"PUBLIC INSPECTION COPY"

Form 990 Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter Social Security numbers on this form as it may be made public.

▶ Information about Form 990 and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

A For the 2013 calendar year, or tax year beginning 10/01, 2013, and ending 09/30, 20 14

B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Terminated ☐ Amended return ☐ Application pending

C Name of organization: THE STAMFORD HOSPITAL

Doing Business As:

Number and street (or P.O. box if mail is not delivered to street address): 30 SHELBURNE RD, P.O. BOX 9317 — Room/suite:

City or town, state or province, country, and ZIP or foreign postal code: STAMFORD, CT 06902

D Employer identification number: 06-0646917

E Telephone number: (203) 276-1000

G Gross receipts $ 518,120,336.

F Name and address of principal officer: KEVIN GAGE
30 SHELBURNE ROAD, PO BOX 9317 STAMFORD, CT 06902

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ HTTPS://STAMFORDHOSPITAL.ORG/

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation: 1893 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: OUR MISSION: TOGETHER WITH OUR PHYSICIANS WE PROVIDE A BROAD RANGE OF HIGH QUALITY HEALTH AND WELLNESS SERVICES FOCUSED ON THE NEEDS OF OUR COMMUNITIES.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	14.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12.
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	2,693.
6	Total number of volunteers (estimate if necessary)	6	650.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	6,844,005.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	4,441,372.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	12,066,222.	27,563,425.
9	Program service revenue (Part VIII, line 2g)	470,829,704.	462,463,843.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,785,873.	3,078,089.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,619,372.	4,119,204.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	490,301,171.	497,224,561.

COPY FOR PUBLIC INSPECTION

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	245,135,746.	230,572,425.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	159,575.	240,152.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 4,737,077.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	206,339,187.	208,965,147.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	451,634,508.	439,777,724.
19	Revenue less expenses. Subtract line 18 from line 12	38,666,663.	57,446,837.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	797,789,880.	811,196,569.
21	Total liabilities (Part X, line 26)	589,414,476.	592,389,998.
22	Net assets or fund balances. Subtract line 21 from line 20	208,375,404.	218,806,571.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ KEVIN GAGE CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
CHRISTOPHER B BOGGS	Christopher B. Boggs	08/14/15		P00032493

Firm's name ▶ ERNST & YOUNG U.S. LLP — Firm's EIN ▶ 34-6565596

Firm's address ▶ 111 MONUMENT CIRCLE, STE 4000 INDIANAPOLIS, IN 46204 — Phone no. 317-681-7000

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2013)

JSA
3E1065 2.000
509980 1274

Part III **Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III . . . . . ☐

1 Briefly describe the organization's mission:

OUR MISSION: TOGETHER WITH OUR PHYSICIANS WE PROVIDE A BROAD RANGE OF HIGH QUALITY HEALTH AND WELLNESS SERVICES FOCUSED ON THE NEED OF OUR COMMUNITIES.

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

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

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

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

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

4a (Code:) (Expenses $ 363,831,221. including grants of $ 0) (Revenue $ 466,651,812.)

IN ADDITION TO A 305 BED HOSPITAL FACILITY, THE STAMFORD HOSPITAL (TSH) OPERATES A 225,000 SQUARE FOOT AMBULATORY CARE CENTER (TULLY CENTER) ALSO IN STAMFORD, CT. KEY OPERATING STATISTICS FOR THE YEAR ENDED 9/30/2014 INCLUDE: ADULT AND PEDIATRIC INPATIENTS CARED FOR AND DISCHARGED 14,848; BABIES BORN 2,082; TOTAL INPATIENT DAYS OF CARE PROVIDED 71,084. PATIENTS SEEKING CARE IN THE STAMFORD HOSPITAL EMERGENCY ROOM: ADMITTED FOR INPATIENT TREATMENT 8,058; TREATED AND RELEASED 41,796; TREATED AT TULLY IMMEDIATE CARE CENTER 26,380. SURGERIES PERFORMED AT THE HOSPITAL AND TULLY CENTER: 17,749. RADIATION THERAPY PROCEDURES PERFORMED: 182,841.

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

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

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

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

4e Total program service expenses ▶ 363,831,221.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24 a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25 a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payable to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	400		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	2,693		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X	
b	If "Yes," enter the name of the foreign country: ▶ BERMUDA See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		X	
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a 14		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent	1b 12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? . . .	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		X
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶KEVIN GAGE 30 SHELBURNE ROAD STAMFORD, CT 06902 (203)276-1000

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

Check if Schedule O contains a response or note to any line in this Part VII . . . . . ☐

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MICHAEL FEDELE	2.00									
CHAIRMAN	2.00	X		X				0	0	0
(2) ANDREW M. MERRILL	2.00									
VICE CHAIRMAN	2.00	X		X				0	0	0
(3) BRIAN GRISSLER	38.00									
PRESIDENT & CEO	2.00	X		X				2,334,937.	0	34,175.
(4) ERNEST ABATE	2.00									
DIRECTOR	2.00	X						0	0	0
(5) DR. RODRIGO ACOSTA	2.00									
PHYSICIAN	40.00	X						0	441,145.	10,244.
(6) ADOLFO DIBIASIO	2.00									
DIRECTOR	2.00	X						0	0	0
(7) EDWIN FORD	2.00									
DIRECTOR	2.00	X						0	0	0
(8) JAY HIGHAM	2.00									
DIRECTOR	2.00	X						0	0	0
(9) DAVID JAHNS	2.00									
DIRECTOR	2.00	X						0	0	0
(10) MARYANN KELLER-CHAI	2.00									
DIRECTOR	2.00	X						0	0	0
(11) ARTHUR A. KLEIN MD	2.00									
DIRECTOR	2.00	X						0	0	0
(12) CHARLES A. KRAUSE, IV	2.00									
DIRECTOR	2.00	X						0	0	0
(13) CHARLES MINER, MD	2.00									
DIRECTOR	2.00	X						0	53,327.	1,475.
(14) GERALD B. RAKOS, MD	2.00									
DIRECTOR	2.00	X						492,865.	0	27,949.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) KEVIN GAGE	38.00									
TREASURER	2.00			X				969,683.	0	38,702.
(16) DARRYL MCCORMICK	38.00									
ASST. SECRETARY	2.00			X				627,318.	0	9,445.
(17) DAVID L. SMITH	38.00									
ASST. SECRETARY	2.00			X				731,627.	0	36,734.
(18) KATHLEEN A. SILARD	38.00									
ASST. SECRETARY	2.00			X				1,246,390.	0	48,334.
(19) SHARON KIELY, MD	38.00									
SR. VP, MEDICAL SERVICES	0				X			848,914.	0	48,890.
(20) MICHAEL COADY, MD	38.00									
CHIEF CARDIAC SURGEON	0					X		923,850.	0	20,520.
(21) DAVID TAYLOR	38.00									
CIO	2.00					X		642,085.	0	47,007.
(22) MICHAEL F. PARRY, MD	38.00									
PHYSICIAN	0					X		650,621.	0	23,087.
(23) LANCE BRUCK, MD	38.00									
CHAIR, DEPARTMENT OF OB/GYN	2.00					X		598,616.	0	46,066.
(24) STEVEN HOROWITZ, MD	38.00									
CHIEF, DIVISION OF CARDIOLOGY	0					X		584,396.	0	46,011.
1b Sub-total ▶								2,827,802.	494,472.	73,843.
c Total from continuation sheets to Part VII, Section A ▶								7,823,500.	0	364,796.
d Total (add lines 1b and 1c) ▶								10,651,302.	494,472.	438,639.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 488

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 57

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII . . . . . ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c	1,187,772.			
	d	Related organizations	1d				
	e	Government grants (contributions)	1e	588,217.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	25,787,436.			
	g	Noncash contributions included in lines 1a-1f: $ 3,747,075.					
	h	**Total.** Add lines 1a-1f ▶		27,563,425.			
Program Service Revenue			**Business Code**				
	2a	PATIENT REVENUE	621300	282,517,958.	282,517,958.		
	b	PHYSICIAN BILLING	621110	10,138,236.	10,138,236.		
	c	WELLNESS AND TRAINING	621400	3,338,045.	3,338,045.		
	d	MEDICARE/MEDICAID PAYMENT	621400	159,576,305.	159,576,305.		
	e	REFERENCE LAB INCOME	621500	6,893,299.		6,893,299.	
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f ▶		462,463,843.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶		2,015,031.		-82,506.	2,097,537.
	4	Income from investment of tax-exempt bond proceeds ▶		0			
	5	Royalties ▶		0			
			(i) Real / (ii) Personal				
	6a	Gross rents	3,212,787.				
	b	Less: rental expenses	3,857,343.				
	c	Rental income or (loss)	-644,556.				
	d	Net rental income or (loss) ▶		-644,556.		33,212.	-677,768.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	17,766,967.				
	b	Less: cost or other basis and sales expenses	16,703,909.				
	c	Gain or (loss)	1,063,058.				
	d	Net gain or (loss) ▶		1,063,058.			1,063,058.
	8a	Gross income from fundraising events (not including $ 1,187,772. of contributions reported on line 1c). See Part IV, line 18	a 298,400.				
	b	Less: direct expenses	b 334,523.				
	c	Net income or (loss) from fundraising events ▶		-36,123.			-36,123.
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities ▶		0			
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less: cost of goods sold	b				
	c	Net income or (loss) from sales of inventory ▶		0			
		Miscellaneous Revenue	**Business Code**				
	11a	CAFETERIA, COFFEE SHOP	722210	1,653,025.	1,653,025.		
	b	MEANINGFUL USE INCOME	621110	1,612,712.	1,612,712.		
	c	INTERCOMPANY STAFF REIMBURSEMENT	900099	1,045,828.	1,045,828.		
	d	All other revenue	532000	488,318.	-123,596.		611,914.
	e	**Total.** Add lines 11a-11d ▶		4,799,883.			
	12	**Total revenue.** See instructions ▶		497,224,561.	459,758,513.	6,844,005.	3,058,618.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	4,045,351.	582,313.	3,463,038.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	180,212,938.	153,943,156.	24,740,931.	1,528,851.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	15,399,742.	12,914,764.	2,357,201.	127,777.
9 Other employee benefits	18,733,919.	15,710,922.	2,867,556.	155,441.
10 Payroll taxes	12,180,475.	10,214,974.	1,864,436.	101,065.
11 Fees for services (non-employees):				
a Management	567,960.	567,960.		
b Legal	2,147,359.	98,811.	1,871,165.	177,383.
c Accounting	468,002.	1,507.	466,495.	
d Lobbying	142,496.		142,496.	
e Professional fundraising services. See Part IV, line 17	240,152.			240,152.
f Investment management fees	144,067.		144,067.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	49,906,163.	36,744,498.	12,878,379.	283,286.
12 Advertising and promotion	3,539,276.	207,777.	1,791,737.	1,539,762.
13 Office expenses	77,940,124.	74,779,351.	3,023,498.	137,275.
14 Information technology	5,977,855.	90,405.	5,882,779.	4,671.
15 Royalties	0			
16 Occupancy	18,290,987.	14,445,242.	3,752,678.	93,067.
17 Travel	496,966.	237,463.	170,683.	88,820.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	379,077.	222,579.	67,678.	88,820.
20 Interest	59,329.	59,329.		
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	22,795,983.	22,466,438.	329,545.	
23 Insurance	9,611,635.	9,611,635.		
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a SERVICE CONTRACTS	9,055,309.	8,994,351.		60,958.
b STATE-FED TAXES	2,152,691.	207,312.	1,945,379.	
c SUBSCRIPTIONS DUES-MBRSHP	2,024,505.	631,763.	1,386,544.	6,198.
d RECRUITING (INCL FOREIGN)	1,818,502.	48,231.	1,770,271.	
e All other expenses	1,446,861.	1,050,440.	292,870.	103,551.
25 **Total functional expenses.** Add lines 1 through 24e	439,777,724.	363,831,221.	71,209,426.	4,737,077.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X . . . . . ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	74,647.	1	166,718.
	2	Savings and temporary cash investments	105,669,646.	2	101,284,928.
	3	Pledges and grants receivable, net	16,814,120.	3	25,771,987.
	4	Accounts receivable, net	68,025,724.	4	68,966,813.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	5,564,103.	8	6,402,714.
	9	Prepaid expenses and deferred charges	6,075,378.	9	6,029,216.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 800,929,892.			
	b	Less: accumulated depreciation — 10b: 385,771,246.	329,579,551.	10c	415,158,646.
	11	Investments - publicly traded securities	201,535,657.	11	121,026,075.
	12	Investments - other securities. See Part IV, line 11	16,033,884.	12	19,007,978.
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	48,417,170.	15	47,381,494.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	797,789,880.	16	811,196,569.
Liabilities	17	Accounts payable and accrued expenses	98,044,582.	17	103,822,599.
	18	Grants payable	0	18	0
	19	Deferred revenue	510,101.	19	667,807.
	20	Tax-exempt bond liabilities	374,738,602.	20	369,677,861.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	4,443,205.	24	3,857,445.
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	111,677,986.	25	114,364,286.
	26	**Total liabilities.** Add lines 17 through 25	589,414,476.	26	592,389,998.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	160,465,828.	27	151,392,178.
	28	Temporarily restricted net assets	39,876,202.	28	59,053,144.
	29	Permanently restricted net assets	8,033,374.	29	8,361,249.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	208,375,404.	33	218,806,571.
	34	Total liabilities and net assets/fund balances	797,789,880.	34	811,196,569.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	497,224,561.
2	Total expenses (must equal Part IX, column (A), line 25)	2	439,777,724.
3	Revenue less expenses. Subtract line 2 from line 1	3	57,446,837.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	208,375,404.
5	Net unrealized gains (losses) on investments	5	2,196,474.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-49,212,144.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	218,806,571.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII . . . . . ☐

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

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization	Employer identification number
THE STAMFORD HOSPITAL	06-0646917

Part I **Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III-Functionally integrated **d** ☐ Type III-Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box . . . . . ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii)	A family member of a person described in (i) above?	11g(ii)	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

h Provide the following information about the supported organization(s).

