SAINT FRANCIS *Care*

Christopher M. Dadlez, F.A.C.H.E.
President and Chief Executive Officer

114 Woodland Street
Hartford, CT 06105-1299

Tel. 860-714-5541
Fax 860-714-7920
cdadlez@stfranciscare.org

April 1, 2013

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

Dear Deputy Commissioner Davis:

On behalf of Saint Francis Hospital and Medical Center, an affiliate of Johnson Memorial Medical Center (JMMC), I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility located in Tolland, Connecticut.

Tolland Imaging Center was established through the collaborative efforts of three independent hospital systems to meet an identified need for outpatient imaging services in the Tolland area. Over the last four years, Tolland Imaging Center has provided high quality imaging services in a convenient, outpatient setting for patients served by all three hospital systems. As an organization familiar with establishing high-quality outpatient centers in the local suburban communities, we recognize the significant contribution the availability of a freestanding imaging center in the Tolland area has provided to the entire health care network served by JMMC, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital.

I encourage you to approve this proposal and allow the Tolland Imaging Center to continue providing the imaging service accessibility that patients in Tolland and the surrounding towns have come to expect in their local community.

Sincerely,

Christopher M. Dadlez, President and Chief Executive Officer
Saint Francis Hospital and Medical Center

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

____	Bone Density	X	MRI (open)
X	CT	X	Radiography (x-ray)
____	Mammography	X	Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

EDWARD S. SAWICKI MD

MED-EAST MEDICAL WALK-IN CENTER
1703 WEST MAIN STREET
WILLIMANTIC, CT 06226
(860) 456-1252

SEE ATTACHED

Med-East Medical Walk-In Center

A Windham Hospital Partner

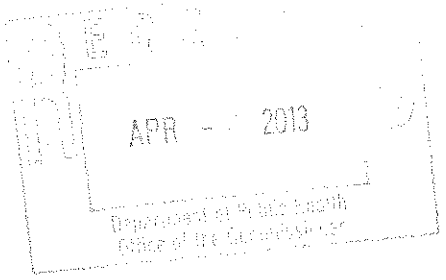
Addendum:

Tolland Imaging Center provides excellent, available and accountable imaging services. It is a particularly valuable service for our Med-East Walk-In Center. With a radiologist on site it provides an immediate report, for complete imaging services, our patients are managed expeditiously.

As a result of the timely and complete services provided at Tolland Imaging, Med-East Walk-In Center closed its on-site x-ray facility and now relies on the Tolland Imaging Center for all of its imaging services.

EDWARD S. SAWICKI MD

1703 West Main Street, Willimantic, CT 06226 860 456 1252 *tel* 860 456 2278 *fax*
200 Merrow Road, (Rte 195) Tolland, CT 06084, 860-871-5452 *tel* 860-8715712 *fax*
www.medeastclinic.com



March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- ✓ Bone Density
- ✓ CT
- ✓ Mammography
- ✓ MRI (open)
- ✓ Radiography (x-ray)
- ✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freest

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Type provider name here

ROSS L. WINAKOR, M.D.
Mansfield Family Practice, LLC
34 Professional Park Road
Storrs, Connecticut 06268

ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

March 18, 2013

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

Dear Deputy Commissioner Davis:

On behalf of Eastern Connecticut Health Network (ECHN), including Manchester Memorial Hospital (MMH) and Rockville General Hospital (RGH), I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility located in Tolland, Connecticut.

Tolland Imaging Center was established through the collaborative efforts of three independent hospital systems to meet an identified need for outpatient imaging services in the Tolland area. While ECHN offered a freestanding facility in South Windsor, we recognized that it did not meet the needs of patients residing in the eastern portion of our service area. We initially planned to establish a freestanding center in Tolland as a joint venture arrangement with our radiologists, similar to previously approved Evergreen Imaging Center in South Windsor. Ultimately, we agreed to participate in the development of the imaging center with Windham Community Memorial Hospital and Johnson Memorial Hospital (now Johnson Memorial Medical Center), at OHCA's recommendation, as these two hospitals had submitted their own joint proposal for a freestanding imaging facility in Tolland during this same time period.

As founding members of the Tolland Imaging Center, MMH and RGH were responsible for contributing a portion of the capital dollars required to launch the imaging center and to support it in its earlier years of operation. Establishment of the facility and subsequent requests for dollars to support ongoing operations has required ECHN (on behalf of its two hospitals) to contribute $600,000 towards this initiative. ECHN did not receive any returns on its investment until the close of FY2012 when the center began generating positive returns. Through the end of FY2013 ECHN is only projected see a return equal to one third of its original investment. The center is now in a position to generate returns that cover its expenses and generate positive returns to its member hospitals while serving residents in this region of Connecticut with a free-standing imaging option.

If Tolland Imaging Center does not receive the necessary approvals to continue providing CT and MRI services at the freestanding location, the facility will not experience enough volumes or

ECHN℠
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

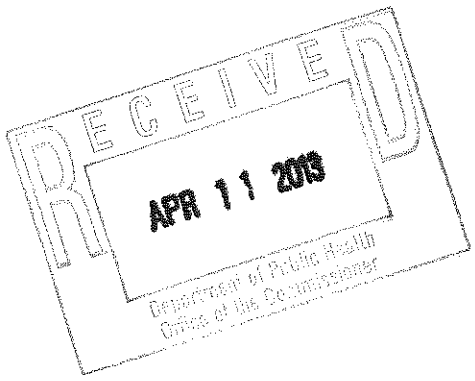
generate the revenue to support operations of a stand-alone facility and will be forced to close. ECHN will continue to be responsible for its share of the ongoing lease obligations and other expenses already incurred by Tolland Imaging Center. These dollars, along with ECHN's original investment, which could have been better utilized to support other more permanent patient care services within the health network instead, will have been wasted on the short-term development of, in effect, temporary imaging services. CON approval allowing the continued operation of Tolland Imaging Center will ensure patient access to these types of imaging services in a convenient, low-cost setting remains an available option in the future.

I encourage you to approve this proposal and allow the Tolland Imaging Center to continue providing the imaging service accessibility that patients in Tolland and the surrounding towns have come to expect in their local community.

Sincerely,

Peter J. Karl, President and Chief Executive Officer
Eastern Connecticut Health Network

mansfield ob gyn



March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓	Bone Density		MRI (open)
✓	CT		Radiography (x-ray)
✓	Mammography	✓	Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Veronica Helgans, M.D., F.A.C.O.G.

A DIVISION OF PHYSICIANS FOR WOMEN'S HEALTH

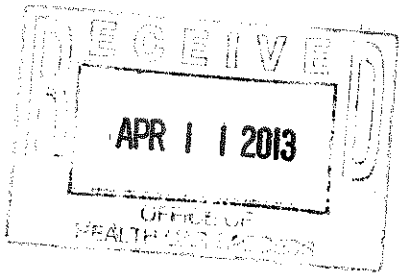
21 LEDGEBROOK DRIVE
MANSFIELD CENTER, CT
06250

PHONE:
860.450.7227

FAX:
860.450.7231

mansfield ob gyn

March 18, 2013



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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

X Bone Density	X MRI (open)
X CT	____ Radiography (x-ray)
X Mammography	X Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

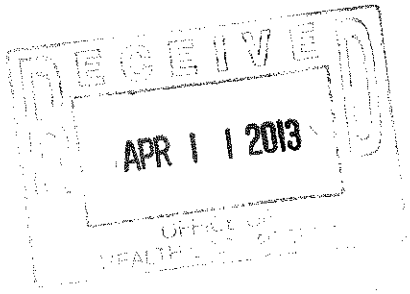
Sincerely,

Robert Gildersleeve, M.D., F.A.C.O.G.

A DIVISION OF PHYSICIANS FOR WOMEN'S HEALTH

21 LEDGEBROOK DRIVE
MANSFIELD CENTER, CT
06250
PHONE:
860.450.7227
FAX:
860.450.7231

mansfield ob gyn



March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	___ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Yvette Martas, M.D., F.A.C.O.G.
A DIVISION OF PHYSICIANS FOR WOMEN'S HEALTH

21 LEDGEBROOK DRIVE
MANSFIELD CENTER, CT
06250
PHONE:
860.450.7227
FAX:
860.450.7231

ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

April 10, 2013

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

Re: Certificate of Need Application, Docket Number TBD
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services.

Dear Deputy Commissioner Davis:

Enclosed are an original and four copies of the Certificate of Need Application for the continued delivery of comprehensive imaging services at Tolland Imaging Center, including an electronic copy of the application and all attachments.

If you have any questions regarding this Certificate of Need Application, please do not hesitate to give me a call at (860) 533-3429.

Sincerely,

Dennis P. McConville
Senior Vice President, Planning, Marketing and Communications

cc: Dan Delgallo, Executive Director, Tolland Imaging Center
Kevin Murphy, President, Tolland Imaging Center

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

X	Bone Density	X	MRI (open)
X	CT	X	Radiography (x-ray)
X	Mammography	X	Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Christine Blake, APRN

Christine Blake, APRN

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- ✓ Bone Density
- ✓ CT
- ✓ Mammography
- ✓ MRI (open)
- ✓ Radiography (x-ray)
- ✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Elise Voss PAC

Elise Voss, PA

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- ✓ Bone Density
- ✓ CT
- ✓ Mammography
- ✓ MRI (open)
- ✓ Radiography (x-ray)
- ✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Antonela Barbu

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- [x] Bone Density
- [x] CT
- [x] Mammography
- [x] MRI (open)
- [x] Radiography (x-ray)
- [x] Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Beth Schweitzer

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

MD

Lawrence M. Arky, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Gerald Bayona G Bayona

Type provider name here GERARD BAYONA

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	___ MRI (open)
___ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Gunn, MD

Carla R. Gunn, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Lon P. Manfredi, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- ✓ Bone Density
- ✓ CT
- ✓ Mammography
- ✓ MRI (open)
- ✓ Radiography (x-ray)
- ✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Angela Biondi PAC
Angela Biondi,PA

Type provider name here Angela Biondi, PA-C

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

____ Bone Density	X MRI (open)
X CT	X Radiography (x-ray)
____ Mammography	X Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

J Michael Herr, DO

Dr. J. Michael Herr

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	___ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

A. Omrani

Aziza Omrani, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

X Bone Density	X MRI (open)
X CT	___ Radiography (x-ray)
X Mammography	X Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Daniel S. Welling, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

_____ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
_____ Mammography	_____ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Kenneth Alleyne

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

N/A Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
N/A Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr.Senatus

Application Checklist

Instructions:

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

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

For OHCA Use Only:

Docket No.: 13-31833-CON **Check No.:** 369808
OHCA Verified by: KKG-H **Date:** 4/10/13

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

Customer: ECHN
Contact: AMBER W. MARTIN Phone: 8606461222

Ad Number: **2537642**
Insert Dates: 03/04/2013 03/05/2013 03/06/2013

Price: 328.38
Section: CL Class: 2174; CONNECTICUT Size: 1 x 1.75
Printed By: JSMIETAN Date: 02/28/2013

Signature of Approval:_____ Date:_____

PUBLIC NOTICE

Statute Reference: 19a-638 et seq. of the Connecticut General Statutes

Applicant: Tolland Imaging Center, LLC

Address: 6 Fieldstone Commons
Tolland, Connecticut 06084

Town: Tolland, CT

Proposal: Continuation of comprehensive imaging services in Tolland through the permanent acquisition of an Open MRI scanner and a four-slice CT scanner.

Capital Expenditure: $1,273,000 (if the application is denied)

Connecticut

PUBLIC NOTICE

Statute Reference: 19a-638 et seq. of the Connecticut General Statutes

Applicant: Tolland Imaging Center, LLC

Address: 6 Fieldstone Commons
Tolland, Connecticut 06084

Town: Tolland, CT

Proposal: Continuation of comprehensive imaging services in Tolland through the permanent acquisition of an Open MRI scanner and a four-slice CT scanner.

Capital Expenditure: $1,273,000 (if the application is denied)

TABLE OF CONTENTS

AFFIDAVIT

Applicant: Tolland Imaging Center, LLC

Project Title: Continued Delivery of Comprehensive Imaging Services including MRI and CT Services.

I, Kevin Murphy (Individual's Name), President (Position Title – CEO or CFO)

of Tolland Imaging Center (Hospital or Facility Name) being duly sworn, depose and state that

Tolland Imaging Center's (Hospital or Facility Name) information submitted in this Certificate of Need

Application is accurate and correct to the best of my knowledge.

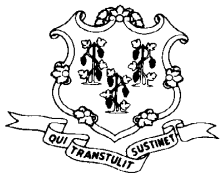
Signature

4/10/13
Date

Subscribed and sworn to before me on 4/10/13

Notary Public/Commissioner of Superior Court

My commission expires: 1/31/17



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: TBD

Applicant: Tolland Imaging Center, LLC

Contact Person: Dennis P. McConville

Contact Person's Title: SVP, Planning, Marketing & Communications

Contact Person's Address: 71 Haynes Street, Manchester, CT 06040

Contact Person's Phone Number: (860) 533-3429

Contact Person's Fax Number: (860) 647-6860

Contact Person's Email Address: dmcconville@echn.org

Project Town: Tolland

Project Name: Continued Delivery of Comprehensive Imaging Services including MRI and CT Services.

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

Estimated Total Capital Expenditure: $1,245,144 (if the application is denied)

1. Project Description

a. Please provide a narrative detailing the proposal.

Response:

On September 18, 2007 the Office of Health Care Access, through an agreed settlement, granted approval for the establishment and operation of a full service imaging center in Tolland through a joint venture arrangement between Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital (see Docket Number 06-30841-CON). This CON was granted as three-year demonstration project because OHCA was "*concerned about the conservative volumes projected for the proposed MRI and CT scanner and the impact of these volumes on the Center's financial viability*".

The Tolland Imaging Center, LLC was established and became operational on September 2, 2008. Services offered by center at its inception included MRI, CT, Bone Density, Mammography, Ultrasound, and Radiography (x-ray). Volumes at the center have grown steadily each year but have never exceeded the volumes projected in the original CON application. Despite this, the Center has made operational adjustments as necessary to accommodate the actual patient demand for services which has enabled the Center to achieve financial viability. Long-term financial viability is dependent upon the Center's ability to continue offering the full spectrum of imaging services. Removing MRI and/or CT capabilities would threaten the provider referral network that generates volume for all imaging services at the Center and would ultimately lead to the closure of the facility as it would be unable to maintain financial viability. Closure of the Tolland Imaging Center would create a geographic barrier for patients to access imaging services as this is the only comprehensive freestanding imaging facility in the northeast region of Connecticut.

Given this, it is imperative that MRI and CT services be allowed to continue at the Tolland Imaging Center. Therefore, per the terms set forth in the agreed settlement and per OHCA's request to the member hospitals made on August 7, 2012 following submission of our CON modification, Tolland Imaging Center (the "Center" or the "Applicant") is now submitting this CON application to request the permission to continue the delivery of comprehensive imaging services at Tolland Imaging Center, including the continued provision of MRI and CT services.

b. Provide letters that have been received in support of the proposal.

Response:

Letters in support of this proposal have been received from the member hospitals and/or their parent corporations where applicable, as well as a number of referring providers.

Copies of the letters of support received to date can be found in **Attachment 1b**.

c. Provide the Manufacturer, Model, Number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Response:

Modality	Manufacturer	Model	Size/Strength
MRI	Hitachi	Altaire	0.7 Tesla
CT	Siemens	Sensation 4	4 Slice

d. List each of the Applicant's sites and the imaging modalities and other services currently offered by location.

Response:

The Applicant's sites and imaging services offered are listed below:

Applicant's Site	Services Offered	
Tolland Imaging Center, LLC	Bone Density	MRI
6 Fieldstone Commons, Suite E	CT	Radiography (X-ray)
Tolland, CT 06084	Mammography	Ultrasound

2. Clear Public Need

a. Explain why there is a clear public need for the proposed equipment. Provide evidence that demonstrates this need.

Response:

Clear public need for the permanent acquisition of the Open MRI and the CT scanner at Tolland Imaging Center is demonstrated by the rapid growth in utilization the center has experienced since it opened in September of 2009 and the sheer number of patients that have been referred to the facility for diagnostic imaging services.

The table below shows the number of patients that have been referred to Tolland Imaging Center since it began operation through the end of FY2012:

	Number of Patients					FY2009 to FY2012	
	FY2008[2]	FY2009	FY2010	FY2011	FY2012	% Change	AAGR
CT	6	390	654	689	751	93%	24%
MRI	18	838	1,299	1,633	1,639	96%	25%
All Modalities[1]	152	5,735	8,086	8,686	9,761	70%	19%

(1) All modalities include the patient volume for patients who were referred to Tolland Imaging Center for all services (CT, MRI, mammography, ultrasound, bone density and x-ray).
(2) FY2008 includes only one month of operation.

The center currently meets the diagnostic imaging needs of over 9,700 patients which represents a 70% increase in patient referrals to the facility since its first full year of operation in FY2009. CT and MRI referrals increased 93% and 96% respectively during that same time period and patient referrals for both modalities nearly doubled in four short years. In terms of patient volumes, CT referrals have grown to meet the scanning needs of 750 patients annually while MRI has grown to accommodate over 1,600 patients each year.

In addition to the number of patients that are accommodated by the Tolland Imaging Center, nearly 1,000 different providers in the region have referred patients to the facility, with 69 consistent providers responsible for 70% of the center's total referrals. That equates to an average of nearly 100 patients referred per consistent provider in FY2012.

The table below summarizes the number of providers who have consistently referred patients to the Tolland Imaging Center from FY2010 to FY2012, the actual number of patients referred by each provider in FY2012 and the resulting average number of patients referred per year by the consistent providers:

	All Modalities	MRI	CT
Total number of providers[1]	990	430	305
Consistent providers[2]	69	42	55
FY2012 patient referrals from consistent providers	6,721	1,121	522
Average referrals per consistent provider in FY2012	97.4	26.7	9.5

(1)The total number of providers who have referred one or more patients to the Tolland Imaging Center from FY2010 to FY2012.

(2) Consistent providers are defined as the providers responsible for 70% or more of the patient referral activity at Tolland Imaging Center from FY2010 to FY2012.

If the Applicant is unable to continue providing MRI and CT services, operation of the Tolland Imaging Center will be unsustainable and the facility will be forced to close. More than 9,700 patients requiring diagnostic imaging services will need to be accommodated by other providers in the region.

While some of the referral activity could be accommodated by other providers in the service area, elimination of the Tolland Imaging Center services would create geographic and logistical barriers for patients to access diagnostic services in the region. Tolland Imaging Center provides convenient outpatient appointments in a freestanding facility for patients in northeastern Connecticut and has satisfied a need for more diagnostic imaging appointment availability in the region over the last four years. There are no other freestanding imaging facilities in this part of Connecticut.

Additionally, Tolland Imaging Center provides the only open MRI in the area, with the next closest open scanner available in South Windsor. The availability of an open MRI is desirable for many patients who require an MRI scan but are uncomfortable using the closed scanners available at the hospital-based facilities in the service area. Patients that originate from Tolland or towns farther east may be unable or unwilling to travel the additional twenty or thirty minutes to access an open scanner in South Windsor and instead, forego the testing recommended by their physician.

b. Provide the utilization of existing health care facilities and health care services in the Applicant's service area.

Response:

The Applicant's service area was determined by identifying the towns where 80% of the Center's patients originate. The towns that satisfy this definition are:

Coventry	Stafford	Vernon (including Rockville)
Ellington	Tolland	Willington
Mansfield	Union	

There are only two other providers of imaging services in the Applicant's service area, both of which have membership interest in the Tolland Imaging Center:

Provider Name Street Address Town, Zip Code	Description of Service	Utilization[1]			
		Inpatient	Outpatient	Emergency	Total
Johnson Memorial Hospital 201 Chestnut Hill Road Stafford Springs, CT 06076	CT	1,785	499	3,480	5,764
	MRI[2]	133	440	22	595
Rockville General Hospital 31 Union Street Rockville, CT 06066	CT	1,780	2,589	3,543	7,908
	MRI	236	1,350	125	1,708

(1) Utilization statistics for the most recent 12-month period (January 1, 2012 through December 31, 2012) provided by each of the applicable entities.
(2) MRI services at the Johnson Memorial Hospital campus are only available two days per week.

NOTE: In the previous Tolland Imaging Center CON submission (06-30841-CON), the Applicants identified two additional providers that were also located in one of the service area towns referenced above. Windham Radiology was a freestanding imaging center established to provide MRI and CT services at East Brook Mall in Mansfield, CT. This center is no longer operational. Med-East Medical Walk-in Center (Med-East) was also identified as a provider of radiography (x-ray) services located in Tolland, CT. Once Tolland Imaging Center opened its doors in 2008, Med-East decommissioned its x-ray equipment and has been referring patients that require imaging services to Tolland Imaging Center.

c. Complete **Table 1** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

Table 1: Existing Equipment Operated by the Applicant

Provider Name Street Address Town, Zip Code	**Description of Service**	**Hours/Days of Operation**[1]	**Utilization**[2]
Tolland Imaging Center, LLC 6 Fieldstone Commons, Suite E Tolland, CT 06084	Bone Density	Monday, Tuesday 8:30am to 4:00pm Wednesday, Friday 7:30 am to 3:00pm Thursday 11:30 to 6:30pm	443
	CT (4-slice)	Monday – Friday 8:30am – 3:30pm	777
	Mammography	Monday, Tuesday 8:30am to 4:00pm Wednesday, Friday 7:30 am to 3:00pm Thursday 11:30 to 6:30pm	2,053
	Open MRI (0.7T)	Monday – Friday 7:30 am to 4pm	1,733
	Ultrasound	Monday - Friday 8:00 am to 3:30pm	2,487
	X-Ray	Monday - Wednesday, Friday 7:30 am to 5:00pm Thursday 7:30am to 6:30pm	3,857

(1) Hours provided are based on the technicians' scheduled hours and actual appointment availability for the particular service. The end time presented represents the last appointment start time in which patients may be scheduled.

(2) Utilization provided for most recent 12-month period (January1, 2012 through December 31, 2012).

d. Provide the following regarding the proposal's location:

i. The rationale for locating the proposed equipment at the proposed site;

Response:

As previously explained in the April 13, 2007 response to OHCA's completeness letter regarding Docket #06-30841-CON, the site for the Tolland Imaging Center was selected due to several factors. The town of Tolland in recent years has experienced considerable growth in population, and this growth is expected to continue. Additionally, Tolland was identified as an attractive location for an imaging center due to the large number of physicians establishing offices in this region. The specific location at Fieldstone Commons off Merrow Road was identified because of its proximity to Route 84 and its central location to each of the Applicants.

The location offers several advantages for patients and physicians. A number of physicians had established offices in the same building as the imaging center when it first opened its doors in 2008, and additional physicians have since established offices in Tolland or one of the neighboring towns. Access to a freestanding, outpatient imaging facility within close proximity of their office contributes to patient compliance with recommended services. Older patients, in particular, are more likely to obtain needed imaging services if the site of service is in close proximity to their home and to their physician. The placement of the facility at this site in Tolland also offers quick and convenient access to the Emergency Room at Rockville General Hospital, in the rare instance that such a transfer is necessary for Tolland Imaging Patients.

ii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

Response:

The service area for Tolland Imaging Center was determined by identifying the towns where 80% of the Center's patients originate. Based on this methodology, the residents of Tolland and the towns immediately adjacent to Tolland (Coventry, Ellington, Mansfield, Stafford, Union, Vernon and Willington) have been identified as the primary population served by the Tolland Imaging Center.

There were over 115,000 residents of the eight-town service area in 2010 according the Connecticut Economic Resource Center (CERC) and that population is projected to grow 2.1% by 2015. The table below summarizes the demographic population of identified service area:

	Service Area Population						% Growth
TIC Service Area	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2010-2015**
Coventry	12,485	12,531	12,576	12,622	12,669	12,715	1.8%
Ellington	14,786	14,949	15,115	15,281	15,450	15,621	5.6%
Mansfield	23,531	23,518	23,504	23,491	23,477	23,464	-0.3%
Stafford/Union	12,901	12,921	12,940	12,960	12,979	12,999	0.8%
Tolland	15,071	15,218	15,365	15,515	15,666	15,818	5.0%
Vernon/Rockville	30,102	30,212	30,322	30,432	30,543	30,654	1.8%
Willington	6,214	6,207	6,200	6,193	6,186	6,179	-0.6%
Service Area Total:	**115,090**	**115,554**	**116,022**	**116,494**	**116,970**	**117,450**	2.1%

Source: Population statistics for 2010 and 2015 provided by CERC; statistics for 2011 to 2014 calculated using the average annual growth rate for 2010 to 2015.

The demand for outpatient diagnostic imaging services was determined utilizing the Advisory Board's Market Estimator Tool. This tool provides an estimate of outpatient volume by zip code for 2011 and the project growth through 2016. Using the volume estimates provided by the tool, the Applicant estimates the demand for CT services in the eight-town service area to be almost 13,500 and the demand for MRI services to be over 8,500. The table below summarizes the outpatient imaging volume estimates for the Tolland Imaging Center's eight-town service area:

	Advisory Board Outpatient Volume Estimates						AAGR	% Growth
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2011-2016**	**2011-2016**
Bone Density	2,732	2,815	2,901	2,989	3,080	3,174	3.0%	16.2%
CT	**13,491**	**13,749**	**14,011**	**14,279**	**14,551**	**14,829**	**1.9%**	**9.9%**
Mammography	10,090	10,218	10,349	10,480	10,614	10,749	1.3%	6.5%
MRI	**8,628**	**8,810**	**8,995**	**9,185**	**9,378**	**9,576**	**2.1%**	**11.0%**
Ultrasound	17,236	17,907	18,605	19,329	20,082	20,864	3.9%	21.0%
X-Ray	39,495	39,880	40,268	40,661	41,057	41,457	1.0%	5.0%

Source: Outpatient volume estimates for 2011 and 2016 (for Tolland's eight-town service area) were provided by the Advisory Board's Outpatient Market Estimator Tool; volumes for 2011 to 2015 calculated using the average annual growth rate for 2011 to 2016.

iii. How and where the proposed patient population is currently being served;

Response:

The patient population is currently being served by Tolland Imaging Center, Rockville General Hospital and Johnson Memorial Hospital.

iv. All existing providers (name, address) of the proposed service in the towns listed above and in nearby towns;

Response:

In addition to the other service area providers identified the response to question 2b above, there are additional providers of MRI and CT services in the towns immediately adjacent to the Applicant's service area. The name and address of those other providers have been summarized below:

Provider Name Street Address Town	CT	MRI
Buckland Hills Imaging Open MRI of South Windsor 491 Buckland Road South Windsor	CT (4-slice)	0.6 Tesla (open)
Evergreen Imaging Center 2800 Tamarack Avenue South Windsor	CT (6-slice)	1.5 Tesla (closed)
Jefferson Radiology 100 Hazard Avenue Enfield	n/a	1.5 Tesla (closed)
Johnson Memorial Hospital 148 Hazard Avenue Enfield	CT (single-slice)	1.5 Tesla (closed) **Mobile**
Open MRI of Enfield 137 Hazard Avenue Enfield	n/a	0.7 Tesla (open)
Manchester Memorial Hospital 71 Haynes Street Manchester	CT (single-slice) CT (16-slice)	1.5 Tesla (closed)
Radiology Associates of Hartford 9 Cranbrook Blvd Enfield	n/a	1.5 Tesla (closed)

v. The effect of the proposal on existing providers; and

Response:

Authorization of this proposal will have not have an adverse impact on the existing providers within or around the Applicant's service area. The Tolland Imaging Center has been in operation for over four years and has established referral patterns with existing providers in the services area.

vi. If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

Response:

Not applicable – this proposal does not involve the development of a new site for imaging services. Tolland Imaging Center has been operational at 6 Fieldstone Commons in Tolland since September of 2008. The rationale for why this site was selected at that time has been provided in the response to question 2di above.

e. Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.

Response:

Tolland Imaging Center has been providing MRI and CT services in the region for the past four years, so authorization of this proposal does not result in the duplication of any services. Additionally, the facility provides the only Open MRI scanner in the service area with the next closest open scanner located in South Windsor, approximately twenty to thirty minutes away.

3. Actual and Projected Volume

a. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each of the Applicant's existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In Table 2a, report the units of service by piece of equipment, and in Table 2b, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

Table 2a: Historical, Current, and Projected Volume, by Equipment Unit

Procedure Volume	**Actual Volume** *(Last 3 Completed FYs[1])*			**CFY Volume[2]**	**Projected Volume[3]**			
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2013**	**FY2014**	**FY2015**	**FY2016**
Bone Density	385	419	462	109	462	462	462	462
CT	949	699	805	166	805	805	805	805
Mammography	1,395	1,638	2,104	564	2,104	2,104	2,104	2,104
MRI	1,403	1,745	1,724	404	1,724	1,724	1,724	1,724
Ultrasound	2,480	2,219	2,571	556	2,571	2,571	2,571	2,571
X-Ray	3,356	3,502	3,795	931	3,795	3,795	3,795	3,795

Patient Volume	**Actual Volume** *(Last 3 Completed FYs[1])*			**CFY Volume[2]**	**Projected Volume[3]**			
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2013**	**FY2014**	**FY2015**	**FY2016**
CT	654	689	751	156	751	751	751	751
Mammography	1,330	1,589	2,043	552	2,043	2,043	2,043	2,043
MRI	1,299	1,633	1,639	392	1,639	1,639	1,639	1,639
Ultrasound	2,024	1,854	2,008	458	2,008	2,008	2,008	2,008
X-Ray[4]	2,779	2,921	3,320	834	3,320	3,320	3,320	3,320

(1) Applicant's fiscal year: October 1 through September 30.
(2) Current fiscal year-to-date data from October 1, 2012 through December 31, 2012.
(3) Projected volume for FY2013, FY2014, and FY2015 assumes 0% growth based on FY2012 actual volumes.
(4) X-ray patient volume includes patients receiving bone density scans.

Table 2b: Historical, Current, and Projected Volume, by Type of Scan/Exam

Procedure Volume	Actual Volume *(Last 3 Completed FYs[1])*			CFY Volume[2]	Projected Volume[3]			
	FY2010	**FY2011**	**FY2012**	**FY2013**	**FY2013**	**FY2014**	**FY2015**	**FY2016**
MRI Scan Type								
Abdomen	1	0	0	0	0	0	0	0
Chest/Thorax	4	0	1	0	1	1	1	1
Head/Neck	416	502	520	122	520	520	520	520
Lower Extremity	356	487	458	108	458	458	458	458
Pelvis	27	22	25	6	25	25	25	25
Thoracic/Lumbar	390	449	437	102	437	437	437	437
Upper Extremity	209	285	283	66	283	283	283	283
MRI Total	**1,403**	**1,745**	**1,724**	**404**	**1,724**	**1,724**	**1,724**	**1,724**
CT Scan Type								
Abdomen	311	106	38	8	38	38	38	38
Abdomen/Pelvis	0	174	318	66	318	318	318	318
Chest/Thorax	127	129	165	34	165	165	165	165
Head/Neck	188	175	205	42	205	205	205	205
Lower Extremity	13	3	15	3	15	15	15	15
Pelvis	281	82	8	2	8	8	8	8
Thoracic/Lumbar	21	19	45	9	45	45	45	45
Upper Extremity	8	11	11	2	11	11	11	11
CT Total	**949**	**699**	**805**	**166**	**805**	**805**	**805**	**805**

(1) Applicant's fiscal year: October 1 through September 30.
(2) Current fiscal year-to-date data from October 1, 2012 through December 31, 2012.
(3) Projected volume for FY2013, FY2014, and FY2015 assumes 0% growth based on FY2012 actual volumes.

b. Provide a breakdown, by town, of the volumes provided in Table 2a for the most recently completed full FY.

Response:

Please see **Attachment 3b** for the breakdown of MRI and CT patient volumes by town for FY2012.

c. Describe existing referral patterns in the area to be served by the proposal.

Response:

As an existing facility providing MRI and CT services, Tolland Imaging Center has an established referral pattern.

Nearly 77% of the MRI patients and close to 83% of the CT patients referred to the facility in FY2012 originated from one of the identified service area towns (Coventry, Ellington, Mansfield, Stafford/Union, Tolland, Vernon and Willington).

Over 83% of the MRI patients referred to Tolland Imaging Center were referred by a primary care physician (including family practice and internal medicine), an orthopedic surgeon or a neurologist.

Provider Specialty	% of MRI Referrals
Orthopedics	39.9%
Family Practice	19.6%
Internal Medicine	17.2%
Neurology	6.3%

Primary care physicians (including family practice and internal medicine) and specialist trained in gastroenterology, pulmonary medicine, otolaryngology (ENT) and orthopedics were responsible for referring almost 80% of CT patients in FY2012.

Provider Specialty	% of CT Referrals
Internal Medicine	26.2%
Family Practice	25.3%
Gastroenterology	8.5%
Pulmonary Medicine	7.3%
Otolaryngology (ENT)	6.6%
Orthopedics	5.7%

d. Explain how the existing referral patterns will be affected by the proposal.

Response:

The Applicant does not expect any impact on the existing referral patterns as a result of approving this proposal because Tolland Imaging Center is already an established facility providing CT and MRI services. If the application is denied, the Applicant expects that the majority of the patients will be referred to Rockville General Hospital (RGH) due to its close proximity to the facility in Tolland. Additionally, many of the providers responsible for a large number of the patient referrals to Tolland Imaging Center also refer patients to RGH for imaging services.

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

Response:

CT procedure volume experienced a decline from FY2010 to FY2011. The biggest factor contributing to this decline was a major CPT coding change that went into effect on January 1, 2011. This change eliminated the separate billing and CPT codes of all abdomen and pelvis CT exams performed on the same day. A new, combined CPT code was established and resulted in the procedure volume decline observed from FY2010 to FY2011. Despite this decline in CT procedure volume, the volume of patients seeking CT services from the Tolland Imaging Center has increased each year, including from FY2010 to FY2011.

The MRI procedure volume declined slightly from FY2011 to FY2012 but, like CT, has experienced an increase in patient volume each year since the Center opened.

f. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Response:

The Applicant has projected no volume growth for any of the imaging services provided at the facility from FY2012 through FY2016. This is consistent with what has been budgeted for FY2013 by Tolland Imaging Center.

The Applicant believes that the assumption of 0% growth is both reasonable and conservative for the Tolland Imaging Center, given that the geographic service area population is projected to grow 2.1% through 2015 and the demand for MRI and CT services is projected to increase by at least 10% from 2011 to 2016 (9.9% for CT and 11.0% for MRI). Please refer to the response to question 2dii above for more information on the geographic service area and medical imaging utilization projections.

g. Provide a copy of any articles, studies, or reports that support the need to acquire the proposed scanner, along with a brief explanation regarding the relevance of the selected articles.

Response:

An article published in Radiology Management titled *Roadmap for Reform: Outlook for Imaging under Accountable Care*[1] further supports the Applicant's conservative volume projection estimates. According to the authors, efforts to control health care utilization and unnecessary costs will have a negligible impact on the utilization of imaging services, including MRI and CT. The expanded availability of health insurance will impact younger segments of the population, individuals that are not currently high users of imaging services. Conversely, the aging of the population already covered by insurance will continue to be a driver of MRI and CT utilization as that segment of the population continues to experience growth in the Applicant's service area.

Please see **Attachment 3g** for a copy of the referenced article.

[1] Lund, Ingrid V. and Hartmann, Jacob. Roadmap for Reform: Outlook for Imaging under Accountable Care. Radiology Management, November/December 2011.

4. 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.

Response:

The key personnel related to this proposal include the following individuals:

Name	Relationship to Tolland Imaging Center
Kevin G. Murphy	President
Daniel Delgallo	Executive Director
John P. Opalacz, M.D.	Medical Director
Laurie S. Kingsbury	Office Supervisor
Nicole Chartier, B.S., R.T. (R),(MR)	CT Technician
Jennifer Lent	Lead Technologist (MRI)

A copy of the Curriculum Vitae has been provided as **Attachment 4a**.

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

Response:

Establishment of the Tolland Imaging Center has improved the quality of health care delivery in the region by facilitating collaboration between three independent hospital systems. Patient results are more easily shared between the Center and its member hospitals as necessary, potentially reducing unnecessary or duplicative testing and contributing to more efficient patient care decision-making by referring providers.

5. Organizational and Financial Information

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

Response:

The Applicant, Tolland Imaging Center, is a limited liability corporation with ownership interest held by four eastern Connecticut hospitals: Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital.

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

Response:

Please see **Attachment 5b** for a copy of the IRS letter documenting the not-for-profit status of Tolland Imaging Center.

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.

Response:

As a freestanding imaging center, Tolland Imaging Center is not required to be licensed by the State of Connecticut, Department of Public Health (DPH).

The equipment at the facility is certified by the following entities:

Modality	**Entity**
CT	• American College of Radiology
Mammography	• American College of Radiology • U.S. Department of Health and Human Services - Food and Drug Administration
MRI	• American College of Radiology
Ultrasound	• American College of Radiology
X-Ray	• Connecticut Department of Energy and Environmental Protection (DEEP)

Copies of the above certificates have been included as **Attachment 5c**.

d. Financial Statements

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

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

Response:

Please see **Attachment 5d** for a copy of the financial statements and independent accountant's compilation report for Tolland Imaging Center and the member hospitals for FY2012.

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

Table 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$	166
Imaging Equipment Purchase	$	10,410
Non-Medical Equipment Purchase	$	9,037
Land/Building Purchase	$	-
Construction/Renovation	$	350,735
Other Non-Construction (Specify)	$	-
Total Capital Expenditure (TCE)	$	**370,348**
Medical Equipment Lease (Fair Market Value)	$	-
Imaging Equipment Lease (Fair Market Value) ***	$	470,517
Non-Medical Equipment Lease (Fair Market Value)	$	-
Fair Market Value of Space	$	403,552
Total Capital Cost (TCC)	$	**874,069**
Total Project Cost (TCE + TCC)	$	**1,244,417**
Capitalized Financing Costs (Informational Purpose Only)	$	726
Total Capital Expenditure with Cap. Fin. Costs	$	1,245,144

*** 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.

Response:

The MRI and CT scanner were acquired and put into operation on September 2, 2008. The original acquisition of the two units was authorized by OHCA as a demonstration project (see Docket #06-30841-CON). Without the revenue

generated by these two services, Tolland Imaging Center would be unable to support the operations associated with a freestanding imaging facility and would be forced to close permanently. The expenditures referenced above represent the expenses that would continue to be incurred by hospital members of Tolland Imaging Center in the event this proposal is **not** granted.

The outstanding balance after October 1, 2013 of $470,517 on the imaging equipment loan (which was refinanced in March, 2011) must still be settled with the applicable lender regardless of whether or not Tolland Imaging Center continues to operate. Additional depreciation costs associated with equipment purchases and tenant improvement costs have also been incurred and are reflected above as an unrecoverable capital expense. These expenses would have to be incurred by the hospital members of Tolland Imaging Center. It is important to note that the expenses above do not include the legal expense associated with closing the facility and dissolving the entity, but this additional expense would also have to be incurred by the hospital members.

The useful life of both the MRI and CT is five years, so the anticipated residual value of the equipment on October 1, 2013 (the effective date of the facility closure if the CON is not approved and prior to the loan term date of February 1, 2015) is zero.

Please find the loan repayment schedule for the imaging equipment capital lease (Tolland Lease Schedule) and the schedule of depreciation in **Attachment 5e**.

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.

Response:

The initial startup of the Tolland Imaging Center in 2008 was funded through the acquisition of three capital leases. Since that time, the lease for the imaging equipment has been refinanced.

The applicable details for each lease have been summarized below. Please note, the original leases for the tenant improvement costs and the non-imaging equipment will be paid off by the end of FY2013, but nearly $500,000 of the refinanced imaging equipment lease will remain outstanding as of October 1, 2013, the effective date of this proposal.

Funding Source (Capital Lease)	Amount	Interest Rate	Start	End	Monthly Payment	Expected by 9/30/2013	
						Paid	Remaining
Lease #1 (Imaging Equipment)	$1,306,757	6.000%	3/1/2011	2/1/2015	$29,407	$806,833	$470,417
Lease #2 (Tenant Improvements)	$470,259	11.926%	9/1/2008	9/1/2013	$11,691	$470,259	$0
Lease #3 (Non-Imaging Equipment)	$149,428	11.68%	9/1/2008	9/1/2013	$3,692	$149,428	$0

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

Response:

The financial viability of hospitals and health systems across the state and nationally is fragile, particularly for small hospitals and health systems that often operate with very small profit margins, if they are even able to generate more revenue to offset their expenses. Authorization of this proposal maintains the financial strength of the state's health care system by ensuring that the dollars spent by the member hospitals to establish the Tolland Imaging Center is not wasted. The member hospitals contributed $860,000 to establish the Center, and all of this investment would be lost if the Applicant's proposal is denied. The member hospitals would continue to be responsible for any outstanding lease or rental payments but would not have the revenue generated by the facility to offset this expense. This unnecessary expense would erode the already small profit margins of the member institutions, negatively affecting the financial strength of the state's health care system.

6. Patient Population Mix: Current and Projected

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

Table 4: Patient Population Mix

Current (FY2012)	Facility	CT	MRI
Medicare*	21.6%	30.5%	19.9%
Medicaid*	6.9%	6.3%	6.4%
CHAMPUS & TriCare	0.9%	0.9%	1.0%
Other Government	0.1%	0.1%	0.1%
Total Government	**29.6%**	**37.8%**	**27.4%**
Commercial Insurers*	67.9%	59.5%	64.7%
Uninsured	1.9%	2.3%	7.8%
Workers Compensation	0.6%	0.4%	0.1%
Total Non-Government	**70.4%**	**62.2%**	**72.6%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**

* Includes managed care activity.

Response:

The projected patient population mix for FY2013, FY2014 and FY2015 will remain constant at the FY2012 population mix.

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

Response:

The projected patient population mix is based on the current mix of patients being served by the Tolland Imaging Center. The Applicant does not anticipate any changes in how it operates or the populations served by the facility as a result of receiving permanent CON authorization for the MRI and CT scanners.

7. 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.

Response:

Please find the completed **Financial Attachment I** included as **Attachment 7a**.

A clarifying note about Financial Attachment I:

Tolland Imaging Center is currently providing MRI and CT services and through this application is requesting CON authorization for the permanent acquisition of this equipment. Given that the equipment is already in-service, denial of this application would result in the closure of the Tolland Imaging Center.

The "without the CON" columns on the Tolland Imaging Center Financial Attachment reflect the expenses that will be incurred by the member hospitals if the facility closes. The percentage of the expenses incurred by each of the member hospitals in this scenario, along with the revenue that the member hospitals could no longer include in their other operating revenue projections, appears in the "Incremental" column on each of the member hospitals' Financial Attachment I worksheets. The incremental values on the hospital worksheets plus the "with CON" values are summed to calculate the "without the CON" projections. As this calculation is typically reversed in most CON applications, the Applicant felt it necessary to clarify this with our submission.

Additionally, the "with CON" columns on the Tolland Imaging Center Financial Attachment reflect the status quo in terms of operations at the Tolland Imaging Center. If the CON is approved, the Applicant intends to maintain the current delivery model for services at the Tolland Imaging Center.

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

Response:

Please find the completed **Financial Attachment II** included as **Attachment 7b**.

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

Response:

In addition to the explanation provided in 7a, please find the assumptions utilized in developing both Financial Attachment I and II below:

Project Commencement

- The Tolland Imaging Center is currently providing MRI and CT services and will continue to provide these services pending a decision from OHCA.
- If the CON to continue providing these services is denied the Applicant will make preparations to transition scheduled patients to other facilities and plan to close the facility by the end of the current fiscal year (by September 30, 2013).
- All assumptions related to the denial of this application will utilize October 1, 2013 as the commencement date of the proposal.

Full-Time Equivalents (FTEs)

- The number of Tolland Imaging Center FTEs will remain constant at FY2012 levels if the CON to continue providing MRI and CT services at Tolland Imaging Center is approved.
- If the CON is denied, and the Applicant is unable to continue providing MRI and CT services, the facility will close and the number of FTEs will be 0.
- The number of FTEs at the member hospitals will not change with or without authorization of this application.

Volume Statistics

- All outpatient imaging volumes for Tolland Imaging Center will remain constant at the FY2012 levels if the CON is approved.
- Imaging volumes at Tolland Imaging Center will be equal to zero if the CON is denied and the Tolland Imaging Center ceases operation.
- All CT and MRI volumes for the member hospitals, including inpatient, outpatient and emergency volumes, will remain constant at FY2012 levels with or without CON approval.

Expenses

- General Operating Expenses
  - General operating expenses for Tolland Imaging Center will increase 1.6%[2] each year if the CON is approved.
  - General operating expenses that will increase at 1.6% each year include salaries, fringe benefits, professional/contracted services, supplies, drugs and other operating expenses.
  - Other operating expenses include repairs and maintenance, marketing and licensing fees.
  - If the CON is denied, Tolland Imaging Center will not incur any general operating expenses.
  - The member hospitals will also experience annual 1.6% increases in general operating expenses.

- Bad Debt Expense
  - In FY2012, bad debt expense experience as a percent of net revenue for Tolland Imaging Center and the member hospitals in FY2012 was:

Facility	Bad Debt (as % of Net Revenue)
Tolland Imaging Center	4.0%
Johnson Memorial Hospital	5.4%
Manchester Memorial Hospital	3.6%
Rockville General Hospital	4.9%

  - If the CON is approved, the expense associated with bad debt at Tolland Imaging Center will continue to be 4.0% of net revenue FY2016.
  - If the CON is denied, the bad debt expense at Tolland Imaging Center will be equal to zero because the facility will be closed prior to the start of fiscal year 2014.
  - The expense associated with bad debt at the member hospitals will remain at the current (FY2012) percentage of net revenue through FY2016 with our without approval of the CON.

- Lease Expense
  - The lease expense associated with the physical space rental at Tolland Imaging Center will increase by 3% each year from the FY2012 rental expense level and will continue as long as the facility is operational.

[2] The United States Department of Labor Bureau of Labor Statistics has reported a 1.6% increase in the Consumer Price Index for the last 12 months ending in January, 2013.
Source: http://www.bls.gov/news.release/cpi.nr0.htm

- The member hospitals will incur the lease expense associated with the physical space rental for the facility if the CON is denied only until the current lease term ends on June 30, 2016.
- Additional lease expense (not related to this proposal) for the member hospitals will increase 1.6% each year with or without the CON.
- The member hospitals will incur the entire balance of the rent expense ($403,552) in FY2014 if the application is denied.
- Additionally, the member hospitals will also incur the remaining capital lease payments associated with Capital Lease #1 (Principle = $457,448.25 / Interest = $13,069) in FY2014 if the application is denied.

- Depreciation, Amortization and Interest Expense
  - If the CON is approved, Tolland Imaging Center will incur the applicable depreciation and interest expenses each fiscal year as outlined in the Schedule of Depreciation and Lease Schedule provided in Attachment 5e.
  - If the CON application is denied, the member hospitals will incur the full value of remaining depreciation ($371,074) for Tolland Imaging Center in FY2014, immediately following closure of the facility.
  - Additional depreciation expense (not related to this proposal) for the member hospitals will increase 1.6% each year with or without the CON.

Revenues

- The overall net revenue payer mix for Tolland Imaging Center and the member hospitals will remain constant at the percent distribution observed in FY2012:

Payer	Tolland	JMH	MMH	RGH	WCMH
Non-Government	82%	53%	56%	61%	43%
Medicare	15%	38%	34%	26%	44%
Medicaid	3%	9%	10%	13%	13%
Other Government	0%	0%	0%	0%	0%

- Total net patient revenue for Tolland Imaging Center will increase 1.6% each year through FY2016 from the levels experienced in FY2012 if the CON is approved as a result of improved managed care contracting.

- The average charge per scan at Tolland Imaging Center will increase each year according to the following schedule in order to generate a 1.6% net revenue increase projected through FY2016:

Modality	Average Charge (Rate)*		
	FY2014	FY2015	FY2016
CT	$ 920	$ 923	$ 926
MRI	$ 1,483	$ 1,486	$ 1,489
Bone Density	$ 203	$ 206	$ 209
Mammography	$ 302	$ 305	$ 308
Radiography (x-ray)	$ 85	$ 89	$ 92
Ultrasound	$ 244	$ 247	$ 250

***Note:** The average charge is the "Rate" value used for Financial Attachment II.

- The average charge for FY2014 was calculated based on the average of the actual charges observed in FY2012 for each modality.

- Total net patient revenue at the member hospitals will also increase 1.6% each year as a result of improved managed care contracting.

- If the CON is denied, net patient revenue for Tolland Imaging Center will equal $0 beginning October 1, 2014.

- Revenue over expense distributions from Tolland Imaging Center to the member hospitals is included in "other operating revenue" in FY2012 and in the projections of other operating revenue through FY2016 with CON approval.

- The value of the projected revenue over expense distributions that would have been received by the member hospitals appears as the incremental column as lost revenue and is backed out of the other operating revenue projection without CON authorization.

- The hospitals' distributions are equal to their membership interest in Tolland Imaging Center and is as follows:

Member	% Ownership	Member Distributions		
		FY2014	FY2015	FY2016
Johnson	15%	$ 88,844	$ 93,395	$ 94,795
Manchester	35%	$ 207,302	$ 217,921	$ 221,188
Rockville	35%	$ 207,302	$ 217,921	$ 221,188
Windham	15%	$ 88,844	$ 93,395	$ 94,795
Total	**-**	**$ 592,293**	**$ 622,631**	**$ 631,967**

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

Response:

Please find the rate schedule for MRI and CT procedures performed at Tolland Imaging Center in **Attachment 7d**.

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

Response:

Tolland Imaging Center has been operational for more than four fiscal years and as of FY2012 has experienced enough patient volume across all modalities to generate a gain from operations. In FY2012 the gain from operations was $96,815 and this is projected to grow to $631,967 by FY2016 if this CON proposal is approved.

It is the member hospitals that will experience a loss if the CON is denied and Tolland Imaging Center is closed beginning in FY2014.

The volume of each modality required to offset the loss was calculated for Rockville General Hospital (RGH) as an example. The table below shows the loss incurred by RGH allocated to each of the modalities based on the volume of these services provided at Tolland Imaging Center in FY2012.

For example, in FY2014, RGH is projected to incur a loss of $643,103 dollars as a result of closing Tolland Imaging Center if the CON is denied. There were 805 CT procedures performed in FY2012 which accounts for 7% of the total procedure activity performed Tolland Imaging Center. This percentage of 7% was used as a proxy to calculate the loss attributable to CT incurred by RGH.

Modality	**FY2014**	**FY2015**	**FY2016**
CT	$ 45,170	$ 15,306	$ 15,536
MRI	$ 96,738	$ 32,780	$ 33,272
Mammography	$ 118,060	$ 40,006	$ 40,605
Radiography (x-ray) + Bone Density	$ 238,870	$ 80,943	$ 82,157
Ultrasound	$ 144,265	$ 48,885	$ 49,618
Total	**$ 643,103**	**$ 217,921**	**$ 221,188**

Note: RGH does not perform Bone Density procedures so the dollars allocated to this modality were included with the radiography allocation.

The average total cost for each of the imaging services provided was calculated using data derived from Rockville's Medicare Cost Report and actual total charges for FY2012. Actual net receivables for FY2012 were used to calculate an average reimbursement by modality at RGH. The difference between the average total coast and the average reimbursement provided an estimate of the revenues over expenses per modality and are summarized below:

	Revenues Over Expenses
CT	$ 500.78
MRI	$ 501.23
Mammography	$ 35.35
Radiography + Bone Density	$ 34.94
Ultrasound	$ 116.19

Based on the estimated revenue over expense per modality experience at RGH, the minimum number of procedures for each modality needed to offset the loss incurred by a closure of Tolland Imaging Center if the CON is denied was calculated:

Modality	Volume to Breakeven		
	FY2014	FY2015	FY2016
CT	90	31	31
MRI	193	65	66
Mammography	236	80	81
Radiography	477	161	164
Ultrasound	288	98	99

Assuming similar experiences at the other member hospitals, the volume required for Manchester Memorial Hospital to breakeven would be identical to RGH as its loss is also based on 35% membership interest in Tolland Imaging Center. The volumes required by Johnson Memorial and Windham would be less than what has been presented in the example above because their loss is based on 15% membership.

It is important to note that the MRI at Tolland Imaging Center is an Open MRI, and is the only open unit owned and operated by all of the member hospitals. Many of the patients who receive their MRI scans at Tolland Imaging Center do so because of the open magnet, and may not utilize the remaining MRI services offered by the members. Additionally, many patients prefer an outpatient, freestanding option for the medical imaging services. For both of these reasons, the feasibility of RGH and the other member hospitals actually capturing enough volume to offset the loss that would incurred by a closure of Tolland Imaging Center is not expected.

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

Response:

There are no losses from operations contained in the financial projections that will result from authorization of this CON proposal. A loss is only incurred by the member hospitals if the CON application is denied and Tolland Imaging Center closes by September 30, 2013. Please see the response to question 7e above for additional information regarding the loss incurred by the member hospitals with denial of this CON proposal.

g. Describe how this proposal is cost effective.

Response:

Authorization of this proposal is cost effective because the financial investment to establish the Tolland Imaging Center has already been expended. The member hospitals invested $860,000 to establish the Tolland Imaging Center which has been in operation since September of 2008. Without authorization to continue providing MRI and CT services, Tolland Imaging Center will need to close as the remaining imaging services cannot support the administrative and overhead costs associated with operating a freestanding imaging center. The member hospitals would continue to be responsible for the outstanding lease and rental costs associated with the Tolland Imaging Center even after it closes its doors. These expenses, combined with the additional depreciation expense associated with the equipment purchased to establish the Center results in $1.2 million of wasted spending that could have been better utilized in the provision of more permanent health care services. Authorization of this proposal, after such a financial commitment has already been made, ensures that the spending to establish the Tolland Imaging Center remains a cost effective endeavor for the member hospitals.

Appendix 1b

ECHN℠
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

March 18, 2013

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

Dear Deputy Commissioner Davis:

On behalf of Eastern Connecticut Health Network (ECHN), including Manchester Memorial Hospital (MMH) and Rockville General Hospital (RGH), I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility located in Tolland, Connecticut.

Tolland Imaging Center was established through the collaborative efforts of three independent hospital systems to meet an identified need for outpatient imaging services in the Tolland area. While ECHN offered a freestanding facility in South Windsor, we recognized that it did not meet the needs of patients residing in the eastern portion of our service area. We initially planned to establish a freestanding center in Tolland as a joint venture arrangement with our radiologists, similar to previously approved Evergreen Imaging Center in South Windsor. Ultimately, we agreed to participate in the development of the imaging center with Windham Community Memorial Hospital and Johnson Memorial Hospital (now Johnson Memorial Medical Center), at OHCA's recommendation, as these two hospitals had submitted their own joint proposal for a freestanding imaging facility in Tolland during this same time period.

As founding members of the Tolland Imaging Center, MMH and RGH were responsible for contributing a portion of the capital dollars required to launch the imaging center and to support it in its earlier years of operation. Establishment of the facility and subsequent requests for dollars to support ongoing operations has required ECHN (on behalf of its two hospitals) to contribute $600,000 towards this initiative. ECHN did not receive any returns on its investment until the close of FY2012 when the center began generating positive returns. Through the end of FY2013 ECHN is only projected see a return equal to one third of its original investment. The center is now in a position to generate returns that cover its expenses and generate positive returns to its member hospitals while serving residents in this region of Connecticut with a free-standing imaging option.

If Tolland Imaging Center does not receive the necessary approvals to continue providing CT and MRI services at the freestanding location, the facility will not experience enough volumes or

ECHN℠
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

generate the revenue to support operations of a stand-alone facility and will be forced to close. ECHN will continue to be responsible for its share of the ongoing lease obligations and other expenses already incurred by Tolland Imaging Center. These dollars, along with ECHN's original investment, which could have been better utilized to support other more permanent patient care services within the health network instead, will have been wasted on the short-term development of, in effect, temporary imaging services. CON approval allowing the continued operation of Tolland Imaging Center will ensure patient access to these types of imaging services in a convenient, low-cost setting remains an available option in the future.

I encourage you to approve this proposal and allow the Tolland Imaging Center to continue providing the imaging service accessibility that patients in Tolland and the surrounding towns have come to expect in their local community.

Sincerely,

Peter J. Karl, President and Chief Executive Officer
Eastern Connecticut Health Network

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

X	Bone Density	X	MRI (open)
X	CT	X	Radiography (x-ray)
X	Mammography	X	Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Christine Blake, APRN

Christine Blake, APRN

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- ✓ Bone Density
- ✓ CT
- ✓ Mammography
- ✓ MRI (open)
- ✓ Radiography (x-ray)
- ✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

EVoss PAC

Elise Voss, PA

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Antonela Barbu

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- [x] Bone Density
- [x] CT
- [x] Mammography
- [x] MRI (open)
- [x] Radiography (x-ray)
- [x] Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Beth Schweitzer

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

MD

Lawrence M. Arky, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	___ MRI (open)
___ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Gunn, MD

Carla R. Gunn, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Gerald Bayona G Bayona

Type provider name here GERALD BAYONA

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Lon P. Manfredi, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

- ✓ Bone Density
- ✓ CT
- ✓ Mammography
- ✓ MRI (open)
- ✓ Radiography (x-ray)
- ✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Angela Biondi PAC

Angela Biondi, PA

Type provider name here Angela Biondi, PA-C

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

____ Bone Density	X MRI (open)
X CT	X Radiography (x-ray)
____ Mammography	X Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

J Michael Herr, DO

Dr. J. Michael Herr

Type provider name here

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

✓ Bone Density	✓ MRI (open)
✓ CT	___ Radiography (x-ray)
✓ Mammography	✓ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Aziza Omrani, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

X Bone Density	X MRI (open)
X CT	___ Radiography (x-ray)
X Mammography	X Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Daniel S. Welling, MD

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

_____ Bone Density	✓ MRI (open)
✓ CT	✓ Radiography (x-ray)
_____ Mammography	_____ Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Kenneth Alleyne

March 18, 2013

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

Dear Deputy Commissioner Davis:

I would like to express my support for the Certificate of Need Application filed by Tolland Imaging Center, LLC (Docket Number TBD) to continue the delivery of comprehensive imaging services, including MRI and CT services, at their outpatient facility locating in Tolland, CT.

Tolland is a growing community, and with this growth comes an increasing demand for health care services. As a practicing physician in the area, I currently refer patients to the facility for services, particularly if my patients express a preference for receiving such services in an ambulatory setting.

Imaging services provided by the facility that I often recommend for my patients include:

N/A	Bone Density	✓	MRI (open)
✓	CT	✓	Radiography (x-ray)
N/A	Mammography	✓	Ultrasound

I am satisfied with the quality of services delivered by the Tolland Imaging Center and believe that the creation of the Tolland Imaging Center has significantly improved patient access to quality diagnostic imaging services in the area. Elimination of any of the services provided by the freestanding center would erase the improvements in patient access that have been achieved since the Tolland Imaging Center was first established. Further, availability of anything less than the full spectrum of imaging services currently available at Tolland Imaging Center could affect my decision to continue referring patients to the freestanding facility, particularly if patients require multiple imaging services at one time or follow-up services involving an imaging service that would no longer offered by the Tolland Imaging Center.

I understand that CON authorization is required for Tolland Imaging Center to continue providing the full spectrum of imaging services, and believe it is imperative that this authorization be given. As the only freestanding imaging facility in the region, I believe it offers my patients the same high quality imaging services also provided by our local hospitals, but in more convenient, accessible and acceptable setting for my patients. Additionally, the availability of MRI services utilizing an open magnet is particularly desirable for some of my patients, and none of the area hospitals provide an open MRI except through their involvement with the Tolland Imaging Center.

I encourage you to approve this proposal and allow Tolland Imaging Center to continue providing the care and imaging service accessibility that my patients have come to expect in their local community.

Sincerely,

Dr. Senatus

Appendix 3b

3b - MRI and CT Patient Volume by Town (FY2012)

Connecticut	MRI
Andover	10
Ashford	81
Avon	1
Berlin	0
Bloomfield	1
Bolton	9
Bristol	0
Brooklyn	4
Canterbury	0
Chaplin	12
Colchester	0
Columbia	10
Coventry	162
Cromwell	1
East Hampton	1
East Hartford	11
East Windsor	7
Eastford	13
Ellington	98
Enfield	7
Fairfield	0
Farmington	3
Franklin	1
Glastonbury	4
Goshen	1
Granby	0
Greenwich	0
Griswold	1
Haddam	0
Hampton	1
Hartford	6
Hebron	4
Killingly	1
Lebanon	4
Manchester	50
Mansfield	130
Marlborough	0
Middlebury	0
Middletown	0
Monroe	1
Montville	0
New Britain	1

Connecticut	CT
Andover	4
Ashford	31
Bolton	5
Bridgeport	2
Brookfield	1
Brooklyn	1
Canterbury	1
Chaplin	0
Colchester	1
Columbia	4
Coventry	63
Cromwell	1
East Hampton	1
East Hartford	3
East Windsor	5
Eastford	1
Ellington	55
Enfield	1
Glastonbury	2
Hampton	0
Hartford	3
Hebron	2
Killingly	2
Lebanon	3
Manchester	16
Mansfield	29
Middletown	1
Norwalk	0
Norwich	1
Plainfield	0
Pomfret	0
Portland	1
Preston	0
Putnam	0
Scotland	0
Somers	8
South Windsor	7
Stafford/Union	44
Suffield	0
Tolland	301
Vernon/Rockville	82
West Hartford	1

3b - MRI and CT Patient Volume by Town (FY2012)

(Continued)

Connecticut	MRI
New Hartford	1
New Haven	1
Newington	0
Newtown	0
North Haven	0
Norwich	2
Plainfield	1
Plymouth	1
Pomfret	5
Preston	0
Putnam	5
Rocky Hill	1
Scotland	2
Shelton	0
Simsbury	3
Somers	8
South Windsor	20
Southington	1
Southport	1
Stafford/Union	111
Sterling	0
Suffield	1
Thompson	2
Tolland	462
Vernon/Rockville	170
Wallingford	1
Watertown	0
West Hartford	1
Wethersfield	2
Willington	122
Wilton	0
Windham	49
Windsor	2
Windsor Locks	5
Wolcott	1
Woodstock	7
Ma	8
NY	0
Unknown	7
MRI Total	**1,639**

Connecticut	CT
Weston	1
Willington	46
Wilton	0
Windham	4
Windsor	1
Windsor Locks	1
Woodstock	3
MA	8
NY	1
Unk	3
CT Total	**751**

Appendix 3g

Roadmap for Reform: Outlook for Imaging under Accountable Care

By Ingrid V. Lund, PhD and Jacob Hartman

The credit earned from the Quick Credit™ test accompanying this article may be applied to the AHRA certified radiology administrator (CRA) fiscal management domain.

EXECUTIVE SUMMARY

- The primary goals of of the Patient Protection and Affordable Care Act are to expand insurance coverage through an individual mandate, and to reduce growing healthcare costs through new risk-based payment models and the formation of ACOs.
- With the high cost of exams and steady growth through the last decade, imaging appears to be a prime target for savings under accountable care.
- Given that some of the reform payment models are set to begin as early as next year, and private payers are increasingly instituting similar risk-based payment models in their plans, it is critical for imaging leaders to understand how these models will affect their growth strategy and prepare accordingly.
- A thorough analysis of the various payment models, considering all possible targets for cost savings, is required to accurately determine the timing and impact for imaging.

Since the passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010, imaging leaders have raised myriad questions about what the legislation might mean for the future of imaging volumes and reimbursement. PPACA aims to accomplish two primary objectives: to dramatically reduce the number of Americans without medical coverage and to slow the growth rate of healthcare spending.[1] As of this writing, the future of coverage expansion is open to question due to judicial challenges now working their way through the court system. However, there is a consensus among politicians on both sides of the aisle, as well as private payers, that healthcare costs are growing too quickly and need to be brought under control through payment reform.

As policy makers look for opportunities to control costs, imaging presents an inviting target. Indeed, the General Accountability Office (GAO) recently described advanced imaging as "the bellwether for the excesses of fee-for-service medical care."[2] Their focus is understandable. Imaging exams are expensive, often extremely profitable, and both volumes and costs have been rising faster than overall medical expenditures for some time. To make matters worse, literature has suggested that the clinical rationale for many imaging studies is questionable and certain tests are ordered more frequently when physicians have a direct financial interest in doing so.[3,4] There is also suggestive evidence that imaging costs can be brought under control: data from Milliman MedInsights shows that in markets where imaging is tightly controlled through integrated physician networks, extensive preauthorization, and financial incentives, physicians order scans much less frequently than their counterparts in markets with looser controls.[5]

For imaging leaders, the key question is how will healthcare reform change imaging volumes or imaging pricing levels? To better understand the answer to this question, it is important to disaggregate the legislation into its component parts. Starting with the coverage expansion provision, which will bring in 31.7 million newly covered lives, close examination of the cohort of patients who will become insured due to coverage expansion reveals that the impact on imaging volumes will be somewhat limited. The prime reason is demographics. The group of newly insured patients skews the young in regard to healthcare utilization.[6] Historically, younger people make

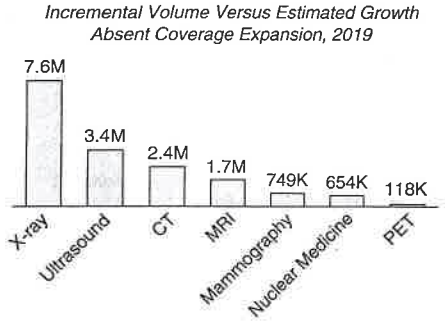


Figure 1 • Projected increase in imaging procedure volumes.

up only a fraction of imaging volumes, whether they are insured or not. However, coverage expansion may lead to some additional volume. Figure 1 models out the incremental impact of coverage expansion on imaging volumes, estimating 16.6 million scans in growth as a best case scenario. Also, because these are national numbers and will be spread out across providers in the United States, the volume impact to any individual institution will likely be negligible.

Payment Models

The other objective of the reform legislation is to implement new payment models that incentivize providers to reduce overall costs, while still rewarding value of care. To achieve this, PPACA includes two large risk-based payment models: episodic bundled payments and shared savings programs, with pilots for each set to launch beginning in 2012.

The piloting of these new payment approaches by CMS has coincided with innovation by private payers as well. In many markets across the country, commercial payers, and in some cases private employers, are piloting new payment models very similar to those in reform with their local providers. In Massachusetts, for example, a number of providers have signed onto the new Blue Cross Blue Shield Alternative Quality Contract which, like the CMS models, aims to limit cost growth while rewarding quality.[7] Therefore, regardless of how legal challenges to the constitutionality of the PPACA legislation play out, the private sector is beginning to pursue efforts to bring costs under control (or to reduce utilization). If more private payers begin driving markets toward accountable care, repeal efforts may be irrelevant, as a significant private sector transition may cement the change.

The two most significant programs aimed at transforming the industry are bundled payments and shared savings. The first, bundled payments, comes in three distinct models: inpatient, post-acute, and episodic. While each of these models varies in scope the basic principle is shared—professional and technical fees accrued over a determined care interval are paid together in a single, discounted payment. In exchange for the discount, hospitals and other care facilities participating may engage in gain-sharing with physicians, paying a bonus to those willing to help lower costs through device standardization and other similar efforts. As for the three types of models, the only real difference between them is the set of services they include. Inpatient bundles will cover all services provided during a single admission, post-acute bundling all those services provided during a defined period following discharge, and episodic bundling will combine the two.

While the bundled payment approach is a departure in terms of how reimbursement is distributed, it is still fundamentally a fee-for-service approach. The strategy for achieving profitability under any form of bundled payment will remain fundamentally constant. To secure a more favorable margin, hospitals will need to manage input costs. For the imaging community, this suggests that the impact on volumes will be minimal, as imaging represents a comparatively minor input cost and therefore will likely not be a target for generating savings under bundled payments. While volumes will be largely unaffected, there may be some lost revenue as a result of episodic bundling, as any imaging conducted following discharge but within the designated episode will be included in the bundled payment. Nevertheless, the total risk to imaging from all forms of bundled payments will be significantly less than that represented by shared savings.

The second new payment approach, shared savings, requires providers to form ACOs, a collaborative group which can include specialty physicians, hospitals, and post-acute care providers, but which must include primary care physicians. The ACO will be responsible for managing the total cost of care for the patients in its network. Procedures are still paid on a fee-for-service basis, but the Centers for Medicare and Medicaid Services (CMS) then distributes bonuses or penalties to providers retrospectively each year based on how well the ACO performs against its cost and quality target. Limiting growth in Medicare expenditures will be a primary goal within the ACO, and organization leaders will be looking to limit utilization in many areas.

The structure of the shared savings program arouses questions regarding what kinds of procedures, admissions, and readmissions should be targeted for reduced utilization. Under the shared savings model, ideal targets for utilization reduction share three features:

1. First, the procedure should have a high variable cost. These procedures are expensive to Medicare but generate comparatively little profit. As a result, the bonus for eliminating such procedures will outweigh the lost profit.
2. Second, it must be feasible to eliminate or substitute for the procedure or service without compromising patient care.
3. Third, reducing costs or utilization can be achieved by working with a manageable number of physicians, making it easier to gain consensus on standardization of care and the reduced or eliminated procedures.

One example that fulfills all those criteria is lumbar spinal fusion. It has a high variable cost (as much as 71% of the revenue for the procedure), allowing for a shared savings bonus larger than

the profit lost from avoiding the procedure.[8] In some cases, a low cost substitute (physical therapy) is available to replace high cost surgery.[9] And finally, the number of spine surgeons and referring orthopedists is comparatively small, suggesting the logistical challenge of inflecting behavior change would be manageable. As a result, if a provider can avoid a lumbar spinal fusion procedure without sacrificing patient care and outcomes, a significant cost may be avoided.

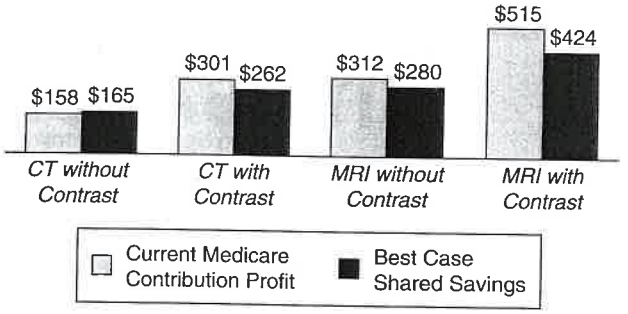


Figure 2 • Estimated financial impact of select procedures under Medicare fee-for-service (FFS) and shared savings.

Utilization Management

Taking into account these three factors, one can next assess how well imaging fits the three criteria for potential utilization management. First, with respect to variable costs, imaging stands as a poor candidate. Imaging is largely a fixed cost business. Providers pay huge sums for capital equipment compared to small incremental costs of supply and labor hours. Similarly, as such a powerful diagnostic tool, imaging is often difficult to eliminate or replace with less costly options. Although inappropriate exams still remain widespread, in many markets, downward pressure on utilization from payers through preauthorization has already eliminated a high percentage of questionably appropriate scans on the outpatient side.[10] As a result, it is unlikely that hospital leaders would be capable of eliminating significant volumes without implementing draconian and clinically questionable measures aimed at limiting utilization. Finally, we consider the potential to effect change in ordering patterns across an organization. Imaging orders originate from a vast number of physicians across the continuum, and inflecting the ordering behavior of such a large cohort in a meaningful way will be daunting.

While imaging fails as a target for utilization reduction according to all three criteria, the rapid growth in imaging costs may mean that, to many, it will still seem a prime target for cost cutting. As a result, the economic rationale for protecting imaging from utilization reduction warrants further attention. To better understand why imaging is a poor source of shared savings, we have modeled the best-case potential shared savings bonus for a single scan across numerous modalities (Figure 2). Even under optimal conditions, where the organization generates adequate savings overall to receive a bonus and achieves success across 65 quality measures (a scenario very few hospitals are likely to reach) the incremental bonus of a forgone scan is usually less than the contribution profit that would be generated by that same scan. In the majority of cases, reducing imaging to generate a shared savings bonus will result in a net loss for the hospital.

The real concern with targeting imaging under shared savings, however, is not the minor incremental losses from forgoing scans under shared savings, but the much larger potential revenue loss that could result from cannibalization of more directly profitable (ie, fee-for-service) volumes. Following the launch of the shared savings program, most providers will still maintain a significant fee-for-service private-payer population. If hospitals are able to influence physician ordering patterns for costly exams, physicians are likely to apply new ordering patterns across all patient populations, not just for those in the ACO. Physicians will be unable to provide different care based on whether or not the patient is covered by the ACO. Any volumes forgone for ACO patients will be mitigated to some degree by the potential shared savings bonus. In contrast, any volumes eliminated for patients not covered by the ACO, such as private payer patients, would represent nothing more than lost profit for the hospital.

Downward pressure on utilization from payers through preauthorization has already eliminated a high percentage of questionably appropriate scans on the outpatient side.

Transitioning to the Future

Despite this strong argument against limiting imaging under the shared savings model, hospital and health system leadership will be under pressure to reduce the total Medicare billings, and thus imaging will not escape scrutiny. Hospital CEOs will be looking to department leaders, including directors of radiology, to find ways to promote quality and reduce unnecessary healthcare costs. It is imperative that imaging leaders begin preparing now for the transition to accountable care and the new role they must play in a new payment environment (Figure 3).

The most critical responsibility of imaging leaders on the transition to accountable care is to serve as educators

Performance Category	Free-for-Service Imperatives	Accountable Care Imperatives
Growth Objectives	Maximize volumes, growth for high-margin modalities	Optimize procedure mix, generate principled growth
Technology Strategy	Acquire state of the art imaging platforms and upgrades	Pursue judicious purchasing strategy focused on workhorse technology
Organizational Role	Function as a profit center; provide ancillary inpatient services as needed	Ensure appropriate utilization within care pathways; limit downstream costs
Contracting Strategy	Contract with maximum number of competent radiologists available to read scans	Establish limited, highly engaged network of radiologists

Figure 3 • The transition for imaging leaders in a new payment environment.

and advocates for their departments. It will be up to leaders in the field to communicate to hospital administrators the valuable role that imaging can play in the accountable care environment. It is likely that shared savings and other emerging payment models will force many programs to look to imaging for some cost savings, and thus administrators and radiologists must work together to ensure that the proper volume cuts are made to ensure clinical quality is maintained along with profitability. At the moment, financial incentive remains strong for outpatient imaging; however, inpatient exams are wrapped into DRGs and emergency imaging exam bills often go unpaid. Thus, it makes sense for imaging leaders to develop mechanisms to limit inappropriate utilization first in inpatient and ED settings. Once these mechanisms are in place, they can be replicated for outpatient imaging when and if risk-based payment models predominate, carving out avoidable scans and potentially opening capacity for more necessary imaging utilization.

Another way to demonstrate the value of imaging is to proactively engage in larger organizational efforts to standardize care. Many of the procedures for which standard protocols are likely to be developed include some imaging component, and imaging leaders can demonstrate their value by participating in committees and workgroups aimed at establishing evidence-based protocols.

The final, and perhaps most challenging, imperative for imaging administrators is to shift perspective to no longer think of their departments as standalone profit centers, but instead as key players in an institutional-wide effort to reduce the total cost of care. To maximize the value of imaging under accountable care, imaging leaders must consider how different procedures impact downstream utilization. For example, MRIs ordered for non-acute low back pain are not only costly on their own, but also have been shown to increase the total downstream cost of care for the patient by nearly $9000, most often because of possibly unnecessary services and procedures that are pursued as result.[11] Imaging leaders can maximize their departments' value to the ACOs by targeting and reducing those avoidable scans which increase total cost of care. Conversely, certain imaging applications, especially those used for screening and early diagnosis, can help limit total cost of care when used more frequently, suggesting the imaging directors should invest in and promote those services.

It makes sense for imaging leaders to develop mechanisms to limit inappropriate utilization first in inpatient and ED settings.

Conclusion

Imaging volumes are unlikely to decline considerably as a result of the transition to accountable care for both financial and practical reasons; however, the way imaging is integrated into larger care processes may shift dramatically. The impact of accountable care on imaging will vary by market in both timing and degree of impact, but is it clear that imaging leaders should begin preparing now for their new roles through proactive outreach to facility leaders and thorough analysis of the impact of imaging on the cost of care at their organizations.

References

[1]United States Senate. "The Patient Protection and Affordable Care Act." March 23, 2010.

[2]General Accounting Office. MedPac Data Book. 2002-2010.

[3]Baker LC. Acquisition of MRI Equipment By Doctors Drives Up Imaging Use And Spending. *Health Affairs.* 2010; 29(12): 2252–2259

[4]Levin DC, Rao VM. The effect of self-referral on utilization of advanced diagnostic imaging. *American Journal of Roentgenology.* 2011;196(4):848–852.

[5]Milliman. MedInsights Benchmarks. 2010.

[6]Trish E. A Profile of Health Insurance Exchange Enrollees. *Kaiser Family Foundation.* 2011.

[7]Chernew ME, Mechanic RE, Landon BE, Safran GB. Private-Payer Innovation In Massachusetts: The 'Alternative Quality Contract.' *Health Affairs.* 2011;30(1):51–61.

[8]The Advisory Board. Innovations Center Futures Database. 2011.

[9]Hayden JA, van Tulder MW, et al. Meta-Analysis: Exercise Therapy for Nonspecific Low Back Pain. *Annals of Internal Medicine.* 2005; 146(9):765–775.

[10]Mitchell JM, LaGalia RR. Controlling the Escalating Use of Advanced Imaging: The

Role of Radiology Benefit Management Programs. *Medical Care Research and Review*. 2009;66:339–351 .

[11]Webster BS, Cifuentes M. Relationship of early magnetic resonance imaging for work-related acute low back pain with disability and medical utilization outcomes. *Journal of Occupational and Environmental Medicine*. 2010;52(9):900–907.

Ingrid V. Lund, PhD is a senior consultant at the Advisory Board Company, currently managing the Imaging Performance Partnership. In this capacity, Dr. Lund co-manages the Partnership membership and leads major annual research studies on areas of operations, marketing, and growth strategy in the radiology hospital service line. Prior to joining the Advisory Board, Dr. Lund worked in research at the National Institute of Mental Health and at Georgetown University's Department of Neuroscience. Dr. Lund received her doctor of philosophy degree in neuroscience from the University of Pennsylvania and her bachelor's degree in biopsychology and cognitive science from the University of Michigan. She can be contacted at lundi@advisory.com.

Jacob Hartman is a consultant with the Advisory Board Company with the Imaging Performance Partnership. In this capacity, he is responsible for leading research studies across each year on a variety of topics related to strategic planning, as well as serving as a resource for the membership in understanding health care reform and its implications. Prior to joining the Advisory Board, Mr. Hartman worked in research at the National Institute of Drug Abuse, studying the impact of methamphetamine on neurological development. He earned his bachelor's degree in biology and philosophy from Duke University. He can be contacted at hartmanj@advisory.com.

Appendix 4a

Kevin G. Murphy, FHFMA

5 Miller Road
Vernon, Ct 06066
(W) (860) 533-2925
(H) (860) 729-3785
(W) kmurphy@echn.org
(H) kevinmurphy42@yahoo.com

SUMMARY OF QUALIFICATIONS:

Senior healthcare executive with extensive experience in all aspects (Financial/Strategic/ Operational) needed to manage a fully integrated Health System. Experience includes creating new programs and services in small and large Health Systems. Well experienced in reengineering initiatives inclusive of revenue/growth opportunities and cost reduction initiatives/program realignment. Strengths include financial management, team building, medical staff relations and operational improvements. A strategic thinker with the ability to grow existing programs, implement new initiatives and operationalize all types of projects, both small and large. In addition, well experienced in funding projects through various avenues; including, but not limited to, joint ventures, REITs, fundraising, short and long term financing, operational surplus' and non-performing asset sales.

PROFESSIONAL BACKGROUND:

August 2010 - Present

Eastern Connecticut Health Network (ECHN): Manchester, CT
Treasurer & Executive Vice President of Network/Business Development

Eastern Connecticut Health Network is a $280 million health system formed in 1995 consisting of two acute care hospitals (305 beds and 102 beds), a 130 bed long term care facility. ECHN serves 19 towns and 350,000 people. Responsible for the Financial Operations of ECHN as well as directly responsible for all our joint ventures that consists of our Physician Employed Company , a real estate arm, and various other joint ventures (Ambulance Companies, Radiation Oncology, Visiting Nurse Association, Occupational Medicine, Imaging Centers, GI Center, MSO). These joint ventures collectively have $123 million and over 1,300 employees. Also responsible for Network Development of ECHN that positions ECHN for healthcare reform and relationships with other tertiary/ community hospitals and providers

March 2001 - Present

Eastern Connecticut Health Network: Manchester, CT
Sr. Vice President, Finance & CFO

As CFO, was responsible for all strategic and financial activities for ECHN. Hired in 2001 due to a huge operating loss ($20 million) caused by the original merger in 1995. Worked with existing senior team to increase revenue stream and minimize downsizing. Over the last 10 years have
been directly responsible for operational areas such as Laboratory, Medical Record, Materials Management and IT. Continued to work with Senior Team and Board to develop ECHN's service to the community . Responsible for many Building Projects and acquisitions to grow ECHN market share.

October 1996 March 2001

HealthStar/Stellaris – Armonk New York
President/CFO of Holding Company

In 1996 Health Star Network, Inc. (d/b/a Stellaris Health Network) was formed as the sole member of White Plains Hospital Center, Northern Westchester Hospital, Lawrence Hospital Center and Phelps Memorial Hospital Center. The network had operating revenue of $800 million and over 5,000 employees. By chairing the operating committee along with the 4 CEO's of the hospitals we initially concentrated on improving our managed care contracts, joint materials management and a single IT platform. Thru collaboration, synergy, and leverage, the alliance also improved health quality and performance, and reduce costs.

October 1986- October 1996

White Plains Hospital Center – White Plains, New York
Chief Financial Officer

CFO responsible for all aspects of the financial operations of the hospital Also responsible for IT and various other major projects for the Board.

October 1980 October 1986

Pannell Kerr Forster- New York New York
Supervisor- Pubic Accounting Firm

Responsible for managing Hospital Audits and various consultative engagements throughout the NY, NJ and CT area. PKF was a medium size accounting firm that allowed me to learn and be responsible for engagements within 2 years.

