Application Checklist

Instructions:

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

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

For OHCA Use Only:

Docket No.: 13-31883-CON **Check No.:** 0073835
OHCA Verified by: KR **Date:** 12-31-13

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

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

X☐ **Attached are completed Financial Attachments I and II.**

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

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

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

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

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

AFFIDAVIT

Applicant: Gaylord Specialty HealthCare

Project Title: Termination of Service, Gaylord Sleep Medicine-Trumbull

I, ____Janine Epright_, ____CFO_____
(Individual's Name) (Position Title – CEO or CFO)

of _____Gaylord Hospital_being duly sworn, depose and state that
(Hospital or Facility Name)

__Gaylord Sleep Medicine, Trumbull's information submitted in this Certificate of
(Hospital or Facility Name)

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

Janine Epright
Signature

12/30/13
Date

Subscribed and sworn to before me on 12/30/13

Notary Public/Commissioner of Superior Court

My commission expires: MAR 31 2016

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

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

Docket Number:

Applicant: Gaylord Hospital

Contact Person: Janine Epright

Contact Person's Title: CFO

Contact Person's Address: Gaylord Hospital, P.O. Box 400, Gaylord Farms Road, Wallingford, CT 06492

Contact Person's Phone Number: 203-284-2800

Contact Person's Fax Number: 203-741-3408

Contact Person's Email Address: jepright@gaylord.org

Project Town: Trumbull

Project Name: Gaylord Sleep Medicine-Trumbull

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

Estimated Total

Capital Expenditure: $0

1. **Project Description: Service Termination**

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

Response: Gaylord Hospital is a long term acute care hospital (LTACH) that provides health care services for patients requiring care for spinal cord injury, traumatic brain injury, stroke, pulmonary disease and other medically complex illnesses and sleep medicine. Gaylord Hospital's services include both inpatient and outpatient care. Gaylord Sleep Medicine-Trumbull is located at 101 Merritt Blvd. Trumbull, Connecticut, 06611. Gaylord Sleep Medicine-Trumbull provides physician consultation and patient evaluation, and the Center is equipped for day and overnight sleep testing as well as CPAP therapy. The sleep service program at the Trumbull location consists of 6 beds. The services include diagnostic polysomnography, split-night polysomnography and therapeutic polysomnography. The Center is accredited by the American Academy of Sleep Medicine.

The Sleep Center has a broad geographic reach, with the top 6 towns of patient origin representing 73% of the total patient population. Patient census information can be found in the Appendix.

Response: The decision to discontinue Gaylord Sleep Medicine-Trumbull was made by Gaylord Specialty Healthcare as it plans for the changing health environment.

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

Response: Gaylord Sleep Medicine-Trumbull began providing services in 2007. A CON authorization was received, Docket Number 06-30788, April 2, 2007. On April 2, 2007, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application of Gaylord Hospital, Inc. seeking authorization to terminate a Sleep Laboratory in Fairfield and establish a Sleep Laboratory in Trumbull and increase the capacity from three to six beds.

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

Response: The decision to discontinue Gaylord Sleep Medicine-Trumbull was made by Gaylord Specialty Healthcare as it plans for the changing health environment. Gaylord's focus will be on those resources that support its core services for complex rehabilitation and medically complex patients. The decision to terminate the service was made by management at Gaylord Specialty Healthcare.

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

Response: The decision to discontinue Gaylord Sleep Medicine - Trumbull did not require a vote of the Board of Directors of Gaylord Hospital.

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

Response: Not Applicable

2. Termination's Impact on Patients and Provider Community

a. **List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.**

Response: PriMed Physicians currently provides sleep medicine services at the Fairfield County Sleep Center, 501 Kings Highway, Fairfield; sleep medicine services are also provided by Bridgeport Hospital through its Center for Sleep Medicine (Affiliated with YNHH) , Grant Street, Bridgeport; Danbury Hospital Sleep Disorders Center, Danbury; Greenwich Hospital Sleep Center (affiliated with YNHH) , Greenwich, and Norwalk Hospital's Norwalk Sleep Disorders Center, Maple Street, Norwalk. Because these are outpatient facilities, patient volume and utilization rates are unavailable.

b. **Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.**

Response: The Applicant, Gaylord Sleep Medicine-Trumbull, and YNHH and Connecticut Children's Medical Center (CCMC) have agreed to work collaboratively to ensure a seamless transition of the clinical service from the patient's perspective. Gaylord Sleep Medicine-Trumbull will notify patients of the availability of sleep medicine services provided by the sleep program affiliated with YNHH for adult patients and CCMC Sleep program for pediatric patients.

c. **For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.**

Response: Since these are outpatient facilities, patient volume, utilization and available capacity are not available.

d. **Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.**

Response: Not applicable.

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

Response: : Gaylord Sleep Medicine-Trumbull has a written agreement with YNHH for the smooth transition of its adult patients and with CCMC for the transition of its pediatric patients. (See Appendix).

f. **Describe how clients will be notified about the termination and transferred to other providers.**

Response: Patients will be sent a letter informing them of treatment options available in the area. (Appendix)

3. Actual and Projected Volume

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

Gaylord Sleep Medicine Trumbull Patient Visit Volume

Row Labels	2013
Ansonia	44
Beacon Falls	13
Bethany	5
Bethel	2
Bridgeport	466
Bristol	1
Brookfield	3
Brooklyn	1
Cave Creek	2
Cheshire	3
Cromwell	6
Danbury	6
Darien	1
DERBY	17
East Haven	1
Easton	11
Fairfield	143
Hamden	5
Huntington	7
Landenberg	2
Meriden	4
Middlebury	2
Middletown	11
Milford	379

Monroe	42
Naugatuck	12
New Britain	1
New Britain	1
New Canaan	2
New Haven	4
New Milford	8
New Rochelle	3
New York	1
Newtown	4
North Haven	8
Norwalk	9
Old Saybrook	1
Orange	59
Oxford	11
Prospect	5
Redding	9
Ridgefield	3
Sandy Hook	9
Seymour	27
Shelton	143
Southbury	5
Southport	20
Stafford Springs	1
Stamford	30
Stratford	225
Torrington	8
Trumbull	167
Wallingford	1
Waterbury	19
Watertown	6
West Hartford	1
West Haven	30
Weston	5
Westport	19
Wilton	7
Winsted	8
Woodbridge	7
Grand Total	**2056**

b. Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.

Table 1: Historical and Current Visits & Admissions (MSLT and Sleep Studies)

	Actual Volume (Last 3 Completed FYs)			**CFY Volume***
	FY 2011	FY 2012	FY 2103	FY2014
Sleep Medicine	726	642	453	33
Total	**726**	**642**	**453**	**33**

Gaylord fiscal year (October 1-September 30)

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

Response: The volume of sleep medicine patients in North Haven has been declining over the course of the last 3 years. Physician referrals and direct patient referrals have both declined. Sleep services are provided by other practices in the area.

For DMHAS-funded programs only, provide a report that provides the following information for the last three full FYs and the current FY to-date:

i. Average daily census;
ii. Number of clients on the last day of the month;
iii. Number of clients admitted during the month; and
iv. Number of clients discharged during the month.

Response: Not applicable

4. Quality Measures

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

Response: The Curriculum Vitae for the following sleep medicine physicians practicing at the Trumbull location has been included in the Attachment: Drs. Keith Dixon and Arthur Turetsky.

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

Response: The decision to discontinue sleep medicine services in Trumbull does not impact the quality of health care services being delivered since sleep medicine services are available in the area.

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

Response: Gaylord Hospital is licensed to operate and maintain an long term acute care hospital through the Department of Public Health (DPH). DPH does not separately specify the types of services that are provided under that license. The termination of this service will not result in any changes to Gaylord Hospital's license from DPH.

5. Organizational and Financial Information

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

Response: Gaylord Specialty HealthCare is a corporation.

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

Response: Documentation provided in the Appendix

c. **Financial Statements**

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

Response: The Audited Financial Statement is provided in the Appendix.

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

Not Applicable

d. **Submit a final version of all capital expenditures/costs.**

Response: There are no capital expenditures/costs to be incurred by Gaylord Hospital as a result of discontinuing this program.

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

Response: Not Applicable

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

Response: This proposal will have no effect on the current financial state of the health care system.

6. **Financial Attachments I & II**

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

Response: Please see **Attachment** for Financial Attachment I.

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

Response: Financial Attachment II has been provided as an **Attachment** however it should be noted that there are no incremental revenue, expense, or volume statistics attributable to the termination of sleep medicine services at Trumbull.

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

Response: The assumptions utilized to develop Financial Attachment I and Financial Attachment II are as follows:

The number of hospital FTEs will decrease by approximately 4.5 FTEs.

All inpatient volumes for Gaylord Hospital will remain constant at FY2013 levels with or without the approval of the CON. Gaylord Sleep Medicine-Trumbull is a physician office which provides evaluations and follow up consultations and does not provide inpatient services.

Operating expenses for Gaylord Hospital will increase 3 % each year though FY2015 from the levels experienced in FY2013 due to inflation and assumes no changes in operations that would contribute to an increase or decrease in expenses beyond the impact of inflation. The overall Payer Mix for the System will remain constant at the percentage distribution reported in the FY2012 audited financial statement.

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

Response: Not Applicable

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

Response: Gaylord Sleep Medicine-Trumbull was reimbursed for sleep services, however the decision to terminate services was not dependent on reimbursement levels but on declining volume and leasing considerations.

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

Response: Not applicable

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

Response: There is no anticipated operating revenue increases with or without this proposal.

h. Describe how this proposal is cost effective.

Response: This proposal will have no effect on the current financial state of the health care system.

APPENDIX

Contents

A. CVs for physicians practicing at Gaylord Sleep Medicine-Trumbull
B. Not-For-Profit Certificate
C. Financial Attachments 1 and 2
D. Patient Census
E. Financial Statement
F. Newspaper Notification
G. Patient Notification
H. Agreement between Gaylord Sleep Medicine and CCMC

A. CV of Keith Dixon, MD

3933 Park Avenue
Fairfield, CT 06825
(201) 923-5421
dixonke1@excite.com

Keith R. Dixon, M.D.

Education

New Jersey Medical School - University of Medicine and Dentistry — M.D, 2000
Newark, New Jersey

Montclair State University — B.S. (Cum Laude), 1996
Montclair, New Jersey — Major: Biology

Training

Sleep Medicine Fellowship (Accredited 1996) — 2003-2005
The Sleep/Wake Institute
Hackensack University Medical Center
Hackensack New Jersey

Internal Medicine Residency — 2000-2003
The University Hospital
Newark, New Jersey

Military Experience

United States Army

Honorable Discharge — 1994

Independent Ready Reserves — 1989 –1994

Active Duty — 1986 -1989

- **Medical Specialist**
  Medical Detachment Group
- **Non-Commissioned-Officer-In-Charge**
  Allergy/Immunization Clinic
  Irwin Army Community Hospital
- **Non-Commissioned-Officer-In-Charge**
  Troop Medical Clinic – 1st Infantry Division

Work Experience

Sleep Physician
Gaylord Hospital – Sleep Medicine Services — 2005 - present

Cardiac Unit Coordinator — 1990 -1996
Holy Name Hospital

Academic Honors

- Greater Newark Alliance Participation Research Scholarship, 1996
- Who's Who Among Students in American Colleges and Universities, 1995
- Award for Academic Excellence, Health Careers Program, 1994
- National Deans List, 1993

Affiliations

American Academy of Sleep Medicine, Member

Research and Presentations

Sleep Medicine

Presentation
Common Sleep Problems For School-Age Children
Gaylord Hospital – North Haven, Connecticut
2007

Presentation
Diagnosis and Treatment of Infantile Apnea in Apparent Life Threatening Events
American College of Chest Physicians Annual Conference - Seattle, Washington
2004

Research – Principal Investigator
Validation of Specific Quantified Parameters vs. Traditional Measurements in the Diagnosis of Increased Upper Airway Resistance Syndrome
Hackensack University Medical Center - Hackensack, New Jersey
Dr. H. Ashtyani
2003- Present

Presentation
Introduction to Sleep Medicine
Hackensack University Medical Center, Internal Medicine Program - Hackensack, New Jersey
2003

Hematology

Presentation
Thrombotic Thrombocytopenic Purpura
The University Hospital, Internal Medicine Program – Newark, NJ
2002 and 2003

Molecular Biology

Research
Joint DNA sequencing project –Microbiology, Biochemistry and Molecular Biology departments
Montclair State University
Dr. Delaney, Dr. L. Lee
1995-1996

Publications

Principal Author - Diagnosis and Treatment of Infantile Apnea in ALTE
Chest, 10/2004 Vol. 126, Issue 4

Extracurricular Activities

University of Medicine and Dentistry of New Jersey (UMDNJ)

Instructor - New Jersey Medical School FIRST Program, 1997
Instructor - High School Scholars Program, 1996
Vice President - Student National Medical Association, 1997-1998

Montclair State University
Peer Tutor – Health Careers Program, 1994

Certification and Licensure

Internal Medicine Board Certification – American Board of Internal Medicine, 2003
Sleep Medicine Board Certification – American Board of Sleep Medicine, 2005

B. Not-for-Profit Certificate

Internal Revenue Service

Department of the Treasury

Washington, DC 20224

Person to Contact: Mr. Gillette

Telephone Number: (202) 566-3586

Refer Reply to: E:EO:R:2-5

Date: JUN 10 1991

Gaylord Farm Association, Inc.
Gaylord Farm Road, Box 400
Wallingford, CT 06492

Legend: H = Gaylord Hospital, Inc.
P = Gaylord Farm Association, Inc.
S = Farm Properties Incorporated

Dear Applicant:

This is in reply to your request of August 22, 1990, and subsequent correspondence for rulings concerning a proposed reorganization.

H is a nonstock not-for-profit hospital. H has been recognized as exempt from federal income taxes under section 501(c)(3) of the Code and classified as a public charity under sections 509(a)(1) and 170(b)(1)(A)(iii).

P is a nonstock not-for-profit corporation. P's Certificate of Incorporation provides that its principal purpose is to benefit, perform the functions of, carry out the purposes of and uphold, promote and further the welfare, programs and activities of H. It has been recognized as exempt from federal income taxes under section 501(c)(3) of the Code and a supporting organization within the meaning of section 509(a)(3).

S is a stock corporation with P as its sole shareholder. S is a for-profit corporation and will be subject to federal income taxes. It is not anticipated that P or H will provide services to S, although some personnel and facilities may be shared in the beginning in an effort to reduce costs. If services are provided, an arms-length fee will be charged. The primary purpose of S is to perform real estate development and management functions for P and H.

In addition to its operation of a hospital, H has significant operational and administrative responsibilities in areas not directly related to the providing of medical care to hospital patients. The complexities of operating H's general acute care hospital and H's associated activities have become increasingly burdensome in recent years. At the same time, the demands on the time of persons on the Board of Trustees and Executive Committee of H have also increased. Furthermore, H's commitment to make its services available to all who may need them requires that some of these services be performed at

C. Financial Attachment I & II

10

FINANCIAL ATTACHMENT DESCRIPTIONS

Financial Attachment A – Long Form Total Facility Not-for-Profit

Financial Attachment B – Long Form Total Facility For-Profit

Financial Attachment C – Long Form Total Hospital Health System Not-for-Profit

Financial Attachment D – Long Form Total Hospital Health System For-Profit

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY 2013 Actual Results	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON
NET PATIENT REVENUE										
Non-Government	$541,770	$530,182	($530,182)	$0	$530,182	($530,182)	$0	$530,182	($530,182)	$0
Medicare	$106,088	$106,088	($106,088)	$0	$106,088	($106,088)	$0	$106,088	($106,088)	$0
Medicaid and Other Medical Assistance	$102,088	$102,088	($102,088)	$0	$102,088	($102,088)	$0	$102,088	($102,088)	$0
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$749,946	$738,358	($738,358)	$0	$738,358	($738,358)	$0	$738,358	($738,358)	$0
Other Operating Revenue	$0	$0			$0			$0		
Revenue from Operations	$749,946	$738,358	($738,358)	$0	$738,358	($738,358)	$0	$738,358	($738,358)	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits	$467,250	$476,595	($476,595)	$0	$486,127	($486,127)	$0	$495,849	($495,849)	$0
Professional / Contracted Services	$32,484	$32,485	($32,485)	$0	$32,485	($32,485)	$0	$32,485	($32,485)	$0
Supplies and Drugs	$16,886	$16,887	($16,887)	$0	$16,887	($16,887)	$0	$16,887	($16,887)	$0
Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Expense	$93,231	$93,232	($93,232)	$0	$93,232	($93,232)	$0	$93,232	($93,232)	$0
Subtotal	$609,851	$619,199	($619,199)	$0	$628,731	($628,731)	$0	$638,453	($638,453)	$0
Depreciation/Amortization	$52,189	$52,189	($52,189)	$0	$52,189	($52,189)	$0	$52,189	($52,189)	$0
Interest Expense	$16,513	$16,513	($16,513)	$0	$16,513	($16,513)	$0	$16,513	($16,513)	$0
Lease Expense	$72,708	$78,498	($78,498)	$0	$80,853	($80,853)	$0	$83,279	($83,279)	$0
Total Operating Expense	$751,261	$766,399	($766,399)	$0	$778,286	($778,286)	$0	$790,434	($790,434)	$0
Gain/(Loss) from Operations	($1,315)	($28,041)	$28,041	$0	($39,928)	$39,928	$0	($52,076)	$52,076	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expense	($1,315)	($28,041)	$28,041	$0	($39,928)	$39,928	$0	($52,076)	$52,076	$0
FTEs	4.50	4.50	(4.50)	-	4.50	(4.50)	-	4.50	(4.50)	-
Volume Sleep Studies	453	446	(446)	0	446	(446)	-	446	(446)	-

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

D. Patient Census

Row Labels	2011	2012	2013	2014	Grand Total
Ansonia	67	38	44	6	155
Atlanta	3				3
Avon	1				1
Beacon Falls	15	9	13		37
Berlin	1				1
Bethany	1	7	5		13
Bethel			2		2
Bethlehem	1				1
Botsford	4				4
Branford	1	4			5
Bridgeport	474	479	466	49	1468
Bristol	5		1		6
Bronx		1			1
Brookfield			3		3
Brooklyn			1		1
Canton		1			1
Cave Creek			2		2
Cheshire	4	7	3		14
Clinton	4				4
Cromwell		3	6		9
Danbury	6	10	6		22
Darien		8	1		9
Deer Park	4				4
DERBY	17	30	17	3	67
Durham	3				3
East Hartford	1				1
East Haven	9	9	1		19
Easton	24	27	11	1	63
Fairfield	194	152	143	16	505
Fairfield	2				2
FORT PLAIN	1				1
Glastonbury	2				2
Hamden	8	8	5		21
Huntington			7	1	8
Hyattsville	1				1
Indianapolis		4			4
Ivoryton		1			1
Kew Garden		9			9
Landenberg	1		2		3
Ledyard	1				1
Madison	1	3			4
Meriden	7	3	4	1	15
Middlebury			2		2
Middletown	1	8	11		20