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) **12**

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) **14** %

15 Public support percentage from 2012 Schedule A, Part II, line 14 **15** %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3 %, and line 17 is not more than 33 1/3 %, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3 %, and line 18 is not more than 33 1/3 %, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

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

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**
▶ **Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2013

Name of the organization
THE STAMFORD HOSPITAL

Employer identification number
06-0646917

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

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

Special Rules

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

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

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

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

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 33,129.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
2		$ 9,100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 1,500,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		$ 16,495.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
10		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
11		$ 510,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
12		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
14		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
15		$ 19,485.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
16		$ 30,549.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
17		$ 11,243.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
18		$ 13,265.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		$ 198,965.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
20		$ 801,034.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
21		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
22		$ 13,118.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
23		$ 38,598.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
24		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
26		$ 10,298.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
27		$ 10,104.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
28		$ 10,062.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
29		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
30		$ 5,051.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
32		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
33		$ 70,745.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
34		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
35		$ 59,143.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
36		$ 12,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
38		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
39		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
40		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
41		$ 500,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
42		$ 110,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
44		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
45		$ 29,800.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
46		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
47		$ 5,036.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
48		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
50		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
51		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
52		$ 6,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
53		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
54		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
56		$ 5,886.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
57		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
58		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
59		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
60		$ 37,680.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
61		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
62		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
63		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
64		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
65		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
66		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
67		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
68		$ 7,575.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
69		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
70		$ 60,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
71		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
72		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
73		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
74		$ 60,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
75		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
76		$ 6,800.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
77		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
78		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
79		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
80		$ 204,550.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
81		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
82		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
83		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
84		$ 14,976.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
85		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
86		$ 5,760.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
87		$ 6,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
88		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
89		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
90		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
91		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
92		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
93		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
94		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
95		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
96		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
97		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
98		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
99		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
100		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
101		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
102		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
103		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
104		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
105		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
106		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
107		$ 12,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
108		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
109		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
110		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
111		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
112		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
113		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
114		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
115		$ 70,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
116		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
117		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
118		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
119		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
120		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
121		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
122		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
123		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
124		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
125		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
126		$ 383,667.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
127		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
128		$ 37,658.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
129		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
130		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
131		$ 35,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
132		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
133		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
134		$ 3,330,285.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
135		$ 373,734.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
136		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
137		$ 5,223.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
138		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
139		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
140		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
141		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
142		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
143		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
144		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
145		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
146		$ 6,312.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
147		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
148		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
149		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
150		$ 75,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
151		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
152		$ 327,874.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
153		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
154		$ 14,235.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
155		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
156		$ 8,629.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
157		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
158		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
159		$ 40,025.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
160		$ 55,748.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
161		$ 104,734.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
162		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
163		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
164		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
165		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
166		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
167		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
168		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
169		$ 5,760.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
170		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
171		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
172		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
173		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
174		$ 5,760.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
175		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
176		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
177		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
178		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
179		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
180		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
181		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
182		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
183		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
184		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
185		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
186		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
187		$ 8,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
188		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
189		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
190		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
191		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
192		$ 520,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
193		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
194		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
195		$ 5,260.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
196		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
197		$ 11,939.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
198		$ 40,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
199		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
200		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
201		$ 125,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
202		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
203		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
204		$ 11,467.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | **Employer identification number** 06-0646917

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
205		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
206		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
207		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
208		$ 5,122.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
209		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
1	STOCK	$ 33,129.	VAR
17	STOCK	$ 11,243.	VAR
19	STOCK	$ 198,965.	VAR
22	STOCK	$ 13,118.	VAR
26	STOCK	$ 10,298.	VAR
28	STOCK	$ 10,062.	VAR

Name of organization THE STAMFORD HOSPITAL | Employer identification number 06-0646917

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

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
30	STOCK	$ 5,051.	VAR
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (see instructions)**	**(d) Date received**
33	STOCK	$ 70,745.	VAR
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (see instructions)**	**(d) Date received**
35	STOCK	$ 59,143.	VAR
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (see instructions)**	**(d) Date received**
47	STOCK	$ 5,036.	VAR
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (see instructions)**	**(d) Date received**
134	STOCK	$ 3,330,285.	VAR
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (see instructions)**	**(d) Date received**
		$	

Name of organization THE STAMFORD HOSPITAL

Employer identification number 06-0646917

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

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

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

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2013

Open to Public Inspection

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

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

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

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

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

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

Name of organization	Employer identification number
THE STAMFORD HOSPITAL	06-0646917

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

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

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

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

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

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

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

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	**(a)** 2010	**(b)** 2011	**(c)** 2012	**(d)** 2013	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?	X		142,496.
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?		X	
j Total. Add lines 1c through 1i			142,496.
2 a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

1	Dues, assessments and similar amounts from members	**1**	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	**2a**	
b	Carryover from last year	**2b**	
c	Total	**2c**	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	**3**	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	**4**	
5	Taxable amount of lobbying and political expenditures (see instructions)	**5**	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

SCHEDULE C PART II LINE 1F

GRANTS FOR LOBBYING

THE HOSPITAL CONTRACTS LOBBYING FIRMS WHO LOBBY LEGISLATIVE ACTION ON BEHALF OF THE HOSPITAL AND THE HEALTHCARE INDUSTRY. ADDITIONALLY, THE HOSPITAL PAYS DUES TO ORGANIZATIONS THAT USE A PORTION OF THE DUES FOR HEALTHCARE LOBBYING EXPENSES.

Part IV **Supplemental Information** *(continued)*

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Attach to Form 990.

▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE STAMFORD HOSPITAL

Employer identification number

06-0646917

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	47,909,132.	40,118,983.	26,695,222.	27,527,319.	28,198,000.
b Contributions	20,339,806.	8,872,941.	16,783,195.	3,087,737.	2,154,945.
c Net investment earnings, gains, and losses	1,151,928.	1,284,155.	1,162,352.	-56,132.	874,515.
d Grants or scholarships			4,521,786.	3,863,702.	
e Other expenditures for facilities and programs	1,986,792.	2,366,947.			3,700,141.
f Administrative expenses					
g End of year balance	67,414,074.	47,909,132.	40,118,983.	26,695,222.	27,527,319.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ 13.6300 %
c Temporarily restricted endowment ▶ 86.3700 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		43,860,945.		43,860,945.
b Buildings		187,756,981.	107,960,354.	79,796,627.
c Leasehold improvements		8,820,421.	4,950,799.	3,869,622.
d Equipment		350,781,424.	269,678,001.	81,103,423.
e Other		209,710,121.	3,182,092.	206,528,029.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				415,158,646.

Schedule D (Form 990) 2013

Part VII Investments - Other Securities.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

Part IX Other Assets.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DONOR RESTRICTED FUNDS	17,892,243.
(2) INVESTMENT IN HEALTHSTAR	11,898,063.
(3) DUE FROM AFFILIATES	6,962,038.
(4) DEBT ISSUANCE COSTS	4,225,788.
(5) MISCELLANEOUS RECEIVABLE	5,064,672.
(6) ORGANIZATION COSTS	1,289,667.
(7) DEPOSITS	49,023.
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	47,381,494.

Part X Other Liabilities.
Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) PENSION LIABILITY	73,007,585.
(3) DUE TO AFFILIATES	22,792,356.
(4) EST FOR PROFESSIONAL LIABILITY	11,301,317.
(5) EST THIRD PART SETTLEMENTS	7,197,918.
(6) CHARITABLE GIFT ANNUITY PAYABLE	65,110.
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	114,364,286.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☐

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	

Part XIII Supplemental Information.

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

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

SCHEDULE D, PART V, LINE 4

THE ENDOWMENT CONSISTS OF TEMPORARILY OR PERMANENTLY RESTRICTED CONTRIBUTIONS RECEIVED WITH DONOR STIPULATIONS THAT LIMIT THE USE OF THE DONATED ASSETS. TEMPORARILY RESTRICTED CONTRIBUTIONS ARE AVAILABLE FOR CERTAIN HEALTH CARE SERVICES AS DEFINED IN THE DONOR AGREEMENTS. PERMANENTLY RESTRICTED NET ASSETS ARE RESTRICTED TO INVESTMENTS TO BE HELD IN PERPETUITY, THE INCOME FROM WHICH IS EXPENDABLE TO SUPPORT HEALTH CARE SERVICES.

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule F (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE STAMFORD HOSPITAL

Employer identification number

06-0646917

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . [X] **Yes** [ ] **No**

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

	(a) Region	**(b)** Number of offices in the region	**(c)** Number of employees, agents, and independent contractors in region	**(d)** Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	**(e)** If activity listed in (d) is a program service, describe specific type of service(s) in region	**(f)** Total expenditures for and investments in region
(1)	CENTRAL AMERICA/CARIBBEAN		1.	INVESTMENTS	N/A	11,898,063.
(2)	CENTRAL AMERICA/CARIBBEAN		1.	PROGRAM SERVICES	MALPRACTICE INSURANCE	10,272,000.
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						
(11)						
(12)						
(13)						
(14)						
(15)						
(16)						
(17)						
3a	Sub-total		2.			22,170,063.
b	Total from continuation sheets to Part I					
c	**Totals** (add lines 3a and 3b)		2.			22,170,063.

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶

3 Enter total number of other organizations or entities . . . . . ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
(13)								
(14)								
(15)								
(16)								
(17)								
(18)								

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	[X] Yes	[ ] No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A)*	[ ] Yes	[X] No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations. (see Instructions for Form 5471)*	[X] Yes	[ ] No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)*	[ ] Yes	[X] No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect To Certain Foreign Partnerships. (see Instructions for Form 8865)*	[ ] Yes	[X] No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713)*	[ ] Yes	[X] No

Part V **Supplemental Information**

Complete this part to provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE G
(Form 990 or 990-EZ)
Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule G (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE STAMFORD HOSPITAL

Employer identification number
06-0646917

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

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** [X] Mail solicitations
- **b** [X] Internet and email solicitations
- **c** [ ] Phone solicitations
- **d** [X] In-person solicitations
- **e** [X] Solicitation of non-government grants
- **f** [ ] Solicitation of government grants
- **g** [X] Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? [X] **Yes** [ ] **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
1 GHIORSI & SORRENTI, INC	CONSULTANT		X	29,623,371.	250,695.	29,372,676.
2 DOUG PICHA CONSULTANTS	CONSULTANT		X	29,623,371.	38,898.	29,584,473.
3						
4						
5						
6						
7						
8						
9						
10						
Total ▶				59,246,742.	289,593.	58,957,149.

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

CT,

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

		(a) Event #1 WALK RUN RIDE (event type)	(b) Event #2 DREAM BALL (event type)	(c) Other events 2. (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	720,514.	613,563.	152,095.	1,486,172.
	2 Less: Contributions	494,364.	575,263.	118,145.	1,187,772.
	3 Gross income (line 1 minus line 2)	226,150.	38,300.	33,950.	298,400.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	780.	8,725.	6,294.	15,799.
	6 Rent/facility costs		179,136.	49,856.	228,992.
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses	45,897.	5,638.	38,197.	89,732.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				334,523.
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				-36,123.

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a	The organization's facility	**13a**	%
b	An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15 a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____.

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

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

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE STAMFORD HOSPITAL

Employer identification number
06-0646917

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			23,156,150.	6,932,560.	16,223,590.	3.69
b Medicaid (from Worksheet 3, column a)			86,786,214.	40,687,610.	46,098,604.	10.48
c Costs of other means-tested government programs (from Worksheet 3, column b)			2,291,321.		2,291,321.	.52
d **Total** Financial Assistance and Means-Tested Government Programs			112,233,685.	47,620,170.	64,613,515.	14.69
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			313,528.	106,420.	207,108.	.05
f Health professions education (from Worksheet 5)			51,600.		51,600.	.01
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			273,188.		273,188.	.06
j **Total.** Other Benefits			638,316.	106,420.	531,896.	.12
k **Total.** Add lines 7d and 7j			112,872,001.	47,726,590.	65,145,411.	14.81

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other	1	150	272,108.	130,106.	142,002.	.03
10 Total	1	150	272,108.	130,106.	142,002.	.03

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	40,336,150.	
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	87,541,282.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	107,846,350.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-20,305,068.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV **Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 THE STAMFORD HOSPITAL 30 SHELBURNE RD STAMFORD CT 06902 WWW.STAMFORDHOSPITAL.ORG 0059	X			X		X	X			
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group THE STAMFORD HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9.	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 1 2			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4		X
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE SCHEDULE H, PART V, SECTION C			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[ ] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[ ] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	X	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)*

Financial Assistance Policy THE STAMFORD HOSPITAL		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:		
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9 X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10 X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 100 %		
	If "No," explain in Section C the criteria the hospital facility used.		
11	Used FPG to determine eligibility for providing *discounted* care?	11 X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %		
	If "No," explain in Section C the criteria the hospital facility used.		
12	Explained the basis for calculating amounts charged to patients?	12 X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a	[X] Income level		
b	[X] Asset level		
c	[X] Medical indigency		
d	[X] Insurance status		
e	[ ] Uninsured discount		
f	[X] Medicaid/Medicare		
g	[X] State regulation		
h	[ ] Residency		
i	[ ] Other (describe in Section C)		
13	Explained the method for applying for financial assistance?	13 X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14 X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a	[X] The policy was posted on the hospital facility's website		
b	[X] The policy was attached to billing invoices		
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	[X] The policy was posted in the hospital facility's admissions offices		
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility		
f	[X] The policy was available on request		
g	[ ] Other (describe in Section C)		
Billing and Collections			
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15 X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	[ ] Reporting to credit agency		
b	[ ] Lawsuits		
c	[ ] Liens on residences		
d	[ ] Body attachments		
e	[ ] Other similar actions (describe in Section C)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17	X
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	[ ] Reporting to credit agency		
b	[ ] Lawsuits		
c	[ ] Liens on residences		
d	[ ] Body attachments		
e	[ ] Other similar actions (describe in Section C)		

Part V Facility Information *(continued)* THE STAMFORD HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** ☐ Other (describe in Section C)

Changes to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☒ Other (describe in Section C)

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	21		X
If "Yes," explain in Section C.			
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	22		X
If "Yes," explain in Section C.			

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 3

IN THE FIRST PHASE OF THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS, DOZENS OF INTERVIEWS WERE CONDUCTED TO ENGAGE THE COMMUNITY IN THE ASSESSMENT PROCESS. THESE INTERVIEWS CAPTURED COMMUNITY PERCEPTIONS ON PRIORITY HEALTH ISSUES, SERVICE GAPS, AND BARRIERS TO ACCESS, AS WELL AS SUGGESTED STRATEGIC INITIATIVES TO ADDRESS THESE ISSUES. IN ALL, NEARLY 100 PEOPLE WERE INTERVIEWED, INCLUDING ADMINISTRATIVE AND CLINICAL STAFF FROM STAMFORD HOSPITAL, REPRESENTATIVES FROM LOCAL HEALTH AND SOCIAL SERVICE AGENCIES, PUBLIC HEALTH OFFICERS, OTHER PUBLIC AND ELECTED OFFICIALS, REPRESENTATIVES FROM ADVOCACY ORGANIZATIONS AND FOUNDATIONS, MEMBERS OF THE CLERGY, AND COMMUNITY RESIDENTS.

FOLLOWING THE COLLECTION OF PRIMARY AND SECONDARY DATA, AS WELL AS THE COMPLETION OF THE KEY INFORMANT INTERVIEWS DESCRIBED ABOVE, COMMUNITY LISTENING SESSIONS WERE HELD TO REVIEW THE NEEDS ASSESSMENT DATA AND INTRODUCE THE PRIORITY HEALTH AREAS IDENTIFIED IN THE PROCESS; THESE LISTENING SESSIONS INCLUDED PARTICIPATION BY KEY STAKEHOLDERS, LOCAL PUBLIC HEALTH OFFICIALS, LEADING HEALTH AND SOCIAL SERVICE PROVIDERS, AND THE COMMUNITY AT-LARGE; AS WELL AS SENIOR STAFF FROM THE CITY OF STAMFORD, INCLUDING KEY STAFF FROM THE CITY'S HEALTH DEPARTMENT.

THE INDIVIDUALS WHO PARTICIPATED IN KEY INFORMANT INTERVIEWS THAT REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING THOSE WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH ARE AS FOLLOWS:

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

INDIVIDUALS WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH

ANNE FOUNTAIN, MPH DIRECTOR STAMFORD DEPT. OF HEALTH AND SOCIAL SERVICES

DAVID A. KNAUF, MPH, MS, RS DIRECTOR OF HEALTH TOWN OF DARIEN

DAVID REED, MD MEDICAL DIRECTOR/DIRECTOR OF PUBLIC HEALTH TOWN OF NEW

CANAAN/STAMFORD HOSPITAL

HENRY YOON, MD MEDICAL ADVISOR STAMFORD DEPT. OF HEALTH & SOCIAL

SERVICES

KAREN GOTTLIEB, EXECUTIVE DIRECTOR AMERICARES

MADHU MATHUR MD, MPH DIRECTOR, KIDS FANS; CHAIR, OBESITY TASK FORCE

CHILDHOOD OBESITY TASK FORCE

TIMOTHY J.CALLAHAN, DIRECTOR OF HEALTH CITY OF NORWALK

ALL OTHER INDIVIDUALS INTERVIEWED

DENNIS TORRES, DIRECTOR OF HEALTHCARE PROGRAMS CHARTER OAK COMMUNITIES

FAMILY CENTER INC.

