Form **990**

Department of the Treasury
Internal Revenue Service

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

2015

Open to Public Inspection

A For the 2015 calendar year, or tax year beginning 10/01, **2015, and ending** 09/30, **20** 16

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) | Room/suite
ONE HOSPITAL PLAZA, PO BOX 9317

City or town, state or province, country, and ZIP or foreign postal code
STAMFORD, CT 06904

D Employer identification number
06-0646917

E Telephone number
(203) 276-1000

G Gross receipts $ 594,840,399.

F Name and address of principal officer: KEVIN GAGE
SAME AS C ABOVE

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:** ▶ WWW.STAMFORDHEALTH.ORG

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

Part I Summary

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	10.
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	3,411.
6	Total number of volunteers (estimate if necessary)	6	0.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	6,721,545.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	3,751,957.

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	28,262,832.	77,091,978.
9	Program service revenue (Part VIII, line 2g)	481,034,881.	499,165,142.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	5,261,487.	4,585,832.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,084,903.	3,054,565.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	517,644,103.	583,897,517.
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)	236,226,854.	243,669,500.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	219,806.	110,734.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 4,068,145.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	207,399,590.	225,205,528.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	443,846,250.	468,985,762.
19	Revenue less expenses. Subtract line 18 from line 12	73,797,853.	114,911,755.

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		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	905,964,794.	1,036,284,703.
21	Total liabilities (Part X, line 26)	596,491,295.	669,463,812.
22	Net assets or fund balances. Subtract line 21 from line 20	309,473,499.	366,820,891.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
NICOLE M SOKOLOWSKI	Nicole M. Sokolowski	08/15/17		P01683199

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

Firm's address ▶ 5 TIMES SQUARE NEW YORK, NY 10036 — Phone no. 212-773-3000

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** (2015)

JSA
5E1065 1.000

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 NEEDS 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 $ 383,997,896. including grants of $) (Revenue $ 496,545,637.)

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 9/30/2016 INCLUDE: ADULT AND PEDIATRIC INPATIENTS CARED FOR AND DISCHARGED 14,905; BABIES BORN 2,170; TOTAL INPATIENT DAYS OF CARE PROVIDED 71,449; PATIENTS SEEKING CARE IN THE STAMFORD HOSPITAL EMERGENCY ROOM: ADMITTED FOR INPATIENT TREATMENT 7,883; TREATED AND RELEASED 41,720; TREATED AT TULLY IMMEDIATE CARE CENTER 25,067. SURGERIES PERFORMED AT THE HOSPITAL AND TULLY CENTER: 20,627. RADIATION THERAPY PROCEDURES PERFORMED: 197,003.

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 ▶ 383,997,896.

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
12a	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
14a	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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	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	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic 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 or for domestic individuals 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	
24a	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
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) 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 payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," 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	
35a	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	491		
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	3,411		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)	2b		X	
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 FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
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.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring 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? **Note.** See the instructions for additional information the organization must report on Schedule O.	13a			
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 10		
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 ▶

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, address, and telephone number of the person who possesses the organization's books and records: ▶
KEVIN GAGE TREASURER/CFO ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904 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) ADOLF DIBIASIO	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(2) DAVID JAHNS	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(3) MARYANN KELLER-CHAI	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(4) GERALD B. RAKOS, M.D.	38.00									
DIRECTOR	2.00	X						513,587.	0.	26,629.
(5) SUZANNE BEITEL	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(6) TERRANCE P. BERLAND	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(7) JOSHUA HERBERT, M.D.	2.00									
DIRECTOR	38.00	X						0.	300,054.	35,584.
(8) MICHAEL FEDELE	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(9) ANDREW M. MERRILL	2.00									
CHAIRMAN	2.00	X		X				0.	0.	0.
(10) BRIAN GRISSLER	38.00									
PRESIDENT & CEO	2.00	X		X				2,075,868.	0.	37,453.
(11) MARK DEWAELE, D.M.D.	2.00									
VICE CHAIRMAN	2.00	X		X				0.	0.	0.
(12) PATRICK HACKETT	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(13) HELEN JAFFE	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(14) CHARLES LITTLEJOHN, M.D.	2.00									
DIRECTOR	38.00	X						0.	408,656.	39,111.

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) KATHLEEN A. SILARD	38.00									
ASST. SECRETARY	2.00			X				878,881.	0.	52,879.
(16) KEVIN GAGE	38.00									
TREASURER/CFO	2.00			X				862,368.	0.	52,807.
(17) DARRYL MCCORMICK	2.00									
ASSISTANT SECRETARY	38.00			X				568,346.	0.	12,912.
(18) DAVID SMITH	2.00									
ASSISTANT SECRETARY	38.00			X				550,894.	0.	39,398.
(19) MICHAEL COADY, M.D.	38.00									
CHIEF OF CARDIAC SURGERY	0.					X		1,064,570.	0.	23,834.
(20) MICHAEL STONE, M.D.	38.00									
CHAIR OF SURGERY	0.					X		840,135.	0.	47,464.
(21) SHARON KIELY, M.D.	38.00									
SVP, MEDICAL AFFAIRS	0.					X		742,185.	0.	52,840.
(22) NICOLA CORVAJA, M.D.	38.00									
CARDIOLOGIST	0.					X		641,380.	0.	35,360.
(23) MICHAEL PARRY, M.D.	38.00									
PHYSICIAN CHIEF INFEC DISEASES	0.					X		630,666.	0.	24,904.
1b Sub-total ▶								2,589,455.	708,710.	138,777.
c Total from continuation sheets to Part VII, Section A ▶								6,779,425.	0.	342,398.
d Total (add lines 1b and 1c) ▶								9,368,880.	708,710.	481,175.

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 ▶ 547

		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 ▶ 247

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	1,271,107.			
	d	Related organizations	1d				
	e	Government grants (contributions)	1e	489,199.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	75,331,672.			
	g	Noncash contributions included in lines 1a-1f: $ 1,397,028.					
	h	**Total.** Add lines 1a-1f ▶		77,091,978.			
Program Service Revenue			**Business Code**				
	2a	PATIENT REVENUE	621300	298,344,299.	298,701,261.		
	b	PHYSICIAN BILLING	621110	12,176,472.	12,176,472.		
	c	WELLNESS AND TRAINING	621400	3,622,976.	3,622,976.		
	d	MEDICARE/MEDICAID PAYMENT	621400	178,128,096.	178,128,096.		
	e	REFERENCE LAB INCOME	621500	6,893,299.		6,536,267.	
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f ▶		499,165,142.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶		1,710,228.			1,710,228.
	4	Income from investment of tax-exempt bond proceeds ▶		0.			
	5	Royalties ▶		0.			
			(i) Real / (ii) Personal				
	6a	Gross rents	3,499,156.				
	b	Less: rental expenses	4,568,679.				
	c	Rental income or (loss)	-1,069,523.				
	d	Net rental income or (loss) ▶		-1,069,523.			-1,069,523.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	8,894,725.				
	b	Less: cost or other basis and sales expenses	6,019,121.				
	c	Gain or (loss)	2,875,604.				
	d	Net gain or (loss) ▶		2,875,604.			2,875,604.
	8a	Gross income from fundraising events (not including $ 1,271,107. of contributions reported on line 1c). See Part IV, line 18	a 205,376.				
	b	Less: direct expenses	b 355,082.				
	c	Net income or (loss) from fundraising events ▶		-149,706.			-149,706.
	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	1,839,719.	1,839,719.		
	b	INTERCOMPANY STAFF REIMB	900099	1,159,285.	1,159,285.		
	c	MEANINGFUL USE INCOME	621110	28,493.	28,493.		
	d	All other revenue	532000	1,246,297.	1,061,019.	185,278.	
	e	**Total.** Add lines 11a-11d ▶		4,273,794.			
	12	**Total revenue.** See instructions. ▶		583,897,517.	496,717,321.	6,721,545.	3,366,603.

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 domestic organizations and domestic governments. See Part IV, line 21	0.			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. 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	6,702,833.		6,702,833.	
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	187,182,166.	162,936,242.	23,045,114.	1,200,810.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	12,637,912.	10,620,594.	1,939,046.	78,272.
9 Other employee benefits	24,361,244.	20,472,598.	3,737,767.	150,879.
10 Payroll taxes	12,785,345.	10,744,493.	1,961,667.	79,185.
11 Fees for services (non-employees):				
a Management	767,562.	767,562.		
b Legal	2,650,878.	50,140.	2,560,465.	40,273.
c Accounting	443,942.	5,500.	438,442.	
d Lobbying	140,422.		140,422.	
e Professional fundraising services. See Part IV, line 17	110,734.			110,734.
f Investment management fees	143,475.		143,475.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) ATCH 2	51,707,475.	38,203,739.	13,290,360.	213,376.
12 Advertising and promotion	5,221,668.	297,103.	3,105,288.	1,819,277.
13 Office expenses	13,357,546.	9,984,809.	3,326,974.	45,763.
14 Information technology	6,767,742.		6,767,742.	
15 Royalties	0.			
16 Occupancy	20,030,104.	18,124,148.	1,760,918.	145,038.
17 Travel	338,753.	35,207.	281,033.	22,513.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	274,727.	25,940.	226,274.	22,513.
20 Interest	38,047.	38,047.		
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	29,354,205.	28,929,852.	424,353.	
23 Insurance	6,235,452.		6,235,452.	
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 MEDICAL EXPENSES	71,186,436.	71,186,436.		
b SERVICE CONTRACTS	10,061,908.	10,022,039.		39,869.
c STATE-FED INCOME TAXES	1,717,259.	252,698.	1,464,561.	
d SUBSCRIPTIONS DUES-MBRSHP	2,227,036.	753,656.	1,460,874.	12,506.
e All other expenses	2,540,891.	547,093.	1,906,661.	87,137.
25 **Total functional expenses.** Add lines 1 through 24e	468,985,762.	383,997,896.	80,919,721.	4,068,145.
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	53,693.	1	50,000.
	2	Savings and temporary cash investments	127,234,047.	2	123,492,820.
	3	Pledges and grants receivable, net	28,893,864.	3	29,858,376.
	4	Accounts receivable, net	72,726,998.	4	73,152,775.
	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	7,429,778.	8	7,591,162.
	9	Prepaid expenses and deferred charges	7,573,399.	9	6,056,827.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 1015875503.			
	b	Less: accumulated depreciation — 10b: 375,041,861.	537,776,769.	10c	640,833,642.
	11	Investments - publicly traded securities	56,182,532.	11	96,365,777.
	12	Investments - other securities. See Part IV, line 11	24,378,481.	12	16,950,449.
	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	43,715,233.	15	41,932,875.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	905,964,794.	16	1,036,284,703.
Liabilities	17	Accounts payable and accrued expenses	107,717,272.	17	108,447,087.
	18	Grants payable	0.	18	0.
	19	Deferred revenue	732,509.	19	2,211,815.
	20	Tax-exempt bond liabilities	364,390,147.	20	405,059,501.
	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	3,582,642.	24	3,513,715.
	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	120,068,725.	25	150,231,694.
	26	**Total liabilities.** Add lines 17 through 25	596,491,295.	26	669,463,812.
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	218,716,388.	27	283,719,534.
	28	Temporarily restricted net assets	82,312,016.	28	21,654,727.
	29	Permanently restricted net assets	8,445,095.	29	61,446,630.
		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	309,473,499.	33	366,820,891.
	34	Total liabilities and net assets/fund balances	905,964,794.	34	1,036,284,703.

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	583,897,517.
2	Total expenses (must equal Part IX, column (A), line 25)	2	468,985,762.
3	Revenue less expenses. Subtract line 2 from line 1	3	114,911,755.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	309,473,499.
5	Net unrealized gains (losses) on investments	5	-1,471,380.
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	-56,092,983.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	366,820,891.

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? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
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	

Form **990** (2015)

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

2015

Open to Public Inspection

Name of the organization
THE STAMFORD HOSPITAL

Employer identification number
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 (Form 990 or 990-EZ).)

3 [X] 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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.

a [ ] **Type I**. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b [ ] **Type II**. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c [ ] **Type III functionally integrated**. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d [ ] **Type III non-functionally integrated**. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e [ ] Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations . . . . . [ ]

g 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 (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
(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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 VI.)						
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 2015 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2014 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3 % support test - 2015.** 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 - 2014.** 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 - 2015.** 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 VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2014.** 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 VI 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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 VI.)						
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 2015 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2014 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2015** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2014** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2015.** 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 - 2014.** 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 Supporting Organizations

(Complete only if you checked a box in line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI****, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV Supporting Organizations *(continued)*

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* ***Part VI.***	11c		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* ***Part VI*** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	1		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard.*	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (****see instructions****):*

a ☐ The organization satisfied the Activities Test. *Complete* ***line 2*** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI*** *the role played by the organization in this regard.*	3b		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	**1**		
2 Recoveries of prior-year distributions	**2**		
3 Other gross income (see instructions)	**3**		
4 Add lines 1 through 3	**4**		
5 Depreciation and depletion	**5**		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	**6**		
7 Other expenses (see instructions)	**7**		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	**8**		

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d Total (add lines 1a, 1b, and 1c)	**1d**		
e Discount claimed for blockage or other factors (explain in detail in **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d	**3**		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by .035	**6**		
7 Recoveries of prior-year distributions	**7**		
8 Minimum Asset Amount (add line 7 to line 6)	**8**		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	**1**		
2 Enter 85% of line 1	**2**		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	**3**		
4 Enter greater of line 2 or line 3	**4**		
5 Income tax imposed in prior year	**5**		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	**6**		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

Part V **Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations** *(continued)*

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2015 from Section C, line 6	
10	Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2015	(iii) Distributable Amount for 2015
1	Distributable amount for 2015 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2015:			
a				
b				
c				
d	From 2013			
e	From 2014			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2015 distributable amount			
i	Carryover from 2010 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2015 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2015 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	**Excess distributions carryover to 2016**. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a				
b				
c	Excess from 2013			
d	Excess from 2014			
e	Excess from 2015			

Part VI **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

2015

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, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[ ] For an organization described in section 501(c)(3) 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), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions 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 an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled 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 totaling $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		$ 42,087.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 149,920.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 22,773.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 339,279.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 5,094.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
6		$ 5,174.	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
7		$ 5,194.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
8		$ 5,566.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
9		$ 9,997.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
10		$ 10,205.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
11		$ 10,225.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
12		$ 10,533.	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
13		$ 26,060.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
14		$ 25,041.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
15		$ 25,391.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
16		$ 26,065.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
17		$ 192,485.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
18		$ 245,000.	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
19		$ 228,002.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
20		$ 101,646.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
21		$ 6,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
22		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
23		$ 10,350.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
24		$ 55,000.	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		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
26		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
27		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
28		$ 56,418.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
29		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
30		$ 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
31		$ 10,350.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
32		$ 9,435.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
33		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
34		$ 29,320.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
35		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
36		$ 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
37		$ 26,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
38		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
39		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
40		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
41		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
42		$ 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
43		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
44		$ 9,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
45		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
46		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
47		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
48		$ 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
49		$ 35,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
50		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
51		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
52		$ 131,899.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
53		$ 203,798.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
54		$ 202,598.	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
55		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
56		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
57		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
58		$ 12,970.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
59		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
60		$ 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
61		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
62		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
63		$ 105,200.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
64		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
65		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
66		$ 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
67		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
68		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
69		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
70		$ 8,463.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
71		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
72		$ 12,499.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 28,700.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
74		$ 211,245.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
75		$ 5,625.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
76		$ 25,000.	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		$ 22,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
81		$ 99,496.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
82		$ 53,890,898.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
83		$ 99,035.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
84		$ 116,480.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 6,150.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
86		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
87		$ 105,690.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
88		$ 7,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
89		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
90		$ 21,300.	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		$ 32,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
92		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
93		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
94		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
95		$ 7,060.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
96		$ 25,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 16,155.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
98		$ 13,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
99		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
100		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
101		$ 700,200.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
102		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
104		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
105		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
106		$ 17,060.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
107		$ 125,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
108		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
110		$ 110,520.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
111		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
112		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
113		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
114		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
116		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
117		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
118		$ 25,050.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
119		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
120		$ 100,135.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 14,175.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
122		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
123		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
124		$ 22,549.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
125		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
126		$ 20,800.	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		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
128		$ 51,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
129		$ 10,071.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
130		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
131		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
132		$ 100,000.	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		$ 15,175.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
134		$ 27,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
135		$ 35,460.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
136		$ 6,325.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
137		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
138		$ 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
139		$ 12,653.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
140		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
141		$ 900,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
142		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
143		$ 29,035.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
144		$ 50,100.	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		$ 78,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
146		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
147		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
148		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
149		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
150		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
152		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
153		$ 19,453.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
154		$ 111,160.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
155		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
156		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 13,600.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
158		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
159		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
160		$ 5,650.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
161		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
162		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 5,200.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
164		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
165		$ 6,050.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
166		$ 100,050.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
167		$ 6,388.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
168		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
170		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
171		$ 12,475.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
172		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
173		$ 50,610.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
174		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 25,275.	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		$ 26,700.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 7,685.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
182		$ 10,025.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
183		$ 261,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
184		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
185		$ 1,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
186		$ 108,375.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
188		$ 25,285.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
189		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
190		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
191		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
192		$ 5,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 9,650.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
194		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
195		$ 8,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
196		$ 20,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
197		$ 10,435.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
198		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 10,624.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
200		$ 13,010.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
201		$ 16,700.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
202		$ 11,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
203		$ 11,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
204		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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		$ 17,670.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
206		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
207		$ 12,480.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
208		$ 13,595.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
209		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
210		$ 12,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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
211		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
212		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
213		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
214		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
215		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
216		$ 13,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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
217		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
218		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
219		$ 50,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
220		$ 425,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
221		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
222		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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
223		$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
224		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
225		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
226		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
227		$ 10,945.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
228		$ 21,618.	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
229		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
230		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
231		$ 13,328.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
232		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
233		$ 5,000,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
234		$ 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
235		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
236		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
237		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
238		$ 100,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
239		$ 12,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
240		$ 10,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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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
241		$ 255,900.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
242		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
243		$ 54,515.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] 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
5	STOCK	$ 5,094.	11/17/2015
6	STOCK	$ 5,174.	12/16/2015
7	STOCK	$ 5,194.	12/16/2015
8	STOCK	$ 5,566.	08/08/2016
9	STOCK	$ 9,997.	10/22/2015
10	STOCK	$ 10,205.	05/25/2016

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
11	STOCK	$ 10,225.	04/15/2016
12	STOCK	$ 10,533.	12/22/2015
13	STOCK	$ 26,060.	06/29/2016
14	STOCK	$ 25,041.	06/09/2016
15	STOCK	$ 25,391.	11/02/2015
16	STOCK	$ 26,065.	07/28/2016

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
17	STOCK 96,825 - 11/13/15 95,660 - 1/14/16	$ 192,485.	VAR
18	BUILDING	$ 245,000.	12/31/2015
19	STOCK	$ 228,002.	05/05/2016
20	STOCK	$ 101,646.	11/17/2015
74	STOCK	$ 211,245.	11/15/2015
129	STOCK	$ 10,071.	12/01/2015

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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
244	STOCK	$ 20,022.	12/14/2015
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
54	STOCK	$ 202,598.	12/09/2015
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(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., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** 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.**
▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.***

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Open to Public Inspection

If the organization answered "Yes," on 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," on 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," on Form 990, Part IV, line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), 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.		

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

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **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 separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(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 on 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	
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		140,422.
j Total. Add lines 1c through 1i			140,422.
2a 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, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

SCHEDULE C, PART II, LINE 1I

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" on 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

2015

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" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of 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" on 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 a 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, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, 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" on 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) Revenue 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 Revenue 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" on 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, for escrow or custodial account liability? ☐ Yes ☐ No

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

Part V Endowment Funds.

Complete if the organization answered "Yes" on 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	90,756,792.	67,414,074.	47,909,132.	40,118,983.	26,695,222.
b Contributions	74,894,440.	25,541,845.	20,339,806.	8,872,941.	16,783,195.
c Net investment earnings, gains, and losses	406,156.	-104,189.	1,151,928.	1,284,155.	1,162,352.
d Grants or scholarships					4,521,786.
e Other expenditures for facilities and programs	83,956,350.	2,094,938.	1,986,792.	2,366,947.	
f Administrative expenses					
g End of year balance	82,101,038.	90,756,792.	67,414,074.	47,909,132.	40,118,983.

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 ▶ 74.0000 %
- c Temporarily restricted endowment ▶ 26.0000 %

The percentages on 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" on line 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" on 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		44,790,206.		44,790,206.
b Buildings		441,407,237.	101,375,071.	340,032,166.
c Leasehold improvements		13,183,920.	7,010,935.	6,172,985.
d Equipment		493,559,514.	263,035,525.	230,523,989.
e Other		22,934,626.	3,620,330.	19,314,296.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				640,833,642.

Part VII Investments - Other Securities.
Complete if the organization answered "Yes" on 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" on 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" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

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

Part X Other Liabilities.
Complete if the organization answered "Yes" on 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	112,002,096.
(3) DUE TO AFFILIATES	22,741,939.
(4) EST FOR PROFESSIONAL LIABILITY	8,679,408.
(5) EST THIRD PART SETTLEMENTS	6,748,855.
(6) CHARITABLE GIFT ANNUITY PAYABLE	59,396.
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	150,231,694.

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

OMB No. 1545-0047

2015

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? . . . . . ☐ **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.	PROGRAM SERVICES	MALPRACTICE INSURANCE	9,018,500.
(2) CENTRAL AMERICA/CARIBBEAN		1.	INVESTMENTS	N/A	11,908,063.
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total		2.			20,926,563.
b Total from continuation sheets to Part I					
c **Totals** (add lines 3a and 3b)		2.			20,926,563.

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 separately 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; do not file with Form 990)*	[ ] 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)*	[X] Yes	[ ] 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 separately file Form 5713, International Boycott Report (see Instructions for Form 5713; do not file with Form 990)*	[ ] 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" on 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

2015

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" on 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	20,059,795.	101,059.	19,958,736.
2 DOUG PICHA CONSULTANTS	CONSULTANT		X	2,228,661.	9,675.	2,219,191.
3						
4						
5						
6						
7						
8						
9						
10						
Total ▶				22,288,456.	110,734.	22,177,927.

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" on 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	137,020.	780,176.	559,287.	1,476,483.
	2 Less: Contributions	108,270.	635,745.	527,092.	1,271,107.
	3 Gross income (line 1 minus line 2)	28,750.	144,431.	32,195.	205,376.
Direct Expenses	4 Cash prizes			0.	
	5 Noncash prizes	7,835.	1,880.	33,649.	43,364.
	6 Rent/facility costs			0.	
	7 Food and beverages	48,170.	9,883.	120,272.	178,325.
	8 Entertainment			0.	
	9 Other direct expenses	57,436.	5,413.	70,544.	133,393.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				355,082.
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				-149,706.

Part III **Gaming.** Complete if the organization answered "Yes" on 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 conducts gaming activities: _____

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

b If "No," explain: _____

10a 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 conduct 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 conducted 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 provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2015

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: [ ] 100% [ ] 150% [ ] 200% [X] Other 250.0000 %	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 criteria used 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		
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		
	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)			6,054,996.		6,054,996.	.01
b Medicaid (from Worksheet 3, column a)			107,316,744.	45,174,876.	62,141,868.	13.25
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			113,371,740.	45,174,876.	68,196,864.	13.26
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,565,214.	115,721.	3,449,493.	.74
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			3,565,214.	115,721.	3,449,493.	.74
k **Total.** Add lines 7d and 7j			116,936,954.	45,290,597.	71,646,357.	14.00

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						
10 Total						

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	37,347,560.	
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	96,142,738.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	114,510,617.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-18,367,879.
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 (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	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 ONE HOSPITAL PLAZA STAMFORD CT 06904 WWW.STAMFORDHEALTH.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 letter of facility reporting group THE STAMFORD HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	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 12	3	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 significant 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)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 15			
5	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	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.STAMFORDHEALTH.ORG			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8		X
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2013			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WWW.STAMFORDHEALTH.ORG			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	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)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, 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 (FAP)

Name of hospital facility or letter of facility reporting group THE STAMFORD HOSPITAL

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250.0000 % and FPG family income limit for eligibility for discounted care of 400.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[ ] Medical indigency			
e	[X] Insurance status			
f	[ ] Underinsurance status			
g	[ ] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] Other (describe in Section C)			

Billing and Collections

17	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 all of the actions the hospital facility or other authorized party may take upon non-payment?	17	X	
18	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(ies)			
b	[ ] Selling an individual's debt to another party			
c	[ ] Actions that require a legal or judicial process			
d	[ ] Other similar actions (describe in Section C)			
e	[X] None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

Name of hospital facility or letter of facility reporting group THE STAMFORD HOSPITAL

			Yes	No
19	Did the hospital facility or other authorized 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?	**19**		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (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)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required 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?	**21**	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)			

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

22 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)

23	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? If "Yes," explain in Section C.	**23**		X
24	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? If "Yes," explain in Section C.	**24**		X

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 5

IN TOTAL, THE HOSPITAL RECEIVED QUALITATIVE INPUT FROM 177 INDIVIDUALS.

MANY INDIVIDUALS PROVIDING INPUT REPRESENT MEDICALLY UNDERSERVED,

LOW-INCOME, AND MINORITY POPULATIONS.

ALL INTERVIEWS AND FOCUS GROUPS WERE CONDUCTED BETWEEN APRIL 1, 2016 AND

JUNE 15, 2016. THE ONLINE SURVEY WAS OPEN FROM APRIL 21, 2016 TO MAY

19,2016.

THROUGH THE FOCUS GROUPS AND INTERVIEWS, THE HOSPITAL WAS ABLE TO GATHER

FEEDBACK FROM MANY KEY ORGANIZATIONS AND INDIVIDUALS. BELOW ARE A FEW OF

THE ORGANIZATIONS FROM WHICH FEEDBACK WAS GATHERED IN THE FORM OF EITHER

AN INTERVIEW OR FOCUS GROUP:

- CITY OF STAMFORD, DEPARTMENT OF HEALTH & SOCIAL SERVICES
- DARIEN HEALTH DEPARTMENT
- STAMFORD EMERGENCY MEDICAL SERVICES
- AMERICARES
- OPTIMUS HEALTH CARE
- DARIEN SENIOR CENTER
- NEIGHBORS LINK
- CHILDCARE LEARNING CENTERS

INDIVIDUALS WITH WHOM WE SPOKE AT ALL OF THE ORGANIZATIONS LISTED ABOVE

EITHER HAVE EXPERTISE IN PUBLIC HEALTH OR REPRESENT A MINORITY AND/OR

UNDERSERVED GROUP IN THE COMMUNITY.

PLEASE REFER TO EXHIBIT A FOR THE COMPLETE LIST OF ORGANIZATIONS

REPRESENTED THROUGH INTERVIEWS AND EXHIBIT B FOR THE COMPLETE LIST OF

ORGANIZATIONS AT WHICH FOCUS GROUPS WERE HOSTED.

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

THROUGH OUR ONLINE SURVEY, WE WERE ABLE TO GATHER INPUT FROM A WIDER RANGE OF INDIVIDUALS REPRESENTING MANY ORGANIZATIONS BASED IN STAMFORD OR DARIEN. BELOW IS A SAMPLE LIST OF THE ORGANIZATIONS AND GROUPS FROM WHICH REPRESENTATIVES PROVIDED FEEDBACK THROUGH OUR ONLINE SURVEY:

- STAMFORD HEALTH COMMISSION
- STAMFORD CHAMBER OF COMMERCE
- PERSON-TO-PERSON
- DARIEN COMMUNITY YMCA
- SHELTER FOR THE HOMELESS
- BUSINESS COUNCIL OF FAIRFIELD COUNTY

PLEASE REFER TO EXHIBIT C FOR A LIST OF ORGANIZATIONS FROM WHICH REPRESENTATIVES PROVIDED FEEDBACK THROUGH OUR ONLINE SURVEY. IT IS IMPORTANT TO NOTE THAT NOT ALL RESPONDENTS TO THE SURVEY PROVIDED CONTACT INFORMATION AND, THEREFORE, ARE NOT INCLUDED IN EXHIBIT C.
FOR A BRIEF DESCRIPTION OF SOME OF THE ORGANIZATIONS FROM WHOM WE GATHERED INPUT, PLEASE REFER TO EXHIBIT D.

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 8

IN RESPONSE TO THE COMMUNITY HEALTH NEEDS ASSESSMENT ADOPTED SEPTEMBER 30, 2016, STAMFORD HEALTH DEVELOPED AN IMPLEMENTATION STRATEGY WHICH WAS ADOPTED AT THE JANUARY 25, 2017 STAMFORD HOSPITAL BOARD OF DIRECTORS MEETING.

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 11

THIS REPORT WAS REVIEWED AND ADOPTED BY THE HOSPITAL'S LEADERSHIP TEAM

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

AND BOARD OF DIRECTORS ON SEPTEMBER 28, 2016.

AS A NEXT STEP, STAMFORD HOSPITAL HAS IDENTIFIED A TASK FORCE THAT WILL BE RESPONSIBLE FOR DEVELOPING A COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) TO ADDRESS THE 2016 HEALTH PRIORITIES. THE TASK FORCE WILL INCLUDE REPRESENTATIVES FROM OUR QUALITY, NURSING, CASE MANAGEMENT, AMBULATORY, FINANCE AND SERVICE LINE TEAMS. ADDITIONALLY, SEVERAL PHYSICIANS WILL BE ASKED TO PARTICIPATE ON THE COMMITTEE AS WELL AS LEADERS FROM THE COMMUNITY.

AS THE TASK FORCE BUILDS THE CHIP, IT WILL CONSIDER THE PROGRAMS, ORGANIZATIONS AND FACILITIES AVAILABLE IN THE COMMUNITY TO HELP ADDRESS THE IDENTIFIED HEALTH PRIORITIES. EXHIBIT G IS A PARTIAL LIST OF COMMUNITY ORGANIZATIONS AND RESOURCES WHICH MAY BE CONSULTED TO ADDRESS THE ISSUES. THE HOSPITAL WILL ALSO CONSIDER THE PARTNERSHIPS WHICH WERE ESTABLISHED OR EXPANDED IN CONNECTION WITH THE 2013 CHIP AS SET FORTH IN EXHIBIT E. FOR ISSUES IDENTIFIED THROUGH THE CHNA, BUT NOT ADDRESSED IN THE 2016 CHIP, STAMFORD HOSPITAL WILL WORK WITH ITS PARTNERS TO DETERMINE THE MOST SUITABLE RESOURCES AVAILABLE IN THE COMMUNITY TO ADDRESS THOSE ISSUES.

THE TASK FORCE WILL WORK THROUGHOUT THE FALL TO DEVELOP THE CHIP. THE FINAL PLAN WILL BE SUBMITTED AND MADE PUBLICLY AVAILABLE IN FEBRUARY 2017.

FORM 990, SCHEDULE H, PART V, SECTION B, LINES 16A, 16B, 16C

HTTP://WWW.STAMFORDHEALTH.ORG/PATIENTS-VISITORS/FAP/

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 22D

FOR AN INDIVIDUAL WHOSE INCOME IS BETWEEN 200% AND 400% OF THE FPG,

STAMFORD HOSPITAL SHALL DETERMINE THE LEVEL OF DISCOUNT FOR THE SERVICE

IF THE PATIENT'S HOUSEHOLD GROSS YEARLY INCOME MEETS OR DOES NOT EXCEED

FOUR TIMES THE MOST RECENT FPG, ACCORDING TO STAMFORD HOSPITAL'S

FINANCIAL ASSISTANCE CALCULATION TABLE. THE DISCOUNT WILL BE APPLIED TO

THE PATIENT'S OBLIGATION, WHICH, FOR UNINSURED PATIENTS, IS THE AGB BASED

ON THE LOOK-BACK METHOD. OR, FOR INSURED PATIENTS, THE DEDUCTIBLE,

COPAYMENT OR COINSURANCE OBLIGATION WILL BE DETERMINED USING THE FPG FOR

THE PATIENT'S GROSS HOUSEHOLD YEARLY INCOME AND THE STAMFORD HOSPITAL

FINANCIAL ASSISTANCE CALCULATION TABLE.

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.

PART I, LINE 7

THE COST-TO-CHARGE RATIO METHODOLOGY WAS UTILIZED TO CALCULATE THE AMOUNT

INCLUDED IN THE TABLE. THE CALCULATION OF THIS RATIO WAS DERIVED FROM

RATIO OF PATIENT CARE COST-TO-CHARGE.

PART III, LINE 2

THE COST OF BAD DEBT EXPENSE IS ESTIMATED BASED ON THE BAD DEBT PROVISION

AT CHARGE, APPLIED TO THE RATIO OF TOTAL PATIENT CARE EXPENSES TO TOTAL

CHARGES FOR ALL SERVICES RENDERED. ANY PAYMENTS OR DISCOUNTS ARE EXCLUDED

FROM BAD DEBT EXPENSE.

PART III, LINE 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

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

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.

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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.

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, TSH 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), TSH 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. 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

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.

ALLOWANCE FOR DOUBTFUL ACCOUNTS.

PART III, LINE 8B

MEDICARE COSTING METHODOLOGY

THE COSTING METHODOLOGY USED FOLLOWS THE METHODOLOGY OF THE MEDICARE COST

REPORT.

PART III, LINE 8A

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.

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

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.

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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.

APPLIES FOR FREE BED FUNDS OR FINANCIAL ASSISTANCE.

FORM 990, SCHEDULE H, PART VI

NEEDS ASSESSMENT

THE STAMFORD HOSPITAL ("SH" OR "HOSPITAL") PARTNERS WITH A NUMBER OF NONPROFIT HEALTH AND SOCIAL SERVICES ORGANIZATIONS THAT SEEK TO BENEFIT THE COMMUNITY AND IMPROVE THE HEALTH AND WELL-BEING OF THEIR CLIENTS. IN ADDITION, TOGETHER WITH OUR PHYSICIANS, THE HOSPITAL WORKS CLOSELY WITH THE STAMFORD DEPARTMENT OF HEALTH AND SOCIAL SERVICES ("STAMFORD HEALTH DEPT.") TO PREVENT AND TREAT HIV AND WITH STAMFORD CARES, A PROGRAM OF FAMILY CENTERS THAT PROVIDES HIV MEDICAL CASE MANAGEMENT; INCLUDES PARTICIPATION IN COMMUNITY HEALTH FAIRS AND EDUCATIONAL OUTREACH EFFORTS; PROVIDES HIV UPDATES FOR AIDS SERVICE PROVIDERS IN THE COMMUNITY; PERFORMS CLIENT HOME VISITS; AND CONDUCTS MONTHLY HIV POSITIVE WOMEN'S SUPPORT GROUP.

SH PARTNERS WITH OPTIMUS HEALTH CENTERS, A FEDERALLY QUALIFIED HEALTH CARE CENTER, TO CREATE AN INTEGRATED PRIMARY CARE DELIVERY NETWORK FOR THE MEDICALLY UNDERSERVED COMMUNITIES IN STAMFORD. DISCOUNTED OR FREE

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.

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

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

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

SUPPLIES, EQUIPMENT AND MEDICATIONS WERE PROVIDED TO INDIGENT PATIENTS

($34,000) IN 2016. SH ALSO PROVIDES AN INFORMATION AND REFERRAL SERVICES

($113,000) TO ENHANCE ACCESS TO CARE.

COMMUNITY INPUT AND ENGAGEMENT TO IMPROVE CHILD HEALTH AND PREVENT

OBESITY IS PROVIDED THROUGH A STAMFORD CITY-WIDE TASK FORCE LEAD BY SH.

THIS COMMUNITY-WIDE COLLABORATION FOCUSES ON PREVENTION, ADVOCACY AND

EDUCATION IS A CITY-WIDE COLLABORATION THAT INCLUDES STAMFORD PUBLIC

SCHOOLS, THE STAMFORD HEALTH DEPARTMENT, EARLY CHILDHOOD EDUCATORS, AFTER

SCHOOL PROGRAMS AND COMMUNITY CENTERS, COMMUNITY PEDIATRICIANS AND FAMILY

MEDICINE PRACTITIONERS. SH'S KIDS'FANS (KIDS' FITNESS AND NUTRITION

SERVICES) PROGRAM, PROMOTING PHYSICAL ACTIVITY AND HEALTH CONSCIOUS

NUTRITION, IS A CORNERSTONE OF THIS CHILDHOOD OBESITY INITIATIVE.

A MAJOR INITIATIVE OF SH IS THE VITA HEALTH & WELLNESS INITIATIVE, WHICH

IS FOCUSED ON TWO CENSUS TRACTS (214 AND 215) IN STAMFORD'S WEST SIDE.

THE VITA COLLABORATIVE BRINGS TOGETHER THE KEY SERVICE PROVIDERS MONTHLY

TO DEVELOP PROGRAMS TO IMPROVE THE ENVIRONMENT AND HEALTH OUTCOMES OF

THIS PRIMARILY LOW-INCOME POPULATION.

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.

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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 WEST SIDE NEIGHBORHOOD REVITALIZATION ZONE (WSNRZ), SEEKS TO IMPROVE NEIGHBORHOOD AT THE HOSPITAL'S SOUTHERN BORDER. THE WEST SIDE, A DENSELY POPULATED, LOW-INCOME NEIGHBORHOOD, SUFFERED FROM A STEADY DECLINE IN HOME OWNERSHIP AND LACK OF INVESTMENT OVER THE LAST THREE DECADES. STAMFORD HOSPITAL AND CHARTER OAK COMMUNITIES (FORMERLY STAMFORD HOUSING AUTHORITY), ACTING AS COMMUNITY ANCHORS, WORK WITH RESIDENTS, BUSINESSES AND THE CITY OF STAMFORD TO PLAN CAPITAL IMPROVEMENTS, IMPROVE TRAFFIC FLOW, REDUCE CRIME AND IMPROVE PEDESTRIAN SAFETY.

TO INCREASE AWARENESS OF THE IMPORTANCE OF MAMMOGRAM SCREENING FOR EARLY DETECTION OF BREAST CANCER, SH SPONSORS PAINT THE TOWN PINK, A COMMUNITY-WIDE BREAST CANCER EDUCATION PROGRAM. "PAINT THE TOWN PINK" HOLDS A MONTH-LONG SERIES OF EVENTS IN OCTOBER OF EACH YEAR.

SH PARTNERS WITH A NUMBER OF NONPROFIT HEALTH AND SOCIAL SERVICES ORGANIZATIONS THAT SEEK TO BENEFIT THE COMMUNITY AND IMPROVE THE HEALTH AND WELL-BEING OF THEIR CLIENTS. IN ADDITION, TOGETHER WITH OUR PHYSICIANS, THE HOSPITAL WORKS CLOSELY WITH THE STAMFORD DEPARTMENT OF

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.

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HEALTH AND SOCIAL SERVICES ("SHD") TO DISSEMINATE HEALTH INFORMATION AND

ADDRESS PUBLIC HEALTH ISSUES THAT ARISE.

IN 2016, STAMFORD HOSPITAL PROVIDED IN-KIND SUPPORT TO TWO MAJOR

INITIATIVES OF THE CITY OF STAMFORD; THE FIRST, STAMFORD INVEST HEALTH,

IS FOCUSED ON YOUTH DEVELOPMENT AND VIOLENCE PREVENTION, LED BY THE

MAYOR'S OFFICE AND FUNDED BY THE ROBERT WOOD JOHNSON FOUNDATION. THE

PLANNING EFFORT RESULTED IN A PLAN TO CONDUCT A COMPREHENSIVE COMMUNITY

ENGAGEMENT PROCESS IN CONJUNCTION WITH THE FERGUSON LIBRARY'S TRAINED

FACILITATORS IN PARTNERSHIP WITH OTHER COMMUNITY ORGANIZATIONS. THE

SECOND EFFORT, STAMFORD CRADLE2CAREER, IS A COLLECTIVE-IMPACT PROJECT

FUNDED IN PART BY THE UNITED WAY OF WESTERN CONNECTICUT, FOCUSED ON

ADDRESSING THE ACHIEVEMENT GAP IN THE STAMFORD PUBLIC SCHOOLS; SH

PROVIDES MANAGEMENT SUPPORT (ACTING AS CO-CHAIR) OF THE COMMUNITY TASK

FORCE AND MEMBERSHIP ON THE COMMUNICATIONS COMMITTEE. SENIOR LEADERSHIP

ALSO PARTICIPATES IN ADVISORY CAPACITIES.

Part VI Supplemental Information

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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 OPTIONS.

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

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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 HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM (FAP) BY THE SOCIAL WORKERS, PATIENT ASSISTANCE COORDINATOR, FINANCIAL ASSISTANCE COUNSELORS, AND THE DSS LIAISON.

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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 HEALTH 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'S STRATEGIC PLAN. THE HOSPITAL'S COMBINED PSA AND SSA

INCLUDE AN ESTIMATED 136,091 HOUSEHOLDS WITH A TOTAL POPULATION OF

372,012 RESIDENTS. THE PSA INCLUDES THE COMMUNITIES OF STAMFORD, DARIEN,

AND ROWAYTON, WITH AN ESTIMATED 54,472 HOUSEHOLDS AND A TOTAL POPULATION

OF 150,116. STAMFORD COMPRISES AN ESTIMATED 46,376 HOUSEHOLDS WITH A

TOTAL POPULATION OF 125,226. THE SSA INCLUDES THE COMMUNITIES OF

GREENWICH, COS COB, RIVERSIDE, OLD GREENWICH, NEW CANAAN, NORWALK,

WESTPORT, WESTON, AND WILTON, WITH AN ESTIMATED 81,619 HOUSEHOLDS AND A

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TOTAL POPULATION OF 221,896. FOR THE PSA, 25.6% OF THE POPULATION IS ESTIMATED TO BE 19 YEARS OF AGE OR LESS; 36.2% IS 20 - 44; 25.6% IS 45-64; AND 12.6% IS 65 YEARS OF AGE AND OLDER. THE SSA HAS A SLIGHTLY OLDER AGE DISTRIBUTION WITH AN ESTIMATED 27.3% OF ITS POPULATION 19 YEARS OF AGE OR LESS; 27.5% IS 20-44; 30.6% IS 45-64; AND 14.6% 65 YEARS OF AGE AND OLDER. REGARDING RACE/ETHNICITY, OF THE ESTIMATED POPULATION IN THE PSA, 56.6% OF RESIDENTS ARE WHITE; 23.1% ARE HISPANIC; 11.0% BLACK; 7.5% ASIAN; AND THE REMAINING PORTION OF THE POPULATION IS MULTI-RACIAL, NATIVE AMERICAN, PACIFIC ISLANDER, OR OTHER. STAMFORD IS ESTIMATED TO HAVE A MORE RACIALLY DIVERSE POPULATION THAN THE PSA AND SSA WITH THE BLACK POPULATION REPRESENTING 13.2%, HISPANIC POPULATION REPRESENTING 27.0% AND ASIAN POPULATION REPRESENTING 8.4% OF ITS TOTAL POPULATION. FOR THE SSA, 72.7% OF THE TOTAL ESTIMATED POPULATION IS WHITE; 6.5% BLACK; 13.0% HISPANIC; 5.6% ASIAN; AND THE REMAINING PORTION OF THE POPULATION IS MULTI-RACIAL, NATIVE AMERICAN, PACIFIC ISLANDER, OR OTHER. ALTHOUGH IN THE PSA AN ESTIMATED 20.8% 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 16.2% OF TOTAL

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HOUSEHOLDS WITH HOUSEHOLD INCOMES EXCEEDING $200,000, AND 22.8% WITH

HOUSEHOLD INCOMES LESS THAN $35,000, 33.2% WITH LESS THAN $45,000. IN THE

SSA, AN ESTIMATED 28.2% OF THE TOTAL HOUSEHOLDS HAVE HOUSEHOLD INCOMES

EXCEEDING $200,000, WHILE AN ESTIMATED 16.7% HAVE HOUSEHOLD INCOMES LESS

THAN $35,000 AND 24.5% LESS THAN $45,000.

THE ESTIMATED PAYOR MIX OF THE PSA IS PREDOMINANTLY COMMERCIAL/PRIVATE

INSURANCE (37.1%), FOLLOWED BY MEDICARE (25.0%); MEDICAID (28.3%); AND

SELF-PAY/OTHER (9.6%). COMPARED TO THE PSA, STAMFORD HAS A HIGHER

ESTIMATED PERCENTAGE OF MEDICAID AT 30.7% AND SELF-PAY/OTHER AT 10.4%.

FOR THE SSA, THE ESTIMATED PAYOR MIX IS ALSO PRIMARILY COMMERCIAL/PRIVATE

INSURANCE (42.5%), FOLLOWED BY MEDICARE (27.5%); MEDICAID (21.9%); AND

SELF-PAY/OTHER (8.1%).

FORM 990, SCHEDULE H, PART VI

PROMOTION OF COMMUNITY HEALTH

SH PROVIDES EXPERTISE AND SUPPORTS THE WEST SIDE NEIGHBORHOOD

REVITALIZATION ZONE (WSNRZ), A COMMUNITY EFFORT TO IMPROVE THE HEALTH,

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SAFETY, INFRASTRUCTURE, AND QUALITY OF LIFE IN THE WEST SIDE OF STAMFORD.

NEIGHBORS WORK SIDE-BY-SIDE WITH LOCAL BUSINESSES, LAW ENFORCEMENT, THE HOSPITAL'S HOUSING PARTNER, CHARTER OAK COMMUNITIES, INC. (FORMERLY THE STAMFORD HOUSING AUTHORITY), AND LOCAL ELECTED AND APPOINTED OFFICIALS.

SH IN PARTNERSHIP WITH CHARTER OAK COMMUNITIES, INC., (FORMERLY STAMFORD HOUSING AUTHORITY) ESTABLISHED THE VITA HEALTH AND WELLNESS DISTRICT IN THE WEST SIDE. IN PARTNERSHIP WITH THE WSNRZ, THE CITY OF STAMFORD AND CHARTER OAK COMMUNITIES (COC) THE VITA PLAN IS INTENDED TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH, INCLUDING HEALTH AND WELLNESS, NUTRITION AND ACCESS TO NUTRITIOUS FOOD, ACTIVE LIVING AND HEALTHY LIFESTYLES, WORKFORCE DEVELOPMENT, ECONOMIC DEVELOPMENT AND IMPROVING THE HOSPITAL AND COMMUNITY CONNECTIONS.

PROMOTION OF COMMUNITY HEALTH

THE STAMFORD HOSPITAL ("SH OR THE "HOSPITAL") PROVIDES A VARIETY OF PROGRAMS THAT BENEFITED THE COMMUNITY. THESE PROGRAMS INCLUDED, FOR EXAMPLE, HEALTH SPECIFIC HEALTH FACTORS OR DISEASE ENTITIES SUCH AS HEART DISEASE, BREAST CANCER, DIABETES SELF-MANAGEMENT, SLEEP DISORDERS,

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ARTHRITIS, HIGH CHOLESTEROL, CANCER PREVENTION, NUTRITION, STRESS MANAGEMENT, CIRCULATORY PROBLEMS, DIGESTIVE DISORDERS, ORTHOPEDICS, PAIN MANAGEMENT, SPORTS INJURIES, AND CHILDREN'S NUTRITION.

SH 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, GASTROENTEROLOGY, GENERAL ANATOMY, GYNECOLOGY, INFECTIOUS DISEASES, INTEGRATIVE MEDICINE, MEDICAL DECISION-MAKING, PULMONARY MEDICINE AND ORTHOPEDICS.

HOSPITAL STAFF PROVIDED SERVICES AT COMMUNITY HEALTH FAIRS AND SERVED AS SPEAKERS AT VARIOUS COMMUNITY GROUPS ON LIFESTYLE/HEALTH IMPROVEMENT TOPICS. IN FISCAL YEARS 2016, SH PARTICIPATED IN SCHOOL LECTURES; PHYSICIAN PRESENTATIONS AS WELL AS CAREER DAYS, SCHOOL TOURS AND INFORMATIONAL SPECIAL EVENTS.

OTHER HIGHLIGHTS OF COMMUNITY HEALTH EDUCATION AND OUTREACH ACTIVITIES PROVIDED IN FY 2016 ARE AS FOLLOWS:

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AMERICARES FREE CLINIC OF STAMFORD:

IMPROVING ACCESS TO CARE FOR UNINSURED: FY 2016 - $863,000

STAMFORD HOSPITAL SUPPORTS THE AMERICARES FREE CLINIC OF STAMFORD, PROVIDING READY ACCESS TO HIGH QUALITY DIAGNOSTICS, ESSENTIAL FOR THIS PATIENT POPULATION WHICH IS UNINSURED AND DOES NOT QUALIFY FOR ANY GOVERNMENT PROGRAMS. AMERICARES FREE CLINICS (AFC) ALSO PARTICIPATES ACTIVELY IN THE STAMFORD COMMUNITY COLLABORATIVE. STAMFORD HOSPITAL PROVIDES SPECIALTY CARE TO AFC PATIENTS PRIMARILY THROUGH STAMFORD HOSPITAL'S NETWORK OF SPECIALTY CLINICS. THE MAJORITY OF THE VISITS MADE TO THE FREE CLINIC ARE BY PATIENTS WITH CHRONIC DISEASES - UNDIAGNOSED AND UNCONTROLLED DIABETES AND HYPERTENSION BEING THE MOST COMMON. WITH ONGOING SUPPORT THROUGH EDUCATION AND CLOSE MEDICAL MANAGEMENT, PATIENTS DEMONSTRATE COMPLIANCE AND GREATER CONTROL THEIR CHRONIC DISEASE AND REDUCTION IN EMERGENCY ROOM UTILIZATION.

ASTHMA EDUCATION:

SH CONDUCTED AN EVENT FOR THE COMMUNITY WITH EXHIBITS TO EDUCATE AND CREATE AN AWARENESS AND UNDERSTANDING OF ASTHMA. TOPICS INCLUDED KEEPING ASTHMA UNDER CONTROL, UTILIZING A TEAM APPROACH IN TREATING ASTHMA, THE

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ROLE OF ALLERGIES, AND THE FUTURE OF ASTHMA THERAPY. THE HOSPITAL ALSO

HELD EDUCATIONAL EVENTS THAT FOCUSED ON PEDIATRIC ASTHMA.

CANCER OUTREACH AND EDUCATION:

AS REQUIRED BY THE AMERICAN COLLEGE OF SURGEONS COMMISSION ON CANCER, A

CANCER COMMITTEE OVERSEES STAMFORD HOSPITAL'S CANCER PROGRAM, OF WHICH

EDUCATIONAL AND OUTREACH PROGRAMS FOR THE COMMUNITY AND PATIENTS ARE A

KEY COMPONENT. A PARTNERSHIP BETWEEN THE CITY OF STAMFORD, THE AMERICAN

CANCER SOCIETY AND STAMFORD HEALTH'S BENNETT CANCER CENTER CONTINUES TO

WORK COLLABORATIVELY AND SUCCESSFULLY TO GET THE MESSAGE OUT TO STAMFORD

AND THE SURROUNDING COMMUNITIES REGARDING THE IMPORTANCE OF SCREENING AND

EARLY DETECTION OF CANCERS.

DIRECT MAIL IS USED TO REMIND WOMEN OF THE IMPORTANCE OF SCREENING FOR

BREAST CANCER. PAINT THE TOWN PINK, A COMMUNITY-WIDE BREAST CANCER

AWARENESS PROGRAM, HELD A MONTH-LONG SERIES OF EVENTS IN OCTOBER. IN

ADDITION, EDUCATIONAL LECTURES OFFERED THROUGHOUT THE YEAR FOR THE

COMMUNITY INCLUDE TOPICS FOCUSED ON RAISING AWARENESS ABOUT THE DANGERS

OF SUN EXPOSURE AND RISKS FOR SKIN CANCER, DIRECT MAIL INITIATIVES AND

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PROGRAMS TO UNDERSCORE THE IMPORTANCE OF SCREENING AND EARLY DETECTION OF

COLORECTAL CANCERS, AS WELL AS EDUCATION SURROUNDING TESTICULAR AND

GYNECOLOGIC CANCERS. CANCER OUTREACH EFFORTS ALSO INCLUDE ANTI-TOBACCO

LECTURES AND AN ANTI-SMOKING POSTER CONTEST FOR ELEMENTARY SCHOOL

CHILDREN. THE HOSPITAL OFFERS A SMOKING CESSATION PROGRAM YEAR-ROUND.

NUTRITION PROGRAMS, LED BY A REGISTERED DIETITIAN, ARE OFFERED THROUGHOUT

THE YEAR.

CANCER SCREENINGS:

STAMFORD HOSPITAL OFFERS MAMMOGRAPHY SCREENING TO THE COMMUNITY AT NO

COST TO PATIENTS WHO ARE UNINSURED. IN FY 16, 18,520 WOMEN RECEIVED

MAMMOGRAMS, OF WHICH 552 WERE PERFORMED AT NO COST. STAMFORD HOSPITAL

ALSO PARTICIPATES IN THE CONNECTICUT BREAST AND CERVICAL CANCER EARLY

DETECTION PROGRAM (CBCCEDP). IN 2016, 85 MAMMOGRAMS, 123 PAP SMEARS AND

116 HPV TESTS WERE PERFORMED.

TO REACH THE UNDERSERVED, THE HOSPITAL COLLABORATED WITH OPTIMUS HEALTH

CARE ("OPTIMUS"), A FEDERALLY QUALIFIED HEALTH CENTER, THE WITNESS

PROJECT OF CT, PLANNED PARENTHOOD OF CT, AND THE HISPANIC COUNCIL OF

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GREATER STAMFORD. OUTREACH WAS TARGETED TO UNDERINSURED AND UNINSURED

WOMEN OF COLOR, AND ASSISTANCE PROVIDED TO ADDRESS LANGUAGE BARRIERS,

NAVIGATE THE HEALTHCARE SYSTEM, AND COPE WITH FEAR. STAMFORD HOSPITAL

FUNDS A CLINICAL NAVIGATOR AT OPTIMUS HEALTH TO ASSIST IN COORDINATING

CARE FOR CANCER SCREENINGS AS WELL AS PATIENTS WHO ARE DIAGNOSED WITH

CANCER THROUGH OUR COLLABORATION.

LUNG CANCER IS THE SECOND MOST COMMON CANCER IN BOTH MEN AND WOMEN IN THE

UNITED STATES. IT'S ALSO THE LEADING CAUSE OF CANCER-RELATED DEATHS, AND

MOST OF THE TIME IS NOT DIAGNOSED UNTIL SYMPTOMS APPEAR. STAMFORD

HOSPITAL HAS A ROBUST LUNG CANCER SCREENING PROGRAM. IN 2016, 359 LUNG

SCREENING CT SCANS WERE PERFORMED. FROM THESE SCREENINGS, 4 EARLY LUNG

CANCERS WERE DETECTED AND TREATED.

TO PROVIDE GREATER ACCESS TO SCREENING FOR COLON CANCER, STAMFORD

HOSPITAL IN PARTNERSHIP WITH OPTIMUS HEALTH CARE BEGAN TO OFFER FIT TESTS

TO PATIENTS THROUGH THE FAMILY MEDICINE AND INTERNAL MEDICINE CLINICS. IN

2016 89 TESTS WERE PROVIDED TO PATIENTS, 4 PATIENTS HAD POSITIVE

FINDINGS. THREE COLONOSCOPIES WERE PERFORMED BASED ON THESE RESULTS; ALL

WERE NEGATIVE FOR COLON CANCER.

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OTHER KEY 2016 ACCOMPLISHMENTS FOR THE BENNETT CANCER CENTER INCLUDE:

- THE BENNETT CANCER CENTER WAS SELECTED AS THE FIRST IN CONNECTICUT TO BECOME A MEMBER OF THE DANA-FARBER/BRIGHAM AND WOMEN'S CANCER CARE COLLABORATIVE.

- AS PART OF THE MAGNET DESIGNATION ACHIEVED IN 2016, STAMFORD HOSPITAL RECEIVED AN EXEMPLAR RATING FOR PROMOTING EXCELLENCE IN ONCOLOGY NURSING.

- STAMFORD HOSPITAL'S CANCER PROGRAM WAS SURVEYED AND RECEIVED COMMENDATION STATUS BY THE AMERICAN COLLEGE OF SURGEONS COMMISSION ON CANCER.

- THE MEDICAL ONCOLOGY PRACTICE BECAME ONE OF 195 PRACTICES IN THE COUNTRY TO PARTICIPATE IN A PILOT PROGRAM, THE ONCOLOGY CARE MODEL (OCM), TESTING A NEW PAYMENT AND DELIVERY MODEL FOR THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

- JAMIE STRATTON, MD JOINED THE HEMATOLOGY ONCOLOGY, PC PRACTICE AT THE BENNETT CANCER CENTER.

- A DEDICATED ONCOLOGY NURSE MANAGER WAS HIRED TO OVERSEE ALL ASPECTS OF

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OUTPATIENT ONCOLOGY NURSING.

- TWO ADDITIONAL ONCOLOGY NURSE NAVIGATORS JOINED THE BENNETT CANCER CENTER TEAM BRINGING THE TOTAL NUMBER OF ONCOLOGY NURSE NAVIGATORS TO FIVE. ONCOLOGY NURSE NAVIGATORS PROVIDE PATIENTS WITH INDIVIDUALIZED SUPPORT THROUGHOUT THEIR CANCER JOURNEY.

- A CARE COORDINATOR POSITION WAS DEVELOPED AND IMPLEMENTED TO ASSIST NEWLY DIAGNOSED CANCER PATIENTS WITH ACCESS TO PHYSICIAN CONSULTATIONS.

- THE MEDICAL ONCOLOGISTS AT THE BENNETT CANCER CENTER WERE RECOGNIZED BY THE QUALITY ONCOLOGY PRACTICE INITIATIVE (QOPI®) CERTIFICATION PROGRAM, AN AFFILIATE OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO). THE QOPI CERTIFICATION PROGRAM PROVIDES A THREE-YEAR CERTIFICATION FOR OUTPATIENT HEMATOLOGY-ONCOLOGY PRACTICES THAT MEET THE HIGHEST STANDARDS FOR QUALITY CANCER CARE.

- 8% OF NEWLY DIAGNOSED CANCER PATIENTS WERE ENROLLED IN CLINICAL TRIALS.

COMMUNITY-BASED CLINICAL CARE:

OUR PARTNERSHIP WITH OPTIMUS HEALTH CARE, A FEDERALLY QUALIFIED HEALTH

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CENTER, INCLUDES HOSPITAL-EMPLOYED PHYSICIANS AND MID-LEVEL PROVIDERS

WORKING IN PRIMARY CARE CENTERS. OPTIMUS EMPLOYS ALL OTHER STAFF. THE

HOSPITAL PROVIDED SUPPLEMENTAL SUPPORT TO OPTIMUS OF $2.293 MILLION IN FY

2016 TO ENSURE ITS CONTINUED VIABILITY.

EMERGENCY SERVICES AND EDUCATION:

STAMFORD'S EMS INSTITUTE, A DEPARTMENT OF SH, PROVIDED EMERGENCY MEDICAL

SERVICE (EMS) TRAINING TO EMERGENCY MEDICAL TECHNICIANS, NURSES,

PHYSICIANS, PARAMEDICS, AND ANYONE IN THE PUBLIC WHO IS INTERESTED IN

LEARNING THESE LIVE-SAVING SKILLS. THE HOSPITAL OFFERED AN INFANT AND

CHILD CARE CLASS, AND AN ADULT CARDIO-PULMONARY RESUSCITATION ("CPR") AND

EMT-BASIC COURSE. THE SH EMS INSTITUTE ALSO COLLABORATED WITH SEMS.

REGARDING DISASTER PREPAREDNESS, THE HOSPITAL'S STAFF WORKED WITH

REGIONAL AGENCIES TO COORDINATE EMERGENCY PLANS AND CONDUCTED JOINT

SIMULATION DRILLS.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS: PEDIATRIC MEDICAL HOME

INITIATIVE OF SWCT (CYSHCN):

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MEDICAL HOME INITIATIVE (MHI) COVERING SOUTHWEST CT ADDRESSES THE NEEDS OF CHILDREN AND YOUTH WITH SPECIAL HEALTHCARE NEEDS. CYSHCN MEETS THEIR MEDICAL, SOCIAL AND EMOTIONAL NEEDS AND PROVIDES LINKAGES TO COMMUNITY RESOURCES AND FAMILY SUPPORT NETWORKS. FAMILIES ARE PROVIDED ASSISTANCE WITH CARE COORDINATION SUCH AS SECURING SPECIALIST APPOINTMENTS, TRANSPORTATION AND FUNDING FOR ESSENTIAL NEEDS LIKE RESPITE SERVICES, MEDICATIONS, DIAPERS, WHEELCHAIRS, RAMPS, ETC. IT ALSO PROVIDES FAMILIES WITH ADVOCACY IN SCHOOLS AND OTHER ORGANIZATIONS; PARENTS ARE OFFERED SUPPORT GROUPS HELD REGULARLY IN STAMFORD AND BRIDGEPORT. IN 2016, 856 CHILDREN WERE SERVED, OF WHOM 537 WERE OF HIGH COMPLEXITY. SOUTHWEST MHI IS FOCUSED ON PREVENTION AND INTERVENTIONS TARGETING CHILDHOOD OBESITY IN SWCT REGION AND BUILDING COMMUNITY COLLABORATION.

HIV-AIDS: RYAN WHITE PROGRAM

THE RYAN WHITE PROGRAM AT STAMFORD HOSPITAL CONTINUES TO SERVE HIV POSITIVE PATIENTS IN THE COMMUNITY. THE TEAM INCLUDES A DEDICATED NURSE PRACTITIONER (NP), ADHERENCE NURSE AND NUTRITIONIST WITH PROGRAM OVERSIGHT BY THE CHIEF OF INFECTIOUS DISEASE, DR. PARRY. THE HIV NP IS A

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RESOURCE AND PROVIDES ONGOING HIV/AIDS PRIMARY CARE UPDATES TO INTERNAL

MEDICINE RESIDENTS AND ATTENDING PHYSICIANS CARING FOR HIV POSITIVE

PATIENTS IN THE STAMFORD HEALTH SYSTEM. MEDICAL RESIDENTS ARE ALSO GIVEN

THE OPPORTUNITY TO CARE FOR HIV POSITIVE OUT-PATIENTS AT A BIMONTHLY

INFECTIOUS DISEASE CLINIC THAT IS TRIAGED AND SCHEDULED BY THE HIV NURSE

PRACTITIONER. AT THIS CLINIC, RESIDENTS WORK DIRECTLY WITH INFECTIOUS

DISEASE ATTENDINGS AND THE HIV NP TO CARE FOR HIV POSITIVE OUT-PATIENTS.

IN TOTAL, THE RYAN WHITE PROGRAM PROVIDES CARE TO APPROXIMATELY 100

PATIENTS IN THE CLINIC, WITH THE HIV NP PROVIDING DIRECT PRIMARY AND HIV

CARE TO 70 OF THOSE PATIENTS. PATIENTS ARE SEEN AT THE CLINIC AND AS

NEEDED DURING AN IN-PATIENT STAY AT THE HOSPITAL.

RYAN WHITE QUALITY IMPROVEMENT PROJECTS FOR THIS YEAR INCLUDE INCREASING

THE NUMBER OF PATIENTS WHO RECEIVED INFLUENZA VACCINES AND ANNUAL

CERVICAL CANCER SCREENING. OTHER RYAN WHITE PERFORMANCE MEASURES,

INCLUDING BIANNUAL CLINIC VISITS, SUPPRESSED HIV VIRAL LOADS AND

SCREENING FOR OTHER SEXUALLY TRANSMITTED INFECTIONS, CONTINUE TO MEET OR

EXCEED BENCHMARKS FOR PRIMARY CARE AND ADHERENCE, WITH AN AGGREGATE SCORE

OF >90%. RYAN WHITE PATIENT SATISFACTION AND FEEDBACK CONTINUES TO BE

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MEASURED BY AN ANNUAL PATIENT SURVEY, WHICH IS DEVELOPED AND REVIEWED

WITH OUR CONTRACTOR, FAMILY CENTERS. THIS YEAR, RESULTS CONTINUED TO SHOW

>80% PATIENT SATISFACTION. SPECIFICALLY, THE RESULTS INDICATE WE ARE

PROVIDING CONVENIENT, CULTURALLY-SENSITIVE COMPREHENSIVE CARE. THE RYAN

WHITE NP IS ALSO PART OF THE PERINATAL INFECTIOUS DISEASE TRANSMISSION

PREVENTION COMMITTEE AND ALONG WITH ID ATTENDINGS, OB, INFECTIONS

PREVENTION NURSES AND SOCIAL WORK, PARTICIPATES IN MANAGEMENT OF

PREGNANCIES AFFECTED BY HIV OR OTHER INFECTIOUS DISEASES. IN THIS ROLE,

THE NP SERVES AS A RESOURCE FOR COMMITTEE MEMBERS AS WELL AS STAFF AND

PATIENTS.

COMMUNITY CARE TEAM:

STAMFORD HOSPITAL FORMED THE COMMUNITY CARE TEAM (CCT) TO STRENGTHEN

COORDINATION AND TO IMPROVE HEALTH OUTCOMES FOR VULNERABLE POPULATIONS,

INCLUDING THOSE WHO ARE CHRONICALLY PHYSICALLY AND/OR MENTALLY ILL,

HOMELESS, OR ABUSING SUBSTANCES. THE GOALS ARE TO IMPROVE CARE, INCREASE

COMMUNITY SAFETY AND REDUCE COSTS BY PROVIDING WRAPAROUND SERVICES

THROUGH A MULTI-AGENCY PARTNERSHIP. THE NAVIGATOR ESTABLISHES A

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RELATIONSHIP WITH THE PATIENT BY MAKING DIRECT AND INDIRECT REFERRALS FOR TREATMENT, BY ENGAGING THE PATIENT TOWARDS FINDING HOUSING AND SOCIAL WRAPAROUND SUPPORT SERVICES. THEY ALSO COMPLETE "CHECK-IN" CALLS FOR THOSE IN THE COMMUNITY WHO ARE STILL STRUGGLING. THE NAVIGATOR EMPLOYED BY STAMFORD HOSPITAL, IS CRITICAL TO THE WORK OF THE CCT IN ENSURING THE TEAM'S ABILITY TO CREATE COORDINATED CARE PLANS FOR EVERY CLIENT PRIORITIZED BY THE TEAM.

THIS HOSPITAL-LED TEAM HAS DEMONSTRATED IMPROVED OUTCOMES AND SIGNIFICANT COST-SAVINGS. THE NAVIGATOR WORKS WITH THE ENTIRE COMMUNITY CARE TEAM, FOCUSING ON COORDINATING CARE FOR THE HIGH USERS OF OUR HOSPITAL EMERGENCY DEPARTMENT, THE MAJORITY OF WHOM ARE HOMELESS, SEVERELY MENTALLY ILL, OR ACTIVELY STRUGGLING WITH ADDICTION. THE STAMFORD CCT CONVENES PROVIDERS FROM ACROSS OUR COMMUNITY WHO CAN ASSIST IN CONNECTING PATIENTS TO CONSISTENT, QUALITY COMMUNITY-BASED HEALTH CARE, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES. THEY ALSO HELP ACCESS TWO FEDERALLY QUALIFIED HEALTH CENTERS (FQHC'S), OTHER MEDICAL SERVICES, CITY SOCIAL SERVICES, THE STAMFORD HOUSING AUTHORITY, FAMILY CENTERS, HOMELESS SHELTERS AND VETERAN'S ADVOCATES. IN THE 90 DAYS PRIOR TO BEING HOUSED A

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HOMELESS DIABETIC WAS HOSPITALIZED A TOTAL OF 63 DAYS. POST HOUSING AND PHYSICIAN VISITS THE SAME PATIENT HAS BEEN HOSPITALIZED ONLY 8 DAYS WITHIN A 90 DAY PERIOD. ALL PATIENTS HAVE FOLLOWED UP WITH PRIMARY CARE PHYSICIANS AND HAVE BEEN COMPLIANT WITH MEDICATION.

THESE RESULTS SHOW SUPERIOR CLINICAL OUTCOMES FOR OUR PATIENTS ALONG WITH SIGNIFICANT FINANCIAL BENEFITS FOR THE HEALTH SYSTEM.

VITA/FAIRGATE FARM:

FAIRGATE FARM, IS A COMMUNITY BUILDING CATALYST FOR STAMFORD'S WEST SIDE AND BEYOND, THROUGH OPERATION OF AN INCLUSIVE, COMMUNAL AND SOCIALLY AND ENVIRONMENTALLY-RESPONSIBLE URBAN FARM THAT AIMS TO REDUCE HEALTH DISPARITIES, EXPAND ACCESS TO HEALTHY FOODS, FOSTER HEALTH-ORIENTED EDUCATION AND JOB TRAINING, AND INCREASE SOCIAL COHESION AMONG DIVERSE RESIDENTS. STAMFORD HOSPITAL SUPPORTED FAIRGATE FARM WITH A PART TIME GARDENER.

VITA HEALTH & WELLNESS INITIATIVE:

VITA STRIVES TO IMPROVE THE HEALTH OF THE WEST SIDE BY IMPROVING LIVING

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CONDITIONS INCLUDING HOUSING, ACCESS TO HEALTH CARE, AVAILABILITY OF NUTRITIOUS FOODS, WORKFORCE TRAINING AND PLANNING PUBLIC SPACES FOR PHYSICAL FITNESS ACTIVITIES. VITA ADDRESSES THE ASPECTS OF HEALTH THAT ARE INFLUENCED BY SOCIO-ECONOMIC FACTORS. IN FY16, VITA CONVENED WEST SIDE MERCHANTS TO WORK WITH THE STAMFORD POLICE DEPARTMENT TO ADDRESS AN INCREASE IN ALCOHOL ABUSE AND VIOLENT CRIME. VITA, WORKING IN COLLABORATION WITH THE CITY OF STAMFORD AND LOCAL ELECTED OFFICIALS IMPLEMENTED TRAFFIC CALMING INITIATIVES, IMPROVED WALKABILITY INITIATIVES AND ADVOCATED FOR INCREASED SAFETY MEASURES IN THE NEIGHBORHOOD. VITA RECEIVED A ROBERT WOOD JOHNSON FOUNDATION GRANT TO SUPPORT THE WORK OF THE COLLABORATIVE.

THE VITA COMMUNITY COLLABORATIVE MEETS MONTHLY. SH AND CHARTER OAK COMMUNITIES (COC) ARE THE TWO BACKBONE INSTITUTIONS FUNDING AND LEADING THE COLLABORATIVE, WHICH INCLUDE KEY STRATEGIC PROVIDERS ALIGNED TO IMPROVE THE HEALTH OF THE PEOPLE LIVING IN THE WEST SIDE, CENSUS TRACTS 214 AND 215. IN ADDITION TO FINANCIAL SUPPORT, SH PROVIDES IN-KIND MANAGEMENT SUPPORT.

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VITA: PARENTS AS CO-EDUCATORS PILOT PROJECT:

SH, AS A CO-BACKBONE LEADER OF THE VITA HEALTH & WELLNESS INITIATIVE, DEVELOPED A THREE-YEAR RESEARCH AND DEVELOPMENT PROJECT TO ADDRESS CULTURALLY RELATED ACHIEVEMENT GAPS BY BRINGING A FULL SPECTRUM OF SERVICES TO THE FAMILIES MOST IN NEED. THE HOSPITAL PARTICIPATED IN THE DESIGN OF THE PROGRAM IN PARTNERSHIP WITH CHARTER OAK COMMUNITIES, FAMILY CENTERS, INC., THE CHILDCARE LEARNING CENTER AND BUILDINGONECOMMUNITY (NEIGHBORSLINK). THE PROJECT IS BASED ON THE PARENTS-AS-TEACHERS MODEL, WHICH HAS PROVEN THAT AS PARENTS BECOME MORE ACTIVE AS CO-EDUCATORS OF THEIR CHILDREN, PUBLIC SCHOOL READINESS DISPARITIES DECREASE SIGNIFICANTLY. THE PROJECT WAS DEVELOPED AND PRIVATELY FUNDED OVER THREE YEARS.

STATE INNOVATION MODEL - IN-KIND CONTRIBUTION OF EXPERTISE - SH CHIEF QUALITY OFFICER

SH CHIEF QUALITY OFFICER WAS APPOINTED TO THE QUALITY COMMITTEE OF CONNECTICUT'S STATE INNOVATION MODEL TASK FORCE. THIS GROUP WILL RECOMMEND A CORE MEASUREMENT SET FOR USE IN THE ASSESSMENT OF PRIMARY

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CARE, SPECIALTY, AND HOSPITAL PROVIDER PERFORMANCE. THE COUNCIL WILL ALSO

RECOMMEND A COMMON PROVIDER SCORECARD FORMAT FOR USE BY ALL PAYERS. THE

MEASUREMENT SET WILL BE REASSESSED ON A REGULAR BASIS TO IDENTIFY GAPS,

TO INCORPORATE NEW NATIONAL MEASURES AS THEY BECOME AVAILABLE, AND TO

KEEP PACE WITH CHANGES IN TECHNOLOGY AND CLINICAL PRACTICE.

KIDS'FANS:

STAMFORD HOSPITAL'S KIDS' FANS (FITNESS AND NUTRITION SERVICES) PROGRAM

PROMOTES CHILDHOOD WELLNESS, OBESITY PREVENTION AND PHYSICAL ACTIVITY

USING A HANDS-ON CURRICULUM WHICH IS DESIGNED TO MAKE LEARNING ABOUT

HEALTHY EATING AND REGULAR EXERCISE ENGAGING AND INTERACTIVE FOR CHILDREN

AGES PRE-K TO HIGH SCHOOL. THE PROGRAM ENCOURAGES EMPOWERMENT AND TEACHES

AGE-APPROPRIATE TOOLS AND SKILLS TO HELP KIDS BEST NAVIGATE THEIR FOOD

ENVIRONMENT.

KIDS' FANS HAS BEEN PROVEN TO INCREASE CHILDREN'S AWARENESS OF HEALTHY

FOODS AND POSITIVELY INFLUENCE THEIR DIETARY BEHAVIORS. THE PROGRAM HAS

SIGNIFICANTLY GROWN SINCE ITS INCEPTION IN 2009 AND HAS EXPANDED ITS

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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.

REACH IN THE LAST THREE YEARS FROM ABOUT THIRTEEN PARTICIPATING SITES AND 300 CHILDREN ENROLLED TO APPROXIMATELY 35 SITES AND OVER 2,200 CHILDREN ESTIMATED FOR THE 2016 - 2017 SCHOOL YEAR. THIS INITIATIVE INCLUDES A COMMUNITY-WIDE NUTRITION PROGRAM NOW BEING TAUGHT IN SCHOOLS FROM PRE-K TO HIGH SCHOOL, AS WELL AS IN SUMMER CAMPS, AFTER-SCHOOL PROGRAMS AND HEALTH FAIRS.

THE CURRICULUM WAS UPDATED TO INCLUDE MORE NUTRITIONAL THEMES, INTERACTIVE ACTIVITIES AND PRACTICAL TIPS FOR KIDS. THE PROGRAM WAS SUBSEQUENTLY PILOTED IN THREE STAMFORD ELEMENTARY SCHOOLS AND RECEIVED POSITIVE REVIEWS. AS A RESULT, KIDS' FANS WAS APPROVED TO TEACH NUTRITION EDUCATION TO ALL 3RD GRADERS (~1,284 STUDENTS) ENROLLED IN STAMFORD'S TWELVE PUBLIC ELEMENTARY SCHOOLS AS PART OF THEIR HEALTH CURRICULUM.

IN 2015, KIDS FANS' TEAMED UP WITH THE FAMILY CENTER'S SCHOOL BASED HEALTH CLINICS (SBHC) AT ONE MIDDLE SCHOOL AND, TWO HIGH SCHOOLS IN STAMFORD TO PROVIDE ONE-ON-ONE NUTRITION COUNSELING TO STUDENTS REFERRED FROM THE CLINIC'S NURSE PRACTITIONER OR SOCIAL WORKER OR AS REQUESTED BY

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 STUDENTS THEMSELVES. THIS PROGRAM CONTINUES TO RUN SUCCESSFULLY.

AS CHILDREN DEVELOP THEIR FOOD PREFERENCES IN INFANCY, KIDS' FANS

PARTNERED WITH THE LARGEST CHILDCARE PROVIDERS IN FAIRFIELD COUNTY WITH

NEARLY 1,000 CHILDREN ENROLLED, TO TEACH NUTRITION EDUCATION TO PRE-K

STUDENTS (AGES 3 - 5) AND NUTRITION EDUCATION CLASSES FOR PARENTS TO

PROMOTE A HEALTHY HOME ENVIRONMENT.

KIDS' FANS COLLABORATES REGULARLY WITH STAMFORD'S URBAN, ORGANIC AND

COMMUNITY-BASED FAIRGATE FARM. IN SUMMER OF 2016, KIDS' FANS TAUGHT THE

CHILDREN'S NUTRITION COMPONENT OF FAIRGATE FARM'S ANNUAL STRAWBERRY JAM

FESTIVAL AND 6-WEEK SUMMER PROGRAM FOCUSED ON ENCOURAGING FARM-TO-TABLE

EATING AND IMPROVING ACCESS TO AFFORDABLE, WHOLE FOODS.

TO REACH KIDS DURING THE OFF-SEASON, KIDS' FANS PARTICIPATED IN FOUR

SUMMER CAMPS IN 2015 WHICH SINCE GREW TO SIX CAMPS DURING THE SUMMER OF

2016. OVER 600 CHILDREN RECEIVED KIDS' FANS CLASSES THIS PAST SUMMER AT

FIVE CAMP PROGRAMS.

KIDS' FANS CONTINUES TO TEACH AFTER SCHOOL PROGRAMS, WHICH INCLUDE A

COOKING COMPONENT TO EXPOSE KIDS TO NEW AND UNFAMILIAR FOODS AS WELL AS

TEACH KIDS HOW TO PREPARE SIMPLE BUT ALSO HEALTHY AND AFFORDABLE MEALS.

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.

COMMUNITY OUTREACH IS AN INTEGRAL PART OF HELPING KIDS' FANS CONTINUE TO

PROMOTE HEALTHY EATING AND PHYSICAL ACTIVITY AND ITS PRESENCE AT LOCAL

HEALTH FAIRS AND REQUEST FOR PRESENTATIONS IS ROBUST AND ONGOING.

IN-KIND COMMUNITY SUPPORT:

SH DONATES ITS CONFERENCE ROOMS WEEKLY TO THE RED CROSS FOR BLOOD DRAW

AND WEEKLY AA MEETINGS. MONTHLY MEETINGS ARE DONATED TO THE NATIONAL

ALLIANCE ON MENTAL HEALTH (NAMI-ADULTS) AND NEW THIS YEAR, A NAMI FOR

CHILDREN AND ADOLESCENTS. SH HOSTS THE BUILDING1COMMUNITY BOARD MEETING;

COMPASSIONATE FRIENDS, FOR PARENTS WHO HAVE LOST CHILDREN. THE TRI-STATE

SCLERODERMA FOUNDATION, THE PARISH NURSES AND THE AMPUTEE SUPPORT GROUP.

ORTHOPEDICS:

HEALTH EDUCATION PROGRAMS FOCUSING ON ORTHOPEDIC HEALTH, SPORTS MEDICINE

AND CONCUSSION PREVENTION INFORMATION.

WOMEN'S HEALTH:

PRESENTATIONS BY PHYSICIANS ON WOMEN'S HEART HEALTH, CONTROLLING HIGH

BLOOD PRESSURE AND STRESS, WERE ALSO CONDUCTED THROUGHOUT THE YEAR AT

BUSINESSES AND COMMUNITY CENTERS.

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" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.**
▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2015

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 on 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		
	[X] Tax indemnification and gross-up payments		
	[ ] Discretionary spending account		
	[X] Housing allowance or residence for personal use		
	[ ] Payments for business use of personal residence		
	[X] 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.		
	[X] Compensation committee		
	[X] Independent compensation consultant		
	[ ] Form 990 of other organizations		
	[X] Written employment contract		
	[X] Compensation survey or study		
	[X] Approval by the board or compensation committee		
4	During the year, did any person listed on 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), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.		
5	For persons listed on 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 on 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" on line 6a or 6b, describe in Part III.		
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described on lines 5 and 6? If "Yes," describe in Part III . . . **7**		X
8	Were any amounts reported on 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 on 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 in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	KATHLEEN A. SILARD	(i)	644,903.	142,062.	91,916.	13,481.	39,398.	931,760.	0.
	ASST. SECRETARY	(ii)	0.	0.	0.	0.	0.	0.	0.
2	GERALD B. RAKOS, M.D.	(i)	448,471.	43,911.	21,205.	0.	26,629.	540,216.	0.
	DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
3	JOSHUA HERBERT, M.D.	(i)	0.	0.	0.	0.	0.	0.	0.
	DIRECTOR	(ii)	294,559.	0.	5,495.	0.	35,584.	335,638.	0.
4	BRIAN GRISSLER	(i)	1,071,347.	330,443.	674,078.	0.	37,453.	2,113,321.	0.
	PRESIDENT & CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
5	CHARLES LITTLEJOHN, M.D	(i)	0.	0.	0.	0.	0.	0.	0.
	DIRECTOR	(ii)	382,274.	20,625.	5,757.	0.	39,111.	447,767.	0.
6	MICHAEL COADY, M.D.	(i)	829,765.	80,000.	154,805.	13,369.	10,465.	1,088,404.	0.
	CHIEF OF CARDIAC SURGERY	(ii)	0.	0.	0.	0.	0.	0.	0.
7	MICHAEL STONE, M.D.	(i)	784,378.	50,000.	5,757.	10,600.	36,864.	887,599.	0.
	CHAIR OF SURGERY	(ii)	0.	0.	0.	0.	0.	0.	0.
8	SHARON KIELY, M.D.	(i)	543,370.	103,958.	94,857.	13,442.	39,398.	795,025.	0.
	SVP, MEDICAL AFFAIRS	(ii)	0.	0.	0.	0.	0.	0.	0.
9	NICOLA CORVAJA, M.D.	(i)	552,534.	74,850.	13,996.	10,600.	24,760.	676,740.	0.
	CARDIOLOGIST	(ii)	0.	0.	0.	0.	0.	0.	0.
10	MICHAEL PARRY, M.D.	(i)	545,930.	44,158.	40,578.	0.	24,904.	655,570.	0.
	PHYSICIAN CHIEF INFEC DISEASES	(ii)	0.	0.	0.	0.	0.	0.	0.
11	KEVIN GAGE	(i)	640,835.	143,274.	78,259.	13,409.	39,398.	915,175.	0.
	TREASURER/CFO	(ii)	0.	0.	0.	0.	0.	0.	0.
12	DARRYL MCCORMICK	(i)	419,469.	97,721.	51,156.	0.	12,912.	581,258.	0.
	ASSISTANT SECRETARY	(ii)	0.	0.	0.	0.	0.	0.	0.
13	DAVID SMITH	(i)	446,251.	72,454.	32,189.	0.	39,398.	590,292.	0.
	ASSISTANT SECRETARY	(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

GROSS-UP PAYMENTS, PER POLICY, ARE PROCESSED ON ALL TAXABLE BENEFITS.

HOUSING ALLOWANCES ARE PAID TO A SELECT GROUP OF EMPLOYEES (AS NEGOTIATED

BY CONTRACTED RESIDENTS). HEALTH CLUB DUES ARE PAID FOR ON-SITE SARNER

(LOCATED OUTPATIENT TULLY) FOR BRIAN GRISSLER, PRESIDENT AND CEO.

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" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2015

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 AUTHORITY	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 AUTHORITY	06-0806186	20774YKQ9	06/20/2012	254,620,769.	CONSTRUCTION OF NEW HOSPITAL		X		X		X
C	STATE OF CT HEALTH AND EDUCATION FAC AUTHORITY	06-0806186	20774U3P8	07/27/2016	50,921,018.	SEE SCHEDULE K, PART VI		X		X		X
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	28,235,000.			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	133,995,069.	254,620,769.	50,921,018.	
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	2,057,323.	2,935,597.	921,018.	
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	24,835,260.	251,685,172.	50,000,000.	
11	Other spent proceeds	107,102,486.			
12	Other unspent proceeds				
13	Year of substantial completion	2011	2016	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		X		
15	Were the bonds issued as part of an advance refunding issue?		X		X		X		
16	Has the final allocation of proceeds been made?	X		X		X			
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		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		X		
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		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		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		X			
c Are there any research agreements that may result in private business use of bond-financed property?	X		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?	X		X		X			
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		X		
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		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		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		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X	X		X			
b Exception to rebate?		X		X		X		
c No rebate due?	X			X		X		
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X		X		
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		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		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		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		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		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

THE STATE OF CONNECTICUT HEALTH AND EDUCATIONAL FACILITIES AUTHORITY

REVENUE BONDS, SERIES I (THE SERIES I BONDS) WERE ISSUED ON MAY 12, 2010,

FOR A TERM OF 20 YEARS, AT A PREMIUM OF $1,002,000. THE SERIES I BONDS

WERE USED FOR

1)REFUNDING OF COMMERCIAL LOANS AND THE STATE OF CONNECTICUT HEALTH AND

EDUCATIONAL FACILITIES AUTHORITY REVENUE BONDS, ISSUED AS FOLLOWS:

11/13/96, 3/24/99, 6/03/08 AND 5/28/09.

2)FINANCING ROUTINE RENOVATION AND OTHER CAPITAL EXPENDITURES

3)FINANCING THE DEVELOPMENT AND CONSTRUCTION OF NEW HOSPITAL FACILITY

4)THE PROCEEDS ALSO REIMBURSED THE STAMFORD HOSPITAL (TSH) FOR CERTAIN

COSTS OF ISSUANCE OF THE SERIES I BONDS.

SCHEDULE K, PART I COLUMN (F) BOND B

THE STATE OF CONNECTICUT HEALTH AND EDUCATIONAL FACILITIES AUTHORITY

REVENUE BONDS, SERIES J (THE SERIES J BONDS) WERE ISSUED ON JUNE 20, 2012

IN THE AMOUNT OF $250,000,000 FOR A TERM OF 30 YEARS, AT A PREMIUM OF

$4,621,000.

THE SERIES J BONDS PROCEEDS WERE USED FOR FINANCING ARCHITECTURAL,

ENGINEERING, SITE PERMITTING, LEGAL PLANNING, AND CONSTRUCTION COSTS

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

RELATING TO THE CONSTRUCTION OF A NEW HOSPITAL FACILITY. THE PROCEEDS

ALSO REIMBURSED TSH FOR CERTAIN COSTS OF ISSUANCE OF THE SERIES J BONDS.

SCHEDULE K, PART I COLUMN (F) BOND C

THE STATE OF CONNECTICUT HEALTH AND EDUCATIONAL FACILITIES AUTHORITY

REVENUE BONDS, SERIES K (THE SERIES K BONDS) WERE ISSUED ON JULY 27,

2016, FOR A TERM OF 30 YEARS, AT A PREMIUM OF $3,301,000. THE SERIES K

BONDS WERE USED FOR

1) REIMBURSING A PORTION OF THE COSTS OF THE CONSTRUCTION, FURNISHING,

AND EQUIPPING A MASTER FACILITY PLAN EXECUTED TO CONSTRUCT A NEW HOSPITAL

BUILDING AND CENTRAL UTILITY PLANT.

2) REIMBURSING TSH FOR CERTAIN COSTS OF ISSUANCE OF THE SERIES K BONDS.

SCHEDULE K, PART II, LINE 3

THERE ARE VARIANCES BETWEEN PROCEEDS AND THE ISSUE AND THE ISSUE PRICE

FOR ALL BONDS DUE TO INVESTMENT EARNINGS.

SCHEDULE K, PART IV, LINE 2C BOND A

THE DATE OF THE MOST RECENT REBATE COMPUTATION WAS JUNE 20, 2016.

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

2015

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	32.	1,152,028.	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	X	1.	245,000.	APPRAISAL
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		
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 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	
32a	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.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization
THE STAMFORD HOSPITAL

Employer identification number
06-0646917

FORM 990, PART VI, LINE 6

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

FORM 990, PART VI, LINE 7A

SHI, THE SOLE MEMBER OF THE HOSPITAL, HAS THE POWER, AS THE SOLE MEMBER: TO ELECT THE BOARD OF DIRECTORS OF 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). SHI 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

SHI 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 HOSPITAL HAS A COMPREHENSIVE REVIEW PROCESS IN PLACE RELATING TO THE REVIEW OF FORM 990. PRIOR TO FINALIZATION OF THE FORM

Name of the organization: THE STAMFORD HOSPITAL

Employer identification number: 06-0646917

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 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 HOSPITAL, OR ITS PATIENTS. EMPLOYEES ARE EXPECTED TO CONDUCT THE BUSINESS OF THE HOSPITAL TO THE BEST OF THEIR ABILITY AND FOR THE BENEFIT OF THE 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 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.

Name of the organization: THE STAMFORD HOSPITAL

Employer identification number: 06-0646917

FORM 990, PART VI, LINE 19

THE HOSPITAL MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY

AND FINANCIAL STATEMENTS AVAILABLE UPON REQUEST.

FORM 990, PART XI, LINE 9

PENSION ADJUSTMENT -	($23,599,983)
SHI EQUITY TRANSFER -	$1,782,000
SHMG EQUITY TRANSFER -	($34,275,000)
TOTAL	($56,092,983)

ATTACHMENT 1

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HEMATOLOGY ONCOLOGY ASSOC., PC ONE HOSPITAL PLAZA STAMFORD, CT 06904	PHYSICIAN FEES/ONCOL	4,509,632.
NEUBERT PEPE AND MONTEITH PC 195 CHURCH STREET 13TH FLOOR NEW HAVEN, CT 06510	LEGAL FEES	957,548.
EXECUTIVE CONSULTING GROUP, LLC 1111 THIRD AVE SEATTLE, WA 98101	IS CONSULTING SERVIC	807,408.
PULMONARY ASSOCIATES OF STAMFORD 190 WEST BROAD ST. STAMFORD, CT 06902	PHYSICIAN FEES	685,667.
ERNST AND YOUNG LLP P.O. BOX 640382 PITTSBURGH, PA 15264	AUDIT SERVICES	609,099.

Name of the organization: THE STAMFORD HOSPITAL

Employer identification number: 06-0646917

ATTACHMENT 2

FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
CONSULTING SERVICES	4,946,448.	1,213,885.	3,593,871.	138,692.
PURCHASED SERVICES	23,141,045.	18,047,769.	5,086,585.	6,691.
PHYSICIAN FEES	10,308,674.	10,308,674.	0.	0.
COLLECTION FEES	3,539,052.	73,965.	3,421,890.	43,197.
DATA PROCESSING FEES	502,957.	51,051.	451,906.	0.
ARCHIVING EXPENSES	12,342.	0.	12,342.	0.
INTERCOMPANY STAFFING FEES	6,040,489.	5,291,927.	723,766.	24,796.
TEMPORARY SERVICES	909,336.	909,336.	0.	0.
COMMUNITY BENEFIT GRANT	2,291,321.	2,291,321.	0.	0.
DISCHARGE EXPENSE-MEDICAL	15,811.	15,811.	0.	0.
TOTALS	51,707,475.	38,203,739.	13,290,360.	213,376.

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.**

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

OMB No. 1545-0047

2015

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) 24 GROVE ST NEW CANAAN LLC 27-4941167 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	MEDICAL RENTA	CT	-17,472.	797,748.	TSH
(2) 36 GROVE ST NEW CANAAN LLC 27-4941529 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	MEDICAL RENTA	CT	36,061.	5,754,185.	TSH
(3) STAMFORD HEALTH OCCUPATIONAL HEALTH SERV 47-5119889 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	OCCUPATIONAL	CT	265,121.	0.	TSH
(4) STAMFORD HEALTHCARE ALLIANCE, LLC ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	INACTIVE	CT	0.	0.	TSH
(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, INC. 22-2476636 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	PARENT	CT	501(C)3	11, TYPE II	N/A		X
(2) THE STAMFORD HOSPITAL FOUNDATION 22-2478748 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	FUNDRAISING	CT	501(C)3	9	SHI	X	
(3) STAMFORD HEALTH MEDICAL GROUP 27-1648289 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	MEDICAL SERVI	CT	501(C)3	9	TSH	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) HEALTHSTAR INDEMNITY CO 45-3801216 ONE HOSPITAL PLAZA PO BOX 9317 STAMFORD, CT 06904	SELF INSURANCE	CT	TSH	C CORP	6,290,717.	78,492,915.	100.0000	X	
(2)									
(3)									
(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 MEDICAL GROUP	B	34,275,319.	BOOK VALUE
(2)	STAMFORD HEALTH MEDICAL GROUP	J	485,924.	BOOK VALUE
(3)	STAMFORD HEALTH MEDICAL GROUP	O	142,257.	BOOK VALUE
(4)	HEALTHSTAR INDEMNITY CO	R	9,018,500.	CASH VALUE
(5)	HEALTHSTAR INDEMNITY CO	Q	6,564,318.	CASH 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 sections 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).