

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

2011

Department of the Treasury
Internal Revenue Service

Open to Public
Inspection

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

A For the **2011** calendar year, or tax year beginning **10/01, 2011**, and ending **09/30, 2012**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization THE WILLIAM W. BACKUS HOSPITAL		D Employer identification number 06-0250773
	Doing Business As		E Telephone number (860) 889-8331
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	G Gross receipts \$ 314,928,667.
	326 WASHINGTON STREET		
City or town, state or country, and ZIP + 4 NORWICH, CT 06360		H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
F Name and address of principal officer: DAVID WHITEHEAD 326 WASHINGTON STREET NORWICH, CT 06360		H(c) Group exemption number ▶	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)() (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website: ▶ WWW.BACKUSHOSPITAL.ORG			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1891 M State of legal domicile: CT	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: BACKUS HOSPITAL DELIVERS AND COORDINATES A CONTINUUM OF HIGH-QUALITY HEALTHCARE THAT IS SENSITIVE TO THE NEEDS OF INDIVIDUALS IN EASTERN CONNECTICUT.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	14.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	9.
	5 Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	2,063.
	6 Total number of volunteers (estimate if necessary)	6	484.
	7a Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	2,161,879.
b Net unrelated business taxable income from Form 990-T, line 34	7b	69,663.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	1,296,004.	1,179,014.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	271,933,218.	285,997,171.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,938,478.	4,525,194.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,609,862.	1,628,784.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	280,777,562.	293,330,163.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	692,681.	752,684.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0	0
	16a Professional fundraising fees (Part IX, column (A), line 11e)	135,892,894.	146,148,497.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶ 325,071.	0	0
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	113,381,675.	115,188,670.
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	249,967,250.	262,089,851.
19 Revenue less expenses. Subtract line 18 from line 12	30,810,312.	31,240,312.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	358,349,465.	393,284,501.
	22 Net assets or fund balances. Subtract line 21 from line 20	195,793,905.	195,088,980.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer	Date		
	Type or print name and title			
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Check if self-employed <input type="checkbox"/>	PTIN
	Firm's name ▶ BKD, LLP		AUG 06 2012	P00788429
	Firm's address ▶ 1201 WALNUT, SUITE 1700 KANSAS CITY, MO 64106-2246		EIN ▶ 44-0160260	Phone no. ▶ 816 221-6300

May the IRS discuss this return with the preparer shown above? (see instructions) Yes No

For Paperwork Reduction Act Notice, see the separate instructions.

- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box **X**.
- Note.** Only complete **Part II** if you have already been granted an automatic 3-month extension on a previously filed Form 8868.
- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print <small>File by the due date for filing your return. See instructions.</small>	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	THE WILLIAM W. BACKUS HOSPITAL	<input checked="" type="checkbox"/> 06-0250773
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	326 WASHINGTON STREET	<input type="checkbox"/>
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	NORWICH, CT 06360	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990	01		
Form 990-BL	02	Form 1041-A	08
Form 990-EZ	01	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

• The books are in the care of DANIEL E. LOHR
Telephone No. 860 889-8331 FAX No.

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____ . If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until 08/15, 20 13.

5 For calendar year _____, or other tax year beginning 10/01, 20 11, and ending 09/30, 20 12.

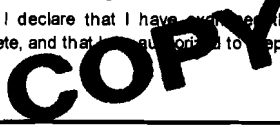
6 If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period

7 State in detail why you need the extension ADDITIONAL TIME IS REQUIRED TO ACCUMULATE THE INFORMATION NECESSARY TO FILE A COMPLETE AND ACCURATE RETURN.

8a If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a \$
8b If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b \$
8c Balance Due. Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c \$

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have prepared this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.



Signature _____ Title _____ Date _____

Application for Extension of Time To File an Exempt Organization Return

► **File a separate application for each return.**

- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** and check this box
- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868.

Electronic filing (e-file). You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit www.irs.gov/efile and click on *e-file for Charities & Nonprofits*.

Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension - check this box and complete

Part I only

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions. THE WILLIAM W. BACKUS HOSPITAL	Employer identification number (EIN) or <input checked="" type="checkbox"/> 06-0250773
	Number, street, and room or suite no. If a P.O. box, see instructions. 326 WASHINGTON STREET	Social security number (SSN) <input type="checkbox"/>
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. NORWICH, CT 06360	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 990-EZ	01	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ► DANIEL E. LOHR

Telephone No. ► 860 889-8331 FAX No. ►

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) . If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 05/15, 2013, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

► calendar year 20__ or

► tax year beginning 10/01, 2011, and ending 09/30, 2012.

2 If the tax year entered in line 1 is for less than 12 months, check reason: Initial return Final return Change in accounting period

3a If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a \$
b If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	3b \$
c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c \$

Caution. If you are going to make an electronic fund withdrawal with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III

1 Briefly describe the organization's mission:

SEE SCHEDULE O

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 210,491,948. including grants of \$ 752,684.) (Revenue \$ 287,011,997.)

IN FISCAL YEAR 2011, BACKUS HOSPITAL HAD 10,974 ADMISSIONS, 68,102 EMERGENCY DEPARTMENT VISITS, AND 440,605 OUTPATIENT VISITS. THE HOSPITAL DELIVERED 919 BABIES AND 6,968 SAME DAY SURGICAL PROCEDURES. BACKUS PERFORMED 122,132 OUTPATIENT IMAGING EXAMS, 7,707 MRI EXAMINATIONS, 9,443 PSYCHIATRIC CLINICAL VISITS, AND 7,914 PSYCHIATRIC PARTIAL HOSPITAL VISITS.

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4d Other program services (Describe in Schedule O.)

(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses ► 210,491,948.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>		X
c Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>		X
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>		X
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>		X
12 a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI, XII, and XIII</i>	X	
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14 a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I (see instructions)</i>		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20 a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	

Part IV Checklist of Required Schedules (continued)

		Yes	No
21	Did the organization report more than \$5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II.</i>	X	
22	Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III.</i>	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J.</i>	X	
24 a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25.</i>	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25 a	Section 501(c)(3) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I.</i>		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I.</i>		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? <i>If "Yes," complete Schedule L, Part II.</i>		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III.</i>		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>		X
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV.</i>	X	
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M.</i>		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M.</i>		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I.</i>		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II.</i>		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I.</i>		X
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1.</i>	X	
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	X	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2.</i>		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI.</i>		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? Note. All Form 990 filers are required to complete Schedule O.	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V. []

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding Form 1096, Form W-2G, backup withholding, Form W-3, federal employment tax returns, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, annual gross receipts, deductible contributions, and Form 990 filings.

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response to any question in this Part VI. [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include questions 1a, 1b, 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9 regarding governing body members and relationships.

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

Table with 3 columns: Question, Yes, No. Rows include questions 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b regarding organizational policies.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection.
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization.

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response to any question in this Part VII X

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
ATTACHMENT 1										
(1) DAVID WHITEHEAD TRUSTEE/PRESIDENT/CEO	40.00	X	X					762,221.	0	43,852.
(2) ROBERT RAMSDALL TRUSTEE/TREASURER	6.00	X	X					0	0	0
(3) JOSEPH FATONE TRUSTEE/SECRETARY	6.00	X	X					0	0	0
(4) ANTHONY JOYCE TRUSTEE/VICE CHAIRMAN	6.00	X	X					0	0	0
(5) JOHN F BILDA TRUSTEE	2.00	X						0	0	0
(6) ELIZABETH CONWAY TRUSTEE	2.00	X						0	0	0
(7) BERT A COPPOTELLI, MD TRUSTEE	2.00	X						0	0	0
(8) PETER MANERI TRUSTEE	2.00	X						0	0	0
(9) DEBORAH MONAHAN TRUSTEE	2.00	X						0	0	0
(10) LYNNE QUINTAL-HILL TRUSTEE	2.00	X						0	0	0
(11) MARK TRAMONTOZZI, MD TRUSTEE	12.25	X						53,700.	0	0
(12) STEPHEN T BRIGGS, MD TRUSTEE	2.00	X						0	0	0
(13) PAUL MAXFIELD TRUSTEE	2.00	X						0	0	0
(14) DONNA ROMITO, DO TRUSTEE	2.00	X						0	0	0

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
15) DANIEL E LOHR SENIOR VP/CFO	40.00			X			514,728.	0	37,462.	
16) PETER SHEA SENIOR VP/MEDICAL DIRECTOR	40.00				X		492,797.	0	36,733.	
17) SERGIO CASILLAS, MD PHYSICIAN	40.00					X	496,355.	0	14,287.	
18) ROBERT SIDMAN, MD PHYSICIAN	40.00					X	409,425.	0	36,502.	
19) MARK TOUSIGNANT, MD PHYSICIAN	40.00					X	335,264.	0	36,733.	
20) JUAN ESCALON, MD PHYSICIAN	40.00					X	346,171.	0	36,733.	
21) WILLIAM HORGAN, MD PHYSICIAN	40.00					X	322,581.	0	33,135.	
22) THOMAS P PIPICELLI FORMER PRESIDENT	0					X	3,777,778.	0	37,462.	
1b Sub-total							815,921.	0	43,852.	
c Total from continuation sheets to Part VII, Section A							6,695,099.	0	269,047.	
d Total (add lines 1b and 1c)							7,511,020.	0	312,899.	

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **139**

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
EXECUTIVE HEALTH RESOURCES PHILADELPHIA, PA 19182	CONSULTING	799,847.
ALLIANCE HEALTHCARE SERVICES CHICAGO, IL 60693	MEDICAL SERVICES	3,204,696.
HURON CONSULTING GROUP CHICAGO, IL 60689	CONSULTING	3,308,146.
YALE NH HOSPITAL NEW HAVEN, CT 06504	MEDICAL SERVICES	2,255,899.
NAVIN, HAFTY & ASSOCIATES WESTBOROUGH, MA 01581	CONSULTING	571,116.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **35**

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	95,705.				
	d Related organizations	1d	3,225.				
	e Government grants (contributions)	1e	614,920.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	465,164.				
	g Noncash contributions included in lines 1a-1f: \$		3,179.				
	h Total. Add lines 1a-1f		1,179,014.				
Program Service Revenue	2a INPATIENT	Business Code 900099	126,151,493.	126,151,493.			
	b OUTPATIENT	900099	108,882,771.	108,882,771.			
	c EMERGENCY DEPARTMENT	900099	45,998,119.	45,998,119.			
	d LAB COURIER SERVICE	621500	2,187,372.		2,187,372.		
	e E.H.R. REVENUE	722320	2,777,416.	2,777,416.			
	f All other program service revenue						
	g Total. Add lines 2a-2f		285,997,171.				
	Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		3,731,395.			3,731,395.
4 Income from investment of tax-exempt bond proceeds			0				
5 Royalties			0				
6a Gross rents		(i) Real	1,025,860.				
		(ii) Personal					
		b Less: rental expenses	2,126,333.				
		c Rental income or (loss)	-1,100,473.				
d Net rental income or (loss)			-1,100,473.		-50,079.	-1,050,394.	
7a Gross amount from sales of assets other than inventory		(i) Securities	19,678,400.				
		(ii) Other	184,772.				
		b Less: cost or other basis and sales expenses	18,855,065.	214,308.			
		c Gain or (loss)	823,335.	-29,536.			
d Net gain or (loss)			793,799.			793,799.	
8a Gross income from fundraising events (not including \$ 95,705. of contributions reported on line 1c). See Part IV, line 18		a	32,160.				
		b Less: direct expenses	49,496.				
		c Net income or (loss) from fundraising events		-17,336.			-17,336.
9a Gross income from gaming activities. See Part IV, line 19		a					
		b Less: direct expenses					
	c Net income or (loss) from gaming activities		0				
10a Gross sales of inventory, less returns and allowances	a	469,919.					
	b Less: cost of goods sold	353,302.					
	c Net income or (loss) from sales of inventory		116,617.			116,617.	
Miscellaneous Revenue		Business Code					
11a CAFETERIA		624410	1,166,526.			1,166,526.	
	b CHILD CARE	900099	398,545.			398,545.	
	c OTHER MISC REVENUE	900099	1,064,905.	1,040,319.	24,586.		
	d All other revenue						
e Total. Add lines 11a-11d			2,629,976.				
12 Total revenue. See instructions			293,330,163.	284,850,118.	2,161,879.	5,139,152.	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Check if Schedule O contains a response to any question in this Part IX