EDUCATIONAL BACKGROUND

October 1996 **Long Island University**
Master in Public Administration

June 1980 **IONA College**
Bachelor of Business Administration/Accounting

Fellow in Healthcare Financial Management Association
Held various leadership positions in local chapters/regional

AFFILIATIONS & COMMUNITY PROJECTS

Rockville Bank - Corporator
Local Bank

Hochanum Valley Community Council – Board Member
Social Agency servicing the community

Manchester Community College
Regional Advisory Board Member

COMPUTER SKILLS

- P.C.

PERSONAL PROFILE

- Married, 2 children

REFERENCES

- References furnished upon request

DANIEL JOSEPH DELGALLO RT (R)(CT)(MRI)
3 Strawberry Fields
Granby, CT 06035
(860) 930-9107

CAREER OBJECTIVE

To obtain a leadership position in the health care industry that capitalizes on my extensive technological experience and strong managerial skills.

EDUCATION

M.B.A. *Entrepreneurial Thinking and Innovative Practice*s, Anticipated Oct 2013, Longmeadow, MA.

B.S. *Diagnostic Imaging***,** 1999, Quinnipiac College, Hamden, CT**.**

- Honors: Dean's List; 4.0 junior year, senior year
- Relevant Courses: Intro to MRI physics; Advanced MRI & CT cross sectional anatomy; Pathology for imaging sciences; Phlebotomy and vital signs.

PROFESSIONAL CREDITS

MRI board certified (August 2002)
ARRT board certified in Computed Tomography (July 1999)
ARRT board certified Radiographer (July 1998)
CPR certified

WORK EXPERIENCE

2/09-Present: Tolland Imaging Center, LLC, Tolland, CT
Contracted Executive Director responsible for all operations including, but not limited to: accrual based accounting, hiring, employee discipline, budgets, business plans, marketing, physician relations, contract negotiation, and quality assurance.

3/06-Present: Evergreen Imaging Center, LLC, South Windsor, CT
Executive Director responsible for all operations including, but not limited to: accrual based accounting, hiring, employee discipline, budgets, business plans, marketing, physician relations, contract negotiation, and quality assurance.

11/02-2/06: Alliance Imaging, Inc., Hartford, CT.
Manager of Operations for Greater Hartford County. Responsibilities include, but are not limited to: hiring, employee discipline, staff scheduling, scanning, marketing, unit and staff budgeting, development of business plans, and building customer relationships. Implemented patient care initiatives in the Northeast through a series of staff training sessions involving power point presentations.

7/00-11/02: Alliance Imaging, Inc.,West Springfield, MA.
MRI lead technologist in mobile environment, responsible for scheduling and site protocols. Performed numerous scans including musculoskeletal, neurological, soft tissue, and all types of MRA exams.

5/99-7/00: Saint Francis Hospital, Hartford, CT.
Worked in all areas of general X-ray at a trauma one hospital, including the E.R., O.R., fluoroscopic department, and clinical department. Supervised other technologists, as well as student interns.

MAGNET EXPERIENCE	Philips Gyroscan 1.5T Philips Intera 1.5T Siemens Symphony (Syngo software) 1.5T Siemens Impact 1.0T GE Excite LX (software 9.0-11.0)
COMPUTER SKILLS	Proficient in Microsoft Word, Excel, PowerPoint, and Outlook.
REFERENCES	Available upon request. .

Curriculum Vitae
John P. Opalacz, M.D.

Personal Data:

Home Address
53 Greentree Drive
Glastonbury, Connecticut 06033

Work Address
Jefferson Radiology, P.C.
85 Seymour Street, Suite 200
Hartford, Connecticut 06106

Telephone
Work 860/289-3375
Pager 860/825-7941

Date of Birth August 4, 1951
Place of Birth Middletown, Connecticut
Marital Status Married

Certification
Diplomate, American Board of Radiology 1981
National Board of Medical Examiners 1977

Work Experience:

Professional Employment

- Jefferson Radiology, P.C. — *July 1, 1982 - Present*
  Hartford, Connecticut
  - Staff Radiologist

Hospital Affiliations

- Hartford Hospital — June 1982 - Present
  Hartford, Connecticut
  - Section Chief, Body CT Scanning
  - Section Chief, General Radiology
  - Senior Staff Radiologist

- Connecticut Children's Medical Center — November 2006 - Present
  Hartford, Connecticut

- Johnson Memorial Hospital — October 1998 - Present
  Stafford Springs, Connecticut

- Windham Hospital — July 2006 - Present
  Willimatic, Connecticut

- Day Kimball Hospital — September 2010 - Present
  Putnam, Connecticut

- Noble Hospital — January 2011 - Present
  Westfield, Massachusetts

Education:

Fellowship

- St. Raphael's Hospital — *Abdominal Imaging*
  New Haven, Connecticut — July *1981 – June 1982*

Residency

- Armed Forces Institute of Pathology — *January - February 1981*
  Washington, DC

- Hartford Hospital — *Diagnostic Radiology*, 7/*1978 – 6/1981*
  Hartford, Connecticut — *Chief Resident, July - December 1980*

Internship

- Baystate Medical Center — *Internal Medicine*
  Springfield, Massachusetts — 7/*1977 – 6/1978*

Medical

- St. Louis University School of Medicine — 9/*1973 – 6/1977*
  St. Louis, Missouri — *Degree: M.D.*

College

- Holy Cross College — 9/*1969 – 6/1973*
  Worcester, Massachusetts — *Degree: B.A.*

Secondary

- Middletown High School — *1965 - 1969*
  Middletown, Connecticut

Memberships/Organizations:

- American College of Radiology — *Member*
- American Roentgen Ray Society — *Member*
- Society of Breast Imaging — *Member*

Publications:

- S.K. Sussman, F.F. Illescas, and J.P. Opalacz. **Renal Streak Artifact During Contact Enhanced Abdominal CT: Comparison of Low Osmolality versus High Osmolality Contrast Media**. *Abdominal Imaging*, 180, 1993.
- J.R. Reese and J.P. Opalacz. **Kikusi's Disease: A Mimic of Lymphoma**. Submitted *Abdominal Imaging*.
- J.R. Reese and J.P. Opalacz. **Pseudotumor of the Liver: Imaging Features**. Submitted *Abdominal Imaging*.

Presentations and Papers:

- **Renal Streak Artifact During Abdominal CT**. ARRS Scientific Meeting, *Orlando, Florida*
  S.K. Sussman, F.F. Illescas, and J.P. Opalacz. *May 1992*
- **Pseudotumor of Liver: Imaging Features**. J.R. Reese and J.P. Opalacz.

Laurie S. Kingsbury
558 Swamp Road Coventry, CT 06238
860-742-1946
Lkpk0252@sbcglobal.net

Objective: To obtain a position in the business field.

Education:

May 2004-Present: Saint Leo University Center for Online Learning, Tampa, FL. Major: BA Business Administration and Accounting. Associates of Business Administration completed 4/25/09; Bachelors in Business Administration in progress.

September 1996-May 1997: Middlesex Community College, Wethersfield CT. Major: Food Service Supervisor Course. Certificate Received 5/1997.

Experience:

August 2008- Present: Tolland Imaging Center Tolland CT Diagnostic Imaging. General office duties, customer service, coding, medical terminology, billing and payments. PACS, transcription, Powerscribe and assisting radiologist and staff with daily tasks.

December 2004-August 2008: Women's Center for Wellness, South Windsor, CT. Office Assistant Diagnostic Imaging. General office duties, customer service, coding, medical terminology, billing and payments. Also assist the imaging and radiology department in their daily tasks.

October 2005-Present: Children's Cooperative Nursery School, Bolton, CT. President of Cooperative Nursery School. Oversee the Running of the school and the school board, make sure that all paperwork and tax forms are prepared and submitted accordingly, and make sure that all officers and committees are performing necessary tasks. General customer service.

August 2003-October 2005: North Coventry Cooperative Nursery School, Coventry, CT. Treasurer of Cooperative Nursery School. Collecting, processing, and depositing tuition Payments and preparation of payroll and taxes. Contact customers about delinquent payments. General customer service.

17 Walnut Drive
Marlborough,CT. 06447

Phone (860) 930-7431
E-mail
Elocin619@comcast.net

Nicole Chartier, B.S., R.T. (R)(MR)

Education

B.S. Diagnostic Imaging May 18, 2008
Quinnipiac University, Hamden, CT.
August 2005 to May 2008- Has completed MRI curriculum. Including cross-sectional anatomy and pathology classes
Major: Diagnostic Imaging

University of Connecticut, Groton, CT. August 2004–May 2005:
Major: Pre-Allied Health

Special Skills: Spanish Speaking (intermediate level); Can read and write in Spanish.

Work experience

- August 2008 to Present: Tolland Imaging Center, Tolland CT,
  Job Title: Full Time Radiologic Technologist and CT Technologist
  Take x-rays and perform CT exams, efficient at starting IV's; perform various MR and DEXA exams; assist with patient registration; explain diagnostic procedures to patients

- June 2007- July 2008: Whitney Imaging, Hamden CT.
  Job Title: Per Diem Radiologic Technologist
  Take x-rays; perform fluoroscopic and IVP procedures; assist with patient registration; explain diagnostic procedures to patients; assist in instructing clinical students.

Accreditations and licenses

- CPR Certified
- ARRT Certified
- Connecticut State License

Clinical Experience

Took and processed x-rays under the supervision of certified Radiologic Technologists; assisted in procedures of patient care; assisted with registering patients.

- March 2007 to May 2007: Radiology Group, Branford, CT.
- January 2007 to March 2007: Whitney Imaging, Hamden, CT.
- October 2006 to December 2006: Milford Hospital, Milford, CT.
- August 2006 to October 2006: Hospital of St. Raphael's, New Haven, CT.
- July 10, 2006 to August 10, 2006: Whitney Imaging Associates, Hamden, CT.
- June 5, 2006 to July 7, 2006: Radiology Group, Hamden, CT.
- March 2006 to May 2006: St. Francis Hospital, Hartford, CT.
- January 2006 to March 2006: Midstate Hospital, Meriden, CT.

Jennifer Lent

12 Randazzo Road, Columbia, CT 06237 (860)573-1078 cell cjlent@charter.net

Experience

Lead Technologist — Tolland, CT
Tolland Imaging Center — August 2008-present

Lead Technologist — Middletown, CT
Middlesex Orthopedic Surgeons — 2006-2008

Effectively established Hitachi 7000 open MRI unit for Orthopedic office. Developed MRI protocols and procedure guidelines, managed medical records, coordinated clinical activities, and ACR credentialing.

Lead technologist — New London, CT
New London MRI — 2005-2006

Lead technologist while maintaining medical records, policies and procedures, scheduling, and ACR credentialing.

Senior/lead technologist — Glastonbury, CT
Mandell & Blau M.D.'s PC — 1999-2005

Assigned as lead technologist to start up second open MRI facility where responsibilities included implementing protocols, overseeing technical staff, and training of all personal on two different magnets.

Staff technologist — Manchester, CT
Insight Health Services/MTI — 1991-1999

Trained with mobile company on two magnets that serviced Manchester Memorial, Rockville General, Johnson Memorial and Mount Sinai Hospitals. Remained at Manchester Memorial full time after the installation of a fixed magnet.

Education

Clayton School of Natural Health, BS of science
Manchester Memorial Hospital, Certificate in Radiology
Coventry High School, high school diploma

Affiliations

Licensed Radiographer
Certified in CT technology, ARRT
Certified in MRI technology, ARRT
ASRT member

Appendix 5b

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: AUG 18 2009

TOLLAND IMAGING CENTER LLC
C/O ROBINSON & COLE LLP
SUSAN E ROBERTS
280 TRUMBULL ST
HARTFORD, CT 06103-3597

Employer Identification Number:
20-8688982
DLN:
17053301312038
Contact Person:
DENISE L. TAMAYO ID# 95120
Contact Telephone Number:
(877) 829-5500
Accounting Period Ending:
September 30
Public Charity Status:
170(b)(1)(A)(iii)
Form 990 Required:
Yes
Effective Date of Exemption:
February 26, 2007
Contribution Deductibility:
Yes
Addendum Applies:
No

Dear Applicant:

We are pleased to inform you that upon review of your application for tax exempt status we have determined that you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. Contributions to you are deductible under section 170 of the Code. You are also qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Code. Because this letter could help resolve any questions regarding your exempt status, you should keep it in your permanent records.

Organizations exempt under section 501(c)(3) of the Code are further classified as either public charities or private foundations. We determined that you are a public charity under the Code section(s) listed in the heading of this letter.

Please see enclosed Publication 4221-PC, Compliance Guide for 501(c)(3) Public Charities, for some helpful information about your responsibilities as an exempt organization.

Letter 947 (DO/CG)

TOLLAND IMAGING CENTER LLC

We have sent a copy of this letter to your representative as indicated in your power of attorney.

Sincerely,

Robert Choi
Director, Exempt Organizations
Rulings and Agreements

Enclosures: Publication 4221-PC

Appendix 5c

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology

Computed Tomography Services of

Tolland Imaging Center

6 Fieldstone Commons
Suite E
Tolland, Connecticut 06084

were surveyed by the
Committee on Computed Tomography Accreditation of the
Commission on Quality and Safety

The following unit was approved

Siemens SOMATOM SENSATION 4 2002

For

Adult and Pediatric Patients

Head/Neck, Chest, Abdomen

Accredited from:

May 14, 2012 through May 14, 2015

Mark Armstrong MD

CHAIRMAN, COMMITTEE ON COMPUTED TOMOGRAPHY ACCREDITATION

Samuel J. Brown MD

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

THIS EQUIPMENT HAS BEEN ACCREDITED BY THE

American College of Radiology

WHILE IN SERVICE AT

Tolland Imaging Center
Tolland, Connecticut

Siemens SOMATOM SENSATION 4 2002
for
Adult and Pediatric Patients
Head/Neck, Chest, Abdomen

EXPIRES: May 14, 2015

CTAP# 04000-01

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology

The Mammographic Imaging Services of

Tolland Imaging Center
Tolland, CT

were surveyed by the
Committee on Mammography Accreditation of the
Commission on Quality and Safety

The following unit was approved :

Siemens Medical Systems MAMMOMAT NOVATION DR 2006

MAP ID # 17061-01

Accredited from :

December 19, 2011 through March 09, 2015

Brett S. Parkinson, MD

HAIR, COMMITTEE ON MAMMOGRAPHY ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Food and Drug Administration

CERTIFIED MAMMOGRAPHY FACILITY

This certifies that

Tolland Imaging Center

has complied with the requirements of the Mammography Quality Standards Act of 1992 and is hereby authorized to perform mammography examinations, pursuant to 42 U.S.C. 263b.

COMMISSIONER OF FOOD & DRUGS
FOOD AND DRUG ADMINISTRATION

Facility ID Number: *238393*

Expiration Date: *March 9, 2015*

Helen Baer MD

DIRECTOR
DIVISION OF MAMMOGRAPHY QUALITY AND RADIATION PROGRAMS
CENTER FOR DEVICES AND RADIOLOGICAL HEALTH

Patients may report comments/complaints to:

Mammography Accreditation Program
American College of Radiology
1891 Preston White Drive
Reston, Virginia 20191-4397

10415220-00 6

FORM FDA 3402A (Rev. 6/08)

THIS CERTIFICATE SHALL BE PROMINENTLY DISPLAYED IN THE MAMMOGRAPHY FACILITY

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology

Magnetic Resonance Imaging Services of

Tolland Imaging Center

6 Fieldstone Commons
Suite E
Tolland, Connecticut 06084

were surveyed by the
Committee on MRI Accreditation of the
Commission on Quality and Safety

The following magnet was approved

Hitachi ALTAIRE 2002

For

Head, Spine, MSK

Accredited from:

March 10, 2012 through March 10, 2015

CHAIRMAN, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 07016-01

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology

Ultrasound Services of

Tolland Imaging Center

6 Fieldstone Commons
Suite E
Tolland, Connecticut, 06084

were surveyed by the
Committee on Ultrasound Accreditation of the
Commission on Quality and Safety

Accredited for

Obstetrical (1st, 2nd and 3rd Trimesters), Gynecological, General

Accredited from:

May 21, 2012 through May 21, 2015

CHAIRMAN, COMMITTEE ON ULTRASOUND ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

UAP# 04294

Connecticut Department of
Energy & Environmental Protection
79 Elm Street
Hartford, CT 06106-5127
www.ct.gov/deep

Certificate of Use

Issued To

Tolland Imaging Center LLC

For

Diagnostic and Therapeutic X-Ray Device Registration

Daniel C. Esty
Commissioner

Site Located at:
6 Fieldstone Cmns,
Tolland, CT 06084

Reference: Facility No. 4795 - Renewing 4 X-Ray Devices (Registration Period May 1, 2012 to April 30, 2014)

Application No: 201202448
Issue Date: 4/20/2012
Expiration Date: 4/30/2014

Appendix 5d

Tolland Imaging Center, LLC
(A Limited Liability Company)

Financial Statements and
Independent Accountant's Compilation Report

September 30, 2012 and 2011

Tolland Imaging Center, LLC

Index

Independent Accountant's Compilation Report

To the Members
Tolland Imaging Center, LLC

We have compiled the accompanying statements of financial position of Tolland Imaging Center, LLC (A Limited Liability Company) (the "Company") as of September 30, 2012 and 2011, and the related statements of unrestricted revenues, expenses and changes in members' equity and cash flows for the years then ended. We have not audited or reviewed the accompanying financial statements and, accordingly, do not express an opinion or provide any assurance about whether the financial statements are in accordance with accounting principles generally accepted in the United States of America.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America and for designing, implementing and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the compilation in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. The objective of a compilation is to assist management in presenting financial information in the form of financial statements without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the financial statements.

Management has elected to omit substantially all of the disclosures ordinarily included in financial statements prepared in accordance with accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations and cash flows. Accordingly, these financial statements are not designed for those who are not informed about such matters.

CohnReznick LLP

Glastonbury, Connecticut
March 7, 2013

Tolland Imaging Center, LLC

Statements of Financial Position
September 30, 2012 and 2011

Assets	2012	2011
Current assets:		
Cash	$ 60,569	$ 41,045
Patient receivables, net of contractual allowances and bad debts of $338,922 and $285,468	236,305	206,718
Prepaid expenses	32,286	17,841
Total current assets	329,160	265,604
Property and equipment, at cost:		
Medical equipment	2,059,416	2,059,416
Leasehold improvements	471,228	471,228
Computer equipment	62,205	62,205
Furniture and equipment	31,863	31,863
Software	17,694	17,694
	2,642,406	2,642,406
Less accumulated depreciation and amortization	(1,737,677)	(1,275,726)
Net property and equipment	904,729	1,366,680
Security deposits	41,366	41,366
Totals	$ 1,275,255	$ 1,673,650

Liabilities and Members' Equity		
Current liabilities:		
Current portion of capital lease obligations	$ 516,233	$ 497,737
Accounts payable	22,094	23,078
Professional and billing fees payable	47,594	40,723
Total current liabilities	585,921	561,538
Capital lease obligations, less current portion	472,517	992,038
Total liabilities	1,058,438	1,553,576
Unrestricted members' equity	216,817	120,074
Totals	$ 1,275,255	$ 1,673,650

See Independent Accountant's Compilation Report.

Tolland Imaging Center, LLC

Statements of Unrestricted Revenues, Expenses and Changes in Members' Equity
Years Ended September 30, 2012 and 2011

	2012		2011	
	Amount	Percent	Amount	Percent
Changes in unrestricted members' equity:				
Revenue:				
Net patient revenue	$ 2,167,635	100.0 %	$ 2,047,119	100.0 %
Total revenue	2,167,635	100.0	2,047,119	100.0
Expenses:				
Depreciation and amortization	461,951	21.3	438,002	21.4
Salaries, wages and benefits	417,511	19.3	423,260	20.7
Repairs and maintenance	325,124	15.0	295,150	14.4
Professional reading fees	295,047	13.6	296,227	14.5
Rent	134,618	6.2	134,618	6.6
Billing service fee	98,647	4.5	103,569	5.1
Bad debts	87,410	4.0	84,066	4.1
Leased employee fees	62,087	2.9	61,521	3.1
Marketing	40,830	1.9	33,717	1.6
Medical supplies	37,601	1.7	36,785	1.8
Office expense	14,803	0.7	20,924	1.0
License fee	10,289	0.5	7,002	0.3
Professional fees	9,143	0.4	12,504	0.6
Collection expense	8,512	0.4	-	-
Medical waste disposal	72	0.0	280	0.0
Totals	2,003,645	92.4	1,947,625	95.2
Other expense:				
Interest expense	67,247	3.1	119,214	5.8
Totals	67,247	3.1	119,214	5.8
Total expenses	2,070,892	95.5	2,066,839	101.0
Change in unrestricted members' equity	96,743	4.5 %	(19,720)	(1.0) %
Unrestricted members' equity, beginning of year	120,074		139,794	
Unrestricted members' equity, end of year	$ 216,817		$ 120,074	

See Independent Accountant's Compilation Report.

Tolland Imaging Center, LLC

Statements of Cash Flows
Years Ended September 30, 2012 and 2011

	2012	2011
Operating activities:		
Change in unrestricted members' equity	$ 96,743	$ (19,720)
Adjustments to reconcile change in unrestricted members' equity to net cash provided by operating activities:		
Depreciation and amortization	461,951	438,002
Bad debts	87,410	84,066
Changes in operating assets and liabilities:		
Patient receivables	(116,997)	(43,721)
Prepaid expenses	(14,445)	(7,755)
Accounts payable	(984)	11,601
Professional and billing fees payable	6,871	(60,414)
Net cash provided by operating activities	520,549	402,059
Investing activities:		
Due from members	-	85,000
Net cash provided by investing activities	-	85,000
Financing activities:		
Payments on capital lease obligations	(501,025)	(481,631)
Net cash used in financing activities	(501,025)	(481,631)
Net increase in cash	19,524	5,428
Cash, beginning of year	41,045	35,617
Cash, end of year	$ 60,569	$ 41,045
Supplemental disclosure of cash flow data:		
Interest paid	$ 67,247	$ 119,214
Supplemental disclosure of non-cash investing and financing transactions:		
Purchase of medical equipment	$ -	$ 276,065
Amount financed through capital lease obligations	-	(276,065)
Net cash paid on purchase of medical equipment	$ -	$ -

See Independent Accountant's Compilation Report.

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED FINANCIAL STATEMENTS AND OTHER FINANCIAL INFORMATION

SEPTEMBER 30, 2012 AND 2011

JOHNSON MEMORIAL HOSPITAL

CONTENTS

MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT

Board of Directors
Johnson Memorial Hospital

We have audited the accompanying consolidated balance sheets of Johnson Memorial Hospital (the Hospital) as of September 30, 2012 and 2011, and the related consolidated 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 of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes 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, as well as 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 financial position of Johnson Memorial Hospital as of September 30, 2012 and 2011, and the results of its operations, changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The accompanying consolidated financial statements have been prepared assuming the Hospital will continue as a going concern. As described in Note 1, the Hospital has experienced recurring losses from operations, debt covenant violations, and had current liabilities that exceeded current assets by $415,876 as of September 30, 2012. These conditions raise substantial doubt about the Hospital's ability to continue as a going concern. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

Marcum LLP

Hartford, CT
January 8, 2013

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2012 AND 2011

	2012	2011
Assets		
Current Assets		
Cash and cash equivalents	$ 819,327	$ 913,716
Patients accounts receivable, net of allowances for uncollectible accounts, $2,702,000 in 2012 and $2,534,000 in 2011	8,403,783	7,541,440
Insurance and other receivables	222,529	1,415,420
Inventories	1,254,591	1,216,495
Prepaid expenses and other current assets	853,062	977,701
Total Current Assets	11,553,292	12,064,772
Assets Whose Use is Limited		
Beneficial interests in perpetual trusts	3,616,492	3,165,722
Restricted cash and board designated investments	363,097	517,407
Investments permanently restricted by donor	843,587	843,587
Total Assets Whose Use is Limited	4,823,176	4,526,716
Other Assets		
Property, plant and equipment, net	19,606,953	21,489,519
Investments in joint ventures	3,106,905	2,856,651
Deferred financing costs, net	356,845	540,827
Other noncurrent assets	445,000	445,000
Total Other Assets	23,515,703	25,331,997
	$ 39,892,171	$ 41,923,485

The accompanying notes are an integral part of these consolidated financial statements.

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED BALANCE SHEETS (CONTINUED)

SEPTEMBER 30, 2012 AND 2011

	2012	2011
Liabilities and Net Assets		
Current Liabilities		
Trade accounts payable	$ 3,400,553	$ 2,676,050
Accrued payroll and related costs	2,172,911	1,911,006
Current portion of payments due under plan of reorganization	997,500	1,323,916
Senior debt under revolving line of credit	3,504,213	4,651,186
Current portion of mortgage payable	342,500	342,500
Current portion of subordinated debt	100,583	94,035
Current portion of capital lease obligations	61,820	180,261
Estimated amounts due to third-party reimbursement agencies	1,272,580	1,266,304
Other current liabilities	116,508	185,834
Total Current Liabilities	11,969,168	12,631,092
Long-Term Obligations		
Due to affiliate corporations	1,817,168	2,065,421
Payments due under plan of reorganization - less current portion	5,505,445	6,132,010
Mortgage payable - less current portion	11,816,250	12,158,750
Subordinated debt - less current portion	231,464	333,115
Other long-term debt	1,300,000	--
Obligations under capital lease - less current portion	58,370	29,810
Self-insurance liabilities	1,141,100	1,575,812
Other liabilities	769,553	752,910
Total Long-Term Obligations	22,639,350	23,047,828
Total Liabilities	34,608,518	35,678,920
Net Assets		
Unrestricted	560,928	1,913,639
Temporarily restricted	262,646	321,617
Permanently restricted	4,460,079	4,009,309
Total Net Assets	5,283,653	6,244,565
	$ 39,892,171	$ 41,923,485

The accompanying notes are an integral part of these consolidated financial statements.

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED SEPTEMBER 30, 2012 AND 2011

	2012	2011
Operating Revenue		
Net patient service revenue	$ 69,334,641	$ 64,582,295
Grant and other income	308,671	609,548
Net assets released from restriction	25,552	33,994
Total Operating Revenue	69,668,864	65,225,837
Expenses		
Salaries	31,433,170	30,947,816
Employee benefits	7,370,190	7,495,713
Provision for uncollectible accounts	3,773,454	2,530,453
Professional fees and outsourced staffing	3,365,845	3,557,873
Depreciation and amortization	3,213,542	3,277,534
Purchased services	3,631,422	4,042,617
Supplies, drugs and patient care	7,130,721	7,036,054
Leases and service contracts	1,675,437	1,555,727
Occupancy costs	3,111,685	2,812,952
Insurance	1,178,515	1,314,629
Other expenses	4,699,010	2,970,876
Interest	1,495,715	1,480,694
Total Expenses	72,078,706	69,022,938
Loss from Operations	(2,409,842)	(3,797,101)
Nonoperating Revenue (Loss)		
Investment income	177,006	123,908
Gain on sale of equipment	3,196	--
Equity earnings (loss) in joint ventures	250,254	(12,760)
	430,456	111,148
Loss Before Reorganization Items	(1,979,386)	(3,685,953)
Reorganization Items		
Gain on discharge of debt	--	1,094,678
Deficiency of Revenues over Expenses	$ (1,979,386)	$ (2,591,275)

The accompanying notes are an integral part of these consolidated financial statements.

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS (DEFICIT)

FOR THE YEARS ENDED SEPTEMBER 30, 2012 AND 2011

	2012	2011
Unrestricted Net Assets		
Deficiency of revenues over expenses	$ (1,979,386)	$ (2,591,275)
Net asset transfer from affiliate	74,638	--
Net assets released from restriction for purchase of property and equipment	552,037	--
Change in Unrestricted Net Assets	(1,352,711)	(2,591,275)
Temporarily Restricted Net Assets		
Grants and contributions	518,618	355,611
Net assets released from restriction	(577,589)	(33,994)
Change in Temporarily Restricted Net Assets	(58,971)	321,617
Permanently Restricted Net Assets		
Increase (decrease) in fair value of beneficial interests in perpetual trusts	450,770	(117,521)
Change in Net Assets	(960,912)	(2,387,179)
Net Assets - Beginning	6,244,565	8,631,744
Net Assets - End	$ 5,283,653	$ 6,244,565

The accompanying notes are an integral part of these consolidated financial statements.

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2012 AND 2011

	2012	2011
Cash Flows From Operating Activities and Reorganization Items		
Change in net assets	$ (960,912)	$ (2,387,179)
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Gain on discharge of debt	--	(1,094,678)
Depreciation and amortization	3,213,542	3,277,534
Accretion of asset retirement obligation	16,643	18,693
Provision for uncollectible accounts	3,773,454	2,530,453
Equity (earnings) loss in joint ventures	(250,254)	12,760
Gain on disposal of equipment	(3,196)	--
Change in net unrealized gains on investments	(450,770)	117,521
Changes in assets and liabilities:		
Patient accounts receivable	(4,635,797)	(1,547,565)
Insurance and other receivables	1,192,891	(1,104,689)
Prepaid expenses and other current assets	124,639	350,829
Inventories	(38,096)	(61,912)
Restricted cash and board designated investments	154,310	445,263
Other noncurrent assets	--	(445,000)
Restricted grants and contributions	(518,618)	(355,611)
Accounts payable and accrued expenses	724,503	(2,939,711)
Accrued payroll and related costs	261,905	(1,412,602)
Estimated amounts due to third-party reimbursement agencies	6,276	194,829
Other liabilities	(69,326)	630,834
Self-insurance liabilities	(434,712)	42,296
Payments due under plan of reorganization	(952,981)	(541,415)
Net Cash Provided by (Used in) Operating Activities and Reorganization Items	1,153,501	(4,269,350)
Cash Flows From Investing Activities		
Capital expenditures	(1,143,798)	(808,294)
Net Cash Used in Investing Activities	(1,143,798)	(808,294)

The accompanying notes are an integral part of these consolidated financial statements.

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2012 AND 2011

	2012	2011
Cash Flows From Financing Activities		
Restricted grants and contributions	$ 518,618	$ 355,611
Principal payments on mortgage and subordinated debt	(437,603)	(837,865)
Proceeds from other long-term debt	1,300,000	--
Net (payments on) proceeds from revolving line of credit	(1,146,973)	651,186
Principal payments on capital lease obligations	(89,881)	(267,840)
Payments (to) from affiliates	(248,253)	1,688,230
Net Cash (Used in) Provided by Financing Activities	(104,092)	1,589,322
Net Change in Cash and Cash Equivalents	(94,389)	(3,488,322)
Cash and Cash Equivalents - Beginning	913,716	4,402,038
Cash and Cash Equivalents - Ending	$ 819,327	$ 913,716
Supplemental Disclosures of Cash Flow Information		
Cash paid for interest	$ 1,036,354	$ 1,025,272
Cash paid for professional fees in connection with reorganization	$ --	$ (1,346,184)
Cash provided by (used in) operating activities	1,153,501	(2,923,166)
	$ 1,153,501	$ (4,269,350)

The accompanying notes are an integral part of these consolidated financial statements.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION

ORGANIZATION

Johnson Memorial Hospital (the Hospital) is an acute care hospital located in Stafford Springs, Connecticut. The Hospital is licensed for 92 beds and provides a broad range of inpatient and outpatient services primarily throughout the Hartford and Tolland Connecticut counties. Admitting physicians are primarily practitioners in this same geographic area. The Hospital has controlling interests in Johnson Professional Associates, P.C. (JPA) and Johnson Memorial Hospital Development Fund, Inc. (Development). The Hospital is a subsidiary of Johnson Memorial Medical Center (the Corporation), a not-for-profit, non-stock holding company. The other subsidiaries of the Corporation are Johnson Health Care, Inc. (Health Care), Home & Community Health Services, Inc. (Home and Community) and Johnson Evergreen Corporation (Evergreen), which are not-for-profit companies, and WellCare, Inc., a taxable entity.

The Hospital's major accounting policies are as summarized below and in Note 2.

EMERGENCE FROM BANKRUPTCY

As a result of the Hospital's severe financial operating deficits, management determined it would be unable to pay its obligations in the normal course of business during fiscal year 2009 or service its debt in a timely fashion. On November 4, 2008, the Hospital, the Corporation and Evergreen, filed voluntary petitions for relief under Chapter 11 (Chapter 11 Proceedings) of the U.S. Bankruptcy Code (Bankruptcy Code) in the U.S. Bankruptcy Court for District of Connecticut, Hartford Division (Bankruptcy Court). This generally delayed payments of liabilities incurred prior to filing those petitions while the Hospital developed a plan of reorganization that was satisfactory to its creditors, and allowed it to continue as a going concern.

On August 11, 2010, the Bankruptcy Court confirmed the Hospital's plan of reorganization which was subject to the Hospital's satisfaction of a number of conditions precedent. One of the conditions precedent was that the Hospital, the Corporation, and Evergreen (collectively the Debtors) were required to obtain a line of credit of at least $6 million. On September 30, 2010, the plan of reorganization became effective when the Debtors received financing under an $8 million line of credit and all other material conditions precedent to the plan becoming binding were resolved. The Bankruptcy Court issued a final decree on December 29, 2010.

There was no change in control as the Hospital's Board of Directors immediately prior to the confirmation of the plan retained control upon emergence from the Chapter 11 proceedings. Therefore, the Hospital did not adopt fresh-start reporting.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

As of September 30, 2012 and 2011, liabilities compromised by the confirmed plan have been recorded at the present values of amounts to be paid, determined at the interest rate of 6.75%.

During the year ended September 30, 2011, management determined that the Hospital would not be eligible to receive electronic medical record stimulus funding. As of September 30, 2010, the Hospital recorded a liability of $1,094,678 related to an estimate of the stimulus funding that would be payable to its creditors under the plan of reorganization. During the year ended September 30, 2011, the Hospital recorded a change in estimate to eliminate this liability which is reflected as a gain on discharge of debt in the 2011 consolidated statement of operations.

The Hospital's confirmed plan provided for the following:

Secured Debt - The Hospital's secured debt with a bank (secured by a first mortgage lien on land and buildings located in Stafford Springs, Connecticut and a blanket lien on all furniture, fixtures, and equipment) was reinstated as such maturity existed before any default, and is payable in quarterly installments of $85,625 through January 1, 2048. The Hospital will also remain obligated as guarantor of the Corporation's and Evergreen's secured debt in the amounts of $3,060,000 and $14,419,102, respectively, as of September 30, 2012.

Other Secured Debt – The Hospital's loan to finance information technology equipment was restructured to be paid in 60 monthly installments of $10,000, including interest. The carrying value of this compromised debt was $332,047 and $427,150 as of September 30, 2012 and 2011, respectively.

Priority and Administrative Claims – All priority and administrative claims will be paid as allowed by the Court.

Trade and Other Miscellaneous Claims - The holders of approximately $11 million of trade and other miscellaneous claims are entitled to receive $705,232 on the effective date, $256,025 on the first anniversary of the effective date, $488,775 on the second anniversary of the effective date and $954,275 on the each of the third, fourth, and fifth anniversaries of the effective date. The distribution could increase if the Hospital receives electronic medical record stimulus funding or if there is a change in control.

The holders of approximately $145,000 of convenience claims are entitled to receive 50% of their allowed claim. Unexpired leases and executory contracts not rejected by the Hospital are paid according to their original or negotiated terms.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

Pension Benefit Guaranty Corporation (PBGC) Claims - The PBGC was entitled to receive $730,402 on the effective date, $266,475 on the first anniversary of the effective date, $508,725 on the second anniversary of the effective date and $993,225 on the each of the third, fourth, and fifth anniversaries of the effective date. The distribution could increase if the Hospital receives electronic medical record stimulus funding, if there is a change in control, or if the Hospital receives litigation claim proceeds related to claims, rights or causes of action arising under Chapter 5 of the Bankruptcy Code.

The Hospital failed to make the initial payment of $730,402 to the PBGC during the year ended September 30, 2011, but has made this payment as well as the payment of $266,475 during the year ended September 30, 2012.

AFFILIATION WITH SAINT FRANCIS CARE, INC.

On July 12, 2012, the Hospital, along with the Corporation and Evergreen (collectively, the Johnson Entities) entered into an affiliation agreement with Saint Francis Care, Inc. (Saint Francis), a Hartford, Connecticut based health system, designed to establish a long-term stable relationship between the two systems, allowing them to work together to maintain and strengthen the Corporation's operating viability and the Hospital's presence in the community as a community hospital, expand the array of health care services available, support the Hospital's medical staff, and enhance the Corporation's efforts to fulfill its mission. Saint Francis made an initial payment to the Johnson Entities of $1,300,000 on the date of the affiliation agreement and made an additional payment of $1,050,000 on October 1, 2012, both payments to be used by the Johnson Entities to satisfy outstanding claims owed under the reorganization plan (the Plan) to the Pension Benefit Guaranty Corporation (PBGC) and the unsecured creditors in classes A6 and B6 of the Plan.

In addition, Saint Francis will have the option, at its sole discretion, to make future annual payments of $2,050,000 on the first day of October from 2013 through 2015 and a payment of $500,000 on the first day of October 2016. The Johnson Entities will use these additional payments to satisfy the payment of claims due on these dates under the Plan. Saint Francis is required to notify the Corporation by June 1 of each year whether it will make the next succeeding additional payment. All payments made by Saint Francis under this agreement will constitute an unsecured loan. This loan will be payable in the event that Johnson seeks the closing of an alternative transaction, but only if the proceeds of this alternative transaction exceed the amounts necessary to satisfy all other secured and unsecured debt owed by Johnson, or breaches the exclusivity provisions granted to Saint Francis in the agreement.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

In the event that the Johnson Entities breach the exclusivity provisions of the affiliation agreement, the Johnson Entities will be required to pay Saint Francis fees of $250,000 for each payment made by Saint Francis to the Johnson Entities up to a maximum fee of $1,000,000.

In connection with the $1,300,000 initial payment, Saint Francis was provided with the right to appoint three members to the Boards of Directors of Johnson Memorial Medical Center, Johnson Memorial Hospital, and Johnson Evergreen Corporation. For each additional payment made by Saint Francis, it will be provided with the right to add one additional board member to the aforementioned boards of directors. Saint Francis will not have the right to appoint a majority of the members of any of the aforementioned boards until all of the payments have been made under the terms of the affiliation agreement. After Saint Francis has made all of these payments, it will have the right to appoint the majority of the members of the boards subject to any necessary governmental approvals.

The affiliation agreement provides Saint Francis with the right to cause the Johnson Entities to be merged with or into Saint Francis, to acquire all of the assets of the Johnson Entities, or to be the sole member of the Johnson Entities as long as Saint Francis assumes or satisfies all of the Johnson Entities' then-existing indebtedness.

The affiliation agreement requires the Johnson Entities to obtain the consent of Saint Francis prior to the occurrence of the following events: merger, dissolution, dilution of Saint Francis' board representation, incurrence of certain additional debt, prepayment of debt, creation of liens, entering into lease obligations in excess of $1 million, the sale or disposition of properties in excess of defined thresholds, distributions of cash, or the addition or termination of any material clinical service.

Saint Francis will provide medical leadership in the Hospital's oncology program, infectious disease program, hospitalist program and management services in both case management and psychiatry which should help the Hospital attract additional volume. It is anticipated that the Hospital will also utilize the informational technology systems of Saint Francis once they have been upgraded in 2014. This should allow the Hospital to recognize economic synergies and enhance its operational performance.

In addition, debt agreements with People's United Bank (People's) and Healthcare Finance Group (HFG) have been modified on the date of the affiliation (see Note 9) to reflect changes in covenant calculations.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

GOING CONCERN

The accompanying financial statements have been prepared assuming that the Hospital will continue as a going concern. For the year ended September 30, 2012, the Hospital experienced a loss of $1,979,386 and had current liabilities that exceeded current assets by $415,876. The Hospital is a party to a credit agreement that requires certain financial and non financial covenants be maintained. These covenants require that the Hospital and its parent and affiliates maintain a fixed charge coverage ratio that was not maintained during 2012 (see Note 9). These conditions raise substantial doubt about the Hospital's ability to continue as a going concern. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

It is the plan of management to ensure that the Hospital continues as a going concern. Management believes that the aforementioned affiliation agreement with Saint Francis will assist in addressing the continuing operational deficiencies to help ensure that the Corporation and Hospital continue as going concerns.

The Hospital's continuation as a going concern is ultimately dependent upon its future financial performance, which will be affected by general economic, competitive and other factors, many of which are beyond the Hospital's control. There can be no assurance that the Hospital's plans to ensure continuation as a going concern will be successful.

PRINCIPLES OF CONSOLIDATION AND PRESENTATION

The accompanying consolidated financial statements include the accounts of Johnson Memorial Hospital, Johnson Professional Associates, P.C., and Johnson Memorial Hospital Development Fund, Inc. (Development). Johnson Professional Associates, P.C. and Development are entities in which the Hospital has a controlling financial interest. All inter-company accounts have been eliminated in consolidation.

The accompanying consolidated financial statements have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

CONSOLIDATION

ASC 810-25, *Consolidations*, requires a not-for-profit entity, among other things, to consolidate into its financial statements the financial results of another not-for-profit in which it has a controlling financial interest and to make certain disclosures. Reference is made to Note 2.

ASC 810-15 requires a for profit entity to be consolidated if an organization has the power through voting or similar rights to direct the economic activities of the entity.

NET ASSET CATEGORIES

To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

Unrestricted – Unrestricted net assets represent available resources which can be used for general operations of the Hospital. Included in unrestricted net assets are assets set aside by the Board of Directors.

Temporarily Restricted – The Hospital reports gifts of cash and other assets as 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 to unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met in within the same year as received are reflected as unrestricted contributions in the accompanying statements of operations. At September 30, 2012 and 2011 the Hospital had temporarily restricted net assets of $262,646 and $321,617, respectively.

Permanently Restricted – Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that income earned thereon is available for operations or a specific purpose.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

USE OF ESTIMATES

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated uncollectible accounts receivable for services to patients, and liabilities, including estimated net settlements with third-party reimbursement agencies and professional liabilities, and disclosure of contingent assets and contingent liabilities at the date of the financial statements. Estimates also affect the amounts of revenues and expenses reported during the period. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term. 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).

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 net assets 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 to unrestricted net assets.

CASH AND CASH EQUIVALENTS

The Hospital considers all highly liquid investments with remaining maturities of three months or less at date of purchase to be cash equivalents. Cash and cash equivalents are held at a limited number of financial institutions and at times, the amounts on deposit exceed insured limits.

ACCOUNTS RECEIVABLE

Patient accounts receivable result from the health care services provided by the Hospital and JPA. The amount of the allowance for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See Note 3 for additional information relative to net patient service revenue recognition and third-party payer programs.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INVENTORIES

Inventories of drugs and supplies are stated at the lower of cost or market, determined using the first in first out method.

INVESTMENTS

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) are included in the deficiency of revenues over expenses unless the income or loss is restricted by donor or law.

Unrealized gains and losses on investments on the Hospital's beneficial interest in perpetual trusts are recorded as changes in permanently restricted net assets.

INVESTMENT IN JOINT VENTURES

The Hospital has two joint ventures that it accounts for using the equity method. The changes in the Hospital's share in the equity of these joint ventures is recorded as a component of nonoperating revenue (loss) in the consolidated statements of operations.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are recorded at cost. The Hospital provides for depreciation of property, plant and equipment and amortization of assets recorded under capital leases using the straight-line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives ranging from 3 to 40 years.

Financial Accounting Standards Board ASC 410-20, *Accounting for Asset Retirement Obligations,* provides guidance on accounting and reporting for obligations associated with the retirement of tangible long-lived assets and the associated asset retirement costs. Asset retirement obligations include, but are not limited to, certain types of environmental issues which are legally required to be remediated upon an asset's retirement as well as contractually required asset retirement obligations. ASC 410-20 provides clarifying guidance on conditional asset retirement obligations. Conditional asset retirement obligations are obligations whose settlement may be uncertain. ASC 410-20's guidance requires such conditional asset retirement obligations to be estimated and recognized. Application of these pronouncements affects the Hospital with respect to required future asbestos remediation.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

Conditional asset retirement obligations of $324,553 and $307,910 as of September 30, 2012 and 2011, respectively, were recorded in other liabilities on the balance sheets. These retirement obligations have been discounted at a rate of 6.75%. The undiscounted amounts of the obligations were $346,000 at September 30, 2012 and 2011. There were no retirement obligations incurred or settled during 2012 or 2011. Reference is made to Note 14 regarding other environmental exposures.

IMPAIRMENT OF LONG-LIVED ASSETS

The Hospital records impairment losses on long-lived assets used in operations when events and circumstances indicate that the assets might be impaired and the undiscounted cash flows estimated to be generated by those assets are less than the carrying amounts of those assets. There were no impairment losses recorded in 2012 or 2011. Management believes that the Hospital will generate undiscounted cash flows that will at least hold the value in its long lived assets at their current carrying values and the economic synergies and additional volume anticipated through the affiliation agreement with Saint Francis are expected to help the Hospital improve its cash flows.

NONOPERATING REVENUE (LOSS)

Activities, other than in connection with providing health care services, are considered to be nonoperating. Nonoperating revenue (loss) consists primarily of income on invested funds, gains on sales of equipment and the changes in the Hospital's share of equity of the joint ventures accounted for under the equity method.

DEFERRED FINANCING FEES

Deferred financing costs, which were incurred in connection with the debt, are being amortized over the term of the related debt. Amortization expense for deferred financing costs amounted to $183,981 for the years ended September 30, 2012 and 2011.

DEFICIENCY OF REVENUE OVER EXPENSES

The statements of operations and changes in net assets include the deficiency of revenue over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from the deficiency of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and permanent transfers of assets to and from affiliates for other than goods and services.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

INCOME TAXES

The Hospital and Development are not-for-profit corporations as defined in Section 501(c)(3) of the Internal Revenue Code, and therefore are exempt from federal and state income taxes, except on net income derived from unrelated business activities. JPA is a professional corporation that has experienced losses since inception and accordingly, no provisions for federal or state income taxes have been recorded.

The Hospital accounts for uncertainty in income tax positions in the consolidated financial statements by applying a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return.

Management has analyzed the tax positions taken and has concluded that as of September 30, 2012, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Hospital, Development, and JPA are subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes that these organizations are no longer subject to income tax examinations prior to 2009.

ESTIMATED MEDICAL MALPRACTICE AND WORKERS' COMPENSATION COSTS

The provision for estimated medical malpractice and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

ADVERTISING

The Hospital expenses advertising costs as incurred. Advertising expenses for the years ended September 30, 2012 and 2011 were $207,107 and $154,129, respectively.

BENEFICIAL INTEREST IN PERPETUAL TRUSTS

The Hospital is the beneficiary of several trust funds. Although the principal balances in the trust funds are permanently restricted, the income earned on the trust funds is unrestricted. The 2012 unrealized gains from the trust funds were $450,770 and the 2011 unrealized losses from the trust fund were $117,521 and are included in changes in permanently restricted net assets.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

RECOGNITION OF GRANT REVENUE

Grants are generally considered to be exchange transactions in which the grantor requires the performance of specified activities. Entitlement to cost reimbursement grants is conditioned on the expenditure of funds in accordance with grant restrictions and, therefore, revenue is recognized to the extent of grant expenditures. Entitlement to performance based grants is conditioned on the attainment of specific performance.

CHARITY CARE

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge, or at amounts less than its established rates. The Hospital does not pursue collection of amounts determined to be charity care. For the year ended September 30, 2012 the charges and costs related to charity care were $193,110 and $77,541 and for the year ended September 30, 2011, the charges and costs related to charity care were $465,815 and $251,560, respectively.

NEW ACCOUNTING PRONOUNCEMENTS

PRESENTATION OF INSURANCE CLAIMS AND RELATED INSURANCE RECOVERIES

Effective October 1, 2011 and retrospectively for all periods presented, the Hospital adopted the provisions of ASU 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*, which further clarifies that health care entities should not net insurance recoveries against the related claim liabilities. In connection with the Hospital's adoption of ASU 2010-24, the Hospital recorded the changes below in the accompanying consolidated balance sheet as of September 30, 2011. The $185,834 increase as of September 30, 2011 represents the Hospital's workers' compensation claims covered by insurance for losses in excess of the maximum premium in the Hospital's retrospectively rated insurance policy.

The $445,000 increase as of September 30, 2011 represents the Hospital's estimate of recoveries for certain claims by a fully insured professional liability insurance policy. The adoption of ASU 2010-24 had no impact on the Hospital's net assets, results of operations or cash flows.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

The following is a summary of the impact of the adoption of ASU 2010-24 on the Hospital's accompanying September 30, 2011 consolidated balance sheet:

	As originally reported	Adjustments for the adoption of ASU 2010-24	As currently reported
Insurance and other receivables	$ 1,229,586	$ 185,834	$ 1,415,420
Other noncurrent assets	--	445,000	445,000
Total assets	41,292,651	630,834	41,923,485
Other current liabilities	--	185,834	185,834
Other liabilities	307,910	445,000	752,910
Total liabilities	35,048,086	630,834	35,678,920

MEASURING CHARITY CARE FOR DISCLOSURE

Self-pay revenues are derived primarily from patients who do not have any form of health care coverage. The revenues associated with self-pay patients are generally reported at the Hospital's gross charges. The Hospital evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the Hospital's policy for charity care. The Hospital provides care without charge to certain patients that qualify under its charity care policy. For the years ended September 30, 2012 and 2011, the Hospital estimates that its costs of care provided under its charity care programs approximated $78,000 and $252,000, respectively.

The Hospital's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Hospital's gross charity care charges provided. The Hospital's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Hospital's charity care policy. To the extent the Hospital receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Hospital does not include these patients charges in its cost of care provided under its charity care program. Additionally, the Hospital does not report a charity care patient's charges in revenues or in the provision for uncollectible accounts as it is the Hospital's policy not to pursue collection of amounts related to these patients.

NOTE 1 – SIGNIFICANT ACCOUNTING POLICIES AND ORGANIZATION (CONTINUED)

Previously, the Hospital reported its estimates of services provided under its charity care program based on gross charges. In connection with the Hospital's adoption of ASU 2010-23, *Measuring Charity Care for Disclosure,* amounts previously reported for care provided under its charity care programs have been restated to reflect the Hospital's estimates of its direct and indirect costs of providing these services. This change had no impact on the Hospital's results of operations.

BAD DEBTS

In July 2011, the FASB issued ASU 2011-07, *Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*, which requires 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 with enhanced footnote disclosures on the policies for recognizing revenue and assessing bad debts, in addition to qualitative and quantitative information about changes in the allowance for doubtful accounts. The pronouncement will be adopted during the fiscal year ending September 30, 2013. The Hospital is evaluating the effect of the pronouncement on its financial statements.

RECLASSIFICATIONS

Certain amounts reported in the prior year's financial statements have been reclassified to conform to the current year's financial statements.

SUBSEQUENT EVENTS

The Hospital evaluates the impact of subsequent events, 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 or for disclosure in the notes to the consolidated financial statements. The Hospital evaluated events occurring subsequent to September 30, 2012 through January 8, 2013, the date on which the accompanying financial statements were available to be issued. During this period, there were no subsequent events that required disclosure or recognition in the financial statements.

NOTE 2 – CONSOLIDATED ENTITIES

JPA is a medical practice that is controlled by the Hospital. Although the Hospital does not have direct ownership interests in JPA, the Hospital has a controlling voting interest in the Board of JPA, thus enabling the Hospital to control the economic activities of JPA. Also, the Hospital provides funding to JPA to fund its operating losses.

Johnson Memorial Hospital Development Fund, Inc. is a not-for-profit organization that raises funds for the Hospital and other affiliates in which the Hospital has a controlling financial interest by virtue of control of its board of directors and the fact that substantially all of Development's assets are for the use of the Hospital.

NOTE 3 – NET REVENUE FROM SERVICES TO PATIENTS AND CHARITY CARE

The following table summarizes net revenue from services to patients during the years ended September 30, 2012 and 2011:

	2012	2011
Gross patient service revenue	$ 161,562,823	$ 159,461,324
Contractual and other allowances	(92,150,641)	(94,627,469)
Charity care provided free of charge - at cost	(77,541)	(251,560)
Net patient service revenue	$ 69,334,641	$ 64,582,295

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payers are different from the established billing rates of the Hospital, and these differences are accounted for as allowances.

The following table represents the percentages of net revenue received from payers during the years ended September 30, 2012 and 2011:

	2012	2011
Medicare	38%	39%
Medicaid	9%	7%
Third parties	39%	41%
Other	14%	13%

NOTE 3 – NET REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE (CONTINUED)

Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the Hospital. The State of Connecticut has announced reductions in the State's Disproportionate Share Reimbursement Program for fiscal year 2013. Management estimates that these reductions will reduce net patient service revenue by approximately $600,000 during the year ending September 30, 2013.

The significant concentrations of net accounts receivable for services to patients by payer at September 30, 2012 and 2011 follow:

	2012	2011
Medicare	26%	27%
Medicaid	10%	11%
Third parties	38%	38%
Other	26%	24%

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. 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. The Hospital believes that it is in compliance with all applicable laws and regulations. Cost reports for the Hospital, which serve as a basis for final settlement with government payors, have been settled by final settlement through 2009 for Medicare and 2007 for Medicaid. Other years remain open for settlement.

The Hospital has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the HMOs make fee-for-service payments to the Hospital for certain covered services based upon discounted fee schedules.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is possible. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized poverty income levels for the State, but also includes certain cases where incurred charges are significant when compared to incomes. These charges are not included in net patient service revenues for financial reporting purposes.

NOTE 4 – ASSETS WHOSE USE IS LIMITED

The composition of assets whose use is limited, which include beneficial interests in perpetual trusts, cash restricted for payment of workers compensation claims and permanently restricted investments by donors are set forth in the following table. Investments are stated at fair value.

	2012		2011	
	Cost	Fair Value	Cost	Fair Value
Cash and cash equivalents	$ 1,206,684	$ 1,206,684	$ 1,538,157	$ 1,538,157
Money market funds	858,411	858,411	10,419	10,419
Mutual funds - equity	94,306	102,080	143,353	147,632
Mutual funds - fixed	106,078	108,381	99,162	95,857
Collective funds - equity	40,979	71,167	28,470	47,842
Collective funds - fixed	32,941	34,524	35,973	36,615
Investment grade taxable bonds	744,647	859,176	764,010	872,421
Global high yield bonds	109,113	104,948	109,654	97,005
Equities				
U.S. large cap	836,560	886,042	1,070,874	1,086,711
U.S. mid cap	192,297	241,423	384,883	369,163
U.S. small cap	65,729	62,424	62,686	50,196
International developed	84,912	86,026	197,341	169,415
Real estate	61,886	70,285	--	--
Tangible assets - commodities	147,088	131,605	4,687	5,283
	$ 4,581,631	$ 4,823,176	$ 4,449,669	$ 4,526,716

NOTE 4 – ASSETS WHOSE USE IS LIMITED (CONTINUED)

Investment income and gains (losses) on investments recorded in the consolidated statements of operations for the years ended September 30 are below.

	2012	2011
Income		
Interest and dividend income	$ 215,020	$ 162,970
Realized (losses) gains on sales of securities	(2,797)	243
	212,223	163,213
Less investment management fees	(35,217)	(39,305)
Net investment gains	$ 177,006	$ 123,908

NOTE 5 – FAIR VALUE MEASUREMENTS

Assets and liabilities recorded at fair value in the financial statements are categorized, for disclosure purposes, based upon whether the inputs used to determine their fair values are observable or unobservable utilizing a three-level fair value hierarchy that prioritizes the inputs used to measure assets and liabilities at fair value. Level inputs are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that the Hospital has the ability to access on the reporting date.

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs that are unobservable for the asset or liability.

The fair values of Level 1 securities were determined through quoted market prices, while fair values of Level 2 securities were determined primarily through prices obtained from third party pricing sources, where quoted market prices for such securities were not available. The fair values of Level 3 securities were determined primarily through information obtained from the relevant counterparties for such investments, as information on which these securities' fair values are based is generally not readily available in the market.

NOTE 5 – FAIR VALUE MEASUREMENTS (CONTINUED)

The following table summarizes fair value measurements, by level, at September 30, 2012 and 2011, for all assets and liabilities which are measured at fair value on a recurring basis in the financial statements:

	Level 1	Level 2	Level 3	Total
September 30, 2012				
Beneficial interests in perpetual trusts				
Money market funds	$ 858,411	$ --	$ --	$ 858,411
Mutual funds - equity	102,080	--	--	102,080
Mutual funds - fixed	108,381	--	--	108,381
Collective funds - equity	--	--	71,167	71,167
Collective funds - fixed	--	--	34,524	34,524
Investment grade taxable bonds	859,176	--	--	859,176
Global high yield bonds	104,948	--	--	104,948
Equities				
U.S. large cap	886,042	--	--	886,042
U.S. mid cap	241,423	--	--	241,423
U.S. small cap	62,424	--	--	62,424
International developed	86,026	--	--	86,026
Real estate	70,285	--	--	70,285
Tangible assets-commodities	--	--	131,605	131,605
Total beneficial interests in perpetual tursts	3,379,196	--	237,296	3,616,492
Restricted cash and board designated investments	363,097	--	--	363,097
Investments permanently restricted by donor	843,587	--	--	843,587
	$ 4,585,880	$ --	$ 237,296	$ 4,823,176

NOTE 5 – FAIR VALUE MEASUREMENTS (CONTINUED)

	Level 1	Level 2	Level 3	Total
September 30, 2011				
Beneficial interests in perpetual trusts				
Cash and cash equivalents	$ 177,163	$ --	$ --	$ 177,163
Money market funds	10,419	--	--	10,419
Mutual funds - equity	147,632	--	--	147,632
Mutual funds - fixed	95,857	--	--	95,857
Collective funds - equity	--	--	47,842	47,842
Collective funds - fixed	--	--	36,615	36,615
Investment grade taxable bonds	872,421	--	--	872,421
Global high yield bonds	97,005	--	--	97,005
Equities				
U.S. large cap	1,086,711	--	--	1,086,711
U.S. mid cap	369,163	--	--	369,163
U.S. small cap	50,196	--	--	50,196
International developed	169,415	--	--	169,415
Real estate	5,283	--	--	5,283
Total beneficial interests in perpetual tursts	3,081,265	--	84,457	3,165,722
Restricted cash and board designated investments	517,407	--	--	517,407
Investments permanently restricted by donor	843,587	--	--	843,587
	$ 4,442,259	$ --	$ 84,457	$ 4,526,716

NOTE 5 – FAIR VALUE MEASUREMENTS (CONTINUED)

The following is a reconciliation of Level 3 assets for which significant unobservable inputs were used to determine fair value:

	Beneficial Interests in Perpetual Trusts
Balance at October 1, 2010	$ 90,279
Change in fair value	(5,822)
Balance at September 30, 2011	84,457
Purchases of investments	147,088
Change in fair value	5,751
Balance at September 30, 2012	$ 237,296

NOTE 6 – RESTRICTED ENDOWMENTS

The Hospital's endowments consist of donor-restricted endowment funds and beneficial interests in perpetual trusts. Net assets associated with endowment funds are classified and reported based on donor-imposed restrictions.

The Hospital's Board of Directors has interpreted the Connecticut Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor restricted endowment funds, absent explicit donor stipulations to the contrary. This does not apply to beneficial interests in perpetual trusts where the fair value of the investments is the basis for the amount recorded as permanently restricted net assets.

As a result of the interpretation of UPMIFA, the Hospital classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and, if applicable, (c) accumulations to the permanent endowment made in accordance with the related gift's donor instructions. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as unrestricted net assets based on the donors' stipulations and those amounts are appropriated for expenditure by the Hospital in a manner consistent with the standard for expenditures as proscribed by UPMIFA.

NOTE 6 – RESTRICTED ENDOWMENTS (CONTINUED)

In accordance with UPMIFA, the Hospital considers 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 Hospital and 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

RETURN OBJECTIVES AND RISK PARAMETERS

For the permanently restricted endowment funds, the bank, acting in its capacity as trustee, determines and directs the investment policy and asset allocation. For the unrestricted endowment funds, the Hospital's Board of Directors has adopted investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowments while seeking to maintain the purchasing power of the endowment assets. The Hospital expects these endowment funds, over time, to provide an average rate of return that exceeds the rate of inflation annually. Actual returns in any given year may vary from this amount.

STRATEGIES EMPLOYED FOR ACHIEVING OBJECTIVES

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints.

SPENDING POLICY AND HOW THE INVESTMENT OBJECTIVES RELATE TO THE SPENDING POLICY

The Hospital has a policy of evaluating the spending decisions for each endowment fund based upon the intentions of the donors and specific contractual agreements. In determining the annual amount to be spent, the Hospital considers the long-term expected return on its endowment. The spending policy is designed to limit spending to the expected long-term real rate of return. The annual distribution from the endowment funds is expected to be contained within a range of the trusts' market value that is consistent with the Hospital's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return.

NOTE 6 – RESTRICTED ENDOWMENTS (CONTINUED)

ENDOWMENT NET ASSET COMPOSITION BY TYPE OF FUND AS OF SEPTEMBER 30, 2012 AND 2011:

	Unrestricted	Permanently Restricted	Total
September 30, 2012			
Donor-restricted endowment funds	$ --	$ 843,587	$ 843,587
Beneficial interests in perpetual trusts	--	3,616,492	3,616,492
	$ --	$ 4,460,079	$ 4,460,079

	Unrestricted	Permanently Restricted	Total
September 30, 2011			
Donor-restricted endowment funds	$ --	$ 843,587	$ 843,587
Beneficial interests in perpetual trusts	--	3,165,722	3,165,722
	$ --	$ 4,009,309	$ 4,009,309

CHANGES IN ENDOWMENT NET ASSETS FOR THE YEARS ENDED SEPTEMBER 30, 2012 AND 2011

	Unrestricted	Permanently Restricted	Total
September 30, 2012			
Endowment net assets, beginning	$ --	$ 4,009,309	$ 4,009,309
Investment return:			
Investment income	177,006	--	177,006
Net unrealized gains	--	450,770	450,770
Total investment return	177,006	450,770	627,776
Appropriation of endowment assets for expenditure	(177,006)	--	(177,006)
Endowment net assets, ending	$ --	$ 4,460,079	$ 4,460,079

NOTE 6 – RESTRICTED ENDOWMENTS (CONTINUED)

	Unrestricted	Permanently Restricted	Total
September 30, 2011			
Endowment net assets, beginning	$ --	$ 4,126,830	$ 4,126,830
Investment return:			
Investment income	120,877	--	120,877
Net unrealized losses	--	(117,521)	(117,521)
Total investment return	120,877	(117,521)	3,356
Appropriation of endowment assets for expenditure	(120,877)	--	(120,877)
Endowment net assets, ending	$ --	$ 4,009,309	$ 4,009,309

NOTE 7 – TEMPORARILY RESTRICTED AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets of $262,646 as of September 30, 2012 consist of $31,803 remaining on the unexpended proceeds of a $350,000 grant received from Northeast Regional Radiation Oncology Network, Inc. (NRRON) to be used for the construction of the new infusion center in Enfield, CT, $67,313 from the Hospital's 100th anniversary fund raising events, and $163,530 to be utilized for the replacement of a generator. The Hospital has a 25% ownership interest in NRRON ($3,055,158 and $2,819,068 at September 30, 2012 and 2011, respectively) that is included in investments in joint ventures on the consolidated balance sheets.

Permanently restricted net assets of $4,460,079 and $4,009,309 at September 30, 2012 and 2011, respectively, represent assets to be held in perpetuity, the income from which is expendable to support health care services and the general operations of the Hospital.

NOTE 8 – PROPERTY, PLANT AND EQUIPMENT

The components of cost and the related accumulated depreciation comprising property, plant and equipment as of September 30, 2012 and 2011 are as follows:

	2012	2011
Land	$ 406,997	$ 406,997
Land improvements	1,558,879	1,237,587
Building and improvements	24,468,554	24,224,435
Fixed and movable equipment	32,571,220	33,042,503
	59,005,650	58,911,522
Less accumulated depreciation	(39,398,697)	(37,422,003)
	$ 19,606,953	$ 21,489,519

Depreciation expense for property, plant and equipment amounted to $2,985,675 and $3,002,181 for the years ended September 30, 2012 and 2011, respectively. Included within depreciation and amortization expense on the statements of operations is amortization for capital leased assets of $43,886 and $91,372 for the years ended September 30, 2012 and 2011, respectively (see Note 10).

NOTE 9 – DEBT

MORTGAGE NOTE PAYABLE

On August 1, 2006, the Hospital entered into a $13,700,000 commercial construction mortgage loan with a bank. The loan was used to finance the expansion and renovation of the emergency department, three nursing units, the psychiatric unit, and two medical and surgical units, and to refinance the Hospital's existing loans (collectively, the Project). In December 2007, the loan was converted to a term loan, which is guaranteed by the United States Department of Agriculture (USDA) through the USDA Rural Development Community Facilities Program. The term loan calls for equal quarterly principal payments of $85,625 over 40 years and will mature on January 1, 2048. Fifty percent of the loan bears interest at the bank's five year cost of borrowing plus 1.50% and fifty percent of the loan bears interest at the three month LIBOR plus 1.25%. The interest rates in effect at September 30, 2012 were 6.63% and 1.71%, respectively.

NOTE 9 – DEBT (CONTINUED)

As of September 30, 2012, there was a balance of $12,158,750 due on the mortgage.

The Hospital is required to meet certain financial covenants under the mortgage. On September 27, 2010, the mortgage was modified and the bank waived all defaults that occurred prior to that date. The quarterly debt service coverage ratio requirement was also modified. The Hospital did not comply with this covenant for the quarter ended December 31, 2010 and on March 30, 2011, the bank waived this default.

In 2006, the Hospital entered into a loan to finance certain information systems equipment at an interest rate of 5.5%. The Hospital failed to make payments in accordance with the loan terms. The Hospital's loan to refinance information equipment was restructured to be paid in 60 monthly installments of $10,000. The present value of the settlement value of this loan was $332,047 and $427,150 at September 30, 2012 and 2011, respectively.

Future minimum payments by year and in the aggregate for the mortgage loan and subordinated debt were as follows at September 30, 2012:

2013	$ 443,083
2014	450,087
2015	457,578
2016	352,445
2017	342,500
Thereafter	10,445,104
	$ 12,490,797

REVOLVING LOAN

In September 2010, the Hospital, along with several affiliates (the Borrowers), entered into a Revolving Loan and Security Agreement (senior debt under revolving line of credit) with a lender for an amount not to exceed the lesser of $8 million or the maximum borrowing base (85% of the book value of all eligible receivables). Under the original agreement, amounts outstanding bear interest at the greater of the 3 month LIBOR rate plus 4.25% or 5.75% payable monthly in arrears. The Hospital has granted the lender a security interest in accounts receivable. On July 12, 2012, this agreement was amended as a result of the affiliation between the Johnson Entities and Saint Francis to extend the line of credit expiration date to September 27, 2014.

NOTE 9 – DEBT (CONTINUED)

The Hospital is jointly and severally liable for the full payment of the debt under this agreement, including any debt incurred by Evergreen and Home & Community Health Services, Inc.

As of September 30, 2012, there were outstanding borrowings of $3,504,213 under the Loan and Security Agreement and $2,125,207 was available for future borrowings.

The Borrowers are subject to a number of covenants and restrictions under the Revolving Loan and Security Agreement. These include the following affirmative and negative covenants: provision of monthly, quarterly and annual financial information, adequate insurance coverage, notice of certain events and changes, change in ownership or management, restrictions on indebtedness and lease agreements, sale of assets, protection of collateral and financial covenants prepared on a consolidated basis for the Borrowers including cash flow and debt service coverage ratio requirements.

During 2011, the Borrowers failed to comply with various covenants under the Revolving Loan and Security Agreement. This resulted in the lender imposing an interest penalty of 4% beginning January 1, 2011 that remained in place until July 12, 2012. During the year ended September 30, 2012, the Borrowers failed to comply with the fixed charge coverage ratio covenant and management is working with the lender to modify this covenant requirement. In the event that the Borrowers don't comply with this or any other covenant, the loan will remain payable on demand.

OTHER DEBT

The other long-term debt of $1,300,000 as of September 30, 2012 represents the amount owed to Saint Francis under the terms of the affiliation agreement. Reference is made to Note 1.

NOTE 10 – LEASE OBLIGATIONS

CAPITAL LEASES

The Hospital has entered into non-cancelable capital lease obligations for certain equipment. The cost of the assets is being amortized over the useful lives of the assets or the shorter of the respective lease term or useful life if the asset does not transfer to the Hospital at the end of the lease term and is summarized as of September 30, 2012 and 2011 are as follows:

	2012	2011
Medical and other equipment	$ 497,904	$ 913,226
Less, accumulated amortization	(129,296)	(258,127)
	$ 368,608	$ 655,099

Future minimum lease payments under the capital leases, together with the present value of future minimum lease payments, as of September 30, 2012 are as follows:

2013	$ 67,292
2014	19,681
2015	18,108
2016	18,108
2017	16,599
Total future minimum lease payments	139,788
Less, amounts representing interest	19,598
Present value of future minimum lease payments	120,190
Less current portion	61,820
	$ 58,370

OPERATING LEASES

The Hospital leases various computer equipment, medical equipment and office space under operating leases, which expire at various dates through 2015. Rent expense under the operating leases was $2,268,594 and $2,058,478 in 2012 and 2011, respectively. These leases have various terms and conditions. The Hospital subleases land to an affiliated corporation under a month-to-month lease arrangement. Sublease income was $180,000 for each of the fiscal years ended September 30, 2012 and 2011.

NOTE 10 – LEASE OBLIGATIONS (CONTINUED)

Minimum future rental commitments on these non-cancelable operating leases with initial or remaining terms of more than one year as of September 30, 2012 are as follows:

2013	$ 688,454
2014	434,628
2015	196,591
	$ 1,319,673

NOTE 11 – EMPLOYEE BENEFIT PLANS

The Hospital formerly had a defined benefit pension plan that covered certain employees. Pursuant to the plan of reorganization, the Pension Benefit Guaranty Corporation assumed control of the defined benefit plan effective September 1, 2011.

The Hospital has a defined contribution plan (the Plan) whereby all employees who have attained the age of 21 and completed one year of employment (1,000 hours of service) are eligible to participate and become fully vested after 5 years. Annually, the Hospital may contribute a defined amount of employees' salaries to the Plan. Effective January 1, 2011, the Hospital suspended the matching of non-union employee contributions; it continued to pay the match on union employees up until June 2012, at which time only those union employees that had been grandfathered in the Plan were matched. The total expense incurred by the Hospital for contributions was $249,482 in 2012. The total expense incurred by the Hospital for contributions made to the Plan was $454,629 in 2011. Management indicated that this match will be reinstituted.

NOTE 12 – SELF-INSURANCE CLAIMS

There have been medical malpractice and workers' compensation claims that have been asserted against the Hospital. In addition, there are known incidents that have occurred through September 30, 2012 that may result in the assertion of claims. Hospital management has accrued its best estimate of these contingent losses. Other claims may be asserted arising from services provided to patients or workers' compensation incidents in the past. Hospital management has provided reserves for these contingent liabilities.

NOTE 13 – PROFESSIONAL, GENERAL LIABILITY AND WORKERS' COMPENSATION INSURANCE

For claims incurred through August 31, 2009, the Hospital was self-insured for professional liability and general liability claims, under a claims made plan, which covered the Corporation's entire health system. The Corporation has an excess umbrella claims made policy for claims in excess of the Corporation's self-insured limits. The Corporation's independent actuary estimated the expected costs to settle such claims. Accrued losses have been discounted at 3%.

The Hospital has accrued self-insurance liabilities of $1,090,230 and $1,269,265 for the estimated costs of settlements for its professional liability and general liability insurance risks as of September 30, 2012 and 2011, respectively. For claims incurred after August 31, 2009, the Hospital was covered under commercial claims made policies with no deductible and coverage of $1,000,000 per claim and an annual aggregate of $3,000,000 for all of the entities covered under the policy.

The Hospital was also self-insured for workers compensation claims through March 16, 2009 at which time it obtained commercial insurance. The Hospital has accrued $50,870 and $306,547 of self-insured liabilities as of September 30, 2012 and 2011, respectively, for workers' compensation cases. The Hospital's workers' compensation policy has no deductible and policy limits of $1,000,000 per case with no aggregate limit for claims incurred after March 16, 2009.

NOTE 14 – COMMITMENTS AND CONTINGENCIES

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 its financial position.

The Hospital also has the following environmental exposures:

The Connecticut Department of Public Health (DPH) issued an order that requires the Hospital to monitor drinking water that comes from its well field, report the results and submit plans for review and approval by DPH to upgrade the drinking water supply system to reduce the level of uranium found in the well water. The Hospital and DPH agreed on plans and specifications for the Hospital to construct improvements to the well system and report to DPH that the work has been completed. The Hospital completed the construction of the well system improvements at a cost of $321,292 and DPH acknowledged the project completion in a letter to the hospital dated June 26, 2012.

NOTE 14 – COMMITMENTS AND CONTINGENCIES (CONTINUED)

The Connecticut Department of Environmental Protection (DEP) issued a consent order (Sewer Order) which requires the Hospital to perform repairs or replacements to the aging wastewater treatment system at the Hospital. The Sewer Order requires a short-term and a long-term solution. The short-term work has been completed in accordance with the Sewer Order and the Hospital has been reporting to the DEP on the status of the short-term solution. Under the long-term solution, the Hospital had until March 30, 2011 to submit to the DEP for review and approval a schedule for: (i) the investigation of and remedial action alternatives to abate any pollution at the site arising from the operation of the on-site sewage treatment system or (ii) the construction of sanitary sewers to connect the Hospital to the Stafford Water Pollution Control Facility. The schedule shall provide for completion of the actions not later than December 31, 2014. The Hospital has designed and engineered a solution that is expected to be acceptable to the DEP. This solution is expected to cost less than approximately $855,000 and to be fully operational by December 31, 2014 in accordance with the DPH directive.

The DEP filed a civil suit in 2007 in which the DEP sought civil penalties and temporary and permanent injunctions prohibiting the Hospital from violating the hazardous waste management regulations, preventing the Hospital from maintaining a discharge to the waters of the state and violating its air permit. Five of the six counts arose from allegations relating to the use of an underground storage tank for the storage of x-ray developer fixer and the release of the developer fixer from the tank. Use of that tank ended in April 2004 and the tank was removed. Part of the injunctive relief sought is an order requiring the investigation and remediation of the release of x-ray development fixer. The sixth count alleged that the Hospital violated its general air permit by submitting its annual compliance certification for 2005 ten months late. The Hospital has recorded a conditional retirement obligation related to the costs of an environmental investigation, but has not recorded a liability for any potential costs to remediate the site due to the fact that such costs, if any, cannot be reasonably estimated until the investigation is performed. The Hospital previously remediated the site when the tank was originally removed. The Hospital and the Department have come to agreement as to a stipulation for judgment resolving the case in which the Hospital agree to: (1) the payment of a civil penalty from the bankruptcy estate (thus having no effect on the Hospital); (2) submit a groundwater monitoring plan which is to determine the sufficiency of the remedial actions taken in 2007 with respect to the removal of the old x-ray developer tank; (3) undertake waste determinations as required by state and federal regulations for all waste generated at the Hospital; and (4) file all annual reports with respect to the general air permit on time in the future.

NOTE 15 – TRANSACTIONS WITH AFFILIATES

During 2012 and 2011, the Hospital billed affiliated organizations $662,160 and $1,131,168, respectively, for certain expenses and rental of space.

The amounts due from (to) affiliates represent receivables from and (payables) to affiliates that do not eliminate in consolidation. These balances are comprised of the following at September 30:

	2012	2011
Due to Johnson Memorial Corporation	$ (1,779,380)	$ (1,439,472)
Due to Home and Community Health Services, Inc.	(217,177)	(217,336)
Due from (to) Johnson Evergreen Corporation	243,340	(338,150)
Due to Johnson Health Care, Inc.	(63,951)	(70,463)
	$ (1,817,168)	$ (2,065,421)

During the year ended September 30, 2012, Johnson Medical Specialists, P.C. transferred net assets of $74,638 to JPA.

The Hospital has provided guarantees of the debt of the Corporation and Evergreen which had balances of $3,060,000 and $14,419,102, respectively, as of September 30, 2012.

Evergreen did not comply with the debt service coverage ratio requirement for the measurement period ended September 30, 2012. The bank waived this default and indicated that the bank will not bring any legal action against Evergreen through March 31, 2013. Management is working with the bank to modify the covenant for the period ending March 31, 2013 in order to include the Hospital and the Corporation in the covenant calculation. In the event that Evergreen does not comply with this covenant for the period ending March 31, 2013, the bank will have the ability to demand repayment of the debt.

NOTE 16 – CONCENTRATIONS OF CREDIT RISK

The Hospital's financial instruments that are exposed to concentrations of credit risk consist primarily of cash, investments and accounts receivable.

The Hospital places its cash deposits with high credit-quality institutions, which, at times, may exceed the Federal Deposit Insurance Corporation limits of $250,000 per bank. The Hospital has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on cash and cash equivalents.

NOTE 17 – FUNCTIONAL EXPENSES

The Hospital provides general patient care services to residents within its geographic location. Expenses related to providing these services are as follows for the years ended September 30:

	2012	2011
Patient care services	$ 55,272,046	$ 55,608,741
General and administrative (including bad debt expense, depreciation and amortization, interest and operations)	16,806,660	13,414,197
	$ 72,078,706	$ 69,022,938

MARCUM
ACCOUNTANTS ▲ ADVISORS

INDEPENDENT AUDITORS' REPORT ON OTHER FINANCIAL INFORMATION

Board of Directors
Johnson Memorial Hospital

Our report on our audits of the basic consolidated financial statements of Johnson Memorial Hospital as of and for the years ended September 30, 2012 and 2011 appears on page 1. Our audit was performed for the purpose of forming an opinion on the financial statements taken as a whole. The following consolidating information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic consolidated financial statements taken as a whole.