Milford	326	405	379	36	1146
Monroe	73	50	42	10	175
Monsey	1	1			2
Naugatuck	38	25	12		75
New Britain			1		1
New Britian			1		1
New Cannan	4	6	2		12
New Haven	10	6	4		20
New London	1				1
New Milford	1	3	8		12
New Rochelle		3	3		6
New York			1		1
Newington	1				1
Newtown	22	9	4	2	37
North Haven	3	6	8		17
Norwalk	19	23	9	3	54
Oakville		1			1
Old Saybrook	4	2	1		7
Orange	34	76	59	9	178
Oxford	24	15	11		50
Plymouth		5			5
Prairie Farm		1			1
Prospect	8	15	5		28
Redding	7	3	9	3	22
Ridgefield	8	1	3		12
Sandy Hook	5	6	9		20
Seymour	20	26	27	3	76
Sharon	2				2
Shelton	202	249	143	17	611
South Port		1			1
Southbury	4	2	5	1	12
Southport	11	19	20		50
Stafford	2				2
Stafford Springs	1		1		2
Stamford	18	9	30	2	59
Stanford	3				3
Stratford	309	230	225	23	787
Teaneck		2			2
Terryville	2				2
Thomaston		3			3
Torrington	9	8	8	1	26
Trumbull	198	201	167	17	583
Wallingford	7	9	1	1	18
Washington Depot		1			1
Waterbury	25	12	19	1	57
Watertown	3	6	6		15
West Hartford	1	5	1		7
West Haven	20	54	30	3	107
Westbrook	1				1
Weston	3	12	5		20

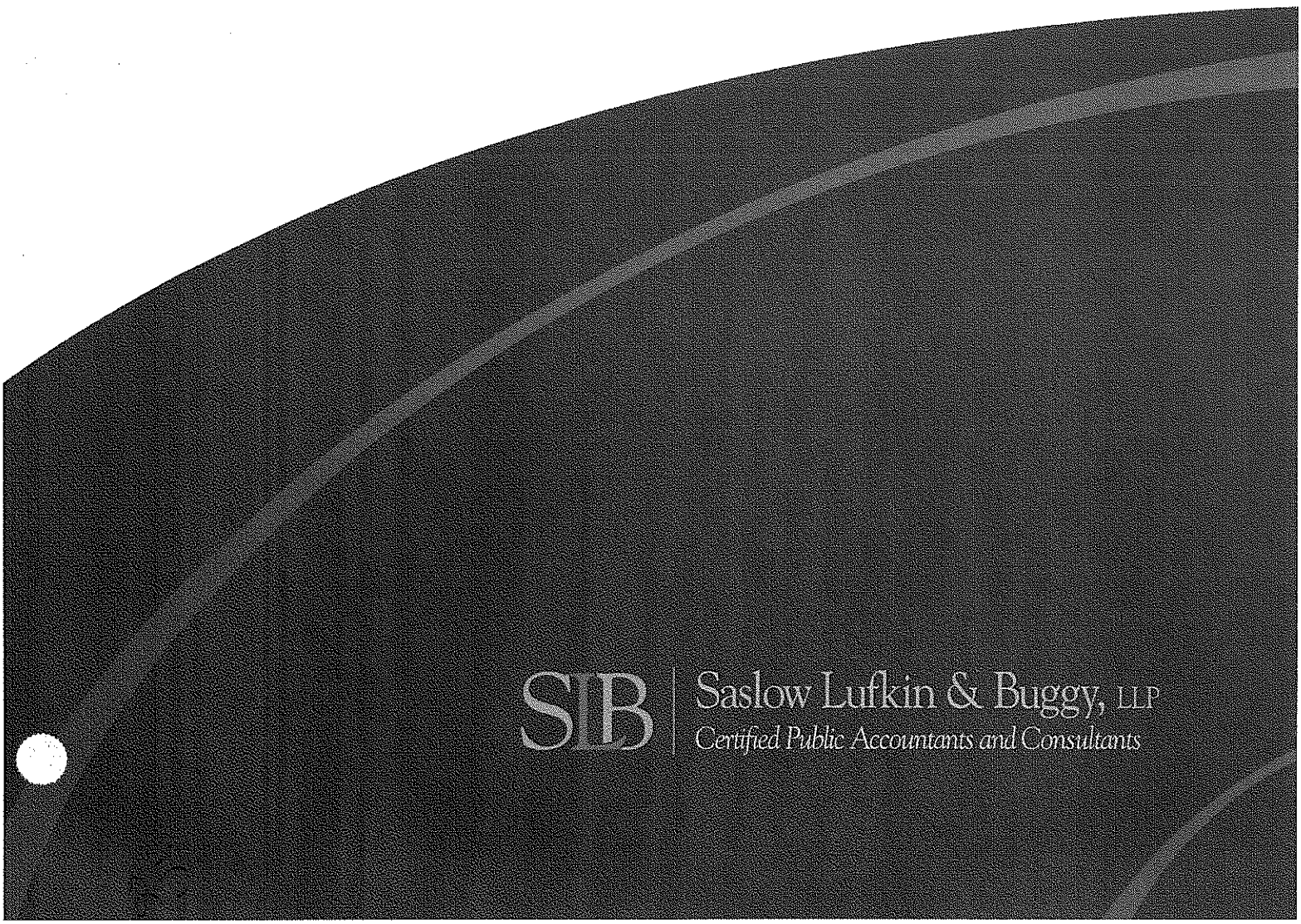
Westport	37	25	19	4	85
Wethersfield	9	1			10
Wilton	1	3	7		11
Windsor		1			1
Winsted	5	1	8		14
Woodbridge	5	12	7		24
Woodbury	8				8
Grand Total	**2359**	**2375**	**2056**	**213**	**7003**

E. Financial Statement

Gaylord Farm Association, Inc.

Independent Auditors' Report,
Consolidated Financial Statements and
Supplemental Information

As of and for the Years Ended
September 30, 2012 and 2011



Gaylord Farm Association, Inc.
Independent Auditors' Report, Consolidated Financial Statements and Supplemental Information
As of and for the Years Ended September 30, 2012 and 2011

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SLB | Saslow Lufkin & Buggy, LLP
Certified Public Accountants and Consultants

Independent Auditors' Report

To the Board of Directors of
Gaylord Farm Association, Inc.:

We have audited the accompanying consolidated balance sheets of Gaylord Farm Association, Inc. (the Association) as of September 30, 2012 and 2011, and the related consolidated statements of operations and changes in net assets and shareholder's equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the financial statements of Gaylord Risk Solutions, Ltd., a wholly-owned subsidiary, whose statements reflect total assets of $5,243,107 and $5,354,067, total liabilities of $3,783,397 and $3,550,951 as of September 30, 2012 and 2011, and total revenues of ($415,079) and ($135,312) and net loss of ($702,372) and ($121,844) for the years then ended, respectively. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Gaylord Risk Solutions, Ltd., is based solely on the report of the other auditors.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Gaylord Farm Association, Inc. as of September 30, 2012 and 2011, and the results of its consolidated operations and its consolidated cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information listed within the Table of Contents is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and it is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and cash flows of the individual companies. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Saslow Lufkin & Buggy, LLP

January 8, 2013
Avon, Connecticut

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Avon, Connecticut 06001
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Gaylord Farm Association, Inc.
Consolidated Balance Sheets
September 30, 2012 and 2011

	2012	2011
Assets		
Current assets:		
Cash and cash equivalents	$ **635,238**	$ 884,695
Patient accounts receivable (less allowance for doubtful accounts of $458,000 in 2012 and $503,000 in 2011)	**10,522,310**	10,001,815
Assets whose use is limited:		
Assets held under bond indenture agreement	**189,467**	179,780
Pledges receivable, net	**90,046**	386,657
Other current assets	**2,003,316**	1,944,851
Total current assets	**13,440,377**	13,397,798
Assets whose use is limited:		
Pledges receivable	**231,120**	310,105
Board-designated investments	**14,349,648**	13,693,257
Donor restricted investments	**5,555,747**	5,529,789
Beneficial interest in trusts held by others	**11,240,066**	9,748,956
	31,376,581	29,282,107
Property, plant and equipment, net	**38,177,394**	41,937,586
Investments held for captive insurance liabilities	**3,846,709**	3,517,224
Reinsurance recoverable relating to captive insurance liabilities	**663,930**	678,921
Other assets (Notes 4 and 7)	**946,160**	1,086,089
Total assets	$ **88,451,151**	$ 89,899,725
Liabilities, Net Assets and Shareholder's Equity		
Current liabilities:		
Accounts payable and accrued expenses	$ **2,811,631**	$ 4,853,991
Accrued payroll and related taxes	**4,730,818**	3,819,490
Line of credit	**-**	450,000
Estimated amounts due to third-party payers	**246,805**	246,805
Current portion of accrued pension obligation	**1,493,193**	2,743,352
Current portion of long-term debt and capital lease obligations	**1,526,815**	1,487,242
Total current liabilities	**10,809,262**	13,600,880
Long-term debt and capital lease obligations, less current portion	**18,153,360**	19,570,309
Accrued pension obligation	**16,609,410**	14,699,268
Captive insurance losses and other reserves	**2,819,498**	2,827,083
Interest rate swap liability	**4,712,094**	4,155,222
Total liabilities	**53,103,624**	54,852,762
Net assets and shareholder's equity:		
Unrestricted net assets	**15,942,540**	16,757,868
Temporarily restricted net assets	**1,149,464**	1,207,234
Permanently restricted net assets	**16,795,813**	15,278,745
Shareholder's equity	**1,459,710**	1,803,116
Total net assets and shareholder's equity	**35,347,527**	35,046,963
Total liabilities, net assets and shareholder's equity	$ **88,451,151**	$ 89,899,725

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

Gaylord Farm Association, Inc.
Consolidated Statements of Operations and
Changes in Net Assets and Shareholder's Equity
For the Years Ended September 30, 2012 and 2011

	2012	2011
Revenues:		
Net patient service revenue	$ 70,326,743	$ 67,064,747
Contributions and bequests	1,076,207	913,165
Ceded premium	(325,000)	(332,500)
Other operating revenue	725,080	637,668
Net assets released from restrictions used for operations	279,175	145,235
Total revenues	72,082,205	68,428,315
Expenses:		
Salaries and related expenses	49,528,721	46,823,400
Other operating expenses	5,606,698	5,531,291
Professional fees and contract services	8,060,187	6,818,453
Supplies	5,034,738	5,064,540
Depreciation and amortization	3,900,452	3,890,429
Occupancy costs	2,145,309	2,099,698
Provision for bad debts	420,830	344,715
Interest	882,966	919,764
Losses and loss adjustment expenses (recoveries)	164,137	(141,200)
Total expenses	75,744,038	71,351,090
Loss from operations	(3,661,833)	(2,922,775)
Other gains, net:		
Dividend and interest income	522,282	586,562
Net realized gains on investments	515,365	140,830
Loss on equity investments	(75,252)	(5,304)
Change in fair value of interest rate swap agreement	(556,872)	(508,193)
Total other gains, net	405,523	213,895
Excess of revenues under expenses	$ (3,256,310)	$ (2,708,880)

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

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Gaylord Farm Association, Inc.
Consolidated Statements of Operations and
Changes in Net Assets and Shareholder's Equity (continued)
For the Years Ended September 30, 2012 and 2011

	2012	2011
Unrestricted net assets:		
Excess of revenues under expenses	**$ (3,256,310)**	$ (2,708,880)
Net unrealized gains (losses) on investments	**2,557,046**	(1,132,499)
Pension related changes other than net periodic pension cost	**(1,708,412)**	(3,183,532)
Net loss of GRS	**702,372**	121,844
Net assets released from restrictions used for purchases of property, plant and equipment	**889,976**	616,837
Change in unrestricted net assets	**(815,328)**	(6,286,230)
Temporarily restricted net assets:		
Restricted pledges and contributions	**719,251**	187,488
Investment income and realized gains on investments	**74,943**	-
Net unrealized gains on investments	**317,187**	-
Net assets released from restrictions	**(1,169,151)**	(762,072)
Change in temporarily restricted net assets	**(57,770)**	(574,584)
Permanently restricted net assets:		
Restricted contributions and bequests	**25,958**	29,320
Change in beneficial interest in trusts held by others	**1,491,110**	(419,464)
Change in permanently restricted net assets	**1,517,068**	(390,144)
Shareholder's equity:		
Net loss of GRS	**(702,372)**	(121,844)
Net unrealized gains (losses) on investments of GRS	**358,966**	(260,304)
Change in shareholder's equity	**(343,406)**	(382,148)
Change in net assets and shareholder's equity	**300,564**	(7,633,106)
Net assets and shareholder's equity, beginning of year	**35,046,963**	42,680,069
Net assets and shareholder's equity, end of year	**$ 35,347,527**	$ 35,046,963

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

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Gaylord Farm Association, Inc.
Consolidated Statements of Cash Flows
For the Years Ended September 30, 2012 and 2011

	2012	2011
Operating activities:		
Change in net assets and shareholder's equity	**$ 300,564**	$ (7,633,106)
Adjustments to reconcile change in net assets and shareholder's equity to net cash (used in) provided by operating activities:		
Depreciation and amortization	**3,900,452**	3,890,429
Pension related changes other than net periodic pension cost	**1,708,412**	3,183,532
Change in fair value of interest rate swap	**556,872**	508,193
Net realized and unrealized (gains) losses on investments	**(3,464,541)**	991,669
Loss from equity investments	**75,252**	5,304
Change in beneficial interest in trusts held by others	**(1,491,110)**	419,464
Restricted contributions and bequests received	**(745,209)**	(216,808)
Changes in operating assets and liabilities:		
Patient accounts receivable	**(520,495)**	(885,966)
Other current assets	**(58,465)**	(219,834)
Pledges receivable	**375,596**	487,544
Investments held for captive insurance liabilities	**(329,485)**	392,772
Reinsurance recoverable relating to captive insurance	**14,991**	78,729
Other assets	**109,677**	121,120
Accounts payable and accrued expenses	**(2,042,360)**	(246,346)
Accrued payroll and related taxes	**911,328**	444,036
Accrued pension obligation	**(1,048,429)**	(830,029)
Captive insurance losses and other reserves	**(7,585)**	(222,216)
Net cash (used in) provided by operating activities	**(1,754,535)**	268,487
Investing activities:		
Assets held under bond indenture agreement	**(9,687)**	(7,997)
Investments in joint ventures	**(45,000)**	(30,601)
Purchases of property, plant and equipment	**(140,260)**	(1,625,423)
Sales and purchases of investments, net	**2,782,192**	1,744,509
Net cash provided by investing activities	**2,587,245**	80,488
Financing activities:		
Principal payments on long-term debt	**(1,220,000)**	(640,000)
Net payments on lines of credit	**(450,000)**	(575,000)
Principal payments on capital lease obligations	**(157,376)**	(842,100)
Restricted contributions and bequests received	**745,209**	216,808
Net cash used in financing activities	**(1,082,167)**	(1,840,292)
Change in cash and cash equivalents	**(249,457)**	(1,491,317)
Cash and cash equivalents, beginning of year	**884,695**	2,376,012
Cash and cash equivalents, end of year	**$ 635,238**	$ 884,695

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

Gaylord Farm Association, Inc.
Notes to the Consolidated Financial Statements
As of and for the Years Ended September 30, 2012 and 2011

Note 1 - General

Organization - Gaylord Farm Association, Inc. (the Association) is a not-for-profit corporation, which is a supporting corporation for Gaylord Hospital, Inc. (Gaylord), Gaylord Research Institute, Inc. (GRI), The Gaylord Foundation, Inc. (TGF), Farm Properties, Inc. (FP), Gaylord Farm Rehabilitation Center (GFRC) and Gaylord Risk Solutions, Ltd. (GRS).

Gaylord operates a chronic disease hospital that specializes in the care and treatment of people with medically complex conditions and rehabilitation including brain and spinal cord injury, pulmonary illness, stroke, neurological and orthopedic conditions. In addition, Gaylord runs outpatient clinics to provide physical therapy, occupational therapy, speech therapy and physiatry services as well as sleep disorder centers.

GRI, TGF and FP are dormant corporations with no activity and GFRC is the supporting corporation for the Traurig House, which is a component of the Association's traumatic brain injury care and treatment department.

GRS was incorporated on December 12, 2007 and operates subject to the provisions of the Companies Law of the Cayman Islands. GRS was granted an Unrestricted Class "B" Insurer's license on December 28, 2007, which it holds subject to the provisions of the Insurance Law of the Cayman Islands. GRS is a wholly owned subsidiary of the Association.

Note 2 - Summary of Significant Accounting Policies

Basis of Presentation - The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The consolidated financial statements include the accounts of the Association and its wholly-owned subsidiaries. All significant inter-company balances and transactions have been eliminated in consolidation.

Use of Estimates - The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and related footnotes. Actual results could differ from those estimates. Significant accounts that are impacted by such estimates and assumptions are the allowance for doubtful accounts, allowances for third-party payer discounts and settlements, accrued pension liabilities, malpractice loss reserves and the reserves for workers' compensation insurance.

Cash and Cash Equivalents - Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. In general, the Federal Deposit Insurance Corporation (FDIC) insures cash balances up to $250,000 per depositor, per bank. The FDIC also provides separate unlimited coverage for deposit accounts that meet the definition of non-interest bearing accounts. Unlimited coverage on non-interest bearing accounts extends until December 31, 2012. It is the Association's policy to monitor the financial strength of the banks that hold its deposits on an ongoing basis. During the normal course of business, the Association maintains cash balances in excess of the FDIC insurance limit.

Property, Plant and Equipment - Property, plant and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Maintenance and repairs are charged to expense as incurred.

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Note 2 - Summary of Significant Accounting Policies (continued)

Gifts of long-lived assets such as land, buildings or equipment are reported as unrestricted support, and are excluded from the excess of revenues over (under) expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Investments - Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over (under) expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over (under) expenses unless the investments are trading securities. Unrealized losses that have been deemed to be other than temporarily impaired are included within excess of revenues over (under) expenses.