DONNA SPELLMAN, DIRECTOR OF OUTREACH FAMILY CENTERS, INC.

ELIZABETH PARIS, COORDINATOR, DARIEN SENIOR CENTER DARIEN, CT

ERIC KOEHLER, CEO JEWISH COMMUNITY CENTER

BOB ARNOLD, CHIEF EXECUTIVE OFFICER FAMILY CENTERS, INC.

BOBBY VALENTINE, DIRECTOR OF PUBLIC SAFETY, HEALTH & WELFARE CITY OF

STAMFORD

JAMES LISHER, CHAIR, HEALTH & HUMAN SERVICES COMMISSION TOWN OF NEW

CANNAN

JEB WALKER, FIRST SELECTMAN TOWN OF NEW CANNAN

JUAN MEDRANO, DIRECTOR OF FINANCE; PRESIDENT, HISPANIC ADVISORY COUNCIL

YERWOOD CENTER

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

KATHY WALSH, PRESIDENT NEIGHBORSLINK

MARIE JOHNSON, EXEC. DIRECTOR, SENIOR SERVICES PARTNERSHIP IN ELDERLY

SERVICES

MICHAEL PAVIA, MAYOR CITY OF STAMFORD

MIKE COTELA, EXECUTIVE DIRECTOR BOYS & GIRLS CLUB

OLGA BROWN, DIRECTOR OF NURSING, CITY OF STAMFORD STAMFORD PUBLIC

SCHOOLS

PETER TESEI, FIRST SELECTMAN CITY OF GREENWICH

SAMUEL E. DEIBLER, DIRECTOR, COMMISSION ON AGING CITY OF GREENWICH SANDRA

PRYOR, YEARWOOD CENTER

SHERRY PERLSTEIN, EXECUTIVE DIRECTOR CHILD GUIDANCE CENTER

TERRY DREW, DIRECTOR STAMFORD YOUTH SERVICES BUREAU

VINCENT J. TUFO, EXECUTIVE DIRECTOR, CHARTER OAK COMMUNITY FAMILY

CENTERS, INC.

WINNIE HAMILTON, ASSISTANT SUPERINTENDENT STAMFORD PUBLIC SCHOOLS

SCHEDULE H, PART V, SECTION B, LINE 5

HTTPS://WWW.STAMFORDHOSPITAL.ORG/DOCUMENTS/STAMFORD-HOSPITAL-CHNA-FINAL-09

13.ASPX

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 20D

THE MAXIMUM AMOUNT CHARGED TO FAP ELIGIBLE INDIVIDUALS IS CALCULATED

BASED ON FEDERAL POVERTY GUIDELINES. INDIVIDUAL FAMILY INCOME LEVELS ARE

COMPARED TO FPG AND TOTAL CHARGES ARE REDUCED FROM 100%-60% BASED ON

LEVEL OF INCOME.

Part V **Facility Information** *(continued)*

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

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

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

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

FORM 990, SCHEDULE H, PART II

COMMUNITY BUILDING ACTIVITIES

TSH, THROUGH RYAN WHITE GRANTS, (PARTS A AND B), ADMINISTERED BY STAMFORD CARES, EMPLOYS AN HIV NURSE PRACTITIONER (DNP, APRN), ADHERENCE NURSE (RN) COUNSELOR, AND A DIETICIAN COMMITTED TO PROVIDING HIV SPECIALTY PRIMARY CARE SERVICES. TSH WORKS IN PARTNERSHIP WITH THE CITY OF STAMFORD HIV PREVENTION PROGRAM AND STAMFORD CARES, A PROGRAM OF FAMILY CENTERS THAT PROVIDE HIV MEDICAL CASE MANAGEMENT. THE HOSPITAL'S HIV NURSE PRACTITIONER AND ADHERENCE NURSE COUNSELOR ATTENDED REGULAR CASE MANAGEMENT MEETINGS WITH STAMFORD CARES' CASE MANAGERS AND OTHER LOCAL COMMUNITY SERVICES SUCH AS SUBSTANCE ABUSE REHABILITATION, MENTAL HEALTH, AND HOUSING SUPPORT. TSH ALSO PROVIDES OFFICE SPACE AND MEDICAL OVERSIGHT OF THE PROGRAM.

FORM 990, SCHEDULE H, PART III, LINES 2 AND 4

BAD DEBT EXPENSE AND TEXT OF BAD DEBT EXPENSE FOOTNOTE

ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE HOSPITAL

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

FORM 990, SCHEDULE H, PART III, LINE 8

TREATMENT OF MEDICARE SHORTFALL AS COMMUNITY BENEFIT

TO THE EXTENT THERE IS A MEDICARE 'SHORTFALL', THE HOSPITAL HAS PROVIDED SERVICES AND IS REIMBURSED LESS THAN THE COST OF THOSE SERVICES. THIS TRANSFER OF VALUE BENEFITS THE PATIENT AND ARGUABLY (DIRECTLY AND INDIRECTLY) THE COMMUNITY IN WHICH THEY LIVE.

FORM 990, SCHEDULE H, PART III, LINE 8

MEDICARE COSTING METHODOLOGY

THE COSTING METHODOLOGY USED FOLLOWS THE METHODOLOGY OF THE MEDICARE COST REPORT.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

FORM 990, SCHEDULE H, PART III, LINE 9B

COLLECTION PRACTICES

APPLICATION OF COLLECTION PRACTICES QUALIFYING FOR FINANCIAL ASSISTANCE

ALL COLLECTION EFFORTS CEASE AT ANY POINT IN THE PROCESS IF THE PATIENT

APPLIES FOR FREE BED FUNDS OR FINANCIAL ASSISTANCE.

FORM 990, SCHEDULE H, PART VI

NEEDS ASSESSMENT

THE HOSPITAL WORKS CLOSELY WITH THE STAMFORD DEPARTMENT OF HEALTH AND

SOCIAL SERVICES TO IDENTIFY NEEDS AND DEVELOP PROGRAMS, PROVIDE

SCREENINGS, AND PROMOTE DISSEMINATION OF HEALTH INFORMATION.

IN 2014, STAMFORD HOSPITAL ("TSH" OR "HOSPITAL") FOCUSED ITS COMMUNITY

OUTREACH AND POPULATION HEALTH EFFORTS ON THE VITA HEALTH & WELLNESS

INITIATIVE IN THE CITY'S WEST SIDE, IN A COMMUNITY COLLABORATIVE OF KEY

STRATEGIC PARTNERS THAT INCLUDE THE CITY OF STAMFORD HEALTH DEPARTMENT,

FAMILY CENTERS, AMERICARES, OPTIMUS HEALTH, COMMUNITY HEALTH CENTER,

DOMUS, NORWALK COMMUNITY CENTER AND AN OUTGROWTH OF THE VITA INITIATIVE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

IS FAIRGATE FARM, LOCATED BETWEEN THE NEW FAIRGATE HOUSING COMMUNITY, STAMFORD HOSPITAL, AND THE EMERGING VITA ECONOMIC DEVELOPMENT CORRIDOR. IN 2011, BLIGHTED HOUSING WAS REMOVED AND TRANSFORMED INTO A SUCCESSFUL URBAN FARM THAT NOW PRODUCES SEVERAL THOUSAND POUNDS OF STRAWBERRIES, SPINACH, TOMATOES, LETTUCE, PUMPKINS, SQUASH AND OTHER VEGETABLES EACH YEAR. GROWN BY LOCAL VOLUNTEERS WHO SHARE IN ITS BOUNTY, THE FARM'S NUTRITIOUS PRODUCE FEEDS PATIENTS AT THE NOT-FOR-PROFIT SCOFIELD MANOR NURSING HOME, THE NEW COVENANT HOUSE SOUP KITCHEN AND THE SHELTER FOR THE HOMELESS, AMONG OTHER HUNGER RELIEF ORGANIZATIONS WHO ARE CURRENTLY PROVIDING 6,000 POUNDS OF HEALTH ORGANIC PRODUCE TO THE NEEDY IN STAMFORD. THE FARM HAS ATTRACTED A LARGE NUMBER OF SEASONAL VOLUNTEERS, INCLUDING YOUNG CHILDREN, FAMILIES AND SENIORS OVER AGE 80. IT IS A LEARNING LAB FOR STAMFORD SCHOOLS, YOUTH GROUPS AND SUMMER CAMPS, INCLUDING THE BOYS & GIRLS CLUB, THE YMCA AND THE YERWOOD COMMUNITY CENTER. A LOCAL GROUP OF MOTIVATED TEENS, BUILDON, VOLUNTEERS REGULARLY, AND THE CITY'S PUBLIC SCHOOL GARDENING PROGRAM, GIVE, ACTIVELY CULTIVATES THE SITE. IN 2014, THE HOSPITAL'S SUPPORTED FAIRGATE FARM WITH A BI-LINGUAL NUTRITIONIST/CHEF TO CONDUCT HEALTHY COOKING AND NUTRITION

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

CLASSES TO ADULTS AND CHILDREN IN THE VITA NEIGHBORHOOD.

FORM 990, SCHEDULE H, PART VI

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

THE STAMFORD HOSPITAL USES SEVERAL VENUES TO NOTIFY OUR PATIENTS OF THE AVAILABLE FINANCIAL OPTIONS.

1) SIGNS AND/OR BROCHURES ARE DISPLAYED IN ENGLISH AND SPANISH IN THE FOLLOWING AREAS:

* EMERGENCY ROOM WAITING ROOMS AND REGISTRATION WORKSTATIONS

* IMMEDIATE CARE CENTER WAITING ROOM

* PATIENT REGISTRATION AREAS ON THE MAIN CAMPUS AND TULLY CAMPUS

* CASHIER'S OFFICE, OFFICES OF THE FINANCIAL COUNSELORS, RECEPTION AREA OF THE PATIENT BUSINESS SERVICES DEPARTMENT

* ANCILLARY DEPARTMENTS

* BROCHURES ARE ALSO AVAILABLE IN CREOLE AND POLISH.

2) THE HOSPITAL'S BILLING STATEMENTS INCLUDE AN INFORMATIONAL PAGE THAT IS PRINTED ON THE REVERSE SIDE OF THE STATEMENT OUTLINING THE FINANCIAL

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

OPTIONS.

3) THE "ARE YOU UNINSURED NOTICE" IN ENGLISH AND SPANISH IS ATTACHED TO

THE TRUE SELF PAY STATEMENTS.

4) STAFFING:

* STAMFORD HOSPITAL HAS A FULL-TIME DSS ST OF CT OUTREACH WORKER ON THE

HOSPITAL CAMPUS.

* SOCIAL SERVICES DEPARTMENT

* CASE MANAGEMENT DEPARTMENT

* PATIENT REGISTRATION HAS ONE FULL TIME FINANCIAL COUNSELOR

* PATIENT BUSINESS SERVICES HAS ONE BILINGUAL PATIENT ASSISTANCE

COORDINATOR AND TWO FULL TIME BILINGUAL FINANCIAL COUNSELORS.

* THE DSS OUTREACH WORKER AND A TSH FINANCIAL COUNSELOR HOLD EDUCATIONAL

AND COUNSELING SESSIONS IN THE OPTIMUS AND STAMFORD HOSPITAL CLINICS ONCE

PER WEEK.

* HAND-OUTS ARE PROVIDED TO PATIENTS BY THE FINANCIAL COUNSELORS AT THE

CLINICS AND THE COMMUNITY HEALTH CENTERS.

* PATIENTS ARE SCREENED FOR FEDERAL OR STATE PROGRAMS, AND THE HOSPITALS

FINANCIAL ASSISTANCE PROGRAM (FAP) BY THE SOCIAL WORKERS,

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

* PATIENT ASSISTANCE COORDINATOR, FINANCIAL ASSISTANCE COUNSELORS, AND

THE DSS LIAISON.

5) NOTIFICATIONS: PATIENTS RECEIVE APPROVAL OR DENIAL LETTERS AND, IF

ELIGIBLE, FINANCIAL ASSISTANCE PROGRAM IDENTIFICATION CARDS.

FORM 990, SCHEDULE H, PART VI

COMMUNITY INFORMATION

STAMFORD HOSPITAL PROVIDES A BROAD RANGE OF COMMUNITY OUTREACH AND

EDUCATIONAL SERVICES TO RESIDENTS OF PREDOMINANTLY ITS PRIMARY SERVICE

AREA (PSA) AND SECONDARY SERVICE AREA (SSA) THAT INCLUDE 12 COMMUNITIES

IN SOUTHERN FAIRFIELD COUNTY, CT. THE HOSPITAL'S SERVICE AREA WAS

DEVELOPED THROUGH THE STRATEGIC PLANNING PROCESS AND IS DEFINED IN

STAMFORD HEALTH SYSTEM, INC.'S STRATEGIC PLAN. THE HOSPITAL'S COMBINED

PSA AND SSA INCLUDE AN ESTIMATED 135,511 HOUSEHOLDS WITH A TOTAL

POPULATION OF 361,418 RESIDENTS. THE PSA INCLUDES THE COMMUNITIES OF

STAMFORD, DARIEN, AND ROWAYTON, WITH AN ESTIMATED 54,392 HOUSEHOLDS AND A

TOTAL POPULATION OF 143,122. STAMFORD COMPRISES AN ESTIMATED 46,195

HOUSEHOLDS WITH A TOTAL POPULATION OF 119,294. THE SSA INCLUDES THE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

COMMUNITIES OF GREENWICH, COS COB, RIVERSIDE, OLD GREENWICH, NEW CANAAN, NORWALK, WESTPORT, WESTON, AND WILTON, WITH AN ESTIMATED 81,119 HOUSEHOLDS AND A TOTAL POPULATION OF 218,296. FOR THE PSA, 24% OF THE POPULATION IS ESTIMATED TO BE LESS THAN 18 YEARS OF AGE; 34.7% IS 18-44; 27.8% IS 45-64; AND 13.5% IS 65 YEARS OF AGE AND OLDER. THE SSA HAS A SLIGHTLY OLDER AGE DISTRIBUTION WITH AN ESTIMATED 25.7% OF ITS POPULATION LESS THAN 18 YEARS OF AGE; 29.2% IS 18-44; 30.7% IS 45-64; AND 14.4% IS 65 YEARS OF AGE AND OLDER.