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	740,184.	740,184.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	12,500.	12,500.		
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	5,580,387.	587,917.	4,992,470.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	108,559,950.	97,665,139.	10,798,732.	96,079.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	9,850,231.	8,865,208.	985,023.	
9 Other employee benefits	13,862,551.	12,476,296.	1,386,255.	
10 Payroll taxes	8,295,378.	7,465,840.	829,538.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	2,167,582.		2,167,582.	
c Accounting	415,616.		415,616.	
d Lobbying	51,213.		51,213.	
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	132,898.		132,898.	
g Other	20,320,485.	15,235,141.	5,084,844.	500.
12 Advertising and promotion	188,256.	166,829.		21,427.
13 Office expenses	6,060,614.	4,152,449.	1,905,902.	2,263.
14 Information technology	3,398,561.	353,216.	3,045,345.	
15 Royalties	0			
16 Occupancy	5,578,019.	553,635.	5,024,384.	
17 Travel	255,725.	108,125.	147,600.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	31,175.	5,560.	25,560.	55.
20 Interest	3,008,114.		3,008,114.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	16,954,609.	8,344,451.	8,610,158.	
23 Insurance	1,720,586.	1,295,901.	424,685.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>MEDICAL SUPPLIES</u>	34,428,304.	34,428,304.		
b <u>BAD DEBT</u>	7,950,269.	7,949,694.	575.	
c <u>MAINTENANCE/SERVICE CONTRACT</u>	5,345,541.	3,840,244.	1,505,297.	
d <u>LAB EXPENSES</u>	4,338,527.	4,338,527.		
e All other expenses	2,842,576.	1,906,788.	731,041.	204,747.
25 Total functional expenses. Add lines 1 through 24e	262,089,851.	210,491,948.	51,272,832.	325,071.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	2,802,148.	1	3,816,199.
	2 Savings and temporary cash investments	90,659,933.	2	103,907,072.
	3 Pledges and grants receivable, net	101,211.	3	31,723.
	4 Accounts receivable, net	32,373,122.	4	32,015,340.
	5 Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6 Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)	0	6	0
	7 Notes and loans receivable, net	100,023.	7	74,517.
	8 Inventories for sale or use	3,757,730.	8	3,602,936.
	9 Prepaid expenses and deferred charges	4,493,355.	9	5,066,915.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 240,354,654.		
	b Less: accumulated depreciation	10b 149,000,168.		
		89,983,664.	10c	91,354,486.
	11 Investments - publicly traded securities	133,516,829.	11	147,043,829.
	12 Investments - other securities. See Part IV, line 11	12,632.	12	12,632.
	13 Investments - program-related. See Part IV, line 11	0	13	0
	14 Intangible assets	0	14	0
15 Other assets. See Part IV, line 11	548,818.	15	6,358,852.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	358,349,465.	16	393,284,501.	
Liabilities	17 Accounts payable and accrued expenses	22,318,404.	17	23,583,670.
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	61,230,000.	20	59,265,000.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22 Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	1,183,176.	23	1,126,557.
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	111,062,325.	25	111,113,753.
	26 Total liabilities. Add lines 17 through 25	195,793,905.	26	195,088,980.
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	153,706,889.	27	187,548,862.
	28 Temporarily restricted net assets	1,399,547.	28	2,890,743.
	29 Permanently restricted net assets	7,449,124.	29	7,755,916.
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	162,555,560.	33	198,195,521.
34 Total liabilities and net assets/fund balances.	358,349,465.	34	393,284,501.	

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	293,330,163.
2	Total expenses (must equal Part IX, column (A), line 25)	2	262,089,851.
3	Revenue less expenses. Subtract line 2 from line 1	3	31,240,312.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	162,555,560.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	4,399,649.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	198,195,521.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
b	Were the organization's financial statements audited by an independent accountant?	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input checked="" type="checkbox"/> Both consolidated and separate basis		
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2011

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 10 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3)**. Check the box that describes the type of supporting organization and complete lines 11e through 11h.
 - a Type I b Type II c Type III - Functionally integrated d Type III - Other
- e By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
- f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
 - (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		
 - (ii) A family member of a person described in (i) above?
 - (iii) A 35% controlled entity of a person described in (i) or (ii) above?
- h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
Total									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2011

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Table with 7 columns: (a) 2007, (b) 2008, (c) 2009, (d) 2010, (e) 2011, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f); 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2007, (b) 2008, (c) 2009, (d) 2010, (e) 2011, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities, whether or not the business is regularly carried on; 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.); 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Description, Percentage. Rows include: 14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2010 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2011; 16b 33 1/3% support test - 2010; 17a 10%-facts-and-circumstances test - 2011; 17b 10%-facts-and-circumstances test - 2010; 18 Private foundation.

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2011 (line 8, column (f) divided by line 13, column (f)).	15	%
16 Public support percentage from 2010 Schedule A, Part III, line 15.	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2011 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2010 Schedule A, Part III, line 17	18	%

- 19a 33 1/3% support tests - 2011.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶
- b 33 1/3% support tests - 2010.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶
- 20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶

Part IV **Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.

2011

Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
---	---

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of \$5,000 or more during the year ▶ \$ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on Part I, line 2, of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization THE WILLIAM W. BACKUS HOSPITAL

Employer identification number
06-0250773

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	----- ----- -----	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

Part III Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ \$ _____

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

For Organizations Exempt From Income Tax Under section 501(c) and section 527
 ▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.
 ▶ See separate instructions.

2011

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

If the organization answered "Yes" to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
---	---

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures ▶ \$ _____
- 3 Volunteer hours _____

Part I-B Complete if the organization is exempt under section 501(c)(3).

- 1 Enter the amount of any excise tax incurred by the organization under section 4955. ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file Form 1120-POL for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)	-----			
(2)	-----			
(3)	-----			
(4)	-----			
(5)	-----			
(6)	-----			

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2011

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

- A Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
1 a Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b Total lobbying expenditures to influence a legislative body (direct lobbying)														
c Total lobbying expenditures (add lines 1a and 1b)														
d Other exempt purpose expenditures														
e Total exempt purpose expenditures (add lines 1c and 1d)														
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">If the amount on line 1e, column (a) or (b) is:</td> <td style="width: 50%;">The lobbying nontaxable amount is:</td> </tr> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) Total
2 a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

Table with columns (a) Yes/No and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation... 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

Table with columns Yes/No. Rows include: 1 Were substantially all (90% or more) dues received nondeductible by members? 2 Did the organization make only in-house lobbying expenditures of \$2,000 or less? 3 Did the organization agree to carry over lobbying and political expenditures from the prior year?

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

Table with columns 1-5. Rows include: 1 Dues, assessments and similar amounts from members 2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid). 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues

Part IV Supplemental Information

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A; and Part II-B, line 1. Also, complete this part for any additional information.

Part IV Supplemental Information *(continued)*

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2011

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

Attach to Form 990. See separate instructions.

Name of the organization

THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: Total number at end of year, Aggregate contributions to (during year), Aggregate grants from (during year), Aggregate value at end of year, and two questions about donor advisement with Yes/No checkboxes.

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

Form for Conservation Easements. Includes checkboxes for purposes (land for public use, natural habitat, open space, historically important area, certified historic structure), a table for 2a-2d (Total number, acreage, certified historic structures, acquired after 8/17/06), and questions 3-9 regarding monitoring, expenses, and reporting.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

Form for Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Includes questions 1a, 1b, 2, and 3 regarding reporting requirements and amounts for art and historical treasures.

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule D (Form 990) 2011

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIV and complete the following table:
- | | Amount |
|---|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21? Yes No
- b If "Yes," explain the arrangement in Part XIV.

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	5,396,859.	5,320,786.	4,841,631.	3,871,631.	
b Contributions		5,000.	358,064.	970,000.	
c Net investment earnings, gains, and losses	5,226.	76,505.	505,259.	142,089.	
d Grants or scholarships					
e Other expenditures for facilities and programs			378,271.	135,254.	
f Administrative expenses	5,226.	5,432.	5,897.	6,835.	
g End of year balance	5,396,859.	5,396,859.	5,320,786.	4,841,631.	

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment ▶ _____ %
 - b Permanent endowment ▶ 100.0000 %
 - c Temporarily restricted endowment ▶ _____ %
- The percentages in lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) unrelated organizations | 3a(i) | X |
| (ii) related organizations | 3a(ii) | X |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4 Describe in Part XIV the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		2,229,795.		2,229,795.
b Buildings	10,381,267.	46,448,280.	33,861,382.	22,968,165.
c Leasehold improvements		80,846,314.	45,668,172.	35,178,142.
d Equipment		98,659,140.	69,428,410.	29,230,730.
e Other		1,747,654.		1,747,654.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				91,354,486.

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A) _____		
(B) _____		
(C) _____		
(D) _____		
(E) _____		
(F) _____		
(G) _____		
(H) _____		
(I) _____		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)		

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) _____		
(2) _____		
(3) _____		
(4) _____		
(5) _____		
(6) _____		
(7) _____		
(8) _____		
(9) _____		
(10) _____		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.)		

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) _____	
(2) _____	
(3) _____	
(4) _____	
(5) _____	
(6) _____	
(7) _____	
(8) _____	
(9) _____	
(10) _____	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) TAX EXEMPT BOND PREMIUM, NET	667,276.
(3) DUE TO 3RD PARTIES	18,193,420.
(4) EMPLOYEE RELATED OBLIGATIONS	75,571,071.
(5) SELF-INSURED PROF LIABILITY	9,685,357.
(6) CAPITAL LEASE OBLIGATIONS	6,344,367.
(7) OTHER LIABILITIES	652,262.
(8) _____	
(9) _____	
(10) _____	
(11) _____	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	111,113,753.

2. FIN 48 (ASC 740) Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740).

Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	293,330,163.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	262,089,851.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	31,240,312.
4	Net unrealized gains (losses) on investments	4	10,067,106.
5	Donated services and use of facilities	5	
6	Investment expenses	6	-365,321.
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-5,302,136.
9	Total adjustments (net). Add lines 4 through 8	9	4,399,649.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	35,639,961.

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements	1	305,112,306.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	10,067,106.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	
e	Add lines 2a through 2d	2e	10,067,106.
3	Subtract line 2e from line 1	3	295,045,200.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	365,321.
b	Other (Describe in Part XIV.)	4b	-2,080,358.
c	Add lines 4a and 4b	4c	-1,715,037.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	293,330,163.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements	1	264,141,267.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIV.)	2d	2,205,365.
e	Add lines 2a through 2d	2e	2,205,365.
3	Subtract line 2e from line 1	3	261,935,902.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV.)	4b	153,949.
c	Add lines 4a and 4b	4c	153,949.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5	262,089,851.

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIV Supplemental Information (continued)

ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

THE PERMANENTLY RESTRICTED ENDOWMENT FUNDS ARE MEANT TO PROVIDE LONG-TERM SUPPORT FOR CAPITAL AND OPERATING PROGRAMS FOR THE HOSPITAL IN ACCORDANCE WITH THE DONOR'S WISHES.

UNCERTAIN TAX POSITIONS DISCLOSURE

SCHEDULE D, PART X, LINE 2

ASC 740-10, UNCERTAIN TAX POSITIONS, PRESCRIBES A RECOGNITION THRESHOLD AND MEASUREMENT ATTRIBUTE FOR THE FINANCIAL STATEMENT RECOGNITION AND MEASUREMENT OF A TAX POSITION TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. THIS INTERPRETATION ALSO PROVIDES GUIDANCE ON DERECOGNITION, CLASSIFICATION, INTEREST AND PENALTIES, ACCOUNTING IN INTERIM PERIODS, AND DISCLOSURE REQUIREMENTS FOR UNCERTAIN TAX POSITIONS. MANAGEMENT HAS EVALUATED THE IMPLICATIONS OF ASC 740-10 AND DETERMINED THAT ITS IMPACT ON THE FINANCIAL STATEMENTS IS NOT SIGNIFICANT.

RECONCILIATION OF CHANGE IN NET ASSETS

SCHEDULE D, PART XI, LINE 8

K-1 LOSS	892
TRANSFER TO AFFILIATES	(1,248,123)
INCREASE IN NET ASSETS HELD IN TRUST	306,792
CHANGE IN PENSION FUNDING	(4,361,697)

TOTAL	\$ (5,302,136)

Part XIV Supplemental Information (continued)

RECONCILIATION OF REVENUE- OTHER ADJUSTMENTS

SCHEDULE D, PART XII, LINE 2D

RECONCILIATION OF REVENUES- OTHER ADJUSTMENTS

SCHEDULE D, PART XII, LINE 4B

AUXILIARY INCOME	125,899
K-1 LOSS	(892)
LOSS ON FIXED ASSETS	(29,536)
RENTAL EXPENSE	(2,126,333)
TEMPORARILY RESTRICTED INCOME	(49,496)

TOTAL	\$ (2,080,358)

RECONCILIATION OF EXPENSES- OTHER ADJUSTMENTS

SCHEDULE D, PART XIII, LINE 2D

RENTAL EXPENSE	2,126,333
GOLF TOURNAMENT EXPENSE	49,496
LOSS ON FIXED ASSETS	29,536

TOTAL	\$2,205,365

Part XIV Supplemental Information *(continued)*

RECONCILIATION OF EXPENSES- OTHER ADJUSTMENTS

SCHEDULE D, PART XIII, LINE 4B

AUXILIARY EXPENSE \$ 153,949

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

**Supplemental Information Regarding
Fundraising or Gaming Activities**

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public
Inspection

Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
---	---

Part I Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17.
Form 990-EZ filers are not required to complete this part.

