 340, 350, 410, 420, 430, 520, 530, and 540, of Backus Medical Center Condominium, together with their interest in the Common Elements appurtenant thereto, said Units and Common Elements being more specifically designated and described in the Declaration of Backus Medical Center Condominium, An Air Rights Condominium, dated February 1, 1999 and recorded in Volume 1416 at Page 271 of the Norwich Land Records.

Together with the rights, benefits, agreements, and easements as set forth in said Declaration, and the Bylaws, Exhibits and Schedules attached thereto, as may be amended and supplemented from time to time.

SCHEDULE B TO SCHEDULE 17.10

William W. Backus Hospital 330 Washington Street, Norwich

Exceptions:

Subject to an Open-End Mortgage and Security Agreement from The William W. Backus Hospital and Backus Foundation to The Connecticut National Bank as Master Trustee in the original aggregate amount of $16,000,000 dated September 1, 1992 and recorded in Volume 1078 Pate 241 of the Norwich Land Record, as supplemented by supplements number 1, 2, and 3 duly recorded in the Norwich Land Records, and as restated in Restated Master Trust Indenture, Open-End Mortgage and Security Agreement in the amount of $500,000,000 between The William W. Backus Hospital and US Bank, National Association, as Master Trustee, dated as of July 1, 2005 and recorded in Volume 2130 Page 43 of the Norwich Land Records and as supplemented by further Supplement No. 4 dated July 1, 2005 and recorded in the Norwich Land Records in Volume 2130 Page 121 and as further supplemented by Supplement No. 5 dated October 31, 2009 in Volume 2585 Page 183 of the Norwich Land Records.

See Schedule B-1 attached for additional exceptions to title.

Description: See Schedule B-2

Leases:

Eric Levine, DPM
John Giacchetto, MD, P. C.
Eastern CT Urology
Backus Physician Services
Chelsea Surgical Care, LLC
Pulmonary Physicians of Norwich
Norwich Sleep Center
Surgical Associates of Norwich, LLC
Anthony G. Alessi, MC
Eastern CT Neurosurgery

NOTE: 326 & 330 Washington Street comprise the William W. Backus Hospital main campus, and the legal description exceptions to title are inclusive of both properties.

. Taxes to the City of Norwich on the Grand List of October 1, 2004 not yet due and payable.

:. Water and sewer use charges to the City of Norwich, payments of which are current.

i. Riparian rights of others in and to the waters of the Yantic River, and any watercourses abutting or flowing through the premises.

l. Terms and provisions set forth in an Indenture by an between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records; as affected by an Indenture by and among William C. Reynolds, Reginald Reynolds, Louise R. Greene, Albert L. Reynolds, John M. Reynolds, The William W. Backus Hospital, and Margaret V. Del Carlo dated January 16, 1915 and recorded in Volume 145 at Page 131 of the said Land Records.

i. Covenants and agreements set forth in a Warranty Deed from George W. Guard to Thomas M. Connor dated May 31, 1919 and recorded in Volume 156 at Page 37 of the Norwich Land Records.

l. Rights in favor of the State of Connecticut as set forth in an instrument dated March 30, 1940 and recorded in Volume 218 at Page 1 of the Norwich Land Records.

'. Building restrictions as more particularly set forth in a Warranty Deed from The William W. Backus Hospital to Norwich Medical Center, Incorporated dated September 4, 1959 and recorded in Volume 302 at Page 652 of the Norwich Land Records.

l. Terms and conditions set forth in Lease from The William W. Backus Hospital to City of Norwich dated December 8, 1964, and recorded in Volume 330 at Page 806 of the Norwich Land Records.

9. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an instrument dated February 11, 1969 and recorded in Volume 352 at Page 754 of the Norwich Land Records.

10. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an instrument dated February 11, 1969 and recorded in Volume 352 at Page 756 of the Norwich Land Records.

11. Possible gas line and drainage easements as referenced in a Warranty Deed from Norwich Medical Center, Incorporated to The William W. Backus Hospital, Inc. dated June 12, 1969 and recorded in Volume 354 at Page 59 of the Norwich Land Records.

12. Sewer easements in favor of the City of Norwich as more particularly set forth in Certificates of Taking dated March 18, 1970 and April 9, 1970 and recorded in Volume 358 at Pages 12 and 218, respectively, of the Norwich Land Records.

13. Permanent easement and right of way in favor of the City of Norwich as more particularly set forth in a Quitclaim Deed dated January 9, 1974 and recorded in Volume 398 at Page 192 of the Norwich Land Records.

14. Maintenance obligations as set forth in a Grant of Easement from the City of Norwich to The William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

15. Maintenance obligations as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

16. Easements in favor of Norwich Medical Center, Incorporated as more particularly described in an Easement dated December 12, 1986 and recorded in Volume 753 at Page 81 of the Norwich Land Records.

17. Conditions and obligations as more particularly set forth in a Grant of Easement from Norwich Medical Center Condominium Association to The William W. Backus Hospital dated March 25, 1992 and recorded in Volume 1053 at Page 121 of the Norwich Land Records.

18. Right of way and easement in favor of Norwich Medical Center Condominium Association dated March 19, 1992 and recorded in Volume 1053 at Page 126 of the Norwich Land Records.

19. Denial of access rights to and from Routes 2 and 32 as more particularly set forth in a Quit-Claim Deed from the State of Connecticut to The William W. Backus Hospital, Inc. dated September 28, 1995 and recorded in Volume 1246 at Page 146 of the Norwich Land Records.

SCHEDULE B-2

All that certain piece or parcel of land, with the buildings and improvements thereon, being shown on a plan entitled "Plan Made for The William W. Backus Hospital Property at Lafayette Street & Washington Streets - Norwich, CT. Scale: 1" = 80' Chandler, Palmer & King Norwich, Connecticut January 8, 1988 Additions: November 8, 1988 Additions 8/7/91 Revised 7/31/92 Additions: Sept. 18, 1992", further revised to 9/31/97. Said premises are more particularly bounded and described as follows:

Beginning at a point at the intersection of the southwesterly line of Washington Street with the northwesterly line of Lafayette Street and running thence South 25° 43' 10" West, 64.67 feet along the said northwesterly line of Lafayette Street to a drill hole; thence South 26° 05' 22" West, 40.00 feet along said street line to a drill hole at land of the Norwich Medical Center, Inc.; thence North 88° 51' 29" West, 242.12 feet to a point; thence South 01° 08' 31" West, 39.20 feet to a point; thence North 87° 17' 04" West, 51.04 feet to a point; thence South 02° 45' 26" West, 36.21 feet to a point; thence North 88° 35' 23" West, 30.05 feet to a point; thence South 02° 45' 44" West, 155.65 feet to a spike; thence South 65° 32' 16" East, 123.00 feet to a spike in the pavement on the said northwesterly line of Lafayette Street, these last seven lines abutting southerly, easterly and northeasterly on said land now or formerly of the Norwich Medical Center, Inc.; thence South 51° 26' 53" West, 38.94 feet along said street line to an iron pipe; thence North 65° 17' 56" West, 102.78 feet to a drill hole; thence North 66° 57' 56" West, 64.07 feet along the face of a retaining wall to a point, these last two lines abutting southwesterly on land now or formerly of Santo J. Grillo; thence North 66° 05' 56" West, 83.15 feet to a point; thence North 81° 47' 49" West, 104.01 feet to a fence post, these last two lines abutting southwesterly on land of S. John Grillo; thence South 11° 52' 14" West, 171.96 feet along a fence to a fence post, abutting easterly on land now or formerly of S. John Grillo and on land of Robert L. Degler and D. Robert Pannone; thence North 82° 35' 07" West, 628.13 feet along a fence line to a fence post; thence South 44° 25' 50 seconds West, 90.13 feet along a fence to an iron pipe; thence South 19° 14' 15" West, 190.18 feet along a fence to a drill hole; thence South 02° 50' 00" West, 114.91 feet along a fence to an iron pipe; thence South 02° 37' 50" East, 84.94 feet along a fence to a fence post; thence South 31° 43' 27" West, 88.70 feet along a fence to a point; thence South 35° 28' 33" West, 202.41 feet to an iron pipe; thence continuing along the extension of the last course about 28 feet to the easterly shore line of the Yantic River, these last seven lines abutting southwesterly, southeasterly, easterly and southeasterly on land of the City of Norwich (Yantic Cemetery); thence running northerly and northeasterly along the shore line of the Yantic River about 1,600 feet to land now or formerly of the State of Connecticut; thence North 84° 05' 59" East, about 20 feet to an iron pin; thence continuing North 84° 05' 59" East, 106.50 feet to a point; thence North 00° 26' 41" East, 94.05 feet to a Connecticut Highway Department Monument; thence South 89° 33' 20" East, 500.00 feet to a Connecticut Highway Department Monument; thence South 85° 21' 11" East, 208.95 feet to a Connecticut Highway Department Monument; thence South 40° 22' 20" East, 71.56 feet to a monument on said southwesterly line of Washington Street, the last five lines abutting northerly, westerly, northerly and northeasterly on land now or formerly of the State of Connecticut; thence along said southwesterly line of Washington Street, South 24° 15' 50" East, 460.31 feet to the point of beginning.

Together with rights granted under a certain indenture by and between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records.

Together with the rights and easement as more particularly set forth in a Grant of Easement from the City of Norwich to the William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

Together with the rights and easements as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

Excepting therefrom the Backus Medical Center Condominium

All those certain condominium units, located in the Town of Norwich, County of New London and State of Connecticut, known as Units 210, 220, 230, 310, 320, 330, 340, 350, 410, 420, 430, 520, 530, and 540, of Backus Medical Center Condominium, together with their interest in the Common Elements appurtenant thereto, said Units and Common Elements being more specifically designated and described in the Declaration of Backus Medical Center Condominium, An Air Rights Condominium, dated February 1, 1999 and recorded in Volume 1416 at Page 271 of the Norwich Land Records.

Together with the rights, benefits, agreements, and easements as set forth in said Declaration, and the Bylaws, Exhibits and Schedules attached thereto, as may be amended and supplemented from time to time.

SCHEDULE C TO SCHEDULE 17.10

William W. Backus Hospital 303 Washington Street, Norwich

Exceptions: None

Description: See Schedule C-1

Leases:

Tanya Hubbard-Walston
Donald Cox

SCHEDULE C-1

A certain tract of parcel of land, together with the buildings and improvements thereon, situated on the easterly side of Washington Street in the Town of Norwich, County of New London and State of Connecticut, bounded and described as follows:

Beginning on the easterly line of said street at the northwesterly corner of land now or formerly of Patrick J. Morley and running southerly thereon 83.7 feet to a drill hole; thence deflecting 88° 8' to the left and running 203.3 feet; thence deflecting 93° 27' to the left and running 78.3 feet to land now or formerly of C. Morgan Williams; thence westerly 201 feet to the place of beginning; said tract is bounded southerly and easterly by land now or formerly of Patrick Morley, northerly by land now or formerly of C. Morgan Williams and westerly by said Washington Street.

Being the same premises conveyed to this Grantor by deed 1/30/98 and recorded in Volume 1355, Page 251 of teh Norwich Land Records..

The Grantee herein hereby agrees and assumes to pay any and all taxes hereinafter falling due.

SCHEDULE D TO SCHEDULE 17.10

William W. Backus Hospital 304 Washington Street, Norwich

Exceptions:

a. Subject to a restriction as to limitations of construction on the premises recorded in Volume 575 Page 33 of the Norwich Land Records. The William W. Backus Hospital has an owner's policy of title insurance affirmatively insuring the William W. Backus Hospital against loss by reason of enforcement or attempted enforcement of said restriction.

b. Subject to a possible encroachment of the driveway onto the adjoining premises.

Description: See Schedule D-1

Leases:

SCHEDULE D-1

A certain tract of land, together with the buildings and improvements thereon, situated in the City of Norwich, County of New London and State of Connecticut, and bounded and described as follows:

Beginning at a point on the westerly side of Washington Street at the northeast corner of land now of Selma Swatsburg, formerly of C. Morgan Williams and the southeast corner of the premises herein conveyed, and running thence northerly along Washington Street, 65 feet; thence westerly at an angle of 90 degrees, 161.4 feet to land now of Alfred P. Savage, formerly of Frederica A. Roos; thence southerly along the land of said Alfred P. Savage, 65.9 feet to the land of said Selma Swatsburg; thence easterly at an angle of 99° 54' along the land of said Selma Swatsburg, 150 feet, more or less, to the point of beginning.

Said lot being known as Lot #10 as shown on a plan of land now or formerly of Fannie L. Bliss and Edith M. Bliss, recorded in Norwich City Clerk's Office.

The premises are subject to the following restrictions: That no building or any part of a building shall be erected on said premises to project easterly of a line sixty-three feet and ten inches, measured from the face of the curb, except that same may be built beyond said line a one-story open piazza, the floor of which shall not exceed eight feet in width and which piazza shall be without lattice work or other obstruction except a railing, not to exceed three feet in height; that there shall be no stables of any description, including chicken coops, erected on any part of the premises; and that said premises shall be used solely for residential purposes.

SCHEDULE E TO SCHEDULE 17.10

William W. Backus Hospital 305 Washington Street, Norwich

Exceptions: None

Description: See Schedule E-1

SCHEDULE E-1

A certain tract of land, with the buildings and improvements thereon, situated in the Town of Norwich, County of New London and State of Connecticut, on the easterly side of Washington Street, known as 305 Washington Street, and bounded and described as follows:

Beginning at a point on the easterly side of Washington Street at the northwesterly corner of the herein conveyed premises and running easterly in a straight line about 274 feet to land now or formerly of Frank A. Sisk abutting northerly on land now or formerly of Arthur C. Brown; said line passes through a point 16.9 feet southerly from the southwesterly corner and in range with the westerly side of the house known as 305 1/2 Washington Street and also passes through a point 16.1 feet northerly from the northeasterly corner and in range with the easterly side of the house on the conveyed premises; thence southerly about 96 feet to land now or formerly of H.P. and L.O. Hull, bounded easterly on land of said Sisk and land now or formerly of Herbert M. Hichon; thence westerly about 249 feet to the easterly line of Washington Street, bounding southerly on land of said Hull and land now or formerly of Johanna J. Wright; thence northerly along the easterly side of Washington Street 84.8 feet to the point of beginning.

SCHEDULE F TO SCHEDULE 17.10

William W. Backus Hospital — 315 Washington Street, Norwich

Exceptions: None

Description: See Schedule F-1

Leases: Debbie McClimon
Joan Munroe

SCHEDULE F-1

All that tract of land with the buildings thereon situated in the Town of Norwich, bounded and described as follows:

Beginning on the southeasterly corner of Washington and Julian Streets and running thence easterly 90 feet by the southerly line of Julian Street; thence southerly at right angles therewith 76 feet to land late of Henry T. Gorman; thence westerly by said Gorman land 73 feet to Washington Street and thence northerly by Washington Street 75 feet to the point of beginning, including the right of way over Julian Street.

Being the same premises conveyed to The William W. Backus Hospital, Inc. by Warranty Deed of George W. Davis from Mildred B. Davis, as recorded in the Norwich Land Records.

SCHEDULE G TO SCHEDULE 17.10

William W. Backus Hospital 321 Washington Street, Norwich

Exceptions: None

Description: See Schedule G-1

Leases: Eugene and Nancy Perez

SCHEDULE G-1

A tract of land, with the buildings thereon, situated on the easterly side of Washington Street in the city of Norwich, New London County, Connecticut, known as No. 321 Washington Street, described as follows:

Beginning on the easterly line of Washington Street at the northwesterly corner of land now or formerly of Pasquale and Grazia Girasoli, and running thence northerly by the easterly line of Washington Street 73 feet to land now or formerly of Doris E. Boyer; thence easterly by said Boyer land 103 feet to land of the William W. Backus Hospital; thence southerly about 72 feet by said Hospital land to said Girasoli land; and thence westerly 77.5 feet by said Girasoli land to the point of beginning.

SCHEDULE H TO SCHEDULE 17.10

William W. Backus Hospital	323 Washington Street, Norwich

Exceptions:

Description: See Schedule H-1

Leases: Andy Trogden

SCHEDULE H-1

All that certain tract or parcel of land, together with the buildings and improvements thereon, situated in the Town of Norwich, County of New London and State of Connecticut, bounded and described as follows:

Beginning at the intersection of the Easterly line of North Washington Street with the Southerly line of Bliss Place, and running thence Easterly by the Southerly line of Bliss Place 110 feet, more or less, to the center of a brook; thence Southerly by the center line of said brook 65 feet; thence Westerly by land of Robert and Adelaide Cochran to the Easterly line of North Washington Street at a point on said line 65 feet Southerly from the Southerly line of said Bliss Place; thence Northerly by the easterly line of North Washington Street 65 feet to the point of beginning.

Excepting therefrom a certain parcel of land conveyed to the State of Connecticut by a Quit-Claim deed of Arthur E. Boyer and Doris E. Boyer dated June 17, 1957 and recorded in Volume 290, Page 421 of the Norwich Land Records.

SCHEDULE I TO SCHEDULE 17.10

William W. Backus Hospital 99 Lafayette Street, Norwich

Exceptions: None

Description: See Schedule I-1

SCHEDULE J-1

Beginning at the westerly corner of land of Letitia E. Waters on the southeasterly side of said Street, and running thence southwesterly by Lafayette Street 90.8 feet to an iron pin at land of Walter and Margarete Adams; thence southeasterly by said Adams land a total distance of 128 feet to an iron pin at land of The Hareth Corporation; thence northeasterly 60 feet by said Hareth land to said Waters land; and thence northwesterly about 168 feet by said Waters land to the point of beginning.

$675 CONNECTICUT TAX RECEIVED
$148.50 CONVEYANCE TAX RECEIVED
BEVERLY C. MULDOON, TOWN CLERK OF NORWICH

Subject to taxes due on the grand list of October 1, 1999 and thereafter.

Subject to also to any and all provisions of any ordinance, municipal regulation or public or private law, including but not limited to building, building line and zoning restrictions established by the Town of Norwich.

Reference is made to a quit claim deed from John J. Caulfield and Jane M. Caulfield to Jane Caulfield Fusaro, Bernard J. Caulfield, Timothy J. Caulfield, Margaret Soulas Caulfield, and Patricia Caulfield Lathrop dated August 2, 1995 and recorded in Volume 1228 Page 063 of the Norwich Land Records.

SCHEDULE J TO SCHEDULE 17.10

William W. Backus Hospital 107 Lafayette Street, Norwich

Exceptions:

Subject to restriction that no stable may be erected on the premises as contained in a deed recorded in Volume 171 Page 109 of the Norwich Land Records.

Subject to a zoning variance permitting use as a medical office and certain buffer waivers as recorded in Volume 713 Page 67 of the Norwich Land Records.

Description: See Schedule J-1

SCHEDULE J-1

That certain piece or parcel of land with the buildings thereon, situated on the southerly side of Lafayette Street in the Town of Norwich, County of New London and State of Connecticut and bounded and described as follows:

Bounded Northerly on said Street 65 feet; Easterly by land now or formerly of Frank G. Rice about 215 feet; Southerly by land now or formerly of C. Del Carlo 65 feet; and Westerly by land now or formerly of Erroll C. Lilibridge about 206 feet.

Being the same premises conveyed to Backus Properties, Inc. by deed of Tom P. Bell dated June 4, 1997 and recorded in Volume 1319 at Page 214 of the Norwich Land Records.

Subject to restrictions as of record appear.

SCHEDULE K TO SCHEDULE 17.10

William W. Backus Hospital 121 Lafayette Street, Norwich

Exceptions:

Effects, if any, of a variance granted November 4, 1986 by the Norwich Zoning Board of Appeals and recorded in Volume 750 Page 152 of the Norwich Land Records.

Description: See Schedule K-1

Leases: Ronald Baratz, DDS
Sarah Beckett and Beverly Carr

SCHEDULE K-1

A certain tract and parcel of land with the buildings and improvements thereon situated, located at La£ayette Street, in the Town o£ Norwich, County o£ New London and State of Connecticut, and more particularly described as follows, to wit:

Beginning at an iron pipe set on the southerly street line of Lafayette Street said point being the northwesterly corner of the herein described parcel and the northeasterly corner of land owned now or formerly of Adam Labenski, thence running in a generally northeasterly direction by and along the southerly street line of La£ayette Street and the arc of a circular curve having a central angle of 4°-02'-28" and a radius of 1200.00 feet and a chord distance of 84.62 feet, a distance of 84.64 feet to an iron pipe at the northeasterly corner of the herein described parcel, bounded northerly by Lafayette Street, thence turning an interior angle of 69°-31'-22" from the chord of the above mentioned curve and running in a southeasterly direction 164.06 feet to a spike set in the base of a tree bounded easterly by properties owned now or formerly by Marjorie H. Johnson and Franklin M. Boller, thence turning an interior angle of 170°-06'-00" and running southerly a distance of 105.20 feet to an iron pipe, said point being the southeasterly corner of the herein described tract, bounded easterly by properties owned now or formerly by Franklin M. Boller, Selma R. Swatsburg, and Alfred P. and Iva A. Savance, thence turning an interior angle of 105°-00'-00" and running southwesterly a distance of 45.00 feet to an iron pipe (existing), said point being the southwesterly corner of the herein described tract, bounded southerly by property owned now or formerly by Alfred P, and Iva A. Savage, thence turning an interior angle of 88°-46'-00" and running northwesterly 242.64 feet to an iron pipe, said iron pipe being the point and place of beginning.

Said last mentioned course forming an interior angle with the chord in said first mentioned course of 106°-36'-38".

Above mentioned description shown on a plan titled: Site Development Plan, Medical or Dental and Professional Offices, Property of Lehigh Petroleum, Inc., 121 Lafayette Street, Norwich, Connecticut, Scale: 1"710', March, 1975, Dicesare-Bentley-Welling Engineers, Inc., Groton-Norwich, Connecticut.

Being the same premises conveyed to the Grantor by deed dated August 2, 1985 and recorded in Vol. 684 at Pg. 96 of the Norwich Land Records.

The Grantee herein hereby agrees and assumes to pay all taxes now or hereinafter due.

SCHEDULE L TO SCHEDULE 17.10

William W. Backus Hospital 1 Matlack Drive, Norwich

Exceptions: See Schedule L-1 attached

Description: See Schedule L-2

SCHEDULE L-1

1. Easements or claims of easements not shown by the public records, boundary-line disputes, overlaps, encroachments, title to filled lands (if any) and any matters not of record which would be disclosed by an accurate survey and inspection of the premises.

2. Real estate taxes to the City of Norwich on the List of October 1, 2002 not yet due and payable.

3. Refuse charges to the City of Norwich as may become due and payable.

4. Water and/or sewer use charges as may be due Norwich Department of Public Utilities

5. Order of the State of Connecticut to Falls Corporation dated August 21, 1967 and recorded December 14, 1967 in Volume 346 at Page 401 of the Norwich Land Records.

6. Effect, if any, of those easements more particularly described in a deed from Falls Corporation to the City of Norwich dated June 13, 1969 and recorded June 18, 1969 in Volume 354 at Page 143 of the Norwich Land Records.

7. Right of way over a strip of land thirty feet (30') in width for the purpose of a railroad siding as contained in a deed from Falls Corporation to Rollins Properties, Inc. dated December 7, 1971 and recorded December 7, 1971 in Volume 369 at Page 558 of the Norwich Land Records. *(as to 4 Matlack Road ONLY)*

8. Special Exception granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated June 12, 1981 and recorded June 29, 1981 in Volume 557 at Page 247 of the Norwich Land Records.

9. Special Permit granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated July 15, 1982 and recorded August 2, 1982 in Volume 579 at Page 118 of the Norwich Land Records.

10. Grant of slope rights to Patricia A. Tramontozzi, Julio Cirillo, Elaine M. Coletti and Martin Foley, Trustees from Rollins Properties, Inc. dated February 28, 1983 and recorded December 28, 1994 in Volume 662 at Page 121 of the Norwich Land Records.

11. Consent Order by Matlack, Incorporated and Brite-Sol Services, Incorporated to the Commissioner of Environmental Protection dated October 6, 1998 and recorded October 19, 1998 in Volume 1399 at Page 288 of the Norwich Land Records.

SCHEDULE L-2

1 Matlack Rd., Norwich, CT

A certain tract or parcel of land with the buildings standing thereon located in the Town of Norwich, County of New London, State of Connecticut, being bounded and described as follows:

Beginning at a monument on the Northerly line of Rollins Road at the dividing line between the herein described tract and land now or formerly of Tramontozzi et. al. and thence running along said road line South 85° 30' East 342.84 feet to a monument at a point of curve to the left having a radius of 61.20 feet; thence Northeastwardly, along the Northwesterly line of Matlack Road, following the arc of said curve 83.84 feet to a monument; thence along said Matlack Road line North 16° 00' East 434.73 feet to a monument; thence North 85° 30' West 386.56 feet, abutting Northerly on remaining land now or formerly of Rollins Properties, Inc.; thence South 23° 43' West 62.00 feet, abutting Northwesterly on land now or formerly of Despin; thence South 69° 50' East 33.00 feet to a drill hole; thence South 20° 10' West 423.26 feet to the point of beginning, these last two lines abutting Southwesterly and Northwesterly on said land now or formerly of Tramontozzi, et. al.

TOGETHER WITH a right of way to pass and repass over a twenty foot (20') strip as being more particularly described in a Deed from Anna T. Bohara to Roy S. Beebe, dated July 31, 1946 and recorded July 31, 1946 in Volume 237, Page 204 of the Norwich Land Records.

SCHEDULE M TO SCHEDULE 17.10

William W. Backus Hospital 4 Matlack Drive, Norwich

Exceptions: See Schedule M-1 attached

Said premises is further subject to an Environmental Land Use Restriction recorded in Volume 2633 Page 138 of the Norwich Land Records and dated August 13, 2010.

Description: See Schedule M-2

NOTE: Although 1 Matlack Drive and 4 Matlack Drive exist as separate parcels, they are effectively one parcel of land and the exceptions to title are applicable to both parcels.

NOTE: Consent Order filed by DEP is of no force and effect, as all remediation having been completed and certified as such by DEP by letter dated September 28, 2010.

SCHEDULE M-1

1. Easements or claims of easements not shown by the public records, boundary-line disputes, overlaps, encroachments, title to filled lands (if any) and any matters not of record which would be disclosed by an accurate survey and inspection of the premises.

2. Real estate taxes to the City of Norwich on the List of October 1, 2002 not yet due and payable.

3. Refuse charges to the City of Norwich as may become due and payable.

4. Water and/or sewer use charges as may be due Norwich Department of Public Utilities

5. Order of the State of Connecticut to Falls Corporation dated August 21, 1967 and recorded December 14, 1967 in Volume 346 at Page 401 of the Norwich Land Records.

6. Effect, if any, of those easements more particularly described in a deed from Falls Corporation to the City of Norwich dated June 13, 1969 and recorded June 18, 1969 in Volume 354 at Page 143 of the Norwich Land Records.

7. Right of way over a strip of land thirty feet (30') in width for the purpose of a railroad siding as contained in a deed from Falls Corporation to Rollins Properties, Inc. dated December 7, 1971 and recorded December 7, 1971 in Volume 369 at Page 558 of the Norwich Land Records. *(as to 4 Matlack Road ONLY)*

8. Special Exception granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated June 12, 1981 and recorded June 29, 1981 in Volume 557 at Page 247 of the Norwich Land Records.

9. Special Permit granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated July 15, 1982 and recorded August 2, 1982 in Volume 579 at Page 118 of the Norwich Land Records.

10. Grant of slope rights to Patricia A. Tramontozzi, Julio Cirillo, Elaine M. Coletti and Martin Foley, Trustees from Rollins Properties, Inc. dated February 28, 1983 and recorded December 28, 1994 in Volume 662 at Page 121 of the Norwich Land Records.

11. Consent Order by Matlack, Incorporated and Brite-Sol Services, Incorporated to the Commissioner of Environmental Protection dated October 6, 1998 and recorded October 19, 1998 in Volume 1399 at Page 288 of the Norwich Land Records.

Said premises are subject to:

1. Building lines, if established, building and zoning ordinances, and any and all municipal and state and federal regulations including inland wetlands regulations and provisions of any public or private law affecting said premises.

2. Taxes on 2002 Grand List, not yet due and payable, which the Grantees herein assume and agree to pay.

3. Order of the State of Connecticut to Falls Corporation dated August 21, 1967 and recorded December 14, 1967 in Volume 346 at Page 401 of the Norwich Land Records.

4. Effect, if any, of those easements more particularly described in a deed from Falls Corporation to the City of Norwich dated June 13, 1969 and recorded June 18, 1969 in Volume 354 at Page 143 of the Norwich Land Records.

5. Right of way over a strip of land thirty feet (30') in width for the purpose of a railroad siding as contained in a deed from Falls Corporation to Rollins Properties, Inc. dated December 7, 1971 and recorded December 7, 1971 in Volume 369 at Page 558 of the Norwich Land Records. *(as to 4 Matlack Road ONLY)*

6. Special Exception granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated June 12, 1981 and recorded June 29, 1981 in Volume 557 at Page 247 of the Norwich Land Records.

7. Special Permit granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated July 15, 1982 and recorded August 2, 1982 in Volume 579 at Page 118 of the Norwich Land Records.

8. Grant of slope rights to Patricia A. Tramontozzi, Julio Cirillo, Elaine M. Coletti and Martin Foley, Trustees from Rollins Properties, Inc. dated February 28, 1983 and recorded December 28, 1994 in Volume 662 at Page 121 of the Norwich Land Records.

9. Consent Order by Matlack, Incorporated and Brite-Sol Services, Incorporated to the Commissioner of Environmental Protection dated October 6, 1998 and recorded October 19, 1998 in Volume 1399 at Page 288 of the Norwich Land Records.

SCHEDULE M-2

4 Matlack Rd., Norwich, CT

ALL that certain tract or parcel of land with the buildings standing thereon located in the Town of Norwich, County of New London, State of Connecticut, being bounded and described as follows:

Beginning at a monument on the Northeasterly line of Rollins Road extending Southeasterly from New London Turnpike, said monument being 483.86 feet from the Southeasterly corner of land of Patricia A. Tramontozzi et. al. and thence running along said road line South 85° 30' East 94.14 feet to a point of curve to the left having a radius of 25.00 feet; thence Eastwardly along said road line, following the arc of said curve 21.03 feet to a point of curve to the right having a radius of 50.00 feet; thence Eastwardly along said road line, following the arc of the said curve 94.41 feet; thence along said road line South 85° 30' East 40.85 feet to a monument at land of the Canadian National Railways, Central Vermont Division; thence North 14° 02' 40" East 398.73 feet to an iron origin; thence North 14° 48' 40" East 208.42 feet to an iron pipe; thence North 9° 56' 20" East 127.46 feet to an angle iron; thence North 5° 07' 50" East 157.90 feet to a monument, these last four lines abutting Southeasterly on said Railroad; thence along a wall South 75° 10' West 292.10 feet to a drill hole; thence along said wall North 88° 39' West 92.33 feet to a drill hole at the end of the wall, these two lines abutting Northwesterly and Northeasterly on land of Henry J. Hanks; thence North 78° 25' West 135.89 feet to an iron pipe; thence North 76° 11' West 65.19 feet to a drill hole in ledge; thence South 65° 37' West 126.41 feet to an iron pipe at land of George and Ruth P. Despin, these last three lines abutting Northeasterly and Northwesterly on a right of way 20 feet wide leading to New London Turnpike; thence South 9° 33' West 137.50 feet to a drill hole in ledge; thence South 13° 31' West 41.19 feet; thence South 23° 43' West 100.60 feet; thence South 85° 30' East 386.56 feet to a monument, located on the Westwardly side of Matlack Road, said monument being a point of curve to the left having a radius of 25.00 feet; thence Northwardly along said road, following the arc of said curve 21.03 feet to a point of curve to the right having a radius of 50.00 feet; thence Eastwardly along said road following the arc of said curve 241.19 feet to a point of curve to the left having a radius 25.00 feet; thence Southwardly along said road following the arc of said curve 21.03 feet to a monument; thence South 16° 00' West 434.73 feet to a point of curve to the left having a radius of 32.68 feet; thence Eastwardly following the arc of said curve 57.90 feet to the point of beginning.

Together with a Right of Way 20 feet wide easterly from New London Turnpike to and along the portion to the north boundary line as set forth in Volume 369 at Page 558 of the Norwich Land Records.

TOGETHER WITH a right of way to pass and repass over a twenty foot (20') strip as being more particularly described in a Deed from Anna T. Bohara to Roy S. Beebe, dated July 31, 1946 and recorded July 31, 1946 in Volume 237, Page 204 of the Norwich Land Records.

SCHEDULE N TO SCHEDULE 17.10

William W. Backus Hospital 12 Case Street, Norwich
(Office condominium units A-5, A-10, A-11, C-8, C-9, C-10, C-15)

Exceptions:

All units are together with and subject to the terms and conditions of a Declaration of Case Street Office Condominium dated May 9, 1979 and recorded in Volume 513 Page 178 of the Norwich Land Records

Description: See Schedule N-1

Leases: Backus Physician Services

SCHEDULE N-1

Four (4) certain condominium units situated in the Town of Norwich, County of New London and State of Connecticut known as **Units A5, A10, A11 and C8** in a condominium known as Case Street Office Condominium as more particularly set forth in a "Declaration of Unit Ownership For Case Street Office Condominium" dated May 9, 1978 and recorded in Volume 513 at Page 178 of the Norwich Land Records, and the plans for said Condominium entitled "Office Building (Condominium) 12 Case Street, Norwich, Connecticut", 1/2" = 1' - 0" prepared by David T. Frigon, AIA and recorded May 20, 1979 in Condo File 1A through 1D, Norwich Town Clerk's Office, together with said units' interest in the Common Elements. Said Declaration having been amended by amendments recorded in volume 678, page 32; volume 747, page 141; volume 747, page 142; and volume 1714, page 298, Norwich Land Records.

Units A5 and A11 having been conveyed to this Grantor by deed recorded in volume 526, page 117, Norwich Land Records. Unit A10 having been conveyed to this Grantor by deed recorded in volume 1202, page 298, Norwich Land Records; and Unit C8 having been conveyed to this Grantor by deed recorded in volume 708, page 82, Norwich Land Records.

SCHEDULE N-1

The following described property situated in the Town of Norwich, County of New London and State of Connecticut:

Units C9 & C10 within the 12 Case Street Office Condominium and an undivided .020536 and .019940 percentage interest respectively, in and to the common elements within the condominium property, as the same are established and identified in the "Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513, at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut, TOGETHER WITH:

1) an exclusive easement to the use of the Limited Common elements appurtenant to said Units.

2) The benefit of the other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SCHEDULE N-1

The following described property situated in the Town of Norwich, County of New London, and State of Connecticut:

Unit No. C-15 within the 12 Case Street Office Condominium and an undivided .019642 percentage interest in and to the common elements within the condominium property, as the same are established and identified in the "Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513 at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut.

Together with:

1) An exclusive easement to the use of the Limited Common elements appurtenant to said unit;

2) The benefit of other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SCHEDULE O TO SCHEDULE 17.10

Backus Home Health Care 12 Case Street, Norwich
(Office condominium units C-11 and C-12)

Exceptions:

All units are together with and subject to the terms and conditions of a Declaration of Case Street Office Condominium dated May 9, 1979 and recorded in Volume 513 Page 178 of the Norwich Land Records

Description: See Schedule O-1

Leases:

SCHEDULE O-1

UNIT NO. C-11 AND UNIT C-12

Unit No. C-11 within the 12 Case Street Office Condominium and an undivided .056777 percentage interest in and to the common elements within the condominium property, as the same are established and identified in the "1 Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513 at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut, TOGETHER WITH:

1) an exclusive easement to the use of the Limited Common elements appurtenant to said Unit.

2) The benefit of the other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time,

SUBJECT TO:

1) The covenants, restrictions, easements and other provisions set forth in the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time;

The term "Unit", "Common Elements", "Limited Common Elements" and any similar terms as they are used in this Deed are more particularly defined and set forth in the Declaration.

The building within the condominium property is located on the land described on Schedule A attached hereto.

The Grantee, by accepting and recording this Deed, accepts the covenants, restrictions, easements, liens, charges and other provisions contained or referred to herein and agrees to perform the obligations imposed by the Declaration.

Unit No. C-12 within the 12 Case Street Office Condominium and an undivided .026168 percentage interest in and to the common elements within the condominium property, as the same are established and identified in the "1 Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513 at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut, TOGETHER WITH:

1) an exclusive easement to the use of the Limited Common elements appurtenant to said Unit.

2) The benefit of the other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SUBJECT TO:

1) The covenants, restrictions, easements and other provisions set forth in the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

The term "Unit", "Common Elements", "Limited Common Elements" and any similar terms as they are used in this Deed are more particularly defined and set forth in the Declaration.

The building within the condominium property is located on the land described on Schedule A attached hereto.

The Grantee, by accepting and recording this Deed, accepts the covenants, restrictions, easements, liens, charges and other provisions contained or referred to herein and agrees to perform the obligations imposed by the Declaration.

SCHEDULE P TO SCHEDULE 17.10

William W. Backus Hospital 11 Stott Avenue, Norwich

Exceptions: Mortgage in favor of Dime Bank in the amount of $1,250,000 dated April 15, 2010 and recorded in Volume 2610 Page 23 of the Norwich Land Records and an Assignment of Leases and Rents recorded in Volume 2610 Page 319 of the Norwich Land Records.

See attached Schedule P-1 for additional exceptions.

Description: See Schedule P-2

SCHEDULE P TO SCHEDULE 17.10

William W. Backus Hospital 11 Stott Avenue, Norwich

Exceptions: Mortgage in favor of Dime Bank in the amount of $1,250,000 dated April 15, 2010 and recorded in Volume 2610 Page 23 of the Norwich Land Records and an Assignment of Leases and Rents recorded in Volume 2610 Page 319 of the Norwich Land Records.

See attached Schedule P-1 for additional exceptions.

Description: See Schedule P-2

SCHEDULE P-1

Said premises are conveyed subject to:

1. Real property taxes of the city of Norwich not yet due and owing.

2. Easement in favor of Algonquin Gas transmission company dated December 11, 1951 and recorded in Volume 258 at Page 393 of the Norwich Land Records.

3. Covenants and Restrictions of the Norwich Industrial Park described in a deed from the Norwich Community Development Corporation, Incorporated to Hilltop Investments, LLC dated January 17, 2001 and recorded in Volume 1626 at Page 119 of the Norwich Land Records.

4. Right of Levine Distributing Company, its heirs and assigns, to discharge surface water from a paved swale described in a deed from The Norwich Community Development Corporation, Incorporated to Hilltop Investments, LLC dated January 17, 2002 and recorded in Volume 1626 at Page 119 of the Norwich Land Records and as shown on the herein referenced map.

5. Easement in favor of the City of Norwich dated August 6, 2002 and recorded in Volume 1679 at page 251 of the Norwich Land Records.

6. Terms and provisions of a ground lease wherein Hilltop Investments, LLC is the landlord and RM Holdings, LLC is the tenant, a Notice of which is dated January 8, 2003 and recorded in Volume 1729 at Page 20 of the Norwich Land records, which lease was assigned to Sopramco, LLC as tenant, which assignment appears of record.

SCHEDULE P-2

A certain tract or parcel of land situated in the Town of Norwich, County of New London and State of Connecticut, depicted on a plan entitled "Boundary Survey Property to be Conveyed to The Wm. W. Backus Hospital #11 Stott Avenue Norwich, Connecticut Project No. CLA-4648 Proj. Engineer RLM Date: 4/8/10 Sheet No. 1" prepared by CLA Engineers, Inc. and being more particularly described as follows:

Beginning at an iron pin (found) on the northerly line of Stott Avenue, said pin marking the southeasterly corner of land of Levine Distributing Company and the southwesterly corner of the herein described tract and running thence N 4° 41' 55" W, a distance of 450.00 feet to an iron pin (destroyed); thence continuing N 4° 41' 55" W a distance of 300.08 feet to a point, these last two lines bounded westerly by land of Levine Distributing Company; thence N 85° 18' 05" E a distance of 363.73 feet to a point on the westerly line of land now or formerly of Kelvin H. Stott, bounded northerly by land now or formerly of Norwich Community Development Corporation; thence S 5° 21' 13" E a distance of 190.00 feet to an iron pin found; thence continuing S 5° 21' 13" E a distance of 540.15 feet to a monument found, these last two lines running generally along a wire fence and bounded easterly by land of said Stott; thence continuing S 5° 21' 13" E a distance of 20.03 feet to an iron pin set on the northerly line of Stott Avenue, bounded easterly by land now or formerly of Norwich Community Development Corporation; thence S 85° 18' 05" W a distance of 372.35 feet by and along the northerly line of Stott Avenue to the point of beginning.

Together with easement rights as more particularly set forth in a Quit Claim Deed from Hilltop Investments, LLC to Norwich Community Development Corporation dated April 9, 2003 and recorded in Volume 1768 at Page 282 of the Norwich Land Records.

SCHEDULE Q TO SCHEDULE 17.10

William W. Backus Hospital 11A Stott Avenue, Norwich

Exceptions: See comments to 11 Stott Avenue above.

Leases: 11A Stott Avenue is a portion of 11 Stott Avenue which is subject to the land lease to Sopramco which is described above. The building located on the leased property is owned by the tenant who may remove the building upon the expiration of the lease. If the building is not removed, it will become the property of the William W. Backus Hospital.

SCHEDULE R TO SCHEDULE 17.10

William W. Backus Hospital 11 Murphy Road, Franklin

Exceptions:

Subject to: drainage rights in favor of the State of Connecticut as of record appear; a drainage easement in favor of Franklin Realty Corporation as set forth in a deed recorded in Volume 23 Page 185 of the Franklin Land Records.

Description: See Schedule R-1

SCHEDULE R-1

A certain tract or parcel of land, with all buildings and improvements thereon, situated in the Town of Franklin, County of New London and State of Connecticut, being bounded and described as follows:

Beginning at monument on the Southerly line of Murphy Road at the Northwesterly corner of the herein described tract as shown on a plan hereinafter referred to and running thence South 2 degrees, 16 minutes and 00 seconds East 347.72 feet to a point abutting Westerly on land now or formerly of James Zeller and Robert Irving; thence North 84 degrees, 14 minutes East 276.23 feet to a monument; thence North 5 degrees, 46 minutes and 00 seconds West 159.00 feet to a point, these last two lines abutting Southerly and Easterly on land now or formerly of Ralph Fargo and Arlene Fargo; thence South 88 degrees, 11 minutes and 41 seconds West 1.00 foot to a monument abutting Northerly on land now or formerly of Joseph Alfiero and Barbara Alfiero; thence North 5 degrees, 46 minutes and 00 seconds West 188.00 feet to a monument on the said Southerly line of Murphy Road abutting Easterly on land now or formerly of Joseph Alfiero and Barbara Alfiero and said road; thence South 84 degrees, and 14 minutes West 254.00 feet along said road line to the monument at the point of beginning.

Containing 2.11 acres, more or less.

Being the land as shown as "2.11 +/- acres" on "Resubdivision Plan made for Franklin Realty Corporation, Rte. 32 & Murphy Road, Franklin, Conn., Scale=1"=60', Chandler, Palmer & King, 27 Aug. 1976, Additions and Revisions to Nov. 16, 1983."

Said premises are conveyed SUBJECT to drainage rights in favor of the State of Connecticut as of record shall appear; a drainage easement in favor of Franklin Realty Corporation, its successors and assigns, and are further conveyed TOGETHER with a drainage easement over land now or formerly of Franklin Realty Corporation; all as more particularly set forth in a Warranty Deed from Franklin Realty Corporation to Walter McGill, dated March 15, 1973 and recorded in Volume 23 at Page 185 of the Franklin Land Records.

SCHEDULE S TO SCHEDULE 17.10

William W. Backus Hospital 120-122 Plainfield Road, Moosup (Plainfield)

Exceptions:

a. Subject to drainage rights as set forth in a deed recorded in Volume 76 Page 160 of the Plainfield Land Records.

b. Subject to a restriction contained in a deed recorded in Volume 123 Page 380 of the Plainfield Land Records, which restriction is subject to a right of reverter. The William W. Backus Hospital has an owner's policy of title insurance which affirmatively insures said William W. Backus Hospital against loss as the result of enforcement or attempted enforcement of said right of reverter.

Description: See Schedule S-1

Leases: CONNCare

SCHEDULE S-1

A certain parcel of land situated on the north side of Plainfield Road in the Village of Moosup, Town of Plainfield, County of Windham and State of Connecticut, bounded and described as follows: Beginning at a point on the north side of Plainfield Road, which point marks the southeast corner of land now or formerly of Emil Dorflinger and the southwest corner of the within described parcel; thence N. 21° 04' E. 291.2 feet, more or less, to a point on the south side of Town Farm Road; thence S. 42° 04' E. 150 feet, more or less, to a point; thence southeast 30 feet, more or less, to a point in the south side of Town Farm Road; thence southeast 159 feet more or less to the intersection of the westerly line of Town Farm Road with the northerly line of Plainfield Road; the last three lines bounded on the northeast by Town Farm Road; thence along the northerly line of Plainfield Road northwesterly 263 feet, more or less, to the point and place of beginning. Containing by estimate 1.04 acres, more or less.

Reference may be had to a certain map on file with the Town Clerk, Town of Plainfield, entitled "Town of Plainfield – Map Showing Land and Rights to Drain Acquired From Paul W. Roper et als by the State of Connecticut, Greenwood-Killingly Expressway, Scale 1" = 40', 1953 Supp. Chap. 107 Part IV, Newman E. Argraves, Highway Commissioner, June 1955, Rev. July 1956, Area = 0.96 acres, plus or minus."

Note to Schedules 17.10

Tax Code Citation: All real property of the William W. Backus Hospital which is exempt from taxation, is exempt as such by virtue of Conn. Gen. Stat. Section 12-81 (16) as being the property of a Connecticut hospital corporation.

Note Regarding Encroachments: Representations as set forth in Section 17.10.1 (j) are made to the best of the knowledge and belief of the Backus Entities, there being no survey of the Real Property.

Disclosure of Right of First Refusal: The Backus Entities disclose that it is the holder of a "Right of First Offer and Right of First Refusal Agreement" dated May 7, 2001 as to property known as 302 Washington Street, Norwich, which is recorded in Volume 1562 Page 325 of the Norwich Land Records.

Disclosure of Option Agreement: The Backus Entities disclose that it is the holder of an Option Agreement to purchase property known at 199 Lafayette Street, Norwich, which is recorded in Volume 1722 Page 190 of the Norwich Land Records.

17.10.3 Backus Environmental Laws

The William W. Backus Hospital

17.10.3 (c)

As to Real Property known as 326 Washington Street, Norwich, on November 14, 1997, a proposal was submitted to ATC Associate, Inc. for the design and installation of a groundwater remediation system for containment of a plume in the area of former underground storage tanks. At the present time the DEEP is requiring that the Backus Entities test this area annually, and the Backus Entities are in compliance with such requirement and conduct testing in September of each year, with testing costs of approximately $200 annually. The Backus Entities have recorded a potential liability of $250,000 in connection with potential cost of remediation of this area.

17.10.3 (x)

List of Oil Tanks Meeting Hazardous Reporting Criteria (SARA Tier II)

Capacity	Type	Use	Date of Installation	Contents
45,000 lbs	Underground tank	Generator – Hospital	2/89	Diesel Fuel
100,000 lbs	Underground tank	Boiler - Hospital	2/89	#2 Fuel Oil
48,000 lbs	Underground tank	Jet fuel for Helipad – Hospital	6/99	Jet A Fuel
20,000 lbs	Above ground tank	Oxygen - Hospital	1/84	Liquid Oxygen
24,320 lbs	Above ground tank	Oxygen – 113 Salem Tpke, Norwich, CT 06360	2007	Liquid Oxygen
1,000 gallons	Above ground tank	Heating – 11 Stott Ave, Norwich, CT 06360	12/2011	Diesel Fuel
600 gallons	Above ground tank	Heating – 11A Stott Ave, Norwich, CT 06360	2003	#2 Fuel Oil
500*	Above ground tank	Heating – 120-122 Plainfield Rd, Moosup, CT 06354		#2 Fuel Oil

17.12 Corporate Form and Tax Status of Certain Backus Entities

WWB Corporation
Backus Home Health Care
CONNCare, Inc.
Backus Physician Services, LLC
Backus Medical Center Condominium Associates
Backus Health Care, Inc.
Community Medical Partners, Inc.

In 2011, the tax advisors of Backus Health Care Inc. (BHC) concluded that BHC no longer met the revenue test to qualify as a public charity and was thus a private foundation. In September 2011, BHC applied to the Internal Revenue Service (IRS) to become a "supporting" organization under Section 509(a)(3) of the Internal Revenue Code. The IRS granted the request for advance ruling on May 2012 (see IRS Letter to BHC, dated May 14, 2012 attached).

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date:
MAY 14 2012

BACKUS HEALTH CARE INC
326 WASHINGTON ST
NORWICH, CT 06360

Employer Identification Number:
22-2481794
DLN:
101286001
Contact Person:
TERRY L MILLER ID# 31222
Contact Telephone Number:
(877) 829-5500

60 Month Period Ends:
September 30, 2016
Addendum Applies:
No

Dear Applicant:

We have received your notification of intent to terminate your private foundation status under section 507(b)(1)(B) of the Internal Revenue Code during a 60 month period beginning October 1, 2011.

The information submitted indicates that you intend to operate as an organization described in section 509(a)(3) of the Code during the 60 month period.

Based on your proposed activities and support, it is held that you can reasonably be expected to terminate your private foundation status under section 507(b)(1)(B) of the Code. Accordingly, you will be treated as a public charity described in section 509(a)(3) of the Code for an advance ruling period of 60 months beginning October 1, 2011.

Within 90 days after the end of your 60 month period, you must establish to the satisfaction of the Internal Revenue Service that you have qualified as an organization which meets the requirements of paragraph (1), (2), or (3) of section 509(a) of the Code for the 60 month period. If you do establish that fact, you will be so classified for all purposes beginning with the first day of the first taxable year of the 60 month period and, thereafter, so long as you continue to meet the requirements of section 509(a)(1), (2), or (3). If, however, you do not meet these requirements for the 60 month period, you will be classified as a private foundation as of the first day of the first taxable year of the 60 month period.

If you satisfy the requirements of section 507(b)(1)(B) of the Code at the end of your 60 month period, you will not be subject to the provisions of section 507(a), (c), or (g) of the Code.

Grantors and donors may rely on the determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you submit the required information within the 90 days, grantors and contributors may continue to rely on the advance determination until the Service makes a final determination of your foundation status.

Letter 2245 (DO/CG)

You are required to file Form 990-PF, Return of Private Foundation or Section 4947(a)(1) Trust Treated as a Private Foundation, until you complete your 60 month termination and are classified as a section 509(a)(3) organization. Form 990-PF must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000 or 5 percent of your gross receipts (whichever is less), for failure to file a return on time unless there is reasonable cause for the delay. For organizations with gross receipts exceeding $1,000,000 in any year, the penalty is $100 per day per return, unless there is reasonable cause for the delay. The maximum penalty for an organization with gross receipts exceeding $1,000,000 shall not exceed $50,000. This penalty may also be charged if a return is not complete, so please be sure your return is complete before you file it.

If you do not pay the tax imposed by section 4940 of the Code for any taxable year or years during the 60 month period, and it is subsequently determined that such tax is due for such year or years, you will be liable for interest in accordance with section 6601 of the Code. Since any failure to pay such taxes during the 60 month period is due to reasonable cause, the penalty under section 6651 with respect to the tax imposed by section 4940 shall not apply.

If the heading of this letter indicate that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

We have sent a copy of this letter to your representative as indicated in your power of attorney.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

Lois G. Lerner
Director, Exempt Organizations

Enclosure(s):
Form 872

Letter 2245 (DO/CG)

Form 872-B (Rev. Dec. 2004)	Department of the Treasury - Internal Revenue Service **Consent to Extend the Time to Assess Miscellaneous Excise Taxes**	In reply refer to: Taxpayer Identification Number

Backus Health Care Inc, taxpayer(s)
(Name(s))

of 326 Washington St, Norwich, CT 06360-2740 and the
(Number, Street, City or Town, State, ZIP Code)

Commissioner of Internal Revenue consent and agree to the following:

(1) The amount of liability for Chapter 42 Excise Tax tax, imposed on the taxpayer(s) by
(Kind)

section 4940-4945 of the Internal Revenue Code due for the period October 1, 2011 through September 30,
(Internal Revenue Code, Revenue Act, etc.)

2016 may be assessed at any time on or before February 15, 2021
(Expiration date)

(2) The collection provisions and limitations now in effect will also apply to any tax assessed within the extended period.

(3) The taxpayer(s) may file a claim for credit or refund and the Service may credit or refund the tax within 6 months after this agreement ends.

Your Rights as a Taxpayer

You have the right to refuse to extend the period of limitations or limit this extension to a mutually agreed-upon issue(s) or mutually agreed-upon period of time. **Publication 1035, *Extending the Tax Assessment Period***, provides a more detailed explanation of your rights and the consequences of the choices you may make. If you have not already received a Publication 1035, the publication can be obtained, free of charge, from the IRS official who requested that you sign this consent or from the IRS' web site at www.irs.gov or by calling toll free at 1-800-829-3676. Signing this consent will not deprive you of any appeal rights to which you would otherwise be entitled.

YOUR SIGNATURE HERE → .....
I am aware that I have the right to refuse to sign this consent or to limit the extension to mutually agreed-upon issues and/or period of time as set forth in I.R.C. § 6501(c)(4)(B). *(Date signed)*

TAXPAYER'S REPRESENTATIVE

SIGN HERE → .....
I am aware that I have the right to refuse to sign this consent or to limit the extension to mutually agreed-upon issues and/or period of time as set forth in I.R.C. § 6501(c)(4)(B). In addition, the taxpayer(s) has been made aware of these rights. *(Date signed)*

CORPORATE NAME → Backus Health Care, Inc.

CORPORATE OFFICER(S) SIGN HERE → Daniel E. Flinn Chief Financial Officer 3-21-12
(Title) *(Date signed)*

....
(Title) *(Date signed)*

I (we) am aware that I (we) have the right to refuse to sign this consent or to limit the extension to mutually agreed-upon issues and/or period of time as set forth in I.R.C. § 6501(c)(4)(B).

INTERNAL REVENUE SERVICE SIGNATURE AND TITLE

....
(Division Executive Name - see instructions) *(Division Executive Title - see instructions)*

BY .....
(Authorized Official Signature and Title - see instructions) *(Date signed)*

Removed premium amounts.

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Property** *All States* Real & BPP Blanket Limit $491,220,726 Business Income $218,305,000 Extra Expense $10,000,000 Flood $5,000,000 Aggregate Flood Zones A, B, Shaded X $50,000,000 Aggregate All Other Insured Premises Flood Zone V Excluded Earthquake $50,000,000 Aggregate Boiler & Machinery Included Builder's Risk $5,000,000 Max-Any OneConstruction Site $5,000,000 Max-All Construction Sites Emergency Patient Evacuation Expense $2,000,000	3/1/12 to 3/1/13	Travelers Indemnity Co.	
Backus Home Health Care	**Healthcare Professional & General Liability** Healthcare Professional Liab. Claims Made $3,000,000 Aggregate $1,000,000 Each Incident Healthcare General Liability $3,000,000 Aggregate $1,000,000 Each Occurrence $3,000,000 Prods/Comp Ops Agg $1,000,000 Pers/Adv Injury $100,000 Damage to Premises Rented to You $5,000 Medical Expense Employee Benefits Liability Claims Made Form $1,000,000 Each Employee $3,000,000 Aggregate Defense In Addition to Limits	10/1/11 to 10/1/12	rch Specialty Insurance Co	Retroactive Date: 10/1/01

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital	**Automobile Liability & Physical Damage** Liability (Symbol 1) $1,000,000 CSL Medical Payments (Symbol 2) $10,000 UM/UIM (Symbol 6) $1,000,000/$1,000,000 Phys. Damage - Comp (Symbol 2, 8)	10/1/11 to 10/1/12	Sentry Casualty Co.	Policy is Composite Rated 25 Vehicles Drive Other Car Coverage 90 Days Notice of Cancellation Hired / Non-Owned Auto Liability Included Hired Car Only - ACV, Cost of Repair, or $50,000, whichever is less, minus $500 for each covered auto
	Actual Cash Value or Cost of Repair Minus Deductible Phys. Damage - Coll (Symbol 2, 8) Actual Cash Value or Cost of Repair Minus Deductible Towing (Symbol 3) $50 per disablement Loss of Use - Rental Reimbursement $30 Per Day; 30 Days			
The William W. Backus Hospital Backus Physician Services, LLC CONNCare, Inc.	**Medical Malpractice** **Employed Physicians &** **Employed Physician Extenders** Medical Malpractice Employed Physicians $1,000,000 Each Claim $4,000,000 Aggregate Employed Physician Extenders $1,000,000 Each Claim	10/1/11 to 10/1/12	CMIC	Includes 10% Commission
The William W. Backus Hospital Backus Physician Services, LLC CONNCare, Inc.	**Umbrella** Excess Healthcare Professional $10,000,000 Aggregate $10,000,000 Each Med Incident Underlying Insurance Self Insured Retention $1M/$5M Employed Physicians $1M/$4M Employed Extenders $1M/$3M Omni PL/GL $1M/$3M Employers' Liability $500k/$500k/$500k Auto Liability $1M Non-Owned Aircraft $5M Helipad Liability $5M	10/1/11 to 10/1/12	orus Specialty Insurance C	Retroactive Date: 10/1/89 Claims Made Retained Limit: $250,000 25% Minimum Earned Premium

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital	**Automobile Liability & Physical Damage** Liability (Symbol 1) $1,000,000 CSL Medical Payments (Symbol 2) $10,000 UM/UIM (Symbol 6) $1,000,000/$1,000,000 Phys. Damage - Comp (Symbol 2, 8)	10/1/11 to 10/1/12	Sentry Casualty Co.	Policy is Composite Rated 25 Vehicles Drive Other Car Coverage 90 Days Notice of Cancellation Hired / Non-Owned Auto Liability Included Hired Car Only - ACV, Cost of Repair, or $50,000, whichever is less, minus $500 for each covered auto
The William W. Backus Hospital Backus Physician Services, LLC CONNCare, Inc.	**Follow Form Excess** Excess Healthcare Professional Liability & Healthcare Umbrella Liability $20,000,000 Aggregate $20,000,000 Each Med Incident Underlying Insurance: Self Insured Retention $1M/$5M Umbrella $10M Employed Physicians $1M/$4M Employed Extenders $1M/$3M Omni PL/GL $1M/$3M Employers' Liability $500k/$500k/$500k Auto Liability $1M Non-Owned Aircraft $5M Helipad Liability $5M	10/1/11 to 10/1/12	ronshore Specialty Ins. Co	Retroactive Date: 10/1/89 Claims Made Dual Towers: Self-Insured Retention Tower 1: Professional Liability SIR Tower 2: General Liability SIR
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Workers' Compensation** Workers' Comp Statutory - CT Employers' Liability $500,000 Each Accident $500,000 Policy Limit $500,000 Each Employee	10/1/11 to 10/1/12	Sentry Casualty Co.	**Terrorism/Taxes/Surcharges/ Assessments** Premium Subject to Audit
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Management Liability** Aggregate Limit All Coverages other than Crime $15,000,000 Employment Practices Liability $15,000,000 Directors & Officers $15,000,000 Additional Side A Coverage $1,000,000 Fiduciary $5,000,000 Max. Aggregate $100,000 Voluntary Compliance Loss $100,000 HIPAA Penalties Coverage Crime $5,000,000 Employee Theft $100,000 Client Property $5,000,000 Forgery & Alteration $5,000,000 Theft of Money & Securities (Inside) $5,000,000 Robbery or Safe Burglary of Other Property (Inside) $5,000,000 Outside the Premises $5,000,000 Computer Fraud $5,000,000 Funds Transfer Fraud $5,000,000 Money Orders & Counterfeit Money	3/1/12 to 3/1/13	Westchester Fire Ins. Co. Includes: Entity Coverage Employment Practices Liability Fiduciary Crime	Payment Plan Annual Includes Third Party Coverage Continuity Date: 1/1/94 Continuity Date: 2/1/87 Continuity Date: 1/1/95 Includes Employee Benefit Plan Coverage

17.13 Backus Insurance Policies

Removed policy numbers and premium amounts.

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Excess Directors & Officers Liability** $5,000,000 Limit of Liability Claims Made Underlying Insurance D&O $15M	3/1/12 to 3/1/13	Zurich American Ins. Co.	Payment Plan Annual
The William W. Backus Hospital	**Non-Owned Aircraft Liability** $5,000,000 Each Occurrence $500,000 Medical Expense Each Occurrence $10,000 Medical Expense Each Person	10/1/11 to 10/1/12	Federal Insurance Co. Chubb	Payment Plan Annual
The William W. Backus Hospital	**Helipad Liability** $5,000,000 Each Occurrence $100,000 Damage to Premises $10,000 Medical Expense $5,000,000 Pers/Adv Injury Agg $5,000,000 Prods/Comp Ops Hangarkeepers $5,000,000 Each Aircraft $5,000,000 Each Loss Limit	10/1/11 to 10/1/12	Federal Insurance Co. Chubb	Payment Plan Annual
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Kidnap & Extortion** Limit of Liability $1,000,000 Per Incident Business Income & Extra Expense $1,000,000 Each Loss Threat Expense $100,000 / $100,000 Annual Agg Child Abduction Coverage $2,000,000 Per Incident	3/1/11 to 3/1/12	ACE American Ins. Co	Up to 15 Days of Coverage

17.14 Backus Taxes

None.

Removed names of Administrators.

17.15.1 Employee Benefits

Benefit	Administered By
Health Insurance/Medical Coverage	
Health Insurance Stop Loss	
Pharmaceutical	
Dental Insurance	
Vision	
COBRA	
Short Term Disability	
Long Term Disability	
Basic Life	
AD & D	
Group Supplemental Life	
Medical Flexible Spending Account	
Dependant Flexible Spending Account	
Employee Assistance Program	
Retiree Health	
403(b)	
401(k)	
Defined Benefit Pension (frozen 12/31/2009)	
457(b)	

The schedules below list the names of the electronic files for all of the documents requested in 17.15.1 and to which entities the documents pertain.

17.15.1 (a) Benefit Plan and amendments

Name of File	Entity
17.15.1	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a 401K Plan Document 1 of 2	Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

Name of File	Entity
17.15.1 a 401k Plan Document 2 of 2	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a 401K plan Document and amendments	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a 403B Plan Document	The William W. Backus Hospital
17.15.1 a Anthem High Option 82 fact sheet 2012	The William W. Backus Hospital
17.15.1 a DB Plan Document with amendments	The William W. Backus Hospital
17.15.1 a DB Plan Signed Amendments to Plan Document - 1995 reinstatement	The William W. Backus Hospital
17.15.1 a Deferred Compensation 457b plan Document	The William W. Backus Hospital
17.15.1 a FSA Plan Document	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a Section 125 Plan Document	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 (b) Form 5500

Name of File	Entity
17.15.1 b 401k 5500 Plan Year 2008	Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

Name of File	Entity
17.15.1 b 401k 5500 Plan Year 2009	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 b 401k 5500 Plan Year 2010	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 b 403b 5500 Plan Year 2009	The William W. Backus Hospital
17.15.1 b 403B 5500 Plan Year 2010	The William W. Backus Hospital
17.15.1 b DB 5500 Plan Year 2008	The William W. Backus Hospital
17.15.1 b DB 5500 Plan Year 2009	The William W. Backus Hospital
17.15.1 b DB 5500 Plan Year 2010	The William W. Backus Hospital
17.15.1 b Welfare 5500 Plan Year 2008	The William W. Backus Hospital
17.15.1 b Welfare 5500 Plan Year 2009	The William W. Backus Hospital
17.15.1 b Welfare 5500 Plan Year 2010	The William W. Backus Hospital

17.15.1 (c) Trust Agreement/Contracts

Name of File	Entity
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc. , Backus Physician Services
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c	The William W. Backus Hospital
17.15.1 c	The William W. Backus Hospital
17.15.1 c	The William W. Backus Hospital
17.15.1 c	Backus Home Health, CONNcare Inc. , Backus Physician Services

17.15.1 Employee Benefits

Name of File	Entity
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc. , Backus Physician Services
17.15.1 c	The William W. Backus Hospital
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17.15.1 c	The William W. Backus Hospital
17.15.1 c	The William W Backus Hospital
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c	The William W. Backus Hospital, Backus Home Health, CONNcare Inc. ,Backus Physician Services
17.15.1 c.	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

17.15.1.(d) Certified Financial Statements

Name of File	Entity
17.15.1 d 401K Plan statements 2008 and 2009	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 d 401k Plan statements 2010	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 d 403b 5500 & financials 2009	The William W. Backus Hospital
17.15.1 d 403b 5500 & financials 2010	The William W. Backus Hospital
17.15.1 d DB Plan statements 2008	The William W. Backus Hospital
17.15.1 d DB Plan statements 2009	The William W. Backus Hospital
17.15.1 d DB Plan statements 2010	The William W. Backus Hospital

17.15.1 (e) Summary plan descriptions

Name of File	Entity
17.15.1 e	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 e	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 e	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 e	The William W. Backus Hospital
17.15.1 e.	The William W. Backus Hospital

17.15.1 Employee Benefits

17.15.1 (f) Collective bargaining agreements

Name of File	Entity
17.15.1 f CBA between AFT and WWBH	The William W. Backus Hospital
17.15.1 f CBA between SPFPA and WWBH	The William W. Backus Hospital

17.15.1 (g) Determination letters

Name of File	Entity
17.15.1 g 401k IRS Opinion Letter	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 g db 11th plan amendment Determination	The William W. Backus Hospital
17.15.1 g DB Plan Determination Letter	The William W. Backus Hospital

17.15.1 (h) IRS, PBGC or Dept of Labor Notices given to Backus
None.

17.15.1 (i) IRS, PBGC or Dept of Labor Notices given by Backus
None.

17.15.1 (j) Voluntary correction filings
None.

17.15.1 (k) Sample correspondence regarding 4980B rights

Name of File	Entity
17.15.1 k 4980B Sample General Notice Letter 090410	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

17.15.1 (l) PBGC-1 forms

Name of File	Entity
17.15.1 l PBGC 2010 Filing Form	The William W. Backus Hospital
17.15.1 l PBGC 2011 Filing Form	The William W. Backus Hospital
17.15.1 l PBGC 2011 Flat Rate Filing Form	The William W. Backus Hospital
17.15.1 l PBGC 2012 Filing Form	The William W. Backus Hospital

Removed names of all payment and procurement programs.

17.16 Backus Payment Programs

The following Backus Entities are participating providers in the private, commercial, and governmental payment and procurement programs listed below:

17.17 Backus Accreditations

The William W. Backus Hospital

Name	Issuing Body
Joint Commission Hospital Accreditation (Deemed Status)	The Joint Commission
College of American Pathologists (CAP) Accreditation-Main Lab	CAP
CAP Accreditation- POCT	CAP
Echocardiology Accreditation	Intersocietal Commission for the Accreditation of Echocardiography Laboratories
Commission on Cancer	American College of Surgeons
National Accreditation Program of Breast Centers	American College of Surgeons
Trauma Accreditation	American College of Surgeons
Primary Stroke Center Designation	State of Connecticut Department of Public Health
CT Scan	American College of Radiology
Nuclear Medicine	American College of Radiology
MRI	American College of Radiology
PET/CT	American College of Radiology
Ultrasound	American College of Radiology
Breast Ultrasound	American College of Radiology
Breast MRI	American College of Radiology
Stereotactic Breast BX	American College of Radiology
Mammography	American College of Radiology

Backus Home Health Care

Name	Issuing Body
Home Health Care Accreditation	Community Health Accreditation Program (CHAP)

17.18 Backus Defaults

None.

17.19 Backus Exclusion from Health Care Programs

None.

Schedule 18.3.1

Hartford HealthCare Third Party Approvals

None.

Schedule 18.3.2

Hartford HealthCare Governmental Approvals

None.

Schedule 18.5

Hartford HealthCare Compliance with Laws

On June 26, 2012, Hartford HealthCare was informed by one of its vendors (EMC Corporation) that one of their laptops which contained Hartford Hospital and VNA Health Care patient data was stolen. Hartford HealthCare is investigating this matter, has noticed affected patients and established appropriate identity theft protections for these patients. All relevant state and federal regulatory authorities have been notified.

Schedule 18.7

Hartford HealthCare Legal Proceedings

None.

21.1.55(c) Backus Capital Expenditures Greater than $5 Million

PROJECT	BUDGET
A3/A4 Window Project	$250,000
E Wing/A Wing Elevator Upgrades Study/Budget	$650,000
Electrical Efficiency Review	$270,000
Emergency Generators Montville & Colchester	$250,000
Lab (55 Town Street)	$350,000
OR Temperature/Humidity	$400,000
Plainfield Emergency Center (remaining balance due developer)	$500,000
Laboratory – Tissue Processor	$150,000
Diagnostic Imaging – CT & Ultrasound Machines	$950,000
IT – Scanning software replacement & Medical Equipment Interfaces	$300,000
Security – Access control upgrades/replacement	$350,000

Exhibit 1.1

Backus Amended and Restated Governing Documents

See attached.

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

OF

BACKUS CORPORATION

1. The name of the corporation is **Backus Corporation** (the "Corporation").

2. The Corporation is organized and shall be operated exclusively for charitable, scientific, literary and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall be operated as a component part of the integrated health care delivery system (the "System") of which the parent is Hartford HealthCare Corporation. The nature and activities to be conducted, or the purposes to be promoted or carried out by the Corporation are as follows:

(a) to promote the delivery of quality and cost-effective health care services in the Eastern Connecticut region as a constituent part of the System, and to foster the accountability of the Corporation's affiliates to the strategic objectives developed by the System; and

(b) otherwise to engage in any lawful act or activity consistent with the foregoing for which corporations may be formed under the Connecticut Revised Nonstock Corporation Act (the "Act").

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions or dividends.

4. The Corporation shall have a single member, namely, Hartford HealthCare Corporation, a Connecticut nonstock corporation (the "Member"). The Member shall have the power to elect directors of the Corporation ("Directors") and to remove Directors with or without cause, shall have the power to adopt and amend the Bylaws of the Corporation (the "Bylaws"), and shall have such other rights, powers and responsibilities as are accorded to members under the Act, this Certificate of Incorporation or the Bylaws.

5. The Corporation shall operate under the management of its Board of Directors (the "Board"), and the Directors who shall be elected by the Member as provided in the Bylaws of the Corporation. The corporate powers of the Board, and any applicable limitations thereon, shall be as set forth in the Bylaws as in effect from time to time. The Bylaws shall prescribe the number, qualifications and manner of election of Directors. In the event a Director ceases to be in office, the Board shall fill the vacancy caused thereby until the next annual meeting of the Member of the Corporation held for the purpose of electing Directors. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio Directors of the Board who may vote and be counted in determining a quorum. As may be further provided in the Bylaws, the terms of elected Directors of the Board may be staggered by dividing the Directors

into up to three (3) groups so that approximately an equal number of such Directors have terms that expire each year.

6. Notwithstanding any other provision of this Amended and Restated Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on: (a) by an organization exempt from federal income tax under Section 501(a) of the Code as an organization described in Section 501(c)(3) of the Code; or (b) by an organization, contributions to which are deductible under Section 170(c)(2) of the Code.

7. The net earnings of the Corporation or any part thereof may not be distributed to or inure to the benefit of any private individual or a Director or officer of the Corporation. However, nothing herein shall restrict the right of the Corporation to reasonably compensate any officer, Director or other individual for services rendered to the Corporation or to reimburse any officer, Director or other individual for expenses, disbursements or liabilities properly made or incurred, on account of that individual's service to the Corporation.

8. A substantial part of the activities of the Corporation shall not consist of carrying on propaganda or attempting to influence legislation. The Corporation may not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

9. Upon dissolution of the Corporation, the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the purposes of the Corporation, to the Member exclusively for its charitable, scientific, literary or educational purposes, provided the Member shall be then exempt from federal taxation as an organization described in Section 501(c)(3) of the Code. If the Member shall not be so qualified as an organization described in Section 501(c)(3) of the Code, then the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the charitable, scientific, literary or educational purposes of the Corporation, to one or more organizations as shall be then exempt from federal taxation as an organization or organizations described in Section 501(c)(3) of the Code, in such proportions and amounts and in such manner as the Board shall determine. No part of the Corporation's assets shall ever be distributed to its Directors or officers, or inure to the benefit of any private individual.

10. The personal liability of a Director of the Corporation to the Corporation for monetary damages for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act or any other applicable laws presently or hereafter in effect. Without limiting the effect of the preceding sentence, no Director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of duty as a Director of the Corporation in an amount greater than the compensation received by the Director for serving the Corporation during the year of the violation if such breach did not: (i) involve a knowing and culpable violation of law by the Director; (ii) enable the Director, or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain; (iii) show a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. No amendment to, or modification or repeal of, this Article 10 shall adversely affect any right or protection of a Director of the Corporation existing hereunder with

respect to any act or omission occurring prior to such amendment, modification or repeal. Nothing contained in this Article 10 shall be construed to deny to the Directors of the Corporation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation.

11. The Corporation shall indemnify a Director for a liability, as defined in Section 33-1116(5) of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that: (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including reasonable attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both: (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Article 10 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Article 11. Such expenses (including reasonable attorneys' fees) incurred by other employees and agents may be so paid upon such terms and conditions, if any, as the Board deems appropriate. The indemnification and advancement of expenses provided by, or granted pursuant to, this Article 11 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

12. References in this Amended and Restated Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act, and references to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or as the same may hereafter be amended from time to time.

AMENDED AND RESTATED
BYLAWS

OF

BACKUS CORPORATION

* * * * * * *

ARTICLE 1

NAME; PURPOSE; DEFINITIONS

1.1 Name. The name of the corporation is Backus Corporation (the "Corporation").

1.2 Purpose. The Corporation is organized and shall be operated for the purposes set forth in the Certificate of Incorporation.

1.3 Definitions. The following terms used in these Bylaws shall have the following

(a) "Act" shall mean the Connecticut Revised Nonstock Corporation Act, as amended from time to time.

(b) "Affiliation Agreement" shall mean the agreement effectuating the full corporate affiliation between the Member and the Corporation, executed as of August 17, 2012 and effective on the Closing Date.

(c) "Backus Hospital" shall mean The William W. Backus Hospital.

(d) "Certificate of Incorporation" shall mean the Corporation's certificate of incorporation, as the same may be amended from time to time.

(e) "Closing Date" shall mean the date on which the affiliation between the Member and the Corporation is fully consummated in accordance with the terms of the Affiliation Agreement.

(f) "Corporation's President and CEO" shall mean the President and Chief Executive Officer of the Corporation.

(g) "Member" shall mean Hartford HealthCare Corporation, a Connecticut nonstock corporation.

(h) "Subsidiary" or "Subsidiaries" shall mean any entity directly or indirectly controlled by the Corporation. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of an entity, whether through the ability to exercise voting power by contract or otherwise. "Controlled" or

"Controlling" have correlative meanings. Without limiting the foregoing, each of the following entities shall be considered a Subsidiary: Backus Hospital; Backus Medical Center Condominium Association, Inc.; Community Medical Partners, Inc.; Backus Health Care, Inc.; CONNCare, Inc.; Backus Physician Services, LLC; WWB Corporation; Omni Home Health Services of Eastern Connecticut, LLC; and MedConn Collection Agency, LLC.

(i) "System" shall mean the comprehensive and integrated health care delivery system operated by the Member.

(j) "Transitional Period" shall mean a period of three years commencing on the Closing Date.

ARTICLE 2

MEMBERSHIP

2.1 Members. The Corporation shall have a single Member, namely, Hartford HealthCare Corporation.

2.2 Member's Rights and Powers. In addition to any other rights and powers which the Member may have under law, under these Bylaws or under the Certificate of Incorporation, the Member shall have the right and power to:

(a) Approve the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation and its Subsidiaries, including but not limited to approving capital and operating budgets;

(b) Approve the mission of the Corporation and its Subsidiaries;

(c) Approve the vision of the Corporation and its Subsidiaries;

(d) Approve the formation or acquisition by the Corporation or any Subsidiary of any direct or indirect subsidiaries, joint ventures or affiliations;

(e) Approve the Certificate of Incorporation and Bylaws of the Corporation and each Subsidiary, and any amendments thereto or restatements thereof; provided, however, the Member: (i) will not, during the Transitional Period, impose any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that are inconsistent with the terms of the Affiliation Agreement; (ii) will consult with the Corporation Board prior to implementing any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that are related to the Member's system-wide changes; and (iii) will, during the Transitional Period, obtain the approval of the Corporation Board prior to imposing any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that only apply to the Corporation and Backus Hospital and are not related to System-wide changes;

(f) Approve the governance documents of the Corporation and each Subsidiary, and any amendments thereto or restatements thereof;

(g) Appoint and remove with or without cause all directors ("Directors") and officers for the Corporation and determine the committee structure for the Corporation, including but not limited to appointing individuals to fill vacancies on the Corporation's Board of Directors ("Board"), subject to the provisions of Sections 3.2(c) and 3.6 of these Bylaws;

(h) Approve all core competencies and qualifications required for selection of the Board;

(i) Approve any guidelines for centralized accounting or debt management programs for the System, establish any debt limits under such programs, and approve any variances from such guidelines and set specific limits for the Corporation and its Subsidiaries;

(j) Approve the Corporation's borrowing of any sum in excess of one million dollars which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's or Backus Hospital's real property or by a security interest in the Corporation's or Backus Hospital's assets or revenues;

(k) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation and its Subsidiaries, subject to any established guidelines;

(l) Approve the spectrum of services offered by the Subsidiaries and approve the introduction or termination of any service, including without limitation the filing of any application for a certificate of need with the State of Connecticut; provided, however, that during the Transitional Period, any decision to reduce or terminate a material clinical service that Backus Hospital provided as of the Execution Date of the Affiliation Agreement shall occur only after prior consultation with, and the consent of, the Corporation Board;

(m) Approve the sale, transfer or substantial change in the use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation or change in corporate membership or ownership, or corporate reorganization of the Corporation or any Subsidiary of the Corporation;

(n) Approve the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(o) Approve the Corporation's filing of a voluntary petition for bankruptcy;

(p) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal government authorities;

(q) Accept evaluations submitted by the Board, with respect to the performance of the Board, the chair of the Board (the "Chair") and the vice chair of the Board (the "Vice Chair");

(r) Delegate to the Member's President and Chief Executive Officer (the "Member's President and CEO") the Member's powers of review or approval of actions on matters related to

the Corporation to the extent permitted by law, the Certificate of Incorporation and these Bylaws;

(s) Approve the giving of any vote, consent or approval by the Corporation as the member, partner, shareholder or other direct or in direct owner of another organization where such vote, consent or approval is required by statute, regulation, the certificate or articles of incorporation, Bylaws, partnership certificate or agreement, operating agreement, voting or shareholders agreement or other similar organizational or organic document of such other organization; and

(t) Take such other actions and steps as maybe necessary to maintain the long-range financial strength and viability of the Corporation.

2.3 System Parent Rights. In addition to the Member's rights and powers set forth above, in the event that the Corporation has the right to give or withhold its approval, vote or consent as a member, partner, shareholder or other owner of a Subsidiary or other organization where such approval, vote or consent is required by statute, regulation, the certificate or articles of incorporation, bylaws, partnership certificate or agreement, operating agreement, voting or shareholders agreement or other similar organizational or organic document of such other organization, the Corporation shall only give or withhold such approval, vote or consent as directed by the Member.

2.4 Manner of Acting. In the exercise of its powers, the Member may act through the Member's President and CEO or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws. All action of the Member may be taken by written consent in lieu of a meeting, including in lieu of the annual meeting of the Member for the election of Directors.

ARTICLE 3

BOARD OF DIRECTORS

3.1 Powers and Duties, Functions. The property and affairs of the Corporation shall be managed and conducted by the Board which may authorize and direct the Corporation to exercise all such powers and do all such things as may be exercised or done by the Corporation but subject nevertheless to the provisions of the Corporation's Certificate of Incorporation, these Bylaws, the laws of the State of Connecticut and the laws of the United States of America, and subject to the powers and rights of the Member. In exercising any of its powers of review or approval of actions or matters relating to any Subsidiary, to the extent permitted by law, the Certificate of Incorporation and these Bylaws, the Board may delegate such powers to the Corporation's President and CEO.

3.2 Election, Number, Term of Office, Class and Term Limits.

(a) Election. The Board may recommend to the Member individuals who meet the core competencies and qualifications recommended by the Member to serve as Directors and officers of the Corporation. The Member shall annually appoint individuals to the Board of Directors from among candidates recommended by the Member's Nominating and Governance Committee. The Member may elect Directors to serve on the Corporation's Board at other special or regular meetings of the Corporation for the purpose of increasing the size of the Board or to fill vacancies on the Board.

(b) Number. Following the Transitional Period, the Board shall be comprised of fifteen (15) Directors. Twelve (12) of the Directors (the "Elected Directors") shall be elected from individuals recommended by the Governance Committee as members of the community served by the Hospital, chosen for their leadership, experience, expertise, voluntary service and philanthropic inclination, and one of whom shall be a member of the Hospital's Medical Staff (the "Elected Director from the Medical Staff"). The Elected Director from the Medical Staff shall be chosen from a list of no more than three (3) members in good standing of the Hospital's Medical Staff provided to the Governance Committee of the Board by the Hospital's Medical Staff; provided, however, that: (i) the Governance Committee may request that the Hospital's Medical Staff recommend for election as the Elected Director from the Medical Staff members in good standing of the Hospital's Medical Staff in addition to those identified on the initial list provided to the Governance Committee; and (ii) if a list of candidates for the Elected Director from the Medical Staff is not provided by the Hospital's Medical Staff to the Governance Committee within thirty (30) days of a written request for such list (or additional list(s)), the Governance Committee may nominate any member in good standing of the Medical Staff of the Hospital for election as the Elected Director from the Medical Staff. The remaining three (3) Directors (the "Ex-Officio Directors") shall be the Chief Executive Officer, the President of the Hospital's Medical Staff and the Vice President of the Hospital's Medical Staff. The Elected Directors and the Ex-Officio Directors shall each have a vote and shall be counted for quorum purposes. Notwithstanding the foregoing, during the Transitional Period, the Board shall be comprised of seventeen (17) Directors, which shall include fifteen (15) directors described above and the two (2) HHC-Appointed Directors (defined below).

(c) Transitional Period. Notwithstanding anything to the contrary contained in these Bylaws, the Directors serving on the Corporation Board on the day prior to the Closing Date will continue to serve as Directors during the Transitional Period (the "Legacy Directors"). The Member shall appoint two (2) representatives to serve as Directors during the Transitional Period (the "HHC-Appointed Directors"). During the Transitional Period, additional Directors may be nominated and elected in accordance with these Bylaws.

(d) Classes; Manner of Election; Term of Office. With respect to all Directors other than the Legacy Directors and the HHC-Appointed Directors, the Board shall be divided into three (3) classes, comprised of as equal a number of Directors per class as possible. Each class of Directors shall serve for term of three (3) years, with terms staggered so that approximately one-third (1/3) of the Directors shall be elected by the Member annually. The Directors so elected annually shall hold their offices for a term to expire at the third (3rd) annual meeting after their election and until others shall be elected or appointed in their places. A Director elected at any other meeting or time to fill a vacancy shall hold office only for the unexpired term, unless elected to continue to fill additional terms. In the event that a Director is filling an

unexpired term created by a Board vacancy, such Director may not serve on the Board for more than nine (9) consecutive years, including any terms preceding or subsequent to such Director's term during which they are filling a vacancy.

(e) Term Limits. There shall be a limit of three (3) consecutive full terms which an individual may serve as a Director. Any Director who shall serve for three (3) consecutive full terms shall not be eligible for appointment to a further term or terms until the annual meeting of the Board immediately following the expiration of such third successive full term. For purposes of this limitation, a partial term served as the result of filling a vacancy shall not be counted as a "full term". The Board may waive the above term limit to permit a Director to serve as Board Chair and/or Board Vice Chair, provided such waiver shall be for not more than one (1) additional year to an existing term. Notwithstanding the foregoing, (i) a Director's term shall end upon his or her death, resignation, or removal as provided in these Bylaws; and (ii) a Director of the Corporation who has served for three (3) consecutive full terms will be immediately eligible for appointment to the board of any one of the health care entities which comprise the System.

(f) Director Restrictions. No Director of the Corporation shall serve simultaneously on the Board of Directors of the Corporation and on the board of directors of the Member; provided, however, pursuant to the Affiliation Agreement, during the Transitional Period, the Corporation may nominate, and the Member shall approve, two individuals from the Corporation Board to serve as directors of the Member. The foregoing restrictions shall not apply to the HHC-Appointed Directors or any executive of the Corporation who serves on the board of directors of any non-hospital Subsidiary in an ex-officio capacity.

(g) Ex-Officio Directors. Each Ex-Officio Director shall cease to be a Director immediately and automatically upon ceasing to hold the office from which his or her ex-officio status derives, without the need for any action by the Member, the Corporation or its Directors. There shall be no other ex-officio members on the Board.

(h) Board Competencies and Qualifications. The Corporation shall have a written policy approved by the Member with respect to the qualifications and core competencies for the selection of the persons appointed to the Board.

(i) Special Requirements for Board. The Board shall ensure that the Member's President and CEO is at all times an invited guest at the Board meetings, with attendance at such Board meetings to be left to the sole discretion of the Member's President and CEO.

(j) Honorary Roles. The Board may grant honorary roles, such as the role of Director Emeritus, for individuals who have ceased to serve as Directors. Such roles shall be without any governance responsibilities, including but not limited to voting rights or the right to attend, receive material from, or participate in meetings of the Board.

3.3 Board Meetings. The Board shall hold a maximum of six (6) regular meetings each year, one of which shall also serve as its annual meeting. All meetings, annual, regular or special, shall be held at such place or places within or without the State of Connecticut as the

Board may from time to time by resolution determine or as shall be specified or fixed in the notice or waiver of notice thereof.

(a) Annual Meetings. An annual meeting of the Board for the transaction of such business as may properly come before the Board shall be held following the annual meeting of the Member of the Corporation in each year, at such time and place as shall be determined by the Board.

(b) Regular Meetings. Regular meetings of the Board shall be held at such times as shall be specified in a resolution adopted by the Board then in effect, or if there shall not be any such resolution then in effect, as shall be specified in a notice of such meeting.

(c) Special Meetings. Special meetings of the Board shall be held whenever called by the Board Chair, by the Corporation's President and CEO, by the Member, or by at least two (2) of the Directors then in office.

(d) Notice. At least two (2) days' written, oral or electronic notice of each special meeting stating the time and place of the meeting shall be given to each Director by the Corporation's President and CEO or by the Secretary, or in the case of a special meeting that has been called by the Directors, by the Directors calling the meeting. Except as otherwise provided in these Bylaws or as otherwise required by law, neither the business to be transacted at, nor the purpose of any special meeting of the Board, need be specified in the notice or waiver of notice of such meeting.

(e) Waiver of Notice. The attendance of a Director at any meeting without protesting prior to the commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him or her of notice of such meeting.

(f) Telephonic Participation at a Board Meeting. Directors may participate in a meeting of the Board by use of a conference telephone or similar communications equipment which allows all persons participating in the meeting to simultaneously hear each other and to communicate with one another.

(g) Quorum. A majority of the number of Directors then in office shall constitute a quorum for the transaction of business.

(h) Adjournment. A majority of the Directors present at any meeting of the Board, including a meeting at which a quorum is not present, thereat may adjourn the meeting to another time and place. Notice of any adjourned meeting need not be given unless the meeting shall have been adjourned for more than three (3) days.

3.4 Vote Required for Action. The act of a majority of the Directors present at any meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the vote of a greater or lesser proportion is otherwise required by law. If all the Directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, such action shall be the act of the Board with the same force and effect as though it had been authorized at a duly called and held meeting of the Board.

3.5 Resignation. Any Director of the Corporation may resign at any time by giving written notice to the Corporation's President and CEO. In the event of a resignation of a Director without written notice, the Corporation's President and CEO shall confirm such resignation in writing. Such resignation shall take effect at the time specified therein. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. A vacancy on the Board thereby created shall be filled as provided in Section 3.7 hereof.

3.6 Removal. Any Director may be removed from the Board of Directors with or without cause by the Member. Such action may be taken at any annual meeting, any regular meeting or any special meeting, provided that due notice of the proposed removal shall have been duly given to the subject Director. Notwithstanding the foregoing, during the Transitional Period the Member shall only exercise its power to remove a Legacy Director if such removal is for cause and after prior consultation with the Chair of the Backus Board.

3.7 Vacancies. In the event a Director ceases to be in office, the Member shall have the power to fill the vacancy caused thereby, and the person elected to fill such vacancy shall hold office for the unexpired portion of the term of his or her predecessor.

ARTICLE 4

COMMITTEES

4.1 Committees. The Board may designate two (2) or more Directors, plus such additional individuals, to constitute a committee, which may be standing or ad hoc. The Member may designate one or more of the Corporation's Directors to chair a committee. Committees shall have and may exercise all such authority of the Board as shall be provided in resolutions of appointment, except that only Directors may be members of a committee that has and exercises the authority of the Board, and no such committee shall have any power or authority prohibited by law or as to the following:

(a) filling of vacancies in the Board or any of its committees;

(b) amending the Certificate of Incorporation;

(c) adopting, amending or repealing these Bylaws;

(d) amending or repealing of any resolution of the Board;

(e) approving a plan of merger, a sale, lease, exchange or other disposition of all or substantially all of the property of the Corporation or of a proposal to dissolve the Corporation;

(f) acting on matters committed by these Bylaws or a resolution of the Board to the Member, or to another committee of the Board.

Except as provided in these Bylaws, members of committees and their respective chairpersons shall be appointed by the Board at the annual meeting of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

4.2 Standing Committees. There shall be a Board Governance Committee, a Fundraising Committee, and such additional standing committees as the Member may from time to time establish. Except as set forth in these Bylaws, members of committees need not be Directors of the Corporation. All chairpersons of a committee shall be Directors of the Corporation.

4.3 Board Governance Committee. The Board Governance Committee shall identify qualified candidates and recommend nominations for Directors, and officers of the Corporation to the Member's Nominating and Governance Committee. The Board Governance Committee shall also oversee any Board self-evaluation process; evaluating the Chair and Vice Chair, and consulting with the Member's President and CEO on any annual performance objectives, performance and compensation of the Corporation's President and CEO. The Board Governance Committee shall also advise the Board on matters related to governance of the Corporation, Director performance evaluation and oversight of any Director conflict of interest matters. The Board Governance Committee shall have the responsibilities and shall follow the procedures set forth in the Board Governance Committee Charter as adopted by the Board.

4.4 Fundraising Committee. The Fundraising Committee shall assist the management of the Corporation in fund development matters, shall participate in the formulation of plans and programs to enhance the Corporation's ability to generate financial support from public and private sources, and shall make recommendations and reports to the Board from time to time as it may deem appropriate and as may be consistent with the System's overall fundraising and development objectives. The Fundraising Committee shall have the responsibilities and shall follow the procedures set forth in the Fundraising Committee Charter as adopted by the Board.

4.5 Procedures, Actions by Committee. Subject to any charter adopted by the Board for the governance of any committee, each committee of the Board shall act in accordance with the following procedures: Each committee shall adopt a schedule of regular meetings and shall hold additional special meetings on the call of the committee chair or any two committee members. Notice of each such meeting shall be given to all committee members in the manner provided for notice of regular meetings of the Board. All members of a committee shall be entitled to participate in committee activities and shall have full voting rights on actions taken by such committee. A majority of voting members of the committee shall constitute a quorum for all business. The act of a majority of voting members of the committee present at any meeting duly held at which a quorum is present at the time of the act shall be the act of the committee; and if less than a quorum is present at any committee meeting, a majority of the voting members of the committee present may adjourn such meeting from time to time without notice. Each committee shall keep a record of its proceedings and shall report to the Board as requested. The term of office of a committee member shall be determined by the Board. Members of a committee may be removed at any time by the Board with or without cause.

ARTICLE 5

OFFICERS

5.1 Term and Election of Officers. The Member shall elect the Corporation's Chair and a Vice Chair of the Board. The Secretary and Treasurer of the Corporation shall be appointed by the Board at the annual meeting of the Corporation upon recommendation of the Corporation's President and CEO. The Member's President and CEO shall appoint the Corporation's President and CEO. Each officer shall hold office for the term for which he or she is elected and until his or her successor shall have been duly elected and qualified. Unless otherwise provided in a resolution electing an officer, his or her term of office shall extend to and expire on the date of the next annual meeting of the Board following his or her election. However if earlier, an officer's term shall end upon his or her death, resignation or removal as provided in these Bylaws.

5.2 Chair. The Chair shall preside at all meetings of the Board and shall have such powers and duties as from time to time may be determined by the Board. The Board shall recommend to the Member an individual from among the Directors to serve as Chair.

5.3 Vice Chair. The Vice Chair shall perform the duties of the Chair in the event of the Chair's absence or disability and shall assist the Chair in such duties as the Chair may from time to time assign to the Vice Chair. The Vice Chair shall not automatically succeed to the position of Chair. The Board shall recommend to the Member an individual from among the Directors to serve as Vice Chair.

5.4 The Corporation's President and CEO. The Member's President and CEO shall appoint the Corporation's President and CEO and shall establish the objectives, evaluate the performance and determine the compensation for the Corporation's President and CEO. The removal of the Corporation's President and CEO shall be at the discretion of the Member's President and CEO; provided, however, that during the Transitional Period, any removal of the Corporation's President and CEO shall be made only after consultation with the Corporation's Board. The Corporation's President and CEO shall be the chief executive officer of the Corporation. Subject to the powers expressly reserved to the Board or the Corporation's Member, the Corporation's President and CEO shall, in general, supervise and control all the business and affairs of the Corporation and shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair or Vice Chair has been appointed or in the absence of the Chair or Vice Chair, the Corporation's President and CEO shall preside at each meeting of the Board. The Corporation's President and CEO shall see that all orders and resolutions of the Board and of the committees of the Board are carried into effect. In general, he or she shall perform all duties incident to the office of President and CEO and such other duties as may from time to time be assigned to the Corporation's President and CEO by these Bylaws, by the Board, or by the Member's President and CEO.

Without limiting the foregoing, the Corporation's President and CEO shall have the power to:

(a) Be responsible for coordinating the business affairs of the Corporation within overall System guidelines;

(b) Recommend the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation and its Subsidiaries, including but not limited to capital and operating budgets, to the Member upon consultation with the Board;

(c) Recommend to the Member the vision of the Corporation and of its Subsidiaries;

(d) Recommend to the Board any incurrence or assumption of debt by the Corporation or its Subsidiaries in accordance with the guidelines established by the Member for the System's centralized debt management program;

(e) Identify the need for the Corporation's formation of any new legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, and/or disposition of assets closures, mergers, consolidations or changes in corporate membership or ownership of the Corporation or any Subsidiary of the Corporation; and

(f) Recommend to the Member the need for the introduction or termination of any service and the filing of any application for a certificate of need with the State of Connecticut.

5.5 Treasurer. The Treasurer shall have charge and custody of and be responsible for all the funds and securities of the Corporation; he or she shall keep full and accurate accounts of assets, liabilities, receipts and disbursements and other transactions of the Corporation in books belonging to the Corporation; and he or she shall see that all moneys and other valuable effects of the Corporation are deposited or invested in the name of and to the credit of the Corporation in such banks or other financial institutions as may be designated by the Board. The Treasurer shall disburse or oversee the disbursement of the funds of the Corporation as may be ordered by the Board, taking proper vouchers for disbursements, and shall render to the Corporation's President and CEO and to the Directors at the meetings of the Board, or whenever they may require it, a statement of all his or her transactions as Treasurer and an account of the financial condition of the Corporation. In general, he or she shall perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Board or by the Corporation's President and CEO.

5.6 Secretary. The Secretary shall serve all notices for the Corporation that have been authorized by the Board; keep the minutes of the meetings of the Board and the Member; be the custodian of the corporate records and of the seal of the Corporation; and in general, perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the Board or the Corporation's President and CEO.

5.7 Other Officers. The Board may from time to time appoint such other Board officers as may be deemed necessary or advisable for the efficient operation of the Corporation's affairs, each of whom shall hold office for such period, have such authority and perform such duties as the Member may from time to time determine.

5.8 Removal of Officers. Irrespective of term of office, but subject to any written contract rights or any other provisions in these Bylaws, any officer of the Board may be removed with or without cause at any time by the Member.

5.9 Vacancies. Except as otherwise provided in these Bylaws, if the office of the President and Chief Executive Officer, the Chair, Vice Chair, or any other officer appointed by the Member becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by the Member. If the office of Treasurer, Secretary, Assistant Secretary, or any other officer appointed by the Board becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by the Board.

5.10 Resignations. Any officer of the Corporation may resign his or her office at any time by giving written notice thereof to the Corporation's President and CEO or to the Board. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

ARTICLE 6

CONFLICT OF INTEREST

All Directors and officers of the Corporation shall be subject to and abide by the terms of the Corporation's Conflict of Interest Policy maintained on record by the Corporation, a copy of which has been provided to all Directors and officers.

ARTICLE 7

INDEMNIFICATION

7.1 Limitation of Liability. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act, or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability (as defined in Section 33-1116 of the Act) to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director, (ii) enabled the Director or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal gain, (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

7.2 Indemnification of Directors and Officers. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect.

7.3 Expenses. Expenses incurred by a Director or officer in defending a civil or criminal action, suit or proceeding shall be paid for or reimbursed by the Corporation to the fullest extent permitted by law in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such Director or officer of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under the Certificate of Incorporation or these Bylaws and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall be ultimately determined that such director or officer is not entitled to be indemnified by the Corporation. Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon the terms and conditions, if any, as the Board of Directors deems appropriate.

7.4 Non-exclusivity. The indemnification and advancement of expenses provided for herein shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a Director or officer and shall inure to the benefit of the heirs, executors and administrators of such a person. Notwithstanding the foregoing, the Corporation shall not provide such indemnification or advancement for expenses to the extent that such indemnification or advancement would constitute self-dealing within the meaning of section 4941(d) of the Internal Revenue Code of 1986, as amended.

7.5 Amendment or Repeal. No amendment to or repeal of this Article 7 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

ARTICLE 8

MISCELLANEOUS PROVISIONS

8.1 Notice. Any notice required or permitted to be given under these Bylaws in writing shall be deemed to have been delivered if delivered in person or if sent by United States mail, overnight delivery, telegraph (charges prepaid), telex, facsimile, fax or email and addressed to such person at the address shown on the records of the Corporation or the address supplied by him or her to the Corporation for the purpose of notice. If such notice is sent by mail, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail.

8.2 Amendment. The Member shall have the exclusive power to make, amend or repeal the Corporation's Certificate of Incorporation or these Bylaws, subject to the limitations set forth in Section 2.2(e).

8.3 Execution of Contracts. The Board may authorize any officer or officers and any agent or agents to enter into any contract or execute any instrument in the name of, and on behalf of, the Corporation, and such authority may be general or limited to specified instances. No officer, agent or employee shall have any power or authority to bind or obligate the Corporation by any commitment, contract or engagement, or to pledge its credit or render it liable for any purpose or in any amount unless duly authorized by the Board.

8.4 Compensation for Services. The Corporation may reimburse any Director for expenses incurred in connection with fulfilling his or her duties as a member of the Board, provided that the amount of such reimbursement is reasonable and not excessive.

8.5 Consistency with Affiliation Agreement. In the event of a conflict between any provision of these Bylaws and the terms of the Affiliation Agreement, the provisions of the Affiliation Agreement shall control.

AMENDED AND RESTATED

CERTIFICATE OF INCORPORATION

OF

THE WILLIAM W. BACKUS HOSPITAL

The William W. Backus Hospital, a specially chartered Connecticut nonstock corporation, was formed under Special Act No. 24 of 1893 by the Connecticut General Assembly, entitled "*Incorporating The William W. Backus Hospital*" (the "Special Act"), which Special Act has been amended several times (as amended to date, the "Charter"). The persons named as corporators in the Special Act and their successors forever are hereby incorporated under the name of The William W. Backus Hospital. The Charter is hereby amended and restated in its entirety as set forth in the following Amended and Restated Certificate of Incorporation:

1. The name of the corporation is **The William W. Backus Hospital** (the "Corporation").

2. The Corporation is organized and shall be operated exclusively for charitable, scientific, literary or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall be operated as a component part of the integrated health care delivery system of which the parent is Hartford HealthCare Corporation (the "System Parent"). The nature and activities to be conducted, or the purposes to be promoted or carried out by the Corporation are as follows:

(a) maintaining one or more hospital facilities in the City of Norwich, Connecticut, and the Eastern Connecticut region;

(b) establishing and maintaining health care facilities in the City of Norwich and additional communities served by the Corporation;

(c) providing health and wellness services, promoting the general health of the communities served by the Corporation and providing educational services in furtherance of the foregoing;

(d) engaging in medical research to improve health care and its delivery;

(e) providing medical and graduate medical education programs; and

(f) in furtherance of the foregoing, engaging in any lawful act or activity for which corporations may be formed under the Revised Nonstock Corporation Act of the State of Connecticut (the "Act") as the same may be amended.

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions or pay dividends.

4. The Corporation shall have a single member, namely, Backus Corporation, a Connecticut nonstock corporation ("Backus" or the "Member"). The Member shall have such rights, powers and responsibilities as are accorded to members under the Act, this Certificate of Incorporation and as are set forth in the Corporation's Bylaws.

5. The Corporation shall operate under the management of a Board of Directors (the "Board"). The corporate powers of the Board, and any applicable limitations thereon, shall be as set forth in the Bylaws as in effect from time to time. The directors of the Corporation (the "Directors") shall be elected as provided in the Corporation's Bylaws, which shall prescribe the number, qualifications and manner of election of Directors. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio Directors of the Board who may vote and be counted in determining a quorum. As may be further provided in the Bylaws, the terms of elected Directors of the Board may be staggered by dividing the Directors into up to three (3) groups so that approximately an equal number of such Directors have terms that expire each year.

6. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on: (a) by an organization exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986, as amended (the "Code") as an organization described in Section 501(c)(3) of the Code; or (b) by an organization, contributions to which are deductible under Section 170(c)(2) of the Code.

7. The net earnings of the Corporation or any part thereof may not be distributed to or inure to the benefit of any private individual or a Director or officer of the Corporation. However, nothing herein shall restrict the right of the Corporation to reasonably compensate any officer, Director or other individual for services rendered to the Corporation or to reimburse any officer, Director or other individual for expenses, disbursements or liabilities properly made or incurred, on account of that individual's service to the Corporation.

8. A substantial part of the activities of the Corporation shall not consist of carrying on propaganda or attempting to influence legislation. The Corporation may not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

9. Upon dissolution of the Corporation, the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the purposes of the Corporation, to the Member or to the System Parent exclusively for its charitable, scientific, literary or educational purposes, provided that either the Member or the System Parent shall be then exempt from federal taxation as an organization described in Section 501(c)(3) of the Code. If either the Member or the System Parent shall not be so qualified as an organization described in Section 501(c)(3) of the Code, then the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the charitable, scientific, literary or educational purposes of the Corporation, to one or more organizations as shall be then exempt from federal taxation as an organization or organizations described in Section 501(c)(3) of the Code, in such proportions and amounts and in such manner as the Board shall determine. No part of the Corporation's assets shall ever be distributed to its Directors or officers, or inure to the benefit of any private individual.

10. The personal liability of a Director of the Corporation to the Corporation for monetary damages for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act or any other applicable laws presently or hereafter in effect. Without limiting the effect of the preceding sentence, no Director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of duty as a Director of the Corporation in an amount greater than the compensation received by the Director for serving the Corporation during the year of the violation if such breach did not: (i) involve a knowing and culpable violation of law by the Director; (ii) enable the Director, or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain; (iii) show a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. No amendment to, or modification or repeal of, this Article 10 shall adversely affect any right or protection of a Director of the Corporation existing hereunder with respect to any act or omission occurring prior to such amendment, modification or repeal. Nothing contained in this Article 10 shall be construed to deny to the Directors of the Corporation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation.

11. The Corporation shall indemnify a Director for a liability, as defined in Section 33-1116(5) of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that: (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both: (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Article 10 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Article 11. Such expenses (including attorneys' fees) incurred by other employees and agents may be so paid upon such terms and conditions, if any, as the Board deems appropriate. The indemnification and advancement of expenses provided by, or granted pursuant to, this Article 11 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

12. References in this Amended and Restated Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act, and references to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or as the same may hereafter be amended from time to time.

AMENDED AND RESTATED

BYLAWS

OF

THE WILLIAM W. BACKUS HOSPITAL

* * * * * * *

ARTICLE 1

NAME AND PURPOSES

1.1 Name. The name of the corporation is The William W. Backus Hospital (the "Corporation").

1.2 Purpose. The Corporation is organized and shall be operated exclusively for religious, charitable, scientific, literary or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), which purposes are set forth in the Corporation's Certificate of Incorporation, as the same may be amended from time to time (the "Certificate of Incorporation"). The Corporation's primary purpose is to operate hospital facilities in the City of Norwich and the Eastern Connecticut region within the health care delivery system administered by Hartford HealthCare Corporation (the "System").

1.3 Definitions. The following terms used in these Bylaws shall have the following

(a) "Act" shall mean the Connecticut Revised Nonstock Corporation Act, as amended from time to time.

(b) "Affiliation Agreement" shall mean the agreement effectuating the full corporate affiliation between the Member and HHC, executed as of August 17, 2012 and effective on the Closing Date.

(c) "Certificate of Incorporation" shall mean the Corporation's certificate of incorporation, as the same may be amended from time to time.

(d) "Closing Date" shall mean the date on which the affiliation between HHC and the Member is fully consummated in accordance with the terms of the Affiliation Agreement.

(e) "Corporation's President and CEO" shall mean the President and Chief Executive Officer of the Corporation.

(f) "HHC" shall mean Hartford HealthCare Corporation, the parent company of the System and the sole member of the Member.

(g) "Member" shall mean Backus Corporation.

(h) "Subsidiary" or "Subsidiaries" shall mean any entity directly or indirectly controlled by the Corporation. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of an entity, whether through the ability to exercise voting power by contract or otherwise. "Controlled" or "Controlling" have correlative meanings.

(i) "System" shall mean the comprehensive and integrated health care delivery system operated by HHC.

(j) "Transitional Period" shall mean a period of three years commencing on the Closing Date.

ARTICLE 2

MEMBERSHIP

2.1 Members. The Corporation shall have a sole member, namely, Backus Corporation.

2.2 Member's Rights and Powers. In addition to any other rights and powers which the Member may have under law, under these Bylaws or under the Certificate of Incorporation, the Member shall have the right and power to:

(a) to approve the strategic plan of the Corporation and the consolidation or closure of significant lines of business, programs or services of the Corporation;

(b) to effectuate the transfer of funds from the Corporation to another corporation affiliated with the Member ("Affiliated Corporation") or from an Affiliated Corporation to the Corporation;

(c) to effectuate the Corporation's payment to or receipt of payment from the Member;

(d) to approve the acquisition or lease of any equipment and any project or construction contract that entails an expenditure by the Corporation in excess of, or with a value over, $400,000 in any fiscal year and that is not already incorporated in an approved budget of the Corporation;

(e) to approve any projects that would require a certificate of need ("CON") or for which a CON determination will be submitted to the Office of Health Care Access;

(f) to approve the reorganization, merger, consolidation or dissolution of the Corporation, or the affiliation of the Corporation with another hospital or health care delivery system, or the creation or acquisition of any subsidiary or affiliate of the Corporation;

(g) to approve the Corporation's annual operating budget and annual capital budget;

(h) to approve plans for the borrowing of any sum in excess of $400,000 which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's real property or by a security interest in the Corporation's assets or revenues; provided, however, that except as incident to the review of the capital budget pursuant to paragraph (g) above, approval by the Member shall not be necessary for any borrowing to purchase or lease equipment which is secured by a purchase money lien on such equipment or a title retention or security agreement relating solely to such equipment; and

(i) to approve amendments to the Certificate of Incorporation or Bylaws of the Corporation.

2.3 Manner of Acting. In the exercise of its powers, the Member may act through the Member's President and CEO or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws. All action of the Member may be taken by written consent in lieu of a meeting, including in lieu of the annual meeting of the Member. Any actions hereunder requiring or providing for both Member and HHC approval under these Bylaws shall not be deemed approved until such time that the Corporation receives approval from both the Member and HHC.

ARTICLE 3

HHC'S AUTHORITY

3.1 HHC's Authority. HHC is the sole member of the Corporation's Member and oversees the System and its affiliated entities, including the Corporation.

3.2 Rights and Powers of HHC. HHC, as the sole member of the Corporation's Member, shall have the ultimate authority to approve any decisions made by the Member by virtue of its rights and powers under state law. Any actions hereunder requiring both Member and HHC approval under these Bylaws shall not be deemed approved until such time that the Corporation receives approval from both the Member and HHC. Such ultimate authority granted to HHC shall include the right and power to:

(a) Approve the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation, including but not limited to approving capital and operating budgets;

(b) Approve the mission of the Corporation;

(c) Approve the vision of the Corporation;

(d) Approve the Corporation's formation or acquisition of any direct or indirect subsidiaries, joint ventures or affiliations;

(e) Approve the Certificate of Incorporation and Bylaws of the Corporation and any amendments thereto or restatements thereof; provided, however, that HHC: (i) will not, during the Transitional Period, impose any changes to the Certificate of Incorporation or Bylaws of the Corporation that are inconsistent with the terms of the Affiliation Agreement; (ii) will consult with the Member's board prior to implementing any changes to the Certificate of Incorporation or Bylaws of the Corporation that are related to HHC's system-wide changes; and (iii) will, during the Transitional Period, obtain the approval of the Member board prior to imposing any changes to the Certificate of Incorporation or Bylaws of the Corporation that only apply System-wide changes;

(f) Approve the Corporation's governance documents and any amendments thereto or restatements thereof;

(g) Appoint and remove with or without cause all directors ("Directors") and officers for the Corporation and determine the committee structure for the Corporation, including but not limited to appointing individuals to fill vacancies on the Corporation's Board of Directors ("Board"), subject to the provisions of Sections 4.2(c) and 4.6 of these Bylaws;

(h) Approve all core competencies and qualifications required for selection of the Board;

(i) Approve any guidelines for centralized accounting or debt management programs for the System, establish any debt limits under such programs, and approve any variances from such guidelines and set specific limits for the Corporation;

(j) Approve the Corporation's borrowing of any sum in excess of one million dollars which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's real property or by a security interest in the Corporation's assets or revenues;

(k) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation, subject to any established guidelines;

(l) Approve the spectrum of services offered by the Corporation and approve the introduction or termination of any service, including without limitation the filing of any application for a certificate of need with the State of Connecticut;

(m) Approve the sale, transfer or substantial change in the use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation or change in corporate membership or ownership, or corporate reorganization of the Corporation or any Subsidiary of the Corporation;

(n) Approve the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(o) Approve the Corporation's filing of a voluntary petition for bankruptcy;

(p) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal government authorities;

(q) Accept evaluations submitted by the Board, with respect to the performance of the Board, the chair of the Board (the "Chair") and the vice chair of the Board (the "Vice Chair");

(r) Delegate to HHC's President and Chief Executive Officer (the "HHC CEO") or to the Member's President and Chief Executive Officer (the "Member's President and CEO") either HHC's or the Member's powers of review or approval of actions on matters related to the Corporation to the extent permitted by law, the Certificate of Incorporation and these Bylaws; and

(s) Take such other actions and steps as maybe necessary to maintain the long-range financial strength and viability of the Corporation.

3.3 Manner of Acting. In the exercise of its powers granted hereunder, HHC may act through the HHC CEO or such other officer duly designated by HHC, acting through its board of directors, and may take such action by written consent, including the election of Directors. In the exercise of its powers, the Member may act through the Member's President and CEO, or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws.

ARTICLE 4

BOARD OF DIRECTORS

4.1 Powers and Duties, Functions. The property and affairs of the Corporation shall be managed and conducted by the Board which may authorize and direct the Corporation to exercise all such powers and do all such things as may be exercised or done by the Corporation but subject nevertheless to the provisions of the Corporation's Certificate of Incorporation, these Bylaws, the laws of the State of Connecticut and the laws of the United States of America.

Without limiting the foregoing, the Board shall have the power to:

(a) Consult with HHC and the Member on the Corporation's objectives, including but not limited to annual scorecard targets and initiatives, core values and strategic and financial plans of the Corporation, including but not limited to capital and operating budgets, subject to the recommendation of the HHC CEO;

(b) Recommend the Corporation's mission to HHC after consultation with the HHC CEO;

(c) Recommend the Corporation's vision to HHC upon the recommendation of the HHC CEO;

(d) Consult with HHC on the formation or acquisition by the Corporation of any new direct or indirect subsidiaries, joint ventures or affiliations:

(e) Recommend to HHC changes to the Corporation's Certificate of Incorporation and Bylaws upon the recommendation of the HHC CEO;

(f) Recommend to HHC changes to the Corporation's governance documents after consultation with the HHC CEO;

(g) Recommend to HHC nominations for and removal of Directors and officers of the Corporation;

(h) Subject to the approval of the Member, approve any incurrence or assumption of debt by the Corporation in accordance with the guidelines for accounting and debt management programs established by HHC;

(i) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation, subject to approval of Member and any guidelines established by HHC;

(j) Recommend the Corporation's introduction or termination of any service and the filing on any application for a certificate of need with the State of Connecticut, subject to the approval of the Member and HHC;

(k) Consult with Member and HHC on the sale, transfer or substantial change in use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any subsidiary of the Corporation, each with the recommendation of the HHC CEO;

(l) Approve the Corporation's uses, investment and management of permanent and temporarily restricted endowment funds, subject to Member's and HHC's approval and with the recommendation of the HHC CEO;

(m) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal governmental authorities, subject to HHC's approval;

(n) Evaluate the Corporation's Board performance, including the performance of the Chair and the Vice Chair for submission to HHC;

(o) Consult with the HHC CEO on the appointment and removal of the Corporation's President and CEO;

(p) Consult with the HHC CEO on the annual performance objectives, performance and compensation of the Corporation's President and CEO:

(q) Approve actions with respect to the privileges and credentials of members of the Corporation's medical staff in accordance with state and federal law, applicable accreditation standards, the Corporation's Medical Staff Bylaws and System guidelines created by HHC;

(r) Approve quality and patient safety programs and initiatives for the Corporation in coordination with the programs and initiatives developed by the System;

(s) Oversee and approve the Corporation's programs to assure corporate and regulatory compliance;

(t) Oversee and approve the Corporation's community needs assessments and community initiatives; and

(u) Approve the Corporation's fundraising and development program.

4.2 Election, Number, Term of Office, Class and Term Limits.

(a) Election. The Board may recommend to HHC individuals who meet the core competencies and qualifications recommended by HHC to serve as Directors and officers of the Corporation. HHC shall annually elect individuals to the Board of Directors from among candidates recommended by HHC's Nominating and Governance Committee. HHC may elect Directors to serve on the Corporation's Board at other special or regular meetings of the Corporation for the purpose of increasing the size of the Board or to fill vacancies on the Board.

(b) Number. Following the Transitional Period, the Board shall be comprised of fifteen (15) Directors. Twelve (12) of the Directors (the "Elected Directors") shall be elected from individuals recommended by the Governance Committee as members of the community served by the Hospital, chosen for their leadership, experience, expertise, voluntary service and philanthropic inclination, and one of whom shall be a member of the Hospital's Medical Staff (the "Elected Director from the Medical Staff"). The Elected Director from the Medical Staff shall be chosen from a list of no more than three (3) members in good standing of the Hospital's Medical Staff provided to the Governance Committee of the Board by the Hospital's Medical Staff; provided, however, that: (i) the Governance Committee may request that the Hospital's Medical Staff recommend for election as the Elected Director from the Medical Staff members in good standing of the Hospital's Medical Staff in addition to those identified on the initial list provided to the Governance Committee; and (ii) if a list of candidates for the Elected Director from the Medical Staff is not provided by the Hospital's Medical Staff to the Governance Committee within thirty (30) days of a written request for such list (or additional list(s)), the Governance Committee may nominate any member in good standing of the Medical Staff of the Hospital for election as the Elected Director from the Medical Staff. The remaining three (3) Directors (the "Ex-Officio Directors") shall be the Chief Executive Officer, the President of the Hospital's Medical Staff and the Vice President of the Hospital's Medical Staff. The Elected Directors and the Ex-Officio Directors shall each have a vote and shall be counted for quorum purposes. Notwithstanding the foregoing, during the Transitional Period, the Board shall be comprised of seventeen (17) Directors, which shall include fifteen (15) directors described above and the two (2) HHC-Appointed Directors defined below.

(c) Transitional Period. Notwithstanding anything to the contrary contained in these Bylaws, the Directors serving on the Corporation Board on the day prior to the Closing Date will constitute the Directors during the Transitional Period (the "Legacy Directors"). HHC shall appoint two representatives to serve as Directors during the Transitional Period (the "HHC-Appointed Directors"). During the Transitional Period additional Directors may be nominated as elected in accordance with these Bylaws.

(d) Classes; Manner of Election; Term of Office. With respect to all other Directors than the Legacy Directors and the HHC-Appointed Directors, the Board shall be divided into three (3) classes, comprised of as equal a number of Directors per class as possible. Except as may be specifically determined by HHC from time to time, each class of Directors shall serve for term of three (3) years, with terms staggered so that approximately one-third (1/3) of the Directors shall be elected by HHC annually. The Directors so elected annually shall hold their offices for a term to expire at the third (3rd) annual meeting after their election and until others shall be elected or appointed in their places. A Director elected at any other meeting or time to fill a vacancy shall hold office only for the unexpired term, unless elected to continue to fill additional terms. In the event that a Director is filling an unexpired term created by a Board vacancy, such Director may not serve on the Board for more than nine (9) consecutive years, including any terms preceding or subsequent to such Director's term during which they are filling a vacancy.

(e) Term Limits. There shall be a limit of three (3) consecutive full terms which an individual may serve as a Director. Any Director who shall serve for three (3) consecutive full terms shall not be eligible for election to a further term or terms until the annual meeting of the Board immediately following the expiration of such third successive full term. HHC may waive the above term limit to permit a Director to serve as Board Chair and/or Board Vice Chair, provided such waiver shall be for not more than one (1) additional year to an existing term. Notwithstanding the foregoing, (i) a Director's term shall end upon his or her death, resignation, or removal as provided in these Bylaws; and (ii) a Director of the Corporation who has served for three (3) consecutive full terms will be immediately eligible for appointment to the board of any one of the health care entities which comprise the System.

(f) Director Restrictions. No Director of the Corporation shall serve simultaneously on the Board of Directors of the Corporation and (i) on the board of directors of HHC, or (ii) on the board of directors of any hospital entity within the System; provided, however, pursuant to the Affiliation Agreement, during the Transitional Period, the Member may nominate, and HHC shall approve, two individuals from the Member board or the Corporation Board to serve as directors of HHC. The foregoing restrictions shall not apply to the HHC-Appointed Directors or any executive of the Corporation who serves on the board of directors of any non-hospital Subsidiary in an ex-officio capacity.

(g) Ex-Officio Directors. Each Ex-Officio Director shall cease to be a Director immediately and automatically upon ceasing to hold the office from which his or her ex-officio status derives, without the need for any action by HHC, the Member, the Corporation or its Directors. There shall be no other ex-officio members on the Board.

(h) Board Competencies and Qualifications. The Corporation shall have a written policy approved by HHC with respect to the qualifications and core competencies for the selection of the persons appointed to the Board.

(i) Special Requirements for Board. The Board shall ensure that the HHC CEO and the Member's President and CEO is each, at all times, an invited guest at the Board meetings, with attendance at such Board meetings to be left to their sole discretion.

(j) Honorary Roles. The Board may grant honorary roles, such as the role of Director Emeritus, for individuals who have ceased to serve as Directors. Such roles shall be without any governance responsibilities, including but not limited to voting rights or the right to attend, receive material from, or participate in meetings of the Board.

4.3 Board Meetings. The Board shall hold a maximum of six (6) regular meetings each year, one of which shall also serve as its annual meeting. All meetings, annual, regular or special, shall be held at such place or places within or without the State of Connecticut as the Board may from time to time by resolution determine or as shall be specified or fixed in the notice or waiver of notice thereof.

(a) Annual Meetings. An annual meeting of the Board for the transaction of such business as may properly come before the Board shall be held following the annual meeting of the Member of the Corporation in each year, at such time and place as shall be determined by the Board.

(b) Regular Meetings. Regular meetings of the Board shall be held at such times as shall be specified in a resolution adopted by the Board then in effect, or if there shall not be any such resolution then in effect, as shall be specified in a notice of such meeting.

(c) Special Meetings. Special meetings of the Board shall be held whenever called by the Board Chair, by the Corporation's President and CEO, by the Member, by HHC or by at least two (2) of the Directors then in office.

(d) Notice. At least two (2) days' written, oral or electronic notice of each special meeting stating the time and place of the meeting shall be given to each Director by the Corporation's President and CEO or by the Secretary, or in the case of a special meeting that has been called by the Directors, by the Directors calling the meeting. Except as otherwise provided in these Bylaws or as otherwise required by law, neither the business to be transacted at, nor the purpose of any special meeting of the Board, need be specified in the notice or waiver of notice of such meeting.

(e) Waiver of Notice. The attendance of a Director at any meeting without protesting prior to the commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him or her of notice of such meeting.

(f) Telephonic Participation at a Board Meeting. Directors may participate in a meeting of the Board by use of a conference telephone or similar communications equipment which allows all persons participating in the meeting to simultaneously hear each other and to

communicate with one another, and such participation in a meeting shall constitute presence in person at such meeting.

(g) Quorum. A majority of the number of Directors then in office shall constitute a quorum for the transaction of business.

(h) Adjournment. A majority of the Directors present at any meeting of the Board, including a meeting at which a quorum is not present, thereat may adjourn the meeting to another time and place. Notice of any adjourned meeting need not be given unless the meeting shall have been adjourned for more than three (3) days.

4.4 Vote Required for Action. The act of a majority of the Directors present at any meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the vote of a greater or lesser proportion is otherwise required by law. If all the Directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, such action shall be the act of the Board with the same force and effect as though it had been authorized at a duly called and held meeting of the Board.

4.5 Resignation. Any Director of the Corporation may resign at any time by giving written notice to the Corporation's President and CEO. In the event of a resignation of a Director without written notice, the Corporation's President and CEO shall confirm such resignation in writing. Such resignation shall take effect at the time specified therein. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. A vacancy on the Board thereby created shall be filled as provided in Section 4.7 hereof.

4.6 Removal. Any Director may be removed from the Board of Directors with or without cause by HHC. Such action may be taken at any annual meeting, any regular meeting or any special meeting, provided that due notice of the proposed removal shall have been duly given to the subject Director. Notwithstanding the foregoing, during the Transitional Period HHC shall only exercise its power to remove a Legacy Director if such removal is for cause only and after prior consultation with the Chair of the Member board.

4.7 Vacancies. In the event a Director ceases to be in office, HHC shall have the power to fill the vacancy caused thereby, and the person elected to fill such vacancy shall hold office for the unexpired portion of the term of his or her predecessor.

ARTICLE 5

COMMITTEES

5.1 Committees. The Board may designate two (2) or more Directors, plus such additional individuals, to constitute a committee, which may be standing or ad hoc. The Member or HHC may designate one or more of the Corporation's Directors to chair a committee. Committees shall have and may exercise all such authority of the Board as shall be provided in resolutions of appointment, except that only Directors may be members of a committee that has

and exercises the authority of the Board, and no such committee shall have any power or authority prohibited by law or as to the following:

(a) filling of vacancies in the Board or any of its committees;

(b) amending the Certificate of Incorporation;

(c) adopting, amending or repealing these Bylaws;

(d) amending or repealing of any resolution of the Board;

(e) approving a plan of merger, a sale, lease, exchange or other disposition of all or substantially all of the property of the Corporation or of a proposal to dissolve the Corporation; or acting on matters committed by these Bylaws or a resolution of the Board to the Member, or to another committee of the Board.

Except as provided in these Bylaws, members of committees and their respective chairpersons shall be appointed at the annual meeting of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

5.2 Standing Committees. There shall be a Board Governance Committee, a Development Committee, a Quality and Credentialing Committee, and such additional standing committees as HHC may from time to time establish. Except as set forth in these Bylaws, members of committees need not be Directors of the Corporation. All chairpersons of a committee shall be Directors of the Corporation.

5.3 Board Governance Committee. The Board Governance Committee shall identify qualified candidates and recommend nominations for Directors and officers of the Corporation to HHC's Nominating and Governance Committee. The Board Governance Committee shall also oversee any Board self-evaluation process; evaluating the Chair and Vice Chair, and consulting with the HHC CEO on any annual performance objectives, performance and compensation of the Corporation's President and CEO. The Board Governance Committee shall also advise the Board on matters related to governance of the Corporation, Director performance evaluation and oversight of any Director conflict of interest matters. The Board Governance Committee shall have the responsibilities and shall follow the procedures set forth In the Board Governance Committee Charter as adopted by the Board.

5.4 Development Committee. The Development Committee shall assist the management of the Corporation in fund development matters, shall participate in the formulation of plans and programs to enhance the Corporation's ability to generate financial support from public and private sources, and shall make recommendations and reports to the Board from time to time as it may deem appropriate and as may be consistent with the System's overall fundraising and development objectives. The Development Committee shall have the responsibilities and shall follow the procedures set forth in the Development Committee Charter as adopted by the Board.

5.5 Quality and Credentialing Committee. The Quality and Credentialing Committee shall assist the Board by: (a) monitoring and assessing the quality of care, clinical safety, patient

safety and services provided by the Corporation; (b) approving appointments and reappointments to the Corporation's Medical Staff as needed, between meetings of the Board; (c) the granting and delineation of medical privileges and credentialing, based on recommendations of the Medical Staff as provided in the Corporation's Medical Staff Bylaws as needed, between meetings of the Board; (d) ensuring that the Corporation and the Medical Staff comply with any state or federal regulatory and applicable accreditation requirements; and (e) assisting the Board with any community needs assessments that may be undertaken from time to time. When engaging in peer review activities (including but not limited to appointment, credentialing and corrective action activities), the Board, the Quality and Credentialing Committee, and any other committee or subcommittee of the Board is a "Medical Review Committee" as defined in Chapter 368a of the Connecticut General Statutes, as amended from time to time. Thus, proceedings of such a Medical Review Committee, including data and information gathering, analyses and reporting by authorized individuals for the purpose of peer review activities, as well as minutes and other documents from meetings or portions of meetings addressing peer review, shall be privileged and confidential to the extent permitted by law. The Quality and Credentialing Committee shall have the responsibilities and shall follow the procedures set forth in the Quality and Credentialing Committee Charter as adopted by the Board.

5.6 Procedures, Actions by Committee. Subject to any charter adopted by the Board for the governance of any committee, each committee of the Board shall act in accordance with the following procedures: Each committee shall adopt a schedule of regular meetings and shall hold additional special meetings on the call of the committee chair or any two committee members. Notice of each such meeting shall be given to all committee members in the manner provided for notice of regular meetings of the Board. All members of a committee shall be entitled to participate in committee activities and shall have full voting rights on actions taken by such committee. A majority of voting members of the committee shall constitute a quorum for all business. The act of a majority of voting members of the committee present at any meeting duly held at which a quorum is present at the time of the act shall be the act of the committee; and if less than a quorum is present at any committee meeting, a majority of the voting members of the committee present may adjourn such meeting from time to time without notice. Each committee shall keep a record of its proceedings and shall report to the Board as requested. The term of office of a committee member shall be determined by the Board. Members of a committee may be removed at any time by the Board with or without cause.

ARTICLE 6

OFFICERS

6.1 Term and Election of Officers. HHC shall elect the Corporation's Chair and a Vice Chair of the Board. The Secretary and Treasurer of the Corporation shall be appointed by the Board at the annual meeting of the Board upon the recommendation of the Corporation's President and CEO. The HHC CEO shall appoint the Corporation's President and CEO. Each officer shall hold office for the term for which he or she is duly elected and until his or her successor shall have been duly elected and qualified. Unless otherwise provided in a resolution electing an officer, his or her term of office shall extend to and expire on the date of the next annual meeting of the Board following his or her election. However, if earlier, an officer's term shall end upon his or her death, resignation or removal as provided in these Bylaws.

6.2 Chair. The Chair shall preside at all meetings of the Board and shall have such powers and duties as from time to time may be determined by the Board. The Board shall recommend to HHC an individual from among the Directors to serve as Chair.

6.3 Vice Chair. The Vice Chair shall perform the duties of the Chair in the event of the Chair's absence or disability and shall assist the Chair in such duties as the Chair may from time to time assign to the Vice Chair. The Vice Chair shall not automatically succeed to the position of Chair. The Board shall recommend to HHC an individual from among the Directors to serve as Vice Chair.

6.4 The Corporation's President and CEO. The HHC CEO shall appoint the Corporation's President and CEO and shall establish the objectives, evaluate the performance and determine the compensation for the Corporation's President and CEO. The removal of the Corporation's President and CEO shall be at the discretion of the HHC CEO. The Corporation's President and CEO shall be the chief executive officer of the Corporation. Subject to the powers expressly reserved to the Board, to the Member or to HHC, the Corporation's President and CEO shall, in general, supervise and control all the business and affairs of the Corporation and shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair or Vice Chair has been appointed or in the absence of the Chair and Vice Chair, the Corporation's President and CEO shall preside at each meeting of the Board. The Corporation's President and CEO shall see that all orders and resolutions of the Board and of the committees of the Board are carried into effect. In general, he or she shall perform all duties incident to the office of President and CEO and such other duties as may from time to time be assigned to the Corporation's President and CEO by these Bylaws, by the Board, or by the HHC CEO. Without limiting the foregoing, the Corporation's President and CEO shall have the following powers:

(a) Be responsible for coordinating the business affairs of the Corporation within overall System guidelines;

(b) Recommend the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation, including but not limited to capital and operating budgets, to the Member upon consultation with the Board;

(c) Recommend the Corporation's vision to HHC;

(d) Recommend to the Board any incurrence or assumption of debt by the Corporation in accordance with the guidelines established by HHC for the System's centralized debt management program;

(e) Identify the need for the Corporation's formation of any new legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, and/or disposition of assets closures, mergers, consolidations or changes in corporate membership or ownership of the Corporation or any Subsidiary of the Corporation; and

(f) Recommend to HHC the need for the introduction or termination of any service and the filing of any application for a certificate of need with the State of Connecticut.

6.5 Treasurer. The Treasurer shall have charge and custody of and be responsible for all the funds and securities of the Corporation; he or she shall keep full and accurate accounts of assets, liabilities, receipts and disbursements and other transactions of the Corporation in books belonging to the Corporation; and he or she shall see that all moneys and other valuable effects of the Corporation are deposited or invested in the name of and to the credit of the Corporation in such banks or other financial institutions as may be designated by the Board. The Treasurer shall disburse or oversee the disbursement of the funds of the Corporation as may be ordered by the Board, taking proper vouchers for disbursements, and shall render to the Corporation's President and CEO and to the Directors at the meetings of the Board, or whenever they may require it, a statement of all his or her transactions as Treasurer and an account of the financial condition of the Corporation. In general, he or she shall perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Board or by the Corporation's President and CEO.

6.6 Secretary. The Secretary shall serve all notices for the Corporation that have been authorized by the Board; keep the minutes of the meetings of the Board and the Member; be the custodian of the corporate records and of the seal of the Corporation; and in general, perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the Board or the Corporation's President and CEO.

6.7 Other Officers. The Member may from time to time appoint such other officers as may be deemed necessary or advisable for the efficient operation of the Corporation's affairs, each of whom shall hold office for such period, have such authority and perform such duties as the Member may from time to time determine.

6.8 Removal of Officers. Irrespective of term of office, but subject to any written contract rights or any other provisions in these Bylaws, any officer of the Corporation may be removed with or without cause at any time by HHC.

6.9 Vacancies. Except as otherwise provided in these Bylaws, if the office of the Chair, the Vice Chair, the President and Chief Executive Officer, or any other officer appointed by HHC becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by HHC. If the office of the Treasurer, the Secretary, or any other officer appointed by the Board becomes vacant at any time, the vacancy may be filled for the unexpired term thereof by the Board.

6.10 Resignations. Any officer of the Corporation may resign his or her office at any time by giving written notice thereof to the Corporation's President and CEO or to the Board. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

ARTICLE 7

MEDICAL STAFF

7.1 Medical Staff of Hospitals. The Board has caused to be created and shall continue to provide for a medical staff organization (the "Medical Staff") for the Corporation, which shall include all physicians, dentists and members of allied professions who are granted by the Board the privilege of caring for or contributing to the care of patients at each hospital facility. Membership on the Medical Staff shall be a prerequisite to the exercise of clinical privileges in each hospital facility, except as otherwise provided in such Bylaws adopted for the governance of the Medical Staff and related governance rules (the "Medical Staff Bylaws").

7.2 Medical Staff Bylaws. The Medical Staff shall be governed by the Medical Staff Bylaws and Medical Staff Credentials Policy, and Medical Staff Rules and Regulations. Medical Staff Bylaws and any amendments thereto may be initiated by the Medical Staff but shall become effective only upon final approval by the Board. The Medical Staff Bylaws and Medical Staff Credentials Policy shall provide for the procedure to be followed in matters relating to Medical Staff membership status, clinical privileges, and corrective action.

7.3 Board Exclusive Appointing Authority. Anything to the contrary herein notwithstanding, the Board shall have the exclusive authority and responsibility to make appointments or reappointments to the Medical Staff. In each case, the Board shall consider the recommendations and reports of the Medical Staff.

ARTICLE 8

CORPORATORS

8.1 General. The Corporation shall have a board of corporators (the "Board of Corporators"). Persons on the Board of Corporators (the "Corporators") shall serve in an honorary and advisory capacity, and except as provided herein or as the Board of Directors shall otherwise designate, shall in such capacity have no right to notice of or to vote at any meeting, shall not be considered for purposes of establishing a quorum and shall have no other rights or responsibilities. The Board of Corporators will be the key link and resource between the Corporation and the community served by the Corporation, and shall have as its principal purpose enhancing the Corporation's ability to fulfill the public purposes for which it has been organized and is intended to be operated. Corporators shall not serve in a fiduciary capacity nor shall they have legal responsibility, power or accountability as Corporators with respect to the affairs of the Corporation.

8.2 Number. The Corporators shall be chosen to represent broad sections of the community area served by the Corporation. The Board of Directors of the Corporation may appoint the chief elected municipal officials of towns and chief elected officials of federally recognized tribal nations within the service area of the Corporation as Corporators, whose terms shall coincide with those of their offices. The original Corporators shall be those persons who are members/corporators of Backus Corporation on the date of adoption of these Bylaws. All Corporators must have either their residence or place of business within the service area of the Corporation, and when this condition ceases to exist will automatically be considered to have resigned.

8.3 Manner of Election. Members of the Board of Corporators shall be elected at the annual meeting of the Corporators from among nominees submitted to such meeting by the Governance Committee, upon a vote of two-thirds of the Corporators present at such annual meeting.

8.4 Meetings of the Board of Corporators. There shall be an annual meeting of the Corporators held at such date, time and place as may be designated by the Board of Directors during the month of November of each year. At such annual meeting, the Corporators shall elect new Corporators, shall hear reports as to the progress of the Corporation, and shall have the opportunity to question, comment and advise the Board of Directors with respect thereto. Any Corporator who misses three consecutive annual meetings may be removed by a majority vote at a meeting of the Board of Directors at which a quorum is present.

8.5 Transfer, Removal, Withdrawal. Membership on the Board of Corporators shall be nontransferable, and shall be terminated by death, voluntary withdrawal or expulsion by either the Board of Directors or the Member of the Corporation.

8.6 Voting. Although Corporators shall have no vote on corporate matters, the Board of Directors of the Corporation may from time to time submit matters to the Board of Corporators for an advisory opinion. Each Corporator shall be entitled to one vote on each such matter so submitted to Corporators for vote. Voting shall be in person, and there shall be no voting by proxy.

ARTICLE 9

AUXILIARY

There shall be an Auxiliary to provide auxiliary services to the Corporation and its patients and to carry on activities designed to raise funds exclusively for the accomplishment of the purposes of the Corporation. The Auxiliary shall organize itself and adopt its own bylaws. It shall conduct its activities in consonance with the goals and policies of the Corporation and keep the Board of Directors informed of its activities. The bylaws of the Auxiliary, and any revisions or amendments thereto, must be approved by the Board of Directors. The Auxiliary shall deliver a report at the annual meeting of the Board of Directors and at such other times as are directed by the Board of Directors, regarding its activities on behalf of the Corporation.

ARTICLE 10

CONFLICT OF INTEREST

All Directors and officers of the Corporation shall be subject to and abide by the terms of the Corporation's Conflict of Interest Policy maintained on record by the Corporation, a copy of which has been provided to all Directors and officers.

ARTICLE 11

INDEMNIFICATION

11.1 Limitation of Liability. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act, or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability (as defined in Section 33-1116 of the Act) to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director, (ii) enabled the Director or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal gain, (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

11.2 Indemnification of Directors and Officers. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect.

11.3 Expenses. Expenses incurred by a Director or officer in defending a civil or criminal action, suit or proceeding shall be paid for or reimbursed by the Corporation to the fullest extent permitted by law in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such Director or officer of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under the Certificate of Incorporation or these Bylaws and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall be ultimately determined that such director or officer is not entitled to be indemnified by the Corporation. Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon the terms and conditions, if any, as the Board of Directors deems appropriate.

11.4 Non-exclusivity. The indemnification and advancement of expenses provided for herein shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a Director or officer and shall inure to the benefit of the heirs, executors and administrators of such a person. Notwithstanding the foregoing, the Corporation shall not provide such indemnification or advancement for expenses to the extent that such indemnification or advancement would constitute self-dealing within the meaning of section 4941(d) of the Internal Revenue Code of 1986, as amended.

11.5 Amendment or Repeal. No amendment to or repeal of this Article 11 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

ARTICLE 12

MISCELLANEOUS PROVISIONS

12.1 Fiscal Year. The fiscal year of the Corporation shall end on September 30 in each year.

12.2 Amendment. HHC shall have the exclusive power to make, amend or repeal the Corporation's Certificate of Incorporation or these Bylaws, subject to the limitations in Section 3.2(e).

12.3 Execution of Contracts. The Board may authorize any officer or officers and any agent or agents to enter into any contract or execute any instrument in the name of, and on behalf of, the Corporation, and such authority may be general or limited to specified instances. No officer, agent or employee shall have any power or authority to bind or obligate the Corporation by any commitment, contract or engagement, or to pledge its credit or render it liable for any purpose or in any amount unless duly authorized by the Board.

12.4 Compensation for Services. The Corporation may reimburse any Director for expenses incurred in connection with fulfilling his or her duties as a member of the Board, provided that the amount of such reimbursement is reasonable and not excessive.

12.5 Notice. Any notice required or permitted to be given under these Bylaws in writing shall be deemed to have been delivered if delivered in person or if sent by United States mail, overnight delivery, telegraph (charges prepaid), facsimile or email and addressed to such person at the address shown on the records of the Corporation or the address supplied by him or her to the Corporation for the purpose of notice. If such notice is sent by mail, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail.

12.6 Consistency with the Affiliation Agreement. In the event of a conflict between any provision of the Bylaws and the terms of the Affiliation Agreement, the provisions of the Affiliation Agreement shall control.

Dated: _____

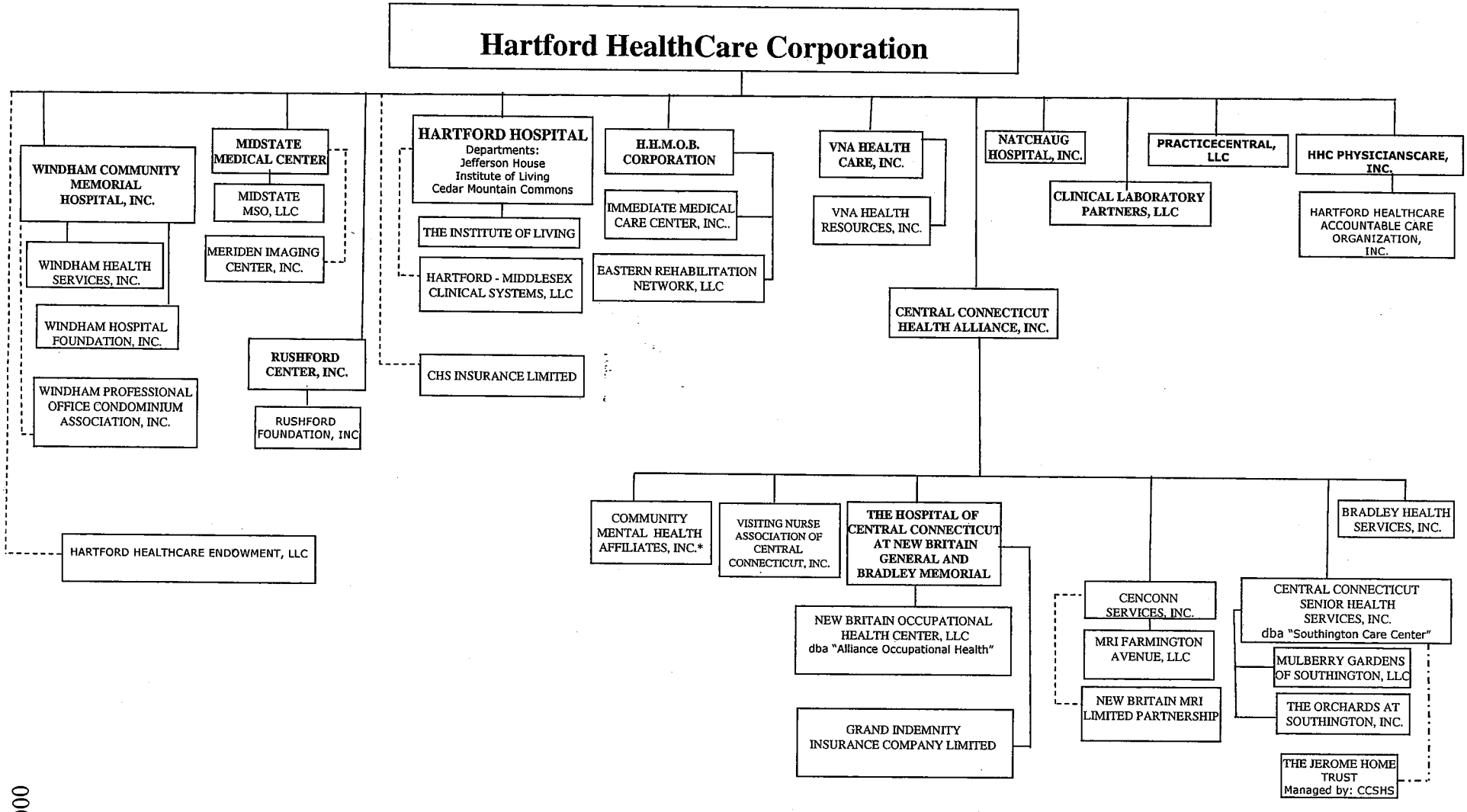
Exhibit 1.3

Schematics

See attached.

CORPORATE ORGANIZATION CHART

Hartford HealthCare Corporation
(Without Backus Corporation)



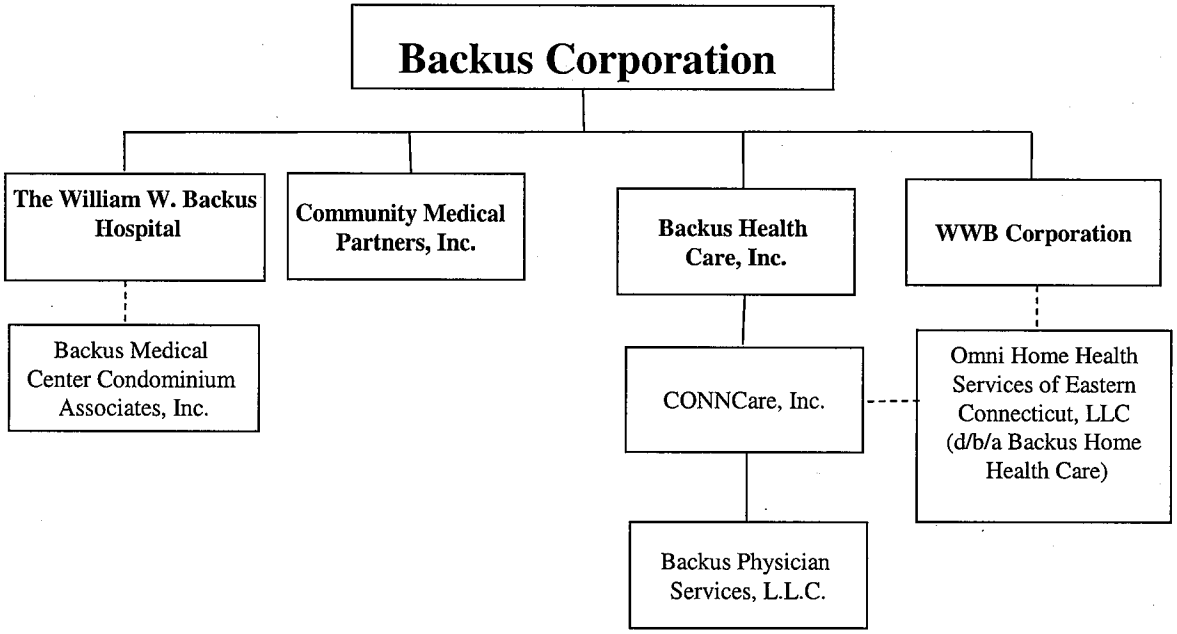
000578

*A CON Application has been filed (see Docket #12-31750-CON) to sever the affiliation between Community mental Health Affiliates and Central Connecticut Health Alliance.

2448522 V.2

CORPORATE ORGANIZATION CHART

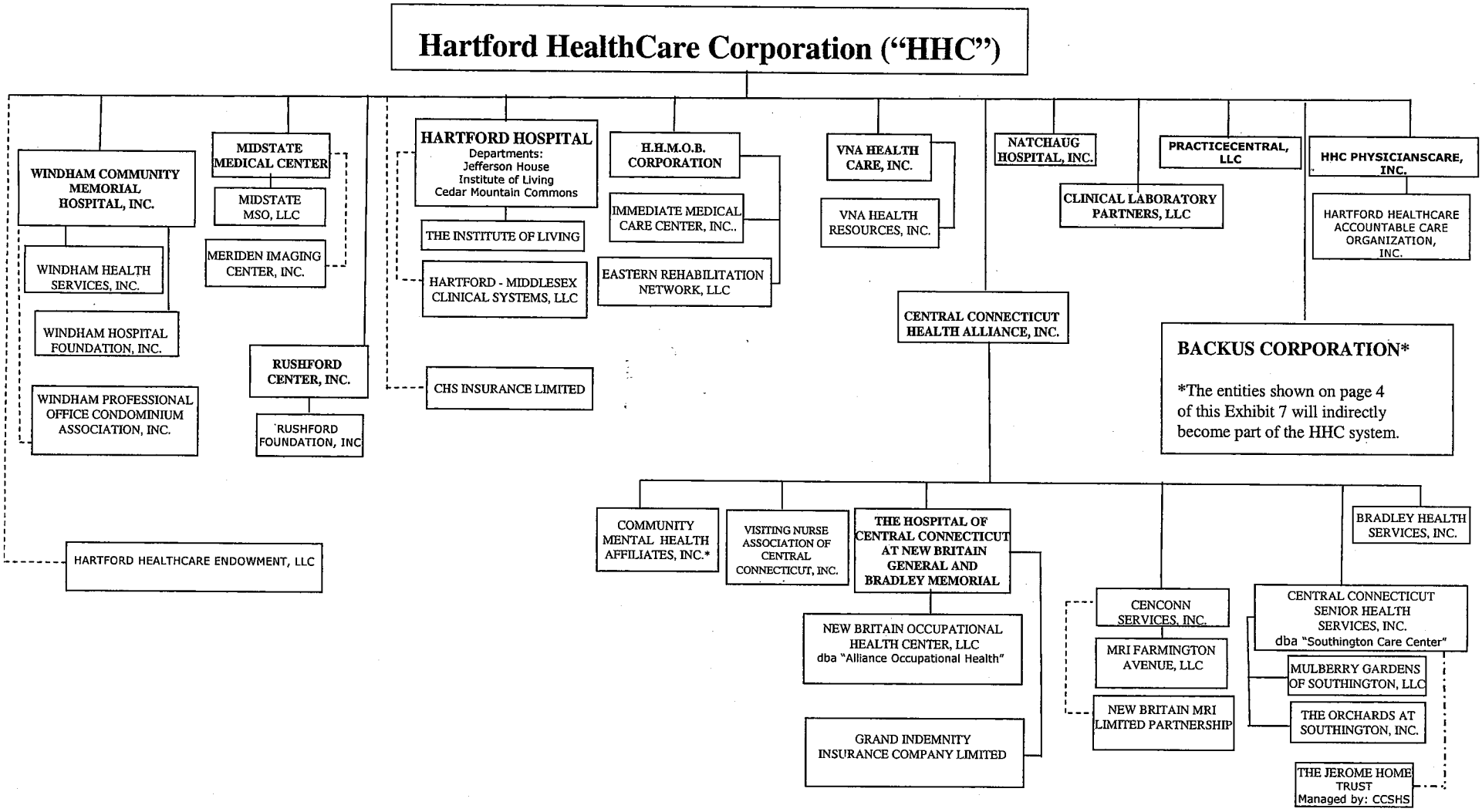
Backus Corporation
(Without Hartford HealthCare Corporation)



000579

CORPORATE ORGANIZATION CHART

Hartford HealthCare Corporation
(With Backus Corporation)

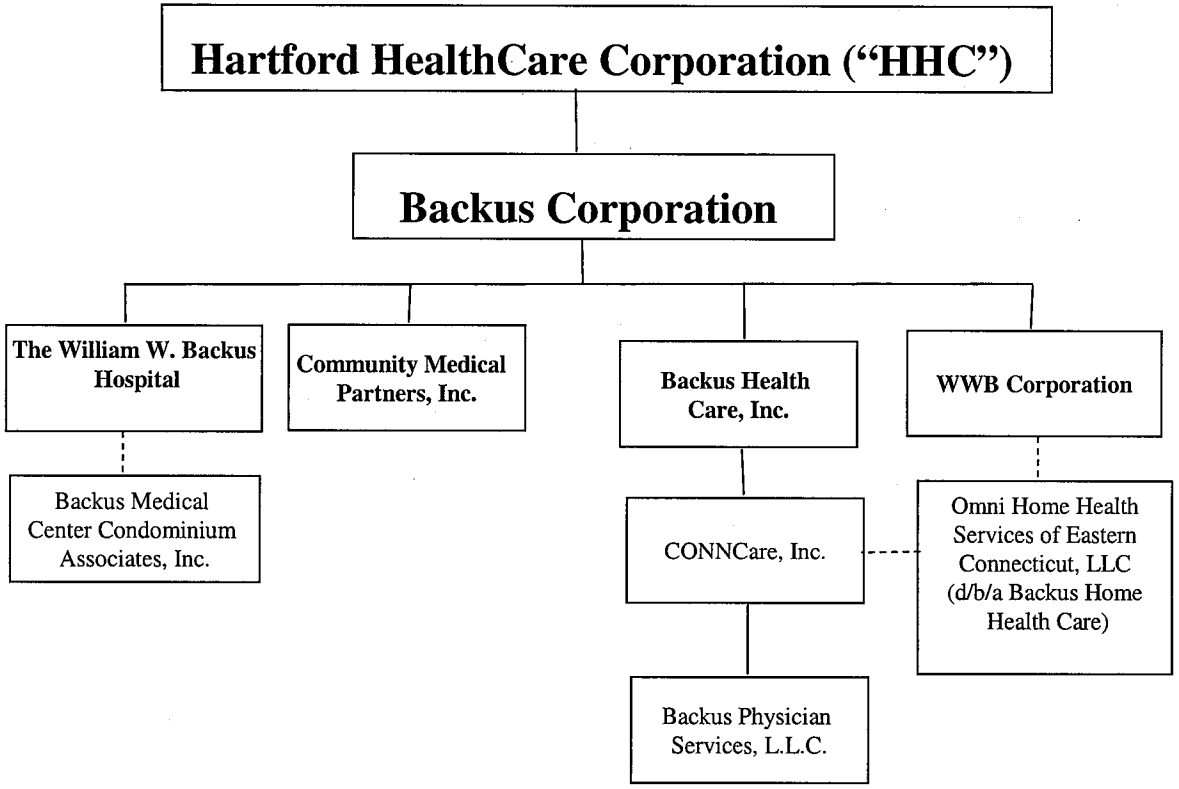


*A CON Application has been filed (see Docket #12-31750-CON) to sever the affiliation between Community mental Health Affiliates and Central Connecticut Health Alliance.

000580

2448522 V.2

Backus Corporation
As Part of Harford HealthCare Corporation



000581

Exhibit 10

Curriculum Vitae For:

HHC:
Elliot Joseph, President and Chief Executive Officer
Thomas Marchozzi, Executive Vice President and Chief Financial Officer
Rocco Orlando, M.D., Chief Medical Officer

Backus Corporation:
David Whitehead, President and Chief Executive Officer
Daniel Lohr, Senior Vice President and Chief Financial Officer
Peter Shea, M.D., Senior Vice President and Chief Medical Officer

ELLIOT JOSEPH
3 Sunningdale
Farmington, CT 06032

CAREER SUMMARY

Fifteen years of health care CEO experience, with special emphasis on large,inte grated delivery systems. Proven track record in visionary strategic leadership, organizational culture building, and operating performance improvement.

PROFESSIONAL EXPERIENCE

April 2008 – Present
President and CEO
Hartford HealthCare
Hartford, Connecticut
Hartford HealthCare is the premiere health care network in Connecticut with more than 15,000 staff members and $2 billion in net revenue. Hartford HealthCare includes Hartford Hospital, one of the Northeast's top medical centers; the Hospital of Central Connecticut, with two campuses; MidState Medical Center; Windham Hospital; The Institute of Living psychiatric hospital; VNA HealthCare; Clinical Laboratory Partners, with more than 80 locations; Hartford Medical Group; the Doctors of Central Connecticut; Eastern Rehabilitation Network; two regional behavioral health centers, Rushford and Natchaug Hospital; and Central Connecticut Senior Health Services, with five assisted-living and skilled-nursing facilities.

Significant Accomplishments:

- Transformed Hartford HealthCare into Connecticut's only truly integrated regional health care system with consistent, high-quality coordinated care for patients.
- Initiated and completed affiliation with $450 million health care system (Central Connecticut Health Alliance), expected to result in $200 million in savings from integration.
- Implemented a culture change, leadership development program, physician leadership development program, and continuous improvement program – using Six Sigma, Lean and other methodologies – resulting in significant quality improvements and improved patient and employee satisfaction.
- Enhanced system integration through information technology, including implementing electronic health records systems. Hartford Hospital and MidState Medical Center have been named among the nation's 100 Most Wired hospitals by *Hospitals & Health Networks*, the journal of the American Hospital Association,fo r several consecutive years.
- Expanded Clinical Laboratory Partners to more than 80 locations serving patients, hospitals and physicians throughout the state.
- Achieved debt refinancing of $385 million for system growth.
- Instituted world-class system Research Institute.
- Implemented system-wide brand.

April 2008 – August 2011
President and CEO
Hartford Hospital
Hartford, Connecticut
Hartford Hospital, with more than 7,000 staff members, is the flagship tertiary care center of Hartford HealthCare. Established more than 150 years ago, the hospital also is a teaching medical and research center and operates the only level one trauma center in the area and the only air ambulance service in Connecticut. Hartford Hospital has received the National Research Corporation's "Consumer Choice Award," the American Heart Association's "Silver Plus Award" for

its Stroke Center and "Blue Distinction" awards for its Joint and Spine Centers. The hospital's Helen and Harry Gray Cancer Center is the only cancer center in the Northeast to be selected by the National Cancer Institute (NCI) as an NCI Community Cancer Center

Significant Accomplishments

- Elevated Hartford Hospital to a nationally recognized medical center:
  - "Best Hospital – Psychiatry" by *U.S. News & World Report.*
  - No. 1 hospital in region by *U.S. News & World Report.*
  - Helen & Henry Gray Cancer Center – one of few in the United States to receive a community grant from the Lance Armstrong Foundation.
  - Surgery Department performs second-highest number of surgeries (30,000) in the Northeast.
  - Robotic surgery staff named among top 10 most-experienced in the country.
  - Center for Education, Simulation and Innovation provides some of the most advanced training in the nation for medical staff from throughout the United States and beyond.
  - Nationally recognized transplant program.
  - Established 24-hour patient transfer center, serving all of New England.
- Transformed hospital into significantly stronger financial institution through process-improvement methodologies, improved quality, increased patient satisfaction and expansion of services into local communities.

June 1998 – March 2008
Ascension Health
Ascension Health, the largest not-for-profit health system in America, is a Catholic-sponsored, mission-focused organization with more than $11 billion in net revenue, 78 hospitals and more than 100,000 associates.

February 2001 – March 2008
President & CEO
St. John Health (Ascension Health)
Warren, Michigan

St. John Health, the largest local health ministry within Ascension Health, operates seven hospitals with approximately $2 billion in annual net revenue; 18,000 associates; 3,200 physicians; and 470 residents and fellows in 61 training programs. St. John Health is the largest provider of hospital services in southeast Michigan.

Significant Accomplishments:

- Improved annual operating margin from 0.9% (FY 01) to 2.5% (FY 07), while increasing "care of the poor" from $95 million (FY 01) to $155 million (FY 07).
- Increased days cash on hand from $137 million (FY 01) to $171 million (FY 07) while investing more than $500 million in major capital projects.
- Decreased mortality rates from 12% (FY 02) favorability over Michigan norms to 23% favorability (FY 07).
- Outperformed market with inpatient growth of +1.1% over two years against average market growth of -0.5%.
- Decreased RN turnover by 26% between FY 06 and FY 07.
- Increased employee "top box" satisfaction from 25.2% (FY 03) to 42.2% (FY 07).

June, 1998 – January, 2001
President & CEO
Genesys Health System (Ascension Health)
Grand Blanc, Michigan
With annual net revenue of $330 million, Genesys is a regionally integrated health care system

resulting from the merger and consolidation of four hospitals into one new 379-bed tertiary medical center campus.

Significant accomplishments:

- Improved operational margin from loss of 0.9% in FY 98 to +1.2% in FY 01 while addressing post-merger dysfunction.
- Results achieved:

	FY 98	FY 01
Operating revenue (million)	$295,972	$330,611
Inpatient discharges	24,142	24,897
Surgical cases	19,707	21,798
FTEs per AOB	6.16	5.44

- Turned around cardiac surgery program with resulting volume increase from 459 (FY 98) to 615 (FY 01).
- Developed and implemented a successful cultural "turnaround" plan addressing both internal and external (community) elements. Achieved dramatic improvements in community awareness and perception.
- Integrated medical staffs and medical education functions of four hospitals, including osteopathic and allopathic teaching facilities.

June, 1993 – May, 1998
The Detroit Medical Center (DMC)
Detroit, Michigan
The Detroit Medical Center is an eight-hospital, $1.6 billion, integrated academic health system with more than 2,500 physicians and 100 ambulatory sites. This system is affiliated with Wayne State University School of Medicine.

November, 1995 - May, 1998
Senior Vice President/Oakland Region

June, 1993 - November, 1995
President
Huron Valley Hospital

Significant accomplishments:

- Integrated medical staffs and medical education functions of four hospitals, including osteopathic and allopathic teaching facilities.
- Instituted strategic planning process resulting in $41 million expansion project, including an outpatient regional specialty center integrating academic faculty practices and local community specialists.
- Inpatient admissions increased from 6,976 (FY 93) to 8,471 (FY 98) while operating margin increased from -4.2% (FY93) to +6.4% (FY 98).

August, 1985 – May, 1993
Mercy Hospital and Medical Center (MHMC)
Chicago, Illinois
A 485-bed,c ommunity-based teaching hospital affiliated with the University of Illinois. Approximately $350 million revenue base.

February, 1991 – May, 1993
Senior Vice President

August, 1985 – January, 1991
Vice President

October, 1981 – August, 1985
Edward Hospital
Naperville, Illinois
A 162-bed community hospital serving west suburban Chicago.

November, 1982 – August, 1985
Vice President/ Marketing and Planning
October, 1981 – November, 1982
Director, Planning

EDUCATION
University of Pennsylvania
Wharton CEO Program for Healthcare Leadership (2006)

University of Michigan/Ann Arbor, Michigan
Master of Health Services Administration (1979)

State University of New York
Binghamton – Binghamton, New York
Bachelor of Science in Business Administration and Psychology (1976)

ACTIVITIES/APPOINTMENTS

- American Hospital Association Regional Policy Board 5 (2005 – present)
- American Heart Association Ball Co-Chair (2004)
- Capital Area Health Consortium Board of Directors (2008 – 2011)
- Caymich Insurance Company, LTD Board of Directors (1998 – 2003)
- Citizens Research Council of Michigan Board of Trustees (2003 – 2008)
- Connecticut Hospital Association Board of Trustees (2010 – present)
- City of Detroit Healthcare Task Force for the Mayor's Transition Team
- Design Regional Detroit Initiative (2006)
- Detroit Opera Board of Trustees
- Detroit Regional Chamber Board of Directors and Executive Committee (2004 – 2008)
- Friends of Scouting 2000 Community Campaign Chairman
- Greater Detroit Area Health Council Inc. Executive Committee (2003 – 2008)
- Greater New York Hospital Association Board of Governors (2011 – present)
- Hartford Healthcare Board of Directors (2008 – present)
- Hartford Hospital Board of Directors (2008 – present)
- JARC Foundation Investment Committee (2006 – 2008)
- Metro Hartford Alliance Board of Directors (2009 – present)
- Michigan Health & Hospital Association Corporation Board (2003 – 2008) and Executive Committee (2004 – 2008)
- Michigan Healthcare Executive Group and Associates Board (2003 – 2008)
- Midstate Medical Center Board of Directors (2008 – present)
- New Detroit Inc. Board of Trustees (2003 – 2008)
- Oakland University School of Health Sciences/Board of Visitors (2002 – 2008)
- The Bushnell Board of Governors (2010 – present)
- The Hospital of Central Connecticut, Corporator (2009 – present)
- The Hospital of Central Connecticut Board of Directors (2009 – present)
- The Institute of Living Board of Directors (2008 – 2011)
- Windham Hospital, Corporator (2009 – present)

RECOGNITION

- American College of Healthcare Executives Fellow (2005 to present)
- Crain's Detroit Business Who's Who in Metro Detroit (2005)
- Wayne State University Pathfinders in Medicine Award (2006)
- **Hartford's Most 50 Influential People**

THOMAS J. MARCHOZZI, CPA
19 Haskins Road Windsor, CT 06095
Cell: (610) 246-1820

SUMMARY

A highly skilled finance executive with over twenty-eight years of concentrated experience in the area of business improvement, planning, budgeting, forecasting and information systems. An executive who applies logic and innovation to further the growth and development of an organization.

JOB HISTORY

Hartford Healthcare, Hartford, Connecticut August 2008 - Present
The largest ($2.2B) Connecticut integrated healthcare delivery system operating five acute care hospitals including a level 1 trauma center, 1,750 licensed beds, a psychiatric hospital, three skilled nursing facilities, visiting nursing association, the only air ambulance in the state of Connecticut, and multiple ambulatory sites.

Executive Vice President and CFO – Hartford Healthcare and Hartford Hospital
Responsibilities:
- System financial management, treasury, investments and insurance, system and business development, and information systems

MedStar Health, Columbia, Maryland July 2002 – August 2008
A $3.0B Maryland and Washington D.C. integrated healthcare delivery system operating six acute care hospitals, 2,650 licensed beds, a national rehabilitation hospital, three skilled nursing facilities, and multiple ambulatory sites.

Senior Vice President and CFO – Washington Hospital Center September 2006 – August 2008
The Washington Hospital Center (WHC) located in the heart of Washington D.C. is a $1.0B tertiary care hospital and the flagship hospital in the MedStar Health System. WHC is presently undergoing a significant design process to expand the campus including new patient towers, emergency department, outpatient facilities and physician joint ventures.

Responsibilities:
- Include business development, patient financial services, central scheduling, financial clearance, physician billing, medical records, management engineering, budgeting, and financial reporting.

Vice President – Finance July 2002 – September 2006
Recruited for an executive position by a large multi-state premier health system which includes the Washington Hospital Center, Georgetown University Hospital, the National Rehabilitation Hospital, and four Maryland Community Hospitals.

Responsibilities:
- Responsible for financial accounting, reporting, forecasting, analysis, and policy implementation including the MedStar Central Business Office operations and Capital resource management.
- Accountable for planning, budgeting, decision support, benchmarking, grants and audit coordination.
- Chief Financial Officer for Helix Family Choice, a managed care insurance product owned by MedStar.
- Financial representative to system-wide initiatives for insurance, executive compensation, pension redesign, supply chain program, operational improvement initiatives, rates and reimbursement, and insurance company contract negotiations.
- Member of the executive leadership team which includes hospital presidents, chief financial officer, chief operating officer, and chief executive officer.
- Staff to Finance Committee of the Board of Directors.

Jefferson Health System (JHS), Radnor, Pennsylvania 1996 - 2002

A $2.5B Pennsylvania integrated healthcare delivery system operating nine acute care hospitals, 2,398 staffed beds, three physical rehabilitation hospitals, three skilled nursing facilities, one psychiatric hospital, and multiple ambulatory sites.

Acting Chief Financial Officer and Treasurer January 2002 - July 2002

Promoted to Acting Chief Financial Officer and Treasurer after the departure of the CFO. Offered, and declined, the permanent CFO position in July 2002.

Vice President – Finance March 2001 - January 2002

Promoted to a higher senior level position in the organization, which involved more interaction with senior level executives and Board members.

Responsibilities: (Additional duties added to the AVP position):

- Accountable, with the Member and System CFO's, for the development and monitoring of system-wide financial disciplines that provide financial targets, performance, and financial integrity assurances.
- Responsible for managing the annual JHS operating budget process and developing appropriate support detail.
- Facilitate the system Standardization Group that produces recommendations for the standardization of various financial issues and standards for the Chief Financial Officer group.
- Financial representative to system-wide initiatives for Alliance activities, executive compensation, and benefits consulting group.

Associate Vice President – Finance 1999 - 2001

Management responsibilities:

- Oversees the timely and accurate preparation of financial statements and highlighting performance using variance analysis and follow-up with member CFOs.
- System office direct expense and operating budgets, including reporting and analysis.
- Review of monthly financial reports and system office financials with member Chief Financial Officers and system office Department Heads.
- Responsible for the review, analysis, and validation of material (> $500,000) capital requests and subsequent presentation to the JHS Finance Committee.
- System capital budget process that includes review and analysis of capital requests.
- Presentation of system capital budget and year-end operating statistics to Board Finance Committee.
- Work with JHS CFO in the management of the JHS business planning process.
- External audit and tax reporting.
- Year-end System Certified Financial Statement Audit.

Director of Finance 1996 - 1999

Responsibilities included budgeting, planning, cost containment, cost analysis, revenue enhancement, acquisitions, and system-wide initiatives in re-engineering, cost reduction, system installations, cash management, reporting and policy standards.

Thomas Jefferson University, Philadelphia, Pennsylvania 1984 - 1996

An academic healthcare center located in Center City Philadelphia involved in healthcare delivery, education, and research with approximately $600M in revenues.

Assistant Controller 1994 -1996

Management of ongoing financial accounting services group personnel. In charge of joint information systems and operational implementation teams installing new client server technology for payroll, human resources, benefits, and general ledger software applications. Established new financial accounting reporting standards. Administered the financial re-engineering of the Controller's Office. Development of various ad hoc reports and sensitivity analyses as required by a rapidly changing environment. Phased out the accounting operations of an unprofitable remote campus hospital. Assisted in the development of financial reporting mechanisms and policies for the JHS which includes several major hospitals.

Manager, Information Systems 1990-1994

Provided application and system support on behalf of an academic healthcare university. Applications include general ledger, university and hospital cash, fixed assets, accounts payable, purchase order, and university and hospital inventory control. Implemented change to the Boston Safe Company for tracking endowments. Evaluation committee member for university-wide cost saving employee suggestion program. Manager of the disaster recovery planning team for financial systems.

Director, Physical Resources 1985 - 1990

Operational responsibility for a $30 million operating budget and a $25 million capital budget. Automated Maintenance, Construction, Facilities Design, and Space Planning Departments. Developed service level improvements. Established a routine and preventative maintenance work order system. Directed the first photo identification badge project for the university. Developed procedures and reporting for the university capital budget.

Auditor, Internal Audit 1984 -1985

Departmental, vendor, and governmental compliance audits. University liaison with outside auditors during annual audit process.

EDUCATION

Doctoral Program, Higher Education Administration
UNIVERSITY OF PENNSYLVANIA, Philadelphia, Pennsylvania
(Completed half of the program prior to formation of JHS)

Masters of Business Administration, December, 1992
Concentration: Finance
VILLANOVA UNIVERSITY, Villanova, Pennsylvania

Bachelor of Business Administration, June, 1984
Majors: Accounting and Finance
DREXEL UNIVERSITY, Philadelphia, Pennsylvania

PROFESSIONAL ACCOMPLISHMENTS

Certified Healthcare Financial Professional – December, 1999
Certified Public Accountant - Pennsylvania, 1986
Member of the American Institute of Certified Public Accountants
Western Association of College and
University Business Officers (WACUBO)
Business Management Institute - Santa Barbara, CA - Four Year Program 1993, 1991, 1990, 1989
Finance Committee Member – American Association of Medical Colleges

PERSONAL

Martial Status: Married with two children, boys ages 25 and 29.
Hobbies: Support of Youth Sporting Activities
Community Activities: Former Board Member - Colonial School District, Founder and Treasurer - Conshohocken Youth Foundation

Rocco Orlando, III, M.D., F.A.C.S.

CURRICULUM VITAE

PERSONAL DATA:

Date of Birth:	January 7, 1953
Spouse:	The Rev. Joanne Papanek Orlando
Home Address:	25 Drumlin Road, So. Glastonbury, CT 06073
Office Address:	85 Seymour Street, Hartford, CT 06106
Licensure:	Connecticut, July, 1980
Board Certification:	General Surgery, 1984, Recertification, 1993, 2003 Added Qualification in Surgical Critical Care, 1987 Recertification 1997, 2006

PROFESSIONAL:

January 2010- Present	Chief Medical Officer, Hartford HealthCare Hartford, Connecticut
January 1998 – Jan 2010	Vice-President, Connecticut Surgical Group Hartford, Connecticut
November 2007- Jan 2010 November 1999 - Nov. 2001	President, Medical Staff, Hartford Hospital, Hartford, Connecticut
November 2005- Nov. 2007 November 1997-Nov. 1999	Vice President, Medical Staff, Hartford Hospital Hartford, Connecticut
July 1984 - Present	Senior Attending Staff, Hartford Hospital, Hartford, Connecticut
July 1984 - Present	Attending Staff, John Dempsey Hospital, University of Connecticut Health Center, Farmington, Connecticut
October 1987 - Present	Associate Director, Surgical Intensive Care Unit, Hartford Hospital Hartford, Connecticut
September 2003 - Present	Professor of Clinical Surgery University of Connecticut School of Medicine

July 1984 - June 1985	Associate Director, Surgical Intensive Care Unit, Hartford Hospital, Hartford, Connecticut
July 1985 - Sept 1987	Co-Director, Surgical Intensive Care Unit, Hartford Hospital, Hartford, Connecticut
July 1996-present	Courtesy Medical Staff CT Children's Medical Center
September 1991-2003	Associate Professor of Clinical Surgery University of Connecticut School of Medicine
July 1984 - 1991	Assistant Professor of Surgery, University of Connecticut School of Medicine,

PROFESSIONAL SOCIETIES:

- Fellow, American College of Surgeons
  - Board Member Connecticut Chapter ACS 1991-1998
- Fellow, American Association for the Surgery of Trauma
- New England Surgical Society
  - Program Committee, 2003-2008, Chair 2007
- Society of Critical Care Medicine
  - Education Committee 1996 - present
- Connecticut Society of American Board Surgeons
  - Secretary Treasurer, 1991-1993
  - President, 1994-1995
- Hartford County Medical Association
- Connecticut State Medical Society
- American Medical Association
- Society of American Gastrointestinal and Endoscopic Surgeons
  - Legislative Committee, 2003-present, Co-Chair, 2005-07
  - Technology Committee 1998-2003
  - Ergonomics Task Force 1998-2003
  - Outcomes Committee 2003-present
  - SAGES representative Am. Coll. Surgeons Surgical Quality Alliance 2006-present
- Hartford Medical Society,
- State Committee on Trauma, American College of Surgeons
  - Social and Political Affairs Subcommittee,
- Connecticut Critical Care Society, Director 1986-87
- Eastern Association for the Surgery of Trauma
  - Program Committee, 1989-1990

- Connecticut Thoracic Society
- New England Chapter, Society of Critical Care Medicine

HOSPITAL COMMITTEES:

- Hartford Hospital Board of Directors: 1997-2001, 2005-present
- Chair, Perioperative Services Committee: 1996-present
- Executive Committee, Dept. of Surgery: 1994-present
- Medical Capital Equipment Steering Group 2001-present
- Clinical Information Steering Committee 2001-2006
- Trauma Committee: 1984-present
- Executive Committee Medical Staff Council: 1993-2008
- Oversight Board, Institute for Outcomes Research
- Co-Chairman, Risk Management Committee: 1999-2001, 2007-08
- Re-Engineering Steering Committee: 1999-2000
- SICU Collaborative Practice Committee
- Joint Conference Committee: 1993-2002, 2005-08
- Research Committee: 1991-1999
- Medical Capital Equipment Committee: 1993-1999
- Utilization Review Committee: 1985-1997
- ICU Coordinating Committee: 1989-1996
- Medical Staff Council: 1991-1999
- Kiwanis Pediatric Trauma Center Committee: 1984-1996
- Medical Records Committee: 1989-1993
- Supply Standards Committee: 1984-1999
- Scientific Review Committee: 1984-1992
- Helicopter Review Committee: 1984-1990
- Transfusion Medicine Committee: 1984-1989

CSG COMMITTEES:

- Board of Directors 1995-present
- Risk Management Committee 2005-present (chair)
- Clinical Practice Committee 2001-present (chair 2001-2007)

OTHER COMMITTEES:

- Oversight Committee, Connecticut Children's Medical Center 2004-05
- Ambulatory Experience Committee (MAX) Univ. of Conn. School of Medicine: 1994-1995
- Surgical Advisory Board, ConnectiCare: 1990-1993
- Payment of New Technologies Committee, ConnectiCare: 1991-1993
- Quality Assurance Committee, Kaiser Permanente Northeast Region: 1993-1996
- Program Committee, New England Critical Care Society: 1993

POST GRADUATE TRAINING:

July 1983 - June 1984	Fellow in Critical Care Medicine, University of Miami-Jackson Memorial Medical Center, Miami, FL.
July 1982 - June 1983	Chief Resident in General Surgery, Hartford Hospital-University of Connecticut, Hartford, CT.
July 1979 - June 1982	Resident, General Surgery, Hartford Hospital-University of Connecticut, Hartford, CT.
July 1978 - June 1979	Intern, General Surgery, Hartford Hospital-University of Connecticut, Hartford, CT.
Jan 1978 - June 1978	Intern, Internal Medicine, Hartford Hospital, Hartford, CT.

EDUCATIONAL RECORD:

Sept 1974 - May 1978	University of Connecticut School of Medicine. M.D.
Research:	Ultrastructural Changes in the Mouse Liver After Transplacental Exposure to the Carcinogen
Awards:	Gabriel Ingenito Scholarship Faculty Award for Outstanding Research
Sept 1970 - May 1974	Hamilton College: A.B. with Honors
	Major areas of study: Biology: Senior thesis on Ultrastructural Changes in the Stimulated Mouse Adrenal. History: Senior thesis on 18th Century Urban Development in Great Britain.
Awards:	Departmental Honors in Biology Departmental Honors in History Hadley S. Depuy Service Award George Watson's College Fellowship Charles Dana Scholarship
Extracurricular:	Hamilton College Student Senate Chapel Board President's Advisory Committee Emerson Literary Society Hamilton College Chess Champion
1966 - 1970	Amity High School, Woodbridge, CT.

AWARDS:

Resident Teaching Award, Univ. of Conn., Integrated Surgical Residency, 1996
Distinguished Alumnus Award, Amity High School, 1986
Ludwig J. Pyrtek Award, 1983
Howard Levine Science Award, Third Prize, 1982
Resident's Trauma Competition, American College of Surgeons, Connecticut Chapter, Third Prize, 1981.
Upjohn Intern of the Year, 1979.

PUBLICATIONS:

1. Orlando, III, R., and Welch, John P. Welch. "Carcinoma of the Stomach After Gastric Operation." Am. J. Surg. 141:487-92, 1981.

2. Orlando, III, R., and A. David Drezner. "Intra-aortic Balloon Counter-pulsation in Blunt Cardiac Injury." J. Trauma. 23:424-27, 1983.

3. Orlando, III, R., Pastuszak, W., Preissler, P., and John P. Welch. "Gastric Lymphoma: a Clinico-pathologic Reappraisal." Am. J. Surg. 143:450-455, 1982.

4. Rosenberg, J., Orlando, III, R., Ludwig, M., and Ludwig J. Pyrtek. "Parathyroid Cysts." Am. J. Surg. 143:473-80, 1982.

5. Orlando, III, R., Gleason, E., and A. David Drezner. "Acute Acalculous Cholecystitis in the Critically Ill Patient." Am. J. Surg. 145:472-476, 1983.

6. Orlando, III, Rocco. "Smoke Inhalation Injury." Emerg. Care Quart. 1:22-30; 1985.

7. Orlando, III, R., Chinniah, N., Riegle, C., and Barbara Morris. "High Frequency Jet Ventilation: Case Studies." Curr Rev Resp Ther, 1986.

8. Orlando, III, Rocco. "Mixed Venous Oximetry in Critically Ill Surgical Patients: "High Tech" Cost Effectiveness." Arch Surg. 121:470-471, 1986.

9. Sardella, W. V., Ciccarelli, O., Rosenberg, J., Drezner, A. D., and Rocco Orlando, III. "A Rational Approach to Tracheostomy in the Surgical Intensive Care Unit." Proceeding of New England Surgical Society, 1985.

10. D'Angio, R., and Rocco Orlando, III. "Fluid Resuscitation: Colloid Versus Crystalloid." Conn Med. 50:689-691, 1986.

11. Crepps, T., Welch, J. P., and Rocco Orlando, III. "Management and Outcome of Retroperitoneal Abscesses." Ann Surg. 205:276-281, 1987.

12. Orlando, III, R., Gluck, E. H., Cohen, M., and C. G. Mesologites. "Ultra-High Frequency Jet Ventilation in a Bronchopleural Fistula Model." Arch Surg. May, 1988.

13. Vignati, P. V., Orlando, III, R., and Kenneth A. Kern. "Guidelines for Administration of Total Parenteral Nutrition Measured versus Predicted Energy Needs." Current Surgery. April, 1988.

14. Yuk, J., Nightingale, C. H., Yeston, N.S., Quintilliani, R., Orlando, III, R., Sweeney, K. R., Dobkin, E. D., Kambe, J.C., and Elizabeth Buonpane. "The Absorption of Ciproflaxin in Normal and Critically Ill Individuals Receiving Nasogastric or Nasoduodenal Enteral Nutrition." J. Diag Microbiol Infect Dis. 13:1990.

15. Dobkin, E. D., Valcour, A., Roher McCloskey, C., Allen, L., Kambe, J. C., Gleason, E., Orlando, III, R., Berger, R., and Neil S. Yeston. "Does pH Paper Accurately Reflect Gastric Ph." Crit. Care Med. Accepted for publication. 18(9):985-988, 1990.

16. Korst, R., Orlando, III, R., Yeston, N., Molin, M., DeGraff, A., and E. Gluck. "Validation of Respiratory Mechanics Software Microprocessor Controlled Ventilators." Crit. Care Med 90:271, 1992.

17. Bartlett R., Quintilliani, R., Nightingale, C., Platt, D., Crowe, H., Grotz, R., Orlando, III, R., Strycharz, C., Tetreault, J., and Lerer, T. "Effect of Providing Recommendation for Antimicrobial Therapy in Bacteriology Laboratory Reports." J. Diag Microbiol Infect Dis. 14:157-166, 1991.

18. Grotz, R., MacDermid, R., Orlando, III, R., and Ludwig Pyrtek. "Choledochal Cyst Diagnosed in Pregnancy." Connecticut Medicine. 55:262-266, 1991.

19. Orlando, III, R., Russell, J., Lynch, J., and Mattie, A. "Laparoscopic Cholecystectomy a Statewide Experience." Arch Surgery. 128:494-9, 1993.

20. Fritts, L., and Rocco Orlando, III. "Laparoscopic Appendectomy." Arch Surgery. 128-521-5, 1993.

21. Safran, D., Sgambatti, S., and Rocco Orlando, III. "Laparoscopic Surgery in High Risk Cardiac Patients." Surg, Gynecol Obstet. 177: 1993.

22. Orlando, III, R., Welch, J. P., Akbari, C., Bloom, G. P., and William P. Macaulay. "Techniques and Complications of Open Packing in Infected Pancreatic Necrosis." Surg, Gynecol Obstet. 179:65-71, 1993.

23. Safran, D., and Rocco Orlando, III. "Physiologic Effects Pneumoperitoneum." Am. J. Surg. 167:281-287, 1994.

24. Robbins, J. M., Keating, K., Orlando, III, R., Corvo, P., Schenarts, P., and Neil S. Yeston. "Effects of Blood Transfusion on Oxygen Delivery and Oxygen Consumption in Critically Ill Surgical Patients." Contemporary Surgery. 43(5):272-326, November 1993.

25. Simchuk, E.J., Welch, J.P., and Orlando. R. "Ante Partum Diagnosis of Pancreatic Carcinoma: A Case Report." Conn. Med. 59:259-62, 1995.

26. Orlando, R., and J.C. Russell. "Cost-effective Approach to Laparoscopic Cholecystectomy." Surg Clin North Amer. 76:117-128, 1996.

27. Orlando, R., Arillaga, A., Charash, W.E., and F.A. Luchette. "Hemostasis in Trauma Surgery." Contemporary Surgery. 51:49-64, 1997.

28. Orlando, R., and Crowell, K. "Laparoscopy in the Critically Ill." Surg. Endosc. 11:1072-4, 1997.

29. Orlando, R, Ahmad A, Bloom, GP, Welch JP. "Laparoscopic repair of paraesophageal hernia". Proceedings of the 6th World Congress of Laparoscopic Surgery. pp 249-252, 1998.

30. Orlando R, "Enteral Nutrition: Should we feed the stomach?" (editorial) Crit Care Med. 27: 334-335, 1999.

31. Antonetti, MC, Killelea B, Orlando R. "Hand-Assisted Laparoscopic Liver Surgery". Arch Surg. 137:407-412, 2002.

32. Orlando R, "Ventilators: How clever, how complex?" (editorial). Crit Care Med. 31:2704-5, 2003.

33. Orlando R, Eddy VA, Jacobs LM Jr, Stadelmann WK, "The abdominal compartment syndrome." Arch Surg. 139:415-22, 2004.

34. Marshall W, Orlando R, "B-Natiuretic peptide as a marker of heart failure: not so specific after all." Crit Care Med 30:2249, 2006

35. Velanovich V, Morton JM, McDonald M, Orlando R, Maupin G, Traverso W, "Analysis of the SAGES outcomes initiative cholecystectomy study." Surg Endos. 20:43-50, 2006.

36. Poultsides G, Bloom GP, Orlando R. "Laparoscopic resection of gastroduodenal tumors". Surg Endosc. 21:1275-9, 2007.

37. Poultsides G, Brown M, Orlando, R. "Hand Assisted laproscopic management of liver tumors". Surg Endosc. 2007.

38. Poultsides G, Orlando R, Hallisey M, Vignati P. "Arteriographic embolization for upper gastrointestinal bleeding." Arch Surg 143:457-461 2007.

ABSTRACTS:

1. Orlando, III, R., and A. David Drezner, "Intra-aortic Balloon Counter-pulsation in Cardiac Contusion." Crit. Care Med. 9:254, 1981.

2. Dake, A., Gleason, E., Orlando, R., and Neil S. Yeston. "Transcutaneous Monitoring in Critically Ill Surgical Patients." Chest. October, 1989.

3. Rocco Orlando, III. "Clinical Utility of Simultaneous Arterial and Venous Oximetry." Crit. Care Med. 14:340, 1986.

4. Orlando, III, R., Conte, C. C., and Lenworth M. Jacobs. "MUGA Scans in the Diagnosis of Cardiac Contusion." J. Trauma. 24:652, 1984.

5. Orlando, III, R., Nelson, L. D., and Joseph M. Civetta. "Invasive Pre-operative Evaluation of High Risk Patients." Crit. Care Med 13:263, 1985.

6. Koenig, W., Adams, K., Platt, D., Drezner, A. D., and Rocco Orlando, III. "Fungal Infections in the SICU." Crit. Care Med. 14:330, 1986.

7. Orlando, III, R., Drezner, A. D., Riley, B., Lawrence, D., and Quinn, A. "High Tech Beds: Clinical Effects and Cost Effective Allocation." Crit. Care Med 15:350, 1987.

8. Orlando, III, R., Schwartz, R., Lee, M., and Lenworth Jacobs. "The Role of the Flight Physician in Helicopter Critical Care Transport." Crit. Care Med. 15:367, 1987.

9. D'Angio, R., Quercia, R., Orlando, III, R., Nightingale, C., A. David Drezner. "The Effect of Heparin on the Clearance of Intravenous Lipid Emulsion in Critically Ill Surgical Patients." JPEN. 11:19S, 1987.

10. Bartlett, R. C., Quintilliani, R., Nightingale, C. H., Platt, D., and Rocco Orlando, III. "Effect of Providing Recommendations for Antimicrobial Therapy in Bacteriology Lab Reports." ICAC Conference, October, 1987.

11. Yuk, J., Nightingale, C. H., Yeston, N. S., Quintilliani, R., Orlando, III, R., Sweeney, K. R., Dobkin, E. D., Kambe, J. C., and Elizabeth Buonpane. "The Absorption of Ciproflaxin in Normal and Critically Ill Individuals Receiving Nasogastric or Nasoduodenal Enteral Nutrition." International Ciproflaxin Symposium, Naples, Florida, April 28-30, 1989.

12. Dobkin, E., Valcour, A., Roher, C., Allen, L., Kambe, J., Gleason, E., Orlando, III, R., and Neil S. Yeston. "Does pH Paper Accurately Reflect Gastric pH." Chest. October, 1989.

13. Korst, R., Orlando, III, R., Yeston, N., Molin, M., DeGraff, A., and E. Gluck. "Validation of Respiratory Mechanics Software Microprocessor Controlled Ventilators." Chest. October, 1989.

14. Orlando, III, R., Eckert, R., Gleason, E., and Neil S. Yeston. "CO_2 Monitoring: Transcutaneous Versus Capnography." Crit. Care Med. 19:S61, 1991.

15. Frigon, L., Orlando, III, R., L Allen. "Nurses' Attitudes to Visiting in Adult Intensive Care Units." Crit. Care Med. 19:S81, 1991.

16. Dobkin, E., Valcour, A., McCloskey, C., Allen, Kambe, J., Gleason, E., Orlando, III, R., Berger, R., Neil S. Yeston. "Does pH Paper Accurately Reflect Gastric pH?" Critical Care Medicine. 18:985-988, 1990.

17. Robbins, J., Keating, K., and Rocco Orlando, III, et. al. "Effects of Blood Transfusion on Oxygen Consumption and Delivery in Critically Ill Surgical Patients." Crit. Care Med. 20:1139, 1992.

18. Safran, D., Sgambatti, S., and Rocco Orlando, III. "Laparoscopic Surgery in High Risk Cardiac Patients." Crit. Care Med. 21:S254, 1993.

19. Orlando, III, R., Kantor, W., Donahue, S., Barkley, K., Molin, M., and Neil S. Yeston. "Effected Aerosolized Bronchodilators in Mechanically Ventilated." Crit. Care Med. 21:S211, 1993.

20. Yeston, N. S., Keating, K., and Rocco Orlando, III, et. al. "Quality Assessment and Improvement in the Adult ICU." Clin Intensive Care. 1993.

21. Bove, P., Sobowale, O., Orlando, III, R., Brady, E., Gleason, E., and N. Yeston. "Cardiac Tamponade After Cardiac Surgery: Early Detection With Right Heart Ejection Fraction Catheters." Crit. Care Med. 12: A81, 1995.

22. Mazo, J., Vignati, P., Orlando, III, O., Cohen, J., and W. Sardella. "Laparoscopic Hartmann Closure: Avoiding the Pitfalls." Surg. Endosc. 11:182, 1997.

23. Adam, J., Beatrice, F., Rosow, E., and R. Orlando, III. "A Virtual Instrumentation System for Fiberoptic Endoscopes. Surg. Endosc. 11:172, 1997.

24. Orlando, III, R., and K. Crowell. "Laparoscopy in the Critically Ill." Surg. Endosc. 11:210, 1997.

25. Orlando, III, R., Ahmad, A., Bloom, G.P. and J.P. Welch. "Laparoscopic Repair of Paraesophageal Hernia." 6th World Congress of Endoscopic Surgery Proceeding, 1998.

26. Orlando, III, R. "Hand Assisted Laparoscopy for Liver Tumors." Surg. Endosc. 14:5209, 2000.

27. Orlando, III, R, Fitzgerald J. "Hand-assisted Laparoscopic Debridement of Infected Pancreatic Necrosis." Surg Endosc. 15: 2003.

28. Velanich V, MacDonald MM, Orlando R, Traverso W. "Analysis of the SAGES Outcomes Initiative Cholecystectomy Registry". Surg Endosc. 19, 2005

BOOK CHAPTERS:

Rocco Orlando, III. "Intussusception" Book Chapter in Intestinal Obstruction, J.P. Welch ed. W. B. Saunders, 1989.

Rocco Orlando, III "Communicating with Patients about Medical Error" in Ethical Issues in Surgery, E. Frezza MD, ed. Cinemed, 2008.

PRESENTATIONS:

"Carcinoma of the Stomach After Gastric Operation", New England Surgical Society, Portsmouth N.H., September, 1980.

"Abdominal and Pelvic Trauma", Symposium on Serious Trauma, Connecticut Hospital Association, Wallingford, Connecticut, March, 1981.

"Intra-aortic Balloon Counterpulsation in Cardiac Contusion", World Congress on Critical Care Medicine, Washington, D.C., May, 1981.

"Gastric Lymphoma: A Clinico-Pathologic Reappraisal", New England Surgical Society, Dixville Notch, N.H., September, 1981.

"Hemodynamic Monitoring", First Inter-City Critical Care Conference, University of Connecticut School of Medicine, Farmington, CT., January, 1982.

"Thoracoscopy", Third World Congress on Bronchology, American College of Chest Physicians, San Diego, California, March, 1982.

"Acute Acalculous Cholecystitis in the Critically Ill Patient", New England Surgical Society, Bretton Woods, N.H., October, 1982.

"Anesthetic Considerations in Blunt Chest Trauma", Grand Rounds, Department of Anesthesia, University of Miami School of Medicine, Miami, Florida, March, 1984.

"New Developments in Oxygen Transport Studies", Grand Rounds, Department of Surgery, University of Connecticut School of Medicine, Farmington, CT, August, 1984.

"Invasive Pre-operative Evaluation of High Risk Patients", Society of Critical Care Medicine, Chicago, Illinois, May, 1985.

"Assessment of Oxygen Transport in the Critically Ill", Grand Rounds, Day-Kimball Hospital, Putnam, Connecticut, June, 1985.

"Invasive Pre-operative Evaluation of High Risk Patients", Combined Anesthesia-Surgery Grand Rounds, University of Connecticut School of Medicine, October, 1985.

"A Rational Approach to Tracheostomy in the Surgical Intensive Care Unit", New England Surgical Society, Dixville Notch, N.H., October, 1985.

"Mixed Venous Oximetry in Critically Ill Surgical Patients", New England Surgical Society, Dixville Notch, N.H., October, 1985.

Scientific Exhibit, Surgical Section of Society of Critical Care Medicine, Clinical Congress, American College of Surgeons, Chicago, November, 1985.

"The Role of the PASG in Multiple Trauma", Trauma Symposium, Hartford Hospital, November, 1985.

"Polyglycolic Acid Mesh Closure of Contaminated Abdominal Wounds", Connecticut Society of American Board Surgeons, Cromwell, CT, December, 1985.

"Fungal Infections in the Surgical Intensive Care Unit", Connecticut Society of American Board Surgeons, Cromwell, CT, December, 1985.

Clinical Investigator, Novametrix Corporation, 1986.

"Principles of Oxygen Transport and Hemodynamic Support in Critically Ill Surgical Patients", New England Surgical Society, Bermuda, March, 1986.

"New Approaches to Nutritional Support in the SICU", New England Surgical Society, Bermuda, March, 1986.

"Fungal Infections in the SICU", Society of Critical Care Medicine, Washington, D.C., May, 1986.

"Clinical Utility of Simultaneous Arterial and Venous Oximetry", Society of Critical Care Medicine, Washington, D.C., May, 1986.

"Pulmonary and Cardiac Contusion", First Annual Board Review Course in Critical Care Medicine, Society of Critical Care Medicine, Washington, D.C., May, 1986.

"The Role of the Flight Physician in Helicopter Emergency Medical Services", Connecticut Society of American Board Surgeons, Cromwell, CT, December, 1986.

"Synthetic Colloid Use in Critically Ill Surgical Patients", American Critical Care, 1986-87, $65,000.

"Ultra-High Frequency Jet Ventilation in a Penetrating Lung Trauma Model", U.S. Army Research Grant, 1986-87.

"Pre-operative Evaluation of High Risk Patients", Surgical Grand Rounds, Waterbury Hospital, Waterbury CT, January, 1987.

"The Effect of Heparin on the Clearance of Intravenous Lipid Emulsion in Critically Ill Surgical Patients", American Society for Parental and Enteral Nutrition. New Orleans, Louisiana, February, 1987.

"Illness Severity Scoring Systems", Connecticut Critical Care Society, Hartford, Connecticut, April, 1987.

"ARDS in the Emergency Department", New England Regional Emergency Nurses Association Symposium. May, 1987, Mystic, Connecticut.

"High Tech Beds: Clinical Efficacy and Cost Effective Allocation", Annual Meeting, Society of Critical Care Medicine, Anaheim, California, May, 1987.

"The Role of the Flight Physician in Helicopter Emergency Medical Systems", Annual Meeting, Society of Critical Care Medicine, Anaheim, California, May 1987.

Moderator, Surgery Papers Session, Annual Meeting, Society of Critical Care Meeting, Anaheim, California, May, 1987.

"Continuous Arteriovenous Hemofiltration", Current Topics in Critical Care (Nursing Symposium), June, 1987.

"Ultra-High Frequency Jet Ventilation in a Bronchopleural Fistula Model", PEEP Society. Anaheim, California, May, 1987.

"Ultra-High Frequency Jet Ventilation in a Bronchopleural Fistula Model", New England Surgical Society Annual Meeting, Bretton Woods, New Hampshire, September, 1987.

Effect of providing recommendations for antimicrobial therapy in bacteriology lab reports. (Abstract) RC Bartlett, R Quintilliani, CH Nightingale, D Platt and R Orlando, III: ICAC Conference, October, 1987.

"Ultra-High Frequency Jet Ventilation in the Physiologic Assessment of Pigs with Bronchopleural Fistulas. Annual Scientific Assembly, American College of Chest Physicians, Atlanta, GA, October, 1987.

Instructor, Advanced Cardiac Life Support Program, American Heart Association.

Instructor, Advanced Trauma Life Support Program, Committee on Trauma, American College of Surgeons.

"Preoperative Evaluation of High Risk Surgical Patients" Grand Rounds, Sharon Hospital, Sharon, CT, February, 1989.

"Hemodynamic Monitoring", Grand Rounds, Meriden-Wallingford Hospital, Meriden, CT, May, 1988.

"Hemodynamics and ICU Monitoring", Grand Rounds, Bradley Memorial Hospital, Southington, CT, May 1989.

"Monitoring Oxygen Transport", Grand Rounds, Stamford Hospital, Stamford, CT, May, 1989.

"Transcutaneous Monitoring in Critically Ill Surgical Patients". XVI World Congress on Disease of the Chest, 55th Annual Scientific Assembly, Boston, MA, November, 1989.

"Validation of Respiratory Mechanics Software Microprocessor Controlled Ventilators". XVI World Congress on Disease of the Chest, 55th Annual Scientific Assembly, Boston, MA, November, 1989.

"Does pH Paper Accurately Reflect Gastric pH". XVI World Congress on Disease of the Chest, 55th Annual Scientific Assembly, Boston, MA, November, 1989.

"New Developments in Critical Care Monitoring" Surgical Grand Rounds, New York, Medical College, Valhalla, NY, December, 1989.

"Open Packing of Infected Pancreatic Necrosis", CSABS, Cromwell, CT, December 1989.

"New Developments in Pulmonary Support", Surgical Grand Rounds, Bridgeport Hospital, Bridgeport, CT, March 1990.

"Monitoring Oxygen Transport", Connecticut Respiratory Care Society, Farmington, CT, April 1990.

Flight Nurse Instructional Course Lectures, "ARDS", "Smoke Inhalation Injury", Hartford Hospital, Hartford, CT, April 1990.

Invited discussant, Eastern Association for the Surgery of Trauma, January, 1991, Sarasota,
Florida.

"Open Packing of Infected Pancreatic Necrosis", presented at Clinical Congress, American College of Surgeons, San Francisco, CA, October, 1990.

Controversies in Surgery - "Surgery in the High Risk and Elderly Patient". University of Connecticut Health Center, Farmington, CT.

"Nurses' Attitudes to Visiting in the Intensive Care Units", Society of Critical Care Medicine,
Washington, D.C., May, 1991.

"CO_2 Monitoring: Transcutaneous versus Capnography", Society of Critical Care Medicine,
Washington, D.C., May, 1991.

"Laparoscopic Surgery", Surgical Grand Rounds, Hartford Hospital, Hartford, CT, August, 1991.

"Laparoscopic Surgery", Medical Grand Rounds, Hartford Hospital, Hartford, CT, September, 1991.

"Laparoscopic General Surgery", Surgical Applications of the KTP Laser, Hartford, CT, November, 1991.

"Laparoscopic Appendectomy", Connecticut Society of American Board Surgeons, Cromwell, CT, December, 1991.

"ARDS: Pathophysiology and Treatment", Grand Rounds, Rockville Hospital, February, 1991.

"Laparoscopic Appendectomy", Advanced Laparoscopic Surgery Workshop, University of Connecticut School of Medicine, Farmington, CT, April, 1992.

"Blunt Chest Trauma", Annual Meeting, Maine State Committee on Trauma, American College of Surgeons. Lewiston, ME, April, 1992.

"New Developments in ICU Monitoring", Surgical Grand Rounds, Maine Medical Center, Portland, ME, April, 1992.

"Blunt Chest Trauma", Trauma Grand Rounds, Yale University School of Medicine, May, 1992.

"Effects of Blood Transfusion on Oxygen Consumption and Oxygen Delivery in Critically Ill Surgical Patients", Society of Critical Care Medicine, San Antonio, TX, May 1992.

"Laparoscopic Appendectomy", New England Surgical Society, Dixville Notch, NH, September, 1992.

"Laparoscopic Cholecystectomy: A Statewide Experience", New England Surgical Society, Dixville Notch, NH, September, 1992.

"Oxygen Transport Monitoring", Conn. Academy of Physician Assistants, Meriden, CT November, 1992.

"Laparoscopic Cholecystectomy in High Risk Cardiac Patients", Connecticut Society of American Board Surgery, Cromwell, CT, December, 1992.

"Laparoscopic Cholecystectomy - Connecticut", Connecticut Hospital Association, Wallingford, CT, January, 1993.

"New Developments in Mechanical Ventilation", New England Surgical Society, Bermuda, March, 1993.

"Laparoscopic Surgery at Hartford Hospital", Surgeons Travel Club, Hartford, CT, May, 1993.

"Effected Aerolized Bronchodilators in Mechanically Ventilated Surgical Patients", Society of Critical Care Medicine, New York, NY, June 1993.

"Laparoscopic Surgery in High Risk Cardiac Patients", Society of Critical Care Medicine, New York, NY, June, 1993.

"Venous Oximetry in Trauma Patients", Trauma Course, American College of Surgeons Critical Congress, San Francisco, CA, October, 1993.

"Physiology, Laparoscopy and Critical Care", Surgical Grand Rounds, Baystate Medical Center, Springfield, MA, November, 1993.

"Laparoscopy in the Critically Ill", Connecticut Society of American Board Surgeons, Cromwell, CT, December, 1993.

"Physiology, Laparoscopy and Critical Care", Surgical Grand Rounds, Winthrop University Hospital, Mineola, LI, NY, December, 1993.

"Does Laparoscopy Change the Indication for Surgery?", Massachusetts Chapter American College of Surgeons Annual Meeting, December, 1993.

"Laparoscopic Antireflux Surgery", Medical Grand Rounds, Hartford Hospital, Hartford, CT, January, 1994.

"Critical Care for the Practicing Surgeon", Controversies in Surgery, University of Connecticut School of Medicine, March, 1994.

"Cardiac Tamponade after Cardiac Surgery: Early Detection with Right Heart Ejection Fraction Catheters", CSABS, December 1994.

"Routine vs. Selective Cholangiography? Controversies in Surgery, Albert Einstein College of Medicine, New York, NY, December 1994.

"Cardiac Tamponade after Cardiac Surgery: Early Detection with Right Heart Ejection Fraction Catheters", Society of Critical Care Medicine, San Francisco, CA, February 1995.

"Managed Care and the Surgeon", Grand Rounds, Department of Surgery, Hartford Hospital, Hartford, CT, April 1995.

"Advances in Laparoscopic Surgery", Grand Rounds, Rockville General Hospital, Rockville, CT, June 1995.

Presidential Address, Connecticut Society of American Board Surgeons, December 1995.

Moderator, "Laparoscopy Herniorraphy", Rocky Hill, CT, November 15, 1996.

"A Virtual Instrumentation System for Fiberoptic Endoscopes", SAGES, March 1997.

"Laparoscopy in the Critically Ill", SAGES, March 1997.

"Laparoscopic Hartmann Closure: Avoiding the Pitfalls", SAGES, March 1997.

"Laparoscopic Anti-reflux Surgery", Association of Surgical Technologists, October 25, 1997.

"Laparoscopic Repair of Paraesophageal Hernia", 6th World Congress of Endoscopic Surgery, Rome, Italy, June 1998.

"The Endotester as a Tool in Assessing Endoscopic Image Quality", Ergonomics Station, SAGES, April 1999.

"Sources of Problems with Endoscopic Visualization", SAGES, April 1999.

"Laparoscopy for Trauma", Westchester Surgical Society, Hartford, CT, May 10, 1999.

Course Director, Westchester Surgical Society Annual Meeting, Hartford, CT, May 10, 1999.

"Laparoscopy for Trauma", Trauma Point and Counterpoint, Atlantic City, NJ, May 25, 1999.

"What's New in Mechanical Ventilation," Trauma Point and Counterpoint, Atlantic City, NJ, May 25, 1999.

"Technical Aspects of Liver Resection," UConn Surgical Residency Program, October 1, 1999.

"Hand-Assisted Laparoscopic Liver Surgery" New England Surgical Society, Providence RI, September, 2001.

"Laparoscopy in the Management of Upper GI Tumors" Surgical Grand Rounds, Waterbury Hospital, October 2001

"Laparoscopic Liver Surgery" Surgical Grand Rounds, Winthrop University Hospital-Stony Brook School of Medicine, Mineola, NY, November 2002.

"Laparoscopic Debridement of Infected Pancreatic Necrosis" SAGES, Los Angeles, CA, April 2002.

"The Open Abdomen" Moderator, Symposium, New England Surgical Society, Newport, RI, September 2003.

"Computers in Medicine" Hartford Hospital Honorary Medical Staff Annual Meeting, October 2003.

"Medical Technology: What's Coming and How to Pay for It" Hamilton Workshop, Hartford Hospital, October, 2003.

"Incorporating technology into your Practice". Moderator, New England Surgical Society, Montreal, Que, Canada. October 2, 2004.
"The Abdominal Compartment Syndrome" Moderator, Panel, New England Surgical Society, Newport, RI, September, 2003.

"Laparoscopic Resection of Gastroduodenal Tumors", SAGES, Dallas, TX, April, 2006.

"Hand-assisted Laparoscopic Management of liver tumors", SAGES, Dallas, TX, April, 2006.

"Arteriographic Embolization for Upper Gastrointestinal Bleeding", New England Surgical Society, Burlington, VT, September, 2007.

"Laparoscopic Surgery for Liver Tumors", invited lecture, New England Surgical Society, Boston, MA, September, 2008.

"Pay for Call?", New England Surgical Society, Boston, MA, September 2008.

RESEARCH GRANTS:

"Synthetic Colloid Use in Critically Ill Surgical Patients", American Critical Care, 1986-87, $65,000.

Clinical Investigator, Novametrix Corporation, 1986.

"Ultra-High Frequency Jet Ventilation in a Penetrating Lung Trauma Model", U.S. Army Research Grant, 1986-87.

"Dermabond/Vicryl Plus Wound Closure Study", Ethicon, 2003, $28,000.

"A prospective Randomized controlled, multicenter study comparing infection rates in a surgical incision closed with DermabondHVD". Ethicon, 2005, $20,000

David A. Whitehead

39 Sachem Street
Norwich, CT 06360

Home: 860-887-2544
Cell: 860-608-0420
Email: dwhitehead@wwbh.org

Highlights

High-energy hospital administrator with extensive healthcare experience in leading strategic development of hospital services to achieve mission accountability. Demonstrated talent for leadership, consensus-building and teambuilding, developing rapport and alignment with physicians, clinicians and support staff, and proven ability to manage large and complex projects. Currently serve primarily as President and Chief Executive Officer for an independent hospital-based healthcare organization.

Professional Experience

THE WILLIAM W. BACKUS HOSPITAL, Norwich, CT 1999-Present

The 213-bed, not-for-profit, acute care community Hospital is the primary source of health services for nearly a quarter-million people. Since its founding in 1893, Backus Hospital has continually expanded, providing new programs and services and forming strategic alliances with other healthcare organizations and providers. Backus is the only state-designated trauma center east of the Connecticut River, and it is the only regional facility that can receive, via air medical transport helicopter, patients with severe traumatic injuries.

President and Chief Executive Officer (July 2009 – Present)

Vice President, Planning (2003 – July 2009)
Lead the full planning spectrum for the Hospital and subsidiary health care service corporations to achieve Board-approved strategic initiatives through capital, clinical, financial, facility and operational business plan development and implementation. Provide leadership oversight for the efforts of the Corporate Communications Division, which implements market development, community health coordination and programming, customer service, philanthropic operations, government relations and patient experience efforts.

Administrator, CONNCare, Inc. (Backus Health Care, Inc.) (2004 – 2006)
Executive leader for the organization's subsidiary healthcare corporation, which provides occupational health services, a network of urgent/primary care health centers, non-hospital-based joint ventures and affiliations and an affiliated multi-specialty surgical practice.

Vice President, Corporate Communications (1999 – 2003)
Led all corporate communications activities including public relations, marketing communications, development and maintenance of Intranet and Internet web sites, publishing of a monthly health magazine, weekly development of an in-house newsletter and development of all constituency communications.

Philanthropic Development (1999 – 2003)
Lead the Corporation's non-profit Foundation (now the Office of philanthropy and Development) through active fundraising and philanthropic development for the purposes of providing health care resources for the direct benefit of the Hospital and community, and through external affiliations with other providers.

Education

University of New Haven, New Haven, CT
Master of Healthcare Administration
Master of Science, Labor Relations

Eastern Connecticut State University, Willimantic, CT
Bachelor of Science, Business Administration

Professional Affiliations

Member, American College of Healthcare Executives	2003 - Present
Member, Society for Healthcare Strategy and Market Development	2003 - Present
Member, Advisory Board – Marketing and Planning Leadership Council	1999 - Present
Member, Connecticut Hospital Association Committee on Government	2000 - Present
Member, Connecticut Hospital Association Task Force on Universal Healthcare	2006 - Present

Community Leadership

Chair, Chamber of Commerce of Eastern Connecticut
Chair, United Way of Southeastern Connecticut
*Chair, Norwich Free Academy
Co-Chair, Norwich Vision
President, Eastern Connecticut Community Foundation
Director and Sole Member Representative, Hospice Southeastern Connecticut
Director, Three Rivers College Foundation
*Corporator, Chelsea-Groton Savings Bank
*Corporator, Dime Bank

* - *current participation*

Recognition

2002 — Eastern Connecticut Citizen of the Year
1997 — Eastern Connecticut Chamber of Commerce Community Spirit Award
1996 — Gannett Spotlight on Service Award
1994 — Gannett President's Ring recipient for Publishing Leadership
1993 — Newspaper Personnel Relations Association Publications Award: *Pay for Performance: A Manager's Guide to Salary Administration*
1991 and 1992 — Gannett President's Ring recipient for Human Resource Leadership

DANIEL E. LOHR, CPA

PROFESSIONAL EXPERIENCE

THE WILLIAM W. BACKUS HOSPITAL, Norwich, CT 1993-Present
Senior Vice President and Chief Financial Officer

Management of the financial operations of a 213-bed, 1,800-employee acute care hospital. Responsibilities include board and regulatory agency reporting and operating responsibility with direct oversight for management information systems, materials management, medical records, business office and patient registration. Other corporate responsibilities include investment/foundation oversight, development of for-profit joint ventures and physician practice activities.

ERNST & YOUNG, Hartford, CT 1974-1992
Partner 1987-1992

Coordinated services to hospitals, healthcare systems, small entrepreneurial companies and multi-national organizations. Facilitated merger and acquisition activities, financing transactions and systems conversions.

EDUCATION

University of New Haven, MBA, 1999

Ohio University, BBA, summa cum laude, 1973

Ernst & Young Partners' Executive Development Program, 1991
Northwestern University, J.L. Kellogg Graduate School of Management

CURRICULUM VITAE

Peter Hagerty Shea, M.D.

Address

The William W. Backus Hospital
326 Washington Street
Norwich, CT 06360

Telephone: (860) 892-6941
Fax: (860) 892-6914
E-mail: pshea@wwbh.org

Personal

Born: May 21, 1953
Married; three children

Education

Harvard College - A.B. cum laude in Biology	1976
University of Connecticut Medical School - M.D.	1980

Postgraduate Training

The Milton S. Hershey Medical Center Pennsylvania State University, Hershey, PA	
Internship, Internal Medicine	1980-1981
Residency, Internal Medicine	1981-1983

Hospital Appointments

The Good Samaritan Hospital, Lebanon, PA (Emergency Room Staff)	1981-1983
Ephrata Community Hospital, Ephrata, PA (Emergency Room Staff)	1982-1983
Uncas-on-Thames Hospital, Norwich, CT (Consulting Staff)	1987-1993
The William W. Backus Hospital, Norwich, CT (Private Practice 1983-2006)	1983-present

Certification/Licensure

National Board of Medical Examiners	1981
American Board of Internal Medicine	1983
Connecticut State License #24359	1983-present

Memberships

American College of Physicians	1980-present
New London County Medical Association	1983-present
Committee on Patient Care Quality of the Connecticut Hospital Association Board of Trustees	2006-present

Appointments/Work History

The William W. Backus Hospital, Norwich, CT

Senior Vice President and Chief Medical Officer	2009-present
Medical Director	2006-2009
Chairman, Division of Medical Services	2000-2009
Acting Chairman, Division of Medical Services	1996-1999
Chairman, Quality Improvement Committee	1994-present
Physician Director, Quality Assessment and Improvement	1994-present
Quality Improvement Officer, Departments of Internal Medicine and Family Practice	1987-present
Member, Board of Trustees	1987-1988 and 1995-2001

Peter Hagerty Shea, M.D.

PUBLICATIONS

1. Shea, Peter H., Maher, John F., Horak, Eva. Prediction of glomerular filtration rate by serum creatinine and beta-2 microglobulin. Nephron 29:30-35 (1981)

2. Horak, Eva, Shea, Peter H., Maher, John F., Kennedy, Thomas L. III, Randolf, Martin T., McLean, Robert H., Suderman, F. William Jr. Radioimmunoassays of beta-2 microglobulin in body fluids of healthy adults, children, patients with renal diseases, and nickel-exposed workers. Annals of Clinical and Laboratory Science 10:5:448 (1980)

3. Shea, Peter H., Maher, John F., Horak, Eva. Prediction of GFR by serum beta-2 microglobulin and creatinine. American Society of Nephrology Eleventh Annual Meeting (1978)

Exhibit 11

Organizational Quality Structure

Hartford HealthCare

Quality at HHC

Rocco Orlando, MD
Chief Medical Officer

Accountability for Quality begins with the Board and cascades through the organization

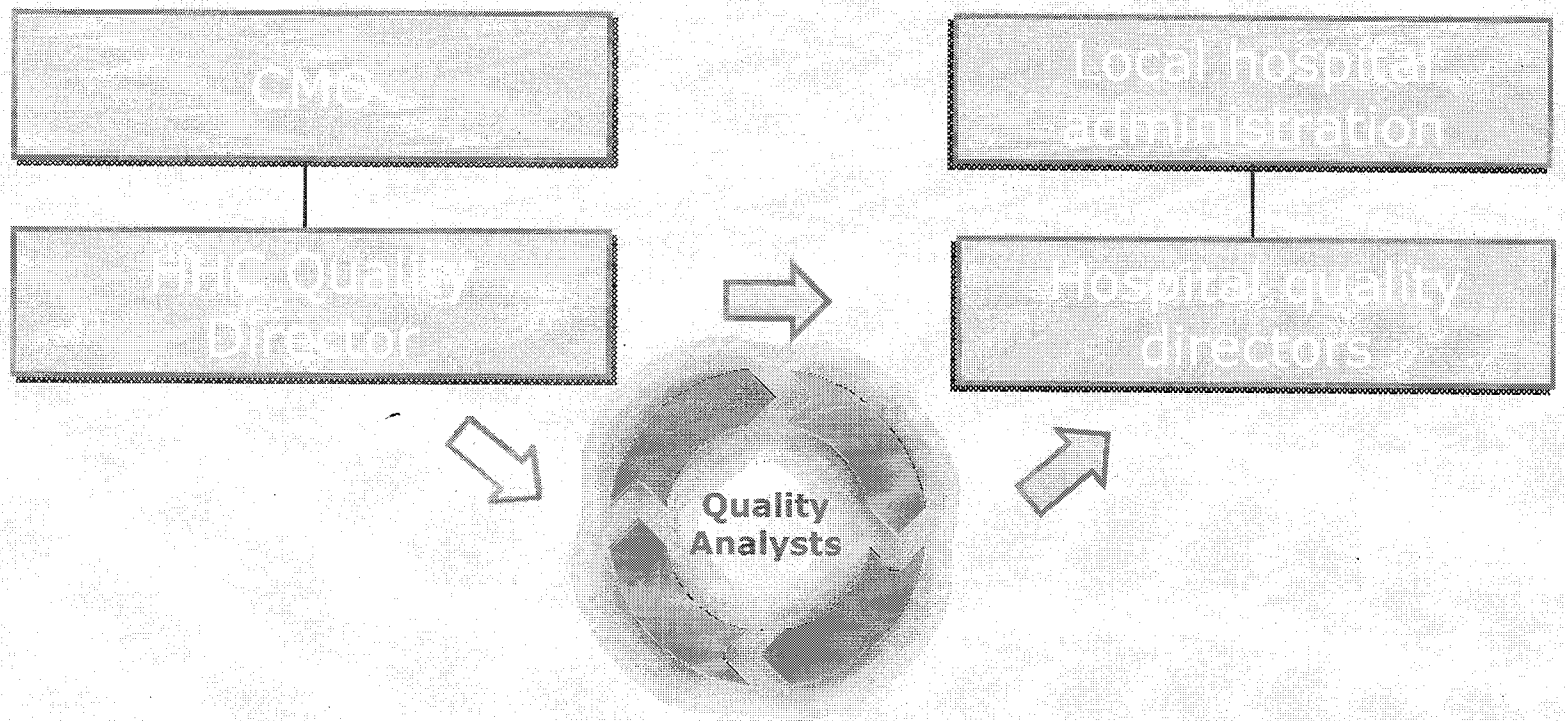
Hartford HealthCare

000615

HHC: Office of Clinical Quality and Safety

- Coordinate Quality and Safety activities across the system
- Ensure use of common informatics and data definitions
- Disseminate quality information across the system – both internal best practices and best practices from other organizations
- Support the HHC Quality Council, the CMO and individual Hospital quality programs
- Initial phase begins with the four acute hospitals

HHC Quality Structure



Hartford HealthCare

HHC Quality Director

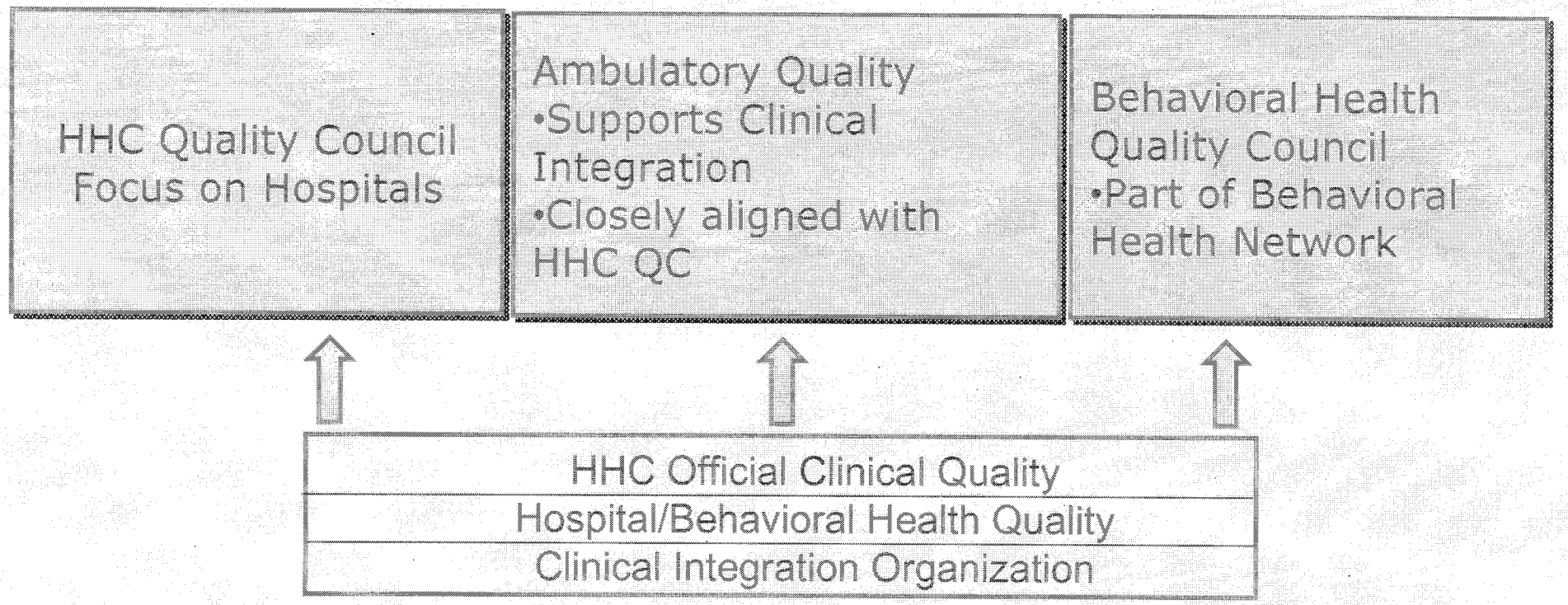
- Directs HHC Office of Clinical Quality
- Hospital Quality Directors: dual report to HHC Quality director and local hospital leadership
- Responsible for coordinating quality informatics
- Assists with coordination of Quality Balanced Scorecard initiatives
- Supervises Quality Analysts
- Coordinates compliance with all publicly reported performance measures across the system

Hartford HealthCare

Quality Analysts: RN consultants

- Experts in Quality Informatics
  - Quality Advisor
  - QMR
  - Safety Surveillor
- Quantros
- Will support hospital quality programs with reports providing data about harm, readmissions, mortality, OPPE, etc.
- Will support hospitals, medical staff and risk management with quality and safety analytics

HHC Quality and Safety Structure



Hartford HealthCare

Exhibit 12

HHC
&
Backus Corporation
IRS Determination
Letters

Internal Revenue Service

Department of the Treasury

Washington, DC 20224

Backus Corporation
326 Washington Street
Norwich, CT 06360

Person to Contact: Mr. Chasin
Telephone Number: (202) 566-3909

Refer Reply to:
OP:E:EO:R:4
Date:
FEB 14 1984

Employer Identification Number: Applied for
Key District: Brooklyn
Accounting Period Ending: September 30
Form 990 Required: Yes

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.

We have further determined that you are not a private foundation within the meaning of section 509(a) of the Code, because you are an organization described in sections 509(a)(3).

If your sources of support, or your purposes, character, or method of operation change, please let your key district know so that office can consider the effect of the change on your exempt status and foundation status. Also, you should inform your key District Director of all changes in your name or address.

Generally, you are not required to pay social security (FICA) taxes unless you file a waiver of exemption certificate as provided in the Federal Insurance Contributions Act. If you have paid FICA taxes without filing the waiver, you should contact your key District Director. You are not required to pay tax under the Federal Unemployment Tax Act (FUTA). Beginning January 1, 1984, unless specifically excepted, you must pay taxes under the Federal Insurance Contributions Act (social security taxes) for each employee who is paid $100 or more in a calendar year.

CHIEF FINANCIAL OFFICER
FEB 20 1984
THE WM. W. BACKUS HOSPITAL

Backus Corporation

Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other Federal excise taxes. If you have questions about excise, employment, or other Federal taxes, contact any Internal Revenue Service office.

Donors may deduct contributions to you as provided in section 170. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522.

You are required to file Form 990 only if your gross receipts each year are normally more than $10,000*. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $10 a day, up to a maximum of $5,000, when a return is filed late, unless there is a reasonable cause for the delay.

You are not required to file Federal income tax returns unless you are subject to the tax on unrelated business income under Code section 511. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513.

We are informing your key District Director of the ruling. Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions about this ruling, please contact the person whose name and telephone number are shown in the heading of this letter. For other matters, including questions concerning reporting requirements, please contact your key District Director.

Sincerely yours,

J E Griffith

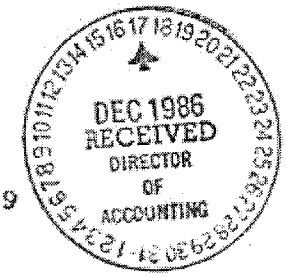
J. E. Griffith
Chief, Exempt Organizations
Rulings Branch

*For tax years ending on and after December 31, 1982, organizations whose gross receipts are not normally more than $25,000 are excused from filing Form 990. For guidance in determining if your gross receipts are "normally" not more than the $25,000 limit, see the instructions for the 1982 Form 990.

Internal Revenue Service

Department of the Treasury

Washington, DC 20224



Person to Contact: Mr. Chasin

Telephone Number: (202) 566-3969

Refer Reply to: OP:E:EO:R:4

Date: 11 DEC 1986

Hartford Health Care
Corporation
80 Seymour Street
Hartford, CT 06115

Employer Identification Number: 22-2672834
Key District: Brooklyn
Accounting Period Ending: September 30
Foundation Status Classification: 509(a)(3)

Dear Applicant:

Based on information supplied and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.

We have further determined that you are not a private foundation within the meaning of Code section 509(a), because you are an organization described in the section of the Code shown above.

If your sources of support, or your purposes, character, or method of operation change, please let your key district know so that office can consider the effect of the change on your exempt status and foundation status. Also, you should inform your key District Director of all changes in your name or address.

Unless specifically excepted, beginning January 1, 1984, you must pay taxes under the Federal Insurance Contributions Act (social security taxes) for each employee who is paid $100 or more in a calendar year. You are not required to pay tax under the Federal Unemployment Tax Act (FUTA).

Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other federal excise taxes. If you have questions about excise, employment, or other federal taxes, contact your key District Director.

Donors may deduct contributions to you as provided in Code section 170. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522.

Hartford Health Care Corporation

You are required to file Form 990, Return of Organization Exempt Income Tax, only if your gross receipts each year are normally more th $25,000. If your gross receipts are not normally more than $25,000 we that you establish that you are not required to file Form 990 by compl Part I of that Form for your first tax year. Thereafter, you will not required to file a return until your gross receipts normally exceed th $25,000 minimum. For guidance in determining if your gross receipts a "normally" not more than the $25,000 limit, see the instructions for t Form 990. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. There a penalty of $10 a day, up to a maximum of $5,000, when a return is fil late, unless you establish, as required by section 6652(d)(1), that the failure to file timely was due to reasonable cause.

You are not required to file federal income tax returns unless you subject to the tax on unrelated business income under Code section 511. you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter w are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513.

Please show your employer identification number on all returns you file and in all correspondence with the Internal Revenue Service.

We are informing your key District Director of this ruling. Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions about this ruling, please contact the pers whose name and telephone number are shown in the heading of this letter. For other matters, including questions concerning reporting requirements, please contact your key District Director.

Sincerely yours,

Milton Cerny

Milton Cerny
Chief, Exempt Organizations
Rulings Branch

Exhibit 13

Table 3
(Patient Population Mix)

Backus Corporation
Corporate Affiliation of Backus Corporation with Hartford HealthCare Corporation

Table 3: Patient Population Mix **Backus Corporation**

Payer Mix	Current *(a)* FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	29.6%	30.1%	31.2%	32.1%
Medicaid & medical assistance	10.3%	10.3%	11.0%	11.6%
CHAMPUS & TriCare	1.4%	1.5%	1.5%	1.6%
Total Government Payers	**41.4%**	**42.0%**	**43.7%**	**45.3%**
Commercial Insurers *	58.6%	58.0%	56.3%	54.7%
Uninsured	0.0%	0.0%	0.0%	0.0%
Workers Compensation	0.0%	0.0%	0.0%	0.0%
Total Non-Government	**58.6%**	**58.0%**	**56.3%**	**54.7%**
Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

(*) Includes managed care activity

(a) Projected FY 2012

Note above percentage calculations based upon revenue dollars

Hartford Health Care WITHOUT the CON
Corporate Affiliation of Backus Corporation with Hartford HealthCare Corporation

Table 3: Patient Population Mix **Hartford HealthCare Corporation**

Payer Mix	Current *(a)* FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	37.0%	37.0%	37.0%	37.0%
Medicaid & medical assistance	14.0%	14.0%	14.0%	14.0%
CHAMPUS & TriCare	0.0%	0.0%	0.0%	0.0%
Total Government Payers	**51.0%**	**51.0%**	**51.0%**	**51.0%**
Commercial Insurers *	46.0%	46.0%	46.0%	46.0%
Uninsured	3.0%	3.0%	3.0%	3.0%
Workers Compensation	0.0%	0.0%	0.0%	0.0%
Total Non-Government	**49.0%**	**49.0%**	**49.0%**	**49.0%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

(*) Includes managed care activity

(a) Projected FY 2012

Note above percentage calculations based upon revenue dollars

Hartford Health Care WITH the CON
Corporate Affiliation of Backus Corporation with Hartford HealthCare Corporation

Table 3: Patient Population Mix **Consolidated Harfford HealthCare and Backus Corporation**

Payer Mix	Current *(a)* FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	36.0%	36.1%	36.2%	36.4%
Medicaid & medical assistance	13.5%	13.5%	13.6%	13.7%
CHAMPUS & TriCare	0.2%	0.2%	0.2%	0.2%
Total Government Payers	**49.7%**	**49.8%**	**50.1%**	**50.3%**
Commercial Insurers *	47.8%	47.6%	47.3%	47.1%
Uninsured	2.6%	2.6%	2.6%	2.6%
Workers Compensation	0.0%	0.0%	0.0%	0.0%
Total Non-Government	**50.3%**	**50.2%**	**49.9%**	**49.7%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

(*) Includes managed care activity

(a) Projected FY 2012

Note above percentage calculations based upon revenue dollars

Exhibit 14

Financial Attachment I
for
Backus Corporation
&
HHC

Financial Attachment I (HHC)

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

Total Hospital Health System: Description	FY2011 Actual Results	FY2012 Projected W/out CON	FY2012 Projected Incremental	FY2012 Projected With CON	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE																
Non-Government	$772,119,000	$848,612,093	$170,842,000	$1,019,454,093	$904,743,096	$169,241,754	$1,073,984,850	$934,654,627	$168,218,132	$1,102,872,759	$962,078,514	$166,584,132	$1,128,662,646	$987,551,610	$163,970,132	$1,151,521,742
Medicare	618,923,000	703,125,354	86,243,000	789,368,354	749,634,038	88,055,645	837,689,683	774,417,161	93,439,153	867,856,314	797,139,207	98,115,153	895,254,360	818,245,401	102,823,153	921,068,554
Medicaid and Other Medical Assistance	219,775,000	243,258,313	30,129,000	273,387,313	259,348,461	30,244,121	289,592,582	267,922,264	32,965,716	300,887,980	275,783,179	35,541,716	311,324,895	283,085,982	38,110,716	321,196,698
Other Government	5,171,000	5,761,422	4,085,000	9,846,422	6,143,404	4,388,480	10,531,884	6,345,948	4,561,999	10,907,947	6,532,100	4,733,999	11,266,099	6,705,007	4,886,999	11,592,006
Total Net Patient Patient Revenue	1,615,988,000	1,800,757,182	291,299,000	2,092,056,182	1,919,868,999	291,930,000	2,211,798,999	1,983,340,000	299,185,000	2,282,525,000	2,041,533,000	304,975,000	2,346,508,000	2,095,588,000	309,791,000	2,405,379,000
Other Operating Revenue	187,975,000	211,167,000	7,930,000	219,097,000	215,606,000	7,306,000	222,912,000	221,616,000	6,749,000	228,365,000	227,950,000	6,176,000	234,126,000	236,533,000	5,821,000	242,354,000
Revenue from Operations	1,803,963,000	2,011,924,182	299,229,000	2,311,153,182	2,135,474,999	299,236,000	2,434,710,999	2,204,956,000	305,934,000	2,510,890,000	2,269,483,000	311,151,000	2,580,634,000	2,332,121,000	315,612,000	2,647,733,000
OPERATING EXPENSES																
Salaries and Fringe Benefits	1,047,834,000	1,154,620,238	156,700,000	1,311,320,238	1,239,795,278	154,745,000	1,394,540,278	1,271,224,544	158,154,000	1,429,378,544	1,317,365,824	161,774,000	1,479,139,824	1,353,805,140	166,504,000	1,520,309,140
Professional / Contracted Services	58,095,000	64,015,543	13,816,000	77,831,543	68,779,480	13,661,000	82,440,480	70,480,429	13,774,000	84,254,429	73,038,637	14,077,000	87,115,637	75,058,940	14,386,000	89,444,940
Supplies and Drugs	228,530,000	251,819,814	42,947,000	294,766,814	270,559,852	41,105,000	311,664,852	277,250,924	42,041,000	319,291,924	287,314,223	43,033,000	330,347,223	295,261,548	44,663,000	339,924,548
Bad Debts	35,420,000	39,029,702	9,374,000	48,403,702	41,934,232	9,631,000	51,565,232	42,971,285	10,559,000	53,530,285	44,531,002	10,987,000	55,518,002	45,762,762	11,423,000	57,185,762
Other Operating Expense	299,728,000	330,273,702	37,302,000	367,575,702	330,446,157	36,353,000	366,799,157	352,120,818	36,584,000	388,704,818	350,596,314	36,111,000	386,707,314	355,517,610	36,103,000	391,620,610
Subtotal	1,669,607,000	1,839,758,999	260,139,000	2,099,897,999	1,951,514,999	255,495,000	2,207,009,999	2,014,048,000	261,112,000	2,275,160,000	2,072,846,000	265,982,000	2,338,828,000	2,125,406,000	273,079,000	2,398,485,000
Depreciation/Amortization	81,701,000	94,551,000	17,355,000	111,906,000	102,032,000	17,386,000	119,418,000	108,815,000	19,949,000	128,764,000	113,318,000	22,507,000	135,825,000	117,762,000	24,802,000	142,564,000
Interest Expense	6,487,000	13,838,000	3,276,000	17,114,000	15,102,000	3,369,000	18,471,000	16,441,000	3,261,000	19,702,000	16,419,000	3,146,000	19,565,000	19,597,000	3,027,000	22,624,000
Lease Expense		-	1,859,000	1,859,000	-	1,897,000	1,897,000	-	1,938,000	1,938,000	-	1,978,000	1,978,000	-	2,020,000	2,020,000
Total Operating Expense	1,757,795,000	1,948,147,999	282,629,000	2,230,776,999	2,068,648,999	278,147,000	2,346,795,999	2,139,304,000	286,260,000	2,425,564,000	2,202,583,000	293,613,000	2,496,196,000	2,262,765,000	302,928,000	2,565,693,000
Gain/(Loss) from Operations	46,168,000	63,776,183	16,600,000	80,376,183	66,826,000	21,089,000	87,915,000	65,652,000	19,674,000	85,326,000	66,900,000	17,538,000	84,438,000	69,356,000	12,684,000	82,040,000
Plus: Non-Operating Revenue	179,991,000	58,376,000	9,252,000	67,628,000	22,600,000	5,078,000	27,678,000	22,286,000	5,255,000	27,541,000	22,105,000	5,441,000	27,546,000	21,945,000	5,635,000	27,580,000
Revenue Over/(Under) Expense	$226,159,000	$122,152,183	$25,852,000	$148,004,183	$89,426,000	$26,167,000	$115,593,000	$87,938,000	$24,929,000	$112,867,000	$89,005,000	$22,979,000	$111,984,000	$91,301,000	$18,319,000	$109,620,000
FTEs	9,668.8	9,958.5	1,674.0	11,632.5	9,955.2	1,642.7	11,597.9	9,989.2	1,595.6	11,584.8	9,995.2	1,560.1	11,555.3	9,999.2	1,554.4	11,553.6

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

Financial Attachment I (Backus Corporation)

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

Total Facility: / Description	FY 2011 Actual Results	FY2012 Projected W/out CON	FY2012 Projected Incremental	FY2012 Projected With CON	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE																
Non-Government	$165,042,000	$170,842,000	$ -	$170,842,000	$168,582,000	$659,754	$169,241,754	$167,040,000	$1,178,132	$168,218,132	$165,406,000	$1,178,132	$166,584,132	$162,792,000	$1,178,132	$163,970,132
Medicare	85,300,000	86,243,000	-	86,243,000	87,509,000	546,645	88,055,645	92,463,000	976,153	93,439,153	97,139,000	976,153	98,115,153	101,847,000	976,153	102,823,153
Medicaid and Other Medical Assistance	30,890,000	30,129,000	-	30,129,000	30,055,000	189,121	30,244,121	32,628,000	337,716	32,965,716	35,204,000	337,716	35,541,716	37,773,000	337,716	38,110,716
Other Government	3,982,000	4,085,000	-	4,085,000	4,384,000	4,480	4,388,480	4,554,000	7,999	4,561,999	4,726,000	7,999	4,733,999	4,879,000	7,999	4,886,999
Total Net Patient Patient Revenue	285,214,000	291,299,000	-	291,299,000	290,530,000	1,400,000	291,930,000	296,685,000	2,500,000	299,185,000	302,475,000	2,500,000	304,975,000	307,291,000	2,500,000	309,791,000
Other Operating Revenue	5,675,000	7,930,000	-	7,930,000	7,306,000	-	7,306,000	6,749,000	-	6,749,000	6,176,000	-	6,176,000	5,821,000	-	5,821,000
Revenue from Operations	290,889,000	299,229,000	-	299,229,000	297,836,000	1,400,000	299,236,000	303,434,000	2,500,000	305,934,000	308,651,000	2,500,000	311,151,000	313,112,000	2,500,000	315,612,000
OPERATING EXPENSES																
Salaries and Fringe Benefits	147,499,000	156,700,000	-	156,700,000	161,505,000	(6,760,000)	154,745,000	166,950,000	(8,796,000)	158,154,000	170,570,000	(8,796,000)	161,774,000	175,300,000	(8,796,000)	166,504,000
Professional / Contracted Services	12,192,000	13,816,000	-	13,816,000	14,106,000	(445,000)	13,661,000	14,402,000	(628,000)	13,774,000	14,705,000	(628,000)	14,077,000	15,014,000	(628,000)	14,386,000
Supplies and Drugs	42,031,000	42,947,000	-	42,947,000	43,549,000	(2,444,000)	41,105,000	45,163,000	(3,122,000)	42,041,000	46,155,000	(3,122,000)	43,033,000	47,785,000	(3,122,000)	44,663,000
Bad Debts	12,595,000	9,374,000	-	9,374,000	9,631,000	-	9,631,000	10,559,000	-	10,559,000	10,987,000	-	10,987,000	11,423,000	-	11,423,000
Other Operating Expense	32,943,000	37,302,000	-	37,302,000	36,353,000	-	36,353,000	36,584,000	-	36,584,000	36,111,000	-	36,111,000	36,103,000	-	36,103,000
Subtotal	247,260,000	260,139,000	-	260,139,000	265,144,000	(9,649,000)	255,495,000	273,658,000	(12,546,000)	261,112,000	278,528,000	(12,546,000)	265,982,000	285,625,000	(12,546,000)	273,079,000
Depreciation/Amortization	17,051,000	17,355,000	-	17,355,000	17,386,000	-	17,386,000	19,949,000	-	19,949,000	22,507,000	-	22,507,000	24,802,000	-	24,802,000
Interest Expense	3,248,000	3,276,000	-	3,276,000	3,369,000	-	3,369,000	3,261,000	-	3,261,000	3,146,000	-	3,146,000	3,027,000	-	3,027,000
Lease Expense	1,785,000	1,859,000	-	1,859,000	1,897,000	-	1,897,000	1,938,000	-	1,938,000	1,978,000	-	1,978,000	2,020,000	-	2,020,000
Total Operating Expense	269,344,000	282,629,000	-	282,629,000	287,796,000	(9,649,000)	278,147,000	298,806,000	(12,546,000)	286,260,000	306,159,000	(12,546,000)	293,613,000	315,474,000	(12,546,000)	302,928,000
Gain/(Loss) from Operations	21,545,000	16,600,000	-	16,600,000	10,040,000	11,049,000	21,089,000	4,628,000	15,046,000	19,674,000	2,492,000	15,046,000	17,538,000	(2,362,000)	15,046,000	12,684,000
Plus: Non-Operating Revenue	2,038,000	9,252,000	-	9,252,000	5,078,000	-	5,078,000	5,255,000	-	5,255,000	5,441,000	-	5,441,000	5,635,000	-	5,635,000
Revenue Over/(Under) Expense	$23,583,000	$25,852,000	$0	$25,852,000	$15,118,000	$11,049,000	$26,167,000	$9,883,000	$15,046,000	$24,929,000	$7,933,000	$15,046,000	$22,979,000	$3,273,000	$15,046,000	$18,319,000
FTEs	1,633.3	1,674.0	-	1,674.0	1,642.7	-	1,642.7	1,595.6	-	1,595.6	1,560.1	-	1,560.1	1,554.4	-	1,554.4

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

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

October 24, 2012 VIA FAX ONLY

Ms. Karen Goyette
Vice President, Strategic Planning and Business Development
Hartford Healthcare Corporation
One State Street
Suite 19
Hartford, CT 06103

RE: Certificate of Need Application, Docket Number 12-31788-CON
Proposal for the affiliation of Backus Corporation with Hartford HealthCare Corporation

Dear Ms. Goyette:

On September 24, 2012, the Office of Health Care Access ("OHCA") received your Certificate of Need application filed on behalf of Hartford HealthCare Corporation ("HHC")and Backus Corporation ("Backus"), (Collectively identified as the "Applicants") for the proposed affiliation of Backus Corporation with Hartford HealthCare Corporation. OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c):

1. On page 10 of the CON application, the Applicants list the specific benefits (items i-xiii) related to the Backus' affiliation with HHCC. Please provide for each benefit listed (items i-xiii) a timeframe and a brief description detailing each item. Additionally, discuss how each of these benefits was determined and provide copies of any studies or community needs assessments performed to arrive at these benefits.

2. Footnote 15 on Page 14 of the application states that executive management for Windham Hospital and Backus Hospital would be centralized to achieve certain operating efficiencies. Provide additional detail on how executive management would be structured at the two hospitals and describe what operating efficiencies would result from this new management structure.

3. Were any Eastern Connecticut region hospitals/health care systems considered for potential affiliation with Backus Corporation? If yes, why was Hartford HealthCare Corporation deemed the better affiliation partner?

4. Please provide a copy of the completed market position summary provided by Kaufman, Hall & Associates to Backus Corporation which determined "that HHC was the most appropriate partner for maximizing…health care delivery in the Eastern Connecticut Region." Page 7-8 of the application.

5. Are there any current collaboration efforts between Backus and other Eastern Connecticut region health care providers? Please describe.

6. On page 8 of the CON application, the Applicants indicate that the "continued viability of Backus Corporation depends, in large part, on its strategic positioning" and indicates in the footnote that both private and government payers are moving toward value-based purchasing (VBP).

    a. How does value-based purchasing relate to the operations of each Corporation and each Hospital, presently?
    b. How will the value-based purchasing be applied with regard to the proposed affiliation?
    c. Quantify the effect value-based purchasing will have on Backus Hospital and its corporate system in the coming years if it remained a stand-alone health care system?
    d. How has the issue of Backus' positioning in value-based purchasing in the coming years been specifically accounted for in the Backus Corporation financial projections on page 632 (Exhibit 14).

7. In response to CON Application Question 3.d.ii., the Applicants provided FY 2011 audited consolidated financial statements for Backus Corporation and HHC. The "Fair Value of Financial Instruments" reported in the notes to the financial statements was $228,951,380 for Backus Corporation and $917,067,000 for Hartford HealthCare Corporation. Please identify by category (Using the FY 2011 Balance Sheet or HRS Report 300) the portion of the fair value of these financial instruments which are unrestricted as to use for each corporate parent.

8. Provide the Fair Value of Financial Instruments, unrestricted as to use for each corporate parent as of September 30, 2012, by identifying these amounts for each corporate parent's FY 2012 unaudited Balance Sheets.

9. Question 3.g. on page 19 of the CON application asks for the following information:

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

The Applicants' response mentions the hospital's attempts to reduce their operating costs in light of expected reimbursement reductions and anticipated costs to be incurred with health care reform. And while HHC points to earlier affiliations with HOCC and Windham Hospital as examples of improvements realized through affiliation with the System, how the proposal will affect the financial strength of the state' health care system is not actually addressed. Please readdress how this proposal will affect the financial strength of the state's health care system as a whole.

10. Question 4.a. on page 19 of the CON application asks for the following information:

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

In Exhibit 13, pages 627 through 629 of the CON application, the Applicants provide three presentations of the current and projected payer population mix (i.e. Backus Corporation with the proposed affiliation, HHC with the proposed affiliation and HHC without the proposed affiliation). Each of the three presentations report that the percentage calculations provided are each based on revenue dollars and not on the number of patients. Please readdress each of the three presentations and provide the percentage calculation based on the number of patients, as requested, and please include a fourth table that addresses Backus Corporation without the proposed affiliation with the percentage calculations based on the number of patients.

11. In addition to the individual Financial Attachment I for Backus Corporation and HHC, presented as Exhibit 14 of the CON application, please provide the following:
Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project for Hartford Hospital and for The William W. Backus Hospital. Complete Financial Attachment I for each hospital. (Note that the actual results for the fiscal year reported in the first column must agree with each Hospital's respective audited financial statements.) The projections must include the first three <u>full</u> fiscal years of the project, FTE projections and volume statistics.

12. The projected incremental revenues and expenses for HHC, Exhibit 14 on page 631 of the CON application are for the Total Hospital Health System. The total incremental revenues and expenses for FY 2013 through FY 2016 agree with the Backus Corporation, Exhibit 14 on page 632 of the CON application total, with the project revenues and expenses for the respective fiscal years. This implies that all HHC incremental increases in net revenue and decreases in expenses for this project will only occur for the Backus Corporation itself and that there will be no direct or indirect impact on the rest of the HHC system and its three currently affiliated hospitals. Please address the following:
    a. Please explain whether this assumption is either correct or incorrect.
    b. If the assumption is correct, why isn't there an incremental impact for the HHC system as a whole?

13. Question 4.a. on page 19 of the CON application asks for the following information:
    "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.)."

    Please address the following related to the assumptions made in the financial projections:

    a. Provide the source information upon which the projected 5% annual revenue growth is based.
    b. Please expand upon the remaining specific assumptions used in the formulation of the financial projections for each Financial Attachment I.

14. With respect to the Applicants' response to Question 5.d., please describe the approach or process that HHC has utilized in negotiating new reimbursement contracts between newly acquired hospital affiliates and payers (e.g. Medicare, Medicaid, commercial, etc.).

15. In response to question 5.g. on page 21 of the CON application, the Applicants' indicate the following:

    "By having Backus Corporation as the administrative and managerial nucleus for the Eastern Connecticut Region, it is projected that the System will be able to deliver more cost-effective care and gain efficiencies beyond those already achieved."

    Please provide additional information addressing how this will be accomplished between the existing and prospective affiliate hospitals in the Eastern Connecticut region. What specific evidence can HHC provide to demonstrate how its MidState and HOCC affiliated hospitals have been able to deliver more cost-effective care and gains in operating efficiencies?

16. With respect to Exhibit 4 on page 67 of the CON application, the Applicants explain that as a result of Windham Community Memorial Hospital's (WCMH) affiliation with HHC, WCMH has been able to realize annual savings of more than $3.55 million. Please address the following:

    a) How were these annual savings quantified?
    b) What fiscal years for WCMH are being compared in this Exhibit?
    c) File tables demonstrating actual cost savings (reductions in expenses) for HOCC and Windham for FY 2010, FY 2011 and FY 2012 and projected cost savings (reductions in expenses) for Backus for FY 2013 - FY 2016 using the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. These categories are consistent with the current OHCA HRS Report 175. These amounts should be reported using a semi-annual basis for the fiscal years (October - March and April - September).

17. The Estimated Total Savings provided on Table 4, page 21, of the application agrees with the projected incremental operating margins for fiscal years FY 2013 through FY 2016 with the CON on Attachment I, page 632 of the application for Backus Corporation. Please explain the reason the amounts agree from the two sources when the projected incremental operating margins on Attachment I contain a combination of projected operating expense reductions and incremental net revenue, also for FY 2013-2016.

18. For the "Areas" of anticipated cost saving and cost avoidance presented in Table 4 on page 21 of the CON application, provide an expanded explanation as to what is contained within each area cited: Non-Labor; Revenue Cycle; Clinical Operations; Human Resources; Labor; Capital Avoidance. For each element recorded in a given "Area" provide the corresponding cost savings or cost avoidance amount attributable to that element.

19. Where is the anticipated $700,000 per year savings attributable to the salary saving at Windham Hospital per the footnote on page 21, found in the Financial Attachment I for HHC?

20. Central Connecticut Health Alliance (CCHA) realized a reduction in operating expenses of $85,168,139 or 23.5% from FY 2010 to FY 2011. This exceeded the projected operating expense cost savings of $67,029,168 from FY 2010-2015 provided by CCHA and HHC in Docket Number 09-31441-CON. Estimate how much of CCHA's reduction in operating expenses between FYs 2011 and FY 2012 can be attributable to its affiliation with HHC?

21. Hospital of Central Connecticut (HOCC) reported operating expense reductions totaling $12,903,150 or 3% from FY 2010 to FY 2011. Estimate how much of the reduction in operating expenses between FYs 2010 and FY 2011 for HOCC can be attributable to its Parent Corporation affiliation with HHC?

22. On page 8 and 9 of the application, the Applicants indicate that it would need an affiliation in order to secure "Greater debt capacity and access to capital on more favorable terms" Please identify Backus Hospital's and the Backus System's total current debt and related interest rates. Will the system refinance its debt to a more favorable debt position following the affiliation? If so, what interest rates have been projected for this restructuring of debt load?

23. The Applicants provide discussion in the CON application related to the affiliation of Windham with the Hartford system and the positive results of that affiliation. However, according to the most recent financial filings for Windham with OHCA in the HRS process, Windham has shown a loss from operations from FY 2009 to FY 2011 (for both operating margins and non-operating margins), has had a consistent decrease in days cash on hand and a consistent increase in the average payment period. Windham's total net assets, equity financing ratio and long term debt to capitalization ratio was negative over the period of FY 2009 to FY 2011. Please provide a discussion which shows in greater detail how the positive aspects of the Windham merger that occurred in FY 2009 has led to a more positive financial positioning for that hospital in light of the FY 2009 to FY 2011 results reported to OHCA.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness letter, late file submissions, and the like) must be numbered sequentially from the Applicant document preceding it. As the current submission for the application concludes with page 632, please begin with the completeness response with page 340. Reference Docket Number: 12-31788-CON and submit one (1) original and six (6) hard copies of your response in its entirety, including any supporting documentation. Submit a scanned copy of your response in Adobe format, an electronic copy in MS Word format and any worksheets in MS Excel, including all attachments, on CD.

Sincerely,

Brian A. Carney

Brian A. Carney,
Associate Research Analyst

Copy (faxed): Keith Fontaine, Backus Corporation

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

FAX SHEET

TO: KAREN GOYETTE, HARTFORD HEALTHCARE CORP.

FAX: (860) 263-4125

AGENCY:

FROM: BRIAN A. CARNEY

DATE: 10/24/12 TIME:

NUMBER OF PAGES: 7
(including transmittal sheet)

Comments: PLEASE SEE ATTACHED COMPLETENESS LETTER - DOCKET 12-31788-CON
CC. KEITH FONTAINE, BACKUS CORP.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

10/24/2012 16:41 FAX 001

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

FAX SHEET

TO: KEITH FONTAINE, BACKUS CORP.

FAX: (860) 892-6964

AGENCY:

FROM: BRIAN A. CARNEY

DATE: 10/24/12 TIME: 4:32

NUMBER OF PAGES: 7
(including transmittal sheet

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: 860-251-5104
Fax: 860-251-5211
jfeldman@goodwin.com

December 20, 2012

Brian A. Carney
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Application, Docket Number 12-31788-CON
Certificate of Need Completeness Letter Responses

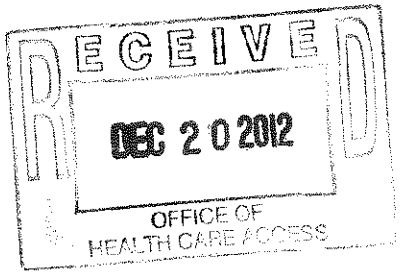
Dear Mr. Carney:

On behalf of the Applicants, enclosed please find the original and 6 hard copies of the Applicants' responses to your Certificate of Need Completeness Letter dated October 24, 2012 for Docket Number: 12-31788-CON. As requested, I have also included a CD with the electronic version of the enclosed documents and materials.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

Joan W. Feldman



Enclosures

000633 (12/20/12)

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1. On page 10 of the CON application, the Applicants list the specific benefits (items i-xiii) related to the Backus' affiliation with HHCC. Please provide for each benefit listed (items i-xiii) a timeframe and a brief description detailing each item. Additionally, discuss how each of these benefits was determined and provide copies of any studies or community needs assessments performed to arrive at these benefits.

The following sets forth the specific benefits listed in the CON Application and the timeframe along with a brief description of each item:

i. **System-level commitment of two hundred million dollars ($200,000,000) over a ten (10)-year period to implement clinical programs and services in accordance with the strategic plan for the Eastern Connecticut Region;**

This specific commitment will go into effect as of the effective date of the corporate affiliation or the date that HHC becomes the sole corporate member of Backus Corporation (the "Effective Date"). HHC is committing to approving at least $200,000,000 in funds over a ten (10)-year period toward clinical programs for the Eastern Connecticut Region. The capital commitments will be determined in accordance with the specific needs of the community and the strategic plan that is developed for the Eastern Connecticut Region. This financial commitment represents a significant commitment to continued investment in the health care needs of the region. There are no specific project items identified at this time other than the general commitments described herein with respect to expanding access to services and technologies for the Eastern Connecticut Region.

ii. **Funding for physician recruitment up to three million dollars ($3,000,000) over a three (3)-year period;**

HHC is committed to providing $3,000,000 in funds over a three (3)-year period towards recruiting physicians identified by Backus Corporation as needed in the Eastern Connecticut Region. HHC and Backus Corporation strongly believe, that aside from the financial commitment described herein, Backus Corporation will be more successful in the recruitment process by virtue of its proposed affiliation with the System.

iii. **Establishment of an extensive primary care and ambulatory care network based on patient-centered medical homes as certified by the National Committee on Quality Assurance;**

The System is developing and implementing an integrated primary care and ambulatory care network that will further enhance access to primary care services in the communities served by the System's affiliates. In connection with establishing such networks, the System is creating the necessary

infrastructure to provide accessible, continuous, coordinated, and patient-centered health care to patients with chronic illnesses. These efforts require strong clinical relationships with both its employed and independent physicians to keep shared patients healthy in the community and reduce the number of avoidable hospital admissions. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include an assessment of Backus Corporation's needs and a timeframe for implementation.

iv. Development of an ambulatory surgery network within the Eastern Connecticut Region;

To the extent that there is identified need for Backus Corporation to own and operate additional ambulatory surgery services, subject to the applicable appropriate regulatory approvals, the System will use its development and management expertise to collaborate with Backus Corporation to develop such ambulatory surgery centers in locations that are identified as needing such services. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include an assessment of Backus Corporation's needs and a timeframe for implementation.

v. Creation of a Preventative Medicine Institute at Backus Hospital;

The System will develop the model for a Preventative Medicine Institute that offers programs that focus on wellness, prevention and managing chronic illnesses for the System patients. The Preventative Medicine Institute will provide community education forums on health care topics of interest, and services that align the patients' interests with that of the System providers to prevent and or reduce avoidable risk factors and maintain wellness among the patient population served. The model for the Preventative Medicine Institute that is developed by the System will be implemented on a System-wide basis, and benefit each of the System affiliated hospitals. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include an assessment of Backus Corporation's needs and a timeframe for implementation.

vi. Increased access to patient data, informatics and reporting systems for cost and quality management;

The System is developing the necessary infrastructure (i.e. using advanced information technology and clinical personnel with information technology expertise) to manage care so that high quality care can be delivered in the

most cost-effective manner across the System. This commitment requires extensive investment in financial and human capital and thus, is most cost-effective and manageable when done on a System-wide basis versus when done as a stand-alone hospital. As a System affiliate, Backus Corporation will have access to a greater scope and depth of information technology ("IT") resources than it would otherwise have access to as a stand-alone hospital. By way of example, the System has recently hired a physician information officer dedicated to working along with other System affiliated personnel in developing clinically relevant algorithms relating to the delivery of health care services. The System is also developing other data-driven initiatives that will integrate independent affiliated physicians and align their incentives along with that of the hospital, payors, and patients to deliver coordinated, cost-effective and high value healthcare services. Backus Corporation will have access to these resources as of the Effective Date.

vii. Development of a peripheral vascular program at Backus Hospital and for the Eastern Connecticut Region;

The System will offer Backus Corporation access to peripheral vascular services by having affiliated physicians who specialize in vascular surgery provide office hours at the Backus Corporation locations to meet the needs of the patients in the service area. In addition, should there be a need to recruit a FTE vascular surgeon for the area, such recruitment potential will be enhanced by recruiting a physician to an established vascular surgery practice with coverage. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include an assessment of Backus Corporation's needs and a timeframe for implementation.

viii. Enhancement of cardiology services with local specialists, to include primary and elective angioplasty, integrated congestive heart failure programs and on-site electrophysiology;

The System provides outstanding and nationally recognized cardiology services, including in the area of interventional cardiology, electrophysiology and congestive heart failure. By way of example, since affiliating with the System, The Hospital of Central Connecticut ("HOCC") has expanded the scope and depth of its cardiology services, including developing a congestive heart failure program that has already produced statistical results which demonstrate a reduction in the frequency of readmissions for patients with congestive heart failure. If the Application is approved, planning will begin to develop some of these same cardiology programs at Backus Hospital.

ix. Participation in Clinical Collaboratives relating to becoming a "High Reliability Organization", readmission reduction, patient experience, reduction of hospital-acquired infections and fall reduction;

All of the informatics and data management previously discussed herein are being developed and implemented for the purpose of improving the quality, safety and efficiency of care, including enhancing patient satisfaction, reducing adverse events, reducing hospital-acquired complications, preventing avoidable admissions and enhancing quality and cost-effectiveness. The System and Backus Corporation are equally committed to embracing the culture of self assessment associated with becoming a "High Reliability Organization". Backus Corporation will have access to these resources as of the Effective Date.

x. Organization and development of a cancer services network with local specialists for the Eastern Connecticut Region;

Backus Corporation already has a robust oncology program of its own. However, to the extent that the System has access to clinical trials (e.g., NIH, Moffitt Hospital), or other cancer research, or new technology or treatment protocols otherwise not available to Backus Corporation, such resources will be shared with Backus Corporation as appropriate. Collaboration with the System's radiation oncology, surgical oncology, including but not limited to gynecological surgical oncology, and medical oncology services will further enhance the quality of oncology services offered to Backus Corporation patients. In essence, through a network referral system, Backus Corporation patients will have access to more expertise and resources than they would otherwise have at a stand-alone community hospital. Conversely, System affiliated oncologists will benefit from cross fertilization with the Backus Hospital affiliated medical oncologists. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include an assessment of Backus Corporation's needs and a timeframe for implementation.

xi. Development of a behavioral health network for the Eastern Connecticut Region;

The System has the largest behavioral health network in the State of Connecticut with Natchaug Hospital, the Institute of Living, HOCC and Rushford Center and is committed to servicing the behavioral health needs of the Eastern Connecticut Region, especially given the proximity of Natchaug Hospital with its expansive outpatient network which is ripe for further development. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include

an assessment of Backus Corporation's needs and a timeframe for implementation.

xii. **Maintenance of a Trauma Program (Level 3 at a minimum) along with a commitment to maintain LIFE STAR on the Backus Hospital campus; and**

The System, in particular Hartford Hospital, has a renowned Level I Trauma Center and is committed to sharing its expertise, knowledge and resources to improve trauma care at Backus Hospital. Backus Hospital and Hartford Hospital have collaborated for years with Backus Hospital having LIFE STAR stationed on the Backus Hospital campus. This LIFE STAR Connecticut collaboration has been enormously successful and provided patients in the Eastern Connecticut Region with ready access to Level I Trauma Centers. Backus Corporation will have access to these resources as of the Effective Date.

xiii. **Enhancement of current neonatology coverage.**

Backus Hospital will have greater access to neonatology coverage for its newborn nursery as a result of being able to participate in the coverage arrangements that already exist within the System. As of the Effective Date, Backus Corporation will become part of the System's strategic planning process, which will include an assessment of Backus Corporation's needs and a timeframe for implementation.

2. Footnote 15 on Page 14 of the application states that executive management for Windham Hospital and Backus Hospital would be centralized to achieve certain operating efficiencies. Provide additional detail on how executive management would be structured at the two hospitals and describe what operating efficiencies would result from this new management structure.

If the Application is approved, the Backus Corporation President & CEO and Chief Financial Officer, in addition to maintaining their roles on behalf of Backus Corporation, will assume the roles of President & CEO and Chief Financial Officer at Windham Community Memorial Hospital ("Windham Hospital"). As a result of these dual roles, there will be cost savings associated with the elimination of two senior executive positions at Windham. The current President & CEO of Windham Hospital would return to serve in the role of President & CEO of Natchaug Hospital, along with serving as the Senior Vice President of Behavioral Health for the System.

3. Were any Eastern Connecticut region hospitals/health care systems considered for potential affiliation with Backus Corporation? If yes, why was Hartford HealthCare Corporation deemed the better affiliation partner?

No hospital and/or health care system in the Eastern Connecticut Region met the criteria for inclusion in the Request for Proposal process that Backus Corporation undertook.

4. Please provide a copy of the completed market position summary provided by Kaufman, Hall & Associates to Backus Corporation which determined "that HHC was the most appropriate partner for maximizing ... health care delivery in the Eastern Connecticut Region." Page 7-8 of the application.

There was no specific written recommendation provided by Kaufman, Hall & Associates ("Kaufman") advising Backus Corporation to affiliate with the System; provided, however, Kaufman was integrally involved in the RFP process and assisted Backus Corporation in assimilating and processing the RFPs, including facilitating and leading discussions regarding the options available to Backus Corporation. Please see Exhibit 15 for copies of select Power Points from various Kaufman presentations to Backus Corporation regarding the need to move toward System integration.

Specifically, in June 2011, the Board of Backus Corporation authorized Kaufman to identify a list of potential partners to solicit RFPs using specified criteria (relating to integrated service delivery and care coordination, risk sharing/care management, physician integration and leadership, process re-engineering and sustainable cost-structure changes, information technology connectivity and platform development, mission accountability, sustainable financial performance and access to capital). Kaufman contacted ten (10) potential partners.

In September 2011, the Board of Backus Corporation received Kaufman's oral report on the eight (8) RFPs received and formed a Strategic Options Subcommittee to perform an in-depth review. The Subcommittee selected four (4) potential partners. Between November 2011 and January 2012, the Subcommittee conducted meetings with key personnel at each of the potential partners' sites; likewise, each of the potential partners had meetings with the Subcommittee at Backus Corporation. The four (4) finalist potential partners were evaluated, again using the criteria listed above. The Subcommittee, based upon the completeness of its RFP response and the visits to and from executive leadership, determined that HHC was the partner of choice.

5. Are there any current collaboration efforts between Backus and other Eastern Connecticut region health care providers? Please describe.

Backus Corporation participates in a joint venture with Lawrence + Memorial Hospital and DaVita with respect to the operation of outpatient renal dialysis centers located in Norwich and New London, Connecticut. There are no other current collaborations with other Connecticut region health care providers and the Proposal will have no bearing on the existing collaboration with Lawrence + Memorial Hospital or DaVita.

6. On page 8 of the CON application, the Applicants indicate that the "continued viability of Backus Corporation depends, in large part, on its strategic positioning" and indicates in the footnote that both private and government payers are moving toward value-based purchasing (VBP).

   a. How does value-based purchasing relate to the operations of each Corporation and each Hospital, presently?

   Value-based purchasing is relevant to both Backus Corporation and the System. Governmental and commercial third-party payors are demanding that providers produce better outcomes and provide more efficient services. More specifically, private and governmental payors are demanding that payment be directly tied to achieving certain outcomes. By way of example, the System has been accepted by CMS to participate in the Medicare Shared Savings Program as of January 1, 2013 (the "MSSP"). The MSSP financially rewards providers based upon the success of achieving certain quality and cost outcomes. In addition, under the Affordable Care Act, it is expressly stated that government payment methodologies under the MSSP will differentiate payment between providers based upon the value that they deliver. Commercial payors will also be looking to enter into new provider contracts that reward value.

   b. How will the value-based purchasing be applied with regard to the proposed affiliation?

   If this Application is approved, Backus Corporation will be well positioned for value-based purchasing in that it will have access to the infrastructure that is necessary to deliver enhanced quality care more efficiently as earlier described in the response to question 6.a. above.

   c. Quantify the effect value-based purchasing will have on Backus Hospital and its corporate system in the coming years if it remained a stand-alone health care system?

   Without the capability to cost-effectively align with its physicians, jointly report on all the required quality indicators and create the infrastructure

necessary to manage the care of its patients in its community, Backus Hospital may not be as well positioned as it could be to deliver the additional value that is being required. Specifically, by not having the ability to achieve economies of scale with respect to the establishment of the required infrastructure, any benefits achieved from value-based purchasing will be quickly absorbed by the costs associated with delivering such care. Value-based purchasing represents a significant challenge for most stand-alone hospitals. Specifically, the System is well along in creating several clinical integration models that will incorporate Backus Corporation should this Application be approved. Please also see the response to question 1.vi. herein.

d. How has the issue of Backus' positioning in value-based purchasing in the coming years been specifically accounted for in the Backus Corporation financial projections on page 632 (Exhibit 14).

The new requirements relating to value-based purchasing, do not provide for additional reimbursement, but rather, withhold a certain percentage of reimbursement based upon the provider's ability to achieve certain quality outcomes. However, being well positioned to thrive under innovative contracting models with managed care payors will be critical to the ability of a provider to benefit from value-based purchasing. Backus Corporation has accounted for the benefit of value-based purchasing by not projecting decreases in its revenue.

7. In response to CON Application Question 3.d.ii., the Applicants provided FY 2011 audited consolidated financial statements for Backus Corporation and HHC. The "Fair Value of Financial Instruments" reported in the notes to the financial statements was $228,951,380 for Backus Corporation and $917,067,000 for Hartford HealthCare Corporation. Please identify by category (Using the FY 2011 Balance Sheet or HRS Report 300) the portion of the fair value of these financial instruments which are unrestricted as to use for each corporate parent.

Backus Corporation 2011:

Backus Corporation - FY 2011				Unrestricted
Fair Value of Instruments				Total
Unrestricted Portion Only	Level 1	Level 2	Level 3	Fair Value
Cash and cash equivalents	$97,326,872	$850,038		$98,176,910
Certificates of Deposit		24,901,139		24,901,139
Money market funds	13,025,298			13,025,298
US government obligations	10,102,323	2,709,273		12,811,596
Corporate bonds	249,858	674,802		924,660
Equity securities	12,925,057			12,925,057
Mutual funds-equity	6,703,510	7,626,777		14,330,287
Mutual funds-international equity	6,842,776			6,842,776
Mutual funds-fixed income	10,138,824			10,138,824
Total Unrestricted Assets	$157,314,518	$ 36,762,029		$194,076,547

Please note that $917,067,000 represents HHC's defined benefit plan assets. None of these assets are unrestricted funds. The unrestricted assets associated with HHC are set forth in the chart below.

HHC 2011 (unrestricted funds associated with its endowment assets):

HHC - FY 2011				Unrestricted
Fair Value of Instruments				Total
Unrestricted Portion Only	Level 1	Level 2	Level 3	Fair Value
Cash and cash equivalents	$141,485,000			$141,485,000
Certificates of Deposit				
Money market funds	54,671,000			54,671,000
US government obligations				
Corporate bonds				
Equity securities	21,604,000			21,604,000
Mutual funds-equity	84,565,000			84,565,000
Mutual funds-international equity	32,461,000			32,461,000
Mutual funds-fixed income		27,972,000		27,972,000
Common Collective		89,207,000		89,207,000
Alternative investments		12,541,000		12,541,000
Other			1,279,000	1,279,000
Total Unrestricted Assets	$334,786,000	$129,720,000	$1,279,000	$465,785,000

8. Provide the Fair Value of Financial Instruments, unrestricted as to use for each corporate parent as of September 30, 2012, by identifying these amounts for each corporate parent's FY 2012 unaudited Balance Sheets.

Backus Corporation 2012[1]:

Backus Corporation - FY 2012				Unrestricted
Fair Value of Instruments				Total
Unrestricted Portion Only	Level 1	Level 2	Level 3	Fair Value
Cash and cash equivalents	$110,028,344	$410,298		$110,438,642
Certificates of Deposit		24,925,922		24,925,922
Money market funds	12,217,129			12,217,129
US government obligations		10,801,121		10,801,121
Corporate bonds		3,456,816		3,456,816
Equity securities	17,114,732			17,114,732
Mutual funds-equity	7,518,344	7,382,889		14,901,233
Mutual funds-international equity	6,535,636			6,535,636
Mutual funds-fixed income	9,477,322			9,477,322
Mutual funds-alternatives	6,195,677	839,395		7,035,072
Total Unrestricted Assets	$169,087,184	$ 47,816,441		$216,903,625

HHC 2012 (unrestricted funds associated with its endowment assets)[2]:

HHC - FY 2011				Unrestricted
Fair Value of Instruments				Total
Unrestricted Portion Only	Level 1	Level 2	Level 3	Fair Value
Cash and cash equivalents	$216,514,000			$216,514,000
Certificates of Deposit				
Money market funds	39,481,000			39,481,000
US government obligations				
Corporate bonds				
Equity securities	27,712,000	1,410,000		29,122,000
Mutual funds-equity	40,823,000	60,719,000		101,542,000
Mutual funds-international equity	46,435,000	83,000		46,518,000
Mutual funds-fixed income	161,000	23,306,000		23,468,000
Common Collective		99,992,000		99,992,000
Alternative Investments		11,902,000	15,897,000	27,798,000
Total Unrestricted Assets	$371,126,000	$197,412,000	$15,897,000	$584,435,000

[1] The numbers populating this Table are based upon draft audited financial statements for FY 2012.
[2] The numbers populating this Table are based upon draft audited financial statements for FY 2012

9. Question 3.g. on page 19 of the CON application asks for the following information:

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

The Applicants' response mentions the hospital's attempts to reduce their operating costs in light of expected reimbursement reductions and anticipated costs to be incurred with health care reform. And while HHC points to earlier affiliations with HOCC and Windham Hospital as examples of improvements realized through affiliation with the System, how the proposal will affect the financial strength of the state's health care system is not actually addressed. Please readdress how this proposal will affect the financial strength of the state's health care system as a whole.

The Applicants believe that by approving the Application, Backus Corporation will be strongly positioned to remain a robust and viable health care provider well into the future. In particular, by providing the Eastern Connecticut Region with access to high quality cost-effective care, the population served by Backus Corporation will likely benefit from enhanced access to wellness programs and advanced levels of care. The Applicants firmly believe that without this proposed affiliation, the same level and quality of services would not be possible for a stand-alone hospital. If Backus Corporation remains financially strong, Eastern Connecticut residents will have excellent choices for the purchase of their health care services. All of the above are reasons why the Applicants believe that this Application financially strengthens the State's health care system.

10. Question 4.a. on page 19 of the CON application asks for the following information:

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

In Exhibit 13, pages 627 through 629 of the CON application, the Applicants provide three presentations of the current and projected payer population mix (i.e. Backus Corporation with the proposed affiliation, HHC with the proposed affiliation and HHC without the proposed affiliation). Each of the three presentations report that the percentage calculations provided are each based on revenue dollars and not on the number of patients. Please readdress each of the three presentations and provide the percentage calculation based on the number of patients, as requested, and please include a fourth table that addresses Backus Corporation without the proposed affiliation with the percentage calculations based on the number of patients.

In populating the following Tables, we relied upon patient inpatient discharges as the measurement for payor mix.

Table 3: Patient Population Mix (Backus Corporation)

Payor Mix (Based on Number of Patients)	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	46.2%	46.7%	47.8%	48.7%
Medicaid & Medical Assistance	19.7%	19.7%	20.4%	21.0%
CHAMPUS/TRICARE	1.9%	2.0%	2.0%	2.1%
Total Government Payors	67.8%	68.4%	70.2%	71.8%
Commercial Insurers	30.3%	29.5%	27.6%	25.8%
Uninsured	1.0%	1.2%	1.3%	1.4%
Workers Compensation	0.9%	0.9%	0.9%	1.0%
Total Non-Government	32.2%	31.6%	29.8%	28.2%
Payor Mix	100.0%	100.0%	100.0%	100.0%

Table 3: Patient Population Mix (HHC)

Payor Mix (Based on Number of Patients)	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	42.9%	42.9%	42.9%	42.9%
Medicaid & Medical Assistance	22.9%	22.9%	22.9%	22.9%
CHAMPUS/TRICARE	0.4%	0.4%	0.4%	0.4%
Total Government Payors	66.2%	66.2%	66.2%	66.2%
Commercial Insurers	32.6%	32.6%	32.6%	32.6%
Uninsured	1.1%	1.1%	1.1%	1.1%
Workers Compensation	0.1%	0.1%	0.1%	0.1%
Total Non-Government	33.8%	33.8%	33.8%	33.8%
Payor Mix	100.0%	100.0%	100.0%	100.0%

Table 3: Patient Population Mix (Consolidated Backus Corporation and HHC)

Payor Mix (Based on Number of Patients)	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	43.3%	43.4%	43.5%	43.7%
Medicaid & Medical Assistance	22.5%	22.5%	22.6%	22.7%
CHAMPUS/TRICARE	0.5%	0.6%	0.6%	0.6%
Total Government Payors	66.3%	66.5%	66.7%	67.0%
Commercial Insurers	32.3%	32.1%	31.9%	31.6%
Uninsured	1.1%	1.1%	1.1%	1.1%
Workers Compensation	0.3%	0.3%	0.3%	0.3%
Total Non-Government	33.7%	33.5%	33.3%	33.0%
Payor Mix	100.0%	100.0%	100.0%	100.0%

Backus Corporation does not anticipate that its payor mix will change as a result of the affiliation and therefore, did not provide a fourth table.

11. In addition to the individual Financial Attachment I for Backus Corporation and HHC, presented as Exhibit 14 of the CON application, please provide the following: Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project for Hartford Hospital and for The William W. Backus Hospital. Complete Financial Attachment I for each hospital. (Note that the actual results for the fiscal year reported in the first column must agree with each Hospital's respective audited financial statements.) The projections must include the first three full fiscal years of the project, FTE projections and volume statistics.

Please see Exhibit 16 for the requested financial information relating to Backus Hospital. We did not provide the information as it relates to Hartford Hospital because the proposed affiliation is with HHC. HHC has four general hospitals within its System.

12. The projected incremental revenues and expenses for HHC, Exhibit 14 on page 631 of the CON application are for the Total Hospital Health System. The total incremental revenues and expenses for FY 2013 through FY 2016 agree with the Backus Corporation, Exhibit 14 on page 632 of the CON application total, with the project revenues and expenses for the respective fiscal years. This implies that all HHC incremental increases in net revenue and decreases in expenses for this project will only occur for the Backus Corporation itself and that there will be no direct or indirect impact on the rest of the HHC system and its three currently affiliated hospitals. Please address the following:

a. Please explain whether this assumption is either correct or incorrect.

Historically, the vast majority of savings as a result of the proposed affiliation will be incurred by the newly affiliated hospital. Nevertheless, while the response focused on the savings to Backus Corporation, it is assumed that as fixed overhead costs get spread across more System providers that the overhead costs for each System member will be reduced. The premise of an integrated healthcare delivery system is based, in part, on the ability to spread fixed costs across a system. By way of example, the area of IT is one area where fixed costs can be efficiently spread across the System thereby reducing the IT costs for each System member and providing a level of service that a stand-alone community hospital could not otherwise provide on its own.

b. If the assumption is correct, why isn't there an incremental impact for the HHC system as a whole?

See response to 12.a. above.

13. Question 4.a. on page 19 of the CON application asks for the following information:
"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.)."

Please address the following related to the assumptions made in the financial projections:

a. Provide the source information upon which the projected 5% annual revenue growth is based.

Please note that the projected 5% annual revenue growth represents a consistent pattern with respect to HHC's historical experience and thus, does not represent an overall increase in revenue growth as a result of the

affiliation. HHC and Backus Corporation projected their revenue increases based on a combination of volume and changes in reimbursement. While market basket adjustments and wage indices are expected to adversely affect Medicare reimbursement, quality initiatives relating to the MSSP and the HHC Clinical Integration Program are expected to offset any decrease in governmental reimbursement. In addition, HHC is investing in data analysis and clinical integration models so that it is positioned to contract for innovative payment models.

b. Please expand upon the remaining specific assumptions used in the formulation of the financial projections for each Financial Attachment I.

Other Major Assumptions for HHC and Backus Corporation Forecast: Salary increases for the Applicants were based on historical experience as well as relevant markets. Employee benefit expense increased overall. Pension increases were based on actuarial reports for the pension plans. Medical and general supply increases were based on current group purchasing contracts, as were pharmacy and energy costs. Interest expense was based on existing debt, and depreciation expense reflects existing capital plans for the Applicants.

Financial Attachment I has been supplemented to show discharges and emergency department visits. Since hospitals are the largest component of each Applicant, we believe that this activity is a good indicator of the impact of the proposed affiliation. Projections in these areas are based on the modest growth that has been seen in the past. Please see Exhibit 17 for the revised Financial Attachment I for HHC and Backus Corporation.

14. With respect to the Applicants' response to Question 5.d., please describe the approach or process that HHC has utilized in negotiating new reimbursement contracts between newly acquired hospital affiliates and payers (e.g. Medicare, Medicaid, commercial, etc.).

There are no negotiations with respect to Medicare and Medicaid contracts. With respect to commercial contracts, the System does not negotiate a single set of terms for the entire System. Rather, the managed care contract terms for each provider will be provider-specific.

15. In response to question 5.g. on page 21 of the CON application, the Applicants' indicate the following:

"By having Backus Corporation as the administrative and managerial nucleus for the Eastern Connecticut Region, it is projected that the System will be able to deliver more cost-effective care and gain efficiencies beyond those already achieved."

Please provide additional information addressing how this will be accomplished between the existing and prospective affiliate hospitals in the Eastern Connecticut region. What specific evidence can HHC provide to demonstrate how its MidState and HOCC affiliated hospitals have been able to deliver more cost-effective care and gains in operating efficiencies?

As discussed in the response to Question 2 herein, the management team of Backus Corporation will also manage Windham Hospital. Nevertheless, Windham Hospital and Backus Hospital will remain separately licensed and distinct hospitals. With respect to the operating efficiencies achieved by HOCC, the Applicants provided significant financial information with respect to the savings achieved by HOCC as a result of administrative and operational efficiencies. These cost savings result in a lower cost structure for the provision of care. MidState achieves similar, if not the same, operational and administrative cost savings. With new demands for enhanced quality and quality reporting, providers will need to be more cost-effective in providing services. Sharing the infrastructure costs across a health care system will make costs related to infrastructure more affordable.

16. With respect to Exhibit 4 on page 67 of the CON application, the Applicants explain that as a result of Windham Community Memorial Hospital's (WCMH) affiliation with HHC, WCMH has been able to realize annual savings of more than $3.55 million. Please address the following:

a) How were these annual savings quantified?