REGARDING RACE/ETHNICITY, OF THE ESTIMATED POPULATION IN THE PSA, 60.0% OF RESIDENTS ARE WHITE; 20.5% HISPANIC; 10.7% BLACK; 6.3% ASIAN; AND THE REMAINDER ARE MULTI-RACIAL, NATIVE AMERICAN, PACIFIC ISLANDER, AND OTHER NON-HISPANIC. STAMFORD IS ESTIMATED TO HAVE A MORE RACIALLY DIVERSE POPULATION THAN THE PSA AND SSA WITH THE BLACK POPULATION REPRESENTING 12.6% OF ITS TOTAL POPULATION; THE HISPANIC POPULATION 23.9%; AND ASIAN POPULATION 7.0%. FOR THE SSA, 75.6% OF THE TOTAL ESTIMATED POPULATION IS WHITE; 11.9% HISPANIC; 6.0% BLACK; 4.6% ASIAN; AND THE REMAINDER ARE MULTI-RACIAL, NATIVE AMERICAN, PACIFIC ISLANDER, AND OTHER NON-HISPANIC.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

ALTHOUGH IN THE PSA AN ESTIMATED 26.4% OF TOTAL HOUSEHOLDS HAVE HOUSEHOLD INCOMES EXCEEDING $200,000, STAMFORD HAS AREAS WITH SIGNIFICANT POVERTY. IN COMPARISON TO THE PSA, STAMFORD HAS ONLY AN ESTIMATED 12.0% OF TOTAL HOUSEHOLDS WITH HOUSEHOLD INCOMES EXCEEDING $200,000, AND 19.3% WITH HOUSEHOLD INCOMES LESS THAN $30,000, 26.3% WITH LESS THAN $40,000. IN THE SSA, AN ESTIMATED 27.9% OF THE TOTAL HOUSEHOLDS HAVE HOUSEHOLD INCOMES EXCEEDING $200,000, WHILE AN ESTIMATED 11.8% HAVE HOUSEHOLD INCOMES LESS THAN $30,000 AND 16.9% LESS THAN $40,000. THE ESTIMATED PAYOR MIX OF THE PSA IS PREDOMINANTLY COMMERCIAL/PRIVATE INSURANCE (68.9%), FOLLOWED BY MEDICARE (11.7%); MEDICAID (9.2%); SELF PAY/UNINSURED (8.6%); AND MEDICARE DUAL ELIGIBLE (1.6%). COMPARED TO THE PSA, STAMFORD HAS A HIGHER ESTIMATED PERCENTAGE OF MEDICAID AT 10.4% AND SELF-PAY/UNINSURED AT 9.8%. FOR THE SSA, THE ESTIMATED PAYOR MIX IS ALSO PRIMARILY COMMERCIAL/PRIVATE INSURANCE (74.8%), FOLLOWED BY MEDICARE (12.6%); MEDICAID (5.7%); SELF-PAY/UNINSURED (5.3%); AND MEDICARE DUAL ELIGIBLE (1.6%).

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

FORM 990, SCHEDULE H, PART VI

PROMOTION OF COMMUNITY HEALTH

PROGRAMS THAT BENEFITED THE COMMUNITY. THESE PROGRAMS INCLUDED, FOR EXAMPLE, HEALTH SCREENINGS, IMMUNIZATION PROGRAMS, SOCIAL SERVICES AND SUPPORT COUNSELING FOR PATIENTS AND FAMILIES, CRISIS INTERVENTION, COMMUNITY HEALTH EDUCATION, AND THE DONATION OF SPACE FOR USE BY COMMUNITY GROUPS. HEALTH EDUCATION PROGRAMS PROVIDED BY THE HOSPITAL FOR THE BENEFIT OF THE COMMUNITY INCLUDED: SMOKING CESSATION; WEIGHT LOSS; STRESS MANAGEMENT; AND PROGRAMS FOCUSED ON SUCH SPECIFIC HEALTH FACTORS OR DISEASE ENTITIES SUCH AS HEART DISEASE, BREAST CANCER, SLEEP DISORDERS, ARTHRITIS, HIGH CHOLESTEROL, CANCER PREVENTION, NUTRITION, STRESS MANAGEMENT, CIRCULATORY PROBLEMS, DIGESTIVE DISORDERS, PAIN MANAGEMENT, SPORTS INJURIES, AND CHILDREN'S NUTRITION.

TSH OFFERED A MINI-MEDICAL SCHOOL, A FREE, SIX-WEEK SERIES OF LECTURES BY VOLUNTEER PHYSICIANS FOCUSING ON COMMON DISEASE STATES AND AVAILABLE TREATMENTS. TOPICS INCLUDE ANESTHESIOLOGY, CANCER, CARDIOLOGY,

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

GASTROENTEROLOGY, GENERAL ANATOMY, GYNECOLOGY, INFECTIOUS DISEASES,

INTEGRATIVE MEDICINE, MEDICAL DECISION-MAKING, PULMONARY MEDICINE AND

ORTHOPEDICS. IN SPRING AND FALL OF 2014 A TOTAL OF 441 PEOPLE ATTENDED

THE CLASSES.

HOSPITAL STAFF PROVIDED SERVICES AT COMMUNITY HEALTH FAIRS AND SERVED AS

SPEAKERS AT VARIOUS COMMUNITY GROUPS ON LIFESTYLE/HEALTH IMPROVEMENT

HEALTH EVENTS; CONDUCTED 9,280 SCREENINGS, WITH TOTAL ATTENDANCE OF

22,476. THE EVENTS INCLUDED HEALTH FAIRS AT COMMUNITY CENTERS, SENIOR

CENTERS, RELIGIOUS INSTITUTIONS, AND SCHOOLS; PHYSICIAN PRESENTATIONS AS

WELL AS CAREER DAYS, SCHOOL TOURS AND INFORMATIONAL SPECIAL EVENTS.

OTHER HIGHLIGHTS OF COMMUNITY HEALTH EDUCATION AND OUTREACH ACTIVITIES

PROVIDED IN FY2014 ARE AS FOLLOWS:

ASTHMA EDUCATION:

TSH CONDUCTED AN EVENT FOR THE COMMUNITY WITH EXHIBITS TO EDUCATE AND

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

CREATE AN AWARENESS AND UNDERSTANDING OF ASTHMA. TOPICS INCLUDED KEEPING ASTHMA UNDER CONTROL, UTILIZING A TEAM APPROACH IN TREATING ASTHMA, THE ROLE OF ALLERGIES, AND THE FUTURE OF ASTHMA THERAPY. THE HOSPITAL ALSO HELD EDUCATIONAL EVENTS THAT FOCUSED ON PEDIATRIC ASTHMA.

CANCER:

IN 2014, STAMFORD HOSPITAL'S CARL & DOROTHY BENNETT CANCER CENTER CONTINUED TO BUILD ON ITS REPUTATION FOR DELIVERING EXPERT CARE IN A WARM, NURTURING ENVIRONMENT. BUILDING ON THE SUCCESS OF THE PATIENT AND FAMILY ADVISORY COUNCIL'S (PFAC) FIRST YEAR, OUR MEMBERS CONTINUED TO ADVISE US ON PROJECTS AND INITIATIVES. THIS APPROACH IS CONSISTENT WITH THE HOSPITAL'S PLANETREE PHILOSOPHY OF PATIENT-CENTERED CARE. WITH MEMBERS THAT INCLUDE STAFF, CANCER SURVIVORS AND CAREGIVERS, THE GOAL OF THE PFAC IS TO CONTINUE TO IMPROVE THE CARE AND SERVICES OFFERED AT THE BENNETT CANCER CENTER. ADDITIONALLY, THE BENNETT CANCER CENTER CONTINUED OUR PARTNERSHIP WITH ONCOLOGY REHAB PARTNERS IN OFFERING THE STAR (SURVIVORSHIP TRAINING & REHABILITATION) PROGRAM TO ITS PATIENTS. STAR IS A NATIONALLY RECOGNIZED CANCER SURVIVORSHIP PROGRAM THAT FOCUSES ON

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

HELPING SURVIVORS HEALTH PHYSICALLY AND EMOTIONALLY. PHYSICIANS AND STAFF

BEGAN TRAINING IN 2013 AND THE PROGRAMMED WAS IMPLEMENTED IN 2014.

FORM 990, SCHEDULE H, PART VI

STATE FILING OF COMMUNITY BENEFIT REPORT

A COMMUNITY BENEFIT REPORT IS PREPARED FOR THE STATE OF CONNECTICUT;

HOWEVER, THAT REPORT IS NOT MADE AVAILABLE TO THE PUBLIC.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 23.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
THE STAMFORD HOSPITAL

Employer identification number
06-0646917

Part I Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
	☐ First-class or charter travel		
	☐ Travel for companions		
	☒ Tax indemnification and gross-up payments		
	☐ Discretionary spending account		
	☒ Housing allowance or residence for personal use		
	☐ Payments for business use of personal residence		
	☐ Health or social club dues or initiation fees		
	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain **1b**	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a? **2**	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
	☒ Compensation committee		
	☒ Independent compensation consultant		
	☐ Form 990 of other organizations		
	☒ Written employment contract		
	☒ Compensation survey or study		
	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a	Receive a severance payment or change-of-control payment? **4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**		X
c	Participate in, or receive payment from, an equity-based compensation arrangement? **4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.		
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a	The organization? **5a**		X
b	Any related organization? **5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.		
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a	The organization? **6a**		X
b	Any related organization? **6b**		X
	If "Yes" to line 6a or 6b, describe in Part III.		
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III **7**		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III **8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**		

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	BRIAN GRISSLER PRESIDENT & CEO	(i)	967,192.	1,095,323.	272,422.	0	34,175.	2,369,112.	0
		(ii)	0	0	0	0	0	0	0
2	KEVIN GAGE TREASURER	(i)	572,955.	304,643.	92,085.	11,753.	26,949.	1,008,385.	0
		(ii)	0	0	0	0	0	0	0
3	DARRYL MCCORMICK ASST. SECRETARY	(i)	390,427.	212,881.	24,010.	0	9,445.	636,763.	0
		(ii)	0	0	0	0	0	0	0
4	DAVID L. SMITH ASST. SECRETARY	(i)	411,987.	216,519.	103,121.	0	36,734.	768,361.	0
		(ii)	0	0	0	0	0	0	0
5	KATHLEEN A. SILARD ASST. SECRETARY	(i)	596,792.	320,427.	329,171.	11,600.	36,734.	1,294,724.	0
		(ii)	0	0	0	0	0	0	0
6	DR. RODRIGO ACOSTA PHYSICIAN	(i)	0	0	0	0	0	0	0
		(ii)	320,590.	49,333.	71,222.	0	10,244.	451,389.	0
7	MICHAEL COADY, MD CHIEF CARDIAC SURGEON	(i)	761,318.	146,939.	15,593.	11,075.	9,445.	944,370.	0
		(ii)	0	0	0	0	0	0	0
8	SHARON KIELY, MD SR. VP, MEDICAL SERVICES	(i)	502,337.	262,869.	83,708.	12,762.	36,128.	897,804.	0
		(ii)	0	0	0	0	0	0	0
9	DAVID TAYLOR CIO	(i)	364,002.	196,194.	81,889.	12,773.	34,234.	689,092.	0
		(ii)	0	0	0	0	0	0	0
10	MICHAEL F. PARRY, MD PHYSICIAN	(i)	501,814.	7,940.	140,867.	0	23,087.	673,708.	0
		(ii)	0	0	0	0	0	0	0
11	LANCE BRUCK, MD CHAIR, DEPARTMENT OF OB/GYN	(i)	520,804.	60,000.	17,812.	11,832.	34,234.	644,682.	0
		(ii)	0	0	0	0	0	0	0
12	STEVEN HOROWITZ, MD CHIEF, DIVISION OF CARDIOLOGY	(i)	567,093.	0	17,303.	11,777.	34,234.	630,407.	0
		(ii)	0	0	0	0	0	0	0
13	GERALD B. RAKOS, MD DIRECTOR	(i)	416,810.	42,207.	33,848.	0	27,949.	520,814.	0
		(ii)	0	0	0	0	0	0	0
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Part III Supplemental Information

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

FORM 990, SCHEDULE J, PART I, LINE 1A

AS PER COMPANY POLICY, ALL NONCASH IMPUTABLE BENEFITS ARE TO BE PROCESSED IN A GROSSED-UP METHOD WITH APPLICABLE WAGE AND TAXES REPORTED ON W2'S FOR ALL EMPLOYEES. HOUSING ALLOWANCES ARE PROVIDED TO CERTAIN SENIOR EXECUTIVES AS PART OF THEIR COMPENSATION.

FORM 990, SCHEDULE J, PART I, LINE 3

IT IS THE POLICY OF THE STAMFORD HOSPITAL TO PAY EMPLOYEES FAIR AND COMPETITIVE WAGES. THE HOSPITAL HAS ADOPTED A WAGE AND SALARY PROGRAM TO ENSURE THAT ALL EMPLOYEES ARE PAID IN RELATION TO THE VALUE OF THE WORK THEY PERFORM. THIS PROGRAM IS REVIEWED ANNUALLY. EXECUTIVE COMPENSATION IS SUBJECT TO A MORE COMPREHENSIVE REVIEW, INCLUDING AN ANNUAL BENCHMARKING ANALYSIS AND BOARD-LEVEL APPROVAL PROCESS. INDEPENDENT COMPENSATION CONSULTANTS ARE USED AND COMPENSATION SURVEYS ARE OBTAINED FROM AT LEAST THREE SOURCES. ONCE THE COMPENSATION IS DETERMINED A WRITTEN EMPLOYMENT CONTRACT IS OBTAINED.

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

▶ Attach to Form 990. ▶ See separate instructions.

▶ Information about Schedule K (Form990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE STAMFORD HOSPITAL

Employer identification number

06-0646917

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	STATE OF CT HEALTH AND EDUCATION FAC AUTHORITIES	06-0806186	2077443P8	05/27/2010	133,992,115.	SEE SCHEDULE K, PART VI		X		X		X
B	STATE OF CT HEALTH AND EDUCATION FAC AUTHORITIES	06-0806186	20774YKQ9	06/20/2012	254,620,769.	CONSTRUCTION OF NEW HOSPITAL		X		X		X
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	133,995,069.	254,620,769.		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds		36,350,996.		
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	2,057,323.	2,935,597.		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	24,835,260.	174,557,172.		
11	Other spent proceeds	107,102,486.			
12	Other unspent proceeds		77,128,000.		
13	Year of substantial completion	2011	2016		

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X			X				
15	Were the bonds issued as part of an advance refunding issue?		X		X				
16	Has the final allocation of proceeds been made?	X			X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

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

Part III Private Business Use *(Continued)* GROUP 1

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6	Total of lines 4 and 5	%		%		%		%	
7	Does the bond issue meet the private security or payment test?		X		X				
8a	Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?	X		X					
b	Exception to rebate?		X		X				
c	No rebate due?		X		X				
	If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X		X				
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X				
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV **Arbitrage** *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X				
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X					

Part V **Procedures To Undertake Corrective Action**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X					

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions).

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

SCHEDULE K, PART I, COLUMN (F), BOND A

STATE OF CONNECTICUT HEALTH AND EDUCATIONAL FACILITIES AUTHORITY BONDS

WERE ISSUED 5/27/10 TO:

1) REFUND THE 11/13/96, 03/24/99, 6/03/08 AND 05/28/09 BOND ISSUES AND

COMMERCIAL LOANS.

2) FINANCE ROUTINE RENOVATIONS AND OTHER CAPITAL EXPENDITURES AND

3) FINANCE DEVELOPMENT AND CONSTRUCTION OF NEW HOSPITAL FACILITY

SCHEDULE K, PART II, LINE 3

BOND A: THERE IS A $3,000 VARIANCE BETWEEN THE PROCEEDS OF ISSUE AND THE

ISSUE PRICE DUE TO INVESTMENT EARNINGS.

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
▶ **Attach to Form 990.**
▶ **Information about Schedule M (Form 990) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization

THE STAMFORD HOSPITAL

Employer identification number

06-0646917

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art - Works of art				
2	Art - Historical treasures				
3	Art - Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities - Publicly traded	X	103.	3,747,075.	MARKET VALUE
10	Securities - Closely held stock				
11	Securities - Partnership, LLC, or trust interests				
12	Securities - Miscellaneous				
13	Qualified conservation contribution - Historic structures				
14	Qualified conservation contribution - Other				
15	Real estate - Residential				
16	Real estate - Commercial				
17	Real estate - Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶(_____)				
26	Other ▶(_____)				
27	Other ▶(_____)				
28	Other ▶(_____)				

			Yes	No
29	Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement	29		
30 a	During the year, did the organization receive by contribution any property reported in Part I, lines 1-28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		X
b	If "Yes," describe the arrangement in Part II.			
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	31	X	
32 a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a		X
b	If "Yes," describe in Part II.			
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.			