Other Than Temporary Impairments on Investments - The Association accounts for other than temporary impairments in accordance with FASB ASC 320-10 *"Investments - Debt and Equity Securities"* and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole, and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other than temporary. There were no impairments recorded in 2012 or 2011.

Equity Investments - The Association has a fifty percent ownership interest in North Haven Fitness & Wellness, LLC (Fitness & Wellness). In addition, the Association has a fifty percent ownership in Gaylord Sleep HealthCenters of Connecticut, LLC (GSHC). The Association accounts for its investment interest in these entities using the equity method of accounting. As such, the Association adjusts its investments by its share of the investees net income (loss).

Deferred Financing Costs - Deferred financing costs have been recorded as an asset and are being amortized using the effective interest method over the term of the related financing agreement.

Temporarily and Permanently Restricted Net Assets - Temporarily restricted net assets are those whose use by the Association has been limited by donors to a specific time frame or purpose and are included in investments. Temporarily restricted net assets are available primarily for health care services, including cancer and pediatric programs and capital replacement.

Permanently restricted net assets consist of funds held in trust by others and the Association's permanently restricted endowments, which are included in donor restricted investments. Permanently restricted endowments are investments to be held in perpetuity, the income from which is expendable to support health care services. The income from funds held in trust by others is expendable to support health care services.

Donor Restricted Gifts - Unconditional promises to give cash and other assets to the Association are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets.

Note 2 - Summary of Significant Accounting Policies (continued)

When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Excess of Revenues Over (Under) Expenses - The consolidated statements of operations and changes in net assets includes excess of revenues over (under) expenses. Changes in unrestricted net assets, which are excluded from excess of revenues over (under) expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, assets released from restrictions for purchase of property, plant and equipment and certain changes in the pension liability.

Income Taxes - The Association is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal and state income taxes on related income pursuant to Section 501(a) of the Code. GRS is a not-for-profit captive insurance company organized under the laws of the Cayman Islands.

The Association accounts for uncertain tax positions with provisions of FASB ASC 740, *"Income Taxes"* which provide a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their consolidated financial statements. The Association may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Association does not have any uncertain tax positions as of September 30, 2012 and 2011. As of September 30, 2012 and 2011, the Association did not record any penalties or interest associated with uncertain tax positions. The Association's prior three tax years are open and subject to examination by the Internal Revenue Service.

Assets Whose Use is Limited - Assets which have limited use include assets deposited with a trustee for debt service, pledges, assets set aside by the Board of Directors for future capital improvements and the Association's beneficial interest in funds held in trust held by others.

Interest Rate Swap Agreement - The Association uses an interest rate swap agreement to modify its variable interest rate debt to a fixed interest rate, thereby reducing the Association's exposure to interest rate market fluctuations. The interest rate swap agreement involves the exchange of amounts based on a fixed interest rate for amounts based on variable rates over the life of the agreement without the exchange of the notional amount upon which payments are based. The differential of amounts paid and received during the year is charged to interest expense and the amounts payable or receivable from the counter-party is included as an adjustment to accrued interest.

Net Patient Service Revenue - Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period in which the related services are rendered and adjusted in the future periods as final settlements are determined.

Charity Care - The Association provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Association does not pursue collection of amounts determined to qualify as charity care, the charges related to charity care services are offset within net patient service revenue.

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Note 2 - Summary of Significant Accounting Policies (continued)

The amount of traditional charity care provided, determined on the basis of cost, was approximately $19,019 and $19,524 for the years ended September 30, 2012 and 2011, respectively. Previously, the Association reported its estimates of services provided under its charity care programs based on gross charges. In connection with the Association's adoption of Accounting Standards Update (ASU) 2010-23, *"Health Care Entities (Topic 954): Measuring Charity Care for Disclosure,"* amounts previously reported for care provided under its charity care programs have been restated to reflect the Association's estimates of its direct and indirect cost of providing these services. This change had no impact on the Association's consolidated results of operations.

Estimated Malpractice Costs - The Association maintains malpractice insurance coverage under claims made policies through GRS in 2012 and 2011. A provision for estimated medical malpractice claims includes estimates of the ultimate costs for claims incurred but not reported and is included within accounts payable and accrued expenses on the Association's consolidated balance sheets.

Workers Compensation Costs - The Association is self-insured for workers' compensation. Estimated self-insurance liabilities are included within accrued payroll and related taxes and are $1,102,510 and $1,092,336 as of September 30, 2012 and 2011, respectively, and include estimates for claim obligations related to claims occurring through September 30, 2012 and 2011.

Unpaid Losses and Loss Adjustment Expenses - The reserve for unpaid losses and loss adjustment expenses and the related reinsurance recoverable includes case basis estimates of reported losses, plus supplemental amounts calculated based upon loss projections utilizing actuarial studies, Gaylord's own historical data and industry data. In establishing this reserve and the related reinsurance recoverable, GRS utilizes the findings of an independent consulting actuary. Management believes that its aggregate reserve for unpaid losses and loss adjustment expenses and the related reinsurance recoverable at year-end represents its best estimate, based on the available data, of the amount necessary to cover the ultimate cost of losses; however, because of the nature of the insured risks and limited historical experience, actual loss experience may not conform to the assumptions used in determining the estimated amounts for such asset and liability at the consolidated balance sheet date. Accordingly, the ultimate asset and liability could be significantly in excess of or less than the amount indicated in these consolidated financial statements. As adjustments to these estimates become necessary, such adjustments are reflected in current operations.

Recognition of Premium Revenues - Premiums written are earned on a pro-rata basis over the related policy period. The portion of premiums that will be earned in the future is deferred and reported as unearned premiums.

Reinsurance - In the normal course of business, GRS seeks to reduce its loss exposure by reinsuring certain levels of risk with reinsurers. Reinsurance is accounted for in accordance with FASB ASC 944-20, *"Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts"*. Premiums ceded are expensed over the term of their related policies and recorded as a reduction of revenues.

Legislation - The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Association is in compliance with fraud and abuse as well as other applicable government laws and regulations. While no known regulatory inquiries are pending, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Note 2 - Summary of Significant Accounting Policies (continued)

Accounting Pronouncements Adopted - In August 2010, the FASB issued ASU No. 2010-23, *"Health Care Entities (Topic 954): Measuring Charity Care for Disclosure"*. ASU No. 2010-23 is intended to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. ASU No. 2010-23 requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct or indirect cost of providing the charity care, and requires disclosure of the method used to identify or determine such costs. This ASU is effective for fiscal years beginning after December 15, 2010, with retrospective application required. The Association's adoption of ASU 2010-23 did not have a material impact on its overall consolidated financial statements.

In August 2010, the FASB issued ASU No. 2010-24, *"Health Care Entities (Topic 954) Presentation of Insurance Claims and Related Insurance Recoveries"*. ASU No. 2010-24 clarifies that a health care entity may not net insurance recoveries against related claim liabilities. In addition, the amount of the claim liability must be determined without consideration of insurance recoveries. This ASU is effective for fiscal years beginning after December 15, 2010. The Association's adoption of ASU 2010-24 did not have an impact on its overall consolidated financial statements.

Pending Accounting Pronouncements - In May 2011, the FASB issued ASU No. 2011-04, *"Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRs"*. ASU No. 2011-04 amends certain guidance in ASC 820, *"Fair Value Measurement"*. ASU 2011-04 expands ASC 820's existing disclosure requirements for fair value measurements and makes other amendments. ASU 2011-04 is effective for interim and annual reporting periods beginning after December 15, 2011 and will be applied on a prospective basis. The Association is currently evaluating the effect that the provisions of ASU 2011-04 will have on the Association's consolidated financial statements.

In July 2011, the FASB issued ASU No. 2011-07, *"Health Care Entities (Topic 954), Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities"*. ASU 2011-07 requires a health care entity to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenues from an operating expense to a deduction from patient service revenues (net of contractual allowances and discounts). Additionally, enhanced disclosures about an entity's policies for recognizing revenue, assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts are required. ASU 2011-07 is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2012. The Association does not believe adoption of ASU 2011-07 will have a material impact on its overall consolidated financial statements.

Reclassification - Certain amounts in the 2011 consolidated financial statements have been reclassified to conform to the 2012 presentation. These reclassifications had no material effect on the 2011 consolidated financial statements.

Subsequent Events - Subsequent events have been evaluated through January 8, 2013, the date through which procedures were performed to prepare the consolidated financial statements for issuance. Management believes there are no subsequent events having a material impact on the consolidated financial statements.

Note 3 - Net Patient Service Revenue

The Association has agreements with third-party payers that provide for payments to the Association at amounts different from its established rates. Contractual payment rates are subject to final determination by reimbursement agencies under each program. A summary of the payment arrangements with major third-party payers follows:

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Note 3 - Net Patient Service Revenue (continued)

Medicare - Inpatient and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Inpatient payments are made based on a per discharge amount under the LTCH-DRG inpatient payment system. Outpatient payments are made based on a per encounter amount under the APC outpatient payment system. The Association is reimbursed under the prospective payment system and files annual cost reports, which are subject to audit.

Medicaid - Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospective rates per day of hospitalization. These rates are not subject to retroactive adjustment. Outpatient services are reimbursed based on a fee schedule or percent of charges based on the services provided.

Blue Cross - Services rendered to Blue Cross beneficiaries are reimbursed on a per diem basis based on contracted rates.

The Association has also entered into payment agreements with certain other commercial insurance carriers and health maintenance organizations. The basis for payment to the Association under these agreements includes prompt payment provisions and discounts from established charges.

Net patient service revenue for the years ended September 30, 2012 and 2011 is as follows:

	2012	2011
Gross patient service revenue	**$ 195,997,746**	$ 195,812,053
Contractual allowances and adjustments	**(125,671,003)**	(128,747,306)
Net patient service revenue	**$ 70,326,743**	$ 67,064,747

Revenue from the Medicare and Medicaid programs accounted for approximately 37% and 10%, respectively, of the Association's net patient revenue for 2012 and 40% and 9%, respectively, for 2011. Revenue from Blue Cross accounted for approximately 22% and 19% in 2012 and 2011, respectively. No other payer accounted for more than 10% of revenue in 2012 and 2011. Net patient service revenues are based upon complex payment systems and include estimates of amounts yet to be collected. As a result, there is at least a reasonable possibility that recorded estimates will change in the near term. Any changes to estimates are recorded within current year operations.

The Association grants credit without collateral to its patients, most of whom are insured under third-party payer agreements. The following summarizes payers that account for more than 10 percent of patient accounts receivable as of September 30, 2012 and 2011:

	2012	2011
Medicare	**38%**	46%
Medicaid	**10%**	11%
Blue Cross	**19%**	14%

Monthly, management reviews accounts receivable for uncollectible amounts and records an allowance for doubtful accounts based on specifically identified accounts, as well as an amount for expected bad debt based on historical losses.

Note 4 - Investments

Board-designated and donor restricted investments are invested as follows as of September 30, 2012 and 2011:

	2012		2011	
	Cost	Market Value	Cost	Market Value
Cash and money market funds	**$ 81,275**	**$ 81,275**	$ 318,590	$ 318,590
Alternative investment funds	**2,080,608**	**2,224,716**	2,519,488	2,047,429
Equity securities	**4,258,787**	**5,324,232**	5,116,350	5,164,432
Mutual funds - fixed income	**5,642,829**	**5,901,987**	5,840,852	5,786,021
Mutual funds - equity	**5,287,290**	**6,373,185**	5,747,393	5,906,574
Total	**$ 17,350,789**	**$ 19,905,395**	$ 19,542,673	$ 19,223,046

Investment balances that have been restricted by donors as of September 30, 2012 and 2011 are $5,555,747 and $5,529,789, respectively. The Board of Directors of the Association has restricted all other investments.

Current assets that are held under a bond indenture agreement, are deposited with a trustee for debt service funds. Such amounts are invested in United States treasury notes. In addition, investments held for funding of captive insurance liabilities of $3,846,709 and $3,517,224 as of September 30, 2012 and 2011, respectively, are invested in bonds and fixed income mutual funds.

The Association also has a beneficial interest in trusts held by others of $11,240,066 and $9,748,956 as of September 30, 2012 and 2011, respectively. These funds are managed by the trustees of each fund and are invested primarily in cash equivalents, fixed income and equity securities.

The following table shows the investments' gross unrealized losses and fair value, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position, as of September 30, 2012 and 2011:

	Less than 12 Months		Greater than 12 Months		Total	
2012	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Equity securities	$ 88,786	$ (13,811)	$ 159,203	$ (25,459)	$ 247,989	$ (39,270)
Alternative investment funds	-	-	996,770	(186,230)	996,770	(186,230)
Mutual funds	-	-	932,271	(21,926)	932,271	(21,926)
Total	$ 88,786	$ (13,811)	$ 2,088,244	$ (233,615)	$ 2,177,030	$ (247,426)

Note 4 - Investments (continued)

2011	Less than 12 Months Fair Value	Less than 12 Months Unrealized Losses	Greater than 12 Months Fair Value	Greater than 12 Months Unrealized Losses	Total Fair Value	Total Unrealized Losses
Equity securities	$ 641,790	$ (141,811)	$ 105,990	$ (18,418)	$ 747,780	$ (160,229)
Alternative investment funds	-	-	1,543,651	(430,058)	1,543,651	(430,058)
Mutual funds	3,788,645	(140,895)	5,542,242	(884,964)	9,330,887	(1,025,859)
Total	$ 4,430,435	$ (282,706)	$ 7,191,883	$ (1,333,440)	$ 11,622,318	$ (1,616,146)

In 2012 and 2011, none of the investments that were in an unrealized loss position were considered to be other than temporarily impaired.

Investment income is comprised of the following for the years ended September 30, 2012 and 2011:

	2012	2011
Income:		
Dividend and interest income	**$ 522,282**	$ 586,562
Net realized gains on investments	**515,365**	140,830
Total investment return	**$ 1,037,647**	$ 727,392
Other changes in unrestricted net assets:		
Unrealized gains (losses) on other than trading securities	**$ 2,557,046**	$ (1,132,499)

Investments in Joint Ventures - The Association has a fifty percent ownership interest in Fitness & Wellness and a fifty percent ownership interest in GSHC. The Association accounts for its investment interest in these entities using the equity method of accounting.

The Association's share of Fitness & Wellness's net loss for the years ended September 30, 2012 and 2011 was $195,647 and $118,629, respectively. In addition, the Association made a capital contribution to Fitness & Wellness of $45,000 and $30,601 during the fiscal years ended September 30, 2012 and 2011, respectively. The carrying amount of the Fitness & Wellness investment was $335,919 and $486,566 as of September 30, 2012 and 2011, respectively, and is included in other assets.

The Association's share of GSHC's net gain for the year ended September 30, 2012 and 2011 was $120,396 and $113,325, respectively. The Association has a receivable of $95,635 and $102,213 due from GSHC for a capital distribution as of September 30, 2012 and 2011, respectively, which is included within other current assets on the accompanying consolidated balance sheets. The carrying amount of the GSHC investment was $125,323 and $100,562 as of September 30, 2012 and 2011, respectively and is included in other assets.

Note 5 - Fair Value Measurements

FASB ASC 820-10, *"Fair Value Measurements and Disclosures"*, provides a framework for measuring fair value. That framework provides a fair value hierarch that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820-10 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Association has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has specified (contractual) terms, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies for assets and liabilities measured at fair value. There have been no changes in methodologies used as of September 30, 2012 and 2011:

Cash and money market funds - Valued at the closing price reported on the active market on which the individual securities are traded.

Equity securities - Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual funds - Valued at the closing price reported on the active market on which the individual securities are traded.

Limited partnerships - Valued based on net asset value (NAV) as calculated separately for each class and subclass of shares and for each series within a class of shares equal to the value of gross assets less gross liabilities at the date of determination divided by the total number of outstanding shares. Certain investments may not have readily available market values and may be subject to certain withdrawal restrictions. Liquidity can vary based on various factors and may include lock-up periods as well as redemption fees and/or restrictions. Audited financial statements were obtained as of December 31, 2011 and 2010, which reported unqualified opinions. Values as of September 30, 2012 and 2011 were determined utilizing the same methodologies as those reported in the audited financial statements as of December 31, 2011 and 2010. The following are the major categories of limited partnerships:

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Note 5 - Fair Value Measurements (continued)

REITs - This asset class seeks to generate net returns in excess of the UBS Global Real Estate Investor Index through the creation and active management of a portfolio of publicly traded securities issued by real estate investment trusts and other publicly held real estate company in North America, Europe, Australia and Asia.

Limited liability companies - Valued periodically based on the NAV per share. The NAV is determined by the investee company's investment manager or custodian by deducting from the value of assets of the investee company all its liabilities and the resulting number is divided by the outstanding number of shares or units. The NAV per share is then multiplied by the total number of shares held by the Fund at the fiscal year end. Certain investments may not have readily available market values and may be subject to certain withdrawal restrictions. Liquidity can vary based on various factors and may include lock-up periods as well as redemption fees and/or restrictions. Audited financial statements were obtained as of December 31, 2011 and 2010, which reported unqualified opinions. Values as of September 30, 2012 and 2011 were determined utilizing the same methodologies as those reported in the audited financial statements as of December 31, 2011 and 2010. The following are the major categories of limited liability companies:

Domestic equity - This asset class seeks to achieve long-term capital appreciation by investing in a portfolio of small and medium capitalization companies defined as companies whose market capitalizations fall within the range of the Russell 2500 index at the time of purchase.

Registered investment companies - Shares of registered investment companies are valued at the NAV of the shares held by the Fund at year end, where NAV is based on the fair value of the underlying assets in each fund. The following are the major categories of registered investment companies:

REITs - This asset class seeks to provide the diversification and total return potential of investments in real estate by investing primarily in companies whose business is to own, operate, develop and manage real estate.

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). Securities typically priced using Level 2 inputs include government securities, corporate bonds and certificates of deposit.

Beneficial interest in trusts held by others - The value of the Association's assets is based on total fund values and the Association's corresponding beneficiary percentage.

Interest rate swap liability - The interest rate swap agreement is valued using third-party models that use observable market conditions as their input.

Investments measured at NAV are subject to various management, incentive and other fees based on NAV, classes, capital account balances and/or capital commitments. Investments may also be subject to lock up periods. The following table outlines restrictions on investments valued at NAV as of September 30, 2012 and 2011:

	Fair Value 2012	Fair Value 2011	Redemption Frequency (if Currently Eligible)	Redemption Notice Period
Limited partnerships - REITs	$ 511,599	$ 525,469	Monthly	15 business days prior to month end
Limited liability companies - domestic equity	$ 1,151,558	$ 1,018,182	Daily	Not applicable
Registered investment companies - REITs	$ 485,172	$ 503,778	Daily	Not applicable

Note 5 - Fair Value Measurements (continued)

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Association believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents the financial instruments carried at fair value as of September 30, 2012 by the valuation hierarchy:

2012	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and money market funds	$ 81,275	$ -	$ -	$ 81,275
Limited partnerships - REITs	-	511,599	-	511,599
Limited liability companies - domestic equity	-	1,151,558	-	1,151,558
Registered investment companies - REITs	-	485,172	-	485,172
Public REITs	-	76,387	-	76,387
Equity securities:				
U.S. large cap	3,724,618	-	-	3,724,618
U.S. mid cap	1,514,569	-	-	1,514,569
International developed	60,820	-	-	60,820
Emerging markets	24,225	-	-	24,225
Mutual funds - fixed income:				
Investment grade taxable	3,901,578	-	-	3,901,578
International developed	2,000,409	-	-	2,000,409
Mutual funds - equity:				
International developed	5,440,914	-	-	5,440,914
Emerging markets	932,271	-	-	932,271
Total	17,680,679	2,224,716	-	19,905,395
Investments held for captive insurance liabilities:				
Mutual funds - fixed income	52,476	979,871	-	1,032,347
Mutual funds - equity	424,542	-	-	424,542
Fixed income securities	-	2,389,820	-	2,389,820
Total	477,018	3,369,691	-	3,846,709
Funds held under bond indenture agreements	189,467	-	-	189,467
Beneficial interest in trusts held by others	-	-	11,240,066	11,240,066
Total	$ 18,347,164	$ 5,594,407	$ 11,240,066	$ 35,181,637
Liabilities:				
Interest rate swap liability	$ -	$ 4,712,094	$ -	$ 4,712,094
Total	$ -	$ 4,712,094	$ -	$ 4,712,094

Note 5 - Fair Value Measurements (continued)

The following table presents the financial instruments carried at fair value as of September 30, 2011 by the valuation hierarchy:

2011	Level 1	Level 2	Level 3	Total
Assets:				
Investments:				
Cash and money market funds	$ 318,590	$ -	$ -	$ 318,590
Limited partnerships - REITs	-	525,469	-	525,469
Limited liability companies - domestic equity	-	1,018,182	-	1,018,182
Registered investment companies - REITs	-	503,778	-	503,778
Equity securities:				
U.S. large cap	3,815,823	-	-	3,815,823
U.S. mid cap	1,320,396	-	-	1,320,396
Emerging markets	28,213	-	-	28,213
Mutual funds - fixed income:				
Investment grade taxable	3,955,053	-	-	3,955,053
International developed	1,830,968	-	-	1,830,968
Mutual funds - equity:				
International developed	4,995,026	-	-	4,995,026
Emerging markets	911,548	-	-	911,548
Total	17,175,617	2,047,429	-	19,223,046
Investments held for captive insurance liabilities:				
Mutual funds - fixed income	47,232	896,974	-	944,206
Mutual funds - equity	269,369	-	-	269,369
Fixed income securities	-	2,303,649	-	2,303,649
Total	316,601	3,200,623	-	3,517,224
Funds held under bond indenture agreements	179,780	-	-	179,780
Beneficial interest in trusts held by others	-	-	9,748,956	9,748,956
Total	$ 17,671,998	$ 5,248,052	$ 9,748,956	$ 32,669,006
Liabilities:				
Interest rate swap liability	$ -	$ 4,155,222	$ -	$ 4,155,222
Total	$ -	$ 4,155,222	$ -	$ 4,155,222

As of September 30, 2012 and 2011, the Association's other financial instruments included accounts receivable, pledges receivable, accounts payable and accrued expenses, line of credit, estimated third-party payer settlements, captive insurance reserves, long-term debt and capital lease obligations. The carrying amounts reported in the consolidated balance sheets for these financial instruments approximate their fair value.

Note 5 - Fair Value Measurements (continued)

The following are the changes within the beneficial interest in trusts held by others for the years ended September 30, 2012 and 2011, which are classified as Level 3 within the fair value hierarchy:

	2012
Balance as of October 1, 2011	$ 9,748,956
Net change in market value	1,960,344
Distributions	(469,234)
Balance as of September 30, 2012	$ 11,240,066

	2011
Balance as of October 1, 2010	$ 10,168,420
Net change in market value	48,072
Distributions	(467,536)
Balance as of September 30, 2011	$ 9,748,956

Note 6 - Property, Plant and Equipment

Property, plant and equipment consists of the following as of September 30, 2012 and 2011:

	2012	2011
Land and improvements	**$ 1,820,966**	$ 3,567,551
Buildings and improvements	**57,491,710**	57,358,538
Fixed and moveable equipment	**33,563,642**	32,234,859
	92,876,318	93,160,948
Less: accumulated depreciation and amortization	**(54,894,036)**	(51,406,912)
	37,982,282	41,754,036
Construction in progress	**195,112**	183,550
Total	**$ 38,177,394**	$ 41,937,586

Depreciation expense for the years ended September 30, 2012 and 2011 amounted to $3,487,125 and $3,455,220, respectively. Amortization expense for equipment under capital lease obligations was $395,108 and $416,990 as of September 30, 2012 and 2011, respectively.

Note 7 - Other Assets

Other assets as of September 30, 2012 and 2011 are as follows:

	2012	2011
Investment in Fitness & Wellness	$ 355,919	$ 486,566
Investment in GSHC	125,323	100,562
Deferred financing costs	336,390	352,214
Deposits and other	128,528	146,747
Total	$ 946,160	$ 1,086,089

Note 8 - Long-Term Debt, Lines of Credit and Lease Arrangements

Lines of Credit - The Association had available a $5,000,000 line of credit agreement, which was available for payment of costs associated with the construction of the 36-bed inpatient pavilion. On January 30, 2009, the Association converted this line of credit to a line of credit note in the amount of $1,625,000. As of September 30, 2012 and 2011, the Association had $0 and $450,000, respectively, outstanding on this line of credit note. Borrowings on the line of credit note were payable in annual installments with the final payment due on July 3, 2012. At the Association's option, the line of credit note bears interest at the bank's prime rate, as defined, plus 150 basis points or LIBOR plus 175 basis points.

Long-term Obligations - The Association also had a $3,000,000 line of credit agreement, which was renewable on an annual basis. On January 30, 2009, the Association converted this line of credit into a term loan promissory note whereby the $3,000,000 is payable in equal monthly installments of $50,000 with a final payment on January 31, 2014. At the Association's option, the term loan promissory note bears interest at the bank's prime rate, as defined, or LIBOR plus 100 basis points. As of September 30, 2012 and 2011, the Association had $850,000 and $1,400,000, respectively, outstanding on this term loan.

In April 2007, the Association, in conjunction with the State of Connecticut Health and Educational Facilities Authority (CHEFA), issued $21,530,000 of Gaylord Hospital Series B variable rate demand revenue bonds (the Series B Bonds). The bond proceeds were used to refinance the amounts outstanding on the CHEFA Series A revenue bonds and for the construction of a 36-bed addition.

The Series B Bonds bear interest at a variable rate as determined by a re-marketing agent (approximately 0.2% and 0.3% as of September 30, 2012 and 2011, respectively), which is adjusted weekly, and matures on July 1, 2037. For as long as the bonds are variable rate, the bond holders have the option to tender their bonds for repayment. The Association has a letter of credit from Bank of America, N.A., which is available to support its obligations under the Series B Bonds during this period. The letter of credit expires on January 3, 2014, subject to extension or earlier termination upon the occurrence of certain events set forth in the letter of credit agreement. At that time, the letter of credit can be renewed, at the bank's discretion, the Association can convert the bonds to a fixed rate or repurchase the bonds outstanding on that date at their par value. Tenders made by bond holders will be remarketed or, if necessary, paid by the drawdowns on the letter of credit. Any tender drawings made under the letter of credit are to be repaid by the Association on the expiration date of the letter of credit. As of September 30, 2012 and 2011, the Association had $18,465,000 and $19,135,000, respectively, outstanding on the Series B Bonds.

Note 8 - Long-Term Debt, Lines of Credit and Lease Arrangements (continued)

The Series B loan and letter of credit agreements include certain financial covenants including a minimum debt service coverage ratio of 1.25 to 1, a minimum required amount of unrestricted liquid assets of $10.0 million, and other restrictions, including limitations on future indebtedness and liens. The Association was in compliance with all covenants for 2012 and 2011.

Lease Abandonment Obligations - During 2010, the Association recorded a loss on abandonment of a long-term rental property in the amount of $147,543. The lease was previously accounted for as an operating lease and the Association was no longer utilizing the rental property and is unable to sublease the property. Consequently, the Association's liability represents the present value of future minimum lease payments under this lease of $23,568 as of September 30, 2012. The lease expires in January 2013.

During 2009, the Association recorded a loss on abandonment of a long-term rental property in the amount of $92,035. The lease was previously accounted for as an operating lease and the Association was no longer utilizing the rental property and is unable to sublease the property. Consequently, the Association's liability represents the present value of future minimum lease payments under this lease of $5,530 as of September 30, 2012. The lease expires in December 2013.

Letter of Credit - As a result of being self-funded for its workers' compensation program, the Association is required by the State of Connecticut Workers' Compensation Commission to hold a letter of credit in the aggregate amount of $650,000 as of September 30, 2012 and 2011. As of September 30, 2012 and 2011, there are no outstanding balances on the letter of credit.

Capital Lease Obligations - The Association leases certain equipment and software under capital lease obligations, expiring through December 2019. Future payments, including interest are as follows:

2013	$	173,687
2014		56,108
2015		32,593
2016		32,593
2017		29,045
Thereafter		55,059
Less: interest		(43,008)
Total	$	336,077

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Note 8 - Long-Term Debt, Lines of Credit and Lease Arrangements (continued)

A summary of long-term debt and capital lease obligations as of September 30, 2012 and 2011 are as follows:

	2012	2011
Long-term debt obligation	**$ 18,465,000**	$ 19,135,000
Term loan promissory note	**850,000**	1,400,000
Capital lease obligations	**336,077**	416,044
Lease abandonment obligation	**29,098**	106,507
	19,680,175	21,057,551
Less: current portion	**(1,526,815)**	(1,487,242)
Total	**$ 18,153,360**	$ 19,570,309

Scheduled principal repayments on the long-term debt and capital lease obligations as of September 30, 2012 are as follows:

2013	$ 1,526,815
2014	983,500
2015	785,919
2016	817,286
2017	850,129
Thereafter	14,716,526
Total	$ 19,680,175

Operating Leases - The Association leases various equipment and space under operating leases expiring at various dates and month-to-month agreements. Some of these leases contain renewal options. Rent expense under such operating leases and agreements is $495,570 and $490,304, in 2012 and 2011, respectively. The following is a schedule of future minimum payments under non-cancellable operating leases as of September 30, 2012:

2013	$ 421,727
2014	422,506
2015	401,315
2016	360,003
2017	198,333
Thereafter	394,222
Total	$ 2,198,106

In addition, the Association leases land under a long-term lease agreement through 2106 to a third-party. Rental income is based on a percentage of the gross income earned by the lessee. Total rental income from this property was $196,124 and $182,096 for 2012 and 2011, respectively, and is included in other operating revenue in the accompanying consolidated statements of operations and changes in net assets and shareholder's equity.

Note 9 - Derivatives

The Association uses derivative instruments, specifically an interest rate swap, to manage its exposure to changes in the interest rate on its CHEFA debt. The use of derivative instruments exposes the Association to additional risks related to the derivative instrument, including market risk, credit risk and termination risk as described below, and the Association has defined risk management practices to mitigate these risks, as appropriate.

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Association will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligation during the term of the contract. When the fair value of a derivative contract is positive, the counterparty owes the Association, which creates credit risk. Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold.

Termination risk represents the risk that the Association may be required to make a significant payment to the counterparty, if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Association's ability to meets its debts or liquidity covenants.

On August 1, 2007, the Association entered into an interest rate swap agreement with an initial notional amount of $21,530,000 to reduce the exposure to fluctuations in interest rates related to its CHEFA debt. The swap agreement, which expires in June 2027, requires that the Association make monthly payments to the counter-party, Bank of America, N.A., based upon a fixed interest rate of 4.28% and in return receives monthly payments from Bank of America, N.A. based on the Bond Index Association Municipal Swap Rate Index rate (0.18% and 0.16% as of September 30, 2012 and 2011, respectively). The notional amount is scheduled to decrease as principal is paid on the CHEFA debt. Net amounts paid under the swap is recorded as additional interest expense. Based on information received from the counter-party, the swap agreement had an unfavorable fair value of $4,712,094 and $4,155,222 as of September 30, 2012 and 2011, respectively.

Management has not designated the swap agreement as a hedging instrument. The change in fair value of the interest rate swap of $556,872 and $508,193 for the years ended September 30, 2012 and 2011, respectively, is recorded in the consolidated statements of operations and changes in net assets as a component of non-operating income.

Note 10 - Net Assets

Temporarily restricted net assets are available for the following purposes as of September 30, 2012 and 2011:

	2012	2011
Health care services:		
Patient special needs	**$ 6,789**	$ 11,506
Other restricted purposes	**821,509**	498,966
Capital campaign	**321,166**	696,762
Total	**$ 1,149,464**	$ 1,207,234

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Note 10 - Net Assets (continued)

The assets in the above table restricted for health care services are included within cash and cash equivalents on the accompanying consolidated balance sheets.

Permanently restricted net assets are restricted to the following purposes as of September 30, 2012 and 2011:

	2012	2011
Investments to be held in perpetuity, the income of which is expendable to support patient special needs and other services	**$ 5,555,747**	$ 5,529,789
Beneficial interest in trusts held by others, the income of which is expendable to support other health care services	**11,240,066**	9,748,956
Total	**$ 16,795,813**	$ 15,278,745

The Association's endowment consists of multiple funds established for a variety of purposes. The endowment includes both donor-restricted endowment fund and funds designated by the Board of Directors to function as endowments. As required by GAAP, net assets associated with endowment funds, included funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor restrictions.

The Association has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Association during its annual budgeting process.

The Association considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Association and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Association; and (7) the investment policies of the Association.

Note 10 - Net Assets (continued)

Changes in net assets for endowments and temporary restricted funds for the year ended September 30, 2012 are as follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balance as of October 1, 2011	$ 13,693,257	$ 510,472	$ 5,529,789	$ 19,733,518
Investment return:				
Investment income	522,282	74,943	-	597,225
Net change in market value	3,357,842	317,187	-	3,675,029
Contributions	-	719,251	25,958	745,209
Expenditures	(3,223,733)	(793,555)	-	(4,017,288)
Balance as of September 30, 2012	$ 14,349,648	$ 828,298	$ 5,555,747	$ 20,733,693

Changes in net assets for endowments and temporary restricted funds for the year ended September 30, 2011 are as follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balance as of October 1, 2010	$ 16,458,755	$ 597,512	$ 5,500,469	$ 22,556,736
Investment return:				
Investment income	586,562	-	-	586,562
Net change in market value	(1,321,431)	-	-	(1,321,431)
Contributions	-	187,488	29,320	216,808
Expenditures	(2,030,629)	(274,528)	-	(2,305,157)
Balance as of September 30, 2011	$ 13,693,257	$ 510,472	$ 5,529,789	$ 19,733,518

Funds with Deficiencies - From time to time the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Association to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2012 and 2011, there were no funds that were below the level required by donor or law.

Return Objectives and Risk Parameters - The Association's investment and spending policies for endowment assets attempts to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results of the S&P 500 index while assuming a moderate level of investment risk.

Strategies Employed for Achieving Objectives - To satisfy its long-term rate-of-return objectives, the Association relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Board targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

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Note 10 - Net Assets (continued)

Spending Policy - During its annual budgeting process, the Association appropriates donor restricted endowment funds for expenditure in accordance with donor purpose and time restrictions. During the year ended September 30, 2012 and 2011, the Board appropriated $3,223,733 and $2,030,629, respectively of funds for expenditure from its board restricted endowment funds. The board restricted endowment funds are being held for long-term growth and to maintain capital reserves for the Association.

Note 11 - Pension Plans

The Association has a noncontributory, defined benefit plan (the Plan). The benefits are based on years of service and an average of the five consecutive calendar years of highest compensation during the last ten years of employment. The Association makes contributions in amounts sufficient to fund the Plan as required by ERISA. The Plan was frozen effective October 31, 2004.

The following summarizes significant disclosures relating to the Plan as of September 30, 2012 and 2011:

	2012	2011
Change in benefit obligations:		
Benefit obligations at beginning of year	**$ 36,167,672**	$ 34,102,808
Interest cost	**1,664,730**	1,712,734
Service cost	**280,000**	250,000
Actuarial loss	**4,540,807**	2,410,259
Expected administrative expenses	**(247,351)**	(250,000)
Benefits and plan expenses paid	**(2,487,533)**	(2,058,129)
Benefit obligations at end of year	**$ 39,918,325**	$ 36,167,672
Change in plan assets:		
Fair value of plan assets at beginning of year	**$ 18,725,052**	$ 19,013,691
Actual return on plan assets	**3,616,821**	418,501
Employer contributions	**2,208,733**	1,669,458
Benefits and plan expenses paid	**(2,487,533)**	(2,058,129)
Administrative expenses	**(247,351)**	(318,469)
Fair value of plan assets at end of year	**$ 21,815,722**	$ 18,725,052
Accrued pension liability:		
Unfunded status	**$ (18,102,603)**	$ (17,442,620)

Note 11 - Pension Plans (continued)

	2012	2011
Net periodic benefit cost:		
Interest cost	**$ 1,664,730**	$ 1,712,734
Service cost	**280,000**	250,000
Actuarial loss recognized	**446,966**	302,929
Expected return on plan assets	**(1,231,392)**	(1,426,234)
Net periodic benefit cost	**$ 1,160,304**	$ 839,429

Benefits expected to be paid over the next five years and the five years thereafter are as follows:

2013	$ 2,477,396
2014	$ 2,749,163
2015	$ 2,538,032
2016	$ 2,489,282
2017	$ 2,698,586
Years 2018-2022	$ 12,769,366

Amounts recorded in unrestricted net assets as of September 30, 2012 and 2011, not yet amortized as components of net periodic benefit cost are as follows:

	2012	2011
Unamortized actuarial loss	**$ 19,876,724**	$ 18,168,312

The amortization of the above items expected to be recognized in net periodic benefit income for the year ended September 30, 2012 is $638,042.