Marcum LLP

Hartford, CT
January 8, 2013

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2012

	Hospital	JPA	Development	Elimination	Total
Assets					
Current Assets					
Cash and cash equivalents	$ 787,925	$ 3,825	$ 27,577	$ --	$ 819,327
Patients accounts receivable, net of allowances for uncollectible accounts	8,023,775	380,008	--	--	8,403,783
Insurance and other receivables	193,008	29,521	--	--	222,529
Inventories	1,254,591	--	--	--	1,254,591
Prepaid expenses and other current assets	759,969	93,093	--	--	853,062
Total Current Assets	11,019,268	506,447	27,577	--	11,553,292
Assets Whose Use is Limited					
Beneficial interests in perpetual trusts	3,616,492	--	--	--	3,616,492
Restricted cash and board designated investments	363,097	--	--	--	363,097
Investments permanently restricted by donor	843,587	--	--	--	843,587
Total Assets Whose Use is Limited	4,823,176	--	--	--	4,823,176
Other Assets					
Property, plant and equipment, net	19,431,008	175,945	--	--	19,606,953
Investment in joint ventures	3,106,905	--	--	--	3,106,905
Due from affiliated corporations	3,858,694	--	--	(3,858,694)	--
Deferred financing costs, net	356,845	--	--	--	356,845
Other noncurrent assets	445,000	--	--	--	445,000
Total Other Assets	27,198,452	175,945	--	(3,858,694)	23,515,703
	$ 43,040,896	$ 682,392	$ 27,577	$ (3,858,694)	$ 39,892,171

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2012

	Hospital	JPA	Development	Elimination	Total
Liabilities and Net Assets (Deficit)					
Current Liabilities					
Trade accounts payable	$ 3,182,062	$ 218,491	$ --	$ --	$ 3,400,553
Accrued payroll and related costs	2,014,282	158,629	--	--	2,172,911
Current portion of payments due under plan of reorganization	997,500	--	--	--	997,500
Revolving line of credit	3,504,213	--	--	--	3,504,213
Current portion of mortgage payable	342,500	--	--	--	342,500
Current portion of subordinated debt	100,583	--	--	--	100,583
Current portion of capital lease obligations	61,820	--	--	--	61,820
Estimated amounts due to third-party agencies	1,272,580	--	--	--	1,272,580
Other current liabilities	116,508	--	--	--	116,508
Total Current Liabilities	11,592,048	377,120	--	--	11,969,168
Long-Term Obligations					
Due to affiliate corporations	942,068	12,702,779	--	(11,827,679)	1,817,168
Payments due under plan of reorganization	5,505,445	--	--	--	5,505,445
Mortgage payable - less current portion	11,816,250	--	--	--	11,816,250
Subordinated debt - less current portion	231,464	--	--	--	231,464
Other long-term debt	1,300,000				1,300,000
Obligations under capital lease - less current portion	58,370	--	--	--	58,370
Self-insurance liabilities	1,141,100	--	--	--	1,141,100
Other liabilities	769,553	--	--	--	769,553
Total Long-Term Obligations	21,764,250	12,702,779	--	(11,827,679)	22,639,350

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2012

	Hospital	JPA	Development	Elimination	Total
Net Assets (Deficit)					
Unrestricted	$ 4,961,873	$ (12,397,507)	$ 27,577	$ 7,968,985	$ 560,928
Temporarily restricted	262,646	--	--	--	262,646
Permanently restricted	4,460,079	--	--	--	4,460,079
Total Net Assets (Deficit)	9,684,598	(12,397,507)	27,577	7,968,985	5,283,653
	$ 43,040,896	$ 682,392	$ 27,577	$ (3,858,694)	$ 39,892,171

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2011

	Hospital	JPA	Development	Elimination	Total
Assets					
Current Assets					
Cash and cash equivalents	$ 884,888	$ 1,251	$ 27,577	$ --	$ 913,716
Patients accounts receivable, net of allowances for uncollectible accounts	7,216,452	324,988	--	--	7,541,440
Insurance and other receivables	1,412,421	2,999	--	--	1,415,420
Inventories	1,216,495	--	--	--	1,216,495
Prepaid expenses and other current assets	901,401	76,300	--	--	977,701
Total Current Assets	11,631,657	405,538	27,577	--	12,064,772
Assets Whose Use is Limited					
Beneficial interests in perpetual trusts	3,165,722	--	--	--	3,165,722
Restricted cash and board designated investments	517,407	--	--	--	517,407
Investments permanently restricted by donor	843,587	--	--	--	843,587
Total Assets Whose Use is Limited	4,526,716	--	--	--	4,526,716
Other Assets					
Property, plant and equipment, net	21,293,270	196,249	--	--	21,489,519
Investment in joint ventures	2,856,651	--	--	--	2,856,651
Due from affiliated corporations	2,019,428	--	--	(2,019,428)	--
Deferred financing costs, net	540,827	--	--	--	540,827
Other noncurrent assets	445,000	--	--	--	445,000
Total Other Assets	27,155,176	196,249	--	(2,019,428)	25,331,997
	$ 43,313,549	$ 601,787	$ 27,577	$ (2,019,428)	$ 41,923,485

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2011

	Hospital	JPA	Development	Elimination	Total
Liabilities and Net Assets (Deficit)					
Current Liabilities					
Trade accounts payable	$ 2,434,285	$ 241,765	$ --	$ --	$ 2,676,050
Accrued payroll and related costs	1,770,107	140,899	--	--	1,911,006
Current portion of payments due under plan of reorganization	1,323,916	--	--	--	1,323,916
Revolving line of credit	4,651,186	--	--	--	4,651,186
Current portion of mortgage payable	342,500	--	--	--	342,500
Current portion of subordinated debt	94,035	--	--	--	94,035
Current portion of capital lease obligations	180,261	--	--	--	180,261
Estimated amounts due to third-party agencies	1,266,304	--	--	--	1,266,304
Other current liabilities	185,834	--	--	--	185,834
Total Current Liabilities	12,248,428	382,664	--	--	12,631,092
Long-Term Obligations					
Due to affiliate corporations	1,392,701	10,661,133	--	(9,988,413)	2,065,421
Payments due under plan of reorganization	6,132,010	--	--	--	6,132,010
Mortgage payable - less current portion	12,158,750	--	--	--	12,158,750
Subordinated debt - less current portion	333,115	--	--	--	333,115
Obligations under capital lease - less current portion	29,810	--	--	--	29,810
Self-insurance liabilities	1,575,812	--	--	--	1,575,812
Other liabilities	752,910	--	--	--	752,910
Total Long-Term Obligations	22,375,108	10,661,133	--	(9,988,413)	23,047,828
Total Liabilities	34,623,536	11,043,797	--	(9,988,413)	35,678,920

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING BALANCE SHEET (CONTINUED)

SEPTEMBER 30, 2011

	Hospital	JPA	Development	Elimination	Total
Net Assets (Deficit)					
Unrestricted	$ 4,359,087	$ (10,442,010)	$ 27,577	$ 7,968,985	$ 1,913,639
Temporarily restricted	321,617	--	--	--	321,617
Permanently restricted	4,009,309	--	--	--	4,009,309
Total Net Assets (Deficit)	8,690,013	(10,442,010)	27,577	7,968,985	6,244,565
	$ 43,313,549	$ 601,787	$ 27,577	$ (2,019,428)	$ 41,923,485

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2012

	Hospital	JPA	Development	Elimination	Total
Operating Revenue					
Net patient service revenues	65,318,418	4,016,223	$ --	$ --	$ 69,334,641
Grant and other income	257,382	930,057	--	(878,768)	308,671
Net assets released from restriction	25,552	--	--	--	25,552
Total Operating Revenues	65,601,352	4,946,280	--	(878,768)	69,668,864
Expenses					
Salaries	27,169,377	3,680,362	--	583,431	31,433,170
Employee benefits	6,788,404	453,433	--	128,353	7,370,190
Provision for uncollectible accounts	3,564,251	209,203	--	--	3,773,454
Professional fees and outsourced staffing	2,874,357	555,730	--	(64,242)	3,365,845
Depreciation and amortization	3,178,071	35,471	--	--	3,213,542
Purchased services	4,029,151	1,128,581	--	(1,526,310)	3,631,422
Supplies, drugs and patient care	7,042,738	87,983	--	--	7,130,721
Leases and service contracts	1,649,063	26,374	--	--	1,675,437
Occupancy costs	2,820,491	291,194	--	--	3,111,685
Insurance	894,280	284,235	--	--	1,178,515
Other expenses	4,475,162	223,848	--	--	4,699,010
Interest	1,495,715	--	--	--	1,495,715
Total Expenses	65,981,060	6,976,414	--	(878,768)	72,078,706
Loss from Operations	(379,708)	(2,030,134)	--	--	(2,409,842)

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING STATEMENT OF OPERATIONS (CONTINUED)

FOR THE YEAR ENDED SEPTEMBER 30, 2012

	Hospital	JPA	Development	Elimination	Total
Nonoperating Revenue (Loss)					
Investment income	$ 177,006	$ --	$ --	$ --	$ 177,006
Gain on sale of equipment	3,196	--	--	--	3,196
Equity earnings in joint ventures	250,254	--	--	--	250,254
	430,456	--	--	--	430,456
Excess (Deficiency) of Revenues over Expenses	$ 50,748	$ (2,030,134)	$ --	$ --	$ (1,979,386)

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2011

	Hospital	JPA	Development	Elimination	Total
Operating Revenue					
Net patient service revenues	$ 59,499,426	$ 5,082,869	$ --	$ --	$ 64,582,295
Grant and other income	589,869	912,760	--	(893,081)	609,548
Net assets released from restriction	33,994	--	--	--	33,994
Total Operating Revenues	60,123,289	5,995,629	--	(893,081)	65,225,837
Expenses					
Salaries	26,208,820	4,268,669	--	470,327	30,947,816
Employee benefits	6,820,412	573,409	--	101,892	7,495,713
Provision for uncollectible accounts	1,928,135	602,318	--	--	2,530,453
Professional fees and outsourced staffing	2,865,585	744,032	--	(51,744)	3,557,873
Depreciation and amortization	3,243,262	34,272	--	--	3,277,534
Purchased services	4,322,218	1,133,955	--	(1,413,556)	4,042,617
Supplies, drugs and patient care	6,946,973	89,081	--	--	7,036,054
Leases and service contracts	1,531,258	24,469	--	--	1,555,727
Occupancy costs	2,512,086	300,866	--	--	2,812,952
Insurance	866,257	448,372	--	--	1,314,629
Other expenses	2,851,463	119,413	--	--	2,970,876
Interest	1,480,694	--	--	--	1,480,694
Total Expenses	61,577,163	8,338,856	--	(893,081)	69,022,938
Loss from Operations	(1,453,874)	(2,343,227)	--	--	(3,797,101)

JOHNSON MEMORIAL HOSPITAL

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2011

	Hospital	JPA	Development	Elimination	Total
Nonoperating Revenue					
Investment income	$ 123,908	$ --	$ --	$ --	$ 123,908
Equity loss in joint ventures	(12,760)	--	--	--	(12,760)
	111,148	--	--	--	111,148
Loss Before Reorganization Items	(1,342,726)	(2,343,227)	--	--	(3,685,953)
Reorganization Items					
Gain on discharge of debt	1,094,678	--	--	--	1,094,678
	1,094,678	--	--	--	1,094,678
Excess (Deficiency) of Revenues over Expenses	$ (248,048)	$ (2,343,227)	$ --	$ --	$ (2,591,275)

The Manchester Memorial Hospital

Independent Auditors' Report and
Financial Statements

As of and for the Years Ended
September 30, 2012 and 2011

Saslow Lufkin & Buggy, LLP
Certified Public Accountants and Consultants

The Manchester Memorial Hospital
Independent Auditors' Report and Financial Statements
As of and for the Years Ended September 30, 2012 and 2011

Table of Contents

Independent Auditors' Report

To the Board of Trustees of
The Manchester Memorial Hospital:

We have audited the accompanying balance sheets of The Manchester Memorial Hospital (the Hospital) (a subsidiary of Eastern Connecticut Health Network, Inc.), as of September 30, 2012 and 2011 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 of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as 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 Manchester Memorial Hospital as of September 30, 2012 and 2011 and the results of its operations and changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Saslow Lufkin & Buggy, LLP

December 18, 2012

The Manchester Memorial Hospital
Balance Sheets
September 30, 2012 and 2011

	2012	2011
Assets		
Current assets:		
Cash and cash equivalents	**$ 6,414,687**	$ 10,880,739
Current portion of assets whose use is limited	**4,781,749**	803,195
Accounts receivable, less allowance for bad debts of $5,492,504 in 2012 and $3,450,113 in 2011	**26,534,856**	24,700,330
Inventory	**2,660,785**	2,591,838
Due from affiliates	**484,258**	419,887
Current portion of estimated settlements due from third-party payers	**3,549,365**	432,832
Prepaid expenses and other current assets	**2,028,449**	2,506,129
Total current assets	**46,454,149**	42,334,950
Assets whose use is limited - net of current portion:		
Donor restricted investments	**2,312,582**	1,677,029
Board designated investments	**7,434,591**	6,346,662
Investments held in trust for estimated self-insurance liabilities	**1,856,635**	2,438,807
Investments held under bond indentures	**3,258,804**	3,259,163
Beneficial interest in trust assets	**5,296,479**	4,800,923
Total assets whose use is limited - net of current portion	**20,159,091**	18,522,584
Interest in net assets of ECHN Community Healthcare Foundation, Inc.	**6,199,192**	3,872,533
Investments	**8,547,933**	7,217,602
Investments in joint ventures	**3,565,975**	3,719,835
Property, plant and equipment, net	**51,317,622**	52,084,498
Other assets:		
Estimated settlements due from third-party payers - net of current portion	**-**	1,306,869
Due from affiliated entities - net of current portion	**31,960,910**	20,842,090
Intangible assets - net	**-**	72,000
Other - net	**1,866,512**	1,856,527
Total other assets	**33,827,422**	24,077,486
Total assets	**$ 170,071,384**	$ 151,829,488
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 17,702,182**	$ 15,290,987
Line of credit	**6,500,000**	6,500,000
Current portion of long-term debt and capital lease obligations	**3,898,759**	3,467,143
Due to affiliated entities	**818,583**	2,283,655
Due to third-party payers	**1,343,126**	1,420,022
Current portion of accrued pension and other postretirement benefits	**2,733,125**	8,678,593
Other current liabilities	**2,426,820**	2,557,626
Total current liabilities	**35,422,595**	40,198,026
Long-term debt and capital lease obligations - net of current portion	**51,672,633**	49,708,745
Estimated self-insurance liabilities	**9,814,802**	5,736,899
Accrued pension and other postretirement benefits - net of current portion	**57,470,806**	43,370,197
Other liabilities	**684,775**	673,979
Total liabilities	**155,065,611**	139,687,846
Net assets:		
Unrestricted	**4,925,515**	3,473,307
Temporarily restricted	**1,905,069**	988,702
Permanently restricted	**8,175,189**	7,679,633
Total net assets	**15,005,773**	12,141,642
Total liabilities and net assets	**$ 170,071,384**	$ 151,829,488

The accompanying notes are an integral part of these financial statements.

The Manchester Memorial Hospital
Statements of Operations and Changes in Net Assets
For the Years Ended September 30, 2012 and 2011

	2012	2011
Revenues:		
Net patient service revenue	**$ 175,217,566**	$ 166,602,261
Change in interest in unrestricted net assets of ECHN Community Healthcare Foundation, Inc.	**2,035,698**	455,096
Other revenues	**15,303,250**	11,857,772
EHR incentive payment revenue	**2,206,302**	356,984
Net assets released from restrictions used for operations	**316,686**	478,506
Total revenues	**195,079,502**	179,750,619
Expenses:		
Salaries and wages	**81,549,825**	77,581,560
Fringe benefits	**24,867,252**	21,779,464
Supplies and other	**62,035,761**	58,149,870
Provision for bad debts	**6,382,307**	6,164,670
Depreciation and amortization	**6,896,812**	7,107,904
Interest and financing costs	**2,714,044**	2,539,198
Total expenses	**184,446,001**	173,322,666
Income from operations	**10,633,501**	6,427,953
Non-operating losses	**(868,637)**	(364,307)
Excess of revenues over expenses	**$ 9,764,864**	$ 6,063,646

The accompanying notes are an integral part of these financial statements.

The Manchester Memorial Hospital
Statements of Operations and Changes in Net Assets (continued)
For the Years Ended September 30, 2012 and 2011

	2012	2011
Unrestricted net assets:		
Excess of revenues over expenses	**$ 9,764,864**	$ 6,063,646
Change in unrealized appreciation (depreciation) on investments	**2,831,138**	(642,132)
Net change on interest rate swap agreement	**(123,039)**	167,734
Equity transfer from ECHN	**1,904,338**	1,681,231
Change in investment of ECHN Community Healthcare Foundation, Inc.	**530,769**	(269,412)
Transfers to other affiliated entities	**(310,801)**	(147,612)
Net assets released from restrictions used for capital	**231,566**	1,652,194
Pension and postretirement-related adjustments	**(13,376,627)**	(10,396,040)
Change in unrestricted net assets	**1,452,208**	(1,890,391)
Temporarily restricted net assets:		
Change in interest in net assets of ECHN Community Healthcare Foundation, Inc.	**450,324**	297,000
Investment income	**18,520**	17,339
Net assets released from restrictions for operations	**(316,686)**	(478,506)
Net assets released from restrictions used for capital	**(231,566)**	(1,652,194)
Change in unrealized appreciation (depreciation) on investments	**345,177**	(14,871)
Transfers from ECHN and other affiliates	**650,598**	915,801
Change in temporarily restricted net assets	**916,367**	(915,431)
Permanently restricted net assets:		
Change in beneficial interest in trust assets	**495,556**	(243,923)
Change in permanently restricted net assets	**495,556**	(243,923)
Change in net assets	**2,864,131**	(3,049,745)
Net assets at beginning of year	**12,141,642**	15,191,387
Net assets at end of year	**$ 15,005,773**	$ 12,141,642

The accompanying notes are an integral part of these financial statements.

The Manchester Memorial Hospital
Statements of Cash Flows
For the Years Ended September 30, 2012 and 2011

	2012	2011
Cash flows from operating activities:		
Change in net assets	**$ 2,864,131**	$ (3,049,745)
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities:		
Depreciation and amortization	**6,896,812**	7,107,904
Amortization of bond costs related to Series B defeasement	**-**	26,692
Provision for bad debts	**6,382,307**	6,164,670
Change in unrealized (appreciation) depreciation on investments	**(3,176,315)**	668,880
Income on investments in joint ventures	**(667,525)**	(444,056)
Transfers from other affiliated entities	**(2,244,135)**	(2,449,420)
Change in interest in net assets of ECHN Community Healthcare Foundation, Inc.	**(2,326,659)**	980,370
Change in beneficial interest in trust assets	**(495,556)**	243,923
Pensions and postretirement-related adjustments	**13,376,627**	10,396,040
Loss on disposal of assets	**-**	63,430
Net change on interest rate swap	**4,808**	(182,676)
Changes in assets and liabilities:		
Accounts receivable, net	**(8,216,833)**	(6,358,231)
Inventory	**(68,947)**	(21,747)
Prepaid expenses and other current assets	**477,680**	109,193
Estimated settlements due to/from third-party payers	**(1,886,560)**	305,259
Due (to) from affiliated entities	**(12,227,278)**	(5,870,383)
Intangible assets - net	**72,000**	108,000
Other - net	**(52,874)**	(765,385)
Accounts payable and accrued expenses	**2,411,195**	(713,024)
Accrued pension and other post-retirement benefits	**(5,221,486)**	(3,550,995)
Estimated self-insurance liabilities	**4,077,903**	(402,579)
Other liabilities	**(124,818)**	1,057,630
Net cash (used in) provided by operating activities	**(145,523)**	3,423,750
Cash flows from investing activities:		
Purchases of property, plant and equipment	**(5,202,968)**	(7,386,712)
Purchases of investments	**(8,011,840)**	(4,234,038)
Investments in joint ventures	**(44,600)**	(35,000)
Distributions from joint ventures	**445,000**	585,000
Proceeds from sales of investments and assets whose use is limited	**4,738,112**	3,900,481
Net cash used in investing activities	**(8,076,296)**	(7,170,269)
Cash flows from financing activities:		
Principal payments on long-term debt	**(10,033,716)**	(4,682,252)
Net borrowings on lines of credit	**-**	1,500,000
Payments for bond issuance costs	**(154,652)**	(72,026)
Payment for termination of interest rate swaps	**-**	(153,423)
Transfers from (to) other affiliated entities	**2,244,135**	2,449,420
Proceeds from issuance of debt	**11,700,000**	8,589,456
Net cash provided by financing activities	**3,755,767**	7,631,175
Change in cash and cash equivalents	**(4,466,052)**	3,884,656
Cash and cash equivalents at beginning of year	**10,880,739**	6,996,083
Cash and cash equivalents at end of year	**$ 6,414,687**	$ 10,880,739
Cash paid for interest	**$ 1,621,018**	$ 2,303,602
Equipment acquisitions under capital lease arrangements	**$ 700,650**	$ 6,574,956

The accompanying notes are an integral part of these financial statements.

The Manchester Memorial Hospital
Notes to the Financial Statements
As of and for the Years Ended September 30, 2012 and 2011

Note 1 - General

Organization - The Manchester Memorial Hospital (the Hospital or MMH) is a not-for-profit, 249-bed acute care hospital that provides inpatient, outpatient and emergency care services for residents of Manchester and surrounding towns. The Hospital is a subsidiary of Eastern Connecticut Health Network, Inc. (ECHN or the Network), which was formed in 1995 by a merger of MMH Corp. and Rockville Area Health Services, Inc. ECHN was organized to provide a broader health care system for the surrounding communities with quality medical care at a reasonable cost and to foster an environment conducive to health and well-being whether in the home or in the community.

Other related entities of MMH include:

The Rockville General Hospital, Inc. (RGH) - RGH is a not-for-profit hospital with 102 licensed beds, located in the Rockville section of Vernon, Connecticut. RGH, which admitted its first patient in 1921, is a short-term, acute care general hospital, which provides inpatient, outpatient and emergency care services for residents of Tolland County and nearby towns, for a total service area of 19 towns.

ECHN ElderCare Services, Inc. (EES) - EES is a not-for-profit, skilled nursing facility with 130 licensed beds and physical, occupational and speech rehabilitation services located in Tolland, Connecticut.

ECHN Community Healthcare Foundation, Inc. (ECHF) - ECHF is a not-for-profit organization, whose purpose is to raise funds on behalf of ECHN and its not-for-profit subsidiaries. It was established in 2000, when the fund-raising efforts of ECHN were consolidated into a single not-for-profit foundation. ECHF focuses primarily on the capital and program needs of ECHN and its not-for-profit subsidiaries.

Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) - ECMPF is a not-for-profit organization that currently operates physician office practices in the Network's service area and a hospitalist program that serves MMH and RGH. Its mission allows it to operate other not-for-profit, separately incorporated allied health ventures.

ECHN Enterprises, Inc. (Enterprises) - Enterprises is a for-profit organization formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. Enterprises owns, leases and has an interest in real estate to support the mission and vision of ECHN. It is also the parent corporation of Haynes Street Property Management, LLC (HSPM). HSPM is a for-profit, limited liability company formed under the laws of the State of Connecticut, which manages the Glastonbury Wellness Center and sublets space to various MMH departments and physician offices, as well as to ECMPF.

Visiting Nurse and Health Services of Connecticut (VNHSC) - VNHSC is a not-for-profit, nonstock Connecticut corporation that provides and administers a comprehensive, multi-disciplinary home health program, hospice program and wellness programs to promote the health of individuals, families and groups in the Greater Northern Central Connecticut area. In addition, VNHSC is the sole member of A Caring Hand, LLC, which is a for-profit Connecticut limited liability company providing and administering homemaker, companion, live-in and personal care assistance services to individuals and families in the Greater Northern Central Connecticut area.

Note 1 - General (continued)

Connecticut Healthcare Insurance Company (CHIC) - CHIC, a captive insurance company, provides hospital and physician professional and general liability coverage to MMH, RGH, EES and all other subsidiaries of ECHN.

ECHN and each of its subsidiaries, except for Enterprises, CHIC and A Caring Hand, LLC, are separate Connecticut not-for-profit corporations, qualified as exempt organizations under Section 501(c)(3) of the Internal Revenue Code (IRC) and governed by separate Boards of Trustees (the Board) - although the membership of the ECHN, MMH, and RGH boards are currently identical. ECHN, acting through its Board of Trustees, is the sole member of each of its subsidiaries.

ECHN has various powers with regard to each of its members, which include approving all operating and capital budgets; controlling the investment of funds, location of services, agreements and transactions, affiliations, controlling changes, amendments or restatements of certificates of incorporation and bylaws, electing trustees and officers, appointing committees, adopting a system-wide vision and strategic plans and approving debt borrowings.

Note 2 - Summary of Significant Accounting Policies

Basis of Presentation - The accompanying financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC).

Use of Estimates - The preparation of financial statements in conformity with 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.

The Hospital's significant estimates relate to the valuation of investments and interest rate swap agreements, allowance for doubtful patient accounts receivable, contractual allowances on patient accounts receivables, self-insurance liabilities, estimated settlements due to and from third parties, conditional asset retirement obligations, postretirement and pension benefit costs and the related obligations.

Cash and Cash Equivalents - The Hospital considers all highly liquid investments with original maturities of three months or less at date of purchase to be cash equivalents, excluding amounts whose use is limited or restricted by Board designation or other arrangements under trust agreements. Cash equivalents include money market funds. In general, the Federal Deposit Insurance Corporation (FDIC) insures cash balance up to $250,000 per depositor, per bank. The FDIC also provides separate unlimited coverage for deposit accounts that meet the definition of non-interest bearing accounts. Unlimited coverage on non-interest bearing accounts extends until December 31, 2012. At times, the Hospital maintains cash balances that are in excess of the insured FDIC limits. The Hospital maintains its cash at various banks and it is the Hospital's policy to monitor the financial strength of the banks on an ongoing basis.

Money market funds are not insured by the FDIC and are not a risk-free investment. Money market funds invest in a variety of instruments including mortgage-backed and asset-backed securities. Although a money market fund seeks to preserve its $1 per share value, it is possible that a money market fund's value can decrease below $1 per share.

Note 2 - Summary of Significant Accounting Policies (continued)

Net Assets - Resources are reported for accounting purposes in separate classes of net assets based on the existence or absence of donor-imposed restrictions. In the accompanying financial statements, net assets that have similar characteristics have been combined as follows:

> ***Permanently Restricted -*** Net assets subject to explicit donor-imposed stipulations that they be maintained by the Hospital in perpetuity are classified as permanently restricted. Such permanently restricted net assets include endowment funds and the Hospital's share of its beneficial interest in trust assets held by third parties. Generally, the donors of these assets permit the Hospital to use all or part of the investment return on these assets for operating purposes.
>
> ***Temporarily Restricted -*** Net assets whose use by the Hospital is subject to explicit donor-imposed stipulations that can be fulfilled upon incurrence of expenditures by the Hospital pursuant to those stipulations or that expire by the passage of time are classified as temporarily restricted.
>
> ***Unrestricted -*** Net assets that are not subject to explicit donor-imposed stipulations are classified as unrestricted. Unrestricted net assets may be designated for specific purposes by action of the Board or may otherwise be limited by contractual agreements with outside parties. Such designated assets are classified as assets whose use is limited in the accompanying balance sheets.
>
> Revenues are reported as increases in unrestricted net assets, unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets, unless their use is restricted by explicit donor stipulations or by law. Expirations of temporary restrictions on net assets, that is, the donor-imposed stipulated purpose has been accomplished and/or stipulated period has elapsed, are reported as reclassifications between the applicable classes of net assets.
>
> Contributions, including unconditional promises to give, are recognized as revenues at the date the promise is received. Contributions of assets other than cash are recorded at their estimated fair value. Contributions to be received after one year are discounted at the appropriate rate commensurate with the risks involved. Amortization of the discount is included in other revenues. Contributions restricted for the acquisition of land, buildings and equipment are reported as temporarily restricted support. These contributions are reclassified to unrestricted net assets when the capital asset is acquired or constructed and placed in service.

Assets Whose Use is Limited - Assets whose use is limited primarily include cash and investments held by trustees under indenture agreements, Board designated investments which include endowments and cash and investments set aside by the Board for future capital improvements over which the Board retains control and may, at its discretion, subsequently use for other purposes, beneficial interests in trust assets, donor restricted and other restricted investments. Amounts required to meet current liabilities of the Hospital have been classified as current assets in the balance sheets as of September 30, 2012 and 2011.

The income earned on restricted funds is generally available for operations of the Hospital and is recorded as revenue in unrestricted net assets, unless restricted by the donor or to pay future split interest obligations, at which time the income is added to the appropriate restricted net asset balance. However, if a specific gift instrument explicitly requires the permanent reinvestment of appreciation, or a portion thereof, such reinvested amounts are recorded within permanently restricted net assets. There were no gifts with reinvestment restrictions for the years ended September 30, 2012 and 2011.

Note 2 - Summary of Significant Accounting Policies (continued)

The Hospital relies on a balanced strategy in which endowment returns are achieved through both capital appreciation and interest and dividends. The Hospital targets a diversified asset allocation of fixed income mutual funds, fixed income equity funds and money market funds.

Assets received as donations or bequests are recorded as contributions on the date received at the estimated fair value. The average cost method is used to determine realized gains or losses on sales of marketable equity securities.

Beneficial Interest in Trust Assets - MMH has been named sole or participating beneficiary in several perpetual trusts, for which third parties act as the trustee. Under the terms of these trusts, MMH has the irrevocable right to receive the income earned on the trust assets in perpetuity. The estimated present value of the future payments to MMH is recorded at the fair value of the assets held in the trust as beneficial interest in trust assets and is classified as permanently restricted.

The income from the trusts is included in the change in interest in net assets of ECHF as unrestricted and temporarily restricted support. For the years ended September 30, 2012 and 2011, income of $335,202 and $190,251, respectively, was recorded in the statements of operations and changes in net assets. Changes in the fair value of the trust assets are recognized as changes in permanently restricted net assets. MMH records the beneficial interest in trust assets when it is notified of the existence of the trust or when information becomes available to record the fair value of the trust assets.

Investments - The Hospital's investment portfolio is classified as available for sale, with unrealized gains and losses excluded from the excess of revenues over expenses, unless the losses are deemed to be other than temporary. Investments in equity securities with readily determinable fair values and all investments in mutual funds are measured at fair value in the balance sheets.

Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses, unless the income or loss is restricted by donor or law.

Other Than Temporary Impairments on Investments - The Hospital accounts for other than temporary impairments in accordance with FASB ASC 320 and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other than temporary. The Hospital has recorded an impairment charge of $0 and $68,497 for the years ended September 30, 2012 and 2011, related to investments held by CHIC.

Property, Plant and Equipment - Property, plant and equipment are stated at cost or, in the case of donated property, at fair value at the date of the gift, less accumulated depreciation and amortization. Major improvements and betterments to existing plant and equipment are capitalized. Expenditures for maintenance and repairs that do not extend the lives of the applicable assets are charged to expense as incurred. Upon disposition or retirement of property, plant and equipment, the cost and related accumulated depreciation and amortization are eliminated from the respective accounts and any resulting gain or loss is included within income or loss from operations.

Note 2 - Summary of Significant Accounting Policies (continued)

Depreciation expense is computed on a straight-line basis over the estimated useful lives as follows:

Buildings	10 - 40 years
Building improvements	5 - 40 years
Machinery and equipment	3 - 15 years
Furniture and fixtures	5 - 20 years

Equipment under capital leases is amortized utilizing the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Depreciation and amortization expense was $6,184,479 and $6,439,247 for the years ended September 30, 2012 and 2011, respectively.

Interest cost incurred on borrowed funds during the construction period of capital assets is capitalized as a component of the cost of acquiring those assets.

Physician loan amortization totaling $106,673 and $138,863 for the years ended September 30, 2012 and 2011, respectively, are included within depreciation and amortization in the accompanying statements of operations and changes in net assets.

Gifts of property and equipment are reported as unrestricted support and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of property and equipment with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire property and equipment are reported as restricted support. Absent explicit donor stipulations about how long those property and equipment must be maintained, expirations of donor restrictions are reported as released from restrictions when the donated or acquired property and equipment assets are placed in service.

Investments in Joint Ventures **-** The Hospital has invested in joint ventures, which are accounted for under the equity method of accounting. These joint ventures include the Hospital's investment in the following:

	2012	Ownership Percentage	2011	Ownership Percentage
Northeast Regional Radiation Oncology Network, Inc.	**$ 3,055,158**	**25%**	$ 2,819,068	25%
Evergreen Endoscopy Center, LLC	**397,153**	**50%**	381,284	50%
Evergreen Imaging Center, LLC	**-**	**0%**	358,201	50%
Medical Practice Partners, LLC	**41,269**	**50%**	121,637	50%
Tolland Imaging Center	**72,395**	**35%**	39,645	35%
Total	**$ 3,565,975**		$ 3,719,835	

Distributions from these joint ventures for the years ended September 30, 2012 and 2011 was $445,000 and $585,000, respectively. The Hospital's share of the earnings of the joint venture is reported as other revenues and is $667,525 and $444,056 for the years ended September 30, 2012 and 2011, respectively.

Note 2 - Summary of Significant Accounting Policies (continued)

Summarized financial information from the financial statements of these organizations as of September 30, 2012 and 2011, and for the years then ended, is as follows:

2012	Total Assets	Net Assets	Change in Net Assets	Excess (Deficiency) of Revenues Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 12,257,336	$ 12,220,632	$ 944,362	$ 961,990
Evergreen Endoscopy Center, LLC	$ 2,199,308	$ 793,946	$ 31,378	$ 731,378
Medical Practice Partners, LLC	$ 1,569,742	$ 185,290	$ (57,983)	$ (127,183)
Tolland Imaging Center	$ 1,258,554	$ 214,706	$ 101,436	$ 100,840

2011	Total Assets	Net Assets	Change in Net Assets	Excess (Deficiency) of Revenues Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 14,987,787	$ 11,276,270	$ (24,696)	$ (24,809)
Evergreen Endoscopy Center, LLC	$ 2,511,718	$ 762,568	$ 762,568	$ 668,513
Evergreen Imaging Center, LLC	$ 1,210,664	$ 716,401	$ 111,908	$ 232,726
Medical Practice Partners, LLC	$ 1,459,023	$ 243,273	$ 64,960	$ 44,960
Tolland Imaging Center	$ 1,696,739	$ 113,270	$ 28,745	$ (52,019)

Unamortized Bond Issue Costs **-** Financing costs associated with the issuance of long-term debt are amortized over the term of the bonds using the effective interest method. Amortization is included in interest and financing costs in the accompanying statements of operations and changes in net assets and the unamortized carrying value is recorded within other - net in the accompanying balance sheets.

Intangible Assets **-** Intangible assets, principally license enhancements, are amortized over the life of the respective intangible property. On average, this amortization period for license enhancements is 5 years. Amortization is included in depreciation and amortization in the accompanying statements of operations and changes in net assets and the unamortized carrying value is recorded within intangible assets - net in the accompanying balance sheets. Any residual value remaining after the amortization period is considered insignificant.

Excess of Revenues Over Expenses **-** The statements of operations and changes in net assets include the excess of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues over expenses, consistent with industry practice, include changes in unrealized appreciation (depreciation) on investments, net gain (loss) on interest rate swap that qualifies for hedge accounting; net assets released from restrictions used for capital acquisitions; pension and postretirement-related adjustments; transfers to and from affiliates and other changes in net assets.

Note 2 - Summary of Significant Accounting Policies (continued)

For purposes of display, transactions deemed by management to be ongoing, major or central to providing of health care services are reported as operating revenues and operating expenses. Operating revenues include net patient service revenue, grant income and investment income. Peripheral or incidental transactions are reported as non-operating gains and losses. Non-operating gains and losses include investment income and expenses related to property management, realized gains and losses on sales of investments, losses recognized on investments representing declines in value considered to be other-than-temporary in nature, gains and losses related to the termination of certain swap instruments, changes in the fair values of interest rate swaps that do not qualify for hedge accounting (net interest expense) and the costs associated with pursuing business combinations.

Charity Care **-** The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established and contractual rates. The Hospital does not pursue collection of amounts determined to qualify as charity care; as such, these amounts are not reported as revenue.

Deferred Revenue **-** Deferred revenue represents payments received for the services to be rendered in the next fiscal year and is recorded within other current liabilities in the accompanying balance sheets.

Net Patient Service Revenue **-** Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. 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.

Contracts, laws and regulations governing Medicare, Medicaid, Blue Cross and the uncompensated care pool programs in the State of Connecticut are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital records adjustments to the amounts accrued for estimated settlements related to prior years.

The Hospital has agreements with third-party payers that provide for payments at amounts different from its established rates. A summary of the payment agreements with major third-party payers is as follows:

> ***Medicare*** **-** Acute care hospitals are subject to a federal prospective payment system for most Medicare inpatient hospital services and for certain outpatient services. Under this prospective payment methodology, Medicare pays a prospectively determined per-discharge or per-visit rate for non-physician services. These rates vary according to the Diagnosis Related Group or Ambulatory Payment Classification of each patient.
>
> Inpatient rehabilitation and mental health services, outpatient services, capital and medical education costs related to Medicare beneficiaries are paid based on a prospective payment system, subject to certain limitations. Certain other outpatient services are reimbursed according to fee screens.
>
> ***Medicaid*** **-** Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost-reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital.
>
> ***Other Payers*** **-** The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment under these agreements includes rates per discharge, discounts from established charges, per diem rates and fee schedule payments.

Note 2 - Summary of Significant Accounting Policies (continued)

Health Care Industry **-** The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to further governmental review and interpretation as well as regulatory actions unknown or unasserted at this time.

EHR Incentive Payment Revenue **-** The American Recovery and Reinvestment Act of 2009 authorized the Centers for Medicare and Medicaid Services (CMS) to award incentive payments to eligible health care providers who demonstrate Meaningful Use of certified electronic health records (EHR). These incentive programs are designed to support providers in this period of health information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care. Total received for Medicare amounted to $1,880,890 and $0, respectively, and the total received for Medicaid amounted to $325,412 and $356,984, respectively, for the years ended September 30, 2012 and 2011.

Future Operations **-** Current trends in the health care industry include mergers and other forms of affiliations among providers, increasing shifts to managed care, overall reduction in inpatient average length of stay, increasingly restrictive reimbursement policies by governmental and private payers and the prospect of significant changes in legislation at the state and national level. Management cannot assess or project the ultimate effect of these or other items on the future operations of the Hospital.

Interest in Net Assets of ECHF **-** ECHF was formed as a not-for-profit organization to supervise the development activities and engage in investment activities for the benefit of all of the ECHN subsidiaries. ECHN is the sole member of ECHF and ECHF's Board of Directors is appointed by ECHN. The Hospital follows the provisions of FASB ASC 958 (formerly, FASB Statement No. 136, "*Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises or Holds Contributions for Others*"). Accordingly, the Hospital has reflected its proportionate interest in the net assets of ECHF in the Hospital's financial statements.

Income Taxes **-** The Hospital is a not-for-profit organization, which is in compliance with the provisions of Internal Revenue Code (IRC) Sec. 501(c)(3) and is exempt from federal tax under IRC Sec. 501(a). At times, the Hospital is involved with activities that subject minor amounts of unrelated business federal income tax, which are paid as they come due in accordance with the IRC and the regulations there under. Such amounts are insignificant to the Hospital's financial statements.

The Hospital accounts for uncertain tax positions in accordance with provisions of FASB ASC 740, "*Income Taxes*" which provides a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their financial statements. The Hospital may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Hospital does not have any uncertain tax positions as of September 30, 2012 and 2011. As of September 30, 2012 and 2011, the Hospital did not record any penalties or interest associated with uncertain tax positions. The Hospital's prior three tax years are open and subject to examination by the Internal Revenue Service.

Note 2 - Summary of Significant Accounting Policies (continued)

Asset Retirement Obligations **-** The Hospital recognizes a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and/or method of settlement of a conditional asset retirement obligation is factored into the measurement of the liability when sufficient information exists. The types of asset retirement obligations that the Hospital recognizes are those for which the Hospital has a legal obligation to perform an asset retirement activity, however, the timing and/or method of settling the obligation are conditional on a future event that may or may not be within its control. The fair value of a liability for the legal obligation associated with an asset retirement is recorded in the period in which the obligation is incurred. When the liability is initially recorded, the cost of the asset retirement is capitalized.

As of September 30, 2012 and 2011, the Hospital has recognized $272,109 and $266,121, respectively, as an obligation to remove asbestos from various buildings upon retirement. This total is included in the balance sheets within other liabilities.

Accounting for Defined Benefit Pension and Other Postretirement Plans **-** The Hospital recognizes the overfunded or underfunded status of their defined-benefit pension and other postretirement benefit plans (collectively, "postretirement benefit plans") in the balance sheets as an asset or liability. The Hospital recognizes changes in the funded status of the plans in the year in which the changes occur as a change in unrestricted net assets presented below the excess of revenues over expenses in its statements of operations and changes in net assets.

Inventory **-** The Hospital records inventory at cost using the first-in, first-out method.

Impairment of Long-Lived Assets **-** Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed are reported at the lower of carrying amount or fair value, less cost to sell.

Estimated Self-Insurance Liabilities **-** The liabilities for outstanding losses and loss related expenses and the related provision for losses and loss related expenses include estimates for malpractice losses, general liability and workers' compensation incurred but not reported claims, as well as losses pending settlement. Such liabilities are necessarily based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be in excess of or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making such estimates and the resulting liability are actuarially reviewed on an annual basis, and any adjustments required are reflected in operations in the current period. The current portion of estimated self-insurance liabilities is recorded within other current liabilities in the accompanying balance sheets.

Concentration of Credit Risk **-** Financial instruments which potentially subject the Hospital to concentration of credit risk consist of accounts receivable, investments, including temporary cash investments, marketable equity and debt securities, mutual funds, government securities and interest rate swap agreements. The Hospital receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payers, including Medicare (a federal program), Medicaid (a State of Connecticut program) and various health insurance companies.

Interest Rate Swap Agreements **-** Interest rate swap agreements are recognized as either assets or liabilities in the balance sheet at fair value regardless of the purpose or intent for holding them. Changes in the fair value of interest rate swap agreements are recognized in non-operating losses or if designated and effective as hedge transactions, as changes in unrestricted net assets.

Note 2 - Summary of Significant Accounting Policies (continued)

Advertising Costs **-** The Hospital expenses advertising costs the first time the advertising takes place. The total amount charged to advertising expense was $1,066,330 and $1,148,031 for the years ended September 30, 2012 and 2011, respectively, and is recorded in supplies and other in the accompanying statements of operations and changes in net assets.

Accounting Pronouncements Adopted **-** In August 2010, the FASB issued Accounting Standards Update (ASU) No. 2010-23, "*Health Care Entities (Topic 954): Measuring Charity Care for Disclosure*". ASU No. 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU No. 2010-23 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct or indirect cost of providing the charity care, and requires disclosure of the method used to identify or determine such costs. This ASU is effective for fiscal years beginning after December 15, 2010, with retrospective application required. The Hospital's adoption of ASU 2010-23 did not have a material impact on its overall financial statements.

In August 2010, the FASB issued ASU No. 2010-24, "*Health Care Entities (Topic 954) Presentation of Insurance Claims and Related Insurance Recoveries*". ASU No. 2010-24 clarifies that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010. The Hospital's adoption of ASU 2010-24 resulted in the recording of additional claims liabilities and insurance recoveries from CHIC in the amount of $7,825,000 and $3,795,000 as of September 30, 2012 and 2011, respectively, which resulted in increasing the due from affiliates and the estimated self insurance liabilities.

Pending Accounting Pronouncements - In May 2011, the FASB issued ASU No. 2011-04, "*Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRS*". ASU No. 2011-04 amends certain guidance in ASC 820, "*Fair Value Measurement*". ASU 2011-04 expands ASC 820's existing disclosure requirements for fair value measurements and makes other amendments. ASU 2011-04 is effective for interim and annual reporting periods beginning after December 15, 2011 and will be applied on a prospective basis. The Hospital is currently evaluating the effect that the provisions of ASU 2011-04 will have on the Hospital's financial statements.

In July 2011, the FASB issued ASU No. 2011-07, "*Health Care Entities (Topic 954), Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*". ASU 2011-07 requires a health care entity to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenues from an operating expense to a deduction from patient service revenues (net of contractual allowances and discounts). Additionally, enhanced disclosures about an entity's policies for recognizing revenue, assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts are required. ASU 2011-07 is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2012. The Hospital does not believe adoption of ASU 2011-07 will have a material impact on its overall financial statements.

Reclassification **-** Certain amounts in the 2011 financial statements have been reclassified to conform to the 2012 presentation. These reclassifications had no material effect on the financial statements.

Subsequent Events **-** Subsequent events have been evaluated through December 18, 2012, the date through which procedures were performed to prepare the financial statements for issuance. Management believes that there are no subsequent events having a material impact on the financial statements.

Note 3 - Assets Whose Use is Limited and Investments

Assets whose use is limited and investments as of September 30, 2012 and 2011, include the following:

	2012		2011	
	Cost	**Fair Value**	**Cost**	**Fair Value**
Board designated and donor-restricted:				
Mutual funds:				
Dodge & Cox Balanced Fund	**$ 3,896,120**	**$ 4,367,798**	$ 3,896,121	$ 3,569,763
Vanguard Wellington Fund	**4,668,043**	**5,379,375**	4,517,303	4,453,928
Total	**$ 8,564,163**	**$ 9,747,173**	$ 8,413,424	$ 8,023,691
Investments held in trust for estimated self-insurance liabilities:				
Money market funds	**$ 120,455**	**$ 120,455**	$ 415,571	$ 415,571
Short-term bond fund	-	-	78,504	79,743
Moderate allocation fund	**1,406,063**	**1,736,180**	1,831,333	1,943,493
Total	**$ 1,526,518**	**$ 1,856,635**	$ 2,325,408	$ 2,438,807
Investments held under bond indentures:				
Money market funds	**$ 7,375,683**	**$ 7,375,683**	$ 3,505,751	$ 3,505,751
U.S. government securities	**665,384**	**664,870**	557,619	556,607
Total	**$ 8,041,067**	**$ 8,040,553**	$ 4,063,370	$ 4,062,358
Beneficial interest in trust assets	**$ 4,692,910**	**$ 5,296,479**	$ 4,908,298	$ 4,800,923
Investments:				
Money market funds	**$ 413,350**	**$ 413,350**	$ 362,494	$ 362,494
Mutual funds:				
Foreign large growth fund	**2,011,719**	**2,349,011**	2,005,524	1,929,010
Value index fund	**2,202,039**	**2,085,213**	2,148,454	1,623,315
Short-term bond fund	**1,689,477**	**1,720,441**	1,648,366	1,646,482
Moderate allocation funds	**1,745,366**	**1,979,918**	1,677,870	1,656,301
Total	**$ 8,061,951**	**$ 8,547,933**	$ 7,842,708	$ 7,217,602
Total assets whose use is limited and investments	**$ 30,886,609**	**$ 33,488,773**	$ 27,553,208	$ 26,543,381

Note 3 - Assets Whose Use is Limited and Investments (continued)

The fair values and gross unrealized losses for all investment categories whose fair value is below its cost and the length of time that the securities have been in an unrealized loss position as of September 30, 2012 and 2011, are as follows:

2012	**Less than 12 months**		**Greater than 12 months**		**Total**	
	Fair Value	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Large value fund	**$ -**	**$ -**	**$ 2,085,213**	**$ (116,825)**	**$ 2,085,213**	**$ (116,825)**
U.S. government securities	**-**	**-**	**664,870**	**(514)**	**664,870**	**(514)**
	$ -	**$ -**	**$ 2,750,083**	**$ (117,339)**	**$ 2,750,083**	**$ (117,339)**

2011	**Less than 12 months**		**Greater than 12 months**		**Total**	
	Fair Value	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Short-term bond fund	$ 1,619,149	$ (2,217)	$ -	$ -	$ 1,619,149	$ (2,217)
Foreign large growth fund	1,929,010	(76,514)	-	-	1,929,010	(76,514)
Value index fund	-	-	1,623,315	(525,139)	1,623,315	(525,139)
U.S. government securities	556,607	(1,012)	-	-	556,607	(1,012)
Moderate allocation funds	4,453,928	(63,375)	4,875,711	(376,336)	9,329,639	(439,711)
	$ 8,558,694	$ (143,118)	$ 6,499,026	$ (901,475)	$ 15,057,720	$ (1,044,593)

The Hospital's unrealized losses on its investments in mutual funds consist mostly of unrealized losses in the Vanguard Group, U.S. government securities and Dodge & Cox diversified equity mutual funds as of September 30, 2012 and 2011. The Hospital has evaluated the near-term prospects of the investments in relation to the severity of the impairment (fair value is approximately 1% to 6% and 1% to 24% less than cost as of September 30, 2012 and 2011, respectively) and recent market trends. Based on that evaluation and the Hospital's ability and intent to hold those investments for a reasonable period of time sufficient for a forecasted recovery of fair value, the Hospital does not consider those investments to be other-than-temporarily impaired as of September 30, 2012 and 2011.

Interest and dividend income on the assets whose use is limited and investments included within other revenues on the statements of operations and changes in net assets totaled $459,119 and $469,526 for the years ended September 30, 2012 and 2011, respectively. There were no realized gains or losses for the year ended September 30, 2012 and 2011.

Note 4 - Fair Value Measurements

FASB ASC 820 provides a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

Note 4 - Fair Value Measurements (continued)

The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has specified (contractual) terms, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

The following table presents the financial instruments carried at fair value as of September 30, 2012 and 2011, by the valuation hierarchy.

2012	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 7,909,488	$ -	$ -	$ 7,909,488
U.S. government securities	664,870	-	-	664,870
Mutual funds:				
Short-term bond fund	1,720,441	-	-	1,720,441
Foreign large growth fund	2,349,011	-	-	2,349,011
Value index fund	2,085,213	-	-	2,085,213
Moderate allocation funds	13,463,271	-	-	13,463,271
Beneficial interest in trust assets	-	-	5,296,479	5,296,479
Total assets at fair value	$ 28,192,294	$ -	$ 5,296,479	$ 33,488,773
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 412,666	$ -	$ 412,666
Total liabilities at fair value	$ -	$ 412,666	$ -	$ 412,666

Note 4 - Fair Value Measurements (continued)

2011	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 4,283,816	$ -	$ -	$ 4,283,816
U.S. government securities	556,607	-	-	556,607
Mutual funds:				
Short-term bond fund	1,726,225	-	-	1,726,225
Foreign large growth fund	1,929,010	-	-	1,929,010
Value index fund	1,623,315	-	-	1,623,315
Moderate allocation funds	11,623,485	-	-	11,623,485
Beneficial interest in trust assets	-	-	4,800,923	4,800,923
Total assets at fair value	$ 21,742,458	$ -	$ 4,800,923	$ 26,543,381
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 407,858	$ -	$ 407,858
Total liabilities at fair value	$ -	$ 407,858	$ -	$ 407,858

During the year ending September 30, 2012 and 2011, the value of the beneficial interest in trusts increased (decreased) for a change in market value of $830,578 and ($53,672) respectively. In addition, the Hospital received $335,202 and $190,251 in distributions from these trusts in 2012 and 2011, respectively.

The Hospital's valuation methodologies used to measure financial assets and liabilities at fair value are outlined below. Where applicable, the Hospital uses quoted prices in active markets for identical assets and liabilities to determine fair value (Level 1 inputs). This pricing methodology applies to money market funds, short-term bonds, foreign large growth funds, value index funds, moderate allocation funds and U.S. government securities.

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). The Level 2 classification includes the interest rate swap agreements. The interest rate swap agreements are valued based on a determination of market expectations relating to the future cash flows associated with the swap contract using sophisticated modeling based on observable market-based inputs, such as interest rate curves.

Assets and liabilities that are valued using significant unobservable inputs, such as extrapolated data, proprietary models, or indicative quotes that cannot be corroborated with market data are classified in Level 3 within the fair value hierarchy. The Level 3 classification includes the Hospital's beneficial interest in trusts. The value of the Hospital's assets is based on total fund values and the Hospital's corresponding beneficiary percentage.

Fair values of the Hospital's Series A and C Bonds are based on current traded value. The fair value of the Series A and C Bonds as of September 30, 2012 and 2011, is approximately $31,677,423 and $30,657,329, respectively. The fair value of the Hospital's remaining long-term debt approximates its carrying value.

Note 4 - Fair Value Measurements (continued)

As of September 30, 2012 and 2011, the Hospital's other financial instruments included accounts receivable, accounts payable and accrued expenses and estimated settlements due from (to) third-party payers. The carrying amounts reported in the balance sheets for these financial instruments approximate their fair value.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Note 5 - Property, Plant and Equipment

Property, plant and equipment as of September 30, 2012 and 2011, consists of the following:

	2012	2011
Land and land improvements	**$ 2,852,720**	$ 2,852,720
Building and building improvements	**91,468,958**	90,405,970
Fixed equipment	**16,360,083**	16,231,441
Moveable equipment	**81,803,222**	78,151,293
	192,484,983	187,641,424
Less: accumulated depreciation and amortization	**(143,593,395)**	(137,494,546)
	48,891,588	50,146,878
Construction in progress	**2,426,034**	1,937,620
Total	**$ 51,317,622**	$ 52,084,498

For the years ended September 30, 2012 and 2011, the Hospital capitalized interest related to construction financed with tax-exempt debt of $53,729 and $37,080, respectively. The cost to complete the construction in progress is approximately $4,135,000 and $2,500,000 as of September 30, 2012 and 2011, respectively.

Note 6 - Unamortized Bond Issue Costs

Unamortized bond issue costs that are recorded within other - net in the accompanying balance sheets as of September 30, 2012 and 2011, are as follows:

	2012	2011
Deferred financing costs	**$ 2,269,765**	$ 2,115,113
Less: accumulated amortization	**(718,397)**	(626,604)
Total	**$ 1,551,368**	$ 1,488,509

Note 7 - Intangible Assets

The gross carrying amount and accumulated amortization related to license enhancements as of September 30, 2012 and 2011 consisted of the following:

	2012	2011
Gross carrying amount	**$ 540,000**	$ 540,000
Accumulated amortization	**(540,000)**	(468,000)
Total	**$ -**	$ 72,000

Amortization expense related to intangible assets was $72,000 and $108,000 for the years ended September 30, 2012 and 2011, respectively.

Note 8 - Related Party Transactions

The Network provides certain administrative and operating services to the Hospital and allocates these expenses along with revenues back to the Hospital. The allocation percentage is as follows: MMH 69.8%, RGH 28.9%, and EES 1.3%. The net expenses allocated were $15,875,973 and $18,459,129 for the years ended September 30, 2012 and 2011, respectively.

Amounts due from related entities as of September 30, 2012 and 2011, consist of the following:

	2012	2011
ECMPF	**$ 10,546,892**	$ 6,644,148
ECHF	**484,258**	248,908
ECHN	**14,216,381**	10,716,012
CHIC	**7,825,000**	3,795,000
Enterprises	**2,074,115**	2,559,387
	35,146,646	23,963,455
Less: allowance for uncollectible accounts	**(2,701,478)**	(2,701,478)
Total	**$ 32,445,168**	$ 21,261,977

Amounts due from affiliates consist of operational, working capital, due from CHIC for insurance recoveries and other advances made to ECHN and its affiliates. Management believes all amounts due from ECHN and its affiliates will be repaid, however, the Hospital has established a $2.7 million reserve against ECMPF. Management believes the amounts due from ECHN, ECMPF and Enterprises can be repaid through the individual entities net asset value and/or ECHN's overall consolidated net asset value.

Note 8 - Related Party Transactions (continued)

The Hospital received an equity transfer from ECHN of $1,904,338 and $1,681,231 for the years ended September 30, 2012 and 2011, respectively.

Amounts due to related entities as of September 30, 2012 and 2011, consist of the following:

	2012	2011
RGH	**$ 774,083**	$ 1,986,032
EES	**44,500**	297,623
Total	**$ 818,583**	$ 2,283,655

Note 9 - Medical Malpractice Insurance

In fiscal year 2007, ECHN established a single-parent captive, CHIC, which covers all of its subsidiaries, including the Hospital. CHIC provides malpractice and general insurance coverage for ECHN and its subsidiaries at $3,000,000 per occurrence and $9,000,000 in the aggregate for the years ending September 30, 2012 and 2011.

Effective October 1, 2009, CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims made basis covering healthcare professional liability, general care liability, automobile liability, employers liability, helipad liability and non-owned aircraft liability. The limit provided is $30,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage is fully reinsured.

Claims that fall within CHIC's policies for medical malpractice and general liability insurance have been asserted against the Hospital by various claimants. The claims are in various stages and some may ultimately be brought to trial. CHIC has employed independent actuaries to estimate the ultimate costs, if any, of the resolution of such claims. Management believes these reserves provide an adequate reserve for loss contingencies.

The Hospital does not self-insure any malpractice risks other than exposures greater than its excess coverage's, however, as of September 30, 2012 and 2011, the Hospital has recorded a liability for estimated incurred but not reported claims, as it currently has a claims-made policy with CHIC. In addition, as mentioned in Note 2, the adoption of ASU 2010-24, the Hospital recorded additional claims liabilities and insurance recoveries from CHIC in the amount of $7,825,000 and $3,795,000 as of September 30, 2012 and 2011, respectively.

Note 10 - Estimated Self-Insurance Liabilities

The Hospital is self-insured for workers' compensation insurance coverage. The Hospital participates in Workers' Compensation Trust, a revocable trust, for the purpose of setting aside assets based on actuarial funding recommendations. The Hospital has a $350,000 limit per occurrence for workers' compensation claims. The Hospital has employed independent actuaries to estimate the ultimate costs, if any, of workers' compensation claims. Accrued workers' compensation reserves have been discounted at 5% as of September 30, 2012 and 2011, and in management's opinion provide an adequate reserve for loss contingencies.

Note 11 - Pension and Other Postretirement Benefits

ECHN has a defined benefit pension plan covering substantially all of the employees of the Hospital and RGH. The benefits are based upon years of service and compensation for the five highest years during the employee's last 10 years of service. MMH contributes amounts sufficient to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as well as such additional amounts as deemed appropriate.

Effective December 31, 2008, ECHN implemented a soft freeze on the defined-benefit pension plan. All employees with age and service credits greater than 65 were given the option to stay in the defined-benefit pension plan or freeze their defined benefits and enter into a defined contribution plan. All other employees were required to enter into the defined contribution plan. Under the defined contribution plan, ECHN contributes 3% of eligible employees' salaries. This match is non-guaranteed for all employees except certain union workers. During fiscal year 2012 and 2011, the Hospital incurred expenses of $1,058,195 and $966,090, respectively, related to this plan.

MMH and RGH also sponsor a postretirement benefit plan that provides health care benefits to those employees who retire. The criterion to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. The postretirement health care plan is contributory and the retiree pays 100% of the premium.

Unrestricted net assets of the Hospital and RGH as of September 30, 2012 include unrecognized actuarial losses of $71,226,109 related to the defined-benefit pension plan and unrecognized actuarial gains of $877,039 related to the postretirement plan. Of this amount, $5,481,445 is expected to be recognized in net periodic pension costs in 2013.

The effects of Medicare Prescription Drug, Improvement and Modernization Act of 2003 were reflected as of September 30, 2012 and 2011, assuming that ECHN will continue to provide a prescription drug benefit to retirees that is at least actuarially equivalent to Medicare Part D and that ECHN will receive the federal subsidy. The subsidy reduced plan liabilities by approximately $1,100,000 for each of the years ended September 30, 2012 and 2011, respectively. Subsidies of $95,241 and $95,233 were received in the years ended September 30, 2012 and 2011, respectively. Future benefits of $397,164 are expected to be paid and future subsidies of $69,237 are expected to be received related to the year ended September 30, 2013.

Note 11 - Pension and Other Postretirement Benefits (continued)

The pension and postretirement plans change in benefit obligation and change in plan assets for the years ended September 30, 2012 and 2011, are as follows (information presented is for the Network (MMH and RGH combined), based on September 30 measurement date):

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Change in benefit obligation:				
Benefit obligation, beginning of year	**$ 188,714,944**	$ 173,024,122	**$ 4,680,687**	$ 4,502,342
Service cost	**2,233,145**	1,694,601	**63,127**	62,573
Interest cost	**10,105,635**	9,607,108	**226,498**	211,052
Plan participants' contributions	**-**	-	**507,918**	676,830
Receipt of Medicare Part D reimbursement	**-**	-	**95,241**	95,233
Actuarial loss (gain)	**30,013,892**	11,875,070	**(140,180)**	105,204
Benefits paid	**(7,966,121)**	(7,485,957)	**(800,286)**	(972,547)
Benefit obligation, end of year	**$ 223,101,495**	$ 188,714,944	**$ 4,633,005**	$ 4,680,687
Change in plan assets:				
Fair value of plan assets, beginning of year	**$ 125,293,980**	$ 118,535,420	**$ -**	$ -
Actual return on plan assets	**20,980,869**	7,674,517	**-**	-
Employer contributions	**10,910,000**	6,570,000	**197,127**	200,484
Plan participants' contributions	**-**	-	**507,918**	676,830
Receipt of Medicare Part D reimbursement	**-**	-	**95,241**	95,233
Benefits paid	**(7,966,121)**	(7,485,957)	**(800,286)**	(972,547)
Fair value of plan assets, end of year	**$ 149,218,728**	$ 125,293,980	**$ -**	$ -
Accrued pension and other postretirement benefits	**$ (73,882,767)**	$ (63,420,964)	**$ (4,633,005)**	$ (4,680,687)
Accumulated benefit obligation	**$ (213,696,232)**	$ (183,312,903)	**$ -**	$ -

The amounts recognized in the Network's consolidated balance sheets as of September 30, 2012 and 2011 are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Current liabilities	**$ 3,500,000**	$ 10,910,000	**$ 397,164**	$ 420,446
Noncurrent liabilities	**70,382,767**	52,510,964	**4,235,841**	4,260,241
Net amount recognized	**$ 73,882,767**	$ 63,420,964	**$ 4,633,005**	$ 4,680,687

Note 11 - Pension and Other Postretirement Benefits (continued)

The allocation of the accrued pension and postretirement benefits for the years ended September 30, 2012 and 2011 is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
MMH	**$ 56,594,968**	$ 48,712,087	**$ 3,608,963**	$ 3,336,703
RGH	**17,287,799**	14,708,877	**1,024,042**	1,343,984
	$ 73,882,767	$ 63,420,964	**$ 4,633,005**	$ 4,680,687

The plan's components of net periodic benefit cost for the years ended September 30, 2012 and 2011, are as follows (pension benefits information presented is for MMH and RGH combined):

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Service cost	**$ 2,233,145**	$ 1,694,601	**$ 63,127**	$ 62,573
Interest cost	**10,105,635**	9,607,108	**226,498**	211,052
Expected return on plan assets	**(10,959,005)**	(10,398,180)	**-**	-
Amortization of prior service (credits) costs	**(234,992)**	(234,992)	**77,724**	77,724
Amortization of net loss (gain)	**2,871,791**	1,304,258	**(43,699)**	(57,507)
Net periodic benefit cost	**$ 4,016,574**	$ 1,972,795	**$ 323,650**	$ 293,842

The allocation of the net periodic benefit cost for the years ended September 30, 2012 and 2011, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
MMH	**$ 3,060,240**	$ 1,340,948	**$ 252,113**	$ 209,470
RGH	**956,334**	631,847	**71,537**	84,372
	$ 4,016,574	$ 1,972,795	**$ 323,650**	$ 293,842

The assumptions used to the determine pension and postretirement benefit obligations as of September 30, 2012 and 2011, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Discount rate	**4.32%**	5.47%	**3.64%**	5.03%
Expected long-term rate of return	**8.00%**	8.00%	**N/A**	N/A
Rate of compensation increase	**2.75%**	2.75%	**N/A**	N/A
Initial medical trend rate	**N/A**	N/A	**7.91%**	8.91%
Ultimate medical trend rate	**N/A**	N/A	**4.50%**	4.50%
Number of years to ultimate medical trend rate	**N/A**	N/A	**15 years**	17 years

Note 11 - Pension and Other Postretirement Benefits (continued)

The assumptions used to determine net periodic benefit cost of the pension and postretirement plans for the years ended September 30, 2012 and 2011, were as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Discount rate	**5.47%**	5.67%	**5.03%**	4.88%
Expected long-term rate of return	**8.00%**	8.00%	**N/A**	N/A
Rate of compensation increase	**2.75%**	2.75%	**N/A**	N/A
Initial medical trend rate	**N/A**	N/A	**7.91%**	8.91%
Ultimate medical trend rate	**N/A**	N/A	**4.50%**	4.50%
Number of years to ultimate medical trend rate	**N/A**	N/A	**15 years**	17 years

The medical trend rate assumption has a significant effect on the amounts reported. A one-percentage point change in assumed health care cost trend rates would have the following effects:

	One-Percentage Point Increase	One-Percentage Point Decrease
Effect on year end postretirement benefit obligation	$ 382,130	$ (338,354)
Effect on total of service and interest cost components	$ 25,275	$ (22,288)

The pension plan's weighted-average asset allocations as of September 30, 2012 and 2011, by asset category, are as follows:

	Pension Benefits	
	2012	**2011**
Asset category:		
Equity securities	**51%**	42%
Debt securities	**48%**	57%
Cash and cash equivalents	**1%**	1%
	100%	100%

Note 11 - Pension and Other Postretirement Benefits (continued)

The pension plan's investment policy includes the following asset allocation guidelines:

	2012		2011	
	Policy Target	**Range**	**Policy Target**	**Range**
Asset category:				
Equity securities	**53%**	**40-60%**	44%	34-54%
Debt securities	**46%**	**45-50%**	56%	51-61%
Cash and cash equivalents	**1%**	**0-4%**	0%	0-4%

The asset allocation policy was developed in consideration of the following long-term investment objectives: maximizing portfolio returns with at least a return of 4%, net of all trading expenses and fees, above inflation, as measured by the Consumer Price Index and achieving portfolio returns which exceed a composite index consisting of the S&P 500, the Russell 2000 Index, Ryan Labs GIC Index and the Barclays Capital Aggregate Bond Index in the same proportion as the fund's average commitment to equity and fixed income, respectively, and to rank in the top quartile of a broad universe of corporate pension plans of similar size.

The expected long-term rate-of-return-on-assets assumption was determined by evaluating portfolio returns based on capital market assumptions over a 20-year time horizon which are reduced by expected transaction costs and expected investment management fees for passively invested assets (to the extent that such fees are expected to be paid out of plan assets rather than directly by the Network).

Fair value methodologies used to assign plan assets to levels in accordance with FASB ASC 820 are consistent with the inputs described in Note 4.

The following table presents the investments of the defined benefit plan carried at fair value as of September 30, 2012, by the valuation hierarchy.

2012	**Level 1**	**Level 2**	**Level 3**	**Total**
Assets:				
Cash and cash equivalents	$ 944,555	$ -	$ -	$ 944,555
Fixed income mutual funds:				
Long duration	53,025,749	-	-	53,025,749
US Core Opportunistic	12,088,551	-	-	12,088,551
US Passive	2,983,658	-	-	2,983,658
Guaranteed investment contract	183,256	-	3,195,313	3,378,569
Equity mutual funds:				
Small/mid cap	8,232,969	-	-	8,232,969
Active long cap	11,917,531	-	-	11,917,531
Large cap	30,277,740	-	-	30,277,740
International	26,369,406	-	-	26,369,406
Total assets at fair value	$ 146,023,415	$ -	$ 3,195,313	$ 149,218,728

Note 11 - Pension and Other Postretirement Benefits (continued)

The following table presents the investments of the defined benefit plan carried at fair value as of September 30, 2011, by the valuation hierarchy.

2011	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 588,004	$ -	$ -	$ 588,004
Fixed income mutual funds:				
Long duration	56,839,238	-	-	56,839,238
US Core Opportunistic	9,716,075	-	-	9,716,075
US Passive	1,738,106	-	-	1,738,106
Guaranteed investment contract	170,915	-	3,374,535	3,545,450
Equity mutual funds:				
Small/mid cap	5,699,196	-	-	5,699,196
Large cap	26,548,136	-	-	26,548,136
International	20,619,775	-	-	20,619,775
Total assets at fair value	$ 121,919,445	$ -	$ 3,374,535	$ 125,293,980

The changes within the level 3 investments as of September 30, 2012 and 2011 is as follows:

2012	Guaranteed Investment Contract
Balance as of October 1, 2011	$ 3,374,535
Investment income	194,239
Expenditures	(373,461)
Balance as of September 30, 2012	$ 3,195,313

2011	Real Estate Securities	Guaranteed Investment Contract	Total
Balance as of October 1, 2010	$ 2,333,339	$ 3,571,198	$ 5,904,537
Investment return:			
Investment income	-	237,985	237,985
Net change in market value	498,504	-	498,504
Proceeds from sale of investment	(2,831,843)	-	(2,831,843)
Expenditures	-	(434,648)	(434,648)
Balance as of September 30, 2011	$ -	$ 3,374,535	$ 3,374,535

Note 11 - Pension and Other Postretirement Benefits (continued)

During fiscal year 2013, ECHN anticipates contributing $3,500,000 to the defined benefit plan.

The future benefit payments, which reflect estimated future service and expected to be paid from the plans for the year ended September 30, 2012, are as follows:

	Pension Benefits	Other Postretirement Benefits
2013	$ 7,839,728	$ 397,164
2014	$ 8,177,609	$ 409,051
2015	$ 8,613,029	$ 401,768
2016	$ 9,079,307	$ 405,187
2017	$ 9,773,496	$ 418,484
2018-2022	$ 58,816,410	$ 2,087,013

The Hospital also has a defined contribution employee savings plan covering substantially all employees. Eligible employees who contribute to the plan will have 20% - 50%, depending upon years of service, of contributions matched by the Hospital, up to a maximum of 6% of annual compensation. The Hospital incurred expenses related to the employee savings plan amounting to $634,787 and $928,889 for the years ended September 30, 2012 and 2011, respectively.

Note 12 - Long-Term Debt and Line of Credit

Long-term debt and capital lease obligations as of September 30, 2012 and 2011, consist of the following:

	2012	2011
The Hospital's portion of Connecticut Health and Educational Facilities Authority (CHEFA) Hospital Revenue Bonds, ECHN Issue Series 2000A bearing interest at rates ranging from 5.625% to 6.375%, net of unamortized original issue discount of $28,582 and $32,806 in 2012 and 2011, respectively.	**$ 4,871,418**	$ 5,217,194
The Hospital's portion of CHEFA Hospital Revenue Bonds, ECHN Issue Series 2005C, bearing interest at rates ranging from 4.00% to 5.125%, net of amortized original issue premium of $286,137 and $302,034 in 2012 and 2011, respectively.	**26,570,087**	27,159,634
The Hospital's portion of CHEFA Hospital Revenue Bonds, ECHN Series D Bonds, bearing interest at a variable rate, adjusted weekly.	**9,952,877**	10,145,791
The Hospital's portion of the CHEFA Demand Revenue Bonds, ECHN Series E bearing interest at a variable rate, adjusted weekly.	**1,807,000**	1,962,500

Note 12 - Long-Term Debt and Line of Credit (continued)

	2012	2011
Loan payable to Sovereign Bank, face amount of $5,200,000 due and payable in semi-annual principal and interest installments maturing on January 3, 2022 and bearing interest at 3.38%.	**5,194,222**	-
Promissory note payable to Rockville Bank, due and payable in monthly principal and interest installments, maturing on July 1, 2025, bearing interest at 5.87%.	**842,967**	884,113
Promissory note payable to Siemens Medical Solutions USA, face amount of $1,547,995 due and payable in monthly principal and interest installments maturing from April 30, 2011 to September 30, 2012, bearing interest at rates ranging from 5.8% to 6.0%.	**-**	165,166
The Hospital's portion of the loan due to Chase Equipment Leasing Inc., face amount allocated to MMH of $1,680,000 due and payable in monthly principal and interest installments maturing on March 20, 2013 and bearing interest at 3.24%.	**180,492**	532,833
Promissory note payable to New Alliance Bank due and payable in monthly principal and interest installments, maturing on June 1, 2012, bearing interest at a variable rate.	**-**	22,286
Capital lease obligations (see Note 14)	**6,152,329**	7,086,371
Total long-term debt	**55,571,392**	53,175,888
Less: current maturities	**(3,898,759)**	(3,467,143)
Long-term debt - net	**$ 51,672,633**	$ 49,708,745

Line of credit obligations as of September 30, 2012 and 2011, consist of the following:

	2012	2011
Revolving line of credit with TD Bank in 2012 and 2011, bearing interest at a variable rate.	**$ 6,500,000**	$ 6,500,000

In February 2000, the Hospital, RGH and EES (collectively, the Series A Obligated Group) entered into an agreement and open-ended mortgage with the Connecticut Health and Educational Facilities Authority (CHEFA) in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series 2000A (the Series A Bonds). A portion of the proceeds from the Series 2000A Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was placed in an irrevocable trust from which the remaining debt service payments for defeased CHEFA bonds will be paid. The remainder was used to finance additions and renovations for various facilities. The Series A Obligated Group has been legally released from any future debt service on the defeased bonds. The Series A Bonds are due on various dates through July 1, 2030.

Note 12 - Long-Term Debt and Line of Credit (continued)

On October 1, 2005, the Hospital, RGH, EES and ECHF (collectively, the Series C Obligated Group) entered into an agreement and open-ended mortgage with the CHEFA to borrow $37,065,000 in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series C (the Series C Bonds). The proceeds from the Series C Bonds, net of the original issue premium and amounts used to establish required reserve accounts, were placed in an irrevocable trust to advance refund and defease a portion of the Series 2000A Bonds. MMH, RGH and EES (collectively, the Series A Obligated Group) have been legally released from any future debt service on the portion of defeased Series 2000A Bonds. The Series C Bonds are due on various dates through July 1, 2030.

In May 2009, the Hospital, RGH, EES and ECHF (collectively, the Series D Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series D (the Series D Bonds). The proceeds from the Series D Bonds, net of amounts used to establish required reserve accounts, were used to finance renovations at MMH, an expansion at EES and other campus improvements. The Series D Bonds are due on various dates through May 14, 2039.

In December 2010, the Hospital, RGH, EES and ECHF (collectively, the Series E Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series E (the Series E Bonds). The proceeds from the Series E Bonds, net of amounts used to establish required reserve accounts, were used to refinance the Series B Bonds and fund interest rate swap agreement termination payments relating to the Series B Bonds. The Series E Bonds are due on various dates through July 1, 2034.

Under the terms of the Series A, Series B, Series C, Series D and Series E Bonds, the Series A Obligated Group, Series B Obligated Group, Series C Obligated Group, Series D Obligated Group and Series E Obligated Group (the "Obligated Groups") are required to maintain certain deposits with a trustee. Such deposits are included in assets whose use is limited. The indenture also places limits on the incurrence of additional borrowings and dispositions of property and requires that the Obligated Groups satisfy certain measures of financial performance as long as the bonds are outstanding.

The Obligated Groups are required to comply with certain financial covenants (as defined in the trust agreements), including a debt service coverage ratio, day's cash on hand requirement and minimum cash to debt ratio. As of September 30, 2012 and 2011, the Obligated Groups were in compliance with the financial covenants of the debt agreements; however, ECHN had to receive a waiver from TD Bank, N.A. (under a letter of credit agreement for Series D and E bonds) for transfers to affiliated organizations outside the Obligated Group in excess of $4.0 million for the year ended September 30, 2011. The letter of credit agreement was amended in fiscal year 2012 to eliminate this requirement.

Under the terms of the CHEFA agreements, each member of the Obligated Groups is jointly and severally liable for the full and prompt payment of the amounts owed by the Obligated Groups. Total debt of the Obligated Groups was $81,999,098 and $80,156,296 as of September 30, 2012 and 2011, respectively. The debt is also secured by the gross receipts of the Obligated Groups.

In June 2012, the Obligated Group entered into a loan agreement with CHEFA for $5,200,000 in connection with purchase of equipment and renovation costs. The proceeds of the loan, net of disbursements, are included in the current portion of assets whose use is limited. Semi-annual principal and interest payments are due through January 2022.

Note 12 - Long-Term Debt and Line of Credit (continued)

The loans due to Chase Equipment Leasing Inc. are collateralized by the related equipment, accessories, attachments, software and other property relating thereto.

The Hospital is party to various capital leases, which are described in Note 14.

The annual maturities of the Hospital's portion of the long-term debt and capital lease obligations in each of the succeeding five years and thereafter as of September 30, 2012 are as follows

2013	$ 3,898,759
2014	3,337,485
2015	3,193,235
2016	3,093,443
2017	2,162,508
Thereafter	39,628,407
	55,313,837
Plus premium - net	257,555
Total	$ 55,571,392

:

On November 11, 2010, ECHN entered into a $6,500,000 unsecured line of credit with TD Bank, N.A., to replace the line of credit agreement with Sovereign Bank. This line of credit carries an interest rate of LIBOR plus 2.25% and expires one year after issuance date. ECHN renewed this line of credit in 2012 and is in the process of renewing it for 2013. As of September 30, 2012 and 2011, MMH had $6,500,000 outstanding under this line of credit.

Note 13 - Derivatives

The Hospital uses derivative instruments, specifically interest rate swap agreements, to manage its exposure to changes in the interest rate on its CHEFA bonds. The use of derivative instruments exposes the Hospital to additional risks related to the derivative instrument, including market risk, credit risk and termination risk as described below and the Hospital has defined risk management practices to mitigate these risks, as appropriate.

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Hospital will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligation during the term of the contract. When the fair value of a derivative contract is positive, the counterparty owes the Hospital, which creates credit risk.

Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold.

Note 13 - Derivatives (continued)

Termination risk represents the risk that the Hospital may be required to make a significant payment to the counterparty, if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Hospital's ability to meets its debts or liquidity covenants.

In connection with the redemption of Series B Bonds and the issuance of Series E Bonds, the related swap was terminated and paid off in May 2011. Total cash paid by the Hospital and RGH was $822,875 and MMH recorded a loss of $82,288 in non-operating losses and an increase in unrestricted net assets of $167,734 in the statements of operations and changes in net assets for the year ended September 30, 2011 relating to the swap termination.

In May 2009, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $15,250,000 of its Series D variable rate debt. Under the terms of this agreement, ECHN pays a fixed rate of 3.89%. Changes in the fair value of this swap are recorded in the statement of operations and changes in net assets.

The Hospital's portion of the swap agreement in force related to this strategy as of September 30, 2012 and 2011 and the approximate liability and interest expense recognized by the Hospital are as follows:

	2012	2011
Notional amount of contract	**$ 9,953,000**	$ 10,146,000
Fair value of swap contract recognized in MMH other liabilities	**$ 290,000**	$ 408,000
Net interest (income) expense recognized in MMH non-operating losses	**$ (118,000)**	$ (66,000)

In June 2012, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $5,200,000 of its debt with Sovereign Bank. Under the terms, ECHN pays a fixed rate of 3.38%. The swap is accounted for as a cash flow hedge in accordance with ASC 815, *"Accounting for Derivative Instruments and Hedging Activities"*. This accounting treatment requires the effective portion of the gain or loss on a derivative instrument designated and qualifying as a cash flow hedging instrument to be reported as a component of other changes in unrestricted net assets and to be reclassified into operations in the same period or periods during which the hedged forecasted transaction affects earnings. The remaining gain or loss on the derivative instrument, if any, shall be recognized currently in non-operating losses. The Hospital's portion of the swap agreement schedule in related to this strategy as of September 30, 2012 is as follows:

	2012
Notional amount of contract	**$ 5,194,222**
Fair value of swap contract recognized in MMH other liabilities	**$ 123,000**
Unrealized loss recognized as a reduction of unrestricted net assets	**$ 123,000**

The counterparty to the above swap transactions is a major financial institution that meets ECHN's criteria for financial stability and creditworthiness.

Note 14 - Lease Commitments

The Hospital leases equipment under various capital lease agreements, which begin to expire in 2014. The net carrying value of equipment under the capital leases was $7,652,382 and $8,184,417 as of September 30, 2012 and 2011, respectively. The Hospital leases various office spaces and certain equipment under operating leases that expire in various years through fiscal year 2019. Certain leases may be renewed at the end of their term.

Future minimum payments under capital leases and non-cancelable operating leases as of September 30, 2012, consists of the following:

	Capital Leases	Operating Leases
2013	$ 2,183,971	$ 1,770,362
2014	1,662,895	1,490,964
2015	1,408,084	1,393,346
2016	1,178,029	1,176,988
2017	145,512	924,763
Thereafter	-	4,825,147
	6,578,491	$ 11,581,570
Less: interest on capital lease	426,162	
Principal amount of capital lease	$ 6,152,329	

Rent expense under operating and month-to-month leases was $2,445,487 and $2,288,147 for the years ended September 30, 2012 and 2011, respectively.

Note 15 - Concentration of Credit Risk

The Hospital grants credit without collateral to its patients, most of who are insured under third-party payer agreements. The mix of patient accounts receivable as of September 30, 2012 and 2011, before allowances for doubtful accounts, consists of the following:

	2012	2011
Medicare	**34%**	34%
Self-pay	**27%**	19%
Managed care	**22%**	27%
Medicaid	**10%**	13%
Commercial insurance	**4%**	4%
Other	**3%**	3%
	100%	100%

Note 16 - Net Patient Service Revenue

Net patient service revenue for the years ended September 30, 2012 and 2011, consists of the following:

	2012	2011
Patient service revenue:		
Inpatient services	**$ 185,302,228**	$ 150,353,329
Outpatient services	**306,599,578**	270,967,534
Gross patient service revenue	**491,901,806**	421,320,863
Deductions - allowances	**(316,684,240)**	(254,718,602)
Net patient service revenue	**$ 175,217,566**	$ 166,602,261

Note 17 - Community Benefit

ECHN's mission is to improve the health of the people and communities ECHN serves.

ECHN provides quality health care to all, regardless of their ability to pay. Charity care is provided to those who are eligible based on ECHN's policy. ECHN also incurs unpaid costs for government programs because reimbursement is not sufficient to cover costs associated with Medicare and Medicaid patients. In addition to the charity care responsibilities, ECHN provides numerous other community benefits. These community benefits include medical education and research, community health education, screenings, support groups, counseling services and in-kind support. To address the need for health care providers, a number of programs are offered for young people who may be interested in a career in health care.

ECHN utilizes guidelines developed by various organizations to quantify community benefit activities. ECHN defines community benefit activities as those that improve access to care, as well as the health of the broader community. In addition to charity care and the unpaid costs of government sponsored health care (Medicare and/or Medicaid shortfalls), community benefit activities will normally fall into one of the following categories: nonbilled community health services / community health improvement services, health professions education, subsidized health services, research, financial and in-kind contributions, community building activities and community benefit operations.

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of traditional charity care provided, determined on the basis of cost, was estimated at $1,602,648 and $1,768,879 for the years ended September 30, 2012 and 2011, respectively. Previously, the Hospital reported its estimates of services provided under its charity care programs based on gross charges. In connection with the Hospital's adoption of ASU 2010-23, *"Health Care Entities (Topic 954): Measuring Charity Care for Disclosure,"* amounts previously reported for care provided under its charity care programs have been restated to reflect the Hospital's estimates of its direct and indirect cost of providing these services. This change had no impact on the Hospital's results of operations.

Note 18 - Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses relating to providing these services for the years ended September 30, 2012 and 2011, are as follows:

	2012	2011
Health care services	**$ 145,780,478**	$ 136,988,934
General and administrative	**38,665,523**	36,333,732
Total	**$ 184,446,001**	$ 173,322,666

Note 19 - Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets as of September 30, 2012 and 2011, are available for the following purposes:

	2012	2011
Departmental and endowment purposes	**$ 1,510,966**	$ 615,243
Capital campaign and pledges	**394,103**	373,459
Total	**$ 1,905,069**	$ 988,702

Permanently restricted net assets as of September 30, 2012 and 2011, consist of the following:

	2012	2011
Beneficial interest in trust assets	**$ 5,296,479**	$ 4,800,923
Endowments restricted for:		
Other departmental purposes	**2,400,189**	2,400,190
Charity care	**320,818**	320,817
Special needs	**151,579**	151,579
Cancer research	**6,124**	6,124
Total	**$ 8,175,189**	$ 7,679,633

The composition of the Hospital's endowment by net asset class as of September 30, 2012 and 2011, are as follows:

2012	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 718,895	$ 1,593,687	$ 2,312,582
Board-designated endowment funds	7,434,591	-	-	7,434,591
Net assets, September 30, 2012	$ 7,434,591	$ 718,895	$ 1,593,687	$ 9,747,173

Note 19 - Temporarily and Permanently Restricted Net Assets (continued)

2011	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 83,342	$ 1,593,687	$ 1,677,029
Board-designated endowment funds	6,346,662	-	-	6,346,662
Net assets, September 30, 2011	$ 6,346,662	$ 83,342	$ 1,593,687	$ 8,023,691

The Hospital's endowments consist of multiple funds established for a variety of purposes. The endowments include both donor-restricted endowment funds and funds designated by the Board of Directors to function as endowments. As required by GAAP, endowments, including funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor restrictions.

The Hospital has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. 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 Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Hospital and 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 and (7) the investment policies of the Hospital.

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a reasonably stable and predictable stream of earnings to support the operations of the endowments and to preserve and enhance over time the real value of the endowment assets. Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment and management costs, over the long-term. Actual returns in any given year may vary from this amount.

The Investment Committee of the Board is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. The asset allocation policy reflects the objective with allocations structured for capital growth and inflation protection over the long-term.

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

The Hospital has not appropriated funds for expenditure from its endowment funds for the years ended September 30, 2012 and 2011.

Note 19 - Temporarily and Permanently Restricted Net Assets (continued)

Changes in endowment net assets for the fiscal years ended September 30, 2012 and 2011, are as follows:

2012	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, September 30, 2011	$ 6,346,662	$ 83,342	$ 1,593,687	$ 8,023,691
Interest income and dividends	132,221	18,520	-	150,741
Unrealized appreciation on investments	1,379,513	193,228	-	1,572,741
Transfer (from) to endowment	(423,805)	423,805	-	-
Net assets, September 30, 2012	$ 7,434,591	$ 718,895	$ 1,593,687	$ 9,747,173

2011	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, September 30, 2010	$ 6,413,846	$ 92,750	$ 1,593,687	$ 8,100,283
Interest income and dividends	123,789	17,339	-	141,128
Unrealized depreciation on investments	(190,973)	(26,747)	-	(217,720)
Net assets, September 30, 2011	$ 6,346,662	$ 83,342	$ 1,593,687	$ 8,023,691

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Hospital to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2012 and 2011, there were no funds that were below the level required by donor or law.

Note 20 - Commitments and Contingencies

The Hospital is involved in various legal actions arising from the normal course of its activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration the advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, upon the balance sheets or the related statements of operations and changes in net assets, or cash flows of the Hospital.

The Hospital and the Hospital's defined benefit pension plans invest in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term.

The Rockville General Hospital, Inc.

Independent Auditors' Report and
Financial Statements

As of and for the Years Ended
September 30, 2012 and 2011

Saslow Lufkin & Buggy, LLP
Certified Public Accountants and Consultants

The Rockville General Hospital, Inc.
Independent Auditors' Report and Financial Statements
As of and for the Years Ended September 30, 2012 and 2011

Table of Contents

Independent Auditors' Report

To the Board of Trustees of
The Rockville General Hospital, Inc.:

We have audited the accompanying balance sheets of The Rockville General Hospital, Inc. (the Hospital) (a subsidiary of Eastern Connecticut Health Network, Inc.), as of September 30, 2012 and 2011, 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 of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as 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 Rockville General Hospital, Inc. as of September 30, 2012 and 2011 and the results of its operations and changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Saslow Lufkin & Buggy, LLP

December 18, 2012

The Rockville General Hospital, Inc.
Balance Sheets
September 30, 2012 and 2011

	2012	2011
Assets		
Current assets:		
Cash and cash equivalents	**$ 1,463,823**	$ 4,739,454
Current portion of assets whose use is limited	**467,222**	501,284
Accounts receivable, less allowance for bad debts of $2,265,004 in 2012 and $1,327,058 in 2011	**10,959,585**	10,246,785
Inventory	**1,519,666**	1,576,966
Due from affiliates	**781,899**	2,196,771
Current portion of estimated settlements due from third-party payers	**853,555**	-
Prepaid expenses and other current assets	**218,802**	270,651
Total current assets	**16,264,552**	19,531,911
Assets whose use is limited - net of current portion:		
Donor restricted investments	**1,696,049**	2,018,549
Board designated investments	**9,011,067**	7,095,031
Investments held under bond indentures	**931,963**	1,890,523
Beneficial interest in trust assets	**2,104,303**	1,887,242
Total assets whose use is limited - net of current portion	**13,743,382**	12,891,345
Interest in net assets of ECHN Community Healthcare Foundation, Inc.	**3,254,582**	2,629,614
Investments in joint ventures	**3,127,553**	2,858,713
Property, plant and equipment, net	**30,472,774**	31,151,854
Investments	**9,554,311**	7,740,794
Other assets:		
Estimated settlements due from third-party payers	**-**	1,856,415
Due from affiliated entities - net of current portion	**2,620,000**	4,058,961
Intangible assets - net	**-**	72,000
Other - net	**831,619**	866,926
Total other assets	**3,451,619**	6,854,302
Total assets	**$ 79,868,773**	$ 83,658,533
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 5,969,615**	$ 4,898,568
Current portion of long-term debt and capital lease obligations	**1,271,671**	1,247,313
Due to affiliated entities	**3,297,172**	2,717,350
Estimated settlements due to third-party payers	**1,157,913**	684,512
Current portion of accrued pension and other postretirement benefits	**1,164,039**	2,650,753
Other current liabilities	**715,430**	1,240,661
Total current liabilities	**13,575,840**	13,439,157
Long-term debt and capital lease obligations - net of current portion	**24,394,084**	25,860,313
Estimated self-insurance liabilities	**3,307,458**	1,813,842
Accrued pension and other postretirement benefits - net of current portion	**17,147,802**	13,402,108
Other liabilities	**128,578**	125,749
Total liabilities	**58,553,762**	54,641,169
Net assets:		
Unrestricted	**17,066,097**	24,688,727
Temporarily restricted	**615,748**	912,532
Permanently restricted	**3,633,166**	3,416,105
Total net assets	**21,315,011**	29,017,364
Total liabilities and net assets	**$ 79,868,773**	$ 83,658,533

The accompanying notes are an integral part of these financial statements.

The Rockville General Hospital, Inc.
Statements of Operations and Changes in Net Assets
For the Years Ended September 30, 2012 and 2011

	2012	2011
Revenues:		
Net patient service revenue	**$ 67,847,638**	$ 63,387,116
Change in interest in unrestricted net assets of ECHN Community Healthcare Foundation, Inc.	**192,851**	237,954
Other revenues	**5,020,030**	3,888,629
EHR incentive payment revenue	**1,626,870**	618,428
Net assets released from restrictions used for operations	**31,857**	48,044
Total revenues	**74,719,246**	68,180,171
Expenses:		
Salaries and wages	**30,268,391**	29,535,778
Fringe benefits	**10,042,713**	8,838,640
Supplies and other	**25,886,843**	21,930,029
Provision for bad debts	**3,309,948**	2,925,278
Depreciation and amortization	**3,811,952**	3,672,297
Interest and financing costs	**719,107**	1,115,177
Total expenses	**74,038,954**	68,017,199
Income from operations	**680,292**	162,972
Non-operating losses	**(179,961)**	(855,256)
Excess (deficiency) of revenues over expenses	**$ 500,331**	$ (692,284)

The accompanying notes are an integral part of these financial statements.

The Rockville General Hospital, Inc.
Statements of Operations and Changes in Net Assets (continued)
For the Years Ended September 30, 2012 and 2011

	2012	2011
Unrestricted net assets:		
Excess (deficiency) of revenues over expenses	**$ 500,331**	(692,284)
Change in unrealized appreciation (depreciation) on investments	**2,852,929**	(611,526)
Net change on interest rate swap agreement	**-**	1,509,597
Equity transfer to ECHN	**(8,205,356)**	(8,575,553)
Transfer of WCW net assets to RGH	**-**	1,740,285
Transfers from other affiliated entities	**424,971**	6,790
Change in investment of ECHN Community Healthcare Foundation, Inc.	**560,369**	(347,084)
Net assets released from restrictions used for capital	**48,524**	1,132,631
Pension and postretirement-related adjustments	**(3,804,398)**	(3,218,413)
Change in unrestricted net assets	**(7,622,630)**	(9,055,557)
Temporarily restricted net assets:		
Change in interest in net assets of ECHN Community Healthcare Foundation, Inc.	**54,835**	55,652
Change in unrealized appreciation (depreciation) on investments	**119,637**	(62,933)
Investment income	**18,801**	9,785
Net assets released from restrictions for operations	**(31,857)**	(48,044)
Net assets released from restrictions used for capital	**(48,524)**	(1,132,631)
Transfer of WCW net assets to RGH	**-**	24,082
Transfers (to) from ECHN and other affiliates	**(409,676)**	633,488
Change in temporarily restricted net assets	**(296,784)**	(520,601)
Permanently restricted net assets:		
Change in beneficial interest in trust assets	**217,061**	(71,109)
Change in permanently restricted net assets	**217,061**	(71,109)
Change in net assets	**(7,702,353)**	(9,647,267)
Net assets at beginning of year	**29,017,364**	38,664,631
Net assets at end of year	**$ 21,315,011**	$ 29,017,364

The accompanying notes are an integral part of these financial statements.

The Rockville General Hospital, Inc.
Statements of Cash Flows
For the Years Ended September 30, 2012 and 2011

	2012	2011
Cash flows from operating activities:		
Change in net assets	**$ (7,702,353)**	$ (9,647,267)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	**3,811,952**	3,672,297
Amortization of bond costs related to Series B defeasement	**-**	390,236
Provision for bad debts	**3,309,948**	2,925,278
Change in unrealized (appreciation) depreciation on investments	**(3,092,203)**	611,526
(Income) loss on investments in joint venture	**(268,841)**	31,113
Transfers to other affiliated entities	**8,190,061**	6,170,908
Change in interest in net assets of ECHN Community Healthcare Foundation, Inc.	**(624,968)**	44,252
Change in beneficial interest in trust assets	**(217,061)**	71,109
Pensions and postretirement-related adjustments	**3,804,398**	3,218,413
Net change on interest rate swap	**-**	(1,047,460)
Changes in assets and liabilities:		
Accounts receivable	**(4,022,748)**	(3,507,173)
Inventory	**57,300**	(77,788)
Prepaid expenses and other current assets	**51,849**	(40,710)
Estimated settlements due to/from third-party payers	**1,476,261**	61,872
Due (from) to affiliates	**2,992,557**	5,754,249
Intangible assets - net	**72,000**	108,000
Other - net	**(9,986)**	55,767
Accounts payable and accrued expenses	**545,816**	689,138
Accrued pension and other postretirement benefits	**(1,545,418)**	(952,851)
Estimated self-insurance liabilities	**1,493,616**	(25,188)
Other liabilities	**2,829**	733,532
Net cash provided by operating activities	**8,325,009**	9,239,253
Cash flows from investing activities:		
Purchases of property and equipment	**(1,728,554)**	(2,020,432)
Purchases of investments, net	**(1,352,726)**	(3,018,939)
Distributions from joint ventures	**-**	(35,000)
Proceeds from sales of investments and assets whose use is limited	**1,988,371**	1,071,513
Net cash used in investing activities	**(1,092,909)**	(4,002,858)
Cash flows from financing activities:		
Principal payments on long-term debt	**(2,317,670)**	(16,920,114)
Payments for bond issuance costs	**-**	(639,258)
Payment for termination of interest rate swaps	**-**	(1,380,804)
Proceeds from issuance of long-term debt	**-**	18,776,732
Transfers to other affiliated entities	**(8,190,061)**	(6,170,908)
Net cash used in financing activities	**(10,507,731)**	(6,334,352)
Change in cash and cash equivalents	**(3,275,631)**	(1,097,957)
Cash and cash equivalents at beginning of year	**4,739,454**	5,837,411
Cash and cash equivalents at end of year	**$ 1,463,823**	$ 4,739,454
Cash paid for interest	**$ 824,710**	$ 1,038,142
Equipment acquisitions under capital lease arrangements	**$ 875,799**	$ 646,232

The accompanying notes are an integral part of these financial statements.

Note 1 - General

The Rockville General Hospital, Inc. (the Hospital or RGH) is a not-for-profit, 102-bed acute care hospital that provides inpatient, outpatient and emergency care services for residents of Vernon-Rockville and surrounding towns. The Hospital is a subsidiary of the Eastern Connecticut Health Network, Inc. (ECHN or the Network), which was formed in 1995 by a merger of MMH Corp. and Rockville Area Health Services, Inc. ECHN was organized to provide a broader health care system for the surrounding communities with quality medical care at a reasonable cost and to foster an environment conducive to health and well-being whether in the home or in the community.

Other related entities of RGH include:

The Manchester Memorial Hospital (MMH) - MMH is a not-for-profit hospital with 249 licensed beds, located in Manchester, Connecticut. MMH, which admitted its first patient in 1920, is a short-term, acute care general hospital, which provides inpatient, outpatient, and emergency care services to the residents of Manchester and 19 nearby towns.

ECHN ElderCare Services, Inc. (EES) - EES is a not-for-profit skilled nursing facility with 130 licensed beds and physical, occupational, and speech rehabilitation services located in Tolland, Connecticut.

ECHN Community Healthcare Foundation, Inc. (ECHF) - ECHF is a not-for-profit organization whose purpose is to raise funds on behalf of ECHN and its not-for-profit subsidiaries. It was established in 2000, when the fund-raising efforts of ECHN were consolidated into a single not-for-profit foundation. ECHF focuses primarily on the capital and program needs of ECHN and its not-for-profit subsidiaries.

Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) - ECMPF is a not-for-profit organization that currently operates physician office practices in the Network's service area and a hospitalist program that serves MMH and RGH. Its mission allows it to operate other not-for-profit, separately incorporated allied health ventures.

ECHN Enterprises, Inc. (Enterprises) - Enterprises is a for-profit organization formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. Enterprises owns, leases and has an interest in real estate to support the mission and vision of ECHN. It is also the parent corporation of Haynes Street Property Management, LLC (HSPM). HSPM is a for-profit limited liability company formed under the laws of the State of Connecticut, which manages the Glastonbury Wellness Center and sublets space to various MMH departments and physician offices, as well as to ECMPF.

Connecticut Healthcare Insurance Company (CHIC) - CHIC, a captive insurance company, provides hospital and physician professional and general liability coverage to MMH, RGH, EES, and all other subsidiaries of ECHN.

Visiting Nurse and Health Services of Connecticut (VNHSC) - VNHSC is a not-for-profit, nonstock Connecticut corporation that provides and administers a comprehensive, multi-disciplinary home health program, hospice program and wellness programs to promote the health of individuals, families and groups in the Greater Northern Central Connecticut area. In addition, VNHSC is the sole member of A Caring Hand, LLC, which is a for-profit Connecticut limited liability company providing and administering homemaker, companion, live-in and personal care assistance services to individuals and families in the Greater Northern Central Connecticut area.

Note 1 - General (continued)

ECHN and each of its subsidiaries, except for Enterprises, CHIC and A Caring Hand, LLC, are separate Connecticut not-for-profit corporations, qualified as exempt organizations under Section 501(c)(3) of the Internal Revenue Code (IRC) and governed by separate Boards of Trustees (the Board) - although the membership of the ECHN, MMH, and RGH boards are currently identical. ECHN, acting through its Board of Trustees, is the sole member of each of its subsidiaries.

ECHN has various powers with regard to each of its members, which include approving all operating and capital budgets; controlling the investment of funds, location of services, agreements and transactions, affiliations, controlling changes, amendments or restatements of certificates of incorporation and bylaws, electing trustees and officers, appointing committees, adopting a system-wide vision and strategic plans and approving debt borrowings.

Note 2 - Summary of Significant Accounting Policies

Basis of Presentation **-** The accompanying financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC).

Use of Estimates **-** The preparation of financial statements in conformity with 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.

The Hospital's significant estimates relate to the valuation of investments and interest rate swap agreements, allowance for doubtful patient accounts receivable, contractual allowances on patient accounts receivable, self-insurance liabilities, estimated settlements due to and from third parties, conditional asset retirement obligations, postretirement and pension benefit costs and the related obligations.

Cash and Cash Equivalents **-** The Hospital considers all highly liquid investments with original maturities of three months or less at date of purchase to be cash equivalents, excluding amounts whose use is limited or restricted by Board designation or other arrangements under trust agreements. Cash equivalents include money market funds. In general, the Federal Deposit Insurance Corporation (FDIC) insures cash balance up to $250,000 per depositor, per bank. The FDIC also provides separate unlimited coverage for deposit accounts that meet the definition of non-interest bearing accounts. Unlimited coverage on non-interest bearing accounts extends until December 31, 2012. At times, the Hospital maintains cash balances that are in excess of the insured FDIC limits. The Hospital maintains its cash at various banks and it is the Hospital's policy to monitor the financial strength of the banks on an ongoing basis.

Money market funds are not insured by the FDIC and are not a risk-free investment. Money market funds invest in a variety of instruments including mortgage-backed and asset-backed securities. Although a money market fund seeks to preserve its $1 per share value, it is possible that a money market fund's value can decrease below $1 per share.

Net Assets **-** Resources are reported for accounting purposes in separate classes of net assets based on the existence or absence of donor-imposed restrictions. In the accompanying financial statements, net assets that have similar characteristics have been combined as follows:

Note 2 - Summary of Significant Accounting Policies (continued)

Permanently Restricted **-** Net assets subject to explicit donor-imposed stipulations that they be maintained by the Hospital in perpetuity are classified as permanently restricted. Such permanently restricted assets include endowment funds and the Hospital's share of its beneficial interest in trust assets held by third parties. Generally, the donors of these assets permit the Hospital to use all or part of the investment return on these assets for operating purposes.

Temporarily Restricted **-** Net assets whose use by the Hospital is subject to explicit donor-imposed stipulations that can be fulfilled upon incurrence of expenditures by the Hospital pursuant to those stipulations or that expire by the passage of time are classified as temporarily restricted.

Unrestricted **-** Net assets that are not subject to explicit donor-imposed stipulations are classified as unrestricted. Unrestricted net assets may be designated for specific purposes by action of the Board or may otherwise be limited by contractual agreements with outside parties. Such designated assets are classified as assets whose use is limited in the accompanying balance sheets.

Revenues are reported as increases in unrestricted net assets, unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets, unless their use is restricted by explicit donor stipulations or by law.

Expirations of temporary restrictions on net assets, that is, the donor-imposed stipulated purpose has been accomplished and/or stipulated period has elapsed, are reported as reclassifications between the applicable classes of net assets.

Contributions, including unconditional promises to give, are recognized as revenues at the date the promise is received. Contributions of assets other than cash are recorded at their estimated fair value. Contributions to be received after one year are discounted at the appropriate rate commensurate with the risks involved. Amortization of the discount is included in other revenues. Contributions restricted for the acquisition of land, buildings and equipment are reported as temporarily restricted support. These contributions are reclassified to unrestricted net assets when the capital asset is acquired or constructed and placed in service.

Assets Whose Use is Limited **-** Assets whose use is limited primarily include cash and investments held by trustees under indenture agreements, Board designated investments which include endowments and cash and investments set aside by the Board for future capital improvements over which the Board retains control and may, at its discretion, subsequently use for other purposes, beneficial interests in trust assets, donor restricted and other restricted investments. Amounts required to meet current liabilities of the Hospital have been classified as current assets in the balance sheets as of September 30, 2012 and 2011.

The income earned on restricted funds is generally available for operations of the Hospital and is recorded as revenue in unrestricted net assets, unless restricted by the donor or to pay future split interest obligations, at which time the income is added to the appropriate restricted net asset balance. However, if a specific gift instrument explicitly requires the permanent reinvestment of appreciation, or a portion thereof, such reinvested amounts are recorded within permanently restricted net assets. There were no gifts with reinvestment restrictions for the years ended September 30, 2012 and 2011.

Note 2 - Summary of Significant Accounting Policies (continued)

The Hospital relies on a balanced strategy in which endowment returns are achieved through both capital appreciation and interest and dividends. The Hospital targets a diversified asset allocation of fixed income mutual funds, fixed income equity funds and money market funds.

Assets received as donations or bequests are recorded as contributions on the date received at the estimated fair value. The average cost method is used to determine realized gains or losses on sales of marketable equity securities.

Beneficial Interest in Trust Assets **-** RGH has been named sole or participating beneficiary in several perpetual trusts, for which third parties act as the trustee. Under the terms of these trusts, RGH has the irrevocable right to receive the income earned on the trust assets in perpetuity. The estimated present value of the future payments to RGH is recorded at the fair value of the assets held in the trust as beneficial interest in trust assets and is classified as permanently restricted.

The income from the trusts is included in the change in interest in unrestricted net assets of ECHF as unrestricted and temporarily restricted support. For the years ended September 30, 2012 and 2011, income of $93,826 and $72,563, respectively, was recorded in the statements of operations and changes in net assets. Changes in the fair value of the trust assets are recognized as changes in permanently restricted net assets. RGH records the beneficial interest in trust assets when it is notified of the existence of the trust or when information becomes available to record the fair value of the trust assets.

Investments **-** The Hospital's investment portfolio is classified as available for sale, with unrealized gains and losses excluded from the excess of revenues over expenses, unless the losses are deemed to be other than temporary. Investments in equity securities with readily determinable fair values and all investments in mutual funds are measured at fair value in the balance sheets.

Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses, unless the income or loss is restricted by donor or law.

Other Than Temporary Impairments on Investments **-** The Hospital accounts for other than temporary impairments in accordance with FASB ASC 320 and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other than temporary. The Hospital has recorded an impairment charge of $0 and $22,832 for the years ended September 30, 2012 and 2011, respectively, related to investments held by CHIC.

Property, Plant and Equipment **-** Property, plant and equipment are stated at cost or, in the case of donated property, at fair value at the date of the gift, less accumulated depreciation and amortization. Major improvements and betterments to existing plant and equipment are capitalized. Expenditures for maintenance and repairs, which do not extend the lives of the applicable assets, are charged to expense as incurred. Upon disposition or retirement of property, plant and equipment, the cost and related accumulated depreciation and amortization are eliminated from the respective accounts and any resulting gain or loss is included in the results of operations.

Note 2 - Summary of Significant Accounting Policies (continued)

Depreciation expense is computed on a straight-line basis over the estimated useful lives as follows:

Buildings	10 - 40 years
Building improvements	5 - 40 years
Machinery and equipment	3 - 15 years
Furniture and fixtures	5 - 20 years

Equipment under capital leases is amortized utilizing the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Depreciation and amortization expense was $3,724,532 and $3,570,884 for the years ended September 30, 2012 and 2011, respectively.

Interest cost incurred on borrowed funds during the construction period of capital assets is capitalized as a component of the cost of acquiring those assets.

Physician loan amortization totaling $42,127 and $57,525 as of September 30, 2012 and 2011, respectively, is included within depreciation and amortization in the accompanying statements of operations and changes in net assets.

Gifts of property and equipment are reported as unrestricted support and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used.

Gifts of property and equipment with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire property and equipment are reported as restricted support. Absent explicit donor stipulations about how long those property, plant and equipment must be maintained, expirations of donor restrictions are reported as released from restrictions when the donated or acquired property, plant and equipment assets are placed in service.

Investments in Joint Ventures **-** The Hospital has invested in joint ventures, which are accounted for under the equity method of accounting. These joint ventures, as of September 30, 2012 and 2011, include the Hospital's investment in the following:

	2012	**Ownership Percentage**	**2011**	**Ownership Percentage**
Northeast Regional Radiation Oncology Network, Inc.	**$ 3,055,158**	**25%**	$ 2,819,068	25%
Tolland Imaging Center	**72,395**	**35%**	39,645	35%
	$ 3,127,553		$ 2,858,713	

Note 2 - Summary of Significant Accounting Policies (continued)

There were no distributions received from these joint ventures in 2012 and 2011. The Hospital's share of the earnings or losses of the joint ventures are reported within other revenues and are $268,841 and ($31,113) for the years ended September 30, 2012 and 2011, respectively.

Summarized financial information from the financial statements of these organizations as of September 30, 2012 and 2011, and for the years then ended, is as follows:

2012	Total Assets	Net Assets	Change in Net Assets	Excess of Revenues Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 12,257,336	$ 12,220,632	$ 944,362	$ 961,990
Tolland Imaging Center	$ 1,258,554	$ 214,706	$ 101,436	$ 100,840

2011	Total Assets	Net Assets	Change in Net Assets	Deficiency of Revenues Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 14,987,787	$ 11,276,270	$ (24,696)	$ (24,809)
Tolland Imaging Center	$ 1,696,739	$ 113,270	$ 28,745	$ (52,019)

Unamortized Bond Issue Costs - Financing costs associated with the issuance of long-term debt are amortized over the term of the bonds using the effective interest method. Amortization is included in depreciation and amortization costs in the accompanying statements of operations and changes in net assets and the unamortized carrying value is recorded within other - net in the accompanying balance sheets.

Intangible Assets - Intangible assets, principally license enhancements, are amortized over the life of the respective intangible property. On average, this amortization period for license enhancements is 5 years. Amortization is included in depreciation and amortization in the accompanying statements of operations and changes in net assets and the unamortized carrying value is recorded within intangible assets - net in the accompanying balance sheets. Any residual value remaining after the amortization period is considered insignificant.

Excess (Deficiency) of Revenues Over Expenses - The statements of operations and changes in net assets include the excess (deficiency) of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess (deficiency) of revenues over expenses, consistent with industry practice, include changes in unrealized appreciation (depreciation) on investments, net loss on interest rate swap that qualifies for hedge accounting; net assets released from restrictions used for capital acquisitions; pension and postretirement-related adjustments; transfers to and from affiliates.

For purposes of display, transactions deemed by management to be ongoing, major or central to providing of health care services are reported as operating revenues and operating expenses. Operating revenues include net patient service revenue, grant income and investment income. Peripheral or incidental transactions are reported as non-operating gains, losses and expenses.

Note 2 - Summary of Significant Accounting Policies (continued)

Non-operating gains and losses include investment income and expenses related to property management, realized gains and losses on sales of investments, losses recognized on investments representing declines in value considered to be other-than-temporary in nature, gains and losses related to the termination of certain swap instruments, changes in the fair values of interest rate swaps that do not qualify for hedge accounting (net interest expense) and the costs associated with pursuing business combinations.

Charity Care **-** The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established and contractual rates. The Hospital does not pursue collection of amounts determined to qualify as charity care; as such, these amounts are not reported as revenue.

Deferred Revenue **-** Deferred revenue represents payments received for the services to be rendered in the next fiscal year and is recorded within other current liabilities in the accompanying balance sheets.

Net Patient Service Revenue **-** Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. 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.

Contracts, laws and regulations governing Medicare, Medicaid, Blue Cross and the uncompensated care pool programs in the State of Connecticut are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital records adjustments to the amounts accrued for estimated settlements related to prior years.

A portion of the accrual for estimated settlements with third-party payers has been classified as long term because such amounts, by their nature or by virtue of regulation or legislation, are not expected to be paid within one year.

The Hospital has agreements with third-party payers that provide for payments at amounts different from its established rates. A summary of the payment agreements with major third-party payers is as follows:

> ***Medicare*** **-** Acute care hospitals are subject to a federal prospective payment system for most Medicare inpatient hospital services and for certain outpatient services. Under this prospective payment methodology, Medicare pays a prospectively determined per discharge or per visit rate for non-physician services. These rates vary according to the Diagnosis-Related Group or Ambulatory Payment Classification of each patient.
>
> Inpatient rehabilitation and mental health services, outpatient services, capital and medical education costs related to Medicare beneficiaries are paid based on a prospective payment system, subject to certain limitations. Certain other outpatient services are reimbursed according to fee screens.
>
> ***Medicaid*** **-** Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost-reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital.

Note 2 - Summary of Significant Accounting Policies (continued)

> ***Other Payers*** **-** The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment under these agreements includes rates per discharge, discounts from established charges, per diem rates, and fee schedule payments.

Health Care Industry **-** The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to further governmental review and interpretation as well as regulatory actions unknown or unasserted at this time.

EHR Incentive Payment Revenue - The American Recovery and Reinvestment Act of 2009 authorized the Centers for Medicare and Medicaid Services (CMS) to award incentive payments to eligible health care providers who demonstrate Meaningful Use of certified electronic health records (EHR). These incentive programs are designed to support providers in this period of health information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care. Total received for Medicare amounted to $1,626,870 and $0, respectively, and the total received for Medicaid amounted to $0 and $618,428, respectively, for the years ended September 30, 2012 and 2011.

Future Operations **-** Current trends in the health care industry include mergers and other forms of affiliations among providers, increasing shifts to managed care, overall reduction in inpatient average length of stay, increasingly restrictive reimbursement policies by governmental and private payers and the prospect of significant changes in legislation at the state and national level. Management cannot assess or project the ultimate effect of these or other items on the future operations of the Hospital.

Interest in Net Assets of ECHF **-** ECHF was formed as a not-for-profit organization to supervise the development activities and engage in investment activities for the benefit of all of the ECHN subsidiaries. ECHN is the sole member of ECHF and ECHF's Board of Directors is appointed by ECHN. The Hospital follows the provisions of FASB ASC 958 (formerly, FASB Statement No. 136, "*Transfers of Assets to a Not-for-Profit Organization or Charitable Trust That Raises or Holds Contributions for Others*"). Accordingly, the Hospital has reflected its proportionate interest in the net assets of ECHF in the Hospital's financial statements.

Income Taxes **-** The Hospital is a not-for-profit organization, which is in compliance with the provisions of Internal Revenue Code (IRC) Sec. 501(c)(3) and is exempt from federal tax under IRC Sec. 501(a). At times, the Hospital is involved with activities that subject minor amounts of unrelated business federal income tax, which are paid as they come due in accordance with the Code and the regulations there under. Such amounts are insignificant to the Hospital's financial statements.

Note 2 - Summary of Significant Accounting Policies (continued)

The Hospital accounts for uncertain tax positions in accordance with provisions of FASB ASC 740, "*Income Taxes*" which provides a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their financial statements. The Hospital may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position.

The Hospital does not have any uncertain tax positions as of September 30, 2012 and 2011. As of September 30, 2012 and 2011, the Hospital did not record any penalties or interest associated with uncertain tax positions. The Hospital's prior three tax years are open and subject to examination by the Internal Revenue Service.

Asset Retirement Obligations **-** The Hospital recognizes a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and/or method of settlement of a conditional asset retirement obligation is factored into the measurement of the liability when sufficient information exists.

The types of asset retirement obligations that the Hospital recognizes are those for which the Hospital has a legal obligation to perform an asset retirement activity, however, the timing and/or method of settling the obligation are conditional on a future event that may or may not be within its control. The fair value of a liability for the legal obligation associated with an asset retirement is recorded in the period in which the obligation is incurred. When the liability is initially recorded, the cost of the asset retirement is capitalized.

As of September 30, 2012 and 2011, the Hospital has recognized $128,578 and $125,749, respectively, as an obligation to remove asbestos from various buildings upon retirement. This total is included in the balance sheets within other liabilities.

Accounting for Defined Benefit Pension and Other Postretirement Plans **-** The Hospital recognizes the overfunded or underfunded status of their defined-benefit pension and other postretirement benefit plans (collectively, postretirement benefit plans) in the balance sheets as an asset or liability.

The Hospital recognizes changes in the funded status of the plans in the year in which the changes occur as a change in unrestricted net assets presented below the excess of revenues over expenses in its statements of operations and changes in net assets.

Inventory **-** The Hospital records inventory at cost using the first-in, first-out method.

Impairment of Long-Lived Assets **-** Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed are reported at the lower of carrying amount or fair value, less cost to sell.

Estimated Self-Insurance Liabilities **-** The liabilities for outstanding losses and loss related expenses and the related provision for losses and loss related expenses include estimates for malpractice losses, general liability, and workers' compensation incurred but not reported claims as well as losses pending settlement. Such liabilities are necessarily based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be in excess of or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making such estimates and the resulting liability are actuarially reviewed on an annual basis, and any adjustments required are reflected in operations in the current period. The current portion of estimated self-insurance liabilities is recorded within other current liabilities in the accompanying balance sheets.

Note 2 - Summary of Significant Accounting Policies (continued)

Concentration of Credit Risk - Financial instruments which potentially subject the Hospital to concentration of credit risk consist of accounts receivable, investments, including temporary cash investments, marketable equity and debt securities, mutual funds, government securities and interest rate swap agreements. The Hospital receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payers, including Medicare (a federal program), Medicaid (a State of Connecticut program) and various health insurance companies.

Interest Rate Swap Agreements - Interest rate swap agreements are recognized as either assets or liabilities in the balance sheet at fair value regardless of the purpose or intent for holding them. Changes in the fair value of interest rate swap agreements are recognized in other non-operating losses or if designated and effective as hedge transactions, as changes in unrestricted net assets.

Advertising Costs - The Hospital expenses advertising costs the first time the advertising takes place. The total amount charged to advertising expense was $399,319 and $428,589 for the years ended September 30, 2012 and 2011, respectively, and is recorded in supplies and other expenses in the accompanying statements of operations and changes in net assets.

Accounting Pronouncements Adopted - In August 2010, the FASB issued ASU No. 2010-23, "*Health Care Entities (Topic 954): Measuring Charity Care for Disclosure*". ASU No. 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU No. 2010-23 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct or indirect cost of providing the charity care, and requires disclosure of the method used to identify or determine such costs. This ASU is effective for fiscal years beginning after December 15, 2010, with retrospective application required. The Hospital's adoption of ASU 2010-23 did not have a material impact on its overall financial statements.

In August 2010, the FASB issued ASU No. 2010-24, "*Health Care Entities (Topic 954) Presentation of Insurance Claims and Related Insurance Recoveries*". ASU No. 2010-24 clarifies that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010. The Hospital's adoption of ASU 2010-24 resulted in the recording of additional claim liabilities and insurance recoveries from CHIC in the amounts of $2,620,000 and $1,265,000, as of September 30, 2012 and 2011, respectively, which resulted in increasing due from affiliates and the estimated self insurance liabilities.

Pending Accounting Pronouncements - In July 2011, the FASB issued ASU No. 2011-07, "*Health Care Entities (Topic 954), Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*", which requires a healthcare entity to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, enhanced disclosures about an entity's policies for recognizing revenue, assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts are required. The adoption of ASU 2011-07 is effective for the Hospital beginning October 1, 2012.

Note 2 - Summary of Significant Accounting Policies (continued)

In May 2011, the FASB issued ASU No. 2011-04, "*Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRS*". ASU No. 2011-04 amends certain guidance in ASC 820, "*Fair Value Measurement*". ASU 2011-04 expands ASC 820's existing disclosure requirements for fair value measurements and makes other amendments. ASU 2011-04 is effective for interim and annual reporting periods beginning after December 15, 2011 and will be applied on a prospective basis.

The Hospital is currently evaluating the effect that the provisions of ASU 2011-04 will have on the Hospital's financial statements.

Reclassification **-** Certain amounts in the 2011 financial statements have been reclassified to conform to the 2012 presentation. These reclassifications had no material effect on the 2011 financial statements.

Subsequent Events **-** Subsequent events have been evaluated through December 18, 2012, the date through which procedures were performed to prepare the financial statements for issuance. Management believes that there are no subsequent events having a material impact on the financial statements.

Note 3 - Assets Whose Use is Limited and Investments

Assets whose use is limited and investments as of September 30, 2012 and 2011, include the following:

	2012		**2011**	
	Cost	**Fair Value**	**Cost**	**Fair Value**
Board designated and donor-restricted:				
Money market funds	**$ 173,616**	**$ 173,616**	$ 72,074	$ 72,074
Mutual funds:				
Short-term bond fund	**4,486,385**	**4,523,909**	4,474,955	4,425,166
Large value fund	**5,610,061**	**6,009,591**	5,493,506	4,616,340
Total	**$ 10,270,062**	**$ 10,707,116**	$ 10,040,535	$ 9,113,580
Investments held under bond indenture:				
Money market funds	**$ 958,137**	**$ 958,137**	$ 1,971,611	$ 1,971,611
U.S. government securities	**440,896**	**441,048**	420,686	420,196
Total	**$ 1,399,033**	**$ 1,399,185**	$ 2,392,297	$ 2,391,807
Beneficial interest in trust assets	**$ 1,878,052**	**$ 2,104,303**	$ 1,741,998	$ 1,887,242

Note 3 - Assets Whose Use is Limited and Investments (continued)

	2012		2011	
	Cost	**Fair Value**	**Cost**	**Fair Value**
Investments:				
Money market funds	**$ 12,307**	**$ 12,307**	$ 7,848	$ 7,848
Mutual funds:				
Short-term bond fund	**22,300**	**22,633**	21,770	21,670
Foreign large growth fund	**3,675,987**	**3,877,646**	3,553,132	3,374,470
Large value fund	**5,217,633**	**5,591,406**	5,109,189	4,295,105
Moderate allocation funds	**41,664**	**50,319**	40,293	41,701
Total	**$ 8,969,891**	**$ 9,554,311**	$ 8,732,232	$ 7,740,794
Total assets whose use is limited and investments	**$ 22,517,038**	**$ 23,764,915**	$ 22,907,062	$ 21,133,423

The fair values and gross unrealized losses for all investment categories whose fair value is below its cost and the length of time that the securities have been in an unrealized loss position as of September 30, 2012 and 2011, are as follows:

2012	**Less than 12 months**		**Greater than 12 months**		**Total**	
	Fair Value	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Foreign large growth fund	$ 400,220	$ (23,713)	$ -	$ -	$ 400,220	$ (23,713)

2011	**Less than 12 months**		**Greater than 12 months**		**Total**	
	Fair Value	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**	**Fair Value**	**Unrealized Losses**
Short-term bond fund	$ 4,446,836	$ (49,889)	$ -	$ -	$ 4,446,836	$ (49,889)
Foreign large growth fund	348,286	(62,965)	3,026,184	(115,697)	3,374,470	(178,662)
Large value fund	-	-	8,911,445	(1,691,250)	8,911,445	(1,691,250)
	$ 4,795,122	$ (112,854)	$ 11,937,629	$ (1,806,947)	$ 16,732,751	$ (1,919,801)

The Hospital's unrealized losses on its investments in mutual funds consist primarily of unrealized losses in the Vanguard Group diversified equity mutual funds as of September 30, 2012 and 2011. The Hospital has evaluated the near-term prospects of the investments in relation to the severity of the impairment (fair value is approximately 1% and 24% less than cost as of September 30, 2012 and 2011, respectively) and recent market trends. Based on that evaluation and the Hospital's ability and intent to hold those investments for a reasonable period of time sufficient for a forecasted recovery of fair value, the Hospital does not consider those investments to be other-than-temporarily impaired as of September 30, 2012 and 2011.

Note 3 - Assets Whose Use is Limited and Investments (continued)

Interest and dividend income on the assets whose use is limited and investments included within other revenues on the statements of operations and changes in net assets totaled $449,329 and $376,415 for the years ended September 30, 2012 and 2011, respectively. There were no realized gains or losses for the years ended September 30, 2012 and 2011.

Note 4 - Fair Value Measurements

FASB ASC 820 provides a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Hospital has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has specified (contractual) terms, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

Note 4 - Fair Value Measurements (continued)

The following table presents the financial instruments carried at fair value as of September 30, 2012 and 2011, by the valuation hierarchy:

2012	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 1,144,060	$ -	$ -	$ 1,144,060
U.S. Government securities	441,048	-	-	441,048
Short-term bond fund	4,546,542	-	-	4,546,542
Foreign large growth fund	3,877,646	-	-	3,877,646
Large value fund	11,600,997	-	-	11,600,997
Moderate allocation funds	50,319	-	-	50,319
Beneficial interest in trusts	-	-	2,104,303	2,104,303
Total assets at fair value	$ 21,660,612	$ -	$ 2,104,303	$23,764,915

2011	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 2,051,533	$ -	$ -	$ 2,051,533
Fixed income mutual funds	420,196	-	-	420,196
Short-term bond fund	4,446,836	-	-	4,446,836
Foreign large growth fund	3,374,470	-	-	3,374,470
Large value fund	8,911,445	-	-	8,911,445
Moderate allocation funds	41,701	-	-	41,701
Beneficial interest in trusts	-	-	1,887,242	1,887,242
Total assets at fair value	$ 19,246,181	$ -	$ 1,887,242	$21,133,423

During the years ended September 30, 2012 and 2011, the value of the beneficial interest in trusts increased for a change in market value of $310,887 and $1,454, respectively. In addition, the Hospital received $93,826 and $72,563 in distributions from these trusts in 2012 and 2011, respectively.

The Hospital's valuation methodologies used to measure financial assets and liabilities at fair value are outlined below. Where applicable, the Hospital uses quoted prices in active markets for identical assets and liabilities to determine fair value (Level 1 inputs). This pricing methodology applies to money market funds, short-term bonds, foreign large growth funds, value index funds, moderate allocation funds and U.S. government securities.

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). As of September 30, 2012 and 2011, the Hospital has no Level 2 inputs.

Note 4 - Fair Value Measurements (continued)

Assets and liabilities that are valued using significant unobservable inputs, such as extrapolated data, proprietary models, or indicative quotes that cannot be corroborated with market data are classified in Level 3 within the fair value hierarchy. The Level 3 classification includes the Hospital's beneficial interest in trusts. The value of the Hospital's assets is based on total fund values and the Hospital's corresponding beneficiary percentage.

Fair values of the Hospital's Series C Bonds are based on current traded value. The fair value of the Series C Bonds as of September 30, 2012 and 2011, is approximately $7,995,981 and $7,588,066, respectively. The fair value of the Hospital's remaining long-term debt approximates its carrying value.

As of September 30, 2012 and 2011, the Hospitals other financial instruments included accounts receivable, accounts payable and accrued expenses and estimated settlements due from (to) third-party payers. The carrying amounts reported in the balance sheets for these financial instruments approximate their fair value.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Note 5 - Property, Plant and Equipment

Property, plant and equipment as of September 30, 2012 and 2011, consists of the following:

	2012	2011
Land and land improvements	**$ 1,152,087**	$ 1,149,997
Building and building improvements	**48,381,424**	47,137,460
Fixed equipment	**8,686,362**	8,579,755
Moveable equipment	**35,311,149**	33,354,035
	93,531,022	90,221,247
Less: accumulated depreciation and amortization	**(63,146,530)**	(59,437,084)
	30,384,492	30,784,163
Construction in progress	**88,282**	367,691
	$ 30,472,774	$ 31,151,854

For the years ended September 30, 2012 and 2011, the Hospital capitalized interest related to construction financed with tax-exempt debt of $15,110 and $8,873, respectively. The cost to complete the construction in progress is approximately $90,000 and $650,000 as of September 30, 2012 and 2011, respectively.

Note 6 - Unamortized Bond Issue Costs

Unamortized bond issue costs that are recorded within other - net in the accompanying balance sheets as of September 30, 2012 and 2011, are as follows:

	2012	2011
Deferred financing costs	**$ 1,346,197**	$ 1,336,197
Less: accumulated amortization	**(514,578)**	(469,271)
	$ 831,619	$ 866,926

Note 7 - Intangible Assets

The gross carrying amount and accumulated amortization related to license enhancements as of September 30, 2012 and 2011 consisted of the following:

	2012	2011
Gross carrying amount	**$ 540,000**	$ 540,000
Accumulated amortization	**(540,000)**	(468,000)
	$ -	$ 72,000

Amortization expense related to intangible assets was $72,000 and $108,000 for the years ended September 30, 2012 and 2011, respectively.

Note 8 - Related Party Transactions

The Network provides certain administrative and operating services to the Hospital and allocates these expenses along with revenues back to the Hospital. The allocation percentage is as follows: MMH 69.8%, RGH 28.9%, and EES 1.3%. The net expenses allocated to the Hospital were $6,390,430 and $7,594,237 for the years ended September 30, 2012 and 2011, respectively.

Amounts due from related entities as of September 30, 2012 and 2011, consist of the following:

	2012	2011
EES	**$ 3,947**	$ 180,545
MMH	**774,082**	1,986,032
Foundation	**3,870**	-
CHIC	**2,620,000**	1,265,000
Enterprises	-	30,194
ECHN	-	2,793,961
	$ 3,401,899	$ 6,255,732

Note 8 - Related Party Transactions (continued)

Amounts due to related entities as of September 30, 2012 and 2011, consist of the following:

	2012	2011
ECHF	**$ -**	$ 5,986
ECHN	**3,297,172**	-
ECMPF	**-**	2,711,364
	$ 3,297,172	$ 2,717,350

Amounts due from affiliates consist of operational, working capital, amounts due from CHIC for insurance recoveries and other advances made to ECHN and its affiliates. Management believes the amounts due from ECHN and affiliates can be repaid through ECHN's individual and overall consolidated net asset value. Amounts due to affiliates relate to general operational cash flows.

The Hospital made an equity transfer to ECHN during 2012 and 2011 of $8,205,356 and $8,575,553, respectively, to help support the ECHN Network activities.

Note 9 - Medical Malpractice Insurance

In fiscal year 2007, ECHN established a single-parent captive, CHIC, which covers all of its subsidiaries, including the Hospital. CHIC provides malpractice and general insurance coverage for ECHN and its subsidiaries at $3,000,000 per occurrence and $9,000,000 in the aggregate for the years ended September 30, 2012 and 2011.

Effective October 1, 2009, CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims made basis covering healthcare professional liability, general care liability, automobile liability, employers liability, helipad liability and non-owned aircraft liability. The limit provided is $30,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage is fully reinsured.

Claims that fall within CHIC's policies for medical malpractice and general liability insurance have been asserted against the Hospital by various claimants. The claims are in various stages and some may ultimately be brought to trial. CHIC has employed independent actuaries to estimate the ultimate costs, if any, of the resolution of such claims. As of September 30, 2012 and 2011, no discount was applied to the accrued medical malpractice and general liability reserves.

The Hospital does not self-insure any malpractice risks other than exposures greater than its excess coverage's, however, as of September 30, 2012 and 2011, the Hospital has recorded a liability for estimated incurred but not reported claims, as it currently has a claims-made policy with CHIC. In addition, as mentioned in Note 2, the adoption of ASU 2011-24 resulted in the recording of additional claim liabilities and insurance recoveries from CHIC in the amounts of $2,620,000 and $1,265,000, as of September 30, 2012 and 2011, respectively.

Note 10 - Estimated Self-Insurance Liabilities

The Hospital is self-insured for workers' compensation insurance coverage. The Hospital participates in Workers' Compensation Trust, a revocable trust, for the purpose of setting aside assets based on actuarial funding recommendations. The Hospital has a $350,000 limit per occurrence for workers' compensation claims. The Hospital has employed independent actuaries to estimate the ultimate costs, if any, of workers' compensation claims. Accrued workers' compensation reserves have been discounted at 5% as of September 30, 2012 and 2011 and in management's opinion provide an adequate reserve for loss contingencies.

Note 11 - Pension and Other Postretirement Benefits

ECHN has a defined benefit pension plan covering substantially all of the employees of the Hospital and MMH. The benefits are based upon years of service and compensation for the five highest years during the employee's last 10 years of service. The Hospital and MMH contribute amounts sufficient to meet the minimum funding requirements of the Employment Retirement Income Security Act of 1974, as well as such additional amounts as deemed appropriate.

Effective December 31, 2008, ECHN implemented a soft freeze on the defined-benefit pension plan. All employees with age and service credits greater than 65 were given the option to stay in the defined-benefit pension plan or freeze their defined benefits and enter into a defined contribution plan. All other employees were required to enter into the defined contribution plan. Under the defined contribution plan, ECHN contributes 3% of eligible employee s' salaries. This match is non-guaranteed for all employees except certain union workers. During fiscal years 2012 and 2011, the Hospital incurred expenses of $757,156 and $670,836, respectively, related to this plan.

RGH and MMH also sponsor a postretirement benefit plan that provides health care benefits to those employees who retire. The criterion to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. The postretirement health care plan is contributory and the retiree pays 100% of the premium.

Unrestricted net assets of the Hospital and MMH as of September 30, 2012 include unrecognized actuarial losses of $71,226,109 related to the defined-benefit pension plan and unrecognized actuarial gains of $877,039 related to the postretirement plan. Of this amount, $5,481,445 is expected to be recognized in net periodic pension costs in 2013.

The effects of Medicare Prescription Drug, Improvement and Modernization Act of 2003 were reflected as of September 30, 2012 and 2011, assuming that ECHN will continue to provide a prescription drug benefit to retirees that is at least actuarially equivalent to Medicare Part D and that ECHN will receive the federal subsidy. The subsidy reduced plan liabilities by approximately $1,100,000 for each of the years ended September 30, 2012 and 2011, respectively. Subsidies of $95,241 and $95,233 were received in the years ended September 30, 2012 and 2011, respectively. Future benefits of $397,164 are expected to be paid and future subsidies of $69,237 are expected to be received related to the year ended September 30, 2012.

Note 11 - Pension and Other Postretirement Benefits (continued)

The pension and postretirement plans change in benefit obligation and change in plan assets for the years ended September 30, 2012 and 2011, are as follows (information presented is for the Network (MMH and RGH combined), based on September 30 measurement date):

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Change in benefit obligation:				
Benefit obligation, beginning of year	**$ 188,714,944**	$ 173,024,122	**$ 4,680,687**	$ 4,502,342
Service cost	**2,233,145**	1,694,601	**63,127**	62,573
Interest cost	**10,105,635**	9,607,108	**226,498**	211,052
Plan participants' contributions	-	-	**507,918**	676,830
Receipt of Medicare Part D reimbursement	-	-	**95,241**	95,233
Actuarial loss (gain)	**30,013,892**	11,875,070	**(140,180)**	105,204
Benefits paid	**(7,966,121)**	(7,485,957)	**(800,286)**	(972,547)
Benefit obligation, end of year	**$ 223,101,495**	$ 188,714,944	**$ 4,633,005**	$ 4,680,687

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Change in plan assets:				
Fair value of plan assets, beginning of year	**$ 125,293,980**	$ 118,535,420	**$ -**	$ -
Actual return on plan assets	**20,980,869**	7,674,517	**-**	-
Employer contributions	**10,910,000**	6,570,000	**197,127**	200,484
Plan participants' contributions	-	-	**507,918**	676,830
Receipt of Medicare Part D reimbursement	-	-	**95,241**	95,233
Benefits paid	**(7,966,121)**	(7,485,957)	**(800,286)**	(972,547)
Fair value of plan assets, end of year	**$ 149,218,728**	$ 125,293,980	**$ -**	$ -
Accrued pension and other postretirement benefits	**$ (73,882,767)**	$ (63,420,964)	**$ (4,633,005)**	$ (4,680,687)
Accumulated benefit obligation	**$ 213,696,232**	$ 183,312,903	**$ -**	$ -

The amounts recognized in the Network's consolidated balance sheets as of September 30, 2012 and 2011 are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Current liabilities	**$ 3,500,000**	$ 10,910,000	**$ 397,164**	$ 420,446
Non-current liabilities	**70,382,767**	52,510,964	**4,235,841**	4,260,241
Net amount recognized	**$ 73,882,767**	$ 63,420,964	**$ 4,633,005**	$ 4,680,687

Note 11 - Pension and Other Postretirement Benefits (continued)

The allocation of the accrued pension and postretirement benefits for the years ended September 30, 2012 and 2011 is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
MMH	**$ 56,594,968**	$ 48,712,087	**$ 3,608,963**	$ 3,336,703
RGH	**17,287,799**	14,708,877	**1,024,042**	1,343,984
Total	**$ 73,882,767**	$ 63,420,964	**$ 4,633,005**	$ 4,680,687

The plan's components of net periodic benefit cost for the years ended September 30, 2012 and 2011, are as follows (pension benefits information presented is for MMH and RGH combined):

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Service cost	**$ 2,233,145**	$ 1,694,601	**$ 63,127**	$ 62,573
Interest cost	**10,105,635**	9,607,108	**226,498**	211,052
Expected return on plan assets	**(10,959,005)**	(10,398,180)	**-**	-
Amortization of prior service (credits) costs	**(234,992)**	(234,992)	**77,724**	77,724
Amortization of net loss (gain)	**2,871,791**	1,304,258	**(43,699)**	(57,507)
Net periodic benefit cost	**$ 4,016,574**	$ 1,972,795	**$ 323,650**	$ 293,842

The allocation of the net periodic benefit cost for the years ended September 30, 2012 and 2011, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
MMH	**$ 3,060,240**	$ 1,340,948	**$ 252,113**	$ 209,470
RGH	**956,334**	631,847	**71,537**	84,372
	$ 4,016,574	$ 1,972,795	**$ 323,650**	$ 293,842

The assumptions used to determine the pension and postretirement benefit obligations as of September 30, 2012 and 2011, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Discount rate	**4.32%**	5.47%	**3.64%**	5.03%
Expected long-term rate of return	**8.00%**	8.00%	**N/A**	N/A
Rate of compensation increase	**2.75%**	2.75%	**N/A**	N/A
Initial medical trend rate	**N/A**	N/A	**7.91%**	8.91%
Ultimate medical trend rate	**N/A**	N/A	**4.50%**	4.50%
Number of years to ultimate medical trend rate	**N/A**	N/A	**15 years**	17 years

Note 11 - Pension and Other Postretirement Benefits (continued)

The assumptions used to determine net periodic benefits cost of the pension and postretirement benefit obligations for the years ended September 30, 2012 and 2011, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Discount rate	**5.47%**	5.67%	**5.03%**	4.88%
Expected long-term rate of return	**8.00%**	8.00%	**N/A**	N/A
Rate of compensation increase	**2.75%**	2.75%	**N/A**	N/A
Initial medical trend rate	**N/A**	N/A	**7.91%**	8.91%
Ultimate medical trend rate	**N/A**	N/A	**4.50%**	4.50%
Number of years to ultimate medical trend rate	**N/A**	N/A	**15 years**	17 years

The medical trend rate assumption has a significant effect on the amounts reported. A one-percentage-point change in assumed medical trend rates would have the following effects:

	One-Percentage Point Increase	One-Percentage Point Decrease
Effect on year-end postretirement benefit obligation	$ 382,130	$ (338,354)
Effect on total of service and interest cost components	$ 25,275	$ (22,288)

The pension plan's weighted-average asset allocations as of September 30, 2012 and 2011, by asset category, are as follows:

	Pension Benefits	
	2012	**2011**
Asset category:		
Equity securities	**51%**	42%
Debt securities	**48%**	57%
Cash and cash equivalents	**1%**	1%
Total	**100%**	100%

The pension plan's investment policy includes the following asset allocation guidelines:

	2012		2011	
	Policy Target	**Range**	**Policy Target**	**Range**
Asset category:				
Equity securities	**53%**	**40-60%**	44%	34-54%
Debt securities	**46%**	**45-50%**	56%	51-61%
Cash and cash equivalents	**1%**	**0-4%**	0%	0-4%

Note 11 - Pension and Other Postretirement Benefits (continued)

The asset allocation policy was developed in consideration of the following long-term investment objectives: maximizing portfolio returns with at least a return of 4%, net of all trading expenses and fees, above inflation, as measured by the Consumer Price Index and achieving portfolio returns, which exceed a composite index consisting of the S&P 500, the Russell 2000 Index, Ryan Labs GIC Index, and the Barclays Capital Aggregate Bond Index in the same proportion as the fund's average commitment to equity and fixed income, respectively, and to rank in the top quartile of a broad universe of corporate pension plans of similar size.

The expected long-term rate-of-return-on-assets assumption was determined by evaluating portfolio returns based on capital market assumptions over a 20-year time horizon which are reduced by expected transaction costs and expected investment management fees for passively invested assets (to the extent that such fees are expected to be paid out of plan assets rather than directly by the Network).

Fair value methodologies used to assign plan assets to levels in accordance with ASC 820 are consistent with the inputs described in Note 4.

The following table presents the investments of the defined benefit plan carried at fair value as of September 30, 2012 and 2011, by the valuation hierarchy.

2012	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 944,555	$ -	$ -	$ 944,555
Fixed income mutual funds:				
Long duration	53,025,749	-	-	53,025,749
US Core Opportunistic	12,088,551	-	-	12,088,551
US Passive	2,983,658	-	-	2,983,658
Guaranteed investment contract	183,256	-	3,195,313	3,378,569
Equities:				
Small/mid cap	8,232,969	-	-	8,232,969
Active long cap	11,917,531	-	-	11,917,531
Large cap	30,277,740	-	-	30,277,740
International	26,369,406	-	-	26,369,406
Total	$ 146,023,415	$ -	$ 3,195,313	$ 149,218,728

Note 11 - Pension and Other Postretirement Benefits (continued)

2011	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 588,004	$ -	$ -	$ 588,004
Fixed income mutual funds:				
Long duration	56,839,238	-	-	56,839,238
US Core Opportunistic	9,716,075	-	-	9,716,075
US Passive	1,738,106	-	-	1,738,106
Guaranteed investment contract	170,915	-	3,374,535	3,545,450
Equities:				
Small/mid cap	5,699,196	-	-	5,699,196
Large cap	26,548,136	-	-	26,548,136
International	20,619,775	-	-	20,619,775
Total	$ 121,919,445	$ -	$ 3,374,535	$ 125,293,980

The changes within the level 3 investments as of September 30, 2012 and 2011 is as follows:

2012	Guaranteed Investment Contract
Balance as of October 1, 2011	$ 3,374,535
Investment income	194,239
Expenditures	(373,461)
Balance as of September 30, 2012	$ 3,195,313

2011	Real Estate Securities	Guaranteed Investment Contract	Total
Balance as of October 1, 2010	$ 2,333,339	$ 3,571,198	$ 5,904,537
Investment return:			
Investment income	-	237,985	237,985
Net change in market value	498,504	-	498,504
Proceeds from sale of investment	(2,831,843)	-	(2,831,843)
Expenditures	-	(434,648)	(434,648)
Balance as of September 30, 2011	$ -	$ 3,374,535	$ 3,374,535

Note 11 - Pension and Other Postretirement Benefits (continued)

During fiscal year 2013, ECHN anticipates contributing $3,500,000 to the defined benefit plan.

The future benefit payments, which reflect estimated future service and expected to be paid from the plans for the year ended September 30, 2012, are as follows:

	Pension Benefits	Other Postretirement Benefits
2013	$ 7,839,728	$ 397,164
2014	$ 8,177,609	$ 409,051
2015	$ 8,613,029	$ 104,768
2016	$ 9,079,307	$ 405,187
2017	$ 9,773,496	$ 418,484
2018-2022	$ 58,816,410	$ 2,087,013

The Hospital also has a defined contribution employee savings plan covering substantially all employees. Eligible employees who contribute to the plan will have 20% - 50%, depending upon years of service, of contributions matched by the Hospital, up to a maximum of 6% of annual compensation. Contributions to the plan were suspended for non-union employees from April 2009 to April 2010. The Hospital incurred expenses related to the employee savings plan amounting to $12,629 and $258,650 for the years ended September 30, 2012 and 2011, respectively.

Note 12 - Long-Term Debt

Long-term debt, as of September 30, 2012 and 2011, consists of the following:

	2012	2011
The Hospital's portion of CHEFA Hospital Revenue Bonds, ECHN Issue, Series C, bearing interest at rates ranging from 4.00% to 5.125% - net of amortized original issue premium of $85,468 and $90,216 in 2012 and 2011, respectively.	**$ 7,936,518**	$ 8,112,616
The Hospital's portion of the CHEFA Hospital Demand Revenue Bonds, ECHN Issue Series E bearing interest at a variable rate, adjusted weekly.	**16,263,000**	17,662,500
The Hospital's portion of the loan due to Chase Equipment Leasing Inc., face amount allocated to RGH of $1,680,000, due and payable in monthly principal and interest installments maturing on March 20, 2013 and bearing interest at 3.24%.	**249,251**	735,817
Capital lease obligations (see Note 13)	**1,216,986**	596,693
Total long-term debt	**25,665,755**	27,107,626
Less: current maturities	**(1,271,671)**	(1,247,313)
Long-term debt - net	**$ 24,394,084**	$ 25,860,313

Note 12 - Long-Term Debt (continued)

In February 2000, the Hospital, MMH and EES (collectively, the Series A Obligated Group) entered into an agreement and open-ended mortgage with Connecticut Health and Educational Facilities Authority (CHEFA) in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series 2000A (the Series A Bonds). A portion of the proceeds from the Series 2000A bonds, net of the original issue discount and amounts used to establish required reserve accounts, was placed in an irrevocable trust from which the remaining debt service payments for defeased CHEFA bonds will be paid. The remainder was used to finance additions and renovations for various facilities. The Series A Obligated Group has been legally released from any future debt service on the defeased bonds. The Series A Bonds are due on various dates through July 1, 2030.

In July 2004, the Hospital, MMH, EES and ECHF (collectively, the Series B Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series B (the Series B Bonds). A portion of the proceeds from the Series B Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was used to finance additions, renovations and purchases of equipment for RGH and MMH.

The Series B bonds were refinanced as part of the issuance of Series E bonds as described below.

On October 1, 2005, the Hospital, MMH, EES and ECHF (collectively, the Series C Obligated Group) entered into an agreement and open-ended mortgage with the CHEFA to borrow $37,065,000 in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series C (the Series C Bonds). The proceeds from the Series C Bonds, net of the original issue premium and amounts used to establish required reserve accounts, were placed in an irrevocable trust to advance refund and defease a portion of the Series 2000A Bonds. MMH, RGH and EES (collectively, the Series A Obligated Group) have been legally released from any future debt service on the portion of defeased Series 2000A Bonds. The Series C Bonds are due on various dates through July 1, 2030.

In May 2009, the Hospital, MMH, EES and ECHF (collectively, the Series D Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series D (the Series D Bonds). The proceeds from the Series D Bonds, net of amounts used to establish required reserve accounts, were used to finance renovations at MMH, an expansion at EES and other campus improvements. The Series D Bonds are due on various dates through May 14, 2039.

In December 2010, the Hospital, MMH, EES and ECHF (collectively, the Series E Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series E (the Series E Bonds). The proceeds from the Series E Bonds, net of amounts used to establish required reserve accounts, were used to redeem the Series B Bonds and fund interest rate swap agreement termination payments relating to the Series B Bonds. Series E Bonds are due on various dates through July 1, 2034.

Under the terms of the Series A, Series B, Series C, Series D and Series E Bonds, the Series A Obligated Group, Series B Obligated Group, Series C Obligated Group, Series D Obligated Group and Series E Obligated Group (the Obligated Groups) are required to maintain certain deposits with a trustee. Such deposits are included in assets whose use is limited. The indenture also places limits on the incurrence of additional borrowings and dispositions of property and requires that the Obligated Groups satisfy certain measures of financial performance as long as the notes are outstanding.

Note 12 - Long-Term Debt (continued)

The Obligated Groups are required to comply with certain financial covenants (as defined in the trust agreements) including a debt service coverage ratio, days cash on hand requirement and minimum cash to debt ratio. As of September 30, 2012 and 2011, the Obligated Groups were in compliance with the financial covenants of the debt agreements; however, ECHN had to receive a waiver from TD Bank, N.A. (under a letter of credit agreement for Series D and E bonds) for transfers to affiliated organizations outside the Obligated Group in excess of $4.0 million for the year ended September 30, 2011. The letter of credit agreement was amended in fiscal year 2012 to eliminate this requirement.

Under the terms of the CHEFA agreements, each member of the Obligated Groups is jointly and severally liable for the full and prompt payment of the amounts owed by the Obligated Groups. Total debt of the Obligated Groups was $81,999,098 and $80,156,296 as of September 30, 2012 and 2011, respectively. The debt is also secured by the gross receipts of the Obligated Groups.

The loans due to Chase Equipment Leasing Inc. are collateralized by the related equipment, accessories, attachments, software and other property relating thereto.

The Hospital is party to various capital leases, which are described in Note 13.

The annual maturities of the Hospital's portion of the long-term debt in each of the succeeding five years and thereafter as of September 30, 2012 are as follows:

2013	$	1,271,671
2014		870,081
2015		886,580
2016		873,156
2017		789,500
Thereafter		20,889,299
		25,580,287
Plus premium - net		85,468
Total	$	25,665,755

Note 13 - Lease Commitments

The Hospital leases equipment under capital lease agreements entered into on May 19, 2011, which expire in 2016. The interest rates range from 3.71% to 4.09%. The net carrying value of the equipment under the capital lease was $1,281,139 and $600,072 as of September 30, 2012 and 2011, respectively and is included in property, plant and equipment.

The Hospital leases various office spaces and certain equipment under operating leases that expire in various years through fiscal year 2013. Certain leases may be renewed at the end of their term.

Note 13 - Lease Commitments (continued)

Future minimum payments under capital and non-cancelable operating leases as of September 30, 2012 are as follows:

	Capital Leases	Operating Leases
2013	$ 449,339	$ 752,729
2014	278,135	629,180
2015	278,135	629,180
2016	218,973	629,180
2017	67,118	629,180
Thereafter	-	4,384,017
	1,291,700	$ 7,653,466
Less: interest on capital lease	74,714	
Principal amount of capital lease	$ 1,216,986	

Rent expense under month-to-month leases was $716,133 and $425,376 for the years ended September 30, 2012 and 2011, respectively.

Note 14 - Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of who are insured under third-party payer agreements. The mix in patient accounts receivable as of September 30, 2012 and 2011, before allowances for doubtful accounts, consists of the following:

	2012	2011
Self-pay	**32%**	26%
Managed care	**20%**	20%
Medicare	**26%**	29%
Commercial insurance	**5%**	5%
Medicaid	**13%**	17%
Other	**4%**	3%
	100%	100%

Note 15 - Net Patient Service Revenue

Net patient service revenue for the years ended September 30, 2012 and 2011, consists of the following:

	2012	2011
Patient service revenue:		
Inpatient services	**$ 69,889,867**	$ 54,124,324
Outpatient services	**118,179,406**	93,948,299
Gross patient service revenue	**188,069,273**	148,072,623
Deductions - allowances	**(120,221,635)**	(84,685,507)
Net patient service revenue	**$ 67,847,638**	$ 63,387,116

Note 16 - Community Benefit

ECHN's mission is to improve the health of the people and communities ECHN serves.

ECHN provides quality health care to all, regardless of their ability to pay. Charity care is provided to those who are eligible based on ECHN's policy. ECHN also incurs unpaid costs for government programs because reimbursement is not sufficient to cover costs associated with Medicare and Medicaid patients. In addition to the charity care responsibilities, ECHN provides numerous other community benefits. These community benefits include medical education and research, community health education, screenings, support groups, counseling services and in-kind support. To address the need for health care providers, a number of programs are offered for young people who may be interested in a career in health care.

ECHN utilizes guidelines developed by various organizations to quantify community benefit activities. ECHN defines community benefit activities as those that improve access to care, as well as the health of the broader community. In addition to charity care and the unpaid costs of government sponsored health care (Medicare and/or Medicaid shortfalls), community benefit activities will normally fall into one of the following categories: nonbilled community health services community health improvement services, health professions education, subsidized health services, research, financial and in-kind contributions, community building activities and community benefit operations.

The Hospital has a policy of providing charity care to patients who are unable to pay. Such patients are identified based on financial information obtained from the patient and subsequent analysis. Since the Hospital does not expect payment, estimated charges for charity care are not included in revenue. The amount of traditional charity care provided, determined on the basis of cost, was estimated at $742,084 and $332,078 for the years ended September 30, 2012 and 2011, respectively. Previously, the Hospital reported its estimates of services provided under its charity care programs based on gross charges. In connection with the Hospital's adoption of ASU 2010-23, "*Health Care Entities (Topic 954): Measuring Charity Care for Disclosure*," amounts previously reported for care provided under its charity care programs have been restated to reflect the Hospital's estimates of its direct and indirect cost of providing these services. This change had no impact on the Hospital's results of operations.

Note 17 - Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses relating to providing these services for the years ended September 30, 2012 and 2011, are as follows:

	2012	2011
Health care services	**$ 62,933,113**	$ 57,814,626
General and administrative	**11,105,841**	10,202,573
Total	**$ 74,038,954**	$ 68,017,199

Note 18 - Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets as of September 30, 2012 and 2011, are available for the following purposes:

	2012	2011
Departmental purposes	**$ 606,707**	$ 893,842
Capital campaign and pledges	**9,041**	18,690
Total	**$ 615,748**	$ 912,532

Permanently restricted net assets as of September 30, 2012 and 2011, consist of the following:

	2012	2011
Endowment restricted for other health care services	**$ 1,309,475**	$ 1,309,475
Endowment restricted for charity care	**219,388**	219,388
Beneficial interest in trust assets	**2,104,303**	1,887,242
Total	**$ 3,633,166**	$ 3,416,105

The composition of the Hospital's endowment by net asset class as of September 30, 2012 and 2011 was as follows:

2012	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 449,474	$ 1,246,575	$ 1,696,049
Board-designated endowment funds	9,011,067	-	-	9,011,067
Net assets, September 30, 2012	$ 9,011,067	$ 449,474	$ 1,246,575	$ 10,707,116

Note 18 - Temporarily and Permanently Restricted Net Assets (continued)

2011	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 771,974	$ 1,246,575	$ 2,018,549
Board-designated endowment funds	7,095,031	-	-	7,095,031
Net assets, September 30, 2011	$ 7,095,031	$ 771,974	$ 1,246,575	$ 9,113,580

The Hospital's endowments consist of multiple funds established for a variety of purposes. The endowments include both donor-restricted endowment funds and funds designated by the Board of Directors to function as endowments. As required by GAAP, endowments, including funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor restrictions.

The Hospital has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. 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 Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Hospital and 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; and (7) the investment policies of the Hospital.

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a reasonably stable and predictable stream of earnings to support the operations of the endowments and to preserve and enhance over time the real value of the endowment assets. Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment and management costs, over the long-term. Actual returns in any given year may vary from this amount.

The Investment Committee of the Board is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. The asset allocation policy reflects the objective with allocations structured for capital growth and inflation protection over the long-term.

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity based investments to achieve its long-term return objectives within prudent risk constraints.

The Hospital has not appropriated funds for expenditure from its endowment funds for the years ended September 30, 2012 and 2011.

Note 18 - Temporarily and Permanently Restricted Net Assets (continued)

Changes in Hospital's endowments for the years ended September 30, 2012 and 2011 are as follows:

2012	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2011	$ 7,095,031	$ 771,974	$ 1,246,575	$ 9,113,580
Interest income and dividends	215,487	14,039	-	229,526
Unrealized appreciation on investments	1,276,744	87,266	-	1,364,010
Transfers (to)/from endowment	423,805	(423,805)	-	-
Net assets, September 30, 2012	$ 9,011,067	$ 449,474	$ 1,246,575	$ 10,707,116

2011	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2010	$ 6,955,185	$ 825,128	$ 1,246,575	$ 9,026,888
Interest income and dividends	173,699	9,779	-	183,478
Unrealized depreciation on investments	(33,853)	(62,933)	-	(96,786)
Net assets, September 30, 2011	$ 7,095,031	$ 771,974	$ 1,246,575	$ 9,113,580

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Hospital to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2012 and 2011, there were no funds that were below the level required by donor or law.

Note 19 - Commitments and Contingencies

The Hospital is involved in various legal actions arising from the normal course of its activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration the advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, upon the balance sheets or the related statements of operations and changes in net assets, or cash flows of the Hospital.

The Hospital and the Hospital's defined benefit pension plans invest in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term.

Audited Combined Financial Statements and Supplementary Information

Windham Community Memorial Hospital, Inc., and Affiliates
Years Ended September 30, 2012 and 2011

Ernst & Young LLP

ERNST & YOUNG

Windham Community Memorial Hospital, Inc., and Affiliates

Audited Combined Financial Statements
and Supplementary Information

Years Ended September 30, 2012 and 2011

Contents

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

Board of Trustees
Windham Community Memorial Hospital, Inc., and Affiliates

We have audited the accompanying combined balance sheets of Windham Community Memorial Hospital, Inc., and Affiliates (the Hospital) as of September 30, 2012 and 2011, and the related combined statements of operations and changes in net assets and cash flows for the years then ended. These combined financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these combined financial statements based on our audits. We did not audit the financial statements of The Hatch Hospital Corporation which statements reflect total assets of $983,206 and $846,394 as of September 30, 2012 and 2011, respectively, and total revenues of $2,818,779 and $2,314,010 for the years then ended. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for The Hatch Hospital Corporation, is based solely on the report of the other auditors.

We conducted our audits in accordance with auditing standards generally accepted in 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, as well as evaluating the overall financial statement presentation. We believe that our audits and the report of other auditors provide a reasonable basis for our opinion.

In our opinion, based on our audits and the report of the other auditors, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of Windham Community Memorial Hospital, Inc. and Affiliates as of September 30, 2012 and 2011, and the combined results of their operations and changes in net assets and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the accompanying combined financial statements, in 2012 the Hospital changed its method of reporting estimated insurance claims receivable and estimated insurance claims liabilities with the adoption of the Accounting Standards Update No. 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*.

Ernst & Young LLP

January 25, 2013

Windham Community Memorial Hospital, Inc., and Affiliates

Combined Balance Sheets

	September 30	
	2012	**2011**
Assets		
Current assets:		
Cash and cash equivalents	**$ 4,122,969**	$ 2,502,682
Current portion of assets whose use is limited	**654,986**	771,378
Accounts receivable, less allowances of approximately $3,039,000 in 2012 and $2,312,000 in 2011	**20,670,040**	14,881,466
Other receivables	**4,081,376**	1,462,066
Inventories of supplies	**1,105,978**	1,113,332
Prepaid expenses	**147,588**	839,664
Pledges receivable	**314,961**	205,369
Total current assets	**31,097,898**	21,775,957
Other assets:		
Investments	**406,468**	325,966
Assets whose use is limited:		
Donor restricted investments	**1,597,574**	1,477,742
Funds held in trust	**2,831,893**	2,505,394
Investments in real estate, net of accumulated depreciation of approximately $771,000 in 2012 and $712,000 in 2011	**787,225**	824,378
Unamortized bond issuance expense	**273,015**	282,429
Debt service reserve fund	**1,439,934**	1,439,934
Deposits and other assets	**2,063,002**	929,932
Total other assets	**9,399,111**	7,785,775
Property, plant and equipment, net of accumulated depreciation	**39,646,124**	36,807,762
Total assets	**$ 80,143,133**	$ 66,369,494

	September 30	
	2012	**2011**
Liabilities and net assets		
Current liabilities:		
Trade accounts payable	**$ 7,315,960**	$ 5,154,628
Salaries, wages, payroll taxes and amounts withheld from employees	**1,194,930**	813,367
Accrued vacation and holiday pay	**618,658**	986,188
Other accrued expenses	**3,210,837**	499,932
Current portion of accrued pension liability and other	**5,125,668**	4,648,892
Due to third-party reimbursement agencies	**1,499,004**	71,283
Due to related party	**2,842,244**	668,962
Current portion of long-term debt and capital lease obligations	**11,337,796**	3,773,980
Total current liabilities	**33,145,097**	16,617,232
Long-term liabilities:		
Accrued pension liability	**64,662,899**	56,931,181
Other liabilities	**1,036,975**	–
Long-term debt, less current portion	**19,376,083**	19,388,119
Interest rate swap obligation	**4,387,733**	4,248,129
Capital lease obligations, less current portion	**57,293**	234,406
Total liabilities	**122,666,080**	97,419,067
Net assets:		
Unrestricted	**(47,943,489)**	(35,978,450)
Temporarily restricted	**1,453,029**	1,318,536
Permanently restricted	**3,967,513**	3,610,341
Total net assets	**(42,522,947)**	(31,049,573)
Total liabilities and net assets	**$ 80,143,133**	$ 66,369,494

See accompanying notes.

Windham Community Memorial Hospital, Inc., and Affiliates

Combined Statements of Operations and Changes in Net Assets

	Year Ended September 30	
	2012	**2011**
Unrestricted operating revenues:		
Net patient revenue	**$ 90,160,381**	$ 85,855,448
Provision for bad debts	**3,122,185**	3,021,253
Net revenue from patients less provision for bad debts	**87,038,196**	82,834,195
Other operating revenues	**5,420,274**	2,697,011
Net assets released from restriction	**341,424**	347,228
Total operating revenues	**92,799,894**	85,878,434
Operating expenses:		
Salaries	**42,907,325**	41,345,796
Employee benefits	**15,336,446**	16,084,939
Physician fees	**930,637**	693,799
Consulting, legal and auditing fees	**960,210**	871,661
Supplies	**9,080,128**	9,296,970
Insurance	**789,345**	885,340
Purchased services	**9,425,502**	6,605,187
Other nonsalary expenses	**7,708,599**	6,996,478
Provision for non-patient bad debts	**717,092**	343,929
Depreciation and amortization	**4,147,105**	4,545,850
Interest	**1,325,543**	1,476,666
Total operating expenses	**93,327,932**	89,146,615
Loss from operations before loss on early extinguishment of debt	**(528,038)**	(3,268,181)
Loss on early extinguishment of debt	**–**	(471,621)
Loss from operations	**(528,038)**	(3,739,802)
Nonoperating income (loss):		
Interest loss, net	**(163)**	(16,806)
Gifts and bequests	**698,728**	265,347
Net realized and unrealized gain (loss) on investments	**52,251**	(10,172)
Net gain from investment in real estate	**16,056**	14,300
Other nonoperating activities	**(952,170)**	(575,677)
Net nonoperating loss	**(185,298)**	(323,008)
Deficiency of revenues over expenses	**(713,336)**	(4,062,810)

Continued on next page.

Windham Community Memorial Hospital, Inc., and Affiliates

Combined Statements of Operations and Changes in Net Assets (continued)

	Year Ended September 30	
	2012	**2011**
Unrestricted net assets:		
Deficiency of revenues over expenses	**$ (713,336)**	$ (4,062,810)
Change in pension funding and post retirement obligations	**(11,323,642)**	(6,778,013)
Net assets released from restriction for capital	**71,939**	66,188
Decrease in unrestricted net assets	**(11,965,039)**	(10,774,635)
Temporarily restricted net assets:		
Gifts and bequests	**301,983**	199,308
Investment income, net	**43,674**	37,801
Realized gain on investments	**24,097**	26,775
Unrealized gain (loss) on investments	**178,102**	(70,221)
Net assets released from restrictions for operations	**(341,424)**	(347,228)
Net assets released from restriction for capital	**(71,939)**	(66,188)
Increase (decrease) in temporarily restricted net assets	**134,493**	(219,753)
Permanently restricted net assets:		
Gifts and bequests	**4,200**	–
Investment income (loss), net	**1,107**	(207)
Realized gain on investments	**25,366**	4,011
Unrealized loss on investments	**–**	(6,404)
Transfer to unrestricted and temporarily restricted net assets	**–**	(14,451)
Change in fair value of funds held in trust	**326,499**	(102,411)
Increase (decrease) in permanently restricted net assets	**357,172**	(119,462)
Decrease in net assets	**(11,473,374)**	(11,113,850)
Net assets, beginning of year	**(31,049,573)**	(19,935,723)
Net assets, end of year	**$ (42,522,947)**	$ (31,049,573)

See accompanying notes.

Windham Community Memorial Hospital, Inc., and Affiliates

Combined Statements of Cash Flows

	Year Ended September 30	
	2012	**2011**
Cash flows from operating activities		
Change in net assets	**$ (11,473,374)**	$ (11,113,850)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Noncash items:		
Depreciation and amortization	**4,147,105**	4,545,850
Change in unrealized gains and losses on investments	**(178,101)**	(76,625)
Change in unrealized gains and losses on investments on funds held in trust by others	**(326,499)**	102,411
Provision for patient bad debts	**3,122,185**	3,021,253
Provision for non-patient bad debts	**717,092**	343,929
Change in net assets related to post retirement and pension plans	**11,323,642**	6,778,013
Loss on early extinguishment of debt	**–**	471,621
Change in fair value of interest rate swap agreements	**139,604**	1,062,660
Restricted contributions, realized gains and losses, and investment income	**(400,427)**	(267,688)
Other changes in net assets:		
Changes in assets and liabilities, net (See Note 12)	**(6,371,880)**	(4,126,980)
Net cash provided by operating activities	**699,347**	740,594
Cash flows from investing activities		
Net purchase of property, plant and equipment	**(6,985,467)**	(5,126,201)
Investment in real estate	**37,153**	55,939
Purchases of investments and assets limited as to use, net	**94,160**	418,326
Net cash used in investing activities	**(6,854,154)**	(4,651,936)
Cash flows from financing activities		
Payments on debt	**(3,782,229)**	(19,966,847)
Proceeds of debt service funds	**–**	658,326
Proceeds from refinancing	**–**	18,740,776
Proceeds from line of credit	**11,156,896**	3,400,000
Restricted contribution, realized gains and losses, and investment income	**400,427**	267,688
Net cash provided by financing activities	**7,775,094**	3,099,943
Net decrease in cash and cash equivalents	**1,620,287**	(811,399)
Cash and cash equivalents at beginning of year	**2,502,682**	3,314,081
Cash and cash equivalents at end of year	**$ 4,122,969**	$ 2,502,682

See accompanying notes.

Windham Community Memorial Hospital, Inc., and Affiliates

Notes to Combined Financial Statements

September 30, 2012

1. Significant Accounting Policies

The accounting policies that affect significant elements of Windham Community Memorial Hospital, Inc. and Affiliate's financial statements are summarized below and in Note 2.

Organization

Windham Community Memorial Hospital, Inc. (Windham or the Hospital) is a voluntary association incorporated under the General Statutes of the State of Connecticut, and as of March 2009, is an affiliate of Hartford HealthCare Corporation (HHC). The Board of Trustees of Windham, appointed by HHC, controls the operations of Windham. The accompanying combined financial statements include Windham Community Memorial Hospital, Inc., The Hatch Hospital Corporation, and the Windham Hospital Foundation, Inc. (together, the Hospital). All material intercompany accounts and transactions have been eliminated in the accompanying combined financial statements.

Windham, located in Willimantic, Connecticut, is a nonprofit acute care hospital. Windham provides inpatient, outpatient and emergency care services for residents of Northeastern Connecticut.

The Hatch Hospital Corporation (Hatch) is a nonprofit organization incorporated under the General Statutes of the State of Connecticut. Its purpose is to promote, foster, aid, carry out and fulfill the aims, objectives and purposes of the trust created under the Tenth Clause of the will of George Hatch. Periodically, amounts are transferred from the trust to Hatch for expenses as the need arises.

Windham Hospital Foundation, Inc. (Foundation) is a nonprofit organization incorporated under the General Statutes of the State of Connecticut. Its purpose is to promote and solicit charitable support for the purposes of Windham.

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. There is at least a reasonable possibility that certain estimates will change by material amounts in the near term.

1. Significant Accounting Policies (continued)

Regulatory Matters

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

Fair Value of Financial Instruments

The carrying value of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of other financial instruments are disclosed in the respective notes and/or in Note 5.

Cash and Cash Equivalents

Cash and cash equivalents include cash, commercial paper and corporate and government bonds, which are available to be converted to liquid assets within three months. Cash and cash equivalents are maintained with domestic financial institutions with deposits that exceed federally insured limits. It is the Hospital's policy to monitor the financial strength of these institutions.

Patient Accounts Receivable

Patient accounts receivable result from the health care services provided by the Hospital. Additions to the allowance for doubtful accounts result from the provision for uncollectible accounts. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts.

The amount of the allowance for doubtful accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage and other collection indicators. See Note 2 for additional information relative to third party payor programs.

The Hospital's primary concentration of credit risk is patient accounts receivable, which consist of amounts owed by various governmental agencies, insurance companies and private patients. The Hospital manages the receivables by regularly reviewing its patient

1. Significant Accounting Policies (continued)

accounts and contracts, and by providing appropriate allowances for uncollectible amounts. Significant concentrations of net patient accounts receivable are comprised of 38%, 14% and 28% and 41%, 15% and 24%, for Medicare, Medicaid and Commercial insurers, respectively, for the fiscal years ending September 30, 2012 and 2011, respectively.

Investments

The Hospital's investment portfolio is classified as trading, with unrealized gains and losses included in the deficiency of revenues over expenses.

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value at the balance sheet date. Valuations of those investments and, therefore, the Hospital's holdings may be determined by the investment manager and are primarily based on the underlying securities.

Inventories

Inventory consists of medical supplies and instruments and is valued at the lower of cost or market. Cost is determined on a first-in, first-out basis.

Property, Plant and Equipment

Property, plant and equipment is stated on the basis of cost. The Hospital provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives. Amortization of equipment held under capital leases is included in depreciation expense.

Conditional asset retirement obligations recorded under the provisions of Accounting Standards Codification (ASC) 410-20, *Asset Retirement Obligations,* amounted to $102,087 and $99,077 as of September 30, 2012 and 2011, respectively. These obligations are recorded in other noncurrent liabilities in the accompanying combined balance sheets. There are no assets that are legally restricted for purposes of settling asset retirement obligations. During 2012 and 2011, retirement obligations incurred and settled were minimal.

1. Significant Accounting Policies (continued)

Assets Whose Use is Limited

Assets whose use is limited includes assets that are set aside internally for nursing support and other health care services. Investments for restricted purposes are those restricted based on donors' intents.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those where use by the Hospital has been limited by donors, to a specific time frame or purpose. Temporarily restricted net assets are available to provide for the support of the new emergency room renovations, purchase of equipment, free care, nursing support, scholarships and various other special purposes. Permanently restricted net assets have been restricted by donors and are maintained by the Hospital in perpetuity. The Hospital is a partial beneficiary to various perpetual trust agreements. Assets recorded under these agreements are recognized at fair value. The investment income generated from these funds is expendable to support healthcare services and the assets are classified as permanently restricted.

Contributions, including unconditional promises to give, are recognized as revenue in the period received. Conditional promises to give are not recognized until the conditions on which they depend are substantially met. Unrestricted contributions are recorded, net of expenses, within other operating revenue.

Pledges receivable to be received after one year are discounted utilizing a discount rate commensurate with the related risks involved. Amortization of the discount is recognized as revenue and is reflected in accordance with donor-imposed restrictions, if any, on the contributions.

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

1. Significant Accounting Policies (continued)

reported in the combined 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 unrestricted contributions in the accompanying financial statements, except those relating to donations of long-lived assets.

Bond Issuance Costs

Bond issuance costs associated with long-term debt for capital projects are amortized over the term of the debt using a method that approximates the effective interest method. Bond issuance costs of $273,015 and $282,429 are recorded in other assets in the combined balance sheets as of September 30, 2012 and 2011, respectively.

Interest Rate Swap Agreements

The Hospital utilizes interest rate swap agreements to reduce risks associated with changes in interest rates. The Hospital does not hold or issue derivative financial instruments for trading purposes. The Hospital is exposed to credit loss in the event of nonperformance by the counterparties to its interest rate swap agreements.

Interest rate swap agreements are reported at fair value. Changes in fair value are recognized in the performance indicator in the statements of operations and changes in net assets.

Other Operating Revenue

Other operating revenue includes electronic health record incentive program revenue, rental income, grant income, and unrestricted contributions.

Nonoperating Revenues

Activities, other than in connection with providing healthcare services, are considered to be nonoperating. Nonoperating gains consist primarily of income earned on invested funds, realized and unrealized gains and losses on unrestricted funds, change in fair value of interest rate swap agreements, and gifts and bequests.

1. Significant Accounting Policies (continued)

Deficiency of Revenues over Expenses

The combined statements of operations and changes in net assets include deficiency of revenues over expenses as the performance indicator. Changes in unrestricted net assets which are excluded from deficiency of revenues over expenses include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), changes in pension funding and postretirement obligations, and net asset transfers.

Professional Liability Insurance

Coverage for professional liability insurance is provided on a claims-made basis. The primary level of coverage is $10,000,000 per medical incident and $39,000,000 in the aggregate. The excess indemnity coverage is layered with four different insurance companies at $15,000,000 per claim and $15,000,000 in the aggregate. The primary and excess coverage is with CHS Insurance Limited, a captive insurance company. Malpractice claims are discounted at 2.49% and a liability for incurred but not reported claims was $298,000 at September 30, 2012 and 2011.

Income Taxes

Windham, Hatch and the Foundation are nonprofit corporations as described in Section 50l(c)(3) of the Internal Revenue Code (the Code) and are exempt from federal income taxes on related income pursuant to Section 50l(a) of the Code.

Electronic Health Record Incentive Program

The Centers for Medicare & Medicaid Services (CMS) have implemented provisions of the American Recovery and Reinvestment Act of 2009 that provides incentive payments for the meaningful use of certified electronic health record (EHR) technology. CMS has defined meaningful use as meeting certain objectives and clinical quality measures based on current and updated technology capabilities over predetermined reporting periods as established by CMS. The Medicare EHR incentive program provides annual incentive payments to eligible professionals, eligible hospitals, and critical access hospitals, as defined, that are meaningful users of certified EHR technology. The Medicaid EHR incentive program provides annual incentive payments to eligible professionals and hospitals for efforts to adopt, implement, and

1. Significant Accounting Policies (continued)

meaningfully use certified EHR technology. The Hospital utilizes a grant accounting model to recognize EHR incentive revenues. The Hospital records EHR incentive payments as revenues when attestation that the EHR meaningful use criteria for the required period of time was demonstrated. Such revenues were recognized ratably over the relevant cost report period to determine the amount of reimbursement. Accordingly, the Hospital recognized approximately $2,400,000 of EHR revenues during the year ended September 30, 2012, approximately $1,900,000 and $500,000 relating to Medicare and Medicaid, respectively. EHR incentive revenues are included in other operating revenues in the accompanying combined statements of operations and changes in net assets.

The Hospital's attestation of compliance with the meaningful use criteria is subject to audit by the federal government or its designee. Additionally, Medicare EHR incentive payments received are subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated.

New Accounting Standards

In August 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Recoveries* (ASU 2010-24), which provides clarification to companies in the health care industry on the accounting for professional liability and similar insurance. ASU 2010-24 states that insurance liabilities should not be presented net of insurance recoveries and that an insurance receivable should be recognized on the same basis as the liabilities, subject to the need for a valuation allowance for uncollectible accounts. ASU 2010-24 is effective for fiscal years beginning after December 15, 2010 and was adopted by the Hospital on October 1, 2011. The adoption of this standard increased other current assets and other current liabilities by approximately $338,000, and other assets and other long-term liabilities by approximately $1.0 million in the combined balance sheet as of September 30, 2012 as compared to September 30, 2011.

In July 2011, FASB issued ASU 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts* (ASU 2011-07). The provisions of ASU 2011-07 require certain health care entities to present the provision for

1. Significant Accounting Policies (continued)

bad debts associated with patient revenue as a deduction from patient revenue (net of contractual allowances and discounts) rather than as an operating expense. Additional disclosures relating to sources of patient revenue and the allowance for doubtful accounts will also be required. 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 adopted those provisions as of and for the year ended September 30, 2012 and retrospectively applied the presentation requirements to all periods presented. See Note 1 and Note 2 for additional disclosures required by ASU 2011-07. There was no material impact to the Hospital's combined financial statements aside from the required changes in presentation.

In August 2010, the FASB issued ASU 2010-23, *Measuring Charity Care for Disclosure* (ASU 2010-23). ASU 2010-23 requires that the level of charity care provided be presented based on the direct and indirect costs of the charity services provided. ASU 2010-23 also requires separate disclosure of the amount of any cash reimbursements received for providing charity care. ASU 2010-23 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The Hospital adopted this guidance in 2012 which had no material impact to the combined financial statements. Refer to Note 2 for disclosure.

Reclassifications

Certain reclassifications have been made to the year ended September 30, 2011 balances previously reported in the combined balance sheets and statements of operations and changes in net assets in order to conform with the year ended September 30, 2012 presentation.

2. Revenues from Services to Patients and Charity Care

Revenues from Medicare, Medicaid, Anthem and Self Pay accounted for approximately 43%, 8%, 20%, and 8% and 41%, 8%, 20%, and 10% for the years ended September 30, 2012 and 2011, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term.

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

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. 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.

The following table summarizes the combined gross and net revenues from services to patients:

	Year Ended September 30	
	2012	**2011**
Gross revenues from patients:		
Inpatients:		
Routine services	**$ 17,346,577**	$ 17,117,272
Special services	**51,593,403**	55,105,246
	68,939,980	72,222,518
Outpatients	**141,210,109**	127,160,607
Gross revenues from patients	**210,150,089**	199,383,125
Deductions:		
Allowances	**116,283,387**	110,493,786
Charity care	**3,706,321**	3,033,891
Net patient revenue	**90,160,381**	85,855,448
Provision for bad debts	**3,122,185**	3,021,253
Net patient revenue less provision for bad debts	**$ 87,038,196**	$ 82,834,195

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. The difference is accounted for as allowances. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, fee-for-service, discounted charges and per diem payments. Net patient service revenue is affected by the State of Connecticut Disproportionate Share program and is reported at the estimated net realizable amounts due from patients, third-party payors and others for services rendered and includes estimated retroactive revenue adjustments due to future audits, reviews and investigations.

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

Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews and investigations. During fiscal 2012 and 2011 the Hospital recorded net changes in estimate of approximately $538,000 and ($404,000), respectively, which relate to previously estimated third party payor settlements.

The Hospital has established estimates based on information presently available, of amounts due to or from Medicare, Medicaid and third-party payors for adjustments to current and prior year payment rates, based on industry-wide and Hospital-specific data. Such amounts are included in the accompanying combined balance sheets.

The Hospital has agreements with various health maintenance organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the HMOs make fee-for-service payments to the Hospital for certain covered services based upon discounted fee schedules.

The Hospital's estimation of the allowance for doubtful accounts is based primarily upon the type and age of the patient accounts receivable and the effectiveness of the Hospital's collection efforts.

The Hospital's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to co-payments and deductibles, as these charges are recorded. On a monthly basis, the Hospital reviews its accounts receivable balances, the effectiveness of the Company's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following:

- Historical write-off and collection experience using a hindsight or look-back approach;
- Revenue and volume trends by payor, particularly the self-pay components;
- Changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent co-payments and deductibles due from patients;
- Various allowance coverage statistics.

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

The Hospital regularly performs hindsight procedures to evaluate historical write-off and collection experience throughout the year to assist in determining the reasonableness of its process for estimating the allowance for doubtful accounts.

The Hospital accepts all patients, regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized poverty income levels but also includes certain cases where incurred charges are significant when compared to incomes. These charges are not included in net patient service revenues for financial reporting purposes.

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 qualify as charity care, such services are not reported as revenue. For patients who were determined by the Hospital to have the ability to pay but did not, the uncollected amounts are recorded as bad debt expense. In distinguishing charity care from bad debt expense, a number of factors are considered, certain of which require a high degree of judgment.

The estimated cost of charity care provided was $1,696,172 and $1,388,439 for the years ended September 30, 2012 and 2011, respectively. The estimated cost of charity care is based on the ratio of cost to charges, as determined by hospital-specific data.

3. Net Assets

Temporarily restricted net assets are available for the following purposes at September 30:

	2012	2011
Purchase of equipment	**$ 262,664**	$ 155,010
Free care	**80,941**	62,553
Nursing support	**245,218**	446,773
Other purpose restrictions	**864,206**	654,200
Total temporarily restricted net assets	**$ 1,453,029**	$ 1,318,536

3. Net Assets (continued)

Permanently restricted net assets at September 30 are restricted for:

	2012	2011
Investments to be held in perpetuity, the income from which is expendable to support health care services	**$ 1,135,620**	$ 1,104,947
Restricted funds held in trust by others, the income from which is expendable to support health care services	**2,831,893**	2,505,394
	$ 3,967,513	$ 3,610,341

The Hospital's endowment consists of various finds established for a variety of purposes. The endowment includes donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor imposed restrictions.

The Board of Trustees of the Hospital has interpreted the Uniform Prudent Management of Institutional Funds Act ("UPMIFA") UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Hospital classifies as permanently net restricted assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of 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 of 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 by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA.

3. Net Assets (continued)

In accordance with UPMIFA, the Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted funds:

1) The duration and preservation of the fund
2) The purposes of the Hospital and 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

The Hospital has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Hospital must hold in perpetuity or for a donor-specific period(s). Under the policy, as approved by the Board of Directors, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment management costs, of at least a 4% over the long term. Actual returns in any given year may vary from this amount.

To satisfy its long-term rate-of-return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based alternative investments to achieve its long-term objective within prudent risk constraints.

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 invest goals.

This is consistent with the Hospital's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment returns.

3. Net Assets (continued)

Changes in endowment funds for the fiscal year ended September 30 consisted of the following:

	2012		
	Temporarily Restricted	**Permanently Restricted**	**Total**
Endowment net assets at beginning of year	**$ 647,096**	**$ 1,104,947**	**$ 1,752,043**
Investment return:			
Investment income	**43,674**	**1,107**	**44,781**
Net appreciation (realized and unrealized)	**202,199**	**25,366**	**227,565**
Total investment return	**245,873**	**26,473**	**272,346**
Appropriation of endowment assets for expenditure	**(281,045)**	**–**	**(281,045)**
Endowment net assets at end of year	**$ 611,924**	**$ 1,131,420**	**$ 1,743,344**

	2011		
	Temporarily Restricted	**Permanently Restricted**	**Total**
Endowment net assets at beginning of year	$ 934,457	$ 1,121,998	$ 2,056,455
Investment return:			
Investment income	37,801	(207)	37,594
Net depreciation (realized and unrealized)	(43,446)	(2,393)	(45,839)
Total investment return	(5,645)	(2,600)	(8,245)
Contributions	350	–	350
	–	–	–
Appropriation of endowment assets for expenditure	(282,066)	(14,451)	(296,517)
	$ 647,096	$ 1,104,947	$ 1,752,043

3. Net Assets (continued)

From time to time, the fair value of assets associated with individual donor-restricted endowments funds may fall below the level that the donor of UPMIFA requires the Hospital to retain as a fund of perpetual duration. These deficiencies result from unfavorable market fluctuations that occurred shortly after the investment of new permanently restricted contributions and continued appropriation for certain programs that was deemed prudent by the Board of Trustees. There were no significant deficiencies of this nature which are reported in unrestricted net assets as of September 30, 2012 or 2011.

4. Investments and Assets Whose Use is Limited

Investments and assets whose use is limited are stated at fair value at September 30 as follows:

	2012	2011
Cash and cash equivalents	**$ 654,986**	$ 771,378
Marketable equity securities	**311,301**	337,050
Corporate and government obligations	**112,549**	162,773
Mutual funds	**1,580,192**	1,303,885
	$ 2,659,028	$ 2,575,086

The composition and presentation of unrestricted investment (loss) income which is included in nonoperating income (loss) are comprised of the following for the years ended September 30:

	2012	2011
Nonoperating income:		
Interest loss, net	**$ (163)**	$ (16,806)
Net realized gain and unrealized (loss) on investments	**52,251**	(10,172)
	$ 52,088	$ (26,978)

4. Investments and Assets Whose Use is Limited (continued)

Investments in real estate at September 30 are as follows:

	2012	2011
Professional building	**$ 889,087**	$ 885,444
Coventry Medical Building	**669,352**	650,869
	1,558,439	1,536,313
Less accumulated depreciation	**771,214**	711,935
Net investment in real estate	**$ 787,225**	$ 824,378

5. Fair Values of Financial Instruments

As defined in ASC 820-10, fair value 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. In order to increase consistency and comparability in fair value measurements, ASC 820-10 establishes a fair value hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels, which are described below:

Level 1: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets or liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.

Level 2: Observable inputs that are based on inputs not quoted in active markets, but corroborated by market data.

Level 3: Unobservable inputs are used when little or no market data is available. The fair value hierarchy gives the lowest priority to Level 3 inputs.

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 utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible. The Hospital also considers counterparty credit risk in its assessment of fair value.

5. Fair Values of Financial Instruments (continued)

Financial assets and liabilities carried at fair value in the accompanying combined balance sheets, excluding assets invested in the Hospital's defined benefit pension plan, are classified in the table below in one of the three categories described above:

	September 30, 2012			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	**$ 4,122,969**	**$ –**	**$ –**	**$ 4,122,969**
Investments and assets limited as to use:				
Cash and cash equivalents	**654,986**	**–**	**–**	**654,986**
Domestic equity securities	**311,301**	**–**	**–**	**311,301**
Domestic fixed income securities		**112,549**		**112,549**
Mutual funds:				
U.S.	**1,534,014**	**–**	**–**	**1,534,014**
International	**46,178**	**–**	**–**	**46,178**
Funds held in trust		**2,831,893**		**2,831,893**
Debt service reserve fund:				
Money market funds	**1,439,934**	**–**	**–**	**1,439,934**
Liabilities				
Interest rate swap agreements	**–**	**4,387,733**	**–**	**4,387,733**

5. Fair Values of Financial Instruments (continued)

Financial assets and liabilities carried at fair value in the accompanying combined balance sheets, excluding assets invested in the Hospital's defined benefit pension plan, are classified in the table below in one of the three categories described above:

	September 30, 2011			
	Level 1	**Level 2**	**Level 3**	**Total**
Assets				
Cash and cash equivalents	$ 2,502,682	$ –	$ –	$ 2,502,682
Assets limited as to use:				
Cash and cash equivalents	1,106,956	–	–	1,106,956
Domestic equity securities	263,145	–	–	263,145
Domestic fixed income securities	–	162,773	–	162,773
Mutual funds:				
U.S.	977,117	–	–	977,117
International	65,094	–	–	65,094
Funds held in trust	–	2,505,394	–	2,505,394
Debt service reserve fund:				
Money market funds	1,439,934	–	–	1,439,934
Liabilities				
Interest rate swap agreements	–	4,248,129	–	4,248,129

Financial assets carried at fair value included in the defined pension plan as of September 30, 2012 are held in a master trust. The Hospital owns participant units in the trust which was established on May 1, 2012. Financial assets classified within the trust are 43.3% Level 1, 45.4% Level 2 and 11.3% for Level 3.

5. Fair Values of Financial Instruments (continued)

Financial assets carried at fair value included in the defined benefit cash balance retirement plan as of September 30, 2011 are classified in the table below in one of the three categories described above:

	Level 1	Level 2	Level 3	Total
Pension fund assets:				
Cash and cash equivalents	$ 495,917	$ –	$ –	$ 495,917
Mutual funds:				
U.S.	54,363,099	–	–	54,363,099
International	6,750,546	–	–	6,750,546
Domestic common collective funds	–	4,460,743	–	4,460,743

Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is based upon 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 public market participants, dealers and brokers.

6. Property, Plant and Equipment

A summary of property, plant and equipment at September 30, is as follows:

	2012	2011
Land and land improvements	**$ 5,258,997**	$ 5,223,872
Buildings and building improvements	**47,562,746**	47,246,557
Equipment	**51,579,545**	48,399,667
	104,401,288	100,870.096
Less accumulated depreciation	**70,034,957**	66,077,045
	34,366,331	34,793,051
Construction in process (estimated cost to complete $5,422,775)	**5,279,793**	2,014,711
Net property, plant and equipment	**$ 39,646,124**	$ 36,807,762

The Hospital capitalized interest expense of $124,835 and $146,951 for the years ended September 30, 2012 and 2011.

7. Debt

Debt arrangements at September 30 include the following:

	2012	2011
Intercompany debt with HHC:		
HHC 2011 Series A, consisting of a tax exempt serial bond and term bonds; interest at rates ranging from 4.4% to 5.0%	**$ 18,740,776**	$ 18,740,776
Line of credit, variable rate at .92%	**8,152,133**	–
Line of credit, variable rate at .92%	**3,004,763**	–
Commercial revolving loan with a bank bearing interest at a rate per annum equal to the Prime Rate; aggregate amount of loan plus all interest due April 1, 2012	–	3,400,000
Promissory mortgage note with a bank bearing interest at 6%, payments are due in equal installments through Authority:		
Series, A, B, A-1 and B-1 November 1, 2032, secured by a mortgage on the related real property	**276,239**	282,558
Premium on long-term debt	**366,062**	371,390
	30,539,973	22,794,724
Less current portion	**11,163,890**	3,406,605
Total long-term debt	**$ 19,376,083**	$ 19,388,119

The future minimum principal payments of long-term debt are as follows:

Year ending September 30:	
2013	$ 11,163,890
2014	215,254
2015	243,097
2016	289,726
2017	4,048,883
Thereafter	14,579,123
	$ 30,539,973

7. Debt (continued)

On September 29, 2011, HHC issued approximately $375,815,000 of CHEFA Revenue Bonds Series A, B, and C (the HHC 2011 Bonds). In conjunction with the issuance of the 2011 Bonds, an obligated group was formed. The members of the obligated group are HHC, Hartford Hospital, The Hospital of Central Connecticut at New Britain General and Bradley Memorial, Windham Community Memorial Hospital and MidState Medical Center (collectively referred to as the "Obligated Group").

Obligated Group members are jointly and severally liable under a Master Trust Indenture (MTI) to make all payments required with respect to obligations under the MTI. HHC does have the right to name designated affiliates, although presently none exist. Though designated affiliates are not obligated to make debt service payments on the obligations under the MTI, each designated affiliate would have an independent designated affiliate agreement and promissory note with HHC with stipulated repayment terms and conditions, each subject to the governing law of the obligated groups' state of incorporation. In addition, HHC may cause each designated affiliate to transfer such amounts as necessary to enable the obligated group members to comply with the terms of the MTI, including payment of the outstanding obligations.

The HHC 2011 Bonds were issued to refund portions of existing debt under HHC, and to obtain funds for future capital needs. As such, the HHC 2011 Bonds are reflected as intercompany debt in the preceding schedule. The Hospital is party to the HHC Series A Revenue Bonds. The HHC Series A Revenue Bonds consist of serial bonds that mature annually from July 1, 2014 through July 1, 2023 and the term bonds mature from July 1, 2024 through July 1, 2041.

The MTI and Supplemental MTI provide for the potential establishment and maintenance of a Debt Service Reserve Fund, a pledge of gross receipts, as defined, and parity with the HHC Series A Revenue Bonds that remain outstanding. The MTI and loan agreements establish certain restrictive covenants, including a debt service coverage ratio and days cash on hand requirement. No violations of covenants existed as of September 30, 2012 or 2011.

7. Debt (continued)

The fair value of the HHC 2011 Bonds was approximately $396,836,000 and $375,815,000 at September 30, 2012 and 2011, respectively. The carrying value of the HHC 2011 Bonds was $375,815,000 as of September 30, 2012 and 2011. The fair value of the HHC 2011 Bonds was determined by HHC's investment advisor using a market approach that uses prices and other relevant information generated by market transactions involving identical or comparable liabilities. The carrying value of the Hospital's other long-term debt approximates fair value at September 30, 2012 and 2011.

As part of the HHC 2011 Bonds, the Obligated Group entered into a line of credit for $20,000,000 from Bank of America. The line expires in March 2014. As of September 30, 2012, the Hospital had not drawn on this line of credit. In 2012, HHC obtained a new $60,000,000 line of credit with another bank. As of September 30, 2012 the Hospital drew $11,156,896 on this line of credit, which is also included in current portion of long-term debt that has a variable rate of 0.92% which expires March 2013.

In conjunction with the issuance of the Series D CHEFA Bonds, the Hospital entered into two interest rate swap agreements with a financial institution, with an original notional amount of $19,745,000, to fix the debt at a rate of 4.15%. The Total Return Swap Transaction was terminated on September 29, 2011 in conjunction with the extinguishment of the Windham Series D Bonds. On September 29, 2011, HHC modified certain terms of the Schedule to the ISDA Master Agreement between Merrill Lynch Capital Services, Inc. and the Hospital in connection with the fixed payer interest rate swap agreement entered into on November 30, 2007.

No financial terms of the swap agreement were modified. The fair value of the swap agreements were $4,387,733 and $4,248,129 at September 30, 2012 and 2011, respectively, and are recorded in the accompanying balance sheets. Although the swap agreements represent economic hedges of the interest rate on the bonds, they do not qualify for hedge accounting. The changes in fair value of these agreements are reported in the accompanying statements of operations and changes in net assets as a component of other nonoperating activities along with the net cash receipts on the swap agreements.

8. Capital Leases

The Hospital has entered into numerous agreements to lease equipment that meet the requirements of a capital lease.

8. Capital Leases (continued)

Capital lease obligations as of September 30 include the following:

	2012	2011
Capital lease obligations	**$ 231,199**	$ 601,782
Less current portion	**173,906**	367,376
Long-term capital lease obligations	**$ 57,293**	$ 234,406

The following is a schedule of future minimum lease payments under capital leases as of September 30:

	2012
2013	$ 183,487
2014	58,380
Total minimum lease payments	241,867
Less amount representing interest	10,668
Present value of net minimum lease payments	$ 231,199

9. Pension and Other Postretirement Benefits

The Hospital has a pension plan that provides for both a contributory and noncontributory defined benefit plan for eligible employees providing for retirement and certain death benefits. The benefits are based on years of service and the employee's compensation during the last five years of employment. The Hospital makes contributions in amounts sufficient to fund the pension plan's minimum funding requirements under the Employee Retirement Income Security Act.

Effective January 1, 2004, Windham began sponsoring the Windham Community Memorial Hospital 401(k) Plan. Under the terms of the plan, eligible employees receive a basic contribution of 2%, and the Hospital matches 50% of the employee's salary contribution up to an additional 3% of the employee's compensation. Effective April 1, 2006, all nonunion employees hired prior to April 1, 2004 have ceased their participation in the defined benefit

9. Pension and Other Postretirement Benefits (continued)

plan, and their pension accruals have been frozen as of that date. A second defined contribution plan known as the Windham Hospital Defined Contribution Plan was established for nonunion employees hired prior to April 1, 2004. Under the terms of the plan, eligible employees receive a basic contribution of 5% with no matching contribution. Effective January 1, 2010, all non-union employees in the 401(k) plan were transferred into the Defined Contribution Plan. Expense for employer contributions was approximately $1,851,000 and $1,728,000 in 2012 and 2011, respectively.

The following table sets forth the funded status and amounts recognized in the combined balance sheets for the pension and postretirement benefits:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Change in benefit obligation				
Benefit obligation at beginning of year	**$ (97,664,397)**	$ (94,607,331)	**$ (29,877,981)**	$ (25,562,300)
Service cost	**(275,000)**	(275,000)	**(92,677)**	(91,367)
Interest cost	**(5,055,459)**	(4,743,159)	**(1,498,044)**	(1,222,531)
Participant contributions	**–**	–	**(133,843)**	–
Benefits paid	**3,536,038**	3,458,662	**1,585,550**	1,105,780
Medicare part D adjustments	**–**	–	**(83,000)**	–
Actuarial loss	**(16,585,782)**	(1,497,569)	**(2,620,089)**	(4,107,563)
Benefit obligation at end of year	**$ (116,044,600)**	$ (97,664,397)	**$ (32,720,084)**	$ (29,877,981)
Change in plan assets				
Fair value of plan assets at beginning of year	**$ 66,070,305**	$ 62,581,311	**$ –**	$ –
Actual return on plan assets	**10,969,851**	250,588	**–**	–
Employer contribution	**5,580,000**	6,697,068	**1,451,707**	1,105,780
Participant contribution	**–**	–	**133,843**	–
Benefits paid	**(3,536,038)**	(3,458,662)	**(1,585,550)**	(1,105,780)
Fair value of plan assets at end of year	**79,084,118**	66,070,305	**–**	–
Unfunded status	**$ (36,960,482)**	$ (31,594,092)	**$ (32,720,084)**	$ (29,877,981)

The accumulated benefit obligations for the defined benefit pension plan and other postretirement benefit plan at September 30, 2012 and 2011 are $148,764,684 and $127,542,378, respectively.

9. Pension and Other Postretirement Benefits (continued)

The following table sets forth the unrecognized items impacting the pension and the postretirement plans as of September 30:

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Unrecognized net loss from past experience different from that assumed and effects of changes in assumptions	**$ 55,061,376**	$ 45,451,056	**$ 14,162,198**	$ 12,724,910
Unrecognized prior service cost	**–**	–	**(445,777)**	(882,812)

Amounts included in unrestricted net assets at September 30, 2012 and expected to be recognized in net periodic benefit cost during the year ended September 30, 2013 are as follows:

Amortization of prior service cost	$ (437,035)
Amortization of net loss	2,931,686
	$ 2,494,651

	Pension Benefits		Other Postretirement Benefits	
	2012	**2011**	**2012**	**2011**
Components of net periodic benefit cost				
Service cost	**$ 275,000**	$ 275,000	**$ 92,677**	$ 91,367
Interest cost	**5,055,459**	4,743,159	**1,498,044**	1,222,531
Return on plan assets	**(5,263,220)**	(4,977,532)	**–**	–
Net amortization and deferral	**1,268,831**	3,229,089	**741,807**	324,974
Benefit cost	**$ 1,336,070**	$ 3,269,716	**$ 2,332,528**	$ 1,638,872

The weighted-average discount rates used in determining the actuarial present value of the projected benefit obligation of the defined benefit plan were 4.10% and 5.25% in 2012 and 2011, respectively. The weighted average discount rates used in determining net periodic benefit cost of the defined benefit plan were 5.25% and 5.08% in 2012 and 2011, respectively. The expected long-term rate of return on plan assets was 8.00% and 8.25% in 2012 and 2011, respectively. The rate of return for fiscal year 2013 will be 7.50%. The expected long-term rate of return assumption is determined by adding expected inflation to expected long-term real returns of various asset classes, taking into account expected volatility and correlation between the returns of various asset classes.

9. Pension and Other Postretirement Benefits (continued)

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) is assumed to grade from 8.5% per year in fiscal year 2011 to 5% in fiscal year 2018. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a 1% point increase in the assumed health care cost trend rate would increase the accumulated postretirement benefit obligation by $4,098,863, at September 30, 2012. A 1% point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation $ 3,437,654 at September 30, 2012.

The Hospital's pension plan weighted-average asset allocations by asset category are as follows:

	Target Allocation	2012	2011
Equity securities	**57%**	**41%**	64%
Fixed income/debt securities	**25%**	**14%**	28%
Commodities/inflation/real estate	**8%**	**34%**	–
Other	**10%**	**11%**	8%
Total	**100%**	**100%**	100%

The asset mix was determined by evaluating the expected return against the plan's long-term objectives. Performance is monitored on a monthly basis, and the portfolio is rebalanced back to target levels to ensure the targets are within range. The investment policy describes which securities are allowed in the portfolios and the financed objectives of the plan which the Investment Committee of the Hospital Board oversees. The Investment Committee monitors the investment performance annually to determine the continued feasibility of achieving the investment objectives and the appropriateness of the investment policy.

Contributions

The Hospital expects to contribute approximately $ 6,837,000 to its pension plan in fiscal year 2013. The Hospital funds its other postretirement plan for actual expenses incurred.

9. Pension and Other Postretirement Benefits (continued)

Estimated Future Benefit Payments

The benefit payments, which reflect expected future services, are expected to be paid as follows:

	Pension Benefits	Other Postretirement Benefits
2013	$ 3,730,404	$ 1,395,264
2014	4,008,133	1,514,942
2015	4,363,593	1,632,004
2016	4,699,286	1,747,710
2017	5,084,747	1,860,734
2018-2022	30,725,454	10,370,541

10. Pledges Receivable

Pledges receivable as of September 30, are expected to be collected as follows:

	2012	2011
Within one year	**$ 340,721**	$ 230,619
Less reserve for uncollectible pledges	**(25,760)**	(25,250)
Net pledges receivable	**$ 314,961**	$ 205,369

11. Commitments and Contingencies

Various lawsuits and claims arising in the normal course of operations are pending or are in progress against the Hospital. Such lawsuits and claims are either specifically covered by insurance as explained in Note 1 or are deemed to be immaterial. While the outcomes of the lawsuits cannot be determined at this time, management believes that any loss which may arise from these actions will not have a material adverse effect on the financial position or changes in net assets of the Hospital.

11. Commitments and Contingencies (continued)

Operating Leases

The Hospital rents certain equipment under terms of leases that qualify as operating leases. Rental and lease expense amounted to $782,319 and $857,867 for the years ended September 30, 2012 and 2011, respectively.

The future minimum lease payments are as follows:

2013	$ 418,830
2014	412,869
2015	312,549
2016	228,592
2017	213,981
Thereafter	499,289
	$ 2,086,110

12. Supplemental Cash Flow Information

The changes in assets and liabilities are as follows:

	Year Ended September 30	
	2012	**2011**
Increase in accounts receivable	**$ (8,910,759)**	$ (4,155,992)
Increase in other receivables	**(3,336,402)**	(429,837)
Increase in pledge receivables	**(109,592)**	(40,326)
Decrease (increase) in inventories of supplies and prepaid expenses	**699,430**	(497,319)
Increase in estimated third-party payor settlements	**1,427,721**	1,657,000
Increase in due to related party	**2,842,244**	
(Increase) decrease in deposits and other assets	**(1,123,656)**	247,233
Increase in accounts payable	**1,492,370**	2,358,383
Increase (decrease) in salaries, wages, payroll taxes and amounts withheld from employees and accrued vacation and holiday pay	**14,033**	(130,243)
Increase (decrease) in other accrued expenses	**2,710,905**	(246,620)
Decrease in other accrued pension and other liabilities	**(2,078,174)**	(2,889,259)
	$ (6,371,880)	$ (4,126,980)

13. Functional Expenses

Windham provides short-term general health care services to acute-care patients. Hatch provides care, treatment and rehabilitation to patients convalescing from acute or chronic illness or injury. Expenses related to providing these services for the years ended September 30, 2012 and 2011, are as follows:

	2012	2011
Health care services	**$ 52,841,856**	$ 49,388,094
General and administrative	**40,486,076**	40,230,142
	$ 93,327,932	$ 89,618,236

14. Subsequent Events

The Hospital evaluated subsequent events through January 25, 2013, which is the date the financial statements were issued. No events occurred that require disclosure or adjustment to the combined financial statements.

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 Supplementary Information

Board of Trustees
Windham Community Memorial Hospital, Inc., and Affiliates

We have audited the combined financial statements of Windham Community Memorial Hospital, Inc., and Affiliates (the Hospital) as of and for the years ended September 30, 2012 and 2011, and have issued our report thereon dated January 25, 2013, which contained an unqualified opinion on those combined financial statements. Our audits were performed for the purpose of forming an opinion on the combined financial statements as a whole. The combining balance sheet and statement of operations are presented for the purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, based on our audit and the report of other auditors, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

Ernst & Young LLP

January 25, 2013

Windham Community Memorial Hospital, Inc., and Affiliates

Combining Balance Sheets

	September 30					
	Windham Community Memorial Hospital, Inc.	The Hatch Hospital Corporation	Windham Hospital Foundation, Inc.	Eliminations	Combined	September 30, 2011 Combined
Assets						
Current assets:						
Cash and cash equivalents	$ 3,805,389	$ 7,305	$ 310,275		$ 4,122,969	$ 2,502,682
Current portion of assets whose use is limited	653,211	1,775			654,986	771,378
Accounts receivable, less allowances of approximately $3,039,000	20,670,040				20,670,040	14,881,466
Other receivables	4,081,376				4,081,376	1,462,066
Inventories of supplies	1,105,978				1,105,978	1,113,332
Prepaid expenses	147,150		438		147,588	839,664
Pledges receivable	109,514		205,447		314,961	205,369
Total current assets	30,572,658	9,080	516,160	–	31,097,898	21,775,957
Other assets:						
Investments	64,018	342,450			406,468	325,966
Assets whose use is limited:						
Donor restricted investments	1,555,178	42,396			1,597,574	1,477,742
Funds held in trust	2,242,617	589,276			2,831,893	2,505,394
Investments in real estate, net of accumulated depreciation of approximately $771,000	787,225				787,225	824,378
Unamortized bond discount and issuance expense	273,015				273,015	282,429
Debt service reserve fund	1,439,934				1,439,934	1,439,934
Deposits and other assets	1,887,919		175,083		2,063,002	929,932
Total other assets	8,249,906	974,122	175,083	–	9,399,111	7,785,775
Property, plant and equipment, net of accumulated depreciation					–	
Total assets	39,646,120	4			39,646,124	36,807,762
	$ 78,468,684	$ 983,206	$ 691,243	$ –	$ 80,143,133	$ 66,369,494
Liabilities and net assets						
Current liabilities:						
Trade accounts payable	$ 7,296,659		$ 19,301		$ 7,315,960	$ 5,823,590
Salaries, wages, payroll taxes and amounts withheld from employees	1,194,930				1,194,930	813,367
Accrued vacation and holiday pay	618,658				618,658	986,188
Other accrued expenses	3,200,337	10,500			3,210,837	499,932
Current portion of accrued pension liability	5,125,668				5,125,668	4,648,892
Due to third-party reimbursement agencies	1,499,004				1,499,004	71,283
Due to related party	2,842,244				2,842,244	–
Current portion of long-term debt and capital lease obligation	11,337,796				11,337,796	3,773,980
Total current liabilities	33,115,296	10,500	19,301	–	33,145,097	16,617,232
Current portion of accrued pension liability	64,662,899				64,662,899	56,931,181
Other liabilities	1,036,975				1,036,975	
Long-term debt, less current portion	19,376,083				19,376,083	19,388,119
Interest rate swap obligation	4,387,733				4,387,733	4,248,129
Capital lease obligations, less current portion	57,293				57,293	234,406
Total liabilities	122,636,279	10,500	19,301	–	122,666,080	97,419,067
Net assets:						
Unrestricted	(48,579,469)	349,763	286,217		(47,943,489)	(35,978,450)
Temporarily restricted	1,033,637	33,667	385,725		1,453,029	1,318,536
Permanently restricted	3,378,237	589,276			3,967,513	3,610,341
Total net assets	(44,167,595)	972,706	671,942	–	(42,522,947)	(31,049,573)
Total liabilities and net assets	$ 78,468,684	$ 983,206	$ 691,243	$ –	$ 80,143,133	$ 66,369,494

Windham Community Memorial Hospital, Inc., and Affiliates

Combining Statements of Operations and Changes in Net Assets

	Year Ended September 30, 2012					
	Windham Community Memorial Hospital, Inc.	The Hatch Hospital Corporation	Windham Hospital Foundation, Inc.	Eliminations	Combined	Year Ended September 30, 2011 Combined
Unrestricted operating revenues:						
Net patient revenue	$ 87,529,888	$ 2,630,493			$ 90,160,381	$ 85,855,448
Less: Provision for bad debts	3,031,329	90,856			3,122,185	3,021,253
Net revenue from patients less bad debts	84,498,559	2,539,637	–	–	87,038,196	82,834,195
Other operating revenue	5,482,556	279,142			5,761,698	3,044,239
Total operating revenues	89,981,115	2,818,779	–	–	92,799,894	85,878,434
Operating expenses:						
Salaries	41,565,280	1,245,802	96,243		42,907,325	41,345,796
Employee benefits	14,854,648	445,226	36,572		15,336,446	16,084,939
Physician fees	903,555	27,082			930,637	693,799
Consulting, legal and auditing fees	932,268	27,942			960,210	871,661
Supplies	8,815,183	264,210	735		9,080,128	9,296,970
Insurance	766,375	22,970			789,345	885,340
Purchased services	9,135,478	273,810	16,214		9,425,502	6,605,187
Other nonsalary expenses	7,463,447	223,696	21,456		7,708,599	6,996,478
Provision for non-patient bad debts	696,225	20,867			717,092	343,929
Depreciation and amortization	4,026,424	120,681			4,147,105	4,545,850
Interest	1,286,970	38,573			1,325,543	1,476,666
Total operating expenses	90,445,853	2,710,859	171,220	–	93,327,932	89,146,615
Loss from operations before loss on early extinguishment of debt and gain transferred to Windham	(464,738)	107,920	(171,220)	–	(528,038)	(3,268,181)
Gain transferred to Windham	107,920	(107,920)			–	
Loss on early extinguishment of debt	–					(471,621)
Loss from operations	(356,818)	–	(171,220)	–	(528,038)	(3,739,802)
Nonoperating (loss) income:						
Investment (loss) income, net	(9,245)	7,978	1,104		(163)	(16,806)
Gifts and bequests	190,721		508,007		698,728	265,347
Net realized and unrealized (loss) gain on investments	8,739	43,512			52,251	(10,172)
Net gains (loss) from investment in real estate	16,056				16,056	14,300
Other nonoperating activities	(937,549)	(14,621)			(952,170)	(575,677)
Total nonoperating (loss) income	(731,278)	36,869	509,111	–	(185,298)	(323,008)
(Deficiency) excess of revenues over expenses	(1,088,096)	36,869	337,891	–	(713,336)	(3,591,189)

Continued on next page.

Windham Community Memorial Hospital, Inc., and Affiliates

Combining Statements of Operations and Changes in Net Assets (continued)

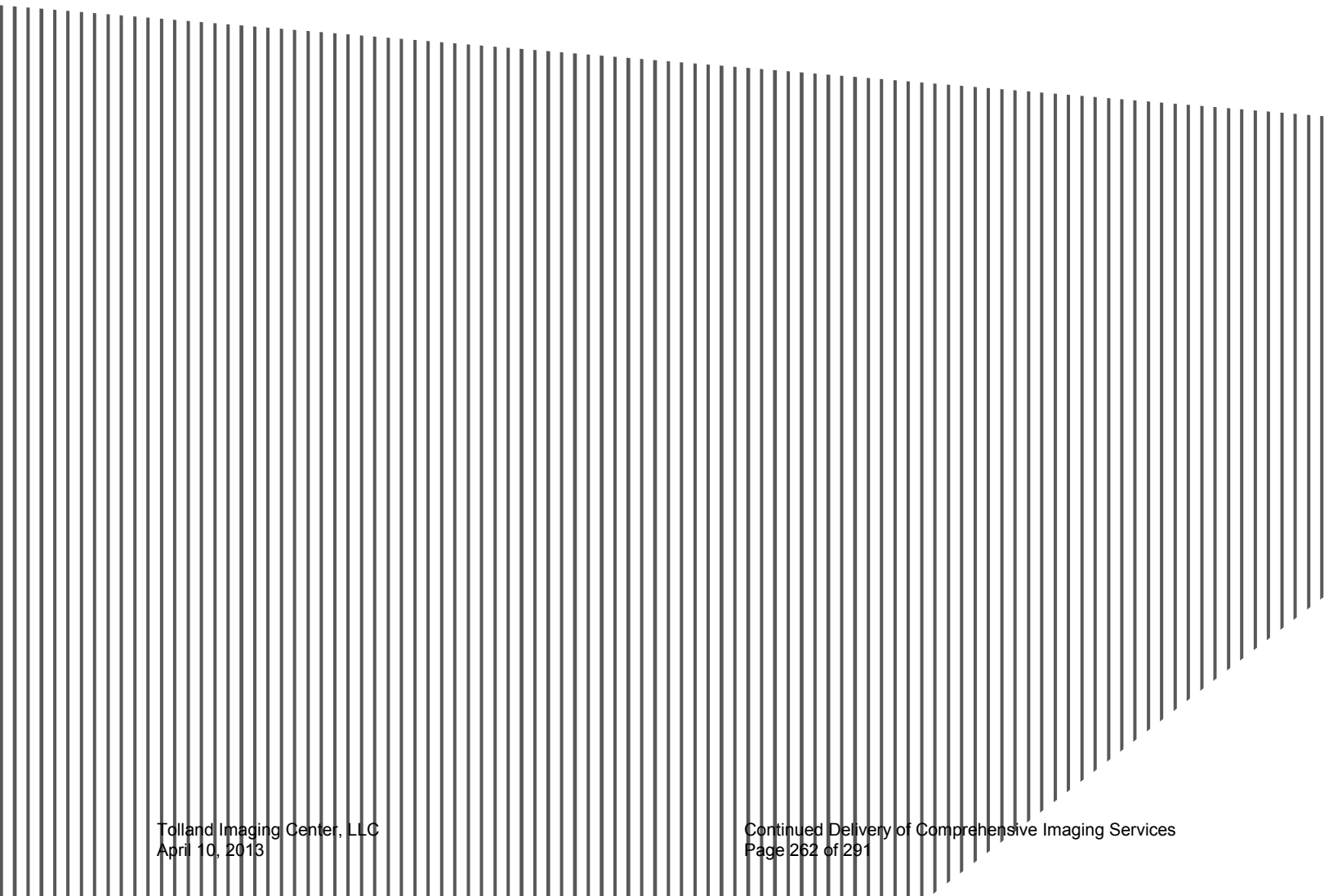
	Year Ended September 30, 2012					
	Windham Community Memorial Hospital, Inc.	The Hatch Hospital Corporation	Windham Hospital Foundation, Inc.	Eliminations	Combined	Year Ended September 30, 2011 Combined
Unrestricted net assets:						
(Deficiency) excess of revenues over expenses	$ (1,088,096)	$ 36,869	$ 337,891	$	$ (713,336)	$ (4,062,810)
Change in pension funding and post retirement obligations	(11,323,642)				(11,323,642)	(6,778,013)
Net assets released from restriction for capital		10,939	61,000		71,939	66,188
Other					–	
Transfer from other entity					–	
Transfer from temporarily restricted net assets					–	
Transfer from (to) Foundation	206,180		(206,180)		–	
(Decrease) increase in unrestricted net assets	(12,205,558)	47,808	192,711	–	(11,965,039)	(10,774,635)
Temporarily restricted net assets:						
Gifts and bequests			301,983		301,983	199,308
Investment income, net	27,593	16,081			43,674	37,801
Realized gain on investments	24,097				24,097	26,775
Unrealized (loss) gain on investments	178,102				178,102	(70,221)
Transfer to permanently restricted net assets					–	–
Net assets released from restriction for operations	(281,036)		(60,388)		(341,424)	(347,228)
Net assets released from restriction for capital		(10,939)	(61,000)		(71,939)	(66,188)
(Decrease) increase in temporarily restricted net assets	(51,244)	5,142	180,595	–	134,493	(219,753)
Permanently restricted net assets:						
Gifts and bequests	4,200				4,200	–
Investment loss, net	1,107				1,107	(207)
Realized gain on investments	25,366				25,366	4,011
Unrealized loss on investments					–	(6,404)
Transfer to unrestricted and temporarily restricted net assets					–	(14,451)
Change in fair value of funds held in trust	242,937	83,562			326,499	(102,411)
(Decrease) increase in permanently restricted net assets	273,610	83,562	–	–	357,172	(119,462)
(Decrease) increase in net assets	(11,983,192)	136,512	373,306	–	(11,473,374)	(11,113,850)
Net assets, beginning of year	(32,184,403)	836,194	298,636		(31,049,573)	(19,935,723)
Net assets, end of year	$ (44,167,595	$ 972,706	$ 671,942	$ –	$ (42,522,947	$ (31,049,573

Ernst & Young LLP

Assurance | Tax | Transactions | Advisory

About Ernst & Young
Ernst & Young is a global leader in assurance, tax, transaction and advisory services. Worldwide, our 167,000 people are united by our shared values and an unwavering commitment to quality. We make a difference by helping our people, our clients and our wider communities achieve their potential.

For more information, please visit www.ey.com



Appendix 5e

Tolland Lease Sch 1A

CASH FLOW DATA

	Event	Start Date	Amount	Number	Period	End Date
1	Loan	03/01/2011	1,306,757.30	1		
2	Payment	03/01/2011	29,407.32	48	Monthly	02/01/2015

AMORTIZATION SCHEDULE - Normal Amortization

	Date	Payment	Interest	Principal	Balance
Loan	03/01/2011				1,306,757.30
1	03/01/2011	29,407.32	0.00	29,407.32	1,277,349.98
2	04/01/2011	29,407.32	4,257.83	25,149.49	1,252,200.49
3	05/01/2011	29,407.32	4,174.00	25,233.32	1,226,967.17
4	06/01/2011	29,407.32	4,089.89	25,317.43	1,201,649.74
5	07/01/2011	29,407.32	4,005.50	25,401.82	1,176,247.92
6	08/01/2011	29,407.32	3,920.83	25,486.49	1,150,761.43
7	09/01/2011	29,407.32	3,835.87	25,571.45	1,125,189.98
8	10/01/2011	29,407.32	3,750.63	25,656.69	1,099,533.29
9	11/01/2011	29,407.32	3,665.11	25,742.21	1,073,791.08
10	12/01/2011	29,407.32	3,579.30	25,828.02	1,047,963.06
2011	Totals	294,073.20	35,278.96	258,794.24	
11	01/01/2012	29,407.32	3,493.21	25,914.11	1,022,048.95
12	02/01/2012	29,407.32	3,406.83	26,000.49	996,048.46
13	03/01/2012	29,407.32	3,320.16	26,087.16	969,961.30
14	04/01/2012	29,407.32	3,233.20	26,174.12	943,787.18
15	05/01/2012	29,407.32	3,145.96	26,261.36	917,525.82
16	06/01/2012	29,407.32	3,058.42	26,348.90	891,176.92
17	07/01/2012	29,407.32	2,970.59	26,436.73	864,740.19
18	08/01/2012	29,407.32	2,882.47	26,524.85	838,215.34
19	09/01/2012	29,407.32	2,794.05	26,613.27	811,602.07
20	10/01/2012	29,407.32	2,705.34	26,701.98	784,900.09
21	11/01/2012	29,407.32	2,616.33	26,790.99	758,109.10
22	12/01/2012	29,407.32	2,527.03	26,880.29	731,228.81
2012	Totals	352,887.84	36,153.59	316,734.25	
23	01/01/2013	29,407.32	2,437.43	26,969.89	704,258.92
24	02/01/2013	29,407.32	2,347.53	27,059.79	677,199.13
25	03/01/2013	29,407.32	2,257.33	27,149.99	650,049.14
26	04/01/2013	29,407.32	2,166.83	27,240.49	622,808.65
27	05/01/2013	29,407.32	2,076.03	27,331.29	595,477.36
28	06/01/2013	29,407.32	1,984.92	27,422.40	568,054.96
29	07/01/2013	29,407.32	1,893.52	27,513.80	540,541.16

Tolland Lease Sch 1A

	Date	Payment	Interest	Principal	Balance
30	08/01/2013	29,407.32	1,801.80	27,605.52	512,935.64
31	09/01/2013	29,407.32	1,709.79	27,697.53	485,238.11
32	10/01/2013	29,407.32	1,617.46	27,789.86	457,448.25
33	11/01/2013	29,407.32	1,524.83	27,882.49	429,565.76
34	12/01/2013	29,407.32	1,431.89	27,975.43	401,590.33
2013	Totals	352,887.84	23,249.36	329,638.48	
35	01/01/2014	29,407.32	1,338.63	28,068.69	373,521.64
36	02/01/2014	29,407.32	1,245.07	28,162.25	345,359.39
37	03/01/2014	29,407.32	1,151.20	28,256.12	317,103.27
38	04/01/2014	29,407.32	1,057.01	28,350.31	288,752.96
39	05/01/2014	29,407.32	962.51	28,444.81	260,308.15
40	06/01/2014	29,407.32	867.69	28,539.63	231,768.52
41	07/01/2014	29,407.32	772.56	28,634.76	203,133.76
42	08/01/2014	29,407.32	677.11	28,730.21	174,403.55
43	09/01/2014	29,407.32	581.35	28,825.97	145,577.58
44	10/01/2014	29,407.32	485.26	28,922.06	116,655.52
45	11/01/2014	29,407.32	388.85	29,018.47	87,637.05
46	12/01/2014	29,407.32	292.12	29,115.20	58,521.85
2014	Totals	352,887.84	9,819.36	343,068.48	
47	01/01/2015	29,407.32	195.07	29,212.25	29,309.60
48	02/01/2015	29,407.32	97.72	29,309.60	0.00
2015	Totals	58,814.64	292.79	58,521.85	
Grand Totals		1,411,551.36	104,794.06	1,306,757.30	

Last interest amount increased by 0.02 due to rounding.

Tolland Imaging Center

Asset Inventory and Depreciation Schedule

						Number of Months (unless noted):	*1*	*12*	*12*	*12*	*12*	*12*	
						Depreciation Schedule							
						Sept 2008	**FY2009**	**FY2010**	**FY2011**	**FY2012**	**FY2013**	**FY2014**
Asset Type	Asset Number	Asset Description	Date Placed in Service	**Amount**	**Useful Life**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**
Computer	TIC000130	Codonics - Mammo Film Printer	9/1/2008	$ 18,595.00	5.0	$ 309.92	$ 3,719.00	$ 3,719.00	$ 3,719.00	$ 3,719.00	$ 3,409.08	
Computer	TIC000140	Codonics - Medical Media Printers	9/1/2008	$ 43,610.00	5.0	$ 726.83	$ 8,722.00	$ 8,722.00	$ 8,722.00	$ 8,722.00	$ 7,995.17	
Computer Software	TIC000070	QuickBooks Software	7/4/2008	$ 211.99	3.0	$ 17.67	$ 70.66	$ 70.66	$ 53.00			
Computer Software	TIC000200	Powerscribe Licenses	10/23/2008	$ 17,482.50	3.0		$ 5,827.50	$ 5,827.50	$ 5,827.50			
Furniture and Fixtures	TIC000080	Yush Sign & Display - Building Ext Sign	9/1/2018	$ 4,390.90	7.0	$ 52.27	$ 627.27	$ 627.27	$ 627.27	$ 627.27	$ 627.27	$ 627.27
Furniture and Fixtures	TIC000090	Yush Sign & Display - Interior ADA Signs	9/1/2018	$ 1,440.00	7.0	$ 17.14	$ 205.71	$ 205.71	$ 205.71	$ 205.71	$ 205.71	$ 205.71
Furniture and Fixtures	TIC000100	WBMason - Office Furniture	9/1/2018	$ 16,992.01	7.0	$ 202.29	$ 2,427.43	$ 2,427.43	$ 2,427.43	$ 2,427.43	$ 2,427.43	$ 2,427.43
Furniture and Fixtures	TIC000150	Americom - Telephone system	9/1/2008	$ 2,984.69	7.0	$ 35.53	$ 426.38	$ 426.38	$ 426.38	$ 426.38	$ 426.38	$ 426.38
Furniture and Fixtures	TIC000190	Start-up furnishings purchased by D. Moulin	9/9/2008	$ 3,669.24	7.0	$ 43.68	$ 524.18	$ 524.18	$ 524.18	$ 524.18	$ 524.18	$ 524.18
Furniture and Fixtures	TIC000260	Stretcher and Wheelchair	8/1/2009	$ 2,386.40	7.0		$ 56.82	$ 340.91	$ 340.91	$ 340.91	$ 340.91	$ 340.91
Leasehold Improvements	TIC000180	Buildout (Casle & ANI)	9/1/2008	$ 470,259.40	20.0	$ 1,959.41	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97
Leasehold Improvements	TIC000220	Capitalized interest related to buildout	10/2/2008	$ 968.61	20.0		$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43
Medical Equipment	TIC000010	Refurbished Sensation 4 Slice CT Scanner	9/1/2008	$ 250,000.00	5.0	$ 4,166.67	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 45,833.33	
Medical Equipment	TIC000020	Refurbished Siemens Novation Digital Mammography System	9/1/2008	$ 220,000.00	5.0	$ 3,666.67	$ 44,000.00	$ 44,000.00	$ 44,000.00	$ 44,000.00	$ 40,333.33	
Medical Equipment	TIC000030	ANTARES*2D 100% Reconditioned Siemens Antares Colorflow System	9/1/2008	$ 65,500.00	5.0	$ 1,091.67	$ 13,100.00	$ 13,100.00	$ 13,100.00	$ 13,100.00	$ 12,008.33	
Medical Equipment	TIC000040	DPX IQ Bone Densitometer (Fan Beam) X Ray Tube	9/1/2008	$ 29,000.00	5.0	$ 483.33	$ 5,800.00	$ 5,800.00	$ 5,800.00	$ 5,800.00	$ 5,316.67	
Medical Equipment	TIC000050	IDC Xplorer 1600 - U-Arm Dr System	9/1/2008	$ 176,913.00	5.0	$ 2,948.55	$ 35,382.60	$ 35,382.60	$ 35,382.60	$ 35,382.60	$ 32,434.05	
Medical Equipment	TIC000060	Hitachi Altaire High Field Open MRI	9/1/2008	$ 935,000.00	5.0	$ 15,583.33	$ 187,000.00	$ 187,000.00	$ 187,000.00	$ 187,000.00	$ 171,416.67	
Medical Equipment	TIC000110	MedRad - CT & MR Injector	9/1/2008	$ 9,786.26	5.0	$ 163.10	$ 1,957.25	$ 1,957.25	$ 1,957.25	$ 1,957.25	$ 1,794.15	
Medical Equipment	TIC000120	MedRad - CT & MR Injector	9/1/2008	$ 20,371.26	5.0	$ 339.52	$ 4,074.25	$ 4,074.25	$ 4,074.25	$ 4,074.25	$ 3,734.73	
Medical Equipment	TIC000160	Scientific Equipment - US Table	9/1/2008	$ 6,327.50	5.0	$ 105.46	$ 1,265.50	$ 1,265.50	$ 1,265.50	$ 1,265.50	$ 1,160.04	
Medical Equipment	TIC000170	Creative Change - Scanning system	9/1/2008	$ 24,930.00	5.0	$ 415.50	$ 4,986.00	$ 4,986.00	$ 4,986.00	$ 4,986.00	$ 4,570.50	
Medical Equipment	TIC000210	Capitalized interest related to BMI Medical Equipment purchase	10/2/2008	$ 40,013.92	5.0		$ 8,002.78	$ 8,002.78	$ 8,002.78	$ 8,002.78	$ 8,002.78	
Medical Equipment	TIC000230	Capitalized interest related to U/S Table from Scientific Liquidators	10/2/2008	$ 87.13	5.0		$ 17.43	$ 17.43	$ 17.43	$ 17.43	$ 17.43	
Medical Equipment	TIC000240	Summitt Imaging VF7-3	4/7/2009	$ 4,000.00	5.0		$ 400.00	$ 800.00	$ 800.00	$ 800.00	$ 800.00	$ 400.00
Medical Equipment	TIC000250	Automatic Electronic Defibrillator	5/6/2009	$ 1,421.90	5.0		$ 118.49	$ 284.38	$ 284.38	$ 284.38	$ 284.38	$ 165.89
Medical Equipment	TIC000270	BMI Medical Equipment increase in basis due to refinance	3/1/2011	$ 190,266.00	4.0		$ 27,747.13	$ 47,566.50	$ 47,566.50	$ 47,566.50	$ 19,819.38	
Medical Equipment	TIC000280	PACS Equipment - Mammography Workstation	5/1/2011	$ 85,799.01	5.0		$ 7,149.92	$ 17,159.80	$ 17,159.80	$ 17,159.80	$ 17,159.80	$ 10,009.88
			Total	**$ 2,642,406.72**		**$ 32,328.55**	**$ 437,169.71**	**$ 467,848.95**	**$ 467,831.29**	**$ 461,950.79**	**$ 404,203.11**	**$ 38,689.06**

Tolland Imaging Center

Asset Inventory and Depreciation Schedule

			12	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
			Depreciation Schedule							**Depreciation Schedule**				
			FY2015	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
Asset Type	Asset Number	Asset Description	**Year 8**	**Year 9**	**Year 10**	**Year 11**	**Year 12**	**Year 13**	**Year 14**	**Year 15**	**Year 16**	**Year 17**	**Year 18**	**Year 19**
Computer	TIC000130	Codonics - Mammo Film Printer												
Computer	TIC000140	Codonics - Medical Media Printers												
Computer Software	TIC000070	QuickBooks Software												
Computer Software	TIC000200	Powerscribe Licenses												
Furniture and Fixtures	TIC000080	Yush Sign & Display - Building Ext Sign	$ 575.00											
Furniture and Fixtures	TIC000090	Yush Sign & Display - Interior ADA Signs	$ 188.57											
Furniture and Fixtures	TIC000100	WBMason - Office Furniture	$ 2,225.14											
Furniture and Fixtures	TIC000150	Americom - Telephone system	$ 390.85											
Furniture and Fixtures	TIC000190	Start-up furnishings purchased by D. Moulin	$ 480.50											
Furniture and Fixtures	TIC000260	Stretcher and Wheelchair	$ 340.91	$ 284.10										
Leasehold Improvements	TIC000180	Buildout (Casle & ANI)	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97	$ 23,512.97
Leasehold Improvements	TIC000220	Capitalized interest related to buildout	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43	$ 48.43
Medical Equipment	TIC000010	Refurbished Sensation 4 Slice CT Scanner												
Medical Equipment	TIC000020	Refurbished Siemens Novation Digital Mammography System												
Medical Equipment	TIC000030	ANTARES*2D 100% Reconditioned Siemens Antares Colorflow System												
Medical Equipment	TIC000040	DPX IQ Bone Densitometer (Fan Beam) X Ray Tube												
Medical Equipment	TIC000050	IDC Xplorer 1600 - U-Arm Dr System												
Medical Equipment	TIC000060	Hitachi Altaire High Field Open MRI												
Medical Equipment	TIC000110	MedRad - CT & MR Injector												
Medical Equipment	TIC000120	MedRad - CT & MR Injector												
Medical Equipment	TIC000160	Scientific Equipment - US Table												
Medical Equipment	TIC000170	Creative Change - Scanning system												
Medical Equipment	TIC000210	Capitalized interest related to BMI Medical Equipment purchase												
Medical Equipment	TIC000230	Capitalized interest related to U/S Table from Scientific Liquidators												
Medical Equipment	TIC000240	Summitt Imaging VF7-3												
Medical Equipment	TIC000250	Automatic Electronic Defibrillator												
Medical Equipment	TIC000270	BMI Medical Equipment increase in basis due to refinance												
Medical Equipment	TIC000280	PACS Equipment - Mammography Workstation												
			$ 27,762.38	**$ 23,845.50**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**	**$ 23,561.40**

Tolland Imaging Center

Asset Inventory and Depreciation Schedule

			12	*11*
			FY2027	**FY2028**
Asset Type	Asset Number	Asset Description	**Year 20**	**Year 21**
Computer	TIC000130	Codonics - Mammo Film Printer		
Computer	TIC000140	Codonics - Medical Media Printers		
Computer Software	TIC000070	QuickBooks Software		
Computer Software	TIC000200	Powerscribe Licenses		
Furniture and Fixtures	TIC000080	Yush Sign & Display - Building Ext Sign		
Furniture and Fixtures	TIC000090	Yush Sign & Display - Interior ADA Signs		
Furniture and Fixtures	TIC000100	WBMason - Office Furniture		
Furniture and Fixtures	TIC000150	Americom - Telephone system		
Furniture and Fixtures	TIC000190	Start-up furnishings purchased by D. Moulin		
Furniture and Fixtures	TIC000260	Stretcher and Wheelchair		
Leasehold Improvements	TIC000180	Buildout (Casle & ANI)	$ 23,512.97	$ 21,553.56
Leasehold Improvements	TIC000220	Capitalized interest related to buildout	$ 48.43	$ 48.43
Medical Equipment	TIC000010	Refurbished Sensation 4 Slice CT Scanner		
Medical Equipment	TIC000020	Refurbished Siemens Novation Digital Mammography System		
Medical Equipment	TIC000030	ANTARES*2D 100% Reconditioned Siemens Antares Colorflow System		
Medical Equipment	TIC000040	DPX IQ Bone Densitometer (Fan Beam) X Ray Tube		
Medical Equipment	TIC000050	IDC Xplorer 1600 - U-Arm Dr System		
Medical Equipment	TIC000060	Hitachi Altaire High Field Open MRI		
Medical Equipment	TIC000110	MedRad - CT & MR Injector		
Medical Equipment	TIC000120	MedRad - CT & MR Injector		
Medical Equipment	TIC000160	Scientific Equipment - US Table		
Medical Equipment	TIC000170	Creative Change - Scanning system		
Medical Equipment	TIC000210	Capitalized interest related to BMI Medical Equipment purchase		
Medical Equipment	TIC000230	Capitalized interest related to U/S Table from Scientific Liquidators		
Medical Equipment	TIC000240	Summitt Imaging VF7-3		
Medical Equipment	TIC000250	Automatic Electronic Defibrillator		
Medical Equipment	TIC000270	BMI Medical Equipment increase in basis due to refinance		
Medical Equipment	TIC000280	PACS Equipment - Mammography Workstation		
			$ 23,561.40	**$ 21,601.99**

Appendix 7a

Tolland Imaging Center

Without CON = Continuation of comprehensive imaging services DENIED
(Reflects what will be incurred by the Members Hospitals)
With CON = Continuation of comprehensive imaging services APPROVED

7a. 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:

					CON Year 1			CON Year 2			CON Year 3		
Total Facility:	**FY2012**	**FY2013**	**FY2013**	**FY2013**	**FY2014**	**FY2014**	**FY2014**	**FY2015**	**FY2015**	**FY2015**	**FY2016**	**FY2016**	**FY2016**
Description	**Actual Results**	**Projected W/out CON**	**Projected Incremental**	**Projected With CON**	**Projected W/out CON**	**Projected Incremental**	**Projected With CON**	**Projected W/out CON**	**Projected Incremental**	**Projected With CON**	**Projected W/out CON**	**Projected Incremental**	**Projected With CON**
NET PATIENT REVENUE													
Non-Government	$1,777,461	$1,805,900	$0	$1,805,900	$0	$1,834,794	$1,834,794	$0	$1,864,151	$1,864,151	$0	$1,893,978	$1,893,978
Medicare	$322,978	$328,145	$0	$328,145	$0	$333,396	$333,396	$0	$338,730	$338,730	$0	$344,150	$344,150
Medicaid and Other Medical Assistance	$67,197	$68,272	$0	$68,272	$0	$69,364	$69,364	$0	$70,474	$70,474	$0	$71,602	$71,602
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$2,167,635	$2,202,317	$0	$2,202,317	$0	$2,237,554	$2,237,554	$0	$2,273,355	$2,273,355	$0	$2,309,729	$2,309,729
Other Operating Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue from Operations	$2,167,635	$2,202,317	$0	$2,202,317	$0	$2,237,554	$2,237,554	$0	$2,273,355	$2,273,355	$0	$2,309,729	$2,309,729
OPERATING EXPENSES													
Salaries and Fringe Benefits	$417,511	$424,191	$0	$424,191	$0	$430,978	$430,978	$0	$437,874	$437,874	$0	$444,880	$444,880
Professional / Contracted Services	$473,436	$481,011	$0	$481,011	$0	$488,707	$488,707	$0	$496,526	$496,526	$0	$504,471	$504,471
Supplies and Drugs	$52,404	$53,242	$0	$53,242	$0	$54,094	$54,094	$0	$54,960	$54,960	$0	$55,839	$55,839
Bad Debts	$87,410	$88,093	$0	$88,093	$0	$89,502	$89,502	$0	$90,934	$90,934	$0	$92,389	$92,389
Other Operating Expense	$376,243	$382,263	$0	$382,263	$0	$388,379	$388,379	$0	$394,593	$394,593	$0	$400,907	$400,907
Subtotal	$1,407,004	$1,428,800	$0	$1,428,800	$0	$1,451,661	$1,451,661	$0	$1,474,888	$1,474,888	$0	$1,498,486	$1,498,486
Depreciation/Amortization	$461,951	$404,203	$0	$404,203	$371,074	($332,385)	$38,689	$0	$27,762	$27,762	$0	$27,762	$27,762
Interest Expense	$67,247	$35,060	$0	$35,060	$13,069	($974)	$12,095	$0	$974	$974	$0	$0	$0
Lease Expense	$134,618	$138,657	$0	$138,657	$861,001	$142,816	$142,816	$0	$147,101	$147,101	$0	($37,878)	$151,514
Total Operating Expense	$2,070,820	$2,006,720	$0	$2,006,720	$1,245,144	$1,261,118	$1,645,261	$0	$1,650,724	$1,650,724	$0	$1,488,370	$1,677,762
Gain/(Loss) from Operations	$96,815	$195,598	$0	$195,598	($1,245,144)	$976,436	$592,293	$0	$622,631	$622,631	$0	$821,359	$631,967
Plus: Non-Operating Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense	$96,815	$195,598	$0	$195,598	($1,245,144)	$976,436	$592,293	$0	$622,631	$622,631	$0	$821,359	$631,967
FTEs	6.2	6.2	0.0	6.2	0.0	(6.2)	6.2	0.0	(6.2)	6.2	0.0	(6.2)	6.2

Procedure Volume Statistics:

Provide projected outpatient statistics for any new services and provide actual and projected outpatient statistics for any existing services which will change due to the proposal.

CT Scanner	805	0.0%	805	0	805	0	805	805	0	805	805	0	805	805
MRI Scanner	1,724	0.0%	1,724	0	1,724	0	1,724	1,724	0	1,724	1,724	0	1,724	1,724
Bone Density	462	0.0%	462	0	462	0	462	462	0	462	462	0	462	462
Mammography	2,104	0.0%	2,104	0	2,104	0	2,104	2,104	0	2,104	2,104	0	2,104	2,104
Radioagraphy (x-ray)	3,795	0.0%	3,795	0	3,795	0	3,795	3,795	0	3,795	3,795	0	3,795	3,795
Ultrasound	2,571	0.0%	2,571	0	2,571	0	2,571	2,571	0	2,571	2,571	0	2,571	2,571

Johnson Memorial Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / Description	Payer Mix	FY2012 Actual Results	% Growth	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	CON Year 1 FY2014 Projected W/out CON	CON Year 1 FY2014 Projected Incremental	CON Year 1 FY2014 Projected With CON	CON Year 2 FY2015 Projected W/out CON	CON Year 2 FY2015 Projected Incremental	CON Year 2 FY2015 Projected With CON	CON Year 3 FY2016 Projected W/out CON	CON Year 3 FY2016 Projected Incremental	CON Year 3 FY2016 Projected With CON
NET PATIENT REVENUE															
Non-Government	53%	$36,747,360		$37,335,317	$0	$37,335,317	$37,932,683	$0	$37,932,683	$38,539,605	$0	$38,539,605	$39,156,239	$0	$39,156,239
Medicare	38%	$26,347,164		$26,768,718	$0	$26,768,718	$27,197,018	$0	$27,197,018	$27,632,170	$0	$27,632,170	$28,074,285	$0	$28,074,285
Medicaid and Other Medical Assistance	9%	$6,240,118		$6,339,960	$0	$6,339,960	$6,441,399	$0	$6,441,399	$6,544,461	$0	$6,544,461	$6,649,173	$0	$6,649,173
Other Government	0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$69,334,641	1.6%	$70,443,995	$0	$70,443,995	$71,571,099	$0	$71,571,099	$72,716,237	$0	$72,716,237	$73,879,697	$0	$73,879,697
Other Operating Revenue		$334,223	1.6%	$339,571	$0	$339,571	$256,160	($88,844)	$345,004	$257,129	($93,395)	$350,524	$261,337	($94,795)	$356,132
Revenue from Operations		$69,668,864		$70,783,566	$0	$70,783,566	$71,827,259	($88,844)	$71,916,103	$72,973,366	($93,395)	$73,066,761	$74,141,034	($94,795)	$74,235,829
OPERATING EXPENSES															
Salaries and Fringe Benefits		$38,803,360	1.6%	$39,424,214	$0	$39,424,214	$40,055,001	$0	$40,055,001	$40,695,881	$0	$40,695,881	$41,347,015	$0	$41,347,015
Professional / Contracted Services		$6,997,267	1.6%	$7,109,223	$0	$7,109,223	$7,222,971	$0	$7,222,971	$7,338,538	$0	$7,338,538	$7,455,955	$0	$7,455,955
Supplies and Drugs		$7,130,721	1.6%	$7,244,813	$0	$7,244,813	$7,360,730	$0	$7,360,730	$7,478,501	$0	$7,478,501	$7,598,157	$0	$7,598,157
Bad Debts		$3,773,454	5.4%	$3,833,829	$0	$3,833,829	$4,042,481	$0	$4,042,481	$4,262,488	$0	$4,262,488	$4,494,469	$0	$4,494,469
Other Operating Expense		$8,989,210	0.0%	$8,989,210	$0	$8,989,210	$8,989,210	$0	$8,989,210	$8,989,210	$0	$8,989,210	$8,989,210	$0	$8,989,210
Subtotal		$65,694,012		$66,601,289	$0	$66,601,289	$67,670,392	$0	$67,670,392	$68,764,619	$0	$68,764,619	$69,884,806	$0	$69,884,806
Depreciation/Amortization		$3,213,542	1.6%	$3,264,959	$0	$3,264,959	$3,372,859	$55,661	$3,317,198	$3,370,273	$0	$3,370,273	$3,424,198	$0	$3,424,198
Interest Expense		$1,495,715	1.6%	$1,519,646	$0	$1,519,646	$1,545,921	$1,960	$1,543,961	$1,568,664	$0	$1,568,664	$1,593,763	$0	$1,593,763
Lease Expense		$1,675,437	1.6%	$1,702,244	$0	$1,702,244	$1,858,630	$129,150	$1,729,480	$1,757,152	$0	$1,757,152	$1,785,266	$0	$1,785,266
Total Operating Expense		$72,078,706		$73,088,138	$0	$73,088,138	$74,447,803	$186,772	$74,261,031	$75,460,708	$0	$75,460,708	$76,688,033	$0	$76,688,033
Gain/(Loss) from Operations		($2,409,842)		($2,304,572)	$0	($2,304,572)	($2,620,544)	($275,615)	($2,344,928)	($2,487,342)	($93,395)	($2,393,947)	($2,546,999)	($94,795)	($2,452,204)
Plus: Non-Operating Revenue		$430,456	1.6%	$437,343	$0	$437,343	$444,341	$0	$444,341	$451,450	$0	$451,450	$458,673	$0	$458,673
Revenue Over/(Under) Expense		($1,979,386)		($1,867,229)	$0	($1,867,229)	($2,176,203)	($275,615)	($1,900,587)	($2,035,891)	($93,395)	($1,942,497)	($2,088,325)	($94,795)	($1,993,530)
FTEs		464.2	0.0%	464.2	0.0	464.2	464.2	0.0	464.2	464.2	0.0	464.2	464.2	0.0	464.2

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

Johnson Memorial Hospital (Main campus location)														
CT Scans														
Inpatient	1,936	0.0%	1,936	0	1,936	1,936	0	1,936	1,936	0	1,936	1,936	0	1,936
Emergent	3,653	0.0%	3,653	0	3,653	3,653	0	3,653	3,653	0	3,653	3,653	0	3,653
Outpatient	584	0.0%	584	0	584	584	0	584	584	0	584	584	0	584
Total CT Scan (procedures):	**6,173**		**6,173**	**0**	**6,173**	**6,173**	**0**	**6,173**	**6,173**	**0**	**6,173**	**6,173**	**0**	**6,173**
MRI Scans														
Inpatient	144	0.0%	144	0	144	144	0	144	144	0	144	144	0	144
Emergent	26	0.0%	26	0	26	26	0	26	26	0	26	26	0	26
Outpatient (excluding ED)	499	0.0%	499	0	499	499	0	499	499	0	499	499	0	499
Total MRI Scan (procedures):	**669**		**669**	**0**	**669**	**669**	**0**	**669**	**669**	**0**	**669**	**669**	**0**	**669**
Johnson Memorial Hospital (Enfield Location)														
Outpatient CT Scans	1,137	0.0%	1,137	0	1,137	1,137	0	1,137	1,137	0	1,137	1,137	0	1,137
Outpatient MRI Scans	962	0.0%	962	0	962	962	0	962	962	0	962	962	0	962

Manchester Memorial Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

				CON Year 1			CON Year 2			CON Year 3		
Total Facility:	**FY2012**	**FY2013**	**FY2013**	**FY2013**	**FY2014**	**FY2014**	**FY2014**	**FY2015**	**FY2015**	**FY2015**	**FY2016**	**FY2016**	**FY2016**
	Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
NET PATIENT REVENUE													
Non-Government	$98,121,837	$99,691,786	$0	$99,691,786	$101,286,855	$0	$101,286,855	$102,907,445	$0	$102,907,445	$104,553,964	$0	$104,553,964
Medicare	$59,573,972	$60,527,156	$0	$60,527,156	$61,495,590	$0	$61,495,590	$62,479,520	$0	$62,479,520	$63,479,192	$0	$63,479,192
Medicaid and Other Medical Assistance	$17,521,757	$17,802,105	$0	$17,802,105	$18,086,938	$0	$18,086,938	$18,376,329	$0	$18,376,329	$18,670,351	$0	$18,670,351
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$175,217,566	$178,021,047	$0	$178,021,047	$180,869,384	$0	$180,869,384	$183,763,294	$0	$183,763,294	$186,703,507	$0	$186,703,507
Other Operating Revenue	$19,861,936	$20,179,727	$0	$20,179,727	$20,295,300	($207,302)	$20,502,603	$20,612,724	($217,921)	$20,830,644	$20,942,746	($221,188)	$21,163,935
Revenue from Operations	$195,079,502	$198,200,774	$0	$198,200,774	$201,164,684	($207,302)	$201,371,986	$204,376,017	($217,921)	$204,593,938	$207,646,253	($221,188)	$207,867,441
OPERATING EXPENSES													
Salaries and Fringe Benefits	$106,417,077	$108,119,750	$0	$108,119,750	$109,849,666	$0	$109,849,666	$111,607,261	$0	$111,607,261	$113,392,977	$0	$113,392,977
Professional / Contracted Services		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Supplies and Drugs	$62,035,761	$63,028,333	$0	$63,028,333	$64,036,787	$0	$64,036,787	$65,061,375	$0	$65,061,375	$66,102,357	$0	$66,102,357
Bad Debts	$6,382,307	$6,484,424	$0	$6,484,424	$6,720,619	$0	$6,720,619	$6,965,418	$0	$6,965,418	$7,219,134	$0	$7,219,134
Other Operating Expense		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$174,835,145	$177,632,507	$0	$177,632,507	$180,607,072	$0	$180,607,072	$183,634,054	$0	$183,634,054	$186,714,468	$0	$186,714,468
Depreciation/Amortization	$6,896,812	$7,007,161	$0	$7,007,161	$7,249,152	$129,876	$7,119,276	$7,233,184	$0	$7,233,184	$7,348,915	$0	$7,348,915
Interest Expense	$2,714,044	$2,757,469	$0	$2,757,469	$2,806,162	$4,574	$2,801,588	$2,846,414	$0	$2,846,414	$2,891,956	$0	$2,891,956
Lease Expense		$0	$0	$0	$301,350	$301,350	$0	$0	$0	$0	$0	$0	$0
Total Operating Expense	$184,446,001	$187,397,137	$0	$187,397,137	$190,963,736	$435,800	$190,527,936	$193,713,652	$0	$193,713,652	$196,955,339	$0	$196,955,339
Gain/(Loss) from Operations	$10,633,501	$10,803,637	$0	$10,803,637	$10,200,948	($643,103)	$10,844,051	$10,662,366	($217,921)	$10,880,286	$10,690,914	($221,188)	$10,912,102
Plus: Non-Operating Revenue	($868,637)	($882,535)	$0	($882,535)	($896,656)	$0	($896,656)	($911,002)	$0	($911,002)	($925,578)	$0	($925,578)
Revenue Over/(Under) Expense	$9,764,864	$9,921,102	$0	$9,921,102	$9,304,292	($643,103)	$9,947,395	$9,751,363	($217,921)	$9,969,284	$9,765,335	($221,188)	$9,986,524
FTEs	1,086.0	1086.0	0.0	1086.0	1,086.0	0.0	1,086.0	1,086.0	0.0	1,086.0	1,086.0	0.0	1,086.0

Procedure Volume Statistics:

Provide projected outpatient statistics for any new services and provide actual and projected outpatient statistics for any existing services which will change due to the proposal.

CT Scans													
Inpatient	3,821	0.0%	3,821	0	3,821	3,821	0	3,821	3,821	0	3,821	3,821	0	3,821
Emergent	6,492	0.0%	6,492	0	6,492	6,492	0	6,492	6,492	0	6,492	6,492	0	6,492
Outpatient	5,818	0.0%	5,818	0	5,818	5,818	0	5,818	5,818	0	5,818	5,818	0	5,818
Total CT Scan (procedures):	**16,131**		**16,131**	**0**	**16,131**	**16,131**	**0**	**16,131**	**16,131**	**0**	**16,131**	**16,131**	**0**	**16,131**
MRI Scans													
Inpatient	520	0.0%	520	0	520	520	0	520	520	0	520	520	0	520
Emergent	187	0.0%	187	0	187	187	0	187	187	0	187	187	0	187
Outpatient (excluding ED)	2,585	0.0%	2,585	0	2,585	2,585	0	2,585	2,585	0	2,585	2,585	0	2,585
Total MRI Scan (procedures):	**3,292**		**3,292**	**0**	**3,292**	**3,292**	**0**	**3,292**	**3,292**	**0**	**3,292**	**3,292**	**0**	**3,292**

Rockville General Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:					CON Year 1			CON Year 2			CON Year 3		
Description	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	$41,387,059	$42,049,252	$0	$42,049,252	$42,722,040	$0	$42,722,040	$43,405,593	$0	$43,405,593	$44,100,082	$0	$44,100,082
Medicare	$17,640,386	$17,922,632	$0	$17,922,632	$18,209,394	$0	$18,209,394	$18,500,744	$0	$18,500,744	$18,796,756	$0	$18,796,756
Medicaid and Other Medical Assistance	$8,820,193	$8,961,316	$0	$8,961,316	$9,104,697	$0	$9,104,697	$9,250,372	$0	$9,250,372	$9,398,378	$0	$9,398,378
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$67,847,638	$68,933,200	$0	$68,933,200	$70,036,131	$0	$70,036,131	$71,156,710	$0	$71,156,710	$72,295,217	$0	$72,295,217
Other Operating Revenue	$6,871,608	$6,981,554	$0	$6,981,554	$6,885,956	($207,302)	$7,093,259	$6,988,830	($217,921)	$7,206,751	$7,100,870	($221,188)	$7,322,059
Revenue from Operations	$74,719,246	$75,914,754	$0	$75,914,754	$76,922,088	($207,302)	$77,129,390	$78,145,540	($217,921)	$78,363,460	$79,396,087	($221,188)	$79,617,276
OPERATING EXPENSES													
Salaries and Fringe Benefits	$40,311,104	$40,956,082	$0	$40,956,082	$41,611,379	$0	$41,611,379	$42,277,161	$0	$42,277,161	$42,953,596	$0	$42,953,596
Supplies and Drugs	$25,886,843	$26,301,032	$0	$26,301,032	$26,721,849	$0	$26,721,849	$27,149,399	$0	$27,149,399	$27,583,789	$0	$27,583,789
Bad Debts	$3,309,948	$3,362,907	$0	$3,362,907	$3,526,967	$0	$3,526,967	$3,699,030	$0	$3,699,030	$3,879,487	$0	$3,879,487
Subtotal	$69,507,895	$70,620,021	$0	$70,620,021	$71,860,195	$0	$71,860,195	$73,125,589	$0	$73,125,589	$74,416,872	$0	$74,416,872
Depreciation/Amortization	$3,811,952	$3,872,943	$0	$3,872,943	$4,064,786	$129,876	$3,934,910	$3,997,869	$0	$3,997,869	$4,061,835	$0	$4,061,835
Interest Expense	$719,107	$730,613	$0	$730,613	$746,877	$4,574	$742,303	$754,179	$0	$754,179	$766,246	$0	$766,246
Lease Expense		$0	$0	$0	$301,350	$301,350	$0	$0	$0	$0	$0	$0	$0
Total Operating Expense	$74,038,954	$75,223,577	$0	$75,223,577	$76,973,208	$435,800	$76,537,407	$77,877,638	$0	$77,877,638	$79,244,953	$0	$79,244,953
Gain/(Loss) from Operations	$680,292	$691,177	$0	$691,177	($51,120)	($643,103)	$591,983	$267,902	($217,921)	$485,823	$151,135	($221,188)	$372,323
Plus: Non-Operating Revenue	($179,961)	($182,840)	$0	($182,840)	($185,766)	$0	($185,766)	($188,738)	$0	($188,738)	($191,758)	$0	($191,758)
Revenue Over/(Under) Expense	$500,331	$508,336	$0	$508,336	($236,886)	($643,103)	$406,217	$79,164	($217,921)	$297,085	($40,623)	($221,188)	$180,565
FTEs	373.0	373.0	0.0	373.0	373.0	0.0	373.0	373.0	0.0	373.0	373.0	0.0	373.0

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

Rockville General Hospital (Main campus location)													
CT Scans													
Inpatient	1,817	1,817	0	1,817	1,817	0	1,817	1,817	0	1,817	1,817	0	1,817
Emergent	3,666	3,666	0	3,666	3,666	0	3,666	3,666	0	3,666	3,666	0	3,666
Outpatient	2,513	2,513	0	2,513	2,513	0	2,513	2,513	0	2,513	2,513	0	2,513
Total CT Scan (procedures):	**7,996**	**7,996**	**0**	**7,996**	**7,996**	**0**	**7,996**	**7,996**	**0**	**7,996**	**7,996**	**0**	**7,996**
MRI Scans													
Inpatient	234	234	0	234	234	0	234	234	0	234	234	0	234
Emergent	127	127	0	127	127	0	127	127	0	127	127	0	127
Outpatient (excluding ED)	1,385	1,385	0	1,385	1,385	0	1,385	1,385	0	1,385	1,385	0	1,385
Total MRI Scan (procedures):	**1,746**	**1,746**	**0**	**1,746**	**1,746**	**0**	**1,746**	**1,746**	**0**	**1,746**	**1,746**	**0**	**1,746**
Evergreen Imaging (South Windsor)*													
Outpatient CT Scans	1,807	1,807	0	1,807	1,807	0	1,807	1,807	0	1,807	1,807	0	1,807
Outpatient MRI Scans	1,950	1,950	0	1,950	1,950	0	1,950	1,950	0	1,950	1,950	0	1,950

*__Note:__ Evergreen Imaging Center became a department of the hospital effective 6/1/2012. The volume presented above is the total volume for Evergreen Imaging Center from October 1, 2011 to September 30, 2012.
FY2012 CT volume for EIC as a department of Rockville General Hospital (June-September only) = 922
FY2012 MRI volume for EIC as a department of Rockville General Hospital (June-September only) = 870

Windham Community Memorial Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / Description	Payer Mix	FY2012 Actual Results	% Growth	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	CON Year 1 FY2014 Projected W/out CON	CON Year 1 FY2014 Projected Incremental	CON Year 1 FY2014 Projected With CON	CON Year 2 FY2015 Projected W/out CON	CON Year 2 FY2015 Projected Incremental	CON Year 2 FY2015 Projected With CON	CON Year 3 FY2016 Projected W/out CON	CON Year 3 FY2016 Projected Incremental	CON Year 3 FY2016 Projected With CON
NET PATIENT REVENUE															
Non-Government	49%	$41,404,294		$42,066,763	$0	$42,066,763	42,739,831	0	42,739,831	43,423,668	0	43,423,668	44,118,447	0	44,118,447
Medicare	43%	$36,334,380		$36,915,730	$0	$36,915,730	37,506,382	0	37,506,382	38,106,484	0	38,106,484	38,716,188	0	38,716,188
Medicaid and Other Medical Assistance	8%	$6,759,885		$6,868,043	$0	$6,868,043	6,977,932	0	6,977,932	7,089,578	0	7,089,578	7,203,012	0	7,203,012
Other Government	0%	$0		$0	$0	$0	0	0	0	0	0	0	0	0	0
Total Net Patient Patient Revenue		$84,498,559	1.6%	$85,850,536	$0	$85,850,536	87,224,145	0	87,224,145	88,619,731	0	88,619,731	90,037,647	0	90,037,647
Other Operating Revenue		$5,482,556	1.6%	$5,570,277	$0	$5,570,277	5,570,557	(88,844)	5,659,401	5,656,557	(93,395)	5,749,952	5,747,156	(94,795)	5,841,951
Revenue from Operations		$89,981,115		$91,420,813	$0	$91,420,813	92,794,702	(88,844)	92,883,546	94,276,288	(93,395)	94,369,683	95,784,802	(94,795)	95,879,598
OPERATING EXPENSES															
Salaries and Fringe Benefits		$56,419,928	1.6%	$57,322,647	$0	$57,322,647	58,239,809	0	58,239,809	59,171,646	0	59,171,646	60,118,392	0	60,118,392
Professional / Contracted Services		$10,971,301	1.6%	$11,146,842	$0	$11,146,842	11,325,191	0	11,325,191	11,506,394	0	11,506,394	11,690,497	0	11,690,497
Supplies and Drugs		$8,815,183	1.6%	$8,956,226	$0	$8,956,226	9,099,526	0	9,099,526	9,245,118	0	9,245,118	9,393,040	0	9,393,040
Bad Debts		$696,225	0.8%	$707,365	$0	$707,365	713,193	0	713,193	719,069	0	719,069	724,994	0	724,994
Other Operating Expense		$8,229,822	0.0%	$8,229,822	$0	$8,229,822	8,229,822	0	8,229,822	8,229,822	0	8,229,822	8,229,822	0	8,229,822
Subtotal		$85,132,459		$86,362,901	$0	$86,362,901	87,607,541	0	87,607,541	88,872,050	0	88,872,050	90,156,745	0	90,156,745
Depreciation/Amortization		$4,026,424	1.6%	$4,090,847	$0	$4,090,847	4,211,961	55,661	4,156,300	4,222,801	0	4,222,801	4,290,366	0	4,290,366
Interest Expense		$1,286,970	1.6%	$1,307,562	$0	$1,307,562	1,330,443	1,960	1,328,483	1,349,738	0	1,349,738	1,371,334	0	1,371,334
Lease Expense			1.6%	$0	$0	$0	129,150	129,150	0	0	0	0	0	0	0
Total Operating Expense		$90,445,853		$91,761,309	$0	$91,761,309	93,279,095	186,772	93,092,324	94,444,589	0	94,444,589	95,818,445	0	95,818,445
Gain/(Loss) from Operations		($464,738)		($340,497)	$0	($340,497)	(484,393)	(275,615)	(208,778)	(168,301)	(93,395)	(74,906)	(33,643)	(94,795)	61,152
Plus: Non-Operating Revenue		($623,358)	1.6%	($633,332)	$0	($633,332)	(643,465)	0	(643,465)	(653,760)	0	(653,760)	(664,221)	0	(664,221)
Revenue Over/(Under) Expense		($1,088,096)		($973,828)	$0	($973,828)	(1,127,858)	(275,615)	(852,243)	(822,062)	(93,395)	(728,667)	(697,863)	(94,795)	(603,068)
FTEs		599.1	0.0%	599.1	0.0	599.1	599.1	0.0	599.1	599.1	0.0	599.1	599.1	0.0	599.1
Procedure Volume Statistics:															
Provide projected outpatient statistics for any new services and provide actual and projected outpatient statistics for any existing services which will change due to the proposal.															
CT Scans															
Inpatient		2,374	0.0%	2,374	0	2,374	2,374	0	2,374	2,374	0	2,374	2,374	0	2,374
Emergent		4,860	0.0%	4,860	0	4,860	4,860	0	4,860	4,860	0	4,860	4,860	0	4,860
Outpatient		3,453	0.0%	3,453	0	3,453	3,453	0	3,453	3,453	0	3,453	3,453	0	3,453
Total CT Scan (procedures):		**10,687**		**10,687**	**0**	**10,687**	**10,687**	**0**	**10,687**	**10,687**	**0**	**10,687**	**10,687**	**0**	**10,687**
MRI Scans															
Inpatient		459	0.0%	459	0	459	459	0	459	459	0	459	459	0	459
Emergent		116	0.0%	116	0	116	116	0	116	116	0	116	116	0	116
Outpatient (excluding ED)		3,718	0.0%	3,718	0	3,718	3,718	0	3,718	3,718	0	3,718	3,718	0	3,718
Total MRI Scan (procedures):		**4,293**		**4,293**	**0**	**4,293**	**4,293**	**0**	**4,293**	**4,293**	**0**	**4,293**	**4,293**	**0**	**4,293**

Appendix 7b

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	CT Scan
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$88,579**									
Total Facility by Payer Category:										
Medicare		$920	120	$110,373	$86,020	$0	$937	$23,417	$13,198	$10,219
Medicaid		$920	25	$22,963.59	$17,897	$0	$195	$4,872	$2,746	$2,126
CHAMPUS/TriCare		$920		$0	$0	$0	$0	$0	$0	$0
Total Governmental			145	$133,337	$103,916	$0	$1,132	$28,289	$15,944	$12,345
Commericial Insurers		$920	660	$607,424.02	$473,396	$0	$5,155	$128,873	$72,635	$56,238
Uninsured		$920		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$920	660	$607,424	$473,396	$0	$5,155	$128,873	$72,635	$56,238
Total All Payers		$920	805	$740,761	$577,313	$0	$6,286	$157,162	$88,579	$68,583

Type of Service Description	CT Scan
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$115,944**									
Total Facility by Payer Category:		0.339%								
Medicare		$923	120	$110,748	$86,005	$0	$952	$23,792	$17,276	$6,516
Medicaid		$923	25	$23,042	$17,894	$0	$198	$4,950	$3,594	$1,356
CHAMPUS/TriCare		$923		$0	$0	$0	$0	$0	$0	$0
Total Governmental			145	$133,790	$103,898	$0	$1,150	$28,742	$20,870	$7,872
Commericial Insurers		$923	660	$609,486	$473,314	$0	$5,237	$130,935	$95,074	$35,861
Uninsured		$923		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$923	660	$609,486	$473,314	$0	$5,237	$130,935	$95,074	$35,861
Total All Payers		$923	805	$743,276	$577,212	$0	$6,387	$159,676	$115,944	$43,732

Type of Service Description	CT Scan
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2016	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$104,540**									
Total Facility by Payer Category:		0.344%								
Medicare		$926	120	$111,129	$85,989	$0	$967	$24,172	$15,577	$8,596
Medicaid		$926	25	$23,121	$17,890	$0	$201	$5,029	$3,241	$1,788
CHAMPUS/TriCare		$926		$0	$0	$0	$0	$0	$0	$0
Total Governmental			145	$134,249	$103,880	$0	$1,168	$29,202	$18,817	$10,384
Commericial Insurers		$926	660	$611,581	$473,230	$0	$5,321	$133,030	$85,723	$47,306
Uninsured		$926		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$926	660	$611,581	$473,230	$0	$5,321	$133,030	$85,723	$47,306
Total All Payers		$926	805	$745,830	$577,110	$0	$6,489	$162,231	$104,540	$57,691

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	MRI
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$189,701**									
Total Facility by Payer Category:										
Medicare		$1,483	257	$380,843	$328,687	$0	$2,006	$50,150	$28,266	$21,885
Medicaid		$1,483	53	$79,236	$68,384	$0	$417	$10,434	$5,881	$4,553
CHAMPUS/TriCare		$1,483		$0	$0	$0	$0	$0	$0	$0
Total Governmental			310	$460,079	$397,071	$0	$2,423	$60,584	$34,146	$26,438
Commericial Insurers		$1,483	1,414	$2,095,915.08	$1,808,880	$0	$11,040	$275,996	$155,555	$120,440
Uninsured		$1,483		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$1,483	1,414	$2,095,915	$1,808,880	$0	$11,040	$275,996	$155,555	$120,440
Total All Payers		$1,483	1,724	$2,555,994	$2,205,951	$0	$13,463	$336,580	$189,701	$146,879

Type of Service Description	MRI
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$248,307**									
Total Facility by Payer Category:		0.211%								
Medicare		$1,486	257	$381,646	$328,655	$0	$2,038	$50,953	$36,998	$13,955
Medicaid		$1,486	53	$79,403	$68,378	$0	$424	$10,601	$7,698	$2,903
CHAMPUS/TriCare		$1,486		$0	$0	$0	$0	$0	$0	$0
Total Governmental			310	$461,048	$397,032	$0	$2,462	$61,554	$44,695	$16,858
Commericial Insurers		$1,486	1,414	$2,100,331	$1,808,703	$0	$11,216	$280,412	$203,612	$76,800
Uninsured		$1,486		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$1,486	1,414	$2,100,331	$1,808,703	$0	$11,216	$280,412	$203,612	$76,800
Total All Payers		$1,486	1,724	$2,561,379	$2,205,735	$0	$13,679	$341,965	$248,307	$93,658

Type of Service Description	MRI
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2016	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$223,885**									
Total Facility by Payer Category:		0.214%								
Medicare		$1,489	257	$382,461	$328,622	$0	$2,071	$51,768	$33,359	$18,409
Medicaid		$1,489	53	$79,572	$68,371	$0	$431	$10,771	$6,940	$3,830
CHAMPUS/TriCare		$1,489		$0	$0	$0	$0	$0	$0	$0
Total Governmental			310	$462,033	$396,993	$0	$2,502	$62,539	$40,299	$22,239
Commericial Insurers		$1,489	1,414	$2,104,818	$1,808,524	$0	$11,396	$284,898	$183,586	$101,312
Uninsured		$1,489		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$1,489	1,414	$2,104,818	$1,808,524	$0	$11,396	$284,898	$183,586	$101,312
Total All Payers		$1,489	1,724	$2,566,851	$2,205,517	$0	$13,897	$347,437	$223,885	$123,551

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	Bone Density
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$50,836**									
Total Facility by Payer Category:										
Medicare		$203	69	$13,987	$10	$0	$538	$13,439	$7,575	$5,865
Medicaid		$203	14	$2,910	$2	$0	$112	$2,796	$1,576	$1,220
CHAMPUS/TriCare		$203		$0	$0	$0	$0	$0	$0	$0
Total Governmental			83	$16,897	$12	$0	$649	$16,235	$9,151	$7,085
Commericial Insurers		$203	379	$76,973.40	$53	$0	$2,958	$73,962	$41,686	$32,276
Uninsured		$203		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$203	379	$76,973	$53	$0	$2,958	$73,962	$41,686	$32,276
Total All Payers		$203	462	$93,870	$65	$0	$3,608	$90,197	$50,836	$39,361

Type of Service Description	Bone Density
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$66,542**									
Total Facility by Payer Category:		1.537%								
Medicare		$206	69	$14,202	$1	$0	$546	$13,654	$9,915	$3,740
Medicaid		$206	14	$2,955	$0	$0	$114	$2,841	$2,063	$778
CHAMPUS/TriCare		$206		$0	$0	$0	$0	$0	$0	$0
Total Governmental			83	$17,156	$1	$0	$660	$16,495	$11,978	$4,518
Commericial Insurers		$206	379	$78,157	$6	$0	$3,006	$75,145	$54,564	$20,581
Uninsured		$206		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$206	379	$78,157	$6	$0	$3,006	$75,145	$54,564	$20,581
Total All Payers		$206	462	$95,313	$7	$0	$3,666	$91,640	$66,542	$25,099

Type of Service Description	Bone Density
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2016 **FY Projected Incremental** Total Incremental Expenses:	(1) **$59,997**	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:		1.538%								
Medicare		$209	69	$14,420	($8)	$0	$555	$13,873	$8,940	$4,933
Medicaid		$209	14	$3,000	($2)	$0	$115	$2,886	$1,860	$1,026
CHAMPUS/TriCare		$209		$0	$0	$0	$0	$0	$0	$0
Total Governmental			83	$17,420	($9)	$0	$670	$16,759	$10,799	$5,960
Commericial Insurers		$209	379	$79,359	($42)	$0	$3,054	$76,347	$49,198	$27,150
Uninsured		$209		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$209	379	$79,359	($42)	$0	$3,054	$76,347	$49,198	$27,150
Total All Payers		$209	462	$96,779	($51)	$0	$3,724	$93,107	$59,997	$33,109

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	Mammography
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$231,515**									
Total Facility by Payer Category:										
Medicare		$302	313	$94,690	$31,037	$0	$2,448	$61,204	$34,496	$26,709
Medicaid		$302	65	$19,701	$6,457	$0	$509	$12,734	$7,177	$5,557
CHAMPUS/TriCare		$302		$0	$0	$0	$0	$0	$0	$0
Total Governmental			379	$114,390	$37,494	$0	$2,958	$73,938	$41,673	$32,266
Commericial Insurers		$302	1,725	$521,110.82	$170,808	$0	$13,473	$336,830	$189,842	$146,988
Uninsured		$302		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$302	1,725	$521,111	$170,808	$0	$13,473	$336,830	$189,842	$146,988
Total All Payers		$302	2,104	$635,501	$208,302	$0	$16,431	$410,768	$231,515	$179,253

Type of Service Description	Mammography
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2015	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$303,038**									
Total Facility by Payer Category:		1.034%								
Medicare		$305	313	$95,669	$30,998	$0	$2,487	$62,184	$45,153	$17,031
Medicaid		$305	65	$19,904	$6,449	$0	$518	$12,938	$9,394	$3,543
CHAMPUS/TriCare		$305		$0	$0	$0	$0	$0	$0	$0
Total Governmental			379	$115,573	$37,447	$0	$3,005	$75,121	$54,547	$20,574
Commericial Insurers		$305	1,725	$526,500	$170,592	$0	$13,689	$342,219	$248,492	$93,728
Uninsured		$305		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$305	1,725	$526,500	$170,592	$0	$13,689	$342,219	$248,492	$93,728
Total All Payers		$305	2,104	$642,073	$208,039	$0	$16,694	$417,340	$303,038	$114,302

Type of Service Description	Mammography
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2016	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$273,234**									
Total Facility by Payer Category:		1.040%								
Medicare		$308	313	$96,664	$30,958	$0	$2,527	$63,179	$40,712	$22,467
Medicaid		$308	65	$20,111	$6,441	$0	$526	$13,145	$8,470	$4,674
CHAMPUS/TriCare		$308		$0	$0	$0	$0	$0	$0	$0
Total Governmental			379	$116,775	$37,399	$0	$3,053	$76,323	$49,182	$27,141
Commericial Insurers		$308	1,725	$531,976	$170,373	$0	$13,908	$347,695	$224,052	$123,643
Uninsured		$308		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$308	1,725	$531,976	$170,373	$0	$13,908	$347,695	$224,052	$123,643
Total All Payers		$308	2,104	$648,751	$207,772	$0	$16,961	$424,018	$273,234	$150,784

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	Radiography (X-Ray)
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2014 **FY Projected Incremental** Total Incremental Expenses: **$417,585** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$85	565	$48,327	($66,483)	$0	$4,416	$110,395	$62,220	$48,175
Medicaid		$85	118	$10,055	($13,832)	$0	$919	$22,968	$12,945	$10,023
CHAMPUS/TriCare		$85		$0	$0	$0	$0	$0	$0	$0
Total Governmental			683	$58,382	($80,316)	$0	$5,335	$133,363	$75,165	$58,198
Commericial Insurers		$85	3,112	$265,962.08	($365,882)	$0	$24,302	$607,543	$342,420	$265,123
Uninsured		$85		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$85	3,112	$265,962	($365,882)	$0	$24,302	$607,543	$342,420	$265,123
Total All Payers		$85	3,795	$324,344	($446,198)	$0	$29,636	$740,906	$417,585	$323,320

Type of Service Description	Radiography (X-Ray)
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2015 **FY Projected Incremental** Total Incremental Expenses: **$546,593** **Total Facility by Payer Category:**	(1)	(2) Rate 3.655%	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$89	565	$50,094	($66,554)	$0	$4,486	$112,161	$81,442	$30,719
Medicaid		$89	118	$10,422	($13,847)	$0	$933	$23,336	$16,944	$6,391
CHAMPUS/TriCare		$89		$0	$0	$0	$0	$0	$0	$0
Total Governmental			683	$60,516	($80,401)	$0	$5,420	$135,497	$98,387	$37,110
Commericial Insurers		$89	3,112	$275,683	($366,271)	$0	$24,691	$617,263	$448,206	$169,057
Uninsured		$89		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$89	3,112	$275,683	($366,271)	$0	$24,691	$617,263	$448,206	$169,057
Total All Payers		$89	3,795	$336,198	($446,672)	$0	$30,110	$752,760	$546,593	$206,167

Type of Service Description	Radiography (X-Ray)
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2016 **FY Projected Incremental** Total Incremental Expenses:	(1) **$492,833**	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:		3.582%								
Medicare		$92	565	$51,888	($66,626)	$0	$4,558	$113,956	$73,432	$40,524
Medicaid		$92	118	$10,796	($13,862)	$0	$948	$23,709	$15,278	$8,431
CHAMPUS/TriCare		$92		$0	$0	$0	$0	$0	$0	$0
Total Governmental			683	$62,684	($80,488)	$0	$5,507	$137,665	$88,710	$48,955
Commericial Insurers		$92	3,112	$285,559	($366,666)	$0	$25,086	$627,139	$404,123	$223,016
Uninsured		$92		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$92	3,112	$285,559	($366,666)	$0	$25,086	$627,139	$404,123	$223,016
Total All Payers		$92	3,795	$348,243	($447,154)	$0	$30,592	$764,804	$492,833	$271,971

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	Ultrasound
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2014 **FY Projected Incremental** Total Incremental Expenses: **$282,902** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$244	383	$93,337	$15,557	$0	$2,992	$74,789	$42,152	$32,637
Medicaid		$244	80	$19,419	$3,237	$0	$622	$15,560	$8,770	$6,790
CHAMPUS/TriCare		$244		$0	$0	$0	$0	$0	$0	$0
Total Governmental			463	$112,757	$18,793	$0	$3,614	$90,349	$50,922	$39,427
Commericial Insurers		$244	2,108	$513,669.32	$85,614	$0	$16,464	$411,592	$231,979	$179,613
Uninsured		$244		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$244	2,108	$513,669	$85,614	$0	$16,464	$411,592	$231,979	$179,613
Total All Payers		$244	2,571	$626,426	$104,407	$0	$20,078	$501,942	$282,902	$219,040

Type of Service Description	Ultrasound
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2015 **FY Projected Incremental** Total Incremental Expenses: **$370,300** **Total Facility by Payer Category:**	(1)	(2) Rate 1.282%	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$247	383	$94,534	$15,509	$0	$3,039	$75,986	$55,175	$20,811
Medicaid		$247	80	$19,668	$3,227	$0	$632	$15,809	$11,479	$4,330
CHAMPUS/TriCare		$247		$0	$0	$0	$0	$0	$0	$0
Total Governmental			463	$114,202	$18,735	$0	$3,672	$91,795	$66,654	$25,141
Commericial Insurers		$247	2,108	$520,255	$85,350	$0	$16,727	$418,178	$303,646	$114,531
Uninsured		$247		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$247	2,108	$520,255	$85,350	$0	$16,727	$418,178	$303,646	$114,531
Total All Payers		$247	2,571	$634,457	$104,086	$0	$20,399	$509,973	$370,300	$139,672

Type of Service Description	Ultrasound
Type of Unit Description:	Procedure
# of Months in Operation	12

FY 2016 **FY Projected Incremental** Total Incremental Expenses: **$333,880**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:		1.286%								
Medicare		$250	383	$95,750	$15,460	$0	$3,088	$77,202	$49,748	$27,454
Medicaid		$250	80	$19,921	$3,217	$0	$642	$16,062	$10,350	$5,712
CHAMPUS/TriCare		$250		$0	$0	$0	$0	$0	$0	$0
Total Governmental			463	$115,671	$18,677	$0	$3,731	$93,264	$60,098	$33,165
Commericial Insurers		$250	2,108	$526,946	$85,083	$0	$16,995	$424,868	$273,782	$151,087
Uninsured		$250		$0	$0	$0	$0	$0	$0	$0
Total NonGovernment		$250	2,108	$526,946	$85,083	$0	$16,995	$424,868	$273,782	$151,087
Total All Payers		$250	2,571	$642,617	$103,759	$0	$20,725	$518,132	$333,880	$184,252

Appendix 7d

Attachment 7d - Rate Schedule (CT)

CPT Code	Description	Charge
70450	CT HEAD/BRAIN WO CONT	$ 580
70460	CT HEAD/BRAIN W/CONT	$ 709
70470	CT HEAD/BRAIN WO & W/CONT	$ 869
70480	CT IAC/SEL/ORB/PFOSS WO CONT	$ 632
70481	CT IAC/SELLA/ORBIT WITH CONT	$ 739
70482	CT IAC/SELLA/ORBITS WO & W/CON	$ 890
70486	CT MAXILOFACIAL WO CONT	$ 614
70487	CT MAXILLOFACIAL W/ CONT	$ 731
70488	CT MAXILLOFACIAL WO & W/CONT	$ 886
70490	CT S.T. NECK WO CONT	$ 632
70491	CT S.T. NECK W/CONT	$ 739
70492	CT S.T. NECK WO & W/CONT	$ 889
70496	CTA HEAD WO & W/CONT	$ 1,285
70498	CTA NECK WO & W/CONT	$ 1,285
71250	CT THORAX WO CONT	$ 738
71260	CT THORAX W/CONTRAST MATERIALS	$ 865
71270	CT THORAX WO & W/CONT	$ 1,061
71275	CTA CHEST WO & W/CONT	$ 1,465
72125	CT C-SPINE WO CONT	$ 738
72126	CT C-SPINE W/CONT	$ 862
72127	CT C-SPINE WO & W/CONT	$ 1,049
72128	CT THORACIC SP WO CONT	$ 738
72129	CT THORACIC SP W/CONT	$ 862
72130	CT THORACIC SP WO & W/CONT	$ 1,049
72131	CT LUMBAR SP WO CONT	$ 738
72132	CT LUMBAR SP W/CONT	$ 862
72133	CT LUMBAR SP WO & W CONT	$ 1,049
72191	CTA PELVIS WO & W/CONT	$ 1,417
72192	CT PELVIS WO CONT	$ 730
72193	CT PELVIS W/CONT	$ 832
72194	CT PELVIS WO & W/CONT	$ 1,004
73200	CT UPPER EXT WO CONT	$ 632
73201	CT UPPER EXT W/CONT	$ 738
73202	CT UPPER EXT WO & W/CONT	$ 897
73206	CTA UPPER EXTREM WO & W/CONT	$ 1,313
73700	CT LOWER EXT WO CONT	$ 632
73701	CT LOWER EXT W/CONT	$ 738
73702	CT LOW EXT W/O CON FOLL BY CON	$ 897
73706	CTA LOWER EXTREM WO & W/CONT	$ 1,323
74150	CT ABDOMEN WO CONT	$ 716
74160	CT ABDOMEN W/CONT	$ 846
74170	CT ABDOMEN WO & W/CONT	$ 1,026
74175	CTA ABDOMEN WO & W/CONT	$ 1,427
74176	CT ABD & PELVIS WITHOUT CONT	$ 855
74177	CT ABD & PELVIS W CONT	$ 1,359
74178	CT ABD & PELVIS WITH & WITHOUT CONT	$ 1,726
76380	CT LIMITED OR FOLLOW-UP	$ 472
77078	CT BONE DENSITY STUDY	$ 329

Attachment 7d - Rate Schedule (MRI)

CPT Code	Description	Charge
77058	MRI BREAST UNILATERAL W/CONT	$ 1,977
77058	MRI BREAST UNILATERAL W/O CONT	$ 1,977
77058	MRI BREAST UNILAT W + W/O CONT	$ 1,977
77059	MRI BREAST BILATERAL W/ CONT	$ 2,612
77059	MRI BREAST BILATERAL W/O CONT	$ 2,612
77059	MRI BREAST BILAT W + W/O CONT	$ 2,612
71555	MRA CHEST W/CONTRAST	$ 1,352
71555	MRA CHEST W/O CONTRAST	$ 1,352
71555	MRA CHEST W/ + W/O CONTRAST	$ 1,352
73725	MRA LOWER EXT W/ CONTRAST	$ 1,353
73725	MRA LOWER EXT W/O CONTRAST	$ 1,353
73725	MRA LOWER EXT W OR W/O CONTRAS	$ 1,353
74185	MRA W/CONTRAST, ABDOMEN	$ 1,350
74185	MRA W/O CONTRAST, ABDOMEN	$ 1,350
74185	MRA WO/W CONTRAST, ABDOMEN	$ 1,350
70336	MRI TMJ(S)	$ 1,312
70540	MRI ORBIT/FACE/NECK W/O CONT	$ 1,280
70542	MRI ORBIT/FACE/NECK W/CONT	$ 1,280
70543	MRI ORBIT/FACE/NECK W+W/O CONT	$ 2,316
70544	MRA HEAD W/O CONTRAST	$ 1,278
70545	MRA HEAD W/CONTRAST	$ 1,277
70546	MRA HEAD W/O & W/CONTRAST	$ 2,439
70547	MRA NECK W/O CONTRAST	$ 1,277
70548	MRA NECK W/CONTRAST	$ 1,277
70549	MRA NECK W/O & W/CONTRAST	$ 2,439
70551	MRI BRAIN WO CONTRAST	$ 1,312
70552	MRI BRAIN WITH CONTRAST	$ 1,574
70553	MRI BRAIN WO & W/CONTRAST	$ 2,801
71550	MRI CHEST W/O CONTRAST	$ 1,298
71551	MRI CHEST WITH CONTRAST	$ 1,555
71552	MRI CHEST W/O & W/CONTRAST	$ 2,741
72141	MRI SPINAL CNL, CERV WO CONT	$ 1,326
72142	MRI SPINAL CANAL, CERV W/CONT	$ 1,592
72146	MRI SPINAL CANAL, THOR WO CONT	$ 1,451
72147	MRI SPINAL CANAL, THOR W/CONT	$ 1,591
72148	MRI SPINAL CANAL LUMB WO CONT	$ 1,437
72149	MRI SPINAL CANAL LUMB W/ CONT	$ 1,575
72156	MRI SPINAL CANAL CERV WO/W CON	$ 2,826
72157	MRI SPINAL CANAL THOR WO/W CON	$ 2,825
72158	MRI SPINAL CANAL, LUMB WO/W CO	$ 2,801
72159	MRA SPINAL CANAL W/WO CONT	$ 1,298
72195	MRI PELVIS W/O CONTRAST	$ 1,298
72196	MRI PELVIS WITH CONTRAST	$ 1,555
72197	MRI PELVIS W/O & W/CONTRAST	$ 2,759
72198	MRA PELVIS WO/W CONTRAST	$ 1,350
72198	MRA PELVIS WO CONTRAST	$ 1,350
72198	MRA PELVIS W/CONTRAST	$ 1,350
73218	MRI UPPER EXTREM W/O CONTRAST	$ 1,280
73219	MRI UPPER EXTREM W/CONTRAST	$ 1,538
73220	MRI UPPER EXT W/O & W/CONT	$ 2,741
73221	MRI UPPER EXTREMITY JT WO CONT	$ 1,280
73222	MRI UPPER EXTREMITY JT W/CONT	$ 1,537
73223	MRI UPPER EXT JT W/O & W/CONT	$ 2,741
73718	MRI LWR EXT W/O CONT	$ 1,280
73719	MRI LWR EXT WITH CONT	$ 1,537
73720	MRI LOWER EXT W/O & W/CONT	$ 2,740
73721	MRI LOWER EXT JT W/O CONT	$ 1,280
73722	MRI LOWER EXT JT W/CONT	$ 1,537
73723	MRI LOWER EXT JT W/O & W/CONT	$ 2,741
74181	MRI ABDOMEN W/O CONTRAST	$ 1,298
74182	MRI ABDOMEN WITH CONTRAST	$ 1,555
74183	MRI ABDOMEN WO & W/CONT	$ 2,759

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 10, 2013

VIA FAX ONLY

Dennis P. McConville
SVP, Planning, Marketing & Communications
Tolland Imaging Center, LLC
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Mr. McConville:

On April 12, 2013, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") application filing on behalf of Tolland Imaging Center, LLC ("Applicant or Center") proposing to continue delivery of comprehensive imaging services including MRI and CT services, with an associated cost of $1,245,144.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the submitted initial Certificate of Need ("CON") application.

1. Please provide the current utilization (January 1, 2013 – April 30, 2013) for all existing equipment operated by the Applicant.

2. On page 14 of the CON application, the Applicant states that "the demand for outpatient diagnostic imaging services was determined utilizing the Advisory Board's Market Estimator Tool". Please provide documentation/calculations to support the above statement.

3. On page 20 of the CON application, the Applicant states that it has projected no volume growth for any of the imaging services provided at the facility from FY 2012 through FY 2016. Given that the geographic service area population is projected to grow 2.1% through 2015 and the demand for MRI and CT services is projected to increase at least 10% from 2011 to 2016 (9.9% for CT services and 11.0% for MRI), please explain why the Applicant projects 0% growth for all imaging services.

4. Please explain the financial impact of the Center on Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital for the last 3 years.

5. Please provide a current Financial Attachment I for the period ending April 30, 1013.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 292 and reference "Docket Number: 13-31833-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7035.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

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

TRANSMISSION OK

TX/RX NO	3475
RECIPIENT ADDRESS	918606476860
DESTINATION ID	
ST. TIME	05/10 13:58
TIME USE	00'34
PAGES SENT	3
RESULT	OK

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

FAX SHEET

TO: DENNIS P. McCONVILLE

FAX: 860 647 6860

AGENCY: TOLLAND IMAGING CENTER

FROM: PAOLO FIDUCIA

DATE: 5/10/13 TIME: 1:50 PM

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: 13-31833-CON

COMPLETENESS LETTER

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

ECHN℠
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

July 9, 2013

Paolo Fiducia, Associate Health Care Analyst
Department of Public Health - Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Mr. Fiducia:

On May 10, 2013 we received OHCA's request for additional information and/or clarification regarding the Certificate of Need Application referenced above. Please find our responses below:

1. Please provide the current utilization (January 1, 2013 - April 30, 2013) for all existing equipment operated by the Applicant.

Response:

2013	Jan	Feb	Mar	Apr
MRI	153	125	147	151
CT	72	62	74	67
XRAY	307	265	334	417
US	203	188	188	213
Mammo	203	149	179	187
Bone Density	38	38	42	47

2. On page 14 of the CON application, the Applicant states that "the demand for outpatient diagnostic imaging services was determined utilizing the Advisory Board's Market Estimator Tool". Please provide documentation/calculations to support the above statement.

Response:

The Advisory Board's Market Estimator is a proprietary demand forecasting tool provided to its members as a membership service.

From the Advisory Board website: We first forecast services based on local demographic projections (specific to age and gender cohorts). We then apply the non-demographic ("use") forecasts that our researchers have developed for each of the 1,400 outpatient services/procedures in our grouping system. The "use" forecasts are based on Innovations Center research into a comprehensive set of potential drivers, including basic trends in epidemiology, the impact of new technologies and procedures, potential physician supply constraints, lifestyle factors such as obesity and diabetes, and the effects of consumerism. In addition to the impact of these "use" factors, many outpatient services are under threat from a variety of competitors, including ambulatory surgery centers (ASCs), freestanding imaging centers, freestanding endoscopy suites and physician offices. The Innovations Center has separately forecasted the impact that this ongoing competition will have on the hospital-based segment of outpatient services/procedures. Those competitive forecasts are built directly into this model.

3. On page 20 of the CON application, the Applicant states that it has projected no volume growth for any of the imaging services provided at the facility from FY 2012 through FY 2016. Given that the geographic service area population is projected to grow 2.1 % through 2015 and the demand for MRI and CT services is projected to increase at least 10% from 201] to 2016 (9.9% for CT services and 11.0% for MRI), please explain why the Applicant projects 0% growth for all imaging services.

Response:

There are (2) reasons why we projected an estimate of Zero (0) volume growth.

Budgetary: During our regular FY-2012 budgeting process we believed the market would not grow and developed an FY2012 operating budget based on zero growth.

Member Hospital Declining Volume: While the TIC location has observed small growth, its member hospitals have seen an overall decline in MRI and CT volumes. The zero estimate is based on factoring in the declining hospital based imaging volume of its 4 hospital members thus canceling out the small growth of the TIC location.

4. Please explain the financial impact of the Center on Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital for the last 3 years.

Response:

	Tolland Imaging Center	JMMC	WCMC	MMH	RGH
Ownership		15%	15%	35%	35%
FY 2009 Net Income*	$ (566,311)	$ (84,947)	$ (84,947)	$ (198,209)	$ (198,209)
FY 2009 Cash Contribution*	$ 660,000	$ (99,000)	$ (99,000)	$ (231,000)	$ (231,000)
FY 2010 Net Income	$ (23,327)	$ (3,499)	$ (3,499)	$ (8,164)	$ (8,164)
FY 2010 Cash Contribution	$ 200,000	$ (30,000)	$ (30,000)	$ (70,000)	$ (70,000)
FY 2011 Net Income	$ (19,720)	$ (2,958)	$ (2,958)	$ (6,902)	$ (6,902)
FY 2011 Cash Contribution	$ -	$ -	$ -	$ -	$ -
FY 2012 Net Income	$ 96,815	$ 14,522	$ 14,522	$ 33,885	$ 33,885
FY 2012 Cash Contribution	$ -	$ -	$ -	$ -	$ -
5 Year Pro forma	$ 347,457	$ (205,881)	$ (205,881)	$ (480,390)	$ (480,390)

*** One Month of FY08 operations rolled in FY09 to simplify.**

Provided above are the last 5 fiscal years of financial impacts to Tolland Imaging Center, LLC and its respected member Hospitals, which were consequently recorded in the financials of each respective Member based on the percentage of ownership.

Page 23-24 of our original CON submission provides the specific breakdown of expenses which would remain if the CON is to be denied. This would significantly increase the losses to the TIC members. The member hospitals contributed $860,000 to establish the Center, and all of this investment would be lost if the Applicant's proposal is denied. The member hospitals would continue to be responsible for any outstanding lease or rental payments but would not have the revenue generated by the facility to offset this expense.

This unnecessary expense would erode the already small profit margins of the member institutions, negatively affecting the financial strength of the state's health care system.

Funding Source (Capital Lease)	Amount	Interest Rate	Start	End	Monthly Payment	Expected by 9/30/2013	
						Paid	Remaining
Lease #1 (Imaging Equipment)	$1,306,757	6.000%	3/1/2011	2/1/2015	$29,407	$806,833	$470,417
Lease #2 (Tenant Improvements)	$470,259	11.926%	9/1/2008	9/1/2013	$11,691	$470,259	$0
Lease #3 (Non-Imaging Equipment)	$149,428	11.68%	9/1/2008	9/1/2013	$3,692	$149,428	$0

5. Please provide a current Financial Attachment I for the period ending April 30, 1013.

Response:

Please see updated Attachment I

Please accept the above as our response to the completeness questions posed on May 10, 2013. If you have any other questions or require additional clarification please do not hesitate to give me a call at (860) 533-2970.

Sincerely,

Phil Candito

Phillip J. Candito
Director, Business Development

cc: Dennis P. McConville, SVP, Planning, Marketing and Communications, ECHN

Updated
Financial Statement I

Tolland Imaging Center **Docket Number 13-31833-CON**

Completeness Question 5. Please provide a current Financial Attachment I for the period ending April 30, 2013

Without CON = Continuation of comprehensive imaging services DENIED
(Reflects what will be incurred by the Members Hospitals)
With CON = Continuation of comprehensive imaging services APPROVED

							CON Year 1			CON Year 2			CON Year 3	
Total Facility: / **Description**	**Payer Mix**	**FY2012 Actual Results**	**% Growth**	**FY2013 Oct-April Actual Projected W/out CON**	**FY 2013 Annualized Projected W/out CON**	**FY 2013 Annualized Projected Incremental**	**FY 2013 Annualized 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**
NET PATIENT REVENUE															
Non-Government	85.7%	$1,857,663		$1,079,458	$1,850,500	$0	$1,850,500	$0	$1,880,108	$1,880,108	$0	$1,910,190	$1,910,190	$0	$1,940,753
Medicare	10.8%	$234,105		$136,034	$233,202	$0	$233,202	$0	$236,933	$236,933	$0	$240,724	$240,724	$0	$244,576
Medicaid and Other Medical Assistance	3.5%	$75,867		$44,085	$75,575	$0	$75,575	$0	$76,784	$76,784	$0	$78,012	$78,012	$0	$79,261
Other Government	0.0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$2,167,635	1.6%	$1,259,578	$2,159,277	$0	$2,159,277	$0	$2,193,825	$2,193,825	$0	$2,228,926	$2,228,926	$0	$2,264,589
Other Operating Revenue		$0	1.6%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue from Operations		$2,167,635		$1,259,578	$2,159,277	$0	$2,159,277	$0	$2,193,825	$2,193,825	$0	$2,228,926	$2,228,926	$0	$2,264,589
OPERATING EXPENSES															
Salaries and Fringe Benefits		$417,511	1.6%	$252,808	$433,385	$0	$433,385	$0	$440,319	$440,319	$0	$447,364	$447,364	$0	$454,522
Professional / Contracted Services		$473,436	1.6%	$270,555	$463,809	$0	$463,809	$0	$471,230	$471,230	$0	$478,770	$478,770	$0	$486,430
Supplies and Drugs		$52,404	1.6%	$28,830	$49,423	$0	$49,423	$0	$50,214	$50,214	$0	$51,017	$51,017	$0	$51,833
Bad Debts		$87,410	4.0%	$52,051	$89,230	$0	$89,230	$0	$87,753	$87,753	$0	$89,157	$89,157	$0	$90,584
Other Operating Expense		$376,243	1.6%	$219,352	$376,032	$0	$376,032	$0	$382,049	$382,049	$0	$388,161	$388,161	$0	$394,372
Subtotal		$1,407,004		$823,596	$1,411,879	$0	$1,411,879	$0	$1,431,564	$1,431,564	$0	$1,454,469	$1,454,469	$0	$1,477,741
Depreciation/Amortization		$461,951	S	$269,471	$461,951	$0	$461,951	$371,074	($332,385)	$38,689	$0	$27,762	$27,762	$0	$27,762
Interest Expense		$67,247	S	$26,107	$44,755	$0	$44,755	$13,069	($974)	$12,095	$0	$974	$974	$0	$0
Lease Expense		$134,618	3.0%	$80,865	$138,626	$0	$138,626	$860,910	$142,784	$142,784	$0	$147,068	$147,068	$0	($37,870)
Total Operating Expense		$2,070,820		$1,200,039	$2,057,210	$0	$2,057,210	$1,245,054	$1,240,990	$1,625,133	$0	$1,630,273	$1,630,273	$0	$1,467,633
Gain/(Loss) from Operations		$96,815		$59,539	$102,066	$0	$102,066	($1,245,054)	$952,835	$568,692	$0	$598,653	$598,653	$0	$796,956
Plus: Non-Operating Revenue		$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense		$96,815		$59,539	$102,066	$0	$102,066	($1,245,054)	$952,835	$568,692	$0	$598,653	$598,653	$0	$796,956
FTEs		6.2	0.0%	6.2	6.2	0.0	6.2	0.0	(6.2)	6.2	0.0	(6.2)	6.2	0.0	(6.2)

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

CT Scanner	805	0.0%	469	804	804	0	804	804	0	804	804	0	804	804	
MRI Scanner	1,724	0.0%	971	1,665	1,665	0	1,665	1,665	0	1,665	1,665	0	1,665	1,665	
Bone Density	462	0.0%	293	502	502	0	502	502	0	502	502	0	502	502	
Mammography	2,104	0.0%	1,333	2,285	2,285	0	2,285	2,285	0	2,285	2,285	0	2,285	2,285	
Radioagraphy (x-ray)	3,795	0.0%	2,192	3,758	3,758	0	3,758	3,758	0	3,758	3,758	0	3,758	3,758	
Ultrasound	2,571	0.0%	1,432	2,455	2,455	0	2,455	2,455	0	2,455	2,455	0	2,455	2,455	

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 15, 2013

VIA FACSIMILE ONLY

Dennis P. McConville
SVP, Planning, Marketing & Communications
Tolland Imaging Center, LLC
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application; Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Mr. McConville:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of August7, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7001.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

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

TRANSMISSION OK

TX/RX NO	3647
RECIPIENT ADDRESS	918606476860
DESTINATION ID	
ST. TIME	08/15 10:11
TIME USE	00'18
PAGES SENT	1
RESULT	OK

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 15, 2013

VIA FACSIMILE ONLY

Dennis P. McConville
SVP, Planning, Marketing & Communications
Tolland Imaging Center, LLC
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application; Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Mr. McConville:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of August7, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7001.

Sincerely,

Greer, Leslie

From: Fiducia, Paolo
Sent: Thursday, August 29, 2013 2:32 PM
To: Riggott, Kaila; Martone, Kim; Hansted, Kevin
Cc: Olejarz, Barbara; Greer, Leslie; Roberts, Karen
Subject: FW: Tolland Imaging Center CON
Attachments: Appearance.pdf

From: Matthews, Rebecca [mailto:RMatthews@wiggin.com]
Sent: Thursday, August 29, 2013 2:18 PM
To: Fiducia, Paolo
Cc: Bayer, Aaron S.; Phillip J. Candito (PCandito@echn.org); Daniel J. Delgallo (DDelgallo@echn.org)
Subject: Tolland Imaging Center CON

Hi Paolo:

I writing to confirm availability for a hearing in the above-reference matter on Wednesday, October 23, 2013. As discussed, Wiggin and Dana LLP has been engaged to represent the Applicant in the matter and both Aaron Bayer and I will plan to attend the hearing. Attached is a notice of appearance, as you requested. I will send the original to you via mail.

I assume that you will send to us a formal notice of the hearing that sets forth: (i) the amount of time we have to present; (ii) any specific matters that OHCA wishes for us to address in our testimony; and (iii) the deadline for submission of prefile testimony. If you need any more information from us to set up the hearing, please let us know.

Thank you.
-Rebecca

Rebecca A. Matthews
WIGGIN AND DANA LLP
One Century Tower
New Haven, CT 06508-1832
ph: +1.203.498.4502
fax: +1.203.782.2889

Two Liberty Place
50 S. 16th Street, Suite 2925
Philadelphia, PA 19102
ph: +1.215.988.8310
fax: +1.215.988.8344

e-mail: rmatthews@wiggin.com
website: www.wiggin.com

STATE OF CONNECTICUT

BEFORE THE DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	: :	DOCKET NO. 13-31833-CON
	:	AUGUST 27, 2013
IN RE APPLICATION OF TOLLAND IMAGING CENTER, LLC FOR CONTINUED DELIVERY OF COMPREHENSIVE IMAGING SERVICES INCLUDING MRI AND CT SERVICES	: : : :	

NOTICE OF APPEARANCE

Please enter the appearance of Wiggin and Dana LLP on behalf of Tolland Imaging Center, LLC.

We both plan to attend the hearing on Wednesday, October 23, 2013 on behalf of our client.

Respectfully submitted,

TOLLAND IMAGING CENTER, LLC

By: Aaron S. Bayer
Rebecca A. Matthews
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832
203-498-4400 (Telephone)
203-782-2889 (Fax)
abayer@wiggin.com
rmatthews@wiggin.com
Its Attorneys

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

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

DATE: August 30, 2013

RE: Certificate of Need Application; Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

---

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 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

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

September 26, 2013

Dennis P. McConville
SVP, Planning, Marketing & Communications
Tolland Imaging Center, Inc.
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, Inc.
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Mr. McConville,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Tolland Imaging Center, Inc. ("Applicant") on August 7, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	Tolland Imaging Center, Inc.
Docket Number:	13-31833-CON
Proposal:	Continued Delivery of Comprehensive Imaging Services including MRI and CT Services with an associated capital expenditure of $1,245,144 (if application is denied)

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: October 23, 2013

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access
410 Capitol Avenue, Third Floor Hearing Room
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in the *Hartford Courant* 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: PF:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

September 26, 2013 Requisition # 43332

Hartford Courant
285 Broad Street
Hartford, CT 06115

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 **Saturday, September 28, 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:PF:lmg

Hartford Courant **September 26, 2013**
Notice of Public Hearing, Docket Number 13-31833-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	Tolland Imaging Center, Inc.
Town:	Tolland
Docket Number:	13-31833-CON
Proposal:	Continued Delivery of Comprehensive Imaging Services including MRI and CT Services with a total capital expenditure of $1,245,144 (if the application is denied)
Date:	October 23, 2013
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than October 18, 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

TX/RX NO	3719
RECIPIENT ADDRESS	98606476860
DESTINATION ID	
ST. TIME	09/26 15:15
TIME USE	00'45
PAGES SENT	5
RESULT	OK

ST. TE OF CONNECTICUT
DEPAR MENT OF PUBLIC HEALTH
OFFIC OF HEALTH CARE ACCESS

FAX SHEET

TO: DENNIS P. MC CONVILLE

FAX: (860) 647-6860

AGENCY: TOLLAND IM GING CENTER, LLC

FROM: PAOLO FIDUC IA

DATE: 9/26/13 **TIME:**

NUMBER OF PAGES: 5
(inc ding transmittal sheet

Comments: DN: 13-31833· CON Hearing Notice

PLEASE PHONE IF TH ERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (8 0) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Thursday, September 26, 2013 2:38 PM
To: Greer, Leslie
Subject: Re: Hearing Notice DN: 13-31833-CON

Good day!

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

*Consider adding **color** to your Chronicle of Higher Education print ads or upgrading to a Featured Job Banner online.*

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.

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

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Thursday, September 26, 2013 2:27 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31833-CON

To Whom it May Concern,
Please run the attached hearing notice in the Hartford Courant by September 28, 2013. For billing reference, refer to requisition 43332. In addition, please forward me a copy of the "proof of publication" for my records.

Thank you,

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

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Friday, September 27, 2013 3:15 PM
To: Greer, Leslie
Subject: FW: Hearing Notice DN: 13-31833-CON
Attachments: 13-31833np Hartford Courant.doc

Your legal notice is all set to run as follows:

Hartford Courant, 9/28 issue - $302.72

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: Thursday, September 26, 2013 2:27 PM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice DN: 13-31833-CON

To Whom it May Concern,
Please run the attached hearing notice in the Hartford Courant by September 28, 2013. For billing reference, refer to requisition 43332. In addition, please forward me a copy of the "proof of publication" for my records.

Thank you,

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

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

October 08, 2013

VIA FAX ONLY

Rebecca A. Matthews, Esq.
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832

RE: Certificate of Need Application; Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Mr. McConville:

The Office of Health Care Access ("OHCA") will hold a public hearing on Wednesday, October 23, 2013, at 10:00 a.m. at the Department of Public Health, Office of Health Care Access, Third Floor Hearing Room, 410 Capitol Avenue, Hartford, 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. The Applicant's prefiled testimony must be submitted to OHCA no later than **12:00 pm, on Friday, October 18, 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 OHCA's attachment outlining the suggested discussion points to prepare for the hearing.

Please contact Paolo Fiducia at (860) 418-7035, if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

ISSUES

for Public Hearing:

Certificate of Need Application, Docket Number: 13-31833-CON

Tolland Imaging Center, LLC

Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Please be fully prepared to discuss the following:

1. How the Center has improved the quality of health care delivery in the region by facilitating collaboration between three independent hospital systems.
2. How does the projected gain in operations reflect the 1.6% growth in revenue and the reduction in expenses and when will each member hospital recover their investment and show a profit.
3. How will the continued operation of the Center enhance access to imaging services for the Medicaid and uninsured population?
4. How are you projecting 1) an increase in net patient revenue and 2) 0% volume growth when your member hospitals have experienced declining or flat utilization? (see Attachment I).
5. What steps will the Center take to continue to improve its referral base?
6. Individual financial impact with and without CON for each member hospital.
7. What is Rockville Hospital's capacity for all modalities should the Center close?
8. Comparison of current charges for MRI and CT services at the Center and its member hospitals (see Attachment II).

Provide a written response to the following as an attachment to the pre-file testimony:

1. Updated FY 2013 (October 1 – September 30) utilization for all existing equipment operated by the Applicant at the Center.
2. Updated Financial Attachment I to include actual FY 2013.
3. Updated Financial Attachment I with 3 years of projections reflecting continued operation not including MRI and CT services.
4. Provide a listing and the number of payor contract for the last three fiscal years (FY 2011, FY 2012, and FY 2013).

Attachment I

Johnson, Manchester, Rockville and Windham MRI and CT scans, FFYs 2010-2012

	Johnson			Manchester			Rockville			Windham		
	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012
MRI	1,378	1,511	1,511	3,840	3,7313	3,290	1,896	1,833	1,745	4,437	4,415	4,348
CT	8,321	7,601	6,834	21,765	18,152	16,124	10,451	8,759	7,993	13,057	10,745	10,948

Source: CT DPH Office of Health Care Access Hospital Reporting System Report 450

Every Hospital has reported a decline for MRI and CT services, except for Johnson which shows an increase of MRI scans from 2010 to 2011.

4 Hosp and Tolland Imaging Ctr Price Scan Comp Attachment II

Highest to Lowest Price	Scan Description	Provider	Price
1st	CT ABDOMEN WITH & WITHOUT	ECHN	$ 2,358.29
2nd	CT ABDOMEN WITH & WITHOUT	Windham CM Hosp	$ 2,331.00
3rd	CT ABDOMEN WITH & WITHOUT	Johnson Mem	$ 2,017.00
4th	CT ABDOMEN WITH & WITHOUT	Tolland Imaging Ctr	$ 1,026.00
1st	CT ABDOMEN WITH CONTRAST	Windham CM Hosp	$ 1,987.00
2nd	CT ABDOMEN WITH CONTRAST	ECHN	$ 1,789.73
3rd	CT ABDOMEN WITH CONTRAST	Johnson Mem	$ 1,720.00
4th	CT ABDOMEN WITH CONTRAST	Tolland Imaging Ctr	$ 846.00
1st	CT ABDOMEN WITHOUT CONTRAST	ECHN	$ 1,452.30
2nd	CT ABDOMEN WITHOUT CONTRAST	Windham CM Hosp	$ 1,452.00
3rd	CT ABDOMEN WITHOUT CONTRAST	Johnson Mem	$ 1,188.00
4th	CT ABDOMEN WITHOUT CONTRAST	Tolland Imaging Ctr	$ 716.00
1st	CT BRAIN W/O CONTRAST	ECHN	$ 1,452.30
2nd	CT BRAIN W/O CONTRAST	Windham CM Hosp	$ 1,373.00
3rd	CT BRAIN W/O CONTRAST	Johnson Mem	$ 1,188.00
4th	CT BRAIN W/O CONTRAST	Tolland Imaging Ctr	$ 580.00
1st	CT BRAIN WITH & WITHOUT CONTRAST	Windham CM Hosp	$ 2,331.00
2nd	CT BRAIN WITH & WITHOUT CONTRAST	Johnson Mem	$ 2,017.00
3rd	CT BRAIN WITH & WITHOUT CONTRAST	ECHN	$ 1,715.57
4th	CT BRAIN WITH & WITHOUT CONTRAST	Tolland Imaging Ctr	$ 869.00
1st	CT BRAIN WITH CONTRAST	Windham CM Hosp	$ 1,987.00
2nd	CT BRAIN WITH CONTRAST	Johnson Mem	$ 1,720.00
3rd	CT BRAIN WITH CONTRAST	ECHN	$ 1,545.00
4th	CT BRAIN WITH CONTRAST	Tolland Imaging Ctr	$ 709.00
1st	CT CHEST W/O CONTRAST	ECHN	$ 1,452.30
2nd	CT CHEST W/O CONTRAST	Windham CM Hosp	$ 1,373.00
3rd	CT CHEST W/O CONTRAST	Johnson Mem	$ 1,188.00
4th	CT CHEST W/O CONTRAST	Tolland Imaging Ctr	$ 738.00
1st	CT CHEST WITH CONTRAST	Windham CM Hosp	$ 1,987.00
2nd	CT CHEST WITH CONTRAST	ECHN	$ 1,727.93
3rd	CT CHEST WITH CONTRAST	Johnson Mem	$ 1,720.00
4th	CT CHEST WITH CONTRAST	Tolland Imaging Ctr	$ 865.00
1st	CT CHEST W-W/O CONTRAST	Windham CM Hosp	$ 2,331.00
2nd	CT CHEST W-W/O CONTRAST	ECHN	$ 2,170.42
3rd	CT CHEST W-W/O CONTRAST	Johnson Mem	$ 2,017.00
4th	CT CHEST W-W/O CONTRAST	Tolland Imaging Ctr	$ 1,061.00
1st	CT PELVIS WITH CONTRAST	Windham CM Hosp	$ 1,987.00
2nd	CT PELVIS WITH CONTRAST	Johnson Mem	$ 1,720.00
3rd	CT PELVIS WITH CONTRAST	ECHN	$ 1,648.82
4th	CT PELVIS WITH CONTRAST	Tolland Imaging Ctr	$ 832.00
1st	CT PELVIS WITHOUT CONTRAST	ECHN	$ 1,452.30
2nd	CT PELVIS WITHOUT CONTRAST	Windham CM Hosp	$ 1,447.00
3rd	CT PELVIS WITHOUT CONTRAST	Johnson Mem	$ 1,188.00
4th	CT PELVIS WITHOUT CONTRAST	Tolland Imaging Ctr	$ 730.00

Highest to Lowest Price	Scan Description	Provider	Price
1st	CT PELVIS W-W/O CONTRAST	Windham CM Hosp	$ 2,331.00
2nd	CT PELVIS W-W/O CONTRAST	ECHN	$ 2,138.28
3rd	CT PELVIS W-W/O CONTRAST	Johnson Mem	$ 2,017.00
4th	CT PELVIS W-W/O CONTRAST	Tolland Imaging Ctr	$ 1,004.00
1st	CT SPINE LUMBAR WITH CONTRAST	Windham CM Hosp	$ 1,987.00
2nd	CT SPINE LUMBAR WITH CONTRAST	ECHN	$ 1,722.98
3rd	CT SPINE LUMBAR WITH CONTRAST	Johnson Mem	$ 1,720.00
4th	CT SPINE LUMBAR WITH CONTRAST	Tolland Imaging Ctr	$ 862.00
1st	CT SPINE LUMBAR WITHOUT CONTRAST	ECHN	$ 1,452.30
2nd	CT SPINE LUMBAR WITHOUT CONTRAST	Windham CM Hosp	$ 1,373.00
3rd	CT SPINE LUMBAR WITHOUT CONTRAST	Johnson Mem	$ 1,188.00
4th	CT SPINE LUMBAR WITHOUT CONTRAST	Tolland Imaging Ctr	$ 738.00
1st	CT SPINE LUMBAR W-W/O CONTRAST	Windham CM Hosp	$ 2,331.00
2nd	CT SPINE LUMBAR W-W/O CONTRAST	ECHN	$ 2,170.42
3rd	CT SPINE LUMBAR W-W/O CONTRAST	Tolland Imaging Ctr	$ 1,049.00
4th	CT SPINE LUMBAR W-W/O CONTRAST	Johnson Mem	$ -
1st	MRI ABDOMEN W&W/O CONTRAST	Johnson Mem	$ 3,255.00
2nd	MRI ABDOMEN W&W/O CONTRAST	Windham CM Hosp	$ 2,828.00
3rd	MRI ABDOMEN W&W/O CONTRAST	Tolland Imaging Ctr	$ 2,759.00
4th	MRI ABDOMEN W&W/O CONTRAST	ECHN	$ 2,595.60
1st	MRI ABDOMEN W/O CONTRAST	Johnson Mem	$ 2,461.00
2nd	MRI ABDOMEN W/O CONTRAST	Windham CM Hosp	$ 1,922.00
3rd	MRI ABDOMEN W/O CONTRAST	ECHN	$ 1,730.40
4th	MRI ABDOMEN W/O CONTRAST	Tolland Imaging Ctr	$ 1,298.00
1st	MRI ABDOMEN WITH CONTRAST	Johnson Mem	$ 2,127.00
2nd	MRI ABDOMEN WITH CONTRAST	ECHN	$ 1,977.60
3rd	MRI ABDOMEN WITH CONTRAST	Tolland Imaging Ctr	$ 1,555.00
4th	MRI ABDOMEN WITH CONTRAST	Windham CM Hosp	$ -
1st	MRI BRAIN WITH & WITHOUT	Windham CM Hosp	$ 3,568.00
2nd	MRI BRAIN WITH & WITHOUT	Johnson Mem	$ 3,255.00
3rd	MRI BRAIN WITH & WITHOUT	Tolland Imaging Ctr	$ 2,801.00
4th	MRI BRAIN WITH & WITHOUT	ECHN	$ 2,472.00
1st	MRI CHEST W/O CONTRAST	Johnson Mem	$ 2,127.00
2nd	MRI CHEST W/O CONTRAST	Windham CM Hosp	$ 1,891.00
3rd	MRI CHEST W/O CONTRAST	ECHN	$ 1,730.40
4th	MRI CHEST W/O CONTRAST	Tolland Imaging Ctr	$ 1,298.00
1st	MRI CHEST WITH CONTRAST	Johnson Mem	$ 2,461.00
2nd	MRI CHEST WITH CONTRAST	Windham CM Hosp	$ 2,215.00
3rd	MRI CHEST WITH CONTRAST	ECHN	$ 1,977.60
4th	MRI CHEST WITH CONTRAST	Tolland Imaging Ctr	$ 1,555.00
1st	MRI CHEST W-W/O CONTRAST	Johnson Mem	$ 3,255.00
2nd	MRI CHEST W-W/O CONTRAST	Tolland Imaging Ctr	$ 2,741.00
3rd	MRI CHEST W-W/O CONTRAST	Windham CM Hosp	$ 2,707.00

4 Hosp and Tolland Imaging Ctr Price Scan Comp Attachment II

Highest to Lowest Price	Scan Description	Provider	Price
4th	MRI CHEST W-W/O CONTRAST	**ECHN**	$ 2,472.00
1st	MRI IAC/BRAIN W/CONTRAST	**Johnson Mem**	$ 2,461.00
2nd	MRI IAC/BRAIN W/CONTRAST	**Windham CM Hosp**	$ 2,287.00
3rd	MRI IAC/BRAIN W/CONTRAST	**ECHN**	$ 1,854.00
4th	MRI IAC/BRAIN W/CONTRAST	**Tolland Imaging Ctr**	$ 1,574.00
1st	MRI IAC/BRAIN W/O CONTRAST	**Johnson Mem**	$ 2,127.00
2nd	MRI IAC/BRAIN W/O CONTRAST	**Windham CM Hosp**	$ 1,960.00
3rd	MRI IAC/BRAIN W/O CONTRAST	**ECHN**	$ 1,730.40
4th	MRI IAC/BRAIN W/O CONTRAST	**Tolland Imaging Ctr**	$ 1,312.00
1st	MRI PELVIS W/O CONTRAST	**Johnson Mem**	$ 2,127.00
2nd	MRI PELVIS W/O CONTRAST	**Windham CM Hosp**	$ 1,824.00
3rd	MRI PELVIS W/O CONTRAST	**ECHN**	$ 1,730.40
4th	MRI PELVIS W/O CONTRAST	**Tolland Imaging Ctr**	$ 1,298.00
1st	MRI PELVIS WITH CONTRAST	**Johnson Mem**	$ 2,461.00
2nd	MRI PELVIS WITH CONTRAST	**Windham CM Hosp**	$ 2,215.00
3rd	MRI PELVIS WITH CONTRAST	**ECHN**	$ 1,977.60
4th	MRI PELVIS WITH CONTRAST	**Tolland Imaging Ctr**	$ 1,555.00
1st	MRI PELVIS W-W/O CONTRAST	**Johnson Mem**	$ 3,255.00
2nd	MRI PELVIS W-W/O CONTRAST	**Tolland Imaging Ctr**	$ 2,759.00
3rd	MRI PELVIS W-W/O CONTRAST	**Windham CM Hosp**	$ 2,722.00
4th	MRI PELVIS W-W/O CONTRAST	**ECHN**	$ 2,595.60
1st	MRI TEMPOROMANDIBULAR JOINT	**Windham CM Hosp**	$ 2,390.85
2nd	MRI TEMPOROMANDIBULAR JOINT	**ECHN**	$ 2,224.80
3rd	MRI TEMPOROMANDIBULAR JOINT	**Johnson Mem**	$ 1,927.00
4th	MRI TEMPOROMANDIBULAR JOINT	**Tolland Imaging Ctr**	$ 1,312.00

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

TRANSMISSION OK

TX/RX NO	3733
RECIPIENT ADDRESS	912037822889
DESTINATION ID	
ST. TIME	10/08 15:21
TIME USE	01'26
PAGES SENT	8
RESULT	OK

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

FAX SHEET

TO: REBECCA A. MATTHEWS

FAX: 12037822889

AGENCY: WIGGIN AND DANA, LLP

FROM: PAOLO FIDUCIA

DATE: 10/08/2013 **Time:** 3:15 pm

NUMBER OF PAGES: 8
(including transmittal sheet

Comments:
13-31833-
CON Pre-file
letter and
Issues

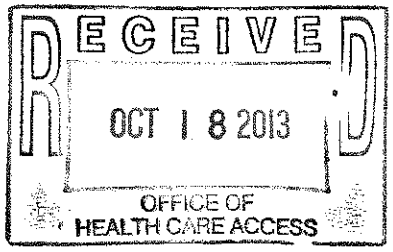
PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

WIGGIN AND DANA

Counsellors at Law

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

Rebecca A. Matthews
203.498.4502
203.782.2889 fax
rmatthews@wiggin.com



VIA EMAIL AND HAND DELIVERY

October 18, 2013

Mr. Kevin T. Hansted, Hearing Officer
Department of Public Health – Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Hearing Officer Hansted,

On behalf of Tolland Imaging Center, LLC ("TIC"), please find enclosed prefile testimony of:

- Daniel J. DelGallo, Executive Director of TIC and Administrative Director of Medical Imaging at Eastern Connecticut Health Network, Inc. ("ECHN")
- Michael Veillette, Chief Financial Officer of ECHN
- Ethan B. Foxman, M.D., President and CEO of Jefferson Radiology, P.C.

Each will attend the hearing to adopt his prefile testimony and answer any questions that you or your colleagues may have.

Please note that in accordance with your office's request dated October 8, 2013 we have provided updated utilization and financial information and have addressed each of the topics you identified as requiring additional discussion. For ease of reference, please find below a chart that shows which speaker's testimony addresses each of the topics you listed:

Topic	Prefile Testimony
1. How Tolland Imaging Center ("TIC") has improved the quality of health care delivery in the region by facilitating collaboration between three independent hospital systems.	Testimony of Dan DelGallo and Ethan Foxman, M.D.
2. How does the projected gain in operations reflect the 1.6% growth in revenue and the reduction in expenses and when will each member hospital recover their investment and show a profit.	Testimony of Dan DelGallo
3. How will the continued operation of TIC enhance access to imaging services for the Medicaid and uninsured population?	Testimony of Dan DelGallo and Ethan Foxman, M.D.
4. How are you projecting 1) an increase in net patient revenue and 2) 0% volume growth when your member hospitals have experienced declining or flat utilization?	Testimony of Dan DelGallo
5. What steps will TIC take to continue to improve its referral base?	Testimony of Dan DelGallo
6. Individual financial impact with and without CON for each member hospital.	Testimony of Dan DelGallo and Michael Veillette
7. What is Rockville Hospital's capacity for all modalities should TIC close?	Testimony of Dan DelGallo
8. Comparison of current charges for MRI and CT services at TIC and its member hospitals.	Testimony of Dan DelGallo
Attachments	**Prefile Testimony**
1. Updated FY2013 utilization for all existing equipment operated at TIC	Attached to Dan DelGallo's testimony as Exhibit A.
2. Updated Financial Attachment I to include actual FY2013	Attached to Dan DelGallo's testimony Exhibit B.
3. Updated Financial Attachment I with three years of projections reflecting continued operation not including MRI and CT services.	Attached to Dan DelGallo's testimony as Exhibit C.
4. Provide a listing and the number of payor contracts for the last three fiscal years (FY 2011 – FY 2013)	Attached to Dan DelGallo's testimony as Exhibit D.

We will be happy to address any additional questions you may have at the hearing.

If you have any questions regarding this submission, please contact me at your earliest convenience at (203) 498-4502.

Sincerely,

Rebecca A. Matthews

Topic	Prefile Testimony
1. How Tolland Imaging Center ("TIC") has improved the quality of health care delivery in the region by facilitating collaboration between three independent hospital systems.	Testimony of Dan DelGallo and Ethan Foxman, M.D.
2. How does the projected gain in operations reflect the 1.6% growth in revenue and the reduction in expenses and when will each member hospital recover their investment and show a profit.	Testimony of Dan DelGallo
3. How will the continued operation of TIC enhance access to imaging services for the Medicaid and uninsured population?	Testimony of Dan DelGallo and Ethan Foxman, M.D.
4. How are you projecting 1) an increase in net patient revenue and 2) 0% volume growth when your member hospitals have experienced declining or flat utilization?	Testimony of Dan DelGallo
5. What steps will TIC take to continue to improve its referral base?	Testimony of Dan DelGallo
6. Individual financial impact with and without CON for each member hospital.	Testimony of Dan DelGallo and Michael Veillette
7. What is Rockville Hospital's capacity for all modalities should TIC close?	Testimony of Dan DelGallo
8. Comparison of current charges for MRI and CT services at TIC and its member hospitals.	Testimony of Dan DelGallo
Attachments	**Prefile Testimony**
1. Updated FY2013 utilization for all existing equipment operated at TIC	Attached to Dan DelGallo's testimony as Exhibit A.
2. Updated Financial Attachment I to include actual FY2013	Attached to Dan DelGallo's testimony Exhibit B.
3. Updated Financial Attachment I with three years of projections reflecting continued operation not including MRI and CT services.	Attached to Dan DelGallo's testimony as Exhibit C.
4. Provide a listing and the number of payor contracts for the last three fiscal years (FY 2011 – FY 2013)	Attached to Dan DelGallo's testimony as Exhibit D.

We will be happy to address any additional questions you may have at the hearing.

If you have any questions regarding this submission, please contact me at your earliest convenience at (203) 498-4502.

Sincerely,

Rebecca A. Matthews

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

Docket No.: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive
Imaging Services including MRI and CT Services

October 18, 2013

Prefile Testimony of Daniel Joseph DelGallo
Executive Director
Tolland Imaging Center, LLC
Administrative Director of Medical Imaging
Eastern Connecticut Health Network, Inc.

My name is Dan DelGallo. I am the Executive Director of Tolland Imaging Center, LLC ("TIC") and the Administrative Director of Medical Imaging for the Eastern Connecticut Health Network ("ECHN"). Thank you for providing us with the opportunity to submit testimony in support of the continued delivery of comprehensive imaging services at TIC.

As you know, TIC is a joint venture among four hospitals, Johnson Memorial Hospital ("Johnson"), Manchester Memorial Hospital ("Manchester"), Rockville General Hospital ("Rockville"), and Windham Community Memorial Hospital ("Windham") (collectively, the "Member Hospitals"). Both Manchester and Rockville are hospitals within the ECHN system. Because this venture is a collaborative effort, there are a number of people here today to support TIC's proposal. You will hear testimony from Ethan Foxman, M.D., who is the President and Chief Executive Officer of Jefferson Radiology P.C. ("Jefferson Radiology"), the group that provides professional radiology services at TIC. You will also hear testimony from Michael Veillette, the Chief Financial Officer at ECHN. Also present today are John Grish, the interim Chief Financial Officer at Johnson, and David Whitehead, the President and Chief Executive Officer at Windham.

By training, I am a radiologic technologist, board certified by the American Registry of Radiologic Technologists in magnetic resonance imaging ("MRI"), computed tomography ("CT") scanning, and diagnostic imaging. I received a Bachelor of Science degree with a

concentration in Diagnostic Imaging and I anticipate graduating from an MBA program in October 2013. I have been involved in diagnostic imaging services since 1999 and have, over the past several years, taken on increasingly greater responsibilities in this area. As the Executive Director of TIC, I oversee all operations and administration of diagnostic imaging services, including oversight of financial management, staffing, strategic planning, marketing, physician relations and quality assurance.

I. Background Information

Prior to 2007, ECHN, Johnson, and Windham each independently identified a need for outpatient imaging services in Tolland County and each submitted a Certificate of Need ("CON") application to develop a separate freestanding imaging center in Tolland. The Office of Health Care Access ("OHCA") agreed that there was a need for a center in the region and, at OHCA's suggestion, the three competitors decided to work together to create TIC as a joint venture. By collaborating, the Member Hospitals were able to efficiently and collectively establish a viable, comprehensive freestanding imaging center that serves the needs of the community and the patients of the Member Hospitals. That three competing hospital systems joined forces to provide greater access to community-based imaging services is unprecedented and demonstrates our dedication to providing quality, accessible, convenient care for our patients and the community in Tolland and the surrounding towns.

In its decision approving the establishment of TIC, OHCA agreed that the joint venture would address the need for comprehensive freestanding imaging services in the service area and would enhance the quality and accessibility of outpatient imaging services for the patients residing in that area. In addition to the public need for the services, OHCA approved our collaboration because it (i) had a ready referral base through affiliations with twenty-eight physicians in the Tolland area; (ii) permitted the Member Hospitals to pool limited resources, thus enhancing financial viability and efficiency; and, (iii) had the potential to enhance relationships among providers in the region, including the Member Hospitals. OHCA, however, granted provisional approval as a demonstration project because OHCA had concerns that the collaboration might not be able to maintain financial viability. The demonstration-project period would allow the joint venture time to demonstrate that the parties could indeed work together

and that we could achieve and maintain financial viability through our MRI and CT utilization. TIC has achieved and is continuing to pursue OHCA's vision for this unique project.

II. TIC's Success

TIC has proved to be a unique, meaningful, and viable joint venture among three competing hospital systems that goes beyond a mere pooling of financial resources. We have truly collaborated to create a comprehensive imaging center that provides efficient continuity of care for our patients and offers CT and open MRI services as well as radiography, mammography, bone densitometry, and ultrasound services. In our five years of operation, TIC has (i) vastly broadened its referral base, (ii) improved patient access to imaging services, (iii) improved the quality of health care delivery in the region, (iv) avoided unnecessary duplication of imaging services in the service area; (v) improved relationships among the providers in the region, and (vi) attained financial viability.

I am proud to report that TIC receives referrals from almost 1,000 providers, sixty-nine of whom consistently refer to TIC (i.e these sixty-nine providers account for 70% of TIC's total referrals). Most of our referring physicians have offices in and around the Tolland area and some practice in the same medical office building in which TIC is located. These physicians practice in the specialties of family practice, gastroenterology, obstetrics and gynecology, and orthopedics; specialties which often require patients to have imaging studies across many modalities for diagnostic purposes or as a component of routine care. TIC can meet the needs of these providers and patients because it is a comprehensive imaging center that offers services across all imaging modalities that are typically used in an outpatient setting.

Additionally, TIC serves the imaging needs of the Med-East Medical Walk-In Center, a neighboring urgent care center and partner of Windham, which allows it to maintain continuity of care and share information with Windham's system. Because the urgent care center can rely on TIC for all of its imaging needs, TIC helps in the mission to ease the burden of residents seeking care from local emergency departments.[1]

Our broad referral base helped us reach almost 10,000 patients in FY 2012 across all offered imaging modalities. In fact, as you can see on the updated utilization information

[1] In fact Med-East Medical Walk-In Center decommissioned its radiography equipment in 2008 and has since referred all patients in need of imaging studies to TIC.

attached as Exhibit A, TIC has experienced an overall 14.9% growth in volume between FY2010 and FY2013. With the exception of ultrasound services, every modality has shown positive growth over this four-year period. The level of growth TIC has enjoyed demonstrates that TIC is a successful venture. In order to build on our success to date, we are expanding our comprehensive marketing plan in an effort to develop additional referrals and increase patient access. Our expanded referral base and the rapid growth we have experienced since opening TIC speaks to the need that TIC fulfills and would continue to fill if OHCA approves our application. Further, by also serving the urgent care center, TIC is leveraging its capacity to be a comprehensive imaging resource to as many providers in the service area as possible. TIC has become an integral part of the medical community for the patients and providers in the region.

TIC provides patients and providers in Tolland and the surrounding towns with convenient access to comprehensive imaging services that did not exist before TIC was established and would not exist if TIC were to close. National trends show patients increasingly seek care in outpatient suburban centers because they do not want to receive care in a hospital setting. This is especially true for imaging exams because of often unpredictable wait times at hospitals due to urgent inpatient and emergency department patient exams that necessarily take priority over routine outpatient exams. As the number of Medicaid beneficiaries dramatically increases with the implementation of the Affordable Care Act, we expect this trend to continue. TIC, as the only comprehensive freestanding outpatient imaging center in the service area, stands ready to serve these patients in the manner in which they wish to receive care.

At TIC we treat all patients. We accept private insurance, Medicare, Medicaid and other government plans. In addition, TIC has a formal charity care policy which provides free care to those uninsured patients who meet certain financial eligibility requirements. TIC also reaches out to the community with events such as free mammogram days that provide uninsured patients, and other members of the community, with access to this lifesaving service. Further, any profit generated from TIC is distributed back to the non-profit Member Hospitals to aid them in their mission to provide additional services to under and uninsured patients, including services they provide at a loss, such as emergency room care and behavioral health care.

Part and parcel of improved access is improving the quality of care in the region. TIC has been uniquely positioned to improve care because, as a joint venture, our collaboration includes numerous providers in the Northeastern corner of Connecticut. As I mentioned earlier,

TIC has partnered with Jefferson Radiology to provide the professional radiology interpretation services for exams performed at TIC. In addition to TIC, Jefferson Radiology also provides services at various hospitals, including Johnson and Windham. As Dr. Foxman will testify, the professional services delivered by Jefferson Radiology are a significant component of TIC's efforts to provide a seamless continuum of care to patients and coordinate results among providers, regardless from which of the community providers or Member Hospitals the patient originates. Through Jefferson Radiology, physicians with access to the systems at each of the Member Hospitals can retrieve patient information about exams performed at TIC. This helps physicians and patients decide upon treatments more quickly and prevents unnecessary duplication by ensuring timely access to a patient's imaging history. Further, the wide array of subspecialty expertise housed within Jefferson Radiology provides TIC's patients and referring providers with ready access to subspecialty consultation. This further streamlines a provider's ability to determine the best course of treatment by avoiding the delays attendant to sending an imaging scan "out" for a subspecialty read. This also protects against unnecessary duplication that can sometimes occur if a consulting provider prefers to take his own images or there are technology barriers that prevent image-sharing.

TIC also provides each of the Member Hospitals with their only access to a hospital-affiliated open MRI. In addition to discussing the significant benefits TIC and Jefferson Radiology provide to patients in the service area, Dr. Foxman will also address the clinical necessity of having access to an open MRI to treat certain types of patients. Not all MRI services are fungible and without an open MRI, the Member Hospitals would be unable to capture the percentage of patients who clinically require or will choose only open MRI services. Access to TIC's open MRI keeps those revenues within the Member Hospitals' non-profit health systems, ensuring those dollars are reinvested in community health services. By providing access to open MRI services for the four Member Hospitals, TIC again leverages its capacity to fulfill the service needs of as many parties as possible and prevents duplication of services among the Member Hospitals.

TIC clearly provides much needed services to the Tolland community and provides patients and practitioners from Tolland and the surrounding towns with access to convenient, comprehensive imaging services and subspecialty radiology consultation in a manner that avoids delays and duplication and permits for the most efficient use of resources along a seamless

continuum of care. For example, TIC provides same day service and immediate reports for the urgent care center to ensure timely and effective care for patients. When urgent care center patients require immediate hospital attention, the images are available at any of the Member Hospitals further expediting physician access to reports and images to facilitate treatment. As another example, one of the physician practices, Manchester Ob/Gyn, located in the same medical office building as TIC sends patients with high-risk pregnancies to TIC for high-risk ultrasound services. TIC routinely provides Manchester Ob/Gyn patients same-day high-risk ultrasound services, without an appointment. If the ultrasound reveals any concerns, TIC contacts Manchester Ob/Gyn by phone before the official report has time to be generated to ensure the physician has the necessary information as soon as possible. More routinely, patients who have appointments with their physicians can see their physicians, be sent down to TIC for imaging, and go back upstairs to discuss the results with their physicians. This is the caliber of coordination of care and collaboration that all health care systems seek to achieve.

Finally from a financial standpoint, TIC helps preserve the financial strength of its Member Hospitals and therefore the financial strength of the state health system. As requested, please find attached as Exhibit B the Updated Financial Attachment 1 which includes our most current FY2013 data. While TIC may not have achieved the MRI and CT volumes OHCA used as a proxy for financial viability five years ago, volumes have grown significantly since 2008 allowing us to achieve financial viability.[2] Further, based on our conservative projections, we will be able to maintain financial viability moving forward if TIC can continue to offer MRI and CT services. We spent the first few years of this joint venture paying off the significant up-front costs associated with creating TIC, including leasehold improvements and non-imaging equipment expenses. As of September 1, 2013, those initial obligations have been paid in full.

---

[2] You will note on Table 2a from our application that CT procedure volume appears to have declined from FY 2010 to FY 2011. The biggest contributing factor to this decline was a major CPT coding change that went into effect January 1, 2011. This change eliminated the separate billing and CPT codes for all abdomen and pelvis CT exams performed on the same day. We have corrected the FY2011, FY2012, and FY2013 volumes so that the method used to count exams is consistent across all of the fiscal years under examination. We have submitted these corrected numbers in Exhibit A, attached hereto and incorporated by reference, in which we update the utilization numbers for FY2013. You will note that the corrected volumes demonstrate that there has been an increase in the use of all imaging modalities from FY2010 through FY2013, except for ultrasound, and that overall TIC has experienced 14.9% growth in utilization from FY2010 through FY2013.

Thus, only now can TIC's profits, which up until September 1, 2013 had been used to pay down those initial expenses, be distributed to each Member Hospital allowing each to begin to recoup their initial investment.

Currently, TIC generates enough revenue to cover its operational costs which include the equipment lease and the real estate lease, obligations which will remain until 2015 and 2016, respectively, whether this CON is approved or not. We have projected 0% volume growth over the next three fiscal years which when coupled with improved managed care contracting will allow us to realize an increase in total net patient revenue of 1.6%.[3] Closing TIC now, at the very moment when the investment made by the Member Hospitals begins to generate a surplus, is fiscally irrational. By permitting TIC to continue operations, OHCA ensures that the Member Hospitals can meet their obligations under the remaining leases and that the Member Hospitals will recoup their initial investment. Currently, we project that the Member Hospitals will recoup their initial investment some time in FY2016.

TIC's continued operation strengthens the financial position of each of the Member Hospitals; positions which are imperiled in the current environment of deep federal and state cuts to health care. Any entity that generates income for the Member Hospitals is desperately needed and helps the three health systems continue their missions to provide critical services that are not profitable as well as charity care to under and uninsured patients.

As a non-hospital based imaging center, TIC provides services in a cost-effective way for patients and the state's health care system. As an independent center, TIC has lower costs and is reimbursed for services at a lower rate than those necessarily charged by hospital-based providers. Our reimbursement rates are set by regulatory bodies (in the case of Medicare and Medicaid) or are negotiated with sophisticated parties on an arm's-length basis. As requested, please find attached as Exhibit D the list of payors with whom TIC has contracts. As a collaboration, TIC provides the best of both worlds—the delivery of cost-effective services that ultimately supports the non-profit mission of the Member Hospitals.[4]

---

[3] Nationally, hospitals have experienced flat or declining growth for MRI and CT services, in part because patients are increasingly seeking care in outpatient suburban centers. Thus, despite the Member Hospitals' flat or declining growth in CT and/or MRI services, the trend of patients seeking care in outpatient suburban centers like TIC allows us to conservatively project 0% volume growth for the next three fiscal years.

[4] While hospital-based imaging services are generally reimbursed at a higher rate than the services provided at centers that bill as independent facilities, the discrepancy in reimbursement is due to the

Overall, as OHCA envisioned, TIC has developed a financially-viable freestanding comprehensive imaging center and the ongoing collaboration between the Member Hospitals, Jefferson Radiology, and our providers has improved relationships, patient access to imaging services and subspecialty radiology care, and delivery of health care in the region.

III. Ramification of TIC's Inability to Provide CT and MRI Services

In short, if OHCA denies this CON, thereby preventing TIC from offering CT and MRI services, TIC will have to close because it will no longer be financially viable. It is evident from reviewing the financial projections of TIC's continued operations without offering MRI and CT services, attached hereto as Exhibit C, that revenue from the other imaging services offered at TIC does not generate enough income to maintain financial viability. In addition to the significant, negative impact on the financial health of the Member Hospitals, removing TIC from the Tolland community would decrease patient access to imaging services and provider access to expedient radiology subspecialty consultation, and severely limit the neighboring urgent care center's access to specialized imaging services such as CT, MRI, and ultrasound.

A. Impact on Patients

If TIC closes, patients of the Member Hospitals, including under and uninsured patients, will not have ready, convenient access to quality outpatient imaging services. While technically there may be capacity on the MRIs and CTs of the Member Hospitals to absorb the volume currently served by TIC, in reality, receiving an MRI or a CT at a hospital is a logistically cumbersome and time intensive endeavor. It is made difficult not only because of the often inconvenient locations and parking limitations, but because hospitals are juggling inpatient and outpatient use of their imaging equipment. This frequently results in delayed routine outpatient scans because inpatients or emergency department patients require urgent assessment. It would not be difficult to imagine that a patient faced with the choice of receiving an MRI at a Member Hospital or at a freestanding outpatient imaging center would choose to receive services at the latter or may even choose to delay or forego testing. The increased difficulty in accessing

---

significantly higher costs associated with providing these services in a hospital. Some of those costs are attributable to the higher overhead expenses of hospitals that must operate twenty-four hours per day and treat higher-risk patients who require a higher level of care, all of which involves greater consumption of supplies and services.

hospital-based imaging is an obstacle to necessary health care services and decreases the likelihood of patient compliance. These inconveniences have a disproportionate impact on under and uninsured patients who tend to be among the most vulnerable and have the fewest options for care.

A patient forced to choose another freestanding imaging center because of TIC's closure would not enjoy the same continuity of care that TIC affords. The patient receiving an exam at an outpatient freestanding imaging center not associated with her referring hospital would have to coordinate her physician's receipt of the report of her result and the images (either CD or films). Not all radiology groups have Jefferson Radiology's depth and breadth of subspecialty expertise and without ready access to such, the physician may need to consult another radiology group to interpret the results, causing the patient further delay. TIC dispenses with the aggravation, delay, and duplication of services and permits patients convenient access to comprehensive imaging services.

Additionally, TIC provides the only hospital-affiliated open MRI for each of the Member Hospitals. As mentioned above and reiterated by Dr. Foxman, all MRI services are not fungible. Access to both open and closed MRIs is needed to meet clinical needs and patient demand. Without TIC, a patient requiring or choosing open MRI services would need to go to an outpatient freestanding imaging center not associated with her referring Member Hospital and would experience the same difficulties in coordination and continuity of care I just discussed. This would effectively transfer the revenue stream from those patients away from the Member Hospitals that need it to support other critically important but unprofitable services for their communities.

Nor would ready access to other open MRI's be a certainty. The next closest open MRI is in South Windsor and, according to the most recent data available from FY2011, that MRI is operating at 88% capacity, well above the recommended 85% capacity OHCA described in the Statewide Health Care Facilities and Services Plan ("Statewide Plan"). The next closest open MRI is in Enfield which can be quite a distance for patients coming from east of Tolland. It is also important to understand that the Member Hospitals cannot exchange one of their hospital-based closed MRIs for an open MRI. There are some types of exams that require the use of a closed MRI and a hospital cannot solely have an open MRI in house. TIC efficiently provides access to open MRI services for the four Member Hospitals thereby preventing the need for

additional imaging equipment or additional expenditures by the Member Hospitals, affording patients greater convenience and continuity of care, and contributing to patient compliance with recommended services.

TIC is the only comprehensive freestanding imaging provider in the service area. None of the four Member Hospitals currently provides the comprehensive array of services provided by TIC in one location. The other area providers are missing at least one of the modalities TIC offers. For example, Rockville might have capacity to absorb the volume of X-rays and CT exams performed at TIC, however, Rockville does not offer bone densitometry and there would be waiting lists for mammography and ultrasound. Finally, while Rockville technically has the capacity to accommodate the volume of MRI exams performed at TIC, it is not likely to capture a significant portion of that volume because Rockville's MRI is closed and thus Rockville cannot offer open MRI services. Closure of TIC effectively sends TIC's MRI patients to other, non-Member Hospital locations, meaning that patients will not enjoy the benefits in access and continuity of care that TIC offers.

B. Impact on Member Hospitals

As Michael Veillette will testify to in more detail, if TIC is forced to close, there will be a significant negative financial impact on each of the four Member Hospitals. While the FY 2013 year-end financial statements are not yet complete, we know that they will show that each of the three hospitals or their systems suffered extraordinary losses this year.[5] The Member Hospitals are operating on breakeven budgets and any financial loss would be devastating. As already discussed, TIC spent the first few years of operation paying down costs associated with opening the center and, while TIC realized modest gains in FY2013 and FY 2013, only now will we begin to generate profits in earnest, permitting the Member Hospitals to recoup their initial investment of $860,000.

The impact of TIC's closure is not limited to the loss of the Member Hospitals' initial investment. TIC currently holds equipment and real estate leases that end in 2015 and 2016, respectively, and those obligations will continue whether or not the CON is approved. Thus, in

[5] Although the updated financial Attachment 1 (all members) reflects a net profit of $3,285,104 for Rockville, Manchester shows a net loss of $1,254,245 and the total loss for the entire ECHN system is expected to be $2,500,000. Certain hospital related business units that do not fall under either the Manchester or Rockville license are accounted for separately and not reflected in the financials of the hospitals. Overall, however, ECHN is projecting a $2,500,000 loss for fiscal year 2013.

addition to the portion of the initial investment still due, TIC has over a million dollars in continuing lease obligations and depreciation expenses, obligations that may have to be assumed by the Member Hospitals.[6] This does not include other direct losses such as the costs that would be associated with the wind up and dissolution of the joint venture, the loss of direct revenue from TIC's operations, and loss of seven full time employees. In addition to the direct losses from TIC's closure, the Member Hospitals will also suffer indirect losses. The loss of affiliated, open MRI services will lead to a loss of patients from the hospitals systems. While we realize that some of the patients who received services at TIC will be recaptured by the Member Hospitals and offset the revenue losses, it is difficult to predict how many patients will seek services elsewhere, and it is unclear how substantial a portion of TIC's patients the Member Hospitals will be able to recapture. The Member Hospitals do not have any profit to absorb a financial loss or a loss of revenues. In order to compensate for the direct and indirect losses resulting from TIC's closure, the Member Hospitals would be forced to make cuts in personnel and key services. This would decrease patient access to services and negatively impact the health of our community.

TIC's closure would have disastrous consequences for the financial strength of the Member Hospitals and the state's healthcare system in the region. TIC's continued operation, however, provides a much needed revenue stream while enhancing access to care. In the current situation, revenue sources are scarce and the smallest contributions to profitability make all the difference.

IV. Conclusion

TIC adds value to our community and our state's healthcare system by increasing patient access to quality, convenient imaging services and subspecialty radiology care regardless of a patient's ability to pay. Our unique collaboration supports information sharing among patients, providers, the neighboring urgent care center, and the Member Hospitals, thereby improving the delivery of health care and decreasing unnecessary duplication. Finally, TIC contributes to the non-profit mission and financial well-being of the Member Hospitals. Denying our application would disrupt the tenuous financial position of the four Member Hospitals, squander the

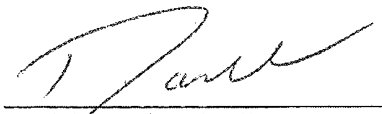
[6] In our application, these costs were estimated to be $1,254,054. After reviewing the calculations, depreciation expenses are likely higher, resulting in costs closer to $1,328,993 to close TIC.

investment already made, and jeopardize the financial strength of the state's health care system in the northeastern part of Connecticut. If TIC closes, patient access to imaging services delivered in the manner in which patients increasingly want to receive care will be diminished and a driving force behind continued collaboration among patients, providers, the urgent care center, and the Member Hospitals will fade. We have achieved OHCA's vision in approving this venture and we should be allowed to continue to serve our community.

Thank you again for the opportunity to testify in support of the continued operation of TIC.

[*remainder of the page intentionally left blank – signature page follows*]

Respectfully submitted,



Daniel Joseph DelGallo
Executive Director, Tolland Imaging Center, LLC
Administrative Director of Medical Imaging, Eastern Connecticut Health Network, Inc.

Exhibit A
Updated FY2013 Utilization for All Existing Equipment at TIC
(Corrected to Reflect Change in CPT Coding)

	2010	2011	2012	2013	2010-2013 % change
MRI	1403	1745	1724	1,653	17.8%
CT	949	873	1123	961	1.3%
X-Ray	3356.	3502	3795	3,810	13.5%
Ultrasound	2480	2219	2571	2,394	-3.5%
Mammography	1395	1638	2104	2,170	55.6%
Bone Density	385	419	462	470	22.1%
TOTAL	9968	10396	11779	11458	14.9%

Exhibit B
Updated Financial Attachment I (with actual FY2013)

Tolland Imaging Center

Without CON = Continuation of comprehensive imaging services DENIED
(Reflects what will be incurred by the Members Hospitals)
With CON = Continuation of comprehensive imaging services APPROVED

7a. 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:		FY2012		FY2013	FY2013	FY2013		CON Year 1		FY2015	CON Year 2		FY2016	CON Year 3	
Description	Payer Mix	Actual Results	% Growth	Projected W/out CON	Projected Incremental	Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON	Projected W/out CON	FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE															
Non-Government	82.0%	$1,777,461		$1,728,093	$0	$1,728,093	$0	$1,755,743	$1,755,743	$0	$1,783,835	$1,783,835	$0	$1,812,376	$1,812,376
Medicare	14.9%	$322,978		$314,007	$0	$314,007	$0	$319,031	$319,031	$0	$324,136	$324,136	$0	$329,322	$329,322
Medicaid and Other Medical Assistance	3.1%	$67,197		$65,330	$0	$65,330	$0	$66,376	$66,376	$0	$67,438	$67,438	$0	$68,517	$68,517
Other Government	0.0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$2,167,635	1.6%	$2,107,431	$0	$2,107,431	$0	$2,141,150	$2,141,150	$0	$2,175,408	$2,175,408	$0	$2,210,215	$2,210,215
Other Operating Revenue		$0	1.6%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue from Operations		$2,167,635		$2,107,431	$0	$2,107,431	$0	$2,141,150	$2,141,150	$0	$2,175,408	$2,175,408	$0	$2,210,215	$2,210,215
OPERATING EXPENSES															
Salaries and Fringe Benefits		$417,511	1.6%	$446,825	$0	$446,825	$0	$453,974	$453,974	$0	$461,238	$461,238	$0	$468,618	$468,618
Professional / Contracted Services		$473,436	1.6%	$456,967	$0	$456,967	$0	$464,278	$464,278	$0	$471,707	$471,707	$0	$479,254	$479,254
Supplies and Drugs		$52,404	1.6%	$35,321	$0	$35,321	$0	$35,886	$35,886	$0	$36,461	$36,461	$0	$37,044	$37,044
Bad Debts		$87,410	1.6%	$97,860	$0	$97,860	$0	$85,646	$85,646	$0	$87,016	$87,016	$0	$88,409	$88,409
Other Operating Expense		$376,243	1.6%	$398,494	$0	$398,494	$0	$404,869	$404,869	$0	$411,347	$411,347	$0	$417,929	$417,929
Subtotal		$1,407,004		$1,435,467	$0	$1,435,467	$0	$1,444,655	$1,444,655	$0	$1,467,769	$1,467,769	$0	$1,491,254	$1,491,254
Depreciation/Amortization		$461,951		$431,950	$0	$431,950	$455,620	($362,215)	$93,405	$0	$57,592	$57,592	$0	$23,845	$23,845
Interest Expense		$67,247		$36,549	$0	$36,549	$13,069	($974)	$12,095	$0	$974	$974	$0	$0	$0
Lease Expense		$134,618	3.0%	$138,417	$0	$138,417	$860,304	$142,570	$142,570	$0	$146,847	$146,847	$0	($37,813)	$151,252
Total Operating Expense		$2,070,820		$2,042,383	$0	$2,042,383	$1,328,993	$1,224,036	$1,692,725	$0	$1,673,181	$1,673,181	$0	$1,477,286	$1,666,351
Gain/(Loss) from Operations		$96,815		$65,048	$0	$65,048	($1,328,993)	$917,114	$448,425	$0	$502,227	$502,227	$0	$732,929	$543,864
Plus: Non-Operating Revenue		$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense		$96,815		$65,048	$0	$65,048	($1,328,993)	$917,114	$448,425	$0	$502,227	$502,227	$0	$732,929	$543,864
FTEs		6.2	0.0%	6.2	0.0	6.2	0.0	(6.2)	6.2	0.0	(6.2)	6.2	0.0	(6.2)	6.2

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

CT Scanner	805	0.0%	740	0	740	0	740	740	0	740	740	0	740	740
MRI Scanner	1,724	0.0%	1,653	0	1,653	0	1,653	1,653	0	1,653	1,653	0	1,653	1,653
Bone Density	462	0.0%	470	0	470	0	470	470	0	470	470	0	470	470
Mammography	2,104	0.0%	2,170	0	2,170	0	2,170	2,170	0	2,170	2,170	0	2,170	2,170
Radioagraphy (x-ray)	3,795	0.0%	3,810	0	3,810	0	3,810	3,810	0	3,810	3,810	0	3,810	3,810
Ultrasound	2,571	0.0%	2,394	0	2,394	0	2,394	2,394	0	2,394	2,394	0	2,394	2,394

Johnson Memorial Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: / Description	Payer Mix	FY2012 Actual Results	% Growth	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	CON Year 1 FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	CON Year 2 FY2015 Projected Incremental	FY2015 Projected With CON	FY2016 Projected W/out CON	CON Year 3 FY2016 Projected Incremental	FY2016 Projected With CON
NET PATIENT REVENUE															
Non-Government	53%	$36,747,360		$34,106,404	$0	$34,106,404	$34,652,106	$0	$34,652,106.11	$35,206,540	$0	$35,206,540	$35,769,844	$0	$35,769,844
Medicare	38%	$26,347,164		$24,453,648	$0	$24,453,648	$24,844,906	$0	$24,844,906	$25,242,425	$0	$25,242,425	$25,646,304	$0	$25,646,304
Medicaid and Other Medical Assistance	9%	$6,240,118		$5,791,653	$0	$5,791,653	$5,884,320	$0	$5,884,320	$5,978,469	$0	$5,978,469	$6,074,125	$0	$6,074,125
Other Government	0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$69,334,641	1.6%	$64,351,705	$0	$64,351,705	$65,381,332	$0	$65,381,332	$66,427,434	$0	$66,427,434	$67,490,273	$0	$67,490,273
Other Operating Revenue		$334,223	1.6%	$444,772	$0	$444,772	$384,625	($67,264)	$451,888	$383,785	($75,334)	$459,119	$384,886	($81,580)	$466,464
Revenue from Operations		$69,668,864		$64,796,477	$0	$64,796,477	$65,765,957	($67,264)	$65,833,221	$66,811,218	($75,334)	$66,886,552	$67,875,157	($81,580)	$67,956,737
OPERATING EXPENSES															
Salaries and Fringe Benefits		$38,803,360	1.6%	$33,108,836	$0	$33,108,836	$33,638,577	$0	$33,638,677	$34,176,795	$0	$34,176,795	$34,723,623	$0	$34,723,623
Professional / Contracted Services		$6,997,267	1.6%	$7,766,447	$0	$7,766,447	$7,890,710	$0	$7,890,710	$8,016,962	$0	$8,016,962	$8,145,233	$0	$8,145,233
Supplies and Drugs		$7,130,721	1.6%	$8,676,653	$0	$8,676,653	$8,815,479	$0	$8,815,479	$8,956,527	$0	$8,956,527	$9,099,832	$0	$9,099,832
Bad Debts		$3,773,454	5.4%	$4,054,157	$0	$4,054,157	$4,274,800	$0	$4,274,800	$4,507,450	$0	$4,507,450	$4,752,763	$0	$4,752,763
Other Operating Expense		$8,989,210	0.0%	$7,862,336	$0	$7,862,336	$7,862,336	$0	$7,862,336	$7,862,336	$0	$7,862,336	$7,862,336	$0	$7,862,336
Subtotal		$65,694,012		$61,468,429	$0	$61,468,429	$62,481,903	$0	$62,481,903	$63,520,070	$0	$63,520,070	$64,583,787	$0	$64,583,787
Depreciation/Amortization		$3,213,642	1.6%	$3,082,729	$0	$3,082,729	$3,200,396	$68,343	$3,132,053	$3,182,166	$0	$3,182,166	$3,233,080	$0	$3,233,080
Interest Expense		$1,495,715	1.6%	$1,368,579	$0	$1,368,579	$1,392,437	$1,960	$1,390,476	$1,412,724	$0	$1,412,724	$1,436,327	$0	$1,436,327
Lease Expense		$1,675,437	1.6%	$1,550,119	$0	$1,550,119	$1,703,966	$129,046	$1,574,921	$1,600,120	$0	$1,600,120	$1,625,722	$0	$1,625,722
Total Operating Expense		$72,078,706		$67,469,856	$0	$67,469,856	$68,778,701	$199,349	$68,579,352	$69,715,079	$0	$69,715,079	$70,877,916	$0	$70,877,916
Gain/(Loss) from Operations		($2,409,842)		($2,673,379)	$0	($2,673,379)	($3,012,744)	($266,613)	($2,746,132)	($2,903,861)	($75,334)	($2,828,527)	($3,002,758)	($81,580)	($2,921,179)
Plus: Non-Operating Revenue		$430,456	1.6%	$150,660	$0	$150,660	$153,071	$0	$153,071	$155,520	$0	$155,520	$158,008	$0	$158,008
Revenue Over/(Under) Expense		($1,979,386)		($2,522,719)	$0	($2,522,719)	($2,859,674)	($266,613)	($2,593,061)	($2,748,341)	($75,334)	($2,673,007)	($2,844,750)	($81,580)	($2,763,171)
FTEs		464.2	0.0%	459.6	0.0	459.6	459.6	0.0	459.6	459.6	0.0	459.6	459.6	0.0	459.6

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

Johnson Memorial Hospital (Main campus location)														
CT Scans														
Inpatient	1,936	0.0%	2,001	0	2,001	2,001	0	2,001	2,001	0	2,001	2,001	0	2,001
Emergent	3,653	0.0%	3,547	0	3,547	3,547	0	3,547	3,547	0	3,547	3,547	0	3,547
Outpatient	584	0.0%	669	0	669	669	0	669	669	0	669	669	0	669
Total CT Scan (procedures):	6,173		6,217	0	6,217	6,217	0	6,217	6,217	0	6,217	6,217	0	6,217
MRI Scans														
Inpatient	144	0.0%	124	0	124	124	0	124	124	0	124	124	0	124
Emergent	26	0.0%	19	0	19	19	0	19	19	0	19	19	0	19
Outpatient (excluding ED)	499	0.0%	412	0	412	412	0	412	412	0	412	412	0	412
Total MRI Scan (procedures):	669		555	0	555	555	0	555	555	0	555	555	0	555
Johnson Memorial Hospital (Enfield Location)														
Outpatient CT Scans	1,137	0.0%	1,064	0	1,064	1,064	0	1,064	1,064	0	1,064	1,064	0	1,064
Outpatient MRI Scans	962	0.0%	829	0	829	829	0	829	829	0	829	829	0	829

Manchester Memorial Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:		FY2012		FY2013	FY2013	FY2013	CON Year 1 FY2014	FY2014	FY2014	CON Year 2 FY2015	FY2015	FY2015	CON Year 3 FY2016	FY2016	FY2016
Description	Payer Mix	Actual Results	% Growth	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON
NET PATIENT REVENUE															
Non-Government	56%	$98,121,837		$98,184,660	$0	$98,184,660	$99,755,615	$0	$99,755,615	$101,351,704	$0	$101,351,704	$102,973,332	$0	$102,973,332
Medicare	34%	$59,573,972		$59,612,115	$0	$59,612,115	$60,565,909	$0	$60,565,909	$61,534,963	$0	$61,534,963	$62,519,523	$0	$62,519,523
Medicaid and Other Medical Assistance	10%	$17,521,757		$17,532,975	$0	$17,532,975	$17,813,503	$0	$17,813,503	$18,098,519	$0	$18,098,519	$18,388,095	$0	$18,388,095
Other Government	0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$175,217,566	1.6%	$175,329,750	$0	$175,329,750	$178,135,026	$0	$178,135,026	$180,985,186	$0	$180,985,186	$183,880,949	$0	$183,880,949
Other Operating Revenue		$19,861,936	1.6%	$19,148,931	$0	$19,148,931	$19,298,365	($156,949)	$19,455,314	$19,590,820	($175,779)	$19,766,599	$19,892,512	($190,352)	$20,082,865
Revenue from Operations		$195,079,502		$194,478,681	$0	$194,478,681	$197,433,391	($156,949)	$197,590,340	$200,576,006	($175,779)	$200,751,785	$203,773,462	($190,352)	$203,963,814
OPERATING EXPENSES															
Salaries and Fringe Benefits		$106,417,077	1.6%	$111,750,114	$0	$111,750,114	$113,638,116	$0	$113,638,116	$115,354,726	$0	$115,354,726	$117,200,401	$0	$117,200,401
Professional / Contracted Services			1.6%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Supplies and Drugs		$62,035,761	1.6%	$66,306,734	$0	$66,306,734	$67,367,642	$0	$67,367,642	$68,445,524	$0	$68,445,524	$69,540,652	$0	$69,540,652
Bad Debts		$6,382,307	3.6%	$5,968,461	$0	$5,968,461	$6,183,326	$0	$6,183,326	$6,405,925	$0	$6,405,925	$6,636,539	$0	$6,636,539
Other Operating Expense			1.6%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal		$174,835,145		$184,025,309	$0	$184,025,309	$187,089,083	$0	$187,089,083	$190,206,175	$0	$190,206,175	$193,377,592	$0	$193,377,592
Depreciation/Amortization		$6,896,812	1.6%	$7,631,719	$0	$7,631,719	$7,913,294	$159,467	$7,753,827	$7,877,888	$0	$7,877,888	$8,003,934	$0	$8,003,934
Interest Expense		$2,714,044	1.6%	$2,685,045	$0	$2,685,045	$2,732,580	$4,574	$2,728,006	$2,771,654	$0	$2,771,654	$2,816,000	$0	$2,816,000
Lease Expense			1.6%	$0	$0	$0	$301,106	$301,106	$0	$0	$0	$0	$0	$0	$0
Total Operating Expense		$184,446,001		$194,342,073	$0	$194,342,073	$198,036,063	$465,147	$197,570,915	$200,855,717	$0	$200,855,717	$204,197,527	$0	$204,197,527
Gain/(Loss) from Operations		$10,633,501		$136,608	$0	$136,608	($602,672)	($622,096)	$19,425	($279,711)	($175,779)	($103,931)	($424,065)	($190,352)	($233,713)
Plus: Non-Operating Revenue		($868,637)	1.6%	($1,390,853)	$0	($1,390,853)	($1,413,107)	$0	($1,413,107)	($1,435,716)	$0	($1,435,716)	($1,458,688)	$0	($1,458,688)
Revenue Over/(Under) Expense		$9,764,864		($1,254,245)	$0	($1,254,245)	($2,015,778)	($622,096)	($1,393,682)	($1,715,427)	($175,779)	($1,539,648)	($1,882,753)	($190,352)	($1,692,400)
FTEs		1,086.0	0.0%	1098.5	0.0	1098.5	1,098.5	0.0	1,098.5	1,098.5	0.0	1,098.5	1,098.5	0.0	1,098.5
Procedure Volume Statistics:															
Provide projected outpatient statistics for any new services and provide actual and projected outpatient statistics for any existing services which will change due to the proposal.															
CT Scans															
Inpatient		3,821	0.0%	4,130	0	4,130	4,130	0	4,130	4,130	0	4,130	4,130	0	4,130
Emergent		6,492	0.0%	6,430	0	6,430	6,430	0	6,430	6,430	0	6,430	6,430	0	6,430
Outpatient		5,818	0.0%	5,016	0	5,016	5,016	0	5,016	5,016	0	5,016	5,016	0	5,016
Total CT Scan (procedures):		**16,131**		**15,576**	**0**	**15,576**	**15,576**	**0**	**15,576**	**15,576**	**0**	**15,576**	**15,576**	**0**	**15,576**
MRI Scans															
Inpatient		520	0.0%	618	0	618	618	0	618	618	0	618	618	0	618
Emergent		187	0.0%	176	0	176	176	0	176	176	0	176	176	0	176
Outpatient (excluding ED)		2,585	0.0%	2,140	0	2,140	2,140	0	2,140	2,140	0	2,140	2,140	0	2,140
Total MRI Scan (procedures):		**3,292**		**2,934**	**0**	**2,934**	**2,934**	**0**	**2,934**	**2,934**	**0**	**2,934**	**2,934**	**0**	**2,934**

Rockville General Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:					CON Year 1			CON Year 2			CON Year 3		
Description	Payer Mix	FY2012 Actual Results	% Growth	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	61%	$41,387,059		$44,561,049.00	$0	$44,561,049	$45,274,026	$0	$45,274,026	$45,998,410	$0	$45,998,410	$46,734,385	$0	$46,734,385
Medicare	26%	$17,640,386		$18,993,234	$0	$18,993,234	$19,297,126	$0	$19,297,126	$19,605,880	$0	$19,605,880	$19,919,574	$0	$19,919,574
Medicaid and Other Medical Assistance	13%	$8,820,193		$9,496,617	$0	$9,496,617	$9,648,563	$0	$9,648,563	$9,802,940	$0	$9,802,940	$9,959,787	$0	$9,959,787
Other Government	0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$67,847,638	1.6%	$73,050,900	$0	$73,050,900	$74,219,714	$0	$74,219,714	$75,407,230	$0	$75,407,230	$76,613,746	$0	$76,613,746
Other Operating Revenue		$6,871,608	1.6%	$6,007,796	$0	$6,007,796	$5,946,972	($156,949)	$6,103,921	$6,025,804	($175,779)	$6,201,583	$6,110,457	($190,352)	$6,300,809
Revenue from Operations		$74,719,246		$79,058,696	$0	$79,058,696	$80,166,686	($156,949)	$80,323,635	$81,433,034	($175,779)	$81,608,813	$82,724,202	($190,352)	$82,914,554
OPERATING EXPENSES															
Salaries and Fringe Benefits		$40,311,104	1.6%	$41,515,318	$0	$41,515,318	$42,179,563	$0	$42,179,563	$42,854,436	$0	$42,854,436	$43,540,107	$0	$43,540,107
Supplies and Drugs		$25,886,843	1.6%	$25,648,029	$0	$25,648,029	$26,058,397	$0	$26,058,397	$26,475,332	$0	$26,475,332	$26,898,937	$0	$26,898,937
Bad Debts		$3,309,948	4.9%	$3,677,214	$0	$3,677,214	$3,857,397	$0	$3,857,397	$4,046,410	$0	$4,046,410	$4,244,684	$0	$4,244,684
Subtotal		$69,507,895		$70,840,561	$0	$70,840,561	$72,095,358	$0	$72,095,358	$73,376,178	$0	$73,376,178	$74,683,728	$0	$74,683,728
Depreciation/Amortization		$3,811,952	1.6%	$3,764,814	$0	$3,764,814	$3,984,315	$159,467	$3,824,848	$3,886,045	$0	$3,886,045	$3,948,222	$0	$3,948,222
Interest Expense		$719,107	1.6%	$682,297	$0	$682,297	$697,788	$4,574	$693,214	$704,305	$0	$704,305	$715,574	$0	$715,574
Lease Expense			1.6%	$0	$0	$0	$301,106	$301,106	$0	$0	$0	$0	$0	$0	$0
Total Operating Expense		$74,038,954		$75,287,472	$0	$76,287,472	$77,078,567	$465,147	$76,613,420	$77,966,528	$0	$77,966,528	$79,347,524	$0	$79,347,524
Gain/(Loss) from Operations		$680,292		$3,771,224	$0	$3,771,224	$3,088,119	($622,096)	$3,710,216	$3,466,505	($175,779)	$3,642,285	$3,376,678	($190,352)	$3,567,030
Plus: Non-Operating Revenue		($179,961)	1.6%	($486,120)	$0	($486,120)	($493,898)	$0	($493,898)	($501,800)	$0	($501,800)	($509,829)	$0	($509,829)
Revenue Over/(Under) Expense		$500,331		$3,285,104	$0	$3,285,104	$2,594,221	($622,096)	$3,216,318	$2,964,705	($175,779)	$3,140,485	$2,866,849	($190,352)	$3,057,201
FTEs		373.0	0.0%	382.2	0.0	382.2	382.2	0.0	382.2	382.2	0.0	382.2	382.2	0.0	382.2

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

Rockville General Hospital (Main campus location)														
CT Scans														
Inpatient	1,817	0.0%	1,806	0	1,806	1,806	0	1,806	1,806	0	1,806	1,806	0	1,806
Emergent	3,666	0.0%	3,606	0	3,606	3,606	0	3,606	3,606	0	3,606	3,606	0	3,606
Outpatient	2,513	0.0%	2,427	0	2,427	2,427	0	2,427	2,427	0	2,427	2,427	0	2,427
Total CT Scan (procedures):	7,996		7,839	0	7,839	7,839	0	7,839	7,839	0	7,839	7,839	0	7,839
MRI Scans														
Inpatient	234	0.0%	272	0	272	272	0	272	272	0	272	272	0	272
Emergent	127	0.0%	114	0	114	114	0	114	114	0	114	114	0	114
Outpatient (excluding ED)	1,385	0.0%	1,240	0	1,240	1,240	0	1,240	1,240	0	1,240	1,240	0	1,240
Total MRI Scan (procedures):	1,746		1,626	0	1,626	1,626	0	1,626	1,626	0	1,626	1,626	0	1,626
Evergreen Imaging (South Windsor)*														
Outpatient CT Scans	1,807	0.0%	1,535	0	1,535	1,535	0	1,535	1,535	0	1,535	1,535	0	1,535
Outpatient MRI Scans	1,950	0.0%	1,340	0	1,340	1,340	0	1,340	1,340	0	1,340	1,340	0	1,340

Windham Community Memorial Hospital

7a. Please provide one year of actual results and three years of ***Hospital*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:		FY2012		CON Year 1 FY2013	FY2013	FY2013	FY2014	FY2014	FY2014	CON Year 2 FY2015	FY2015	FY2015	CON Year 3 FY2016	FY2016	FY2016
Description	Payer Mix	Actual Results	% Growth	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON
NET PATIENT REVENUE															
Non-Government	49%	$41,404,294		$37,965,359	$0	$37,965,359	38,572,805	0	38,572,805	39,189,969	0	39,189,969	39,817,009	0	39,817,009
Medicare	43%	$36,334,380		$33,316,539	$0	$33,316,539	33,849,604	0	33,849,604	34,391,198	0	34,391,198	34,941,457	0	34,941,457
Medicaid and Other Medical Assistance	8%	$6,759,885		$6,198,426	$0	$6,198,426	6,297,601	0	6,297,601	6,398,362	0	6,398,362	6,500,736	0	6,500,736
Other Government	0%	$0		$0	$0	$0	0	0	0	0	0	0	0	0	0
Total Net Patient Patient Revenue		$84,498,559	1.6%	$77,480,324	$0	$77,480,324	78,720,009	0	78,720,009	79,979,529	0	79,979,529	81,259,202	0	81,259,202
Other Operating Revenue		$5,482,556	1.6%	$5,501,009	$0	$5,501,009	5,521,761	(67,264)	5,589,025	5,603,116	(75,334)	5,678,450	5,687,725	(81,580)	5,769,305
Revenue from Operations		$89,981,115		$82,981,333	$0	$82,981,333	84,241,771	(67,264)	84,309,034	85,582,645	(75,334)	85,657,979	86,946,927	(81,580)	87,028,507
OPERATING EXPENSES															
Salaries and Fringe Benefits		$56,419,928	1.6%	$54,295,465	$0	$54,295,465	55,164,192	0	55,164,192	56,046,820	0	56,046,820	56,943,569	0	56,943,569
Professional / Contracted Services		$10,971,301	1.6%	$11,829,204	$0	$11,829,204	12,018,471	0	12,018,471	12,210,767	0	12,210,767	12,406,139	0	12,406,139
Supplies and Drugs		$8,815,183	1.6%	$9,331,043	$0	$9,331,043	9,480,340	0	9,480,340	9,632,025	0	9,632,025	9,786,138	0	9,786,138
Bad Debts		$696,225	0.6%	$0	$0	$0	0	0	0	0	0	0	0	0	0
Other Operating Expense		$8,229,822	1.6%	$8,762,617	$0	$8,762,617	8,902,819	0	8,902,819	9,045,264	0	9,045,264	9,189,988	0	9,189,988
Subtotal		$85,132,459		$84,218,329	$0	$84,218,329	85,565,822	0	85,565,822	86,934,875	0	86,934,875	88,325,833	0	88,325,833
Depreciation/Amortization		$4,026,424	1.6%	$4,163,008	$0	$4,163,008	4,297,959	68,343	4,229,616	4,297,290	0	4,297,290	4,366,047	0	4,366,047
Interest Expense		$1,286,970	1.6%	$1,103,393	$0	$1,103,393	1,123,008	1,960	1,121,047	1,138,984	0	1,138,984	1,157,208	0	1,157,208
Lease Expense			1.6%	$996,430	$0	$996,430	1,141,418	129,046	1,012,373	1,028,571	0	1,028,571	1,045,028	0	1,045,028
Total Operating Expense		$90,445,853		$90,481,160	$0	$90,481,160	92,128,207	199,349	91,928,859	93,399,720	0	93,399,720	94,894,116	0	94,894,116
Gain/(Loss) from Operations		($464,738)		($7,499,827)	$0	($7,499,827)	(7,886,437)	(266,613)	(7,619,824)	(7,817,075)	(75,334)	(7,741,741)	(7,947,189)	(81,580)	(7,865,609)
Plus: Non-Operating Revenue		($623,358)	1.6%	$1,516,000	$0	$1,516,000	1,540,256	0	1,540,256	1,564,900	0	1,564,900	1,589,938	0	1,589,938
Revenue Over/(Under) Expense		($1,088,096)		($5,983,827)	$0	($5,983,827)	(6,346,181)	(266,613)	(6,079,568)	(6,252,175)	(75,334)	(6,176,841)	(6,357,250)	(81,580)	(6,275,671)
FTEs		599.1	0.0%	576.0	0.0	576.0	576.0	0.0	576.0	576.0	0.0	576.0	576.0	0.0	576.0
Procedure Volume Statistics:															
Provide projected outpatient statistics for any new services and provide actual and projected outpatient statistics for any existing services which will change due to the proposal.															
CT Scans															
Inpatient		2,374	0.0%	2,477	0	2,477	2,477	0	2,477	2,477	0	2,477	2,477	0	2,477
Emergent		4,860	0.0%	4,375	0	4,375	4,375	0	4,375	4,375	0	4,375	4,375	0	4,375
Outpatient		3,453	0.0%	3,663	0	3,663	3,663	0	3,663	3,663	0	3,663	3,663	0	3,663
Total CT Scan (procedures):		**10,687**		**10,515**	**0**	**10,515**	**10,515**	**0**	**10,515**	**10,515**	**0**	**10,515**	**10,515**	**0**	**10,515**
MRI Scans															
Inpatient		459	0.0%	519	0	519	519	0	519	519	0	519	519	0	519
Emergent		116	0.0%	88	0	88	88	0	88	88	0	88	88	0	88
Outpatient (excluding ED)		3,718	0.0%	3,636	0	3,636	3,636	0	3,636	3,636	0	3,636	3,636	0	3,636
Total MRI Scan (procedures):		**4,293**		**4,243**	**0**	**4,243**	**4,243**	**0**	**4,243**	**4,243**	**0**	**4,243**	**4,243**	**0**	**4,243**

Exhibit C

Updated Financial Attachment I

(with Three Years of Projected Operation without MRI and CT Services)

Tolland Imaging Center

7a. 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:

Without CON = Continuation of comprehensive imaging services DENIED
(Reflects what will be incurred by the Members Hospitals)
With CON = Continuation of comprehensive imaging services APPROVED

Total Facility:					CON Year 1			CON Year 2			CON Year 3		
Description	Payer Mix	FY2012 Actual Results	% Growth	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	82.0%	$1,777,461		$1,728,093	$0	$1,728,093	$650,373	$1,755,743	$1,755,743	$660,779	$1,783,835	$1,783,835	$671,352	$1,812,376	$1,812,376
Medicare	14.9%	$322,978		$314,007	$0	$314,007	$118,178	$319,031	$319,031	$120,068	$324,136	$324,136	$121,989	$329,322	$329,322
Medicaid and Other Medical Assistance	3.1%	$67,197		$65,330	$0	$65,330	$24,587	$66,376	$66,376	$24,981	$67,438	$67,438	$25,380	$68,517	$68,517
Other Government	0.0%	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue		$2,167,635	1.6%	$2,107,431	$0	$2,107,431	$793,138	$2,141,150	$2,141,150	$805,828	$2,175,408	$2,175,408	$818,721	$2,210,215	$2,210,215
Other Operating Revenue		$0	1.6%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue from Operations		$2,167,635		$2,107,431	$0	$2,107,431	$793,138	$2,141,150	$2,141,150	$805,828	$2,175,408	$2,175,408	$818,721	$2,210,215	$2,210,215
OPERATING EXPENSES															
Salaries and Fringe Benefits		$417,511	1.6%	$446,825	$0	$446,825	$291,057	$453,974	$453,974	$295,714	$461,238	$461,238	$300,445	$468,618	$468,618
Professional / Contracted Services		$473,436	1.6%	$456,967	$0	$456,967	$232,039	$464,278	$464,278	$235,752	$471,707	$471,707	$239,524	$479,254	$479,254
Supplies and Drugs		$52,404	1.6%	$35,321	$0	$35,321	$14,231	$35,886	$35,886	$14,459	$36,461	$36,461	$14,690	$37,044	$37,044
Bad Debts		$87,410	0.0%	$97,860	$0	$97,860	$48,930	$85,646	$85,646	$50,887	$87,016	$87,016	$52,923	$88,409	$88,409
Other Operating Expense		$376,243	1.6%	$398,494	$0	$398,494	$323,185	$404,869	$404,869	$328,356	$411,347	$411,347	$333,609	$417,929	$417,929
Subtotal		$1,407,004		$1,435,467	$0	$1,435,467	$909,442	$1,444,655	$1,444,655	$925,167	$1,467,769	$1,467,769	$941,191	$1,491,254	$1,491,254
Depreciation/Amortization		$461,951		$431,950	$0	$431,950	$93,405	($362,216)	$93,405	$93,405	$57,592	$57,592	$93,405	$23,845	$23,845
Interest Expense		$67,247		$36,549	$0	$36,549	$12,095	($974)	$12,095	$12,095	$974	$974	$12,095	$0	$0
Lease Expense		$134,618	1.6%	$138,417	$0	$138,417	$140,632	$140,632	$140,632	$142,882	$142,882	$142,882	$145,168	($36,292)	$145,168
Total Operating Expense		$2,070,820		$2,042,383	$0	$2,042,383	$1,155,574	$1,222,098	$1,690,787	$1,173,550	$1,669,217	$1,669,217	$1,191,860	$1,478,807	$1,660,267
Gain/(Loss) from Operations		$96,815		$65,048	$0	$65,048	($362,436)	$919,052	$450,363	($367,722)	$506,192	$506,192	($373,138)	$731,408	$549,948
Plus: Non-Operating Revenue		$0	1.6%	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Revenue Over/(Under) Expense		$96,815		$65,048	$0	$65,048	($362,436)	$919,052	$450,363	($367,722)	$506,192	$506,192	($373,138)	$731,408	$549,948
FTEs		6.2	0.0%	6.2	0.0	6.2	6.2	(6.2)	6.2	6.2	(6.2)	6.2	6.2	(6.2)	6.2
Procedure Volume Statistics:															
Provide projected outpatient statistics for any new services and provide actual and projected outpatient statistics for any existing services which will change due to the proposal.															
CT Scanner		805	0.0%	740	0	740		740	740	0	740	740	0	740	740
MRI Scanner		1,724	0.0%	1,653	0	1,653		1,653	1,653	0	1,653	1,653	0	1,653	1,653
Bone Density		462	0.0%	470	0	470	470	470	470	470	470	470	470	470	470
Mammography		2,104	0.0%	2,170	0	2,170	2,170	2,170	2,170	2,170	2,170	2,170	2,170	2,170	2,170
Radioagraphy (x-ray)		3,795	0.0%	3,810	0	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810	3,810
Ultrasound		2,571	0.0%	2,394	0	2,394	2,394	2,394	2,394	2,394	2,394	2,394	2,394	2,394	2,394

Exhibit D

Tolland Imaging Center Payor Contracts FY2011–FY2013

1. AETNA
2. AIM
3. ANTHEM BCBS
4. ANTHEM UNICARE PPO*
5. CARE CORE
6. CARE TO CARE
7. CHARTER OAK
8. CHN
9. CIGNA
10. CONNECTICARE
11. HEALTHCARE FINANCE
12. CT STATE MEDICAL SOCIETY IPA
13. CYPRESS
14. GENEX
15. GREAT WEST
16. HUMANA
17. HUSKY A & B
18. MEDICAID
19. MEDICARE
20. MEDICAL DIAGNOSTIC ASSOCIATES
21. MED SOLUTIONS
22. MULTIPLAN/PHCS
23. NIA
24. ONE CALL MEDICAL
25. OXFORD
26. SAGA
27. TRICARE
28. UNITED HEALTHCARE
29. UNITED HEALTHCARE
30. MEDICARE ADVANTAGE PLANS
31. US IMAGING
32. WELLCARE
33. ANTHEM UNICARE PPO INCLUDES:
    a. BLUECARE HEALTH PLAN (STATE BLUECARE, NEW ENGLAND HEALTH PLANS, BLUECARE POS)
    b. CENTURY PREFERRED (CENTURY PREFERRED COMP, CENTURY PREFERRED DIRECT, BLUECARD PPO, STATE PREFERRED)
    c. FEDERAL EMPLOYEES PLAN, CENTURY 90, BLUECARD TRADITIONAL
    d. EMPIRE BLUECROSS & BLUESHIELD OF NEW YORK HMO, POS
    e. MEDIBLUE

765/2610/2951250.10

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

Docket No.: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive
Imaging Services including MRI and CT Services

October 18, 2013

Prefile Testimony of Michael Veillette
Chief Financial Officer
Eastern Connecticut Health Network, Inc.

My name is Mike Veillette and I am the Chief Financial Officer ("CFO") for Eastern Connecticut Health Network, Inc. ("ECHN"). Manchester Memorial Hospital ("Manchester") and Rockville General Hospital ("Rockville") are hospitals with the ECHN system, and, together with Johnson Memorial Hospital ("Johnson"), and Windham Community Memorial Hospital ("Windham") (collectively, the "Member Hospitals"), comprise the joint venture of the Tolland Imaging Center, LLC ("TIC"). Thank you for providing us with the opportunity to submit testimony in support of the continued operation of TIC and its provision of comprehensive imaging services to the communities in Tolland and surrounding towns.

As ECHN's CFO, I oversee the financial aspects of ECHN's activities, including its joint venture arrangements. My responsibilities include management of financial risk, financial planning and reporting. I have nearly 30 years' experience in health care finance, having provided finance and accounting services at a number of hospitals. My curriculum vitae is attached as Exhibit A.

Dan provided you with an overview of the many benefits that will be realized if TIC is granted a Certificate of Need ("CON") to continue operations. He also testified that if TIC is no longer authorized to offer CT and MRI services, TIC will close because it will no longer generate enough to revenue to maintain financial viability. TIC's closure would have a disastrous impact on patient access to freestanding imaging services and on the financial strength of the Member Hospitals. I would like to provide some additional details as to the financial impact TIC's closure will have on the Member Hospitals.

While our financials for the fiscal year that just ended on September 30, 2013 ("FY2013") are not yet complete, our current estimates for FY2013 indicate that each of the Member Hospitals or their systems suffered multi-million dollar losses.[1] With the impending federal and state cuts, each of the Member Hospitals is operating on a breakeven budget. As such, any additional financial loss or projected revenue not realized will have direct and serious repercussions that will reverberate throughout each of our health systems.

Here are the cold hard numbers. TIC has equipment and real estate lease obligations that extend to 2015 and 2016, respectively, with or without the CON. That means that at a minimum, the closure of TIC will cost the Member Hospitals over a million dollars in continuing lease obligations and depreciation expenses.[2] That number does not include other expenses of closure, such as legal and operation expenses of windup and dissolution.

In addition to incurring these significant direct costs, if TIC is forced to dissolve, the Member Hospitals will lose the capital already committed to the venture – $860,000 in total – and will lose anticipated future revenues from operations. As Dan mentioned, TIC had a number of front-loaded costs to commence operations. Some significant capital expenses were just fully paid as of the end of September 2013. While TIC earned small profits in FY2012 and FY2013, it is anticipated that without these front-loaded expenses still on the books, TIC's profits will increase considerably and the Member Hospitals' capital contributions will be repaid (i.e. TIC will hit "breakeven") sometime in 2016. All of this will be lost if TIC is not permitted to continue to provide needed imaging services to the community.

In short, if the CON is denied, closure will take place at the worst possible time financially—after the Hospitals have paid most of the front-loaded costs, but before they can recoup those costs from profits going forward, and still having to pay their lease obligations for another two years but with no revenues coming in from TIC. In other words, if forced to close now, the Hospitals will have incurred all of the significant costs of this wonderful joint venture, but will have closed before it can reap and put to good use any of the profits.

---

[1] Although the updated financial Attachment 1 (all members) submitted to OHCA (and attached to Dan Delgallo's testimony) reflects a net profit of $3,285,104 for Rockville, Manchester shows a net loss of $1,254,245 and the total loss for the entire ECHN system is expected to be $2,500,000. Certain hospital related business units that do not fall under either the Manchester or Rockville license are accounted for separately and not reflected in the financials of the hospitals. Overall, however, ECHN is projecting a $2,500,000 loss for fiscal year 2013.

[2] In our application, these costs were estimated to be $1,254,054. After reviewing the calculations, depreciation expenses are likely higher, resulting in costs closer to $1,328,993 to close TIC.

While it is true that each of the Member Hospitals may be able to capture a portion of the patients that received imaging services at TIC and thereby offset some of the direct revenue losses, it is difficult to predict how many patients will seek services elsewhere and we will undoubtedly be unable to recapture 100% of TIC's patients. Without an affiliated open MRI, many patients requiring MRI services will choose to go to free-standing centers outside the service area that are not affiliated with the Member Hospitals. Other patients will need to find alternatives for specific services outside the service area, such as bone densitometry (for example, Rockville and Manchester do not offer bone densitometry). In addition, at some locations, we anticipate waiting lists for mammography and ultrasound services which may cause patients to go elsewhere.

Importantly, you should note that this will result in a situation whereby former collaborative partners will have to compete for patients they once worked together to treat. This is antithetical to OHCA's vision when it initially approved this unique joint venture.

As I mentioned, our breakeven budgets leave no cushion for us to absorb losses or lack of revenue. At least for ECHN, without further cuts, these losses could put ECHN in jeopardy of defaulting on bank and lending covenants. The only option to address these losses will be cuts to personnel and key services. Any loss or reduction in services will limit access, harm the health of the community, and damage the continued viability of the health system in the service area.

In short, TIC's closure would have a domino effect with numerous adverse consequences for the financial strength of the Member Hospitals and the state's healthcare system in the region. TIC's continued operation, however, will allow the Member Hospitals to recoup already sunk capital and establish a much needed revenue stream from anticipated increased distributions, revenue that is crucial for each of our health systems.

While OHCA certainly has many concerns when evaluating a CON application, it is fiscally irrational to close TIC now, after the time, money, and hard work to begin the business and make it flourish have been invested and just as the business begins to make good on that investment. Not only will TIC's closure squander the investments already made by the Member Hospitals, but it will further imperil our financial well-being at time when we have no capacity to absorb losses or a lack of revenue. TIC's continued operation, however, enhances the financial strength of the Member Hospitals. And most importantly, it ensures continued access to key services for patients, in furtherance of each of the Member Hospital's missions.

Thank you again for the opportunity to testify in support of the continued operation of TIC.

[*remainder of the page intentionally left blank – signature page follows*]

Respectfully submitted,

Michael Veillette
Chief Financial Officer, Eastern Connecticut Health Network, Inc.

EXHIBIT A

Curriculum Vitae

MICHAEL D. VEILLETTE
905 Upper Maple Street
Dayville, CT 06241
(860) 912-3236 (cell)
(860) 779-1535 (home)
veillette56@yahoo.com
mveillette@echn.org

Senior Vice President of Finance & Chief Financial Officer

Healthcare Financial Executive with nearly 30 years of progressive experience, including 10 years as the top finance decision-maker or second in command of a $300 million dollar healthcare system – 25 years experience of managerial experience. Skilled in financial reporting and analysis, accounting, strategic planning & financial forecasting, budgeting, reimbursement, managed care, treasury functions and revenue cycle. Demonstrated ability to lead key initiatives, manage professional staff, foster teamwork and build consensus, strategic thought, and achieve goals. Respected by peers for commitment and passion, results-oriented, and for having fun, integrity, and vision.

Promoted to Chief Financial Officer upon completion of EMBA at Boston University, June 14, 2013.

Executive Performance

Extensive interaction with Hospital Executives and Board Members. Providing: financial results; fiscal and strategic analysis; insight and recommendations on strategic issues and planning. Presents financial reports/results to all Boards (system Board and all Affiliate Boards) as well as to Finance Committee.

Integral part of, and participant in, the annual development of the Hospital's strategic plan.

Key member of the System Acquisition Team comprised of Board members and Hospital Executives.

Restructured the Finance Department to improve overall customer service (internally and externally) and performance.

Integrated the Finance Department into clinical areas to facilitate an understanding of both clinical and financial perspectives on issues.

Employment

Eastern Connecticut Health Network, Inc. • June 2010 – Present, Manchester, CT
Senior Vice President of Finance & Information Services

Areas of Responsibility & Committees:
Same basic areas of responsibility and staffing to various boards and committees as I held as VP of Finance with the following differences: Report directly to the CEO and now staffed to the Planning Committee and ISSO (Information Systems & Services Oversight) Committee.

Key Accomplishments:

Worked closely with the CEO as part of a "grassroots" effort to bring attention to and eventually garner pension funding relief via the Pension Relief Act (passed in 2010 and again in 2012) by lobbying our federal legislators down in Washington – made several trips to discuss face to face. This made a substantial difference to our financial future by bringing about more reasonable pension funding obligations.

Currently involved in another lobbying effort via the Affordable Care Act to bring about additional funding to our two hospitals that qualify for Urban Medicare Dependent Hospital status.

Financially positioned the System to meet it's budgeted surplus target in each of the last three years after raising the financial bar at the beginning of the three year run to prepare to meet the financial challenges of Pension Protection Act and other regulatory changes.

Recently joined the Chief Financial Officer Roundtable organization and attended my first semi-annual conference – approximately 100-150 healthcare CFO's from around the country participate. Excellent for networking.

Eastern Connecticut Health Network, Inc. • January 2004 – May 2010, Manchester, CT

Vice President of Finance

$300 million healthcare network with two acute care community-based Hospitals with 351 beds and Subsidiaries including; 100 Bed Skilled Nursing Facility, Diagnostic Imaging Center for Women, Fundraising "Arm", Real Estate Company, Captive Insurance Company and over 20 Physician Practices. Also hold interests in the following joint ventures: Visiting Nurse Company, two Ambulance Companies, Cancer Center, Gastroenterology Free-Standing Facility, and two Free-Standing Imaging Centers.

Areas of Responsibility:
Reports directly to the C.F.O. Directs a finance team of over 110 employees. General accounting, corporate accounting, G.A.A.P. compliance, accounts payable, payroll, treasury, cash management, internal control, tax exempt bond compliance, taxes, external and regulatory reporting, financial analysis and reporting, long range financial planning, budgeting, reimbursement, managed care, revenue cycle improvement, revenue compliance, and financial information systems. Performance oversight of Patient Access, Centralized Scheduling and Patient Accounting areas.

Board Committees:
System Board, Affiliate Boards, Finance Committee, Audit Committee, and the Pension and Investment Committee.

Key Accomplishments:

Point person on establishing the System's financial targets for the next 3-5 years during President Staff Retreat in 2007. First year of new financial vision was FY 2008 – financial target of $8 million from operations was met.

Architect of the change to the paid leave benefit program in FY 2008 which netted nearly $2 million in operational savings.

At forefront of re-charting financial course considering current economic crisis and challenges. Financial goals to remain intact but course to follow has changed and plans have been drafted and will be implemented shortly.

Have been part of team that lead changes to Pension benefits, moving from defined benefit (except for a small few meeting age and tenure criteria) to defined contribution plan to save the system millions in potential funding requirements in future years. Have already realized annual expense savings or expense avoidance with the change for FY 2009.

Improved Revenue Cycle Performance 5 years running while absorbing responsibility of all Managed Care oversight and negotiations while staffing kept flat and in some cases reduced as part of overall hospital "belt-tightening" measures.

Directed the issuance and/or refunding of just under $100 million tax exempt bond offerings for a variety of hospital renovations at both sites spanning the last 10 years through Connecticut's funding agency, CHEFA.

Have also successfully secured other CHEFA sponsored financing (Easy Loan and Easy Lease) to procure other critical clinical equipment needs.

Realized $100,000 annually in additional Medicare Revenue by reviewing and correcting Medicare underpayments related to transfer DRG's.

Increased managed care rates significantly over the past five years by tough negotiating tactics, and through tactical price increases. Have also negotiated several large settlements with major managed care payers on past year's underpayments.

Have been at the point working with Clinical and Operational Leadership on initiatives to squeeze expenses out of the system. In FY 2007, identified $6 million in salary and non-salary expense reduction opportunities that were eventually implemented to achieve full annual benefit for FY 20008. Working with team again in current fiscal year on CRI (cost reduction initiative) to reduce annual expenses by another $4 million.

Serve as member along with Senior VP of Patient Care and VP of Quality on LEAN. LEAN is simply a process of reducing waste – wasted time, wasted energy, and wasted steps. The end game is to improve the efficiency and delivery of a service, to reduce cost and to improve throughput. We have earmarked annually 6-8 initiatives (starting in FY 2007).

Serve as member along with Senior VP of Human Resources and VP of Operations on FHT (Financial Health Team). Collaborative approach to monitor and help manage poor financial performers in the organization at all levels. Eventually can be used as a tool to weed out continued inability to manage financial performance/budget.

Worked closely with the ED on post implementation monitoring of a new system designed to better track patients through the ED throughput process, improved documentation, and track supply utilization and charge capture.

Co-sponsored evaluation and eventually purchase of Surgery Compass software license to identify Operating Room Service trends and cost saving opportunities along service lines or specific to surgeons.

Worked on financial feasibility analysis on the following: new ICU, expansion of Skilled Nursing Facility from 100 beds to 130 beds, move of Women's Wellness Center to new site and acquisition of two digital units, new Wound Care program with hyperbaric chambers, sale of outpatient Dialysis site, Gastroenterology Joint Venture, and two Imaging Joint Ventures.

Eastern Connecticut Health Network, Inc.

Senior Director of Finance (2002-2003)
Reported directly to the Vice President of Finance. Scope of oversight applicable to entire system – hospitals and affiliates. Areas of responsibility included: accounting, budgets, accounts payable, and payroll. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

Director of Finance for Hospitals (2000-2001)
Reported directly to the Vice President of Finance. Scope of oversight applicable to the two hospitals. Areas of responsibility included: accounting, budgets, accounts payable, and payroll. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

Director of Finance for Affiliates (1998-2000)
Reported to the Vice President of Finance and the Administrator of the Skilled Nursing Facility. Scope of oversight applicable to SNF and two other affiliates (Women's Center for Wellness and Physician Practices). Areas of responsibility included: accounting, budgets, external audits, reimbursement, cost reporting, managed care, accounts payable, payroll and other financial analysis. Presented financial results to the affiliate Boards.

Hartford Hospital • July 1989 – November 1998, Hartford, CT

An 867 bed tertiary and teaching hospital affiliated with the University of Connecticut Medical School.

Patient Accounts Manager (1994-1998)
Reported directly to the Director of Patient Financial Services. Departmental liaison to Finance on all reporting metrics. Oversight for Remittance Processing & Cashiers Office, and Self-Pay Unit. Was instrumental in the development and implementation of automated remittance processing and posting for Medicare, Medicaid, Anthem and several other managed care payer remittances.

Accounting Supervisor (1989-1993)
Reported directly to the Accounting Manager. Primary responsibilities included the month end close calendar and journal entry processing, review of all intercompany transactions and loans, and all fund accounting.

Mount Auburn Hospital • January 1985 – June 1989, Cambridge, MA

A 191 Bed regional teaching hospital closely affiliated with Harvard Medical School.

Assistant Controller (1988-1989)
Reported directly to the Controller. Primary responsibilities included the month end close calendar and all journal entry processing.

Senior Accountant (1987-1988)
Reported directly to the Controller. Primary responsibilities included the month end close calendar and all journal entry processing. Assisted Budget/Reimbursement Department as needed.

Accounts Payable Manager (1986-1987)
Reported directly to the Controller. Responsible for oversight and direction of Accounts Payable staff of four. Department previously lacked organization. Continued to maintain accounting responsibilities.

Staff Accountant (1985-1986)
Reported directly to the Accounting Manager. Assisted Finance Department in various ways including: statistical reporting, cost reporting, budgeting, month end close and analysis, and year end audit requirements.

Education

Boston University • 2013
EMBA -- Executive Master's Business Administration

Eastern Connecticut State University • 1984
Bachelor of Science – Business, Concentration in Accounting.

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

Docket No.: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive
Imaging Services including MRI and CT Services

October 18, 2013

Prefile Testimony of Ethan B. Foxman, M.D.
President and Chief Executive Officer
Jefferson Radiology, P.C.

My name is Ethan Foxman and I am the President and Chief Executive Officer of Jefferson Radiology, P.C. ("Jefferson Radiology"). Jefferson Radiology provides professional radiology services at Tolland Imaging Center, LLC ("TIC") as well as at various hospitals, including Johnson Memorial Hospital ("Johnson") and Windham Community Memorial Hospital ("Windham"). Thank you for providing us with the opportunity to submit testimony in support of the continued operation of TIC in order to ensure access for patients in Tolland and surrounding towns to convenient, comprehensive imaging services.

Manchester Memorial Hospital ("Manchester"), Rockville General Hospital ("Rockville"), Johnson and Windham (collectively, the "Member Hospitals") have created a truly unique and successful collaboration. That collaboration has provided enhanced access to comprehensive, high-quality, community-based imaging services for patients and providers from Tolland and the surrounding towns. In fact, TIC is the only free-standing comprehensive imaging center in the service area and it supports a number of key primary and urgent care providers, including numerous physicians who have offices in the same building or nearby, as well as Med-East Medical Walk-In Center, the neighboring urgent care center affiliated with Windham.

In its initial Certificate of Need ("CON") decision, the Office of Health Care Access ("OHCA") envisioned a unique arrangement that would allow otherwise competitive hospitals to pool limited resources to establish a single center, avoiding unnecessary and inefficient

duplication of services, while at the same time providing a higher quality of care through collaboration. TIC has clearly achieved that vision.

More specifically, through the collaborative efforts of the four Member Hospitals and Jefferson Radiology, TIC provides (i) enhanced coordination of care for patients in the service area; (ii) increased access to radiology subspecialists; (iii) access to a hospital-affiliated open MRI for patients who are claustrophobic, obese, or otherwise can be scanned more effectively, comfortably, and efficiently on an open MRI; and (iv) convenient access to services local to the community and to key primary and urgent care providers who provide important care to patients in the Tolland area, including Medicaid beneficiaries and uninsured patients. These benefits improve both access and quality of health care in the region.

1. Enhanced Coordination of Care

Images from exams performed at TIC are stored on the ECHN picture archiving and communication system ("PACS") permitting any physician with access to the ECHN system, including community practitioners and physicians at Manchester and Rockville, to have access to the images of their patients taken at TIC. In addition, through Jefferson Radiology and its proprietary software, physicians at Windham and Johnson have remote access to patient images as well. As such, physicians at all four hospitals can easily access images in order to make treatment decisions more quickly.

In addition to ready access by hospital-based physicians, images performed at TIC are available to patients of the nearby urgent care center and local community practitioners. As such, TIC plays a critical role in ensuring access to necessary services in the Tolland area.

This high-tech collaboration among the four hospitals and Jefferson Radiology facilitates prompt diagnosis and care. It also prevents unnecessary duplication of testing by ensuring timely access to patients' imaging histories. We at Jefferson Radiology are proud to be an integral component of this collaboration.

2. Increased Access to Subspecialty Expertise

Jefferson Radiology is a large specialty group that includes radiologists with a wide array of subspecialty expertise, including in the areas of cardiovascular imaging, neuroradiology, oncology imaging, pediatric services, sports medicine and specialty women's services.

Patients seen at TIC have access to the full staff at Jefferson Radiology, ensuring subspecialty expertise when necessary for critical patient-care and treatment decisions. With these subspecialties "in-house," patients avoid the need for outside consults that can delay care. Instead, subspecialty consults can be quickly coordinated, enhancing the quality of care to patients in the region.

3. *Access to Hospital-Affiliated Open MRI*

As Dan mentioned, TIC provides each of the Member Hospitals with access to the only hospital-affiliated open MRI in the service area. This access is important because there is a certain segment of the population for whom an exam on a closed MRI is not possible without sedation or who, because of anxiety or claustrophobia, may require multiple attempts to successfully complete an imaging study. There are also numerous patients who may, theoretically, be able to tolerate a scan on a closed MRI, but who will delay or avoid exams on a closed MRI out of fear and anxiety.

Patient fear and anxiety, both of the exam itself and of what the exam may reveal, can be powerful motivators. The availability of all modalities at TIC, including access to an affiliated open MRI, significantly decreases one of the obstacles that can prevent patients from receiving timely, necessary care and treatment—removing impediments and increasing access to critical care for patients in the community.

Each of the Member Hospitals has one closed MRI on its campus. That is true of any hospital, because certain exams can only be performed on a closed MRI. A hospital must have at least one closed MRI available twenty-four hours per day, seven days per week for urgent and emergent assessments and for complex inpatient imaging needs. Thus, without TIC, patients who need or prefer an open MRI will have to go elsewhere, perhaps quite a distance from their homes, or the Member Hospitals will be forced to seek approval to acquire an open MRI.[1] That would not further OHCA's goal of efficient use of existing resources or preventing unnecessary duplication within the state.

[1] There is an open MRI in South Windsor. However, according to the most recent data available from FY 2011, that scanner is running at 88% capacity, well above the 85% capacity OHCA's recommended in the Statewide Health Care Facilities and Services Plan. There is also an open MRI in Enfield, but that is a considerable distance for patients traveling from east of Tolland.

The current arrangement leverages TIC's open MRI scanner to serve a multitude of patients and practitioners affiliated with each of the four Member Hospitals, all of which are nonprofit hospitals serving the needs of the uninsured and underinsured. If that access is cut off, patients will have to be scheduled, within availability, at privately owned and operated imaging centers that have an open MRI. That not only inconveniences patients; it also transfers the revenue stream from those patients away from the hospitals that need it to support other critically important but unprofitable services to their communities and redirecting it to for-profit imaging center owners.

4. *Accessible, Community-Based Care, Including for Medicaid Patients and Uninsured Patients*

National trends demonstrate that patients are increasingly seeking health care in suburban, outpatient centers. I have seen this trend with patients seeking imaging services as well, often because patients want to avoid the frequently unpredictable schedules of hospital-based imaging exams. Hospitals have to manage inpatient and outpatient use of hospital-based imaging equipment, including the needs of patients in a busy emergency department. As such, routine outpatients often find that they must wait while an inpatient or emergency department patient urgently receives his or her exam. This can be time consuming and frustrating for patients and functions as an obstacle to health care services.

As health care delivery models shift to meet this growing suburban, outpatient demand, practitioners in these centers need to have local access to the full complement of tools and services to diagnose and treat their patients. This includes imaging services. There will always be a portion of outpatient studies that need to be done in a hospital setting for a variety of reasons. That does not, however, minimize the importance of access to community-based outpatient imaging centers that can examine patients efficiently, reducing the burdens on the hospital-based imaging equipment that must first serve emergent patients, inpatients, and those outpatients who clinically require a hospital-based imaging study.

TIC supports its community of physicians, patients, and the urgent care center by providing comprehensive imaging services locally. In fact, it is the only free-standing comprehensive imaging center in the service area. If TIC were no longer permitted to offer comprehensive imaging services, patients would be forced to use other facilities, whether

freestanding or hospital-based, and would not enjoy the broad coordination of care among many different providers that TIC facilitates.

In addition, because TIC (i) is a freestanding outpatient imaging center offering almost every imaging modality, including open MRI, (ii) offers superb subspecialty expertise, and (iii) accepts all patients regardless of their ability to pay, TIC is in a unique position to meet the increased need that is expected as Medicaid and insurance coverage expands with implementation of the Affordable Care Act.

The Ramifications of Closing TIC

As Dan testified, if TIC is no longer authorized to offer CT and MRI services, TIC will not be financially viable and will have to close. In addition to the financial ramifications for the four Member Hospitals, removing TIC from the Tolland community would negatively impact patient access to imaging services. TIC provides open MRI, CT, radiography, mammography, bone densitometry, and ultrasound services. Without TIC, the convenience and efficiency of comprehensive care in a single location would be gone and patients would have to go to a hospital or leave the service area for their imaging needs. This lack of access and convenience can be especially difficult for TIC's under and uninsured patients.

In addition, providers who have come to rely upon the convenient access to subspecialty radiology consultation with Jefferson Radiology specialists would instead have to seek those services elsewhere. The impact would be especially difficult for the urgent care center as it decommissioned its x-ray equipment in 2008 when TIC began providing services. TIC's closure would require the urgent care center to purchase new radiography equipment. Without TIC, patients and providers would not benefit from the coordination of care afforded by this unique collaboration that prevents delays in patient care, diagnosis, and treatment.

Conclusion

As a freestanding outpatient provider, TIC improves patient access to imaging services and subspecialty radiology care in the way that patients increasingly wish to receive health care. TIC treats patients regardless of their ability to pay in accordance with the non-profit mission of its Member Hospitals and, as a joint venture, profits generated by TIC are distributed to the Member Hospital for use in furtherance of that mission. As a unique collaboration among three

competing health systems, TIC crosses traditional barriers, supports information sharing among patients, providers, an urgent care center, and the four Member Hospitals, and provides a continuum of care that facilitates the wellness of its community. This in turn prevents unnecessary duplication in the state health care system. In every way, TIC has realized OHCA's vision in authorizing this unique venture – replacing competition with collaboration, scattered and duplicative services with coordinated care, hospital-based service with community-based care. TIC furthers OHCA's mission to ensure all patients have access to efficient and convenient care, and it should be allowed to continue to serve patients and providers in the region.

[*remainder of the page intentionally left blank – signature page follows*]

Respectfully submitted,

Ethan B. Foxman, M.D.
President and CEO, Jefferson Radiology, P.C.

765/2610/2951401.7

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

TRANSMISSION OK

TX/RX NO	3777
RECIPIENT ADDRESS	912037822889
DESTINATION ID	
ST. TIME	10/22 09:35
TIME USE	00'41
PAGES SENT	5
RESULT	OK

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

FAX SHEET

TO: REBECCA A. MATTHEWS

FAX: 1203 782-2889

AGENCY: WIGIN AND DUNNA, LLP

FROM: PAOLO FIDUCIA

DATE: 10/22/13 Time:

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:

Information regarding tomorrow's hearing on Tolland Imaging. There are parking issues in the back lot at 410 Capitol Ave, due to construction. Please leave yourself enough time in case you are sent to another parking lot.

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

FAX SHEET

TO: REBECCA A. MATTHEWS

FAX: 1203 782-2889

AGENCY: WIGIN AND DANA, LLP

FROM: PAOLO FIDUCIA

DATE: 10/22/13 **Time:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:

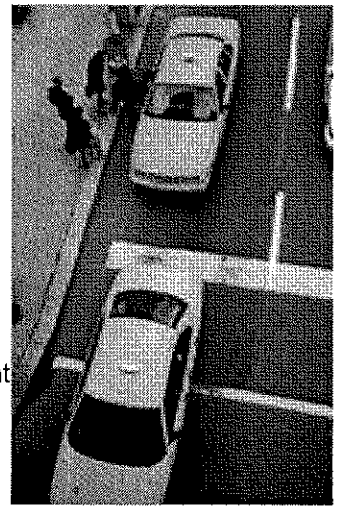
Information regarding tomorrow's hearing on Tolland Imaging. There are parking issues in the back lot at 410 Capitol Ave. due to construction. Please leave yourself enough time in case you are sent to another parking lot.

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

Directions to the Office of Health Care Access



From I-91 North or South and from East of the River:

In Hartford take I-84 westbound. Exit at Asylum Street, exit 48.

At the signal at the bottom of the ramp, make a gradual right, staying to the left of the fork in the road.

At the first light, take an immediate left onto Broad Street.

Travel on Broad Street to the light at the first four-way intersection; take a right onto Capitol Avenue. OHCA (tan brick building at 410 Capitol Avenue) is two blocks down on the right.

* Pass 410 and enter in the driveway between 410 and 450 Capitol Avenue. Turn right into the parking lot behind the building and proceed to the Security building in the lot. You will be directed to available parking.

From the West:

Take I-84 East to Capitol Avenue, Exit 48B. Bear right on the exit ramp. At the end of the ramp, turn right onto Capitol Avenue. OHCA is 3 blocks down on the right (tan brick building at 410 Capitol Avenue).

Proceed from * above

Directions to Forest and Sisson (Lot C) for visitor shuttle service:

From I-91 (north or south) and from east of the river

In Hartford, take I-84 west. Take Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the signal light onto Sisson Avenue. Take your first left onto **Capitol Ave. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes.**

From the West

Take I-84 East to Exit 46, Sisson Avenue. At the end of the exit ramp, turn left at the light onto Sisson Avenue. Take you first left onto **Capitol Avenue. Take your first left onto Forest Street. The parking lot is on your left and is labeled State of Connecticut. A shuttle bus to take you to our offices will either be waiting, or will appear in a few minutes**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Tolland Imaging Center, LLC**

DOCKET NUMBER: **13-31833-CON**

PUBLIC HEARING: **October 23, 2013 at 10:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letters of support to OHCA in the matter of the CON application under Docket Number 13-31833, received by OHCA on various dates. (9 pages)
B	Letter from Tolland Imaging Center, LLC ("Applicant") dated April 10, 2013 enclosing the CON application for the continued delivery of comprehensive imaging services including MRI and CT services under Docket Number 13-31833, received by OHCA on April 12, 2013. (291 pages)
C	OHCA's letter to the Applicant dated May 10, 2013 requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31833. (2 pages)
D	Applicant's responses to OHCA's letter of May 10, 2013, dated July 9, 2013, in the matter of the CON application under Docket Number 13-31833, received by OHCA on July 10, 2013. (6 pages)
E	OHCA's letter to the Applicant dated August 15, 2013 deeming the application complete as of August 7, 2013in the matter of the CON application under Docket Number 13-31833. (1 page)
F	Email from the Applicant dated August 29, 2013 confirming availability for the hearing, along with a notice of appearance from Wiggin and Dana LLP in the matter of the CON application under Docket Number 13-31833. (2 pages)
G	Designation letter of Kevin Hansted as hearing officer dated August 30, 2013 in the matter of the CON application under Docket Number 13-31833 (1 page)

H	OHCA's request for legal notification in the ***Hartford Courant*** and OHCA's Notice to the Applicant of the public hearing scheduled for October 23, 2013 in the matter of the CON application under Docket Number 13-31833, dated September 26, 2013. (4 pages)
I	OHCA's letter to the Applicant dated October 8, 2013 requesting prefile testimony in the matter of the CON application under Docket Number 13-31833. (7 pages)
J	Letter from the Applicant enclosing prefile testimony dated October 18, 2013 in the matter of the CON application under Docket Number 13-31833, received by OHCA on October 18, 2013. (45 pages)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31833-CON

Tolland Imaging Center, LLC

Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

October 23, 2013 at 10:00 a.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony (10 minutes)

III. OHCA's Questions

IV. Closing Remarks

V. Public Hearing Adjourned

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31833-CON

Tolland Imaging Center, LLC

Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

October 23, 2013 at 10:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **OHCA's Questions**

IV. **Closing Remarks**

V. **Public Hearing Adjourned**

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Tolland Imaging Center, LLC**

DOCKET NUMBER: **13-31833-CON**

PUBLIC HEARING: **October 23, 2013 at 10:00 a.m.**

PLACE: **410 Capitol Avenue, Third Floor Hearing Room**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letters of support to OHCA in the matter of the CON application under Docket Number 13-31833, received by OHCA on various dates. (9 pages)
B	Letter from Tolland Imaging Center, LLC ("Applicant") dated April 10, 2013 enclosing the CON application for the continued delivery of comprehensive imaging services including MRI and CT services under Docket Number 13-31833, received by OHCA on April 12, 2013. (291 pages)
C	OHCA's letter to the Applicant dated May 10, 2013 requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31833. (2 pages)
D	Applicant's responses to OHCA's letter of May 10, 2013, dated July 9, 2013, in the matter of the CON application under Docket Number 13-31833, received by OHCA on July 10, 2013. (6 pages)
E	OHCA's letter to the Applicant dated August 15, 2013 deeming the application complete as of August 7, 2013in the matter of the CON application under Docket Number 13-31833. (1 page)
F	Email from the Applicant dated August 29, 2013 confirming availability for the hearing, along with a notice of appearance from Wiggin and Dana LLP in the matter of the CON application under Docket Number 13-31833. (2 pages)
G	Designation letter of Kevin Hansted as hearing officer dated August 30, 2013 in the matter of the CON application under Docket Number 13-31833 (1 page)

H	OHCA's request for legal notification in the ***Hartford Courant*** and OHCA's Notice to the Applicant of the public hearing scheduled for October 23, 2013 in the matter of the CON application under Docket Number 13-31833, dated September 26, 2013. (4 pages)
I	OHCA's letter to the Applicant dated October 8, 2013 requesting prefile testimony in the matter of the CON application under Docket Number 13-31833. (7 pages)
J	Letter from the Applicant enclosing prefile testimony dated October 18, 2013 in the matter of the CON application under Docket Number 13-31833, received by OHCA on October 18, 2013. (45 pages)

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

October 23, 2013
10:00 a.m.

Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

PRINT NAME	Phone	Fax	Representing Organization
Dan DelGallo	860-830-9107	860-647-6444	Tolland Imaging
John Geisl	340-578-8297		Johnson Memorial Hospital
Michael Veillette	860-912-3236		ECHN, Inc.
Ethan Foxman	860-291-6560		Jefferson Radiology
Phillip Candito	860-533-2920		ECHN

Tolland Imaging Center, LLC

PRINT NAME	Phone	Fax	Representing Organization
Cary Trantalis	860 456-6722		Windham Hospital
Aaron Bayer	860 2973759		Wiggin + Dana
Cynthia McClarran	860- 456-6757		Windham Hospital

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 23, 2013 VIA FAX ONLY

Rebecca A. Matthews, Esq.
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832

RE: Certificate of Need Application; Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services
Closure of Public Hearing

Dear Ms. Matthews:

On October 23, 2013 a public hearing was held at the Office of Health Care Access ("OHCA"). As there were no late files ordered, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Paolo Fiducia at (860) 418-7001.

Sincerely,

Kevin T. Hansted
Hearing Officer

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

TRANSMISSION OK

TX/RX NO	3787
RECIPIENT ADDRESS	912037822889
DESTINATION ID	
ST. TIME	10/23 15:07
TIME USE	00'19
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 23, 2013 VIA FAX ONLY

Rebecca A. Matthews, Esq.
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832

RE: Certificate of Need Application: Docket Number: 13-31833-CON
Tolland Imaging Center, LLC
Continued Delivery of Comprehensive Imaging Services including MRI and CT Services
Closure of Public Hearing

Dear Ms. Matthews:

On October 23, 2013 a public hearing was held at the Office of Health Care Access ("OHCA"). As there were no late files ordered, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Paolo Fiducia at (860) 418-7001.

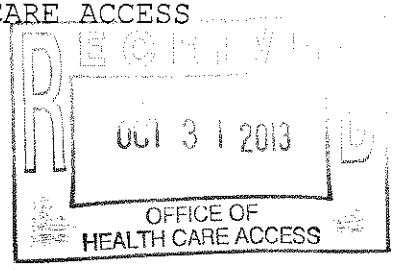
Sincerely,

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



TOLLAND IMAGING CENTER, LLC

CONTINUED DELIVERY OF COMPREHENSIVE
IMAGING SERVICES INCLUDING MRI
AND CT SERVICES

DOCKET NO. 13-31833-CON

OCTOBER 23, 2013

10:00 A.M.

410 CAPITOL AVENUE
HARTFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

HEARING RE: TOLLAND IMAGING CENTER, LLC
OCTOBER 23, 2013

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Tolland Imaging Center, LLC, Continued Delivery of Comprehensive Imaging Services including MRI and CT Services, held at the Department of Public Health, 410 Capitol Avenue, Hartford, Connecticut, on October 23, 2013 at 10:00 a.m. . . .

HEARING OFFICER KEVIN HANSTED: Good morning, everyone. This public hearing before the Office of Health Care Access, identified by Docket No. 13-31833-CON, is being held on October 23, 2013 to consider Tolland Imaging Center, LLC's application to continue delivery of comprehensive Imaging Services, including MRI and CT services.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen to act as the Hearing Officer here today.

The staff member assigned to assist me in this case is Ms. Kaila Riggott, and the hearing is being recorded by Post Reporting Services.

Following the hearing, a decision will be rendered 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.

The Applicant, Tolland Imaging Center, LLC, has been designated as a party in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this case. All documents have been identified in a Table of the Record for reference purposes. Ms. Riggott?

MS. KAILA RIGGOTT: Kaila Riggott, OHCA staff. The Table of Record contains Exhibits A through J.

HEARING OFFICER HANSTED: Thank you. Are

there any objections to the exhibits? No? Thank you. At this time, I will ask anyone, who is going to testify on behalf of the Applicant, to please stand, raise your right hand, and be sworn in.

(Whereupon, the parties were duly sworn.)

HEARING OFFICER HANSTED: And I know all three of you have submitted pre-filed testimony today. Before you each present today, just please adopt your pre-filed testimony for the record.

MR. DANIEL DelGALLO: Sure.

HEARING OFFICER HANSTED: Thank you. At this time, you may proceed.

MR. DelGALLO: Okay, so, I'll start off the group. My name is Dan DelGallo.

HEARING OFFICER HANSTED: Good morning.

MR. DelGALLO: Good morning. I'm the Executive Director of Tolland Imaging Center. I'm also the Administrative Director of Medical Imaging for Eastern Connecticut Health Network, and I hereby adopt by pre-filed testimony to you, but I do have some updates that I would like to talk through in my oral testimony.

HEARING OFFICER HANSTED: Absolutely. That's fine. You can testify, as to anything you want today. I just need you to adopt the pre-filed testimony.

MR. DelGALLO: I do adopt the pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. DelGALLO: So I just want to do quick introductions. In case you have questions at the end, we have several people here, who can answer.

We have Ethan Foxman, the President and CEO of Jefferson Radiology. Michael Veillette, the CFO of Eastern Connecticut Health Network.

John Grish, the CFO of Johnson Memorial Hospital. Also, David Whitehead is not here today. He has been replaced by Carolyn Trantellis, V.P. of Operations. Cindy McClarran, who is a manager on the Tolland Imaging Board. Also, the Director of Clinical Support Services.

HEARING OFFICER HANSTED: Okay. Before you continue, do you expect any of those folks to testify here today?

MR. DelGALLO: The three of us are going to testify orally, but if you have questions respective to their hospitals, they may have to answer it, because I won't be able to answer for them.

HEARING OFFICER HANSTED: Okay. Before we go any further, let's just get them sworn in, if we may.

MR. DelGALLO: Okay.

HEARING OFFICER HANSTED: If you could just please stand, raise your right hand, and be sworn in?

(Whereupon, the parties were duly sworn.)

HEARING OFFICER HANSTED: Thank you, all. You may proceed. Thank you.

MR. DelGALLO: So we're here today, obviously, because OHCA granted a three-year demonstration CON, based on several concerns that OHCA originally had.

One is can Tolland Imaging Center achieve financial viability, which I will get to in a few minutes, and, secondly, can the four hospitals, the three hospital systems all together achieve a collaboration, where they pool their resources when they have abutting and competing markets? I'll speak to the latter right now, and I'll get to the financial viability in a second.

So as the Executive Director, I meet with the leaders, some who are in this room right now, and their ancillary staff, such as Marketing Departments.

I meet on a regular basis as part of reporting to a board of managers, and I can say, unequivocally, that they have met that standard, and

there is a true collaboration, and we do cross-market each other, and we do share resources quite frequently, and it's kind of amazing the commonality that the three, when you get the leaders together at a Board of Managers, the commonality that they have and the vision for Tolland Imaging, so I would say that removed from the three hospitals as the Executive Director we have met that unequivocally.

So what has Tolland Imaging accomplished through this collaboration, which is what OHCA wants us to demonstrate, that we can collaborate together?

So I'm an MRI tech. I'm an experienced MRI tech, so I know going into this that open MRI is a niche market. I know that open MRI is going to be successful at Tolland Imaging. That's why Mandel and Blau are so successful.

But our other services, ancillary modalities at Tolland Imaging, have become successful, as well. And I know we're here for the CON for the CT and MRI, but we cannot forget about the other services, such as ultrasound, mammography and bone density, and we really solidified ourselves as a women's imaging center, per se, for those types of services, along with the MRI and CT, so we have a strong referral base of over 1,000

physicians.

We have 69 physicians that consistently refer to us on a regular basis in a given year, and I think that speaks volumes, as to how important Tolland Imaging has become in the community.

In the building that we reside in, there is many sub-specialties. There's OB groups. There's family practice. There's orthopedics. We've had some ENTs rotate through there, and we really provide that comprehensive service for them. They rely on us for that service.

And I also want to speak of the importance of an urgent care walk-in center right next to Tolland Imaging, called Med-East, which is half owned by Windham Community Memorial Hospital.

They divested their radiology services in 2008 when we opened, and, as a result, we perform 100 percent of their radiology services.

If you were to ask what those are, it's x-ray, for the most part, and, to a lesser degree, CT and MRI, but we do provide 100 percent of those services, so if we were to close, they would have to reinvest into those services for their own facility.

Ethan in a little bit is going to talk

about the importance of Jefferson Radiology and their consistent care across all the systems, since they read at Windham Community and Johnson Memorial Hospital, and how that integrates, so I'll leave that to Ethan.

I want to talk a little bit about, briefly, has, to your second concern, has Tolland Imaging achieved financial viability?

We have not met the volumes or the revenue that was originally projected in 2008. I would argue the landscape, the health care landscape, has changed significantly since then, and we don't have to go through every detail, but it is dramatic to changes, as far as reimbursement rates and high deductible plans.

What I will say is that, yes, we have achieved financial viability the last two years, so 2012 fiscal year and 2013 are both financially-viable years with positive net incomes, and that is going to continue to grow incrementally through the next few years, especially since we've had some major capital leases expire.

We had two capital leases expire just last month in September, so we're going to start to see that net income creep up, as well as the cash flow, and we will reinvest that back into the hospital systems.

Our volumes, while we haven't met the original expectations, have grown 15 percent since 2010, so, from 2010 to 2013, they have grown 15 percent, and we have a solid, consistent referral base.

So what would happen -- my last point is what would happen if OHCA denies the CT and MRI CON? There is no debate on that. If you were to talk to the three hospital members, we will have to close Tolland Imaging.

We cannot sustain operations with the loss of that revenue. It represents about 60 percent of our revenue, CT and MRI. I can certainly save significantly on costs. There's no denying that I can save, and maintenance cost, staffing, etcetera, but it doesn't make up for the lost revenue from the closure of those two modalities.

What's more important is that we are starting now to recoup and get back some of those lost sum costs that we had in the beginning.

We have some leases that go through 2016, so whether or not you deny or accept the CONs for both MRI and CT, we still have leases that go through 2016, two in particular, and we will be on the hook for about 1.3 million dollars in liability, and that includes

depreciation and lease costs from two leases.

I just want to make note in my testimony now that that 1.3 million differs from what we submitted in March, which was about 1.2 million. It's off by about $84,000, and that's because I realized there was a posting depreciation error that I corrected, so the accurate number, which is real, is 1.3 million dollars.

And, then, finally, there is no open MRI in either of the three hospital systems, so if you were to deny this, we would be left without an open MRI, and I would argue that we would not absorb those anywhere in any of the systems.

People, patients are (coughing) to an open MRI, because it is a niche market. If you close, those patients do not go to a closed marked. It doesn't work like that, and I know that, because I'm an MRI tech and I've seen that.

These patients are going to go to Mandel and Blau. They're going to go to South Windsor. They're going to go to Enfield, so the hospitals will lose I'll project about 90 percent of that bounty.

Michael is going to talk about financially how this effects the hospital systems and the losses that they have incurred. The financials that were presented

in our testimonies were draft, and those have had a few updates, specifically, ECHN, and, with that, I'll turn it over to Michael.

HEARING OFFICER HANSTED: Thank you.

MR. MICHAEL VEILLETTE: Good morning.

HEARING OFFICER HANSTED: Good morning.

MR. VEILLETTE: Again, my name is Michael Veillette, and I am the Chief Financial Officer for ECHN and the two member hospitals that they have participating in the Tolland Imaging Corporation joint venture.

So I just want to pick up where Dan left off and kind of just make mention of, you know, not getting too much into the weeds here, but just mention that there was one accounting adjustment that we were made aware of in the last 30 days with respect to the freezing of a defined pension, defined benefit pension plan.

There's about a 1.1-million-dollar accounting credit that ECHN will realize, and it's a favorable adjustment, so that's just one example of something that will be a one-time occurrence.

HEARING OFFICER HANSTED: Okay.

MR. VEILLETTE: It will not be something that we'd be carrying forward in future years.

HEARING OFFICER HANSTED: Okay and before you proceed any further, would you, just for the record, adopt your pre-filed testimony for me?

MR. VEILLETTE: Glad to.

HEARING OFFICER HANSTED: Thank you.

MR. VEILLETTE: I do adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. VEILLETTE: At the risk of being redundant, I do want to just hit upon a couple of points Dan has already made, just from a financial perspective.

The member hospitals have made significant investment upwards of close to $900,000 in this joint venture, with the expectation that they would be able to recoup that investment and perhaps also see performance beyond that in future years.

The last couple of years, 2012/2013, modest profits have been realized, with an expectation looking forward, where that number will start to improve, as some of the fixed costs will start to fall off respective to lease expenses.

It is in those years, outwards of 2016, where the expectation is that initial investment would be recouped.

I think that is important to know from the standpoint that ECHN and its member hospitals have gone through rather challenging times these last three fiscal years, and, looking forward, we're not seeing any, you know, significant improvement beyond the losses that we sustained in '11, '12 and '13.

Our budget for 2014 is a modest 100,000-dollar surplus. We are dealing, obviously, with a number of issues, including significant federal and state cutbacks that have made the task of performing to break even very, very difficult and has led us in our 2014 budget to already make some significant personnel reductions and service changes to the hospital and to the system.

Although the financials are not yet final for 2013, they are unaudited draft, and they have been turned over this week to our audit team, and we expect that, again, in 2013, that there will be a loss to ECHN's system.

I guess, with that, I will turn it over to Ethan.

DR. ETHAN FOXMAN: Mr. Hansted and Ms. Riggott, thank you for having me here today. I'm Ethan Foxman. I'm President and CEO of Jefferson Radiology and

a physician within the Tolland Imaging Center. I wish to adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

DR. FOXMAN: Thank you. I'm here today to speak about the clinical services provided at the Tolland Imaging Center.

The Tolland Imaging Center, as you well know, was inaugurated with a very unique vision of bringing together multiple institutions and organizations to provide coordinated care in partnership with one another to serve the Tolland area.

The reality around health care in our world is that coordination of care is still very difficult, even at the level of imaging. An imaging study done in one facility is not always available for review or transmission to another facility.

I wish to share with you just some of the day-to-day operations of the imaging center and share that by way of the fact of representing that the way patients are taken care of within the imaging center is true to the original vision, if you will, of how the center was crafted to be a center with collaboration between multiple institutions.

The clinical services are provided by

Jefferson Radiology, which is a sub-specialized radiology service provider with various sub-specialization in multiple fields, and, also, the physicians of Jefferson Radiology are on the medical staffs at multiple institutions.

As a consequence of this, when a patient receives an imaging study at the Tolland Imaging Center, the physician working in that environment has a few unique resources at his or her hands.

That physician is able to look at comparison examinations or old studies at different institutions where those patients were previously seen.

That's an enhancement to patient care, because, in real time, the progression of disease or the absence of progression of disease can be corroborated at the time of the original rendering of the imaging interpretation, so that's how this center is working on a daily basis in a collaborative fashion, true to the vision of the initial inauguration of the center.

Furthermore, because of the large scope of the physician practice, sub-specialty care is able to be rendered in that environment, so, in a practical level, a patient having I'll say a knee MRI or imaging of the joint it's possible to have in consultation a physician,

who specializes in sports medicine or orthopedic imaging.

Similarly, there's physicians, who specialize in pediatric imaging, oncology imaging, brain and spine imaging, or neuroradiology.

So I wish to represent that, in the daily practice, the center, through its clinical operations, is true to the original conception of the center as being a collaborative partnership across multiple institutions.

There's both the physician expertise on site and, actually, the technological infrastructure, which allows viewing of images for multiple institutions installed and used on a daily clinical basis in that environment.

I think that's a fairly unique situation, and I think it speaks to how the clinical services have been true, again, to the mission and conception of the Tolland Imaging Center.

We'll also support the imaging center on a go-forward basis to continue to provide that level of access to the quality of care. Thank you.

MR. DelGALLO: Mr. Hansted, would I be able to make a quick statement?

HEARING OFFICER HANSTED: Absolutely.

MR. DelGALLO: Okay. Just one point that

I don't think was emphasized, that, fiscally, I think this is the worst possible time to close the center, well, deny the CON, which, in turn, we would close the center, based on the cuts that the hospitals have.

And the losses that would be incurred from the closure of Tolland Imaging would have to be put onto the hospitals, based on their ownership split, and those cuts would be in staff reductions, or service reductions in their respective hospitals, because I believe, and I'll let the partners speak better to that, they're essentially running on break-even budgets, so any further cuts that they have to incur would have to be made up somehow with either some kind of expense reductions.

HEARING OFFICER HANSTED: Thank you. Does that conclude your testimony this morning?

MR. DelGALLO: That concludes our testimony, yes.

HEARING OFFICER HANSTED: Okay, thank you. We just have a few questions. Ms. Riggott?

MS. RIGGOTT: Do you want to go first?

HEARING OFFICER HANSTED: No, go ahead.

MS. RIGGOTT: I actually had a couple of questions on the revised Exhibit A that was submitted in your pre-file. I know you said you corrected the numbers

to reflect the change in the CPT coding that took place. I believe that started to be reflected in 2011. Could you just explain for the record how you made those corrections or changes?

MR. DelGALLO: Would I be able to look at the exhibits?

MS. RIGGOTT: Sure.

MR. DelGALLO: Oh, yes. I'm sorry. I'm sorry. So, in 2010, that was one of the major coding changes that nationally was made, and it really hit CT, so a common test in CAT scan is abdomen/pelvis.

You used to be able to bill separately for the abdomen and for the pelvis, and you would count it as two exams. They eliminated that in 2010, and they no longer count it as two exams, but one exam, and they significantly reduce the reimbursement.

So, prior to that, we realized significantly more revenue and volume that you had considered in 2008 when you projected out our volumes, so that exercise that we submitted was just simply to show you how those changes effected our volumes for CT.

HEARING OFFICER HANSTED: So you used the pre-2010 formula and applied that to the 2011 through 2013 numbers?

MR. DelGALLO: That's correct. Yeah. Merely just to show what the changes did.

HEARING OFFICER HANSTED: Right. Okay.

MS. RIGGOTT: And, then, my second question also pertains to the volume. I know you also show in Exhibit A that you have overall almost a 15 percent increase.

From 2012 to 2013, there is a decline just from year-to-year in MRI, CT and ultrasound. Can you speak to that decline?

MR. DelGALLO: Yeah. So, overall in the facility, there was a two percent loss. To pinpoint exactly, you know, what caused that loss, it's very hard.

I can point to a whole number of things, such as the increase of our bad debt and high deductible plans, which I think correlate together; more people on high deductible plans, more people going into collections and increasing our bad debt.

I think that has something to do with it, less people going to the physicians' offices. Ethan and the other partners can speak of the volumes at the hospitals where they lost double-digit growth, and I think a two percent loss was actually -- Tolland Imaging fared fairly well, considering the losses that the

hospitals and other imaging centers nationally and in Connecticut have realized.

MS. RIGGOTT: Thank you.

DR. FOXMAN: If I could just underscore, I think there's quite a bit of data from the Connecticut Hospital Association and other data that's in the public form.

That would confirm that, in the past 12 months or so, there's significant, even double-digit drops statewide seen in ambulatory services and outpatient and utilization of outpatient imaging.

I think, actually, by comparison, a two percent drop is actually a fairly robust number in the context of what has been a marketplace for significant drops that have been seen across the board for all the reasons that Dan mentioned.

MS. RIGGOTT: Thank you.

HEARING OFFICER HANSTED: Thank you. I just have one follow-up question to the testimony. Can you discuss for me the cost difference between a patient receiving either an MRI or CAT scan at your facility versus receiving one at a hospital?

MR. DelGALLO: Sure. It's almost like comparing apples to oranges, and I'll explain why. At

Tolland Imaging Center, we're not a hospital-based department. We're an independent testing facility, and what that means is we are required to bill globally, so we don't separate the professional from the technical. We bill one global fee, and then we give a percentage to Jefferson Radiology, who does the professional reading, whereas, the hospital, they bill separately the professional and technical.

They're held to a different fee schedule, because they're hospital-based. Their rates are much higher, because they have more overhead. Tolland Imaging has less overhead, and that's just not between those two centers. That's globally, nationally.

Hospital-based rates are significantly higher, because of the overhead cost, and we are also set by guidelines for Medicare on how we bill those out and the rates that are set by Medicare.

Usually, the commercial insurances bill their rates based off of a percentage of those Medicare rates, so that's why they're significantly different.

My rates are based off of global Medicare charges and insurances. My rates, contracted rates with insurances are based off of percentages of that, where the contracting with the hospital is done much different,

because they separate that global into professional and technical.

HEARING OFFICER HANSTED: Okay, so, it's fair to say that, if Tolland Imaging were to close and those patients had to go to the hospital, they'd be paying a higher fee for the CT and MRI scans?

MR. DelGALLO: That's exactly right. It would be in the best interest for the insurance companies not to divert them to the hospital. They would divert them to outpatient systems, so I think that would emphasize that closing that.

The hospitals want to gain a lot of that volume, because insurances are ruthless right now moving them away from the hospital.

HEARING OFFICER HANSTED: To another outpatient facility for a scan?

MR. DelGALLO: That's right.

HEARING OFFICER HANSTED: Okay and I won't hold you to an exact number today. We may possibly order a late file.

MR. DelGALLO: Sure.

HEARING OFFICER HANSTED: But can you tell me the difference in price between a scan done at Tolland Imaging versus one done at one of the hospitals?

MR. DelGALLO: Sure. Not concrete data.

HEARING OFFICER HANSTED: Absolutely. I won't hold you to it. I'm just trying to get an idea, rough idea.

MR. DelGALLO: So it's very different by modality. I would say, in the aggregate, with all the modalities, it's anywhere from 10 to 15 percent higher at the hospital.

HEARING OFFICER HANSTED: Okay.

DR. FOXMAN: Mr. Hansted, if I could, just to dovetail onto some of --

HEARING OFFICER HANSTED: Sure.

DR. FOXMAN: Your question was around cost and such, and there is, as you heard, a difference, in terms of fee schedules related to an --

HEARING OFFICER HANSTED: Well my question wasn't so much towards the cost. It was the charge to the patient, just to make that clear.

DR. FOXMAN: Just something in the financial calculus of how things work, I'll just say, again, speak from the physician side.

There are costs that enter into the system when patients have duplication of imaging studies, or studies that are not fully interpreted, and then I'll say

a treatment pathway is initiated, whereas, if the old study was available upon review, a different treatment pathway, more effective pathway would have been initiated, but it is not an uncommon scenario, where someone shows up at one hospital and everyone is aware that there have been past imaging in some other venue. It's not easily attainable, can't be seen on the spot, and, so, actually, imaging is duplicated.

So I can't quantitate the costs around duplication of services, but that is a reality in the absence of coordinated care.

HEARING OFFICER HANSTED: Can you give me a rough percentage on how often the duplication of scans actually is forced to occur at the hospital?

DR. FOXMAN: I can only speculate. I'll say, in the emergency room environment, I'm going to speculate on a 10 percent basis.

HEARING OFFICER HANSTED: Okay.

DR. FOXMAN: Ten to 15 percent.

HEARING OFFICER HANSTED: Thank you. Okay. That's all I have for questions. Attorney Matthews, did you want to give a closing statement or Attorney Bayer?

COURT REPORTER: You have to do it in

front of the microphone.

HEARING OFFICER HANSTED: Yes. Please come up to the microphone.

COURT REPORTER: I'm sorry. I didn't get your name.

MR. AARON BAYER: It's Aaron, A-A-R-O-N, Bayer, B-A-Y-E-R. I hadn't planned to make closing remarks, but I guess I won't pass up the opportunity to talk with you.

I think what I want to do most is reiterate that, in 2008, OHCA actually took a chance when three hospitals came before it with competing proposals and had a vision for something that was unique.

We were discussing it before the hearing, and there really is nothing like this at the time anywhere in the country, and OHCA suggests that a collaborative venture that would hopefully reduce costs, reduce duplication of services, improve patient care through coordination, and provide greater access to specialized benefits, and OHCA had the right vision in 2008.

It was done provisionally to make sure that a new vision worked, that it achieved financial viability, and that patients were really benefiting, and

OHCA did the right thing.

Now the results are in. The patients clearly in this community, where OHCA identified a need, patients clearly have benefited. There's no question about that. Duplication has been reduced, access to specialized care has been increased dramatically, and they're on the cusp now, having repaid some of those upfront costs, they're on the cusp now of actually benefiting the owners from having invested deeply in this collaborative venture.

To force closure now would be to undue OHCA's vision prematurely, and it's kind of the worst possible time, because you have fixed costs remaining, and you have the initial capital investment that now will be repaid over the next few years.

The hospitals will be able to reap the benefits, as well as patients, so to end that now is kind of the worst possible thing to do.

It undoes the vision that OHCA had that's been achieved to a certain extent, but will be achieved fiscally and much more so on a going-forward basis through 2016, when the lease cost expires and when they're able to pay back their investment and reinvest more in the facility.

It's an opportune time to be before OHCA, but it's also an opportune time for OHCA to sort of reinforce its vision and why the hospitals invested in this venture at OHCA's suggestion, and we strongly encourage OHCA to allow it to move forward.

HEARING OFFICER HANSTED: Thank you, Attorney Bayer. Before we end today, are there any members of the public, who wish to give a public comment on this application today?

Let the record reflect that there are none, and, with that, I thank you, all, for attending today, and this hearing is adjourned.

(Whereupon, the hearing adjourned at 10:40 a.m.)

HEARING RE: TOLLAND IMAGING CENTER, LLC
OCTOBER 23, 2013

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 28th day of October, 2013.

Paul Landman
President

Post Reporting Service
1-800-262-4102

CTShopsHere.com
Buy. Sell. Save.

To advertise, call 860-525-2525
or ctshopshere.com/advertise

SCAN HERE TO SAVE

Stuff

Antiques/ Collectibles

CASH FOR U.S. GERMAN, JAPANESE WWII Items, guns, etc. **860-543-3617**

MGA 1962 Many spare parts, red. $14,000 Best Offer. 860-738-1004

SET OF 3 ANTIQUE ROOSTER PRINTS in maple frames $250. 860-657-9331

Auto & Truck Parts

WHEELS+SNOW TIRES 4, 245/65R17. Used one season, used on Toyota Highlander hose on 4.25 inch on center $90/whl+ tire (860)673-7168 eves

Boating

BOAT TOPS & UPHOLSTRY Bristol Uph. 860-283-8055 or 1800boattops.com

CANOE 16 ft. Old Town. Fiberglass. Allagash veteran. $75. 860-429-4160

AT YOUR SERVICE

At Your Service

AFFORDABLE HOUSE CLEANING 3RD CLEANING $25 OFF (860) 518-9150

ARBORVITAE FALL tree sale. All sizes del. + planted. 1 yr. guar. Mem. BBB. HIC #0555978. LIC/INSU/REF. Call for price 860-533-1572 or 860-209-2079. Cascadelandscapect.com

AUTO BODY REPAIR Self empl. man. Minor collision, & welding. 860-659-3398

CLEANING Home & office. 3rd cleaning-50% off. Ins., refs. 860-538-4885

MEDICAL CAREER TRAINING
- CNA F/T 2 -wks or 10- wk Eve/Sats
- On Site State Testing/Placement Asst

ETW 415 Silas Deane Hwy #304 Wethersfield, CT (860) 571-7666

MR. REFINISH Bathtub & tile reglazing. Don't pay thousands to replace! Refinish! www.mrrefinish.com 203-574-2950

OKTOBERFEST & Holiday PIG ROASTS 860-529-6865, petethebutcher.com

SEAMANSHIP COURSE Hartford Power Squadron offers 8 week course in Farmington. Starts 10/3 at 7p.m. $120. 860-673-1584

SUNFISH - Dolly & cover. Value $1500-$2200. Best offer. 860-669-5318

Stuff

BASKETBALL-BACKBRD& STAND *DRIVEWAY FUN!! $99. 539-5174

BATH EXHAUST FAN, 110 CFM, W/Wall Humidistat. $40/BO 860-649-2254

BUREAU Maple Bureau with Cherry Inserts 28" x 50" $80 860-489-6177

CAMERA Olympus, film, unused in box 35m orig.$149 $20. 860-6448203

CHIPPER/SHREDDER
Chipper/shredder 3 in. Sears. 305cc Briggs motor; Includes bagger Used 6 times $400.00 860-742-5400

CLOTHES CLOSET Metal, portable 20"x22"x60" $45. 860-644-8203

COUNTER STOOLS
Two (2) 24" Swivel Top Solid Oak - Like New Cond. $250 EACH 860-232-7829

DESK AND DRESSER oak finish, excellent condition $80 860-633-0501

DIESEL FUEL SUPPLEMENT new, 80 fl oz $5.00 860 6231118

DOOR, NEW. Slab, 2 coats quality paint. only $45.00 860-716-4377

Dresser & vanity w/ mirrors. Maple Deco. 1948. $200/ea. 860-645-6445

ELECTRIC GENERATOR 7000 watts rated. 8000 watts surge. Coleman Powermate. Model PM7022. Ashford. $600 860-429-4160

FIREWOOD seasoned 1/2 cord $85 full cord. $169 8607966132

FULL SIZE DRYER Whirlpool-electric-bought sep 12 $350 860-371-1514

FULL SIZE WASHER Whirlpool,bought sept12 $350 860-371-1514

FURNACE Rheem hot air, gas, 80K BTU. New in box. $400. 860-646-4242

FURNITURE For Sale: Office chair, bar stool; $10, $30 860-523-5672

GARDEN TRACTOR Murray 38" with bagger $375 860-568-4032

GAS GRILL Stainless, 2 burners, cover and tank. $150. 860-644-7732

HANDYMAN ENCYCLOPEDIA 1984 25 hardcovers. $75 OBO. 860-568-3275

HOT TUB, 6 person, 51 jets, all options, w/cover & warranty, never used, cost $6800, sell for **only $3600! 860-344-1244**

JASON ALEXANDER Oct 4th @ Bushnell. 2 Tix only $85.00 860-716-4377

KENMORE DRYER Electric. Excellent condition. $175 **(860)523-0202**

LEAFBLOWER Craftsman Electric $35 860-489-6177

ORGAN, Yamaha,keyboard,stand ,seat elec./bat.excd $100. 860-644-8203

PAINTING Hand Painted Scenic on Canvas $75 860-489-6177

RIDING MOWER - 38 in. cut. Needs battery $160. 860-463-6165

ROOFING TOOLS & MATERIALS call for details $150 860-828-7498

SCREENED DARK/RICH TOP SOIL $25/yd. 5 yd. min. Free Delivery. Over 10 yds. - 10% discount. Hartford County. Firewood seasoned, cut, split,delivered. $175/Cord, min 2. Call for pricing 860-228-2003

SELF PROPELLED CHIPPER VAC troybilt csv200 bristol $380 8605931702

SNOWBLOWER REO MATICO 7hp, elec. start snowblower $65.00 6516553

SNOWBLOWER Snowblower Ariens 524, electrical start. $485 860 667-4026

SPRING WONDER HORSE brown, height adj48"x23x42"H $50 860-644-8203

STUFF COMPACT STEREO SYSTEM CD PHONO TAPE $75 860 633-2589

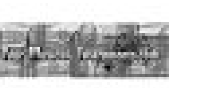
TV STAND 3 glass shelves, metal frame. 42"x22" excd. $50. 860-644-8203

Tickets

RED SOX PLAYOFFS Fri. 10/4 Sec 17 Game 1 ALDS $300 860-794-7111

Wanted To Buy

1 BUY VINTAGE ELECTRONICS GUITARS, AMPS, TUBE HI-FI, RECEIVERS, AUDIO EQ, RADIOS, HAM, CB, SAXOPHONES. CALL 860-707-9350



All Musical Instruments Accordians Sax,, Guitars, drums, trumpets. Cash paid, Any Condition. Lasalle Music. 993 Main St., E. Hartford **860-289-3500**

BUYING 1900s-1960s: Toys·Antiques·Costume jewelry·BarRoom items/signs·Sports souvenirs·Political·Oil/Gas items·Bsement & Attic·**860-561-1817**

BUYING MACHINIST TOOLBOXES Tools & tooling, contents of machine shops, mechanic and carpentry tools. Call anytime 860-985-5760

BUYING OLD MAHJONG SETS Incompl. sets okay. Greater Hrftd. 860-231-8466

TYPEWRITERS WANTED Collector Paying Cash for Rare, Early & Interesting TYPEWRITERS & related items. 860-729-2252 Antikey.Chop@gmail.com

Announcements

Lost/Found

IMPOUND #248 pit bull mixed f. blk/wht Call Hartford PD (860)527-6300

IMPOUND #249 Pit Bull, F, blk/wht. #250 Pit Bull,M, Blk/wht. #251 Pit Bull, F, gray/wht. Call HPD 860-527-6300

IMPOUND #32 Red/Brwn Chihuahua mixed F. Windsor ACO 860-688-5273

LOST Gray cat. Area of Plymoth Rd, Windsor. Lv msg. 860-683-4231

LOST CAT last seen Chester CT Grey with orange tabby female. Reward for safe return. 203-536-0460

LOST CAT last seen Chester CT Grey with orange tabby female. Reward for safe return. 203-536-0460

Business

Business Opportunities

NOTICE

Investigate Before Investing

Call the Connecticut Department of Banking **BEFORE** investing in a business opportunity or franchise. See if the seller or the investment is registered with the Securities Division.
Call 860-240-8230 or visit our Web site at www.ct.gov/dob.
This notice provided as a public service by The Hartford Courant.

Real Estate

Rentals

BRISTOL - 1 & 2 BR. Spacious layouts. Several locations. Renovated. On-site laundry $575 & up **860-584-1654**

www.Harvest-Properties.com

BRISTOL/FARMINGTON TOWN LINE 2 large bedroom, 1.5 baths, large basement, large yard, emacculate condition. Central A/C, Gas, Heat. No pets. Close to 84 and 72. $1,075/month. 860-677-6880

BRISTOL-NEW LISTING! 5 rooms, 3BR, Immaculate. Hdwd flrs, applis, w&d hkup. Closed in porch. Close to schools, short distance to RT 72, 84, ESPN. Non smoking unit. Parking. No pets. Available now. Must be seen! 860-583-4783

Canton Boulder Ridge 1 & 2BR available. Ranch style, private entrance, patio, washer/dryer in every unit. Must be 55+ and meet income restrictions. **Call Sandy 860-269-0116 Metro-Prime.com**

E. HARTFORD 1BR @ OCTOBER HILLS $ 1ST MONTH FREE RENT/HT & HW $ 860-282-7454 860-424-6981

East Windsor - Enormous Eff. Clean & quiet. Secure Bld. Appliances, carpet & private balcony. On-site Indry. Heat & H.Wtr inc. $625 and up 860-875-9500

EAST GRANBY - 1 & 2 BR apartments available. **Call 677-1381.**

ELLINGTON - Autumn Chase Brand new 1 & 2BR Luxury Apartments with garage. Close to I84, I91 and Bradley Airport **Please call 860-872-1000**

FARMINGTON - FOREST PARK APTS. 2BRs, 1½ bth Twnhses & Ranches. New Kits. Starting at $1410 + utils. No pets. **860-678-8800 rwrenterprises.com**

HARTFORD - 2BR, Lg, beautiful Farm. Ave Condo near Aetna. At Bus-stop, completely remodeled unit, HT/HW incl. Storage, Lndry rm, Roof patio. Safe neighborhood. No pets/smoke. $875/mo. Available Immed. 860-678-8170.

HARTFORD - Studio $550, 1BR $660, 2BR $850. Well-kept, elev building, ht/hw included, parking available. No Pets. **860-549-3181**

HARTFORD 820 Wethersfield Ave South and on busline, heat, hot water, and parking incld. Studios, 1 bdrm, 2 bdrms, $600, 700, $850. 860-296-7369

HARTFORD Regency Towers 1BR, balcony, pool. All util, AC, cable FREE. 24/7 doorman. Near St. Francis & Blue Back. $995/mo. Avail Oct. 860-667-0288

HARTFORD spacious 1br apartments available. Recently updated. Starting at $620/mo. Heat & hot water included. Off-street parking avail. Near Bus, off of Asylum Ave. Call Carmelo 860-726-6868

HARTFORD
Westland Place
2 BD: $700
All apartments include HT & HW
JRH Asset Mgmt 860-246-0613

HARTFORD-Southend, 3BR, near bus lines $1100/mo 860-296-0658

MANCHESTER Charming, clean, quiet, 1 bdrm. Hrdwd flrs, appliances, porch, washer dryer hk up. New kitchen, garage, storage area. 2nd floor. Available immediately. $750/mo plus utilities. 860-521-1234

MANCHESTER Luxury 2 bd Townhouse. **w/out gar $1025. w/gar $1075. ALSO** 1bd flat, $725 & up. Quiet area. **FREE HT/Hot Water** No dogs **721-1013 EOH**

MIDDLETOWN - Highview Apts Huge 1&2 BR. Fully appl.eat in kitchen. Large liv.room w/ balcony. Laundry, prkg **Free H&HW. $895/$925 860-704-0102**.

NEW BRITAIN Spac 2 bd, lrg kitch, w/w, appl, clean, on-site Indry, lrg closets, off st prkg. On bus line. No dogs. **Free Heat/HW.** $675. **223-8866** EOH

NEW BRITAIN 860-223-8866
Evergreen Townhouse Apartments Remodeled 2 & 3 Bedroom Town-homes in quiet area. Private entry, h a r d w o o d floors. Laundry. On bus line. Heat & Hot Water included. $750 & up for two beds.

www.Harvest-Properties.com

Plainville Castle Apartments
Subsidized Property is NOW Accepting Applications for 2 and 3 BR Apts. Rent based on Income & Include HT & HW **Call 860-677-4647** Professionally Managed by Konover Residential Corp.

EQUAL HOUSING OPPORTUNITY

Plainville- xlg studio apt inc. stove, refg, dw, a/c and balcony. $615.00/mo. **Pls call CPI @ 860-225-1570 (x1.)**

ROCKVILLE Well Maint. 1,2&3 BR, Quiet bldg, wall/wall, appls, laundry. **Heat & HW Incl.** Short term leases. **$725, $825 & $925 860-875-9500 EOH**

Simsbury 1 & 2BR apts, Twnhses, flats, some w/garages. **Call 860-677-1381**.

VERNON: 1&2 BD. & 2 BD TWHSE. Spacious layouts. Priv. Entry. Some incl. H & HW $750 & up. 860-721-1013 **www.harvest-properties.com**

WEST HARTFORD CENTER newly remodeled large 1br, 1ba, new kitchen, new applcs, new carpet, new bath, $1100/mo Call: Mike: (860)236-1253

WEST HARTFORD Clean, sunny, remod. 1 & 2 bd, quiet area. Appls, w/w, Indry. on busline, great schools, community rm **FREE HT/HW** $895/m. **953-8030** EOH

www.Harvest-Properties.com

WEST HARTFORD Large 1BR, clean quiet bldg, southern exposure, plenty of closets, H/HW/AC, parking (1 car) I84 access $875 (860) 675-5423

Wethersfield
Welcome to Goodwin Gardens
*Spacious Garden Style Units
*Beautiful Courtyard Views
*Includes new kitchens, h/hw, a/c
*Open House Sat 1-4pm
1BR $835/2 BR $990 and TH $1230
37 Fairway Dr
860-529-7544
equitymanagement.com

WINDSOR LOCKS - Beautiful Spacious 1&2 bd, quiet building. W/W , appls, on-site laundry, c/air, elevator, busline. **Free Heat/HW.** $750-$850 and up **860-875-9500 EOHH**

www.Harvest-Properties.com

Real Estate For Sale

BERLIN
Open House Sun 9-29 11am-1pm 8602502488

Bloomfield Ave- Gracious 8 room dutch colonial, 5 bed, 3.5 bath, 190's.
Hartford SW- Oversized 3 family 5-5-5, siding, separtate furnaces, excellent income 130's.
Harford Harvard St- Desirable 6 rm col, lrg enclosed porch, fam sized kit, 160's
Windsor, Kate Way- Amazing 9 room colonial, spacious open floor plan + many extras, 350's
Shimkus, Murphy & Lemkuil
860-249-1396, 860-559-0178, 860- 978-3725.

CANTON Cape 3bdr, 1.5bth, LR & DR, 2Car Gar, Add'l Wkshp Bldg Michelle Mateo 203-868-1224

EAST HADDAM
Dir: X7 off Rte 9 N, over Bridge. Stay on Rte 82 Veering R @ Stop Sign Take L. Follow to Cedar Meadow on L (Across from School). L to Valley Brook Rd. (#3). 860-277-3500 - 860-739-1998 RANDALL REALTORS kate@randallrealtors.com

GLASTONBURY $539,900
OPEN HOUSE 1:00 to 3:00
Farmcliff gem! Immaculate 4BR 3.1 Bth COL, end of culdesac, Granite&SS Kit, HDWD flrs, Sunrm/Office, Fin LL W/out, 2 FPs, CAIR, level drvwy & lot. DIR: Hopewell to Heather Glen to 24 Ashley Ct.
Karen Iuliano 860-918-6264

VERNON 3 bedroom 1 bath ranch. 912 sq. ft. Large yard. Open house 9/29, 1p.m.-3p.m. Move in ready. 23 Watson Road. $175,000. 860-324-2868

WEST HARTFORD 18 Hugh St Open 1-3 Sunday 9/29. Walk to Ctr! Updated 3BR/1.1BA home w/hwd flrs, fin LL. $259,900 Matt Lloyd 860-264-5856

Office Space / Retail

Wethersfield 1400-2500sf space aval. Silas Deane. $13 gr. **860-529-5158**

www.courant.com/pets

pets
POWERED BY gadzoo.com
Adoption • News • Advice • More

Birds

YELLOW NAPED AMAZON PARROT - 3 years old, talks, pamed, healthy, must sell. Loving and affectionate! $800 or make offer. Call 860-354-5461 or 860-384-2640

Cats

SIAMESE KITTENS males/females, 1st shots, playful/affectionate. $400. Ready to go. 508-798-8292

Dogs

BEAGLE PUPPIES 10 weeks old, males/females, tri-color, great with kids. $200 each. 860-543-1114

BEAGLE pups, AKC, m/f, shots & wormed, parents here $350.00 860-608-2461

BORDER COLLIE PUPPIES 10 weeks, Scottish bloodlines, shots/wormed, black & white. $500. 860-207-0962

Bulldogs, Yorkie, Chihuahua, Shih Tzu, Beagles, Poodle X, Huskies $150+ 860-930-4001

DESIGNER PUPPIES MINI POODLE CROSS SHIH TZU Adorable, non-shed, 1st shots. $450. 860-684-1314

DOBERMAN PINCHER PUPS Cropped & docked, excellent health/temperament. 413-229-8117

DOBERMAN PUPPIES health, hips, temperament; Guaranteed. Oversized/ Housebroken $600 203-231-7177

ENGLISH SPRINGER SPANIEL PUPS Field bred. Excep. 12 weeks. $800. 860-623-0674

ENGLISH SPRINGER SPANIEL PUPS AKC, Ready to go! $600 ea. 860-889-3130

GERMAN SHEPHERD PUPS AKC, German working lines. Vet checked. Large boned. Going fast! 860-442-5422

GERMAN SHEPHERD PUPS AKC, German working lines. Vet checked. Large boned. Going fast! 860-442-5422

GERMAN SHEPHERD PUPPIES - 8wks Imported parents, raised by professional trainer. $1500. 860-889-0339

GERMAN SHORTHAIRED POINTER GSP puppies AKC registration Dewormed shots up to date Champion Bloodlines Ready to go $600.00 (860)3076692

GOLDEN RETRIEVER PUPS AKC , 2 females. 1st shots, vet chkd, $600 603-762-2945 : dbcb419@yahoo.com

GOLDEN RETRIEVER AKC, Eng. Creams Ch Russian bloodlines. Beautiful! Ready 9/28 $1800 (860)377-8213

GOLDEN DOODLE 10 wks, 1 cream female. Shots wormed. Farm raised. Parents on site. $1,095. 401-741-7717

GOLDEN RETRIEVER
AKC Puppies Handled & Socialized daily with Children & other Goldens on the premises,Vet checked, First Shots, Dewormed, Health Guarantee, Paper trained. Ready for loving homes October 20 Excepting Deposits $850.00 860-584-9950

LAB Pups,Black, AKC Reg, Exc. Temp. and health, Blocky heads, shots, ready,10/20 $1000 860-236-5200

LOVING PUPS Rescued puppies for adoption. To view the puppies & notice of our next adoption day event, visit us at **www.lovingpups.com** $250-300. Call 828-208-0757 .

PUG AKC Pug pups black boys fawn girls. Www.phoenix pugs.net $800 860-377-2188

ROTTWEILER Pups Shots. Ready to go. 2 Females, 6 Males. $600-700. 860-209-4854

SHELTIE PUPS AKC Bi-black beauty's. M&Fem vetted and shots. 860-546-6775 nesr@charter.net

SHIH TZU PUPS Simply gorgeous! Happy and healthy. Hand raised. $550. 203-731-7548

YORKACHON PUPS goregeous! Yorkshire Terrier x Bichon Frise. Non-shed, raised with love $650 203-731-7548

YORKSHIRE TERRIER PUPS! top quality, adorable, teacups avail. hand raised w/love. $750 (203)731-7548

TAG SALES

Tag Sales & Flea Markets

BLOOMFIELD 49 Prospect St. Estate sale. Furniture for sale. Bring your truck. Cash only. 9/28. 9a.m.-2p.m.

BLOOMFIELD 614 Park Ave. Sun 9/29, 8am-4pm. Furn glassware, househld items & clothing A little bit of everything

Bloomfield Cliffmount Dr. Sat 9/28, 9-4 Multi-fam. Antiques, collectibles, tools, jewelry, electronics, garden, furn, DVD.

BLOOMFIELD Outstanding 1 day estate sale featuring antique furniture and decorative accessories, lighting, architectural elements, art glass, ceramics, paintings, and a lot more. 944 Mountain Rd., across from Balbrae. 9/28. 9a.m.-5p.m. No early birds. Cash or in state checks only.

BRISTOL 9/28 & 9/29 9am-4pm 24 Primrose Lane. Estate/moving sale. Everything must go! All furniture, patio, lawnmower, snowblower, tons of household and home decor. Fantastic Sale! www.estatesalesbysally.com

BURLINGTON Estate sale. 25 Black Walnut Ln. Sat. 9/28, 9-4p.m. and Sun. 9/29, 9-2p.m. Antiques, art, furn., HH, tools, 10" Delta saw, Craftsman saw, vac leaf blower, generator , and garden

BURLINGTON Final moving tag sale. Everything half price or free. Huge selection. Sat. 9/28. 9-1. 9 Barnes Hill Rd.

COLCHESTER, 43 PARKSIDE DRIVE, SATURDAY, 9/28/2013, 8 - 4, RT 16 TO BIGELOW TO PARKSIDE

CROMWELL ESTATE SALE
192 Shunpike Rd, Fri Sept 27, 9-4, Sat Sept 28 - 9-3, ESTATE SALE Pack rat house, Indian artifacts,ant furn, many ant & coll. See estatesales.net for many photos. Cash

EAST HADDAM
12 Boardman Road, Friday - Sunday, 9/27 - 9/29, 8 AM - 4 PM, Antiques and Collectibles Tag Sale in Beautiful Rural Environment - Fri - Sun 9/27 - 9/29 12 Boardman Road, East Haddam, Ct.

EAST HARTFORD, 85 Scott Street, Sat. 9/28, (Rain 9/29), 8am - 4pm, Multi-Family Tag Sale: W&D, furn., kids toys

GLASTONBURY Estate Sale. Sat. 9/28 8am-3pm. 18 Kinne Road. Rosewood dining set, Yamaha piano, fur jacket, vintage kitchen set, and household items.

GLASTONBURY, 158 partridge landing , saturday, sept 28, 2013, 8 am - 12 pm, moving sale furniture sports equipment toys games household items

MANCHESTER 151 Bella Vista Lane Sat 9/28 & Sun 9/29, 8-3. Several Houses household items, clothing, tools & antiques & something for everyone

MANCHESTER Multi-Fam Sale Don't miss this! 54 Huckleberry Rd Sat 9/28, 8-3p. Furn, antiques household & more

MANCHESTER Sat 9/28, 8a-1p. Huge Indoor Baby/Child Sale w/ clothes, toys, books, & furniture. 199 Deming Street.

MANCHESTER Sat. 9/28 9am-4pm. 643 Keeney St. Stuff, things, and more stuff.

MANCHESTER
20 Gardner St, Sat, Sept 28, 7 am - 1 pm, Home goods, clothing, holiday decorations, furniture, books and more

MANSFIELD Huge yard sale. Rain or shine (tent). 75 Fern Rd. 9/28 and 9/29. 8a.m.-5p.m. 100's of items. Household supplies. Old (rockers, albums, hutch, trunks) Collectibles and clothing. Too much to mention! Check it out!

MIDDLETOWN ESTATE SALE
500 Washington ST. #17 Huge Sat 9/28+ Sun 9/29. 8am. Most in. health-care equip. Hoveround Scooter, A1 2-4X clothes, collectables, angels, antiques, household & all must go.

MIDDLETOWN ALTRUSA, Faith Lutheran 300Washington, Sat, 9/28, 9AM - 1PM, Household, Garden, Books, Toys, Clothing, Jewelry, Perennials, more

MOODUS 58 Moodus Leesville Rd, corner of Johnsville & 151 "Hear, Hear!" Moving Sale: from the Beautiful to the betrocious! Sat 9/28 & Sun 9/29, 9am

NEW BRITAIN - 9/28-29, 9am-3pm. Home goods, fishing, hair salon tools, something for everyone! 14 Cadwell Ct

NEW BRITAIN - Sat. 9/28, 9am-3pm. Tools, Household, clothing, misc. 72 Lowell St

NEW BRITIAN 9/27, 9/28 & 9/29 9am-6pm. 225 Vine St. Lots of great items! Check out this sale!

NEW BRITIAN 9/28 & 9/29 9am-4pm 40 Edbert Dr. Large variety of items, something for everyone. Great prices!

NEW BRITIAN Sat. 9/28 8am-2:30pm. 1988 Stanley St. Large moving sale! Lots of furniture, gas grill, pull behind 6x8 trailer. Everything must go.

NEW HARTFORD
GIANT FLEA MARKET
Rain or Shine/ New Hartford Lions Benefits Local Charities & Scholarships
Saturday, Sept. 28, 2013, 8am-3pm
Brodie Park, 580 West Hill Rd.
New Hartford CT.
Adult Adm. $1.50
******* $1.00 WITH THIS AD *******
Early buying $5- 6:30-8:00am
Food / Free Parking
Door Prizes / No Pets
Spaces available, call **860-489-9188.**
fleamarket@newhartfordctlions.org

NEW BRITAIN
99 South Mountain Dr., 9/28/13, 9/28/13, 9:00 AM - 12:00 PM, MOVING SALE Solid cherry furniture- chairs, tables, desks, end tables, children's bedroom set, wicker furniture, sofas, double recliner, lamps, pictures mirrors, even woman's clothing, all excellent quality and condition, cash and carry

NEWINGTON - HUGE BIG K FLEA MARKET/CRAFT FAIR/Tag Sale Spot 8AM - 2PM EVERY SUNDAY. Housewares, tools, clothing, etc.39 E. Cedar St. Adm. $1. Spaces $15. Park FREE. Call 860-667-2864, 839-1597. Visit our page: Facebook.com/NewingtonFleaMarket.

NEWINGTON 128 Jeffrey Ln. SAT 9/28 9am-2pm. Neighborhood tag sale. Tools, collectibles, antiques, household.

NEWINGTON 9/28 & 9/29. 9am-4pm. 14 Francis Ave. **MOVING!** Rooms of furniture, furnishings, lawn equipment, etc.

NEWINGTON ESTATE SALE Fri. 9/27-Sat. 9/28 8am-3pm. 3 Homecrest St. Oak Larkin fall-front desk, oak Hoosier, clocks, glassware including jadite, vintage toys, costume jewelry, tools including wrenches, sockets, Snap-on, Husqvarna 15HP riding mower, Toro 22" recycler mower, 60 gal compressor. Sean Mahoney

NEWINGTON, 147 Hillcrest Ave, Fri- Sun, Sept. 27,28,29, 8:00 am - 3:00 pm, Estate Sale-furn, clothes,holiday

PLAINVILLE, 28 Broad St, Sat, 9/28, 8 - 2 , 7-family , clothes, teacher stuff, household, books, kitchen

SIMSBURY Oct. 4th, 5th, & 6th. 10am-5pm. Rain or Shine. 100 Quarry Rd. Vintage &antique furniture, dinnerware sets including Tendarvis, Noritake & Yorktown. Cast iron cookware. Come in and explore.

SIMSBURY, 178 stratton brook road, 9/28-9, 10/5-6, 9 - 5, Entire house contents 50s 60s kitsch chabby chic retro 1000+ items antiques tools see craigslist for pictures & list

SOUTH WINDSOR GIANT SALE 347 Main St Sat 9/28 8am-2pm. Antiques, dishes, furniture. Rain date 9/29

SOUTHINGTON Flea market. Every Sunday 8-2. 2165 Meriden Waterbury Tpke. I-84 exit 28. 860-384-1155

SOUTHINGTON, 224 Washington Drive, Saturday, 09/28/2013, 9am - 2pm, Tag sale Saturday 9/28. Gently used clothing, toys & games, books & household items. Also some bikes and kids VHS.

SOUTH WINDSOR, Sunfield Dr, SAT, 9/28, 8 AM - 3 PM, Multi Family some new Items in boxes

UNIONVILLE Multiple Family Sale Burlington Rd. Fri 9/27 & Sat 9/28, 9-3. Furn, books, silver & household item

VERNON 720 Dart Hill Rd. 9AM-2PM. 9/28, 29. Estate Sale. 30yrs of major league baseball collectibles, photos, baseballs, clothing, plus hand tools, garage tools, and misc. HH goods.

W. HARTFORD 85 Waterside. 9/28 - 9/29. 9-3pm. X-mas tree, Keurig, leaf blower, bicycle, etc. Sun. reduced .

WEST HARTFORD 23 Foxridge Rd Sat Only 9/28, 10am-3pm. Furniture, lamps, etc

WEST HARTFORD 90 White Ave. 9/28 and 9/29. 8a.m.-4p.m. Furniture, household, blanket, decorations, tools, trailer, and much more.

WEST HARTFORD Estate Sale 62 Manchester. 9/28 & 29th 7am. Washer /dryer, furniture, art & collectibles, Hummels, glassware, crystal, Playschool items, snowblower, lawnmower, lawn edger, lawn furniture, dining room, kitchen, electronics, couch, lamps, & vehicles.

WEST HARTFORD Sat. 9/28 9am-12pm. Cherryfield Dr. Something for everyone. Lots of kid items.

WEST HARTFORD Sat. 9/28, 9-2. 302 N. Quaker Ln. Lots of household items. Something for everyone. No early birds

WEST HARTFORD, 134 Richmond Lane, Saturday, 9/28, 8:00am - 3:00pm, Pine corner cabinet, cedar chest, Hitchcock table/chairs, rugs, framed prints, and other household items. No early birds please.

WEST HARTFORD, 25 Foxcroft Rd, Saturday, 09/28/2013, 9:00 AM - 12:00 PM, Moving & Downsizing. Cheap$$

WEST HARTFORD
32 Clearview Ave, Sat,9-28, ., 9a - 3p, Must see! Electronics,sporting goods,furn,appliances,much more!

WEST HARTFORD, Knight Hall School 411 Park Rd, Sat., September 28, 2013, 8 a.m. - 12 p.m. , PMC Charity Tag-Bake Sale

WETHERSFIELD 1 Day Estate Sale! Sat. 9/28 9am-3pm. 81 Round Hill Rd. Everything Goes!

WETHERSFIELD 220 Maple ST Sat 9/28, 8-2. Home appliances, fishings equipment, games and everything else

WETHERSFIELD 9/27, 9/28 & 9/29. 9am-5pm. 76 Saxon Rd. Indoor estate sale. Full house. Literally thousands of items!

WETHERSFIELD, 15 Grass Bonnet Lane, 9/28/2013, Sat 9/28, 8:00 AM - 2:00 PM, Household Items and more

WETHERSFIELD, 1 Day Estate Sale!, Sat. 9/28, 138 Mapleside Drive , 9am - 3pm, Lots of stuff, everything goes!

WINDSOR - Sat. 9/28, 9am-4pm. Multi-family tag sale, childrens clothing, fishing items, items A-Z! 1412 Palisado Ave

PUBLIC NOTICES

Connecticut

NOTICE OF PUBLIC SALE OF COLLATERAL
PENNSYLVANIA UNIFORM COMMERCIAL CODE,
DIVISION 9, SECURED TRANSACTIONS, TITLE 13 PA.C.S.A. §9610

NOTICE IS HEREBY GIVEN that the collateral described below will be sold to the highest qualified bidder at a PUBLIC SALE to be held on **MONDAY, OCTOBER 14, 2013**, at 2:00 P.M. local time at the law offices of Leech Tishman Fuscaldo & Lampl, LLC, located at 525 William Penn Place, 28th Floor, Pittsburgh, Pennsylvania 15219, by dck North America, LLC, a Delaware limited liability company and/or its successors or assigns ("Secured Party"), the secured party under that certain Pledge Agreement, dated as of June 23, 2009, executed by Halden Acquisition Group II, LLC, a Rhode Island limited liability company ("Halden") and Pacifica Ventures, LLC, a California limited liability company ("Pacifica", and collectively with Halden, "Pledgor"), in favor of Secured Party, as such may have been amended from time to time ("Pledge Agreement"). The collateral to be sold is security for certain indebtedness owed to Secured Party, which indebtedness includes, without limitation, the debt evidenced by that certain Amended and Restated Promissory Note in the principal amount of $1,389,594.00 (the "A&R Note"), executed by Connecticut Studios, LLC ("Borrower") in favor of Secured Party. Borrower is in default under the A&R Note and certain other related loan documents. The total amount due under the A&R Note as of September 30, 2013 (principal and interest) is $1,666,496.00 **plus** yet to be determined fees, charges and attorneys' fees.

The collateral to be sold at public sale is, collectively, all of the Pledged Member's Interests (defined below), all of the Pledged Interest Distributions (defined below), and all of the income, proceeds and products of any thereof. The Secured Party understands, but does not represent or warrant, that the percentage interest of each Pledgor in and to Borrower to be as follows: 50% - Halden, 50% - Pacifica.

"Pledged Interest Distributions" means, collectively, (i) all distributions of every kind whatever which shall become and be due and payable or distributable on or in respect of all or any of the Pledged Member's Interests or equity interests, (ii) all payments of every kind whatever which shall become and be due and payable or distributable on account of the purchase, redemption, repurchase or other retirement of all or any of the Pledged Member's Interests or equity interests, and (iii) all other distributions of every kind whatever (including, without limitation, all capital distributions) which shall become and be due and payable or distributable on or in respect of all or any of the Pledged Member's Interests or equity interests.

"Pledged Member's Interests" means, collectively, (i) all of the issued and outstanding interests of every class in the equity of Borrower (A) which are legally and beneficially owned, whether jointly or severally, by Halden and Pacifica, and (B) the certificates, or other evidence of ownership of the membership interests in Borrower and (ii) all other equity interests in Borrower (A) which have been or shall be issued or distributed at any time or times, or (B) which have been or shall be purchased or otherwise acquired by or on behalf of Halden and/or Pacifica from any other persons at any time or times.

The collateral described above will be sold to the person or entity who is the highest qualified bidder at such public sale. **The collateral will be sold to only one bidder. Any prospective purchaser will be required to provide evidence and to represent that such prospective purchaser is (a) an "accredited investor" as such term is defined in Regulation D of the Securities Act of 1933 and (b) purchasing the collateral for such prospective purchaser's own investment and its own acc**ount and not with a view towards subsequent resale or distribution, in whole or part. Any prospective purchaser who is the highest qualified bidder, other than Secured Party, will be required to pay the purchase price of the collateral (i) at the time of such public sale, and (ii) in cash, by cashier's check, or in other immediately available funds. If Secured Party is the highest bidder at such public sale, Secured Party may pay the purchase price of the collateral, in whole or in part, by crediting the amount of such purchase price against the balance of the unpaid indebtedness evidenced by the A&R Note.

Secured Party reserves the right to withdraw all or any of the collateral from the sale at any time and without notice, to postpone and re-notice the time, place and/or date of the sale by oral announcement and to make credit bids at the sale or any continuance thereof. If competing offers with different terms and conditions are submitted, Secured Party will determine which offers will be accepted, and its decision in this regard shall be final. The sale may be adjourned or cancelled from time to time, and notice of any adjourned sale date will be given only at the time of the scheduled sale and to those who attend the sale.

Secured Party cannot and will not warrant what (if any) rights any Pledgor or Borrower may have in the collateral, the extent of the interest in or title to the collateral that can or will be conveyed or transferred, or the accuracy or completeness of its information regarding the collateral and any Pledgor's or Borrower's rights therein. Prospective buyers are responsible to conduct their own investigation regarding the collateral to be sold. The sale will be made AS-IS, WHERE-IS, WITH ALL DEFECTS AND FAULTS, WITHOUT RECOURSE AGAINST SECURED PARTY, AND WITHOUT COVENANTS, WARRANTIES OR REPRESENTATIONS, EXPRESS OR IMPLIED, FROM SECURED PARTY.

Information now available and pertaining to the collateral to be sold will be available for inspection by appointment. Each interested party must sign a confidentiality agreement as a precondition to reviewing these materials. TO SCHEDULE AN APPOINTMENT TO REVIEW THESE MATERIALS OR FOR MORE INFORMATION RELATING TO THE PUBLIC SALE ANNOUNCED HEREIN OR THE COLLATERAL DESCRIBED ABOVE, PLEASE CONTACT: Pete A. Fuscaldo, Esq., Leech Tishman Fuscaldo & Lampl, LLC, 525 William Penn Place, 28th Floor, Pittsburgh, Pennsylvania 15219, (412) 261-1600.

DATED: September 27, 2013

PUBLIC NOTICE
Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicant:	Tolland Imaging Center, Inc.
Town:	Tolland
Docket Number:	13-31833-CON
Proposal:	Continued Delivery of Comprehensive Imaging Services including MRI and CT Services with a total capital expenditure of $1,245,144 (if the application is denied)
Date:	October 23, 2013
Time:	10:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than October 18, 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.

CREC Request for Proposal

CREC will receive sealed cost proposals for District Wide Seasonal Landscaping Services.

The Request for Proposal package may be obtained at CREC's reception desk no sooner than Monday September 30, 10:00 am at 111 Charter Oak Avenue, Hartford, CT 06106. There will be a **mandatory walkthrough** of the building locations on Monday October 7, beginning at 9:00 am at CREC, 111 Charter Oak Avenue, Hartford, CT 06106. Participants are asked to meet in the front lobby of the building. RFP responses are due no later than Friday October 18, 2013 at 2:00 pm.

CREC reserves the right to reject any or all proposals, and in particular, to reject a proposal incomplete or irregular. CREC reserves the right to waive any informality or irregularity in any proposal received, to negotiate changes to offered terms and to accept the proposal that, in its judgment, will be in the best interest of CREC.

Connecticut

ADVERTISEMENT FOR BID
Bids: October 22, 2013
Eugene O'Neill Theater Center
Rehearsal Building and Laundry & Housing Cottages
305 Great Neck Rd
Waterford, CT 06385

Eugene O'Neill Theater Center, will receive sealed bids on a general contract for 9 new buildings in two sets of construction documents as described below:

1. Rehearsal Building –This new single story building has one practice room, one classroom and support spaces. This building is about 2,965 square feet. The site work includes the adjacent parking lot and new utilities.
2. Laundry & Housing Cottages – This project consists of 7 separate two story cottages that house a total of 65 beds and one central single story laundry cottage. All of the buildings together are about 15,239 square feet.

Bids shall be on a single stipulated sum basis; segregated bids will not be accepted. **Owner requires all bidders to be DAS preapproved.**

The Eugene O'Neill Theater Center will receive bids until 12:00 PM Eastern Standard Time on Tuesday, October 22, 2013 at 305 Great Neck Rd and the bid opening will be held after the bids are received. A mandatory pre-bid conference will be held on Wednesday, October 2, 2013 from 8:30 AM to 10:00 AM. A 5% bid bond will be required. This project is funded by the State of Connecticut. No bids will be received unless bidders have attended the pre-bid conference and delivered the bid before the time and date stated above.

Copies of the Procurement Documents may be obtained, upon request, on Thursday, September 26, 2013 from the printing house and contact noted below:

Lisa Gorman
Joseph Merritt & Company, Inc.
650 Franklin Avenue
Hartford, CT 06114
Phone: 860.296.2500
lgorman@merrittgraphics.com

An Affirmative Action/Equal Opportunity Employer. Minority/Woman's Business Enterprises are encouraged to apply.

Thank you for your interest in this exciting project.

Preston Whiteway
Executive Director
Eugene O'Neill Theater Center

Greer, Leslie

From: Carney, Brian
Sent: Tuesday, January 14, 2014 10:54 AM
To: Greer, Leslie
Cc: Riggott, Kaila; Fiducia, Olivia
Subject: FW: Tolland Imaging Center
Attachments: TIC OHCA Filing re 2014-2016 Projections.PDF

Leslie, can you please add page numbers to this document and add to the record. Also, can you let me know what the page numbers will be and also what Exhibit?

Thanks,
Brian

From: Riggott, Kaila
Sent: Monday, January 13, 2014 12:22 PM
To: Carney, Brian
Subject: FW: Tolland Imaging Center

Brian,
Here is info to be inserted. Have not looked at it yet.
Kaila

From: Matthews, Rebecca [mailto:RMatthews@wiggin.com]
Sent: Monday, January 13, 2014 12:07 PM
To: Fiducia, Paolo
Cc: Riggott, Kaila; Bayer, Aaron S.; Pimentel, Elisabeth; Daniel J. Delgallo (DDelgallo@echn.org); Dennis P. McConville (dmcconville@echn.org); Schroff, Kim
Subject: RE: Tolland Imaging Center

Hi Paolo:

I hope you had a nice weekend. As requested, we are submitting projections for Tolland Imaging Center. The attached documents will also be hand-delivered to your office today.

Please let us know if you need any additional information.

-Rebecca

Rebecca A. Matthews
Direct: 203.498.4502 | rmatthews@wiggin.com

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

---

From: Fiducia, Paolo [mailto:Paolo.Fiducia@ct.gov]
Sent: Friday, January 10, 2014 11:08 AM
To: Matthews, Rebecca

Cc: Riggott, Kaila
Subject: Tolland Imaging Center

Hi Rebecca,

OHCA is requesting three years of projections (FYYs 2014-2016) for all existing equipment at Tolland Imaging Center based on actual FY 2013 utilization provided on page 361 (Exhibit A) of the pre file testimony.

Please provide the requested information no later than Monday, January 13, 2014.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst
Office of Health Care Access
A DIVISION OF DEPARTMENT OF PUBLIC HEALTH
paolo.fiducia@po.state.ct.us
860.418.7035 Direct Line
860.418.7053 Fax

WIGGIN AND DANA

Counsellors at Law

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

Rebecca A. Matthews
203.498.4502
203.782.2889 fax
rmatthews@wiggin.com

VIA EMAIL AND HAND DELIVERY

January 13, 2014

Mr. Kevin T. Hansted, Hearing Officer
Department of Public Health – Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Hearing Officer Hansted,

On behalf of Tolland Imaging Center, LLC ("TIC"), attached is a chart showing actual volumes, by modality, for fiscal year 2013, together with projections for fiscal years 2014, 2015 and 2016. As you know from TIC's application and the testimony presented at the hearing, TIC has projected zero percent (0%) growth. Accordingly, TIC is projecting that the volumes will remain the same as the volumes in fiscal year 2013 over the next three (3) years. Please note also that the attached chart shows *actual* volumes for fiscal year 2013. The chart submitted as Exhibit A to Mr. Delgallo's testimony adjusted the volumes for CT services to account for the CPT coding change that went into effect January 1, 2011. That change eliminated the separate billing and CPT codes for all abdomen and pelvis CT exams performed on the same day and thus resulted in a reduction in reported volume.

If you have any questions regarding this submission, please contact me at your earliest convenience at (203) 498-4502.

Sincerely,

Rebecca A Matthews RAS

Rebecca A. Matthews

cc: Paolo Fiducia, Health Care Analyst, Office of Health Care Access
Daniel Delgallo, Tolland Imaging Center

Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Facility	Modality	ECHN Fiscal	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	Total
Tolland	MRI	2013	137	141	126	145	125	147	151	159	130	119	138	135	1,653
Tolland	CT	2013	52	63	51	72	62	74	67	79	65	55	45	55	740
Tolland	X-Ray	2013	327	304	300	295	265	334	417	312	264	314	335	343	3,810
Tolland	Ultrasound	2013	205	163	188	195	188	188	213	208	226	218	196	206	2,394
Tolland	Mammo	2013	218	179	167	195	149	179	187	208	153	207	143	185	2,170
Tolland	Bone Density	2013	41	35	33	35	38	42	47	32	35	54	29	49	470

	FY 13 Actual	FY 14*	FY 15*	FY 16*
MRI	1653	1653	1653	1653
CT	740	740	740	740
XR	3810	3810	3810	3810
Ultrasound	2394	2394	2394	2394
Mammography	2170	2170	2170	2170
Bone Density	470	470	470	470
TOTAL	11237	11237	11237	11237

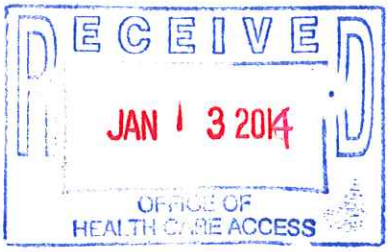
*Based on 0% growth

WIGGIN AND DANA

Counsellors at Law

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

Rebecca A. Matthews
203.498.4502
203.782.2889 fax
rmatthews@wiggin.com



VIA EMAIL AND HAND DELIVERY

January 13, 2014

Mr. Kevin T. Hansted, Hearing Officer
Department of Public Health – Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Dear Hearing Officer Hansted,

On behalf of Tolland Imaging Center, LLC ("TIC"), attached is a chart showing actual volumes, by modality, for fiscal year 2013, together with projections for fiscal years 2014, 2015 and 2016. As you know from TIC's application and the testimony presented at the hearing, TIC has projected zero percent (0%) growth. Accordingly, TIC is projecting that the volumes will remain the same as the volumes in fiscal year 2013 over the next three (3) years. Please note also that the attached chart shows *actual* volumes for fiscal year 2013. The chart submitted as Exhibit A to Mr. Delgallo's testimony adjusted the volumes for CT services to account for the CPT coding change that went into effect January 1, 2011. That change eliminated the separate billing and CPT codes for all abdomen and pelvis CT exams performed on the same day and thus resulted in a reduction in reported volume.

If you have any questions regarding this submission, please contact me at your earliest convenience at (203) 498-4502.

Sincerely,

Rebecca A Matthews RAS

Rebecca A. Matthews

cc: Paolo Fiducia, Health Care Analyst, Office of Health Care Access
Daniel Delgallo, Tolland Imaging Center

Certificate of Need Application, Docket Number 13-31833-CON
Tolland Imaging Center, LLC Continued Delivery of Comprehensive Imaging Services including MRI and CT Services

Facility	Modality	ECHN Fiscal	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	Total
Tolland	MRI	2013	137	141	126	145	125	147	151	159	130	119	138	135	1,653
Tolland	CT	2013	52	63	51	72	62	74	67	79	65	55	45	55	740
Tolland	X-Ray	2013	327	304	300	295	265	334	417	312	264	314	335	343	3,810
Tolland	Ultrasound	2013	205	163	188	195	188	188	213	208	226	218	196	206	2,394
Tolland	Mammo	2013	218	179	167	195	149	179	187	208	153	207	143	185	2,170
Tolland	Bone Density	2013	41	35	33	35	38	42	47	32	35	54	29	49	470

	FY 13 Actual	FY 14*	FY 15*	FY 16*
MRI	**1653**	**1653**	**1653**	**1653**
CT	**740**	**740**	**740**	**740**
XR	**3810**	**3810**	**3810**	**3810**
Ultrasound	**2394**	**2394**	**2394**	**2394**
Mammography	**2170**	**2170**	**2170**	**2170**
Bone Density	**470**	**470**	**470**	**470**
TOTAL	11237	11237	11237	11237

*Based on 0% growth

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

February 6, 2014

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 13-31833-CON
Tolland Imaging Center, LLC	**Continued Delivery of Comprehensive Imaging Services including MRI and CT Services**

To:

Rebecca A. Matthews, Esq.
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832

Dear Attorney Matthews:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter pursuant to Connecticut General Statutes § 4-180. On February 6, 2014, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:pf

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **Tolland Imaging Center, Inc.**
6 Fieldstone Commons, Tolland, CT 06084

Docket Number: **13-31833-CON**

Project Title: **Continued Operation of Tolland Imaging Center, Inc.**

Project Description: Tolland Imaging Center, Inc. ("Applicant" or "Tolland Imaging Center") proposes to continue delivery of comprehensive imaging services including Magnetic Resonance Imaging ("MRI") and Computed Tomography ("CT") scanning services, with an associated cost of $1,300,000.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in The Hartford Courant on March 4, 5, and 6, 2013. On April 1, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project. On August 7, 2013, OHCA deemed the application complete.

On September 26, 2013, the Applicant was notified of the date, time, and place of the public hearing. On September 26, 2013, a notice to the public announcing the hearing was published in The Hartford Courant. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on October 23, 2013.

Commissioner Jewel Mullen designated Attorney Kevin Hansted as the hearing officer for the public hearing. The public hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(f). The public hearing record was closed on October 23, 2013. Thereafter, Deputy Commissioner Davis considered the entire record in this matter and rendered this decision. To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

Findings of Fact and Conclusions of Law

1. On September 18, 2007, OHCA granted approval (DN: 06-30841-CON), as a three year demonstration project, for the establishment of Tolland Imaging Center, a joint venture between Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital. Exhibit A, p. 7.

2. Tolland Imaging Center became operational on September 2, 2008. Exhibit A, p. 7.

3. The Applicant is requesting authorization to continue the delivery of comprehensive imaging services, including the continued provision of MRI and CT scanning services. Exhibit A, p. 7.

4. Tolland Imaging Center is currently equipped with a Hitachi Altaire 0.7 Tesla High Field Open MRI and a Siemens Sensation 4, 4-Slice CT Scanner. Exhibit A, p. 8.

5. Tolland Imaging Center offers the following complement of modalities: MRI, CT, mammography, bone density, radiography and ultrasound services. Exhibit A, p. 7.

6. Tolland Imaging Center's service area includes Coventry, Ellington, Mansfield, Stafford, Tolland, Union, Vernon and Willington. Exhibit A, p. 11.

7. Tolland Imaging Center has established solid referral patterns with health care providers in its service area. Exhibit A, p. 15.

8. The number of patients referred to Tolland Imaging Center for MRI and CT scans, as well as overall patient volume, has increased steadily since FY 2008, serving nearly ten thousand patients in FY 2012.

Table 1: Patients referred to the Center, FY 2008-FY 2012

	Number of Patients				
	FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**
CT	6	390	654	689	751
MRI	18	838	1,299	1,633	1,639
All Modalities*	152	5,735	8,086	8,686	9,761

*Includes patient referrals for all services offered at Tolland Imaging Center.
**FY 2008 includes only one month of operation.
Exhibit A, p. 9.

9. Tolland Imaging Center performed more than 11,000 imaging procedures in FY 2013, a 12.7% increase from FY 2010.

Table 2: Historical Utilization by Equipment Type

Procedure Volume	Historical Volume[1]				
	FY 2010	FY 2011	FY 2012	FY 2013	% Change FY 2010-13
Bone Density	385	419	462	470	22.1%
CT[2]	949	699	805	740	na[3]
Mammography	1,395	1,638	2,104	2,170	55.6%
MRI	1,403	1,745	1,724	1,653	17.8%
Ultrasound	2,480	2,219	2,571	2,394	-3.5%
X-Ray	3,356	3,502	3,795	3,810	13.5%
Total	**9,968**	**10,222**	**11,461**	**11,237**	**12.7%**

[1] Applicant's fiscal year: October 1 through September 30.
[2] Effective 1/1/2011 CPT coding change eliminated separate billing and CPT codes for all abdomen and pelvis CT exams performed on the same day.
[3] Percentage change omitted – significant CPT coding changes reduced volumes in FY 2011-13. The resulting percent change from FY10-13 would overstate the drop in volume.
Exhibit A, p. 17, Exhibit M, pp. 388-389.

10. The future demand for imaging services is projected to be similar to FY 2013's historical volumes and remain constant over the next three years.

Table 3: Projected Utilization by Equipment Type

Procedure Volume	Projected Volume*		
	FY 2014	FY 2015	FY 2016
Bone Density	470	470	470
CT	740	740	740
Mammography	2,170	2,170	2,170
MRI	1,653	1,653	1,653
Ultrasound	2,394	2,394	2,394
X-Ray	3,810	3,810	3,810
Total	**11,237**	**11,237**	**11,237**

*Projected volume for FY 2014, FY 2015, and FY 2016 assumes 0% growth based on FY 2013 volumes.
Exhibit M, pp. 388-389.

11. From FY 2012 to FY 2013, Tolland Imaging Center only experienced a 2% loss in volume, compared to a double-digit drop for statewide ambulatory services and outpatient imaging. Hearing Transcript, p. 21, Ethan B. Foxman, M.D., President and Chief Executive Officer, Jefferson Radiology, P.C.

12. Tolland Imaging Center's long-term financial viability is dependent upon its ability to continue offering the full spectrum of imaging services; removing MRI and/or CT capabilities would threaten the provider referral network that generates volume for all imaging services at Tolland Imaging Center. Exhibit A, p. 7.

13. Tolland Imaging Center's profits and losses are allocated at the end of each fiscal year among the owners in accordance with their respective membership interest. Owner members are identified in the table below:

Table 4: Ownership of Tolland Imaging Center, LLC

Member	% Owned
Johnson Memorial Hospital, Inc.	15%
Windham Community Memorial Hospital, Inc.	15%
Manchester Memorial Hospital, Inc.	35%
Rockville General Hospital, Inc.	35%
Total Ownership Percentage	**100%**

Exhibit A, p. 32.

14. Tolland Imaging Center is the only freestanding imaging center in northeastern Connecticut and has helped to eliminate any geographic or logistical barriers to services that would occur absent its existence. Exhibit A, p. 10.

15. There are only two other providers of imaging services in the Applicant's service area, Johnson Memorial Hospital and Rockville General Hospital; both of which are hospitals that have an owner membership interest in Tolland Imaging Center. Exhibit A, p. 11.

16. Due to billing differences, different fee schedules and lower overhead, the charge for an MRI or CT scan at Tolland Imaging Center is lower than a comparable scan performed at a hospital. Hearing Transcript, pp. 22-23, Daniel J. DelGallo, Executive Director of Tolland Imaging Center and Administrative Director of Medical Imaging at Eastern Connecticut Health Network, Inc. ("ECHN").

17. The establishment of Tolland Imaging Center has improved the quality of health care delivery in the region by facilitating collaboration between three independent hospital systems; Johnson Memorial Hospital, Eastern Connecticut Health network (comprised of Manchester Memorial Hospital and Rockville General Hospital), and Windham Community Memorial Hospital. Exhibit A, p. 22.

18. The expenditures in Table 6 represent the expenses that would continue to be incurred by Tolland Imaging Center ownership members in the event Tolland Imaging Center ceased operation.

Table 5: Total Capital Expenditure

Description	Cost
Medical Equipment Purchase	$166
Imaging Equipment Purchase	$10,410
Non-Medical Equipment Purchase	$9,037
Construction/Renovation	$350,735
Total Capital Expenditure	**$370,348**
Imaging Equipment Lease (Fair Market Value)	$470,517
Fair Market Value of Space	$403,552
Total Capital Cost	**$874,069**
Total Project Cost	**$1,244,417**
Capitalized Financing Costs (Informational Purpose Only)	$726
Total Capital Expenditure with Cap. Fin. Costs	$1,245,144

Exhibit A, pp. 24-25.

19. Tolland Imaging Center has been financially viable for the last two years; positive net income was recorded in both FY 2012 and FY 2013. Net income is expected to grow incrementally over the next few years and will benefit from the September 2013 expiration of two capital leases. Hearing Transcript, p. 9, Daniel J. DelGallo, Executive Director of Tolland Imaging Center and Administrative Director of Medical Imaging at ECHN.

20. The MRI and CT services provided by Tolland Imaging Center account for approximately 60% of its total revenue. Hearing Transcript, p. 10, Daniel J. DelGallo, Executive Director of Tolland Imaging Center and Administrative Director of Medical Imaging at ECHN.

21. Tolland Imaging Center will still be responsible for depreciation and lease costs of $1.3 million, through 2016, for both MRI and CT, even if it ceases operation. Hearing Transcript, p. 10, Daniel J. DelGallo, Executive Director of Tolland Imaging Center and Administrative Director of Medical Imaging at ECHN.

22. The Applicant projects incremental gains from operations as follows:

Table 6: Incremental Gain/(Loss) from Operations

	FY 2014	FY 2015	FY 2016
Revenue from Operations	$2,141,150	$2,175,408	$2,210,215
Total Operating Expenses*	$1,224,036	$1,673,181	$1,477,286
Gain/(Loss) from Operations	**$917,114**	**$502,227**	**$732,929**

*Operating expenses include salaries and fringe benefits, contracted services, supplies and drugs, bad debt, interest and lease expenses required to operate the Center and support the forecasted volumes. Exhibit J, p. 363.

23. Tolland Imaging Center's current payer mix, based on Net Patient Revenue, is as follows:

Table 7: Tolland Imaging Center's Current Payer Mix

Description	Facility	CT	MRI
Medicare*	21.6%	30.5%	19.9%
Medicaid*	6.9%	6.3%	6.4%
CHAMPUS &TriCare	0.9%	0.9%	1.0%
Other Government	0.1%	0.1%	0.1%
Total Government	**29.6%**	**37.8%**	**27.4%**
Commercial Insurers*	67.9%	59.5%	64.7%
Uninsured	1.9%	2.3%	7.8%
Workers Compensation	0.6%	0.4%	0.1%
Total Non-Government	**70.4%**	**62.2%**	**72.6%**
Total Payer Mix	**100%**	**100%**	**100%**

*Includes managed care activity.
Exhibit A, p. 27.

24. The projected patient population mix for FY 2014, FY 2015 and FY 2016 will remain the same. Tolland Imaging Center does not anticipate any changes in operations or the population it serves. Exhibit A, p. 27.

25. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

26. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).

27. The Applicant has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

28. The Applicant has satisfactorily demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

29. The Applicant has satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region and potentially improve quality in the region by facilitating collaboration between three independent hospital systems. (Conn. Gen. Stat. § 19a-639(a)(5)).

30. The Applicant has shown that there would be no change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6)).

31. The Applicant has satisfactorily identified the population to be served and has satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7)).

32. The historical utilization of overall imaging services in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

33. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

On September 18, 2007, OHCA granted approval (DN: 06-30841-CON) for the establishment and operation of a full-service imaging center in Tolland as a three-year demonstration project. The facility, Tolland Imaging Center, is a joint venture between Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital and Windham Community Memorial Hospital. *FF1.* Since 2008, Tolland Imaging Center has been providing MRI, CT, mammography, bone density, radiography, and ultrasound services. *FF2&5.* The Applicant is seeking authorization to continue the delivery of comprehensive imaging services at Tolland Imaging Center, including the continued provision of MRI and CT scanning services. *FF3.*

Tolland Imaging Center's service area consists of the towns of Coventry, Ellington, Mansfield, Stafford, Tolland, Union, Vernon and Willington. *FF6.* Tolland Imaging Center has established solid referral patterns with health care providers in its service area. *FF7.* It has a strong referral base of over 1,000 physicians; 69 of these physicians provide consistent referrals within a given year. *Hearing Transcript, p. 8, Daniel J. DelGallo.* The number of patients referred for MRI and CT, as well as overall patient volume at Tolland Imaging Center, has increased steadily from FY 2008 to FY 2012, serving nearly ten thousand patients and providing more than 11,000 imaging procedures in FY 2013. *FF8&9.* The Applicant provides comprehensive services for many sub-specialty groups (e.g., obstetrics, orthopedics, and family practice) located in its service area. *Hearing Transcript, p. 8, Daniel J. DelGallo.* Tolland Imaging Center also serves the imaging needs of Med-East Medical Walk-In Center, an urgent care facility located in close proximity to Tolland Imaging Center. *Hearing Transcript, p. 8, Daniel J. DelGallo.*

The establishment of Tolland Imaging Center has improved the quality of health care delivery in the region by facilitating collaboration between three independent hospital systems; Johnson Memorial Hospital, Eastern Connecticut Health network (comprised of Manchester Memorial Hospital and Rockville General Hospital), and Windham Community Memorial Hospital. *FF17.*

Tolland Imaging Center is the only freestanding imaging center in northeastern Connecticut; it has helped to eliminate any geographic or logistical barriers to services that would occur absent its existence. *FF14.* While there are two other providers of imaging services in Tolland Imaging Center's service area, Johnson Memorial Hospital and Rockville General Hospital, Tolland Imaging Center provides an added benefit to the community it serves since it can provide MRI and CT scanning services at a lower cost than a comparable scan at a hospital. This is due to billing differences, different fee schedules and lower overhead than a hospital. *FF15&16.* Based upon the amount of patients served and the lower cost of the services provided, it is clear that Tolland Imaging Center serves an important role within its service area. Additionally, since the two hospitals in the service area have an ownership interest in Tolland Imaging Center, approval

of this proposal will not have an adverse impact on either hospital. Therefore, the Applicant has satisfactorily demonstrated that its proposal satisfies a clear public need without an unnecessary duplication of services or negative financial impact upon other providers in the service area.

The long-term financial viability of Tolland Imaging Center is dependent upon its continued ability to provide the full spectrum of imaging services, including MRI and CT, which account for 60% of its total revenue. As a result, removing MRI and/or CT capabilities would threaten the provider referral network that generates volume for all imaging services at Tolland Imaging Center and may ultimately lead to the closure of the facility. *FF12&20.* Furthermore, Tolland Imaging Center, and indirectly its hospital owner members, incurred certain financial obligations in the amount of $1.3 million in order to establish its operations, and will still be responsible for those liabilities even if the facility ceases operations. *FF13,18&21.* The result would be a financial detriment to the owner hospitals without the opportunity to recoup the funds through the continued operation of Tolland Imaging Center.

Tolland Imaging Center recorded positive net income in both FY 2012 and FY 2013. *FF19.* With approval of the project, the Applicant projects operational incremental gains of $917,114 in FY 2014, $502,227 in FY 2015 and $732,929 in FY 2016. *FF22.* With no associated capital expenditures, and projected volumes that appear reasonable and achievable, OHCA concludes that the Applicant's proposal is financially feasible.

Order

Based upon the foregoing Findings of Fact and Discussion, the Certificate of Need application of Tolland Imaging Center, Inc. to continue delivery of comprehensive imaging services including MRI and CT services, is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

2/6/14
Date

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

* * * COMMUNICATION RESULT REPORT (FEB. 7. 2014 11:34AM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 7. 2014 11:32AM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
060 MEMORY TX		912037822889	OK	12/12

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

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

FAX SHEET

TO: REBECCA A. MATTHEWS

FAX: 12037822889

AGENCY: WIGGIN AND DANA, LLP

FROM: PAOLO FIDUCIA

DATE: 02/07/2014 **Time:** 11:30 am

NUMBER OF PAGES: 12
(including transmittal sheet

Comments:
13-31833-
CON Final
Decision

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

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