Part II **Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

FORM 990, PART VI, LINE 6

STAMFORD HEALTH SYSTEM (SHS), A TAX-EXEMPT ORGANIZATION, IS THE SOLE MEMBER OF THE STAMFORD HOSPITAL.

FORM 990, PART VI, LINE 7A

STAMFORD HEALTH SYSTEM (SHS), THE SOLE MEMBER OF THE STAMFORD HOSPITAL, HAS THE POWER, AS THE SOLE MEMBER: TO ELECT THE BOARD OF DIRECTORS OF THE STAMFORD HOSPITAL (THE "HOSPITAL") (EXCEPT FOR THE HOSPITAL PRESIDENT/CEO, WHO SERVES AS AN EX OFFICIO DIRECTOR) (SECTIONS V.2, VI,.2), TO ELECT/ REMOVE/REPLACE THE HOSPITAL'S OFFICERS OTHER THAN THE PRESIDENT/CEO (SECTIONS VII.1, VII.4-5), AND TO ADOPT/AMEND/RESTATE/ REPEAL THE BYLAWS (ART. XII). SHS HAS CERTAIN STATUTORY APPROVAL RIGHTS AS THE SOLE MEMBER, SUCH AS THE RIGHT TO APPROVE MOST AMENDMENTS TO THE HOSPITAL'S CERTIFICATE AND THE HOSPITAL'S MERGER, DISSOLUTION, OR SALE OF ALL ASSETS LEAVING THE HOSPITAL WITH NO SIGNIFICANT CONTINUING ACTIVITY.

FORM 990, PART VI, LINE 7B

SHS HAS CERTAIN STATUTORY APPROVAL RIGHTS AS THE SOLE MEMBER, SUCH AS THE RIGHT TO APPROVE MOST AMENDMENTS TO THE HOSPITAL'S CERTIFICATE AND THE HOSPITAL'S MERGER, DISSOLUTION, OR SALE OF ALL ASSETS LEAVING THE HOSPITAL WITH NO SIGNIFICANT CONTINUING ACTIVITY.

FORM 990, PART VI, LINE 11B

THE STAMFORD HOSPITAL HAS A COMPREHENSIVE REVIEW PROCESS IN PLACE

Name of the organization: THE STAMFORD HOSPITAL

Employer identification number: 06-0646917

RELATING TO THE REVIEW OF FORM 990. PRIOR TO FINALIZATION OF THE 990, MANAGEMENT PRESENTS THE DRAFT FORM 990 TO THE FULL BOARD OF DIRECTORS FOR REVIEW AND DISCUSSION. THE HOSPITAL'S EXTERNAL TAX ACCOUNTANTS ATTEND THIS MEETING WITH MANAGEMENT TO ADDRESS ANY SPECIFIC CONCERNS OR QUESTIONS. THIS REVIEW PROCEDURE HELPS TO ASSURE SOUND REPORTING AND COMPLIANCE WITH TAX LAW.

FORM 990, PART VI, LINE 12C

IT IS THE POLICY OF THE STAMFORD HOSPITAL TO PROHIBIT ITS EMPLOYEES AND OTHER ASSOCIATES FROM ENGAGING IN ANY ACTIVITY, PRACTICE, OR ACT WHICH CONFLICTS WITH, OR APPEARS TO CONFLICT WITH, THE INTERESTS OF THE STAMFORD HOSPITAL, OR ITS PATIENTS. EMPLOYEES ARE EXPECTED TO CONDUCT THE BUSINESS OF THE STAMFORD HOSPITAL TO THE BEST OF THEIR ABILITY AND FOR THE BENEFIT OF THE STAMFORD HOSPITAL AND ITS PATIENTS. THE POLICY ALSO REQUIRES BOARD MEMBERS, OFFICERS, SENIOR LEADERS, MEDICAL STAFF LEADERS, COMMITTEE MEMBERS AND OTHER INDIVIDUALS AS APPROPRIATE TO DISCLOSE ANY POTENTIAL CONFLICT OF INTEREST THEY OR THEIR IMMEDIATE FAMILY MAY HAVE ON AN ANNUAL BASIS. SURVEYS ARE DISTRIBUTED ANNUALLY AND TIMELY RECEIPT IS MONITORED BY THE HOSPITAL'S COMPLIANCE DEPARTMENT.

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

IT IS THE POLICY OF THE STAMFORD HOSPITAL TO PAY EMPLOYEES FAIR AND COMPETITIVE WAGES. THE HOSPITAL HAS ADOPTED A WAGE AND SALARY PROGRAM TO ENSURE THAT ALL EMPLOYEES ARE PAID IN RELATION TO THE VALUE OF THE WORK THEY PERFORM. THIS PROGRAM IS REVIEWED ANNUALLY. EXECUTIVE COMPENSATION IS SUBJECT TO A MORE COMPREHENSIVE REVIEW, INCLUDING AN ANNUAL

Name of the organization: THE STAMFORD HOSPITAL

Employer identification number: 06-0646917

BENCHMARKING ANALYSIS AND BOARD-LEVEL APPROVAL PROCESS.

FORM 990, PART VI, LINE 19

THE STAMFORD HOSPITAL MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS AVAILABLE UPON REQUEST.

FORM 990, PART IX, LINE 11G

FEES FOR OTHER SERVICES

PURCHASED SERVICES - $21,999,365

PHYSICIAN FEES - $10,919,257

CONSULTING - $5,096,138

COLLECTION FEES - $4,005,246

INTERCOMPANY STAFFING FEES - $3,749,411

COMMUNITY BENEFIT GRANT - $2,291,321

TEMP NURSING - $1,298,029

DATA PROCESSING SVCS - $547,396

TOTAL - $49,906,163

PART XI, LINE 9

OTHER CHANGES IN NET ASSETS

PENSION ADJUSTMENT - (18,572,247)

EQUITY TRANSFER TO SHIP - (30,639,897)

TOTAL (49,212,144)

Name of the organization: THE STAMFORD HOSPITAL

Employer identification number: 06-0646917

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HEMATOLOGY ONCOLOGY PC 34 SHELBURNE RD STAMFORD, CT 06902	PHYS FEES/ONCOLOGY	4,314,984.
OUTSOURCE GROUP P.O. BOX 12414 NEWARK, NJ 07101	COLLECTIONS/PUR SVCS	950,074.
ERNST AND YOUNG LLP P.O. BOX 640382 PITTSBURGH, PA 15264	AUDIT SERVICES	894,877.
PATHOLOGY AND LABORATORY SERV. LLC 11 RESEARCH DRIVE, SUITE 4 WOODBRIDGE, CT 06525-2348	LAB SERVICES	784,499.
CARDIOLOGY ASSOC OF FAIRFIELD CTY 1177 SUMMER STREET STAMFORD, CT 06525	PHYSICIAN FEES	762,499.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

▶ **Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE STAMFORD HOSPITAL

Employer identification number

06-0646917

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) 36 GROVE ST NEW CANAAN LLC 27-4941529 30 SHELBURNE RD STAMFORD, CT 06902	MED RENTALS	CT	79,348.	3,894,424.	TSH
(2) 24 GROVE ST NEW CANAAN LLC 27-4941167 30 SHELBURNE RD STAMFORD, CT 06902	MED RENTALS	CT	-19,032.	374,770.	TSH
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) STAMFORD HEALTH SYSTEM, INC. 22-2476636 30 SHELBURNE RD STAMFORD, CT 06902	HOSP PARENT	CT	501(C)(3)	11, TYPE I	N/A		X
(2) THE STAMFORD HOSPITAL FOUNDATION 22-2478748 30 SHELBURNE RD STAMFORD, CT 06902	FUNDRAISING	CT	501(C)(3)	9	SHS	X	
(3) STAMFORD HEALTH INTERGRATED PRACTICES 27-1648289 30 SHELBURNE RD STAMFORD, CT 06902	MEDICAL SVCS	CT	501(C)(3)	9	SHS	X	
(4)							
(5)							
(6)							
(7)							

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) STAMFORD OB/GYN ASSOCIATES 06-1330879 30 SHELBURNE RD STAMFORD, CT 06902	OBSTETRICAL CARE	CT	SHS	C CORP	0	0		X	
(2) HEALTHSTAR INDEMNITY CO LIMITED F.B. PERRY BUILDING 40 CHURCH ST, HAMILTON BD	SELF INSURANCE	BD	TSH	C CORP	3,551,000.	75,707,000.	100.0000	X	
(3) SOUTHWEST CONNECTICUT RADIOLOGY 45-3801216 30 SHELBURNE RD STAMFORD, CT 06902	RADIOLOGY	CT	SHS	S CORP	0	0		X	
(4)									
(5)									
(6)									
(7)									

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	STAMFORD HEALTH SYSTEM	K	128,413.	FMV
(2)	STAMFORD HEALTH SYSTEM	R	927,402.	BOOK VALUE
(3)	STAMFORD HEALTH SYSTEM	P	965,439.	BOOK VALUE
(4)	STAMFORD HEALTH INTEGRATED PRACTICES	B	30,639,897.	BOOK VALUE
(5)	STAMFORD HEALTH INTEGRATED PRACTICES	J	408,332.	BOOK VALUE
(6)	STAMFORD HEALTH INTEGRATED PRACTICES	O	106,488.	BOOK VALUE

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	HEALTHSTAR INDEMNITY CO	S	10,272,000.	BOOK VALUE
(2)	HEALTHSTAR INDEMNITY CO	Q	1,701,229.	BOOK VALUE
(3)	STAMFORD OB/GYN	R	99,618.	BOOK VALUE
(4)	SOUTHWEST CONNECTICUT RADIOLOGY	R	1,200,000.	CASH VALUE
(5)	STAMFORD HEALTH SYSTEM	E	154,000.	BOOK VALUE
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

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

Form **8865**

Department of the Treasury
Internal Revenue Service

Return of U.S. Persons With Respect to Certain Foreign Partnerships

▶ **Attach to your tax return.**
▶ **Information about Form 8865 and its separate instructions is at *www.irs.gov/form8865.***
Information furnished for the foreign partnership's tax year
beginning 02/23/2012 , and ending 12/31/2012

OMB No. 1545-1668

2013

Attachment
Sequence No. **118**

Name of person filing this return	**Filer's identifying number**
THE STAMFORD HOSPITAL	06-0646917

Filer's address (if you are not filing this form with your tax return)
30 SHELBURNE RD, P.O. BOX 9317
STAMFORD, CT 06902

A Category of filer (see **Categories of Filers** in the instructions and check applicable box(es)):
1 [ ] 2 [ ] 3 [X] 4 [ ]

B Filer's tax year beginning 10/01/2013 , and ending 09/30/2014

C Filer's share of liabilities: Nonrecourse $ Qualified nonrecourse financing $ Other $

D If filer is a member of a consolidated group but not the parent, enter the following information about the parent:

Name	EIN
Address	

E Information about certain other partners (see instructions)

(1) Name	(2) Address	(3) Identifying number	(4) Check applicable box(es)		
			Category 1	Category 2	Constructive owner

F1 Name and address of foreign partnership
RIVERSTONE GLOBAL ENERGY AND POWER FUND V FT
712 FIFTH AVENUE, 19TH FLOOR
NEW YORK, NY 10019

2(a) EIN (if any)
30-0745378

2(b) Reference ID number (see instr.)

3 Country under whose laws organized

4 Date of organization	**5** Principal place of business	**6** Principal business activity code number	**7** Principal business activity	**8a** Functional currency	**8b** Exchange rate (see instr.)
02/23/2012		523900	INVESTMENTS	USD	1.000000000000

G Provide the following information for the foreign partnership's tax year:

1 Name, address, and identifying number of agent (if any) in the United States

2 Check if the foreign partnership must file:
[ ] Form 1042 [ ] Form 8804 [X] Form 1065 or 1065-B
Service Center where Form 1065 or 1065-B is filed:
OGDEN

3 Name and address of foreign partnership's agent in country of organization, if any

4 Name and address of person(s) with custody of the books and records of the foreign partnership, and the location of such books and records, if different

5 Were any special allocations made by the foreign partnership? ▶ [ ] Yes [X] No

6 Enter the number of Forms 8858, Information Return of U.S. Persons With Respect To Foreign Disregarded Entities, attached to this return (see instructions) ▶

7 How is this partnership classified under the law of the country in which it is organized? ▶ PARTNERSHIP

8a Does the filer have an interest in the foreign partnership, or an interest indirectly through the foreign partnership, that is a separate unit under Reg. 1.1503(d)-1(b)(4) or part of a combined separate unit under Reg. 1.1503(d)-1(b)(4)(ii)? If "No," skip question 8b. ▶ [ ] Yes [X] No

b If "Yes," does the separate unit or combined separate unit have a dual consolidated loss as defined in Reg. 1.1503(d)-1(b)(5)(ii)? ▶ [ ] Yes [ ] No

9 Does this partnership meet **both** of the following requirements?
- The partnership's total receipts for the tax year were less than $250,000 and
- The value of the partnership's total assets at the end of the tax year was less than $1 million.

If "Yes," **do not** complete Schedules L, M-1, and M-2. ▶ [ ] Yes [ ] No

Sign Here Only If You Are Filing This Form Separately and Not With Your Tax Return.

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

▶ Signature of general partner or limited liability company member — ▶ Date

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN

Firm's name ▶ ERNST & YOUNG U.S. LLP — Firm's EIN ▶ 34-6565596

Firm's address ▶ 111 MONUMENT CIRCLE, STE 4000
INDIANAPOLIS, IN 46204 — Phone no. 317-681-7000

Schedule A **Constructive Ownership of Partnership Interest.** Check the boxes that apply to the filer. If you check box **b,** enter the name, address, and U.S. taxpayer identifying number (if any) of the person(s) whose interest you constructively own. See instructions.

a [X] Owns a direct interest **b** [ ] Owns a constructive interest

Name	Address	Identifying number (if any)	Check if foreign person	Check if direct partner

Schedule A-1 **Certain Partners of Foreign Partnership** (see instructions)

Name	Address	Identifying number (if any)	Check if foreign person

Does the partnership have any other foreign person as a direct partner? [ ] **Yes** [ ] **No**

Schedule A-2 **Affiliation Schedule.** List all partnerships (foreign or domestic) in which the foreign partnership owns a direct interest or indirectly owns a 10% interest.

Name	Address	EIN (if any)	Total ordinary income or loss	Check if foreign partnership

Schedule B **Income Statement - Trade or Business Income**

Caution. Include **only** trade or business income and expenses on lines 1a through 22 below. See the instructions for more information.