The following summarizes the key weighted-average actuarial assumptions used in determining the Plan's benefit obligation and net benefit income:

	2012	2011
Benefit obligations:		
Discount rate	**3.85%**	4.75%
Net periodic benefit cost:		
Discount rate	**4.75%**	5.25%
Expected long-term return on plan assets	**6.00%**	6.80%

Note 11 - Pension Plans (continued)

The fair values of the Association's plan assets, by asset category are as follows, for the year ended September 30, 2012 and 2011:

2012	Level 1	Level 2	Level 3	Total
Money market funds	$ 750,129	$ -	$ -	$ 750,129
Mutual funds - fixed income	9,541,727	-	-	9,541,727
Mutual funds - equities	7,911,780	-	-	7,911,780
Equity securities:				
Consumer discretionary	502,451	-	-	502,451
Consumer staples	269,917	-	-	269,917
Energy	174,229	-	-	174,229
Financial	218,765	-	-	218,765
Health care	331,953	-	-	331,953
Industrials	140,853	-	-	140,853
Information technology	954,988	-	-	954,988
Other	168,623	-	-	168,623
Limited liability company	-	749,504	-	749,504
REIT	-	100,803	-	100,803
Total	$ 20,965,415	$ 850,307	$ -	$ 21,815,722

2011	Level 1	Level 2	Level 3	Total
Money market funds	$ 634,938	$ -	$ -	$ 634,938
Mutual funds - fixed income	8,943,175	-	-	8,943,175
Mutual funds - equities	6,302,610	-	-	6,302,610
Equity securities:				
Consumer discretionary	357,790	-	-	357,790
Consumer staples	233,928	-	-	233,928
Energy	193,891	-	-	193,891
Financial	173,403	-	-	173,403
Health care	228,892	-	-	228,892
Industrials	96,075	-	-	96,075
Information technology	773,860	-	-	773,860
Other	208,820	-	-	208,820
Limited liability company	-	577,670	-	577,670
Total	$ 18,147,382	$ 577,670	$ -	$ 18,725,052

Note 11 - Pension Plans (continued)

The Association's investment policy is to minimize risk by balancing investments between equity securities and fixed income debt securities, utilizing a weighted average approach with a minimum split of 60% equity securities and 40% fixed income debt securities and a maximum split of 80% equity securities and 20% fixed income debt securities. The expected return on plan assets assumption was determined based on a review of the Plan's asset mix, capital market assumptions, and a review of the actual return on plan assets over the past ten years.

The Association has a defined contribution benefit plan, which became effective January 1, 2005. Substantially all full time employees are eligible to participate in the defined contribution plan. The Association made contributions to this plan totaling $194,812 and $131,973 in 2012 and 2011, respectively. Employees become vested in the Association's contributions in three to five years. The portion of the employees contributions unvested upon termination are forfeited and used to reduce future contributions made by the Association on a dollar-for-dollar basis.

The Association also has established a 403(b) plan. Participants may elect to contribute a specific percentage of their compensation in pre-tax deferrals subject to established Internal Revenue Code limitations. Currently, the Association does not contribute to this plan.

The Association also has supplemental retirement plan agreements with certain former and current senior executives. The obligation related to this agreement is approximately $50,000 and $1,067,000 as of September 30, 2012 and 2011, respectively, and is recorded within accounts payable and accrued expenses within the accompanying consolidated balance sheets. During 2012, the Association made a payment of approximately $1,230,000 related to these agreements.

Note 12 - Functional Expenses

The Association provides health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2012 and 2011 is as follows:

	2012	2011
Health care services	$ **57,381,203**	$ 54,890,641
General and administrative	**17,551,669**	15,821,689
Fundraising	**811,166**	638,760
Total	$ **75,744,038**	$ 71,351,090

Note 13 - Captive Insurance Activities

Effective January 1, 2008, GRS provided commercial and general liability coverage on a claims made basis to the Association. The coverage limits for the Association were $1,000,000 per claim with an annual aggregate of $4,000,000, plus $100,000 each incident in the event the aggregate is fully eroded. There is no aggregate limit for the commercial general liability.

Effective January 1, 2008, GRS provided an umbrella liability claims-made policy with a limit of $10,000,000 each claim and in the aggregate. GRS has fully reinsured this coverage with a highly rated commercial reinsurance carrier.

Note 13 - Captive Insurance Activities (continued)

Effective January 1, 2008, GRS assumed through a loss portfolio transfer the outstanding loss obligations produced by CHCP, which covered incidents of healthcare professional liability and commercial general liability occurring at the Association from April 1, 2003 through December 31, 2007. The amount of the loss portfolio transfer was $1,482,688.

During the years ended September 30, 2012 and 2011, GRS issued a return premium in the amount of $900,000 and $675,000, respectively, to the Association. This return premium remains unpaid as of September 30, 2012 and 2011 and is reflected within due from affiliates on the accompanying consolidating balance sheet of the Association and is eliminated in consolidation.

A reconciliation of direct to net premiums on a written and earned basis is summarized as follows for years ended September 30, 2012 and 2011:

	Premium Written		Premium Earned	
	2012	**2011**	**2012**	**2011**
Direct premiums	**$ (157,031)**	$ 201,875	**$ (90,079)**	$ 197,188
Ceded premiums	**(325,000)**	(325,000)	**(325,000)**	(332,500)
Total	**$ (482,031)**	$ (123,125)	**$ (415,079)**	$ (135,312)

The liability for unpaid losses and loss adjustment expenses is included within captive insurance loss and other reserves on the accompanying consolidated balance sheets. Activity in the liability for unpaid losses and loss adjustment expenses is summarized as follows for the years ended September 30, 2012 and 2011:

	2012	**2011**
Balance at beginning of the year	**$ 2,388,646**	$ 2,615,549
Less: reinsurance recoverables	**(678,921)**	(757,650)
Net balance beginning of the year	**1,709,725**	1,857,899
Incurred related to:		
Current year	**290,301**	333,402
Prior years	**(126,164)**	(474,602)
Total incurred	**164,137**	(141,200)
Paid related to:		
Current year	**-**	-
Prior years	**(89,779)**	(6,974)
Total paid	**(89,779)**	(6,974)
Net balance end of the year	**1,784,083**	1,709,725
Plus: reinsurance recoverables	**663,930**	678,921
Balance at end of the year	**$ 2,448,013**	$ 2,388,646

Note 13 - Captive Insurance Activities (continued)

As a result of changes in estimates of insured events in prior years, the provision for losses and loss adjustment expenses decreased by $126,164 and $474,602 in 2012 and 2011, respectively.

The above liability for loss and loss adjustment expenses have been determined using a 4% discount rate. The ultimate settlement of losses may vary significantly from the reserves recorded. In particular, ultimate settlements on medical malpractice claims depend, among other things, on the resolution of litigation, the outcome of which is difficult to predict. Also, since the reserves have been discounted, there is the possibility that the timing of loss payments and income earned on invested assets will be significantly different than anticipated.

Included on the accompanying consolidated balance sheets is a reinsurance recoverable of $663,930 and $678,921 as of September 30, 2012 and 2011, respectively, which is due from one reinsurer. GRS continually evaluates the reinsurer's financial condition. There can be no assurance that reinsurance will continue to be available to GRS to the same extent, and at the same cost, as it has in the past. GRS may choose in the future to reevaluate the use of reinsurance to increase or decrease the amounts of risk it cedes to reinsurers.

Note 14 - Commitments and Contingencies

The Association is involved in various legal actions arising in the normal course of activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, upon the Association's financial condition.

ASC 410-20 *"Accounting for Asset Retirement Obligations"* addresses financial accounting and reporting for obligations associated with the retirement of tangible long-lived assets such as facilities containing asbestos, when the amount of the liability can be reasonably estimated. No Asset Retirement Obligation (ARO) has been established as of September 30, 2012 and 2011, as no plans to renovate or sell any facility, or area within, with significant asbestos have been identified and therefore no settlement date has been determined. Management will continue to evaluate its exposure to asbestos removal and establish an ARO for the fair value of the associated costs once sufficient information has been obtained and a settlement date has been determined. Management does not believe that the liability is material to the overall consolidated financial results of the Association.

Note 15 - Risks and Uncertainties

Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the consolidated statements of financial position.

In addition, the Plan invests in various investments securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the consolidated statements of financial position.

Note 16 - Pledges Receivable

Pledges receivable represent unconditional promises to give for the 36-bed addition. The following pledges are due to the Association as of September 30, 2012:

Due within one year	$	90,046
Due in one to five years		266,805
		356,851
Less: allowance for uncollectible pledges		(35,685)
Total	$	321,166

Note 17 - Supplemental Cash Flow Disclosures

The Association paid interest in the amount of $882,966 and $919,764 for the years ended September 30, 2012 and 2011, respectively.

Gaylord Farm Association, Inc.
Consolidating Balance Sheet
September 30, 2012

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Assets						
Current assets:						
Cash and cash equivalents	$ 392,491	$ 242,747	$ -	$ -	$ -	$ 635,238
Patient accounts receivable (less allowance of $458,000)	10,522,310	-	-	-	-	10,522,310
Assets whose use is limited:						
Assets held under bond indenture agreement	189,467	-	-	-	-	189,467
Pledges receivable, net	90,046	-	-	-	-	90,046
Due from affiliates	3,143,230	-	-	1,972	(3,145,202)	-
Other current assets	1,513,595	489,721	-	-	-	2,003,316
Total current assets	15,851,139	732,468	-	1,972	(3,145,202)	13,440,377
Assets whose use is limited:						
Pledges receivable	231,120	-	-	-	-	231,120
Board-designated investments	14,349,648	-	-	-	-	14,349,648
Donor restricted investments	5,555,747	-	-	-	-	5,555,747
Beneficial interest in trusts held by others	11,240,066	-	-	-	-	11,240,066
	31,376,581	-	-	-	-	31,376,581
Property, plant and equipment, net	38,177,394	-	-	-	-	38,177,394
Investments held for captive insurance liabilities	-	3,846,709	-	-	-	3,846,709
Reinsurance recoverable relating to captive insurance liabilities	-	663,930	-	-	-	663,930
Other assets	946,160	-	-	-	-	946,160
Total assets	$ 86,351,274	$ 5,243,107	$ -	$ 1,972	$ (3,145,202)	$ 88,451,151
Liabilities, Net Assets and Shareholder's Equity						
Current liabilities:						
Accounts payable and accrued expenses	$ 2,747,732	$ 63,899	$ -	$ -	$ -	$ 2,811,631
Accrued payroll and related taxes	4,730,818	-	-	-	-	4,730,818
Line of credit	-	-	-	-	-	-
Due to affiliates	-	900,000	2,245,202	-	(3,145,202)	-
Estimated amounts due to third-party payers	246,805	-	-	-	-	246,805
Current portion of accrued pension obligation	1,493,193	-	-	-	-	1,493,193
Current portion of long-term debt and capital lease obligations	1,526,815	-	-	-	-	1,526,815
Total current liabilities	10,745,363	963,899	2,245,202	-	(3,145,202)	10,809,262
Long-term debt and capital lease obligations, less current portion	18,153,360	-	-	-	-	18,153,360
Accrued pension obligation	16,609,410	-	-	-	-	16,609,410
Captive insurance losses and other reserves	-	2,819,498	-	-	-	2,819,498
Interest rate swap liability	4,712,094	-	-	-	-	4,712,094
Total liabilities	50,220,227	3,783,397	2,245,202	-	(3,145,202)	53,103,624
Net assets and shareholder's equity:						
Unrestricted	18,185,770	-	(2,245,202)	1,972	-	15,942,540
Temporarily restricted	1,149,464	-	-	-	-	1,149,464
Permanently restricted	16,795,813	-	-	-	-	16,795,813
Shareholder's equity	-	1,459,710	-	-	-	1,459,710
Total net assets and shareholder's equity	36,131,047	1,459,710	(2,245,202)	1,972	-	35,347,527
Total liabilities, net assets and shareholder's equity	$ 86,351,274	$ 5,243,107	$ -	$ 1,972	$ (3,145,202)	$ 88,451,151

See accompanying Independent Auditors' Report.

Gaylord Farm Association, Inc.
Consolidating Balance Sheet
September 30, 2011

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Assets						
Current assets:						
Cash and cash equivalents	$ 487,626	$ 397,069	$ -	$ -	$ -	$ 884,695
Patient accounts receivable (less allowance of $540,000)	10,001,815	-	-	-	-	10,001,815
Assets whose use is limited:						
Assets held under bond indenture agreement	179,780	-	-	-	-	179,780
Pledges receivable, net	386,657	-	-	-	-	386,657
Due from affiliates	2,543,065	-	-	1,972	(2,545,037)	-
Other current assets	1,183,998	760,853	-	-	-	1,944,851
Total current assets	14,782,941	1,157,922	-	1,972	(2,545,037)	13,397,798
Assets whose use is limited:						
Pledges receivable	310,105	-	-	-	-	310,105
Board-designated investments	13,693,257	-	-	-	-	13,693,257
Donor restricted investments	5,529,789	-	-	-	-	5,529,789
Beneficial interest in trusts held by others	9,748,956	-	-	-	-	9,748,956
	29,282,107	-	-	-	-	29,282,107
Property, plant and equipment, net	41,937,586	-	-	-	-	41,937,586
Investments held for captive insurance liabilities	-	3,517,224	-	-	-	3,517,224
Reinsurance recoverable relating to captive insurance liabilities	-	678,921	-	-	-	678,921
Other assets	1,086,089	-	-	-	-	1,086,089
Total assets	$ 87,088,723	$ 5,354,067	$ -	$ 1,972	$ (2,545,037)	$ 89,899,725
Liabilities, Net Assets and Shareholder's Equity						
Current liabilities:						
Accounts payable and accrued expenses	$ 4,805,123	$ 48,868	$ -	$ -	$ -	$ 4,853,991
Accrued payroll and related taxes	3,819,490	-	-	-	-	3,819,490
Line of credit	450,000	-	-	-	-	450,000
Due to affiliates	-	675,000	1,870,037	-	(2,545,037)	-
Estimated amounts due to third-party payers	246,805	-	-	-	-	246,805
Current portion of accrued pension obligation	2,743,352	-	-	-	-	2,743,352
Current portion of long-term debt and capital lease obligations	1,487,242	-	-	-	-	1,487,242
Total current liabilities	13,552,012	723,868	1,870,037	-	(2,545,037)	13,600,880
Long-term debt and capital lease obligations, less current portion	19,570,309	-	-	-	-	19,570,309
Accrued pension obligation	14,699,268	-	-	-	-	14,699,268
Captive insurance reserves	-	2,827,083	-	-	-	2,827,083
Interest rate swap liability	4,155,222	-	-	-	-	4,155,222
Total liabilities	51,976,811	3,550,951	1,870,037	-	(2,545,037)	54,852,762
Net assets and shareholder's equity:						
Unrestricted	18,625,933	-	(1,870,037)	1,972	-	16,757,868
Temporarily restricted	1,207,234	-	-	-	-	1,207,234
Permanently restricted	15,278,745	-	-	-	-	15,278,745
Shareholder's equity	-	1,803,116	-	-	-	1,803,116
Total net assets and shareholder's equity	35,111,912	1,803,116	(1,870,037)	1,972	-	35,046,963
Total liabilities, net assets and shareholder's equity	$ 87,088,723	$ 5,354,067	$ -	$ 1,972	$ (2,545,037)	$ 89,899,725

See accompanying Independent Auditors' Report.

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Gaylord Farm Association, Inc.
Consolidating Statement of Operations
For the Year End September 30, 2012

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Revenues:						
Net patient service revenue	$ 70,082,884	$ -	$ 243,859	$ -	$ -	$ 70,326,743
Contributions and bequests	1,076,207	-	-	-	-	1,076,207
Earned written premium	-	(90,079)	-	-	90,079	-
Ceded premium	-	(325,000)	-	-	-	(325,000)
Other operating revenue	599,996	-	125,084	-	-	725,080
Net assets released from restrictions used for operations	279,175	-	-	-	-	279,175
Total revenues	72,038,262	(415,079)	368,943	-	90,079	72,082,205
Expenses:						
Salaries and related expenses	48,881,515	-	647,206	-	-	49,528,721
Other operating expenses	5,263,601	203,897	49,121	-	90,079	5,606,698
Professional fees and contract services	8,060,187	-	-	-	-	8,060,187
Supplies	5,034,738	-	-	-	-	5,034,738
Depreciation and amortization	3,857,816	-	42,636	-	-	3,900,452
Occupancy costs	2,145,309	-	-	-	-	2,145,309
Provision for bad debts	420,830	-	-	-	-	420,830
Interest	877,821	-	5,145	-	-	882,966
Loss and loss adjustment expenses	-	164,137	-	-	-	164,137
Total expenses	74,541,817	368,034	744,108	-	90,079	75,744,038
Loss from operations	(2,503,555)	(783,113)	(375,165)	-	-	(3,661,833)
Other gains, net:						
Dividend and interest income	441,541	80,741	-	-	-	522,282
Net realized gains on investments	515,365	-	-	-	-	515,365
Loss on equity investments	(75,252)	-	-	-	-	(75,252)
Change in fair value of interest rate swap agreement	(556,872)	-	-	-	-	(556,872)
Total other gains, net	324,782	80,741	-	-	-	405,523
Excess of revenues under expenses	$ (2,178,773)	$ (702,372)	$ (375,165)	$ -	$ -	$ (3,256,310)

See accompanying Independent Auditors' Report.

Gaylord Farm Association, Inc.
Consolidating Statement of Operations
For the Year Ended September 30, 2011

	Gaylord Hospital, Inc.	Gaylord Risk Solutions, Ltd.	Gaylord Farm Rehabilitation Center	Gaylord Research Institute, Inc.	Eliminations	Gaylord Farm Association, Inc.
Revenues:						
Net patient service revenue	$ 66,776,439	$ -	$ 288,308	$ -	$ -	$ 67,064,747
Contributions and bequests	913,165	-	-	-	-	913,165
Earned written premium	-	197,188	-	-	(197,188)	-
Ceded premium	-	(332,500)	-	-	-	(332,500)
Other operating revenue	507,069	-	130,599	-	-	637,668
Net assets released from restrictions used for operations	145,235	-	-	-	-	145,235
Total revenues	68,341,908	(135,312)	418,907	-	(197,188)	68,428,315
Expenses:						
Salaries and related expenses	46,226,061	-	597,339	-	-	46,823,400
Other operating expenses	5,490,261	178,205	60,013	-	(197,188)	5,531,291
Professional fees and contract services	6,818,453	-	-	-	-	6,818,453
Supplies	5,064,540	-	-	-	-	5,064,540
Depreciation and amortization	3,825,731	-	64,698	-	-	3,890,429
Occupancy costs	2,099,698	-	-	-	-	2,099,698
Provision for bad debts	344,715	-	-	-	-	344,715
Interest	912,115	-	7,649	-	-	919,764
Loss and loss adjustment expenses	-	(141,200)	-	-	-	(141,200)
Total expenses	70,781,574	37,005	729,699	-	(197,188)	71,351,090
Loss from operations	(2,439,666)	(172,317)	(310,792)	-	-	(2,922,775)
Other gains, net:						
Dividend and interest income	536,089	50,473	-	-	-	586,562
Net realized gains on investments	140,830	-	-	-	-	140,830
Loss on equity investments	(5,304)	-	-	-	-	(5,304)
Change in fair value of interest rate swap agreement	(508,193)	-	-	-	-	(508,193)
Total other gains, net	163,422	50,473	-	-	-	213,895
Excess of revenues under expenses	$ (2,276,244)	$ (121,844)	$ (310,792)	$ -	$ -	$ (2,708,880)

See accompanying Independent Auditors' Report.

F. Newspaper Notification

PUBLIC NOTIFICATION (Insert Dates: 11/20/2013 11/21/2013 11/22/2013)

NEW HAVEN REGISTER THE REGISTER CITIZEN The Middletown Press Farmington Valley Times CONNECTICUT
SHORELINE TIMES The Foothills Trader WEST HARTFORD NEWS MINUTEMAN
Bulletin THE GRANBY NEWS the Bulletin THE LITCHFIELD COUNTY TIMES Post-Chronicle

Proof of Ad 11/15/13

Account:	141051
Name:	
Company:	GAYLORD HOSPITAL
Address:	GAYLORD FARM RD P.O. BOX 400 WALLINGFORD, CT 06492
Telephone:	(203) 284-2830
Ad ID:	179474
Description:	PUBLIC NOTICE Gaylord Hospital is ap
Run Dates:	11/18/13 to 11/20/13
Class:	1201
Orig User:	CREOLELLO
Words:	58
Lines:	14
Agate Lines:	16
Column width:	1
Depth:	1.75
Blind Box:	

PUBLIC NOTICE

Gaylord Hospital is applying for a Certificate of Need pursuant to section 19a-638 of the general statutes for the sale of its Sleep Medicine site located at 8 Devine St., North Haven. There is no capital expenditure associated with this closing as it is a transfer of ownership.

G. NOTICE TO PATIENTS

To All Our Patients:

We are writing to inform you of an upcoming change at Gaylord Sleep Medicine-Trumbull. As of (Date), Gaylord Sleep Medicine will be closing its Trumbull location. We understand that you may still require sleep medicine services, and your Gaylord provider and Manager of Sleep Services will work collaboratively to ensure a smooth transition for your care. Their contact information is listed below.

Should you have any questions, would like a copy of your medical records, or if you prefer to select another sleep medicine provider, please contact us at 203-284-2756. We thank you for the opportunity to serve your health care needs.

Sincerely,

Margaret Kelley
Manager, Outpatient Medical Services and Sleep Medicine
Gaylord Farm Road
Wallingford, CT 06492

H. Agreement between Gaylord and CCMC

Agreement between Gaylord Hospital, its Sleep Medicine Division
and Connecticut Children's Medical Center

The Applicant, Gaylord Hospital, its Sleep Medicine Division and Connecticut Children's Medical Cente have agreed to work collaboratively in the implementation of external communications and outreach activities to ensure that pediatric patients have access to necessary sleep medicine services. Gaylord Sleep lab in Glastonbury shall send all pediatric patients within the prior two years a written communication (See Below). It is understood between the Parties that nothing in this Agreement is intended to require nor provides payment or benefits of any kind for the referral of individuals to Connecticut Children's Medical Center.

Janine L. Epright, CFO
Gaylord Hospital

Theresa Hendricksen, EVP & COO
Connecticut Children's Medical Center

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 29, 2014

VIA FAX ONLY

Janine Epright
CFO
Gaylord Hospital
P.O. Box 400
Gaylord Farms Road
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31883-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine Services in Trumbull, CT

Dear Ms. Epright:

On December 30, 2013, the Office of Health Care Access ("OHCA") received your initial Certificate of Need application filing on behalf of Gaylord Hospital ("Applicant") for the termination of Gaylord Sleep Medicine Services in Trumbull, CT, with no associated capital expenditure.

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

1. Please provide the hours of operations for the services provided at the Trumbull location.

2. On page 6 of the CON Application, the Applicant responded N/A to question e. Please resubmit a response to "why there is a clear public need for the proposal, provide evidence that demonstrates this need."

3. Please provide the written agreements that the Applicant has with Yale-New Haven Hospital for the transition of its adult patients and with Connecticut Children's Medical Center for the transition of its pediatric patients from the Trumbull location.

4. Please provide the current utilization (October 1, 2013 – to the present) for sleep studies performed at the Trumbull location.

5. On page 8 of the CON Application, the Applicant states a grand total of 2056 patient visits by town for the most recently completed FY, where on page 9 the Applicant states 453 as the number of sleep studies for FY 2013. Please provide an explanation as to why these two numbers are different.

6. Please report the patient/payer mix for the last two fiscal years and the current fiscal year.

7. Please address the following regarding the Applicant's Medicaid population:

    a. Provide evidence as to how the Applicant has demonstrated how this proposal will improve or maintain quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to:

        i. Provision of any change in the access to services for Medicaid recipients and indigent persons, and

        ii. The impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

8. Provide the Applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons.

9. If the Applicant has failed to provide or reduced access to services to Medicaid recipients or indigent persons, demonstrate how the Applicant has done this due to good cause or demonstrate that it was not solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

10. Has the Applicant considered an alternative to closing the Trumbull location (e.g., reducing hours, etc.)? Please provide supporting documentation.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 65 and reference "Docket Number: 13-31883-CON." Submit one (1) original and two (2) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information not later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than March 30, 2014, otherwise your application will be automatically considered withdrawn. If you have any questions concerning this letter, please feel free to contact me by email or at (860) 418-7035.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

* * * COMMUNICATION RESULT REPORT (JAN. 29. 2014 9:34AM) * * *

FAX HEADER:

TRANSMITTED/STORED : JAN. 29. 2014 8:59AM

FILE MODE	OPTION	ADDRESS	RESULT	PAGE
012 MEMORY TX		912037413408	OK	4/4

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: 12037413408

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 01/29/2014 **Time:** 9:00 am

NUMBER OF PAGES: 4
(including transmittal sheet

Comments:
13-31883-
CON
Completeness
Letter

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

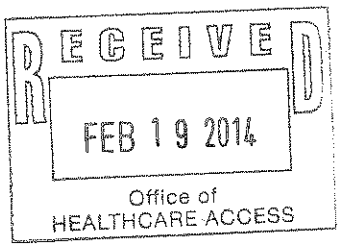
410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

GAYLORD SLEEP MEDICINE TRUMBULL

RESPONSE TO ADDITIONAL QUESTIONS

DOCKET NUMBER 13-31883-CON

February 6, 2014



1. **Please provide the hours of operation for the services provided at Trumbull.**

Response

The hours of operation at Gaylord Sleep Medicine Trumbull are the following:

Sleep Studies: Monday, Tuesday, Wednesday, Friday 8:00pm-7:00 am

Physician Patient Hours: Tuesday 8:00 am-5:00 pm;

Wednesday 8:00 am-4:30 pm;

Thursday (First and Third weeks) 8:00 am-4:30 pm;

Thursday (Second and Fourth weeks) 8:00 am-5:20 pm

CPAP: Tuesday, First and third weeks 8:00 am-4:30 pm

Tuesday, Second and Fourth weeks 7:00 am-4:00 pm

2. **Question e.**

"On Page 6 of the CON application, the Applicant responded N/A to question e. Please resubmit a response as to why there is a clear public need for the proposal, provide evidence that states this need."

Response

There are three main reasons why there is a public need for the proposal:

- Diminished in-lab patient volume. Since the opening of the Center, patient volume has diminished and it was determined that maintaining the sleep program in Trumbull was not an efficient use of resources. In 2013, overnight in-lab sleep volume had fallen to 453 in FY 2013 from 725 in FY11, representing a 37% decrease. The decision to terminate the sleep practice in Trumbull is based on a careful evaluation of how Gaylord can best serve the needs of its patients within its core business: comprehensive health care services for individuals with brain injuries, spinal cord injuries, complex pulmonary conditions, and complex medical illnesses. Our purpose is to provide high quality, cost-efficient care while ensuring the financial health of our organization.
- Changing models of the delivery of sleep medicine services. There is an increasing trend of delivering sleep medicine away from lab testing to home-based testing, thus not necessitating as much need for free-standing sleep labs. This trend is expected to continue and thus will continue to impact volume. (Appendix: Journal of Clinical Sleep Medicine, Vol. 9, No.1, 2013 PRO: Sliding into Home: Portable Sleep testing is Effective for Diagnosis of Obstructive Sleep Apnea)
- Unnecessary duplication of services. With declining volumes and the fact that sleep services are provided by other providers in the area, this proposal supports cost-avoidance.

3. **Please provide written agreement that the Applicant has with Yale-New Haven Hospital for the transition of its adult patients and with Connecticut Children's Medical Center for the transition of its pediatric patients from the Trumbull location.**

Response

Agreement: Gaylord Sleep Medicine and Connecticut Children's Medical Center

Agreement between Gaylord Hospital, its Sleep Medicine Division
and Connecticut Children's Medical Center

The Applicant, Gaylord Hospital, its Sleep Medicine Division and Connecticut Children's Medical Center have agreed to work collaboratively in the implementation of external communications and outreach activities to ensure that pediatric patients have access to necessary sleep medicine services. Gaylord Sleep lab in Glastonbury shall send all pediatric patients within the prior two years a written communication (See Below). It is understood between the Parties that nothing in this Agreement is intended to require nor provides payment or benefits of any kind for the referral of individuals to Connecticut Children's Medical Center.

Janine L. Epright, CFO
Gaylord Hospital

Theresa Hendricksen, EVP & COO
Connecticut Children's Medical Center

Agreement: Gaylord Sleep Medicine and Yale New Haven Hospital

YALE-NEW HAVEN HOSPITAL

February 10, 2014

George Kyriacou
President & Chief Executive Officer
Gaylord Hospital, Inc.
Gaylord Farm Road
P.O. Box 400
Wallingford, Connecticut 06492

RE: Sleep Medicine Patient Transition

Dear George,

This letter confirms Yale-New Haven Hospital's ("YNHH") commitment to accept Gaylord Hospital's Sleep Medicine patients after Gaylord's termination of its Sleep Medicine service line.

YNHH and Gaylord Hospital's Sleep Division will work collaboratively to implement external communications and outreach activities to ensure that Gaylord patients have access to the necessary sleep medicine services. Prior to the closing of the sleep medicine asset purchase transaction contemplated between YNHH and Gaylord Hospital, Gaylord will send every adult patient seen within the last two years at its North Haven, Glastonbury, Guilford and Trumbull sites a written communication notifying them that they can continue to receive treatment from YNHH. Similarly for pediatric patients, a notification will sent that informs patients that they can be served by either YNHH or Connecticut Children's Medical Center. An example of the communication is attached to this letter.

It is understood by YNHH and Gaylord hospital that nothing in this letter is intended to require or provide payment or benefits of any kind for the referral of patients to YNHH.

Please countersign below indicating your acceptance of this plan of transition.

Sincerely,

Richard D'Aquila
President & Chief Operating Officer

Agreed upon and accepted by:
Gaylord Hospital, Inc.

George Kyriacou
President & Chief Executive Officer

Attachment: Example Patient Communication

[Gaylord Hospital Letterhead]

NOTICE TO OUR SLEEP MEDICINE PATIENTS

[DATE]

To Our Sleep Medicine Patients:

We are writing to inform you that Gaylord Hospital's Sleep Medicine Division is closing its operations. As of [DATE], Gaylord Hospital will be selling the assets of its North Haven laboratory to Yale-New Haven Hospital, and closing its Glastonbury, Trumbull and Guilford locations. We understand that you may still require sleep medicine services, and Yale-New Haven Hospital and Connecticut Children's Medical Center have agreed to work collaboratively to ensure a smooth transition for your care. You may contact their Sleep Medicine departments at [INSERT NUMBERS].

Should you have any questions, would like a copy of your medical records, or if you prefer to select another sleep medicine provider, please contact us at [INSERT NUMBER]. We thank you for the opportunity to serve your health care needs.

Sincerely,

Gaylord Hospital, Inc.

4. **Please provide the current utilization (October 1, 2013-to the present) for sleep studies performed at the Trumbull location.**

Response

Sleep Studies, October 1, 2013-Current

Trumbull	
2013	2,056
YTD 2014	474
TOTAL	2,530

5. **On page 8 of the CON application, the Applicant states a grand total of 2,056 patient visits by town for the most recently completed FY, where on page 9 the Applicant states 453 as the number of sleep studies for FY2013. Please provide an explanation as to why these two numbers are different.**

Response

The two numbers are different because the grand total of patient visits reported on page 8 reflects all patient visits to the Trumbull facility. The 453 represents visits for sleep studies only. The financial worksheet has been amended to reflect all patient visits and is included in the Appendix.

6. **Please report the patient/payer mix for the last two fiscal years and the current fiscal year.**

Response

PAYOR	2011	2012	2013	YTD 2014
Medicare	17%	20%	17%	26%
Medicaid	7%	17%	23%	27%
Commercial	76%	63%	60%	47%
Other	0%	0%	0%	0
TOTAL	100%	100%	100%	100%

7. **Please address the following regarding the Applicant's Medicaid population:**

a. **Provide evidence as to how the Applicant has demonstrated how this proposal will improve or maintain quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to:**

   i. **Provision of any change in the access to services for Medicaid recipients and indigent persons, and**

   ii. **The impact upon the cost effectiveness of providing access to services provided under the Medicaid program.**

Response

There will be no adverse impact on the quality and access of sleep medicine services for Medicaid recipients. Medicaid patients can continue to be referred by their physicians, and Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients. Both organizations have sleep medicine programs accredited by the American Academy of Sleep Medicine.

8. **Provide the Applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including but not limited to access to services by Medicaid recipients and indigent persons.**

Response

Gaylord Sleep Medicine Trumbull has accepted patient referrals, including Medicaid patients, for sleep services. (Payor Mix table). There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients. Sleep medicine services are currently offered by providers in the geographic area currently served by Trumbull Sleep Medicine.

PAYOR	2011	2012	2013	YTD 2014
Medicare	17%	20%	17%	26%
Medicaid	7%	17%	23%	27%
Commercial	76%	63%	60%	47%
Other	0%	0%	0%	0
TOTAL	100%	100%	100%	100%

9. **If the Applicant has failed to provide or reduce access to services to Medicaid recipients or indigent persons, demonstrate how the Applicant has done thus due to good cause or demonstrate that it was not solely on the basis of difference in reimbursement rates between Medicaid and other health payers.**

Response

Gaylord has provided sleep services to Medicaid recipients. (Payor Mix Table) The decision to terminate sleep medicine services at Trumbull was not based in any measure on differences in reimbursement rates between Medicaid and other health payers. Changes in the practice of sleep medicine including new technology used to diagnose sleep disorders has resulted in declining in-lab volumes toward home studies. This, coupled with the need to provide high quality, cost-effective care to patients with spinal cord injuries, brain injuries, complex pulmonary diseases, and medically complex patients influenced the decision to terminate sleep services in Trumbull.

There will be no adverse impact on the Medicaid population, and the termination of services will not impact access to services for Medicaid recipients. Gaylord has made arrangements with Yale-New Haven Hospital for the transition of its adult and pediatric patients and with Connecticut Children's Medical Center for the transition of its pediatric patients. Additionally, there are other providers in the area that provide sleep medicine services.

PAYOR	2011	2012	2013	YTD 2014
Medicare	17%	20%	17%	26%
Medicaid	7%	17%	23%	27%
Commercial	76%	63%	60%	47%
Other	0%	0%	0%	0
TOTAL	100%	100%	100%	100%

10. Has the Applicant considered an alternative to closing the North Haven location (e.g., reducing hours, etc.)? Please provide documentation.

Response

As part of Gaylord's strategic planning process, the decision was made to concentrate scare resources on Gaylord's core health care services which did not include sleep medicine services. Gaylord made the decision to terminate its Trumbull sleep medicine services and did not consider alternatives to closing the Trumbull location.

APPENDIX

PRO/CON DEBATE

ANALYSIS AND PERSPECTIVES

JCSM
Journal of Clinical Sleep Medicine

http://dx.doi.org/10.5664/jcsm.2324

PRO: Sliding into Home: Portable Sleep Testing Is Effective for Diagnosis of Obstructive Sleep Apnea

Douglas B. Kirsch, M.D., F.A.A.S.M.

Clinical Instructor, Harvard Medical School, Regional Medical Director, Sleep HealthCenters, Brighton, Mi

Whether you call it home sleep testing (HST), out of center sleep testing, portable monitoring, or something else, the debate about the use of medical devices to assess patients for obstructive sleep apnea outside the sleep laboratory setting has been ongoing for almost 20 years. In the last few years, the discussion has intensified as many United States-based insurance providers, including the government-run Center for Medicare and Medicaid Services (CMS), have approved the use of these devices for diagnosis of obstructive sleep apnea (OSA).[1] This article will briefly review the epidemic of OSA, the history of home sleep testing, and the reasons that home sleep testing is likely to play an increasingly large role in the practice of sleep medicine in the next several years.

Obstructive Sleep Apnea (OSA)

The medical community has been increasingly aware of sleep disorders over the last several years, and in particular, OSA evaluations have been occurring at an increasing rate; CMS data demonstrates that payments for polysomnography alone increased from $62 million in 2001 to $235 million in 2009.[1] These payments do not include the cost of medical consultations or the treatments for these patients. This 4-fold increase over 8 years may be explained by several factors: increasing availability for testing as sleep medicine has grown as a field (more than 2,000 centers were listed as accredited by the American Academy of Sleep Medicine in 2010),[2] the worsening epidemic of obesity in the United States (in 2010, no state had a prevalence of obesity [defined by a BMI of 30] < 20%; 12 of these states had a prevalence ≥ 30%),[3] and increasing knowledge that untreated OSA has medical and societal consequences (such as the potential to increase the risk of motor vehicle crashes, morbidity, and mortality).[4,5] Though the total amount of money used for polysomnography is small on a percentage basis when looking at the budget for CMS, it is probable that the rate of increase was particularly of concern. In the current US budget climate, many methods for reducing cost while maintaining quality were reviewed, including procedures for OSA diagnosis.

Home Sleep Testing and Auto-titrating Positive Airway Pressure (PAP) Therapy

Studying sleep objectively has generally required a laboratory, given the large amount of signals needed for a full polysomnogram (EEG, respiratory parameters, leg/chin movements, EKG, oxygen saturation), as well as the amplifiers, output methods (in recent years, computers), and technical staff. A diagnosis for OSA is typically given when a patient has an apnea-hypopnea index (AHI) ≥ 15 events/h, or an AHI ≥ 5 associated with sleep symptoms or medical disorders.[7] OSA is a relatively common disorder (data from 1993 suggests that 4% of middle-aged men and 2% of middle-aged women have the disorder[6]), and it is one of the most commonly diagnosed problems in a sleep laboratory. As well, sleep laboratories are typically localized to sites with larger populations, making testing of scattered or rural populations more difficult. Thus, portable methods have been evaluated for diagnosis of OSA.

Testing for OSA in the home only solves half of the problem. Prior to the last few years, after a diagnosis of OSA was made, an attended in-laboratory PAP titration study was also necessary to ensure the appropriate pressure was chosen for treatment. At times, both a diagnostic study and a titration study were performed in the same night as a "split-night" protocol. However, the creation, validation, and clinical use of the auto-titrating PAP device minimizes the need for an in-laboratory titration study. While there are still some lingering questions regarding the equivalence of continuous use of auto-titrating PAP therapy and standard PAP therapy, the algorithm of HST for diagnosis and auto-titrating PAP for treatment clearly allows for cost-effective patient management.

The History of Home Sleep Testing

Scarce data about home sleep testing in the early 1990s limited the use of the devices on a larger scale. A review was performed by the American Sleep Disorders Association (a precursor to the American Academy of Sleep Medicine) in 1994,[9] which suggested that home sleep testing be used only in the following situations:

1. Patients with severe symptoms or when treatment is urgent and PSG is not readily available
2. Patients unable to be studied in the laboratory
3. Follow-up study after diagnosis established by polysomnography to evaluate response to therapy

A repeated review in 1997 repeated those recommendations, suggesting that there was not enough validated data for unattended use of home sleep testing devices.[10] A Tri-Society (formed of the American Academy of Sleep Medicine, American Thoracic Society, and the American College of Chest

Physicians) Practice Parameter in 2003 stated that type 3 studies (limited channel home sleep tests) were acceptable in the *attended* setting, but that these testing methods were not recommended in unattended settings, for general screening, or for patients with comorbid conditions.[11]

An AHRQ (Agency for Healthcare Research and Quality) task force performed a technology assessment in 2007, this time with additional data from newer studies and a different viewpoint.[12] Not only did they compare baseline AHI on an in-laboratory polysomnogram to the AHI from a HST, but also they recognized that AHI data did not support that a precise AHI predicted PAP use. Thus, they evaluated outcomes of positive pressure use comparing patients who had been tested in and out of the laboratory. The major findings:

1. Type 3 home testing devices have the ability to predict AHI suggestive of OSA with high positive likelihood ratios and low negative likelihood ratios, particularly when manual scoring is employed.
2. For people with a high probability of OSA, use of laboratory-based PSG does not result in better outcomes over an ambulatory approach in terms of diagnosis and PAP titration

Studies from the last 4-5 years have examined the outcomes from home testing algorithms versus standard in-laboratory polysomnography. One of the pivotal studies used by CMS as evidence for approving HSTs was Mulgrew et al. in 2007, which demonstrated that in subjects with high pre-test probability of obstructive sleep apnea (demonstrated by oximetry and questionnaire), an ambulatory approach (portable monitoring and auto-titrating positive pressure titration) was at least equivalent to in-laboratory testing in terms of adherence of positive pressure therapy and resolution of sleep apnea symptoms after 3 months.[13] One year later, Berry et al. examined 106 Veterans Administration Medical Center (VAMC) patients with excessive daytime sleepiness and a high risk of OSA and randomized them to either portable monitoring with a 2-3 day titration via auto-titrating positive pressure therapy or in-laboratory polysomnography. Both groups were then placed on standard CPAP with no difference in adherence rates to CPAP or improvement in sleep symptoms after 6 weeks.[14] The study of Kuna et al., published in 2011, evaluated 260 VAMC patients and demonstrated that a home testing pathway was not inferior to a laboratory-based pathway for treatment of OSA. Lastly, the 2012 HomePAP study by Rosen et al., assessed 373 subjects, testing the utility of an integrated clinical pathway for obstructive sleep apnea (OSA) diagnosis and continuous positive airway pressure (CPAP) treatment using portable monitoring devices. The findings determined that there was clinical equivalence between the pathways from a standpoint of PAP adherence (in fact, PAP adherence was higher in the ambulatory group) and that a cost analysis favored the ambulatory approach.[15]

Home Sleep Testing: What Is It?

At the heart of home sleep testing is the ability to accurately make a correct diagnosis of OSA while minimizing false positives and false negatives. Most devices will rely on 3 primary signals to assess a patient's sleep-disordered breathing:

1. Airflow (nasal-oral thermistor, nasal pressure, or preferably both),
2. Respiratory effort (ideally with respiratory inductance plethysmography)
3. Oximetry (with a standard maximum signal averaging time $\leq$ 3 sec at a heart rate $\geq$ 80 beats per minute)

Additional factors on home testing devices may include cardiovascular measurements (such as pulse rate or rhythm strips), positional monitoring, and measurement of sleep time. There are several devices which use alternative metrics: venous pulsation substituting for respiratory effort (ARES device, currently under FDA review), arterial tonometry instead of nasal airflow and respiratory effort (WatchPAT), or the analysis of EKG rhythms as a surrogate for respiratory channels.

A home testing device should be validated against in-laboratory polysomnography to ensure that it functions at an adequate level. The American Academy of Sleep Medicine constructed a technology evaluation in 2011, updating their 2007 Clinical Guidelines paper.[16,17] The 2011 paper suggested that an out of center testing device should have a positive likelihood ratio ($LR+$) $\geq$ 5 coinciding with an in-lab- polysomnography (PSG)-generated apnea hypopnea index (AHI) $\geq$ 5, and an adequate sensitivity ($\geq$ 0.825). A review of many of the currently available devices can be found in this 2011 article.

Home sleep testing though generally effective, has some important limitations. Many portable tests underestimate OSA severity because of the differences in methods to detect obstructive events and amount of sleep. The numerator of the AHI (respiratory events) is lower for a portable test than an in-laboratory test, as subtle sleep-disordered breathing not as easily identified as it would on an in-laboratory test because of the inability to detect arousal-related events. Also, the denominator (time) is larger with portable tests because recording time is assessed rather than sleep time (EEG signal for sleep scoring is not available in many home testing devices). As well, many devices are prone to artifact and have a failure rate that ranges from 3% to 18% depending on study and device.[17]

Why Home Sleep Testing Is Here Now and Why It Might Not Be All Bad?

At this point in time, HSTs are going to play an increasing role in the practice of Sleep Medicine. That is in large part due to the changes in insurance practices around the use of HST. In the northeastern United States, particularly in Massachusetts, prior authorization programs run by utilization management companies have begun to proliferate, shunting many patients from the sleep laboratories and into home testing. Though these programs have not clearly been built exactly on the existing 2007 Practice Parameters from the AASM, it is clear that many patients who are seeking evaluations for OSA will be first evaluated in the home setting; one utilization management company's (American Imaging Management) estimate is as high as 70%.[18] Clearly, the view of these insurance companies is that money will be saved in this process as a home sleep study costs about $200-$300, whereas a sleep study may be $800 and up. Other health insurance companies, such as Aetna and United, have begun utilization management programs applying prior authorization protocols on a national level. Home sleep testing cannot be replaced back into Pandora's box.

Though viewed with much suspicion by some sleep practitioners, HSTs may actually help the field of Sleep Medicine. Certainly, adopting this method of evaluation will result in many changes in physician habits and sleep laboratories. However, as we adjust our practice styles to the new world ahead of us, we may reach a larger number of patients when not limited to a physical location of a sleep laboratory. Patients who might be intimidated by an in-laboratory test may be more willing to consider testing in the home environment. Pre-surgical sleep testing with portable sleep monitors may become a more practical method of patient assessment. Large-deductible insurance programs are proliferating as businesses try to rein in costs, and in a struggling economy, patients may see an expensive in-laboratory test as an unnecessary expense but might view a home sleep test as a more economical option. In order to maintain the cost-effectiveness of use of home studies and promote better adherence to PAP therapy, many insurance programs are limiting testing and interpretation to qualified, high-quality providers. This system provides an opportunity for sleep specialists with comprehensive management and treatment programs to increase the number of patients directed their way.

Essential Points

1. Limited channel testing outside the sleep laboratory can appropriately diagnose OSA in patients with high pre-test probability for OSA.
2. Portable monitoring appears to be a cost-efficient diagnostic measure at a time when medical costs are being closely scrutinized.
3. In combination with auto-titrating PAP and with proper standards for use, testing and treatment of OSA may be done outside of the laboratory setting.

Closing

Regardless of your personal viewpoint on home testing, all sleep medicine clinicians should begin to evaluate their practices, assessing how they might integrate home sleep testing. Developing a reasonable home testing plan will likely involve several steps: becoming familiar with the HST devices and each device's pros and cons, learning how to interpret these studies carefully and appropriately, and finally, developing a business plan for your centers, which may include shrinking the size of the physical sleep laboratory. Many coaches say that preparation is the key to victory; for the field of sleep medicine to continue to be successful, we will have to organize and adapt to new circumstances.

CITATION

Kirsch DB. Pro: Sliding into home: portable sleep testing is effective for diagnosis of obstructive sleep apnea. *J Clin Sleep Med* 2013;9(1):5-7.

REFERENCES

1. http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=226&ncdver=3&NCAId=204&NcaName=Continuous+Positive+Airway+Pressure+(CPAP)+Therapy+for+Obstructive+Sleep+Apnea+(OSA)&IsPopup=y&bc=AAAAAAAAIAAA& (Accessed 7/1/12)
2. http://oig.hhs.gov/publications/workplan/2011/FY11_WorkPlan-All.pdf (Accessed 7/1/12)
3. http://www.aasmnet.org/articles.aspx?id=1728 (Accessed 7/1/12)
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6. Young T, Finn L, Peppard PE, et al. Sleep disordered breathing and mortality: eighteen-year follow-up of the Wisconsin sleep cohort. *Sleep* 2008;31:1071-8.
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13. Mulgrew AT, Fox N, Ayas NT, et al. Diagnosis and initial management of obstructive sleep apnea without polysomnography: a randomized validation study. *Ann Intern Med* 2007;146:157-66.
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16. Collop NA, Tracy SL, Kapur V, et al. Obstructive sleep apnea devices for out-of-center (OOC) testing: technology evaluation. *J Clin Sleep Med* 2011;7:531-48.
17. Collop NA, Anderson WM, Boehlecke B, et al. Clinical guidelines for the use of unattended portable monitors in the diagnosis of obstructive sleep apnea in adult patients. Portable Monitoring Task Force of the American Academy of Sleep Medicine. *J Clin Sleep Med* 2007;3:737-47.
18. http://www.npr.org/blogs/health/2012/01/16/145182935/the-sleep-apnea-business-is-booming-and-insurers-arent-happy (Accessed 8/30/12)

SUBMISSION & CORRESPONDENCE INFORMATION

Submitted for publication August, 2012
Submitted in final revised form August, 2012
Accepted for publication August, 2012

Address correspondence to: Douglas B. Kirsch, M.D., 1506 Commonwealth Ave., 5th Floor, Sleep HealthCenters, Brighton, MA 02135; Tel: (617) 783-1441; Fax: (781) 439-5881; E-mail: Doug_Kirsch@sleephealth.com

DISCLOSURE STATEMENT

Dr. Kirsch has indicated no financial conflicts of interest.

FINANCIAL WORKSHEET

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and vol without, incremental to and with the CON proposal in the following reporting format:

Total Facility:	FY 2013	FY 2014	FY 2014	FY 201	FY 2015	FY 2015	FY 201	FY 2016	FY 2016	FY 2016
	Actual	Projected	Projected	Project	Projected	Projected	Project	Projected	Projected	Projecte
Description	Results	W/out CON	Incremental	With C	W/out CON	Incremental	With C	W/out CON	Incremental	With CC
NET PATIENT REVENUE										
Non-Government	$541,770	$530,182	($530,182)	$0	$530,182	($530,182)	$0	$530,182	($530,182)	$0
Medicare	$106,088	$106,088	($106,088)	$0	$106,088	($106,088)	$0	$106,088	($106,088)	$0
Medicaid and Other Medical	$102,088	$102,088	($102,088)	$0	$102,088	($102,088)	$0	$102,088	($102,088)	$0
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Rev	$749,946	$738,358	($738,358)	$0	$738,358	($738,358)	$0	$738,358	($738,358)	$0
Other Operating Revenue	$0	$0			$0			$0		
Revenue from Operations	$749,946	$738,358	($738,358)	$0	$738,358	($738,358)	$0	$738,358	($738,358)	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits	$467,250	$476,595	($476,595)	$0	$486,127	($486,127)	$0	$495,849	($495,849)	$0
Professional / Contracted Se	$32,484	$32,485	($32,485)	$0	$32,485	($32,485)	$0	$32,485	($32,485)	$0
Supplies and Drugs	$16,886	$16,887	($16,887)	$0	$16,887	($16,887)	$0	$16,887	($16,887)	$0
Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Expense	$93,231	$93,232	($93,232)	$0	$93,232	($93,232)	$0	$93,232	($93,232)	$0
Subtotal	$609,851	$619,199	($619,199)	$0	$628,731	($628,731)	$0	$638,453	($638,453)	$0
Depreciation/Amortization	$52,189	$52,189	($52,189)	$0	$52,189	($52,189)	$0	$52,189	($52,189)	$0
Interest Expense	$16,513	$16,513	($16,513)	$0	$16,513	($16,513)	$0	$16,513	($16,513)	$0
Lease Expense	$72,708	$78,498	($78,498)	$0	$80,853	($80,853)	$0	$83,279	($83,279)	$0
Total Operating Expense	$751,261	$766,399	($766,399)	$0	$778,286	($778,286)	$0	$790,434	($790,434)	$0
Gain/(Loss) from Operations	($1,315)	($28,041)	$28,041	$0	($39,928)	$39,928	$0	($52,076)	$52,076	$0
Plus: Non-Operating Revenue				$0			$0			$0
Revenue Over/(Under) Expe	($1,315)	($28,041)	$28,041	$0	($39,928)	$39,928	$0	($52,076)	$52,076	$0
FTEs	4.50	4.50	(4.50)	-	4.50	(4.50)	-	4.50	(4.50)	-
Volume Sleep Studies	2,056	2,015	(2,015)	0	2,015	(2,015)	-	2,015	(2,015)	-

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 22, 2014

VIA FAX ONLY

Janine Epright
CFO
Gaylord Hospital
P.O. Box 400
Gaylord Farms Road
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31883-CON, 13-31884-CON, 13-31885-Con, and 14-31902-CON
Gaylord Hospital
Additional Questions

Dear Ms. Epright:

Please complete the following two questions for Docket Number 13-31883-CON, Docket Number 13-31884-CON, Docket Number 13-31885-CON, and Docket Number 14-31902-CON:

1.

Table 1: Gaylord Sleep Medicine's Historical and Current Services Volume

Service	FY 2011	FY 2012	FY 2013	FY 2014*
Total				

*(October 1, 2013 – April 30, 2014)

2.**Table 2: Gaylord Sleep Medicine's Historical and Current Payer Mix by volume and by %**

Description	FY 2011		FY 2012		FY 2013		FY 2014**	
	Volume	%	Volume	%	Volume	%	Volume	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

*Includes managed care activity
**(October 1, 2013 – April 30, 2014)

Please respond by May 6, 2014. If you have any questions regarding the above, please contact me at (860) 418-7035..

Sincerely,

Paolo Fiducia
Associate Health Care Analyst

* * * COMMUNICATION RESULT REPORT (APR. 22. 2014 2:39PM) * * *

FAX HEADER:

TRANSMITTED/STORED : APR. 22. 2014 2:38PM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
240 MEMORY TX		912037413408	OK	3/3

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

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JANINE EPRIGHT

FAX: 12037413408

AGENCY: GAYLORD HOSPITAL

FROM: PAOLO FIDUCIA

DATE: 04/22/2014 **Time:** 2:45 pm

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
Additional Questions

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

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

Greer, Leslie

From: Fiducia, Paolo
Sent: Wednesday, June 04, 2014 11:39 AM
To: Olejarz, Barbara
Cc: Greer, Leslie
Subject: FW: Additional Questions
Attachments: Volumes and Services for CON Request-OCHA.xlsx

FYI

From: Sitler, Michele [mailto:msitler@gaylord.org]
Sent: Tuesday, May 27, 2014 4:19 PM
To: Riggott, Kaila
Cc: Fiducia, Paolo
Subject: RE: Additional Questions

Kaila,

Attached is the information you requested this morning.
Please let me know if you need anything else.

Regards,

Michele Sitler
Executive Assistant
Gaylord Hospital
Gaylord Farm Road, Box 400
Wallingford, Connecticut 06492
203-284-2741 -Phone
203-741-3408- Fax
Msitler@gaylord.org

From: Riggott, Kaila [mailto:Kaila.Riggott@ct.gov]
Sent: Tuesday, May 27, 2014 9:56 AM
To: Sitler, Michele
Cc: Fiducia, Paolo
Subject: RE: Additional Questions

Thank you very much Michele.

From: Sitler, Michele [mailto:msitler@gaylord.org]
Sent: Tuesday, May 27, 2014 9:34 AM
To: Riggott, Kaila
Subject: RE: Additional Questions

Kaila,

I can see from the email address used below that Janine never received this email. The email address is incorrect. It was Janine.Epright@gaylord.org. I will need to see who can help with this information. I will get back to you to let you know when it will be done.

Regards,

Michele Sitler
Executive Assistant
Gaylord Hospital
Gaylord Farm Road, Box 400
Wallingford, Connecticut 06492
203-284-2741 -Phone
203-741-3408- Fax
Msitler@gaylord.org

Gaylord Specialty Healthcare
Care beyond the ordinary.

From: Riggott, Kaila [mailto:Kaila.Riggott@ct.gov]
Sent: Tuesday, May 27, 2014 9:23 AM
To: Sitler, Michele
Cc: Fiducia, Paolo
Subject: FW: Additional Questions

Here is the file that was sent to Janine on 4/22. Thanks very much for your help.

From: Fiducia, Paolo
Sent: Tuesday, April 22, 2014 2:25 PM
To: epright@gaylord.org
Cc: Riggott, Kaila; Carney, Brian
Subject: Additional Questions

Hi Janine,

Please complete the following two questions for Docket Number 13-31883-CON, Docket Number 13-31884-CON, Docket Number 13-31885-CON, and Docket Number 14-31902-CON:

1.

Table 1: Gaylord Sleep Medicine's Historical and Current Services Volume

Service	FY 2011	FY 2012	FY 2013	FY 2014*

Total				

*(October 1, 2013 – April 30, 2014)

2.**Table 2: Gaylord Sleep Medicine's Historical and Current Payer Mix by volume and by %**

Description	FY 2011		FY 2012		FY 2013		FY 2014**	
	Volume	%	Volume	%	Volume	%	Volume	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

*Includes managed care activity

**(October 1, 2013 – April 30, 2014)

Please respond by May 6, 2014. If you have any questions regarding the above please contact me.

Sincerely,

Paolo Fiducia
Associate Health Care Analyst
Office of Health Care Access
A DIVISION OF DEPARTMENT OF PUBLIC HEALTH
paolo.fiducia@po.state.ct.us
860.418.7035 Direct Line
860.418.7053 Fax

Gaylord Hospital, Inc.
Sleep Volume Data - Trumbull
FY 2011,2012,2013, FYTD 2014

Provided Services

Service	FY 2011	FY 2012	FY 2013	FY 2014
Study/Interp	726	642	453	200
Initial Eval	374	338	373	231
Follow Up	633	643	535	309
PAP NAP	-	4	10	2
CLINIC	591	661	604	342
Other	35	87	81	59
Total	2,359	2,375	2,056	1,143

Volume and Payor Mix	Volume FY 11	% FY 11	Volume FY 12	% FY 12	Volume FY 13	% FY 13	Volume FY 14	% FY 14
Medicare	486	21%	518	22%	370	18%	266	23%
Medicaid	314	13%	395	17%	387	19%	278	24%
Tricare	7	0%	-	0%	-	0%	3	0%
Total Government	807	34%	913	38%	757	37%	547	48%
Commercial	1,547	66%	1,459	61%	1,296	63%	595	52%
Uninsured	5	0%	3	0%	3	0%	1	0%
Worker's Comp	-	0%	-	0%	-	0%		0%
Total Non-Governement	1,552	66%	1,462	62%	1,299	63%	596	52%
Total All	2,359	100%	2,375	100%	2,056	100%	1,143	100%

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 11, 2014

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Agreed Settlement Office of Health Care Access Docket Number: 13-31883-CON
Gaylord Hospital	**Termination of Gaylord Sleep Medicine Services in Trumbull**

To:

Art Tedesco
Interim Chief Executive Officer
Gaylord Hospital
P.O. Box 400
Gaylord Farms Rd.
Wallingford, CT 06492

RE: Certificate of Need Application, Docket Number 13-31883-CON
Gaylord Hospital
Termination of Gaylord Sleep Medicine Services in Trumbull

Dear Mr. Tedesco:

This letter will serve as notice of the approved Certificate of Need Application in the above-referenced matter. On July 11, 2014, the Agreed Settlement, attached hereto, was adopted and issued as an Order by the Department of Public Health, Office of Health Care Access.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:lkg

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicant: **Gaylord Hospital**
Gaylord Farms Road, Wallingford, CT 06492

Docket Number: **13-31883-CON**

Project Title: **Termination of Gaylord Sleep Medicine Services in Trumbull, Connecticut**

Project Description: Gaylord Hospital ("Hospital" or "Applicant") seeks authorization to terminate Gaylord Sleep Medicine Services in Trumbull, Connecticut, with no associated capital expenditure.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *New Haven Register* on November 20, 21 and 22, 2013. On December 30, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on March 10, 2014. OHCA received no responses from the public concerning the Applicant's proposal and no hearing requests were received from the public pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a. Deputy Commissioner Davis considered the entire record in this matter.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.*, 605 F.Supp. 816 (Md. Tenn. 1985).

Findings of Fact and Conclusions of Law

1. The Applicant is a long term acute care hospital located at Gaylord Farms Road, Wallingford, Connecticut. Ex. A, p. 5.

2. The Hospital provides health care services for patients requiring care for spinal cord injury, traumatic brain injury, stroke, pulmonary disease and other medically complex illnesses and sleep medicine. It includes both inpatient and outpatient care. Ex. A, p. 5.

3. Gaylord Sleep Medicine-Trumbull ("Sleep Center") is located at 101 Merritt Blvd., Trumbull, Connecticut and utilizes six beds in its sleep laboratory. Ex. A, p. 5.

4. On April 2, 2007, OHCA granted Gaylord Hospital approval (DN: 06-30788-CON) to terminate a sleep laboratory in Fairfield and to establish Gaylord Sleep Medicine-Trumbull, increasing bed capacity from three to six beds. Ex. A, p. 5.

5. The Hospital is now proposing the termination of all services at the Sleep Center. Ex. A, p. 5.

6. The Sleep Center provides physician consultation and patient evaluation, as well as continuous positive airway pressure (CPAP) therapy, and is equipped for day and overnight sleep testing. In addition, diagnostic, split-night and therapeutic polysomnography services are provided. Ex. A, p. 5.

7. Nearly three quarters (74%) of patient visits to the Sleep Center originated from six towns in FY 2013:

TABLE 1
GAYLORD SLEEP MEDICINE TRUMBULL
PATIENT VISITS (FY 2013*)

Town	Visits	Percent
Bridgeport	466	23%
Milford	379	18%
Stratford	225	11%
Trumbull	167	8%
Fairfield	143	7%
Shelton	143	7%
Top 6 Towns	**1,523**	**74%**
All Other	533	26%
Total	**2,056**	**100%**

*Gaylord Hospital fiscal year (October 1-September 30)
Ex. A, pp. 5, 7-8.

8. The following table shows the existing providers of sleep medicine services in the Applicant's service area:

TABLE 2
EXISTING SLEEP LAB FACILITIES IN THE APPLICANT'S SERVICE AREA

Service	Provider Name and Location
Sleep Laboratory	PriMed Physicians Fairfield County Sleep Center 501 Kings Highway, Fairfield
Sleep Laboratory	Bridgeport Hospital Grant Street, Bridgeport
Sleep Laboratory	Danbury Hospital Sleep Disorder Center Danbury , CT
Sleep Laboratory	Greenwich Hospital Sleep Center Greenwich, CT
Sleep Laboratory	Norwalk Hospital Sleep Disorder Center Norwalk, CT

Ex. A, p. 6.

9. The primary reasons for the Applicant's request to terminate services in Trumbull are diminished in-lab patient volume, changing models of sleep medicine service delivery and duplicative sleep services in the service area. Ex. C, p. 66.

10. Since the opening of the Sleep Center, sleep medicine visits have declined and it was determined that maintaining the program at the Trumbull location was not an efficient use of resources. Ex. C, p. 66.

11. The overall decline in sleep medicine visits at the Applicant's Trumbull location is illustrated in the table below:

TABLE 3
HOSPITAL'S HISTORICAL AND CURRENT VISITS

Visits Description	Fiscal Year			
	2011	2012	2013	2014* (annualized)
Sleep Medicine Study (full service study with physician interpretation)	726	642	453	343
Initial Consultation with Medical Staff	374	338	373	396
Follow-up visit to review study results and plan of care	633	643	535	530
PAP NAP **	---	4	10	3
Clinic***	591	661	604	586
Other****	35	87	81	101
Total	**2,359**	**2,375**	**2,056**	**1,959**

* October 1, 2013 – April 2014
** Day time visit of 3-4 hours to help patients learn to use marks and improve patient compliance.
*** CPAP set up; working with patients on compliance or mask issues.
****Includes in-home sleep studies; HST rental; psychology visits for insomnia management.
Ex. D, p. 81

12. Overnight sleep lab volume dropped from 726 in FY2011 to 453 in FY13, representing a nearly 38% decrease. Ex. C, p. 66, Ex. D, p. 81

13. The decision to terminate the Sleep Center was based on an evaluation of how the Hospital could best serve the needs of its patients within its core business: comprehensive health services for individuals with brain or spinal cord injuries, complex pulmonary conditions or complex medical illnesses. Ex. C, p. 66.

14. There is an increasing trend of delivering sleep medicine away from lab testing to home-based sleep testing (HST), thus reducing the need for freestanding sleep labs. Ex. C, p. 66.

15. According to the Journal of Clinical Sleep Medicine, HST is likely to play an increasingly larger role in the practice of sleep medicine in the next several years, in large part due to changes in insurance practices around HST devices used in the diagnosis of obstructive sleep apnea (OSA). As prior authorization programs run by utilization management companies have begun to proliferate, many patients have been shunted from sleep laboratories into home testing. Portable, home-based testing appears to be a cost-efficient diagnostic measure at a time when medical costs are being closely scrutinized. Additionally, HST may reach a larger number of patients when not limited to a physical location of a sleep laboratory. Ex. C, pp. 76-78.

16. The Applicant will implement external communications and outreach activities to help transition patients to alternative clinical services following the termination of the Sleep Center. Ex. A, p. 6, Ex. C, pp. 67-68.

17. The Applicant will notify patients seen within the last two years, in writing, about the availability of sleep medicine services at Yale-New Haven Hospital (adult and pediatric patients) and Connecticut Children's Medical Center (pediatric patients). The Applicant will also provide copies of medical records upon request and help patients transition to alternative providers of their choice. Ex. A, p. 6, Ex. C, p. 67a, 67b.

18. No capital expenditures/costs will be incurred from the termination of sleep medicine services at the Sleep Center. Ex. A, p. 11.

19. The decision to terminate the Sleep Center services was not dependent on reimbursement levels, but on declining volume and cost to continue the program. Ex. A, p. 12

20. The continued operation of sleep medicine services at the Sleep Center would result in continued and increasing losses in each of the next three fiscal years.

TABLE 4
APPLICANT'S GAIN / (LOSS) FROM OPERATIONS

	FY 2013* (Actual)	FY 2014	FY 2015	FY 2016
Revenue from Operations	749,946	738,358	738,358	738,358
Total Operating Expenses	751,261	766,399	778,286	790,434
Gain/(Loss) from Operations	($1,315)	(28,041)	(39,928)	(52,076)

*Gaylord Hospital fiscal year (October 1-September 30)
Assumptions: Gaylord Sleep Medicine Services in Trumbull recorded an operational loss in FY 2013 and projects continued losses in FY 2014-FY 2016 due to operating expenses in excess of revenues. If the proposal is approved, the number of FTEs will be reduced by 4.5, producing cost savings of $476,595, $486,127 and $495,849, respectively. Other significant reductions will come from depreciation/amortization, lease expense, professional/contracted services and other operating expenses.
Ex. A, p. 12, Ex. C, p. 80.

21. The Applicant's historical and current payer mix is as follows:

TABLE 5
APPLICANT'S HISTORICAL AND CURRENT PAYER MIX

Payer	FY 2011		FY 2012		FY 2013		FY 2014*	
	Volume	%	Volume	%	Volume	%	Volume	%
Medicare*	486	21%	518	22%	370	18%	266	23%
Medicaid*	314	13%	395	17%	387	19%	278	24%
CHAMPUS & TriCare	7	<1%	---	0%	---	0%	3	<1%
Total Government	**807**	**34%**	**913**	**38%**	**757**	**37%**	**547**	**48%**
Commercial Insurers	1,547	66%	1,459	61%	1,296	63%	595	52%
Uninsured	5	<1%	3	<1%	3	<1%	1	<1%
Workers Compensation	---	0%	---	0	---	0%	---	0%
Total Non-Government	**1,552**	**66%**	**1,462**	**62%**	**1,299**	**63%**	**596**	**52%**
Total Payer Mix	**2,359**	**100%**	**2,375**	**100%**	**2,056**	**100%**	**1,143**	**100%**

*(October 1, 2013 – to April 2014)
Ex. D, p. 81

22. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

23. This CON application is consistent with the overall goals of the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

24. The Applicant has established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

25. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

26. The Applicant has satisfactorily demonstrated that quality and access to services in the region will be maintained for all relevant patient populations and that the proposal will reduce overall system costs by eliminating duplicative services and allowing for the greater use of a more cost-efficient diagnostic method with the potential to reach a broader population. (Conn. Gen. Stat.§ 19a-639(a)(5))

27. The Applicant has shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including Medicaid patients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)).

28. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).

29. The declining historical utilization of sleep medicine visits in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

30. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

31. The Applicant has demonstrated good cause for the reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

The Hospital is a long term acute care hospital located at Gaylord Farms Road, Wallingford, Connecticut. *FF1* The Hospital, which began offering sleep medicine services in 2007, is proposing to terminate all sleep medicine services at Gaylord Sleep Medicine-Trumbull ("Sleep Center"), located at 101 Merritt Blvd., Trumbull, Connecticut. *FF3-4* The Sleep Center currently provides physician consultation and patient evaluation of sleep disorders. The Sleep Center is equipped for day and overnight sleep testing and performs diagnostic, split-night and therapeutic polysomnography, as well as continuous positive airway pressure (CPAP) therapy. *FF6*

The primary reasons for the Applicant's request to terminate services at the Sleep Center are diminished in-lab patient volume, changing models of sleep medicine service delivery and duplicative sleep services in the service area. *FF9&10* Overall volume at the Sleep Center has declined almost 13% between FY 2011 and FY 2013 and overnight sleep studies have dropped by nearly 38% over the same time period. *FF11&12* The decline in volume is the result of the recent trend toward delivering sleep medicine testing in the home as opposed to lab-based testing. *FF14* According to the Journal of Clinical Sleep Medicine, home-based sleep testing (HST) is likely to play an increasingly larger role in the practice of sleep medicine in the next several years, in large part due to changes in insurance practices around HST devices use in the diagnosis of obstructive sleep apnea (OSA). As prior authorization programs run by utilization management companies have begun to proliferate, many patients have been shunted from sleep laboratories into home testing. Portable, home-based testing appears to be a cost-efficient diagnostic measure at a time when medical costs are being closely scrutinized. Additionally, HST may reach a larger number of patients when not limited to a physical location of a sleep laboratory. *FF15* The trend toward moving sleep medicine testing to the home evidences forward thinking in an effort to reduce the cost of providing this service thereby strengthening the financial stability of Connecticut's health care system while maintaining access to this service for the patient population. In fact, this trend makes it easier for the patient to receive sleep medicine services by eliminating the need to travel to, and stay overnight at, the hospital.

In order to help patients transition following the closure of its program, the Hospital will implement external communications and outreach activities to ensure that patients have continued access to sleep medicine services. *FF16* All patients seen within the past two years will be notified in writing about the availability of alternative sleep medicine services including those at Yale-New Haven Hospital (adult and pediatric patients) and Connecticut Children's Medical Center (pediatric patients). *FF17* The Applicant will provide copies of medical records and help patients transition to alternative providers of their choice. *FF17* Most importantly, there are five other sleep medicine service providers available to patients within the Applicant's service area. *FF7&8* Based upon the foregoing, the Applicant has satisfactorily demonstrated that access to

sleep medicine services will be maintained and there will be no adverse impact on the quality of sleep medicine services for the relevant patient populations, including Medicaid patients.

The proposal to terminate the Sleep Center was based on an evaluation of how the Hospital could best serve the needs of its patients within its core business: comprehensive health services for individuals with brain or spinal cord injuries, complex pulmonary conditions or complex medical illnesses. *FF13* The decision to terminate services was not dependent on reimbursement levels, but rather was predicated on declining volume and program costs. *FF19* The Applicant experienced an operational loss in FY 2013 and projects that the continued operation of the Sleep Center would result in ongoing and increasing losses over the next three fiscal years. *FF20* No capital expenditures/costs will be incurred from the program's termination. *FF18.* The decision to focus on its core services and avoid future losses from the Sleep Center will ultimately benefit the population served by the Hospital. Therefore, the Applicant has demonstrated that its proposal is financially feasible by ultimately resulting in cost avoidance for the Hospital while providing a more focused health care delivery model for the patient.

One of the overarching goals of the Statewide Health Care Facilities and Services Plan is the use of health care facility resources in an efficient, cost-effective manner while maintaining or improving patients' access to quality health care services. This proposal will allow for sleep medicine services to be provided in a more cost-effective setting and eliminate the duplication of services in the Applicant's service area. It is also reflective of the changing model of sleep medicine service delivery that has the potential to reach a larger number of patients. Thus, the Applicant has sufficiently demonstrated a clear public need for this proposal.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA") and Gaylord Hospital ("Hospital") hereby stipulate and agree to the terms of settlement with respect to the termination of services of Gaylord Sleep Medicine Services, 101 Merritt Blvd., Trumbull, Connecticut, as follows:

1. Gaylord Hospital's request to termination of service at Gaylord Sleep Medicine Services, at 101 Merritt Blvd., Trumbull, Connecticut, is **approved.**

2. Gaylord Hospital shall release a one-time notification to all current patients, and those seen within the past two years, of the Gaylord Sleep Medicine Services that clearly identifies all existing providers of sleep medicine services in the service area where patients can receive the same services. A copy of such notification shall be filed with OHCA within (10) days of the signing of this Agreed Settlement.

3. Gaylord Hospital shall assist former Gaylord Sleep Medicine Services patients in transitioning to alternative providers of their choice and provide copies of medical records upon request.

4. This Agreed Settlement is an order of OHCA with all rights and obligations attendant thereto, and OHCA may enforce this Agreed Settlement under the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 with all fees and costs of such enforcement being the responsibility of the Hospital.

5. OHCA and Gaylord Hospital agree that this Agreed Settlement represents a final agreement between OHCA and all parties with respect to this Application. The signing of this Agreed Settlement resolves all objections, claims, and disputes that may have been raised by the Applicant with regard to Docket Number: 13-31883-CON.

6. This Agreed Settlement shall be binding upon Gaylord Hospital and its successors and assigns.

Signed by George M. Kyriacou, _____
(Print name) (Title)

7/8/14
Date

Duly Authorized Agent for
Gaylord Hospital

The above Agreed Settlement is hereby accepted and so ordered by the Department of Public Health Office of Health Care Access on July 11, 2014.

7/11/14
Date:

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

* * * COMMUNICATION RESULT REPORT (JUL. 15. 2014 9:48AM) * * *

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Art Tedesco

FAX: (203) 741-3408

AGENCY: Gaylord Hospital

FROM: Paolo Fiducia

DATE: 7/15/14

NUMBER OF PAGES: 12
(including transmittal sheet

Comments:
Please see the attached Agreed Settlement in the matter of 13-31883-CON: Termination of Gaylord Sleep Medicine Services in Trumbull

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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

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