The savings were quantified as follows:

Area	Benefit	Assumption/Quantification
Streamlined System Coding and Document Review	$1,300,000	This assumption is quantified using comparable experience with other System hospitals.
Centralization of Revenue Cycle Staff	$1,100,000	This assumption is quantified using comparable experience with other System hospitals.
Refinancing - Reduced Existing Interest Costs	$600,000	This assumption is quantified based upon actual interest rates relating to 2011 System debt refinancing.
Group Purchasing - Blood Products, Lab Reference Testing, Implants, Pacemakers, Waste Management	$300,000	This assumption is quantified based upon a comparison between new purchasing vendor and prior purchasing vendor.
Malpractice Captive and Other Insurance Savings	$250,000	This assumption is quantified based upon actual premium amounts.
Annualized Total	**$3,550,000**	

b) What fiscal years for WCMH are being compared in this Exhibit?

The savings in Exhibit 4 were based upon experience in FY 2010 prior to the affiliation with HHC.

c) File tables demonstrating actual cost savings (reductions in expenses) for HOCC and Windham for FY 2010, FY 2011 and FY 2012 and projected cost savings (reductions in expenses) for Backus for FY 2013 - FY 2016 using the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. These categories are consistent with the current OHCA HRS Report 175. These amounts should be reported using a semi-annual basis for the fiscal years (October - March and April - September).

See Exhibit 18 for HOCC and Windham Hospital.

See Exhibit 19 for Backus Corporation.

17. The Estimated Total Savings provided on Table 4, page 21, of the application agrees with the projected incremental operating margins for fiscal years FY 2013 through FY 2016 with the CON on Attachment I, page 632 of the application for Backus Corporation. Please explain the reason the amounts agree from the two sources when the projected incremental operating margins on Attachment I contain a combination of projected operating expense reductions and incremental net revenue, also for FY 2013-2016.

The total "savings" in Table 4 do include improvements to reimbursement, which were not specifically delineated. See Exhibit 19 for further details.

18. For the "Areas" of anticipated cost saving and cost avoidance presented in Table 4 on page 21 of the CON application, provide an expanded explanation as to what is contained within each area cited: Non-Labor; Revenue Cycle; Clinical Operations; Human Resources; Labor; Capital Avoidance. For each element recorded in a given "Area" provide the corresponding cost savings or cost avoidance amount attributable to that element.

See Exhibit 19 for the expanded explanations and corresponding cost saving and avoidance amounts.

19. Where is the anticipated $700,000 per year savings attributable to the salary saving at Windham Hospital per the footnote on page 21, found in the Financial Attachment I for HHC?

These cost savings relate to shared administrative personnel in the areas of executive management (e.g., CEO and CFO) and other finance and operational areas. These savings can be found in the Salaries and Fringe Benefits line item in Backus Corporation's Financial Attachment I. See Exhibit 16.

20. Central Connecticut Health Alliance (CCHA) realized a reduction in operating expenses of $85,168,139 or 23.5% from FY 2010 to FY 2011. This exceeded the projected operating expense cost savings of $67,029,168 from FY 2010-2015 provided by CCHA and HHC in Docket Number 09-31441-CON. Estimate how much of CCHA's reduction in operating expenses between FYs 2011 and FY 2012 can be attributable to its affiliation with HHC?

Please note that the amount of $85,168,139 does not accurately represent the annual expense savings for CCHA because different entities were reported in each of the fiscal years being compared. More specifically, for FY 2010, the consolidated operating expenses for CCHA and all of its affiliated entities were reported on OHCA Form/Report 350. Whereas, for FY 2011, the consolidated operating expenses for HOCC and Grand Indemnity Company, LTD were reported on OHCA Form/Report 350 with no other entities included. Therefore, the $85,168,139 does not represent a fair representation of the expense savings between those two (2) years. Regardless of the foregoing, please refer to Exhibit 18 for the realized expense savings for CCHA/HOCC resulting from the affiliation.

21. Hospital of Central Connecticut (HOCC) reported operating expense reductions totaling $12,903,150 or 3% from FY 2010 to FY 2011. Estimate how much of the reduction in operating expenses between FYs 2010 and FY 2011 for HOCC can be attributable to its Parent Corporation affiliation with HHC?

The affiliation between HHC and CCHA became effective on or about February 1, 2011. Of the HOCC overall $12,903,150 expense reduction, $3,215,415 relates directly to the affiliation as described in Exhibit 18.

22. On page 8 and 9 of the application, the Applicants indicate that it would need an affiliation in order to secure "Greater debt capacity and access to capital on more favorable terms". Please identify Backus Hospital's and the Backus System's total current debt and related interest rates. Will the system refinance its debt to a more favorable debt position following the affiliation? If so, what interest rates have been projected for this restructuring of debt load?

Backus Corporation - Total Current Debt		
Description	**Balance @ 9/30/12**	**Interest Rates**
Series E bonds	$7,515,000	Term maturities from 2017-2022 at 5.00%
Series F bonds	$27,250,000	Serial maturities ($5,125,000) from 2013-2018 rates from 4.00%-4.25%; term maturities ($22,125,000) from 2023 to 2035 rates of 5.00%-5.25%
Series G bonds	$24,500,000	Serial maturities ($17,080,000) from 2013-2026 rates from 3.50%-5.00%; term maturities ($7,420,000) in 2035 rate of 5.00%
Mortgage-Dime Bank	$1,126,557	6.125%
TOTAL	$60,391,557	

There are no immediate plans to refinance Backus Corporation debt. This, along with any consideration for additional debt, will be assessed in the course of future financing if needed.

23. The Applicants provide discussion in the CON application related to the affiliation of Windham with the Hartford system and the positive results of that affiliation. However, according to the most recent financial filings for Windham with OHCA in the HRS process, Windham has shown a loss from operations from FY 2009 to FY 2011 (for both operating margins and non-operating margins), has had a consistent decrease in days cash on hand and a consistent increase in the average payment period. Windham's total net assets, equity financing ratio and long term debt to capitalization ratio was negative over the period of FY 2009 to FY 2011. Please provide a discussion which shows in greater detail how the positive aspects of the Windham merger that occurred in FY 2009 has led to a more positive financial positioning for that hospital in light of the FY 2009 to FY 2011 results reported to OHCA.

Windham Hospital's financial performance for the period mentioned above was primarily attributable to its defined benefit pension obligations to its employees. The System is continually working on ways to reduce its costs and improve its performance given its large underinsured and uninsured populations. Had Windham Hospital not become an affiliate, its future prospects would be less favorable.

Exhibit 15
Kaufman, Hall & Associates
Power Points

Confidential Discussion Materials
Prepared for Board of Backus Hospital

Choose wisely. Choose Backus

Norwich, Connecticut / January 11, 2012

Confidential

KaufmanHall

Financial Strategies for Healthcare
5202 Old Orchard Road
Suite N700
Skokie, IL 60077
847.441.8780 phone
847.965.3511 fax
kaufmanhall.com

Agenda

- **Review: How we got here:**
  - Backus New Era Readiness and Sustainability Assessments
  - Backus Goals and Objectives
- **Status Update**
- **Overview of Site Visits**
- **Factors to Consider** When Selecting a Potential Partner
- **Next Steps**

How We Got Here

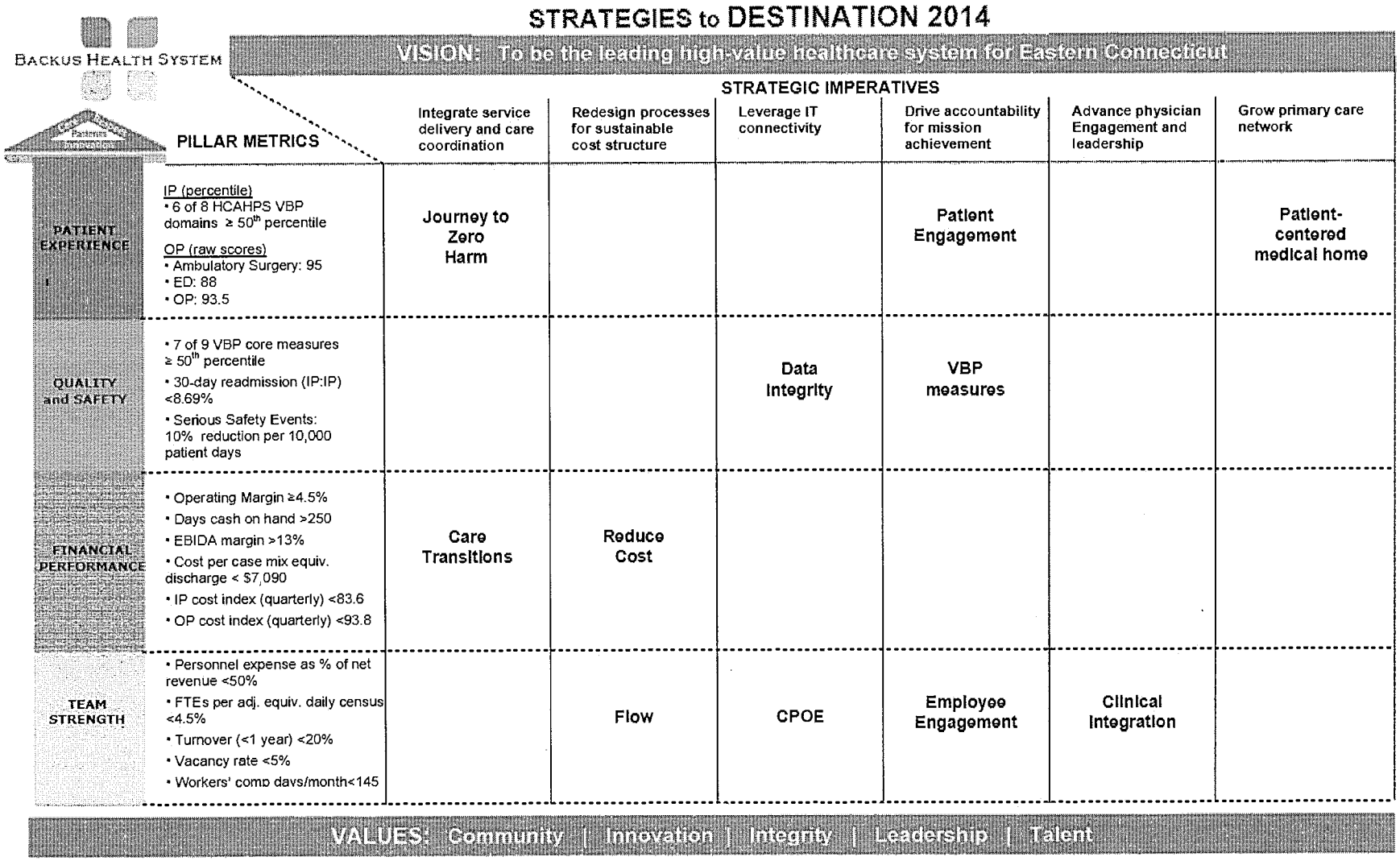
Key engagement activities to achieve the objective

	Complete
1) Establish understanding of industry outlook and implications for healthcare providers	✓
2) Assess Backus's market and position across key competency areas required under the new era of healthcare	✓
3) Develop current state financial projections and performance requirements for Backus	✓
4) Establish critical success factors for Backus under current state or any alternative strategic scenario	✓
5) Preliminarily assess Backus's ability to meet critical success factors in its current state	✓
6) Evaluate potential partners and partnership scenarios and the ability to advance Backus's position across its key success requirements	Today's focus
7) Decide as an organization if further exploration and due diligence of a partner is the next step	Decision to be made within next 30 days

Agreed-upon critical strategic goals and objectives for Backus under any scenario

- Integrated service delivery and care coordination
- Risk sharing / management
- Physician engagement and leadership
- Primary care network development
- Process re-engineering and sustainable cost structure changes
  - Achieve the greatest performance at the most effective cost setting; requires new models of care delivery
- IT connectivity and platform development
- Sustainable financial performance and access to capital
  - Requires consistent revenue growth, cost management/ structure changes while investing the required capital to address the above transformational strategic goals/ objectives
- Mission accountability
  - Represents continued ability of organization to adequately serve its mission

Board-designated strategic goals and objectives created basis Backus for strategy map

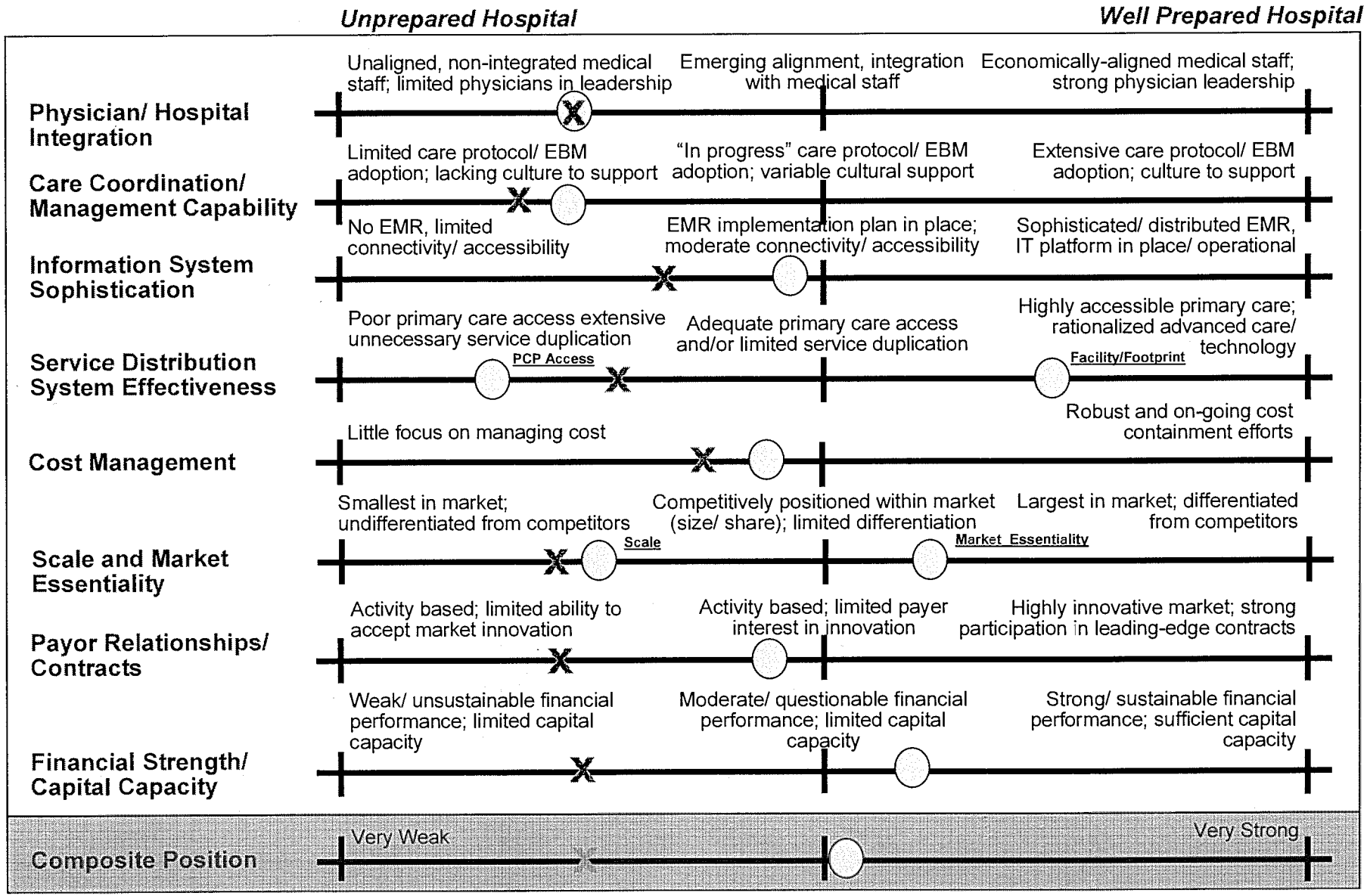


Summary of key strategic imperatives

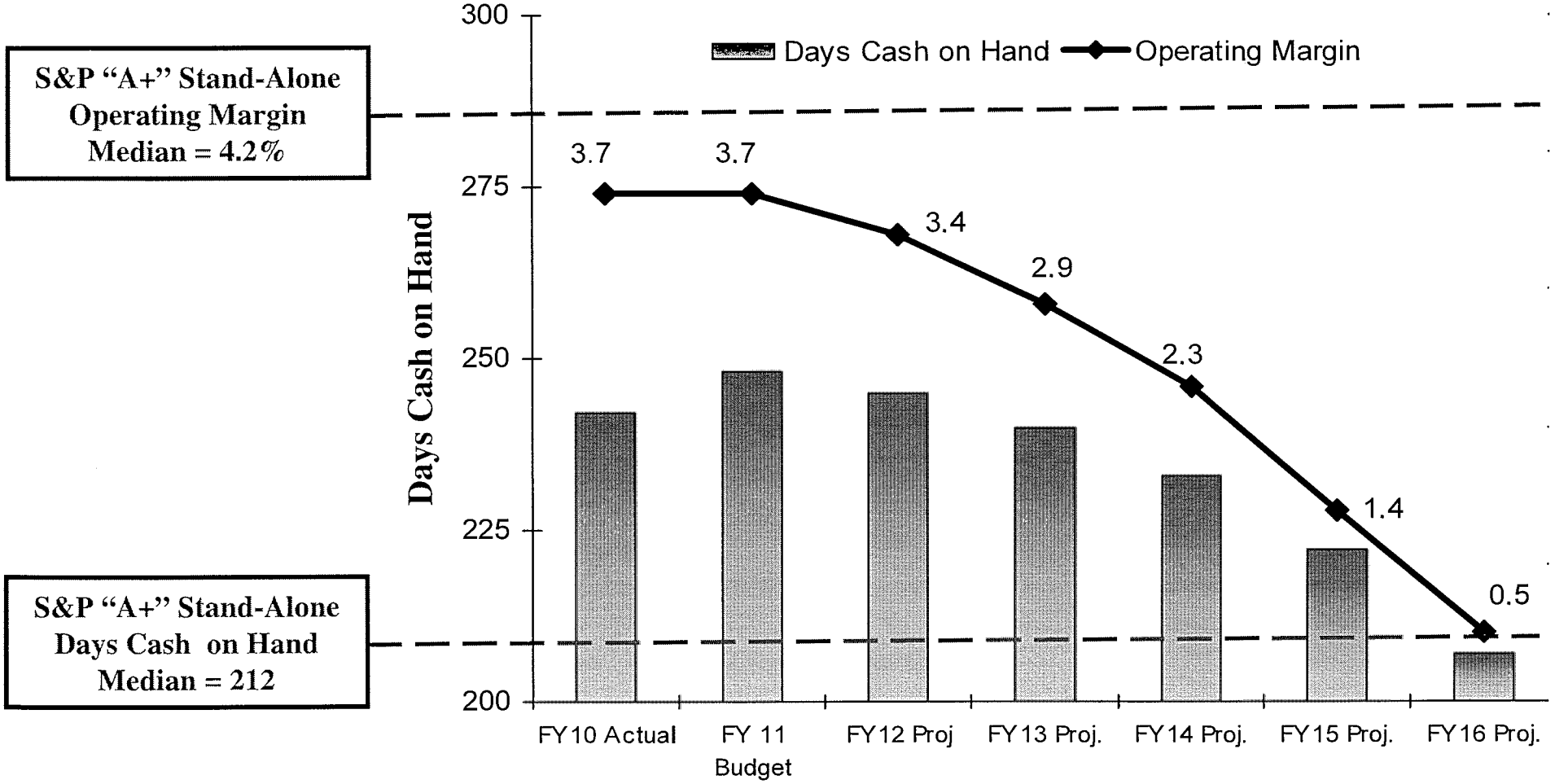
- Backus and its market is in a state of flux
  - Market dynamics
  - Regulatory and legislative changes
- A heretofore stable medical community has recently undergone significant stress due to economic and regulatory pressures
- Backus must address the needs of its medical staff while preparing the organization to thrive after the industry reorganizes, namely to
  - Become more accountable for community health
  - Improving performance and position in a low growth environment
  - Developing a culture consistent with emerging performance criteria

Summary of Backus's overall position

X = KHA National Est. ◯ = KHA Est. of Backus



Backus's strategic direction needs to keep the organization generating at least a 4% margin and 225+ days cash on hand



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Our vision and strategic direction for the future

Choose wisely, Choose Backus — Strategic Options — Desired Future State

What are the Key Objectives of any Backus Strategic Option?

- Ensure mission accountability
- Physician leadership and alignment
- Sustainable financial strength and capital access
- Clinical quality and integration
- Population health management
- System-wide connectivity through information technology
- Expand geographic reach and system access

Recap: There was consensus that Backus's critical strategic goals and objectives could be better achieved through ***some level of partnership beyond the current state***

Goal/ Objective Areas	Current State	Current State+	Full-Integration
Integrated service delivery and care coordination		This is where we ended up in March 2011	
Risk sharing/ management			
Physician engagement and leadership			
Primary care network development			
Process re-engineering and sustainable cost structure changes			
IT connectivity and platform development			
Sustainable financial performance and access to capital			
Mission Accountability			

Why are we assessing potential partners and scenarios?

We agreed Backus cannot meet all critical strategic objectives continuing forward in its current state

	Rationale	Ability to Advance in Current State
Integrated Service Delivery and Care Coordination	• Requires significant investment and new skills and capabilities • Backus does not currently own the full continuum of care, so either building those missing pieces or maintaining some level of partnership is required to fully coordinate care	▲
Risk Sharing and Management	• The hospital/ health system industry as a whole is not ready to accept risk despite the proliferation of ACO planning • Proficiency in this area will require a significant investment in actuarial resources and scale and experience managing covered lives, which will require some level of partnership for most providers	▲
Physician Engagement and Leadership	• Backus is in the emerging stage of physician engagement and leadership development and can likely achieve some of this continuing in its current state • Along with IT, physician engagement and leadership development will demand significant financial commitments in the near future • Additional scale and investment in physician infrastructure is required to support these growing physician enterprises and to continue to effectively recruit, develop and retain physicians	□

Ability to advance critical success factor: ▲ Limited □ Fair ● Good

Why are we assessing potential partners and scenarios?

We agreed Backus cannot meet all critical strategic objectives continuing forward in its current state *(continued)*

	Rationale	Ability to Advance in Current State
Primary Care Network Development	• Backus has a strong physician footprint in the market today, but limited primary care access • Backus can begin to develop a primary care physician network in its market in its current state, but again, associated investment and capability requirements are significant for this effort	▢
Process re-engineering and sustainable cost structure changes	• Backus has recently undergone a significant cost reduction through a process redesign engagement. The organization has demonstrated its ability to manage costs to achieve targeted financial performance • Backus can continue many of these efforts in its current state, but significant reductions to cost structure through centralizing back office and other duplicative cost areas are achieved through partnership	▢
IT connectivity and platform development	• Backus has made significant investments in its IT platform, but still has key components such as CPOE to implement and operationalize. • IT infrastructure will require significant capital both financial and human to be successful, which is difficult to manage as a small scale provider	▢

Ability to advance critical success factor: ▲ Limited ▢ Fair ● Good

Why are we assessing potential partners and scenarios?

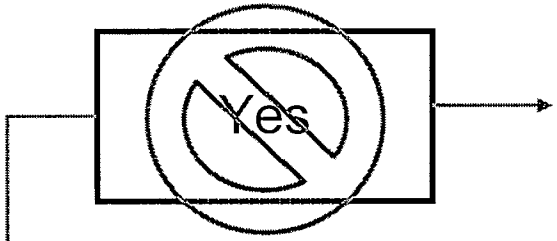
We agreed Backus cannot meet all critical strategic objectives continuing forward in its current state *(continued)*

	Rationale	Ability to Advance in Current State
Sustainable financial performance and access to capital	• Backus is strong financially today, but the current state financial projection set developed suggests that Backus's financial strength can deteriorate quickly with a set of not so pessimistic assumptions • Greater scale will be required in the future and Backus is at the low end of the spectrum in this area operating in its current state	▲
Mission Accountability	• Mission accountability is a result of successful achievement of the preceding critical strategic goals and objectives. Given the baseline financial projection results, discussions to date and assessment of Backus's ability to achieve its critical success requirements, Backus's ability to achieve Mission Accountability is limited in the current state.	▲

Ability to advance critical success factor: ▲ Limited ☐ Fair ● Good

We have answered the first question, **but critical questions still remain**

Will Backus be able to sustain a viable healthcare delivery system for Eastern Connecticut in its current state?



No

- How will Backus develop and sustain the human talent, capabilities and financial capital to remain successful in the changing environment?
- **How will Backus work with others to create a platform that ensures we continue our mission and achieve our critical strategic goals and objectives?**
- **What is our preferred partnership model?**
- **Who is/ are our best potential partner(s)?**

Backus Goals and Objectives

Partnership goals and objectives

- Overarching principles
  - Enhance service line presence and physician recruitment opportunities in order to continue as a leading healthcare provider in the region
  - Ensure adequate resources to accelerate implementation of the strategic plan
  - Ensuring the highest level of clinical quality and patient safety
  - Assure adequate supply of board certified physicians in primary care and appropriate specialties and subspecialties through effective recruitment and retention
  - Targeted programs and geographical areas for growth to reduce out-migration and recapture market share
  - Align facilities with market demand and clinical service line development
  - Retention of a community hospital providing a scope of services in demand from the community
  - Build upon outstanding existing clinical affiliations

What defines "success" for Backus?

- Remain **identifiable** with some sense of **autonomy**
  - "Others would want to emulate Backus"
- **Highest quality** patient care
- More **integrated care** delivery
  - Restructured processes (clinical and non-clinical) and effective use and delivery site access
- **Engaged physician** leadership
- **Financial viability**
- **Effective IT** to **drive care coordination** inside and outside the hospital walls
- Effective **recruitment and development of talent** and resources both clinical and non-clinical

PLUS: Partnership goals and objectives already identified

- Integrated service delivery and care coordination
- Risk sharing/ management
- Physician engagement and leadership
- Primary care network development
- Process re-engineering and sustainable cost structure changes
  - Achieve the greatest performance at the most effective cost setting; requires new models of care delivery
- IT connectivity and platform development
- Sustainable financial performance and access to capital
  - Requires consistent revenue growth, cost management/ structure changes while investing the required capital to address the above transformational strategic goals/ objectives
- Mission accountability
  - Represents continued ability of organization to adequately serve its mission

Backus site visit attendees

Members of the Backus sub-committee attended site visits at partner facilities and hosted potential partners at Backus

Representatives from Backus

- **Peter Disch,** Chair, Board of Directors/Board of Trustees
- **Tony Joyce**, Vice Chair, Board of Directors/Board of Trustees
- **David Whitehead,** President and Chief Executive Officer
- **Bob Ramsdell,** Treasurer, Board of Directors/Board of Trustees
- **Lynne Quintal-Hill,** Member, Board of Directors/Board of Trustees
- **Peter Shea, MD,** Senior Vice President and Chief Medical Officer
- **Mark Tramontozzi, MD,** Vice President, Medical Staff
- **Daniel Lohr,** Senior Vice President and Chief Financial Officer
- **Keith Fontaine,** Vice President and Chief Administrative Officer

- **Patrick Allen,** Kaufman Hall and Associates
- **Jared Langus,** Kaufman Hall and Associates
- **Rob York,** Kaufman Hall and Associates

Revisit: *What defines "success" for Backus?*

- Remain **identifiable** with some sense of **autonomy**
  - "Others would want to emulate Backus"
- **Highest quality** patient care
- More **integrated care** delivery
  - Restructured processes (clinical and non-clinical) and effective use and delivery site access
- **Engaged physician** leadership
- **Financial viability**
- **Effective IT** to **drive care coordination** inside and outside the hospital walls
- Effective **recruitment and development of talent** and resources both clinical and non-clinical

Common factors to consider when seeking a strategic partner

Qualitative Considerations	Ongoing Control	Monetary Considerations
Alignment of mission and vision	Governance structure	Amount of capital commitment
History with potential partner	Real local control and involvement - Strategic planning and direction - Operating and capital budgets - Service continuation/enhancement	Fulfillment of debt obligations
Strategic plans		Strategic projects and prioritization
Reputation and Branding	Physician involvement in governance	Timing of capital commitment
Continuation/enhancement of services		Information systems
Focus on quality patient care		Transaction proceeds
Physician retention and recruitment		Funding community foundation
Employee plan and relations		
Focus on patient satisfaction		
Operational culture		

Next Steps

The process so far …

- ✓ **Backus New Era Readiness Assessment:** Fall 2010
- ✓ **Backus Strategic Options Assessment:** Winter 2010 – Spring 2011
- ✓ **Backus M&A Educational Session:** April 2011

Major decisions to date

- ✓ **Backus Board approves Goals and Objectives:** June 22, 2011
- ✓ **Backus approves Confidential Memorandum** and potential partner list and "tests the market": July – September 2011
- ✓ **Backus Board reviews initial indications of interest; appoints sub-committee** to perform an in-depth review of the proposals and conduct interviews and site visits – September 26, 2011

- ❑ **Sub-committee recommendation**
- ❑ **Act on committee recommendation** *["Go" / "No-Go"]*

Next steps if "Yes"

If a prospective partner is chosen:

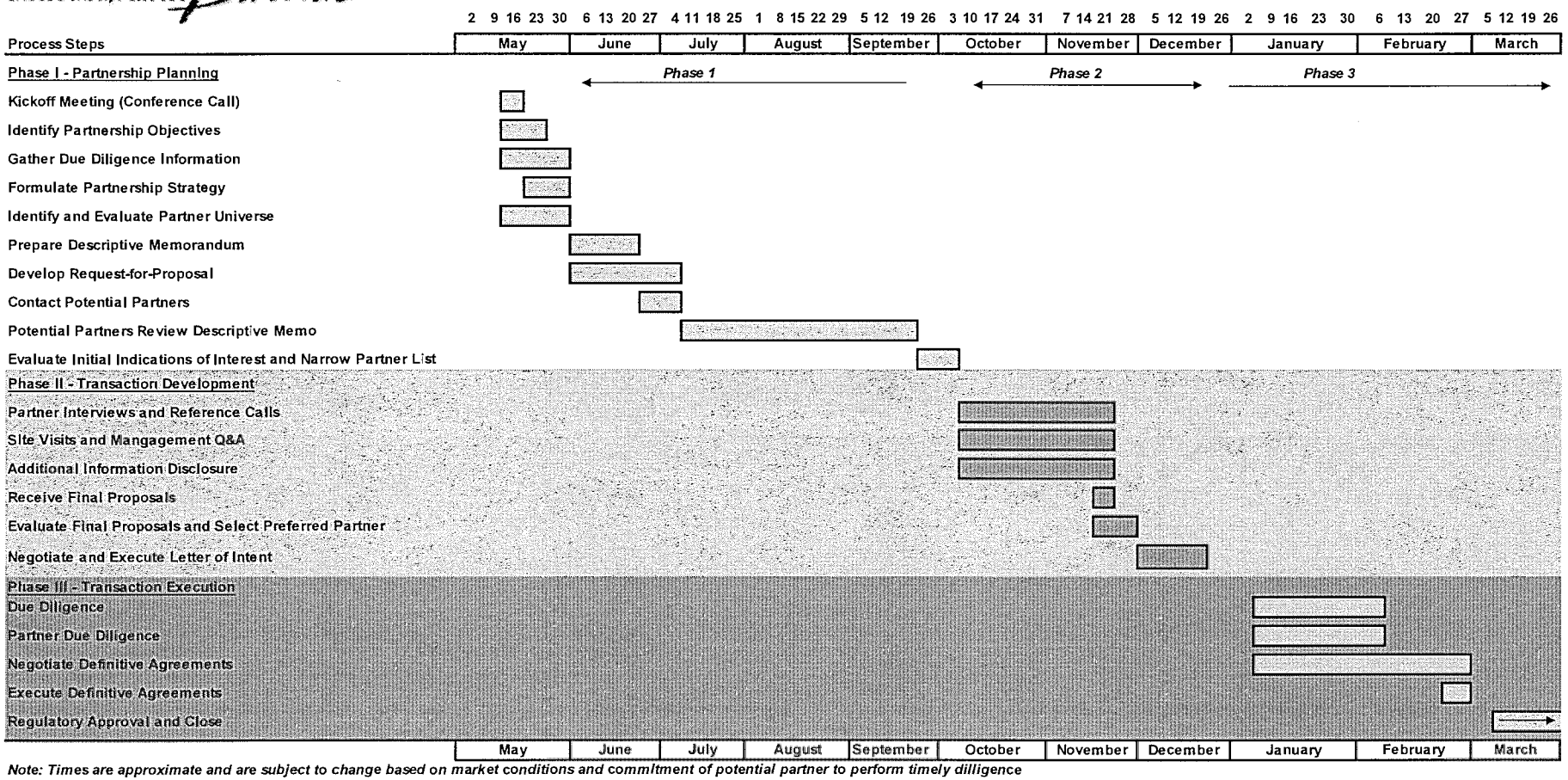
- ❑ Determine party for further diligence
- ❑ Solicit revised proposal
- ❑ Evaluate final proposal
- ❑ Negotiate Letter of Intent
- ❑ **"Go / No-Go" Decision**

Then what happens in Phase III?

- ❑ Due diligence
- ❑ Partner due diligence
- ❑ Negotiate definitive agreements
- ❑ Execute definitive agreements
- ❑ Regulatory approval and closing

Timeline

Choose wisely. Choose Backus



Note: Times are approximate and are subject to change based on market conditions and commitment of potential partner to perform timely dilligence

Appendix

Market Overview and Update

The watchword of the moment for healthcare is "unsustainable"

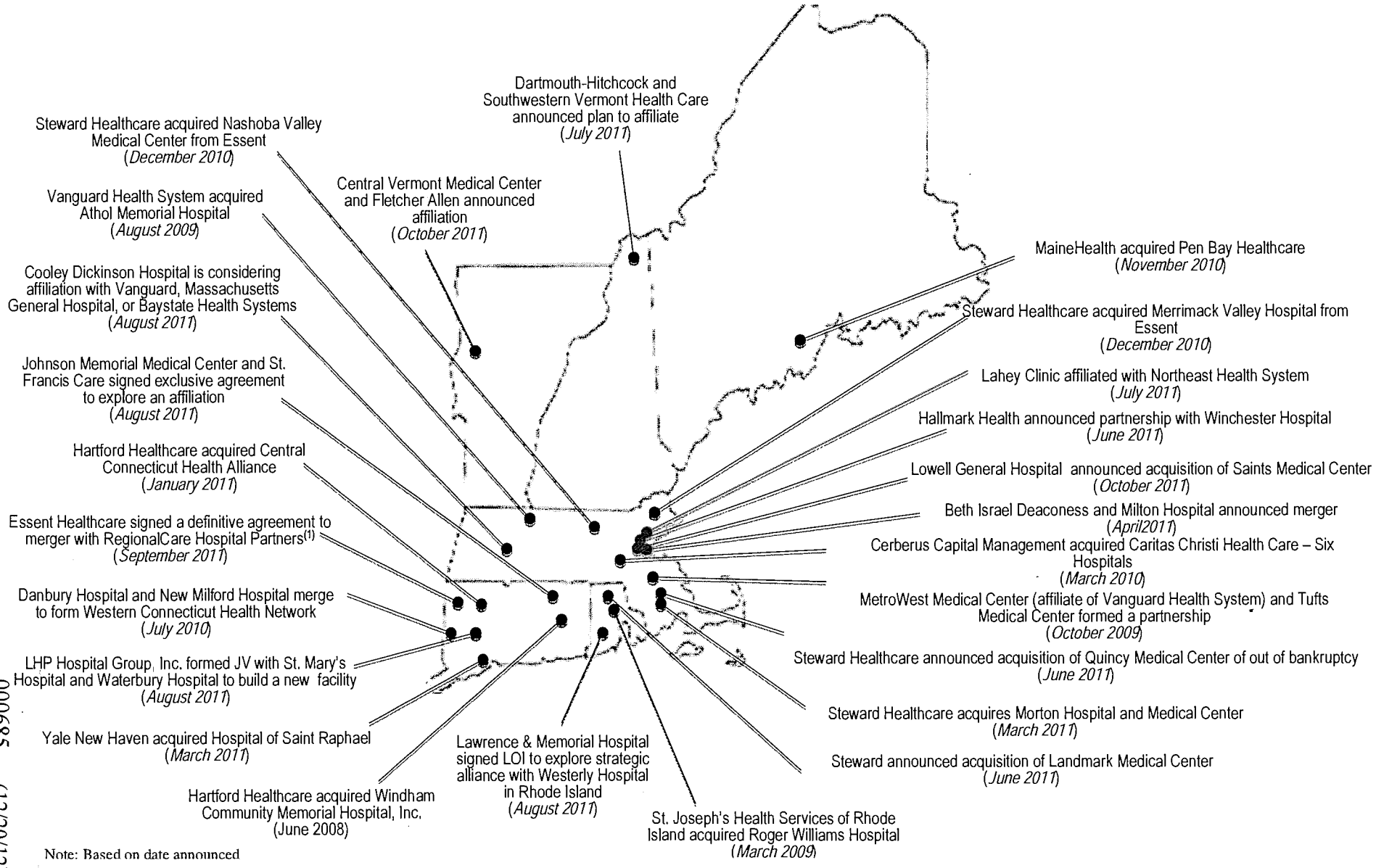
As in:

- ☑ The size of the federal budget deficit is unsustainable
- ☑ The annual increase in the Medicare budget is unsustainable
- ☑ The percentage of healthcare spending to GDP is unsustainable
- ☑ State Medicaid programs are unsustainable
- ☑ The continued transfer of costs to employers and consumers is unsustainable

Kaufman Hall's point of view

1. Provider revenues will be under severe pressure and payment mechanisms will migrate toward value based approaches
2. A new set of core competencies will be required for provider success
3. Inpatient and outpatient use rates will decline
4. Providers will learn how to solve a manufacturing problem
5. Providers will consolidate at an accelerated pace – horizontally and vertically
6. The competitive landscape will be reshaped

Changes to the New England provider landscape since 2008



Note: Based on date announced

Changes to the Connecticut provider landscape since 2008

Essent Healthcare merged with RegionalCare Hospital Partners[1]

(November 2011)

Hartford Healthcare acquired Central Connecticut Health Alliance

(January 2011)

Johnson Memorial Medical Center and St. Francis Care signed exclusive agreement to explore an affiliation

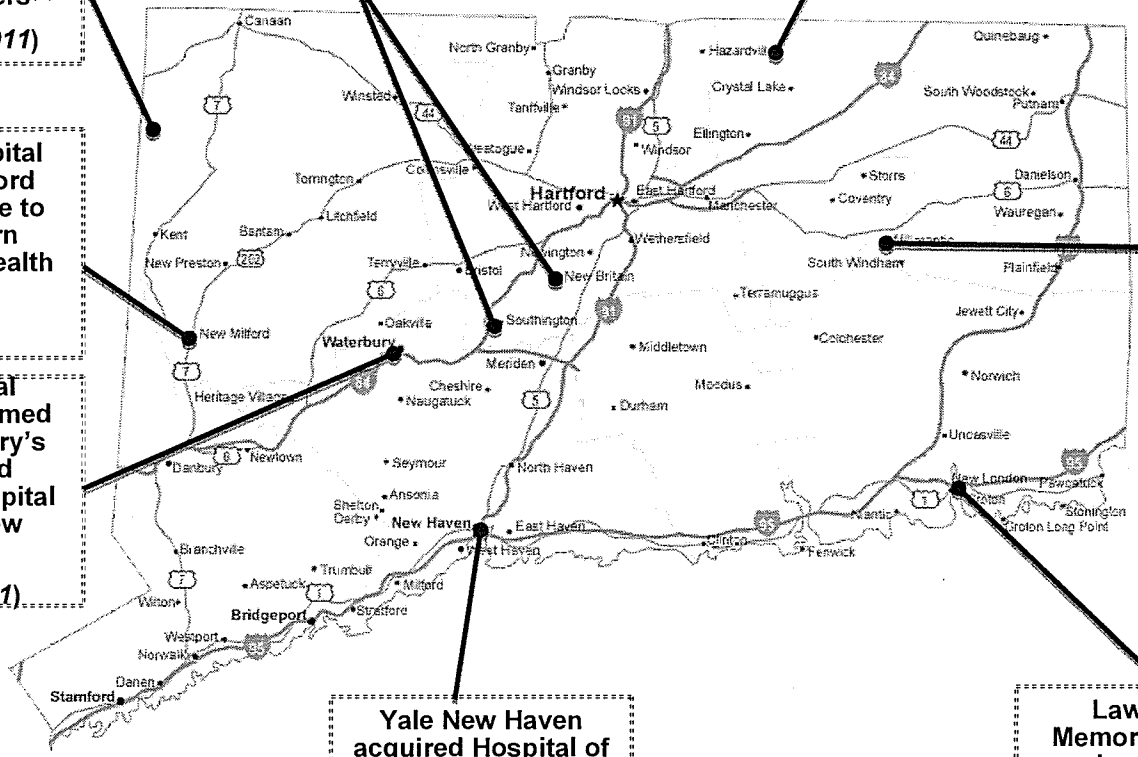
(August 2011)

Danbury Hospital and New Milford Hospital merge to form Western Connecticut Health Network

(July 2010)

LHP Hospital Group, Inc. formed JV with St. Mary's Hospital and Waterbury Hospital to build a new facility

(August 2011)



Hartford Healthcare acquired Windham Community Memorial Hospital, Inc.

(June 2008)

Yale New Haven acquired Hospital of Saint Raphael

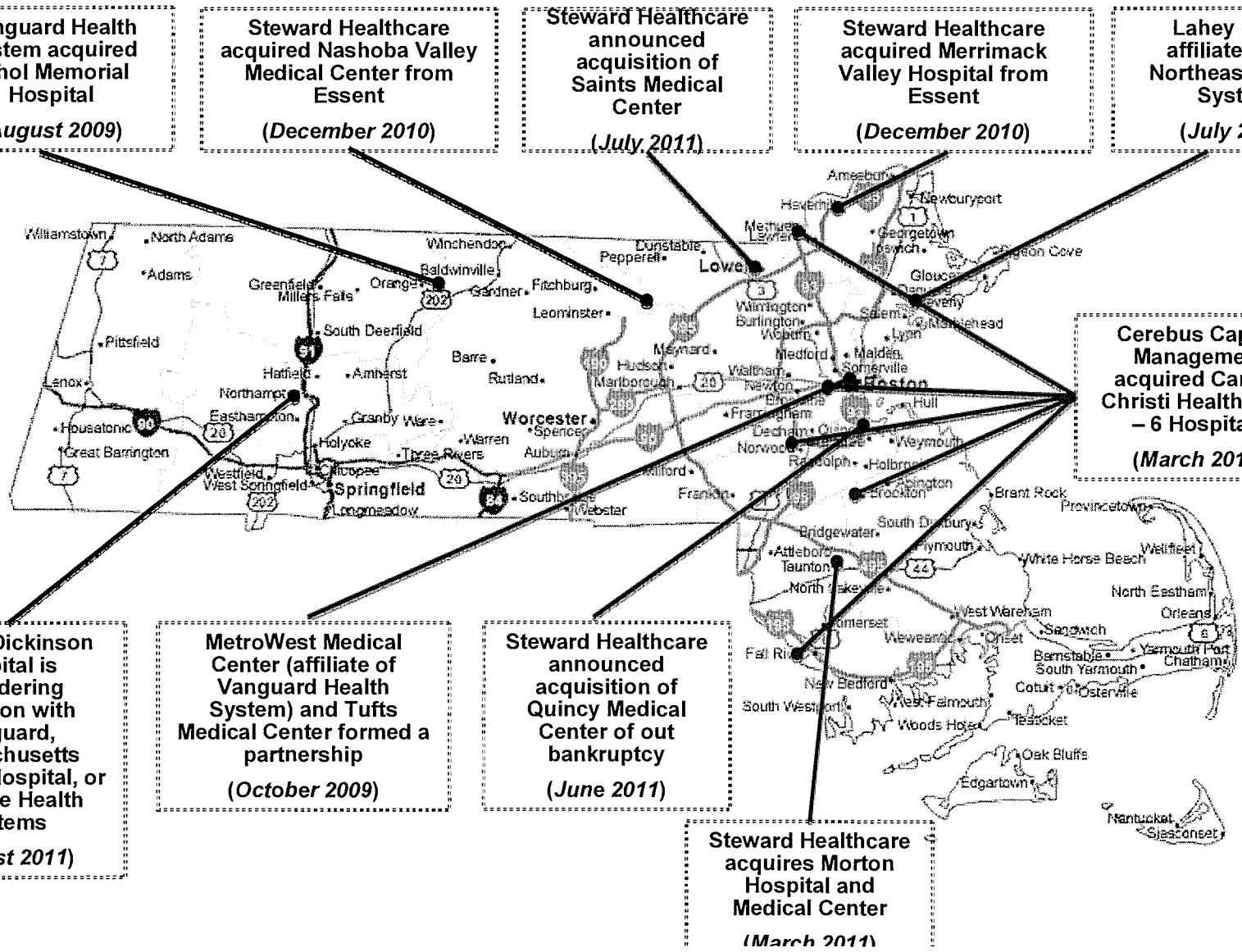
(March 2011)

Lawrence & Memorial Hospital signed LOI to explore strategic alliance with Westerly Hospital in Rhode Island

(August 2011)

Note (1): Location is Sharon Hospital: Essent also owns and operates hospitals in Texas and Pennsylvania. RegionalCare operates four hospitals in Alabama, Iowa and Ohio.

Changes to the Massachusetts provider landscape since 2008



The blurring of the lines between not-for-profit and for-profit healthcare as a new flexibility, or a new pragmatism, has emerged

Recent Examples of Partnerships Between Not-for-Profit and For-Profit Health Systems

Joint Venture to Form New System

DukeMedicine

LifePoint Hospitals®

Joint Venture to Acquire Catholic Hospitals

Ascension Health

Oak Hill Capital Partners

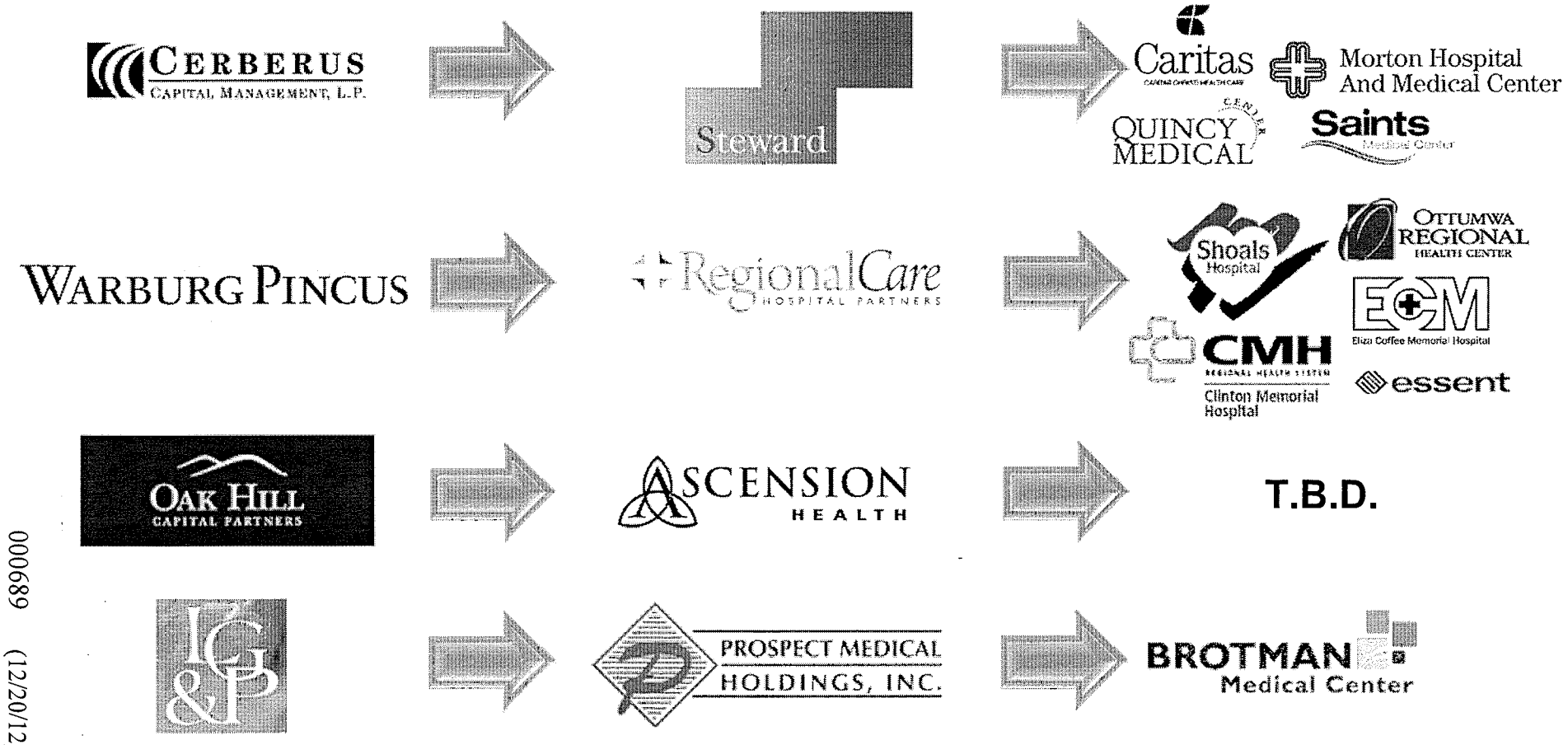
Joint Venture to Run Rural Hospitals

ShandsHealthCare

Health Management Associates™

New Entrants Are Making a Profound and Immediate Market Impact

The transactions below are noteworthy due to: (i) the size/ scale of the targets, (ii) nature/ form of solicitation, (iii) the terms/ conditions of the transaction or (iv) the lack of previous experience with hospitals of the acquirer



Focus on Massachusetts: Market players continue to shift

Providers

Northeast Health System | Lahey Clinic — ***Announced merger***

Tufts Medical Center | Vanguard Health Systems | MetroWest Medical Center — ***"Formed a partnership"***

Quincy Medical Center | Steward — ***Quincy Sold to Steward***

Beth Israel Deaconess Medical Center | Milton Hospital — ***Likely to merge***

Saints Medical Center | LGH Lowell General Hospital — ***Announce Affiliation***

Physicians

Choice PLUS network — *Lawrence General Ind. Phys. Group* | Beth Israel Deaconess Physician Organization, LLC — ***Choice PLUS joins BIDPO***

Southcoast Physicians Network — *Phys. Org. of Southcoast Health System* | NEQCA New England Quality Care Alliance — ***Southcoast Phys. Network joins NEQCA***

Payers

Massachusetts — *Partners Joins AQC* | Tufts Health Plan — No one does more to keep you healthy. | Steward | Neighborhood Health Plan — *Affiliation with Partners* | Tufts Health Plan — No one does more to keep you healthy. | Network Health — ***All in Play***

Exhibit 16
Financial Attachment I
(Backus Hospital)

Exhibit 16

Financial Attachment I (William W. Backus Hospital Only)

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

Total Facility: Description	FY 2011 Actual Results	FY2012 Projected W/out CON	FY2012 Projected Incremental	FY2012 Projected With CON	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE																
Non-Government	$158,452,539	$163,472,654	$ -	$163,472,654	$160,058,000	$659,754	$160,717,754	$157,215,900	$1,178,132	$158,394,032	$153,765,322	$1,178,132	$154,943,454	$150,047,568	$1,178,132	$151,225,700
Medicare	81,710,463	82,868,000	-	82,868,000	83,340,000	546,645	83,886,645	87,579,701	976,153	88,555,854	91,492,210	976,153	92,468,363	95,618,482	976,153	96,594,635
Medicaid and Other Medical Assistance	28,016,895	26,881,203	-	26,881,203	26,543,275	189,121	26,732,396	28,672,786	337,716	29,010,502	30,801,652	337,716	31,139,368	33,038,465	337,716	33,376,181
Other Government	3,753,321	3,847,797	-	3,847,797	4,106,725	4,480	4,111,205	4,223,203	7,999	4,231,202	4,326,579	7,999	4,334,578	4,437,335	7,999	4,445,334
Total Net Patient Patient Revenue	271,933,218	277,069,654	-	277,069,654	274,048,000	1,400,000	275,448,000	277,691,590	2,500,000	280,191,590	280,385,763	2,500,000	282,885,763	283,141,850	2,500,000	285,641,850
Other Operating Revenue	5,521,392	7,741,498	-	7,741,498	7,112,068	-	7,112,068	6,550,709	-	6,550,709	5,971,799	-	5,971,799	5,612,470	-	5,612,470
Revenue from Operations	277,454,610	284,811,152	-	284,811,152	281,160,068	1,400,000	282,560,068	284,242,299	2,500,000	286,742,299	286,357,562	2,500,000	288,857,562	288,754,320	2,500,000	291,254,320
OPERATING EXPENSES																
Salaries and Fringe Benefits	135,825,203	143,083,187	-	143,083,187	145,725,001	(6,760,000)	138,965,001	148,902,544	(8,796,000)	140,106,544	150,115,864	(8,796,000)	141,319,864	153,956,713	(8,796,000)	145,160,713
Professional / Contracted Services	12,192,000	13,816,000	-	13,816,000	13,521,464	(445,000)	13,076,464	13,569,507	(628,000)	12,941,507	13,410,875	(628,000)	12,782,875	13,459,918	(628,000)	12,831,918
Supplies and Drugs	42,030,994	42,947,000	-	42,947,000	43,549,000	(2,444,000)	41,105,000	45,163,000	(3,122,000)	42,041,000	46,155,000	(3,122,000)	43,033,000	47,785,000	(3,122,000)	44,663,000
Bad Debts	12,522,978	9,301,999	-	9,301,999	9,526,000	-	9,526,000	10,413,424	-	10,413,424	10,789,659	-	10,789,659	11,195,687	-	11,195,687
Other Operating Expense	28,371,864	33,488,076	-	33,488,076	32,774,162	-	32,774,162	32,891,612	-	32,891,612	32,506,097	-	32,506,097	32,627,971	-	32,627,971
Subtotal	230,943,039	242,636,262	-	242,636,262	245,095,628	(9,649,000)	235,446,628	250,940,087	(12,546,000)	238,394,087	252,977,495	(12,546,000)	240,431,495	259,025,289	(12,546,000)	246,479,289
Depreciation/Amortization	16,971,187	17,282,209	-	17,282,209	17,316,530	-	17,316,530	19,882,568	-	19,882,568	22,444,709	-	22,444,709	24,741,782	-	24,741,782
Interest Expense	3,247,718	3,276,000	-	3,276,000	3,369,000	-	3,369,000	3,261,000	-	3,261,000	3,146,000	-	3,146,000	3,027,000	-	3,027,000
Lease Expense	1,323,897	1,358,860	-	1,358,860	1,387,396	-	1,387,396	1,416,531	-	1,416,531	1,446,279	-	1,446,279	1,476,650	-	1,476,650
Total Operating Expense	252,485,841	264,553,331	-	264,553,331	267,168,554	(9,649,000)	257,519,554	275,500,186	(12,546,000)	262,954,186	280,014,483	(12,546,000)	267,468,483	288,270,721	(12,546,000)	275,724,721
Gain/(Loss) from Operations	24,968,769	20,257,821	-	20,257,821	13,991,514	11,049,000	25,040,514	8,742,113	15,046,000	23,788,113	6,343,079	15,046,000	21,389,079	483,599	15,046,000	15,529,599
Plus: Non-Operating Revenue	174,374	7,934,153	-	7,934,153	4,017,242	-	4,017,242	4,194,001	-	4,194,001	4,379,598	-	4,379,598	4,574,474	-	4,574,474
Revenue Over/(Under) Expense	$25,143,143	$28,191,974	$0	$28,191,974	$18,008,756	$11,049,000	$29,057,756	$12,936,114	$15,046,000	$27,982,114	$10,722,677	$15,046,000	$25,768,677	$5,058,073	$15,046,000	$20,104,073
FTEs	1,501.0	1,530.0	-	1,530.0	1,493.5	-	1,493.5	1,441.4	-	1,441.4	1,400.9	-	1,400.9	1,390.2	-	1,390.2
*Volume Statistics:																
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.																
Discharges	11,999	12,016		12,016	12,016		12,016	12,016		12,016	12,016		12,016	12,016		12,016
Emergency Department Visits	56,352	58,139		58,139	58,720		58,720	59,601		59,601	60,495		60,495	61,402		61,402

Exhibit 17
Revised Financial Attachment I
HHC and Backus Corporation

Exhibit 17

Revised Financial Attachment I (HHC)

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

Total Hospital Health System: Description	FY2011 Actual Results	FY2012 Projected W/out CON	FY2012 Projected Incremental	FY2012 Projected With CON	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE																
Non-Government	$772,119,000	$848,612,093	$170,842,000	$1,019,454,093	$904,743,096	$169,241,754	$1,073,984,850	$934,654,627	$168,218,132	$1,102,872,759	$962,078,514	$166,584,132	$1,128,662,646	$987,551,610	$163,970,132	$1,151,521,742
Medicare	618,923,000	703,125,354	86,243,000	789,368,354	749,634,038	88,055,645	837,689,683	774,417,161	93,439,153	867,856,314	797,139,207	98,115,153	895,254,360	818,245,401	102,823,153	921,068,554
Medicaid and Other Medical Assistance	219,775,000	243,258,313	30,129,000	273,387,313	259,348,461	30,244,121	289,592,582	267,922,264	32,965,716	300,887,980	275,783,179	35,541,716	311,324,895	283,085,982	38,110,716	321,196,698
Other Government	5,171,000	5,761,422	4,085,000	9,846,422	6,143,404	4,388,480	10,531,884	6,345,948	4,561,999	10,907,947	6,532,100	4,733,999	11,266,099	6,705,007	4,886,999	11,592,006
Total Net Patient Patient Revenue	1,615,988,000	1,800,757,182	291,299,000	2,092,056,182	1,919,868,999	291,930,000	2,211,798,999	1,983,340,000	299,185,000	2,282,525,000	2,041,533,000	304,975,000	2,346,508,000	2,095,588,000	309,791,000	2,405,379,000
Other Operating Revenue	187,975,000	211,167,000	7,930,000	219,097,000	215,606,000	7,306,000	222,912,000	221,616,000	6,749,000	228,365,000	227,950,000	6,176,000	234,126,000	236,533,000	5,821,000	242,354,000
Revenue from Operations	1,803,963,000	2,011,924,182	299,229,000	2,311,153,182	2,135,474,999	299,236,000	2,434,710,999	2,204,956,000	305,934,000	2,510,890,000	2,269,483,000	311,151,000	2,580,634,000	2,332,121,000	315,612,000	2,647,733,000
OPERATING EXPENSES																
Salaries and Fringe Benefits	1,047,834,000	1,154,620,238	156,700,000	1,311,320,238	1,239,795,278	154,745,000	1,394,540,278	1,271,224,544	158,154,000	1,429,378,544	1,317,365,824	161,774,000	1,479,139,824	1,353,805,140	166,504,000	1,520,309,140
Professional / Contracted Services	58,095,000	64,015,543	13,816,000	77,831,543	68,779,480	13,661,000	82,440,480	70,480,429	13,774,000	84,254,429	73,038,637	14,077,000	87,115,637	75,058,940	14,386,000	89,444,940
Supplies and Drugs	228,530,000	251,819,814	42,947,000	294,766,814	270,559,852	41,105,000	311,664,852	277,250,924	42,041,000	319,291,924	287,314,223	43,033,000	330,347,223	295,261,548	44,663,000	339,924,548
Bad Debts	35,420,000	39,029,702	9,374,000	48,403,702	41,934,232	9,631,000	51,565,232	42,971,285	10,559,000	53,530,285	44,531,002	10,987,000	55,518,002	45,762,762	11,423,000	57,185,762
Other Operating Expense	299,728,000	330,273,702	37,302,000	367,575,702	330,446,157	36,353,000	366,799,157	352,120,818	36,584,000	388,704,818	350,596,314	36,111,000	386,707,314	355,517,610	36,103,000	391,620,610
Subtotal	1,669,607,000	1,839,758,999	260,139,000	2,099,897,999	1,951,514,999	255,495,000	2,207,009,999	2,014,048,000	261,112,000	2,275,160,000	2,072,846,000	265,982,000	2,338,828,000	2,125,406,000	273,079,000	2,398,485,000
Depreciation/Amortization	81,701,000	94,551,000	17,355,000	111,906,000	102,032,000	17,386,000	119,418,000	108,815,000	19,949,000	128,764,000	113,318,000	22,507,000	135,825,000	117,762,000	24,802,000	142,564,000
Interest Expense	6,487,000	13,838,000	3,276,000	17,114,000	15,102,000	3,369,000	18,471,000	16,441,000	3,261,000	19,702,000	16,419,000	3,146,000	19,565,000	19,597,000	3,027,000	22,624,000
Lease Expense		-	1,859,000	1,859,000	-	1,897,000	1,897,000	-	1,938,000	1,938,000	-	1,978,000	1,978,000	-	2,020,000	2,020,000
Total Operating Expense	1,757,795,000	1,948,147,999	282,629,000	2,230,776,999	2,068,648,999	278,147,000	2,346,795,999	2,139,304,000	286,260,000	2,425,564,000	2,202,583,000	293,613,000	2,496,196,000	2,262,765,000	302,928,000	2,565,693,000
Gain/(Loss) from Operations	46,168,000	63,776,183	16,600,000	80,376,183	66,826,000	21,089,000	87,915,000	65,652,000	19,674,000	85,326,000	66,900,000	17,538,000	84,438,000	69,356,000	12,684,000	82,040,000
Plus: Non-Operating Revenue	179,991,000	58,376,000	9,252,000	67,628,000	22,600,000	5,078,000	27,678,000	22,286,000	5,255,000	27,541,000	22,105,000	5,441,000	27,546,000	21,945,000	5,635,000	27,580,000
Revenue Over/(Under) Expense	$226,159,000	$122,152,183	$25,852,000	$148,004,183	$89,426,000	$26,167,000	$115,593,000	$87,938,000	$24,929,000	$112,867,000	$89,005,000	$22,979,000	$111,984,000	$91,301,000	$18,319,000	$109,620,000
FTEs	9,668.8	9,958.5	1,674.0	11,632.5	9,955.2	1,642.7	11,597.9	9,989.2	1,595.6	11,584.8	9,995.2	1,560.1	11,555.3	9,999.2	1,554.4	11,553.6

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

Discharges	76,191	77,047	12,016	89,063	76,351	12,016	88,367	76,945	12,016	88,961	77,407	12,016	89,423	77,810	12,016	89,826
Emergency Department Visits	296,124	298,232	58,139	356,371	308,731	58,720	367,451	312,802	59,601	372,403	315,936	60,495	376,431	319,123	61,402	380,525

Exhibit 17

Revised **Financial Attachment I (Backus Corporation)**

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

Total Facility: Description	FY 2011 Actual Results	FY2012 Projected W/out CON	FY2012 Projected Incremental	FY2012 Projected With CON	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE																
Non-Government	$165,042,000	$170,842,000	$ -	$170,842,000	$168,582,000	$659,754	$169,241,754	$167,040,000	$1,178,132	$168,218,132	$165,406,000	$1,178,132	$166,584,132	$162,792,000	$1,178,132	$163,970,132
Medicare	85,300,000	86,243,000	-	86,243,000	87,509,000	546,645	88,055,645	92,463,000	976,153	93,439,153	97,139,000	976,153	98,115,153	101,847,000	976,153	102,823,153
Medicaid and Other Medical Assistance	30,890,000	30,129,000	-	30,129,000	30,055,000	189,121	30,244,121	32,628,000	337,716	32,965,716	35,204,000	337,716	35,541,716	37,773,000	337,716	38,110,716
Other Government	3,982,000	4,085,000	-	4,085,000	4,384,000	4,480	4,388,480	4,554,000	7,999	4,561,999	4,726,000	7,999	4,733,999	4,879,000	7,999	4,886,999
Total Net Patient Patient Revenue	285,214,000	291,299,000	-	291,299,000	290,530,000	1,400,000	291,930,000	296,685,000	2,500,000	299,185,000	302,475,000	2,500,000	304,975,000	307,291,000	2,500,000	309,791,000
Other Operating Revenue	5,675,000	7,930,000	-	7,930,000	7,306,000	-	7,306,000	6,749,000	-	6,749,000	6,176,000	-	6,176,000	5,821,000	-	5,821,000
Revenue from Operations	290,889,000	299,229,000	-	299,229,000	297,836,000	1,400,000	299,236,000	303,434,000	2,500,000	305,934,000	308,651,000	2,500,000	311,151,000	313,112,000	2,500,000	315,612,000
OPERATING EXPENSES																
Salaries and Fringe Benefits	147,499,000	156,700,000	-	156,700,000	161,505,000	(6,760,000)	154,745,000	166,950,000	(8,796,000)	158,154,000	170,570,000	(8,796,000)	161,774,000	175,300,000	(8,796,000)	166,504,000
Professional / Contracted Services	12,192,000	13,816,000	-	13,816,000	14,106,000	(445,000)	13,661,000	14,402,000	(628,000)	13,774,000	14,705,000	(628,000)	14,077,000	15,014,000	(628,000)	14,386,000
Supplies and Drugs	42,031,000	42,947,000	-	42,947,000	43,549,000	(2,444,000)	41,105,000	45,163,000	(3,122,000)	42,041,000	46,155,000	(3,122,000)	43,033,000	47,785,000	(3,122,000)	44,663,000
Bad Debts	12,595,000	9,374,000	-	9,374,000	9,631,000	-	9,631,000	10,559,000	-	10,559,000	10,987,000	-	10,987,000	11,423,000	-	11,423,000
Other Operating Expense	32,943,000	37,302,000	-	37,302,000	36,353,000	-	36,353,000	36,584,000	-	36,584,000	36,111,000	-	36,111,000	36,103,000	-	36,103,000
Subtotal	247,260,000	260,139,000	-	260,139,000	265,144,000	(9,649,000)	255,495,000	273,658,000	(12,546,000)	261,112,000	278,528,000	(12,546,000)	265,982,000	285,625,000	(12,546,000)	273,079,000
Depreciation/Amortization	17,051,000	17,355,000	-	17,355,000	17,386,000	-	17,386,000	19,949,000	-	19,949,000	22,507,000	-	22,507,000	24,802,000	-	24,802,000
Interest Expense	3,248,000	3,276,000	-	3,276,000	3,369,000	-	3,369,000	3,261,000	-	3,261,000	3,146,000	-	3,146,000	3,027,000	-	3,027,000
Lease Expense	1,785,000	1,859,000	-	1,859,000	1,897,000	-	1,897,000	1,938,000	-	1,938,000	1,978,000	-	1,978,000	2,020,000	-	2,020,000
Total Operating Expense	269,344,000	282,629,000	-	282,629,000	287,796,000	(9,649,000)	278,147,000	298,806,000	(12,546,000)	286,260,000	306,159,000	(12,546,000)	293,613,000	315,474,000	(12,546,000)	302,928,000
Gain/(Loss) from Operations	21,545,000	16,600,000	-	16,600,000	10,040,000	11,049,000	21,089,000	4,628,000	15,046,000	19,674,000	2,492,000	15,046,000	17,538,000	(2,362,000)	15,046,000	12,684,000
Plus: Non-Operating Revenue	2,038,000	9,252,000	-	9,252,000	5,078,000	-	5,078,000	5,255,000	-	5,255,000	5,441,000	-	5,441,000	5,635,000	-	5,635,000
Revenue Over/(Under) Expense	$23,583,000	$25,852,000	$0	$25,852,000	$15,118,000	$11,049,000	$26,167,000	$9,883,000	$15,046,000	$24,929,000	$7,933,000	$15,046,000	$22,979,000	$3,273,000	$15,046,000	$18,319,000
FTEs	1,633.3	1,674.0	-	1,674.0	1,642.7	-	1,642.7	1,595.6	-	1,595.6	1,560.1	-	1,560.1	1,554.4	-	1,554.4

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

Discharges	11,999	12,016	12,016	12,016	12,016	12,016	12,016	12,016	12,016	12,016	12,016	12,016
Emergency Department Visits	56,352	58,139	58,139	58,720	58,720	59,601	59,601	60,495	60,495	61,402	61,402	61,402

Exhibit 18
HOCC's and Windham Hospital's Actual Cost Savings

Exhibit 18

Windham & HOCC Actual Cost Savings

Area	Hospital	Category	FY 2011	FY 2012
Streamlined System Coding and Document Review	Windham	Business		$1,300,000
Centralization of Revenue Cycle Staff	Windham	Salaries & Wages		$1,100,000
Refinancing - Reduced Existing Interest Costs	Windham	Interest		$600,000
Group Purchasing	Windham	Medical Supplies	$300,000	$300,000
Malpractice Captive and Other Insurance	Windham	Malpractice	$250,000	$250,000
Reduced Consulting	HOCC	Business Expense	$837,500	$638,500
Vendor Savings	HOCC	Business Expense	$1,046,575	$2,610,720
Fringe Benefit Consolidation	HOCC	Fringe Benefits	$0	$1,357,601
Vendor Savings for medical items	HOCC	Medical Supplies	$222,960	$1,048,833
Revenue Enhancements	HOCC	Revenue	$74,500	$1,084,161
Consolidated Support Services	HOCC	Salaries and Wages	$1,015,130	$919,274
Vendor Savings	HOCC	Utilities	$18,750	$1,145,037
Totals			$3,765,415	$12,354,126
		Windham	$550,000	$3,550,000
		HOCC	$3,215,415	$8,804,126
			$3,765,415	$12,354,126

000697 (12/20/12)

Exhibit 19
Backus Corporation's
Projected Cost Savings

Exhibit 19

Table 4 "Areas"	Description	Report 175 Category	FY 2013	FY 2014	FY 2015	FY 2016	Anticipated
Revenue Cycle	New processes (improved write offs)	**Net Revenue**	$ 1,400,000	$ 2,500,000	$ 2,500,000	$ 2,500,000	
Labor	Revenue Cycle	Salaries and Wages	$ (460,000)	$ (855,000)	$ (855,000)	$ (855,000)	
Labor	Fiscal, Supply Chain, etc.	"	(1,760,000)	(2,155,000)	(2,155,000)	(2,155,000)	
Labor	Administrative & Other	"	(3,310,000)	(4,230,000)	(4,230,000)	(4,230,000)	
Clinical Operations	Transfer Center, Care Coordination & Bed Management	"	(425,000)	(637,500)	(637,500)	(637,500)	
Human Resources	Absence Management	"	(180,000)	(192,500)	(192,500)	(192,500)	
Human Resources	Premium Pay	"	(160,000)	(213,000)	(213,000)	(213,000)	
Human Resources	Employee Benefits	Fringe Benefits	(465,000)	(513,000)	(513,000)	(513,000)	
		Salaries & Benefits	(6,760,000)	(8,796,000)	(8,796,000)	(8,796,000)	
Clinical Operations	Best Practices	Contractual Labor Fees	(250,000)	(400,000)	(400,000)	(400,000)	
Human Resources	HR Purchased Services	"	(195,000)	(228,000)	(228,000)	(228,000)	
		Prof/Contract Services	(445,000)	(628,000)	(628,000)	(628,000)	
Non-Labor	Pharmacy	Supplies and Drugs	(400,000)	(500,000)	(500,000)	(500,000)	
Non-Labor	Lab	"	(300,000)	(350,000)	(350,000)	(350,000)	
Non-Labor	Clinical Supplies	"	(185,000)	(225,000)	(225,000)	(225,000)	
Revenue Cycle	Vendor Cost Savings	Business Expenses	(80,000)	(165,000)	(165,000)	(165,000)	
Non-Labor	Asset Management & Insurance	"	(1,479,000)	(1,882,000)	(1,882,000)	(1,882,000)	
		Supplies & Drugs	$ (2,444,000)	$ (3,122,000)	$ (3,122,000)	$ (3,122,000)	
		Expenses	$ (9,649,000)	$ (12,546,000)	$ (12,546,000)	$ (12,546,000)	
		Margin	$ 11,049,000	$ 15,046,000	$ 15,046,000	$ 15,046,000	
Capital Avoidance	Development of Urgent Care & Primary Care Sites						$ 20,000,000
"	One Ambulance Service vs. two						3,600,000
"	Shared Information Technolgy Services						5,000,000
							$ 28,600,000
Table 4 Subtotals	Non-Labor		$ 2,364,000	$ 2,957,000	$ 2,957,000	$ 2,957,000	
	Revenue Cycle		1,480,000	2,665,000	2,665,000	2,665,000	
	Clinical Operations		675,000	1,037,500	1,037,500	1,037,500	
	Human Resources		1,000,000	1,146,500	1,146,500	1,146,500	
	Labor		5,530,000	7,240,000	7,240,000	7,240,000	
	Capital Avoidance						$ 28,600,000
		TABLE 4 Total	$ 11,049,000	$ 15,046,000	$ 15,046,000	$ 15,046,000	$ 28,600,000

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

January 18, 2013 VIA FAX & EMAIL ONLY

Ms. Karen Goyette
Vice President, Strategic Planning and Business Development
Hartford Healthcare Corporation
One State Street
Suite 19
Hartford, CT 06103

RE: Certificate of Need Application, Docket Number 12-31788-CON
Proposal for the affiliation of Backus Corporation with Hartford HealthCare Corporation
2nd Completeness Letter

Dear Ms. Goyette:

On December 20, 2012, the Office of Health Care Access ("OHCA") received your Completeness Letter responses for your Certificate of Need application of Hartford HealthCare Corporation ("HHC") and Backus Corporation ("Backus"), (Collectively identified as the "Applicants") for the proposed affiliation of Backus Corporation with Hartford HealthCare Corporation. OHCA has reviewed your responses and requests the following additional information pursuant to General Statutes §19a-639a(c):

1. On page 634, in response to question #1 (iii), the Applicants indicate that "In connection with establishing such (primary care and ambulatory care) networks, the System is creating the necessary infrastructure to provide accessible, continuous, coordinated, and patient centered health care to patients with chronic illnesses" in an effort to "reduce the number of avoidable hospital admissions." Please provide further detailed explanation as to the "necessary infrastructure" as used in this response. Provide some examples and indicate how this has been done or is underway at the other HHC system hospitals.

2. On page 636, in response to question #1 (vi) related to patient data, informatics and reporting systems, the Applicants indicate that "The System is also developing other data-driven initiatives that will integrate independent affiliated physicians and align their incentives along with that of the hospital, payors, and patients ..." What is specifically meant by "align their incentives"? Please provide examples to illustrate.

3. On page 637, in response to question #1 (x) related to cancer services network development, the Applicants indicate that "System affiliated oncologists will benefit from cross fertilization with the Backus Hospital affiliated medical oncologists." Please provide further explanation and examples related to this cross fertilization.

4. On page 638, in response to question #1 (xii), the Applicants imply that this affiliation is needed in order to provide a "commitment to maintain LIFE STAR on the Backus Hospital campus". Why is such a commitment necessary? Is a relocation of the second LIFE STAR helicopter contemplated if this CON is not approved?

5. On page 640, in response to question #6 (a), the Applicants indicate that the system has been accepted by CMS to participate in the Medicare Shared Savings Program (MSSP) as of January 1, 2013. How will the financial rewards for the participation in the MSSP benefit the William W. Backus Hospital?

6. On page 641, in response to question #6 (d), the Applicants indicate that Backus Corporation "has accounted for the benefit of value-based purchasing by not projecting decreases in its revenue." As further clarification, please indicate whether the "without the project" financial projections have been developed to assume a negative position related to value-based purchasing in the future (as a stand-alone organization).

7. Please provide a table for Backus Hospital, Backus Corporation and Hartford Healthcare Corporation for the same timeframes provided in Exhibits 16 and 17 (FY 2011 actual through FY 2016 projected) which lists the following financial measurements or indicators.

	With the CON	Without the CON
Operating Margin		
Non-Operating Margin		
Total Margin		
Ratio of Cost to Charges		
Current Ratio		
Days Cash on Hand		
Days in Patients Accounts Receivable		
Average Payment Period		
Equity Financing Ratio		
Cash Flow to Total Debt Ratio		
Long-Term Debt to Capitalization Ratio		

N/A is acceptable if the financial measurement is specifically not-applicable to the system entities. Please identify the statement of operations and/or balance sheet figures that resulted in (or were used in) each listed financial measurement or indicator.

8. Please provide a discussion on the impact of the proposed affiliation on the provision of health care services to the relevant patient population and payer mix. How might this proposal provide a positive impact on the payers of services (i.e. self-pay, commercial payers, government payers) provided by Backus Hospital and throughout the Backus Corporation system in both the short-term and long-term?

9. On page 659 in Exhibit 15 (PowerPoint presentation by Kaufman, Hall & Associates) the strategic goals and objectives titled "Strategies to Destination 2014" lists various 'Pillar Metrics," (e.g., Days cash on hand of $\geq$ 250 days) that will be used to achieve future strategic goals and objectives associated with this proposal. Please discuss how this proposal is designed to assist Backus Health System and Backus Hospital in achieving these "Pillar Metrics."

10. On page 699 in Exhibit 19 there is a category entitled "Capital Avoidance," which identifies three avoidance items. Please provide the background information pertaining to item number 2 –"One Ambulance Service vs. two" and describe how the $3.6 million attributable to this category was calculated.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness letter, late file submissions, and the like) must be numbered sequentially from the Applicant document preceding it. As the current submission for the application concludes with page 699, please begin with the completeness response with **page 700**. Reference Docket Number: 12-31788-CON and submit one (1) original and six (6) hard copies of your response in its entirety, including any supporting documentation. Submit a scanned copy of your response in Adobe format, an electronic copy in MS Word format and any worksheets in MS Excel, including all attachments, on CD.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

Copy (faxed): Keith Fontaine, Backus Corporation

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

TRANSMISSION OK

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TIME USE	00'48
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RESULT	OK

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

FAX SHEET

TO: Karen Goyette

FAX: (860) 263-4125

AGENCY: Hartford Healthcare

FROM: Steven Lazarus

DATE: 1/18/13 TIME: ~~2~~ 12:45 pm

NUMBER OF PAGES: 4
(including transmittal sheet

Comments:
2nd Completeness Letter for DN: 12-31788-ROV enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** ERROR TX REPORT ***
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TX FUNCTION WAS NOT COMPLETED

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PAGES SENT	0	
RESULT	NG	#0018 BUSY/NO SIGNAL

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

FAX SHEET

TO: Keith Fontaine

FAX: (860) 892-8964

AGENCY: Bacics

FROM: Steven Lazarus

DATE: 1/18/13 TIME: 12:45 pm

NUMBER OF PAGES: 4
(including transmittal sheet

Comments:
2nd Completed Letter under DN: 12-31788-cw
Enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, January 18, 2013 12:58 PM
To: karen.goyette@hhchealth.org; kfontaine@wwbh.org
Cc: Greer, Leslie
Subject: Re: 2nd Completeness Letter, Docket No.: 12-31788
Attachments: 31778_2nd CL.pdf; 12-31788 Completeness Letter 2nd_1_18_2013.docx

Dear Ms. Goyette & Mr. Fontaine,

Please see the attached courtesy electronic copy (blank without signature and a signed pdf) of the 2nd Completeness Letter regarding Docket Number: 12-31788.

Please feel free to contact me if you have any questions.

Sincerely,
Steven

Ps. Signed copies were faxed over to your attention a few minutes ago.

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone (Direct): 860.418.7012
Fax (Main): 860.418.7053

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

January 18, 2013 VIA FAX & EMAIL ONLY

Ms. Karen Goyette
Vice President, Strategic Planning and Business Development
Hartford Healthcare Corporation
One State Street
Suite 19
Hartford, CT 06103

RE: Certificate of Need Application, Docket Number 12-31788-CON
Proposal for the affiliation of Backus Corporation with Hartford HealthCare Corporation
2nd Completeness Letter

Dear Ms. Goyette:

On December 20, 2012, the Office of Health Care Access ("OHCA") received your Completeness Letter responses for your Certificate of Need application of Hartford HealthCare Corporation ("HHC") and Backus Corporation ("Backus"), (Collectively identified as the "Applicants") for the proposed affiliation of Backus Corporation with Hartford HealthCare Corporation. OHCA has reviewed your responses and requests the following additional information pursuant to General Statutes §19a-639a(c):

1. On page 634, in response to question #1 (iii), the Applicants indicate that "In connection with establishing such (primary care and ambulatory care) networks, the System is creating the necessary infrastructure to provide accessible, continuous, coordinated, and patient centered health care to patients with chronic illnesses" in an effort to "reduce the number of avoidable hospital admissions." Please provide further detailed explanation as to the "necessary infrastructure" as used in this response. Provide some examples and indicate how this has been done or is underway at the other HHC system hospitals.

2. On page 636, in response to question #1 (vi) related to patient data, informatics and reporting systems, the Applicants indicate that "The System is also developing other data-driven initiatives that will integrate independent affiliated physicians and align their incentives along with that of the hospital, payors, and patients ..." What is specifically meant by "align their incentives"? Please provide examples to illustrate.

3. On page 637, in response to question #1 (x) related to cancer services network development, the Applicants indicate that "System affiliated oncologists will benefit from cross fertilization with the Backus Hospital affiliated medical oncologists." Please provide further explanation and examples related to this cross fertilization.

4. On page 638, in response to question #1 (xii), the Applicants imply that this affiliation is needed in order to provide a "commitment to maintain LIFE STAR on the Backus Hospital campus". Why is such a commitment necessary? Is a relocation of the second LIFE STAR helicopter contemplated if this CON is not approved?

5. On page 640, in response to question #6 (a), the Applicants indicate that the system has been accepted by CMS to participate in the Medicare Shared Savings Program (MSSP) as of January 1, 2013. How will the financial rewards for the participation in the MSSP benefit the William W. Backus Hospital?

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7. Please provide a table for Backus Hospital, Backus Corporation and Hartford Healthcare Corporation for the same timeframes provided in Exhibits 16 and 17 (FY 2011 actual through FY 2016 projected) which lists the following financial measurements or indicators.

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Equity Financing Ratio		
Cash Flow to Total Debt Ratio		
Long-Term Debt to Capitalization Ratio		

N/A is acceptable if the financial measurement is specifically not-applicable to the system entities. Please identify the statement of operations and/or balance sheet figures that resulted in (or were used in) each listed financial measurement or indicator.

8. Please provide a discussion on the impact of the proposed affiliation on the provision of health care services to the relevant patient population and payer mix. How might this proposal provide a positive impact on the payers of services (i.e. self-pay, commercial payers, government payers) provided by Backus Hospital and throughout the Backus Corporation system in both the short-term and long-term?

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In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness letter, late file submissions, and the like) must be numbered sequentially from the Applicant document preceding it. As the current submission for the application concludes with page 699, please begin with the completeness response with **page 700**. Reference Docket Number: 12-31788-CON and submit one (1) original and six (6) hard copies of your response in its entirety, including any supporting documentation. Submit a scanned copy of your response in Adobe format, an electronic copy in MS Word format and any worksheets in MS Excel, including all attachments, on CD.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

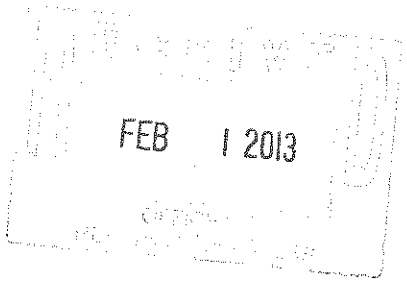
Copy (faxed): Keith Fontaine, Backus Corporation

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: 860-251-5104
Fax: 860-251-5211
jfeldman@goodwin.com

February 1, 2013



Steven W. Lazarus
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Application, Docket Number 12-31788-CON
Certificate of Need Completeness Letter Responses (Round 2)

Dear Mr. Lazarus:

On behalf of the Applicants, enclosed please find the original and 6 hard copies of the Applicants' responses to your Certificate of Need Completeness Letter dated January 18, 2013 for Docket Number: 12-31788-CON. As requested, I have also included a CD with the electronic version of the enclosed documents and materials.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

Joan W. Feldman

Enclosures

000700 (02/01/13)

1. On page 634, in response to question #1 (iii), the Applicants indicate that "In connection with establishing such (primary care and ambulatory care) networks, the System is creating the necessary infrastructure to provide accessible, continuous, coordinated, and patient centered health care to patients with chronic illnesses" in an effort to "reduce the number of avoidable hospital admissions." Please provide further detailed explanation as to the "necessary infrastructure" as used in this response. Provide some examples and indicate how this has been done or is underway at the other HHC system hospitals.

   The System is indeed creating the necessary infrastructure to provide accessible, continuous, coordinated and patient-centered healthcare to patients with chronic illnesses. However, the creation of such infrastructure does not involve a single approach, nor is it done in isolation, but rather it involves the creation of a multi-layered and multi-faceted infrastructure dedicated to promoting the health of the population being managed. From an information technology ("IT") perspective, the System has hired a physician with expertise in informatics and IT to lead the System in acquiring and implementing the necessary IT infrastructure to manage care and reduce unnecessary healthcare costs. From a quality management perspective, the System has created a quality management group to spearhead programs to monitor and measure quality reporting and outcomes on a System-wide level. With respect to physician integration, the System has recently created a clinically integrated physician organization comprised of affiliated physicians committed to being clinically integrated and at financial risk for managing patient care and keeping patients healthy. The System also created an accountable care organization ("ACO") to participate in the Medicare Shared Savings Program ("MSSP"). See Question 8 below. Along with the ACO, the System has created a medical foundation (known as the "Hartford HealthCare Medical Group") comprised of employed primary care and specialist physicians committed to participation in the ACO and other similar initiatives to improve quality outcomes and population health. The development of the affiliated medical foundation has also allowed the System to develop its Family Health Centers which offer improved access to urgent and primary care services in the surrounding communities served by the System (offering the same service standards, accessibility and connectivity to a network of HHC providers). The System's home care provider will be facilitating care coordination efforts and implementation of the medical home model. In terms of current success in reducing the number of avoidable hospital admissions, the System is implementing congestive heart failure clinics that have successfully reduced the number of avoidable hospital admissions by more effectively managing the patient with greater care coordination on an outpatient basis. All of the foregoing initiatives are part of the multi-layered and multi-faceted infrastructure to respond to the demands for greater quality and more efficient care.

2. On page 636, in response to question #1 (vi) related to patient data, informatics and reporting systems, the Applicants indicate that "The System is also developing other data-driven initiatives that will integrate independent affiliated physicians and align their incentives along with that of the hospital, payors, and patients ..." What is specifically meant by "align their incentives"? Please provide examples to illustrate.

In response to question #1 above, a description was provided for the clinically integrated physician organization developed by the System. This clinically integrated physician organization will hold the physicians clinically and financially accountable for the care they provide. Thus, if physicians in the organization are not properly managing the care of their patients (e.g., avoidable hospital admissions are occurring or medically unnecessary services are being provided), the entire group of physicians is at financial risk and corrective action will be taken. This is what is meant by "align their incentives".

3. On page 637, in response to question #1 (x) related to cancer services network development, the Applicants indicate that "System affiliated oncologists will benefit from cross fertilization with the Backus Hospital affiliated medical oncologists." Please provide further explanation and examples related to this cross fertilization.

As stated in the response to question #1 (x), "cross fertilization" occurs when providers have the opportunity to work directly with one and another and refer their patients to providers within a network based upon the provider's specific expertise. In the instant case, the work of the System's oncologists will be enhanced through the addition of the Backus Corporation's nationally accredited cancer program, which includes clinical research, multiple tumor boards, a cancer registry, and numerous educational and survivorship programs. Backus Corporation's services include radiation therapy, medical oncology, diagnostic imaging, reconstructive surgery, robotic surgery, palliative care, integrative therapies, a Breast Health Center, patient navigator, survivorship program and a collaborative approach to patient care. Regardless of which direction the referrals are going, (i.e. from Backus Corporation to another System provider or from another System provider to Backus Corporation) the System's network would be more diverse with the addition of Backus Corporation and patients would benefit by having enhanced access to the latest technologies and the most qualified clinician to meet their specific healthcare needs.

4. On page 638, in response to question #1 (xii), the Applicants imply that this affiliation is needed in order to provide a "commitment to maintain LIFE STAR on the Backus Hospital campus". Why is such a commitment necessary? Is a relocation of the second LIFE STAR helicopter contemplated if this CON is not approved?

One of the State's two LIFE STAR helicopters has been stationed at Backus Hospital under a highly successful 13-year partnership with Hartford Hospital. Backus Corporation provides a full-scale support facility consisting of a licensed heliport with

hangar, helipad and fueling station, for the aircraft on its main hospital campus. Approximately forty percent of all LIFE STAR flights in Connecticut originate from Backus Corporation. This is especially significant, as Backus Corporation operates the only Trauma Center east of the Connecticut River. At least twice in the past five years (in 2009 and 2011), the State has proposed eliminating grant funding to the LIFE STAR air medical transport program in its biennial budget. The proposed affiliation with the System will give the Eastern Connecticut communities that Backus Corporation serves greater security with respect to the continued presence of LIFE STAR on its hospital campus. While no relocation of LIFE STAR is contemplated should this CON not be approved, pursuant to the proposed affiliation Agreement, LIFE STAR would be permanently located at Backus Corporation.

5. On page 640, in response to question #6 (a), the Applicants indicate that the system has been accepted by CMS to participate in the Medicare Shared Savings Program (MSSP) as of January 1, 2013. How will the financial rewards for the participation in the MSSP benefit the William W. Backus Hospital?

   HHC organized an ACO, in part, so that it could participate in the MSSP and more generally, so that it could create the infrastructure necessary to effectively manage care in order to provide the highest quality of care at the lowest cost. To be accepted to participate in the MSSP, an ACO must demonstrate that it is significantly committed to evidence-based medicine practices, quality reporting and the lowering of unnecessary medical costs, along with meeting all of the requirements of the federal program relating thereto. As an ACO participating in the MSSP, there are significant costs associated with the creation of the infrastructure, and of course, it is preferable to spread those costs across a larger group of providers. In addition, because there is a very steep learning curve associated with participation in the MSSP, participants must have enough financial capacity to cushion the learning curve. The Applicants believe that if the CON is approved, Backus Corporation will benefit from both HHC's experience in the MSSP and from the ability to participate in the MSSP ACO and other similar initiatives. The proposed affiliation will also obviate the need for Backus to invest financial and professional resources in the creation of a stand-alone ACO.

6. On page 641, in response to question #6 (d), the Applicants indicate that Backus Corporation "has accounted for the benefit of value-based purchasing by not projecting decreases in its revenue." As further clarification, please indicate whether the "without the project" financial projections have been developed to assume a negative position related to value-based purchasing in the future (as a stand-alone organization).

   Yes, the financial projections have been developed to assume a negative position related to value-based purchasing in the future (as a stand-alone organization). Notwithstanding, it is difficult for Backus Corporation to precisely predict the financial impact that value-based purchasing will have on Backus Corporation as a

standalone hospital, but we can assume that Backus Corporation will not have the same degree of success as a standalone that it will have if it is part of the System, given the System's commitment to creating the required infrastructure and achieving cost efficiencies.

7. Please provide a table for Backus Hospital, Backus Corporation and Hartford Healthcare Corporation for the same timeframes provided in Exhibits 16 and 17 (FY 2011 actual through FY 2016 projected) which lists the following financial measurements or indicators.

	With the CON	Without the CON
Operating Margin		
Non-Operating Margin		
Total Margin		
Ratio of Cost to Charges		
Current Ratio		
Days Cash on Hand		
Days in Patients Accounts Receivable		
Average Payment Period		
Equity Financing Ratio		
Cash Flow to Total Debt Ratio		
Long-Term Debt to Capitalization Ratio		

N/A is acceptable if the financial measurement is specifically not-applicable to the system entities. Please identify the statement of operations and/or balance sheet figures that resulted in (or were used in) each listed financial measurement or indicator.

See Exhibit 20 for the requested table. With respect to the table set forth in Exhibit 20, please note the following. First, for FYs 2011 and 2012, the Applicants inserted "Not Applicable" in the column entitled "With the CON" as there was no approved CON for this proposal in FYs 2011 and 2012. Second, this CON Application did not require or include the Applicants' Gross Revenues or Balance Sheets. Accordingly, for FYs 2013 - 2016, the Applicants inserted "Not Available" for the following financial measurements or indicators: "Ratio of Cost to Charges"; "Current Ratio"; "Days Cash on Hand"; "Days in Patients Accounts Receivable"; "Average Payment Period"; "Equity Financing Ratio"; "Cash Flow to Total Debt Ratio"; and "Long-Term Debt to Capitalization Ratio". Although the combined balance sheet ratios are not available, it is certain they would only improve as a result of the improved bottom line, and capital avoidance, of the combined entities.

See Exhibit 21 for the statement of operations and/or balance sheet figures that resulted in (or were used in) each listed financial measurement or indicator.

8. Please provide a discussion on the impact of the proposed affiliation on the provision of health care services to the relevant patient population and payer mix. How might this proposal provide a positive impact on the payers of services (i.e. self-pay, commercial payers, government payers) provided by Backus Hospital and throughout the Backus Corporation system in both the short-term and long-term?

The proposed affiliation should not have an impact on the relevant patient population and payer mix at all. With respect to the provision of health care services, Backus Corporation patients will benefit from access to a greater range of services available at a System-wide level, as more particularly described in the CON Application. By way of example, access to a system-wide network of oncology providers and services, will directly benefit Backus Corporation oncology patients by allowing them to have greater and more seamless access to new technologies, protocols, clinical trials and medical experts.

The Applicants also believe that Backus Corporation's proposed affiliation with an integrated healthcare delivery system that is developing and implementing the infrastructure required to manage care and control costs, will have a stabilizing effect on Backus Corporation that will ultimately benefit all the payors and the entire State health care system. In particular, with respect to the Medicare program, Backus Corporation will be eligible to participate in the MSSP Hartford HealthCare Accountable Care Organization, which is focused upon improving quality outcomes, improving the health of the population and reducing unnecessary costs.

9. On page 659 in Exhibit 15 (PowerPoint presentation by Kaufman, Hall & Associates) the strategic goals and objectives titled "Strategies to Destination 2014" lists various 'Pillar Metrics," (e.g., Days cash on hand of $\geq$ 250 days) that will be used to achieve future strategic goals and objectives associated with this proposal. Please discuss how this proposal is designed to assist Backus Health System and Backus Hospital in achieving these "Pillar Metrics."

The Backus Corporation Board identified six Strategic Imperatives that the organization would need to achieve, or make significant strides in, by 2014. The Pillar Metrics are approved each year by the Board, and vary from year to year. (The metrics shown in Exhibit 15 are for Fiscal Year 2012.) The metrics provide the basis for organization-wide planning, management accountability and performance measurement. As a member of HHC's integrated health care delivery system, it is expected that Backus Corporation will participate in System-wide quality councils, take part in best practice methodologies embraced by the System, and gain access to System-level expertise when Backus Corporation is challenged with under-performance in any area. Similarly, this proposal would allow Backus Corporation to share its expertise regarding areas for which it has demonstrated successful performance. A recent study by Truven Health Analytics (Thompson Reuters' health care division) supports this position. The study, "Hospital System membership and

Performance," examined performance measures for 2,791 short-term, general, non-federal hospitals. Of that group, 1,628 hospitals were members of a larger system, and 1,163 were independent. The study concluded that "hospitals that are part of systems provide more cost-efficient care," and "also deliver a higher quality of care," "outperform[ing] their independent peers on safety, quality and cost-effectiveness measures." A key strategy for successful systems is "identifying successful practices in one hospital and trying to replicate them across the organization." See Exhibit 22 for the Modern Healthcare, June 18, 2012 article.

10. On page 699 in Exhibit 19 there is a category entitled "Capital Avoidance," which identifies three avoidance items. Please provide the background information pertaining to item number 2 –"One Ambulance Service vs. two" and describe how the $3.6 million attributable to this category was calculated.

Backus Corporation contemplates operating a hospital-affiliated ambulance service to provide transportation using advance life support (ALS) ambulances. The service, as envisioned, would work closely with first responders, local fire departments, other ambulance services and emergency dispatchers to coordinate 911 responses and provide transportation from Backus Corporation to other facilities, or between Backus Corporation facilities, as appropriate. HHC already operates an ambulance service, thus obviating the need to acquire, affiliate or create one for Backus Corporation. The amount shown is an estimate of savings from Backus Corporation not having to incur this additional investment.

Exhibit 20
Table in Response to Question # 7

EXHIBIT 20

Second Completeness, Question #7

	Based on Audited FY 2011 and FY 2012 Financial Statements**				Based on FA A and FA C							
	FY 2011 Actual		FY 2012 Actual**		FY 2013 Projected		FY 2014 Projected		FY 2015 Projected		FY 2016 Projected	
Hartford HealthCare	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON
Operating Margin		2.20%		2.88%	3.57%	3.10%	3.36%	2.95%	3.24%	2.92%	3.07%	2.95%
Non-Operating Margin		10.19%		0.69%	1.12%	1.05%	1.08%	1.00%	1.06%	0.96%	1.03%	0.93%
Total Margin		11.45%		6.14%	4.69%	4.14%	4.45%	3.95%	4.29%	3.88%	4.10%	3.88%
Ratio of Cost to Charges		0.45		0.47								
Current Ratio		1.68		1.67								
Days Cash on Hand	Not Applicable	31	Not Applicable	39								
Days in Patients Accounts Receivable		46		49								
Average Payment Period		61		67								
Equity Financing Ratio		39.9		37.8								
Cash Flow to Total Debt Ratio		44.7		29.3								
Long-Term Debt to Capitalization Ratio		32.8		30.7								

Backus Corporation	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON
Operating Margin		7.37%		7.40%	6.93%	3.31%	6.32%	1.50%	5.54%	0.79%	3.95%	-0.74%
Non-Operating Margin		0.70%		4.42%	1.67%	1.68%	1.69%	1.70%	1.72%	1.73%	1.75%	1.77%
Total Margin		8.07%		11.82%	8.60%	4.99%	8.01%	3.20%	7.26%	2.53%	5.70%	1.03%
Ratio of Cost to Charges		0.43		0.43								
Current Ratio		4.06		4.74								
Days Cash on Hand	Not Applicable	138	Not Applicable	150								
Days in Patients Accounts Receivable		38		39								
Average Payment Period		50		46								
Equity Financing Ratio		44.8		50.0								
Cash Flow to Total Debt Ratio		41.8		56.9								
Long-Term Debt to Capitalization Ratio		27.7		24.7								

Backus Hospital	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON	With the CON	Without the CON
Operating Margin		9.01%		8.74%	8.74%	4.91%	8.18%	3.03%	7.29%	2.18%	5.25%	0.16%
Non-Operating Margin		0.06%		4.22%	1.40%	1.41%	1.44%	1.45%	1.49%	1.51%	1.55%	1.56%
Total Margin		9.07%		12.96%	10.14%	6.31%	9.62%	4.48%	8.79%	3.69%	6.80%	1.72%
Ratio of Cost to Charges		0.41		0.42								
Current Ratio		4.14		4.99								
Days Cash on Hand	Not Applicable	145	Not Applicable	159								
Days in Patients Accounts Receivable		37		40								
Average Payment Period		51		46								
Equity Financing Ratio		45.3		50.4								
Cash Flow to Total Debt Ratio		44.1		59.8								
Long-Term Debt to Capitalization Ratio		27.8		24.7								

Not Available

Not Available

Not Available

**Please note that for FY 2012, the information submitted is based on Audited Financial Statements, which was not available at the time of the submission of the CON Application and the first round of Completeness Questions. Prior information for and resulting from FY 2012 was based on projected data.

Exhibit 21
Statement of Operations
and/or
Balance Sheet Figures

Exhibit 21 (Hartford HealthCare Ratio Detail) Based on Audited FY 2011 and FY 2012 Financials	FY2011 Actual Results	FY2012 *Actual*** Results	FY2013 Projected W/out CON	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected With CON
Income from operations	43,533,000	60,576,000	56,826,000	87,915,000	65,652,000	85,326,000	66,900,000	84,438,000	69,356,000	82,040,000
Total Revenue	1,974,522,000	2,104,656,000	2,158,074,999	2,462,388,999	2,227,242,000	2,538,431,000	2,291,588,000	2,608,180,000	2,354,066,000	2,675,313,000
% Operating Margin	**2.20%**	**2.88%**	**3.10%**	**3.57%**	**2.95%**	**3.36%**	**2.92%**	**3.24%**	**2.95%**	**3.07%**
Nonoperating Revenue	201,200,000	14,563,000	22,600,000	27,678,000	22,286,000	27,541,000	22,105,000	27,546,000	21,945,000	27,580,000
Total Revenue	1,974,522,000	2,104,656,000	2,158,074,999	2,462,388,999	2,227,242,000	2,538,431,000	2,291,588,000	2,608,180,000	2,354,066,000	2,675,313,000
% Non-operating Margin	**10.19%**	**0.69%**	**1.05%**	**1.12%**	**1.00%**	**1.08%**	**0.96%**	**1.06%**	**0.93%**	**1.03%**
Total Margin										
Excess of revenue over expenses	226,159,000	129,139,000	89,426,000	115,593,000	87,936,000	112,867,000	89,005,000	111,984,000	91,301,000	109,620,000
Total Revenue	1,974,522,000	2,104,656,000	2,158,074,999	2,462,388,999	2,227,242,000	2,538,431,000	2,291,588,000	2,608,180,000	2,354,066,000	2,675,313,000
% Total Margin	**11.45%**	**6.14%**	**4.14%**	**4.69%**	**3.95%**	**4.45%**	**3.88%**	**4.29%**	**3.88%**	**4.10%**

Total Operating Expenses	1,727,154,000	2,029,517,000
Toal Gross Revenue	3,624,354,000	4,294,961,000
Total Other Operating Revenue	201,200,000	14,563,000
Ratio of Cost to Charges	**0.451**	**0.471**
Current Assets	462,240,000	596,941,000
Current Liabilities	275,311,000	356,533,000
Current Ratio	**1.68**	**1.67**
Cash and cash equivalents	139,631,000	206,896,000
Short term investments	-	-
Total Cash and short term investments	139,631,000	206,896,000
Total Operating Expenses	1,727,154,000	2,029,517,000
Depreciation Expense	81,701,000	93,592,000
Operating expenses less depreciation	1,645,453,000	1,935,925,000
Days Cash on Hand	**30.97**	**39.01**
Net Patient Accounts Receivable	235,816,000	272,907,000
Due from/(to) third party payors	(34,065,000)	(29,931,000)
Total Patient accounts receivable and third party	201,751,000	242,976,000
Total Net Patient Revenue	1,585,347,000	1,822,555,000
Days in Patients Accounts Receivable	**46.45**	**48.66**
Current Liabilites	275,311,000	356,533,000
Total Operating Expenses	1,727,154,000	2,029,517,000
Depreciation expense	81,701,000	93,592,000
Operating expenses less depreciation	1,645,453,000	1,935,925,000
Average Payment Period	**61.07**	**67.22**
Total Net Assets	847,957,000	911,913,000
Total Assets	2,123,561,000	2,413,698,000
Equity Financing Ratio	**0.399**	**0.378**
Excess of Revenues over Expenses	226,159,000	129139000
Depreciation expense	81,701,000	93,592,000
Excess of Revenues and Depreciation expense	307,860,000	222,731,000
Total Current Liabilities	275,311,000	356,533,000
Total Long Term Debt	413,327,000	403,991,000
Total Current Liabilities and Long term debt	688,638,000	760,524,000
Cash Flow to Total Debt Ratio	**0.447**	**0.293**
Total Long Term Debt	413,327,000	403,991,000
Total Net Assets	847,957,000	911,913,000
Total Long term debt and Total Net assets	1,261,284,000	1,315,904,000
Long-Term Debt to Capitalization Ratio	**0.328**	**0.307**

**Please note that for FY 2012, the information submitted is based on Audited Financial Statements, which was not available at the time of the submission of the CON Application and the first round of Completeness Questions. Prior information for and resulting from FY 2012 was based on projected data.

Exhibit 21 (Backus Corporation Ratio Details) Based on Audited FY 2011 and FY 2012 Financials	FY2011 Actual Results	FY2012 *Actual*** *Results*	FY2013 Projected W/out CON	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected With CON
Income from operations	21,540,819	23,626,745	10,040,000	21,089,000	4,628,000	19,674,000	2,492,000	17,538,000	(2,362,000)	12,684,000
Total Revenue	292,226,781	319,163,535	302,914,000	304,314,000	308,689,000	311,189,000	314,092,000	316,592,000	318,747,000	321,247,000
% Operating Margin	**7.37%**	**7.40%**	**3.31%**	**6.93%**	**1.50%**	**6.32%**	**0.79%**	**5.54%**	**-0.74%**	**3.95%**
Nonoperating Revenue	2,038,205	14,102,638	5,078,000	5,078,000	5,255,000	5,255,000	5,441,000	5,441,000	5,635,000	5,635,000
Total Revenue	292,226,781	319,163,535	302,914,000	304,314,000	308,689,000	311,189,000	314,092,000	316,592,000	318,747,000	321,247,000
% Non-operating Margin	**0.70%**	**4.42%**	**1.68%**	**1.67%**	**1.70%**	**1.69%**	**1.73%**	**1.72%**	**1.77%**	**1.75%**
Total Margin										
Excess of revenue over expenses	23,579,024	37,729,383	15,118,000	26,167,000	9,883,000	24,929,000	7,933,000	22,979,000	3,273,000	18,319,000
Total Revenue	292,226,781	319,163,535	302,914,000	304,314,000	308,689,000	311,189,000	314,092,000	316,592,000	318,747,000	321,247,000
% Total Margin	**8.07%**	**11.82%**	**4.99%**	**8.60%**	**3.20%**	**8.01%**	**2.53%**	**7.26%**	**1.03%**	**5.70%**
Total Operating Expenses	268,647,757	281,434,152								
Total Gross Revenue	624,460,853	639,940,838								
Total Other Operating Revenue	4,307,817	7,282,268								
Ratio of Cost to Charges	**0.427**	**0.435**								
Current Assets	141,187,465	156,391,235								
Current Liabilities	34,770,075	33,013,340								
Current Ratio	**4.06**	**4.74**								
Cash and cash equivalents	95,434,551	108,322,462								
Short term investments	-	-								
Total Cash and short term investments	95,434,551	108,322,462								
Total Operating Expenses	268,647,757	281,434,152								
Depreciation Expense	17,045,582	18,079,091								
Operating expenses less depreciation	251,602,175	263,355,061								
Days Cash on Hand	**138.45**	**150.13**								
Net Patient Accounts Receivable	34,428,013	33,684,894								
Due from/(to) third party payors	(5,023,840)	(1,481,120)								
Total Patient accounts receivable and third party	29,404,173	32,203,774								
Total Net Patient Revenue	285,207,565	297,604,077								
Days in Patients Accounts Receivable	**37.63**	**39.50**								
Current Liabilites	34,770,075	33,013,340								
Total Operating Expenses	268,647,757	281,434,152								
Depreciation expense	17,045,582	18,079,091								
Operating expenses less depreciation	251,602,175	263,355,061								
Average Payment Period	**50.44**	**45.76**								
Total Net Assets	162,762,614	198,024,302								
Total Assets	363,434,139	396,221,469								
Equity Financing Ratio	**0.448**	**0.500**								
Excess of Revenues over Expenses	23,579,024	37,729,383								
Depreciation expense	17,045,582	18,079,091								
Excess of Revenues and Depreciation expense	40,624,606	55,808,474								
Total Current Liabilities	34,770,075	33,013,340								
Total Long Term Debt	62,389,713	65,056,990								
Total Current Liabilities and Long term debt	97,159,788	98,070,330								
Cash Flow to Total Debt Ratio	**0.418**	**0.569**								
Total Long Term Debt	62,389,713	65,056,990								
Total Net Assets	162,762,614	198,024,302								
Total Long term debt and Total Net assets	225,152,327	263,081,292								
Long-Term Debt to Capitalization Ratio	**0.277**	**0.247**								

**Please note that for FY 2012, the information submitted is based on Audited Financial Statements, which was not available at the time of the submission of the CON Application and the first round of Completeness Questions. Prior information for and resulting from FY 2012 was based on projected data.

Exhibit 21 (Backus Hospital Ratio Detail) Based on Audited FY 2011 and FY 2012 Financials	FY2011 Actual Results	FY2012 *Actual**** *Results*	FY2013 Projected W/out CON	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected With CON
Income from operations	24,968,769	26,564,716	13,991,514	25,040,514	8,742,113	23,788,113	6,343,079	21,389,079	483,599	15,529,599
Total Revenue	277,216,878	303,987,739	285,177,310	286,577,310	288,436,300	290,936,300	290,737,160	293,237,160	293,328,794	295,828,794
% Operating Margin	**9.01%**	**8.74%**	**4.91%**	**8.74%**	**3.03%**	**8.18%**	**2.18%**	**7.29%**	**0.16%**	**5.25%**
Nonoperating Revenue	174,374	12,819,113	4,017,242	4,017,242	4,194,001	4,194,001	4,379,598	4,379,598	4,574,474	4,574,474
Total Revenue	277,216,878	303,987,739	285,177,310	286,577,310	288,436,300	290,936,300	290,737,160	293,237,160	293,328,794	295,828,794
% Non-operating Margin	**0.06%**	**4.22%**	**1.41%**	**1.40%**	**1.45%**	**1.44%**	**1.51%**	**1.49%**	**1.56%**	**1.55%**
Total Margin										
Excess of revenue over expenses	25,143,143	39,383,829	18,008,756	29,057,756	12,936,114	27,982,114	10,722,677	25,768,677	5,058,073	20,104,073
Total Revenue	277,216,878	303,987,739	285,177,310	286,577,310	288,436,300	290,936,300	290,737,160	293,237,160	293,328,794	295,828,794
% Total Margin	**9.07%**	**12.96%**	**6.31%**	**10.14%**	**4.48%**	**9.62%**	**3.69%**	**8.79%**	**1.72%**	**6.80%**

Total Operating Expenses	252,073,735	264,603,910
Toal Gross Revenue	604,060,585	615,524,464
Total Other Operating Revenue	5,109,286	7,948,871
Ratio of Cost to Charges	**0.414**	**0.424**
Current Assets	136,970,305	154,349,678
Current Liabilities	33,059,842	30,958,015
Current Ratio	**4.14**	**4.99**
Cash and cash equivalents	93,136,217	107,428,365
Short term investments	-	-
Total Cash and short term investments	93,136,217	107,428,365
Total Operating Expenses	252,073,735	264,603,910
Depreciation Expense	16,971,187	18,006,195
Operating expenses less depreciation	235,102,548	246,597,715
Days Cash on Hand	**144.60**	**159.01**
Net Patient Accounts Receivable	32,373,122	32,015,340
Due from/(to) third party payors	(4,683,178)	(1,193,235)
Total Patient accounts receivable and third party	27,689,944	30,822,105
Total Net Patient Revenue	271,933,218	283,219,755
Days in Patients Accounts Receivable	**37.17**	**39.72**
Current Liabilites	33,059,842	30,958,015
Total Operating Expenses	252,073,735	264,603,910
Depreciation expense	16,971,187	18,006,195
Operating expenses less depreciation	235,102,548	246,597,715
Average Payment Period	**51.33**	**45.82**
Total Net Assets	162,176,033	197,862,113
Total Assets	357,969,938	392,951,093
Equity Financing Ratio	**0.453**	**0.504**
Excess of Revenues over Expenses	25,143,143	39,383,829
Depreciation expense	16,971,187	18,006,195
Excess of Revenues and Depreciation expense	42,114,330	57,390,024
Total Current Liabilities	33,059,842	30,958,015
Total Long Term Debt	62,389,713	65,056,990
Total Current Liabilities and Long term debt	95,449,555	96,015,005
Cash Flow to Total Debt Ratio	**0.441**	**0.598**
Total Long Term Debt	62,389,713	65,056,990
Total Net Assets	162,176,033	197,862,113
Total Long term debt and Total Net assets	224,565,746	262,919,103
Long-Term Debt to Capitalization Ratio	**0.278**	**0.247**

**Please note that for FY 2012, the information submitted is based on Audited Financial Statements, which was not available at the time of the submission of the CON Application and the first round of Completeness Questions. Prior information for and resulting from FY 2012 was based on projected data.

000712 (02/01/13)

Exhibit 22
Modern Healthcare Article

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Modern Healthcare
Modern Healthcare

June 18, 2012

SECTION: Pg. 6

LENGTH: 1714 words

HEADLINE: The Buddy System;
Leveraging a partnership improves **hospitals'** quality, lovers costs: report

BYLINE: Beth Kutscher

BODY:

Acquisition activity has reached a fever pitch, motivated in large part by healthcare reform and economic uncertainty. But what has long been a clear business case for consolidation may also be among best practices for clinical outcomes.

Squeezed by declining volumes and shrinking reimbursement, **hospitals** are finding it harder to go it alone. And new research from Truven Health **Analytics** has found that the impact of being an independent **hospital** is felt not only on the balance sheet, but also at the bedside.

Hospitals that are part of systems not only provide more cost-efficient care, but they also deliver a higher quality of care, according to the Truven analysis, which used data from its 100 Top **Hospitals** and 15 Top Health Systems studies.

(The 15 Top Health System list appears on p. 12. The list of 100 Top **Hospitals** starts on p. 17.)

Its research found that **hospitals** that were part of larger chains outperformed their independent peers on safety, quality and cost-effectiveness measures. In addition, **hospitals** that were part of systems were about three times more likely to appear on the 100 Top **Hospitals** list.

"While the formation of health systems was primarily for economic reasons, historically, we are finding that being part of a system is actually driving higher quality in today's world, as of 2010," says Jean Chenoweth, senior vice president of performance improvement and 100 Top **Hospitals** programs at Truven. "And that bodes very, very well."

Previous studies have not been able to show that systems lower the cost of delivering care or improve patient outcomes. But systems have continued to get bigger, seeking out opportunities to acquire acute-care **hospitals** and other facilities. Many independent **hospitals,** meanwhile, have sought to leverage partnerships.

The Patient Protection and Affordable Care Act in particular has encouraged collaboration among different parts of the healthcare system, Chenoweth says, particularly the push to form accountable care organizations or ACO-like programs.

In addition, healthcare reform has put the spotlight on improving the quality of care as well as lowering the cost of care.

"I think the systems offer many of the original benefits that systems always offered," Chenoweth says, citing access to capital and economies of scale. But with the goals of healthcare reform requiring greater collaboration among different types of providers, "these systems are providing a continuum of care."

And that means individual medical centers no longer have to be all things to all patients.

"What a smaller **hospital** gains from being part of a larger system is access to protocols, access to expertise," Chenoweth says. She adds that, rather than invest in every latest piece of technology or try to add every service line, they can take advantage of telemedicine or the ability to transfer patients to another facility.

That's how it works at Baystate Health, a three-**hospital** system in Springfield, Mass., which also includes a children's **hospital,** large physician practice, visiting nurse association and hospice. The system has also built an academic affiliation with Tufts University School of Medicine and serves as the largest teaching site for the institution.

Dr. Evan Benjamin, the system's senior vice president and chief quality officer, notes that its two smaller community **hospitals**-90-bed Baystate Franklin Medical Center and 31-bed Baystate Mary Lane **Hospital**-can draw on the resources of the flagship 659-bed Baystate Medical Center to provide tertiary care.

"That's really the goal for us-to be a regional integrated delivery system," Benjamin says. "The idea is to work together."

The Truven study, **Hospital** System **Membership** and Performance, looked at performance measures for 2,791 short-term, general, non-federal **hospitals.** Of that group, 1,628 **hospitals** were identified as members of a larger system, and 1,163 **hospitals** as independent.

Hospitals were further classified into three subgroups: major teaching **hospitals**; teaching **hospitals**; and large, medium and small community **hospitals.** David Foster, lead scientist at Truven's Center for Healthcare **Analytics**, notes that the subgroups helped control for differences in patient mix, such as the more complicated cases that tend to be treated at academic medical centers.

The study used data from the CMS' **Hospital** Compare, MedPAR and Medicare cost reports to calculate performance on 30-day readmission rates, severity-adjusted average lengths of stay, adjusted inpatient expense per discharge, adjusted operating profit margin and patient perception of care.

The data covered a period from 2005 to 2010 and was used to analyze current performance as well as five-year performance improvement.

A composite score was used to identify the best performing **hospitals,** and a percentile rank was assigned to each facility. And the results found that **hospital** system members averaged a score in the 54th percentile, compared with the 45th percentile for independent **hospitals.**

The results were closer when Truven analyzed five-year improvement-52nd percentile versus 48th-but system members still had the edge over independent facilities.

As a result, **hospitals** had nearly a three-fold higher likelihood of earning a spot on Truven's 100 Top **Hospitals** list if they were part of a system, Foster says. A total of 1.63% of independent **hospitals** made the list compared with 4.73% of **hospital** system members.

Chenoweth notes that the results were "really highly significant" with a p-value less than 0.0001. "The end result was really important because most studies looked at the value of systems based on economics," she says.

While systems do provide opportunities to lower the cost of care, Chenoweth notes that quality, safety, cost and efficiency must be in balance in order for a **hospital** to be a top performer. "Those organizations are providing higher value and they're stable," she says, adding that many systems are taking it upon themselves to implement quality improvement measures.

Prime Healthcare Services, Ontario, Calif., has been an active acquirer of underperforming **hospitals,** closing on one deal June 1 with two more in the pipeline. The **hospitals** on its radar were "struggling financially, operationally-pretty much everything," says Luis Leon, chief operationg officer, who notes that it typically takes about a year to get them up to its standards. "It's a complete overhaul; it's overall from A to Z."

Some of the resources Prime provides to the new **hospitals** in its system include running training programs for medical staff, building a case management team, establishing a hospitalist program, and installing a medical director to

focus on patient care and quality of care. The system has also strengthened the corporate position of performance improvement director.

"We tend to put emphasis on all those clinical areas that are probably the vehicle to quality and good patient care," Leon says. "We start from the clinical point of view" and financial benefits follow.

One strategy the system employs is identifying successful practices at one **hospital** and trying to replicate them across the organization-whether it's a facility that has a particularly efficient linen department or Desert Valley **Hospital,** Victorville, Calif., becoming the first Prime **hospital** to win a 100 Top **Hospitals** award seven years ago.

After Desert Valley won its place on the list, Leon, who was then its administrator, recalls that an effort was made to use the award criteria to reproduce the results across the system.

It's that sort of exchange that helped a facility such as 369-bed Centinela **Hospital** Medical Center in the underserved community of Inglewood, Calif., earn its spot on the 100 Top **Hospitals** list, Leon notes. Prime itself, which owns 17 **hospitals,** has twice been named a 15 Top Health System.

"We are a hands-on system," Leon says, adding that **hospitals** are compared against each other and held to task to raise standards. CEOs also meet regularly to discuss what's going well and what's not going well. "For us, the motivation is to be the best."

At Baystate, which this year was named a 15 Top Health System for the first time, board members set a goal last year of eliminating **hospital**-acquired infections and getting bloodstream infections down to zero. The system tracked measures that led to those complications and instituted best practices to prevent them, Benjamin notes.

"It essentially starts at a board level and cascades down to the individual level so that everyone is aligned around that goal," he says.

Health systems, Benjamin notes, have the advantage of being able to tap into a centralized quality department to make improvements across the organization.

"To do quality well, you need an infrastructure," he says. "From my experience, most health systems take advantage of back room economies of scale to focus not only on financial (measures), but also quality."

The difference in clinical outcomes between 100 Top **Hospitals** winners and their peer group is apparent.

In 2005, patients treated at both groups of **hospitals** had about a 4.3% 30-day risk-adjusted mortality rate. But their performance diverged over the next five years.

"Overall, post-discharge 30-day mortality is going up," Foster says. But not necessarily at Top **Hospitals,** which outperformed their peer group every year between 2006 and 2010.

In 2010, the most recent year the study looked at, patients treated at a 100 Top **Hospitals** facility had about a 4.4% risk adjusted 30-day mortality rate compared with 4.6% for patients treated at a **hospital** in the comparator group.

Baystate has formalized its focus on patient outcomes in its own Center for Quality of Care, which works closely with its Division for Healthcare Quality. The system established the center in 2008 to conduct research on safety, quality and effectiveness.

Its studies have looked at clinical issues such as getting doctors to wash their hands, improving treatment options for sepsis and inappropriate medication use in surgery patients.

Benjamin notes that the center came to much of the same conclusion in its own work to try to understand why some **hospitals** improve while others lag behind. "**Hospitals** that really have robust infrastructure for quality, have leadership for quality, tend to do better," he says.

LOAD-DATE: June 21, 2012

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 4, 2013 VIA FAX ONLY

Ms. Karen Goyette
Vice President, Strategic Planning and Business Development
Hartford Healthcare Corporation
One State Street
Suite 19
Hartford, CT 06103

RE: Certificate of Need Application; Docket Number: 12-31788-CON
Hartford Health Care Carnation and Backus Corporation
Backus Corporation's Affiliation with Hartford Health Care Corporation

Dear Ms. Goyette:

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 determined that the above-referenced application has been deemed complete as of March 4, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7012.

Sincerely,

Steven W. Lazarus
Associate Healthcare Analyst

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

TRANSMISSION OK

TX/RX NO	3310
RECIPIENT ADDRESS	918602634125
DESTINATION ID	
ST. TIME	03/04 14:39
TIME USE	00'25
PAGES SENT	2
RESULT	OK

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

FAX SHEET

TO: Karen Goyette

FAX: (860) 263-4125

AGENCY:

FROM: Steven Lazarus

DATE: 3/4/13 TIME: 1:30 pm

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Letter deeming the Con Application under DN 12-31788 Complete enclosed.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

March 5, 2013

Karen Goyette
Vice President, Strategic Planning and
Business Development
Hartford HealthCare Corporation
One State Street, Suite 19
Hartford, CT 06103

Keith Fontaine
VP, and Chief Administrative Officer
Backus Corporation
326 Washington Street
Norwich, CT 06360

RE: Certificate of Need Application, Docket Number 12-31788-CON
Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc.
Backus Corporation's Affiliation with Hartford Health Care Corporation

Dear Ms. Goyette and Mr. Fontaine:

With the receipt of the Certificate of Need ("CON") application submitted by Backus Corporation, Inc. and Hartford Health Care Corporation, Inc. ("Applicants") on September 24, 2012, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant(s):	Hartford HealthCare Corporation, Inc. Backus Corporation, Inc.
Docket Number:	12-31788-CON
Proposal:	Backus Corporation's Affiliation with Hartford Health Care Corporation with no capital expenditure

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: March 26, 2013

Time: 3:00 p.m.

Place: Backus Business and Technology Center
11 Stott Avenue
Norwich, CT 06360

The Applicants are 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 Norwich Bulletin* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: SWL:BC:JAH:TF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

March 5, 2013 Requisition # 41249

The Norwich Bulletin
66 Franklin Street
Norwich, CT 06360

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Thursday, March 7, 2013.** Please provide the following **within 30 days** of publication:

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

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BAC:JAC:TF:lmg

The Norwich Bulletin **March 5, 2013**
Notice of Public Hearing, Docket Number 12-31788-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant(s):	Backus Corporation, Inc. Hartford HealthCare Corporation, Inc.
Town:	Norwich
Docket Number:	12-31788-CON
Proposal:	Backus Corporation's Affiliation with Hartford HealthCare Corporation with no capital expenditure
Date:	March 26, 2013
Time:	3:00 p.m.
Place:	Backus Business and Technology Center 11 Stott Avenue Norwich, CT 06360

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 21, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

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

TRANSMISSION OK

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RECIPIENT ADDRESS	98602634125
DESTINATION ID	
ST. TIME	03/05 17:27
TIME USE	00'44
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: KAREN GOYETTE

FAX: (860) 263-4125

AGENCY: HARTFORD HEALTHCARE CORPORATION

FROM: BRIAN CARNEY

DATE: 3/5/13 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 12-31788-CON Public Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** ERROR TX REPORT ***
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TX FUNCTION WAS NOT COMPLETED

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RESULT	NG	#0018 BUSY/NO SIGNAL

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

FAX SHEET

TO: KEITH FONTAINE

FAX: (860) 892-8964

AGENCY: BACKUS CORPORATION

FROM: BRIAN CARNEY

DATE: 3/5/13 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 12-31788-CON Public Hearing Notice

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Tuesday, March 05, 2013 4:15 PM
To: Greer, Leslie
Subject: Re: Public Hearing Notice DN: 12-31788-CON

Good day!

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

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

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

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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: Tuesday, March 5, 2013 4:11 PM
To: ads <ads@graystoneadv.com>
Subject: Public Hearing Notice DN: 12-31788-CON

Please run the attached hearing notice in The Norwalk Bulletin by 3/7/13. For billing purposes, refer to requisition 41249. In addition, please forward me a copy of the "proof of publication" when available.

Thank you,

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

Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, March 06, 2013 2:50 PM
To: 'kfontaine@wwbh.org'
Cc: 'Carney, Brian'; Lazarus, Steven; 'Huber, Jack'; 'Tillman.Foster@po.state.ct.us'
Subject: Hartford HealthCare and Backus Corporation Hearing Notice
Attachments: 31788.pdf

Tracking:

Recipient	Delivery
'kfontaine@wwbh.org'	
'Carney, Brian'	Delivered: 3/6/2013 2:50 PM
Lazarus, Steven	Delivered: 3/6/2013 2:50 PM
'Huber, Jack'	Delivered: 3/6/2013 2:50 PM
'Tillman.Foster@po.state.ct.us'	Delivered: 3/6/2013 2:50 PM

Mr. Fontaine,
Attached is the public hearing notice for Hartford HealthCare and Backus Corporation being held on March 26, 2013.

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

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Wednesday, March 06, 2013 2:35 PM
To: Greer, Leslie
Subject: FW: Public Hearing Notice DN: 12-31788-CON
Attachments: 12-31788np Bulletin.doc

Your legal notice is all set to run as follows:

Norwich Bulletin, 3/7 issue - $302.18

I just realized you have Norwalk Bulletin written below. I placed it in the Norwich Bulletin, I just looked at the notice, and that seems to be the correct paper. If you wanted the Norwalk Hour instead, please let me know asap.

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Tuesday, March 5, 2013 4:11 PM
To: ads <ads@graystoneadv.com>
Subject: Public Hearing Notice DN: 12-31788-CON

Please run the attached hearing notice in The Norwalk Bulletin by 3/7/13. For billing purposes, refer to requisition 41249. In addition, please forward me a copy of the "proof of publication" when available.

Thank you,

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 8, 2013

Ms. Karen Goyette
Vice President, Strategic Planning and Business Development
Hartford Healthcare Corporation
One State Street
Suite 19
Hartford, CT 06103

RE: Certificate of Need Application, Docket Number 12-31788-CON
Hartford Health Care Corporation, Inc. and Backus Corporation, Inc.
Affiliation of Backus Corporation with Hartford HealthCare Corporation
Request for Prefile Testimony and Issues

Dear Ms. Goyette:

The Office of Health Care Access ("OHCA") will hold a public hearing on Tuesday, March 26, 2013, at 3:00 p.m.at Backus Business and Technology Center, located at 11 Scott Avenue, Norwich, CT, 06360, regarding the Certificate of Need ("CON") application identified above. 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. Hartford Health Care Corporation, Inc. and Backus Corporation, Inc. (herein collectively known as "Applicants") must submit prefiled testimony to OHCA no later than 12:00 p.m. on March 21, 2013.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues outlining the topics that may be discussed at the hearing.

Please feel free to contact me at (860) 418-7012, if you have any questions concerning this request.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

Attachment

Copy (faxed): Keith Fontaine, Backus Corporation

Issues

for Public Hearing:

Certificate of Need Application, Docket Number: 12-31788-CON

Hartford Health Care Corporation, Inc. and Backus Corporation, Inc.

Please be fully prepared to discuss topics as described below:

1. The effect of this proposed affiliation on Hartford Health Care Corporation Inc.'s other affiliated hospitals, including but not limited to Windham Memorial Community Hospital and Natchaug Hospital.
2. Any Community Needs Assessment conducted by either of the Applicants and in particular the impact of this proposal on those individual assessments.
3. Any and all communications taken place between Backus Corporation, Inc., Harford Health Care Corporation and the residents, clinicians and other health care providers in the region.
4. The financial attachments to the CON Application and the Completeness Letters, as well as any and all financial projections submitted as part of this proposal.
5. The continued funding and operation of Lifestar without State funding.

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: March 4, 2013

RE: Certificate of Need Application; Docket Number: 12-31788-CON
Backus Corporation and Hartford HealthCare Corporation
Proposal for the Affiliation of Backus Corporation with Hartford HealthCare Corporation

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph
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SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

RECEIVED
MAR 2 1 2013
OFFICE OF
HEALTH CARE ACCESS

March 21, 2013

VIA HAND DELIVERY
Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: IN THE MATTER OF AFFILIATION OF BACKUS CORPORATION WITH HARTFORD HEALTHCARE CORPORATION; DOCKET NO. 12--31788-CON

Dear Ms. Martone:

Enclosed please find the Notice of Appearance form regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Enclosure

000717 (03/21/13)

2729790v2

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

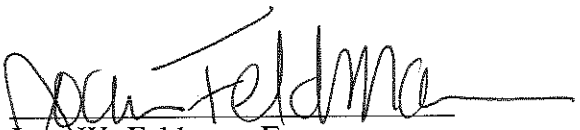
IN THE MATTER OF AFFILIATION OF BACKUS CORPORATION WITH HARTFORD HEALTHCARE CORPORATION	:	DOCKET NO. 12--31788-CON
	:	March 26, 2013

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of the Applicants in the above-referenced matter.

Respectfully Submitted,

Hartford HealthCare Corporation
Backus Corporation

By: 

Joan W. Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Their Attorney

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

IN THE MATTER OF AFFILIATION OF BACKUS CORPORATION WITH HARTFORD HEALTHCARE CORPORATION	:	DOCKET NO. 12--31788-CON
	:	March 26, 2013

PRE-FILED TESTIMONY OF DAVID WHITEHEAD AND PRE-FILED TESTIMONY OF ELLIOT JOSEPH ON BEHALF OF THE APPLICANTS

Accompanying this cover sheet is the pre-filed testimony of David Whitehead and Elliot Joseph on behalf of the Applicants in the above-captioned application.

Respectfully Submitted,

Hartford HealthCare Corporation
Backus Corporation

By:

Joan W. Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Their Attorney

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

IN THE MATTER OF AFFILIATION OF	:	**DOCKET NO. 12--31788-CON**
BACKUS CORPORATION WITH	:	
HARTFORD HEALTHCARE	:	
CORPORATION	:	**March 26, 2013**

PRE-FILED TESTIMONY OF DAVID WHITEHEAD, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF BACKUS CORPORATION

Good Morning, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is David Whitehead and I am the President and Chief Executive Officer of Backus Corporation, the parent corporation of The William W. Backus Hospital ("Backus") and related subsidiaries, otherwise known as the Backus Health System. I am grateful to have this opportunity to personally speak with and convey to you my reasons for recommending to OHCA that it approve the above-referenced application (the "Application") to permit Backus Corporation to affiliate with Hartford HealthCare Corporation ("Hartford HealthCare").

While the Applicants believe that they have stated the specific reasons for the proposed affiliation (the "Proposal") in the Application, it is worth restating more briefly here today that the most important reason for this Proposal is to preserve continued access to high quality healthcare services for individuals in the Eastern Connecticut Region (the "Region"). As you have probably observed by now, the momentum for consolidation within the healthcare industry, on both a local and national level, is

undeniable.[1] It is also quite evident that the momentum for consolidation is not merely a trend, but rather it is both an appropriate solution for the provision of coordinated high quality care at lower cost.

I. Driving Forces for Consolidation.

Consolidation is an outgrowth of a sea change in health care — a shift that requires hospitals to provide effective care, quality outcomes, at lower cost and for a defined patient population over a continuum of care needs and settings. As hospitals and health systems undertake this transition from a traditional fee-for-service environment to a value-based delivery system, they will need to create, access or grow all the components of a fully integrated delivery model. This shift requires sufficiently developed pre- and post-acute care programs, a robust portfolio of appropriate care models (including preventative, primary, acute, surgical, rehabilitative and palliative), access to capital to fund technology and resource development, and the managerial resources to measurably improve population health. When you couple this shift with the continued need for infrastructure improvements, a growing population of older and sicker adults, demands for more effective medical treatments and technologies, it becomes clear that the challenges for hospitals and health systems are great on many

[1] Forecasts by Moody's, the bond credit rating company, have consistently recognized that the hospitals that will fare the best in the future are those hospitals that are integrated with an integrated healthcare delivery system with access to the critical resources required to thrive in a demanding and competitive marketplace. See Moody's *Hospital Consolidation and Deferred Capital Support Issuance Volume,* March 5, 2012; Moody's *New Forces Driving Rise in Not-for-Profit Hospital Consolidation-Rating Impact to Vary*, March 8, 2012; and HFMA's *Hospital Consolidation Outlook Surviving in a Tough Economy*, November 2009 attached hereto as Exhibit 23.

levels, not the least of which are financial challenges.[2] Put simply, these strategic and financial realities require organizations like Backus to study and decide whether they can remain viable as an essential community health care provider while remaining a stand-alone system of care, or whether partnership with a larger established integrated healthcare delivery system is necessary. For Backus, this decision involved two years of planning and review. Ultimately, the decision for our Board was clear that remaining a stand-alone hospital provider was not in the best interest of the regional communities we serve. This led to the proposed affiliation with Hartford HealthCare which offered the most promise for the reasons I will now briefly discuss.[3]

A. Access to Innovative Care Models. The value-based reimbursement environment will require innovative responses to meet the demands for higher quality care at lower costs. Whether the chosen model is an Accountable Care Organization, a clinically integrated organization (i.e. physician and hospital participants share financial risk for providing higher quality care under alternative payment models), a medical home, or a medical foundation, each of these models will require a certain degree of size, depth and breadth of experience and capital to be viable, let alone successful.

More specifically, each of these models must be large enough in order to: (i) spread the financial risk associated with increased capital demands and reduced revenue; (ii) maximize efficiencies through leveraging economies of scale; and (iii) access the logistical resources and data to develop evidence-based best practices for the purpose of

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[2] "Capital requirements for new or updated facilities, physician strategies (particularly physician employment), IT, and service-line growth may now be far beyond what can be afforded by some organizations." See http://www.hfma.org/hfm/2009archives/month07/HFM0709CovSty_Kaufman.htm.
[3] See Standard & Poor's *U.S. Not-for-Profit Health Care Sector Outlook: Providers Prove Adaptable But Face A Test In 2013 As Reform Looms*, January 4, 2013 attached hereto as Exhibit 24.

achieving the highest levels of performance and managing the risks associated with care management.[4]

By way of example, Hartford HealthCare was approved to participate in the Medicare Shared Savings Program as of January 1, 2013. This program rewards Accountable Care Organizations ("ACOs") for the total cost of care and end-to-end management of Medicare patients. The Hartford HealthCare ACO is comprised of the System's members, of which Backus would become a part through this Proposal.

To qualify for participation, Hartford HealthCare invested significant resources to prepare the proposal for participation along with creating the underlying infrastructure necessary to prudently manage the health care costs of the assigned Medicare beneficiaries.[5] A project of this magnitude would not be possible for Backus as a stand-alone entity. Being able to spread the infrastructure costs needed for care management, and the ability to spread the risk associated with being financially responsible for the health care costs of the assigned Medicare beneficiaries, will allow Backus to participate in an ACO delivery model without jeopardizing its financial integrity or the quality of services it delivers.[6]

The potential to transform the delivery of health care in our Region is of vital importance to Backus and the health of our patients and the community we serve.

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[4] "Research by Elliott Fisher, Mark McClellan, and colleagues demonstrates that such a program, implemented with the establishment of Accountable Care Organizations (ACOs), would benefit patients, payers, and providers. The ACO shared savings concept would eliminate waste, reduce overuse and misuse of care, and support the development of health systems that can deliver high quality, affordable care...." See http://www.dartmouthatlas.org/press/HA_Fisher_McClellan.pdf.

[5] Hartford HealthCare engaged consultants, legal expertise, recruited physician experts and technology staff to be positioned to manage this delivery model with success.

[6] Accountable care systems require that the health care system be large enough so that the cost savings are truly tied to quality improvements rather than fluctuations in care. See http://www.ama-assn.org/amednews/2009/08/31/gvsa0831.htm.

Participation by Backus in the alternative care delivery models is essential and affiliation with Hartford HealthCare will allow Backus many more options for the future.

B. Access to Technology. Backus has invested many millions of dollars in medical technology to allow its providers to serve our community with access to high quality, leading-edge care. For stand-alone hospitals, continued technological investments pose a significant financial challenge. It would not be financially prudent for Backus to procure all the new available technology on its own unless there is a justifiable service need or community demand for such a purchase. It would be more fiscally responsible for Backus to partner with a large integrated delivery system, such as Hartford HealthCare, that will allow Backus patients access to the latest equipment and medical technology.[7] If Backus is going to serve the needs of its community well into the future, it will need the capability to balance looming challenges with significant capital, greater efficiencies, risk stratification strategies and more cooperative and collaborative approaches that involve the sharing of resources.

C. Strategic Planning, Synergies. Unlike recent hospital acquisitions, mergers and affiliations in Connecticut and New England, it is important to note that this Proposal is not predicated on Backus' need to improve its immediate financial performance or provide for current capital needs. In its current state, Backus has demonstrated sustained financial success, with annual operating margins at 9 percent or more for the past two fiscal years and 4.5 percent in Fiscal Year 2010, and maintained A+ Stable credit ratings from both Standard & Poor's and Fitch Ratings. Rather, the decision to seek a

[7] Of course, this does not mean that Backus patients will not have access to new technologies within its local community. Backus patients and medical staff will continue to have all the technology that they need locally, along with ready access to technologies within the Hartford HealthCare system.

partner is based on the previously discussed changes that are fundamentally shifting health care's long-standing performance models.

As fully described in the Application, the Proposal will allow Backus to meet the needs of the Region through a Strategic Plan (the "Plan") to be jointly developed by the Applicants and overseen by Backus. This Plan will specifically focus on the areas of greatest needs for communities in the Region, including but not limited to the creation of primary care and ambulatory care networks, an ambulatory surgery network, a preventative medicine institute at Backus, and better alignment of service lines including but not limited to oncology, cardiology, trauma and behavioral health.

In this difficult and uncertain financial climate, the Proposal will also assist in obtaining continued access to capital by maintaining its recognized creditworthiness[8] with strong management, operations and governance structure. Backus believes it will be even better positioned as a member of a financially stable obligated group with strong leadership, wide geographic coverage, broad service capabilities, and exceptional quality services.

By way of example, Hartford HealthCare has borrowed significant capital on very favorable terms for its system hospital members as one obligated group. As a member of the Hartford HealthCare obligated group, Backus could potentially avail itself to credit on more favorable terms. Put simply, the collective financial strength of the entire Hartford HealthCare system is much greater than the financial strength of any of its individual members on their own.

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[8] See page 100 from "Essentials of Health Care Organization Finance," Dennis D. Pointer and Dennis M. Stillman (2004).

II. Meeting the Needs of the Community.

Backus did not arrive at the decision to affiliate with Hartford HealthCare in a vacuum. As stated in the Application, Backus engaged in a very thoughtful and deliberate analytical process with the assistance of a third-party consultant who facilitated the analysis which allowed Backus to arrive at a decision that would best meet the needs of the community. However, even before engaging in this process, Backus has been regularly engaged with its constituents in determining what the current community health needs are and how to best meet such needs. See attached example of the latest community needs assessment documentation in Exhibit 25 attached hereto. In the most recent completed community health needs assessment, behavioral health services were identified as an area needing additional resources. If this Application is approved, Backus will collaborate with Natchaug Hospital, a Hartford HealthCare system member, to address ways in which the behavioral health care needs of the Region can be met most effectively and efficiently. Essentially, whatever the community needs are, Hartford HealthCare has committed to addressing the clinical needs of the community.

Once Backus determined that Hartford HealthCare was the most logical partner, it shared its thinking and plans with the community in the form of a publication of Frequently Asked Questions.[9] In written communications with the community, Backus stated its reasons for the proposed affiliation as follows:

- The healthcare landscape is changing fast. In this challenging environment, healthcare organizations are more likely to thrive when they create formal partnerships to work together;

[9] See Backus FAQs attached hereto as Exhibit 26.

- Affiliations allow organizations to share the knowledge and expertise of physicians, nurses, and other staff members and to give patients easier access to a wider range of services and treatments;
- As part of Hartford HealthCare, Backus patients would benefit from a more integrated system to provide seamless coordination to top-quality services -- this includes primary care, laboratory services, complex hospital care, home care and other services;
- Together Hartford HealthCare and Backus would be able to serve more communities to deliver excellent, personalized, coordinated care.

Given the shared values, mission and collaborative working history of the Applicants, along with all the reasons more specifically stated in the Application, the Applicants strongly believe that the proposed affiliation will allow Backus and Hartford HealthCare to mutually benefit and thrive long into the future. Therefore, the objective of this Proposal is to provide a sustainable level of high quality coordinated care to our patients and communities without sacrificing the quality or access to services offered in our community.

As you can see, our motivation and purpose with respect to this Proposal is and has been at all times to meet the present and future needs of the community. Without the proposed affiliation, we believe that Backus will have significantly less options and long-term capacity to serve the needs in the community at a level that it deserves. It is my hope that you are equally persuaded that our needs to meet the competing demands of the

marketplace will require significant capital, integration, managerial and financial strength, collaboration and a commitment to a shared vision.

Thank you for your time and attention today and I adopt this pre-filed testimony as my own.

David Whitehead, President and CEO
Backus Corporation

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

IN THE MATTER OF AFFILIATION OF BACKUS CORPORATION WITH HARTFORD HEALTHCARE CORPORATION	:	**DOCKET NO. 12--31788-CON**
	:	**March 26, 2013**

PRE-FILED TESTIMONY OF ELLIOT JOSEPH, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF HARTFORD HEALTHCARE CORPORATION

Good Morning, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is Elliot Joseph and I am the President and Chief Executive Officer of Hartford HealthCare Corporation ("Hartford HealthCare"). I am very appreciative of this opportunity to personally speak with and convey to you my reasons for recommending to OHCA that it approve the above-referenced application (the "Application") to allow Backus Corporation to affiliate with Hartford HealthCare.

It has been two years since I was before you and highlighted the reasons for The Hospital of Central Connecticut at New Britain General and Bradley Memorial ("HOCC") to join Hartford HealthCare. Since such time, the healthcare environment has changed even more rapidly than I would have anticipated. Today, hospitals and healthcare systems are confronted with: (i) significant reductions in both state and federal funding; (ii) the need to invest strategically in a single platform information system that integrates clinical information and data analytics (to support population health management); (iii) the need to offer the highest level of quality health care and a high level of patient satisfaction; and (iv) the need to significantly reduce costs and provide additional value. It is the position of the Applicants that this proposal will further

enhance the stability and strength of Backus and Hartford Healthcare in meeting the healthcare needs of the community served by Backus in the Eastern Region (the "Region").

As background, the Applicants have chosen each other as partners because we share a common philosophy and vision toward the rational deployment of technology, improving service and accessibility at a lower cost, and clinical integration with our physicians so that we can succeed in a pay-for-performance environment that promotes quality, innovation and service excellence.[1] Specifically, Hartford HealthCare recognizes that Backus, enjoys a quality medical staff, has financial strength, shares a strong commitment to quality care and patient safety, and shares the goal of improving the health status of the communities it serves. I will now discuss the reasons why the Applicants believe that the proposed affiliation (the "Proposal") is the most appropriate solution to those challenges, and finally, I will address OHCA's directed discussion topics.

I. The Challenges.

While hospitals have always faced considerable challenges, never before have hospitals been faced with so many pressures converging upon them simultaneously. Mr. Whitehead has already discussed the competing demands relating to aging infrastructure, new and expensive medical treatments and technologies, and improved performance at a lower level of cost. These demands, as understood by the Applicants, require responsible planning and action. More pointedly, if our hospitals are going to thrive

[1] See http://www.hfma.org/hfm/2009archives/month01/HFM0109_Moore.htm.

under health care reform, they will need to achieve significant economies of scale, integration, and collaboration.

II. The Vision.

Our vision necessitates that Hartford HealthCare become the sole corporate member of Backus Corporation, the parent and sole corporate member of The William W. Backus Hospital. As the sole member of Backus, Hartford HealthCare will have certain reserved powers that will allow the entire integrated delivery system to function as a unified whole with greater agility and strength and thus, greater potential for innovative strategies to meet the needs of the community. More specifically, the Applicants' vision includes the further development of the Hartford HealthCare integrated delivery system with expanded geographic coverage, a full continuum of care, strong local primary, secondary and tertiary care services, high standards of clinical care, enhanced patient access, and sharing of the most advanced technologies and coordinated and integrated clinical care.

Based upon our experience to date, additional direct benefits of System integration have been, to name a few, new opportunities for clinical research, teaching, implementation of quality initiatives, shared best practices, administrative consolidation, deployment of expensive technologies throughout the Hartford HealthCare system, spreading of financial risk, recruitment of world-class medical talent (by virtue of the system's size and coordinated efforts), opportunities for employees to pursue professional development and advancement, and the ability to effectively utilize specialized executive

management expertise across the Hartford HealthCare system. We believe that Backus will enjoy the same benefits as an affiliated member.

III. The Proposal as the Solution.

While the challenges discussed herein are indeed complex and multifaceted, the principal and overall objective in responding to these challenges is to enhance access to high quality and low cost care for all patients at a local community level. In my opinion, the solution requires: (i) affordable access to capital; (ii) an organizational and operational structure that is capable of sharing risk; and (iii) a commitment to quality, safety, and patient satisfaction.

There is no question that with significant budgetary cuts on both a State and Federal level, it will undoubtedly be difficult for hospitals and other community providers to satisfy their existing financial obligations. My opinion is that standalone hospitals will be quite limited in their ability to invest in the infrastructure, technology, and a highly skilled workforce given their capital constraints. This opinion is not simply theoretical, but based upon my own experience and understanding of the costs and resources necessary to put the infrastructure in place in order to operationalize value-driven healthcare delivery models. To say that the paradigms have shifted, may be a bit cliché, but it is also an understatement. The challenges for hospitals are daunting, but with collaboration, partnership, integration and consolidation, meeting the healthcare needs of the communities is more achievable.

In summary, in the last three years, Hartford HealthCare has found many opportunities through collaboration and joint strategic planning to judiciously allocate and

share resources, to cut costs, to standardize operations, to improve quality, to increase research opportunities, to enhance investments, to obtain capital on more favorable terms, to improve patient access and most importantly, to transform the Hartford HealthCare System through the development of innovative care delivery models.

Since HOCC and Windham have affiliated with Hartford HealthCare, Hartford HealthCare has made significant progress toward centralized operations for the purpose of achieving greater System-wide efficiencies, integration and performance effectiveness. The following are just a few of the examples:

- Centralization of administrative functions in the area of information technology, finance, revenue cycle, marketing, human resources, quality improvement, corporate compliance, consulting and legal, and strategic planning;
- Formation of a System-wide medical foundation focused entirely on enhancing access to primary and specialty in order to better meet the healthcare needs of the communities we serve;
- Alignment of certain clinical services, such as behavioral health, orthopedics, cardiology, and oncology; and
- Development of a hospital - physician clinically integrated organization that is focused on achieving quality and value-driven outcomes through disease management.

The foregoing examples are simply a fragment of all that the System is doing to achieve efficiencies and be nationally respected for excellence in patient care and most trusted for personalized coordinated care.

IV. Response to Specific OHCA Questions.

In its March 8, 2013 letter, OHCA asked the Applicants to address the following topics:

A. The effect of this proposed affiliation on Hartford HealthCare's other affiliated hospitals, including but not limited to Windham Memorial Community Hospital and Natchaug Hospital.

The proposed affiliation will inevitably have a positive impact on each of the affiliated hospitals in the Hartford HealthCare System. As we have discussed in our Application and our pre-filed testimony, the addition of Backus to the Hartford HealthCare system will allow us to spread the financial cost and risks across a larger number of providers which will reduce potential liability for any one hospital member. In addition, to the extent that Backus offers additional medical expertise, all of the system hospitals will be able to have their patients seamlessly access those same clinicians and resources. Windham Hospital, in particular will benefit from the expertise and leadership that Backus has to offer, but with much less administrative overhead costs. Natchaug Hospital's leadership and operations will not change, but it is expected that there will be greater opportunity for Natchaug Hospital and Backus to collaborate in the provision of behavioral health services in the Region, an area that was recently identified as needing more services.

B. Any community needs assessment conducted by either of the Applicants and in particular the impact of this proposal on those individual assessments.

Please see Exhibit 25 for the most recent community needs assessment performed by Backus. As you will see, Backus performed an impressive and thorough assessment of its community needs and decided that its priority needs for the next three years were

in the areas of access to care, chronic health conditions and behavioral health. Hartford HealthCare is committed to enhancing access to primary care in the Region and has the infrastructure to effectively respond to such needs. The Applicants believe that the ability to address chronic health conditions is inextricably tied to the ability to engage in disease management and improved access to care. Hartford HealthCare is investing significantly so that it is well positioned to manage and coordinate the care of individuals with chronic health care conditions. The Applicants also believe that Natchaug Hospital will be a valuable resource in helping Backus address the behavioral health needs of the Region. Moreover, Hartford HealthCare is coordinating its Community Needs and Benefits Assessment on a System-wide basis so that it can determine common needs and develop a more effective program and infrastructure to address those identified needs.

C. Any and all communications taken place between Backus, Hartford HealthCare and the residents, clinicians and other health care providers in the region.

Please see Exhibit 27 for copies of written communications with the community.

D. The continued funding and operation of LifeStar without State funding.

Hartford HealthCare is committed to maintaining LifeStar's operation and its continued funding will inevitably require the Hartford HealthCare system to subsidize losses. The Backus campus is the home base for LifeStar services in the Region.

V. Benefits to Our Patients and Our Communities.

A stronger Backus is of vital importance to the well being of its surrounding community, the local economy and the Hartford HealthCare system as a whole. If the Proposal is approved, the Backus community can expect Backus to continue its role in

delivering high-quality care, provide health education and wellness programs, and remain a vital employer and purchaser of goods and services in the community. If not approved, the growing pressures on hospital bottom lines, coupled with a growing mandate to meet national quality and cost benchmarks, is going to make it exceptionally difficult for Backus to transform its model and fully respond to the healthcare needs of the community it serves.

In closing, we expect that transformation will not be overnight and that there will inevitably be difficult times ahead, but it is clearly understood by the Applicants that we must collaborate and partner if we are going to be stable and strong enough to mitigate the challenges that are real and that lie ahead.

Thank you for the opportunity to present my testimony and I adopt this pre-filed testimony as my own.

Elliot Joseph

President & Chief Executive Officer
Hartford HealthCare Corporation

Exhibit 23

MOODY'S INVESTORS SERVICE

SECTOR COMMENT

Hospital Consolidation and Deferred Capital Support Issuance Volume

From Debt Drivers 2012

Analyst Contacts:

NEW YORK	1.212.553.1653
Lisa Goldstein *Associate Managing Director* lisa.goldstein@moodys.com	1.212.553.4431

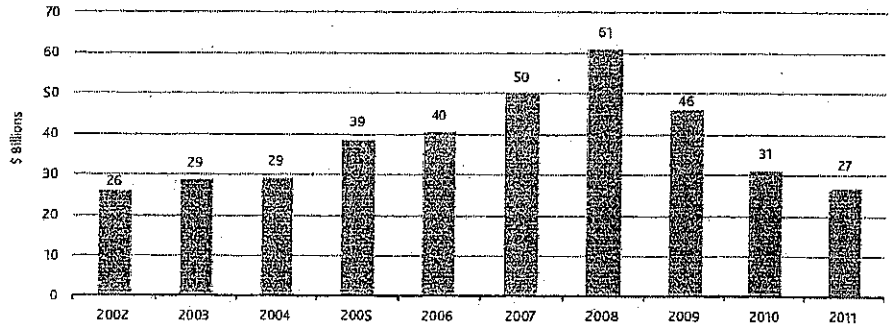
Not-for-profit hospital debt issuance will likely increase in 2012 even as the industry faces continued uncertainty about federal healthcare reform and funding cuts as well as sector-wide revenue pressure. Our expectation is based on two primary factors: 1) more hospital consolidation that will require capital to acquire or merge facilities and possibly construct new facilities for greater integration and reform readiness; and 2) catch-up capital spending so that facilities and equipment remain competitive following recent years of deferred capital spending.

Healthcare Debt Issuance Was Extremely Low In 2011

Not-for-profit healthcare debt issuance showed a dramatic decline over the past three years, reaching an anemic $25 billion in 2011 following a peak of $61 billion in 2008 (Exhibit 1). Over the past decade, annual issuance has averaged $38 billion.

EXHIBIT 1

Healthcare Debt Issuance Reaches Decade Low in 2011



Source: Bond Buyer

Issuance volume in 2008 was particularly high and heavily affected by debt restructurings as hospitals converted their failing auction rate securities to either fixed rate or variable rate demand bonds (VRDBs). Many of the VRDB structures utilized three-year letter of credit (LOC) agreements, allowing hospitals to return their focus to the income statement and operations until the LOC expiration date in 2011. In 2011, many hospitals succeeded in extending their LOC agreements or finding new banks to provide liquidity, precluding the need to issue refunding bonds.

The decline in issuance since 2008 is also due to many hospitals' decision not to encumber their balance sheet with more debt as healthcare reform was debated by Congress. Despite the passage of the Patient Protection and Affordable Care Act (known as healthcare reform) two years ago in early 2010, many of the implications of healthcare reform are still quite opaque. One of the most uncertain elements of the reform is the mandate for individuals to have healthcare insurance. In June, the Supreme Court will rule on the constitutionality of the mandate and its severability from the rest of the law. The result could have a major impact on reimbursements to hospitals for the uninsured populations they treat, and affect hospital expectations about future revenue and projected capital spending needs.

The healthcare reform law also contains numerous forms of Medicare rate reductions. Medicare provides a median 42% of rated hospitals revenues.[1] Hospital management teams have recently shown a weaker appetite for debt, which is likely a direct result of the revenue pressures hospitals are facing as the industry acknowledges that the current payment system is unsustainable. As a result, hospitals are engaging in expense reductions, developing process re-designs, restraining capital spending and achieving new operating efficiencies to maintain and increase cash flow.

Consolidation May Increase Debt Issuance

Over the next one to three years, we expect to see a material increase in the developing trend toward industry consolidation in order to accelerate cost reductions and gain more operating efficiencies. Smaller, independent hospitals that cannot absorb reimbursement rate reductions or can no longer access the capital markets will need larger hospital partners. Some hospitals may be acquired by for-profit hospital companies, while others will merge into larger not-for-profit health systems. These larger systems, such as regional or multi-state systems, will look to gain further size and scale through consolidation strategies. Many have already commenced such strategies with acquisitions of other hospitals that are contiguous to their service area or represent new service areas.

An increase in consolidation activity in 2012 will drive an increase in debt issuance due to sizable debt issuances needed to refinance the existing debt of the acquired or merged facilities. Managements may also determine that more debt is needed to fund strategic new investments to build a larger system and add more competitive infrastructure such as more ambulatory care facilities. Such new investments could consolidate clinical services or capture the continued migration of services to the outpatient setting, requiring capital.

Years Of Deferred Capital May Stimulate An Increase In 2012 Debt Issuance

Data from Moody's healthcare medians show a material decline in capital spending since 2008 as hospitals deferred capital spending during the recession. The capital spending median fell to 1.1 times in 2011 from a peak of 1.6 times in 2008. At the same time, the average age of plant broke through the 10-year ceiling to reach 10.3 years, up from 9.8 years in 2008 (Exhibit 2).

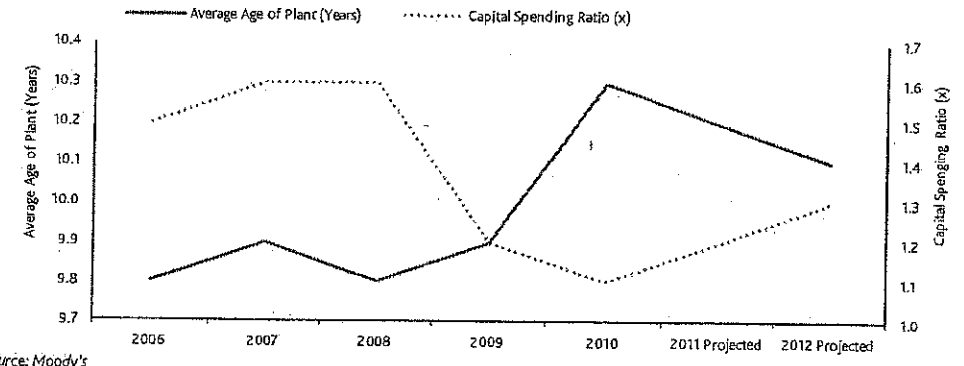
We expect that spending for routine replacement and renovations will increase as capital spending by hospitals can only be deferred for so long before it leads to an increase in debt issuance. Hospitals need to keep up with the latest technology and offer state-of-the-art facilities, especially those hospitals that contend in competitive markets. A commitment to maintaining attractive, high-tech facilities is also an important tool for recruiting physicians. In many markets, recruiting "superstar" physicians is a critical strategy in building market share and one that requires increased capital spending.

[1] Please see "U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook" August 2011.

000741 (03/21/13)

EXHIBIT 2

Median Average Age of Plant Reaches 5-Year Peak in 2010 as Capital Spending Declines



Source: Moody's

New Capital Spending Also Likely For Physician Alignment And Information Technology, Although Not Likely To Be Funded With Debt

New capital spending will also be earmarked for physician alignment and information technology (IT). Strategic focusing on physician alignment, often in more integrated organizations, will allow many not-for-profit hospitals to achieve some revenue growth and create a uniform voice when negotiating with private payers.

There will be long-term financial advantages in terms of enhanced Medicare reimbursements for those integrated systems that can demonstrate higher quality outcomes in a lower-cost setting. A key strategy in achieving better quality outcomes is achieving better physician integration and securing higher volume patient referrals from independent physicians practicing in their communities. This strategy mainly takes the form of the hospital employing key physicians, or buying out their practices, and is another form of industry consolidation.

The poor past track record of hospitals attempting physician employment in the mid 1990s appears to be not so financially disastrous today. Many hospitals paid high "good-will" when they acquired physician practices in the 1990s, another demand on finite capital. Most management teams report that there is little purchasing of good-will today.

Likewise, we anticipate more capital spending earmarked for IT rather than bricks and mortar. Hospitals report that they spend one quarter to one-third of their annual capital budgets on IT and we expect this spending to increase in coming years because it is very important in achieving better quality clinical results and gaining new operating efficiencies. The acquisition and installation of these systems can be quite costly and spread over a number of years. Beyond the capital costs, there are also annual operating costs that must be incurred for expenses related to IT, such as training and technology upgrades.

We do not anticipate that hospitals will use the public debt market to fund the physician alignment and information technology strategies. Many are using either internal cash flow (for physicians and IT) or leases (mainly for IT) to fund these expenditures. A few hospitals have included debt to cover some of the near-term capital costs of IT if they are already planning to issue debt for other long-lived projects.

000742 (03/21/13)

Report Number: 140388

Author
Lisa Goldstein

Production Associate
David Dombrovskis

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SPECIAL COMMENT

New Forces Driving Rise in Not-for-Profit Hospital Consolidation

Rating Impact to Vary

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Analyst Contacts:

NEW YORK 1.212.553.1653

Lisa Goldstein 1.212.553.4431
Associate Managing Director
lisa.goldstein@moodys.com

John Nelson 1.212.553.4096
Managing Director – Public Finance
john.nelson@moodys.com

Summary

The growing trend toward not-for-profit hospital consolidation is positive for the financial health of many, but not all, hospitals. Consolidation offers the promise of greater operating efficiency and risk diversification across larger organizations, likely leading to stronger and more stable bond ratings for affected hospitals. However, given current looming headwinds confronting the sector, those hospitals left out of consolidations, especially smaller stand-alone hospitals that cannot match the financial, managerial or market access capabilities of larger multi-hospital systems, will face greater negative rating pressure going forward[1]. For bondholders or lenders, consolidation can also provide an exit strategy if bonds or loans are fully redeemed or assumed by the consolidator.

Akin to the last pronounced wave of hospital consolidation in the late 1990s to mid 2000s, the forces behind the current round of consolidation are numerous, with both similarities and differences. Reimbursement challenges, spiraling healthcare costs, and a slow economic recovery are some of the market forces that have ignited the national explosion of consolidation, much like in the past. Driven by healthcare reform and an unsustainable payment system, the deep and impactful financial changes that are undoubtedly coming have led many hospitals to seek long-term partnerships. The current consolidation participants vary greatly and consolidation models are different, each with unique credit risks.

In the past, hospital mergers and acquisitions (M&A) was the primary vehicle to consolidation with a goal to increase market share and leverage with payers. Gaining size and scale remains a key reason to consolidate. Because the opportunities to gain leverage and higher rates from commercial payers are quickly dissipating, size and scale are now a more important means to gaining greater efficiencies and driving waste and costs out of the delivery system. The ability to demonstrate lower costs while providing high quality care will be the key driver in governmental and commercial reimbursement going forward. Physician alignment, another form of consolidation that many are pursuing, is also a strategy to control costs and drive improved quality by adopting evidence-based medicine.

[1] See Moody's U.S. Not-For-Profit Healthcare Outlook Remains Negative for 2012, January 2012

This report outlines the drivers of current hospital consolidation strategies and what Moody's looks for when evaluating these strategies and their impact on bond ratings. We will publish additional research on our rating analysis of consolidations, including specific research on hospital-physician alignment strategies.

The New World of Consolidation

The Drivers: Weak Economy, Insurmountable Federal Deficit and Looming Reimbursement Changes New to the Equation

Many of the forces behind today's consolidation are similar to those in the past. However, this cycle's deeper and more prolonged economic downturn is the key backdrop driving the recent wave of consolidations (see figure 1). Data from Moody's FY 2010 medians showed a -0.4% decline in hospital admissions from FY 2009, the first time we have observed such a decline even during other economic downturns. Inpatient volumes are down for many hospitals, while uncompensated care has increased, creating greater financial challenges and contributing to many recent downgrades. Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner.

Spiraling healthcare costs and the insurmountable federal deficit necessitate reducing waste and gaining efficiencies through consolidation. Medicare reductions, such as those legislated by the Balanced Budget Act of 1997, drove much of the consolidation in the late 1990s and Medicare reductions continue to loom. In 2010, national healthcare expenditures represented 17.9% of GDP[2] and The Patient Protection and Affordable Care Act (federal healthcare reform) is focused on reducing Medicare costs. Annual reductions to Medicare inpatient hospital payment rates are now hardwired into the Medicare payment formula. Hospitals are also facing lower Medicare reimbursement related to bundled payment programs, readmissions, and continued recovery audit contractor (RAC) reviews that seek to recoup overpayments made to hospitals. Bundled payment programs in particular will reimburse hospitals a flat amount that must cover hospital, physician, and post-acute care costs, driving the need for greater efficiencies.

During the last consolidation wave in the late 1990s to mid 2000 period, hospitals generally received favorable annual increases from commercial payers that subsidized losses with governmental payers. Hospitals are now facing significant reimbursement changes from commercial payers that will force changes to how hospitals operate. Most hospitals now report moderate to low single-digit rate increases after years of double-digit increases as a result of leverage gained from consolidation. Some large hospital systems have proactively negotiated global cost and quality contracts that include a reduction in reimbursement rates and shifts much of the financial risk to the hospital. This new payment platform requires hospitals to achieve greater cost reductions and efficiencies to manage this risk, much as capitation did in the 1990s.

Managing increased regulation and absorbing the costs of regulation is another reason to consolidate. Already subject to close regulatory scrutiny, hospitals face even tighter regulations stemming from healthcare reform. Medicare more closely scrutinizes more closely hospital admissions, readmissions and in-hospital patient safety violations, for example.

Largely absent in the last consolidation wave, significant pension liabilities for hospitals with defined benefit plans is a new issue in consolidation discussions. Falling discount rates, lackluster long-term

[2] Centers for Medicare & Medicaid Services

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investment returns and federal requirements to be 80% funded have created overwhelming pension obligations relative to unrestricted resources that many hospitals cannot afford, driving the need for a capital partner.

FIGURE 1

Factors Behind Current Consolidation Strategies Are Different

	Historical Factors:
1	Medicare reimbursement pressures
2	Increased need for capital for inpatient facilities
3	Possibility that tax-exemption benefits will diminish
4	Limited access to capital for lower-rated hospitals
5	Need to reduce operating expenses
6	Need to increase admissions, market share
7	Need for size and scale to leverage with payers

	Current Factors:
1	All payers creating reimbursement pressures
2	Increased need for capital for outpatient facilities, information technology
3	Pressure to justify tax-exempt status
4	Costly access to capital for smaller hospitals
5	Need for fundamental changes in healthcare delivery
6	Need to increase covered lives
7	Need for size and scale to gain greater efficiencies
8	Costly regulatory and compliance changes
9	Riskier debt structures with costly interest rate swaps, onerous bank covenants
10	Need for greater alignment with physicians, payers to create ACO or ACO-like structures
11	Spiraling healthcare costs and insurmountable federal deficit
12	Large unfunded pension liabilities
13	Prolonged economic downturn

The Consolidators: New Players Join Traditional Participants

In this cycle, there is a noticeable difference in the type of participants involved in consolidations. In addition to the traditional market consolidators, such as large not-for-profit or established for-profit hospital companies, new players have entered the hospital industry.

One of the more interesting developments is the expansion of health insurance companies into healthcare services. Since the passage of healthcare reform, there have been several mergers, acquisitions and partnerships of insurers and provider systems with the goal of reducing healthcare costs and improving quality. The proposed affiliation between Highmark, Inc. in western Pennsylvania and West Penn Allegheny Health System is one of the largest movements of a payer into the hospital industry. Other recent examples include Humana's December 2010 acquisition of Concentra, which provides physical therapy, urgent care and occupational medicine, and WellPoint's August 2011 acquisition of CareMore Health Plan, a Medicare Advantage plan and clinic network[3].

Hospitals and payers are affiliating to form new coordinated global healthcare insurance plans, such as Banner Health Network and Aetna in Arizona. Steward Health Care and Tufts Health Plan, both in Boston, have also created a narrow network to provide healthcare services at a lower cost. We expect payer and provider affiliations to become more common as additional aspects of healthcare reform are defined and implemented and the demand for low cost/high quality healthcare escalates.

[3] See Moody's Affiliation with Highmark Would Be Credit Positive for West Penn Allegheny Health System, July 2011.

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Private equity is not new to the hospital industry as many private equity funds have long backed some of the largest for-profit hospital companies, including HCA and Vanguard. However, two new private equity firms recently entered the hospital ownership model. In 2010, Cerberus acquired six-hospital system Caritas Christi Health System in Boston, now called Steward Health Care, and continues to pursue a growth strategy through the acquisition of other not-for-profit hospitals. In 2011, Oak Hill Capital Partners established a joint venture with Ascension Health, the largest faith-based hospital system in the country, to acquire distressed Catholic hospitals. If these ventures prove to be successful, we anticipate more private equity firms may enter the hospital industry through acquisition.

The Models: Innovative but not without Risk, Credit Implications Depend on a Number of Factors

We expect that full-asset mergers or acquisitions will be the most common form of consolidation strategies over the near term although some new models are evolving, each with different credit risks and implications for bond ratings (see figure 2).

In acquisition strategies, the "cost" of the acquisition may include debt and other obligations of the acquired hospital, such as pension liabilities, along with a multi-year capital commitment. When a for-profit hospital acquires a not-for-profit hospital, the debt is redeemed and the rating is withdrawn upon receipt and review of redemption documents.

In many not-for-profit merger strategies, the debt of both organizations is refinanced by debt of the newly combined organization, or the higher-rated entity may guarantee or assume the debt of the lower-rated provider. In other cases, each hospital may join each other's obligated group, effectively creating one new credit group. We will assess the impact of the guaranty on the higher rated credit or the creditworthiness of the combined organization. Sometimes the different debt securities of the merging hospitals are not changed, warranting a determination of the near-term and long-term impact on each borrower's rating.

Joint ventures between not-for-profit and for-profit healthcare systems are emerging across the country. The percentage of each party's ownership interest in the operations usually determines a hospital's tax status. In most joint ventures of this type, the for-profit company usually has majority ownership, which leads to redemption of all debt and exit strategy for bondholders. Health Management Associates, LHP Hospital Group and Lifepoint have engaged in this joint venture strategy usually with rural not-for-profit community hospitals, and we expect this trend to continue.

Joint operating companies (JOCs) or joint operating agreements (JOAs) between not-for-profit hospitals largely function like a full asset merger. Our assessment mostly weighs the strength of security on the bonds and which joint operating partner assumes the debt obligation. Accordingly, we evaluate the creditworthiness of a JOC or JOA if they provide security for the debt. As we have seen in the past, disruptions may occur if management and governance roles are complex or not clearly defined, such as requiring multiple approvals from multiple boards. In one instance, management at the JOA had to seek approvals from three different boards for capital spending, budgets, and strategies, creating an onerous process and ambiguity as to which board had final authority.

We expect to see some of the larger systems create separate obligated groups, particularly those that have a faith-based mission but want to merge with secular hospitals. Other not-for-profit systems have created joint ventures with for-profit companies to assist distressed hospitals with their financial and capital needs. Finally, some not-for-profit systems have different obligated groups largely because of state regulatory issues. Catholic Health East, for example, is the sole corporate member of St. Peter's Health Partners in Albany, NY. New York regulation currently prohibits hospitals from being

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obligated on the debt of a corporate parent that is located outside of the state. Nonetheless, the Baa2 rating assigned to St. Peter's debt reflects the shared benefits of being part of a national system while Catholic Health East's A2 rating reflects its strong geographic diversity. Our ratings reflect the creditworthiness of the security pledged to the bondholders, which includes the impact of non-obligated entities on the obligated group, requiring an analysis of the entire enterprise to understand the management, governance, strategic and financial relationship among the various entities[4].

Irrespective of the model used, management teams should be able to engage in much better financial planning than in the past due to better technology to assess the short-term and long-term financial risks. These tools include much more sophisticated software tools to assess costs and clinical outcomes, and to produce more detailed financial data.

FIGURE 2

Consolidation Models Have Varied Rating Impact

	Consolidation Model	Credit Positives	Credit Negatives
1	Acquisition of a not-for-profit hospital by a for-profit hospital	100% debt repayment	N/A as rating is withdrawn
2	Acquisition of a not-for-profit hospital by larger not-for-profit hospital	100% debt repayment	N/A as rating is withdrawn
3	Merger between not-for-profit hospitals:		
	- scenario 1: debt remains outstanding for both hospitals with no change in debt security	» Greater synergies as a larger system with critical mass, particularly if in same or adjacent markets	» Hospital may lose local control over strategic direction and expenditures once part of a larger system; more restricted ability to determine capital spending may result in loss of market share
		» Ability to spread costs over a larger enterprise	» Increase demands on finite capital as part of a larger system
		» Greater diversification of cash flows	» Short-term merger difficulties, such as medical staff integration or cultural differences
		» Greater access to capital as a larger enterprise	» Governance issues of legacy hospitals; "us" versus "them" mentality
		» May result in higher rating for both organizations either immediately or over time	» Financial disruptions if financial systems are different, or reserve methodologies are different
	- scenario 2: debt is guaranteed by higher rated hospital	» Upgrade of lower rated hospital to that of higher rated hospital if guaranty meets Moody's methodology and Moody's determines there is no impact to the guarantor's rating	» Downgrade may occur if the performance of the lower rated hospital weakens the creditworthiness of the higher rated hospital
	-scenario 3: each hospital joins the other's obligated group	» May result in higher rating for both organizations either immediately or over time	» Downgrade may occur for the higher rated hospitals if the performance of the lower rated hospital weakens the creditworthiness
4	Affiliation between payer and not-for-profit hospital (no change in debt security)	» Access to larger unrestricted resources	» Untested strategy for both payer and provider
		» Benefits of joining larger enterprise with financial expertise	» Potential misalignment of focus and resources if mission is unclear and goals conflict, leading to a downgrade
		» May result in upgrade of hospital's rating if financial performance improves over the longer term	

[4] See Moody's Not-for-Profit Hospital and Health Systems Rating Methodology, January 2008

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FIGURE 2

Consolidation Models Have Varied Rating Impact

	Consolidation Model	Credit Positives	Credit Negatives
5	Joint operating companies or agreements between not-for-profit hospitals	» Nearly the same as a full asset merger » Upgrade may occur if debt is guaranteed by the larger JOC hospital	» Disruptions may occur if leadership and governance roles are blurred or unclear from the start; multiple boards may create governance issues and inability to execute strategies
6	Joint ventures with between not-for-profit hospitals and for-profit hospitals	» Likely the same as an acquisition with 100% debt repayment	N/A as rating is withdrawn
7	Joint ventures between not-for-profit hospitals with for-profit hospitals to form limited liability company (LLC) for growth strategy	» Incremental cash flow; geographic diversification	» Credit implications may be present depending on the strategic and financial linkages of the LLC to the not-for-profit system, such as debt guarantees or potential capital calls; use of system's resources

Consolidation Through the Lens of a Bond Rating

For all types of consolidation models, our analysis incorporates the five key rating factors in our general rating methodology for not-for-profit hospitals. Below is a list of the key areas Moody's assesses within these broad rating factors. More detailed research on how we assess hospital consolidations will be forthcoming.

1. Governance and Management
   - » Clarity of roles for senior management team including the CEO, CFO and medical staff and nursing leadership
   - » Composition of parent and subsidiary boards and clearly defined reserve powers
   - » Extent of centralized functions, coordination and control over system entities
   - » Likelihood of successfully forming a cohesive governance structure that provides unified direction and avoids conflict caused by historical allegiances
   - » Ability of the board to execute strategies and respond to unforeseen challenges quickly
   - » Adequacy of disclosure practices to all stakeholders including bondholders
2. Market Position
   - » Integration of physician leadership to support the consolidation and goals to engage physicians in the planning and execution stages
   - » Plans to engage and align with community and teaching medical staff, employed and independent physicians, and small- and large-group practices
   - » Strategies to address merger of unionized and non-unionized hospitals
   - » Goals to achieve market share growth, increase covered lives

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3. Operating Performance
   - » Integrated operating, financial and capital plans that outline the short-term risks as well as the expected long-term benefits of the consolidation, including service and facility consolidation or coordination, IT interoperability and medical staff compatibility
   - » Multi-year projections based on conservative assumptions of reimbursement, volumes and expense reductions
   - » Scenario planning in the event of an economic downturn or unforeseen challenge and strategies to respond to these events
   - » Thorough review by management of methodologies between the hospitals to assess accounting differences in areas such as charity care policies, provision for bad debt, discount policies and contractual allowances
   - » Plans to address inequities in salary and benefits including pension plans
   - » Approach to commercial payer contracting (centralized or local; payment methodologies, unified terms)
4. Balance Sheet and Capital Plan
   - » Assessment of current and future capital needs and funding sources, including information technology, inpatient and ambulatory needs and pension requirements
   - » Decisions on asset allocation and investment strategies, along with the use of consultants and investment managers
5. Debt Structure and Legal Covenants
   - » Assessment of outstanding debt and lease obligations including covenants and exposure to third parties such as banks and swap counterparties
   - » Decisions around debt obligations and changes to security packages
   - » Receipt of all regulatory and bond approvals, including church approval, university approval, and municipal parent approval, if needed

Moody's Related Research

Special Comments:

- » New Jersey Hospitals: M&A Activity Heats Up as Financial Challenges Rise, February 2012 (138898)
- » Achieving Greater Cost and Quality Accountability Will Be Credit Positive for Not-for-Profit Hospitals in Era of Reform, May 2011 (132964)
- » Hospital Revenues In Critical Condition; Downgrades May Follow, August 2011 (134473)

Outlook:

- » U.S. Not-For-Profit Healthcare Outlook Remains Negative for 2012, January 2012 (139377)

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Report Number: 140181

Author
Lisa Goldstein

Production Associates
Wing Chan
Judy Torre

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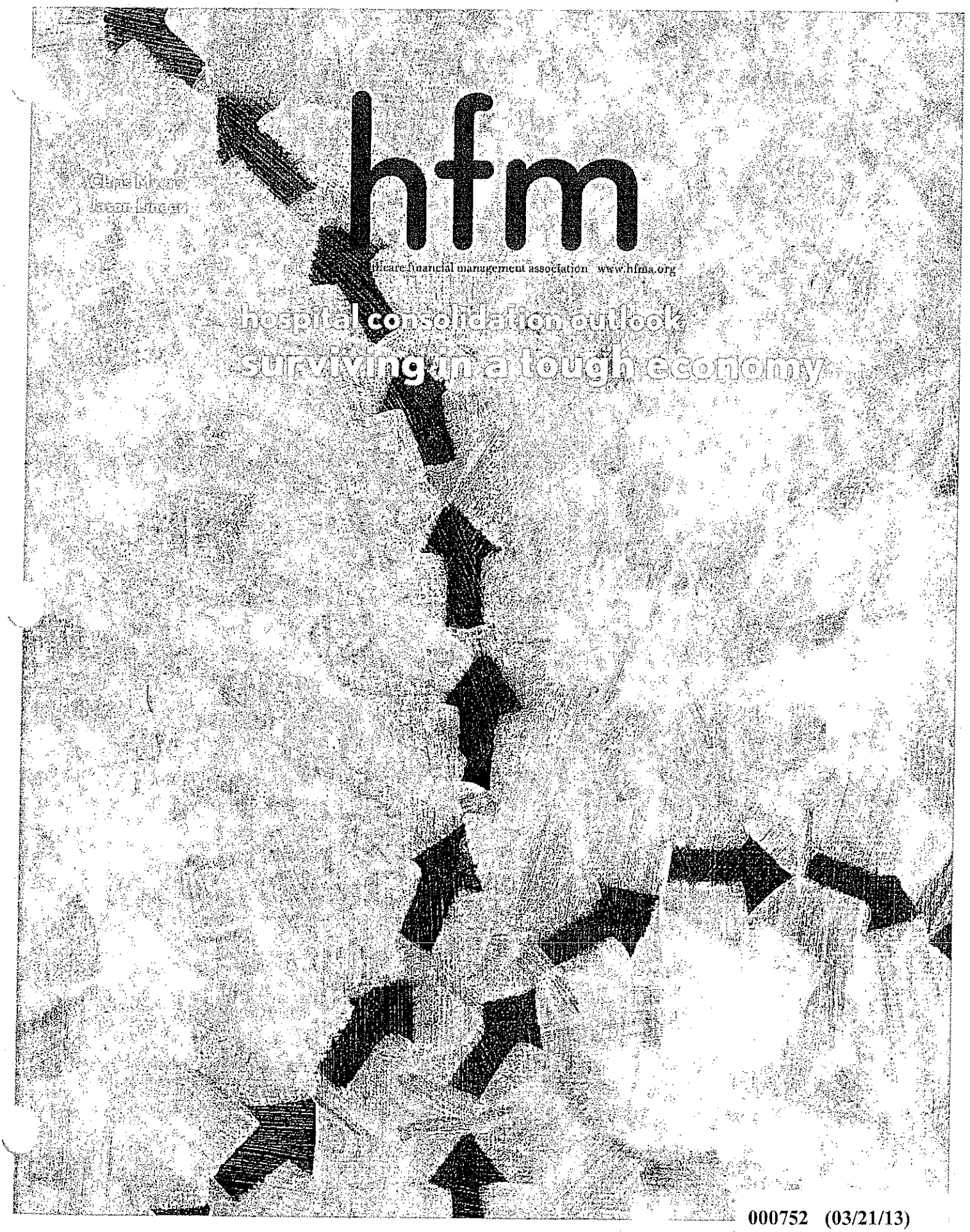
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hospital consolidation outlook
surviving in a tough economy

hospital consolidation outlook
surviving in a tough economy

Consolidation activity is expected to increase as hospitals position themselves for survival in the current economic environment.

AT A GLANCE

- The rapid hospital consolidation activity of the late 1990s has tapered off, but it's expected to pick up again.
- The reasons for hospital consolidation have shifted from gaining leverage with payers to achieving cost savings and operating efficiencies to survive in the market.
- The hospital industry can expect to undergo more profound structural and organizational changes in the decade ahead than it did in the past decade.

Most major service industries in the United States have experienced considerable transformation, consolidation, and reorganization over the past 25 years. Unlike the banking, airline, hotel, telecommunications, media, and other industries, however, hospitals remain predominantly local businesses. Consider how many times the name of your bank and telephone company have changed since the 1980s. During the same period, the name of your local hospital likely has not changed. In fact, many tax-exempt hospitals continue to behave more like school districts than traditional businesses and have not expanded much beyond their original and contiguous boundaries.

Relatively few truly national health systems exist, and some of the best known "brand name" organizations are available in a limited number of markets (e.g., the Mayo Clinic, headquartered in Rochester, Minn., operates in four states; Johns Hopkins Health System, Baltimore, in one). In fact, the largest U.S. operator of hospitals—HCA, based in Nashville, Tenn.—has only 3 percent market share nationally (about 160 hospitals out of roughly 4,900 nonfederal, short-term general community hospitals). The top 10 systems in the United States together have less than 15 percent market share. On the other hand, payers are highly concentrated, with the government insuring approximately 26 percent of the total population (through Medicare, Medicaid, and other public programs) and the 10 largest managed care companies collectively accounting for more than 70 percent of the estimated 170 million privately insured lives in the nation.

With the exception of the for-profit chains and the large faith-based systems, most hospitals have consolidated on a local basis. Although the pace of change in health care has been glacial, the growing pressure on hospital bottom lines, coupled with a growing mandate to meet national quality and cost benchmarks, could drive increased consolidation among hospitals over the long term into regional or national super systems.

A Look Back

The era of most rapid consolidation activity occurred between 1995 and 2000, when 550 hospitals became part of systems and the overall percentage of hospitals in systems increased dramatically from 38.3 percent to 51.7 percent. Since then, the pace of consolidation has slowed, as hospitals benefited from increased operating income and investment income between 2001 and 2007. This phenomenon is reflected in a

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slowdown in the number of hospital merger and acquisition (M&A) transactions since 2001. In 2007, 2,730 hospitals were part of a system, representing 55.7 percent of total U.S. community hospitals.

Much of the system formation activity occurred in response to the rapid consolidation of commercial payers. To further study this relationship, we analyzed commercial payer and health system concentration in the 85 largest U.S. Metropolitan Statistical Areas (MSAs) as measured by the Herfindahl-Hirschman Index (HHI). Our analysis found that commercial payers are concentrated in a remarkable 91 percent of the 85 largest markets, whereas health systems are concentrated in only 66 percent of the largest markets (see exhibit, page 59).

The analysis disclosed that hospitals located in highly concentrated commercial payer markets (e.g., Austin, Texas, and Charlotte, N.C.) have more aggressively pursued consolidation activities than hospitals in moderately concentrated commercial payer markets (e.g., Miami and New York). Also, hospital sectors in smaller markets (< 1 million in population) tend to have higher concentration levels than larger markets, and none of the top largest markets are concentrated with regard to health systems. Only a handful of markets have a greater concentration among health systems than among commercial payers (e.g., Albuquerque, N.M.; Buffalo, N.Y.; Cape Coral, Fla.; Charlotte, N.C.; Colorado Springs, Colo.; Fresno, Calif.; Jacksonville, Fla.; Norfolk, Va.; Orlando, Fla.; Portland, Ore.; Salt Lake City; Springfield, Mass.; West Palm Beach, Fla.; Wilmington, N.C.; and Worcester, Mass.).

Lessons Learned

The analysis of health system and payer concentration brings to mind the pragmatic difficulties in achieving material market concentration among hospitals in large cities. Simply put, two mergers may accomplish in a small market what may require up to 10 mergers in a large market. Furthermore, the exercise yielded the following broad observations.

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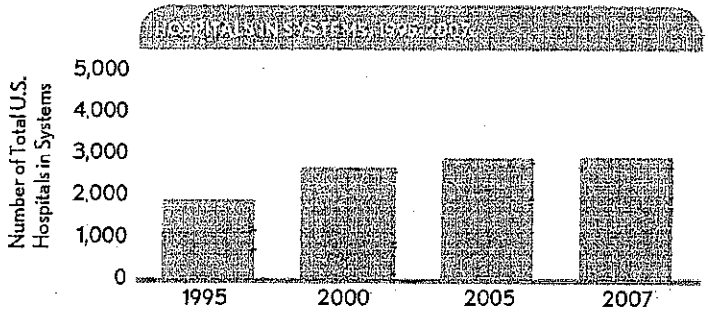
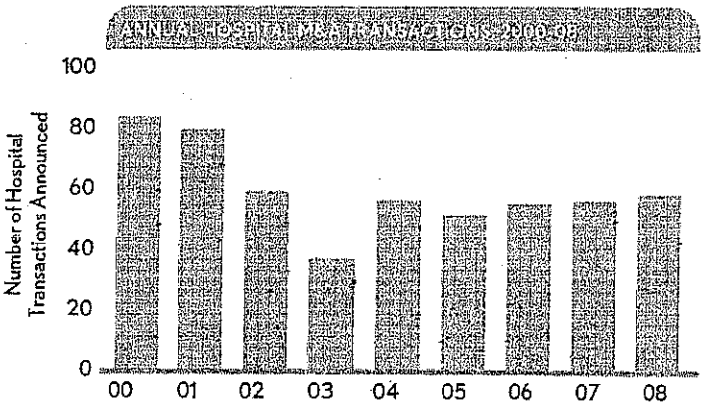
Driven as a response to commercial payer concentration, most M&A activity among tax-exempt hospitals predictably occurred between organizations in the same market. In addition to improving leverage with managed care plans, local consolidation enabled modest administrative economies of scale, shared branding, improved access to capital, avoidance of duplicative capital, and limited consolidation of clinical programs. Few systems to date have strayed beyond their original and contiguous borders and have linked with hospitals in nearby metropolitan areas (with notable exceptions being MedStar Health in Baltimore and Washington, D.C., and Novant Health in Charlotte and Winston-Salem, N.C., as well as other nearby areas.



Source: American Hospital Association, *AHA Hospital Statistics*, 2009 Edition, 2005 Edition, 2000 Edition.



Source: Irving Levin Associates, Inc., *The Health Care M&A Report*, 2000-2008 Quarterly Reports.

Excluding activity by the for-profit chains, the key exception among tax-exempt hospitals has been the formation and growth activity of the faith-based national systems, driven primarily by the reconfiguration of Catholic congregations. Between 1990 and 2003, the growth of cosponsored Catholic systems proliferated from two to 17 systems with multiple sponsors. Although much of this consolidation activity has enabled these systems to achieve significant economies of scale through the integration of administrative functions such as finance, supply chain, IT, and others, it has done little to drive greater penetration in local markets. One notable exception is Ascension Health's expansion in Michigan over the past 10 years, which now includes 14 affiliated general acute care hospitals across the state.

There has been only one notable example of a tax-exempt health system that has significantly migrated markets. Since its formation about 15 years ago, Banner Health has shed assets in slow-growth markets (such as North Dakota) to generate capital to invest heavily in the high-growth Phoenix market.

More recently, there has been an increase in the number of partnership conversations and transactions between "full" academic medical center hospitals and community hospitals with available capacity to provide a more efficient venue of care for lower acuity patients (e.g., Loyola University Medical Center purchased Gottlieb Memorial Hospital in 2007, with plans to relocate its low-risk obstetrics and orthopedics programs).

A Look Forward

In the coming decade, the hospital industry will undergo more profound structural and organizational changes than it did in the last. Although the

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last big wave of hospital consolidation was largely driven by accelerating managed care consolidation, the next wave is being jolted into action by the current economic and political tsunami. Facing the perfect storm of decreasing demand, tightening payment, rising bad debt, escalating fixed costs, and investment income losses, U.S. hospitals are once again turning to mergers, affiliations, and partnership strategies to remain viable.

For example, in the Chicago MSA, where only one health system has double-digit market share (Advocate Health Care, based in Oak Brook, Ill., with 12 percent) and where health systems are not concentrated (unlike commercial payers), M&A activity historically has been limited. This began to change in 2007 when Loyola University Health System, Maywood, Ill., acquired Gottlieb Memorial Hospital, Melrose Park, Ill., and MSMC Investors LLC, a group of investors, acquired St. Francis Hospital and Health Center, Blue Island, Ill., and in 2008, when NorthShore University HealthSystem, based in Evanston, Ill., acquired Rush North Shore Medical Center, Skokie, Ill., and Advocate acquired Condell Medical Center, Libertyville, Ill.

COMMERCIAL PAYER AND HOSPITAL MARKET CONCENTRATION IN 85 LARGEST HOSPITAL MSAs, 2008

Payers	Health Systems: Concentrated	Health Systems: Moderately Concentrated	Health Systems: Not Concentrated	Total
Commercial Payers: Concentrated	53 MSAs (62%) Austin, Texas; Charlotte, N.C.	18 MSAs (21%) Boston, Detroit	6 MSAs (7%) Los Angeles, Chicago	77 MSAs (91%)
Commercial Payers: Moderately Concentrated	3 MSAs (4%) Portland, Ore.	4 MSAs (5%) Miami	1 MSA (1%) New York	8 MSAs (9%)
Commercial Payers: Not Concentrated	0 MSAs (0%)	0 MSAs (0%)	0 MSAs (0%)	0 MSAs (0%)
Total	56 MSAs (66%)	22 MSAs (26%)	7 MSAs (8%)	85 MSAs (100%)

* The Herfindahl-Hirschman Index (HHI) is a measure of market concentration and is used by the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) to evaluate the impact of a proposed merger on the level of competition within a market. The HHI is calculated as the sum of the squared market shares of each organization in a market.

HHI Score	Category	DOJ/FTC Approach to Potential Mergers
<1,000	Not concentrated	Generally will not restrict merger activity where the postmerger HHI is still <1,000.
1,000–1,800	Moderately concentrated	A merger that raises the HHI by >100 points may result in significant competitive concerns.
>1,800	Concentrated	A merger that raises the HHI by >50 points may raise significant competitive concerns, and a merger that raises the HHI by >100 points is presumed to be anticompetitive.

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In the current economic environment, health systems using the old playbook seeking scale to gain leverage with payers is an increasingly short-sighted strategy, as community officials, employers, and hospital board members alike are weary of annual double-digit medical inflation increases, particularly while all other sectors of the global economy are retracting. Therefore, the rationale for hospital mergers needs to be much broader than simply the ability to negotiate better managed care rates.

Hospitals and health systems evaluating their partnership options *before* a declining financial position pins them in a corner will be best positioned for success.

So in these uncertain times, what is the emerging mandate driving the next wave of hospital consolidation in the new economy? First and foremost, the most vulnerable organizations are driven by sheer survival. Health systems that have heavily relied upon investment income to bolster operating revenue are now forced to confront the stark reality of expenses accelerating faster than revenue. Further, some organizations experiencing a dramatic drop in days cash on hand due to investment losses are, at best, indefinitely freezing capital spending and, at worst, in danger of breaching debt covenants.

In the new economy, the case for hospital consolidation has shifted from the revenue side of the equation to improved efficiency and expense reduction. Employers can no longer afford double-digit premium increases that allow providers to subsidize rising shortfalls from government payers. Further, the recent era of historically low interest rates and cheap capital has not produced the most efficient infrastructure for care delivery in many communities. For example, do MSAs the size of Kalamazoo, Mich., and Rockford, Ill., really need multiple Level I trauma centers? Are private rooms with flat screen HDTVs the best value for a community's healthcare dollar? The credit crisis has rapidly reintroduced the cost of capital concept that will temper the medical arms races for duplicative services going forward. However, expansion projects already completed and approved on the premise of growing volumes and strong payer mix are facing serious challenges. Whether driven by visionary collaboration efforts or survival strategies, the new economy will force a rationalization of hospital services through clinical affiliations, joint ventures, mergers, acquisitions, divestitures, and bankruptcies.

Acknowledging the new revenue realities and constrained access to capital, providers that were once staunchly independent are beginning to explore their partnership options. Economies of scale and other partnership advantages that come at the expense of local control are hard to ignore in the current economic environment. As a result, board members of independent hospitals are beginning to ask the tough question, "Is it better to have a viable organization or local control of a declining asset?" To prepare for any potential M&A conversations, it is prudent for hospitals to undertake the following activities in advance:

- Gain an understanding of the entire M&A life cycle, including definition of common terms, typical phases, activities, and key decision points
- Think through the likelihood of M&A activity in your market and consider the range of potential partners for your hospital and the pros and cons associated with each potential combination
- Get agreement among key leaders on the organization's preferred position on all critical deal terms, such as organization mission and name,

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governance, leadership, organizational chart, job losses if any, change in scope of clinical services if any, and future capital commitments

Despite the rise of a handful of health systems with a presence in several parts of the country, health care remains a highly fragmented cottage industry. History tells us that external shocks (e.g., managed care consolidation, Balanced Budget Act of 1997) are required to stimulate hospital M&A activity. As one would expect, there will be winners and losers in the next round of consolidation. Hospitals and health systems evaluating their partnership options *before* a declining financial position pins them in a corner will be best positioned for success. ■

About the authors

Chris Myers
is a director, healthcare provider strategy practice, Navigant Consulting, Inc., Chicago (cmyers@navigantconsulting.com).

Jason Lineen
is an associate director, healthcare provider strategy practice, Navigant Consulting, Inc., Chicago, and a member of HFMA's First Illinois Chapter (jlineen@navigantconsulting.com).

NAVIGANT
CONSULTING

Chris Myers
cmyers@navigantconsulting.com
312.583.4161

Jason Lineen
jlineen@navigantconsulting.com
312.583.2631

Reprinted from the November 2009 issue of *hfm*.
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Exhibit 24

STANDARD &POOR'S

Standard & Poor's Research

U.S. Not-For-Profit Health Care Sector

Outlook: Providers Prove Adaptable But Face A Test In 2013 As Reform Looms

Primary Credit Analysts:
Liz Sweeney, New York (1) 212-438-1000; liz_sweeney@standardandpoors.com
Martin D Arrick, New York (1) 212-438-1000; martin_arrick@standardandpoors.com

Secondary Contacts:
Cynthia S Keller, New York (1) 212-438-1000; cynthia_keller-macdonald@standardandpoors.com
Stephen Infranco, New York (1) 212-438-1000; stephen_infranco@standardandpoors.com
J. Kevin K Holloran, Dallas (1) 214-871-1412; kevin_holloran@standardandpoors.com

Research Contributors:
Sinto Inasu, CRISIL Global Analytical Center, an S&P affiliate, Mumbai
Meghana P Hattangady, Mumbai; meghana_hattangady@standardandpoors.com
Misha Jashnani, Mumbai; misha_jashnani@standardandpoors.com

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U.S. Not-For-Profit Health Care Sector Outlook: Providers Prove Adaptable But Face A Test In 2013 As Reform Looms

Standard & Poor's Ratings Services expects the ratings on most U.S. not-for-profit health care providers to remain stable in 2013 due to the financial cushion many providers have built in the last few years, successful and ongoing cost containment efforts, and the benefits of consolidation. However, we expect credit quality trends to be less favorable compared with 2010-2012, as providers will confront a number of growing challenges, including federal reimbursement reductions in the fiscal cliff bill passed by Congress this week, the remaining threat of sequestration or negotiated Medicare cuts later this year, increased health care reform preparation, and new incentives and penalties for meeting or failing to meet value-based purchasing standards.

The U.S. Supreme Court ruling upholding the Patient Protection and Affordable Care Act of 2010 (ACA) has given hospital providers more confidence to move ahead and accelerate their health reform preparation activities, although some providers are clearly further along compared with those who chose to take more of a wait-and -see approach. However, the costs and risks of reform preparation activities have caused some financial strain and, in some cases, rating changes.

Overview

- Rating actions are likely to be stable in 2013 although the trend will be less favorable than the prior two years.
- Health care reform preparation is a high strategic and operating priority for most providers, although the transition to new payment models creates risk.
- Competition will continue to intensify on all fronts because of soft utilization trends and revenue pressures.
- The stepped-up pace of hospital consolidation will continue.
- The economy still negatively affects credit trends despite a recent recovery.

We are encouraged by what we view as management's responsiveness and resilience, which has resulted in positive credit metrics since 2010 despite many incremental pressures that aggregate to an increasingly difficult operating environment. In the last few years, the sector has maintained and improved credit quality through aggressive cost cutting, mergers and acquisitions (M&A), restrained capital spending, a lower cost of capital, and new sources of revenue such as state provider taxes and federal funding for meaningful information technology use. Yet, we question the ability of providers to sustain these favorable trends as we believe that we are now at the top of this credit cycle. We believe that credit quality and ratings will be negatively affected, most likely beginning in 2014, due to federal reimbursement cuts as part of deficit reduction efforts, health reform-related cuts and penalties, health reform preparation costs, and volume trends that are stable at best and, in many cases, declining. As we have seen from past credit cycles, providers who have generally weaker financial profiles and are at the lower end of the rating scale could see a disproportionate share of the rating pressure, although higher-rated credits will not be immune.

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A Changing Landscape

As the individual health insurance mandate begins in 2014, U.S. hospital providers will face a host of changes that could fundamentally alter the health care delivery and financing landscape. Uncertainties abound, including the number of currently uninsured individuals who will become insured, estimating the number of newly insured who will be insured through Medicaid versus the insurance exchanges, which states will choose to participate in the Medicaid expansion, the adequacy of payment rates for the newly insured, and whether there will be a shift from employer-sponsored commercial insurance to exchange products. We believe it will be beyond 2014 when answers to many of these questions become clear. There will be benefits to hospitals from the reduction in the uninsured population, and there may be a short-term surge in volume and revenues as newly insured seek medical care in large numbers. However, the longer-term implications are also likely to include lower payment rates per unit of service, reduced utilization after the initial surge, and more revenue at risk for performance on quality and population management measures, all of which increase credit risk for providers.

Health Care Reform Preparation Leads Strategic and Operating Priorities

Most providers have responded forcefully to the current environment and looming changes due to reform of the health care delivery system by aggressively lowering costs. These efforts have been highly successful for many, which is reflected in the favorable upgrade to downgrade rating trend in 2010-2012 (see chart 1). However, the upgrade to downgrade ratio narrowed in 2012 as tougher operating conditions emerged, volume reductions remained persistent, ongoing cost cutting opportunities decreased, and the high costs and risks of strategic activities escalated.

In 2013, we believe that most providers will continue to develop and hone their health care reform readiness strategies. Most realize that under reform there will be broad changes in financial incentives that ultimately aim to reward better quality of care and improved disease management with payments for treatment outcomes instead of per unit of service provided. Changing how care is delivered is a process that may include aligning incentives with physicians, greater use of employed physicians and physician extenders, increased risk-sharing arrangements -- although this is still a relatively small percentage of overall business -- and evolving relationships with third-party insurers.

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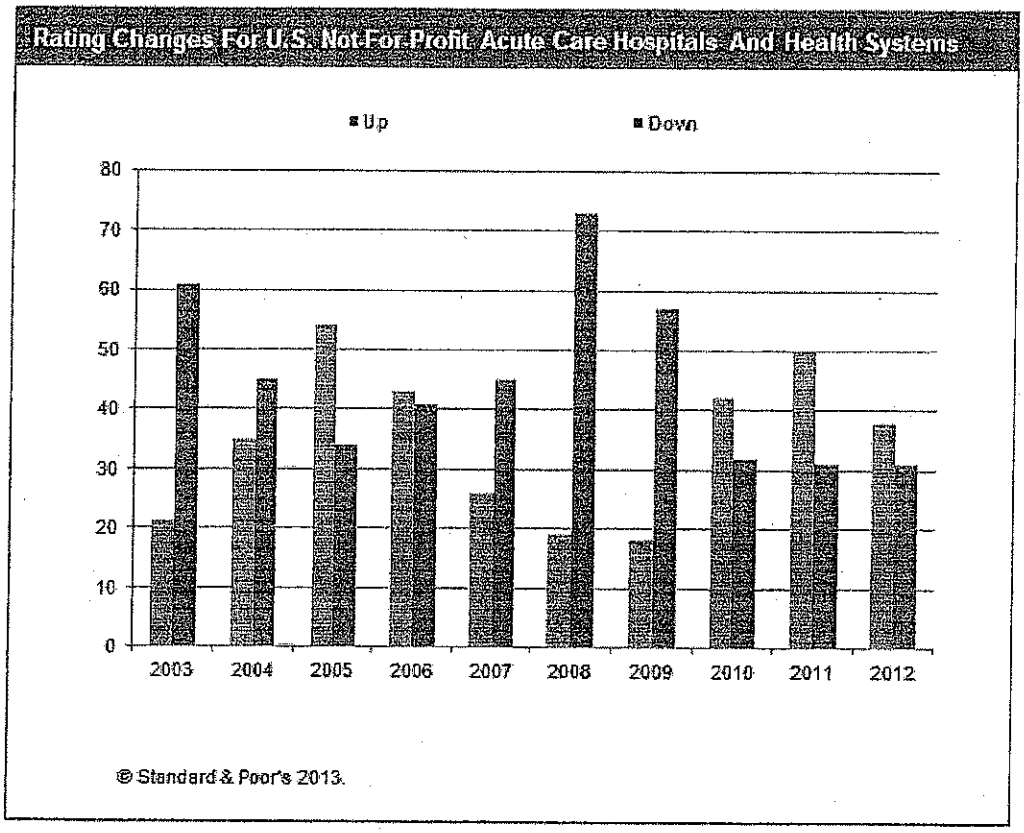
Chart 1



A complicated transition

Moving from volume-based reimbursement to value-based reimbursement is complicated as most providers have a wide variety of payors with different reimbursement models and, at times, reform readiness activities. For example, activities which result in reduced admissions or readmissions will have a negative financial impact, albeit small initially, as the payment incentives are not yet aligned with the new strategies. In some more-advanced markets, providers have moved to shared-risk models where health insurers and providers share the financial benefit of cost reductions. While these arrangements clearly provide some financial benefit for lowering use rates and costs, providers still often end up with revenue and operating margins that are below what they would have received under the original fee for service model and the prior use rates.

In 2012, most providers continued to develop their reform preparation strategies, which in many cases have accelerated with the Supreme Court ruling. Many providers are trying to gain experience with different payment models, such as accountable care, medical homes, and bundling, through limited experiments for a portion of their patient population, often with limited downside risk. Some are experimenting through creative payment arrangements with a commercial health plan serving their markets, others are participating in Medicare's various pilot and demonstration projects, and many are using their self-insured employee populations to gain experience. At the same time, hospitals are focusing on the fee for service strategies that continue to be a key driver of current profitability.

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Managing both volume-driven and value-driven strategies, with their often-conflicting incentives and very different cultural attributes, is challenging for management teams and medical staffs, but we believe most have done a good job so far and few have taken what we view as extraordinary risk. However, those providers that have done little in the way of reform preparedness and continue to focus solely on the fee for service strategy will be at a disadvantage as the delivery system shifts toward value. Many of these providers do not have the size and economies of scale, depth and breadth of services, and large physician component to effectively make a transition to or experiment with different payment models. These providers will likely need to affiliate or partner with a larger organization that can provide the foundation, infrastructure, and physician base to succeed in a value-based environment.

Value-based delivery requires infrastructure support

In addition to payment model experimentation, hospitals continue to build the infrastructure needed to manage patient populations across a continuum of care. These include physician practice employment and acquisition; building capabilities for home health, nursing, rehabilitation, hospice, and other ancillary business through acquisitions and partnerships; more partnerships with, or, in some cases, ownership of, health plans; and expanding the acute care footprint through hospital acquisitions.

While many of the ACA's provisions – such as the establishment of functioning health exchanges and some of the quality-based penalties – haven't started yet, some providers have moved ahead on a very small scale and on a voluntary basis. The level of affiliations, mergers, and acquisitions - horizontal and vertical – is very high. Many hospital management teams believe that they need to be proactive about forming the necessary affiliations for success in the future, before their competitors affiliate with the most attractive partners in the market. We are observing more nontraditional acquisitions and affiliations than at any time in the last decade. Examples include Catholic and non-Catholic providers merging, Dignity Health's acquisition of U.S. HealthWorks, an occupational medicine and urgent care provider with 172 medical centers in 15 states, and several large systems working with for-profit partners to expand their networks. Examples are the Ascension Health Care Network and Duke University Health System's joint venture with LifePoint Hospitals.

While these strategies are increasingly popular for managing under health reform, in some cases there has been significant strategic acquisitions and physician integration costs that have strained credit quality. Catholic Health Initiatives' sizable $1.5 billion bond issue in 2012 to finance its acquisition strategy resulted in a rating downgrade, while Sanford Health's accelerated capital plans following its merger with MeritCare Health System also resulted in a downgrade. Although acquisitions are expected to help many providers continue their cost-cutting initiatives on a larger scale and position themselves for reform, we do not expect every merger to go smoothly, at least initially.

Heavy investment in information technology

Under the federal stimulus law, the federal government is rewarding providers who meet "meaningful use" targets for implementing electronic medical and patient systems. Capital and operating costs for information technology (IT) are rising rapidly but at least on the capital side, growing IT costs have been offset by even larger reductions in more-traditional capital spending on bricks and mortar.

Many providers started receiving payments for achieving meaningful use targets in fiscal 2011 and the number of hospitals that qualified for payments grew rapidly in fiscal 2012. We expect that meaningful use funding will continue

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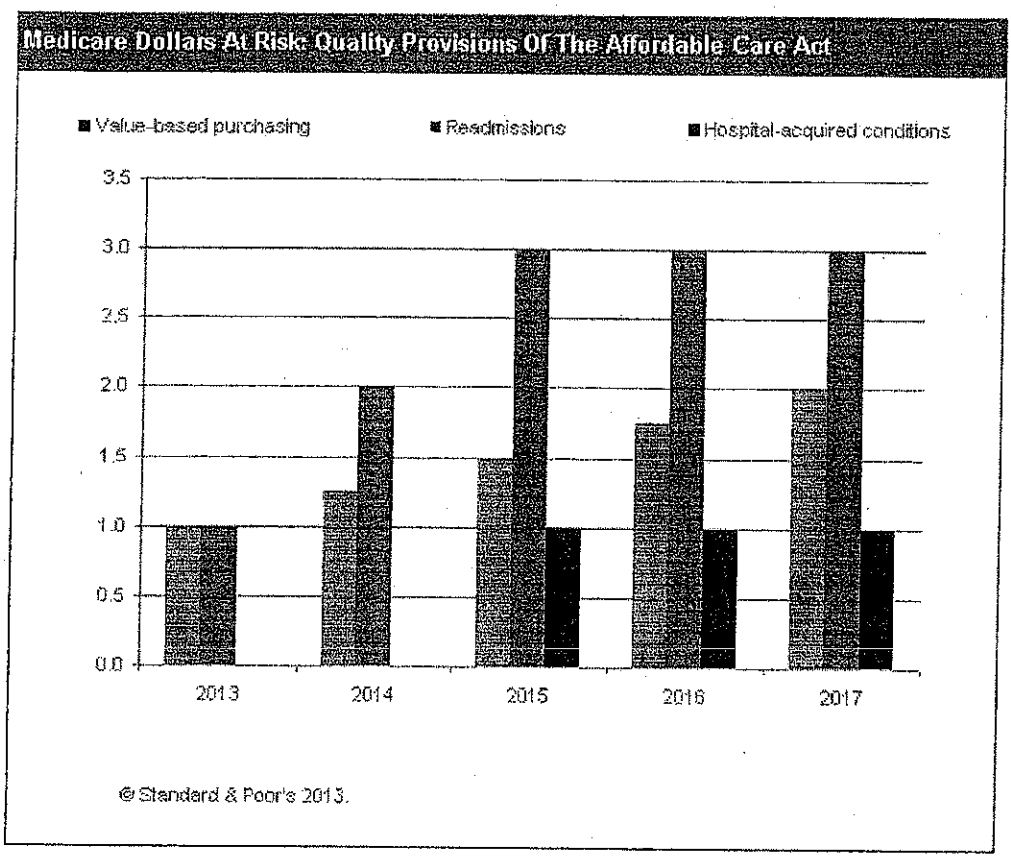
to bolster income over the next four years until the program's scheduled conclusion in 2016. According to the Centers for Medicare and Medicaid Services (CMS), from the program's inception in 2011 through October 2012, a total of 1,716 hospitals received $2.9 billion in incentive payments, while 88,000 physicians received $1.4 billion.

Providers whose information systems are already in place are starting to turn their attention to using it to enable clinical transformation to provide care more efficiently and at a lower cost. In addition, IT is also increasingly important in defining best practices and disseminating them across the system. Given the potential pressure on payment and use rates due to health reform and the fact that many of the easier cost-cutting tactics have already been deployed, clinical transformation may be one of the best sources of further performance improvement for the sector.

Quality-based incentives and penalties will ramp up through 2017

CMS began its hospital value-based purchasing initiative in October 2012, under which each hospital will see its Medicare reimbursement reduced 1% in the first year, with the reduction growing annually to 2% in federal fiscal year 2017. However, only some providers will be able to offset these reductions by receiving incentive payments for top scores in predefined quality and patient satisfaction metrics. CMS also introduced other quality-based penalties for federal fiscal year 2013. In total, the three largest -- value-based purchasing, high readmissions, and hospital-acquired conditions -- could put 6% of hospitals' inpatient Medicare reimbursement at risk by 2017 (see chart 2).

Chart 2



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While these payment changes directly reflect quality of care and satisfaction for Medicare and Medicaid patients, we believe the broader potential impact is that private insurers are increasingly implementing similar incentives in commercial insurance plans, which are typically very profitable for providers. As quality and patient satisfaction results become more measurable and transparent, we believe competition among hospitals could further intensify, with both patients seeking and physicians sending business to better-performing providers. In many ways, the initial incentives and penalties are small, but we believe the importance lies in creating the path for future health care delivery changes as the dollar amount of these incentives and penalties grows over time.

Physician integration is a key management priority

Physician integration and employment predate health reform, but physician employment is accelerating and, in some cases, providers are pursuing salaried medical staff models. We believe physician employment, including the use of hospitalists and intensivists, will continue to grow because many of the expected incentives under reform call for tighter care coordination to manage services that are bundled together for reimbursement purposes or simply to better manage patients with chronic conditions. However, in the short term, physician employment can be costly because it frequently requires subsidizing physician practices operating at a loss, which raises fixed costs and can hurt overall operating margins. We understand that management's goal is to have the hospital and physician share a common payment within the same organization because most believe success under reform will mean better care coordination, improved quality, reducing redundancies, and treating patients in lower-cost facilities such as nursing homes or outpatient centers. So, while we expect that the benefits to an organization – including the ability to manage a changing payment structure and improve business volumes – should accrue over the long term, the higher cost base and losses need to be managed now.

Furthermore, with reform looming and a still-weak economy, we believe that volume is likely to continue to decline or at best stabilize. This will heighten competition among providers who already are under intense pressure to increase revenues. If the market is not growing, seizing market share – through physician employment as a key strategy and building larger referral networks as another – remain time-honored approaches. As such, providers may find that the need to expand their business and coordinate care can be best accomplished with a physician employment and integration strategy. Increasingly well-defined standards of care, IT linkages, payment incentives for care coordination, and the changing demographics of physicians – many of whom are much more interested in being a salaried employee than entrepreneurial – are trends that we expect will accelerate over the next few years.

Consolidation pace to remain strong

We expect the accelerated pace of mergers and acquisitions in 2012 to continue this year. The impetus comes from a perennial drive to lower costs, boost revenues, enhance IT capabilities, broaden the range and depth of service to better determine and disseminate best clinical practices, prepare for health care reform, and increase collaboration with others, both horizontally and vertically.

Even organizations that are already very large – like Trinity Health, Mich. (AA/Stable) and Catholic Health East (A/Stable), with $13 billion of revenue combined – have agreed to explore a merger partly to achieve additional economies of scale. Other large systems not specifically looking to merge with a peer may want to increase their footprint in some markets and reduce their presence in markets where they feel they cannot achieve sufficient depth. For instance, Catholic Health Initiatives (AA-/Stable), with over $9 billion in revenue, wants to significantly expand its

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presence in Nebraska and Washington, where it already has a strong presence, and at the same time divest itself of its stakes in Maryland and New Jersey, where it has a limited presence. We expect system-to-system M&A activity to increase, and we also believe many stand-alone providers will overcome traditional community control concerns and seek larger not-for-profit or for-profit partners to prepare for reform challenges. New structures that make it easier for religious and nonreligious organizations to work together are emerging as well.

We expect M&A activity will increase as reimbursement pressure intensifies. In addition, as many providers are forced to hold down or lower costs year after year to maintain operating margins, it remains unclear how hospitals can come up with additional reductions. As a result, many may eventually be forced to cut services or accept service line consolidations to achieve targeted margins. In cases where additional cost reductions are becoming harder to find, M&A could precipitate the next generation of cost-cutting, which we believe will increasingly include historically hard-to-implement service alignments in shared markets.

Operating Conditions Will Deteriorate In 2013

In our opinion, the sector will face increased operating pressures. While many hospitals will have the capacity to cope in 2013, we believe that these pressures will adversely affect the sector's credit quality, perhaps as soon as 2014. Hardest hit will be providers who have not been able to adapt to new regulations, those who are already in fiscal distress and cannot find a partner, and hospitals operating in overserved markets.

Key concerns for the sector remain:

- A still-sluggish economy with relatively high unemployment and reduced health insurance benefits;
- High levels of uninsured and underinsured patients;
- Smaller rate and reimbursement increases from commercial payors as well as federal and state sources, given budgetary pressures at both levels of government;
- Tougher decisions on cost-cutting as many obvious and easier-to-implement actions have already been taken;
- Reduced patient volumes stemming from increased out-of-pocket costs from high-deductible plans, the slow economic recovery, and new incentives that reward avoidance of hospitalization or frequent readmissions;
- Ongoing competition from physician offices and privately-owned treatment centers;
- Increased costs from subsidies usually required when employing physicians;
- Only-adequate trends in nonoperating revenues, including fundraising and investment performance;
- Increased scrutiny of the sector's nonprofit status; and
- Rising average age of plant, highlighting the deferral of capital spending since 2008.

Cost containment strategies bolster earnings – for now

Lowering costs has proven to be a very effective tactic amid health care reform and has been implemented as a direct response to expected drops in reimbursement per unit of service and inpatient use rates. Over the past several years, providers have maintained, and, in many cases, improved earnings and cash flow through concentrated efforts to control costs. For many, these cost controls exceeded revenue reductions, at least initially, and as a result, have been a key factor in improving operating margins. For nonsalary costs, strategies include gaining economies of scale between various hospital departments or reaching out to join other health care organizations to standardize products and make group purchasing decisions, streamlining clinical and operational processes, renegotiating supply contracts, and

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heightening staff awareness about spending. Management has also been fairly successful in holding down salary increases, gaining union concessions, and curbing short- and long-term employee benefit expense.

Cost containment continued in 2012 but for many hospitals, cost controls barely kept up with deteriorating operating conditions, leading to generally flat operating margins. As a consequence, we saw fewer upgrades of providers compared with a year earlier. Some providers are reaching the point where routine cost cutting becomes harder, and they will need to seek a partner or a more radical redesign of care management practices to achieve the next level of efficiencies.

Revenue outlook remains constrained

The constrained revenue environment of 2011 and 2012 appeared to ease somewhat when Medicare announced an inpatient rate increase of 2.8% for federal fiscal year 2013, which exceeded the 1.1% bump in 2012 and slightly negative update in 2011. However, most of the increase was due to a technical adjustment, and we do not believe 2013's increase sets a higher baseline of expectations for future update factors. The increase for hospital outpatient departments was 2.1%. However, some of the increase will be offset by Medicare cuts built into the American Taxpayer Relief Act of 2012, the law which averted the fiscal cliff. In addition, the act postpones the possibility of sequestration and its 2% across-the-board reduction in Medicare rates, by only two months.

Medicaid funding is mixed for 2013. While 32 states enacted general fund increases in spending for Medicaid, much of the increase is absorbed by higher enrollment, with payment rates unchanged in many states. In addition, 47 states planned to implement at least one new policy to control Medicaid costs in fiscal 2013, according to information from the Fiscal Survey of the States Fall 2012 (National Governors Association and The National Association of State Budget Officers).

On the commercial and managed care insurance side, many providers are reporting smaller rate increases in contract renewals, with modest single-digit annual rate increases that are well below the peaks of the past decade and even a few years ago. This trend remains a concern and partly informs our view of a weakening revenue outlook. In addition, commercial plans are showing more interest in alternative payment mechanisms that incentivize care coordination and wellness, including medical homes, shared savings models, and narrow network products. These mechanisms may provide incentives to providers to participate but they also introduce payment risk and the possibility of accelerated volume and revenue declines.

While revenue declines in absolute terms are still rare for rated providers, many are preparing for an environment where both reimbursement rates per unit of service and the number of units of service are driven down by health reform-related forces and the growth of high-deductible plans. Specifically, insurance exchange products may offer lower rates to compete for consumers, causing a reduction in rates that insurers offer hospitals as reimbursement. At the same time, there may be a shift of insured individuals from commercial group policies, which typically provide profitable rates to hospitals, to what we expect will be less-lucrative exchange products. Both of these would reduce revenue to hospitals. In addition, use rates could fall if the various health reform-related provisions of ACA are successful, with perhaps a parallel decline in use rates among the commercially insured population as private insurers seek the same reform benefits.

The bright spots for revenue in recent years include new provider taxes in some states, including North Carolina,

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California, and Pennsylvania, and meaningful use revenue for implementation of electronic medical records. Risks related to provider tax programs include expirations and the need to be reapproved in order to continue (programs in Pennsylvania and California will expire this year if they aren't renewed). In addition, the proliferation of provider taxes may eventually draw national scrutiny over their cost. The meaningful use program is currently scheduled to run through 2016, with providers required to meet increasing levels of IT functionality in order to continue qualifying.

Commercial insurers are preparing for 2014

While commercial health insurance companies have generally performed well (see the article "U.S. Health Insurers Are On Firm Footing As They Prepare For Reforms", published Nov. 28, 2012, on RatingsDirect on the Global Credit Portal), we expect insurers' margins to be less robust in 2012-2013 than in 2010-2011 when financial performance was significantly stronger than expected because of favorable prior-period claim development and continued lower-than-expected utilization.

We believe there are risks for health care providers regarding the overall affordability of insurance, the movement toward high-deductible plans, and the decreasing number of people covered by commercial insurance (see chart 3). Furthermore, health insurers have been very actively pursuing their own accountable care organization-type models, as well as new patient-based medical homes, narrow network/tiered products, cobranded payer-provider products, and new payment models. In pursuing these models, insurers are emphasizing their need to have tighter control of the actual delivery and coordination of health care services to improve their cost structures in the long term. We believe these activities shift risks to providers and will have an adverse effect on reimbursement rates.

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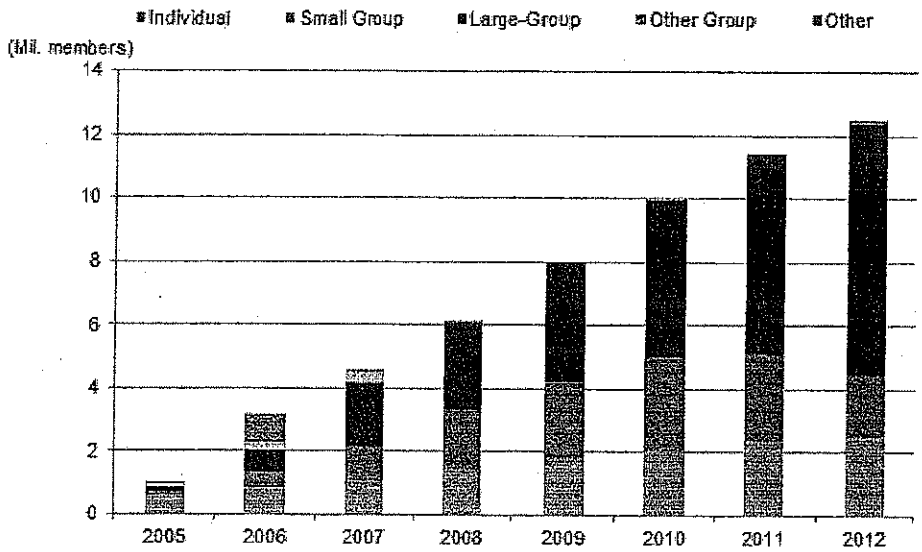
Chart 3

Growth Of High-Deductible Health Insurance Memberships



Source: America's Health Insurance Plans, Center for Policy Research

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Inpatient volume decline is likely to continue

Inpatient volumes have shrunk for many rated providers due to several factors in the past few years. In our view, these include:

- Continued technology-driven shift to less-invasive procedures that have shortened hospital stays but increased outpatient business;
- The continued sluggish economy, which has reduced demand, particularly for elective procedures;
- Focus on quality of care, including reducing duplication, readmissions, and hospital-acquired conditions;
- The growing use of high-deductible insurance plans, which increasingly shift the cost of care to subscribers, who sometimes choose not to use health care services because of the costs (see chart 3);
- Federal government audits of hospitalizations that result in reimbursement denials on a retroactive basis and result in hospitals' increased conservatism in medical coding; and
- Competition from investor- and physician-owned ambulatory and specialty hospital providers.

While inpatient volume declines have been somewhat offset by increasing observation and same-day medical and surgical visits, the reimbursement for these types of services is much lower than for a comparable inpatient day. The shift from inpatient to outpatient has also continued, which, combined with the shift from inpatient to same day, has resulted in declining volume – perhaps as much as 5% or more year over year – and, in turn, flat or declining revenue.

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The focus on clinical quality is one reason patient volumes remained relatively soft in many places even as the economy slowly emerged from recession. Hospitals' focus on quality of care, adhering to evidence-based practices, reducing readmissions, reducing hospital-acquired conditions, eliminating duplication, and other clinical transformation activities, all have a negative effect on patient volume.

Economic Outlook

Standard & Poor's projects that the economic recovery will remain sluggish, with continued slow growth in employment and income. Our baseline forecast is for 2.2% GDP growth in 2012 and 1.8% in 2013. We believe the chance of another U.S. recession is about 20%-25%. While we view the health care sector as only moderately influenced by macroeconomic trends, we believe that relatively high unemployment and slow job growth have hurt many hospitals' payor mixes. In addition, patient volumes, particularly elective procedures, have dropped as more people were deprived of employer-sponsored insurance when they lost their jobs.

We base our industry and company-specific forecasts on the baseline scenario, although we recognize that economic performance in specific markets may be better or worse than the national averages. Due to the nature of forecasting, we recognize that actual economic performance is likely to differ from the baseline. We realize that credit market participants are also interested in our view of downside risks, and have provided two more scenarios. The first is our optimistic forecast, to which we currently attribute a 15% likelihood, and a pessimistic scenario with a 20%-25% likelihood. Highlights of the three scenarios for key variables that influence the acute care sector are in table 1.

Table 1

Standard & Poor's Economic Outlook: Indicators From U.S. Public Finance, Not-for-Profit Health Care

Baseline impact on sectors:							
	Forecast/Scenarios*						**Actual**
	Pessimistic		**Baseline**		**Optimistic**		
	2012e	**2013**	**2012e**	**2013**	**2012e**	**2013**	**2011**
Federal government spending (% change)	(1.6)	(3.8)	(1.6)	(2.9)	(1.6)	2.9	(2.8)
Fiscal consolidation will negatively impact Medicare spending							
Unemployment Rate (%)	8.1	8.6	8.1	7.7	8.1	7.1	9.0
Relatively high unemployment levels increase hospitals' uncompensated care burden							
Payroll Employment (mil.)	133.2	133.4	133.3	135.5	133.3	136.2	131.4
Moderate job growth may increase the commercially insured population							
Population (mil.)	315.2	318.0	315.3	318.4	315.4	318.8	312.4
Population growth increases a hospital's business base.							
Real disposable income (% change)	1.3	(0.4)	1.3	1.9	1.3	1.6	1.3
Income growth increases consumers' capacity for discretionary health care spending							

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Table 1

Standard & Poor's Economic Outlook: Indicators From U.S. Public Finance, Not-for-Profit Health Care (cont.)

S&P 500 Common Stock Index	1,376	1,151	1,381	1,471	1,380	1,622	1,269
Growth in unrestricted reserves and investment income are positive credit factors							

Standard & Poor's U.S. economic team's forecasts are derived using the Global Insight model of the U.S. economy. *Pessimistic and optimistic forecasts are from the article, "U.S. Economic Forecast: We Can Work It Out," published on Dec. 21, 2012, on RatingsDirect. Baseline forecast is from the U.S. Monthly Forecast Report. e--Estimate.

Our scenarios project a decline in federal spending in 2013 of 3.2%-3.7%. Medicare is funded by the federal government, with some contribution by beneficiaries. Medicare typically is the largest payor for hospitals. Lower federal spending is likely to hurt Medicare spending, on top of planned cuts to Medicare's annual update factors that are part of the ACA.

We expect unemployment to stay above 7% even in our optimistic scenario. Employment status is a key driver of insurance availability in the U.S., as most commercial insurance is purchased by employers on behalf of their employees. When consumers become unemployed and lose their insurance, they often cut back their use of health care services significantly, or become uncompensated care patients.

Our baseline projection for real disposable income growth of 1.9% could have a modest favorable effect on the hospital sector. Although consumers have been reluctant to spend recently, focusing instead on reducing their personal debt, their out-of-pocket responsibility for health care costs has been growing. As such, income growth enhances consumers' capacity to meet their out-of-pocket costs and discretionary health care spending.

An advancing stock market will be positive for the sector, which relies heavily on investment earnings and appreciation of its relatively large investment portfolios for credit strength and debt service coverage. Population growth in our baseline forecast will be 0.98% in 2013. We view population and growth a key factor in creating demand for health care services.

Rating Actions In 2012: The Favorable Trend Narrowed While M&A Gained Momentum

In 2012, the number of upgrades exceeded the number of downgrades for the third straight year (see chart 4). The rating actions substantiate our view that the sector's credit quality has stabilized since the sharp downturn of 2008 and 2009. However, the upgrade to downgrade ratio narrowed in 2012, and the par amount of downgrades exceeded upgrades. We believe this less-favorable credit trend will continue in 2013 as some providers will struggle to find additional cost efficiencies while still absorbing the costs of IT implementation, physician integration, and other health reform preparation. Still, most providers enter 2013 with enough cushion so that even in the face of tighter and declining operating conditions, most ratings will remain stable. At the end of 2012, the ratings distribution was comparable to 2011 with the majority of acute care ratings in the 'A' (45%) and 'BBB' (30%) categories (see chart 5).

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Chart 4

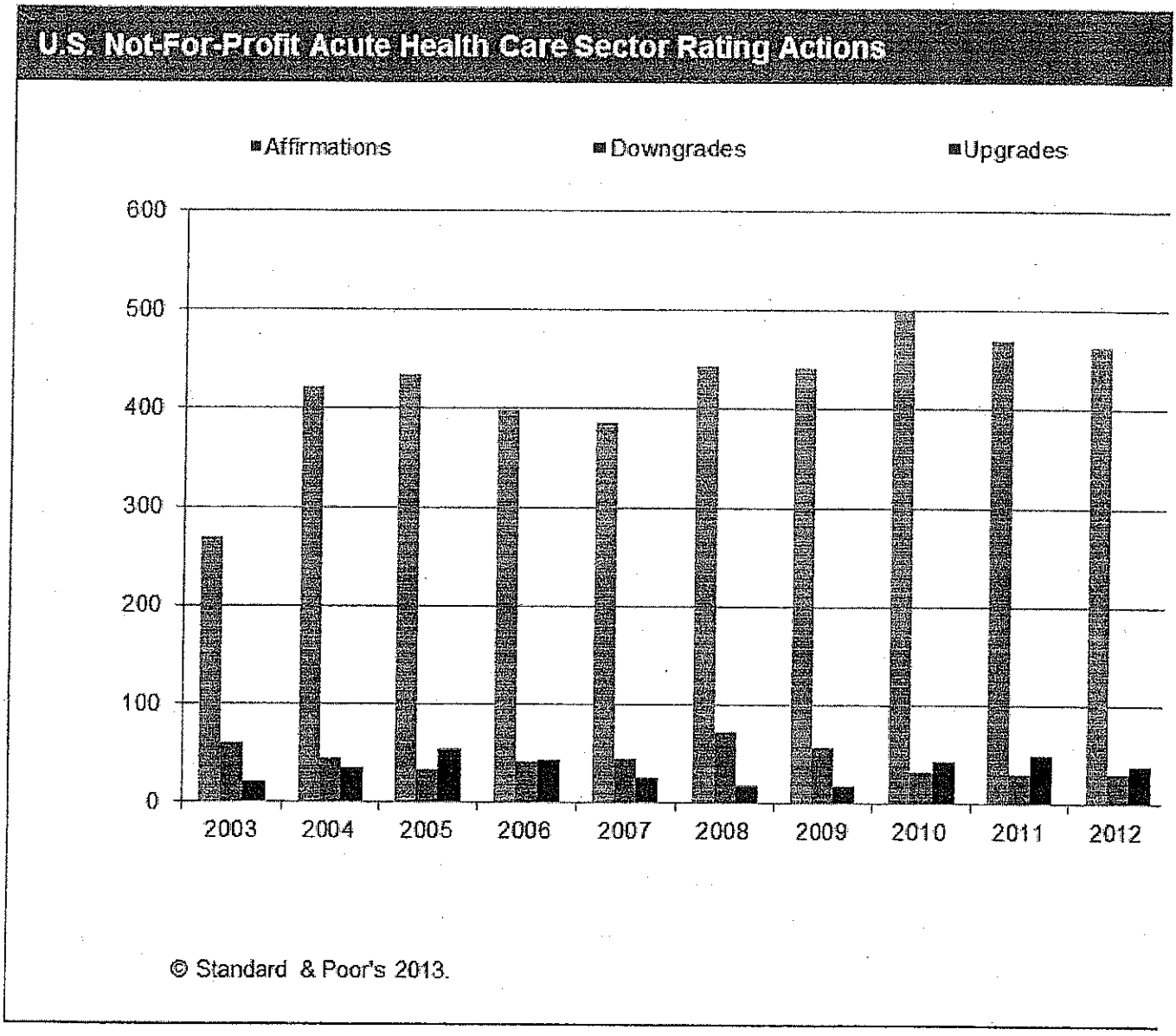

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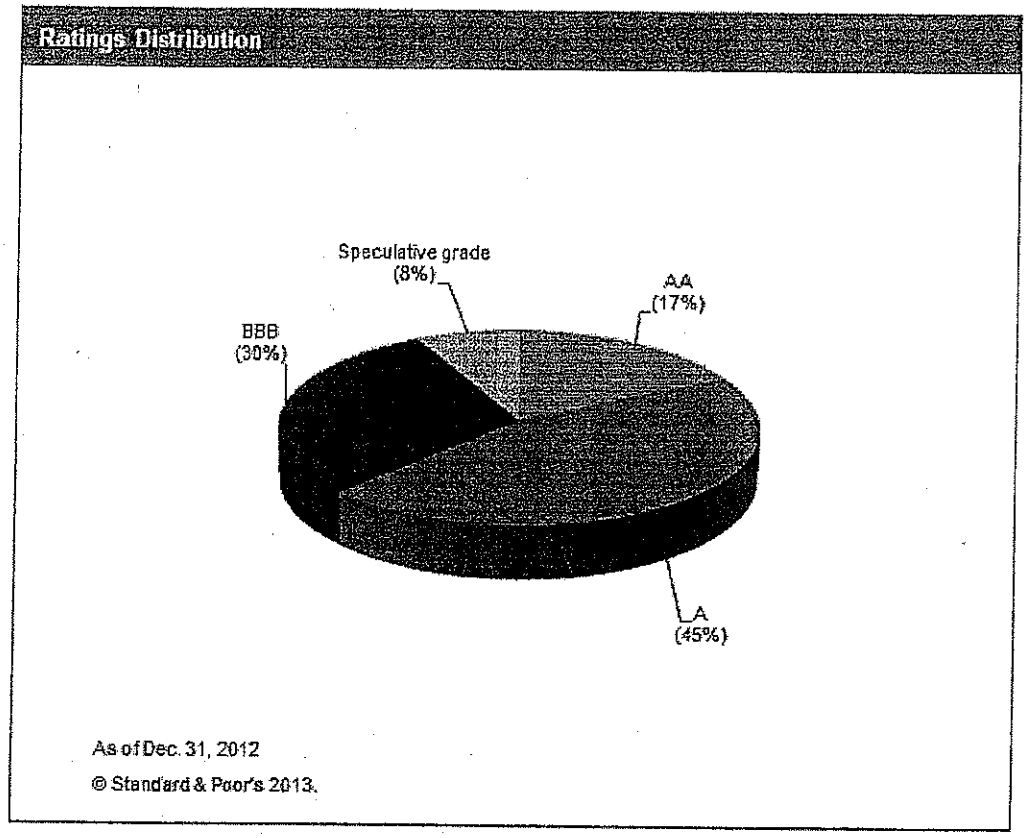
Chart 5



During 2012, we upgraded 38 providers and downgraded 31 for a ratio of 1.2:1 (see table 2), a significant narrowing from a 1:6 ratio in 2011. Overall rating changes were a sizable 14% of the total number of organizations that were reviewed at least once in 2012. This is a relatively high percentage and reflects the sector's volatility, but is below 2011's 17%. In fiscal 2012, the par amount for upgrades totaled $9.3 billion, compared to $9.8 billion for downgrades.

M&A activity played an increasing role in rating actions last year, with several ratings raised or lowered due to mergers, acquisitions, debt issued to finance acquisitions, and, in West Penn Allegheny's case, difficulties of a still-pending merger. Often, when a hospital or health system joins another, the rating on one party is withdrawn as its debt is retired or refunded by the acquiring organization. In many cases, the acquired organization had a low or declining rating, and may have been downgraded or even eventually defaulted if the organization didn't merge with a stronger partner. We believe the strength of rating trends in recent years underestimates the level of stress that many hospitals in the country are experiencing, because their ratings never reach the lower level that they might otherwise if they hadn't joined a partner.

The number of outlook revisions without accompanying rating changes in 2012 supports a broader view of the sector's less buoyant momentum (see chart 6). Negative outlook revisions exceeded the number of positive revisions 43 to 37. By comparison, the number of positive revisions was more than double that of negative revisions a year earlier (see

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charts 7a and 7b). There was an overall shift in a negative direction in 2012 at 11%, compared with 9% at the end of 2011, while the percentage of positive outlooks was steady at 8%. Of the negative outlook revisions, about two-thirds went to negative from stable, which is an indicator of future rating pressure. The remaining third went to stable from positive, which foretells fewer potential upgrades over the next two years, which is the period our outlooks typically cover.

Chart 6

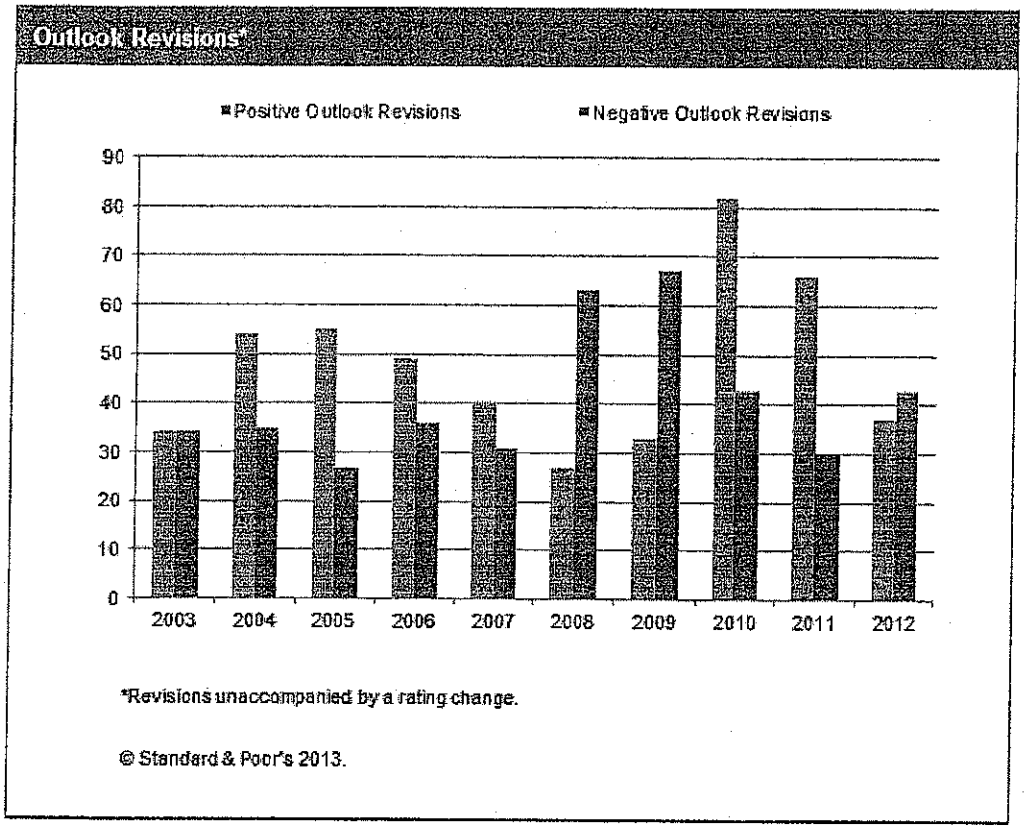

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Chart 7a

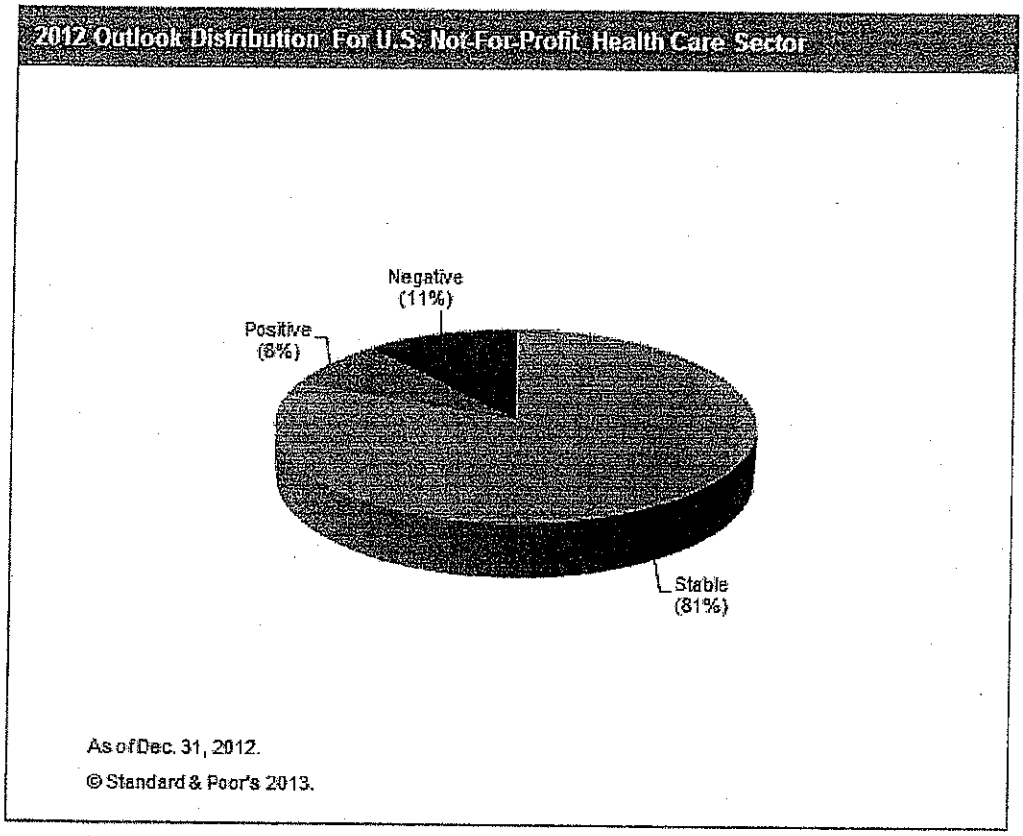

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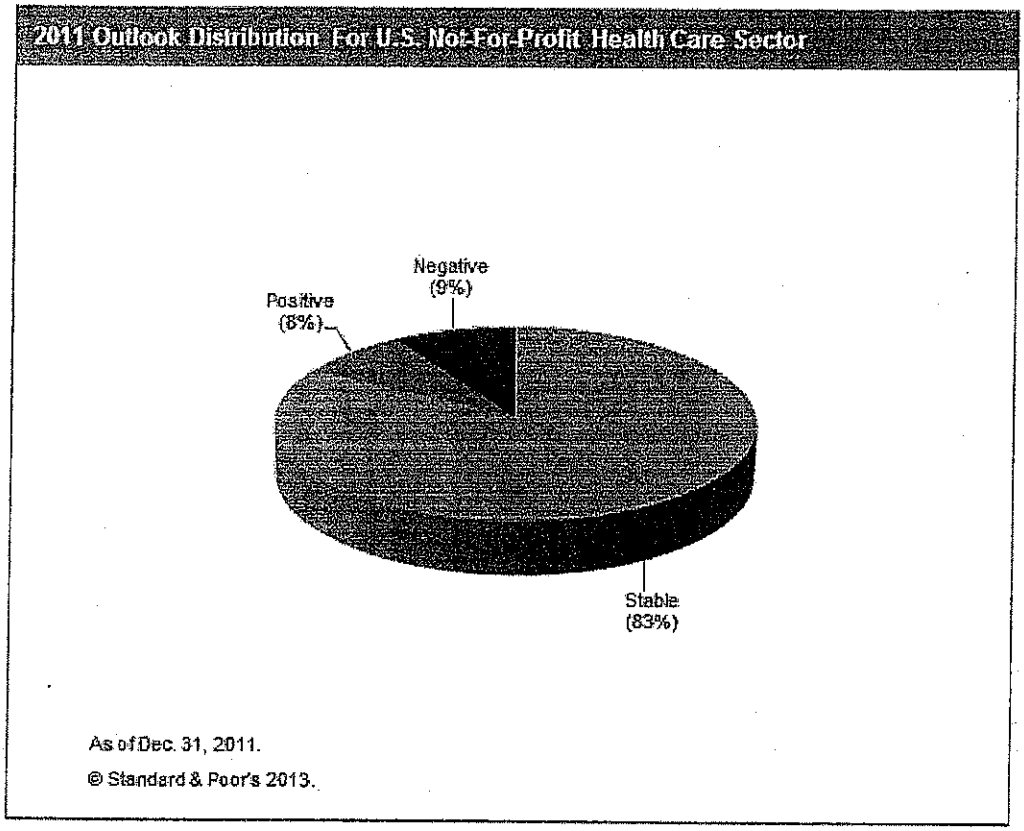
Chart 7b



Among the 38 upgrades, health systems were more heavily represented than stand-alone hospitals. Multihospital health systems, which represent approximately one-fourth of the not-for-profit ratings, accounted for 12, or one-third of upgrades, while 68% (26) were stand-alone hospitals. This highlights our view that health systems can have significant advantages over stand-alone providers because of the revenue and geographic dispersion and the ability to take advantage of economies of scale. About three-fifths (61%) of the upgrades occurred for providers whose new rating was medium-investment-grade or higher ('A-' and above), 35% were for providers whose new rating was in the low-investment-grade category ('BBB-' to 'BBB+'), and 5% (two credits) were in or to noninvestment-grade ('BB+' and below). The downgrades were disproportionately weighted toward stand-alone hospitals (25) compared to only six health care systems. Furthermore, 71% of the downgrades resulted in ratings of 'BBB+' or lower, highlighting the longstanding credit quality gap between higher- and lower-rated providers, systems and stand-alone providers, and the fact that lower-rated credits tend to be more volatile (see chart 8).

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Chart 8

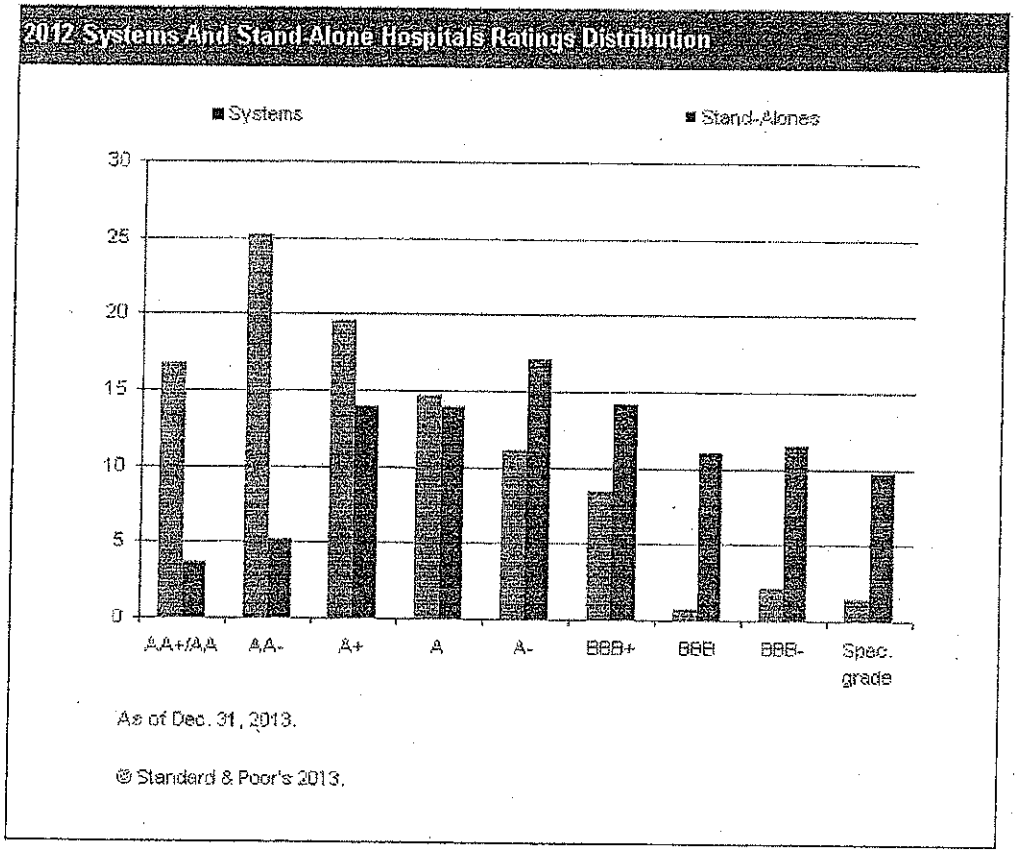

Table 2

2012 Rating Changes

	State	Ratings		Outlook		Month
		To	From	To	From	
Upgrades						
Sharp Healthcare	CA	A+	A	Stable	Stable	January
Children's Hospital of Central California	CA	A+	A	Stable	Stable	January
University of North Carolina Hospitals	NC	AA	AA-	Stable	Positive	January
Carolinas Medical Center-Union	NC	AA-	A+	Stable	Stable	January
Sky Lakes Medical Center	OR	BBB	BBB-	Stable	Stable	February
Sky Lakes Medical Center	OR	BBB+	BBB	Stable	Stable	October
Mercy Memorial Hospital Corporation Obligated Group	MI	BBB	BBB-	Stable	Positive	February
Jackson County Schneck Memorial Hospital	IN	A	A-	Stable	Positive	February
St. Francis Regional Medical Center	MN	BBB+	BBB	Stable	Positive	March
Wheaton Franciscan Services	WI	A-	BBB+	Stable	Stable	March
Virtua Health Inc.	NJ	A+	A	Stable	Positive	April

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Table 2

2012 Rating Changes (Cont.)						
Delnor Community Hospital	IL	A+	A	Stable	Positive	April
Stanford Hospital & Clinics	CA	AA-	A+	Stable	Positive	May
Vernon Memorial Hospital	WI	BBB	BBB-	Stable	Positive	May
John C. Lincoln Health Network	AZ	BBB+	BBB	Stable	Positive	May
Princeton Community Hospital	WV	BBB	BBB-	Stable	Stable	May
Via Christi Health Inc.	KS	AA-	A+	Stable	Positive	May
Bowling Green-Warren County Community Hospital Corporation	KY	A	A-	Stable	Stable	June
Hawaii Pacific Health	HI	A-	BBB+	Stable	Stable	July
St. Clair Memorial Hospital of Pittsburgh	PA	A+	A	Stable	Stable	July
NYU Hospitals Center	NY	A-	BBB+	Stable	Positive	July
Wilcox Memorial Hospital	HI	A-	BBB+	Stable	Stable	July
Fletcher Allen Health Care	VT	BBB+	BBB	Stable	Positive	July
St. John's Riverside Hospital	NY	B+	B	Positive	Stable	August
Dallas Methodist Hospitals	TX	AA-	A+	Stable	Positive	August
Methodist Richardson Medical Center	TX	A+	A	Stable	Positive	August
HealthEast Care System	MN	BBB-	BB+	Stable	Stable	August
Conemaugh Health System	PA	BBB+	BBB	Stable	Positive	August
Saratoga Hospital	NY	A-	BBB+	Stable	Stable	August
OhioHealth	OH	AA+	AA	Stable	Positive	August
Poudre Valley Health System	CO	A+	A	Stable	Stable	September
Northern Arizona Healthcare System	AZ	AA	AA-	Stable	Positive	September
Highland Hospital of Rochester	NY	A-	BBB+	Stable	Positive	October
Community Foundation of Northwest Indiana Obligated Group	IN	A-	BBB+	Stable	Stable	October
Barnabas Health	NJ	BBB+	BBB	Stable	Stable	November
Beebe Medical Center	DE	B+	B-	Developing	Developing	June
Beebe Medical Center	DE	BBB-	B+	Stable	Developing	December
Yampa Valley Medical Center	CO	BBB+	BBB	Stable	Stable	December
Downgrades						
Martin Memorial Medical Center	FL	BBB	BBB+	Stable	Negative	January
Oak Valley Hospital District	CA	BB+	BBB-	Negative	Stable	January
Kalispell Regional Medical Center	MT	A-	A	Stable	Stable	January
Akron General Health System	OH	BBB	BBB+	Stable	Negative	January
Westerly Hospital	RI	C	CCC	Negative	Negative	February
Westerly Hospital	RI	D	C	N.M.	Negative	September
Trinity Health	ND	BBB-	BBB+	Stable	CreditWatch Negative	February
Yakima Valley Memorial Hospital	WA	BB+	BBB-	Stable	Stable	February
Parrish Medical Center	FL	A-	A	Stable	Negative	March
Gritman Medical Center	ID	BBB-	BBB	Stable	Stable	April
Anderson Hospital	IL	BBB-	BBB	Stable	Negative	April
Saint Joseph Health Services	RI	CCC	B-	Negative	Negative	April
Adena Health System	OH	A-	A	Stable	Stable	June

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Table 2

2012 Rating Changes (cont.)

Halifax Regional Hospital	VA	BBB+	A-	Stable	Negative	June
Iglesia Episcopal Puertoriquenna	PR	CCC	B-	Negative	Stable	August
Cheshire Medical Center	NH	A-	A	Stable	Negative	October
Salem Hospital Regional Health Services	OR	A	A+	Stable	Negative	August
Emanuel Medical Center	CA	BBB-	BBB	Negative	Stable	August
Mission Health Inc.	NC	AA-	AA	Stable	Stable	August
Sanford Health	SD	A+	AA-	Stable	Stable	September
Oconee Regional Medical Center	GA	B+	BB	Negative	Negative	September
Mercy Medical Center	OH	BB	BB+	Stable	Negative	September
CareAlliance Health Services	SC	BBB+	A-	Stable	Stable	October
Ryder Memorial Hospital	PR	BB-	BB	Negative	Negative	October
Great Plains Regional Medical Center	NE	A-	A	Stable	Stable	October
Catholic Health Initiatives	CO	AA-	AA	Stable	Negative	October
West Penn Allegheny Health System	PA	B-	B+	CreditWatch Negative	Developing	September
West Penn Allegheny Health System	PA	CC	B-	Negative	CreditWatch Negative	December
St. Peter's University Hospital	NJ	BB+	BBB-	Stable	Stable	December
Baxter County Regional Hospital	AR	BBB-	BBB	Stable	Negative	December
Tuomey Healthcare System	SC	BBB-	BBB	Stable	Developing	December

N.M.--Not meaningful

Upgrades

The 38 upgraded providers showed improved financial performance, with many posting several years of solid financial results despite, in some instances, declining patient utilization, in line with the 2011 trend. About 18% of the upgrades were into or within the 'AA' category, with most exhibiting what we consider leading market positions, good business growth, and stronger operating results. OhioHealth was upgraded to 'AA+' from 'AA' based on its sharply improved financial performance since fiscal 2009, combined with a healthier balance sheet. The current rating on OhioHealth puts the organization in a group of only six in the acute care sector. Another upgrade was Methodist Hospital of Dallas, which was upgraded to 'AA-' from 'A+' on the strength of its improving liquidity, continued solid operating performance, and favorable business position.

We also raised the rating on several low-investment-grade providers, including Mercy Memorial Hospital System, Mich., Princeton Community Hospital, W.Va., and Barnabas Health, N.J., all due to their ability to exploit their strong market positions to improve operations and expand volume. Furthermore, we raised the ratings on two noninvestment-grade credits to investment grade: HealthEast Care System, Minn.; and Beebe Medical Center, Del., The latter was upgraded four notches due to the final settlement of a major litigation against the hospital.

Mergers and acquisitions also contributed to upgrades. Delnor Community Hospital, Ill. was upgraded to 'A+' from 'A' due to benefits of its merger with Central DuPage Health, Ill., which is rated 'AA'. We raised the rating on Carolinas Medical Center-Union, N.C. to 'AA-' from 'A+' due to a guaranty agreement with Carolinas Healthcare System.

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Downgrades

Operational weakness and low liquidity were the key reasons for our downgrades. Also, low interest rates and hospitals' pent-up capital needs after several years of constrained spending spurred many providers to return to the debt market. Some providers - whose other credit characteristics remained stable - were downgraded after taking on additional debt. Among them was Mission Health, N.C, whose rating dropped to 'AA-' from 'AA'.

Among large systems, Catholic Health Initiatives (CHI), Colo. was downgraded to 'AA-' from 'AA' due to its issuance of $1.5 billion of taxable bonds. The debt was issued to finance various growth initiatives, including some specified and some yet-to-be determined acquisitions. However the value from these initiatives is uncertain. The downgrade was due to the additional debt and execution risk, in conjunction with CHI's financial metrics, which were no longer commensurate with a 'AA' rating. Sanford Health, S.D. was downgraded to 'A+' from 'AA-' due to the acceleration of larger capital projects totaling $1.4 billion over the next five years following its successful merger with MeritCare Health System, N.D.

In another noteworthy action, we downgraded West Penn Allegheny Health System (WPAHS), Pa. to 'CC' from 'B-' due to a breakdown in the affiliation discussions with insurer Highmark Inc. Talks resumed later because a legal ruling prohibited WPAHS from seeking other suitors. The affiliation is crucial for WPAHS because it has incurred huge operating losses of $113 million and low reserves of just 55 days' cash on hand, or 25% of outstanding debt as of Sept 30, 2012.

Among the stand-alone hospitals, Cheshire Medical Center, N.H. was downgraded to 'A-' from 'A' because of continued operating losses, an ongoing decline in inpatient admissions, and a significantly underfunded defined-benefit pension obligation. Cheshire has reported operating losses since fiscal 2010, with margins of negative 1% to negative 1.7%, which are also anticipated for 2013. Another factor was the loss of revenue associated with a revision in Medicaid reimbursements. Trinity Health, N.D. was downgraded two notches to 'BBB-' from 'BBB+' due to a weakened financial profile, weak liquidity, and high turnover among senior management. Also, a flood that lasted more than 30 days in its primary service area had a significant impact on the hospital's operations.

Prasad Patil of CRISIL contributed to this report.

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Exhibit 25

BACKUS HEALTH SYSTEM

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION STRATEGY

BACKGROUND

The Backus Health System led a comprehensive **Community Health Needs Assessment** (CHNA) to evaluate the health needs of its service area defined as New London and Windham Counties, Connecticut.

The purpose of the CHNA was to gather information about local health needs and behaviors to ensure Backus community health improvement initiatives and community benefit activities are aligned with community need. The assessment examined a variety of community, household and health statistics to portray a full picture of the health and social determinants of health in the Backus Health System service area.

The primary goals of the CHNA were to:

- **Provide a baseline measure** of key health indicators
- **Guide health policy** and health strategies
- **Offer a platform** for collaboration among community groups
- **Identify** community health needs
- **Establish benchmarks** and monitor health trends
- **Assist** with community benefit requirements

The study included research conducted in 2009-10 and 2012-13.

Research components included:

- **Statistical Secondary Data Profile** of New London/Windham Counties
- **A household telephone survey** with 461 community residents focused on the Ancillary Service Area, to augment study of 1,109 households focused on the Primary and Secondary Service Areas in 2010
- **Key Informant Interviews** with 49 community stakeholders
- **Focus group discussions** with 24 healthcare consumers

Backus engaged Holleran Consulting, a research and consulting firm based in Lancaster, Pennsylvania, as its research partner.

Since the Backus Health System extends beyond the walls of the hospital, and serves communities throughout New London and Windham Counties, Backus initiated a CHNA in 2013 to enhance existing data that was gathered as part of a 2010 study.

The datasets are used in tandem, and provide a full, comprehensive picture of the Eastern Connecticut region. Further, data is now easily comparable to gold standard studies and national benchmarks, such as the Robert Wood Johnson Foundation County Health Ranking, and Healthy People 2020. All study components will be made available to the public; the new, enhanced data will be useful to a wider audience, including agencies throughout the region.

The complete study will be used as a baseline to measure the impact of programs and services offered.

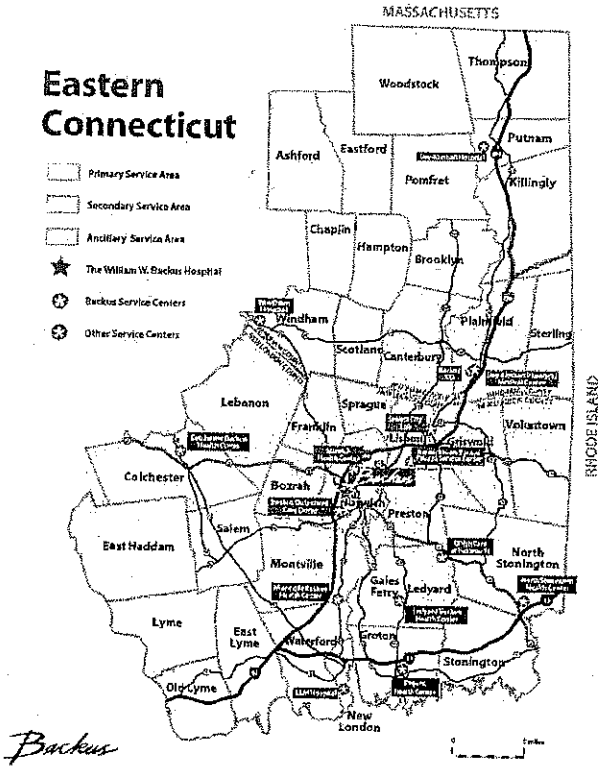
The CHNA research was reviewed by Backus and its Advisory Task Force, which included Backus leadership, Public Health experts, and agencies representing medically underserved and vulnerable communities. A review of the research findings and a facilitated Prioritization Session was held with community partners to identify priority needs within the community. Backus reviewed feedback from the Prioritization Session, along with its current services and programs, resources and areas of expertise, and other existing community assets, to determine what identified needs it would address, and those it would play a support role in addressing.

BACKUS HEALTH SYSTEM SERVICE AREA

The Backus Health System defines the communities it serves as Primary, Secondary and Ancillary Service Areas.

The Primary and Secondary Service Areas are defined utilizing percentage of hospital inpatient discharges.

Backus leaders included an "Ancillary" service area encompassing all remaining towns in New London and Windham Counties to get a true picture of health for the region. Pieces of the Health System, including outpatient health centers, and a full service 24/7 satellite emergency department, touch patients residing in all towns in Eastern Connecticut.



SELECTION OF THE COMMUNITY HEALTH PRIORITIES

On January 23, 2013, Backus hosted a Prioritization Session with hospital and community representatives to review the research findings and prioritize the key issues for adoption and inclusion in the Backus Implementation Plan.

The objectives of the half-day strategic planning session were to:

- **Provide an overview** of recently compiled community health data and highlight key research findings
- **Initiate discussions** around key health issues and prioritize based on select criteria
- **Brainstorm goals** and objectives to guide the Backus Implementation Plan
- **Examine the Backus Health System's role** in addressing community health priorities

A total of 25 individuals attended the strategic planning session, including experts in public health, representatives of underserved populations, health and social services agencies, and other community stakeholders. A full list of attendees is included below.

Name	Agency
Thomas Reynolds	United Way
Nancy Cowser	United Community & Family Services
Jillian Corbin	St. Vincent DePaul Soup Kitchen
Lee-Ann Gomes	Norwich Human Services
Kelcey Johnson	United Community & Family Services
Yolanda Bowes	United Community & Family Services
John Wong	Chinese American Cultural Association
Beverly Goulet	Norwich Human Services
Gregory Allard	American Ambulance
Patrick McCormack	Uncas Health District
Cindy Arpin	Uncas Health District
Bethany Duval	Plainfield School Nurse Coordinator
Kathy Sinnett	APRN, Norwich Public Schools
Michele Devine	South Eastern Regional Action Council
Deborah Monahan	Thames Valley Council for Community Action
David Yovaisis	Thames Valley Council for Community Action
Scott Sjoquist	Mohegan Sun Tribal Health Director
Dee Boisclair	Backus Home Health Care
Sue Starkey	Northeast District Department of Health
Robert Mills	Norwich Community Development Corporation
Shawn Mawhiney	Backus Hospital
Alice Facente	Backus Hospital
Lisa Cook	Backus Hospital
Janette Edwards	Backus Hospital

Holleran facilitated an open group discussion for attendees to share what they perceived to be the needs and areas of opportunity in the region. This included a discussion of overlapping issues, root

causes of health, and the ability for regional health and human services providers to effectively address the various needs. After some consolidation and a considerable amount of dialogue, a list was developed by the attendees. The list was considered a "master list" of needs to be evaluated as potential priority areas for community health improvement activities. The list is presented in alphabetical order:

- Access to Care (physician ratio/insurance, cultural competency, other barriers, hospitalizations)
- Built Environment
- Infectious Disease
- Mental Health: Depression and Anxiety
- Obesity and Related Chronic Conditions (diabetes management)
- Preventative Health (mammograms, pneumonia vaccinations, oral health, seatbelts)
- Respiratory Disease: Asthma/Lung Cancer (smoking)
- Substance Abuse

Prioritization of Community Issues

To further identify the most urgent priority areas, participants were asked to rank the master list. The participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures.

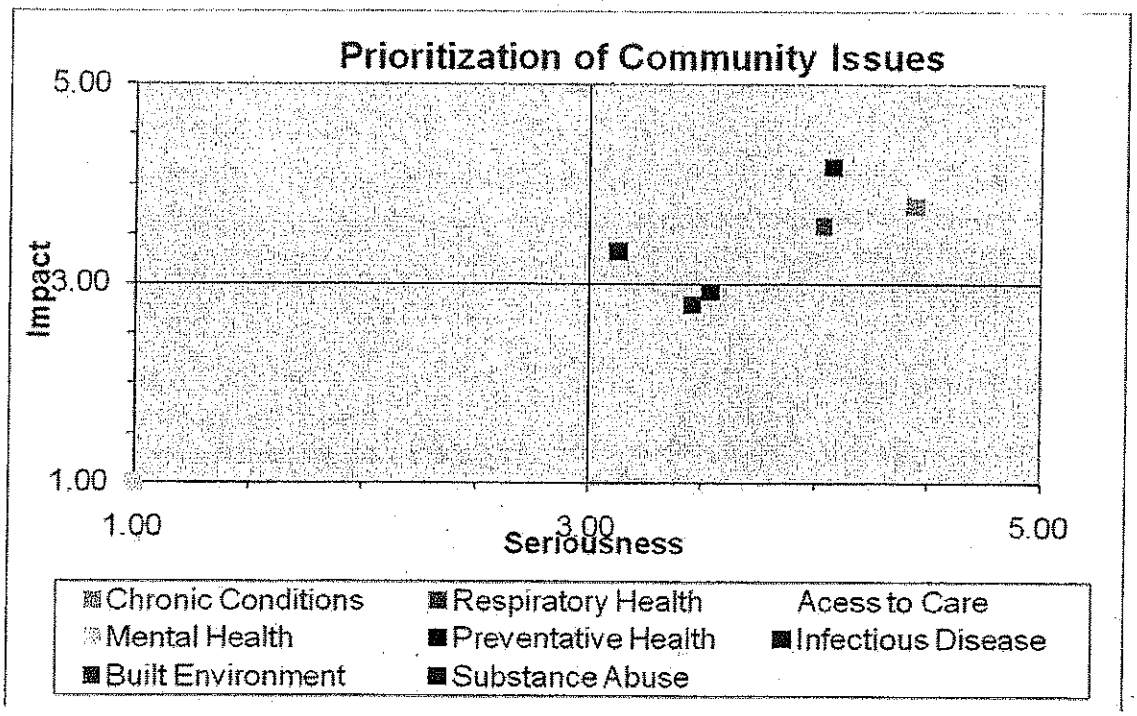
Participants were asked to rate each need based on two criteria: seriousness of the issue and the ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. The following tables reveal the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)
Access to Care	4.46	3.96
Preventative Health	4.08	4.17
Chronic Conditions	4.44	3.79
Respiratory Health	4.04	3.58
Mental Health	4.00	3.25
Infectious Disease	3.13	3.33
Substance Abuse	3.54	2.92
Built Environment	3.46	2.79

The priority area that was perceived as the most serious was Access to Care (4.46 average rating), followed by Chronic Conditions (4.44 average rating). The ability to impact Preventative

Health was rated the highest at 4.17, followed by Access to Care with an impact rating of 3.96. The matrix below outlines the intersection of the seriousness and impact ratings. The scores are graphed below in Figure A1. The needs in the upper right quadrant are rated the most serious and with the greatest ability to impact.

Figure A1: Results of Seriousness and Impact Voting



NEEDS THAT THE BACKUS HEALTH SYSTEM WILL ADDRESS

Backus reviewed feedback from the Prioritization Session, along with its current services and programs, resources and areas of expertise, and other existing community assets, to determine which identified needs it would address.

The following needs were identified by Backus as its priority areas for the following three-year cycle:

- **Access to Care**
- **Preventative Health** (including chronic and infectious disease, respiratory health, and obesity)
- **Mental Health** (including substance abuse)

STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

In support of the 2013 Community Health Needs Assessment, and ongoing community benefit initiatives, Backus plans to implement the following strategies to impact and measure community health improvement.

Access to Quality Health Care

Backus supports the Institute for Healthcare Improvement's "Triple Aim" assertion that providing access to the right care, in the right setting, at the right time improves health status and outcomes.

By utilizing the quantitative and qualitative data gathered as part of the 2012-2013 Community Health Needs Assessment, Backus plans to enhance and increase access to care for vulnerable populations in Eastern Connecticut. Backus expects that by providing access to primary care in community-based settings, a reduction in Emergency Department utilization among affected populations will occur. Backus plans to leverage existing Access to Care programs and initiatives to meet this goal.

GOAL: Increase access to quality health care for Eastern Connecticut residents, through the Backus Health System Access to Care program (a partnership with United Community & Family Services), and the My Health Direct system.

OBJECTIVES:

- Increase the number of residents who have access to primary care providers
- Increase utilization of free and low cost health care services

KEY INDICATORS:

- #/% of adults who are connected to a medical home via My Health Direct
- #/% of adults who attend scheduled appointments through My Health Direct
- #/% of adults who have health coverage, after participating in the Access to Care program
- #/% of Emergency Department visits for non-emergency care, in those patients who participated in Access to Care or received a My Health Direct appointment
- #/% of hospital admissions or readmissions in those patients who participated in Access to Care or received a My Health Direct appointment

BACKUS HEALTH SYSTEM STRATEGIES:

- ***Identify and enroll uninsured individuals in health coverage programs***
- ***Assist individuals with no primary care provider with establishing a primary medical home.***
  - **Access to Care,** A partnership with the United Community and Family Services, which provides on-site screenings, during first and second shifts, at the Emergency Department, the Plainfield Backus Emergency Care Center, and the Backus Health Centers for Medicaid programs, the Supplemental Nutrition Assistance Program, Prescription Assistance Program, and other health and human services. The Access to Care program also provides education to patients regarding the importance of establishing a primary care medical home, and can create appointments for patients with a primary care physician.
  - **My Health Direct,** An online tool the Hospital subscribes to that allows hospital staff to create follow up appointments with community providers for patients post discharge from the Emergency Department, an inpatient unit, or an outpatient program. My Health Direct is used throughout the Backus Health System, including in the Emergency Departments, Care Management, Behavioral Health, the Cardiac Unit, the Mobile Health Resource Center Van, and the Backus CareVan.

- ***Provide free or reduced cost primary care services.***
  - **Partnerships with Generations Family Health Centers,** A fully-funded 501(c)3 Federally Qualified Health Center with locations throughout Eastern Connecticut.
  - **Partnerships with United Community & Family Services,** A 501(c)3 Federally Qualified Health Center look-alike, with locations throughout New London and Windham Counties.

EXISTING COMMUNTY ASSETS AND RESOURCES:

- Backus CareVan
- Backus Mobile Health Resource Center (MHRC)
- United Community & Family Services (UCFS)
- Generations Family Health Centers
- Thames Valley Council for Community Action (TVCCA)
- St. Vincent de Paul Place
- Uncas Health District (UHD)
- Northeast District Department of Health

Preventative Health, Including Chronic & Infectious Disease, Respiratory Health, and Obesity

Backus plays a leadership role in preventative health in Eastern Connecticut. Acknowledging chronic disease conditions that were identified in the CHNA, (Diabetes, Cardiovascular Disease, Lung Cancer, Asthma, Hepatitis C, and HIV/AIDS) and their relationship to diet, exercise, smoking, and other preventable risk factors, Backus will seek to reduce chronic conditions by focusing on education and awareness programs. A reduction in disease rates will likely not be seen in the initial three-year cycle, however, Backus expects that success in reducing the prevalence of residents who are at risk for chronic conditions and better managing current chronic conditions will positively impact chronic disease in the future.

GOAL: Reduce risk factors that contribute to disease, and management for patients with a diagnosis of chronic disease.

OBJECTIVES:

- Reduce overweight and obesity rates in patients enrolled in a Backus Health System weight loss initiative
- Reduce prevalence of smoking among adults enrolled in a Backus Health System smoking cessation or prevention initiative
- Reduce Emergency Department visits for unmanaged chronic conditions including Asthma, Heart Failure, and Diabetes among individuals enrolled in a Backus Health System chronic disease management initiative

KEY INDICATORS:

- #/% of patients who attend Backus Health System health improvement programs
- #/% ED/hospital admissions/readmissions for chronic conditions, among individuals enrolled in a Backus Health System Chronic Disease Management program
- #/% of individuals participating in free or reduced cost health screenings sponsored by the Backus Health System

BACKUS HEALTH SYSTEM STRATEGIES:

- ***Provide education and opportunities to improve diet and increase physical activity***
  - **Healthy Community Initiative** — focusing on identifying uninsured individuals and families, providing health screenings, and mobile health care to improve access to care and the overall health of the community residents. Backus will partner with organizations like the United Way, the Mobile Food Pantry, and schools to build upon existing assets to reach residents through established resources and channels of communication.
  - **Backus StrongKids** — a pilot program in the local schools focusing on education on healthy eating and exercise.

- **Life Happens** — a collaborative program in a local technical high school with monthly presentations on physical and mental health topics, based on student survey results.
- **Rx For Health** — a program that allows participating physicians to "prescribe" farmers' market fare for children who are obese or at risk to be obese.
- **Enjoy LIFE (Lifelong investment in Fitness & Exercise)** — a collaboration between Backus Hospital and Plainfield Recreation Department to promote healthy lifestyle changes for the people of Windham County.
- **Medical Weight Loss Center and Wellness Program** — a 17-week comprehensive, multi-disciplinary approach to weight loss for those individuals seeking significant weight loss and lifestyle changes to improve long-term health and overall wellness.The program includes education and support from registered dietitians, physical therapists and behavioral health specialists. Participants receive one-on-one consults as well as 16, one-hour education classes.

- ***Provide education and opportunities to prevent and manage chronic disease***
  - **Backus Hospital Heart Failure and Wellness Program** — designed to meet special needs of adult patients and families suffering from heart failure. The goal of the program is to prolong life and improve patient's quality of life.
  - **Smoking Cessation** — a seven-week, eight-session course, ALA "Freedom from Smoking" cessation classes, offered six times per year.
  - **Asthma Initiative** — a program designed to teach participants management skills to keep their asthma under control, have fewer symptoms and gain a better quality of life.
  - **Outpatient Diabetes Self Management Program** — provides comprehensive care through a collaboration between a multi-disciplinary team and primary care provider. The goal is for the person with diabetes to be involved in the establishment of a management program based on the individual's needs.

- ***Support preventative care programming through "hot-spotting" to determine health care conditions and utilization by geography***
  - **Connecticut Hospital Association *ChimeMaps,*** Interactive GIS-mapping software used to evaluate hospital, health, and population data for the purposes of strategic planning and business development, community analysis and population health assessment. The *ChimeMaps* tool is used to provide targeted outreach in neighborhoods and communities, by analyzing hospital utilization for specific diagnoses. The tool gives Backus Health System the ability to address health needs proactively, providing preventative care to reduce the need for residents to seek care in an acute setting.

EXISTING COMMUNITY ASSETS AND RESOURCES:

- Backus CareVan
- Connecticut Hospital Association (CHA)
- Backus Mobile Health Resource Center (MHRC)
- Uncas Health District (UHD)
- United Community & Family Services (UCFS)
- Generations Family Health Centers
- Thames Valley Council for Community Action (TVCCA)
- St. Vincent de Paul Soup Kitchen
- New London County Food Policy Council
- Children First (Norwich, Griswold, Colchester)
- Parks and Recreation departments (Norwich, Griswold, Colchester, Plainfield, Sprague)
- Public School Systems (Norwich, Griswold, Colchester, Plainfield, Sprague)
- Northeast District Department of Health

Mental Health and Substance Abuse

GOAL: Improve the access to, and coordination of, mental health services and substance abuse treatment for residents of Eastern Connecticut.

OBJECTIVES:

- Improve collaboration between community agencies providing residential and outpatient substance abuse treatment programs
- Increase awareness and utilization of Access to Care and Prescription Assistance Programs among Emergency Department psychiatric clinicians
- Increase community outreach and education efforts focusing on mental health and substance abuse

KEY INDICATORS:

- #/% of Emergency Department psychiatric patients who are referred to the Access to Care program by an Emergency Department psychiatric clinician prior to discharge
- #/% of psychiatric patients who are referred and accepted into regional substance abuse programs
- # of community education and outreach programs focused on mental health and substance abuse

BACKUS HEALTH SYSTEM STRATEGIES:

- ***Increase collaboration between community agencies that offer residential and outpatient substance abuse treatment programs***
  - **Center for Mental Health** — an outpatient component of the full continuum of care in the Department of Psychiatric Services. Provides individual and group assessments and therapy sessions, as well as medication evaluation and treatment visits.
  - **Partial Hospitalization Program** — provides intensive psychiatric treatment to patients who are experiencing acute symptoms that require a highly structured environment in which to receive treatment. Partial hospitalization — which is offered for five hours a day, for up to five days per week — can follow a course of inpatient treatment, or to avoid inpatient treatment altogether.
  - **Inpatient Psychiatric Services** — an 18-bed unit that provides high quality inpatient services to individuals with any psychiatric disorder including major depression, schizophrenia, bipolar disorder, anxiety disorders, postpartum psychosis, as well as those with dual diagnosis of substance abuse and psychiatric illness.

- ***Reduce identified barriers to accessing mental health and substance abuse services for those patients being discharged from the Emergency Department***
  - **Access to Care** — a partnership with the United Community & Family Services, which provides on-site screenings, during first and second shifts, at the Backus Emergency Department, the Plainfield Backus Emergency Care Center, and the Backus Health Centers for Medicaid programs, the Supplemental Nutrition Assistance Program, Prescription Assistance Program, and other health and human services. The Access to Care program also provides education to patients regarding the importance of establishing a primary care medical home, and can create appointments for patients with a primary care physician.
  - **Prescription Assistance** — a service offered by United Community and Family Services through the Access to Care program, in addition to Generations Family Health Center, that assists low-income and uninsured patients enroll in prescription assistance programs to receive pharmaceuticals at no or low cost.
  - **Connecticut Hospital Association *ChimeMaps*** — interactive GIS-mapping software used to evaluate hospital, health, and population data for the purposes of strategic planning and business development, community analysis and population health assessment. The *ChimeMaps* tool is used to provide targeted outreach in neighborhoods and communities, by analyzing hospital utilization for specific diagnoses. The tool gives Backus the ability to address health needs proactively, providing preventative care to reduce the need for residents to seek care in an acute setting.
  - **Mental Health First Aid** — a 12-hour internationally recognized, interactive training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Mental Health First Aiders learn to apply a 5-step action plan to:
    - help someone through a panic attack
    - engage with someone who may be suicidal
    - support a person experiencing psychosis
    - help an individual who has overdosed

- ***Educate the community and reduce stigma associated with mental health and substance abuse through community outreach efforts***
  - **Life Happens** — a collaborative program in regional technical high school with monthly presentations on physical and mental health topics, based on student survey results.
  - **Tics and Tourette's in Teens and Children** — an educational program for parents focusing on recognition and treatment in youth.
  - **Thrive4Life** — a collaborative initiative with Norwich Public Schools to discuss mental health issues identified by a youth survey.

- **Evening Educational Seminars and Program** — various educational opportunities open to the public and free of charge focusing on anxiety, depression, and bullying.
- **Autism Awareness in Public School Nurses and Staff** — workshops on identifying and managing Autism in school age children.
- **Emergency Management of the Autistic Patient** — a workshop designed for Emergency Department clinical staff to become familiar with techniques to better manage autistic patients.
- **Partnership with University of Connecticut Study** — coordination of local pediatric practices in Eastern Connecticut participating in an Autism Early Detection Study to evaluate the use of a new screening tool.

- ***Improve the discharge process and care coordination for homeless psychiatric patients by utilizing existing models within the region***
  - **Primary Care at St. Vincent de Paul Place** — free primary care is offered at the St. Vincent de Paul Place Soup Kitchen every Monday in partnership with Generations Family Health Center.

EXISTING COMMUNTY ASSETS AND RESOURCES:

- Natchaug Hospital, including the Care Plus Program
- Stonington Institute
- SouthEastern Council on Alcohol and Drug Dependence (SCADD)
- Lebanon Pines
- SouthEastern Regional Action Council (SERAC)
- Norwich Hospitality Center
- SouthEastern Mental Health Authority (SMHA)
- Danielson Shelter
- St. James' Place, New London
- Reliance House

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

By focusing efforts the cross-cutting issues of **Access to Care, Preventative Health (including chronic and infectious disease, respiratory health, and obesity)**, and **Mental Health (including substance abuse)**, the Backus Health System will take a comprehensive approach to addressing eight of the nine most urgent needs in the communities it serves. As with all Backus Health System programs, it will continue to monitor community needs and adjust programming and services accordingly.

Backus recognizes that there are a numerous partners in the community that can help to improve the identified health needs. In some cases, partners are better suited to lead the initiative to impact certain health needs. Such is the case with the built environment. Backus Health System will support ongoing and new efforts to improve the community's physical environment and infrastructure to improve safety, the transportation system, and create more opportunities for physical activity, but sees its primary role as allocating resources to address direct health needs for the community.

To secure commitment of support from community partner agencies, Backus will seek formal letters of support from community agencies that participated in the study. These letters of support verify that community partners are willing to work together to address the priority areas identified through the Needs Assessment, and acknowledge that Backus cannot address all concerns alone.

Exhibit 26

FAQs

Exploration of an affiliation by

BACKUS HEALTH SYSTEM and Hartford HealthCare

February 3, 2012

Here are some of the more frequently asked questions, and some answers, about a proposed affiliation between Backus and Hartford HealthCare.

As always, if you have other questions, please feel free to contact your manager or a Human Resources representative.

[1] What is this proposal about?

- Backus and Hartford HealthCare have announced the first stage of what will be a multi-step process. If completed, the two healthcare organizations — which include the hospitals and their other entities, like home healthcare and clinics — would formally affiliate.
- If that happens, Backus would become a Hartford HealthCare Partner — a member of the Hartford HealthCare network, like Hartford Hospital, the Hospital of Central Connecticut, MidState Medical Center and Windham Hospital.
- Nothing will become official until the Boards of both organizations give their approval, and that is expected to take several months.
- In the meantime, the Boards will be studying whether an affiliation is in the best interests of their respective patients, doctors, employees and the communities they serve.

[2] Why are the two health systems thinking of affiliating?

- The healthcare landscape is changing fast. In this challenging environment, healthcare organizations are more likely to thrive when they create formal partnerships to work together.
- Affiliations enable organizations to share the knowledge and expertise of physicians, nurses and other staff members and give patients easier access to a wider range of services and treatments.
- As part of Hartford HealthCare, Backus patients would benefit from a more coordinated system to provide seamless coordination of top-quality services — this includes primary care, laboratory services, complex hospital care, home care and other services.
- Together, Hartford HealthCare and Backus would be able to serve more communities to deliver excellent, personalized, coordinated care.

[3] Would this be a sale? Is Backus Hospital or Backus Health System in financial trouble?

- The proposed process would lead to an affiliation, not a sale. So, Backus would not be purchased by Hartford HealthCare. Instead, if the process is completed, it is expected that Hartford HealthCare would become the corporate member of Backus Corporation. We also expect that local operational decisions would continue to be made at Backus.
- Backus has been, and continues to be, successful operationally and financially. As we have said, our success is due to the combined efforts of our staff.
- The proposed affiliation is a strategic decision to sustain the viability of an integrated healthcare delivery system for eastern Connecticut.

[4] What is happening between Backus and Hartford HealthCare and what could happen next?

- Representatives of the two healthcare systems have just signed a Letter of Intent. This expresses their willingness to work with each other to share information as they continue to explore affiliation.
- Both systems will exchange information to provide a deeper understanding of each other's organizations. This process, called "due diligence," will help determine if an affiliation is in everyone's best interests.
- If successful, this would lead to a Memorandum of Understanding that would describe the general principles for reaching a final binding agreement for an affiliation.
- The governing authorities (the Boards of Directors) for both organizations must approve a final agreement. Affiliations of this nature also require state and federal regulatory approvals.
- This entire process typically takes several months. We will continue to keep you updated.

[5] Would Backus remain a not-for-profit hospital?

- Yes. Hartford HealthCare and all its hospitals are community-based not-for-profit organizations.
- If the health systems become affiliated, Backus would retain its not-for-profit status, continue to provide community benefits, and continue to solicit and accept donations to support its mission.

[6] Why did Backus select Hartford HealthCare? What does Hartford see in Backus?

- Hartford HealthCare and Backus share similar missions: to improve the health and healing of the communities they serve.
- We already work together. Residents have been the beneficiaries of a highly successful 12-year partnership between Backus and Hartford Hospital — the state's LIFE STAR helicopter program.
- Both Backus and Hartford HealthCare are interested in advancing opportunities in eastern Connecticut to coordinate care, enable sharing of existing expertise, and new levels of capabilities and technologies.
- Hartford HealthCare views Backus as a strong potential partner, with clinical excellence, strong leadership and a belief in patient-centered care.
- Hartford HealthCare wants to ensure that Backus's tradition of providing the highest levels of care at the local level would be preserved and enhanced under an affiliation.

[7] What would affiliation mean for Backus employees?

- If an affiliation were approved, day-to-day operations would continue as usual, and you would be expected to continue to perform your job as you always have.
- At other health systems that have affiliated with Hartford HealthCare, integration teams have been developed, with representatives from Hartford as well as with the new partner.

[8] How will we be kept informed?

- Backus will conduct a series of meetings with local stakeholders — patients, employees, physicians, Corporators, organizations that work with Backus, elected officials and regional leaders — to explain the process, answer questions, and provide updates.
- We will also report significant milestones about the proposed affiliation in *HospiTell,* and on the hospital's website, www.backushospital.org

THANK YOU.

FAQs

UPDATE

Exploration of an affiliation by

BACKUS HEALTH SYSTEM and Hartford HealthCare

May 24, 2012

Here are some of the more frequently asked questions, and some answers, about a proposed affiliation between Backus and Hartford HealthCare.

As always, if you have other questions, please feel free to contact your manager or a Human Resources representative.

[1] What is this proposal about?

- Since February, Backus and Hartford HealthCare have been exploring a formal affiliation of the two healthcare organizations.
- This partnership would include the hospitals and their other entities, like home healthcare and clinics.
- If that happens, Backus would become a Hartford HealthCare Partner — a member of the Hartford HealthCare network, like Hartford Hospital, the Hospital of Central Connecticut, MidState Medical Center and Windham Hospital.

[2] What has happened so far, and what may happen next?

- Both organizations have signed a Letter of Intent, announcing their interest to learn more about an affiliation. That was signed the first week of February.
- Since then, the Boards of both healthcare systems created subcommittees to study whether an affiliation would be in the best interests of the individuals and communities they serve.
- This review included "due diligence," in which both hospitals requested and examined information about each other, and meetings during which they created a framework for how a partnership would work.
- Both Boards approved the Memorandum of Understanding, and will now work on Definitive Agreements — a final binding agreement for an affiliation. That is the final step before state and federal regulatory approvals are sought.
- We expect to have definitive agreements by July; the regulatory process typically takes several months.

[3] Why are the two health systems thinking of affiliating?

- The healthcare landscape is changing fast. In this challenging environment, healthcare organizations are more likely to thrive when they create formal partnerships to work together.
- Affiliations enable organizations to share the knowledge and expertise of physicians, nurses and other staff members and give patients easier access to a wider range of services and treatments.
- As part of Hartford HealthCare, Backus patients would benefit from a more coordinated system to provide seamless coordination of top-quality services — this includes primary care, laboratory services, complex hospital care, home care and other services.
- Together, Hartford HealthCare and Backus would be able to serve more communities to deliver excellent, personalized, coordinated care — close to home.

[4] Would this be a sale? Is Backus Hospital or Backus Health System in financial trouble?

- Backus would not be purchased by Hartford HealthCare. If the process is completed, it is expected that Hartford HealthCare would become the corporate member of Backus Corporation; local operational decisions will continue to be made at Backus.
- Backus has been, and continues to be, successful operationally and financially. As we have said, our success is due to the combined efforts of our staff.
- The proposed affiliation is a strategic decision to sustain the viability of an integrated healthcare delivery system for eastern Connecticut.

[5] Would Backus remain a not-for-profit hospital?

- Yes. Hartford HealthCare and all its hospitals are community-based not-for-profit organizations.
- If the health systems become affiliated, Backus would retain its not-for-profit status, continue to provide community benefits, and continue to solicit and accept donations to support its mission.

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- Both Backus and Hartford HealthCare are interested in advancing opportunities in eastern Connecticut to coordinate care, enable sharing of existing expertise, and new levels of capabilities and technologies.
- Hartford HealthCare views Backus as a strong potential partner, with clinical excellence, strong leadership and a belief in patient-centered care.
- Hartford HealthCare wants to ensure that Backus's tradition of providing the highest levels of care at the local level would be preserved and enhanced under an affiliation.

[7] What would affiliation mean for Backus employees?

- If an affiliation were approved, day-to-day operations would continue as usual, and you would be expected to continue to perform your job as you always have.
- At other health systems that have affiliated with Hartford HealthCare, integration teams have been developed, with representatives from Hartford as well as with the new partner.

[8] How will we be kept informed?

- We have already conducted a series of meetings with staff and physicians, and these will continue.
- We will also meet with local stakeholders — patients, employees, physicians, Corporators, organizations that work with Backus, elected officials and regional leaders — to explain the process, answer questions, and provide updates.
- We will also report significant milestones about the proposed affiliation in *HospiTell,* and on the hospital's website, www.backushospital.org/affiliation

THANK YOU.

Exhibit 27

building our
CONNECTIONS

Hartford HealthCare

Feb. 3, 2012

I'm very pleased to announce that consistent with our vision to continue to build a nationally recognized health care system that provides excellent, coordinated care to patients in their local communities, Hartford HealthCare and Backus Corporation have entered into a non-binding Letter of Intent to affiliate.

Hartford HealthCare and Backus have had a strong relationship for many years, including sharing the LIFESTAR air-ambulance program. Like the current members of HHC, Backus has a century-old heritage of community-based care and shares our mission and vision.

If the affiliation is approved, Backus, based in Norwich, would become a Hartford HealthCare partner like The Hospital of Central Connecticut, Hartford Hospital, MidState Medical Center, Natchaug Hospital, Windham Hospital and other HHC member organizations. The integration of HHC and Backus would be beneficial for everyone. Our organizations would share the knowledge and expertise of physicians, nurses and other staff members, and patients would have easier access to a wider range of services and treatments. The affiliation also would allow the sharing of innovative technology and enable cost reductions through improved safety, quality and larger-volume purchase discounts. In addition, staff members would have greater opportunities for professional development in a larger health care system.

Backus Corporation is the parent of the Backus Healthcare System, which includes The William W. Backus Hospital, Backus Health Care Inc., Backus Home Health Care, Backus Physician Services, Community Medical Partners, CONNCare and WWB Corporation. Backus would bring tremendous competencies to Hartford HealthCare that will strengthen us as we work to serve our communities.

Backus, which has a legacy of high-quality patient care, very thoughtfully selected Hartford HealthCare as a potential partner. This illustrates that we are on the right track as the region's leading integrated health care system. Together, we can do great work for those who need us most, especially the underserved in eastern Connecticut.

The Letter of Intent begins a multi-step process expected to take several months. HHC and Backus will conduct focus groups with community members, volunteers, staff members, physicians, corporators, volunteers and others to determine if the affiliation would be in everyone's best interest. If HHC and Backus decide to move forward, we will work together to write a Memorandum of Understanding and then a Definitive Agreement, which must be approved by both boards of directors and state and federal agencies. We will keep you posted on further developments.

Sincerely,

Elliot Joseph
President and CEO

The William W. Backus Hospital

David A. Whitehead
President and
Chief Executive Officer

February 3, 2012

Dear Colleagues:

I am pleased to announce that the Backus Corporation Board of Directors has approved exploring a formal affiliation with Hartford HealthCare. A copy of our press release and a question-and-answer sheet are included. There is more information on our website, backushospital.org.

The Board has approved a non-binding Letter of Intent. At the outset, let me underscore two words in our announcement: **"non-binding"** and **"exploring."** We are at the very beginning of a process that is expected to take several months. At this point, the signing of the Letter of Intent allows the Backus Corporation and Hartford HealthCare Corporation to conduct a round of initial due diligence. As is customary, and required in these discussions, Backus and all other parties signed confidentiality agreements. For that reason, no member of the Board or Senior Leadership can discuss which hospitals and systems were under consideration, or which partners we did not select. It is fair to say, however, that each proposal, visit and interview provided a valuable perspective about the direction of healthcare in our region and nation.

This is a crucial first step, as it can help us, and our colleagues in Hartford, further determine whether an affiliation would be in the best interests of our patients, communities, providers, and partners. If we proceed past that point, the next task would be to negotiate a Memorandum of Understanding. This would lead to a second phase of more intensive due diligence and help us clearly define the objectives for an affiliation.

All of this would lead to a Definitive Agreement. And none of that will happen without approval by the governing Boards of both organizations.

So, yes, there is a lot of work to do. Allow me to be absolutely clear at the outset:

- This is not a "done deal."
- This is not the sale of our hospital's assets.
- This is the start of an exploratory process.

For Backus patients, the affiliation would mean access to a broader regional delivery system of care — with the availability of expanded primary, ambulatory and specialty clinical services. This partnership would not preclude the continuation of other clinical affiliations we have enjoyed.

The Board and senior management at Backus are fully committed to a transparent process — one that addresses questions, and deals proactively with concerns as we move forward. That is why, over the next several months, we will conduct a series of focus groups with key stakeholders: our employees, Medical Staff members, volunteers, Corporators, civic leaders, other health and human services providers, and the community at large. We will have the opportunity to discuss this further at our next round of quarterly staff meetings in early March.

Thank you for all you do in service to our patients,

326 Washington Street • Norwich, Connecticut • 06360 • Tel: (860) 892-2722 • Fax: (860) 823-6329

The William W. Backus Hospital

February 3, 2012

Dear Corporator:

We are pleased to announce that the Backus Corporation Board of Directors has approved exploring a formal affiliation with Hartford HealthCare. A copy of our press release and a question-and-answer sheet for our employees and medical staff are included with this mailing. There is more information on our website, backushospital.org.

This is a significant development, and we would like to review with you some of the background and offer some context for this decision.

The Board has approved a non-binding Letter of Intent. At the outset, let us underscore two words in our announcement: **non-binding** and **exploring**. We are at the very beginning of a process that is expected to take several months. At this point, the signing of the Letter of Intent allows the Backus Corporation and Hartford HealthCare Corporation to conduct a round of initial due diligence.

This is a crucial first step. It can help us, and our colleagues in Hartford, further determine whether an affiliation would be in the best interests of our patients, communities, providers, and partners. If we proceed past that point, the next task would be to negotiate a Memorandum of Understanding. This would lead to a second phase of more intensive due diligence and help us clearly define the objectives for an affiliation.

All of this would lead to a Definitive Agreement. And none of that will happen without approval by the governing Boards of both organizations.

So, yes, there is a lot of work to do. Allow us to be absolutely clear at the outset:

- This is not a "done deal."
- This is not the sale of our hospital's assets.
- This is the start of an exploratory process.

As we discussed at our Annual Meeting in November, Backus is well positioned for today's healthcare landscape. But as we also noted, that landscape is rapidly changing.

Backus, led by its Board, initiated this process. Thanks to the hard work, dedication and vision of the members who serve on our Board and throughout our organization, Backus is well positioned — today. We have a talented and diversified medical staff, a solid team on the frontlines and in leadership roles, resulting in solid performance organizationally and financially.

All of this — combined with our hospital's programs, technology, services and reputation — make Backus successful. And yet, for all of this, we know we will not be able to sustain the care this community needs — and deserves — in the face of sweeping changes in healthcare. These changes are driving hospital affiliations and consolidations in Connecticut and nationwide.

For more than a year, our Board has been testing this assumption: "Based on all we know, and all we can learn: Will Backus be able to sustain a viable healthcare delivery system for Eastern Connecticut in its current state?"

The answer: "For a while — longer than most stand-alone community hospitals — *perhaps*. For the long run — *no*."

You don't make a decision to start a process like this without significant research and extensive fact-finding. Our Board has provided that diligence and dedication to study the landscape and select what we believe is the best strategic option. These have been the guiding principles;

* **A vision:** "To be the leading high-value healthcare system for eastern Connecticut."
* **A goal:** "To develop a sustainable system of integrated healthcare delivery at the local level."

Using national experts Kaufman Hall Associates as our consultants, we selected a number of prospective partners. They run the gamut of organizational models. As is customary, and required in these discussions, Backus and all other parties signed confidentiality agreements. For that reason, neither of us — nor any other member of the Board or Senior Leadership — can discuss which hospitals and systems were under consideration, or which partners we did not select. It is fair to say, however, that each proposal, visit and interview provided a valuable perspective about the direction of healthcare in our region and nation.

The Board's Strategic Options Subcommittee selected Hartford HealthCare as the recommended partner for Backus.

For Backus patients, the affiliation would mean access to a broader regional delivery system of care — with the availability of expanded primary, ambulatory and specialty clinical services. This partnership would not preclude the continuation of other clinical affiliations we have enjoyed.

The Board and senior management at Backus are fully committed to a transparent process — one that addresses questions, and deals proactively with concerns as we move forward. That is why, over the next several months, we will conduct a series of focus groups with key stakeholders: our employees, medical staff members, volunteers, Corporators, civic leaders, other health and human services providers, and the community at large. We hope you will be able to share your input.

With this announcement, there is little doubt that we stand at the beginning of a new road. For all of us, the objective and the challenge can be easily summarized: How do we best build a system of sustainable care for our patients— as our founders expected, and as our mission requires? That mission does not call for Backus to be independent. Rather, and significantly, it directs that we provide "a continuum of high-quality healthcare" in the service of individuals in eastern Connecticut.

Holding fast to that core vision and that mission in this time of challenge and change is the task. We have proposed an answer. Together, we look forward to the results.

Thank you, and we look forward to talking with you more.

Peter V. Disch
Chairman, Board of Directors

David A. Whitehead
President and Chief Executive Officer

BACKUS HEALTH SYSTEM

Hartford HealthCare

For Immediate Release

Contacts:
Keith Fontaine
Vice President and Chief Administrative Officer
860-608-2169 (cell)
kfontaine@wwbh.org

Rebecca Stewart
Director of Media Relations
860-726-8283 (cell)
rstewart@harthosp.org

Backus and Hartford HealthCare to explore affiliation

NORWICH (Feb. 3, 2012) — Backus Corporation and Hartford HealthCare Corporation have jointly announced that they are exploring a formal affiliation of the two healthcare systems.

The two organizations entered into a non-binding Letter of Intent, beginning a process that is expected to take several months. If successful, Backus would become a member of the Hartford HealthCare network, which includes Hartford Hospital, the Hospital of Central Connecticut, MidState Medical Center, Natchaug Hospital, Windham Hospital and a wide spectrum of additional pre- and post-acute health services.

Backus Corporation is the parent of the Backus Health System, which includes The William W. Backus Hospital, Backus Health Care, Backus Home Health Care, Backus Physician Services, Community Medical Partners, CONNCare and the WWB Corporation.

The Backus Board of Directors has been reviewing opportunities for strategic alignment for more than a year, and initiated the process of seeking potential partners. A six-member subcommittee of the 15-member Board researched several proposals in depth, and the full Board voted to explore a formal integration with Hartford HealthCare.

"Backus and Hartford HealthCare have enjoyed a long and beneficial partnership for many years. There is no better example of this than the LIFE STAR program," said David Whitehead, Backus President and Chief Executive Officer. "I am proud to be associated with such a forward-thinking Board that has chosen to explore this strategic partnership to create a sustainable system of integrated, high-value healthcare for the regional community of eastern Connecticut."

An affiliation would enable both organizations to share the knowledge and expertise of their staffs and physicians, and give patients easier access to a wider range of services and treatments.

"We believe Backus would be a truly exceptional partner," said Elliot Joseph, President and Chief Executive Officer of Hartford HealthCare. "It is a highly successful organization with an excellent medical staff, a strong management team, dedicated employees, and a firm commitment to providing high-quality care to the communities it serves. Like the current members of Hartford HealthCare, Backus shares a century-old heritage of community-based care. They share our mission and vision. Coming together, we strengthen our ability to serve the communities of Eastern Connecticut for the next 100 years and beyond.

As part of the process, both health systems will conduct focus groups with key stakeholders — Backus employees, members of the medical staff, its Corporators, volunteers, government and community leaders, providers of other health and human services and the community-at-large.

"We want to involve all stakeholders in this discussion as we explore affiliation," Mr. Whitehead said. "This represents a unique opportunity to combine complementary strengths, and create an integrated health system for our region."

Board Chairman Peter V. Disch said the goal of the process is to position Backus to meet the healthcare needs of the community, in the midst of a rapidly changing healthcare landscape.

"Our community needs a system of patient care to meet this region's healthcare needs for years to come," Mr. Disch said. "The Board has studied this issue, and we believe a partnership with Hartford HealthCare could create a model to meet those changing needs, right here in eastern Connecticut."

The signing of a Letter of Intent is the first of several steps before an affiliation can be created. Both organizations will perform due diligence to determine if an affiliation would be in the best interest of patients and communities served by the institutions. If there is agreement to move forward, a Memorandum of Understanding followed by a Definitive Agreement would be created. This final step would require the approval of their respective governing Boards, and regulatory approval by appropriate state and federal agencies.

###

***Hartford HealthCare**'s members include Hartford Hospital (an 867-bed regional referral center that is one of the largest teaching hospitals and tertiary care centers in New England), and three acute care community hospitals: the Hospital of Central Connecticut (414 beds, with campuses in New Britain and Southington), MidState Medical Center (144 beds, in Meriden), and Windham Hospital (130 beds, in Willimantic). Other system member providers include two regional behavioral health centers, a statewide clinical laboratory operation, a large primary care physician practice group, a large multi-specialty surgical group, a regional home care system, long-term care facilities and a physical therapy and rehabilitation network.*

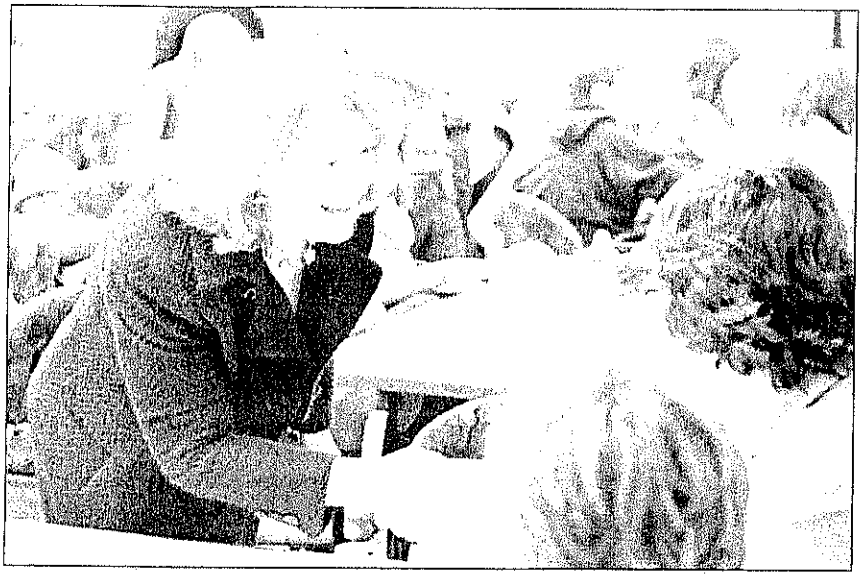
***The Backus Health System** includes The William W. Backus Hospital, a 213-bed acute care hospital that is the only state-licensed Trauma Center east of the Connecticut River; a home healthcare agency; primary care and walk-in urgent care centers in Ledyard, Plainfield, Montville and Colchester; Backus Physician Services, a multi-specialty surgical group; and Community Medical Partners, a medical foundation. Backus is one of two sole members of Hospice Southeastern Connecticut, and has an ownership interest in dialysis centers in the region.*

Hospitell

VOL. 41, NO. 5

FEBRUARY 3, 2012

Susan Keane Baker speaks



National motivational speaker Susan Keane Baker greets employees before the start of one of her presentations Thursday at Backus.

Good patient experience requires personal touch

National speaker makes impression at Backus

When 13-year-old Natalie Gilbert forgot the words to the Star Spangled Banner in the midst of her performance at a National Basketball Association playoff game with 20,000 fans, the results could have been disastrous.

> *"Exceptional people don't hesitate."*
>
> **Susan Keane Baker**

Instead, former NBA head coach and player Maurice Cheeks placed a hand on her shoulder and the youngster received a rousing ovation.

That unsolicited act of kindness served as a cornerstone of Susan Keane Baker's presentations at Backus Thursday. The nationally known speaker, author and patient experience guru spoke to hundreds of Backus employees throughout the day, and her talks continued on Friday for night shift employees and the

Backus, Hartford HealthCare to explore affiliation

Backus Corporation and Hartford HealthCare Corporation have jointly announced that they are exploring a formal affiliation of the two healthcare systems.

The two organizations entered into a non-binding Letter of Intent, beginning a process that is expected to take several months. If successful, Backus would become a member of the Hartford HealthCare network, which includes Hartford Hospital, the Hospital of Central Connecticut, MidState Medical

See HARTFORD, page 4

Inside

- Read a letter from Backus President and Chief Executive Officer Dave Whitehead. **Dave's Desk, page 5.**

To learn

- To read a Q&A about the affiliation with Hartford Healthcare, visit the **Digital Dialog blog** on the Backus Intranet.

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spectrum of additional pre- and post-acute health services.

Backus Corporation is the parent of the Backus Health System, which includes The William W. Backus Hospital, Backus Health Care, Backus Home Health Care, Backus Physician Services, Community Medical Partners, CONNCare and the WWB Corporation.

The Backus Board of Directors has been reviewing opportunities for strategic alignment for more than a year, and initiated the process of seeking potential partners. A six-member subcommittee of the 15-member Board researched several proposals in depth, and the full Board voted to explore a formal integration with Hartford HealthCare.

"Backus and Hartford HealthCare have enjoyed a long and beneficial partnership for many years. There is no better example of this than the LIFE STAR program," said David Whitehead, Backus President and Chief Executive Officer. "I am proud to be associated with such a forward-thinking Board that has chosen to explore this strategic partnership to create a sustainable system of integrated, high-value healthcare for the regional community of eastern Connecticut."

An affiliation would enable both organizations to share the knowledge and expertise of their staffs and physicians, and give patients easier access to a wider range of services and treatments.

"We believe Backus would be a truly exceptional partner," said Elliot Joseph, President and Chief Executive Officer of Hartford HealthCare. "It is a highly successful organization with an excellent medical staff, a strong management team, dedicated employees, and a

our mission and vision. Coming together, we strengthen our ability to serve the communities of Eastern Connecticut for the next 100 years and beyond."

As part of the process, both health systems will conduct focus groups with key stakeholders — Backus employees, members of the medical staff, its Corporators, volunteers, government and community leaders, providers of other health and human services and the community-at-large.

"We want to involve all stakeholders in this discussion as we explore affiliation," Mr. Whitehead said. "This represents a unique opportunity to combine complementary strengths, and create an integrated health system for our region."

Board Chairman Peter V. Disch said the goal of the process is to position Backus to meet the healthcare needs of the community, in the midst of a rapidly changing healthcare landscape.

"Our community needs a system of patient care to meet this region's healthcare needs for years to come," Mr. Disch said. "The Board has studied this issue, and we believe a partnership with Hartford HealthCare could create a model to meet those changing needs, right here in eastern Connecticut."

The signing of a Letter of Intent is the first of several steps before an affiliation can be created. Both organizations will perform due diligence to determine if an affiliation would be in the best interest of patients and communities served by the institutions. If there is agreement to move forward, a Memorandum of Understanding followed by a Definitive Agreement would be created. This final step would

act of kindness to the impact healthcare workers can have every day.

Organized by Director of Patient Experience and Service Excellence Lauren Mallozzi, the presentations are the kickoff to a patient experience initiative at Backus. Ms. Keane Baker offered a wide array of tips that staff can utilize immediately in their personal and professional lives.

She said when stress causes a person to be negative, that negativity spreads to others and before long patients will think twice before choosing Backus.

"Negativity does nothing to enhance your life or your career," she said. "What people hear about Backus is important."

But a positive approach can go a long way. She offered these tips, among others:

- The first few minutes you meet patients is critical. Be "nice" first by introducing yourself clearly, make eye contact, orient patients about their stay and speak to them on their level (for example, if a patient is in a bed or chair, sit down to talk with them).
- Make sure patients see you following standard precautions and protocols.
- Make sure your clothes and work area are free of any inappropriate humor or information.
- If you appear to enjoy what you do, it sets people at ease.
- Speed stuns. If you can do something in two minutes, take care of it immediately. It impresses the patient and stops the buildup of numerous 2-minute jobs. Another example is calling someone back immediately, which is very much appreciated.
- If you are going to do something for someone, tell them you are going to do it for them, and then follow through. This ensures that they realize you are on their side and acting quickly.
- Take the time to learn something about the person you are dealing with, or find something in common with them. People think that if you like them, they will receive better care.
- Find out what is important to a person. Ask them what they do with their free time or extra money — from g
to grandchildren.

Dialog blog on the Intranet. Our series on the year's strategic initiatives will resume next week.

Dear Colleagues:

I am pleased to announce that the Backus Corporation Board of Directors has approved exploring a formal affiliation with Hartford HealthCare. A copy of our press release and a question-and-answer sheet are included. There is more information on our website, backushospital.org.

The Board has approved a non-binding Letter of Intent. At the outset, let me underscore two words in our announcement: "non-binding" and "exploring." We are at the very beginning of a process that is expected to take several months. At this point, the signing of the Letter of Intent allows the Backus Corporation and Hartford HealthCare Corporation to conduct a round of initial due diligence.

As is customary, and required in these discussions, Backus and all other parties signed confidentiality agreements. For that reason, no member of the Board or Senior Leadership can discuss which hospitals and systems were under consideration, or which partners we did not select. It is fair to say, however, that each proposal, visit and interview provided a valuable perspective about the direction of healthcare in our region and nation.

This is a crucial first step, as it can help us, and our colleagues in Hartford, further determine whether an affiliation would be in the best interests of our patients, communities, providers, and partners. If we proceed past Memorandum of Understanding. This would lead to a second phase of more intensive due diligence and help us clearly define the objectives for an affiliation.

All of this would lead to a Definitive Agreement. And none of that will happen without approval by the governing Boards of both organizations.

So, yes, there is a lot of work to do. Allow me to be absolutely clear at the outset:

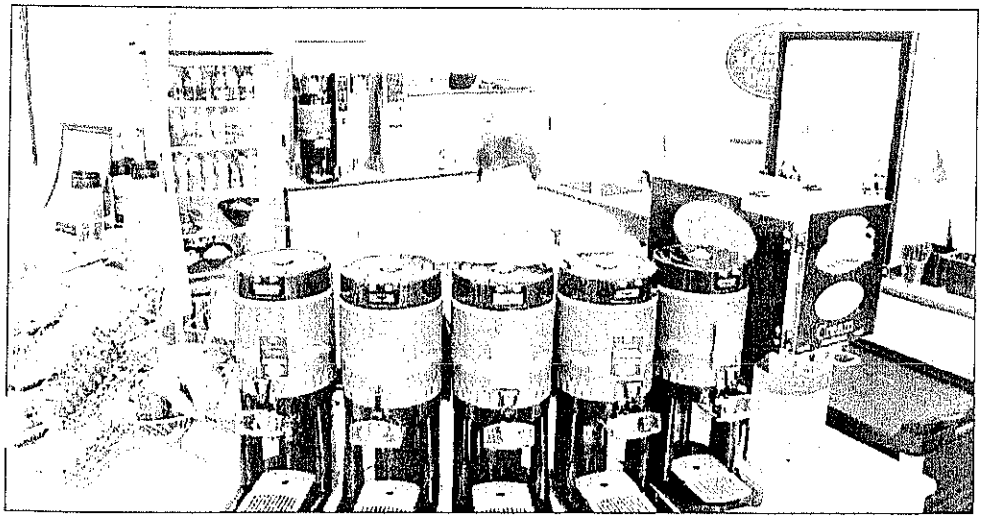
- This is not a "done deal."
- This is not the sale of our hospital's assets.
- This is the start of an exploratory process.

For Backus patients, the affiliation would mean access to a broader regional delivery system of care — with the availability of expanded primary, ambulatory and specialty clinical services. This partnership would not preclude the continuation of other clinical affiliations we have enjoyed.

The Board and senior management at Backus are fully committed to a transparent process — one that addresses questions, and deals proactively with concerns as we move forward. That is why, over the next several months, we will conduct a series of focus groups with key stakeholders: our employees, Medical Staff members, volunteers, Corporators, civic leaders, other health and human services providers, and the community at large. We will have the opportunity to discuss this further at our next round of quarterly staff meetings in early March.

Thank you for all you do in service to our patients,

Open for business



Juli Avery of Food and Nutrition is ready for customers at the new Medical Office Building Coffee Shop that opened for business Wednesday. Located in the MOB main entrance, the shop is open Monday thru Friday from 6:30 a.m. to

Backus supplies comfort in a time of need

Words cannot express how blessed and grateful I am for my Backus family, especially my friends in Diagnostic Imaging, CT Scan, Nuclear Medicine, PACU, the Cardiopulmunary Department, ECHO, Communications and Sister Rita. Your thoughtfulness and generosity has provided comfort for my fa
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your supp

Update

News on the proposed affiliation between Backus and Hartford HealthCare

May 22, 2012

Dear Colleagues:

I am pleased to announce that Backus has reached an important stage in its proposed affiliation with Hartford HealthCare. Monday night, the Board of Directors of Backus Corporation approved a Memorandum of Understanding — a legal document that outlines how a formal partnership of our healthcare systems would function.

This process requires approvals from both organizations' governing boards. Later this week, the Board of Hartford HealthCare will meet. If they, likewise, approve the Memorandum of Understanding, the affiliation process will be able to move to its final stage, during which we will work to agree on Definitive Agreements. We have set a July target for this decision, after which we would need to seek regulatory approvals for the affiliation from state and federal authorities.

If successful, Backus would become a member of the Hartford HealthCare system, which includes Hartford Hospital, the Hospital of Central Connecticut, MidState Medical Center, Natchaug Hospital, Windham Hospital and a wide spectrum of additional pre- and post-acute health services.

We have had a busy three months.

Since signing the Letter of Intent on Feb. 2, we have conducted a series of information and focus group sessions for physicians and employees. I hope you have had an opportunity to participate in one or more of these sessions, including our extensive round of quarterly meetings in March. More will be scheduled soon.

Also since February, the governing Boards of both health systems have formed subcommittees to assess the strategic alignment of Backus and Hartford HealthCare. Representatives from both potential partners have also been engaged in providing insight into their respective operations and community needs.

The Memorandum of Understanding is a result of these efforts, as we worked to determine whether an affiliation would be in the best interests of our patients, communities, employees, providers and partners. As a result of this analysis, our Board has concluded that the integration of Backus and Hartford HealthCare would provide the necessary benefits for the individuals and communities we serve. Our organizations would share the knowledge and expertise of physicians, nurses and other staff members; and patients would have easier access to a wider range of services, technology and treatments close to home.

The Board and senior management at Backus remain committed to sharing as much information as we can as this process moves forward. We understand this is a crucial decision about our healthcare system's future; that is why we are sharing important news about this affiliation with our hospital community first. This "Update" message has been distributed to physicians, employees, Corporators and volunteers. Others will follow.

Further discussions with key stakeholders — including employees, physicians, Corporators, volunteers, government and community leaders, providers of other health and human services and the community-at-large — will be scheduled once the Memorandum of Understanding is finalized. We intend to use these sessions to begin the conversation on the development of the integrated healthcare delivery system for our eastern Connecticut region.

My colleagues and I are enthused about this process, and the stronger, more integrated system of care we believe it will provide. As always, I encourage you to participate in any meetings or discussions about the affiliation.

Thank you for all you do in service of our patients,

Dave Whitehead
President and Chief Executive Officer

building our
CONNECTIONS

Hartford HealthCare

May 24, 2012

I am pleased to inform you that Hartford HealthCare and Backus Corporation have signed a Memorandum of Understanding (MOU) to move forward with our proposed affiliation.

We expect to reach a definitive agreement in July and then work with state and federal officials to obtain regulatory approval. This process usually takes several months. We are working to complete it as quickly as possible.

We are excited about the opportunities our affiliation will bring to our patients, communities and staff members. Patients and community members will benefit from the work that Backus and HHC will do together to enhance the services provided in communities, especially in eastern Connecticut. Together, we will improve the quality of care by increasing the sharing of best practices, treatments, services and innovative technology throughout our system. HHC staff members will benefit from the greater professional opportunities available in a larger health care system.

In working with the Backus Board, medical staff and administration over the past eight months, we have developed a high level of confidence that we share a common vision of the future and similar core values.

Our two organizations have a long successful history together, including cooperation with our LIFE STAR air ambulance service: One of our helicopters is stationed at Backus to better serve the communities of eastern Connecticut. We also share a mission and vision focused on achieving excellence in patient care and service to our communities. Like HHC, Backus is a highly successful organization with an excellent medical staff, a strong management team, dedicated employees, and a firm commitment to providing high-quality care.

This affiliation will be another important step in building a high-performance, integrated health care system that provides patients with the right care, at the right time and in the right place.

Any organization is only as great as its people. Thank you for the contributions you make every day. You are helping to make HHC the great health care system that we aspire to become.

Sincerely,

Elliot Joseph
President and CEO

BACKUS HEALTH SYSTEM

Hartford HealthCare

For Immediate Release

Contacts
Shawn Mawhiney
Director of Communications and Community Relations
860-367-1447
smawhiney@wwbh.org

Rebecca Stewart
Director of Media Relations
860-726-8283
RStewart@harthosp.org

Backus and Hartford HealthCare sign Memorandum of Understanding

NORWICH (May 24, 2012) — Backus Corporation and Hartford HealthCare have signed a Memorandum of Understanding — a legal document that outlines how a formal partnership of the healthcare systems would function. The agreement marks a significant milestone as both organizations continue to move forward with their proposed affiliation.

If approved, Backus would become a member of the Hartford HealthCare network, which includes Hartford Hospital, the Hospital of Central Connecticut, MidState Medical Center, Natchaug Hospital, Windham Hospital, a large primary care physician group and a wide spectrum of additional health services.

The governing boards of both organizations signed a Letter of Intent to explore a formal affiliation in February. Since then, both boards have formed subcommittees to assess the strategic alignment of Backus and Hartford HealthCare. Representatives from both potential partners have also been engaged in providing insight into their respective operations and community needs.

"My colleagues and I are enthused about this process, and the stronger, more integrated system of care we believe an affiliation will provide," said David Whitehead, Backus president and chief executive officer. "After serious review, our board has concluded that the integration of Backus and Hartford HealthCare would provide the necessary benefits for the individuals and communities we serve."

An affiliation would enable both organizations to share the knowledge and expertise of their staffs and physicians and give patients easier access to a wider range of services, technology and treatments.

— MORE —

"Throughout this process, we continue to be impressed with the caliber of Backus — its Medical Staff, employees and leadership," said Elliot Joseph, president and chief executive officer of Hartford HealthCare. "Backus and Hartford HealthCare share a true commitment to community-based care. Coming together, we strengthen our ability to serve the communities of Eastern Connecticut well into the future."

Before signing the Memorandum of Understanding, both organizations performed due diligence to determine if an affiliation would be in the best interest of patients and communities served by the institutions. Backus and Hartford HealthCare will now work on creating a definitive agreement, which is expected to be in place by July. They will then work with state and federal officials to obtain regulatory approval. This process usually takes several months.

Backus Corporation is the parent of the Backus Healthcare System, which includes The William W. Backus Hospital, Backus Health Care Inc., Backus Home Health Care, Backus Physician Services, Community Medical Partners, CONNCare and WWB Corp.

# # #

Hartford HealthCare's *members include Hartford Hospital (an 867-bed regional referral center that is one of the largest teaching hospitals and tertiary care centers in New England), a community tertiary hospital and two acute-care community hospitals: The Hospital of Central Connecticut (414 beds, with campuses in New Britain and Southington), MidState Medical Center (144 beds, in Meriden) and Windham Hospital (130 beds, in Willimantic). Other system member providers include two regional behavior health centers, a statewide clinical laboratory operation, a large primary care physician practice group, a large multi-specialty surgical group, a regional home care system, long-term care facilities and a physical therapy and rehabilitation network.*

The Backus Health System *includes The William W. Backus Hospital, a 213-bed acute care hospital that is the only state-licensed Trauma Center east of the Connecticut River; a home healthcare agency; primary care and walk-in urgent care centers in Ledyard, Plainfield, Montville and Colchester; Backus Physician Services, a multi-specialty surgical group; and Community Medical Partners, a medical foundation. Backus is one of two sole members of Hospice Southeastern Connecticut, and has an ownership interest in dialysis centers in the region.*

Update

News on the proposed affiliation between Backus and Hartford HealthCare

June 13, 2012

Dear Corporator:

I would like to follow up with you on the invitation you received about our information session for Corporators on June 12. As you know, Hartford HealthCare's Chief Executive Officer, Elliot Joseph, was our guest that evening. He and I explained the purposes of the proposed affiliation of our two health systems, and answered questions.

For those of you who were able to attend, thank you for your time and I hope this small gathering met your expectations. A few of you have commented to me that you found the session informative, which is gratifying. As this process continues, we will hold additional sessions to share information, and hear your comments.

In our ongoing efforts to keep you informed, I'm happy to provide this brief summary of some of the information we shared. I hope you find this helpful, and look forward to seeing you again soon. As always, please feel free to call me at 860-889-8331 ext. 2201 or email me at dwhitehead@wwbh.org

David Whitehead
President and Chief Executive Officer

Hartford HealthCare's "geared" model

We reviewed Hartford HealthCare's approach to healthcare integration. The model is based on gears that inter-relate, rather than a more traditional "hub-and-spoke" model which is centered around a major teaching hospital with community hospitals "feeding the mother ship."

The role of the Backus Board in an affiliation

Under our plans, and the Memorandum of Understanding both our organizations have approved, Backus will continue to have a local Board with essentially the same duties and responsibilities it has today. For a transitional period of three years, in order to allow

the Backus Board to understand more of the culture of the Hartford HealthCare system, two of our Board members would serve in the larger system Board; two system members would serve on the Backus Board.

Fundraising and philanthropy

There is great sensitivity to the intent of donors who have given — and we hope will give — to Backus. All restricted contributions that have been given to Backus will be used as the donors wished, here at Backus. Furthermore, Hartford HealthCare does not use funds donated to one hospital at another partner organization. Doing so would violate the intent of the donors and damage philanthropic efforts at a time when charitabke giving to not-for-profit hospitals will be more important that ever.

Changes in the healthcare landscape

Mr. Joseph called the changes that are happening right now in healthcare "profound," and he cited the breaking of "three sacred boundaries":

- Partnerships of providers across state lines
- Insurance companies changing their focus — either by getting out of the risk business and becoming data companies, or by purchasing providers (large health systems and large practices)
- The rise of for-profit healthcare companies in even some not-for-profit community-based models

What's next

Backus and Hartford HealthCare signed a Letter of Intent on Feb. 2, and we finalized our Memorandum of Understanding on May 24, 2012. Both parties have been undergoing due diligence to ensure that the proposed affiliation would be in the best interests of the communities they serve. We are hopeful of signing Definitive Agreement some time in July. The affiliation would then require state and federal regulatory approvals, which are likely to take several months. The State of Connecticut Department of Public Health's Office of Health Care Access would need to approve a Certificate of Need; and the Connecticut Attorney General and the Federal Trade Commission would also need to grant approvals before the transaction could take effect.

More information

We will always share information with Corporators first, but please be advised that you can always find news about the affiliation — including a helpful "Frequently Asked Questions" list — on the Backus website: www.backushospital.org/affiliation It is a good place to turn if someone you know asks you a question about this important process.

Thank you, as always for being our eyes and ears in the communities we serve.

Hartford HealthCare

CEOs and their Boards – send to leadership and medical staff leadership
8 p.m. August 16

August 16, 2012

Message from Elliot Joseph, President & CEO, Hartford HealthCare

I am pleased to inform you that the boards of Hartford HealthCare (HHC) and Backus Corporation have signed a definitive agreement, which describes the terms of our proposed affiliation. Our next step is to work with state officials and the Federal Trade Commission to obtain approval, which usually takes several months.

Once the affiliation is approved, Backus Corporation, which is based in Norwich, will become a member of Hartford HealthCare. Backus Corporation is the parent of the Backus Healthcare System, which includes The William W. Backus Hospital, a 213-bed, acute-care hospital that is the only state-licensed trauma center east of the Connecticut River; Backus Home Health Care; primary care and walk-in urgent care centers in Ledyard, Plainfield, Montville and Colchester; Backus Physician Services, a multi-specialty surgical group; and Community Medical Partners, a medical foundation. Together, these organizations employ a total of about 2,000 staff members.

The affiliation agreement calls for Hartford HealthCare to create the HHC Eastern Connecticut Health Region, consisting of New London and Windham counties. Based on information from existing health and human services organizations and community leaders, a strategic plan will be developed for health care delivery in the region.

Our affiliation will enable us to continue to expand access to care. Patients – especially those in eastern Connecticut – will benefit from a broader range of services and availability of specialists, and staff throughout HHC will benefit from greater professional opportunities. HHC and Backus will work together to improve the quality of care by increasing the sharing of best practices, treatments and innovative technology throughout our system.

These are interesting and exciting times for us. Together, we're building a true system of care that can provide more patients with all the care they require throughout their lives. We're also building a unique culture based on strong leadership behaviors and strong values of excellence, integrity, caring and safety, which will assist us in serving our patients and communities in the best possible way.

Thank you for your hard work and commitment. We will keep you posted on the affiliation process.

Sincerely,

Elliot

Elliot Joseph
President and CEO

Hartford HealthCare

HHC Board v2
Updated Draft – August 13, 2012
Daphne to send 8 p.m. August 16

August 16, 2012

Message from Elliot Joseph, President & CEO, Hartford HealthCare

Dear Board Members:

I'm very pleased to inform you that the Backus Board of Directors has signed the definitive agreement describing the terms of our proposed affiliation.

As you know, our next steps are to jointly file a Certificate of Need Application with the Connecticut Office of Health Care Access, seek approval from the State's Attorney General, and file for antitrust approval from the Federal Trade Commission. We expect this process to take several months.

I want to express my deep appreciation for your time and commitment to painstakingly evaluating the information concerning this important opportunity and your vision in realizing the efficiencies this partnership will create for our system as a whole.

Amid rapid changes and increasing government requirements in our industry, this affiliation will enable us to continue to build a strong health care system that provides high-quality care to an increasing number of communities and to provide that care in a cost-effective manner.

Patients - especially those in eastern Connecticut - will benefit from a broader range of services and availability of specialists, and staff throughout HHC will benefit from greater professional opportunities. We look forward to the many possibilities this partnership will present.

Again, thank you for your vision and extraordinary support.

Sincerely,

Elliot Joseph
President and CEO

Update

News on the proposed affiliation between Backus and Hartford HealthCare

August 17, 2012

Dear Colleagues:

I am pleased to announce that the Backus Board of Directors last night approved an affiliation agreement with Hartford HealthCare (HHC). This important decision clears the way for us to seek regulatory approvals to complete this process. Attached to this letter is a press release that will be sent later today. The media statement contains highlights of the affiliation agreement, which I hope you will find interesting — even exciting. Here, I would like to share some thoughts about this decision.

Truly, this affiliation decision marks a major moment in the proud life of our 118-year-old hospital.

We have talked about this proposed affiliation since early February, immediately after we signed a Letter of Intent to explore a formal partnership with HHC. In the intervening months, through dozens of meetings and focused discussions, our two organizations have learned a great deal about each other — how we see the direction of health care, how we view opportunities to improve access to care for patients, and how we can improve our region's health. Our visions are remarkably alike, as we have considered whether this decision would be in the best interests of our patients, employees, medical staff and communities.

These months of intense review and negotiation have left the Boards and executive leadership teams of both institutions even more convinced that this Backus–HHC affiliation is beneficial for all concerned.

Our agreement calls for the creation of a strategic plan to advance health care delivery for Eastern Connecticut, the necessary capital commitments to carry out that plan, and the combined expertise of the Backus team and HHC to make that regional vision a reality. A plan, the funding, and the leadership to make it happen — those are the key components of our agreement. This is an exciting opportunity, combining the expertise and vision of two strong organizations to better serve the Eastern Connecticut region. It's a direct reflection of our mission statement, and a clear expression of the value of the work you do every day.

In these changing and challenging times, there is an indisputable need for successful health care organizations to work more closely together. Nationally and regionally, we see once-strong community hospitals risk financial disaster or closure. Fully aware of these realities, and working to ensure the viability of our regional health care delivery system, our Board has made this important decision to affiliate with HHC. In so doing, our goal is to improve access to care, share best practices and technology, and work together to improve the quality of care we deliver. If you live, work or do business in Eastern Connecticut, that is good news, indeed.

As you know, we still must seek regulatory approvals from the state and federal governments before an affiliation can become official. We have already begun working on that process, which could take several months. In the meantime, I look forward to this opportunity to create a strong partnership, and I remain excited about the many opportunities ahead.

On behalf of our Board and the entire community we serve, thank you for your support and the work you do every day for our patients and communities.

Sincerely,

Dave Whitehead
President and Chief Executive Officer

BACKUS HEALTH SYSTEM

Hartford HealthCare

For Immediate Release

Contacts
Shawn Mawhiney
Director of Communications and Community Relations
860-367-1447
smawhiney@wwbh.org

Rebecca Stewart
Director of Media Relations
860-726-8283
RStewart@harthosp.org

Backus and Hartford HealthCare agree to affiliate, seek needed approvals

NORWICH (August 17, 2012) — Backus Corporation and Hartford HealthCare (HHC) have formally agreed to an affiliation. The health care systems now will seek state and federal regulatory approvals for the partnership. Once the affiliation is approved, Backus will become a member of the Hartford HealthCare system.

The Backus Corporation Board of Directors voted Thursday evening to approve the definitive agreement the two organizations created over the past five months. The Hartford HealthCare Board has also approved the agreement.

The agreement outlines how a partnership of the health care systems would function and clears the way for the organizations to jointly file a Certificate of Need application with the Connecticut Office of Health Care Access, seek approval from the state's Attorney General, and file for federal approval from the Federal Trade Commission. That process is expected to take several months.

"When approved, this will be a major milestone for our entire regional community, and an important moment for Backus," said David Whitehead, Backus president and chief executive officer. "In the midst of sweeping change in health care, this strategic partnership will create a viable, high-value health care delivery system for the future. If you live, work or do business in eastern Connecticut, this affiliation is great news."

"We are excited about the opportunities our affiliation will bring to our patients, communities and staff members," said Elliot Joseph, president and chief executive officer of Hartford HealthCare. "Together, we will improve the quality of care by increasing the sharing of best practices, treatments, services and innovative technology throughout our system. Our staff members will benefit from the greater professional opportunities available in a larger health care system."

— MORE —

The affiliation agreement calls for the creation of a new Eastern Connecticut health region for Hartford HealthCare, comprised of New London and Windham Counties, with the Backus Health System serving as the region's clinical nucleus. Working as a coordinated system, system members will develop a strategic plan for fully integrated health care delivery in the region. The plan, which will be developed after final approvals, will include information from existing health and human services organizations, community leaders and regional stakeholders.

"The top reason the Backus board sought an affiliation was to secure viability and enhance access to health care for our patients," Whitehead said. "We are proud and pleased to say that Hartford HealthCare has provided those assurances."

The agreement contains several key provisions, pending state and federal approval:

- A capital commitment to the Eastern Connecticut region in support of the strategic plan
- A replenishable fund for medical staff development
- Maintenance of a trauma program at Backus, with commitment that a LIFE STAR helicopter will be permanently stationed at the hospital
- Establishment of an extensive primary care and ambulatory care network, with certified Patient-Centered Medical Homes
- Organization and development of a comprehensive cancer services network for the region, using the expertise of local medical specialists
- Enhancement of the delivery of cardiac care for the region, using the expertise of local medical specialists
- Creation of a Preventive Medicine Institute at Backus
- Development of an ambulatory surgery network in Eastern Connecticut
- Enhanced neonatology coverage at Backus

The agreement also includes commitments to funding community benefit activities, the use of existing and future donations to Backus as donors intended, the exploration of a system data center using Backus, and ongoing robust charity care policies.

Patients are expected to benefit from expanded access to home care and rehabilitative care services, a more coordinated behavioral health network, and enhanced programs using local specialists for cardiac, vascular and cancer care.

The Backus Board of Directors will remain, with the addition of two new members from the Hartford HealthCare system. Likewise, two Backus board members will be added to the HHC Board of Directors.

Backus employees will remain employed by Backus. Backus will retain its name, identity, medical staff and separate hospital and affiliate licenses.

— MORE —

If the affiliation is approved, Backus will become a member of the Hartford HealthCare network, which includes Hartford Hospital, the Hospital of Central Connecticut, MidState Medical Center, Natchaug Hospital, Windham Hospital, and a wide spectrum of additional health services.

The governing boards of both organizations signed a Letter of Intent in February to explore a formal affiliation. Subcommittees from both boards worked to create the affiliation agreement to ensure the affiliation would be in the best interests of patients and communities served by the institutions.

Hartford HealthCare's members include Hartford Hospital (an 867-bed regional referral center that is one of the largest teaching hospitals and tertiary care centers in New England), a community tertiary hospital and two acute-care community hospitals: The Hospital of Central Connecticut (414 beds, with campuses in New Britain and Southington), MidState Medical Center (144 beds, in Meriden) and Windham Hospital (130 beds, in Willimantic). Other system member providers include two regional behavior health centers, a statewide clinical laboratory operation, a large primary care physician practice group, a large multi-specialty surgical group, a regional home care system, long-term care facilities and a physical therapy and rehabilitation network.

Backus Corporation is the parent of the Backus Healthcare System. The system includes The William W. Backus Hospital, a 213-bed acute care hospital that is the only state-licensed Trauma Center east of the Connecticut River; Backus Home Health Care; primary care and walk-in urgent care centers in Ledyard, Plainfield, Montville and Colchester; Backus Physician Services, a multi-specialty surgical group; and Community Medical Partners, a medical foundation. Backus is one of two sole members of Hospice Southeastern Connecticut, and has an ownership interest in dialysis centers in the region.

###

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

FAX SHEET

TO: ATTORNEY JOAN FELDMAN

FAX: 860251-~~5211~~ 5311

AGENCY: SHIPMAN & GOODWIN LLP

FROM: STEVEN LAZARUS

DATE: 3/25/13 **Time:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments:

Agenda and Table of the Record for DN: 12-31788 hearing tomorrow.

Please contact Steven Lazarus at 860 418-7012 with any questions.

PLEASE PHONE Barbara K. Olejarz 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

TABLE OF THE RECORD

APPLICANTS: **Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc.**

DOCKET NUMBER: **12-31788-CON**

PUBLIC HEARING: **March 26, 2013 at 3:00 p.m.**

PLACE: **Backus Business and Technology Center**
11 Stott Avenue
Norwich, CT 06360

EXHIBIT	DESCRIPTION
A	Letter from the Applicant dated September 24, 2012, enclosing the CON application under Docket Number 12-31788, received by OHCA on September 24, 2012. (631 pages)
B	OHCA's letter to the Applicant dated October 24, 2012, requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31788.(6 pages)
C	Applicant's responses to OHCA's letter of October 24, 2012, dated December 20, 2012, in the matter of the CON application under Docket Number 12-31788, received by OHCA on December 20, 2012. (66 pages)
D	OHCA's letter to the Applicant dated January 18, 2013, requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31788. (3 pages)
E	Applicant's responses to OHCA's letter of January 18, 2013, dated February 1, 2013, in the matter of the CON application under Docket Number 12-31788, received by OHCA on February 1, 2013.
F	Designation of hearing officer dated March 4, 2013 in the matter of the CON application under Docket Number 12-31788. (1 page)
G	OHCA's letter to the Applicant dated March 4, 2013 deeming the application complete as of March 4, 2013 in the matter of the CON application under Docket Number 12-31788. (1 page)
H	OHCA's request for legal notification in *The Norwich Bulletin* and OHCA's Notice to the Applicant of the public hearing scheduled for March 26, 2013, in the matter of the CON application under Docket Number 12-31788, dated March 5, 2013. (4 pages)

I	OHCA's letter to the Applicant dated March 8, 2013, requesting prefile testimony and enclosing discussion issues in the matter of the CON application under Docket Number 12-31788. (3 pages)
J	Letter from the Applicant enclosing Prefile Testimony and notice of appearance dated March 21, 2013 in the matter of the CON application under Docket Number 12-31788, received by OHCA on March 21, 2013. (109 pages)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 12-31788-CON

Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc.

Affiliation of Backus Corporation with Hartford Health Care Corporation

March 26, 2013 at 3:00 p.m.

I. **Convening of the Public Hearing**

II. **Applicants' Direct Testimony (10 minutes each)**

III. **OHCA's Questions**

IV. **Public Comment (3 minutes per speaker)**

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

From: Olejarz, Barbara
Sent: Monday, March 25, 2013 2:46 PM
To: JFeldman@goodwin.com
Cc: 'Lazarus, Steven'
Subject: for tomorrows hearing
Attachments: hearing31788.pdf

3/25/13

Hi Joan,

I was not able to fax the attached, the 5311 phone number you gave was busy.

Barbara K. Olejarz
Administrative Assistant
Office of Health Care Access
Division of The Department of Public Health
410 Capitol Ave., MS#13HCA
Hartford, CT 06134
Phone: 860 418-7005
Email: Barbara.olejarz@ct.gov

I	OHCA's letter to the Applicant dated March 8, 2013, requesting prefile testimony and enclosing discussion issues in the matter of the CON application under Docket Number 12-31788. (3 pages)
J	Letter from the Applicant enclosing Prefile Testimony and notice of appearance dated March 21, 2013 in the matter of the CON application under Docket Number 12-31788, received by OHCA on March 21, 2013. (109 pages)

LATE FILES REQUESTED: ALL DUE 4/1/13 (MONDAY)

LATE FILE 1: Applicants to update and resubmit Attach 1 for Hartford HealthCare, Backus Corp and Backus Hospital utilizing [redacted] the same base year

LATE FILE 2: The Hartford HealthCare's Community Health Needs Assessment for each of it's affiliate hospitals it collected to utilize for its system Community Health Needs Assmt

PUBLIC HEARING
APPLICANT
SIGN UP SHEET
March 26, 2013
3:00 p.m.

Docket Number: 12-31788-CON
Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc.
Affiliation of Backus Corporation with Hartford HealthCare Corporation

PRINT NAME	Phone	Fax	Representing Organization
Elliot Joseph			HHC
David Whitehead			Backus Corp.
Thomas Marchozzi			HHC
Dan Lohr			Backus Corp.
Keith Fontaine			Backus Corp.

Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc

PRINT NAME	Phone	Fax	Representing Organization
Carol Wardell			HHC
Kathy York			Backus Corp

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

March 26, 2013
3:00 p.m.

Docket Number: 12-31788-CON
Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc.
Affiliation of Backus Corporation with Hartford HealthCare Corporation

PRINT NAME	Representing Organization
Elizabeth Conway	Board, Backus Hospital
Stephen W Larson	Windham Hospital X by request.

Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc

PRINT NAME	Representing Organization
Tony Sheridan	Chamber of Commerce.

Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc

PRINT NAME	Representing Organization
Marc Tramontozzi	President Backus Medical Staff.
Clarence Silvia	President Hosp of Central CT

SHIPMAN & GOODWIN LLP
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

RECEIVED
APR 1 2013
OFFICE OF
HEALTH CARE ACCESS

April 1, 2013

VIA HAND DELIVERY
Steven W. Lazarus
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: Late-File Testimony; Docket No. 12-31788-CON

Dear Mr. Lazarus:

On behalf of the Applicants in the above-referenced matter and as requested by the Office of Health Care Access at the Public Hearing held on March 26, 2013, enclosed please find the following late-files:

Late-File # 1 - Updated Financial Attachment # 1s for:
(a) Hartford HealthCare Corporation
(b) Backus Corporation
(c) The William W. Backus Hospital

Late-File # 2 - Community Needs Assessments for:
(a) Hartford Hospital
(b) MidState Medical Center
(c) The Hospital of Central Connecticut
(d) Windham Community Memorial Hospital
(e) Natchaug Hospital

Please do not hesitate to contact me directly at 860-251-5104 if you have any questions.

Respectfully Submitted,

Joan Feldman, Esq.

Enc.

2740241v2

Financial Attachment I (HHC)
Late File

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

Total Hospital Health System: UPDATED**	FY2012 Actual Results	Revised FY 2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	Revised FY 2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	Revised FY 2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	Revised FY 2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$921,076,520	$904,743,096	$56,194,000	$960,937,096	$934,654,627	$167,699,754	$1,102,354,381	$962,078,514	$166,584,132	$1,128,662,646	$987,551,610	$163,970,132	$1,151,521,742
Medicare	714,304,240	744,772,411	28,877,970	773,650,381	764,770,204	91,160,385	855,930,589	787,311,888	96,172,373	883,484,261	808,220,798	100,786,213	909,007,011
Medicaid and Other Medical Assistance	300,032,122	238,846,447	8,075,000	246,921,447	237,123,841	25,871,121	262,995,062	228,843,167	23,227,716	261,870,883	235,945,970	25,796,716	261,742,686
Other Government	6,579,118	6,143,404	1,461,333	7,604,737	6,345,848	4,558,480	10,904,428	6,532,100	4,733,999	11,266,099	6,705,007	4,886,999	11,592,006
Total Net Patient Patient Revenue	1,941,992,000	1,894,505,358	94,608,303	1,989,113,661	1,942,894,720	289,289,740	2,232,184,460	1,984,565,670	290,718,220	2,275,283,890	2,038,423,386	295,440,060	2,333,863,446
						-	-		-	-		-	-
Other Operating Revenue	267,538,000	215,606,000	2,435,333	218,041,333	221,616,000	6,749,000	228,365,000	227,950,000	6,176,000	234,126,000	236,533,000	5,821,000	242,354,000
Revenue from Operations	2,209,530,000	2,110,111,358	97,043,637	2,207,154,995	2,164,510,720	296,038,740	2,460,549,460	2,212,515,670	296,894,220	2,509,409,890	2,274,956,386	301,261,060	2,576,217,446
						-	-		-	-		-	-
OPERATING EXPENSES													
Salaries and Fringe Benefits	1,203,434,000	1,239,795,278	53,835,000	1,293,630,278	1,271,224,544	160,190,000	1,431,414,544	1,317,365,824	161,774,000	1,479,139,824	1,353,805,140	166,504,000	1,520,309,140
Professional / Contracted Services	65,155,000	68,779,480	4,702,000	73,481,480	70,480,429	13,957,000	84,437,429	73,038,637	14,077,000	87,115,637	75,058,940	14,386,000	89,444,940
Supplies and Drugs	246,175,000	270,559,852	14,516,333	285,076,185	277,250,924	42,719,000	319,969,924	287,314,223	43,033,000	330,347,223	295,261,548	44,663,000	339,924,548
Bad Debts	77,212,000	41,834,232	3,210,333	45,144,565	42,971,285	10,559,000	53,530,285	44,531,002	10,987,000	55,518,002	45,762,762	11,423,000	57,185,762
Other Operating Expense	450,165,000	330,446,157	12,117,667	342,563,824	352,120,818	36,584,000	388,704,818	350,596,314	36,111,000	386,707,314	355,517,610	36,103,000	391,620,610
Subtotal	2,042,141,000	1,951,514,999	88,381,333	2,039,896,332	2,014,048,000	264,009,000	2,278,057,000	2,072,846,000	265,982,000	2,338,828,000	2,125,406,000	273,079,000	2,398,485,000
Depreciation/Amortization	93,592,000	102,032,000	5,795,333	107,827,333	108,815,000	19,949,000	128,764,000	113,318,000	22,507,000	135,825,000	117,762,000	24,802,000	142,564,000
Interest Expense	13,221,000	15,102,000	1,123,000	16,225,000	16,441,000	3,261,000	19,702,000	16,419,000	3,146,000	19,565,000	19,597,000	3,027,000	22,624,000
Lease Expense			632,333	632,333		1,938,000	1,938,000		1,978,000	1,978,000	-	2,020,000	2,020,000
Total Operating Expense	2,148,954,000	2,068,648,999	95,932,000	2,164,580,999	2,139,304,000	289,157,000	2,428,461,000	2,202,583,000	293,613,000	2,496,196,000	2,262,765,000	302,928,000	2,565,693,000
						-	-		-	-		-	-
Gain/(Loss) from Operations	60,576,000	41,462,359	1,111,637	42,573,996	25,206,720	6,881,740	32,088,460	9,932,670	3,281,220	13,213,890	12,191,386	(1,666,940)	10,524,446
						-	-		-	-		-	-
Plus: Non-Operating Revenue	68,563,000	22,600,000	$1,692,667	24,292,667	22,286,000	5,255,000	27,541,000	22,105,000	5,441,000	27,546,000	21,845,000	5,635,000	27,580,000
Revenue Over/(Under) Expense	$129,139,000	$64,062,359	$2,804,303	$66,866,662	$47,492,720	$12,136,740	$ 59,629,460	$ 32,037,670	$ 8,722,220	$ 40,759,890	$ 34,136,386	$ 3,968,060	$ 38,104,446
							-			-			-
FTEs	9,958.5	9,955.2	1,642.7	11,597.9	9,989.2	1,595.6	11,584.8	9,995.2	1,560.1	11,555.3	9,999.2	1,554.4	11,553.6

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

Volume Statistics:

IP Discharges	77,047	76,351	4,005	80,356	76,945	12,016	88,961	77,407	12,016	89,423	77,810	12,016	89,826
ED Visits	298,232	308,731	19,573	328,304	312,802	59,601	372,403	315,936	60,495	376,431	319,123	61,402	380,525

** Please note that the updated projections for FYs 2013-2016 now incorporate the State of Connecticut's DSH & Sequestration impact and budget cuts. Please also note that the Applicants have assumed, for purposes of this Financial Attachment I, that the proposed affiliation will become effective as of June 1, 2013.

Financial Attachment I (Backus Corporation)
Late File

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

Backus Corporation UPDATED**	FY2012 Actual Results	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$166,776,535	$168,582,000		$168,582,000	$167,040,000	$659,754	$167,699,754	$165,406,000	$1,178,132	$166,584,132	$162,792,000	$1,178,132	$163,970,132
Medicare	96,523,020	85,758,820		86,633,910	90,613,740	546,645	91,160,385	95,196,220	976,153	96,172,373	99,810,060	976,153	100,786,213
Medicaid and Other Medical Assistance	30,151,911	24,225,000		24,225,000	25,682,000	189,121	25,871,121	22,890,000	337,716	23,227,716	25,459,000	337,716	25,796,716
Other Government	4,152,611	4,384,000		4,384,000	4,554,000	4,480	4,558,480	4,726,000	7,999	4,733,999	4,879,000	7,999	4,886,999
Total Net Patient Patient Revenue	297,604,077	283,824,910	-	283,824,910	287,889,740	1,400,000	289,289,740	288,218,220	2,500,000	290,718,220	292,940,060	2,500,000	295,440,060
Other Operating Revenue	7,456,820	7,306,000	-	7,306,000	6,749,000	-	6,749,000	6,176,000	-	6,176,000	5,821,000	-	5,821,000
Revenue from Operations	305,060,897	291,130,910	-	291,130,910	294,638,740	1,400,000	296,038,740	294,394,220	2,500,000	296,894,220	298,761,060	2,500,000	301,261,060
OPERATING EXPENSES													
Salaries and Fringe Benefits	158,530,032	161,505,000		161,505,000	166,950,000	(6,760,000)	160,190,000	170,570,000	(8,796,000)	161,774,000	175,300,000	(8,796,000)	166,504,000
Professional / Contracted Services	17,270,894	14,106,000		14,106,000	14,402,000	(445,000)	13,957,000	14,705,000	(628,000)	14,077,000	15,014,000	(628,000)	14,386,000
Supplies and Drugs	43,279,019	43,549,000		43,549,000	45,163,000	(2,444,000)	42,719,000	46,155,000	(3,122,000)	43,033,000	47,785,000	(3,122,000)	44,663,000
Bad Debts	8,743,002	9,631,000		9,631,000	10,559,000	-	10,559,000	10,987,000	-	10,987,000	11,423,000	-	11,423,000
Other Operating Expense	30,694,072	36,353,000		36,353,000	36,584,000	-	36,584,000	36,111,000	-	36,111,000	36,103,000	-	36,103,000
Subtotal	258,517,019	265,144,000	-	265,144,000	273,658,000	(9,649,000)	264,009,000	278,528,000	(12,546,000)	265,982,000	285,625,000	(12,546,000)	273,079,000
Depreciation/Amortization	18,079,091	17,386,000		17,386,000	19,949,000	-	19,949,000	22,507,000	-	22,507,000	24,802,000	-	24,802,000
Interest Expense	3,276,169	3,369,000		3,369,000	3,261,000	-	3,261,000	3,146,000	-	3,146,000	3,027,000	-	3,027,000
Lease Expense	1,561,873	1,897,000		1,897,000	1,938,000	-	1,938,000	1,978,000	-	1,978,000	2,020,000	-	2,020,000
Total Operating Expense	281,434,152	287,796,000	-	287,796,000	298,806,000	(9,649,000)	289,157,000	306,159,000	(12,546,000)	293,613,000	315,474,000	(12,546,000)	302,928,000
Gain/(Loss) from Operations	23,626,745	3,334,910	-	3,334,910	(4,167,260)	11,049,000	6,881,740	(11,764,780)	15,046,000	3,281,220	(16,712,940)	15,046,000	(1,666,940)
Plus: Non-Operating Revenue	14,102,638	5,078,000	-	5,078,000	5,255,000	-	5,255,000	5,441,000	-	5,441,000	5,635,000	-	5,635,000
Revenue Over/(Under) Expense	$37,729,383	$8,412,910	$0	$8,412,910	$1,087,740	$11,049,000	$12,136,740	($6,323,780)	$15,046,000	$8,722,220	($11,077,940)	$15,046,000	$3,968,060
FTEs	1,692.9	1,642.7	-	1,642.7	1,595.6	-	1,595.6	1,560.1	-	1,560.1	1,554.4	-	1,554.4
Volume Statistics:													
IP Discharges	11,911	12,016		12,016	12,016		12,016	12,016		12,016	12,016		12,016
ED Visits	60,738	58,720		58,720	59,601		59,601	60,495		60,495	61,402		61,402

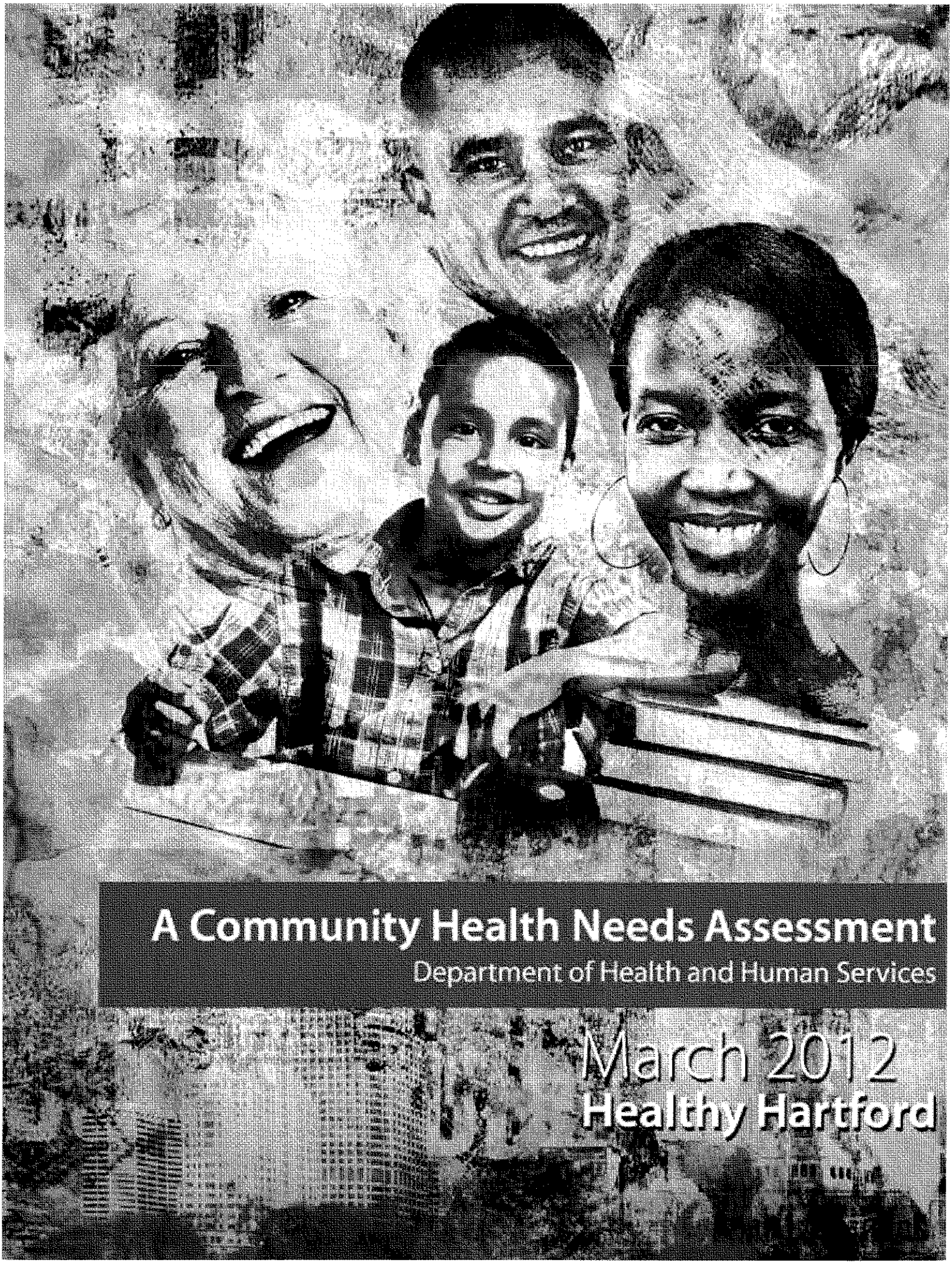
** Please note that the updated projections for FYs 2013-2016 now incorporate the State of Connecticut's DSH & Sequestration impact and budget cuts. Please also note that the Applicants have assumed, for purposes of this Financial Attachment I, that the proposed affiliation will become effective as of June 1, 2013.

Financial Attachment I (William Backus Hospital)
Late File

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

Backus Hospital UPDATED**	FY2012 Actual Results	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE													
Non-Government	$158,715,599	$160,058,000		$160,058,000	$157,215,900	$659,754	$157,875,654	$153,765,322	$1,178,132	$154,943,454	$150,047,568	$1,178,132	$151,225,700
Medicare	91,857,700	82,506,600		82,506,600	85,828,107	546,645	86,374,752	89,662,366	976,153	90,638,519	93,706,112	976,153	94,682,265
Medicaid and Other Medical Assistance	28,694,556	20,713,275		20,713,275	21,726,786	189,121	21,915,907	18,487,652	337,716	18,825,368	20,724,465	337,716	21,062,181
Other Government	3,951,900	4,106,725		4,106,725	4,223,203	4,480	4,227,683	4,326,579	7,999	4,334,578	4,437,335	7,999	4,445,334
Total Net Patient Patient Revenue	283,219,755	267,384,600	-	267,384,600	268,993,996	1,400,000	270,393,996	266,241,919	2,500,000	268,741,919	268,915,480	2,500,000	271,415,480
Other Operating Revenue	7,456,692	7,112,068	-	7,112,068	6,550,709	-	6,550,709	5,971,799	-	5,971,799	5,612,470	-	5,612,470
Revenue from Operations	290,676,447	274,496,668	-	274,496,668	275,544,705	1,400,000	276,944,705	272,213,718	2,500,000	274,713,718	274,527,950	2,500,000	277,027,950
OPERATING EXPENSES													
Salaries and Fringe Benefits	144,375,103	145,725,001		145,725,001	148,902,544	(6,760,000)	142,142,544	150,115,864	(8,796,000)	141,319,864	153,956,713	(8,796,000)	145,160,713
Professional / Contracted Services	16,364,051	13,521,464		13,521,464	13,569,507	(445,000)	13,124,507	13,410,875	(628,000)	12,782,875	13,459,918	(628,000)	12,831,918
Supplies and Drugs	42,571,533	43,549,000		43,549,000	45,163,000	(2,444,000)	42,719,000	46,155,000	(3,122,000)	43,033,000	47,785,000	(3,122,000)	44,663,000
Bad Debts	7,950,266	9,526,000		9,526,000	10,413,424	-	10,413,424	10,789,659	-	10,789,659	11,195,687	-	11,195,687
Other Operating Expense	30,217,869	32,774,162		32,774,162	32,891,612	-	32,891,612	32,506,097	-	32,506,097	32,627,971	-	32,627,971
Subtotal	241,478,824	245,095,628	-	245,095,628	250,940,087	(9,649,000)	241,291,087	252,977,495	(12,546,000)	240,431,495	259,025,289	(12,546,000)	246,479,289
Depreciation/Amortization	18,006,195	17,316,530		17,316,530	19,882,568	-	19,882,568	22,444,709	-	22,444,709	24,741,782	-	24,741,782
Interest Expense	3,276,169	3,369,000		3,369,000	3,261,000	-	3,261,000	3,146,000	-	3,146,000	3,027,000	-	3,027,000
Lease Expense	1,350,542	1,387,396		1,387,396	1,416,531	-	1,416,531	1,446,279	-	1,446,279	1,476,650	-	1,476,650
Total Operating Expense	264,111,730	267,168,554	-	267,168,554	275,500,186	(9,649,000)	265,851,186	280,014,483	(12,546,000)	267,468,483	288,270,721	(12,546,000)	275,724,721
Gain/(Loss) from Operations	26,564,717	7,328,114	-	7,328,114	44,519	11,049,000	11,093,519	(7,800,765)	15,046,000	7,245,235	(13,742,770)	15,046,000	1,303,230
Plus: Non-Operating Revenue	12,819,113	4,017,242		4,017,242	4,194,001	-	4,194,001	4,379,598	-	4,379,598	4,574,474	-	4,574,474
Revenue Over/(Under) Expense	$39,383,830	$11,345,356	$0	$11,345,356	$4,238,520	$11,049,000	$15,287,520	($3,421,167)	$15,046,000	$11,624,833	($9,168,296)	$15,046,000	$5,877,704
FTEs	1,542.8	1,493.5		1,493.5	1,441.4	-	1,441.4	1,400.9	-	1,400.9	1,390.2	-	1,390.2
Volume Statistics:													
IP Discharges	11,911	12,016		12,016	12,016		12,016	12,016		12,016	12,016		12,016
ED Visits	60,738	58,720		58,720	59,601		59,601	60,495		60,495	61,402		61,402

** Please note that the updated projections for FYs 2013-2016 now incorporate the State of Connecticut's DSH & Sequestration impact and budget cuts. Please also note that the Applicants have assumed, for purposes of this Financial Attachment I, that the proposed affiliation will become effective as of June 1, 2013.



A Community Health Needs Assessment

Department of Health and Human Services

March 2012

Healthy Hartford

The mission of the Hartford Department of Health

and Human Services is:

To protect the well-being of the people in Hartford, to promote an environment conducive to healthy lifestyles, and to prevent adverse health outcomes. Whenever possible, the Department will endeavor to employ strategies, policies and interventions through community partnerships to reduce health disparities.

A Community Health Needs Assesment

Hartford Department of Health and Human Services

This report is funded in part by:

Hartford Hospital

Connecticut Children's Medical Center

SAINT FRANCIS Hospital and Medical Center

Acknowledgements

Community Health Needs Assessment Consortium
City of Hartford Department of Health and Human Services
Connecticut Children Medical Center
Hartford Hospital
Saint Francis Hospital and Medical Center
University of Connecticut Health Center

Under the direction of the Community Health Needs Assessment Consortium, the Community Health Needs Assessment Workgroup began planning this assessment in early 2010. Much thought was put into creating a process and document that would be both useful and enlightening to healthcare organizations, community-based health and social services organizations, and the community at large. The City of Hartford Department of Health and Human Services wishes to thank our community health needs assessment partners for their generous support to this project and to their designated representatives on the Community Health Needs Assessment Workgroup for their professional contributions and collaborative efforts throughout the study process. Special thanks go to the Urban Alliance for providing data, analysis, and review of the Hartford Survey Project: Understanding Needs and Service Opportunities.

We would also like to thank Holleran Consulting LLC for their expertise in community health assessments and for preparing the community profile. This document has been produced for the benefit of the community. The City of Hartford Department of Health and Human Services and its community health needs assessment partners encourage use of this report for planning purposes and are interested in learning of its utilization. We would appreciate your comments and questions, which may be directed to the City of Hartford Department of Health and Human Services by phone at (860) 757-4700.

The report, as well as the raw data used to generate our findings is available for download at: http://hhs.hartford.gov.

City of Hartford
Department of Health & Human Services
131 Coventry Street
Hartford, CT 06112

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I. Introduction: What We Hope to Accomplish

National health reform, known as the Patient Protection and Affordable Care Act ("PPACA"), sets forth new requirements via Internal Revenue Code Section 501(r) to hospital organizations to conduct a periodic assessment of health needs of those living in their service area in order to maintain tax-exempt status. The Community Health Needs Assessment ("CHNA") process for Hartford began in October 2010 with an initial meeting of representatives from area hospitals, namely Connecticut Children's Medical Center, Hartford Hospital, Saint Francis Hospital and Medical Center, and the University of Connecticut Health Center. This consortium of health care organizations ("The Consortium"), including the City of Hartford Department of Health and Human Services ("HHS"), came together to address this requirement and to collaborate on a community health needs assessment which would maximize resources and develop a comprehensive and useful document for agencies working in the City of Hartford.

In order to complete the community health needs assessment the Consortium contracted with Holleran, a health research consulting firm, to complete a secondary data analysis and to conduct telephone interviews of 59 Key Informants identified by the steering committee of the CHNA group. The Urban Alliance, a local non-profit organization that provides capacity building and technical assistance to improve the quality of life for under-resourced residents by facilitating a network of faith-based organizations, aided in this process by conducting a resident survey on human service needs. Additionally, the Health Equity Index ("HEI") developed by the Connecticut Association of Directors of Health ("CADH") provided recent trend data that were used to bolster our findings. From these various data sources we are able to present a framework to better understand the importance of social determinants of health.

Social determinants of health refer to factors and resources that are essential to the health of communities and individuals. These include income, shelter, education, access to nutritious food, community norms and cohesion. They are the circumstances in which people are born, grow up, live, and work, as well as the resources available to support their health and help them deal effectively with illness and disease. These social health determinants can be described in terms of factors threatening health, promoting health and protecting health [1]. From the perspective of a Community Health Needs Assessment, the social determinants of health provide a lens through which to view different populations and communities in terms of which community conditions are most important and which are the most limiting for population health.

The goals of this CHNA are:

- To provide a baseline measure of key health indicators
- To inform health policy and health strategies
- To provide a platform for collaboration among community groups including schools, businesses, policy makers, and others to impact current health status
- To act as a resource for individuals, agencies, and institutions looking to identify community health needs and priorities
- To establish benchmarks and monitor trends in health status of Hartford residents
- To assist with community benefit requirements as outlined in the PPACA

The information included in the CHNA provides the foundation upon which community health programs and interventions can be targeted, developed, and evaluated with the ultimate goal of improving the health of the community and its members.

II. Summary of Key Findings

Social Determinants – Many socioeconomic and cultural characteristics of the population living in Hartford drive the main health concerns. The findings in the secondary data profile point to higher concentrations of people that are at increased risk for unhealthy living merely because of their race, age, income, educational status, or family status. The Key Informant interviews, the Hartford Survey Project, and data from the Health Equity Index validate the concern for marginalized and underserved populations.

- The top 5 quality of life issues mentioned by Key Informants as currently having the most negative impact in Hartford were **poverty**, **job opportunities**, **quality of housing**, **neighborhood safety**, and **education**.

- Hartford has a greater number of renters than owners, more households with mothers being the sole head of household, and lower residential property values than the state, overall. These are associated with poor health outcomes. There is also a higher rate of service occupations when compared to the state and nearly 1/5 of the city's labor force unemployed. With subpar housing and employment levels, overall economic security rates low.

- Nearly a third of Hartford's adults do not have a high school diploma, and the average graduation rate is 77%; high educational attainment is one of the key determinants of community health since it leads to increased economic security and occupational prestige.

- More than 10% of all of the crimes committed in Connecticut in 2009 were committed in Hartford, even though Hartford accounts for less than 4% of Connecticut's population, and there are certain types of crimes that occur with greater frequency in Hartford than in the state overall.

- Compared to other Connecticut cities, the overall environmental quality in Hartford is poor; HEI scoring for waste stream and water discharge pollutants were low. The underlying perception of the city as "unclean" could also impact individual health decisions.

- Less than half of Hartford's residents are registered to vote; a trend that is often associated with fewer community resources and support networks.

Health Indicators

Cancer incidence for all types (specifically lung and prostate) is well below the national and state levels; however, it is important to keep in mind that Hartford has a relatively young population when compared to state and national figures. Key Informants also perceived cancer as less of a priority with only 11.9% respondents ranking it within their top five health issues.

- In general, chronic lower respiratory disease death is lower in Hartford than across the nation or in the state; however, asthma hospitalization rates in Hartford are much higher when compared to the state, with children and adult rates that are at least three times higher than the state rate. Asthma, not one of the options provided in the Key Informant survey, was the most frequently written-in health issue by participants.

- Although one of the top health issues identified by Key Informants was violence, most respondents perceive that violent acts, while isolated in Hartford, are a product of a depressed economic situation. Hartford accounts for more than a third of all murders in the state, and experiences a higher percentage of assaults. This disproportionate and avoidable indicator negatively impacts the overall quality of life in the city.

- There is a much younger population in Hartford compared to the state and nation that is reflected in the mortality rate. This is also reflected in a lower occurrence of the top ten national causes of death, which are often age-related. However, the much higher age-adjusted rate suggests that the elderly population, albeit small, is dying at a very high rate. Infant and neonatal death rates are much higher in Hartford than the state and nation. Hartford also has considerably higher rates of infectious/communicable diseases than the state.

- There is an indication that obesity is a concern for Hartford. Health indicators for heart disease are worse for Blacks and Hispanics, and those who live below the poverty threshold; diabetes rates in Hartford have been increasing in recent years.

Access to Care – Access to care was commonly cited in both the Key Informant study and the Hartford Survey Project. While the Hartford Survey Project concluded that the top four barriers to care were lack of knowledge about existing services, lack of available services, inability to pay, and lack of transportation, the Key Informant study showed a need for improving access to care across the board for a variety of underserved populations.

III. Methods: How We Obtained the Data

The data in this report were compiled from a variety of resources, and includes both quantitative and qualitative data. Additionally, it includes very specific information on critical health indicators and broader information regarding the social determinants of health.

The CHNA report synthesizes findings and data from the following three sources:

Key Informant Interviews – Each Workgroup member identified 5 to 10 people in management or leadership positions with various community organizations including health and human services, religious organizations, and government agencies; 85 unique Key Informants were identified by the Workgroup. Respondents were asked to critically evaluate health needs pertinent to the community through their experience. Survey questions focused on underserved populations and access to care issues in Hartford. In total, 59 interviews were conducted; see Appendix for a complete list.

The Hartford Survey Project – In order to better understand Hartford's human service needs and barriers to receiving services, a face-to-face survey conducted by the Urban Alliance was completed between October 2010 and January 2011. 402 resident surveys were completed at 12 locations throughout the city to promote geographical and ethnic diversity among respondents; these locations included grocery stores, pharmacies, and community events and programs. Respondents were asked if they would benefit from any of 12 service areas, the possible barriers to obtaining these services, and which three areas of the 12 have a need for additional services. In addition, they were asked to rank the top three service areas in Hartford that they believed were in most need.

Of the total respondents, 57% were female and 43% were male. The ethnicity breakdown was 39% African American, 37% Latino, 9% white, and 8% West Indian. Age categories for respondents were 27% between 18 and 29 years old, 42% between 30 and 49, 24% between 50 and 64, and 6% were 65 and older.

Secondary Data – Holleran, in coordination with HHS, prepared the initial community profile for Hartford from secondary data sources. In addition the following sources of data were used throughout this assessment:

- Connecticut Department of Public Health Vital Statistics and Health Outcomes
- Women's Health Quick Health Data Online via the Office on Women's Health (US Department of Health and Human Services)
- Health Data Interactive via the Centers for Disease Control and Prevention
- Connecticut Labor Market Information via the Connecticut Department of Labor

There was also an analysis of local, state, and national 2009 U.S. Census Bureau data collected via the annual American Community Survey; this data is available via the Census Bureau's website.

HHS was also able to use the Connecticut Health Equity Index (HEI) to build upon and enhance the findings from the original information. Developed by the Connecticut Association of Directors of Health (CADH), a non-profit membership organization that represents local directors of health departments and/or districts in the state, the HEI can be used to identify social, economic, and environmental conditions and their correlations or relationships to specific health outcomes. Key social determinants of the HEI include: civic involvement, community safety, economic security, education, employment, environmental quality, and housing. Collectively, these social determinants form the fabric of social and economic opportunity and a healthy environment, as well as provide insight to how social determinants may affect health outcomes and health care services of various populations living in the area of interest. The HEI is an excellent tool for determining how social factors are associated with community health, and by using up-to-date data sources, HEI's commitment to quality improvement evolves along with Connecticut's communities.

Hartford is one of three pilot sites in the state that was selected to test and evaluate the HEI for its use in mobilizing a community, stimulating sustainable action, increasing knowledge of health equity concepts and their application, and prompting structural changes that reflect local needs. Data collection for the HEI began in 2007 and continues through 2012. The HEI is based on a ten-point measurement scale, where 1 is a low score, which represents a less favorable community condition or health outcome, and 10 is a high score, which symbolizes a more favorable community condition or health outcome.

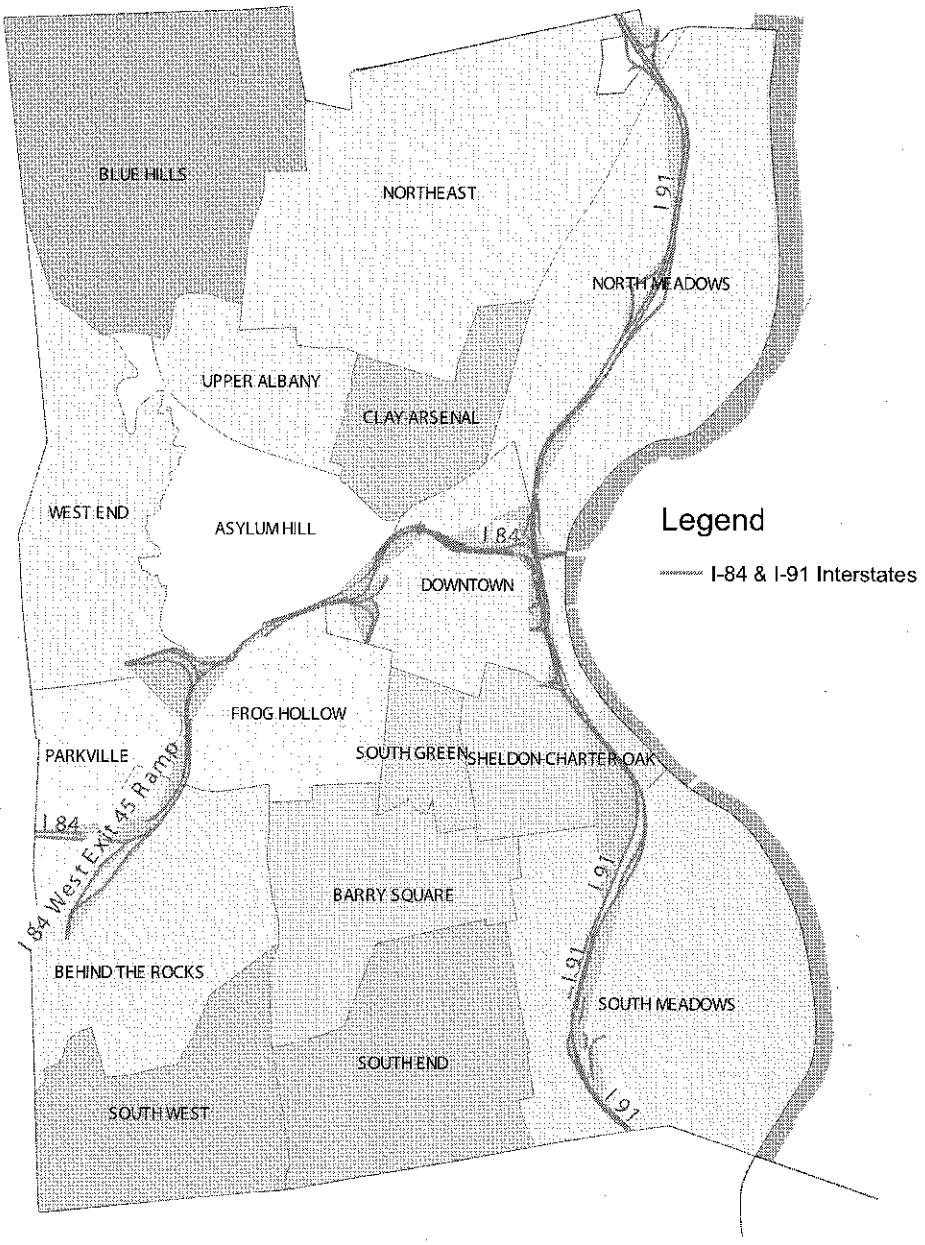
HEI maps were used to compare neighborhoods by social determinant or health outcome indicators. This comparison includes both the North Meadows and South Meadows neighborhoods for analysis, although the former is mainly comprised of car dealerships and landfill, and the latter with a small airport, a water pollution plant, and various commercial and industrial businesses. Together, both neighborhoods are home to less than 3% of Hartford's total population and must be considered when viewing the maps.

A feature of the HEI is that for every social determinant listed (civic involvement, community safety, economic security, education, employment, environmental quality, and housing), the varying factors used to determine the indexing are analyzed with each of the health outcomes in the index (accident/violence, cancer, cardiovascular, childhood illness, diabetes, health care access, infectious disease, life expectancy, liver disease, mental health, prenatal care, renal disease, and respiratory illness). Strength correlations are derived using Spearman's rank correlations, and are generated between the social determinant selected and significant health outcomes. The strength of a correlation is measured between 0 and 1, and the closer the coefficient is to 1 the stronger the correlation between the measures; a correlation of 0

signifies no statistical relationship between measures. Direction of a correlation is measured by signaling a correlation as positive or negative. A positive correlation signals a direct relation between two measures, while a negative correlation signals an inverse relationship. All correlations generated by the HEI are statistically significant.

The maps displayed throughout this report use a color gradient to indicate how Hartford neighborhoods rank with each other with regard to a specific social determinant or health indicator; the darker the color means the lower the rank. The subsequent map is a legend for all Hartford neighborhood names and should be referred to for neighborhood identification.

Map 1. City of Hartford and Neighborhoods



IV. Demographics

Hartford is the capital of the State of Connecticut and the seventh largest city in New England. At almost 400 years old, Hartford is one of the oldest cities in the country and at one point was one of the wealthiest. Still rich with history, it is home to the oldest public art museum and oldest public park in the nation. Starting in the late 1950s, many of the city's residents began moving to the suburbs, possibly accelerated by the construction of two major interstate highways intersecting within the city. And even though the metropolitan area ranked 32 out of 318 nationally in total economic production (second behind San Francisco in per capita economic activity) and the sixth lowest poverty rate of all Metropolitan Statistical Areas (metropolitan statistical area is a geographical region with a relatively high population density at its core and close economic ties throughout the area) for the 2010 census, the city itself remains one of the poorest in the nation; 31.9% of all its residents, and 38.3% of its families with children under 18 years old are living below the poverty line.

The population in Hartford is 124,775, with a **gender** ratio close to state and national ratios of 49% male and 51% female. Hartford is proportionally younger than the state and the U.S., which impacts numerous aspects of health including rates of some types of cancer, violence, and levels of unintended injury.

Table 1. **Age Categories for Hartford, Connecticut and the U.S.**

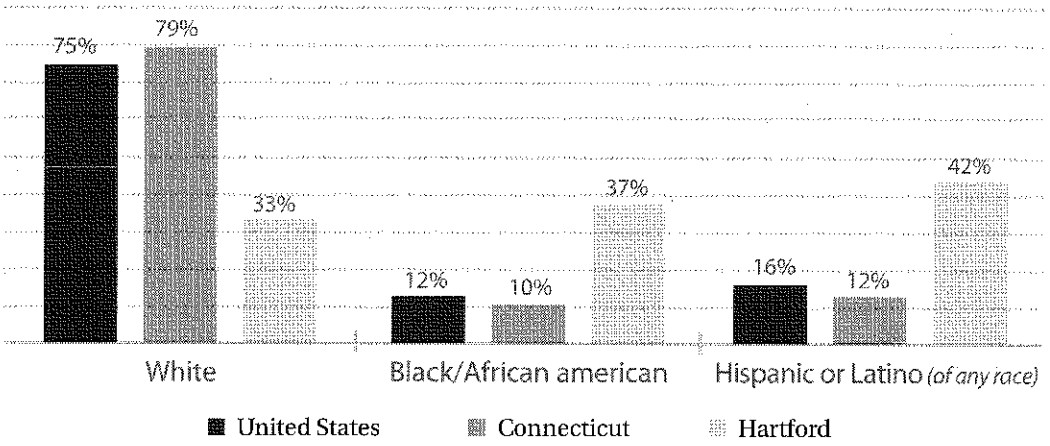
	HARTFORD	CT	US
0-19 years	**34%**	26%	27%
20-44 years	**37%**	32%	34%
45-64 years	**20%**	28%	26%
65 and older	**10%**	14%	13%

The **ethnic composition** of Hartford is mostly a mix between Hispanic/Latino of any race, Black/African American, and white. Hartford's white population is at a lower ratio than the U.S. and state while the proportion of Black and Hispanic/Latino residents is significantly higher. Ethnic variation in cultural norms, English comprehension, and beliefs about health impact the mode of health care delivery and how patients respond to health care services. This variation creates a need for increased awareness and sensitivity among service providers.

A significant percentage of Hartford residents can trace their heritage to Puerto Rico and the West Indies; in the 1940s, many immigrants from these areas moved to Connecticut to work in tobacco fields. 78% of Hartford's Hispanic/Latinos self-reported to be Puerto Rican in the 2010 census. Typically, West Indians are grouped with "Black/African American" in census data, which makes it difficult to highlight cultural differences. However, it is important to

note that the ethnic landscape in Hartford is changing as a greater number of families and individuals from Eastern Europe, Africa, and Southeast Asia continue to make Hartford their home.

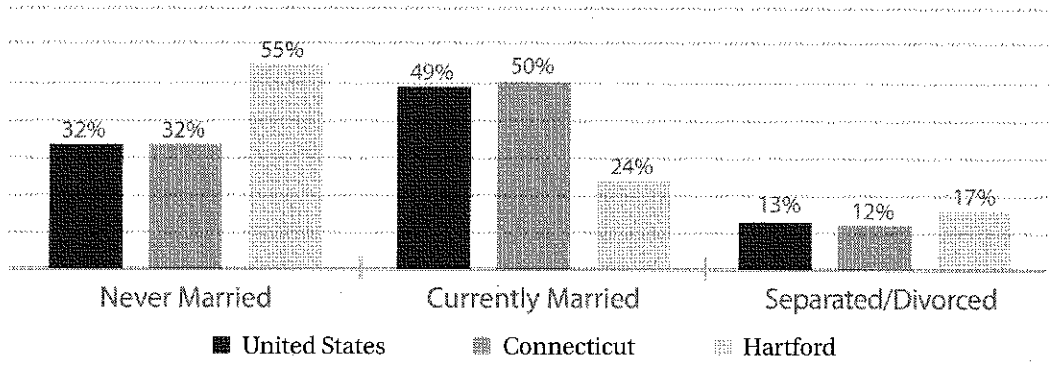
Figure 1. **Ethnic Composition for Hartford, Connecticut, and the U.S. (2009)**



This ethnic breakdown impacts the primary **language spoken** at home. The percentage of Hartford's population who only speak English is 52%, which is lower than a state and the nation comparison. Additionally, approximately 35% of Hartford residents speak a language other than English; the high percentage of non-English speakers could pose a barrier for access to all kinds of health promoting opportunities.

With regard to **marital status**, Hartford's population has a notably larger percentage of people who have never been married when compared to the state and the nation; the City of Hartford also has a smaller comparative percentage of people who are currently married and not separated. The data regarding separated/divorced residents and widowed residents are similar to state and national averages; however, the rate of legally separated couples (de facto separation while remaining legally married) in Hartford (5%) is twice that of the nation (2%).

Figure 2. **Marital Status Statistics for Hartford, Connecticut, and the U.S. (2009)**



VI. Social Determinants of Health

Quality of life issues are indicators that include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging [2]. During this assessment, Key Informants were asked a variety of questions about quality of life in Hartford. For nearly all quality of life questions, 50% or more of informants ranked them as "Poor" or "Very Poor."

Table 2. **Poorly Rated Quality of Life Measures by Key Informants**

QUALITY OF LIFE	RATED "POOR" OR "VERY POOR"
Poverty	93.1%
Job opportunities	87.3%
Quality of housing (affordable, in good condition)	72.4%
Neighborhood safety	71.9%
Schools/education	65.5%
Clean, litter-free neighborhoods	63.1%
Road/traffic conditions	53.6%
Availability of recreational activities	52.6%
Availability of care for children	31.6%
Water or air pollution	26.4%

This information provides insight for those who are regularly involved in the health and human services sector. The following section will addresses social determinants of health, and how Hartford rates relative to state and national figures.

Housing

Adequate housing provides shelter and comfort to its inhabitants, both of which impact overall well-being. One of the measures used to evaluate the association of housing and health is the number of subsidized housing units per 1000 local residents as defined by the Connecticut Housing Finance Authority. Using 2005 data, the HEI correlated housing strongly with infectious disease in Connecticut, and Hartford received the overall lowest housing score in the HEI when compared to the rest of the state.

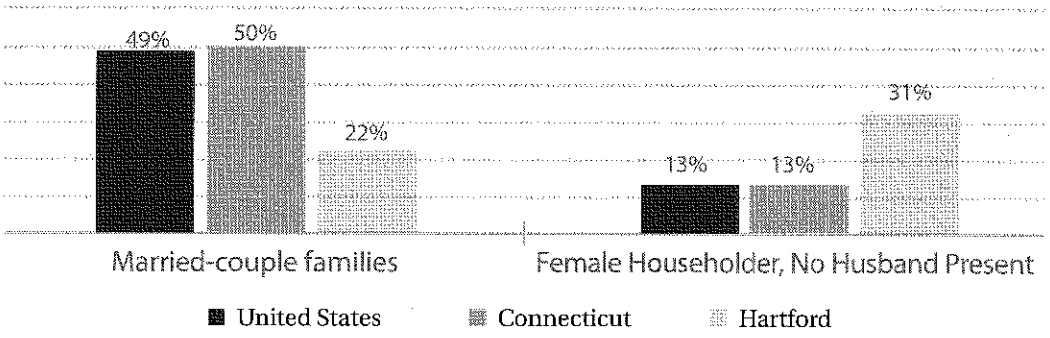
Subsidized housing is abundant in Hartford. As is typical throughout the United States, these subsidized housing units have become a feature of low-income and resource-poor areas. In Hartford, residing in subsidized housing is correlated with numerous health outcomes, such as increased rates of chlamydia and/or gonorrhea, asthma hospitalizations, infectious and parasitic diseases, homicides, drug-induced deaths, mental health hospitalizations, and births not receiving prenatal care in the first trimester.

A cursory analysis of **housing occupancy** in Hartford reveals that the city has over 44,000 occupied housing units of which 26% are owner-occupied; the state average is 69%. A higher rate of rental units is associated with poorer quality of housing and impacts health. Over 70% of Key Informants surveyed ranked housing quality at either "Poor" or "Very Poor." Further highlighting the housing issue, homelessness was the issue recognized as most in need of additional services by those surveyed by the Urban Alliance (45%).

Lower residential property values, accompanied by lower sales prices and a greater number of foreclosures are strongly associated with lower quality neighborhoods. Neighborhoods with these negative housing characteristics typically have higher crime rates, lower quality school systems and a poor physical environment (sidewalks, parks and properties). For 2010, the average assessed residential property value in Hartford was $43,689, which is significantly lower than the state's average value of $209,025; and the average sales price of an existing home was $164,462, which is lower than the state's average home sales price of $288,948.

Hartford **household statistics** for family (59%) and non-family households (42%) are similar to state and national rates, but deviate substantially for the percentage of female householders with no husband present (much higher than state and national) and the percentage of married-couple families (much lower than state and national). Additionally children in Hartford are almost three times as likely (19%) than those in the rest of Connecticut (7%) to live in households with no husband present.

Figure 3. Household Types for Hartford, Connecticut, and the U.S. (2009)



In the HEI, Hartford has a housing indexed score of 3, which is a less favorable condition in this category. Some of the calculating factors used to determine this score are rental vacancy rates as a percentage of rental units, owner occupied housing as a percentage of total housing units, and median gross rent as a percent of household income. These measures were calculated using data from the 2000 US Census.

Table 3. **Health Indicators Related to *Housing***

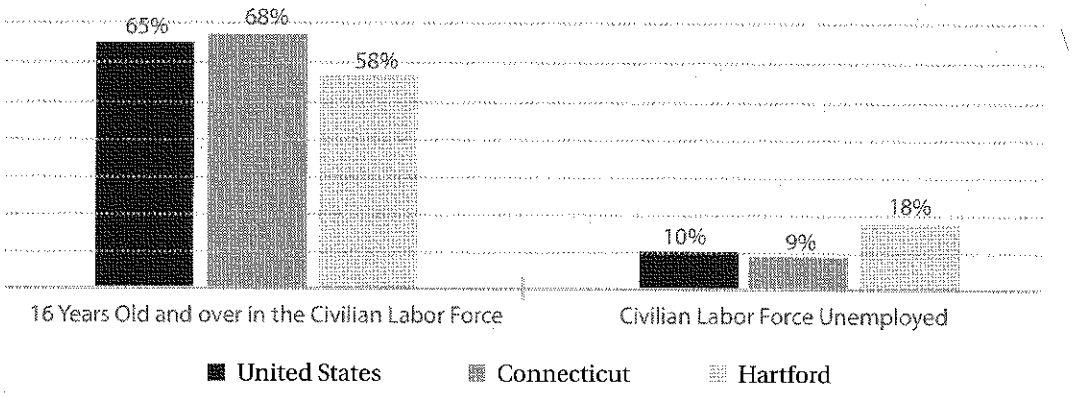
	HEI INDEX	CORRELATION COEFFICIENT
Infectious Disease	2	0.55
Health Care Access	2	0.47
Childhood Illness	1	0.42
Accidents/Violence	3	0.40
Mental Health	2	0.37
Renal Disease	2	0.33
Life Expectancy	3	0.31
Cardiovascular	3	0.29
Respiratory Illness	4	0.29
Diabetes	3	0.24
Perinatal Care	3	0.22
Liver Disease	2	0.20
Cancer	5	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Employment

As of September 2011, Hartford's unemployment rate was 15.6% according to the Connecticut Department of Labor's Labor Force Data, which is nearly twice the rate as the United States (8.8%). Against this backdrop, it is fitting that surveyed residents of Hartford rank job training/employment assistance as one of the top three service needs in the community. Key Informants had a similar view with 87% ranking job opportunities in Hartford as "Poor" or "Very Poor."

Figure 4. Employment in Hartford, Connecticut, and the U.S. (2009)



The percentage of workers in Hartford in management, professional, and related occupations (21.1%) is smaller than the state and nation (40.3% and 35.7%, respectively). Conversely, the percentage of those in the labor force with service occupations is much higher in Hartford

(34.4%) than across Connecticut and the nation (17.3% and 17.8%, respectively). With this disproportionate representation of Hartford residents across these occupational groups and the strong correlation between employment and health care access, one can see how Hartford struggles to maintain a healthy community profile.

Table 4. **Health Indicators Related to *Employment***

	HEI INDEX	CORRELATION COEFFICIENT
Health Care Access	2	0.54
Childhood Illness	1	0.48
Accidents/Violence	3	0.37
Life Expectancy	3	0.35
Respiratory Illness	4	0.28
Infectious Disease	2	0.28
Cardiovascular	3	0.28
Perinatal Care	3	0.26
Mental Health	2	0.23
Cancer	5	-0.19

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

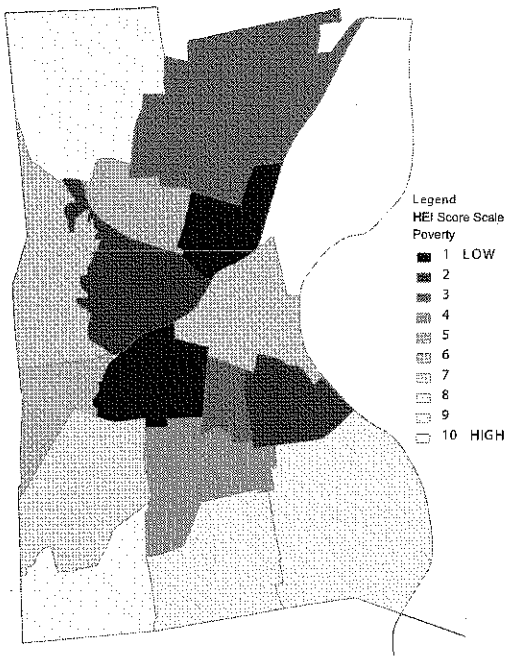
The lack of employment has long been linked to increased rates of mortality. For Connecticut, unemployment has been strongly correlated with decreased health care access, which can serve as a partial explanation for the correlations with a decreased life expectancy, and increased incidences of respiratory illness, and infectious and cardiovascular disease, as well as illness among children. This is reinforced by responses to the Key Informant survey where finances and access to health care were identified as significant barriers.

Economic Security

Hartford received the lowest possible score on the HEI for the majority of factors that determine economic security. Additionally, 93% of Key Informants rated Hartford's poverty level as either "Poor" or "Very Poor" on the Quality of Life section of the survey. Results from the Urban Alliance survey were similar, with employment opportunities and financial assistance topping the list of services needed. According to a report from the Robert Wood Johnson Foundation, income and educational attainment are the two most commonly used markers of socioeconomic status or position in the United States [3]. Both are strongly related measures of health and health-related behaviors. These factors can influence health through the direct effects of extreme poverty (such as malnutrition or exposure to extreme heat or cold) as well as health effects due to chronic stress; these can include the triggering and exacerbation of depression and cardiovascular disease [4].

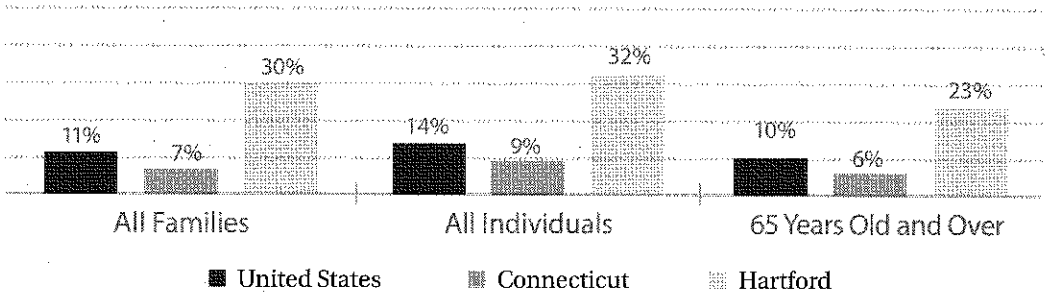
Below is a representation of how Hartford neighborhoods compare to each other with regard to poverty using HEI indexing from the 2000 U.S. Census. Using the color gradient in the legend, the darker colors indicate a lower ranking and higher level of poverty.

Map 2. **HEI Poverty Score by Neighborhood**



With 30.25% of Hartford's families living in poverty, the poverty statistics for the city are three times higher for families than in the United States overall and over 4 times greater than in Connecticut. Similar patterns have been documented for residents and for those over the age of 65.

Figure 5. **Poverty in Hartford, Connecticut, and the U.S. (2009)**



The **income statistics** for Hartford illustrate that the median income per household and family, are significantly less than the state and national figures.

Table 5. **Income Statistics for Hartford versus State and Nation**

	HARTFORD	CT	US
Median Household	**$28,300**	$67,034	$55,221
Median Family	**$33,805**	$83,069	$61,082

In Connecticut, living in poverty is correlated with higher rates of chlamydia and gonorrhea, trauma-related hospitalizations and ED visits, mental health ED treatments, homicide, hepatitis C, diabetes, drug and alcohol induced deaths, low and very low birth weight babies, and infectious and parasitic diseases.

Education

Just as low levels of employment impact community health, so does low educational attainment. 13.9% of Hartford residents perceive education to be one of the top three needs for the community. Key Informant survey respondents noted that the best way to promote wellness and prevention of illnesses in Hartford residents is through education. One respondent noted that starting with school-age children is the best way to achieve these goals. Another declared that it is necessary to tailor the education to "racial, cultural and other different types of understandings to get to the people of the city," and that the frequency of wellness education should be "not just doing it once a year" in order to convey necessary concepts.

Results from the Connecticut Mastery Test and Connecticut Department of Education were used to establish a connection to community health, as indicated in the following table:

Table 6. **Health Indicators Related to *Education***

	INDEX SCORE	CORRELATION COEFFICIENT
Childhood Illness	1	0.73
Life Expectancy	3	0.64
Infectious Disease	2	0.59
Health Care Access	2	0.57
Accidents/Violence	3	0.55
Cardiovascular	3	0.51
Mental Health	2	0.42
Respiratory Illness	4	0.41
Renal Disease	2	0.39
Diabetes	3	0.38
Perinatal Care	3	0.34
Liver Disease	2	0.21

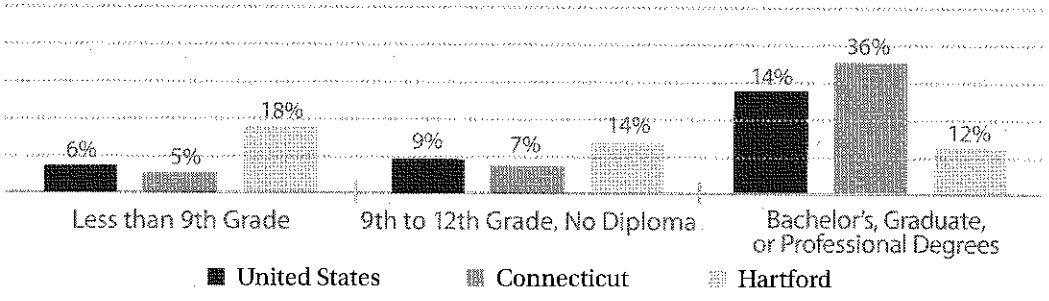
Note: All shown correlations are statistically significant and ranked in order from strong to weak.

As the demographic data indicates, Hartford residents are less likely to graduate from high school and are less likely to obtain post-secondary education when compared to the state or nation as a whole. The strong correlations suggest that a higher educational attainment leads to better health throughout an individual's lifespan, and better health and education enable people to realize their capabilities to be productive members of society [5], with greater potential for positively impacting the community.

In Hartford, low rates of educational attainment are coupled with lower standardized test scores and less frequent renovations of the city's public school facilities; according to the Connecticut State Department of Education's Connecticut Education Data and Research (CEDaR) website, the average number of years since a major renovation for Hartford's elementary, middle, and high schools is 25.8, 33.8, and 17.5 years, respectively. As indicated in the table above, education is correlated with a host of preventable poor health outcomes including increased rates of childhood illness, respiratory illness, renal and liver disease, diabetes, and infectious diseases; poorer cardiovascular health; and frequency of accidents and violent incidents. Other correlations to education include lower life expectancy, lower rates of perinatal care and health care access, and worse mental health outcomes.

Over 30% of Hartford's adults of 25 years and older do not have a high school diploma, which is significantly higher than the 12% for the state. Conversely, the percentage of Hartford's population with a bachelor's degree or higher is also lower than both state and national figures at 12% when compared to 36% for the state. When these data are examined more closely it becomes clear that the problem of low **educational attainment** begins early for many, with 18% of Hartford residents over age 25 having less than a 9th grade education and another 14% having attained from 9th and 12th grade but without a diploma.

Figure 6. **Educational Attainment of Adults 25 Years and Older for Hartford, Connecticut, and the U.S. (2009)**

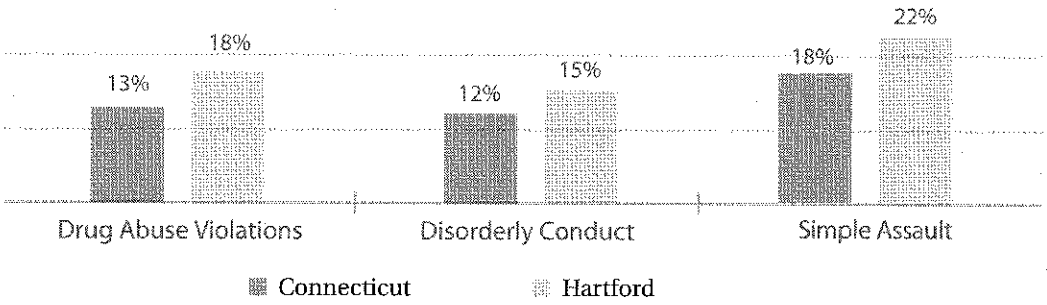


Community Safety

The HEI measures community safety by the rate of crimes against persons or property published by the 2004/2005 Connecticut Uniform Crime Reports, and within this framework Hartford receives the lowest score of 1 indicating high rates of crime. However, the crime statistics found in the Secondary Data Profile are potentially inconclusive because a high

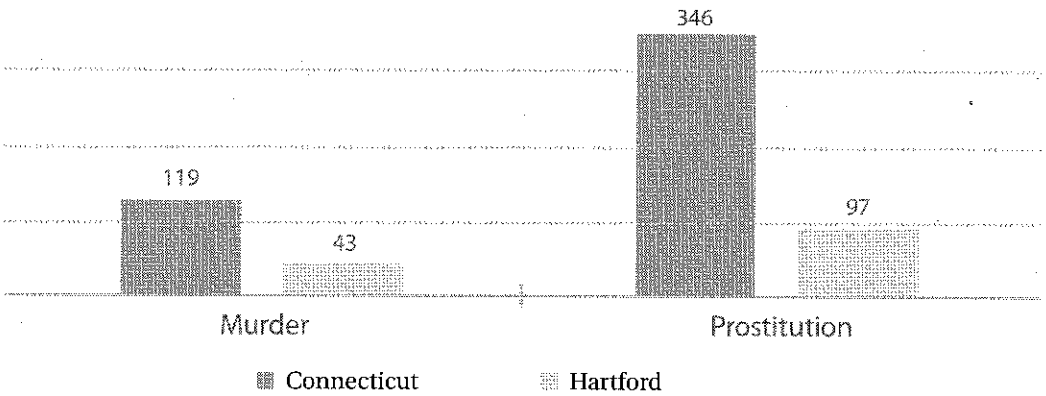
rate of arrests in the city could either indicate that crimes are more prevalent or that more effective law enforcement approaches have been implemented. Nevertheless, according to the 2009 Uniform Crime Report from the Connecticut Department of Public Safety, over one third of all murder arrests in Connecticut occurred in Hartford. Moreover, almost 20% of the state's drug abuse violations occur in the city. Other violent crimes that occur more frequently in the Hartford than in the state are simple assault and disorderly conduct.

Figure 7. **Percent of All Crimes in Hartford and Connecticut (2009)**



Over 70% of Key Informants rated neighborhood safety in Hartford as "Poor" or "Very Poor." Given the opportunity to define a healthy community, one Key Informant stated that it should be "a community where individuals and families would choose to live [and one that can] provide a quality of life that is safe and engaged. People are being physically healthy, not being subject to lead poisoning and toxic things. Violence and noise pollution are not issues." Unfortunately, this community scenario is not widely available for the majority of Hartford residents, but community safety has multiple measures and Hartford experienced proportionally less crime than the state on infractions involving larceny/theft, gambling, liquor laws, and driving under the influence.

Figure 8. **Crime in Hartford and Connecticut (2009)**



In 1982, Wilson and Kelling introduced the broken windows theory to explain urban disorder and vandalism on crime and anti-social behavior [6]. The appearance of the environment can suggest what is acceptable, with a disordered environment implying that behaviors that are usually unacceptable can be perpetrated without fear of consequences. And although this theory has been met with criticism cities such as New York and Albuquerque have implemented policy shifts to address "quality of life" issues and have seen improvements in the overall community security and decreases in crime. Generally speaking, a safer community is synonymous with a healthier community.

Hartford has taken strides to address its issue with violence in the city. Since the re-instatement of the Shooting Task Force in 2011, shootings have decreased by 35% [7]. Although the partnership with neighboring cities, the Connecticut State Police, and the Office of the Attorney General has been effective in reducing shootings, a more comprehensive approach in crime intervention is needed. The City of Hartford is also making a concerted effort to improve the condition of its neighborhoods through the implementation of the Livable and Sustainable Neighborhoods Initiative. As part of this initiative, city government is partnering with homeowners and other neighborhood stakeholders throughout the city to address blighted properties and revitalize Hartford's sense of community. By addressing the needs of some of Hartford's most vulnerable areas, the city is taking proactive steps to rebuild its infrastructure, reduce crime, and restore hope.

Environmental Quality

The environment where we live, work and play; the quality of the air we breathe; the water we drink – all of these have an impact on our health. While individual education and behavior change are important to improving health, the real power in making progress on health is in changing the environment and systems that structure and affect our world.

The HEI measures the relative environmental burden of Connecticut's municipalities by using specific Federal Toxic Release Inventory data, examining levels of locally generated air and water pollution, and industrial density. These two measures are positively correlated with employment opportunities; however, they are however negatively correlated with health outcomes. Hartford receives an average score (4) in the Health Equity Index for both the number of facilities reporting and the total air emissions in pounds. Total water discharge and waste stream in pounds, measures of water pollution, are strong indicators of localized pollution levels, and Hartford has high levels of both. These two measures strongly correlated with the chlamydia and gonorrhea rates.

While potential relationships between high STD rates and a high environmental burden may initially seem attenuated at best, both act as a highly reliable indication of a marginalized neighborhood impacted by blighted property and compromised opportunities for fulfillment. Strong correlations between two seemingly distinct and independent realms such as environment and STDs speak to the vast array of various social and health burdens underserved communities bear disproportionately.

Civic Involvement

According to the HEI, Hartford receives the lowest possible score in terms of civic involvement. Civic involvement impacts health because it is a direct measure of social equity, activism and sustainability of a community; the HEI indicates a strong correlation of low civic involvement with infectious diseases, accident/violence, childhood illness, and life expectancy.

Table 7. **Health Indicators Related to *Civic Involvement***

	INDEX SCORE	CORRELATION COEFFICIENT
Infectious Disease	2	0.59
Accident/Violence	3	0.57
Childhood Illness	1	0.51
Life Expectancy	3	0.50
Mental Health	2	0.45
Cardiovascular	3	0.42
Health Care Access	2	0.42
Liver Disease	2	0.33
Renal Disease	2	0.32
Respiratory Illness	4	0.31
Diabetes	3	0.29
Perinatal Care	3	0.29

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Communities with demonstrated social cohesiveness are more likely to have greater resources and support networks, which would allow for improved health outcomes. Approximately 45% of Hartford's adult residents are registered to vote indicating that an inadequate proportion of the community selects state and municipal government officials. Several factors may prevent an individual from registering to vote including a lack of motivation, frustration with current leaders, or language or cultural barriers. In order to increase the number of registered voters, community-based education initiatives should be employed and should focus on demonstrating to individual residents that they are valued members of the community, and that their vote does in fact make a difference.

Community Food Security

Although not identified as a social determinant of health within the HEI, food security plays a vital role in urban settings like Hartford. While there are 14 medium and large grocery store retailers in the city, corner markets, convenience stores, and fast-food outlets are far more abundant, making a healthy diet difficult to maintain. Pre-packaged and prepared foods are more readily available at such establishments, and their lack of fresh and healthy foods can contribute to various poor health outcomes. In response to this deficiency, the City of Hartford, in partnership with farmers and community-based organizations, is working to

increase the number of farmers' market in the city. In 2011, there were 6 certified farmers' markets in the city accepting grant funds from the Women, Infants and Children federal program and its supplemental nutrition program, the Farmers' Market Nutrition Program. Furthermore, three of the markets were certified to accept Supplemental Nutrition Assistance Program benefits, which helped low-income people and families buy the food necessary for good health.

A report distributed by the University of Connecticut College of Agriculture and Natural Resources found that the presence of food retail resources were not significantly associated with community food security but income and lack of transportation that limit access to food are significantly associated. Despite high numbers of families enrolled in public food assistance, towns with greater rates of households headed by females or the elderly, or lack of education experience greater rates of food insecurity [8].

Foods that are highly processed contain both trans fats and refined sugars, and can lead to both diabetes and heart disease by increasing weight and cholesterol levels. The healthy food shopping choices available to Hartford residents are limited, and signal poor community health. More attention is needed for the overall food system components, including a greater focus on nutrition and cooking skills development.

VII. Health Indicators

As part of the assessment process, Key Informants were asked to rank the **five most significant health issues** in the City of Hartford. The respondents could choose from a list of 25 health issues as well as suggest their own that were not on the list. The five most identified – obesity, diabetes, mental illness, heart disease, and asthma – consisted of four health issues from the list and one write–in response.Mortality statistics are also noted in this section and infectious disease was included due in part to the unique age distribution of Hartford.

This section will also highlight how Hartford rates low in community health when compared to other Connecticut municipalities. As a result of its relatively low standing, this assessment focuses on a Hartford neighborhood comparative using city–specific indexing from the HEI in order to gain a richer understanding of city health concerns. The health outcomes included here are Life Expectancy, Mortality, Infant Mortality, Infectious Diseases, Respiratory Illness, Obesity/Heart Disease, Diabetes, and Mental Health.

Life Expectancy

Percent of deaths for the City of Hartford due to any of the top 10 causes of death in the U.S. are overall smaller when compared to the state and nation. The strongest positive determinant correlations with life expectancy are education, economic security, and civic involvement; with Hartford rating very low in each (HEI index of 2, 2, and 1, respectively).

Table 8. **Social Determinants of Health Related to *Life Expectancy***

	INDEX SCORE	CORRELATION COEFFICIENT
Education	2	0.64
Economic Security	2	0.61
Civic Involvement	1	0.50
Community Safety	1	0.41
Employment	3	0.35
Environmental Quality	4	0.34
Housing	3	0.31

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Table 9. **Top 10 Leading Causes of Death for Hartford, Connecticut and the U.S. (ranked from most to least common for Hartford; 2005-2007)**

	CITY OF HARTFORD	CONNECTICUT	U. S.
Heart Disease	**24.2%**	25.6%	25.4%
Malignant Neoplasms (Cancer)	**18.2%**	23.8%	23.1%
Accidents (Unintentional Injuries)	**5.5%**	4.2%	4.8%
Stroke (Cerebrovascular Disease)	**4.8%**	5.2%	5.5%
Chronic Lower Respiratory Diseases	**3.7%**	4.9%	5.3%
Diabetes	**3.4%**	2.6%	3.1%
Septicemia	**2.6%**	2.1%	1.4%
Influenza/Pneumonia	**2.4%**	2.9%	2.2%
Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Disease)	**2.3%**	1.9%	1.9%
Alzheimer's Disease	**1.2%**	2.6%	2.9%

However, the age-adjusted mortality rate (AAMR; defined as a death rate that controls for the effects of differences in population age distributions.) for all causes of death for the city is notably larger than that of the state and nation (876 compared to 692 and 778, respectively). With a younger population, this dramatic difference in the age-adjusted rate suggests that the mortality rate for older populations in Hartford is very high even though the elderly population itself may not be very large. Therefore, deaths due to heart disease and cancer low compared to the state and the U. S.

The Years of Potential Life Lost (YPLL; defined as an estimate of the average years a person would have lived if he or she had not died prematurely.) for Hartford was 10,647 per 100,000 for 2005-2007 for all causes of death. HEI scores Hartford 2 for YPLL. This measure correlated inversely with obtaining a bachelor's degree, and having a higher median household income and median value for owner occupied housing. It had a reverse effect for adults with less than a 9th grade education, so the lower level of education, the greater the years of potential life lost.

Infant/neonatal mortality is a major concern for Hartford; the mortality rates in Hartford for infants and neonates are markedly greater than those across Connecticut and the United States. Upon further examination, there is a pronounced disparity among infant deaths for infants of different races and ethnicities in Hartford; from 2001 through 2008, the mortality rate for Black infants was consistently higher than either the white or Hispanic infant mortality rate.

Figure 9. **Infant and Neonatal Mortality Rates* for Hartford, Connecticut, and the U.S. (2006)**

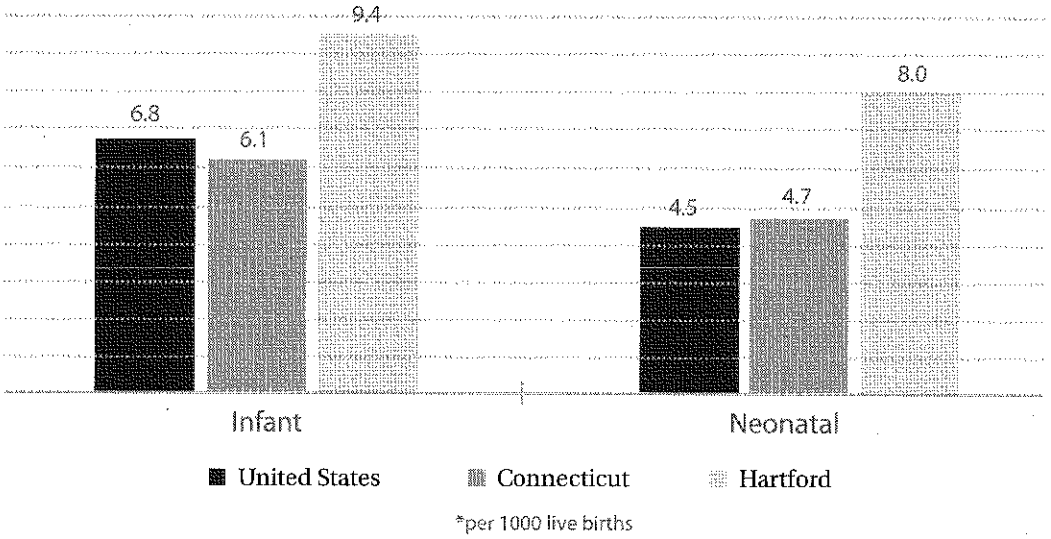
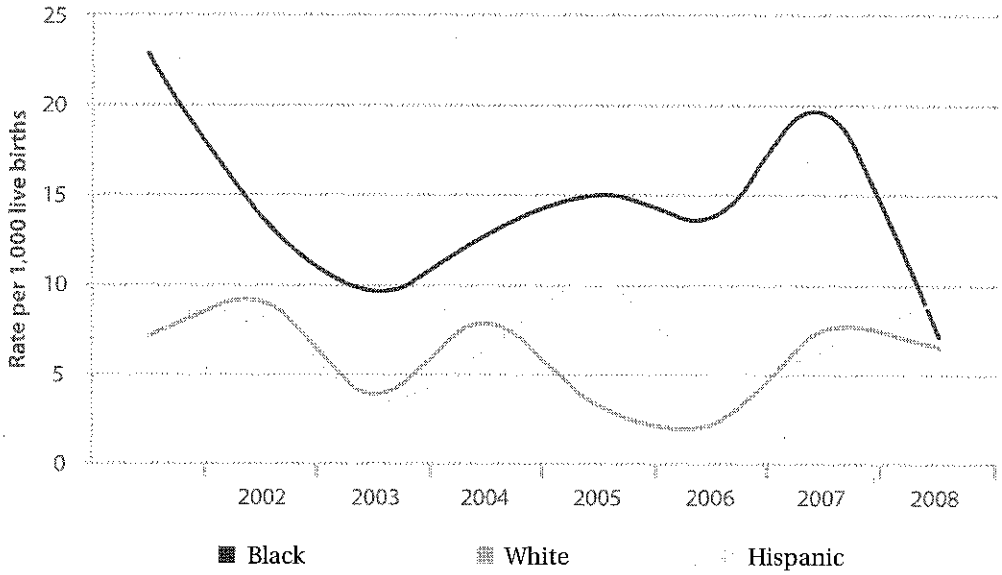
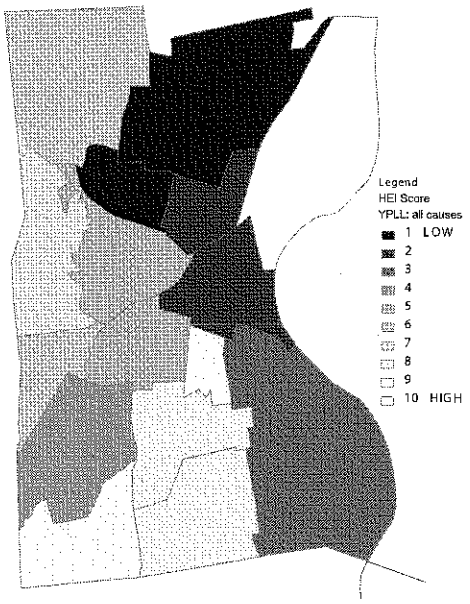


Figure 10. **Infant Mortality Rates by Race/Ethnicity, Hartford, CT (2001-2008)**



These adverse infant health outcomes greatly contribute to a lower than average life expectancy in Hartford. The following map highlights how its neighborhoods compare to each other with regard to the YPLL measure; the darker colors indicate a lower rating (greater number of years) for potential life lost. Six out of 15 neighborhoods (excluding the North and South Meadows neighborhoods) rated low on the YPLL. Per the HEI, the Northeast and Upper Albany neighborhoods were the lowest rated of all Hartford neighborhoods.

Map 3. **HEI Years of Potential Life Loss (YPLL) Score: All Causes by Neighborhood**



Infectious Diseases

In the state of Connecticut, there is a strong correlation of infectious disease with multiple social determinants, as demonstrated in Table 10.

Table 10. **Social Determinants of Health Related to *Infectious Disease***

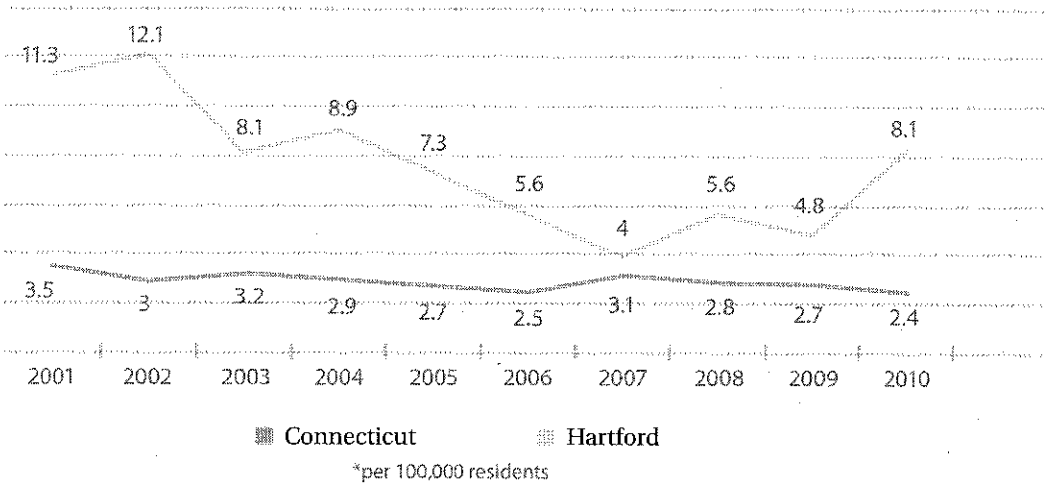
	INDEX SCORE	CORRELATION COEFFICIENT
Community Safety	1	0.67
Education	2	0.59
Environmental Quality	4	0.59
Civic Involvement	1	0.59
Economic Security	2	0.58
Housing	3	0.55
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

There is particular concern when examining **HIV** trends in the city. From 2002 through 2009 per the Connecticut Department of Public Health HIV Surveillance Program, the number of HIV infection cases declined for the city; however, there has been a 221% increase of new HIV infections among self-reporting men who have sex with men over the same time period, as well as a 123% increase in new infections amongst Hartford's Black residents.

There is an established correlation between HIV rates and rates of tuberculosis infection [9]; however, that does not seem to be the case in Hartford. Data from the Connecticut Department of Public Health's Tuberculosis Control Program shows that while tuberculosis rates in Connecticut are in decline, tuberculosis rates in Hartford are increasing.

Figure 11. Tuberculosis Prevalence* in Hartford and Connecticut (2004-2010)



The Connecticut Department of Public Health's STD Control Program provides information on infections more commonly associated with reproductive health. From 2007-2010, a total of 7768 cases of **chlamydia** were reported in Hartford (rate of 157 per 10,000 residents), which is almost 1.5 times higher than the next highest rate of chlamydia infection in the state. Among Blacks and Latinos, the rates were 12.1 and 5.3 times higher than those for whites, respectively. Of all the diagnoses reported during this period, approximately 70% of the cases were among 15 to 24-year olds; Black and Latino female adolescents and young adults accounted for about 36% and 20%, respectively, of all reported chlamydia cases during this same period.

Gonorrhea is the second most commonly reported STI in Hartford after chlamydia. Between 2007 and 2010, approximately 20% of the total reported cases of gonorrhea in the state occurred in Hartford (a rate of 40.5 per 10,000 residents). The rate of infection of women when compared to men was 1.5 times higher (119 versus 78 per 10,000 residents, respectively). Blacks and Latinos also had a disproportionate rate of infection when compared to whites (15.3 and 4.1 times greater, respectively); infection rates were also the highest for 15- to 24-year olds.

Since 2008 the prevalence of **syphilis** in Hartford has increased from 4.1 to 10.5 cases per 100,000 residents; and approximately 94% of all reported cases were male. A racial and ethnic disproportion is also reflected, as African American and Latino male rates were 9.2 and 4.3 times higher than white males, respectively.

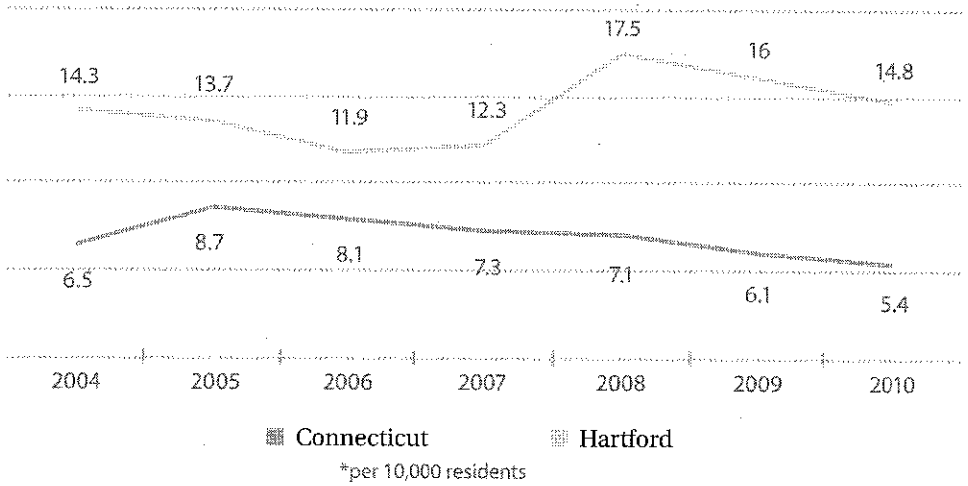
Table 11. **Syphilis in Hartford among Males by Age Category (2007-2010)**

	PERCENT INFECTED
15-24 years old	**34%**
25-34 years old	**10%**
35-44 years old	**41%**

During this same time period, syphilis prevalence among males 25-34 year old increased 81% to 32 cases per 100,000; and among males 35-44 years old it increased 51% to 79 cases per 100,000.

The information concerning **Hepatitis C** (HCV) for the state and the city is limited. From the data available, chronic HCV rates in Hartford have been declining for the past 3 years, yet they still remain 2.7 times greater than the state prevalence.

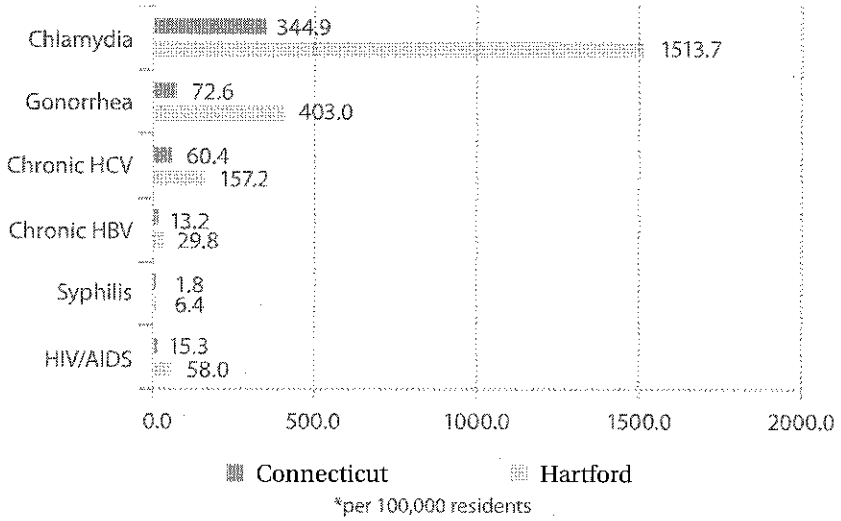
Figure 12. **Chronic HCV Prevalence* in Hartford and Connecticut (2004-2010)**



*per 10,000 residents

With these disproportionate rates of infection, it is not surprising that when compared to the state the city's HEI rating is 2 for all infectious diseases. The following displays a summary of how the city rates when looking at some of the infectious disease trends:

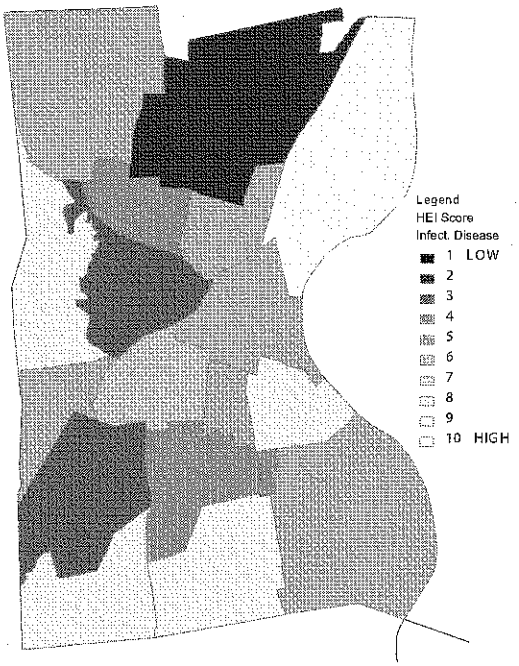
Figure 13. **Infectious/Communicable Diseases Prevalence* in Hartford and Connecticut (2009)**



*per 100,000 residents

Using data from Connecticut's Department of Public Health, a comparison of how Hartford's neighborhoods compare to each other with regard to infectious diseases is demonstrated in the following map using the same HEI rating system; the Northeast rated lowest out of 17 total neighborhoods.

Map 4. **HEI Infectious Disease Score by Neighborhood**



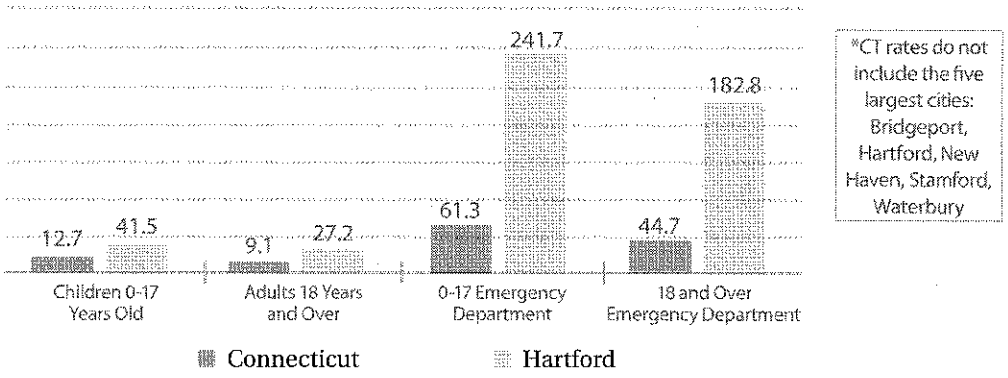
Based on secondary data analysis, Hartford has considerably higher rates of preventable infectious/communicable diseases than the state with the exception of Lyme disease.

The Department of Health and Human Services and the Consortium can identify the prevalence of infectious diseases and provide resources to those who are in most need. The Department's division of Disease Prevention and Health Promotion has both an STD and TB clinic, as well as an HIV program, all geared to curtail infection rates and keep Hartford residents informed and educated. The federal government has passed legislation that provides for individuals who live with HIV/AIDS affordable, high-quality HIV care and related services. For those who are already established Ryan White consumers, there is a network of agencies and area providers that are connected to the city and in position to provide needed services and resources.

Respiratory Illness

Based on data gathered in the Secondary Data Profile, asthma is an area of concern for the community. According to the Connecticut Department of Health, the hospitalization rates for asthma are notably higher for Hartford when compared to the state as seen in the following figure.

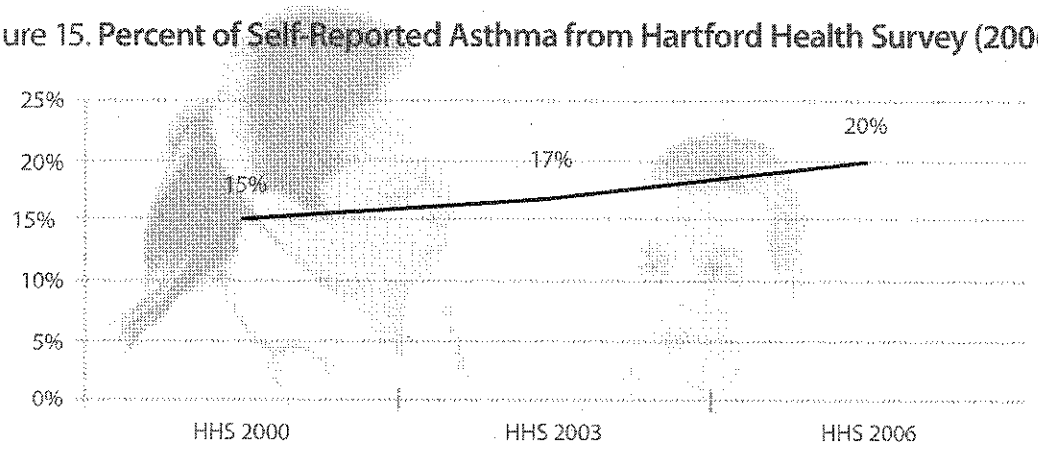
Figure 14. **Asthma Hospitalization Rates* in Hartford and Connecticut (2009)**



*per 10,000 residents

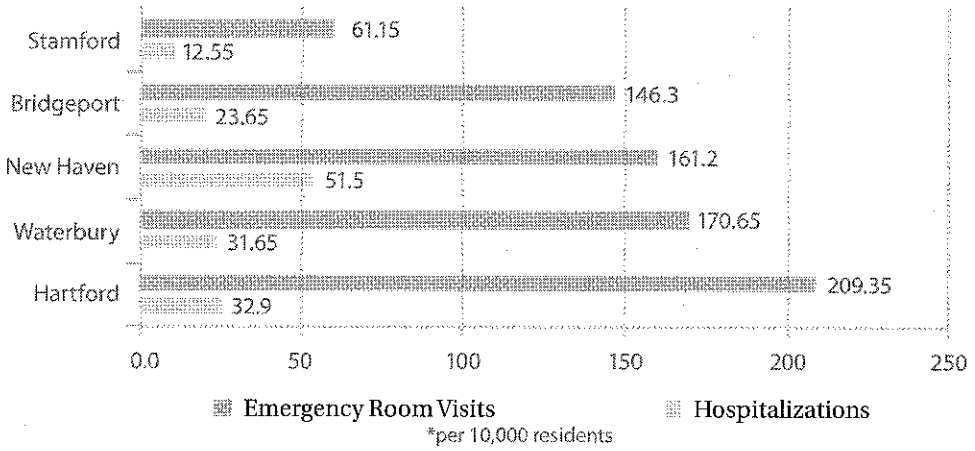
In 2006, the self-reported responses of current asthma among adults were 20%. This is the highest percentage of self-reported asthma in the past three Hartford Health Surveys, an HHS survey conducted through community partners every three years to gauge resident health and access to health care.

Figure 15. Percent of Self-Reported Asthma from Hartford Health Survey (2006)



Regardless of how residents self-report, Hartford has the highest rate of emergency room usage (209 ER visits for every 10,000) and the second highest rate of hospitalization for asthma as the primary cause of diagnosis (33 admissions per 10,000) when compared to other major Connecticut cities.

Figure 16. Asthma Hospitalizations and Emergency Room Visit Rates* for All Residents by Connecticut City (2001-2007)



Similar to asthma hospitalization rates, mortality rates are also an area of concern when compared to the rest of the state. The asthma-related mortality rate for men in Hartford is 22.4 per 10,000 men compared to 7.9 for the rest of Connecticut. Similarly, the mortality rate for women in Hartford is 42.5 compared to Connecticut's rate of 16.5.

In general, respiratory illness in Hartford has some moderate correlations, as noted in the following table, but the HEI indexed score is very low for each of the social determinants correlated to respiratory illness.

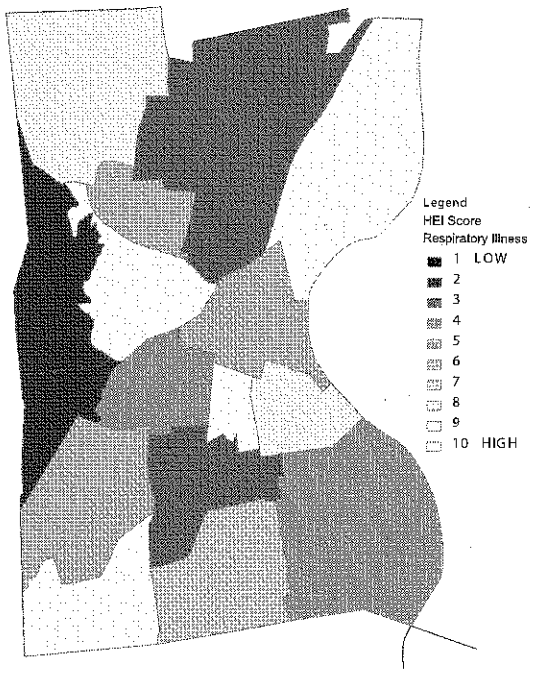
Table 12. **Social Determinants of Health Related to *Respiratory Illness***

	INDEX SCORE	CORRELATION COEFFICIENT
Economic Security	2	0.45
Education	2	0.41
Civic Involvement	1	0.31
Housing	3	0.29
Employment	3	0.28
Community Safety	1	0.26
Environmental Quality	4	0.18

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Using Connecticut Department of Health Office of Vital Records data, the HEI scores Hartford an overall indexed score of 4 when compared to other Connecticut towns and cities. The following map gives an indication of where the lowest scores lie when comparing among Hartford's neighborhood; the West End and Parkville neighborhoods ranked the lowest among Hartford neighborhoods with regard to respiratory health.

Map 5. HEI Respiratory Illness Score by Neighborhood



To help address these issues, the Asthma Call to Action Taskforce, a coalition of representatives from Hartford's Department of Health and Human Services, public schools, area hospitals, community organizations, and other agencies that are concerned about asthma in Hartford, seek to increase awareness about asthma to its residents, improve asthma care, establish a network of individuals and organizations to provide education and resources, and define asthma rate improvement strategies.

Obesity and Cardiovascular Disease

The percentages of obese Connecticut adults 20 years and older are notably higher for the Black and Hispanic populations (39.8% and 29%, respectively) than the state's white population (20.6%) [10]. Obesity is most commonly measured as a percentage of body fat based on height and weight. The following table shows the percent of healthy, overweight, and obese adults in the UnitedStates for all income levels as determined by the National Health and Nutrition Examination Survey. These weight category trends are similar when looking solely at people who are classified as "poor" (those who lived below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22, 314 for a family of four) by the US government. With a high rate of unemployment and a low HEI ranking for economic security, it can be assumed that obesity trends in Hartford are similar and that there is an increased relative risk for hypertension and adverse cardiovascular outcomes [11]."

Table 13. **United States Weight Categories**

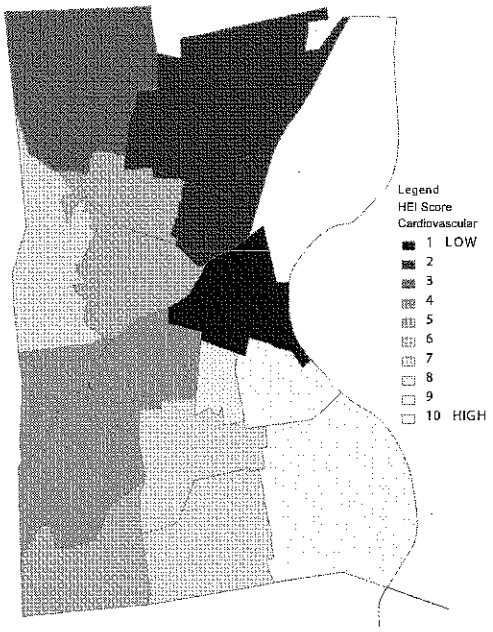
	HEALTHY WEIGHT	OVERWEIGHT	OBESE
1988-1994	41.9%	33.0%	22.7%
2001-2004	32.4%	34.7%	31.2%
2005-2008	30.9%	33.5%	33.9%

Similar rates emerge when looking at people who are classified as "poor" by the US government (those who live below the poverty threshold, currently set at a yearly income of $11,139 for individuals and $22,314 for a family of 4). With high rates of unemployment and a low HEI rating for economic security in Hartford, this trend is most likely mirrored in the city.

Downtown, the neighborhood with the lowest residential density, has the highest economic security and education scores, as well as the largest proportion of white residents. Despite such a low percentage of Hartford residents living Downtown, the fact that this population enjoys greater employment as well as health care coverage contributes to an increase in cardiovascular diagnoses and ultimately prevents undesirable health outcomes. For the remainder of Hartford's residents, cardiovascular health indicators remain elusive.

Obesity has been linked to both cardiovascular health and diabetes [12], and heart disease was the leading cause of death for Hartford from 2005 to 2007. The Northeast and Frog Hollow neighborhoods rate the poorest for these two significant risk factors.

Map 6. **HEI Cardiovascular Disease Score by Neighborhood**



There are several strong and moderate correlations with cardiovascular health, the top being education and economic security; below is a table listing the top five.

Table 14. **Social Determinants of Health Related to *Cardiovascular Health***

	INDEX SCORE	R_s VALUE
Education	2	0.51
Economic Security	2	0.48
Civic Involvement	1	0.42
Environmental Quality	4	0.36
Community Safety	1	0.33
Housing	3	0.29
Employment	3	0.28

Note: All shown correlations are statistically significant and ranked in order from strong to weak.

Diabetes

The fact that diabetes often presents as a co-morbidity with other diseases, it is difficult to segregate the information for just diabetes. The following table shows the age-adjusted percentages for adults 20+ for selected ethnic groups throughout the state; the data are from the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS).

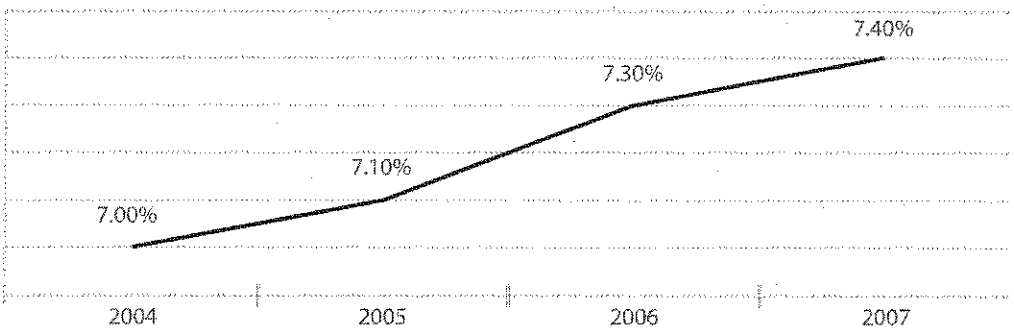
Table 15. **Connecticut Residents with Diabetes by Race**

YEAR	ALL ADULTS	NON-HISPANIC WHITE	NON-HISPANIC BLACK	MEXICAN-AMERICAN
2005	7.2%	6.6%	14.3%	15.1%
2006	6.9%	6.4%	15.0%	10.4%
2007	8.3%	7.1%	20.4%	13.5%
2008	7.2%	6.2%	16.1%	11.6%
2009	6.8%	6.4%	13.0%	9.7%
2010	7.6%	7.0%	13.9%	9.5%

The rates are alarmingly higher for non-Hispanic Blacks, and Hispanics; these trends are the same across all economic levels, and substantially higher for those who live below and near the poverty threshold. Since 2007, there has been a significant improvement in these high rates as both the Black and Hispanic populations in the state have experienced a drop in the rate of diabetes, but there is still a diabetes health disparity drawn along racial lines for the state.

While Hartford's diabetes rate is lower than the state's, the CDC indicates that Hartford's rate is on the rise. If the state trend in diabetes is any indication of how the city is afflicted by this disease, then the assumption would be that the Black population is disproportionately affected when compared to other racial/ethnic groups.

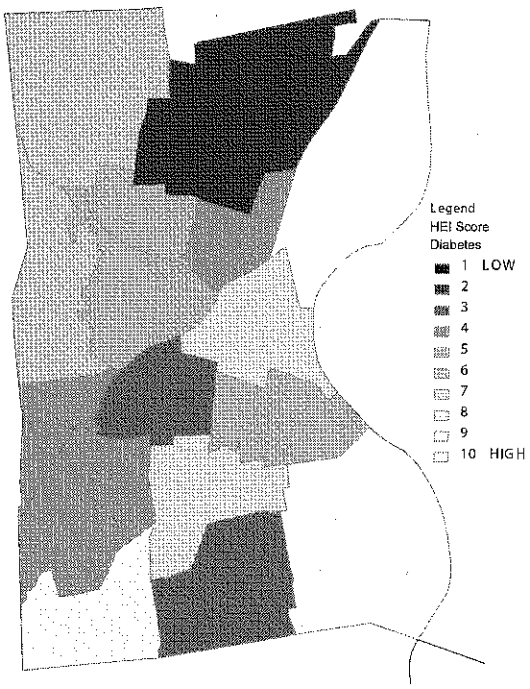
Figure 17. **Diabetes in Hartford for Adults**



Source: US Dept of Health and Human Services, The Office on Women's Health

The neighborhoods are compared to one another in the following map using the HEI indexing giving an indication where in Hartford diabetes is more of a health issue. The Northeast neighborhood ranks the lowest among Hartford neighborhoods.

Map 7. **HEI Diabetes Score by Neighborhood**

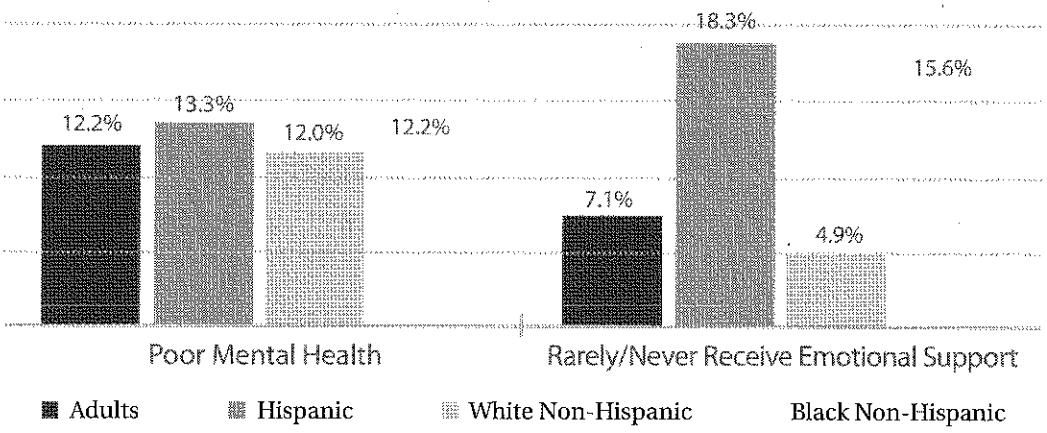


Behavioral Health

The HEI, using discharge data from the Connecticut Hospital Association and death information from the Connecticut Office of Vital Records, calculated an aggregate index score of 2 for mental health as a health indicator for Hartford. There are several significant correlations with mental health, including community safety (Rs=0.55), economic security (Rs=0.47), environmental quality (Rs=0.45), civic involvement (Rs=0.45), education (Rs=0.42), housing (Rs=0.37), and employment (Rs=0.23). With a low-indexed social determinant score, it can be inferred mental health issues are a significant health risk for the city. The BRFSS, a national system of state-based surveys, annually assessed how the residents fare with mental health issues. The results show that there is clearly a greater rate of Hispanics and Blacks self-reporting a lack of emotional support.

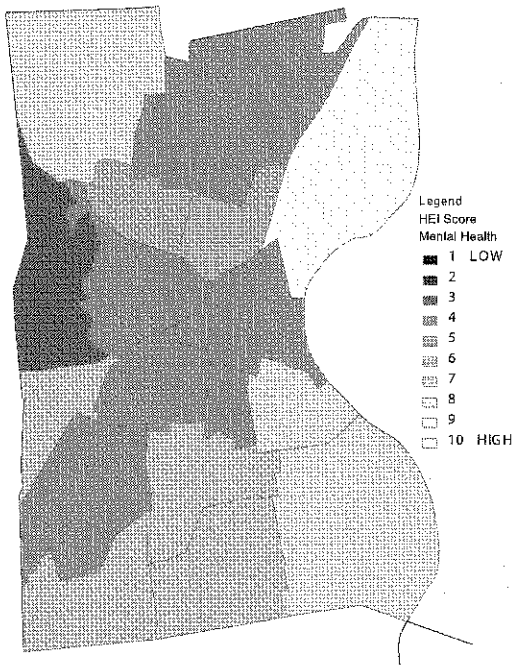
The behavioral health infrastructure is headed by the state through the Department of Mental Health and Addiction Services and its various partners; the complexity of mental health services designed to cater to large geographic regions encompassing the city as well as 37 other municipalities calls for a more thorough investigation and coordinated approach. HHS is currently engaged in a collaborative partnership that includes planning for a Behavioral Health Needs Assessment in order to fully understand the nature of these services.

Figure 18. **Mental Health in Connecticut (Age Adjusted; 2007-2009)**



The neighborhood with the highest utilization of mental health services is the West End, which happens to be relatively affluent when compared to other city neighborhoods. The Consortium could hypothesize that individuals with greater access to specialized health care services would experience higher rates of diagnoses.

Map 8. **HEI Mental Health Score by Neighborhood**



VIII. Barriers to Services

The Urban Alliance survey asked respondents to consider barriers to health services and community resources. The most commonly reported barriers to service areas included not knowing about existing services (27%), lack of available services (22%), not able to pay (20%), and lack of transportation (20%).

Respondents were also asked to identify the most crucial **perceived service needs** for Hartford. Areas perceived as the most in need of additional services included homelessness/ housing (45%), education (41%), job training/employment assistance (39%), and basic needs/food assistance (36%). The top **actual service needs** were determined by respondents indicating that someone in their household would benefit from having additional service in this area. This resident survey found that the actual needs of the respondents were, for the most part, similar to the perceived needs of Hartford; three of the top five needs mentioned were common to both (see table below; ranked by most common responses and common responses bolded). The two areas - perceived and actual service needs - were explored separately to note differences, but with such high correlations in Connecticut between employment, education, and housing, as well as other factors, the overlap between the two areas is not as discordant as they appear to be.

Table 16. **Top 5 Needs for Hartford**

ACTUAL NEEDS	PERCEIVED NEEDS
Basic needs/food assistance services	**Homelessness/housing**
Financial support services	**Education**
Job training/employment assistance	**Job training/employment assistance**
Health and wellness	**Basic needs/food assistance**
Education	**Youth development**

The Key Informant interviews completed by the Consortium had similar findings. More than half of Key Informants chose either "Disagree" or "Strongly Disagree" with positive statements about access to care regarding dental services, medical specialists, a comprehensive model of primary care, providers who accept Medicaid, transportation, and health care delivery in Hartford.

Table 17. **Key Informant Perceptions of Health Care**

ACCESS/ BARRIERS TO CARE	"DISAGREE" OR "STRONGLY DISAGREE"
The majorities of Hartford residents are able to access and afford a dentist when needed.	88%
The majority of Hartford residents are able to access needed medical specialists.	83%
The majorities of Hartford residents are able to access and afford a primary care provider.	76%
Transportation to medical appointments is available to residents when needed.	73%
The healthcare delivery system in Hartford has a comprehensive approach to patient care.	71%
There is a sufficient number of providers accepting Medicaid or other forms of medical assistance.	70%
There is a sufficient number of bilingual healthcare providers in Hartford.	63%

IX. Conclusions

This Community Health Needs Assessment was assembled to give readers an overview of Hartford public health trends and to provide a platform to increase the communication across non-governmental as well as governmental agencies to improve the lives of city residents. The findings from this process demonstrate that Hartford residents include high concentrations of people at an increased risk for unhealthy living. After examining all the data sources used to create this report – the Key Informant Survey, the Hartford Survey Project, and the various secondary data that were analyzed – it is clear that marginalized and underserved populations are overrepresented in the city, and the need for establishing and expanding effective partnerships among city agencies is critical. Poverty, job opportunities, education, quality of housing, and neighborhood safety are quality of life measures that were most often mentioned by the Key Informants. All of these were highlighted in the data as areas where collaboration and renewed effort are necessary.

According to a recent model created by the University of Wisconsin's Population Health Institute, at least half of community wellness is driven by non-health factors such as education, housing, and pollution [13]. Connecticut, consistently one of the wealthiest states in the union, is also home to some of the nation's most significant gaps in leading societal determinants of health. For instance, when looking at poverty, Latinos are 4.7 times and Blacks are almost 3.6 times more likely to be living in poverty when compared with their white counterparts in Connecticut. These poverty rates among Black and Latino population reflect, in part, the terribly high unemployment rates in cities like Hartford, which have been crippled by unemployment rates at least 50% higher than that of the state. Coupled with things like a high percentage of single parent households with children present, these compromising circumstances make it difficult for Hartford residents and their families to achieve optimal health.

In addition to a high concentration of poverty, this assessment identifies other actionable non-medical factors that drive the state of health in Hartford. **Education**, for example, is a key indicator for economic security; low educational attainment coupled with limited employment opportunities adversely impact economic security of the city on a whole. Hartford's battle is a difficult one as one-third of Hartford adults do not have a high school diploma. And with one-fifth of the city's labor force unemployed and a high rate of service occupations for those who are employed, it is apparent that when people get off on the wrong foot, the path to occupations with increased responsibility and higher wages become all the more difficult.

The **housing** situation in Hartford makes it difficult to find up-to-date accomodations. The housing stock in Hartford is an aging one, where more than half of the housing available for both renters and buyers was built prior to 1950. And of all the housing occupied, less than a quarter of Hartford residents own their domicile; the majority has to choose from these old housing options.

Crime continues to be a problem in Hartford. With such a high number of youth living in the city, there is going to be an increased rate of violent and injury-related deaths. The city, having about 3.5% of the entire state's population, accounts for more than a third of all murders. In addition, there are some very specific health issues that should be highlighted:

- High age-adjusted mortality rates despite a population that is relatively young suggest that the senior population is dying at a high rate
- The diabetes rate, although well below Connecticut's rate, has climbed steadily in recent years
- As a percent of the total population in Hartford, residents who are obese are increasing while the percent of healthy weight adults declines
- The infant mortality rate in Hartford is much higher than Connecticut and the United States

Preventing problems before they arise is a particularly powerful tool in population health. These prevention efforts will result in a dramatic cost savings and reduction in social problems to our community. In 2009, the Mayor's office in collaboration with HHS designed and launched the Healthy Hartford wellness campaign, focused on many aspects of daily life in our urban environment. The goal of this campaign is to increase the availability of health related information and have community discussions designed to influence the choices that the Hartford citizenry at all ages makes regarding health behaviors like physical activity, proper eating, and other aspects of disease prevention. HHS launched a set of creative teams to design high-impact activities and approaches targeting all residents; the Healthy Hartford campaign was recently recognized by the U.S. Surgeon General and received the *Healthy Youth for a Healthy Future Champion Award* for its efforts to curb and prevent childhood overweight and obesity within our community. The Healthy Hartford campaign along with its many partners strives to reach the largest possible number of residents by designing interactive activities that target specific demographic groups throughout Hartford's 17 neighborhoods.

The Healthy Hartford campaign is a collaborative effort with area health providers and organizations to promote healthy choices and solutions to health problems by focusing efforts on a specific segment of the population or aspect of living in Hartford (i.e., youth, women, and men; Hartford workforce; and public policies that affect the health of the people). As an example, the recently formed Hartford Childhood Wellness Alliance draws on the combined leadership and expertise of community and professional groups across a spectrum of public health, medicine, academia, child care, and recreation to address the critical issue of childhood health and weight in Hartford. The Alliance provides a structure through which individuals and organizations can join together in the common interest of creating healthy environments for children and families, which in turn would be a cost saver to the city. Early in 2011, the Society of Actuaries calculated that the total economic cost of overweight and obesity in the United States is $270 billion per year as a result of an increased need for medical care, loss of worker productivity due to higher rates of death, loss of productivity due to disability of active workers, and loss of productivity due to total disability. Providing increased accurate chronic

disease self-management training to Hartford residents would have a positive impact on total cost to the city.

Collaboration holds the promise of allowing progress on issues where multiple parties are involved. Sustaining collaborations in Hartford is possible not only because of established partnerships but also because of efforts like such as this needs assessment, which will further strengthen existing relationships by highlighting where the major needs are. Any local health department is limited by available resources. Therefore, HHS' standard operating procedure is to constantly search for, and partner with, other organizations in order to better the lives of Hartford's citizenry.

The Public Health Advisory Council, a city charter-supported advisory panel, is an example of a sustained collaboration relative to residential health and chronic disease. Members of the panel include high-level representation from area hospitals, the Hispanic Health Council, the State of Connecticut Department of Mental Health and Addiction Services, the Connecticut Association of Directors of Health, and other community health organizations, and has regularly met for approximately the last 15 years. As experts on community health, the Public Health Advisory Council advices the city on many public health policies and initiatives.

In order to have improved collaborations throughout the city, there needs to be better data exchange among health organizations. Both health and societal data are not consistently collected, are difficult to compare longitudinally, and frequently may not tell the whole story. To improve the health of Hartford residents, HHS and its partners must have access to accurate local data. There are opportunities to make significant improvements in gathering and tracking such data on all of these issues, particularly on the issues of chronic diseases and risk factors that contribute to health disparities. It is imperative that those working in public health and providers of direct clinical services collaborate to develop a strategic plan for delivery of health care (including preventive care and mental health services) in a manner best suited to the community being served.

This report has presented a case that trends in health outcomes are determined not just by individual-level factors such as genetic make-up or access to medical services. Rather, these rates are a result of but also social, political, and environmental conditions. At the population level, major influences on health are structural. Throughout the development of this report, it has become clear that the disproportionate rates of morbidity and mortality borne by the city's marginalized communities result from far more than access to medical services, a result of cumulative social and environmental conditions in which Hartford's low-income residents are born, grow up, live and work. Hartford stakeholders can no longer afford to ignore evidence linking social determinants of health with health outcomes. By building on the analysis in this report and partnerships throughout the city, Hartford will take significant steps to build the capacity to understand and address the conditions contributing to the compromised health of our most vulnerable neighborhoods.

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XI. Appendix

A. Agencies that participated with the Key Informant Interviews:

Alcohol and Drug Recovery Centers, Inc.	Family Life Education
Asian Family Services (CRT)	Gay and Lesbian Health Collective
Blue Hills Civic Association	Greater Hartford Interdenominational Ministerial Alliance, Inc.
Boys and Girls Clubs	Greater Hartford Interfaith Coalition for Equity and justice
Cancer Program at Hartford Hospital	Hartford 2000
Capital Workforce Partners	Hartford Behavioral Health
Capitol Region Education Council	Hartford Community Schools
Casey Family Services	Hartford Foundation for Public Giving
Catholic Charities (Archdiocese of Hartford)	Hartford Hospital
Catholic Worker House	Hartford Office of Youth Services
Charter Oak Health Center	Hartford Public Schools
Child Health and Development Institute of Connecticut, Inc.	Hispanic Health Council
Children's Trust Fund	Immaculate Conception Shelter and Housing Corp.
Clay Arsenal Neighborhood Revitalization Zone	Injury Prevention Center at CCMC
Commission on Children	Institute for Community Research
Community Health Service	Institute for Hispanic Families s
Community Renewal Team, Inc. (CRT)	Interval House
Conference of Churches	Khmer Health Advocates
Connecticut Children's Medical Center (CCMC)	Latino Community Services
Connectikids	Malta House of Care, Inc.
CT African-American Affairs Commission	My Sister's Place
CT Association of Directors of Health (CADH)	Office for Young Children (COH)
CT Association of Human Services	Pediatric Clinic at Saint Francis Hospital
CT Coalition for Environmental Justice	Saint Francis Hospital
CT Department of Mental Health and Addiction Services	The Village for Families and Children
CT Department of Public Health	UConn Health Center
CT Department of Social Services	UConn School of Social Work
CT Voices for Children	United Way
Daughters of Eve	Urban League of Greater Hartford
Department of Community Outreach at Saint Francis Hospital Wellness	Easy Breathing at the Hartford Alliance for Childhood
Emergency Department at Hartford Hospital	Women's League Child Development Center

B. Key Informant Survey

City of Hartford 2010 Key Informant Survey

Good morning/afternoon, my name is _____ and I'm calling on behalf of the City of Hartford Department of Health and Human Services, CCMC, Saint Francis Hospital and Hartford Hospital. You should have received a letter from those institutions soliciting your participation in a brief survey that is part of a community needs assessment for the City of Hartford. You should have received a survey in advance to help us in this process; if that is not the case I could send one now and schedule for a latter time.

Do you have approximately 15-20 minutes to complete the survey with me? If not, I would be glad to schedule a time that is convenient with your schedule and call you back.

Please know that all of your responses will be held in strict confidence. No individual from the sponsoring organizations will have access to your individual survey. I'd like to emphasize that I am not an employee of the City of Hartford, but am affiliated with Holleran, a research firm located in Lancaster, Pennsylvania commissioned to conduct this research.

DEMOGRAPHICS

Area of Expertise:
Education Level:
Years providing services:

1. What is your vision of a healthy community?

2. What are the most significant barriers that residents of Hartford face when they attempt to access healthcare?

3. What specific populations in Hartford do you feel are not being adequately served by the healthcare system?

_____

_____

_____

4. In your opinion, what proportion of the population in Hartford views the hospital emergency room as their key source of primary care? _____%

Key Health Issues

1. In your opinion what are the five most significant health issues (most severe or most serious) you perceive in your community. The first one being the least important and the last one being the most important.

Caller: Read the list only if respondent needs prompting.

- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ Obesity
- ☐ Daily Life Stressors
- ☐ Reproductive Health
- ☐ Substance Abuse
- ☐ Mental Illness
- ☐ Domestic/Family Violence
- ☐ Abuse of Children
- ☐ Sexually Transmitted Diseases – does not include HIV/AIDS
- ☐ HIV/AIDS
- ☐ Violence

Other _____

2. In your opinion what would be the best way to promote health prevention and wellness?

3. Regarding health and well-being, what needs of Hartford residents are currently begin met the best?

4. Regarding health and well-being, what would you say are the greatest unmet needs among residents of Hartford?

5 If you had to identify two key improvements that you feel are needed to provide better healthcare for area residents, what would they be?

a. _____

b. _____

Comments regarding Key Health Issues:

_____

_____

_____

_____

Quality of Life

1. On a scale of 1 (very poor) through 5 (excellent), please rate each of the following within the community.

1 = very poor; 2 = poor; 3 = average; 4 = good; and 5 = excellent.

NEIGHBORHOOD/ENVIRONMENT	Very poor « » Excellent
a. Availability of recreational activities	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. Neighborhood safety	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. Clean, litter-free neighborhoods	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. Water or air pollution	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Quality of housing (affordable, in good condition)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. Road/traffic conditions	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
g. Schools/education	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
h. Job opportunities	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
i. Availability of care for children	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
j. Poverty	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Quality of Life or any example that illustrates your answers:

2. What specific suggestions do you have for area hospitals and public health agencies to improve the quality of life in the community?

Quality of Care

1. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements.

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree

HEALTHCARE	Strongly disagree « » Strongly agree
a. There are a sufficient number of bilingual providers in Hartford.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. The majority of residents in the area are able to access a primary care provider.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. The majority of residents in the area are able to access a medical specialist.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. The majority of residents in the area are able to access a dentist when needed.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Transportation for medical appointments is available to the majority of residents.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Healthcare or any example that illustrates your answers:

SOCIAL SERVICES	Strongly disagree « » Strongly agree
a. The majority of the residents in Hartford would know where to go if they needed mental health/ behavioral health treatment.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. The majority of residents in Hartford would know where to go if they needed help with a substance abuse problem.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. There are a sufficient number of behavioral health providers in the area.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. The healthcare delivery system in Hartford has a holistic approach to patient care?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you have any additional comments on Social Services or any example that illustrates your answers:

That concludes the survey. Thank you very much for your time today and we appreciate your feedback!

C. Hartford Resident Survey: English

URBAN ALLIANCE

HARTFORD RESIDENT SURVEY

You are being invited to complete this survey because you are a Hartford resident. We are interested in learning about services that would be helpful to you and your family as well as barriers to receiving these services. It is our hope that the results of this survey will enhance and increase services offered in the city of Hartford.

QUESTIONS ABOUT YOU

This survey begins with questions about you and your family. These help us to describe who completed the survey.

1. Do you live in the city of Hartford?
☐ Yes ☐ No
Please provide your Zip Code: _____

2. What is your ethnicity?
☐ Latino ☐ West Indian ☐ Multi-ethnic
☐ White ☐ African ☐ Other
☐ Asian American *Specify:* _____

3. What is your gender? ☐ Female ☐ Male

4. Do you attend a church?
☐ Yes *If yes, please specify which church:* _____
☐ No

5. How many adults live in your household? _____

6. How many children live in your household? _____

7. Check the box that best describes your age:
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

QUESTIONS ABOUT SERVICES IN HARTFORD

*In the **first column (questions a & b)**, indicate if you or someone in your household (someone who lives with you) would benefit from additional services in each area and barriers to receiving each type of service.*

*In the **second column (question c)**, rank (1 through 3) the three areas most in need of additional services in the city of Hartford. Place the ranking in the box corresponding to each service area (1 indicates the area most in need of additional services). Complete this column after you have completed the first column (questions a & b) for each type of service.*

1. SUBSTANCE ABUSE RECOVERY *(e.g. treatment, prevention)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access substance abuse recovery services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

2. BASIC NEEDS/FOOD ASSISTANCE *(e.g. food pantry, meals, clothing, utility assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access basic needs/food services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

3. HOMELESSNESS/HOUSING *(e.g. emergency shelter, affordable housing)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access housing services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

4. COUNSELING/EMOTIONAL SUPPORT *(e.g. counseling, support groups, stress management)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access counseling/emotional support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

5. YOUTH DEVELOPMENT *(e.g. leadership training, mentoring, after-school programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access youth development services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

6. HEALTH AND WELLNESS *(e.g. health care, screenings)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access health and wellness services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Uninsured
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves ☐ Other:

c. Rank the three areas most in need of additional services in Hartford ☐

7. EDUCATION *(e.g. tutoring, GED classes, ESL, literacy)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access education services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

8. FINANCIAL SUPPORT SERVICES *(e.g. personal finance planning, financial literacy, tax preparation)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access financial support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

9. ELDERLY SERVICES *(e.g. convalescent home, meals, senior center/programs)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access services for seniors? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

10. PRISONER /RE-ENTRY SERVICES *(e.g. visitation, re-entry assistance, support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access prisoner/re-entry services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

11. JOB TRAINING/EMPLOYMENT ASSISTANCE *(e.g. skill development, resume assistance)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access job training/employment services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

12. PREGNANCY/PARENTING SUPPORT *(e.g. parenting/prenatal education and support)*

a. I or someone living in my ***household*** would benefit from additional services in this area. ☐ Yes ☐ No

b. Which factors make it difficult to access pregnancy/parenting support services? (mark all that apply)

☐ **Never needed services in this area** ☐ Lack of child care ☐ Lack of transportation ☐ Lack of time
☐ Don't know about existing services ☐ Not able to pay ☐ Language barrier ☐ Other
☐ Lack of available services ☐ Bad past experience ☐ Family/friend disapproves

c. Rank the three areas most in need of additional services in Hartford ☐

D. Hartford Resident Survey: Spanish

ALIANZA URBANA
ENCUESTA SOBRE RESIDENTE HARTFORD

Usted está invitado a terminar esta encuesta porque usted es un residente de Hartford. Estamos interesados en aprender sobre los servicios que le serían provechosos a usted y su familia así como barreras para recibir estos servicios. Nuestra meta es mejorar y aumentar el alcance de los servicios ofrecidos en la ciudad de Hartford.

PREGUNTAS DE USTED

Esta encuesta comienza con preguntas sobre usted y su familia y nos ayudan a describir quién terminó la encuesta.

1. ¿Usted vive en la ciudad de Hartford?
☐ Sí ☐ No
Proporcione por favor su Código postal: _____

2. ¿Cuál es su pertenencia étnica?
☐ Latino ☐ Oeste Indio ☐ Multi-étnico
☐ Blanco ☐ Africano ☐ Otro
☐ Asiático Americano *Especifique:* _____

3. ¿Género? ☐ Femenino ☐ Masculino

4. ¿Usted asiste a alguna iglesia?
☐ Sí *Especifique por favor qué iglesia:* _____
☐ No

5. ¿Cuántos adultos viven en su casa? _____

6. ¿Cuántos niños viven en su casa? _____

7. ¿Está entre las edades de?:
☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

PREGUNTAS SOBRE SERVICIOS EN HARTFORD

*En la **primera columna** (preguntas a y b), indique si usted o alguien en su hogar serían beneficiado por servicios adicionales en cada área y también indique las barreras para recibir cada tipo de servicio.*

*En la **segunda columna** (pregunta c), Marque (1 a 3) las tres áreas más necesitadas de servicios adicionales en la ciudad de Hartford. Marque la caja que corresponde a cada área de servicio (1 indica la área más en necesidad de servicios adicionales). Termina esta columna después de que usted haya terminado la primera columna (preguntas a y b) para cada servicio.*

1. RECUPERACIÓN DEL ABUSO DE LA SUSTANCIA *(e.g. tratamiento, prevención)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de recuperación del abuso de la sustancia?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de niños ☐ Falta de transportación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera lingüística ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos económicos ☐ Otro:

c. Marque las tres áreas más necesitando adicional servicios ☐

2. NECESIDADES BASICAS/ASISTENCIA DE ALIMENTOS *(e.g. despensa de alimento, ropa, ayuda para utilidades)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de necesidades básicas/asistencia de alimentos?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de niños ☐ Falta de transportación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera lingüística ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos económicos _____

c. Marque las tres áreas más necesitando adicional servicios ☐

3. PERSONAS SIN HOGAR/VIVIENDA *(e.g. albrigo de emergencia, cubierta comprable)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de personas sin hogar/vivienda?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de niños ☐ Falta de transportación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera lingüística ☐ Otro
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos económicos _____

c. Marque las tres áreas más necesitando adicional servicios ☐

4. ASESORAMIENTO/APOYO EMOCIONAL *(e.g. asesoramiento, grupo de ayuda)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de asesoramiento/apoyo emocional?

☐ **Nunca he necesitado estos servicios** ☐ Falta de cuidado de niños ☐ Falta de transportación ☐ Falta de tiempo
☐ No sé sobre los servicios existentes ☐ Familia/amigo desaprueba ☐ Barrera lingüística ☐ Sin seguro medico
☐ Falta de servicios disponibles ☐ Malas experiencias ☐ Recursos económicos ☐ Otro:

c. Marque las tres áreas más necesitando adicional servicios ☐

5. DESARROLLO DE LA JUVENTUD *(e.g. programas después de la escuela)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de desarrollo de la juventud?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

6. SALUD Y BIENESTAR *(e.g. cuidado médico, exámenes)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de salud?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Sin seguro médico
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	☐ Otro:

c. Marque las tres áreas más necesitando adicional servicios ☐

7. EDUCACIÓN *(e.g. tutoría, GED, ESL)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

¿Qué factores hacen difícil de tener acceso a servicios de educación?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

8. SERVICIOS DE APOYO FINANCIERO *(e.g. preparación de impuesto, planificación financiero)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

9. SERVICIOS ENUEJECIENTES *(e.g. clínica de reposo, comidas, centro mayor/programas)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de envejecientes?

☐ **Nunca henecesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

10. SERVICIOS DE PRISIÓN Y DE REINTEGRARSE *(e.g. visitation, ayuda del reingreso)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de re-entry del preso?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

11. ENTRENAMIENTO/BUSQUEDA DE TRABAJO *(e.g. ayuda de resume)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios de existencia trabajo de formación?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

12. SERVICIOS DE EMBARAZO/ CRIANZA DE LOS HIJOS *(e.g. educación y apoyo)*

a. Yo o alguien **en mi hogar** nos beneficiaríamos de servicios adicionales en esta área. ☐ Sí ☐ No

b. ¿Qué factores hacen difícil de tener acceso a servicios del embarazos o crianza de los hijos?

☐ **Nunca he necesitado estos servicios**	☐ Falta de cuidado de niños	☐ Falta de transportación	☐ Falta de tiempo
☐ No sé sobre los servicios existentes	☐ Familia/amigo desaprueba	☐ Barrera lingüística	☐ Otro
☐ Falta de servicios disponibles	☐ Malas experiencias	☐ Recursos económicos	_____

c. Marque las tres áreas más necesitando adicional servicios ☐

E. Data Sources for HEI Social Determinants

Social Determinants

- Civic Involvement
- Community Safety
- Economic Security
- Education
- Employment
- Environmental Quality
- Housing

Health Outcomes

- Accidents/Violence
- Cancer
- Cardiovascular Disease
- Childhood Illness
- Diabetes
- Health Care Access
- Infectious Disease
- Life Expectancy
- Liver Disease
- Mental Health
- Perinatal Care
- Renal Disease
- Respiratory Illness

For additional information about the HEI social determinants and health outcomes, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

F. Data Sources for Health Equity Index

Connecticut Secretary of State Office Voter Registration Statistics
Connecticut Department of Public Safety Uniform Crime Reports
2008 Warren Group Residential Statistics Report
2006-07 Home Mortgage Disclosure Act, Aggregate Reports; 2006-07 FFIEC Census Reports 2006-07
Housingpolicy.org
2000 US Census
Connecticut Department of Health Vital Records
RealtyTrac website, September 2008
2008 Connecticut Department of Social Services Temporary Family Assistance Data
Connecticut Department of Education's CEDaR site
2006 US Annual Economic Census ZIP Code Business Patterns reports; 2000 US Census
Connecticut Housing Finance Authority; 2005 US Census Population Survey
1995-2006 U.S. Annual Economic Survey
2002 US Economic Census Zip Code Statistics
US Environmental Protection Agency Toxic Release Inventory Program
Connecticut Housing Finance Authority; 2005 US Census Population Survey
Connecticut Department of Health, Office of Vital Records Death Certificates; 2007 Nielsen Claritas Population Facts Demographic Report
Connecticut Department of Health Tumor Registry; 2007 Nielsen Claritas Pop-Facts Demographic Report
2005 Connecticut Hospital Association CHIME Hospital Discharge Data
Connecticut Department of Health, Lead Poisoning Prevention and Control Program
Connecticut Department of Health, Office of Vital Records Birth Certificates
Connecticut Department of Health, Sexually Transmitted Surveillance Program

For additional information about the HEI data sources, please visit the Health Equity Index website at http://index.healthequityalliance.us/ or contact Connecticut Association of Directors of Health (CADH) at (860) 727-9874.

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Statement of Confidentiality and Ownership

All of the analyses, findings and recommendations contained within this report are the exclusive property of MidState Medical Center and The United Way of Meriden & Wallingford.

As required by the Code of Ethics of the National Council on Public Polls and the United States Privacy Act of 1974, The Center for Research and Public Policy maintains the anonymity of respondents to surveys the firm conducts. No information will be released that might, in any way, reveal the identity of the respondent.

Moreover, no information regarding these findings will be released without the written consent of an authorized representative of MidState Medical Center or The United Way of Meriden & Wallingford.

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Survey Instrument

1 INTRODUCTION

The Center for Research & Public Policy (CRPP) is pleased to present the results of a Community Needs Assessment conducted among residents of Cheshire, Meriden and Wallingford.

The Community Health Assessment was designed to provide resident input on current health status and community needs.

The Community Needs Assessment included a comprehensive telephone survey.

Telephone interviews (604) were conducted among residents of Cheshire, Meriden and Wallingford.

This report summarizes information collected from residential surveys conducted on November 14 – 19, 2011.

The survey instrument employed in the Community Health Assessment included the following areas for investigation:

- Health Care Access;
- Physical Activity;
- Cardiovascular Disease;
- Tobacco Use;
- Alcohol Consumption;
- Substance Abuse;
- Women's Health;
- Prostate Cancer Screening;
- Colorectal Cancer Screening;
- Pre-Diabetes / Diabetes;
- Healthy Days;
- BMIs;
- Community Needs; and
- Demographics.

Section II of this report discusses the Methodology used in the study, while Section III includes Highlights derived from an analysis of the quantitative research. Section IV is a Summary of Findings for the residential telephone surveys - a narrative account of the data.

Section V is an Appendix to the report containing cross tabulation tables and the survey instrument.

METHODOLOGY

Residential Telephone Survey

Using a quantitative research design, CRPP completed 604 interviews among residents of Cheshire, Meriden and Wallingford, Connecticut.

All telephone interviews were conducted November 14 - 19, 2011. Residents were contacted between 5:00 p.m. and 9:00 p.m. weekdays and 10:00 a.m. and 4:00 p.m. on the weekend.

Survey input and approval was provided by MidState project directors.

Survey design at CRPP is a careful, deliberative process to ensure fair, objective and balanced surveys. Staff members, with years of survey design experience, edit out any bias. Further, all scales used by CRPP (either numeric, such as one through ten, or wording such as strongly agree, somewhat agree, somewhat disagree, or strongly agree) are evenly balanced. And, placement of questions is carefully accomplished so that order has minimal impact.

All population-based surveys conducted by CRPP are proportional to population contributions within states, towns, and known census tract, group blocks and blocks. This distribution ensures truly representative results without significant under or over representation of various geographic or demographic groups within a sampling frame.

CRPP utilized a "super random digit" sampling procedure, which derives a working telephone sample of both listed and unlisted telephone numbers. This method of sample selection eliminates any bias toward only-listed telephone numbers. Additionally, this process allows randomization of numbers which equalizes the probability of qualified respondents being included in the sampling frame. Cell phone respondents were included in the sampling process and represented 4.0% of the total sample.

Respondents qualified for the survey if they confirmed they were at least 18 years of age and were current residents of one of the qualifying communities.

Training of telephone researchers and pre-test of the survey instrument occurred on November 13, 2011.

All facets of the study were completed by CRPP's senior staff and researchers. These aspects include: survey design, pre-test, computer programming, fielding, coding, editing, data entry, verification, validation and logic checks, computer analysis, analysis, and report writing.

Completion rates are a critical aspect of any telephone survey research. Because one group of people might be easier to reach than another group, it is important that concentrated efforts are made to reach all groups to an equal degree. A high completion rate means that a high percentage of the respondents within the original sample were actually contacted, and the resulting sample is not biased toward one potential audience. CRPP maintained a **72%** completion rate on all calls made. And, a high completion rate, many times, indicates an interest in the topic.

Statistically, a sample of 604 surveys represents a margin for error of +/-4.0% at a 95% confidence level.

In theory, a sample of all Cheshire, Meriden and Wallingford residents will differ no more than +/-4.0% than if all region residents were contacted and included in the survey. That is, if random probability sampling procedures were reiterated over and over again, sample results may be expected to approximate the large population values within plus or minus 4.0% -- 95 out of 100 times.

Readers of this report should note that any survey is analogous to a snapshot in time and results are only reflective of the time period in which the survey was undertaken. Should concerted public relations or information campaigns be undertaken during or shortly after the fielding of the survey, the results contained herein may be expected to change and should be, therefore, carefully interpreted and extrapolated.

Furthermore, it is important to note that all surveys contain some component of "sampling error". Error that is attributable to systematic bias has been significantly reduced by utilizing strict random probability procedures. This sample was strictly random in that selection of each potential respondent was an independent event, based on known probabilities.

Each qualified household within Cheshire, Meriden and Wallingford had an equal chance for participating in the study. Statistical random error, however, can never be eliminated but may be significantly reduced by increasing sample size.

HIGHLIGHTS

ON HEALTH CARE ACCESS…

- A large majority of residential respondents, 92.1%, indicated they have some form of health care coverage including health insurance, prepaid plans such as HMOs or government plans such as Medicare. However, 7.8% suggested they do not currently have any health care coverage. Extrapolated on the total population of Cheshire, Meriden and Wallingford – the number of those without insurance may be 10,393. Statewide 2010 BRFSS (CDC's Behavioral Risk Factor Surveillance Survey) results indicate 90.2% have coverage while 9.8% do not.

- While 88.9% indicated there was not a time over the past 12 months when they needed to see a doctor but could not because of cost, 10.9% suggested there was. Extrapolated on the total population, the number would be 14,523.

ON PHYSICAL ACTIVITY…

- A majority of respondents, 69.4% said they do moderate or vigorous physical activity in a usual week that causes small to large increases in breathing. Another 30.5% suggested they do not. Statewide 2010 BRFSS data show that 79.3% suggested they do any physical activities.

- When doing moderate or vigorous physical activity, respondents reported doing so for an average of 47.04 minutes.

ON CARDIOVASCULAR DISEASE…

- Researchers found that 3.6%, 3.0%, and 0.7% of respondents have been told they have had a heart attack, stroke, or both a heart attack and a stroke, respectively.

- Statewide 2010 BRFSS data show results of 3.1 and 1.7 for heart attack and a stroke, respectively.

- While 93.7% suggested they have not been told they have had angina, congestive heart failure or coronary heart disease, 5.3% said they have.

ON TOBACCO USE…

- The 2011 research found that 15.1% of all respondents are currently smoking everyday (11.1%) or some days (4.0%). Statewide 2010 BRFSS data show 13.2% of the adult respondents currently smoke.

ON ALCOHOL CONSUMPTION…

- Just over half of all respondents, 56.9% suggested they have had at least one drink of alcohol over the past 30 days.

- When respondents did drink, the average number of alcoholic drinks consumed was 3.01.

ON SUBSTANCE ABUSE…

- While 97.4% of all respondents indicated they have not used any illegal drugs or drugs prescribed to someone else over the last thirty days, 2.6% suggested they had. Extrapolated on the region's population, the total indicating illegal drug use is 3464 individuals.

ON WOMEN'S HEALTH…

- A majority of all women surveyed, 85.4%, reported they have had, at some point, a mammogram. Among women surveyed over 40 years of age, the percent is 95.3% while among those over 50 years of age the percent is 97.6%. Statewide 2010 BRFSS data show that 81.4% of Connecticut women over 40 years of age have had a mammogram, and 83.8% of those over 50 years of age have had a mammogram.

- 95.7% of all women surveyed reported they have had a clinical breast exam.

- Another 97.0% of all women stated they have had a Pap test. Statewide 2010 BFRSS data show 85.6% of Connecticut women had a Pap test.

ON PROSTATE SCREENING…

- Males 39 years of age or older were asked if they have ever had a PSA test. Just over half, 57.3% suggested they had. Similarly, statewide 2010 BRFSS data show that 59.8% had a PSA test.

- Three quarters of all respondents, 76.3%, suggested they have had, at some point, a digital rectal exam. Another 22.4% had not and 0.4% were unsure.

ON COLORECTAL CANCER SCREENING...

- Three-quarters, 78.2%, of respondents 49 years of age or older suggested they have had a sigmoidoscopy or colonoscopy exam. Statewide 2010 BRFSS data show that 75.7% reported they have had one of the two exams.

ON PRE-DIABETES / DIABETES...

- Nearly two-thirds, 64.1%, of all respondents indicated they have had a test for high blood sugar or diabetes within the last three years. About one-third, 32.0%, suggested they had not and 3.8% were unsure.

- Twenty percent (20.5%) of all respondents said they have been told by a doctor, nurse or other health care professional that they have pre-diabetes, diabetes, diabetes during pregnancy or are borderline diabetes. Statewide 2010 BRFSS data show that 8.9% were told they had diabetes (7.3%), diabetes during pregnancy (0.8%), or were pre-diabetes / borderline (0.8%).

ON HEALTH DAYS...

- A large percentage, 47.7%, suggested that there were days over the last month when they felt sad, blue or depressed. On average, there were 7.43 days each month when this group had sad or depressed feelings.

- While 98.0% suggested there was not a time over the last year when they thought of taking their own life, 1.8% suggested there was. When extrapolated on the total region population, the number of individuals is approximately, 2398.

ON BMIS...

- **CRPP calculated BMIs for each of the respondents who provided researchers both their weight and height. The following table presents the results. The district (Cheshire, Meriden and Wallingford) average was 28.55 – classified as "overweight". Statewide 2010 BRFSS data show 23.0% as obese, 37.8% as overweight and 39.4% either normal or underweight.**

BMI Calculations	Percent	BRFSS
Underweight: <18	2.8	---
Normal: 18.5 – 24.9	32.5	---
Underweight & Normal	---	39.4
Overweight: 25 – 29.9	33.5	37.8
Obese: 30.0 – 39.9	26.9	23.0
Extreme Obesity: 40.0+	4.3	---
Average District BMI	28.55	---

ON COMMUNITY NEEDS...

Researchers asked survey respondents to suggest if there were too few, too many or about the right amount of 28 different community programs and services. Community need is often viewed when large numbers of residents see too few of various services and programs.

As a strong indication of the current difficult economic conditions many face, eight of 13 top and second tier reported needs are economy related.

Top tier of community need was reported to be, in declining order:

- **Health insurance support;**
- **Domestic violence prevention and treatment;**
- **Free counseling on foreclosure, bankruptcy, taxes/finance, home buying, leases, contracts, and budgeting;**
- **Adult job training and placement and supports such as mentoring and life skills;**
- **Child abuse prevention and treatment programs;**
- **Drop-out prevention programs; and**
- **Bullying and violence prevention programs.**

Second tier community needs were reported to be:

- Homeless programs and supports such as shelters, counseling and laundry;
- Obesity and fitness education;
- Affordable childcare for working parents;
- Affordable housing;
- Affordable housing for seniors; and
- Parenting programs.

ON BRFSS COMPARISONS…

Comparisons to the Connecticut Department of Health's Behavioral Risk Factor Surveillance Survey show that the region (Cheshire, Meriden and Wallingford) does better than statewide results in the following areas:

- Health insurance coverage;
- Mammograms (40 years of age or older);
- Mammograms (50 years of age or older);
- Pap tests;
- Colonoscopies.

And, the region is behind the state survey statistics in the following areas:

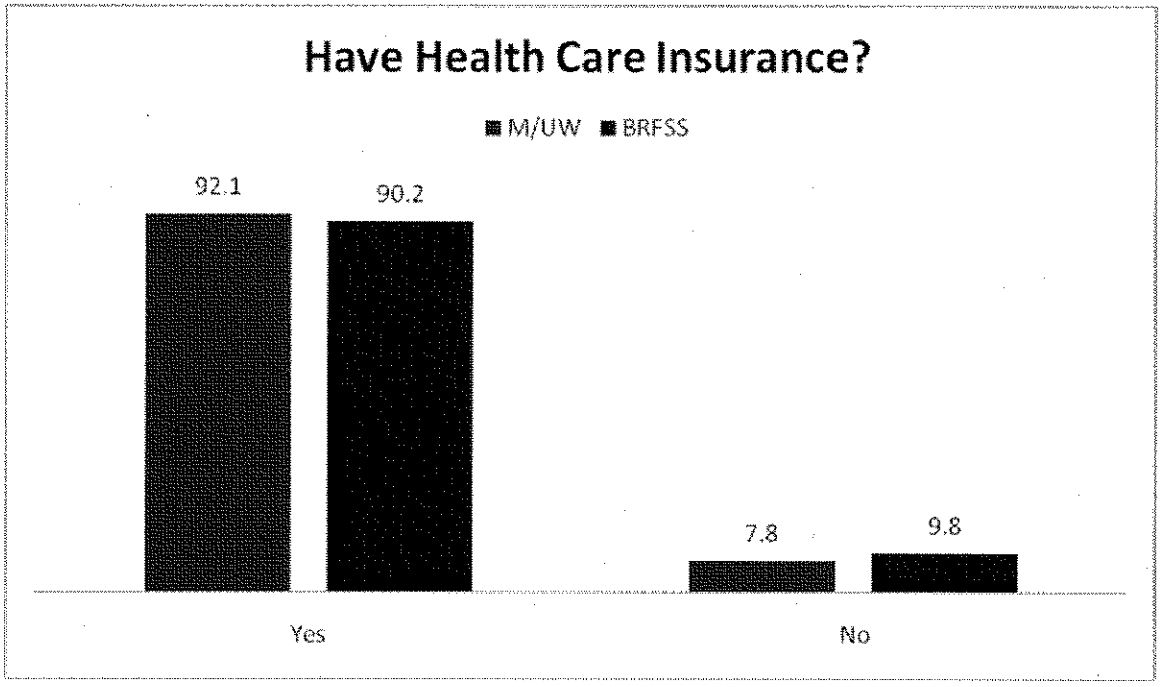
- Smoking;
- Prostate screening;
- Physical activity;
- Diabetes;
- BMIs;
- Heart attacks;
- Stroke.

SUMMARY OF FINDINGS

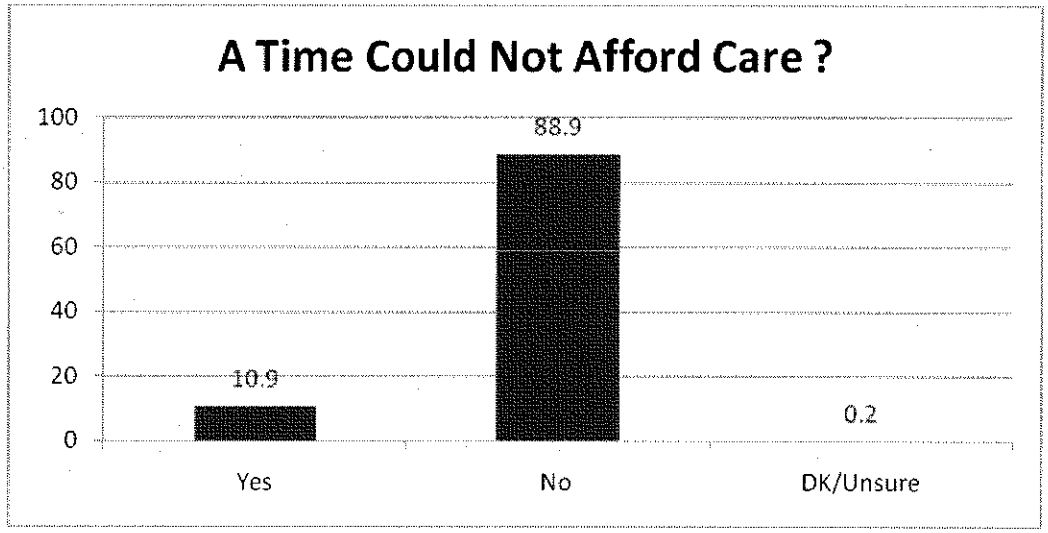
Readers are reminded that the following section summarizes statistics collected from the telephone survey of 604 residents within Cheshire, Meriden and Wallingford, CT. Wherever comparable data is available from the Connecticut Department of Public Health's Behavioral Risk Factor Surveillance Survey (BRFSS), tables and graphs depict these as well.

HEALTH CARE ACCESS

All respondents were asked if they had any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare. A majority, 92.1% indicated they do have coverage as presented in the following graph.

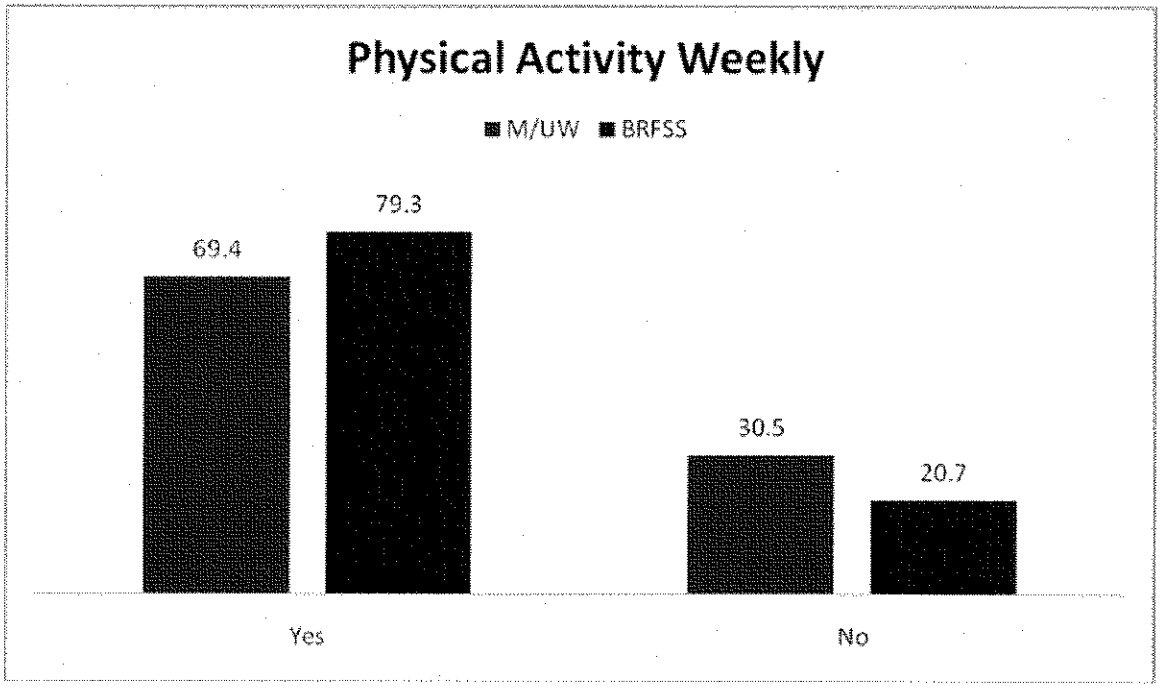


Researchers asked all respondents if there was a time, over the last 12 months, when they needed to see a doctor but could not because of the cost. While 88.9% suggested there was not, 10.9% said there was such a time. The following graph presents the results as collected.



PHYSICAL ACTIVITY

A majority of respondents, 69.4%, indicated that when they are not working, they do moderate or vigorous physical activity in a usual week that causes small increases in breathing and heart rate such as brisk walking, biking, vacuuming or yard work. Another 30.5% suggested they do not.



Respondents who do moderate and vigorous physical activity were asked how many minutes they keep at it when exercising. The following table presents the results. "Don't know" respondents were removed from the data.

How Long, In Minutes, You Exercise?	Moderate or Vigorous Physical Activity
<20 Minutes	12.5
20 - <30 Minutes	11.7
30 - <45 Minutes	32.1
45 - <60 Minutes	8.7
60 - <90 Minutes	19.4
90 Minutes or more	15.6

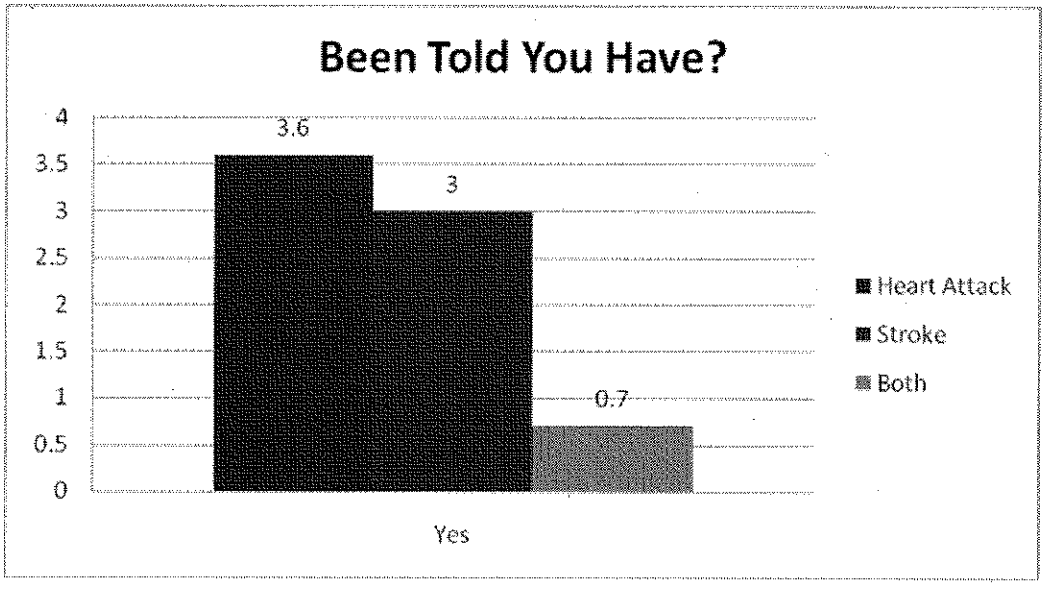
On average, respondents exercised (either moderate or vigorous) 47.04 minutes when participating in their respective physical activity.

CARDIOVASCULAR DISEASE

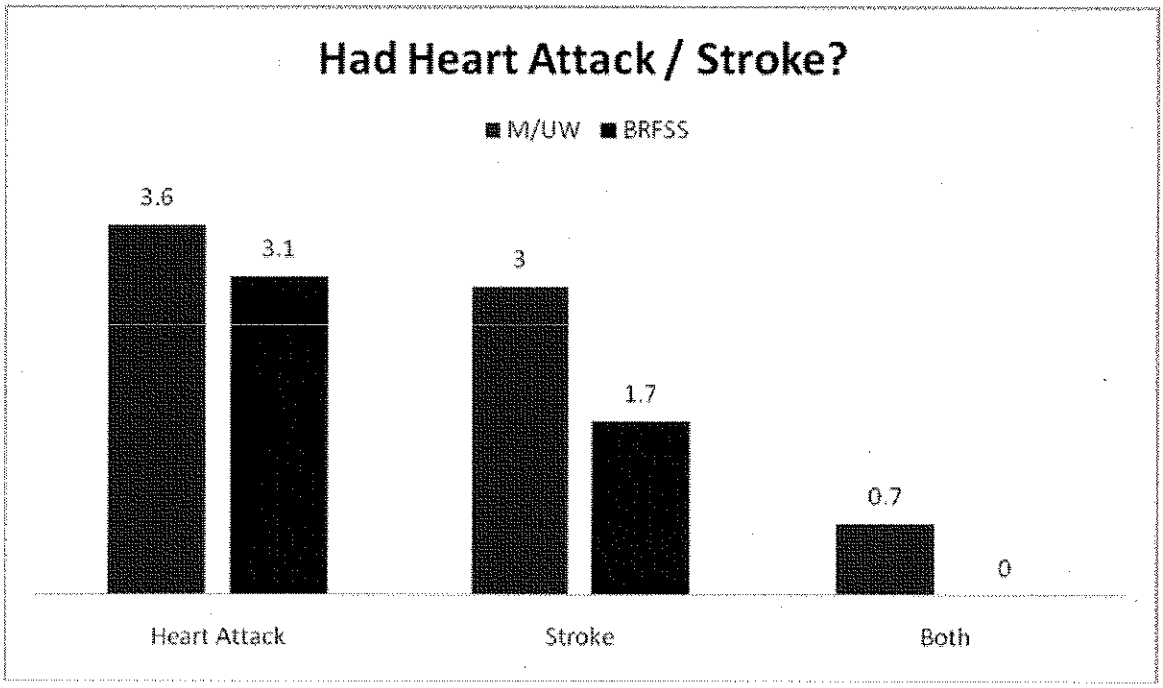
Respondents were asked if they had ever been told by a doctor, nurse or other health professional that they have had:

- A heart attack or myocardial infarction;
- A stroke;
- Both a heart attack and a stroke.

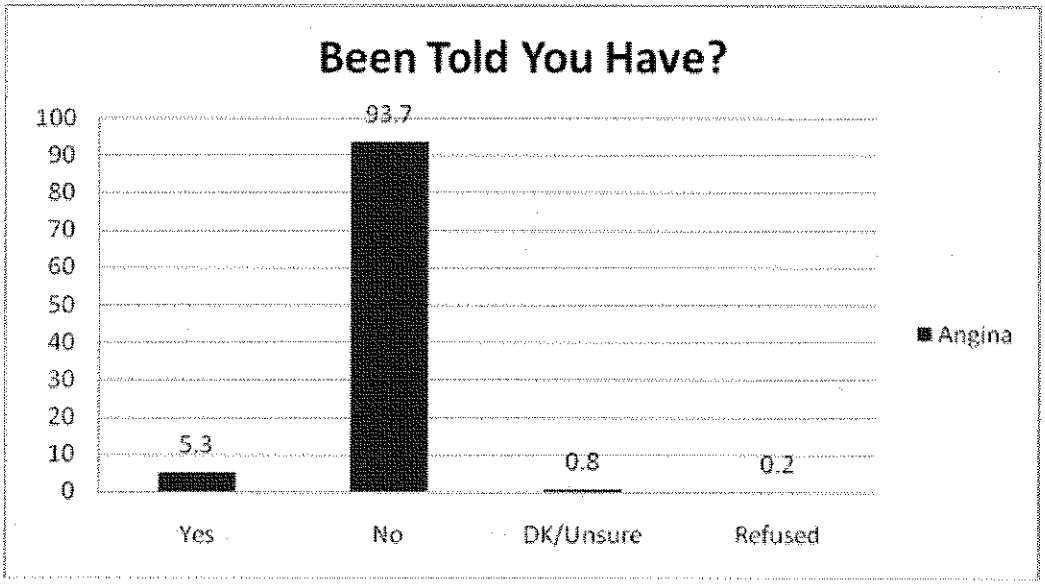
The following graph presents the results as collected.



The following graph presents regional results along with statewide BRFSS results.

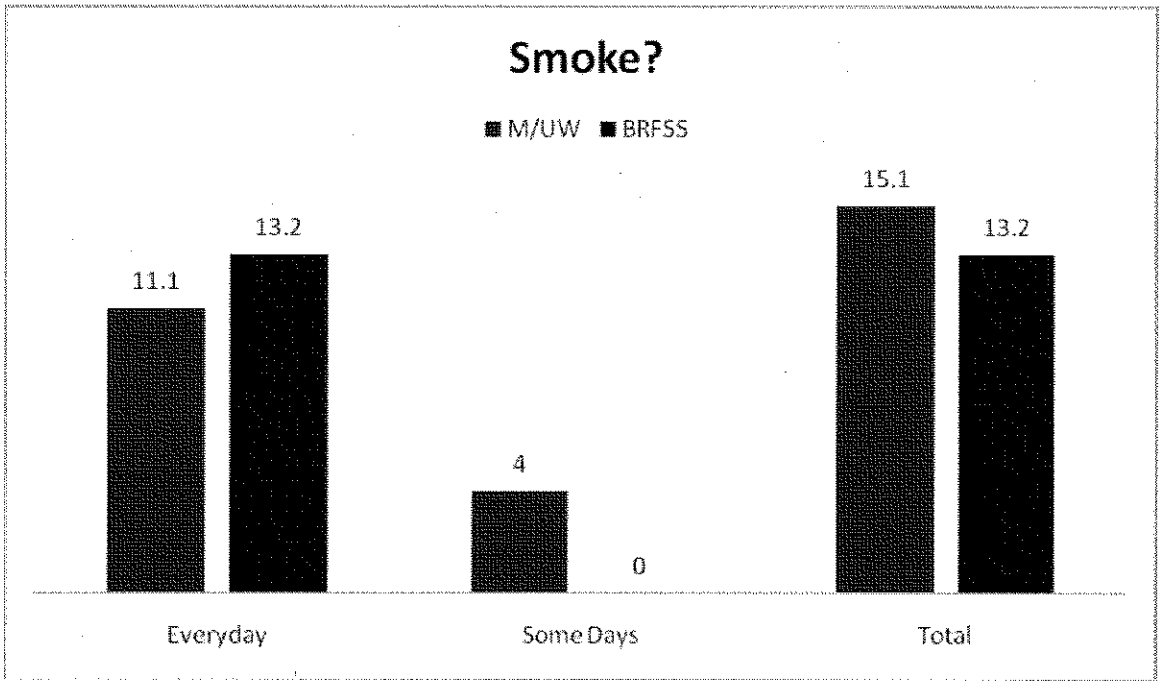


All respondents were asked if they had ever been told if they had angina, congestive heart failure or coronary heart disease. While 93.7% suggested they had not, 5.3% said they have. The following graph depicts the results as collected.



TOBACCO USE

Researchers asked respondents if they smoke cigarettes every day, some days, or not at all. While most, 84.9% indicated they do not smoke, another 15.1% suggested they smoked everyday (11.1%) or some days (4.0%).



ALCOHOL CONSUMPTION

All respondents were asked if they have had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor during the last 30 days.

Just over half, 56.9%, indicated they have had at least one drink over the last 30 days as presented in the following table. Another 40.7 did not drink over the last 30 days and some, 2.4% were unsure or refused.

Had a Drink of Alcohol Over 30 Days?	Percent
Yes	56.9
No	40.7
Don't Know / Unsure	1.2
Refused	1.2

Among those that did drink 56.9%, the following table presents the number of drinks respondents had at times when they did drink. On average, respondents drank 3.01 drinks.

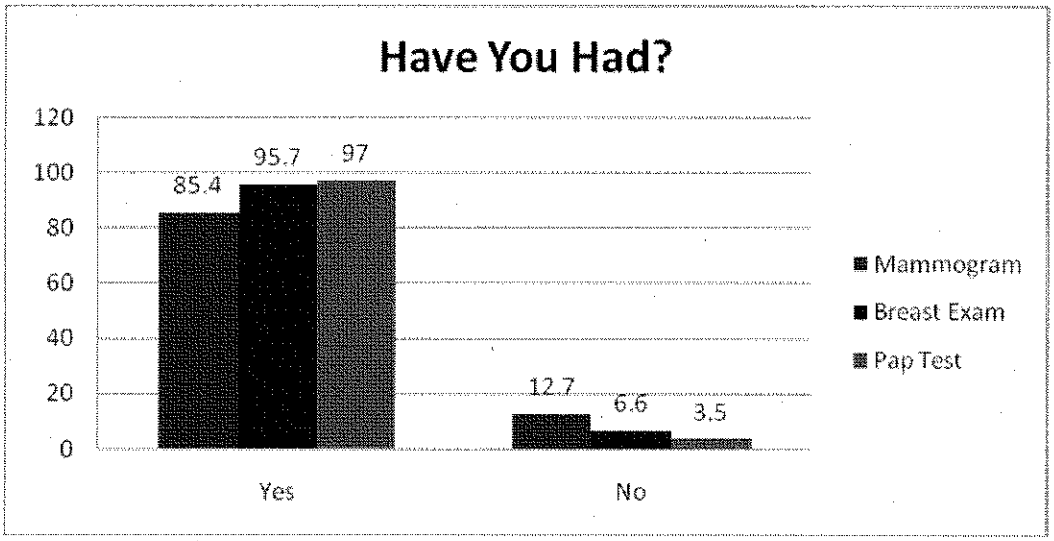
Number of Drinks	Percent
One	24.5
Two	16.6
Three	5.3
Four	3.6
Five	2.5
Six or more	4.1

SUBSTANCE ABUSE

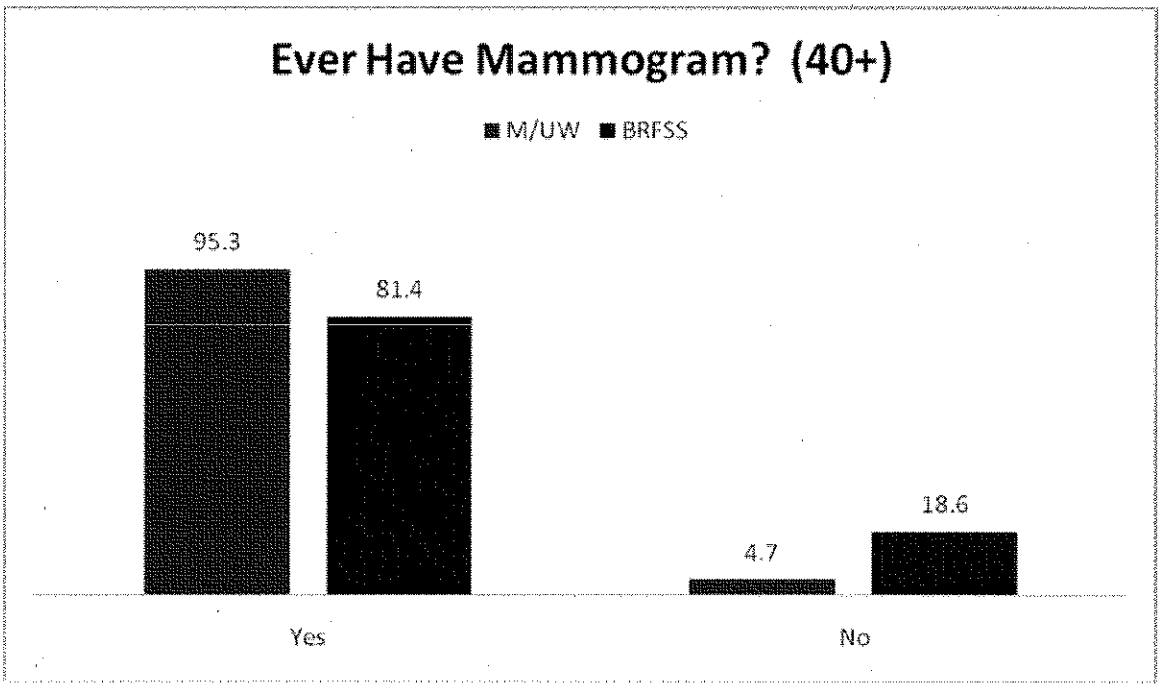
While 97.4% of all respondents suggested they did not use an illegal drugs or drugs prescribed to someone else over the last thirty days, 2.6% indicated they had.

WOMEN'S HEALTH

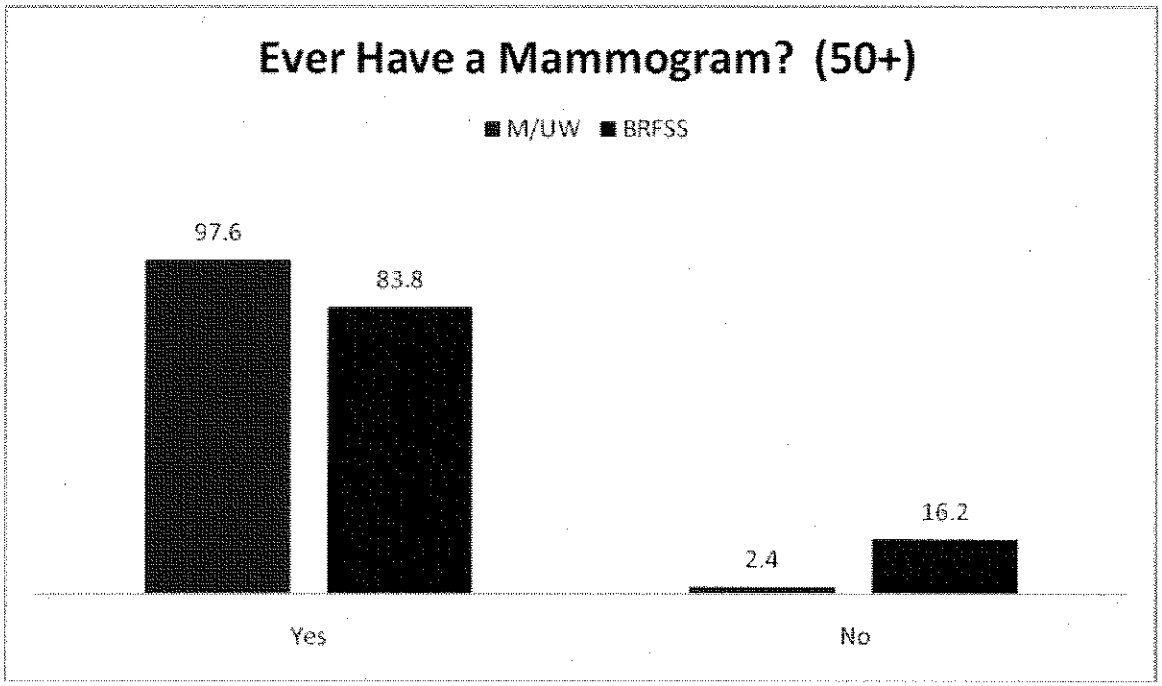
Female respondents were asked if they have ever had a mammogram, a clinical breast exam or a Pap test for cancer of the cervix. The following table presents the results collected.

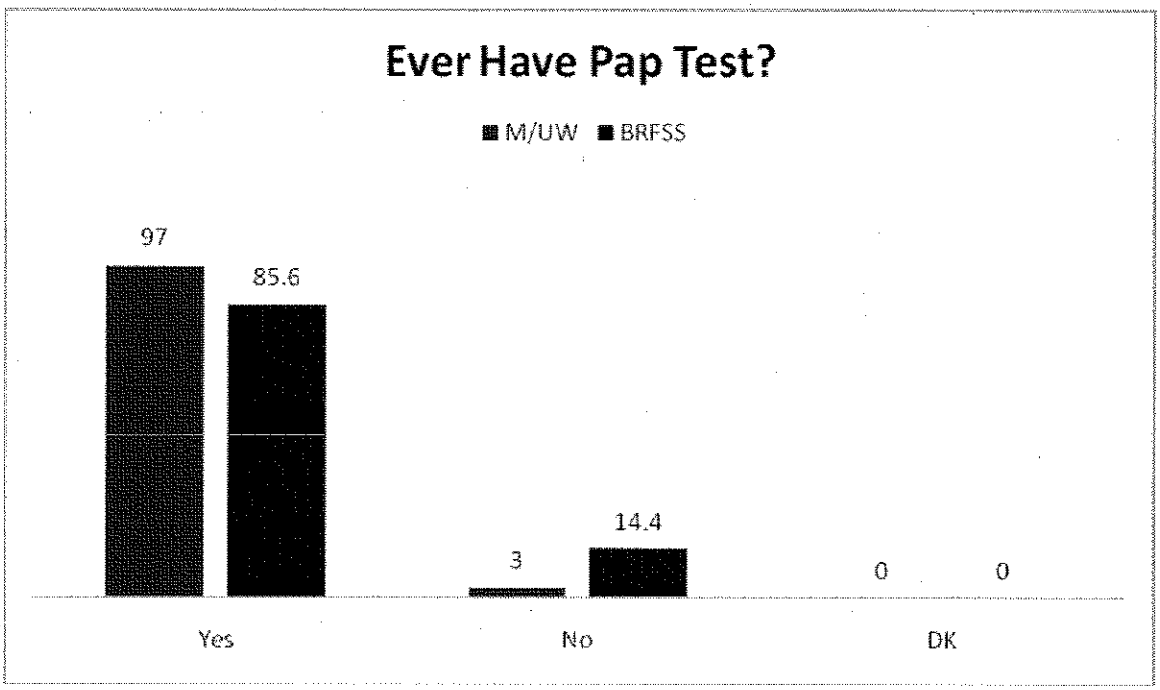


A larger majority of women over 40 years of age (95.3%) reported having had a mammogram.



And, 97.6% of women over 50 years of age reported having had a mammogram.



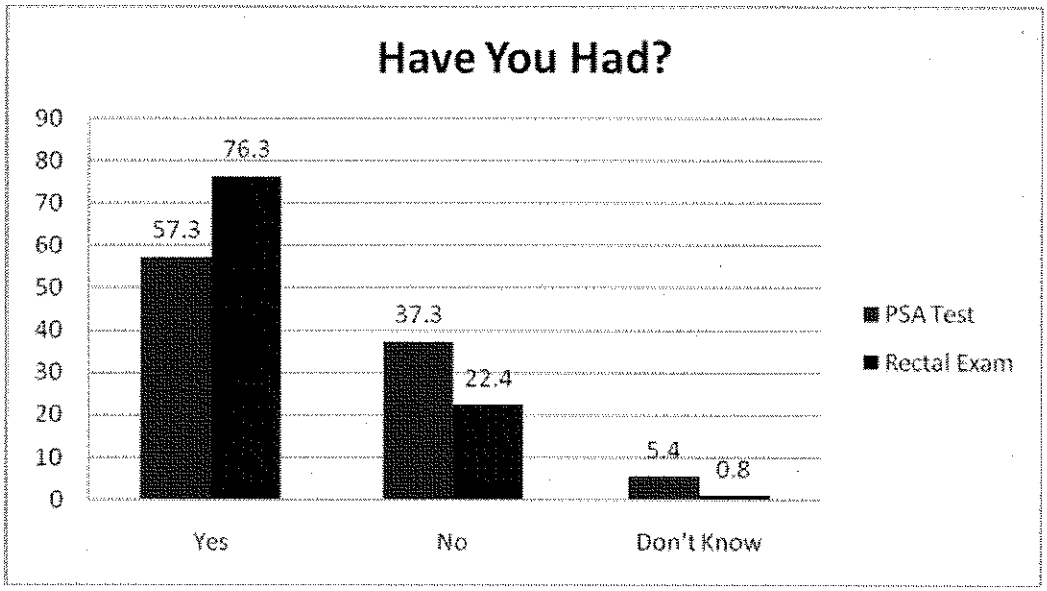


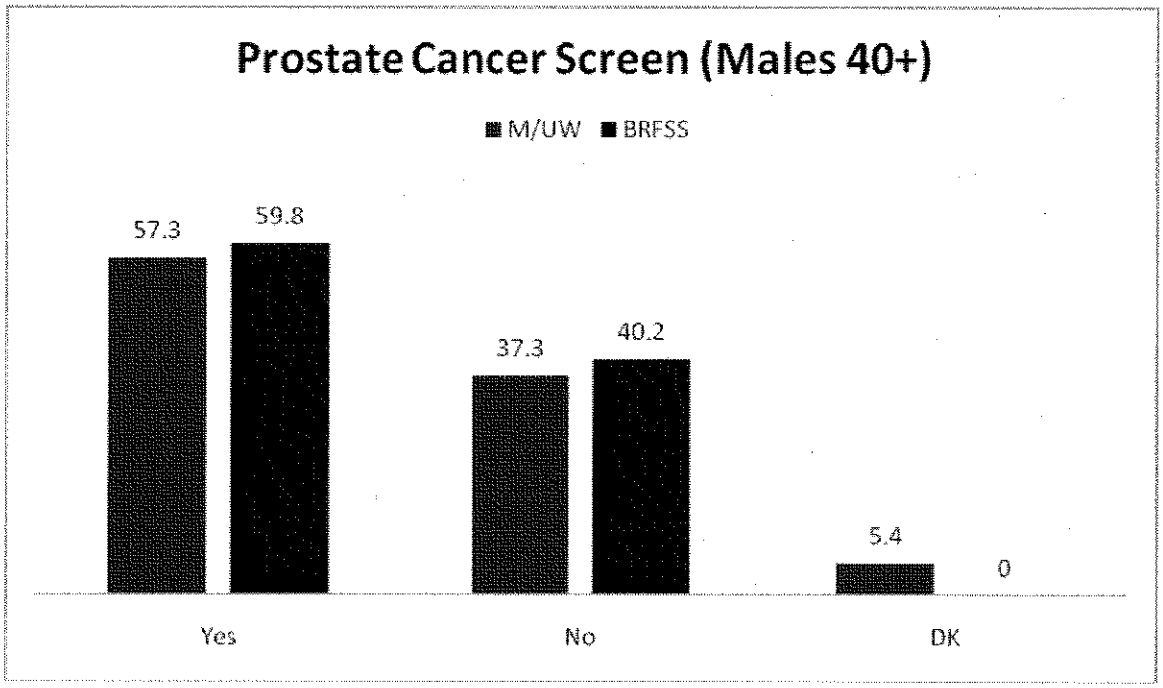
Female respondents who reported having a mammogram, a clinical breast exam or a Pap Test were asked to report how long it had been since the last exam/test. Results are held in the following table.

How Long Since Last ?	Mammogram	Clinical Breast Exam	Pap Test
Within past year	74.5	79.9	63.6
Within the past two years	12.4	10.9	14.6
Within the past three years	2.6	1.4	3.1
Within past five years	2.6	2.0	4.1
Five or more years	5.2	4.1	11.6
Not sure / Don't know	1.9	1.4	2.0

PROSTATE CANCER SCREENING

Males 39 years of age or older were asked if they have ever had a Prostate-Specific Antigen test (PSA test) or a digital rectal exam. The following graph presents the results.





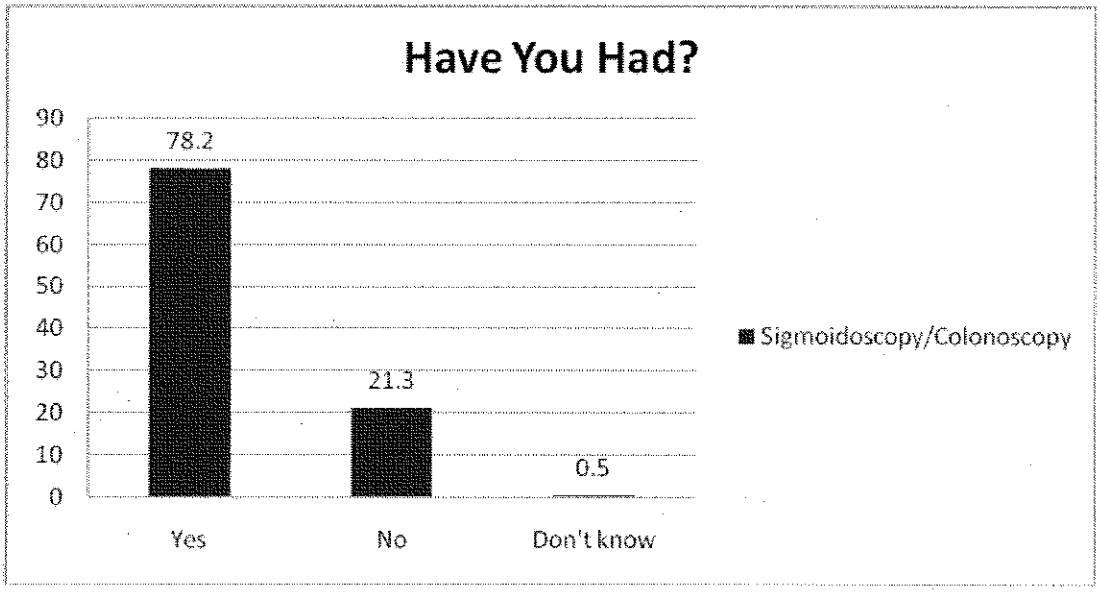
Males who reported having a PSA Test, or digital rectal exam, were asked how long it had been since the last test/exam. The following table holds the results.

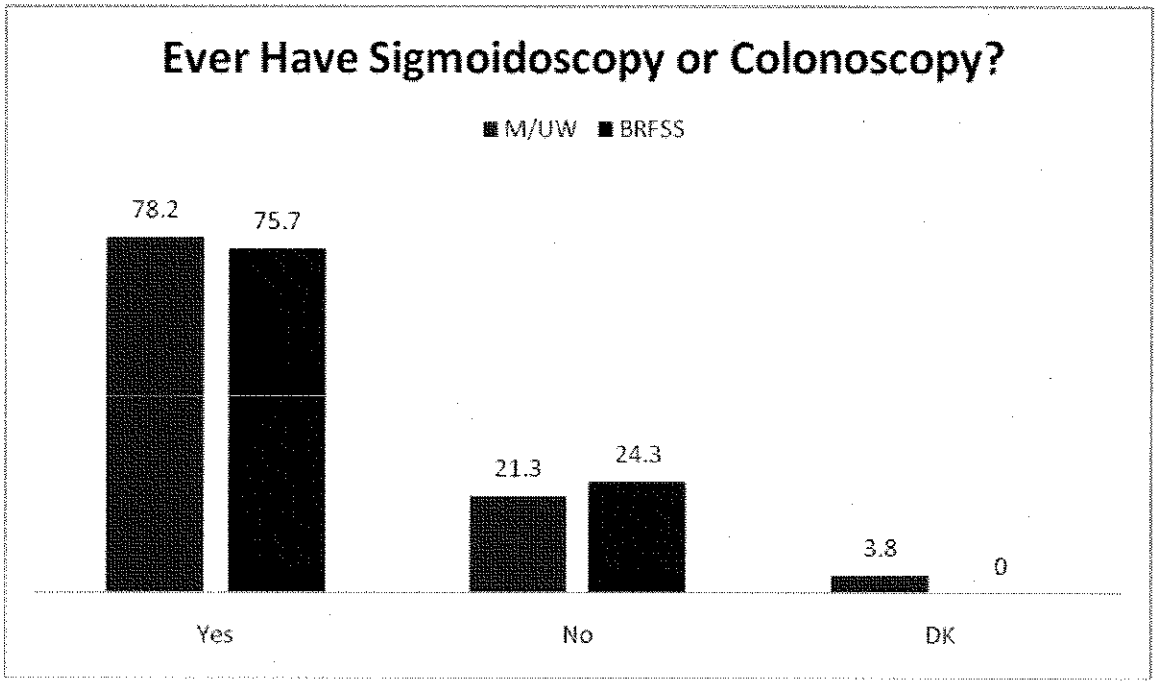
How Long Since Last Test/Exam?	PSA Test	Digital Rectal Exam
Within past year	47.7	60.3
Within the past two years	8.7	13.9
Within the past three years	3.2	6.7
Within past 5 years	2.3	5.2
Five or more years	9.2	8.2
Not sure / Don't know	24.3	5.2
Refused	4.6	0.5

COLORECTAL CANCER SCREENING

Respondents 49 years of age or older were asked about colorectal cancer screening.

Each respondent was asked if they had either a sigmoidoscopy or colonoscopy exam. Results are presented here.

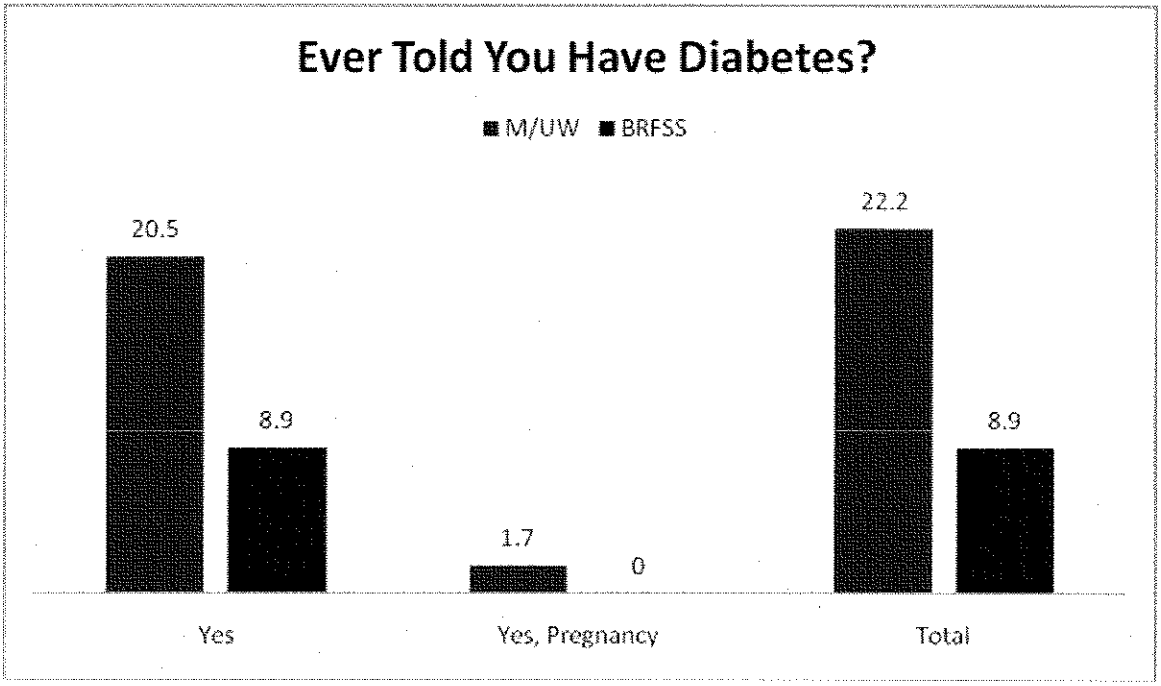




PRE-DIABETES /DIABETES

Among all respondents, 64.1% indicated they have had a test for high blood sugar or diabetes within the last three years. Another 32.0% have not, and 0.5% were unsure.

One-fifth of all respondents, 22.2%, indicated that they have been told by a doctor, nurse or other health professional that they have pre-diabetes, borderline diabetes or diabetes.



HEALTH DAYS

Nearly half of all respondents, 47.7%, suggested there were one or more days, during the last 30, that they felt sad, blue or depressed. On average, the number of days was 7.43.

The number of days that this group felt sad, blue or depressed is presented here.

Number of Days Over Last 30 Felt Sad, Blue, Depressed	Percent
1-7	64.4
8-15	15.8
16-20	3.3
21-30	16.3

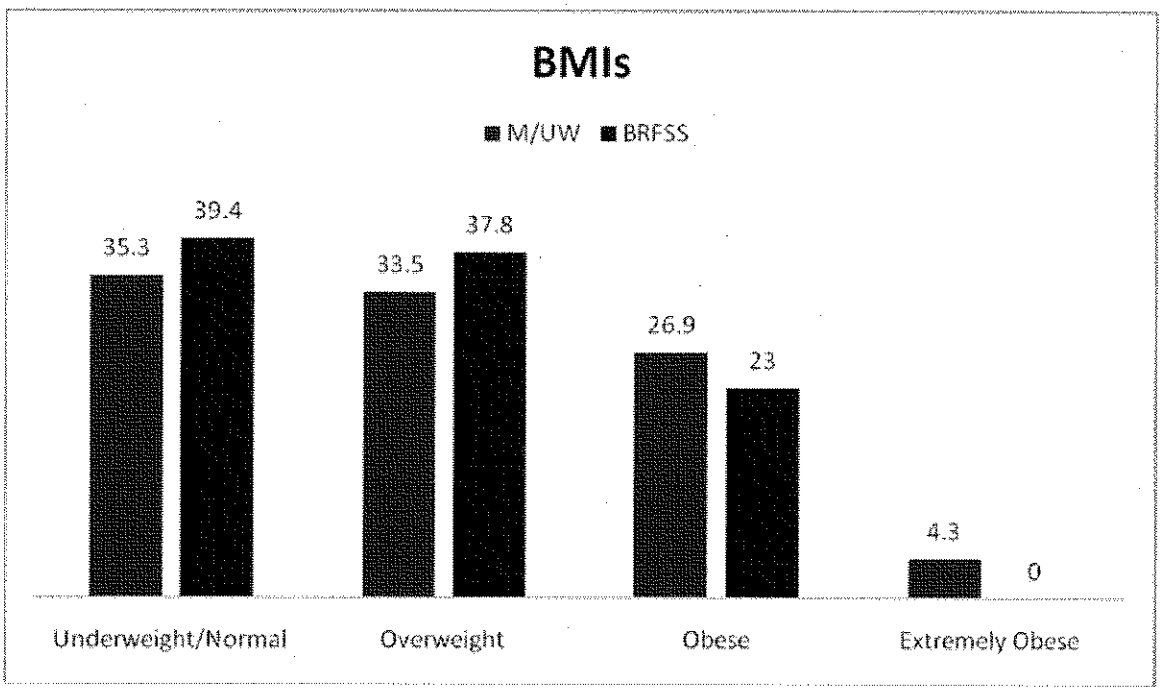
Among all respondents, 3.3%, suggested there has been a time in the past 12 months when they thought of taking their own lives.

BMI CALCULATIONS

CRPP calculated BMIs for all respondents who provided both height and weight. The average overall district average is 28.55 – an average that is considered "overweight".

The following table holds the percentages for each BMI category.

BMI Calculations	Percent	BRFSS
Underweight: <18	2.8	---
Normal: 18.5 – 24.9	32.5	---
Underweight & Normal	---	39.4
Overweight: 25 – 29.9	33.5	37.8
Obese: 30.0 – 39.9	26.9	23.0
Extreme Obesity: 40.0+	4.3	---
Average District BMI	28.55	---



COMMUNITY NEEDS

All respondents were read a number of community services. Each was asked if they believed there were too few, too many or about the right amount of each service or program in the community. The following table (by category) depicts the "too few" results – typically representing community need. Don't know respondents were removed from the data.

Transportation	**Too Few**
Public transportation availability	40.2
Employment	**Too Few**
Adult job training, placement and supports including mentoring, and life skills	58.8
Affordable childcare for working parents	53.7
Recreation	**Too Few**
Recreation programs for area residents(including sports	22.9
Education	**Too Few**
Drop-out prevention programs	58.0
Tutoring and mentoring for school age children	46.6
Out-of-school programming including before, after and vacations	34.7
Family and Community	**Too Few**
Domestic violence prevention and treatment programs	59.4
Free counseling on issues such as foreclosure, bankruptcy, taxes/finance, home buying, leases, contracts, personal budgeting and rental agreements	59.1
Child abuse prevention & treatment programs	58.7
Parenting programs	50.6
Food distribution centers or pantries	42.1
Crisis intervention hotlines	34.3
Housing	**Too Few**
Homeless programs and supports such as shelters, counseling & laundry	56.6

Affordable housing	53.6
Temporary financial support for heat and/or utilities	48.4
Children and Youth	**Too Few**
Bullying and violence prevention programs	58.0
Children & youth mental health services	49.6
Youth substance abuse prevention & services	48.5
Safe sex education and teen pregnancy prevention programs	47.4
Seniors	**Too Few**
Affordable housing for seniors	52.1
Health Care	**Too Few**
Health Insurance Support	63.9
Obesity and Fitness Education	55.4
Substance Abuse Prevention	48.1
Walk-in Centers or Urgent Care Clinics	26.0
Primary Care Physician	23.7
Dental Services / Dentists	21.5
Medical Specialists	20.3

The following presentation depicts overall need, across all without categories. Shading occurs where more than half of all respondents see a need. "Don't know" respondents were removed from the data.

Community Services / Programs	**Too Few Percent**
Health Insurance Support	63.9
Domestic violence prevention and treatment programs	59.4
Free counseling on issues such as foreclosure, bankruptcy, taxes/finance, home buying, leases, contracts, personal budgeting and rental agreements	59.1
Adult job training, placement and supports including mentoring, and life skills	58.8
Child abuse prevention & treatment programs	58.7
Drop-out prevention programs	58.0
Bullying and violence prevention programs	58.0
Homeless programs and supports such as shelters, counseling & laundry	56.6
Obesity and Fitness Education	55.4
Affordable childcare for working parents	53.7
Affordable housing	53.6
Affordable housing for seniors	52.1
Parenting programs	50.6
Children & youth mental health services	49.6
Youth substance abuse prevention & services	48.5
Temporary financial support for heat and/or utilities	48.4
Substance Abuse Prevention	48.1
Safe sex education and teen pregnancy prevention programs	47.4
Tutoring and mentoring for school age children	46.6
Food distribution centers or pantries	42.1

Public transportation availability	40.2
Out-of-school programming including before, after and vacations	34.7
Crisis intervention hotlines	34.3
Walk-in Centers or Urgent Care Clinics	26.0
Primary Care Physician	23.7
Recreation programs for area residents(including sports	22.9
Dental Services / Dentists	21.5
Medical Specialists	20.3

The following table presents all results, across all categories and includes "unsure or don't know" respondents.

Transportation	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Public transportation availability	34.1	49.3	1.3	15.2
Employment	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Adult job training, placement and supports including mentoring, and life skills	37.6	25.5	0.8	36.1
Affordable childcare for working parents	35.3	28.6	2.0	34.3
Recreation	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Recreation programs for area residents(including sports	20.4	65.6	2.8	11.3
Education	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Out-of-school programming including before, after and vacations	24.7	45.0	1.3	29.0
Tutoring and mentoring for school age children	29.8	33.3	0.8	36.1
Drop-out prevention programs	31.1	21.4	1.2	46.4
Family and Community	**Too**	**About the**	**Too**	**Unsure40.7/DK**

	Few	Right Amount	Many	
Child abuse prevention & treatment programs	34.8	23.7	0.8	40.7
Food distribution centers or pantries	34.9	47.0	1.0	17.1
Parenting programs	30.1	28.6	0.8	40.7
Domestic violence prevention and treatment programs	37.6	24.5	1.2	36.8
Crisis intervention hotlines	22.0	41.2	1.0	35.8
Free counseling on issues such as foreclosure, bankruptcy, taxes/finance, home buying, leases, contracts, personal budgeting and rental agreements	41.6	27.2	1.7	29.6
Housing	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Affordable housing	45.7	36.8	3.3	14.7
Homeless programs and supports such as shelters, counseling & laundry	45.2	33.1	1.5	20.2
Temporary financial support for heat and/or utilities	37.9	38.4	2.0	21.7
Children and Youth	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Safe sex education and teen pregnancy prevention programs	31.8	33.6	1.7	32.9
Bullying and violence prevention programs	42.2	29.0	1.7	27.2
Children & youth mental health services	32.8	32.0	1.3	33.9
Youth substance abuse prevention & services	35.9	36.4	1.7	26.0
Seniors	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/D17.4K**
Affordable housing for seniors	43.0	38.4	1.2	17.4
Health Care	**Too Few**	**About the Right Amount**	**Too Many**	**Unsure/DK**
Obesity and Fitness Education	42.5	32.5	2.9	23.2
Health Insurance Support	47.5	25.8	1.0	25.7
Substance Abuse Prevention	35.1	36.4	1.5	27.0
Walk-in Centers or Urgent Care Clinics	23.8	65.2	2.6	8.3
Dental Services / Dentists	19.4	66.9	3.6	10.1
Primary Care Physician	22.2	69.5	2.0	0.3
Medical Specialists	18.0	64.4	6.5	11.1

DEMOGRAPHICS

Age	2011
Next Generation (18-25)	4.7
Generation X (26-40)	14.9
Boom Generation (41-60)	48.4
Seniors (60 +)	32.0

Education	2011
Never attended school / or Kindergarten	0.3
Grades 1 - 8	0.7
Grades 9 – 11	4.1
Grades 12 or GED	25.7
College 1 – 3 years	26.3
College 4 years or more	42.5
Refused	0.3

Hispanic, Latin American, Puerto Rican, Cuban or Mexican	2011

Yes	13.7
No	85.9
Unsure	0.2
RF	0.2

Ethnicity	2011
White	87.7
Black, African-American	4.3
Asian, Pacific Islander	1.0
Aleutian, Eskimo or American Indian	0.5
Other	5.1
Refused	1.0

Income	2011
Less than $25,000	15.1
$25,000 to under $40,000	10.6
$40,000 to under $60,000	12.6
$60,000 to under $100,000	22.7
$100,000 or more	22.4
Don't Know	4.0
RF	12.7

Gender	2011
Male	50.2
Female	49.8

Appendix

INTERPRETATION OF AGGREGATE RESULTS

The computer processed data for this survey is presented in the following frequency distributions. It is important to note that the wordings of the variable labels and value labels in the computer-processed data are largely abbreviated descriptions of the Questionnaire items and available response categories.

The frequency distributions include the category or response for the question items. Responses deemed not appropriate for classification have been grouped together under the "Other" code.

The "NA" category label refers to "No Answer" or "Not Applicable." This code is also used to classify ambiguous responses. In addition, the "DK/RF" category includes those respondents who did not know their answer to a question or declined to answer it. In many of the tables, a group of responses may be tagged as "Missing" – occasionally, certain individual's responses may not be required to specific questions and, thus, are excluded. Although when this category of response is used, the computations of percentages are presented in two (2) ways in the frequency distributions: 1) with their inclusion (as a proportion of the total sample), and 2) their exclusion (as a proportion of a sample sub-group).

Each frequency distribution includes the absolute observed occurrence of each response (i.e. the total number of cases in each category). Immediately adjacent to the right of the column of absolute

frequencies is the column of relative frequencies. These are the percentages of cases falling in each category response, including those cases designated as missing data. To the right of the relative frequency column is the adjusted frequency distribution column that contains the relative frequencies based on the legitimate (i.e. non-missing) cases. That is, the total base for the adjusted frequency distribution excludes the missing data. For many Questionnaire items, the relative frequencies and the adjusted frequencies will be nearly the same. However, some items that elicit a sizable number of missing data will produce quite substantial percentage differences between the two columns of frequencies. The careful analyst will cautiously consider both distributions.

The last column of data within the frequency distribution is the cumulative frequency distribution (Cum Freq). This column is simply an adjusted frequency distribution of the sum of all previous categories of response and the current category of response. Its primary usefulness is to gauge some ordered or ranked meaning.

2012 Community Health Needs Assessment

Behavioral Risk Factor Surveillance Survey

The Hospital of Central Connecticut

A Hartford HealthCare Partner

October 8, 2012

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Methodology

- Phone interviews with 630 individuals were conducted by Holleran's teleresearch center between July 17, 2012 and September 10, 2012.
  - Respondents were randomly selected for participation based on a statistically valid sampling frame developed by Holleran to represent the service area of The Hospital of Central Connecticut.
  - Respondents were 18 years of age or older and resided in the following 11 zip codes within Hartford County, CT: 06010, 06023, 06037, 06051, 06052, 06053, 06062, 06111, 06444, 06479, 06489
- The survey was adapted from the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). The survey tool assesses health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.
- All data sets utilized in the report are statistically weighted to counter for demographic imbalances (e.g. Over-representation of females compared to males) with the exception of the actual demographic information.

Respondent Demographics

Frequency of Responses by Zip Code

Zip	Percent
06010	11.9%
06023	0.6%
06037	9.0%
06051	14.4%
06052	4.0%
06053	16.5%
06062	8.6%
06111	14.6%
06444	0.2%
06479	4.9%
06489	15.2%

Gender

Gender	The Hospital of Central Connecticut CHNA 2012	The Hospital of Central Connecticut Census*
Male	36.8%	48.2%
Female	63.2%	51.8%

*Per the 2010 U.S. Census.

N=630

What is your age?

Age Group	The Hospital of Central Connecticut CHNA 2012	The Hospital of Central Connecticut Census*
18 - 24	2.2%	9.4%
25 - 34	5.3%	12.7%
35 - 44	7.1%	13.3%
45 - 54	23.6%	15.3%
55 - 64	23.6%	12.4%
65 years and over	38.3%	15.1%

*Per the 2010 U.S. Census.

N=624

Are you Hispanic/Latino?

Hispanic/Latino	The Hospital of Central Connecticut CHNA 2012	The Hospital of Central Connecticut Census*
Yes	8.5%	15.6%
No	91.5%	84.4%

*Per the 2010 U.S. Census.

N=627

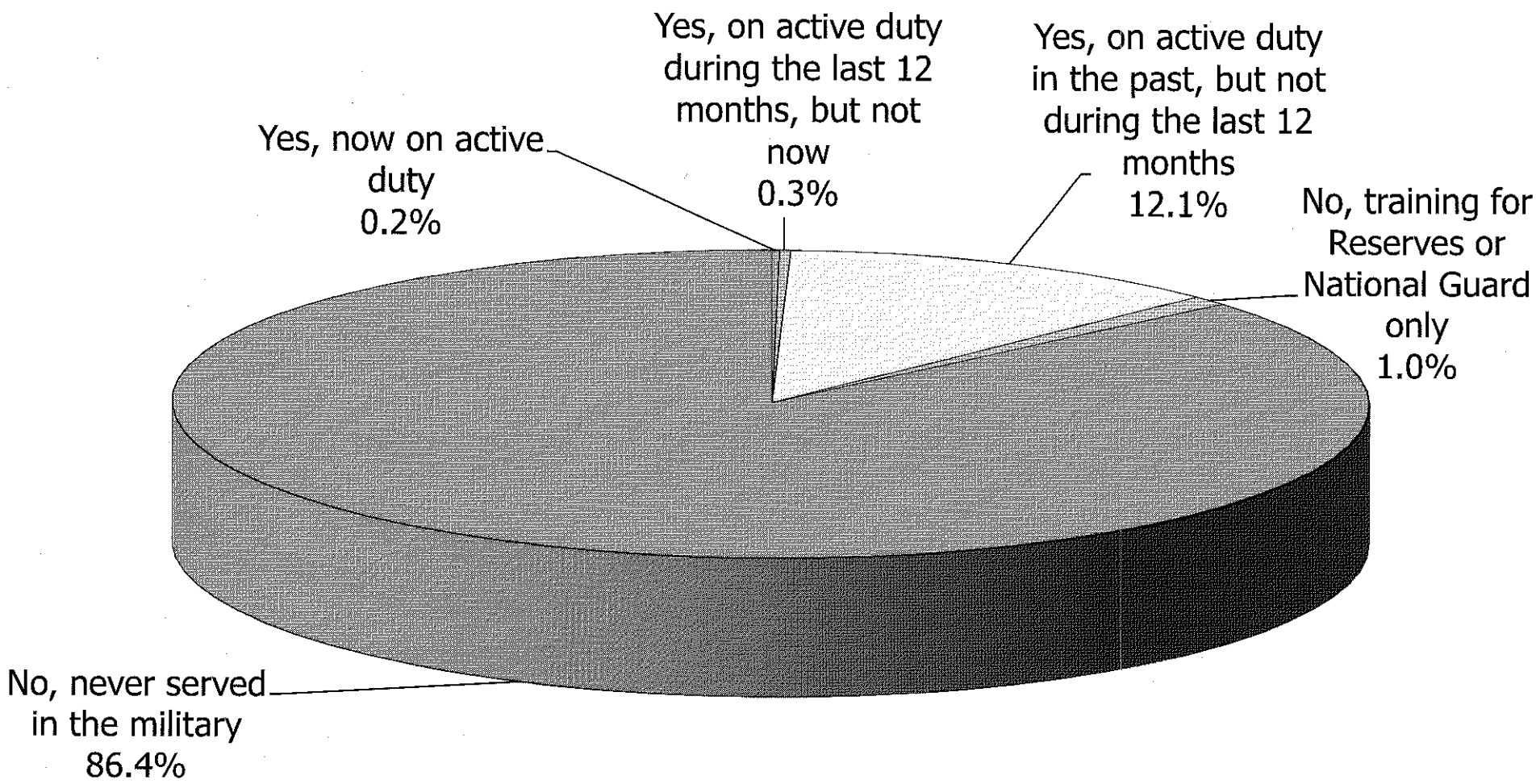
What is your race?

Race	The Hospital of Central Connecticut CHNA 2012	The Hospital of Central Connecticut Census*
White	88.6%	82.3%
Black or African American	4.9%	5.8%
Asian	0.8%	2.7%
American Indian or Alaska Native	0.7%	0.2%
Other	5.0%	6.4%

*Per the 2010 U.S. Census.

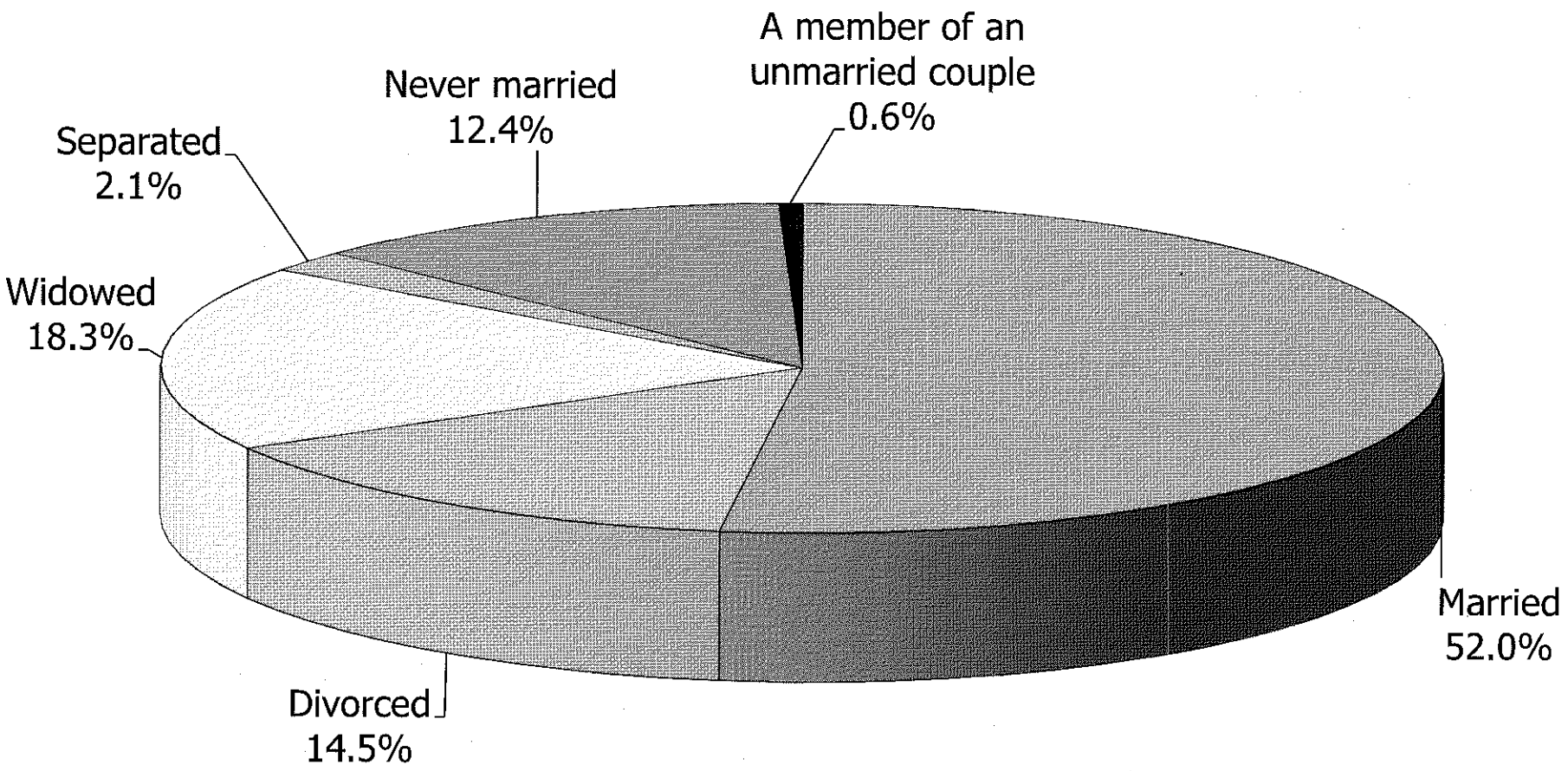
N=615

Have you ever served on active duty in the United States Armed Forces?



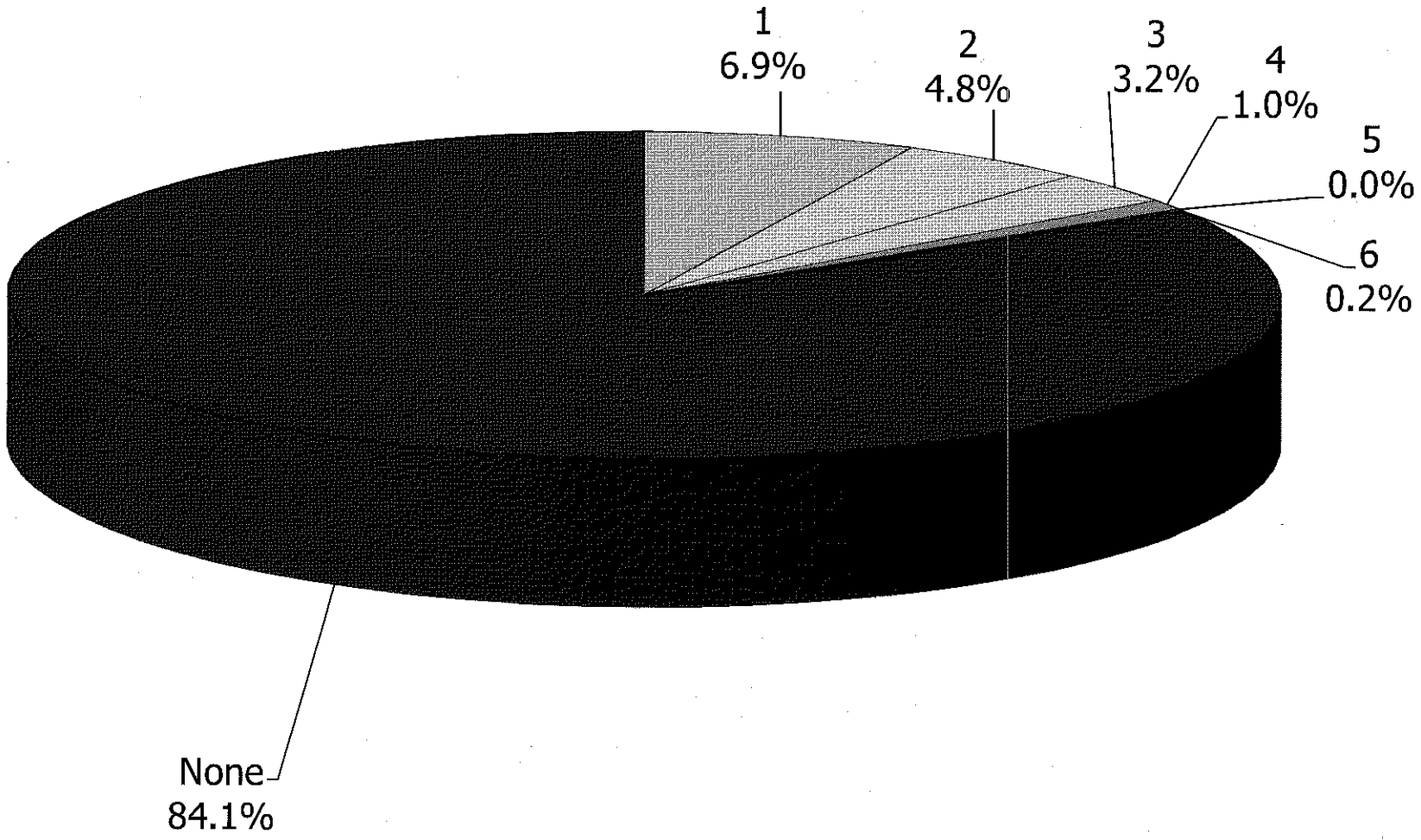
N=626

Marital Status



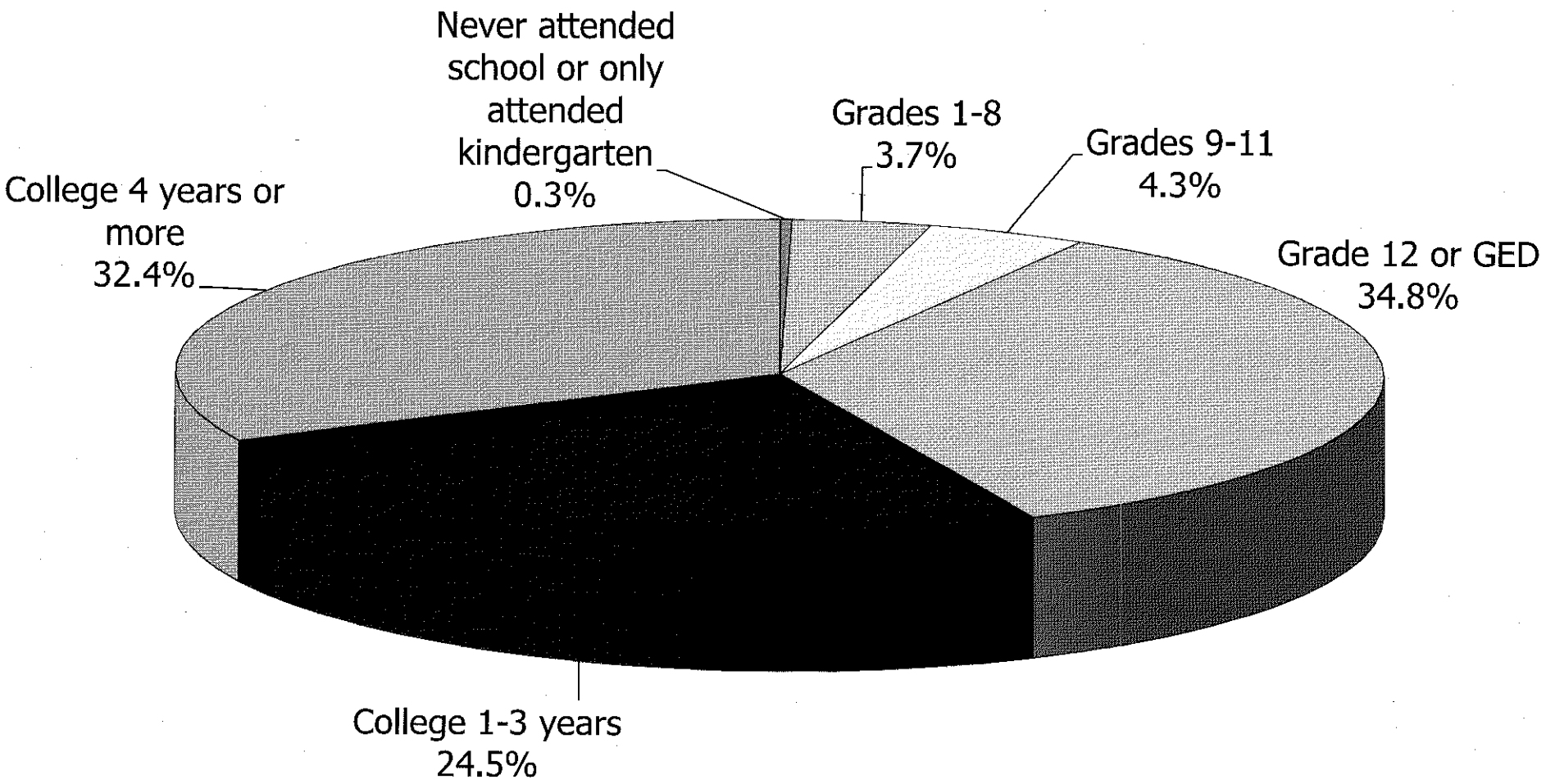
N=627

Number of children in household who are less than 18 years old



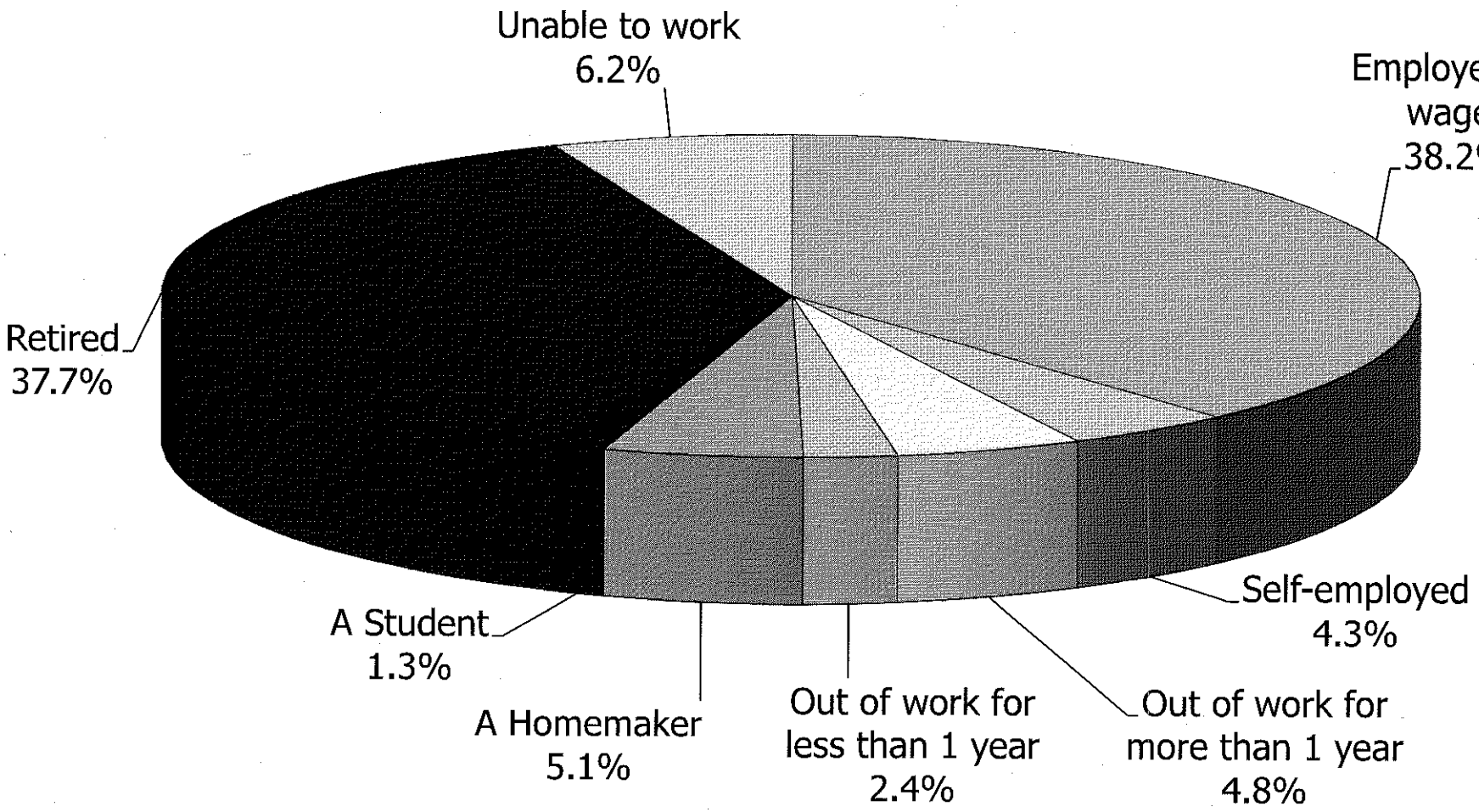
N=627

Highest Grade/Year of School Completed



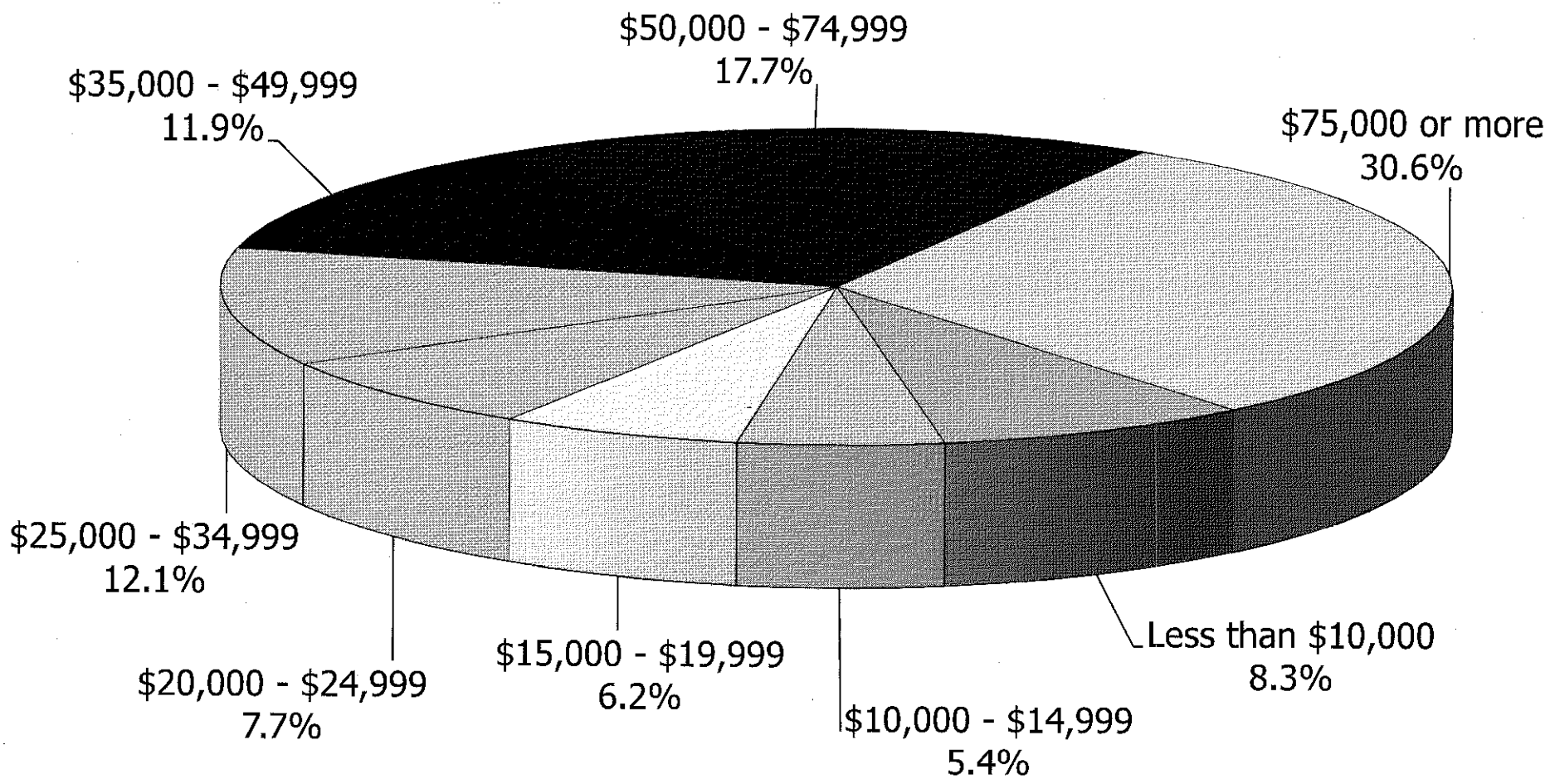
N=629

Employment Status



N=628

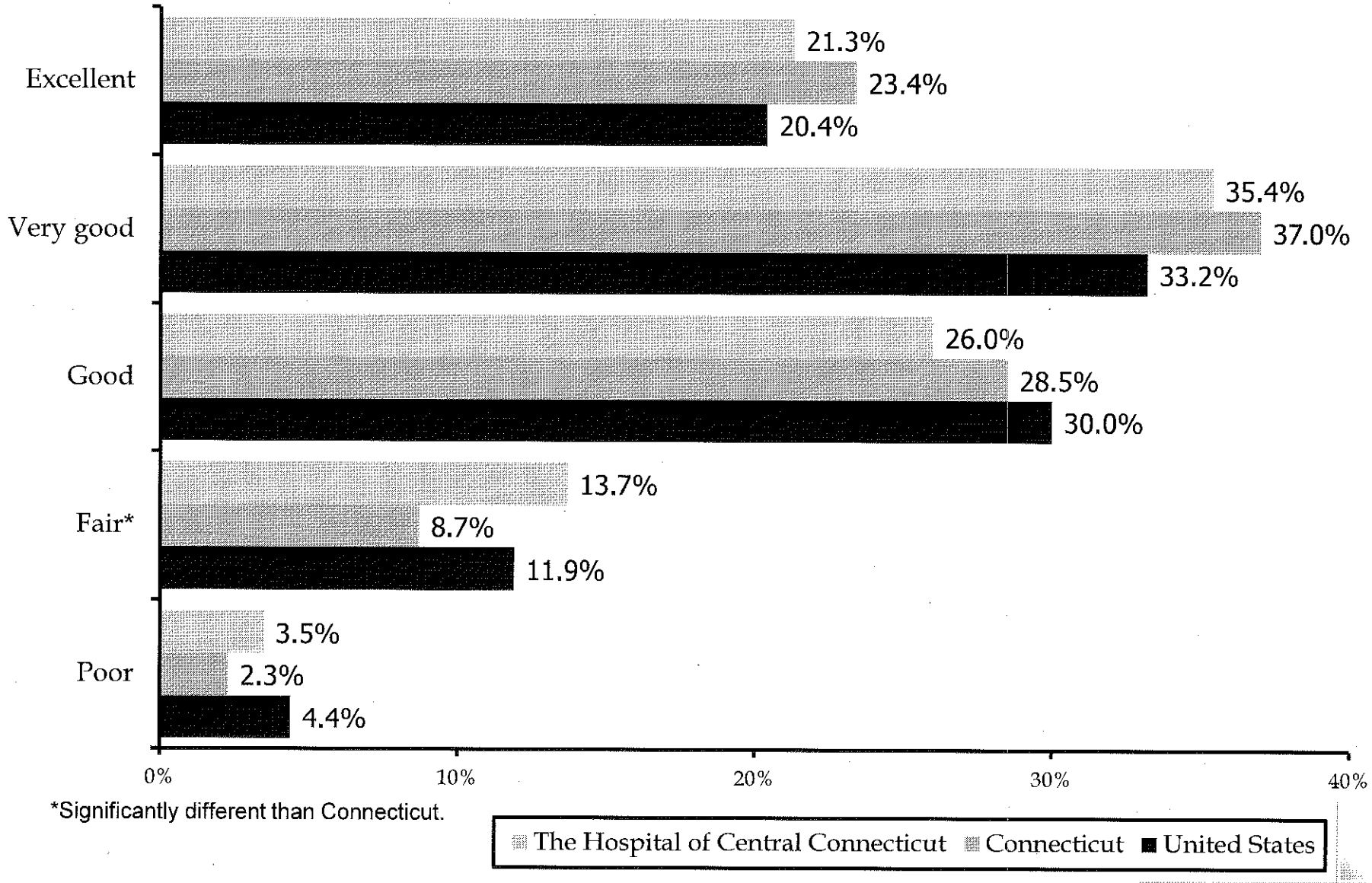
Annual household income from all sources



N=496

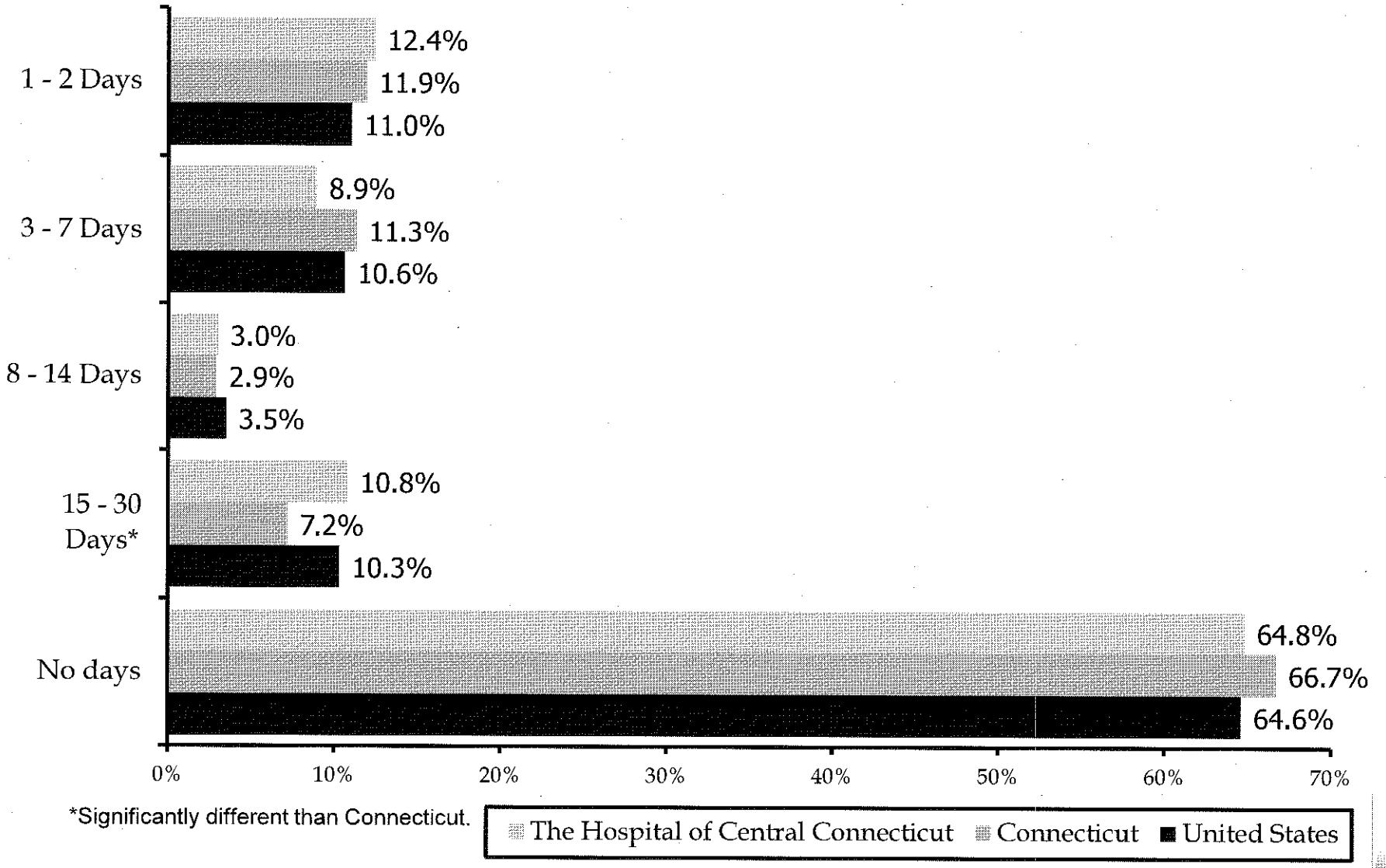
Health Status

Would you say that in general your health is-

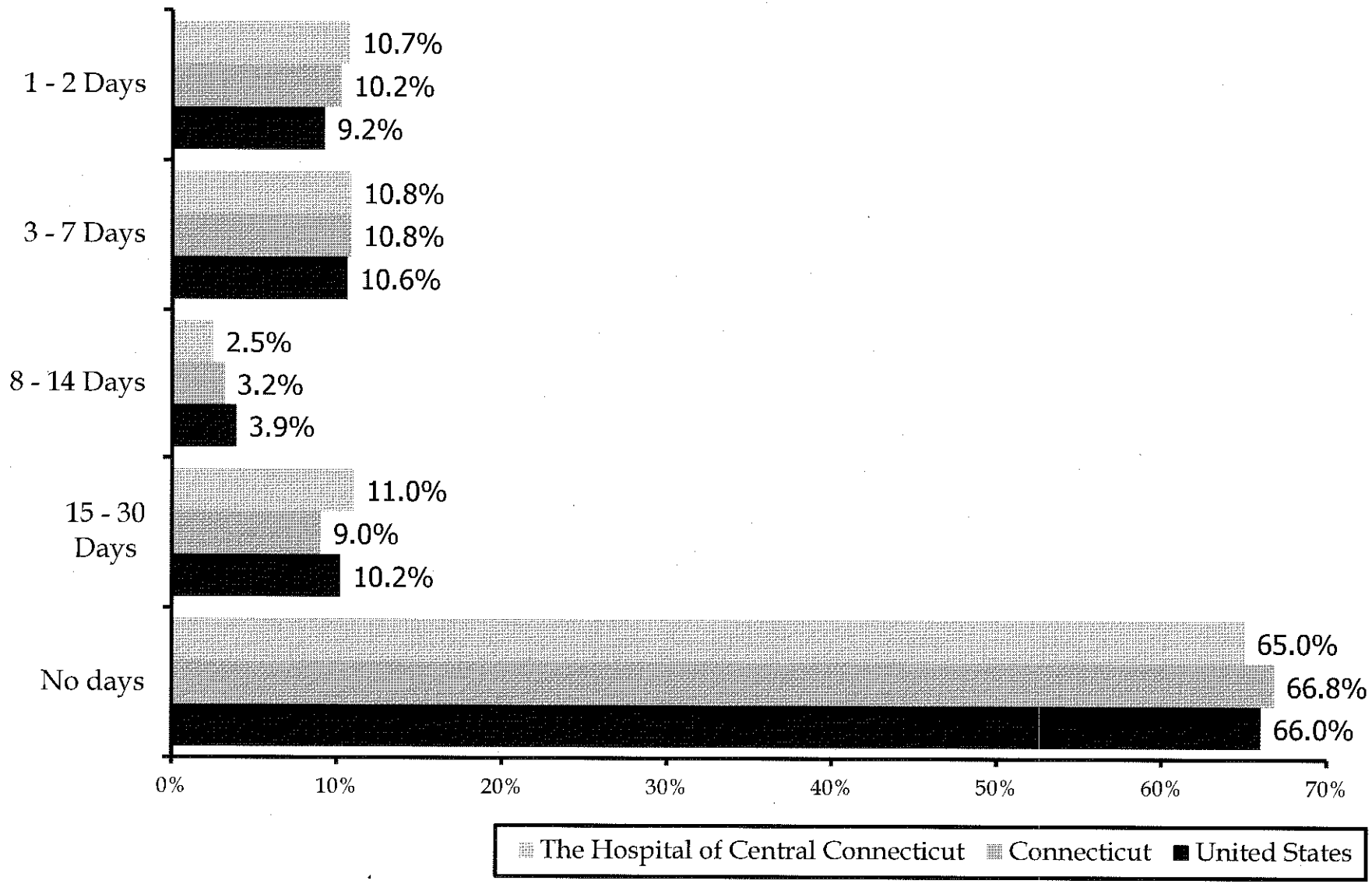


*Significantly different than Connecticut.