Income	1a	Gross receipts or sales	1a		
	b	Less returns and allowances	1b		1c
	2	Cost of goods sold			2
	3	Gross profit. Subtract line 2 from line 1c			3
	4	Ordinary income (loss) from other partnerships, estates, and trusts (attach statement) *			4
	5	Net farm profit (loss) (attach Schedule F (Form 1040))			5
	6	Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797)			6
	7	Other income (loss) (attach statement)			7
	8	**Total income (loss).** Combine lines 3 through 7			8
Deductions (see instructions for limitations)	9	Salaries and wages (other than to partners) (less employment credits)			9
	10	Guaranteed payments to partners			10
	11	Repairs and maintenance			11
	12	Bad debts			12
	13	Rent			13
	14	Taxes and licenses			14
	15	Interest			15
	16a	Depreciation (if required, attach Form 4562)	16a		
	b	Less depreciation reported elsewhere on return	16b		16c
	17	Depletion (**Do not** deduct oil and gas depletion.)			17
	18	Retirement plans, etc.			18
	19	Employee benefit programs			19
	20	Other deductions (attach statement)			20
	21	**Total deductions.** Add the amounts shown in the far right column for lines 9 through 20			21
	22	**Ordinary business income (loss)** from trade or business activities. Subtract line 21 from line 8			22

*

Schedule K	Partners' Distributive Share Items		Total amount
Income (Loss)	1 Ordinary business income (loss) (page 2, line 22)	1	
	2 Net rental real estate income (loss) (attach Form 8825)	2	
	3a Other gross rental income (loss) 3a		
	b Expenses from other rental activities (attach statement) 3b		
	c Other net rental income (loss). Subtract line 3b from line 3a	3c	
	4 Guaranteed payments	4	
	5 Interest income	5	
	6 Dividends: a Ordinary dividends	6a	
	b Qualified dividends 6b		
	7 Royalties	7	
	8 Net short-term capital gain (loss) (attach Schedule D (Form 1065))	8	
	9a Net long-term capital gain (loss) (attach Schedule D (Form 1065))	9a	
	b Collectibles (28%) gain (loss) 9b		
	c Unrecaptured section 1250 gain (attach statement) 9c		
	10 Net section 1231 gain (loss) (attach Form 4797)	10	
	11 Other income (loss) (see instructions) Type ▶	11	
Deductions	12 Section 179 deduction (attach Form 4562)	12	
	13a Contributions	13a	
	b Investment interest expense	13b	
	c Section 59(e)(2) expenditures: (1) Type ▶ _____ (2) Amount ▶	13c(2)	
	d Other deductions (see instructions) Type ▶	13d	
Self-Employment	14a Net earnings (loss) from self-employment	14a	
	b Gross farming or fishing income	14b	
	c Gross nonfarm income	14c	
Credits	15a Low-income housing credit (section 42(j)(5))	15a	
	b Low-income housing credit (other)	15b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468)	15c	
	d Other rental real estate credits (see instructions) Type ▶ _____	15d	
	e Other rental credits (see instructions) Type ▶ _____	15e	
	f Other credits (see instructions) Type ▶	15f	
Foreign Transactions	16a Name of country or U.S. possession ▶ _____		
	b Gross income from all sources	16b	
	c Gross income sourced at partner level	16c	
	Foreign gross income sourced at partnership level		
	d Passive category ▶ _____ e General category ▶ _____ f Other (attach statement) ▶	16f	
	Deductions allocated and apportioned at partner level		
	g Interest expense ▶ _____ h Other ▶	16h	
	Deductions allocated and apportioned at partnership level to foreign source income		
	i Passive category ▶ _____ j General category ▶ _____ k Other (attach statement) ▶	16k	
	l Total foreign taxes (check one): ▶ ☐ Paid ☐ Accrued	16l	
	m Reduction in taxes available for credit (attach statement)	16m	
	n Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	17a Post-1986 depreciation adjustment	17a	
	b Adjusted gain or loss	17b	
	c Depletion (other than oil and gas)	17c	
	d Oil, gas, and geothermal properties - gross income	17d	
	e Oil, gas, and geothermal properties - deductions	17e	
	f Other AMT items (attach statement)	17f	
Other Information	18a Tax-exempt interest income	18a	
	b Other tax-exempt income	18b	
	c Nondeductible expenses	18c	
	19a Distributions of cash and marketable securities	19a	
	b Distributions of other property	19b	
	20a Investment income	20a	
	b Investment expenses	20b	
	c Other items and amounts (attach statement)		

Schedule L **Balance Sheets per Books.** (Not required if Item G9, page 1, is answered "Yes.")

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
1 Cash				
2 a Trade notes and accounts receivable				
b Less allowance for bad debts				
3 Inventories				
4 U.S. government obligations				
5 Tax-exempt securities				
6 Other current assets (attach statement)				
7a Loans to partners (or persons related to partners)				
b Mortgage and real estate loans				
8 Other investments (attach statement)				
9 a Buildings and other depreciable assets				
b Less accumulated depreciation				
10 a Depletable assets				
b Less accumulated depletion				
11 Land (net of any amortization)				
12 a Intangible assets (amortizable only)				
b Less accumulated amortization				
13 Other assets (attach statement)				
14 **Total** assets				
Liabilities and Capital				
15 Accounts payable				
16 Mortgages, notes, bonds payable in less than 1 year				
17 Other current liabilities (attach statement)				
18 All nonrecourse loans				
19 a Loans from partners (or persons related to partners)				
b Mortgages, notes, bonds payable in 1 year or more				
20 Other liabilities (attach statement)				
21 Partners' capital accounts				
22 **Total** liabilities and capital				

Schedule M Balance Sheets for Interest Allocation

	(a) Beginning of tax year	(b) End of tax year
1 Total U.S. assets		
2 Total foreign assets:		
a Passive category		
b General category		
c Other (attach statement)		

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return. (Not required if Item G9, page 1, is answered "Yes.")

1 Net income (loss) per books		6 Income recorded on books this year not included on Schedule K, lines 1 through 11 (itemize):	
2 Income included on Schedule K, lines 1, 2, 3c, 5, 6a, 7, 8, 9a, 10, and 11 not recorded on books this year (itemize):		a Tax-exempt interest $	
3 Guaranteed payments (other than health insurance)		7 Deductions included on Schedule K, lines 1 through 13d, and 16l not charged against book income this year (itemize):	
4 Expenses recorded on books this year not included on Schedule K, lines 1 through 13d, and 16l (itemize):		a Depreciation $	
a Depreciation $			
b Travel and entertainment $		8 Add lines 6 and 7	
		9 Income (loss). Subtract line 8 from line 5	
5 Add lines 1 through 4			

Schedule M-2 Analysis of Partners' Capital Accounts. (Not required if Item G9, page 1, is answered "Yes.")

1 Balance at beginning of year		6 Distributions: a Cash	
2 Capital contributed:		b Property	
a Cash		7 Other decreases (itemize):	
b Property			
3 Net income (loss) per books			
4 Other increases (itemize):		8 Add lines 6 and 7	
		9 Balance at end of year. Subtract line 8 from line 5	
5 Add lines 1 through 4			

Form **8865** (2013)

Schedule N Transactions Between Controlled Foreign Partnership and Partners or Other Related Entities

Important: Complete a separate Form 8865 and Schedule N for each controlled foreign partnership. Enter the totals for each type of transaction that occurred between the foreign partnership and the persons listed in columns (a) through (d).

Transactions of foreign partnership	**(a)** U.S. person filing this return	**(b)** Any domestic corporation or partnership controlling or controlled by the U.S. person filing this return	**(c)** Any other foreign corporation or partnership controlling or controlled by the U.S. person filing this return	**(d)** Any U.S. person with a 10% or more direct interest in the controlled foreign partnership (other than the U.S. person filing this return)
1 Sales of inventory				
2 Sales of property rights (patents, trademarks, etc.)				
3 Compensation received for technical, managerial, engineering, construction, or like services				
4 Commissions received				
5 Rents, royalties, and license fees received				
6 Distributions received				
7 Interest received				
8 Other				
9 Add lines 1 through 8				
10 Purchases of inventory				
11 Purchases of tangible property other than inventory				
12 Purchases of property rights (patents, trademarks, etc.)				
13 Compensation paid for technical, managerial, engineering, construction, or like services				
14 Commissions paid				
15 Rents, royalties, and license fees paid				
16 Distributions paid				
17 Interest paid				
18 Other				
19 Add lines 10 through 18				
20 Amounts borrowed (enter the maximum loan balance during the year). See instructions				
21 Amounts loaned (enter the maximum loan balance during the year). See instructions				

SCHEDULE O (Form 8865)
Department of the Treasury
Internal Revenue Service

Transfer of Property to a Foreign Partnership (under section 6038B)

▶ Attach to Form 8865. See Instructions for Form 8865.
▶ Information about Schedule O (Form 8865) and its separate instructions is at *www.irs.gov/form8865*.

OMB No. 1545-1668
2013

Name of transferor	Filer's identifying number
THE STAMFORD HOSPITAL	06-0646917

Name of foreign partnership	EIN (if any)	Reference ID number (see instructions)
RIVERSTONE GLOBAL ENERGY AND POWER FUND	30-0745378	

Part I Transfers Reportable Under Section 6038B

Type of property	(a) Date of transfer	(b) Number of items transferred	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Section 704(c) allocation method	(f) Gain recognized on transfer	(g) Percentage interest in partnership after transfer
Cash	VAR		538,275.				.058
Stock, notes receivable and payable, and other securities							
Inventory							
Tangible property used in trade or business							
Intangible property							
Other property							

Supplemental Information Required To Be Reported (see instructions):

Part II Dispositions Reportable Under Section 6038B

(a) Type of property	(b) Date of original transfer	(c) Date of disposition	(d) Manner of disposition	(e) Gain recognized by partnership	(f) Depreciation recapture recognized by partnership	(g) Gain allocated to partner	(h) Depreciation recapture allocated to partner

Part III

Is any transfer reported on this schedule subject to gain recognition under section 904(f)(3) or section 904(f)(5)(F)? . . . . . ▶ ☐ Yes ☒ No

Form **8865**

Department of the Treasury
Internal Revenue Service

Return of U.S. Persons With Respect to Certain Foreign Partnerships

▶ **Attach to your tax return.**
▶ **Information about Form 8865 and its separate instructions is at *www.irs.gov/form8865.***
Information furnished for the foreign partnership's tax year
beginning 01/01/2013 , and ending 12/31/2013

OMB No. 1545-1668

2013

Attachment
Sequence No. **118**

Name of person filing this return	**Filer's identifying number**
THE STAMFORD HOSPITAL	06-0646917

Filer's address (if you are not filing this form with your tax return)
30 SHELBURNE RD, P.O. BOX 9317
STAMFORD, CT 06902

A Category of filer (see **Categories of Filers** in the instructions and check applicable box(es)):
1 [ ] 2 [ ] 3 [X] 4 [ ]

B Filer's tax year beginning 10/01/2013 , and ending 09/30/2014

C Filer's share of liabilities: Nonrecourse $ Qualified nonrecourse financing $ Other $

D If filer is a member of a consolidated group but not the parent, enter the following information about the parent:

Name | EIN

Address

E Information about certain other partners (see instructions)

(1) Name	(2) Address	(3) Identifying number	(4) Check applicable box(es)		
			Category 1	Category 2	Constructive owner

F1 Name and address of foreign partnership
RIVERSTONE GLOBAL ENERGY AND POWER FUND V FT
712 FIFTH AVENUE, 19TH FLOOR
NEW YORK, NY 10019

2(a) EIN (if any) 30-0745378

2(b) Reference ID number (see instr.)

3 Country under whose laws organized

4 Date of organization	**5** Principal place of business	**6** Principal business activity code number	**7** Principal business activity	**8a** Functional currency	**8b** Exchange rate (see instr.)
02/23/2012		523900	INVESTMENTS	USD	1.000000000000

G Provide the following information for the foreign partnership's tax year:

1 Name, address, and identifying number of agent (if any) in the United States

2 Check if the foreign partnership must file:
[ ] Form 1042 [ ] Form 8804 [X] Form 1065 or 1065-B
Service Center where Form 1065 or 1065-B is filed: OGDEN

3 Name and address of foreign partnership's agent in country of organization, if any

4 Name and address of person(s) with custody of the books and records of the foreign partnership, and the location of such books and records, if different

5 Were any special allocations made by the foreign partnership? ▶ [ ] Yes [X] No

6 Enter the number of Forms 8858, Information Return of U.S. Persons With Respect To Foreign Disregarded Entities, attached to this return (see instructions) ▶

7 How is this partnership classified under the law of the country in which it is organized? ▶ PARTNERSHIP

8a Does the filer have an interest in the foreign partnership, or an interest indirectly through the foreign partnership, that is a separate unit under Reg. 1.1503(d)-1(b)(4) or part of a combined separate unit under Reg. 1.1503(d)-1(b)(4)(ii)? If "No," skip question 8b. ▶ [ ] Yes [X] No

b If "Yes," does the separate unit or combined separate unit have a dual consolidated loss as defined in Reg. 1.1503(d)-1(b)(5)(ii)? ▶ [ ] Yes [ ] No

9 Does this partnership meet **both** of the following requirements?
- The partnership's total receipts for the tax year were less than $250,000 and
- The value of the partnership's total assets at the end of the tax year was less than $1 million.

If "Yes," **do not** complete Schedules L, M-1, and M-2. ▶ [ ] Yes [ ] No

Sign Here Only If You Are Filing This Form Separately and Not With Your Tax Return.

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

▶ Signature of general partner or limited liability company member — ▶ Date

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN

Firm's name ▶ ERNST & YOUNG U.S. LLP — Firm's EIN ▶ 34-6565596

Firm's address ▶ 111 MONUMENT CIRCLE, STE 4000
INDIANAPOLIS, IN 46204 — Phone no. 317-681-7000

Schedule A **Constructive Ownership of Partnership Interest.** Check the boxes that apply to the filer. If you check box **b,** enter the name, address, and U.S. taxpayer identifying number (if any) of the person(s) whose interest you constructively own. See instructions.

a [X] Owns a direct interest **b** [ ] Owns a constructive interest

Name	Address	Identifying number (if any)	Check if foreign person	Check if direct partner

Schedule A-1 **Certain Partners of Foreign Partnership** (see instructions)

Name	Address	Identifying number (if any)	Check if foreign person

Does the partnership have any other foreign person as a direct partner? [ ] **Yes** [ ] **No**

Schedule A-2 **Affiliation Schedule.** List all partnerships (foreign or domestic) in which the foreign partnership owns a direct interest or indirectly owns a 10% interest.

Name	Address	EIN (if any)	Total ordinary income or loss	Check if foreign partnership

Schedule B **Income Statement - Trade or Business Income**

Caution. Include **only** trade or business income and expenses on lines 1a through 22 below. See the instructions for more information.