- 1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- | | |
|---|--|
| a <input type="checkbox"/> Mail solicitations | e <input type="checkbox"/> Solicitation of non-government grants |
| b <input type="checkbox"/> Internet and email solicitations | f <input type="checkbox"/> Solicitation of government grants |
| c <input type="checkbox"/> Phone solicitations | g <input type="checkbox"/> Special fundraising events |
| d <input type="checkbox"/> In-person solicitations | |
- 2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? Yes No
- b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total						

- 3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.
-
-
-
-
-
-
-
-
-
-
-

Part II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other Events	(d) Total events	
		GOLF TOURNAMENT (event type)	SEDER GOLF (event type)	(total number)	(add col. (a) through col. (c))	
Revenue	1	Gross receipts	90,515.	37,350.	0	127,865.
	2	Less: Charitable contributions	67,715.	27,990.	0	95,705.
	3	Gross income (line 1 minus line 2).	22,800.	9,360.	0	32,160.
Direct Expenses	4	Cash prizes			0	
	5	Noncash prizes	5,136.	1,560.	0	6,696.
	6	Rent/facility costs	20,118.	4,680.	0	24,798.
	7	Food and beverages	3,265.		0	3,265.
	8	Entertainment			0	
	9	Other direct expenses	11,609.	3,128.	0	14,737.
	10	Direct expense summary. Add lines 4 through 9 in column (d) ▶				
11	Net income summary. Combine line 3, column (d), and line 10 ▶					-17,336.

Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))	
		1	Gross revenue			
Direct Expenses	2	Cash prizes				
	3	Noncash prizes				
	4	Rent/facility costs				
	5	Other direct expenses				
6	Volunteer labor	Yes _____ % No	Yes _____ % No	Yes _____ % No		
7	Direct expense summary. Add lines 2 through 5 in column (d) ▶					()
8	Net gaming income summary. Combine line 1, column d, and line 7 ▶					

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? Yes No

b If "No," explain: _____

10 a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? Yes No

b If "Yes," explain: _____

- 11 Does the organization operate gaming activities with nonmembers? Yes No
- 12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? Yes No
- 13 Indicate the percentage of gaming activity operated in:

a The organization's facility	13a	%
b An outside facility	13b	%
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

- 15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ _____ and the amount of gaming revenue retained by the third party ▶ \$ _____.
- c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ \$ _____

Description of services provided ▶ _____

- Director/officer
- Employee
- Independent contractor

17 Mandatory distributions:

- a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? Yes No
- b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ _____

Part IV Supplemental Information. Complete this part to provide the explanation required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2011

Open to Public Inspection

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**
▶ **Attach to Form 990. ▶ See separate instructions.**

Department of the Treasury
Internal Revenue Service

Name of the organization

THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1 a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
1 b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>250.0000</u> %	X	
b Did the organization use FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____%	X	
c If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5 a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6 a Did the organization prepare a community benefit report during the tax year?		X
b If "Yes," did the organization make it available to the public?		

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			3,313,006.	1,038,468.	2,274,538.	.90
b Medicaid (from Worksheet 3, column a)			55,952,799.	39,553,595.	16,399,204.	6.45
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			59,265,805.	40,592,063.	18,673,742.	7.35
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	96	41062	658,308.	12,340.	645,968.	.25
f Health professions education (from Worksheet 5)	17	4531	275,274.	2,250.	273,024.	.11
g Subsidized health services (from Worksheet 6).		22476	5,140,665.		5,140,665.	2.02
h Research (from Worksheet 7)	1		24,431.		24,431.	.01
i Cash and in-kind contributions for community benefit (from Worksheet 8).	22	23	669,064.		669,064.	.26
j Total. Other Benefits	136	68092	6,767,742.	14,590.	6,753,152.	2.65
k Total. Add lines 7d and 7j.	136	68092	66,033,547.	40,606,653.	25,426,894.	10.00

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule H (Form 990) 2011

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support	8		69,051.		69,051.	.03
4 Environmental improvements						
5 Leadership development and training for community members	1		1,848.		1,848.	
6 Coalition building	2		18,320.		18,320.	.01
7 Community health improvement advocacy	1		510.		510.	
8 Workforce development						
9 Other	1		100.		100.	
10 Total	13		89,829.		89,829.	.04

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		X
2 Enter the amount of the organization's bad debt expense		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	62,914,770.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	90,995,950.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-28,081,180.

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

Cost accounting system Cost to charge ratio Other

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	9a	X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV Management Companies and Joint Ventures (see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name and address

Name and address		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1	WILLIAM W. BACKUS HOSPITAL 326 WASHINGTON ST. NORWICH CT 06360	X	X					X		
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: WILLIAM W. BACKUS HOSPITAL

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)			
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8. If "Yes," indicate what the Needs Assessment describes (check all that apply):	1	
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 __ __		
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	
5	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	5	
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>5</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	9	X

Part V Facility Information (continued) WILLIAM W. BACKUS HOSPITAL

		Yes	No
10	Used FPG to determine eligibility for providing <i>discounted care</i> ? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>4</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
11	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
12	Explained the method for applying for financial assistance?	X	
13	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
15	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
a	<input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d	<input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e	<input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) WILLIAM W. BACKUS HOSPITAL

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why:			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input checked="" type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?		X
If "Yes," explain in Part VI.			

Part V Facility Information (continued)

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 11

Name and address	Type of Facility (describe)
1 BACKUS OUTPATIENT CARE CENTER 111 SALEM TURNPIKE NORWICH CT 06360	OUTPATIENT SERVICES
2 MEDICAL OFFICE BUILDING 330 WASHINGTON STREET NORWICH CT 06360	RADIATION THERAPY/LAB
3 COLCHESTER BACKUS HEALTH CENTER 163 BROADWAY COLCHESTER CT 06415	RADIOLOGY/LAB/PRIMARY CARE
4 MONTVILLE BACKUS HEALTH CARE 80 NORWICH/NEW LONDON TURNPIKE UNCASVILLE CT 06382	RADIOLOGY/LAB/PRIMARY CARE
5 PAIN MANAGEMENT 112 LAFAYETTE STREET NORWICH CT 06360	PAIN MANAGEMENT CLINIC
6 LEDYARD BACKUS HEALTH CENTER 743 COLONEL LEDYARD HWY LEDYARD CT 06339	LAB/PRIMARY CARE
7 JEWETT CITY PATIENT SERVICE CENTER 70 MAIN STREET JEWETT CITY CT 06351	LAB
8 INFECTIOUS DISEASE CLINIC 107 LAFAYETTE STREET NORWICH CT 06360	CLINIC
9 NORTH STONINGTON BACKUS HEALTH CENTER 82 NORWICH-WESTERLY ROAD NORTH STONINGTON CT 06359	PRIMARY CARE
10 NORWICHTOWN BACKUS PATIENT SERVICE CNTR 55 TOWN STREET NORWICH CT 06360	LAB

Part V Facility Information (continued)

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1 PLAINFIELD EMERGENCY CENTER 582 NORWICH ROAD PLAINFIELD CT 06374	LAB/RADIOLOGY/EMERGENCY SRVCS
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

FINANCIAL ASSISTANCE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST

SCHEDULE H, PART I, LINE 7

FROM OCTOBER 2011 THROUGH SEPTEMBER OF 2012 THE WILLIAM W. BACKUS HOSPITAL SUPPORTED 146 PROGRAMS THAT SERVED 68,101 PEOPLE, TOTALING A COMMUNITY BENEFIT OF \$6,859,351. PROGRAMS IMPROVED THE HEALTH AND WELLNESS OF THE COMMUNITY, ADDRESSING STRATEGIC COMMUNITY HEALTH PRIORITY AREAS. SUCH PRIORITY HEALTH AREAS INCLUDE REDUCING OBESITY, AUTISM, DRUG AND ALCOHOL USE, AND INCREASING ACCESS TO HEALTH CARE. PROGRAMS ALSO INCLUDED CLINICAL SERVICES PROVIDED BY THE HOSPITAL AT A FINANCIAL LOSS (SUBSIDIZED SERVICES). THESE SERVICES, IF DISCONTINUED, WOULD NOT BE AVAILABLE TO THE COMMUNITY OR WOULD FALL TO ANOTHER NOT-FOR-PROFIT OR GOVERNMENT AGENCY TO PROVIDE. HEALTH PROFESSIONAL EDUCATION WAS ALSO ENHANCED, THROUGH MENTORSHIPS, INTERNING OPPORTUNITIES, AND STUDENT ROTATIONS THROUGH THE FACILITY. THE HOSPITAL ALSO SUPPORTED COMMUNITY PARTNERSHIPS THROUGH CASH AND IN-KIND DONATIONS. SUCH SUPPORT INCLUDED ASSISTING A LOCAL FEDERALLY-QUALIFIED LOOK-ALIKE IN SUSTAINING A GYNECOLOGY SERVICES PROGRAM FOR UNDERSERVED AND UNINSURED WOMEN, AS WELL AS DONATING A BUILDING TO ESTABLISH A SATELLITE FQHC FACILITY TO PROVIDE

Part VI Supplemental Information

Complete this part to provide the following information.

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PRIMARY CARE IN AN UNDERSERVED COMMUNITY. LASTLY, THE HOSPITAL COMMITTED RESOURCES TO FINDING "NOT-FOR-PROFIT" RESEARCH OPPORTUNITIES (IN OTHER WORDS, THOSE RESEARCH OPPORTUNITIES IN WHICH THE HOSPITAL HAS NO FINANCIAL INCENTIVE) TO HELP IMPROVE CLINICAL CARE AVAILABLE TO THE RESIDENTS OF EASTERN CONNECTICUT.

SCHEDULE H, PART I, LINE 7

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THE COLUMN IS \$7,950,269.

SCHEDULE H, PART I LINE 7

THE COSTING METHODOLOGY USED TO CALCULATE THE AMOUNTS REPORTED IN THE TABLE WAS COST TO CHARGE RATIO DERIVED FROM WORKSHEET 2.

Part VI Supplemental Information

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COMMUNITY BUILDING ACTIVITIES

SCHEDULE H, PART II

BACKUS HOSPITAL CONDUCTS AND SPONSORS 10 SUPPORT GROUPS THAT PROVIDE ONGOING EDUCATION AND COUNSELING FOR A WIDE ARRAY OF HEALTH-RELATED ISSUES, FROM INFANT CHILD LOSS TO CANCER.

HOSPITAL EMPLOYEES VOLUNTEER THEIR SERVICE ON DOZENS OF COMMUNITY NOT-FOR-PROFIT ORGANIZATIONS, MANY OF WHICH HAS HEALTHCARE AS A PRIMARY OR MAJOR FOCUS. EXAMPLES INCLUDE THE HEALTH CARE COUNCIL OF EASTERN CONNECTICUT, THE FOUNDATION OF THREE RIVERS COMMUNITY COLLEGE (WHICH PROVIDES FUNDING FOR NURSING STUDENT EDUCATION AND EQUIPMENT), THE REGION'S NON-PROFIT HOSPICE ORGANIZATION, THE NORWICH CHAMBER OF COMMERCE HEALTH CARE COMMITTEE, UNITED WAY OF SOUTHEASTERN CONNECTICUT (WHICH PROVIDES FUNDING FOR MANY REGIONAL HUMAN SERVICES, INCLUDING THOSE THAT ARE HEALTH-RELATED); AS WELL AS SERVICE AND BOARD MEMBERSHIPS ON THE REGION'S TWO FEDERALLY QUALIFIED HEALTH CENTERS.

ADDITIONALLY, BACKUS PERSONNEL VOLUNTEER ON OTHER BOARDS AND

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ORGANIZATIONS THAT ADVANCE THE QUALITY OF LIFE AND ECONOMIC WELL-BEING OF THE REGION, INCLUDING THE LOCAL LIBRARY, FAMILY SUPPORT AND SOCIAL SERVICE ORGANIZATIONS, THE REGIONAL CHAMBER OF COMMERCE, NUMEROUS CIVIC AND GOVERNMENTAL BODIES, AND VARIOUS VOLUNTEER FIRE COMPANIES AND AMBULANCE SERVICES.

MEMBERS OF THE ADMINISTRATIVE STAFF ROUTINELY SUBMIT GOVERNMENT TESTIMONY ON BEHALF OF REGIONAL NOT-FOR-PROFIT HEALTH-RELATED ORGANIZATIONS, AND PROVIDE RESEARCH AND ADVOCACY FOR THE HEALTHCARE ACCESS.

BAD DEBT EXPENSE

SCHEDULE H, PART III, LINES 4, 8 AND 9B

THE HOSPITAL PROVIDES SERVICES WITHOUT CHARGE, OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES, TO PATIENTS WHO MEET THE CRITERIA OF ITS CHARITY CARE POLICY. BECAUSE THE HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO BE CHARITY CARE, SUCH SERVICES ARE NOT REPORTED AS NET REVENUE. THE HOSPITAL'S CHARITY CARE POLICY UTILIZES THE GENERALLY RECOGNIZED POVERTY INCOME LEVELS FOR THE STATE. FOR PATIENTS WHO DO NOT

Part VI Supplemental Information

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APPLY OR DO NOT QUALIFY, THE UNCOLLECTED AMOUNTS ARE RECOGNIZED AS BAD DEBT EXPENSE. ESTIMATED COST OF BAD DEBT IS BASED ON THE RATIO OF COST TO CHARGES AS DETERMINED BY HOSPITAL SPECIFIC DATA.

MEDICARE SHORTFALL

SCHEDULE H, PART III, LINE 8

THE MEDICARE SHORTFALL WAS NOT INCLUDED IN THE COMMUNITY BENEFIT COST.

THE COSTING METHODOLOGY CONSISTED OF INFORMATION FROM THE HOSPITAL'S COST ACCOUNTING SYSTEM AS WELL AS COSTS FROM THE MEDICARE COST REPORT.

COLLECTION POLICY

SCHEDULE H, PART III, LINE 9B

IN THE SELF-PAY POLICY, SECTION II, B STATES THAT THE MEDICAL BUREAU OF ECONOMICS ("MBE") RECEIVES A WEEKLY LIST OF PATIENTS WHO WERE SENT FINANCIAL ASSISTANCE APPLICATIONS FROM BACKUS STAFF. THIS INFORMATION IS FROM THE PATIENT ACCOUNTS OR FINANCIAL COUNSELING DEPARTMENTS. MBE'S COLLECTION ACTIVITY ON THESE PATIENTS IS HALTED UNTIL IT HAS BEEN DETERMINED IF THE PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE UNDER THE

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HOSPITAL'S POLICY, BY THE HOSPITAL FINANCIAL COUNSELING UNIT. COLLECTION ACTION IS ONLY RESUMED ONCE IT IS DETERMINED THE PATIENT DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE.

AVAILABILITY OF FINANCIAL ASSISTANCE

SCHEDULE H, PART V, LINES 13G, 17E

THE WILLIAM W. BACKUS HOSPITAL PROVIDES FINANCIAL ASSISTANCE FOR CERTAIN QUALIFIED PATIENTS WHO ARE UNABLE TO PAY ALL OR PART OF THEIR BILL FOR INPATIENT, OUTPATIENT, AND EMERGENCY SERVICES RENDERED AT THE HOSPITAL.

IF YOU ARE COPING WITH A FINANCIAL HARDSHIP AND ARE FACING DEBTS OWED TO THE WILLIAM W. BACKUS HOSPITAL, FINANCIAL ASSISTANCE SUCH AS FREE CARE OR A SLIDING SCALE DISCOUNT MAY BE AVAILABE TO YOU. THE FINANCIAL COUNSELING PROCESS WILL INDICATE WHAT OPTIONS EXIST TO ASSIST YOU WITH YOUR OUTSTANDING BALANCE.

FINANCIAL ASSISTANCE APPLIES TO BACKUS HOSPITAL BILLS ONLY. IT DOES NOT APPLY TO RADIOLOGISTS, PATHOLOGISTS, ANESTHESIOLOGISTS OR OTHER

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PROFESSIONAL SERVICES INVOLVED IN YOUR CARE THAT ARE BILLED SEPARATELY.

TO APPLY PLEASE SUBMIT THE ATTACHED APPLICATION FOR FINANCIAL ASSISTANCE
AND THE FOLLOWING VERIFICATIONS OF INCOME INFORMATION:

- MOST RECENT FEDERAL TAX RETURN AND W-2
- MOST RECENT 3 PAYROLL CHECKS
- COPIES OF UNEMPLOYMENT CHECKS
- COPIES OF ANY PENSION, ALIMONY, CHILD SUPPORT OR OTHER SOURCES OF
INCOME
- COPIES OF SOCIAL SECURITY EARNINGS, IF ANY
- ANY OTHER PERTINENT INFORMATION.

PROOF OF INCOME OR EARNINGS IS REQUIRED WITH APPLICATION OR THE
APPLICATION WILL NOT BE CONSIDERED.

PLEASE ALLOW 3 TO 4 WEEKS FOR PROCESSING TIME; YOU WILL BE NOTIFIED BY
MAIL OF THE OUTCOME OF YOUR APPLICATION. IF YOU HAVE ANY QUESTIONS PLEASE

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CONTACT CUSTOMER SERVICE:

MONDAY THRU FRIDAY, 9:00 AM TO 4:00 PM

(860) 823-6394 / FAX: (860) 892-6902.

FURTHER, AS DETAILED IN THE HOSPITAL'S BAD DEBT WRITE OFF POLICY, A SERIES OF STATEMENTS, ALL INDICATING THE AVAILABILITY OF FINANCIAL ASSISTANCE (PER THE LETTER DESCRIBED PREVIOUSLY) ARE SENT OUT PRIOR TO COLLECTING ON THE OPEN ACCOUNT. THE BAD-DEBT COLLECTIONS AND WRITE OFF POLICY IS DESCRIBED BELOW:

I SELF PAY ACCOUNTS COLLECTION PROCESS (ACCOUNTS THAT DO NOT QUALIFY FOR MBE OUTSOURCE)

A INITIAL LETTER IS SENT 5 DAYS AFTER DISCHARGE.

B STATEMENT #1 IS SENT 30 DAYS LATER.

C STATEMENT # 2 IS SENT 30 DAYS LATER.

D PRECOLLECT LETTER IS SENT 15 DAYS LATER (BY MEDCONN).

E ACCOUNT WILL BE WRITTEN OFF TO BAD DEBT 45 DAYS LATER.

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II SELF PAY BALANCES AFTER INSURANCE (ACCOUNTS THAT DO NOT QUALIFY FOR
MBE OUTSOURCE)

A STATEMENT # 1 IS SENT 15 DAY AFTER ACCOUNT GOES TO SELF PAY.

B STATEMENT # 2 IS SENT 30 DAYS LATER.

C STATEMENT # 3 IS SENT 21 DAYS LATER.

D PRECOLLECT LETTER IS SENT 21 DAYS LATER.

E ACCOUNT WILL BE WRITTEN OFF TO BAD DEBT 45 DAYS LATER.

III ALL FINAL BILLED ACCOUNTS WITH SELF-PAY BALANCES ONLY WILL BE
OUTSOURCED TO MEDICAL BUREAU OF ECONOMICS (MBE). (REFER TO SELF PAY
COLLECTIONS POLICY)

A STATEMENT # 1 IS SENT AT PLACEMENT WITH MBE. (5 DAYS AFTER DISCHARGE)

B STATEMENT # 2 IS SENT 30 DAYS LATER.

C STATEMENT # 3 IS SENT 30 DAYS LATER.

D FINAL STATEMENT SENT 15 DAYS LATER.

E ACCOUNT CLOSED AND RETURNED TO WWBH FOR BAD DEBT PROCESS 45 DAYS LATER

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1 ACCOUNTS WITH BALANCES OF \$1000 OR MORE.

A. IF TIME PERMITS THE STAFF WILL ATTEMPT TO CONTACT THE PATIENT TO ATTEMPT TO DETERMINE IF THEY MAY QUALIFY FOR FREE BED FUNDS, CHARITY CARE OR A PAYMENT CONTRACT.

B. IF THE PATIENT MAY QUALIFY, AND APPLICATION IS SENT AND THE ACCOUNT IS NOT SENT TO BAD DEBT, PENDING A RESPONSE WITHIN 14 DAYS. IF NO RESPONSE IS RECEIVED THE ACCOUNT WILL BE SENT TO BAD DEBT IN THE NEXT WEEKLY PROCESSING CYCLE.

C. THE ACCOUNT WILL BE PLACED ON "BAD DEBT HOLD". A NOTE IS PLACED ON THE ACCOUNT INDICATING THE APPLICATION FOR FREE BED AND CHARITY CARE.

D. A REMINDER WILL BE SET UP TO REVIEW THE ACCOUNT IN 14 DAYS. IF THE APPLICATION IS RECEIVED THE HOLD WILL BE REMOVED AND THE ACCOUNT WILL BE PROCESSED ACCORDING TO THE FREE BED/CHARITY CARE POLICY. IF THE PATIENT DOES NOT QUALIFY, THE HOLD WILL BE REMOVED AND THE ACCOUNT WILL GO TO BAD DEBT IN THE NEXT WEEKLY PROCESSING CYCLE. IF THE APPLICATION IS NOT

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RECEIVED BACK IN 14 DAYS THE HOLD WILL BE REMOVED AND THE ACCOUNT WILL GO TO BAD DEBT IN THE NEXT WEEKLY PROCESSING CYCLE.

E. IF TIME PERMITS THE STAFF WILL ATTEMPT TO PROCESS THE ACCOUNTS THROUGH PASSPORT ONE/SSI TO DETERMINE IF MEDICAID COVERAGE HAS BEEN ESTABLISHED FOR THE PATIENT. IF SO, THE ACCOUNT WILL BE UPDATED AND MEDICAID BILLED.
 UPDATED AND MEDICAID BILLED.

COMMUNITY HEALTH NEEDS ASSESSMENT

SCHEDULE H, PART V, SECTION B

(A) IN ADDITION TO CONDUCTING ITS OWN RESEARCH, BACKUS HOSPITAL COLLABORATES WITH LOCAL AND REGIONAL HEALTH CARE ORGANIZATIONS TO DETERMINE THE NEED FOR HEALTH-RELATED PROGRAMS AND SERVICES.

(B) IN 2010, THE HOSPITAL COMMISSIONED A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT CONDUCTED BY HOLLERAN, A PROFESSIONAL RESEARCH FIRM. THE ASSESSMENT CONSISTED OF 1,109 BRFSS TELEPHONE SURVEYS WHICH WERE CONDUCTED THROUGHOUT THE HOSPITAL'S SERVICE REGION (BOTH NEW LONDON AND

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WINDHAM COUNTIES). THE ASSESSMENT ALSO INCLUDED A DETAILED ANALYSIS OF SECONDARY DATA SOURCES, AS WELL AS TWO COMPREHENSIVE FOCUS GROUPS TO GAIN QUALITATIVE DATA ON IDENTIFIED PRIORITY HEALTH AREAS. THE NEEDS ASSESSMENT WAS PRESENTED AND DISTRIBUTED, AND CAN BE ACCESSED AT WWW.BACKUSHOSPITAL.ORG/HEALTHSURVEY. SUBSEQUENTLY THE HOSPITAL HAS DEVELOPED A COMMUNITY NEEDS STRATEGIC PLAN WHICH IDENTIFIES AND OUTLINES TOP PRIORITY HEALTH NEEDS AS DETERMINED BY THE NEEDS ASSESSMENT. PRIORITY HEALTH AREAS INCLUDE OBESITY AND OVERWEIGHT, AUTISM, SMOKING, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH, CHRONIC LOWER RESPIRATORY DISEASES, AND ACCESS TO HEALTHCARE. THIS PLAN HAS GUIDED HOSPITAL'S OUTREACH EFFORTS FOR THE LAST TWO FISCAL YEARS. A SECOND NEEDS ASSESSMENT WAS UNDERTAKEN IN THE FOURTH QUARTER OF FY 2012 TO MEASURE THE HOSPITAL'S PROGRESS, AND AUGMENT EXISTING RESEARCH. BASED ON THE HOLLERAN SURVEY, THE HOSPITAL PARTNERED WITH UNITED WAY OF SOUTHEASTERN CONNECTICUT TO CREATE THE NEW LONDON COUNTY FOOD POLICY COUNCIL, WHICH IS USING THE DATA TO ADDRESS OBESITY AND OTHER FOOD-RELATED ISSUES, AS WELL AS NORWICH TECHNICAL HIGH SCHOOL, TO FOCUS ON ADOLESCENT HEALTH ISSUES SUCH AS SELF-ESTEEM, DEPRESSION, AND SUBSTANCE ABUSE.

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(C) THE HOSPITAL IDENTIFIES HEALTH PROBLEMS IN THE COMMUNITY THROUGH INDICATORS AND MEASURES OF HEALTH RISK, DISEASE PREVALENCE, DISEASE MANAGEMENT AND OUTCOMES USING SOURCES SUCH AS BIRTH AND MORTALITY RECORDS, CENSUS DATA, BEHAVIORAL RISK FACTOR SURVEY DATA, ROBERT WOOD JOHNSON COUNTY HEALTH RANKINGS, AND OTHER DATASETS. PRIORITY AREAS WERE RANKED UTILIZING A METHODOLOGY WHICH DETERMINED THE SEVERITY OF THE PROBLEM AND THE HOSPITAL'S ABILITY TO IMPACT IT.

(D) THE HOSPITAL PARTNERS WITH TWO REGIONAL FEDERALLY QUALIFIED HEALTH CENTERS ("FQHC") - UNITED COMMUNITY AND FAMILY SERVICES, AND GENERATIONS HEALTHCARE. MANAGERS FROM THE HOSPITAL AND FQHCS MEET TO DETERMINE UNMET COMMUNITY NEEDS TO DEVELOP EDUCATIONAL, OUTREACH AND PREVENTATIVE HEALTH PROGRAMS TO MEET THESE NEEDS.

(E) THE HOSPITAL CONDUCTS FOLLOW-UP SURVEYS WITH ALL PARTICIPANTS IN ITS FREE EDUCATIONAL PROGRAMS. THE SURVEYS ASSESS PARTICIPANTS' SATISFACTION WITH THE PROGRAM, AND SOLICIT INFORMATION ABOUT OTHER NEEDS.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

SCHEDULE H, PART VI, LINE 3

(A) NOTIFICATION ABOUT CHARITABLE CARE AND ASSISTANCE PROGRAMS IS AVAILABLE AT ALL REGISTRATION AREAS, ON AND OFF THE MAIN HOSPITAL CAMPUS, IN WAITING AREAS, IN THE PATIENT HANDBOOK, ON OUR WEBSITE, ON PROMINENTLY PLACED SIGNS (IN ENGLISH AND SPANISH). ADDITIONALLY, CARE MANAGEMENT SOCIAL WORKERS MEET WITH PATIENTS, FAMILY, CLERGY AND OTHERS AS APPROPRIATE TO DISCUSS ASSISTANCE PROGRAMS AND SERVICES THAT MAY BE AVAILABLE.

IN ADDITION TO THE COMPLETE FINANCIAL ASSISTANCE POLICY AND APPLICATION FOR FINANCIAL ASSISTANCE, HERE IS THE INFORMATION INCLUDED ON THE HOSPITAL'S WEBSITE:

FINANCIAL ASSISTANCE

BACKUS HOSPITAL PROVIDES FINANCIAL ASSISTANCE PROGRAMS FOR CERTAIN QUALIFIED PATIENTS WHO ARE UNABLE TO PAY ALL OR PART OF THEIR BILL FOR INPATIENT, OUTPATIENT AND EMERGENCY SERVICES RENDERED AT THE HOSPITAL.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IF YOU ARE COPING WITH A FINANCIAL HARDSHIP, AND ARE FACING DEBTS OWED TO BACKUS HOSPITAL, FINANCIAL ASSISTANCE MAY BE AVAILABLE TO YOU.

INCOME VERIFICATION

BACKUS REQUESTS INCOME INFORMATION FROM THE APPLICANT. VERIFICATION OF REPORTED INCOME SHOULD BE INCLUDED WITHIN THE APPLICATION PACKAGE.

APPROPRIATE VERIFICATION SOURCES INCLUDE:

- MOST RECENT FEDERAL TAX RETURN AND W-2
- MOST RECENT 3 PAYROLL CHECKS
- COPIES OF UNEMPLOYMENT CHECKS
- COPIES OF ANY PENSION, ALIMONY, CHILD SUPPORT OR OTHER SOURCES OF INCOME
- COPIES OF SOCIAL SECURITY EARNINGS, IF ANY
- ANY OTHER PERTINENT INFORMATION

IF THE APPLICANT HAS NO INCOME A STATEMENT DETAILING THE CURRENT METHOD OF SUPPORT WILL BE ACCEPTED. PROOF OF INCOME OR EARNINGS IS REQUIRED WITH

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

APPLICATION OR THE APPLICATION WILL NOT BE CONSIDERED.

FINANCIAL ASSISTANCE OPTIONS

THE LEVEL OF FINANCIAL ASSISTANCE THAT YOU MAY BE ELIGIBLE TO RECEIVE WILL BE BASED UPON THE CRITERIA DEFINED IN THE FINANCIAL ASSISTANCE POLICY.

THE WILLIAM W. BACKUS HOSPITAL CONSIDERS FINANCIAL ASSISTANCE AWARDS ON A CASE-BY-CASE BASIS. PLEASE CONTACT US IF YOU HAVE QUESTIONS REGARDING ELIGIBILITY.

FINANCIALLY INDIGENT

FINANCIALLY INDIGENT IS DEFINED AS AN INDIVIDUAL WHOSE TOTAL GROSS ANNUAL INCOME IS LESS THAN OR EQUAL TO 250% OF THE FEDERAL POVERTY GUIDELINES (FPG).

PATIENTS AT OR BELOW 250% FPG ARE ELIGIBLE FOR A 100% DISCOUNT OFF OF THEIR OUTSTANDING BALANCES. INDIVIDUALS ABOVE 250% UP TO 400% FPG ARE

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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ELIGIBLE FOR A DISCOUNT BASED ON THEIR TOTAL GROSS ANNUAL INCOME.

MEDICALLY INDIGENT

BACKUS HOSPITAL CONSIDERS AN INDIVIDUAL TO BE MEDICALLY INDIGENT IF THEIR TOTAL ANNUAL GROSS INCOME IS ABOVE 400% FPG AND THEIR OUTSTANDING MEDICAL OBLIGATIONS ARE GREATER THAN 50% OF THEIR TOTAL ANNUAL GROSS INCOME.

THESE INDIVIDUALS MAY BE ELIGIBLE FOR A DISCOUNT SEPARATE FROM TRADITIONAL FINANCIAL ASSISTANCE. PLEASE REFER TO THE FINANCIAL ASSISTANCE POLICY FOR DETAILS REGARDING ELIGIBILITY AND THE DISCOUNT SCHEDULE.

MEDICALLY INDIGENT IS DEFINED BY THE IRS AS: 'PERSONS WHOM THE ORGANIZATION HAS DETERMINED ARE UNABLE TO PAY SOME OR ALL OF THEIR MEDICAL BILLS BECAUSE THEIR MEDICAL BILLS EXCEED A CERTAIN PERCENTAGE OF THEIR FAMILY OR HOUSEHOLD INCOME OR ASSETS (FOR EXAMPLE, DUE TO CATASTROPHIC COSTS OR CONDITIONS), EVEN THOUGH THEY HAVE INCOME OR ASSETS THAT OTHERWISE EXCEED THE GENERALLY APPLICABLE ELIGIBILITY

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

REQUIREMENTS FOR FREE OR DISCOUNTED CARE UNDER THE ORGANIZATION'S
FINANCIAL ASSISTANCE POLICY.'

BACKUS HOSPITAL TREATS EACH APPLICATION INDIVIDUALLY. IF YOU HAVE ANY
QUESTIONS ABOUT YOUR SPECIFIC SITUATION, PLEASE CONTACT OUR CUSTOMER
SERVICE REPRESENTATIVES AT 860-889-8331, EXT. 2917, MONDAY THROUGH FRIDAY
FROM 7:30 AM TO 4 PM.

FINANCIAL ASSISTANCE LETTER

THE WILLIAM W. BACKUS HOSPITAL PROVIDES FINANCIAL ASSISTANCE FOR CERTAIN
QUALIFIED PATIENTS WHO ARE UNABLE TO PAY ALL OR PART OF THEIR BILL FOR
INPATIENT, OUTPATIENT AND EMERGENCY SERVICES RENDERED AT THE HOSPITAL.

IF YOU ARE COPING WITH A FINANCIAL HARDSHIP AND ARE FACING DEBTS OWED TO
THE WILLIAM W. BACKUS HOSPITAL, FINANCIAL ASSISTANCE SUCH AS FREE CARE OR
A SLIDING SCALE DISCOUNT MAY BE AVAILABLE TO YOU. THE FINANCIAL
COUNSELING PROCESS WILL INDICATE WHAT OPTIONS EXIST TO ASSIST YOU WITH
YOUR OUTSTANDING BALANCE.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

FINANCIAL ASSISTANCE APPLIES TO BACKUS HOSPITAL BILLS ONLY. IT DOES NOT APPLY TO RADIOLOGISTS, PATHOLOGISTS, ANESTHESIOLOGISTS OR OTHER PROFESSIONAL SERVICES INVOLVED IN YOUR CARE THAT ARE BILLED SEPARATELY.

FREQUENTLY ASKED QUESTIONS

1. DOES THE HOSPITAL HAVE A FINANCIAL ASSISTANCE POLICY?

THE WILLIAM W. BACKUS HOSPITAL DOES HAVE A WRITTEN FINANCIAL ASSISTANCE POLICY THAT DEFINES THE DISCOUNT STRUCTURE AND PROGRAMS AVAILABLE TO QUALIFYING PATIENTS.

THE WILLIAM W. BACKUS HOSPITAL BASES ALL FINANCIAL ASSISTANCE ON THE MOST CURRENT FEDERAL POVERTY GUIDELINES (FPG), WHICH ARE BASED ON THE GROSS INCOME AND HOUSEHOLD SIZE. BACKUS GRANTS 100% CHARITY CARE TO THOSE APPLICANTS WHOSE GROSS HOUSEHOLD INCOME IS AT OR BELOW 250% FPG. A SLIDING DISCOUNT IS AVAILABLE TO THOSE PATIENTS WHO HAVE GROSS INCOME UP TO 400% FPG.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CURRENTLY, THE FEDERAL GOVERNMENT DEFINES 100% OF POVERTY AS AN INDIVIDUAL EARNING A GROSS INCOME OF \$10,890 PER YEAR. THE WILLIAM W. BACKUS HOSPITAL FINANCIAL ASSISTANCE POLICY GRANTS 100% CHARITY CARE TO A FAMILY OF ONE EARNING UP TO \$21,780 PER YEAR, OR 250% FPG. INCOME THRESHOLDS INCREASE RELATIVE TO HOUSEHOLD SIZE. A DISCOUNT IS AVAILABLE FOR APPLICANTS EARNING UP TO 400% FPG.

2. WHAT SERVICES DOES THE FINANCIAL ASSISTANCE POLICY COVER?

THE WILLIAM W. BACKUS HOSPITAL'S FINANCIAL ASSISTANCE POLICY COVERS SERVICES RENDERED AT THE WILLIAM W. BACKUS HOSPITAL, INCLUDING INPATIENT, EMERGENCY, AND OUTPATIENT PROCEDURES. FINANCIAL ASSISTANCE MAY NOT BE GRANTED FOR SOME PROCEDURES, SUCH AS ELECTIVE PROCEDURES OR SOME SPECIAL SITUATIONS, SUCH AS THAT OF AN INDIVIDUAL WHO IS ELIGIBLE FOR INSURANCE BUT HAS REFUSED TO APPLY OR FUNDS ARE AVAILABLE THROUGH ANOTHER SOURCE FOR PAYMENT (I.E. SETTLEMENTS, STATE FUNDED PROGRAMS).

Part VI Supplemental Information

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FINANCIAL ASSISTANCE APPLIES TO BACKUS HOSPITAL BILLS ONLY. IT DOES NOT APPLY TO RADIOLOGISTS, PATHOLOGISTS, ANESTHESIOLOGISTS OR OTHER PROFESSIONAL SERVICES INVOLVED IN YOUR CARE THAT ARE BILLED SEPARATELY.

3. DOES THE HOSPITAL PROVIDE PERSONNEL TO HELP WITH APPLICATIONS AND TO ANSWER QUESTIONS?

THE WILLIAM W. BACKUS HOSPITAL EMPLOYS FINANCIAL COUNSELORS TO HELP PATIENTS APPLY FOR FINANCIAL ASSISTANCE, MEDICAID, AND OTHER STATE HEALTH PROGRAMS.

THE HOSPITAL ALSO HAS RESOURCES TO HELP WITH APPLICATIONS FOR STATE NUTRITIONAL ASSISTANCE PROGRAMS (SNAP) AND PHARMACY ASSISTANCE PROGRAMS. FINANCIAL COUNSELORS CAN HELP TO DETERMINE APPROPRIATE REFERRALS TO THESE RESOURCES.

THE WILLIAM W. BACKUS HOSPITAL PROVIDES LANGUAGE TRANSLATION VIA CYRACOM AND MARTTI LANGUAGE LINES.

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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4. DOES THE HOSPITAL COMMUNICATE THE AVAILABILITY OF FINANCIAL ASSISTANCE TO THE COMMUNITY?

THE WILLIAM W. BACKUS HOSPITAL BELIEVES IT IS IMPORTANT TO COMMUNICATE THE AVAILABILITY OF FINANCIAL ASSISTANCE TO THE COMMUNITIES IT SERVES. THEREFORE, A NOTICE OF THE AVAILABILITY OF FINANCIAL ASSISTANCE IS INCLUDED WITH THE PAPER BILL SENT TO THE PATIENT'S HOME, IS POSTED IN ALL MAIN REGISTRATION AREAS, IS AVAILABLE ON THE HOSPITAL'S WEBSITE, AND UPON REQUEST OF HOSPITAL STAFF OR REPRESENTATIVES.

5. DOES THE HOSPITAL EVER DENY CARE BASED ON INABILITY TO PAY?

THE WILLIAM W. BACKUS HOSPITAL WILL NEVER DELAY OR DENY EMERGENCY CARE OR NECESSARY SERVICES DUE TO AN INABILITY TO PAY.

6. DOES THE HOSPITAL HAVE A PROGRAM FOR PATIENTS WHO DON'T QUALIFY FOR TRADITIONAL FINANCIAL ASSISTANCE BUT INCUR CATASTROPHIC MEDICAL DEBTS?

Part VI Supplemental Information

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THE HOSPITAL HAS A WRITTEN POLICY THAT COVERS CATASTROPHIC FINANCIAL ASSISTANCE FOR THE MEDICALLY INDIGENT. THE POLICY IS INCLUDED IN THE FINANCIAL ASSISTANCE POLICY, IS AVAILABLE ON THE WEBSITE, AND UPON REQUEST.

(B) THE HOSPITAL PROVIDES TWO ACCESS TO CARE SPECIALISTS (BOTH FIRST AND SECOND SHIFT) IN ITS EMERGENCY DEPARTMENTS AND TWO HEALTH CENTERS, WHO PROVIDES FREE INSURANCE ELIGIBILITY SCREENINGS TO UNINSURED CLIENTS SEEKING CARE. THE SPECIALISTS WORK WITH UNINSURED PATIENTS TO CONNECT THEM WITH A PRIMARY MEDICAL HOME, SO THEY CAN RECEIVE PREVENTATIVE CARE, RATHER THAN USING COSTLY EMERGENCY SERVICES FOR ILLNESSES THAT ARE NOT MEDICAL EMERGENCIES. SIGNIFICANT ONE-ON-ONE FOLLOW-UP IS PROVIDED THROUGH PHONE CALLS OR LETTERS TO MAKE APPOINTMENTS TO SCREEN PATIENTS AND HELP THEM FILL OUT APPLICATIONS FOR HUSKY OR CHARTER OAK APPLICATIONS. UNINSURED PATIENTS TO CONNECT THEM WITH A PRIMARY MEDICAL HOME, SO THEY CAN RECEIVE PREVENTATIVE CARE, RATHER THAN USING COSTLY EMERGENCY SERVICES FOR ILLNESSES THAT ARE NOT MEDICAL EMERGENCIES. SIGNIFICANT ONE-ON-ONE FOLLOW-UP IS PROVIDED THROUGH PHONE CALLS OR LETTERS TO MAKE

Part VI Supplemental Information

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APPOINTMENTS TO SCREEN PATIENTS AND HELP THEM FILL OUT APPLICATIONS FOR
HUSKY OR CHARTER OAK APPLICATIONS.

COMMUNITY INFORMATION

SCHEDULE H, PART VI, LINE 4

THE WILLIAM W. BACKUS HOSPITAL IS LOCATED IN NORWICH, 45 MINUTES
SOUTHEAST OF HARTFORD. IN THE PAST DECADE, THE REGION HAS UNDERGONE MAJOR
ECONOMIC CHANGES, DUE TO THE OPERATION OF TWO NATIVE AMERICAN-OWNED
ENTERTAINMENT VENUES BRING BRINGING AN AVERAGE OF 40,000 VISITORS INTO
THE REGION EACH DAY. THE CASINOS ARE THE LARGEST EMPLOYERS, AND ARE
EXPERIENCING LAYOFFS AND CUTBACKS AS THE ECONOMY CONTINUES TO DECLINE.

THE HOSPITAL'S PRIMARY SERVICE AREA HAS AN ESTIMATED POPULATION OF ABOUT
118,000. THE SECONDARY SERVICE AREA CONSISTS OF LARGER COMMUNITIES, SUCH
AS NEW LONDON AND GROTON, AND SMALLER LOWER-DENSITY RURAL COMMUNITIES.
THE TOTAL POPULATION OF THE SECONDARY SERVICE AREA IS ABOUT 123,000. THE
SERVICE AREAS CONTAIN MUNICIPALITIES IN NEW LONDON AND WINDHAM COUNTIES.

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THE FASTEST GROWING SEGMENT OF THE REGION'S POPULATION IS THE ELDERLY.

FOR THE LAST DECENNIAL CENSUS, THE REGION'S ELDERLY POPULATION GREW AT 10

TIMES THE RATE OF GROWTH FOR THE TOTAL POPULATION.

THE REGION'S LACK OF AFFORDABLE HOUSING BEGAN TO EMERGE AS A CRITICAL ISSUE EVEN BEFORE THE ECONOMIC DOWNTURN. HOMELESSNESS IS A GROWING CONCERN, AS THE NUMBER OF MORTGAGE FORECLOSURES GROW. FURTHER, THE 2012 ROBERT WOOD JOHNSON COUNTY HEALTH RANKINGS REPORTED THAT IN NEW LONDON AND WINDHAM COUNTIES BETWEEN 12-15% OF CHILDREN ARE LIVING IN POVERTY, AND 31-32% ARE LIVING IN SINGLE PARENT HOUSEHOLDS.

UNEMPLOYMENT IN THE REGIONAL LABOR MARKET (PER THE 2012 ROBERT WOOD JOHNSON COUNTY HEALTH RANKING) STANDS AT 8.7-10.3% IN NEW LONDON AND WINDHAM COUNTIES, HOVERING AROUND STATE AVERAGE OF 9.1%, AND WELL ABOVE THE NATIONAL AVERAGE OF 5.4%.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PROMOTION OF COMMUNITY HEALTH

SCHEDULE H, PART VI, LINE 5

- A) THE HOSPITAL IS GOVERNED BY A VOLUNTEER COMMUNITY BOARD OF DIRECTORS/TRUSTEES. THESE INDIVIDUALS REPRESENT AN ARRAY OF PROFESSIONS AND BACKGROUNDS.
- B) THE HOSPITAL HAS 110 CORPORATORS - VOLUNTEER MEMEBERS CHOSEN FROM ALL THE COMMUNITIES IN OUR PRIMARY AND SECONDARY SERVICE AREAS. IN ADDITION TO THEIR OFFICIAL CAPACITY AS NOMINATORS OF BOARD MEMBERS, THE CORPORATORS SERVE AS THE HOSPITAL'S EYES AND EARS THROUGHOUT ITS SERVICE AREA.
- C) THE HOSPITAL OWNS AND OPERATES A MOBILE HEALTH RESOURCE CENTER - A 40-FOOT VAN THAT TRAVELS TO VARIOUS LOCATIONS IN EASTERN CONNECTICUT OFFERING HEALTH EDUCATION, COUNSELING, AND SCREENINGS. THE VAN MAKES REGULARLY SCHEDULED STOPS AT SENIOR CITIZENS CENTERS, SOUP KITCHENS, ELDERLY HOUSING COMPLEXES AND HOMELESS SHELTERS. NOT-FOR-PROFIT GROUPS ARE ENCOURAGED TO REQUEST THE VAN AND ITS SERVICES AT THEIR FUNCTIONS OR

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

OFFICES.

D) THE HOSPITAL PROVIDES INDIVIDUALS WHO DO NOT IDENTIFY AS HAVING A PRIMARY MEDICAL HOME WITH A FOLLOW UP VISIT POST DISCHARGE FROM TO BECOME LINK THESE INDIVIDUALS WITH A PRIMARY CARE PHYSICIAN IN THE COMMUNITY. THIS IS FACILITATED THROUGH THE MY HEALTH DIRECT PROGRAM, A WEB-BASED TOOL THAT ALLOWS HOSPITAL STAFF TO ACCESS BLOCKED APPOINTMENTS FOR PHYSICIANS IN THE COMMUNITY. FROM 10/1/11 TO 9/30/12 THE HOSPITAL LINKED 582 INDIVIDUALS WITH PRIMARY CARE.

E) THE HOSPITAL PROVIDES FREE COMMUNITY PROSTATE SCREENINGS, DIABETES EDUCATION, BACKPACK SAFETY, HIV EDUCATION/TESTING, BLOOD PRESSURE TESTS, SKIN CANCER SCREENINGS, NUTRITION EDUCATION AND MANY OTHERS SERVICES.

F) THE HOSPITAL PROVIDES A COMPREHENSIVE MEDICAL LIBRARY, WHICH IS OPEN TO ALL STAFF. THE LIBRARY HAS SUBSCRIPTIONS TO HUNDREDS OF MAJOR SCIENTIFIC AND CLINICAL JOURNALS, AS WELL AS AN ON-STAFF LIBRARIAN TO HELP WITH SPECIFIC RESEARCH REQUESTS.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

G) THE HOSPITAL PROVIDES FREE WEBSITE ACCESS TO COMPLETE AND CURRENT MEDICAL INFORMATION TO ANSWER CLINICAL QUESTIONS, THROUGH UPTODATE.COM, A PEER-REVIEWED ONLINE MEDICAL REFERENCE. UPTODATE COVERS MORE THAN 7,400 TOPICS IN 13 MEDICAL SPECIALTIES AND INCLUDES MORE THAN 76,000 PAGES OF TEXT, GRAPHICS, LINKS TO MEDLINE ABSTRACTS, MORE THAN 254,000 REFERENCES, AND A DRUG DATABASE.

H) THE HOSPITAL PROVIDES FREE MEDICATION CARDS TO HELP PATIENTS KEEP TRACK OF THEIR CURRENT MEDICATIONS, AND ITS PHARMACISTS OFFER FREE REGULAR MEDICATION REVIEWS TO CHECK FOR POSSIBLE INTERACTIONS AND EXPIRED MEDICATIONS.

I) THE HOSPITAL OFFERS FREE WIRELESS INTERNET (WI-FI) USE THROUGHOUT THE CAMPUS, AND PROVIDES FREE COMPUTER USE TO VISITORS.

J) THE HOSPITAL PUBLISHES A MONTHLY CONSUMER HEALTH MAGAZINE. THE PUBLICATION CONTAINS INFORMATION ABOUT HEALTH ISSUES AND TRENDS, A

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
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- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CALENDAR OF FREE HEALTHCARE EDUCATION AND SCREENINGS, AND CONTACT INFORMATION FOR HEALTHCARE PROVIDERS. 44,000 COPIES ARE DISTRIBUTED MONTHLY. PUBLICATION CONTAINS INFORMATION ABOUT HEALTH ISSUES AND TRENDS, A CALENDAR OF FREE HEALTHCARE EDUCATION AND SCREENINGS, AND CONTACT INFORMATION FOR HEALTHCARE PROVIDERS. 44,000 COPIES ARE DISTRIBUTED MONTHLY.

STATE FILING OF COMMUNITY BENEFIT REPORT

SCHEDULE H, PART VI, LINE 7

THE HOSPITAL FILES A COMMUNITY BENEFIT REPORT WITH THE CONNECTICUT OFFICE OF THE HEALTH ADVOCATE ("OHA").

**SCHEDULE I
(Form 990)**

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.

Name of the organization

THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Check this box if no one recipient received more than \$5,000. Part II can be duplicated if additional space is needed

1	(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)	HOSPICE OF SE CONNECTICUT NORWICH, CT 06360	22-2667260	501 (C) (3)	8,500.				SPONSORSHIP
(2)	AMERICAN HEART ASSOC ROBBINSVILLE, NJ 08691	13-5613797	501 (C) (3)	7,500.				SPONSORSHIP
(3)	UNITED COMMUNITY & FAMILY SERVICES NORWICH, CT 06360	06-0653142	501 (C) (3)	200,000.				WOMEN'S HEALTH
(4)	CHAMBER OF COMMERCE WATERFORD, CT 06385	06-0475490	501 (C) (6)	6,500.				SPONSORSHIP
(5)	THREE RIVERS COLLEGE NORWICH, CT 06360	23-7303151	501 (C) (3)	16,000.				SPONSORSHIP
(6)	BROADWAY KIDS NIANTIC, CT 06357			5,100.				SPONSORSHIP
(7)	UNITED COMMUNITY & FAMILY SERVICES NORWICH, CT 06360	06-0653142	501 (C) (3)		410,000.	APPRAISAL	BUILDING	PRIMARY CARE
(8)								
(9)								
(10)								
(11)								
(12)								

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 5.
- 3 Enter total number of other organizations listed in the line 1 table 2.

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule I (Form 990) (2011)

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1 SCHOLARSHIPS	5.	12,500.			
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

PROCEDURES FOR MONITORING THE USE OF GRANT FUNDS IN THE U.S.

SCHEDULE I, PART I, LINE 2

DONATIONS MADE FOR LOCAL EVENTS, SUCH AS SPONSORSHIPS, ARE TYPICALLY ATTENDED BY HOSPITAL EMPLOYEES. FIVE SCHOLARSHIPS IN THE AMOUNT OF \$2,500 EACH ARE AWARDED TO STUDENTS WHO WILL ATTEND SCHOOL EITHER FOR NURSING OR IN THE MEDICAL FIELD. THE APPLICANTS ARE REVIEWED BY THE SCHOLARSHIP COMMITTEE OF THE AUXILIARY AND WINNERS ARE CHOSEN BASED ON ACADEMICS AS WELL AS COMMUNITY SERVICE.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

**Open to Public
Inspection**

Name of the organization
THE WILLIAM W. BACKUS HOSPITAL

Employer identification number
06-0250773

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|---|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input checked="" type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input checked="" type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.

5 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 5a or 5b, describe in Part III.

6 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 6a or 6b, describe in Part III.

7 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1b		X
2	X	
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2011

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 DAVID WHITEHEAD	(i)	740,686.	0	21,535.	20,580.	23,272.	806,073.	
	(ii)	0	0	0	0	0	0	
2 DANIEL E LOHR	(i)	491,649.	0	23,079.	20,580.	16,882.	552,190.	
	(ii)	0	0	0	0	0	0	
3 PETER SHEA	(i)	491,146.	0	1,651.	13,230.	23,503.	529,530.	
	(ii)	0	0	0	0	0	0	
4 SERGIO CASILLAS, MD	(i)	378,355.	118,000.	0	13,230.	1,057.	510,642.	
	(ii)	0	0	0	0	0	0	
5 ROBERT SIDMAN, MD	(i)	296,400.	96,525.	16,500.	13,230.	23,272.	445,927.	
	(ii)	0	0	0	0	0	0	
6 MARK TOUSIGNANT, MD	(i)	265,264.	70,000.	0	13,230.	23,503.	371,997.	
	(ii)	0	0	0	0	0	0	
7 JUAN ESCALON, MD	(i)	341,282.	0	4,889.	13,230.	23,503.	382,904.	
	(ii)	0	0	0	0	0	0	
8 THOMAS P PIPICELLI	(i)	608,153.	0	3,169,625.	20,580.	16,882.	3,815,240.	2,782,763.
	(ii)	0	0	0	0	0	0	
9 WILLIAM HORGAN, MD	(i)	252,291.	58,890.	11,400.	9,632.	23,503.	355,716.	
	(ii)	0	0	0	0	0	0	
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

GROSS-UP PAYMENTS

SCHEDULE J, PART I, LINE 1A

THE FORMER PRESIDENT RECEIVED GROSS-UP PAYMENTS ON SELECTED EXPENSES.

THEY WERE PROPERLY INCLUDED IN HIS W-2 WAGES.

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DAVID WHITEHEAD, DANIEL E LOHR AND PETER SHEA PARTICIPATE IN A
SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN, HOWEVER THERE WERE NO ACCRUALS
OR CONTRIBUTIONS THAT WERE MADE TO THE PLAN DURING THE REPORTING PERIOD.

NON-FIXED PAYMENTS

SCHEDULE J, PART I, LINE 7

BASE COMPENSATION FOR EXECUTIVES IS APPROVED BASED ON THE CRITERIA LISTED
IN PART I, LINE 3, HOWEVER A PORTION OF THAT IS HELD BACK AND
SUBSEQUENTLY DISTRIBUTED BASED ON EVALUATION OF THE INDIVIDUALS
PERFORMANCE AND ACCOMPLISHMENT OF THE GOALS SET AT THE BEGINNING OF THE
YEAR BY AN INDEPENDENT COMPENSATION COMMITTEE. PHYSICIAN BONUSSES ARE
BASED ON MEETING PREESTABLISHED GOALS.

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

RETIREMENT AND OTHER DEFERRED COMPENSATION EXPLANATION

SCHEDULE J, PART II, COLUMN C

COMPENSATION IS REPORTED ON THE FORM 990 IN THE YEAR THE COMPENSATION IS EARNED BY OR AWARDED TO AN INDIVIDUAL, EVEN IF THE COMPENSATION IS NOT PAID TO THE INDIVIDUAL, IS NOT FULLY VESTED, OR IS SUBJECT TO SUBSTANTIAL RISK OF FORFEITURE. IF COMPENSATION IS EARNED OR AWARDED IN ONE YEAR BUT PAID IN A LATER YEAR, THEN THE COMPENSATION IS GENERALLY REPORTED A SECOND TIME ON THE FORM 990 IN THE YEAR THE COMPENSATION IS PAID TO THE INDIVIDUAL. AS A RESULT OF THE REPORTING REQUIREMENT, AN ORGANIZATION COULD BE REQUIRED TO REPORT THE SAME COMPENSATION ON FORM 990 IN TWO DIFFERENT YEARS.

ADDITIONAL INFORMATION

SCHEDULE J, PART II, LINE 10

THOMAS PIPICELLI'S COMPENSATION INCLUDES AMOUNTS ESTABLISHED AND PAID PURSUANT TO AN EMPLOYMENT AGREEMENT DATED DECEMBER 15, 2008, UNDER WHICH EMPLOYEE'S EMPLOYMENT WOULD TERMINATE ON DECEMBER 31, 2011. THE AMOUNT OF COMPENSATION RECOGNIZED THE EMPLOYEE'S DECADES-LONG SERVICE TO THE ORGANIZATION AS PRESIDENT AND CEO, AND HIS SERVICES IN TRANSITIONING TO

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

THE ORGANIZATION'S CURRENT MANAGEMENT TEAM.

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2011

Open to Public
Inspection

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

▶ Attach to Form 990. ▶ See separate instructions.

Department of the Treasury
Internal Revenue Service

Name of the organization
THE WILLIAM W. BACKUS HOSPITAL

Employer identification number
06-0250773

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A STATE OF CT HEALTH & EDUCATIONAL FACILITIES	06-0806186	20774LSV3	08/10/2005	28,992,719.	SEE SCHEDULE K, PART V		X		X		X
B STATE OF CT HEALTH & EDUCATIONAL FACILITIES	06-0806186	20774UC86	07/02/2008	30,168,922.	SEE SCHEDULE K, PART V		X		X		X
C											
D											

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	3,535,000.		2,850,000.					
2 Amount of bonds legally defeased								
3 Total proceeds of issue	28,992,719.		30,168,922.					
4 Gross proceeds in reserve funds	755,086.							
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows	16,750,062.		30,100,000.					
7 Issuance costs from proceeds	369,723.		68,922.					
8 Credit enhancement from proceeds	583,673.							
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds	10,514,252.							
11 Other spent proceeds	19,923.							
12 Other unspent proceeds								
13 Year of substantial completion	2008		2008					
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?		X	X					
15 Were the bonds issued as part of an advance refunding issue?	X			X				
16 Has the final allocation of proceeds been made?	X		X					
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X				

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule K (Form 990) 2011

Part III Private Business Use (Continued)

SEE SCHEDULE K, PART V

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6 Total of lines 4 and 5		%		%		%		%
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X					

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X	X					
2 Is the bond issue a variable rate issue?		X	X					
3a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X					
b Name of provider			UBS AG					
c Term of hedge			29.900					
d Was the hedge superintegrated?				X				
e Was the hedge terminated?				X				
4a Were gross proceeds invested in a guaranteed investment contract (GIC)?				X				
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
5 Were any gross proceeds invested beyond an available temporary period?		X		X				
6 Did the bond issue qualify for an exception to rebate?		X		X				

Part V Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations Yes No

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.**

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2011

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Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
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Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected?	
			Yes	No
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 ▶ \$ _____

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ \$ _____

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

(a) Name of interested person and purpose	(b) Loan to or from the organization?		(c) Original principal amount	(d) Balance due	(e) In default?		(f) Approved by board or committee?		(g) Written agreement?	
	To	From			Yes	No	Yes	No	Yes	No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
Total ▶ \$ _____										

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule L (Form 990 or 990-EZ) 2011

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SEE SCHEDULE L, PART V					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

BUSINESS TRANSACTION INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

(B) DAVID WHITEHEAD, DANIEL E LOHR, AND PETER SHEA ARE OFFICERS, TRUSTEES, DIRECTORS AND/OR KEY EMPLOYEES OF THE WILLIAM W. BACKUS HOSPITAL (WWBH) AND CONNCARE, INC. (CI)

(C)/(D) \$3,375,000 REIMBURSEMENTS PAID BY CI TO WWBH
 \$ 96,142 PERFORMANCE OF SERVICES BY WWBH FOR CI
 \$ 367,717 LEASED PROPERTY

(E) NO

(B) DAVID WHITEHEAD AND DANIEL LOHR ARE OFFICERS OF THE WILLIAM W BACKUS HOSPITAL AND WWB, INC.

(C)/(D) \$8,017,000 REIMBURSEMENTS PAID BY WWB TO WWBH

(E) NO

(B) DAVID WHITEHEAD AND DANIEL LOHR ARE OFFICERS OF THE WILLIAM W BACKUS HOSPITAL AND OMNI HOME HEALTH.

(C)/(D) \$120,000 ACCOUNTING AND MANAGEMENT FEES PAID BY OMNI TO WWBH
 \$ 5,263 PERFORMANCE OF SERVICES BY WWBH FOR OMNI

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

2011

**Open to Public
Inspection**

**Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.**

Department of the Treasury
Internal Revenue Service

Name of the organization

THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

ORGANIZATION'S MISSION

FORM 990, PART I, LINE 1 & PART III, LINE 1

THE WILLIAM W. BACKUS HOSPITAL DELIVERS AND COORDINATES A CONTINUUM OF HIGH QUALITY HEALTH CARE THAT IS SENSITIVE TO THE NEEDS OF INDIVIDUALS IN EASTERN CONNECTICUT. THE HOSPITAL IS COMMITTED TO BEING RESPONSIVE AND ACCOUNTABLE TO THOSE FOR WHOSE BENEFIT IT EXISTS, AND TO IMPROVING THE HEALTH OF ITS COMMUNITIES.

INDEPENDENT VOTING MEMBERS

FORM 990, PART VI, SECTION A, LINE 1B

THE TAXPAYER IS REPORTING SEVERAL MEMBERS OF THE BOARD OF DIRECTORS AS NOT BEING INDEPENDENT, EVEN THOUGH THEY DO NOT MEET ANY OF THE DEFINITIONS FROM THE 990 INSTRUCTIONS FOR DETERMINING INDEPENDENT DIRECTORS. HOWEVER, THEY DO HAVE PRIVILEGES AT THE HOSPITAL WHICH IS WHY THE HOSPITAL CONSIDERS THEM NOT INDEPENDENT.

BUSINESS RELATIONSHIPS

FORM 990, PART VI, SECTION A, LINE 2

DAVID WHITEHEAD AND DANIEL E LOHR HAVE A BUSINESS RELATIONSHIP WITH EACH OTHER. THEY SERVE AS AN OFFICER OR DIRECTOR FOR CONNCARE, INC., WWB CORPORATION, AND BACKUS HOME HEALTH WHICH ARE RELATED FOR PROFIT COMPANIES.

Name of the organization

THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

MEMBERS

FORM 990, PART VI, SECTION A, LINE 6

BACKUS CORPORATION, A NOT-FOR-PROFIT, 501(C)(3) ORGANIZATION, IS THE SOLE MEMBER OF THE WILLIAM W. BACKUS HOSPITAL.

MEMBERS WHO MAY ELECT THE GOVERNING BODY

FORM 990, PART VI, SECTION A, LINE 7A

BACKUS CORPORATION, BEING THE SOLE MEMBER OF THE WILLIAM W. BACKUS HOSPITAL, HAS THE RIGHT TO ELECT ALL THE BOARD OF TRUSTEES.

DECISIONS SUBJECT TO APPROVAL OF MEMBERS

FORM 990, PART VI, SECTION A, LINE 7B

THE ADMINISTRATIVE POWERS OF THE HOSPITAL SHALL BE VESTED IN THE BOARD OF TRUSTEES WHO SHALL HAVE CHARGE, CONTROL AND MANAGEMENT OF THE PROPERTY, AFFAIRS AND FUNDS OF THE HOSPITAL, SHALL BE RESPONSIBLE FOR THE DELIVERY AND MAINTENANCE OF QUALITY PATIENT CARE, THE PROMOTION OF QUALITY IMPROVEMENT, OVERSIGHT OF RISK MANAGEMENT ACTIVITIES, AND WHICH SHALL HAVE THE POWER AND AUTHORITY TO DO AND PERFORM ALL ACTS AND FUNCTIONS NOT INCONSISTENT WITH THE BYLAWS. THE BOARD OF TRUSTEES SHALL MAKE ALL POLICIES AND RULES THAT GOVERN THE HOSPITAL AND SHALL PROVIDE FOR THE ABILITY OF HOSPITAL LEADERSHIP TO ESTABLISH AND IMPLEMENT POLICIES AND TO PROVIDE NECESSARY RESOURCES.

990 REVIEW PROCESS

FORM 990, PART VI, SECTION B, LINE 11B

THE 990 IS PREPARED BY THE ACCOUNTING STAFF AND THEN REVIEWED BY AN

Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
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INDEPENDENT ACCOUNTING FIRM. THE 990 IS THEN REVIEWED BY THE CFO AND ANY QUESTIONS OR CONCERNS THE CFO MAY HAVE ARE ADDRESSED. THE FINANCE COMMITTEE OF THE BOARD WILL THEN REVIEW THE 990 AND ANY QUESTIONS OR CONCERNS THE FINANCE COMMITTEE HAVE ARE ADDRESSED. THE FINAL FORM 990 WITH ALL REQUIRED SCHEDULES IS THEN PROVIDED TO ALL VOTING MEMBERS OF THE BOARD PRIOR TO FILING.

CONFLICT OF INTEREST POLICY

FORM 990, PART VI, SECTION B, LINE 12C

ALL TRUSTEES, OFFICERS, AND KEY EMPLOYEES OF THE HOSPITAL SHALL COMPLETE AND SIGN A DISCLOSURE STATEMENT. THE STATEMENT WILL INCLUDE AN ITEMIZATION AND DESCRIPTION OF ANY ACTUAL OR POTENTIAL CONFLICT OF INTEREST AND ALL MATERIAL FACTS RELATED THERETO FOR SUCH TRUSTEE, OFFICER, OR KEY EMPLOYEE BY VIRTUE OF HIS OR HER ACTIVITIES OR THE ACTIVITIES OF RELATED PERSONS. TRUSTEES, OFFICERS, AND KEY EMPLOYEES ARE URGED TO BE INCLUSIVE IN THIS DISCLOSURE OF POTENTIAL AND ACTUAL CONFLICTS OF INTEREST IS ESSENTIAL TO ENSURING DISCUSSION OF CONFLICT. DISCLOSURE STATEMENTS SHALL BE RETURNED TO THE CORPORATE COMPLIANCE OFFICER. ALL DISCLOSURES MADE WILL BE REVIEWED BY THE COMPLIANCE OFFICER, UNDER THE DIRECTION OF THE CHAIR AND THE PRESIDENT, WHO SHALL EXERCISE GOOD FAITH JUDGEMENT AS TO WHETHER A CONFLICT EXISTS. THE CHAIR AND THE PRESIDENT SHALL BE RESPONSIBLE FOR MONITORING TRANSACTIONS OR ARRANGMENTS IN WHICH A TRUSTEE, OFFICER, OR KEY EMPLOYEE MAY HAVE A CONFLICT OF INTEREST AND FOR ASSURING THAT THE TRUSTEE, OFFICER, OR KEY EMPLOYEE SERVES THE HOSPITAL'S BEST INTERESTS. THE COMPLIANCE OFFICER, THE CHAIR AND/OR PRESIDENT MAY CONSULT WITH ANY TRUSTEE, OFFICER, OR KEY EMPLOYEE

Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
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AND OBTAIN INFORMATION NECESSARY FOR AN ORDINARILY PRUDENT PERSON TO MAKE A JUDGMENT AS TO WHETHER A CONFLICT EXISTS AND EACH TRUSTEE, OFFICER, AND KEY EMPLOYEE SHALL COOPERATE WITH SUCH REQUESTS. THE COMPLIANCE OFFICER, THE CHAIR, AND/OR THE PRESIDENT SHALL PROVIDE GUIDANCE TO THE TRUSTEE, OFFICER, OR KEY EMPLOYEE AND TO THE BOARD OF TRUSTEES AS TO THE APPROPRIATE COURSE OF ACTION. WHEN DEEMED PRUDENT BY THE CHAIR OR THE PRESIDENT, THE CHAIR AND THE PRESIDENT SHALL SEEK THE ADVICE AND APPROVAL OF THE FULL BOARD OF TRUSTEES OR GOVERNANCE COMMITTEE IN DETERMINING WHETHER A CONFLICT OF INTEREST EXISTS AND THAT THE TRUSTEE, OFFICER, OR KEY EMPLOYEE SERVES THE HOSPITAL'S BEST INTERESTS. IF, AFTER COMPLETING AND SIGNING THE ANNUAL DISCLOSURE STATEMENT, AN ACTUAL OR POTENTIAL CONFLICT ARISES, THE TRUSTEE, OFFICER, OR KEY EMPLOYEE WITH THE CONFLICT SHALL PROMPTLY NOTIFY THE COMPLIANCE OFFICER IN WRITING. TRUSTEES, OFFICERS, AND KEY EMPLOYEES WHO HAVE DECLARED OR HAVE BEEN DEEMED TO HAVE A CONFLICT OF INTEREST MUST REFRAIN FROM CONSIDERATION OF PROPOSED TRANSACTIONS OR ARRANGMENTS, UNLESS FOR SPECIAL REASON THE BOARD OF TRUSTEES REQUESTS INFORMATION OR INTERPRETATIONS.

COMPENSATION REVIEW

FORM 990, PART VI, SECTION B, LINES 15A & B

A PERFORMANCE REVIEW COMMITTEE CONSISTING OF INDEPENDENT BOARD MEMBERS REVIEWS THE PERFORMANCE OF THE SENIOR MANAGEMENT TEAM. COMPENSATION IS BASED ON THE RESULTS OF THESE REVIEWS. THE COMMITTEE ALSO TAKES INTO CONSIDERATION INFORMATION FROM COMPENSATION SURVEYS.

JOINT VENTURES

Name of the organization THE WILLIAM W. BACKUS HOSPITAL	Employer identification number 06-0250773
--	--

FORM 990, PART VI, SECTION B, LINE 16B

ALL NEW VENTURES ARE REVIEWED BY OUTSIDE COUNSEL AND PRESENTED TO THE BOARD FOR REVIEW AND APPROVAL.

AVAILABILITY OF DOCUMENTS

FORM 990, PART VI, SECTION C, LINE 19

THE ORGANIZATION'S GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST. PLEASE CONTACT DANIEL E LOHR AT 326 WASHINGTON STREET, NORWICH, CT, 06360, ABOUT INSPECTING THE ORGANIZATION'S DOCUMENTS.

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 5

K-1 GAIN	892
TRANSFER TO AFFILIATE	(1,248,123)
INCREASE IN ASSETS HELD IN TRUST	306,792
CHANGE IN PENSION FUNDING	(4,361,697)
UNREALIZED GAIN	10,067,106
INVESTMENT EXPENSES	(365,321)

TOTAL	\$ 4,399,649

ATTACHMENT 1

FORM 990, PART VII, COLUMN B - ESTIMATED AVERAGE PER WEEK

NAME AND TITLE	HOURS DEVOTED FOR RELATED ORGANIZATION
----------------	--

Name of the organization	Employer identification number
THE WILLIAM W. BACKUS HOSPITAL	06-0250773

ATTACHMENT 1 (CONT'D)

DAVID WHITEHEAD	
TRUSTEE/PRESIDENT/CEO	7.00
ROBERT RAMSDELL	
TRUSTEE/TREASURER	1.00
JOSEPH FATONE	
TRUSTEE/SECRETARY	1.00
ANTHONY JOYCE	
TRUSTEE/VICE CHAIRMAN	1.00
JOHN F BILDA	
TRUSTEE	1.00
ELIZABETH CONWAY	
TRUSTEE	1.00
BERT A COPPOTELLI, MD	
TRUSTEE	1.00
PETER MANERI	
TRUSTEE	1.00
DEBORAH MONAHAN	
TRUSTEE	1.00
LYNNE QUINTAL-HILL	
TRUSTEE	1.00
MARK TRAMONTOZZI, MD	
TRUSTEE	1.00
STEPHEN T BRIGGS, MD	
TRUSTEE	1.00
PAUL MAXFIELD	
TRUSTEE	1.00
DONNA ROMITO, DO	
TRUSTEE	1.00
DANIEL E LOHR	
SENIOR VP/CFO	9.00
THOMAS P PIPICELLI	
FORMER PRESIDENT	10.00

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2011

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**

Name of the organization

THE WILLIAM W. BACKUS HOSPITAL

Employer identification number

06-0250773

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) -----					
(2) -----					
(3) -----					
(4) -----					
(5) -----					
(6) -----					

Part II Identification of Related Tax-Exempt Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) BACKUS HEALTH CARE INC. 22-2481794 326 WASHINGTON ST. NORWICH, CT 06360	SUPPORT	CT	501 (C) (3)	11A	BACKUS CORP	X	
(2) BACKUS CORPORATION 22-2757608 326 WASHINGTON ST. NORWICH, CT 06360	SUPPORT	CT	501 (C) (3)	11B	N/A		X
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2011

Part III Identification of Related Organizations Taxable as a Partnership (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) OMNI HOME HEALTH 06-1458837 NORWICH, CT 06360	HOME HEALTH CARE	CT	N/A									
(2) -----												
(3) -----												
(4) -----												
(5) -----												
(6) -----												
(7) -----												

Part IV Identification of Related Organizations Taxable as a Corporation or Trust (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) WWB CORPORATION 06-1094836 326 WASHINGTON ST NORWICH, CT 06360	HOLDING COMPANY	CT	N/A	C-CORP			
(2) CONNCARE, INC. 06-1387598 326 WASHINGTON ST NORWICH, CT 06360	HEALTH CARE SRVCS	CT	N/A	C CORP			
(3) BACKUS MEDICAL CENTER CONDO ASSOC, INC. 06-1542647 330 WASHINGTON ST. NORWICH, CT 06360	CONDO ASSOCIATION	CT	N/A	C-CORP	0	0	65.0000
(4) -----							
(5) -----							
(6) -----							
(7) -----							

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35, 35a, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)		X
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Sale of assets to related organization(s)		X
g Purchase of assets from related organization(s)		X
h Exchange of assets with related organization(s)		X
i Lease of facilities, equipment, or other assets to related organization(s)	X	
j Lease of facilities, equipment, or other assets from related organization(s)		X
k Performance of services or membership or fundraising solicitations for related organization(s)	X	
l Performance of services or membership or fundraising solicitations by related organization(s)		X
m Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
n Sharing of paid employees with related organization(s)	X	
o Reimbursement paid to related organization(s) for expenses		X
p Reimbursement paid by related organization(s) for expenses	X	
q Other transfer of cash or property to related organization(s)		X
r Other transfer of cash or property from related organization(s)		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) CONNCARE INC	I	367,717.	COST
(2) OMNI HOME HEALTH	K	125,263.	COST
(3) CONNCARE INC	K	96,142.	COST
(4) CONNCARE INC	P	3,375,000.	COST
(5) WWB INC	P	8,017,000.	COST
(6)			