For how many days during the past 30 days was your physical health not good?



For how many days during the past 30 days was your mental health not good?



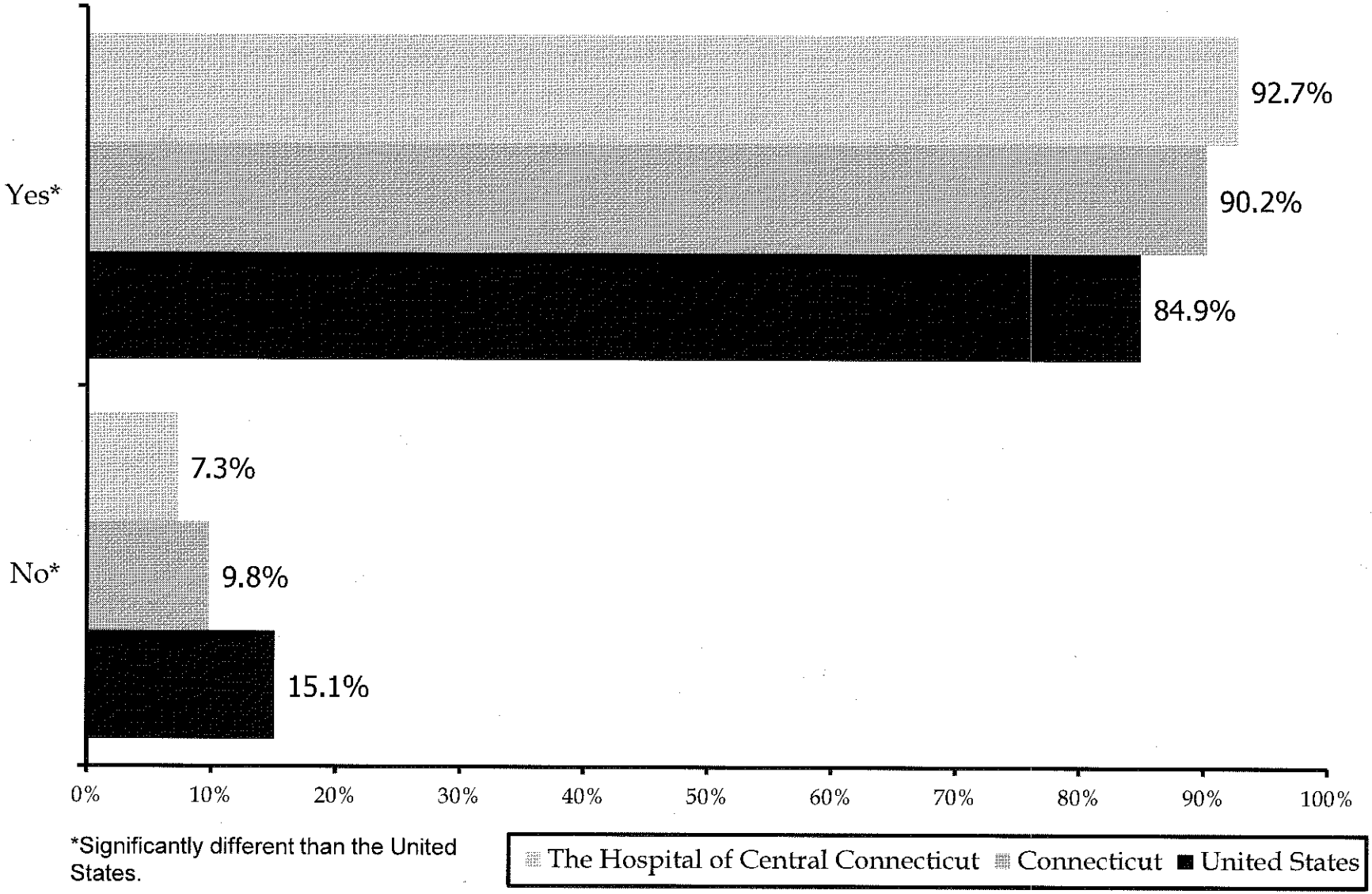
Statistically Significant Differences by Gender and Race

Health Status

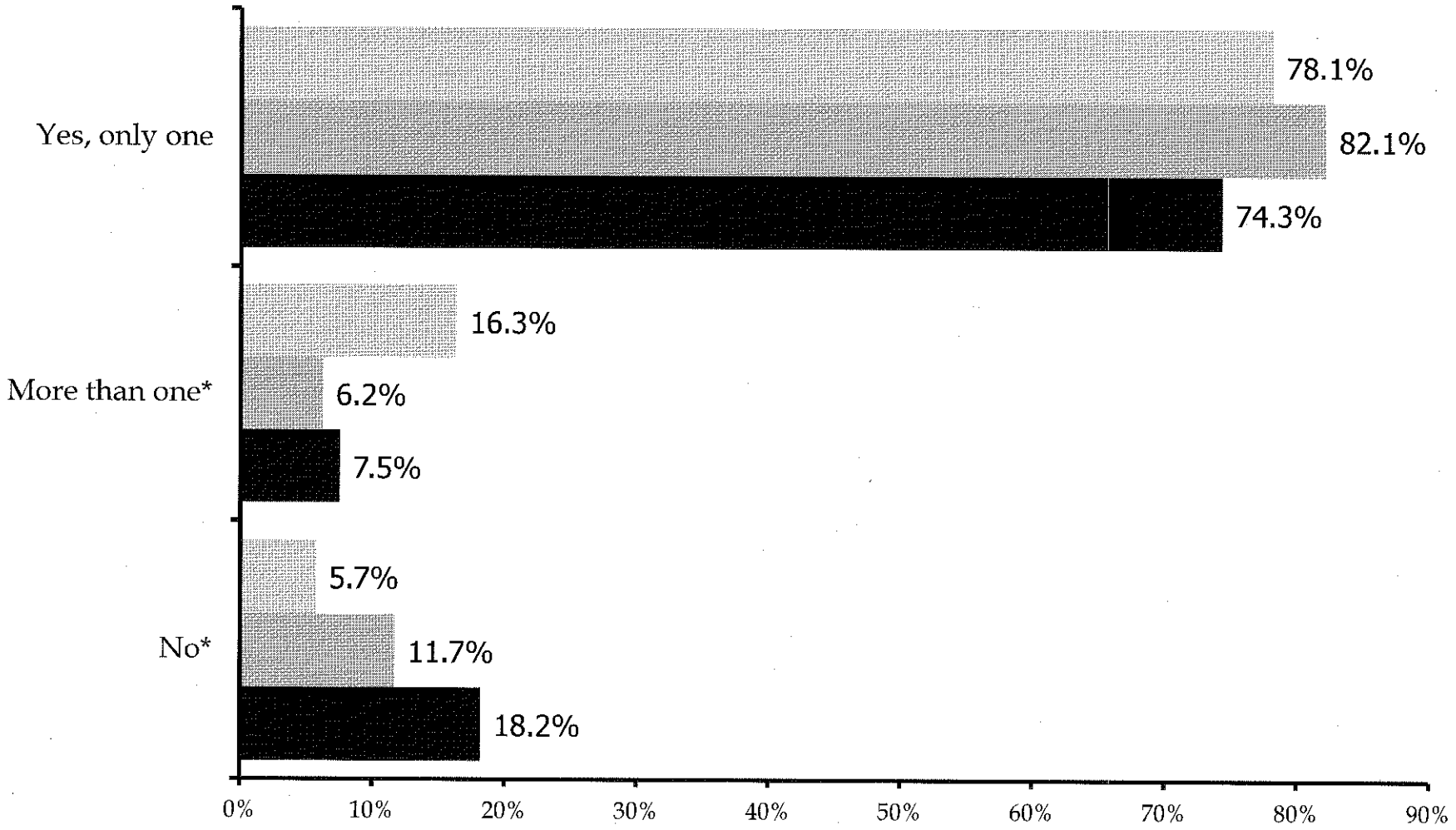
- Asian respondents are more likely than White, Black/African American, and Other race respondents to report very good health in general.
- Black/African American respondents are more likely than White respondents to report poor health in general.
- Female respondents are more likely than male respondents to report 3 – 7 days in which their physical health was not good.
- Female respondents are more likely to report 3 – 7 days and 15 – 30 days in which their mental health was not good. Male respondents are more likely to report no days in which their mental health was not good.
- Hispanic respondents are more likely than Non-Hispanic respondents to report 15 – 30 days in which their physical health was not good.

Health Care Access

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

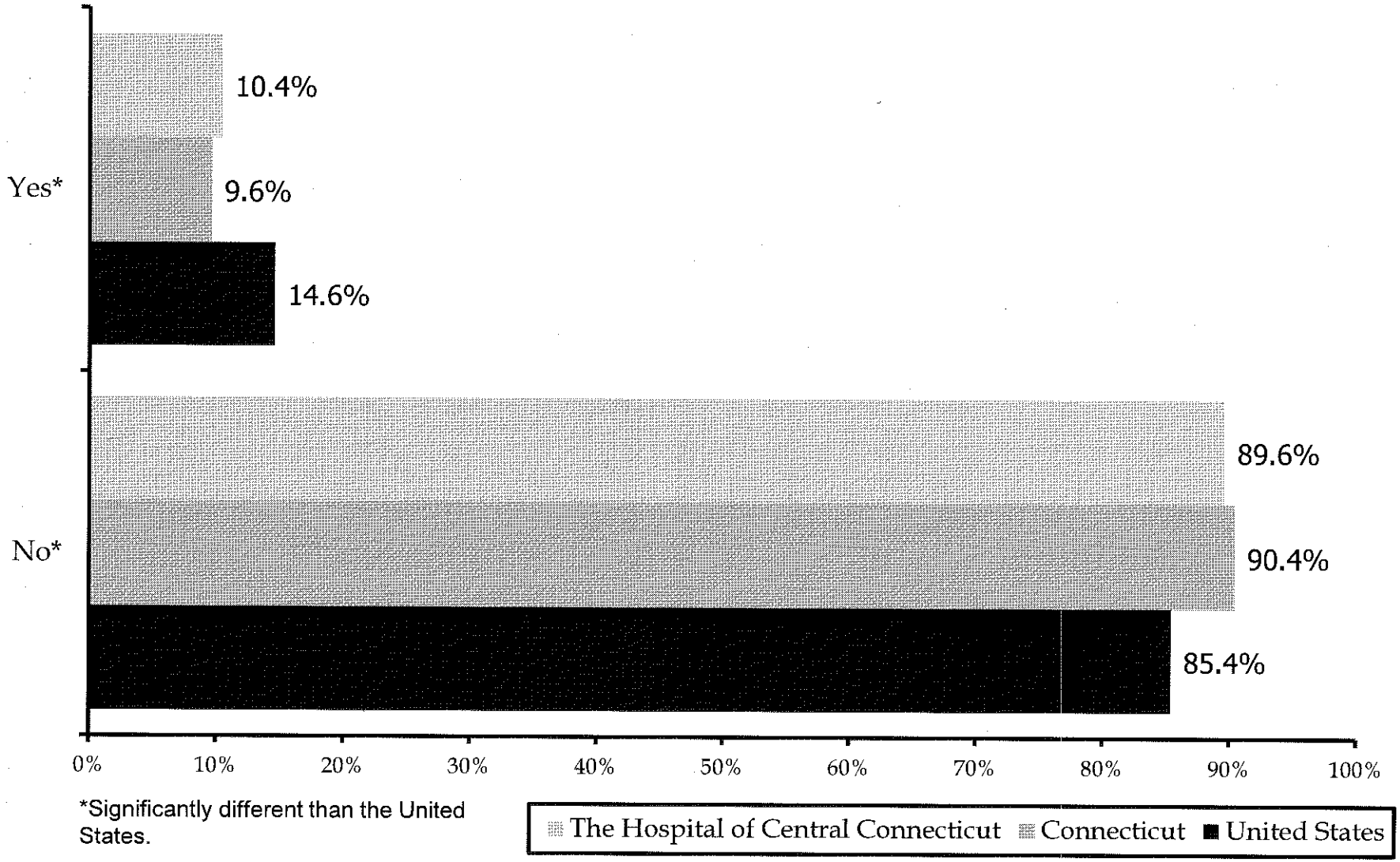


Do you have one person you think of as your personal doctor or health care provider?

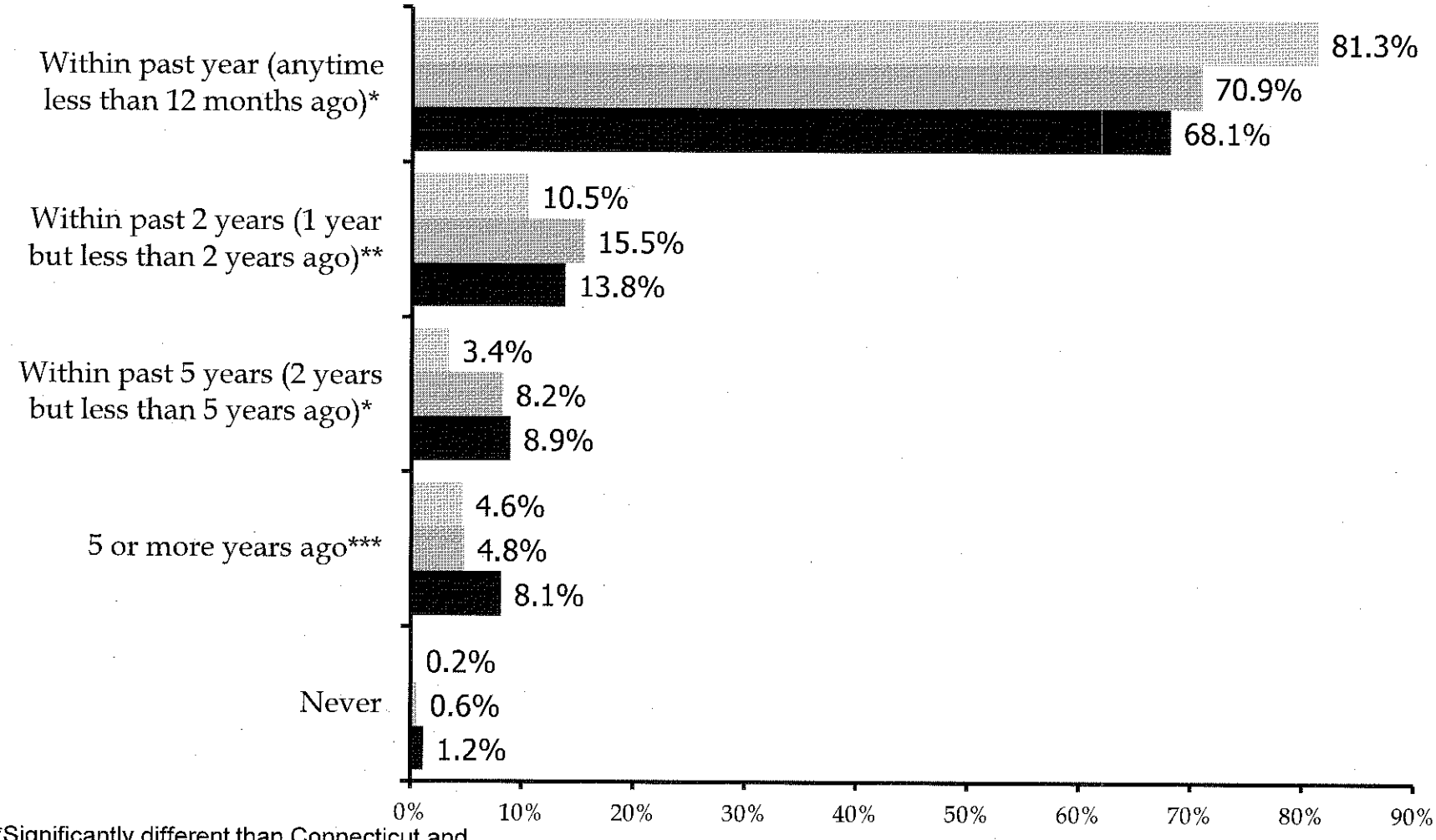


*Significantly different than Connecticut and the United States.

Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?



About how long has it been since you last visited a doctor for a routine checkup?



*Significantly different than Connecticut and the United States.
**Significantly different than Connecticut.
***Significantly different than the United States.

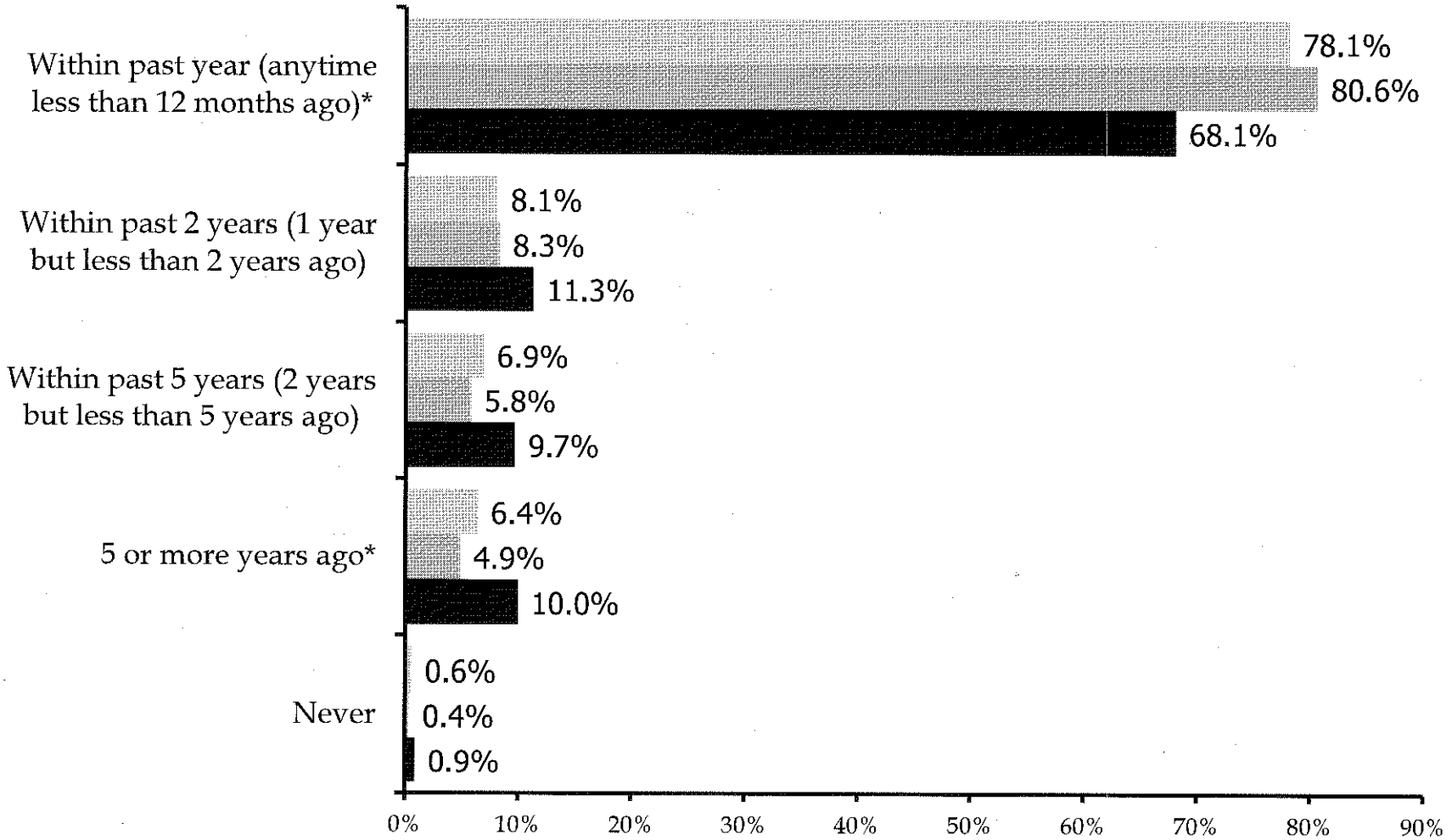
Statistically Significant Differences by Gender and Race

Health Care Access

- Male respondents are more likely than female respondents to have health care coverage.
- Female respondents are more likely than male respondents to have had a time in the past 12 months when they needed to see a doctor but could not because of cost.
- Non-Hispanic respondents are more likely than Hispanic respondents to have health care coverage.
- Hispanic respondents are more likely than Non-Hispanic respondents to not have one person that they think of as their personal doctor or health care provider.
- Hispanic respondents are more likely than Non-Hispanic respondents to have had a time in the past 12 months when they needed to see a doctor but could not because of cost.

Oral Health

How long has it been since you last visited a dentist or dental clinic for any reason?



*Significantly different than the United States.

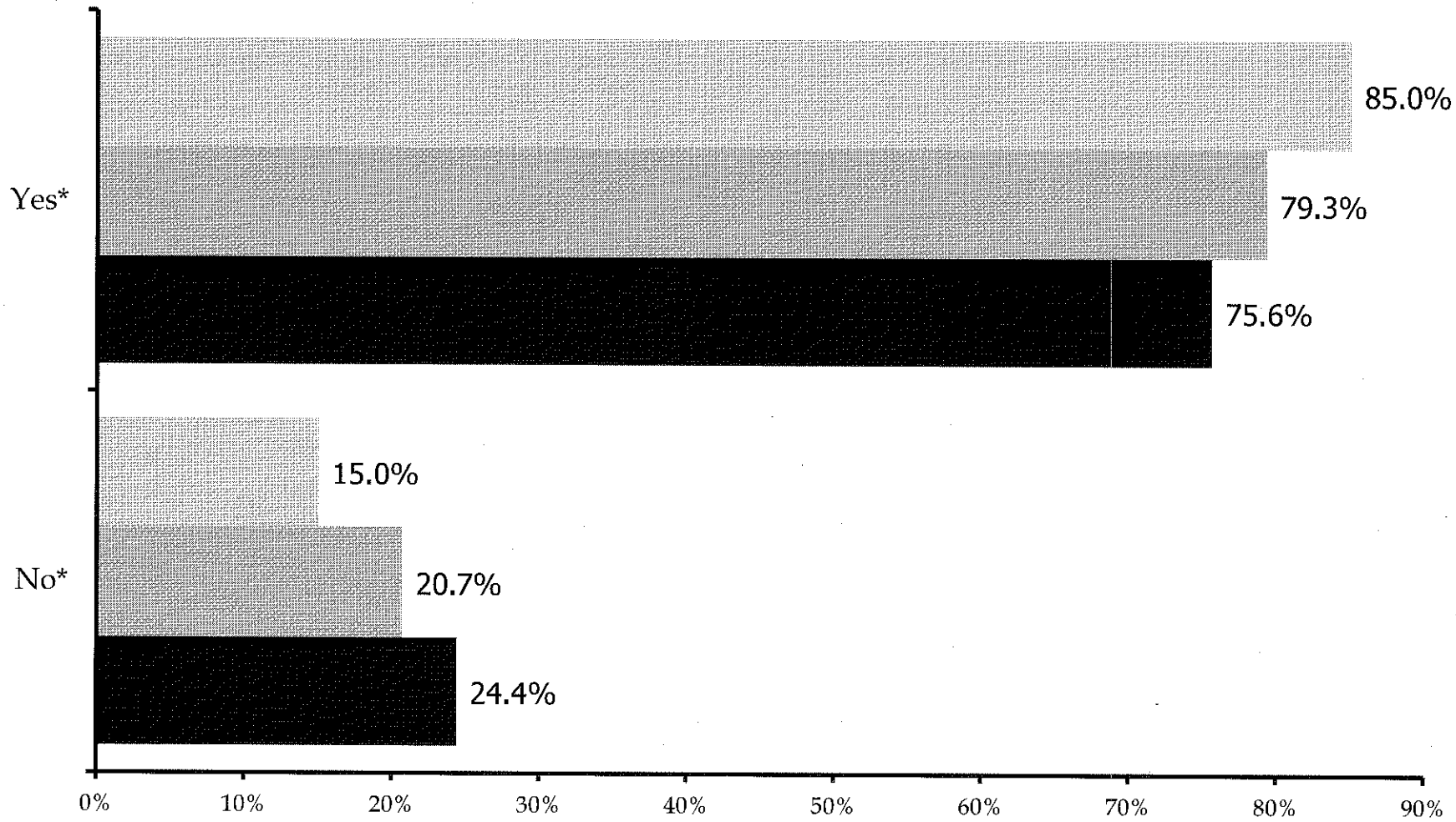
Statistically Significant Differences by Gender and Race

Oral Health

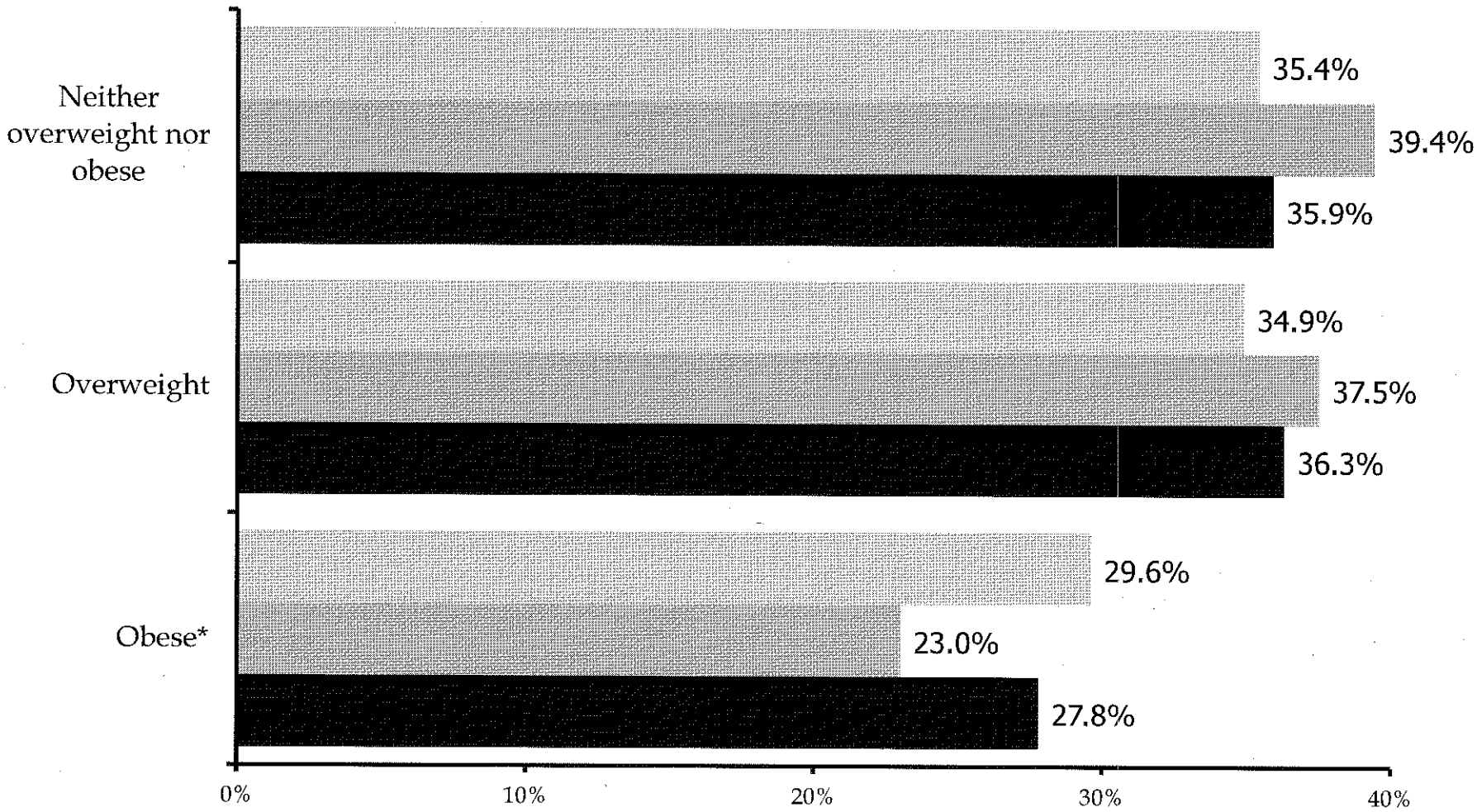
- Black respondents are more likely than White respondents to have last visited a dentist or dental clinic within the past 2 years.
- Asian respondents are more likely than White and Other race respondents to have last visited a dentist or dental clinic 5 or more years ago.
- Other race respondents are more likely than White respondents to have never visited a dentist or dental clinic.

Exercise

During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?



Calculated BMI



*Significantly different than Connecticut.

Statistically Significant Differences by Gender and Race

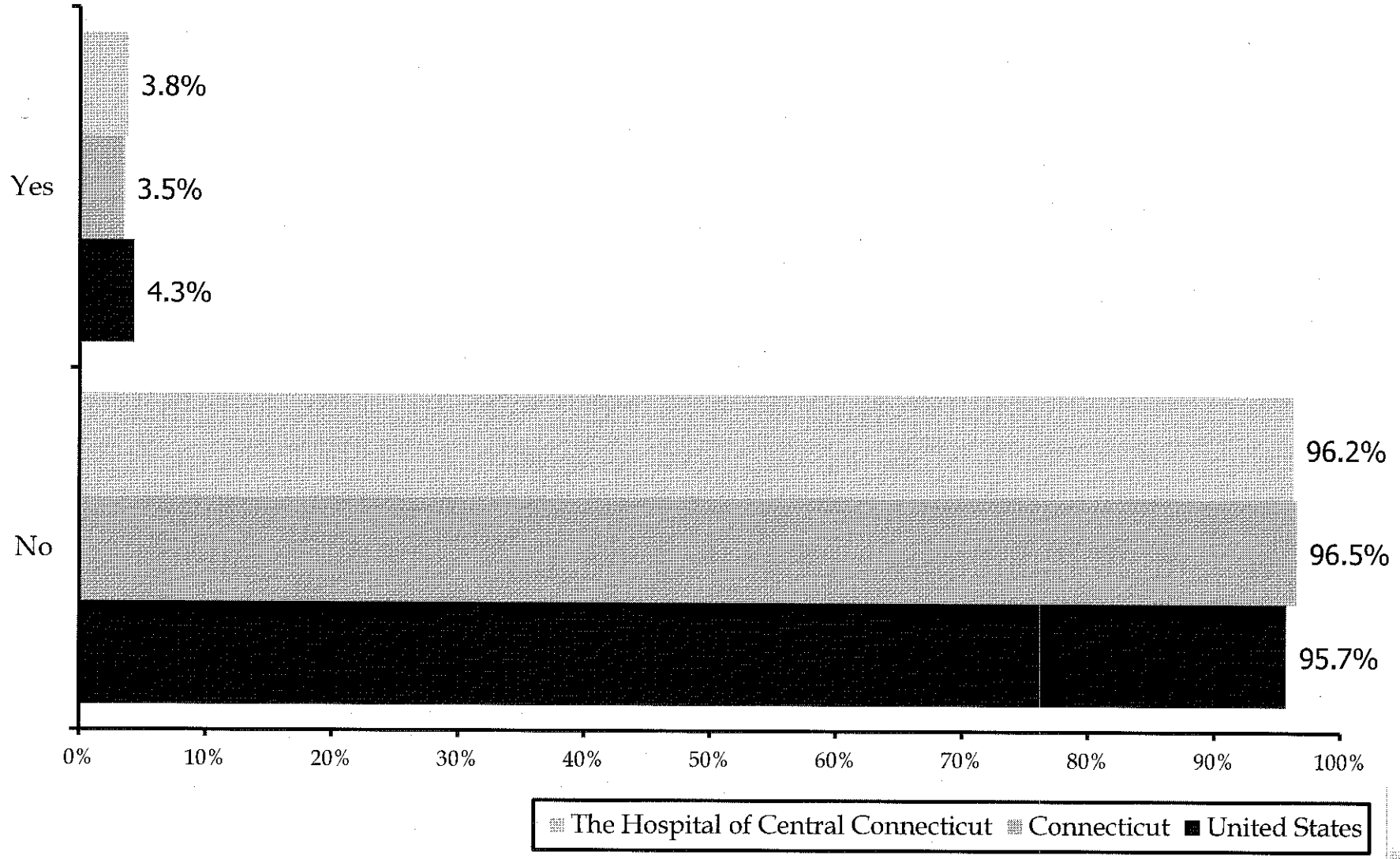
Exercise

- Male respondents are more likely than female respondents to have participated in any physical activities during the past month.
- Non-Hispanic respondents are more likely than Hispanic respondents to have participated in any physical activities during the past month.

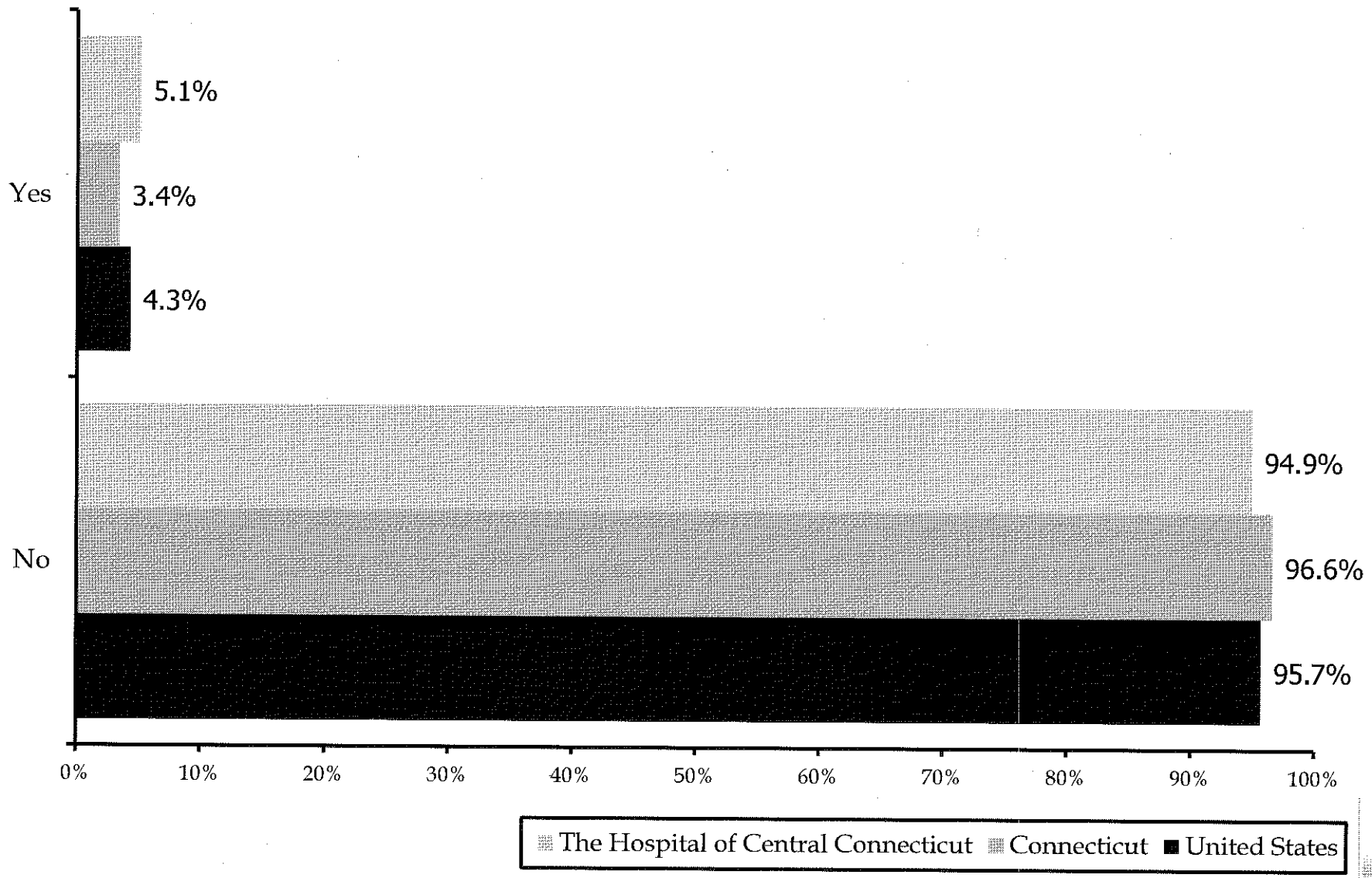
Chronic Health Conditions

United States and Connecticut BRFSS results represent 2011 data

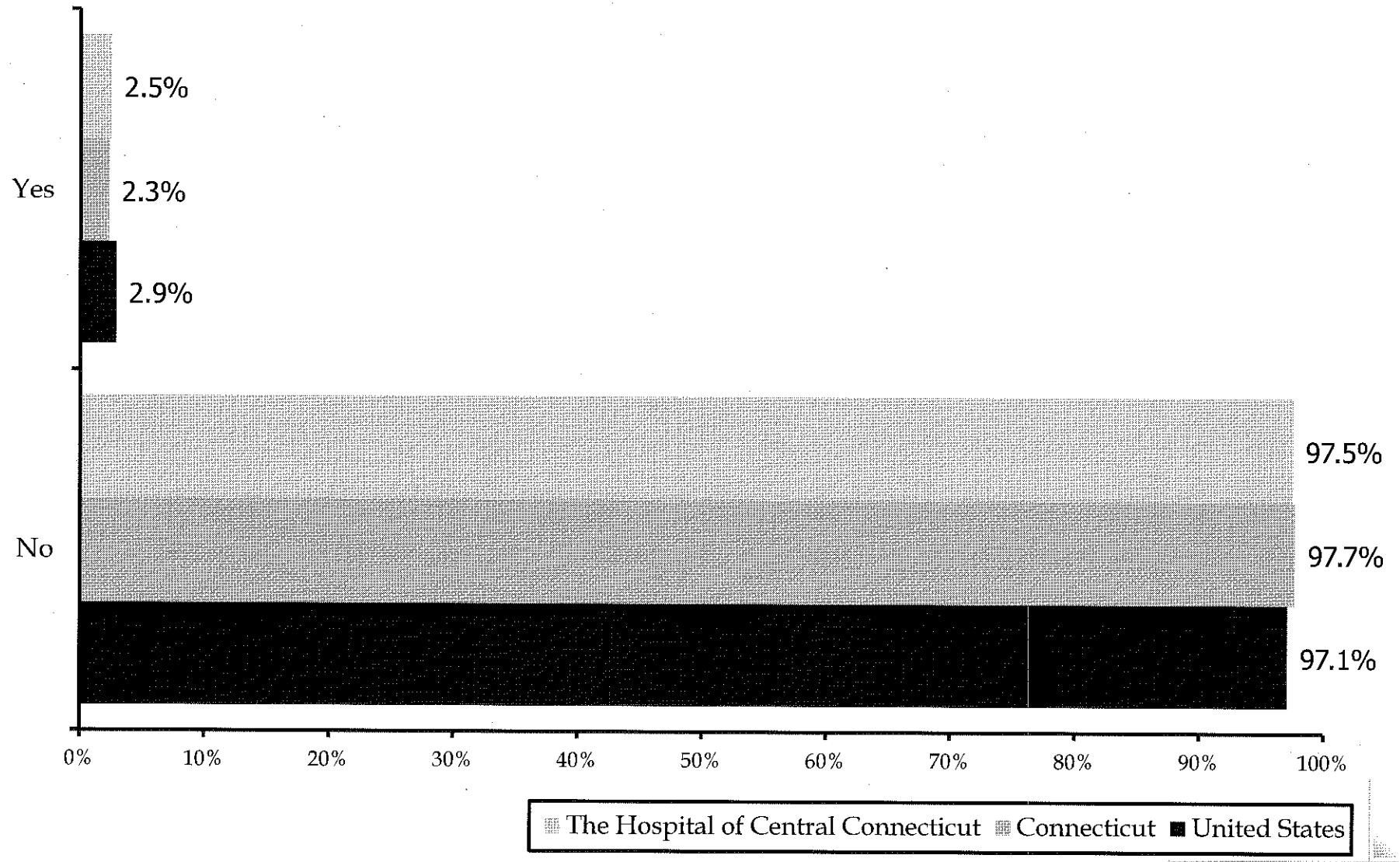
Has a doctor, nurse, or other health professional ever told you that you had a heart attack, also called a myocardial infarction?



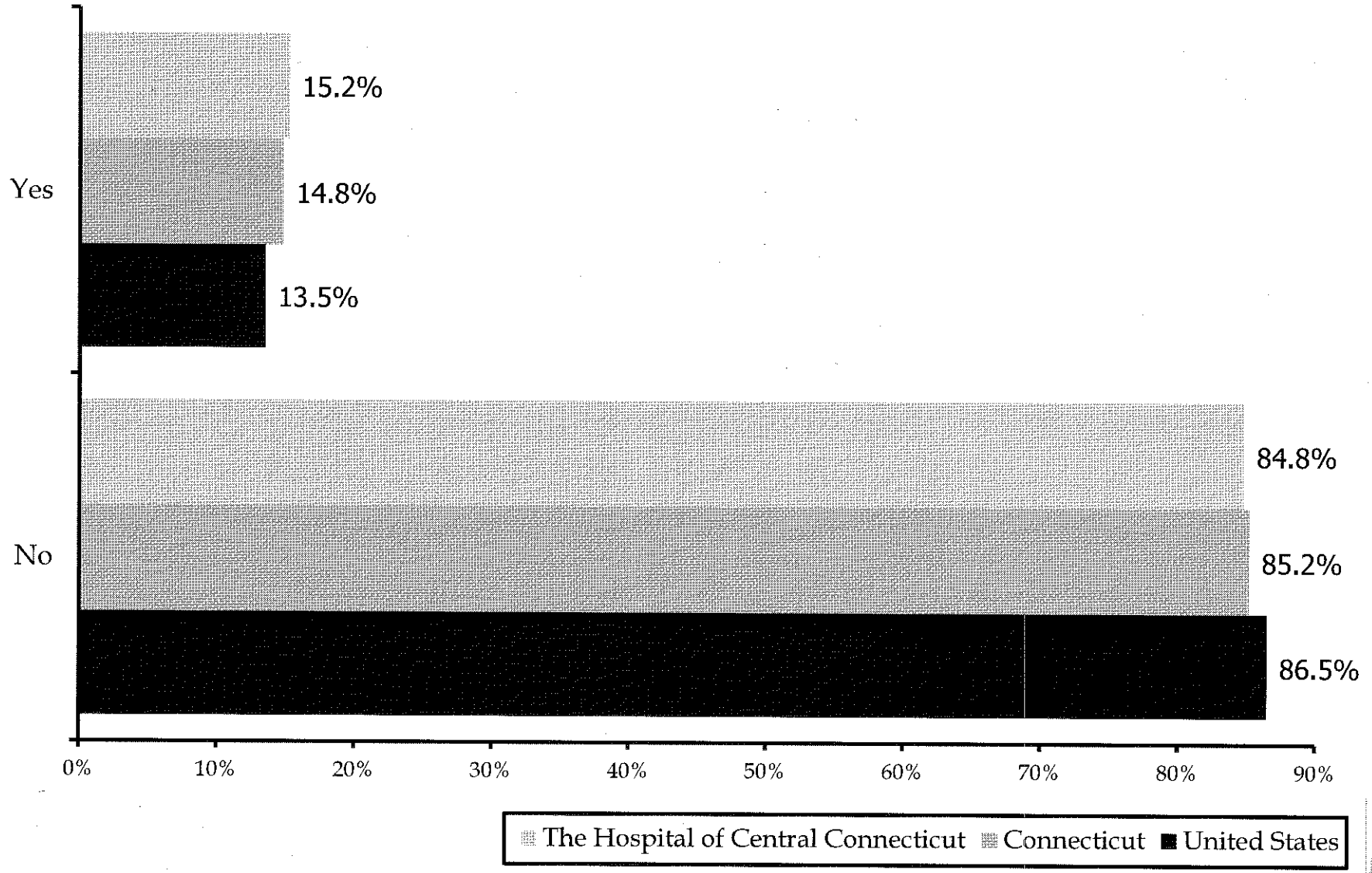
Has a doctor, nurse, or other health professional ever told you that you had angina or coronary heart disease?



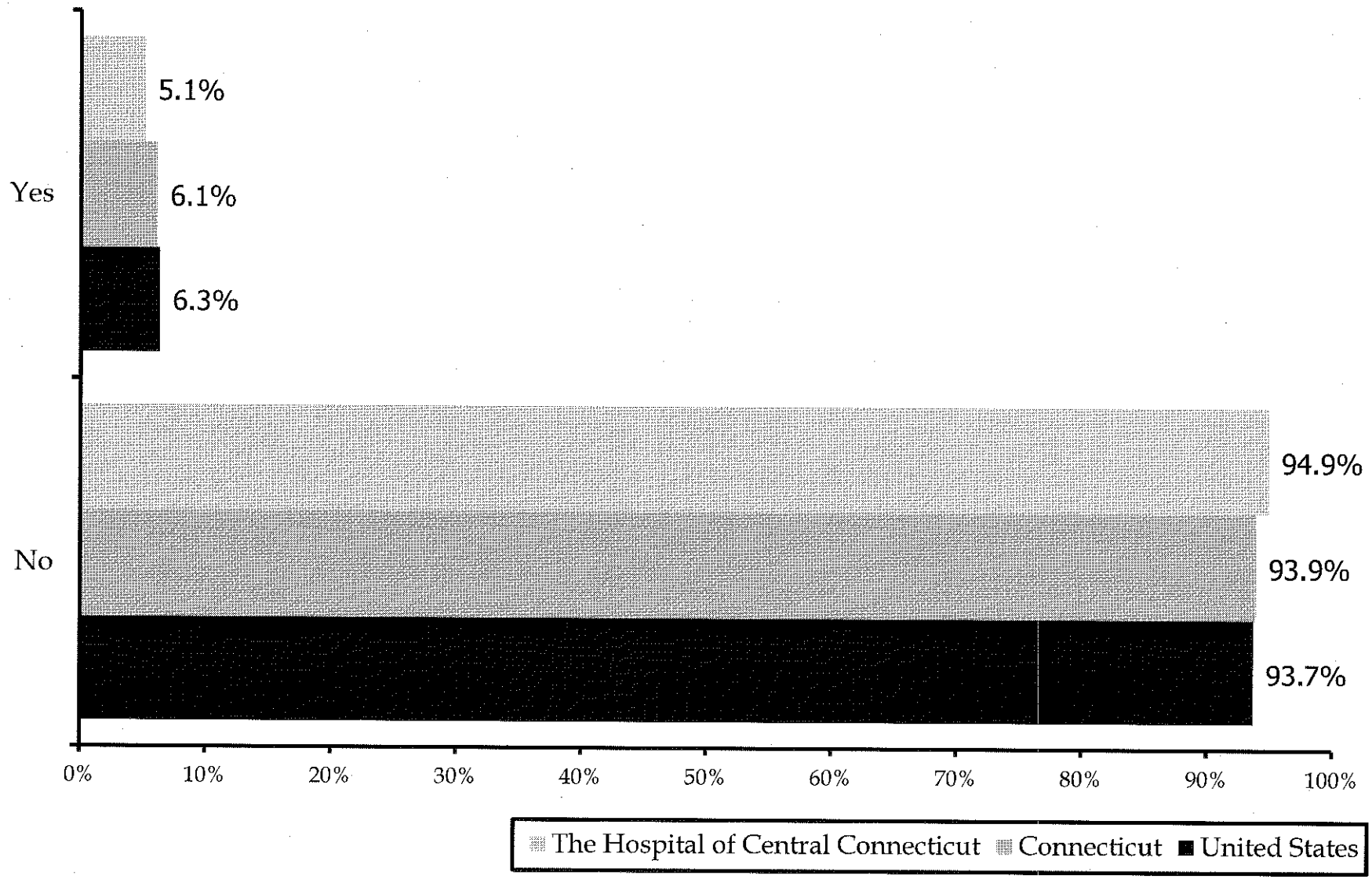
Has a doctor, nurse, or other health professional ever told you that you had a stroke?



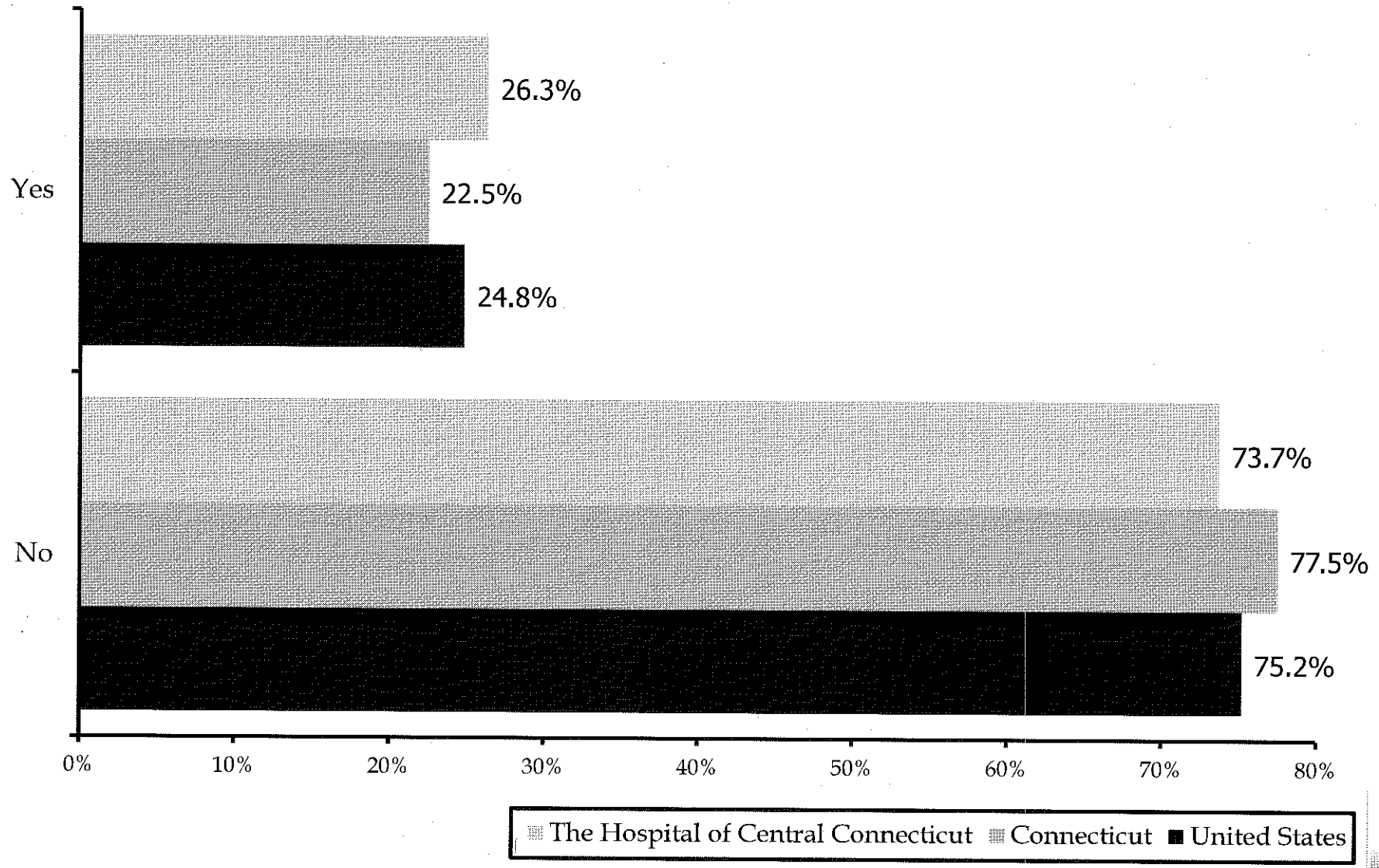
Has a doctor, nurse, or other health professional ever told you that you had asthma?



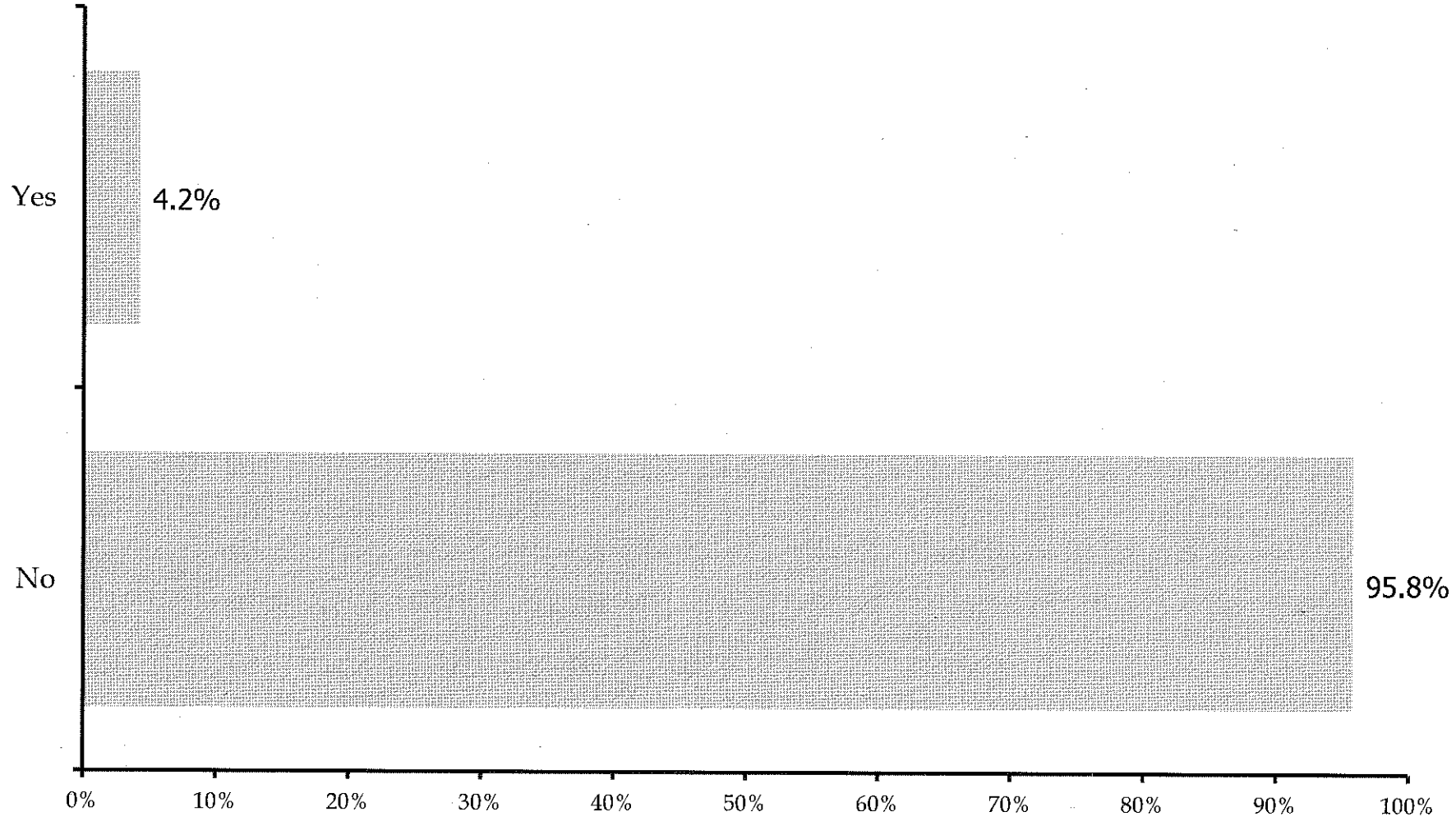
Has a doctor, nurse, or other health professional ever told you that you have (COPD) chronic obstructive pulmonary disease, emphysema, or chronic bronchitis?



Has a doctor, nurse, or other health professional ever told you that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

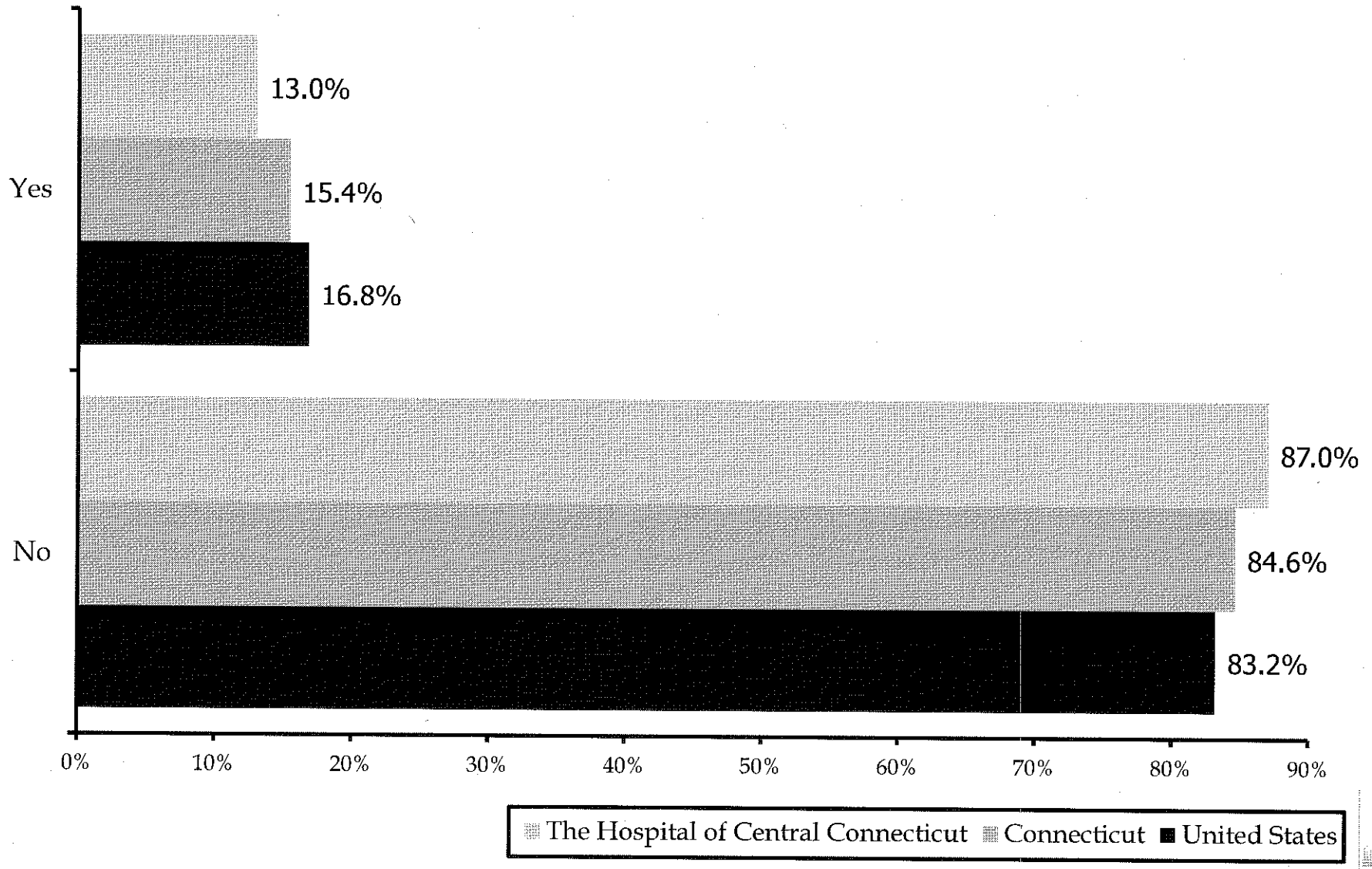


Has a doctor, nurse, or other health professional ever told you that you some form of neuromuscular disease?*

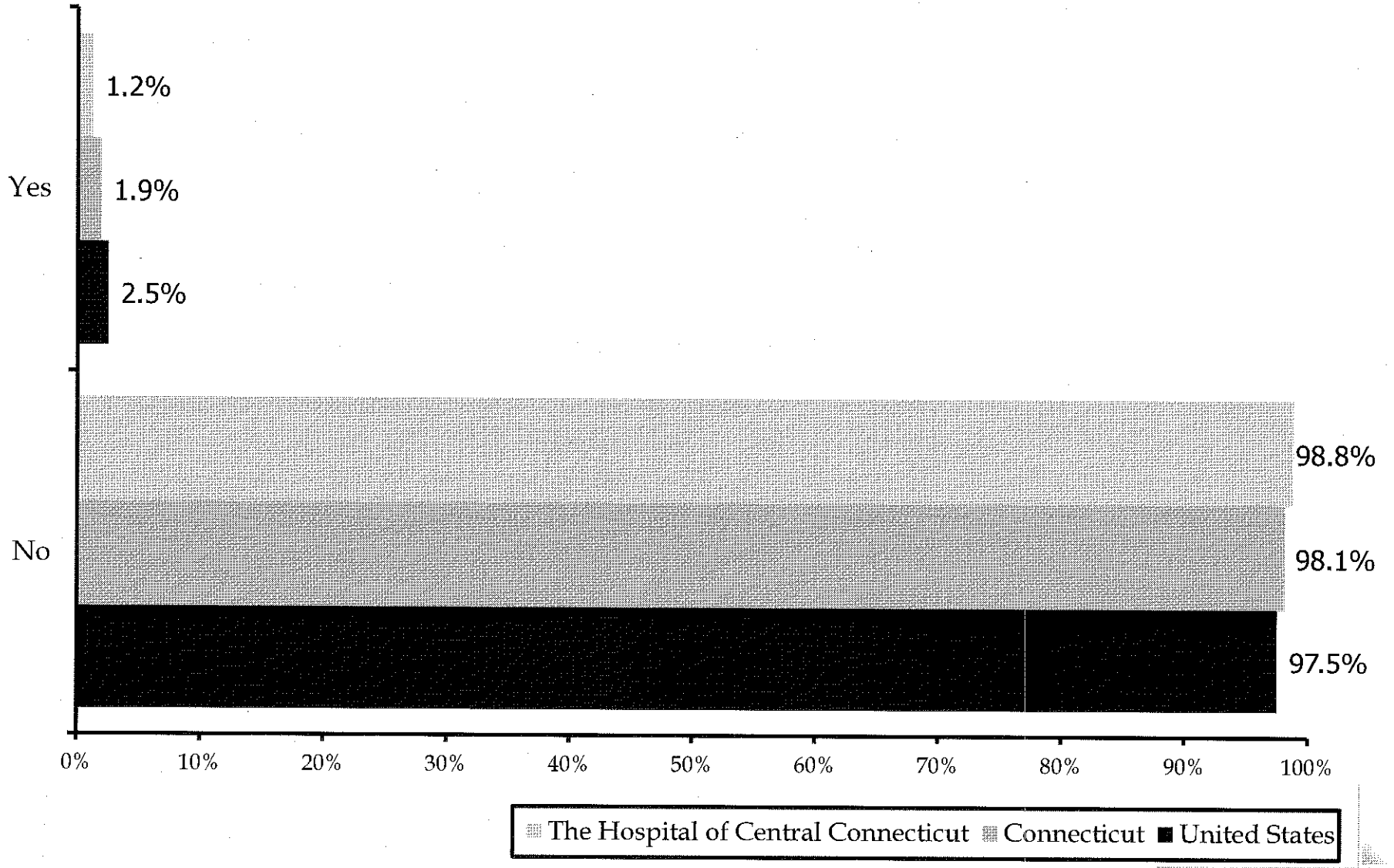


*Custom Question: Comparisons for Connecticut and United States not available.

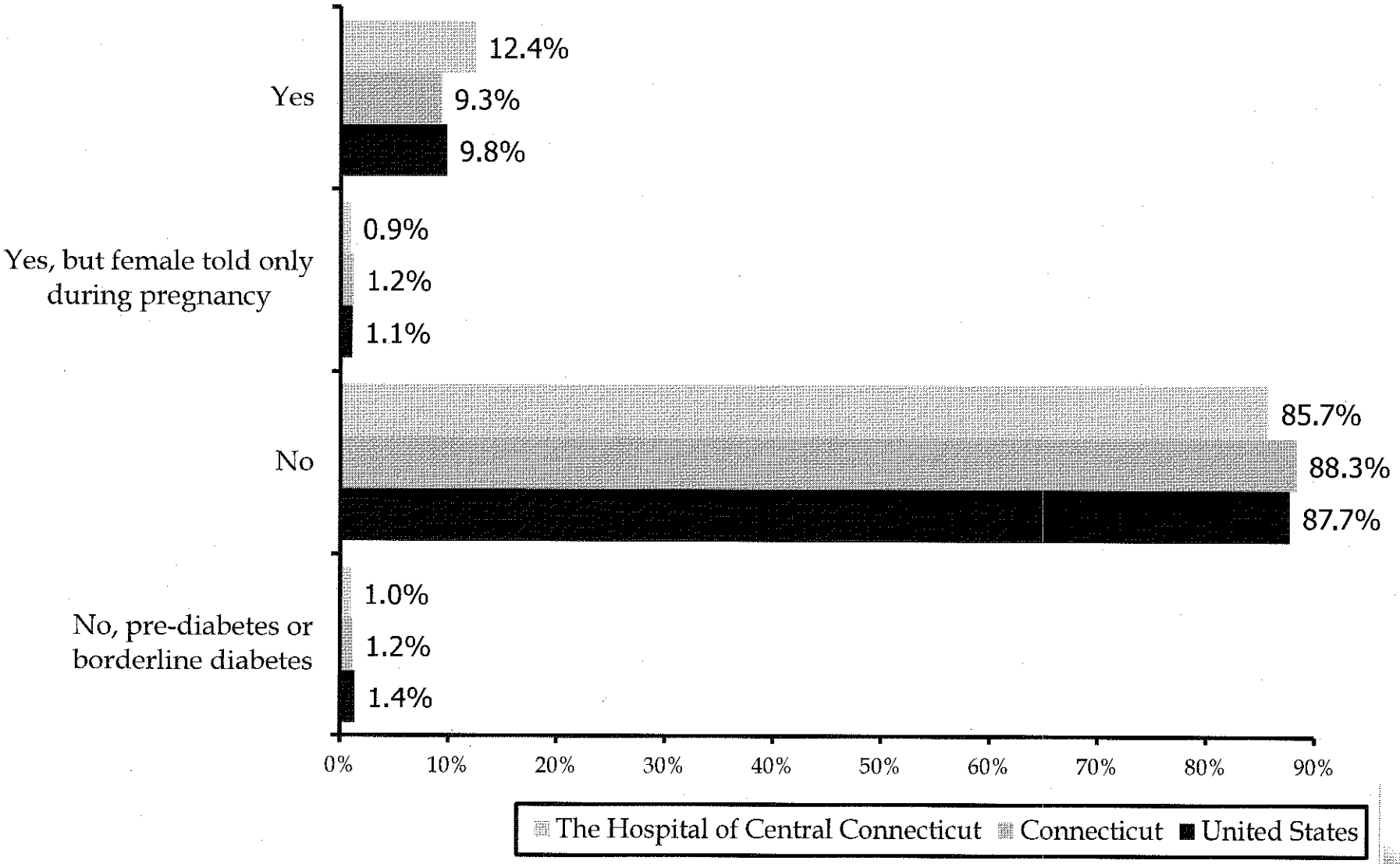
Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder?



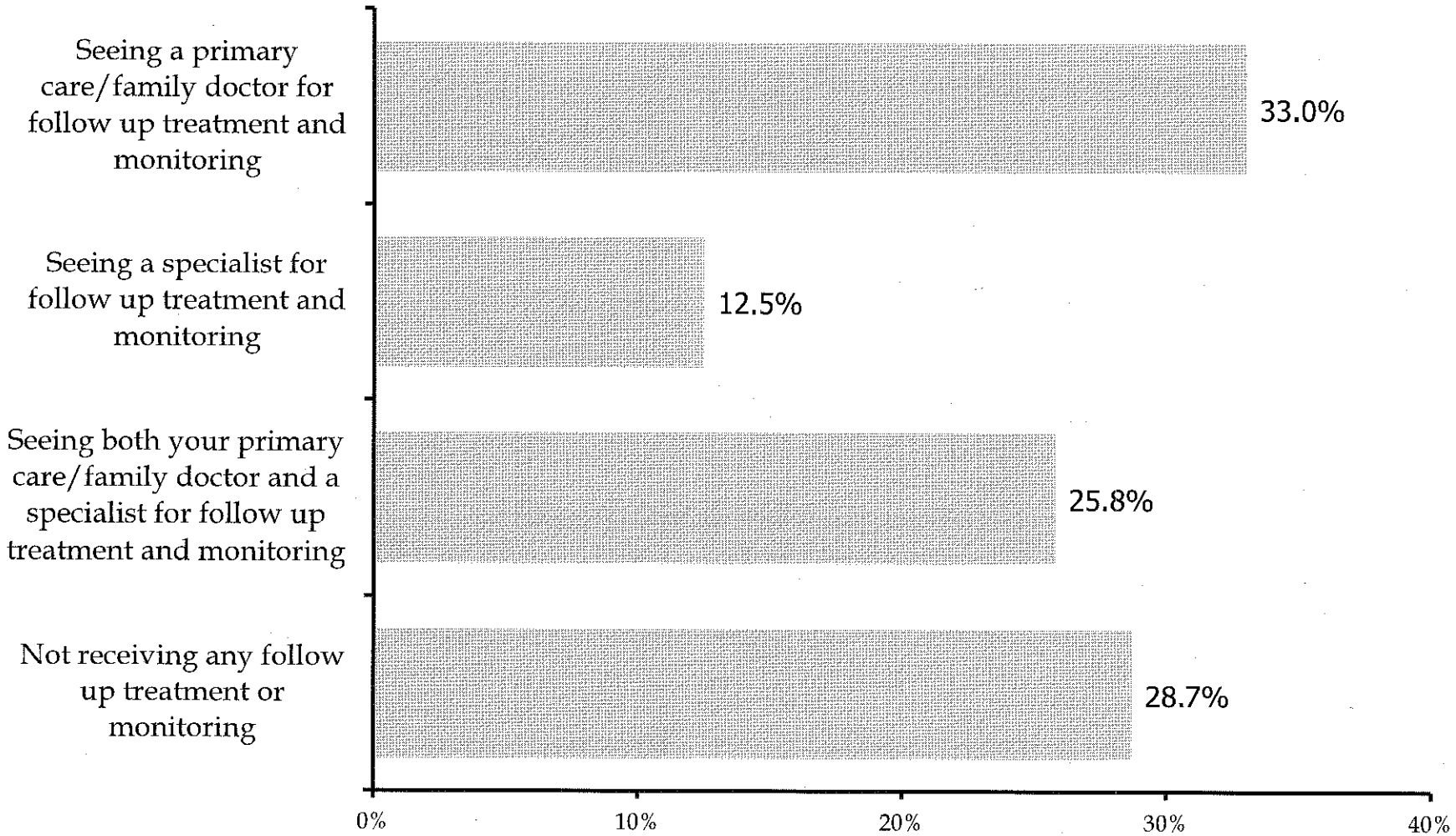
Has a doctor, nurse, or other health professional ever told you that you have kidney disease?



Has a doctor, nurse, or other health professional ever told you that you have diabetes?



Earlier, you indicated that you had been diagnosed with a chronic illness.* Are you:



*Custom Question: Comparisons for Connecticut and United States not available.

Statistically Significant Differences by Gender and Race

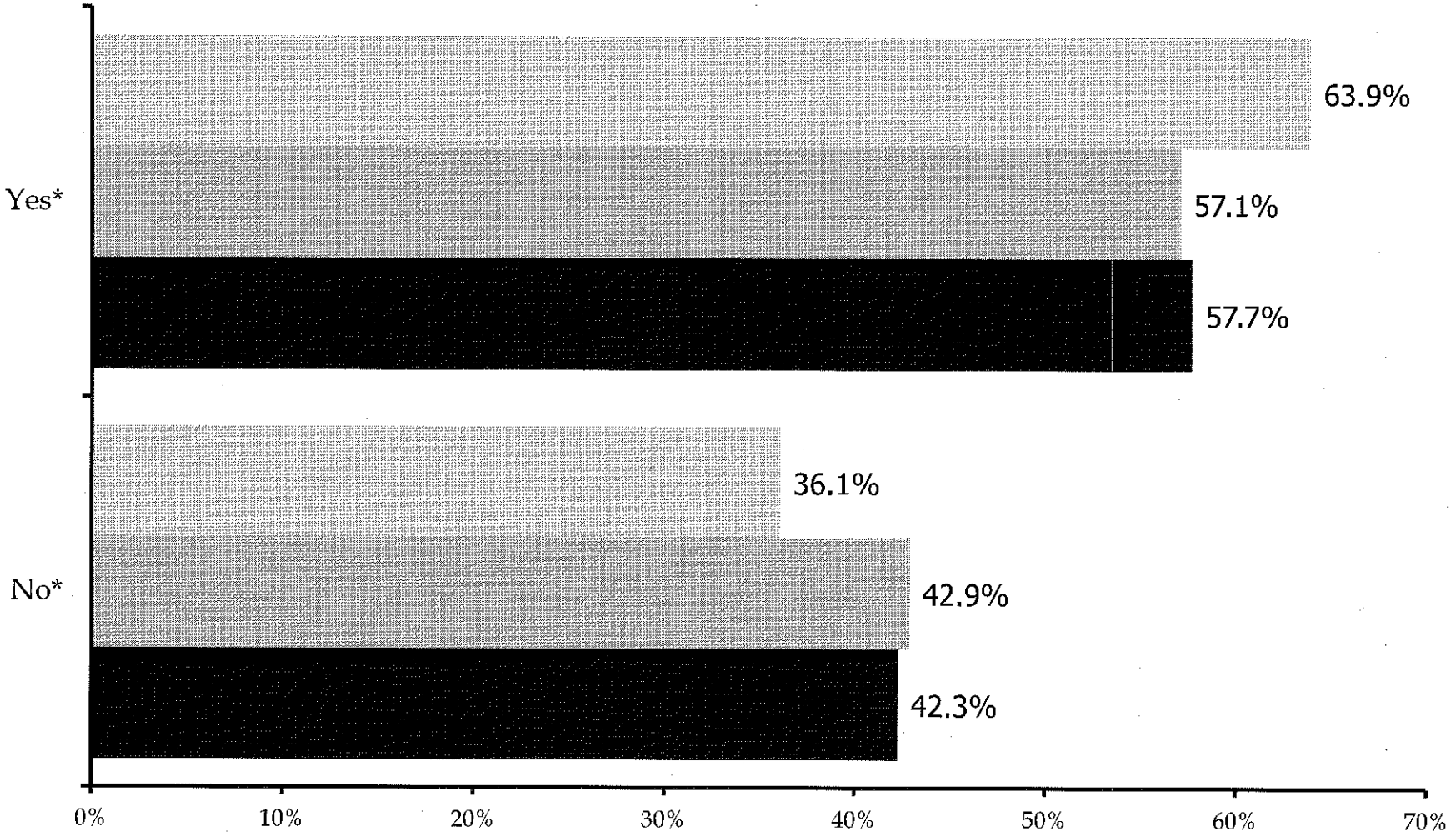
Chronic Health Conditions

- Female respondents are more likely than male respondents to have a depressive disorder.
- Asian respondents are more likely than White and Black/African American respondents to have asthma.
- Other race respondents are more likely than White respondents to have some form of neuromuscular disease.
- Hispanic respondents are more likely than Non-Hispanic respondents to have asthma.
- Hispanic respondents are more likely than Non-Hispanic respondents to have some form of neuromuscular disease.
- Hispanic respondents are more likely than Non-Hispanic respondents to have a depressive disorder.

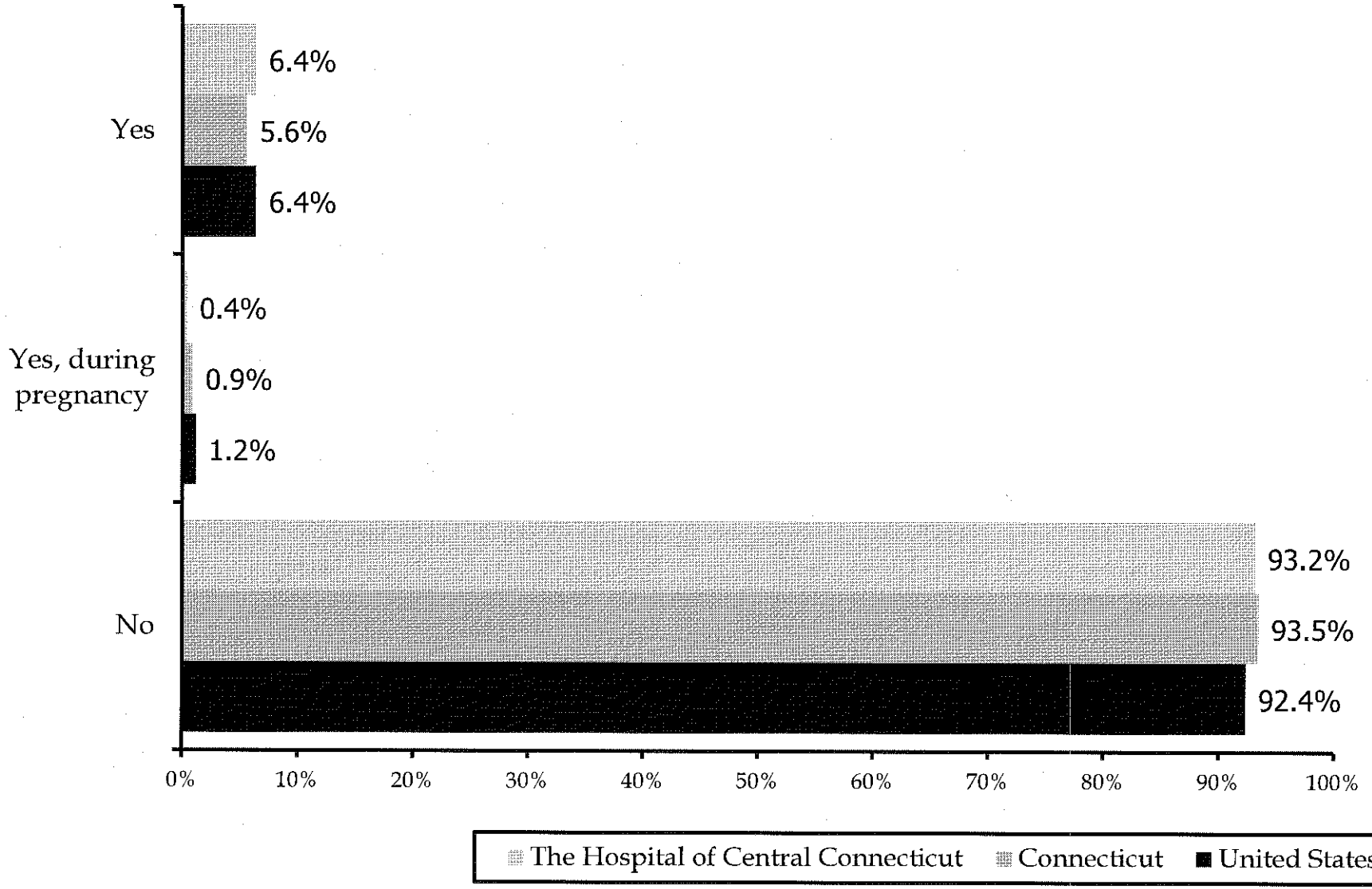
Pre-Diabetes

Only asked of respondents who have not been told they have diabetes

Have you ever had a test for high blood sugar or diabetes within the past three years?



Have you ever been told by a doctor or other health care professional that you have pre-diabetes or borderline diabetes?



Statistically Significant Differences by Gender and Race

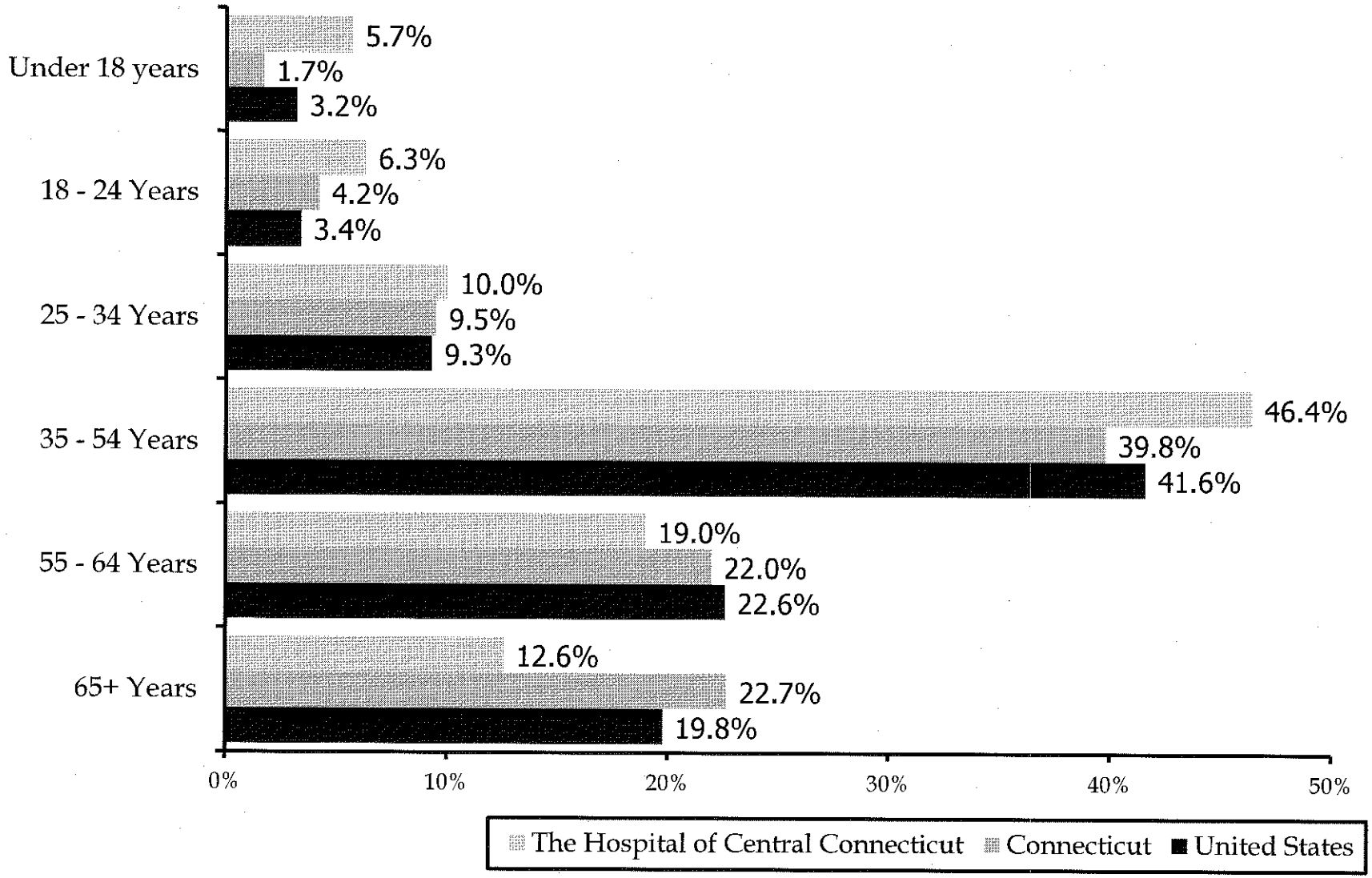
Pre-Diabetes

- White and Other race respondents are more likely than Asian respondents to have had a test for high blood sugar or diabetes within the past three years.
- Hispanic respondents are more likely than Non-Hispanic respondents to have had a test for high blood sugar or diabetes within the past three years.

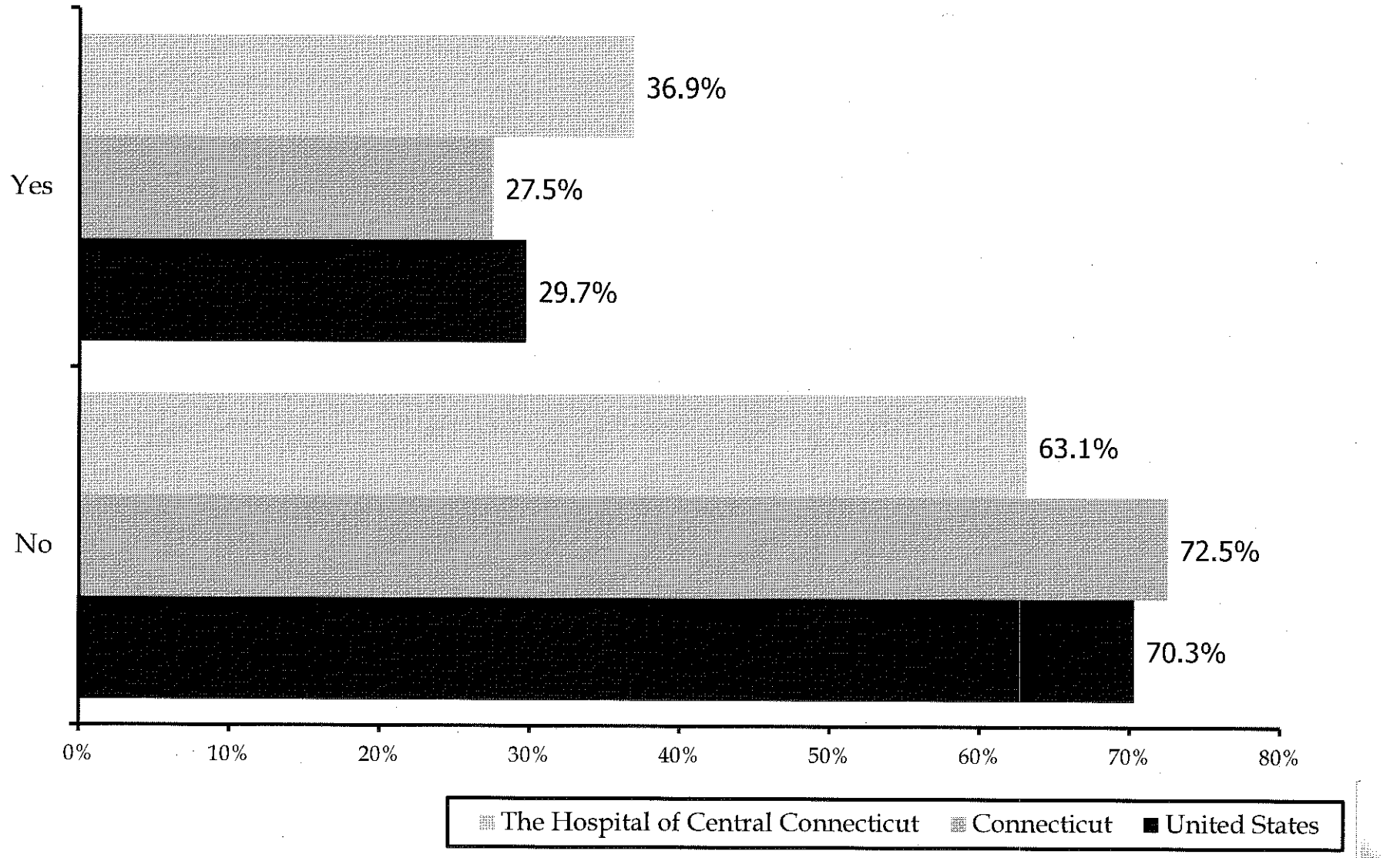
Diabetes

Only asked of respondents who have been told they have diabetes

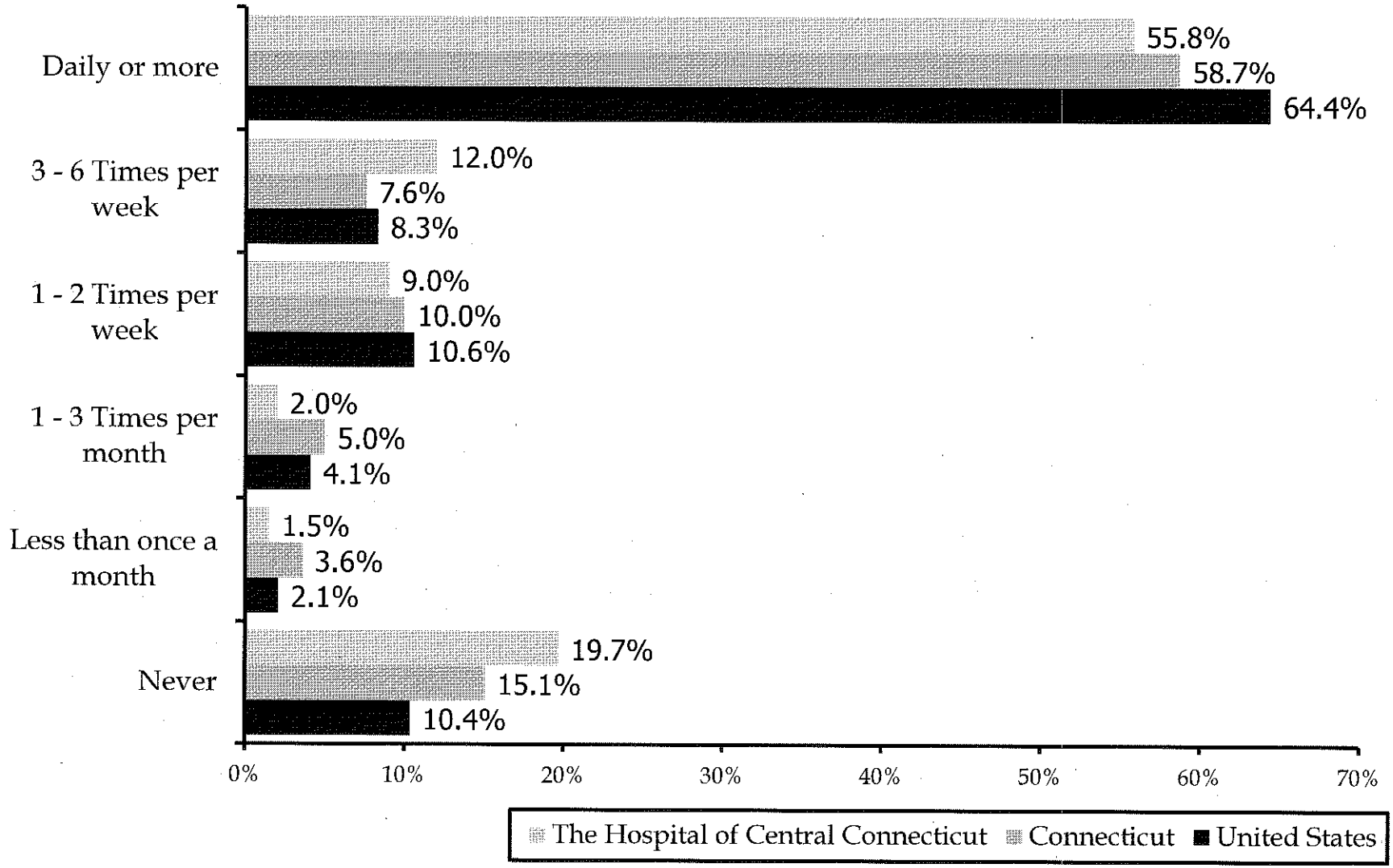
How old were you when you were told you have diabetes?



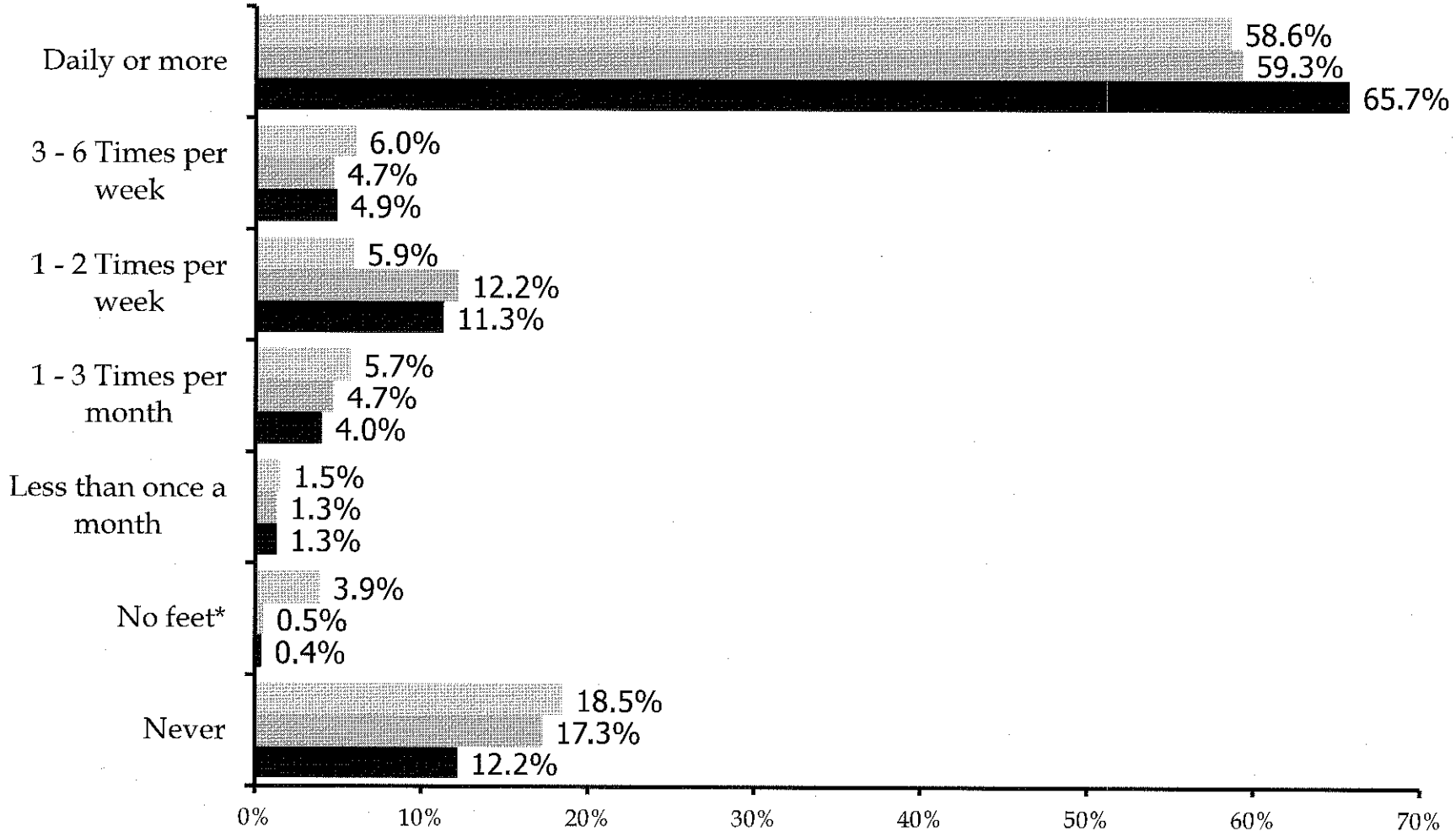
Are you now taking insulin?



About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do not include times when checked by a health professional.

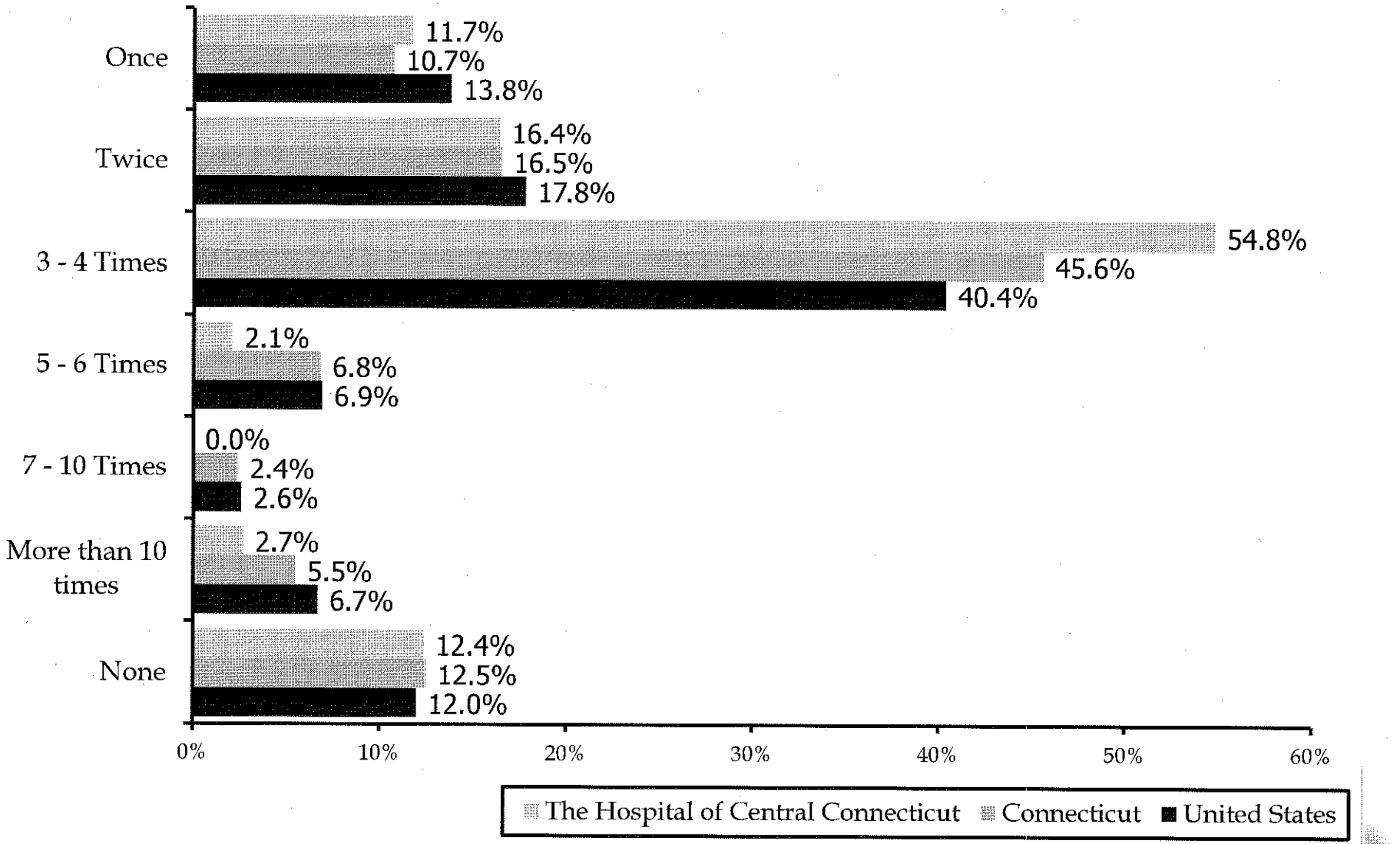


About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, but do not include times when checked by a health professional.

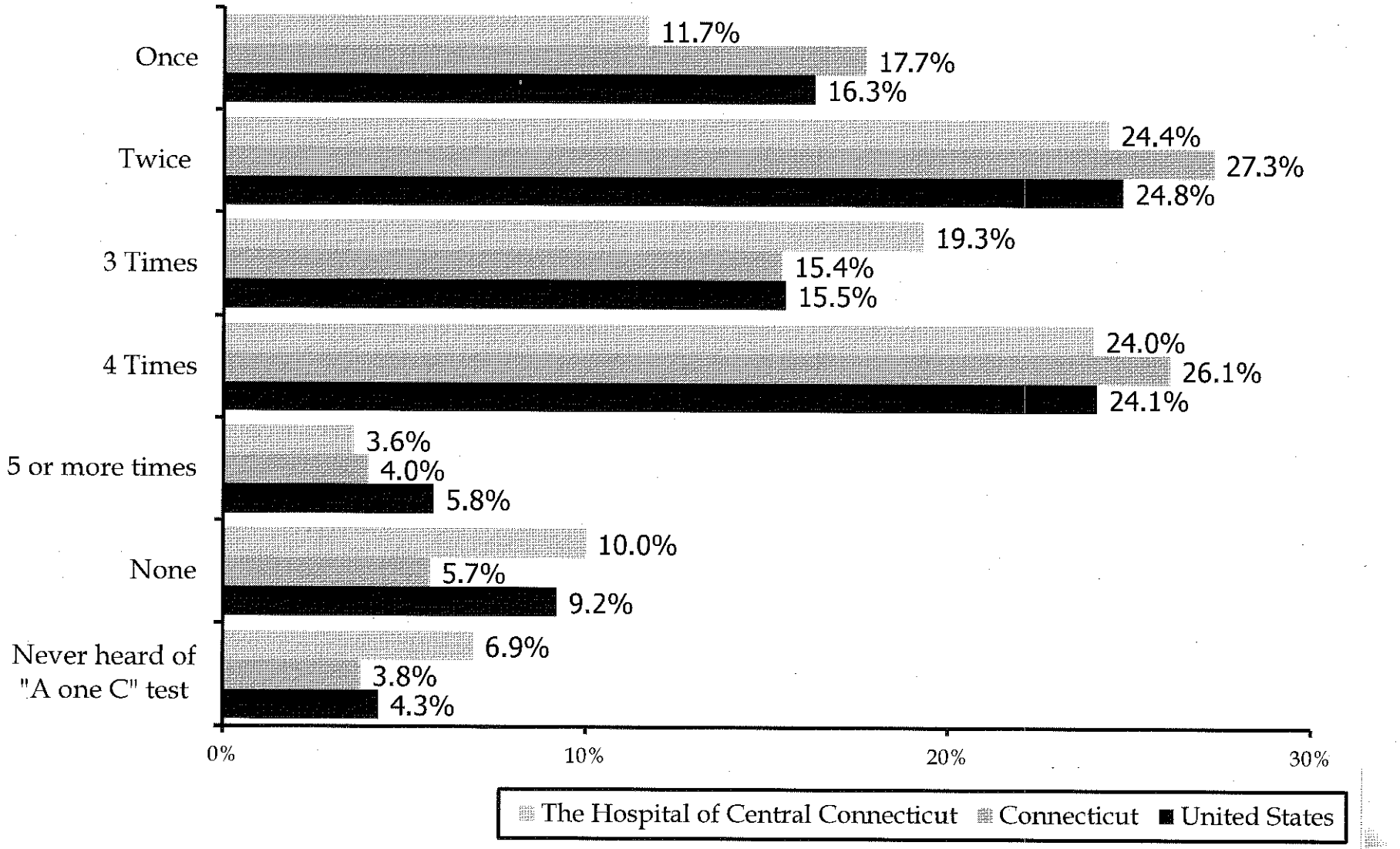


*Significantly different than Connecticut and the United States.

About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?



About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A one C"?



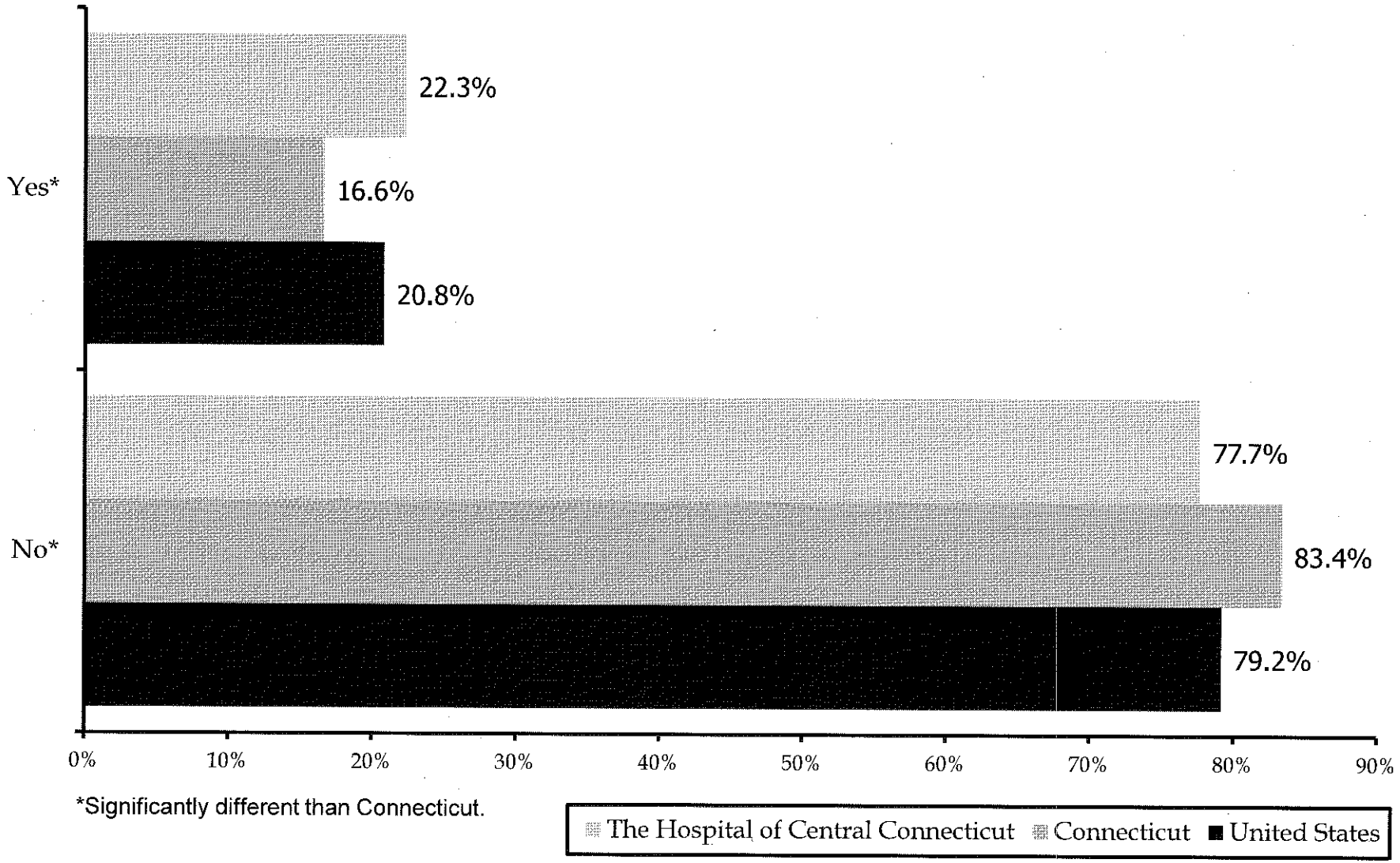
Statistically Significant Differences by Gender and Race

Diabetes

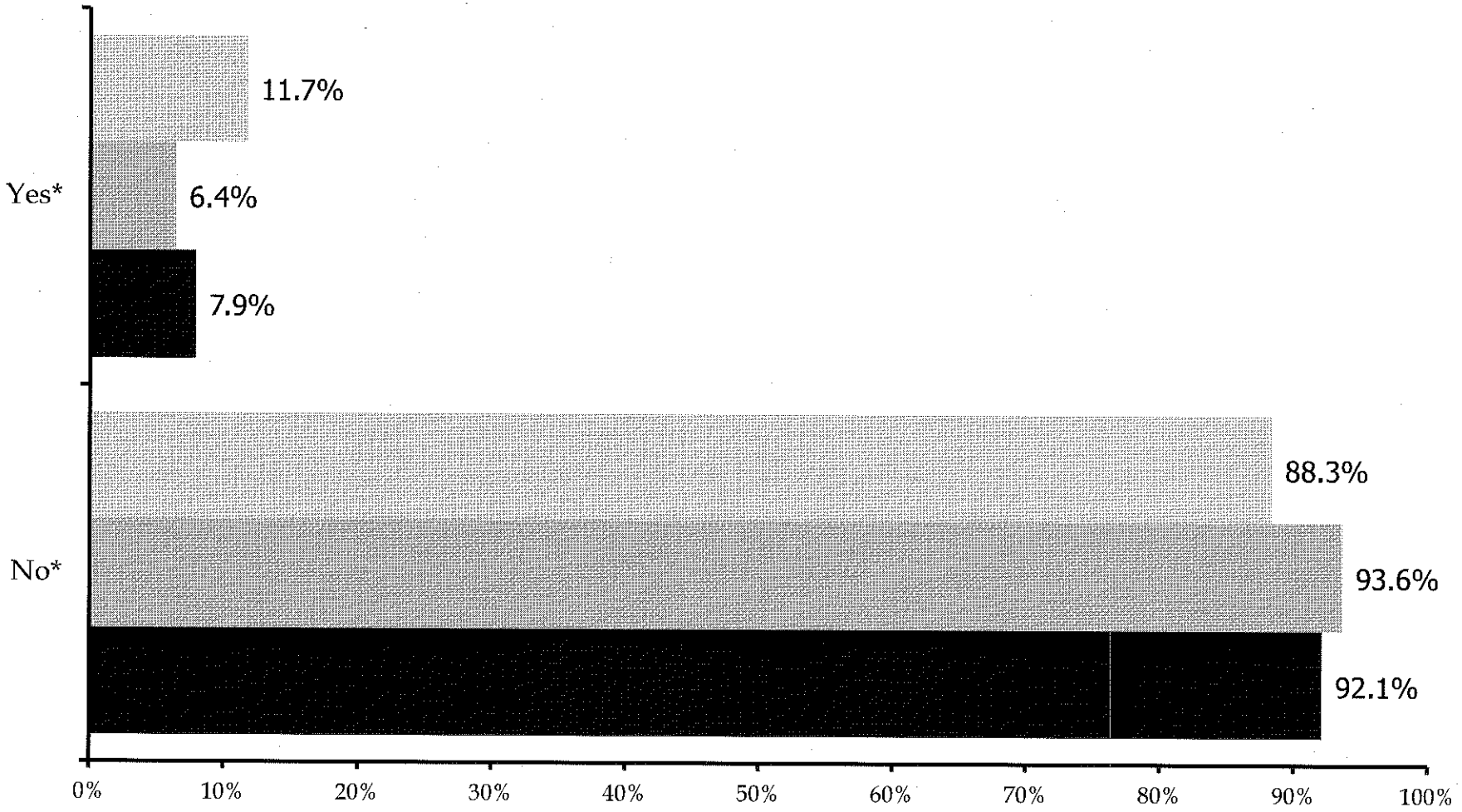
- Other race respondents are more likely than White respondents to have not had a test for "A one C" in the past 12 months.
- Hispanic respondents are more likely than Non-Hispanic respondents to have not had a test for "A one C" in the past 12 months.

Disability

Are you limited in any way in any activities because of physical, mental, or emotional problems?



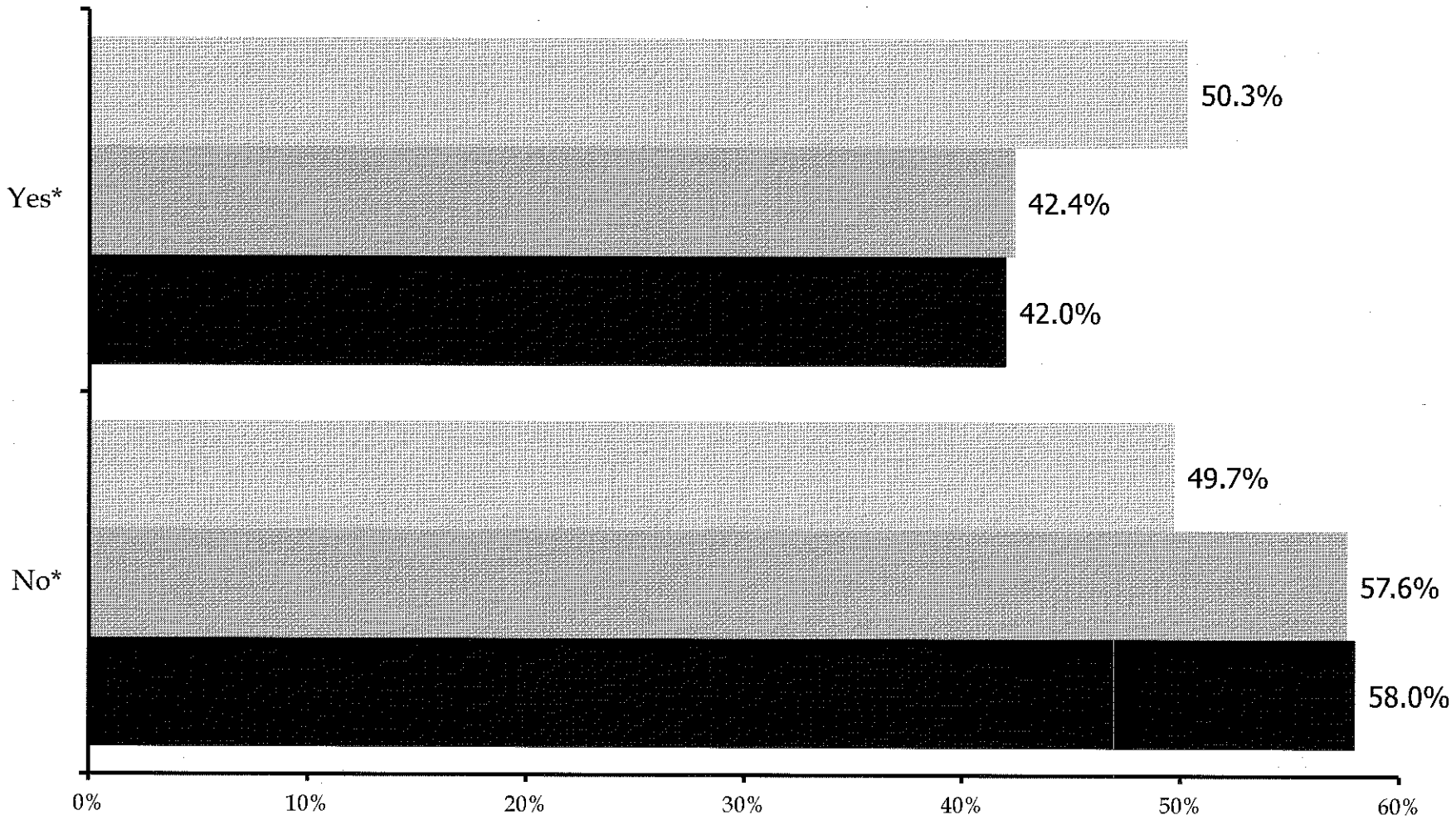
Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?



*Significantly different than Connecticut and the United States.

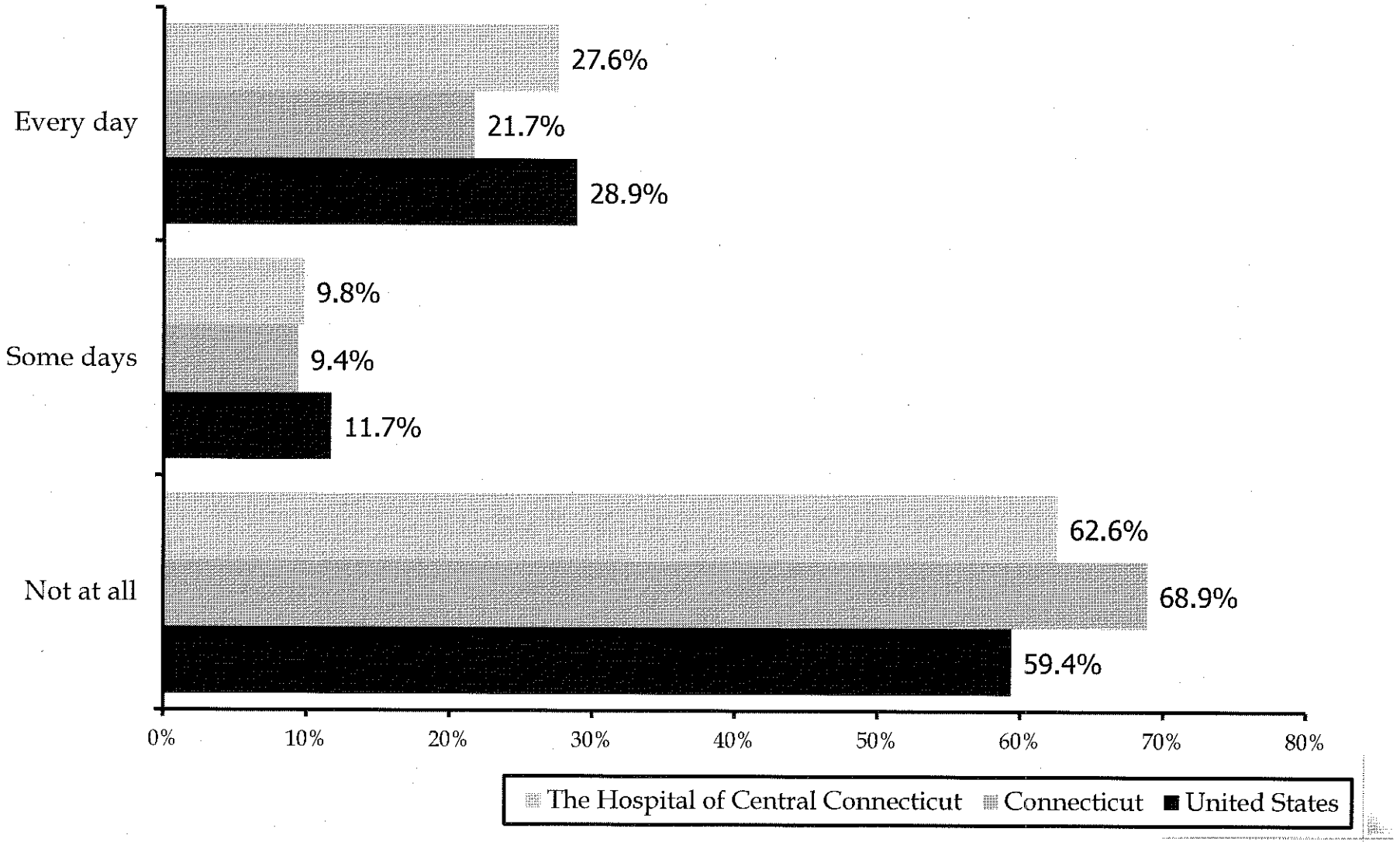
Tobacco Use

Have you smoked at least 100 cigarettes in your entire life?



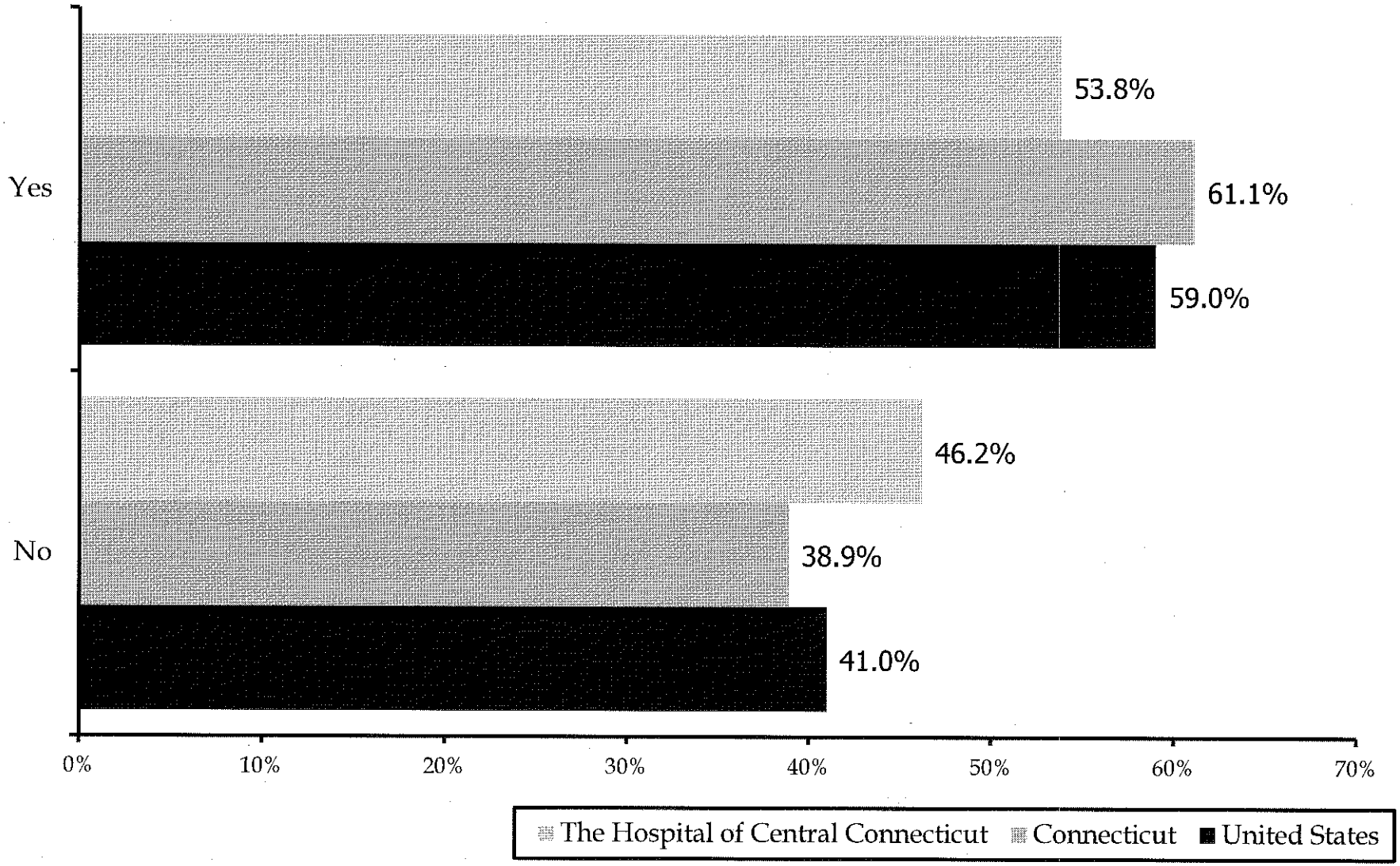
Do you now smoke cigarettes every day, some days, or not at all?

Respondents who have smoked at least 100 cigarettes in their entire life



During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

Respondents who now smoke cigarettes every day or some days



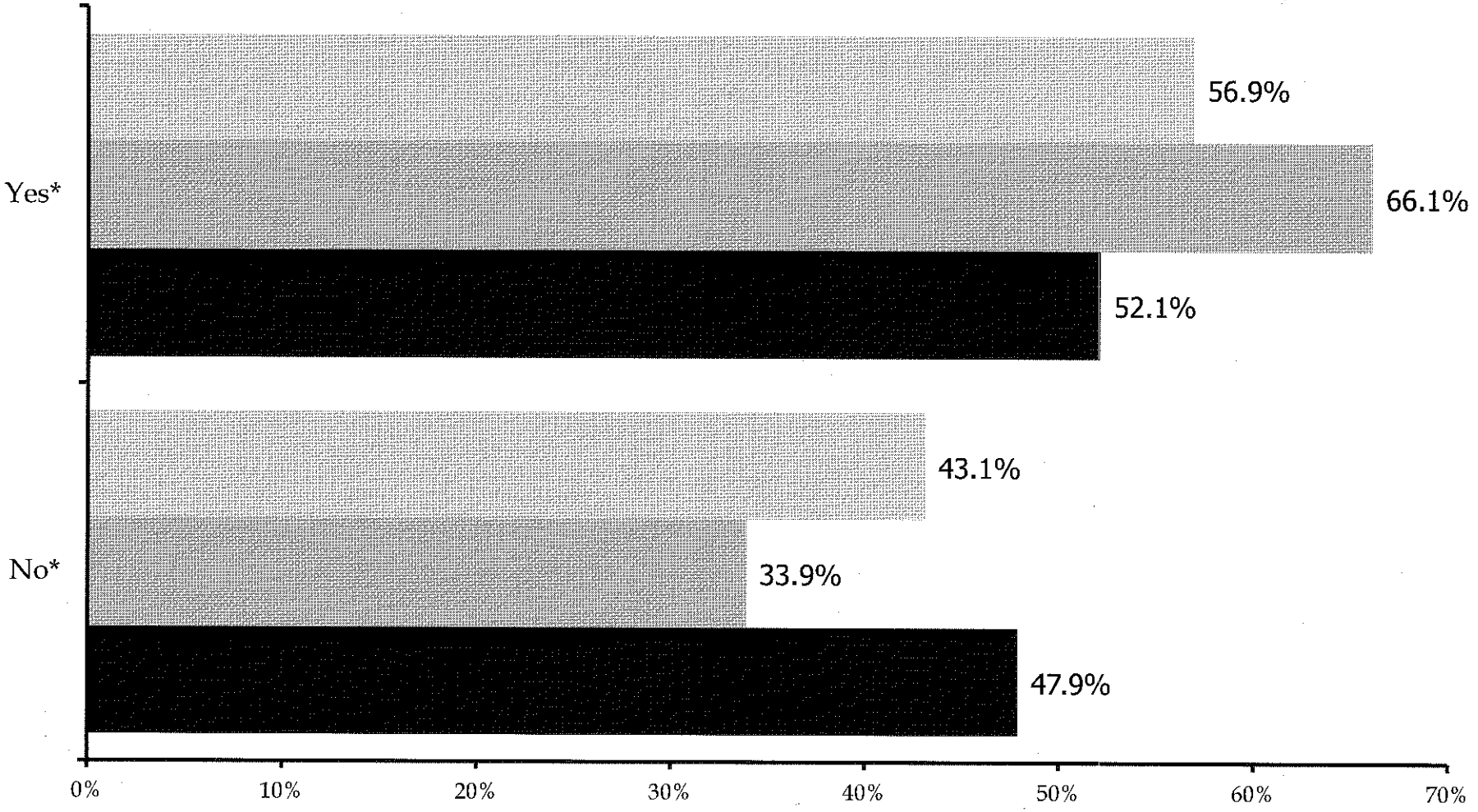
Statistically Significant Differences by Gender and Race

Tobacco Use

- Male respondents are more likely than female respondents to have smoked at least 100 cigarettes in their entire life.
- White and Other race respondents are more likely than Black/African American respondents to have smoked at least 100 cigarettes in their entire life.
- Other race respondents are more likely than White respondents to now smoke every day.
- Hispanic respondents are more likely than Non-Hispanic respondents to now smoke every day.

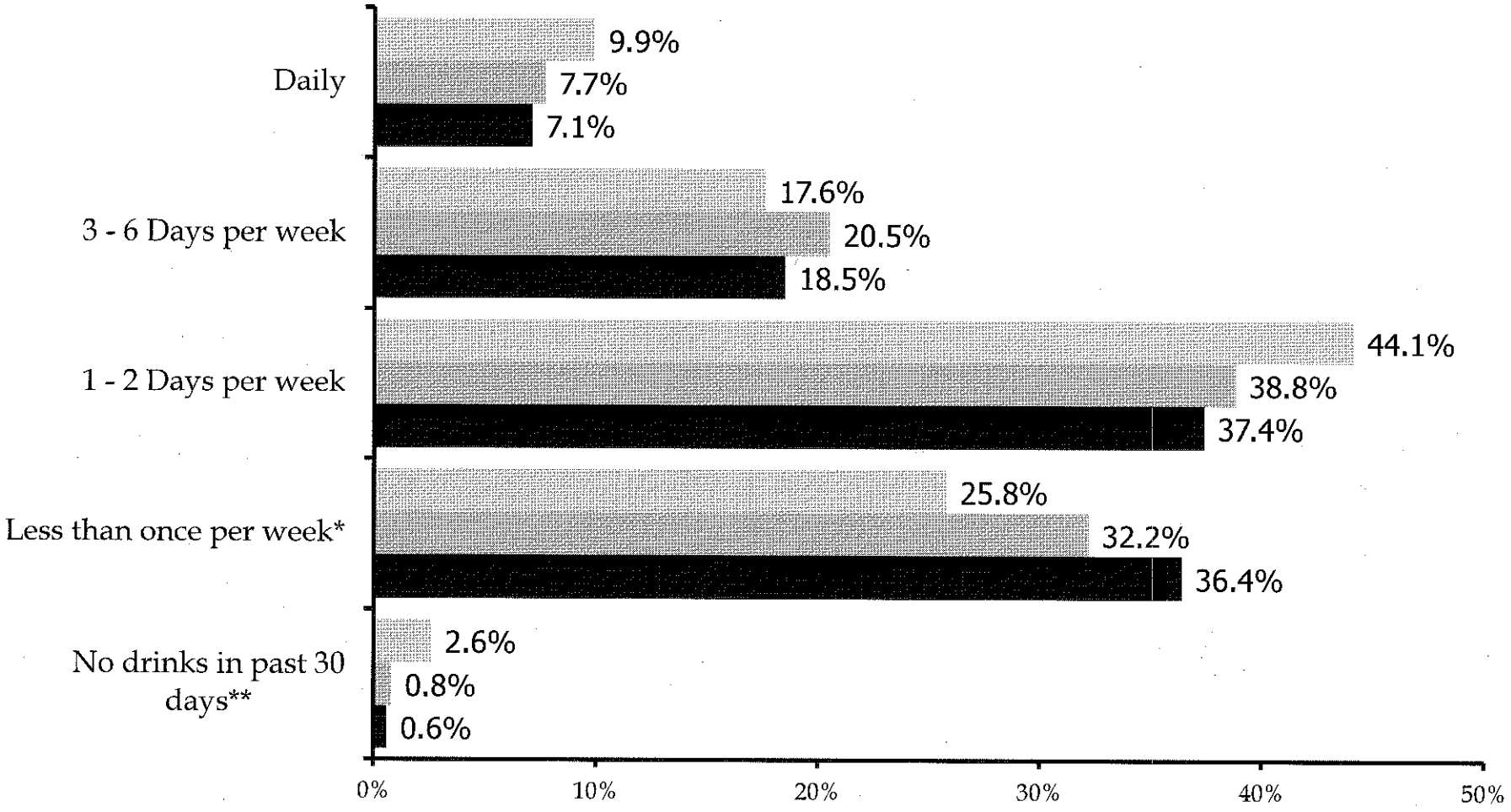
Alcohol Consumption

During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?



During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage?

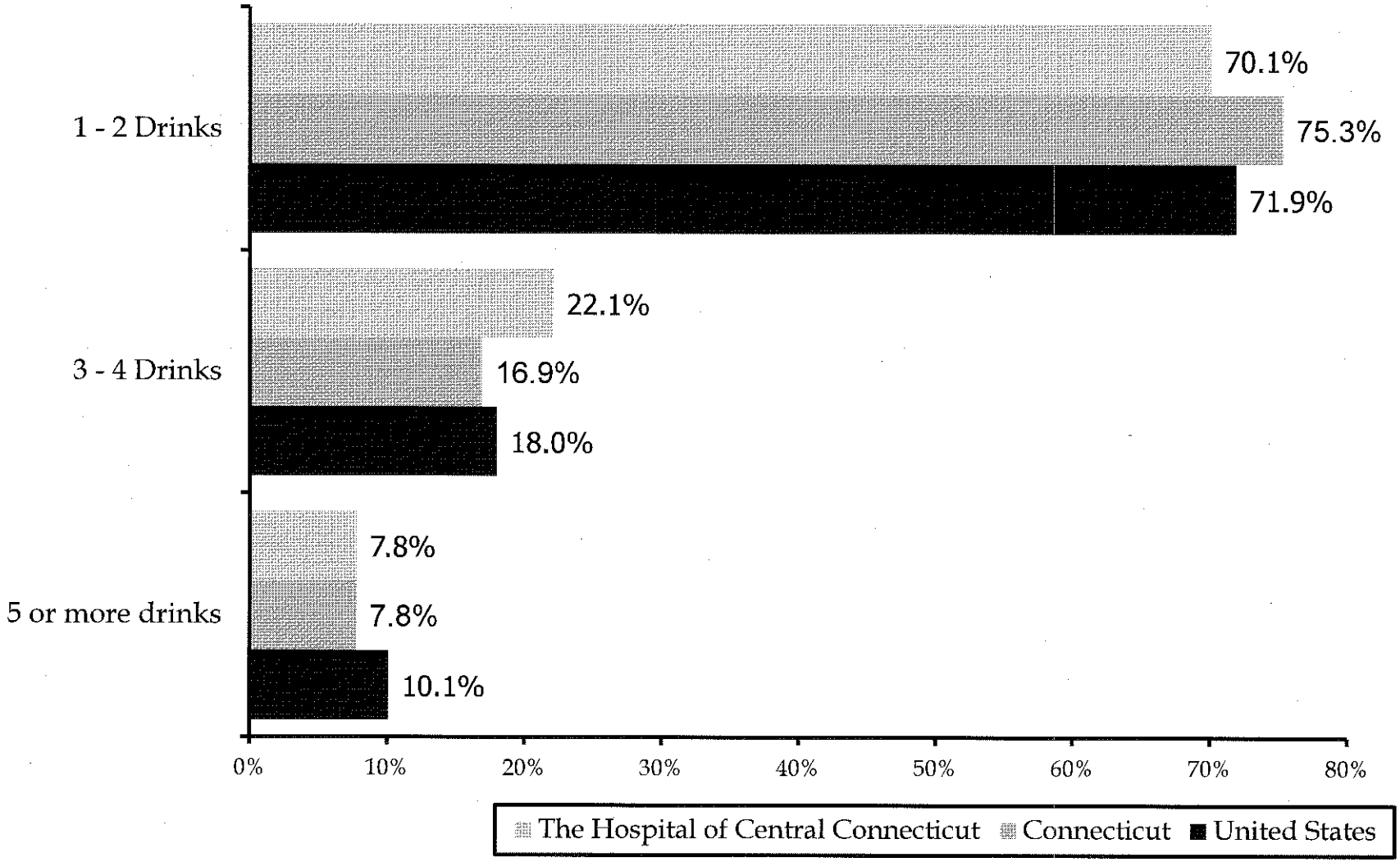
Respondents who drank an alcoholic beverage within the past 30 days



*Significantly different than the United States.
**Significantly different than Connecticut and the United States.

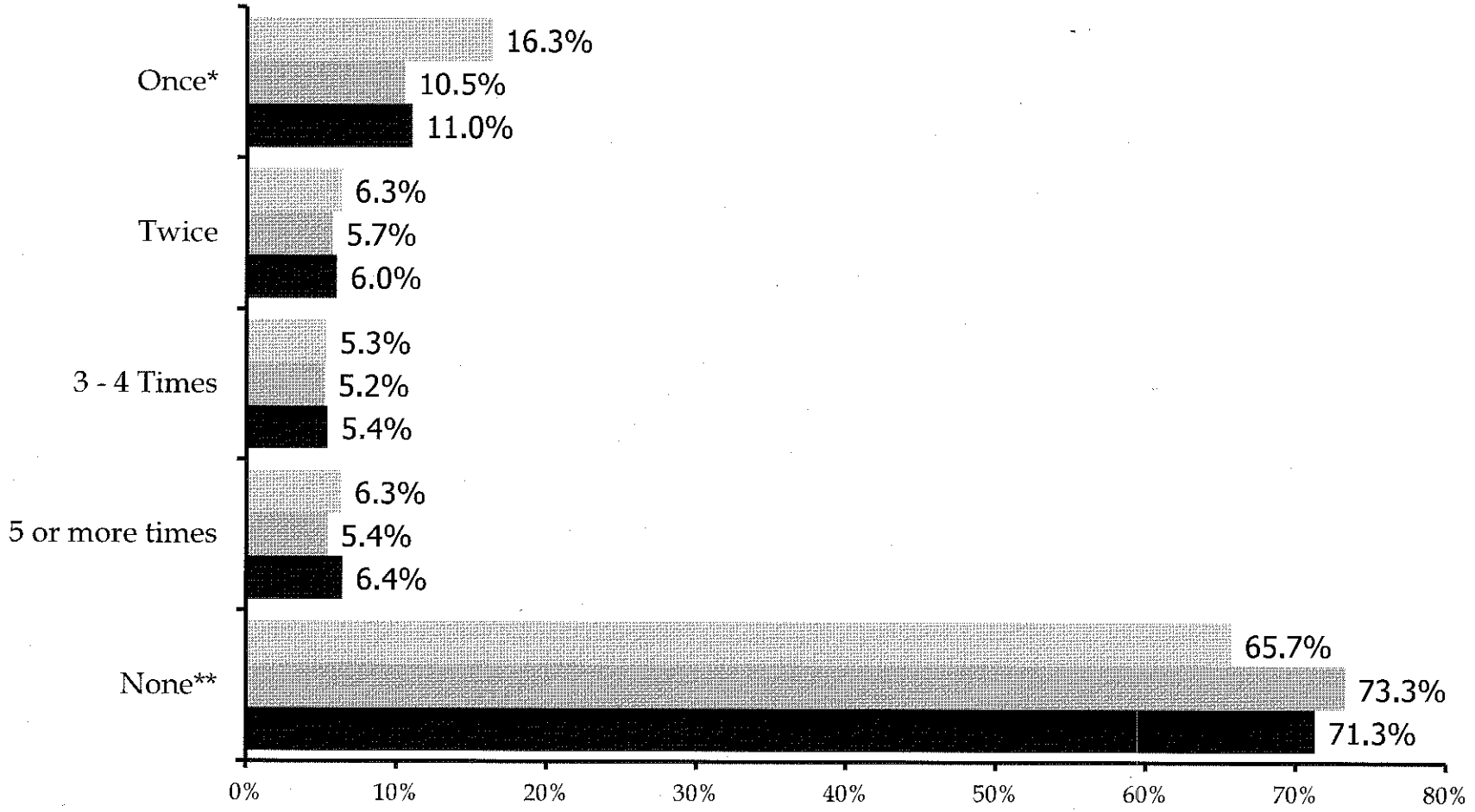
During the past 30 days, on the days when you drank, about how many drinks did you drink on average?

Respondents who drank an alcoholic beverage within the past 30 days



Considering all types of alcoholic beverages, how many times during the past 30 days did you have four (Women)/five (Men) or more drinks on an occasion?

Respondents who drank an alcoholic beverage within the past 30 days



*Significantly different than Connecticut and the United States.
**Significantly different than Connecticut.

Statistically Significant Differences by Gender

Alcohol Consumption

- Male respondents are more likely than female respondents to have had at least one drink of any alcoholic beverage during the past 30 days.
- Male respondents are more likely to drink alcoholic beverages 3 – 6 days per week, while female respondents are more likely to not drink any alcoholic beverages.
- Male respondents are more likely to have drank 5 or more alcoholic beverages on one occasion, while female respondents are more likely to have not drank 4 or more alcoholic beverages on any occasion.

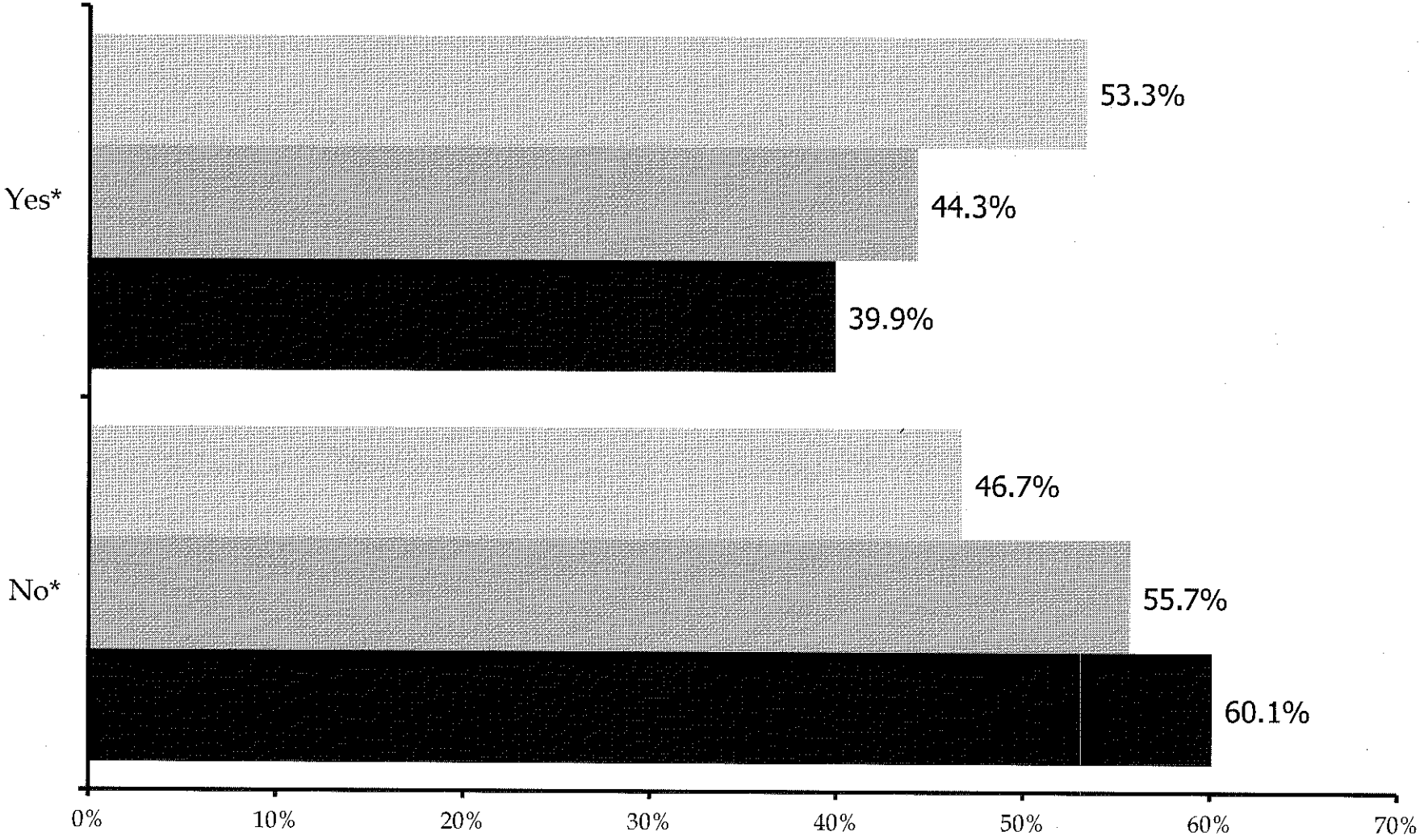
Statistically Significant Differences by Race

Alcohol Consumption

- Asian respondents are more likely than White and Black/African American respondents to drink alcoholic beverages 3 – 6 days per week.
- Other race respondents are more likely than White respondents to have not drank during the past 30 days.
- Asian respondents are more likely than White and Other race respondents to have drank 5 (men)/4 (women) or more alcoholic beverages on 5 or more occasions.
- Hispanic respondents are more likely than Non-Hispanic respondents to have had no drinks during the past 30 days. However, those Hispanic respondents that did drink were more likely to have 5 or more drinks on average.

Immunization

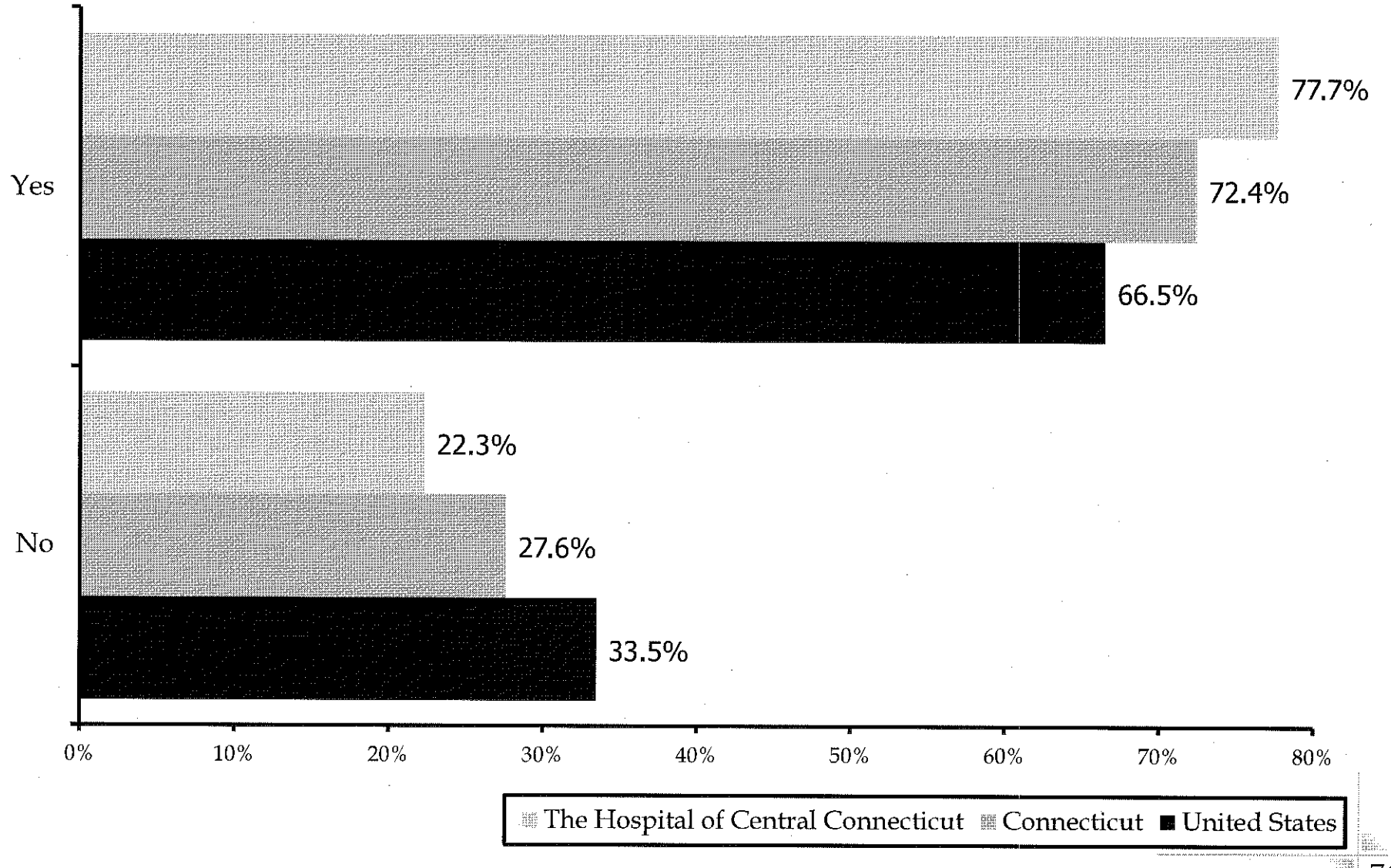
During the past 12 months, have you had a seasonal flu shot?



*Significantly different than Connecticut and the United States.

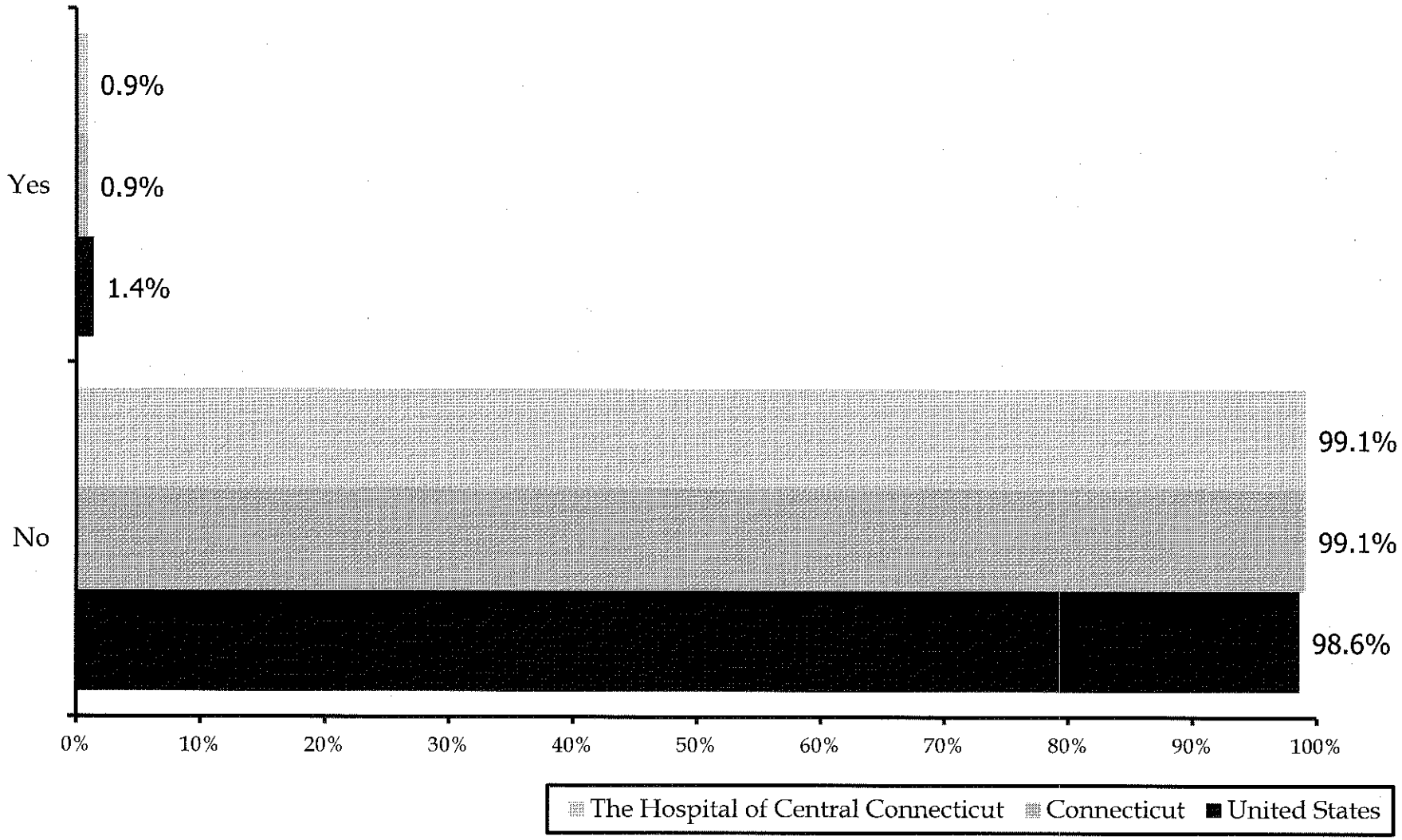
During the past 12 months, have you had a seasonal flu shot?

Respondents who are 65 years of age or older



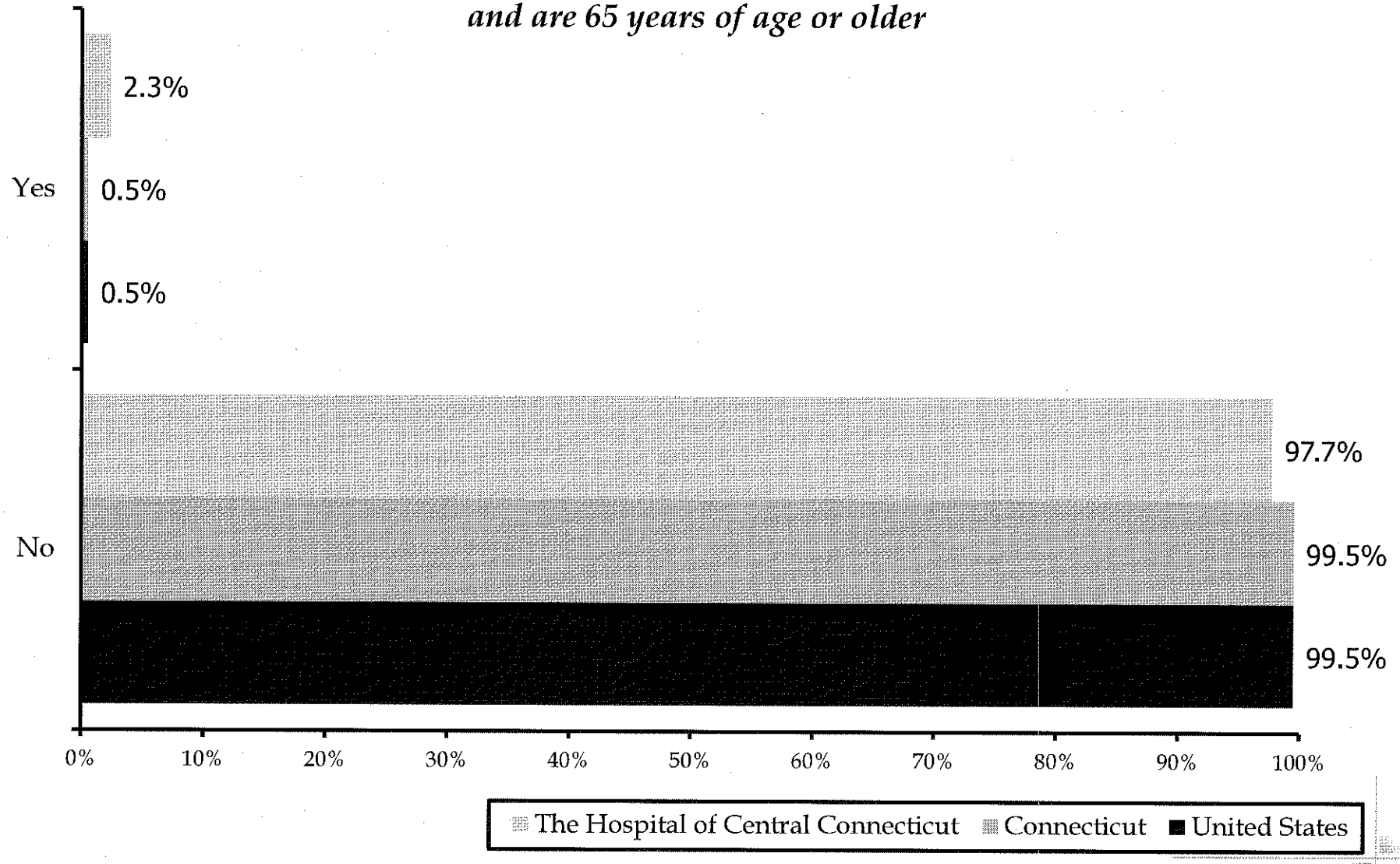
During the past 12 months, have you had a seasonal flu vaccine that was sprayed in your nose?

Respondents who have not had a seasonal flu shot in the past 12 months

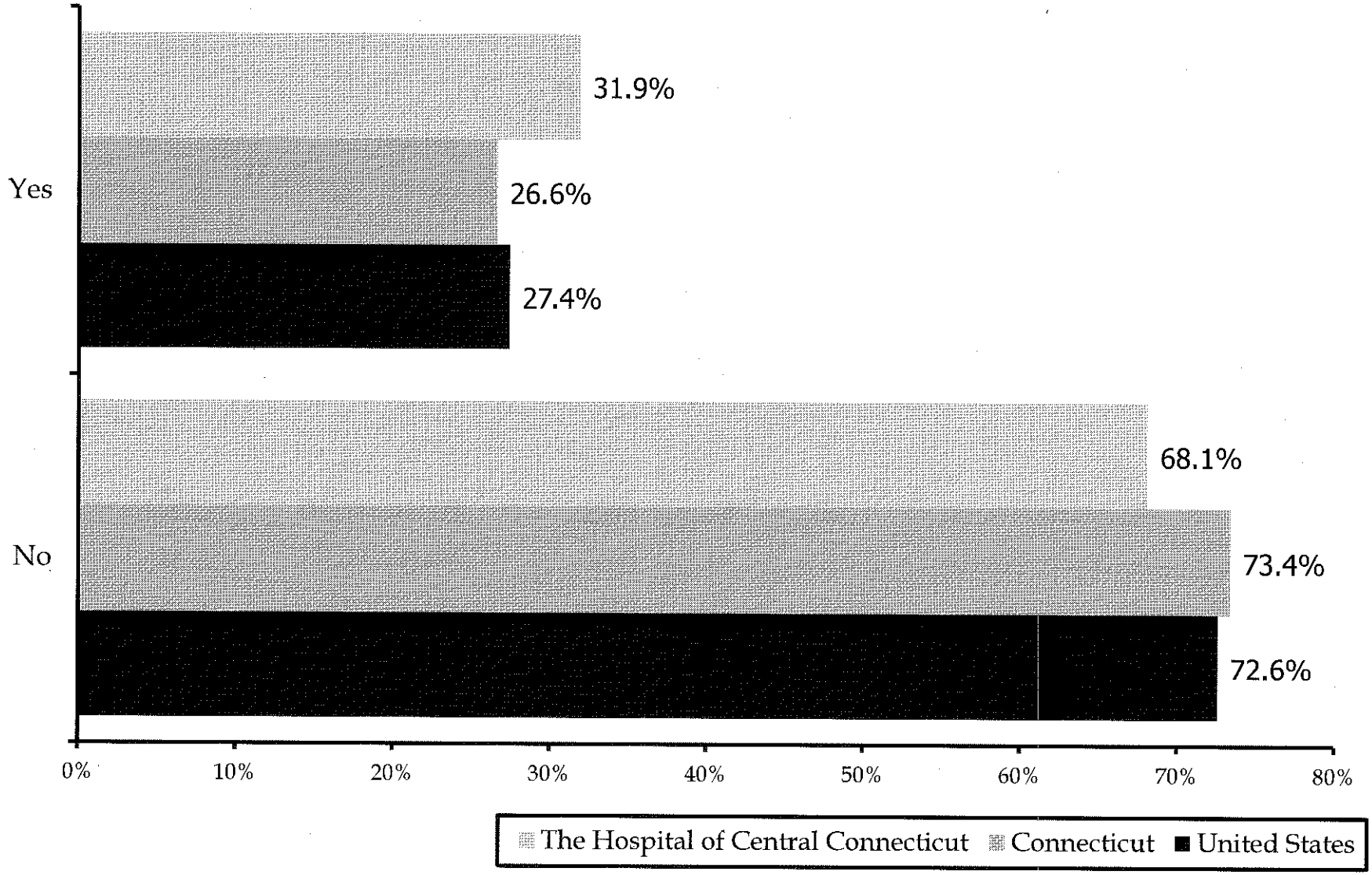


During the past 12 months, have you had a seasonal flu vaccine that was sprayed in your nose?

Respondents who have not had a seasonal flu shot in the past 12 months and are 65 years of age or older

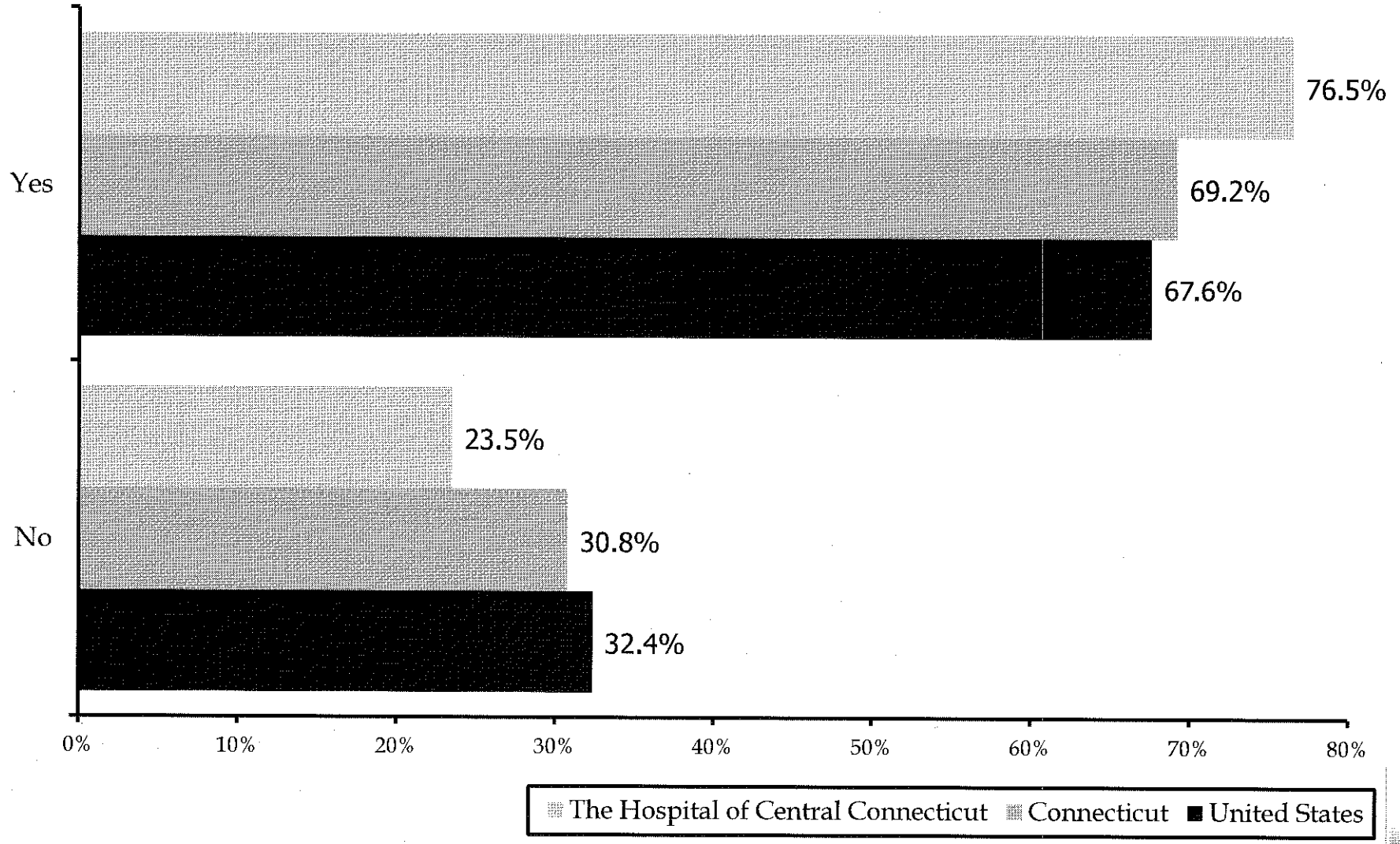


Have you ever had a pneumonia shot?



Have you ever had a pneumonia shot?

Respondents who are 65 years of age or older



Statistically Significant Differences by Gender and Race

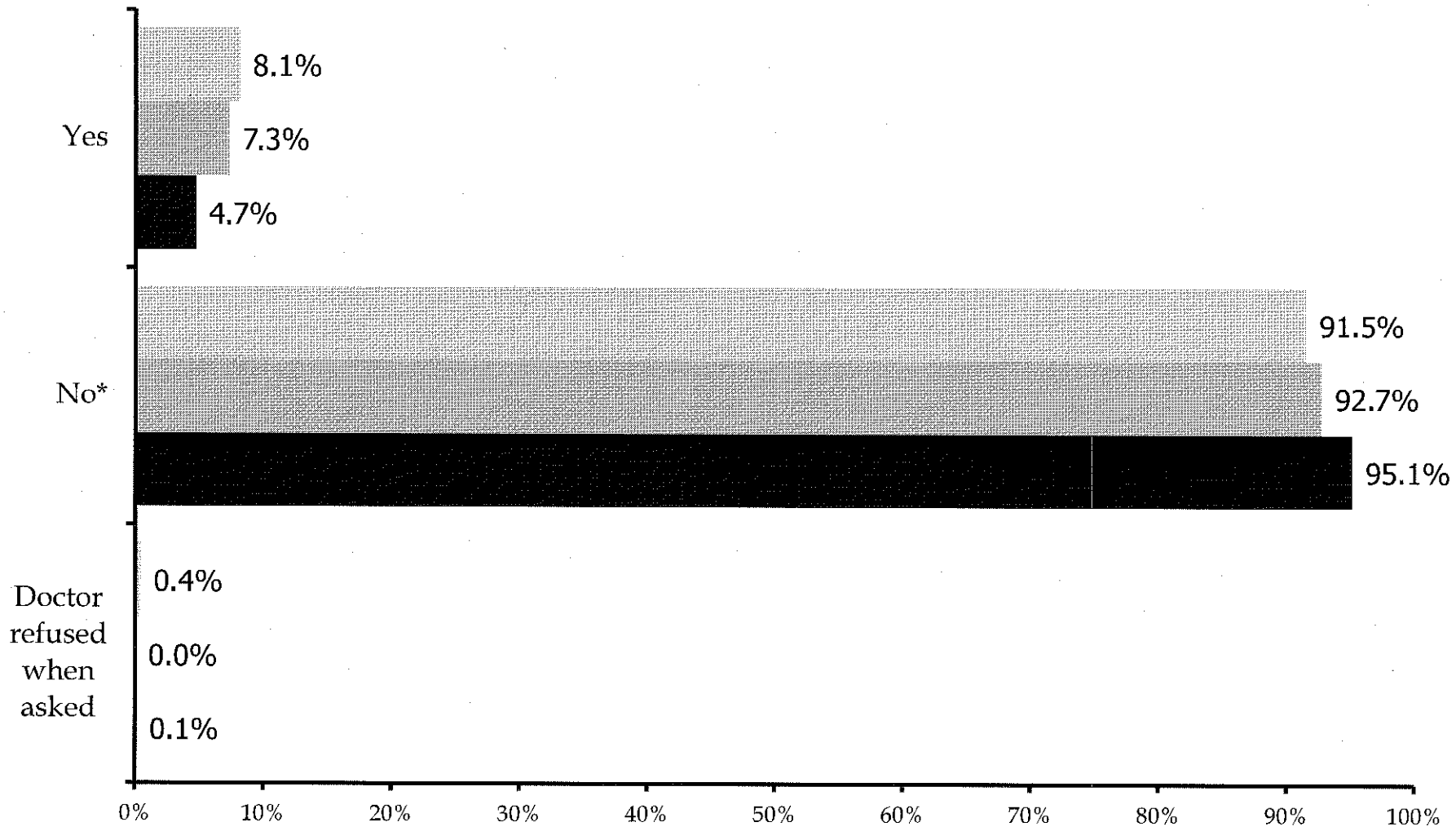
Immunization

- White respondents are more likely than Asian respondents to have had a seasonal flu shot during the past 12 months.

Adult Human Papilloma Virus (HPV) Vaccination

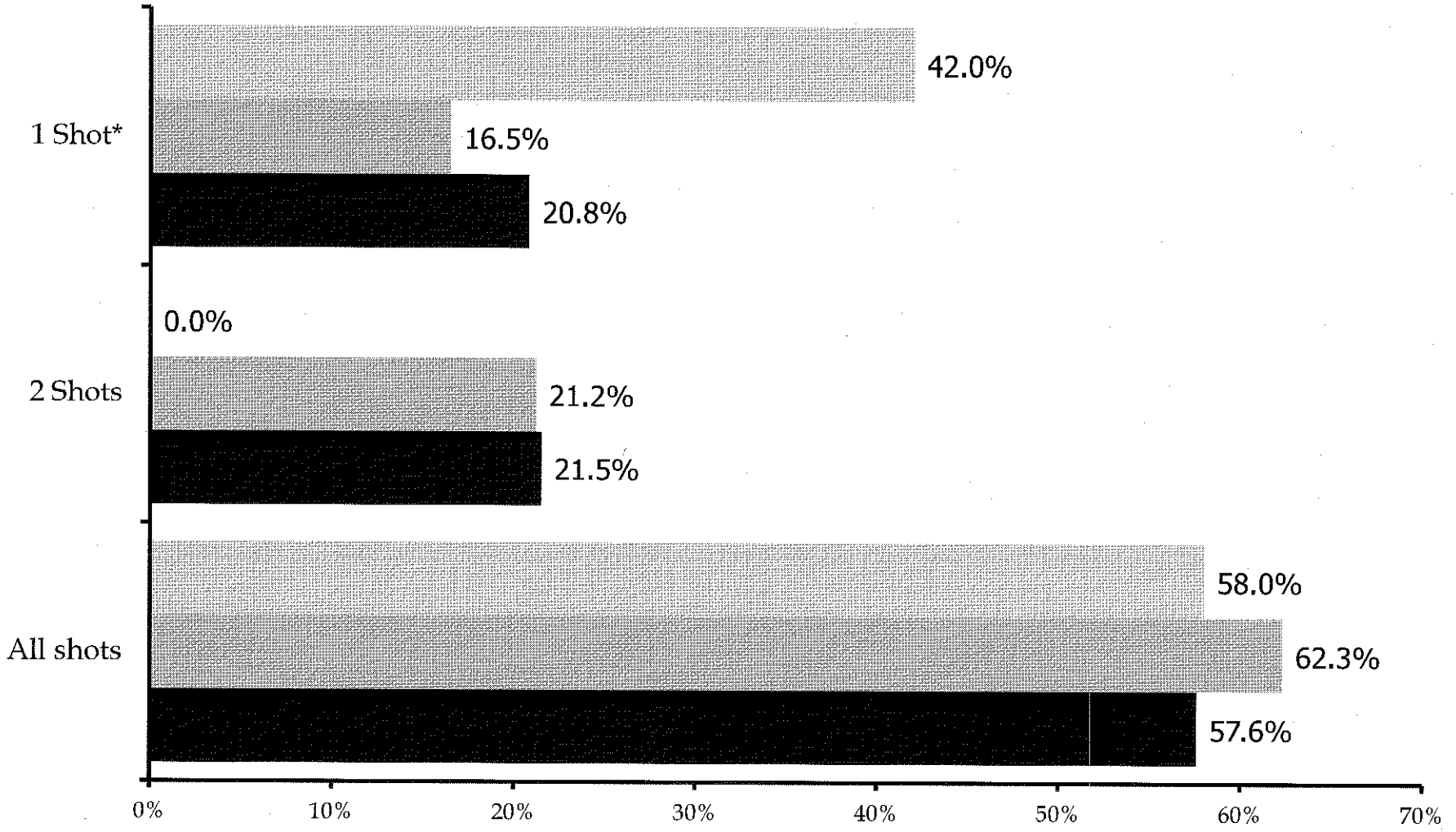
Only asked of respondents 18 to 49 years of age

Have you ever had an HPV vaccination?



*Significantly different than the United States.

How many HPV shots did you receive?



*Significantly different than Connecticut.

Statistically Significant Differences by Gender and Race

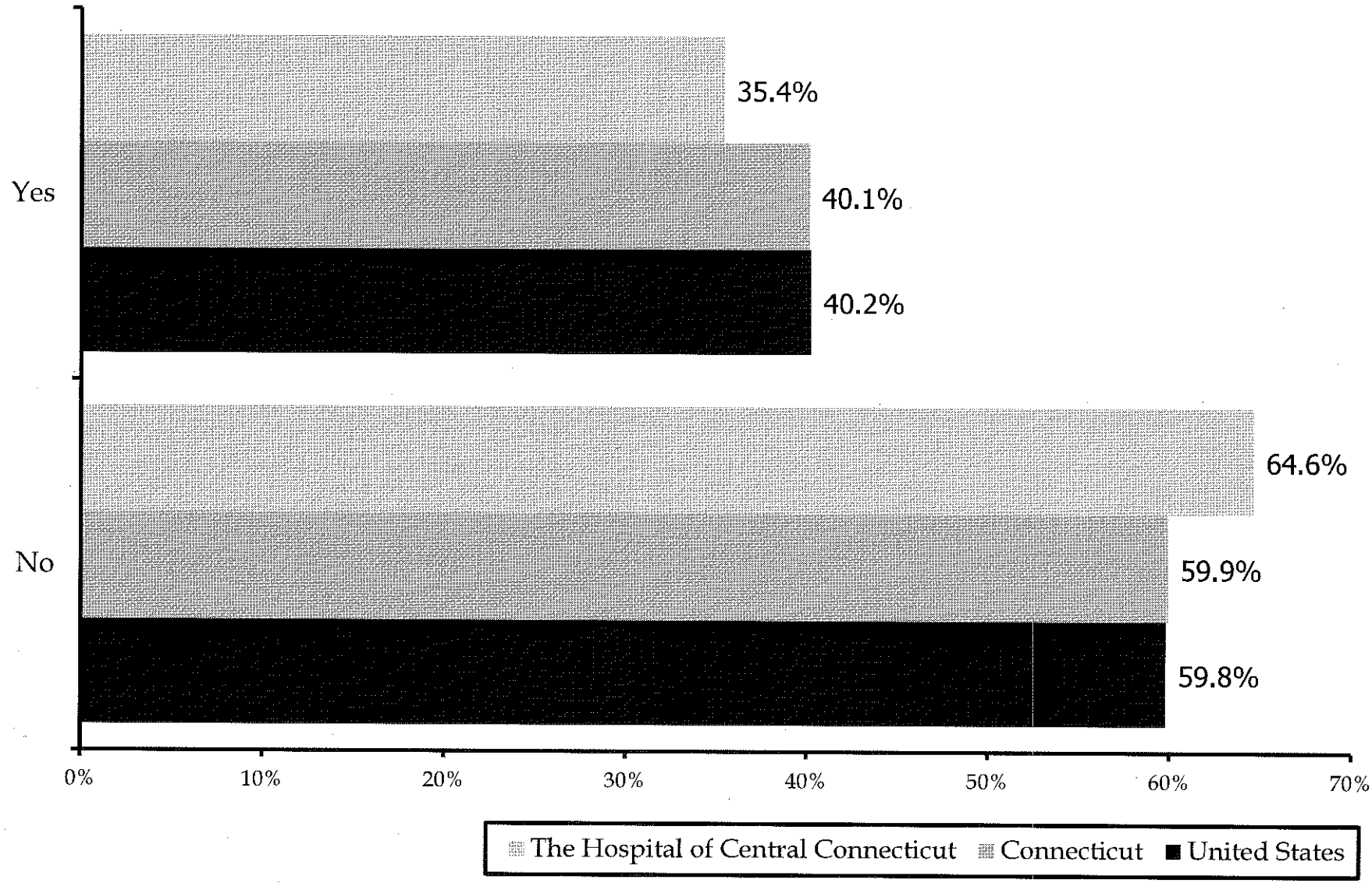
Adult Human Papilloma Virus (HPV)

- Female respondents are more likely than male respondents to have ever had an HPV vaccination.

HIV/AIDS

Only asked of respondents 64 years of age or younger

Have you ever been tested for HIV?



Statistically Significant Differences by Gender and Race

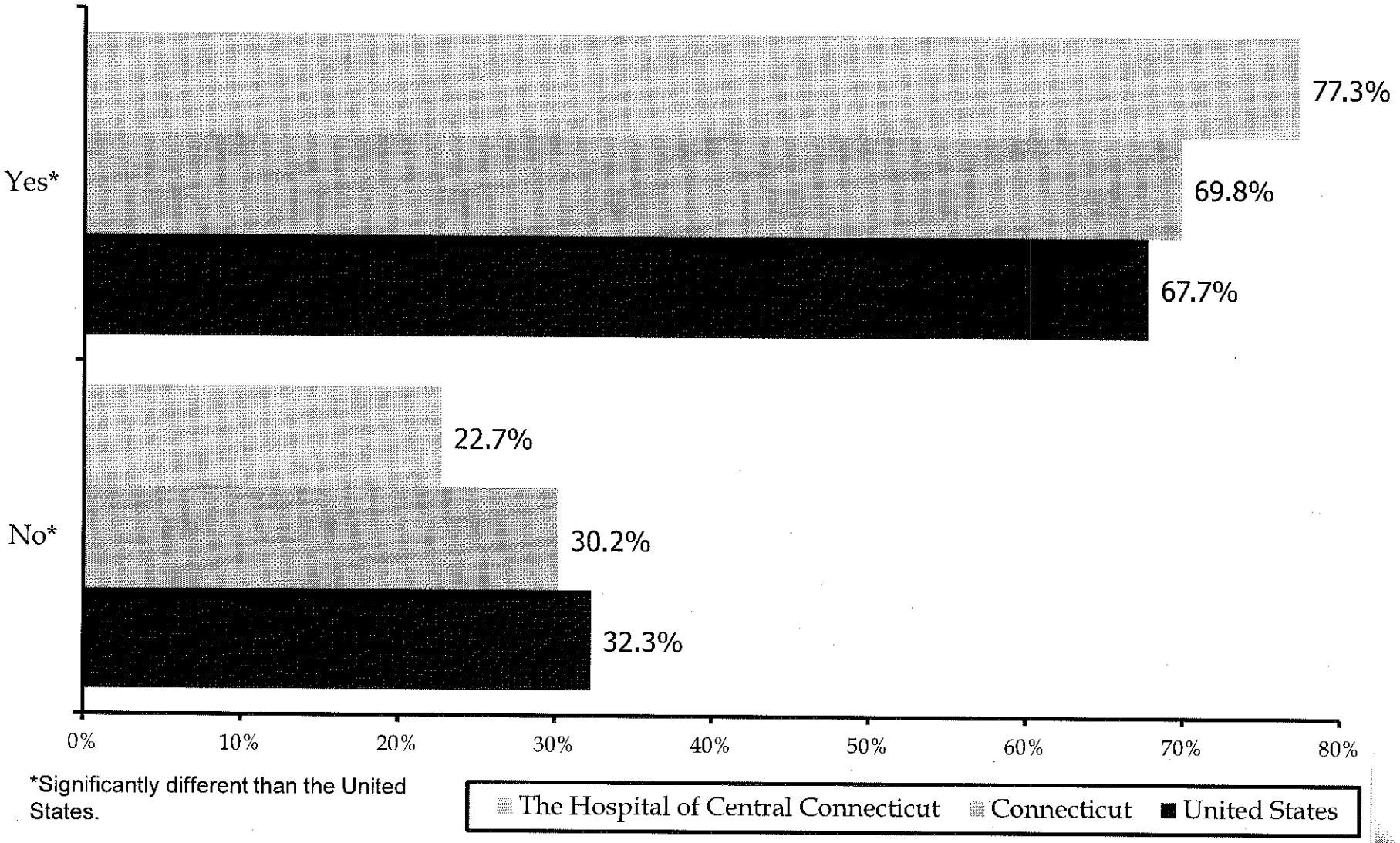
HIV/AIDS

- Black respondents are more likely than White respondents to have been tested for HIV.

Women's Health

Only asked of female respondents

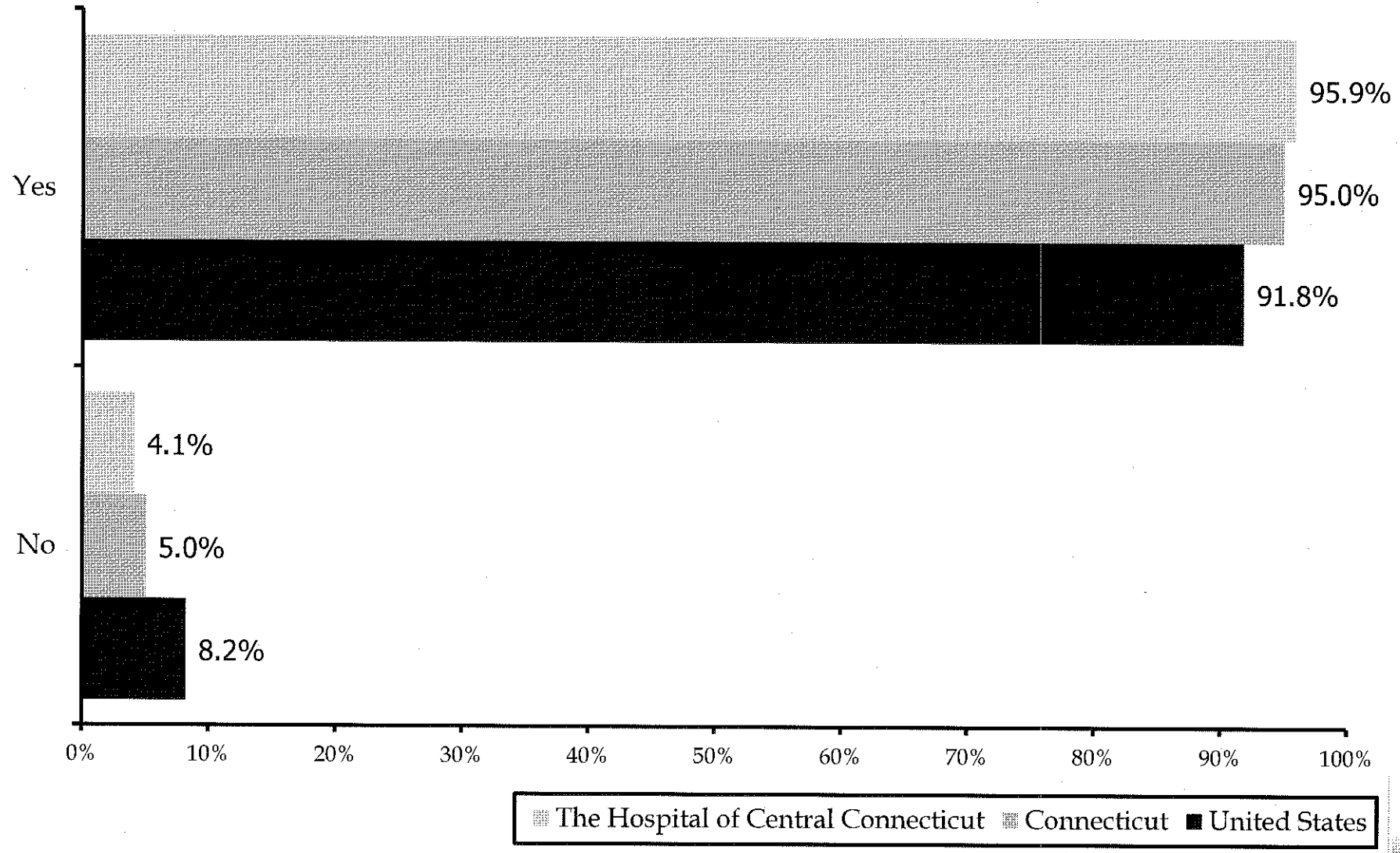
Have you ever had a mammogram?



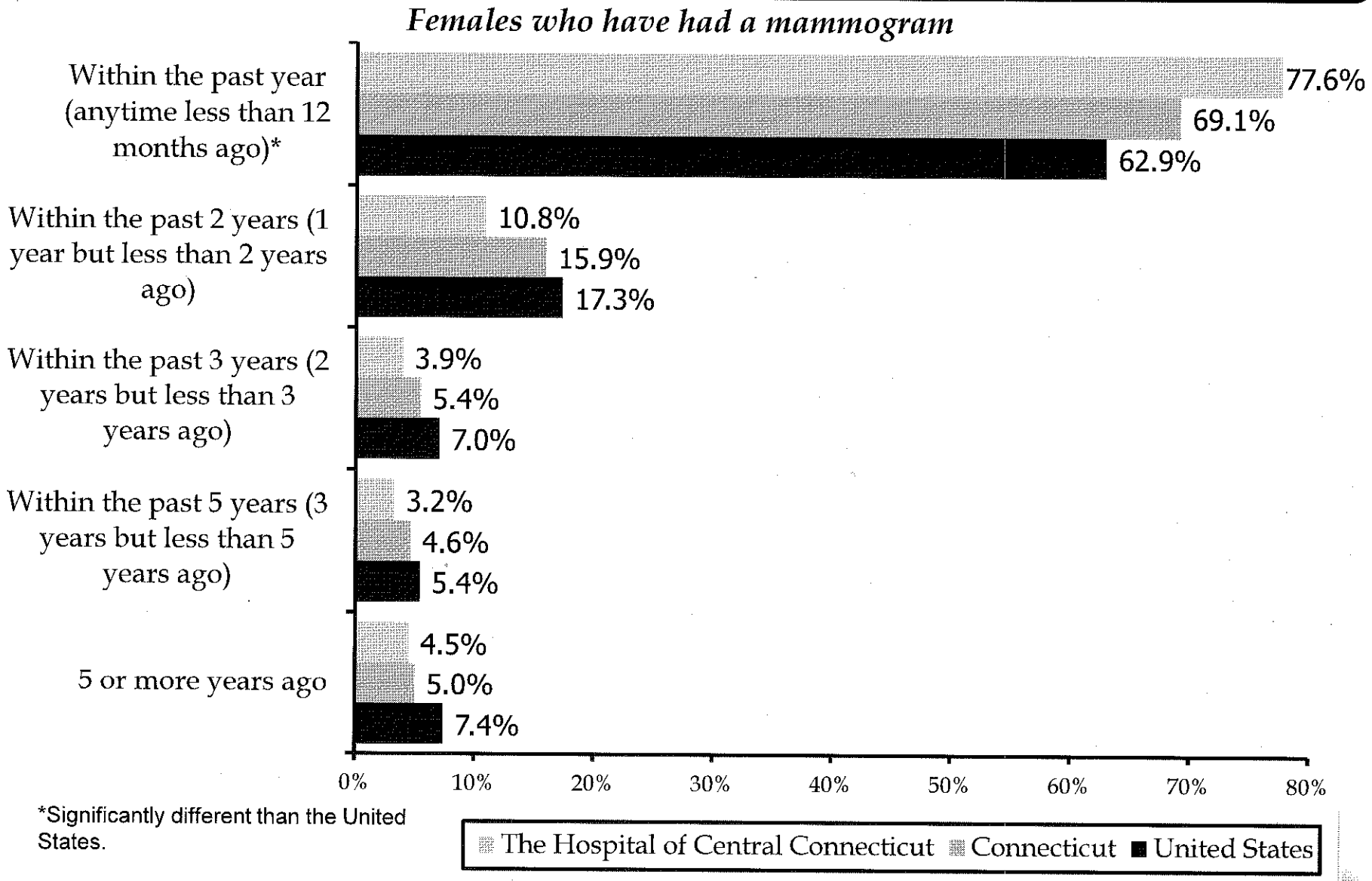
*Significantly different than the United States.

Have you ever had a mammogram?

Females respondents 40 years of age or older



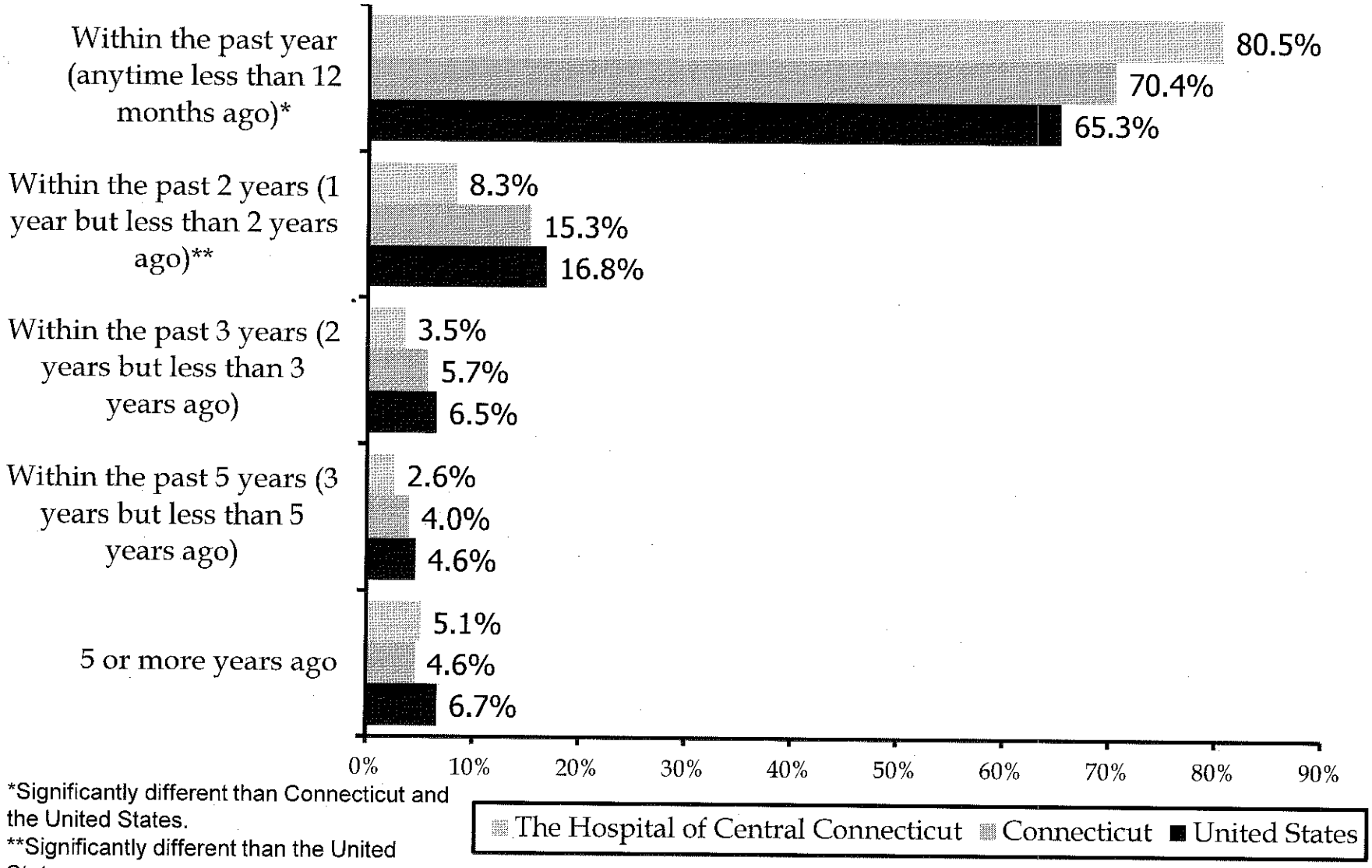
How long has it been since you had your last mammogram?



*Significantly different than the United States.

How long has it been since you had your last mammogram?

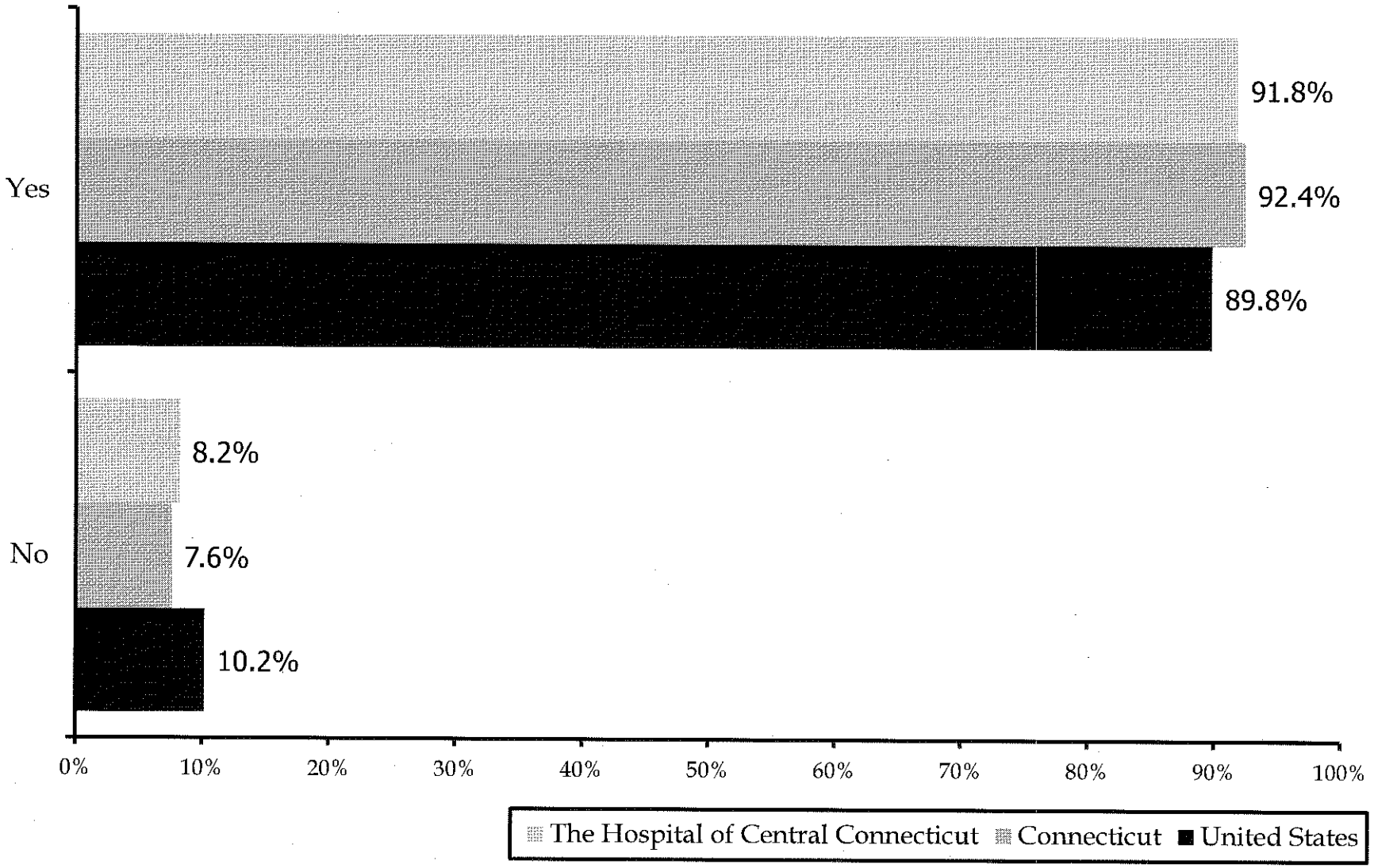
Females who have had a mammogram and are 40 years of age or older



*Significantly different than Connecticut and the United States.

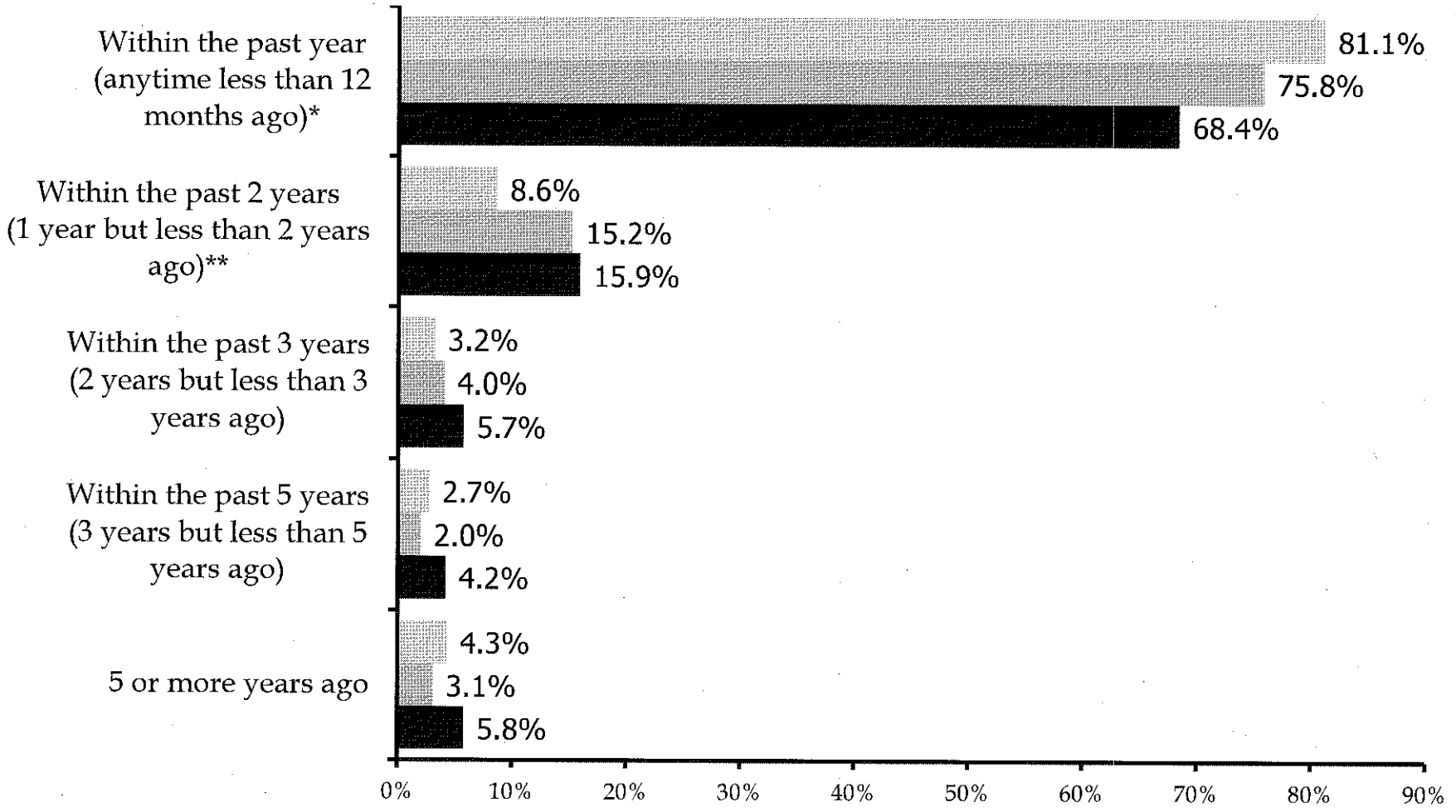
**Significantly different than the United States.

Have you ever had a clinical breast exam?



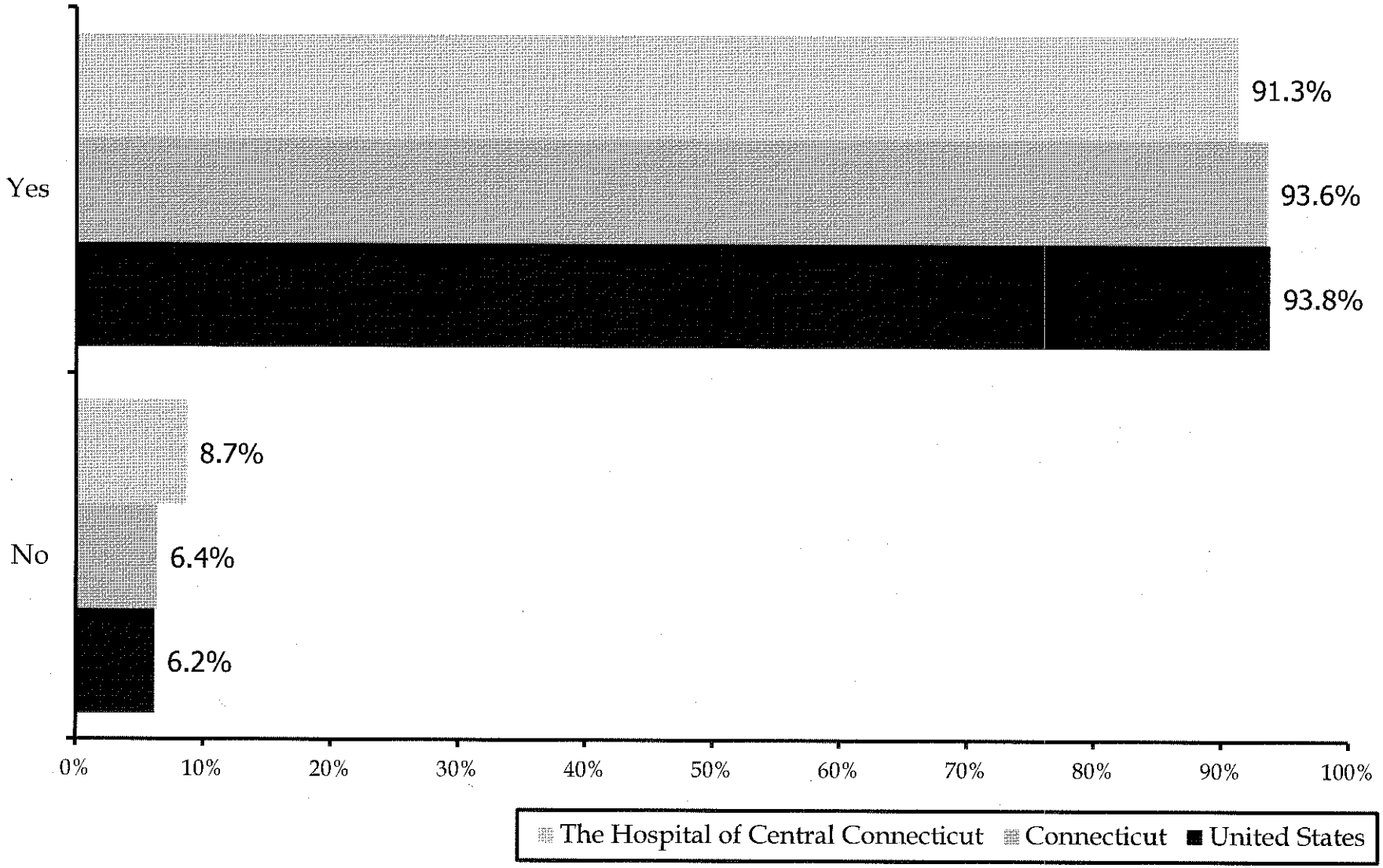
How long has it been since your last breast exam?

Females who have had a clinical breast exam



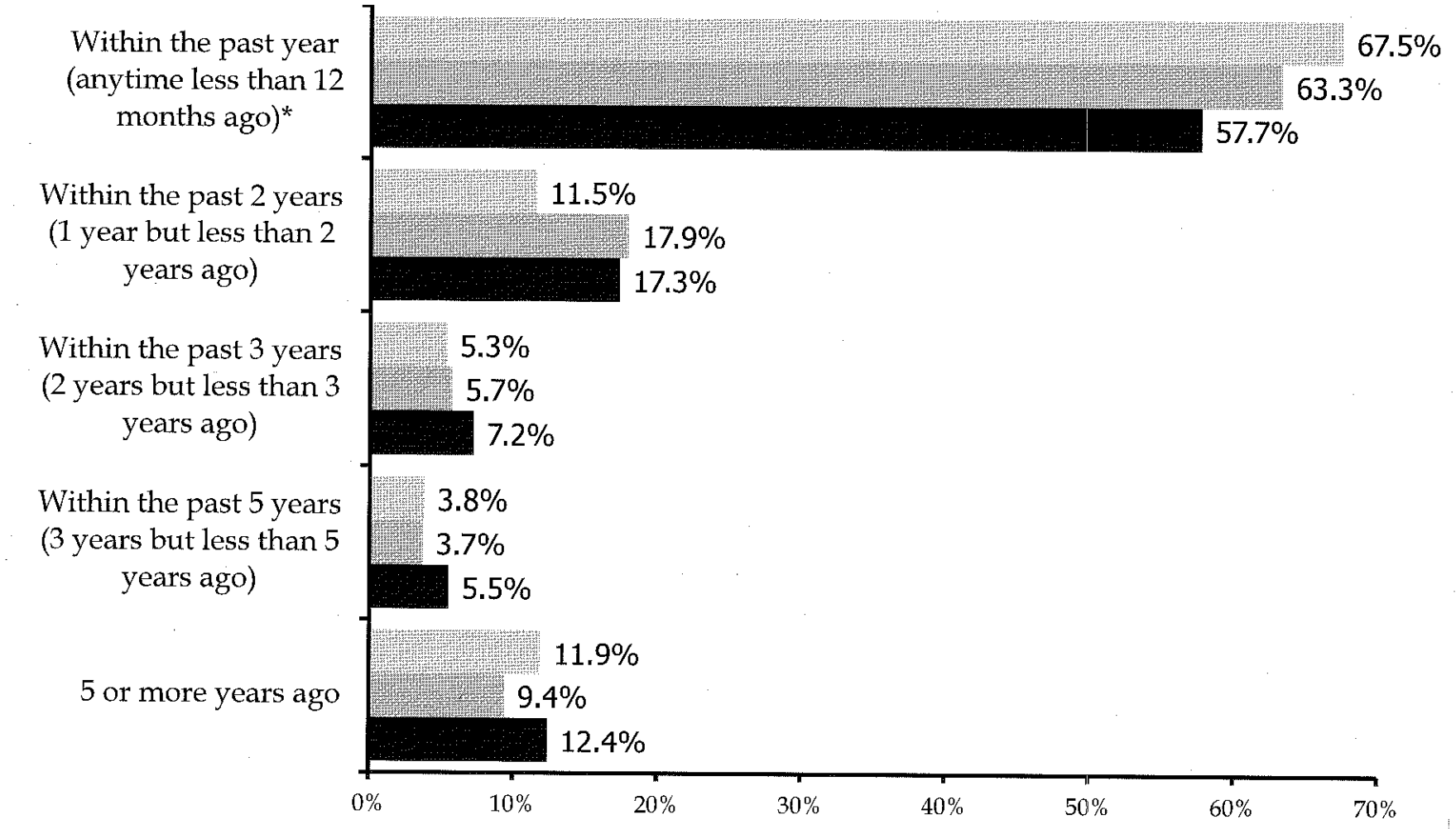
*Significantly different than the United States.
**Significantly different than Connecticut and the United States.

Have you ever had a Pap test?



How long has it been since you had your last Pap test?

Females who have had a Pap test



*Significantly different than the United States.

Statistically Significant Differences by Race

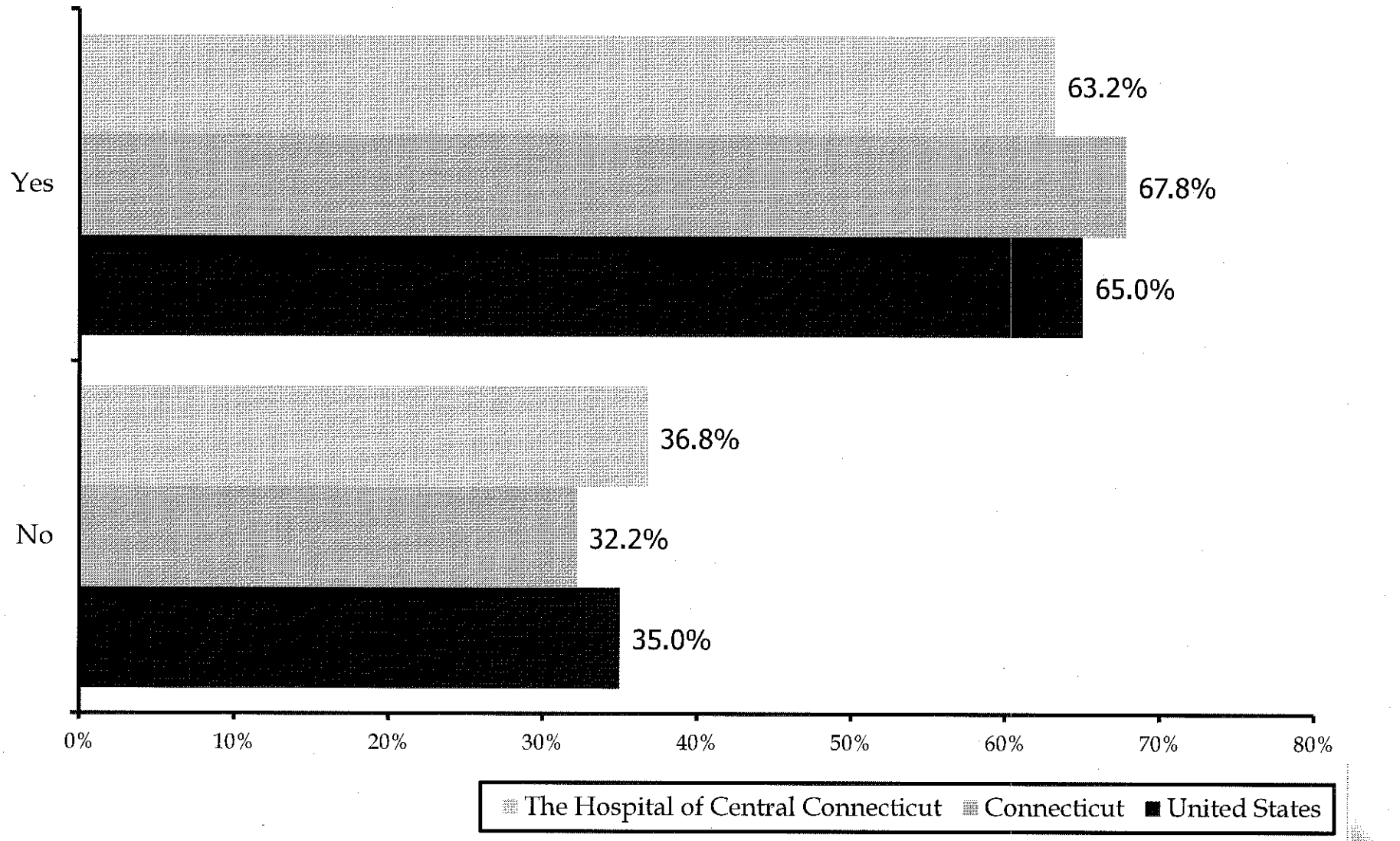
Women's Health

- White respondents are more likely than Other race respondents to have had a Pap test.

Prostate Cancer Screening

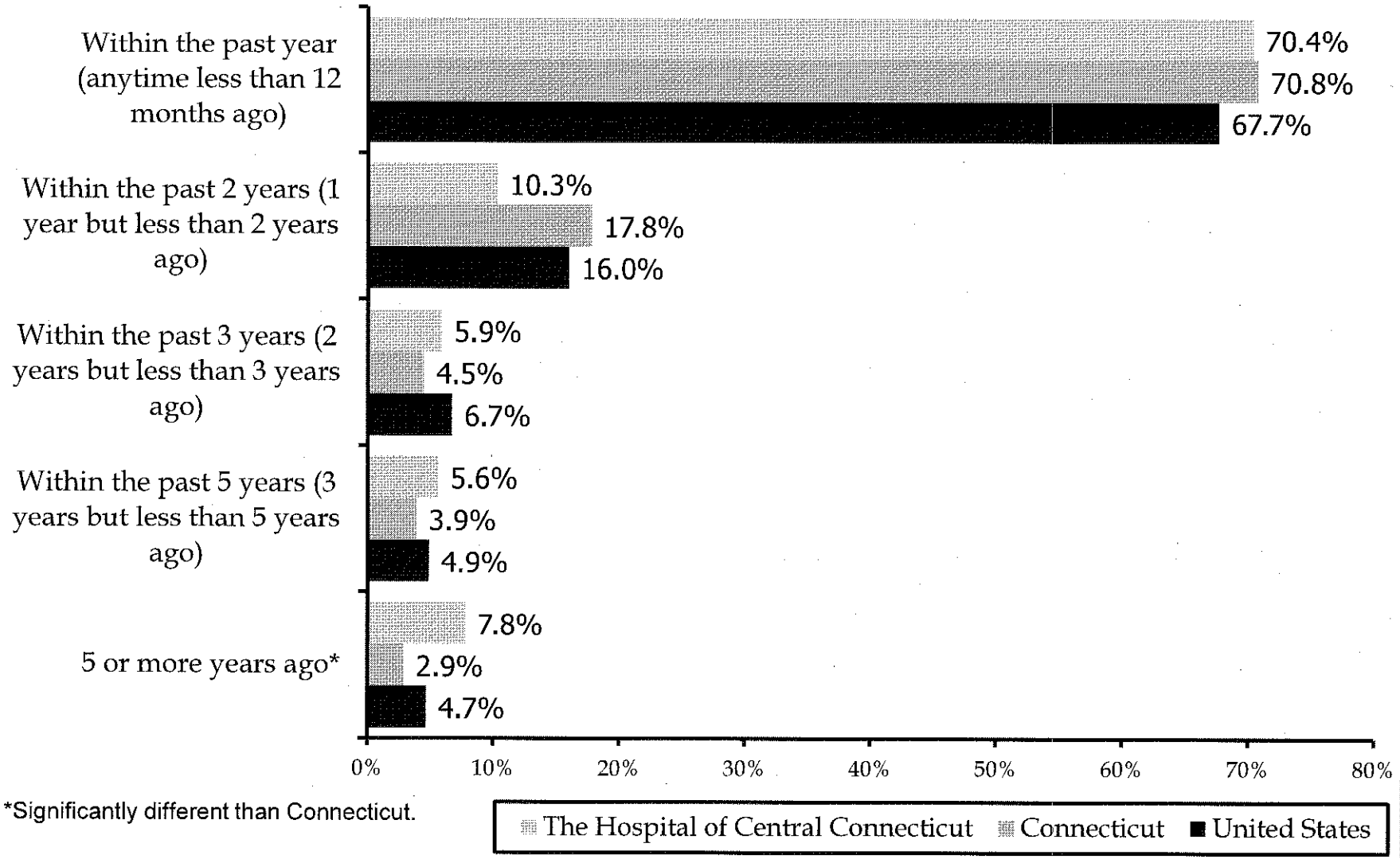
Only asked of male respondents 40 years of age or older

Have you ever had a PSA test?



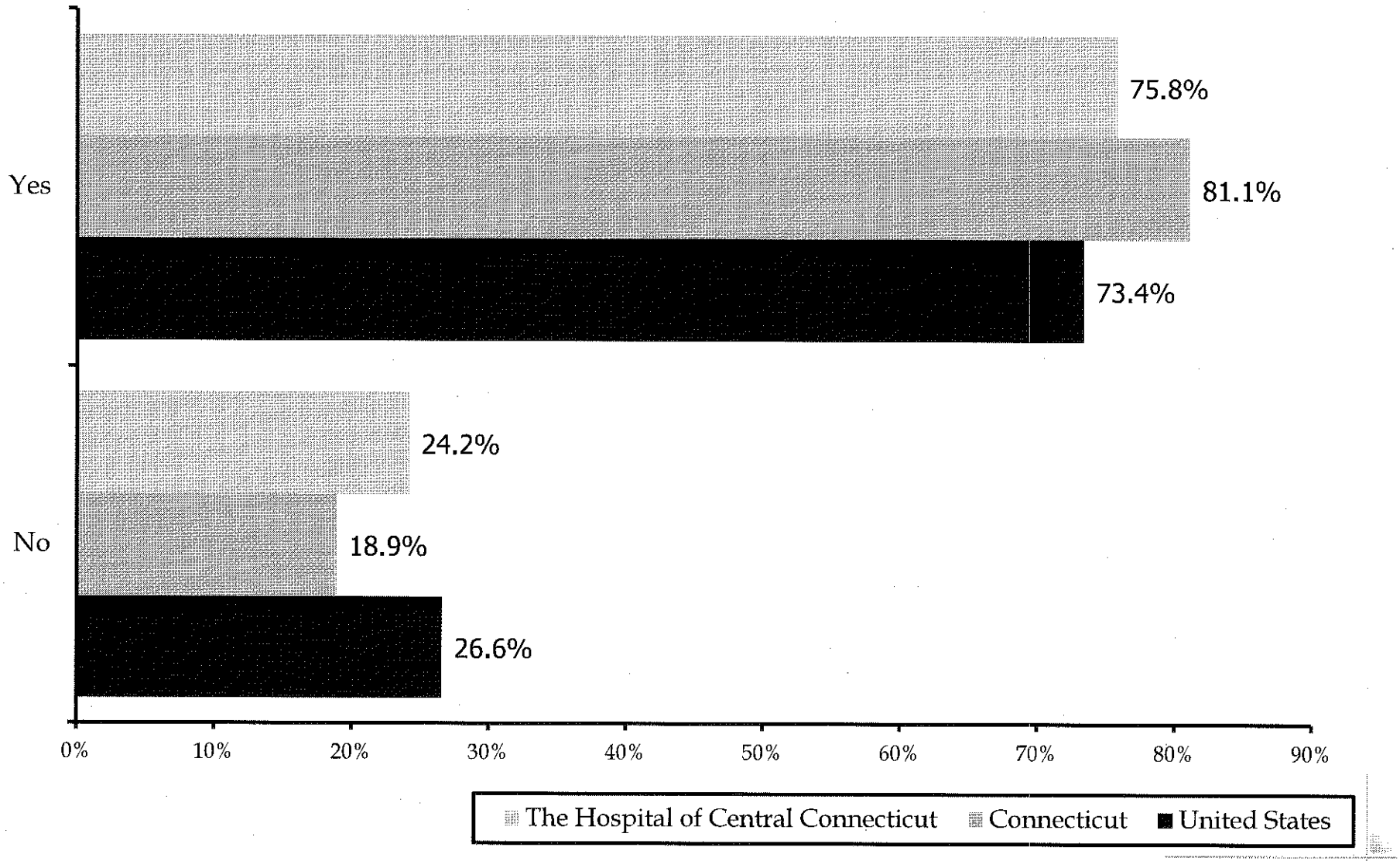
How long has it been since you had your last PSA test?

Males who have had a PSA test

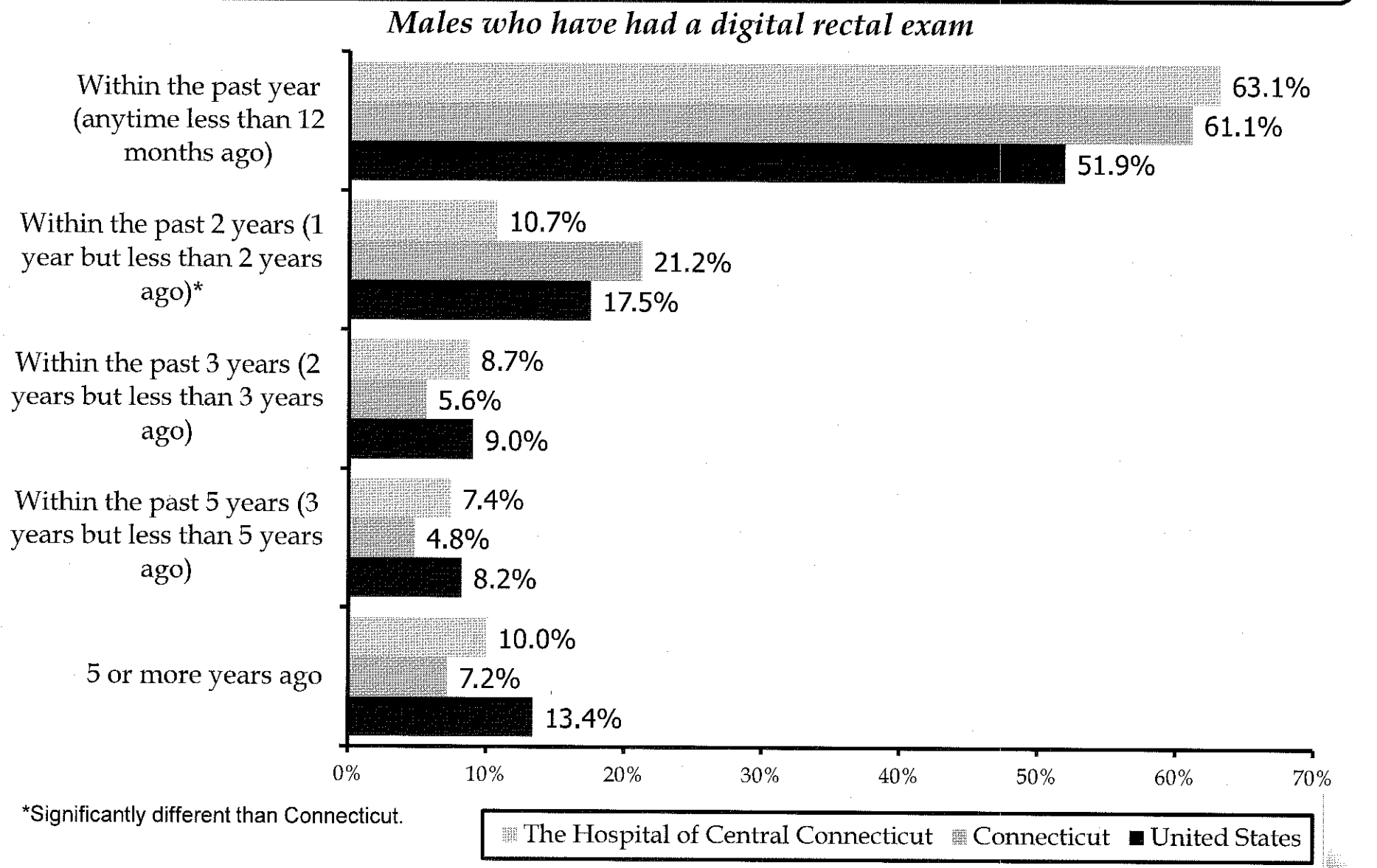


*Significantly different than Connecticut.

Have you ever had a digital rectal exam?



How long has it been since you had your last digital rectal exam?



*Significantly different than Connecticut.

Statistically Significant Differences by Race

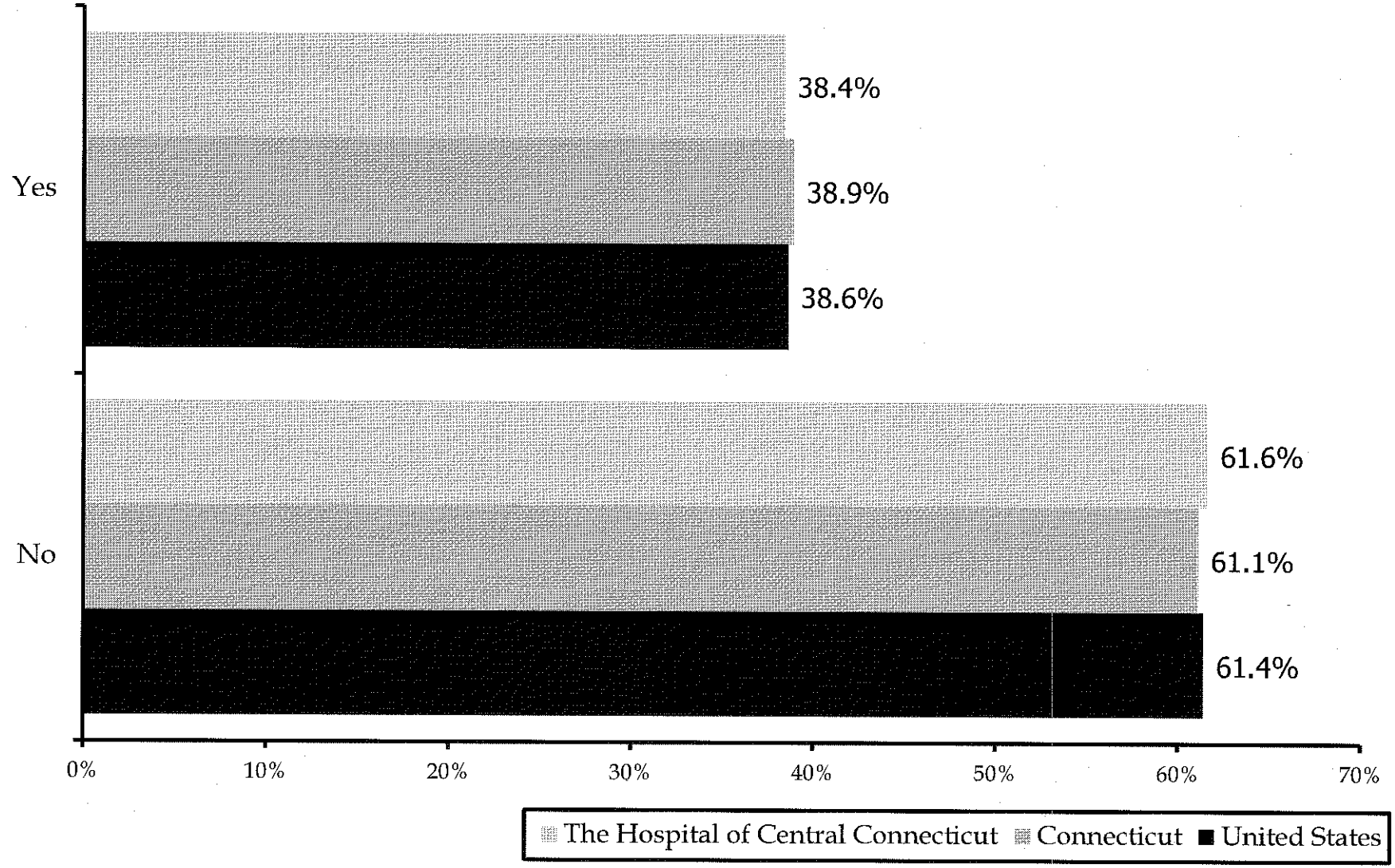
Prostate Cancer Screening

- White respondents are more likely than Black/African American respondents to have had a digital rectal exam.
- Other race respondents are more likely than White respondents to have last had a PSA test 5 or more years ago.

Colorectal Cancer Screening

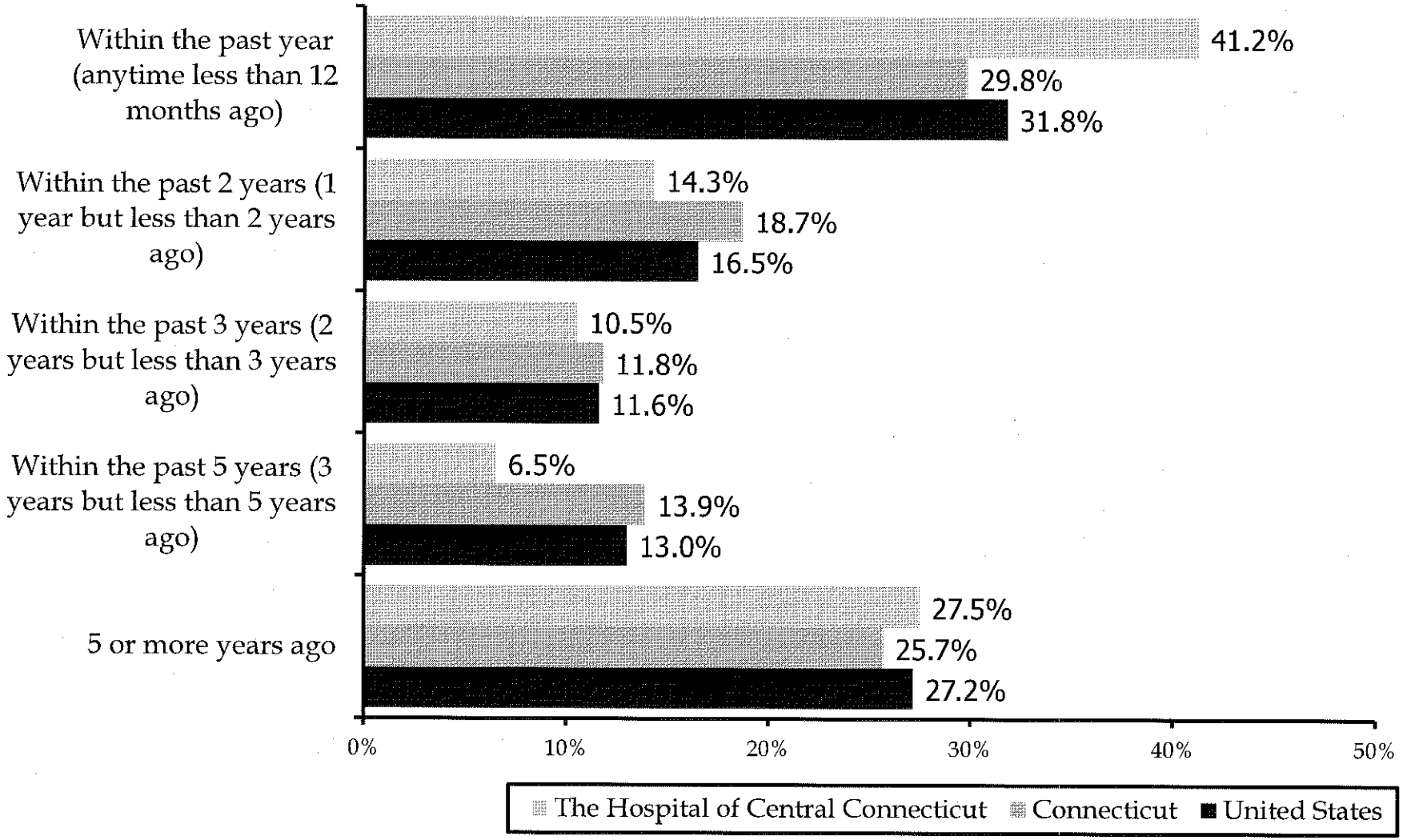
Only asked of respondents 50 years of age or older

Have you ever had a blood stool test using a home kit?

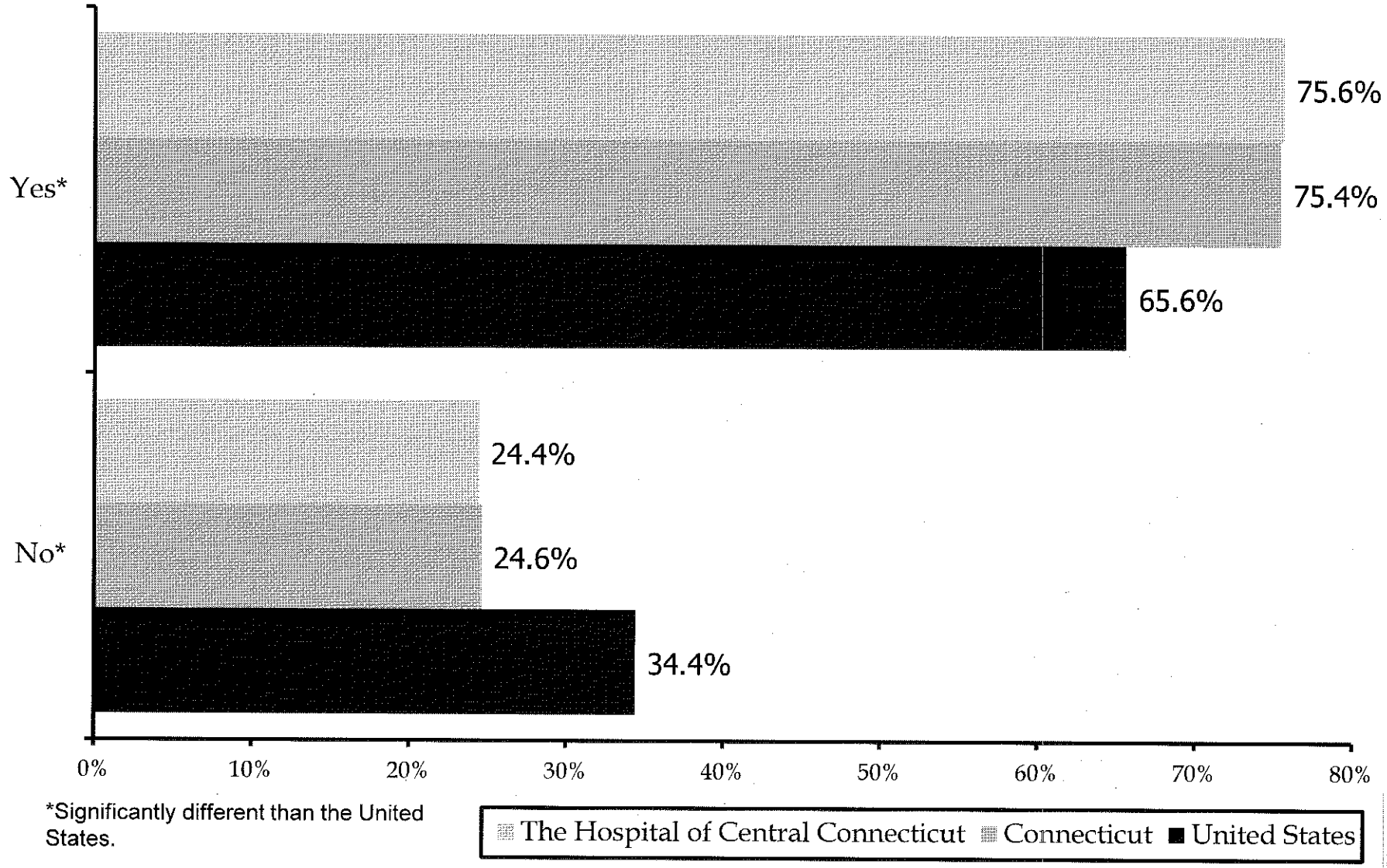


How long has it been since you had your last blood stool test using a home kit?

Respondents who have had a blood stool test



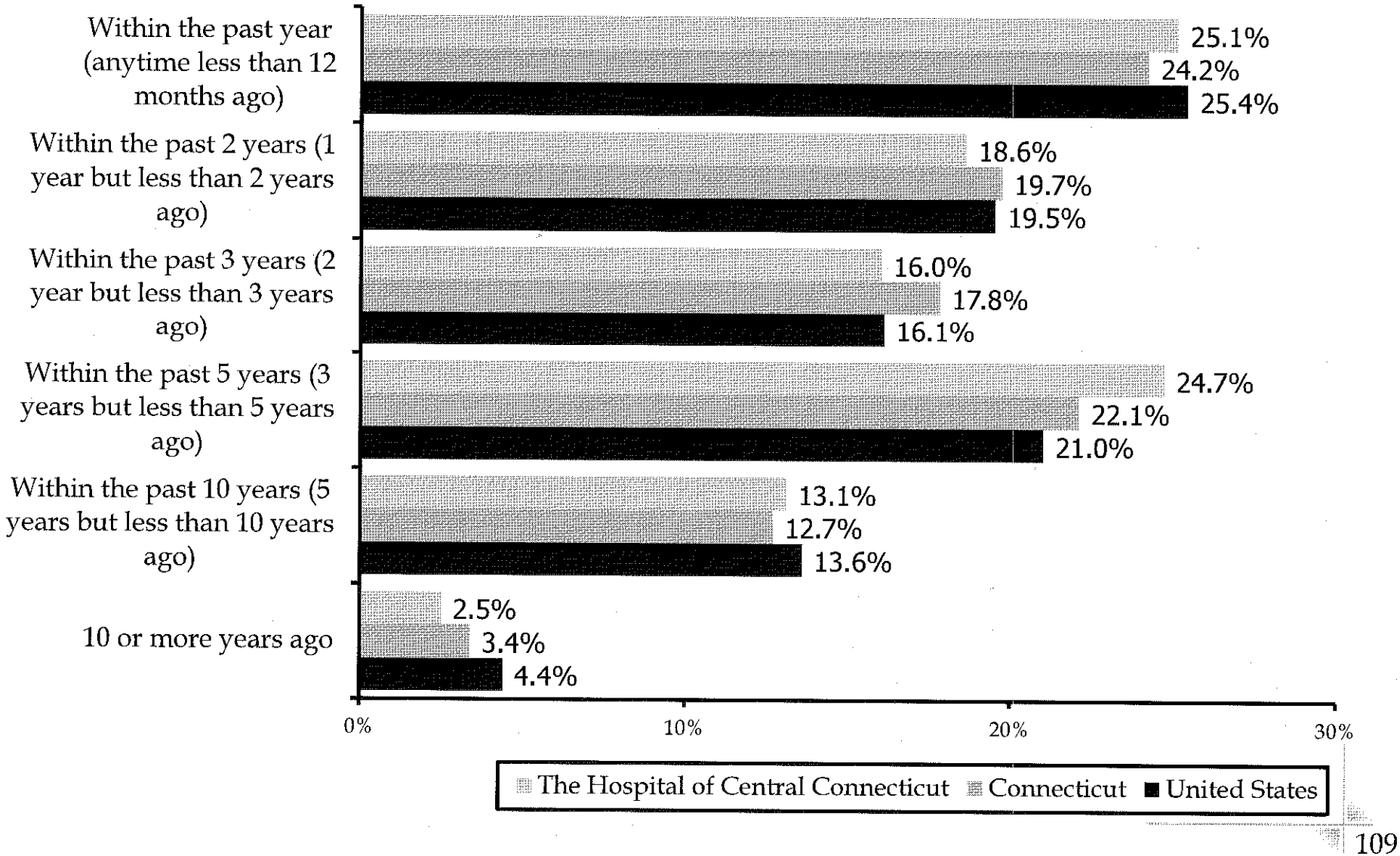
Have you ever had a sigmoidoscopy or colonoscopy exam?



*Significantly different than the United States.

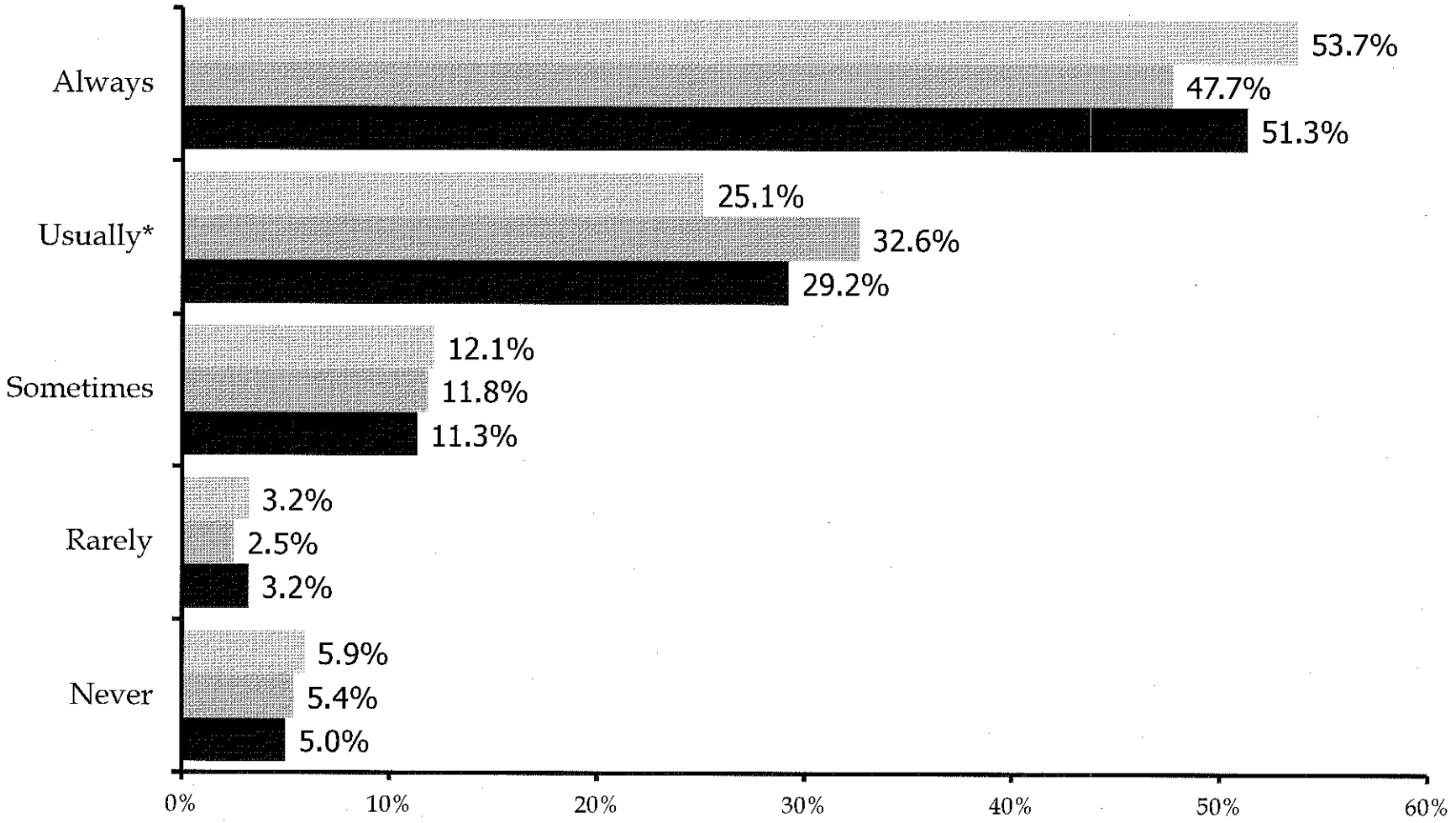
How long has it been since you had your last sigmoidoscopy or colonoscopy?

Respondents who have had a sigmoidoscopy or colonoscopy



Emotional Support and Life Satisfaction

How often do you get the social and emotional support you need?



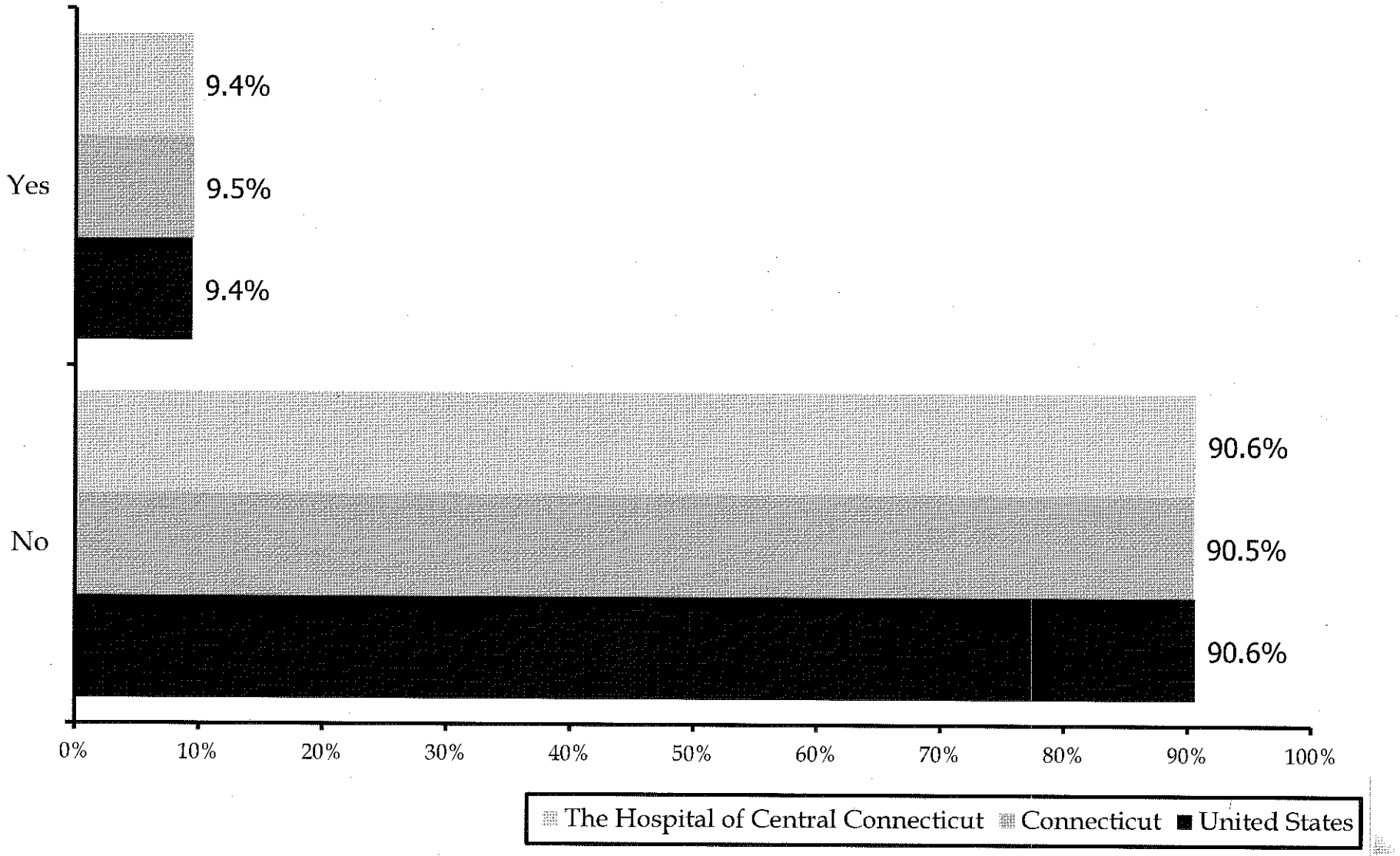
Statistically Significant Differences by Gender and Race

Emotional Support and Life Satisfaction

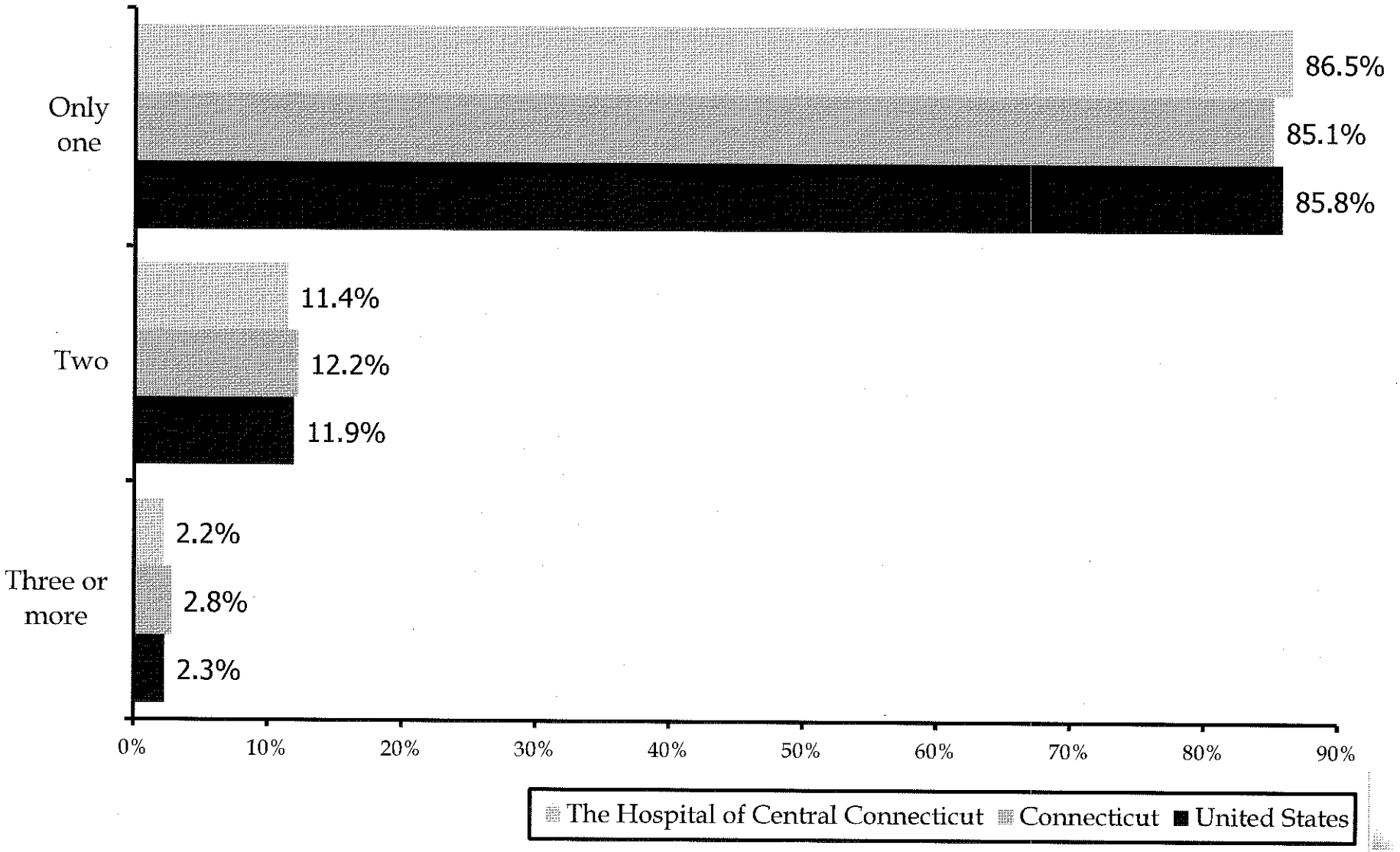
- White and Other race respondents are more likely than Black/African American respondents to usually get the social and emotional support that they need.
- Asian respondents are more likely than White respondents to rarely get the social and emotional support that they need.

Cancer Survivorship

Have you ever been told by a doctor, nurse, or other health professional that you had cancer?



Have many different types of cancer have you had?



What type of cancer was it? (Most recent diagnosis if more than one)

Respondents who have had cancer

Cancer Type	The Hospital of Central Connecticut	Connecticut	United States
Breast	16.0%	18.2%	16.9%
Cervical	6.2%	5.2%	8.6%
Endometrial	0.8%	1.8%	2.7%
Ovarian	3.3%	0.8%	1.9%
Head and neck	0.0%	0.0%	0.6%
Oral	0.0%	0.5%	0.3%
Pharyngeal	1.2%	0.3%	0.4%
Thyroid	0.0%	2.2%	2.5%
Colon	2.0%	4.3%	4.7%
Esophageal	0.8%	0.3%	0.4%
Liver	0.0%	0.0%	0.3%
Pancreatic	0.0%	1.5%	0.7%

What type of cancer was it? (Most recent diagnosis if more than one)

Respondents who have had cancer

Cancer Type	The Hospital of Central Connecticut	Connecticut	United States
Rectal	0.0%	0.3%	0.4%
Stomach	0.8%	0.1%	0.4%
Hodgkin's Lymphoma	3.7%	2.3%	1.3%
Leukemia	1.2%	1.0%	1.3%
Non-Hodgkin's Lymphoma	0.0%	0.6%	1.6%
Prostate*	23.9%	12.1%	10.7%
Testicular	0.0%	0.7%	0.8%
Melanoma	3.8%	7.8%	8.6%
Other skin	17.0%	19.2%	20.8%
Heart	0.0%	0.0%	0.0%
Lung	3.3%	2.2%	2.0%

*Significantly different than the United States.

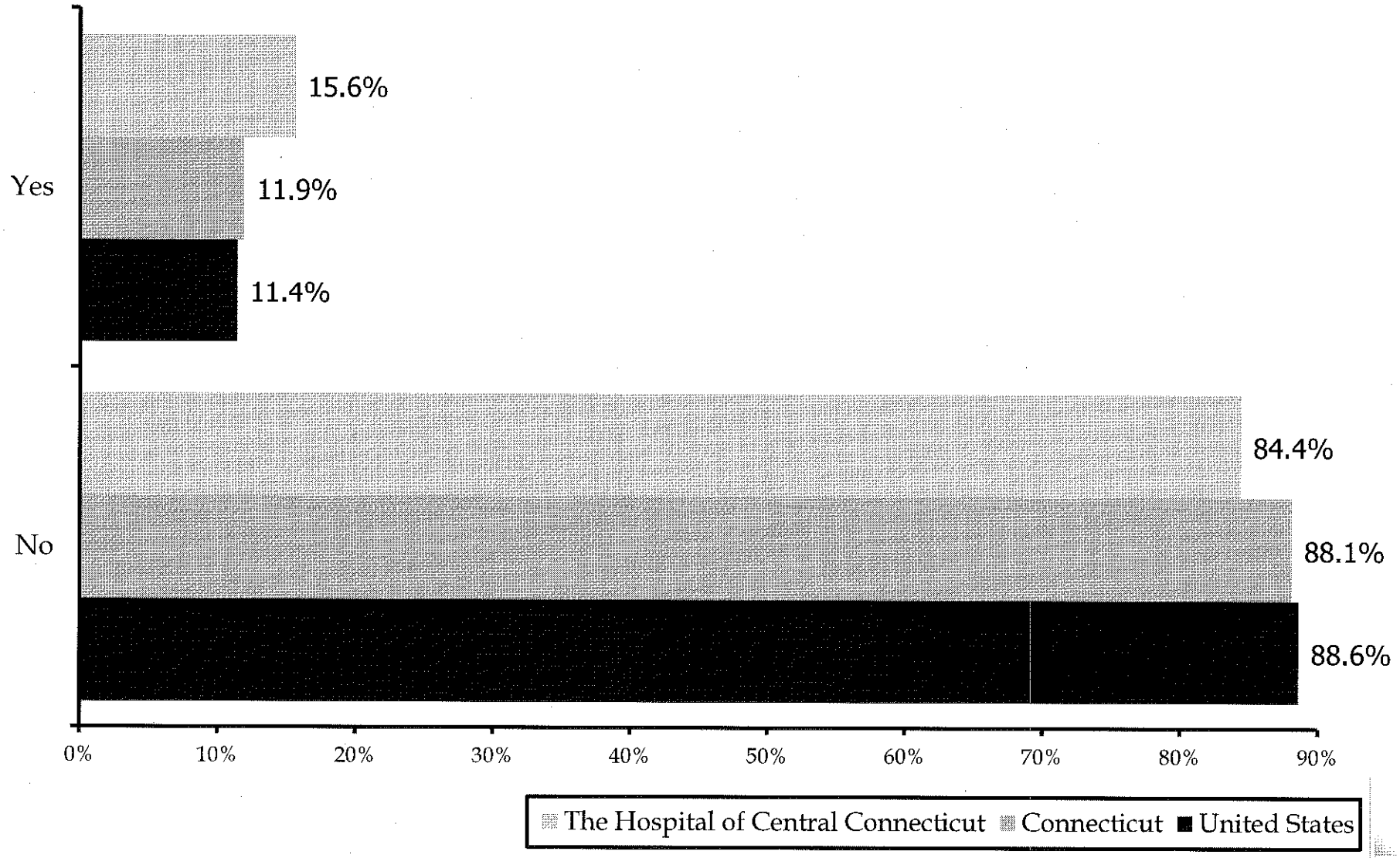
What type of cancer was it? (Most recent diagnosis if more than one)

Respondents who have had cancer

Cancer Type	The Hospital of Central Connecticut	Connecticut	United States
Bladder	6.0%	1.6%	2.4%
Renal	2.7%	1.6%	1.0%
Bone	0.0%	0.3%	0.7%
Brain	3.5%	0.6%	0.6%
Neuroblastoma	0.0%	0.0%	0.0%
Other	3.9%	14.3%	7.2%

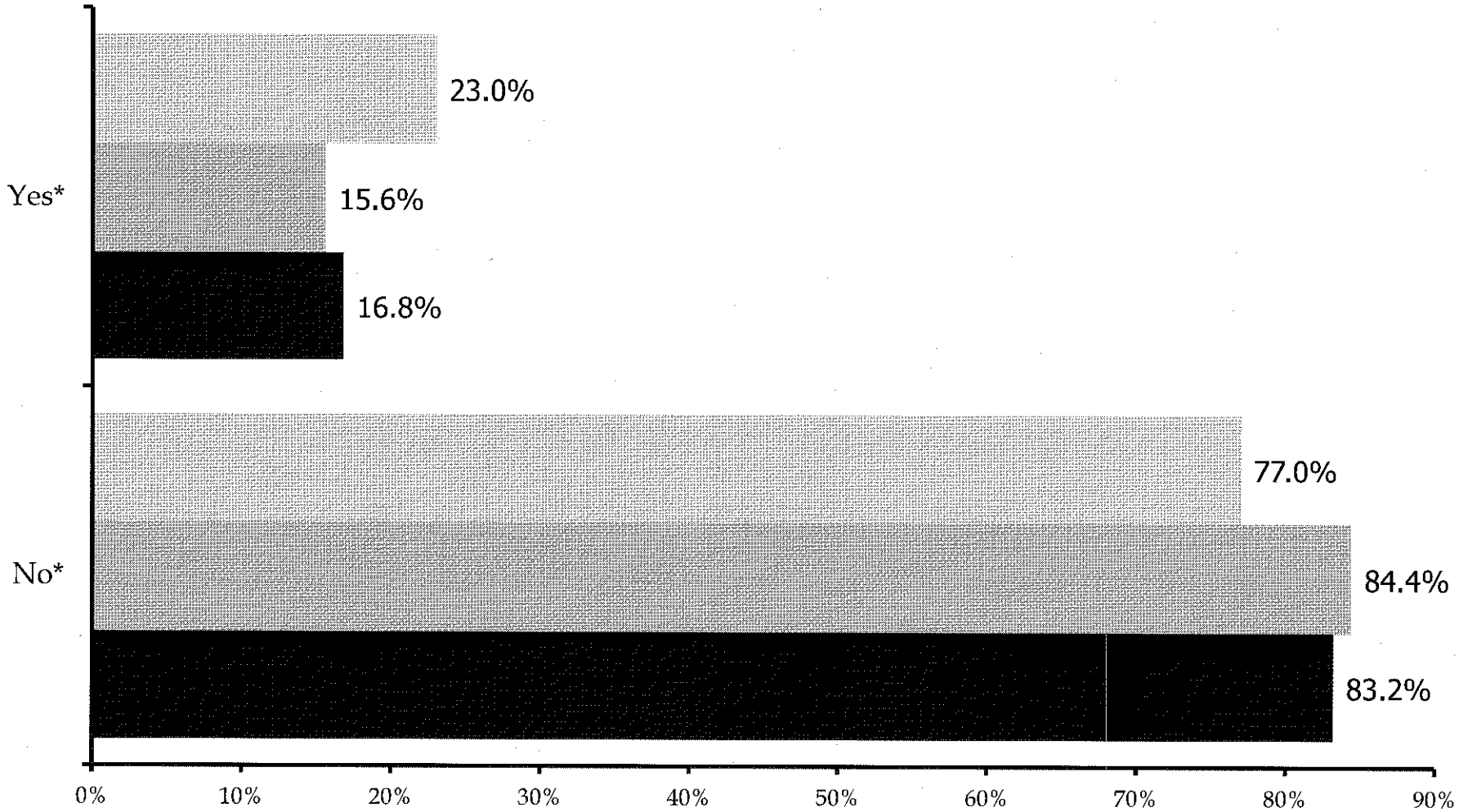
Responses for Other Cancer Types	Frequency
Multiple Myeloma	1
T-cell lymphoma	1
Gastric	1
Carcinoma	1

Are you currently receiving treatment for cancer?



Caregiver

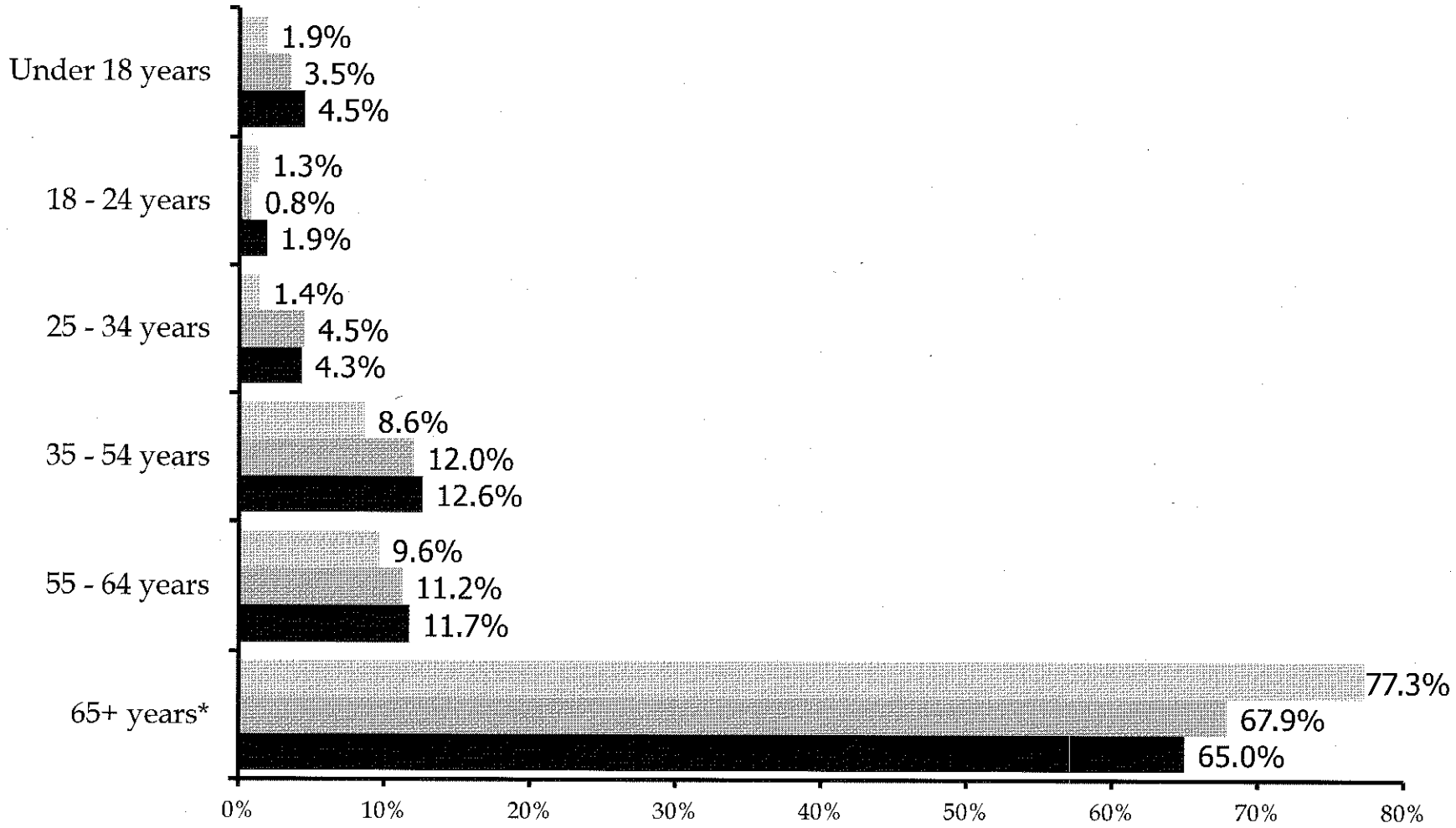
During the past month, did you provide regular care or assistance to a friend or family member?



*Significantly different than Connecticut and the United States.

What age is the person to whom you are giving care?

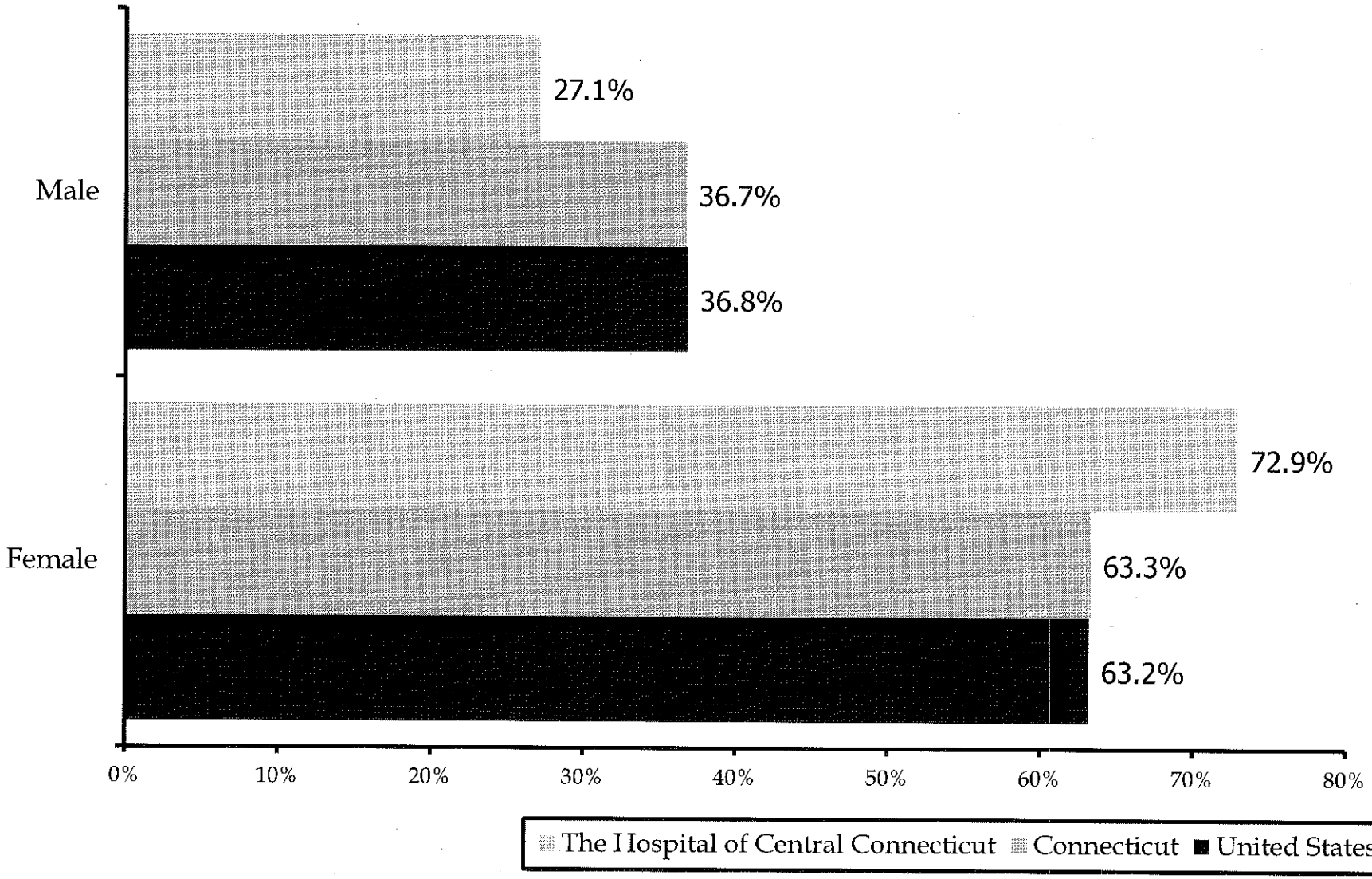
Respondents who provide regular care or assistance to a friend or family member



*Significantly different than the United States.

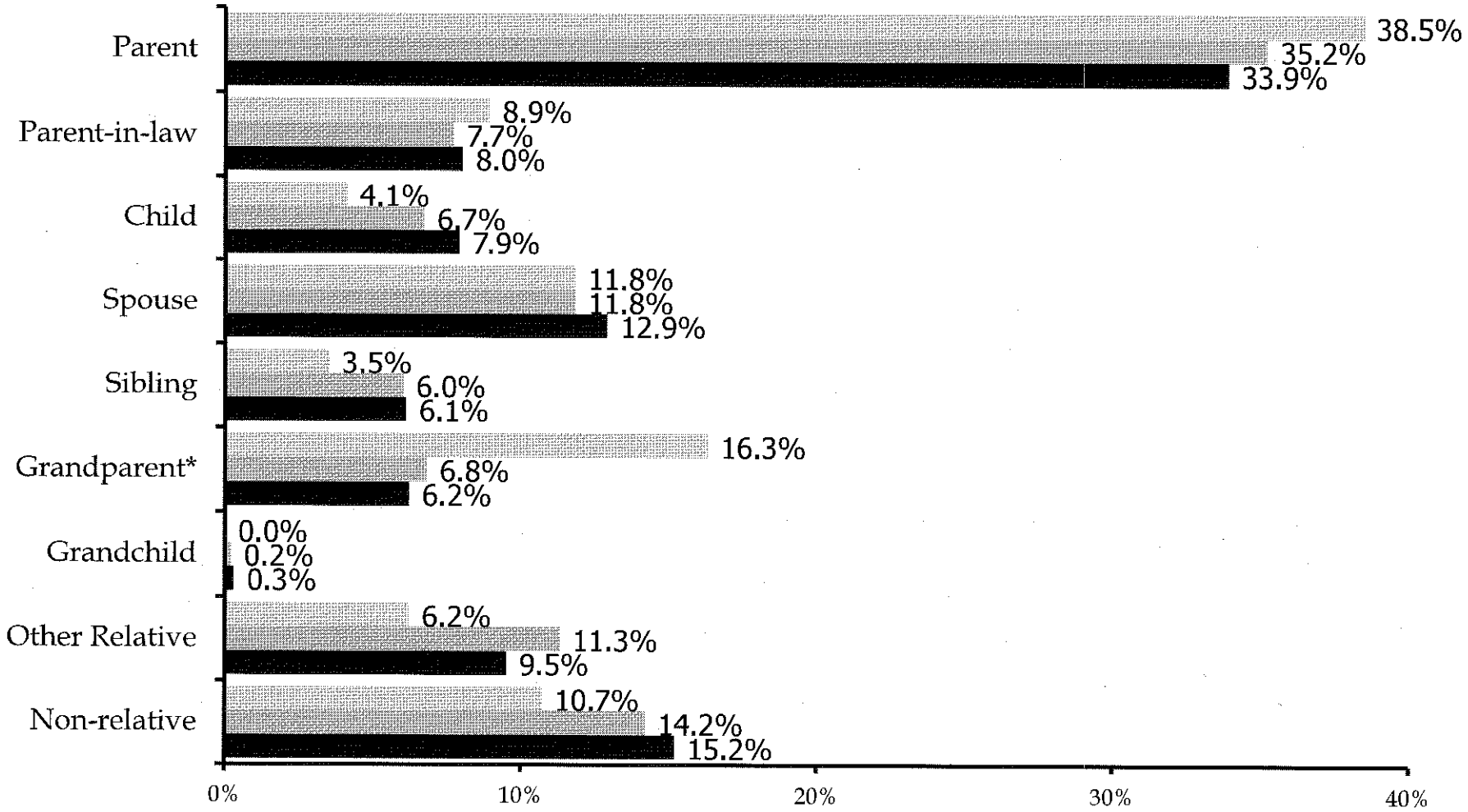
Is this person male or female?

Respondents who provide regular care or assistance to a friend or family member



What is his/her relationship to you?

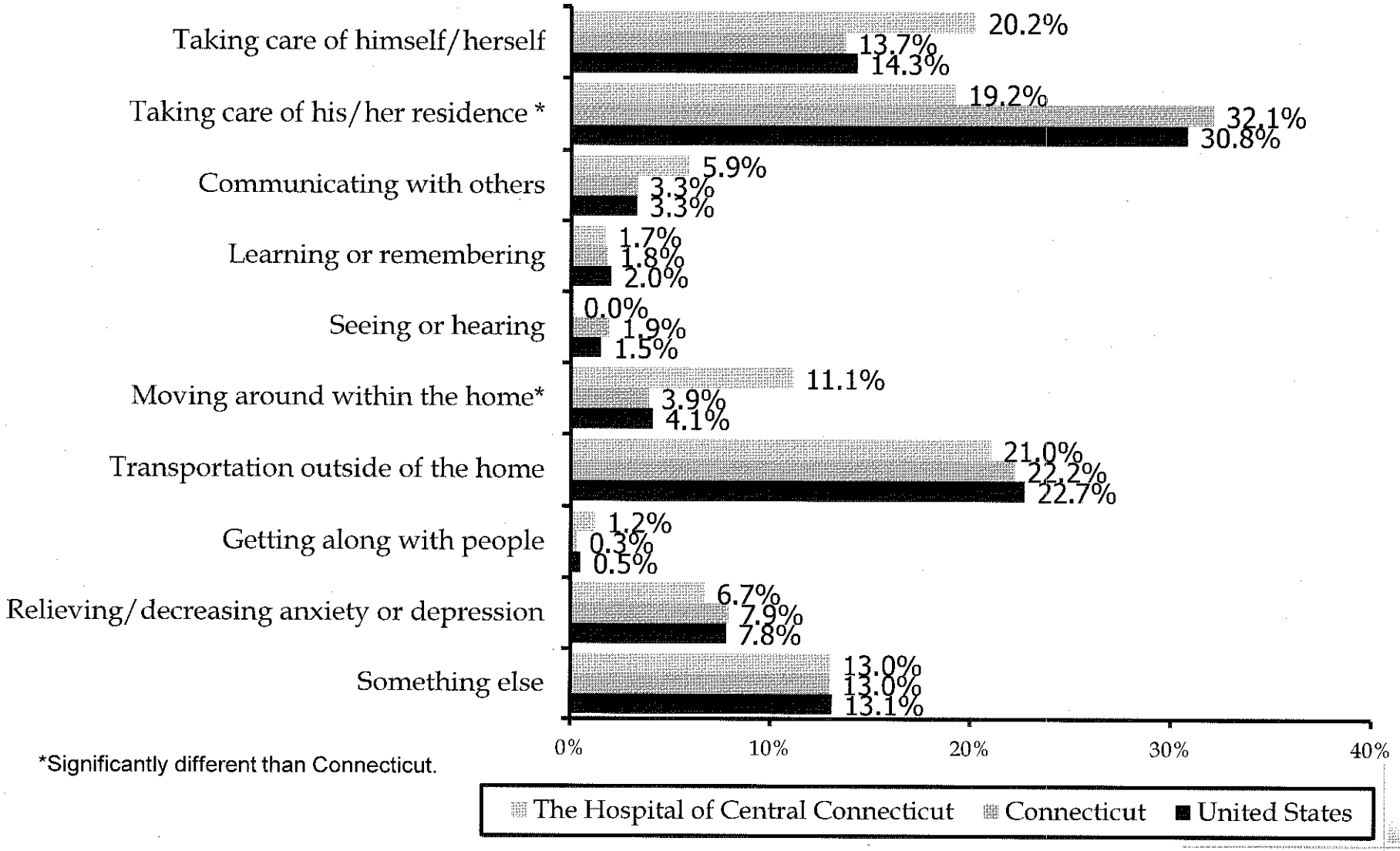
Respondents who provide regular care or assistance to a friend or family member



*Significantly different than Connecticut and the United States.

In which one of the following areas does the person you care for most need your help?

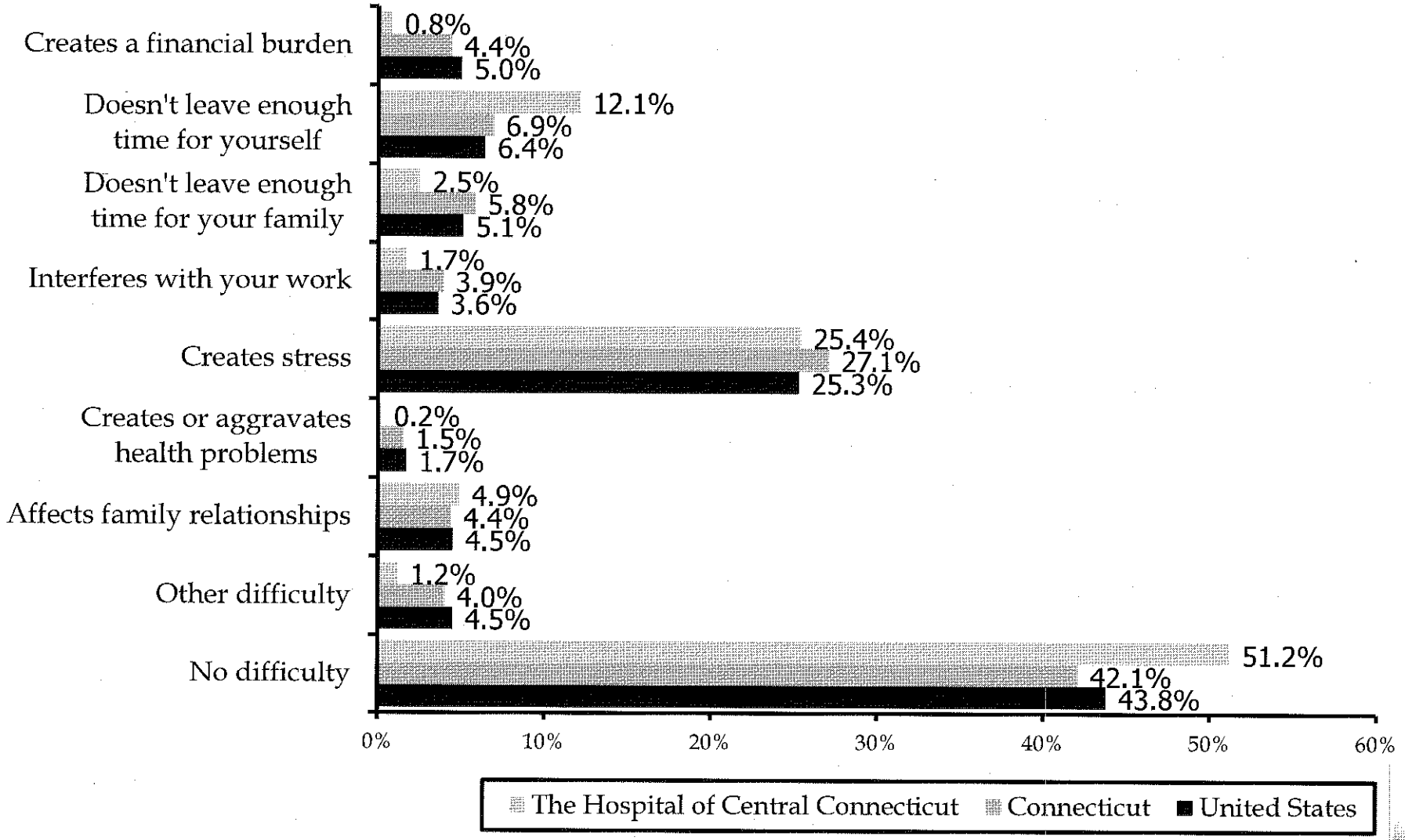
Respondents who provide regular care or assistance to a friend or family member



*Significantly different than Connecticut.

Please indicate which one of the following is the greatest difficulty you have faced as a caregiver.

Respondents who provide regular care or assistance to a friend or family member



Statistically Significant Differences by Gender and Race

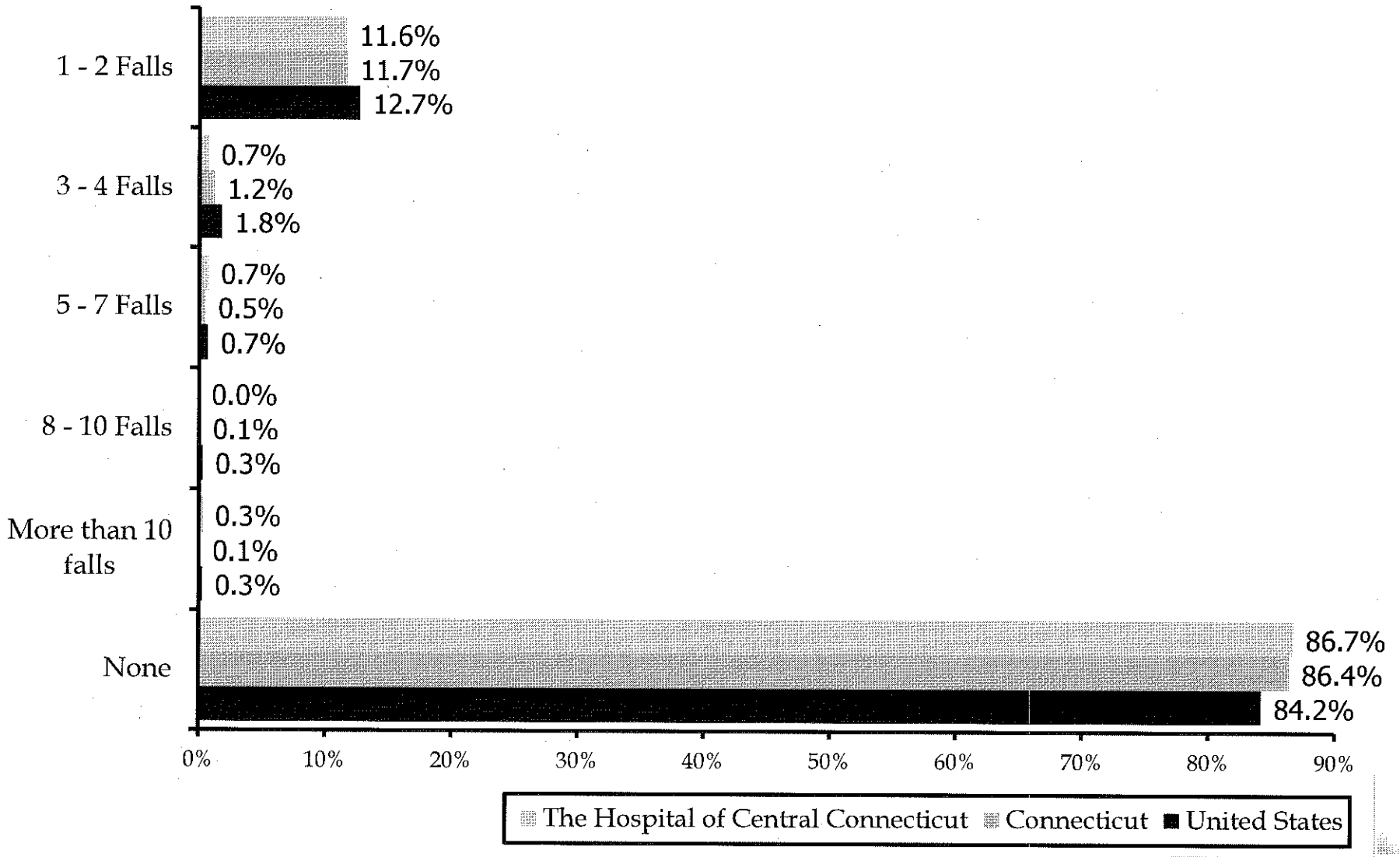
Caregiver

- Male respondents are more likely than female respondents to provide care or assistance to a grandparent.
- Other race respondents are more likely than White respondents to provide care or assistance to an individual 55 – 64 years of age.
- Other race respondents are more likely than White respondents to state that the individual they care for most needs help in moving around within the home.

Falls

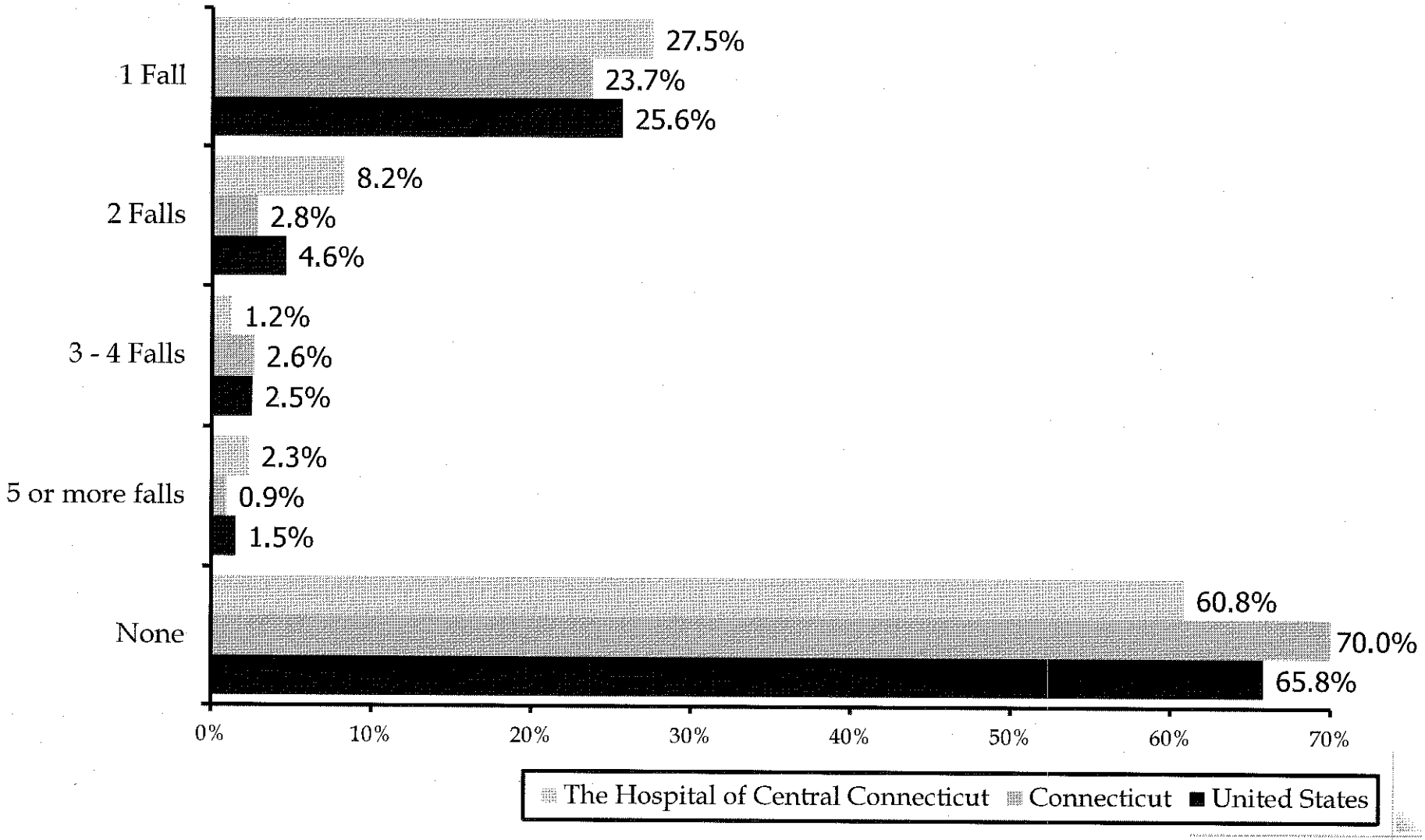
Only asked of respondents 45 years of age or older

In the past 3 months, how many times have you fallen?



How many of these falls caused an injury (caused you to limit your regular activities for at least a day or to go see a doctor)?

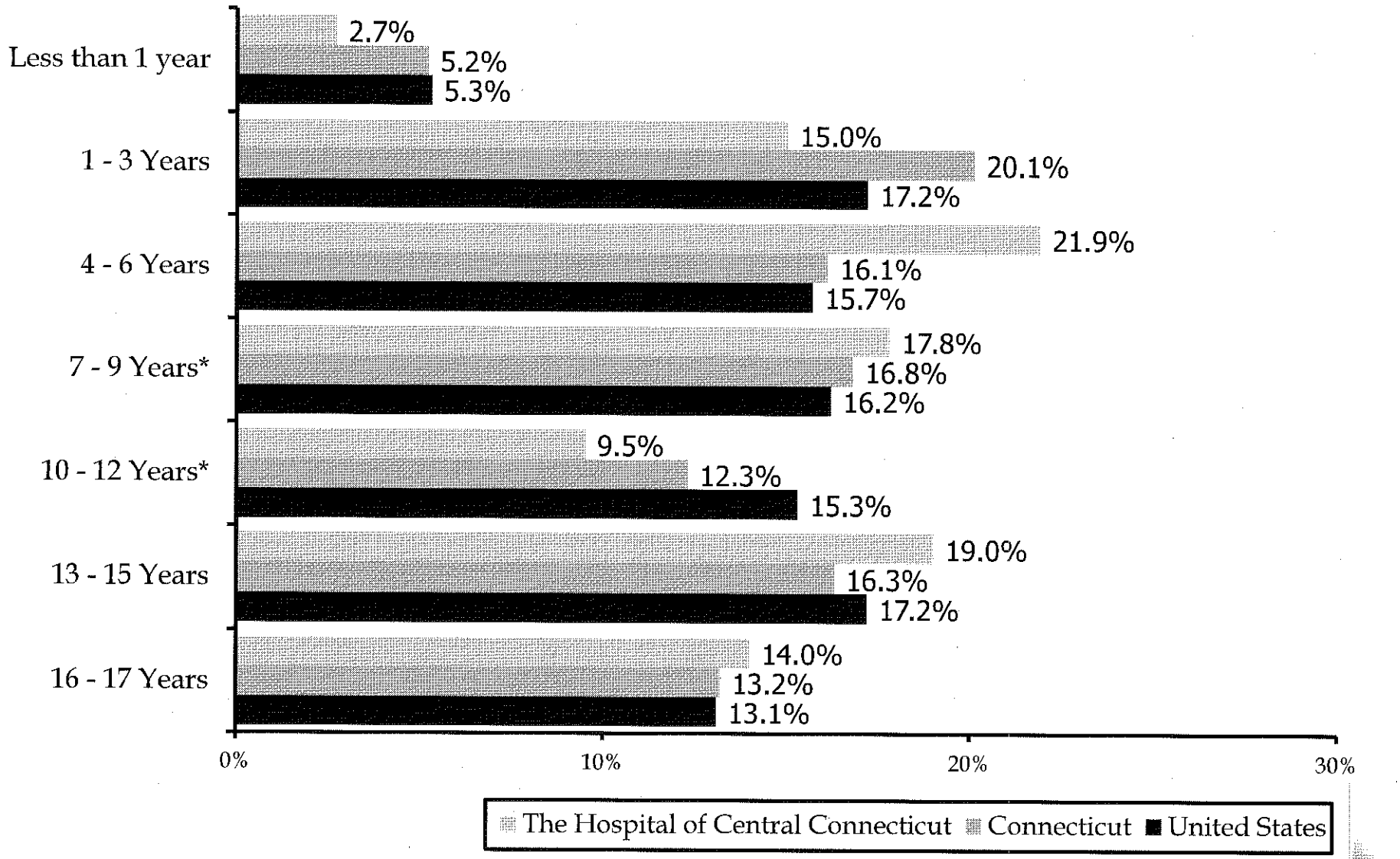
Respondents who have fallen in the past 3 months



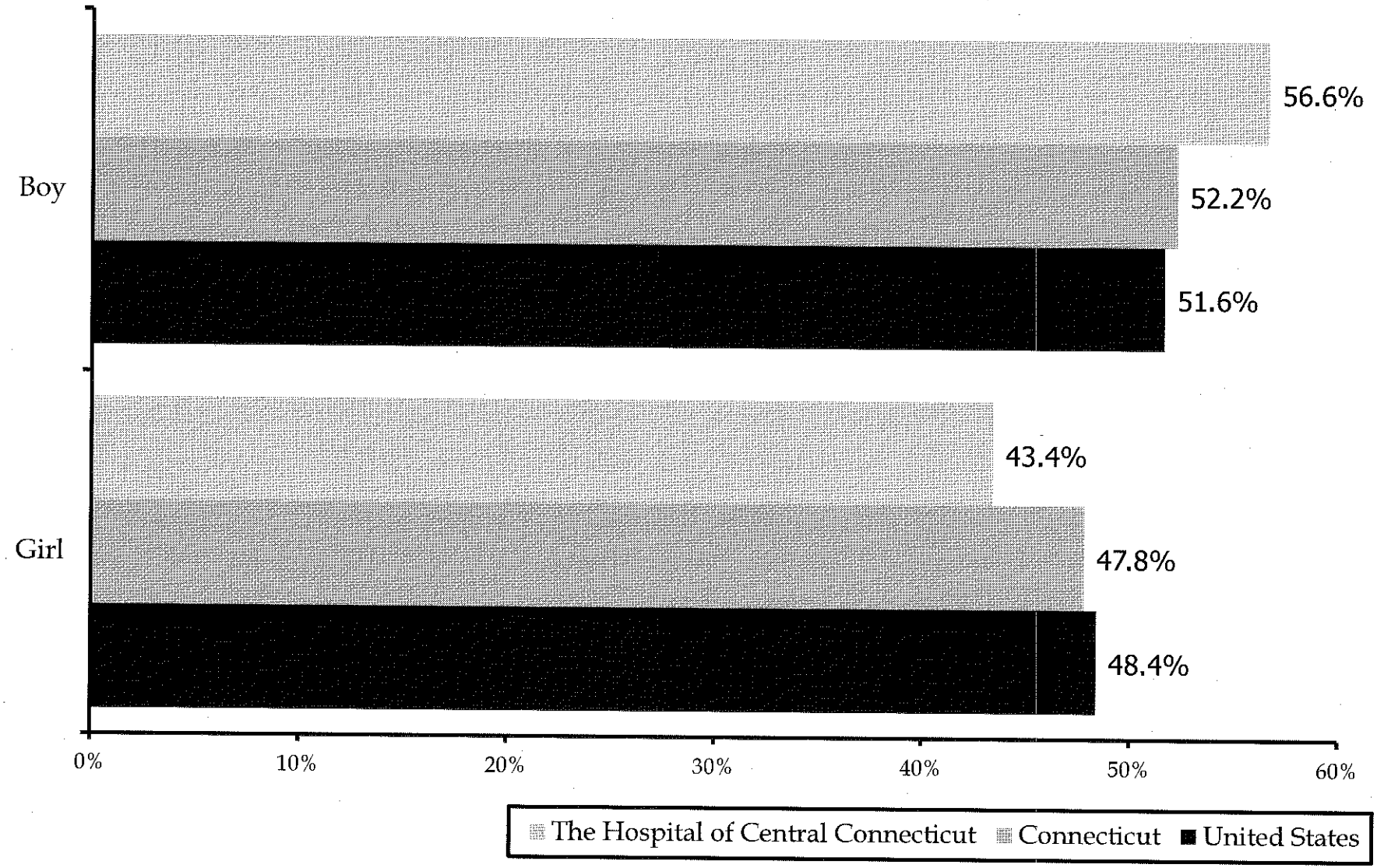
Random Child Selection

Only asked of respondents with children under age 18 in the household. If the household had more than one child under age 18, one was selected at random and referenced for all questions.

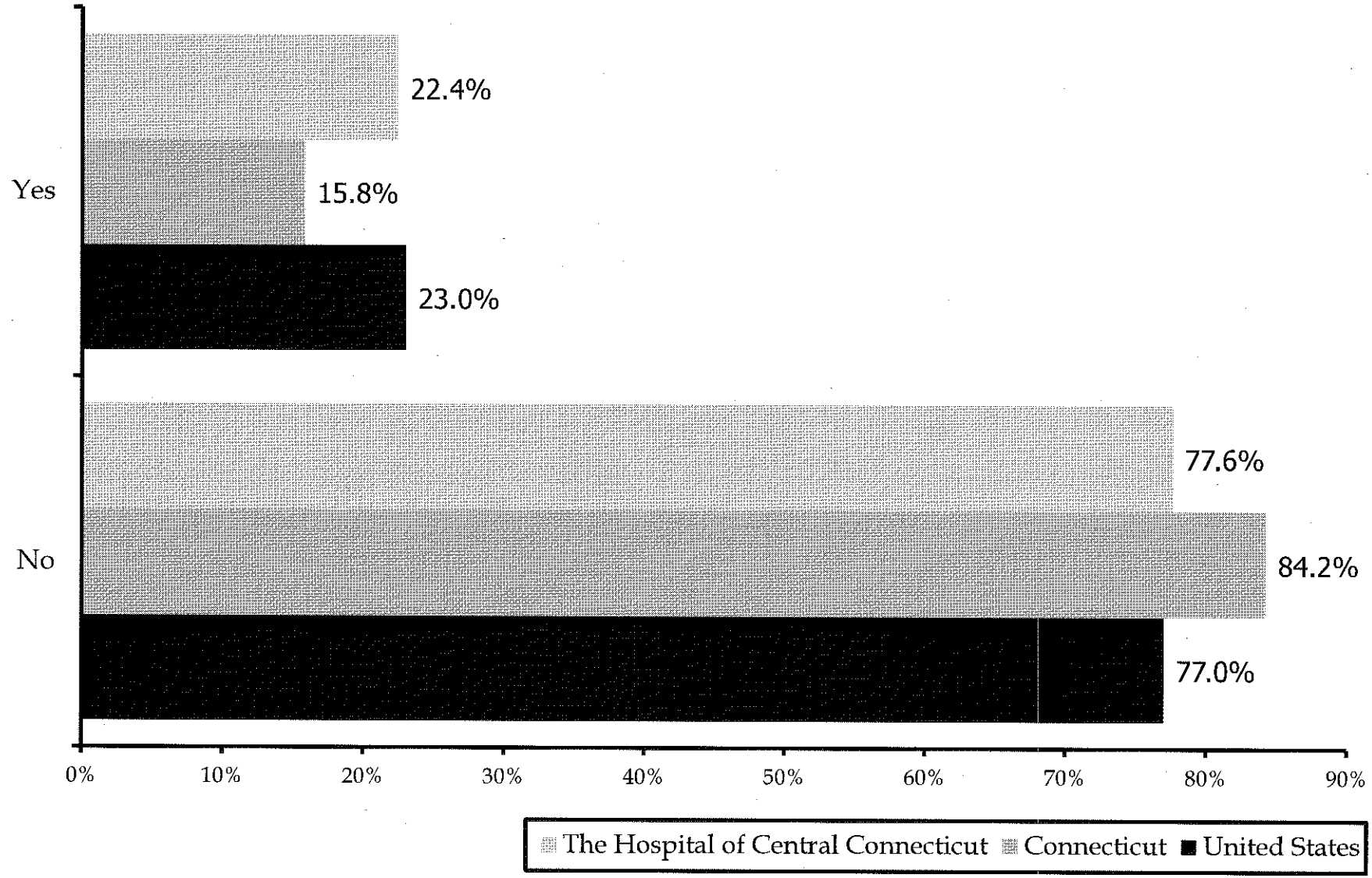
What is the age of the child in your household?



Is the child a boy or a girl?

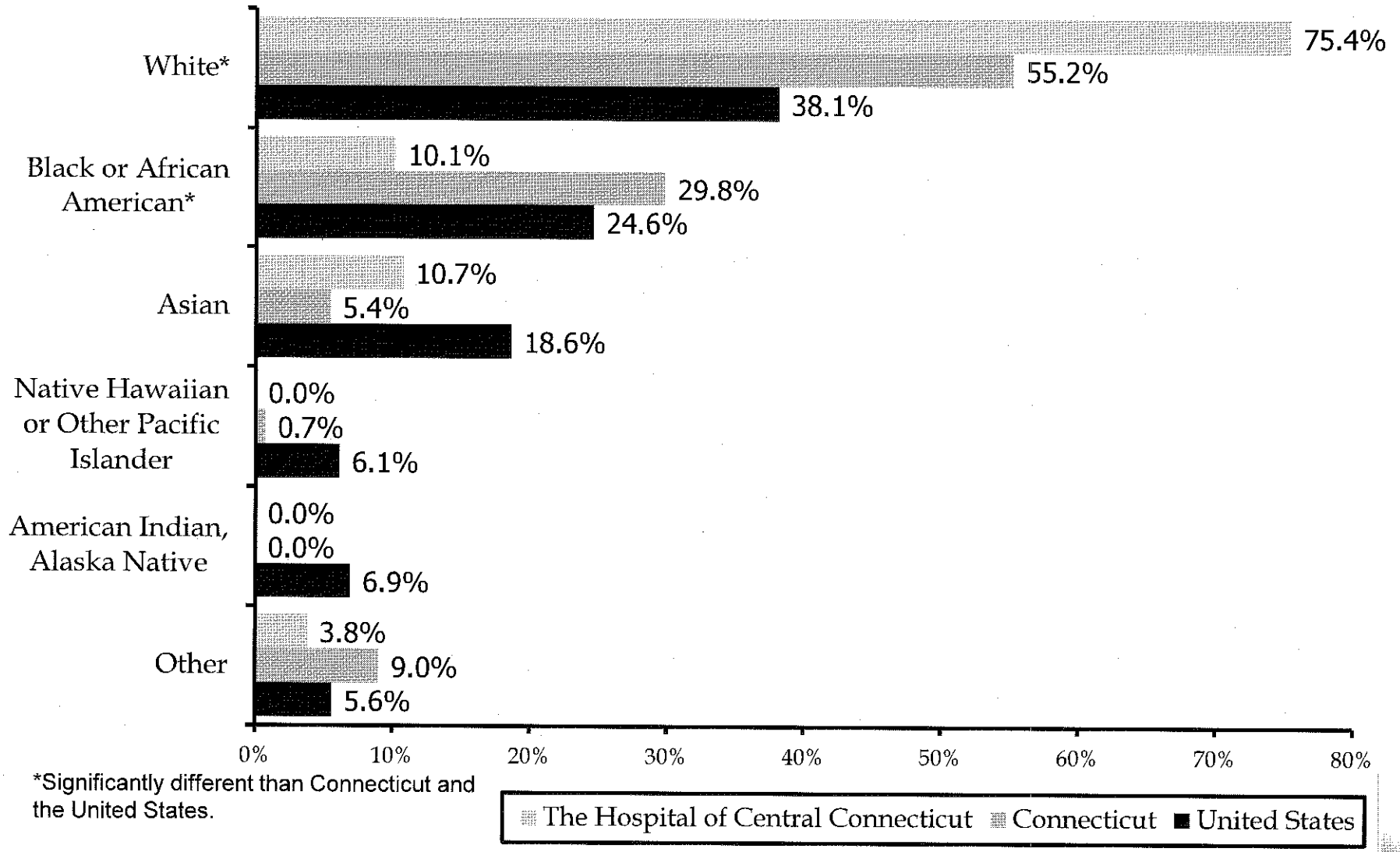


Is the child Hispanic or Latino?



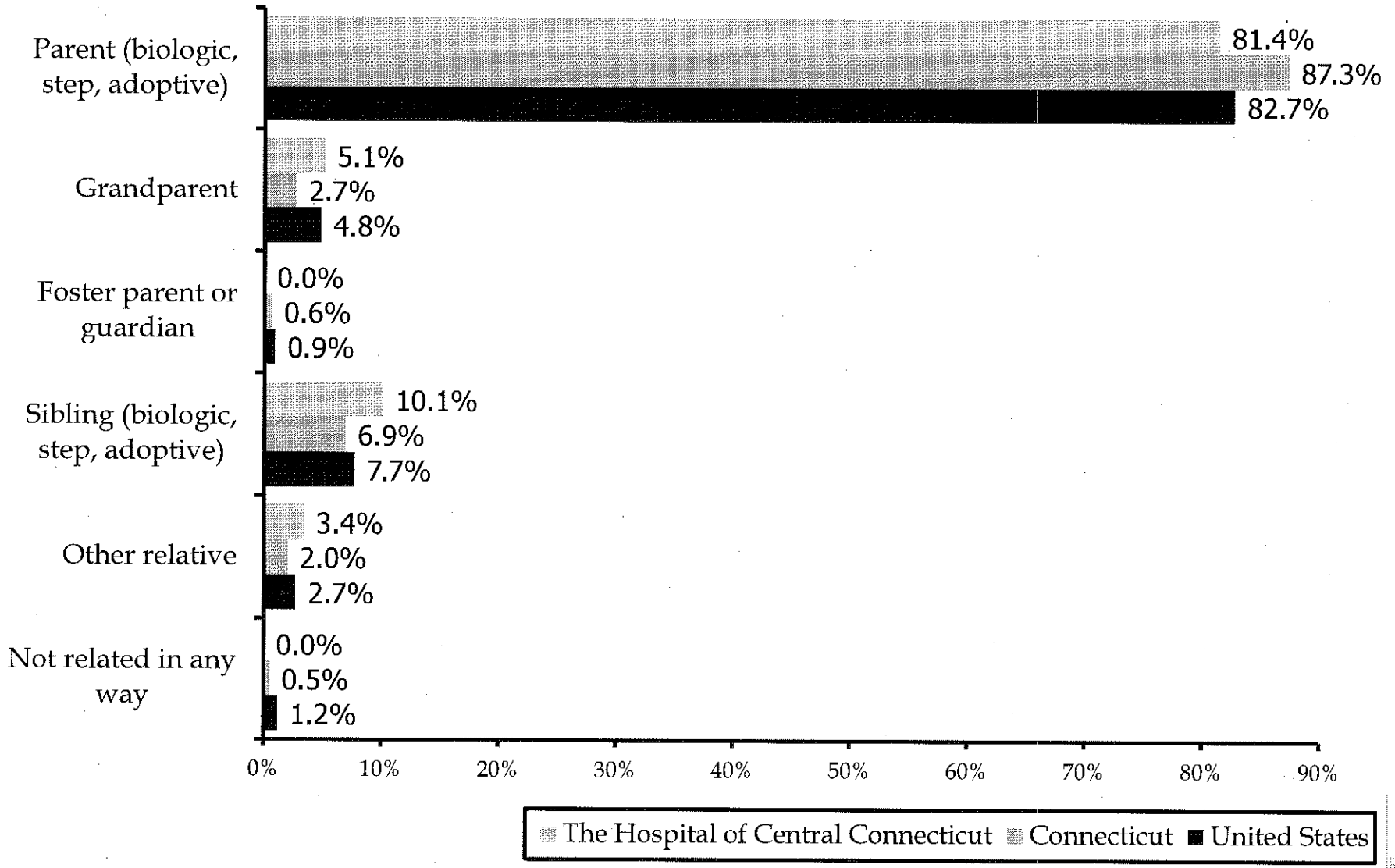
Which one of these groups would you say best represents the child's race?

Respondents who reported more than one race for their child

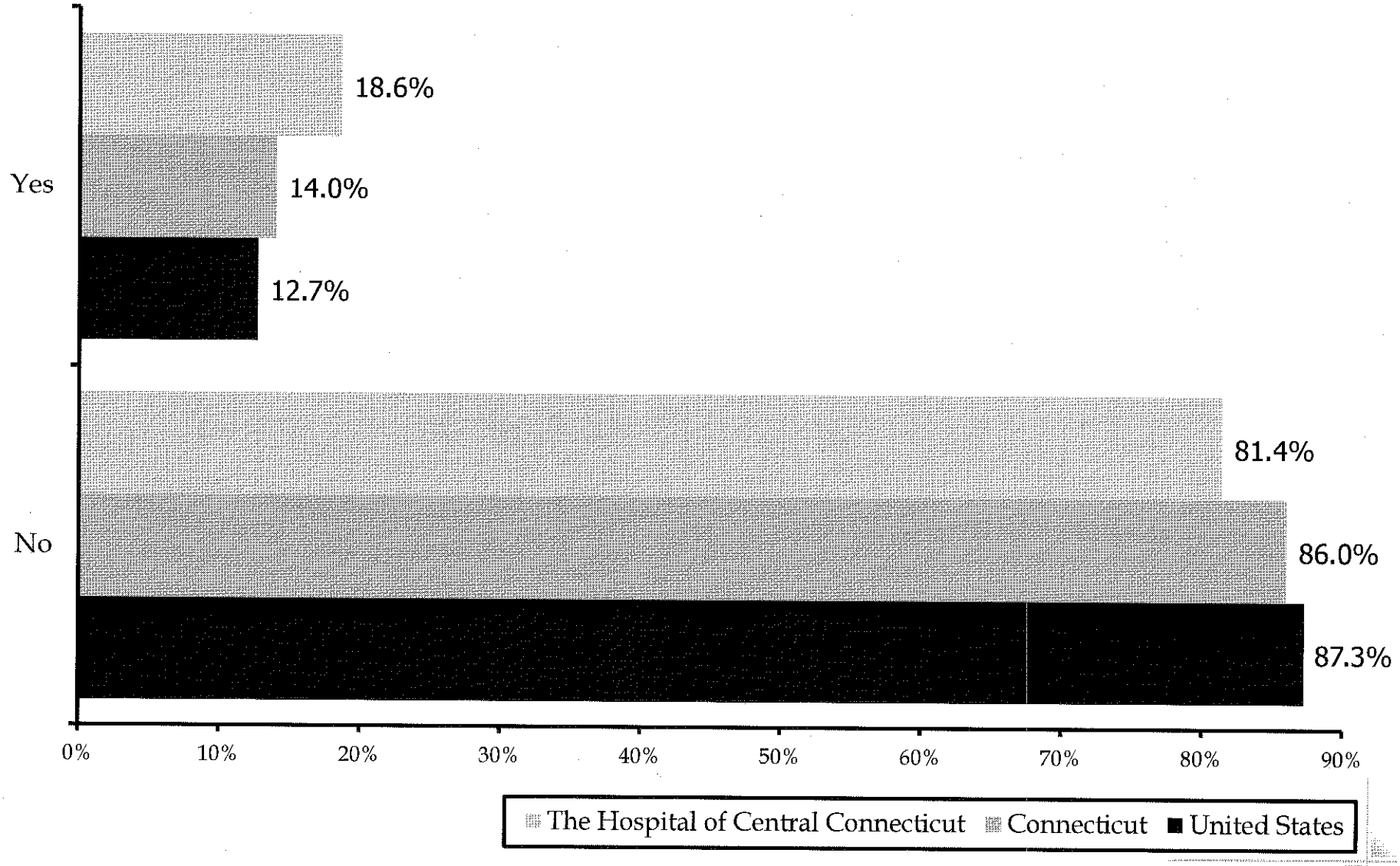


*Significantly different than Connecticut and the United States.

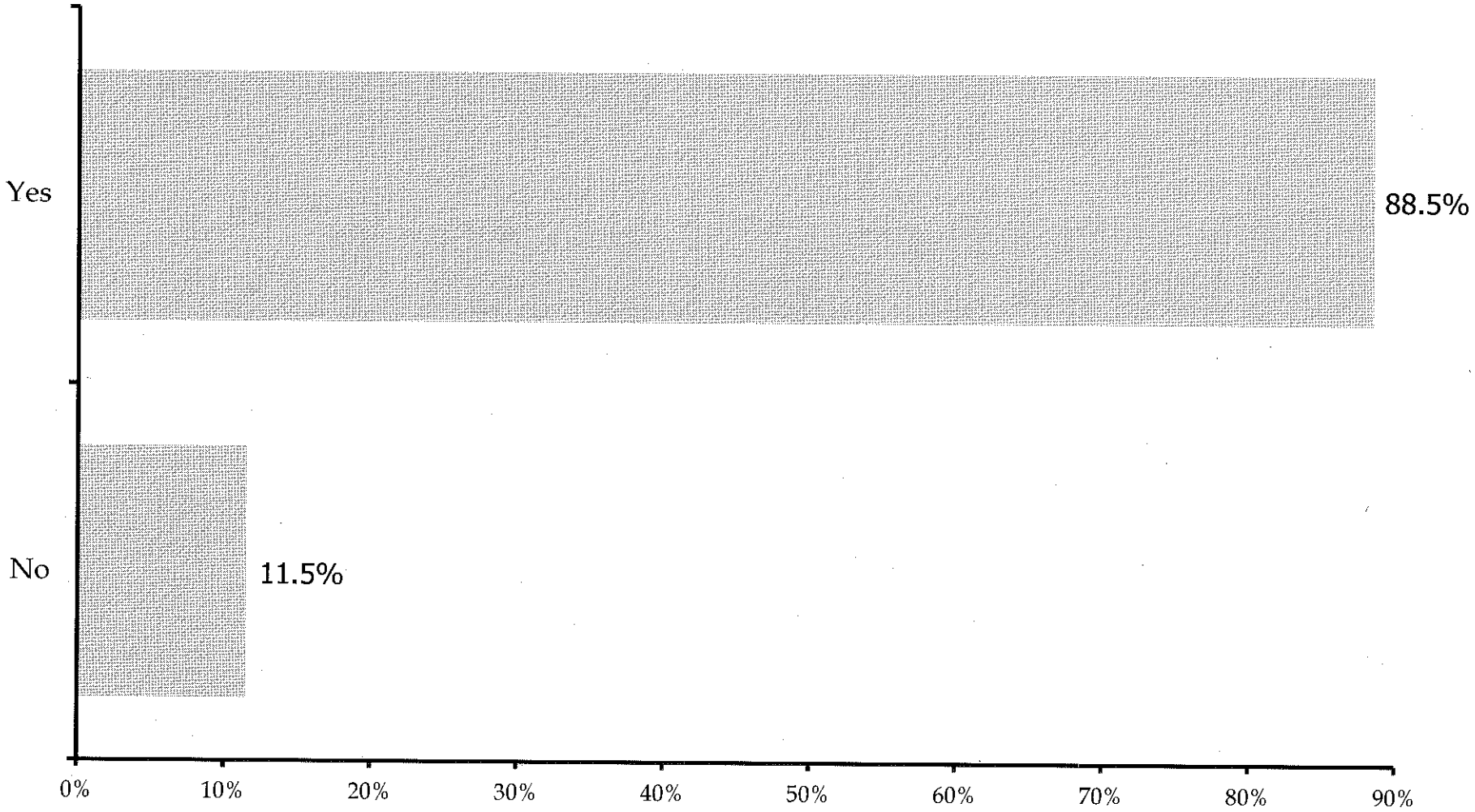
How are you related to the child?



Has a doctor, nurse, or other health professional ever said that the child has asthma?



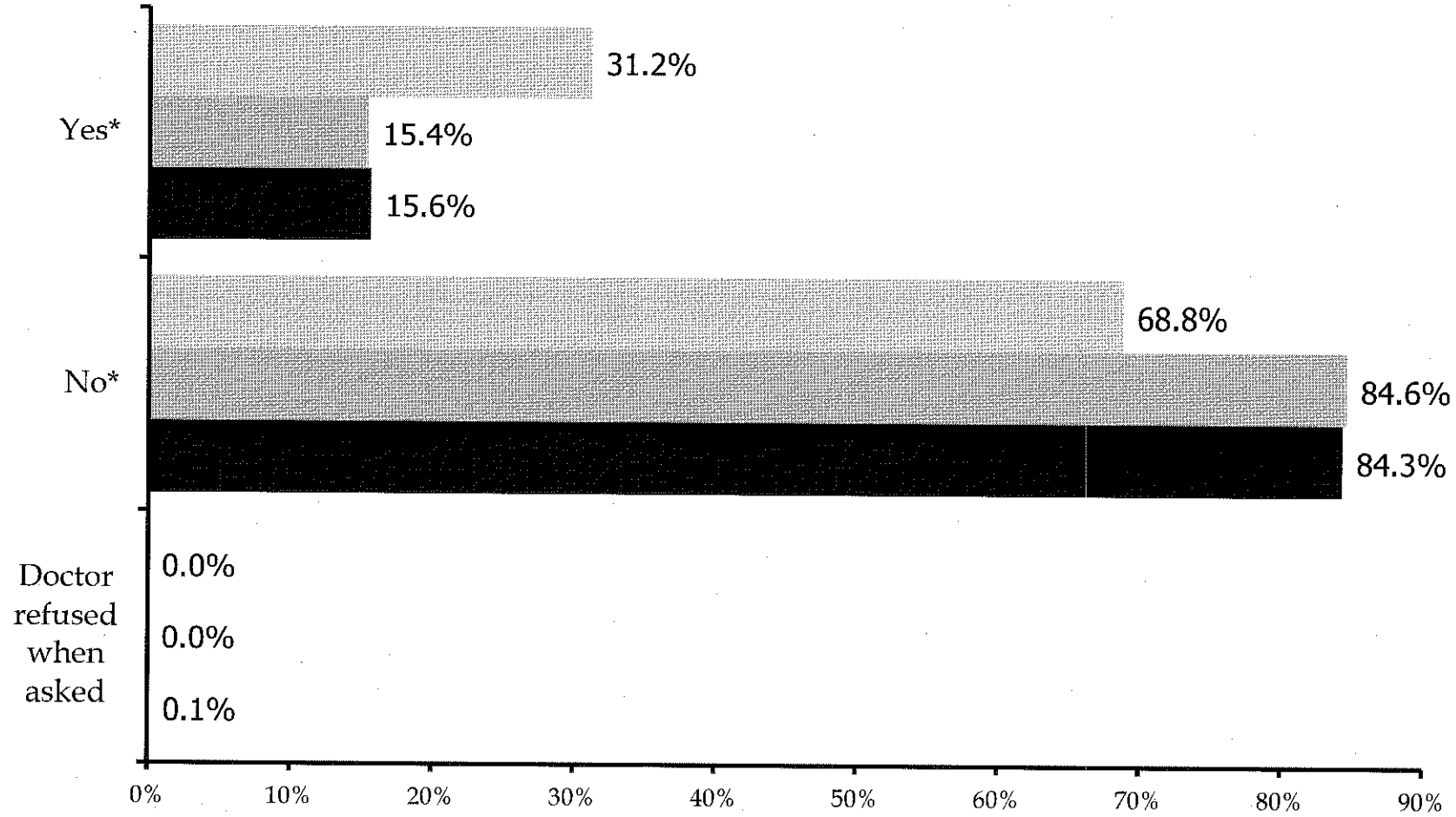
In the past 12 months, has that child seen a dental provider?*



*Custom Question: Comparisons for Connecticut and United States not available.

Has this child ever had an HPV vaccination?

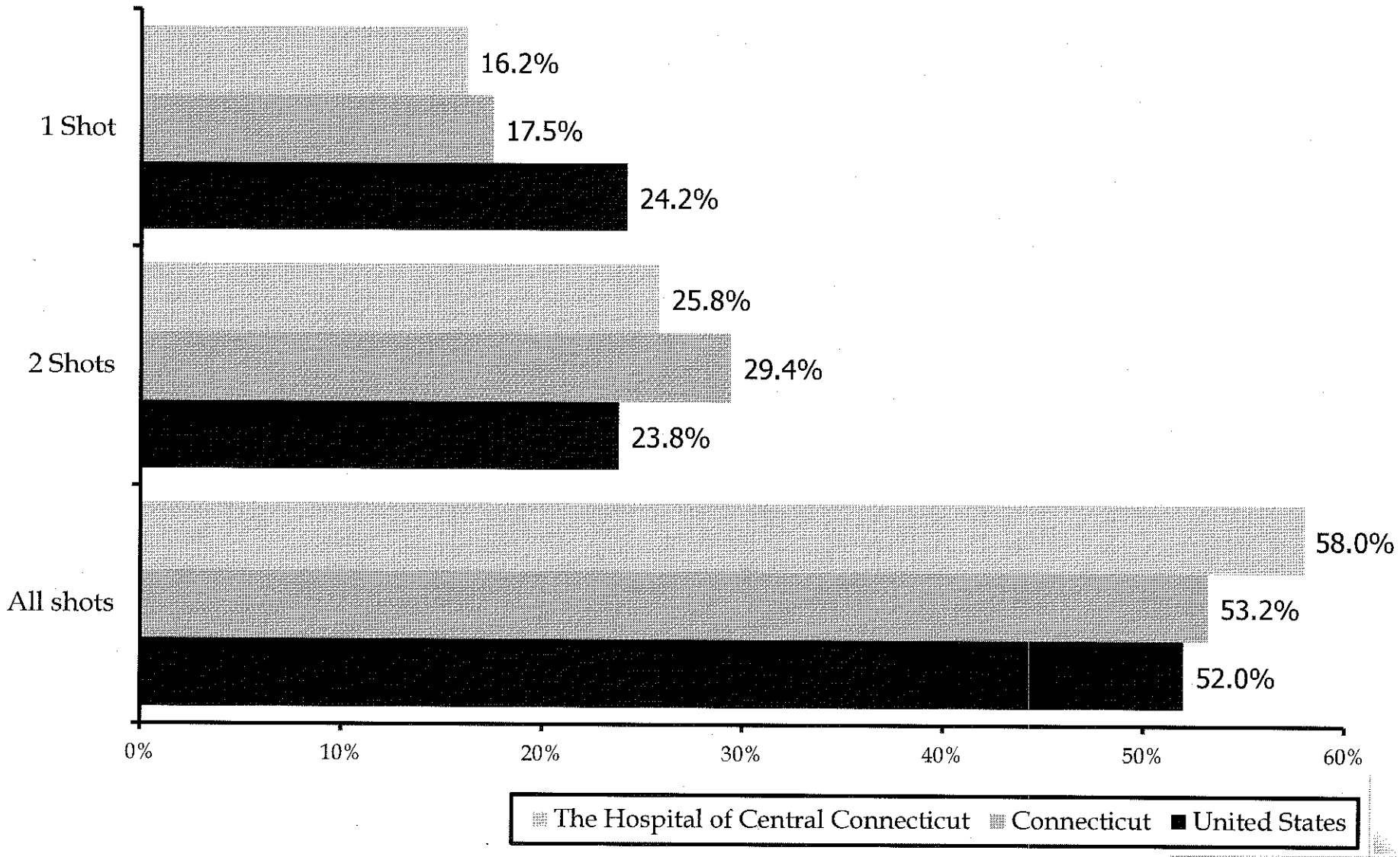
Only asked of respondents with children 9 to 17 years old



*Significantly different than Connecticut and the United States.

The Hospital of Central Connecticut

How many HPV shots did he/she receive?



Community Health Care Needs Assessment Quantitative Research

The Windham Consortium
September 2011

Statement of Confidentiality and Ownership

All of the analyses, findings and recommendations contained within this report are the exclusive property of The Windham Consortium. The Consortium membership includes: United Services, Windham Hospital, Day Kimball Hospital, Natchaug Hospital, Generations Family Health Center, VNA East, Northeast District Department of Health and Community Health Resources.

As required by the Code of Ethics of the National Council on Public Polls and the United States Privacy Act of 1974, The Center for Research and Public Policy maintains the anonymity of respondents to surveys and participants in focus groups the firm conducts. No information will be released that might, in any way, reveal the identity of the respondent.

Moreover, no information regarding these findings will be released without the written consent of an authorized representative of the Windham Consortium.

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1 INTRODUCTION

The Center for Research & Public Policy (CRPP) is pleased to present the results of a Community Health Assessment conducted among residents of Windham County, Connecticut.

The Community Health Assessment was designed to provide resident input on current health status and needs.

The Health Assessment included a comprehensive telephone survey.

Telephone interviews (630) were conducted among residents of the 15 municipalities served.

This report summarizes information collected from residential surveys conducted on September 9 – 19, 2011.

The survey instrument employed in the Community Health Assessment included the following areas for investigation:

- Health Care Access;
- Exercise;
- Dental Care;
- Cardiovascular Disease;
- Tobacco Use;
- Immunizations;
- Falls;
- Women's Health;
- Prostate Cancer Screening;
- Colorectal Cancer Screening;
- Pre-Diabetes / Diabetes;
- Nutrition;
- Sleep;
- Alcohol Consumption;
- Healthy Days;
- Family Planning;
- Visual / Access to Eye Care;
- Care Giver;
- Veteran's Health;
- BMIs; and
- Demographics.

Section II of this report discusses the Methodology used in the study, while Section III includes Highlights derived from an analysis of the quantitative research. Section IV is a Summary of Findings for the residential telephone surveys - a narrative account of the data.

Section V is an Appendix to the report containing cross-tabulation tables and the survey instrument.

METHODOLOGY

Residential Telephone Survey

Using a quantitative research design, CRPP completed 630 interviews among residents of Windham County in Connecticut.

All telephone interviews were conducted September 9 – 19, 2011. Residents were contacted between 5:00 p.m. and 9:00 p.m. weekdays and 10:00 a.m. and 4:00 p.m. on the weekend.

Survey input and approval was provided by Consortium officials.

Survey design at CRPP is a careful, deliberative process to ensure fair, objective and balanced surveys. Staff members, with years of survey design experience, edit out any bias. Further, all scales used by CRPP (either numeric, such as one through ten, or wording such as strongly agree, somewhat agree, somewhat disagree, or strongly agree) are evenly balanced. And, placement of questions is carefully accomplished so that order has minimal impact.

All population-based surveys conducted by CRPP are proportional to population contributions within states, towns, and known census tract, group blocks and blocks. This distribution ensures truly representative results without significant under or over representation of various geographic or demographic groups within a sampling frame.

CRPP utilized a "super random digit" sampling procedure, which derives a working telephone sample of both listed and unlisted telephone numbers. This method of sample selection eliminates any bias toward only-listed telephone numbers. Additionally, this process allows randomization of numbers which equalizes the probability of qualified respondents being included in the sampling frame. Cell phone respondents were included in the sampling process and represented 4.0% of the total sample.

Respondents qualified for the survey if they confirmed they were at least 18 years of age and were current residents of one of the qualifying communities.

Training of telephone researchers and pre-test of the survey instrument occurred on September 7, 2011.

All facets of the study were completed by CRPP's senior staff and researchers. These aspects include: survey design, pre-test, computer programming, fielding, coding, editing, data entry, verification, validation and logic checks, computer analysis, analysis, and report writing.

Completion rates are a critical aspect of any telephone survey research. Because one group of people might be easier to reach than another group, it is important that concentrated efforts are made to reach all groups to an equal degree. A high completion rate means that a high percentage of the respondents within the original sample were actually contacted, and the resulting sample is not biased toward one potential audience. CRPP maintained a **70%** completion rate on all calls made. And, a high completion rate, many times, indicates an interest in the topic.

Statistically, a sample of 630 surveys represents a margin for error of +/-4.0% at a 95% confidence level.

In theory, a sample of all Windham County residents will differ no more than +/-4.0% than if all region residents were contacted and included in the survey. That is, if random probability sampling procedures were reiterated over and over again, sample results may be expected to approximate the large population values within plus or minus 4.0% -- 95 out of 100 times.

Readers of this report should note that any survey is analogous to a snapshot in time and results are only reflective of the time period in which the survey was undertaken. Should concerted public relations or information campaigns be undertaken during or shortly after the fielding of the survey, the results contained herein may be expected to change and should be, therefore, carefully interpreted and extrapolated.

Furthermore, it is important to note that all surveys contain some component of "sampling error". Error that is attributable to systematic bias has been significantly reduced by utilizing strict random probability procedures. This sample was strictly random in that selection of each potential respondent was an independent event, based on known probabilities.

Each qualified household within Windham County had an equal chance for participating in the study. Statistical random error, however, can never be eliminated but may be significantly reduced by increasing sample size.

HIGHLIGHTS

ON HEALTH CARE ACCESS…

- A large majority of residential respondents, 89.0%, indicated they have some form of health care coverage including health insurance, prepaid plans such as HMOs or government plans such as Medicare. However, 10.5% suggested they do not currently have any health care coverage. Extrapolated on the total Windham County population – the number of those without insurance may be 12,240. Statewide 2010 BRFSS (CDC's Behavioral Risk Factor Surveillance Survey) results indicate 90.2% have coverage while 9.8% do not.

- Among those with health care coverage, 56.0% said their coverage is provided by their employer or someone else's employer. Others mentioned a self-purchased plan, Medicare, Medicaid or the U.S. Military's plan – 8.4, 24.6, 2.3, 2.3 respectively.

- While 11.3% indicated they do not have one or more individuals they consider their personal doctor or health care provider, 88.3% suggested they have one person (81.0%) or more than one person (7.3%).

- And, while 87.5% indicated there was not a time over the past 12 months when they needed to see a doctor but could not because of cost, 12.2% suggested there was. Extrapolated on the total population, the number would be 14,448.

- Just over three-quarters, 76.8%, said they have visited a doctor for a routine checkup within the past year.

ON EXERCISE…

- A majority of respondents, 78.6% said they do moderate or vigorous physical activity in a usual week that causes small to large increases in breathing. Another 21.6% suggested they do not. Statewide 2010 BRFSS data show that 79.3% suggested they do any physical activities.

- When doing moderate or vigorous physical activity, respondents reported doing so for an average of 69.99 minutes.

ON DENTAL CARE…

- A strong majority, 72.1%, reported they have visited a dentist or dental clinic within the past year. Another 9.7% said their last visit was within the past two years while 5.4% suggested the last visit was within the past five years. Some, 12.1% suggested their last visit was five or more years ago. Statewide 2008 BRFSS data suggested 80.3% had visited a dentist or dental clinic over the most recent 12-month period.

ON CARDIOVASCULAR DISEASE…

- Researchers found that 4.3%, 2.7% and 0.5% of respondents have been told they have had a heart attack, stroke, or both a heart attack and a stroke, respectively.

- Statewide 2010 BRFSS data show results of 3.1 and 1.7 for heart attack and a stroke, respectively.

- While 91.9% suggested they have not been told they have had angina, congestive heart failure or coronary heart disease, 7.8% said they have.

ON TOBACCO USE…

- The Windham Consortium 2011 research found that 16.8% of all respondents are currently smoking everyday (12.2%) or some days (4.6%). Statewide 2010 BRFSS data show 13.2% of the adult respondents currently smoke.

- More than half , 58.5%, of current smokers said they stopped smoking for one day or longer over the past 12 months in an effort to quit smoking.

ON IMMUNIZATIONS…

- Under half of all respondents, 42.1%, said they had a flu shot since August, 2010. Among respondents over 65 years of age, 57.9% indicated they have had a flu shot since August of 2010. Statewide 2010 BRFSS data indicated that 72.4% had received a flu shot since August of 2010.

- Nearly three-quarters of respondents 65 years of age or older, 73.6%%, suggested they have had a pneumonia shot or pneumococcal vaccine. Statewide 2010 BRFSS data indicate 69.2% of those 65 years of age or older had the shot or vaccine at some point.

ON FALLS...

- Respondents 45 years of age and older were asked how many, if any, falls they have experienced over the past three months. Nearly one fifth, 17.1%, suggested they had experienced a fall. On average, across all respondents 45 and older, the average number of falls over the three month period was 0.67.

- Of this group that had at least one fall, 49.3% experienced one fall while the remainder experienced multiple falls.

- And, among those who had fallen, 44.0% (N=33), suggested their fall(s) did result in an injury. The average number of falls causing injuries was 1.88.

ON WOMEN'S HEALTH...

- A majority of all women surveyed, 87.3%, reported they have had, at some point, a mammogram. Among women surveyed over 40 years of age, the percent is 96.4% while among those over 50 years of age the percent is 98.6%. Statewide 2010 BRFSS data show that 81.4% of Connecticut women over 40 years of age have had a mammogram, and 83.8% of those over 50 years of age have had a mammogram.

- 93.0% of all women surveyed reported they have had a clinical breast exam.

- Another 95.9% of all women stated they have had a Pap test. Statewide 2010 BFRSS data show 85.6% of Connecticut women had a Pap test.

ON PROSTATE SCREENING...

- Males 39 years of age or older were asked if they have ever had a PSA test. Just over half, 58.0% suggested they had. Similarly, statewide 2010 BRFSS data show that 59.8% had a PSA test.

- Three quarters of all respondents, 80.9%, suggested they have had, at some point, a digital rectal exam. Another 18.7% had not and 0.4% were unsure.

ON COLORECTAL CANCER SCREENING...

- Over one-third, 37.9%, of survey respondents 49 years of age or older said they have had, at some point, a blood stool test using a home kit. Statewide 2010 BRFSS data show that 18.7% reported the same.

- Three-quarters, 75.7%, of respondents 49 years of age or older suggested they have had a sigmoidoscopy or colonoscopy exam. Statewide 2010 BRFSS data show that 75.7% reported they have had one of the two exams.

ON PRE-DIABETES / DIABETES...

- Nearly two-thirds, 64.6%, of all respondents indicated they have had a test for high blood sugar or diabetes within the last three years. About one-third, 33.2%, suggested they had not and 2.2% were unsure.

- Just under twenty percent (16.2%) of all respondents said they have been told by a doctor, nurse or other health care professional that they have pre-diabetes, diabetes, diabetes during pregnancy or are borderline diabetes. Statewide 2010 BRFSS data show that 8.9% were told they had diabetes (7.3%), diabetes during pregnancy (0.8%), or were pre-diabetes / borderline (0.8%).

- The average age respondents were told they had diabetes was 47.12.

- Nearly half of those with diabetes, 42.0%, said they have taken a course or class in how to manage their diabetes themselves.

- Just over two-fifths with diabetes (43.8%) knew their percent resulting from a test for "A one C".

ON NUTRITION...

- On average, respondents are eating 2.32 servings of vegetables and 1.93 servings of fruit daily. The USDA recommends four to five servings of vegetables and two servings of fruits daily.

ON SLEEP…

- A large number of respondents, 69.8%, indicated there were days over the past 30 days that they did not get enough rest or sleep. Among this group, the average number of days during the month they felt they did not get enough rest or sleep was 13.73.

ON ALCOHOL CONSUMPTION…

- Just over half of all respondents, 56.3% suggested they have had at least one drink of alcohol over the past 30 days. Of this group, the average number of days, over the past month, the respondent had at least one drink was 8.71.

- When respondents did drink, the average number of alcoholic drinks consumed was 2.61.

ON HEALTH DAYS…

- One-third of all respondents, 32.9%, suggested there were days over the last month that pain made it hard to perform their usual activities. Of this group, the average number of days per month when pain prevented usual activities was 15.69.

- A larger percentage, 38.9%, suggested that there were days over the last month when they felt sad, blue or depressed. On average, there were 9.48 days each month when this group had sad or depressed feelings.

- While 96.2% suggested there was not a time over the last year when they thought of taking their own life, 3.3% suggested there was. When extrapolated on the total Windham County population, the number of individuals is approximately, 3908.

ON FAMILY PLANNING…

- Just under half of all respondents, 46.3%, indicated they are taking one or more precautions to keep themselves or their partner from getting pregnant.

- Mostly, respondents cited the following actions used to keep from becoming pregnant: vasectomy (30.2%), tubes tied (17.5%), birth control pills (12.7%), male condoms (12.7%), IUD (5.6%) and female condoms (4.8%).

ON VISUAL / ACCESS TO EYE CARE…

- Just less than two-thirds (60.4%) reported having their eyes examined over the last year. Some, 14.9%, said they had an exam within the last two years while 21.7% said it's been two or more years. A few, 1.1% said they have never had an eye exam.

- Reasons for not having an eye exam or having a more recent exam included: cost of insurance and no reason to go or no problems.

ON CARE GIVERS…

- A large percent of respondents, 31.1%, suggested they are providing regular care or assistance to a friend or family member who has a health problem, long-term illness or disability.

- The average age of the person in care is 68.97.

ON VETERAN'S HEALTH…

- Researchers found that 5.9% of those surveyed did serve in the U.S. Military in a combat or war zone.

- Of this group, 18.9% have been told by a doctor or health professional that they have depression, anxiety or post traumatic stress disorder (PTSD). Of this group, 85.7% have secured psychological or psychiatric counseling or treatment.

ON BMIS…

- CRPP calculated BMIs for each of the respondents who provided researchers both their weight and height. The following table presents the results. The district average was 28.28. Statewide 2010 BRFSS data show 23.0% as obese, 37.8% as overweight and 39.4% either normal or underweight.

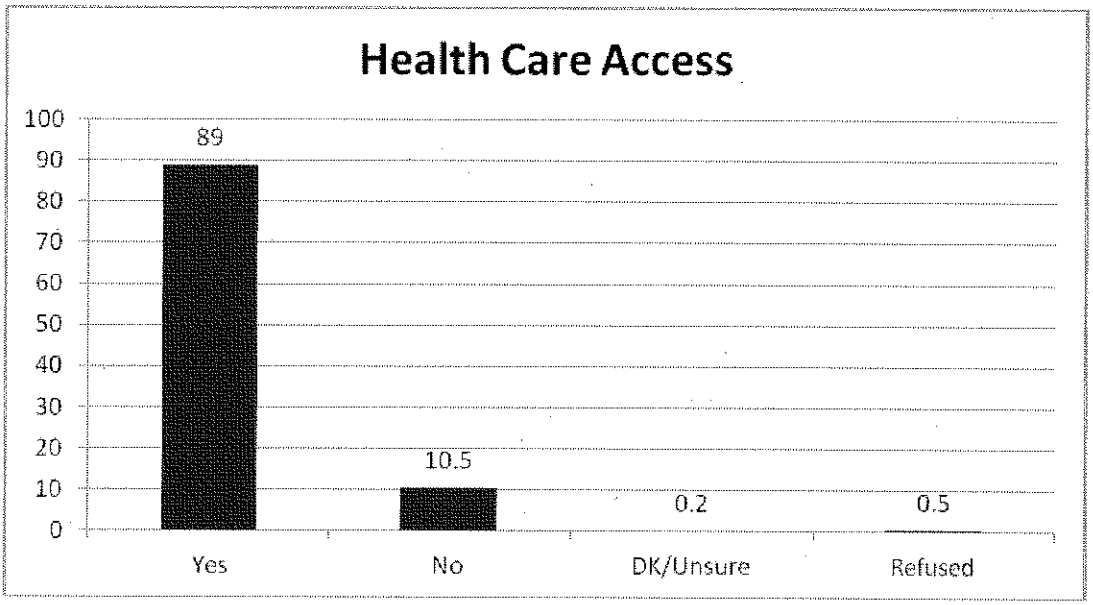
BMI Calculations	Percent
Underweight: <18	4.1
Normal: 18.5 – 24.9	28.1
Overweight: 25 – 29.9	36.9
Obese: 30.0 – 39.9	25.7
Extreme Obesity: 40.0+	5.2
Average District BMI	28.28

SUMMARY OF FINDINGS

Readers are reminded that the following section summarizes statistics collected from the telephone survey of 630 residents within Windham County.

HEALTH CARE ACCESS

All respondents were asked if they have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare. A majority, 89.0% indicated they do have coverage as presented in the following graph.



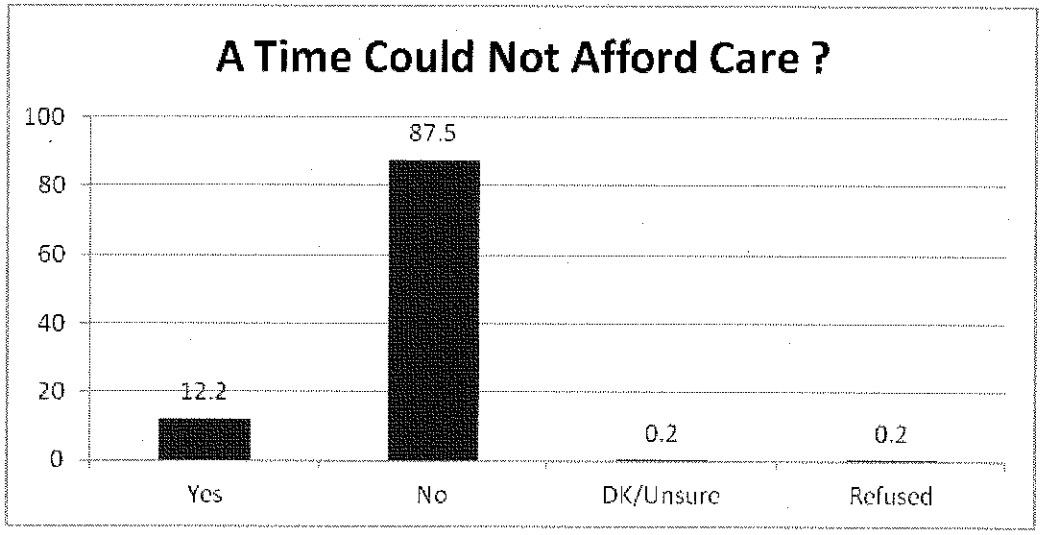
Respondents who reported having health care coverage, 89.0%, were asked to report the type of coverage they use to pay for most of their medical care. The following table presents the results as collected.

Type of Health Care Coverage?	Percent
Employer	41.5
Someone else's employer	14.5
A plan that you or someone else buys on your own	8.4
Medicare	24.6
Medicaid or Medical Assistance	2.3
The military, CHAMPUS, TriCare or the VA	2.3
Some other source	6.3

All respondents were asked if they have one or more individuals they think of as their personal doctor or health care provider. Nearly ninety percent, 88.3%, indicated they have one (81.0%) or more than one (7.3%) provider. Some, 11.3% said they did not have one or more individuals they consider their personal doctor or health care provider.

Have One or More Health Care Provider or Personal Doctor?	Percent
Yes, one	81.0
Yes, more than one	7.3
No	11.3

Researchers asked all respondents if there was a time, over the last 12 months, when they needed to see a doctor but could not because of the cost. While 87.5% suggested there was not, 12.5% said there was such a time. The following graph presents the results as collected.



All respondents were asked to report how long it has been since they last visited a doctor for a routine checkup – a general physical exam – not including an exam for a specific injury, illness or condition.

The following table presents the results as collected.

How Long Since Last Routine Checkup?	Percent
Within past year	76.8
Within the past two years	11.6
Within past five years	5.2
Five or more years	5.1

EXERCISE

A majority of respondents, 78.6%, indicated that when they are not working, they do moderate or vigorous physical activity in a usual week that causes small increases in breathing and heart rate such as brisk walking, biking, vacuuming or yard work. Another 21.6% suggested they do not while 0.3% were unsure.

Respondents who do moderate and vigorous physical activity were asked how many minutes they keep at it when exercising. The following table presents the results. "Don't know" respondents were removed from the data.

How Long, In Minutes, You Exercise?	Moderate or Vigorous Physical Activity
<20 Minutes	14.6
20 - <30 Minutes	9.7
30 - <45 Minutes	29.3
45 - <60 Minutes	6.3
60 - <90 Minutes	18.8
90 Minutes or more	21.0

On average, respondents exercised (either moderate or vigorous) 69.99 minutes when participating in their respective physical activity.

DENTAL CARE

Researchers asked respondents to report how long it has been since they last visited a dentist or dental clinic for any reason including visits to dental specialists such as orthodontists. The following table presents the results as collected.

How Long Since Last Dental Visit?	Percent
Within past year	72.1
Within the past two years	9.7
Within past five years	5.4
Five or more years	12.1

Respondents were asked how long it has been since they last had their teeth cleaned by a dentist or dental hygienist. The following table presents the results.

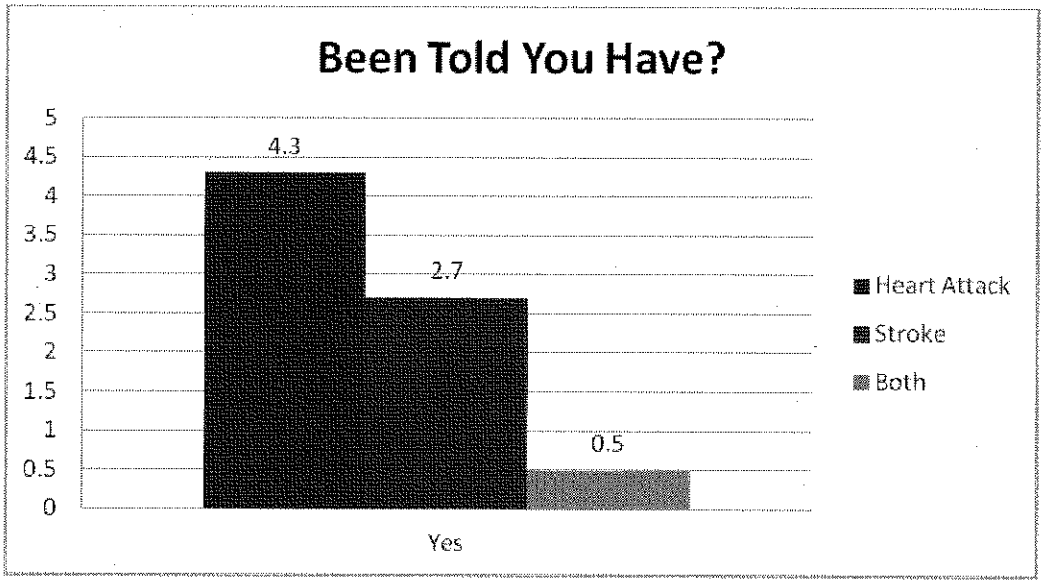
How Long Since Last Teeth Cleaning?	Percent
Within past year	70.7
Within the past two years	8.4
Within past five years	5.9
Five or more years	11.8
Not sure	1.0
Never	2.1

CARDIOVASCULAR DISEASE

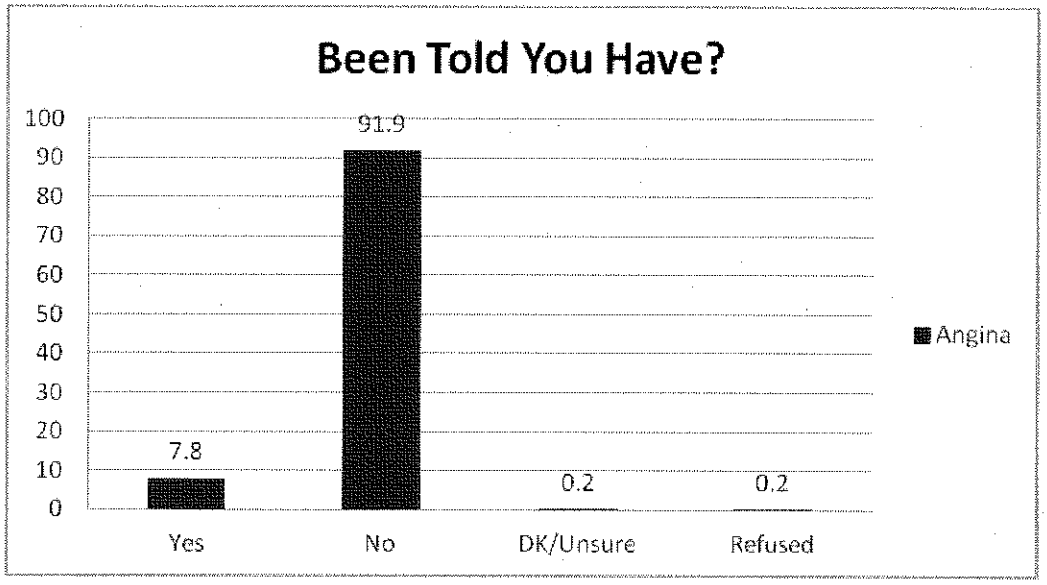
Respondents were asked if they have ever been told by a doctor, nurse or other health professional that they have had:

- A heart attack or myocardial infarction;
- A stroke;
- Both a heart attack and a stroke.

The following graph presents the results as collected.



All respondents were asked if they have ever been told if they had angina, congestive heart failure or coronary heart disease. While 91.9% suggested they had not, 7.8 said they have. The following graph depicts the results as collected.

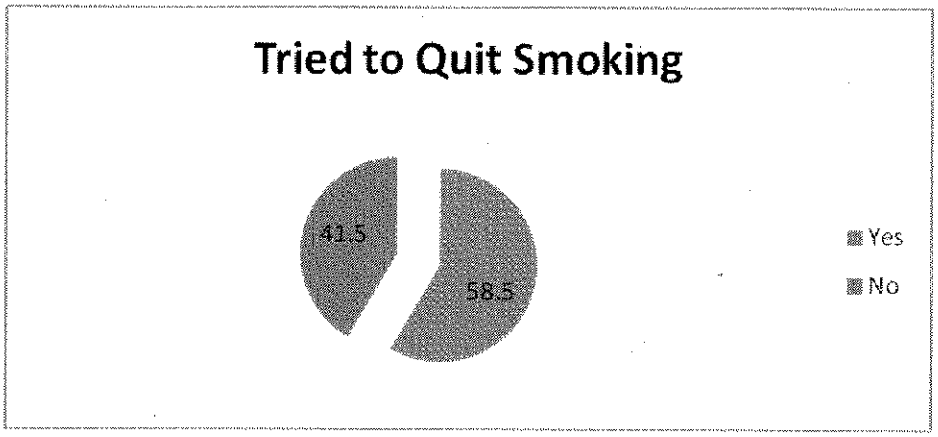


TOBACCO USE

Researchers asked respondents if they smoke cigarettes every day, some days, or not at all. While most, 83.0% indicated they do not smoke, another 16.8% suggested they smoked everyday (12.2%) or some days (4.6%).

Do You Smoke?	Percent
Everyday	12.2
Some days	4.6
Not at all	83.0
Refused	0.2
TOTAL SMOKE	16.8

Among smokers, over half (58.5%) said they have stopped smoking for one day or longer over the last 12 months because they were trying to quit smoking. The following presents the results.



IMMUNIZATIONS

Under half of all respondents, 42.1%, indicated they have received an injected influenza vaccine since August, 2010. Another 57.5% had not received the flu shot.

Among respondents over 65 years of age, 57.9% suggested they have received an injected influenza vaccine since August, 2010.

Respondents who received the influenza vaccine (42.1%) were asked who gave them their most recent flu shot. The following table presents the results collected.

Who Provided the Flu Shot?	Percent
Doctor/Doctor's Office	54.7
Other	17.0
Pharmacy	11.7
Hospital	7.2
Visiting Nurse Association (VNA)	4.9
Supermarket Pharmacy	4.5

Respondents over 65 years of age were asked if they have ever had a pneumonia shot. Nearly three-quarters, 73.6%, indicated they have. The following table depicts the results.

Ever Receive a Pneumonia Shot?	Percent
Yes	73.6
No	22.6
Don't know / Unsure	3.8

FALLS

Respondents, over 45 years of age, were asked if they have fallen over the past three months. Just under one-fifth (17.1%) of those over 45 years of age suggested they have fallen. The average number of falls among all respondents over 45 years of age, over the last 3 months, was 0.67.

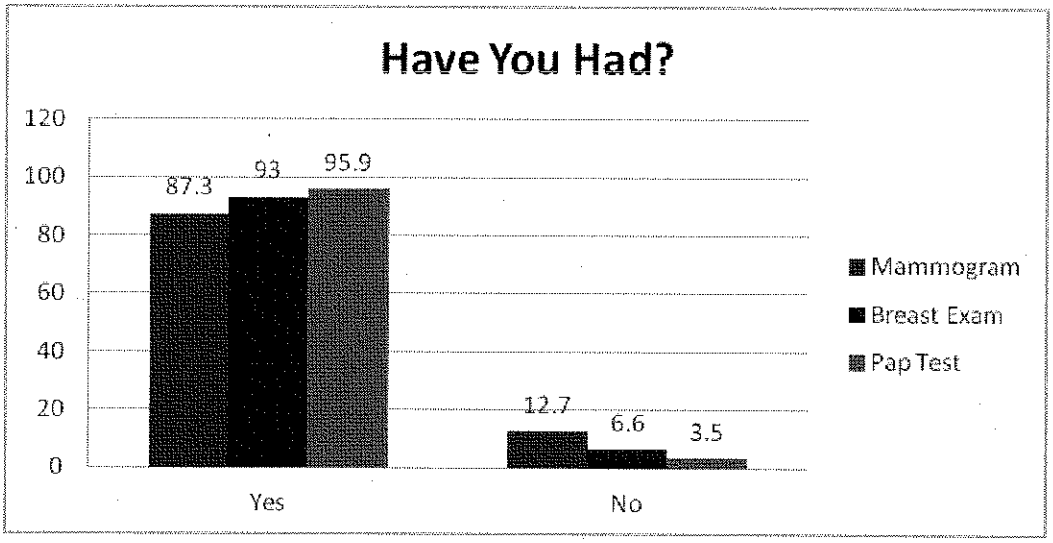
These respondents (17.1%) were asked to report the number of times they had fallen during the three-month period. The following table presents the results as collected.

Number of Falls?	Percent
One	49.3
Two	23.0
Three	160
Four	5.3
Six	2.7
Nine	1.3
Ten	1.3
Fifteen	1.3

A total of 33, or 44.0%, of those who experienced falls reported that the fall(s) caused injuries that limited regular activities for at least a day or caused a visit to the doctor's office. And, the average number of falls causing injuries was 1.88.

WOMEN'S HEALTH

Female respondents were asked if they have ever had a mammogram, a clinical breast exam or a Pap test for cancer of the cervix. The following table presents the results collected.



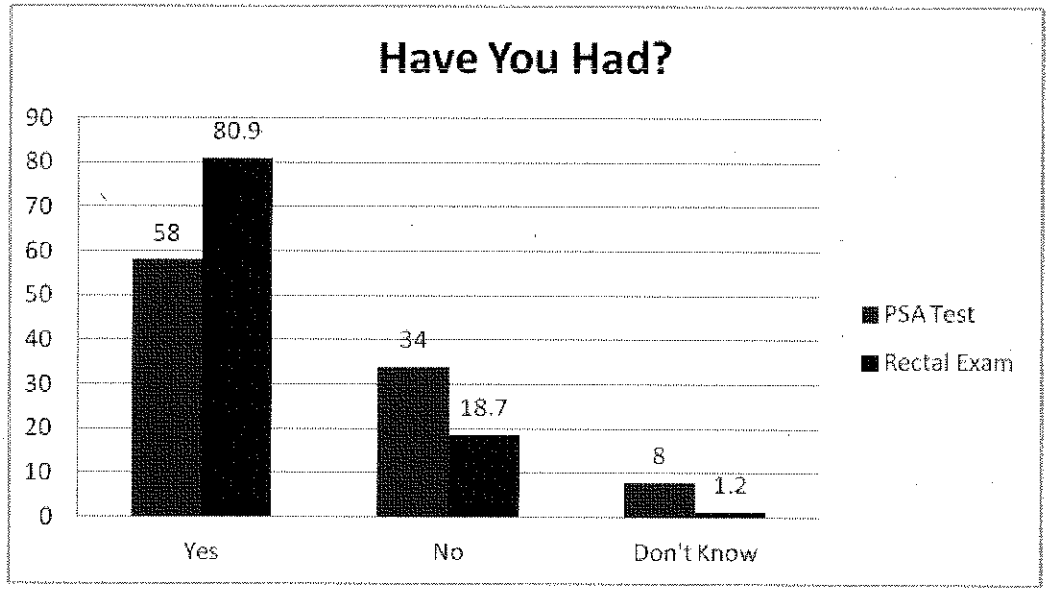
A larger majority of women over 40 years of age (96.4%) reported having had a mammogram. And, 98.6% of women over 50 years of age reported having had a mammogram.

Female respondents who reported having a mammogram, a clinical breast exam or a Pap Test were asked to report how long it has been since the last exam/test. Results are held in the following table.

How Long Since Last ?	Mammogram	Clinical Breast Exam	Pap Test
Within past year	61.2	68.4	47.5
Within the past two years	19.6	16.3	26.5
Within the past three years	7.2	7.5	9.6
Within past five years	3.6	2.4	5.3
Five or more years	8.0	5.1	17.2
Not sure / Don't know	0.4	0.3	---

PROSTATE CANCER SCREENING

Males 39 years of age or older were asked if they have ever had a Prostate-Specific Antigen test (PSA test) or a digital rectal exam. The following graph presents the results.



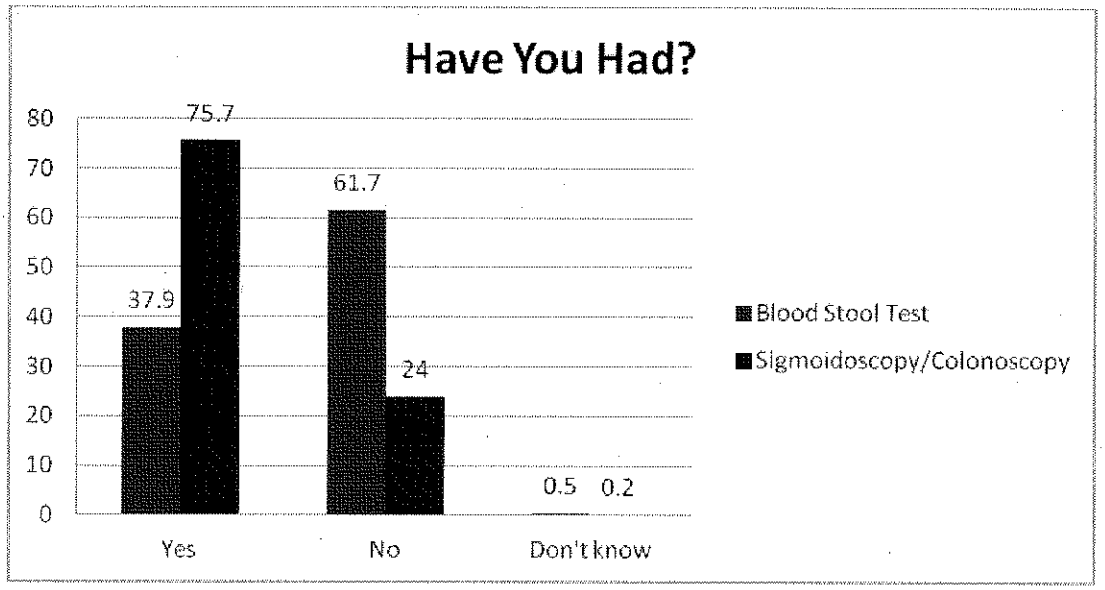
Males who reported having a PSA Test, or digital rectal exam, were asked how long it had been since the last test/exam. The following table holds the results.

How Long Since Last Test/Exam?	PSA Test	Digital Rectal Exam
Within past year	73.0	67.5
Within the past two years	13.2	17.0
Within the past three years	5.3	4.2
Within past 5 years	3.9	2.4
Five or more years	3.3	8.5
Not sure / Don't know	1.3	---
Refused	---	0.5

COLORECTAL CANCER SCREENING

Respondents 49 years of age or older were asked a series of questions about colorectal cancer screening.

Each respondent was asked if they used a home blood stool test kit and if they had either a sigmoidoscopy or colonoscopy exam. Results are presented here.



PRE-DIABETES /DIABETES

Among all respondents, 64.5% indicated they have had a test for high blood sugar or diabetes within the last three years. Another 33.2% have not, and 2.2% were unsure.

Nearly one-fifth of all respondents, 16.2%, indicated that they have been told by a doctor, nurse or other health professional that they have pre-diabetes, borderline diabetes or diabetes.

Researchers asked respondents with diabetes how old they were when they were told they have diabetes. The following table holds the results. The average age was 47.12.

Age Told You Have Diabetes?	Percent
Under 40 years of age	27.0
40 to <50 years of age	23.3
50 to <60 years of age	27.8
60 years of age or older	16.2

Three-quarters of respondents with diabetes, 73.2%, said they have seen a doctor, nurse or other health professional for their diabetes in the past 12 months. Of this group, the frequency of visits is reported within the following table.

Frequency of Medical Visits for Care of Diabetes Over Past 12 Months	Percent
One time	19.5
Two times	20.7
Three times	9.5
Four times	23.2
Six times	4.9
Seven times	1.2
Eight times	3.7
Nine times	1.2
Twelve times	3.7
Twenty-four times	1.2

Researchers asked respondents with diabetes to report whether, as a result of a test for "A One C", if they knew their own percent.

Know Your Percent?	Percent
Yes	43.9
No	48.2
Never heard of "A One C"	0.9
Don't Know / Unsure	7.1

Just over two-fifths of all those respondents with diabetes, 42.0%, indicated they have taken a class or course to help them learn to manage their diabetes.

NUTRITION

Respondents were asked to report the number of daily services of vegetables and fruit they consume.

On average, the number of servings of vegetables was reported at 2.32.

On average, the number of servings of fruit was reported at 1.93.

USDA recommendation for daily servings for adults: four to five servings of vegetables and two servings of fruits.

SLEEP

A large percent, 69.8%, of all respondents suggested there were days, during the last 30 days, when they felt they did not get enough sleep. The average was 13.73 among this group.

The following table presents the number of days respondents felt they did not get enough sleep.

Number of Days Over Last 30 – You Did Not Get Enough Sleep	Percent
1-7	45.7
8-15	19.1
16-20	6.2
21-30	29.4

ALCOHOL CONSUMPTION

All respondents were asked if they have had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor during the last 30 days.

Just over half, 56.3%, indicated they have had at least one drink over the last 30 days as presented in the following table.

Had a Drink of Alcohol Over 30 Days?	Percent
Yes	56.3
No	43.2
Don't Know / Unsure	0.3
Refused	0.2

On average, respondents had at least one alcoholic beverage 8.71 days over the past 30 days.

On average, respondents had 2.61 drinks on days when they did drink.

HEALTH DAYS

Nearly one-third of all respondents (32.9%) said there was one or more days, during the last 30, that pain made it hard to do usual activities such as self-care, work or recreation.

The number of days, during the last 30, that pain prevented this group from usual activities is presented in the following table. The average number of days was 15.69.

Number of Days Over Last 30 That Pain Prevented Usual Activities Enough Sleep	Percent
1-7	43.0
8-15	11.0
16-20	5.8
21-30	40.1

Over one-third, 38.9%, suggested there were one or more days, during the last 30, that they felt sad, blue or depressed. On average the number of days was 9.48.

The number of days that this group felt sad, blue or depressed is presented here.

Number of Days Over Last 30 Felt Sad, Blue, Depressed	Percent
1-7	64.4
8-15	15.8
16-20	3.3
21-30	16.3

Among all respondents, 3.3%, suggested there has been a time in the past 12 months when they thought of taking their own lives.

FAMILY PLANNING

Females under 45 years of age and males under 60 years of age were asked if they (and their husband/wife/partner) are doing anything to prevent pregnancy. Nearly half, 46.3% of this group (N=272) suggested they were.

The following table presents the results as collected.

Action to Prevent Pregnancy?	Percent
Yes	46.3
No	31.8
No / Partner not sexually active	9.9
Same Sex Partner	1.5
No, had hysterectomy	7.4
No, currently pregnant	0.7
Don't know / Not Sure	0.4
Refused	2.2

Researchers asked this group of respondents (N=126) what they were doing to prevent pregnancy. The following table depicts the results as collected.

Action to Prevent Pregnancy?	Percent
Vasectomy	30.2
Tubes tied	17.5
Birth control pills	12.7
Male condoms	12.7
Other	7.9
IUD	5.6
Female condoms	4.8
Withdrawl	2.4
Shots	1.6
Contraceptive ring	1.6
Diaphragm, cervical cap or sponge	0.8
Don't know / Unsure	0.8
Refused	0.8

VISUAL / ACCESS TO EYE CARE

All respondents were asked to report when they last had their eyes examined by any doctor or eye care provider. Just 1.1% said never. Other time frames are presented in the following table.

How Long Since Last Eye Exam?	Percent
Within past month	19.0
Within the past year	41.4
Within the past two years	14.9
Two or more years ago	21.7
Never	1.1
Not sure / Don't know	1.6
Refused	0.2

Reasons for never having an eye exam included: no reason to go (57.1%), cost/insurance (14.3%), other (14.3%), and some, 14.3% were unsure.

CARE GIVER

Nearly one third of all respondents (31.1%) suggested that they currently provide regular care or assistance to a friend or family member who has a health problem, long-term illness or disability.

This group (N=196) was asked to report the ages of those in care. The following table presents the ages provided by respondents. On average, the age of the person in care was 68.97.

Age of Person in Care	Percent
Birth - 25	7.5
26 - 40	3.5
41 - 60	19.5
60 +	69.5

Researchers asked respondents to report the relationship of the person in care. The following table presents the results as collected.

Relationship of Person in Care	Percent
Parent	40.8
Non-relative	17.3
Spouse	12.8
Parent-in-law	7.1
Child	6.6
Sibling	6.6
Other relative	5.6
Grandparent	2.6
Grandchild	0.5

VETERAN'S HEALTH

Respondents found that 5.9% of all respondents had served with the U.S. Military in a combat or war zone. Of this group, 18.9% (N=7) suggested they have been told by a doctor or health professional that they had depression, anxiety or post traumatic stress disorder (PTSD).

While 14.3% of this group did not receive any psychological or psychiatric counseling or treatment, the majority did.

Researchers asked where care was provided. Results are held in the following table.

Where Care Was Provided	Percent
Yes, from a VA facility	57.1
Yes, from a non-VA facility	14.3
Yes, from both	14.3
No care secured	14.3

BMI CALCULATIONS

CRPP calculated BMIs for all respondents who provided both height and weight. The average overall district average is 28.28 – an average that is considered "overweight".

The following table holds the percentages for each BMI category.

BMI Calculations	2011
Underweight: <18	4.1
Normal: 18.5 – 24.9	28.1
Overweight: 25 – 29.9	36.9
Obese: 30.0 – 39.9	25.7
Extremely Obese: 40.0+	5.2
Average District BMI	28.28

DEMOGRAPHICS

Age	2011
Next Generation (18-25)	2.9
Generation X (26-40)	12.8
Boom Generation (41-60)	54.5
Seniors (60 +)	29.1

Education	2011
Never attended school / or Kindergarten	0.0
Grades 1 - 8	1.3
Grades 9 – 11	4.9
Grades 12 or GED	30.0
College 1 – 3 years	28.9
College 4 years or more	34.8
Refused	0.2

Hispanic, Latin American, Puerto Rican, Cuban or Mexican	2011
Yes	7.1
No	92.2
Unsure	0.2
RF	0.5

Ethnicity	2011
White	92.2
Black, African-American	1.1
Asian, Pacific Islander	0.5
Aleutian, Eskimo or American Indian	1.0
Other	3.8
Refused	1.0

Children (Among 28.9% with Children)	2011
1	52.7
2	26.3
3	16.5
4	2.0
5	0.5
6	0.5
7	0.5
10	0.5
Average Number Among Those With Children	1.79

Income	2011
Less than $25,000	19.4
$25,000 to under $40,000	15.7
$40,000 to under $60,000	16.7
$60,000 to under $100,000	21..4
$100,000 or more	16.0
Don't Know	2.2
RF	8.6

Gender	2011
Male	49.8
Female	50.2

Employment	2011
Employed for wages	58.8%
Self-employed	6.5
Out of work > one year	5.0
Out of work < one year	2.0
Homemaker	2.5
Student	0.8
Retired	21.5
Unable to work	3.0

Appendix

INTERPRETATION OF AGGREGATE RESULTS

The computer processed data for this survey is presented in the following frequency distributions. It is important to note that the wordings of the variable labels and value labels in the computer-processed data are largely abbreviated descriptions of the Questionnaire items and available response categories.

The frequency distributions include the category or response for the question items. Responses deemed not appropriate for classification have been grouped together under the "Other" code.

The "NA" category label refers to "No Answer" or "Not Applicable." This code is also used to classify ambiguous responses. In addition, the "DK/RF" category includes those respondents who did not know their answer to a question or declined to answer it. In many of the tables, a group of responses may be tagged as "Missing" – occasionally, certain individual's responses may not be required to specific questions and, thus, are excluded. Although when this category of response is used, the computations of percentages are presented in two (2) ways in the frequency distributions: 1) with their inclusion (as a proportion of the total sample), and 2) their exclusion (as a proportion of a sample sub-group).

Each frequency distribution includes the absolute observed occurrence of each response (i.e. the total number of cases in each category). Immediately adjacent to the right of the column of absolute frequencies is the column of relative frequencies. These are the percentages of cases falling in each category response, including those cases designated as missing data. To the right of the relative frequency column is the adjusted frequency distribution column that contains the relative frequencies based on the legitimate (i.e. non-missing) cases. That is, the total base for the adjusted frequency distribution excludes the missing data. For many Questionnaire items, the relative frequencies and the adjusted frequencies will be nearly the same. However, some items that elicit a sizable number of missing data will produce quite substantial percentage differences between the two columns of frequencies. The careful analyst will cautiously consider both distributions.

The last column of data within the frequency distribution is the cumulative frequency distribution (Cum Freq). This column is simply an adjusted frequency distribution of the sum of all previous categories of response and the current category of response. Its primary usefulness is to gauge some ordered or ranked meaning.

Statement of Confidentiality

All of the analyses, findings, data and recommendations contained within this report are exclusive property of the Windham Consortium.

As required by the Code of Ethics of the National Council on Public Polls of the United States Privacy Act of 1974, The Center for Research & Public Policy maintains the anonymity of respondents to surveys the firm conducts as well as participants in focus group sessions. No information will be released that might, in any way, reveal the identity of the respondent/participant.

Moreover, no information regarding these findings will be released without the written consent of an authorized representative of the Windham Consortium.

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Focus Group Guidebook
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1 INTRODUCTION

The Center for Research & Public Policy (CRPP) is pleased to present the results to a series of seven focus group sessions conducted on behalf of the Windham Consortium. The Consortium membership includes: United Services, Windham Hospital, Day Kimball Hospital, Natchaug Hospital, Generations Family Health Center, VNA East, Northeast District Department of Health and Community Health Resources

Using a qualitative research design, CRPP conducted seven focus group sessions, which took place at the Access Agency in Willimantic, United Services in Dayville and Day Kimball's Plainfield Healthcare in Plainfield. The core composition of each group includes: First Responders, Latinos, Community Leaders, School Based Health, Boomers, Faith Based and Youth.

Residential sample for recruitment purposes was provided by CRPP. Sample for the professional groups was developed and provided by both CRPP and the Windham Consortium.

All sessions were organized by CRPP staff. Windham Consortium members donated focus group meeting facilities in the three cities. A total of 86 participants participated in the seven groups. This report summarizes information collected from the focus group sessions which occurred on August 1, 2 and 3, 2011.

The areas for investigation during the skier/boarder focus groups included:

- Perceptions of community health care status;
- Current health insurance status, having PCPs and Oral health providers;
- Perceptions of current community standard of living;
- Awareness of area health care facilities and organizations;
- Input on the availability of area specialists and walk-ins;
- Views on use of emergency rooms;
- Expectations of area health care service organizations;
- Strengths and weaknesses of are health care service organizations;
- Area health care needs – under-met and unmet;
- Views on emerging needs;
- Needs specific to Faith Based, School Based, First Responders and Community Leaders;
- Views on needs related to addictions, care givers, health/fitness, and mental health; and
- Barriers to receiving needed health care in the community.

Section II of this report discusses the methodology used in conducting the focus group study.

Section III includes highlights and select verbatim responses derived from an analysis of the quantitative research.

Section IV is an appendix including a copy of the focus group guidebook used by the moderator while facilitating the study, as well as a full written transcript for each of the seven focus groups which took place.

2 METHODOLOGY

The Center for Research & Public Policy moderated and organized a series of focus groups on behalf of the Windham Consortium.

The focus groups took place August 1, 2 and 3, 2011 in Willimantic, Dayville and Plainfield, CT.

Following each group within the study, CRPP project staff would review information collected and look for common themes displayed throughout the study. Section 3 of this report presents each covered section of the focus group guidebook along with select verbatim responses provided by group participants to help summarize and support common views expressed by the actual participants during the study.

The focus group sessions were organized by CRPP staff. CRPP ensured that nearly 100 potential participants were recruited for each group to ensure 8 – 12 participants actually attended. A total of 86 participants attended the sessions.

For their time and participation, all respondents received a cash incentive "as a small token of appreciation."

Each session was approximately 90 minutes in length.

For more detailed information, readers may refer to the full, written transcripts which may be found in a separate bound appendix to this report. Additionally, audio recordings of each group are submitted along with this report and will be live on a designated website for one year.

HIGHLIGHTS

The following is a summary of results from the seven focus group sessions. Select verbatim responses related to the topic discussed are presented in italics. Each set of verbatim responses is preceded by First Responders, Latinos, Community Leaders, School Based, Boomers, Faith Based and Youth – indicating the seven participant groups. Highlights may be followed by group initials (FR, L, CL, SB, B, FB, Y) – indicating the originating group. This summary follows the order of the moderator's guidebook.

ON HEALTH STATUS …

Health Status Today: Improving, Declining?

- **Nearly all participants, in all groups, see a direct link between the downturn in the economy and declining health care of residents in area communities. They note that the number of under-insured is increasing significantly. SB**

- **Working parents, reportedly, are finding it difficult to get children to needed medical care. SB**

- **Many see patients coming home from hospitals too early. B**

- **Most see little difficulty finding physicians but suggest that Veterans need to travel to Newington, CT or Rhode Island for needed care. B**

- **Participants reported seeing growing incidence of tick borne illness along with mental health problems and cancer. B / FB**

- **Among youth, diabetes, mental illness, asthma, obesity and chronic illness is seen as increasing. There appears to be insufficient dental care and child psychiatry in the area for youth as well. Some offered that youth tend to eat cheaper, unhealthy foods compared to older residents. B / Y / SB**

- **First Responders suggested they are seeing more "self-pays", drug abuse, alcohol, and mental health transports than in years past. And, because of lack of insurance, they are transporting more complaints such as upset stomachs. FR**

- **Participants see many seniors in dire situations caused by negative changes to Title 19. L**

- **Nearly all participants agreed with those reporting there appears to be two States of Connecticut. Many described themselves as living in "a different Connecticut" when it comes to health and economic status. And, many see strong demographic differences between Windham and Windham County as well. CL**

First Responders

Well, my sense is declining. Since I will admit that I have a very skewed perspective for what I do. I'm a pathologist in the emergency room. So, lots of substance abuse. So. And recently, I think - the last year and a half, the economy has really laid out, as far as I can see. I hear it in the stories of the mental health, and I see it in increased deaths. Alcohol and substance.

And my thinking says declining too.

And then there are people who work and can't afford insurance. So they might be the - this had been at the Cumberland Farms. And they're making money, but they're not making enough to also get health insurance.

It seems, in the last few years, being in the transport business of patients, that I've seen increase in self-pays. Increase in drug abuse, increase in alcohol abuse, increase in medical disorders.

The patient can come for a number of reasons to a single appointment, and - but the doctor, of course, can only write one code for that visit. And basically have to eat all the other things that she might do. You know, so that's - it's a disincentive to continue accepting new state patients, for instance. But on the other hand, the patients themselves have trouble, because they find it very - a lot of them are sort of marginally employed, if they have jobs at all

How is it, you know - agreeing with Lindy, I mean, the first responder aspect. We see that - a lot more people going up to the medical places with a lot less in the way of problems. You know. Stomach problems, a headache, a migraine, you know. That type of thing. And it used to be, you didn't call an ambulance unless you really had a problem. Nowadays, like I said, it's for the simplest little things.

You know what, I think that - you know, so far, our discussion has been, like, kind of pointing the fingers at insurance companies and bad employers who don't - but, you know, I think there's a certain amount of personal responsibility in healthcare. In addition to working in the ED, I do case management. And so, screen all the admission to the hospital. And I always wanted to actually count the numbers of the triple threat. Alcohol, drugs, obesity, you know, that were in people. That - people don't take a lot of personal responsibility for their health.

Latinos

From what I see on TV, pretty bad.

I don't know, with the elderly. There are a lot of things that they take away. It's not right.

Yeah, or they limit them as to what medications and stuff they can get.

That is a big issue.

Yeah, I think it's limited, too, to how much medicine you're - to how much medicine you can get that are not coming out of your pocket.

Another thing - a new thing came out in the news where I go to Beaumont Healthcare. I don't know if it's going to be affected to Title 19 or Social Security or stuff like that, because I'm mentally ill, and I get the help, but I don't know if they can all get help. So I don't know how it's going to be for a poor person, you know.

Community Leaders

Well, one of the things that we find is that we have, in the Windham County, is we have a lot of undocumented citizens. So, you know, healthcare for them is problematic. Lots of times, they don't want to come to the hospital and really don't want anyone to know that they're here. And we are here to try to get them whatever services we can.

And I think one of the biggest struggles for Windham County is the dichotomy between the Windham section of Windham County and the rest of Windham County statistically, and what that looks like. I think we have this micropolitan with very significant and unique needs that are different in a lot of ways than what the rural outlining communities in Windham County need, and I think that often makes it difficult to partner on funding opportunities to meet some of those needs. As far as the current health status, I think, particularly the area of behavioral health, that we are declining as a county. But, it is the lowest income part of the state, and so we're already affected by people with mental health needs, and then as the services continue to diminish, it puts an excessive burden on the justice system and the hospital system to meet the needs that the community is no longer meeting.

Just recently, I think it was the Trust for America's Health that released health status rankings on a national level, of which Connecticut was ranked as the 4th healthiest state in the United States, which I guess is kudos to us, but Windham County is not that Connecticut that they are referring to. And some of the recent county health rankings that came out list Windham County as either 7th out of 8 counties or 8th out of 8 for our health status, health outcomes.

Specifically what Donna was saying about behavioral health needs, and I know I'm biased toward the child population, but there is even a greater need within the pediatric population for behavioral services. Even worse for kids. And we're working towards improving that. At the hospital, they're bringing in a child psychiatrist, but I think there is still much more work that needs to be done. But my other sort of passion is trying to work towards the, working on the obesity epidemic in the area, and I just - it's extremely difficult when there aren't many services to try to counsel families and help people out, because there really are limited opportunities for families, especially low-income families, to make any progress with helping them battle the obesity of their kids and the adults in the families. I just wanted to add one other thing to the previous comments. We also have the third highest rate of teenage pregnancy in the state, only behind Hartford and Bridgeport. Our teenage pregnancy rate is 18-19%, and I think that also is a significant problem. And we all know that we have the highest rate of child sexual assault or molestation by a family member in the state, and the state is the highest in the country.

Just one more comment on the obesity. That is a terrible problem. I see a lot of teenage girls, particularly Latina, and we see Type 2 diabetes now in very young individuals, and also a syndrome called polycystic ovarian syndrome, which is associated with menstrual difficulties and diabetes and hypertension.

School Based

Healthcare - I feel that there's a need for more education on healthcare of how - especially mothers. I've been very involved with moms and children and health issues concerning moms who don't know how to cook, moms who don't know how to take care of their children. And I think just more education of motherhood, taking care of families is very important.

I'm happy with it. They just built a - Day Kimball Hospital just built a new facility right down the road from my house, and it's beautiful. It has - they have everything in there, x-rays, mental health, walk in, blood, everything. They have everything. It's a big, huge, new building, and it's kind of like a mini-hospital, but they have all kinds of radiology.

I see declining. I see a lot of people with chronic health conditions that are not taking good care of themselves. I see a lot of young diabetics. I see a lot of young people with chronic renal failure that are having to go for dialysis. A lot of kids who have chronic medical conditions, so overall I see a decline in the overall population.

I think that families in general are encumbered by increased health needs today, and there are services out there. Sometimes the ability to access them can be difficult because of transportation, because of parents - sometimes parents are working, and just, I think just taking the time and knowing that it's time to take that next step in seeking help.

I think our area too it's indigenous. We're so spread out. There's not really a nucleus, not a big town and we are an agricultural community mostly up here so a lot of the people - it's a widespread situation. And I agree. I think there are a lot more health issues that - you know. You need some help. You can't get it.

Yeah, I think a gap is growing between the families that have insurance and the families that don't have insurance where the family is either on state insurance. I think by and large the families who get state insurance do not receive the same level of care as those who are better insured. There's also a whole group of people where the families are employed, but they make too much money to qualify for Husky insurance, and their jobs don't carry health benefits, and so those folks. And I work with some of the aids at school and others are uninsured. They might make $50,000 a year, but they're uninsured and they can't really afford to get sick. So there's more and more of that now too.

That middle person with the co-pay is too high for those - you know - for some of those families. They can't pay the co-pays on them.

There's probably some concern there with declining health because you're not seeking care because you either can't afford to pay or you can't be seen because you haven't paid.

The economic times are playing a part in that.

Boomers

Declining.

Nutrition and exercise.

We could say we're a more aging population in this area, so I know we're declining, but there are different needs.

I think you would think the older people are the ones - the healthiest because I think the most of the money in the community is with the older people. With the younger people, there's not jobs around here economically like there used to be. So I think they're the ones that have to eat the cheaper food and they eat more fast food and stuff. I think that's part of the reason why there's such declining health, because you see a lot of younger people who are very overweight.

I would add to that only because I happen to be a health care professional, too, and I've seen people who are coming home sicker than they used to in the past. And the services are not necessarily easily available to them. I do home care.

Coming home from hospitals, nursing homes, transitional care units. Sometimes people take other family members out of facilities when they're not really capable of caring for them in the home. And I - because we're such a rural area, the services just aren't readily available. Transportation is a big one. We have people who can't get anywhere.

I've got to say that I never would get active in the community, but I feel rising health costs and co-pays and cuts are keeping people away from health care.

I agree with that.

I mean, you get a little older, your money's tighter and you can shy away from things that you - don't appear to be necessary.

There's a lot of people around with no health insurance at all and it's because economically things are so bad.

Faith Based

It just seems that I've been running into so many people that are afflicted with cancer and I just - its mind blowing. Almost every week, you know, at church we have somebody with new or are praying for somebody and it just seems to me that there's been an increase in that.

I've seen a lot more tick related illnesses.

Some of what I'm seeing is great decline in physical health, but I think mental health issues are becoming more prominent.

I think in the elderly housing units - that's one of the things that was brought up is that assessments for people who are living there for dementia, for Alzheimer's. Sometimes not enough assessment by the MD's because possibly they shouldn't be living alone. They shouldn't be living in elderly housing by themselves without any assistance. And they don't know where to go.

There's not enough information out there for the elderly.

Youth

I'm healthy.

I think I hear more about diabetes.

It runs in my family a lot.

Yeah. Well, like for a couple years my uncle wasn't able to take care of himself and due to that he passed away.

My uncle had a health induced diabetes. He got that from alcoholism which I didn't know you could kinda like give yourself it, but certain things that you do -

Yeah, exactly. It's amazing stuff that's out there 'cause it'll tell you, hey, should I be an alcoholic or not? No. I'm gonna get psoriasis when I'm 30. I probably shouldn't drink. Probably should change my life around. I'm gonna get lung cancer. I should start running and quit smoking or whatever 'cause if people see the numbers that this is what your blood is telling you is gonna happen, listen to your body as opposed to listening to Lipitor commercials.

Have Insurance? / PCPs? / Oral Health Care?

- **Among youth group participants, under half had health care insurance and others will lose their insurance at 26 years of age. About half reported having a primary care physician, and many said they typically can find care when needed but rarely can afford resulting prescriptions. Y**
- **Many participants describe the need for more geriatric physicians in the area. FB**
- **Nearly all tended to agree with participants that health insurance is a very complex, confusing and difficult process to navigate. Some suggested this is intentional and always an ongoing battle for reimbursement or coverage. FR**
- **Others discussed stressed employers who are hiring at less than 30 hours weekly to avoid the cost of health insurance. FR**
- **Participants noted that many PCPs are not taking Medicare patients. FR**

- **Most see the region having enough PCPs and Dentists but not enough that are taking Medicare and Medicaid. L**

- **Some describe the State Medicaid reimbursement rates for dental services as awful. CL**

- **Others see it becoming increasingly difficult to get insurance to cover the placement of patients in psychiatric facilities. CL**

First Responders

Over the years, we've definitely seen a dramatic increase in people who are self-pay, or who are effectively self-pay if they have a high deductible, which means they're paying first out of pocket.

And there's the additional complications with the health managed savings account, and healthcare accounts, helping to count. Very often, patients don't really understand how that works. So what we do is, they see - they end up seeing the doctor a number of times. The doctor bills out to the patient's insurance, which may or may not have changed some internals. And it comes back, you know, for several visits' worth of services that are not covered.

I know of a person who works full time, and she just had to let go of her insurance, because her insurance for herself was going to be $1,000 a month. That was going to be her out-of-pocket cost.

Once we bring the patient to the hospital. Then - and if it's a self-pay, sometimes I'll go back and ask the hospital a week later if there's any changes in this A, B, C patients' insurance status. Otherwise we have to bill them privately. And the collection on private pays is dismal. And over 20% of our patients are self-pay.

It's definitely getting worse.

And I think the pay people are making is - has not risen as the cost of insurance. I think insurance prices have gone up so quickly that the wages have not been keeping up with it. And I think that's a big issue.

And they hire them for just under the number of hours where it would be required that they provide insurance. And it's just - so, these people - although they may have, you know, 30 hours of work a week with this one employer, they don't - they're not entitled to benefits.

Difficult to find PCPS.

Yeah. And I think if they have - on Medicaid or Medicare, sometimes they're restricted.

I know our endocrinologist here at the hospital says, when he takes a Medicare patient, by the time he pays his employees to fill out the paperwork to get reimbursed for that care, and he gets that reimbursement back, he's put out $10 in care - in cost to his staff. So he doesn't make any money at all from that.

I do know of one private physician, local to me, who has chosen to not accept insurance at all. And it's just a cash only arrangement, much like a small town doctor. And I think that's the way he's setting himself up, and I think that's attractive to a certain segment of what - population.

You're starting to see that. I think it's a $500 retainer on your doctor for the year. You show up, I bill you direct. There's no deductible, there's no insurance. So he can work with his fees. That's interesting.

Latinos

So I think right now I have a physician in healthcare with the hospital and everything with Title 19.

No, not with our insurance, no. It's hard. A lot of people are not accepting people, newcomers. You just have to call and ask them, see if they have openings.

We have a problem. If you're sick now, they want to see you two weeks from now.

And it depends on what insurance you got, that they'll take you.

Yeah, I mean they're burning the candle at both ends.

Not a lot of dental.

Yeah, not around here.

Well, not for dental. It use to be everything six months you got a cleaning. Now it's every year that they will pay.

And for some of the children it's impossible, because like with my son, they don't see him, because one, he's little, and two, he'll bite the dentist. So I have to try to get into the Children's Hospital in Hartford, and they're booked, so he hasn't been able to go anywhere.

I have a one and a half year old, and she gets seen by Generations. They usually come when he's here every six months, which is great.

Community Leaders

I'd just like to add one, another problem that I've seen, not myself, but what I've heard about is the lack of dental care for children. It's unbelievable. I'm, I was appalled when I heard what the statistics were.

But, that's an insurance issue, as well, since you raised the insurance issue. I mean, that has manifested in part, in large part, by the awful rates that our State Medicaid program pays for dental care. Nobody wants to take a Medicaid patient. And I think that is increasingly being reflected in other areas of care, as well. And, since I know about Medicare, the squeeze is put on providers more and more and more by Medicare, as well, and all of these insurance issues actually are started to create - have and continue to create - worse access issues. They will only be exacerbated what has happened yesterday and today.

Yeah, there are plenty of dentists.

I have to get authorization from insurances for placing people in psychiatric facilities and nursing homes. We're seeing the spectrum where it's more and more difficult. It's more difficult to get authorization for patients to obtain psychiatric help. There are some managed Medicares where a person goes into the hospital and they're going to need rehab in a nursing facility one to two weeks, or whatever. You call to get pre-cert and you'll hear, "Well, the person has $120.00 a day that they have to pay," which they aren't aware of whatsoever, so they aren't going to go because they don't have that kind of money. So, the insurance is getting more difficult to get authorization, and when you get authorization for mental health, sometimes they are in there two days and out the door they go.

As someone in the trenches doing that authorization for any kind of surgery or any kind of patient, no matter what the age or insurance, it's getting more and more difficult to get authorization for general surgery.

We are having to refer them on, and we cannot get the authorization even for things such as MRIs. And we would spend, we were having spending hours trying to wade through these.

School Based

There are a lot of dentists in the area, but if you don't have a commercial insurance, you're out of luck.

Boomers

And I know it's a big problem for people my age. I have some friends that are 60 who retired and then they're stuck with these huge health care payments to keep insurance. I have a friend, he's my age, he doesn't live in Windham, but he lives in the State of Connecticut and he's thinking of only getting catastrophic insurance.

My costs are quite up there and I'm very healthy, but preventative or having any tests done, it's all out of pocket.

Faith Based

I have a significant number of parishioners who do not have health insurance. Adults I mean children seem to get under the HUSKY plan and are able to get coverage, but parents and grandparents - particularly people in that range where they're not quite eligible yet for Medicare, but they're, you know, 50 somethings.

I think that the elderly population there is a problem with finding good geriatric doctors. Doctors who can really look at the needs of the elderly. But I think geriatric doctors are very much in need because of the population. Everybody's living longer.

People needing surgery and can't find a surgeon who will, you know, the parishioner has had chronic sick trouble for years and years and years and years and it was labeled a pre-existing condition and she couldn't afford - she's Medicare and couldn't afford to do it.

I think there's enough.

Well I know my son he had the insurance and there wasn't a dentist that would take him. He called every dentist that he could find in the book basically and nobody would take him.

No one would take the insurance. Once he said what he had for insurance they wouldn't take him.

Youth

So I'm trying to get onto SAGA now 'cause I'm in between jobs so to speak.

Yeah, they keep me on until I'm 25. And I'm not sure if they can - They can keep me on if they want to with paying or something, but that's what they said. It doesn't matter - I don't have to be in school or anything. They just keep me on until I'm 25. I don't have to worry about it yet.

We have the best dental plan that the state has to offer through whatever, Anthem Blue Cross or whatever, but it doesn't cover anything. I mean it covers like cleanings so I mean yeah, I guess I go for cleanings, but it doesn't cover - I think it covers like 10% of everything else. It like covers nothing and it's expensive.

Standard of Living: Improving, remaining the same, or declining?

- **Over half of the participants in the youth group were unemployed. Working youth suggested they can't save at minimum wage and cite the high area cost of living compared to places like Texas. Y**
- **Others, in older groups, noted that college graduates are leaving the area because of the local economy. B**
- **The dire economic situation is described by one participant who suggested she can't even afford to get work – suggesting the cost of transportation to work is insurmountable. L**
- **Other community needs assessments are showing that transportation is a leading need – driving everything from access to work and health care appointments.**

- **One community leader indicated that food bank use is up 58% within the last 12 months alone – as a metric used to demonstrate growing numbers of working poor. CL**

First Responders

I see quite a bit of - and experienced myself - people who work very hard, work throughout the week, but they work - they're cobbling together three or four jobs, occupations. Also may be doing volunteer stuff too. But at the end of the day, there's nothing that amounts to - I don't have insurance. It goes through my spouse. I do a bunch of stuff. I've got, like, five part time jobs, and I do things in the community. But it could be a lot of those people out there that are working, they're doing good things for the community, but they're not insured.

I mean, we have plenty of people that are no-shows. They'll make an appointment to come in for diabetes education, but they don't show up for their appointments. They may or may not have insurance. I think people are stressed in a lot of different ways. I think grandparents are now watching grandkids, because people need to - are going to save money. They can't bring them to daycare anymore. So they have a lot more stressors that way. And then people will say, I can't afford the gas to come.

Latinos

It's going downhill quick, man. Just getting back and forth to work, you have people that can't even afford to get to work. It use to be that someone in the area, down where I'm living, you'd go to Providence in a heartbeat. It's a 40 minute drive. Now they're limited to - they can't afford to get there. So you start with, you know, working at the Wal-Mart, McDonald's, Burger King, and that's all that town has to offer.

It's a lot - I mean a lot of people use to carpool, but it's getting hard.

No. That's going downhill real quick.

Community Leaders

Not improving dramatically.

But there is a difference from the Northeast corner of the county to the Southwestern corner. It's a bit of a different demographic in education level.

In regard to standard of living, Windham County is the most insecure region of the state, and one of the programs we also run is a food bank. We've seen a significant, or at least 50 - what, last time I looked, it was 58%, but I know it has gone up since then - increase in the last 12 months in utilization of the food campaign, mostly by elderly and the working poor. A lot of people were laid off from other jobs that are now at entry-level jobs and cannot make it without food support, even though they are working.

We link our food bank to every kind of service we can through literature, but there's also a literacy issue. So, just putting it in a handout doesn't always necessarily get the job done.

School Based

Declining.

Declining which is just a direct result of the economy, but there's no way around that. I mean -

I say over the last several years it's been declining. I think, personally, it's declining at a much slower rate right now than it has been. I'm not saying it's plateaued or in the upswing or anything, but it's not a straight cut down for a lot people now. It's - the decline is a little less steep so.

You see a lot of houses that are just abandoned. Yeah, there's a sticker on it that says this house has been found to abandoned/vacant.

Boomers

When I was a kid, everyone was middle class. Everyone worked at a factory. People had money. And now, there's no industry.

I'm a retired school teacher and in Putnam 57 percent of the entire school is on reduced or free lunches.

At best, when I moved here, and it's - as I understand it - it's gotten worse.

But I don't see it - I don't see it depressed. And I don't see the work force being depleted. I see young people around. I see everybody - I couldn't believe that they were going to build that mall.

I know the Community Development Administrator in Killingly. And she fills me in on this stuff at times. But it's - factually, it's economically depressed. And maybe you don't see it, but it's there.

And factually, it is getting worse. And factually, high school graduates generally, as they're looking for viable employment, they're leaving. And college graduates don't return.

I would just say in Pomfret we have people who are always on the edge. You go and you talk to people and some of their - you find that people are trying to stretch out tires on their car. They're waiting longer to have their cars serviced. Filling up their oil tanks is now a difficulty. And you find people who are both working and we still have this in our public school that both parents are both working, just trying to stay where they are. I say it's tough times.

Faith Based

I think the economic downturn, you know, the numbers aren't real numbers. For example if you just look at unemployment - the figures. Well, you know, they're hovering around nine, nine and half - that kind of thing, but what's happened is that people have left good paying job that had benefits. Now they're working jobs that don't offer the same kind of benefits that they used to have. So they're not in the unemployment figure, but they're in a job that doesn't offer them the benefits that they had before and they don't have the money to purchase it themselves

They're not hired to work the number of hours that would qualify them for insurance. They work at a job that, you know, are capped at 25 or 30 hours and the employer says you have to be working 40 to get the coverage.

Youth

Yeah, I've been looking for a job.

Yeah. Most people I've talked to are. Out of work. Like they said that we're coming out of the recession, but I don't think a lot of people are.

Yeah. Everyone's having trouble right now, even people that I know that are financially stable and well off so to speak and yet everyone's pretty much struggling right now.

The cost of living is disgusting in Connecticut.

Disgusting.

We're one of the top three counties for the cost of living.

Just to have car insurance, health insurance and pay for an apartment you gotta be making $900 a week and that doesn't even include food.

It was like $595 a month for a three bedroom, two bathroom apartment in Texas and then you come up here and it's like $1000 for a nice one.

Down South it's so much cheaper.

We're trying to get out and start our lives and it's impossible it seems. You're stuck at your parent's house until who knows when really until you get a good enough job.

And paid minimum wage you have no way to save money.

ON AWARENESS OF HEALTH CARE FACILITIES / SERVICES…

- **All focus group participants were asked to report the names of health care organizations and facilities they were aware of in the area. The following are those named across all groups…**

- **ARC,, VNA, Walk-in on the Green, CareNet, Crossroads, Eastern Connecticut State University, Holland Road, Mansfield OBGYN, Quality Homemakers, Wingdale, NetChild, Union Joshua, Windham Hospital, Day Kimball Hospital, CPASS, Natchaug Hospital, Generations, Planned Parenthood, CPAP, Ness, Backus Hospital, Mansfield Family Practice, walk-ins, Putnam, Plainfield, the new Backus ER facility, Perceptions Program, Prompt Care, Community Companions & Homemakers, DNA, CCCI, CCS, Access, WAIM, Daily Bread, Interfaith, TEEG, Covenant Soup Kitchen, New Ways and Hospice.**

- **Overall awareness levels of area health care providers, among non-health care professionals would be described as limited. Just one participant, across seven groups, named 211 as a resource.**

Can You Name Health Facilities / Organizations?

First Responders

Windham Hospital and Day Kimball.

Generations.

Well, in Danielson, up in Killingly, there are one, two, three - I would call them doctor's offices, but medical centers.

Some of them are owned by Day Kimball. And the doctors work for them.

Walk-in clinic in Putnam. Or there's a walk-in clinic in Plainfield.

Willimantic has one.

There's a Planned Parenthood in Danielson.

The hospitals seem to be branching out in smaller areas, in smaller units, to help get these people in. To get them the help that they need.

Well, Backus Hospital. It's actually building an ER, emergency room, in Plainfield currently. And we do transport from Danielson area to Backus.

For Day Kimball, diversion is very rare. I can recollect once in the last five years. But, they test it daily for the population and the ER. It's a sad - I think this is a result of the fact that people with Medicaid and without a car or any way of transportation to a doctor's office just assume to call 911 and have us take them to the hospital for anything.

Latinos

You're talking about the hospital over here, Generations right next door?

There's Day Kimball Hospital. There's a facility on Green Hollow Drive which is associated with Day Kimball. There's Windham Hospital. There's Backus Hospital.

The walk-in.

The walk in clinic, there's one down in Plainfield.

Windham Hospital.

This is the only one that's here. I mean there's doctor's offices, but they're different than Generations.

Then I'll go to New Ways.

New Ways that's on Main Street.

With my children. Generations.

He won't go to the doctor's unless he's sick.

Like me, I've been sick. I stopped going for care.

Satisfaction with Health Care Organizations and Services?

- **Generally, all participants were very satisfied with the health care organizations and facilities in the area.**
- **Nearly all agreed that emergency room waits as well as lack of communication between doctors was troubling but did not necessarily impact their levels of satisfaction with each.**
- **And, conversations returned to insurance – that doctors won't see them until their bills are paid so they are forced to go to the emergency rooms.**

First Responders

Yeah.

Nodding your head yes.

Well, I - I think the main complaint would be, in these people we just spoke about, going to a Day Kimball and having to wait six or seven hours.

Usually the wait time.

Latinos

I like my doctor. I'm having actually issues right now with payments, my insurance payments, my bills. So they won't see me until that bill's paid, and it's been like over six months. So, it's the hospital emergency room for me.

Every time I've had absolutely no issues. I've been in, taken care of it. She went to a new doctor today because the one she had quit. The lady walks in with her file and goes, "I haven't even got a chance to read your file yet," shows up a half hour late. You know, she had no idea what she's doing, just decided she's going to change all the medication, all the protocols. So they really need to communicate more.

The emergency room is a nightmare in here. It really is.

There's a lot of bureaucracy involved. I mean, they have to follow all this protocol, like if this thing goes in this basket or this bag or this bag. I mean I think the organization could be quite a bit shortened.

School Based

Mine's been very high.

Mine has been high with Backus and mediocre for Day Kimball.

People just wait, and wait and wait. And then they get they get mad because they're waiting. Someone in the waiting room they called the police on her by the time I was leaving because she was so upset that she was just waiting even though she had an appointment.

I didn't want to say in terms of like - satisfaction. One thing that I do really like about Day Kimball is the new computerized system and that every time I go to a doctor who's in the Day Kimball System, they can pull up my history within the Day Kimball System and see what medications I'm on and stuff, and that's really wonderful.

I do like that very much. The only problem I've ever had was with the ER. That was the only - with the physicians, and I had surgery at Day Kimball. Those were fine. It's just the ER that I've had issues.

I think one good idea that I've seen is that at Windham Hospital they post on the computer or they post in the area the waiting time.

Boomers

No. I feel that my doctor's an insurance lackey.

She'll do whatever the insurance company - she states she shares a distaste for insurance companies. In practice, it's not true. She'll do whatever the insurance company suggests.

I think - I pick and choose. Depends what it is. There's some things that - I find my general practitioner, I think is great. And there's some services I take at the hospital. For a number of services it's been great as opposed to going to Hartford. You walk in and it's - you're taken care of quickly. But there's some things I would rather go somewhere else for. Providers that are specialists.

Youth

Day Kimball, I've used everything for Day Kimball and I like them honestly. I mean they do, they give you a lot of unnecessary tests

I went there with my kidney stones, but I went in there screaming. I was screaming. I couldn't do anything. I was horrible. They treated you pretty quickly, though, right? Yeah.

I loved Day Kimball. And I love their pediatric center except for making appointments. It sucks, but other than that it's good.

The Mansfield OB/GYN where I go they're really good.

Are Specialists Available to You?

- **It appears that residents and leaders throughout all seven groups agree there is a lack of specialists in the area but have become resigned to trips to Hartford, Boston, New York and Rhode Island are necessary. And, some add that this lack of regional specialists is a barrier to care because many do not have the means to reach distances for appointments.**

- **Some participants note that the lack of specialists is especially critical for children. Any need to see a child specialist typically means a trip to Hartford. L / SB**

First Responders

Child, adolescents - child and adolescents. I would - we have terrible shortage in the Danielson area. They do around here too, I don't know. We also have a terrible shortage of dentists and oral surgeons that are willing to accept Medicaid, state.

And endocrinologists.

I think we need a neurologist too.

Latinos

For specialists, like for my kids, I have to go out into Hartford.

You usually have to go to like Hartford, Norwich - Norwich Hospital.

You can go to specialists at Norwich. They have a lot of them.

And the majority of specialists, the state won't pay for it.

Community Leaders

I think what you allude to is, it's not just dental. It's any specialization. I have a client who has some kind of growth on his face. It's pretty hideous. He can't find a dermatologist who is willing to take his damn insurance.

I can comment on that. At Windham Hospital, we have been looking for a dermatologist now for a long, long, long time and have not been successful. Dermatology, most of them are not going into general dermatology. They are going into cosmetic dermatology. You don't have to fuss with the insurance companies and you have a nice life. So, that's a significant problem.

No.

Particularly in primary care, which I consider a specialty. Pediatrics, internal medicine, family medicine. A tremendous problem there.

School Based

For children they're very difficult to access in this community.

So again transportation comes into play, and Husky does provide transportation for services, but you have to call in ahead of time. You have to set it up, and there has to be an adult there. So there's many variables that come into play that really impede access I think.

It's fine if the way that if you have to go for testing or something - my son had to go for some testing. It's an all-day process because you do have to get there and get your kids in there. And then you wait and you see the doctor. You don't go on your lunch break, or you don't take the morning off to take your kid to the desk. It's an all-day thing.

And they do have satellites primarily in the greater-Hartford area, and then they come out with some of their specialty clinics into the different neck of the woods. A cardiology clinic, there's a pulmonary clinic. There's an orthopedic clinic, and they maybe come once a month. Make it easier.

I haven't had a problem finding specialists.

Boomers

No.

I know Day Kimball pulls in a - they pull in a lot of specialists out of UMass. For clinics. Some come once a week. Sometimes once a month. They pull in specialists.

Faith Based

People don't seem to mind going to Hartford.

I just had a parishioner with a massive heart attack a week and a half ago and he was transported immediately from Day Kimball to UMass in Worcester and was out to see him a number of times during his stay and got excellent attention and care there.

I think the populations adjusted from what we just talked about. I don't know that I've heard any complaints about, you know, gotta have a heart surgery, you know, gotta go down to Saint Francis or something.

It's hard to know that a community of this size could really support that kind of care and that number of specialists.

I mean transportation becomes an issue sometimes.

Youth

I definitely think so. If you need anything really targeted, you have to go to U-Mass or to Hartford. Hartford is the main place if you want a good targeted specialist for something. They have a few here and there for hospitals and stuff, but if it's anything where they really have to look into it or you need targeted help or anything that's too complex, they send you up there. So I definitely think so.

Yeah. We got, right after we had the baby, we got sent to Hartford with them because - All they had to do was like they gave him a pill and they did a picture thing to see if his digestive system was working right. So we had to go all the way over there and stay there for three days just for that one test. Yeah.

Enough There Enough PCP's in Your Community?

- **Nearly all participants, across all seven groups, agree there appears to be enough PCPs in the area – that the issue is acceptance of insurance.**
- **Some noted that the region lost a designation allowing it to receive medical students locally. CL**
- **Others cite a growing problem of seeing PAs or assistants instead of physicians. B**

First Responders

Not really.

Latinos

I think there is.

I think there - yeah, that's true. There is. It's just who covers what, or who will accept the insurance that you have. There's a lot of dentists around.

Community Leaders

Well, I can speak as far as Day Kimball Healthcare, we have an LLC which we have over now of more than half of primary care physicians in our 13-town service area, as part of our LLC. And what we're seeing is patient visits go down, and I think that relates to the insurance issue. The insurance issue, again, is two problems: One, people without insurance; and, number two, people with insurance who can't afford the co-pays or the deductibles, so they are utilizing their insurance less.

I don't think it's a breach of confidence to say a constant problem was finding practitioners. Constant. And it's a combination of the pay scale in Northeast Connecticut, and people don't want to come.

We lost our designation, too. We used to be an area that had a federal designation to receiver medical students for med loan forgiveness, and there are still, some sections of the county are still a HIFSA, we're still an MUA, certain sections of the county, or an MUC, but we are not designated any longer to be on that physician forgiveness region. It's so limited now to sparsely rural, pioneer or American Indian, and that really sort of change recruitment, I think, 15 years ago or 12 years ago when that changed.

A lot of them are going to be retiring.

The average age of physicians in Connecticut is well over 50. At Windham Hospital - it's been awhile since I've looked at the data, but maybe you know - a good proportion of the primary care doctors are over 60.

So, the aging, and I always mention nurses, the average age of the nurse at our hospital is 45. The average age of the specialty nurses, the ones that work in the ICU, is something like 50. And then that's a whole other issue, the nursing shortage, but maybe we'll talk about it later.

School Based

I had a problem with that. When I first moved here four years ago, I called several primary care doctors and asked if they were accepting new patients, and they weren't.

Boomers

But now it's - even though you're already his patient, you don't see him. You see him the admin. And I don't think - in three or four years, I don't think I've seen my doctor.

No.

I don't have any figures and numbers, but I do know - and you brought up a point about Windham Hospital taking over that office. The hospitals are buying up these doctors.

Because of that malpractice insurance. They kind of have to answer to someone else now, too. I think that makes all the assistants. So now you have one doctor working and then having assistants. You're not getting - they apparently don't have enough primary care doctors because we don't get a one-on-one always.

Youth

I think there are.

I was gonna say maybe there wouldn't be enough if everybody wanted to go look for one at once.

There are actually more than I remember. I think there's enough around.

I don't know because there's been a few times where I've had to make an emergency appointment and I couldn't get in for a week or two and maybe if there was more, they'd be able to take you for something.

If you need an emergency appointment, you're gonna try your doctor, you're gonna try your place. You're not just gonna call around. So I think there's definitely enough, but in that kind of situation you're not just gonna call other places and try and get in to be a new - 'Cause you're new and you gotta go there and do the paperwork and see if they accept your insurance and then if you have financial problems like you need to only go certain places so I mean in that sense it's a problem.

Are There Enough Walk in Centers in Your Community?

- **Interestingly, while most see enough walk-in centers in the County, many suggest there would not be if more people needing care had access to transportation. FR**
- **Some first responders offered that new walk-ins won't really help with overcrowding in ERs because they don't transport to walk-ins. FR**
- **Most welcome the anticipated new Backus ER facility.**
- **Some participants presented concerns about continuity of care when residents go to walk-ins, and ERs as well as their physician offices. CL**
- **Others suggested that, going forward, any new walk-in facilities should be more strategically placed – that they may not be covering all areas of the County. B**
- **Nearly all agreed there needs to be a community wide effort to clarify when to use walk-ins as opposed to ERs. FB**

First Responders

In our area, I think they're branching out. They're doing a great job. They're trying to do their job.

That's where you would think the pink-eye would go, if they didn't have a physician. But I think that's probably - don't provide transportation to the walk-in clinic. So that would be an issue.

Transportation, to be able to walk in.

You have to drive or walk.

Latinos

Well, sometimes it's a wait. It depends on what kind of day they're having.

Community Leaders

Yes. They do.

In Windham, in Willimantic, we only have one urgent care center.

I manage the walk-in center that is in Willimantic. We see approximately 45-50 patients a day. We're open seven days a week. Whether you could really support another walk-in center right in Willimantic, I don't know. I think that would just kind of slip. But, one of the problems that you have is physicians, to have sufficient physicians. I mean, I struggle all the time, and our physicians are working a lot of hours to keep us open seven days a week. And we do

provide an alternative to the emergency room. And we have a 50% ownership with Windham Hospital. We're very cooperative with their ER.

I'd say, too, that even with offices, if the offices are staffed so that they do not have a physician in their office, they defer patients to the walk-in clinics or the ER. That's the only choices they have. And we found that even people who are Generations patients still come to the ED a lot. They claim that they waited at Generations for hours and never got seen. Whether that's true or not, we don't know.

One of the problems with a walk-in center is we're urgent care, and these people need primary care help. So, we need to be able to refer them one. There is an insufficient number of primary cares who are taking new patients for us to be able to take these people and get them to the next step so they can maintain their healthcare.

And those that use the walk-in that have a primary care, you know, can be diverted back. I mean, a lot of times we're just appointed if patients are going to a walk-in when we're open and ready to see patients, because you lose the continuity of care and you can't get, you know, the same level of care, because it's somebody who has never met you before, who doesn't know any of your history, who has no access to your records, and, you know, you're putting them in charge of your healthcare. We struggle with that. I mean, we understand the need for walk-ins, but at the same time we're trying to get our population that, you know, identify yourself with a doctor, because we do not like to be referred to as a clinic, because we're a physician practice.

One of the problems that we have at Generations, and I'm a consultant over there two days a week, is no-show rate. The no-show rate is at least 30-40%. So, I think we need to develop some sort of system or align the system or something. Transportation help or something to get the patients there. I mean, that's a lot of patients. And I'll go and I'll be scheduled for maybe seven or eight patients, and I've had days where maybe two or three show up.

And I think that really exacerbates so many of the issues with chronic disease, because you have and exacerbation of the issue, you know, you're having difficulty breathing, so you go to the ER because you can't breathe. They fix it, but you don't reconnect with the primary care, so you don't get ongoing care and you're not getting to the bottom of some of the chronic disease issues that we could manage better if we had a more connected system.

Boomers

I don't think there's anything up northeast. Really northeast.

Could use some more strategically placed.

Faith Based

There may be confusion too about when to use the walk in clinic versus the emergency room. I know that's not always clear and, you know, in the middle of a crisis or, you know, somebody's taken a fall or has an injury that needs stitches.

Youth

I think they're pretty good with those, but every time I've walked in it's been pretty nice, not very long waits and stuff.

I don't know about for guys, but I know with Planned Parenthood you can just walk in and get an appointment.

There's a lotta access in Willimantic and Mansfield.

Yeah. There's one in Pond Hill, a walk-in center, and that's pretty fast.

When Do You / Others Use of the Emergency Rooms?

- **From first responders to youth, group participants see misuse of the emergency rooms. Many attribute it to the lack of transportation available to many residents. Some even suggest physicians are to blame – sending patients unnecessarily to the ER when they are busy. B / FB**

First Responders

Pink-eye. You know? It's - and these are the kind of things that are really putting an undue burden on emergency health services in the ERs.

Strongly agree – ERs are overused.

Yes.

Well, that's where the issue is. They don't have a primary care person, so where else are they going to go to if they don't have their own transportation? You know. You know, if they have their own transportation, well, maybe there's not enough out there about walk-in clinics. I don't know.

Just out of curiosity, a particular patient that we have has been a frequent flier at Day Kimball Hospital. And sees a lot of services. And we calculated once, just out of interest. She's cost over $1 million. Just one patient. So, we go back and forth.

It's psychological problems. But there ought to be some place that would be better suited to her visions that she has. Or the - going to, you know, Hotel Day Kimball.

But the - that - but the ED can't turn people away.

And they can't.

Latinos

I'm dead.

For me, the last time I used the emergency room, it was because I was drinking a pill. They was doing - they was numbing me. When I was taking it, I was shaking, and you know, when I drink the pill, I feel like it was crack or something like that with it. I was like, "Oh my god, I don't do no drugs, no nothing, and now this place is doing this to me?"

I don't know. Like when I'm hurt or something.

No, I don't like being in the hospital.

You know, to be honest about something, going back a little, I think that's one of the major problems why in the hospital we have issues with somebody like him, because he's sick, and he could go into the emergency room and like to give you something for the pain, they'll look at you automatic in a whole different way, because there's such a major problem in this town. You don't get what you need because so many people go in there, you know, to get proscriptions just to abuse them, and when you go in there and you're really in pain or something, they won't give it to the people who need it.

School Based

I work in the Emergency Room and there are people that access ER services that should not be there.

Last week there was a girl in there who wanted a pregnancy test.

Boomers

Emergencies. I tell you, the last time I went - and that's why I didn't want to visit that place anymore. I went with bronchitis and they were taking me in for CT scans and all sorts of stuff.

You think you got unnecessary care? Totally.

My daughter took my grandson to the emergency room because he was having difficulty breathing. He had a bad cold. When she took him there, they told her that she should not have gone to the emergency room. This was one o'clock in the morning. They told her she should have waited until her doctor's office opened. So the insurance denied and my daughter got stuck with not only a sick kid, but the emergency room bill.

That sounds like a typical breathing call.

I was scared.

Are people that you know using the ER inappropriately? Yes.

Most of the people that don't have insurance go because they can't get into a doctor's office.

Or, you call a doctor and find he's on call or something and instead of seeing the patient in the office, they'll say send them to the emergency room.

Go for accidents. You may be cut off your finger. What are you going to do? Wait to go to the doctor's office?

Faith Based

I think so, so far for those kind of, you know, more acute.

I think it depends upon the kinds of insurance that they have. Or lack thereof. The folks who don't have insurance I think they just kind of do what they need to do. They depend upon it being covered at the emergency room and hopefully being able to be received and treated. I think that insurance does play a big factor in that decision.

If I've got insurance then I've got more options. If I've got no insurance the emergency room will at least have to see me.

To that point, my husband worked for the fire department. He's up in Sterling and either people haven't called the ambulance for a stomach ache, so it's only emergency room for a stomach ache or minor little things that you could go to a walk in clinic for or you could call a doctor. It also depends on the time of day. Because, you know, the hours at the walk in clinics or whatever that's a big factor too on that. But it's amazing on how many little things they call the fire department for and an ambulance for and so -

That's education again. People don't know, you know, the distinction. They don't know who does what.

I think that's very important, you know, when do you go to your doctor. When do you go to a walk in clinic, when do you go to emergency room and I know doctors will help.

Youth

Massive loss of blood.

That'd be a good idea, Jonathan.

Like the kidney stones, something like urgent, you can't wait another day, you can't wait to make an appointment.

Like broken bones, things like that.

They have a number which I think, 'cause I didn't know about this until recently, they have a number and you can call and you tell them your symptoms and stuff like that and they tell you if you really should come in right away or wait.

They know they're in pain and something's not right, but they don't know if it's gonna go away tomorrow or it's gonna get worse and a lotta people wait until the point where they have to go to the emergency room.

ON EXPECTATIONS …

What Are Your Expectations of Health Care Delivery Organizations / Facilities?

- **Boomers suggested their expectations of the area health care organizations and facilities included 20 minute waits when seeking care, reasonable fees, access, and to receive care with or without insurance.**

- **Youth expect not to be "talked down to" as well as have reasons for waits in ER explained to them – suggesting this would relax them. As readers might expect, youth participants expect the best technology available for care delivery.**

- **Faith Based participants sought personal, prompt care with digitalized quick access to records as well as competence. Participants in this group represented others in their growing anger over the tough books or tablets more common to physicians during exams. Many report "talking to the ceiling while each physician is busy staring at their tablets".**

- **School Based professionals added accuracy, quality, cleanliness, best effort, follow through, good communication, outreach and privacy.**

- **First Responders and Latinos were looking for shorter wait times to get in for care.**

- **Community Leaders spoke more about constituent expectations as they described an expectation of immediacy – warranted or not. They see patients expecting not only health care but financial counseling on how to secure needed insurance coverage for care.**

First Responders

And I had to wait three months to go see them. So I think having a shorter wait time is - just to see the specialist.

And I know the endocrinologist up here has a pretty long wait just to see. So -

Up to a month, I would say. Would be acceptable in my eyes. And like, you know, people would feel that way.

I have to have surgery on this finger tomorrow morning at Day Kimball. And the doctor with whom I consulted - I think it was about a month and a half before I could get in to see him.

Be there when you need them.

Latinos

I mean, to get my needs met.

I mean, because the money wants to be shared among that same group of whether it be doctors, researchers, politicians. You know, they got their own little groups of people That's a want expectation.

Some people want courteousness, others want quick service.

I would expect that with the state take of healthcare that they would have more shared information between each other. They would know who's out there. They would know who specializes in what. They would make sure people get to the doctors they need. They would provide transportation if they needed it.

Community Leaders

I think the immediate, you know, the immediacy of it. They want to be seen now, you know, and that's part of the reason, like I said, for the EDs for primary care problems, or even for physicals. People will go to a walk-in clinic for a physical, which really rocks our world.

That's really interesting, because that immediate gratification piece is so prevalent in a depressed, economically depressed, community, is I don't have much, so I'm going to take what I have and I'm going to spend it now or get it now or fix it now, and there isn't, you know, there aren't high levels of education. You know, it's sort of there's got to be this whole community campaign to educate a group of people who don't come to the table, many with high school diplomas, about the benefits, the personal benefits, to ongoing care or ongoing planning, whether it's economic planning or healthcare planning. So, I think some of it is just the reality that we live in an economically depressed community with so few, so many residents being educationally challenged and economically challenged, and it's all about in the moment. Everybody is living in the moment.

The other piece I'd like to add to the conversation is the technology piece. What we've seen as that immediacy, you know, it's got to be served and it's going to be served now. With the advent of the Internet and technology, people who do have resources there, now they have already self-diagnosed, because they already went out on WebMD, they've already gone to a million different Websites.

I just have to say for one thing, from a hospital viewpoint, is that what we are seeing more and more is that patients are coming to us with the expectation of not just receiving medical care. They come in with the expectation that financial counseling is going to get them the insurance that they need. But, you know, we get people insurance. Our financial counselors are great. And you're always going to have those undocumented. You're going to have those people that are afraid and they will come to the hospital at the last minute. And then you have the elderly that we find they're coming back in, because they don't have the money for their prescriptions.

School Based

Quality.

Accuracy.

Cleanliness.

Best effort.

I don't expect everybody to get everything 100 percent of the time, but -

Follow through.

Faster follow up and also friendly would be nice.

Good communications.

Outreach yeah.

Privacy.

Boomers

I would say a reasonable charge for reasonable service and, just as an example, I took my daughter - she had extra ear wax in her ear and because the insurance code for that requires not a Q-Tip, but an instrument that they - a cotton clip on the end - they charged $240. That's ridiculous.

I expect, when I go to a doctor, I expect to not wait more than 20 minutes.

Access. I go with access. You can't just get up and quote and telling you if you can't wait, go to the emergency room. We're not experts. We don't know if I have an emergency whether it's dehydration or whatever. So you're putting the onus on me to make a judgment about my critical health at that moment. And I may not be lucid enough to know what I should do.

My expectation is that somebody who's sick and needs care will get it, whether they can afford to pay for it or not. I don't think that - if you can't afford health insurance and you're sick, I think you should still get care.

Faith Based

Personally prompt care.

They take my insurance.

Competent care and ability, you know, with the sort of advent of having digital medical records to be able to access those records quickly.

I think somebody who really listens to them too. And I think the advent of the computer has - you go into some doctors offices and they will be looking more at the computer then they're listening to the patient and I have a mother who's 103 and I - and primary care for her and she, you know, I've gone to different doctors, but her primary medical doctor is one who really will listen to her.

There's no eye contact, there's just them looking at the monitor and you talking into space.

But one doctor who probably looked at her for 30 seconds - most of time he asked her questions looking at the screen. Something's missing.

Competence - just personal care.

Particularly in the emergency room. I mean I hear a lot of complaints of this - part of that and I think most people understand the need to triage when you're in the emergency room there's so many more acutes that are gonna get seen first and you might need to wait to get your finger stitched.

Youth

Well, sometimes I've noticed at Day Kimball, like I have bad teeth so like not having dental insurance, I go there when it's like really bad and severe to try to find something to help. So like they're - Sometimes when they think you're in pain, but they're not sure, you get sat out in the hallway on like a bed with curtains covering you if there's no one there to really help you. They're just like we'll get to you when we get to you, but you see nurses standing around drinking coffee and looking through magazines when there are people lying all over the hallway.

Have someone actually inform you of what the situation is. Like I'm fine if someone tells me we're having a backup, like then it's understandable. It's like I can't rush you if someone else has a more important problem, but like if there was nothing to be done and there's people sitting there in pain like it's your job to help them so why not do it instead of sitting around.

I think that he was saying about communication is an issue.

It definitely needs to be better at sorting out who needs more attention and who doesn't. Some people do abuse the emergency - They just go in there for every little thing, but then there's some people who are really there for something serious and they treat everybody the same.

Don't leave people isolated 'cause the biggest thing is if you're isolated and you're sitting in a hallway or sitting in a corner, you're forgotten unless you're screaming.

Not use age as a discrimination.

Strengths of Area Health Care Services / Providers?

- **Admittedly, the sessions were all geared to collect views on health care needs, concerns, problems and issues. Participants, however, readily offered praise for the collective of providers in the region when asked.**

- **Participants saw strengths that included the collaborative nature of the providers that benefit everyone. They saw a large, cooperative system tied together and working together in unison.**

- **They saw the "small" community of providers offering care and compassion. They see the local hospitals as a draw for employers seeking new out-of-state employees, committed health care professionals, and some new PCPs in the area making house calls.**

- **Others specifically praised home draws for lab work for the homebound and the professionalism of area home care professionals. Reminder calls for appointments were also appreciated.**

First Responders

I think that it's that - I think that Windham Hospital, I think it's still very personalized care. I think it's pretty compassionate, because it's still pretty small. And a lot of times, the doctors recognize the patients' names on the trackers, and they know that they've treated them.

We also try to be culturally connected. We have a lot of Hispanic patients, so we really try to do things, we have the interpreters available.

From the EMS perspective, one thing is that they very much know the community.

Well, we do have many patients that we transport many, many times. And I probably know the person you're referring to. And, so, I think that's good, because they recognize myself when I'm on the ambulance from when I own a business.

Latinos

Well, I know for me, they always make sure I get my appointments - what I need to get done is getting done.

Yeah, I like it when they call you. Like you have so much to do throughout the day, and you get that phone call and it's like. "You have your appointment tomorrow at such time." I love that, when I get that phone call. It's like I forgot my appointment, and they just reminded me. I like it. It's great.

I haven't really bumped into or have had my family complain about people being real mad or rude to them. Everybody seems to be on board, and they want to do what's best.

Community Leaders

Well, psychologically, when we talk to small business or larger business or employers that are thinking about coming to the area, we use the fact that there is a local hospital in Windham as a real, as an important weapon. We consider it a real asset.

I think that a real asset is that people who provide healthcare around here, they're really committed. Or else they wouldn't be here. They'd be somewhere else. And I think that's a huge asset that we have here.

I think it's an amazing spirit of collaboration that exists in Northeastern Connecticut. And you used the word "system," and, indeed, from a public health perspective we view it as a public health system. Clearly, alone we cannot do it, like any of us in any of the silos, so to sit on this large coalition that includes social service agencies, physicians, hospitals, healthcare providers, the college, we have Senate Pro Tem Don Williams who sits on it, on the Representatives. We have major stakeholders involved who are seeing the entire picture, and it's a wonderful opportunity - we meet once a month - to be able to come together collectively and hear about not only the challenges, but the good things that other organizations are doing. And we're constantly piggybacking.

Approximately three years ago, my mother went into her final illness, and had a local doctor for many years, a primary care physician. And I was just so totally blown away by the way he was able to tell me, "OK, you get in touch with this person now. You get in touch with this group here." We were able to keep her at home rather than trying to get her into a nursing home. That was just out of the question from a family point of view. But, the groups that came together to take care of her through her last days were just fabulous. Truly incredible. And you talk about care - it was just amazing.

That's wonderful. At Windham Hospital, there's actually kind of a revolution going on in healthcare. In association with a Hartford healthcare organization, I think is going through some changes and I think they're good. We've been able to recruit a wonderful group of radiologists and also a wonderful group of oncologists that are functioning very well.

I think a real strength in Northeastern Connecticut is the ability of the community to support itself. I think that because we've been the quite corner for a very long time, we've had to figure out how to get it done without a whole lot of other supports and services, and there's a spirit of generosity that really supports a lot of what needs to happen in the healthcare infrastructure that comes from the community.

School Based

I already said the electronic information is really good, and the Day Kimball that I've dealt with in all of the offices that are associated with that have been very friendly.

I think they're all trying to meet the needs of the community with the resources that they've got.

I'm alive.

Actually I'm too, but they do - I think that they work together pretty well in terms of - My father-in-law, I'm sorry my husband's uncle had a heart attack and they transferred him up to U Mass and they - He lives in this area and all his follow-up is sort of back and forth between here and there, and the doctors in both areas, despite that they're across state lines and such, have been working together very well, and that's nice to hear because that's not always the case.

That's been a long-term collaborative relationship.

Boomers

I think that walk-in clinic in Willimantic is very nice. I haven't had - when I first moved here I didn't have a doctor and I went there and they were great.

I think the two gerontologists I know here are making home visits, which for elderly patients.

If you're having difficulty getting a family member out because they're bed-bound or whatever, these people are making home visits.

I think if you need blood work or you need x-ray or you need some - and your doctor wants you to have tests run, I've found that if I go to Day Kimball I can go in and I can walk right in and the wait is very short.

The lab is great.

I agree with that.

They do home draws. If there's somebody that's homebound, you can get arranged through your doctors, and this is anywhere, to get blood work done in your home.

I think we do have a lot of home care people in Windham County. There's a lot of different groups and I think that's a wonderful thing.

Contrary to consensus, I've never had a problem with a referral to a specialist in the area. They've always been in the immediate area with the exception of the dermatologist was in Willimantic. Which is a half-hour drive.

I've seen an increase in alternative care just in the six years I've been here. Chiropractors, acupuncture. There's a waiting list - a two-month waiting list to see acupuncturists. That's awesome. That wasn't around when I moved here six years ago.

Faith Based

I know people in the congregation last year who was just in the hospital speak very highly of the care given at the Day Kimball Hospitals, so has a very favorable reputation.

I like my own doctor. I mean of all the doctors I've dealt with for different things and my wife has dealt with, you know, operations and things they've all been very competent. I'd say they have the three - timely appointments is sometimes an issue, but by in large I've been very happy with the treatment.

I think that most of them will want to do the best they can for the patient or they think they do.

Youth

Clean. A clean environment.

They are obviously trying to improve and from what I've heard from older people up till now - Like I know people who won't even go to a hospital anymore and they really have, they have improved a lot. They are getting better, but there is still a lot of things to work on.

I think the financial end of it, too, they're really trying to find a lotta ways to help people pay for stuff, not just send 'em a bill. Now they'll sit down and talk to you after you go there and try to put you on a plan or really just try to help you figure out how you're gonna pay for it.

Technology definitely. I mean we can even go to a place that has a robot surgeon that has those magnifiers or whatever for the surgeries. That's amazing right there. It's just a matter of getting to the big hospital that has it if you have something that serious that needs to be taken care of and you can't put one of those machines in every little town kinda thing.

Yeah, technology is really good now. It's helped a lotta things.

Local EMTs, too. Our neighbor's Life Alert went off yesterday and the ambulance came rolling through. It was a false alarm, but something happened and they were there right away.

And volunteer firefighters the same thing. They're the first to respond.

Weaknesses Of Area Health Care Services and Providers?

- **Participants offered perceived weaknesses including hallways packed with patients in the local ERs, having ERs used for primary and not emergency care. FR**
- **Others offered long wait times to schedule an appointment, as well as at an appointment, as a weakness. L**
- **The lack of translators and data were added as weaknesses. CL**
- **Some suggested the lack of mental health care especially children psychiatrists and psychologists was a significant weakness. These participants also saw a lack of training for teachers on mental health issues in children as a weakness.**
- **Others considered the general lack of information on wellness or wellness education a weakness.**

First Responders

Well, it would be the - on the other hand, the ER is overwhelmed on many occasions. They're lined up down the hallways like suitcases. And that becomes a problem. We have issues with patient turnover, which - it's starting the ones out of service for a longer than normal time, because we're waiting to turn over to a nurse.

We're being utilized as a primary care institution, as opposed to an emergency care.

Do you think people call 911 and take the ambulance to the ER because they think they'll get into the doctor than if they were to drive themselves? Yeah. That is absolutely one of the perceptions that patients have.

I would - that was actually - it's the reality, too.

And then I think - you're someone who doesn't overuse the ER, but you do have to use it at one point in time. That's very difficult when you get there, and you want that emergent care, but you have to wait behind the other people who have taken the ambulance because they need primary care.

Latinos

Yeah, and taking forever.

Taking a long time waiting for them to see you.

And even getting an appointment. I know like to see an eye doctor, you need to wait.

Community Leaders

Back up the tape, the first hour.

Clearly, the funding piece of it, as I've alluded to, puts us at a disadvantage in so many different ways. Again, because of the lack of data, and this is why we're so grateful for the assessment that is being done, the general lack of data to support the needs and the outcomes and the health status that we see specifically in Northeastern Connecticut.

I think particularly in Windham, but other parts of the county, you know, in our state, for example, the federal government requires that there be interpretive services paid for through Medicaid. It's not funded in this state. And there have been several tries to get it funded, and it has failed several times. And they're violating the law in Connecticut, but that's how it is here.

If I could, it's a huge issue for Latinos. Bringing a child and asking them to interpret for you. Bringing a sister, talking about sensitive sexual issues, sexual history, abuse history, victimization.

The weakness is that we are very fractured and we have a very difficult system to navigate. So, it's great if you're an insider, if you've been here forever and you know the players.

School Based

But it's still, even when there's some long-term relationship in any organization, the communication isn't always there, so it's nice that it's not just that they have that collaboration and that they can do that, but that they maintain the good communication because -

I think for me one of the critical pieces that's missing is the mental healthcare and good coordination of mental healthcare. It is extremely difficult to find a good psychiatrist. There are not children's psychiatrists and psychologists around. There's not really good training for teachers around mental-health issues in children.

Mansfield is over a thousand kids. It's very difficult for a kid who has any mental-health challenges to adapt to a building that size. And the hoops that they have to jump through to be able to be in a smaller, supportive environment are very difficult.

I think children come to school and work the high school population and they come with baggage. It's not as simple as - you know - I think as in the past. There's many more variables playing into it. I work at a school-based health center and I think it's - which is located in the high school, and I think it's a very positive - These kids are lucky to have access to that care because they can come for mental-health services or medical services right in the school so they have a safe place to go to come and to unburden themselves as to what the issue is. And that goes from guys - you know - male and female many times with their sexual health needs we deal a lot. You know - played a bit with that. And mental-health needs I think that it just runs the gamut. Some of them haven't had a physical in they can't tell me how long it's been.

Boomers

Again, I'd just like to bring up the fact that they should have more wellness for people. I know that they have a cardiac at Windham Hospital. They have a cardiac kind of thing that's supposed to be really good. I have a friend that's in it and she really likes it a lot. And I think they should offer more stuff like that. More wellness.

Yes. Like taking classes.

Opportunities for the Area Health Care System?

- **Participants saw some regulation changes – allowing reverse transports by area ambulances – freeing up emergency room and other beds. And, they saw strategic public transportation to walk-ins helping reduce ER numbers and even EMS vans to walk-ins. FR**

First Responders

Opportunities in respect of increased volumes, increased revenues. Increase my employees' pays. Better benefits. I would like to see some changes in regulations, in regard to what emergency medical services can do. There was a bill in the Connecticut legislature that never made it out of subcommittee, where - this is kind of technical stuff. But if I hold a PSA in the town of Killingly, I can do emergency transports. Well, if I'm at Day Kimball, and we took a patient from the nursing home earlier, why not allow us to take that patient out of Day Kimball and get them back to the nursing home to free up the dead space? So, that does two things. It gets us, rather than going back to our home base. And it gets Day Kimball a free bed. So, things of that nature, I would like to see.

Well, I think it would be cool to have some kind of a van or something that would be available, if there's a walk-in clinic. It'll get some of these people. Just trying to take off room - all of the emergency services, you know. Have some kind of public - more public transportation that could get them to walkins.

On Regional Health Care Needs…

What Are Community Under-met / Unmet Health Care Needs?

- **Uniformly, across all groups, participants called for more mental health services, health insurance support, transportation to health care providers, childhood mental health services and dentists and physicians who take all insurance plans.**

- **Other reported needs were reported to be: care for autism, diabetes, tick borne illnesses, sexual abuse programs, orthodontist care, dental clinics, eye clinics, sex education, services for special needs children, more immediate care for those needing mental health services, oral surgeons that accept state insurance, homeless falling through cracks, shelters, alcohol/drug counseling, convalescent rehabilitation, lifting devices for obese patients, pediatric dental care, health, nutrition and fitness programming, caregiver support (education, home support, companions), community health care education, inexpensive ways to eat healthy, coordination of efforts between church and state, and delivery services for medications to patients – especially seniors.**

Deliberative Community Health Care Needs

Following approximately 90 minute discussions during each focus group session, participants were asked to review an extensive list of health care programs and services. Each was asked to indicate if they felt there were too few, too many or about the right number of each of the programs and services presented. The following tables report the results on a composite basis (all participants in all groups) as well as separately by each group. "Don't know" responses were removed from the data. "Too Few" is often viewed as need. The programs and services that 80.0% or more suggested as a need are shaded for easy reference.

Deliberative Community Health Care Needs

Composite Results: The following table presents the composite results from participants in all seven focus group sessions. "Don't know" responses were removed from the data.

Community Health Care Programs and Services	Too Few	About Right	Too Many
Childcare – allowing travel to medical appointments	95.8	4.2	---
Fitness and obesity education / programs	94.0	4.8	1.2
Transportation to health care services	93.9	6.1	---
Health insurance support	93.8	4.9	1.2
Veterans health care	90.9	7.8	1.3
Caregiver education and support	89.9	10.1	---
Behavioral risk prevention programs	85.5	11.8	2.6
Alzheimer's/Dementia support groups	85.5	13.0	---
Caring for elderly parents / support	85.5	11.8	2.6
Nutrition education	84.1	15.9	---
Food/meals for those in need	84.1	15.9	---
School age bullying prevention services	83.6	13.7	2.7
Parenting support programs	82.5	17.5	---
Behavioral / mental health services	80.0	18.8	1.2
Domestic violence prevention education	79.2	20.8	---
Alcohol & substance abuse prevention	79.2	16.9	3.9
Health and lifestyle education	75.5	24.5	---
Recreation programs	74.7	24.1	1.2
Health advocates	73.8	22.5	3.8
School based health care services	72.0	28.0	---
Family planning care	71.4	25.7	2.9
Diabetes education/services	70.7	28.0	1.3
Fitness centers or gyms	65.9	30.5	3.5
Dental services	65.5	28.6	6.0
Alternative health care	62.7	33.3	3.9
Home health care services	59.5	40.5	---
Alternative medicines	58.0	34.0	8.0
Health care centers / facilities / walk-ins	54.1	44.7	1.2
Emergency medical services (EMTs, paramedics)	49.4	50.6	---
Emergency preparedness	45.8	52.1	2.1
Youth / child abuse programs / prevention	44.1	55.9	---
Addiction support	43.0	53.2	3.8
Gambling addiction support	39.1	59.4	1.4
Smoking cessation programs	38.6	60.0	1.4
Alcohol & substance abuse care	34.6	59.0	6.4
Access to birth control	33.8	62.2	4.1
Sleep disorder programs	31.9	68.1	---
Safe sex education	31.5	64.4	4.1
Primary care physicians	31.4	64.0	4.7
Eye care physicians / services	26.7	73.3	---
Pre-natal care services	25.0	72.7	2.3
Dentists	23.5	71.8	4.7
Hospice care	12.9	87.1	---

Deliberative Community Health Care Needs

Composite and Leadership Results: The following table presents **"Too Few"** results on a composite basis as well as by the four leadership focus group sessions. "Don't know" responses were removed.

Community Health Care Programs and Services	Composite	First Responders	Community Leaders	School Based	Faith Based
Childcare – allowing travel to medical appointments	95.8	100.0	100.0	100.0	100.0
Fitness and obesity education / programs	94.0	75.0	92.3	100.0	100.0
Transportation to health care services	93.9	62.5	100.0	100.0	100.0
Health insurance support	93.8	100.0	100.0	90.0	100.0
Veterans health care	90.9	100.0	76.9	87.5	100.0
Caregiver education and support	89.9	100.0	92.9	100.0	84.6
Behavioral risk prevention programs	85.5	100.0	84.6	100.0	100.0
Alzheimer's/Dementia support groups	85.5	100.0	66.7	75.0	92.3
Caring for elderly parents / support	85.5	100.0	83.3	88.9	92.3
Nutrition education	84.1	50.0	84.6	80.0	100.0
Food/meals for those in need	84.1	75.0	64.3	77.8	92.3
School age bullying prevention services	83.6	57.1	100.0	90.9	100.0
Parenting support programs	82.5	71.4	78.6	100.0	83.3
Behavioral / mental health services	80.0	75.0	78.6	100.0	100.0
Domestic violence prevention education	79.2	85.7	72.7	81.8	91.7
Alcohol & substance abuse prevention	79.2	71.4	85.7	100.0	90.0
Health and lifestyle education	75.5	40.0	81.8	57.1	87.5
Recreation programs	74.7	37.5	46.2	90.9	84.6
Health advocates	73.8	71.4	61.5	70.0	92.9
School based health care services	72.0	37.5	66.7	100.0	66.7
Family planning care	71.4	66.7	69.2	66.7	72.7
Diabetes education/services	70.7	85.7	30.8	62.5	90.9
Fitness centers or gyms	65.9	25.0	64.3	70.0	84.6
Dental services	65.5	85.7	92.9	54.5	71.4
Alternative health care	62.7	33.3	40.0	71.4	87.5
Home health care services	59.5	50.0	21.4	60.0	69.2
Alternative medicines	58.0	33.3	40.0	71.4	75.0
Health care centers / facilities / walk-ins	54.1	50.0	21.4	45.5	61.5
Emergency medical services (EMTs, paramedics)	49.4	50.0	7.1	45.5	66.7
Emergency preparedness	45.8	20.0	25.0	66.7	42.9
Youth / child abuse programs / prevention	44.1	40.0	81.8	70.0	36.4
Addiction support	43.0	28.6	69.2	60.0	38.5
Gambling addiction support	39.1	20.0	71.4	14.3	41.7
Smoking cessation programs	38.6	40.0	58.3	---	45.5
Alcohol & substance abuse care	34.6	42.9	57.1	54.5	30.0
Access to birth control	33.8	20.0	84.6	45.5	23.1
Sleep disorder programs	31.9	16.7	8.3	20.0	33.3
Safe sex education	31.5	14.3	53.8	50.0	18.2
Primary care physicians	31.4	37.5	78.6	9.1	14.3
Eye care physicians / services	26.7	---	21.4	30.0	36.4
Pre-natal care services	25.0	---	20.0	---	20.0
Dentists	23.5	37.5	64.3	27.3	21.4
Hospice care	12.9	12.5	---	12.5	9.1

Deliberative Community Health Care Needs

Composite and Residential Results: The following table presents **"Too Few"** results on a composite basis (all seven groups) and by the three residential groups. "Don't know" responses have been removed.

Community Health Care Programs and Services	Composite	Latinos	Boomers	Youth
Childcare – allowing travel to medical appointments	95.8	90.0	100.0	83.3
Fitness and obesity education / programs	94.0	90.0	100.0	92.9
Transportation to health care services	93.9	100.0	100.0	83.3
Health insurance support	93.8	80.0	100.0	85.7
Veterans health care	90.9	90.0	100.0	85.7
Caregiver education and support	89.9	90.0	91.7	75.0
Behavioral risk prevention programs	85.5	60.0	91.7	66.7
Alzheimer's/Dementia support groups	85.5	87.5	100.0	80.0
Caring for elderly parents / support	85.5	77.8	93.3	63.6
Nutrition education	84.1	90.0	85.7	85.7
Food/meals for those in need	84.1	100.0	86.7	92.9
School age bullying prevention services	83.6	100.0	81.8	53.8
Parenting support programs	82.5	90.0	91.7	64.3
Behavioral / mental health services	80.0	50.0	73.3	76.9
Domestic violence prevention education	79.2	70.0	85.7	66.7
Alcohol & substance abuse prevention	79.2	66.7	71.4	69.2
Health and lifestyle education	75.5	100.0	85.7	66.7
Recreation programs	74.7	88.9	86.7	78.6
Health advocates	73.8	60.0	84.6	69.2
School based health care services	72.0	90.0	83.3	53.8
Family planning care	71.4	77.8	81.8	63.6
Diabetes education/services	70.7	80.0	76.9	76.9
Fitness centers or gyms	65.9	70.0	71.4	61.5
Dental services	65.5	50.0	46.7	61.5
Alternative health care	62.7	80.0	83.3	55.6
Home health care services	59.5	90.0	80.0	50.0
Alternative medicines	58.0	40.0	83.3	62.5
Health care centers / facilities / walk-ins	54.1	80.0	80.0	42.9
Emergency medical services (EMTs, paramedics)	49.4	80.0	71.4	35.7
Emergency preparedness	45.8	60.0	66.7	57.1
Youth / child abuse programs / prevention	44.1	22.2	18.2	36.4
Addiction support	43.0	11.1	35.7	46.2
Gambling addiction support	39.1	25.0	18.2	50.0
Smoking cessation programs	38.6	37.5	30.8	50.0
Alcohol & substance abuse care	34.6	11.1	21.4	23.1
Access to birth control	33.8	44.4	10.0	92.3
Sleep disorder programs	31.9	80.0	28.6	66.7
Safe sex education	31.5	30.0	30.0	16.7
Primary care physicians	31.4	20.0	33.3	21.4
Eye care physicians / services	26.7	40.0	18.2	36.4
Pre-natal care services	25.0	66.7	---	50.0
Dentists	23.5	20.0	93.3	92.3
Hospice care	12.9	28.6	15.4	18.2

First Responders

I was going to say. Maybe true emergent care is well covered. I mean, I think that the people who really need care get there. They're not - you know, there aren't people, bodies laying around in the street. They really get there. There really are a good group of doctors. There's a priority system, that if you are really in need, clutching your chest or whatever, you're going to go to the head of the line. So that triage system is very good up there.

She said that child/adolescent psychiatry is definitely a problem in the Danielson area for sure. And then, you get this in oral surgeons that accept state insurance. I mean, we don't have any.

Alcohol counseling, drug counseling. People - homeless people that seem to fall through the cracks. That end up with the lightest thing in the ER and the ambulance, for just a place to stay and a meal.

Well, we don't have a shelter up here. So the homeless are truly homeless. There's a family shelter, and there's a no-freeze shelter that sees them. But otherwise, there's no shelters..

I don't know, like transportation and walk-in center could be expanded. So they'll get the patients to facilities where they could get care, other than the ER.

I think we could use some more convalescent rehab-type homes, too. Especially for the older people, like - you know, if they have any still-type situations, and they need places to stay

I think autism.

And associated disabilities. That's becoming more and more and more prevalent.

Well, of course relates to diabetes. That's prevalent. And it's not only an issue for the patient, it's an issue for their caretakers, for ambulance services. The lifting mechanisms. It's a very expensive proposition.

Latinos

The insurance coverage is varied here. So that's a need I guess. I mean, probably including some education in the school systems, so by the time these kids are out on their own, they got some clue as to where to go, how to go about it, who to contact, how to deal with insurance companies.

Absolutely. I mean, they teach you a lot about sex education, how not to do drugs, how to eat healthy, how to stay physically fit. When a kid is out on his own, and he gets sick, he goes, "I don't even know how to call a doctor."

Helping a person make sure they're going to get to their appointments.

Transportation - I get to, how you call, stuff for the kids to do, because there ain't nothing around here. So some of those things.

Sometimes in this town, it's not accessible all the time.

Community Leaders

I think one at the beginning of the session was a lot of comments about behavioral health. And I think that is one where we need the players to come together and do a better job. United Services. Natchaug Hospital runs on Day Kimball campus in Putnam the Day Clinic. And, of course, we have our psychiatric in-patient unit, about 15 beds, and the census is high almost every day. But, there is a lack.

Access to public transportation.

If you're on Medicaid, you have access to appointments, medical appointments, dental appointments, through your Medicaid. It's Logistic Care. We have to call them up for people going home all the time. But, what I find is so interesting is a lot of people on Medicaid don't know they exist.

Pediatric dental care.

But, so, in an attempt to work on the obesity problem, we're having to get a YMCA for the area and it's still in process, but I'm hoping that it will help, especially because from the months of October through March, it's pretty miserable outside and most people will not go out and exercises, so those are the months that people look at me and I tell them that their kids need to be more active, and they say, "How?"

Well, it has been made, but the oral health.

School Based

Sex education.

And mental health believe me, yes.

Special need.

Even at that mental-health services are very hard to come by in our area - good ones.

Or the waiting time.

The services - when you have that need you have it today. You're not going to have it three weeks from now or four weeks from now, you have it today.

Transportation -

Other children's needs that are not well met are around the dental clinics, around orthodontic work and eye clinics for those children who are uninsured or underinsured.

I think that that's another - for the seniors who are on Medicare to find a provider who takes Medicare, because the providers only take so many Medicare patients because of reimbursement purposes.

Right and so therefore for you to try to get a provider, a primary care provider, or physician or - you know - nurse practitioner, some provider may be difficult if they've met their quota.

Obesity, diabetes.

Autism, Asperger's.

I think in this area one of the things that really needs more attention is people need to look at the effects of tick-borne illnesses.

This community has one of the highest statistical rates of sexual abuse and incest.

Boomers

More walk-in clinics, probably, right? At least a couple.

I'm going to go with - not necessarily home care, nursing and that, but home support services. Caregivers, companions.

I think they need to advertise the services that are available too.

Directory. That's it. I have a directory out of Day Kimball that had everything that was available in - and I don't think it's been published for 10 years. I'm still carrying around my dog-eared copy.

I really think they need to offer more mental health services because you see a lot of people out on the streets that you know were kicked out of Norwich Hospital.

More transportation.

We have volunteer programs where people will drive people for cancer treatments. But I wouldn't know where to find that. That's another thing.

I'd like to see a senior center where we can - and have it open with education, preventative, connection, communication. All of that.

Yes. Transportation.

Faith Based

I don't know if there's a weakness much but I see a need in my congregation around this sort of health and wellness education. And there's not a lot of stuff around. They're Christian and, you know, the answer is no we shouldn't smoke, we should eat well, we should exercise, but on a sort of practical level how do we do that. Or for folks who are smoking how do they get help and support to quit?

I think that there's a segment of the population that's just starting into a greater risk with the economy and its people who struggle with mental illness or mental retardation and that - not necessarily severe, but are in that fringe group. They're very qualified prior to the economic downturn, but now, you know, programs and funding and budgets are decreasing and the services that were offered to them are shrinking.

I often thought, you know, churches really support families a lot of time that if it wasn't for the church they would fall apart and you know, it is partly economic stresses and a lot of times it is mental health issues. All a lack of employment opportunities for people who are not highly skilled.

Related to that just in probably the last year and half and probably related to the economic - larger economic issues, but suicide prevention concept. I've had a couple of crisis in the last year and half with parishioners or family members of parishioners that were in suicide crisis and, you know, first time to have got that - involved in that - no sense of where I can go for support for me is the priest trying - the parishioner in crisis. But I know of other folks there are reaching those levels of desperation and you know even something as simple as a list in a book of sort of who to call could, you know, with the resources. Before it gets into the actual crisis itself.

The transportation issue that we talked about a few moments ago - I think, you know, particularly in the more rural areas that information is unknown.

The other thing with transportation is very often the elderly can't get their medications. There's only one pharmacy in our area that delivers.

Bonneville was the only one in Danielson that delivers. And so it makes it difficult for people who don't drive, who don't have a homemaker or a companion who can go get it for them, who don't have a family member.

I think having support groups for those kinds of issues would be very, very beneficial.

Youth

Definiely more available facilities that are affordable and not just practical.

And more education.

It's - I would say it's the nutrition in the schools because if you set up quality nutrition in the schools and you tell the parents to set it up at home then what do they do? Eat junk food at their friend's house. I mean if you can set up a

community they see groups of vegetables, have a garden in your backyard or grow some plants on your porch or whatever you can do. Every little plant helps in foods or nutrition. And then exercise.

Yeah. It's very expensive to have the really good nutritional plans.

What Are Emerging Health Care Needs in the Community?

- **Participants frequently suggested that mental health care was not so much a need as was effective, mental health care. The distinction was made across several groups.**
- **Others complained that mentally ill patients were getting pills instead of education on healthy living.**
- **Others offered emerging needs as diabetes, obesity, and tick borne illnesses.**

First Responders

You touched on mental illness, mental healthcare? Is that an emerging need? Is that getting larger in the area? Absolutely.

I think it's - I think it's the - I mean, I - again, it's not particular to this community. But I think it's just totally ineffective. I mean, I think there's a lot of things that - all you do is get a prescription. You go, you get a prescription. It's not - there's no - how do you live a healthy life? How do you prevent this sort of stuff from happening? How do we teach you? You know? Everything is - it kills versus skills. And it's obviously - it's on the cheap, because it's about time face to face with a physician, and how long it takes to do that.

And there needs to be better stress management than smoking a cigarette, or downing a bottle of vodka.

ON GROUP SPECIFIC INSIGHT…

Health Care Needs Specific to the Faith Based?

- **Faith based participants regretted that sometimes they face Church/State barriers to cooperation. Some cited specific lost opportunities to cooperatively run programming. Others held high interest in and sought education on resources available.**

Faith Based

I think most of it would be just helping us be educated about what the resources are so that we could then pass that along to the folks that need services. And whether that's a piece of paper that we hand them or just an awareness of, you know, oh you're a diabetic in my congregation, your having - you just mentioned you're having trouble controlling your sugar here's - you have a couple of - not just going back to your doctor but here are some other resources that I know about or here are teenagers in crisis in my congregation I have a sense.

And we always try - and we have a couple of RN's in the congregation who a few years ago with that H1N1 flu bug got out came up with the idea of just doing a forum at coffee hour with our own congregation and doing some just basic education around what that new flu was and where vaccines were able to be gotten and sort of who qualified for them, you know, first it was sort of, you know, more high risk people who could get the first wave of those.

And there was concerns about sharing communion in our church. Were they all gonna get the flu together and so it was really a great for local contact and it was kind of safe place 'cause it nurses that were members of our congregation. But those were very well attended and they've kept doing it so that was a crisis point a couple years ago, but they've done it the last couple of winters as well.

It's all communication. To have communication for people to give you stuff so you can communicate it to other people.

I think having some kind of a form informing us of programs, support groups, possible solutions to different issues is maybe a time or two a year. Inviting community leaders to come together and say this is what we have in our community and give us, you know, give me a menu. And I don't probably want it in the mail. I get too much mail that I just can't sort through.

An e-mail too.

Health Care Needs Seen by Community Leaders?

- **Community leaders also sought sharing of information and coordination of outreach and other activities.**

Community Leaders

Sharing of information, I think is critical. That is one of many successes we saw with this coalition that we brought together, is that for the first time in quite a long time, that spirit - and not to say that it didn't exist before - it exists now on a different level, because everybody realizes, you know, we're all floating in the same pool, really with the same life jackets on, and unless we help each other up into the life boats somebody is going to sink. It's that simple. And we can't afford to let one more provider, one more agency, one more organization sink. We can't do it. We owe that to our communities to help keep each other afloat so we can save them. So, I think that sharing of resources is critical.

Health Care Needs Seen by School Based Professionals?

- **School Based participants were looking for training in mental health / severe behaviors as well as special needs. They called for a resource for educators – someone to email with questions they faced in specific situations.**

School Based

I would definitely like some training in the mental health severe behaviors. I had a couple of kids. I'm teaching for six years, and I've had a few that have had some severe behaviors that I've had to call my administration to come - I'm taking the kids out into the hallway. You need to come and get so and so who's in the room throwing things and at them and skipping over desks and stuff like that. You know that kind of thing.

I don't think that the schools are prepared to meet with mental-health needs, and it's the bottom of the list of things that need to go on. And they're all so overwhelmed and concerned about trying to bring their scores up and improve their numbers and all of that kind of good stuff that the kids that's acting out, that's not going to be such the highest priority because the dollars and cents are going to say it's going to cost us a lot more to provide a one-to-one or additional -

Not only the training for the emotional and behavioral, but also for special needs too. You mentioned autism earlier, I would love to attend a training on how to reach student who has autism or some other specific need. It would be great to have a different - a variety of trainings. geared to teachers.

Just again to reinforce that people in the schools are not prepared to deal with mental-health issues, and the schools are not prepare to provide the training for their staff.

I think that's a bonus to have the school-based health center where I know that I as a nurse practitioner - I do receive lots of questions from the educators. They come in quite frequently with questions and concerns and how can I work with this student.

If there was a regional person that they could e-mail or - you know - just get their - to get their questions answered. I would think that would be really be beneficial. So that when you're faced with something and you don't know what to do, and your principal doesn't know where to send you, and your school nurse doesn't know what to do, at least you know who to e-mail.

Health Care Needs Seen by EMS?

- **EMS professionals called for more training, more local training. They cited the need for living wages for their EMTs/Paramedics.**

- **They called on medical professionals not to make it so easy for ER patients to get pills – helping to break the cycle of their "frequent flyers".**

- **Economically, allowing charges for transfers would help them significantly and they sought better technology to communicate such things as EKGs from the rigs.**

First Responders

More training. And we're seeing some of that. Right now, training of - for all these different groups is very spotty, hard to come by. Northeast Connecticut is always - it is rarely a place where statewide trainings go on. You usually get the notice of training - there's training available in several locations, and there's not one east of the river. Or if it is, it's New London or Norwich. So. Multiple training opportunities.

We're making it too easy for these people in the hospital. Don't make it so easy to get that prescription. You know? Make - I don't know if there's something that's cause to put the liability back on the doctor. But if they're willing to give a prescription so easily, it's just a roundabout for the patient. If they come in, they get prescription, they go back out.

For each pain, they get another pill. Or another prescription.

Or they say, don't write the prescription. After awhile, they'll give them that there in the ED. So now you're encouraging an ED visit.

There's got to be a way to break that cycle.

I don't know, I hate to say - I used to live in Belgium. And I think it's as free as is possible. And there, everybody has essentially Medicare. And through the government, you do pay in taxes. But it costs a lot less than paying for insurance package here. And I had to take advantage of the system there. I was in the hospital for awhile after an accident. And it's wonderful not to have to think of medical bills. And there is a co-pay for everybody. So they don't have people come in, choosing just the ER for things they can go to a doctor about. And there's a small co-pay, so everybody has to pay something. So, I guess it lessens the tendency to abuse the system there. And I - you know. It's just too bad that we've become so fully entrenched in the insurance system here. That - I think that's a major problem. I think if we didn't have all these different payors, and all the bureaucracy and administrative costs, we could focus more on providing the care for people that need it. It wouldn't solve all the problems, but I think it would go a long way towards dealing with the issues that we've discussed here.

I think they'll provide a more timely turnover of patients. I can see down the road better use of technology, and being able to communicate, to let me through an ER from an ambulance. The EKGs and that - those critical components is where a person is really having an MI, versus just chest pain. And whether that doctor can say, we're going to divert you to - directly to UMass. And bypass the community hospital, so they can get to the lab and can get some work done. That kind of thing.

I think it's going to be - and in the reverse of that, that makes the EMS workers like myself more excited about our field, in that it makes it easier to attract more people, and retain the ones we have. If we have more tools to work with.

ON SPECIFIC HEALTH CARE NEEDS …

Degree Services are Needed for Addictions?

- **Interestingly, when discussing addictions, many suggested that cell phones, iPods, iTouches and video games are addictions – all also related to the issue of obesity. CL**
- **Some thought smoking programs related to kids were increasingly important. SB**
- **Others noted that there are enough addiction services in the area – what is needed is effective, addiction services. FR**
- **Some saw the damage gambling is doing to the stability of families already on the edge. CL**

First Responders

We have enough treatment places.

You know, I'm thinking, when we were talking about the treatment, we didn't mention the methadone clinic. There's a methadone clinic that's in the area too. We don't have enough effective treatment in the area.

And I don't know that anything has been identified as particularly effective.

I don't even know if there's anything out there. I don't feel that enough, I guess. We're talking about the emergency basis, I guess it's not where people are ending up. And even hearing the stories, unless they're not saying it, I can honestly say - probably in the last year, I've heard gambling mentioned once in a clinical case that I was involved in.

Latinos

I think there is. I think there's too many of them. I think it's overwhelming, as a matter of fact. The amount of help that's out there for people with addictions. I mean, I happen to know personally people who are addicted to heroin. They don't work. It's considered a disability. They get a house. They get food. They get transportation, and they don't work.

Community Leaders

Easily over half of our clients will come in with a mental health issue, a combination of trauma and substance abuse.

It is. Yes.

The casinos have really ramped up how hard it is to have a stable family in Northeastern Connecticut.

It is one of our best attended groups and we run it on Monday night, 52 weeks a year, even if Christmas falls on a Monday, and it is heavily attended even on Christmas. More on Christmas. Holidays are a tough time for gamblers. Yeah.

I know this one probably hasn't hit the clinical diagnosis yet, but technology addiction to cell phones, iPods, iTouches, video games. We are seeing, well, we're going into schools and talking to kids about obesity issues as a result of sedentary lifestyles and physical activity, and we're seeing it, in a large degree, to adults.

And again, when you talk Windham County, we're fairly rural, fairly isolated, and that technology is one of the few things that most households have access to. They may not have a car to get to a youth center or senior center, but they've got a computer.

School Based

Right there's definitely drug and alcohol issues. Gambling - I think that there is some.

I think there is probably some gambling programming needed. I mean you just see it in the newspapers with this person stealing money.

AA in this area has a lot of good meetings.

I think smoking programs still need to be targeted to kids. I'd say still are picking it up at a very young age.

I would say not only prevention of smoking for youth, but the two people that I know in our family that have had major heart attacks are smokers, and they've been smoking since they were 12 years old and they're in their fifties now, and they are having a really hard time stopping.

Some of them are there, and you know with young kids it's chewing tobacco. It's not just cigarettes. It's another mode of tobacco too.

I know the D.A.R.E. program came to my kids' school. Bo,y my kids are afraid of ever doing it.

The other hot issue that is not getting enough prevention is pot.

It's very accessible.

I mean I live in the town where they - what was it the biggest pot field in the history of the state in Canterbury recently?

Boomers

Willimantic I believe offers some addiction services.

You can't just go there. You have to be referred. You first go to Windham Hospital or another hospital like Backus and then they can refer you, but you can't just say I need help.

Smoking. I see a lot of people in this area still smoke. And I really think they should offer smoking - non-smoking - how to stop smoking stuff and advertise it. It's ridiculous the price of cigarettes.

Faith Based

I think so.

There always seems to be somebody in the hospital with an addiction problem. A lot of times they themselves don't avail themselves up to others, so I'm not sure how to best answer that.

I think it's the statewide directory of AA meetings that we keep available in the parish. They seem to disappear over the course of the year. But I don't have anything related to smoking cessation groups or gambling addiction groups and that is something I'm aware of.

Youth

I agree with Linda with helping people with problems and stuff, but a big problem is people who wanna go through with it and pay the money I mean people who are addicts don't really have money to do, to go to any of those programs or get treatment and if they don't have health insurance then they're gonna tell them basically the answer is just go out and get high because we can't pay for it. It's cheaper just to buy drugs. I think that's an issue.

Degree Programming is Needed for Bullying?

- **While adults disagreed, based on the results to the Deliberative Community Health Care Needs Card, youth participants didn't see bullying as a large problem – except perhaps at the middle school level.**

Youth

To tell you the truth, from what I've seen, what I've heard, like back in the day and now, when I was in high school, I went to two different high schools, and I never saw any bullying at all. And I was friends with like groups of kids and I was friends with like popular kids, too, and I never really saw any of that, very, very little.

I mean people that like pick on each other and some people are just gonna be assholes, but I mean I haven't seen anything outrageous.

I think it's with the younger kids honestly. Middle school.

Younger than high school.

Middle school actually I know of people who were bullied in middle school.

I definitely think middle school is like where everyone has to try and see almost how far they can push their levels and everyone else. In high school no one really cares what anyone else do and they're just like all right, peace. Like see you later.

Degree Services / Support is Needed for Care Givers?

- **Interestingly, many could not name any or did not know of any existing support groups for care givers. CL**
- **Others suggested there was a strong need for care giver support in the community. They see professional home care services as too expensive and not covered by insurance. They also see this group as underpaid FR**
- **Some called for training and certification of care givers as well as transportation for the elderly. L**
- **Others called for education and training for care givers on how to advocate for those in their care. B / L**

First Responders

It's too expensive for a lot of them to get support. And it's not always covered by their insurance.

I mean, I think the families aren't so, you know, close as they used to be. People are traveling, and the families - you know, you go where the job is. You don't stay near your mom and dad anymore.

Absolutely. I think a lot of you don't have that family unit type, as much as you used to.

Latinos

Again, transportation is an issue. I think if you're a caregiver, you should be required to go to some of these meetings with the doctors. You should be required to get them information. If you're going to be issued as a caregiver, you to need to have some knowledge as to what you're doing.

Education. Again, communication between doctors and clients and doctors and caregivers is not the most forthcoming, and if you're not acclimated enough or don't have time enough to go out and get it on your own, it's just not there.

Yeah, a lot of elderly people need the transportation. I mean, a lot of them can't drive. I've seen a couple of them take the only bus we have here, and you see them having a hard time just getting off the bus, but they don't have nobody to depend on. They have to do it on their own.

I think it's hard, because these people need to advocate for the person they're caring for, and they don't have the education to advocate for them, so they just go with the flow.

Community Leaders

They may not be in the best of health themselves, and, so, where is that caregiver for the mom or dad, or where is the caregiver because in today's economy everybody is working? So, it makes it very difficult. If you have financial resources, we've got all kinds of help for you. If you don't, then -

The Caregiver Support Group, but I don't think it's running anymore. There used to be.

School Based

They need a respite.

Boomers

People - a lot of people don't have a good understanding of what they're undertaking when they say I can do this. And a lot of education is needed there and no matter how close it is within a family, they need somebody else to kind of give them a break for a while.

And the problem around the caregivers is it's a very low paying job. So the people that go for these jobs are not well educated and they're doing it because they need a job. Not because - out of the goodness of their hearts.

Faith Based

Yes because like I said I go to a lot of elderlies and stuff and I've been through with my parents all the stuff and that with them being sick and everything in that and they'll talk to me - their kids and stuff and say well you do understand what I'm going through. And I'm like yeah I understand, but they're like well how do we get this and how do we get that and I'm like I really don't know. I wish I knew.

Degree Health / Fitness / Wellness Programming is Needed?

- **The consensus across all the groups that there are likely enough health and fitness centers in the area but not enough affordable ones. SB**
- **And, some returned to the issue of personal responsibility suggesting there were enough programs available but residents are not availing themselves. FR**
- **Some suggested subsidies for health and fitness facility use/membership or reimbursement based on use. L**
- **Transportation, again, became an issue when discussing gym / fitness center facilities. These participants also noted how they are educated to eat healthy but how much more expensive it is to eat well. L**

First Responders

I know we've done several programs. They'll be signed up to come, fifteen, twenty people, and they just don't show up.

And there's walking trails all over the place. And facilities are great, but to me, if you can get out the door and walk, that is your fitness program right there. It's incumbent upon the person to do it themselves.

There's all kinds of fitness groups, and fitness places to go to. Walking trails, the whole thing. You've just got to get out there and do it.

Latinos

Not enough.

I have a place to go.

There is two, and I think - I mean, I don't know if it's enough, honestly.

Yeah, but nobody can afford them.

Yeah, because you're paying $20 a month or whatever.

And getting there.

Getting there is an issue.

Actually, I think they should do programs for the kids on like exercises and stuff like that. I think that's a major thing that they need to do.

It's after school, and she would take the little girl - the teacher would jog while the little girl rides the bike and helping her to lose weight. I mean, if you see people getting together and helping the children out - give them something to do. The kids really don't have anything to do here.

Because in middle school you're suppose play dodge ball and stuff like that, but they don't got like a gym for them. So like a little bit of weight lifting or walking or riding the bicycle after school. They've actually got that stuff in high school, but not really in middle school.

The poorer you are, the more crap food you're forced to eat.

I can go to McDonald's for three bucks and eat every day [LAUGHTER].

That's true, though.

That's true. I didn't think about it.

What's a salad cost you? $5, and that's at McDonald's with the sweet sauce on top? You know, go in the store and do some grocery shopping. You go, "Oh my God." I come out with one little bag and it costs me $40 for decent food.

Rather expensive.

One thing, if you eat well, you'll be skinny because you can't afford to eat that much anyways [LAUGHTER].

If you want to buy something cheap, too, go to the Latino section and just buy rice and you're always going to -

Rice and beans, white bread, you're in like Flynn. Oh yeah, don't forget Pop-Tarts.

So yeah, you have to eat rice and beans.

You know, how many people are sick, because they eat crappy all the time? You don't have the energy, you don't want to get up and do anything, and you know, they need to do something about turning this food thing around, because people are going to buy what they can afford.

I mean, I get it for my daughter, which is good. I get the cereal, the milk, so I mean it's good. Eggs.

They give you fruits now.

Fruits and vegetables.

And vegetables, yeah.

It's a need.

Community Leaders

That are accessible to everybody.

Yeah, affordable.

Free or low fees.

School Based

People cannot just afford that.

We've been trying to bring the Y in to Putnam.

Yes and it's - you can provide a whole family with different opportunities of health. There's swimming and different exercise programs and I find - I know there's a lot of controversy with the fitness gyms that are in the area versus the Y and how the Y has done in the past in Norwich.

Especially affordable swimming lessons.

A couple of programs but, $200, $300. I mean it's crazy.

Boomers

Recreation.

Faith Based

There's a need for it, but then it's how much does it cost? It all comes down to, you know, people are losing their jobs and everything and stuff. They don't have the money.

Like we have in our church a group that deals with healthy eating and directing - dealing with issues of obesity and, you know, and those kinds of things. I'm not sure that I could go to any of the health centers though and advertise that. If I'd even be permitted to do that because most times there's a - oh if this is church related you know we can't really sign off on that. We can't, you know, that kind of a thing. So it'd be nice if there was a openness that as we developed these kinds of programs in our church and we can that the health institutions would be willing to allow us to promote them. You know in the centers.

Degree Behavioral / Mental Health Services are Needed?

- **All participants see area mental health programs but wonder about effectiveness of each. FR**

First Responders

Effective, no. I mean, I think that the problems with kids are through the roof.

No, you're right too. That's it's effective. Because now that I'm thinking about this - and I'm not taking any shots at United Services. But their facility in Danielson is one of our best customers, because as soon as any of the patients act out in any way negatively, they're on the phone to the ambulance to take them to the ER. Instead of, like you said, dealing with the problem in an effective manner.

School Based

There is really very few child psychiatrists in the area.

I think it's middle school years. I think when they get to middle school it's just that the stress level increases and the academic stress, course load increases as well.

Degree Pre-Natal Care Services / Programs are Needed?

Latinos

I think there's only one. I think it's only one, but it has - the Windham Hospital and OB/GYN are connected.

They have some care, but that's not enough.

I mean, I'll admit some of the hospitals have made huge, huge improvements. It use to be vaccinations weren't even legal in this state. They use to have nothing to do with midwives. They use to have no sorts of - they did some nutrition, but again, they were basically giving you vouchers for junk food.

School Based

It's available.

It's available.

I know at Windham hospital, I think.

Day Kimball has a program too.

And they're very - it's a very welcoming environment.

And actual Backus has -. They have a prenatal program through United Community Family Services, UCFS. So there are program that hits three big areas.

ON BARRIERS …

What Are the Barriers to Receiving Required Medical / Health Care?

- **Barriers to needed health care were large, but relatively limited to: cultural (including translation), financial, education on where to secure care, transportation, cost of prescriptions, the stigma of mental health illness, and HIPPA Laws (with unintended consequences).**

- **Expanded upon, participants called for seminars on HIPPA Laws to accurately project what can and cannot be done.**

- **And, Faith Based participants see the Church/State issue as needing defining and clarity. Participants suggest the issue has served as a barrier to cooperation and care for parishioners and church goers.**

First Responders

In some ways, culture.

Financial. Educational.

Latinos

People are working, can't afford it.

I think it's just not knowing and education.

Not knowing where they can get it.

A lot of people are not aware. You'd be surprised. A lot of people are not aware, "Hey, you know, you're this ill. You can walk in and go to this place, and maybe they really will help you.

And it's money. I mean, I have to take this type of drug because that's what the state will pay for, when even the doctor that's giving it to you says, "You really need to have something else."

Even at the pharmacy, sometimes I even have to ask if they have a different brand of the same medication, because it's so expensive.

Community Leaders

Translation.

Translation issues. And it's not just the Hispanic population, because at our walk-in center, we're doing a lot with the students that are coming in to Eastern from foreign countries, or their children or their spouses who are speaking Korean and Japanese and who knows what other, needing school physicals. I think it's beyond just the Spanish.

Policies, because some of the legislation that just gets in the way of people who are willing to help.

You mentioned transportation and insurance issues, and now we're adding to it.

School Based

There's a lot of language barriers, which is a huge issue not only in this area but as you go down a little further south into the Norwich community, I think the Norwich Public Schools have close to forty languages being spoken. So how would those families being able to access healthcare? In this area, there's quite a few of the Asian languages that are being spoken, and in Windham there's a lot of Mexican and Puerto Rican, Spanish, South American. As you look around, that's where we're all light.

Transportation.

Most people aren't just going to walk into the doctor's office and not pay anything whether it be for services, prescriptions, different other -

And I have some people that have $50 co-pays.

And that - talk about a cost. And then to get the medication, it's $15 or $20 many times so not only is it the co-pay at the provider, it's the medication and all of the sudden you've racked up a bill.

And if you're someone who is working at a job where you have to be there until six o'clock so that you can get paid because you don't get sick time, then your only option available to you is Emergency Room. So that's why we're seeing the people in the Emergency Room for the ear infection or something along those lines which then, of course, racks up everybody else's costs.

I think in terms of mental health there's that stigma. People don't want to be known as their diagnosis. They want to be known as a person.

Boomers

Money.

Transportation:

Language.

Shyness.

Awareness.

The lack of knowledge. The directory. The advertising.

Faith Based

I mean it's – part of the lack of communication is almost as an intentional interpretation of these privacy laws.

Youth

How expensive it's gonna be.

People that have specific health issues, but maybe can't afford to go all the way to Hartford or Boston or wherever there is a special needs hospital that they need.

Age discrimination again.

Making a conscious decision do I have six hours to waste right now? Like I have 104 fever, is it worth it? Should I try to sleep it off?

The Interesting / The Unexpected Highlights

- **The serious nature of lack of transportation – getting to work, getting to needed health care, getting to walk-ins, getting to health clubs/fitness programs, getting to specialists.**
- **The growing difficulty reported getting insurance authorizations for needed health care and surgeries.**
- **The idea of subsidies for reimbursable support for health club use.**
- **The notion of new education programs for youth on navigating the health care insurance maze.**
- **And, allowing EMS to transport both ways to open beds quicker.**
- **The need to not only educate residents on how to eat healthy but where to buy healthy food at reasonable costs.**
- **How few participants knew of 211 and called for a new print directory or asset map of all County health care providers, programs and services – such as one that was vaguely recalled created by Day Kimball 10 years ago.**
- **The overriding need for mental health care for adults and young people alike. And, the associated call for effective care.**
- **The struggle for continuity of care when patients scatter to the ER, to walk-ins, and to their respective physicians.**
- **The consensus that the area sees a system of care in the area that is effectively working together with professionals putting forward their best effort.**
- **How casinos are viewed by many as negatively impacting the stability of area families – already stressed and hanging by a tread economically.**
- **How cell phones, iPods, iTouches, video games and other electronic personal devices are increasingly considered addictions requiring remediation. And, increasing obesity.**
- **The need to add the topic of health care services and programs when teaching parenting.**
- **The associated decline in the health status of the community as the economy struggles.**

- **The call for training educators in severe mental health behaviors and providing more resources for their questions.**

- **The continuing stigma of mental health illness as a barrier to care.**

- **The serious and troubling concern expressed about Church/State divisions as a barrier to health care cooperation.**

- **How area residents have adjusted and accepted the lack of specialists.**

- **How the leading need among youth is dental care.**

- **The disdain held for the newer tablets used by physicians while treating or visiting with their respective patients. As one participant summed it up: "Something's missing when the doctor looked at me for 30 seconds and most of the time asked questions while fixated on a screen".**

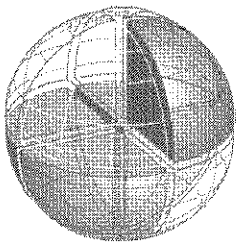
- **The call among First Responders for more training on suicidal patients – or minimally more information.**

- **Community leaders saw themselves as new allies with the health community but needed more training, education and communication.**

- **How HIPPA laws can be an unintended barrier to care.**

Appendix

THE CENTER
FOR RESEARCH



& PUBLIC POLICY

WINDHAM CONSORTIA
WINDHAM COUNTY HEALTH ASSESSMENT

September 2011

Researcher:	Date:
Time start:	CB:
Time end:	Supervisor:

Hello, my name is _____. I am a research assistant at The Center for Research and Public Policy. I am calling on behalf of eight Windham County health care organizations including Windham Hospital, Day Kimball Hospital, and Natchaug Hospital. We are talking today with residents of the County about public health services, health status, programs, and needs. Results of this survey will help guide and improve public health service over the years ahead. Your responses are strictly confidential. We will not ask for your name.

SCREENER

A. Are you at least 18 years of age or older?

01 Yes **(Continue)**
02 No **(Ask for qualified respondent)**
03 DK **(Thank and terminate)**

B. Are you currently a resident of _____? **(RESEARCHERS: Confirm respondent resides in Windham County towns / see quota)**

01 Yes **(Continue)**
02 No **(Thank and terminate)**
03 DK **(Thank and terminate)**

Health Care Access (3)

1. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

1 Yes
2 No (Go to Q3)
7 Don't know / Not sure (Go to Q3
9 Refused (Go to Q3

2. What type of health care coverage do you use to pay for most of your medical care?

Is it coverage through:
Please Read
1 Your employer
2 Someone else's employer
3 A plan that you or someone else buys on your own
4 Medicare
5 Medicaid or Medical Assistance
6 The military, CHAMPUS, TriCare, or the VA ***[or CHAMP-VA]***
7 The Indian Health Service
8 Some other source

Do not read these responses

77 Don't know / Unsure
88 None
99 Refused

3. Do you have one person you think of as your personal doctor or health care provider?
If "No," ask: "Is there more than one, or is there no person who you think of as your personal doctor or health care provider?"

1 Yes, only one
2 More than one
3 No
7 Don't know / Not sure
9 Refused

4. Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

5. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

1 Within past year (anytime less than 12 months ago)
2 Within past 2 years (1 year but less than 2 years ago)
3 Within past 5 years (2 years but less than 5 years ago)
4 5 or more years ago
7 Don't know / Not sure
8 Never
9 Refused

Exercise (5)

6. When you are not working, do you do moderate physical activity in a usual week that causes small to large increases in breathing and heart rate such as running, working out, brisk walking, biking, vacuuming, or yard work?

01 Yes (Continue)
02 No (Go to Q8)
03 DK/Unsure (Go to Q8)

7. When you do moderate physical activity how many minutes do you keep at it?

01 Minutes: _____
02 DK/Unsure
03 Don't exercise

8. When you are not working, do you do vigorous physical activity in a usual week that causes large increases in breathing and heart rate such as running, jogging, or weight lifting?

01 Yes (Continue)
02 No (Go to Q10)
03 DK/Unsure (Go to Q10)

9. When you do vigorous physical activity how many minutes do you keep at it?

01 Minutes: _____
02 DK/Unsure
03 Don't exercise

Dental (7)

10. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 5 years (2 years but less than 5 years ago)
4 5 or more years ago
Do not read:
7 Don't know / Not sure
8 Never **(Go to Q 12)**
9 Refused
If Q10 = 8 (Never) go to Q12.
11. How long has it been since you had your teeth cleaned by a dentist or dental hygienist?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 5 years (2 years but less than 5 years ago)
4 5 or more years ago
Do not read:
7 Don't know / Not sure
8 Never
9 Refused

12. Do you have one person you think of as your dentist or oral health care provider?
If "No," ask: "Is there more than one, or is there no person who you think of as your personal doctor or health care provider?"

1 Yes, only one
2 More than one
3 No
7 Don't know / Not sure

Cardiovascular Disease (8)

Now I would like to ask you some questions about cardiovascular disease.

Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, tell me "Yes," "No," or you're "Not sure."

13. (Ever told) you had a heart attack, also called a myocardial infarction?

1 Yes

2 No
7 Don't know / Not sure
9 Refused

14. (Ever told) you had angina, congestive heart failure, or coronary heart disease?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

15. (Ever told) you had a stroke?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Tobacco Use (11)

16. Have you smoked at least 100 cigarettes in your entire life?

NOTE: 5 packs = 100 cigarettes
1 Yes
2 No **[Go to Q20]**
7 Don't know / Not sure **[Go to Q20]**
9 Refused **[Go to Q20]**

17. Do you now smoke cigarettes every day, some days, or not at all?

1 Every day
2 Some days
3 Not at all **[Go to Q20]**
7 Don't know / Not sure **[Go to Q20]**
9 Refused **[Go to Q20]**

18. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

19. How long has it been since you last smoked cigarettes regularly?

0 1 Within the past month (less than 1 month ago)
0 2 Within the past 3 months (1 month but less than 3 months ago)
0 3 Within the past 6 months (3 months but less than 6 months ago)
0 4 Within the past year (6 months but less than 1 year ago)
0 5 Within the past 5 years (1 year but less than 5 years ago)
0 6 Within the past 10 years (5 years but less than 10 years ago)
0 7 10 years or more
0 8 Never smoked regularly
7 7 Don't know / Not sure
9 9 Refused

Demographics (12)

20. What is your age?

_ _ Code age in years
0 7 Don't know / Not sure
0 9 Refused

21. Are you Hispanic or Latino?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

22. Which one of the following would you say is your race?

Please read:
1 White
2 Black or African American
3 Asian
4 Native Hawaiian or Other Pacific Islander
5 American Indian or Alaska Native
6 Other [specify] _____
Do not read:
7 Don't know / Not sure
9 Refused

23. Are you…?

Please read:
1 Married
2 Divorced
3 Widowed
4 Separated
5 Never married
Or
6 A member of an unmarried couple
Do not read:
9 Refused

24. How many children less than 18 years of age live in your household?

_ _ Number of children
8 8 None
9 9 Refused

25. What is the highest grade or year of school you completed?
Read only if necessary:
1 Never attended school or only attended kindergarten
2 Grades 1 through 8 (Elementary)
3 Grades 9 through 11 (Some high school)
4 Grade 12 or GED (High school graduate)
5 College 1 year to 3 years (Some college or technical school)
6 College 4 years or more (College graduate)
Do not read:
9 Refused

26. Are you currently…?

Please read:
1 Employed for wages
2 Self-employed
3 Out of work for more than 1 year
4 Out of work for less than 1 year
5 A Homemaker
6 A Student
7 Retired
Or
8 Unable to work
Do not read:
9 Refused

27. Is your annual household income from all sources—

If respondent refuses at ANY income level, code '99' (Refused)
Read only if necessary:
0 4 Less than $25,000 **If "no," ask 05; if "yes," ask 03**
($20,000 to less than $25,000)
0 3 Less than $20,000 **If "no," code 04; if "yes," ask 02**
($15,000 to less than $20,000)
0 2 Less than $15,000 **If "no," code 03; if "yes," ask 01**
($10,000 to less than $15,000)
0 1 Less than $10,000 **If "no," code 02**
0 5 Less than $35,000 **If "no," ask 06**
($25,000 to less than $35,000)
0 6 Less than $50,000 **If "no," ask 07**
($35,000 to less than $50,000)
0 7 Less than $75,000 **If "no," code 08**
($50,000 to less than $75,000)
0 8 $75,000 or more
Do not read:
7 7 Don't know / Not sure
9 9 Refused

28. About how much do you weigh without shoes?

Round fractions up
_ _ _ _ Weight
(pounds)
7 7 7 7 Don't know / Not sure
9 9 9 9 Refused

29. About how tall are you without shoes?

Round fractions down
_ _ / _ _ Height
(f t / inches)
7 7/ 7 7 Don't know / Not sure
9 9/ 9 9 Refused

30. Indicate sex of respondent. Ask only if necessary.

1 Male
2 Female

Immunization (14)

31. Now I will ask you questions about seasonal flu. A flu shot is an influenza vaccine injected into your arm. Since August of 2010, have you had a seasonal flu shot?

1 Yes **(Continue)**
2 No **(Go to Q33)**
7 Don't know / Not sure **[Go to Q33]**
9 Refused **[Go to Q33]**

32. Please tell me who gave you your most recent flu shot?

1 Central Connecticut Health District
2 Super Market Pharmacy
3 Visiting Nurse Association (VNA)
4 Doctor / Doctor's office
5 Pharmacy
6 Other

33. During what month and year did you receive your most recent seasonal flu shot?

_ _ / _ _ _ _ Month / Year
7 7 / 7 7 7 7 Don't know / Not sure
9 9 / 9 9 9 9 Refused

Ask Q34 ONLY if respondent is 65 years of age or older.
34. A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

35. Have you received a tetanus shot in the past 10 years?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Falls (15)

If respondent is 45 years or older continue, otherwise go to next section.
The next questions ask about recent falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

36. In the past 3 months, how many times have you fallen?

_ _ Number of times **[76 = 76 or more]**
8 8 None **[Go to next section]**
7 7 Don't know / Not sure **[Go to next section]**
9 9 Refused **[Go to next section]**

37. [Fill in "Did this fall (from Q36) cause an injury?"]. If only one fall from Q36 and response is "Yes" (caused an injury); code 01. If response is "No," code 88.
How many of these falls caused an injury? By an injury, we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.

_ _ Number of falls **[76 = 76 or more]**
8 8 None
7 7 Don't know / Not sure
9 9 Refused

Women's Health (18)

CATI note: If respondent is male, go to the next section.
The next questions are about breast and cervical cancer.

39. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

1 Yes
2 No **[Go to Q41]**
7 Don't know / Not sure **[Go to Q41]**
9 Refused **[Go to Q41]**

40. How long has it been since you had your last mammogram?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 3 years (2 years but less than 3 years ago)
4 Within the past 5 years (3 years but less than 5 years ago)
5 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

41. A clinical breast exam is when a doctor, nurse, or other health professional feels the breasts for lumps. Have you ever had a clinical breast exam?

1 Yes
2 No **[Go to Q43]**
7 Don't know / Not sure **[Go to Q43]**
9 Refused **[Go to Q43]**

42. How long has it been since your last breast exam?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 3 years (2 years but less than 3 years ago)
4 Within the past 5 years (3 years but less than 5 years ago)
5 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

43. A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?

1 Yes
2 No **[Go to Q45]**
7 Don't know / Not sure **[Go to Q45]**
9 Refused **[Go to Q45]**

44. How long has it been since you had your last Pap test?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 3 years (2 years but less than 3 years ago)
4 Within the past 5 years (3 years but less than 5 years ago)
5 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

Prostate Cancer Screening (19)

If respondent is <39 years of age, <u>or is female</u>, go to next section.
Now, I will ask you some questions about prostate cancer screening.

45. A Prostate-Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?

1 Yes
2 No **[Go to Q47]**
7 Don't Know / Not sure **[Go to Q47]**
9 Refused **[Go to Q47]**

46. How long has it been since you had your last PSA test?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years)
3 Within the past 3 years (2 years but less than 3 years)
4 Within the past 5 years (3 years but less than 5 years)
5 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

47. A digital rectal exam is an exam in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape, and hardness of the prostate gland. Have you ever had a digital rectal exam?

1 Yes
2 No **[Go to Q49]**
7 Don't know / Not sure **[Go to Q49]**
9 Refused **[Go to Q49]**

48. How long has it been since your last digital rectal exam?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
Within the past
2 years (1 year but less than 2 years)
3 Within the past 3 years (2 years but less than 3 years)
4 Within the past 5 years (3 years but less than 5 years)
5 or more years ago
Do Not Read:
7 Don't know/unsure
9 Refused

49. Have you ever been told by a doctor, nurse, or other health professional that you had prostate cancer?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Colorectal Cancer Screening (20)

CATI note: If respondent is < 49 years of age, go to next section.
The next questions are about colorectal cancer screening.

50. A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?

1 Yes
2 No **[Go to Q52]**
7 Don't know / Not sure **[Go to Q52]**
9 Refused **[Go to Q52]**

51. How long has it been since you had your last blood stool test using a home kit?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 3 years (2 years but less than 3 years ago)
4 Within the past 5 years (3 years but less than 5 years ago)
5 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

52. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?

1 Yes
2 No **[Go to next section]**
7 Don't know / Not sure **[Go to next section]**
9 Refused **[Go to next section]**

53. For a SIGMOIDOSCOPY, a flexible tube is inserted into the rectum to look for problems.

A COLONOSCOPY is similar, but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. Was your MOST RECENT exam a sigmoidoscopy or a colonoscopy?

1 Sigmoidoscopy
2 Colonoscopy
7 Don't know / Not sure
9 Refused

54. How long has it been since you had your last sigmoidoscopy or colonoscopy?

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 3 years (2 years but less than 3 years ago)
4 Within the past 5 years (3 years but less than 5 years ago)
5 Within the past 10 years (5 years but less than 10 years ago)
6 10 or more years ago

Do not read:
7 Don't know / Not sure
9 Refused

Pre-Diabetes / Diabetes (6)

55. Have you had a test for high blood sugar or diabetes within the past three years?
1 Yes
2 No
7 Don't know / Not sure
9 Refused

CATI note: If Core Q6.1 = 4 (No, pre-diabetes or borderline diabetes); answer Q2 "Yes" (code = 1).

56. Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes?

If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"

1 Yes
2 Yes, during pregnancy
3 No
7 Don't know / Not sure
9 Refused

57. Have you EVER been told by a doctor, nurse or other health professional that you have diabetes?

1 Yes
2 No **(Go to Q63)**
7 Don't know / Not sure **(Go to Q63)**
9 Refused **(Go to Q63)**

58. How old were you when you were told you have diabetes?

_ _ Code age in years **[97 = 97 and older]**
9 8 Don't know / Not sure
9 9 Refused

59. Are you now taking insulin?

1 Yes
2 No
9 Refused

60. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

1 _ _ Times per day
2 Less than once per day
7 7 7 Don't know / Not sure
9 9 9 Refused

61. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

_ _ Number of times **[76 = 76 or more]**
8 8 None
7 7 Don't know / Not sure
9 9 Refused

62. A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A one C"?

_ _ Number of times **[76 = 76 or more]**
8 8 None
9 8 Never heard of "A one C" test
7 7 Don't know / Not sure
9 9 Refused

63. Have you ever taken a course or class in how to manage your diabetes yourself?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Nutrition

64. How many servings of vegetables do you usually eat per day? A serving is one medium sized vegetable or ½ cup.

01 Servings per day: _____
77 DK/Unsure

65. How many servings of fruit do you usually eat per day? A serving is one medium sized fruit or a ½ cup of fruit.

01 Servings per day: _____
77 DK/Unsure

Sleep

66. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?

_ _ Number of days
8 8 None
7 7 Don't know / Not sure
9 9 Refused

Alcohol Consumption

67. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

1 Yes
2 No **[Go to next section]**
7 Don't know / Not sure **[Go to next section]**
9 Refused **[Go to next section]**

68. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage?

1 _ _ Days per week
2 _ _ Days in past 30 days
8 8 8 No drinks in past 30 days **[Go to next section]**
7 7 7 Don't know / Not sure
9 9 9 Refused

69. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?

NOTE: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

_ _ Number of drinks
7 7 Don't know / Not sure
9 9 Refused

Healthy Days

70. During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation?

_ _ Number of days
8 8 None
7 7 Don't know / Not sure
9 9 Refused

71. During the past 30 days, for about how many days have you felt sad, blue, or depressed?

_ _ Number of days
8 8 None
7 7 Don't know / Not sure
9 9 Refused

Anxiety / Depression

72. Over the last 2 weeks, how many days have you had little interest or pleasure in doing things?

_ _ 01–14 days
8 8 None
7 7 Don't know / Not sure
9 9 Refused

Family Planning

NOTE: If respondent is female and 45 years of age or older, has had a hysterectomy, is pregnant, or male 60 years of age or older, go to next module.

The next set of questions asks you about your thoughts and experiences with family planning. Please remember that all of your answers will be kept confidential.

Some things people do to keep from getting pregnant include not having sex at certain times, withdrawal, using birth control methods such as the pill, implants, shots, condoms, diaphragm, foam, IUD, having their tubes tied, or having a vasectomy.

73. Are you or your [If female, insert "husband/partner," if male, insert "wife/partner"] doing anything now to keep [If female, insert "you," if male, insert "her"] from getting pregnant?

NOTE: If more than one partner, consider usual partner.

1 Yes
2 No [Go to Q3]
3 No partner/not sexually active [Go to next module]
4 Same sex partner [Go to next module]
7 Don't know / Not sure [Go to next module]
9 Refused [Go to next module]

74. What are you or your [If female, insert "husband/partner," if male, insert "wife/partner"] doing now to keep [If female, insert "you," if male, insert "her"] from getting pregnant?

NOTE: If more than one partner, consider usual partner.

NOTE: If respondent reports using "condom," probe to determine if "female condoms" or "male condoms."

Read only if necessary:
0 1 Tubes tied (or female sterilization) [Go to next module]
0 2 Vasectomy (or male sterilization) [Go to next module]
0 3 Birth control pills, any kind [Go to Q4]
0 4 Male condoms [Go to Q4]
0 5 Female condoms [Go to Q4]
0 6 Contraceptive implant (for example, Implanon) [Go to Q4]
0 7 Shots (for example, Depo-Provera) [Go to Q4]
0 8 Contraceptive ring (for example, Nuvaring) [Go to Q4]
0 9 Contraceptive patch (for example, Ortho Evra) [Go to Q4]
1 0 Diaphragm, cervical cap, or sponge [Go to Q4]
1 1 Foam, jelly, or cream [Go to Q4]
1 2 IUD (for example, Mirena) [Go to Q4]
1 3 Emergency contraceptive (morning after pill) [Go to Q4]
1 4 Withdrawal (or pulling out) [Go to Q4]
1 5 Other method [Go to Q4]

Do not read:
7 7 Don't know/ Not sure [Go to Q4]
9 9 Refused

Visual Access to Eye Care

75. When was the last time you had your eyes examined by any doctor or eye care provider?

Read only if necessary:

1 Within the past month (anytime less than 1 month ago) [Go to Q5]
2 Within the past year (1 month but less than 12 months ago) [Go to Q5]
3 Within the past 2 years (1 year but less than 2 years ago)
4 2 or more years ago
5 Never
Do not read:
7 Don't know / Not sure
8 Not applicable (Blind) [Go to next module]
9 Refused

76. What is the main reason you have not visited an eye care professional in the past 12 months?

Read only if necessary:
0 1 Cost/insurance
0 2 Do not have/know an eye doctor
0 3 Cannot get to the office/clinic (too far away, no transportation)
0 4 Could not get an appointment
0 5 No reason to go (no problem)
0 6 Have not thought of it
0 7 Other

Do not read:
7 7 Don't know / Not sure
0 8 Not Applicable (Blind) [Go to next module]
9 9 Refused

77. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.
(278)
Read only if necessary:
1 Within the past month (anytime less than 1 month ago)
2 Within the past year (1 month but less than 12 months ago)
3 Within the past 2 years (1 year but less than 2 years ago)
4 2 or more years ago
5 Never

Caregiver

78. During the past month, did you provide any such care or assistance to a friend or family member?

1 Yes
2 No **[Go to next module]**
7 Don't know / Not sure **[Go to next module]**
9 Refused **[Go to next module]**
2. What age is the person to whom you are giving care?

79. What is his/her relationship to you?
Read only if necessary: "For example is he/she your (mother/daughter or father/son)?
Do not read:
0 1 Parent
0 2 Parent-in-law
0 3 Child
0 4 Spouse
0 5 Sibling
0 6 Grandparent
0 7 Grandchild
0 8 Other Relative
0 9 Non-relative
7 7 Don't know / Not sure
9 9 Refused

Veteran's Health

80. Did you ever serve in a combat or war zone?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

81. Has a doctor or other health professional ever told you that you have depression, anxiety, or post traumatic stress disorder (PTSD)?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

82. In the past 12 months, did you receive any psychological or psychiatric counseling or treatment?

Please Read:
1 Yes, from a VA facility
2 Yes, from a non-VA facility
3 Yes, from both VA and non-VA facilities
4 No

Do not read:
7 Don't know / Not sure
9 Refused

83. Has there been a time in the past 12 months when you thought of taking your own life?

1 Yes
2 No [Go to next module]
7 Don't know / Not sure [Go to next module]
9 Refused

Thank you very much for your participation.

84. Code Town:

	Windham County Towns	**Quota**
01	Woodstock	43
02	Thompson	50
03	Ashford	24
04	Eastford	9
05	Pomfret	23
06	Putnam	50
07	Chaplin	14
08	Hampton	11
09	Brooklyn	42
10	Killingly	94
11	Windham	127
12	Scotland	10
13	Canterbury	27
14	Plainfield	82
15	Sterling	19
	Total Surveys	**625**

Summary
of
Community Needs Assessments

Community Needs Assessment
United Way of Southeastern Connecticut
December 2010

Community Health Care Needs Assessment
Windham Consortium
Qualitative and Quantitative
September 2011

Prepared for Natchaug Hospital
Prepared by The Center for Research and Public Policy

Community Needs Assessment
United Way of Southeastern Connecticut
December 2010

1 INTRODUCTION

The Center for Research & Public Policy (CRPP) is pleased to present the results of a Community Needs Assessment conducted among residents and community leaders on behalf of the United Way of Southeastern Connecticut (UWSECT).

The Assessment was designed to provide resident and community leader input on quality of life, current standard of living and community met, under-met and unmet needs.

The Assessment research included a comprehensive telephone survey, email survey, focus group sessions and supporting secondary data.

Telephone interviews (1006) were conducted among residents of the municipalities served by UWSECT. Focus group sessions were held among youth, service providers, United Way partners, and community business and civic leaders and the general population.

This report summarizes information collected from focus group sessions conducted on October 19 and 20, 2010 as well as telephone and online surveys conducted throughout November, 2010.

The survey instruments and focus group guidebooks employed in the Community Needs Assessment included the following areas for investigation:

- Quality of life;
- Standard of living;
- Awareness / perceptions of UWSECT;
- Issues, problems, concerns faced by area residents;

- Met, under-met and unmet needs in the areas of:
  - ✓ Health
  - ✓ Employment
  - ✓ Recreation
  - ✓ Transportation
  - ✓ Family/community
  - ✓ Housing
  - ✓ Children/youth

- ✓ Seniors
- ✓ Emergency response services

- ➢ Health status, access, needs and behaviors

Section II of this report discusses the Methodology used in the study, while Section III includes Highlights derived from an analysis of the quantitative research. Section IV is a Summary of Findings for the residential telephone surveys - a narrative account of the data.

Section V is a Summary of the focus group sessions. An Appendix to the report contains crosstabulation tables, the survey instrument, and the focus group guidebook.

METHODOLOGY

Focus Group Sessions

The Center for Research & Public Policy moderated and organized a series of five focus groups on behalf of UWSECT. The five groups consisted of youth, service providers, general public, United Way partners, and community business and civic leaders.

The focus groups took place on October 19 and 20, 2010 at the Gales Ferry offices of UWSECT as well as the Connecticut College campus.

The focus groups were designed to inform the development of the phone and online survey instruments and add to the areas for investigation.

Following the focus group sessions, CRPP project staff reported findings to the UWSECT Work Group. Common themes displayed throughout the groups were reported and incorporated into the quantitative research.

Section 5 of this report presents each covered section of the focus group guidebook along with select verbatim responses provided by group participants to help summarize and support common views expressed by the actual participants during the study.

The focus group sessions were organized by CRPP and UWSECT staff. Approximately 14 individuals participated in each of the five focus groups.

For their time and participation, all respondents (except United Way partners) received a cash incentive "as a small token of appreciation." Many service providers and some community leaders reversed the cash incentive back to the United Way as donations.

Each session was approximately 90 minutes in length.

For more detailed information, readers may refer to the full written transcripts which may be found in the appendix of this report. Additionally, the audio for the five sessions will remain live for one year on a designated website.

Residential Telephone Survey

Using a quantitative research design, CRPP completed 1,006 interviews among residents of the 21 communities served by UWSECT.

All telephone interviews were conducted November 11 – 30, 2010. Residents were contacted between 5:00 p.m. and 9:00 p.m. weekdays and 10:00 a.m. and 4:00 p.m. on the weekend.

Survey input was provided by the UWSECT Work Group.

Survey design at CRPP is a careful, deliberative process to ensure fair, objective and balanced surveys. Staff members, with years of survey design experience, edit out any bias. Further, all scales used by CRPP (either numeric, such as one through ten, or wording such as strongly agree, somewhat agree, somewhat disagree, or strongly agree) are balanced evenly. And, placement of questions is carefully accomplished so that order has minimal impact. Questions printed in bold, within the survey instrument, are tracking questions from previous surveys of residents.

All population-based surveys conducted by CRPP are proportional to population contributions within states, towns, and known census tract, group blocks and blocks. This distribution ensures truly representative results without significant under or over representation of various geographic or demographic groups within a sampling frame.

CRPP utilized a "super random digit" sampling procedure, which derives a working telephone sample of both listed and unlisted telephone numbers. This method of sample selection eliminates any bias toward only listed telephone numbers. Additionally, this process allows randomization of numbers, which equalizes the probability of qualified respondents being included in the sampling frame. Cell phone respondents were included in the sampling process and represented 4.0% of the total sample.

Respondents qualified for the survey if they confirmed they were at least 18 years of age and were current residents of one of the qualifying communities.

Training of telephone researchers and pre-test of the survey instrument occurred on November 8, 2010.

All facets of the study were completed by CRPP's senior staff and researchers. These aspects include: survey design, pre-test, computer programming, fielding, coding, editing, data entry, verification, validation and logic checks, computer analysis, analysis, and report writing.

Some respondents (31) completed the survey in Spanish. This group included both those who answered their phone in Spanish or accepted an offer to conduct the survey in Spanish.

Completion rates are a critical aspect of any telephone survey research. Because one group of people might be easier to reach than another group, it is important that concentrated efforts are made to reach all groups to an equal degree. A high completion rate means that a high percentage of the respondents within the original sample were actually contacted, and the resulting sample is not biased toward one potential audience. CRPP maintained a **71%** completion rate on all calls made. And, a high completion rate, many times, indicates an interest in the topic.

Statistically, a sample of 1,006 surveys represents a margin for error of +/-3.0% at a 95% confidence level.

In theory, a sample of all UWSECT region residents will differ no more than +/-3.0% than if all region residents were contacted and included in the survey. That is, if random probability sampling procedures were reiterated over and over again, sample results may be expected to approximate the large population values within plus or minus 3.0% -- 95 out of 100 times.

Readers of this report should note that any survey is analogous to a snapshot in time and results are only reflective of the time period in which the survey was undertaken. Should concerted public relations or information campaigns be undertaken during or shortly after the fielding of the survey, the results contained herein may be expected to change and should be, therefore, carefully interpreted and extrapolated.

Furthermore, it is important to note that all surveys contain some component of "sampling error". Error that is attributable to systematic bias has been significantly reduced by utilizing strict random probability procedures. This sample was strictly random in that selection of each potential respondent was an independent event, based on known probabilities.

Each qualified household within the UWSECT region had an equal chance for participating in the study. Statistical random error, however, can never be eliminated but may be significantly reduced by increasing sample size.

Online Community Survey

An online version of the community telephone survey was developed for distribution to email addresses of contacts held at UWSECT offices in Gales Ferry.

The online version was distributed by CRPP to approximately 8000 contacts provided by UWSECT in mid-November, 2010.

A total of 375 responses were submitted on or prior to the deadline of December 3, 2010.

Secondary Data

The United Way Work Group, during a September 29, 2010 meeting, reviewed potential secondary data that would be useful to have "in hand" while allocators of funds reviewed this Community Needs Assessment Report.

The Work Group and CRPP decided to collect the following secondary data by each community served by the United Way of Southeastern Connecticut: population, age under five, age above 65, race, ethnicity, poverty rates, median household incomes, number of households, education levels, employment levels, housing stock owned/rented, median housing prices, housing units, day care facilities, crime rate, disability over five years of age, languages spoken other than English, foreign born, average high school class size and SAT scores in math and verbal.

This secondary data has been submitted to the United Way. The anticipated release of the 2010 U.S. Census Data will require some adjustments in the tables to such categories as population and ages.

CRPP acknowledges and thanks the following groups for this data: The William W. Backus Hospital (Community Needs Assessment), Connecticut Strategic School Profile, Connecticut Economic Resource Center (CERC), the United States Census Bureau, Connecticut State Department of Education and The Yankee Institute.

Online United Way Research Panel

In an effort to build a "ready to go", cost effective and statistically valid means to more regularly survey residents and community leaders, CRPP assisted the United Way in developing an Online Research Panel.

Focus group participants as well as respondents to the community phone survey and the stakeholder online survey were asked if they would participate in such a panel.

A total of 410 respondents/participants agreed to serve on the new Online Research Panel. These email addresses have been provided to the United Way.

HIGHLIGHTS

ON THE PROCESS…

Community Needs Assessments are built in an inverted pyramid format. Through the assessment process, the pyramid turns to look more traditional. The United Way of Southeastern Connecticut followed this process to reach this point of reporting out results.

The four-month process began with the United Way Working Group, together with The Center for Research and Public Policy (CRPP), looking closely at nearly 100 potential programs and services with an eye toward those it might advocate on behalf of or directly support.

An initial listing of nearly 100 programs and service needs to measure was narrowed to 76. The Work Group and CRPP continued to study these services and programs with the help of community members divided into five randomly recruited focus group sessions. These sessions consisted of youth, general population, service providers, United Way partners and business/civic leaders.

Input from participants in the focus group helped the Work Group and CRPP narrow (and expand) the list of services and programs to 40. The nature of focus group sessions is "open-ended". This allowed for important contributions to the initial list by the group participants.

Using a quantitative research approach, a phone survey was designed to interview a random set of 1006 residents. Additionally, an online survey was completed by 375 community leaders or stakeholders. Both groups, residents and stakeholders, were asked to provide input on the community needs developed by focus group participants, CRPP and the United Way Work Group.

This report, built like the more traditional pyramid, depicts what the community sees as the most pressing needs in the community served by the United Way of Southeastern Connecticut. And, while the report is built so "bottom line readers" can quickly see the results, it is recommended that all readers reach the end of the report to see select verbatim responses from focus group participants. This will provide a good feel of the climate of community needs in 2010 and the years ahead.

ON THE DIFFICULT ECONOMIC TIMES…

- Focus group participants and survey respondents helped demonstrate the economic difficulties many are currently facing and expect to face for years to come. The United Way will see many community needs tied directly to a difficult economy and help in retaining jobs.

- Twelve of the top 18 community needs were centered on economic needs or support in keeping / maintaining employment.

ON QUALITY OF LIFE…

- A large majority of residential survey respondents, 95.1%, reported their quality of life was very good or good. Among Online Stakeholder respondents, the percentage reporting very good and good was 97.6%.

- One quarter of all residential respondents, 25.0%, suggested their current financial standard of living was improving. Another 29.4% indicated their standard of living was declining and 44.3% said it was the same.

- Among Online Stakeholders, 29.4% indicated their current financial standard of living was improving. Another 27.2% suggested their standard of living was declining, and 42.6% said it was the same.

ON COMMUNITY NEEDS…

- Researchers asked all residential respondents to report if there were "too few", "too many" or "about the right amount" of 40 different community services and programs.

  Readers of Community Needs Assessment Survey results may view "Too Few" as requiring more funding, services, or programming in these areas.

- The top eight community needs, where over 70.0% of all residential respondents agreed there were "too few", were reported to be:

  - ✓ Home repair or financial support for maintenance
  - ✓ Fatherhood support programs
  - ✓ Homeless programs and supports (such as shelters, counseling & laundry)

- ✓ Affordable childcare for working parents
- ✓ Free counseling on issues such as foreclosure, bankruptcy, taxes/finance, leases, contracts and rental agreements
- ✓ Youth job training
- ✓ Health insurance financial support (such as help with co-pays or sliding fee scale primary care)
- ✓ Affordable housing

➢ Second tier, or the next ten community needs (over 60% of all residential respondents agreeing) were reported to be:

- ✓ Drop-out prevention programs
- ✓ Domestic violence prevention and treatment programs
- ✓ Adult job training, placement and supports (including mentoring, money management and life skills)
- ✓ Car repair training and financial support for car maintenance
- ✓ Bullying and violence prevention programming
- ✓ Parenting programs
- ✓ Affordable housing for seniors
- ✓ Adult day care
- ✓ Public transportation availability
- ✓ Child abuse prevention and treatment programs

➢ Lower or third tier community programs and services included 13 that were viewed by over half of all residential respondents as having "too few" in the community.

ON HEALTH STATUS, ACCESS, NEEDS, AND BEHAVIOR…

In collaboration with the United Way of Southeast Connecticut, Lawrence and Memorial Hospital submitted a series of health-related questions important in the assessment of community health needs.

Highlights from the residential survey of 1006 respondents included:

➢ Three quarters of all residential respondents, 95.5%, indicated they had at least one person they think of as their personal doctor or health care provider.

➢ A large percent of residential respondents, 14.2%, indicated there was a time during the past 12 months when they or another person living in their household didn't receive medical care because of cost.

- While 87.5% suggested they had a routine checkup within the past year, another 11.6% suggested it has been anywhere from over a year ago to more than five years ago.

- A significant percent of residents, 12.3% suggested there was a time, over the past year, they or another living in their household needed prescription medicines but did not receive them due to cost.

- And, a larger percentage (18.8%) said they or another person living in their household needed but did not receive dental care because of the cost.

- While 81.2% of all respondents reported having their teeth cleaned by a dentist or dental hygienist within the past year, 16.8% suggested it's been over one year to more than five years since their last cleaning.

- When asked about mental health care, 6.1% indicated there was a time over the past year when they needed mental health treatment or counseling but didn't receive it. Of this group, 44.4% suggested they could not afford the care.

- A strong majority of respondents, 82.8%, said they did participate in physical activities such as running, calisthenics, golf, tennis or walking for exercise over the past month. However, 16.8% said they had not.

- One quarter of all respondents, 24.4% said they have been advised by a doctor, nurse or other health care professional to lose weight.

- Some, 8.2%, reported there was a time period of "almost every day for two weeks or more in a row" when feeling sad or hopeless stopped them from doing usual activities.

- And, 15.4% indicated they smoke cigarettes everyday (11.3%) or some days (4.1%).

Phone Surveys:

C. "Too Few" Results by Category

The following table presents "Too Few" results by both residential and online respondents. Each category table is presented in declining order by residential respondents.

Health	Too Few: Residential	Too Few: Online
Health insurance financial support (such as help with co-pays or sliding fee scale primary care)	70.6%	78.9%
Prescription drug discounts	55.4	62.5
Mental & behavioral health services	54.4	65.1
Alcohol & substance abuse prevention and treatment	50.3	44.5
HIV-AIDS prevention and care	50.3	36.1
Dental services	49.0	64.0
Food, nutrition, hunger services (including food pantries & meal centers)	48.8	46.5
Health education (including workshops and screenings)	42.0	48.4

Transportation	Too Few	Too Few: Online
Car repair training or financial support for car maintenance	66.8	77.8
Public transportation availability	60.7	72.9

Employment	Too Few	Too Few: Online
Affordable childcare for working parents	75.7	83.4
Adult job training, placement and supports (including mentoring, money management and life skills)	67.7	63.9

Recreation	Too Few	Too Few: Online
Recreation programs for area residents (including sports)	30.6	34.7

Education	Too Few	Too Few: Online
Drop-out prevention programs	69.2	77.7
Free, or low cost, community programs using school sites during off hours	59.3	72.8
Parental involvement in schools	56.6	78.0
Special needs assessment and funding	53.2	53.3
Tutoring and mentoring for school age children	50.5	64.6
College and vocational school readiness programs	48.2	61.5
Out-of-school programming (including before, after and vacations)	44.7	64.8

Family and Community	Too Few	Too Few: Online
Fatherhood support programs	79.3	75.7
Free counseling on issues such as foreclosure, bankruptcy, taxes/finance, home buying, leases, contracts and rental agreements	75.6	74.2
Domestic violence prevention and treatment programs	68.3	63.9
Parenting programs	64.1	64.2
Child abuse prevention & treatment programs	60.1	62.9
Volunteer matching services	59.5	54.1
Legal aid support	58.7	59.0
Crisis intervention hotlines	33.7	29.5

Housing	Too Few	Too Few: Online
Home repair training or financial support for maintenance	79.7	84.4
Homeless programs and supports (such as shelters, counseling & laundry)	76.3	81.0
Affordable housing	70.1	79.5
Temporary financial support for heat and/or utilities	47.7	64.4

Children and Youth	Too Few	Too Few: Online
Youth job training	72.0	72.5
Bullying and violence prevention programs	64.9	69.6

Children & youth mental health services	59.4	65.1
Youth substance abuse prevention & services	58.9	68.9
Safe sex education and teen pregnancy prevention programs	50.6	56.9
Pre-K school readiness programs	39.0	47.3

Seniors	Too Few	Too Few: Online
Affordable housing for seniors	63.3	70.0
Adult day care	62.9	70.1

Mental Health

Researchers followed by asking a similar question about mental health. Each was asked how many days, during the past 30 days, in which their mental health including stress, depression and problems with emotions was not good. A large majority, 97.7%, responded. Another 1.5% were unsure and 0.8% refused to respond. Results are presented in the following table.

How Many Days Mental Health Was Not Good	Residents
Zero	64.5%
1-7	18.3
8-14	2.9
15-21	4.8
22-30	5.5
Other response	4.0

Mental Health Care

While 93.2%, of all respondents indicated there was not a time in the past year when they required mental health care but did not receive it, 6.1% said there was.

A Time When You Needed Mental Health Care But Did Not Receive It	Residents
Yes	6.1%
No	93.2
DK/Unsure	0.2
RF	0.5

Most of those in need of care, but not receiving it, cited "cost issues" as the primary reason. The results are presented here.

Reasons Respondents In Need of Mental Health Care Didn't Receive It	Residents
Could not afford it	44.4%
Didn't know where to go	7.9
Took too much time	6.3
Didn't think it would help	4.8
Other	31.7
DK/Unsure	3.2
RF	1.6

"Others" included: Couldn't afford to take time off of work for an appointment, didn't have the time, hard to get a referral, thought it was pointless, just dealt with it, looking for alternatives due to health centers being overbooked, pride, and no proper doctor in my area.

Focus Group Sessions:

On Community Needs…

Health

Youth

Insurance?

Health insurance for young people.

I think with the insurance, understanding of insurance, understanding what you're not covered, what you don't have.

Someone to go, or someplace to go to besides your family, who's not always in the best position to help them, so that could mean a sex-ed program, or a clinic nearby. If we had facilities, something like that.

Youth with disabilities.

Having these resources available, because a lot of these resources are available, but they're available during the week. What about on weekends.

United Way Partners

The Department of Public Health says there are 511 people with HIV/AIDS. Alliance for Living, which serves Southeastern Connecticut, is covering 281 people. Two years ago, we served 220 people. We have a smaller staff. We have the same budget. No additional income.

The biggest issue that, I think, worries a lot of us is that when they're truly unemployed, and either COBRA expires, or they can't afford COBRA, to begin with. We see in our school-based health centers the huge jump in the number of young people who are being enrolled, and when we say, "Well, jeez"-you know, "we got [INAUDIBLE] pediatrician," and then we don't.

And I will not-just to throw those numbers that-we just ran them for UCFS-over the last three years, demand has increased 43%, and that's dental, our primary care, and many of our health. Funding has decreased 11%.

A lot of my parents are not-do not receive healthcare, because of the position, jobs, that they are-currently have, and that's the issue. How can they take care of their kids, if they're not healthy, themselves?

And those that have commercial health insurance often don't go, because the copays are too high.

I'd just like to stress mental health, which you mentioned.

I worked-before this position, I worked in the prison system. And what I saw coming out were people who had been in the system with mental illnesses-coming out, and not receiving services.

Mental health.

Business/Community Leaders

In order to drive down the cost of healtheare, we need to get people out of the emergency rooms.

And in terms of the HIV/AIDS there might be, there's one organization specifically out there--Alliance for Living--but the resources are diminishing.

One is that I very rarely see interagency work here, meaning where I'm sitting down as organizational leader with healthcare leaders, with social service leaders, with legal service leaders, etc. It absolutely has to happen and to be happening on a regular basis so that we know what's available out there. The second is we have to talk about regional service delivery.

We're providing a, we're going to start providing a supper program because we've got lots of kids who don't eat unless we feed them.

The least threatening point of access in 90% of communities for most people are schools. So one of the things I think we really need to consider is how do we keep the schools open longer? Make them multi-agent sites, agency sites for healthcare, social services, legal services, food, whatever it is cause we're wasting time when we're not using the buildings for extracurricular activities.

Service Providers

I think access to health care. I'm also with UCFS. I'm representing [INAUDIBLE] here today.

Access to health care.
Access to health care. Actually dental health is the most restrictive. More so than mental health.

And specialty care. We offer primary care services, but we have a very hard time referring to specialty care providers. They - typically, these folks either end up in - at UCONN, or they don't get served.

OB/GYN.

Orthopedics?

Orthopedics is very difficult. I've heard stories of people who get their arm set at the emergency department. They can't get an appointment, and they have to go back to the emergency department to get their cast taken off.

Substance abuse treatment. I would include with that smoking cessation.

Copay assistance. If they're - if the patients are lucky enough to have insurance, we're finding more times than not that they can't afford the copay.

I think what we're seeing a lot of is people are getting insurance that is basically just catastrophic coverage only. And even that is very limited, so their insurance is covering very little.

Several of the folks I see are really struggling to pay for their medications.

Access to healthy food for kids - well, actually for families. Problems with obesity.

I would like to see much more energetic program in the school systems to emphasize healthy food.

General Public

One problem I find myself in is a lot of times you can't find a lot of doctors that take Husky kids. That's a problem I have, and it's like the only resource you have is the Community Health Center.

Some of the people I come in contact with have limited education in terms of exercising and even nutrition. So I find the nutritional area is one that additional services or education could be provided.

I'd say most people with diabetes and borderline diabetes don't even know about it.

Health fairs, too.

I see a really low number of options for community wellness. If you're fortunate enough to work for a corporation, I think that sector is really encouraging their employees to be healthy and they give them incentives to be healthy and to learn more about what they may not have learned before. But if you don't work for that, or even if you are able to find a program though a hospital or through, for example, a Parks and Rec department, oftentimes the cost is not affordable.

Deliberative Needs Card Results

The second column holds the percentage of focus group participants, across all five groups, that believe the need in the first column should become a United Way priority.

Health

05 Food / Hunger	69.0
09 Behavioral / Mental health	46.6
01 Health education	41.3
14 Mental Health	37.9
16 Alcohol / Substance abuse care	37.9
17 Alcohol / Substance abuse prevention	37.9
03 Insurance	36.2
12 Safe sex / HIV-AIDS services	36.2
15 Nutrition	36.2
10 Fitness / obesity	34.5
18 Maternal health / pre-natal care	29.3
19 Prescription drug access	29.3
08 Dental	25.9
04 Screening / Care	20.7
11 Providers (availability)	20.7
13 Behavioral risks	20.7
06 Facilities	13.8
02 Unhealthy habits programming / smoking cessation	12.1
07 Health advocates	10.3
20 Hospice care	10.3

Community Health Care Needs Assessment
Windham Consortium
Qualitative and Quantitative
September 2011

Telephone Surveys:

1 INTRODUCTION

The Center for Research & Public Policy (CRPP) is pleased to present the results of a Community Health Assessment conducted among residents of Windham County, Connecticut.

The Community Health Assessment was designed to provide resident input on current health status and needs.

The Health Assessment included a comprehensive telephone survey.

Telephone interviews (630) were conducted among residents of the 15 municipalities served.

This report summarizes information collected from residential surveys conducted on September 9 – 19, 2011.

The survey instrument employed in the Community Health Assessment included the following areas for investigation:

- Health Care Access;
- Exercise;
- Dental Care;
- Cardiovascular Disease;
- Tobacco Use;
- Immunizations;
- Falls;
- Women's Health;
- Prostate Cancer Screening;
- Colorectal Cancer Screening;
- Pre-Diabetes / Diabetes;
- Nutrition;
- Sleep;

- Alcohol Consumption;
- Healthy Days;
- Family Planning;
- Visual / Access to Eye Care;
- Care Giver;
- Veteran's Health;
- BMIs; and
- Demographics.

Section II of this report discusses the Methodology used in the study, while Section III includes Highlights derived from an analysis of the quantitative research. Section IV is a Summary of Findings for the residential telephone surveys - a narrative account of the data.

Section V is an Appendix to the report containing crosstabulation tables and the survey instrument.

2 METHODOLOGY

Residential Telephone Survey

Using a quantitative research design, CRPP completed 630 interviews among residents of Windham County in Connecticut.

All telephone interviews were conducted September 9 – 19, 2011. Residents were contacted between 5:00 p.m. and 9:00 p.m. weekdays and 10:00 a.m. and 4:00 p.m. on the weekend.

Survey input and approval was provided by Consortia officials.

Survey design at CRPP is a careful, deliberative process to ensure fair, objective and balanced surveys. Staff members, with years of survey design experience, edit out any bias. Further, all scales used by CRPP (either numeric, such as one through ten, or wording such as strongly agree, somewhat agree, somewhat disagree, or strongly agree) are evenly balanced. And, placement of questions is carefully accomplished so that order has minimal impact.

All population-based surveys conducted by CRPP are proportional to population contributions within states, towns, and known census tract, group blocks and blocks. This distribution ensures truly representative results without significant under or over representation of various geographic or demographic groups within a sampling frame.

CRPP utilized a "super random digit" sampling procedure, which derives a working telephone sample of both listed and unlisted telephone numbers. This method of sample selection eliminates any bias toward only-listed telephone numbers. Additionally, this process allows randomization of numbers which equalizes the probability of qualified respondents being included in the sampling frame. Cell phone respondents were included in the sampling process and represented 4.0% of the total sample.

Respondents qualified for the survey if they confirmed they were at least 18 years of age and were current residents of one of the qualifying communities.

Training of telephone researchers and pre-test of the survey instrument occurred on September 7, 2011.

All facets of the study were completed by CRPP's senior staff and researchers. These aspects include: survey design, pre-test, computer programming, fielding, coding, editing, data entry, verification, validation and logic checks, computer analysis, analysis, and report writing.

Completion rates are a critical aspect of any telephone survey research. Because one group of people might be easier to reach than another group, it is important that concentrated efforts are made to reach all groups to an equal degree. A high completion rate means that a high percentage of the respondents within the original sample were actually contacted, and the resulting sample is not biased toward one potential audience. CRPP maintained a **70%** completion rate on all calls made. And, a high completion rate, many times, indicates an interest in the topic.

Statistically, a sample of 630 surveys represents a margin for error of +/-4.0% at a 95% confidence level.

In theory, a sample of all Windham County residents will differ no more than +/-4.0% than if all region residents were contacted and included in the survey. That is, if random probability sampling procedures were reiterated over and over again, sample results may be expected to approximate the large population values within plus or minus 4.0% -- 95 out of 100 times.

Readers of this report should note that any survey is analogous to a snapshot in time and results are only reflective of the time period in which the survey was undertaken. Should concerted public relations or information campaigns be undertaken during or shortly after the fielding of the survey, the results contained herein may be expected to change and should be, therefore, carefully interpreted and extrapolated.

Furthermore, it is important to note that all surveys contain some component of "sampling error". Error that is attributable to systematic bias has been significantly reduced by utilizing strict random probability procedures. This sample was strictly random in that selection of each potential respondent was an independent event, based on known probabilities.

Each qualified household within Windham County had an equal chance for participating in the study. Statistical random error, however, can never be eliminated but may be significantly reduced by increasing sample size.

HIGHLIGHTS

ON HEALTH CARE ACCESS…

- A large majority of residential respondents, 89.0%, indicated they have some form of health care coverage including health insurance, prepaid plans such as HMOs or government plans such as Medicare. However, 10.5% suggested they do not currently have any health care coverage. Extrapolated on the total Windham County population – the number of those without insurance may be 12,240. Statewide 2010 BRFSS (CDC's Behavioral Risk Factor Surveillance Survey) results indicate 90.2% have coverage while 9.8% do not.

- Among those with health care coverage, 56.0% said their coverage is provided by their employer or someone else's employer. Others mentioned a self-purchased plan, Medicare, Medicaid or the U.S. Military's plan – 8.4, 24.6, 2.3, 2.3 respectively.

- While 11.3% indicated they do not have one or more individuals they consider their personal doctor or health care provider, 88.3% suggested they have one person (81.0%) or more than one person (7.3%).

- And, while 87.5% indicated there was not a time over the past 12 months when they needed to see a doctor but could not because of cost, 12.2% suggested there was. Extrapolated on the total population, the number would be 14,448.

- Just over three-quarters, 76.8%, said they have visited a doctor for a routine checkup within the past year.

ON EXERCISE…

- A majority of respondents, 78.6% said they do moderate or vigorous physical activity in a usual week that causes small to large increases in breathing. Another 21.6% suggested they do not. Statewide 2010 BRFSS data show that 79.3% suggested they do any physical activities.

- When doing moderate or vigorous physical activity, respondents reported doing so for an average of 69.99 minutes.

ON DENTAL CARE…

- A strong majority, 72.1%, reported they have visited a dentist or dental clinic within the past year. Another 9.7% said their last visit was within the past two years while 5.4% suggested the last visit was within the past five years. Some, 12.1% suggested their last visit was five or more years ago. Statewide 2008 BRFSS data suggested 80.3% had visited a dentist or dental clinic over the most recent 12-month period.

ON CARDIOVASCULAR DISEASE…

- Researchers found that 4.3%, 2.7% and 0.5% of respondents have been told they have had a heart attack, stroke, or both a heart attack and a stroke, respectively.

- Statewide 2010 BRFSS data show results of 3.1 and 1.7 for heart attack and a stroke, respectively.

- While 91.9% suggested they have not been told they have had angina, congestive heart failure or coronary heart disease, 7.8% said they have.

ON TOBACCO USE…

- The Windham Consortia 2011 research found that 16.8% of all respondents are currently smoking everyday (12.2%) or some days (4.6%). Statewide 2010 BRFSS data show 13.2% of the adult respondents currently smoke.

- More than half , 58.5%, of current smokers said they stopped smoking for one day or longer over the past 12 months in an effort to quit smoking.

ON IMMUNIZATIONS…

- Under half of all respondents, 42.1%, said they had a flu shot since August, 2010. Among respondents over 65 years of age, 57.9% indicated they have had a flu shot since August of 2010. Statewide 2010 BRFSS data indicated that 72.4% had received a flu shot since August of 2010.

- Nearly three-quarters of respondents 65 years of age or older, 73.6%%, suggested they have had a pneumonia shot or pneumococcal vaccine. Statewide 2010 BRFSS data indicate 69.2% of those 65 years of age or older had the shot or vaccine at some point.

ON FALLS…

- Respondents 45 years of age and older were asked how many, if any, falls they have experienced over the past three months. Nearly one fifth, 17.1%, suggested they had experienced a fall. On average, across all respondents 45 and older, the average number of falls over the three month period was 0.67.

- Of this group that had at least one fall, 49.3% experienced one fall while the remainder experienced multiple falls.

- And, among those who had fallen, 44.0% (N=33), suggested their fall(s) did result in an injury. The average number of falls causing injuries was 1.88.

ON WOMEN'S HEALTH…

- A majority of all women surveyed, 87.3%, reported they have had, at some point, a mammogram. Among women surveyed over 40 years of age, the percent is 96.4% while among those over 50 years of age the percent is 98.6%. Statewide 2010 BRFSS data show that 81.4% of Connecticut women over 40 years of age have had a mammogram, and 83.8% of those over 50 years of age have had a mammogram.

- 93.0% of all women surveyed reported they have had a clinical breast exam.

- Another 95.9% of all women stated they have had a Pap test. Statewide 2010 BFRSS data show 85.6% of Connecticut women had a Pap test.

ON PROSTATE SCREENING…

- Males 39 years of age or older were asked if they have ever had a PSA test. Just over half, 58.0% suggested they had. Similarly, statewide 2010 BRFSS data show that 59.8% had a PSA test.

- Three quarters of all respondents, 80.9%, suggested they have had, at some point, a digital rectal exam. Another 18.7% had not and 0.4% were unsure.

ON COLORECTAL CANCER SCREENING...

- Over one-third, 37.9%, of survey respondents 49 years of age or older said they have had, at some point, a blood stool test using a home kit. Statewide 2010 BRFSS data show that 18.7% reported the same.

- Three-quarters, 75.7%, of respondents 49 years of age or older suggested they have had a sigmoidoscopy or colonoscopy exam. Statewide 2010 BRFSS data show that 75.7% reported they have had one of the two exams.

ON PRE-DIABETES / DIABETES...

- Nearly two-thirds, 64.6%, of all respondents indicated they have had a test for high blood sugar or diabetes within the last three years. About one-third, 33.2%, suggested they had not and 2.2% were unsure.

- Just under twenty percent (16.2%) of all respondents said they have been told by a doctor, nurse or other health care professional that they have pre-diabetes, diabetes, diabetes during pregnancy or are borderline diabetes. Statewide 2010 BRFSS data show that 8.9% were told they had diabetes (7.3%), diabetes during pregnancy (0.8%), or were pre-diabetes / borderline (0.8%).

- The average age respondents were told they had diabetes was 47.12.

- Nearly half of those with diabetes, 42.0%, said they have taken a course or class in how to manage their diabetes themselves.

- Just over two-fifths with diabetes (43.8%) knew their percent resulting from a test for "A one C".

ON NUTRITION...

- On average, respondents are eating 2.32 servings of vegetables and 1.93 servings of fruit daily. The USDA recommends four to five servings of vegetables and two servings of fruits daily.

ON SLEEP…

- A large number of respondents, 69.8%, indicated there were days over the past 30 days that they did not get enough rest or sleep. Among this group, the average number of days during the month they felt they did not get enough rest or sleep was 13.73.

ON ALCOHOL CONSUMPTION…

- Just over half of all respondents, 56.3% suggested they have had at least one drink of alcohol over the past 30 days. Of this group, the average number of days, over the past month, the respondent had at least one drink was 8.71.

- When respondents did drink, the average number of alcoholic drinks consumed was 2.61.

ON HEALTH DAYS…

- One-third of all respondents, 32.9%, suggested there were days over the last month that pain made it hard to perform their usual activities. Of this group, the average number of days per month when pain prevented usual activities was 15.69.

- A larger percentage, 38.9%, suggested that there were days over the last month when they felt sad, blue or depressed. On average, there were 9.48 days each month when this group had sad or depressed feelings.

- While 96.2% suggested there was not a time over the last year when they thought of taking their own life, 3.3% suggested there was. When extrapolated on the total Windham County population, the number of individuals is approximately, 3908.

ON FAMILY PLANNING…

- Just under half of all respondents, 46.3%, indicated they are taking one or more precautions to keep themselves or their partner from getting pregnant.

- Mostly, respondents cited the following actions used to keep from becoming pregnant: vasectomy (30.2%), tubes tied (17.5%), birth control pills (12.7%), male condoms (12.7%), IUD (5.6%) and female condoms (4.8%).

ON VISUAL / ACCESS TO EYE CARE…

- Just less than two-thirds (60.4%) reported having their eyes examined over the last year. Some, 14.9%, said they had an exam within the last two years while 21.7% said it's been two or more years. A few, 1.1% said they have never had an eye exam.

- Reasons for not having an eye exam or having a more recent exam included: cost of insurance and no reason to go or no problems.

ON CARE GIVERS…

- A large percent of respondents, 31.1%, suggested they are providing regular care or assistance to a friend or family member who has a health problem, long-term illness or disability.

- The average age of the person in care is 68.97.

ON VETERAN'S HEALTH…

- Researchers found that 5.9% of those surveyed did serve in the U.S. Military in a combat or war zone.

- Of this group, 18.9% have been told by a doctor or health professional that they have depression, anxiety or post traumatic stress disorder (PTSD). Of this group, 85.7% have secured psychological or psychiatric counseling or treatment.

ON BMIS...

- **CRPP calculated BMIs for each of the respondents who provided researchers both their weight and height. The following table presents the results. The district average was 28.28. Statewide 2010 BRFSS data show 23.0% as obese, 37.8% as overweight and 39.4% either normal or underweight.**

BMI Calculations	Percent
Underweight: <18	4.1
Normal: 18.5 – 24.9	28.1
Overweight: 25 – 29.9	36.9
Obese: 30.0 – 39.9	25.7
Extreme Obesity: 40.0+	5.2
Average District BMI	28.28

HEALTH DAYS

Nearly one-third of all respondents (32.9%) said there was one or more days, during the last 30, that pain made it hard to do usual activities such as self-care, work or recreation.

The number of days, during the last 30, that pain prevented this group from usual activities is presented in the following table. The average number of days was 15.69.

Number of Days Over Last 30 That Pain Prevented Usual Activities Enough Sleep	Percent
1-7	43.0
8-15	11.0
16-20	5.8
21-30	40.1

Over one-third, 38.9%, suggested there were one or more days, during the last 30, that they felt sad, blue or depressed. On average the number of days was 9.48.

The number of days that this group felt sad, blue or depressed is presented here.

Number of Days Over Last 30 Felt Sad, Blue, Depressed	Percent
1-7	64.4
8-15	15.8
16-20	3.3
21-30	16.3

Among all respondents, 3.3%, suggested there has been a time in the past 12 months when they thought of taking their own lives.

Focus Groups:

1 INTRODUCTION

The Center for Research & Public Policy (CRPP) is pleased to present the results to a series of seven focus group sessions conducted on behalf of the Windham Consortia. The Consortia membership includes: United Services, Windham Hospital, Day Kimball Hospital, Natchaug Hospital, Generations Family Health Center, VNA East, Northeast District Department of Health and Community Health Resources

Using a qualitative research design, CRPP conducted seven focus group sessions, which took place at the Access Agency in Willimantic, United Services in Dayville and Day Kimball's Plainfield Healthcare in Plainfield. The core composition of each group includes: First Responders, Latinos, Community Leaders, School Based Health, Boomers, Faith Based and Youth.

Residential sample for recruitment purposes was provided by CRPP. Sample for the professional groups was developed and provided by both CRPP and the Windham Consortia.

All sessions were organized by CRPP staff. Windham Consortia members donated focus group meeting facilities in the three cities. A total of 86 participants participated in the seven groups. This report summarizes information collected from the focus group sessions which occurred on August 1, 2 and 3, 2011.

The areas for investigation during the skier/boarder focus groups included:

- Perceptions of community health care status;
- Current health insurance status, having PCPs and Oral health providers;
- Perceptions of current community standard of living;
- Awareness of area health care facilities and organizations;
- Input on the availability of area specialists and walk-ins;
- Views on use of emergency rooms;
- Expectations of area health care service organizations;
- Strengths and weaknesses of are health care service organizations;
- Area health care needs – under-met and unmet;
- Views on emerging needs;
- Needs specific to Faith Based, School Based, First Responders and Community Leaders;
- Views on needs related to addictions, care givers, health/fitness, and mental health; and
- Barriers to receiving needed health care in the community.

Section II of this report discusses the methodology used in conducting the focus group study.

Section III includes highlights and select verbatim responses derived from an analysis of the quantitative research.

Section IV is an appendix including a copy of the focus group guidebook used by the moderator while facilitating the study, as well as a full written transcript for each of the seven focus groups which took place.

METHODOLOGY

The Center for Research & Public Policy moderated and organized a series of focus groups on behalf of the Windham Consortia.

The focus groups took place August 1, 2 and 3, 2011 in Willimantic, Dayville and Plainfield, CT.

Following each group within the study, CRPP project staff would review information collected and look for common themes displayed throughout the study. Section 3 of this report presents each covered section of the focus group guidebook along with select verbatim responses provided by group participants to help summarize and support common views expressed by the actual participants during the study.

The focus group sessions were organized by CRPP staff. CRPP ensured that nearly 100 potential participants were recruited for each group to ensure 8 – 12 participants actually attended. A total of 86 participants attended the sessions.

For their time and participation, all respondents received a cash incentive "as a small token of appreciation."

Each session was approximately 90 minutes in length.

For more detailed information, readers may refer to the full, written transcripts which may be found in a separate bound appendix to this report. Additionally, audio recordings of each group are submitted along with this report and will be live on a designated website for one year.

ON HEALTH STATUS …

Health Status Today: Improving, Declining?

- **Nearly all participants, in all groups, see a direct link between the downturn in the economy and declining health care of residents in area communities. They note that the number of under-insured is increasing significantly. SB**

- **Working parents, reportedly, are finding it difficult to get children to needed medical care. SB**

- **Many see patients coming home from hospitals too early. B**

- **Most see little difficulty finding physicians but suggest that Veterans need to travel to Newington, CT or Rhode Island for needed care. B**

- **Participants reported seeing growing incidence of tick borne illness along with mental health problems and cancer. B / FB**

- **Among youth, diabetes, mental illness, asthma, obesity and chronic illness is seen as increasing. There appears to be insufficient dental care and child psychiatry in the area for youth as well. Some offered that youth tend to eat cheaper, unhealthy foods compared to older residents. B / Y / SB**

- **First Responders suggested they are seeing more "self-pays", drug abuse, alcohol, and mental health transports than in years past. And, because of lack of insurance, they are transporting more complaints such as upset stomachs. FR**

- **Participants see many seniors in dire situations caused by negative changes to Title 19. L**

- **Nearly all participants agreed with those reporting there appears to be two States of Connecticut. Many described themselves as living in "a different Connecticut" when it comes to health and economic status. And, many see strong demographic differences between Windham and Windham County as well. CL**

Degree Behavioral / Mental Health Services are Needed?

- **All participants see area mental health programs but wonder about effectiveness of each. FR**

First Responders

Effective, no. I mean, I think that the problems with kids are through the roof.

No, you're right too. That's it's effective. Because now that I'm thinking about this - and I'm not taking any shots at United Services. But their facility in Danielson is one of our best customers, because as soon as any of the patients act out in any way negatively, they're on the phone to the ambulance to take them to the ER. Instead of, like you said, dealing with the problem in an effective manner.

School Based

There is really very few child psychiatrists in the area.

I think it's middle school years. I think when they get to middle school it's just that the stress level increases and the academic stress, course load increases as well.

What Are Emerging Health Care Needs in the Community?

- **Participants frequently suggested that mental health care was not so much a need as was effective, mental health care. The distinction was made across several groups.**

- **Others complained that mentally ill patients were getting pills instead of education on healthy living.**

- **Others offered emerging needs as diabetes, obesity, and tick borne illnesses.**

Deliberative Community Health Care Needs

Composite Results: The following table presents the composite results from participants in all seven focus group sessions. "Don't know" responses were removed from the data.

Community Health Care Programs and Services	Too Few	About Right	Too Many
Childcare – allowing travel to medical appointments	95.8	4.2	---
Fitness and obesity education / programs	94.0	4.8	1.2
Transportation to health care services	93.9	6.1	---
Health insurance support	93.8	4.9	1.2
Veterans health care	90.9	7.8	1.3
Caregiver education and support	89.9	10.1	---
Behavioral risk prevention programs	85.5	11.8	2.6
Alzheimer's/Dementia support groups	85.5	13.0	---
Caring for elderly parents / support	85.5	11.8	2.6
Nutrition education	84.1	15.9	---
Food/meals for those in need	84.1	15.9	---
School age bullying prevention services	83.6	13.7	2.7
Parenting support programs	82.5	17.5	---
Behavioral / mental health services	80.0	18.8	1.2
Domestic violence prevention education	79.2	20.8	---
Alcohol & substance abuse prevention	79.2	16.9	3.9
Health and lifestyle education	75.5	24.5	---
Recreation programs	74.7	24.1	1.2
Health advocates	73.8	22.5	3.8
School based health care services	72.0	28.0	---
Family planning care	71.4	25.7	2.9
Diabetes education/services	70.7	28.0	1.3
Fitness centers or gyms	65.9	30.5	3.5
Dental services	65.5	28.6	6.0
Alternative health care	62.7	33.3	3.9
Home health care services	59.5	40.5	---
Alternative medicines	58.0	34.0	8.0
Health care centers / facilities / walk-ins	54.1	44.7	1.2
Emergency medical services (EMTs, paramedics)	49.4	50.6	---
Emergency preparedness	45.8	52.1	2.1
Youth / child abuse programs / prevention	44.1	55.9	---
Addiction support	43.0	53.2	3.8
Gambling addiction support	39.1	59.4	1.4
Smoking cessation programs	38.6	60.0	1.4
Alcohol & substance abuse care	34.6	59.0	6.4
Access to birth control	33.8	62.2	4.1
Sleep disorder programs	31.9	68.1	---
Safe sex education	31.5	64.4	4.1
Primary care physicians	31.4	64.0	4.7
Eye care physicians / services	26.7	73.3	---
Pre-natal care services	25.0	72.7	2.3
Dentists	23.5	71.8	4.7
Hospice care	12.9	87.1	---

Deliberative Community Health Care Needs

Composite and Leadership Results: The following table presents **"Too Few"** results on a composite basis as well as by the four leadership focus group sessions. "Don't know" responses were removed.

Community Health Care Programs and Services	Composite	First Responders	Community Leaders	School Based	Faith Based
Childcare – allowing travel to medical appointments	95.8	100.0	100.0	100.0	100.0
Fitness and obesity education / programs	94.0	75.0	92.3	100.0	100.0
Transportation to health care services	93.9	62.5	100.0	100.0	100.0
Health insurance support	93.8	100.0	100.0	90.0	100.0
Veterans health care	90.9	100.0	76.9	87.5	100.0
Caregiver education and support	89.9	100.0	92.9	100.0	84.6
Behavioral risk prevention programs	85.5	100.0	84.6	100.0	100.0
Alzheimer's/Dementia support groups	85.5	100.0	66.7	75.0	92.3
Caring for elderly parents / support	85.5	100.0	83.3	88.9	92.3
Nutrition education	84.1	50.0	84.6	80.0	100.0
Food/meals for those in need	84.1	75.0	64.3	77.8	92.3
School age bullying prevention services	83.6	57.1	100.0	90.9	100.0
Parenting support programs	82.5	71.4	78.6	100.0	83.3
Behavioral / mental health services	80.0	75.0	78.6	100.0	100.0
Domestic violence prevention education	79.2	85.7	72.7	81.8	91.7
Alcohol & substance abuse prevention	79.2	71.4	85.7	100.0	90.0
Health and lifestyle education	75.5	40.0	81.8	57.1	87.5
Recreation programs	74.7	37.5	46.2	90.9	84.6
Health advocates	73.8	71.4	61.5	70.0	92.9
School based health care services	72.0	37.5	66.7	100.0	66.7
Family planning care	71.4	66.7	69.2	66.7	72.7
Diabetes education/services	70.7	85.7	30.8	62.5	90.9
Fitness centers or gyms	65.9	25.0	64.3	70.0	84.6
Dental services	65.5	85.7	92.9	54.5	71.4
Alternative health care	62.7	33.3	40.0	71.4	87.5
Home health care services	59.5	50.0	21.4	60.0	69.2
Alternative medicines	58.0	33.3	40.0	71.4	75.0
Health care centers / facilities / walk-ins	54.1	50.0	21.4	45.5	61.5
Emergency medical services (EMTs, paramedics)	49.4	50.0	7.1	45.5	66.7
Emergency preparedness	45.8	20.0	25.0	66.7	42.9
Youth / child abuse programs / prevention	44.1	40.0	81.8	70.0	36.4
Addiction support	43.0	28.6	69.2	60.0	38.5
Gambling addiction support	39.1	20.0	71.4	14.3	41.7
Smoking cessation programs	38.6	40.0	58.3	---	45.5
Alcohol & substance abuse care	34.6	42.9	57.1	54.5	30.0
Access to birth control	33.8	20.0	84.6	45.5	23.1
Sleep disorder programs	31.9	16.7	8.3	20.0	33.3
Safe sex education	31.5	14.3	53.8	50.0	18.2
Primary care physicians	31.4	37.5	78.6	9.1	14.3
Eye care physicians / services	26.7	---	21.4	30.0	36.4
Pre-natal care services	25.0	---	20.0	---	20.0
Dentists	23.5	37.5	64.3	27.3	21.4
Hospice care	12.9	12.5	---	12.5	9.1

Deliberative Community Health Care Needs

Composite and Residential Results: The following table presents **"Too Few"** results on a composite basis (all seven groups) and by the three residential groups. "Don't know" responses have been removed.

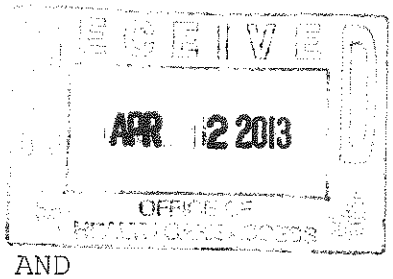
Community Health Care Programs and Services	Composite	Latinos	Boomers	Youth
Childcare – allowing travel to medical appointments	95.8	90.0	100.0	83.3
Fitness and obesity education / programs	94.0	90.0	100.0	92.9
Transportation to health care services	93.9	100.0	100.0	83.3
Health insurance support	93.8	80.0	100.0	85.7
Veterans health care	90.9	90.0	100.0	85.7
Caregiver education and support	89.9	90.0	91.7	75.0
Behavioral risk prevention programs	85.5	60.0	91.7	66.7
Alzheimer's/Dementia support groups	85.5	87.5	100.0	80.0
Caring for elderly parents / support	85.5	77.8	93.3	63.6
Nutrition education	84.1	90.0	85.7	85.7
Food/meals for those in need	84.1	100.0	86.7	92.9
School age bullying prevention services	83.6	100.0	81.8	53.8
Parenting support programs	82.5	90.0	91.7	64.3
Behavioral / mental health services	80.0	50.0	73.3	76.9
Domestic violence prevention education	79.2	70.0	85.7	66.7
Alcohol & substance abuse prevention	79.2	66.7	71.4	69.2
Health and lifestyle education	75.5	100.0	85.7	66.7
Recreation programs	74.7	88.9	86.7	78.6
Health advocates	73.8	60.0	84.6	69.2
School based health care services	72.0	90.0	83.3	53.8
Family planning care	71.4	77.8	81.8	63.6
Diabetes education/services	70.7	80.0	76.9	76.9
Fitness centers or gyms	65.9	70.0	71.4	61.5
Dental services	65.5	50.0	46.7	61.5
Alternative health care	62.7	80.0	83.3	55.6
Home health care services	59.5	90.0	80.0	50.0
Alternative medicines	58.0	40.0	83.3	62.5
Health care centers / facilities / walk-ins	54.1	80.0	80.0	42.9
Emergency medical services (EMTs, paramedics)	49.4	80.0	71.4	35.7
Emergency preparedness	45.8	60.0	66.7	57.1
Youth / child abuse programs / prevention	44.1	22.2	18.2	36.4
Addiction support	43.0	11.1	35.7	46.2
Gambling addiction support	39.1	25.0	18.2	50.0
Smoking cessation programs	38.6	37.5	30.8	50.0
Alcohol & substance abuse care	34.6	11.1	21.4	23.1
Access to birth control	33.8	44.4	10.0	92.3
Sleep disorder programs	31.9	80.0	28.6	66.7
Safe sex education	31.5	30.0	30.0	16.7
Primary care physicians	31.4	20.0	33.3	21.4
Eye care physicians / services	26.7	40.0	18.2	36.4
Pre-natal care services	25.0	66.7	---	50.0
Dentists	23.5	20.0	93.3	92.3
Hospice care	12.9	28.6	15.4	18.2

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



BACKUS CORPORATION, INC. AND
HARTFORD HEALTH CARE CORPORATION, INC.

AFFILIATION OF BACKUS CORPORATION WITH
HARTFORD HEALTH CARE CORPORATION

DOCKET NO. 12-31788-CON

MARCH 26, 2013

3:00 P.M.

BACKUS BUSINESS & TECH CENTER
11 STOTT AVENUE
NORWICH, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of the Affiliation of Backus Corporation with Hartford Health Care Corporation, held at the Backus Business and Tech Center, 11 Stott Avenue, Norwich, Connecticut, on March 26, 2013 at 3:06 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. Before we begin, would everyone please turn off their cell phones, just so we don't get interrupted? Certainly, if there's a doctor in the room that needs their cell phone on, please feel free to keep that on.

This public hearing before the Office of Health Care Access, identified by Docket No. 12-31788-CON, is being held on March 26, 2013 to consider Backus Corporation, Inc. and Hartford Health Care Corporation, Inc.'s application for the affiliation of Backus Corporation and Hartford Health Care Corporation.

This public hearing is being held pursuant to Connecticut General Statute, Section 19a-639a, and

will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, the Uniform Administrative Procedure Act.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this matter this afternoon.

Assisting me today with the public hearing are Kaila Riggott, Steven Lazarus and Brian Carney. The hearing is being recorded by Post Reporting Services.

The way that we will proceed with the hearing today is to first hear from the Applicants for a brief 10-minute overview of the project, followed by OHCA's questions. I'll give each Applicant 10 minutes, and, due to the lack of public here today, feel free to take your time. I won't hold you to that 10 minutes.

Out of deference to legislators and municipal officials, if we have any here today, we will call them first, and then we will go to the public section of the sign-up sheet.

Each person, who wishes to speak, should write their name on the sign-up sheets, which have been provided here today.

Following the hearing, I will issue a

proposed final decision, in accordance with Connecticut General Statutes, Section 4-179.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record. All documents have been identified in the Table of the Record for reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good afternoon. Seven Lazarus. OHCA would like to enter into the record Exhibits A through J.

HEARING OFFICER HANSTED: Thank you. Any objection, Attorney Feldman?

MS. JOAN FELDMAN: No.

HEARING OFFICER HANSTED: Thank you. The Applicants, Backus Corporation, Inc. and Hartford Health Care Corporation, Inc., have been designated as parties in this proceeding.

At this time, I would like all the individuals, who are going to testify on behalf of the Applicants, to stand, raise your right hand, and be sworn

in.

(Whereupon, the parties were sworn.)

HEARING OFFICER HANSTED: Thank you. Attorney Feldman, you may proceed.

MS. FELDMAN: Well, thank you. I would just like to make a few remarks in connection with this application. I think that we have set forth in the application the nature of the proposal, but today we're going to basically tell you a story of sorts about a shared commitment to the provision of quality cost-effective care, health care services in the Eastern Connecticut region.

This is not about disruption of services. This is about strengthening and stabilization of services in Eastern Connecticut.

As you know from our application and our pre-filed testimony, hospitals and health care systems are faced with many challenges today, and I'm just going to name a few.

Less reimbursement, declining volumes, reduced health insurance benefits, expensive new technologies, aging infrastructure, reductions in charitable contributions, and weak investment performance.

Most hospitals, as you know, have done as much as they can, in terms of aggressively cutting and lowering costs, without compromising care, but it's not enough, simply because cost reductions can no longer exceed the revenue reductions that we are experiencing.

Hospitals and health care systems must respond in a responsible manner to achieve economies of scale, share financial risk, in order to continue to maintain access to care and deliver a high-quality care.

Collaboration and consolidation are essential, and this fact has not gone unnoticed by the Federal Trade Commission, which has already approved the proposed affiliation before you today.

This proposal is about creating the needed infrastructure and integration pathways necessary to secure the quality care that this community deserves now and into the future.

We must act now. We can't waste time. We can't lose ground. We're hopeful that our testimony today and our answers to your questions will be sufficiently responsive and will further demonstrate the added value that this affiliation will bring the health care system of Eastern Connecticut.

We'd like to start with the pre-file.

HEARING OFFICER HANSTED: Absolutely.

MS. FELDMAN: Okay.

MR. DAVID WHITEHEAD: Well, good afternoon, Attorney Hansted and staff of the Office of Health Care Access. My name is David Whitehead, and I am the President and Chief Executive Officer of Backus Corporation, the parent corporation of the William W. Backus Hospital.

It's my pleasure to welcome you to one of our Backus facilities today, and I adopt my pre-filed testimony as my own.

HEARING OFFICER HANSTED: Thank you.

MR. WHITEHEAD: I'm here today to request your approval for this proposed affiliation between Hartford Health Care and Backus Corporation.

At the outset, I would like to call your attention to a piece of my pre-filed testimony, section one on page two.

This, I believe, encapsulates the issues that caused the Backus Board to ask whether Backus could continue to stand alone, given the many changes in health care and, ultimately, to seek a partner.

And I quote, "Consolidation is an outgrowth of a C change in health care, a shift that

requires hospitals to provide effective care, quality outcomes at lower cost, and for it to find patient population over continuum of care needs and settings."

That understanding led to the Board's development of a new vision for the organization, to be the leading, high-value health care system for Eastern Connecticut, and a defined goal of creating a sustainable, fully-integrated health care delivery system across the entire continuum of care.

It is about meeting the triple aim set forth by the Institute for Health Care Improvement, better care, improved outcomes at a lower cost.

This is what our Board has set accountability for, because it is the sort of care our community expects and deserves.

We believe, for the reasons fully set forth in the affiliation agreement, that Hartford Health Care is the best partner for Backus in the communities of Eastern Connecticut.

We have seen how our two organizations mission, vision and values are similarly aligned, and that we share a common goal, improving patient access, including the underserved population to a full continuum of health care services.

Backus did not arrive at this juncture without a lot of thought and deliberation and a keen focus on a health care reform readiness strategy. As you are aware, Backus has been a successful standalone organization, demonstrating solid performance on quality, safety and financial measures.

This affiliation proposal is not, nor has it ever been, driven by a need to immediately access more capital or to shore up weakened resources.

For Backus, this decision has been about one thing only, taking strategic steps today to insure that our community will continue to have broader access to health care in a drastically-altered industry landscape.

No one can deny that major changes in health care are underway and accelerating, and many of them are absolutely necessary.

The changes will not come easily, and the technological infrastructure and strategic resources required to effect these fundamental shifts are beyond the ability of even a successful standalone organization.

That is the cold splash of reality, as I call it, that our Board faced head-on. Simply put, there are elements of a more coordinated care delivery model,

such as Hartford Health Care's recent formation of an accountable care organization that are beyond the present abilities of Backus.

When you combine this reality with demands for more effective treatments, the care for a population of older and sicker adults, the need for more robust information technologies, and the desire to share best clinical and managerial practices, the need for a partnership becomes even clearer.

The strategies to achieve broad clinical integration create an advanced primary care network of patient-centered medical homes, develop more effective and efficient outpatient services, provide seamless specialty and sub-specialty health care, and the most appropriate care settings.

All of these components are part and parcel of the affiliation plan Hartford Health Care and Backus have committed to if this affiliation is approved by you.

Our process began in July of 2010, when our Board authorized a sustainability assessment for the organization. Between the time that report was received in October of 2010 and the Board approved the definitive agreement with Hartford Health Care in July 2012, we

undertook a deliberative and diligent review of options.

Given our past performance, one of those options was and continued to be, until the final agreements were signed, to remain as a standalone organization, but our factual and honest review of the data and scan of the health care environment caused us to review potential partnership scenarios, and, after that extensive review, to select Hartford Health Care as our partner of choice, and led us to this point where we are today.

Throughout this process, we have communicated often and openly with our stakeholders. By design and through our cascading communications plan, the hospital staff and medical staff were always the first to learn of our letter of intent, memorandum of understanding, and joint approval of the definitive agreement.

Our Corporators received updates and letters at a special meeting with Hartford Health Care President and Chief Executive Officer, Elliot Joseph.

Moreover, our entire community was able to learn about this proposed affiliation to our website, where we created a special microsite, backushospital.org/affiliation, which included

frequently-asked questions.

Public presentations at civic and social organizations have likewise provided information and an opportunity for discussion.

As our staff, stakeholders and community members have been informed, the guiding principle of this affiliation is a creation of a comprehensive strategic plan for the entire region.

This strategic plan would be developed upon approval of our CON jointly with Backus, Hartford Health Care, and other regional system members, and the accountability for its implementation will rest with regional leadership.

This plan will specifically address the areas of greatest need for communities in New London and Windham Counties.

The elements to be addressed in the plan are enumerated fully in the affiliation agreement, but they notably include creation of primary care ambulatory care networks, an ambulatory surgery network, a preventative medicine institute, and better alignment of key clinical service lines using Backus and Hartford Health Care expertise, including oncology, cardiology, trauma, behavioral health and chronic disease management.

My colleagues and I firmly believe that the proposed affiliation of Backus and Hartford Health Care will allow the patients served by our organizations to benefit, therefore, I respectfully request that you approve the proposal now before you.

Thank you for your time and attention, and I'd be happy to entertain any questions you might have.

HEARING OFFICER HANSTED: Thank you.

MR. ELLIOT JOSEPH: Good afternoon, Attorney Hansted and OHCA staff. I'm pleased to be with you this afternoon. I'm Elliot Joseph. I'm the President and CEO of Hartford Health Care, and I do adopt my pre-filed testimony as my own.

HEARING OFFICER HANSTED: Thank you.

MR. JOSEPH: Just to add onto what David has shared with you, it was clear to us from the onset of our conversations with Backus and David and his Board that his organization and our organization share a common vision of what's required to transform the health care delivery system here in Connecticut and across the country, quite frankly.

It's been well-documented that our delivery system today here in Connecticut and across America is characterized by three fundamental problems

that are going to -- that have to be fixed and addressed by us on the delivery side.

One is the enormous variation in clinical outcomes that our processes produce that need to be addressed and are being addressed.

Two is the high degree of fragmentation that people receive, particularly people with chronic disease and multiple acute problems. Our delivery system is not a system.

It's a system that's organized today that will take care of episodes of interaction with people when they get sick, and does not do a good job of treating folks with chronic disease, and it's the old 80/20 rule, as we well know and it's well-documented, that 80 percent of the costs of health care are used by those, who are most sick and in most need of coordinated delivery.

And, thirdly, beyond the variation and the fragmentation, probably the piece that's gotten the most attention is that it's unaffordable.

For us, we know that those issues have to be fixed. They have to be addressed, and that's what brought Backus and Hartford Health Care together.

I know you're also aware there are other

pressures that are coming down on us, one of which I actually describe as an opportunity that calls for us to try to create a greater integrated delivery system, is the Health Care Reform Act that was passed this past year and is now being enacted.

That Bill alone, that law alone has dramatically changed everything around us, but, also, I think provides for us a pathway for organizations like ours to come together and address those three fundamental problems in the health care delivery system.

The other piece of this, which is very concerning to all of us I know, is the profound negative budget situation here in our state.

I'm not going to recount the details for you. You're probably as familiar with it, if not more so than I am at this point, but the impact on our organizations and the communities we serve is profound, and we're still trying to figure out how best to address the impact of those cuts on our ability to serve.

So I really give the Backus Board an enormous amount of credit, having started, as you heard from David, in 2010, with a vision of doing something different, even while they were performing at a high level organizationally on virtually every metric that we

do follow.

So you're actually hearing a proposal and reviewing a proposal by two strong organizations, who felt it was necessary to come together to sustain ourselves and invest in this delivery system that needs to be developed sooner, rather than later.

I feel confident hypothesizing that future Applicants, who sit in front of you, given the environment we're in, it will be rare to find two strong organizations left, who are ahead of the curve, in terms of what we're facing today and what's very shortly down the road for us, so this is a unique moment, we feel, and a great opportunity for us.

The partnership moves along two different paths that we like to think about in allowing us to do the transformational work that's required in the delivery system.

One path is scale, quite frankly, being able to get larger. You know, the science demonstrates this in multiple ways. Allows us to lower our cost to a much greater degree.

It allows us to afford to make the investments in technology, it allows us to make the investments in new care delivery and care management

systems, and allows us to make investments in hiring the new kind of people required to do the new kind of work in managing care, which we don't do today, we're not equipped to do today, so there are tremendous benefits from this need to have a larger, more scalable organization.

The other path that we are moving down is integration, and you can't have one without the other and be successful, so getting large, without integration, or getting integrated, without having to scale, there's no question in certainly our mind that we can't get to the destination we need to get to to address what ails the delivery system, so integration.

Part of our vision, we have something we call our five ones, and so that at Hartford Health Care we really want to develop, for the people that we serve, one registration system, so they don't have to register multiple times, one electronic health record that follows patients wherever they go.

Ultimately, one bill. After all the services you receive, we can get it all together in one bill. One state of excellence, one standard of excellence that, again, reducing its variation requires us to be able to produce standard excellence over time,

and, lastly, one relationship.

Those five ones define our long-term ambition, define why we think an integrated delivery system will add the kind of value that's necessary over time.

The idea of a vision like that does two things. We hope it inspires us, and we also know it produces some tension for us internally, because we're so far away from being able to do it today, but, again, without that scale and without that integration, we can't possibly deliver on those five ones that are part of our vision.

And these are the things, these five ones, those represent for me the kind of health care system I want to be a patient in, so we're building something that we think has to be suitable for us, and those we love, and people we serve in this community, so it's an important ambition for us.

That's a little bit of the forward-looking thing. I want to reflect for a minute, sort of looking backwards, because we were here a couple of years ago, talking about the Hospital of Central Connecticut, and I'm very proud to say that we've done a lot of good work in the first few years of us being together.

We've been very thoughtful about the use of our limited resources and stewards of community resources that we've been able to cut costs. We've been able to begin to standardize some of our operations. We've been able to demonstrate improvement in quality.

We have access capital at a lower cost, more favorable terms, and we've improved access and innovated on delivery models, so I feel very good that we're delivering on the promise of the organization that we're constructing while we're moving forward and attracting other partners to join us on this journey.

Some specific examples, reflecting on the CCHA partnership, include the following. We have been approved for implementing a Medicare shared service, the Accountable Care Organization, with one of the state's insurance companies, so we're excited about being a pilot in leading through this new work.

Number two -- again, we have more than 10 minutes, and I understand I could go on for hours, but there are a lot of examples of things we've done, so number two is the formation of a new organization, called Integrated Care Partners, which is the organization for us that will work on the important work of clinical integration, which is bringing our physicians together,

our private physicians that are employed physicians, across all of our medical staffs to work together to organize around value, how they can identify standards of care, how they can begin to reduce the cost of care, and work together to take that value-oriented care into the marketplace.

We've also established a medical foundation. As I'm sure you're aware, there's a large call from physicians to become employees of large integrated systems like ours, and we have begun -- well we're into installing this foundation.

One of the important parts of the foundation, the part that I feel most excited about, is there's a sub-section of the foundation, which is solely primary care, and, today, we have over 100 doctors in a large primary care medical group.

That did not exist two years ago, and the profound shortage of primary care we suffer from in the State of Connecticut we've now built a model that we think will be helpful in retaining primary care doctors, number one, recruiting new primary care doctors, number two, and, number three, allowing us to create new models of primary care, because, again, we have scale and we have integration inside a primary care organization.

Number four, recruitment of quality experts at the system level to innovate around quality and program initiatives. There's probably nothing more important to us than the work of improving quality and reducing variation.

One simple metric is all-cause mortality, so, when people die in your hospitals, we have a way, or people a lot smarter than me have a way of figuring out, based on your case severity, what number or what percentage of patients should actually die in your hospital, so the index is one.

Prior to our work together, our hospitals were all over the map. Some were over one. Some were under one. There was lots of variation and ample opportunity.

Today, all four of our hospitals today are operating under one, in terms of all-cause mortality, and that's because we've installed the systems, and the processes, and the incentives, and the structures to improve quality across a large complicated organization.

We've recruited new staff people. A sample would be a physician IT expert, who is leading our data analytics and informatics capability. All the work that David talked about and that we are in pursuit of

together requires new kinds of expertise that we don't have today and, certainly, we couldn't afford by ourselves. Again, this gets back to scale for us.

The accessibility of capital at a system level Wall Street has responded very favorably to what we've done here in Connecticut, and it's because we've been able, again, to get this scale and get this integration, and have been able to access capital at a favorable rate for Connecticut members, and then significantly cut costs across the entire system.

We took 66 million dollars of costs, real costs, out of our organization last year. We had set a goal of taking 200 million over five years. We're walking down that path now.

Unfortunately, 200 million now pales in comparison with the recent budget cuts that we have to accelerate this work, so there's an even greater sense of urgency to attract partners in with us to help us do this important work.

As Joan mentioned, we're pleased to note that the FTC has approved this application, and they see the benefits that we are suggesting we are going to achieve through this partnership, and they have seen the benefits we have achieved through our prior affiliations.

I appreciate the chance to share a little bit more of the story with you and look forward to answering questions. Thank you.

HEARING OFFICER HANSTED: Thank you. Okay. OHCA has some questions. Steve, did you want to start?

MR. LAZARUS: I'll have Brian start.

HEARING OFFICER HANSTED: Brian?

MR. BRIAN CARNEY: Good afternoon. My name is Brian Carney. I'm a member of the OHCA staff. I just have two small things I request of you, one question and one follow-up.

If I can direct you to page 10 of the application, Roman Numeral IX towards the bottom of the page, under benefits to Backus Corporation and the Eastern Region, you state that participation in clinical collaboratives relating to becoming a high reliability organization.

Can you please provide some examples of these clinical collaboratives and describe what becoming a high reliability organization means?

MR. JIM CARDON: Jim Cardon, Chief Clinical Integration Officer at Hartford Health Care.

The clinical collaboratives are a group of

physicians from across the organization that come together to define for themselves quality standards that they're going to hold themselves accountable for and report on performance.

They have leadership, and they are multi-disciplinary, including nursing and support staff, and both report and work on their own metrics, but, then, share best practices, in terms of how they work through what kind of quality measures they're going to hold themselves to, and they have been developed somewhat two ways.

It started with a sort of a top down, we need some thought leadership around certain initiatives, infection control and pharmacy and therapeutics, but they've started to spring up as providers and come together and say we'd like to participate in this work and have been chartered to do that.

As those practices are rolled out, they are then brought across the entire systems hospitals to be implemented.

In terms of a high reliability, there has been a program in place with HBI Health to engage all systems hospitals in becoming high reliable organizations. This is in partnership with Connecticut

hospital systems.

HOCC has been doing that work for about two years. The rest of the systems hospitals are coming on board in this year to continue that.

MR. JOSEPH: If I may, Jim, if I may? Am I allowed to do this?

HEARING OFFICER HANSTED: Sure.

MR. JOSEPH: I'm not quite sure what the rules are. Clarence Silvia, who is the CEO of the Hospital of Central Connecticut, is here, and he would be instructive, I think, in terms of giving some examples.

For example, the early warning system for hospital infections. Clarence, would you mind speaking for a minute about some of the high reliability work you're doing? Would that be --

HEARING OFFICER HANSTED: That's fine. Sure.

MR. CLARENCE SILVIA: Clarence Silvia, President of Hospital of Central Connecticut.

MS. FELDMAN: I don't think he was here when we did the --

HEARING OFFICER HANSTED: You weren't sworn in?

MR. SILVIA: No. I was at 11 Scott

Avenue. (Laughter)

(Whereupon, Clarence Silvia was sworn.)

MR. SILVIA: The high reliability Hospital of Central Connecticut started down this road about two years ago, and there's a number of pieces to it.

Really, what it is is implementing what we call a culture, culture of doing no harm. We are in the process now we have probably trained close to 70 percent of the hospital staff, about half of the medical staff, and really what it is is implementing behaviors that everybody in the hospital is going to practice. That leads one to a culture of high reliability, do no harm.

We've also implemented a number of initiatives as a result of this. For instance, we have, in the first of the year, we implemented with our Cerner system what we call an early warning system, where, depending upon various algorithms within the system, physicians are notified that a patient may be leaning towards a situation, where they need intervention.

We have seen, just since we've implemented it, at least once week, where we have been able to intervene to help a patient from going down a road that would lead to harm.

We've also done a number of things, in

terms of infection prevention, and really what we're starting to see now is the benefits of that, where I can relate a number of stories, where situations, where -- in fact, one I can tell you about is a case, where we had a patient that was arresting.

There was a number of people in the room, and just using those behaviors, where the nurse that came in said I'm concerned, everybody stopped, the physician stopped, and they re-reassessed where they were going and changed the direction they were going in, and, as a result, the patient was saved as a result of that, so it is really taking root.

The literature shows that if you move to a culture of high reliability, you can reduce harm. The individuals that we've worked with and are working with have gone from hospitals, where there was patient harm every 16 to 20 days, to situations, where they've gone a full year without harming the patients and preventable harm.

MR. JOSEPH: And we're spreading this across all of our hospitals, and it's really the science that's taken from the nuclear power industry and the airline industry, who really dramatically reduced safety issues.

I'm pleased to say that one of our four core values organizationally is safety, so, again, that's what allows us to spread these kind of practices across all of Hartford Health Care relatively quickly.

MS. FELDMAN: Just to also give you a specific example with respect to readmission reduction, there are many initiatives across the system, from our home care agencies, to our skilled nursing facilities, to our acute hospitals, to study various outcomes related to specific diseases that have been identified by Medicare as being high-risk areas, like pneumonia, congestive heart failure, acute MI.

Hartford Health Care is well into studying congestive heart failure and looking at the data across the system, so that they could come up with an algorithm that would reduce the readmission rate for CHF.

MR. JOSEPH: And this gets to your collaboratives question, the collaboratives of the groups of clinicians that are coming together to solve these problems and create solutions and then spread them.

MR. SILVIA: Just to add on to what Dr. Cardon was saying, which is, at the Hospital of Central Connecticut, we have a major initiative on CHF readmissions, where we implemented a procedure, where we

had all the patients upon discharge get appointments, follow-up appointments in our CHF clinic, where we have dietitians, we have APRNs, and we have a cardiologist, that they come back post-discharge, they are educated on nutrition, they are given things, so they can put their pills in, they are given scales, so they can weigh themselves, and we, with the patients who have come back to us and followed up on those appointments, we've reduced the readmission rate from 22 percent to four percent.

And, so, it's this model that we now, with these collaboratives, can then bring to all the other hospitals within Hartford Health Care.

MR. CARNEY: Very good. Thank you very much. The second question is financial in nature, and what I would like to come in the form of a late file would be to get an updated financial attachment one for Hartford Health Care Corporation, Backus Corporation and Backus Hospital, so that the actual results begin with fiscal year 2012. The ones you submitted had fiscal year 2011.

HEARING OFFICER HANSTED: I'll order that as Late File No. 1. Attorney Feldman?

MS. FELDMAN: Okay.

MR. CARNEY: In addition, just to let you know, one that was submitted for I think it was Hartford Health Care Corporation had some information in the incremental column for 2012. I think that --

MS. FELDMAN: I'm sorry?

MR. CARNEY: Erroneous data that was in, because the project hasn't been approved yet, so there shouldn't be anything in incremental fiscal year 2012.

MS. FELDMAN: Okay.

MR. LAZARUS: How long would that take to submit?

MS. FELDMAN: Well we're eager to have the application deemed complete and the process to move into the determination period, so we can probably get that to you Friday.

MR. LAZARUS: Is Friday a holiday for State?

MS. FELDMAN: Maybe during the break, right?

MR. LAZARUS: So Monday? Would Monday be okay?

MS. FELDMAN: Monday would be better.

MR. CARNEY: Refers to Exhibit 16 and 17.

MR. LAZARUS: Monday is April 1st.

HEARING OFFICER HANSTED: April 1st? So April 1st.

MR. CARNEY: Thank you. That's all I have.

MR. LAZARUS: I have a couple of questions, and they're actually from the pre-filed testimony. The first one I think, Mr. Whitehead, you had stated, on page 25 I believe of your testimony, you talked about alignment of certain clinical services, such as behavior health, orthopedic, cardiology/oncology, and that there were advantages involved to have the system-wide approach.

Can you please elaborate a little bit about that, those specific services and how your proposals you see those being -- bringing an advantage for those services?

MR. WHITEHEAD: Sure. I think it actually goes back to part of Brian's question about clinical collaborations and using that collaborative model by taking practitioners and providers in each of those clinical service lines and sharing best practice.

As a standalone organization, you're having those conversations amongst yourself. When you're within a system framework, you're having those

conversations across a much broader spectrum, so the lessons learned from that, I think, which Clarence identified at HOCC, you can share that best practice in a much more rapid format, and that shared practice, that shared best practice is going to lead to better outcomes across each of those service lines.

The other issue is, you know, as we look at this from a regional perspective, the advancement of clinical service lines in each of those areas are benefited through a systems approach.

Clearly, we need to go through the planning process around each of those, but how can we, again, improve the delivery of clinical services by looking at the talent and resources within the overall system, not just as a standalone, independent, general acute care hospital, and I think that's what we're trying to get to at that point.

MR. LAZARUS: Do you expect, when you talked about realignment, is it only from best practice and quality perspective, or are you also thinking as far as some of the service shifting, as far as --

MR. WHITEHEAD: No. It's about access.

MR. LAZARUS: It's about access?

MR. WHITEHEAD: It's about access.

MR. LAZARUS: Okay.

MR. WHITEHEAD: To your question, Steve, I think there's been a real commitment on both parties part, and the Board has had great discussions around this about maintaining and improving access to care close to home and keeping what can be kept in the home community of the Eastern Connecticut region and really develop better access in appropriate care settings within that regional framework, so it's not about shifting volumes to another location.

MR. LAZARUS: Okay, thank you. Mr. Elliot, on page 736 of your testimony, I think you mentioned that Hartford Health Care is performing a system-wide community needs health assessment.

Where do you stand in that process at the moment?

MR. JOSEPH: Well, right now, we've completed the surveys of each of our hospitals, and there's a steering committee system-wide that has been evaluating the results of those surveys, and they've identified an individual area for the system to apply itself to focusing on dealing with particular situations in every community we're serving, so there will be a system-wide approach to addressing that one particular

health status issue, and then each of the individual hospitals are also developing their own community benefit and health improvement plan for their individual communities beyond the singular focus that we're going to deal with across the entire organization.

I'm pleased to say, actually, we have our system-wide Board meeting on Thursday, and, in fact, this whole issue of community benefit and health status will occupy probably at least an hour of discussion sharing the results of these surveys with the parent Board, so we're very excited about it and very committed to it.

MR. LAZARUS: And do the hospitals, the field lead hospitals, do they have an input, as far as --

MR. JOSEPH: Yes. The survey results are developed. The whole survey is instituted by the individual hospitals. The survey tool is standardized, and the local Boards and local medical staff leadership and management teams receive the results directly, and that allows them to develop their local community response to those health needs, in addition to the overall system-wide effort, because we know that we can't boil the ocean here.

We can't solve multiple health status issues that plague the poor communities that hospitals

like ours serve here in Connecticut or around the country, so we have to have a focus, so that we can devote our resources to really making a difference.

MS. FELDMAN: Just to add to that, when you do a system-wide assessment, you're going to see, in addition to the individual hospital assessments, you're going to see certain common themes throughout all the hospitals.

MR. JOSEPH: That's what I meant by we're devoting ourselves to a single issue, but our Board has not approved that. In fact, they're going to be working on that Thursday.

MR. LAZARUS: Mr. Whitehead, you had mentioned in your testimony, talking about the plan, the Eastern Region Plan. Is that -- that, I'm assuming, is separate than what the other plan, the Community Health Needs Assessment Plan.

MR. WHITEHEAD: Well, I think, upon your approval, when we come together to develop that strategic plan, I think the Community Health Needs Assessment, which we had provided you, become informative. It's part of the knowledge base that you have to use to then look at how are you going to create a region-wide system to deliver fully-integrated care.

Our Board, in its most recent Board meeting, approved the implementation plan for Backus, and it goes right back to some of the issues we talked about, access to care, preventative health and behavioral health.

So I would assume that, if we were to look at other Hartford Health Care partners in the eastern region, it's going to be access to care, preventative care and behavioral health.

So as we begin to build that plan, we'll use that as a good starting point and a baseline to really look at the delivery of services and how we can actually advance those delivery services and get back to access again, and, again, we'll be right back to access.

COURT REPORTER: One moment, please.

MR. LAZARUS: Mr. Elliot, when do you expect the Community Needs Health Assessment Plan to be finished timeline-wise?

MR. JOSEPH: Clarence, do you know offhand?

MR. SILVIA: The community assessment for each of our respective communities is complete, and what we are doing now is a couple of things.

One is, we have brought our Community

Health Improvement Plan to our Boards for approval, and what we're in the process of doing right now is doing the system Hartford Health Care Community Plan.

What we are doing is identifying a single issue, in terms of community needs, that we're then going to implement across all of Hartford Health Care.

All of the member hospitals, as well as all of the affiliate members of Hartford Health Care, are on the committee that's doing that.

We expect that what we would have in place by the end of this fiscal year, meaning by September 30th, is a defined plan and an implementation of exactly what we're going to be doing, in terms of furthering the issue that we have identified.

MR. LAZARUS: Thank you.

HEARING OFFICER HANSTED: The Community Health Assessments you referred to for each of the hospitals, are those currently in a format, whereby they could be submitted to OHCA?

MR. SILVIA: Yes, they are.

MS. FELDMAN: We included, by way of example, we included Backus's most recent Community Needs Assessment in the pre-filed testimony.

HEARING OFFICER HANSTED: Right, right. I

have that, but for Hartford Health Care, for the other individual hospitals within Hartford Health Care.

MS. FELDMAN: Definitely, we can provide you with each of the hospitals' assessments, and, by doing a system-wide assessment, it's not the intention to discontinue the hospital specific assessments. They're in tandem.

HEARING OFFICER HANSTED: Right. Understood. Understood.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: I'd just like to see the individual hospitals.

MS. FELDMAN: Sure.

HEARING OFFICER HANSTED: I understand there will be an overall. Okay, if you could submit those? How long do you need for that?

MS. FELDMAN: Say April 1st.

HEARING OFFICER HANSTED: April 1st?

MS. FELDMAN: Yes.

HEARING OFFICER HANSTED: That's fine. Thank you.

MR. LAZARUS: We'll call that Late File Exhibit 2. I'm all set. Thank you.

HEARING OFFICER HANSTED: I don't have any

further questions, Attorney Feldman, so, at this point, I just want to find out do we have any public officials or legislators in the room that would like to make a comment?

Okay, let the record reflect there are none. At this point, we'll move to the public comment portion, and I see we have a couple of folks signed up.

(Whereupon, the public comment portion of the hearing commenced.)

AFFILIATION OF BACKUS CORP. WITH HARTFORD HEALTH CARE
MARCH 26, 2013

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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 1st day of April, 2013.

Paul Landman
President

Post Reporting Service
1-800-262-4102

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 29, 2013

Via Facsimile

Ms. Karen Goyette
Vice President, Strategic Planning and Business Development
Hartford Healthcare Corporation
One State Street
Suite 19
Hartford, CT 06103

RE: Certificate of Need Application, Docket Number 12-31788-CON
Hartford Health Care Corporation, Inc. and Backus Corporation, Inc.
Affiliation of Backus Corporation with Hartford HealthCare Corporation

Dear Ms. Goyette:

On April 1, 2013, the Office of Health Care Access ("OHCA") received the information requested by OHCA as a late file submission from the public hearing held in this matter on March 26, 2013. With the receipt of the late file submission, and upon consideration of all motions filed, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please contact Brian Carney or Steve Lazarus at (860) 418-7001.

Sincerely,

Kevin T. Hansted
Hearing Officer

Copy: Keith Fontaine, Backus Corporation
Joan W. Feldman, Esq., Shipman & Goodwin LLP

****
*** TX REPORT ***
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TO: KAREN GOYETTE, HARTFORD HEALTH CARE CORP.

FAX: (860) 263-4125

AGENCY:

FROM: BRIAN A. CARNEY - OHCA

DATE: 4/29/13 TIME:

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12-31788-CON

Comments: PLEASE SEE ATTACHED NOTICE CLOSING THE HEARING.

CC: KEITH FONTAINE, JOAN FELDMAN, ESQ

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FAX SHEET

TO: KEITH FONTAINE, BACKUS CORP.

FAX: (860) 892-6964

AGENCY:

FROM: BRIAN A. CARNEY - OHCA

DATE: 4/29/13 TIME:

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12-31788-CON

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FAX SHEET

TO: JOAN FELDMAN, ESQ, SHIPMAN & GOODWIN

FAX: (860) 251-5211

AGENCY:

FROM: BRIAN A. CARNEY

DATE: 4/29/13 TIME:

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12-31788-CON

Comments: PLEASE SEE ATTACHED NOTICE CLOSING HEARING.

CC: KAREN GOYETTE, KEITH FONTAINE

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 19, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by: Backus Corporation, Inc. and Hartford HealthCare Corporation, Inc	Notice of Agreed Settlement Office of Health Care Access Docket Number: 12-31788-CON

To:

Joan W. Feldman, Esq
Shipman & Goodman, LLP
One Constitution Plaza
Hartford, CT 06103-1919

Dear Attorney Feldman:

This letter will serve as notice of the approved Certificate of Need Application in the above-referenced matter. On July 19, 2013, the Agreed Settlement, attached hereto, was adopted and issued as an Order by the Department of Health, Office of Health Care Access.

Kimberly R. Martone
Director of Operations

Copy: Keith Fontaine, Backus Corporation
Karen Goyette, Hartford Health Care Corporation

Enclosures
KRM:swl

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants: **Hartford HealthCare Corporation**
One State Street, Suite 19, Hartford, CT 06103

Backus Corporation
326 Washington Street, Norwich, CT 06360

Docket Number: **12-31788-CON**

Project Title: **Affiliation of Backus Corporation with Hartford HealthCare Corporation**

Project Description: Backus Corporation proposes having Hartford HealthCare Corporation ("HHC") ("Backus Corporation" and "HHC" are herein collectively referred to as the "Applicants") become its sole corporate member for the purpose of establishing a corporate affiliation, with no associated capital expenditure.

Procedural History: The Applicants published notice of their intent to file a CON application in The Bulletin (Norwich) on July 6, 7 and 8, 2012. On September 24, 2012, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicants for the above-referenced project. On March 4, 2013, OHCA deemed the application complete.

On March 5, 2013, the Applicants were notified of the date, time, and place of the public hearing. On March 7, 2013, a notice to the public announcing the hearing was published in the Norwich Bulletin. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on March 26, 2013.

Commissioner Jewel Mullen designated Attorney Kevin Hansted as the hearing officer in this matter. The hearing was conducted as a contested case in accordance with the provisions of the

Uniform Administrative Procedure Act (Chapter 54 of the General Statutes) and Conn. Gen. Stat. § 19a-639a. The public hearing record was closed on April 29, 2013.

Findings of Fact

1. Hartford HealthCare Corporation ("HHC") is the parent organization of Hartford Hospital, Windham Community Memorial Hospital, MidState Medical Center and the Hospital of Central Connecticut and is located at One State Street, Suite 19, Hartford, Connecticut. Ex. A, p. 6 & 73.

2. Backus Corporation is the parent organization of The William W. Backus Hospital ("Backus Hospital") and is located at 326 Washington Street, Norwich, Connecticut. Ex. A, p. 6 & 73.

3. Under this Proposal, HHC will become the sole corporate member of Backus Corporation for the purpose of effectuating a corporate affiliation (the "Proposal"). Ex. A, p. 7.

4. HHC will have rights with respect to Backus Corporation's governance, financial matters and strategic planning. Ex. A, p. 7.

5. Backus Hospital receives 75% of its patients from the following areas identified by zip code: 06360, 06351, 06382, 06374, 06415, 06365, 06331, 06380, 06370, 06330, 06354, 06339 and 06384. These zip codes include Norwich and the surrounding towns in New London County, as well as the towns of Plainfield and Canterbury. This proposal will not impact these populations. Rather, this Proposal strengthens the ability of Backus Hospital to serve these populations long into the future. Ex. A, p.15

6. In order to successfully respond to the market demands associated with a fully reformed health care delivery system, and in particular, to thrive in a value-based purchasing environment, Backus Hospital determined it needed to affiliate with a strong integrated healthcare delivery system to secure:

    a. Greater debt capacity and access to capital on more favorable terms;
    b. Opportunities for capital avoidance;
    c. Economies of scale to reduce costs;
    d. Standardization and process redesign;
    e. Improved care coordination along clinical service lines;
    f. Sufficient scale to attract highly qualified clinical talent;
    g. Innovative care delivery models;
    h. Rational service distribution systems ensuring patient access across the continuum, including pre-acute, acute and post-acute settings; and

i. Information systems that support clinical decision making, information management, and quality improvement.

Ex. A, p. 8 & 9.

7. According to Backus Corporation, the driving forces behind the proposed affiliation with HHC are access to innovative care models and technology, strategic planning synergies and the desire to address the clinical needs of the community, rather than Backus' "[n]eed to improve its immediate financial performance or provide for current capital needs," as "Backus has demonstrated sustained financial success, with annual operating margins at 9 percent or more for the past two fiscal years…"

Prefile testimony of David Whitehead, President and Chief Executive Officer of Backus Corporation, pp. 720-727.

8. The Applicants testified that the technological infrastructure and strategic resources required to ensure that the community will continue to have broader access to health care in a significantly changing industry landscape "are beyond the ability of even a successful standalone organization," and that "[t]here are elements of a more coordinated care delivery model, such as HHC's recent formation of an accountable care organization, that are beyond the present abilities of Backus."

Testimony of David Whitehead, President and Chief Executive Officer of Backus Corporation, Hearing Transcript, pp. 9-10.

9. Backus Corporation selected HHC's integrated health care delivery system as the partner of choice for the affiliation due to the following factors:
   a. Backus Corporation and HHC share a common mission, vision and values;
   b. Backus Corporation and HHC share common short and long-term strategic objectives that strive to provide strong local, primary, secondary and tertiary care services and enhance patient access with the most advanced technologies and service lines;
   c. Backus Corporation and HHC are committed to providing high-value health care services in the Eastern Connecticut Region through the development of a collaborative strategic plan; and
   d. HHC has a demonstrated track record for successfully integrating with and adding value to its affiliated system hospitals (e.g., Windham Community Memorial Hospital, Hospital of Central Connecticut and MidState Medical Center).

   Ex. A, p. 7.

10. The Applicants testified that the two organizations' mission, vision and values are similarly aligned, and share a common goal: improving patient access, including the underserved population, to a full continuum of health care services.

Testimony of David Whitehead, President and Chief Executive Officer of Backus Corporation, Hearing Transcript, p. 8.

11. The Applicants also testified that "the guiding principle of this affiliation is a creation of a comprehensive strategic plan for this entire region. This strategic plan would be developed upon approval of our CON jointly with Backus, Hartford Health Care, and other regional system members, and the accountability for its implementation will rest with regional leadership."
Testimony of David Whitehead, President and Chief Executive Officer of Backus Corporation, Hearing Transcript, pp. 11-12.

12. According to the Applicants, "the strategic plan will specifically address the areas of greatest community needs in New London and Windham counties." These needs, identified in a recent Community Health Needs Assessment (CHNA) to evaluate the health needs of New London and Windham Counties, include access to care, preventative health, chronic conditions, respiratory health, mental health infectious disease and substance abuse. Moreover, as detailed in the affiliation agreement, the elements to be addressed in the plan include "the creation of primary care ambulatory care networks, an ambulatory surgery network, a preventative medicine institute, and better alignment of key clinical service lines using Backus Hospital and HCC expertise including oncology, cardiology, trauma, behavioral health and chronic disease management."
Ex. J, p. 784 & 788.Testimony of David Whitehead, President and Chief Executive Officer of Backus Corporation, Hearing Transcript, p. 12.

13. According to the Applicants, the current health care delivery system is characterized by three fundamental problems: enormous variation in clinical outcomes, a high degree of fragmentation, and unaffordability. The Affordable Care Act provides a pathway for their organizations to "[c]ome together and address these three fundamental problems in the health care delivery system."
Testimony of Elliot Joseph, President and Chief Executive Officer, Hartford Healthcare Corporation, Hearing Transcript, pp. 13-14.

14. The affiliations of HHC with Windham Hospital and the Hospital of Central Connecticut ("HOCC") are recent examples of the favorable cost savings and improvements that have been achieved through affiliation with HHC. Ex. A, p. 21.

15. As a result of Windham Hospital's affiliation with HHC, Windham Hospital has been able to realize savings of nearly $3.6 million annually. The savings were quantified as follows:

Table 1: Annual Savings Generated from the Affiliation of Windham Hospital with HHC

Area	Benefit	Assumption/Quantification
Streamlined System Coding and Document Review	$1,300,000	This assumption is quantified using comparable experience with other System hospitals.
Centralization of Revenue Cycle Staff	$1,100,000	This assumption is quantified using comparable experience with other System hospitals.
Refinancing - Reduced Existing Interest Costs	$600,000	This assumption is quantified based upon actual interest rates relating to 2011 System debt refinancing.
Group Purchasing - Blood Products, Lab Reference Testing, Implants, Pacemakers, Waste Management	$300,000	This assumption is quantified based upon a comparison between new purchasing vendor and prior purchasing vendor.
Malpractice Captive and Other Insurance Savings	$250,000	This assumption is quantified based upon actual premium amounts.
FY 2012 Total Savings	**$3,550,000**	

Ex. C, p. 697.

16. HHC offered the following examples of how Windham Hospital has benefitted from its affiliation with the System:

a. Savings relating to risk management and professional liability coverage;
b. More effective investment management expertise at lower cost;
c. Savings relating to third-party consultant services;
d. Development of a primary care network and integration of certain of its primary care physicians with Hartford Medical Group;
e. Savings relating to human resource and employee benefit management;
f. Capital avoidance;
g. More favorable debt financing as a member of a System-wide obligated group facilitating the investment in an MRI, a Picture Archiving Communications System (PACS), a medical office building and ambulatory clinic;
h. Senior management services (e.g., CEO and CFO);
i. Marketing, legal and governmental relations services;
j. Centralization of business functions - integrating the billing and collection functions (i.e., $1,400,000 in annual savings);
k. Savings resulting from a more effective GPO;
l. Physician recruitment success from System Graduate Medical Education (GME) training programs;

m. Clinical integration in oncology, gynecology and obstetrics (e.g., protocols for breast cancer patients improving patient experience and clinical outcomes);
n. Tumor registry services;
o. Access to interventional radiology services;
p. Information technology, hardware, software and management expertise (e.g., EMR and CPOE);
q. Biomedical engineering services (i.e., annual savings of approximately $40,000);
r. Savings relating to more cost-effective reference laboratories (i.e., $50,000 in annual savings);
s. Participation in Clinical Councils (e.g., readmission reduction, patient experience, and reduction in hospital acquired infections); and
t. Enhanced access to specialty clinical care.

Ex. A, p.11-12.

17. As a result of HOCC's affiliation with HHC in FY 2012, HOCC has been able to realize savings of more than $8.8 million. The savings are quantified as follows:

Table 2: FY 2012 Savings from the Affiliation

Area	Benefit
Reduced Consulting	$638,500
Vendor Savings	$2,610,720
Fringe Benefit Consolidation	$1,357,601
Medical Supplies	$1,048,833
Revenue Enhancements	$1,084161
Salaries and Wages	$919,274
Utilities	$1,145,037
Total Savings	$8,804,126

Ex. C, p. 697.

18. HHC offered the following as examples of the benefits that HOCC has derived since the affiliation:
    a. Group purchasing savings in the first 6 months (i.e., $2,000,000);
    b. Reduction in HOCC's information technology costs as a result of it becoming the System's main data hub;
    c. Annual savings from using the System's reference laboratory (i.e., $400,000);
    d. Annual savings from preferred system pricing for pharmacy (i.e., $250,000);
    e. Shared Chief Financial Officer with MidState Medical Center;
    f. Cost-effective investment management; and
    g. Savings resulting from a Central Business Office.

Ex. A, p. 14.

19. The Applicants maintain that the Proposal is intended to integrate Backus Corporation with HHC's integrated health care delivery system on both clinical and operational/administrative levels in order to maximize efficiencies and deliver high quality services in a pay for performance environment. Ex. A. p. 21.

20. The following benefits have been identified as being immediately available to Backus Corporation and the Eastern Connecticut Region upon approval of this Proposal:

    a) Expansion and enhancement of clinical programs and services available in the Eastern Connecticut Region, providing access to care delivery models that will allow Backus Corporation to align its physicians with HHC for the purpose of collaboratively improving quality, gaining efficiencies and sharing risk (e.g. clinical integration, accountable care organizations, medical foundation practice model, and patient-centered medical homes);
    b) Access to clinical care protocols and other care management tools that will further improve quality, ensure best practices and reduce health care delivery costs;
    c) Access to software and information technologies that allow monitoring and real time measurement from both a quality and cost perspective;
    d) Access to clinical and management expertise to more accurately assess utilization and cost by provider and service line;
    e) Coordination with System providers to enhance patient flow processes;
    f) Access to capital on more favorable terms as a member of a System-wide obligated group;
    g) Avoidance of service redundancies in the Eastern Connecticut Region through coordinated strategic planning;
    h) Capacity to direct care to the lowest cost setting without compromising quality or access for the patient;
    i) Ability to participate in supply chain management and supply choice standardization; and
    j) Access to translational research.

    Ex. A, p. 9 & 10.

21. HHC has standardized some of its operations with respect to its partnerships. Specifically, HHC has:
    - been approved for participation in a Medicare Shared Savings Program (an ACO);
    - formed Integrated Care Partners, comprised of medical staff working together to identify standards of care and reduce costs;
    - established a medical foundation that includes a primary care component with over 100 doctors; and
    - recruited quality experts at the system level to innovate around quality and program initiatives.

    Testimony of Elliot Joseph, President and Chief Executive Officer, Hartford Healthcare Corporation, Hearing Transcript, pp. 19-20.

22. As an example of the success of standardizing operations, all four of HHC's member hospitals have improved their all-cause mortality index, because they have "[i]nstalled the systems, and the processes, and the structures to improve quality across a large complicated organization."
    Testimony of Elliot Joseph, President and Chief Executive Officer, Hartford Healthcare Corporation, Hearing Transcript, pp. 20-21.

23. HHC's vision is to develop an integrated system whereby there is one registration system, one electronic health record, one bill for all services received, one standard of excellence for reducing variation and one relationship.
    Testimony of Elliot Joseph, President and Chief Executive Officer, Hartford Healthcare Corporation, Hearing Transcript, pp. 17-18.

24. The following are more specific benefits that Backus Corporation and the Eastern Connecticut Region will realize if the Proposal is approved:

    a. System-level commitment of two hundred million dollars ($200,000,000) over a ten (10) year-period to implement clinical programs and services in accordance with the strategic plan for the Eastern Connecticut Region;
    b. Funding for physician recruitment up to three million dollars ($3,000,000) over a (3) three-year period;
    c. Establishment of an extensive primary care and ambulatory care network based on patient-centered medical homes as certified by the National Committee on Quality Assurance;
    d. Development of an ambulatory surgery network within the Eastern Connecticut Region;
    e. Creation of a Preventative Medicine Institute at Backus Hospital;

f. Increased access to patient data, informatics and reporting systems for cost and quality management;
g. Development of a peripheral vascular program at Backus Hospital and for the Eastern Connecticut Region;
h. Enhancement of cardiology services with local specialists, to include primary and elective angioplasty, integrated congestive heart failure programs and on-site electrophysiology;
i. Participation in Clinical Collaboratives relating to becoming a "High Reliability Organization," readmission reduction, patient experience, reduction of hospital-acquired infections and fall reduction;
j. Organization and development of a cancer services network with local specialists for the Eastern Connecticut Region;
k. Development of a behavioral health network for the Eastern CT Region;
l. Maintenance of a Trauma Program (Level 3 at a minimum) along with a commitment to maintain LIFE STAR on the Backus Hospital campus;
m. Enhancement of current neonatology coverage;
n. Expanded access to post-acute care (e.g., home care, skilled nursing and outpatient rehabilitation);
o. Participation in System Clinical Councils (Hospitalist Medicine, Emergency Medicine, Pharmacy/Therapeutics, Infectious Disease/Epidemiology, Anesthesiology, Oncology, and Cardiovascular Diseases) for the implementation of evidence-based medicine and prevention (e.g., Antibiotic Stewardship Program);
p. Cost reduction programs through standardization of physician preference items;
q. Access to the System Center of Education, Simulation and Innovation;
r. Access to regional physician coverage arrangements;
s. Opportunities for sharing of new technologies;
t. Participation in extensive quality and patient safety infrastructure focused on process redesign, data warehousing, internal and external benchmarking and best practices;
u. Participation in risk-based reimbursement initiatives and the formation of new, System-sponsored risk-based organizations and programs;
v. Participation in the System captive insurance program at both the Backus Hospital and physician level;
w. Shared clinical information systems (i.e., a system-wide health information exchange, centralized scheduling, and consistent patient financial assistance counseling);
x. Guarantee by HHC of Backus Corporation's pension obligations; and

y. System-level board designated fund to finance and support community benefit activities in the Eastern Connecticut Region.

Ex. A, p. 10 & 11.

25. Clinical Collaboratives is a multi-disciplinary group of physicians, nurses and support staff from across the organization that come together to define quality standards that they are going to hold themselves accountable for, report on performance and share best practices.

Testimony of Jim Cardon, Chief Clinical Integration Officer, Harford Healthcare Corporation, Hearing Transcript, pp. 23-24.

26. There is currently a program in place with a consultant, HBI Health, to engage all system hospitals in becoming high reliable organizations. HOCC has been doing that work for almost two years and the rest of the system hospitals are coming on board this year.

Testimony of Jim Cardon, Chief Clinical Integration Officer, Harford Healthcare Corporation, Hearing Transcript, pp. 23-24.

27. At HOCC, nearly 70 percent of the hospital staff has been trained and a number of initiatives have been put in place relating to reassessing and intervening, infection prevention and readmission reduction. For example, HOCC's initiative on congestive heart failure readmissions has reduced the readmission rate from 22 percent to four percent.

Testimony of Clarence Silvia, President, Hospital of Central Connecticut, Hearing Transcript pp. 26-29.

28. The Proposal is intended to improve access to primary, specialty and tertiary care services in the Eastern Connecticut Region. By having Backus Corporation as the administrative and managerial nucleus for the Eastern Connecticut Region, it is projected that the System[1] will be able to deliver more cost-effective care and gain efficiencies beyond those already achieved. Ex. A. p. 21.

Table 3: The Proposal's Operational Cost Saving and Avoidance Projections

Area	FY 2013	FY 2014	FY 2015	FY 2016	Anticipated
Non-Labor: Savings due to asset management and insurance, pharmacy, laboratory and clinical supplies.	$2,364,000	$2,957,000	$2,957,000	$2,957,000	
Revenue Cycle: Savings due to vendor cost reductions, consolidated staffing and new processes.	$1,480,000	$2,665,000	$2,665,000	$2,665,000	
Clinical Operations: Savings due to Transfer Center, Care Coordination, Bed Management, and other Best Practices.	$675,000	$1,037,500	$1,037,500	$1,037,500	
Human Resources: Savings from employee benefits, absence management, premium pay and purchased services.	$1,000,000	$1,146,500	$1,146,500	$1,146,500	
Labor: Savings from revenue cycle, fiscal services and Central Business Office, supply chain and administrative practices.	$5,530,000	$7,240,000	$7,240,000	$7,240,000	
Capital Avoidance: Avoidance of duplication with respect to the development of urgent care and primary care centers in the Eastern Connecticut Region, one ambulance service versus two, and shared Information Technology Services.					$28,600,000
Estimated Total Savings	$11,049,000	$15,046,000	$15,046,000	$15,046,000	$28,600,000

Ex. A, p. 21.

29. There are no capital expenditures or financing expenses associated with the Proposal. Ex. A, p. 18&19.

[1] The System consists of Windham Community Memorial Hospital, Midstate Medical Center, Hartford Hospital and HOCC.

30. Backus Corporation revenues have exceeded expenses in each of the last four fiscal years (FY 2009-2012) and have steadily risen from $13.6 to $37.7 million. After posting a deficit of 6.9 million in FY 2009, HHC has reported revenues in excess of expenses of $50.0, $220.9 and $129.1 million, respectively.

Table 4: Applicants' Actual Excess/(Deficiency) of Revenue Over Expenses

Description	FY 2009	FY 2010	FY 2011	FY 2012
Backus Corporation	$13,583,423	$19,505,205	$23,579,024	$37,729,384
Hartford HealthCare Corporation	($6,874,000)	$49,987,000	$220,889,000	$129,139,000

Source: Hospital Reporting System Report 385 – Parent Corporation Consolidated Financial Data Analysis for FYs 2009, 2010 & 2011; and FY 2012 Audited Consolidated Financial Statements.

31. Backus Corporation reported unrestricted assets of $216.9 million in FY 2012; HHC reported $584.4 million, respectively.

Table 5: Applicants' Actual Fair Value of Financial Instruments Unrestricted as to Use

Description	FY 2009	FY 2010	FY 2011	FY 2012
Backus Corporation	$168,773,000	$198,544,835	$194,076,547	$216,903,625
Hartford HealthCare Corporation	$608,850,000	$1,388,129,000	$465,785,000	$584,435,000

Source: Audited Consolidated Financial Statements of each Corporation for FYs 2009, 2010 & 2011; and FY 2012 Audited Consolidated Financial Statements.

32. As a result of the proposal's cost savings, Backus Corporation projects revenues in excess of expenses of approximately $11.0 million (M) in FY 2014 and $15.0 M in FYs 2015 and 2016. HHC projects revenues in excess of expenses of $2.8M in FY 2013, $12.1M in FY 2014, $8.7M in FY 2015, and $4.0M in FY 2016. Although FY 2015 and FY 2016 project decreasing net income, incremental non-operating revenue attributable to Backus Corporation will help bolster overall financial performance through FY 2016.

Table 6: Financial Projections Incremental to the Proposal for Backus Corporation

Description	FY 2013	FY 2014	FY 2015	FY 2016
Incremental Op. Revenue	$0	$1,400,000	$2,500,000	$2,500,000
Incremental Op. Expenses	$0	($9,649,000)	($12,546,000)	($12,546,000)
Incremental Gain (Loss)	**$0**	**$11,049,000**	**$15,046,000**	**$15,046,000**
Incremental Non-Op. Revenue	**$0**	**$0**	**$0**	**$0**
Rev. Over/(Under) Expense	**$0**	**$11,049,000**	**$15,046,000**	**$15,046,000**

Assumes that the proposed affiliation will occur in the last quarter of FY 2013.
Fiscal years 2014 through 2016 represent the first three full years of the proposed affiliation.
Backus Corporation, Late File Attachment I

Table 7: Financial Projections Incremental to the Proposal for HHC

Description	FY 2013	FY 2014	FY 2015	FY 2016
Incremental Revenue	$97,043,637	$296,038,740	$296,718,220	$301,261,060
Incremental Expenses	$95,932,000	$289,157,000	$293,613,000	$302,928,000
Incremental Gain (Loss)	**$1,111,637**	**$6,881,740**	**$3,281,220**	**($1,666,940)**
Incremental Non-Op. Revenue	**$1,692,667**	**$5,255,000**	**$5,441,000**	**$5,635,000**
Rev. Over/(Under) Expense	**$2,804,303**	**$12,136,000**	**$8,722,220**	**$3,968,060**

Assumes that the proposed affiliation will occur in the last quarter of FY 2013.
Fiscal years 2014 through 2016 represent the first three full years of the proposed affiliation.
HHC, Late File Attachment I

33. The Applicants' projected revenue increases are based on a combination of volume and reimbursement changes. While market basket adjustments and wage indices are expected to adversely affect Medicare reimbursement, quality initiatives relating to the Medicare Shared Saving Program and the Clinical Integration Program are expected to offset any decrease in government reimbursement. In addition, HHC is investing in data analysis and clinical integration models so that it is positioned to contract for innovative payment models. Ex. C, p. 648.

34. Historically, the vast majority of savings is achieved by the newly affiliated hospital. However, it is assumed that individual system members will benefit from fixed overhead cost reductions, as major expenses (e.g., IT systems) are distributed across more system providers. Ex. C, p. 647

35. Other assumptions made for Backus Corporation and HHC's financial projections are as follows:
    a. Salary increases for the Applicants were based on historical experience as well as relevant markets;
    b. Employee benefit expenses increased overall;
    c. Pension increases were based on actuarial reports for the pension plans;
    d. Medical and general supply increases were based on current group purchasing contracts, as were pharmacy, and energy costs;
    e. Interest expense was based on existing debt, and depreciation expense reflects existing capital plans for the Applicants;
    f. Volume projections were based on the system's hospitals;
    g. The FY 2013 -2016 financial projections assume disproportionate share payments (DSH) and sequestration impact budget cuts for HHC, Backus Corporation and William W. Backus Hospital; and
    h. The incremental increases for HHC in the Late File Attachment I, assume a June 1, 2013, effective date for the proposal.

    Ex. K

36. Backus Corporation's current patient population mix and three year projected population mix with the CON proposal is as follows:

Table 8: Current and Three-Year Projected Population Mix with the CON Proposal

Backus Corporation	2012 Current Payer Mix	2013 Projected Payer Mix	2014 Projected Payer Mix	2015 Projected Payer Mix
Medicare	46.2%	46.7%	47.8%	48.7%
Medicaid (includes other medical assistance)	19.7%	19.7%	20.4%	21.0%
TRICARE and CHAMPUS	1.9%	2.0%	2.0%	2.1%
Total Government	**67.8%**	**68.4%**	**70.2%**	**71.8%**
Commercial Insurers	30.3%	29.5%	27.6%	25.8%
Uninsured	1.0%	1.2%	1.3%	1.4%
Workers Compensation	0.9%	0.9%	0.9%	1.0%
Total Non-Government	**32.2%**	**31.6%**	**29.8%**	**28.2%**
Total Population Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 8 represents inpatient discharges from the Backus Hospital. Ex. C, p. 645.

37. HHC's current population mix and three year projected population mix with the CON proposal is as follows:

Table 9: Current and Three-Year Projected Population Mix with the CON Proposal

Total HHC w/ Backus Corp.	2012 Current Payer Mix	2013 Projected Payer Mix	2014 Projected Payer Mix	2015 Projected Payer Mix
Medicare	43.3%	43.4%	43.5%	43.7%
Medicaid (includes other medical assistance)	22.5%	22.5%	22.6%	22.7%
TRICARE and CHAMPUS	0.5%	0.6%	0.6%	0.6%
Total Government	**66.3%**	**66.5%**	**66.7%**	**67.0%**
Commercial Insurers	32.3%	32.1%	31.9%	31.6%
Uninsured	1.1%	1.1%	1.1%	1.1%
Workers Compensation	0.3%	0.3%	0.3%	0.3%
Total Non-Government	**33.7%**	**33.5%**	**33.3%**	**33.0%**
Total Population Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 9 represents inpatient discharges from HHC hospitals (i.e. Windham Community Memorial Hospital, MidState Medical Center, Hospital of Central Connecticut and Hartford Hospital) plus The William W. Backus Hospital. Ex. C, p. 646.

38. There will be no changes in the billing of services as a result of the Proposal. Ex. A, p. 20.

39. There will be no immediate change to existing reimbursement contracts between the Applicants' affiliate hospitals and payers (e.g. Medicare, Medicaid, commercial, etc.). Ex. A, p. 20.

40. As a result of the proposal, Backus Corporation's Net Revenue is expected to increase by $2.5 million in FYs 2014 through FY 2016, largely as a result of improved write-offs in the revenue cycle. Expenses are expected to decrease $12.5 million during the same time period. These savings are largely due to decreases in salaries and benefits (-$8.8m) and supply and drug costs (-$3.1m). In addition, capital avoidance of $28.6 m is anticipated due to the HHC system commitment to help develop urgent and primary care sites, share information technology and ambulance services.

Table 10: Backus Corporation's Projected Cost Saving and Anticipated Capital Avoidance

Area	FY 2013	FY 2014	FY 2015	FY 2016	Anticipated
Net Revenue Revenue Cycle (improved write-offs)	**$1,400,000**	**$2,500,000**	**$2,500,000**	**$2,500,000**	
Salaries & Benefits	($6,760,000)	($8,796,000)	($8,796,000)	($8,796,000)	
Prof/Contract Services	($445,000)	($628,000)	($628,000)	($628,000)	
Supplies & Drugs	($2,444,000)	($3,122,000)	($3,122,000)	($3,122,000)	
Expenses	**($9,649,000)**	**($12,546,000)**	**($12,546,000)**	**($12,546,000)**	
Margin	**$11,049,000**	**$15,046,000**	**$15,046,000**	**$15,046,000**	
Capital Avoidance					
Development of Urgent & Primary Care Sites					$20,000,000
One Ambulance Service vs. Two					$3,600,000
Shared Information Technology					$5,000,000
Total					**$28,600,000**

Ex. C, p. 699.

41. HHC has borrowed significant capital on very favorable terms for its system hospital members as one obligated group. As a member of HHC's obligated group, Backus Corporation could potentially avail itself to credit on more favorable terms, as the collective financial strength of the entire HHC system is much greater than the financial strength of any of its individual members on their own. Ex. J, p. 725.

42. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

43. This CON application complies with the intent of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

44. The Applicants have established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

45. The Applicants have satisfactorily demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

46. The Applicants have satisfactorily demonstrated that the proposal would improve quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5))

47. The Applicants have shown that there would be no significant change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

48. The Applicants have satisfactorily identified the population to be served by the proposal, and have satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

49. The historical utilization of health care facilities and services in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

50. The Applicants have satisfactorily demonstrated that the proposal would not result in an unnecessary duplication of existing health care facilities or services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790 (2008).*

Backus Corporation, parent company of The William Backus Hospital is proposing to have Hartford HealthCare Corporation ("HHC"), parent company of Hartford Hospital, MidState Medical Center, Windham Community Memorial Hospital ("Windham Hospital") and the Hospital of Central Connecticut ("HOCC") become its sole corporate member for the purpose of establishing a corporate affiliation. HHC will have rights with respect to Backus Corporation's governance, financial matters and strategic planning. *FF1-4.*

Backus Hospital receives 75% of its patients from the following areas identified by zip code: 06360, 06351, 06382, 06374, 06415, 06365, 06331, 06380, 06370, 06330, 06354, 06339 and 06384. These zip codes include Norwich and the surrounding towns in New London County, as well as the towns of Plainfield and Canterbury. This proposal will not impact these populations. Rather, this Proposal strengthens the ability of Backus Hospital to serve these populations long into the future. *FF5.*

In order to successfully respond to the market demands associated with a fully reformed health care delivery system and to thrive in a value-based purchasing environment, Backus Corporation needs to affiliate with a strong integrated health care delivery system. *FF6.* Backus Corporation's affiliation with HHC will create financial and organizational synergies, provide access to innovative care models, technology and IT systems and provide a partner to jointly develop a strategic plan for the region. *FF7 & 7.* Although Backus Hospital has had strong annual operating margins, the technological infrastructure and strategic resources necessary to ensure access to health care in the Eastern Connecticut community are beyond the ability of even a successful standalone facility such as Backus Hospital. *FF8 & 30.*

According to the Applicants, the current health care delivery system is characterized by three fundamental problems: enormous variation in clinical outcomes, a high degree of fragmentation and unaffordability. The Affordable Care Act provides a pathway for HHC and Backus Corporation to align resources and combat such problems. *FF13.* The guiding principle of the proposed affiliation will be the creation of a comprehensive strategic plan for the Eastern Connecticut region that will focus on the greatest needs of the community: including access to care, preventative health, chronic conditions, respiratory disease and mental health. Initiatives to

address these identified regional health care needs will include, but are not limited to, the development of primary care, ambulatory surgery and behavioral health networks in the region, a preventative medicine institute at Backus Hospital, expanding access to post-acute care and the enhancement of clinical programs. *FF11, 12, 20 & 24.*

The Proposal is expected to improve access to primary, specialty and tertiary care services in the Eastern Connecticut Region. By having Backus Corporation as the administrative and managerial nucleus for the Eastern Connecticut Region, it is projected that the System will be able to deliver more cost-effective care and gain efficiencies beyond those already achieved. FF28.

HHC's recent affiliations with Windham Hospital and HOCC have produced both cost savings and integration improvements. *FF14-18.* The Windham Hospital affiliation has realized nearly $3.6 million annual savings since its approval in 2009. *FF15.* HOCC's 2012 affiliation with HCC has resulted in savings of more than $8.8 million. *FF17.* In addition, the affiliations have created clinical, as well as operational and administrative efficiencies. *FF16 & 18.* For example, HHC is currently engaging all system hospitals in becoming high reliable organizations. At HOCC, where such a system has been in place for almost two years, the hospital has reduced readmission rates for congestive heart failure from 22 percent to four percent. *FF26 & 27.*

The economies of scale created by joining the HHC System will help Backus Corporation significantly reduce expenses, ensure continued financial success and help avoid future capital expenditures devoted to primary/urgent care sites and Information Technology systems. HHC will also benefit from an infusion of non-operating revenue to bolster future financial performance and system members will gain an additional member to share fixed overhead costs. *FF28 & 32.*

Under this proposal, Backus Corporation will receive a system-level commitment of $200 million over a ten-year period to implement clinical programs and services in accordance with the strategic plan; $3 million over a three-year period for physician recruitment, and additionally, HHC will guarantee Backus Corporation's pension obligations. *FF24.* As a result of the proposal, Backus Corporation's Net Revenue is expected to increase by $2.5 million in FYs 2014 through FY 2016, largely as a result of improved write-offs in the revenue cycle. Expenses are expected to decrease $12.5 million during the same time period. These savings are largely due to decreases in salaries and benefits (-$8.8m) and supply and drug costs (-$3.1m). In addition, capital avoidance of $28.6 m is anticipated due to the HHC system commitment to help develop urgent and primary care sites, share information technology and ambulance services. *FF40.*

Based on the foregoing, OHCA finds that the Applicants have demonstrated that there is a need for the proposed affiliation as the quality, accessibility and cost effectiveness of health care in Eastern Connecticut will be improved.

Since the Applicants have represented that specific service integration and cost savings will occur as a result of the proposed affiliation, OHCA has set forth certain conditions as set forth in the attached Order.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA"), Hartford HealthCare Corporation and Backus Corporation (Hartford HealthCare Corporation and Backus Corporation are herein collectively referred to as the "Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to establish a corporate affiliation as follows:

1. The request of the Applicants to have Hartford HealthCare Corporation become the sole corporate member of Backus Corporation for the purpose of establishing a corporate affiliation is hereby approved.

2. Within 60 days of the closing date, the Applicants shall file with OHCA a full, non-redacted copy of any and all signed, dated and completed final affiliation agreement documents, including attachments. The non-redacted documents will be entered as part of the permanent record in this proceeding.

3. Within 60 days of completion of the Eastern Connecticut Region Strategic Plan, the Applicants shall submit a high-level summary description of said plan to OHCA. If the Eastern Connecticut Region Strategic Plan is not completed by the Applicants by May 31, 2015, Applicants shall provide a written explanation to OHCA. Once such summary description of said plan is submitted to OHCA, such document shall be considered by OHCA as a trade secret and therefore, exempt from disclosure pursuant to the Connecticut General Statutes Section 1-210.

4. On an annual basis, for two years from the date of execution of this Agreed Settlement, the Applicants must report to OHCA how the benefits/cost savings enumerated in Findings 24 & 28 have been achieved and once all the benefits/savings have been accounted for, the Applicants shall provide a final summary enumerating all aforementioned benefits/cost savings.

5. The Applicants agree to submit to OHCA, no later than October 31, 2013, a detailed and comprehensive document showing the plan to integrate the operations of both parent corporations to the hospital and attain the cost savings stated within the CON Application. At a minimum, the submission shall address anticipated cost savings, staffing and quality improvements, and affiliation-related revenue enhancements. Subsequent to the submission of the plan, HHC and Backus Hospital shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the Order, semi-annual periods are October 1 – March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31, 2014, November 30, 2014, May 31, 2015, November 30, 2015, May 31, 2016, and November 30, 2016, HHC and Backus Corporation shall submit the following on a semi-annual basis:

a. HHC agrees to file narrative updates on the progress of the implementation of the plan.

b. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, the William W. Backus Hospital, for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, the William W. Backus Hospital. The format shall be consistent with HRS Reports 350/150, or successor reports.

d. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, the William W. Backus Hospital. The format shall be consistent with HRS Reports 300/100, or successor reports.

6. The Applicants shall obtain CON authorization prior to any merger of the William W. Backus Hospital with any entities controlled by Hartford HealthCare Corporation.

7. OHCA and the Applicants agree that this Agreed Settlement represents a final agreement between OHCA and the Applicants with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes that may have been raised by the Applicants with regard to Docket Number: 12-31788-CON.

8. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 at the Applicants' expense if the Applicants fail to comply with its terms.

9. This Agreed Settlement shall ensure to the benefit of and be binding upon the Office of Health Care Access and the Applicants, and their successors and assigns.

Signed by Elliot Joseph,
(Print name)

President & CEO
(Title)

07/16/13
Date

Duly Authorized for
Hartford HealthCare Corporation

Signed by David Whitehead,
(Print name)

President & CEO
(Title)

07/16/13
Date

Duly Authorized for
Backus Corporation

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on July 19, 2013.

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

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*** TX REPORT ***
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FAX SHEET

TO: KAREN GOYETTE, HARTFORD HEATHCARE

FAX: (860) 263-4125

AGENCY:

FROM: BRIAN A. CARNEY, MBA

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FAX SHEET

TO: KEITH FONTAINE, BACKUS CORP.

FAX: (860) 892-6964

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FROM: BRIAN A. CARNEY, MBA

DATE: 7/19/13 TIME:

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FAX SHEET

TO: JOAN W. FELDMAN, ESQ SHIPMAN & GOODWIN

FAX: (860) 251-5211

AGENCY:

FROM: BRIAN A. CARNEY, MBA

DATE: 7/19/13 TIME:

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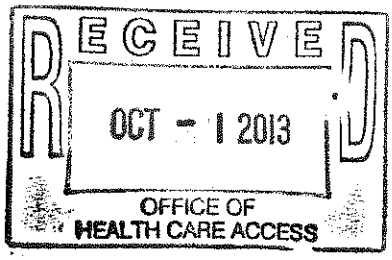
Hartford HealthCare



October 1, 2013

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capital Avenue, MS#13HCA
Hartford, CT 06106

Re: **Hartford HealthCare Corporation and Backus Corporation Affiliation**
DN 12-31788-CON
Final Agreed Settlement – Regulatory Reporting Requirements

Dear Ms. Martone:

Enclosed please find a copy of the full non-redacted, fully executed final affiliation agreement documents including all attachments.

Please feel free to contact me directly if you have any questions regarding the enclosed filing.

Sincerely,

Barbara A. Durdy
Director, Strategic Planning

Enclosures

CONFIDENTIAL

AFFILIATION AGREEMENT

BY AND BETWEEN

HARTFORD HEALTHCARE CORPORATION

AND

BACKUS CORPORATION

August 17, 2012

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AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (the "**Agreement**") is made and entered into as of August 17, 2012 (the "**Execution Date**"), to be effective as of the Effective Time by and between Backus Corporation ("**Backus**") and Hartford HealthCare Corporation ("**Hartford HealthCare**"). Backus and Hartford HealthCare are each referred to herein as a "**Party**" and, collectively, as the "**Parties**" to this Agreement. ARTICLE 21 contains a glossary of all capitalized terms used in this Agreement.

RECITALS

WHEREAS, Hartford HealthCare, a Connecticut nonstock corporation exempt from federal income tax under 501(c)(3) of the Internal Revenue Code (the "**Code**"), is the sole corporate member of Hartford Hospital, MidState Medical Center, Natchaug Hospital, Windham Hospital, The Hospital of Central Connecticut, and other providers of health care services, and is the planning and integrating body for that system of health care entities (the "**Hartford System**"). The members of the Hartford System are collectively referred to herein as the "**Hartford System Members**."

WHEREAS, Backus, a Connecticut nonstock corporation exempt from federal income tax under 501(c)(3) of the Code, is the sole corporate member of The William W. Backus Hospital, a Connecticut nonstock corporation exempt from federal income tax under 501(c)(3) of the Internal Revenue Code ("**Backus Hospital**") and other Affiliates listed on Schedule 1. Each of Backus, Backus Hospital and the Affiliates of Backus is referred to herein as a "**Backus Entity**" and are collectively referred to herein as the "**Backus Entities**."

WHEREAS, Backus and Hartford HealthCare share a mutual commitment to develop an integrated delivery system with: expanded geographic coverage; a full continuum of care; strong local primary, secondary and tertiary care services; the highest standards of clinical care, enhanced patient access, including for underserved populations; and the most advanced technologies and service lines. The Parties recognize that the development of a truly integrated healthcare delivery system will further enhance their ability and the ability of their affiliated physicians and other health care providers to support their missions, identity and respective community roles.

WHEREAS, the Parties desire to expand Hartford HealthCare's integrated health care delivery system to achieve a higher level of quality, performance and efficiency. Central to this goal is the development of an Eastern Connecticut region consisting of Windham and New London counties (the "**Eastern CT Region**") utilizing Backus as its clinical nucleus. The Eastern CT Region will be integrated within the Hartford System and will expand and enhance the clinical programs and services available to those communities within the Eastern CT Region. Consistent with Hartford HealthCare's collaborative, value-driven geared approach, a strategic plan for acute and ambulatory care for the Eastern CT Region (the "**Strategic Plan**") will be developed by Backus, Hartford HealthCare and other Hartford System Members serving the Eastern CT Region in a manner consistent with the overall strategic plan for the Hartford System and will be implemented by Backus as further described herein.

WHEREAS, through collaborative planning to meet the challenging needs of the Eastern CT Region, including responsible decision-making and appropriate sharing of services, resources and technologies, Hartford HealthCare and Backus expect to achieve certain economies of scale that will benefit the communities they serve, including, but not limited to, additional opportunities for clinical research, teaching, implementation of quality initiatives (including sharing of best practices and clinical and process innovations), volume purchasing, consolidation of certain administrative services, opportunities for deployment of expensive technologies throughout the Hartford System, and the spreading of risk under risk-based payor contracts.

WHEREAS, pursuant to a Memorandum of Understanding dated May 25, 2012 (the "**MOU**"), the Parties agreed that the Backus Entities would become part of the Hartford System as of the Closing Date upon the terms and conditions set forth in the MOU.

WHEREAS, as contemplated by the MOU, the Parties wish to set forth the full and complete terms of their agreement with respect to the foregoing matters.

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which are forever acknowledged and confessed, the Parties agree as follows:

ARTICLE 1

CHANGE OF CORPORATE STRUCTURE

1.1 **Change of Membership**. Effective as of 12:00:01 a.m. (the "**Effective Time**") on the day after the Closing Date, as defined in Section 15.1, (the "**Closing**") of the transaction contemplated hereby (the "**Contemplated Transaction**"), Backus shall amend and restate its Governing Documents to provide that Hartford HealthCare shall be its sole corporate member, and to otherwise fulfill the terms and conditions of this Agreement. Backus will continue as the sole corporate member of Backus Hospital. Backus shall cause Backus Hospital and the other Backus Entities to amend and restate their Governing Documents to make them consistent with those of the other Hartford System Members. The amended and restated Governing Documents of Backus, Backus Hospital and the other Backus Entities shall be effective as of the Effective Time and are attached as Exhibit 1.1.

1.2 **Assets and Liabilities**. Except as otherwise set forth in this Agreement, the Contemplated Transaction shall not result in the transfer or conveyance as of the Closing Date of any asset or liability of either Party or any affiliate of either Party.

1.3 **Schematics**. Attached as Exhibit 1.3 are schematics showing the relevant pre-Closing and post-Closing organizational structure of the Parties.

ARTICLE 2

GOVERNANCE

2.1 Boards of Directors.

2.1.1 Composition. As of the Effective Time, the board of directors of each of Backus, Backus Hospital, and Hartford HealthCare (each a "**Board**") shall be structured and consist of directors ("**Directors**") as further described in this Section 2.1.

2.1.2 Post Closing-Date Board Structures.

(a) The pre-Closing Date Backus and Backus Hospital Board membership will be retained for a period of not less than three years after the Closing Date (the "**Transitional Period**"), subject to the provisions of the revised Backus and Backus Hospital Governing Documents adopted as of the Effective Time. During the Transitional Period, Directors of the Backus and Backus Hospital Boards will be nominated and appointed in accordance with such Governing Documents and the bylaws of Hartford HealthCare. The two individuals who are listed on Schedule 2.1.2(a)(i) shall be appointed by Hartford HealthCare as of the Effective Time to each serve on both the Backus and Backus Hospital Boards (the "**Hartford-Appointed Directors**"). The Hartford-Appointed Directors, or their replacements as appointed by Hartford HealthCare, shall serve on the Backus and Backus Hospital Boards throughout the Transitional Period. During the Transitional Period, without limiting Hartford HealthCare's authority, prior to the removal of any Backus or Backus Hospital Director, the Chair of the Hartford HealthCare Board shall consult with the Chair of the Backus Board regarding such proposed removal; provided, however, that during the Transitional Period, Hartford HealthCare shall only exercise its powers to remove a Backus or Backus Hospital Director if such removal is for cause. The names of the initial post-Closing Backus and Backus Hospital Directors are set forth on Schedule 2.1.2(a)(ii).

(b) The two individuals who are listed on Schedule 2.1.2(b)(i) shall be nominated by Backus and approved by Hartford HealthCare as of the Effective Time to serve on the Hartford HealthCare Board (the "**Backus-Appointed Directors**"). The Backus-Appointed Directors, or their replacements as nominated by Backus and approved by Hartford HealthCare, shall serve on the Hartford HealthCare Board throughout the Transitional Period. During the Transitional Period, consistent with Hartford HealthCare's bylaws, Hartford HealthCare will appoint members of the Backus Board to serve on the Hartford HealthCare Board committees listed on Schedule 2.1.2(b)(ii).

2.2 Reserved Powers. As the sole corporate member of Backus, Hartford HealthCare shall have the reserved powers (the "**Reserved Powers**") set forth in the amended and restated Governing Documents of Backus, Backus Hospital and the other Backus Entities, attached hereto as Exhibit 1.1 and as amended from time to time. Notwithstanding the foregoing, Hartford HealthCare agrees that in exercising its Reserved Powers the following provisions contained in this Section 2.2 shall apply.

2.2.1 During the Transitional Period, any decision to reduce or terminate any material clinical service listed on Schedule 2.2.1 that Backus Hospital provided as of the Execution Date shall occur only after prior consultation with, and the consent of, the Backus Hospital Board.

2.2.2 During the Transitional Period, any removal of the Backus Chief Executive Officer (the "**Backus CEO**") shall be made only after consultation with the Backus Board.

2.2.3 Until such time as Backus joins Hartford HealthCare's obligated group, no transfer of cash will be made from any Backus Entity to Hartford HealthCare, except for fair-market-value transfers occurring in the ordinary course of business or as otherwise permitted under applicable bond documents.

2.2.4 During the Transitional Period, Hartford HealthCare will maintain Backus Hospital as a separately-incorporated acute care hospital and will not transfer ownership of Backus or Backus Hospital.

2.2.5 For a period of ten years after the Closing Date, prior to initiating any action, including merger, dissolution, consolidation or sale of Backus or Backus Hospital, or amendments to Backus or Backus Hospital's Governing Documents that would result in: (a) Backus Hospital ceasing to operate its licensed acute care hospital; or (b) change of Backus Hospital's corporate existence or tax-exempt status, Hartford HealthCare shall consult with the Backus Board regarding such proposed action. During the Transitional Period, in the event the actions described in (a) or (b) are contemplated by Hartford HealthCare solely with respect to Backus, Backus shall first have an option to initiate an unwind process (the "**Unwind**") of the Contemplated Transaction by providing written notice to Hartford HealthCare. Upon receiving such notice, the Parties shall meet in good faith to establish a written plan that will describe the processes by which the Unwind shall be accomplished and the time frame in which the Unwind shall be accomplished; provided, however, that, among other items, the Unwind will include a fair and reasonable transaction period (e.g., two years) for continuation at fair market value of information technology and other support services that cannot practicably be transferred sooner.

2.2.6 In exercising its Reserved Powers, Hartford HealthCare, as sole corporate member of Backus, will act in a manner it reasonably believes is in the best interests of the communities served by Backus and Hartford HealthCare.

ARTICLE 3

STRATEGIC PLAN

3.1 **Strategic Plan**. Consistent with the Parties' vision as described in the Recitals, the Parties desire to create an integrated health system that expands and enhances the clinical programs and services available to the communities of the Eastern CT Region. The development

of the Strategic Plan and the subsequent operation of the Eastern CT Region shall be a collaborative process consistent with the Hartford System's integrated geared model.

3.2 Process. The Parties shall develop the Strategic Plan through a collaborative process among Backus' executive management team and Board, Hartford HealthCare's executive management team, and other Hartford System leadership and boards in the Eastern CT Region. The Strategic Plan shall be coordinated with the Hartford System's strategic plan and shall be presented to the Hartford HealthCare Board (which shall include two Directors appointed by Backus as described in Section 2.1.2(b)) for approval. The Strategic Plan shall be developed within 120 days after the Closing Date and shall include: (a) a projected capital budget and an estimated timeline for capital expenditures to be made in furtherance of the Strategic Plan in accordance with the capital commitments set forth in Section 16.1 and the program commitments set forth in Section 4.6; and (b) a comprehensive assessment and formal implementation plan for the Eastern CT Region, which will include, but not be limited to, the development of an ambulatory network.

3.3 Implementation.

3.3.1 Once approved by the Hartford HealthCare Board, responsibility for the effective implementation of the Strategic Plan for the Eastern CT Region will: (a) reside with the Backus CEO, under the direction of Hartford HealthCare with input from Hartford System leadership and boards in the Eastern CT Region; and (b) will be coordinated and integrated with the strategic process and plan for the Hartford System; provided, however, that the implementation and accountability for certain service line elements/components of the Strategic Plan will reside with applicable Hartford System management. The Hartford HealthCare Strategic Planning Committee will review progress under the Strategic Plan at least annually during the term of the capital commitments described in Section 16.1 and the applicable program/service line commitments set forth in Section 4.6.

3.3.2 Within 90 days of the end of each year under the Strategic Plan, Hartford HealthCare will provide a report to the Backus Board on progress in meeting Strategic Plan objectives. In addition, the Annual Community Report issued by Backus and/or Hartford HealthCare shall contain detailed information regarding the current status of the implementation of each component of the Strategic Plan in a format suitable for distribution to the Eastern CT Region communities. It is the intention of the Parties that the Strategic Plan be developed in a collaborative manner, as described above, and implemented in a transparent manner designed to make Hartford HealthCare and Backus fully and continuously accountable to the communities served by the Eastern CT Region for the implementation of the Strategic Plan.

3.3.3 If, during the Transitional Period, the Backus Board determines the Strategic Plan is not being implemented in a manner consistent with the provisions of this Agreement, including the requisite expenditure of capital funds sufficient to implement the Strategic Plan, after first consulting with the President of Hartford HealthCare, the Chairman of the Backus Board may require that such matter be placed

on the agenda of a meeting of the Hartford HealthCare Board within 60 days of such consultation. At such meeting, the Chairman of the Backus Board will be given the opportunity to make a presentation setting forth the concerns of the Backus Board. The Hartford HealthCare Board will carefully consider such presentation and, within 60 days of such meeting, will provide the Backus Board with a plan for addressing such concerns.

3.3.4 To further assure the timely implementation of the Strategic Plan, in the event that during the Transitional Period, Hartford HealthCare does not spend, or is not otherwise legally obligated to spend, at least $25 million on items specifically identified in the Strategic Plan, then an amount equal to the difference between the amount actually spent or otherwise legally committed by Hartford HealthCare on items specifically identified in the Strategic Plan and $25 million, (the "**Shortfall**"), shall be promptly deposited into an account to be used to implement the elements of the approved Strategic Plan. For purposes of determining whether a Shortfall exists, amounts which have been authorized by Hartford HealthCare but not actually expended, due to delays in receiving regulatory approvals, shall be counted towards satisfaction of Hartford HealthCare's commitment under the Strategic Plan (i.e., shall decrease the amount of the Shortfall).

ARTICLE 4

POST-CLOSING OPERATIONS OF BACKUS

4.1 Governance Generally. Following the Closing Date, the management and Board of Backus Hospital will continue to operate and manage Backus Hospital's facilities, programs, and services on a day-to-day basis in accordance with Hartford HealthCare policies and procedures in effect from time to time and subject to the Reserved Powers set forth in Section 2.2.

4.2 Hospital Name. From and after the Closing Date and in accordance with Hartford HealthCare policies and procedures in effect from time to time, the Backus Entities shall add a reference to their affiliation with Hartford HealthCare when using their respective names and to their signage, stationery and marketing materials.

4.3 Donor-Restricted Funds. Following the Closing Date, all bequests, gifts and endowments restricted as to use or manner of investment shall continue to be so restricted, and the Parties shall honor the donors' intent with respect thereto. All grants or funds received at any time by a Backus Entity and restricted by the donor to use by or at such entity, shall be the property of such Backus Entity.

4.4 Medical Staff.

4.4.1 The Closing shall not affect or otherwise change: (a) the medical staff privileges held by members of the medical staff of Backus Hospital on the Closing Date; or (b) the medical staff bylaws, rules and regulations, or credentialing procedures of Backus Hospital in effect on the Closing Date; provided, however, that the

Parties shall work to facilitate a cooperative Hartford system-wide privileging process and, where feasible, pursue opportunities for medical staff/clinical integration where doing so offers opportunities for advancement in quality of care.

4.4.2 Subject to generally-applicable Hartford HealthCare policies and procedures in effect from time to time, physicians on the medical staff of Backus Hospital shall have access to clinical research activities being conducted throughout the Hartford System, use of the Center for Education, Simulation and Innovation, and have access to regional coverage arrangements on the same basis as similarly-situated physicians on the medical staffs of other Hartford System Members. Backus shall have access to the physician recruitment infrastructure and management services organization functions of Hartford HealthCare. Backus Hospital and its physicians will not be required to terminate any existing clinical affiliations as of the Effective Time as a result of the Contemplated Transaction.

4.5 Risk Management/Insurance. Backus and its employed physicians shall participate in Hartford HealthCare's captive insurance program and private physicians affiliated with Backus shall be eligible to participate in the captive insurance program, subject to customary underwriting requirements.

4.6 Post-Closing Programs and Services. As part of completing the corporate member substitution and consistent with Backus becoming a Hartford System Member, and in developing the integrated health care system contemplated by the Parties, the services and programs described in this Section 4.6 shall be maintained and/or considered for implementation, as well as any other items identified in the Strategic Plan and programs and services identified from time to time as part of Hartford System-wide planning activities. Backus nominees will also be included on the Hartford HealthCare Quality Council and applicable focused clinical councils. The following programs, or enhancements to programs, shall be maintained or considered for implementation in the Strategic Plan as part of the Contemplated Transaction:

(a) Maintenance, at current levels and consistent with applicable health and safety requirements, a trauma program verification of at least Level 3 at Backus Hospital.

(b) Maintenance, on a permanent basis, of a LIFE STAR air ambulance at the Backus Hospital campus in Norwich, Connecticut.

(c) Establishment of an extensive primary care and ambulatory care network based on Patient-Centered Medical Homes, as certified by the National Committee for Quality Assurance.

(d) Development of an ambulatory surgery network within the Eastern CT Region.

(e) Creation of a Preventive Medicine Institute at Backus Hospital.

(f) Enhancement of the delivery of cardiac care at Backus Hospital and for the Eastern CT Region, with local specialists to include at least primary and an elective angioplasty, a congestive heart failure program integrated with existing programs in the Hartford System and on-site electrophysiology capability.

(g) Development of a peripheral vascular program at Backus Hospital serving the Eastern CT Region in partnership with local providers.

(h) Organization and development of a cancer services network for the Eastern CT Region with local specialist participation in coordination with statewide programs developed by Hartford HealthCare.

(i) Organization and development of a behavioral health network for the Eastern CT Region in coordination with statewide programs developed by Hartford HealthCare.

(j) Enhancement of current neonatology coverage at Backus Hospital to enable 24/7 coverage.

4.7 **Central Support Services**. The Parties anticipate that Hartford HealthCare will provide certain management, administrative or other services to the Backus Entities. Hartford HealthCare shall allocate a portion of the cost of such services to Backus based upon a reasonable allocation methodology determined by Hartford HealthCare that is consistent with the allocation methodology used for other Hartford System Members.

ARTICLE 5

EMPLOYEES

5.1 **Employment of Chief Executive Officer of Backus**. The Backus CEO will become an employee of Hartford HealthCare or its designee, effective as of the Effective Time. Such employment will be accomplished by the assignment of the Backus CEO's existing employment agreement with Backus to Hartford HealthCare. As part of the integration of Backus and Hartford HealthCare, the Backus CEO will report to the Hartford HealthCare Chief Executive Officer and the Backus and Backus Hospital Boards.

5.2 **Employment of other Backus Employees**. The Parties agree that the employees of the Backus Entities in good standing as of the Closing Date, other than the CEO of Backus described in Section 5.1 (the "**Employees**"), shall continue to be employed as of the Effective Time by the same Backus Entity in the same position and location at the same pay rates and with the same employee benefits and seniority as such Employees have on the Closing Date. No Employee shall be terminated from employment as a result of the Closing; provided, however, that nothing herein is intended to restrict the right of a Backus Entity to terminate, discipline, or change the duties of any Employee, or to engage in staff reductions or consolidations, prior to or after the Closing Date (to the extent such actions are consistent with the then-current applicable policies and procedures, any collective bargaining agreements, any employment agreements, and Applicable Law). All current Employee policies, promises, commitments and Benefit Plans

described in Schedule 17.15.1, including but not limited to policies regarding at-will employment, shall remain in effect after the Closing Date until the same are amended, modified, replaced or terminated and Employees shall retain credit for current employment experience and service with the applicable Backus Entity under the Contemplated Transaction for purposes of seniority recognition, benefits eligibility and accruals and vesting of benefits, in accordance with the provisions of those policies, promises, commitments, and Benefit Plans in effect from time to time and as governed by Applicable Law.

5.3 **Backus Pension Obligations**. Hartford HealthCare will guarantee all pension obligations of existing Backus Employees as of the Closing Date.

ARTICLE 6

COMMUNITY CONSIDERATIONS

6.1 **Community Benefit Activities Fund**. The Parties are committed to addressing the critical health care needs of the communities they serve, facilitating the continuation of community benefit programs and reinvestment in the Eastern CT Region, and ensuring the provision of care at the highest level of quality and patient safety delivered in an efficient manner. To demonstrate Hartford HealthCare's commitment to responding to the health care needs of the Hartford System Members' communities, Hartford HealthCare shall establish a Hartford System-level, Hartford HealthCare Board-designated fund to support community benefit activities in the Eastern CT Region and other communities served by the Hartford System. The fund will assure the continuation of the provision of community benefits through various programs and services provided from time to time by Backus Hospital and Hartford HealthCare and serve as a catalyst for expanded efforts to serve communities throughout the Eastern CT Region.

6.2 **Backus Hospital Charity and Indigent Care Policies**. To further the implementation of the Parties' commitment to responding to the health care needs of the Hartford System Members' communities, Backus Hospital shall maintain charity and indigent care policies that are consistent with Hartford HealthCare's charity and indigent care policies.

6.3 **Local Care Delivery**. To support an integrated delivery system with expanded geographic coverage, a full continuum of care and strong local primary, secondary and tertiary care services, the Parties agree to work cooperatively to encourage the return of patients originating within the Eastern CT Region back to the originating facility and its physicians for local and specialty care following treatment at any other Hartford System Member facility.

ARTICLE 7

INFORMATION TECHNOLOGY

7.1 **Integrated Information System**. As part of an integrated information system that will promote patient access and enhance the quality of services throughout the Hartford System, the Parties shall share information technology ("**IT**") system resources and develop new and expanded capabilities as part of a consistent information system. Hartford HealthCare shall assist

Backus Hospital in developing an integration plan for electronic medical record system ("**EMR**") and shall develop an integration plan for cost accounting or financial planning systems to assist Backus in assessing variability of utilization costs by physician and service line.

7.2 **Assessment of IT Synergies and Opportunities**. To facilitate the development of this integrated information system, the Parties shall undertake a comprehensive assessment to determine the capacity and feasibility of the Backus Business and Technology Center serving as an information system data center for the Hartford System. The Parties have performed an initial joint comprehensive IT assessment to identify synergies and opportunities to integrate the existing Backus EMR technology into Hartford HealthCare IT system. The Parties shall integrate the existing Backus ambulatory clinical IT platforms into the Hartford HealthCare IT system. Notwithstanding the foregoing, following the Closing Date and during the Transitional Period, Hartford HealthCare will consult with Backus prior to affecting any change in Backus' clinical, financial or management IT platform(s).

ARTICLE 8

EXECUTION OF THIS AGREEMENT

8.1 **Execution Date Deliveries**. The execution of this Agreement by the Parties shall be subject to receipt of the items specified in Sections 8.1.1, 8.1.2 and 8.1.3. No Party shall be deemed to have executed this Agreement until it has received or waived all required deliveries.

8.1.1 Hartford HealthCare Board Resolutions. On the Execution Date, Hartford HealthCare shall deliver to Backus a copy of resolutions of the Hartford HealthCare Board, certified by the Secretary of Hartford HealthCare as having been duly adopted and still in effect as of the Execution Date, authorizing and approving the execution of this Agreement, the performance of all actions to be taken on behalf of Hartford HealthCare pursuant to this Agreement, and the completion of all transactions contemplated herein.

8.1.2 Backus Board Resolutions. On the Execution Date, Backus shall deliver to Hartford HealthCare a copy of resolutions of the Backus Board, certified by the Secretary of Backus as having been duly adopted and still in effect as of the Execution Date, authorizing and approving the execution of this Agreement, the performance of all actions to be taken on behalf of the Backus Entities pursuant to this Agreement, and the completion of all transactions contemplated herein.

8.1.3 Exhibits and Schedules. On the Execution Date, each of Backus and Hartford HealthCare shall deliver to the other the Exhibits and Schedules that it is obligated to provide in accordance with Section 13.7 or Section 14.7, as applicable.

ARTICLE 9

TERMINATION

9.1 Termination of Agreement. This Agreement may be terminated prior to the Closing as set forth in this Section 9.1.

9.1.1 Termination by Hartford HealthCare or Backus. Either Hartford HealthCare or Backus may terminate this Agreement upon the occurrence of any of the following:

(a) the Closing shall not have occurred by 4:00 p.m. Eastern time on July 31, 2013 (the "**Termination Date**"); provided, however, that if the Closing shall not have occurred on or before the Termination Date due to a material breach of any representations, warranties, covenants or agreements contained in this Agreement by Hartford HealthCare or Backus, then the breaching Party may not terminate this Agreement pursuant to this Section 9.1.1(a) and the non-breaching Party may not terminate this Agreement until any applicable cure period required pursuant to Section 9.1.3(b) or 9.1.4(b) has ended. Notwithstanding the foregoing, if, despite having pursued with due diligence and timely submitted any and all applications or other filings required to obtain the regulatory approvals described in Sections 13.1 and 14.1, the Parties have not obtained all such regulatory approvals but are otherwise in compliance with their obligations under this Agreement, then either Party shall have the right to delay the Closing by 30 days by delivering to the other Party a written notice of its exercise of this right by not later than five business days prior to the earlier of the Termination Date or the date upon which the Parties have agreed the Closing is otherwise scheduled to occur; or

(b) there shall be in effect a final, non-appealable order of a court or other decision by a governmental body of competent jurisdiction restraining, enjoining, failing to issue a required consent or approval for, or otherwise prohibiting the consummation of the Contemplated Transaction.

9.1.2 Termination by Mutual Written Consent. This Agreement may be terminated at any time by the mutual written consent of Backus and Hartford HealthCare.

9.1.3 Termination by Hartford HealthCare. Hartford HealthCare may terminate this Agreement upon the occurrence of any of the following:

(a) if any of the conditions to the obligations of Hartford HealthCare set forth in ARTICLE 14 shall have become incapable of fulfillment, other than as a result of a breach by Hartford HealthCare of any covenant or agreement contained in this Agreement, and such condition is not waived by Hartford HealthCare; or

(b) if there shall be a material breach by Backus of any representation or warranty, or any covenant or agreement contained in this Agreement, which breach would provide Hartford HealthCare the right not to close the Contemplated Transaction pursuant to Sections 14.2 or 14.3 and which breach cannot be cured or has not been cured by the later of 20

business days after the giving of written notice by Hartford HealthCare to Backus of such breach or the Termination Date;

9.1.4 Termination by Backus. Backus may terminate this Agreement upon the occurrence of any of the following:

(a) if any of the conditions to the obligations of Backus set forth in ARTICLE 13, shall have become incapable of fulfillment, other than as a result of a breach by Backus of any covenant or agreement contained in this Agreement, and such condition is not waived by Backus; or

(b) if there shall be a material breach by Hartford HealthCare of any representation or warranty, or any covenant or agreement contained in this Agreement that would provide Backus the right not to close the Contemplated Transaction pursuant to Sections 13.2 or 13.3 and which breach cannot be cured or has not been cured by the later of 20 business days after the giving of written notice by Backus to Hartford HealthCare of such breach or the Termination Date.

9.1.5 Procedure For Termination. In the event of termination of this Agreement by Hartford HealthCare or Backus, or both, pursuant to Section 9.1, written notice thereof shall forthwith be given to the other Party, and upon the giving of such notice (or at such time as specified in the particular termination right set forth in Section 9.1) the Contemplated Transaction shall be abandoned and this Agreement shall terminate to the extent and with the effect provided by Section 9.1.6, without further action by Hartford HealthCare or Backus.

9.1.6 Effect of Termination.

(a) In the event that this Agreement is validly terminated as provided herein so that the Closing contemplated hereunder does not occur, then: (i) each of the Parties shall be relieved of its duties and obligations arising under this Agreement after the date of such termination; provided, however, that the obligations of the Parties set forth in the Confidentiality Agreement and those obligations specifically identified in this Agreement as surviving termination, shall survive any such termination and shall be enforceable in accordance with their terms; and (ii) each Party shall upon request return as soon as practicable any or all documents, work papers and other material of any other Party relating to its business or affairs or the Contemplated Transaction, whether obtained before or after the execution hereof, to the Party furnishing the same, other than any material that is, or has become, publicly available other than as a result of the breach of this Agreement.

(b) In the event that this Agreement is terminated pursuant to Section 9.1, all further obligations of the Parties under this Agreement shall terminate without further liability of either Party to the other, other than as provided in Section 9.1.1; provided, however, that nothing in this Section 9.1.6 shall relieve Backus or Hartford HealthCare of any liability for an intentional breach of any covenant in this Agreement prior to the date of termination.

ARTICLE 10

PRE-CLOSING COVENANTS OF BACKUS

Backus hereby agrees to keep, perform and fully discharge, or to cause to be kept, performed and fully discharged, as applicable, the following covenants and agreements, as applicable:

10.1 Interim Conduct of Business. From the Execution Date to the Closing Date:

10.1.1 Each Backus Entity shall:

(a) use commercially reasonable efforts to preserve, protect and maintain its business, properties and assets;

(b) operate its businesses as a going concern, consistent with prior practices and not other than in the ordinary course of business;

(c) use commercially reasonable efforts to preserve the goodwill of all individuals having business or other relations with it, including, without limitation, physicians, employees, patients, customers and suppliers; and

(d) obtain all documents called for by this Agreement and required to facilitate the consummation of the Contemplated Transaction.

10.1.2 Backus shall provide Hartford HealthCare with interim financial statements of the Backus Entities, as referenced in Section 17.4.1, as soon as practicable.

10.1.3 Unless the prior approval of Hartford HealthCare has been obtained, none of the Backus Entities shall:

(a) make any material changes, or permit any such changes to be made, in the Governing Documents of the Backus Entities, except for changes expressly authorized by this Agreement; or

(b) except as disclosed on Schedule 10.1.3(b), enter into any transaction which could constitute a Material Adverse Change with respect to the businesses of the Backus Entities, except for transactions expressly authorized by this Agreement.

10.2 Preserve Accuracy of Representations and Warranties. From the Execution Date to the Closing Date:

10.2.1 The Backus Entities shall take no action which would render any representation or warranty contained in ARTICLE 17 inaccurate or untrue as of the Closing Date.

10.2.2 Backus shall promptly notify Hartford HealthCare of any material lawsuits, claims, administrative actions or other proceedings asserted or commenced against any of the Backus Entities or their respective officers, directors or members, or materially affecting the businesses, properties or assets of the Backus Entities, or of the Real Property.

10.2.3 Backus shall promptly notify Hartford HealthCare of any facts or circumstances which come to its attention and which cause, or through the passage of time may cause, any of the representations and warranties made by Backus and contained in ARTICLE 17 to be untrue or misleading at any time from the Execution Date to the Closing Date.

10.3 Access to Information.

10.3.1 From the Execution Date to the Closing Date, each of the Backus Entities shall give to Hartford HealthCare and to its representatives full and free access, during normal business hours, to all properties, books, records and contracts and other materials pertaining to the businesses, properties and assets of the Backus Entities, as may be reasonably requested, and in accordance with guidelines approved by the Parties' antitrust counsel, subject to reasonable advance notice and provided that Hartford HealthCare shall not exercise such rights of access in such manner as would unduly interfere with the operations of the Backus Entities' personnel or the activities of patients or guests.

10.3.2 Backus shall cooperate in keeping Hartford HealthCare fully informed and shall promptly notify Hartford HealthCare of any Material Adverse Change in the normal course of business or prospects of the Backus Entities.

10.4 Maintain Books and Accounting Practices. From the Execution Date to the Closing Date, the Backus Entities shall maintain the books of account of the Backus Entities in the usual, regular and ordinary manner in accordance with generally accepted accounting principles ("**GAAP**") consistently applied and on a basis consistent with prior years, including, without limitation, the consistent use of assumptions, practices, procedures and terminology, and except as otherwise required by GAAP, the Backus Entities shall not make or cause to be made any material changes in the accounting methods or practices of the Backus Entities.

10.5 Compliance with Laws; Consents. From the Execution Date to the Closing Date, Backus shall use commercially reasonable efforts to, and to cause each of the other Backus Entities to:

10.5.1 comply with all Applicable Laws;

10.5.2 keep, hold and maintain all certificates, certificates of need, certificates of exemption, accreditation, licenses and other permits necessary for the conduct and operation of the Backus Entities; and

10.5.3 obtain expeditiously and, as applicable, cooperate fully with Hartford HealthCare in its efforts to obtain, all consents, approvals, exemptions and authorizations of third parties, whether governmental or private, make all filings, and give all notices which may be necessary or appropriate under all Applicable Laws and under all contracts, agreements and commitments to which the Backus Entity is a party or is bound in order to consummate the Contemplated Transaction and to the extent necessary for the valid execution, delivery and performance of this Agreement by Backus.

10.6 No Merger or Consolidation. From the Execution Date to the Closing Date, no Backus Entity shall merge or consolidate with any other entity, except with another Backus Entity, and the Backus Entities shall not acquire (except in the ordinary course) any of the assets of any other corporation, business or person, except as may first be agreed to in writing by Hartford HealthCare.

ARTICLE 11

PRE-CLOSING COVENANTS OF HARTFORD HEALTHCARE

Hartford HealthCare hereby agrees to keep, perform and fully discharge the following covenants and agreements:

11.1 Interim Conduct of Business. From the Execution Date to the Closing Date, Hartford HealthCare shall provide Backus with interim financial statements as soon as practicable.

11.2 Preserve Accuracy of Representations and Warranties. From the Execution Date to the Closing Date:

11.2.1 Hartford HealthCare shall take no action which would render any representation or warranty contained in ARTICLE 18 inaccurate or untrue as of the Closing Date.

11.2.2 Hartford HealthCare shall promptly notify Backus of any lawsuits, claims, administrative actions or other proceedings asserted or commenced against Hartford HealthCare, or its officers, directors or member involving in any material way the ability of Hartford HealthCare to consummate the Contemplated Transaction, or materially affecting Hartford HealthCare's business properties or its assets.

11.2.3 Hartford HealthCare shall promptly notify Backus in writing of any facts or circumstances which come to Hartford HealthCare's attention and which cause, or through the passage of time may cause, any of the representations and warranties contained in ARTICLE 18 to be untrue or misleading at any time from the Execution Date to the Closing Date.

11.3 No Merger or Consolidation; Similar Affiliation Arrangement. From the Execution Date to the Closing Date, Hartford HealthCare shall not merge into or consolidate with any other corporation, in a transaction in which Hartford Healthcare is not the surviving corporation, or sell or transfer substantially all its assets to any other entity. In addition, from the Execution Date until the Closing Date, in the event Hartford HealthCare enters into a similar affiliation arrangement with another community acute care hospital or health system, Hartford HealthCare shall provide a copy to Backus of the agreements relating to such arrangement within fifteen (15) days of Hartford HealthCare entering into a binding agreement with such entity. If Backus determines in good faith that the terms of such arrangement are more favorable to such entity than the terms applicable to Backus hereunder, Backus shall provide written notice to Hartford HealthCare within fifteen (15) days of receipt of the binding agreements. Within forty-five (45) days of Backus's delivery of such notice, Hartford HealthCare and Backus agree to amend the terms of this Agreement, as applicable, to incorporate for the benefit of Backus such more favorable terms.

11.4 Access to Information.

11.4.1 From the Execution Date to the Closing Date, Hartford HealthCare shall give Backus and its representatives full and free access, during normal business hours, to all properties, books, records and contracts and other materials pertaining to the businesses, properties and assets of Hartford HealthCare, as may be reasonably requested, and in accordance with guidelines approved by the Parties' antitrust counsel, subject to reasonable advance notice and provided that Backus shall not exercise such rights of access in such manner as would unduly interfere with the operations of Hartford Healthcare or the work of Hartford HealthCare personnel.

11.4.2 Hartford HealthCare shall cooperate in keeping Backus fully informed and shall promptly notify Backus of any Material Adverse Change in the normal course of business or prospects of Hartford HealthCare.

11.5 Compliance with Laws; Consents. From the Execution Date to the Closing Date, Hartford HealthCare shall:

11.5.1 comply with all Applicable Laws;

11.5.2 keep, hold and maintain all certificates, certificates of need, certificates of exemption, accreditation, licenses and other permits necessary for the conduct and operation of Hartford HealthCare; and

11.5.3 use commercially reasonable efforts to obtain and, as applicable, cooperate fully with Backus in its efforts to obtain, all consents, approvals, exemptions and authorizations of third parties, whether governmental or private, make all filings, and give all notices which may be necessary or appropriate under all Applicable Laws and under all contracts, agreements and commitments to which Hartford HealthCare is a party or is bound in order to consummate the Contemplated Transaction and to the extent necessary for the valid execution, delivery and performance of this Agreement by Backus.

11.6 Third Party Authorizations. From the Execution Date to the Closing Date, Hartford HealthCare shall cooperate fully with Backus in its efforts to obtain all consents, approvals, exemptions and authorizations of third parties, whether governmental or private, and to make all filings, necessary in order to consummate the Contemplated Transaction.

ARTICLE 12

PRE-CLOSING COVENANTS OF THE PARTIES

12.1 Publicity. No Party shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the Contemplated Transaction without the prior consent of the other Party, except for information and filings reasonably necessary to be directed to governmental agencies to effect fully and lawfully the Contemplated Transaction or required by Applicable Law; provided, however, that a Party shall notify the other prior to making any such filing with a governmental agency and provide the other Party with an opportunity to review such filing in accordance with guidance from its antitrust counsel.

12.2 Consummation of Transactions. Each Party shall use its commercially reasonable efforts to: (a) take all actions necessary or appropriate to consummate the Contemplated Transaction; and (b) cause the fulfillment at the earliest practicable date of all of the conditions to their respective obligations to consummate the Contemplated Transaction. Neither Party shall deliberately take any action or deliberately fail to take any action not permitted by this Agreement with the Knowledge and intention that such action or failure to take action would result in: (y) any of the representations and warranties of Backus or Hartford HealthCare, as the case may be, set forth in this Agreement becoming untrue; or (z) any of the conditions to the obligations of Backus or Hartford HealthCare, as the case may be, to close the Contemplated Transaction not being satisfied.

ARTICLE 13

CONDITIONS PRECEDENT TO OBLIGATIONS OF BACKUS

The obligation of Backus to consummate the Contemplated Transaction are subject to the fulfillment, prior to or on the Closing Date, of each of the following conditions contained in this ARTICLE 13 (any or all of which may be waived by Backus in whole or in part to the extent permitted by applicable Law).

13.1 Regulatory Approvals. All regulatory consents and approvals required for the consummation of the Contemplated Transaction shall have been obtained on or before the Closing Date, including, without limitation:

13.1.1 Hart-Scott-Rodino. The Parties shall have submitted their respective filings under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the rules and regulations thereunder (collectively, "**HSR Act**"), and all required waiting periods under the HSR Act shall have expired.

13.1.2 Health Planning. The Parties shall have obtained a certificate of need from the Connecticut Department of Public Health to consummate the Contemplated Transaction.

13.2 Accuracy of Representations and Warranties. The representations and warranties of Hartford HealthCare contained in ARTICLE 18, subject to any qualification as to materiality, shall be true and correct in all material respects at and as of the Closing Date as though made on the Closing Date, except to the extent such representations and warranties relate to an earlier date (in which case such representations and warranties shall be true and correct in all material respects on and as of such earlier date), and Backus shall have received a certificate signed by an authorized officer of Hartford HealthCare, dated the Closing Date, to the foregoing effect.

13.3 Performance of Covenants. Hartford HealthCare shall have performed all of the obligations and complied with each and all of the covenants, agreements and conditions required to be performed or complied with by it on or prior to the Closing Date.

13.4 No Pending Action. No action or proceeding before any court or governmental body shall be pending or threatened wherein an unfavorable judgment, decree or order would prevent the carrying out of this Agreement or the Contemplated Transaction, declare unlawful the Contemplated Transaction or cause such transactions to be rescinded.

13.5 No Bankruptcy. Hartford HealthCare shall not: (a) be in receivership or dissolution; (b) have made any assignment for the benefit of creditors; (c) have admitted in writing its inability to pay its debts as they mature; (d) have been adjudicated bankrupt; or (e) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Hartford HealthCare.

13.6 Consents. All consents, approvals and authorizations of third parties required for the consummation of the Contemplated Transaction or required by this Agreement shall have been obtained on or before the Closing Date.

13.7 Exhibits, Schedules and Statements. On the Execution Date, Hartford HealthCare shall deliver to Backus all Exhibits and Schedules required to be completed and delivered by Hartford HealthCare under this Agreement. Subsequent to the Execution Date, Hartford HealthCare may only revise any such Exhibits or Schedules upon the written consent of Backus.

13.8 Delivery of Hartford HealthCare Closing Documents. Hartford HealthCare shall have delivered, on or before the Closing Date, the Hartford HealthCare Closing Documents.

13.9 Delivery of Other Agreements. Hartford HealthCare shall have executed and delivered all other agreements reasonably determined by the Parties to be necessary or appropriate to be entered into as of the Closing Date, relating to the Contemplated Transaction.

13.10 No Catastrophic Losses or Liabilities. Following the Execution Date, Hartford HealthCare shall not have suffered or incurred any uninsured liabilities outside of the ordinary course of their businesses or uninsured casualty losses exceeding $200,000,000 in the aggregate.

13.11 Due Diligence. Backus shall have completed its due diligence investigation of Hartford HealthCare, and the resulting information from such investigation shall have been acceptable to Backus in its sole discretion; provided, however, that the Parties agree to have each completed their due diligence investigation of the other as of the Execution Date.

ARTICLE 14

CONDITIONS PRECEDENT TO OBLIGATIONS OF HARTFORD HEALTHCARE

The obligations of Hartford HealthCare to consummate the Contemplated Transaction are, at the option of Hartford HealthCare, subject to the satisfaction, on or prior to the Closing Date, of the following conditions:

14.1 Regulatory Approvals. All regulatory consents and approvals required for the consummation of the Contemplated Transaction shall have been obtained on or before the Closing Date, including, without limitation:

14.1.1 Hart-Scott-Rodino. The Parties shall have submitted their respective filings under HSR Act, and all required waiting periods under the HSR Act shall have expired.

14.1.2 Health Planning. The Parties shall have obtained a certificate of need from the Connecticut Department of Public Health to consummate the Contemplated Transaction.

14.2 Accuracy of Representations and Warranties. The representations and warranties of Backus contained in ARTICLE 17), subject to any qualification for materiality, shall be true and correct in all material respects at and as of the Closing, except to the extent such representations and warranties expressly relate to an earlier date (in which case such representations and warranties shall be true and correct in all material respects on and as of such earlier date) and Hartford HealthCare shall have received a certificate signed by an authorized officer of Backus, dated the Closing Date, to the foregoing effect; provided, however, that in the event any such representation or warranty has been breached the condition set forth in this Section 14.2 shall nevertheless be deemed satisfied unless the effect of all such breaches of representations and warranties taken together result in a Material Adverse Effect.

14.3 Performance of Covenants. Backus shall have performed all of the obligations and complied with each and all of the covenants, agreements and conditions required to be performed or complied with by it on or prior to the Closing Date.

14.4 No Pending Action. No action or proceeding before any court or governmental body shall be pending or threatened wherein an unfavorable judgment, decree or order would

prevent the carrying out of this Agreement or the Contemplated Transaction, declare unlawful the Contemplated Transaction or cause such transactions to be rescinded.

14.5 No Bankruptcy. No Backus Entity shall: (a) be in receivership or dissolution; (b) have made any assignment for the benefit of creditors; (c) have admitted in writing its inability to pay its debts as they mature; (d) have been adjudicated bankrupt; or (e) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against any Backus Entity.

14.6 Consents. All consents, approvals and authorizations of third parties, required for the consummation of the Contemplated Transaction shall have been obtained on or before the Closing Date.

14.7 Exhibits, Schedules and Statements. On the Execution Date, Backus shall deliver to Hartford HealthCare all Exhibits and Schedules required to be completed and delivered by Backus under this Agreement. Subsequent to the Execution Date, Backus may only revise any such Exhibits or Schedules upon the written consent of Hartford HealthCare.

14.8 Delivery of Closing Documents. Backus shall have delivered on or before the Closing Date the Backus Closing Documents.

14.9 Delivery of Other Agreements. The Backus shall have executed and delivered all other agreements reasonably determined by the Parties to be necessary or appropriate to be entered into as of the Closing Date, relating to the Contemplated Transaction.

14.10 No Catastrophic Losses or Liabilities. Following the Execution Date, no Backus Entity shall have suffered or incurred any uninsured liabilities outside of the ordinary course of their businesses or uninsured casualty losses exceeding $5,000,000 in the aggregate.

14.11 Due Diligence. Hartford HealthCare shall have completed its due diligence investigation of the Backus Entities, and the resulting information from such investigation shall have been acceptable to Hartford HealthCare in its sole discretion; provided, however, that the Parties agree to have each completed their due diligence investigation of the other as of the Execution Date.

ARTICLE 15

CLOSING

15.1 Closing Date; Closing. The Parties shall mutually agree upon a Closing Date that is as soon as practicable after the satisfaction or waiver by the appropriate Party of all of the conditions precedent to the Closing specified in ARTICLE 13, ARTICLE 14 and ARTICLE 15 (the "Closing Date"). Upon successful completion of the Closing pursuant to this Agreement, the Contemplated Transaction shall be effective as of the Effective Time.

15.2 Pre-Closing Actions. Prior to the Closing, the Parties shall take and cause to be taken all actions necessary or appropriate on their respective parts to implement the Contemplated Transaction on the Closing Date, including the following:

15.2.1 Actions by Hartford HealthCare: Prior to the Closing Date, the Hartford HealthCare Board shall approve the execution on behalf of Hartford HealthCare of any and all agreements and other documents and the taking of any and all other actions contemplated or required by this Agreement to be executed or taken by Hartford HealthCare on or before the Closing Date.

15.2.2 Actions by Backus: Prior to the Closing Date, the Backus Board shall approve the execution on behalf of Backus of any and all agreements and other documents, and the taking of any and all other actions contemplated or required by this Agreement to be executed or taken by Backus and the other Backus Entities on or before the Closing Date, including, without limitation, the following:

(a) approve the amended and restated Governing Documents of the Backus Entities, in substantially the forms attached as Exhibits 1.1, to become effective at the Effective Time; and

(b) take or approve the taking of any and all such other actions as are necessary or appropriate to consummate the Contemplated Transaction.

15.2.3 Actions by Backus Entities. Prior to the Closing Date, the Boards of the Backus Entities (other than Backus), as applicable, shall approve the execution on behalf of the applicable Backus Entity of any and all agreements and other documents, and the taking of any and all other actions contemplated or required by this Agreement to be executed or taken by such Backus Entity on or before the Closing Date, including, without limitation, the following:

(a) approve the amended and restated Governing Documents of the applicable Backus Entity, in substantially the forms attached as Exhibits 1.1, to become effective at the Effective Time; and

(b) take or approve the taking of any and all such other actions as are necessary or appropriate to consummate the Contemplated Transaction.

15.3 Closing Document Deliveries. At the Closing, the Parties shall deliver the documents described below.

15.3.1 Hartford HealthCare. At the Closing, Hartford HealthCare shall deliver the following documents (the "**Hartford HealthCare Closing Documents**"):

(a) a certificate of an authorized officer of Hartford HealthCare, dated as of the Closing Date, certifying as to the continued accuracy and completeness of Hartford HealthCare's representations and warranties, and its performance of the covenants and conditions precedent, set forth in this Agreement;

(b) a certificate of an authorized officer of Hartford HealthCare, dated as of the Closing Date, certifying as to the continued accuracy and completeness of the Exhibits and Schedules delivered by Hartford HealthCare in accordance with Section 13.7;

(c) a certificate of the Secretary of Hartford HealthCare, dated as of the Closing Date, certifying as to the due adoption and continued effectiveness of, and attaching a copy of, the resolutions of the Hartford HealthCare Board approving, with respect to Hartford HealthCare, the actions and transactions required or contemplated by this Agreement; and

(d) such other instruments and documents as may be reasonably necessary to carry out the Contemplated Transaction and to comply with the terms hereof.

15.3.2 Backus. At the Closing, Backus shall deliver the following documents (the "**Backus Closing Documents**"):

(a) a certificate of an authorized officer of Backus, dated as of the Closing Date, certifying as to the continued accuracy and completeness of representations and warranties of the Backus Entities and their respective performance of the covenants and conditions precedent, set forth in this Agreement;

(b) a certificate of an authorized officer of Backus, dated as of the Closing Date, certifying as to the continued accuracy and completeness of the Exhibits and Schedules delivered by Backus in accordance with Section 14.7;

(c) a certificate of the Chief Financial Officer of Backus, dated as of the Closing Date, certifying to the Knowledge of such officer as of the date thereof, as to the accuracy of the financial representations and warranties relating to the Backus Entities set forth at Sections 17.4 and 17.5;

(d) a certificate of the Secretary of Backus, dated as of the Closing Date, certifying as to the due adoption and continued effectiveness of, and attaching a copy of: (i) the resolutions of the Backus Board approving the Contemplated Transaction, including the amended and restated Governing Documents of the Backus Entities; (ii) the resolutions of the other Backus Entities approving amended Governing Documents for those Backus Entities and any transactions contemplated hereunder which are required, pursuant to the Backus Governing Documents in effect as of the Execution Date, to be approved by Backus; and (iii) the amended and restated Governing Documents of the Backus Entities;

(e) a certificate of the Secretary of Backus Hospital, dated as of the Closing Date, certifying as to the due adoption and continued effectiveness of, and attaching a copy of the resolutions of the Backus Hospital Board approving the Contemplated Transaction, including the amended and restated Governing Documents of the Backus Hospital set forth in Exhibit 1.1;

(f) a copy of the amended and restated applicable Governing Documents of the Backus Entities certified as of a recent date by the Secretary of State of the state of formation; and

(g) such other instruments and documents as may be reasonably necessary to carry out the transactions contemplated or required by this Agreement and to comply with the terms hereof.

ARTICLE 16

POST-CLOSING COVENANTS

16.1 Capital Commitments. In consideration for the carrying out of the Contemplated Transaction and consistent with Backus becoming a Hartford System Member, Hartford HealthCare hereby makes the following binding capital commitments, which shall be expended consistent with the Strategic Plan and pursuant to applicable Hartford HealthCare policies and procedures in effect from time to time, including its capital allocation policies and procedures:

16.1.1 Hartford HealthCare commits to spend $200 million in capital expenditures over a period of 10 years commencing on the Closing Date to enhance and support clinical and operational capabilities, services and programs in the Eastern CT Region in a manner consistent with the Strategic Plan; provided, however, that $25–$50 million of such $200 million shall be spent during an initial period specified in the Strategic Plan and shall be used to implement Eastern CT Regional programs and services including, but not limited to, operationalizing a comprehensive ambulatory network; and

16.1.2 Hartford HealthCare commits (in addition to the $200 million described in Section 16.1.1 above) to establish a $3 million Hartford HealthCare Board designated fund to support medical staff development and recruitment efforts for Backus and the Eastern CT Region (the "**Medical Staff Development Fund**"). The Medical Staff Development Fund shall be available as of the Effective Time and, at the end of each of the three succeeding years following the Closing, to the extent that the amount of the Medical Staff Development Fund is less than $3 million, Hartford HealthCare will deposit an amount into the Medical Staff Development Fund to bring the total amount available in the such fund to $3 million.

16.2 Capital Allocation. In addition to the capital commitments described above in Section 16.1, Backus will be treated in the same manner as all other Hartford System Members for purposes of capital allocation approvals, and in accordance with the Hartford HealthCare Corporate Treasury Operating Guidelines, and any other applicable policies and procedures, in effect from time to time. Expenditures required to satisfy state or federal life safety requirements or to maintain the licensure status of Backus Entities will be authorized outside of the normal budgetary process. Backus shall provide Hartford HealthCare as much advance notice as possible with respect to the necessity to make such expenditures.

16.3 Obligated Group. On the earliest date that is economically feasible, as determined by Hartford HealthCare, following the Closing, unless Hartford HealthCare determines that the Hartford System would be better served by selecting a later date, Backus and Backus Hospital shall join Hartford HealthCare's obligated group. Backus shall, and shall cause

Backus Hospital to, take such actions as are necessary to cause Backus and Backus Hospital to join Hartford HealthCare's obligated group.

ARTICLE 17

REPRESENTATIONS AND WARRANTIES OF BACKUS

Backus gives, as of the Execution Date, the following representations and warranties to Hartford HealthCare:

17.1 Due Organization; Legal Existence; Power. Each of the Backus Entities is duly formed and is validly existing under the laws of the respective states of formation, and has the corporate power and authority to own, operate or hold under lease its properties and assets and to carry on its business and operations as presently conducted. Each of the Backus Entities has registered with the proper governmental authorities all assumed names under which each of the Backus Entities operates its businesses, and continuously maintained all such filings in good standing.

17.2 Corporate Authorization.

17.2.1 Backus has the full corporate power and authority to enter into and to perform its obligations under this Agreement.

17.2.2 The execution, delivery and performance of this Agreement by Backus has been duly and properly authorized by all necessary corporate action in accordance with its Governing Documents.

17.2.3 This Agreement constitutes the valid and legally binding obligation of Backus, enforceable against it in accordance with its terms, except as enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium or other laws of general application now or hereafter in effect relating to or affecting the enforcement of creditors' rights generally.

17.3 No Violation; Approvals.

17.3.1 Except to the extent specified in Schedule 17.3.1, the execution, delivery and performance of this Agreement shall not result in the creation of any lien, charge, or encumbrance of any kind or the termination or acceleration of any indebtedness or other obligation of any Backus Entity, and is not prohibited by, does not violate or conflict with any provision of, and does not constitute a default under or breach of any Material Contract to which any Backus Entity is a party or is subject or by which any such corporation is bound, or any Applicable Law.

17.3.2 Except to the extent specified in Schedule 17.3.2, no approval, authorization, registration, consent, order or other action of or filing that has not occurred or been obtained with or from any person, including any court, administrative agency or other governmental authority, is required for the execution and delivery by

Backus of this Agreement or the consummation by Backus of the Contemplated Transaction, except for filings required pursuant to the HSR Act and the Connecticut certificate of need statute and regulations.

17.4 Financial Statements.

17.4.1 Attached as Schedule 17.4.1 are true and correct copies of: (a) audited, where available, financial statements of each of the Backus Entities for the three years ended September 30, 2009, September 30, 2010 and September 30, 2011; (b) audited consolidated financial statements of the Backus Entities for the three years ended September 30, 2009, September 30, 2010 and September 30, 2011; and (c) unaudited financial statements of the Backus Entities for the interim period from October 1, 2011, through the most recent month-end date for which financial statements were available prior to the Execution Date. From the Execution Date to the Closing Date, by the fifteenth day of the following month, Backus shall provide Hartford HealthCare with monthly unaudited financial statements for the immediately preceding month. (The financial statements referred to in this Section 17.4.1 shall collectively be referred to herein as the "**Backus Financial Statements**").

17.4.2 The Backus Financial Statements are complete and present fairly in all material respects the financial position of the Backus Entities, respectively, and the results of the respective operations of the Backus Entities at the dates and for the periods indicated, in conformity with GAAP (except as otherwise disclosed on Schedule 17.4.2), applied consistently for the periods specified, including the consistent use of assumptions, practices, procedures and terminology, except that the interim financial statements need not contain any of the footnotes required to comply with GAAP.

17.4.3 From and after October 1, 2011, (except as set forth in Schedule 17.4.3), the Backus Entities have not made any material changes to their accounting methods or practices, including methods or practices used to:

(a) establish reserves on any patient and notes and accounts receivable;

(b) establish estimates of any third-party settlements; and

(c) determine the value of any other accounts which require subjective determinations.

17.4.4 Except as disclosed on Schedule 17.4.4, to the Knowledge of Backus, the Backus Entities have no liabilities or obligations of any kind, whether contingent or absolute, direct or indirect, or matured or unmatured, which are not shown or provided for in the Backus Financial Statements provided to Hartford HealthCare prior to the Execution Date, other than claims covered by insurance and any individual liability or other obligation of less than $100,000, provided such liabilities and obligations in the aggregate do not exceed $1 million.

17.4.5 Except as disclosed on Schedule 17.4.5, none of the assets of the Backus Entities is subject to restrictions imposed by the donors of specific funds or other assets.

17.4.6 Set forth on Schedule 17.4.6 is an accurate and complete list of all of the accounts in which funds of or attributable to employee pension plans of all Backus Entities are invested or otherwise held. No Backus Entity has taken, or caused or permitted to be taken any action which would change the legal or beneficial ownership status of such funds prior to the Closing Date.

17.5 Interim Changes. Except for matters expressly permitted or authorized by this Agreement and except as set forth on Schedule 17.5, there has not been, after the date of the most recent interim financial statements provided for the Backus Entities on Schedule 17.4.1:

17.5.1 to the Knowledge of Backus, any change in the financial condition, assets, liabilities, properties or results of operation of the Backus Entities which has had or could have, in the aggregate, a materially adverse effect on the Backus Entities;

17.5.2 any damage, destruction or loss, whether or not covered by insurance, which has had or could have, in the aggregate, a Materially Adverse Effect on the Backus Entities;

17.5.3 any disposition by the Backus Entities of any property, rights or other assets owned by or employed in the Backus Entities, except for dispositions in the usual and ordinary course of the business;

17.5.4 any change to the make-up or composition of the Backus Board; and

17.5.5 any amendment or termination of any Material Contract which has had or could have, in the aggregate, a materially adverse effect on the Backus Entities.

17.6 Legal Proceedings. Except as disclosed on Schedule 17.6, none of the Backus Entities is a defendant in, or, to the Knowledge of Backus, threatened with any action, suit, proceeding, complaint, charge, hearing or arbitration which may materially and adversely affect their respective businesses or financial conditions or the ability of any of such corporations to perform hereunder. Except as disclosed on Schedule 17.6, none of the Backus Entities has received notice of any investigation or threatened investigation by any Federal, state or local governmental or regulatory agency, including those involving its business practices and policies, which could have, in the aggregate, a materially adverse effect on the Backus Entities.

17.7 Licenses and Permits.

17.7.1 To the Knowledge of Backus, each of the Backus Entities holds and is in compliance with all material and applicable governmental licenses, permits,

certificates, consents and approvals, noncompliance with which would have a material effect on its business and operations (the "**Licenses and Permits**"). The Licenses and Permits, each of which is listed on Schedule 17.7.1, are current, unrestricted and valid.

17.7.2 To the Knowledge of Backus, no statement of deficiencies, survey report, inspection report, notice of audit, audit results, complaint or other notice of noncompliance with the requirements, standards or other conditions of any revocation, termination, suspension or limitation of any of the Licenses and Permits has been issued, received, proposed or threatened, for which any actual or potential payment or other obligation exists, nor does Backus have any Knowledge of a material basis for any such action.

17.8 No Material Omissions.

17.8.1 Backus has responded in all material respects to all requests for information and documentation made by Hartford HealthCare in connection with its due diligence review of the business, operations, assets and liabilities of the Backus Entities. Backus has not knowingly omitted any material information relating to the businesses, operations, assets or liabilities of the Backus Entities in their respective responses to Hartford HealthCare's requests. Since the delivery of such responses to Hartford HealthCare, none of the Backus Entities has received and not disclosed any information which would render untrue or misleading in any material respect any information previously disclosed to Hartford HealthCare in response to their requests for information.

17.8.2 To the Knowledge of Backus, the representations and warranties of Backus contained in this Agreement, and each Exhibit, Schedule, certificate or other written statement delivered at Closing by Backus and Backus Hospital pursuant to this Agreement, are accurate, correct and complete in all material respects, do not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements and information contained therein not misleading.

17.9 Compliance with Law. Except as otherwise disclosed on Schedule 17.9, to the Knowledge of Backus, each of the Backus Entities is in compliance with all Applicable Laws, including without limitation all Health Care Laws, noncompliance with which would have a material effect on its business and operations.

17.10 Title to Real Property and Other Assets.

17.10.1 Schedule 17.10 lists all real property owned by any Backus Entity by common address, legal description and property identification number (the "**Owned Real Property**"). Except as set forth on Schedule 17.10, one or more of the Backus Entities is the sole and exclusive owner of all right, title and interest in and has good, marketable, and insurable fee simple title to the Owned Real Property free and clear of all liens, mortgages, security interests, options, pledges, charges, covenants, conditions, restrictions and other encumbrances and claims of any kind or character

whatsoever, other than covenants, restrictions and easements listed on Schedule 17.10 hereto. No Backus Entity knows of any unrecorded or undisclosed legal or equitable interest in any Real Property. Schedule 17.10 lists each lease or agreement to which any Backus Entity is a party under which it is a lessee or a lessor of any real property (together with any amendments thereto or other agreements affecting same, the "**Leases**", and the real property subject to such Leases, the "**Leased Real Property**", which together with the Owned Real Property is referred to as the "**Real Property**"). Each Lease is a valid agreement, duly authorized and entered into, without any default of any Backus Entity under such Lease and, to the Knowledge of the Backus Entities, without any default under such Lease of any other party to such Lease. With respect to each Lease, all insurance required to be obtained thereunder has been obtained and is currently in force and effect. The Backus Entities have not received or given a notice of default under the Leases other than notices with respect to defaults which have either been cured or waived. Except as set forth in Schedule 17.10, the Backus Entities have not assigned, transferred, conveyed, mortgaged, deeded in trust, or encumbered any interest in any leasehold or subleasehold under any Lease. All facilities leased or subleased under any Lease are supplied with utilities and other services to the extent reasonably necessary for the present operation of the facilities. Except as set forth in Schedule 17.10, no Backus Entity has leased or otherwise granted to any person or entity the right to use any Real Property or any portion thereof.

There are no outstanding options, right of first refusal, rights of first offer, or other rights to purchase any Real Property or any portion thereof or interest therein. The Real Property is accurately described in Schedule 17.10 and includes all real estate owned by the Backus Entities and used in connection with their current operations. Except as described on Schedule 17.10, with respect to the Real Property:

(a) No Backus Entity has received during the past three years notice of a violation of any Applicable Law;

(b) The Real Property and its operation are in compliance with, or has proper variances from, all applicable zoning, land use, public health, fire safety, building code or other similar ordinances, and the consummation of the Contemplated Transaction will not result in a violation of any ordinance or the termination of any such variance now existing;

(c) The Real Property is subject to no easements, restrictions, ordinances or such other limitations on title which restrict or impair its current use, except those which would have only an immaterial effect on such impacted Real Property, or the operation of the facilities thereon;

(d) There are no tenants or other persons or entities occupying any space in the Real Property, or claiming any possession, adverse or not, to any portion of the Real Property, other than pursuant to tenant leases described in Schedule 17.10, and no tenants have paid rent in advance for more than one month and no improvement credit or other tenant allowance of any nature is owed to any tenant, nor is any landlord improvement work required;

(e) As set forth in Schedule 17.10, each parcel of Real Property is either: (i) exempt from real property or ad valorem taxation pursuant to CONN. GEN. STAT. § 12-81(7) and the Backus Entities have received no notice and have no Knowledge that the status of such Real Property will change from exempt to taxable; or (ii) separately assessed for real estate tax purposes (with all imposed real estate taxes and assessment having been paid through the date hereof) and is not combined with any land or real estate which is not a part of the Real Property for real estate tax assessment purposes and the Backus Entities have not received any notice of change in assessed value which is not reflected in real property tax bills;

(f) No Backus Entity has received any notice of any existing, proposed or contemplated plans or contemplated eminent domain proceeding that would result in the taking of all or any part of the Real Property or that would adversely affect the current use of any part of the Real Property;

(g) To the Knowledge of Backus, all permanent certificates of occupancy and all other licenses, permits, authorizations, consents, certificates and approvals required by all governmental authorities having jurisdiction and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions) have been issued for the Real Property (and all individual items constituting the Real Property), have been paid for, are in full force and effect, are assignable by the Backus Entities, and will not be invalidated, violated or otherwise adversely affected by the assignment thereof or by any transfer of the Real Property to a Hartford System Member or by any change of Control of any Backus Entity;

(h) Water, sanitary sewer, storm sewer, drainage, electric, telephone, gas, fuel, oil, cable television and other public utility systems and lines serve the Real Property with capacity and in a manner adequate for the present use of the Real Property and are directly connected to the lines and/or other facilities of the respective public authorities or utility companies providing such services or accepting such discharge, either adjacent to the Real Property (in public ways abutting same) or through easements or rights-of-way appurtenant to and forming a part of the Real Property; and, to the Knowledge of the Backus Entities, such easements or rights-of-way have been fully granted, and all charges therefore have been fully paid by the Backus Entities and all charges for such utility systems and the connection of the Real Property to such systems, including, without limitation, connections fees, "tie-in" charges and other charges now or hereafter to become due and payable, have been fully paid by the Backus Entities; and the water and sanitary sewer service described above is supplied by public authority;

(i) None of the Real Property is served by a septic tank, and To the Knowledge of Backus Entities, there are no septic tanks located on any Real Property;

(j) The existing improvements located upon the Real Property do not encroach upon adjacent premises or upon existing utility company easements of record and existing restrictions of record on the applicable Real Property are not violated by the improvements located on the Real Property;

(k) All buildings, structures, fixtures, building systems and equipment on the Real Property and all components thereof are in sufficient repair and condition for the operation of the Backus Entities as currently conducted, reasonable wear and tear excepted. No Backus Entity knows of any latent or other defects in the Real Property, including but not limited to, roofs, electrical, plumbing, drainage, sewerage and HVAC and other mechanical systems at or serving the Real Property which have not been specifically reveal to Hartford Healthcare in writing prior to the date hereof.

(l) The Real Property is subject to no conditions, restrictions, ordinances, or other limitations that would make such property unusable for its current use or the title to such property unmarketable, which materially restrict or impair the current use or operation of the business in a manner consistent with the current use, or which would require the removal of any improvements, except which individually would not materially impair the value of or the continued use and operation by the Backus Entities.

17.10.2 Each of the Backus Entities has good and defensible title to all of its personal property of every kind, character and description, whether tangible or intangible, used in connection with the operation of the businesses of the Backus Entities, free and clear of all liens, mortgages, security interests, options, pledges, charges, covenants, conditions, restrictions and other encumbrances and claims of any kind or character whatsoever.

17.10.3 Except as set forth on Schedule 17.10.3: (a) to the Knowledge of Backus, the Real Property is in compliance, in all material respects, with all Environmental Laws; (b) the Backus Entities have not received any notice from the federal, state, or local government within the past three years alleging or asserting either a violation of any Environmental Law or a legal obligation to investigate, assess, remove, or remediate any part or all of the Real Property under or pursuant to any Environmental Law, nor have the Backus Entities received such notice from any other party within that time period alleging or asserting either a material violation of any Environmental Law or a legal obligation to investigate, assess, remove, or remediate any part or all of the Real Property under or pursuant to any Environmental Law; (c) the Backus Entities have not possessed, managed, processed, released, handled or disposed of or discharged Hazardous Substances at, on, or from the Real Property (including groundwater), except in compliance in all material respects with applicable Environmental Law; (d) the Backus Entities have no Knowledge that any prior owners, operators or occupants of the Real Property have caused or allowed any Hazardous Substances to be discharged, possessed, managed, processed, released, or otherwise handled on the Real Property in violation of any Environmental Law; (e) to the Knowledge of Backus, the Backus Entities are complying and, for the previous 3 years, have complied in all material respects with all applicable Environmental Law; (f) to the Knowledge of the Backus Entities, the Real Property does not contain asbestos-containing material in such form or condition for which abatement, repair or removal is required by applicable Environmental Law; and (g) there are no, nor to the Knowledge of the Backus Entities, have there ever been any, dumps, pits, landfills, or surface impoundments located on the Real Property for the disposal or containment of

Hazardous Substances. Backus shall promptly notify Hartford HealthCare should the Backus Entities obtain Knowledge, prior to the Closing Date, of any lien, written notice, litigation, or threat of litigation relating to any alleged or actual unauthorized release of any Hazardous Substance with respect to any part of the Real Property. Except as set forth on Schedule 17.10.3, to the Knowledge of the Backus Entities, none of the Backus Entities has sent, arranged for disposal or treatment, arranged with a transporter for transport for disposal or treatment, transported, or accepted for transport any Hazardous Substances, to a facility, site or location, which, pursuant to federal, state, or local law: (i) has been placed or has been publicly proposed by authorities having jurisdiction to be placed, on the National Priorities List or its state equivalent; or (ii) is subject to a claim, administrative order or other demand to take removal or remedial action by any person having jurisdiction and authority in the matter. Without limiting the generality of the foregoing, (x) all current or former underground storage tanks located on the Real Property of which the Backus Entities have Knowledge and all information in Backus Entities' possession relating to the capacity, uses, dates of installation and contents of such underground storage tanks located on the Real Property are identified in Schedule 17.10.3; and (y) all existing above ground and underground storage tanks used by the Backus Entities to store Hazardous Substances are in compliance in all materials respects with applicable Environmental Law.

17.11 Affiliates and Subsidiaries. Schedule 1 sets forth an accurate and complete list of all Backus Entities.

17.12 Tax-Exempt Status. Except as set forth on Schedule 17.12, each of the Backus Entities is exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code and is not a "private foundation" within the meaning of Section 509(a) of the Code. The IRS has not taken, or, to the Knowledge of the Backus Entities, proposed to take, any action to revoke the tax-exemption of any of the tax-exempt Backus Entities. Except as set forth on Schedule 17.12, the IRS has not determined in writing or, to the Knowledge of the Backus Entities, proposed to announce, that any of the Backus Entities is a "private foundation" within the meaning of Section 509(a) of the Code. Except as set forth on Schedule 17.12, none of the Backus Entities has Knowledge of any change in the organization or operation of any of the tax-exempt Backus Entities that would result in a loss of the Backus Entity's status as an organization described in Section 501(c)(3) of the Code or which could cause the Backus Entity to be treated as a "private foundation" within the meaning of Section 509(a) of the Code.

17.13 Insurance. Schedule 17.13 sets forth an accurate, correct and complete list (including the name of the insurer, coverage, premium and expiration date) of all binders and policies of insurance (collectively, the "**Insurance Policies**") maintained by the Backus Entities in which a Backus Entity is a named insured; or which otherwise insure assets used primarily in connection with the operation of the Backus Entities. Except as set forth on Schedule 17.13, the Insurance Policies are in full force and effect and shall remain in full force and effect through the Closing Date. Further, Backus' professional liability trust is solvent and actuarially sound.

17.14 Taxes. Backus Entities have filed, or shall file, all returns, declarations, and reports and all information returns and statements required to be filed or sent with respect to all Taxes for all periods ending on or within the six-year period preceding the Execution Date (collectively, the "**Returns**"). Except as set forth on Schedule 17.14, as of the time of filing, the Returns correctly reflected, and Returns prepared or being prepared but not yet filed as of the Execution Date, shall correctly reflect, the income, business, assets, operations, activities and status of the Backus Entities and any other information required to be shown therein. The Backus Entities have timely paid or made provision for all Taxes shown as due and payable on its Returns required to be filed or sent prior to the Execution Date and has made provision for timely payment of all Taxes that shall be shown as due and payable on its Returns required to be filed or sent by it after the Execution Date and relating to any period prior to the Closing Date.

17.15 Employee Benefits.

17.15.1 Schedule 17.15.1 sets forth an accurate, correct and complete list of all "employee welfare benefit plans" (as defined in Section 3(1) of ERISA), "employee pension benefit plans" (as defined in Section 3(2) of ERISA), and all other employee benefit plan agreements and arrangements and employee benefit policies, whether funded or unfunded, qualified or nonqualified, written or unwritten, subject to ERISA or not, maintained or contributed to (or required to be contributed to) by Backus Entities for the benefit of any of its officers, employees or other persons (all the foregoing being herein referred to as "**Benefit Plans**"). Backus Entities have delivered to Hartford HealthCare accurate, correct and complete copies of:

(a) Each Benefit Plan and all amendments thereto.

(b) The three most recent annual reports on Form 5500, if required, filed with the IRS or the Department of Labor with respect to any Benefit Plan, including all schedules and attachments.

(c) Each trust agreement, group annuity contract, insurance contract or other funding vehicle relating to any Benefit Plan and any amendments thereto.

(d) The three most recent certified financial statements relating to each Benefit Plan, as applicable, and the three most recent actuarial reports for any Benefit Plan which is a tax-qualified defined benefit pension plan.

(e) The summary plan description and all summaries of material modifications for each Benefit Plan.

(f) All collective bargaining agreements or other such contracts, including any riders or amendments thereto.

(g) Each determination letter, ruling letter or any outstanding ruling request on the tax-exempt status of any qualified Benefit Plan or any voluntary employees' beneficiary association implementing a Benefit Plan.

(h) A complete copy of any and all notices that were given by the IRS, the PBGC, or the Department of Labor to Backus Entities or its affiliates or any Benefit Plan within the three (3) years preceding the date of this Agreement (e.g., IRS audit requests, etc.).

(i) Complete copies of any and all notices that were given by Backus Entities or any Affiliate or any Benefit Plan to the IRS, the PBGC, the Department of Labor or any participant or beneficiary, pursuant to statute, within the three (3) years preceding the date of this Agreement, including notices that are expressly mentioned elsewhere in this Agreement.

(j) Complete copies of any voluntary correction filings made with respect to any Benefit Plan to the IRS or Department of Labor regarding any qualification or operational failure under such Benefit Plan whether submitting in writing to the governmental entity or pursued through self-correction methodologies.

(k) Each sample correspondence to employees giving notice of their rights under Section 4980B of the Code and any other documents indicating compliance with said Section 4980B, if applicable.

(l) The three most recent annual PBGC-1 forms, if required, filed with the PBGC with respect to any Benefit Plan, including all schedules and attachments.

17.15.2 To the Knowledge of the Backus Entities, the following statements with respect to the Benefit Plans are true in all material respects:

(a) Each such Benefit Plan listed on Schedule 17.15.1 is legally valid and binding as of the date of this Agreement and in full force and effect.

(b) All contributions to, and payments from, the Benefit Plans required to be made in accordance with the terms of the Benefit Plans and Applicable Law have been timely made. Except for those Benefit Plans disclosed on Schedule 17.15.1, no Benefit Plan is subject to the funding rules of Section 302 of ERISA or Section 412 of the Code.

(c) All Benefit Plans (and all related trust agreements or annuity contracts or any funding instruments) have been administered in accordance with their terms and comply currently, and have complied in the past, both as to form and operation, with the provisions of applicable tax laws, the Code and Applicable Law. To the extent that any Benefit Plan is a tax-qualified retirement plan, it has been maintained and administered in accordance with its terms and the provisions of applicable tax laws and the Code, where required for the Benefit Plan to be tax-qualified under Sections 401(a) and 501(a) of the Code, and all other Applicable Laws (including Code Section 403(b), if applicable), rules and regulations. The Benefit Plans that are pension benefit plans have received determination letters or private letter rulings from the IRS to the effect that such Benefit Plans are qualified and exempt from Federal income taxes under Sections 401(a) and 501(a), respectively, of the Code, or are church plans as defined in Code Section 414(e), and no such determination letter or private letter ruling has been revoked nor, to the Knowledge of any Backus Entity, has revocation been threatened, nor has any such Benefit Plan been amended or experienced any change in facts or circumstances since

the date of its most recent determination letter or private letter ruling or application therefor in any respect which would adversely affect its qualification or materially increase its cost.

(d) All reports, returns and similar documents with respect to the Benefit Plans required to be filed with any government agency or distributed to any Benefit Plan participant have been, or will be, duly and timely filed or distributed. To the Knowledge of the Backus Entities, there are no threatened or pending investigations by any governmental agency, termination proceedings or other claims (except claims for benefits payable in the normal operation of the Benefit Plans), suits or proceedings against or involving any Benefit Plan or asserting any rights or claims to benefits under any Benefit Plan that could give rise to any material liability, nor are there any facts that could give rise to any material liability in the event of any such investigation, claim, suit or proceeding.

(e) No "prohibited transaction" (as defined in Section 4975 of the Code or Section 406 of ERISA) has occurred which involves the assets of any Benefit Plan and which could subject any of the Backus Entities, or any of their respective Employees, or a trustee, administrator or other fiduciary of any trust created under any Benefit Plan, to the tax or penalty on prohibited transactions imposed by Section 4975 of the Code or the sanctions imposed under Title I of ERISA. No Benefit Plan which has been terminated has or may cause liability to any of the Backus Entities.

(f) Backus Entities has made appropriate entries in its financial records and statements for all obligations and liabilities under such Benefit Plans that have accrued but are not due.

(g) Neither Backus Entities nor any Affiliate has made any voluntary correction program submission to either the IRS or the Department of Labor with respect to any compliance failure or operational failure as relates to any Benefit Plan listed in Schedule 17.15.1.

(h) No statement, either written or oral, has been made by Backus Entities to any person with regard to any Benefit Plan that was not in accordance with the Benefit Plan and that could have an adverse economic consequence to Backus Entities or to Hartford.

(i) Each Benefit Plan contains authority to terminate providing Backus with the ability to terminate such Benefit Plan in the future, subject to Applicable Law.

(j) Neither Backus Entities nor any affiliate has filed a notice of intent to terminate any Benefit Plan or has adopted any amendment to treat a Benefit Plan as terminated. The PBGC has not instituted proceedings to treat any Benefit Plan as terminated. No event has occurred or circumstance exists that may constitute grounds under ERISA § 4042 for the termination of, or the appointment of a trustee to administer, any Benefit Plan.

(k) With respect to any defined benefit pension plan, Backus Entities has paid, if applicable, all amounts due to the PBGC pursuant to ERISA Section 4007. Further, no amendment has been made, or is reasonably expected to be made, to any Benefit Plan that has required or could require the provision of security under Code Section 401(a)(29). The actuarial

report for any pension plan pursuant to which Backus Entities or any affiliate participated, fairly presents the financial condition and the results of operations of each such pension plan in accordance with GAAP. Since the last valuation date for each pension plan pursuant to which Backus Entities or any affiliate participated, no event has occurred or circumstance exists that would increase the amount of benefits under any such pension plan or that would cause the excess of pension plan assets over benefit liabilities (as defined in ERISA Section 4001) to decrease, or the amount by which benefit liabilities exceed assets to increase, other than the normal market fluctuation of the investments from time to time. No reportable event (as defined in ERISA Section 4043 and in regulations issued thereunder) has occurred. There is no fact or circumstance that may give rise to any liability of Backus Entities or Hartford HealthCare to the PBGC under Title IV of ERISA.

(l) With respect to any health and welfare plan, no event has occurred or circumstance exist that could result in an increase in premium costs of Benefit Plans that are insured, or an increase in benefit costs of such Benefit Plans that are self-insured, other than any such increase that has not had and is not reasonably likely to have a Material Adverse Effect. Further, neither Backus Entities nor any affiliate has established, maintained, or contributed to, or had any obligation to establish, maintain or contribute to: (I) a multiple employer welfare arrangement within the meaning of ERISA Section 3(40)(A), or (II) a voluntary employees' beneficiary association under Code Section 501(c)(9). Neither Backus Entities nor any other affiliate has any obligation to provide any medical, life or similar benefits to current or future retired or terminated employees, their spouses or dependents following termination of employment except as required in ERISA Section 601. Backus Entities has complied with the provisions of ERISA Section 601 et seq. and IRC Section 4980B.

(m) With respect to any executive compensation related matters, the consummation of the contemplated transactions will not: (I) entitle any current or former employee, officer, director or independent contractor of Backus Entities to severance pay, unemployment compensation or any other payment, (II) accelerate the time or payment or vesting, or increase the amount of payments or compensation due any such individual, or (III) result in any prohibited transaction described in ERISA Section 406 or IRC Section 4975 for which an exemption is not available. No payment that is owed or may become due to any director, officer, employee, or agent of Backus Entities or any affiliate will be non-deductible to Backus Entities or subject to tax under IRC Section 280G or Section 4999; nor will Backus Entities or any affiliate be required to "gross up" or otherwise compensate any such person because of the imposition of any excise tax on a payment to such person. Each Benefit Plan that is a "nonqualified deferred compensation plan" (as defined in Code Section 409A(d)(1)) has been operated since January 1, 2005 in good faith compliance with Code Section 409A and the underlying IRS guidance and Department of Treasury regulations.

17.16 Payment Programs. The Backus Entities listed on Schedule 17.16 are participating providers in the private, commercial and governmental payment and procurement programs (including, without limitation, Medicare and Medicaid) set forth on Schedule 17.16, which includes a complete and accurate list of all such Payment Programs in which the Backus Entities currently participate or with which they contract (the "**Payment Programs**"). Except as set forth on Schedule 17.16:

17.16.1 to the Knowledge of Backus, no Backus Entity is engaged in termination proceedings as to its respective participation in any Payment Program, nor has any Backus Entity received notice that its current participation in any Payment Program is subject to any contest, termination or suspension as a result of alleged violations or any noncompliance with participation requirements;

17.16.2 to the Knowledge of Backus, no Backus Entity has taken or committed to any action, entered into any agreement, contract or undertaking, or taken or omitted to take any other action of any nature whatsoever that was or is in violation of any applicable Payment Program condition of participation, contract, standard, policy, rule, regulation, procedure or other requirement, that individually or in the aggregate would be material;

17.16.3 and except as disclosed on the Backus Financial Statements, all billing and collection practices of each Backus Entity and, of any billing and/or collection agent acting on behalf of any Backus Entity, have been in compliance with all Health Care Laws and the conditions for participation, contracts, standards, policies, rules, regulations, manuals, procedures and requirements of all Payment Programs, noncompliance with which would have a material effect on its business and operations;

17.16.4 and except as disclosed on the Backus Financial Statements, to the Knowledge of Backus, all cost reports and cost statements submitted by the Backus Entities to any Payment Program are true, accurate and complete in all material respects and have been prepared and submitted in accordance with cost and accounting principles consistently applied that comply with all applicable Payment Program conditions for participation, contracts, standards, policies, rules, regulations, manuals, procedures and requirements, including, without limitation, Payment Program interpretations and guidance;

17.16.5 no cost reports or cost statements are open and unresolved;

17.16.6 and except as disclosed on the Backus Financial Statements, to the Knowledge of Backus, no Backus Entity has taken any of the following actions: submitted to any Payment Program any false, fraudulent, abusive or improper claim for payment, billed any Payment Program for any service not rendered or not rendered as claimed, or received and retained any payment or reimbursement from any Payment Program in excess of the proper amount allowed by Applicable Law and applicable contracts or agreements with the Payment Programs;

17.16.7 to the Knowledge of the Backus Entities, there is no audit, investigation, adverse action, or civil, administrative, or criminal proceeding threatened or pending relating to participation in any Payment Program by any Backus Entity; and with respect to the matters disclosed on Schedule 17.16, to the Knowledge of the Backus Entities, there is no basis for any such adverse action by the Payment Program against any Backus Entity;

17.16.8 to the Knowledge of the Backus Entities, no Payment Program has requested or threatened any recoupment, refund, or set-off from any Backus Entity, or imposed any fine, penalty or other sanction on any Backus Entity; and

17.16.9 the Backus Entities have complied, or will comply, in a timely manner with any notice, approval, application, submission, filing or other requirements of the Payment Programs with respect to the Contemplated Transaction, including, without limitation, any transfer or change of ownership requirements.

17.17 Accreditation. The Backus Entities listed on Schedule 17.17 are accredited by the organizations as are listed on Schedule 17.17 (collectively, the "**Accreditations**"). Except as set forth on Schedule 17.17; (a) the Accreditations have been duly obtained and are held by the Backus Entities, are current and valid, and are in full force and effect; (b) to the Knowledge of Backus, no event has occurred or other fact exists with respect to the Accreditations that allows, or after notice or lapse of time or both would allow, revocation, suspension, restriction, limitation or termination of any of the Accreditations or would result in any other impairment of the rights of the holder of any of the Accreditations that individually or in the aggregate would be material; (c) no notice from any accreditation organization in respect to the revocation, suspension, restriction, limitation or termination of any Accreditations has been issued, received or, to the Knowledge of Backus, proposed or threatened; and (d) no statement of deficiencies, survey report, inspection report, notice of audit, audit results, complaint or other notice of noncompliance with the requirements, standards or other conditions of any Accreditation has been issued, received or, to the Knowledge of Backus, proposed or threatened by any accreditation organization, for which any actual or potential payment or other obligation exists.

17.18 No Defaults. Except as listed on Schedule 17.18, to the Knowledge of Backus, no Backus Entity is in breach or default in any material respect under any term or provision of any Material Contract.

17.19 Exclusion from Health Care Programs. Except as listed on Schedule 17.19, neither any Backus Entity nor any of their respective officers, directors, agents or managing employees (as such term is defined in 42 U.S.C. §1320a-5(b)) nor any other employee, agent or independent contractor of any Backus Entity has been: (a) excluded from participating in any Federal Health Care Program (as defined in 42 U.S.C. § 1320a-7b(f)); (b) subject to sanction or been indicted or convicted of a crime, or pled *nolo contendere* or to sufficient facts, in connection with any allegation of violation of any Federal Health Care Program requirement or Health Care Law; (c) debarred or suspended from any federal or state procurement or nonprocurement program by any government agency; or (d) designated a Specially Designated National or Blocked Person by the Office of Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE 18

REPRESENTATIONS AND WARRANTIES OF HARTFORD HEALTHCARE

Hartford HealthCare gives as of the Execution Date the following representations and warranties to Backus:

18.1 Due Organization; Legal Existence; Power. Hartford HealthCare is an Connecticut nonstock corporation, exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code and is not a "private foundation" within the meaning of Section 509(a) of the Code. Hartford HealthCare is duly formed and is validly existing under the laws of the State of Connecticut and has the corporate power and authority to own, operate or hold under lease its properties and assets and to carry on its business and operations as presently conducted.

18.2 Corporate Authorization.

18.2.1 Hartford HealthCare has the full corporate power and authority to enter into and to perform their obligations under this Agreement.

18.2.2 The execution, delivery and performance of this Agreement by Hartford HealthCare has been duly and properly authorized by all necessary corporate action in accordance with its respective Governing Documents.

18.2.3 This Agreement constitutes the valid and legally binding obligation of Hartford HealthCare, enforceable against it in accordance with its terms, except as enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium or other laws of general application now or hereafter in effect relating to or affecting the enforcement of creditors' rights generally.

18.3 No Violation; Approvals.

18.3.1 Except to the extent specified in this Agreement or in Schedule 18.3.1, the execution, delivery and performance of this Agreement shall not result in the creation of any lien, charge, or encumbrance of any kind or the termination or acceleration of any indebtedness or other obligation of Hartford HealthCare, and is not prohibited by, does not violate or conflict with any provision of, and does not constitute a default under or breach of any Material Contract to which Hartford HealthCare is a party or is subject or by which any such corporation is bound, or any Applicable Law.

18.3.2 Except to the extent specified in Schedule 18.3.2, no approval, authorization, registration, consent, order or other action of or filing that has not occurred or been obtained with or from any person, including any court, administrative agency or other governmental authority, is required for the execution and delivery by Hartford HealthCare of this Agreement or the consummation by Hartford HealthCare of

the Contemplated Transaction, except for filings required pursuant to the HSR Act and the Connecticut certificate of need statute and regulations.

18.4 No Material Omissions.

18.4.1 Hartford HealthCare has responded in all material respects to all requests for information and documentation made by Backus in connection with its due diligence review of the business, operations, assets and liabilities of Hartford HealthCare. Hartford HealthCare has not knowingly omitted any material information relating to the businesses, operations, assets or liabilities of Hartford HealthCare or any of the Hartford System Members in it responses to Backus' requests. Since the delivery of such responses to Backus, Hartford HealthCare has not received and not disclosed any information which would render untrue or misleading in any material respect any information previously disclosed to Backus in response to their requests for information.

18.4.2 To the Knowledge of Hartford HealthCare, the representations and warranties of Hartford HealthCare contained in this Agreement, and each Exhibit, Schedule, certificate or other written statement delivered at Closing by Hartford HealthCare pursuant to this Agreement, are accurate, correct and complete in all material respects, do not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements and information contained therein not misleading.

18.5 Compliance with Law. To the Knowledge of Hartford HealthCare, except as set forth on Schedule 18.5, each of the Hartford System Members is in compliance with all Applicable Laws which are material to Hartford HealthCare's business and operations, taken as a whole.

18.6 Tax Exempt Status. Hartford HealthCare is exempt from federal income taxation under Section 501(a) of the Code, as an organization described in Section 501(c)(3) of the Code and is not a "private foundation" within the meaning of Section 509(a) of the Code. The IRS has not taken, or, to the Knowledge of Hartford HealthCare, proposed to take, any action to revoke the tax-exemption of Hartford HealthCare, and has not determined in writing or, to the Knowledge of Hartford HealthCare, proposed to announce, that Hartford HealthCare is a "private foundation" within the meaning of Section 509(a) of the Code. Hartford HealthCare does not have Knowledge of any change in its the organization or operation that would result in a loss of its status as an organization described in Section 501(c)(3) of the Code or which could cause it to be treated as a "private foundation" within the meaning of Section 509(a) of the Code.

18.7 Legal Proceedings. Except as disclosed on Schedule 18.7, none of the Hartford System Members is a defendant in, or, to the Knowledge of Hartford HealthCare, threatened with any action, suit, proceeding, complaint, charge, hearing, arbitration or state or federal governmental investigation which would materially and adversely affect the ability of Hartford HealthCare to perform its obligations under this Agreement. Except as disclosed on Schedule 18.7, Hartford HealthCare has not received notice of any investigation or threatened investigation by any Federal, state or local governmental or regulatory agency, including those

involving its business practices and policies, which could have, in the aggregate, a materially adverse effect on Hartford HealthCare.

ARTICLE 19

DISPUTE RESOLUTION

19.1 Dispute Resolution Procedures.

19.1.1 Meet and Confer. In the event of a dispute between Hartford HealthCare and Backus prior to the Closing or during the Transitional Period either may give notice to the other setting forth the nature of such dispute and requesting that the Parties meet and confer to discuss the dispute (the "**Meet and Confer Request**"). Not later than 30 days after receipt of a Meet and Confer Request, the Dispute Representatives shall meet and confer to discuss the dispute in good faith in an attempt to resolve the dispute. The Dispute Representatives shall meet at such dates and times as are mutually convenient to the Dispute Representatives within such 30-day period. For purposes of this ARTICLE 19:

(a) "**Dispute Representatives**" shall mean the Hartford HealthCare Dispute Representatives and the Backus Dispute Representatives.

(b) "**Hartford HealthCare Dispute Representatives**" shall mean the Hartford HealthCare Chief Executive Officer and his or her designee.

(c) "**Backus Dispute Representatives**" shall mean the Backus Chief Executive Officer and his or her designee.

19.1.2 Binding Arbitration. All Material Disputes shall be decided through a binding arbitration process. A "Material Dispute" shall mean any dispute related to the limitations on Hartford HealthCare's Reserved Powers described in Sections 2.2.1 through 2.2.5 and with respect to the removal of a Backus or Backus Hospital Board Director pursuant to Section 2.1.2. Either Party shall provide notice of such Party's intention to submit the Material Dispute to the binding arbitration process pursuant to this Section 19.1.2.

(a) Not later than 30 days after such notice, the Parties shall jointly select an arbitrator. Arbitration proceedings shall be conducted in Hartford, Connecticut, in accordance with the American Health Lawyers' Association ("**AHLA**") Alternative Resolution Service arbitration rules, except as modified herein.

(b) Not later than 60 days after the date on which the arbitrator is selected, the arbitrator shall conduct a formal hearing into the Material Dispute in accordance with the applicable rules for arbitration of the AHLA then in effect.

(c) The arbitrator shall not have the authority to order the termination or rescission of this Agreement unless Hartford HealthCare and Backus otherwise agree in writing prior to the commencement of the formal hearing.

(d) The arbitrator's decision shall be final and binding upon the Parties and shall be enforceable in accordance with its terms under Connecticut law.

(e) The Parties shall share equally in the cost of arbitration, including the arbitrator's fees, but each Party shall bear its own legal and other expenses incurred by it in connection with the arbitration.

ARTICLE 20

GENERAL PROVISIONS

20.1 **Confidentiality**. The Parties agree that the Confidential Information provided to each other in connection with this Agreement and the consummation of the Contemplated Transaction is subject to the terms of the Confidentiality and Non-Disclosure Agreement entered into between the Parties and dated July 20, 2011 (the "**Confidentiality Agreement**"), the terms of which are incorporated herein by reference and, to the extent applicable, supersede any conflicting or inconsistent provisions contained in this Agreement. For purposes of this Section 20.1, "**Confidential Information**" means any confidential information with respect to, including, methods of operation, customers, customer lists, prices, fees, costs, technology, inventions, trade secrets, know-how, software, marketing methods, plans, personnel, suppliers, competitors, markets or other specialized information or proprietary matters.

20.2 **Notices**. All notices, requests, demands and other communications under this Agreement shall be in writing and shall be deemed to have been duly given or made as follows: (a) if sent by registered or certified mail in the United States return receipt requested, upon receipt; (b) if sent designated for overnight delivery by nationally recognized overnight air courier (such as Federal Express, UPS or DHL), one business day after mailing; (c) if sent by facsimile transmission or electronic mail before 5:00 p.m. (sender's time), when transmitted and receipt is confirmed through a delivery report; (d) if sent by facsimile transmission or electronic mail after 5:00 p.m. (sender's time) and receipt is confirmed through a delivery report, on the following business day; and (e) if otherwise actually personally delivered, when delivered, provided that such notices, requests, demands and other communications are delivered to the address set forth below, or to such other address as either Party shall provide by like notice to the other Parties:

Hartford HealthCare: One State Street
Suite 19
Hartford, CT 06103
Attn: President and CEO

With a simultaneous copy to:	One State Street Suite 19 Hartford, CT 06103 Attn: General Counsel
Backus:	Backus Corporation 326 Washington Street, Norwich, Connecticut 06360 Attn: President and CEO
With a simultaneous copy to:	Ropes & Gray LLP Prudential Tower, 800 Boylston Street Boston, MA 02199-3600 Attn: Anne P. Ogilby

20.3 **Expenses**. Except as otherwise provided in this Agreement, the Parties shall each pay their own fees and expenses and those of their respective agents, advisors, consultants, attorneys and accountants with respect to the transactions described in this Agreement, their respective due diligence investigations, and the negotiation of the Agreement and the Closing. Notwithstanding anything to the contrary, Hartford HealthCare and Backus shall share equally in the cost of any fees charged by any government agency in connection with notices or other filings as may be required under the HSR Act.

20.4 **No Brokerage**. The Parties represent to each other that no broker has in any way been contacted in connection with the Contemplated Transaction. Each Party agrees to indemnify the other Parties from and against all loss, cost, damage or expense arising out of claims for fees or commissions of brokers employed or alleged to have been employed by such indemnifying Party.

20.5 **Entire Agreement; Amendment**. This Agreement, including all Schedules, Exhibits and statements required hereunder, supersedes all previous agreements, oral or written, and constitutes the entire agreement among the Parties respecting the subject matter of this Agreement, and no Party shall be entitled to benefits other than those specified herein. Each Exhibit, Schedule and statement referenced in this Agreement shall be considered a part hereof as if set forth herein in full. As among the Parties, oral statements or prior written material which are not specifically incorporated herein shall not be of any force and effect. The Parties specifically acknowledge that in entering into and executing this Agreement, the Parties rely solely upon the representations and agreements contained in this Agreement and no others. This Agreement may be amended or modified only by an agreement in writing signed by all the Parties.

20.6 **Non-Assignment**. This Agreement shall be binding upon and inure to the benefit of the Parties and their respective permitted successors, assigns and legal representatives, but no Party may assign its rights in this Agreement or delegate its duties under this Agreement to a third party by any means without first obtaining the prior written consent of the other Party.

20.7 No Third-Party Beneficiaries. Except as expressly set forth herein, this Agreement shall not confer any rights or remedies upon any person or other third party other than the Parties and their respective successors and permitted assigns.

20.8 Third Party Authorizations. From the Execution Date to the Effective Time, each of the Parties shall use its reasonable best efforts to obtain expeditiously all consents, authorizations and other approvals of third parties necessary for the valid execution, delivery and performance of this Agreement by the Party.

20.9 Consents, Approvals and Discretion. Except as herein expressly provided to the contrary, whenever this Agreement requires any consent or approval to be given by a Party or a Party must or may exercise discretion, the Parties agree that such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

20.10 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable, in whole or in part, for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice or disturb the validity of any remaining provision of this Agreement, which shall be and remain in full force and effect, and binding and enforceable in accordance with its terms.

20.11 Applicable Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Connecticut; provided, however, that the conflicts of law principles of the State of Connecticut shall not apply to the extent they would operate to apply the laws of another state. The Parties hereby consent to the jurisdiction of Connecticut courts over all matters relating to this Agreement.

20.12 Headings; Cross References. Headings of Articles and Sections in this Agreement and the table of contents hereof are solely for convenience or reference, do not constitute a part hereof and shall not affect the meaning, construction or effect hereof. Unless indicated otherwise, references in this Agreement to Articles, Sections, Schedules and Exhibits are to articles, sections, schedules and exhibits of this Agreement.

20.13 Construction. Each Party has engaged separate independent legal counsel and independent advisors to provide advice and guidance to such Party. This Agreement and all documents or instruments delivered pursuant hereto shall be construed without regard to the identity of the person who drafted the various provisions of the same. Each and every provision of this Agreement and such other documents and instruments shall be construed as though the Parties participated equally in the drafting of the same. Consequently, the Parties acknowledge and agree that any rule of construction that a document is to be construed against the drafting Party shall not be applicable to this Agreement.

20.14 Waiver of Terms. The failure of either Party to insist, in any one or more instances, on performance of any of the terms, covenants and conditions of this Agreement shall not be construed as a waiver or relinquishment of any rights granted hereunder or thereunder or of the future performance of any such term, covenant or condition, but the obligations of the Parties with respect thereto shall continue in full force and effect. A waiver by one Party of the performance of any covenant, condition, representation or warranty of the other Party shall not

invalidate this Agreement, nor shall such waiver be construed as a waiver of any other covenant, condition, representation or warranty. A waiver by either Party of the time for performing any act shall not constitute a waiver of the time for performing any other act or the time for performing an identical act required to be performed at a later time.

20.15 Counterparts; Facsimile and pdf Signatures. The Parties agree that this Agreement may be executed in multiple originals, each of which shall be considered an original for all purposes and, collectively, shall be considered to constitute this Agreement. The Parties further agree that signatures transmitted by facsimile or in Portable Document Format (pdf) may be considered an original for all purposes, including, without limitation, the execution of this Agreement and enforcement of this Agreement.

20.16 Time is of the Essence. Time is hereby expressly made of the essence with respect to each and every term and provision of this Agreement and any other agreements determined by the Parties to be necessary or appropriate to be entered into in connection with the Contemplated Transaction.

20.17 Force Majeure. If either Party is rendered unable to perform its duties under this Agreement, in whole or in part, by reason of any event that is not reasonably under its control (including, but not limited to, Acts of God, fires, floods, earthquakes, accidents, strikes, riots, national emergencies, changes of law or regulations and other such *force majeure* events), then any duty so impacted will be suspended during such event. The Party rendered unable to perform due to *force majeure* must promptly notify the other Party and use reasonable efforts to overcome the *force majeure* event, and neither Party shall be responsible to the other Party for any losses resulting from such force majeure.

ARTICLE 21

GLOSSARY

21.1 Glossary. For convenience, set forth below is a glossary of defined terms used in this Agreement:

21.1.1 "**Accreditations**" shall have the meaning set forth in Section 17.17.

21.1.2 "**Affiliate**" means any entity which is under the Control of, or which is under common Control with, the subject entity.

21.1.3 "**Agreement**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.4 "**AHLA**" shall have the meaning set forth in Section 19.1.2(a).

21.1.5 "**Applicable Law**" shall mean all applicable federal, state and local laws, statutes, ordinances, rules, regulations, codes and any judgment, decree, order, writ or injunction of any court or regulatory authority.

21.1.6 "**Backus**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.7 **"Backus-Appointed Directors"** shall have the meaning set forth in Section 2.1.2(b).

21.1.8 "**Backus CEO**" shall have the meaning set forth in Section 2.2.2

21.1.9 **"Backus Closing Documents"** shall have the meaning set forth in Section 15.3.2.

21.1.10 "**Backus Dispute Representative**" shall have the meaning set forth in Section 19.1.1(c).

21.1.11 "**Backus Entity**" or "**Backus Entities**" shall have the meaning set forth in the Recitals.

21.1.12 "**Backus Financial Statements**" shall have the meaning set forth in Section 17.4.1.

21.1.13 "**Backus Hospital**" shall have the meaning set forth in the Recitals.

21.1.14 "**Backus Hospital Board**" means the Board of Directors of Backus Hospital.

21.1.15 "**Benefit Plans**" shall have the meaning set forth in Section 17.15.1.

21.1.16 "**Board**" shall have the meaning set forth in Section 2.1.1.

21.1.17 "**Closing**" shall have the meaning set forth in Section 1.1.

21.1.18 "**Closing Date**" shall have the meaning set forth in Section 15.1.

21.1.19 "**Code**" shall have the meaning set forth in the Recitals.

21.1.20 "**Confidential Information**" shall have the meaning set forth in Section 20.1.

21.1.21 "**Confidentiality Agreement**" shall have the meaning set forth in Section 20.1.

21.1.22 "**Contemplated Transaction**" shall have the meaning set forth in Section 1.1.

21.1.23 **"Control"** means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity whether through ownership of voting securities, by contract or otherwise.

21.1.24 "**Directors**" shall have the meaning set forth in Section 2.1.1.

21.1.25 "**Dispute Representatives**" shall have the meaning set forth in Section 19.1.1(a).

21.1.26 "**Eastern CT Region**" shall have the meaning set forth in the Recitals.

21.1.27 "**Effective Time**" shall have the meaning set forth in Section 1.1.

21.1.28 "**Employees**" shall have the meaning set forth in Section 5.2.

21.1.29 "**EMR**" has the meaning set forth in Section 7.1.

21.1.30 "**Environmental Law**" shall mean federal, state or local statutes and ordinances, and all rules and regulations promulgated thereunder, common law, orders, consent decrees, permits, and binding judicial and administrative interpretations thereof, pertaining or relating to: (a) natural resources and the environment, (b) public and worker health and safety; and (c) the identification, reporting, generation, manufacture, processing, distribution, use, treatment, storage, disposal, emission, discharge, release, transport or other handling of any Hazardous Substances, including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act, as amended ("CERCLA"), and the Resource Conservation and Recovery Act, as amended ("RCRA").

21.1.31 "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

21.1.32 "**Excluded Matter**" means any one or more of the following: (i) any action taken by Hartford HealthCare with respect to the Contemplated Transaction; (ii) any matter that has already been disclosed in writing (including via posting in any electronic data room established by or on behalf of Backus for purposes of due diligence or otherwise in conjunction with the Contemplated Transaction) to Hartford HealthCare by Backus on or before the Execution Date; (iii) the public announcement of this Agreement, compliance with terms of this Agreement or the consummation of the Contemplated Transaction; (iv) any fact, circumstance, event, change, effect, condition or occurrence, or series of such items, to the extent affecting (A) global or national or regional economic, business, regulatory, market or political conditions or national or global financial markets, including changes in interest or exchange rates, (B) the healthcare industry generally or such industry in Connecticut, or (C) the long-term acute care hospital business generally or in Connecticut; (v) any changes or any proposed changes in law after the Execution Date that are not directed at

Backus or Hartford HealthCare, in each instance to the exclusion of others; (vi) any changes in government programs or the implementation of the Patient Protection and Affordable Care Act; (vii) any variability in the financial or operating performance of Backus in the ordinary course of business; (viii) any increase in competitive activity by other health care providers in Backus' service area; (ix) any activities related to efforts to unionize any of the employees of the Backus Entities, (x) any delay in the Closing of the Contemplated Transaction due to circumstances beyond the Control of Backus; (xi) any action taken by Backus at the direction of, or with the written consent of, Hartford HealthCare; or (xii) any changes or any proposed changes in GAAP after the Execution Date.

21.1.33 "**Execution Date**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.34 "**Exhibit**" shall mean any exhibit required under this Agreement.

21.1.35 "**GAAP**" shall have the meaning set forth in Section 10.4.

21.1.36 "**Governing Documents**" shall mean the articles of incorporation, certificate of incorporation, bylaws, partnership agreement, operating agreement or other documents by and through which a business organization is formed and governed.

21.1.37 "**Hartford-Appointed Directors**" shall have the meaning set forth in Section 2.1.2(a).

21.1.38 "**Hartford HealthCare**" shall have the meaning set forth in the introductory paragraph to this Agreement.

21.1.39 "**Hartford HealthCare Board**" means the Board of Directors of Hartford HealthCare.

21.1.40 "**Hartford HealthCare Closing Documents**" shall have the meaning set forth in Section 15.3.1.

21.1.41 "**Hartford HealthCare Dispute Representatives**" shall have the meaning set forth in Section 19.1.1(b).

21.1.42 "**Hartford System**" shall have the meaning set forth in the Recitals.

21.1.43 "**Hartford System Member**" and "**Hartford System Members**" shall have the meanings set forth in the Recitals.

21.1.44 "**Hart-Scott-Rodino Act**" or "**HSR Act**" shall have the meaning set forth in Section 13.1.1.

21.1.45 "**Hazardous Substances**" shall mean petroleum or petroleum products, polychlorinated biphenyls, asbestos-containing materials, lead-based paint, radioactive materials, toxic mold or fungus of any kind or species, medical wastes, and any substances, materials, chemicals, pollutants, constituents, or wastes regulated by any Environmental Law due to their actual or potentially hazardous, toxic, noxious, dangerous, or polluting properties or effects.

21.1.46 "**Health Care Laws**" shall mean all federal, state and local laws, statutes, rules, regulations, ordinances and codes applicable to health care providers and facilities; federal and state health care program conditions of participation, standards, policies, rules, procedures and other requirements; and accreditation standards of any applicable accrediting organization. Health Care Laws include, without limitation, the following laws: the federal (Title XIX of the Social Security Act) and state Medicaid programs and their implementing regulations, the Medicare Program (Title XVIII of the Social Security Act) and its implementing regulations, the federal False Claims Act (31 U.S.C. §§3729 et seq.), the Federal Health Care Program Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)), the Federal Physician Self-Referral Law (42 U.S.C. §1395nn), the Federal Administrative False Claims Law (42 U.S.C. §1320a-7b(a)), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rule, the HIPAA Security Rule and the HIPAA Standards for Transactions and Code Sets (42 U.S.C. 1320d-1329d-8; 45 CFR Parts 160 and 164), the federal Confidentiality of Alcohol and Drug Abuse Patient Records Act (42 U.S.C. 290ee-3), the Rehabilitation Act, the Americans with Disabilities Act, the Occupational Safety and Health Administration statutes and regulations for blood borne pathogens and workplace risks, and any state and local laws that address the same or similar subject matter. Health Care Laws also include federal, state and local laws applicable to health care providers and facilities, including, without limitation, laws related to: federal and state health care program billing, cost reporting, revenue reporting, payment and reimbursement; federal and state health care program fraud, abuse, theft or embezzlement; procurement of health care services, human and social services, and other health related services; employee background checks and credentialing of employees; credentialing and licensure of facilities or providers of such services; zoning, maintenance, safety and operations of group homes, residential facilities and day programs, and other building health and safety codes and ordinances; certificate of need laws; state law restrictions on the corporate practice of medicine (or the corporate practice of any other health related profession); eligibility for federal and state health care program contracting, including any requirements limiting contracting to nonprofit or tax-exempt entities; patient information and medical record confidentiality, including psychotherapy and mental health records; splitting of health care fees; patient brokering, patient solicitation, patient capping, and/or payment of inducements to recommend or refer, or to arrange for the recommendation or referral of, patients to health care providers or facilities; standards of care, quality assurance, risk management, utilization review, peer review, and/or mandated reporting of incidents, occurrences, diseases and events; advertising or marketing of health care services; and the enforceability of restrictive covenants on health care providers.

21.1.47 "**Insurance Policies**" shall have the meaning set forth in Section 17.13.

21.1.48 "**IRS**" means the Internal Revenue Service.

21.1.49 "**IT**" shall have the meaning set forth in Section 7.1.

21.1.50 "**Joint Commission**" shall mean The Joint Commission.

21.1.51 "**Knowledge**", "**known**", "**knowingly**", "**to the knowledge of**" **or any variant thereof shall, when qualifying** any representation, warranty or other statement in this Agreement, means as of the Execution Date the actual knowledge of any member of the applicable Party's senior officers (after making reasonable inquiry of department or clinical service heads including the person responsible for environmental compliance, as applicable) actually and materially involved in any of the Contemplated Transaction.

21.1.52 **"Leased Real Property"** shall have the meaning set forth in Section 17.10.

21.1.53 "**Leases**" shall have the meaning set forth in Section 17.10.

21.1.54 "**Licenses and Permits**" shall have the meaning set forth in Section 17.7.1.

21.1.55 "**Material Adverse Change**" means any change, or event that could reasonably be expected to result in a change during any rolling 12-month period, in the assets, results of operation or the financial condition of a Party taken as a whole: (a) as to any reduction in the total net assets of the entity in an amount in the aggregate greater than ten percent of the Party's total net assets as reflected on the Party's interim unaudited balance sheet for the initial month of the 12-month period; (b) as to any change in the financial condition of the Party, has resulted in or is reasonably likely to result, on a normalized basis (i.e., after taking into account whether the effects of such change or event are reasonably likely to continue over such period), in a reduction in earnings before deductions for interest, taxes, depreciation and amortization of the Party ("EBITDA") and/or Net Revenue over the 12-month period ending in the month in which the change or event occurs, in an amount greater than ten percent of the Party's total net assets (as reflected on the Party's interim unaudited balance sheets for the initial month of that 12-month period); or (c) as to any capital expenditures greater than $5 million in the aggregate, other than the capital expenditures set forth on Schedule 21.1.55(c). Notwithstanding anything to the contrary, "Material Adverse Change" shall not include: (i) changes in the financial or operating performance of the Party due to or caused by the announcement of the Contemplated Transaction; (ii) changes or proposed changes to any law, reimbursement rates or policies of governmental agencies or bodies that are generally applicable to hospitals or healthcare facilities; or (iii) requirements, reimbursement rates, policies or procedures of third party payors or accreditation

commissions or organizations that are generally applicable to hospitals or healthcare facilities.

21.1.56 "**Material Adverse Effect**" means any fact, circumstance, event, change, effect, condition or occurrence that, individually or in the aggregate, has had or is reasonably likely to have a material adverse effect: (i) on the property or the condition of the asset owned as of the Closing Date by the Backus Entities; or (ii) on the ability of Backus to consummate the Contemplated Transaction or to perform its obligations under this Agreement, other than an effect resulting from one or more Excluded Matters.

21.1.57 "**Material Contracts**" shall mean the following: all contracts, leases (capital and operating), and other agreements entered into by or on behalf of any one or more of the Backus Entities or Hartford HealthCare, which are in effect as of the Execution Date and involve a material aspect of the operations of such entity, including, without limitation, the following, as applicable:

(a) any management contracts whereby Backus or Backus Hospital, or any of their officers or employees provide management services to other hospitals, educational, or other healthcare institutions and involving payment of more than $250,000 in the aggregate per year;

(b) all management or consulting agreements involving payment of more than $250,000 in the aggregate per year;

(c) all service contracts, shared service agreements, joint purchasing agreements, or similar agreements involving payment of more than $250,000 in the aggregate;

(d) all leases of space and/or equipment involving payment of more than $250,000 in the aggregate;

(e) all agreements for the sale or acquisition of capital assets involving payment of more than $250,000 in the aggregate;

(f) all service agreements and warranties with respect to assets of Backus Hospital involving payment of more than $250,000 in the aggregate;

(g) all installment payment agreements involving payment of more than $250,000 in the aggregate;

(h) all membership or other agreements with groups or entities, which engage in quality review or rate review procedures, involving payment of more than $250,000 in the aggregate;

(i) all agreements with third-party administrators involving payment of more than $250,000 in the aggregate;

(j) all membership or other agreements with groups formed to coordinate facilities or services planning involving payment of more than $250,000 in the aggregate;

(k) all affiliation and transfer agreements or contracts with educational institutions, other health care facilities, and government agencies involving payment of more than $250,000 in the aggregate;

(l) all supply agreements involving payment of more than $250,000 in the aggregate;

(m) all brokers' or finders' agreements involving payment of more than $250,000 in the aggregate;

(n) all agreements pursuant to which any department of a Backus Entity is operated under a lease arrangement;

(o) all joint venture agreements or shareholder agreements to which a Backus Entity is a party;

(p) all agreements or commitments related to physician hospital organizations (PHOs), medical services organizations (MSOs), physician networks, community care networks, integrated delivery networks, or other health care delivery systems or networks;

(q) all indemnity arrangements for officers, directors, members, shareholders, or advisory board members of Backus Hospital; and

(r) license and sublicense agreements with respect to any computer software and involving payment of more than $250,000 in the aggregate.

21.1.58 **"Material Dispute"** has the meaning set forth in Section 19.1.2.

21.1.59 **"Medical Staff Development Fund"** shall have the meaning set forth in Section 16.1.2.

21.1.60 "**Meet and Confer Request**" shall have the meaning set forth in Section 19.1.1.

21.1.61 "**MOU**" shall have the meaning set forth in the Recitals.

21.1.62 "**Owned Real Property**" shall have the meaning set forth in Section 17.10.

21.1.63 **"PBGC"** means the Pension Benefit Guaranty Corporation.

21.1.64 "**Party**" and "**Parties**" shall have the meanings set forth in the introductory paragraph of this Agreement.

21.1.65 "**Payment Programs**" shall have the meaning set forth in Section 17.16.

21.1.66 "**Real Property**" shall have the meaning set forth in Section 17.10.

21.1.67 "**Reserved Powers**" shall have the meaning set forth in Section 2.2.

21.1.68 "**Returns**" shall have the meaning set forth in Section 17.14.

21.1.69 "**Schedule**" shall mean any schedule required under this Agreement.

21.1.70 "**Shortfall**" shall have the meaning set forth in Section 3.3.4.

21.1.71 "**Strategic Plan**" shall have the meaning set forth in the Recitals.

21.1.72 "**Taxes**" means all federal, state, county, local and other taxes of every kind.

21.1.73 "**Termination Date**" shall have the meaning set forth in Section 9.1.1(a).

21.1.74 "**Transitional Period**" shall have the meaning set forth in Section 2.1.2(a).

21.1.75 "**Unwind**" shall have the meaning set forth in Section 2.2.5.

[signatures attached]

IN WITNESS WHEREOF, the Parties, acting through their duly authorized representatives, have executed this Affiliation Agreement as of the Execution Date.

HARTFORD HEALTHCARE CORPORATION

By: _____
Elliot Joseph
President and CEO

BACKUS CORPORATION

By: _____
Dave Whitehead
President and CEO

Signature Page to Affiliation Agreement

IN WITNESS WHEREOF, the Parties, acting through their duly authorized representatives, have executed this Affiliation Agreement as of the Execution Date.

HARTFORD HEALTHCARE CORPORATION

By: _____
Elliot Joseph
President and CEO

BACKUS CORPORATION

By: _____ 08/17/12
Dave Whitehead
President and CEO

Signature Page to Affiliation Agreement

LIST OF SCHEDULES & EXHIBITS

Schedule 1	Backus Entities
Schedule 2.1.2(a)(i)	Hartford-Appointed Directors
Schedule 2.1.2(a)(ii)	Post-Closing Backus and Backus Hospital Directors
Schedule 2.1.2(b)(i)	Backus-Appointed Directors
Schedule 2.1.2(b)(ii)	Hartford HealthCare Board Committees
Schedule 2.2.1	Backus Material Clinical Services
Schedule 10.1.3(b)	Backus Transactions Potentially Constituting a Material Adverse Change
Schedule 17.3.1	Backus Third Party Approvals
Schedule 17.3.2	Backus Governmental Approvals and Filings
Schedule 17.4.1	Backus Financial Statements
Schedule 17.4.2	Backus Financial Statement Disclosures
Schedule 17.4.3	Backus Accounting Disclosures
Schedule 17.4.4	Backus Liabilities
Schedule 17.4.5	Backus Donor-Restricted Funds
Schedule 17.4.6	Backus Pension Funds
Schedule 17.5	Backus Interim Changes
Schedule 17.6	Backus Legal Proceedings
Schedule 17.7.1	Backus Licenses and Permits
Schedule 17.9	Compliance with Law
Schedule 17.10	Backus Real Property
Schedule 17.10.3	Backus Environmental Laws
Schedule 17.12	Corporate Form and Tax Status of Certain Backus Entities
Schedule 17.13	Backus Insurance Policies
Schedule 17.14	Backus Taxes
Schedule 17.15.1	Backus Employee Benefit Plans
Schedule 17.16	Backus Payment Programs
Schedule 17.17	Backus Accreditations
Schedule 17.18	Backus Defaults
Schedule 17.19	Backus Exclusion from Health Care Programs
Schedule 18.3.1	Hartford HealthCare Third Party Approvals
Schedule 18.3.2	Hartford HealthCare Governmental Approvals
Schedule 18.5	Hartford HealthCare Compliance with Laws
Schedule 18.7	Hartford HealthCare Legal Proceedings
Schedule 21.1.55(c)	Backus Capital Expenditures Greater than $5 Million
Exhibit 1.1	Backus Amended and Restated Governing Documents
Exhibit 1.3	Schematics

1 Backus Entities

The William W. Backus Hospital
Backus Corporation
WWB Corporation
Backus Health Care, Inc.
CONNCare, Inc.
Backus Physician Services, LLC
Backus Medical Center Condominium Associates
Community Medical Partners, Inc.
Omni Home Health Services of Eastern Connecticut, LLC (d/b/a Backus Home Health Care)

Schedule 2.1.2(a)(i)

Hartford-Appointed Directors

To be determined prior to Closing.

2.1.2(a)(ii) Post-Closing Backus and Backus Hospital Directors*

BACKUS CORPORATION
and
THE WILLIAM W. BACKUS HOSPITAL

2011 - 2012

Officers

Chairman	Vacated
Vice Chairman	Anthony A. Joyce (2010)
President	David A. Whitehead
Secretary	Joseph A. Fatone (2007)
Treasurer	Robert T. Ramsdell (2010)

Board of Directors / Trustees

Term Expiring 2014	Term Expiring 2013	Term Expiring 2012
Stephen T. Briggs, M.D. (2011)	Elizabeth Conway (2005)	Vacated
Anthony Joyce (2008)	Joseph A. Fatone (1997)	John F. Bilda (2010)
Peter Wm. Maneri, Jr. (2010)	Lynne Quintal-Hill (2010)	Deborah Monahan (2010)
Paul C. Maxfield (2011)	Donna Romito, D.O. (2011)	Robert T. Ramsdell (2005)

Ex-officio: Bert A. Coppotelli, M.D. – President, Medical Staff
Mark Tramontozzi, M.D. – Vice President, Medical Staff
David A. Whitehead – President and CEO, Backus Corporation and WWBH

*This represents the current Backus and Backus Hospital Board of Directors/Trustees, but this is subject to change based on timing of the Closing.

Schedule 2.1.2(b)(i)

Backus-Appointed Directors

To be determined prior to Closing.

Schedule 2.1.2(b)(ii)

Hartford HealthCare Board Committees

1. Nominating and Governance (must be Backus-Appointed Director(s))
2. Audit and Compliance (must be the Backus-Appointed Director(s))
3. Finance
4. Quality and Safety
5. Investments
6. Pension
7. Strategic Planning & Community Benefit

2.2.1 Backus Material Clinical Services

Anesthesia
Backus Health Centers
Bariatrics
CardiologyCHF program
Critical Care Unit (CCU)
Dentistry
Dermatology
Diagnostic Imaging
Dialysis — Acute and Chronic
Emergency Department
Endocrinology
Family Medicine
Gastroenterology/Endoscopy
Home Health Care
Hospitalist Program
Internal Medicine
Interventional Radiology
Laboratory Services
LIFESTAR
Medical Foundation
Nephrology
Neurology
Newborn Nursery
Obstetrics/Gynecology
Occupational Medicine
Oncology
Opthalmology
Otolaryngology
Pain Management Clinic
Palliative Care
Pathology
Pediatrics
Pharmacy
Psychiatry
    Inpatient
    Partial Hospitalization Program
    Mental Health Center
Pulmonology
Radiation Therapy
Rehabilitation Services
Rheumatology
Stroke Center
Surgical Services
    General
    Bariatric
    Orthopaedic
    Plastic
    Neurologic
    Robotic
Trauma Center Level III
Urology
Wound Care/Hyperbaric Oxygen Therapy

10.1.3(b) Backus Transactions Potentially Constituting a Material Adverse Change

None.

17.3.1 Backus Third Party Approvals

Approval from Ambac Assurance Corporation, Assured Guarantee (FSA) and the Connecticut Health and Educational Facilities Authority is still pending.

17.3.2 Backus Governmental Approvals and Filings

None.

17.4.1 Backus Financial Statements

Attached are true and correct copies of the following financial statements:

17.4.1 (a)
The William W. Backus Hospital

Statement	Attachment Name
Audited statements for September 30, 2009	Item 17.4.1a Hospital Financials 2009
Audited statements for September 30, 2010	Item 17.4.1a Hospital Financials 2010
Audited statements for September 30, 2011	Item 17.4.1a Hospital Financials 2011

17.4.1 (a)
Backus Home Health Care

Statement	Attachment Name
Audited statements for September 30, 2011	Item 17.4.1a Backus Home Health Care Financials 2011
Audited statements for September 30, 2010	Item 17.4.1a Backus Home Health Care Financials 2010
Audited statements for September 30, 2009	Item 17.4.1a Backus Home Health Care Financials 2009

17.4.1 (b)
Backus Corporation and Subsidiaries

Statement	Attachment Name
Audited statements for September 30, 2009	Item 17.4.1b Consolidated Financials 2009
Audited statements for September 30, 2010	Item 17.4.1b Consolidated Financials 2010
Audited statements for September 30, 2011	Item 17.4.1b Consolidated Financials 2011

17.4.1 (c)
Backus Corporation and Subsidiaries

Statement	Attachment Name
The William W. Backus Hospital-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Condominium Assoc-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Corporation-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Health Care Inc-unaudited July 2012	Item 17.4.1c Entities July 2012
ConnCare Inc.-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Physician Services LLC-unaudited July 2012	Item 17.4.1c Entities July 2012
WWB Corp-unaudited July 2012	Item 17.4.1c Entities July 2012
Backus Home Health Care-unaudited July 2012	Item 17.4.1c Entities July 2012

Audited Financial Statements and Other Financial Information

The William W. Backus Hospital
Years Ended September 30, 2009 and 2008
With Report of Independent Auditors

The William W. Backus Hospital

Audited Financial Statements
and Other Financial Information

Years Ended September 30, 2009 and 2008

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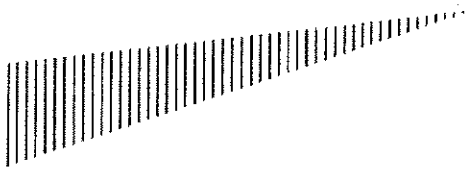

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors

The Board of Trustees
The William W. Backus Hospital

We have audited the accompanying balance sheets of The William W. Backus Hospital (the Hospital) as of September 30, 2009 and 2008, and the related statements of operations, changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Hospital's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The William W. Backus Hospital as of September 30, 2009 and 2008, and the results of its operations, changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 1, 2009

The William W. Backus Hospital

Balance Sheets

	September 30 2009	2008
Assets		
Current assets:		
Cash and cash equivalents	**$ 57,570,735**	$ 46,717,416
Assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
Accounts receivable, less allowance for uncollectible accounts (2009 – $20,629,000; 2008 – $15,610,000)	**36,111,295**	33,683,248
Due from affiliates	**3,901,924**	3,388,030
Inventories of supplies	**3,252,641**	1,923,318
Prepaid expenses and other	**925,340**	1,779,906
Total current assets	**109,002,747**	94,140,105
Assets whose use is limited:		
Board-designated investments	**44,500,233**	43,002,912
Held by trustee	**22,743,662**	18,156,456
Total assets whose use is limited	**67,243,895**	61,159,368
Less assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
	60,003,083	54,511,181
Interest in Foundation	**41,147,474**	39,032,937
Property, plant, and equipment, net	**98,131,132**	95,130,673
Deferred financing costs	**2,025,397**	2,118,397
Other assets	**1,801,751**	3,788,338
Total assets	**$ 312,111,584**	$ 288,721,631

	September 30	
	2009	**2008**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,508,835**	$ 9,994,419
Salaries and wages, payroll taxes, and taxes withheld from payroll	**8,205,022**	6,787,976
Other accrued liabilities	**6,325,794**	5,843,160
Due to third-party reimbursement agencies	**1,831,013**	1,270,638
Interest payable	**864,418**	880,518
Current portion of long-term debt	**1,825,000**	1,755,000
Total current liabilities	**29,560,082**	26,531,711
Other liabilities:		
Long-term debt – State of Connecticut Health and Educational Facilities Authority Revenue Bonds, less current portion	**63,931,536**	65,808,169
Employee related obligations	**84,442,697**	39,209,762
Self-insured professional liability	**10,580,762**	11,939,205
Due to third-party reimbursement agencies	**10,307,215**	3,892,438
Other	**667,654**	534,191
	169,929,864	121,383,765
Net assets:		
Unrestricted	**102,312,376**	132,409,920
Temporarily restricted	**3,447,432**	2,475,427
Permanently restricted	**6,861,830**	5,920,808
Total net assets	**112,621,638**	140,806,155
Total liabilities and net assets	**$ 312,111,584**	$ 288,721,631

See accompanying notes.

The William W. Backus Hospital

Statements of Operations

	Year Ended September 30	
	2009	**2008**
Operating revenues:		
Net patient service revenue	**$ 259,652,271**	$ 242,131,827
Other operating revenues	**4,213,341**	4,727,859
	263,865,612	246,859,686
Operating expenses:		
Salaries, wages, and professional fees	**112,184,033**	102,256,348
Payroll taxes and other fringe benefits	**27,425,902**	23,695,796
Supplies, insurance, and other	**74,547,698**	78,669,671
Provision for uncollectible accounts	**16,898,318**	14,162,003
Depreciation and amortization	**16,939,369**	16,453,137
Interest	**3,091,298**	3,003,005
	251,086,618	238,239,960
Operating income	**12,778,994**	8,619,726
Nonoperating gains and (losses):		
Income (loss) from investments	**2,799,208**	(4,802,633)
Change in value of swap		(843,514)
Other	**(366,280)**	201,183
Change in equity interest in net assets of Foundation	**(3,735,563)**	(167,456)
Excess of revenues over expenses	**$ 11,476,359**	$ 3,007,306

See accompanying notes.

The William W. Backus Hospital

Statements of Changes in Net Assets

	Total	Unrestricted	Temporarily Restricted	Permanently Restricted
Net assets, October 1, 2007	$ 163,733,063	$ 154,458,390	$ 2,945,255	$ 6,329,418
Excess of revenues over expenses	3,007,306	3,007,306		
Investment income	2,550		2,550	
Change in pension funding and postretirement obligation	(14,558,507)	(14,558,507)		
Change in equity interest in net unrealized losses of Foundation	(10,497,269)	(10,497,269)		
Change in equity interest in net assets of Foundation	(880,988)		(472,378)	(408,610)
Decrease in net assets	(22,926,908)	(22,048,470)	(469,828)	(408,610)
Net assets, September 30, 2008	140,806,155	132,409,920	2,475,427	5,920,808
Excess of revenues over expenses	**11,476,359**	**11,476,359**		
Investment income	**1,350**		**1,350**	
Effect of early measurement date elimination	**(1,762,428)**	**(1,762,428)**		
Change in pension funding and postretirement obligation	**(43,749,898)**	**(43,749,898)**		
Changes in equity interest in net unrealized gains of Foundation	**3,938,423**	**3,938,423**		
Change in equity interest in net assets of Foundation	**1,911,677**		**970,655**	**941,022**
(Decrease) increase in net assets	**(28,184,517)**	**(30,097,544)**	**972,005**	**941,022**
Net assets, September 30, 2009	**$ 112,621,638**	**$ 102,312,376**	**$ 3,447,432**	**$ 6,861,830**

See accompanying notes.

The William W. Backus Hospital

Statements of Cash Flows

	Year Ended September 30 2009	2008
Operating activities		
Decrease in net assets	**$ (28,184,517)**	$ (22,926,908)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**16,939,369**	16,453,137
Provision for uncollectible accounts	**16,898,318**	14,162,003
Effect of early measurement date elimination	**1,762,428**	
Change in pension funding and postretirement obligation	**43,749,898**	14,558,507
(Purchase) proceeds from sale of investments – board designated, net	**(1,497,321)**	1,409,265
Change in equity interest in net assets of Foundation	**(2,114,537)**	13,542,282
Changes in operating assets and liabilities *(Note 15)*	**(12,446,239)**	(17,206,997)
Net cash provided by operating activities	**35,107,399**	19,991,289
Investing activities		
Purchase of investments – held in trust, net	**(4,587,206)**	(1,279,461)
Net additions to property, plant, and equipment	**(18,720,156)**	(15,818,207)
Decrease (increase) in other assets	**859,915**	(504,083)
Net cash used in investing activities	**(22,447,447)**	(17,601,751)
Financing activities		
Principal payments on long-term debt	**(1,755,000)**	(815,000)
Change in deferred financing costs and amortization of bond premium	**(51,633)**	(127,164)
Net cash used in financing activities	**(1,806,633)**	(942,164)
Net increase in cash and cash equivalents	**10,853,319**	1,447,374
Cash and cash equivalents at beginning of year	**46,717,416**	45,270,042
Cash and cash equivalents at end of year	**$ 57,570,735**	$ 46,717,416

See accompanying notes.

The William W. Backus Hospital

Notes to Financial Statements

September 30, 2009

1. Significant Accounting Policies

Organization

The William W. Backus Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Backus Corporation (the sole member). The Board of Directors of Backus Corporation elects a Board of Trustees that has control of the operations of the Hospital. Refer to Note 7 for further discussion of related party transactions.

The financial statements include the operations of Backus Medical Center Condominium Association, Inc. (the Association). All intercompany transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

Cash Equivalents

The Hospital considers all highly liquid time deposits, commercial paper, and money market mutual funds purchased with a maturity at date of acquisition of three months or less to be cash equivalents.

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman, or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements of the Hospital. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority), as more fully explained in Note 6. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenues over expenses unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method), or market.

Property, Plant, and Equipment

Property, plant, and equipment are stated on the basis of cost. The Hospital provides for depreciation using the straight-line method in amounts sufficient to depreciate the cost of its assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

1. Significant Accounting Policies (continued)

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds, and changes in the equity interest in net assets of Backus Foundation, Inc. (the Foundation).

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions, which is included in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying financial statements.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for 2009 and for 2008. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues Over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in equity interest in net unrealized gains of Foundation, change in equity interest in net assets of Foundation, the change in pension funding and postretirement obligation changes in the fair value of the interest rate swap, and the effect of early measurement date elimination.

1. Significant Accounting Policies (continued)

Interest in Foundation

The interest in Foundation represents the Hospital's interest in the net assets of the Foundation. This investment is accounted for in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-20, *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises or Holds Contributions for Others.*

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Association is a taxable entity; however, any taxes are immaterial to the financial statements of the Hospital taken as a whole.

ASC 740-10, *Uncertain Tax Positions*, prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the financial statements is not significant.

Adoption of New Authoritative Pronouncements

In June 2009, FASB issued FASB ASC 105, *Generally Accepted Accounting Principles* (ASC 105), which establishes the FASB Accounting Standards Codification as the sole source of authoritative generally accepted accounting principles. Pursuant to the provisions of ASC 105, the Hospital has updated references to GAAP in its financial statements for the year ended September 30, 2009. The adoption of ASC 105 did not impact the Hospital's financial position or results of operations.

Effective 2009, the Hospital adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with GAAP, and expands disclosure about fair value measurements.

In 2009, the Hospital adopted ASC 825-10, *Fair Value Option*, which permits companies to choose to measure certain financial instruments and other items at fair value that are not currently required to be measured at fair value. The Hospital did not elect fair value accounting for any asset or liability not currently required to be measured at fair value.

1. Significant Accounting Policies (continued)

In June 2009, the Hospital adopted the provisions of ASC 855-10, *Subsequent Events*, which establishes standards of accounting for disclosure of events or transactions that occur after the balance sheet date, but before the financial statements are issued or available to be issued. ASC 855-10 is effective on a prospective basis for financial periods ended after June 15, 2009. The Hospital evaluated the impact of subsequent events through December 1, 2009, representing the date at which the financial statements were available to be issued. The adoption of ASC 855-10 in 2009 did not impact the Hospital's financial position or results of operations. Management evaluated subsequent events through December 1, 2009, the date the financial statements were available to be issued.

2. Revenues from Services to Patients and Charity Care

Net patient service revenue for the years ended September 30, 2009 and 2008 consists of the following:

	Year Ended September 30	
	2009	**2008**
Gross patient service revenue	**$ 560,641,054**	$ 512,314,357
Deductions:		
Allowances	**(294,073,379)**	(263,580,702)
Charity care (at charges)	**(6,915,404)**	(6,601,828)
	(300,988,783)	(270,182,530)
	$ 259,652,271	$ 242,131,827

Patient accounts receivable and revenues are recorded when patient services are performed. Differences between amounts received from most third-party payors and the established billing rates of the Hospital are accounted for as allowances.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $671,000 and $3,600 in 2009 and 2008, respectively.

2. Revenues from Services to Patients and Charity Care (continued)

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 7%, respectively, of the Hospital's net patient service revenue for the year ended September 30, 2009 and 30% and 6% for the year ended September 30, 2008. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

3. Charity Care

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Hospital does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Hospital's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,915,404**	**$ 3,042,778**
Bad debt	**16,898,318**	**7,435,260**
Total uncompensated care, September 30, 2009	**$ 23,813,722**	**$ 10,478,038**
Charity care	$ 6,601,828	$ 3,016,131
Bad debt	14,162,003	6,470,095
Total uncompensated care, September 30, 2008	$ 20,763,831	$ 9,486,226

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2009 and 2008:

	Year Ended September 30	
	2009	**2008**
Realized and unrealized gains (losses) on investments	**$ 1,621,546**	$ (5,689,835)
Interest and dividend income	**1,331,067**	1,352,412
Other investment income (loss)	**14,767**	(222,664)
Investment fees	**(168,172)**	(242,546)
	$ 2,799,208	$ (4,802,633)

The market value of assets whose use is limited at September 30 is set forth in the following table:

	2009	**2008**
Board designated:		
Cash and cash equivalents	**$ 16,508,452**	$ 16,123,886
Common stocks	**13,153,726**	11,361,170
Government bonds	**9,679,063**	12,538,088
Corporate bonds	**5,158,992**	2,979,768
	$ 44,500,233	$ 43,002,912
Held by trustee:		
Mutual funds	**$ 17,496,461**	$ 9,613,200
Cash and cash equivalents	**4,804,214**	8,096,731
Government bonds	**442,987**	446,525
	$ 22,743,662	$ 18,156,456

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which, among other things, provides guidance on the net asset classification of donor-restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

4. Investments (continued)

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift at the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Hospital's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Hospital's inflation-adjusted value over time. The Hospital's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The Investment Committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider expenditures based on need and current market conditions as well as long-term investment goals.

4. Investments (continued)

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets. The activity for the year ended September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$ 3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$ 4,841,631	$ 4,976,846

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2009	2008
Capital projects	**$ 1,548,434**	$ 933,829
Preventive care	**763,501**	778,537
Health care services	**414,281**	340,180
Other	**358,416**	66,956
Laboratory	**184,552**	181,410
Extraordinary nursing care	**97,635**	96,765
Nursing education	**70,948**	68,085
Free beds	**9,665**	9,665
	$ 3,447,432	$ 2,475,427

5. Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets at September 30 are restricted to the following:

	2009	2008
Income to be used:		
For general uses and purposes	**$ 6,018,245**	$ 5,077,223
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 6,861,830	$ 5,920,808

6. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2009	2008
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,630,000) from 2010 to 2012, with interest rates ranging from 4.60% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 9,145,000**	$ 9,640,000
Series F, serial maturities ($7,300,000) from 2010 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**29,425,000**	30,100,000
Series G, serial maturities ($18,960,000) from 2010 to 2026, with interest rates of 3.25% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5%	**26,380,000**	26,965,000
	64,950,000	66,705,000
Add net unamortized bond premium	**806,536**	858,169
Less current portion	**(1,825,000)**	(1,755,000)
Long-term debt	**$ 63,931,536**	$ 65,808,169

6. Long-Term Debt (continued)

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital, and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets, and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principal and interest on the Series E, Series F and Series G bonds.

Series E bonds maturing on or after July 1, 2008 are subject to redemption prior to maturity. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015 are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015 are subject to optional redemption prior to maturity.

Future minimum principal payments during each of the next five fiscal years, and in the aggregate, are as follows:

2010	$ 1,825,000
2011	1,895,000
2012	1,965,000
2013	2,045,000
2014	2,120,000
Aggregate thereafter	55,100,000
	64,950,000
Less current portion	1,825,000
Add net unamortized bond premium	806,536
	$ 63,931,536

The Hospital paid interest of $3,158,024 and $2,706,703 in 2009 and 2008, respectively. Interest incurred in 2009 and 2008 was $3,091,298 and $3,003,005, respectively.

In June 2008 the Hospital remarketed its Series F bonds, converting them from a variable auction rate to a fixed rate. As a result, the swap associated with the original bond issue, which was intended to effectively fix the interest rate paid on the bonds, was terminated. The change in the value of the swap presented in the statement of operations at September 30, 2008 of $(843,514) reflects the change in the fair value of the swap plus the reclassification of prior deferrals.

7. Related Party Transactions

Amounts due from affiliates at September 30, 2009 and 2008 includes advances to Backus Properties of approximately $1,720,000 and $1,883,000 for building improvements and property acquisitions during 2009 and 2008, respectively. Amounts due from the Foundation include monies in support of charity care and Hospital programs of approximately $43,000 and $93,000 for 2009 and 2008, respectively. In addition, the Hospital processes payroll and disbursements for several of its affiliated entities for which it is reimbursed. Reimbursements due to the Hospital at September 30, 2009 and 2008 were approximately $668,000 and $760,000, respectively.

The Hospital has unconditionally guaranteed full and prompt payment and performance of all liabilities of an affiliate organization to the lessor for a term of twenty years. The maximum potential amount of future payments includes lease payments for the first ten years of $2,095,890. Payments over the remaining term of the lease are based on a future interest rate that is not yet determinable. There are no recourse provisions available to the Hospital upon breach of contract by the affiliate.

Subsequent to year end, Backus Foundation Inc. and Backus Properties Inc. (Properties) will cease to exist as separate entities and all assets, liabilities, equity and operations will merge into the Hospital. The merger of the Foundation will not impact net assets as it is currently accounted for under ASC 958-20 as described in Note 1. The merger of Properties will result in an increase in unrestricted net assets of approximately $1,400,000.

8. Retirement Benefit Plans

The Hospital maintains a noncontributory defined benefit pension plan covering substantially all of its employees. The Hospital also provides noncontributory postretirement health care benefits to eligible retirees and eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsors a nonqualified pension benefit program. Included in long-term liabilities at September 30, 2009 and 2008 is approximately $3,600,000 and $850,000, respectively, related to the future obligation for the nonqualified benefits.

Effective January 1, 2010, the Hospital will amend its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants. Management anticipates that the change in the pension plan will result in a reduction of the unfunded liability of approximately $35 million. It is the Hospital's intention to establish a defined contribution plan concurrent with the amendment of the defined benefit plan.

8. Retirement Benefit Plans (continued)

Effective October 1, 2008, the Hospital adopted ASC 715-20, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, which requires elimination of the early measurement date of the plans.

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2009	2008	2009	2008
	(In thousands)			
Unrecognized actuarial (loss) gain	$ (67,240)	$ (26,335)	$ 1,249	$ 2,223
Unrecognized prior service cost	(15)	(19)		
Unrecognized transition obligation			(1,213)	(1,617)
	$ (67,255)	$ (26,354)	$ 36	$ 606

The prior service cost, actuarial (loss) gain and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2010 are $3,323, $5,129,108 and $323,491, respectively.

At September 30, 2008, the unfunded status of the pension plan is included in long-term liabilities in the amount of $30,206,752. The unfunded status of the postretirement benefits is $5,045,761, with $479,175 included in short-term liabilities, and the remainder of $4,566,586 included in long-term liabilities. At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities.

8. Retirement Benefit Plans (continued)

The following table sets forth the funded status of the plans as of the measurement date of September 30 in 2009 and June 30 in 2008 for each plan and amounts recognized in the Hospital's balance sheets at September 30. In 2008, contributions made subsequent to the measurement date, but prior to September 30, reduced the accrued benefit liability.

	Pension Benefits		Postretirement Benefits	
	2009	2008	2009	2008
	(In thousands)			
Change in projected benefit obligation				
Benefit obligation at beginning of year	$ (133,189)	$ (124,809)	$ (5,156)	$ (5,524)
Service cost	(4,484)	(4,620)	(22)	(30)
Interest cost	(9,002)	(7,986)	(338)	(334)
Change in assumptions	(38,217)	5,256	(558)	134
Actuarial (loss) gain	(2,156)	(4,249)	382	199
Effect of early measurement date elimination	11,740		295	
Benefits paid	3,477	3,219	428	399
Benefit obligation at end of year	$ (171,831)	$ (133,189)	$ (4,969)	$ (5,156)
Change in plan assets				
Fair value of plan assets at beginning of year	$ 100,957	$ 102,625		
Actual return on plan assets	2,662	(7,224)		
Effect of early measurement date elimination	(8,097)			
Contributions	8,100	8,775	$ 428	$ 399
Benefits paid	(3,477)	(3,219)	(428)	(399)
Fair value of plan assets at end of year	$ 100,145	$ 100,957	$	$
Reconciliation of underfunded status				
Underfunded status	$ (71,686)	$ (32,232)	$ (4,969)	$ (5,156)
Contribution subsequent to measurement date		2,025		111
Accrued benefit liability recognized in the balance sheets	$ (71,686)	$ (30,207)	$ (4,969)	$ (5,045)
Components of net periodic benefit cost				
Service cost	$ 4,484	$ 4,620	$ 22	$ 30
Interest cost	9,002	7,986	338	334
Expected return on plan assets	(7,605)	(8,417)		
Net amortization and deferral	1,129	3	(541)	(260)
Net periodic benefit cost	$ 7,010	$ 4,192	$ (181)	$ 104

8. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2009	2008	2009	2008
	(In thousands)			
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.60%**	6.50%	**5.60%**	6.50%
Rate of compensation increase	**5.00**	5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**7.25**	6.25	**7.25**	6.25
Expected long-term rate of return on plan assets	**8.00**	8.00		
Rate of compensation increase	**5.00**	5.00		

The expected long-term rate of return on plan assets was determined by the expected return on each asset class based on a model that considers historical and expected future performance.

The accumulated benefit obligation at September 30, 2009 and 2008 was $137,279,286 and $107,697,366, respectively.

The asset allocations for the retirement plan at the end of 2009 and 2008 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	Minimum	Maximum	2009	2008
US Equity Large Cap	35%	45%	**27%**	34%
US Equity Small Cap		10	**4**	5
International Equity	17	27	**17**	19
Core Fixed Income	25	35	**52**	42
Real estate		6		
Total			**100%**	100%

8. Retirement Benefit Plans (continued)

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2010	$ 8,100,000	$ 462,097
Estimated future benefit payments:		
2010	4,462,917	462,097
2011	4,982,416	464,756
2012	5,495,548	472,761
2013	6,025,576	481,792
2014	6,719,521	481,673
2015-2019	46,736,124	2,066,165

Assumed healthcare cost trend rates for 2009 are as follows:	
Health care trend rate assumed for next year	8.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 2	$ (2)
Effect on postretirement benefit obligation	$ 26	$ (22)

9. Property, Plant, and Equipment

Property, plant, and equipment at September 30 consist of the following:

	2009	2008
Land and land improvements	**$ 2,408,486**	$ 2,373,312
Buildings and leasehold improvements	**109,893,844**	102,370,729
Equipment	**95,975,645**	86,262,740
Construction in process (2009 estimated cost to complete $6,900,000)	**4,251,661**	4,429,799
Less accumulated depreciation	**(114,398,504)**	(100,305,907)
	$ 98,131,132	$ 95,130,673

Included in construction in progress at September 30, 2009 are $1,280,000 of internally developed software costs. The Hospital wrote off approximately $1,426,000 of fully depreciated assets in 2009.

In 2004, the Hospital began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2009 and 2008 was $705,436 and $667,384, respectively.

The Hospital leases various types of equipment with annual payments ranging from $103 to $119,064. Expenses as a result of these leases were approximately $478,000 and $928,000 for the years ended September 30, 2009 and 2008, respectively.

The Hospital also leases various properties from a related party. Rent expense for those leases totaled approximately $644,000 and $610,000 for the years ended September 30, 2009 and 2008, respectively. As described in Note 7, the related party will be merged with the Hospital for years beginning in 2010. As a result, no lease payments to that related party are included in the future minimum payments listed below. However, leases between the related party and unrelated lessors are included.

9. Property, Plant, and Equipment (continued)

Future minimum lease payments under the above leases during each of the next five years were as follows:

2010	$ 1,233,982
2011	1,042,391
2012	775,265
2013	748,603
2014	145,161
Aggregate thereafter	1,102,588
	$ 5,047,990

10. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of accounts receivable, net of contractual allowances, from patients and third-party payors at September 30 is as follows:

	2009	**%**	**2008**	**%**
Medicare	**$ 14,223,122**	**25%**	$ 12,265,855	25%
Medicaid	**4,685,984**	**8**	3,166,368	6
Anthem Blue Cross/Blue Shield	**7,989,343**	**14**	8,128,274	16
Health Maintenance Organizations	**9,452,755**	**17**	7,671,571	16
Commercial	**2,776,338**	**5**	3,140,618	6
Self pay	**13,430,756**	**24**	11,688,493	24
Other state agencies	**4,182,234**	**7**	3,231,784	7
	56,740,532	**100%**	49,292,963	100%
Less allowance for uncollectible accounts	**20,629,237**		15,609,715	
	$ 36,111,295		$ 33,683,248	

11. Contingencies

There have been malpractice claims that fall within the Hospital's partially self-insured program (see Note 1) which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2009 that may result in the assertion of claims. Hospital management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

11. Contingencies (continued)

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position or results of operations.

12. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2009	**2008**
Cafeteria sales	**$ 1,049,650**	$ 989,415
Grants	**642,728**	630,810
Rental income	**568,148**	482,704
Interest	**476,907**	1,505,928
Condominium income	**440,047**	306,803
Miscellaneous	**424,282**	326,336
Child care	**336,700**	350,051
Purchase discounts	**274,879**	135,812
	$ 4,213,341	$ 4,727,859

13. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2009	**2008**
Health care services	**$ 188,561,536**	$ 180,224,412
General and administrative	**62,525,082**	58,015,548
	$ 251,086,618	$ 238,239,960

Costs for interest and insurance are included in general and administrative expenses. Malpractice insurance is included in health care services.

14. Fair Value of Financial Instruments

On October 1, 2008, the Hospital adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Financial assets as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 57,570,735			$ 57,570,735
Assets whose use is limited	67,243,895			67,243,895

The carrying amount of certain of the Hospital's financial instruments, including cash and cash equivalents, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at fiscal year end. The fair value of long-term debt is $68,087,973 and $65,336,934 at September 30, 2009 and 2008, respectively.

15. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2009	2008
Increase in assets:		
Accounts receivable	**$ (19,326,365)**	$ (17,003,287)
Due from affiliates	**(513,894)**	(1,144,405)
Inventories of supplies, prepaid expenses, and other	**(474,757)**	(25,215)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**6,975,152**	2,676,010
Accounts payable	**514,416**	(3,105,471)
Employee related obligations	**(279,391)**	(3,431,132)
Interest payable and other accrued liabilities	**466,534**	(15,500)
Salaries and wages, payroll taxes, and taxes withheld from payroll	**1,417,046**	1,264,820
Self-insured professional liability	**(1,358,443)**	3,297,056
Other liabilities	**133,463**	280,127
Changes in operating assets and liabilities	**$ (12,446,239)**	$ (17,206,997)

Other Financial Information

ERNST & YOUNG

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Trustees
The William W. Backus Hospital

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Ernst & Young LLP

December 1, 2009

The William W. Backus Hospital

Consolidating Balance Sheet

September 30, 2009

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 57,570,735			$ 57,570,735
Assets whose use is limited – required for current liabilities	7,240,812			7,240,812
Accounts receivable, less allowance for uncollectible accounts	36,111,295			36,111,295
Due from affiliates	3,901,924			3,901,924
Inventories of supplies	3,252,641			3,252,641
Prepaid expenses and other	905,576	$ 19,764		925,340
Total current assets	108,982,983	19,764		109,002,747
Assets whose use is limited:				
Board-designated investments	44,500,233			44,500,233
Held by trustee	22,743,662			22,743,662
Total assets whose use is limited	67,243,895			67,243,895
Less assets whose use is limited – required for current liabilities	7,240,812			7,240,812
	60,003,083			60,003,083
Interest in Foundation	41,147,474			41,147,474
Property, plant, and equipment, net	98,131,132			98,131,132
Deferred financing costs	2,025,397			2,025,397
Other assets	1,801,751			1,801,751
Total assets	$ 312,091,820	$ 19,764		$ 312,111,584

The William W. Backus Hospital

Consolidating Balance Sheet (continued)

September 30, 2009

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable -- trade	$ 10,508,835			$ 10,508,835
Salaries and wages, payroll taxes, and taxes withheld from payroll	8,205,022			8,205,022
Other accrued liabilities	6,324,099	$ 1,695		6,325,794
Due to third-party reimbursement agencies	1,831,013			1,831,013
Interest payable	864,418			864,418
Current portion of long-term debt	1,825,000			1,825,000
Total current liabilities	29,558,387	1,695		29,560,082
Other liabilities:				
Long-term debt, less current portion	63,931,536			63,931,536
Employee related obligations	84,442,697			84,442,697
Self-insured professional liability	10,580,762			10,580,762
Due to third-party reimbursement agencies	10,307,215			10,307,215
Other	667,654			667,654
	169,929,864			169,929,864
Net assets:				
Unrestricted	102,294,307	18,069		102,312,376
Temporarily restricted	3,447,432			3,447,432
Permanently restricted	6,861,830			6,861,830
Total net assets	112,603,569	18,069		112,621,638
Total liabilities and net assets	$ 312,091,820	$ 19,764		$ 312,111,584

The William W. Backus Hospital

Consolidating Statement of Operations

Year Ended September 30, 2009

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Operating revenues:				
Net patient service revenue	$ 259,652,271			$ 259,652,271
Other operating revenues	3,773,294	$ 482,183	$ (42,136)	4,213,341
	263,425,565	482,183	(42,136)	263,865,612
Operating expenses:				
Salaries, wages, and professional fees	112,184,033			112,184,033
Payroll taxes and other fringe benefits	27,425,902			27,425,902
Supplies, insurance, and other	74,107,651	482,183	(42,136)	74,547,698
Provision for uncollectible accounts	16,898,318			16,898,318
Depreciation and amortization	16,939,369			16,939,369
Interest	3,091,298			3,091,298
	250,646,571	482,183	(42,136)	251,086,618
Operating income	12,778,994			12,778,994
Nonoperating gains and (losses):				
Income from investments	2,799,208			2,799,208
Other	(366,280)			(366,280)
Change in equity interest in net assets of Foundation	(3,735,563)			(3,735,563)
Excess of revenues over expenses	$ 11,476,359			$ 11,476,359

Audited Financial Statements and Other Financial Information

The William W. Backus Hospital
Years Ended September 30, 2010 and 2009
With Report of Independent Auditors

The William W. Backus Hospital

Audited Financial Statements
and Other Financial Information

Years Ended September 30, 2010 and 2009

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
The William W. Backus Hospital

We have audited the accompanying balance sheets of The William W. Backus Hospital (the Hospital) as of September 30, 2010 and 2009, and the related statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Hospital's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The William W. Backus Hospital as of September 30, 2010 and 2009, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Balance Sheets

	September 30	
	2010	**2009**
Assets		
Current assets:		
Cash and cash equivalents	**$ 72,131,779**	$ 57,570,735
Assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
Accounts receivable, less allowance for uncollectible accounts (2010 – $20,081,000; 2009 – $20,629,000)	**30,758,941**	36,111,295
Pledges receivable	**185,866**	
Due from affiliates	**661,088**	3,901,924
Inventories of supplies	**3,799,896**	3,252,641
Prepaid expenses and other	**1,277,144**	925,340
Total current assets	**116,746,304**	109,002,747
Assets whose use is limited:		
Board-designated investments	**96,626,409**	44,500,233
Held by trustee	**26,988,802**	22,743,662
Total assets whose use is limited	**123,615,211**	67,243,895
Less assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
	115,683,621	60,003,083
Interest in Foundation		41,147,474
Property, plant, and equipment, net	**99,122,387**	98,131,132
Deferred financing costs	**1,933,364**	2,025,397
Other assets	**1,603,864**	1,801,751
Total assets	**$ 335,089,540**	$ 312,111,584

	September 30	
	2010	**2009**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,129,146**	$ 10,508,835
Salaries and wages, payroll taxes, and taxes withheld from payroll	**6,206,054**	8,205,022
Other accrued liabilities	**8,213,638**	6,325,794
Due to third-party reimbursement agencies	**2,614,222**	1,831,013
Interest payable	**754,026**	864,418
Current portion of long-term debt	**2,032,691**	1,825,000
Total current liabilities	**29,949,777**	29,560,082
Other liabilities:		
Long-term debt	**64,591,831**	63,931,536
Employee related obligations	**57,973,203**	84,442,697
Self-insured professional liability	**10,514,332**	10,580,762
Due to third-party reimbursement agencies	**12,767,632**	10,307,215
Other	**349,678**	667,654
	146,196,676	169,929,864
Net assets:		
Unrestricted	**147,366,124**	102,312,376
Temporarily restricted	**4,101,543**	3,447,432
Permanently restricted	**7,475,420**	6,861,830
Total net assets	**158,943,087**	112,621,638
Total liabilities and net assets	**$ 335,089,540**	$ 312,111,584

See accompanying notes.

The William W. Backus Hospital

Statements of Operations

	Year Ended September 30	
	2010	**2009**
Operating revenues:		
Net patient service revenue	**$ 270,048,715**	$ 259,652,271
Other operating revenues	**4,673,356**	4,213,341
Net assets released from restriction	**91,211**	
	274,813,282	263,865,612
Operating expenses:		
Salaries, wages, and professional fees	**109,179,026**	112,184,033
Payroll taxes and other fringe benefits	**27,181,443**	27,425,902
Supplies, insurance, and other	**91,056,415**	74,547,698
Provision for uncollectible accounts	**14,409,876**	16,898,318
Depreciation and amortization	**17,480,126**	16,939,369
Interest	**3,185,038**	3,091,298
	262,491,924	251,086,618
Operating income	**12,321,358**	12,778,994
Nonoperating gains and (losses):		
Income from investments	**6,218,347**	2,799,208
Contributions	**328,840**	
Other	**(116,761)**	(366,280)
Change in equity interest in net assets of Foundation		(3,735,563)
Excess of revenues over expenses	**$ 18,751,784**	$ 11,476,359

See accompanying notes.

The William W. Backus Hospital

Statements of Changes in Net Assets

	Total	Unrestricted	Temporarily Restricted	Permanently Restricted
Net assets, September 30, 2008	$ 140,806,155	$ 132,409,920	$ 2,475,427	$ 5,920,808
Excess of revenues over expenses	11,476,359	11,476,359		
Investment income	1,350		1,350	
Effect of early measurement date elimination	(1,762,428)	(1,762,428)		
Change in pension funding and postretirement obligation	(43,749,898)	(43,749,898)		
Changes in equity interest in net unrealized gains of Foundation	3,938,423	3,938,423		
Change in equity interest in net assets of Foundation	1,911,677		970,655	941,022
(Decrease) increase in net assets	(28,184,517)	(30,097,544)	972,005	941,022
Net assets, September 30, 2009	112,621,638	102,312,376	3,447,432	6,861,830
Excess of revenues over expenses	**18,751,784**	**18,751,784**		
Investment income	**739,782**		**618,691**	**121,091**
Curtailment gain	**34,536,288**	**34,536,288**		
Change in pension funding and postretirement obligation	**(9,564,206)**	**(9,564,206)**		
Transfer to affiliates	**(73,056)**	**(73,056)**		
Merger of Properties	**1,402,938**	**1,402,938**		
Contributions	**484,695**		**126,631**	**358,064**
Change in net assets held in trust	**134,435**			**134,435**
Net assets released from restriction	**(91,211)**		**(91,211)**	
Increase in net assets	**46,321,449**	**45,053,748**	**654,111**	**613,590**
Net assets, September 30, 2010	**$ 158,943,087**	**$ 147,366,124**	**$ 4,101,543**	**$ 7,475,420**

See accompanying notes.

The William W. Backus Hospital

Statements of Cash Flows

	Year Ended September 30 2010	2009
Operating activities		
Increase (decrease) in net assets	**$ 46,321,449**	$ (28,184,517)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,480,126**	16,939,369
Provision for uncollectible accounts	**14,409,876**	16,898,318
Curtailment gain	**(34,536,288)**	
Effect of early measurement date elimination		1,762,428
Change in pension funding and postretirement obligation	**9,564,206**	43,749,898
Transfer to affiliates	**73,056**	
Merger of Properties	**(1,402,938)**	
Purchase of investments – board designated, net	**(15,613,572)**	(1,497,321)
Permanently restricted contributions and income	**(613,590)**	
Change in equity interest in net assets of Foundation		(2,114,537)
Changes in operating assets and liabilities *(Note 16)*	**(9,177,820)**	(12,446,239)
Net cash provided by operating activities	**26,504,505**	35,107,399
Investing activities		
Purchase of investments – held in trust, net	**(1,917,827)**	(4,587,206)
Net additions to property, plant, and equipment	**(12,056,041)**	(18,720,156)
(Increase) decrease in other assets	**(72,956)**	859,915
Cash transfer from merger	**2,226,244**	
Net cash used in investing activities	**(11,820,580)**	(22,447,447)
Financing activities		
Proceeds from loan	**1,250,000**	
Principal payments on long-term debt and capital lease obligations	**(1,863,950)**	(1,755,000)
Change in deferred financing costs and amortization of bond premium	**(49,465)**	(51,633)
Permanently restricted contributions and income	**613,590**	
Transfer to affiliates	**(73,056)**	
Net cash used in financing activities	**(122,881)**	(1,806,633)
Net increase in cash and cash equivalents	**14,561,044**	10,853,319
Cash and cash equivalents at beginning of year	**57,570,735**	46,717,416
Cash and cash equivalents at end of year	**$ 72,131,779**	$ 57,570,735

See accompanying notes.

The William W. Backus Hospital

Notes to Financial Statements

September 30, 2010

1. Significant Accounting Policies

Organization

The William W. Backus Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Backus Corporation (the sole member). The Board of Directors of Backus Corporation elects a Board of Trustees that has control of the operations of the Hospital. Refer to Note 9 for further discussion of related party transactions.

The financial statements include the operations of Backus Medical Center Condominium Association, Inc. (the Association). All intercompany transactions have been eliminated in consolidation.

Merger

Effective November 1, 2009, Backus Foundation, Inc. and Backus Properties Inc. were merged into the Hospital. The merger was accounted for as a "pooling of interests". The accompanying financial statements reflect the consolidated assets, liabilities and net assets of the three entities at September 30, 2010 and the revenue, expenses and changes in net assets for the entire fiscal year. The merger of the Foundation had no impact on net assets because the Foundation was previously accounted for in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-20, *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises of Holds Contributions for Others* and as such, the 2009 presentation would not be materially different. The merger of Properties increased unrestricted net assets by approximately $1,400,000 in 2010.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Cash Equivalents

The Hospital considers all highly liquid time deposits, commercial paper, and money market mutual funds purchased with a maturity at date of acquisition of three months or less to be cash equivalents.

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman, or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements of the Hospital. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority), as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenues over expenses unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method), or market.

Property, Plant, and Equipment

Property, plant, and equipment are stated on the basis of cost. The Hospital provides for depreciation using the straight-line method in amounts sufficient to depreciate the cost of its assets over their estimated useful lives.

1. Significant Accounting Policies (continued)

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions, which is included in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying financial statements.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for both 2010 and for 2009. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues Over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include pension curtailment gains, equity transfers from affiliates, both temporarily and permanently restricted donations and investment income, changes in perpetual trust arrangements, changes in equity interest in net unrealized gains of Foundation, change in equity interest in net assets of Foundation, the change in pension funding and postretirement obligation and the effect of early measurement date elimination.

1. Significant Accounting Policies (continued)

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Association is a taxable entity; however, any taxes are immaterial to the financial statements of the Hospital taken as a whole.

ASC 740-10, *Uncertain Tax Positions*, prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the financial statements is not significant.

Adoption of New Authoritative Pronouncements

Effective 2010, the Hospital adopted ASC 715-20, *Retirement Benefits*, which requires additional disclosures relating to defined benefit pension plans, including additional fair value disclosures for pension assets.

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which is delayed until 2011, the guidance in ASU 2010-06 becomes effective for reporting periods beginning after December 15, 2009. Management is currently evaluating the effect that the provisions of ASU 2010-06 will have on the consolidated financial statements.

1. Significant Accounting Policies (continued)

Reclassifications

Certain reclassifications were made to the 2009 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Net patient service revenue for the years ended September 30, 2010 and 2009 consists of the following:

	Year Ended September 30	
	2010	**2009**
Gross patient service revenue	**$ 585,390,725**	$ 560,641,054
Deductions:		
Allowances	**(308,845,388)**	(294,073,379)
Charity care (at charges)	**(6,496,622)**	(6,915,404)
	(315,342,010)	(300,988,783)
	$ 270,048,715	$ 259,652,271

Patient accounts receivable and revenues are recorded when patient services are performed. Differences between amounts received from most third-party payors and the established billing rates of the Hospital are accounted for as allowances.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates had no impact on net patient service revenue for 2010, and increased net patient service revenue by approximately $671,000 in 2009.

2. Revenues from Services to Patients and Charity Care (continued)

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 8%, respectively, of the Hospital's net patient service revenue for the year ended September 30, 2010 and 28% and 7% for the year ended September 30, 2009. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

3. Charity Care

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Hospital does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Hospital's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,496,622**	**$ 2,858,514**
Bad debt	**14,409,876**	**6,340,345**
Total uncompensated care, September 30, 2010	**$ 20,906,498**	**$ 9,198,859**
Charity care	$ 6,915,404	$ 3,042,778
Bad debt	16,898,318	7,435,260
Total uncompensated care, September 30, 2009	$ 23,813,722	$ 10,478,038

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2010
BackusCare campaign	$ 185,114
Other	7,077
Unconditional promises to give before unamortized discount	192,191
Less unamortized discount and allowance	(6,325)
	$ 185,866
Amounts due in:	
Less than one year	$ 133,366
One to five years	52,500
Total	$ 185,866

5. Investments

Investment income and gains are comprised of the following for the years ended September 30:

	2010	2009
Realized and unrealized gains on investments	**$ 4,574,175**	$ 1,621,546
Interest and dividend income	**1,813,339**	1,331,067
Other investment income	**11,600**	14,767
Investment fees	**(180,767)**	(168,172)
	$ 6,218,347	$ 2,799,208

5. Investments (continued)

The market value of assets whose use is limited at September 30 is set forth in the following table:

	2010	2009
Board designated:		
Mutual funds	**$ 38,540,722**	$ -
Cash and cash equivalents	**33,837,100**	16,508,452
Common stocks	**13,327,371**	13,153,726
Government bonds	**8,462,882**	9,679,063
Corporate bonds	**2,458,334**	5,158,992
	$ 96,626,409	$ 44,500,233
Held by trustee:		
Mutual funds	**$ 22,211,515**	$ 17,496,461
Cash and cash equivalents	**4,430,958**	4,804,214
Common stock	**287,581**	
Real estate	**58,748**	
Government bonds		442,987
	$ 26,988,802	$ 22,743,662

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which, among other things, provides guidance on the net asset classification of donor-restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift at the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

5. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Hospital's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Hospital's inflation-adjusted value over time. The Hospital's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The Investment Committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets.

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

5. Investments (continued)

The activity for the year ended September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$ 3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$ 4,841,631	$ 4,976,846

6. Fair Value of Financial Instruments

On October 1, 2008, the Hospital adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 75,157,255	$ 2,738		$ 75,159,993
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)			$ 58,751	58,751
Total	$ 160,542,096	$ 35,146,143	$ 58,751	$ 195,746,990

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Real Estate (REIT)
Beginning balance	-
Purchases	$ 54,286
Unrealized gains	4,465
Total	$ 58,751

Financial assets as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 57,578,855			$ 57,578,855
Certificates of deposit		$ 4,815,074		4,815,074
Money market funds	14,207,293			14,207,293
US government obligations	9,075,929			9,075,929
Corporate bonds		8,487,292		8,487,292
Equity securities	13,153,726			13,153,726
Mutual funds	17,496,461			17,496,461
Total	$ 111,512,264	$ 13,302,366		$ 124,814,630

6. Fair Value of Financial Instruments (continued)

The carrying amount of certain of the Hospital's financial instruments, including cash and cash equivalents and pledge receivables approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Hospital's fiscal year end. The fair value of long-term debt is $69,437,056 and $68,087,973 at September 30, 2010 and 2009, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2010	2009
Capital projects	**$ 1,733,950**	$ 1,548,434
Preventive care	**792,377**	763,501
Other	**626,772**	358,416
Health care services	**499,200**	414,281
Laboratory	**228,659**	184,552
Extraordinary nursing care	**109,852**	97,635
Nursing education	**84,912**	70,948
Free beds	**25,821**	9,665
	$ 4,101,543	$ 3,447,432

Permanently restricted net assets at September 30 are restricted to the following:

	2010	2009
Income to be used:		
For general uses and purposes	**$ 6,631,835**	$ 6,018,245
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,475,420	$ 6,861,830

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2010	2009
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,110,000) from 2011 to 2012, with interest rates ranging from 4.75% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,625,000**	$ 9,145,000
Series F, serial maturities ($6,600,000) from 2011 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,725,000**	29,425,000
Series G, serial maturities ($18,355,000) from 2011 to 2026, with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5%	**25,775,000**	26,380,000
Other long-term debt:		
Mortgage, maturing May 1, 2025 with a fixed interest rate of 6.125%	**1,236,586**	
Obligations under capital leases	**1,505,864**	
	65,867,450	64,950,000
Add net unamortized bond premium	**757,072**	806,536
Less current portion	**(2,032,691)**	(1,825,000)
Long-term debt	**$ 64,591,831**	$ 63,931,536

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital, and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets, and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principal and interest on the Series E, Series F and Series G bonds.

8. Long-term Debt (continued)

Series E bonds maturing on or after July 1, 2008 are subject to redemption prior to maturity. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015 are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015 are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years, and in the aggregate, are as follows:

	Long-Term Debt	Capital Leases
2011	$ 1,948,410	$ 386,104
2012	2,021,619	386,104
2013	2,105,440	386,104
2014	2,184,302	386,104
2015	2,303,411	355,554
Aggregate thereafter	53,798,404	2,375,136
	64,361,586	4,275,106
Add net unamortized bond premium	757,072	
Less interest		(2,769,242)
	$ 65,118,658	$ 1,505,864

The Hospital paid interest of $3,323,608 and $3,158,024 in 2010 and 2009, respectively. Interest incurred in 2010 and 2009 was $3,185,038 and $3,091,298, respectively.

In 2010 the Hospital entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

In 2010 the Hospital also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2010 was $441,720. Under the terms of the lease, the Hospital has the option to renew for five periods for five years each.

Deferred financing costs are amortized over a period consistent with the life of the bonds.

9. Related Party Transactions

The Hospital processes payroll and disbursements for several of its affiliated entities for which it is reimbursed. Reimbursements due to the Hospital at September 30, 2010 and 2009 were approximately $647,000 and $668,000, respectively. Amounts due from affiliates at September 30, 2009 include advances to Backus Properties of approximately $1,720,000 for building improvements and property acquisitions during 2009. Amounts due from the Foundation include monies in support of charity care and Hospital programs of approximately $43,000 for 2009. Amounts due the Hospital from Backus Properties and the Foundation were eliminated upon the merger of those entities as described in Note 1.

10. Retirement Benefit Plans

Effective January 1, 2010, the Hospital amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Hospital will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Hospital will also make a non-elective transition contribution equal to 3% of employee's eligible earnings for all employees who meet the transition participant criteria. The Hospital may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the year ended September 30, 2010 is $3,589,500.

The Hospital also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsored a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2010 and 2009 is approximately $2,600,000 and $3,600,000, respectively, related to the future obligation for the nonqualified benefits.

10. Retirement Benefit Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2010	2009	2010	2009
	(In thousands)			
Unrecognized actuarial (loss) gain	**$ (43,157)**	$ (67,240)	**$ 1,734**	$ 1,249
Unrecognized prior service cost		(15)		
Unrecognized transition obligation			**(889)**	(1,213)
	$ (43,157)	$ (67,255)	**$ 845**	$ 36

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2011 are $2,743,736 and $323,491, respectively.

At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities. At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities.

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2010 and 2009.

	Pension Benefits		Postretirement Benefits	
	2010	2009	2010	2009
	(In thousands)			
Change in projected benefit obligation				
Benefit obligation at beginning of year	**$ (171,831)**	$ (133,189)	**$ (4,969)**	$ (5,156)
Service cost	**(1,836)**	(4,484)	**(15)**	(22)
Interest cost	**(7,684)**	(9,002)	**(267)**	(338)
Change in assumptions	**(11,951)**	(38,217)	**387**	(558)
Actuarial (loss) gain	**(3,598)**	(2,156)	**154**	382
Effect of curtailment	**34,551**			
Effect of early measurement date elimination		11,740		295
Benefits paid	**4,083**	3,477	**444**	428
Benefit obligation at end of year	**$ (158,266)**	$ (171,831)	**$ (4,266)**	$ (4,969)

10. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
		(In thousands)		
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,145**	$ 100,957		
Actual return on plan assets	**10,017**	2,662		
Effect of early measurement date elimination		(8,097)		
Contributions	**8,124**	8,100	**$ 444**	$ 428
Benefits paid	**(4,083)**	(3,477)	**(444)**	(428)
Fair value of plan assets at end of year	**$ 114,203**	$ 100,145	**$**	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	**$ (44,063)**	$ (71,686)	**$ (4,266)**	$ (4,969)
Components of net periodic benefit cost				
Service cost	**$ 1,836**	$ 4,484	**$ 15**	$ 22
Interest cost	**7,684**	9,002	**267**	338
Expected return on plan assets	**(6,901)**	(7,605)		
Net amortization and deferral	**1,964**	1,129	**269**	(541)
Net periodic benefit cost	**$ 4,583**	$ 7,010	**$ 551**	$ (181)
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.10%**	5.60%	**5.10%**	5.60%
Rate of compensation increase		5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.60**	7.25	**5.60**	7.25
Expected long-term rate of return on plan assets	**6.75**	8.00		
Rate of compensation increase	**5.00**	5.00		

The accumulated benefit obligation at September 30, 2010 and 2009 was $158,266,226 and $137,279,286, respectively.

10. Retirement Benefit Plans (continued)

The asset allocations for the retirement plan at the end of 2010 and 2009 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	**Minimum**	**Maximum**	**2010**	**2009**
US Equity Large Cap	20%	50%	**31%**	27%
US Equity Small Cap		15	**5**	4
International Equity	10	30	**17**	17
Core Fixed Income	20	60	**47**	52
Total			**100%**	100%

The following table presents the Hospital Plan's fair value hierarchy for those assets measured at fair value as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity(b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category invests primarily in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital by investing at least 80% in international equity securities.
(c) This category seeks maximum current income by investing primarily in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

10. Retirement Benefit Plans (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ -	$ -	$ -
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

The Hospital Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Hospital Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2011	$ 8,100,000	$ 452,466
Estimated future benefit payments:		
2011	5,057,112	452,466
2012	5,586,022	439,761
2013	6,060,768	433,204
2014	6,598,072	424,838
2015	7,158,748	401,741
2016-2020	43,816,630	1,669,284

10. Retirement Benefit Plans (continued)

Assumed healthcare cost trend rates for 2010 are as follows:	
Health care trend rate assumed for next year	8.00%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (2)
Effect on postretirement benefit obligation	$ 9	$ (7)

11. Property, Plant, and Equipment

Property, plant, and equipment at September 30 consist of the following:

	2010	2009
Land and land improvements	**$ 4,889,512**	$ 2,408,486
Buildings and leasehold improvements	**125,274,358**	109,893,844
Equipment	**101,055,036**	95,975,645
Construction in process (2010 estimated cost to complete $4,601,400)	**630,806**	4,251,661
Less accumulated depreciation	**(132,727,325)**	(114,398,504)
	$ 99,122,387	$ 98,131,132

Unamortized internally developed software costs totaled $968,970 and $1,280,233 at September 30, 2010 and 2009, respectively. Amortization expense for the years ended September 30, 2010 and 2009 was $591,171 and $213,372, respectively.

The Hospital wrote off approximately $853,000 of fully depreciated assets in 2010.

11. Property, Plant, and Equipment (continued)

In 2004, the Hospital began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2010 and 2009 was $640,018 and $705,436, respectively.

The Hospital leases various types of equipment with annual payments ranging from $103 to $55,600. Expenses as a result of these leases were approximately $375,000 and $478,000 for the years ended September 30, 2010 and 2009, respectively.

Prior to the merger described in Note 1, the Hospital leased various properties from a related party. Rent expense for those leases totaled approximately $644,000 for the year ended September 30, 2009. Leases with unrelated parties previously held by the related party were assumed by the Hospital.

Future minimum lease payments under the above leases during each of the next five years were as follows:

2011	$ 935,358
2012	726,417
2013	718,648
2014	137,725
2015	65,380
	$ 2,583,528

12. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross accounts receivable from patients and third-party payors at September 30 is as follows:

	2010	2009
Medicare	**27%**	25%
Self pay	**24**	24
Health Maintenance Organizations	**15**	17
Anthem Blue Cross/Blue Shield	**14**	14
Medicaid	**10**	8
Commercial	**5**	5
Other state agencies	**5**	7
	100%	100%

13. Contingencies

There have been malpractice claims that fall within the Hospital's partially self-insured program (see Note 1) which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2010 that may result in the assertion of claims. Hospital management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position or results of operations.

14. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2010	**2009**
Rental income	**$ 1,222,133**	$ 568,148
Cafeteria sales	**1,063,020**	1,049,650
Grants	**733,844**	642,728
Condominium income	**389,640**	440,047
Miscellaneous	**361,626**	424,282
Child care	**355,497**	336,700
Purchase discounts	**351,343**	274,879
Interest	**196,253**	476,907
	$ 4,673,356	$ 4,213,341

15. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2010	**2009**
Health care services	**$ 213,627,999**	$ 202,673,597
General and administrative	**48,673,060**	48,413,021
Fundraising	**190,865**	
	$ 262,491,924	$ 251,086,618

Costs for interest and insurance are included in general and administrative expenses. Malpractice insurance is included in health care services.

16. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2010	2009
(Increase) decrease in assets:		
Accounts receivable	**$ (9,057,522)**	$ (19,326,365)
Collection on pledges	**348,127**	
Due from affiliates	**(141,929)**	(513,894)
Inventories of supplies, prepaid expenses, and other	**(783,378)**	(474,757)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**3,243,626**	6,975,152
Accounts payable	**(421,931)**	514,416
Employee related obligations	**(1,497,412)**	(279,391)
Interest payable and other accrued liabilities	**1,523,472**	466,534
Salaries and wages, payroll taxes, and taxes withheld from payroll	**(1,998,968)**	1,417,046
Self-insured professional liability	**(66,430)**	(1,358,443)
Other liabilities	**(325,475)**	133,463
Changes in operating assets and liabilities	**$ (9,177,820)**	$ (12,446,239)

Noncash investing and financing activities include the following:

Trusts acquired in merger of Foundation	$ 2,327,313
Net property acquired in merger of Properties	$ 5,593,682
Capital lease acquired in merger of Properties	$ 1,072,619
Capital lease	$ 458,781

17. Subsequent Events

Management evaluated subsequent events through December 2, 2010, the date the financial statements were issued.

Other Financial Information

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Trustees
The William W. Backus Hospital

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Consolidating Balance Sheet

September 30, 2010

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 72,131,779			$ 72,131,779
Assets whose use is limited – required for current liabilities	7,931,590			7,931,590
Accounts receivable, less allowance for uncollectible accounts	30,758,941			30,758,941
Pledges receivable	185,866			185,866
Due from affiliates	647,255	$ 13,833		661,088
Inventories of supplies	3,799,896			3,799,896
Prepaid expenses and other	1,271,686	5,458		1,277,144
Total current assets	116,727,013	19,291		116,746,304
Assets whose use is limited:				
Board-designated investments	96,626,409			96,626,409
Held by trustee	26,988,802			26,988,802
Total assets whose use is limited	123,615,211			123,615,211
Less assets whose use is limited – required for current liabilities	7,931,590			7,931,590
	115,683,621			115,683,621
Property, plant, and equipment, net	99,122,387			99,122,387
Deferred financing costs	1,933,364			1,933,364
Other assets	1,603,864			1,603,864
Total assets	$ 335,070,249	$ 19,291		$ 335,089,540

The William W. Backus Hospital

Consolidating Balance Sheet (continued)

September 30, 2010

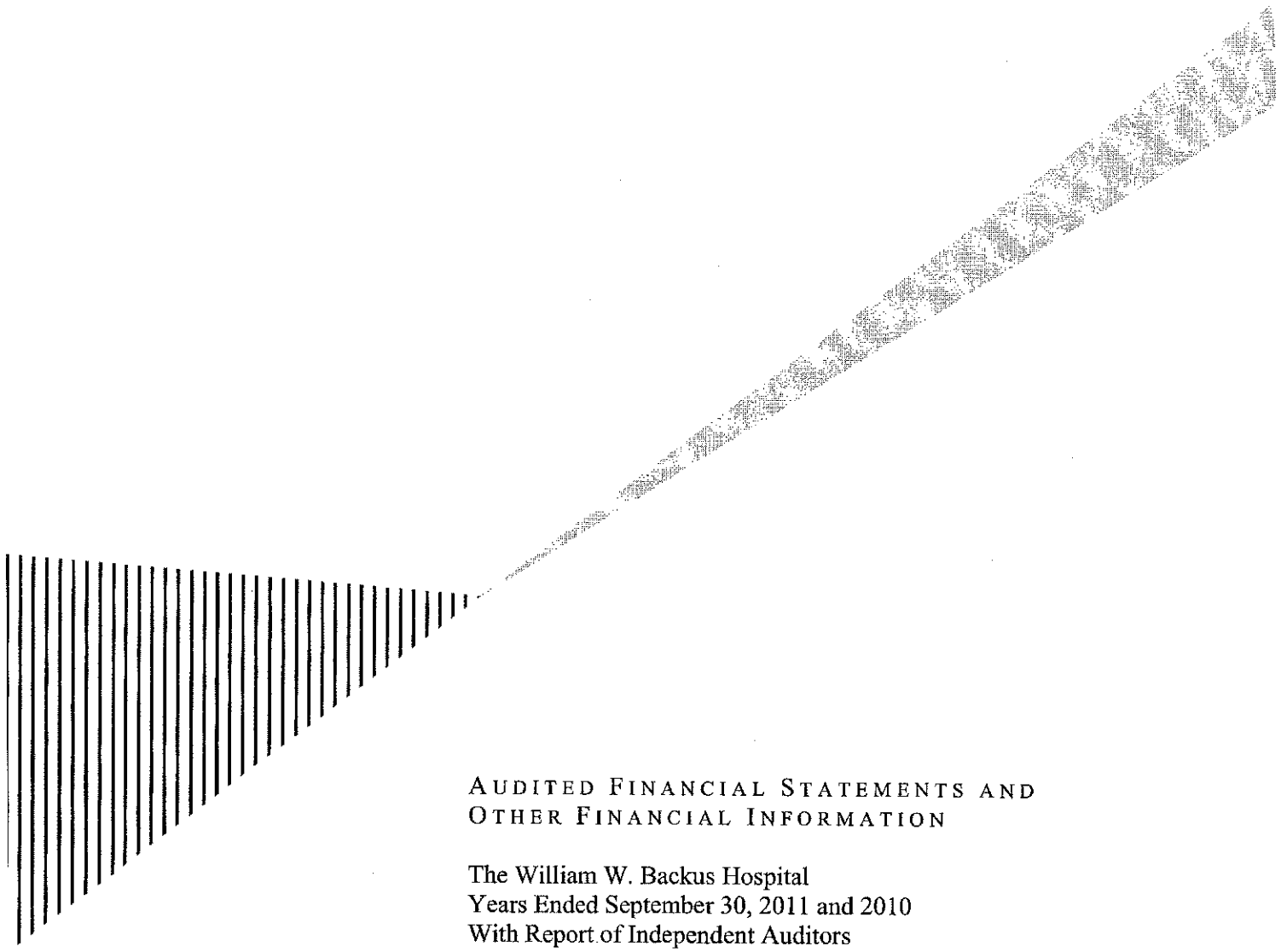
	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable – trade	$ 10,129,146			$ 10,129,146
Salaries and wages, payroll taxes, and taxes withheld from payroll	6,206,054			6,206,054
Other accrued liabilities	8,212,416	$ 1,222		8,213,638
Due to third-party reimbursement agencies	2,614,222			2,614,222
Interest payable	754,026			754,026
Current portion of long-term debt	2,032,691			2,032,691
Total current liabilities	29,948,555	1,222		29,949,777
Other liabilities:				
Long-term debt, less current portion	64,591,831			64,591,831
Employee related obligations	57,973,203			57,973,203
Self-insured professional liability	10,514,332			10,514,332
Due to third-party reimbursement agencies	12,767,632			12,767,632
Other	349,678			349,678
	146,196,676			146,196,676
Net assets:				
Unrestricted	147,348,055	18,069		147,366,124
Temporarily restricted	4,101,543			4,101,543
Permanently restricted	7,475,420			7,475,420
Total net assets	158,925,018	18,069		158,943,087
Total liabilities and net assets	$ 335,070,249	$ 19,291		$ 335,089,540

The William W. Backus Hospital

Consolidating Statement of Operations

Year Ended September 30, 2010

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Operating revenues:				
Net patient service revenue	$ 270,048,715			$ 270,048,715
Other operating revenues	4,283,716	$ 414,529	$ (24,889)	4,673,356
Net assets released from restriction	91,211			91,211
	274,423,642	414,529	(24,889)	274,813,282
Operating expenses:				
Salaries, wages, and professional fees	109,179,026			109,179,026
Payroll taxes and other fringe benefits	27,181,443			27,181,443
Supplies, insurance, and other	90,666,775	414,529	(24,889)	91,056,415
Provision for uncollectible accounts	14,409,876			14,409,876
Depreciation and amortization	17,480,126			17,480,126
Interest	3,185,038			3,185,038
	262,102,284	414,529	(24,889)	262,491,924
Operating income	12,321,358			12,321,358
Nonoperating gains and (losses):				
Income from investments	6,218,347			6,218,347
Contributions	328,840			328,840
Other	(116,761)			(116,761)
Excess of revenues over expenses	$ 18,751,784			$ 18,751,784



Audited Financial Statements and Other Financial Information

The William W. Backus Hospital
Years Ended September 30, 2011 and 2010
With Report of Independent Auditors

Ernst & Young LLP

Ernst & Young

The William W. Backus Hospital

Audited Financial Statements
and Other Financial Information

Years Ended September 30, 2011 and 2010

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
The William W. Backus Hospital

We have audited the accompanying balance sheets of The William W. Backus Hospital (the Hospital) as of September 30, 2011 and 2010, and the related statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Hospital's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The William W. Backus Hospital as of September 30, 2011 and 2010, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Balance Sheets

	September 30	
	2011	**2010**
Assets		
Current assets:		
Cash and cash equivalents	**$ 93,136,217**	$ 72,131,779
Assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
Accounts receivable, less allowance for uncollectible accounts (2011 – $21,200,000; 2010 – $20,081,000)	**32,373,122**	30,758,941
Pledges receivable	**101,211**	185,866
Due from affiliates	**164,147**	661,088
Inventories of supplies	**3,704,067**	3,799,896
Prepaid expenses and other	**1,624,606**	1,277,144
Total current assets	**136,988,852**	116,746,304
Assets whose use is limited:		
Board-designated investments	**105,438,402**	96,626,409
Held by trustee	**28,078,427**	26,988,802
Total assets whose use is limited	**133,516,829**	123,615,211
Less assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
	127,631,347	115,683,621
Property, plant, and equipment, net	**89,983,664**	99,122,387
Deferred financing costs	**1,842,330**	1,933,364
Other assets	**1,542,292**	1,603,864
Total assets	**$ 357,988,485**	$ 335,089,540

	September 30	
	2011	**2010**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 9,918,459**	$ 10,129,146
Salaries and wages, payroll taxes, and taxes withheld from payroll	**6,666,138**	6,206,054
Other accrued liabilities	**4,999,447**	8,213,638
Employee related obligations	**3,942,900**	3,589,500
Due to third-party reimbursement agencies	**4,683,178**	2,614,222
Interest payable	**734,838**	754,026
Current portion of long-term debt	**2,115,360**	2,032,691
Total current liabilities	**33,060,320**	33,539,277
Other liabilities:		
Long-term debt	**62,389,713**	64,591,831
Employee related obligations	**69,884,879**	54,383,703
Self-insured professional liability	**10,853,762**	10,514,332
Due to third-party reimbursement agencies	**19,162,526**	12,767,632
Other	**443,183**	349,678
	162,734,063	142,607,176
Net assets:		
Unrestricted	**153,345,431**	147,366,124
Temporarily restricted	**1,399,547**	4,101,543
Permanently restricted	**7,449,124**	7,475,420
Total net assets	**162,194,102**	158,943,087
Total liabilities and net assets	**$ 357,988,485**	$ 335,089,540

See accompanying notes.

The William W. Backus Hospital

Statements of Operations

	Year Ended September 30	
	2011	**2010**
Operating revenues:		
Net patient service revenue	**$ 271,933,218**	$ 270,048,715
Other operating revenues	**4,848,198**	4,673,356
Net assets released from restriction	**673,194**	91,211
	277,454,610	274,813,282
Operating expenses:		
Salaries, wages, and professional fees	**110,169,857**	109,179,026
Payroll taxes and other fringe benefits	**25,655,346**	27,181,443
Supplies, insurance, and other	**83,918,758**	91,056,415
Provision for uncollectible accounts	**12,522,978**	14,409,876
Depreciation and amortization	**16,971,187**	17,480,126
Interest	**3,247,715**	3,185,038
	252,485,841	262,491,924
Operating income	**24,968,769**	12,321,358
Nonoperating gains and (losses):		
Income from investments	**581,947**	6,218,347
Contributions	**158,300**	328,840
Other	**(565,873)**	(116,761)
Excess of revenues over expenses	**$ 25,143,143**	$ 18,751,784

See accompanying notes.

The William W. Backus Hospital

Statements of Changes in Net Assets

	Total	Unrestricted	Temporarily Restricted	Permanently Restricted
Net assets, September 30, 2009	$ 112,621,638	$ 102,312,376	$ 3,447,432	$ 6,861,830
Excess of revenues over expenses	18,751,784	18,751,784		
Investment income	739,782		618,691	121,091
Curtailment gain	34,536,288	34,536,288		
Change in pension funding and postretirement obligation	(9,564,206)	(9,564,206)		
Transfer to affiliates	(73,056)	(73,056)		
Merger of Properties	1,402,938	1,402,938		
Contributions	484,695		126,631	358,064
Change in net assets held in trust	134,435			134,435
Net assets released from restriction	(91,211)		(91,211)	
Increase in net assets	46,321,449	45,053,748	654,111	613,590
Net assets, September 30, 2010	158,943,087	147,366,124	4,101,543	7,475,420
Excess of revenues over expenses	**25,143,143**	**25,143,143**		
Investment (loss) income	**(275,296)**		**(346,369)**	**71,073**
Change in pension funding and postretirement obligation	**(21,176,691)**	**(21,176,691)**		
Transfer to affiliates	**(245,005)**	**(245,005)**		
Contributions	**580,427**		**575,427**	**5,000**
Change in net assets held in trust	**(102,369)**			**(102,369)**
Net assets released from restriction used for purchase of equipment	**2,257,860**	**2,257,860**		
Net assets released from restriction	**(2,931,054)**		**(2,931,054)**	
Increase (decrease) in net assets	**3,251,015**	**5,979,307**	**(2,701,996)**	**(26,296)**
Net assets, September 30, 2011	**$ 162,194,102**	**$ 153,345,431**	**$ 1,399,547**	**$ 7,449,124**

See accompanying notes.

The William W. Backus Hospital

Statements of Cash Flows

	Year Ended September 30 2011	2010
Operating activities		
Increase in net assets	**$ 3,251,015**	$ 46,321,449
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**16,971,187**	17,480,126
Provision for uncollectible accounts	**12,522,978**	14,409,876
Curtailment gain		(34,536,288)
Change in pension funding and postretirement obligation	**21,176,691**	9,564,206
Transfer to affiliates	**245,005**	73,056
Merger of Properties		(1,402,938)
Purchase of investments – board designated, net	**(8,811,993)**	(15,613,572)
Permanently restricted contributions and income	**26,296**	(613,590)
Changes in operating assets and liabilities *(Note 16)*	**(13,216,508)**	(9,177,820)
Net cash provided by operating activities	**32,164,671**	26,504,505
Investing activities		
Purchase of investments – held in trust, net	**(1,089,625)**	(1,917,827)
Net additions to property, plant, and equipment	**(7,741,430)**	(12,056,041)
Decrease (increase) in other assets	**61,572**	(72,956)
Cash transfer from merger		2,226,244
Net cash used in investing activities	**(8,769,483)**	(11,820,580)
Financing activities		
Proceeds from loan		1,250,000
Principal payments on long-term debt and capital lease obligations	**(2,074,347)**	(1,863,950)
Change in deferred financing costs and amortization of bond premium	**(45,102)**	(49,465)
Permanently restricted contributions and income	**(26,296)**	613,590
Transfer to affiliates	**(245,005)**	(73,056)
Net cash used in financing activities	**(2,390,750)**	(122,881)
Net increase in cash and cash equivalents	**21,004,438**	14,561,044
Cash and cash equivalents at beginning of year	**72,131,779**	57,570,735
Cash and cash equivalents at end of year	**$ 93,136,217**	$ 72,131,779

See accompanying notes.

The William W. Backus Hospital

Notes to Financial Statements

September 30, 2011

1. Significant Accounting Policies

Organization

The William W. Backus Hospital (the Hospital), a voluntary association incorporated under the General Statutes of the State of Connecticut, is a wholly-owned subsidiary of Backus Corporation (the sole member). The Board of Directors of Backus Corporation elects a Board of Trustees that has control of the operations of the Hospital. Refer to Note 9 for further discussion of related party transactions.

The financial statements include the operations of Backus Medical Center Condominium Association, Inc. (the Association). All intercompany transactions have been eliminated in consolidation.

Merger

Effective November 1, 2009, Backus Foundation, Inc. and Backus Properties Inc. were merged into the Hospital. The merger was accounted for as a "pooling of interests". The merger of the Foundation had no impact on net assets because the Foundation was previously accounted for in accordance with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-20, *Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises of Holds Contributions for Others* . The merger of Properties increased unrestricted net assets by approximately $1,400,000 in 2010.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Department of Public Health, Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Cash Equivalents

The Hospital considers all highly liquid time deposits, commercial paper, and money market mutual funds purchased with a maturity at date of acquisition of three months or less to be cash equivalents.

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman, or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements of the Hospital. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority), as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenues over expenses unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method), or market.

Property, Plant, and Equipment

Property, plant, and equipment are stated on the basis of cost. The Hospital provides for depreciation using the straight-line method in amounts sufficient to depreciate the cost of its assets over their estimated useful lives.

1. Significant Accounting Policies (continued)

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions, which is included in other operating revenue. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying financial statements.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $5,000,000 annually for 2011 and $4,000,000 for 2010. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues Over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include pension curtailment gains, equity transfers from affiliates, both temporarily and permanently restricted donations and investment income, changes in perpetual trust arrangements and the change in pension funding and postretirement obligations.

1. Significant Accounting Policies (continued)

Income Taxes

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Association is a taxable entity; however, any taxes are immaterial to the financial statements of the Hospital taken as a whole.

Adoption of New Authoritative Pronouncements

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which will be effective for the Hospital's fiscal 2012, the guidance in ASU 2010-06 became effective for the Hospital's fiscal 2011. The adoption of the provisions of ASU 2010-06 did not impact the Hospital's consolidated financial statements.

In January 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions*, (ASU 2010-07), which establishes accounting and disclosure requirements for how a not-for-profit entity determines whether a combination is a merger or an acquisition, how to account for each, and the required disclosures. In addition, ASU 2010-07 included amendments to FASB's Accounting Standards Codification (the Codification, or ASC) Topic 350, *Intangibles – Goodwill and Other*, (ASC Topic 350), and Topic 810, *Consolidation*, (ASC Topic 810) to make both applicable to not-for-profit entities. ASC Topic 350 clarifies the accounting for goodwill and indefinite-lived identifiable intangible assets recognized in a not-for-profit entity's acquisition of a business or nonprofit activity. Such assets are not amortized and are tested for impairment at least annually. The Hospital adopted the guidance relative to ASU 2010-07 as of October 1, 2010.

1. Significant Accounting Policies (continued)

In August 2010, the FASB issued Accounting Standards Codification ("ASC") 954-605, *Measuring Charity Care for Disclosure.* ASC 954-605 requires that the level of charity care provided be presented based on the direct and indirect costs of the charity services provided. ASC 954-605 also requires separate disclosure of the amount of any cash reimbursements received for providing charity care. ASC 954-605 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Hospital is evaluating the effect of ASC 954-605 on its consolidated financial statements.

In August 2010, the FASB also issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries.* Under ASU 2010-24, anticipated insurance recoveries and estimated liabilities for medical malpractice claims or similar contingent liabilities will be presented separately on the balance sheet. The guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Hospital is evaluating the effect of ASU 2010-24 on its consolidated financial statements.

In July 2011, FASB issued new guidance, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts.* The guidance requires certain health care entities to present the bad debt expense associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense. The guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. The Hospital is evaluating the effect of the new guidance on its consolidated financial statements.

Reclassifications

Certain reclassifications were made to the 2010 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Net patient service revenue for the years ended September 30, 2011 and 2010 consists of the following:

	Year Ended September 30	
	2011	**2010**
Gross patient service revenue	**$ 604,060,585**	$ 585,390,725
Deductions:		
Allowances	**(327,123,232)**	(308,845,388)
Charity care (at charges)	**(5,004,135)**	(6,496,622)
	(332,127,367)	(315,342,010)
	$ 271,933,218	$ 270,048,715

Patient accounts receivable and revenues are recorded when patient services are performed. Differences between amounts received from most third-party payors and the established billing rates of the Hospital are accounted for as allowances.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $2,065,000 in 2011 and had no impact on net patient service revenue for 2010.

Revenues from the Medicare and Medicaid programs accounted for approximately 27.5% and 9.5%, respectively, of the Hospital's net patient service revenue for the year ended September 30, 2011 and 28% and 8% for the year ended September 30, 2010. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations, except as noted in Note 13. While no regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital.

3. Charity Care

The Hospital provides services without charge, or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Hospital does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Hospital's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following table summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 5,004,135**	**$ 2,201,819**
Bad debt	**12,522,978**	**5,510,110**
Total uncompensated care, September 30, 2011	**$ 17,527,113**	**$ 7,711,929**
Charity care	$ 6,496,622	$ 2,858,514
Bad debt	14,409,876	6,340,345
Total uncompensated care, September 30, 2010	$ 20,906,498	$ 9,198,859

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2011	2010
BackusCare campaign	**$ 45,546**	$ 185,114
Other	**57,077**	7,077
Unconditional promises to give before unamortized discount	**102,623**	192,191
Less unamortized discount and allowance	**(1,412)**	(6,325)
	$ 101,211	$ 185,866
Amounts due in:		
Less than one year	**$ 96,211**	$ 133,366
One to five years	**5,000**	52,500
Total	**$ 101,211**	$ 185,866

5. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30:

	2011	2010
Realized and unrealized (losses) gains on investments	**$ (1,163,661)**	$ 4,574,175
Interest and dividend income	**1,959,569**	1,813,339
Other investment income	**12,600**	11,600
Investment fees	**(226,561)**	(180,767)
	$ 581,947	$ 6,218,347

5. Investments (continued)

The market value of assets whose use is limited at September 30 is set forth in the following table:

	2011	2010
Board designated:		
Cash and cash equivalents	**$ 41,525,574**	$ 33,837,100
Mutual funds	**37,251,516**	38,540,722
Common stocks	**12,925,056**	13,327,371
Government bonds	**12,811,596**	8,462,882
Corporate bonds	**924,660**	2,458,334
	$105,438,402	$ 96,626,409
Held by trustee:		
Cash and cash equivalents	**$ 24,668,758**	$ 4,430,958
Mutual funds	**2,327,261**	22,211,515
Government bonds	**731,506**	
Common stock	**292,470**	287,581
Real estate	**58,432**	58,748
	$ 28,078,427	$ 26,988,802

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) provides guidance on investment decisions and endowment expenditures for nonprofit organizations. The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift at the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

5. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Hospital's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Hospital's inflation-adjusted value over time. The Hospital's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The Investment Committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets. Any deficits are funded with available temporarily restricted or unrestricted funds so as to maintain the corpus. Subsequent positive market returns replace the deficits.

The activity for the year ended September 30, 2011 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 513,486	$ 5,320,786	$ 5,834,272
Investment return:			
Investment income		151,536	151,536
Net depreciation (realized and unrealized)		(176,945)	(176,945)
Earnings reclassified	(96,482)	96,482	
Total investment (loss) return	(96,482)	71,073	(25,409)
Contributions		5,000	5,000
Endowment net assets at end of year	$ 417,004	$ 5,396,859	$ 5,813,863

5. Investments (continued)

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

6. Fair Value of Financial Instruments

For assets and liabilities required to be measured at fair value, the Hospital measures fair value based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are applied based on the unit of account from the Hospital's perspective. The unit of account determines what is being measured by reference to the level at which the asset or liability is aggregated (or disaggregated) for purposes of applying other accounting pronouncements.

The Hospital follows a valuation hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad categories. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Fair value for Level 2 assets are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers. Level 3 assets consist of asset backed and mortgage backed obligations held by the defined benefit plan which are priced using model-based valuations using market information that best represents the value at which the security could be sold.

6. Fair Value of Financial Instruments (continued)

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Hospital uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

Financial assets as of September 30, 2011 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 95,941,634	$ 852,014		$ 96,793,648
Certificates of deposit		24,901,139		24,901,139
Money market funds	37,571,306	64,456		37,635,762
US government obligations (a)	10,833,829	2,709,273		13,543,102
Corporate bonds (b)	249,858	674,802		924,660
Equity securities	13,217,526			13,217,526
Mutual funds-equities (c)	8,773,825	9,707,473		18,481,298
Mutual funds-international equities (d)	8,140,798	219,147		8,359,945
Mutual funds-fixed income (e)	12,062,082	675,452		12,737,534
Real estate (REIT)		58,432		58,432
Total	$ 186,790,858	$ 39,862,188	–	$ 226,653,046

(a) Includes both Treasury bonds and Treasury stripped bonds.
(b) Includes both foreign and domestic corporate bonds.
(c) This category primarily represents investments in common stock or similar securities of high-quality, financially secure companies listed on principal exchanges.
(d) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(e) This category seeks maximum current income primarily thorough investments in fixed income securities of varying maturities.

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 75,157,255	$ 2,738		$ 75,159,993
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)		58,751		58,751
Total	$ 160,542,096	$ 35,204,894	–	$ 195,746,990

The following table presents the Hospital's fair value hierarchy for defined benefit plan assets as of September 30, 2011. At September 30, 2011, Level 3 assets comprise approximately 0.2% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 10,173,248			$ 10,173,248
Mutual funds-equity (a)	23,965,541	$ 25,514,446		49,479,987
Mutual funds-international equity(b)	22,103,407			22,103,407
Mutual funds-fixed income (c)	9,739,453	38,850		9,778,303
US Government obligations(d)	6,277,919	319,903		6,597,822
Corporate bonds (e)		9,553,768		9,553,768
Mortgage backed obligations		7,777,727	$180,660	7,958,387
Total	$ 72,259,568	$ 43,204,694	$ 180,660	$ 115,644,922

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily thorough investments in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

6. Fair Value of Financial Instruments (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2010 to September 30, 2011.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ 250,065	$ 88,920	$ 338,985
Purchases		99,500	99,500
Unrealized gains (losses)	716	(7,760)	(7,044)
Sales	(250,781)		(250,781)
Total	$ –	$180,660	$ 180,660

The following table presents the Hospital's fair value hierarchy for defined benefit plan assets as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity(b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily through investments in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

6. Fair Value of Financial Instruments (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ –	$ –	$ –
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

The carrying amount of certain of the Hospital's financial instruments, including cash and cash equivalents and pledge receivables approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Hospital's fiscal year end. The fair value of long-term debt is $70,878,867 and $69,437,056 at September 30, 2011 and 2010, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2011	2010
Health care services	**$ 789,466**	$ 499,200
Preventative care	**193,861**	792,377
Extraordinary nursing care	**105,444**	109,852
Nursing education	**87,446**	84,912
Laboratory	**8,522**	228,659
Free beds	**8,066**	25,821
Capital projects		1,733,950
Other	**206,742**	626,772
	$ 1,399,547	$ 4,101,543

7. Temporarily and Permanently Restricted Net Assets (continued)

Income generated by permanently restricted net assets at September 30 is restricted to the following purposes:

	2011	2010
Income to be used:		
For general uses and purposes	**$ 6,605,539**	$ 6,631,835
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,449,124	$ 7,475,420

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2011	2010
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($565,000) to 2012, with an interest rate of 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,080,000**	$ 8,625,000
Series F, serial maturities ($5,875,000) from 2012 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,000,000**	28,725,000
Series G, serial maturities ($17,730,000) from 2012 to 2026, with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5%	**25,150,000**	25,775,000
Other long-term debt:		
Mortgage, maturing May 1, 2025 with a fixed interest rate of 6.125%	**1,183,176**	1,236,586
Obligations under capital leases	**1,379,926**	1,505,864
	63,793,102	65,867,450
Add net unamortized bond premium	**711,971**	757,072
Less current portion	**(2,115,360)**	(2,032,691)
Long-term debt	**$ 62,389,713**	$ 64,591,831

8. Long-term Debt (continued)

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital, and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets, and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principal and interest on the Series E, Series F and Series G bonds.

Series E bonds are subject to redemption prior to maturity. Series F bonds are subject to optional redemption prior to maturity. Series G bonds maturing after July 1, 2015 are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years, and in the aggregate, are as follows:

	Long-Term Debt	Capital Leases
2012	$ 2,021,619	$ 361,204
2013	2,105,440	361,204
2014	2,184,302	361,204
2015	2,303,411	336,859
2016	2,387,624	263,904
Aggregate thereafter	51,410,780	2,111,232
	62,413,176	3,795,607
Add net unamortized bond premium	711,971	
Less interest		(2,415,681)
	$ 63,125,147	$ 1,379,926

The Hospital paid interest of $3,312,005 and $3,323,608 in 2011 and 2010, respectively. Interest incurred in 2011 and 2010 was $3,247,715 and $3,185,038, respectively.

In 2010 the Hospital entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

8. Long-term Debt (continued)

In 2010 the Hospital also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2011 was $326,520. Under the terms of the lease, the Hospital has the option to renew for five periods of five years each.

Deferred financing costs are amortized over the life of the bonds.

9. Related Party Transactions

The Hospital processes payroll and disbursements for several of its affiliated entities for which it is reimbursed. Reimbursements due to the Hospital at September 30, 2011 and 2010 were approximately $165,000 and $647,000, respectively.

10. Retirement Benefit Plans

Effective January 1, 2010, the Hospital amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Hospital will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Hospital will also make a non-elective transition contribution equal to 3% of employee's eligible earnings for all employees who meet the transition participant criteria. The Hospital may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the years ended September 30, 2011 and 2010 was $5,206,397 and $3,589,500, respectively.

The Hospital also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the cost based on years of service. In addition, the Hospital sponsors a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2011 and 2010 is approximately $2,600,000 related to the future obligation for the nonqualified benefits.

10. Retirement Benefit Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
	(In thousands)			
Unrecognized actuarial (loss) gain	**$ (64,522)**	$ (43,157)	**$ 1,600**	$ 1,734
Unrecognized transition obligation			**(565)**	(889)
	$ (64,522)	$ (43,157)	**$ 1,035**	$ 845

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2012 are $4,557,386 and $323,491, respectively.

At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities. At September 30, 2011, the unfunded status of the pension plan is included in long-term liabilities in the amount of $60,301,776. The unfunded status of the postretirement benefits is $4,083,669, with $435,510 included in short-term liabilities, and the remainder of $3,648,159 included in long-term liabilities.

10. Retirement Benefit Plans (continued)

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2011 and 2010.

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
		(In thousands)		
Change in projected benefit obligation				
Benefit obligation at beginning of year	**$ (158,266)**	$ (171,831)	**$ (4,266)**	$ (4,969)
Service cost		(1,836)	**(4)**	(15)
Interest cost	**(7,963)**	(7,684)	**(207)**	(267)
Change in assumptions	**(12,536)**	(11,951)	**(147)**	387
Actuarial (loss) gain	**(2,006)**	(3,598)	**113**	154
Effect of curtailment		34,551		
Benefits paid	**4,825**	4,083	**428**	444
Benefit obligation at end of year	**$ (175,946)**	$ (158,266)	**$ (4,083)**	$ (4,266)
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 114,203**	$ 100,145		
Actual return on plan assets	**(1,834)**	10,017		
Contributions	**8,100**	8,124	**$ 428**	$ 444
Benefits paid	**(4,825)**	(4,083)	**(428)**	(444)
Fair value of plan assets at end of year	**$ 115,644**	$ 114,203	**$**	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	**$ (60,302)**	$ (44,063)	**$ (4,083)**	$ (4,266)
Components of net periodic benefit cost				
Service cost		$ 1,836	**$ 4**	$ 15
Interest cost	**$ 7,963**	7,684	**207**	267
Expected return on plan assets	**(7,832)**	(6,901)		
Net amortization and deferral	**2,843**	1,964	**224**	269
Net periodic benefit cost	**$ 2,974**	$ 4,583	**$ 435**	$ 551
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**4.60%**	5.10%	**4.60%**	5.10%
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.10**	5.60	**5.10**	5.60
Expected long-term rate of return on plan assets	**6.75**	6.75		

10. Retirement Benefit Plans (continued)

The accumulated benefit obligation at September 30, 2011 and 2010 was $175,946,699 and $158,266,226, respectively.

The asset allocations for the retirement plan at the end of 2011 and 2010 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	**Minimum**	**Maximum**	**2011**	**2010**
US Equity Large Cap	20%	50%	**34%**	31%
US Equity Small Cap		15	**5**	5
International Equity	10	30	**15**	17
Core Fixed Income	20	60	**46**	47
Total			**100%**	100%

The Hospital Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Hospital Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2012	$ 8,100,000	$ 435,510
Estimated future benefit payments:		
2012	5,621,240	435,510
2013	6,120,026	423,489
2014	6,721,770	414,800
2015	7,280,102	392,976
2016	7,768,999	370,874
2017-2021	47,330,022	1,533,884

10. Retirement Benefit Plans (continued)

Assumed healthcare cost trend rates for 2011 are as follows:	
Health care trend rate assumed for next year	7.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2015

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (1)
Effect on postretirement benefit obligation	$ 6	$ (5)

11. Property, Plant, and Equipment

Property, plant, and equipment at September 30 consist of the following:

	2011	2010
Land and land improvements	**$ 4,862,121**	$ 4,889,512
Buildings and leasehold improvements	**125,984,685**	125,274,358
Equipment	**98,557,288**	101,055,036
Construction in process (2012 estimated cost to complete $5,995,000)	**1,365,773**	630,806
Less accumulated depreciation	**(140,786,203)**	(132,727,325)
	$ 89,983,664	$ 99,122,387

The net unamortized value of internally developed software was $388,314 and $968,970 at September 30, 2011 and 2010, respectively. Amortization expense for the years ended September 30, 2011 and 2010 was $596,429 and $591,171, respectively.

The Hospital wrote off approximately $7,299,000 of fully depreciated assets in 2011.

11. Property, Plant, and Equipment (continued)

The Hospital leases space to be used for patient services. Two years remain on the initial term, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2011 and 2010 was $655,574 and $640,018, respectively.

The Hospital leases various types of equipment with annual payments ranging from $103 to $39,000. Expenses as a result of these leases were approximately $362,000 and $375,000 for the years ended September 30, 2011 and 2010, respectively

Future minimum lease payments under the above leases during each of the next five years were as follows:

2012	$ 907,327
2013	831,624
2014	173,838
2015	118,349
2016	11,378
	$ 2,042,516

12. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross accounts receivable from patients and third-party payors at September 30 is as follows:

	2011	**2010**
Medicare	**26%**	27%
Self pay	**23**	24
Health Maintenance Organizations	**17**	15
Anthem Blue Cross/Blue Shield	**15**	14
Medicaid	**10**	10
Commercial	**5**	5
Other state agencies	**4**	5
	100%	100%

13. Contingencies

There have been malpractice claims that fall within the Hospital's partially self-insured program (see Note 1) which have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2011, that may result in the assertion of claims. Hospital management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

Hospital management believes that it may not have conformed to all applicable laws and regulations regarding certain arrangements with outside parties. An internal investigation is underway and management has estimated and accrued a liability related to this matter. Except for this matter, Hospital management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of any potential wrongdoing.

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position or results of operations.

14. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2011	**2010**
Rental income	**$ 1,336,398**	$ 1,222,133
Cafeteria sales	**1,102,713**	1,063,020
Miscellaneous	**590,792**	361,626
Grants	**578,977**	733,844
Condominium income	**412,106**	389,640
Child care	**391,976**	355,497
Purchase discounts	**269,594**	351,343
Interest	**165,642**	196,253
	$ 4,848,198	$ 4,673,356

15. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2011	**2010**
Health care services	**$ 200,530,936**	$ 213,627,999
General and administrative	**51,760,982**	48,673,060
Fundraising	**193,923**	190,865
	$ 252,485,841	$ 262,491,924

Costs for interest and insurance are included in general and administrative expenses. Malpractice insurance is included in health care services.

16. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2011	**2010**
(Increase) decrease in assets:		
Accounts receivable	**$ (14,137,159)**	$ (9,057,522)
Pledges receivable	**84,655**	348,127
Due from affiliates	**496,941**	(141,929)
Inventories of supplies, prepaid expenses, and other	**(251,633)**	(783,378)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**8,463,850**	3,243,626
Accounts payable	**(210,687)**	(421,931)
Employee related obligations	**(5,322,115)**	(1,497,412)
Interest payable and other accrued liabilities	**(3,233,379)**	1,523,472
Salaries and wages, payroll taxes, and taxes withheld from payroll	**460,084**	(1,998,968)
Self-insured professional liability	**339,430**	(66,430)
Other liabilities	**93,505**	(325,475)
Changes in operating assets and liabilities	**$ (13,216,508)**	$ (9,177,820)

17. Subsequent Events

The Hospital evaluates the impact of subsequent events, which are events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date for the year ended September 30, 2011. The Hospital evaluated subsequent events through January 27, 2012, which is the date the financial statements were issued. No events occurred that require disclosure or adjustment to the combined financial statements.

Other Financial Information

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Trustees
The William W. Backus Hospital

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the financial statements taken as a whole.

Ernst & Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

The William W. Backus Hospital

Consolidating Balance Sheet

September 30, 2011

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Assets				
Current assets:				
Cash and cash equivalents	$ 93,136,217			$ 93,136,217
Assets whose use is limited – required for current liabilities	5,885,482			5,885,482
Accounts receivable, less allowance for uncollectible accounts	32,373,122			32,373,122
Pledges receivable	101,211			101,211
Due from affiliates	161,210	$ 2,937		164,147
Inventories of supplies	3,704,067			3,704,067
Prepaid expenses and other	1,608,996	15,610		1,624,606
Total current assets	136,970,305	18,547		136,988,852
Assets whose use is limited:				
Board-designated investments	105,438,402			105,438,402
Held by trustee	28,078,427			28,078,427
Total assets whose use is limited	133,516,829			133,516,829
Less assets whose use is limited – required for current liabilities	5,885,482			5,885,482
	127,631,347			127,631,347
Property, plant, and equipment, net	89,983,664			89,983,664
Deferred financing costs	1,842,330			1,842,330
Other assets	1,542,292			1,542,292
Total assets	$ 357,969,938	$ 18,547		$ 357,988,485

The William W. Backus Hospital

Consolidating Balance Sheet (continued)

September 30, 2011

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Liabilities and net assets				
Current liabilities:				
Accounts payable – trade	$ 9,918,459			$ 9,918,459
Salaries and wages, payroll taxes, and taxes withheld from payroll	6,666,138			6,666,138
Other accrued liabilities	4,998,969	$ 478		4,999,447
Employee related obligations	3,942,900			3,942,900
Due to third-party reimbursement agencies	4,683,178			4,683,178
Interest payable	734,838			734,838
Current portion of long-term debt	2,115,360			2,115,360
Total current liabilities	33,059,842	478		33,060,320
Other liabilities:				
Long-term debt, less current portion	62,389,713			62,389,713
Employee related obligations	69,884,879			69,884,879
Self-insured professional liability	10,853,762			10,853,762
Due to third-party reimbursement agencies	19,162,526			19,162,526
Other	443,183			443,183
	162,734,063			162,734,063
Net assets:				
Unrestricted	153,327,362	18,069		153,345,431
Temporarily restricted	1,399,547			1,399,547
Permanently restricted	7,449,124			7,449,124
Total net assets	162,176,033	18,069		162,194,102
Total liabilities and net assets	$ 357,969,938	$ 18,547		$ 357,988,485

The William W. Backus Hospital

Consolidating Statement of Operations

Year Ended September 30, 2011

	The William W. Backus Hospital	Backus Medical Center Condominium Association, Inc.	Eliminations	Consolidated
Operating revenues:				
Net patient service revenue	$ 271,933,218			$ 271,933,218
Other operating revenues	4,436,092	$ 440,909	$ (28,803)	4,848,198
Net assets released from restriction	673,194			673,194
	277,042,504	440,909	(28,803)	277,454,610
Operating expenses:				
Salaries, wages, and professional fees	110,169,857			110,169,857
Payroll taxes and other fringe benefits	25,655,346			25,655,346
Supplies, insurance, and other	83,506,652	440,909	(28,803)	83,918,758
Provision for uncollectible accounts	12,522,978			12,522,978
Depreciation and amortization	16,971,187			16,971,187
Interest	3,247,715			3,247,715
	252,073,735	440,909	(28,803)	252,485,841
Operating income	24,968,769			24,968,769
Nonoperating gains and (losses):				
Income from investments	581,947			581,947
Contributions	158,300			158,300
Other	(565,873)			(565,873)
Excess of revenues over expenses	$ 25,143,143			$ 25,143,143

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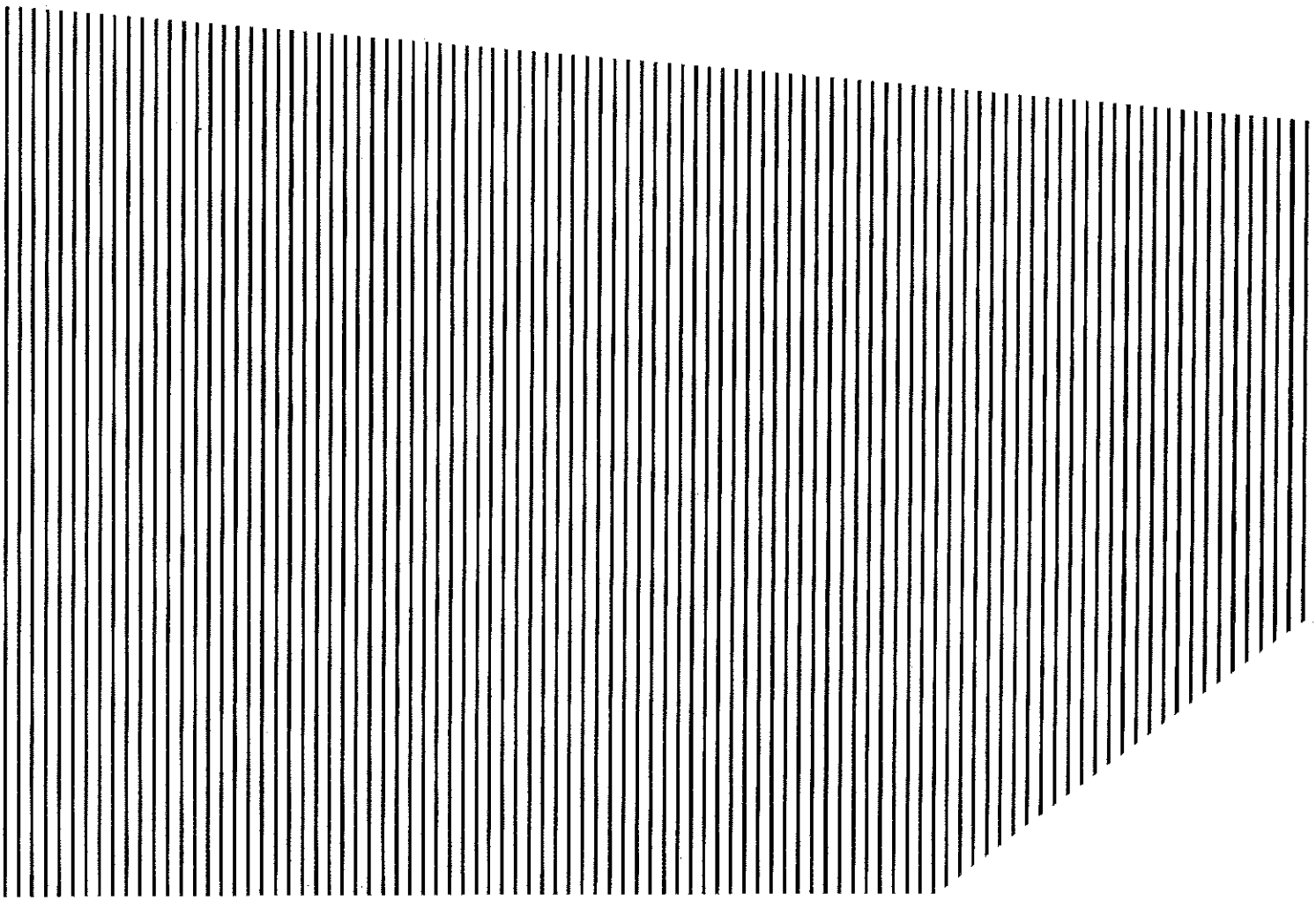
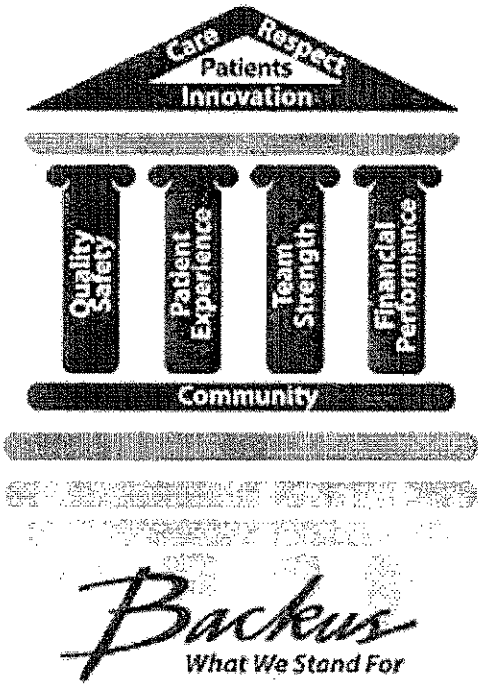


Backus

Year-To-Date Financial Report
June 30, 2012



Appendix A: Consolidated Financial Statements

Unaudited Financial Statements of the Backus Corporation and Subsidiaries

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
June 30,2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Assets						
Current assets:						
Cash and cash equivalents	$ 84,070	$ 105,809,659	$ 653,991	$ 423,400		$ 106,971,120
Assets whose use is limited-required for current liabilities		7,155,095				7,155,095
Accounts receivable, less allowance		27,622,168	1,058,997	885,893	-	29,567,058
Pledges receivable		31,004				31,004
Inventories of supplies		3,813,399				3,813,399
Prepaid expenses		1,842,942	63,507	19,924		1,926,373
Due from affiliates	140,436	630,561			$ (770,997)	-
Total current assets	224,506	146,904,828	1,776,495	1,329,217	(770,997)	149,464,049
Assets whose use is limited:						
Board designated and donor restricted		113,246,171				113,246,171
Held by trustee		31,469,316				31,469,316
Total assets whose use is limited	-	144,715,487	-	-	-	144,715,487
Less assets whose use is limited-required for current liabilities		7,155,095				7,155,095
	-	137,560,392	-	-	-	137,560,392
Other assets:						
Deferred financing costs		1,774,640				1,774,640
Other assets, less allowance	1,000	1,520,170	597,038	71,074	(16,845)	2,172,437
Total other assets	1,000	3,294,810	597,038	71,074	(16,845)	3,947,077
Property, plant and equipment						
Land and land improvements		4,862,121				4,862,121
Buildings and leasehold improvements		125,830,703	19,619	455,405		126,305,727
Equipment		96,825,571	372,755	127,894		97,326,220
Construction in progress		18,244,176				18,244,176
Accumulated depreciation		(151,422,853)	(234,016)	(114,193)		(151,771,062)
	-	94,339,718	158,358	469,106	-	94,967,182
	$ 225,506	$ 382,099,748	$ 2,531,891	$ 1,869,397	$ (787,842)	$ 385,938,700

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
June 30,2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Liabilities and Net Assets						
Current liabilities						
Accounts payable-trade		$ 10,598,148	$ 232,965	$ 268,735	-	$ 11,099,848
Salaries and wages, payroll taxes and taxes withheld from payroll		4,075,460	367,907	304,219	-	4,747,586
Due to affiliates	$ 110,976		390,523	269,498	$ (770,997)	-
Other accrued liabilities		7,628,468	1,817	176,631		7,806,916
Employee related obligations		2,706,450				2,706,450
Due to third parties		6,518,622		299,953		6,818,575
Current portion of long-term debt		2,031,354				2,031,354
Total current liabilities	110,976	33,558,502	993,212	1,319,036	(770,997)	35,210,729
Other Liabilities:						
Long-term debt, less current portion		67,414,405				67,414,405
Employee related obligations		66,732,298				66,732,298
Self-insured professional liability		10,200,336	2,509,957			12,710,293
Due to third parties		19,262,893				19,262,893
Other		590,717			-	590,717
	-	164,200,649	2,509,957	-	-	166,710,606
Net Assets:						
Common stock				1,000	(1,000)	-
Unrestricted net assets	114,530	174,065,995	(971,278)	549,361	(15,845)	173,742,763
Temporarily restricted net assets		2,519,764				2,519,764
Permanently restricted net assets		7,754,838				7,754,838
	114,530	184,340,597	(971,278)	550,361	(16,845)	184,017,365
	$ 225,506	$ 382,099,748	$ 2,531,891	$ 1,869,397	$ (787,842)	$ 385,938,700

*includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Statement of Operations and Change in Net Assets
June 30, 2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Revenues:						
Net patient service revenue		$ 205,983,824	$ 4,451,761	$ 6,018,261	$ (4,995)	$ 216,448,851
Provision for bad debt		$ (10,016,639)	$ (67,590)	$ (78,899)		(10,163,128)
Other operating revenue	$ 41,940	3,714,027	95,354	8,245	(496,996)	3,362,570
Net assets released from restrictions		146,347			-	146,347
	41,940	199,827,559	4,479,525	5,947,607	(501,991)	209,794,640
Expenses:						
Salaries and wages	110,976	82,926,178	4,118,831	3,440,432		90,596,417
Payroll taxes and fringe benefits		23,539,669	859,354	1,102,962		25,501,985
Supplies and expenses		65,602,005	973,974	1,690,119	(501,991)	67,764,107
Depreciation and amortization		13,097,011	27,167	27,360		13,151,538
Interest		2,419,633			-	2,419,633
	110,976	187,584,496	5,979,326	6,260,873	(501,991)	199,433,680
Operating income (loss)	(69,036)	12,243,063	(1,499,801)	(313,266)	-	10,360,960
Nonoperating gains and (losses)						
Contributions and donations		114,120			-	114,120
Investment income	84	8,225,045	942,917	24,280	-	9,192,326
Other		125,693		19,607		145,300
Excess (deficiency) of revenue over expenses	(68,952)	20,707,921	(556,884)	(269,379)	-	19,812,706
Unrestricted net assets:						
Excess of revenue over expenses	(68,952)	20,707,921	(556,884)	(269,379)	-	19,812,706
Assets released from restriction-pp&e		16,114				16,114
Intercompany transfer		(3,471)	3,471			-
Increase (decrease) in unrestricted net assets	(68,952)	20,720,564	(553,413)	(269,379)	-	19,828,820
Temporarily restricted net assets:						
Contributions		367,053				367,053
Income from investments		915,624				915,624
Net assets released from restrictions		(162,460)				(162,460)
Increase (decrease) in temp restricted net assets		1,120,217	-	-	-	1,120,217
Permanently restricted net assets						
Change in net assets held in trust		305,714				305,714
Increase (decrease) in perm restricted net assets	-	305,714	-	-	-	305,714
Increase (decrease) in net assets	(68,952)	22,146,495	(553,413)	(269,379)	-	21,254,751
Net assets (deficit) at beginning of year	183,482	162,194,102	(417,865)	819,740	(16,845)	162,762,614
Net assets (deficit) at end of year	$ 114,530	$ 184,340,597	$ (971,278)	$ 550,361	$ (16,845)	$ 184,017,365

Appendix B: Hospital Financial Statements

Unaudited Financial Statements of the Backus Hospital

The William W. Backus Hospital

Statements of Financial Position

Assets	June 2012	September 2011
Current assets:		
Cash and cash equivalents	$ 105,809,659	$ 93,136,217
Assets whose use is limited-required for current liabilities	7,155,095	5,885,482
Accounts receivable, less allowance for uncollectible accounts (2012-$22,475,942 2011-$21,200,088)	27,622,168	32,373,122
Pledge receivable	31,004	101,211
Due from affiliates, less allowance	954,380	165,240
Inventories of supplies	3,813,399	3,704,067
Prepaid expenses and other	1,820,835	1,604,965
Total Current Assets	147,206,540	136,970,304
Assets whose use is limited:		
Board designated	113,246,171	105,438,550
Held by trustee	2,667,551	2,356,916
Malpractice reserve	22,268,273	21,536,349
Debt service reserve fund	2,512,745	2,516,792
Debt service fund	4,020,746	1,668,222
Total assets whose use is limited	144,715,486	133,516,829
Less assets whose use is limited-required for current liabilities	(7,155,095)	(5,885,482)
	137,560,391	127,631,347
Property, plant and equipment:		
Land and land improvements	4,862,121	4,862,121
Buildings	125,830,703	125,984,685
Equipment	96,825,571	98,557,288
Construction in process	18,244,175	1,365,774
Accumulated depreciation (deduction)	(151,422,853)	(140,786,203)
	94,339,717	89,983,665
Deferred financing costs	1,774,642	1,842,329
Other assets	1,520,171	1,542,292
	$ 382,401,461	$ 357,969,937

Statements of Financial Position (con't)

	June 2012	September 2011
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 10,598,148	$ 9,918,459
Salaries and wages, payroll taxes and taxes witheld from payrolls	4,075,460	6,666,138
Other accrued liabilities	6,158,791	4,998,968
Employee related obligations	2,706,450	3,942,900
Due to third parties	6,898,893	4,683,178
Interest payable	1,469,677	734,838
Current portion of long-term debt	2,031,354	2,115,359
Total current liabilities	33,938,773	33,059,840
Other liabilities:		
Long-term debt	67,414,405	62,389,713
Accrued pension and other retirement costs	66,732,299	69,884,880
Self-insured professsional liability	10,200,336	10,853,762
Due to third-party reimbursement agencies	19,262,893	19,162,526
Other	590,717	443,182
	164,200,650	162,734,063
Net assets:		
Unrestricted	173,987,436	153,327,362
Temporarily restricted	2,519,764	1,399,547
Permanently restricted	7,754,838	7,449,125
	184,262,038	162,176,034
	$ 382,401,461	$ 357,969,937

The William W. Backus Hospital

Statements of Operations

	Nine months ended June	
	2012	2011
Operating revenues:		
Net revenues from services to patients	$ 205,983,824	$ 205,422,944
Bad debt	(10,016,639)	(11,786,625)
Other operating revenues	3,327,259	3,087,647
Net assets released from restriction	146,347	256,367
	199,440,791	196,980,333
Operating expenses:		
Salaries, wages and professional fees	82,926,178	79,904,734
Payroll taxes and other fringe benefits	23,539,669	21,691,809
Supplies and expenses	65,275,726	62,186,084
Provision for depreciation and amortization	13,097,011	14,029,097
Interest	2,419,633	2,450,228
	187,258,217	180,261,952
Operating Income	12,182,574	16,718,381
Non-operating gains and (losses):		
Income from investments	8,225,044	8,677,160
Contributions and Donations	114,120	107,858
Other	125,693	(508,004)
Excess of revenues over expenses	$ 20,647,431	$ 24,995,395

The William W. Backus Hospital

Statement of Changes in Net Assets

	Nine months ended June	
	2012	2011
Unrestricted net assets:		
Excess of revenues over expenses	$ 20,647,431	$ 24,995,395
Intercompany Transfers	(3,471)	-
Assets released from restriction-PPE	16,114	1,997,872
Increase in unrestricted assets	20,660,074	26,993,267
Temporarily restricted net assets:		
Income from investments	915,624	703,344
Contributions and Donations	367,053	490,347
Net assets released from restriction	(162,460)	(2,254,239)
Increase (decrease) in temporarily restricted net assets	1,120,217	(1,060,548)
Permanently restricted net assets:		
Income from investments	-	71,073
Contributions and Donations	-	5,000
Change in net assets held in trust	305,714	207,243
Increase in permanently restricted net assets	305,714	283,316
Increase in net assets	22,086,005	26,216,035
Net assets at beginning of period	162,176,033	158,925,018
Net assets at end of period	$ 184,262,038	$ 185,141,052

The William W. Backus Hospital

Statement of Cash Flows

	Nine Months ended June 2012	2011
Operating activities		
Increase in net assets	$ 22,086,005	$ 26,216,035
Adjustments to reconcile increase(decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	13,097,011	14,029,097
Provision for uncollectible accounts	10,016,639	11,788,663
Transfers to affiliates	3,471	-
Purchase of investments-board designated, net	(6,662,540)	(18,776,558)
Changes in operating assets and liabilities:		
Accounts receivable	(5,265,686)	(10,652,200)
Collection on pledges	70,207	58,709
Due to affiliates	(789,140)	(394,366)
Inventories of supplies, prepaid expenses and other	(325,201)	(512,612)
Accounts payable	679,689	(274,623)
Employee related obligations	(4,389,031)	(5,079,117)
Interest payable and other accrued liabilities	1,894,662	(99,360)
Salaries and wages, payroll taxes and taxes withheld from payrolls	(2,590,678)	(1,814,374)
Self-insured professional liability	(653,426)	2,266,099
Due to third parties and taxes payable	2,316,082	2,636,285
Other liabilities	147,535	66,974
Net cash provided by operating activities	29,635,599	19,458,652
Investing activities		
Purchases of investments-held in trust, net	(4,536,118)	(3,038,577)
Net additions to property, plant and equipment	(12,277,361)	(5,619,897)
Decrease in other assets	22,122	730,608
Net cash used in investing activities	(16,791,357)	(7,927,866)
Financing activities		
Principal payments and capital lease obligations	(133,839)	(117,690)
Change in deferred financing and amortization of bond premuim	(33,490)	(18,855)
Transfers to affiliates	(3,471)	-
Net cash used in financing activities	(170,800)	(136,545)
Increase in cash and cash equivalents	12,673,442	11,394,241
Cash and cash equivalents at beginning of period	93,136,217	72,131,779
Cash and cash equivalents at end of period	$ 105,809,659	$ 83,526,020

THE WILLIAM W. BACKUS HOSPITAL
REVENUE AND EXPENSES
JUNE 2012

	Current Month		Prior Year	Year-to-Date		Prior Year
	Actual	Budget	Actual	Actual	Budget	Actual
Patient Revenue						
Patient revenue-inpatient	$18,583	$20,248	$19,834	$177,606	$183,621	$184,143
Patient revenue-outpatient	30,726	28,687	30,831	280,010	266,170	267,962
Gross patient revenue	49,309	48,935	50,665	457,616	449,791	452,105
Deductions from Patient Revenue						
Contractual discounts	26,555	26,732	27,310	251,632	243,719	246,682
Provisions for bad debts	965	1,147	1,342	10,017	10,501	11,787
Total deductions from revenue	27,520	27,879	28,652	261,649	254,220	258,469
Net patient revenue	21,789	21,056	22,013	195,967	195,571	193,636
Other operating revenue	336	267	312	3,327	2,872	3,088
Net assets released from restriction	4	2	7	147	65	256
Total operating revenue	22,129	21,325	22,332	199,441	198,508	196,980
Operating Expenses						
Salary & wages	8,817	8,818	8,689	81,583	79,628	78,623
Fringe benefits	1,909	2,662	2,092	23,540	23,868	21,692
Medical fees	167	134	138	1,343	1,270	1,282
Medical & general supplies/drugs	3,279	3,383	3,326	31,473	31,307	31,151
Purchased services	1,251	1,216	1,091	10,362	9,829	8,791
Depreciation	1,427	1,410	1,486	13,097	13,337	14,029
Interest	300	264	272	2,419	2,379	2,450
Ins, food & other operating expenses	3,783	2,872	2,820	23,441	24,273	22,244
Net operating expenses	20,933	20,759	19,914	187,258	185,891	180,262
Excess of revenue over expenses	1,196	566	2,418	12,183	12,617	16,718
Nonoperating Revenue						
Investment income	1,939	247	(805)	8,225	6,706	8,677
Contributions and donations	10	19	21	114	85	108
Other	105		9	125		(508)
Net non-operating revenue	2,054	266	(775)	8,464	6,791	8,277
Excess of revenue over expense	$3,250	$832	$1,643	$20,647	$19,408	$24,995

THE WILLIAM W. BACKUS HOSPITAL
REVENUE AND EXPENSES
JUNE 2012

	Quarter-to-Date		Prior Year	Year-to-Date		Prior Year
	Actual	Budget	Actual	Actual	Budget	Actual
Patient Revenue						
Patient revenue-inpatient	$57,117	$60,920	$60,222	$177,606	$183,621	$184,143
Patient revenue-outpatient	94,579	87,986	91,242	280,010	266,170	267,962
Gross patient revenue	151,696	148,906	151,464	457,616	449,791	452,105
Deductions from Patient Revenue						
Contractual discounts	85,507	82,886	86,203	251,632	243,719	246,682
Provisions for bad debts	1,551	1,667	1,584	10,017	10,501	11,787
Total deductions from revenue	87,058	84,553	87,787	261,649	254,220	258,469
Net patient revenue	64,638	64,353	63,677	195,967	195,571	193,636
Other operating revenue	969	869	1,011	3,327	2,872	3,088
Net assets released from restriction	25	42	168	147	65	256
Total operating revenue	65,632	65,264	64,856	199,441	198,508	196,980
Operating Expenses						
Salary & wages	26,693	26,568	26,378	81,583	79,628	78,623
Fringe Benefits	7,653	8,198	7,005	23,540	23,868	21,692
Medical fees	456	416	432	1,343	1,270	1,282
Medical & general supplies/drugs	10,294	10,165	10,065	31,473	31,307	31,151
Purchased services	3,848	3,335	3,335	10,362	9,829	8,791
Depreciation	4,014	4,254	4,516	13,097	13,337	14,029
Interest	829	793	817	2,419	2,379	2,450
Ins, food & other operating expenses	8,222	8,375	7,784	23,441	24,273	22,244
Net operating expenses	62,009	62,104	60,332	187,258	185,891	180,262
Excess of revenue over expenses	3,623	3,160	4,524	12,183	12,617	16,718
Nonoperating Revenue						
Investment income	($1,868)	1,930	1,288	8,225	6,706	8,677
Contributions and donations	$57	56	60	114	85	108
Other	$163		(479)	125		(508)
Net non-operating revenue	(1,648)	1,986	869	8,464	6,791	8,277
Excess of revenue over expense	$1,975	$5,146	$5,393	$20,647	$19,408	$24,995

THE WILLIAM W. BACKUS HOSPITAL
SELECTED OPERATING AND FINANCIAL STATISTICS

OPERATING STATISTICS	Jun-12	May-12	Apr-12	Mar-12	Feb-12	Jan-12	Dec-11	Nov-11	Oct-11	FY 11
Med/Surg/ICU Patient Days	3,296	3,370	3,195	3,604	3,621	3,570	3,290	3,179	3,476	40,731
Med/Surg/ICU Discharges	768	779	732	849	808	818	816	825	798	9,471
Med/Surg/ICU Occupancy Rate	72.8%	72.0%	70.5%	77.0%	82.7%	76.3%	70.3%	70.2%	74.3%	73.9%
Med/Surg /ICU Average Length of Stay	4.3	4.3	4.4	4.2	4.5	4.4	4.0	3.9	4.4	4.3
Case Mix Index (exclude IP Psych)	1.2511	1.3506	1.2294	1.2711	1.2618	1.3414	1.3023	1.2307	1.2607	1.3034
Case Mix Index Medicare	1.3924	1.4784	1.3500	1.3237	1.4294	1.4289	1.3837	1.3628	1.3860	1.4654
Case Mix Index Other Gov't	0.9333	1.1244	0.9685	1.0470	0.9476	1.1566	1.0107	0.9284	0.9541	1.0040
Case Mix Index Non Gov't	1.2581	1.2909	1.2106	1.3235	1.2306	1.3208	1.3469	1.2399	1.2462	1.2691
Total Equivalent Discharges	2,600	2,543	2,518	2,673	2,466	2,499	2,621	2,679	2,581	29,683
Full Time Equivalents (FTEs)	1,548	1,521	1,510	1,519	1,526	1,533	1,536	1,542	1,543	1,501
FTE Per Adj Average Daily Census	4.3	4.4	4.4	4.3	4.2	4.5	4.6	4.6	4.5	4.6
Salary Per FTE (Annualized)	69,280	71,272	69,855	70,093	71,840	70,616	71,061	69,846	69,387	72,220
Gross Revenue Per Equivalent Discrg	18,962	21,214	19,237	19,473	20,720	20,501	19,031	18,978	19,686	20,350
Net Revenue Per Equivalent Dischrg	8,510	9,056	8,563	8,596	9,618	9,450	8,892	8,744	9,189	9,161
Contractuals as a % of Gross Revenue excluding Bad Debt	53.9%	56.1%	56.1%	56.8%	54.3%	55.0%	53.8%	54.5%	54.3%	55.0%
Net Expense Per Equivalent Dischrg	8,050	8,174	8,490	8,335	9,098	8,877	8,474	8,085	8,303	8,492
FINANCIAL STATISTICS										
Current Ratio	4.3	5.2	4.8	4.5	4.3	4.1	4.2	4.8	4.4	4.1
Gross Days in Accounts Receivable	69.4	71.0	69.7	70.2	71.3	71.8	67.0	71.4	74.7	74.1
Operating Profit Margin	5.5%	9.9%	0.9%	3.1%	5.5%	6.2%	4.8%	7.6%	9.8%	12.8%
Days Cash on Hand > **75**	313.3	300.9	304.6	304.7	305.7	298.8	300.6	305.8	307.0	286.9
Debt Service Coverage > **1.25**	6.71	7.24	7.03	7.41	7.76	7.83	8.09	8.60	8.90	9.44
Capitalization < **.60**	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Liquidity > **2.0**	34.0	35.2	35.7	35.7	35.8	34.3	34.4	34.7	34.1	32.3

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
July 31,2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Assets						
Current assets:						
Cash and cash equivalents	$ 84,081	$ 102,501,960	$ 356,608	$ 499,852		$ 103,442,501
Assets whose use is limited-required for current liabilities		6,053,832				6,053,832
Accounts receivable, less allowance		29,119,093	1,242,774	964,366	-	31,326,233
Pledges receivable		49,776				49,776
Inventories of supplies		3,836,806				3,836,806
Prepaid expenses		1,678,614	46,106	16,551		1,741,271
Due from affiliates	145,096	392,597			$ (537,693)	-
Total current assets	229,177	143,632,678	1,645,488	1,480,769	(537,693)	146,450,419
Assets whose use is limited:						
Board designated and donor restricted		114,132,492				114,132,492
Held by trustee		28,378,990				28,378,990
Total assets whose use is limited	-	142,511,482	-	-	-	142,511,482
Less assets whose use is limited-required for current liabilities		6,053,832				6,053,832
	-	136,457,650	-	-	-	136,457,650
Other assets:						
Deferred financing costs		1,766,921				1,766,921
Other assets, less allowance	1,000	1,519,918	509,293	80,457	(16,845)	2,093,823
Total other assets	1,000	3,286,839	509,293	80,457	(16,845)	3,860,744
Property, plant and equipment						
Land and land improvements		4,862,121				4,862,121
Buildings and leasehold improvements		125,830,703	19,619	455,405		126,305,727
Equipment		96,403,124	372,755	127,894		96,903,773
Construction in progress		19,400,489				19,400,489
Accumulated depreciation		(152,582,935)	(236,617)	(117,126)		(152,936,678)
	-	93,913,502	155,757	466,173	-	94,535,432
	$ 230,177	$ 377,290,669	$ 2,310,538	$ 2,027,399	$ (554,538)	$ 381,304,245

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Liabilities and Net Assets						
Current liabilities						
Accounts payable-trade		$ 8,480,999	$ 233,490	$ 487,121	-	$ 9,201,610
Salaries and wages, payroll taxes and taxes withheld from payroll		6,433,558	408,405	354,244	-	7,196,207
Due to affiliates	$ 121,527		(58,407)	474,573	$ (537,693)	-
Other accrued liabilities		6,641,322	2,173	190,408		6,833,903
Employee related obligations		2,962,820				2,962,820
Due to third parties		4,040,032		293,390		4,333,422
Current portion of long-term debt		2,092,342				2,092,342
Total current liabilities	121,527	30,651,073	585,661	1,799,736	(537,693)	32,620,304
Other Liabilities:						
Long-term debt, less current portion		65,365,670				65,365,670
Employee related obligations		65,906,439				65,906,439
Self-insured professional liability		7,000,490	1,787,984			8,788,474
Due to third parties		19,331,656				19,331,656
Other		600,814			-	600,814
	-	158,205,069	1,787,984	-	-	159,993,053
Net Assets:						
Common stock				1,000	(1,000)	-
Unrestricted net assets	108,650	178,207,297	(63,107)	226,663	(15,845)	178,463,658
Temporarily restricted net assets		2,557,409				2,557,409
Permanently restricted net assets		7,669,821				7,669,821
	108,650	188,434,527	(63,107)	227,663	(16,845)	188,690,888
	$ 230,177	$ 377,290,669	$ 2,310,538	$ 2,027,399	$ (554,538)	$ 381,304,245

*includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Statement of Operations and Change in Net Assets
July 31, 2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Revenues:						
Net patient service revenue		$ 228,719,505	$ 5,646,573	$ 6,707,095	$ (4,995)	$ 241,068,178
Provision for bad debt		(9,471,130)	(539,927)	(91,757)		(10,102,814)
Other operating revenue	$ 46,600	4,965,072	112,170	8,247	(552,353)	4,579,736
Net assets released from restrictions		150,086			-	150,086
	46,600	224,363,533	5,218,816	6,623,585	(557,348)	235,695,186
Expenses:						
Salaries and wages	121,527	94,036,472	4,615,831	3,846,992		102,620,822
Payroll taxes and fringe benefits		26,751,310	950,048	1,484,434		29,185,792
Supplies and expenses		71,527,325	421,010	1,907,313	(557,348)	73,298,300
Depreciation and amortization		14,253,545	30,269	30,293		14,314,107
Interest		2,708,250			-	2,708,250
	121,527	209,276,902	6,017,158	7,269,032	(557,348)	222,127,271
Operating income (loss)	(74,927)	15,086,631	(798,342)	(645,447)	-	13,567,915
Nonoperating gains and (losses)						
Contributions and donations		130,766			-	130,766
Investment income	95	9,426,235	1,149,629	33,763	-	10,609,722
Other		125,693		19,607		145,300
Excess (deficiency) of revenue over expenses	(74,832)	24,769,325	351,287	(592,077)	-	24,453,703

Backus Corporation and Subsidiaries
Consolidating Statement of Operations and Change in Net Assets
July 31, 2012

	Backus Corp	William W Backus Hospital *(combined)	Backus Health Care, Inc	WWB Corp.	Eliminations	Combined
Unrestricted net assets:						
Excess of revenue over expenses	(74,832)	24,769,325	351,287	(592,077)	-	24,453,703
Assets released from restriction-pp&e		96,014				96,014
Intercompany transfer		(3,471)	3,471			-
Increase (decrease) in unrestricted net assets	(74,832)	24,861,868	354,758	(592,077)	-	24,549,717
Temporarily restricted net assets:						
Contributions		409,214				409,214
Income from investments		994,748				994,748
Net assets released from restrictions		(246,100)				(246,100)
Increase (decrease) in temp restricted net assets		1,157,862	-	-	-	1,157,862
Permanently restricted net assets		220,695				220,695
Change in net assets held in trust	-	220,695	-	-	-	220,695
Increase (decrease) in perm restricted net assets	(74,832)	26,240,425	354,758	(592,077)	-	25,928,274
Increase (decrease) in net assets						
Net assets (deficit) at beginning of year	183,482	162,194,102	(417,865)	819,740	(16,845)	162,762,614
Net assets (deficit) at end of year	$ 108,650	$ 188,434,527	$ (63,107)	$ 227,663	$ (16,845)	$ 188,690,888

Backus Health Care and Subsidiaries
Consolidating Balance Sheet
July 31,2012

	Backus Health Care Unconsolidated	ConnCare	Backus Physician Services LLC	Eliminations	Combined Backus Health Care
Assets					
Current assets:					
Cash and cash equivalents	$ 11,472	$ 127,224	$ 217,912		$ 356,608
Accounts receivable, less allowance		429,002	813,772		1,242,774
Prepaid expenses		870	45,236		46,106
Due from affiliates	129,276	4,399,857		$ (4,529,133)	-
Total current assets	140,748	4,956,953	1,076,920	(4,529,133)	1,645,488
Other assets:					
Covenant not to compete		31,000			31,000
Net investment in Davita-Norwich		-			-
Net investment in Davita-New London		478,293			478,293
Total other assets		509,293			509,293
Property, plant and equipment					
Buildings and leasehold improvements		19,619			19,619
Equipment		307,636	65,119		372,755
Accumulated depreciation		(192,837)	(43,780)		(236,617)
		134,418	21,339		155,757
	140,748	5,600,664	1,098,259	(4,529,133)	2,310,538
Liabilities and Net Assets					
Current liabilities					
Accounts payable-trade		144,632	88,858		233,490
Salaries and wages, payroll taxes and taxes withheld from payroll		273,684	134,721		408,405
Due to affiliates	142,280	(71,411)	4,399,857	(4,529,133)	(58,407)
Other accrued liabilities		1,080,984	709,173		1,790,157
Total current liabilities	142,280	1,427,889	5,332,609	(4,529,133)	2,373,645
Net Assets:					
Fund Balance	(1,532)	4,172,775	(4,234,350)		(63,107)
Total Liabilities and Capital	$ 140,748	$ 5,600,664	$ 1,098,259	$ (4,529,133)	$ 2,310,538

Backus Health Care and Subsidiaries
Consolidating Income Statement
July 31,2012

	Backus Health Care Unconsolidated	ConnCare	Backus Physician Services LLC	Eliminations	Combined Backus Health Care
Revenues:					
Net patient service revenue		$ 2,832,561	$ 2,814,012		$ 5,646,573
Provision for bad debt		(188,844)	(351,083)		(539,927)
Other operating revenue	$ 30,780	93,137	19,033	$ (30,780)	112,170
Total Revenues	30,780	2,736,854	2,481,962	(30,780)	5,218,816
Expenses:					
Salaries and wages		2,315,814	2,300,017		4,615,831
Payroll taxes and fringe benefits		523,826	426,222		950,048
Supplies and expenses	33,355	1,043,902	(625,467)	(30,780)	421,010
Depreciation and amortization		24,431	5,838		30,269
	33,355	3,907,973	2,106,610	(30,780)	6,017,158
Net income	(2,575)	(1,171,119)	375,352	-	(798,342)
Nonoperating gains (losses):					
Investment income	3	1,149,545	81		1,149,629
Deficiency of revenue over expenses	(2,572)	(21,574)	375,433	-	351,287
Fund Balance (deficit) at beginning of year	1,040	4,194,349	(4,613,254)		(417,865)
Intercompany transfer			3,471		3,471
Fund Balance (deficit) at end of year	$ (1,532)	$ 4,172,775	$ (4,234,350)	$ -	$ (63,107)

WWB Corporation
Consolidating Balance Sheet
July 31, 2012

	WWB Corp.	BHHC	Eliminations	Consolidated
Assets				
Current Assets:				
Cash and cash equivalents	$415,741	$84,111		$499,852
Net Accounts Receivable		964,366		964,366
Due from affiliates	1,181,198		$ (1,181,198)	-
Prepaid Expenses		16,551		16,551
Total Current Assets	1,596,939	1,065,028	(1,181,198)	1,480,769
Property, Plant, & Equipment		466,173		466,173
Other assets	80,457	-		80,457
Total Investments	80,457	-	-	80,457
Total Assets	1,677,396	1,531,201	(1,181,198)	2,027,399
Liabilities and Stockholder's Equity				
Current Liabilities:				
Accounts Payable & Accrued Expenses		487,121		487,121
Due to affiliates	474,573	1,181,198	(1,181,198)	474,573
Due to third parties		293,390		293,390
Other Accrued Expenses		190,408		190,408
Accrued Payroll & Related Taxes		354,244		354,244
Total Current Liabilities	474,573	2,506,361	(1,181,198)	1,799,736
Stockholder's Equity:				
Common Stock issued and outstanding	1,000			1,000
Retained Earnings/Equity	1,201,823	(975,160)		226,663
	1,202,823	(975,160)	-	227,663
Total Liabilities and Stockholder's Equity	$1,677,396	$1,531,201	($1,181,198)	$2,027,399

WWB Corporation
Consolidating Income Statement
July 31,2012

	WWB Corp.	BHHC	Eliminations	Consolidated
Operating revenue:				
Net patient service revenue		$6,707,095		$6,707,095
Provision for bad debt		($91,757)		($91,757)
Other operating revenue		8,247		8,247
Total operating revenue	-	6,623,585	-	6,623,585
Operating expenses:				
Salaries and wages		3,846,992		3,846,992
Payroll taxes and fringe benefits		1,484,434		1,484,434
Supplies and other	$ 46,218	1,861,095		1,907,313
Depreciation		30,293		30,293
Total operating expenses	46,218	7,222,814	-	7,269,032
Operating (loss) Income	(46,218)	(599,229)		(645,447)
Nonoperating gains				
Investment income	33,713	50		33,763
Other	19,607			19,607
Net Income (Loss)	7,102	(599,179)	-	(592,077)
Retained Earnings beginning of the period	1,194,721	(375,981)		818,740
Retained Earnings end of Period	$1,201,823	($975,160)		$226,663

BACKUS MEDICAL CONDOMINIUM ASSOCIATION
BALANCE SHEET
JUN 2012

	CURRENT YTD	PRIOR FISCAL YEAR END
ASSETS		
CASH	0	0
TENANT AR	22,105	15,610
DUE FROM WWBH	380,272	0
TOTAL ASSETS	402,377	15,610
LIABILITIES AND FUND BALANCE		
LIABILITIES		
MM/AP GROSS ACCRUAL	0	477
DUE TO WWBH	323,818	(2,937)
TOTAL LIABILITIES	323,818	(2,460)
FUND BALANCE	78,559	18,069
TOTAL LIABILITIES AND FUND BALANCE	402,377	15,610

BACKUS MEDICAL CONDOMINIUM ASSOCIATION
OPERATING STATEMENT
JUN 2012

	CURRENT YTD	PRIOR FISCAL YEAR END
CAM REVENUE	386,768	440,909
ALLOCATED EXPENSES	63,485	120,701
REPAIRS & MAINT	186,787	260,311
UTILS-ELECTRICITY	23,131	33,583
UTILS-WATER/SEWER	449	784
UTILS-CABLE EXP	2,479	3,690
MAINTENANCE CONTRACTS	166	418
OFFICE SUPPLIES	146	0
OTHER SUPPLIES	495	32
LEGAL SERVICES	1,061	464
AUDITING FEES	5,740	1,080
PURCHASED SERVICE EXP	42,290	83,367
PROPERTY TAXES	0	5,455
SIGNAGE	50	(68,976)
WWBH SERVICES		
TOTAL ALLOCATED EXPENSES	326,278	440,909
OTHER INCOME	0	0
NET INCOME(LOSS)	60,490	1

17.4.2 Backus Financial Statement Disclosures

None.

17.4.3 Backus Accounting Disclosures

None.

17.4.4 Backus Liabilities

None.

17.4.5 Backus Donor-Restricted Funds

See attached.

Donor restricted Funds

	Balance @ 7/31/12	Restricted purpose
Temporarily Restricted Funds		
Basile, Doris Educ Cardiac Care	13,613	health care services
Brewer Fund Income	(1,699)	laboratory
Callahan Fund Income	124,821	extraordinary nursing care
Dean, Roland C. For Trauma Center	6,252	trauma
H. Ross Institute	222,562	preventative care
L. E. Roath	65,209	laboratory
Levine Annuity	19,867	general use
Saxton Fund Income	88,735	nursing education
Special C Fund Income	52,463	free bed
Wood Fund Income	23,991	free bed
Perkins Bequest	71,866	equipment or cap construction
Norwich Cardiac	2,624	cardiology
Levine Annuity-#2	23,145	general use
Earnings on perm restricted-not purpose restricted	701,838	general use
Grace & Lewis Sears	125,899	general use
Memorial funds	990,958	various uses
Nursing Education funds	15,600	nursing education
Free Bed funds	9,665	free bed
	2,557,409	
Permanently Restricted Funds		
Adelman Endowment	29,153	general use
Ann Barnes	100,000	general use
Baer Endowment	231,389	general use
Brewer Fund	174,218	laboratory
Callahan Fund	25,000	extraordinary nursing care
Ellen TW Bard Fund	993,711	general use
Ethel Manych	5,000	general use
Grace & Lewis Sears Fund	1,703,879	general use
Irving Wood Fund	300,000	free bed
LE Roath Fund	83,964	laboratory
Masterson Endowment	100,000	general use
Miranda Endowment	34,374	general use
Saxton Nursing Fund	10,140	nursing education
Seeman Endowment	47,500	general use
Special C Funds	227,060	free bed
Tramontozzi Fund	100,000	general use
Undesignated	1,148,248	general use
Podurgal	50,000	general use
Charles & Susan Seeman	10,020	general use
Frank Johnson Perpetual Trust	1,128,826	general use
George Gildersleeve Perpetual Trust	238,154	general use
Nathan Johnson Perpetual Trust	905,982	general use
Nursing funds	23,203	extraordinary nursing care
	7,669,821	

17.4.6 Backus Pension Funds

The William W. Backus Hospital

Plan Type	Trustee	Account Number
Defined Benefit Plan	Marshall & Ilsley Trust Company N.A.	91-K067-AA3 (Hospital)
403B	Charles Schwabb	790092
457[1]	LPL Financial	3378-0321

CONNCare, Inc, Backus Home Health Care, Backus Physician Services, LLC

Plan Type	Trustee	Account Number
401K Plan	MG Trust Company LLC	07C26849

[1] Note, these are voluntarily segregated funds for this non-qualified plan. There is no requirement to fund this plan.

17.5 Backus Interim Changes

17.5.3: The Backus Entities may record acquisitions or dispositions of assets to or from other Backus Entities, including the acquisition of certain assets of CONNCare, Inc. and Backus Physician Services, LLC by Community Medical Partners, Inc.

17.6 Backus Legal Proceedings

A lawsuit pending in Connecticut Superior Court (#KNL-cv-10-600425-S) as described in the letter to R. Edwards of Ernst & Young dated October 25, 2010.

17.7.1 Backus Licenses and Permits

The following Backus Entities hold licenses, permits, certificates, consents, or approvals as listed below:

The William W. Backus Hospital	
Name	Issuing Body
Hospital License	State of Connecticut Department of Public Health (DPH)
Pharmacy – State Controlled Substance Registration CSP.0003826	State of Connecticut Dept of Consumer Protection
Pharmacy – DEA Number AT155642	US Drug Enforcement Administration
Plainfield Emergency Department - Controlled Substance Registration CSP.0038215	State of Connecticut Dept of Consumer Protection
Plainfield Emergency Department – DEA Number FS3199646	US Drug Enforcement Administration
Mary Allen Ross Child Care Center License	State of Connecticut Department of Public Health
Mary Allen Ross Child Care Center Food Service License	Uncas Health District
Diagnostic and Therapeutic X-ray Device Registration	Connecticut Department of Energy and Environmental Protection, Bureau of Air Management Radiation Division
Radioactive Material and Industrial X-ray Device Registration	Connecticut Department of Energy and Environmental Protection, Bureau of Air Management Radiation Division
NRC	United States Nuclear Regulatory Commission
MQSA – Mammography Quality Standards Act	United States Food & Drug Administration
Clinical Laboratory Improvement Amendments (CLIA) License- Main Lab	Centers for Medicare & Medicaid Services (CMS)
CLIA License- Nursing	CMS
CLIA License- STD Clinic	CMS
CT Lab License- Main Lab	State of Connecticut DPH
CT Lab License- Blood Bank	State of Connecticut DPH
CT Lab License- STD	State of Connecticut DPH
Industrial Alcohol User Permit	Department of the Treasury, Bureau of Alcohol, Tobacco, and Firearms

17.7.1 Backus Licenses and Permits

The William W. Backus Hospital	
Name	Issuing Body
Blood Collection Facility Certification-MOB	State CT DPH
Blood Collection Facility Certification-Colchester	State CT DPH
Blood Collection Facility Certification-BOCC	State CT DPH
Blood Collection Facility Certification-Montville	State CT DPH
Blood Collection Facility Certification-Jewett City	State CT DPH
Blood Collection Facility Certification-Plainfield	State CT DPH
Air Management General Permit to Limit the Potential to Emit	State of Connecticut (CT) Department of Energy and Environmental Protection (DEEP)
Flood Plain Parking Permit	CT DEEP
Photographic Wastewater Discharge Permit	CT DEEP
Permit for Discharge of Minor Boiler Blowdown Wastewater	CT DEEP
Food Preparation Wastewater	CT DEEP
Vehicle Maintenance Wastewater Registration	CT DEEP
General Permit for Miscellaneous Discharges of Sewer Compatible (MISC) Wastewater and Domestic Sewerage Registration	CT DEEP
Underground Oil Tank Registrations UST I.D. Numbers, A1R1, B2R2, B3R1, C3	CT DEEP
8/8/88 Oil Spill Monitoring	CT DEEP
Certificate #3 Boiler	CT Dept. of Public Safety
Certificate #2 Boiler	CT Dept. Public Safety
Certificate #1 Boiler	CT Dept. Public Safety
Lo Pres. Water heater certificate #082262	CT Dept. Public Safety
Low Pres. Water Heater certificate #082295	CT Dept. Public Safety
Low Pres. Water Heater cert. # 08299	CT Dept. Public Safety
Low Pres. Water heater cert. #098399	CT Dept. Public Safety
Low pres. Cast iron boiler #033250 315 Wash. St.	CT Dept. Public Safety
Lo Pres. Cast Iron boiler #045668	CT Dept. Public Safety
Lo Pres. Cast Iron Boiler #045666	Ct Dept. Public Safety

17.7.1 Backus Licenses and Permits

The William W. Backus Hospital	
Name	Issuing Body
Lo Pres. Cast iron boiler	CT Dept. Public Safety
Lo Pres. CI Boiler	CT Dept. Public Safety
Lo Pres Firetube Boiler #045673	CT Dept. Public Safety
Lo Pres Firetube Boiler#080613	CT Dept. Public Safety
Lo pres. Cast iron boiler #045672	CT Dept. Public Safety
Lo pres. Cast Iron boiler #045671	CT Dept. Public Safety
Elevator 104-0247	CT Bureau of Elevators
Elevator 104-0246	CT Bureau of Elevators
Elev. 104-0278	CT Bureau of Elev.
Dumbwaiter 104-0202	CT Bureau of Elev.
Dumbwaiter 104-0118	CT Bureau of Elev.
Elev. 104-0228	CT Bureau of Elev.
Elev. 104-0227	CT Bureau of Elev.
Elev. 104-0193	CT Bureau of Elev.
Elev. 104-0123	CT Bureau of Elev.
Class 4 Food Service License	Uncas Health District (local health department)
Special Permit Authorization DOT-SP 13556	State of Connecticut Department of Transportation
State of Connecticut Department of Energy and Environmental Protection Hazardous Waste Transport Permit (Veolia)	State of CT/Veolia for chemo waste
Airport License	State of Connecticut Department of Transportation
WMTS Coordination Certificate (Cardiac Rehab certificate)	The American Society for Healthcare Engineering of the American Hospital Association, WMTS Frequency Coordinator
WMTS Coordination Certificate (facility-wide telemetry)	The American Society for Healthcare Engineering of the American Hospital Association, WMTS Frequency Coordinator
WMTS Coordination Certificate (portable monitoring)	The American Society for Healthcare Engineering of the American Hospital Association, WMTS Frequency Coordinator

17.7.1 Backus Licenses and Permits

Backus Home Health Care	
Name	Issuing Body
Home Health Care Agency License	State of CT Department of Public Health
Clinical Laboratory Improvements Amendment Certificate of Waiver	State of CT Department of Public Health

CONNCare, Inc.	
Name	Issuing Body
Colchester Outpatient Clinic License	State of Connecticut (CT) Department of Public Health (DPH)
Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver – Colchester Outpatient Clinic	Centers for Medicare & Medicaid Services (CMS)
Foxwoods Industrial Health Facility License	State of Connecticut Department of Public Health
Ledyard Outpatient Clinic License	State of CT DPH
CLIA Certificate of Waiver – Ledyard Outpatient Clinic	CMS
Montville Outpatient Clinic License	State of CT DPH
CLIA Certificate of Waiver – Montville Outpatient Clinic	CMS
Plainfield Outpatient Clinic License	State of CT DPH
CLIA Certificate of Waiver – Plainfield Outpatient Clinic	CMS

17.9 Backus Compliance with Law

In 2011 and 2012, the Hospital identified certain arrangements that may not have been documented in full compliance with certain technical provisions of applicable law, as disclosed to Hartford HealthCare's counsel on July 16, 2012.

17.10 Backus Real Property

The William W. Backus Hospital - Owned Real Property

Section 17.10.1 Address	Section 17.10.1 Legal Description (attached)	Section 17.10.1 Property ID	Section 17.10.1 Encumbrances/ Liens	Section 17.10.1 Leases	Section 17.10.1 (c) Easements, etc.	Section 17.10.1 (e) Tax Exempt	Section 17.10.1 (j) Encroachments
326 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule A	n/a	17.10.1 Attachment Schedule A		17.10.1 Attachment Schedule A	Exempt	
330 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule B	2010010012509	17.10.1 Attachment Schedule B	17.10.1 Attachment Schedule B	17.10.1 Attachment Schedule B	Flr 1 Exempt Flrs 2-5 Not Exempt	
303 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule C	2010010012517	17.10.1 Attachment Schedule C	17.10.1 Attachment Schedule C		Not Exempt	
304 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule D	n/a	17.10.1 Attachment Schedule D		17.10.1 Attachment Schedule D	Exempt	17.10.1 Attachmen Schedule D
305 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule e	2010010012520	17.10.1 Attachment Schedule e			Not Exempt	
315 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule F	2010010012512	17.10.1 Attachment Schedule F	17.10.1 Attachment Schedule F	17.10.1 Attachment Schedule F	Not Exempt	
321 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule G	2010010012513	17.10.1 Attachment Schedule G	17.10.1 Attachment Schedule G	17.10.1 Attachment Schedule G	Not Exempt	
323 Washington Street Norwich, CT 06360	17.10.1 Attachment Schedule H	2010010012511	17.10.1 Attachment Schedule H	17.10.1 Attachment Schedule H	17.10.1 Attachment Schedule H	Not Exempt	
99 Lafayette Street Norwich, CT 06360	17.10.1 Attachment Schedule I	2010010012514	17.10.1 Attachment Schedule I			Not Exempt	
107 Lafayette Street Norwich, CT 06360	17.10.1 Attachment Schedule J	n/a	17.10.1 Attachment Schedule J		17.10.1 Attachment Schedule J	Exempt	
121 Lafayette Street Norwich, CT 06360	17.10.1 Attachment Schedule K	n/a	17.10.1 Attachment Schedule K	17.10.1 Attachment Schedule K	17.10.1 Attachment Schedule K	Exempt	
1-4 Matlack Drive Norwich, CT 06360	17.10.1 Attachment Schedules L & M	2010010012518	17.10.1 Attachment Schedules L & M			Lot 1 Not Exempt Lot 4 Exempt	
12 Case Street, Suite 101 Norwich, CT 06360	17.10.1 Attachment Schedule N		17.10.1 Attachment Schedule N		17.10.1 Attachment Schedule N	Exempt	
12 Case Street, Suite 313 Norwich, CT 06360	17.10.1 Attachment Schedule N	2010010012515	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	Not Exempt	
12 Case Street, Suites 314/315 Norwich, CT 06360	17.10.1 Attachment Schedule N	2010010012515	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	Not Exempt	
12 Case Street, Suite 303 Norwich, CT 06360	17.10.1 Attachment Schedule N	2010010012519	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	17.10.1 Attachment Schedule N	Not Exempt	
11 & 11A Stott Avenue Norwich, CT 06360	17.10.1 Attachment Schedules P & Q	2010010012508	17.10.1 Attachment Schedules P & Q		17.10.1 Attachment Schedules P & Q	Exempt	
11 Murphy Road Franklin, CT 06254	17.10.1 Attachment Schedule R	2010010000068	17.10.1 Attachment Schedule R		17.10.1 Attachment Schedule R	Exempt	
120-122 Plainfield Road Moosup, CT 06354	17.10.1 Attachment Schedule S	2010010005874	17.10.1 Attachment Schedule S	17.10.1 Attachment Schedule S	17.10.1 Attachment Schedule S	Exempt	

17.10 Backus Real Property

The William W. Backus Hospital

Leased Real Property

Section 17.10.1 **Leased Property Address**	Section 17.10.1 (i) **Septic**	Section 17.10.1 **Lessee**
Owner: John Grillo 112 Lafayette Street Norwich, CT 06360		Pain & Palliative Care CONNCare Billing BPS Billing
Owner: J. Leland Lichtenstein, DDS 105 Lafayette Street Norwich, CT 06360		n/a
Owner: Plaza Enterprises 113 Salem Turnpike Norwich, CT 06360		Advanced Dermatology
Owner: PC 80 LLC 80 Norwich New London Tpke Uncasville, CT 06382		CONNCare, Inc.
Owner: UCFS 76 Main Street Jewett City, CT 06351		n/a
Owner: BRG Interests 123 Broadway Colchester, CT 06415		Pulmonary Physicians
Owner: Paradise Agency 163 Broadway Colchester, CT 06415		CONNCare, Inc.
Owner: Mark Rachwal 743 Colonel Ledyard Highway Ledyard, CT 06339	Served by Septic	CONNCare, Inc.
Owner: OR&L Construction 582 Norwich Road Plainfield, CT 06374		n/a

Backus Home Health Care

17.10 Backus Real Property

Owned Real Property

Section 17.10.1 **Address**	Section 17.10.1 **Legal Description (attached)**	Section 17.10.1 **Property ID**	Section 17.10.1 **Encumbrances/ Liens**	Section 17.10.1 c **Easements, etc.**	Section 17.10.1 (e) **Tax Exempt**
12 Case Street, Suites 316/317 Norwich, CT 06360	17.10.1 Attachment Schedule O	2010010008818 2010020041198	17.10.1 Attachment Schedule O	17.10.1 Attachment Schedule O	Not Exempt

Backus Home Health Care

Leased Real Property

Leased Property Address
Owner: Norwich Orthopedic Group 82 New Park Avenue Franklin, CT 06254

Backus Physician Services, LLC

Leased Real Property

Section 17.10.1 **Leased Property Address**	Section 17.10.1 **Lessee**
Owner: John Grillo 112 Lafayette Street Norwich	Pain & Palliative Care CONNCare Billing BPS Billing
Owner: WWBH 330 Washington Street Norwich	n/a

17.10 Backus Real Property

CONNCare, Inc.
Leased Real Property

Section 17.10.1	Section 17.10 (i)
Leased Property Address	**Septic**
Owner: John Grillo 112 Lafayette Street Norwich	
Owner: PC 80 LLC 80 Norwich New London Tpke Uncasville	
Owner: Paradise Agency 163 Broadway Colchester	
Owner: Mark Rachwal 743 Colonel Ledyard Highway Ledyard	Served by Septic

The 17.10.1 Attachment file contains the Tax Code Citation, a Note regarding Encroachments, Disclosure of Right of First Refusal, and Disclosure of Option Agreement.

17.10.1 Attachment

SCHEDULE A TO SCHEDULE 17.10

Entity	**Address**
William W. Backus Hospital	326 Washington Street, Norwich

Exceptions: See Schedule A-1 attached.

Description: See Schedule A-2

See also 330 Washington Street

SCHEDULE A-1

. Taxes to the City of Norwich on the Grand List of October 1, 2004 not yet due and payable.

:. Water and sewer use charges to the City of Norwich, payments of which are current.

l. Riparian rights of others in and to the waters of the Yantic River, and any watercourses abutting or flowing through the premises.

l. Terms and provisions set forth in an Indenture by an between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records; as affected by an Indenture by and among William C. Reynolds, Reginald Reynolds, Louise R. Greene, Albert L. Reynolds, John M. Reynolds, The William W. Backus Hospital, and Margaret V. Del Carlo dated January 16, 1915 and recorded in Volume 145 at Page 131 of the said Land Records.

i. Covenants and agreements set forth in a Warranty Deed from George W. Guard to Thomas M. Connor dated May 31, 1919 and recorded in Volume 156 at Page 37 of the Norwich Land Records.

l. Rights in favor of the State of Connecticut as set forth in an Instrument dated March 30, 1940 and recorded in Volume 218 at Page 1 of the Norwich Land Records.

'. Building restrictions as more particularly set forth in a Warranty Deed from The William W. Backus Hospital to Norwich Medical Center, Incorporated dated September 4, 1959 and recorded in Volume 302 at Page 652 of the Norwich Land Records.

l. Terms and conditions set forth in Lease from The William W. Backus Hospital to City of Norwich dated December 8, 1964, and recorded in Volume 330 at Page 806 of the Norwich Land Records.

9. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an Instrument dated February 11, 1969 and recorded in Volume 352 at Page 754 of the Norwich Land Records.

10. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an Instrument dated February 11, 1969 and recorded in Volume 352 at Page 756 of the Norwich Land Records.

11. Possible gas line and drainage easements as referenced in a Warranty Deed from Norwich Medical Center, Incorporated to The William W. Backus Hospital, Inc. dated June 12, 1969 and recorded in Volume 354 at Page 59 of the Norwich Land Records.

12. Sewer easements in favor of the City of Norwich as more particularly set forth in Certificates of Taking dated March 18, 1970 and April 9, 1970 and recorded in Volume 358 at Pages 12 and 218, respectively, of the Norwich Land Records.

13. Permanent easement and right of way in favor of the City of Norwich as more particularly set forth in a Quitclaim Deed dated January 9, 1974 and recorded in Volume 398 at Page 192 of the Norwich Land Records.

14. Maintenance obligations as set forth in a Grant of Easement from the City of Norwich to The William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

15. Maintenance obligations as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

16. Easements in favor of Norwich Medical Center, Incorporated as more particularly described in an Easement dated December 12, 1986 and recorded in Volume 753 at Page 81 of the Norwich Land Records.

17. Conditions and obligations as more particularly set forth in a Grant of Easement from Norwich Medical Center Condominium Association to The William W. Backus Hospital dated March 25, 1992 and recorded in Volume 1053 at Page 121 of the Norwich Land Records.

18. Right of way and easement in favor of Norwich Medical Center Condominium Association dated March 19, 1992 and recorded in Volume 1053 at Page 126 of the Norwich Land Records.

19. Denial of access rights to and from Routes 2 and 32 as more particularly set forth in a Quit-Claim Deed from the State of Connecticut to The William W. Backus Hospital, Inc. dated September 28, 1995 and recorded in Volume 1246 at Page 148 of the Norwich Land Records.

SCHEDULE A (LEGAL DESCRIPTION)

All that certain piece or parcel of land, with the buildings and improvements thereon, being shown on a plan entitled "Plan Made for The William W. Backus Hospital Property at Lafayette Street & Washington Streets - Norwich, CT. Scale: 1" = 80' Chandler, Palmer & King Norwich, Connecticut January 8, 1988 Additions: November 8, 1988 Additions 6/7/91 Revised 7/31/92 Additions: Sept. 18, 1992", further revised to 3/31/97. Said premises are more particularly bounded and described as follows:

Beginning at a point at the intersection of the southwesterly line of Washington Street with the northwesterly line of Lafayette Street and running thence South 25° 43' 10" West, 64.67 feet along the said northwesterly line of Lafayette Street to a drill hole; thence South 28° 05' 22" West, 40.00 feet along said street line to a drill hole at land of the Norwich Medical Center, Inc.; thence North 88° 51' 29" West, 242.12 feet to a point; thence South 01° 08' 31" West, 39.20 feet to a point; thence North 87° 17' 04" West, 51.04 feet to a point; thence South 02° 45' 26" West, 38.21 feet to a point; thence North 88° 35' 23" West, 30.05 feet to a point; thence South 02° 46' 44" West, 155.65 feet to a spike; thence South 65° 32' 16" East, 123.00 feet to a spike in the pavement on the said northwesterly line of Lafayette Street, these last seven lines abutting southerly, easterly and northeasterly on said land now or formerly of the Norwich Medical Center, Inc.; thence South 51° 25' 58" West, 38.94 feet along said street line to an iron pipe; thence North 65° 17' 56" West, 102.78 feet to a drill hole; thence North 66° 57' 56" West, 64.07 feet along the face of a retaining wall to a point, these last two lines abutting southwesterly on land now or formerly of Santo J. Grillo; thence North 66° 05' 55" West, 83.15 feet to a point; thence North 81° 47' 49" West, 104.01 feet to a fence post, these last two lines abutting southwesterly on land of S. John Grillo; thence South 11° 52' 14" West, 171.96 feet along a fence to a fence post, abutting easterly on land now or formerly of S. John Grillo and on land of Robert L. Degler and D. Robert Pannone; thence North 82° 35' 07" West, 628.13 feet along a fence line to a fence post; thence South 44° 25' 50 seconds West, 90.13 feet along a fence to an iron pipe; thence South 19° 14' 15" West, 190.18 feet along a fence to a drill hole; thence South 02° 50' 00" West, 114.91 feet along a fence to an iron pipe; thence South 02° 37' 50" East, 84.94 feet along a fence to a fence post; thence South 31° 43' 27" West, 68.70 feet along a fence to a point; thence South 35° 28' 33" West, 202.41 feet to an iron pipe; thence continuing along the extension of the last course about 28 feet to the easterly shore line of the Yantic River, these last seven lines abutting southwesterly, southeasterly, easterly and southeasterly on land of the City of Norwich (Yantic Cemetery); thence running northerly and northeasterly along the shore line of the Yantic River about 1,600 feet to land now or formerly of the State of Connecticut; thence North 84° 05' 59" East, about 20 feet to an iron pin; thence continuing North 84° 05' 59" East, 106.60 feet to a point; thence North 00° 26' 41" East, 94.05 feet to a Connecticut Highway Department Monument; thence South 89° 33' 20" East, 500.00 feet to a Connecticut Highway Department Monument; thence South 85° 21' 11" East, 208.95 feet to a Connecticut Highway Department Monument; thence South 40° 22' 20" East, 71.56 feet to a monument on said southwesterly line of Washington Street, the last five lines abutting northerly, westerly, northerly and northeasterly on land now or formerly of the State of Connecticut; thence along said southwesterly line of Washington Street, South 24° 15' 50" East, 460.31 feet to the point of beginning.

Together with rights granted under a certain Indenture by and between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records.

Together with the rights and easement as more particularly set forth in a Grant of Easement from the City of Norwich to the William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

Together with the rights and easements as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

Excepting therefrom the Backus Medical Center Condominium

All those certain condominium units, located in the Town of Norwich, County of New London and State of Connecticut, known as Units 210, 220, 230, 310, 320, 330, 340, 350, 410, 420, 430, 520, 530, and 540, of Backus Medical Center Condominium, together with their interest in the Common Elements appurtenant thereto, said Units and Common Elements being more specifically designated and described in the Declaration of Backus Medical Center Condominium, An Air Rights Condominium, dated February 1, 1999 and recorded in Volume 1416 at Page 271 of the Norwich Land Records.

Together with the rights, benefits, agreements, and easements as set forth in said Declaration, and the Bylaws, Exhibits and Schedules attached thereto, as may be amended and supplemented from time to time.

SCHEDULE B TO SCHEDULE 17.10

William W. Backus Hospital 330 Washington Street, Norwich

Exceptions:

Subject to an Open-End Mortgage and Security Agreement from The William W. Backus Hospital and Backus Foundation to The Connecticut National Bank as Master Trustee in the original aggregate amount of $16,000,000 dated September 1, 1992 and recorded in Volume 1078 Pate 241 of the Norwich Land Record, as supplemented by supplements number 1, 2, and 3 duly recorded in the Norwich Land Records, and as restated in Restated Master Trust Indenture, Open-End Mortgage and Security Agreement in the amount of $500,000,000 between The William W. Backus Hospital and US Bank, National Association, as Master Trustee, dated as of July 1, 2005 and recorded in Volume 2130 Page 43 of the Norwich Land Records and as supplemented by further Supplement No. 4 dated July 1, 2005 and recorded in the Norwich Land Records in Volume 2130 Page 121 and as further supplemented by Supplement No. 5 dated October 31, 2009 in Volume 2585 Page 183 of the Norwich Land Records.

See Schedule B-1 attached for additional exceptions to title.

Description: See Schedule B-2

Leases:

Eric Levine, DPM
John Giacchetto, MD, P. C.
Eastern CT Urology
Backus Physician Services
Chelsea Surgical Care, LLC
Pulmonary Physicians of Norwich
Norwich Sleep Center
Surgical Associates of Norwich, LLC
Anthony G. Alessi, MC
Eastern CT Neurosurgery

NOTE: 326 & 330 Washington Street comprise the William W. Backus Hospital main campus, and the legal description exceptions to title are inclusive of both properties.

SCHEDULE B-1

. Taxes to the City of Norwich on the Grand List of October 1, 2004 not yet due and payable.

:. Water and sewer use charges to the City of Norwich, payments of which are current.

l. Riparian rights of others in and to the waters of the Yantic River, and any watercourses abutting or flowing through the premises.

l. Terms and provisions set forth in an Indenture by an between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records; as affected by an Indenture by and among William C. Reynolds, Reginald Reynolds, Louise R. Greene, Albert L. Reynolds, John M. Reynolds, The William W. Backus Hospital, and Margaret V. Del Carlo dated January 16, 1915 and recorded in Volume 145 at Page 131 of the said Land Records.

i. Covenants and agreements set forth in a Warranty Deed from George W. Guard to Thomas M. Connor dated May 31, 1919 and recorded in Volume 156 at Page 37 of the Norwich Land Records.

l. Rights in favor of the State of Connecticut as set forth in an instrument dated March 30, 1940 and recorded in Volume 218 at Page 1 of the Norwich Land Records.

'. Building restrictions as more particularly set forth in a Warranty Deed from The William W. Backus Hospital to Norwich Medical Center, Incorporated dated September 4, 1959 and recorded in Volume 302 at Page 652 of the Norwich Land Records.

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9. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an Instrument dated February 11, 1969 and recorded in Volume 352 at Page 754 of the Norwich Land Records.

10. Permanent right of way and easement in favor of the City of Norwich as more particularly set forth in an Instrument dated February 11, 1969 and recorded in Volume 352 at Page 756 of the Norwich Land Records.

11. Possible gas line and drainage easements as referenced in a Warranty Deed from Norwich Medical Center, Incorporated to The William W. Backus Hospital, Inc. dated June 12, 1969 and recorded in Volume 354 at Page 59 of the Norwich Land Records.

12. Sewer easements in favor of the City of Norwich as more particularly set forth in Certificates of Taking dated March 18, 1970 and April 9, 1970 and recorded in Volume 358 at Pages 12 and 218, respectively, of the Norwich Land Records.

13. Permanent easement and right of way in favor of the City of Norwich as more particularly set forth in a Quitclaim Deed dated January 9, 1974 and recorded in Volume 398 at Page 192 of the Norwich Land Records.

14. Maintenance obligations as set forth in a Grant of Easement from the City of Norwich to The William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

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16. Easements in favor of Norwich Medical Center, Incorporated as more particularly described in an Easement dated December 12, 1986 and recorded in Volume 753 at Page 81 of the Norwich Land Records.

17. Conditions and obligations as more particularly set forth in a Grant of Easement from Norwich Medical Center Condominium Association to The William W. Backus Hospital dated March 25, 1992 and recorded in Volume 1053 at Page 121 of the Norwich Land Records.

18. Right of way and easement in favor of Norwich Medical Center Condominium Association dated March 19, 1992 and recorded in Volume 1053 at Page 126 of the Norwich Land Records.

19. Denial of access rights to and from Routes 2 and 32 as more particularly set forth in a Quit-Claim Deed from the State of Connecticut to The William W. Backus Hospital, Inc. dated September 28, 1995 and recorded in Volume 1246 at Page 146 of the Norwich Land Records.

SCHEDULE B-2

All that certain piece or parcel of land, with the buildings and improvements thereon, being shown on a plan entitled "Plan Made for The William W. Backus Hospital *Property at Lafayette Street & Washington Streets* - Norwich, CT. Scale: 1" = 80' Chandler, Palmer & King Norwich, Connecticut January 8, 1988 Additions: November 8, 1988 Additions 8/7/91 Revised 7/31/92 Additions: Sept. 18, 1992", further revised to 3/31/97. Said premises are more particularly bounded and described as follows:

Beginning at a point at the intersection of the southwesterly line of Washington Street with the northwesterly line of Lafayette Street and running thence South 25° 43' 10" West, 64.67 feet along the said northwesterly line of Lafayette Street to a drill hole; thence South 28° 05' 22" West, 40.00 feet along said street line to a drill hole at land of the Norwich Medical Center, Inc.; thence North 88° 51' 29" West, 242.12 feet to a point; thence South 01° 08' 31" West, 39.20 feet to a point; thence North 87° 17' 04" West, 51.04 feet to a point; thence South 02° 45' 26" West, 36.21 feet to a point; thence North 88° 35' 23" West, 30.05 feet to a point; thence South 02° 45' 44" West, 155.65 feet to a spike; thence South 65° 32' 16" East, 123.00 feet to a spike in the pavement on the said northwesterly line of Lafayette Street, these last seven lines abutting southerly, easterly and northeasterly on said land now or formerly of the Norwich Medical Center, Inc.; thence South 51° 25' 53" West, 38.94 feet along said street line to an iron pipe; thence North 65° 17' 56" West, 102.78 feet to a drill hole; thence North 66° 57' 56" West, 64.07 feet along the face of a retaining wall to a point, these last two lines abutting southwesterly on land now or formerly of Santo J. Grillo; thence North 66° 05' 56" West, 83.15 feet to a point; thence North 81° 47' 49" West, 104.01 feet to a fence post, these last two lines abutting southwesterly on land of S. John Grillo; thence South 11° 52' 14" West, 171.96 feet along a fence to a fence post, abutting easterly on land now or formerly of S. John Grillo and on land of Robert L. Degler and D. Robert Pannone; thence North 82° 35' 07" West, 628.13 feet along a fence line to a fence post; thence South 44° 25' 50 seconds West, 90.18 feet along a fence to an iron pipe; thence South 19° 14' 15" West, 190.16 feet along a fence to a drill hole; thence South 02° 50' 00" West, 114.91 feet along a fence to an iron pipe; thence South 02° 37' 50" East, 84.94 feet along a fence to a fence post; thence South 81° 43' 27" West, 88.70 feet along a fence to a point; thence South 36° 28' 33" West, 202.41 feet to an iron pipe; thence continuing along the extension of the last course about 28 feet to the easterly shore line of the Yantic River, these last seven lines abutting southwesterly, southeasterly, easterly and southeasterly on land of the City of Norwich (Yantic Cemetery); thence running northerly and northeasterly along the shore line of the Yantic River about 1,600 feet to land now or formerly of the State of Connecticut; thence North 84° 05' 59" East, about 20 feet to an iron pin; thence continuing North 84° 05' 59" East, 106.50 feet to a point; thence North 00° 26' 41" East, 94.05 feet to a Connecticut Highway Department Monument; thence South 89° 33' 20" East, 500.00 feet to a Connecticut Highway Department Monument; thence South 85° 21' 11" East, 209.95 feet to a Connecticut Highway Department Monument; thence South 40° 22' 20" East, 71.56 feet to a monument on said southwesterly line of Washington Street, the last five lines abutting northerly, westerly, northerly and northeasterly on land now or formerly of the State of Connecticut; thence along said southwesterly line of Washington Street, South 24° 15' 50" East, 460.31 feet to the point of beginning.

Together with rights granted under a certain indenture by and between Mary W. Reynolds and The William W. Backus Hospital dated September 21, 1892 and recorded in Volume 101 at Page 395 of the Norwich Land Records.

Together with the rights and easement as more particularly set forth in a Grant of Easement from the City of Norwich to the William W. Backus Hospital dated November 12, 1980 and recorded in Volume 545 at Page 177 of the Norwich Land Records.

Together with the rights and easements as more particularly set forth in an Agreement by and between The William W. Backus Hospital and Norwich Medical Center, Incorporated dated November 10, 1983 and recorded in Volume 621 at Page 93 of the Norwich Land Records.

Excepting therefrom the Backus Medical Center Condominium

All those certain condominium units, located in the Town of Norwich, County of New London and State of Connecticut, known as Units 210, 220, 230, 310, 320, 330, 340, 350, 410, 420, 430, 520, 530, and 540, of Backus Medical Center Condominium, together with their interest in the Common Elements appurtenant thereto, said Units and Common Elements being more specifically designated and described in the Declaration of Backus Medical Center Condominium, An Air Rights Condominium, dated February 1, 1999 and recorded in Volume 1416 at Page 271 of the Norwich Land Records.

Together with the rights, benefits, agreements, and easements as set forth in said Declaration, and the Bylaws, Exhibits and Schedules attached thereto, as may be amended and supplemented from time to time.

SCHEDULE C TO SCHEDULE 17.10

William W. Backus Hospital 303 Washington Street, Norwich

Exceptions: None

Description: See Schedule C-1

Leases:

Tanya Hubbard-Walston
Donald Cox

SCHEDULE C-1

A certain tract of parcel of land, together with the buildings and improvements thereon, situated on the easterly side of Washington Street in the Town of Norwich, County of New London and State of Connecticut, bounded and described as follows:

Beginning on the easterly line of said street at the northwesterly corner of land now or formerly of Patrick J. Morley and running southerly thereon 83.7 feet to a drill hole; thence deflecting 88° 8' to the left and running 203.3 feet; thence deflecting 93° 27' to the left and running 78.3 feet to land now or formerly of C. Morgan Williams; thence westerly 201 feet to the place of beginning; said tract is bounded southerly and easterly by land now or formerly of Patrick Morley, northerly by land now or formerly of C. Morgan Williams and westerly by said Washington Street.

Being the same premises conveyed to this Grantor by deed 1/30/98 and recorded in Volume 1355, Page 251 of teh Norwich Land Records.

The Grantee herein hereby agrees and assumes to pay any and all taxes hereinafter falling due.

SCHEDULE D TO SCHEDULE 17.10

William W. Backus Hospital 304 Washington Street, Norwich

Exceptions:

a. Subject to a restriction as to limitations of construction on the premises recorded in Volume 575 Page 33 of the Norwich Land Records. The William W. Backus Hospital has an owner's policy of title insurance affirmatively insuring the William W. Backus Hospital against loss by reason of enforcement or attempted enforcement of said restriction.

b. Subject to a possible encroachment of the driveway onto the adjoining premises.

Description: See Schedule D-1

Leases:

SCHEDULE D-1

A certain tract of land, together with the buildings and improvements thereon, situated in the City of Norwich, County of New London and State of Connecticut, and bounded and described as follows:

Beginning at a point on the westerly side of Washington Street at the northeast corner of land now of Selma Swatsburg, formerly of C. Morgan Williams and the southeast corner of the premises herein conveyed, and running thence northerly along Washington Street, 65 feet; thence westerly at an angle of 90 degrees, 161.4 feet to land now of Alfred P. Savage, formerly of Frederica A. Roos; thence southerly along the land of said Alfred P. Savage, 65.9 feet to the land of said Selma Swatsburg; thence easterly at an angle of 99° 54' along the land of said Selma Swatsburg, 150 feet, more or less, to the point of beginning.

Said lot being known as Lot #10 as shown on a plan of land now or formerly of Fannie L. Bliss and Edith M. Bliss, recorded in Norwich City Clerk's Office.

The premises are subject to the following restrictions: That no building or any part of a building shall be erected on said premises to project easterly of a line sixty-three feet and ten inches, measured from the face of the curb, except that some may be built beyond said line a one-story open piazza, the floor of which shall not exceed eight feet in width and which piazza shall be without lattice work or other obstruction except a railing, not to exceed three feet in height; that there shall be no stables of any description, including chicken coops, erected on any part of the premises; and that said premises shall be used solely for residential purposes.

SCHEDULE E TO SCHEDULE 17.10

William W. Backus Hospital 305 Washington Street, Norwich

Exceptions: None

Description: See Schedule E-1

SCHEDULE E-1

A certain tract of land, with the buildings and improvements thereon, situated in the Town of Norwich, County of New London and State of Connecticut, on the easterly side of Washington Street, known as 305 Washington Street, and bounded and described as follows:

Beginning at a point on the easterly side of Washington Street at the northwesterly corner of the herein conveyed premises and running easterly in a straight line about 274 feet to land now or formerly of Frank A. Sisk abutting northerly on land now or formerly of Arthur C. Brown; said line passes through a point 16.9 feet southerly from the southwesterly corner and in range with the westerly side of the house known as 305 1/2 Washington Street and also passes through a point 16.1 feet northerly from the northeasterly corner and in range with the easterly side of the house on the conveyed premises; thence southerly about 96 feet to land now or formerly of H.P. and L.O. Hull, bounded easterly on land of said Sisk and land now or formerly of Herbert M. Hichon; thence westerly about 249 feet to the easterly line of Washington Street, bounding southerly on land of said Hull and land now or formerly of Johanna J. Wright; thence northerly along the easterly side of Washington Street 84.8 feet to the point of beginning.

SCHEDULE F TO SCHEDULE 17.10

William W. Backus Hospital — 315 Washington Street, Norwich

Exceptions: None

Description: See Schedule F-1

Leases: Debbie McClimon
Joan Munroe

SCHEDULE F-1

All that tract of land with the buildings thereon situated in the Town of Norwich, bounded and described as follows:

Beginning on the southeasterly corner of Washington and Julian Streets and running thence easterly 90 feet by the southerly line of Julian Street; thence southerly at right angles therewith 76 feet to land late of Henry T. Gorman; thence westerly by said Gorman land 73 feet to Washington Street and thence northerly by Washington Street 75 feet to the point of beginning, including the right of way over Julian Street.

[illegible] same premises conveyed to The William W. Backus Hospital, Inc. by Warranty Deed of George W. Davis and Mildred B. Davis, as recorded in the Norwich Land Records.

SCHEDULE G TO SCHEDULE 17.10

William W. Backus Hospital 321 Washington Street, Norwich

Exceptions: None

Description: See Schedule G-1

Leases: Eugene and Nancy Perez

SCHEDULE G-1

A tract of land, with the buildings thereon, situated on the easterly side of Washington Street in the city of Norwich, New London County, Connecticut, known as No. 321 Washington Street, described as follows:

Beginning on the easterly line of Washington Street at the northwesterly corner of land now or formerly of Pasquale and Grazia Girasoli, and running thence northerly by the easterly line of Washington Street 73 feet to land now or formerly of Doris E. Boyer; thence easterly by said Boyer land 103 feet to land of the William W. Backus Hospital; thence southerly about 72 feet by said Hospital land to said Girasoli land; and thence westerly 77.5 feet by said Girasoli land to the point of beginning.

SCHEDULE H TO SCHEDULE 17.10

William W. Backus Hospital	323 Washington Street, Norwich
Exceptions:	
Description:	See Schedule H-1
Leases:	Andy Trogden

SCHEDULE H-1

All that certain tract or parcel of land, together with the buildings and improvements thereon, situated in the Town of Norwich, County of New London and State of Connecticut, bounded and described as follows:

Beginning at the intersection of the Easterly line of North Washington Street with the Southerly line of Bliss Place, and running thence Easterly by the Southerly line of Bliss Place 110 feet, more or less, to the center of a brook; thence Southerly by the center line of said brook 65 feet; thence Westerly by land of Robert and Adelaide Cochran to the Easterly line of North Washington Street at a point on said line 65 feet Southerly from the Southerly line of said Bliss Place; thence Northerly by the easterly line of North Washington Street 65 feet to the point of beginning.

Excepting therefrom a certain parcel of land conveyed to the State of Connecticut by a Quit-Claim deed of Arthur E. Boyer and Doris E. Boyer dated June 17, 1957 and recorded in Volume 290, Page 421 of the Norwich Land Records.

SCHEDULE I TO SCHEDULE 17.10

William W. Backus Hospital 99 Lafayette Street, Norwich

Exceptions: None

Description: See Schedule I-1

SCHEDULE I-1

Beginning at the westerly corner of land of Letitia E. Waters on the southeasterly side of said Street, and running thence southwesterly by Lafayette Street 90.8 feet to an iron pin at land of Walter and Margarete Adams; thence southeasterly by said Adams land a total distance of 128 feet to an iron pin at land of The Hareth Corporation; thence northeasterly 60 feet by said Hareth land to said Waters land; and thence northwesterly about 168 feet by said Waters land to the point of beginning.

$675 CONNECTICUT TAX RECEIVED
$148.50 CONVEYANCE TAX RECEIVED
BEVERLY C. MULDOON, TOWN CLERK OF NORWICH

Subject to taxes due on the grand list of October 1, 1999 and thereafter.

Subject to also to any and all provisions of any ordinance, municipal regulation or public or private law, including but not limited to building, building line and zoning restrictions established by the Town of Norwich.

Reference is made to a quit claim deed from John J. Caulfield and Jane M. Caulfield to Jane Caulfield Fusaro, Bernard J. Caulfield, Timothy J. Caulfield, Margaret Soulas Caulfield, and Patricia Caulfield Lathrop dated August 2, 1995 and recorded in Volume 1228 Page 063 of the Norwich Land Records.

SCHEDULE J TO SCHEDULE 17.10

William W. Backus Hospital 107 Lafayette Street, Norwich

Exceptions:

Subject to restriction that no stable may be erected on the premises as contained in a deed recorded in Volume 171 Page 109 of the Norwich Land Records.

Subject to a zoning variance permitting use as a medical office and certain buffer waivers as recorded in Volume 713 Page 67 of the Norwich Land Records.

Description: See Schedule J-1

SCHEDULE J-1

That certain piece or parcel of land with the buildings thereon, situated on the southerly side of Lafayette Street in the Town of Norwich, County of New London and State of Connecticut and bounded and described as follows:

Bounded Northerly on said Street 65 feet; Easterly by land now or formerly of Frank G. Rice about 215 feet; Southerly by land now or formerly of C. Del Carlo 65 feet; and Westerly by land now or formerly of Erroll C. Lilibridge about 206 feet.

Being the same premises conveyed to Backus Properties, Inc. by deed of Tom P. Bell dated June 4, 1997 and recorded in Volume 1319 at Page 214 of the Norwich Land Records.

Subject to restrictions as of record appear.

SCHEDULE K TO SCHEDULE 17.10

William W. Backus Hospital 121 Lafayette Street, Norwich

Exceptions:

Effects, if any, of a variance granted November 4, 1986 by the Norwich Zoning Board of Appeals and recorded in Volume 750 Page 152 of the Norwich Land Records.

Description: See Schedule K-1

Leases: Ronald Baratz, DDS
Sarah Beckett and Beverly Carr

SCHEDULE K-1

A certain tract and parcel of land with the buildings and improvements thereon situated, located at La£ayette Street, in the Town o£ Norwich, County o£ New London and State of Connecticut, and more particularly described as follows, to wit:

Beginning at an iron pipe set on the southerly street line of Lafayette Street said point being the northwesterly corner of the herein described parcel and the northeasterly corner of land owned now or formerly of Adam Labenski, thence running in a generally northeasterly direction by and along the southerly street line of La£ayette Street and the arc of a circular curve having a central angle of 4°-02'-28" and a radius of 1200.00 feet and a chord distance of 84.62 feet, a distance of 84.64 feet to an iron pipe at the northeasterly corner of the herein described parcel, bounded northerly by Lafayette Street, thence turning an interior angle of 69°-31'-22" from the chord of the above mentioned curve and running in a southeasterly direction 164.06 feet to a spike set in the base of a tree bounded easterly by properties owned now or formerly by Marjorie H. Johnson and Franklin M. Boller, thence turning an interior angle of 170°-06'-00" and running southerly a distance of 105.20 feet to an iron pipe, said point being the southeasterly corner of the herein described tract, bounded easterly by properties owned now or formerly by Franklin M. Boller, Selma R. Swatsburg, and Alfred P. and Iva A. Savance, thence turning an interior angle of 105°-00'-00" and running southwesterly a distance of 45.00 feet to an iron pipe (existing), said point being the southwesterly corner of the herein described tract, bounded southerly by property owned now or formerly by Alfred P, and Iva A. Savage, thence turning an interior angle of 88 -46'-00" and running northwesterly 242.64 feet to an iron pipe, said iron pipe being the point and place of beginning.

Said last mentioned course forming an interior angle with the chord in said first mentioned course of 106°-36'-38".

Above mentioned description shown on a plan titled: Site Development Plan, Medical or Dental and Professional Offices, Property of Lehigh Petroleum, Inc., 121 I,afayette Street, Norwich, Connecticut, Scale: 1"710', March, 1975, Dicesare-Bentley-Welling Engineers, Inc., Groton-Norwich, Connecticut.

Being the same premises conveyed to the Grantor by deed dated August 2, 1985 and recorded in Vol. 684 at Pg. 96 of the Norwich Land Records.

The Grantee herein hereby agrees and assumes to pay all taxes now or hereinafter due.

SCHEDULE L TO SCHEDULE 17.10

William W. Backus Hospital 1 Matlack Drive, Norwich

Exceptions: See Schedule L-1 attached

Description: See Schedule L-2

SCHEDULE L-1

1. Easements or claims of easements not shown by the public records, boundary-line disputes, overlaps, encroachments, title to filled lands (if any) and any matters not of record which would be disclosed by an accurate survey and inspection of the premises.

2. Real estate taxes to the City of Norwich on the List of October 1, 2002 not yet due and payable.

3. Refuse charges to the City of Norwich as may become due and payable.

4. Water and/or sewer use charges as may be due Norwich Department of Public Utilities

5. Order of the State of Connecticut to Falls Corporation dated August 21, 1967 and recorded December 14, 1967 in Volume 346 at Page 401 of the Norwich Land Records.

6. Effect, if any, of those easements more particularly described in a deed from Falls Corporation to the City of Norwich dated June 13, 1969 and recorded June 18, 1969 in Volume 354 at Page 143 of the Norwich Land Records.

7. Right of way over a strip of land thirty feet (30') in width for the purpose of a railroad siding as contained in a deed from Falls Corporation to Rollins Properties, Inc. dated December 7, 1971 and recorded December 7, 1971 in Volume 369 at Page 558 of the Norwich Land Records. *(as to 4 Matlack Road ONLY)*

8. Special Exception granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated June 12, 1981 and recorded June 29, 1981 in Volume 557 at Page 247 of the Norwich Land Records.

9. Special Permit granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated July 15, 1982 and recorded August 2, 1982 in Volume 579 at Page 118 of the Norwich Land Records.

10. Grant of slope rights to Patricia A. Tramontozzi, Julio Cirillo, Elaine M. Coletti and Martin Foley, Trustees from Rollins Properties, Inc. dated February 28, 1983 and recorded December 28, 1994 in Volume 662 at Page 121 of the Norwich Land Records.

11. Consent Order by Matlack, Incorporated and Brite-Sol Services, Incorporated to the Commissioner of Environmental Protection dated October 6, 1998 and recorded October 19, 1998 in Volume 1399 at Page 288 of the Norwich Land Records.

SCHEDULE L-2

1 Matlack Rd., Norwich, CT

A certain tract or parcel of land with the buildings standing thereon located in the Town of Norwich, County of New London, State of Connecticut, being bounded and described as follows:

Beginning at a monument on the Northerly line of Rollins Road at the dividing line between the herein described tract and land now or formerly of Tramontozzi et. al. and thence running along said road line South 85° 30' East 342.84 feet to a monument at a point of curve to the left having a radius of 61.20 feet; thence Northeastwardly, along the Northwesterly line of Matlack Road, following the arc of said curve 83.84 feet to a monument; thence along said Matlack Road line North 16° 00' East 434.73 feet to a monument; thence North 85° 30' West 386.56 feet, abutting Northerly on remaining land now or formerly of Rollins Properties, Inc.; thence South 23° 45' West 62.00 feet, abutting Northwesterly on land now or formerly of Despin; thence South 69° 50' East 33.00 feet to a drill hole; thence South 20° 10' West 423.26 feet to the point of beginning, these last two lines abutting Southwesterly and Northwesterly on said land now or formerly of Tramontozzi, et. al.

TOGETHER WITH a right of way to pass and repass over a twenty foot (20') strip as being more particularly described in a Deed from Anna T. Bohara to Roy S. Beebe, dated July 31, 1946 and recorded July 31, 1946 in Volume 237, Page 204 of the Norwich Land Records.

SCHEDULE M TO SCHEDULE 17.10

William W. Backus Hospital 4 Matlack Drive, Norwich

Exceptions: See Schedule M-1 attached

Said premises is further subject to an Environmental Land Use Restriction recorded in Volume 2633 Page 138 of the Norwich Land Records and dated August 13, 2010.

Description: See Schedule M-2

NOTE: Although 1 Matlack Drive and 4 Matlack Drive exist as separate parcels, they are effectively one parcel of land and the exceptions to title are applicable to both parcels.

NOTE: Consent Order filed by DEP is of no force and effect, as all remediation having been completed and certified as such by DEP by letter dated September 28, 2010.

SCHEDULE M-1

1. Easements or claims of easements not shown by the public records, boundary-line disputes, overlaps, encroachments, title to filled lands (if any) and any matters not of record which would be disclosed by an accurate survey and inspection of the premises.

2. Real estate taxes to the City of Norwich on the List of October 1, 2002 not yet due and payable.

3. Refuse charges to the City of Norwich as may become due and payable.

4. Water and/or sewer use charges as may be due Norwich Department of Public Utilities

5. Order of the State of Connecticut to Falls Corporation dated August 21, 1967 and recorded December 14, 1967 in Volume 346 at Page 401 of the Norwich Land Records.

6. Effect, if any, of those easements more particularly described in a deed from Falls Corporation to the City of Norwich dated June 13, 1969 and recorded June 18, 1969 in Volume 354 at Page 143 of the Norwich Land Records.

7. Right of way over a strip of land thirty feet (30') in width for the purpose of a railroad siding as contained in a deed from Falls Corporation to Rollins Properties, Inc. dated December 7, 1971 and recorded December 7, 1971 in Volume 369 at Page 558 of the Norwich Land Records. *(as to 4 Matlack Road ONLY)*

8. Special Exception granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated June 12, 1981 and recorded June 29, 1981 in Volume 557 at Page 247 of the Norwich Land Records.

9. Special Permit granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated July 15, 1982 and recorded August 2, 1982 in Volume 579 at Page 118 of the Norwich Land Records.

10. Grant of slope rights to Patricia A. Tramontozzi, Julio Cirillo, Elaine M. Coletti and Martin Foley, Trustees from Rollins Properties, Inc. dated February 28, 1983 and recorded December 28, 1994 in Volume 662 at Page 121 of the Norwich Land Records.

11. Consent Order by Matlack, Incorporated and Brite-Sol Services, Incorporated to the Commissioner of Environmental Protection dated October 6, 1998 and recorded October 19, 1998 in Volume 1399 at Page 288 of the Norwich Land Records.

Said premises are subject to:

1. Building lines, if established, building and zoning ordinances, and any and all municipal and state and federal regulations including inland wetlands regulations and provisions of any public or private law affecting said premises.

2. Taxes on 2002 Grand List, not yet due and payable, which the Grantees herein assume and agree to pay.

3. Order of the State of Connecticut to Falls Corporation dated August 21, 1967 and recorded December 14, 1967 in Volume 346 at Page 401 of the Norwich Land Records.

4. Effect, if any, of those easements more particularly described in a deed from Falls Corporation to the City of Norwich dated June 13, 1969 and recorded June 18, 1969 in Volume 354 at Page 143 of the Norwich Land Records.

5. Right of way over a strip of land thirty feet (30') in width for the purpose of a railroad siding as contained in a deed from Falls Corporation to Rollins Properties, Inc. dated December 7, 1971 and recorded December 7, 1971 in Volume 369 at Page 558 of the Norwich Land Records. *(as to 4 Matlack Road ONLY)*

6. Special Exception granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated June 12, 1981 and recorded June 29, 1981 in Volume 557 at Page 247 of the Norwich Land Records.

7. Special Permit granted to Rollins Properties, Inc. by the City of Norwich Zoning Board of Appeals dated July 15, 1982 and recorded August 2, 1982 in Volume 579 at Page 118 of the Norwich Land Records.

8. Grant of slope rights to Patricia A. Tramontozzi, Julio Cirillo, Elaine M. Coletti and Martin Foley, Trustees from Rollins Properties, Inc. dated February 28, 1983 and recorded December 28, 1994 in Volume 662 at Page 121 of the Norwich Land Records.

9. Consent Order by Matlack, Incorporated and Brite-Sol Services, Incorporated to the Commissioner of Environmental Protection dated October 6, 1998 and recorded October 19, 1998 in Volume 1399 at Page 288 of the Norwich Land Records.

SCHEDULE M-2

4 Matlack Rd., Norwich, CT

ALL that certain tract or parcel of land with the buildings standing thereon located in the Town of Norwich, County of New London, State of Connecticut, being bounded and described as follows:

Beginning at a monument on the Northeasterly line of Rollins Road extending Southeasterly from New London Turnpike, said monument being 483.86 feet from the Southeasterly corner of land of Patricia A. Tramontozzi et. al. and thence running along said road line South 85° 30' East 94.14 feet to a point of curve to the left having a radius of 25.00 feet; thence Eastwardly along said road line, following the arc of said curve 21.03 feet to a point of curve to the right having a radius of 50.00 feet; thence Eastwardly along said road line, following the arc of the said curve 94.41 feet; thence along said road line South 85° 30' East 40.85 feet to a monument at land of the Canadian National Railways, Central Vermont Division; thence North 14° 02' 40" East 398.73 feet to an iron origin; thence North 14° 48' 40" East 208.42 feet to an iron pipe; thence North 9° 56' 20" East 127.46 feet to an angle iron; thence North 5° 07' 50" East 137.90 feet to a monument, these last four lines abutting Southeasterly on said Railroad; thence along a wall South 75° 10' West 292.10 feet to a drill hole; thence along said wall North 88° 39' West 92.33 feet to a drill hole at the end of the wall, these two lines abutting Northwesterly and Northeasterly on land of Henry J. Hanks; thence North 76° 25' West 135.89 feet to an iron pipe; thence North 76° 11' West 65.19 feet to a drill hole in ledge; thence South 65° 37' West 126.41 feet to an iron pipe at land of George and Ruth P. Despin, these last three lines abutting Northeasterly and Northwesterly on a right of way 20 feet wide leading to New London Turnpike; thence South 9° 33' West 137.50 feet to a drill hole in ledge; thence South 13° 31' West 41.19 feet; thence South 23° 43' West 100.60 feet; thence South 85° 30' East 386.56 feet to a monument, located on the Westwardly side of Matlack Road, said monument being a point of curve to the left having a radius of 25.00 feet; thence Northwardly along said road, following the arc of said curve 21.03 feet to a point of curve to the right having a radius of 50.00 feet; thence Eastwardly along said road following the arc of said curve 241.19 feet to a point of curve to the left having a radius 25.00 feet; thence Southwardly along said road following the arc of said curve 21.03 feet to a monument; thence South 16° 00' West 434.73 feet to a point of curve to the left having a radius of 32.68 feet; thence Eastwardly following the arc of said curve 57.90 feet to the point of beginning.

Together with a Right of Way 20 feet wide eastedly from New London Turnpike to and along the portion to the north boundary line as set forth in Volume 369 at Page 558 of the Norwich Land Records.

TOGETHER WITH a right of way to pass and repass over a twenty foot (20') strip as being more particularly described in a Deed from Anna T. Bohara to Roy S. Beebe, dated July 31, 1946 and recorded July 31, 1946 in Volume 237, Page 204 of the Norwich Land Records.

SCHEDULE N TO SCHEDULE 17.10

William W. Backus Hospital 12 Case Street, Norwich
(Office condominium units A-5, A-10, A-11, C-8, C-9, C-10, C-15)

Exceptions:

All units are together with and subject to the terms and conditions of a Declaration of Case Street Office Condominium dated May 9, 1979 and recorded in Volume 513 Page 178 of the Norwich Land Records

Description: See Schedule N-1

Leases: Backus Physician Services

SCHEDULE N-1

Four (4) certain condominium units situated in the Town of Norwich, County of New London and State of Connecticut known as **Units A5, A10, A11 and C8** in a condominium known as Case Street Office Condominium as more particularly set forth in a "Declaration of Unit Ownership For Case Street Office Condominium" dated May 9, 1978 and recorded in Volume 513 at Page 178 of the Norwich Land Records, and the plans for said Condominium entitled "Office Building (Condominium) 12 Case Street, Norwich, Connecticut", 1/2" = 1' - 0" prepared by David T. Frigon, AIA and recorded May 20, 1979 in Condo File 1A through 1D, Norwich Town Clerk's Office, together with said units' interest in the Common Elements. Said Declaration having been amended by amendments recorded in volume 678, page 32; volume 747, page 141; volume 747, page 142; and volume 1714, page 298, Norwich Land Records.

Units A5 and A11 having been conveyed to this Grantor by deed recorded in volume 526, page 117, Norwich Land Records. Unit A10 having been conveyed to this Grantor by deed recorded in volume 1202, page 298, Norwich Land Records; and Unit C8 having been conveyed to this Grantor by deed recorded in volume 708, page 82, Norwich Land Records.

SCHEDULE N-1

The following described property situated in the Town of Norwich, County of New London and State of Connecticut:

Units C9 & C10 within the 12 Case Street Office Condominium and an undivided .020536 and .019940 percentage interest respectively, in and to the common elements within the condominium property, as the same are established and identified in the "Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513, at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut, TOGETHER WITH:

1) an exclusive easement to the use of the Limited Common elements appurtenant to said Units.

2) The benefit of the other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SCHEDULE N-1

The following described property situated in the Town of Norwich, County of New London, and State of Connecticut:

Unit No. C-15 within the 12 Case Street Office Condominium and an undivided .019642 percentage interest in and to the common elements within the condominium property, as the same are established and identified in the "Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513 at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut.

Together with:

1) An exclusive easement to the use of the Limited Common elements appurtenant to said unit;

2) The benefit of other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SCHEDULE O TO SCHEDULE 17.10

Backus Home Health Care 12 Case Street, Norwich
(Office condominium units C-11 and C-12)

Exceptions:

All units are together with and subject to the terms and conditions of a Declaration of Case Street Office Condominium dated May 9, 1979 and recorded in Volume 513 Page 178 of the Norwich Land Records

Description: See Schedule O-1

Leases:

SCHEDULE O-1

UNIT NO. C-11 AND UNIT C-12

Unit No. C-11 within the 12 Case Street Office Condominium and an undivided .056777 percentage interest in and to the common elements within the condominium property, as the same are established and identified in the "1 Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513 at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut, TOGETHER WITH:

1) an exclusive easement to the use of the Limited Common Elements appurtenant to said Unit.

2) The benefit of the other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SUBJECT TO:

1) The covenants, restrictions, easements and other provisions set forth in the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time;

The term "Unit", "Common Elements", "Limited Common Elements" and any similar terms as they are used in this Deed are more particularly defined and set forth in the Declaration.

The building within the condominium property is located on the land described on Schedule A attached hereto.

The Grantee, by accepting and recording this Deed, accepts the covenants, restrictions, easements, liens, charges and other provisions contained or referred to herein and agrees to perform the obligations imposed by the Declaration.

Unit No. C-12 within the 12 Case Street Office Condominium and an undivided .026168 percentage interest in and to the common elements within the condominium property, as the same are established and identified in the "1 Declaration of Unit Ownership for Case Street Office Condominium" dated May 9, 1979, which Declaration is recorded in Volume 513 at Page 178 in the Office of the Town Clerk of Norwich, Connecticut, and the survey entitled "Site Plan, Office Building (Condominium) 12 Case Street, Norwich, Connecticut" dated December 1, 1978, filed in the Office of the Town Clerk of Norwich, Connecticut, TOGETHER WITH:

1) an exclusive easement to the use of the Limited Common elements appurtenant to said Unit.

2) The benefit of the other covenants, restrictions, easements and provisions of the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

SUBJECT TO:

1) The covenants, restrictions, easements and other provisions set forth in the Declaration (including the schedules and exhibits thereto), as it may be amended from time to time.

The term "Unit", "Common Elements", "Limited Common Elements" and any similar terms as they are used in this Deed are more particularly defined and set forth in the Declaration.

The building within the condominium property is located on the land described on Schedule A attached hereto.

The Grantee, by accepting and recording this Deed, accepts the covenants, restrictions, easements, liens, charges and other provisions contained or referred to herein and agrees to perform the obligations imposed by the Declaration.

SCHEDULE P TO SCHEDULE 17.10

William W. Backus Hospital 11 Stott Avenue, Norwich

Exceptions: Mortgage in favor of Dime Bank in the amount of $1,250,000 dated April 15, 2010 and recorded in Volume 2610 Page 23 of the Norwich Land Records and an Assignment of Leases and Rents recorded in Volume 2610 Page 319 of the Norwich Land Records.

See attached Schedule P-1 for additional exceptions.

Description: See Schedule P-2

SCHEDULE P TO SCHEDULE 17.10

William W. Backus Hospital 11 Stott Avenue, Norwich

Exceptions: Mortgage in favor of Dime Bank in the amount of $1,250,000 dated April 15, 2010 and recorded in Volume 2610 Page 23 of the Norwich Land Records and an Assignment of Leases and Rents recorded in Volume 2610 Page 319 of the Norwich Land Records.

See attached Schedule P-1 for additional exceptions.

Description: See Schedule P-2

SCHEDULE P-1

Said premises are conveyed subject to:

1. Real property taxes of the city of Norwich not yet due and owing.

2. Easement in favor of Algonquin Gas transmission company dated December 11, 1951 and recorded in Volume 258 at Page 393 of the Norwich Land Records.

3. Covenants and Restrictions of the Norwich Industrial Park described in a deed from the Norwich Community Development Corporation, Incorporated to Hilltop Investments, LLC dated January 17, 2001 and recorded in Volume 1626 at Page 119 of the Norwich Land Records.

4. Right of Levine Distributing Company, its heirs and assigns, to discharge surface water from a paved swale described in a deed from The Norwich Community Development Corporation, Incorporated to Hilltop Investments, LLC dated January 17, 2002 and recorded in Volume 1626 at Page 119 of the Norwich Land Records and as shown on the herein referenced map.

5. Easement in favor of the City of Norwich dated August 6, 2002 and recorded in Volume 1679 at page 251 of the Norwich Land Records.

6. Terms and provisions of a ground lease wherein Hilltop Investments, LLC is the landlord and RM Holdings, LLC is the tenant, a Notice of which is dated January 8, 2003 and recorded in Volume 1729 at Page 20 of the Norwich Land records, which lease was assigned to Sopramco, LLC as tenant, which assignment appears of record.

SCHEDULE P-2

A certain tract or parcel of land situated in the Town of Norwich, County of New London and State of Connecticut, depicted on a plan entitled "Boundary Survey Property to be Conveyed to The Wm. W. Backus Hospital #11 Stott Avenue Norwich, Connecticut Project No. CLA-4648 Proj. Engineer RLM Date: 4/8/10 Sheet No. 1" prepared by CLA Engineers, Inc. and being more particularly described as follows:

Beginning at an iron pin (found) on the northerly line of Stott Avenue, said pin marking the southeasterly corner of land of Levine Distributing Company and the southwesterly corner of the herein described tract and running thence N 4° 41' 55" W, a distance of 450.00 feet to an iron pin (destroyed); thence continuing N 4° 41' 55" W a distance of 300.08 feet to a point, these last two lines bounded westerly by land of Levine Distributing Company; thence N 85° 18' 05" E a distance of 363.73 feet to a point on the westerly line of land now or formerly of Kelvin H. Stott, bounded northerly by land now or formerly of Norwich Community Development Corporation; thence S 5° 21' 13" E a distance of 190.00 feet to an iron pin found; thence continuing S 5° 21' 13" E a distance of 540.15 feet to a monument found, these last two lines running generally along a wire fence and bounded easterly by land of said Stott; thence continuing S 5° 21' 13" E a distance of 20.03 feet to an iron pin set on the northerly line of Stott Avenue, bounded easterly by land now or formerly of Norwich Community Development Corporation; thence S 85° 18' 05" W a distance of 372.35 feet by and along the northerly line of Stott Avenue to the point of beginning.

Together with easement rights as more particularly set forth in a Quit Claim Deed from Hilltop Investments, LLC to Norwich Community Development Corporation dated April 9, 2003 and recorded in Volume 1768 at Page 282 of the Norwich Land Records.

SCHEDULE Q TO SCHEDULE 17.10

William W. Backus Hospital 11A Stott Avenue, Norwich

Exceptions: See comments to 11 Stott Avenue above.

Leases: 11A Stott Avenue is a portion of 11 Stott Avenue which is subject to the land lease to Sopramco which is described above. The building located on the leased property is owned by the tenant who may remove the building upon the expiration of the lease. If the building is not removed, it will become the property of the William W. Backus Hospital.

SCHEDULE R TO SCHEDULE 17.10

William W. Backus Hospital 11 Murphy Road, Franklin

Exceptions:

Subject to: drainage rights in favor of the State of Connecticut as of record appear; a drainage easement in favor of Franklin Realty Corporation as set forth in a deed recorded in Volume 23 Page 185 of the Franklin Land Records.

Description: See Schedule R-1

SCHEDULE R-1

A certain tract or parcel of land, with all buildings and improvements thereon, situated in the Town of Franklin, County of New London and State of Connecticut, being bounded and described as follows:

Beginning at monument on the Southerly line of Murphy Road at the Northwesterly corner of the herein described tract as shown on a plan hereinafter referred to and running thence South 2 degrees, 16 minutes and 00 seconds East 347.72 feet to a point abutting Westerly on land now or formerly of James Zeller and Robert Irving; thence North 84 degrees, 14 minutes East 276.23 feet to a monument; thence North 5 degrees, 46 minutes and 00 seconds West 159.00 feet to a point, these last two lines abutting Southerly and Easterly on land now or formerly of Ralph Fargo and Arlene Fargo; thence South 88 degrees, 11 minutes and 41 seconds West 1.00 foot to a monument abutting Northerly on land now or formerly of Joseph Alfiero and Barbara Alfiero; thence North 5 degrees, 46 minutes and 00 seconds West 188.00 feet to a monument on the said Southerly line of Murphy Road abutting Easterly on land now or formerly of Joseph Alfiero and Barbara Alfiero and said road; thence South 84 degrees, and 14 minutes West 254.00 feet along said road line to the monument at the point of beginning.

Containing 2.11 acres, more or less.

Being the land as shown as "2.11 +/- acres" on "Resubdivision Plan made for Franklin Realty Corporation, Rte. 32 & Murphy Road, Franklin, Conn., Scale=1"=60', Chandler, Palmer & King, 27 Aug. 1976, Additions and Revisions to Nov. 16, 1983."

Said premises are conveyed SUBJECT to drainage rights in favor of the State of Connecticut as of record shall appear; a drainage easement in favor of Franklin Realty Corporation, its successors and assigns, and are further conveyed TOGETHER with a drainage easement over land now or formerly of Franklin Realty Corporation; all as more particularly set forth in a Warranty Deed from Franklin Realty Corporation to Walter McGill, dated March 15, 1973 and recorded in Volume 23 at Page 185 of the Franklin Land Records.

SCHEDULE S TO SCHEDULE 17.10

William W. Backus Hospital 120-122 Plainfield Road, Moosup (Plainfield)

Exceptions:

a. Subject to drainage rights as set forth in a deed recorded in Volume 76 Page 160 of the Plainfield Land Records.

b. Subject to a restriction contained in a deed recorded in Volume 123 Page 380 of the Plainfield Land Records, which restriction is subject to a right of reverter. The William W. Backus Hospital has an owner's policy of title insurance which affirmatively insures said William W. Backus Hospital against loss as the result of enforcement or attempted enforcement of said right of reverter.

Description: See Schedule S-1

Leases: CONNCare

SCHEDULE S-1

A certain parcel of land situated on the north side of Plainfield Road in the Village of Moosup, Town of Plainfield, County of Windham and State of Connecticut, bounded and described as follows: Beginning at a point on the north side of Plainfield Road, which point marks the southeast corner of land now or formerly of Emil Dorflinger and the southwest corner of the within described parcel; thence N. 21° 04' E. 291.2 feet, more or less, to a point on the south side of Town Farm Road; thence S. 42° 04' E. 150 feet, more or less, to a point; thence southeast 30 feet, more or less, to a point in the south side of Town Farm Road; thence southeast 159 feet more or less to the intersection of the westerly line of Town Farm Road with the northerly line of Plainfield Road; the last three lines bounded on the northeast by Town Farm Road; thence along the northerly line of Plainfield Road northwesterly 263 feet, more or less, to the point and place of beginning. Containing by estimate 1.04 acres, more or less.

Reference may be had to a certain map on file with the Town Clerk, Town of Plainfield, entitled "Town of Plainfield – Map Showing Land and Rights to Drain Acquired From Paul W. Roper et als by the State of Connecticut, Greenwood-Killingly Expressway, Scale 1" = 40', 1953 Supp. Chap. 107 Part IV, Newman E. Argraves, Highway Commissioner, June 1955, Rev. July 1956, Area = 0.96 acres, plus or minus."

Note to Schedules 17.10

Tax Code Citation: All real property of the William W. Backus Hospital which is exempt from taxation, is exempt as such by virtue of Conn. Gen. Stat. Section 12-81 (16) as being the property of a Connecticut hospital corporation.

Note Regarding Encroachments: Representations as set forth in Section 17.10.1 (j) are made to the best of the knowledge and belief of the Backus Entities, there being no survey of the Real Property.

Disclosure of Right of First Refusal: The Backus Entities disclose that it is the holder of a "Right of First Offer and Right of First Refusal Agreement" dated May 7, 2001 as to property known as 302 Washington Street, Norwich, which is recorded in Volume 1562 Page 325 of the Norwich Land Records.

Disclosure of Option Agreement: The Backus Entities disclose that it is the holder of an Option Agreement to purchase property known at 199 Lafayette Street, Norwich, which is recorded in Volume 1722 Page 190 of the Norwich Land Records.

17.10.3 Backus Environmental Laws

The William W. Backus Hospital

17.10.3 (c)

As to Real Property known as 326 Washington Street, Norwich, on November 14, 1997, a proposal was submitted to ATC Associate, Inc. for the design and installation of a groundwater remediation system for containment of a plume in the area of former underground storage tanks. At the present time the DEEP is requiring that the Backus Entities test this area annually, and the Backus Entities are in compliance with such requirement and conduct testing in September of each year, with testing costs of approximately $200 annually. The Backus Entities have recorded a potential liability of $250,000 in connection with potential cost of remediation of this area.

17.10.3 (x)

List of Oil Tanks Meeting Hazardous Reporting Criteria (SARA Tier II)

Capacity	Type	Use	Date of Installation	Contents
45,000 lbs	Underground tank	Generator – Hospital	2/89	Diesel Fuel
100,000 lbs	Underground tank	Boiler - Hospital	2/89	#2 Fuel Oil
48,000 lbs	Underground tank	Jet fuel for Helipad – Hospital	6/99	Jet A Fuel
20,000 lbs	Above ground tank	Oxygen - Hospital	1/84	Liquid Oxygen
24,320 lbs	Above ground tank	Oxygen – 113 Salem Tpke, Norwich, CT 06360	2007	Liquid Oxygen
1,000 gallons	Above ground tank	Heating – 11 Stott Ave, Norwich, CT 06360	12/2011	Diesel Fuel
600 gallons	Above ground tank	Heating – 11A Stott Ave, Norwich, CT 06360	2003	#2 Fuel Oil
500*	Above ground tank	Heating – 120-122 Plainfield Rd, Moosup, CT 06354		#2 Fuel Oil

17.12 Corporate Form and Tax Status of Certain Backus Entities

WWB Corporation
Backus Home Health Care
CONNCare, Inc.
Backus Physician Services, LLC
Backus Medical Center Condominium Associates
Backus Health Care, Inc.
Community Medical Partners, Inc.

In 2011, the tax advisors of Backus Health Care Inc. (BHC) concluded that BHC no longer met the revenue test to qualify as a public charity and was thus a private foundation. In September 2011, BHC applied to the Internal Revenue Service (IRS) to become a "supporting" organization under Section 509(a)(3) of the Internal Revenue Code. The IRS granted the request for advance ruling on May 2012 (see IRS Letter to BHC, dated May 14, 2012 attached).

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date:
MAY 14 2012

BACKUS HEALTH CARE INC
326 WASHINGTON ST
NORWICH, CT 06360

Employer Identification Number:
22-2481794
DLN:
101286001
Contact Person:
TERRY L MILLER ID# 31222
Contact Telephone Number:
(877) 829-5500

60 Month Period Ends:
September 30, 2016
Addendum Applies:
No

Dear Applicant:

We have received your notification of intent to terminate your private foundation status under section 507(b)(1)(B) of the Internal Revenue Code during a 60 month period beginning October 1, 2011.

The information submitted indicates that you intend to operate as an organization described in section 509(a)(3) of the Code during the 60 month period.

Based on your proposed activities and support, it is held that you can reasonably be expected to terminate your private foundation status under section 507(b)(1)(B) of the Code. Accordingly, you will be treated as a public charity described in section 509(a)(3) of the Code for an advance ruling period of 60 months beginning October 1, 2011.

Within 90 days after the end of your 60 month period, you must establish to the satisfaction of the Internal Revenue Service that you have qualified as an organization which meets the requirements of paragraph (1), (2), or (3) of section 509(a) of the Code for the 60 month period. If you do establish that fact, you will be so classified for all purposes beginning with the first day of the first taxable year of the 60 month period and, thereafter, so long as you continue to meet the requirements of section 509(a)(1), (2), or (3). If, however, you do not meet these requirements for the 60 month period, you will be classified as a private foundation as of the first day of the first taxable year of the 60 month period.

If you satisfy the requirements of section 507(b)(1)(B) of the Code at the end of your 60 month period, you will not be subject to the provisions of section 507(a), (c), or (g) of the Code.

Grantors and donors may rely on the determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you submit the required information within the 90 days, grantors and contributors may continue to rely on the advance determination until the Service makes a final determination of your foundation status.

BACKUS HEALTH CARE INC

You are required to file Form 990-PF, Return of Private Foundation or Section 4947(a)(1) Trust Treated as a Private Foundation, until you complete your 60 month termination and are classified as a section 509(a)(3) organization. Form 990-PF must be filed by the 15th day of the fifth month after the end of your annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000 or 5 percent of your gross receipts (whichever is less), for failure to file a return on time unless there is reasonable cause for the delay. For organizations with gross receipts exceeding $1,000,000 in any year, the penalty is $100 per day per return, unless there is reasonable cause for the delay. The maximum penalty for an organization with gross receipts exceeding $1,000,000 shall not exceed $50,000. This penalty may also be charged if a return is not complete, so please be sure your return is complete before you file it.

If you do not pay the tax imposed by section 4940 of the Code for any taxable year or years during the 60 month period, and it is subsequently determined that such tax is due for such year or years, you will be liable for interest in accordance with section 6601 of the Code. Since any failure to pay such taxes during the 60 month period is due to reasonable cause, the penalty under section 6651 with respect to the tax imposed by section 4940 shall not apply.

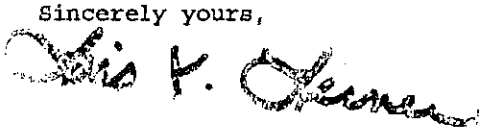
If the heading of this letter indicate that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

We have sent a copy of this letter to your representative as indicated in your power of attorney.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,



Lois G. Lerner
Director, Exempt Organizations

Enclosure(s):
Form 872

Form **872-B** (Rev. Dec. 2004)	Department of the Treasury - Internal Revenue Service **Consent to Extend the Time to Assess Miscellaneous Excise Taxes**	In reply refer to: Taxpayer Identification Number

Backus Health Care Inc , taxpayer(s)
(Name(s))

of 326 Washington St, Norwich, CT 06360-2740 and the
(Number, Street, City or Town, State, ZIP Code)

Commissioner of Internal Revenue consent and agree to the following:

(1) The amount of liability for Chapter 42 Excise Tax tax, imposed on the taxpayer(s) by
(Kind)

section 4940-4945 of the Internal Revenue Code due for the period October 1, 2011 through September 30,
(Internal Revenue Code, Revenue Act, etc.)

2016 may be assessed at any time on or before February 15, 2021
(Expiration date)

(2) The collection provisions and limitations now in effect will also apply to any tax assessed within the extended period.

(3) The taxpayer(s) may file a claim for credit or refund and the Service may credit or refund the tax within 6 months after this agreement ends.

Your Rights as a Taxpayer

You have the right to refuse to extend the period of limitations or limit this extension to a mutually agreed-upon issue(s) or mutually agreed-upon period of time. Publication 1035, *Extending the Tax Assessment Period*, provides a more detailed explanation of your rights and the consequences of the choices you may make. If you have not already received a Publication 1035, the publication can be obtained, free of charge, from the IRS official who requested that you sign this consent or from the IRS' web site at www.irs.gov or by calling toll free at 1-800-829-3676. Signing this consent will not deprive you of any appeal rights to which you would otherwise be entitled.

YOUR SIGNATURE HERE → .....
(Date signed)

I am aware that I have the right to refuse to sign this consent or to limit the extension to mutually agreed-upon issues and/or period of time as set forth in I.R.C. § 6501(c)(4)(B).

TAXPAYER'S REPRESENTATIVE

SIGN HERE → .....
(Date signed)

I am aware that I have the right to refuse to sign this consent or to limit the extension to mutually agreed-upon issues and/or period of time as set forth in I.R.C. § 6501(c)(4)(B). In addition, the taxpayer(s) has been made aware of these rights.

CORPORATE NAME → Backus Health Care, Inc.

CORPORATE OFFICER(S) SIGN HERE → Daniel E. Flinn Chief Financial Officer 3-21-12
(Title) *(Date signed)*

....
(Title) *(Date signed)*

I (we) am aware that I (we) have the right to refuse to sign this consent or to limit the extension to mutually agreed-upon issues and/or period of time as set forth in I.R.C. § 6501(c)(4)(B).

INTERNAL REVENUE SERVICE SIGNATURE AND TITLE

....
(Division Executive Name - see instructions) *(Division Executive Title - see instructions)*

BY .....
(Authorized Official Signature and Title - see instructions) *(Date signed)*

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Property** *All States* Real & BPP Blanket Limit $491,220,726 Business Income $218,305,000 Extra Expense $10,000,000 Flood $5,000,000 Aggregate Flood Zones A, B, Shaded X $50,000,000 Aggregate All Other Insured Premises Flood Zone V Excluded Earthquake $50,000,000 Aggregate Boiler & Machinery Included Builder's Risk $5,000,000 Max-Any OneConstruction Site $5,000,000 Max-All Construction Sites Emergency Patient Evacuation Expense $2,000,000	3/1/12 to 3/1/13	Travelers Indemnity Co.	$179,862
Backus Home Health Care	**Healthcare Professional & General Liability** Healthcare Professional Liab. Claims Made $3,000,000 Aggregate $1,000,000 Each Incident Healthcare General Liability $3,000,000 Aggregate $1,000,000 Each Occurrence $3,000,000 Prods/Comp Ops Agg $1,000,000 Pers/Adv Injury $100,000 Damage to Premises Rented to You $5,000 Medical Expense Employee Benefits Liability Claims Made Form $1,000,000 Each Employee $3,000,000 Aggregate Defense In Addition to Limits	10/1/11 to 10/1/12	arch Specialty Insurance Co	$21,194 **Plus $847.76 for Surplus Lines Tax** Retroactive Date: 10/1/01 Retroactive Date: 10/1/01

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital	**Automobile Liability & Physical Damage** Liability (Symbol 1): $1,000,000 CSL Medical Payments (Symbol 2): $10,000 UM/UIM (Symbol 6) $1,000,000/$1,000,000 Phys. Damage - Comp (Symbol 2, 8)	10/1/11 to 10/1/12	Sentry Casualty Co.	**$39,650** Policy is Composite Rated 25 Vehicles Drive Other Car Coverage 90 Days Notice of Cancellation Hired / Non-Owned Auto Liability Included Hired Car Only - ACV, Cost of Repair, or $50,000, whichever is less, minus $500 for each covered auto
	Actual Cash Value or Cost of Repair Minus Deductible Phys. Damage - Coll (Symbol 2, 8) Actual Cash Value or Cost of Repair Minus Deductible Towing (Symbol 3) $50 per disablement Loss of Use - Rental Reimbursement $30 Per Day; 30 Days			
The William W. Backus Hospital Backus Physician Services, LLC CONNCare, Inc.	**Medical Malpractice** **Employed Physicians &** **Employed Physician Extenders** Medical Malpractice Employed Physicians $1,000,000 Each Claim $4,000,000 Aggregate Employed Physician Extenders $1,000,000 Each Claim	10/1/11 to 10/1/12	CMIC	**$749,875** Includes 10% Commission
The William W. Backus Hospital Backus Physician Services, LLC CONNCare, Inc.	**Umbrella** Excess Healthcare Professional $10,000,000 Aggregate $10,000,000 Each Med Incident Underlying Insurance: Self Insured Retention $1M/$5M Employed Physicians $1M/$4M Employed Extenders $1M/$3M Omni PL/GL $1M/$3M Employers' Liability $500k/$500k/$500k Auto Liability $1M Non-Owned Aircraft $5M Helipad Liability $5M	10/1/11 to 10/1/12	orus Specialty Insurance C	**$1,065,000** **Plus $42,600 Surplus Lines Tax** Retroactive Date: 10/1/89 Claims Made Retained Limit: $250,000 25% Minimum Earned Premium

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital	**Automobile Liability & Physical Damage** Liability (Symbol 1) $1,000,000 CSL Medical Payments (Symbol 2) $10,000 UM/UIM (Symbol 6) $1,000,000/$1,000,000 Phys. Damage - Comp (Symbol 2, 8)	10/1/11 to 10/1/12	Sentry Casualty Co.	**$39,650** Policy is Composite Rated 25 Vehicles Drive Other Car Coverage 90 Days Notice of Cancellation Hired / Non-Owned Auto Liability Included Hired Car Only - ACV, Cost of Repair, or $50,000, whichever is less, minus $500 for each covered auto
The William W. Backus Hospital Backus Physician Services, LLC CONNCare, Inc.	**Follow Form Excess** Excess Healthcare Professional Liability & Healthcare Umbrella Liability $20,000,000 Aggregate $20,000,000 Each Med Incident Underlying Insurance: Self Insured Retention $1M/$5M Umbrella $10M Employed Physicians $1M/$4M Employed Extenders $1M/$3M Omni PL/GL $1M/$3M Employers' Liability $500k/$500k/$500k Auto Liability $1M Non-Owned Aircraft $5M Helipad Liability $5M	10/1/11 to 10/1/12	ronshore Specialty Ins. Co	**$141,250** **Plus $5,650 Surplus Lines Tax** Retroactive Date: 10/1/89 Claims Made Dual Towers: Self-Insured Retention Tower 1: Professional Liability SIR Tower 2: General Liability SIR
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Workers' Compensation** Workers' Comp Statutory - CT Employers' Liability $500,000 Each Accident $500,000 Policy Limit $500,000 Each Employee	10/1/11 to 10/1/12	Sentry Casualty Co.	**$474,129** **Includes $82,147 for Terrorism/Taxes/Surcharges/ Assessments** Premium Subject to Audit
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Management Liability** Aggregate Limit All Coverages other than Crime $15,000,000 Employment Practices Liability $15,000,000 Directors & Officers $15,000,000 Additional Side A Coverage $1,000,000 Fiduciary $5,000,000 Max. Aggregate $100,000 Voluntary Compliance Loss $100,000 HIPAA Penalties Coverage Crime $5,000,000 Employee Theft $100,000 Client Property $5,000,000 Forgery & Alteration $5,000,000 Theft of Money & Securities (Inside) $5,000,000 Robbery or Safe Burglary of Other Property (Inside) $5,000,000 Outside the Premises $5,000,000 Computer Fraud $5,000,000 Funds Transfer Fraud $5,000,000 Money Orders & Counterfeit Money	3/1/12 to 3/1/13	Westchester Fire Ins. Co. Includes: Entity Coverage Employment Practices Liability Fiduciary Crime	**$90,919** Payment Plan Annual Includes Third Party Coverage Continuity Date: 1/1/94 Continuity Date: 2/1/87 Continuity Date: 1/1/95 Includes Employee Benefit Plan Coverage

17.13 Backus Insurance Policies

Backus Entities Covered	COVERAGE	POLICY TERM	CARRIER	ANNUAL PREMIUM
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Excess Directors & Officers Liability** $5,000,000 Limit of Liability Claims Made Underlying Insurance D&O $15M	3/1/12 to 3/1/13	Zurich American Ins. Co. DOC 488811701	**$16,050** Payment Plan Annual
The William W. Backus Hospital	**Non-Owned Aircraft Liability** $5,000,000 Each Occurrence $500,000 Medical Expense Each Occurrence $10,000 Medical Expense Each Person	10/1/11 to 10/1/12	Federal Insurance Co. Chubb 9958-4699-01	**$5,228** Payment Plan Annual
The William W. Backus Hospital	**Helipad Liability** $5,000,000 Each Occurrence $100,000 Damage to Premises $10,000 Medical Expense $5,000,000 Pers/Adv Injury Agg $5,000,000 Prods/Comp Ops Hangarkeepers $5,000,000 Each Aircraft $5,000,000 Each Loss Limit	10/1/11 to 10/1/12	Federal Insurance Co. Chubb 9958-4708-01	**$5,628** Payment Plan Annual
The William W. Backus Hospital Backus Home Health Care Backus Physician Services, LLC CONNCare, Inc.	**Kidnap & Extortion** Limit of Liability $1,000,000 Per Incident Business Income & Extra Expense $1,000,000 Each Loss Threat Expense $100,000 / $100,000 Annual Agg Child Abduction Coverage $2,000,000 Per Incident	3/1/11 to 3/1/12	ACE American Ins. Co. N05667550 002	**$5,827** Up to 15 Days of Coverage

17.14 Backus Taxes

None.

17.15.1 Employee Benefits

Benefit	Administered By
Health Insurance/Medical Coverage	Aetna Life Insurance Company
Health Insurance Stop Loss	Aetna Life Insurance Company
Pharmaceutical	Pequot Pharmaceutical Network
Dental Insurance	Delta Dental of New Jersey
Vision	Eye Med Vision Care
COBRA	Benefit Concepts
Short Term Disability	United Healthcare Insurance Company
Long Term Disability	United Healthcare Insurance Company
Basic Life	United Healthcare Insurance Company
AD & D	United Healthcare Insurance Company
Group Supplemental Life	United Healthcare Insurance Company
Medical Flexible Spending Account	Aetna Life Insurance Company
Dependant Flexible Spending Account	Aetna Life Insurance Company
Employee Assistance Program	The William W. Backus Hospital Care Management Department
Retiree Health	Anthem
403(b)	Hooker & Holcombe/Charles Schwab
401(k)	Hughes & Hughes
Defined Benefit Pension (frozen 12/31/2009)	M&I
457(b)	Hughes & Hughes

The schedules below list the names of the electronic files for all of the documents requested in 17.15.1 and to which entities the documents pertain.

17.15.1 (a) Benefit Plan and amendments

Name of File	Entity
17.15.1 a AETNA PRXN Delta Dental United Healthcare & Eye Med Plan Documents	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a 401K Plan Document 1 of 2	Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

Name of File	Entity
17.15.1 a 401k Plan Document 2 of 2	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a 401K plan Document and amendments	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a 403B Plan Document	The William W. Backus Hospital
17.15.1 a Anthem High Option 82 fact sheet 2012	The William W. Backus Hospital
17.15.1 a DB Plan Document with amendments	The William W. Backus Hospital
17.15.1 a DB Plan Signed Amendments to Plan Document - 1995 reinstatement	The William W. Backus Hospital
17.15.1 a Deferred Compensation 457b plan Document	The William W. Backus Hospital
17.15.1 a FSA Plan Document	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 a Section 125 Plan Document	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 (b) Form 5500

Name of File	Entity
17.15.1 b 401k 5500 Plan Year 2008	Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

Name of File	Entity
17.15.1 b 401k 5500 Plan Year 2009	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 b 401k 5500 Plan Year 2010	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 b 403b 5500 Plan Year 2009	The William W. Backus Hospital
17.15.1 b 403B 5500 Plan Year 2010	The William W. Backus Hospital
17.15.1 b DB 5500 Plan Year 2008	The William W. Backus Hospital
17.15.1 b DB 5500 Plan Year 2009	The William W. Backus Hospital
17.15.1 b DB 5500 Plan Year 2010	The William W. Backus Hospital
17.15.1 b Welfare 5500 Plan Year 2008	The William W. Backus Hospital
17.15.1 b Welfare 5500 Plan Year 2009	The William W. Backus Hospital
17.15.1 b Welfare 5500 Plan Year 2010	The William W. Backus Hospital

17.15.1 (c) Trust Agreement/Contracts

Name of File	Entity
17.15.1 c Aetna- FSA William+Backus+2012+Renewal(1)	The William W. Backus Hospital, Backus Home Health, CONNcare Inc. , Backus Physician Services
17.15.1 c Aetna Renewal ASC Fee_StopLoss Fee_2012	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c Anthem Renewal	The William W. Backus Hospital
17.15.1 c Charles Schwab Trust Agreement Amendment	The William W. Backus Hospital
17.15.1 c Charles Schwab Trust Agreement	The William W. Backus Hospital
17.15.1 c ConnCareServAgreement with ACG	Backus Home Health, CONNcare Inc. , Backus Physician Services

17.15.1 Employee Benefits

Name of File	Entity
17.15.1 c Delta dental plan agreement Amendment	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c EyeMed Agreement	The William W. Backus Hospital, Backus Home Health, CONNcare Inc. , Backus Physician Services
17.15.1 c H&H and Charles Schwab agreement	The William W. Backus Hospital
17.15.1 c Hooker and Holcombe Service Agreement A 2009	The William W. Backus Hospital
17.15.1 c Hooker and Holcombe Service Agreement B 2009	The William W. Backus Hospital
17.15.1 c M & I Service Agreement	The William W. Backus Hospital
17.15.1 c M & I Trust Agreement	The William W Backus Hospital
17.15.1 c Pequot Agreement	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c TW 2012 Actuarial Services	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c United Health Care Agreement	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 c United Healthcare 2012 Renewal	The William W. Backus Hospital, Backus Home Health, CONNcare Inc. ,Backus Physician Services
17.15.1 c. Benefit Concepts- Administrative Services Agreement	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

17.15.1.(d) Certified Financial Statements

Name of File	Entity
17.15.1 d 401K Plan statements 2008 and 2009	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 d 401k Plan statements 2010	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 d 403b 5500 & financials 2009	The William W. Backus Hospital
17.15.1 d 403b 5500 & financials 2010	The William W. Backus Hospital
17.15.1 d DB Plan statements 2008	The William W. Backus Hospital
17.15.1 d DB Plan statements 2009	The William W. Backus Hospital
17.15.1 d DB Plan statements 2010	The William W. Backus Hospital

17.15.1 (e) Summary plan descriptions

Name of File	Entity
17.15.1 e 401k SPD	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 e 2012SolutionsBenefitBook	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 e AETNA PRXN Delta Dental United Healthcare & Eye Med SPD	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 e DB Plan SPD	The William W. Backus Hospital
17.15.1 e. 403(b) SPD	The William W. Backus Hospital

17.15.1 Employee Benefits

17.15.1 (f) Collective bargaining agreements

Name of File	Entity
17.15.1 f CBA between AFT and WWBH	The William W. Backus Hospital
17.15.1 f CBA between SPFPA and WWBH	The William W. Backus Hospital

17.15.1 (g) Determination letters

Name of File	Entity
17.15.1 g 401k IRS Opinion Letter	Backus Home Health, CONNcare Inc., Backus Physician Services
17.15.1 g db 11th plan amendment Determination	The William W. Backus Hospital
17.15.1 g DB Plan Determination Letter	The William W. Backus Hospital

17.15.1 (h) IRS, PBGC or Dept of Labor Notices given to Backus
None.

17.15.1 (i) IRS, PBGC or Dept of Labor Notices given by Backus
None.

17.15.1 (j) Voluntary correction filings
None.

17.15.1 (k) Sample correspondence regarding 4980B rights

Name of File	Entity
17.15.1 k 4980B Sample General Notice Letter 090410	The William W. Backus Hospital, Backus Home Health, CONNcare Inc., Backus Physician Services

17.15.1 Employee Benefits

17.15.1 (l) PBGC-1 forms

Name of File	Entity
17.15.1 l PBGC 2010 Filing Form	The William W. Backus Hospital
17.15.1 l PBGC 2011 Filing Form	The William W. Backus Hospital
17.15.1 l PBGC 2011 Flat Rate Filing Form	The William W. Backus Hospital
17.15.1 l PBGC 2012 Filing Form	The William W. Backus Hospital

17.16 Backus Payment Programs

The following Backus Entities are participating providers in the private, commercial, and governmental payment and procurement programs listed below:

The William W. Backus Hospital

Aetna **(**)**
Americas Health Plan
Anthem BC& BS of CT **(**)**
Beech Street Corp
Caresys
CIGNA **(**)**
Colonial Cooperative Care
Community Health Network of Connecticut
Connecticare **(**)**
Connecticut Community Care Inc
Connecticut Health Plan
Connecticut Hospital Lab Network
Consumer Health Network
CorVel Corp
First Health/CCN
GAMBRO/Davita (Lab Services)
Health Connecticut
Health Net
Health Payors Organization
Healthcare Value Management
Hospice of Southeast Connecticut
Lifechoice Donor Services
Mashantucket Pequot Tribal Nation/Pequot Plus **(**)**
Medicare **(**)**
Medrisk
MetraComp
MultiPlan/PHCS (**)
National Health Quest
Northeast Direct Health
Northeast Healthcare Alliance/HMC (**)
NYLCare
Preferred Health Network
Prime Health Services
Quest Diagnostics
Select Pro
State of Connecticut: **(**)**

- Medicaid
- DMHAS Behavioral Health Program
- SEMHA Lab Services

TriCare (**)

The William W. Backus Hospital (continued)

United Healthcare (including Oxford) (**)
United Payors & Providers
US Coast Guard Academy Clinic
Waterford Public Schools
WellCare
Women & Infants IVF Cases

Behavioral Health Companies
Behavioral Health Connecticut
CMG Health
Green Spring Health Services
Human Affairs International
Magellan Behavioral Health
Managed Health Network
Merit Behavioral Care Systems
PRO Behavioral Health
Value Behavioral Health

PPA Discount Agreements
Arrow Paper Supply
AZ Electric
BeneCorp
City of Norwich
Connecticut Bricklayers Health Fund
Connecticut Pipe Trades Health Fund, Local 777
Focus-United Healthcare Corp
General Dynamics – Electric Boat
Insurance Programmers
International Union of Operating Engineers, Local 478
Iron Workers Locals #15 & 424
Phoenix Mutual
Plumbers & Steamfitters Local #305
Plumbers & Steamfitters Local #84

Rehab Services to Home Health Agencies
CT VNA of Dayville
CT VNA Southeast
Day Kimball Homecare
Griswold Public Health Agency
Health Network Home Health
Ledyard Public Health Nursing
VNA of Southeast CT
**Representing greater than $100,000 in annual payments to the Hospital

The William W. Backus Hospital (continued)

The exceptions to the representations made in Section 17.16 are as follows:

- 17.16.1 The Hospital is currently in negotiation with Anthem BC& BS of CT. The existing agreement was terminated by Anthem effective July 1, 2012 and is currently on extension to August 31, 2012.
- 17.16.5 The following cost reports of The William W. Backus Hospital are currently open:
    - MEDICARE: FY2006 – FY2011. Desk reviews by National Government Services, Inc. are currently in process for FY2010 & FY2011. FY2006 – FY2009 remain open due to outstanding SSI ratio calculation.
    - MEDICAID: FY2009 – FY2011. No estimated time frame for Department of Social Services regarding filing dates.
    - TRICARE: FY2011
- 17.16.6 In December of 2010, The William W. Backus Hospital discovered, as a result of a patient complaint investigation, that it had failed to file price changes made on May 1, 2010 with the Office of Health Care Access. As a result, and in working in conjunction with the Assistant Attorney General's office, uninsured patients that were overcharged based on the May 2010 prices that were not on file are to be re-billed and refunds made where appropriate. To date, the accounts have been identified and are under review for price correction and patient notification.
- 17.16.7 The Hospital was audited by the State of Connecticut in March, 2011 regarding the Medicaid program. The findings of this audit are not yet known as we have not yet received a draft or final version of the findings.
- 17.16.8 The Hospital sued Health Net to recover the value of wrongful underpayments. In that lawsuit, Health Net filed an equitable set-off. If Health Net is successful with its claim, it would only be entitled to a reduction in the amount it owes to the Hospital. The Hospital is also on notice of requested refunds, which the Hospital is challenging.

17.16 Backus Payment Programs

Backus Home Health Care

Aetna
Alliance for Living
Anthem BC & BS of CT (**)

- Home Health
- BlueCare Family Plan/Federal BCBS
- Immunization Services
- Medicare Advantage HMO/PPO
- Unicare PPO

Care Centrix
Community Health Network
ConnectiCare – The Home Care Entity is currently in negotiation
Connecticut Community Care, Inc.
Medicare (**)
Private Insurances – The Home Care Entity negotiates on a case by case basis
Private Pay (**) – General Public Rates
Town of Lisbon
State of Connecticut (**)

- Medicaid

United Healthcare (including Oxford) – The Hospital is currently in negotiations for the Home Care Entity
Veterans Administration MC - General Public Rates
Workers' Compensation – General Public Rates

(*) Active in FY2012
(**) Representing greater than $100,000 in annual payments to the Home Care Entity

The exceptions to the representations made in Section 17.16 are as follows:

- 17.16.8 Backus Home Health Care has been threatened with a recoupment of $175,961.36 for Year 1 Third Party Liability (TPL) Claims which are for services provided to dually eligible patients during 2008 – 2009.

17.16 Backus Payment Programs

Backus Physician Services, LLC

Aetna
Aetna Better Health
Aetna Medicare
Americhoice
Anthem BC BS (**)
Auto-Geico
Auto-Nationwide
Auto-Progressive
Auto-Safeco
Benecorp
Blue Cross (out of state)
Blue Cross Federal
Blue Cross Medicare
Blue Cross National Plan
Breast Health Initiative Plan
Cigna
Cigna HMO
Cigna PPO
Connecticare
Connecticare VIP Medicare Plan
Diversified
Fallon Community Health Plan
First Health
GEHA
Golden Rule
Guardian East Bridgewater
Harvard Pilgrim
HealthNet Medicare
HealthNet of CT
Husky A
Husky B
Husky ext
Mailhandlers
Managed Medicare
Medicaid Community Health Network Husky A&B only
Medicaid low income adult (SAGA)
Medicaid Title 19
Medicare Part B (**)
Meritain
Midwest
Mohegan Tribe District Health Plan
Mutual of Omaha
Oxford Health Plan
Principal Financial
Railroad Medicare
S&S Healthcare Local 919
State of CT Connect card

Backus Physician Services, LLC (continued)

Tricare Prime
Tricare/CHAMPVA
United Health Integrated (Foxwood employees) (**)
UnitedHealthcare Atlanta (EB&Pfizer) (**)
UnitedHealthcare Medicare
WC - Commercial Line Services
WC - CT Healthcare Workers Compensation Trust
WC - Electric Boat
WC - ESIS
WC - GAB Robbins
WC - Gallagher Bassett
WC - Liberty Mutual
WC - Liberty Mutual
WC - National Grange Mutual
WC - St. Paul Travelers
WC - The Hartford
WC- US Dept of Labor
WC. Gallagher Bassett

**Representing greater than $100,000 in annual payments to the Backus Physician Services

CONNCare, Inc.

AARP
Aetna Better Health
Aetna Chickering
Aetna Commercial
Aetna HMO
Aetna Medicare
Amalgamated Local 371
Auto - Progressive
Bankers Life & Casualty
Blue Cross Federal
Blue Cross National Plan
Blue Cross of CT (**)
Celtic Life
Cigna HMO
Cigna PPO
Community Health Network of CT
Connecticare HMO
Diversified
First Health
GEHA (Govm't Employee Hospital Association)
Golden Rule
Great West Life
Harvard Pilgrim

CONNCare, Inc. (continued)

HealthNet of CT
HMC PPO
Husky A
Husky B
Mailhandlers
Medicaid
Medicaid Healthnet
Medicaid Low income
Medicaid Title 19
Medicaid UnitedHealthcare
Medicare BC Smart Value
Medicare Connecticare VIP Prime
Medicare HealthNet Smart Choice
Medicare Managed Plan
Medicare Part B (**)
Medicare UnitedHealthcare
Midwest
Mohegan Tribe Health District
Mutual of Omaha
NALC Health Benefit Plan
Nationwide
NorthEast Health Direct - Assurance
Oxford Health Plan
Pequot Plus
Railroad Medicare
S&S Healthcare Local 919
State Mutual Life Assurance
Tricare
Tricare/CHAMPVA
United Health Integreted Services
UnitedHealthcare Atlanta (**)
UnitedHealthcare other
WC - Utica Mutual Insurance
WC- Crawford and Company
WC- MAC Risk Management
WC- PMA Corporate Processing Center
WC-AIG
WC-Bunch & Associates
WC-CIRMA
WC-CT Healthcare Workers Compensation Trust
WC-Electric Boat
WC-ESIS
WC-Foxwoods Vistas Project
WC-GAB Robbins
WC-Gallagher Bassett
WC-Liberty Mutual
WC-OEM of CT
WC-Sedgewick

CONNCare, Inc. (continued)

WC-St. Paul Travelers
WC-The Hartford
WC-US Department of Labor
WC-Webster Insuance
WPS Tricare for Life

**Representing greater than $100,000 in annual payments to CONNCare

17.17 Backus Accreditations

The William W. Backus Hospital

Name	Issuing Body
Joint Commission Hospital Accreditation (Deemed Status)	The Joint Commission
College of American Pathologists (CAP) Accreditation- Main Lab	CAP
CAP Accreditation- POCT	CAP
Echocardiology Accreditation	Intersocietal Commission for the Accreditation of Echocardiography Laboratories
Commission on Cancer	American College of Surgeons
National Accreditation Program of Breast Centers	American College of Surgeons
Trauma Accreditation	American College of Surgeons
Primary Stroke Center Designation	State of Connecticut Department of Public Health
CT Scan	American College of Radiology
Nuclear Medicine	American College of Radiology
MRI	American College of Radiology
PET/CT	American College of Radiology
Ultrasound	American College of Radiology
Breast Ultrasound	American College of Radiology
Breast MRI	American College of Radiology
Stereotactic Breast BX	American College of Radiology
Mammography	American College of Radiology

Backus Home Health Care

Name	Issuing Body
Home Health Care Accreditation	Community Health Accreditation Program (CHAP)

17.18 Backus Defaults

None.

17.19 Backus Exclusion from Health Care Programs

None.

Schedule 18.3.1

Hartford HealthCare Third Party Approvals

None.

Schedule 18.3.2

Hartford HealthCare Governmental Approvals

None.

Schedule 18.5

Hartford HealthCare Compliance with Laws

On June 26, 2012, Hartford HealthCare was informed by one of its vendors (EMC Corporation) that one of their laptops which contained Hartford Hospital and VNA Health Care patient data was stolen. Hartford HealthCare is investigating this matter, has noticed affected patients and established appropriate identity theft protections for these patients. All relevant state and federal regulatory authorities have been notified.

Schedule 18.7

Hartford HealthCare Legal Proceedings

None.

21.1.55(c) Backus Capital Expenditures Greater than $5 Million

PROJECT	BUDGET
A3/A4 Window Project	$250,000
E Wing/A Wing Elevator Upgrades Study/Budget	$650,000
Electrical Efficiency Review	$270,000
Emergency Generators Montville & Colchester	$250,000
Lab (55 Town Street)	$350,000
OR Temperature/Humidity	$400,000
Plainfield Emergency Center (remaining balance due developer)	$500,000
Laboratory – Tissue Processor	$150,000
Diagnostic Imaging – CT & Ultrasound Machines	$950,000
IT – Scanning software replacement & Medical Equipment Interfaces	$300,000
Security – Access control upgrades/replacement	$350,000

Exhibit 1.1

Backus Amended and Restated Governing Documents

See attached.

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

OF

BACKUS CORPORATION

1. The name of the corporation is **Backus Corporation** (the "Corporation").

2. The Corporation is organized and shall be operated exclusively for charitable, scientific, literary and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall be operated as a component part of the integrated health care delivery system (the "System") of which the parent is Hartford HealthCare Corporation. The nature and activities to be conducted, or the purposes to be promoted or carried out by the Corporation are as follows:

(a) to promote the delivery of quality and cost-effective health care services in the Eastern Connecticut region as a constituent part of the System, and to foster the accountability of the Corporation's affiliates to the strategic objectives developed by the System; and

(b) otherwise to engage in any lawful act or activity consistent with the foregoing for which corporations may be formed under the Connecticut Revised Nonstock Corporation Act (the "Act").

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions or dividends.

4. The Corporation shall have a single member, namely, Hartford HealthCare Corporation, a Connecticut nonstock corporation (the "Member"). The Member shall have the power to elect directors of the Corporation ("Directors") and to remove Directors with or without cause, shall have the power to adopt and amend the Bylaws of the Corporation (the "Bylaws"), and shall have such other rights, powers and responsibilities as are accorded to members under the Act, this Certificate of Incorporation or the Bylaws.

5. The Corporation shall operate under the management of its Board of Directors (the "Board"), and the Directors who shall be elected by the Member as provided in the Bylaws of the Corporation. The corporate powers of the Board, and any applicable limitations thereon, shall be as set forth in the Bylaws as in effect from time to time. The Bylaws shall prescribe the number, qualifications and manner of election of Directors. In the event a Director ceases to be in office, the Board shall fill the vacancy caused thereby until the next annual meeting of the Member of the Corporation held for the purpose of electing Directors. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio Directors of the Board who may vote and be counted in determining a quorum. As may be further provided in the Bylaws, the terms of elected Directors of the Board may be staggered by dividing the Directors

into up to three (3) groups so that approximately an equal number of such Directors have terms that expire each year.

6. Notwithstanding any other provision of this Amended and Restated Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on: (a) by an organization exempt from federal income tax under Section 501(a) of the Code as an organization described in Section 501(c)(3) of the Code; or (b) by an organization, contributions to which are deductible under Section 170(c)(2) of the Code.

7. The net earnings of the Corporation or any part thereof may not be distributed to or inure to the benefit of any private individual or a Director or officer of the Corporation. However, nothing herein shall restrict the right of the Corporation to reasonably compensate any officer, Director or other individual for services rendered to the Corporation or to reimburse any officer, Director or other individual for expenses, disbursements or liabilities properly made or incurred, on account of that individual's service to the Corporation.

8. A substantial part of the activities of the Corporation shall not consist of carrying on propaganda or attempting to influence legislation. The Corporation may not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

9. Upon dissolution of the Corporation, the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the purposes of the Corporation, to the Member exclusively for its charitable, scientific, literary or educational purposes, provided the Member shall be then exempt from federal taxation as an organization described in Section 501(c)(3) of the Code. If the Member shall not be so qualified as an organization described in Section 501(c)(3) of the Code, then the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the charitable, scientific, literary or educational purposes of the Corporation, to one or more organizations as shall be then exempt from federal taxation as an organization or organizations described in Section 501(c)(3) of the Code, in such proportions and amounts and in such manner as the Board shall determine. No part of the Corporation's assets shall ever be distributed to its Directors or officers, or inure to the benefit of any private individual.

10. The personal liability of a Director of the Corporation to the Corporation for monetary damages for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act or any other applicable laws presently or hereafter in effect. Without limiting the effect of the preceding sentence, no Director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of duty as a Director of the Corporation in an amount greater than the compensation received by the Director for serving the Corporation during the year of the violation if such breach did not: (i) involve a knowing and culpable violation of law by the Director; (ii) enable the Director, or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain; (iii) show a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. No amendment to, or modification or repeal of, this Article 10 shall adversely affect any right or protection of a Director of the Corporation existing hereunder with

respect to any act or omission occurring prior to such amendment, modification or repeal. Nothing contained in this Article 10 shall be construed to deny to the Directors of the Corporation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation.

11. The Corporation shall indemnify a Director for a liability, as defined in Section 33-1116(5) of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that: (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including reasonable attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both: (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Article 10 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Article 11. Such expenses (including reasonable attorneys' fees) incurred by other employees and agents may be so paid upon such terms and conditions, if any, as the Board deems appropriate. The indemnification and advancement of expenses provided by, or granted pursuant to, this Article 11 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

12. References in this Amended and Restated Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act, and references to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or as the same may hereafter be amended from time to time.

AMENDED AND RESTATED
BYLAWS

OF

BACKUS CORPORATION

* * * * * * *

ARTICLE 1

NAME; PURPOSE; DEFINITIONS

1.1 Name. The name of the corporation is Backus Corporation (the "Corporation").

1.2 Purpose. The Corporation is organized and shall be operated for the purposes set forth in the Certificate of Incorporation.

1.3 Definitions. The following terms used in these Bylaws shall have the following

(a) "Act" shall mean the Connecticut Revised Nonstock Corporation Act, as amended from time to time.

(b) "Affiliation Agreement" shall mean the agreement effectuating the full corporate affiliation between the Member and the Corporation, executed as of August 17, 2012 and effective on the Closing Date.

(c) "Backus Hospital" shall mean The William W. Backus Hospital.

(d) "Certificate of Incorporation" shall mean the Corporation's certificate of incorporation, as the same may be amended from time to time.

(e) "Closing Date" shall mean the date on which the affiliation between the Member and the Corporation is fully consummated in accordance with the terms of the Affiliation Agreement.

(f) "Corporation's President and CEO" shall mean the President and Chief Executive Officer of the Corporation.

(g) "Member" shall mean Hartford HealthCare Corporation, a Connecticut nonstock corporation.

(h) "Subsidiary" or "Subsidiaries" shall mean any entity directly or indirectly controlled by the Corporation. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of an entity, whether through the ability to exercise voting power by contract or otherwise. "Controlled" or

"Controlling" have correlative meanings. Without limiting the foregoing, each of the following entities shall be considered a Subsidiary: Backus Hospital; Backus Medical Center Condominium Association, Inc.; Community Medical Partners, Inc.; Backus Health Care, Inc.; CONNCare, Inc.; Backus Physician Services, LLC; WWB Corporation; Omni Home Health Services of Eastern Connecticut, LLC; and MedConn Collection Agency, LLC.

(i) "System" shall mean the comprehensive and integrated health care delivery system operated by the Member.

(j) "Transitional Period" shall mean a period of three years commencing on the Closing Date.

ARTICLE 2

MEMBERSHIP

2.1 Members. The Corporation shall have a single Member, namely, Hartford HealthCare Corporation.

2.2 Member's Rights and Powers. In addition to any other rights and powers which the Member may have under law, under these Bylaws or under the Certificate of Incorporation, the Member shall have the right and power to:

(a) Approve the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation and its Subsidiaries, including but not limited to approving capital and operating budgets;

(b) Approve the mission of the Corporation and its Subsidiaries;

(c) Approve the vision of the Corporation and its Subsidiaries;

(d) Approve the formation or acquisition by the Corporation or any Subsidiary of any direct or indirect subsidiaries, joint ventures or affiliations;

(e) Approve the Certificate of Incorporation and Bylaws of the Corporation and each Subsidiary, and any amendments thereto or restatements thereof; provided, however, the Member: (i) will not, during the Transitional Period, impose any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that are inconsistent with the terms of the Affiliation Agreement; (ii) will consult with the Corporation Board prior to implementing any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that are related to the Member's system-wide changes; and (iii) will, during the Transitional Period, obtain the approval of the Corporation Board prior to imposing any changes to the Certificate of Incorporation or Bylaws of the Corporation or Backus Hospital that only apply to the Corporation and Backus Hospital and are not related to System-wide changes;

(f) Approve the governance documents of the Corporation and each Subsidiary, and any amendments thereto or restatements thereof;

(g) Appoint and remove with or without cause all directors ("Directors") and officers for the Corporation and determine the committee structure for the Corporation, including but not limited to appointing individuals to fill vacancies on the Corporation's Board of Directors ("Board"), subject to the provisions of Sections 3.2(c) and 3.6 of these Bylaws;

(h) Approve all core competencies and qualifications required for selection of the Board;

(i) Approve any guidelines for centralized accounting or debt management programs for the System, establish any debt limits under such programs, and approve any variances from such guidelines and set specific limits for the Corporation and its Subsidiaries;

(j) Approve the Corporation's borrowing of any sum in excess of one million dollars which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's or Backus Hospital's real property or by a security interest in the Corporation's or Backus Hospital's assets or revenues;

(k) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation and its Subsidiaries, subject to any established guidelines;

(l) Approve the spectrum of services offered by the Subsidiaries and approve the introduction or termination of any service, including without limitation the filing of any application for a certificate of need with the State of Connecticut; provided, however, that during the Transitional Period, any decision to reduce or terminate a material clinical service that Backus Hospital provided as of the Execution Date of the Affiliation Agreement shall occur only after prior consultation with, and the consent of, the Corporation Board;

(m) Approve the sale, transfer or substantial change in the use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation or change in corporate membership or ownership, or corporate reorganization of the Corporation or any Subsidiary of the Corporation;

(n) Approve the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(o) Approve the Corporation's filing of a voluntary petition for bankruptcy;

(p) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal government authorities;

(q) Accept evaluations submitted by the Board, with respect to the performance of the Board, the chair of the Board (the "Chair") and the vice chair of the Board (the "Vice Chair");

(r) Delegate to the Member's President and Chief Executive Officer (the "Member's President and CEO") the Member's powers of review or approval of actions on matters related to

the Corporation to the extent permitted by law, the Certificate of Incorporation and these Bylaws;

(s) Approve the giving of any vote, consent or approval by the Corporation as the member, partner, shareholder or other direct or in direct owner of another organization where such vote, consent or approval is required by statute, regulation, the certificate or articles of incorporation, Bylaws, partnership certificate or agreement, operating agreement, voting or shareholders agreement or other similar organizational or organic document of such other organization; and

(t) Take such other actions and steps as maybe necessary to maintain the long-range financial strength and viability of the Corporation.

2.3 System Parent Rights. In addition to the Member's rights and powers set forth above, in the event that the Corporation has the right to give or withhold its approval, vote or consent as a member, partner, shareholder or other owner of a Subsidiary or other organization where such approval, vote or consent is required by statute, regulation, the certificate or articles of incorporation, bylaws, partnership certificate or agreement, operating agreement, voting or shareholders agreement or other similar organizational or organic document of such other organization, the Corporation shall only give or withhold such approval, vote or consent as directed by the Member.

2.4 Manner of Acting. In the exercise of its powers, the Member may act through the Member's President and CEO or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws. All action of the Member may be taken by written consent in lieu of a meeting, including in lieu of the annual meeting of the Member for the election of Directors.

ARTICLE 3

BOARD OF DIRECTORS

3.1 Powers and Duties, Functions. The property and affairs of the Corporation shall be managed and conducted by the Board which may authorize and direct the Corporation to exercise all such powers and do all such things as may be exercised or done by the Corporation but subject nevertheless to the provisions of the Corporation's Certificate of Incorporation, these Bylaws, the laws of the State of Connecticut and the laws of the United States of America, and subject to the powers and rights of the Member. In exercising any of its powers of review or approval of actions or matters relating to any Subsidiary, to the extent permitted by law, the Certificate of Incorporation and these Bylaws, the Board may delegate such powers to the Corporation's President and CEO.

3.2 Election, Number, Term of Office, Class and Term Limits.

(a) Election. The Board may recommend to the Member individuals who meet the core competencies and qualifications recommended by the Member to serve as Directors and officers of the Corporation. The Member shall annually appoint individuals to the Board of Directors from among candidates recommended by the Member's Nominating and Governance Committee. The Member may elect Directors to serve on the Corporation's Board at other special or regular meetings of the Corporation for the purpose of increasing the size of the Board or to fill vacancies on the Board.

(b) Number. Following the Transitional Period, the Board shall be comprised of fifteen (15) Directors. Twelve (12) of the Directors (the "Elected Directors") shall be elected from individuals recommended by the Governance Committee as members of the community served by the Hospital, chosen for their leadership, experience, expertise, voluntary service and philanthropic inclination, and one of whom shall be a member of the Hospital's Medical Staff (the "Elected Director from the Medical Staff"). The Elected Director from the Medical Staff shall be chosen from a list of no more than three (3) members in good standing of the Hospital's Medical Staff provided to the Governance Committee of the Board by the Hospital's Medical Staff; provided, however, that: (i) the Governance Committee may request that the Hospital's Medical Staff recommend for election as the Elected Director from the Medical Staff members in good standing of the Hospital's Medical Staff in addition to those identified on the initial list provided to the Governance Committee; and (ii) if a list of candidates for the Elected Director from the Medical Staff is not provided by the Hospital's Medical Staff to the Governance Committee within thirty (30) days of a written request for such list (or additional list(s)), the Governance Committee may nominate any member in good standing of the Medical Staff of the Hospital for election as the Elected Director from the Medical Staff. The remaining three (3) Directors (the "Ex-Officio Directors") shall be the Chief Executive Officer, the President of the Hospital's Medical Staff and the Vice President of the Hospital's Medical Staff. The Elected Directors and the Ex-Officio Directors shall each have a vote and shall be counted for quorum purposes. Notwithstanding the foregoing, during the Transitional Period, the Board shall be comprised of seventeen (17) Directors, which shall include fifteen (15) directors described above and the two (2) HHC-Appointed Directors (defined below).

(c) Transitional Period. Notwithstanding anything to the contrary contained in these Bylaws, the Directors serving on the Corporation Board on the day prior to the Closing Date will continue to serve as Directors during the Transitional Period (the "Legacy Directors"). The Member shall appoint two (2) representatives to serve as Directors during the Transitional Period (the "HHC-Appointed Directors"). During the Transitional Period, additional Directors may be nominated and elected in accordance with these Bylaws.

(d) Classes; Manner of Election; Term of Office. With respect to all Directors other than the Legacy Directors and the HHC-Appointed Directors, the Board shall be divided into three (3) classes, comprised of as equal a number of Directors per class as possible. Each class of Directors shall serve for term of three (3) years, with terms staggered so that approximately one-third (1/3) of the Directors shall be elected by the Member annually. The Directors so elected annually shall hold their offices for a term to expire at the third (3rd) annual meeting after their election and until others shall be elected or appointed in their places. A Director elected at any other meeting or time to fill a vacancy shall hold office only for the unexpired term, unless elected to continue to fill additional terms. In the event that a Director is filling an

unexpired term created by a Board vacancy, such Director may not serve on the Board for more than nine (9) consecutive years, including any terms preceding or subsequent to such Director's term during which they are filling a vacancy.

(e) Term Limits. There shall be a limit of three (3) consecutive full terms which an individual may serve as a Director. Any Director who shall serve for three (3) consecutive full terms shall not be eligible for appointment to a further term or terms until the annual meeting of the Board immediately following the expiration of such third successive full term. For purposes of this limitation, a partial term served as the result of filling a vacancy shall not be counted as a "full term". The Board may waive the above term limit to permit a Director to serve as Board Chair and/or Board Vice Chair, provided such waiver shall be for not more than one (1) additional year to an existing term. Notwithstanding the foregoing, (i) a Director's term shall end upon his or her death, resignation, or removal as provided in these Bylaws; and (ii) a Director of the Corporation who has served for three (3) consecutive full terms will be immediately eligible for appointment to the board of any one of the health care entities which comprise the System.

(f) Director Restrictions. No Director of the Corporation shall serve simultaneously on the Board of Directors of the Corporation and on the board of directors of the Member; provided, however, pursuant to the Affiliation Agreement, during the Transitional Period, the Corporation may nominate, and the Member shall approve, two individuals from the Corporation Board to serve as directors of the Member. The foregoing restrictions shall not apply to the HHC-Appointed Directors or any executive of the Corporation who serves on the board of directors of any non-hospital Subsidiary in an ex-officio capacity.

(g) Ex-Officio Directors. Each Ex-Officio Director shall cease to be a Director immediately and automatically upon ceasing to hold the office from which his or her ex-officio status derives, without the need for any action by the Member, the Corporation or its Directors. There shall be no other ex-officio members on the Board.

(h) Board Competencies and Qualifications. The Corporation shall have a written policy approved by the Member with respect to the qualifications and core competencies for the selection of the persons appointed to the Board.

(i) Special Requirements for Board. The Board shall ensure that the Member's President and CEO is at all times an invited guest at the Board meetings, with attendance at such Board meetings to be left to the sole discretion of the Member's President and CEO.

(j) Honorary Roles. The Board may grant honorary roles, such as the role of Director Emeritus, for individuals who have ceased to serve as Directors. Such roles shall be without any governance responsibilities, including but not limited to voting rights or the right to attend, receive material from, or participate in meetings of the Board.

3.3 Board Meetings. The Board shall hold a maximum of six (6) regular meetings each year, one of which shall also serve as its annual meeting. All meetings, annual, regular or special, shall be held at such place or places within or without the State of Connecticut as the

Board may from time to time by resolution determine or as shall be specified or fixed in the notice or waiver of notice thereof.

(a) Annual Meetings. An annual meeting of the Board for the transaction of such business as may properly come before the Board shall be held following the annual meeting of the Member of the Corporation in each year, at such time and place as shall be determined by the Board.

(b) Regular Meetings. Regular meetings of the Board shall be held at such times as shall be specified in a resolution adopted by the Board then in effect, or if there shall not be any such resolution then in effect, as shall be specified in a notice of such meeting.

(c) Special Meetings. Special meetings of the Board shall be held whenever called by the Board Chair, by the Corporation's President and CEO, by the Member, or by at least two (2) of the Directors then in office.

(d) Notice. At least two (2) days' written, oral or electronic notice of each special meeting stating the time and place of the meeting shall be given to each Director by the Corporation's President and CEO or by the Secretary, or in the case of a special meeting that has been called by the Directors, by the Directors calling the meeting. Except as otherwise provided in these Bylaws or as otherwise required by law, neither the business to be transacted at, nor the purpose of any special meeting of the Board, need be specified in the notice or waiver of notice of such meeting.

(e) Waiver of Notice. The attendance of a Director at any meeting without protesting prior to the commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him or her of notice of such meeting.

(f) Telephonic Participation at a Board Meeting. Directors may participate in a meeting of the Board by use of a conference telephone or similar communications equipment which allows all persons participating in the meeting to simultaneously hear each other and to communicate with one another.

(g) Quorum. A majority of the number of Directors then in office shall constitute a quorum for the transaction of business.

(h) Adjournment. A majority of the Directors present at any meeting of the Board, including a meeting at which a quorum is not present, thereat may adjourn the meeting to another time and place. Notice of any adjourned meeting need not be given unless the meeting shall have been adjourned for more than three (3) days.

3.4 Vote Required for Action. The act of a majority of the Directors present at any meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the vote of a greater or lesser proportion is otherwise required by law. If all the Directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, such action shall be the act of the Board with the same force and effect as though it had been authorized at a duly called and held meeting of the Board.

3.5 Resignation. Any Director of the Corporation may resign at any time by giving written notice to the Corporation's President and CEO. In the event of a resignation of a Director without written notice, the Corporation's President and CEO shall confirm such resignation in writing. Such resignation shall take effect at the time specified therein. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. A vacancy on the Board thereby created shall be filled as provided in Section 3.7 hereof.

3.6 Removal. Any Director may be removed from the Board of Directors with or without cause by the Member. Such action may be taken at any annual meeting, any regular meeting or any special meeting, provided that due notice of the proposed removal shall have been duly given to the subject Director. Notwithstanding the foregoing, during the Transitional Period the Member shall only exercise its power to remove a Legacy Director if such removal is for cause and after prior consultation with the Chair of the Backus Board.

3.7 Vacancies. In the event a Director ceases to be in office, the Member shall have the power to fill the vacancy caused thereby, and the person elected to fill such vacancy shall hold office for the unexpired portion of the term of his or her predecessor.

ARTICLE 4

COMMITTEES

4.1 Committees. The Board may designate two (2) or more Directors, plus such additional individuals, to constitute a committee, which may be standing or ad hoc. The Member may designate one or more of the Corporation's Directors to chair a committee. Committees shall have and may exercise all such authority of the Board as shall be provided in resolutions of appointment, except that only Directors may be members of a committee that has and exercises the authority of the Board, and no such committee shall have any power or authority prohibited by law or as to the following:

(a) filling of vacancies in the Board or any of its committees;

(b) amending the Certificate of Incorporation;

(c) adopting, amending or repealing these Bylaws;

(d) amending or repealing of any resolution of the Board;

(e) approving a plan of merger, a sale, lease, exchange or other disposition of all or substantially all of the property of the Corporation or of a proposal to dissolve the Corporation;

(f) acting on matters committed by these Bylaws or a resolution of the Board to the Member, or to another committee of the Board.

Except as provided in these Bylaws, members of committees and their respective chairpersons shall be appointed by the Board at the annual meeting of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

4.2 Standing Committees. There shall be a Board Governance Committee, a Fundraising Committee, and such additional standing committees as the Member may from time to time establish. Except as set forth in these Bylaws, members of committees need not be Directors of the Corporation. All chairpersons of a committee shall be Directors of the Corporation.

4.3 Board Governance Committee. The Board Governance Committee shall identify qualified candidates and recommend nominations for Directors, and officers of the Corporation to the Member's Nominating and Governance Committee. The Board Governance Committee shall also oversee any Board self-evaluation process; evaluating the Chair and Vice Chair, and consulting with the Member's President and CEO on any annual performance objectives, performance and compensation of the Corporation's President and CEO. The Board Governance Committee shall also advise the Board on matters related to governance of the Corporation, Director performance evaluation and oversight of any Director conflict of interest matters. The Board Governance Committee shall have the responsibilities and shall follow the procedures set forth in the Board Governance Committee Charter as adopted by the Board.

4.4 Fundraising Committee. The Fundraising Committee shall assist the management of the Corporation in fund development matters, shall participate in the formulation of plans and programs to enhance the Corporation's ability to generate financial support from public and private sources, and shall make recommendations and reports to the Board from time to time as it may deem appropriate and as may be consistent with the System's overall fundraising and development objectives. The Fundraising Committee shall have the responsibilities and shall follow the procedures set forth in the Fundraising Committee Charter as adopted by the Board.

4.5 Procedures, Actions by Committee. Subject to any charter adopted by the Board for the governance of any committee, each committee of the Board shall act in accordance with the following procedures: Each committee shall adopt a schedule of regular meetings and shall hold additional special meetings on the call of the committee chair or any two committee members. Notice of each such meeting shall be given to all committee members in the manner provided for notice of regular meetings of the Board. All members of a committee shall be entitled to participate in committee activities and shall have full voting rights on actions taken by such committee. A majority of voting members of the committee shall constitute a quorum for all business. The act of a majority of voting members of the committee present at any meeting duly held at which a quorum is present at the time of the act shall be the act of the committee; and if less than a quorum is present at any committee meeting, a majority of the voting members of the committee present may adjourn such meeting from time to time without notice. Each committee shall keep a record of its proceedings and shall report to the Board as requested. The term of office of a committee member shall be determined by the Board. Members of a committee may be removed at any time by the Board with or without cause.

ARTICLE 5

OFFICERS

5.1 Term and Election of Officers. The Member shall elect the Corporation's Chair and a Vice Chair of the Board. The Secretary and Treasurer of the Corporation shall be appointed by the Board at the annual meeting of the Corporation upon recommendation of the Corporation's President and CEO. The Member's President and CEO shall appoint the Corporation's President and CEO. Each officer shall hold office for the term for which he or she is elected and until his or her successor shall have been duly elected and qualified. Unless otherwise provided in a resolution electing an officer, his or her term of office shall extend to and expire on the date of the next annual meeting of the Board following his or her election. However if earlier, an officer's term shall end upon his or her death, resignation or removal as provided in these Bylaws.

5.2 Chair. The Chair shall preside at all meetings of the Board and shall have such powers and duties as from time to time may be determined by the Board. The Board shall recommend to the Member an individual from among the Directors to serve as Chair.

5.3 Vice Chair. The Vice Chair shall perform the duties of the Chair in the event of the Chair's absence or disability and shall assist the Chair in such duties as the Chair may from time to time assign to the Vice Chair. The Vice Chair shall not automatically succeed to the position of Chair. The Board shall recommend to the Member an individual from among the Directors to serve as Vice Chair.

5.4 The Corporation's President and CEO. The Member's President and CEO shall appoint the Corporation's President and CEO and shall establish the objectives, evaluate the performance and determine the compensation for the Corporation's President and CEO. The removal of the Corporation's President and CEO shall be at the discretion of the Member's President and CEO; provided, however, that during the Transitional Period, any removal of the Corporation's President and CEO shall be made only after consultation with the Corporation's Board. The Corporation's President and CEO shall be the chief executive officer of the Corporation. Subject to the powers expressly reserved to the Board or the Corporation's Member, the Corporation's President and CEO shall, in general, supervise and control all the business and affairs of the Corporation and shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair or Vice Chair has been appointed or in the absence of the Chair or Vice Chair, the Corporation's President and CEO shall preside at each meeting of the Board. The Corporation's President and CEO shall see that all orders and resolutions of the Board and of the committees of the Board are carried into effect. In general, he or she shall perform all duties incident to the office of President and CEO and such other duties as may from time to time be assigned to the Corporation's President and CEO by these Bylaws, by the Board, or by the Member's President and CEO.

Without limiting the foregoing, the Corporation's President and CEO shall have the power to:

(a) Be responsible for coordinating the business affairs of the Corporation within overall System guidelines;

(b) Recommend the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation and its Subsidiaries, including but not limited to capital and operating budgets, to the Member upon consultation with the Board;

(c) Recommend to the Member the vision of the Corporation and of its Subsidiaries;

(d) Recommend to the Board any incurrence or assumption of debt by the Corporation or its Subsidiaries in accordance with the guidelines established by the Member for the System's centralized debt management program;

(e) Identify the need for the Corporation's formation of any new legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, and/or disposition of assets closures, mergers, consolidations or changes in corporate membership or ownership of the Corporation or any Subsidiary of the Corporation; and

(f) Recommend to the Member the need for the introduction or termination of any service and the filing of any application for a certificate of need with the State of Connecticut.

5.5 Treasurer. The Treasurer shall have charge and custody of and be responsible for all the funds and securities of the Corporation; he or she shall keep full and accurate accounts of assets, liabilities, receipts and disbursements and other transactions of the Corporation in books belonging to the Corporation; and he or she shall see that all moneys and other valuable effects of the Corporation are deposited or invested in the name of and to the credit of the Corporation in such banks or other financial institutions as may be designated by the Board. The Treasurer shall disburse or oversee the disbursement of the funds of the Corporation as may be ordered by the Board, taking proper vouchers for disbursements, and shall render to the Corporation's President and CEO and to the Directors at the meetings of the Board, or whenever they may require it, a statement of all his or her transactions as Treasurer and an account of the financial condition of the Corporation. In general, he or she shall perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Board or by the Corporation's President and CEO.

5.6 Secretary. The Secretary shall serve all notices for the Corporation that have been authorized by the Board; keep the minutes of the meetings of the Board and the Member; be the custodian of the corporate records and of the seal of the Corporation; and in general, perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the Board or the Corporation's President and CEO.

5.7 Other Officers. The Board may from time to time appoint such other Board officers as may be deemed necessary or advisable for the efficient operation of the Corporation's affairs, each of whom shall hold office for such period, have such authority and perform such duties as the Member may from time to time determine.

5.8 Removal of Officers. Irrespective of term of office, but subject to any written contract rights or any other provisions in these Bylaws, any officer of the Board may be removed with or without cause at any time by the Member.

5.9 Vacancies. Except as otherwise provided in these Bylaws, if the office of the President and Chief Executive Officer, the Chair, Vice Chair, or any other officer appointed by the Member becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by the Member. If the office of Treasurer, Secretary, Assistant Secretary, or any other officer appointed by the Board becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by the Board.

5.10 Resignations. Any officer of the Corporation may resign his or her office at any time by giving written notice thereof to the Corporation's President and CEO or to the Board. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

ARTICLE 6

CONFLICT OF INTEREST

All Directors and officers of the Corporation shall be subject to and abide by the terms of the Corporation's Conflict of Interest Policy maintained on record by the Corporation, a copy of which has been provided to all Directors and officers.

ARTICLE 7

INDEMNIFICATION

7.1 Limitation of Liability. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act, or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability (as defined in Section 33-1116 of the Act) to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director, (ii) enabled the Director or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal gain, (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

7.2 Indemnification of Directors and Officers. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect.

7.3 Expenses. Expenses incurred by a Director or officer in defending a civil or criminal action, suit or proceeding shall be paid for or reimbursed by the Corporation to the fullest extent permitted by law in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such Director or officer of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under the Certificate of Incorporation or these Bylaws and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall be ultimately determined that such director or officer is not entitled to be indemnified by the Corporation. Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon the terms and conditions, if any, as the Board of Directors deems appropriate.

7.4 Non-exclusivity. The indemnification and advancement of expenses provided for herein shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a Director or officer and shall inure to the benefit of the heirs, executors and administrators of such a person. Notwithstanding the foregoing, the Corporation shall not provide such indemnification or advancement for expenses to the extent that such indemnification or advancement would constitute self-dealing within the meaning of section 4941(d) of the Internal Revenue Code of 1986, as amended.

7.5 Amendment or Repeal. No amendment to or repeal of this Article 7 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

ARTICLE 8

MISCELLANEOUS PROVISIONS

8.1 Notice. Any notice required or permitted to be given under these Bylaws in writing shall be deemed to have been delivered if delivered in person or if sent by United States mail, overnight delivery, telegraph (charges prepaid), telex, facsimile, fax or email and addressed to such person at the address shown on the records of the Corporation or the address supplied by him or her to the Corporation for the purpose of notice. If such notice is sent by mail, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail.

8.2 Amendment. The Member shall have the exclusive power to make, amend or repeal the Corporation's Certificate of Incorporation or these Bylaws, subject to the limitations set forth in Section 2.2(e).

8.3 Execution of Contracts. The Board may authorize any officer or officers and any agent or agents to enter into any contract or execute any instrument in the name of, and on behalf of, the Corporation, and such authority may be general or limited to specified instances. No officer, agent or employee shall have any power or authority to bind or obligate the Corporation by any commitment, contract or engagement, or to pledge its credit or render it liable for any purpose or in any amount unless duly authorized by the Board.

8.4 Compensation for Services. The Corporation may reimburse any Director for expenses incurred in connection with fulfilling his or her duties as a member of the Board, provided that the amount of such reimbursement is reasonable and not excessive.

8.5 Consistency with Affiliation Agreement. In the event of a conflict between any provision of these Bylaws and the terms of the Affiliation Agreement, the provisions of the Affiliation Agreement shall control.

AMENDED AND RESTATED

CERTIFICATE OF INCORPORATION

OF

THE WILLIAM W. BACKUS HOSPITAL

The William W. Backus Hospital, a specially chartered Connecticut nonstock corporation, was formed under Special Act No. 24 of 1893 by the Connecticut General Assembly, entitled "*Incorporating The William W. Backus Hospital*" (the "Special Act"), which Special Act has been amended several times (as amended to date, the "Charter"). The persons named as corporators in the Special Act and their successors forever are hereby incorporated under the name of The William W. Backus Hospital. The Charter is hereby amended and restated in its entirety as set forth in the following Amended and Restated Certificate of Incorporation:

1. The name of the corporation is **The William W. Backus Hospital** (the "Corporation").

2. The Corporation is organized and shall be operated exclusively for charitable, scientific, literary or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). The Corporation shall be operated as a component part of the integrated health care delivery system of which the parent is Hartford HealthCare Corporation (the "System Parent"). The nature and activities to be conducted, or the purposes to be promoted or carried out by the Corporation are as follows:

(a) maintaining one or more hospital facilities in the City of Norwich, Connecticut, and the Eastern Connecticut region;

(b) establishing and maintaining health care facilities in the City of Norwich and additional communities served by the Corporation;

(c) providing health and wellness services, promoting the general health of the communities served by the Corporation and providing educational services in furtherance of the foregoing;

(d) engaging in medical research to improve health care and its delivery;

(e) providing medical and graduate medical education programs; and

(f) in furtherance of the foregoing, engaging in any lawful act or activity for which corporations may be formed under the Revised Nonstock Corporation Act of the State of Connecticut (the "Act") as the same may be amended.

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions or pay dividends.

4. The Corporation shall have a single member, namely, Backus Corporation, a Connecticut nonstock corporation ("Backus" or the "Member"). The Member shall have such rights, powers and responsibilities as are accorded to members under the Act, this Certificate of Incorporation and as are set forth in the Corporation's Bylaws.

5. The Corporation shall operate under the management of a Board of Directors (the "Board"). The corporate powers of the Board, and any applicable limitations thereon, shall be as set forth in the Bylaws as in effect from time to time. The directors of the Corporation (the "Directors") shall be elected as provided in the Corporation's Bylaws, which shall prescribe the number, qualifications and manner of election of Directors. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio Directors of the Board who may vote and be counted in determining a quorum. As may be further provided in the Bylaws, the terms of elected Directors of the Board may be staggered by dividing the Directors into up to three (3) groups so that approximately an equal number of such Directors have terms that expire each year.

6. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on: (a) by an organization exempt from federal income tax under Section 501(a) of the Internal Revenue Code of 1986, as amended (the "Code") as an organization described in Section 501(c)(3) of the Code; or (b) by an organization, contributions to which are deductible under Section 170(c)(2) of the Code.

7. The net earnings of the Corporation or any part thereof may not be distributed to or inure to the benefit of any private individual or a Director or officer of the Corporation. However, nothing herein shall restrict the right of the Corporation to reasonably compensate any officer, Director or other individual for services rendered to the Corporation or to reimburse any officer, Director or other individual for expenses, disbursements or liabilities properly made or incurred, on account of that individual's service to the Corporation.

8. A substantial part of the activities of the Corporation shall not consist of carrying on propaganda or attempting to influence legislation. The Corporation may not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

9. Upon dissolution of the Corporation, the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the purposes of the Corporation, to the Member or to the System Parent exclusively for its charitable, scientific, literary or educational purposes, provided that either the Member or the System Parent shall be then exempt from federal taxation as an organization described in Section 501(c)(3) of the Code. If either the Member or the System Parent shall not be so qualified as an organization described in Section 501(c)(3) of the Code, then the Board shall dispose of and distribute the assets remaining, after payment of all liabilities, exclusively for the charitable, scientific, literary or educational purposes of the Corporation, to one or more organizations as shall be then exempt from federal taxation as an organization or organizations described in Section 501(c)(3) of the Code, in such proportions and amounts and in such manner as the Board shall determine. No part of the Corporation's assets shall ever be distributed to its Directors or officers, or inure to the benefit of any private individual.

10. The personal liability of a Director of the Corporation to the Corporation for monetary damages for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act or any other applicable laws presently or hereafter in effect. Without limiting the effect of the preceding sentence, no Director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of duty as a Director of the Corporation in an amount greater than the compensation received by the Director for serving the Corporation during the year of the violation if such breach did not: (i) involve a knowing and culpable violation of law by the Director; (ii) enable the Director, or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain; (iii) show a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. No amendment to, or modification or repeal of, this Article 10 shall adversely affect any right or protection of a Director of the Corporation existing hereunder with respect to any act or omission occurring prior to such amendment, modification or repeal. Nothing contained in this Article 10 shall be construed to deny to the Directors of the Corporation the benefit of Section 52-557m of the Connecticut General Statutes as in effect at the time of the violation.

11. The Corporation shall indemnify a Director for a liability, as defined in Section 33-1116(5) of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that: (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both: (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Article 10 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Article 11. Such expenses (including attorneys' fees) incurred by other employees and agents may be so paid upon such terms and conditions, if any, as the Board deems appropriate. The indemnification and advancement of expenses provided by, or granted pursuant to, this Article 11 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

12. References in this Amended and Restated Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act, and references to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or as the same may hereafter be amended from time to time.

AMENDED AND RESTATED

BYLAWS

OF

THE WILLIAM W. BACKUS HOSPITAL

* * * * * * *

ARTICLE 1

NAME AND PURPOSES

1.1 Name. The name of the corporation is The William W. Backus Hospital (the "Corporation").

1.2 Purpose. The Corporation is organized and shall be operated exclusively for religious, charitable, scientific, literary or educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), which purposes are set forth in the Corporation's Certificate of Incorporation, as the same may be amended from time to time (the "Certificate of Incorporation"). The Corporation's primary purpose is to operate hospital facilities in the City of Norwich and the Eastern Connecticut region within the health care delivery system administered by Hartford HealthCare Corporation (the "System").

1.3 Definitions. The following terms used in these Bylaws shall have the following

(a) "Act" shall mean the Connecticut Revised Nonstock Corporation Act, as amended from time to time.

(b) "Affiliation Agreement" shall mean the agreement effectuating the full corporate affiliation between the Member and HHC, executed as of August 17, 2012 and effective on the Closing Date.

(c) "Certificate of Incorporation" shall mean the Corporation's certificate of incorporation, as the same may be amended from time to time.

(d) "Closing Date" shall mean the date on which the affiliation between HHC and the Member is fully consummated in accordance with the terms of the Affiliation Agreement.

(e) "Corporation's President and CEO" shall mean the President and Chief Executive Officer of the Corporation.

(f) "HHC" shall mean Hartford HealthCare Corporation, the parent company of the System and the sole member of the Member.

(g) "Member" shall mean Backus Corporation.

(h) "Subsidiary" or "Subsidiaries" shall mean any entity directly or indirectly controlled by the Corporation. "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of an entity, whether through the ability to exercise voting power by contract or otherwise. "Controlled" or "Controlling" have correlative meanings.

(i) "System" shall mean the comprehensive and integrated health care delivery system operated by HHC.

(j) "Transitional Period" shall mean a period of three years commencing on the Closing Date.

ARTICLE 2

MEMBERSHIP

2.1 Members. The Corporation shall have a sole member, namely, Backus Corporation.

2.2 Member's Rights and Powers. In addition to any other rights and powers which the Member may have under law, under these Bylaws or under the Certificate of Incorporation, the Member shall have the right and power to:

(a) to approve the strategic plan of the Corporation and the consolidation or closure of significant lines of business, programs or services of the Corporation;

(b) to effectuate the transfer of funds from the Corporation to another corporation affiliated with the Member ("Affiliated Corporation") or from an Affiliated Corporation to the Corporation;

(c) to effectuate the Corporation's payment to or receipt of payment from the Member;

(d) to approve the acquisition or lease of any equipment and any project or construction contract that entails an expenditure by the Corporation in excess of, or with a value over, $400,000 in any fiscal year and that is not already incorporated in an approved budget of the Corporation;

(e) to approve any projects that would require a certificate of need ("CON") or for which a CON determination will be submitted to the Office of Health Care Access;

(f) to approve the reorganization, merger, consolidation or dissolution of the Corporation, or the affiliation of the Corporation with another hospital or health care delivery system, or the creation or acquisition of any subsidiary or affiliate of the Corporation;

(g) to approve the Corporation's annual operating budget and annual capital budget;

(h) to approve plans for the borrowing of any sum in excess of $400,000 which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's real property or by a security interest in the Corporation's assets or revenues; provided, however, that except as incident to the review of the capital budget pursuant to paragraph (g) above, approval by the Member shall not be necessary for any borrowing to purchase or lease equipment which is secured by a purchase money lien on such equipment or a title retention or security agreement relating solely to such equipment; and

(i) to approve amendments to the Certificate of Incorporation or Bylaws of the Corporation.

2.3 Manner of Acting. In the exercise of its powers, the Member may act through the Member's President and CEO or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws. All action of the Member may be taken by written consent in lieu of a meeting, including in lieu of the annual meeting of the Member. Any actions hereunder requiring or providing for both Member and HHC approval under these Bylaws shall not be deemed approved until such time that the Corporation receives approval from both the Member and HHC.

ARTICLE 3

HHC'S AUTHORITY

3.1 HHC's Authority. HHC is the sole member of the Corporation's Member and oversees the System and its affiliated entities, including the Corporation.

3.2 Rights and Powers of HHC. HHC, as the sole member of the Corporation's Member, shall have the ultimate authority to approve any decisions made by the Member by virtue of its rights and powers under state law. Any actions hereunder requiring both Member and HHC approval under these Bylaws shall not be deemed approved until such time that the Corporation receives approval from both the Member and HHC. Such ultimate authority granted to HHC shall include the right and power to:

(a) Approve the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation, including but not limited to approving capital and operating budgets;

(b) Approve the mission of the Corporation;

(c) Approve the vision of the Corporation;

(d) Approve the Corporation's formation or acquisition of any direct or indirect subsidiaries, joint ventures or affiliations;

(e) Approve the Certificate of Incorporation and Bylaws of the Corporation and any amendments thereto or restatements thereof; provided, however, that HHC: (i) will not, during the Transitional Period, impose any changes to the Certificate of Incorporation or Bylaws of the Corporation that are inconsistent with the terms of the Affiliation Agreement; (ii) will consult with the Member's board prior to implementing any changes to the Certificate of Incorporation or Bylaws of the Corporation that are related to HHC's system-wide changes; and (iii) will, during the Transitional Period, obtain the approval of the Member board prior to imposing any changes to the Certificate of Incorporation or Bylaws of the Corporation that only apply System-wide changes;

(f) Approve the Corporation's governance documents and any amendments thereto or restatements thereof;

(g) Appoint and remove with or without cause all directors ("Directors") and officers for the Corporation and determine the committee structure for the Corporation, including but not limited to appointing individuals to fill vacancies on the Corporation's Board of Directors ("Board"), subject to the provisions of Sections 4.2(c) and 4.6 of these Bylaws;

(h) Approve all core competencies and qualifications required for selection of the Board;

(i) Approve any guidelines for centralized accounting or debt management programs for the System, establish any debt limits under such programs, and approve any variances from such guidelines and set specific limits for the Corporation;

(j) Approve the Corporation's borrowing of any sum in excess of one million dollars which has a stated term greater than one year or which is secured by a mortgage of all or any portion of the Corporation's real property or by a security interest in the Corporation's assets or revenues;

(k) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation, subject to any established guidelines;

(l) Approve the spectrum of services offered by the Corporation and approve the introduction or termination of any service, including without limitation the filing of any application for a certificate of need with the State of Connecticut;

(m) Approve the sale, transfer or substantial change in the use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation or change in corporate membership or ownership, or corporate reorganization of the Corporation or any Subsidiary of the Corporation;

(n) Approve the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(o) Approve the Corporation's filing of a voluntary petition for bankruptcy;

(p) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal government authorities;

(q) Accept evaluations submitted by the Board, with respect to the performance of the Board, the chair of the Board (the "Chair") and the vice chair of the Board (the "Vice Chair");

(r) Delegate to HHC's President and Chief Executive Officer (the "HHC CEO") or to the Member's President and Chief Executive Officer (the "Member's President and CEO") either HHC's or the Member's powers of review or approval of actions on matters related to the Corporation to the extent permitted by law, the Certificate of Incorporation and these Bylaws; and

(s) Take such other actions and steps as maybe necessary to maintain the long-range financial strength and viability of the Corporation.

3.3 Manner of Acting. In the exercise of its powers granted hereunder, HHC may act through the HHC CEO or such other officer duly designated by HHC, acting through its board of directors, and may take such action by written consent, including the election of Directors. In the exercise of its powers, the Member may act through the Member's President and CEO, or such other officer duly designated by the Member, acting through the Member's board of directors. The Member's President and CEO or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws.

ARTICLE 4

BOARD OF DIRECTORS

4.1 Powers and Duties, Functions. The property and affairs of the Corporation shall be managed and conducted by the Board which may authorize and direct the Corporation to exercise all such powers and do all such things as may be exercised or done by the Corporation but subject nevertheless to the provisions of the Corporation's Certificate of Incorporation, these Bylaws, the laws of the State of Connecticut and the laws of the United States of America.

Without limiting the foregoing, the Board shall have the power to:

(a) Consult with HHC and the Member on the Corporation's objectives, including but not limited to annual scorecard targets and initiatives, core values and strategic and financial plans of the Corporation, including but not limited to capital and operating budgets, subject to the recommendation of the HHC CEO;

(b) Recommend the Corporation's mission to HHC after consultation with the HHC CEO;

(c) Recommend the Corporation's vision to HHC upon the recommendation of the HHC CEO;

(d) Consult with HHC on the formation or acquisition by the Corporation of any new direct or indirect subsidiaries, joint ventures or affiliations:

(e) Recommend to HHC changes to the Corporation's Certificate of Incorporation and Bylaws upon the recommendation of the HHC CEO;

(f) Recommend to HHC changes to the Corporation's governance documents after consultation with the HHC CEO;

(g) Recommend to HHC nominations for and removal of Directors and officers of the Corporation;

(h) Subject to the approval of the Member, approve any incurrence or assumption of debt by the Corporation in accordance with the guidelines for accounting and debt management programs established by HHC;

(i) Approve all projects or transactions involving the expenditure of funds or divestiture of assets of the Corporation, subject to approval of Member and any guidelines established by HHC;

(j) Recommend the Corporation's introduction or termination of any service and the filing on any application for a certificate of need with the State of Connecticut, subject to the approval of the Member and HHC;

(k) Consult with Member and HHC on the sale, transfer or substantial change in use of all or substantially all of the assets of the Corporation, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any subsidiary of the Corporation, each with the recommendation of the HHC CEO;

(l) Approve the Corporation's uses, investment and management of permanent and temporarily restricted endowment funds, subject to Member's and HHC's approval and with the recommendation of the HHC CEO;

(m) Approve the Corporation's entering into any settlement agreement or consent decree with any state or federal governmental authorities, subject to HHC's approval;

(n) Evaluate the Corporation's Board performance, including the performance of the Chair and the Vice Chair for submission to HHC;

(o) Consult with the HHC CEO on the appointment and removal of the Corporation's President and CEO;

(p) Consult with the HHC CEO on the annual performance objectives, performance and compensation of the Corporation's President and CEO:

(q) Approve actions with respect to the privileges and credentials of members of the Corporation's medical staff in accordance with state and federal law, applicable accreditation standards, the Corporation's Medical Staff Bylaws and System guidelines created by HHC;

(r) Approve quality and patient safety programs and initiatives for the Corporation in coordination with the programs and initiatives developed by the System;

(s) Oversee and approve the Corporation's programs to assure corporate and regulatory compliance;

(t) Oversee and approve the Corporation's community needs assessments and community initiatives; and

(u) Approve the Corporation's fundraising and development program.

4.2 Election, Number, Term of Office, Class and Term Limits.

(a) Election. The Board may recommend to HHC individuals who meet the core competencies and qualifications recommended by HHC to serve as Directors and officers of the Corporation. HHC shall annually elect individuals to the Board of Directors from among candidates recommended by HHC's Nominating and Governance Committee. HHC may elect Directors to serve on the Corporation's Board at other special or regular meetings of the Corporation for the purpose of increasing the size of the Board or to fill vacancies on the Board.

(b) Number. Following the Transitional Period, the Board shall be comprised of fifteen (15) Directors. Twelve (12) of the Directors (the "Elected Directors") shall be elected from individuals recommended by the Governance Committee as members of the community served by the Hospital, chosen for their leadership, experience, expertise, voluntary service and philanthropic inclination, and one of whom shall be a member of the Hospital's Medical Staff (the "Elected Director from the Medical Staff"). The Elected Director from the Medical Staff shall be chosen from a list of no more than three (3) members in good standing of the Hospital's Medical Staff provided to the Governance Committee of the Board by the Hospital's Medical Staff; provided, however, that: (i) the Governance Committee may request that the Hospital's Medical Staff recommend for election as the Elected Director from the Medical Staff members in good standing of the Hospital's Medical Staff in addition to those identified on the initial list provided to the Governance Committee; and (ii) if a list of candidates for the Elected Director from the Medical Staff is not provided by the Hospital's Medical Staff to the Governance Committee within thirty (30) days of a written request for such list (or additional list(s)), the Governance Committee may nominate any member in good standing of the Medical Staff of the Hospital for election as the Elected Director from the Medical Staff. The remaining three (3) Directors (the "Ex-Officio Directors") shall be the Chief Executive Officer, the President of the Hospital's Medical Staff and the Vice President of the Hospital's Medical Staff. The Elected Directors and the Ex-Officio Directors shall each have a vote and shall be counted for quorum purposes. Notwithstanding the foregoing, during the Transitional Period, the Board shall be comprised of seventeen (17) Directors, which shall include fifteen (15) directors described above and the two (2) HHC-Appointed Directors defined below.

(c) Transitional Period. Notwithstanding anything to the contrary contained in these Bylaws, the Directors serving on the Corporation Board on the day prior to the Closing Date will constitute the Directors during the Transitional Period (the "Legacy Directors"). HHC shall appoint two representatives to serve as Directors during the Transitional Period (the "HHC-Appointed Directors"). During the Transitional Period additional Directors may be nominated as elected in accordance with these Bylaws.

(d) Classes; Manner of Election; Term of Office. With respect to all other Directors than the Legacy Directors and the HHC-Appointed Directors, the Board shall be divided into three (3) classes, comprised of as equal a number of Directors per class as possible. Except as may be specifically determined by HHC from time to time, each class of Directors shall serve for term of three (3) years, with terms staggered so that approximately one-third (1/3) of the Directors shall be elected by HHC annually. The Directors so elected annually shall hold their offices for a term to expire at the third (3rd) annual meeting after their election and until others shall be elected or appointed in their places. A Director elected at any other meeting or time to fill a vacancy shall hold office only for the unexpired term, unless elected to continue to fill additional terms. In the event that a Director is filling an unexpired term created by a Board vacancy, such Director may not serve on the Board for more than nine (9) consecutive years, including any terms preceding or subsequent to such Director's term during which they are filling a vacancy.

(e) Term Limits. There shall be a limit of three (3) consecutive full terms which an individual may serve as a Director. Any Director who shall serve for three (3) consecutive full terms shall not be eligible for election to a further term or terms until the annual meeting of the Board immediately following the expiration of such third successive full term. HHC may waive the above term limit to permit a Director to serve as Board Chair and/or Board Vice Chair, provided such waiver shall be for not more than one (1) additional year to an existing term. Notwithstanding the foregoing, (i) a Director's term shall end upon his or her death, resignation, or removal as provided in these Bylaws; and (ii) a Director of the Corporation who has served for three (3) consecutive full terms will be immediately eligible for appointment to the board of any one of the health care entities which comprise the System.

(f) Director Restrictions. No Director of the Corporation shall serve simultaneously on the Board of Directors of the Corporation and (i) on the board of directors of HHC, or (ii) on the board of directors of any hospital entity within the System; provided, however, pursuant to the Affiliation Agreement, during the Transitional Period, the Member may nominate, and HHC shall approve, two individuals from the Member board or the Corporation Board to serve as directors of HHC. The foregoing restrictions shall not apply to the HHC-Appointed Directors or any executive of the Corporation who serves on the board of directors of any non-hospital Subsidiary in an ex-officio capacity.

(g) Ex-Officio Directors. Each Ex-Officio Director shall cease to be a Director immediately and automatically upon ceasing to hold the office from which his or her ex-officio status derives, without the need for any action by HHC, the Member, the Corporation or its Directors. There shall be no other ex-officio members on the Board.

(h) Board Competencies and Qualifications. The Corporation shall have a written policy approved by HHC with respect to the qualifications and core competencies for the selection of the persons appointed to the Board.

(i) Special Requirements for Board. The Board shall ensure that the HHC CEO and the Member's President and CEO is each, at all times, an invited guest at the Board meetings, with attendance at such Board meetings to be left to their sole discretion.

(j) Honorary Roles. The Board may grant honorary roles, such as the role of Director Emeritus, for individuals who have ceased to serve as Directors. Such roles shall be without any governance responsibilities, including but not limited to voting rights or the right to attend, receive material from, or participate in meetings of the Board.

4.3 Board Meetings. The Board shall hold a maximum of six (6) regular meetings each year, one of which shall also serve as its annual meeting. All meetings, annual, regular or special, shall be held at such place or places within or without the State of Connecticut as the Board may from time to time by resolution determine or as shall be specified or fixed in the notice or waiver of notice thereof.

(a) Annual Meetings. An annual meeting of the Board for the transaction of such business as may properly come before the Board shall be held following the annual meeting of the Member of the Corporation in each year, at such time and place as shall be determined by the Board.

(b) Regular Meetings. Regular meetings of the Board shall be held at such times as shall be specified in a resolution adopted by the Board then in effect, or if there shall not be any such resolution then in effect, as shall be specified in a notice of such meeting.

(c) Special Meetings. Special meetings of the Board shall be held whenever called by the Board Chair, by the Corporation's President and CEO, by the Member, by HHC or by at least two (2) of the Directors then in office.

(d) Notice. At least two (2) days' written, oral or electronic notice of each special meeting stating the time and place of the meeting shall be given to each Director by the Corporation's President and CEO or by the Secretary, or in the case of a special meeting that has been called by the Directors, by the Directors calling the meeting. Except as otherwise provided in these Bylaws or as otherwise required by law, neither the business to be transacted at, nor the purpose of any special meeting of the Board, need be specified in the notice or waiver of notice of such meeting.

(e) Waiver of Notice. The attendance of a Director at any meeting without protesting prior to the commencement of the meeting the lack of proper notice shall be deemed to be a waiver by him or her of notice of such meeting.

(f) Telephonic Participation at a Board Meeting. Directors may participate in a meeting of the Board by use of a conference telephone or similar communications equipment which allows all persons participating in the meeting to simultaneously hear each other and to

communicate with one another, and such participation in a meeting shall constitute presence in person at such meeting.

(g) Quorum. A majority of the number of Directors then in office shall constitute a quorum for the transaction of business.

(h) Adjournment. A majority of the Directors present at any meeting of the Board, including a meeting at which a quorum is not present, thereat may adjourn the meeting to another time and place. Notice of any adjourned meeting need not be given unless the meeting shall have been adjourned for more than three (3) days.

4.4 Vote Required for Action. The act of a majority of the Directors present at any meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the vote of a greater or lesser proportion is otherwise required by law. If all the Directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, such action shall be the act of the Board with the same force and effect as though it had been authorized at a duly called and held meeting of the Board.

4.5 Resignation. Any Director of the Corporation may resign at any time by giving written notice to the Corporation's President and CEO. In the event of a resignation of a Director without written notice, the Corporation's President and CEO shall confirm such resignation in writing. Such resignation shall take effect at the time specified therein. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective. A vacancy on the Board thereby created shall be filled as provided in Section 4.7 hereof.

4.6 Removal. Any Director may be removed from the Board of Directors with or without cause by HHC. Such action may be taken at any annual meeting, any regular meeting or any special meeting, provided that due notice of the proposed removal shall have been duly given to the subject Director. Notwithstanding the foregoing, during the Transitional Period HHC shall only exercise its power to remove a Legacy Director if such removal is for cause only and after prior consultation with the Chair of the Member board.

4.7 Vacancies. In the event a Director ceases to be in office, HHC shall have the power to fill the vacancy caused thereby, and the person elected to fill such vacancy shall hold office for the unexpired portion of the term of his or her predecessor.

ARTICLE 5

COMMITTEES

5.1 Committees. The Board may designate two (2) or more Directors, plus such additional individuals, to constitute a committee, which may be standing or ad hoc. The Member or HHC may designate one or more of the Corporation's Directors to chair a committee. Committees shall have and may exercise all such authority of the Board as shall be provided in resolutions of appointment, except that only Directors may be members of a committee that has

and exercises the authority of the Board, and no such committee shall have any power or authority prohibited by law or as to the following:

(a) filling of vacancies in the Board or any of its committees;

(b) amending the Certificate of Incorporation;

(c) adopting, amending or repealing these Bylaws;

(d) amending or repealing of any resolution of the Board;

(e) approving a plan of merger, a sale, lease, exchange or other disposition of all or substantially all of the property of the Corporation or of a proposal to dissolve the Corporation; or acting on matters committed by these Bylaws or a resolution of the Board to the Member, or to another committee of the Board.

Except as provided in these Bylaws, members of committees and their respective chairpersons shall be appointed at the annual meeting of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

5.2 Standing Committees. There shall be a Board Governance Committee, a Development Committee, a Quality and Credentialing Committee, and such additional standing committees as HHC may from time to time establish. Except as set forth in these Bylaws, members of committees need not be Directors of the Corporation. All chairpersons of a committee shall be Directors of the Corporation.

5.3 Board Governance Committee. The Board Governance Committee shall identify qualified candidates and recommend nominations for Directors and officers of the Corporation to HHC's Nominating and Governance Committee. The Board Governance Committee shall also oversee any Board self-evaluation process; evaluating the Chair and Vice Chair, and consulting with the HHC CEO on any annual performance objectives, performance and compensation of the Corporation's President and CEO. The Board Governance Committee shall also advise the Board on matters related to governance of the Corporation, Director performance evaluation and oversight of any Director conflict of interest matters. The Board Governance Committee shall have the responsibilities and shall follow the procedures set forth In the Board Governance Committee Charter as adopted by the Board.

5.4 Development Committee. The Development Committee shall assist the management of the Corporation in fund development matters, shall participate in the formulation of plans and programs to enhance the Corporation's ability to generate financial support from public and private sources, and shall make recommendations and reports to the Board from time to time as it may deem appropriate and as may be consistent with the System's overall fundraising and development objectives. The Development Committee shall have the responsibilities and shall follow the procedures set forth in the Development Committee Charter as adopted by the Board.

5.5 Quality and Credentialing Committee. The Quality and Credentialing Committee shall assist the Board by: (a) monitoring and assessing the quality of care, clinical safety, patient

safety and services provided by the Corporation; (b) approving appointments and reappointments to the Corporation's Medical Staff as needed, between meetings of the Board; (c) the granting and delineation of medical privileges and credentialing, based on recommendations of the Medical Staff as provided in the Corporation's Medical Staff Bylaws as needed, between meetings of the Board; (d) ensuring that the Corporation and the Medical Staff comply with any state or federal regulatory and applicable accreditation requirements; and (e) assisting the Board with any community needs assessments that may be undertaken from time to time. When engaging in peer review activities (including but not limited to appointment, credentialing and corrective action activities), the Board, the Quality and Credentialing Committee, and any other committee or subcommittee of the Board is a "Medical Review Committee" as defined in Chapter 368a of the Connecticut General Statutes, as amended from time to time. Thus, proceedings of such a Medical Review Committee, including data and information gathering, analyses and reporting by authorized individuals for the purpose of peer review activities, as well as minutes and other documents from meetings or portions of meetings addressing peer review, shall be privileged and confidential to the extent permitted by law. The Quality and Credentialing Committee shall have the responsibilities and shall follow the procedures set forth in the Quality and Credentialing Committee Charter as adopted by the Board.

5.6 Procedures, Actions by Committee. Subject to any charter adopted by the Board for the governance of any committee, each committee of the Board shall act in accordance with the following procedures: Each committee shall adopt a schedule of regular meetings and shall hold additional special meetings on the call of the committee chair or any two committee members. Notice of each such meeting shall be given to all committee members in the manner provided for notice of regular meetings of the Board. All members of a committee shall be entitled to participate in committee activities and shall have full voting rights on actions taken by such committee. A majority of voting members of the committee shall constitute a quorum for all business. The act of a majority of voting members of the committee present at any meeting duly held at which a quorum is present at the time of the act shall be the act of the committee; and if less than a quorum is present at any committee meeting, a majority of the voting members of the committee present may adjourn such meeting from time to time without notice. Each committee shall keep a record of its proceedings and shall report to the Board as requested. The term of office of a committee member shall be determined by the Board. Members of a committee may be removed at any time by the Board with or without cause.

ARTICLE 6

OFFICERS

6.1 Term and Election of Officers. HHC shall elect the Corporation's Chair and a Vice Chair of the Board. The Secretary and Treasurer of the Corporation shall be appointed by the Board at the annual meeting of the Board upon the recommendation of the Corporation's President and CEO. The HHC CEO shall appoint the Corporation's President and CEO. Each officer shall hold office for the term for which he or she is duly elected and until his or her successor shall have been duly elected and qualified. Unless otherwise provided in a resolution electing an officer, his or her term of office shall extend to and expire on the date of the next annual meeting of the Board following his or her election. However, if earlier, an officer's term shall end upon his or her death, resignation or removal as provided in these Bylaws.

6.2 Chair. The Chair shall preside at all meetings of the Board and shall have such powers and duties as from time to time may be determined by the Board. The Board shall recommend to HHC an individual from among the Directors to serve as Chair.

6.3 Vice Chair. The Vice Chair shall perform the duties of the Chair in the event of the Chair's absence or disability and shall assist the Chair in such duties as the Chair may from time to time assign to the Vice Chair. The Vice Chair shall not automatically succeed to the position of Chair. The Board shall recommend to HHC an individual from among the Directors to serve as Vice Chair.

6.4 The Corporation's President and CEO. The HHC CEO shall appoint the Corporation's President and CEO and shall establish the objectives, evaluate the performance and determine the compensation for the Corporation's President and CEO. The removal of the Corporation's President and CEO shall be at the discretion of the HHC CEO. The Corporation's President and CEO shall be the chief executive officer of the Corporation. Subject to the powers expressly reserved to the Board, to the Member or to HHC, the Corporation's President and CEO shall, in general, supervise and control all the business and affairs of the Corporation and shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair or Vice Chair has been appointed or in the absence of the Chair and Vice Chair, the Corporation's President and CEO shall preside at each meeting of the Board. The Corporation's President and CEO shall see that all orders and resolutions of the Board and of the committees of the Board are carried into effect. In general, he or she shall perform all duties incident to the office of President and CEO and such other duties as may from time to time be assigned to the Corporation's President and CEO by these Bylaws, by the Board, or by the HHC CEO. Without limiting the foregoing, the Corporation's President and CEO shall have the following powers:

(a) Be responsible for coordinating the business affairs of the Corporation within overall System guidelines;

(b) Recommend the objectives, including but not limited to annual scorecard targets and initiatives, core values, and strategic and financial plans of the Corporation, including but not limited to capital and operating budgets, to the Member upon consultation with the Board;

(c) Recommend the Corporation's vision to HHC;

(d) Recommend to the Board any incurrence or assumption of debt by the Corporation in accordance with the guidelines established by HHC for the System's centralized debt management program;

(e) Identify the need for the Corporation's formation of any new legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, and/or disposition of assets closures, mergers, consolidations or changes in corporate membership or ownership of the Corporation or any Subsidiary of the Corporation; and

(f) Recommend to HHC the need for the introduction or termination of any service and the filing of any application for a certificate of need with the State of Connecticut.

6.5 Treasurer. The Treasurer shall have charge and custody of and be responsible for all the funds and securities of the Corporation; he or she shall keep full and accurate accounts of assets, liabilities, receipts and disbursements and other transactions of the Corporation in books belonging to the Corporation; and he or she shall see that all moneys and other valuable effects of the Corporation are deposited or invested in the name of and to the credit of the Corporation in such banks or other financial institutions as may be designated by the Board. The Treasurer shall disburse or oversee the disbursement of the funds of the Corporation as may be ordered by the Board, taking proper vouchers for disbursements, and shall render to the Corporation's President and CEO and to the Directors at the meetings of the Board, or whenever they may require it, a statement of all his or her transactions as Treasurer and an account of the financial condition of the Corporation. In general, he or she shall perform all the duties incident to the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Board or by the Corporation's President and CEO.

6.6 Secretary. The Secretary shall serve all notices for the Corporation that have been authorized by the Board; keep the minutes of the meetings of the Board and the Member; be the custodian of the corporate records and of the seal of the Corporation; and in general, perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the Board or the Corporation's President and CEO.

6.7 Other Officers. The Member may from time to time appoint such other officers as may be deemed necessary or advisable for the efficient operation of the Corporation's affairs, each of whom shall hold office for such period, have such authority and perform such duties as the Member may from time to time determine.

6.8 Removal of Officers. Irrespective of term of office, but subject to any written contract rights or any other provisions in these Bylaws, any officer of the Corporation may be removed with or without cause at any time by HHC.

6.9 Vacancies. Except as otherwise provided in these Bylaws, if the office of the Chair, the Vice Chair, the President and Chief Executive Officer, or any other officer appointed by HHC becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term thereof by HHC. If the office of the Treasurer, the Secretary, or any other officer appointed by the Board becomes vacant at any time, the vacancy may be filled for the unexpired term thereof by the Board.

6.10 Resignations. Any officer of the Corporation may resign his or her office at any time by giving written notice thereof to the Corporation's President and CEO or to the Board. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

ARTICLE 7

MEDICAL STAFF

7.1 Medical Staff of Hospitals. The Board has caused to be created and shall continue to provide for a medical staff organization (the "Medical Staff") for the Corporation, which shall include all physicians, dentists and members of allied professions who are granted by the Board the privilege of caring for or contributing to the care of patients at each hospital facility. Membership on the Medical Staff shall be a prerequisite to the exercise of clinical privileges in each hospital facility, except as otherwise provided in such Bylaws adopted for the governance of the Medical Staff and related governance rules (the "Medical Staff Bylaws").

7.2 Medical Staff Bylaws. The Medical Staff shall be governed by the Medical Staff Bylaws and Medical Staff Credentials Policy, and Medical Staff Rules and Regulations. Medical Staff Bylaws and any amendments thereto may be initiated by the Medical Staff but shall become effective only upon final approval by the Board. The Medical Staff Bylaws and Medical Staff Credentials Policy shall provide for the procedure to be followed in matters relating to Medical Staff membership status, clinical privileges, and corrective action.

7.3 Board Exclusive Appointing Authority. Anything to the contrary herein notwithstanding, the Board shall have the exclusive authority and responsibility to make appointments or reappointments to the Medical Staff. In each case, the Board shall consider the recommendations and reports of the Medical Staff.

ARTICLE 8

CORPORATORS

8.1 General. The Corporation shall have a board of corporators (the "Board of Corporators"). Persons on the Board of Corporators (the "Corporators") shall serve in an honorary and advisory capacity, and except as provided herein or as the Board of Directors shall otherwise designate, shall in such capacity have no right to notice of or to vote at any meeting, shall not be considered for purposes of establishing a quorum and shall have no other rights or responsibilities. The Board of Corporators will be the key link and resource between the Corporation and the community served by the Corporation, and shall have as its principal purpose enhancing the Corporation's ability to fulfill the public purposes for which it has been organized and is intended to be operated. Corporators shall not serve in a fiduciary capacity nor shall they have legal responsibility, power or accountability as Corporators with respect to the affairs of the Corporation.

8.2 Number. The Corporators shall be chosen to represent broad sections of the community area served by the Corporation. The Board of Directors of the Corporation may appoint the chief elected municipal officials of towns and chief elected officials of federally recognized tribal nations within the service area of the Corporation as Corporators, whose terms shall coincide with those of their offices. The original Corporators shall be those persons who are members/corporators of Backus Corporation on the date of adoption of these Bylaws. All Corporators must have either their residence or place of business within the service area of the Corporation, and when this condition ceases to exist will automatically be considered to have resigned.

8.3 Manner of Election. Members of the Board of Corporators shall be elected at the annual meeting of the Corporators from among nominees submitted to such meeting by the Governance Committee, upon a vote of two-thirds of the Corporators present at such annual meeting.

8.4 Meetings of the Board of Corporators. There shall be an annual meeting of the Corporators held at such date, time and place as may be designated by the Board of Directors during the month of November of each year. At such annual meeting, the Corporators shall elect new Corporators, shall hear reports as to the progress of the Corporation, and shall have the opportunity to question, comment and advise the Board of Directors with respect thereto. Any Corporator who misses three consecutive annual meetings may be removed by a majority vote at a meeting of the Board of Directors at which a quorum is present.

8.5 Transfer, Removal, Withdrawal. Membership on the Board of Corporators shall be nontransferable, and shall be terminated by death, voluntary withdrawal or expulsion by either the Board of Directors or the Member of the Corporation.

8.6 Voting. Although Corporators shall have no vote on corporate matters, the Board of Directors of the Corporation may from time to time submit matters to the Board of Corporators for an advisory opinion. Each Corporator shall be entitled to one vote on each such matter so submitted to Corporators for vote. Voting shall be in person, and there shall be no voting by proxy.

ARTICLE 9

AUXILIARY

There shall be an Auxiliary to provide auxiliary services to the Corporation and its patients and to carry on activities designed to raise funds exclusively for the accomplishment of the purposes of the Corporation. The Auxiliary shall organize itself and adopt its own bylaws. It shall conduct its activities in consonance with the goals and policies of the Corporation and keep the Board of Directors informed of its activities. The bylaws of the Auxiliary, and any revisions or amendments thereto, must be approved by the Board of Directors. The Auxiliary shall deliver a report at the annual meeting of the Board of Directors and at such other times as are directed by the Board of Directors, regarding its activities on behalf of the Corporation.

ARTICLE 10

CONFLICT OF INTEREST

All Directors and officers of the Corporation shall be subject to and abide by the terms of the Corporation's Conflict of Interest Policy maintained on record by the Corporation, a copy of which has been provided to all Directors and officers.

ARTICLE 11

INDEMNIFICATION

11.1 Limitation of Liability. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act, or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability (as defined in Section 33-1116 of the Act) to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director, (ii) enabled the Director or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal gain, (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

11.2 Indemnification of Directors and Officers. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such directors and officers pursuant to Sections 33-1116 to 33-1124, inclusive, of the Act or any other applicable laws presently or hereafter in effect.

11.3 Expenses. Expenses incurred by a Director or officer in defending a civil or criminal action, suit or proceeding shall be paid for or reimbursed by the Corporation to the fullest extent permitted by law in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such Director or officer of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under the Certificate of Incorporation or these Bylaws and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall be ultimately determined that such director or officer is not entitled to be indemnified by the Corporation. Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon the terms and conditions, if any, as the Board of Directors deems appropriate.

11.4 Non-exclusivity. The indemnification and advancement of expenses provided for herein shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a Director or officer and shall inure to the benefit of the heirs, executors and administrators of such a person. Notwithstanding the foregoing, the Corporation shall not provide such indemnification or advancement for expenses to the extent that such indemnification or advancement would constitute self-dealing within the meaning of section 4941(d) of the Internal Revenue Code of 1986, as amended.

11.5 Amendment or Repeal. No amendment to or repeal of this Article 11 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

ARTICLE 12

MISCELLANEOUS PROVISIONS

12.1 Fiscal Year. The fiscal year of the Corporation shall end on September 30 in each year.

12.2 Amendment. HHC shall have the exclusive power to make, amend or repeal the Corporation's Certificate of Incorporation or these Bylaws, subject to the limitations in Section 3.2(e).

12.3 Execution of Contracts. The Board may authorize any officer or officers and any agent or agents to enter into any contract or execute any instrument in the name of, and on behalf of, the Corporation, and such authority may be general or limited to specified instances. No officer, agent or employee shall have any power or authority to bind or obligate the Corporation by any commitment, contract or engagement, or to pledge its credit or render it liable for any purpose or in any amount unless duly authorized by the Board.

12.4 Compensation for Services. The Corporation may reimburse any Director for expenses incurred in connection with fulfilling his or her duties as a member of the Board, provided that the amount of such reimbursement is reasonable and not excessive.

12.5 Notice. Any notice required or permitted to be given under these Bylaws in writing shall be deemed to have been delivered if delivered in person or if sent by United States mail, overnight delivery, telegraph (charges prepaid), facsimile or email and addressed to such person at the address shown on the records of the Corporation or the address supplied by him or her to the Corporation for the purpose of notice. If such notice is sent by mail, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail.

12.6 Consistency with the Affiliation Agreement. In the event of a conflict between any provision of the Bylaws and the terms of the Affiliation Agreement, the provisions of the Affiliation Agreement shall control.

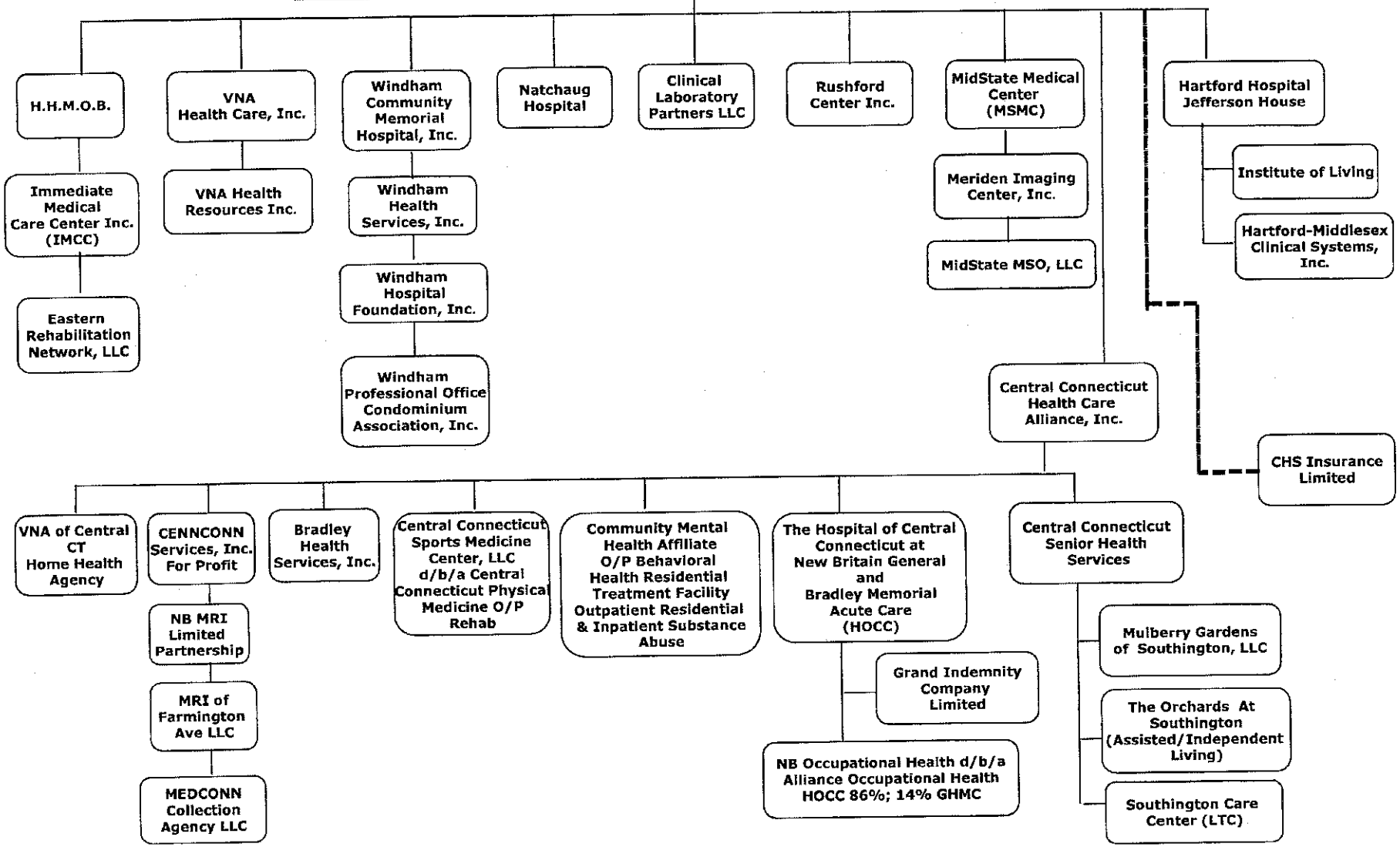
Dated: _____

Exhibit 1.3

Schematics

See attached.

Corporate Organization Chart
Hartford HealthCare Corporation (Pre)

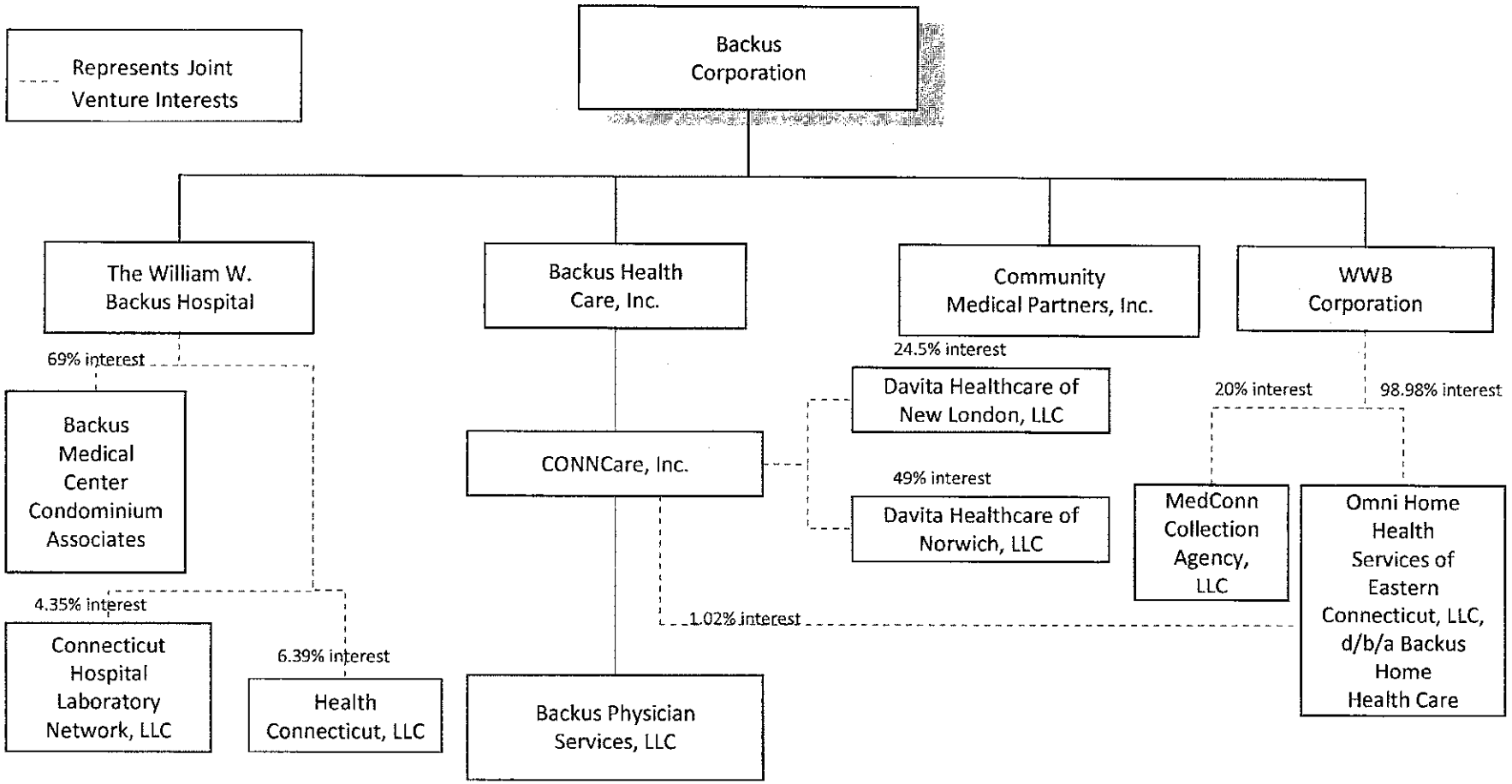


As of 07/13/2012

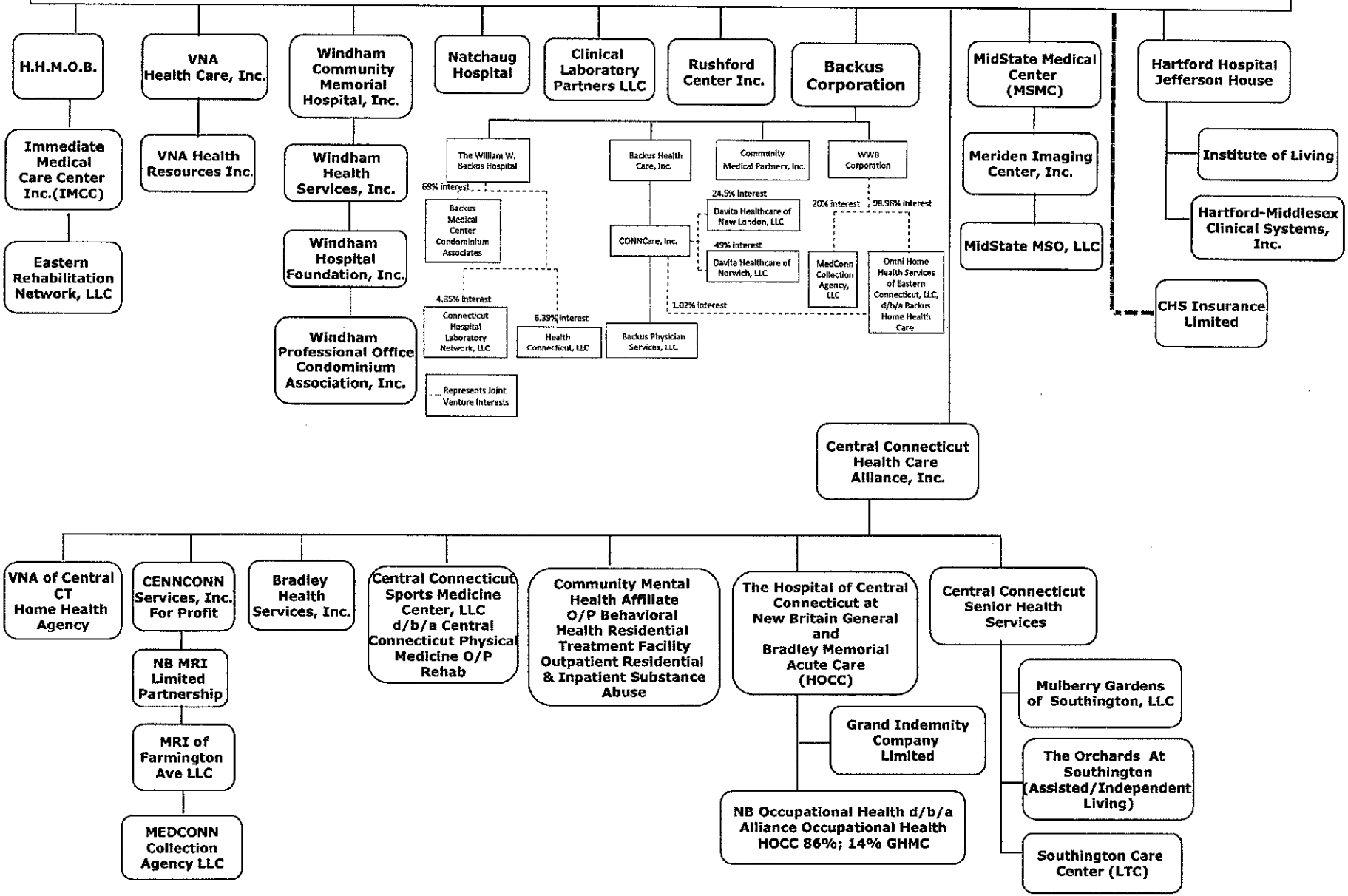
BACKUS CORPORATION (Pre)

BACKUS CORPORATE STRUCTURE

2012



Corporate Organization Chart
Hartford HealthCare Corporation (Post)



As of 08/13/2012

AUDITED CONSOLIDATED FINANCIAL STATEMENTS AND OTHER FINANCIAL INFORMATION

Backus Corporation and Subsidiaries
Years Ended September 30, 2009 and 2008
With Report of Independent Auditors

Backus Corporation and Subsidiaries

Audited Consolidated Financial Statements
and Other Financial Information

Years Ended September 30, 2009 and 2008

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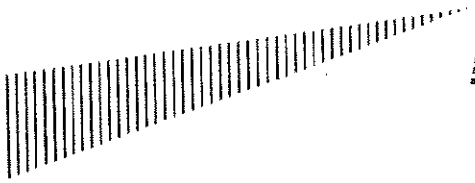


ERNST & YOUNG

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors

The Board of Trustees
Backus Corporation and Subsidiaries

We have audited the accompanying consolidated balance sheets of Backus Corporation and Subsidiaries (the Corporation) as of September 30, 2009 and 2008, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Corporation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Backus Corporation and Subsidiaries as of September 30, 2009 and 2008, and the consolidated results of its operations, changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 1, 2009

Backus Corporation and Subsidiaries

Consolidated Balance Sheets

	September 30 2009	2008
Assets		
Current assets:		
Cash and cash equivalents	**$ 62,155,067**	$ 50,429,864
Assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
Accounts receivable, less allowance for uncollectible accounts (2009 – $21,206,000; 2008 – $16,169,000)	**38,032,269**	35,783,224
Pledges receivable	**533,993**	1,103,017
Inventories of supplies	**3,367,607**	2,004,317
Prepaid expenses and other	**1,023,236**	1,871,894
Total current assets	**112,352,984**	97,840,503
Assets whose use is limited:		
Board-designated and donor restricted	**81,012,837**	77,540,189
Held by trustee	**25,070,975**	20,554,290
Total assets whose use is limited	**106,083,812**	98,094,479
Less assets whose use is limited – required for current liabilities	**7,240,812**	6,648,187
	98,843,000	91,446,292
Property, plant and equipment, net	**103,839,068**	100,690,508
Deferred financing costs	**2,025,397**	2,118,397
Other assets	**2,837,828**	4,325,328
Total assets	**$ 319,898,277**	$ 296,421,028

	September 30 2009	2008
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 11,143,511**	$ 10,146,787
Salaries and wages, payroll taxes and taxes withheld from payroll	**8,955,228**	7,358,943
Other accrued liabilities	**9,568,027**	7,548,447
Due to third-party reimbursement agencies	**2,310,804**	1,750,429
Current portion of long-term debt	**1,833,475**	1,810,232
Total current liabilities	**33,811,045**	28,614,838
Other liabilities:		
Long-term debt, less current portion	**64,995,680**	67,121,518
Employee related obligations	**84,442,697**	39,209,762
Self-insured professional liability	**10,580,762**	11,939,205
Due to third-party reimbursement agencies	**10,307,215**	3,892,438
Other	**675,153**	541,666
	171,001,507	122,704,589
Net assets:		
Unrestricted	**104,776,463**	136,705,366
Temporarily restricted	**3,447,432**	2,475,427
Permanently restricted	**6,861,830**	5,920,808
Total net assets	**115,085,725**	145,101,601
Total liabilities and net assets	**$ 319,898,277**	$ 296,421,028

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Operations

	Years Ended September 30	
	2009	**2008**
Operating revenues:		
Net patient service revenue	**$ 271,765,388**	$ 251,767,293
Other operating revenue	**4,412,193**	4,930,976
Net assets released from restrictions	**86,494**	72,396
	276,264,075	256,770,665
Operating expenses:		
Salaries, wages and professional fees	**120,907,812**	109,220,049
Payroll taxes and other fringe benefits	**29,445,026**	25,284,879
Supplies, insurance and other	**80,131,898**	82,630,439
Provision for uncollectible accounts	**17,106,501**	14,689,011
Depreciation and amortization	**17,335,024**	16,814,826
Interest	**3,361,670**	3,277,607
	268,287,931	251,916,811
Operating income	**7,976,144**	4,853,854
Nonoperating gains and (losses)		
Contributions and donations	**429,646**	384,478
Investment income	**5,177,633**	(12,766,293)
	5,607,279	(12,381,815)
Excess (deficiency) of revenues over expenses	**$ 13,583,423**	$ (7,527,961)

Backus Corporation and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Total	Unrestricted	Restricted	Permanently Restricted
Net assets, October 1, 2007	$168,392,530	$ 159,117,857	$ 2,945,255	$ 6,329,418
Excess of revenues over expenses	(7,527,961)	(7,527,961)		
Contributions	797,210		792,190	5,020
Investment income	(715,227)		(715,227)	
Net assets released from restriction	(546,791)		(546,791)	
Change in pension funding and postretirement obligation	(14,558,507)	(14,558,507)		
Current year acquisition	(326,023)	(326,023)		
Change in net assets held in trust	(413,630)			(413,630)
Increase in net assets	(23,290,929)	(22,412,491)	(469,828)	(408,610)
Net assets, September 30, 2008	145,101,601	136,705,366	2,475,427	5,920,808
Contributions	**1,712,752**		**742,752**	**970,000**
Investment income	**315,747**		**315,747**	
Excess of revenues over expenses	**13,583,423**	**13,583,423**		
Net assets released from restriction	**(86,494)**		**(86,494)**	
Effect of early measurement date elimination	**(1,762,428)**	**(1,762,428)**		
Change in pension funding and postretirement obligation	**(43,749,898)**	**(43,749,898)**		
Change in net assets held in trust	**(28,978)**			**(28,978)**
(Decrease) increase in net assets	**(30,015,876)**	**(31,928,903)**	**972,005**	**941,022**
Net assets, September 30, 2009	**$115,085,725**	**$ 104,776,463**	**$ 3,447,432**	**$ 6,861,830**

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	Years Ended September 30	
	2009	**2008**
Operating activities		
Decrease in net assets	**$ (30,015,876)**	$ (23,290,929)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,335,024**	16,814,826
Provision for uncollectible accounts	**17,106,501**	14,689,011
Effect of early measurement date elimination	**1,762,428**	
Change in pension funding and postretirement obligation	**43,749,898**	14,558,507
(Purchase) proceeds from sale of investments-board designated, net	**(3,472,648)**	14,928,912
Changes in operating assets and liabilities:		
Accounts receivable and pledge receivable	**(18,786,522)**	(18,499,304)
Inventories of supplies, prepaid expenses and other	**(514,632)**	170,941
Accounts payable	**996,724**	(3,026,456)
Employee related obligations	**(279,391)**	(3,431,132)
Other accrued liabilities	**2,019,580**	456,030
Salaries and wages, payroll taxes and taxes withheld from payroll	**1,596,285**	1,605,186
Due to third-party reimbursement agencies	**6,975,152**	3,155,801
Self-insured professional liability	**(1,358,443)**	3,297,056
Other liabilities	**133,487**	280,127
Net cash provided by operating activities	**37,247,567**	21,708,576
Investing activities		
Purchase of investments-held in trust, net	**(4,516,685)**	(810,209)
Net additions to property, plant and equipment	**(19,263,913)**	(16,728,230)
Decrease in other assets	**360,829**	99,522
Net cash used in investing activities	**(23,419,769)**	(17,438,917)
Financing activities		
Principal payments on long-term debt	**(2,050,962)**	(900,485)
Change in deferred financing costs and amortization of bond premium	**(51,633)**	(127,164)
Net cash used in financing activities	**(2,102,595)**	(1,027,649)
Net increase in cash and cash equivalents	**11,725,203**	3,242,010
Cash and cash equivalents at beginning of year	**50,429,864**	47,187,854
Cash and cash equivalents at end of year	**$ 62,155,067**	$ 50,429,864

See accompanying notes.

Backus Corporation and Subsidiaries

Notes to Consolidated Financial Statements

September 30, 2009

1. Significant Accounting Policies

Organization

Backus Corporation (Corporation) is a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation provides overall direction and control for The William W. Backus Hospital (the Hospital), Backus Foundation, Inc. (Foundation) and Backus Health Care, Inc. Backus Properties, Inc. (Properties), a not-for-profit organization, holds and manages certain nonpatient related properties for the Corporation. WWB Corporation conducts the related for-profit activities of the Corporation, its sole shareholder. Omni Home Health Services of Eastern Connecticut LLC dba Backus Home Health Services provides continual home care to patients. Backus Physician Services, LLC provides surgical services. The accompanying consolidated statements of operations include the excess (deficiency) of revenue over expenses as the performance indicator. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenues and expenses; peripheral or incidental transactions are reported as nonoperating items. All intercompany transactions have been eliminated in consolidation. Subsequent to year end, Backus Foundation Inc. and Backus Properties Inc. will cease to exist as separate entities and all assets, liabilities, equity and operations will merge into the Hospital. The merger will not impact the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority) as more fully explained in Note 6. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities, with readily determinable fair values, are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenue over expense unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

Property, Plant and Equipment

Property, plant and equipment are stated on the basis of cost. The Corporation and its subsidiaries provide for depreciation using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

1. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying consolidated financial statements.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in nonoperating gains and losses. Conditional promises to give are not included as support until the conditions are substantially met.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for 2009 and 2008. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in pension funding and postretirement obligation, changes in the fair value of the interest rate swap current year acquisitions, and the effect of early measurement date elimination.

Cash Equivalents

The Corporation considers all highly liquid time deposits, commercial paper and money market mutual funds purchased with a maturity date at acquisition of three months or less to be cash equivalents.

1. Significant Accounting Policies (continued)

Income Taxes

The Corporation, the Hospital, the Foundation, and Backus Health Care, Inc. are not-for-profit organizations exempt from federal income taxes on related income under Section 501(c)(3); Backus Properties, Inc. is a not-for-profit title holding corporation exempt from federal income taxes under Section 501(c)(2); WWB Corporation is a taxable stock corporation; CONNCare Inc., a subsidiary of Backus Health Care, is a taxable, nonstock corporation. Backus Home Health Services is a partnership taxable to its members and Backus Physician Services, LLC is a taxable, nonstock corporation.

Accounting Standards Codification (ASC) 740-10, *Uncertain Tax Positions*, (ASC 740-10), prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the consolidated financial statements is not significant.

CONNCare, Inc. has a net operating loss carry-forward of $5,390,745. This net operating loss results in a potential deferred tax asset in the amount of approximately $2,200,000. WWB Corporation, Inc. has a net operating loss carry-forward of $459,599. This net operating loss results in a potential deferred tax asset in the amount of approximately $184,000. Neither asset has been recorded as these assets are offset by valuation allowances of the same amounts.

Adoption of New Authoritative Pronouncements

In June 2009, the Financial Accounting Standards Board (FASB) issued FASB ASC 105, *Generally Accepted Accounting Principles* (ASC 105), which establishes the FASB Accounting Standards Codification as the sole source of authoritative GAAP. Pursuant to the provisions of ASC 105, the Corporation has updated references to GAAP in its financial statements for the year ended September 30, 2009. The adoption of ASC 105 did not impact the Corporation's consolidated financial position or results of operations.

Effective 2009, the Corporation adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with GAAP, and expands disclosure about fair value measurements.

1. Significant Accounting Policies (continued)

In 2009, the Corporation adopted ASC 825-10, *Fair Value Option*, which permits companies to choose to measure certain financial instruments and other items at fair value that are not currently required to be measured at fair value. The Corporation did not elect fair value accounting for any asset or liability not currently required to be measured at fair value.

In June 2009, the Corporation adopted provisions of ASC 855-10, *Subsequent Events*, which establishes standards of accounting for disclosure of events or transactions that occur after the balance sheet date, but before the financial statements are issued or available to be issued. ASC 855-10 is effective on a prospective basis for financial periods ended after June 15, 2009. The adoption of ASC 855-10 in 2009 did not impact the Corporation's consolidated financial position or results of operations. Management evaluated subsequent events through December 1, 2009, the date the consolidated financial statements were available to be issued.

2. Revenues from Services to Patients and Charity Care

Patient accounts receivable and revenues are recorded when patient services are performed.

For 2009 and 2008, Hospital revenue accounted for 96% of net patient service revenue. The following summarizes net patient service revenue:

	Year Ended September 30	
	2009	**2008**
Gross patient service revenue	**$ 578,445,014**	$ 524,204,277
Deductions:		
Allowances	**(299,764,222)**	(265,835,156)
Charity care (at charges)	**(6,915,404)**	(6,601,828)
	(306,679,626)	(272,436,984)
Net patient service revenue	**$ 271,765,388**	$ 251,767,293

2. Revenues from Services to Patients and Charity Care (continued)

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $671,000 and $3,600 in 2009 and 2008, respectively.

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 7%, respectively, of the Corporation's net patient service revenue for the year ended September 30, 2009 and 30% and 6% for the year ended September 30, 2008. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Corporation.

3. Charity Care

The Corporation provides services without charge or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Corporation does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Corporation's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

3. Charity Care (continued)

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,915,404**	**$ 3,042,778**
Bad debt	**17,106,501**	**7,526,860**
Total uncompensated care, September 30, 2009	**$ 24,021,905**	**$ 10,569,638**
Charity care	$ 6,601,828	$ 3,016,131
Bad debt	14,689,011	6,710,866
Total uncompensated care, September 30, 2008	$ 21,290,839	$ 9,726,997

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2009 and 2008:

	Year Ended September 30	
	2009	2008
Realized and unrealized gains (losses) on investments	**$ 1,229,304**	$ (15,367,123)
Interest and dividend income	**2,015,679**	2,420,054
Investment in joint ventures	**2,420,701**	1,306,303
Other investment losses	**(269,976)**	(809,893)
Investment fees	**(218,075)**	(315,634)
	$ 5,177,633	$ (12,766,293)

4. Investments (continued)

The market value of assets whose use is limited at September 30, is set forth in the following table:

	2009	2008
Board designated:		
Cash and cash equivalents	**$ 18,129,468**	$ 16,123,886
Common stock	**13,153,726**	15,281,005
Corporate bonds	**9,815,901**	6,875,227
Government bonds	**15,780,860**	17,695,487
Mutual funds	**24,132,882**	21,564,584
	$ 81,012,837	$ 77,540,189
Held by trustee:		
Cash and cash equivalents	**$ 4,804,214**	$ 8,096,731
Mutual funds	**17,496,461**	9,613,200
Government bonds	**442,987**	446,525
Other marketable securities	**2,327,313**	2,397,834
	$ 25,070,975	$ 20,554,290

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which provides guidance on the net asset classification of donor restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

4. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Corporation's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Corporation's inflation-adjusted value over time. The Corporation's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The investment committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider expenditures based on need and current market conditions as well as long-term investment goals.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets. The activity for year end September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$4,841,631	$ 4,976,846

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2009	2008
Capital Projects	**$ 1,548,434**	$ 933,829
Preventative care	**763,501**	778,537
Health care services	**414,281**	340,180
Other	**358,416**	66,956
Laboratory	**184,552**	181,410
Extraordinary nursing care	**97,635**	96,765
Nursing education	**70,948**	68,085
Free beds	**9,665**	9,665
	$ 3,447,432	$ 2,475,427

Permanently restricted net assets at September 30 are restricted to the following:

	2009	2008
Income to be used:		
For general purposes	**$ 6,018,245**	$ 5,077,223
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 6,861,830	$ 5,920,808

6. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2009	2008
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,630,000) from 2010 to 2012 with interest rates ranging from 4.60% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 9,145,000**	$ 9,640,000
Series F, serial maturities ($7,300,000) from 2010 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**29,425,000**	30,100,000
Series G, serial maturities ($18,960,000) from 2010 to 2026 with interest rates of 3.25% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5.00%	**26,380,000**	26,965,000
Other long-term debt:		
Mortgage paid in full August 2009		289,273
Obligation under capital lease	**1,072,619**	1,079,308
	66,022,619	68,073,581
Add net unamortized bond premium	**806,536**	858,169
Less current portion	**(1,833,475)**	(1,810,232)
Long-term debt	**$ 64,995,680**	$ 67,121,518

The Master Indenture related to the tax-exempt Hospital revenue bonds, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. The mortgages are secured by a warehouse and by certain leasehold improvements. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principle and interest on the Series E, Series F, and Series G bonds.

6. Long-term Debt (continued)

Bonds maturing on or after July 1, 2008, are subject to redemption prior to maturity commencing July 1, 2008. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015, are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015, are subject to optional redemption prior to maturity.

Future minimum principal payments during each of the next five fiscal years and in the aggregate are as follows:

	Hospital	Backus Properties	Total
2010	$ 1,825,000	$ 8,475	$ 1,833,475
2011	1,895,000	10,738	1,905,738
2012	1,965,000	13,604	1,978,604
2013	2,045,000	17,235	2,062,235
2014	2,120,000	21,836	2,141,836
Aggregate thereafter	55,100,000	1,000,731	56,100,731
	64,950,000	1,072,619	66,022,619
Less current portion	1,825,000	8,475	1,833,475
Add net unamortized bond premium	806,536		806,536
	$ 63,931,536	$ 1,064,144	$ 64,995,680

The Corporation paid interest of $3,428,396 and $2,981,305 in 2009 and 2008, respectively. Interest incurred in 2009 and 2008 was $3,361,670 and $3,277,607, respectively.

In June 2008 the Hospital remarketed its Series F bonds, converting them from a variable auction rate to a fixed rate. As a result, the swap associated with the original bond issue, which was intended to effectively fix the interest rate paid on the bonds, was terminated. The change in the value of the swap presented in the statement of operations at September 30, 2008 of $(843,514) reflects the change in the fair value of the swap plus the reclassification of prior deferrals.

7. Retirement Benefit Plans

The Corporation maintains a noncontributory defined benefit pension plan covering substantially all of its employees. The Corporation also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsored a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2009 and 2008 is approximately 3,600,000 and 850,000 respectively, related to the future obligation for the nonqualified benefits.

Effective January 1, 2010, the Corporation will amend its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants. Management anticipates that the change in the pension plan will result in a reduction of the unfunded liability of approximately $35 million. It is the Corporation's intention to establish a defined contribution plan concurrent with the amendment of the defined benefit plan.

Effective October 1, 2008, the Corporation adopted ASC 715-20, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, which requires elimination of the early measurement date of the plans.

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2009	**2008**	**2009**	**2008**
	(In Thousands)			
Unrecognized actuarial (loss) gain	**$ (67,240)**	$ (26,335)	**$ 1,249**	$ 2,223
Unrecognized prior service cost	**(15)**	(19)		
Unrecognized transition obligation			**(1,213)**	(1,617)
	$ (67,255)	$ (26,354)	**$ 36**	$ 606

The prior service cost, actuarial (loss) gain and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2010 are $3,323, $5,129,108 and $323,491, respectively.

7. Retirement Benefit Plans (continued)

At September 30, 2008, the unfunded status of the pension plan is included in long-term liabilities in the amount of $30,206,752. The unfunded status of the postretirement benefits is $5,045,761, with $479,175 included in short-term liabilities, and the remainder of $4,566,586 included in long-term liabilities. At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities.

The following table sets forth the funded status of the plans as of the measurement date of September 30 in 2009 and June 30 in 2008 for each plan and amounts recognized in the Corporation's consolidated balance sheets at September 30. In 2008, contributions made subsequent to the measurement date, but prior to September 30, reduced the accrued benefit liability.

	Pension Benefits		Postretirement Benefits	
	2009	**2008**	**2009**	**2008**
	(In Thousands)			
Change in benefit obligations				
Benefit obligations at beginning of year	**$ (133,189)**	$ (124,809)	**$ (5,156)**	$ (5,524)
Service cost	**(4,484)**	(4,620)	**(22)**	(30)
Interest cost	**(9,002)**	(7,986)	**(338)**	(334)
Change in assumptions	**(38,217)**	5,256	**(557)**	134
Actuarial (loss) gain	**(2,156)**	(4,249)	**383**	199
Effect of early measurement date elimination	**11,740**		**295**	
Benefits paid	**3,477**	3,219	**428**	399
Benefit obligations at end of year	**$ (171,831)**	$ (133,189)	**$ (4,967)**	$ (5,156)
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,957**	$ 102,625		
Actual return on plan assets	**2,662**	(7,224)		
Effect of early measurement date elimination	**(8,097)**			
Contributions	**8,100**	8,775	**$ 428**	$ 399
Benefits paid	**(3,477)**	(3,219)	**(428)**	(399)
Fair value of plan assets at end of year	**$ 100,145**	$ 100,957	**$**	**$**
Reconciliation of underfunded status				
Underfunded status	**$ (71,686)**	$ (32,232)	**$ (4,969)**	$ (5,156)
Contribution subsequent to measurement date		2,025		111
Accrued benefit liability recognized in the balance sheets	**$ (71,686)**	$ (30,207)	**$ (4,969)**	$ (5,045)

7. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2009	2008	2009	2008
	(in thousands)			
Components of net periodic benefit cost				
Service cost	**$ 4,484**	$ 4,620	**$ 22**	$ 30
Interest cost	**9,002**	7,986	**338**	334
Expected return on plan assets	**(7,605)**	(8,417)		
Net amortization and deferral	**1,129**	3	**(541)**	(260)
Net periodic benefit cost	**$ 7,010**	$ 4,192	**$ (181)**	$ 104
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.60%**	6.50%	**5.60%**	6.50%
Rate of compensation increase	**5.00**	5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**7.25**	6.25	**7.25**	6.25
Expected long-term rate of return on plan assets	**8.00**	8.00		
Rate of compensation increase	**5.00**	5.00		

The expected long-term rate of return on plan assets was determined by the expected return on each asset class based on a model that considers historical and expected future performance.

The accumulated benefit obligation at September 30, 2009 and 2008 was $137,279,286 and $107,697,366, respectively.

The asset allocation for the retirement plan at the end of 2009 and 2008 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	**Minimum**	**Maximum**	**2009**	**2008**
US Equity Large Cap	35%	45%	**27%**	34%
US Equity Small Cap		10	**4**	5
International Equity	17	27	**17**	19
Core Fixed Income	25	35	**52**	42
Real estate		6		
Total			**100%**	100%

7. Retirement Benefit Plans (continued)

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2010	$ 8,100,000	$ 462,097
Estimated future benefit payments:		
2010	4,462,917	462,097
2011	4,982,416	464,756
2012	5,495,548	472,761
2013	6,025,576	481,792
2014	6,719,521	481,673
2015-2019	46,736,124	2,066,165

Assumed healthcare cost trend rates for 2009 are as follows:	
Health care trend rate assumed for next year	8.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 2	$ (2)
Effect on postretirement benefit obligation	$ 26	$(22)

8. Contingencies

There have been malpractice claims that fall within the Corporation's partially self-insured program (see Note 1, Organization and Accounting Policies) which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2009 that may result in the assertion of claims. Corporation management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

The Corporation is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Corporation's financial position.

9. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2009	2008
BackusCare campaign	**$ 553,353**	$ 1,163,035
Other	**7,077**	7,077
Unconditional promises to give before unamortized discount	**560,430**	1,170,112
Less unamortized discount and allowance	**(26,437)**	(67,095)
	$ 533,993	$ 1,103,017
Amounts due in:		
Less than one year	**$ 414,993**	$ 490,504
One to five years	**119,000**	612,513
Total	**$ 533,993**	$ 1,103,017

10. Property, Plant and Equipment

Property, plant and equipment at September 30 consist of the following:

	2009	2008
Land and land improvements	**$ 4,905,192**	$ 4,741,682
Buildings and leasehold improvements	**115,686,063**	107,777,362
Equipment	**96,886,734**	87,154,025
Construction in process (2009 estimated cost to complete $6,900,000)	**4,251,661**	4,438,532
Less accumulated depreciation	**(117,890,582)**	(103,421,093)
	$ 103,839,068	$ 100,690,508

Included in construction in progress at September 30, 2009 are $1,280,000 of internally developed software costs. The Corporation wrote off approximately $1,426,000 of fully depreciated assets in 2009.

In 2004, the Corporation began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2009 and 2008 was $705,436 and $667,384, respectively.

The Corporation leases various types of equipment with annual payments ranging from $103 to $119,064. Expenses as a result of these leases were approximately $478,000 and $928,000 for the years ended September 30, 2009 and 2008, respectively.

Future minimum lease payments under the above leases during each of the next five years were as follows:

2010	$ 1,257,360
2011	1,042,391
2012	775,265
2013	748,603
2014	145,161
Aggregate thereafter	1,102,588
	$ 5,071,368

11. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2009	**2008**
Cafeteria sales	**$ 1,049,650**	$ 989,415
Grants	**642,728**	630,810
Rental income	**663,647**	630,448
Interest	**476,907**	1,505,928
Condominium income	**440,047**	306,803
Miscellaneous	**527,635**	381,709
Child care	**336,700**	350,051
Purchase discounts	**274,879**	135,812
	$ 4,412,193	$ 4,930,976

12. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2009	**2008**
Health care services	**$ 200,628,303**	$ 189,364,177
General and administrative	**67,467,717**	62,248,517
Fundraising	**191,911**	304,117
	$ 268,287,931	$ 251,916,811

13. Concentrations of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. For 2009 and 2008, Hospital receivables accounted for 95% and 94%, respectively. The mix of accounts receivable, net of contractual allowances, from patients and third-party payors at September 30 is as follows:

	2009	%	2008	%
Medicare	**$ 14,223,122**	**25%**	$ 12,265,855	25%
Medicaid	**4,685,984**	**8**	3,166,368	6
Anthem Blue Cross/Blue Shield	**7,989,343**	**14**	8,128,274	16
Health Maintenance Organizations	**9,452,755**	**17**	7,671,571	16
Commercial	**2,776,338**	**5**	3,140,618	6
Self pay	**13,430,756**	**24**	11,688,493	24
Other state agencies	**4,182,234**	**7**	3,231,784	7
	56,740,532	**100%**	49,292,963	100%
Less allowance for uncollectible accounts	**20,629,237**		15,609,715	
	$36,111,295		$ 33,683,248	

14. Fair Value of Financial Instruments

On October 1, 2008, the Corporation adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

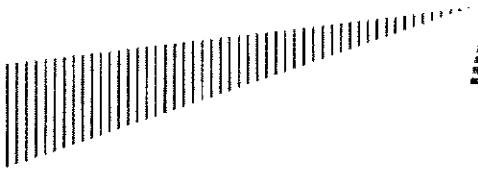
14. Fair Value of Financial Instruments (continued)

Financial assets and liabilities as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 62,155,067		$	$ 62,155,067
Assets whose use is limited	106,083,812			106,083,812
Pledges receivable	533,993			533,993

The carrying amount of certain of the Corporation's financial instruments, including cash and cash equivalents and pledges receivable, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at fiscal year end. The fair value of fixed rate debt is $68,087,973 and $65,336,934 at September 30, 2009 and 2008, respectively.

Other Financial Information



ERNST & YOUNG

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103
Main tel: 1+ 860 247 3100
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Directors
Backus Corporation and Subsidiaries

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Ernst & Young LLP

December 1, 2009

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 45,846	$ 57,570,735	$ 2,085,506	$ 1,108,911	$ 140,738	$ 1,203,331		$ 62,155,067
Assets whose use is limited – required for current liabilities		7,240,812						7,240,812
Accounts receivable, less allowance for uncollectible accounts		36,111,295		839,709	30,125	1,051,140		38,032,269
Pledges receivable			533,993					533,993
Inventories of supplies		3,252,641		114,966				3,367,607
Prepaid expenses and other		925,340		9,671	85,556	2,669		1,023,236
Due from affiliates	27,582	3,901,924					$ (3,929,506)	
Total current assets	73,428	109,002,747	2,619,499	2,073,257	256,419	2,257,140	(3,929,506)	112,352,984
Assets whose use is limited:								
Board-designated and donor restricted		44,500,233	36,512,604					81,012,837
Held by trustee		22,743,662	2,327,313					25,070,975
Total assets whose use is limited		67,243,895	38,839,917					106,083,812
Less assets whose use is limited – required for current liabilities		7,240,812						7,240,812
		60,003,083	38,839,917					98,843,000
Interest in Foundation		41,147,474					(41,147,474)	
Property, plant, and equipment, net		98,131,132		90,657	5,593,682	23,597		103,839,068
Deferred financing costs		2,025,397						2,025,397
Other assets	1,000	1,801,751		966,810		85,112	(16,845)	2,837,828
	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable-trade		$ 10,508,835	$ 11,448	$ 394,244	$ 30,263	$ 198,721		$ 11,143,511
Salaries and wages, payroll taxes and taxes withheld from payroll		8,205,022	531	369,819		379,856		8,955,228
Due to affiliates	$284,800		45,983	118,309	3,336,782	143,632	$ (3,929,506)	
Other accrued liabilities		7,190,212	253,980	1,801,202		322,633		9,568,027
Due to third-party reimbursement agencies		1,831,013				479,791		2,310,804
Current portion of long-term debt		1,825,000			8,475			1,833,475
Total current liabilities	284,800	29,560,082	311,942	2,683,574	3,375,520	1,524,633	(3,929,506)	33,811,045
Other liabilities:								
Long-term debt, less current portion		63,931,536			1,064,144			64,995,680
Employee related obligations		84,442,697						84,442,697
Self-insured professional liability		10,580,762						10,580,762
Due to third-party reimbursement agencies		10,307,215						10,307,215
Other		667,654			7,499			675,153
		169,929,864			1,071,643			171,001,507
Net assets:								
Common stock						1,000	(1,000)	
Unrestricted	(210,372)	102,312,376		447,150	1,402,938	840,216	(15,845)	104,776,463
Temporarily restricted		3,447,432	34,308,847				(34,308,847)	3,447,432
Permanently restricted		6,861,830	6,838,627				(6,838,627)	6,861,830
Total net assets	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Total liabilities and net assets	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 259,652,271		$ 5,073,240		$ 7,128,542	$ (88,665)	$ 271,765,388
Other operating revenue	$ 125,004	4,213,341		81,199	$ 1,099,706	22,154	(1,129,211)	4,412,193
Net assets released from restrictions			$ 547,411				(460,917)	86,494
	125,004	263,865,612	547,411	5,154,439	1,099,706	7,150,696	(1,678,793)	276,264,075
Operating expenses:								
Salaries, wages and professional fees	256,742	112,184,033	155,336	4,348,579	24,755	3,938,367		120,907,812
Payroll taxes and other fringe benefits	35,218	27,425,902	40,414	969,731	3,238	970,523		29,445,026
Supplies, insurance and other	18,420	74,547,698	351,661	3,963,600	741,108	1,727,287	(1,217,876)	80,131,898
Provision for uncollectible accounts		16,898,318		74,663		133,520		17,106,501
Depreciation and amortization		16,939,369		28,162	352,257	15,236		17,335,024
Interest		3,091,298			270,372			3,361,670
	310,380	251,086,618	547,411	9,384,735	1,391,730	6,784,933	(1,217,876)	268,287,931
Operating (loss) income	(185,376)	12,778,994		(4,230,296)	(292,024)	365,763	(460,917)	7,976,144
Nonoperating gains and (losses):								
Contributions and donations							429,646	429,646
Change in equity interest in net assets of the Foundation		(3,735,563)					3,735,563	
Investment income	92	2,432,928		2,347,772	(2,049)	164,759	234,131	5,177,633
	92	(1,302,635)		2,347,772	(2,049)	164,759	4,399,340	5,607,279
Excess (deficiency) of revenues over expenses	$ (185,284)	$ 11,476,359	$	$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ (185,284)	$ 11,476,359		$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423
Change in equity interest in net assets of the Foundation		3,938,423					(3,938,423)	
Change in pension funding obligation		(45,512,326)						(45,512,326)
Increase (decrease) in unrestricted net assets	(185,284)	(30,097,544)		(1,882,524)	(294,073)	530,522		(31,928,903)
Temporarily restricted net assets:								
Contributions			$ 1,172,398				(429,646)	742,752
Income from investments		1,350	548,528				(234,131)	315,747
Change in equity interest in net assets of the Foundation		970,655					(970,655)	
Net assets released from restrictions			(547,411)				460,917	(86,494)
Increase (decrease) in temporarily restricted net assets		972,005	1,173,515				(1,173,515)	972,005
Permanently restricted net assets								
Contributions			970,000					970,000
Change in net assets held in trust			(28,978)					(28,978)
Change in equity interest in net assets of the Foundation		941,022					(941,022)	
Increase in permanently restricted net assets		941,022	941,022				(941,022)	941,022
Increase (decrease)in net assets	(185,284)	(28,184,517)	2,114,537	(1,882,524)	(294,073)	530,522	(2,114,537)	(30,015,876)
Net assets (deficit) at beginning of year	(25,088)	140,806,155	39,032,937	2,329,674	1,697,011	310,694	(39,049,782)	145,101,601
Net assets (deficit) at end of year	$ (210,372)	$ 112,621,638	$ 41,147,474	$ 447,150	$ 1,402,938	$ 841,216	$ (41,164,319)	$ 115,085,725

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,457	$ 834,815	$ 262,639		$ 1,108,911
Accounts receivable, less allowance for uncollectible accounts		511,479	328,230		839,709
Inventories of supplies		114,966			114,966
Prepaid expenses		9,113	558		9,671
Due from affiliates	24,624	749,606		$ (774,230)	
Total current assets	36,081	2,219,979	591,427	(774,230)	2,073,257
Property, plant and equipment:					
Buildings and leasehold improvements		59,768			59,768
Equipment		268,112	48,323		316,435
Accumulated depreciation		(270,306)	(15,240)		(285,546)
		57,574	33,083		90,657
Other assets		966,810			966,810
	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 13,318	$ 380,926		$ 394,244
Salaries and wages, payroll taxes and taxes withheld from payroll		270,617	99,202		369,819
Other accrued liabilities		1,801,202			1,801,202
Due to affiliates	$ 28,334	114,599	749,606	$ (774,230)	118,309
Total current liabilities	28,334	2,199,736	1,229,734	(774,230)	2,683,574
Net assets (deficit)	7,747	1,044,627	(605,224)		447,150
Total liabilities and net assets	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,943,958	$ 1,129,282		$ 5,073,240
Other operating revenue	$ 36,936	67,042	14,157	$ (36,936)	81,199
Total revenues	36,936	4,011,000	1,143,439	(36,936)	5,154,439
Expenses:					
Salaries and wages		2,870,703	1,477,876		4,348,579
Payroll taxes and fringe benefits		805,491	164,240		969,731
Supplies and other	38,486	3,098,692	863,358	(36,936)	3,963,600
Provision for uncollectible accounts		4,057	70,606		74,663
Depreciation and amortization		17,434	10,728		28,162
Total expenses	38,486	6,796,377	2,586,808	(36,936)	9,384,735
Operating loss	(1,550)	(2,785,377)	(1,443,369)		(4,230,296)
Nonoperating gains:					
Investment income	20	2,347,630	122		2,347,772
Deficiency of revenue over expenses	(1,530)	(437,747)	(1,443,247)		(1,882,524)
Net assets at beginning of year	9,277	1,482,374	838,023		2,329,674
Net assets (deficit) at end of year	$ 7,747	$ 1,044,627	$ (605,224)	$	$ 447,150

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2009

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,061,007	$ 142,324		$ 1,203,331
Accounts receivable, less allowance for uncollectible accounts		1,051,140		1,051,140
Prepaid expenses and other		2,669		2,669
Due from affiliates	184,628		$ (184,628)	
Total current assets	1,245,635	1,196,133	(184,628)	2,257,140
Property, plant and equipment:				
Lease improvements		3,872		3,872
Equipment		350,608		350,608
Accumulated depreciation		(330,883)		(330,883)
		23,597		23,597
Other assets	81,312	3,800		85,112
	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 198,721		$ 198,721
Salaries and wages, payroll taxes and taxes withheld from payroll		379,856		379,856
Other accrued liabilities		322,633		322,633
Due to third party reimbursement agencies		479,791		479,791
Due to affiliates	$ 143,632	184,628	$ (184,628)	143,632
Total current liabilities	143,632	1,565,629	(184,628)	1,524,633
Common stock	1,000			1,000
Retained earnings (deficit)	1,182,315	(342,099)		840,216
Total liabilities and net assets	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,128,542		$ 7,128,542
Other operating revenue		22,154		22,154
Total revenues		7,150,696		7,150,696
Expenses:				
Salaries and wages		3,938,367		3,938,367
Payroll taxes and fringe benefits		970,523		970,523
Supplies and other	$ 80,645	1,646,642		1,727,287
Provision for uncollectible accounts		133,520		133,520
Depreciation and amortization		15,236		15,236
Total expenses	80,645	6,704,288		6,784,933
Operating (loss) income	(80,645)	446,408		365,763
Nonoperating gains:				
Investment income	164,599	160		164,759
Excess of revenue over expenses	83,954	446,568		530,522
Net assets (deficit) at beginning of year	1,098,361	(788,667)		309,694
Net assets (deficit) at end of year	$ 1,182,315	$ (342,099)	$	$ 840,216

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Assets								
Current assets:								
Cash and cash equivalents	$ 63,252	$ 46,717,416	$ 1,409,496	$ 961,177	$ 93,566	$ 1,184,957		$ 50,429,864
Assets whose use is limited – required for current liabilities		6,648,187						6,648,187
Accounts receivable, less allowance for uncollectible accounts		33,683,248		1,218,969	35,643	845,364		35,783,224
Pledges receivable			1,103,017					1,103,017
Inventories of supplies		1,923,318		80,999				2,004,317
Prepaid expenses and other		1,779,906			65,646	26,342		1,871,894
Due from affiliates	133,816	3,388,030					$ (3,521,846)	
Total current assets	197,068	94,140,105	2,512,513	2,261,145	194,855	2,056,663	(3,521,846)	97,840,503
Assets whose use is limited:								
Board-designated and donor restricted		43,002,912	34,537,277					77,540,189
Held by trustee		18,156,456	2,397,834					20,554,290
Total assets whose use is limited		61,159,368	36,935,111					98,094,479
Less assets whose use is limited – required for current liabilities		6,648,187						6,648,187
		54,511,181	36,935,111					91,446,292
Interest in Foundation		39,032,937					(39,032,937)	
Property, plant, and equipment, net		95,130,673		104,554	5,420,321	34,960		100,690,508
Deferred financing costs		2,118,397						2,118,397
Other assets	1,000	3,788,338		486,913		65,922	(16,845)	4,325,328
	$198,068	$ 288,721,631	$ 39,447,624	$ 2,852,612	$ 5,615,176	$ 2,157,545	$ (42,571,628)	$ 296,421,028

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable-trade		$ 9,994,419	$ 10,792	$ 24,535	$ 6,699	$ 110,342		$ 10,146,787
Salaries and wages, payroll taxes and taxes withheld from payroll		6,787,976	12,401	264,014		294,552		7,358,943
Due to affiliates	$221,061		95,972	185,987	2,535,410	483,416	$ (3,521,846)	
Other accrued liabilities	2,095	6,723,678	295,522	48,402		478,750		7,548,447
Due to third-party reimbursement agencies		1,270,638				479,791		1,750,429
Current portion of long-term debt		1,755,000			55,232			1,810,232
Total current liabilities	223,156	26,531,711	414,687	522,938	2,597,341	1,846,851	(3,521,846)	28,614,838
Other liabilities:								
Long-term debt, less current portion		65,808,169			1,313,349			67,121,518
Accrued pension and other retirement costs		35,623,338						35,623,338
Self-insured professional liability		11,939,205						11,939,205
Due to third-party reimbursement agencies		3,892,438						3,892,438
Other		4,120,615			7,475			4,128,090
		121,383,765			1,320,824			122,704,589
Net assets:								
Common stock						1,000	(1,000)	
Unrestricted (deficit)	(25,088)	132,409,920		2,329,674	1,697,011	309,694	(15,845)	136,705,366
Temporarily restricted		2,475,427	33,135,332				(33,135,332)	2,475,427
Permanently restricted		5,920,808	5,897,605				(5,897,605)	5,920,808
Total net assets	(25,088)	140,806,155	39,032,937	2,329,674	1,697,011	310,694	(39,049,782)	145,101,601
Total liabilities and net assets	$198,068	$ 288,721,631	$ 39,447,624	$ 2,852,612	$ 5,615,176	$ 2,157,545	$ (42,571,628)	$ 296,421,028

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 242,131,827		$ 4,787,746		$ 5,014,824	$ (167,104)	$ 251,767,293
Other operating revenue	$125,004	4,727,859		53,348	$ 1,066,064	2,025	(1,043,324)	4,930,976
Net assets released from restrictions			$ 1,432,392				(1,359,996)	72,396
	125,004	246,859,686	1,432,392	4,841,094	1,066,064	5,016,849	(2,570,424)	256,770,665
Operating expenses:								
Salaries, wages and professional fees	173,816	102,256,348	158,918	3,328,371	21,133	3,281,463		109,220,049
Payroll taxes and other fringe benefits	23,870	23,695,796	37,862	765,249	2,868	759,234		25,284,879
Supplies, insurance and other	26,550	78,669,671	1,235,612	1,726,009	645,645	1,537,380	(1,210,428)	82,630,439
Provision for uncollectible accounts		14,162,003		55,644		(17,098)	488,462	14,689,011
Depreciation and amortization		16,453,137		26,072	318,021	17,596		16,814,826
Interest		3,003,005			274,602			3,277,607
	224,236	238,239,960	1,432,392	5,901,345	1,262,269	5,578,575	(721,966)	251,916,811
Operating (loss) income	(99,232)	8,619,726		(1,060,251)	(196,205)	(561,726)	(1,848,458)	4,853,854
Nonoperating gains and (losses):								
Contributions and donations							384,478	384,478
Change in equity interest in net assets of the Foundation		(167,456)					167,456	
Investment income	63	(5,444,964)		1,207,007		160,808	(8,689,207)	(12,766,293)
	63	(5,612,420)		1,207,007		160,808	(8,137,273)	(12,381,815)
(Deficiency) excess of revenues over expenses	$ (99,169)	$ 3,007,306	$	$ 146,756	$ (196,205)	$ (400,918)	$ (9,985,731)	$ (7,527,961)

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations Changes in Net Assets (continued)

September 30, 2008

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess of revenues over expenses (continued)	$ (99,169)	$ 3,007,306		$ 146,756	$ (196,205)	$ (400,918)	$ (9,985,731)	$ (7,527,961)
Change in equity interest in net assets of the Foundation		(10,497,269)					10,497,269	
Change in pension funding obligation		(14,558,507)						(14,558,507)
Current year acquisition						(326,023)		(326,023)
Equity contribution				6,148,491			(6,148,491)	
Transfer to affiliates				1,000,000			(1,000,000)	
(Decrease) increase in unrestricted net assets	(99,169)	(22,048,470)		7,295,247	(196,205)	(726,941)	(6,636,953)	(22,412,491)
Temporarily restricted net assets:								
Contributions			$ 702,273				89,917	792,190
Income from investments		2,550	(9,406,984)				8,689,207	(715,227)
Change in equity interest in net assets of the Foundation		(472,378)					472,378	
Net assets released from restrictions			(1,432,392)				885,601	(546,791)
Transfers to (from) affiliates			(2,996,569)				2,996,569	
(Decrease) increase in temporarily restricted net assets		(469,828)	(13,133,672)				13,133,672	(469,828)
Permanently restricted net assets								
Contributions			5,020					5,020
Change in net assets held in trust			(413,630)					(413,630)
Change in equity interest in net assets of the Foundation		(408,610)					408,610	
Decrease in permanently restricted net assets		(408,610)	(408,610)				408,610	(408,610)
Increase (decrease) in net assets	(99,169)	(22,926,908)	(13,542,282)	7,295,247	(196,205)	(726,941)	6,905,329	(23,290,929)
Net assets (deficit) at beginning of year	74,081	163,733,063	52,575,219	(4,965,573)	1,893,216	1,037,635	(45,955,111)	168,392,530
Net assets (deficit) at end of year	$ (25,088)	$ 140,806,155	$ 39,032,937	$ 2,329,674	$ 1,697,011	$ 310,694	$ (39,049,782)	$ 145,101,601

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2008

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,437	$ 477,609	$ 472,131		$ 961,177
Accounts receivable, less allowance for uncollectible accounts		830,900	388,069		1,218,969
Inventories of supplies		80,999			80,999
Due from affiliates	129,276			$ (129,276)	
Total current assets	140,713	1,389,508	860,200	(129,276)	2,261,145
Property, plant and equipment:					
Buildings and leasehold improvements		59,768			59,768
Equipment		265,246	39,799		305,045
Accumulated depreciation		(255,105)	(5,154)		(260,259)
		69,909	34,645		104,554
Other assets		486,913			486,913
	$ 140,713	$ 1,946,330	$ 894,845	$ (129,276)	$ 2,852,612
Liabilities and net assets					
Current liabilities:					
Accounts payable		$ 7,477	$ 17,058		$ 24,535
Salaries and wages, payroll taxes and taxes withheld from payroll		224,250	39,764		264,014
Other accrued liabilities		48,402			48,402
Due to affiliates	$ 131,436	183,827		$ (129,276)	185,987
Total current liabilities	131,436	463,956	56,822	(129,276)	522,938
Net assets (deficit)	9,277	1,482,374	838,023		2,329,674
Total liabilities and net assets	$ 140,713	$ 1,946,330	$ 894,845	$ (129,276)	$ 2,852,612

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2008

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 4,370,665	$ 417,081		$ 4,787,746
Other operating revenue	$ 36,936	53,348		$ (36,936)	53,348
Total revenues	36,936	4,424,013	417,081	(36,936)	4,841,094
Expenses:					
Salaries and wages		2,948,686	379,685		3,328,371
Payroll taxes and fringe benefits		733,842	31,407		765,249
Supplies and other	38,186	1,562,087	162,672	(36,936)	1,726,009
Provision for uncollectible accounts		55,504	140		55,644
Depreciation and amortization		20,918	5,154		26,072
Total expenses	38,186	5,321,037	579,058	(36,936)	5,901,345
Operating loss	(1,250)	(897,024)	(161,977)		(1,060,251)
Nonoperating gains:					
Investment income	38	1,206,969			1,207,007
(Deficiency) excess of revenue over expenses	(1,212)	309,945	(161,977)		146,756
Net assets (deficit) at beginning of year	10,489	(4,976,062)			(4,965,573)
Contributions		6,148,491	1,000,000		7,148,491
Net assets (deficit) at end of year	$ 9,277	$ 1,482,374	$ 838,023	$	$ 2,329,674

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2008

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 976,620	$ 208,337		$ 1,184,957
Accounts receivable, less allowance for uncollectible accounts		845,364		845,364
Prepaid expenses and other	17,405	8,937		26,342
Due from affiliates	522,830		$ (522,830)	
Total current assets	1,516,855	1,062,638	(522,830)	2,056,663
Property, plant and equipment:				
Equipment		350,608		350,608
Accumulated depreciation		(315,648)		(315,648)
		34,960		34,960
Other assets	65,922			65,922
	$ 1,582,777	$ 1,097,598	$ (522,830)	$ 2,157,545
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 110,342		$ 110,342
Salaries and wages, payroll taxes and taxes withheld from payroll		294,552		294,552
Other accrued liabilities		478,750		478,750
Due to third party reimbursement agencies		479,791		479,791
Due to affiliates	$ 483,416	522,830	$ (522,830)	483,416
Total current liabilities	483,416	1,886,265	(522,830)	1,846,851
Common stock	1,000			1,000
Retained earnings	1,098,361	(788,667)		309,694
Total liabilities and net assets	$ 1,582,777	$ 1,097,598	$ (522,830)	$ 2,157,545

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2008

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 5,014,824		$ 5,014,824
Other operating revenue		2,025		2,025
Total revenues		5,016,849		5,016,849
Expenses:				
Salaries and wages		3,281,463		3,281,463
Payroll taxes and fringe benefits		759,234		759,234
Supplies and other	$ 96,626	1,440,754		1,537,380
Provision for uncollectible accounts		(17,098)		(17,098)
Depreciation and amortization		17,596		17,596
Total expenses	96,626	5,481,949		5,578,575
Operating loss	(96,626)	(465,100)		(561,726)
Nonoperating gains:				
Investment income	158,352	2,456		160,808
(Deficiency) excess of revenue over expenses	61,726	(462,644)		(400,918)
Net assets (deficit) at beginning of year	1,037,635			1,037,635
Current year acquisition		(326,023)		(326,023)
Net assets (deficit) at end of year	$ 1,099,361	$ (788,667)	$ –	$ 310,694

Audited Consolidated Financial Statements and Other Financial Information

Backus Corporation and Subsidiaries
Years Ended September 30, 2010 and 2009
With Report of Independent Auditors

Backus Corporation and Subsidiaries

Audited Consolidated Financial Statements
and Other Financial Information

Years Ended September 30, 2010 and 2009

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Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
Backus Corporation and Subsidiaries

We have audited the accompanying consolidated balance sheets of Backus Corporation and Subsidiaries (the Corporation) as of September 30, 2010 and 2009, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Corporation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Backus Corporation and Subsidiaries as of September 30, 2010 and 2009, and the consolidated results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidated Balance Sheets

	September 30 2010	2009
Assets		
Current assets:		
Cash and cash equivalents	**$ 74,929,624**	$ 62,155,067
Assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
Accounts receivable, less allowance for uncollectible accounts (2010 – $20,574,000; 2009 – $21,206,000)	**32,546,895**	38,032,269
Pledges receivable	**185,866**	533,993
Inventories of supplies	**3,885,317**	3,367,607
Prepaid expenses and other	**1,303,628**	1,023,236
Total current assets	**120,782,920**	112,352,984
Assets whose use is limited:		
Board-designated and donor restricted	**96,626,409**	81,012,837
Held by trustee	**26,988,802**	25,070,975
Total assets whose use is limited	**123,615,211**	106,083,812
Less assets whose use is limited – required for current liabilities	**7,931,590**	7,240,812
	115,683,621	98,843,000
Property, plant and equipment, net	**99,769,244**	103,839,068
Deferred financing costs	**1,933,364**	2,025,397
Other assets	**2,413,877**	2,837,828
Total assets	**$ 340,583,026**	$ 319,898,277

	September 30	
	2010	**2009**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,942,326**	$ 11,143,511
Salaries and wages, payroll taxes and taxes withheld from payroll	**6,905,328**	8,955,228
Other accrued liabilities	**10,711,877**	9,568,027
Due to third-party reimbursement agencies	**2,963,415**	2,310,804
Current portion of long-term debt	**2,032,691**	1,833,475
Total current liabilities	**33,555,637**	33,811,045
Other liabilities:		
Long-term debt, less current portion	**64,591,831**	64,995,680
Employee related obligations	**57,973,203**	84,442,697
Self-insured professional liability	**10,514,332**	10,580,762
Due to third-party reimbursement agencies	**12,767,632**	10,307,215
Other	**349,678**	675,153
	146,196,676	171,001,507
Net assets:		
Unrestricted	**149,253,750**	104,776,463
Temporarily restricted	**4,101,543**	3,447,432
Permanently restricted	**7,475,420**	6,861,830
Total net assets	**160,830,713**	115,085,725
Total liabilities and net assets	**$ 340,583,026**	$ 319,898,277

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Operations

	Years Ended September 30	
	2010	**2009**
Operating revenues:		
Net patient service revenue	**$ 282,901,504**	$ 271,765,388
Other operating revenue	**4,357,277**	4,412,193
Net assets released from restrictions	**91,211**	86,494
	287,349,992	276,264,075
Operating expenses:		
Salaries, wages and professional fees	**117,710,320**	120,907,812
Payroll taxes and other fringe benefits	**29,622,058**	29,445,026
Supplies, insurance and other	**94,223,260**	80,131,898
Provision for uncollectible accounts	**14,462,163**	17,106,501
Depreciation and amortization	**17,534,609**	17,335,024
Interest	**3,185,038**	3,361,670
	276,737,448	268,287,931
Operating income	**10,612,544**	7,976,144
Nonoperating gains:		
Contributions and donations	**328,840**	429,646
Investment income	**8,486,755**	5,177,633
Other	**77,066**	
	8,892,661	5,607,279
Excess of revenues over expenses	**$ 19,505,205**	$ 13,583,423

Backus Corporation and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Total	Unrestricted	Restricted	Permanently Restricted
Net assets, September 30, 2008	$145,101,601	$ 136,705,366	$ 2,475,427	$ 5,920,808
Contributions	1,712,752		742,752	970,000
Investment income	315,747		315,747	
Excess of revenues over expenses	13,583,423	13,583,423		
Net assets released from restriction	(86,494)		(86,494)	
Effect of early measurement date elimination	(1,762,428)	(1,762,428)		
Change in pension funding and postretirement obligation	(43,749,898)	(43,749,898)		
Change in net assets held in trust	(28,978)			(28,978)
(Decrease) increase in net assets	(30,015,876)	(31,928,903)	972,005	941,022
Net assets, September 30, 2009	115,085,725	104,776,463	3,447,432	6,861,830
Contributions	**484,695**		**126,631**	**358,064**
Investment income	**739,782**		**618,691**	**121,091**
Excess of revenues over expenses	**19,505,205**	**19,505,205**		
Net assets released from restriction	**(91,211)**		**(91,211)**	
Curtailment gain	**34,536,288**	**34,536,288**		
Change in pension funding and postretirement obligation	**(9,564,206)**	**(9,564,206)**		
Change in net assets held in trust	**134,435**			**134,435**
Increase in net assets	**45,744,988**	**44,477,287**	**654,111**	**613,590**
Net assets, September 30, 2010	**$160,830,713**	**$ 149,253,750**	**$ 4,101,543**	**$ 7,475,420**

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	Years Ended September 30	
	2010	**2009**
Operating activities		
Increase (decrease) in net assets	**$ 45,744,988**	$(30,015,876)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,534,609**	17,335,024
Provision for uncollectible accounts	**14,462,163**	17,106,501
Curtailment gain	**(34,536,288)**	
Effect of early measurement date elimination		1,762,428
Change in pension funding and postretirement obligation	**9,564,206**	43,749,898
Purchase of investments-board designated, net	**(15,613,572)**	(3,472,648)
Permanently restricted contributions and income	**(613,590)**	
Changes in operating assets and liabilities *(Note 15)*	**(9,310,288)**	(9,217,760)
Net cash provided by operating activities	**27,232,228**	37,247,567
Investing activities		
Purchase of investments-held in trust, net	**(1,917,827)**	(4,516,685)
Net additions to property, plant and equipment	**(12,643,127)**	(19,263,913)
Decrease in other assets	**153,108**	360,829
Net cash used in investing activities	**(14,407,846)**	(23,419,769)
Financing activities		
Proceeds from loan	**1,250,000**	
Principal payments on long-term debt and capital lease obligations	**(1,863,950)**	(2,050,962)
Change in deferred financing costs and amortization of bond premium	**(49,465)**	(51,633)
Permanently restricted contributions and income	**613,590**	
Net cash used in financing activities	**(49,825)**	(2,102,595)
Net increase in cash and cash equivalents	**12,774,557**	11,725,203
Cash and cash equivalents at beginning of year	**62,155,067**	50,429,864
Cash and cash equivalents at end of year	**$ 74,929,624**	$ 62,155,067

See accompanying notes.

Backus Corporation and Subsidiaries

Notes to Consolidated Financial Statements

September 30, 2010

1. Significant Accounting Policies

Organization

Backus Corporation (Corporation) is a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation provides overall direction and control for The William W. Backus Hospital (the Hospital), Backus Foundation, Inc. (Foundation) and Backus Health Care, Inc. Backus Properties, Inc. (Properties), a not-for-profit organization, holds and manages certain nonpatient related properties for the Corporation. WWB Corporation conducts the related for-profit activities of the Corporation, its sole shareholder. Omni Home Health Services of Eastern Connecticut LLC dba Backus Home Health Services provides continual home care to patients. Backus Physician Services, LLC provides surgical services. The accompanying consolidated statements of operations include the excess (deficiency) of revenue over expenses as the performance indicator. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenues and expenses; peripheral or incidental transactions are reported as nonoperating items. All intercompany transactions have been eliminated in consolidation. Effective November 1, 2009, the Foundation and Properties were merged into the Hospital. The merger did not impact the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority) as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities, with readily determinable fair values, are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenue over expense unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

Property, Plant and Equipment

Property, plant and equipment are stated on the basis of cost. The Corporation and its subsidiaries provide for depreciation using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

1. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying consolidated financial statements.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in nonoperating gains and losses. Conditional promises to give are not included as support until the conditions are substantially met.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $4,000,000 annually for both 2010 and 2009. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in pension funding and postretirement obligation, pension curtailment gains, both temporarily and permanently restricted donations and investment income ,changes in trust arrangements , and the effect of early measurement date elimination.

1. Significant Accounting Policies (continued)

Cash Equivalents

The Corporation considers all highly liquid time deposits, commercial paper and money market mutual funds purchased with a maturity date at acquisition of three months or less to be cash equivalents.

Income Taxes

The Corporation, the Hospital, the Foundation, and Backus Health Care, Inc. are not-for-profit organizations exempt from federal income taxes on related income under Section 501(c)(3); Backus Properties, Inc. is a not-for-profit title holding corporation exempt from federal income taxes under Section 501(c)(2); WWB Corporation is a taxable stock corporation; CONNCare Inc., a subsidiary of Backus Health Care, is a taxable, nonstock corporation. Backus Home Health Services is a partnership taxable to its members and Backus Physician Services, LLC is a taxable, nonstock corporation.

Accounting Standards Codification (ASC) 740-10, *Uncertain Tax Positions*, (ASC 740-10), prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This interpretation also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods and disclosure requirements for uncertain tax positions. Management has evaluated the implications of ASC 740-10 and determined that its impact on the consolidated financial statements is not significant.

CONNCare, Inc. has a net operating loss carry-forward of $5,947,728. This net operating loss results in a potential deferred tax asset in the amount of approximately $2,400,000. No asset has been recorded as these assets are offset by valuation allowances of the same amounts.

Adoption of New Authoritative Pronouncements

Effective 2010, the Hospital adopted ASC 715-20, *Retirement Benefits*, which requires additional disclosures relating to defined benefit pension plans, including additional fair value disclosures for pension assets.

1. Significant Accounting Policies (continued)

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which is delayed until 2011, the guidance in ASU 2010-06 becomes effective for reporting periods beginning after December 15, 2009. Management is currently evaluating the effect that the provisions of ASU 2010-06 will have on the consolidated financial statements.

Reclassifications

Certain reclassifications were made to the 2009 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Patient accounts receivable and revenues are recorded when patient services are performed.

Hospital revenue accounted for 95% and 96% of net patient service revenue, respectively for the years ended September 30, 2010 and 2009. The following summarizes net patient service revenue:

	Year Ended September 30	
	2010	**2009**
Gross patient service revenue	**$ 604,461,491**	$ 578,445,014
Deductions:		
Allowances	**(315,063,365)**	(299,764,222)
Charity care (at charges)	**(6,496,622)**	(6,915,404)
	(321,559,987)	(306,679,626)
Net patient service revenue	**$ 282,901,504**	$ 271,765,388

2. Revenues from Services to Patients and Charity Care (continued)

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates had no impact on net patient service revenue for 2010, and increased net patient service revenue by approximately $671,000 in 2009.

Revenues from the Medicare and Medicaid programs accounted for approximately 28% and 8%, respectively, of the Corporation's net patient service revenue for the year ended September 30, 2010 and 28% and 7% for the year ended September 30, 2009. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Corporation.

3. Charity Care

The Corporation provides services without charge or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Corporation does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Corporation's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

3. Charity Care (continued)

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 6,496,622**	**$ 2,858,514**
Bad debt	**14,462,163**	**6,363,352**
Total uncompensated care, September 30, 2010	**$ 20,958,785**	**$ 9,221,866**
Charity care	$ 6,915,404	$ 3,042,778
Bad debt	17,106,501	7,526,860
Total uncompensated care, September 30, 2009	$ 24,021,905	$ 10,569,638

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2010	2009
BackusCare campaign	**$ 185,114**	$ 553,353
Other	**7,077**	7,077
Unconditional promises to give before unamortized discount	**192,191**	560,430
Less unamortized discount and allowance	**(6,325)**	(26,437)
	$ 185,866	$ 533,993
Amounts due in:		
Less than one year	**$ 133,366**	$ 414,993
One to five years	**52,500**	119,000
Total	**$ 185,866**	$ 533,993

5. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2010 and 2009:

	Year Ended September 30	
	2010	**2009**
Realized and unrealized gains on investments	**$ 4,574,175**	$ 1,229,304
Interest and dividend income	**1,819,741**	2,015,679
Investment in joint ventures	**2,262,006**	2,420,701
Other investment losses	**11,600**	(269,976)
Investment fees	**(180,767)**	(218,075)
	$ 8,486,755	$ 5,177,633

The market value of assets whose use is limited at September 30, is set forth in the following table:

	2010	**2009**
Board designated:		
Mutual funds	**$ 38,540,722**	$ 24,132,882
Cash and cash equivalents	**33,837,100**	18,129,468
Common stocks	**13,327,371**	13,153,726
Government bonds	**8,462,882**	15,780,860
Corporate bonds	**2,458,334**	9,815,901
	$ 96,626,409	$ 81,012,837
Held by trustee:		
Mutual funds	**$ 22,211,515**	$ 19,516,650
Cash and cash equivalents	**4,430,958**	4,804,214
Common stock	**287,581**	307,124
Real estate	**58,748**	
Government bonds		442,987
	$ 26,988,802	$ 25,070,975

In 2009, the Hospital adopted ASC 958-205, *Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act and Enhanced Disclosures for All Endowment Funds,* which provides guidance on the net asset classification of donor restricted endowment funds subject to the Uniform Prudent Management of Institutional Funds Act (UPMIFA), as well as requiring additional disclosures about endowment funds.

5. Investments (continued)

The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Corporation's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Corporation's inflation-adjusted value over time. The Corporation's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The investment committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Hospital and are included in permanently restricted net assets.

5. Investments (continued)

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

The activity for year end September 30, 2009 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year		$3,871,631	$ 3,871,631
Investment return:			
Investment income		85,680	85,680
Net appreciation (realized and unrealized)		49,535	49,535
Earnings reclassified	$ 135,215	(135,215)	
Total investment return	135,215	3,871,631	4,006,846
Contributions		970,000	970,000
Endowment net assets at end of year	$ 135,215	$4,841,631	$ 4,976,846

6. Fair Value of Financial Instruments

On October 1, 2008, the Corporation adopted ASC 820-10, *Fair Value*, which defines fair value, establishes a framework for measuring fair value in accordance with U.S. GAAP, and expands disclosure about fair value measurements.

6. Fair Value of Financial Instruments (continued)

Fair value, as defined in ASC 820-10, is based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. To increase consistency and comparability, ASC 820-10 established a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 77,955,100	$ 2,738		$ 77,957,838
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)			$ 58,751	58,751
Total	$ 163,339,941	$ 35,146,143	$ 58,751	$ 198,544,835

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Real Estate (REIT)
Beginning balance	-
Purchases	$ 54,286
Unrealized gains	4,465
Total	$ 58,751

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2009 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 63,823,514	$ 2,142		$ 63,825,656
Certificates of deposit		4,815,074		4,815,074
Money market funds	14,248,373	50,247		14,298,620
US government obligations	9,075,929			9,075,929
Corporate bonds		8,487,292		8,487,292
Equity securities	13,412,497			13,412,497
Mutual funds	39,000,401	15,323,410		54,323,811
Total	$ 139,560,714	$ 28,678,165		$ 168,238,879

The carrying amount of certain of the Corporation's financial instruments, including cash and cash equivalents, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Corporation's fiscal year end. The fair value of long-term debt is $69,437,056 and $68,087,973 at September 30, 2010 and 2009, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2010	2009
Capital Projects	**$ 1,733,950**	$ 1,548,434
Preventative care	**792,377**	763,501
Other	**626,772**	358,416
Health care services	**499,200**	414,281
Laboratory	**228,659**	184,552
Extraordinary nursing care	**109,852**	97,635
Nursing education	**84,912**	70,948
Free beds	**25,821**	9,665
	$ 4,101,543	$ 3,447,432

7. Temporarily and Permanently Restricted Net Assets (continued)

Permanently restricted net assets at September 30 are restricted to the following:

	2010	2009
Income to be used:		
For general purposes	**$ 6,631,835**	$ 6,018,245
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,475,420	$ 6,861,830

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2010	2009
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($1,110,000) from 2011 to 2012 with interest rates ranging from 4.75% to 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,625,000**	$ 9,145,000
Series F, serial maturities ($6,600,000) from 2011 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,725,000**	29,425,000
Series G, serial maturities ($18,355,000) from 2011 to 2026 with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5.00%	**25,775,000**	26,380,000
Other long-term debt:		
Mortgage, maturing May 1,2025 with a fixed rate of 6.125%	**1,236,586**	
Obligation under capital leases	**1,505,864**	1,072,619
	65,867,450	66,022,619
Add net unamortized bond premium	**757,072**	806,536
Less current portion	**(2,032,691)**	(1,833,475)
Long-term debt	**$ 64,591,831**	$ 64,995,680

8. Long-term Debt (continued)

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. The mortgages are secured by a warehouse and by certain leasehold improvements. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principle and interest on the Series E, Series F, and Series G bonds.

Bonds maturing on or after July 1, 2008, are subject to redemption prior to maturity commencing July 1, 2008. Series F bonds maturing after July 1, 2018 are subject to optional redemption prior to maturity. Series G bonds maturing on or before July 1, 2015, are not subject to optional redemption prior to maturity; however, those maturing after July 1, 2015, are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years and in the aggregate are as follows:

	Long-Term Debt	Capital Leases
2011	$ 1,948,410	$ 386,104
2012	2,021,619	386,104
2013	2,105,440	386,104
2014	2,184,302	386,104
2015	2,303,411	355,554
Aggregate thereafter	53,798,404	2,375,136
	64,361,586	4,275,106
Add net unamortized bond premium	757,072	
Less interest		(2,769,242)
	$ 65,118,658	$ 1,505,864

The Corporation paid interest of $3,323,608 and $3,428,396 in 2010 and 2009, respectively. Interest incurred in 2010 and 2009 was $3,185,038 and $3,361,670, respectively.

In 2010 the Corporation entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

8. Long-term Debt (continued)

In 2010 the Corporation also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2010 was $441,720. Under the terms of the lease, the Hospital has the option to renew for five periods for five years each.

Deferred financing costs are amortized over a period consistent with the life of the bonds.

9. Retirement Benefit Plans

Effective January 1, 2010, the Corporation amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Corporation will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Corporation will also make a non-elective transition contribution equal to 3% for all employees who meet the transition participant criteria. The Corporation may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the year ended September 30, 2010 is $3,589,500.

The Corporation also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the costs based on years of service. In addition, the Hospital sponsored a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2010 and 2009 is approximately $2,600,000 and $3,600,000, respectively, related to the future obligation for the nonqualified benefits.

9. Retirement Benefit Plans (continued)

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
	(In Thousands)			
Unrecognized actuarial (loss) gain	**$ (43,157)**	$ (67,240)	**$ 1,734**	$ 1,249
Unrecognized prior service cost		(15)		
Unrecognized transition obligation			**(889)**	(1,213)
	$ (43,157)	$ (67,255)	**$ 845**	$ 36

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2011 are $2,743,736 and $323,491, respectively.

At September 30, 2009, the unfunded status of the pension plan is included in long-term liabilities in the amount of $71,685,446. The unfunded status of the postretirement benefits is $4,968,915, with $462,097 included in short-term liabilities, and the remainder of $4,506,818 included in long-term liabilities. At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities.

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2010 and 2009.

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
	(In Thousands)			
Change in benefit obligations				
Benefit obligations at beginning of year	**$ (171,831)**	$ (133,189)	**$ (4,969)**	$ (5,156)
Service cost	**(1,836)**	(4,484)	**(15)**	(22)
Interest cost	**(7,684)**	(9,002)	**(267)**	(338)
Change in assumptions	**(11,951)**	(38,217)	**387**	(558)
Actuarial (loss) gain	**(3,598)**	(2,156)	**154**	382
Effect of curtailment	**34,551**			
Effect of early measurement date elimination		11,740		295
Benefits paid	**4,083**	3,477	**444**	428
Benefit obligations at end of year	**$ (158,266)**	$ (171,831)	**$ (4,266)**	$ (4,969)

9. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2010	**2009**	**2010**	**2009**
		(In Thousands)		
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 100,145**	$ 100,957		
Actual return on plan assets	**10,017**	2,662		
Effect of early measurement date elimination		(8,097)		
Contributions	**8,124**	8,100	**$ 444**	$ 428
Benefits paid	**(4,083)**	(3,477)	**(444)**	(428)
Fair value of plan assets at end of year	**$ 114,203**	$ 100,145	**$**	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	**$ (44,063)**	$ (71,686)	**$ (4,266)**	$ (4,969)
Components of net periodic benefit cost				
Service cost	**$ 1,836**	$ 4,484	**$ 15**	$ 22
Interest cost	**7,684**	9,002	**267**	338
Expected return on plan assets	**(6,901)**	(7,605)		
Net amortization and deferral	**1,964**	1,129	**269**	(541)
Net periodic benefit cost	**$ 4,583**	$ 7,010	**$ 551**	$ (181)
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**5.10%**	5.60%	**5.10%**	5.60%
Rate of compensation increase		5.00		
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.60**	7.25	**5.60**	7.25
Expected long-term rate of return on plan assets	**6.75**	8.00		
Rate of compensation increase	**5.00**	5.00		

The accumulated benefit obligation at September 30, 2010 and 2009 was $158,266,226 and $137,279,286, respectively.

9. Retirement Benefit Plans (continued)

The asset allocation for the retirement plan at the end of 2010 and 2009 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	**Minimum**	**Maximum**	**2010**	**2009**
US Equity Large Cap	20%	50%	**31%**	27%
US Equity Small Cap		15	**5**	4
International Equity	10	30	**17**	17
Core Fixed Income	20	60	**47**	52
Total			**100%**	100%

The following table presents the Hospital Plan's fair value hierarchy for those assets measured at fair value as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Hospital Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity (b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category invests primarily in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital by investing at least 80% in international equity securities.
(c) This category seeks maximum current income by investing primarily in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

9. Retirement Benefit Plans (continued)

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ -	$ -	$ -
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

The Hospital Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Hospital Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2011	$ 8,100,000	$ 452,466
Estimated future benefit payments:		
2011	5,057,112	452,466
2012	5,586,022	439,761
2013	6,060,768	433,204
2014	6,598,072	424,838
2015	7,158,748	401,741
2016-2020	43,816,630	1,669,284

Assumed healthcare cost trend rates for 2010 are as follows:	
Health care trend rate assumed for next year	8.00%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2014

9. Retirement Benefit Plans (continued)

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	One-Percentage-Point Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (2)
Effect on postretirement benefit obligation	$ 9	$ (7)

10. Contingencies

There have been malpractice claims that fall within the Corporation's partially self-insured program (see Note 1, Organization and Accounting Policies) which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2010 that may result in the assertion of claims. Corporation management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

The Corporation is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Corporation's financial position.

11. Property, Plant and Equipment

Property, plant and equipment at September 30 consist of the following:

	2010	2009
Land and land improvements	**$ 4,889,512**	$ 4,905,192
Buildings and leasehold improvements	**125,739,952**	115,686,063
Equipment	**101,463,454**	96,886,734
Construction in process (2010 estimated cost to complete $4,601,400)	**630,806**	4,251,661
Less accumulated depreciation	**(132,954,480)**	(117,890,582)
	$ 99,769,244	$ 103,839,068

Unamortized internally developed software costs totaled $968,970 and $1,280,233 at September 30, 2010 and 2009, respectively. Amortization expense for the years ended September 30, 2010 and 2009 was $591,171 and $213,372, respectively.

11. Property, Plant and Equipment (continued)

The Corporation wrote off approximately $853,000 of fully depreciated assets in 2010.

In 2004, the Corporation began leasing space to be used for patient services. The initial lease term is for a period of ten years, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2010 and 2009 was $640,018 and $705,436, respectively.

The Corporation leases various types of equipment with annual payments ranging from $103 to $55,600. Expenses as a result of these leases were approximately $375,000 and $478,000 for the years ended September 30, 2010 and 2009, respectively.

Future minimum lease payments under the above leases during each of the next five years were as follows:

2011	$ 935,358
2012	726,417
2013	718,648
2014	137,725
2015	65,380
	$ 2,583,528

12. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2010	**2009**
Cafeteria sales	**$ 1,063,020**	$ 1,049,650
Rental income	**812,182**	663,647
Grants	**733,844**	642,728
Miscellaneous	**455,498**	527,635
Condominium income	**389,640**	440,047
Child care	**355,497**	336,700
Purchase discounts	**351,343**	274,879
Interest	**196,253**	476,907
	$ 4,357,277	$ 4,412,193

13. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2010	**2009**
Health care services	**$ 224,821,690**	$ 214,740,364
General and administrative	**51,724,893**	53,355,656
Fundraising	**190,865**	191,911
	$ 276,737,448	$ 268,287,931

14. Concentrations of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. For 2010 and 2009, Hospital receivables accounted for 96% and 95%, respectively. The mix of gross accounts receivable, net of contractual allowances, from patients and third-party payors at September 30 is as follows:

	2010	**2009**
Medicare	**27%**	25%
Self pay	**24**	24
Health Maintenance Organizations	**15**	17
Anthem Blue Cross/Blue Shield	**13**	14
Medicaid	**11**	8
Commercial	**5**	5
Other state agencies	**5**	7
	100%	100%

15. Cash Flows

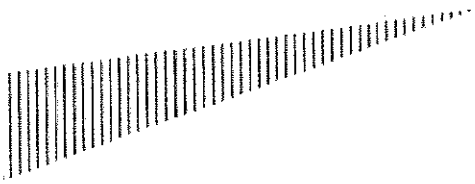
Changes in operating assets and liabilities at September 30 include the following:

	2010	2009
(Increase) decrease in assets:		
Accounts receivable	**$ (8,976,789)**	$ (19,355,546)
Collection on pledges	**348,127**	569,024
Inventories of supplies, prepaid expenses, and other	**(798,102)**	(514,632)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**3,113,028**	6,975,152
Accounts payable	**(201,185)**	996,724
Employee related obligations	**(1,497,412)**	(279,391)
Interest payable and other accrued liabilities	**1,143,850**	2,019,580
Salaries and wages, payroll taxes, and taxes withheld from payroll	**(2,049,900)**	1,596,285
Self-insured professional liability	**(66,430)**	(1,358,443)
Other liabilities	**(325,475)**	133,487
Changes in operating assets and liabilities	**$ (9,310,288)**	$ (9,217,760)

16. Subsequent Events

Management evaluated subsequent events through December 2, 2010, the date the financial statements were issued.

Other Financial Information



Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Directors
Backus Corporation and Subsidiaries

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Ernst & Young LLP

December 2, 2010

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 63,324	$ 72,131,779	$ 1,612,700	$ 1,121,821		$ 74,929,624
Assets whose use is limited – required for current liabilities		7,931,590				7,931,590
Accounts receivable, less allowance for uncollectible accounts		30,758,941	838,941	949,013		32,546,895
Pledges receivable		185,866				185,866
Inventories of supplies		3,799,896	85,421			3,885,317
Prepaid expenses and other		1,277,144	20,282	6,202		1,303,628
Due from affiliates	63,142	661,088			$ (724,230)	
Total current assets	126,466	116,746,304	2,557,344	2,077,036	(724,230)	120,782,920
Assets whose use is limited:						
Board-designated and donor restricted		96,626,409				96,626,409
Held by trustee		26,988,802				26,988,802
Total assets whose use is limited		123,615,211				123,615,211
Less assets whose use is limited – required for current liabilities		7,931,590				7,931,590
		115,683,621				115,683,621
Property, plant, and equipment, net		99,122,387	145,235	501,622		99,769,244
Deferred financing costs		1,933,364				1,933,364
Other assets	1,000	1,603,864	782,197	43,661	(16,845)	2,413,877
	$ 127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable-trade		$ 10,129,146	$ 625,229	$ 187,951		$ 10,942,326
Salaries and wages, payroll taxes and taxes withheld from payroll		6,206,054	309,223	390,051		6,905,328
Due to affiliates			203,033	521,197	$ (724,230)	
Other accrued liabilities		8,967,664	1,281,437	462,776		10,711,877
Due to third-party reimbursement agencies		2,614,222		349,193		2,963,415
Current portion of long-term debt		2,032,691				2,032,691
Total current liabilities		29,949,777	2,418,922	1,911,168	(724,230)	33,555,637
Other liabilities:						
Long-term debt, less current portion		64,591,831				64,591,831
Employee related obligations		57,973,203				57,973,203
Self-insured professional liability		10,514,332				10,514,332
Due to third-party reimbursement agencies		12,767,632				12,767,632
Other		349,678				349,678
		146,196,676				146,196,676
Net assets:						
Common stock				1,000	(1,000)	
Unrestricted	$127,466	147,366,124	1,065,854	710,151	(15,845)	149,253,750
Temporarily restricted		4,101,543				4,101,543
Permanently restricted		7,475,420				7,475,420
Total net assets	127,466	158,943,087	1,065,854	711,151	(16,845)	160,830,713
Total liabilities and net assets	$127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 270,048,715		$ 5,497,679		$ 7,378,559	$ (23,449)	$ 282,901,504
Other operating revenue	$ 593,530	4,673,356		87,120		6,752	(1,003,481)	4,357,277
Net assets released from restrictions		91,211						91,211
	593,530	274,813,282		5,584,799		7,385,311	(1,026,930)	287,349,992
Operating expenses:								
Salaries, wages and professional fees	174,812	109,179,026		4,740,065		4,148,270	(531,853)	117,710,320
Payroll taxes and other fringe benefits	55,510	27,181,443		978,613		1,406,492		29,622,058
Supplies, insurance and other	25,447	91,056,415		1,716,164		1,920,311	(495,077)	94,223,260
Provision for uncollectible accounts		14,409,876		(11,974)		64,261		14,462,163
Depreciation and amortization		17,480,126		27,483		27,000		17,534,609
Interest		3,185,038						3,185,038
	255,769	262,491,924		7,450,351		7,566,334	(1,026,930)	276,737,448
Operating (loss) income	337,761	12,321,358		(1,865,552)		(181,023)		10,612,544
Nonoperating gains and (losses):								
Contributions and donations		328,840						328,840
Investment income	77	6,218,347		2,213,811		54,520		8,486,755
Other		(116,761)		197,389		(3,562)		77,066
	77	6,430,426		2,411,200		50,958		8,892,661
Excess (deficiency) of revenues over expenses	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205
Merger of Properties		1,402,938			$(1,402,938)			
Intercompany transfer		(73,056)		73,056				
Pension curtailment		34,536,288						34,536,288
Change in pension funding obligation		(9,564,206)						(9,564,206)
Increase (decrease) in unrestricted net assets	337,838	45,053,748		618,704	(1,402,938)	(130,065)		44,477,287
Temporarily restricted net assets:								
Contributions		126,631						126,631
Income from investments		618,691						618,691
Merger of Foundation			$(34,308,847)				34,308,847	
Net assets released from restrictions		(91,211)						(91,211)
Increase (decrease) in temporarily restricted net assets		654,111	(34,308,847)				34,308,847	654,111
Permanently restricted net assets								
Contributions		358,064						358,064
Income from investments		121,091						121,091
Merger of Foundation			(6,838,627)				6,838,627	
Change in net assets held in trust		134,435						134,435
Increase (decrease) in permanently restricted net assets		613,590	(6,838,627)				6,838,627	613,590
Increase (decrease)in net assets	337,838	46,321,449	(41,147,474)	618,704	(1,402,938)	(130,065)	41,147,474	45,744,988
Net assets (deficit) at beginning of year	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Net assets at end of year	$ 127,466	$ 158,943,087	$	$ 1,065,854	$	$ 711,151	$ (16,845)	$ 160,830,713

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,463	$ 1,228,148	$ 373,089		$ 1,612,700
Accounts receivable, less allowance for uncollectible accounts		369,242	469,699		838,941
Inventories of supplies		85,421			85,421
Prepaid expenses		9,376	10,906		20,282
Due from affiliates	61,560	2,340,589		$(2,402,149)	
Total current assets	73,023	4,032,776	853,694	(2,402,149)	2,557,344
Property, plant and equipment:					
Buildings and leasehold improvements		19,619			19,619
Equipment		244,681	61,648		306,329
Accumulated depreciation		(152,895)	(27,818)		(180,713)
		111,405	33,830		145,235
Other assets		782,197			782,197
	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 10,233	$ 614,996		$ 625,229
Salaries and wages, payroll taxes and taxes withheld from payroll		246,716	62,507		309,223
Other accrued liabilities		1,281,437			1,281,437
Due to affiliates	$ 67,520	197,073	2,340,589	$ (2,402,149)	203,033
Total current liabilities	67,520	1,735,459	3,018,092	(2,402,149)	2,418,922
Net assets (deficit)	5,503	3,190,919	(2,130,568)		1,065,854
Total liabilities and net assets	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,608,723	$ 1,888,956		$ 5,497,679
Other operating revenue	$ 36,936	68,042	19,078	$ (36,936)	87,120
Total revenues	36,936	3,676,765	1,908,034	(36,936)	5,584,799
Expenses:					
Salaries and wages		2,634,018	2,106,047		4,740,065
Payroll taxes and fringe benefits		719,574	259,039		978,613
Supplies and other	39,186	714,272	999,642	(36,936)	1,716,164
Provision for uncollectible accounts		(69,754)	57,780		(11,974)
Depreciation and amortization		14,905	12,578		27,483
Total expenses	39,186	4,013,015	3,435,086	(36,936)	7,450,351
Operating loss	(2,250)	(336,250)	(1,527,052)		(1,865,552)
Nonoperating gains:					
Investment income	6	2,213,805			2,213,811
Other		197,389			197,389
(Deficiency) excess of revenue over expenses	(2,244)	2,074,944	(1,527,052)		545,648
Net assets (deficit) at beginning of year	7,747	1,044,627	(605,224)		447,150
Intercompany transfer		71,348	1,708		73,056
Net assets (deficit) at end of year	$ 5,503	$ 3,190,919	$(2,130,568)	$	$ 1,065,854

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2010

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,087,166	$ 34,655		$ 1,121,821
Accounts receivable, less allowance for uncollectible accounts		949,013		949,013
Prepaid expenses and other		6,202		6,202
Due from affiliates	563,194		$(563,194)	
Total current assets	1,650,360	989,870	(563,194)	2,077,036
Property, plant and equipment:				
Buildings and leasehold improvements		445,975		445,975
Equipment		102,089		102,089
Accumulated depreciation		(46,442)		(46,442)
		501,622		501,622
Other assets	39,861	3,800		43,661
	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 187,951		$ 187,951
Salaries and wages, payroll taxes and taxes withheld from payroll		390,051		390,051
Other accrued liabilities		462,776		462,776
Due to third party reimbursement agencies		349,193		349,193
Due to affiliates	$ 521,197	563,194	$ (563,194)	521,197
Total current liabilities	521,197	1,953,165	(563,194)	1,911,168
Common stock	1,000			1,000
Retained earnings (deficit)	1,168,024	(457,873)		710,151
Total liabilities and net assets	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,378,559		$ 7,378,559
Other operating revenue		6,752		6,752
Total revenues		7,385,311		7,385,311
Expenses:				
Salaries and wages		4,148,270		4,148,270
Payroll taxes and fringe benefits		1,406,492		1,406,492
Supplies and other	$ 67,510	1,852,801		1,920,311
Provision for uncollectible accounts		64,261		64,261
Depreciation and amortization		27,000		27,000
Total expenses	67,510	7,498,824		7,566,334
Operating (loss) income	(67,510)	(113,513)		(181,023)
Nonoperating gains:				
Investment income	53,219	1,301		54,520
Other		(3,562)		(3,562)
Excess of revenue over expenses	(14,291)	(115,774)		(130,065)
Net assets (deficit) at beginning of year	1,182,315	(342,099)		840,216
Net assets (deficit) at end of year	$ 1,168,024	$ (457,873)	$	$ 710,151

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

Assets	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Current assets:								
Cash and cash equivalents	$ 45,846	$ 57,570,735	$ 2,085,506	$ 1,108,911	$ 140,738	$ 1,203,331		$ 62,155,067
Assets whose use is limited – required for current liabilities		7,240,812						7,240,812
Accounts receivable, less allowance for uncollectible accounts		36,111,295		839,709	30,125	1,051,140		38,032,269
Pledges receivable			533,993					533,993
Inventories of supplies		3,252,641		114,966				3,367,607
Prepaid expenses and other		925,340		9,671	85,556	2,669		1,023,236
Due from affiliates	27,582	3,901,924					$ (3,929,506)	
Total current assets	73,428	109,002,747	2,619,499	2,073,257	256,419	2,257,140	(3,929,506)	112,352,984
Assets whose use is limited:								
Board-designated and donor restricted		44,500,233	36,512,604					81,012,837
Held by trustee		22,743,662	2,327,313					25,070,975
Total assets whose use is limited		67,243,895	38,839,917					106,083,812
Less assets whose use is limited – required for current liabilities		7,240,812						7,240,812
		60,003,083	38,839,917					98,843,000
Interest in Foundation		41,147,474					(41,147,474)	
Property, plant, and equipment, net		98,131,132		90,657	5,593,682	23,597		103,839,068
Deferred financing costs		2,025,397						2,025,397
Other assets	1,000	1,801,751		966,810		85,112	(16,845)	2,837,828
	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets								
Current liabilities:								
Accounts payable-trade		$ 10,508,835	$ 11,448	$ 394,244	$ 30,263	$ 198,721		$ 11,143,511
Salaries and wages, payroll taxes and taxes withheld from payroll		8,205,022	531	369,819		379,856		8,955,228
Due to affiliates	$284,800		45,983	118,309	3,336,782	143,632	$ (3,929,506)	
Other accrued liabilities		7,190,212	253,980	1,801,202		322,633		9,568,027
Due to third-party reimbursement agencies		1,831,013				479,791		2,310,804
Current portion of long-term debt		1,825,000			8,475			1,833,475
Total current liabilities	284,800	29,560,082	311,942	2,683,574	3,375,520	1,524,633	(3,929,506)	33,811,045
Other liabilities:								
Long-term debt, less current portion		63,931,536			1,064,144			64,995,680
Employee related obligations		84,442,697						84,442,697
Self-insured professional liability		10,580,762						10,580,762
Due to third-party reimbursement agencies		10,307,215						10,307,215
Other		667,654			7,499			675,153
		169,929,864			1,071,643			171,001,507
Net assets:								
Common stock						1,000	(1,000)	
Unrestricted	(210,372)	102,312,376		447,150	1,402,938	840,216	(15,845)	104,776,463
Temporarily restricted		3,447,432	34,308,847				(34,308,847)	3,447,432
Permanently restricted		6,861,830	6,838,627				(6,838,627)	6,861,830
Total net assets	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Total liabilities and net assets	$ 74,428	$ 312,111,584	$ 41,459,416	$ 3,130,724	$ 5,850,101	$ 2,365,849	$ (45,093,825)	$ 319,898,277

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 259,652,271		$ 5,073,240		$ 7,128,542	$ (88,665)	$ 271,765,388
Other operating revenue	$ 125,004	4,213,341		81,199	$ 1,099,706	22,154	(1,129,211)	4,412,193
Net assets released from restrictions			$ 547,411				(460,917)	86,494
	125,004	263,865,612	547,411	5,154,439	1,099,706	7,150,696	(1,678,793)	276,264,075
Operating expenses:								
Salaries, wages and professional fees	256,742	112,184,033	155,336	4,348,579	24,755	3,938,367		120,907,812
Payroll taxes and other fringe benefits	35,218	27,425,902	40,414	969,731	3,238	970,523		29,445,026
Supplies, insurance and other	18,420	74,547,698	351,661	3,963,600	741,108	1,727,287	(1,217,876)	80,131,898
Provision for uncollectible accounts		16,898,318		74,663		133,520		17,106,501
Depreciation and amortization		16,939,369		28,162	352,257	15,236		17,335,024
Interest		3,091,298			270,372			3,361,670
	310,380	251,086,618	547,411	9,384,735	1,391,730	6,784,933	(1,217,876)	268,287,931
Operating (loss) income	(185,376)	12,778,994		(4,230,296)	(292,024)	365,763	(460,917)	7,976,144
Nonoperating gains and (losses):								
Contributions and donations							429,646	429,646
Change in equity interest in net assets of the Foundation		(3,735,563)					3,735,563	
Investment income	92	2,432,928		2,347,772	(2,049)	164,759	234,131	5,177,633
	92	(1,302,635)		2,347,772	(2,049)	164,759	4,399,340	5,607,279
Excess (deficiency) of revenues over expenses	$ (185,284)	$ 11,476,359	$	$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2009

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ (185,284)	$ 11,476,359		$ (1,882,524)	$ (294,073)	$ 530,522	$ 3,938,423	$ 13,583,423
Change in equity interest in net assets of the Foundation		3,938,423					(3,938,423)	
Change in pension funding obligation		(45,512,326)						(45,512,326)
Increase (decrease) in unrestricted net assets	(185,284)	(30,097,544)		(1,882,524)	(294,073)	530,522		(31,928,903)
Temporarily restricted net assets:								
Contributions			$ 1,172,398				(429,646)	742,752
Income from investments		1,350	548,528				(234,131)	315,747
Change in equity interest in net assets of the Foundation		970,655					(970,655)	
Net assets released from restrictions			(547,411)				460,917	(86,494)
Increase (decrease) in temporarily restricted net assets		972,005	1,173,515				(1,173,515)	972,005
Permanently restricted net assets								
Contributions			970,000					970,000
Change in net assets held in trust			(28,978)					(28,978)
Change in equity interest in net assets of the Foundation		941,022					(941,022)	
Increase in permanently restricted net assets		941,022	941,022				(941,022)	941,022
Increase (decrease)in net assets	(185,284)	(28,184,517)	2,114,537	(1,882,524)	(294,073)	530,522	(2,114,537)	(30,015,876)
Net assets (deficit) at beginning of year	(25,088)	140,806,155	39,032,937	2,329,674	1,697,011	310,694	(39,049,782)	145,101,601
Net assets (deficit) at end of year	$ (210,372)	$ 112,621,638	$ 41,147,474	$ 447,150	$ 1,402,938	$ 841,216	$ (41,164,319)	$ 115,085,725

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,457	$ 834,815	$ 262,639		$ 1,108,911
Accounts receivable, less allowance for uncollectible accounts		511,479	328,230		839,709
Inventories of supplies		114,966			114,966
Prepaid expenses		9,113	558		9,671
Due from affiliates	24,624	749,606		$ (774,230)	
Total current assets	36,081	2,219,979	591,427	(774,230)	2,073,257
Property, plant and equipment:					
Buildings and leasehold improvements		59,768			59,768
Equipment		268,112	48,323		316,435
Accumulated depreciation		(270,306)	(15,240)		(285,546)
		57,574	33,083		90,657
Other assets		966,810			966,810
	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 13,318	$ 380,926		$ 394,244
Salaries and wages, payroll taxes and taxes withheld from payroll		270,617	99,202		369,819
Other accrued liabilities		1,801,202			1,801,202
Due to affiliates	$ 28,334	114,599	749,606	$ (774,230)	118,309
Total current liabilities	28,334	2,199,736	1,229,734	(774,230)	2,683,574
Net assets (deficit)	7,747	1,044,627	(605,224)		447,150
Total liabilities and net assets	$ 36,081	$ 3,244,363	$ 624,510	$ (774,230)	$ 3,130,724

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,943,958	$ 1,129,282		$ 5,073,240
Other operating revenue	$ 36,936	67,042	14,157	$ (36,936)	81,199
Total revenues	36,936	4,011,000	1,143,439	(36,936)	5,154,439
Expenses:					
Salaries and wages		2,870,703	1,477,876		4,348,579
Payroll taxes and fringe benefits		805,491	164,240		969,731
Supplies and other	38,486	3,098,692	863,358	(36,936)	3,963,600
Provision for uncollectible accounts		4,057	70,606		74,663
Depreciation and amortization		17,434	10,728		28,162
Total expenses	38,486	6,796,377	2,586,808	(36,936)	9,384,735
Operating loss	(1,550)	(2,785,377)	(1,443,369)		(4,230,296)
Nonoperating gains:					
Investment income	20	2,347,630	122		2,347,772
Deficiency of revenue over expenses	(1,530)	(437,747)	(1,443,247)		(1,882,524)
Net assets at beginning of year	9,277	1,482,374	838,023		2,329,674
Net assets (deficit) at end of year	$ 7,747	$ 1,044,627	$ (605,224)	$	$ 447,150

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2009

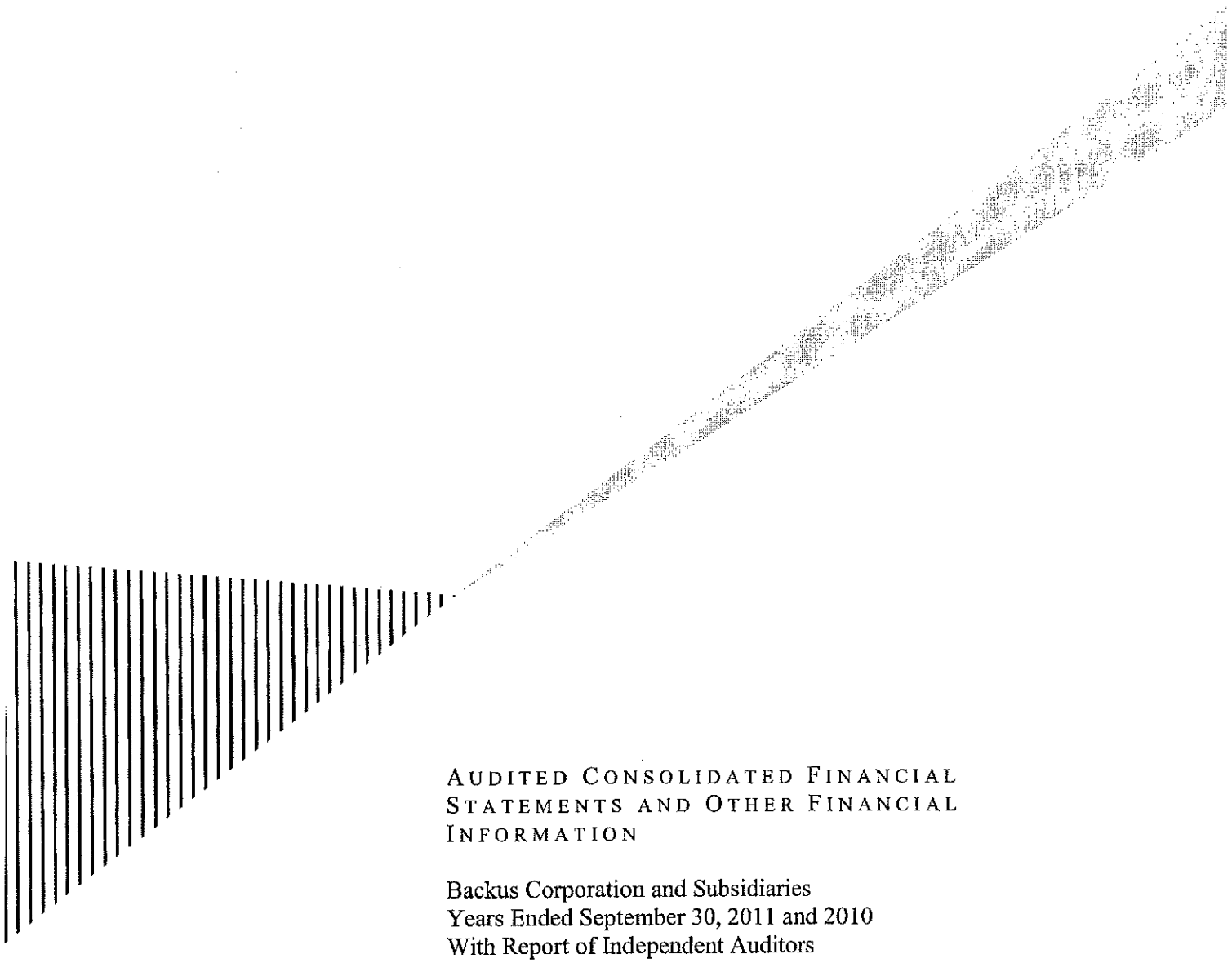
	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,061,007	$ 142,324		$ 1,203,331
Accounts receivable, less allowance for uncollectible accounts		1,051,140		1,051,140
Prepaid expenses and other		2,669		2,669
Due from affiliates	184,628		$ (184,628)	
Total current assets	1,245,635	1,196,133	(184,628)	2,257,140
Property, plant and equipment:				
Lease improvements		3,872		3,872
Equipment		350,608		350,608
Accumulated depreciation		(330,883)		(330,883)
		23,597		23,597
Other assets	81,312	3,800		85,112
	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 198,721		$ 198,721
Salaries and wages, payroll taxes and taxes withheld from payroll		379,856		379,856
Other accrued liabilities		322,633		322,633
Due to third party reimbursement agencies		479,791		479,791
Due to affiliates	$ 143,632	184,628	$ (184,628)	143,632
Total current liabilities	143,632	1,565,629	(184,628)	1,524,633
Common stock	1,000			1,000
Retained earnings (deficit)	1,182,315	(342,099)		840,216
Total liabilities and net assets	$ 1,326,947	$ 1,223,530	$ (184,628)	$ 2,365,849

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2009

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,128,542		$ 7,128,542
Other operating revenue		22,154		22,154
Total revenues		7,150,696		7,150,696
Expenses:				
Salaries and wages		3,938,367		3,938,367
Payroll taxes and fringe benefits		970,523		970,523
Supplies and other	$ 80,645	1,646,642		1,727,287
Provision for uncollectible accounts		133,520		133,520
Depreciation and amortization		15,236		15,236
Total expenses	80,645	6,704,288		6,784,933
Operating (loss) income	(80,645)	446,408		365,763
Nonoperating gains:				
Investment income	164,599	160		164,759
Excess of revenue over expenses	83,954	446,568		530,522
Net assets (deficit) at beginning of year	1,098,361	(788,667)		309,694
Net assets (deficit) at end of year	$ 1,182,315	$ (342,099)	$	$ 840,216



Audited Consolidated Financial Statements and Other Financial Information

Backus Corporation and Subsidiaries
Years Ended September 30, 2011 and 2010
With Report of Independent Auditors

Ernst & Young LLP

Ernst & Young

Backus Corporation and Subsidiaries

Audited Consolidated Financial Statements
and Other Financial Information

Years Ended September 30, 2011 and 2010

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ERNST & YOUNG

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors

The Board of Trustees
Backus Corporation and Subsidiaries

We have audited the accompanying consolidated balance sheets of Backus Corporation and Subsidiaries (the Corporation) as of September 30, 2011 and 2010, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Corporation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Backus Corporation and Subsidiaries as of September 30, 2011 and 2010, and the consolidated results of its operations and changes in net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidated Balance Sheets

	September 30	
	2011	**2010**
Assets		
Current assets:		
Cash and cash equivalents	**$ 95,434,551**	$ 74,929,624
Assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
Accounts receivable, less allowance for uncollectible accounts (2011 – $21,442,000; 2010 – $20,574,000)	**34,428,013**	32,546,895
Pledges receivable	**101,211**	185,866
Inventories of supplies	**3,704,067**	3,885,317
Prepaid expenses and other	**1,634,141**	1,303,628
Total current assets	**141,187,465**	120,782,920
Assets whose use is limited:		
Board-designated and donor restricted	**105,438,402**	96,626,409
Held by trustee	**28,078,427**	26,988,802
Total assets whose use is limited	**133,516,829**	123,615,211
Less assets whose use is limited – required for current liabilities	**5,885,482**	7,931,590
	127,631,347	115,683,621
Property, plant and equipment, net	**90,635,773**	99,769,244
Deferred financing costs	**1,842,330**	1,933,364
Other assets	**2,137,224**	2,413,877
Total assets	**$ 363,434,139**	$ 340,583,026

	September 30	
	2011	**2010**
Liabilities and net assets		
Current liabilities:		
Accounts payable – trade	**$ 10,347,081**	$ 10,342,325
Salaries and wages, payroll taxes and taxes withheld from payroll	**7,383,760**	6,905,328
Other accrued liabilities	**5,957,134**	9,430,440
Employee related obligations	**3,942,900**	3,589,500
Due to third-party reimbursement agencies	**5,023,840**	2,963,415
Current portion of long-term debt	**2,115,360**	2,032,691
Total current liabilities	**34,770,075**	35,263,699
Other liabilities:		
Long-term debt, less current portion	**62,389,713**	64,591,831
Employee related obligations	**69,884,879**	54,383,703
Self-insured professional liability	**14,021,149**	12,395,770
Due to third-party reimbursement agencies	**19,162,526**	12,767,632
Other	**443,183**	349,678
	165,901,450	144,488,614
Net assets:		
Unrestricted	**153,913,943**	149,253,750
Temporarily restricted	**1,399,547**	4,101,543
Permanently restricted	**7,449,124**	7,475,420
Total net assets	**162,762,614**	160,830,713
Total liabilities and net assets	**$ 363,434,139**	$ 340,583,026

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Operations

	Years Ended September 30	
	2011	**2010**
Operating revenues:		
Net patient service revenue	**$ 285,207,565**	$ 282,901,504
Other operating revenue	**4,307,817**	4,357,277
Net assets released from restrictions	**673,194**	91,211
	290,188,576	287,349,992
Operating expenses:		
Salaries, wages and professional fees	**119,644,775**	117,710,320
Payroll taxes and other fringe benefits	**27,854,316**	29,622,058
Supplies, insurance and other	**88,087,439**	94,223,260
Provision for uncollectible accounts	**12,767,930**	14,462,163
Depreciation and amortization	**17,045,582**	17,534,609
Interest	**3,247,715**	3,185,038
	268,647,757	276,737,448
Operating income	**21,540,819**	10,612,544
Nonoperating gains (losses):		
Contributions and donations	**158,300**	328,840
Investment income	**2,445,778**	8,486,755
Other	**(565,873)**	77,066
	2,038,205	8,892,661
Excess of revenues over expenses	**$ 23,579,024**	$ 19,505,205

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Changes in Net Assets

	Total	Unrestricted	Restricted	Permanently Restricted
Net assets, September 30, 2009	$115,085,725	$ 104,776,463	$ 3,447,432	$ 6,861,830
Excess of revenues over expenses	19,505,205	19,505,205		
Contributions	484,695		126,631	358,064
Investment income	739,782		618,691	121,091
Curtailment gain	34,536,288	34,536,288		
Change in pension funding and postretirement obligation	(9,564,206)	(9,564,206)		
Change in net assets held in trust	134,435			134,435
Net assets released from restriction	(91,211)		(91,211)	
Increase in net assets	45,744,988	44,477,287	654,111	613,590
Net assets, September 30, 2010	160,830,713	149,253,750	4,101,543	7,475,420
Excess of revenues over expenses	**23,579,024**	**23,579,024**		
Contributions	**580,427**		**575,427**	**5,000**
Investment (loss) income	**(275,296)**		**(346,369)**	**71,073**
Change in pension funding and postretirement obligation	**(21,176,691)**	**(21,176,691)**		
Change in net assets held in trust	**(102,369)**			**(102,369)**
Net assets released from restriction used for purchase of equipment	**2,257,860**	**2,257,860**		
Net assets released from restriction	**(2,931,054)**		**(2,931,054)**	
Increase (decrease) in net assets	**1,931,901**	**4,660,193**	**(2,701,996)**	**(26,296)**
Net assets, September 30, 2011	**$162,762,614**	**$ 153,913,943**	**$ 1,399,547**	**$ 7,449,124**

See accompanying notes.

Backus Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	Years Ended September 30 2011	2010
Operating activities		
Increase in net assets	**$ 1,931,901**	$ 45,744,988
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	**17,045,582**	17,534,609
Provision for uncollectible accounts	**12,767,930**	14,462,163
Curtailment gain		(34,536,288)
Change in pension funding and postretirement obligation	**21,176,691**	9,564,206
Purchase of investments-board designated, net	**(8,811,993)**	(15,613,572)
Permanently restricted contributions and income	**26,296**	(613,590)
Changes in operating assets and liabilities *(Note 15)*	**(12,851,686)**	(9,310,288)
Net cash provided by operating activities	**31,284,721**	27,232,228
Investing activities		
Purchase of investments-held in trust, net	**(1,089,625)**	(1,917,827)
Net additions to property, plant and equipment	**(7,821,077)**	(12,643,127)
Decrease in other assets	**276,653**	153,108
Net cash used in investing activities	**(8,634,049)**	(14,407,846)
Financing activities		
Proceeds from loan		1,250,000
Principal payments on long-term debt and capital lease obligations	**(2,074,347)**	(1,863,950)
Change in deferred financing costs and amortization of bond premium	**(45,102)**	(49,465)
Permanently restricted contributions and income	**(26,296)**	613,590
Net cash used in financing activities	**(2,145,745)**	(49,825)
Net increase in cash and cash equivalents	**20,504,927**	12,774,557
Cash and cash equivalents at beginning of year	**74,929,624**	62,155,067
Cash and cash equivalents at end of year	**$ 95,434,551**	$ 74,929,624

See accompanying notes.

Backus Corporation and Subsidiaries

Notes to Consolidated Financial Statements

September 30, 2011

1. Significant Accounting Policies

Organization

Backus Corporation (Corporation) is a not-for-profit organization under the Non-Stock Corporation Act of the State of Connecticut. The Corporation provides overall direction and control for The William W. Backus Hospital (the Hospital) and Backus Health Care, Inc. WWB Corporation conducts the related for-profit activities of the Corporation, its sole shareholder. Omni Home Health Services of Eastern Connecticut LLC dba Backus Home Health Services provides continual home care to patients. Backus Physician Services, LLC provides surgical services. The accompanying consolidated statements of operations include the excess (deficiency) of revenue over expenses as the performance indicator. For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operating revenues and expenses; peripheral or incidental transactions are reported as nonoperating items. All intercompany transactions have been eliminated in consolidation. Effective November 1, 2009, the Foundation and Properties were merged into the Hospital. The merger did not impact the consolidated financial statements of the Corporation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Regulatory Matters

The Hospital is required to file annual operating information with the State of Connecticut Department of Public Health, Office of Health Care Access (OHCA).

1. Significant Accounting Policies (continued)

Assets Whose Use Is Limited

The Board of Trustees has designated certain unrestricted funds, including principal and income, for construction and other purposes. The President and Chief Executive Officer of the Hospital may, after consultation with the Chairman, Vice Chairman or the Board of Trustees, use board-designated funds, if required, to meet short-term operating cash requirements. Assets whose use is limited also include assets obtained through a financing arrangement with the State of Connecticut Health and Educational Facilities Authority (the Authority) as more fully explained in Note 8. The portion of those amounts required for funding current liabilities is included in current assets. The carrying amounts reported in the balance sheets are stated at fair value.

Investments

Marketable securities are classified as trading securities. Investments in debt and equity securities, with readily determinable fair values, are reported at fair value based on quoted market prices. Investment income or loss (including realized gains and losses on investments, interest and dividends) and the change in the net unrealized gains and losses are included in the excess of revenue over expense unless the income or loss is restricted by the donor.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

Property, Plant and Equipment

Property, plant and equipment are stated on the basis of cost. The Corporation and its subsidiaries provide for depreciation using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Nonoperating Gains and Losses

Activities other than those in connection with providing health care services are considered to be nonoperating. Nonoperating gains and losses primarily consist of income on invested funds.

1. Significant Accounting Policies (continued)

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are classified as unrestricted contributions in the accompanying consolidated financial statements.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in nonoperating gains and losses. Conditional promises to give are not included as support until the conditions are substantially met.

General and Professional Liability Self-Insurance

The Hospital has adopted the policy of self-insuring the deductible portion of its general and professional liability insurance coverage. The deductible limits are $1,000,000 per claim and $5,000,000 annually for 2011 and $4,000,000 for 2010. Management accrues its best estimate of ultimate losses for both reported claims and claims incurred but not reported.

Excess of Revenues over Expenses

The statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses (the performance indicator), consistent with industry practice, include changes in pension funding and postretirement obligation, pension curtailment gains, both temporarily and permanently restricted donations and investment income and changes in trust arrangements.

1. Significant Accounting Policies (continued)

Cash Equivalents

The Corporation considers all highly liquid time deposits, commercial paper and money market mutual funds purchased with a maturity date at acquisition of three months or less to be cash equivalents.

Income Taxes

The Corporation, the Hospital, and Backus Health Care, Inc. are not-for-profit organizations exempt from federal income taxes on related income under Section 501(c)(3); WWB Corporation is a taxable stock corporation; CONNCare Inc., a subsidiary of Backus Health Care, is a taxable, nonstock corporation. Backus Home Health Services is a partnership taxable to its members and Backus Physician Services, LLC is a taxable, nonstock corporation.

CONNCare, Inc. has a net operating loss carry-forward of $5,755,000. This net operating loss results in a potential deferred tax asset in the amount of approximately $2,300,000. No asset has been recorded as these assets are offset by valuation allowances of the same amounts.

Adoption of New Authoritative Pronouncements

In January 2010, the Financial Accounting Standards Board issued Accounting Standards Update 2010-06, *Improving Disclosures about Fair Value Measurements*, (ASU 2010-06). ASU 2010-06 amended ASC 820 to clarify certain existing fair value disclosures and require a number of additional disclosures. The guidance in ASU 2010-06 clarified that disclosures should be presented separately for each "class" of assets and liabilities measured at fair value and provided guidance on how to determine the appropriate classes of assets and liabilities to be presented. ASU 2010-06 also clarified the requirement for entities to disclose information about both the valuation techniques and inputs used in estimating Level 2 and Level 3 fair value measurements. In addition, ASU 2010-06 introduced new requirements to disclose the amounts (on a gross basis) and reasons for any significant transfers between Levels 1, 2 and 3 of the fair value hierarchy and present information regarding the purchases, sales, issuances and settlements of Level 3 assets and liabilities on a gross basis. With the exception of the requirement to present changes in Level 3 measurements on a gross basis, which will be effective for the Hospital's fiscal 2012, the guidance in ASU 2010-06 became effective for the Hospital's fiscal 2011. The adoption of the provisions of ASU 2010-06 did not impact the Corporation's financial statements.

1. Significant Accounting Policies (continued)

In January 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2010-07, *Not-for-Profit Entities: Mergers and Acquisitions*, (ASU 2010-07), which establishes accounting and disclosure requirements for how a not-for-profit entity determines whether a combination is a merger or an acquisition, how to account for each, and the required disclosures. In addition, ASU 2010-07 included amendments to FASB's Accounting Standards Codification (the Codification, or ASC) Topic 350, *Intangibles – Goodwill and Other*, (ASC Topic 350), and Topic 810, *Consolidation*, (ASC Topic 810) to make both applicable to not-for-profit entities. ASC Topic 350 clarifies the accounting for goodwill and indefinite-lived identifiable intangible assets recognized in a not-for-profit entity's acquisition of a business or nonprofit activity. Such assets are not amortized and are tested for impairment at least annually. The Corporation adopted the guidance relative to ASU 2010-07 as of October 1, 2010.

In August 2010, the FASB issued Accounting Standards Codification ("ASC") 954-605, *Measuring Charity Care for Disclosure*. ASC 954-605 requires that the level of charity care provided be presented based on the direct and indirect costs of the charity services provided. ASC 954-605 also requires separate disclosure of the amount of any cash reimbursements received for providing charity care. ASC 954-605 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Corporation is evaluating the effect of ASC 954-605 on its consolidated financial statements.

In August 2010, the FASB also issued ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*. Under ASU 2010-24, anticipated insurance recoveries and estimated liabilities for medical malpractice claims or similar contingent liabilities will be presented separately on the balance sheet. The guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Corporation is evaluating the effect of ASU 2010-24 on its consolidated financial statements.

In July 2011, FASB issued new guidance, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*. The guidance requires certain health care entities to present the bad debt expense associated with patient service revenue as a deduction from patient service revenue (net of contractual allowances and discounts) rather than as an operating expense. The guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. The Corporation is evaluating the effect of the new guidance on its consolidated financial statements.

1. Significant Accounting Policies (continued)

Reclassifications

Certain reclassifications were made to the 2010 financial statements in order that they may be consistent with the current year presentation.

2. Revenues from Services to Patients and Charity Care

Patient accounts receivable and revenues are recorded when patient services are performed.

Hospital revenue accounted for 95% of net patient service revenue for the years ended September 30, 2011 and 2010. The following summarizes net patient service revenue:

	Year Ended September 30	
	2011	**2010**
Gross patient service revenue	**$ 624,460,853**	$ 604,461,491
Deductions:		
Allowances	**(334,249,153)**	(315,063,365)
Charity care (at charges)	**(5,004,135)**	(6,496,622)
	(339,253,288)	(321,559,987)
Net patient service revenue	**$ 285,207,565**	$ 282,901,504

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Changes in estimates increased net patient service revenue by approximately $2,065,000 in 2011 and had no impact on net patient service revenue for 2010.

2. Revenues from Services to Patients and Charity Care (continued)

Revenues from the Medicare and Medicaid programs accounted for approximately 27.5% and 9.5%, respectively, of the Corporation's net patient service revenue for the year ended September 30, 2011 and 28% and 8% for the year ended September 30, 2010. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations, except as described in Note 10. While no regulatory inquiries are outstanding, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Corporation.

3. Charity Care

The Corporation provides services without charge or at amounts less than its established rates, to patients who meet the criteria of its charity care policy. Because the Corporation does not pursue collection of amounts determined to be charity care, such services are not reported as net revenue. The Corporation's charity care policy utilizes the generally recognized poverty income levels for the state. For patients who do not apply or do not qualify, the uncollected amounts are recognized as bad debt expense.

Together, charity care and bad debt expense represent uncompensated care. The following summarizes uncompensated care:

	At Charge	Estimated Cost
Charity care	**$ 5,004,135**	**$ 2,201,819**
Bad debt	**12,767,930**	**5,617,889**
Total uncompensated care, September 30, 2011	**$ 17,772,065**	**$ 7,819,708**
Charity care	$ 6,496,622	$ 2,858,514
Bad debt	14,462,163	6,363,352
Total uncompensated care, September 30, 2010	$ 20,958,785	$ 9,221,866

Estimated cost is based on the ratio of cost to charges, as determined by Hospital-specific data.

4. Promises to Give

Included in pledges receivable at September 30 are the following unconditional promises to give:

	2011	2010
BackusCare campaign	$ 45,546	$ 185,114
Other	57,077	7,077
Unconditional promises to give before unamortized discount	102,623	192,191
Less unamortized discount and allowance	(1,412)	(6,325)
	$ 101,211	$ 185,866
Amounts due in:		
Less than one year	$ 96,211	$ 133,366
One to five years	5,000	52,500
Total	$ 101,211	$ 185,866

5. Investments

Investment income and gains (losses) are comprised of the following for the years ended September 30, 2011 and 2010:

	Year Ended September 30	
	2011	2010
Realized and unrealized (losses) gains on investments	$(1,163,661)	$ 4,574,175
Interest and dividend income	1,962,447	1,819,741
Investment in joint ventures	1,860,953	2,262,006
Other investment losses	12,600	11,600
Investment fees	(226,561)	(180,767)
	$ 2,445,778	$ 8,486,755

5. Investments (continued)

The market value of assets whose use is limited at September 30, is set forth in the following table:

	2011	2010
Board designated:		
Cash and cash equivalents	**$ 41,525,574**	$ 33,837,100
Mutual funds	**37,251,516**	38,540,722
Common stocks	**12,925,056**	13,327,371
Government bonds	**12,811,596**	8,462,882
Corporate bonds	**924,660**	2,458,334
	$105,438,402	$ 96,626,409
Held by trustee:		
Cash and cash equivalents	**$ 24,668,758**	$ 4,430,958
Mutual funds	**2,327,261**	22,211,515
Government bonds	**731,506**	
Common stock	**292,470**	287,581
Real estate	**58,432**	58,748
	$ 28,078,427	$ 26,988,802

The Uniform Prudent Management of Institutional Funds Act (UPMIFA) provides guidance on investment decisions and endowment expenditures for nonprofit organizations. The Board of Trustees of the Hospital has interpreted UPMIFA as requiring the preservation of the fair value of the original gift as the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Hospital classifies as permanently restricted net assets (a) the original value of the gifts donated to the permanent endowment, (b) the original value of the subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure.

5. Investments (continued)

The primary objective of the endowment fund is to provide long-term support for the Hospital's capital and operating programs. The Corporation's investment goals are to maximize total return (capital appreciation, dividends and interest) while also protecting the Corporation's inflation-adjusted value over time. The Corporation's assets are diversified across multiple asset classes (e.g., common stocks, bonds and cash) to achieve an optimal balance between risk and return and between current income and capital appreciation. The investment program is structured to offer reasonably high probability of generating a real return of 5% per year over a period of five to ten years to protect the real inflation-adjusted value of assets and to meet the spending requirements. The investment committee reviews investment policies annually to determine if changes need to be made due to changing market conditions or other factors.

Management evaluates endowment spending in light of capital replacement and expansion plans. The spending policy does not apply a prescribed rate of spending in a given year, but does consider the following factors in making determinations to appropriate or accumulate donor restricted endowment funds:

(1) The duration and preservation of the fund.
(2) The purposes of the donor-restricted endowment fund.
(3) General economic conditions.
(4) The possible effect of inflation and deflation.
(5) The expected total return from income and the appreciation of investments.
(6) Other resources of the Hospital.
(7) The investment policies of the Hospital.

Endowment assets are donor-restricted gifts which are meant to provide a permanent source of income to the Corporation and are included in permanently restricted net assets. Any deficits are funded with available temporarily restricted or unrestricted funds so as to maintain the corpus. Subsequent positive market returns replace the deficits.

5. Investments (continued)

The activity for the year ended September 30, 2011 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 513,486	$ 5,320,786	$ 5,834,272
Investment return:			
Investment income		151,536	151,536
Net depreciation (realized and unrealized)		(176,945)	(176,945)
Earnings reclassified	(96,482)	96,482	
Total investment (loss) return	(96,482)	71,073	(25,409)
Contributions		5,000	5,000
Endowment net assets at end of year	$ 417,004	$ 5,396,859	$ 5,813,863

The activity for the year ended September 30, 2010 is as follows:

	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 135,215	$ 4,841,631	$ 4,976,846
Investment return:			
Investment income		179,170	179,170
Net appreciation (realized and unrealized)		320,192	320,192
Earnings reclassified	378,271	(378,271)	
Total investment return	378,271	121,091	499,362
Contributions		358,064	358,064
Endowment net assets at end of year	$ 513,486	$ 5,320,786	$ 5,834,272

6. Fair Value of Financial Instruments

For assets and liabilities required to be measured at fair value, the Corporation measures fair value based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are applied based on the unit of account from the Corporation's perspective. The unit of account determines what is being measured by reference to the level at which the asset or liability is aggregated (or disaggregated) for purposes of applying other accounting pronouncements.

6. Fair Value of Financial Instruments (continued)

The Corporation follows a valuation hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad categories. Level one inputs are quoted market prices in active markets that are accessible at the measurement date. Level two inputs are observable, but not quoted in active markets. Level three inputs are unobservable and are used when little or no market data is available.

Fair value for Level 2 assets are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers. Level 3 assets consist of asset backed and mortgage backed obligations held by the defined benefit plan which are priced using model-based valuations using market information that best represents the value at which the security could be sold.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Corporation uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

6. Fair Value of Financial Instruments (continued)

Financial assets as of September 30, 2011 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 98,239,968	$ 852,014		$ 99,091,982
Certificates of deposit		24,901,139		24,901,139
Money market funds	37,571,306	64,456		37,635,762
US government obligations (a)	10,833,829	2,709,273		13,543,102
Corporate bonds (b)	249,858	674,802		924,660
Equity securities	13,217,526			13,217,526
Mutual funds-equities (c)	8,773,825	9,707,473		18,481,298
Mutual funds-international equities (d)	8,140,798	219,147		8,359,945
Mutual funds-fixed income (e)	12,062,082	675,452		12,737,534
Real estate (REIT)		58,432		58,432
Total	$ 189,089,192	$ 39,862,188	–	$ 228,951,380

(a) Includes both Treasury bonds and Treasury stripped bonds.
(b) Includes both foreign and domestic corporate bonds.
(c) This category primarily represents investments in common stock or similar securities of high-quality, financially secure companies listed on principal exchanges.
(d) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(e) This category seeks maximum current income primarily thorough investments in fixed income securities of varying maturities.

Financial assets as of September 30, 2010 are classified in the table below:

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 77,955,100	$ 2,738		$ 77,957,838
Certificates of deposit		14,873,395		14,873,395
Money market funds	19,578,731	35,017		19,613,748
US government obligations	7,751,442			7,751,442
Corporate bonds	150,001	3,772,474		3,922,475
Equity securities	13,614,952			13,614,952
Mutual funds	44,289,715	16,462,519		60,752,234
Real estate (REIT)		58,751		58,751
Total	$ 163,339,941	$ 35,204,894	–	$ 198,544,835

6. Fair Value of Financial Instruments (continued)

The following table presents the Corporation's fair value hierarchy for defined benefit plan assets as of September 30, 2011. At September 30, 2011, Level 3 assets comprise approximately 0.2% of the Corporation Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 10,173,248			$ 10,173,248
Mutual funds-equity (a)	23,965,541	$ 25,514,446		49,479,987
Mutual funds-international equity(b)	22,103,407			22,103,407
Mutual funds-fixed income (c)	9,739,453	38,850		9,778,303
US Government obligations(d)	6,277,919	319,903		6,597,822
Corporate bonds (e)		9,553,768		9,553,768
Mortgage backed obligations		7,777,727	$180,660	7,958,387
Total	$ 72,259,568	$ 43,204,694	$ 180,660	$ 115,644,922

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily through investment in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2010 to September 30, 2011.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ 250,065	$ 88,920	$ 338,985
Purchases		99,500	99,500
Unrealized gains (losses)	716	(7,760)	(7,044)
Sales	(250,781)		(250,781)
Total	$ –	$ 180,660	$ 180,660

6. Fair Value of Financial Instruments (continued)

The following table presents the Corporation's fair value hierarchy for defined benefit plan assets as of September 30, 2010. At September 30, 2010, Level 3 assets comprise approximately 0.3% of the Corporation Plan's total investment portfolio fair value.

	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents	$ 6,692,388			$ 6,692,388
Mutual funds-equity (a)		$ 35,874,257		35,874,257
Mutual funds-international equity(b)	24,860,967			24,860,967
Mutual funds-fixed income (c)	24,136,988			24,136,988
US Government obligations(d)	18,403,319			18,403,319
Asset backed obligations		542,186	$ 250,065	792,251
Corporate bonds (e)		1,738,845		1,738,845
Mortgage backed obligations		1,615,755	88,920	1,704,675
Total	$ 74,093,662	$ 39,771,043	$ 338,985	$ 114,203,690

(a) This category primarily represents investments in common stocks or similar securities of high-quality, financially secure companies listed on principal exchanges.
(b) This category seeks long term growth of capital with at least 80% of its investments in international equity securities.
(c) This category seeks maximum current income primarily through investments in fixed income securities of varying maturities.
(d) Includes both Treasury bonds and Treasury stripped bonds.
(e) Includes both foreign and domestic corporate bonds.

The following table presents reconciliation for all Level 3 assets measured at fair value for the period October 1, 2009 to September 30, 2010.

	Asset Backed Obligations	Mortgage Backed Obligations	Total
Beginning balance	$ –	$ –	$ –
Purchases	249,998	85,975	335,973
Unrealized gains	67	2,945	3,012
Total	$ 250,065	$ 88,920	$ 338,985

6. Fair Value of Financial Instruments (continued)

The carrying amount of certain of the Corporation's financial instruments, including cash and cash equivalents, approximate fair value due to the relatively short maturities of such instruments. Fair values of investments are based on quoted market prices and are recorded on the balance sheets as such. Fair value of the long-term debt is estimated using discounted cash flow analysis which is based on the AAA insured bond rate at the Corporation's fiscal year end. The fair value of long-term debt is $70,878,867 and $69,437,056 at September 30, 2011 and 2010, respectively.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2011	2010
Health care services	**$ 789,466**	$ 499,200
Preventative care	**193,861**	792,377
Extraordinary nursing care	**105,444**	109,852
Nursing education	**87,446**	84,912
Laboratory	**8,522**	228,659
Free beds	**8,066**	25,821
Capital projects		1,733,950
Other	**206,742**	626,772
	$ 1,399,547	$ 4,101,543

Permanently restricted net assets at September 30 are restricted to the following:

	2011	2010
Income to be used:		
For general purposes	**$ 6,605,539**	$ 6,631,835
To provide free beds	**527,060**	527,060
For laboratory	**258,182**	258,182
To provide extraordinary nursing care	**48,203**	48,203
For nursing education	**10,140**	10,140
	$ 7,449,124	$ 7,475,420

8. Long-term Debt

A summary of long-term debt at September 30 is as follows:

	2011	2010
Tax-exempt Hospital Revenue Bonds:		
Series E, serial maturities ($565,000) to 2012 with an interest rate of 4.80%, term maturities ($7,515,000) from 2017 to 2022 at an interest rate of 5.00%	**$ 8,080,000**	$ 8,625,000
Series F, serial maturities ($5,875,000) from 2012 to 2018, with interest rates of 4.00% to 4.25%, term maturities ($22,125,000) from 2023 to 2035 with interest rates of 5.00% to 5.25%	**28,000,000**	28,725,000
Series G, serial maturities ($17,730,000) from 2012 to 2026 with interest rates of 3.50% to 5.00%, term maturities ($7,420,000) in 2035 at an interest rate of 5.00%	**25,150,000**	25,775,000
Other long-term debt:		
Mortgage, maturing May 1,2025 with a fixed rate of 6.125%	**1,183,176**	1,236,586
Obligation under capital leases	**1,379,926**	1,505,864
	63,793,102	65,867,450
Add net unamortized bond premium	**711,971**	757,072
Less current portion	**(2,115,360)**	(2,032,691)
Long-term debt	**$ 62,389,713**	$ 64,591,831

The Master Indenture, as amended and supplemented by Supplemental Master Indenture No. 4, provides for, among other things, a pledge of the gross receipts, as defined, of the Hospital, restriction on the incurrence of certain indebtedness of the Hospital and covenants regarding the Hospital's debt service coverage ratios, sale and lease of assets and other covenants similar in financings of this type. The bonds are secured by the real property of the Hospital, including all buildings and equipment. The mortgages are secured by a warehouse and by certain leasehold improvements. Pursuant to the loan agreements, the Hospital is obligated to provide amounts which will be sufficient to enable the Authority to pay the principle and interest on the Series E, Series F, and Series G bonds.

8. Long-term Debt (continued)

Series E bonds are subject to redemption prior to maturity. Series F bonds are subject to optional redemption prior to maturity. Series G bonds maturing after July 1, 2015, are subject to optional redemption prior to maturity.

Future minimum principal payments on long-term debt and future minimum principal payments and interest on capital leases during each of the next five fiscal years and in the aggregate are as follows:

	Long-Term Debt	Capital Leases
2012	$ 2,021,619	$ 361,204
2013	2,105,440	361,204
2014	2,184,302	361,204
2015	2,303,411	336,859
2016	2,387,624	263,904
Aggregate thereafter	51,410,780	2,111,232
	62,413,176	3,795,607
Add net unamortized bond premium	711,971	
Less interest		(2,415,681)
	$ 63,125,147	$ 1,379,926

The Corporation paid interest of $3,312,005 and $3,323,608 in 2011 and 2010, respectively. Interest incurred in 2011 and 2010 was $3,247,715 and $3,185,038, respectively.

In 2010 the Corporation entered into a fixed rate commercial mortgage of $1,250,000 for a period of fifteen years at a rate of 6.125%. The note is secured by real property located at 11 Stott Avenue, Norwich, CT.

In 2010 the Corporation also entered into a five year capital lease of $458,781 with an interest rate of 5.9% for a building located at 80 Route 32, Montville, CT, to be used for patient services. The outstanding balance on this capital lease at September 30, 2011 was $326,520. Under the terms of the lease, the Hospital has the option to renew for five periods of five years each.

Deferred financing costs are amortized over the life of the bonds.

9. Retirement Benefit Plans

Effective January 1, 2010, the Corporation amended its defined benefit pension plan to close the plan to new participants and to freeze accruals for the existing participants in favor of a defined contribution plan. The change in the defined benefit plan resulted in a curtailment gain and a reduction of long-term liabilities of $34,536,288.

The defined contribution plan covers substantially all of the employees of the Hospital. Under the provisions of the plan, the Corporation will make non-elective contributions to the plan on behalf of each eligible employee in the amount of 3% of the employee's eligible earnings. The Corporation will also make a non-elective transition contribution equal to 3% for all employees who meet the transition participant criteria. The Corporation may also, at the discretion of the Board of Trustees, make an elective matching contribution at the end of the plan year based on the Hospital's financial performance. The cost recorded for the years ended September 30, 2011 and 2010 was $5,206,397 and $3,589,500, respectively.

The Corporation also provides noncontributory postretirement health care benefits to eligible retirees and to eligible spouses of retirees who retired prior to January 1, 1994. Subsequent to 1993, covered retirees contribute a percentage of the cost based on years of service. In addition, the Hospital sponsors a nonqualified pension benefit program. Included in other long-term liabilities at September 30, 2011 and 2010 is approximately $2,600,000, related to the future obligation for the nonqualified benefits.

Included in unrestricted net assets at September 30 are the following amounts that have not yet been recognized in net periodic benefit cost:

	Pension Benefits		Postretirement Benefits	
	2011	**2010**	**2011**	**2010**
	(In Thousands)			
Unrecognized actuarial (loss) gain	**$ (64,522)**	$ (43,157)	**$ 1,600**	$ 1,734
Unrecognized transition obligation			**(565)**	(889)
	$ (64,522)	$ (43,157)	**$ 1,035**	$ 845

The actuarial loss and transition obligation included in unrestricted net assets and expected to be recognized in net periodic benefit cost during the year ending September 30, 2011 are $4,557,386 and $323,491, respectively.

9. Retirement Benefit Plans (continued)

At September 30, 2010, the unfunded status of the pension plan is included in long-term liabilities in the amount of $44,062,536. The unfunded status of the postretirement benefits is $4,266,082, with $452,466 included in short-term liabilities, and the remainder of $3,813,616 included in long-term liabilities. At September 30, 2011, the unfunded status of the pension plan is included in long-term liabilities in the amount of $60,301,776. The unfunded status of the postretirement benefits is $4,083,669, with $435,510 included in short-term liabilities, and the remainder of $3,648,159 included in long-term liabilities

The following table sets forth the funded status of the plans as of the measurement date of September 30, 2011 and 2010.

	Pension Benefits		Postretirement Benefits	
	2011	**2010**	**2011**	**2010**
		(In Thousands)		
Change in benefit obligations				
Benefit obligations at beginning of year	**$ (158,266)**	$ (171,831)	**$ (4,266)**	$ (4,969)
Service cost		(1,836)	**(4)**	(15)
Interest cost	**(7,963)**	(7,684)	**(207)**	(267)
Change in assumptions	**(12,536)**	(11,951)	**(147)**	387
Actuarial (loss) gain	**(2,006)**	(3,598)	**113**	154
Effect of curtailment		34,551		
Benefits paid	**4,825**	4,083	**428**	444
Benefit obligations at end of year	**$ (175,946)**	$ (158,266)	**$ (4,083)**	$ (4,266)
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 114,203**	$ 100,145		
Actual return on plan assets	**(1,834)**	10,017		
Contributions	**8,100**	8,124	**$ 428**	$ 444
Benefits paid	**(4,825)**	(4,083)	**(428)**	(444)
Fair value of plan assets at end of year	**$ 115,644**	$ 114,203	**$**	$
Underfunded status				
Accrued benefit liability recognized in the balance sheets	**$ (60,302)**	$ (44,063)	**$ (4,083)**	$ (4,266)
Components of net periodic benefit cost				
Service cost		$ 1,836	**$ 4**	$ 15
Interest cost	**$ 7,963**	7,684	**207**	267
Expected return on plan assets	**(7,832)**	(6,901)		
Net amortization and deferral	**2,843**	1,964	**224**	269
Net periodic benefit cost	**$ 2,974**	$ 4,583	**$ 435**	$ 551

9. Retirement Benefit Plans (continued)

	Pension Benefits		Postretirement Benefits	
	2011	**2010**	**2011**	**2010**
	(In Thousands)			
Assumptions:				
Weighted-average assumptions used to determine benefit obligations:				
Discount rate	**4.60%**	5.10%	**4.60%**	5.10%
Rate of compensation increase				
Weighted-average assumptions used to determine net periodic benefit cost:				
Discount rate	**5.10**	5.60	**5.10**	5.60
Expected long-term rate of return on plan assets	**6.75**	6.75		

The accumulated benefit obligation at September 30, 2011 and 2010 was $175,946,699 and $158,266,226, respectively.

The asset allocation for the retirement plan at the end of 2011 and 2010 and the target allocation by asset category are as follows:

	Target Allocation		Percentage of Plan Assets	
Asset Category	**Minimum**	**Maximum**	**2011**	**2010**
US Equity Large Cap	20%	50%	**34%**	31%
US Equity Small Cap		15	**5**	5
International Equity	10	30	**15**	17
Core Fixed Income	20	60	**46**	47
Total			**100%**	100%

The Corporation Plan's investment policy includes target asset allocations percentages as shown above. The investment objective for the Corporation Plan is to produce a total rate of return (net of fees) that meets or exceeds the actuarial return assumption used for funding purposes, while generally striving to minimize significant variations in annual contribution levels through investment diversification. Investment return assumptions are developed through a multi-step process using external economic research including industry surveys and published economic research combined with internal economic scenario analysis, historical market returns and correlation trends.

9. Retirement Benefit Plans (continued)

Information about the expected cash flows for both plans is as follows:

	Pension Benefits	Postretirement Benefits
Expected employer contributions for 2012	$ 8,100,000	$ 435,510
Estimated future benefit payments:		
2012	5,621,240	435,510
2013	6,120,026	423,489
2014	6,721,770	414,800
2015	7,280,102	392,976
2016	7,768,999	370,874
2017-2021	47,330,022	1,533,884

Assumed healthcare cost trend rates for 2011 are as follows:

Health care trend rate assumed for next year	7.50%
Rate to which the cost rate trend rate is assumed to decline (the ultimate trend rate)	5.00%
Year that the rate reaches the ultimate trend rate	2015

A one-percentage-point change in assumed health care cost trend rates would have the following effects on the postretirement benefit plan:

	One-Percentage-Point Increase	Decrease
	(In thousands)	
Effect on total of service and interest cost components	$ 1	$ (1)
Effect on postretirement benefit obligation	$ 6	$ (5)

10. Contingencies

There have been malpractice claims that fall within the Corporation's partially self-insured program (see Note 1, Organization and Accounting Policies) which have been asserted against the Corporation. In addition, there are known incidents that have occurred through September 30, 2011, that may result in the assertion of claims. Corporation management, in conjunction with its consulting actuaries, has accrued its best estimate of these contingent losses.

10. Contingencies (continued)

The Corporation's management believes that it may not have conformed to all applicable laws and regulations regarding certain arrangements with outside parties. An internal investigation is underway and management has estimated and accrued a liability related to this matter. Except for this matter, the Corporation's management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of any potential wrongdoing.

The Corporation is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Corporation's financial position.

11. Property, Plant and Equipment

Property, plant and equipment at September 30 consist of the following:

	2011	2010
Land and land improvements	**$ 4,862,121**	$ 4,889,512
Buildings and leasehold improvements	**126,459,709**	125,739,952
Equipment	**99,035,255**	101,463,454
Construction in process (2012 estimated cost to complete $5,995,000)	**1,365,773**	630,806
Less accumulated depreciation	**(141,087,085)**	(132,954,480)
	$ 90,635,773	$ 99,769,244

The net unamortized value of internally developed software was $388,314 and $968,970 at September 30, 2011 and 2010, respectively. Amortization expense for the years ended September 30, 2011 and 2010 was $596,429 and $591,171, respectively.

The Corporation wrote off approximately $7,299,000 of fully depreciated assets in 2011.

The Corporation leases space to be used for patient services. Two years remain on the initial term, with two five-year renewal options available at the discretion of the Hospital. Rent expense for the years ended September 30, 2011 and 2010 was $655,574 and $640,018, respectively.

The Corporation leases various types of equipment with annual payments ranging from $103 to $39,000. Expenses as a result of these leases were approximately $362,000 and $375,000 for the years ended September 30, 2011 and 2010, respectively.

11. Property, Plant and Equipment (continued)

Future minimum lease payments under the above leases during each of the next five years were as follows:

2012	$ 907,327
2013	831,624
2014	173,838
2015	118,349
2016	11,378
	$ 2,042,516

12. Other Operating Revenues

Other operating revenues consist of the following:

	Year Ended September 30	
	2011	**2010**
Cafeteria sales	**$ 1,102,713**	$ 1,063,020
Rental income	**698,837**	812,182
Miscellaneous	**687,972**	455,498
Grants	**578,977**	733,844
Condominium income	**412,106**	389,640
Child care	**391,976**	355,497
Purchase discounts	**269,594**	351,343
Interest	**165,642**	196,253
	$ 4,307,817	$ 4,357,277

13. Functional Expenses

The Hospital provides inpatient medical and surgical, outpatient, psychiatric and emergency care services to residents of eastern Connecticut. Expenses related to providing these services are as follows:

	Year Ended September 30	
	2011	**2010**
Health care services	**$ 212,969,557**	$ 224,821,690
General and administrative	**55,484,277**	51,724,893
Fundraising	**193,923**	190,865
	$ 268,647,757	$ 276,737,448

14. Concentrations of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. For 2011 and 2010, Hospital receivables accounted for 95% and 96%, respectively. The mix of gross accounts receivables from patients and third-party payors at September 30 is as follows:

	2011	**2010**
Medicare	**26%**	27%
Self pay	**23**	24
Health Maintenance Organizations	**16**	15
Anthem Blue Cross/Blue Shield	**14**	13
Medicaid	**11**	11
Commercial	**5**	5
Other state agencies	**5**	5
	100%	100%

15. Cash Flows

Changes in operating assets and liabilities at September 30 include the following:

	2011	2010
(Increase) decrease in assets:		
Accounts receivable	**$ (14,649,048)**	$ (8,976,789)
Pledge receivable	**84,655**	348,127
Inventories of supplies, prepaid expenses, and other	**(149,263)**	(798,102)
Increase (decrease) in liabilities:		
Due to third-party reimbursement agencies	**8,455,319**	3,113,028
Accounts payable	**4,756**	(201,185)
Employee related obligations	**(5,322,115)**	(1,497,412)
Interest payable and other accrued liabilities	**(3,473,306)**	1,143,850
Salaries and wages, payroll taxes, and taxes withheld from payroll	**478,432**	(2,049,900)
Self-insured professional liability	**1,625,379**	(66,430)
Other liabilities	**93,505**	(325,475)
Changes in operating assets and liabilities	**$ (12,851,686)**	$ (9,310,288)

16. Subsequent Events

The Hospital evaluates the impact of subsequent events, which are events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date for the year ended September 30, 2011. The Hospital evaluated subsequent events through January 27, 2012, which is the date the financial statements were issued. No events occurred that require disclosure or adjustment to the combined financial statements.

Other Financial Information

Ernst & Young LLP
Goodwin Square
225 Asylum Street
Hartford, CT 06103-1506
Tel: +1 860 247 3100
Fax: +1 860 725 6040
www.ey.com

Report of Independent Auditors on Other Financial Information

Board of Directors
Backus Corporation and Subsidiaries

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Ernst & Young LLP

January 27, 2012

A member firm of Ernst & Young Global Limited

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 83,986	$ 93,136,217	$ 1,681,599	$ 532,749		$ 95,434,551
Assets whose use is limited – required for current liabilities		5,885,482				5,885,482
Accounts receivable, less allowance for uncollectible accounts		32,373,122	1,040,962	1,013,929		34,428,013
Pledges receivable		101,211				101,211
Inventories of supplies		3,704,067				3,704,067
Prepaid expenses and other		1,624,606		9,535		1,634,141
Due from affiliates	98,496	164,147			$ (262,643)	
Total current assets	182,482	136,988,852	2,722,561	1,556,213	(262,643)	141,187,465
Assets whose use is limited:						
Board-designated and donor restricted		105,438,402				105,438,402
Held by trustee		28,078,427				28,078,427
Total assets whose use is limited		133,516,829				133,516,829
Less assets whose use is limited – required for current liabilities		5,885,482				5,885,482
		127,631,347				127,631,347
Property, plant, and equipment, net		89,983,664	162,224	489,885		90,635,773
Deferred financing costs		1,842,330				1,842,330
Other assets	1,000	1,542,292	512,931	97,846	(16,845)	2,137,224
	$ 183,482	$ 357,988,485	$ 3,397,716	$ 2,143,944	$ (279,488)	$ 363,434,139

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable-trade		$ 9,918,459	$ 26,928	$ 401,694		$ 10,347,081
Salaries and wages, payroll taxes and taxes withheld from payroll		6,666,138	394,468	323,154		7,383,760
Due to affiliates			226,021	36,622	$ (262,643)	
Other accrued liabilities		5,734,285	777	222,072		5,957,134
Employee related obligations		3,942,900				3,942,900
Due to third-party reimbursement agencies		4,683,178		340,662		5,023,840
Current portion of long-term debt		2,115,360				2,115,360
Total current liabilities		33,060,320	648,194	1,324,204	(262,643)	34,770,075
Other liabilities:						
Long-term debt, less current portion		62,389,713				62,389,713
Employee related obligations		69,884,879				69,884,879
Self-insured professional liability		10,853,762	3,167,387			14,021,149
Due to third-party reimbursement agencies		19,162,526				19,162,526
Other		443,183				443,183
		162,734,063	3,167,387			165,901,450
Net assets:						
Common stock				1,000	(1,000)	
Unrestricted	183,482	153,345,431	(417,865)	818,740	(15,845)	153,913,943
Temporarily restricted		1,399,547				1,399,547
Permanently restricted		7,449,124				7,449,124
Total net assets	183,482	162,194,102	(417,865)	819,740	(16,845)	162,762,614
Total liabilities and net assets	$ 183,482	$ 357,988,485	$ 3,397,716	$ 2,143,944	$ (279,488)	$ 363,434,139

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:						
Net patient service revenue		$ 271,933,218	$ 5,513,552	$ 7,769,219	$ (8,424)	$ 285,207,565
Other operating revenue	$ 55,920	4,848,198	95,365	1,815	(693,481)	4,307,817
Net assets released from restrictions		673,194				673,194
	55,920	277,454,610	5,608,917	7,771,034	(701,905)	290,188,576
Operating expenses:						
Salaries, wages and professional fees	186,263	110,169,857	4,542,201	4,746,454		119,644,775
Payroll taxes and other fringe benefits	58,738	25,655,346	890,706	1,249,526		27,854,316
Supplies, insurance and other	3	83,918,758	3,326,153	1,544,430	(701,905)	88,087,439
Provision for uncollectible accounts		12,522,978	102,603	142,349		12,767,930
Depreciation and amortization		16,971,187	34,004	40,391		17,045,582
Interest		3,247,715				3,247,715
	245,004	252,485,841	8,895,667	7,723,150	(701,905)	268,647,757
Operating (loss) income	(189,084)	24,968,769	(3,286,750)	47,884		21,540,819
Nonoperating gains and (losses):						
Contributions and donations		158,300				158,300
Investment income	95	581,947	1,803,031	60,705		2,445,778
Other		(565,873)				(565,873)
	95	174,374	1,803,031	60,705		2,038,205
Excess (deficiency) of revenues over expenses	$ (188,989)	$ 25,143,143	$ (1,483,719)	$ 108,589		$ 23,579,024

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2011

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:						
Excess (deficiency) of revenues over expenses (continued)	$ (188,989)	$ 25,143,143	$ (1,483,719)	$ 108,589		$ 23,579,024
Change in pension funding obligation		(21,176,691)				(21,176,691)
Intercompany transfer	245,005	(245,005)				
Assets released from restriction used for purchase of equipment		2,257,860				2,257,860
Increase (decrease) in unrestricted net assets	56,016	5,979,307	(1,483,719)	108,589		4,660,193
Temporarily restricted net assets:						
Contributions		575,427				575,427
Income from investments		(346,369)				(346,369)
Net assets released from restrictions		(2,931,054)				(2,931,054)
Decrease in temporarily restricted net assets		(2,701,996)				(2,701,996)
Permanently restricted net assets						
Contributions		5,000				5,000
Income from investments		71,073				71,073
Change in net assets held in trust		(102,369)				(102,369)
Decrease in permanently restricted net assets		(26,296)				(26,296)
Increase (decrease)in net assets	56,016	3,251,015	(1,483,719)	108,589		1,931,901
Net assets at beginning of year	127,466	158,943,087	1,065,854	711,151	$ (16,845)	160,830,713
Net assets (deficit) at end of year	$ 183,482	$ 162,194,102	$ (417,865)	$ 819,740	$ (16,845)	$ 162,762,614

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2011

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,469	$ 1,654,736	$ 15,394		$ 1,681,599
Accounts receivable, less allowance for uncollectible accounts		424,360	616,602		1,040,962
Due from affiliates	98,496	3,091,170		$ (3,189,666)	
Total current assets	109,965	5,170,266	631,996	(3,189,666)	2,722,561
Property, plant and equipment:					
Buildings and leasehold improvements		19,619			19,619
Equipment		295,006	61,648		356,654
Accumulated depreciation		(176,106)	(37,943)		(214,049)
		138,519	23,705		162,224
Other assets		512,931			512,931
	$ 109,965	$ 5,821,716	$ 655,701	$ (3,189,666)	$ 3,397,716
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 22,003	$ 4,925		$ 26,928
Salaries and wages, payroll taxes and taxes withheld from payroll		228,385	166,083		394,468
Other accrued liabilities			777		777
Self-insured professional liability		1,161,387	2,006,000		3,167,387
Due to affiliates	$ 108,925	215,592	3,091,170	(3,189,666)	226,021
Total current liabilities	108,925	1,627,367	5,268,955	(3,189,666)	3,815,581
Net assets (deficit)	1,040	4,194,349	(4,613,254)		(417,865)
Total liabilities and net assets	$ 109,965	$ 5,821,716	$ 655,701	$ (3,189,666)	$ 3,397,716

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2011

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,077,468	$ 2,436,084		$ 5,513,552
Other operating revenue	$ 36,936	90,102	5,263	$ (36,936)	95,365
Total revenues	36,936	3,167,570	2,441,347	(36,936)	5,608,917
Expenses:					
Salaries and wages		2,168,572	2,373,629		4,542,201
Payroll taxes and fringe benefits		560,111	330,595		890,706
Supplies and other	41,405	1,158,068	2,163,616	(36,936)	3,326,153
Provision for uncollectible accounts		56,527	46,076		102,603
Depreciation and amortization		23,879	10,125		34,004
Total expenses	41,405	3,967,157	4,924,041	(36,936)	8,895,667
Operating loss	(4,469)	(799,587)	(2,482,694)		(3,286,750)
Nonoperating gains:					
Investment income	6	1,803,017	8		1,803,031
(Deficiency) excess of revenue over expenses	(4,463)	1,003,430	(2,482,686)		(1,483,719)
Net assets (deficit) at beginning of year	5,503	3,190,919	(2,130,568)		1,065,854
Net assets (deficit) at end of year	$ 1,040	$ 4,194,349	$ (4,613,254)	$	$ (417,865)

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2011

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 345,033	$ 187,716		$ 532,749
Accounts receivable, less allowance for uncollectible accounts		1,013,929		1,013,929
Prepaid expenses and other		9,535		9,535
Due from affiliates	789,464		$ (789,464)	
Total current assets	1,134,497	1,211,180	(789,464)	1,556,213
Property, plant and equipment:				
Buildings and leasehold improvements		455,405		455,405
Equipment		121,313		121,313
Accumulated depreciation		(86,833)		(86,833)
		489,885		489,885
Other assets	97,846			97,846
	$ 1,232,343	$ 1,701,065	$ (789,464)	$ 2,143,944
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 401,694		$ 401,694
Salaries and wages, payroll taxes and taxes withheld from payroll		323,154		323,154
Other accrued liabilities		222,072		222,072
Due to third party reimbursement agencies		340,662		340,662
Due to affiliates	$ 36,622	789,464	$ (789,464)	36,622
Total current liabilities	36,622	2,077,046	(789,464)	1,324,204
Common stock	1,000			1,000
Retained earnings (deficit)	1,194,721	(375,981)		818,740
Total liabilities and net assets	$ 1,232,343	$ 1,701,065	$ (789,464)	$ 2,143,944

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2011

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,769,219		$ 7,769,219
Other operating revenue		1,815		1,815
Total revenues		7,771,034		7,771,034
Expenses:				
Salaries and wages		4,746,454		4,746,454
Payroll taxes and fringe benefits		1,249,526		1,249,526
Supplies and other	$ 33,989	1,510,441		1,544,430
Provision for uncollectible accounts		142,349		142,349
Depreciation and amortization		40,391		40,391
Total expenses	33,989	7,689,161		7,723,150
Operating (loss) income	(33,989)	81,873		47,884
Nonoperating gains:				
Investment income	60,686	19		60,705
Excess of revenue over expenses	26,697	81,892		108,589
Net assets (deficit) at beginning of year	1,168,024	(457,873)		710,151
Net assets (deficit) at end of year	$ 1,194,721	$ (375,981)	$	$ 818,740

Backus Corporation and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Assets						
Current assets:						
Cash and cash equivalents	$ 63,324	$ 72,131,779	$ 1,612,700	$ 1,121,821		$ 74,929,624
Assets whose use is limited – required for current liabilities		7,931,590				7,931,590
Accounts receivable, less allowance for uncollectible accounts		30,758,941	838,941	949,013		32,546,895
Pledges receivable		185,866				185,866
Inventories of supplies		3,799,896	85,421			3,885,317
Prepaid expenses and other		1,277,144	20,282	6,202		1,303,628
Due from affiliates	63,142	661,088			$ (724,230)	
Total current assets	126,466	116,746,304	2,557,344	2,077,036	(724,230)	120,782,920
Assets whose use is limited:						
Board-designated and donor restricted		96,626,409				96,626,409
Held by trustee		26,988,802				26,988,802
Total assets whose use is limited		123,615,211				123,615,211
Less assets whose use is limited – required for current liabilities		7,931,590				7,931,590
		115,683,621				115,683,621
Property, plant, and equipment, net		99,122,387	145,235	501,622		99,769,244
Deferred financing costs		1,933,364				1,933,364
Other assets	1,000	1,603,864	782,197	43,661	(16,845)	2,413,877
	$ 127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Balance Sheet (continued)

September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Health Care, Inc.	WWB Corp.	Eliminations	Consolidated
Liabilities and net assets						
Current liabilities:						
Accounts payable-trade		$ 10,129,146	$ 25,228	$ 187,951		$ 10,342,325
Salaries and wages, payroll taxes and taxes withheld from payroll		6,206,054	309,223	390,051		6,905,328
Due to affiliates			203,033	521,197	$ (724,230)	
Other accrued liabilities		8,967,664		462,776		9,430,440
Employee related obligations		3,589,500				3,589,500
Due to third-party reimbursement agencies		2,614,222		349,193		2,963,415
Current portion of long-term debt		2,032,691				2,032,691
Total current liabilities		33,539,277	537,484	1,911,168	(724,230)	35,263,699
Other liabilities:						
Long-term debt, less current portion		64,591,831				64,591,831
Employee related obligations		54,383,703				54,383,703
Self-insured professional liability		10,514,332	1,881,438			12,395,770
Due to third-party reimbursement agencies		12,767,632				12,767,632
Other		349,678				349,678
		142,607,176	1,881,438			144,488,614
Net assets:						
Common stock				1,000	(1,000)	
Unrestricted	$ 127,466	147,366,124	1,065,854	710,151	(15,845)	149,253,750
Temporarily restricted		4,101,543				4,101,543
Permanently restricted		7,475,420				7,475,420
Total net assets	127,466	158,943,087	1,065,854	711,151	(16,845)	160,830,713
Total liabilities and net assets	$ 127,466	$ 335,089,540	$ 3,484,776	$ 2,622,319	$ (741,075)	$ 340,583,026

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Operating revenues:								
Net patient service revenue		$ 270,048,715		$ 5,497,679		$ 7,378,559	$ (23,449)	$ 282,901,504
Other operating revenue	$ 593,530	4,673,356		87,120		6,752	(1,003,481)	4,357,277
Net assets released from restrictions		91,211						91,211
	593,530	274,813,282		5,584,799		7,385,311	(1,026,930)	287,349,992
Operating expenses:								
Salaries, wages and professional fees	174,812	109,179,026		4,740,065		4,148,270	(531,853)	117,710,320
Payroll taxes and other fringe benefits	55,510	27,181,443		978,613		1,406,492		29,622,058
Supplies, insurance and other	25,447	91,056,415		1,716,164		1,920,311	(495,077)	94,223,260
Provision for uncollectible accounts		14,409,876		(11,974)		64,261		14,462,163
Depreciation and amortization		17,480,126		27,483		27,000		17,534,609
Interest		3,185,038						3,185,038
	255,769	262,491,924		7,450,351		7,566,334	(1,026,930)	276,737,448
Operating income (loss)	337,761	12,321,358		(1,865,552)		(181,023)		10,612,544
Nonoperating gains and (losses):								
Contributions and donations		328,840						328,840
Investment income	77	6,218,347		2,213,811		54,520		8,486,755
Other		(116,761)		197,389		(3,562)		77,066
	77	6,430,426		2,411,200		50,958		8,892,661
Excess (deficiency) of revenues over expenses	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205

* Includes Backus Condominium Association

Backus Corporation and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)

Year Ended September 30, 2010

	Backus Corp.	William W. Backus Hospital *(consolidated)	Backus Foundation	Backus Health Care, Inc.	Backus Properties Inc.	WWB Corp.	Eliminations	Consolidated
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses (continued)	$ 337,838	$ 18,751,784		$ 545,648		$ (130,065)		$ 19,505,205
Merger of Properties		1,402,938			$ (1,402,938)			
Intercompany transfer		(73,056)		73,056				
Pension curtailment		34,536,288						34,536,288
Change in pension funding obligation		(9,564,206)						(9,564,206)
Increase (decrease) in unrestricted net assets	337,838	45,053,748		618,704	(1,402,938)	(130,065)		44,477,287
Temporarily restricted net assets:								
Contributions		126,631						126,631
Income from investments		618,691						618,691
Merger of Foundation			$ (34,308,847)				34,308,847	
Net assets released from restrictions		(91,211)						(91,211)
Increase (decrease) in temporarily restricted net assets		654,111	(34,308,847)				34,308,847	654,111
Permanently restricted net assets								
Contributions		358,064						358,064
Income from investments		121,091						121,091
Merger of Foundation			(6,838,627)				6,838,627	
Change in net assets held in trust		134,435						134,435
Increase (decrease) in permanently restricted net assets		613,590	(6,838,627)				6,838,627	613,590
Increase (decrease)in net assets	337,838	46,321,449	(41,147,474)	618,704	(1,402,938)	(130,065)	41,147,474	45,744,988
Net assets (deficit) at beginning of year	(210,372)	112,621,638	41,147,474	447,150	1,402,938	841,216	(41,164,319)	115,085,725
Net assets at end of year	$ 127,466	$ 158,943,087	$	$ 1,065,854	$	$ 711,151	$ (16,845)	$ 160,830,713

* Includes Backus Condominium Association

Backus Health Care, Inc., and Subsidiaries

Consolidating Balance Sheet

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Assets					
Current assets:					
Cash and cash equivalents	$ 11,463	$ 1,228,148	$ 373,089		$ 1,612,700
Accounts receivable, less allowance for uncollectible accounts		369,242	469,699		838,941
Inventories of supplies		85,421			85,421
Prepaid expenses		9,376	10,906		20,282
Due from affiliates	61,560	2,340,589		$ (2,402,149)	
Total current assets	73,023	4,032,776	853,694	(2,402,149)	2,557,344
Property, plant and equipment:					
Buildings and leasehold improvements		19,619			19,619
Equipment		244,681	61,648		306,329
Accumulated depreciation		(152,895)	(27,818)		(180,713)
		111,405	33,830		145,235
Other assets		782,197			782,197
	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776
Liabilities and net assets					
Current liabilities:					
Accounts payable – trade		$ 10,233	$ 14,995		$ 25,228
Salaries and wages, payroll taxes and taxes withheld from payroll		246,716	62,507		309,223
Self-insured professional liability		1,281,437	600,001		1,881,438
Due to affiliates	$ 67,520	197,073	2,340,589	$ (2,402,149)	203,033
Total current liabilities	67,520	1,735,459	3,018,092	(2,402,149)	2,418,922
Net assets (deficit)	5,503	3,190,919	(2,130,568)		1,065,854
Total liabilities and net assets	$ 73,023	$ 4,926,378	$ 887,524	$ (2,402,149)	$ 3,484,776

Backus Health Care, Inc., and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	Backus Health Care, Inc. (Parent)	CONNCare	BPS, LLC	Eliminations	Backus Health Care, Inc., and Subsidiaries
Operating revenues:					
Net patient service revenue		$ 3,608,723	$ 1,888,956		$ 5,497,679
Other operating revenue	$ 36,936	68,042	19,078	$ (36,936)	87,120
Total revenues	36,936	3,676,765	1,908,034	(36,936)	5,584,799
Expenses:					
Salaries and wages		2,634,018	2,106,047		4,740,065
Payroll taxes and fringe benefits		719,574	259,039		978,613
Supplies and other	39,186	714,272	999,642	(36,936)	1,716,164
Provision for uncollectible accounts		(69,754)	57,780		(11,974)
Depreciation and amortization		14,905	12,578		27,483
Total expenses	39,186	4,013,015	3,435,086	(36,936)	7,450,351
Operating loss	(2,250)	(336,250)	(1,527,052)		(1,865,552)
Nonoperating gains:					
Investment income	6	2,213,805			2,213,811
Other		197,389			197,389
(Deficiency) excess of revenue over expenses	(2,244)	2,074,944	(1,527,052)		545,648
Net assets (deficit) at beginning of year	7,747	1,044,627	(605,224)		447,150
Intercompany transfer		71,348	1,708		73,056
Net assets (deficit) at end of year	$ 5,503	$ 3,190,919	$ (2,130,568)	$	$ 1,065,854

WWB, Inc., and Subsidiary

Consolidating Balance Sheet

September 30, 2010

	WWB (Parent)	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Assets				
Current assets:				
Cash and cash equivalents	$ 1,087,166	$ 34,655		$ 1,121,821
Accounts receivable, less allowance for uncollectible accounts		949,013		949,013
Prepaid expenses and other		6,202		6,202
Due from affiliates	563,194		$ (563,194)	
Total current assets	1,650,360	989,870	(563,194)	2,077,036
Property, plant and equipment:				
Buildings and leasehold improvements		445,975		445,975
Equipment		102,089		102,089
Accumulated depreciation		(46,442)		(46,442)
		501,622		501,622
Other assets	39,861	3,800		43,661
	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319
Liabilities and net assets				
Current liabilities:				
Accounts payable		$ 187,951		$ 187,951
Salaries and wages, payroll taxes and taxes withheld from payroll		390,051		390,051
Other accrued liabilities		462,776		462,776
Due to third party reimbursement agencies		349,193		349,193
Due to affiliates	$ 521,197	563,194	$ (563,194)	521,197
Total current liabilities	521,197	1,953,165	(563,194)	1,911,168
Common stock	1,000			1,000
Retained earnings (deficit)	1,168,024	(457,873)		710,151
Total liabilities and net assets	$ 1,690,221	$ 1,495,292	$ (563,194)	$ 2,622,319

WWB, Inc., and Subsidiary

Consolidating Statement of Operations and Changes in Net Assets

September 30, 2010

	WWB	Backus Home Health Care	Eliminations	WWB, Inc., and Subsidiary
Operating revenues:				
Net patient service revenue		$ 7,378,559		$ 7,378,559
Other operating revenue		6,752		6,752
Total revenues		7,385,311		7,385,311
Expenses:				
Salaries and wages		4,148,270		4,148,270
Payroll taxes and fringe benefits		1,406,492		1,406,492
Supplies and other	$ 67,510	1,852,801		1,920,311
Provision for uncollectible accounts		64,261		64,261
Depreciation and amortization		27,000		27,000
Total expenses	67,510	7,498,824		7,566,334
Operating (loss) income	(67,510)	(113,513)		(181,023)
Nonoperating gains:				
Investment income	53,219	1,301		54,520
Other		(3,562)		(3,562)
Excess of revenue over expenses	(14,291)	(115,774)		(130,065)
Net assets (deficit) at beginning of year	1,182,315	(342,099)		840,216
Net assets (deficit) at end of year	$ 1,168,024	$ (457,873)	$	$ 710,151

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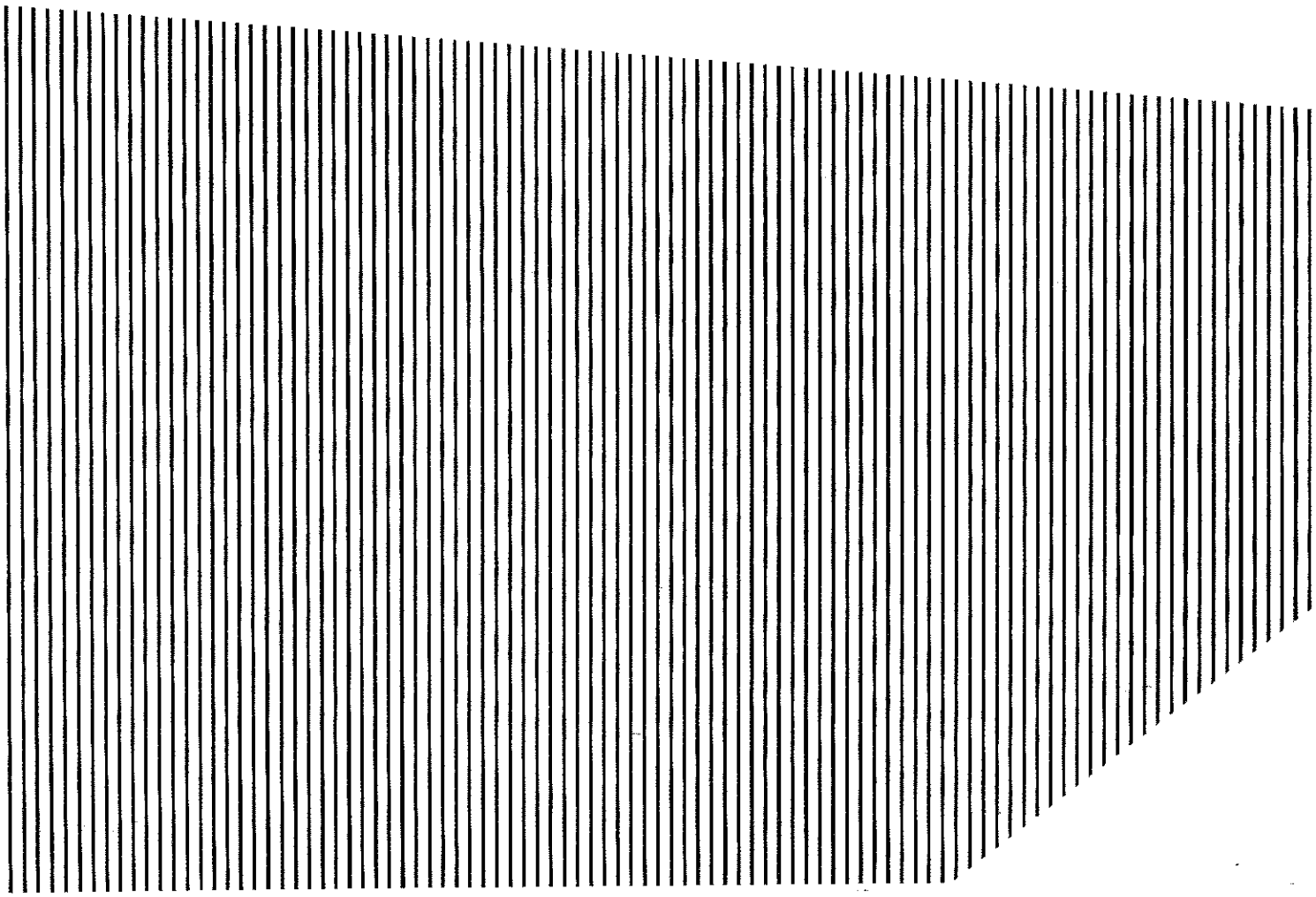
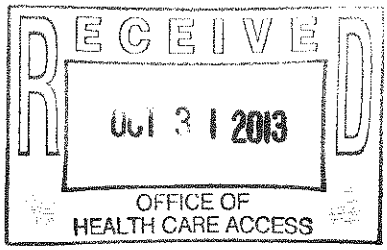


Hartford HealthCare



October 31, 2013

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
Division of the Department of Public Health
410 Capital Avenue, MS#13HCA
Hartford, CT 06106

Re: Hartford HealthCare Corporation and Backus Corporation Affiliation
DN 12-31788-CON
Final Agreed Settlement – Regulatory Reporting Requirements

Dear Ms. Martone:

The Office of Health Care Access approved the affiliation of Hartford HealthCare Corporation and Backus Corporation through an Agreed Settlement approved on July 19, 2013. Stipulation number 5 in the Order states that the Applicants agree to submit a detailed and comprehensive document showing the plan to integrate the operations of both parent corporations to the hospital and attain the cost savings stated within the CON Application.

Hartford HealthCare and Backus Corporation have formed an Integration Committee which is responsible for the developing and implementing the integration plan for this affiliation. The Committee has developed a four-phase approach as follows:

Phase 1- Conduct a formal assessment of the resources, needs strengths and weaknesses of both Hartford HealthCare and Backus Corporation.

Phase 2 – Develop prioritized list of areas that require focus during the first year including financing, access to advanced technologies, access to primary care, physician recruitment, Quality Improvement, employee satisfaction, operating efficiencies, clinical coordination, information systems and sharing management talent.

Phase 3 – Develop action plans to implement integration efforts and realize the benefits of the affiliation.

Phase 4 – Develop process for quarterly reporting on the progress of the integration plan to executive leadership of Hartford HealthCare and Backus Corporation.

Hartford HealthCare and Backus Corporation are currently drafting the detailed action plans necessary to implement the integration plan. It is therefore necessary to respectfully request a 120 day extension of the filing date for the detailed implementation plan agreed to in Stipulation number five of the Order.

Please feel free to contact me directly if you have any questions regarding the need for the extension for this filing.

Sincerely,

Barbara A. Durdy
Director, Strategic Planning

SN: bd

One State Street Suite 19 Hartford, CT 06103 *tel* 860.263.4100 *fax* 860.263.4115 www.hartfordhealthcare.org

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

November 1, 2013

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare Corporation
One State Street
Suite 19
Hartford, CT 06103

Re: Docket Number 13-31788-MDF: A Request to Modify Docket Number 12-31788-CON
Hartford HealthCare Corporation and Backus Corporation Affiliation
Request to Modify Condition 5 of the Order under Docket No.: 12-31788-CON

Dear Ms. Durdy:

On October 31, 2013, the Office of Health Care Access ("OHCA") received a request from Hartford HealthCare Corporation and Backus Corporation ("Applicants") to modify the Certificate of Need ("CON") issued under Docket No.: 12-31788-CON, which authorized the affiliation between the Applicants. The Applicants request a modification of Condition 5 of the Order under the Agreed Settlement for a 120 day extension of the filing date for the detailed implementation plan.

In accordance with Connecticut General Statutes § 4-181a(b), OHCA hereby modifies Conditon 5 of the Order under Docket No.: 12-31788-CON as follows:

5. The Applicants agree to submit to OHCA, no later than February 28, 2014, a detailed and comprehensive document showing the plan to integrate the operations of both parent corporations to the hospital and attain the cost savings stated within the CON Application. At a minimum, the submission shall address anticipated cost savings, staffing and quality improvements, and affiliation-related revenue enhancements. Subsequent to the submission of the plan, HHC and Backus Hospital shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the Order, semi-annual periods are October 1 – March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31, 2014, November 30, 2014, May 31, 2015, November 30, 2015, May 31, 2016, and November 30, 2016, HHC and Backus Corporation shall submit the following on a semi-annual basis:

Connecticut Department of Public Health
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

a. HHC agrees to file narrative updates on the progress of the implementation of the plan.

b. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, the William W. Backus Hospital, for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, the William W. Backus Hospital. The format shall be consistent with HRS Reports 350/150, or successor reports.

d. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, the William W. Backus Hospital. The format shall be consistent with HRS Reports 300/100, or successor reports.

If you have any questions regarding this action, please contact Paolo Fiducia, Associate Health Care Analyst at (860) 418-7035.

Sincerely,

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

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

FAX SHEET

TO: BARBARA DURDY

FAX: 860 972-4650

AGENCY: HARTFORD HEALTHCARE CORPORATION

FROM: OHCA

DATE: 11/5/13 **Time:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:

Modification request for DN: 12-31788 for Condition 5
Hartford HealthCare and Backus Coporation Affiliation

PLEASE PHONE Barbara K. Olejarz 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

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

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

FAX SHEET

TO: BARBARA DURDY

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DATE: 11/5/13 Time:

NUMBER OF PAGES: 3
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Comments:

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Hartford Health Care and Backus Coporation Affiliation

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION

Hartford HealthCare

February 27, 2014

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Docket #12-31788-CON
Affiliation of Backus Corporation with Hartford HealthCare Corporation
Agreed Settlement- Stipulation #5 Reporting

Dear Ms. Martone:
In response to the reporting requirements of Stipulation #5 of the Agreed Settlement in the above-referenced matter, Hartford HealthCare Corporation and Backus Corporation provide the attached plan to integrate the operations of Backus Corporation, Backus Hospital and Hartford HealthCare ("HHC"). Also included is a summary of the anticipated financial savings to be achieved in fiscal years 2014 and 2015 through the implementation of this plan.
This plan which outlines the proposed initiatives to be undertaken to achieve this operational integration is in accordance with the HHC Integration Playbook (Exhibit #3) referenced in the CON application.

Please contact me if you have any questions or require further information.

Sincerely,

Barbara A. Durdy
Director, Strategic Planning
Hartford HealthCare

One State Street Suite 19 Hartford, CT 06103 *tel* 860.263.4100 *fax* 860.263.4115 www.hartfordhealthcare.org

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

As of January 31, 2014

	CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
1	Administrative	$3,668,839	$5,591,353	$9,260,192
2	Clinical Integration	$0	$0	$0
3	Clinical	$130,000	$130,000	$260,000
4	Finance	$809,000	$509,000	$1,318,000
5	Human Resources	$527,000	$527,000	$1,054,000
6	Information Technology	$0	$0	$0
7	Supply Chain	$2,137,474	$2,137,474	$4,274,948
8	Other Operations	$0	$0	$0
9	Total Savings Identified	$7,272,312	$8,894,827	$16,167,140
10	Target Savings from CON	$11,039,000	$15,036,000	$26,075,000
11	Variance from Target	($3,766,688)	($6,141,173)	($9,907,860)

	ANNUAL	Fiscal Year 14	Fiscal Year 15	Total
1	Administrative	$3,668,839	$1,922,515	$5,591,353
2	Clinical Integration	$0	$0	$0
3	Clinical	$130,000	$0	$130,000
4	Finance	$809,000	($300,000)	$509,000
5	Human Resources	$527,000	$0	$527,000
6	Information Technology	$0	$0	$0
7	Supply Chain	$2,137,474	$0	$2,137,474
8	Other Operations	$0	$0	$0
9	Total Savings Identified	$7,272,312	$1,622,515	$8,894,827
10	Target Savings from CON	$11,039,000	$3,997,000	$15,036,000
11	Variance from Target	($3,766,688)	($2,374,485)	($6,141,173)

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
ADM01	Administration	Creation of HHC Eastern Region
ADM02	Administration	East Region Shared Services Organization

INT01	Clinical Integration	Integrate Backus employed physicians into HHCMG
INT02	Clinical Integration	Align Backus recruitment efforts and Medical Staff Development Plan with HHC
INT03	Clinical Integration	Integrate independent and employed primary care practices into ICP shared savings - provide assessment
INT04	Clinical Integration	Involve Backus physicians in Integrated Care Partners Governance
INT05	Clinical Integration	Include Backus in Care Coordination Planning at HHC

CL02	Clinical	Backus included in Quality Council
CL03	Clinical	Develop a plan to integrate IRB and research activities at WWBH under the HHC structure
CL05	Clinical	Backus Physician Infrastructure (Primary Care)
CL06	Clinical	Backus Included in Physician Infrastructure
CL07	Clinical	Backus included in ACO planning
CL10	Clinical	Sharing Technology - capital planning process (over $1M)
CL12	Clinical	Sharing Technology - sharing HH simulation lab

		Short project description
CL13	Clinical	Sharing Technology - 3 to 5 year strategic plan (radiology/imaging/robotics)
CL14	Clinical	Curative wound care program
CL16	Clinical	Backus incorporated in Community Connect / E.H.R. support
CL17	Clinical	Backus included in (16) clinical councils
CL18	Clinical	Include Backus in HHC Common Credentialing Platform (Complete assessment)
CL19	Clinical	Dialysis program evaluation
CL21	Clinical	Evaluate WWBH utilizing CLP as primary reference lab
CL22	Clinical	Evaluate WWBH utilizing CLP/Quest reference lab contract
CL23	Clinical	Medical Library Services
CL24	Clinical	Include Backus in Universal Flu Immunization Program
CL25	Clinical	Risk Management Education
CL26	Clinical	Implement best practices from each facility to lower direct, variable cost of care for highest opportunity DRG

FIN01	Finance	Fair Value Accounting
FIN02	Finance	Legal Structure
FIN03	Finance	Audits - Financial

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
FIN04	Finance	General Accounting / Financial Reporting
FIN05	Finance	Sponsored Programs / Grant Accounting
FIN06	Finance	Financial Systems
FIN07	Finance	Government Reimbursement
FIN08	Finance	Tax Returns and Reporting
FIN09	Finance	Budget
FIN10	Finance	Decision Support
FIN11	Finance	Treasury
FIN12	Finance	Pension Issues - Treasury
FIN13	Finance	Risk Management/Insurance
FIN14	Finance	Other Finance Items
FIN15	Finance	Payroll
FIN16	Treasury	Electronic payment (AMEX)
FIN17	Treasury	Investment management
FIN18	RevCycle	Centralize and consolidate revenue cycle business office

		Short project description
HR03	Human Resources	Conduct employee benefits review and timeline to adopt model plan designs for health, dental, time off and other ancillary benefits
HR04	Human Resources	Incorporate Backus Hospital and physicians into Tier 1 network and HHC into Backus' network as applicable
HR05	Human Resources	Adopt standard HHC PTO provisions including designated holidays
HR06	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (e.g. Aetna TPA, Delta Dental, reinsurance)
HR07	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (e.g. Life, AD&D, disability)
HR08	Human Resources	Integrate into Captive for purposes of health plan reinsurance (Medical Stop Loss)
HR09	Human Resources	Integrate into Aon Hewitt Benefits Eligibility TPA
HR10	Human Resources	Integrate into Prudential Single DC Record-keeper
HR11	Human Resources	Integrate into Prudential Leave TPA
HR12	Human Resources	Introduce Healthy Together, premium credits and cost sharing strategy
HR13	Human Resources	Upgrade to Kronos 6.3
HR14	Human Resources	Review and adopt standard HHC HR P&Ps and workstreams driving PeopleSoft build and HR Future State Transformation
HR17	Human Resources	Review other HR policies and processes to identify best practices and adopt throughout HHC (e.g., Travel)
HR18	Human Resources	Integrate and participate in HHC Human Resources Future State Centralized Services and/or Centers of Expertise
HR20	Human Resources	Introduce HHC Core Values & Making A Difference Training
HR21	Human Resources	Introduce H3W Leadership Behaviors

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
HR22	Human Resources	Consolidate contingent labor vendors and implement ShiftWise
HR23	Human Resources	Adopt HHC Transfer Policy and Single Employer Guidelines
HR24	Human Resources	Participate in HHC Administrative Fiduciary for retirement plans
HR26	Human Resources	Include Backus MDs in HHC Physician Leadership Institute
HR28	Human Resources	Scale occupational/employee health support services and related processes
HR29	Human Resources	Participate in the HHC Pulse engagement survey in Fall 2013
HR30	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (Vision 2014 - all others 2015 Project HR07)

IT01	Information Technology	Develop plans for 2nd HHC Data Center (assessment complete)
IT02	Information Technology	Email Integration (all employees by 3/3/14)
IT04	Information Technology	Consolidation/inventory of ITS contracts and applications
IT05	Information Technology	ICD-10 Project Management
IT06	Information Technology	Launch HHC SharePoint application for Backus

SC01	Supply Chain	Transition GPO relationship from Amerinet to GNYHA
SC02	Supply Chain	Align contracts and standardize supplies & services: Phase I - Private supply contracts (HHC/Backus same supplier)

		Short project description
SC03	Supply Chain	Align contracts and standardize supplies & services: Phase II - Private supply contracts requiring product conversions
SC04	Supply Chain	Secure HHC system pricing for Press Ganey/Moorehead/Advisory Board

ST01	Strategy	Implement communication plan
ST02	Strategy	Eastern Region ambulatory strategy (Current Opportunities)

OT02	Other Operations	VNA (Business and Human Resource components)
OT03	Other Operations	HHC Rehabilitation Network opportunities
OT04	Other Operations	Long-term care
OT05	Other Operations	Clinical Lab Partners - additional integration efforts
OT06	Other Operations	Biomedical Services - Assessment
OT07	Other Operations	Facilities: Utilities expense
OT08	Other Operations	Legal - review system-wide resources and use of external legal firms
OT09	Other Operations	Pharmacy opportunities (non-labor)
OT10	Other Operations	Pharmacy - integrate and utilized clinical pharmacy experience & physcian support

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
GOV01	Governance / Legal	Board Resolution - Investment Committee
GOV02	Governance / Legal	Board Resolution - Fiduciary
GOV03	Governance / Legal	Board Resolution - Pension Trustee
GOV04	Governance / Legal	HHC Board Committee Appointments
GOV05	Governance / Legal	CON: file full non-redacted final affiliation agreement
GOV06	Governance / Legal	CON: Submit detailed and comprehensive integration document
GOV07	Governance / Legal	CON: Semi-annual reporting by HHC & Backus regarding integration plan (GOV06)
GOV08	Governance / Legal	CON: Submit high level summary of Eastern CT Region Strategic Plan
GOV09	Governance / Legal	CON: File detailed benefits / cost savings report (2 years - 26 Required Items)
GOV10	Governance / Legal	CON: Final Accounting all benefits and cost savings

Huber, Jack

From:	Martone, Kim
Sent:	Monday, June 02, 2014 8:07 AM
To:	Roberts, Karen; Huber, Jack
Cc:	Greer, Leslie; Olejarz, Barbara
Subject:	FW: Affiliation Agreement CON - Order Responses - DN 12-31788-CON
Attachments:	Condition 3 High Level Summary of Strategic Plan 5.30.14 FINAL.pdf; Condition 5 Semi Annual Filing 5.30.14 FINAL.pdf

---

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Friday, May 30, 2014 4:12 PM
To: Martone, Kim
Cc: Whitehead, David; Goyette, Karen T.; Chaty, Beth; Hertkorn, Butch
Subject: Affiliation Agreement CON - Order Responses - DN 12-31788-CON

HELD SEPARATELY
see next page for explanation

Ms. Martone,

Please find attached the responses to the reporting requirements as stated in Conditions 3 and 5 of the Agreed Settlement for the Affiliation of Backus Corporation with Hartford HeathCare Corporation, DN 12-31788-CON.

Please don't hesitate to contact me with questions.

Thanks,

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Note to File: This document is exempt from public disclosure.

Applicants:	Hartford HealthCare Corporation and Backus Corporation
Proposal:	Backus Corporation's Affiliation with Hartford HealthCare Corporation
Docket:	12-31788-CON

On July 19, 2013, the Office of Health Care Access, Hartford HealthCare Corporation (HHC) and Backus Corporation (BC) stipulated and agreed to the terms of settlement with respect to the Applicants' request to establish a corporate affiliation. Stipulation #3 of the agreed settlement is worded as follows:

> "Within 60 days of completion of the Eastern Connecticut Region Strategic Plan, the Applicants shall submit a high-level summary description of said plan to OHCA.....Once such summary description of said plan is submitted to OHCA, such document shall be considered by OHCA as a trade secret and therefore, exempt from disclosure pursuant to the Connecticut General Statutes Section 1-210."

On May 30, 2014, the Applicants filed the following document, indicating that it was the Eastern Connecticut Region Strategic Plan (ECRS) Plan. This document is to remain outside of the docket's record.

May 30, 2014

RECEIVED
MAY 30 2014
Office of
HEALTHCARE ACCESS

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, please find attached a comprehensive integration document as requested in Condition 5.

This document provides OHCA information on the plan to integrate the operations of both parent corporations to the hospital, the information on anticipated cost savings stated in the CON Application, and other affiliation related revenue enhancements.

Please contact me if you require further information, at 860-425-3872.

Sincerely,

Janette E. Edwards

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

Acknowledging the need to drive and regularly monitor the integration activities between the William W. Backus Hospital ("Backus" or "Backus Hospital") and Hartford HealthCare ("HHC") an Integration Steering Committee ("Steering Committee" or "Committee") was formed. The Steering Committee meets on a regularly scheduled, monthly basis, and membership includes Executive Leadership of both Backus Hospital and HHC.

In these meetings, leadership discusses, plans, implements, and monitors the integration and alignment of the two organizations across the following areas:

- *Administration*
- *Clinical*
- *Financial*
- *Human Resources*
- *Information Technology ("IT")*
- *Supply Chain*
- *Strategy*
- *Governance/Legal*

Since August 1, 2013 (the effective date of the Affiliation agreement between Backus and HHC), the Steering Committee has identified 99 projects that are all in various stages of implementation. Some projects have been completed, some are in-process, and some have not yet been started. The Steering Committee involves Subject Matter Experts ("SME") from across the HHC organization when expertise is required for successful planning and implementation of key strategies. Examples of such SMEs that are included in discussions are leadership from Senior Care, the Visiting Nurses Association, and Clinical Lab Partners.

First and foremost of these projects was the creation of the HHC Eastern Region, and the subsequent East Region Shared Service Organization. The HHC Eastern Region includes both Backus and Windham Hospital ("Windham") and all of their affiliated entities. Such entities include CONNCare, Inc. and Backus Physician Services ("BPS").

By creating the Eastern Region, HHC gained efficiencies that are a direct result of achieving economies of scale and eliminating redundant processes. The creation of the region

resulted in a reorganization of staff and management, which included identifying a shared Executive Leadership Team between Backus and Windham. Key members of the Regional Executive Team are also employees of the system, with direct reporting relationships to HHC Executive System Leadership. The regional Vice President of Physician Affairs moved to the position of President of the HHC Medical Group ("HHC MG"), and the regional Chief Administrative Officer moved to become the system's Vice President of Marketing and Branding. These staffing transitions directly place regional talent in leadership positions at the system level, ensuring the region remains closely tied to the goals of the larger system.

This reorganization also created a Regional Leadership Team. Similar to the Regional Executive Leadership Team, the Regional Leadership Team is comprised of Directors, Managers, and Supervisors who have dual responsibilities for both Hospital campuses, and across entities. Another result of this reorganization was the centralizing of services, such as marketing, communications, human resources, and IT to the system level.

In addition to reorganizing and integrating the Executive and Leadership teams, the Committee has taken steps to integrate the Medical Staff into the larger system. The employed providers working within CONNCare and BPS joined HHC's Integrated Care Partners ("ICP"). The move into ICP will allow BPS and CONNCare providers to participate in ICP's Medicare Shared Savings program, and implement ICP's evidence-based protocols into their daily practice. Such integration also provides ICP with data for analysis and trending to determine the impact the developed best practices have on population health. Further, Backus has been included in care coordination planning efforts at the system level; ensuring regional clinical and administrative leaders are providing insight and direction to the system as a whole.

There is an ongoing effort to enroll private providers within ICP, more fully aligning the region's private providers with the system. Both employed and private physicians from the region will have opportunities to participate in ICP's governance, giving regional clinical leaders the chance to directly impact the direction and future of the organization. Backus physicians have also been included in the HHC Physician Leadership Institute.

In the near-term, Backus providers employed by CONNCare and BPS will become part of HHC MG). This step will bring these providers and their practices fully under the management, contracting, and leadership of HHC MG, while remaining tied to the East Region. Additionally, physician recruitment efforts and the Medical Staff Development Plan at Backus are becoming more aligned with HHC's system-wide plans.

Since the effective date of the affiliation, Backus leaders have been included in the HHC Quality Council, and eighteen other Clinical Councils. The purpose of these Councils is to promote excellence in clinical care, foster professional development to identify best practices in specific specialties and to achieve the highest level of excellence. The Councils will identify potential gaps, variations in practice, and integrate common practices and standardization for optimal outcomes.

These Councils cover major service lines such as surgery, obstetrics, behavioral health quality, and neurosurgery, in addition to perioperative services, emergency medicine, hospital medicine, anesthesiology, infection prevention, radiology, pharmacy and therapeutics, patient experience, robotic surgery, and pathology. In addition to these Clinical Councils, Backus participates in four HHC Cancer Disease Management Teams ("DMT"). These DMTs function as the Clinical Councils in the Cancer arena. The DMTs focus on Breast Cancer, Genitourinary Cancer, Thoracic Cancer, and Gynecologic Oncology.

The process of financially integrating Backus into the system is also underway. The integration of Fair Value Accounting is complete, and Backus is now part of the system's Risk Management and Insurance processes; Backus is also being integrated into the system's legal structure, financial audits, general accounting, and other financial systems.

Multiple Human Resources initiatives are planned and in progress, in addition to the recent regional reorganization. Examples of some of these initiatives include consolidating and gaining volume pricing for health and welfare vendors such as Aetna TPA, Delta Dental, Life, AD&D, disability, and reinsurance. The process of incorporating Backus and affiliated physicians into the HHC Tier One network, and HHC providers into the Backus network (as applicable) has been completed. Further, a review of employee benefits was conducted, and a

timeline to adopt model plan designs for health, dental, time off and other ancillary benefits has been developed.

The Leadership Development Program, "How Hartford HealthCare Works" ("H3W") has been introduced to the Executive Leadership and Regional Leadership Teams, and trainings will be rolled out to staff over the summer months. H3W not only sets expectations for leadership behavior, but also introduces and ingrains the HHC culture within the region. This step will further solidify Backus as part of a larger health care delivery system.

With patient safety as the top line priority, Backus is on the path of becoming a "Highly Reliable Organization" ("HRO"). Over the course of the last year, Backus trained every employee on HRO safety concepts. At Backus, HRO concepts are not viewed simply as tools to reduce patient harm, but as the culture, and delivery ideology, of health care. In an HRO environment, the patient's wellbeing is at the center of every decision. HRO education is now taking place at Windham, with the goal of 100% employee participation in training sessions. To date, 90% of the Medical Staff at Windham has been trained in HRO concepts, in addition to 55% of employees. Implementing the HRO concepts at Windham, like H3W, introduces the Backus culture to Windham, and refocuses all employees on achieving one common goal: the elimination of patient harm.

To reduce redundancy within the system and gain economies of scale where able, a consolidation and inventory of IT contracts and applications is on track. IT leadership within the region is working closely with system IT leaders to streamline services at Backus and Windham. This effort includes ICD-10 project management, email integration, and other clinical IT requirements. Backus has been incorporated in the CareConnect/E.H.R. support, included in the shared technology capital planning process, and a three to five year strategic plan focusing on radiology and imaging technology.

Many integration efforts have been completed within the existing supply chain at Backus. There has been a transition of Backus' GPO (Group Purchasing Organization) relationship with Amerinet to The Greater New York Hospital Association,, and private supply contracts have been aligned and standardized. Going forward, Backus and HHC will utilize the same

suppliers, realizing further cost savings, and reducing variability. In the future, private supply contracts requiring product conversions will also be standardized. Backus secured HHC system pricing for consulting, benchmarking, and other advisory services, which not only achieves cost savings but also provides Backus with enhanced access to industry thought leaders and best-practices.

Revenue enhancements are found within the 99 initiatives delineated by the Steering Committee, and discussed previously. Many of these initiatives focus on business development. These include additional integration efforts with Clinical Laboratory Partners, a biomedical services assessment, a review of system-wide resources, non-labor pharmacy opportunities, and rehabilitation network opportunities. Further revenue enhancements will be found through centralizing and consolidating the revenue cycle business office, the Institutional Review Boards, centralizing investment management, and government reimbursements.

Finally, the HHC Eastern Region's strategic plan has been developed and recommended for adoption by the Backus Board of Directors, and endorsed by the HHC Board of Directors. This comprehensive strategic plan sets overall direction and strategic imperatives for the region, which align with the system's overarching vision for the future.

In summary, the affiliation created efficiencies in staffing models, quality improvements across eighteen distinct Clinical Councils, and cost savings through economies of scales gained through the creation of a larger system of care. Although much progress has been made to integrate Backus into HHC, more will be done. The Steering Committee is closely monitoring the progress made on each of the identified initiatives, and is subsequently adding new initiatives regularly. The East Region is well on track to becoming fully integrated as a HHC partner.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Attachment 1 for detailed savings totals by major category.

a. **Salaries & Wages**

b. **Fringe Benefits**

c. **Contractual Labor Fees**

d. **Medical Supplies & Pharmaceutical Costs**

e. **Depreciation and Amortization**

f. **Bad Debts**

g. **Interest Expense**

h. **Malpractice Expense**

i. **Utilities**

j. **Business Expenses**

k. **Other Operating Expenses**

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

See Attachment 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachment 3 for the Balance Sheet for both Backus Corporation and Backus Hosptial.

Attachment 1

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

As of 5/20/14

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$3,668,839	$5,591,353	$9,260,192
Clinical Integration	$0	$0	$0
Clinical	$176,971	$176,971	$353,942
Finance	$1,409,000	$1,309,000	$2,718,000
Human Resources	$740,218	$986,402	$1,726,620
Information Technology	$0	$0	$0
Supply Chain	$2,399,282	$2,952,771	$5,352,053
Other Operations	$0	$0	$0
Total Savings	$8,394,310	$11,016,497	$19,410,807
Target Savings	$11,039,000	$15,036,000	$26,075,000
Variance from Target	($2,644,690)	($4,019,503)	($6,664,193)

ANNUAL	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$3,668,839	$1,922,515	$5,591,353
Clinical Integration	$0	$0	$0
Clinical	$176,971	$0	$176,971
Finance	$1,409,000	($100,000)	$1,309,000
Human Resources	$740,218	$246,184	$986,402
Information Technology	$0	$0	$0
Supply Chain	$2,399,282	$553,488	$2,952,771
Other Operations	$0	$0	$0
Total Savings	$8,394,310	$2,622,187	$11,016,497
Target Savings	$11,039,000	$3,997,000	$15,036,000
Variance from Target	($2,644,690)	($1,374,813)	($4,019,503)

Attachment 2

Backus Corporation
Consolidated Statement Of Operations
(In Thousands)

	Year to Date March 31, 2014		Variance to Budget	Year to Date March 31, 2013	Variance to Prior Year
	Actual	Budget	Fav. (Unfav.)		Fav. (Unfav.)
Gross Patient Service Revenue					
Inpatient			$ 0		$ 0
Outpatient	6,034	6,301	(267)		6,034
Professional Service Revenue	8,983	7,185	1,798		8,983
	15,017	13,486	1,531	0	15,017
Contractual Allowances	5,978	5,177	(801)		(5,978)
Bad Debt	175	189	14		(175)
Charity Care			0		0
	6,153	5,366	(787)	0	(6,153)
Net Revenues from Services to Patient	8,864	8,120	744	0	8,864
Other Operating Revenue	(299)	(259)	(40)		(299)
Net Assets Released from Restriction			0		0
Total Revenues	8,565	7,861	704	0	8,565
Operating Expenses					
Salaries and Fringe	7,566	7,142	(424)	0	(7,566)
Pension			0		0
Supplies and Other	1,093	827	(266)		(1,093)
Purchased Services	1,500	1,268	(232)		(1,500)
Malpractice	97	101	4		(97)
Depreciation and Amortization	18	20	2		(18)
Rental Expense	116	80	(36)		(116)
Interest Expense			0		0
	10,390	9,438	(952)	0	(10,390)
Operating Income (Loss)	(1,825)	(1,577)	(248)	0	(1,825)
Other Income:					
Income from Investments, Gifts and Bequests, Net	816	608	208		816
Other	(4)		(4)		(4)
Chg in Unrealized Gain (Loss) on Invest			0		0
	812	608	204	0	812
Excess (Deficiency) of Revenues over Expenses	$ (1,013)	$ (969)	$ (44)	$ 0	$ (1,013)

BACKUS HOSPITAL
Consolidated Statement Of Operations
(In Thousands)

	Year to Date March 31, 2014 Actual	Year to Date March 31, 2014 Budget	Variance to Budget Fav. (Unfav.)	Year to Date March 31, 2013	Variance to Prior Year Fav. (Unfav.)
Gross Patient Service Revenue					
Inpatient	$ 116,365	$ 116,797	$ (432)	$ 113,293	$ 3,072
Outpatient	205,361	187,191	18,170	185,859	19,502
Professional Service Revenue	17,955	17,052	903	16,467	1,488
	339,681	321,040	18,641	315,619	24,062
Contractual Allowances	197,150	185,034	(12,116)	176,697	(20,453)
Bad Debt	4,582	4,357	(225)	4,217	(365)
Charity Care	2,814	2,916	102	2,803	(11)
	204,546	192,307	(12,239)	183,717	(20,829)
Net Revenues from Services to Patient	135,135	128,733	6,402	131,902	3,233
Other Operating Revenue	2,498	2,288	210	2,724	(226)
Net Assets Released from Restriction	173	67	106	91	82
Total Revenues	137,806	131,088	6,718	134,717	3,089
Operating Expenses					
Salaries and Fringe	66,011	64,706	(1,305)	66,919	908
Pension	2,251	4,495	2,244	4,179	1,928
Supplies and Other	20,649	20,039	(610)	20,668	19
Purchased Services	25,311	23,588	(1,723)	19,640	(5,671)
Malpractice	2,908	2,600	(308)	2,024	(884)
Depreciation and Amortization	7,857	9,044	1,187	9,132	1,275
Rental Expense	679	662	(17)	621	(58)
Interest Expense	1,241	1,641	400	1,695	454
	126,907	126,775	(132)	124,878	(2,029)
Operating Income (Loss)	10,899	4,313	6,586	9,839	1,060
Other Income					
Income from Investments, Gifts and Bequests, Net	6,791	5,391	1,400	5,784	1,007
Other	(722)		(722)	(79)	(643)
Chg in Unrealized Gain (Loss) on Invest	(83)	(71)	(12)		(83)
	5,986	5,320	666	5,705	281
Excess (Deficiency) of Revenues over Expenses	$ 16,885	$ 9,633	$ 7,252	$ 15,544	$ 1,341
Operating Margin	7.91%	3.29%		7.30%	

Attachment 3

Backus Corporation

Consolidated Balance Sheet
(In Thousands)

	March 31, 2014	September 30, 2013	March 31, 2013
ASSETS			
Current Assets:			
Cash and Equivalents	$ 997	$ 2,200	
Accounts Receivable, Less Allowances of $1,464 at March 2014 and $1,427 at September 2013 and $0 at March 2013	2,981	1,381	
Other Receivables			
Due from Affiliates and Other Related Parties	(1,264)	(185)	
Inventories of Supplies			
Prepaid and Other Assets	66	27	
Estimated Third Party Payor Settlements			
Current Portion of Assets Whose Use is Limited			
Total Current Assets	2,780	3,431	0
Other Assets:			
Board Designated Assets			
Investment for Restricted Purposes			
Escrow Funds for Long Term Debt			
Funds Designated for Debt Service			
	0	0	0
Funds Held in Trust by Others			
Other Assets	730	712	
Net Property, Plant and Equipment	633	504	
Total Assets	$ 4,143	$ 4,647	$ -
LIABILITIES AND NET ASSETS			
Current Liabilities:			
Accounts Payable	$ 869	$ 693	
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	1,214	987	
Accrued Expenses	457	258	
Due to Affiliates and Other Related Parties			
Estimated Third Party Payor Settlements	253	246	
Current Portion of Accrued Pension Liability			
Current Portion of Long Term Debt			
Current Portion of Long Term Liabilities			
Total Current Liabilities	2,793	2,184	0
Long Term Debt, Less Current Portion			
Accrued Pension Liability			
Other Liabilities	548	648	
NET ASSETS			
Unrestricted	802	1,815	
Temporary Restricted			
Permanently Restricted			
Total Net Assets	802	1,815	0
Total Liabilities and Net Assets	$ 4,143	$ 4,647	$ -

BACKUS HOSPITAL
Consolidated Balance Sheet
(In Thousands)

	March 31, 2014	September 30, 2013	March 31, 2013
ASSETS			
Current Assets:			
Cash and Equivalents	$ 143,019	$ 132,348	$ 112,649
Accounts Receivable, Less Allowances of $16,228 at March 2014 and $16,761 at September 2013 and $17,314 at March 2013	32,907	31,014	31,894
Other Receivables	29	29	31
Due from Affiliates and Other Related Parties	1,480	185	1,285
Inventories of Supplies	4,381	3,715	3,858
Prepaid and Other Assets	3,499	3,010	2,136
Estimated Third Party Payor Settlements			
Current Portion of Assets Whose Use is Limited			
Total Current Assets	185,315	170,301	151,853
Other Assets:			
Board Designated Assets	151,128	144,392	139,681
Investment for Restricted Purposes	8,249	7,936	7,587
Escrow Funds for Long Term Debt			
Funds Designated for Debt Service	0	3,737	4,765
	159,377	155,975	152,033
Funds Held in Trust by Others	2,636	2,515	2,361
Other Assets	9,169	9,206	7,578
Net Property, Plant and Equipment	132,067	138,744	86,391
Total Assets	$ 488,564	$ 476,741	$ 400,216
LIABILITIES AND NET ASSETS			
Current Liabilities:			
Accounts Payable	$ 9,087	$ 8,031	$ 7,564
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	5,018	6,965	4,815
Accrued Expenses	5,988	6,320	7,387
Due to Affiliates and Other Related Parties	2,822		
Estimated Third Party Payor Settlements	2,024	1,826	860
Current Portion of Accrued Pension Liability	1,271	3,553	839
Current Portion of Long Term Debt	335	2,443	2,195
Current Portion of Long Term Liabilities			
Total Current Liabilities	26,545	29,140	24,060
Long Term Debt, Less Current Portion	66,484	67,194	65,035
Accrued Pension Liability	14,488	18,269	52,392
Other Liabilities	38,123	36,647	44,769
NET ASSETS			
Unrestricted	331,039	314,118	202,846
Temporary Restricted	3,522	3,306	3,181
Permanently Restricted	8,363	8,067	7,913
Total Net Assets	342,924	325,491	213,940
Total Liabilities and Net Assets	$ 488,564	$ 476,741	$ 400,216

Huber, Jack

From: Martone, Kim
Sent: Wednesday, July 16, 2014 7:49 AM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie
Subject: FW: Backus/HHC Annual Filing DN12-31788-CON
Attachments: Backus and HHC Affiliation 7.15.14 Response FINAL.pdf

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From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Tuesday, July 15, 2014 4:53 PM
To: Martone, Kim
Cc: Goyette, Karen T.; Whitehead, David; Durdy, Barbara; Chaty, Beth
Subject: Backus/HHC Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 4 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

RECEIVED
JUL 16 2014
Office of
HEALTHCARE ACCESS

July 15, 2014

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 4, please find attached the requested annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings described in Table 1 are attributed to multiple specific projects, detailed in Table 2. Many of these specific projects have been completed, while others are in progress, and still others are slated for future implementation.

Please contact me if you require further information.

Sincerely,

Janette Edwards

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

TABLE 1

Summary: Financial Savings for HHC and Backus Affiliation

As of July 1, 2014

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$3,946,052	$6,032,797	$9,978,849
Clinical Integration	$0	$351,000	$351,000
Clinical	$176,971	$176,971	$353,942
Finance	$1,409,000	$1,309,000	$2,718,000
Human Resources	$739,802	$986,402	$1,726,204
Information Technology	$0	$0	$0
Supply Chain	$2,428,580	$3,036,524	$5,465,104
Other Operations	$201,291	$251,450	$452,741
Total Savings	$8,901,695	$12,144,144	$21,045,839
Target Savings	$11,039,000	$15,036,000	$26,075,000
Variance from Target	($2,137,305)	($2,891,856)	($5,029,161)

TABLE 2

Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Status as of July 1, 2014

Code	Area	Project	Status
ADM01	Administration	Creation of HHC Eastern Region	Complete
ADM02	Administration	East Region Shared Services Organization	Complete
INT01	Clinical Integration	Integrate Backus employed physicians into HHCMG	In Process
INT02	Clinical Integration	Align Backus recruitment efforts and Medical Staff Development Plan with HHC	Complete
INT03	Clinical Integration	Integrate independent and employed primary care practices into ICP shared savings - provide assessment	Complete
INT04	Clinical Integration	Involve Backus physicians in Integrated Care Partners Governance	Complete
INT05	Clinical Integration	Include Backus in Care Coordination Planning at HHC	Complete
CL02	Clinical	Backus included in Quality Council	Complete
CL03	Clinical	Develop a plan to integrate IRB and research activities at WWBH under the HHC structure	In Process
CL07	Clinical	Backus included in ACO planning	Complete
CL10	Clinical	Sharing Technology - capital planning process (over $1M)	In Process
CL12	Clinical	Sharing Technology - sharing HH simulation lab	Future
CL13	Clinical	Sharing Technology - 3 to 5 year strategic plan (radiology/imaging/robotics)	In Process
CL14	Clinical	Curative wound care program	In Process
CL16	Clinical	Backus incorporated in Community Connect / E.H.R. support	Complete
CL17	Clinical	Backus included in (16) clinical councils	Complete
CL18	Clinical	Include Backus in HHC Common Credentialing Platform (Complete assessment)	Complete

CL19	Clinical	Dialysis	Future
CL21	Clinical	Evaluate WWBH utilizing CLP as primary reference lab	Complete
CL21a	Clinical	Implementation of WWBH utilizing CLP as primary reference lab (within 90 days)	Complete
CL22	Clinical	Evaluate WWBH utilizing CLP/Quest reference lab contract	Complete
CL22a	Clinical	Implementation of WWBH utilizing CLP/Quest reference lab contract (within 90 days)	Complete
CL23	Clinical	Medical Library Services	Complete
CL24	Clinical	Include Backus in Universal Flu Immunization Program	Complete
CL25	Clinical	Risk Management Education	Complete
CL26	Clinical	Implement best practices from each facility to lower direct, variable cost of care for highest opportunity DRG	Future

FIN01	Finance	Fair Value Accounting	Complete
FIN02	Finance	Legal Structure	In Process
FIN03	Finance	Audits - Financial	In Process
FIN04	Finance	General Accounting / Financial Reporting	In Process
FIN05	Finance	Sponsored Programs / Grant Accounting	In Process
FIN06	Finance	Financial Systems	In Process
FIN07	Finance	Government Reimbursement	In Process
FIN08	Finance	Tax Returns and Reporting	In Process
FIN09	Finance	Budget	In Process
FIN10	Finance	Decision Support	Future
FIN11	Finance	Treasury	In Process
FIN12	Finance	Pension Issues - Treasury	In Process
FIN13	Finance	Risk Management/Insurance	Complete
FIN14	Finance	Other Finance Items	In Process
FIN15	Finance	Payroll	In Process

FIN16	Treasury	Electronic payment (AMEX)	In Process
FIN17	Treasury	Investment management	Complete
FIN18	RevCycle	Centralize and consolidate revenue cycle business office	Complete
FIN19	RevCycle	JA Thomas revenue integrity audit	In Process

HR03	Human Resources	Conduct employee benefits review and timeline to adopt model plan designs for health, dental, time off and other ancillary benefits	Complete
HR04	Human Resources	Incorporate Backus Hospital and physicians into Tier 1 network and HHC into Backus' network as applicable	Complete
HR05	Human Resources	Adopt standard HHC PTO provisions including designated holidays - 2015	Future
HR06	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (e.g. Aetna TPA, Delta Dental, reinsurance) - 2014	Complete
HR07	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (e.g. Life, AD&D, disability) - 2015	Future
HR08	Human Resources	Integrate into Captive for purposes of health plan reinsurance (Medical Stop Loss)	Complete
HR09	Human Resources	Integrate into Aon Hewitt Benefits Eligibility TPA - 2015 (3/4)	Complete
HR10	Human Resources	Integrate into Prudential Single DC Record-keeper	Future
HR11	Human Resources	Integrate into Prudential Leave TPA - 2015	Future
HR12	Human Resources	Introduce Healthy Together, premium credits and cost sharing strategy - 2015	Complete
HR13	Human Resources	Upgrade to Kronos 7.0	Future
HR14	Human Resources	Review and adopt standard HHC HR P&Ps and workstreams driving PeopleSoft build and HR Future State Transformation	In Process
HR17	Human Resources	Review other HR policies and processes to identify best practices and adopt throughout HHC (e.g., Travel)	In Process
HR18	Human Resources	Integrate and participate in HHC Human Resources Future State Centralized Services and/or Centers of Expertise	In Process
HR20	Human Resources	Introduce HHC Core Values & Making A Difference Training	In Process
HR21	Human Resources	Introduce H3W Leadership Behaviors	Complete
HR22	Human Resources	Consolidate contingent labor vendors and implement ShiftWise	In Process
HR23	Human Resources	Adopt HHC Transfer Policy and Single Employer Guidelines	Complete

HR24	Human Resources	Participate in HHC Administrative Fiduciary for retirement plans	Complete
HR26	Human Resources	Include Backus MDs in HHC Physician Leadership Institute	Complete
HR28	Human Resources	Scale occupational/employee health support services and related processes (2015)	In Process
HR29	Human Resources	Participate in the HHC Pulse engagement survey in Fall 2013	Complete
HR30	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (Vision 2014 - all others 2015 Project HR07)	Complete

IT01	Information Technology	Develop plans for 2nd HHC Data Center (assessment complete)	Complete
IT02	Information Technology	Email Integration (all employees by 3/3/14)	Complete
IT04	Information Technology	Consolidation/inventory of ITS contracts and applications	In Process
IT05	Information Technology	ICD-10 Project Management - shared management	Complete
IT06	Information Technology	Launch HHC SharePoint application for Backus	In Process

SC01	Supply Chain	Transition GPO relationship from Amerinet to GNYHA	Complete
SC02	Supply Chain	Align contracts and standardize supplies & services: Phase I - Private supply contracts (HHC/Backus same supplier)	Complete
SC03	Supply Chain	Align contracts and standardize supplies & services: Phase II - Private supply contracts requiring product conversions	In Process
SC04	Supply Chain	Secure HHC system pricing for Press Ganey/Moorehead/Advisory Board	Complete

ST01	Strategy	Implement communication plan	Complete

OT02	Other Operations	VNA (Business and Human Resource components)	In Process
OT03	Other Operations	HHC Rehabilitation Network opportunities	In Process
OT04	Other Operations	Senior Care	In Process
OT05	Other Operations	Clinical Lab Partners - additional integration efforts	In Process

OT06	Other Operations	Biomedical Services: 1. service contract renewal, 2. Phillips Ultrasound contract, 3. train BioMed technicians, 4. standardize BioMed policies & procedures, 5. reduce cost of service contracts on equipment (9/30/14) & 6. standardize on manufacturers and vendors (FY15-FY16)	In Process
OT07	Other Operations	Facilities related expenses	In Process
OT08	Other Operations	Legal - review system-wide resources and use of external legal firms	Complete
OT09	Other Operations	Pharmacy opportunities (non-labor)	In Process
OT10	Other Operations	Pharmacy - integrate and utilized clinical pharmacy experience & physician support	Future

GOV01	Governance / Legal	Board Resolution - Investment Committee	Complete
GOV02	Governance / Legal	Board Resolution - Fiduciary	Complete
GOV03	Governance / Legal	Board Resolution - Pension Trustee	Complete
GOV04	Governance / Legal	HHC Board Committee Appointments	Complete
GOV05	Governance / Legal	CON: file full non-redacted final affiliation agreement	Complete
GOV06	Governance / Legal	CON: Submit detailed and comprehensive integration document	Complete
GOV07	Governance / Legal	CON: Semi-annual reporting by HHC & Backus regarding integration plan (GOV06)	Complete
GOV08	Governance / Legal	CON: Submit high level summary of Eastern CT Region Strategic Plan	Complete
GOV09	Governance / Legal	CON: File detailed benefits / cost savings report (2 years - 26 Required Items)	In Process
GOV10	Governance / Legal	CON: Final Accounting all benefits and cost savings	Future

Huber, Jack

From:	Martone, Kim
Sent:	Monday, December 01, 2014 1:52 PM
To:	Roberts, Karen; Huber, Jack
Cc:	Greer, Leslie
Subject:	FW: Backus/HHC Semi-Annual Filing DN12-31788-CON
Attachments:	11.30.14 semi annual filing FINAL DRAFT.pdf

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, December 01, 2014 1:32 PM
To: Martone, Kim
Subject: Backus/HHC Semi-Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 5 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

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Office of
HEALTHCARE ACCESS

November 24, 2014

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. Further, Table 2 provides comparison between savings over identified fiscal years, and Table 3 illustrates actual vs. targeted savings in graph form. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.

Sincerely,

Janette E. Edwards

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Hartford HealthCare

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of the affiliation, as of September 2014, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total projected cumulative savings of $19M in FY2015.

Success has been accomplished through the regular oversight provided by an Integration Steering Committee established in 2013, which brings together leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing):

- *Administration*
- *Clinical*
- *Clinical Integration*
- *Financial*
- *Human Resources*
- *Information Technology*
- *Supply Chain*
- *Other Operations*
- *Strategy*
- *Governance/Legal*

In the new Fiscal Year the Integration Committee will continue to meet to identify further cost-savings and quality enhancing opportunities. These opportunities will be driven in collaboration with front-line subject matter experts in the development of Management Action Plans ("MAPs"). MAPs identify efficiencies, savings, or revenue-generating strategies that can be gained through new ways of working by using Lean techniques, through newly identified purchasing and procurement tactics, and through new business lines. It is fully anticipated that

Hartford HealthCare

additional savings will be realized throughout the Fiscal Year, impacting the overall integration benefits enjoyed by Backus and HHC.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 and 2 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

Hartford HealthCare

See the Attachment 1 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachment 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

Hartford HealthCare

- **Table 1**

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

As of 9/12/14

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$4,088,498	$6,602,581	$10,691,079
Clinical Integration	$0	$351,000	$351,000
Clinical	$179,782	$309,621	$489,403
Finance	$8,009,000	$7,309,000	$15,318,000
Human Resources	$739,802	$986,402	$1,726,204
Information Technology	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$6,403,462
Other Operations	$17,871	$251,450	$269,321
Total Savings	**$15,567,040**	**$19,681,428**	**$35,248,468**
Target Savings	**$11,039,000**	**$15,036,000**	**$26,075,000**
Variance from Target	**$4,528,040**	**$4,645,428**	**$9,173,468**

ANNUAL	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$4,088,498	$2,514,084	$6,602,581
Clinical Integration	$0	$351,000	$351,000
Clinical	$179,782	$129,839	$309,621
Finance	$8,009,000	($700,000)	$7,309,000
Human Resources	$739,802	$246,601	$986,402
Information Technology	$0	$0	$0
Supply Chain	$2,532,088	$1,339,285	$3,871,374
Other Operations	$17,871	$233,579	$251,450
Total Savings	**$15,567,040**	**$4,114,388**	**$19,681,428**
Target Savings	**$11,039,000**	**$3,997,000**	**$15,036,000**
Variance from Target	**$4,528,040**	**$117,388**	**$4,645,428**

Hartford HealthCare

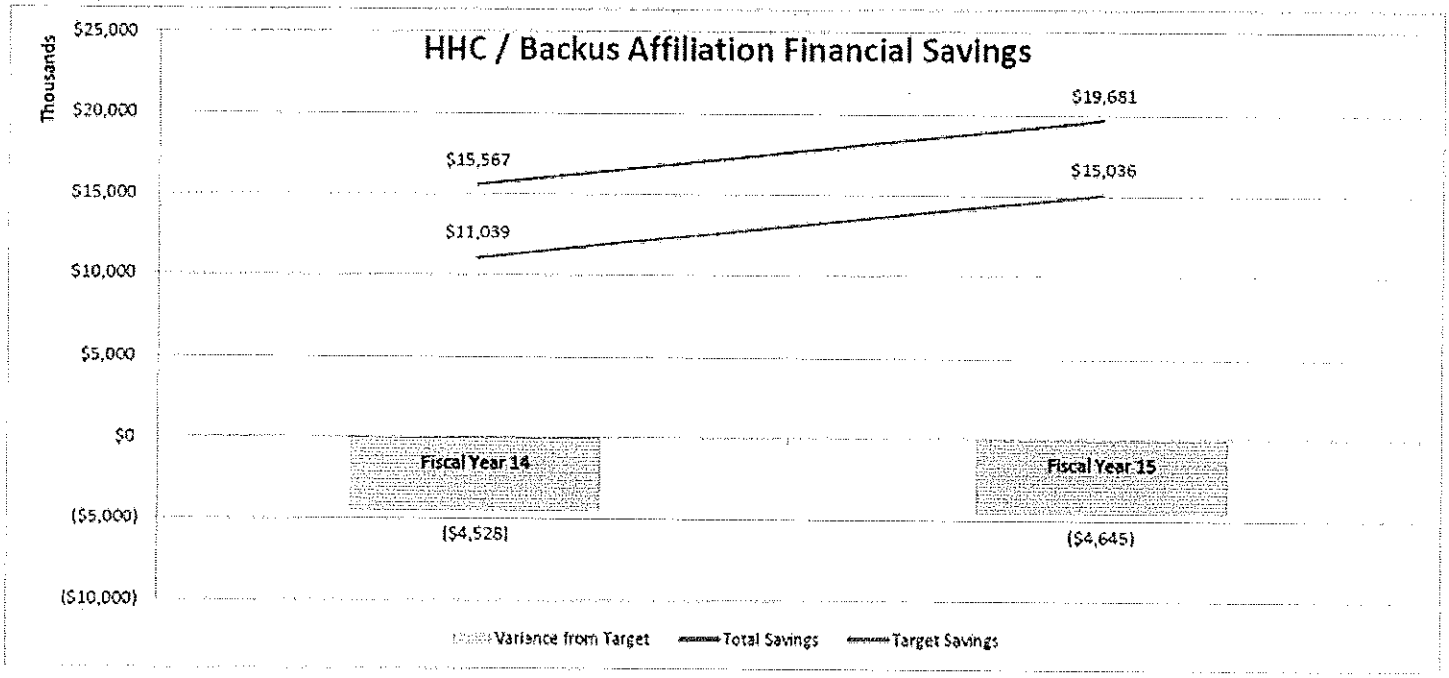
- **Table 2**

HHC Backus Affiliation
Huron Report Summary
Huron Report Date: July 12, 2012

Area	CUMMULATIVE FY2013	CUMMULATIVE FY2014	CUMMULATIVE FY2015	BY YEAR FY2013	BY YEAR FY2014	BY YEAR FY2015	BY YEAR Total
Non-Labor - Total Assessment Opportunity							
Non Clinical Purchased Services	$1,479,000	$1,882,000	$2,284,000	$1,479,000	$403,000	$402,000	$2,284,000
Pharmacy	$400,000	$500,000	$600,000	$400,000	$100,000	$100,000	$600,000
Lab	$300,000	$350,000	$400,000	$300,000	$50,000	$50,000	$400,000
Clinical Supplies	$185,000	$225,000	$265,000	$185,000	$40,000	$40,000	$265,000
Annualized Sub Total	$2,364,000	$2,957,000	$3,549,000	$2,364,000	$593,000	$592,000	$3,549,000
Revenue Cycle - Total Assessment Opportunity							
Vendor Cost Savings	$80,000	$165,000	$250,000	$80,000	$85,000	$85,000	$250,000
Denials/Write-Off Improvements	$1,400,000	$2,500,000	$3,600,000	$1,400,000	$1,100,000	$1,100,000	$3,600,000
FTE Savings	(See Labor Section)						
Annualized Sub Total	$1,480,000	$2,665,000	$3,850,000	$1,480,000	$1,185,000	$1,185,000	$3,850,000
Clinical Operations - Total Assessment Opportunity							
Clinical Operations	$250,000	$400,000	$580,000	$250,000	$150,000	$180,000	$580,000
Direct Variable Cost Savings	$425,000	$637,500	$850,000	$425,000	$212,500	$212,500	$850,000
FTE Savings	(See Labor Section)						
Annualized Sub Total	$675,000	$1,037,500	$1,430,000	$675,000	$362,500	$392,500	$1,430,000
Human Resources - Total Assessment Opportunity							
Employee Benefits	$465,000	$513,000	$560,000	$465,000	$48,000	$47,000	$560,000
Absence Management	$180,000	$192,500	$205,000	$180,000	$12,500	$12,500	$205,000
Premium Pay	$160,000	$213,000	$265,000	$160,000	$53,000	$52,000	$265,000
HR Purchased Services	$195,000	$228,000	$260,000	$195,000	$33,000	$32,000	$260,000
Annualized Sub Total	$1,000,000	$1,146,500	$1,290,000	$1,000,000	$146,500	$143,500	$1,290,000
Labor - Total Assessment Opportunity							
Revenue Cycle (CBO/HIM/Access)	$460,000	$855,000	$1,250,000	$460,000	$395,000	$395,000	$1,250,000
Fiscal Services (Finance/IT/Materials Management)	$1,760,000	$2,155,000	$2,550,000	$1,760,000	$395,000	$395,000	$2,550,000
Administrative (Admin/Lab/HR/Facilities) & Home Health Services	$3,300,000	$4,220,000	$5,140,000	$3,300,000	$920,000	$920,000	$5,140,000
Annualized Sub Total	$5,520,000	$7,230,000	$8,940,000	$5,520,000	$1,710,000	$1,710,000	$8,940,000
Grand Total	$11,039,000	$15,036,000	$19,059,000	$11,039,000	$3,997,000	$4,023,000	$19,059,000

Hartford HealthCare

- **Table 3**



The William W. Backus Hospital
Balance Sheet
September 30, 2014 *

Assets	Draft
Current assets:	
Cash and cash equivalents	$ 187,018,905
Assets whose use is limited-required for current liabilities	3,285,815
Accounts receivable, less allowance	36,980,052
Other receivables	1,320,143
Inventories of supplies	3,771,462
Prepaid expenses	1,643,561
Due from affiliates	2,052,950
Total current assets	236,072,888
Assets whose use is limited:	
Investments and other assets	57,081,792
Interest in investments held by Endowment LLC	47,662,263
Donor restricted int in investments Endowment LLC	8,311,558
Investments for restricted purposes	26,640,012
	139,695,625
Funds held in trust by others	2,633,503
Other assets	7,214,261
Property, plant and equipment	
Land and land improvements	8,427,224
Buildings and leasehold improvements	184,043,214
Equipment	110,441,761
Construction in progress	185,693
Accumulated depreciation	(175,263,190)
	127,834,702
	$ 513,450,979
Liabilities and Net Assets	
Current liabilities	
Accounts payable-trade	$ 8,403,969
Salaries and wages, payroll taxes and taxes withheld from payroll	7,611,745
Due to affiliates	2,841,766
Accrued liabilities	6,965,890
Current portion of pension liability	3,828,400
Due to third parties	8,036,715
Current portion of long-term liabilities	653,974
Current portion of long-term debt	399,818
Total current liabilities	38,742,277
Other Liabilities:	
Long-term debt, less current portion	68,199,710
Accrued pension liability	30,076,502
Self-insured professional liability	8,527,863
Other	4,532,110
	111,336,185
Net Assets:	
Common stock	
Unrestricted net assets	351,485,071
Temporarily restricted net assets	3,534,497
Permanently restricted net assets	8,352,949
	363,372,517
	$ 513,450,979

*Includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
September 30, 2014

Draft

Assets		
Current assets:		
Cash and cash equivalents	$	187,885,111
Assets whose use is limited-required for current liabilities		3,285,815
Accounts receivable, less allowance		38,557,357
Other receivables		1,341,254
Inventories of supplies		3,771,462
Prepaid expenses		1,671,760
Due from affiliates		2,358,949
Total current assets		238,871,708
Assets whose use is limited:		
Investments and other assets		57,081,792
Interest in investments held by Endowment LLC		47,662,263
Donor restricted int in investments Endowment LLC		8,311,558
Investments for restricted purposes		26,640,012
		139,695,625
Funds held in trust by others		2,633,503
Other assets		8,357,721
Property, plant and equipment		
Land and land improvements		8,427,224
Buildings and leasehold improvements		184,197,093
Equipment		111,491,808
Construction in progress		185,693
Accumulated depreciation		(175,584,689)
		128,717,129
	$	518,275,686
Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	8,540,858
Salaries and wages, payroll taxes and taxes withheld from payroll		9,007,281
Due to affiliates		2,865,926
Accrued liabilities		6,967,449
Current portion of pension liability		3,828,400
Due to third parties		8,663,714
Current portion of long-term liabilities		653,974
Current portion of long-term debt		399,818
Total current liabilities		40,927,420
Other Liabilities:		
Long-term debt, less current portion		68,199,710
Accrued pension liability		30,076,502
Self-insured professional liability		8,846,276
Other		4,532,110
		111,654,598
Net Assets:		
Unrestricted net assets		353,806,222
Temporarily restricted net assets		3,534,497
Permanently restricted net assets		8,352,949
		365,693,668
	$	518,275,686

The William W. Backus Hospital
Income Statement
As of September 30, 2014 - YTD

Draft

	9/30/2014 *
Revenues:	
Gross patient service revenue:	
Inpatient	$ 234,370,174
Outpatient	430,068,177
Professional service revenue	37,267,111
	701,705,462
Contractual allowances	394,788,265
Charity care	5,263,975
Provision for bad debt	8,035,283
Net revenue from service to patients	293,617,939
Other operating revenue	7,226,224
Net assets released from restrictions	287,246
Total revenues	301,131,409
Expenses:	
Salaries and wages	110,166,889
Payroll taxes and fringe benefits	18,336,102
Pension	3,111,387
Supplies and expenses	44,235,640
Purchased service	54,305,989
Malpractice	1,363,097
Depreciation and amortization	15,651,354
Rental expense	1,609,189
Interest	2,992,001
	251,771,648
Operating income (loss) before bond refinancing	49,359,761
Loss on bond refinancing	(722,310)
Operating income (loss)	48,637,451
Nonoperating gains and (losses)	
Investment income	9,253,115
Other	(186,851)
Excess (deficiency) of revenue over expenses	$ 57,703,715

*includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Statement of Operations
As of September 30, 2014 - YTD

Draft

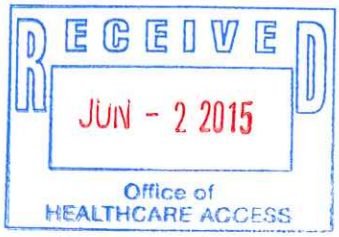
9/30/2014

Revenues:		
Gross patient service revenue:		
Inpatient	$	234,370,174
Outpatient		438,834,599
Professional service revenue		59,415,543
		732,620,316
Contractual allowances		409,557,356
Charity care		5,263,975
Provision for bad debt		8,520,064
Net revenue from service to patients		309,278,921
Other operating revenue		8,779,703
Net assets released from restrictions		287,246
Total revenues		318,345,870
Expenses:		
Salaries and wages		122,973,389
Payroll taxes and fringe benefits		21,292,907
Pension		3,114,970
Supplies and expenses		46,608,626
Purchased service		57,290,669
Malpractice		1,382,002
Depreciation and amortization		15,759,885
Rental expense		1,759,277
Interest		2,992,001
		273,173,726
Operating income (loss) before bond refinancing		45,172,144
Loss on bond refinancing		(722,310)
Operating income (loss)		44,449,834
Nonoperating gains and (losses)		
Investment income		11,402,396
Other		(190,849)
Excess (deficiency) of revenue over expenses	$	55,661,381

Huber, Jack

From: Martone, Kim
Sent: Tuesday, June 02, 2015 10:08 AM
To: Greer, Leslie; Roberts, Karen; Huber, Jack
Subject: FW: Backus/HHC Semi-Annual Filing DN12-31788-CON
Attachments: 5 31 15 semi annual filing FINAL.pdf

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Tuesday, June 02, 2015 10:02 AM
To: Martone, Kim
Subject: RE: Backus/HHC Semi-Annual Filing DN12-31788-CON



Kim:

My apologies! Please see the attached.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare

Backus Hospital

Windham Hospital

11 Stott Avenue

Norwich, CT 06360

Office: 860.425.3872

Fax number 860.892.2796

janette.edwards@hhchealth.org

www.hartfordhealthcare.org

From: Martone, Kim [mailto:Kimberly.Martone@ct.gov]
Sent: Tuesday, June 02, 2015 9:49 AM
To: Edwards, Janette
Subject: RE: Backus/HHC Semi-Annual Filing DN12-31788-CON

Janette, do you have the attachment?

Kim

Kimberly R. Martone

Director of Operations
Office of Health Care Access
Department of Public Health
Phone: 860-418-7029
Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov
Website: www.ct.gov/ohca

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, June 01, 2015 5:12 PM
To: Martone, Kim
Cc: Durdy, Barbara; Goyette, Karen T.; Whitehead, David
Subject: Backus/HHC Semi-Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 5 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

Hartford HealthCare

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May 31, 2015

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. At this time, all integration targeted savings have been met. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.

Sincerely,

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Hartford HealthCare

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of the affiliation, as of September 2014, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total projected cumulative savings of $19.6M in FY2015, and a projected total savings of $19.7M in FY 2016.

Success has been accomplished through the regular oversight provided by an Integration Steering Committee established in 2013, which brings together leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing):

- *Administration*
- *Clinical*
- *Clinical Integration*
- *Financial*
- *Human Resources*
- *Information Technology*
- *Supply Chain*
- *Other Operations*
- *Strategy*
- *Governance/Legal*

The Integration Committee continues to identify further cost-savings and quality enhancing opportunities. These opportunities will be driven in collaboration with front-line subject matter experts in the development of Management Action Plans ("MAPs"). MAPs identify efficiencies, savings, or revenue-generating strategies that can be gained through new ways of working by using Lean techniques, through newly identified purchasing and procurement tactics, and through new business lines. It is fully anticipated that additional savings will be realized

Hartford HealthCare

throughout the Fiscal Year, impacting the overall integration benefits enjoyed by Backus and HHC.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

Hartford HealthCare

See the Attachments 1and 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachments 1 and 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

Hartford HealthCare

- **Table 1**

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Fiscal Year 16	Total
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

Hartford HealthCare

Attachment 1: *Backus Corporation & Subsidiaries Consolidating Balance Sheets & Statement of Operations, April 30, 2015*

Backus Corporation and Subsidiaries
Consolidating Statement of Operations

	Year to Date April 30,2015
Revenues:	
Gross patient service revenue:	
Inpatient	$ 136,655,108
Outpatient	259,283,767
Professional service revenue	40,063,701
	436,002,576
Contractual allowances	258,668,238
Charity care	2,372,183
Provision for bad debt	5,138,073
Net revenue from service to patients	169,824,082
Other operating revenue	5,892,574
Net assets released from restrictions	102,153
Total revenues	175,818,809
Expenses:	
Salaries and wages	70,305,102
Payroll taxes and fringe benefits	14,257,452
Pension	1,083,866
Supplies and expenses	26,109,470
Purchased service	30,611,531
Malpractice	40,891
Depreciation and amortization	8,990,509
Rental expense	1,357,065
Interest	1,964,840
	154,720,726
Operating income	21,098,083
Nonoperating gains and (losses)	
Investment income	7,747,195
Other	62,220
Excess of revenue over expenses	$ 28,907,498

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
April 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	176,136,195
Assets whose use is limited-required for current liabilities		6,190,478
Accounts receivable, less allowance		35,287,110
Other receivables		317,481
Inventories of supplies		4,018,675
Prepaid expenses		5,062,686
Due from third parties		0
Due from affiliates		4,006,745
Total current assets		231,019,370
Assets whose use is limited:		
Investments and other assets		56,759,333
Interest in investments held by Endowment LLC		75,415,263
Donor restricted int in investments Endowment LLC		8,514,171
Investments for restricted purposes		19,586,682
		160,275,449
Funds held in trust by others		2,664,290
Other assets		16,068,306
Property, plant and equipment		
Land and land improvements		8,427,224
Buildings and leasehold improvements		184,159,797
Equipment		109,699,284
Construction in progress		3,551,991
Accumulated depreciation		(182,871,216)
		122,967,080
	$	532,994,495

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Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
April 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	5,387,220
Salaries and wages, payroll taxes and taxes withheld from payroll		4,639,540
Due to affiliates		1,774,676
Accrued liabilities		6,157,861
Current portion of pension liability		2,114,823
Due to third parties		8,004,144
Current portion of long-term liabilities		845,859
Current portion of long-term debt		243,577
Total current liabilities		29,167,700
Other Liabilities:		
Long-term debt, less current portion		68,068,729
Accrued pension liability		36,543,714
Self-insured professional liability		8,280,287
Other		5,035,491
		117,928,221
Net Assets:		
Common stock		-
Unrestricted net assets		373,030,814
Temporarily restricted net assets		4,484,024
Permanently restricted net assets		8,383,736
		385,898,574
	$	532,994,495

0

Hartford HealthCare

Attachment 2: *The William W. Backus Hospital Consolidating Balance Sheets & Statement of Operations, April 30, 2015*

BACKUS HOSPITAL
Consolidated Balance Sheet
(In Thousands)

	April 30, 2015
ASSETS	
Current Assets:	
Cash and Equivalents	$ 175,104
Accounts Receivable, Less Allowances of $5,513 at April 2015 and $15,457 at September 2014 and $16,002 at April 2014	33,960
Other Receivables	280
Due from Affiliates and Other Related Parties	4,827
Inventories of Supplies	4,019
Prepaid and Other Assets	4,993
Estimated Third Party Payor Settlements	
Current Portion of Assets Whose Use is Limited	
Total Current Assets	222,091
Other Assets:	
Board Designated Assets	157,952
Investment for Restricted Purposes	8,514
Escrow Funds for Long Term Debt	
Funds Designated for Debt Service	
	166,466
Funds Held in Trust by Others	2,684
Other Assets	14,718
Net Property, Plant and Equipment	121,995
Total Assets	$ 528,832
LIABILITIES AND NET ASSETS	
Current Liabilities:	
Accounts Payable	$ 5,361
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	3,998
Accrued Expenses	6,156
Due to Affiliates and Other Related Parties	1,744
Estimated Third Party Payor Settlements	7,377
Current Portion of Accrued Pension Liability	2,115
Current Portion of Long Term Debt	244
Current Portion of Long Term Liabilities	845
Total Current Liabilities	27,840
Long Term Debt, Less Current Portion	66,069
Accrued Pension Liability	36,544
Other Liabilities	12,998
NET ASSETS	
Unrestricted	370,614
Temporary Restricted	4,484
Permanently Restricted	8,383
Total Net Assets	383,381
Total Liabilities and Net Assets	$ 528,832

Hartford HealthCare

BACKUS HOSPITAL
Consolidated Statement Of Operations
(In Thousands)

	Year to Date April 30, 2015 Actual
Gross Patient Service Revenue	
Inpatient	$ 136,653
Outpatient	259,253
Professional Service Revenue	23,037
	418,943
Contractual Allowances	248,211
Bad Debt	5,005
Charity Care	2,374
	255,590
Net Revenues from Services to Patient	163,353
Other Operating Revenue	3,892
Net Assets Released from Restriction	102
Total Revenues	167,347
Operating Expenses:	
Salaries and Fringe	75,811
Pension	1,082
Supplies and Other	24,963
Purchased Services	29,023
Malpractice	(170)
Depreciation and Amortization	8,865
Rental Expense	1,265
Interest Expense	1,966
	142,805
Operating Income (Loss)	24,542
Other Income:	
Income from Investments, Gifts and Bequests, Net	5,910
Other	63
Chg in Unrealized Gain (Loss) on Invest	
	5,973
Excess (Deficiency) of Revenues over Expenses	$ 30,515
Operating Margin	14.67%

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Huber, Jack

From: Martone, Kim
Sent: Thursday, July 23, 2015 9:43 AM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie
Subject: FW: Backus/HHC Annual Filing DN12-31788-CON
Attachments: 7.20.15 Annual Filing Response.pdf

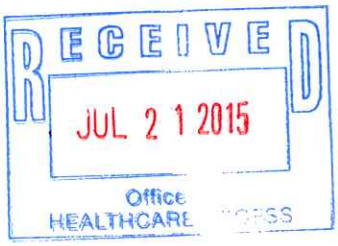
From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, July 20, 2015 5:56 PM
To: Martone, Kim
Cc: Durdy, Barbara; Goyette, Karen T.
Subject: Backus/HHC Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 4 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette



Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

July 20, 2015

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

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JUL 21 2015
Office of
HEALTHCARE ACCESS

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 4, please find attached the requested annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings as enumerated in Findings 24 and 28 have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings described in Table 1 are attributed to multiple specific projects, detailed in Table 2. Many of these specific projects have been completed, while others are in progress, and still others are slated for future implementation. At this time, all integration targeted savings have been met.

Please contact me if you require further information.

Sincerely,

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

TABLE 1

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Fiscal Year 16	Total
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

TABLE 2

Code	Area	Project
ADM	Administration	Staffing changes – Clinical & Non Clinical
ADM	Administration	Convert IP inhaler
ADM	Administration	Transfer Radiation Oncology to Hartford
INT	Clinical Integration	Creation of East Region Cardiology Team
CL	Clinical	Integrate IRB and research activities under HHC
CL	Clinical	Implementation of CLP/Quest reference lab contract
FIN	Finance	Fair Value Accounting
FIN	Finance	Risk Management / Insurance
FIN	Finance	Malpractice
FIN	Finance	Pension
FIN	Finance	Investment management: Custodian & Trustee Fees
FIN	Finance	Investment management: Investment Consulting Fees
FIN	Finance	Investment management: Pension Investment Manager Fees
FIN	Finance	Investment management: Investment Mgr Fees
FIN	Finance	Investment management: Administration & Governance Costs
HR	Human Resources	Consolidate and gain volume pricing for health & welfare vendors
HR	Human Resources	Integrate into captive for Medical Stop Loss
SC	Supply Chain	Pharmacy
SC	Supply Chain	Medsurg
SC	Supply Chain	Sentient
SC	Supply Chain	American Red Cross
SC	Supply Chain	Medtronic
SC	Supply Chain	St. Jude
SC	Supply Chain	Iron Mountain
SC	Supply Chain	Smith & Nephew
SC	Supply Chain	Hologic
SC	Supply Chain	Davol
SC	Supply Chain	Radiopharmaceuticals
SC	Supply Chain	Advisory Corp
SC	Supply Chain	Davol-Surgical Mesh
SC	Supply Chain	Integra Life Sciences
SC	Supply Chain	MTF
SC	Supply Chain	Olympus
SC	Supply Chain	Medcomp
SC	Supply Chain	Getinge

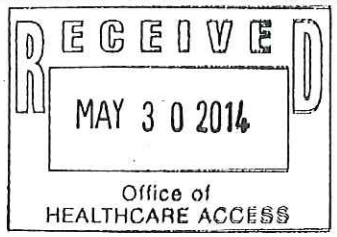
SC	Supply Chain	Stryker CMF
SC	Supply Chain	Stericycle
SC	Supply Chain	Unitex
SC	Supply Chain	Alcon
SC	Supply Chain	Md-Buyline
SC	Supply Chain	Governance Institute
SC	Supply Chain	Stryker total joint agreement
SC	Supply Chain	Roche Diagnostics
SC	Supply Chain	Multiple-Capital
SC	Supply Chain	Covidien/Superdimension
SC	Supply Chain	Synthes Trauma
SC	Supply Chain	Synthes Trauma: HHC receiving Backus' pricing
SC	Supply Chain	Philips Ultrasound Service
SC	Supply Chain	Roche Coaguchek
SC	Supply Chain	Globus
SC	Supply Chain	Advanced Sterilization
SC	Supply Chain	RR Donnelly
SC	Supply Chain	Convatec
SC	Supply Chain	Mortua Instrument
SC	Supply Chain	Divicor
SC	Supply Chain	Delage Landen Mosaic Service
SC	Supply Chain	Elekta
SC	Supply Chain	Progressive Medical
SC	Supply Chain	Solar Winds
SC	Supply Chain	EPIC/Careconnect
SC	Supply Chain	Elsevier
SC	Supply Chain	McKesson
SC	Supply Chain	USPS
SC	Supply Chain	Backus moving to HHC Provisions system pricing (food)
OT	Other Operations	HHC Rehab Network opportunities
OT	Other Operations	Biomedical Services opportunities
OT	Other Operations	Pharmacy Wholesaler Agreement

Huber, Jack

From: Martone, Kim
Sent: Monday, June 02, 2014 8:07 AM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie; Olejarz, Barbara
Subject: FW: Affiliation Agreement CON - Order Responses - DN 12-31788-CON
Attachments: Condition 3 High Level Summary of Strategic Plan 5.30.14 FINAL.pdf; Condition 5 Semi Annual Filing 5.30.14 FINAL.pdf

---

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Friday, May 30, 2014 4:12 PM
To: Martone, Kim
Cc: Whitehead, David; Goyette, Karen T.; Chaty, Beth; Hertkorn, Butch
Subject: Affiliation Agreement CON - Order Responses - DN 12-31788-CON



Ms. Martone,

Please find attached the responses to the reporting requirements as stated in Conditions 3 and 5 of the Agreed Settlement for the Affiliation of Backus Corporation with Hartford HeathCare Corporation, DN 12-31788-CON.

Please don't hesitate to contact me with questions.

Thanks,

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Note to File: This document is exempt from public disclosure.

Applicants:	Hartford HealthCare Corporation and Backus Corporation
Proposal:	Backus Corporation's Affiliation with Hartford HealthCare Corporation
Docket:	12-31788-CON

On July 19, 2013, the Office of Health Care Access, Hartford HealthCare Corporation (HHC) and Backus Corporation (BC) stipulated and agreed to the terms of settlement with respect to the Applicants' request to establish a corporate affiliation. Stipulation #3 of the agreed settlement is worded as follows:

> "Within 60 days of completion of the Eastern Connecticut Region Strategic Plan, the Applicants shall submit a high-level summary description of said plan to OHCA.....Once such summary description of said plan is submitted to OHCA, such document shall be considered by OHCA as a trade secret and therefore, exempt from disclosure pursuant to the Connecticut General Statutes Section 1-210."

On May 30, 2014, the Applicants filed the following document, indicating that it was the Eastern Connecticut Region Strategic Plan (ECRS) Plan. This document is to remain outside of the docket's record.

May 30, 2014

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

RECEIVED
MAY 30 2014
Office of
HEALTHCARE ACCESS

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, please find attached a comprehensive integration document as requested in Condition 5.

This document provides OHCA information on the plan to integrate the operations of both parent corporations to the hospital, the information on anticipated cost savings stated in the CON Application, and other affiliation related revenue enhancements.

Please contact me if you require further information, at 860-425-3872.

Sincerely,

Janette E. Edwards

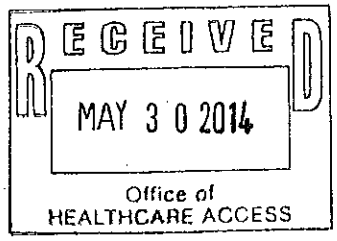
Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

Acknowledging the need to drive and regularly monitor the integration activities between the William W. Backus Hospital ("Backus" or "Backus Hospital") and Hartford HealthCare ("HHC") an Integration Steering Committee ("Steering Committee" or "Committee") was formed. The Steering Committee meets on a regularly scheduled, monthly basis, and membership includes Executive Leadership of both Backus Hospital and HHC.

In these meetings, leadership discusses, plans, implements, and monitors the integration and alignment of the two organizations across the following areas:

- *Administration*
- *Clinical*
- *Financial*
- *Human Resources*
- *Information Technology ("IT")*
- *Supply Chain*
- *Strategy*
- *Governance/Legal*



Since August 1, 2013 (the effective date of the Affiliation agreement between Backus and HHC), the Steering Committee has identified 99 projects that are all in various stages of implementation. Some projects have been completed, some are in-process, and some have not yet been started. The Steering Committee involves Subject Matter Experts ("SME") from across the HHC organization when expertise is required for successful planning and implementation of key strategies. Examples of such SMEs that are included in discussions are leadership from Senior Care, the Visiting Nurses Association, and Clinical Lab Partners.

First and foremost of these projects was the creation of the HHC Eastern Region, and the subsequent East Region Shared Service Organization. The HHC Eastern Region includes both Backus and Windham Hospital ("Windham") and all of their affiliated entities. Such entities include CONNCare, Inc. and Backus Physician Services ("BPS").

By creating the Eastern Region, HHC gained efficiencies that are a direct result of achieving economies of scale and eliminating redundant processes. The creation of the region

resulted in a reorganization of staff and management, which included identifying a shared Executive Leadership Team between Backus and Windham. Key members of the Regional Executive Team are also employees of the system, with direct reporting relationships to HHC Executive System Leadership. The regional Vice President of Physician Affairs moved to the position of President of the HHC Medical Group ("HHC MG"), and the regional Chief Administrative Officer moved to become the system's Vice President of Marketing and Branding. These staffing transitions directly place regional talent in leadership positions at the system level, ensuring the region remains closely tied to the goals of the larger system.

This reorganization also created a Regional Leadership Team. Similar to the Regional Executive Leadership Team, the Regional Leadership Team is comprised of Directors, Managers, and Supervisors who have dual responsibilities for both Hospital campuses, and across entities. Another result of this reorganization was the centralizing of services, such as marketing, communications, human resources, and IT to the system level.

In addition to reorganizing and integrating the Executive and Leadership teams, the Committee has taken steps to integrate the Medical Staff into the larger system. The employed providers working within CONNCare and BPS joined HHC's Integrated Care Partners ("ICP"). The move into ICP will allow BPS and CONNCare providers to participate in ICP's Medicare Shared Savings program, and implement ICP's evidence-based protocols into their daily practice. Such integration also provides ICP with data for analysis and trending to determine the impact the developed best practices have on population health. Further, Backus has been included in care coordination planning efforts at the system level; ensuring regional clinical and administrative leaders are providing insight and direction to the system as a whole.

There is an ongoing effort to enroll private providers within ICP, more fully aligning the region's private providers with the system. Both employed and private physicians from the region will have opportunities to participate in ICP's governance, giving regional clinical leaders the chance to directly impact the direction and future of the organization. Backus physicians have also been included in the HHC Physician Leadership Institute.

In the near-term, Backus providers employed by CONNCare and BPS will become part of HHC MG). This step will bring these providers and their practices fully under the management, contracting, and leadership of HHC MG, while remaining tied to the East Region. Additionally, physician recruitment efforts and the Medical Staff Development Plan at Backus are becoming more aligned with HHC's system-wide plans.

Since the effective date of the affiliation, Backus leaders have been included in the HHC Quality Council, and eighteen other Clinical Councils. The purpose of these Councils is to promote excellence in clinical care, foster professional development to identify best practices in specific specialties and to achieve the highest level of excellence. The Councils will identify potential gaps, variations in practice, and integrate common practices and standardization for optimal outcomes.

These Councils cover major service lines such as surgery, obstetrics, behavioral health quality, and neurosurgery, in addition to perioperative services, emergency medicine, hospital medicine, anesthesiology, infection prevention, radiology, pharmacy and therapeutics, patient experience, robotic surgery, and pathology. In addition to these Clinical Councils, Backus participates in four HHC Cancer Disease Management Teams ("DMT"). These DMTs function as the Clinical Councils in the Cancer arena. The DMTs focus on Breast Cancer, Genitourinary Cancer, Thoracic Cancer, and Gynecologic Oncology.

The process of financially integrating Backus into the system is also underway. The integration of Fair Value Accounting is complete, and Backus is now part of the system's Risk Management and Insurance processes; Backus is also being integrated into the system's legal structure, financial audits, general accounting, and other financial systems.

Multiple Human Resources initiatives are planned and in progress, in addition to the recent regional reorganization. Examples of some of these initiatives include consolidating and gaining volume pricing for health and welfare vendors such as Aetna TPA, Delta Dental, Life, AD&D, disability, and reinsurance. The process of incorporating Backus and affiliated physicians into the HHC Tier One network, and HHC providers into the Backus network (as applicable) has been completed. Further, a review of employee benefits was conducted, and a

timeline to adopt model plan designs for health, dental, time off and other ancillary benefits has been developed.

The Leadership Development Program, "How Hartford HealthCare Works" ("H3W") has been introduced to the Executive Leadership and Regional Leadership Teams, and trainings will be rolled out to staff over the summer months. H3W not only sets expectations for leadership behavior, but also introduces and ingrains the HHC culture within the region. This step will further solidify Backus as part of a larger health care delivery system.

With patient safety as the top line priority, Backus is on the path of becoming a "Highly Reliable Organization" ("HRO"). Over the course of the last year, Backus trained every employee on HRO safety concepts. At Backus, HRO concepts are not viewed simply as tools to reduce patient harm, but as the culture, and delivery ideology, of health care. In an HRO environment, the patient's wellbeing is at the center of every decision. HRO education is now taking place at Windham, with the goal of 100% employee participation in training sessions. To date, 90% of the Medical Staff at Windham has been trained in HRO concepts, in addition to 55% of employees. Implementing the HRO concepts at Windham, like H3W, introduces the Backus culture to Windham, and refocuses all employees on achieving one common goal: the elimination of patient harm.

To reduce redundancy within the system and gain economies of scale where able, a consolidation and inventory of IT contracts and applications is on track. IT leadership within the region is working closely with system IT leaders to streamline services at Backus and Windham. This effort includes ICD-10 project management, email integration, and other clinical IT requirements. Backus has been incorporated in the CareConnect/E.H.R. support, included in the shared technology capital planning process, and a three to five year strategic plan focusing on radiology and imaging technology.

Many integration efforts have been completed within the existing supply chain at Backus. There has been a transition of Backus' GPO (Group Purchasing Organization) relationship with Amerinet to The Greater New York Hospital Association,, and private supply contracts have been aligned and standardized. Going forward, Backus and HHC will utilize the same

suppliers, realizing further cost savings, and reducing variability. In the future, private supply contracts requiring product conversions will also be standardized. Backus secured HHC system pricing for consulting, benchmarking, and other advisory services, which not only achieves cost savings but also provides Backus with enhanced access to industry thought leaders and best-practices.

Revenue enhancements are found within the 99 initiatives delineated by the Steering Committee, and discussed previously. Many of these initiatives focus on business development. These include additional integration efforts with Clinical Laboratory Partners, a biomedical services assessment, a review of system-wide resources, non-labor pharmacy opportunities, and rehabilitation network opportunities. Further revenue enhancements will be found through centralizing and consolidating the revenue cycle business office, the Institutional Review Boards, centralizing investment management, and government reimbursements.

Finally, the HHC Eastern Region's strategic plan has been developed and recommended for adoption by the Backus Board of Directors, and endorsed by the HHC Board of Directors. This comprehensive strategic plan sets overall direction and strategic imperatives for the region, which align with the system's overarching vision for the future.

In summary, the affiliation created efficiencies in staffing models, quality improvements across eighteen distinct Clinical Councils, and cost savings through economies of scales gained through the creation of a larger system of care. Although much progress has been made to integrate Backus into HHC, more will be done. The Steering Committee is closely monitoring the progress made on each of the identified initiatives, and is subsequently adding new initiatives regularly. The East Region is well on track to becoming fully integrated as a HHC partner.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Attachment 1 for detailed savings totals by major category.

a. **Salaries & Wages**

b. **Fringe Benefits**

c. **Contractual Labor Fees**

d. **Medical Supplies & Pharmaceutical Costs**

e. **Depreciation and Amortization**

f. **Bad Debts**

g. **Interest Expense**

h. **Malpractice Expense**

i. **Utilities**

j. **Business Expenses**

k. **Other Operating Expenses**

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

See Attachment 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachment 3 for the Balance Sheet for both Backus Corporation and Backus Hosptial.

Attachment 1

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

As of 5/20/14

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$3,668,839	$5,591,353	$9,260,192
Clinical Integration	$0	$0	$0
Clinical	$176,971	$176,971	$353,942
Finance	$1,409,000	$1,309,000	$2,718,000
Human Resources	$740,218	$986,402	$1,726,620
Information Technology	$0	$0	$0
Supply Chain	$2,399,282	$2,952,771	$5,352,053
Other Operations	$0	$0	$0
Total Savings	$8,394,310	$11,016,497	$19,410,807
Target Savings	$11,039,000	$15,036,000	$26,075,000
Variance from Target	($2,644,690)	($4,019,503)	($6,664,193)

ANNUAL	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$3,668,839	$1,922,515	$5,591,353
Clinical Integration	$0	$0	$0
Clinical	$176,971	$0	$176,971
Finance	$1,409,000	($100,000)	$1,309,000
Human Resources	$740,218	$246,184	$986,402
Information Technology	$0	$0	$0
Supply Chain	$2,399,282	$553,488	$2,952,771
Other Operations	$0	$0	$0
Total Savings	$8,394,310	$2,622,187	$11,016,497
Target Savings	$11,039,000	$3,997,000	$15,036,000
Variance from Target	($2,644,690)	($1,374,813)	($4,019,503)

Attachment 2

Backus Corporation
Consolidated Statement Of Operations
(In Thousands)

	Year to Date March 31, 2014 Actual	Year to Date March 31, 2014 Budget	Variance to Budget Fav. (Unfav.)	Year to Date March 31, 2013	Variance to Prior Year Fav. (Unfav.)
Gross Patient Service Revenue					
Inpatient			$ 0		$ 0
Outpatient	6,034	6,301	(267)		6,034
Professional Service Revenue	8,983	7,185	1,798		8,983
	15,017	13,486	1,531	0	15,017
Contractual Allowances	5,978	5,177	(801)		(5,978)
Bad Debt	175	189	14		(175)
Charity Care			0		0
	6,153	5,366	(787)	0	(6,153)
Net Revenues from Services to Patient	8,864	8,120	744	0	8,864
Other Operating Revenue	(299)	(259)	(40)		(299)
Net Assets Released from Restriction			0		0
Total Revenues	8,565	7,861	704	0	8,565
Operating Expenses					
Salaries and Fringe	7,566	7,142	(424)	0	(7,566)
Pension			0		0
Supplies and Other	1,093	827	(266)		(1,093)
Purchased Services	1,500	1,268	(232)		(1,500)
Malpractice	97	101	4		(97)
Depreciation and Amortization	18	20	2		(18)
Rental Expense	116	80	(36)		(116)
Interest Expense			0		0
	10,390	9,438	(952)	0	(10,390)
Operating Income (Loss)	(1,825)	(1,577)	(248)	0	(1,825)
Other Income:					
Income from Investments, Gifts and Bequests, Net	816	608	208		816
Other	(4)		(4)		(4)
Chg in Unrealized Gain (Loss) on Invest			0		0
	812	608	204	0	812
Excess (Deficiency) of Revenues over Expenses	$ (1,013)	$ (969)	$ (44)	$ 0	$ (1,013)

BACKUS HOSPITAL
Consolidated Statement Of Operations
(In Thousands)

	Year to Date March 31, 2014 Actual	Year to Date March 31, 2014 Budget	Variance to Budget Fav. (Unfav.)	Year to Date March 31, 2013	Variance to Prior Year Fav. (Unfav.)
Gross Patient Service Revenue					
Inpatient	$ 116,365	$ 116,797	$ (432)	$ 113,293	$ 3,072
Outpatient	205,361	187,191	18,170	185,859	19,502
Professional Service Revenue	17,955	17,052	903	16,467	1,488
	339,681	321,040	18,641	315,619	24,062
Contractual Allowances	197,150	185,034	(12,116)	176,697	(20,453)
Bad Debt	4,582	4,357	(225)	4,217	(366)
Charity Care	2,814	2,916	102	2,803	(11)
	204,546	192,307	(12,239)	183,717	(20,829)
Net Revenues from Services to Patient	135,135	128,733	6,402	131,902	3,233
Other Operating Revenue	2,498	2,288	210	2,724	(226)
Net Assets Released from Restriction	173	67	106	91	82
Total Revenues	137,806	131,088	6,718	134,717	3,089
Operating Expenses					
Salaries and Fringe	66,011	64,706	(1,305)	66,919	908
Pension	2,251	4,495	2,244	4,179	1,928
Supplies and Other	20,649	20,039	(610)	20,668	19
Purchased Services	25,311	23,588	(1,723)	19,640	(5,671)
lalpractice	2,908	2,600	(308)	2,024	(884)
epreciation and Amortization	7,857	9,044	1,187	9,132	1,275
Rental Expense	679	662	(17)	621	(58)
Interest Expense	1,241	1,641	400	1,695	454
	126,907	126,775	(132)	124,878	(2,029)
Operating Income (Loss)	10,899	4,313	6,586	9,839	1,060
Other Income					
Income from Investments, Gifts and Bequests, Net	6,791	5,391	1,400	5,784	1,007
Other	(722)		(722)	(79)	(643)
Chg in Unrealized Gain (Loss) on Invest	(83)	(71)	(12)		(83)
	5,986	5,320	666	5,705	281
Excess (Deficiency) of Revenues over Expenses	$ 16,885	$ 9,633	$ 7,252	$ 15,544	$ 1,341
Operating Margin	7.91%	3.29%		7.30%	

Attachment 3

Backus Corporation

Consolidated Balance Sheet
(In Thousands)

	March 31, 2014	September 30, 2013	March 31, 2013
ASSETS			
Current Assets:			
Cash and Equivalents	$ 697	$ 2,200	
Accounts Receivable, Less Allowances of $1,464 at March 2014 and $1,427 at September 2013 and $0 at March 2013	2,981	1,381	
Other Receivables			
Due from Affiliates and Other Related Parties	(1,264)	(185)	
Inventories of Supplies			
Prepaid and Other Assets	66	27	
Estimated Third Party Payor Settlements			
Current Portion of Assets Whose Use is Limited			
Total Current Assets	2,780	3,431	0
Other Assets:			
Board Designated Assets			
Investment for Restricted Purposes			
Escrow Funds for Long Term Debt			
Funds Designated for Debt Service			
	0	0	0
Funds Held in Trust by Others			
Other Assets	730	712	
Net Property, Plant and Equipment	633	604	
Total Assets	$ 4,143	$ 4,647	$ -
LIABILITIES AND NET ASSETS			
Current Liabilities:			
Accounts Payable	$ 869	$ 693	
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	1,214	987	
Accrued Expenses	457	256	
Due to Affiliates and Other Related Parties			
Estimated Third Party Payor Settlements	253	246	
Current Portion of Accrued Pension Liability			
Current Portion of Long Term Debt			
Current Portion of Long Term Liabilities			
Total Current Liabilities	2,793	2,184	0
Long Term Debt, Less Current Portion			
Accrued Pension Liability			
Other Liabilities	548	648	
NET ASSETS			
Unrestricted	802	1,815	
Temporary Restricted			
Permanently Restricted			
Total Net Assets	802	1,815	0
Total Liabilities and Net Assets	$ 4,143	$ 4,647	$ -

BACKUS HOSPITAL
Consolidated Balance Sheet
(In Thousands)

	March 31, 2014	September 30, 2013	March 31, 2013
ASSETS			
Current Assets:			
Cash and Equivalents	$ 143,019	$ 132,348	$ 112,649
Accounts Receivable, Less Allowances of $16,228 at March 2014 and $16,761 at September 2013 and $17,314 at March 2013	32,907	31,014	31,894
Other Receivables	29	29	31
Due from Affiliates and Other Related Parties	1,480	185	1,285
Inventories of Supplies	4,381	3,715	3,658
Prepaid and Other Assets	3,499	3,010	2,135
Estimated Third Party Payor Settlements			
Current Portion of Assets Whose Use is Limited			
Total Current Assets	185,315	170,301	151,653
Other Assets:			
Board Designated Assets	151,128	144,302	139,681
Investment for Restricted Purposes	8,249	7,936	7,587
Escrow Funds for Long Term Debt			
Funds Designated for Debt Service	0	3,737	4,765
	159,377	155,975	152,033
Funds Held in Trust by Others	2,636	2,515	2,361
Other Assets	9,169	9,206	7,570
Net Property, Plant and Equipment	132,067	139,744	86,391
Total Assets	$ 488,564	$ 476,741	$ 400,216
LIABILITIES AND NET ASSETS			
Current Liabilities			
Accounts Payable	$ 9,087	$ 8,031	$ 7,964
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	5,018	6,965	4,815
Accrued Expenses	5,989	6,320	7,387
Due to Affiliates and Other Related Parties	2,822		
Estimated Third Party Payor Settlements	2,024	1,828	860
Current Portion of Accrued Pension Liability	1,271	3,553	839
Current Portion of Long Term Debt	335	2,443	2,195
Current Portion of Long Term Liabilities			
Total Current Liabilities	26,546	29,140	24,060
Long Term Debt, Less Current Portion	66,484	67,194	65,035
Accrued Pension Liability	14,488	18,269	52,302
Other Liabilities	38,123	36,647	44,789
NET ASSETS			
Unrestricted	331,039	314,118	202,846
Temporary Restricted	3,522	3,306	3,181
Permanently Restricted	8,363	8,067	7,913
Total Net Assets	342,924	325,491	213,940
Total Liabilities and Net Assets	$ 488,564	$ 476,741	$ 400,216

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

As of January 31, 2014

	CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
1	Administrative	$3,668,839	$5,591,353	$9,260,192
2	Clinical Integration	$0	$0	$0
3	Clinical	$130,000	$130,000	$260,000
4	Finance	$809,000	$509,000	$1,318,000
5	Human Resources	$527,000	$527,000	$1,054,000
6	Information Technology	$0	$0	$0
7	Supply Chain	$2,137,474	$2,137,474	$4,274,948
8	Other Operations	$0	$0	$0
9	Total Savings Identified	$7,272,312	$8,894,827	$16,167,140
10	Target Savings from CON	$11,039,000	$15,036,000	$26,075,000
11	Variance from Target	($3,766,688)	($6,141,173)	($9,907,860)

	ANNUAL	Fiscal Year 14	Fiscal Year 15	Total
1	Administrative	$3,668,839	$1,922,515	$5,591,353
2	Clinical Integration	$0	$0	$0
3	Clinical	$130,000	$0	$130,000
4	Finance	$809,000	($300,000)	$509,000
5	Human Resources	$527,000	$0	$527,000
6	Information Technology	$0	$0	$0
7	Supply Chain	$2,137,474	$0	$2,137,474
8	Other Operations	$0	$0	$0
9	Total Savings Identified	$7,272,312	$1,622,515	$8,894,827
10	Target Savings from CON	$11,039,000	$3,997,000	$15,036,000
11	Variance from Target	($3,766,688)	($2,374,485)	($6,141,173)

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
ADM01	Administration	Creation of HHC Eastern Region
ADM02	Administration	East Region Shared Services Organization

INT01	Clinical Integration	Integrate Backus employed physicians into HHCMG
INT02	Clinical Integration	Align Backus recruitment efforts and Medical Staff Development Plan with HHC
INT03	Clinical Integration	Integrate independent and employed primary care practices into ICP shared savings - provide assessment
INT04	Clinical Integration	Involve Backus physicians in Integrated Care Partners Governance
INT05	Clinical Integration	Include Backus in Care Coordination Planning at HHC

CL02	Clinical	Backus included in Quality Council
CL03	Clinical	Develop a plan to integrate IRB and research activities at WWBH under the HHC structure
CL05	Clinical	Backus Physician Infrastructure (Primary Care)
CL06	Clinical	Backus Included in Physician Infrastructure
CL07	Clinical	Backus included in ACO planning
CL10	Clinical	Sharing Technology - capital planning process (over $1M)
CL12	Clinical	Sharing Technology - sharing HH simulation lab

		Short project description
CL13	Clinical	Sharing Technology - 3 to 5 year strategic plan (radiology/imaging/robotics)
CL14	Clinical	Curative wound care program
CL16	Clinical	Backus incorporated in Community Connect / E.H.R. support
CL17	Clinical	Backus included in (16) clinical councils
CL18	Clinical	Include Backus in HHC Common Credentialing Platform (Complete assessment)
CL19	Clinical	Dialysis program evaluation
CL21	Clinical	Evaluate WWBH utilizing CLP as primary reference lab
CL22	Clinical	Evaluate WWBH utilizing CLP/Quest reference lab contract
CL23	Clinical	Medical Library Services
CL24	Clinical	Include Backus in Universal Flu Immunization Program
CL25	Clinical	Risk Management Education
CL26	Clinical	Implement best practices from each facility to lower direct, variable cost of care for highest opportunity DRG

FIN01	Finance	Fair Value Accounting
FIN02	Finance	Legal Structure
FIN03	Finance	Audits - Financial

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
FIN04	Finance	General Accounting / Financial Reporting
FIN05	Finance	Sponsored Programs / Grant Accounting
FIN06	Finance	Financial Systems
FIN07	Finance	Government Reimbursement
FIN08	Finance	Tax Returns and Reporting
FIN09	Finance	Budget
FIN10	Finance	Decision Support
FIN11	Finance	Treasury
FIN12	Finance	Pension Issues - Treasury
FIN13	Finance	Risk Management/Insurance
FIN14	Finance	Other Finance Items
FIN15	Finance	Payroll
FIN16	Treasury	Electronic payment (AMEX)
FIN17	Treasury	Investment management
FIN18	RevCycle	Centralize and consolidate revenue cycle business office

		Short project description
HR03	Human Resources	Conduct employee benefits review and timeline to adopt model plan designs for health, dental, time off and other ancillary benefits
HR04	Human Resources	Incorporate Backus Hospital and physicians into Tier 1 network and HHC into Backus' network as applicable
HR05	Human Resources	Adopt standard HHC PTO provisions including designated holidays
HR06	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (e.g. Aetna TPA, Delta Dental, reinsurance)
HR07	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (e.g. Life, AD&D, disability)
HR08	Human Resources	Integrate into Captive for purposes of health plan reinsurance (Medical Stop Loss)
HR09	Human Resources	Integrate into Aon Hewitt Benefits Eligibility TPA
HR10	Human Resources	Integrate into Prudential Single DC Record-keeper
HR11	Human Resources	Integrate into Prudential Leave TPA
HR12	Human Resources	Introduce Healthy Together, premium credits and cost sharing strategy
HR13	Human Resources	Upgrade to Kronos 6.3
HR14	Human Resources	Review and adopt standard HHC HR P&Ps and workstreams driving PeopleSoft build and HR Future State Transformation
HR17	Human Resources	Review other HR policies and processes to identify best practices and adopt throughout HHC (e.g., Travel)
HR18	Human Resources	Integrate and participate in HHC Human Resources Future State Centralized Services and/or Centers of Expertise
HR20	Human Resources	Introduce HHC Core Values & Making A Difference Training
HR21	Human Resources	Introduce H3W Leadership Behaviors

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
HR22	Human Resources	Consolidate contingent labor vendors and implement ShiftWise
HR23	Human Resources	Adopt HHC Transfer Policy and Single Employer Guidelines
HR24	Human Resources	Participate in HHC Administrative Fiduciary for retirement plans
HR26	Human Resources	Include Backus MDs in HHC Physician Leadership Institute
HR28	Human Resources	Scale occupational/employee health support services and related processes
HR29	Human Resources	Participate in the HHC Pulse engagement survey in Fall 2013
HR30	Human Resources	Consolidate and gain volume pricing for health & welfare vendors (Vision 2014 - all others 2015 Project HR07)

IT01	Information Technology	Develop plans for 2nd HHC Data Center (assessment complete)
IT02	Information Technology	Email Integration (all employees by 3/3/14)
IT04	Information Technology	Consolidation/inventory of ITS contracts and applications
IT05	Information Technology	ICD-10 Project Management
IT06	Information Technology	Launch HHC SharePoint application for Backus

SC01	Supply Chain	Transition GPO relationship from Amerinet to GNYHA
SC02	Supply Chain	Align contracts and standardize supplies & services: Phase I - Private supply contracts (HHC/Backus same supplier)

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
SC03	Supply Chain	Align contracts and standardize supplies & services: Phase II - Private supply contracts requiring product conversions
SC04	Supply Chain	Secure HHC system pricing for Press Ganey/Moorehead/Advisory Board

ST01	Strategy	Implement communication plan
ST02	Strategy	Eastern Region ambulatory strategy (Current Opportunities)

OT02	Other Operations	VNA (Business and Human Resource components)
OT03	Other Operations	HHC Rehabilitation Network opportunities
OT04	Other Operations	Long-term care
OT05	Other Operations	Clinical Lab Partners - additional integration efforts
OT06	Other Operations	Biomedical Services - Assessment
OT07	Other Operations	Facilities: Utilities expense
OT08	Other Operations	Legal - review system-wide resources and use of external legal firms
OT09	Other Operations	Pharmacy opportunities (non-labor)
OT10	Other Operations	Pharmacy - integrate and utilized clinical pharmacy experience & physcian support

Hartford HealthCare
Projects Identified for the Integration of Backus Hospital into Hartford HealthCare
Project list as of January 31, 2014

		Short project description
GOV01	Governance / Legal	Board Resolution - Investment Committee
GOV02	Governance / Legal	Board Resolution - Fiduciary
GOV03	Governance / Legal	Board Resolution - Pension Trustee
GOV04	Governance / Legal	HHC Board Committee Appointments
GOV05	Governance / Legal	CON: file full non-redacted final affiliation agreement
GOV06	Governance / Legal	CON: Submit detailed and comprehensive integration document
GOV07	Governance / Legal	CON: Semi-annual reporting by HHC & Backus regarding integration plan (GOV06)
GOV08	Governance / Legal	CON: Submit high level summary of Eastern CT Region Strategic Plan
GOV09	Governance / Legal	CON: File detailed benefits / cost savings report (2 years - 26 Required Items)
GOV10	Governance / Legal	CON: Final Accounting all benefits and cost savings

Greer, Leslie

From: Martone, Kim
Sent: Monday, December 01, 2014 1:52 PM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie
Subject: FW: Backus/HHC Semi-Annual Filing DN12-31788-CON
Attachments: 11.30.14 semi annual filing FINAL DRAFT.pdf

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, December 01, 2014 1:32 PM
To: Martone, Kim
Subject: Backus/HHC Semi-Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 5 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

November 24, 2014

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. Further, Table 2 provides comparison between savings over identified fiscal years, and Table 3 illustrates actual vs. targeted savings in graph form. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.

Sincerely,

Janette E. Edwards

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Hartford HealthCare

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of the affiliation, as of September 2014, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total projected cumulative savings of $19M in FY2015.

Success has been accomplished through the regular oversight provided by an Integration Steering Committee established in 2013, which brings together leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing):

- *Administration*
- *Clinical*
- *Clinical Integration*
- *Financial*
- *Human Resources*
- *Information Technology*
- *Supply Chain*
- *Other Operations*
- *Strategy*
- *Governance/Legal*

In the new Fiscal Year the Integration Committee will continue to meet to identify further cost-savings and quality enhancing opportunities. These opportunities will be driven in collaboration with front-line subject matter experts in the development of Management Action Plans ("MAPs"). MAPs identify efficiencies, savings, or revenue-generating strategies that can be gained through new ways of working by using Lean techniques, through newly identified purchasing and procurement tactics, and through new business lines. It is fully anticipated that

Hartford HealthCare

additional savings will be realized throughout the Fiscal Year, impacting the overall integration benefits enjoyed by Backus and HHC.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 and 2 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

Hartford HealthCare

See the Attachment 1 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachment 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

Hartford HealthCare

- **Table 1**

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

As of 9/12/14

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$4,088,498	$6,602,581	$10,691,079
Clinical Integration	$0	$351,000	$351,000
Clinical	$179,782	$309,621	$489,403
Finance	$8,009,000	$7,309,000	$15,318,000
Human Resources	$739,802	$986,402	$1,726,204
Information Technology	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$6,403,462
Other Operations	$17,871	$251,450	$269,321
Total Savings	$15,567,040	$19,681,428	$35,248,468
Target Savings	$11,039,000	$15,036,000	$26,075,000
Variance from Target	$4,528,040	$4,645,428	$9,173,468

ANNUAL	Fiscal Year 14	Fiscal Year 15	Total
Administrative	$4,088,498	$2,514,084	$6,602,581
Clinical Integration	$0	$351,000	$351,000
Clinical	$179,782	$129,839	$309,621
Finance	$8,009,000	($700,000)	$7,309,000
Human Resources	$739,802	$246,601	$986,402
Information Technology	$0	$0	$0
Supply Chain	$2,532,088	$1,339,285	$3,871,374
Other Operations	$17,871	$233,579	$251,450
Total Savings	$15,567,040	$4,114,388	$19,681,428
Target Savings	$11,039,000	$3,997,000	$15,036,000
Variance from Target	$4,528,040	$117,388	$4,645,428

Hartford HealthCare

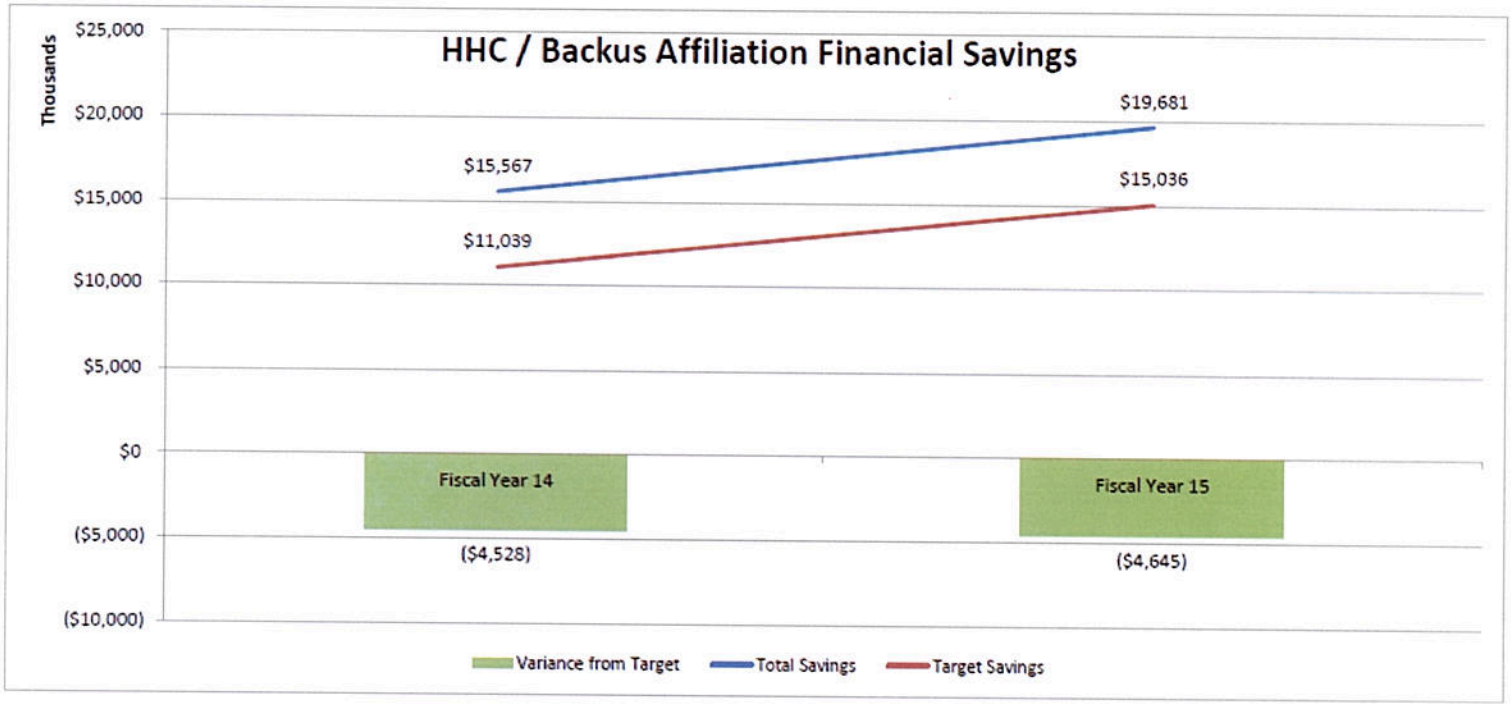
- **Table 2**

HHC Backus Affiliation
Huron Report Summary
Huron Report Date: July 12, 2012

Area	CUMMULATIVE FY2013	CUMMULATIVE FY2014	CUMMULATIVE FY2015	BY YEAR FY2013	BY YEAR FY2014	BY YEAR FY2015	BY YEAR Total
Non-Labor - Total Assessment Opportunity							
Non Clinical Purchased Services	$1,479,000	$1,882,000	$2,284,000	$1,479,000	$403,000	$402,000	$2,284,000
Pharmacy	$400,000	$500,000	$600,000	$400,000	$100,000	$100,000	$600,000
Lab	$300,000	$350,000	$400,000	$300,000	$50,000	$50,000	$400,000
Clinical Supplies	$185,000	$225,000	$265,000	$185,000	$40,000	$40,000	$265,000
Annualized Sub Total	$2,364,000	$2,957,000	$3,549,000	$2,364,000	$593,000	$592,000	$3,549,000
Revenue Cycle - Total Assessment Opportunity							
Vendor Cost Savings	$80,000	$165,000	$250,000	$80,000	$85,000	$85,000	$250,000
Denials/Write-Off Improvements	$1,400,000	$2,500,000	$3,600,000	$1,400,000	$1,100,000	$1,100,000	$3,600,000
FTE Savings	(See Labor Section)						
Annualized Sub Total	$1,480,000	$2,665,000	$3,850,000	$1,480,000	$1,185,000	$1,185,000	$3,850,000
Clinical Operations - Total Assessment Opportunity							
Clinical Operations	$250,000	$400,000	$580,000	$250,000	$150,000	$180,000	$580,000
Direct Variable Cost Savings	$425,000	$637,500	$850,000	$425,000	$212,500	$212,500	$850,000
FTE Savings	(See Labor Section)						
Annualized Sub Total	$675,000	$1,037,500	$1,430,000	$675,000	$362,500	$392,500	$1,430,000
Human Resources - Total Assessment Opportunity							
Employee Benefits	$465,000	$513,000	$560,000	$465,000	$48,000	$47,000	$560,000
Absence Management	$180,000	$192,500	$205,000	$180,000	$12,500	$12,500	$205,000
Premium Pay	$160,000	$213,000	$265,000	$160,000	$53,000	$52,000	$265,000
HR Purchased Services	$195,000	$228,000	$260,000	$195,000	$33,000	$32,000	$260,000
Annualized Sub Total	$1,000,000	$1,146,500	$1,290,000	$1,000,000	$146,500	$143,500	$1,290,000
Labor - Total Assessment Opportunity							
Revenue Cycle (CBO/HIM/Access)	$460,000	$855,000	$1,250,000	$460,000	$395,000	$395,000	$1,250,000
Fiscal Services (Finance/IT/Materials Management)	$1,760,000	$2,155,000	$2,550,000	$1,760,000	$395,000	$395,000	$2,550,000
Administrative (Admin/Lab/HR/Facilities) & Home Health Services	$3,300,000	$4,220,000	$5,140,000	$3,300,000	$920,000	$920,000	$5,140,000
Annualized Sub Total	$5,520,000	$7,230,000	$8,940,000	$5,520,000	$1,710,000	$1,710,000	$8,940,000
Grand Total	$11,039,000	$15,036,000	$19,059,000	$11,039,000	$3,997,000	$4,023,000	$19,059,000

Hartford HealthCare

- **Table 3**



326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

The William W. Backus Hospital
Balance Sheet
September 30, 2014 *

Assets	Draft
Current assets:	
Cash and cash equivalents	$ 187,018,905
Assets whose use is limited-required for current liabilities	3,285,815
Accounts receivable, less allowance	36,980,052
Other receivables	1,320,143
Inventories of supplies	3,771,462
Prepaid expenses	1,643,561
Due from affiliates	2,052,950
Total current assets	236,072,888
Assets whose use is limited:	
Investments and other assets	57,081,792
Interest in investments held by Endowment LLC	47,662,263
Donor restricted int in investments Endowment LLC	8,311,558
Investments for restricted purposes	26,640,012
	139,695,625
Funds held in trust by others	2,633,503
Other assets	7,214,261
Property, plant and equipment	
Land and land improvements	8,427,224
Buildings and leasehold improvements	184,043,214
Equipment	110,441,761
Construction in progress	185,693
Accumulated depreciation	(175,263,190)
	127,834,702
	$ 513,450,979
Liabilities and Net Assets	
Current liabilities	
Accounts payable-trade	$ 8,403,969
Salaries and wages, payroll taxes and taxes withheld from payroll	7,611,745
Due to affiliates	2,841,766
Accrued liabilities	6,965,890
Current portion of pension liability	3,828,400
Due to third parties	8,036,715
Current portion of long-term liabilities	653,974
Current portion of long-term debt	399,818
Total current liabilities	38,742,277
Other Liabilities:	
Long-term debt, less current portion	68,199,710
Accrued pension liability	30,076,502
Self-insured professional liability	8,527,863
Other	4,532,110
	111,336,185
Net Assets:	
Common stock	
Unrestricted net assets	351,485,071
Temporarily restricted net assets	3,534,497
Permanently restricted net assets	8,352,949
	363,372,517
	$ 513,450,979

*includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
September 30, 2014

Draft

Assets	
Current assets:	
Cash and cash equivalents	$ 187,885,111
Assets whose use is limited-required for current liabilities	3,285,815
Accounts receivable, less allowance	38,557,357
Other receivables	1,341,254
Inventories of supplies	3,771,462
Prepaid expenses	1,671,760
Due from affiliates	2,358,949
Total current assets	238,871,708
Assets whose use is limited:	
Investments and other assets	57,081,792
Interest in investments held by Endowment LLC	47,662,263
Donor restricted int in investments Endowment LLC	8,311,558
Investments for restricted purposes	26,640,012
	139,695,625
Funds held in trust by others	2,633,503
Other assets	8,357,721
Property, plant and equipment	
Land and land improvements	8,427,224
Buildings and leasehold improvements	184,197,093
Equipment	111,491,808
Construction in progress	185,693
Accumulated depreciation	(175,584,689)
	128,717,129
	$ 518,275,686
Liabilities and Net Assets	
Current liabilities	
Accounts payable-trade	$ 8,540,858
Salaries and wages, payroll taxes and taxes withheld from payroll	9,007,281
Due to affiliates	2,865,926
Accrued liabilities	6,967,449
Current portion of pension liability	3,828,400
Due to third parties	8,663,714
Current portion of long-term liabilities	653,974
Current portion of long-term debt	399,818
Total current liabilities	40,927,420
Other Liabilities:	
Long-term debt, less current portion	68,199,710
Accrued pension liability	30,076,502
Self-insured professional liability	8,846,276
Other	4,532,110
	111,654,598
Net Assets:	
Unrestricted net assets	353,806,222
Temporarily restricted net assets	3,534,497
Permanently restricted net assets	8,352,949
	365,693,668
	$ 518,275,686

The William W. Backus Hospital
Income Statement
As of September 30, 2014 - YTD

Draft

	9/30/2014 *
Revenues:	
Gross patient service revenue:	
Inpatient	$ 234,370,174
Outpatient	430,068,177
Professional service revenue	37,267,111
	701,705,462
Contractual allowances	394,788,265
Charity care	5,263,975
Provision for bad debt	8,035,283
Net revenue from service to patients	293,617,939
Other operating revenue	7,226,224
Net assets released from restrictions	287,246
Total revenues	301,131,409
Expenses:	
Salaries and wages	110,166,889
Payroll taxes and fringe benefits	18,336,102
Pension	3,111,387
Supplies and expenses	44,235,640
Purchased service	54,305,989
Malpractice	1,363,097
Depreciation and amortization	15,651,354
Rental expense	1,609,189
Interest	2,992,001
	251,771,648
Operating income (loss) before bond refinancing	49,359,761
Loss on bond refinancing	(722,310)
Operating income (loss)	48,637,451
Nonoperating gains and (losses)	
Investment income	9,253,115
Other	(186,851)
Excess (deficiency) of revenue over expenses	$ 57,703,715

*includes Backus Condominium Association

Backus Corporation and Subsidiaries
Consolidating Statement of Operations
As of September 30, 2014 - YTD

	Draft 9/30/2014
Revenues:	
Gross patient service revenue:	
Inpatient	$ 234,370,174
Outpatient	438,834,599
Professional service revenue	59,415,543
	732,620,316
Contractual allowances	409,557,356
Charity care	5,263,975
Provision for bad debt	8,520,064
Net revenue from service to patients	309,278,921
Other operating revenue	8,779,703
Net assets released from restrictions	287,246
Total revenues	318,345,870
Expenses:	
Salaries and wages	122,973,389
Payroll taxes and fringe benefits	21,292,907
Pension	3,114,970
Supplies and expenses	46,608,626
Purchased service	57,290,669
Malpractice	1,382,002
Depreciation and amortization	15,759,885
Rental expense	1,759,277
Interest	2,992,001
	273,173,726
Operating income (loss) before bond refinancing	45,172,144
Loss on bond refinancing	(722,310)
Operating income (loss)	44,449,834
Nonoperating gains and (losses)	
Investment income	11,402,396
Other	(190,849)
Excess (deficiency) of revenue over expenses	$ 55,661,381

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, June 02, 2015 7:51 AM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie
Subject: FW: Backus/HHC Semi-Annual Filing DN12-31788-CON

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, June 01, 2015 5:12 PM
To: Martone, Kim
Cc: Durdy, Barbara; Goyette, Karen T.; Whitehead, David
Subject: Backus/HHC Semi-Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 5 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

May 31, 2015

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. At this time, all integration targeted savings have been met. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.

Sincerely,

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

Hartford HealthCare

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of the affiliation, as of September 2014, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total projected cumulative savings of $19.6M in FY2015, and a projected total savings of $19.7M in FY 2016.

Success has been accomplished through the regular oversight provided by an Integration Steering Committee established in 2013, which brings together leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing):

- *Administration*
- *Clinical*
- *Clinical Integration*
- *Financial*
- *Human Resources*
- *Information Technology*
- *Supply Chain*
- *Other Operations*
- *Strategy*
- *Governance/Legal*

The Integration Committee continues to identify further cost-savings and quality enhancing opportunities. These opportunities will be driven in collaboration with front-line subject matter experts in the development of Management Action Plans ("MAPs"). MAPs identify efficiencies, savings, or revenue-generating strategies that can be gained through new ways of working by using Lean techniques, through newly identified purchasing and procurement tactics, and through new business lines. It is fully anticipated that additional savings will be realized

Hartford HealthCare

throughout the Fiscal Year, impacting the overall integration benefits enjoyed by Backus and HHC.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

Hartford HealthCare

See the Attachments 1and 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachments 1 and 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

Hartford HealthCare

- **Table 1**

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Fiscal Year 16	Total
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

Hartford HealthCare

Attachment 1: *Backus Corporation & Subsidiaries Consolidating Balance Sheets & Statement of Operations, April 30, 2015*

Backus Corporation and Subsidiaries
Consolidating Statement of Operations

	Year to Date April 30,2015
Revenues:	
Gross patient service revenue:	
Inpatient	$ 136,655,108
Outpatient	259,283,767
Professional service revenue	40,063,701
	436,002,576
Contractual allowances	258,668,238
Charity care	2,372,183
Provision for bad debt	5,138,073
Net revenue from service to patients	169,824,082
Other operating revenue	5,892,574
Net assets released from restrictions	102,153
Total revenues	175,818,809
Expenses:	
Salaries and wages	70,305,102
Payroll taxes and fringe benefits	14,257,452
Pension	1,083,866
Supplies and expenses	26,109,470
Purchased service	30,611,531
Malpractice	40,891
Depreciation and amortization	8,990,509
Rental expense	1,357,065
Interest	1,964,840
	154,720,726
Operating income	21,098,083
Nonoperating gains and (losses)	
Investment income	7,747,195
Other	62,220
Excess of revenue over expenses	$ 28,907,498

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
April 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	176,136,195
Assets whose use is limited-required for current liabilities		6,190,478
Accounts receivable, less allowance		35,287,110
Other receivables		317,481
Inventories of supplies		4,018,675
Prepaid expenses		5,062,686
Due from third parties		0
Due from affiliates		4,006,745
Total current assets		231,019,370
Assets whose use is limited:		
Investments and other assets		56,759,333
Interest in investments held by Endowment LLC		75,415,263
Donor restricted int in investments Endowment LLC		8,514,171
Investments for restricted purposes		19,586,682
		160,275,449
Funds held in trust by others		2,664,290
Other assets		16,068,306
Property, plant and equipment		
Land and land improvements		8,427,224
Buildings and leasehold improvements		184,159,797
Equipment		109,699,284
Construction in progress		3,551,991
Accumulated depreciation		(182,871,216)
		122,967,080
	$	532,994,495

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
April 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	5,387,220
Salaries and wages, payroll taxes and taxes withheld from payroll		4,639,540
Due to affiliates		1,774,676
Accrued liabilities		6,157,861
Current portion of pension liability		2,114,823
Due to third parties		8,004,144
Current portion of long-term liabilities		845,859
Current portion of long-term debt		243,577
Total current liabilities		29,167,700
Other Liabilities:		
Long-term debt, less current portion		68,068,729
Accrued pension liability		36,543,714
Self-insured professional liability		8,280,287
Other		5,035,491
		117,928,221
Net Assets:		
Common stock		-
Unrestricted net assets		373,030,814
Temporarily restricted net assets		4,484,024
Permanently restricted net assets		8,383,736
		385,898,574
	$	532,994,495

0

Hartford HealthCare

Attachment 2: *The William W. Backus Hospital Consolidating Balance Sheets & Statement of Operations, April 30, 2015*

BACKUS HOSPITAL
Consolidated Balance Sheet
(In Thousands)

	April 30, 2015
ASSETS	
Current Assets:	
Cash and Equivalents	$ 175,104
Accounts Receivable, Less Allowances of $5,513 at April 2015 and $15,457 at September 2014 and $16,002 at April 2014	33,960
Other Receivables	288
Due from Affiliates and Other Related Parties	4,627
Inventories of Supplies	4,019
Prepaid and Other Assets	4,993
Estimated Third Party Payor Settlements	
Current Portion of Assets Whose Use is Limited	
Total Current Assets	222,991
Other Assets:	
Board Designated Assets	157,952
Investment for Restricted Purposes	8,514
Escrow Funds for Long Term Debt	
Funds Designated for Debt Service	
	166,466
Funds Held in Trust by Others	2,684
Other Assets	14,716
Net Property, Plant and Equipment	121,995
Total Assets	$ 528,832
LIABILITIES AND NET ASSETS	
Current Liabilities:	
Accounts Payable	$ 5,361
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	3,998
Accrued Expenses	6,156
Due to Affiliates and Other Related Parties	1,744
Estimated Third Party Payor Settlements	7,377
Current Portion of Accrued Pension Liability	2,115
Current Portion of Long Term Debt	244
Current Portion of Long Term Liabilities	845
Total Current Liabilities	27,840
Long Term Debt, Less Current Portion	68,069
Accrued Pension Liability	36,544
Other Liabilities	12,998
NET ASSETS	
Unrestricted	370,514
Temporary Restricted	4,484
Permanently Restricted	8,383
Total Net Assets	383,381
Total Liabilities and Net Assets	$ 528,832

Hartford HealthCare

BACKUS HOSPITAL
Consolidated Statement Of Operations
(In Thousands)

	Year to Date April 30, 2015 Actual
Gross Patient Service Revenue	
Inpatient	$ 136,653
Outpatient	259,253
Professional Service Revenue	23,037
	418,943
Contractual Allowances	248,211
Bad Debt	5,005
Charity Care	2,374
	255,590
Net Revenues from Services to Patient	163,353
Other Operating Revenue	3,892
Net Assets Released from Restriction	102
Total Revenues	167,347
Operating Expenses:	
Salaries and Fringe	75,811
Pension	1,082
Supplies and Other	24,963
Purchased Services	29,023
Malpractice	(170)
Depreciation and Amortization	8,865
Rental Expense	1,265
Interest Expense	1,966
	142,805
Operating Income (Loss)	24,542
Other Income:	
Income from Investments, Gifts and Bequests, Net	5,910
Other	63
Chg in Unrealized Gain (Loss) on Invest	
	5,973
Excess (Deficiency) of Revenues over Expenses	$ 30,515
Operating Margin	14.67%

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, June 02, 2015 7:51 AM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie
Subject: FW: Backus/HHC Semi-Annual Filing DN12-31788-CON

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, June 01, 2015 5:12 PM
To: Martone, Kim
Cc: Durdy, Barbara; Goyette, Karen T.; Whitehead, David
Subject: Backus/HHC Semi-Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 5 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

May 31, 2015

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. At this time, all integration targeted savings have been met. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.

Sincerely,

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

Hartford HealthCare

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of the affiliation, as of September 2014, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total projected cumulative savings of $19.6M in FY2015, and a projected total savings of $19.7M in FY 2016.

Success has been accomplished through the regular oversight provided by an Integration Steering Committee established in 2013, which brings together leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing):

- *Administration*
- *Clinical*
- *Clinical Integration*
- *Financial*
- *Human Resources*
- *Information Technology*
- *Supply Chain*
- *Other Operations*
- *Strategy*
- *Governance/Legal*

The Integration Committee continues to identify further cost-savings and quality enhancing opportunities. These opportunities will be driven in collaboration with front-line subject matter experts in the development of Management Action Plans ("MAPs"). MAPs identify efficiencies, savings, or revenue-generating strategies that can be gained through new ways of working by using Lean techniques, through newly identified purchasing and procurement tactics, and through new business lines. It is fully anticipated that additional savings will be realized

Hartford HealthCare

throughout the Fiscal Year, impacting the overall integration benefits enjoyed by Backus and HHC.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

See Response to Condition A, above.

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

Hartford HealthCare

See the Attachments 1and 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachments 1 and 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

Hartford HealthCare

- **Table 1**

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Fiscal Year 16	Total
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

Hartford HealthCare

Attachment 1: *Backus Corporation & Subsidiaries Consolidating Balance Sheets & Statement of Operations, April 30, 2015*

Backus Corporation and Subsidiaries
Consolidating Statement of Operations

	Year to Date April 30,2015
Revenues:	
Gross patient service revenue:	
Inpatient	$ 136,655,108
Outpatient	259,283,767
Professional service revenue	40,063,701
	436,002,576
Contractual allowances	258,668,238
Charity care	2,372,183
Provision for bad debt	5,138,073
Net revenue from service to patients	169,824,082
Other operating revenue	5,892,574
Net assets released from restrictions	102,153
Total revenues	175,818,809
Expenses:	
Salaries and wages	70,305,102
Payroll taxes and fringe benefits	14,257,452
Pension	1,083,866
Supplies and expenses	26,109,470
Purchased service	30,611,531
Malpractice	40,891
Depreciation and amortization	8,990,509
Rental expense	1,357,065
Interest	1,964,840
	154,720,726
Operating income	21,098,083
Nonoperating gains and (losses)	
Investment income	7,747,195
Other	62,220
Excess of revenue over expenses	$ 28,907,498

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
April 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	176,136,195
Assets whose use is limited-required for current liabilities		6,190,478
Accounts receivable, less allowance		35,287,110
Other receivables		317,481
Inventories of supplies		4,018,675
Prepaid expenses		5,062,686
Due from third parties		0
Due from affiliates		4,006,745
Total current assets		231,019,370
Assets whose use is limited:		
Investments and other assets		56,759,333
Interest in investments held by Endowment LLC		75,415,263
Donor restricted int in investments Endowment LLC		8,514,171
Investments for restricted purposes		19,586,682
		160,275,449
Funds held in trust by others		2,664,290
Other assets		16,068,306
Property, plant and equipment		
Land and land improvements		8,427,224
Buildings and leasehold improvements		184,159,797
Equipment		109,699,284
Construction in progress		3,551,991
Accumulated depreciation		(182,871,216)
		122,967,080
	$	532,994,495

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
April 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	5,387,220
Salaries and wages, payroll taxes and taxes withheld from payroll		4,639,540
Due to affiliates		1,774,676
Accrued liabilities		6,157,861
Current portion of pension liability		2,114,823
Due to third parties		8,004,144
Current portion of long-term liabilities		845,859
Current portion of long-term debt		243,577
Total current liabilities		29,167,700
Other Liabilities:		
Long-term debt, less current portion		68,068,729
Accrued pension liability		36,543,714
Self-insured professional liability		8,280,287
Other		5,035,491
		117,928,221
Net Assets:		
Common stock		-
Unrestricted net assets		373,030,814
Temporarily restricted net assets		4,484,024
Permanently restricted net assets		8,383,736
		385,898,574
	$	532,994,495

0

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Hartford HealthCare

Attachment 2: *The William W. Backus Hospital Consolidating Balance Sheets & Statement of Operations, April 30, 2015*

BACKUS HOSPITAL
Consolidated Balance Sheet
(In Thousands)

	April 30, 2015
ASSETS	
Current Assets:	
Cash and Equivalents	$ 175,184
Accounts Receivable, Less Allowances of $5,513 at April 2015 and $15,457 at September 2014 and $16,002 at April 2014	33,960
Other Receivables	288
Due from Affiliates and Other Related Parties	4,627
Inventories of Supplies	4,019
Prepaid and Other Assets	4,993
Estimated Third Party Payor Settlements	
Current Portion of Assets Whose Use is Limited	
Total Current Assets	222,981
Other Assets:	
Board Designated Assets	157,952
Investment for Restricted Purposes	8,514
Escrow Funds for Long Term Debt	
Funds Designated for Debt Service	
	166,466
Funds Held in Trust by Others	2,664
Other Assets	14,716
Net Property, Plant and Equipment	121,995
Total Assets	$ 528,832
LIABILITIES AND NET ASSETS	
Current Liabilities:	
Accounts Payable	$ 5,361
Salaries, Wages, Payroll Taxes and Amounts Withheld from Employees	3,998
Accrued Expenses	6,156
Due to Affiliates and Other Related Parties	1,744
Estimated Third Party Payor Settlements	7,377
Current Portion of Accrued Pension Liability	2,115
Current Portion of Long Term Debt	244
Current Portion of Long Term Liabilities	845
Total Current Liabilities	27,840
Long Term Debt, Less Current Portion	66,069
Accrued Pension Liability	36,544
Other Liabilities	12,998
NET ASSETS	
Unrestricted	370,514
Temporary Restricted	4,484
Permanently Restricted	8,383
Total Net Assets	383,381
Total Liabilities and Net Assets	$ 528,832

Hartford HealthCare

BACKUS HOSPITAL
Consolidated Statement Of Operations
(In Thousands)

	Year to Date April 30, 2015 Actual
Gross Patient Service Revenue	
Inpatient	$ 136,653
Outpatient	259,253
Professional Service Revenue	23,037
	418,943
Contractual Allowances	246,211
Bad Debt	5,005
Charity Care	2,374
	255,590
Net Revenues from Services to Patient	163,353
Other Operating Revenue	3,892
Net Assets Released from Restriction	102
Total Revenues	167,347
Operating Expenses:	
Salaries and Fringe	75,811
Pension	1,082
Supplies and Other	24,963
Purchased Services	29,023
Malpractice	(170)
Depreciation and Amortization	8,865
Rental Expense	1,265
Interest Expense	1,966
	142,805
Operating Income (Loss)	24,542
Other Income:	
Income from Investments, Gifts and Bequests, Net	5,910
Other	63
Chg in Unrealized Gain (Loss) on Invest	
	5,973
Excess (Deficiency) of Revenues over Expenses	$ 30,515
Operating Margin	14.67%

326 Washington Street Norwich, CT 06360 860 425 3872 tel 860 892 2796 fax www.backushospital.org

Greer, Leslie

From: Martone, Kim
Sent: Thursday, July 23, 2015 9:43 AM
To: Roberts, Karen; Huber, Jack
Cc: Greer, Leslie
Subject: FW: Backus/HHC Annual Filing DN12-31788-CON
Attachments: 7.20.15 Annual Filing Response.pdf

From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, July 20, 2015 5:56 PM
To: Martone, Kim
Cc: Durdy, Barbara; Goyette, Karen T.
Subject: Backus/HHC Annual Filing DN12-31788-CON

Ms. Martone,

Please see the attached report, as requested in Condition 4 of the Final Agreed Settlement for DN 12-31788-CON.

Please don't hesitate to contact me if you have questions or require further information.

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Hartford HealthCare
Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796
janette.edwards@hhchealth.org
www.hartfordhealthcare.org

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Hartford HealthCare

July 20, 2015

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 4, please find attached the requested annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings as enumerated in Findings 24 and 28 have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings described in Table 1 are attributed to multiple specific projects, detailed in Table 2. Many of these specific projects have been completed, while others are in progress, and still others are slated for future implementation. At this time, all integration targeted savings have been met.

Please contact me if you require further information.

Sincerely,

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

TABLE 1

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Fiscal Year 16	Total
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

TABLE 2

Code	Area	Project
ADM	Administration	Staffing changes – Clinical & Non Clinical
ADM	Administration	Convert IP inhaler
ADM	Administration	Transfer Radiation Oncology to Hartford
INT	Clinical Integration	Creation of East Region Cardiology Team
CL	Clinical	Integrate IRB and research activities under HHC
CL	Clinical	Implementation of CLP/Quest reference lab contract
FIN	Finance	Fair Value Accounting
FIN	Finance	Risk Management / Insurance
FIN	Finance	Malpractice
FIN	Finance	Pension
FIN	Finance	Investment management: Custodian & Trustee Fees
FIN	Finance	Investment management: Investment Consulting Fees
FIN	Finance	Investment management: Pension Investment Manager Fees
FIN	Finance	Investment management: Investment Mgr Fees
FIN	Finance	Investment management: Administration & Governance Costs
HR	Human Resources	Consolidate and gain volume pricing for health & welfare vendors
HR	Human Resources	Integrate into captive for Medical Stop Loss
SC	Supply Chain	Pharmacy
SC	Supply Chain	Medsurg
SC	Supply Chain	Sentient
SC	Supply Chain	American Red Cross
SC	Supply Chain	Medtronic
SC	Supply Chain	St. Jude
SC	Supply Chain	Iron Mountain
SC	Supply Chain	Smith & Nephew
SC	Supply Chain	Hologic
SC	Supply Chain	Davol
SC	Supply Chain	Radiopharmaceuticals
SC	Supply Chain	Advisory Corp
SC	Supply Chain	Davol-Surgical Mesh
SC	Supply Chain	Integra Life Sciences
SC	Supply Chain	MTF
SC	Supply Chain	Olympus
SC	Supply Chain	Medcomp
SC	Supply Chain	Getinge

SC	Supply Chain	Stryker CMF
SC	Supply Chain	Stericycle
SC	Supply Chain	Unitex
SC	Supply Chain	Alcon
SC	Supply Chain	Md-Buyline
SC	Supply Chain	Governance Institute
SC	Supply Chain	Stryker total joint agreement
SC	Supply Chain	Roche Diagnostics
SC	Supply Chain	Multiple-Capital
SC	Supply Chain	Covidien/Superdimension
SC	Supply Chain	Synthes Trauma
SC	Supply Chain	Synthes Trauma: HHC receiving Backus' pricing
SC	Supply Chain	Philips Ultrasound Service
SC	Supply Chain	Roche Coaguchek
SC	Supply Chain	Globus
SC	Supply Chain	Advanced Sterilization
SC	Supply Chain	RR Donnelly
SC	Supply Chain	Convatec
SC	Supply Chain	Mortua Instrument
SC	Supply Chain	Divicor
SC	Supply Chain	Delage Landen Mosaic Service
SC	Supply Chain	Elekta
SC	Supply Chain	Progressive Medical
SC	Supply Chain	Solar Winds
SC	Supply Chain	EPIC/Careconnect
SC	Supply Chain	Elsevier
SC	Supply Chain	McKesson
SC	Supply Chain	USPS
SC	Supply Chain	Backus moving to HHC Provisions system pricing (food)
OT	Other Operations	HHC Rehab Network opportunities
OT	Other Operations	Biomedical Services opportunities
OT	Other Operations	Pharmacy Wholesaler Agreement

Greer, Leslie

From: Roberts, Karen
Sent: Tuesday, December 01, 2015 8:49 AM
To: Greer, Leslie
Cc: Huber, Jack
Subject: FW: 11/30/15 Backus Semi Annual Filing
Attachments: 11.30.15 semi annual filing v1.pdf

-----Original Message-----
From: Martone, Kim
Sent: Tuesday, December 01, 2015 8:47 AM
To: Huber, Jack
Cc: Roberts, Karen
Subject: FW: 11/30/15 Backus Semi Annual Filing

-----Original Message-----
From: Edwards, Janette [mailto:Janette.Edwards@hhchealth.org]
Sent: Monday, November 30, 2015 11:28 PM
To: Martone, Kim
Subject: 11/30/15 Backus Semi Annual Filing

Ms. Martone:

Please find attached the semi-annual filing as requested per the Backus/Hartford HealthCare Affiliation CON Agreed Settlement. Please don't hesitate to contact me if you require further information.

Sincerely,

Janette

Janette Edwards, MPH, MBA
Regional Director
Planning & Business Development

Backus Hospital
Windham Hospital
11 Stott Avenue
Norwich, CT 06360
Office: 860.425.3872
Fax number 860.892.2796

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Hartford HealthCare

November 30, 2015

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. At this time, all integration targeted savings have been met. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.

Sincerely,

Janette Edwards, MPH, MBA
Regional Director, Planning & Business Development

Hartford HealthCare

A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of affiliation, the Backus/HHC integration savings topped $15.7M, achieving a savings $4.7M greater than the target. Savings were continually realized in the second year of the affiliation; as of September 2015, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total cumulative savings of $19.6M in FY2015. Total projected savings for FY 2016 exceed $19M. In total, from 2014-2016 a total savings of $55.2M is anticipated of which $35.4M has already been achieved. To date, the Backus/HHC affiliation has surpassed its integration savings targets by $9.35M.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

Hartford HealthCare

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

Success has been accomplished through regular oversight of leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing).

C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

See the Attachments 1 and 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachments 1 and 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

Hartford HealthCare

- **Table 1**

Hartford HealthCare

Summary: Financial Savings for HHC and Backus Affiliation

CUMMULATIVE	Fiscal Year 14	Fiscal Year 15	Fiscal Year 16	Total
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

Hartford HealthCare

Attachment 1: *Backus Corporation & Subsidiaries Consolidating Statement of Operations & Balance Sheets, Year End September 30, 2015*

Backus Corporation and Subsidiaries
Consolidating Statement of Operations
Year Ended September 30,2015

Revenues:	
Gross patient service revenue:	
Inpatient	$ 233,828,175
Outpatient	463,618,242
Professional service revenue	70,184,408
	767,630,825
Deductions:	
Contractual allowances	457,505,869
Charity care	4,309,525
Provision for bad debt	9,296,806
Net revenue from service to patients	296,518,625
Other operating revenue	8,308,513
Net assets released from restrictions	217,950
Total revenues	305,045,088
Expenses:	
Salaries and wages	119,561,370
Payroll taxes and fringe benefits	24,131,400
Pension	1,836,679
Supplies and expenses	45,724,329
Purchased service	54,278,742
Malpractice	3,674,108
Depreciation and amortization	15,267,349
Rental expense	2,430,209
Interest	3,380,083
	270,284,269
Operating income	34,760,819
Nonoperating gains and (losses)	
Investment income	1,796,505
Other	55,526
Excess of revenue over expenses	$ 36,612,850
Operating Margin	11.40%

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
September 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	193,329,590
Assets whose use is limited-required for current liabilities		5,448,010
Accounts receivable, less allowance		37,156,767
Other receivables		972,364
Inventories of supplies		3,621,065
Prepaid expenses		3,040,704
Due from affiliates		2,405,892
Total current assets		245,974,392
Assets whose use is limited:		
Investments and other assets		42,282,113
Interest in investments held by Endowment LLC		84,458,257
Donor restricted int in investments Endowment LLC		7,965,135
Investments for restricted purposes		19,015,194
		153,720,699
Funds held in trust by others		2,385,647
Other assets		14,502,352
Property, plant and equipment		
Land and land improvements		8,496,315
Buildings and leasehold improvements		184,375,956
Equipment		115,397,876
Construction in progress		1,246,289
Accumulated depreciation		(188,985,410)
		120,531,026
	$	537,114,116

Hartford HealthCare

Backus Corporation and Subsidiaries
Consolidating Balance Sheets
September 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	6,919,642
Salaries and wages, payroll taxes and taxes withheld from payroll		6,801,054
Due to affiliates		1,711,676
Accrued liabilities		5,445,341
Current portion of pension liability		4,082,801
Due to third parties		9,749,411
Current portion of long-term liabilities		2,415,231
Current portion of long-term debt		399,931
Total current liabilities		37,525,087
Other Liabilities:		
Long-term debt, less current portion		68,372,572
Accrued pension liability		49,998,130
Self-insured professional liability		7,553,484
Other		4,464,677
		130,388,863
Net Assets:		
Unrestricted net assets		357,187,808
Temporarily restricted net assets		3,907,265
Permanently restricted net assets		8,105,093
		369,200,166
	$	537,114,116

Hartford HealthCare

Attachment 2: *The William W. Backus Hospital Consolidating Statement of Operations & Balance Sheets, Year End September 30, 2015*

Backus Hospital
Consolidated Statement of Operations
Year Ended September 30,2015

Revenues:		
Gross patient service revenue:		
Inpatient	$	233,828,175
Outpatient		463,588,233
Professional service revenue		41,186,738
Deductions:		738,603,146
Contractual allowances		440,279,045
Charity care		4,309,525
Provision for bad debt		8,486,887
Net revenue from service to patients		285,527,689
Other operating revenue		6,784,683
Net assets released from restrictions		217,950
Total revenues		292,530,322
Expenses:		
Salaries and wages		108,506,446
Payroll taxes and fringe benefits		21,936,083
Pension		1,833,901
Supplies and expenses		43,807,199
Purchased service		51,373,593
Malpractice		3,434,966
Depreciation and amortization		15,041,302
Rental expense		2,266,659
Interest		3,380,083
		251,580,232
Operating income		40,950,090
Nonoperating gains and (losses)		
Investment loss		(881,539)
Other		56,355
Excess of revenue over expenses	$	40,124,906
Operating Margin		14.00%

Hartford HealthCare

Backus Hospital
Consolidated Balance Sheets
September 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	192,740,131
Assets whose use is limited-required for current liabilities		5,448,010
Accounts receivable, less allowance		36,077,266
Other receivables		962,031
Inventories of supplies		3,621,065
Prepaid expenses		3,040,704
Due from affiliates		2,053,814
Total current assets		243,943,021
Assets whose use is limited:		
Investments and other assets		42,282,113
Interest in investments held by Endowment LLC		84,458,257
Donor restricted int in investments Endowment LLC		7,965,135
Investments for restricted purposes		19,015,194
		153,720,699
Funds held in trust by others		2,385,647
Other assets		13,785,077
Property, plant and equipment		
Land and land improvements		8,496,315
Buildings and leasehold improvements		184,193,015
Equipment		114,129,557
Construction in progress		1,246,289
Accumulated depreciation		(188,485,953)
		119,579,223
	$	533,413,667

Hartford HealthCare

Backus Hospital
Consolidating Balance Sheets
September 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	6,818,414
Salaries and wages, payroll taxes and taxes withheld from payroll		6,080,822
Due to affiliates		1,676,365
Accrued liabilities		5,445,341
Current portion of pension liability		4,082,801
Due to third parties		9,211,505
Current portion of long-term liabilities		2,415,231
Current portion of long-term debt		399,931
Total current liabilities		36,130,410
Other Liabilities:		
Long-term debt, less current portion		68,372,572
Accrued pension liability		49,998,130
Self-insured professional liability		7,352,922
Other		4,464,677
		130,188,301
Net Assets:		
Unrestricted net assets		355,082,598
Temporarily restricted net assets		3,907,265
Permanently restricted net assets		8,105,093
		367,094,956
	$	533,413,667

Backus Hospital
Connect to healthier.

RECEIVED
MAY 27 2016
Office of
HEALTHCARE ACCESS

May 25, 2016

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

RE: A Request for Certificate of Need Modification
Docket Number 12-31788-CON

Ms. Martone:

On behalf of Backus Corporation, Inc. and Hartford HealthCare, Corporation, Inc. enclosed please find a Request for Modification of the Certificate of Need authorized under DN 12-31788- CON.

Please feel free to contact me directly at 860-972-4231 with questions or if you need additional information. Thank you for your consideration of this matter.

Sincerely,

Barbara Durdy
Director, Strategic Planning
Hartford HealthCare

Enclosure

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	The William W. Backus Hospital	Hartford HealthCare
Doing Business As	The William W. Backus Hospital	Hartford HealthCare Corporation
Name of Parent Corporation	Hartford HealthCare Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	326 Washington Street, Norwich, CT 06360	1 State Street, Hartford, CT 06105
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP	NP
Name of Contact person, including title	Janette Edwards, Regional Director, Planning & Business Development	Janette Edwards, Regional Director, Planning & Business Development
Contact person's street mailing address	326 Washington Street, Norwich, CT 06360	326 Washington Street, Norwich, CT 06360

Contact person's phone, fax and e-mail address	Phone: 860-425-3872 Fax: 860-892-2796	Phone: 860-425-3872 Fax: 860-892-2796

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):

Affiliation of Backus Corporation with Hartford HealthCare Corporation, DN 12-31788-CON

b. Location of proposal (Town including street address):

326 Washington Street, Norwich, CT 06360

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Extension of CON Expiration Date

☒ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: _____

b. Requested revised CON expiration date: _____

c. Rationale for increased time to fully complete and implement the authorized project:

_____

_____

_____

_____

_____

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

Conditions to be vacated: Conditions 5 and 6

b. Provide the rationale for such requested change:

As demonstrated within the requested filings, submitted May 30, 2014, July 15, 2014, November 24, 2014, May 31, 2015, July 18, 2015, and November 30, 2015 to the Office of Health Care Access, the integration benefits enumerated in findings 24 and 28, as well as all anticipated cost savings associated with affiliation, have been achieved and surpassed. Reporting conditions 2, 3, and 4 have been satisfied per OHCA's specifications in the Final Agreed Settlement.

Hartford HealthCare respectfully requests that the CON Reporting Condition 5 in the Final Agreed Settlement dated July 19, 2013 are vacated by the Office of Health Care Access.

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

c. Identify what has been accomplished to date in terms of full project implementation.

CON MODIFICATION AFFIDAVIT

Applicant: *The William W. Backus Hospital*

Project Title: *Modification of the Final Agree Settlement for DN12-31788-CON, Affiliation of Backus Corporation with Hartford HealthCare Corporation*

I, *Bimal Patel*, *President* of *The William W. Backus Hospital* being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature _____ Date 5/26/16

Subscribed and sworn to before me on 5/26/16

Notary Public/Commissioner of Superior Court

My commission expires: 9/30/17

JULIE L. VIGIL
NOTARY PUBLIC
MY COMMISSION EXPIRES SEP. 30, 2017

CON MODIFICATION AFFIDAVIT

Applicant: *Hartford HealthCare, Corp.*

Project Title: *Modification of the Final Agree Settlement for DN12-31788-CON, Affiliation of Backus Corporation with Hartford HealthCare Corporation*

I, Elliot Joseph, being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature

5/26/16
Date

Subscribed and sworn to before me on 5/26/16

Julie L Vigil
Notary Public/Commissioner of Superior Court

My commission expires: 9/30/17

JULIE L. VIGIL
NOTARY PUBLIC
MY COMMISSION EXPIRES SEP. 30, 2017

Backus Hospital
Connect to healthier.

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MAY 27 2016
Office of
HEALTHCARE ACCESS

May 25, 2016

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

RE: A Request for Certificate of Need Modification
Docket Number 12-31788-CON

Ms. Martone:

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Please feel free to contact me directly at 860-972-4231 with questions or if you need additional information. Thank you for your consideration of this matter.

Sincerely,

Barbara Durdy
Director, Strategic Planning
Hartford HealthCare

Enclosure

State of Connecticut
Office of Health Care Access
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SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	The William W. Backus Hospital	Hartford HealthCare
Doing Business As	The William W. Backus Hospital	Hartford HealthCare Corporation
Name of Parent Corporation	Hartford HealthCare Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	326 Washington Street, Norwich, CT 06360	1 State Street, Hartford, CT 06105
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP	NP
Name of Contact person, including title	Janette Edwards, Regional Director, Planning & Business Development	Janette Edwards, Regional Director, Planning & Business Development
Contact person's street mailing address	326 Washington Street, Norwich, CT 06360	326 Washington Street, Norwich, CT 06360

Contact person's phone, fax and e-mail address	Phone: 860-425-3872 Fax: 860-892-2796	Phone: 860-425-3872 Fax: 860-892-2796

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):

Affiliation of Backus Corporation with Hartford HealthCare Corporation, DN 12-31788-CON

b. Location of proposal (Town including street address):

326 Washington Street, Norwich, CT 06360

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Extension of CON Expiration Date

☒ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: _____

b. Requested revised CON expiration date: _____

c. Rationale for increased time to fully complete and implement the authorized project:

_____

_____

_____

_____

_____

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

Conditions to be vacated: Conditions 5 and 6

b. Provide the rationale for such requested change:

As demonstrated within the requested filings, submitted May 30, 2014, July 15, 2014, November 24, 2014, May 31, 2015, July 18, 2015, and November 30, 2015 to the Office of Health Care Access, the integration benefits enumerated in findings 24 and 28, as well as all anticipated cost savings associated with affiliation, have been achieved and surpassed. Reporting conditions 2, 3, and 4 have been satisfied per OHCA's specifications in the Final Agreed Settlement.

Hartford HealthCare respectfully requests that the CON Reporting Condition 5 in the Final Agreed Settlement dated July 19, 2013 are vacated by the Office of Health Care Access.

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

c. Identify what has been accomplished to date in terms of full project implementation.

CON MODIFICATION AFFIDAVIT

Applicant: *The William W. Backus Hospital*

Project Title: *Modification of the Final Agree Settlement for DN12-31788-CON, Affiliation of Backus Corporation with Hartford HealthCare Corporation*

I, *Bimal Patel*, *President* of *The William W. Backus Hospital* being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature _____ Date 5/26/16

Subscribed and sworn to before me on 5/26/16

Notary Public/Commissioner of Superior Court

My commission expires: 9/30/17

JULIE L. VIGIL
NOTARY PUBLIC
MY COMMISSION EXPIRES SEP. 30, 2017

CON MODIFICATION AFFIDAVIT

Applicant: *Hartford HealthCare, Corp.*

Project Title: *Modification of the Final Agree Settlement for DN12-31788-CON, Affiliation of Backus Corporation with Hartford HealthCare Corporation*

I, Elliot Joseph, being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature

5/26/16
Date

Subscribed and sworn to before me on 5/26/16

Julie L Vigil
Notary Public/Commissioner of Superior Court

My commission expires: 9/30/17

JULIE L. VIGIL
NOTARY PUBLIC
MY COMMISSION EXPIRES SEP. 30, 2017

Greer, Leslie

From: Greer, Leslie
Sent: Friday, July 01, 2016 9:46 AM
To: 'Janette.Edwards@hhchealth.org'; Barbara Durdy; 'Jason.Laabs@hhchealth.org'
Cc: Hansted, Kevin; Riggott, Kaila; Martone, Kim; Olejarz, Barbara
Subject: Willaim W. Backus Hospital & Hartford HealthCare Corporation CON Modification
Attachments: 31788_201607010906.pdf

Tracking:

Recipient	Delivery
'Janette.Edwards@hhchealth.org'	
Barbara Durdy	
'Jason.Laabs@hhchealth.org'	
Hansted, Kevin	Delivered: 7/1/2016 9:46 AM
Riggott, Kaila	Delivered: 7/1/2016 9:46 AM
Martone, Kim	Delivered: 7/1/2016 9:46 AM
Olejarz, Barbara	Delivered: 7/1/2016 9:46 AM

Good morning,
Attached is the modification decision for William W. Backus Hospital & Hartford HealthCare Corporation's request to vacate Condition Number 5 within the CON.

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

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

Final Decision

Modification of a Previously Authorized Certificate of Need

Applicants:	**The William W. Backus Hospital** **326 Washington Street** **Norwich, CT 06360** **Hartford HealthCare Corporation** **1 State Street** **Hartford, CT 06105**
Docket Number:	**16-31788-MDF**
Project Description:	**Modification of Previous Certificate of Need Authorization 12-31788-CON**

Procedural History: On July 19, 2013, the Office of Health Care Access ("OHCA") granted a Certificate of Need ("CON") to Hartford HealthCare Corporation and Backus Corporation issued under Docket Number 12-31788-CON, for the affiliation of Backus Corporation and Hartford HealthCare Corporation ("Final Decision").

On May 27, 2016, OHCA received a Request for Modification from Backus Corporation and Hartford HealthCare Corporation seeking to vacate Condition Number 5 within the CON.

As required by Conn. Gen. Stat. § 19a-639b(b), OHCA noticed this request on its website for 30 days. During the posting period, OHCA did not receive any written comments or requests for a public hearing. Deputy Commissioner Brancifort reviewed the entire record in this matter.

Findings of Fact

1. The CON issued under Docket Number 12-31788-CON permitted the affiliation of Hartford HealthCare Corporation and Backus Corporation.

2. The CON issued under Docket Number 12-31788 included several conditions.

3. Condition Number 5 states the following:

> 5. The Applicants agree to submit to OHCA, no later than October 31, 2013, a detailed and comprehensive document showing the plan to integrate the operations of both parent corporations to the hospital and attain the cost savings stated within the CON Application. At a minimum, the submission shall address anticipated cost savings, staffing and quality improvements, and affiliation-related revenue enhancements. Subsequent to the submission of the plan, HHC and Backus Hospital shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the Order, semi-annual periods are October 1 – March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31, 2014, November 30, 2014, May 31, 2015, November 30, 2015, May 31, 2016, and November 30, 2016, HHC and Backus Corporation shall submit the following on a semi-annual basis:
>
> a. HHC agrees to file narrative updates on the progress of the implementation of the plan.
>
> b. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, the William W. Backus Hospital, for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major expense categories.
>
> c. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, the William W. Backus Hospital. The format shall be consistent with HRS Reports 350/150, or successor reports.
>
> d. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, the William W. Backus Hospital. The format shall be consistent with HRS Reports 300/100, or successor reports.

4. The Applicants are requesting that Condition Number 5 be vacated as a result integration benefits and cost savings associated with the affiliation being achieved and surpassed.

Discussion

Connecticut General Statutes § 4-181a (b) provides in relevant part: "On a showing of changed conditions, the agency may reverse or modify the final decision, at any time, at the request of any person or on the agency's own motion." While OHCA is pleased to see that the Applicants have attained certain integration benefits and cost-savings as a result of the affiliation, the Applicants have failed to identify a change in conditions that would justify vacating Condition Number 5.

Order

Based upon the foregoing, the request to modify the CON issued under Docket Number 12-31788-CON to vacate Condition Number 5 is hereby **DENIED**.

July 1, 2016
Date

Janet M. Brancifort
Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Greer, Leslie

From: Martone, Kim
Sent: Friday, July 08, 2016 1:56 PM
To: Roberts, Karen
Cc: Greer, Leslie
Subject: FW: Willaim W. Backus Hospital & Hartford HealthCare Corporation CON: Docket # 12-31788
Attachments: Backus Hartford HealthCare SemiAnnual Filing.docx

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Laabs, Jason [mailto:Jason.Laabs@hhchealth.org]
Sent: Friday, July 08, 2016 1:40 PM
To: Martone, Kim
Cc: Durdy, Barbara
Subject: Willaim W. Backus Hospital & Hartford HealthCare Corporation CON: Docket #12-31788

Dear Ms. Martone:

Re: Docket #12-31788-CON Affiliation of Backus Corporation with Hartford HealthCare Corporation Agreed Settlement- Stipulation #5 Reporting

In response to the reporting requirements of Stipulation #5 of the Agreed Settlement in the above-referenced matter, Hartford HealthCare Corporation and Backus Corporation provide the attached plan to integrate the operations of Backus Corporation, Backus Hospital and Hartford HealthCare ("HHC"). Also included is a summary of the anticipated financial savings to be achieved in fiscal years 2014 and 2015 through the implementation of this plan.
This plan which outlines the proposed initiatives to be undertaken to achieve this operational integration is in accordance with the HHC Integration Playbook (Exhibit #3) referenced in the CON application.
Please contact me if you have any questions or require further information.

An original copy of the attached will be mailed as well to your attention.

Sincerely,
Jason Laabs

Regional Director, Planning & Communication
Hartford HealthCare – East Region

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July 8, 2016

Ms. Kimberly Martone
Director of Operations
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capital Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Re: Compliance with the conditions as set forth in Certificate of Need Docket #12-31788-CON Agreed Settlement, Affiliation of Backus Corporation with Hartford HealthCare Corporation

Ms. Martone:

Per the regulatory reporting requirements as set forth in the Hartford HealthCare Corporation and Backus Corporation Affiliation (*Docket #12-31788-CON*) Final Agreed Settlement, Condition 5, please find attached the requested semi-annual report detailing the cost savings and benefits realized from affiliation for Backus and Hartford HealthCare.

The attached document provides OHCA information on how the benefits and cost savings, as enumerated in Findings 24 and 28, have been achieved to date. Savings and benefits have been realized across the broad areas of non-labor, revenue cycle, clinical operations, human resources, labor, administration, information technology, and capital avoidance. The cumulative savings by major category are described in Table 1. At this time, all integration targeted savings have been met. Also attached are the Operating Statements and Balance Sheets for Backus Hospital and Backus Corporation.

Please contact me if you require further information.
Sincerely,

Jason Laabs
Regional Director, Planning & Communication

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A. HHC agrees to file narrative updates on the progress of the implementation of the plan.

The integration between Backus Hospital and Hartford HealthCare ("Backus," and "HHC") continues to drive savings and increase quality. At the end of the first year of affiliation, the Backus/HHC integration savings topped $15.7M, achieving a savings $4.7M greater than the target. Savings were continually realized in the second year of the affiliation; as of September 2015, the cost-savings realized through the Backus/HHC integration exceeded targets by $4.6M, creating a total cumulative savings of $19.6M in FY2015. Total projected savings for FY 2016 exceed $19M. In total, from 2014-2016 a total savings of $55.2M is anticipated of which $35.4M has already been achieved. To date, the Backus/HHC affiliation has surpassed its integration savings targets by $9.35M.

B. The Applicants shall report cost saving totals of the affiliation for both Backus Corporation and its affiliate, The William W. Backus Hospital, for the following Operating Expense Categories:

See Table 1 for detailed savings totals by major category.

a. Salaries & Wages

b. Fringe Benefits

c. Contractual Labor Fees

d. Medical Supplies & Pharmaceutical Costs

e. Depreciation and Amortization

f. Bad Debts

g. Interest Expense

h. Malpractice Expense

i. Utilities

j. Business Expenses

k. Other Operating Expenses

Backus Corporation shall also file a narrative describing the specifics of the cost savings for each of these major categories.

Success has been accomplished through regular oversight of leadership from both Backus and HHC to focus on ensuring success throughout the integration process. The almost 100 projects identified by the Steering Committee in August of 2013 are closely monitored, and focus on the following areas (a detailed description of these focus-areas was provided in the May 31, 2014 semi-annual filing).

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C. The Applicants shall file a completed Statement of Operations for both Backus Corporation and its affiliate, The William W. Backus Hospital

See Attachments 1 and 2 for the Statement of Operations for both Backus Corporation and Backus Hospital.

D. The Applicants shall file a completed Balance Sheet for both Backus Corporation and its affiliate, The William W. Backus Hospital.

See Attachments 1 and 2 for the Balance Sheet for both Backus Corporation and Backus Hospital.

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Table 1

Hartford HealthCare				
Summary: Financial Savings for HHC and Backus Affiliation				
CUMMULATIVE	**Fiscal Year 14**	**Fiscal Year 15**	**Fiscal Year 16**	**Total**
Administrative	$4,088,498	$6,602,581	$6,602,581	$17,293,660
Clinical Integration	$0	$351,000	$445,000	$796,000
Clinical	$179,782	$309,621	$309,621	$799,024
Finance	$8,009,000	$7,309,000	$7,309,000	$22,627,000
Human Resources	$739,802	$986,402	$986,402	$2,712,606
Information Technology	$0	$0	$0	$0
Supply Chain	$2,532,088	$3,871,374	$3,871,374	$10,274,836
Other Operations	$201,291	$251,450	$251,450	$704,191
Total Savings	$15,750,460	$19,681,428	$19,775,428	$55,207,316
Target Savings	$11,039,000	$15,036,000	$19,059,000	$45,134,000
Variance from Target	$4,711,460	$4,645,428	$716,428	$10,073,316

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Attachment 1: *Backus Corporation & Subsidiaries Consolidating Statement of Operations & Balance Sheets, Year End September 30, 2015*

Backus Corporation and Subsidiaries
Consolidating Statement of Operations
Year Ended September 30,2015

Revenues:	
Gross patient service revenue:	
Inpatient	$ 233,828,175
Outpatient	463,618,242
Professional service revenue	70,184,408
Deductions:	767,630,825
Contractual allowances	457,505,869
Charity care	4,309,525
Provision for bad debt	9,296,806
Net revenue from service to patients	296,518,625
Other operating revenue	8,308,513
Net assets released from restrictions	217,950
Total revenues	305,045,088
Expenses:	
Salaries and wages	119,561,370
Payroll taxes and fringe benefits	24,131,400
Pension	1,836,679
Supplies and expenses	45,724,329
Purchased service	54,278,742
Malpractice	3,674,108
Depreciation and amortization	15,267,349
Rental expense	2,430,209
Interest	3,380,083
	270,284,269
Operating income	34,760,819
Nonoperating gains and (losses)	
Investment income	1,796,505
Other	55,526
Excess of revenue over expenses	$ 36,612,850
Operating Margin	11.40%

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Backus Corporation and Subsidiaries
Consolidating Balance Sheets
September 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	193,329,590
Assets whose use is limited-required for current liabilities		5,448,010
Accounts receivable, less allowance		37,156,767
Other receivables		972,364
Inventories of supplies		3,621,065
Prepaid expenses		3,040,704
Due from affiliates		2,405,892
Total current assets		245,974,392
Assets whose use is limited:		
Investments and other assets		42,282,113
Interest in investments held by Endowment LLC		84,458,257
Donor restricted int in investments Endowment LLC		7,965,135
Investments for restricted purposes		19,015,194
		153,720,699
Funds held in trust by others		2,385,647
Other assets		14,502,352
Property, plant and equipment		
Land and land improvements		8,496,315
Buildings and leasehold improvements		184,375,956
Equipment		115,397,876
Construction in progress		1,246,289
Accumulated depreciation		(188,985,410)
		120,531,026
	$	537,114,116

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Backus Corporation and Subsidiaries
Consolidating Balance Sheets
September 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	6,919,642
Salaries and wages, payroll taxes and taxes withheld from payroll		6,801,054
Due to affiliates		1,711,676
Accrued liabilities		5,445,341
Current portion of pension liability		4,082,801
Due to third parties		9,749,411
Current portion of long-term liabilities		2,415,231
Current portion of long-term debt		399,931
Total current liabilities		37,525,087
Other Liabilities:		
Long-term debt, less current portion		68,372,572
Accrued pension liability		49,998,130
Self-insured professional liability		7,553,484
Other		4,464,677
		130,388,863
Net Assets:		
Unrestricted net assets		357,187,808
Temporarily restricted net assets		3,907,265
Permanently restricted net assets		8,105,093
		369,200,166
	$	537,114,116

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Attachment 2: *The William W. Backus Hospital Consolidating Statement of Operations & Balance Sheets, Year End September 30, 2015*

Backus Hospital
Consolidated Statement of Operations
Year Ended September 30,2015

Revenues:		
Gross patient service revenue:		
Inpatient	$	233,828,175
Outpatient		463,588,233
Professional service revenue		41,186,738
Deductions:		738,603,146
Contractual allowances		440,279,045
Charity care		4,309,525
Provision for bad debt		8,486,887
Net revenue from service to patients		285,527,689
Other operating revenue		6,784,683
Net assets released from restrictions		217,950
Total revenues		292,530,322
Expenses:		
Salaries and wages		108,506,446
Payroll taxes and fringe benefits		21,936,083
Pension		1,833,901
Supplies and expenses		43,807,199
Purchased service		51,373,593
Malpractice		3,434,966
Depreciation and amortization		15,041,302
Rental expense		2,266,659
Interest		3,380,083
		251,580,232
Operating income		40,950,090
Nonoperating gains and (losses)		
Investment loss		(881,539)
Other		56,355
Excess of revenue over expenses	$	40,124,906
Operating Margin		14.00%

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Backus Hospital
Consolidated Balance Sheets
September 30,2015

Assets		
Current assets:		
Cash and cash equivalents	$	192,740,131
Assets whose use is limited-required for current liabilities		5,448,010
Accounts receivable, less allowance		36,077,266
Other receivables		962,031
Inventories of supplies		3,621,065
Prepaid expenses		3,040,704
Due from affiliates		2,053,814
Total current assets		243,943,021
Assets whose use is limited:		
Investments and other assets		42,282,113
Interest in investments held by Endowment LLC		84,458,257
Donor restricted int in investments Endowment LLC		7,965,135
Investments for restricted purposes		19,015,194
		153,720,699
Funds held in trust by others		2,385,647
Other assets		13,785,077
Property, plant and equipment		
Land and land improvements		8,496,315
Buildings and leasehold improvements		184,193,015
Equipment		114,129,557
Construction in progress		1,246,289
Accumulated depreciation		(188,485,953)
		119,579,223
	$	533,413,667

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Backus Hospital
Consolidating Balance Sheets
September 30,2015

Liabilities and Net Assets		
Current liabilities		
Accounts payable-trade	$	6,818,414
Salaries and wages, payroll taxes and taxes withheld from payroll		6,080,822
Due to affiliates		1,676,365
Accrued liabilities		5,445,341
Current portion of pension liability		4,082,801
Due to third parties		9,211,505
Current portion of long-term liabilities		2,415,231
Current portion of long-term debt		399,931
Total current liabilities		36,130,410
Other Liabilities:		
Long-term debt, less current portion		68,372,572
Accrued pension liability		49,998,130
Self-insured professional liability		7,352,922
Other		4,464,677
		130,188,301
Net Assets:		
Unrestricted net assets		355,082,598
Temporarily restricted net assets		3,907,265
Permanently restricted net assets		8,105,093
		367,094,956
	$	533,413,667