Income	1a	Gross receipts or sales	1a		
	b	Less returns and allowances	1b		1c
	2	Cost of goods sold			2
	3	Gross profit. Subtract line 2 from line 1c			3
	4	Ordinary income (loss) from other partnerships, estates, and trusts (attach statement) *			4
	5	Net farm profit (loss) (attach Schedule F (Form 1040))			5
	6	Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797)			6
	7	Other income (loss) (attach statement)			7
	8	**Total income (loss).** Combine lines 3 through 7			8
Deductions (see instructions for limitations)	9	Salaries and wages (other than to partners) (less employment credits)			9
	10	Guaranteed payments to partners			10
	11	Repairs and maintenance			11
	12	Bad debts			12
	13	Rent			13
	14	Taxes and licenses			14
	15	Interest			15
	16a	Depreciation (if required, attach Form 4562)	16a		
	b	Less depreciation reported elsewhere on return	16b		16c
	17	Depletion (**Do not** deduct oil and gas depletion.)			17
	18	Retirement plans, etc.			18
	19	Employee benefit programs			19
	20	Other deductions (attach statement)			20
	21	**Total deductions.** Add the amounts shown in the far right column for lines 9 through 20			21
	22	**Ordinary business income (loss)** from trade or business activities. Subtract line 21 from line 8			22

*

Schedule K	Partners' Distributive Share Items		Total amount
Income (Loss)	1 Ordinary business income (loss) (page 2, line 22)	1	
	2 Net rental real estate income (loss) (attach Form 8825)	2	
	3a Other gross rental income (loss) 3a		
	b Expenses from other rental activities (attach statement) 3b		
	c Other net rental income (loss). Subtract line 3b from line 3a	3c	
	4 Guaranteed payments	4	
	5 Interest income	5	
	6 Dividends: a Ordinary dividends	6a	
	b Qualified dividends 6b		
	7 Royalties	7	
	8 Net short-term capital gain (loss) (attach Schedule D (Form 1065))	8	
	9a Net long-term capital gain (loss) (attach Schedule D (Form 1065))	9a	
	b Collectibles (28%) gain (loss) 9b		
	c Unrecaptured section 1250 gain (attach statement) 9c		
	10 Net section 1231 gain (loss) (attach Form 4797)	10	
	11 Other income (loss) (see instructions) Type ▶	11	
Deductions	12 Section 179 deduction (attach Form 4562)	12	
	13a Contributions	13a	
	b Investment interest expense	13b	
	c Section 59(e)(2) expenditures: (1) Type ▶ _____ (2) Amount ▶	13c(2)	
	d Other deductions (see instructions) Type ▶	13d	
Self-Employment	14a Net earnings (loss) from self-employment	14a	
	b Gross farming or fishing income	14b	
	c Gross nonfarm income	14c	
Credits	15a Low-income housing credit (section 42(j)(5))	15a	
	b Low-income housing credit (other)	15b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468)	15c	
	d Other rental real estate credits (see instructions) Type ▶ _____	15d	
	e Other rental credits (see instructions) Type ▶ _____	15e	
	f Other credits (see instructions) Type ▶	15f	
Foreign Transactions	16a Name of country or U.S. possession ▶ _____		
	b Gross income from all sources	16b	
	c Gross income sourced at partner level	16c	
	Foreign gross income sourced at partnership level		
	d Passive category ▶ _____ e General category ▶ _____ f Other (attach statement) ▶	16f	
	Deductions allocated and apportioned at partner level		
	g Interest expense ▶ _____ h Other ▶	16h	
	Deductions allocated and apportioned at partnership level to foreign source income		
	i Passive category ▶ _____ j General category ▶ _____ k Other (attach statement) ▶	16k	
	l Total foreign taxes (check one): ▶ ☐ Paid ☐ Accrued	16l	
	m Reduction in taxes available for credit (attach statement)	16m	
	n Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	17a Post-1986 depreciation adjustment	17a	
	b Adjusted gain or loss	17b	
	c Depletion (other than oil and gas)	17c	
	d Oil, gas, and geothermal properties - gross income	17d	
	e Oil, gas, and geothermal properties - deductions	17e	
	f Other AMT items (attach statement)	17f	
Other Information	18a Tax-exempt interest income	18a	
	b Other tax-exempt income	18b	
	c Nondeductible expenses	18c	
	19a Distributions of cash and marketable securities	19a	
	b Distributions of other property	19b	
	20a Investment income	20a	
	b Investment expenses	20b	
	c Other items and amounts (attach statement)		

Schedule L **Balance Sheets per Books.** (Not required if Item G9, page 1, is answered "Yes.")

Assets	Beginning of tax year (a)	Beginning of tax year (b)	End of tax year (c)	End of tax year (d)
1 Cash				
2 a Trade notes and accounts receivable				
b Less allowance for bad debts				
3 Inventories				
4 U.S. government obligations				
5 Tax-exempt securities				
6 Other current assets (attach statement)				
7a Loans to partners (or persons related to partners)				
b Mortgage and real estate loans				
8 Other investments (attach statement)				
9 a Buildings and other depreciable assets				
b Less accumulated depreciation				
10 a Depletable assets				
b Less accumulated depletion				
11 Land (net of any amortization)				
12 a Intangible assets (amortizable only)				
b Less accumulated amortization				
13 Other assets (attach statement)				
14 **Total** assets				
Liabilities and Capital				
15 Accounts payable				
16 Mortgages, notes, bonds payable in less than 1 year				
17 Other current liabilities (attach statement)				
18 All nonrecourse loans				
19 a Loans from partners (or persons related to partners)				
b Mortgages, notes, bonds payable in 1 year or more				
20 Other liabilities (attach statement)				
21 Partners' capital accounts				
22 **Total** liabilities and capital				

Schedule M Balance Sheets for Interest Allocation

	(a) Beginning of tax year	(b) End of tax year
1 Total U.S. assets		
2 Total foreign assets:		
a Passive category		
b General category		
c Other (attach statement)		

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return. (Not required if Item G9, page 1, is answered "Yes.")

1 Net income (loss) per books		6 Income recorded on books this year not included on Schedule K, lines 1 through 11 (itemize):	
2 Income included on Schedule K, lines 1, 2, 3c, 5, 6a, 7, 8, 9a, 10, and 11 not recorded on books this year (itemize):		a Tax-exempt interest $	
3 Guaranteed payments (other than health insurance)		7 Deductions included on Schedule K, lines 1 through 13d, and 16l not charged against book income this year (itemize):	
4 Expenses recorded on books this year not included on Schedule K, lines 1 through 13d, and 16l (itemize):		a Depreciation $	
a Depreciation $			
b Travel and entertainment $		8 Add lines 6 and 7	
		9 Income (loss). Subtract line 8 from line 5	
5 Add lines 1 through 4			

Schedule M-2 Analysis of Partners' Capital Accounts. (Not required if Item G9, page 1, is answered "Yes.")

1 Balance at beginning of year		6 Distributions: a Cash	
2 Capital contributed:		b Property	
a Cash		7 Other decreases (itemize):	
b Property			
3 Net income (loss) per books			
4 Other increases (itemize):		8 Add lines 6 and 7	
		9 Balance at end of year. Subtract line 8 from line 5	
5 Add lines 1 through 4			

Form **8865** (2013)

Schedule N Transactions Between Controlled Foreign Partnership and Partners or Other Related Entities

Important: Complete a separate Form 8865 and Schedule N for each controlled foreign partnership. Enter the totals for each type of transaction that occurred between the foreign partnership and the persons listed in columns (a) through (d).

Transactions of foreign partnership	**(a)** U.S. person filing this return	**(b)** Any domestic corporation or partnership controlling or controlled by the U.S. person filing this return	**(c)** Any other foreign corporation or partnership controlling or controlled by the U.S. person filing this return	**(d)** Any U.S. person with a 10% or more direct interest in the controlled foreign partnership (other than the U.S. person filing this return)
1 Sales of inventory				
2 Sales of property rights (patents, trademarks, etc.)				
3 Compensation received for technical, managerial, engineering, construction, or like services				
4 Commissions received				
5 Rents, royalties, and license fees received				
6 Distributions received				
7 Interest received				
8 Other				
9 Add lines 1 through 8				
10 Purchases of inventory				
11 Purchases of tangible property other than inventory				
12 Purchases of property rights (patents, trademarks, etc.)				
13 Compensation paid for technical, managerial, engineering, construction, or like services				
14 Commissions paid				
15 Rents, royalties, and license fees paid				
16 Distributions paid				
17 Interest paid				
18 Other				
19 Add lines 10 through 18				
20 Amounts borrowed (enter the maximum loan balance during the year). See instructions				
21 Amounts loaned (enter the maximum loan balance during the year). See instructions				

SCHEDULE O (Form 8865)
Department of the Treasury
Internal Revenue Service

Transfer of Property to a Foreign Partnership (under section 6038B)

▶ Attach to Form 8865. See Instructions for Form 8865.
▶ Information about Schedule O (Form 8865) and its separate instructions is at *www.irs.gov/form8865*.

OMB No. 1545-1668
2013

Name of transferor	Filer's identifying number
THE STAMFORD HOSPITAL	06-0646917

Name of foreign partnership	EIN (if any)	Reference ID number (see instructions)
RIVERSTONE GLOBAL ENERGY AND POWER FUND	30-0745378	

Part I Transfers Reportable Under Section 6038B

Type of property	(a) Date of transfer	(b) Number of items transferred	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Section 704(c) allocation method	(f) Gain recognized on transfer	(g) Percentage interest in partnership after transfer
Cash	VAR		385,384.				.053
Stock, notes receivable and payable, and other securities							
Inventory							
Tangible property used in trade or business							
Intangible property							
Other property							

Supplemental Information Required To Be Reported (see instructions):

Part II Dispositions Reportable Under Section 6038B

(a) Type of property	(b) Date of original transfer	(c) Date of disposition	(d) Manner of disposition	(e) Gain recognized by partnership	(f) Depreciation recapture recognized by partnership	(g) Gain allocated to partner	(h) Depreciation recapture allocated to partner

Part III

Is any transfer reported on this schedule subject to gain recognition under section 904(f)(3) or section 904(f)(5)(F)? . . . . . ▶ ☐ Yes ☒ No

Form **5471**
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Information Return of U.S. Persons With Respect To Certain Foreign Corporations

▶ **For more information about Form 5471, see *www.irs.gov/form5471***

Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning 10/01/2013 , and ending 09/30/2014

OMB No. 1545-0704

Attachment Sequence No. **121**

Name of person filing this return	**A** Identifying number
THE STAMFORD HOSPITAL	06-0646917
Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)	**B** Category of filer (See instructions. Check applicable box(es)):
30 SHELBURNE RD, P.O. BOX 9317	1 (repealed) 2 ☐ 3 ☐ 4 ☒ 5 ☒
City or town, state, and ZIP code	**C** Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 100.0000 %
STAMFORD CT 06902	

Filer's tax year beginning 10/01/2013 , and ending 09/30/2014

D Person(s) on whose behalf this information return is filed:

(1) Name	(2) Address	(3) Identifying number	(4) Check applicable box(es)		
			Shareholder	Officer	Director

Important: *Fill in all applicable lines and schedules. All information **must** be in English. All amounts **must** be stated in U.S. dollars unless otherwise indicated.*

1a Name and address of foreign corporation

HEALTHSTAR INDEMNITY COMPANY, LTD
FP PERRY BUILDING, 40 CHURCH STREET
HAMILTON, BERMUDA HM HX BD

b(1) Employer identification number, if any: FOREIGN

b(2) Reference ID number (see instructions): HSTAR6917

c Country under whose laws incorporated: BERMUDA

d Date of incorporation	**e** Principal place of business	**f** Principal business activity code number	**g** Principal business activity	**h** Functional currency
11/29/2002	BD	524290	INSURANCE	USD

2 Provide the following information for the foreign corporation's accounting period stated above.

a Name, address, and identifying number of branch office or agent (if any) in the United States

N/A

,

b If a U.S. income tax return was filed, enter:

(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)

c Name and address of foreign corporation's statutory or resident agent in country of incorporation

QUEST MANAGEMENT SERVICES LIMITED
40 CHURCH STREET
HAMILTON HM 11 BD

d Name and address (including corporate department, if applicable) of person (or persons) with custody of the books and records of the foreign corporation, and the location of such books and records, if different

THE STAMFORD HOSPITAL FINANCE DEPARTMENT
30 SHELBURNE ROAD, P.O. BOX 9317
STAMFORD, CT 06902

Schedule A Stock of the Foreign Corporation

(a) Description of each class of stock	**(b)** Number of shares issued and outstanding	
	(i) Beginning of annual accounting period	*(ii)* End of annual accounting period
COMMON	120,000.	120,000.

Schedule B U.S. Shareholders of Foreign Corporation (see instructions)

(a) Name, address, and identifying number of shareholder	(b) Description of each class of stock held by shareholder. **Note:** *This description should match the corresponding description entered in Schedule A, column (a).*	(c) Number of shares held at beginning of annual accounting period	(d) Number of shares held at end of annual accounting period	(e) Pro rata share of subpart F income (enter as a percentage)
THE STAMFORD HOSPITAL	COMMON	120,000.	120,000.	
SHELBURNE RD P.O. BOX 9317				
STAMFORD CT 06902				
06-0646917				100.000

Schedule C Income Statement (see instructions)

Important: *Report all information in functional currency in accordance with U.S. GAAP. Also, report each amount in U.S. dollars translated from functional currency (using GAAP translation rules). However, if the functional currency is the U.S. dollar, complete only the U.S. Dollars column. See instructions for special rules for DASTM corporations.*

				Functional Currency	U.S. Dollars
Income	1 a	Gross receipts or sales	1a		7,600,000.
	b	Returns and allowances	1b		
	c	Subtract line 1b from line 1a	1c		7,600,000.
	2	Cost of goods sold	2		
	3	Gross profit (subtract line 2 from line 1c)	3		7,600,000.
	4	Dividends	4		
	5	Interest	5		1,219,938.
	6 a	Gross rents	6a		
	b	Gross royalties and license fees	6b		
	7	Net gain or (loss) on sale of capital assets	7		
	8	Other income (attach statement) ATTACHMENT 1	8		957,360.
	9	Total income (add lines 3 through 8)	9		9,777,298.
Deductions	10	Compensation not deducted elsewhere	10		
	11 a	Rents	11a		
	b	Royalties and license fees	11b		
	12	Interest	12		
	13	Depreciation not deducted elsewhere	13		
	14	Depletion	14		
	15	Taxes (exclude provision for income, war profits, and excess profits taxes)	15		
	16	Other deductions (attach statement - exclude provision for income, war profits, and excess profits taxes) ATTACHMENT 2	16		6,235,727.
	17	Total deductions (add lines 10 through 16)	17		6,235,727.
Net Income	18	Net income or (loss) before extraordinary items, prior period adjustments, and the provision for income, war profits, and excess profits taxes (subtract line 17 from line 9)	18		3,541,571.
	19	Extraordinary items and prior period adjustments (see instructions)	19		
	20	Provision for income, war profits, and excess profits taxes (see instructions)	20		
	21	Current year net income or (loss) per books (combine lines 18 through 20)	21		3,541,571.

Schedule E Income, War Profits, and Excess Profits Taxes Paid or Accrued (see instructions)

	(a) Name of country or U.S. possession	Amount of tax (b) In foreign currency	(c) Conversion rate	(d) In U.S. dollars
1	U.S.			
2				
3				
4				
5				
6				
7				
8	Total ▶			

Schedule F Balance Sheet

Important: *Report all amounts in U.S. dollars prepared and translated in accordance with U.S. GAAP. See instructions for an exception for DASTM corporations.*

	Assets		(a) Beginning of annual accounting period	(b) End of annual accounting period
1	Cash	1	64,259,382.	72,287,917.
2a	Trade notes and accounts receivable	2a	150,004.	
b	Less allowance for bad debts	2b	( )	( )
3	Inventories	3		
4	Other current assets (attach statement) ATTACHMENT 3	4	4,052,463.	3,420,391.
5	Loans to shareholders and other related persons	5		
6	Investment in subsidiaries (attach statement)	6		
7	Other investments (attach statement)	7		
8a	Buildings and other depreciable assets	8a		
b	Less accumulated depreciation	8b	( )	( )
9a	Depletable assets	9a		
b	Less accumulated depletion	9b	( )	( )
10	Land (net of any amortization)	10		
11	Intangible assets:			
a	Goodwill	11a		
b	Organization costs	11b		
c	Patents, trademarks, and other intangible assets	11c		
d	Less accumulated amortization for lines 11a, b, and c	11d	( )	( )
12	Other assets (attach statement)	12		
13	Total assets	13	68,461,849.	75,708,308.
	Liabilities and Shareholders' Equity			
14	Accounts payable	14	105,243.	50,620.
15	Other current liabilities (attach statement)	15		
16	Loans from shareholders and other related persons	16		
17	Other liabilities (attach statement) ATTACHMENT 4	17	30,078,358.	33,837,869.
18	Capital stock:			
a	Preferred stock	18a		
b	Common stock	18b	120,000.	120,000.
19	Paid-in or capital surplus (attach reconciliation) ATTACHMENT 5	19	11,788,063.	11,788,063.
20	Retained earnings	20	26,370,185.	29,911,756.
21	Less cost of treasury stock	21	( )	( )
22	Total liabilities and shareholders' equity	22	68,461,849.	75,708,308.

Schedule G Other Information

		Yes	No
1	During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership? If "Yes," see the instructions for required statement.		X
2	During the tax year, did the foreign corporation own an interest in any trust?		X
3	During the tax year, did the foreign corporation own any foreign entities that were disregarded as entities separate from their owners under Regulations sections 301.7701-2 and 301.7701-3 (see instructions)? If "Yes," you are generally required to attach Form 8858 for each entity (see instructions).		X
4	During the tax year, was the foreign corporation a participant in any cost sharing arrangement?		X
5	During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement?		X
6	During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4? If "Yes," attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(i)(G).		X
7	During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)?		X
8	During the tax year, did the foreign corporation pay or accrue foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended?		X

Schedule H Current Earnings and Profits (see instructions)

Important: *Enter the amounts on lines 1 through 5c in **functional** currency.*

		Net Additions	Net Subtractions		
1	Current year net income or (loss) per foreign books of account			1	3,541,571.
2	Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):				
a	Capital gains or losses				
b	Depreciation and amortization				
c	Depletion				
d	Investment or incentive allowance				
e	Charges to statutory reserves				
f	Inventory adjustments				
g	Taxes				
h	Other (attach statement) ATCH 6	7,600,000.	5,398,542.		
3	Total net additions	7,600,000.			
4	Total net subtractions		5,398,542.		
5a	Current earnings and profits (line 1 plus line 3 minus line 4)			5a	5,743,029.
b	DASTM gain or (loss) for foreign corporations that use DASTM (see instructions)			5b	
c	Combine lines 5a and 5b			5c	5,743,029.
d	Current earnings and profits in U.S. dollars (line 5c translated at the appropriate exchange rate as defined in section 989(b) and the related regulations (see instructions)) Enter exchange rate used for line 5d ▶			5d	

Schedule I Summary of Shareholder's Income From Foreign Corporation (see instructions)

If item D on page 1 is completed, a separate Schedule I must be filed for each Category 4 or 5 filer for whom reporting is furnished on this Form 5471. This Schedule I is being completed for:

Name of U.S. shareholder ▶THE STAMFORD HOSPITAL Identifying number ▶ 06-0646917

1	Subpart F income (line 38b, Worksheet A in the instructions)	1	
2	Earnings invested in U.S. property (line 17, Worksheet B in the instructions)	2	
3	Previously excluded subpart F income withdrawn from qualified investments (line 6b, Worksheet C in the instructions)	3	
4	Previously excluded export trade income withdrawn from investment in export trade assets (line 7b, Worksheet D in the instructions)	4	
5	Factoring income	5	
6	Total of lines 1 through 5. Enter here and on your income tax return. See instructions	6	
7	Dividends received (translated at spot rate on payment date under section 989(b)(1))	7	
8	Exchange gain or (loss) on a distribution of previously taxed income	8	

	Yes	No
• Was any income of the foreign corporation blocked?		X
• Did any such income become unblocked during the tax year (see section 964(b))?		X

If the answer to either question is "Yes," attach an explanation.

SCHEDULE J (Form 5471)
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Accumulated Earnings and Profits (E&P) of Controlled Foreign Corporation

▶ **Information about Schedule J (Form 5471) and its instructions is at *www.irs.gov/form5471.***
▶ **Attach to Form 5471.**

OMB No. 1545-0704

Name of person filing Form 5471		**Identifying number**
THE STAMFORD HOSPITAL		06-0646917
Name of foreign corporation	EIN (if any)	Reference ID number (see instructions)
HEALTHSTAR INDEMNITY COMPANY, LTD	FOREIGN	HSTAR6917

Important: Enter amounts in functional currency.	**(a)** Post-1986 Undistributed Earnings (post-86 section 959(c)(3) balance)	**(b)** Pre-1987 E&P Not Previously Taxed (pre-87 section 959(c)(3) balance)	**(c)** Previously Taxed E&P (see instructions) (sections 959(c)(1) and (2) balances)			**(d)** Total Section 964(a) E&P (combine columns (a), (b), and (c))
			(i) Earnings Invested in U.S. Property	*(ii)* Earnings Invested in Excess Passive Assets	*(iii)* Subpart F Income	
1 Balance at beginning of year	13,602,767.					13,602,767.
2a Current year E&P	5,743,029.					
b Current year deficit in E&P						
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a **or** line 1 minus line 2b)	19,345,796.					
4 Amounts included under section 951(a) or reclassified under section 959(c) in current year						
5a Actual distributions or reclassifications of previously taxed E&P						
b Actual distributions of nonpreviously taxed E&P						
6a Balance of previously taxed E&P at end of year (line 1 plus line 4, minus line 5a)						
b Balance of E&P not previously taxed at end of year (line 3 minus line 4, minus line 5b)	19,345,796.					
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	19,345,796.					19,345,796.

For Paperwork Reduction Act Notice, see the Instructions for Form 5471.

Schedule J (Form 5471) (Rev. 12-2012)

JSA
3X1665 1.000

SCHEDULE M (Form 5471)
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Transactions Between Controlled Foreign Corporation and Shareholders or Other Related Persons

▶ **Information about Schedule M (Form 5471) and its instructions is at *www.irs.gov/form5471*.**
▶ **Attach to Form 5471.**

OMB No. 1545-0704

Name of person filing Form 5471: THE STAMFORD HOSPITAL
Identifying number: 06-0646917

Name of foreign corporation: HEALTHSTAR INDEMNITY COMPANY, LTD
EIN (if any): FOREIGN
Reference ID number (see instructions): HSTAR6917

Important: *Complete a **separate** Schedule M for each controlled foreign corporation. Enter the totals for each type of transaction that occurred during the annual accounting period between the foreign corporation and the persons listed in columns (b) through (f). All amounts must be stated in U.S. dollars translated from functional currency at the average exchange rate for the foreign corporation's tax year. See instructions.*

Enter the relevant functional currency and the exchange rate used throughout this schedule ▶ USD

	(a) Transactions of foreign corporation	**(b)** U.S. person filing this return	**(c)** Any domestic corporation or partnership controlled by U.S. person filing this return	**(d)** Any other foreign corporation or partnership controlled by U.S. person filing this return	**(e)** 10% or more U.S. shareholder of controlled foreign corporation (other than the U.S. person filing this return)	**(f)** 10% or more U.S. shareholder of any corporation controlling the foreign corporation
1	Sales of stock in trade (inventory)					
2	Sales of tangible property other than stock in trade					
3	Sales of property rights (patents, trademarks, etc.)					
4	Platform contribution transaction payments received					
5	Cost sharing transaction payments received					
6	Compensation received for technical, managerial, engineering, construction, or like services					
7	Commissions received					
8	Rents, royalties, and license fees received					
9	Dividends received (exclude deemed distributions under subpart F and distributions of previously taxed income)					
10	Interest received					
11	Premiums received for insurance or reinsurance					
12	Add lines 1 through 11					
13	Purchases of stock in trade (inventory)					
14	Purchases of tangible property other than stock in trade					
15	Purchases of property rights (patents, trademarks, etc.)					
16	Platform contribution transaction payments paid					
17	Cost sharing transaction payments paid					
18	Compensation paid for technical, managerial, engineering, construction, or like services					
19	Commissions paid					
20	Rents, royalties, and license fees paid					
21	Dividends paid					
22	Interest paid					
23	Premiums paid for insurance or reinsurance					
24	Add lines 13 through 23					
25	Amounts borrowed (enter the maximum loan balance during the year) - see instructions					
26	Amounts loaned (enter the maximum loan balance during the year) - see instructions					

FORM 5471, PAGE 2 DETAIL

ATTACHMENT 1

SCH C, LINE 8 - OTHER INCOME

UNREALIZED GAIN/LOSS ON INVESTMENTS	652,938.
REALIZED GAIN	304,422.
TOTAL	957,360.

ATTACHMENT 2

SCH C, LINE 16 - OTHER DEDUCTIONS

LOSSES PAID	1,127,001.
CHANGE IN OSLR	4,447,001.
CHANGE IN CASE DEVELOPMENT RESERVES	-175,460.
AUDIT FEES	39,276.
CONSULTING FEES	134,209.
LEGAL CONSULTING FEES	4,045.
CORPORATE SECRETARIAL FEES	6,342.
GOVERNMENT AND INSURANCE FEES	12,302.
TRAVEL EXPENSES	29,485.
BANK CHARGES	662.
CUSTODY FEES	17,825.
INVESTMENT FEES	25,225.
MANAGEMENT FEES	80,500.
MISCELLANEOUS	1,333.
RISK MANAGEMENT SUPPORT	485,981.
TOTAL	6,235,727.

FORM 5471, PAGE 3 DETAIL

	BEGINNING US CURRENCY	ENDING US CURRENCY
		ATTACHMENT 3
SCH F, LINE 4 - OTHER CURRENT ASSETS		
ACCRUED INVESTMENT INCOME	60,204.	40,777.
REINSURANCE BALANCE RECOVERABLE	3,989,294.	3,377,134.
PREPAID EXPENSES	2,965.	2,480.
TOTALS	4,052,463.	3,420,391.
		ATTACHMENT 4
SCH F, LINE 17 - OTHER LIABILITIES		
LOSS PAYABLE	42,143.	163,076.
DUE TO PARENT	1.	
OUTSTANDING LOSS RESERVES	11,819,886.	16,996,084.
RESERVE FOR MALPRACTICE INSURANCE	18,216,328.	16,678,709.
TOTALS	30,078,358.	33,837,869.
		ATTACHMENT 5
SCH F, LINE 19 - PAID-IN OR CAP SURPLUS		
CONTRIBUTED SURPLUS	11,788,063.	11,788,063.
TOTALS	11,788,063.	11,788,063.

ATTACHMENT 6

FORM 5471, PAGE 4 DETAIL

SCH H, LINE 2H - OTHER RECONCILING ITEMS	NET ADDITIONS	NET SUBTRACTS
ACCRUED INSURANCE RESERVES		5,398,542.
DEPOSIT ACCOUNTING ADJUSTMENT	7,600,000.	
TOTALS	7,600,000.	5,398,542.

Form **926**
(Rev. December 2013)
Department of the Treasury
Internal Revenue Service

Return by a U.S. Transferor of Property to a Foreign Corporation

▶ **Information about Form 926 and its separate instructions is at *www.irs.gov/form926.***
▶ **Attach to your income tax return for the year of the transfer or distribution.**

OMB No. 1545-0026
Attachment Sequence No. **128**

Part I **U.S. Transferor Information** (see instructions)

Name of transferor	**Identifying number** (see instructions)
THE STAMFORD HOSPITAL	06-0646917

1 If the transferor was a corporation, complete questions 1a through 1d.

a If the transfer was a section 361(a) or (b) transfer, was the transferor controlled (under section 368(c)) by 5 or fewer domestic corporations? ☐ **Yes** ☐ **No**

b Did the transferor remain in existence after the transfer? ☐ **Yes** ☐ **No**

If not, list the controlling shareholder(s) and their identifying number(s):

Controlling shareholder	**Identifying number**

c If the transferor was a member of an affiliated group filing a consolidated return, was it the parent corporation? ☐ **Yes** ☐ **No**

If not, list the name and employer identification number (EIN) of the parent corporation:

Name of parent corporation	**EIN of parent corporation**

d Have basis adjustments under section 367(a)(5) been made? ☐ **Yes** ☐ **No**

2 If the transferor was a partner in a partnership that was the actual transferor (but is not treated as such under section 367), complete questions 2a through 2d.

a List the name and EIN of the transferor's partnership:

Name of partnership	**EIN of partnership**

b Did the partner pick up its pro rata share of gain on the transfer of partnership assets? ☐ **Yes** ☐ **No**

c Is the partner disposing of its **entire** interest in the partnership? ☐ **Yes** ☐ **No**

d Is the partner disposing of an interest in a limited partnership that is regularly traded on an established securities market? ☐ **Yes** ☐ **No**

Part II **Transferee Foreign Corporation Information** (see instructions)

3 Name of transferee (foreign corporation)	**4a Identifying number,** if any
HEALTHSTAR INDEMNITY COMPANY, LTD	FOREIGNUS
5 Address (including country)	**4b** Reference ID number (see instructions)
FP PERRY BUILDING, 40 CHURCH STREET HAMILTON BERMUDA BD HM HX	HEALTHSTAR

6 Country code of country of incorporation or organization (see instructions)

BD

7 Foreign law characterization (see instructions)

CORPORATION

8 Is the transferee foreign corporation a controlled foreign corporation? ☒ **Yes** ☐ **No**

Part III **Information Regarding Transfer of Property** (see instructions)

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash	VAR		10,272,000.		
Stock and securities					
Installment obligations, account receivables or similar property					
Foreign currency or other property denominated in foreign currency					
Inventory					
Assets subject to depreciation recapture (see Temp. Regs. sec. 1.367(a)-4T(b))					
Tangible property used in trade or business not listed under another category					
Intangible property					
Property to be leased (as described in final and temp. Regs. sec. 1.367(a)-4(c))					
Property to be sold (as described in Temp. Regs. sec. 1.367(a)-4T(d))					
Transfers of oil and gas working interests (as described in Temp. Regs. sec. 1.367(a)-4T(e))					
Other property					

Supplemental Information Required To Be Reported (see instructions):

TRANSFER OF $10,272,000 CASH AND DEEMED CASH CONTRIBUTIONS ON VARIOUS DATES DURING THE FISCAL YEAR ENDED 9/30/14. THE AMOUNTS TRANSFERRED WERE IN THE FORM OF A PREMIUM PAID TO A CAPTIVE. FOR U.S. FEDERAL INCOME TAX PURPOSES, THE ARRANGEMENT IS NOT BEING TREATED AS INSURANCE.

Part IV **Additional Information Regarding Transfer of Property** (see instructions)

9 Enter the transferor's interest in the foreign transferee corporation before and after the transfer:

(a) Before <10 % **(b)** After <10 %

10 Type of nonrecognition transaction (see instructions) ▶ IRC SECTION 351

11 Indicate whether any transfer reported in Part III is subject to any of the following:

a	Gain recognition under section 904(f)(3)	☐ Yes	☒ No
b	Gain recognition under section 904(f)(5)(F)	☐ Yes	☒ No
c	Recapture under section 1503(d)	☐ Yes	☒ No
d	Exchange gain under section 987	☐ Yes	☒ No

12 Did this transfer result from a change in the classification of the transferee to that of a foreign corporation? ☐ Yes ☒ No

13 Indicate whether the transferor was required to recognize income under final and temporary Regulations sections 1.367(a)-4 through 1.367(a)-6 for any of the following:

a	Tainted property	☐ Yes	☒ No
b	Depreciation recapture	☐ Yes	☒ No
c	Branch loss recapture	☐ Yes	☒ No
d	Any other income recognition provision contained in the above-referenced regulations	☐ Yes	☒ No

14 Did the transferor transfer assets which qualify for the trade or business exception under section 367(a)(3)? ☐ Yes ☒ No

15a Did the transferor transfer foreign goodwill or going concern value as defined in Temporary Regulations section 1.367(a)-1T(d)(5)(iii)? ☐ Yes ☒ No

b If the answer to line 15a is "Yes," enter the amount of foreign goodwill or going concern value transferred ▶ $

16 Was cash the only property transferred? ☒ Yes ☐ No

17a Was intangible property (within the meaning of section 936(h)(3)(B)) transferred as a result of the transaction? ☐ Yes ☒ No

b If "Yes," describe the nature of the rights to the intangible property that was transferred as a result of the transaction: