

Form 990

Return of Organization Exempt From Income Tax

2012

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

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

A For the 2012 calendar year, or tax year beginning 10/01, 2012, and ending 09/30, 2013

Form header section containing organization name (MIDDLESEX HOSPITAL), EIN (06-0646718), address (28 CRESCENT STREET, MIDDLETOWN, CT 06457), and principal officer (VINCENT CAPECE - PRESIDENT/CEO).

Part I Summary

Summary table with columns for Revenue, Expenses, and Net Assets or Fund Balances. Includes rows for mission statement, revenue (Total: 369,588,316), expenses (Total: 345,789,354), and net assets (Total: 264,166,000).

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.

Signature block area with fields for Sign Here, Signature of officer, Date, and Type or print name and title.

Paid Preparer Use Only section containing fields for Preparer's name (CHRISTOPHER B. BOGGS), signature, date (08/15/14), firm name (ERNST & YOUNG U.S. LLP), and EIN (34-6565596).

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form 990 (2012)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

MIDDLESEX HOSPITAL EXISTS TO PROVIDE THE SAFEST, HIGHEST-QUALITY HEALTH CARE AND THE BEST EXPERIENCE POSSIBLE FOR OUR COMMUNITY.

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 [X] No

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

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 \$ 139,147,876. including grants of \$ 0) (Revenue \$ 159,829,791.)

IN THE FISCAL YEAR ENDING 9/30/2013, INPATIENT CARE REPRESENTED 15,162 DISCHARGES AND 62,546 PATIENT CARE DAYS. ARMED WITH SKILLED STAFF, PROGRESSIVE DIAGNOSTIC TOOLS AND ADVANCED SURGICAL TECHNIQUES, THE HOSPITAL WAS WELL POSITIONED TO ENSURE A COMFORTABLE, SAFE ENVIRONMENT FOR EXCEPTIONAL MEDICAL TREATMENT AND RECOVERY. SEE SCHEDULE O FOR FURTHER DETAIL.

4b (Code:) (Expenses \$ 48,185,941. including grants of \$ 0) (Revenue \$ 64,796,539.)

MIDDLESEX HOSPITAL EMERGENCY DEPARTMENT DELIVERS CARE AT THE WHALEN EMERGENCY CENTER AT THE HOSPITAL'S MAIN CAMPUS AS WELL AS TWO SATELLITE SITES LOCATED AT THE SHORELINE MEDICAL CENTER IN ESSEX AND THE MIDDLESEX HOSPITAL MEDICAL CENTER IN MARLBOROUGH. THE EMERGENCY DEPARTMENT TREAT AND RELEASE VISITS FOR THE FISCAL YEAR ENDING 9/30/2013 WERE 81,193. IN EACH, EMERGENCY CARE IS DEPLOYED BY EXPERT, BOARD-CERTIFIED EMERGENCY MEDICINE DOCTORS AND SPECIFICALLY TRAINED PHYSICIAN ASSISTANTS, NURSES, PATIENT CARE TECHNICIANS AND OTHER SUPPORT PERSONNEL. SEE SCHEDULE O FOR FURTHER DETAIL.

4c (Code:) (Expenses \$ 16,510,261. including grants of \$ 0) (Revenue \$ 27,603,446.)

IN FISCAL YEAR ENDING 09/30/2013 THERE WERE 6,705 REVENUE GENERATING AMBULATORY SURGERY CASES FROM ENDOSCOPY/COLONOSCOPY TO ORTHOPEDIC AND OTHER OUTPATIENT PROCEDURES. SEE SCHEDULE O FOR FURTHER DETAIL.

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

(Expenses \$ 77,540,092. including grants of \$ 2,999,000.) (Revenue \$ 100,803,253.)

4e Total program service expenses 281,384,170.

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 | X | |
| 2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? | X | |
| 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I | | X |
| 4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II | 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 | | 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 | | 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 | | X |
| 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III | | 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 | | 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 | 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 | 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 | | 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 | | 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 | | X |
| e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X | 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 | | X |
| 12 a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII | 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 | X | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | | X |
| 14 a Did the organization maintain an office, employees, or agents outside of the United States? | | X |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV | | X |
| 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV | | X |
| 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV | | 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) | | 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 | 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 | | X |
| 20 a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H | X | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | X | |

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding IRS filings and tax compliance.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members... 1b Enter the number of voting members included... 2 Did any officer, director, trustee, or key employee have a family relationship... 3 Did the organization delegate control over management duties... 4 Did the organization make any significant changes to its governing documents... 5 Did the organization become aware during the year of a significant diversion of the organization's assets?... 6 Did the organization have members or stockholders?... 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?... 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?... 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body?... b Each committee with authority to act on behalf of the governing body?... 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.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates?... 10b 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?... 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?... 11b 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... 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?... 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done... 13 Did the organization have a written whistleblower policy?... 14 Did the organization have a written document retention and destruction policy?... 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... b Other officers or key employees of the organization... 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?... 16b 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?

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed CT,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. [X] Own website [] Another's website [X] Upon request [] Other (explain in Schedule O)
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: DONALD LUDWIG, CPA, 28 CRESCENT STREET, MIDDLETOWN, CT 06457 860-358-6879

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

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

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) JOHN RAFAL DIRECTOR | 1.00 1.00 | X | | | | | | 0 | 0 | 0 |
| (2) ERIC THORNBURG DIRECTOR | 1.00 1.00 | X | | | | | | 0 | 0 | 0 |
| (3) BARBARA WEISS DIRECTOR | 1.00 1.00 | X | | | | | | 0 | 0 | 0 |
| (4) VINCENT CAPECE, JR. PRESIDENT CEO | 40.00 1.00 | X | | X | | | | 757,217. | 0 | 362,397. |
| (5) DAVID BAGGISH, MD CHIEF OF MEDICINE & SECRETARY | 40.00 1.00 | X | | X | | | | 331,012. | 0 | 5,037. |
| (6) R. CHRISTOPHER SEATON CHAIRMAN | 1.00 1.00 | X | | X | | | | 0 | 0 | 0 |
| (7) GARY WILLIS VICE CHAIRMAN | 1.00 1.00 | X | | X | | | | 0 | 0 | 0 |
| (8) GEOFFREY HERTER, MD ASSISTANT SECRETARY | 1.00 1.00 | X | | X | | | | 0 | 0 | 0 |
| (9) CHANDLER HOWARD DIRECTOR | 1.00 1.00 | X | | | | | | 0 | 0 | 0 |
| (10) HUGH MACKENZIE DIRECTOR | 1.00 1.00 | X | | | | | | 0 | 0 | 0 |
| (11) BRUCE MACMILLIAN DIRECTOR | 1.00 1.00 | X | | | | | | 0 | 0 | 0 |
| (12) SUSAN MARTIN VP FINANCE TREASURER | 40.00 1.00 | | | X | | | | 1,369,857. | 0 | 90,670. |
| (13) ARTHUR MCDOWELL, MD VP CLINICAL AFFAIRS | 40.00 0 | | | | X | | | 659,889. | 0 | 240,208. |
| (14) HARRY EVERT SR. VP STRATEGIC PLANNING OPS | 40.00 0 | | | | X | | | 411,866. | 0 | 58,782. |

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) JESSE WAGNER, MD VP QUALITY AND PATIENT SAFETY | 40.00 0 | | | | X | | | 411,976. | 0 | 101,642. |
| (16) GREGORY NOKES VP HUMAN RESOURCES | 40.00 0 | | | | X | | | 459,586. | 0 | 148,140. |
| (17) JACQUELYN CALAMARI VP NURSING | 40.00 0 | | | | X | | | 282,936. | 0 | 70,256. |
| (18) GARRETT HAVICAN VP OPERATIONS | 40.00 0 | | | | X | | | 222,278. | 0 | 63,488. |
| (19) MICHAEL SAXE, MD CHAIRMAN EMERGENCY MEDICINE | 40.00 0 | | | | X | | | 402,948. | 0 | 6,440. |
| (20) DAVID GIUFFRIDA VP, FACILITIES & SUPPORT SVCS | 40.00 0 | | | | X | | | 258,983. | 0 | 62,000. |
| (21) JONATHAN BANKOFF, MD PHYSICIAN EMERGENCY DEPARTMENT | 40.00 0 | | | | | X | | 352,111. | 0 | 5,642. |
| (22) RANDOLPH GOODWIN, MD CLINICAL DIR. INFECTIOUS DIS. | 40.00 0 | | | | | X | | 357,538. | 0 | 1,225. |
| (23) MARIO CAPUZZI, MD MEDICAL DIR., EMERGENCY DEPT. | 40.00 0 | | | | | X | | 319,742. | 0 | 6,552. |
| (24) DAVID CONSENTINO, MD MEDICAL DIR., EMERGENCY DEPT. | 40.00 0 | | | | | X | | 318,543. | 0 | 5,147. |
| (25) ROBERT GRILLO, MD CHIEF, DEPT. OF PSYCHIATRY | 40.00 0 | | | | | X | | 312,231. | 0 | 5,525. |
| 1b Sub-total | | | | | | | | 3,529,841. | 0 | 757,094. |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | 3,698,872. | 0 | 476,057. |
| d Total (add lines 1b and 1c) | | | | | | | | 7,228,713. | 0 | 1,233,151. |

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 ▶ 259

| | Yes | No |
|---|-----|----|
| 3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> | | 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? <i>If "Yes," complete Schedule J for such individual</i> | 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? <i>If "Yes," complete Schedule J for such person</i> | | 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 ▶ 70

Part VIII Statement of Revenue

Check if Schedule O contains a response to any question 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, 513, or 514 | |
|---|--|--|----------------------|----------------------|--|---|---|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns | 1a | | | | | | |
| | b Membership dues | 1b | | | | | | |
| | c Fundraising events | 1c | 99,006. | | | | | |
| | d Related organizations | 1d | | | | | | |
| | e Government grants (contributions) | 1e | 1,026,164. | | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 3,907,380. | | | | | |
| | g Noncash contributions included in lines 1a-1f: \$ | | 557,840. | | | | | |
| | h Total. Add lines 1a-1f | | | 5,032,550. | | | | |
| Program Service Revenue | Business Code | | | | | | | |
| | 2a PATIENT REVENUES | | 621110 | 343,984,296. | 343,984,296. | | | |
| | b SPECIMEN LABORATORY | | 621500 | 3,186,704. | | 3,186,704. | | |
| | c TECHNICAL LABORATORY | | 621500 | 1,208,202. | | 1,208,202. | | |
| | d _____ | | | | | | | |
| | e _____ | | | | | | | |
| | f All other program service revenue | | | | | | | |
| g Total. Add lines 2a-2f | | | 348,379,202. | | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) | | | 760,275. | | | 760,275. | |
| | 4 Income from investment of tax-exempt bond proceeds | | | 20,018. | | | 20,018. | |
| | 5 Royalties | | | 0 | | | | |
| | 6a Gross rents | (i) Real | | | | | | |
| | | (ii) Personal | | | | | | |
| | | | 643,540. | | | | | |
| | | b Less: rental expenses | | | 389,545. | | | |
| | c Rental income or (loss) | | | 253,995. | | | | |
| | d Net rental income or (loss) | | | 253,995. | | | 253,995. | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | | | | | | |
| | | (ii) Other | | | | | | |
| | | | 14,952,760. | | | | | |
| | | b Less: cost or other basis and sales expenses | | | 8,876,760. | | | |
| | c Gain or (loss) | | | 6,076,000. | | | | |
| | d Net gain or (loss) | | | 6,076,000. | | | 6,076,000. | |
| 8a Gross income from fundraising events (not including \$ 99,006. of contributions reported on line 1c). See Part IV, line 18 | a | | 77,416. | | | | | |
| b Less: direct expenses | b | | 75,479. | | | | | |
| c Net income or (loss) from fundraising events | | | 1,937. | | | 1,937. | | |
| 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 REVENUE | | 722210 | 1,245,629. | 1,245,629. | | | | |
| b MEDICARE DEMONSTRATION PR | | 900099 | 1,642,000. | 1,642,000. | | | | |
| c EQUITY IN JOINT VENTURE INCOME | | 900099 | 2,021,783. | 2,021,783. | | | | |
| d All other revenue | | 900099 | 4,154,927. | 4,139,321. | 15,606. | | | |
| e Total. Add lines 11a-11d | | | 9,064,339. | | | | | |
| 12 Total revenue. See instructions | | | 369,588,316. | 353,033,029. | 4,410,512. | 7,112,225. | | |

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 to any question in this Part IX

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|-----------------------|---------------------------------|--|-----------------------------|
| 1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 . | 0 | | | |
| 2 Grants and other assistance to individuals in the United States. See Part IV, line 22 | 0 | | | |
| 3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16 | 0 | | | |
| 4 Benefits paid to or for members | 0 | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 5,476,483. | 4,381,186. | 1,095,297. | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 235,005. | 235,005. | | |
| 7 Other salaries and wages | 159,897,043. | 143,629,874. | 16,267,169. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 11,159,520. | 10,070,406. | 1,089,114. | |
| 9 Other employee benefits | 13,656,796. | 12,268,535. | 1,388,261. | |
| 10 Payroll taxes | 11,080,727. | 9,941,471. | 1,139,256. | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 39,954,882. | 23,446,778. | 15,607,243. | 900,861. |
| b Legal | 447,095. | | 447,095. | |
| c Accounting | 194,525. | | 194,525. | |
| d Lobbying | 51,500. | | 51,500. | |
| e Professional fundraising services. See Part IV, line 17 | 0 | | | |
| f Investment management fees | 0 | | | |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) | 0 | | | |
| 12 Advertising and promotion | 1,530,208. | 735,084. | 795,124. | |
| 13 Office expenses | 11,706,022. | 8,729,379. | 2,976,643. | |
| 14 Information technology | 0 | | | |
| 15 Royalties | 0 | | | |
| 16 Occupancy | 6,628,988. | 3,995,782. | 2,633,206. | |
| 17 Travel | 1,639,800. | 1,279,087. | 360,713. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 Conferences, conventions, and meetings | 648,989. | 441,835. | 207,154. | |
| 20 Interest | 3,016,511. | | 3,016,511. | |
| 21 Payments to affiliates | 0 | | | |
| 22 Depreciation, depletion, and amortization | 22,145,057. | 21,133,028. | 1,012,029. | |
| 23 Insurance | 5,009,092. | | 5,009,092. | |
| 24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) | | | | |
| a <u>MEDICAL EXPENSES</u> | 36,955,430. | 36,955,430. | | |
| b <u>TRANS TO MHS PRIMARY CARE</u> | 2,999,000. | 2,999,000. | | |
| c <u>STATE NET PATIENT REV TAX</u> | 9,221,970. | | 9,221,970. | |
| d <u>ALL OTHER EXPENSES</u> | 2,134,711. | 1,142,290. | 992,421. | |
| e All other expenses | | | | |
| 25 Total functional expenses. Add lines 1 through 24e | 345,789,354. | 281,384,170. | 63,504,323. | 900,861. |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | 0 | | | |

Part X Balance Sheet

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

| | | (A) Beginning of year | | (B) End of year |
|---|--|--------------------------|--------------|-------------------------|
| Assets | 1 Cash - non-interest-bearing | 54,769,000. | 1 | 39,387,000. |
| | 2 Savings and temporary cash investments | 10,187,000. | 2 | 20,741,000. |
| | 3 Pledges and grants receivable, net | 1,668,000. | 3 | 2,082,000. |
| | 4 Accounts receivable, net | 47,154,000. | 4 | 45,387,000. |
| | 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 | 645,000. | 7 | 617,000. |
| | 8 Inventories for sale or use | 1,347,000. | 8 | 1,251,000. |
| | 9 Prepaid expenses and deferred charges | 3,970,000. | 9 | 4,058,000. |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a 416,504,000. | | |
| | b Less: accumulated depreciation | 10b 230,191,000. | 179,846,000. | 10c 186,313,000. |
| | 11 Investments - publicly traded securities | 138,950,000. | 11 | 151,822,000. |
| | 12 Investments - other securities. See Part IV, line 11 | 0 | 12 | 0 |
| | 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 | 1,549,000. | 15 | 8,653,000. |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 440,085,000. | 16 | 460,311,000. | |
| Liabilities | 17 Accounts payable and accrued expenses | 53,975,000. | 17 | 50,292,000. |
| | 18 Grants payable | 0 | 18 | 0 |
| | 19 Deferred revenue | 671,000. | 19 | 769,000. |
| | 20 Tax-exempt bond liabilities | 66,330,000. | 20 | 63,180,000. |
| | 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 | 1,620,000. | 23 | 47,000. |
| | 24 Unsecured notes and loans payable to unrelated third parties | 0 | 24 | 0 |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | 156,484,000. | 25 | 81,857,000. |
| | 26 Total liabilities. Add lines 17 through 25 | 279,080,000. | 26 | 196,145,000. |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | |
| | 27 Unrestricted net assets | 144,992,000. | 27 | 247,940,000. |
| | 28 Temporarily restricted net assets | 9,049,000. | 28 | 9,250,000. |
| | 29 Permanently restricted net assets | 6,964,000. | 29 | 6,976,000. |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | |
| | 30 Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building, or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 Total net assets or fund balances | 161,005,000. | 33 | 264,166,000. |
| | 34 Total liabilities and net assets/fund balances | 440,085,000. | 34 | 460,311,000. |

Part XI Reconciliation of Net Assets

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

| | | | |
|-----------|--|-----------|--------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 369,588,316. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 345,789,354. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 23,798,962. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 161,005,000. |
| 5 | Net unrealized gains (losses) on investments | 5 | 5,770,000. |
| 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 | 73,592,038. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 264,166,000. |

Part XII Financial Statements and Reporting

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

- 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?
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?
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.
- 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?
- 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

| | Yes | No |
|-----------|-----|----|
| | | |
| 2a | | X |
| | | |
| 2b | X | |
| | | |
| 2c | X | |
| | | |
| 3a | X | |
| | | |
| 3b | X | |

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

MIDDLESEX HOSPITAL

Employer identification number

06-0646718

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)

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

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

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

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

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

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

- (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?
- (ii) A family member of a person described in (i) above?
- (iii) A 35% controlled entity of a person described in (i) or (ii) above?

| | Yes | No |
|----------|-----|----|
| 11g(i) | | |
| 11g(ii) | | |
| 11g(iii) | | |

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

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

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

Schedule A (Form 990 or 990-EZ) 2012

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

Section A. Public Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Percentage, %. Rows include: 14 Public support percentage for 2012; 15 Public support percentage from 2011 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2012; b 33 1/3% support test - 2011; 17a 10%-facts-and-circumstances test - 2012; b 10%-facts-and-circumstances test - 2011; 18 Private foundation.

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

Section A. Public Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support (Subtract line 7c from line 6).

Section B. Total Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income. Do not include gain or loss from the sale of capital assets; 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

Table with 3 columns: Description, 2012, 2011. Row 15: Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f)). Row 16: Public support percentage from 2011 Schedule A, Part III, line 15.

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, 2012, 2011. Row 17: Investment income percentage for 2012 (line 10c, column (f) divided by line 13, column (f)). Row 18: Investment income percentage from 2011 Schedule A, Part III, line 17.

19a 33 1/3% support tests - 2012. 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.

19b 33 1/3% support tests - 2011. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization.

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

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

Schedule of Contributors

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

2012

Name of the organization
 MIDDLESEX HOSPITAL

Employer identification number
 06-0646718

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 22,500. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 2 | ----- ----- ----- | \$ 6,460. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 3 | ----- ----- ----- | \$ 31,910. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 4 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 5 | ----- ----- ----- | \$ 10,440. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 6 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 8 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 9 | ----- ----- ----- | \$ 5,293. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 10 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 11 | ----- ----- ----- | \$ 26,696. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 12 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 14 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 15 | ----- ----- ----- | \$ 12,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 16 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 17 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 18 | ----- ----- ----- | \$ 102,121. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 77,348. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 20 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 21 | ----- ----- ----- | \$ 18,728. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 22 | ----- ----- ----- | \$ 8,481. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 23 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 24 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 5,050. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 26 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 27 | ----- ----- ----- | \$ 11,866. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 28 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 29 | ----- ----- ----- | \$ 5,860. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 30 | ----- ----- ----- | \$ 16,916. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 50,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 32 | ----- ----- ----- | \$ 50,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 33 | ----- ----- ----- | \$ 21,738. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 34 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 35 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 36 | ----- ----- ----- | \$ 279,177. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 9,766. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 38 | ----- ----- ----- | \$ 25,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 39 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 40 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 41 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 42 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

| | |
|--|---|
| Name of organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|---|

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

| (a) No. | (b) Name, address, and ZIP + 4 | (c) Total contributions | (d) Type of contribution |
|------------|-----------------------------------|----------------------------|---|
| 43 | ----- ----- ----- | \$ 10,500. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 44 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 45 | ----- ----- ----- | \$ 267,867. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 46 | ----- ----- ----- | \$ 60,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 47 | ----- ----- ----- | \$ 5,730. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 48 | ----- ----- ----- | \$ 5,300. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 50 | ----- ----- ----- | \$ 70,691. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 51 | ----- ----- ----- | \$ 15,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 52 | ----- ----- ----- | \$ 28,848. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 53 | ----- ----- ----- | \$ 20,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 54 | ----- ----- ----- | \$ 14,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ ----- 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 56 | ----- ----- ----- | \$ ----- 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 57 | ----- ----- ----- | \$ ----- 20,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 58 | ----- ----- ----- | \$ ----- 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 59 | ----- ----- ----- | \$ ----- 50,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 60 | ----- ----- ----- | \$ ----- 14,789. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

| | |
|--|---|
| Name of organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|---|

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 <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 62 | ----- ----- ----- | \$ ----- 95,800. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 63 | ----- ----- ----- | \$ ----- 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 64 | ----- ----- ----- | \$ ----- 5,050. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 65 | ----- ----- ----- | \$ ----- 5,460. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 66 | ----- ----- ----- | \$ ----- 25,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization **MIDDLESEX HOSPITAL**

Employer identification number

06-0646718

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 | ----- ----- ----- | \$ 20,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 68 | ----- ----- ----- | \$ 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| 69 | ----- ----- ----- | \$ 6,666. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| --- | ----- ----- ----- | \$ ----- | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| --- | ----- ----- ----- | \$ ----- | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |
| --- | ----- ----- ----- | \$ ----- | Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.) |

Name of organization MIDDLESEX HOSPITAL

Employer identification number

06-0646718

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 |
|---------------------------|--|--|----------------------|
| 36 | STOCKS ----- ----- ----- | \$ 279,177. | 01/17/2013 |
| 45 | STOCKS ----- ----- ----- | \$ 267,867. | 09/23/2013 |
| --- | ----- ----- ----- | \$ ----- | ----- |
| --- | ----- ----- ----- | \$ ----- | ----- |
| --- | ----- ----- ----- | \$ ----- | ----- |
| --- | ----- ----- ----- | \$ ----- | ----- |
| --- | ----- ----- ----- | \$ ----- | ----- |
| --- | ----- ----- ----- | \$ ----- | ----- |
| --- | ----- ----- ----- | \$ ----- | ----- |

Name of organization MIDDLESEX HOSPITAL

Employer identification number
06-0646718

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

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

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

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

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**

▶ **See separate instructions.**

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

| | |
|--|--|
| Name of organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|--|

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

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

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

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

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

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

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

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

Schedule C (Form 990 or 990-EZ) 2012

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

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

| Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.) | | (a) Filing organization's totals | (b) Affiliated group totals | | | | | | | | | | | | |
|---|---|---|--|--------------------|-------------------------------|---|--|---|--|--|---|-------------------|--------------|--|--|
| 1 a | Total lobbying expenditures to influence public opinion (grass roots lobbying) | | | | | | | | | | | | | | |
| b | Total lobbying expenditures to influence a legislative body (direct lobbying) | | | | | | | | | | | | | | |
| c | Total lobbying expenditures (add lines 1a and 1b) | | | | | | | | | | | | | | |
| d | Other exempt purpose expenditures | | | | | | | | | | | | | | |
| e | Total exempt purpose expenditures (add lines 1c and 1d) | | | | | | | | | | | | | | |
| f | Lobbying nontaxable amount. Enter the amount from the following table in both columns. | | | | | | | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table> | | If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | Not over \$500,000 | 20% of the amount on line 1e. | Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000. | Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000. | Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000. | Over \$17,000,000 | \$1,000,000. | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | | | | | | | | | | | | | | |
| Not over \$500,000 | 20% of the amount on line 1e. | | | | | | | | | | | | | | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000. | | | | | | | | | | | | | | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000. | | | | | | | | | | | | | | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000. | | | | | | | | | | | | | | |
| Over \$17,000,000 | \$1,000,000. | | | | | | | | | | | | | | |
| g | Grassroots nontaxable amount (enter 25% of line 1f) | | | | | | | | | | | | | | |
| h | Subtract line 1g from line 1a. If zero or less, enter -0- | | | | | | | | | | | | | | |
| i | Subtract line 1f from line 1c. If zero or less, enter -0- | | | | | | | | | | | | | | |
| j | If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | |

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

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|--|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) Total |
| 2 a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column (e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

Table with 3 main columns: Question, (a) Yes/No, and (b) Amount. Rows include questions about influencing legislation, media advertisements, mailings, publications, grants, and other activities, with a total amount of 51,500.

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

Table with 3 columns: Question, Yes, and No. Rows include questions about dues received, in-house lobbying expenditures, and carryover of lobbying and political expenditures.

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

Table with 2 main columns: Question and sub-column (1-5). Rows include questions about dues from members, nondeductible lobbying and political expenditures, and taxable amount of lobbying and political expenditures.

Part IV Supplemental Information

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

SEE PAGE 4

Part IV Supplemental Information (continued)

LOBBYING ACTIVITY

SCHEDULE C, PART II-B, LINE 11

MIDDLESEX HOSPITAL PAYS DUES TO BOTH THE AMERICAN HOSPITAL ASSOCIATION (AHA) AND THE CONNECTICUT HOSPITAL ASSOCIATION (CHA). A PERCENTAGE OF THOSE DUES FUNDED LOBBYING ACTIVITIES DURING THE FISCAL YEAR. THE PORTION OF AHA DUES TOTALED \$10,112 AND THE PORTION OF CHA DUES TOTALED \$25,448. IN ADDITION, MIDDLESEX HOSPITAL CONTRACTED WITH A CONSULTANT WHO PERFORMED LOBBYING ACTIVITIES. THOSE EXPENSES TOTALED \$15,940.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Name of the organization

MIDDLESEX HOSPITAL

Employer identification number

06-0646718

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate contributions to (during year), 3 Aggregate grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 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?

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 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, 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?, 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B) (i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

Table with 2 columns: \$, \$, \$, \$. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items. b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenues included in Form 990, Part VIII, line 1, (ii) Assets included in Form 990, Part X, 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenues included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X

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

Schedule D (Form 990) 2012

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

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

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

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

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

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

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

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

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

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

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

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

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance | 102,354,000. | 87,389,000. | 87,748,000. | 80,828,000. | 79,900,000. |
| b Contributions | 869,000. | 83,000. | 85,000. | 208,000. | 416,000. |
| c Net investment earnings, gains, and losses | 11,675,000. | 14,929,000. | -354,000. | 6,856,000. | 597,000. |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | 111,000. | 47,000. | 90,000. | 144,000. | 85,000. |
| f Administrative expenses | | | | | |
| g End of year balance | 114,787,000. | 102,354,000. | 87,389,000. | 87,748,000. | 80,828,000. |

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

- a Board designated or quasi-endowment 90.0000 %
- b Permanent endowment 6.0000 %
- c Temporarily restricted endowment 4.0000 %

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

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

- (i) unrelated organizations
- (ii) related organizations

| | Yes | No |
|--------|-----|----|
| 3a(i) | | X |
| 3a(ii) | | X |
| 3b | | |

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

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

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

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land | | 8,674,000. | | 8,674,000. |
| b Buildings | | 237,627,000. | 118,816,000. | 118,811,000. |
| c Leasehold improvements | | 2,062,000. | 1,302,000. | 760,000. |
| d Equipment | | 145,685,000. | 107,175,000. | 38,510,000. |
| e Other | | 22,456,000. | 2,898,000. | 19,558,000. |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) | | | | 186,313,000. |

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

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

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

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

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

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

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

| 1. (a) Description of liability | (b) Book value | |
|---|----------------|--|
| (1) Federal income taxes | | |
| (2) ACCRUED RETIREMENT LIABILITIES | 49,029,000. | |
| (3) SELF INSURANCE LIABILITIES | 18,079,000. | |
| (4) ASSET RETIREMENT OBLIGATION | 1,040,000. | |
| (5) LEASE INCENTIVE OBLIGATION | 25,000. | |
| (6) UNALLOCATED 3RD PARTY | 13,680,000. | |
| (7) SECURITY DEPOSITS | 4,000. | |
| (8) | | |
| (9) | | |
| (10) | | |
| (11) | | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 81,857,000. | |

2. FIN 48 (ASC 740) Footnote. 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

| | | | | |
|----------|--|-----------|------------|--------------|
| 1 | Total revenue, gains, and other support per audited financial statements | | 1 | 366,407,000. |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | | |
| a | Net unrealized gains on investments | 2a | | |
| b | Donated services and use of facilities | 2b | | |
| c | Recoveries of prior year grants | 2c | | |
| d | Other (Describe in Part XIII.) | 2d | | |
| e | Add lines 2a through 2d | | 2e | |
| 3 | Subtract line 2e from line 1 | | 3 | 366,407,000. |
| 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 | 3,181,316. | |
| c | Add lines 4a and 4b | | 4c | 3,181,316. |
| 5 | Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.) | | 5 | 369,588,316. |

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

| | | | | |
|----------|---|-----------|------------|--------------|
| 1 | Total expenses and losses per audited financial statements | | 1 | 342,279,000. |
| 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 | 342,279,000. |
| 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 | 3,510,354. | |
| c | Add lines 4a and 4b | | 4c | 3,510,354. |
| 5 | Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.) | | 5 | 345,789,354. |

Part XIII Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, 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)

ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

BOARD-DESIGNATED (QUASI-ENDOWMENT) FUNDS ARE ASSETS SET ASIDE BY THE BOARD FOR FUTURE UNSPECIFIED USES AND TO SUPPORT EDUCATION AND OTHER PROGRAMS OVER WHICH THE BOARD RETAINS CONTROL AND MAY, AT ITS DISCRETION, SUBSEQUENTLY USE FOR OTHER PURPOSES.

PERMANENT ENDOWMENT FUNDS ARE ASSETS RECEIVED WITH THE DONOR STIPULATION THAT THE PRINCIPAL BE INVESTED IN PERPETUITY AND THAT ONLY THE INCOME EARNED THEREON IS AVAILABLE FOR SPECIFIC OR GENERAL SERVICES, SUCH AS FREE BED FUNDS AND SUPPORT OF HOSPITAL OPERATIONS.

TEMPORARILY RESTRICTED ENDOWMENT FUNDS ARE ASSETS RESTRICTED BY THE DONOR EITHER AS TO PURPOSE AND/OR AS TO TIME OF EXPENDITURE, SUCH AS EDUCATION, HEALTH SERVICES AND CAPITAL PURCHASES.

RECONCILIATION OF REVENUE PER AFS WITH REVENUE PER RETURN

SCHEDULE D, PART XI, LINE 4B

| | |
|------------------------------|-----------|
| RESTRICTED CONTRIBUTIONS | 2,295,000 |
| RESTRICTED INVESTMENT INCOME | 375,000 |
| NET FUND RAISING ACTIVITIES | 900,861 |
| RENTAL EXPENSES | (389,545) |
| LINE 4B TOTAL | 3,181,316 |

RECONCILIATION OF EXPENSES PER AFS WITH EXPENSES PER RETURN

SCHEDULE D, PART XII, LINE 4B

Part XIII Supplemental Information *(continued)*

| | |
|-----------------------------|-----------|
| PAYMENTS TO AFFILIATES | 2,999,000 |
| NET FUND RAISING ACTIVITIES | 900,861 |
| RENTAL EXPENSES | (389,545) |
| ROUNDING | 38 |
| LINE 4B TOTAL | 3,510,354 |

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

| | | (a) Event #1 | (b) Event #2 | (c) Other events | (d) Total events |
|-----------------|---|--------------------------|------------------------------|----------------------|---------------------------------|
| | | TPC GOLF (event type) | HOSPICE GOLF (event type) | 2. (total number) | (add col. (a) through col. (c)) |
| Revenue | 1 Gross receipts | 114,015. | 45,776. | 16,631. | 176,422. |
| | 2 Less: Contributions | 77,200. | 15,550. | 6,256. | 99,006. |
| | 3 Gross income (line 1 minus line 2) | 36,815. | 30,226. | 10,375. | 77,416. |
| Direct Expenses | 4 Cash prizes | | | | |
| | 5 Noncash prizes | 2,450. | 3,044. | | 5,494. |
| | 6 Rent/facility costs | 36,066. | 17,463. | | 53,529. |
| | 7 Food and beverages | | | | |
| | 8 Entertainment | | | | |
| | 9 Other direct expenses | 9,356. | 240. | 6,860. | 16,456. |
| | 10 Direct expense summary. Add lines 4 through 9 in column (d) ▶ | | | | (75,479.) |
| | 11 Net income summary. Combine line 3, column (d), and line 10 ▶ | | | | 1,937. |

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

| | | |
|-------------------------------|------------|---|
| a The organization's facility | 13a | % |
| b An outside facility | 13b | % |

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

Name ▶ _____

Address ▶ _____

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

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2012

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

| | |
|---|---|
| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|---|---|

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 | X | |
| b If "Yes," was it a written policy? | X | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % | X | |
| b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500.0000</u> % | X | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | X | |
| 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | X | |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | X | |
| c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | | X |
| 6a Did the organization prepare a community benefit report during the tax year? | X | |
| b If "Yes," did the organization make it available to the public? | X | |

| 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) | | 6751 | 4,484,459. | 1,618,666. | 2,865,793. | .83 |
| b Medicaid (from Worksheet 3, column a) | | 16107 | 58,491,447. | 38,087,735. | 20,403,712. | 5.90 |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | 378 | 744,832. | 551,750. | 193,082. | .06 |
| d Total Financial Assistance and Means-Tested Government Programs | | 23236 | 63,720,738. | 40,258,151. | 23,462,587. | 6.79 |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | 26051 | 4,586,704. | 17,037. | 4,569,667. | 1.32 |
| f Health professions education (from Worksheet 5) | | 1304 | 8,287,968. | 2,033,063. | 6,254,905. | 1.81 |
| g Subsidized health services (from Worksheet 6) | | 25735 | 43,914,282. | 26,546,337. | 17,367,945. | 5.02 |
| h Research (from Worksheet 7) | | 123 | 884,550. | | 884,550. | .26 |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | 5951 | 364,882. | | 364,882. | .11 |
| j Total. Other Benefits | | 59164 | 58,038,386. | 28,596,437. | 29,441,949. | 8.52 |
| k Total. Add lines 7d and 7j. | | 82400 | 121,759,124. | 68,854,588. | 52,904,536. | 15.31 |

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 | | | 12,346. | | 12,346. | |
| 3 Community support | | 10 | 193,019. | | 193,019. | .06 |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | 991 | 12,651. | | 12,651. | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | 104 | 67,546. | | 67,546. | .02 |
| 9 Other | | | | | | |
| 10 Total | | 1105 | 285,562. | | 285,562. | .08 |

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 | 11,094,963. |
| 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 | 1,109,496. |
| 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 | 85,392,574. |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 102,250,037. |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | -16,857,463. |
| 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: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> 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 (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group MIDDLESEX HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

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

Part V Facility Information (continued)

| Financial Assistance Policy MIDDLESEX HOSPITAL | | Yes | No |
|---|--|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | X | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used. | X | |
| 11 | Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>5</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used. | X | |
| 12 | Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply): | X | |
| a | <input checked="" type="checkbox"/> Income level | | |
| b | <input checked="" type="checkbox"/> Asset level | | |
| c | <input type="checkbox"/> Medical indigency | | |
| d | <input type="checkbox"/> Insurance status | | |
| e | <input type="checkbox"/> Uninsured discount | | |
| f | <input type="checkbox"/> Medicaid/Medicare | | |
| g | <input checked="" type="checkbox"/> State regulation | | |
| h | <input checked="" type="checkbox"/> Other (describe in Part VI) | | |
| 13 | Explained the method for applying for financial assistance? | X | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | X | |
| a | <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website | | |
| b | <input checked="" type="checkbox"/> The policy was attached to billing invoices | | |
| c | <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms | | |
| d | <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices | | |
| e | <input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility | | |
| f | <input checked="" type="checkbox"/> The policy was available on request | | |
| g | <input type="checkbox"/> Other (describe in Part VI) | | |

Billing and Collections

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

Part V Facility Information (continued) MIDDLESEX HOSPITAL

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

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

Policy Relating to Emergency Medical Care

19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?
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 Part VI)
- d Other (describe in Part VI)

| | Yes | No |
|-----------|-----|----|
| 19 | X | |
| | | |
| | | |
| | | |

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

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

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

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |

21 During the tax year, did the hospital facility charge any of its FAP- eligible individuals, 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 Part VI.

| | | |
|-----------|--|---|
| 21 | | X |
| | | |

22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

If "Yes," explain in Part VI.

| | | |
|-----------|--|---|
| 22 | | X |
| | | |

Part V Facility Information (continued)

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 1

| Name and address | Type of Facility (describe) |
|--|---|
| 1 MIDDLESEX HOSPITAL HOMECARE 770 SAYBROOK ROAD MIDDLETOWN CT 06457 | HOMECARE SERVICES, REHAB, HEART HEALTH, OTHER SERVICES |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART I, LINE 3C: IN GENERAL, MIDDLESEX HOSPITAL ("THE HOSPITAL") USES FPG TO DETERMINE ELIGIBILITY. THERE ARE, HOWEVER, SPECIAL CIRCUMSTANCES (SUCH AS A CATASTROPHIC EVENT) WHICH MAY AFFECT A PATIENT'S ABILITY TO PAY. IN THIS CASE, THE HOSPITAL EVALUATES THE APPLICATION WITH CONSIDERATION GIVEN TO THE PATIENT'S CURRENT SITUATION. WITH SPECIAL CIRCUMSTANCES THE FPG THRESHOLD MAY BE IGNORED AND THE HOSPITAL MAY USE THE PATIENT'S ASSETS AND/OR TAX RETURN ITEMIZED DEDUCTIONS TO DETERMINE THE AMOUNT OF FINANCIAL ASSISTANCE.

PART I, LINE 6A: N/A

PART I, LINE 7G: MIDDLESEX HOSPITAL INCLUDES ITS FAMILY MEDICINE GROUP AS A SUBSIDIZED SERVICE. FOR FY13, 9,803 UNIQUE INDIVIDUALS WERE SERVED WITH A TOTAL HOSPITAL SUBSIDY OF \$1,910,055. MIDDLESEX COUNTY HAS BEEN DESIGNATED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) TO BE A MEDICALLY UNDERSERVED AREA EXPERIENCING A SHORTAGE OF SELECT HEALTH SERVICES WHICH INCLUDE TOO FEW PRIMARY CARE PROVIDERS. IN ADDITION, HRSA

Part VI Supplemental Information

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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

REPORTS THAT MIDDLESEX COUNTY IS A HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) FOR PRIMARY MEDICAL CARE. MIDDLESEX HOSPITAL'S FAMILY MEDICINE GROUP FILLS A VITAL COMMUNITY HEALTH NEED BY PROVIDING ACCESS TO PRIMARY CARE SERVICES.

PART I, LINE 7, COLUMN (F): N/A

PART I, LINE 7: FOR PART 1, LINE 7 SECTIONS (A) FINANCIAL ASSISTANCE AT COST, (B) MEDICAID, (C) COSTS OF OTHER MEANS-TESTED GOVERNMENT PROGRAMS, PORTIONS OF (F) HEALTH PROFESSIONS EDUCATION, AND (G) SUBSIDIZED HEALTH SERVICES, THE COSTING METHODOLOGY USED IS A HYBRID COST ACCOUNTING/MEDICARE COST-TO-CHARGE RATIO CALCULATION. THE PERCENTAGES ARE DERIVED FROM THE MOST CURRENT MEDICARE COST REPORT AND APPLIED BY CHARGE LINE APPROPRIATELY. INDIRECT COSTS WERE APPLIED TO SUBSIDIZED HEALTH SERVICES. THE MEDICARE COST REPORT DOES NOT ADDRESS ALL AREAS OF THE HOSPITAL IN THE SAME DETAIL, BUT DOES ACCURATELY ADDRESS INPATIENT AND OUTPATIENT, HOMECARE AND TO AN EXTENT PHYSICIAN SERVICES. SECTIONS (E)

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

COMMUNITY HEALTH IMPROVEMENT; PORTIONS OF (F) HEALTH PROFESSIONS EDUCATION, (H) RESEARCH, AND (I) CASH AND IN-KIND CONTRIBUTIONS TO COMMUNITY GROUPS ARE COMPRISED (EXCEPT FOR CASH DONATIONS AND IN-KIND MATERIAL DONATIONS) OF 1) SUPPLY EXPENSES; 2) PURCHASED SERVICES; AND 3) THE DIRECT SALARY COSTS FOR HOSPITAL STAFF WHOSE TIME WAS COMPENSATED BY THE HOSPITAL FOR TIME SPENT PARTICIPATING IN ACTIVITIES THAT QUALIFY AS COMMUNITY BENEFITS PLUS THE CURRENT FISCAL YEAR FRINGE BENEFIT RATE. INDIRECT COSTS WERE APPLIED TO SUBSIDIZED SERVICES AND TO A SMALL SELECTION OF SALARIES AND SERVICES UNDER COMMUNITY HEALTH IMPROVEMENT, RESEARCH, AND COMMUNITY BENEFIT OPERATIONS, BUT NOT BROADLY ACROSS ALL COMMUNITY BENEFIT ACTIVITY ENTRIES.

PART II: MIDDLESEX HOSPITAL'S PARTICIPATION IN COMMUNITY BUILDING ACTIVITIES HAS A VITAL ROLE IN CONTINUING TO PROMOTE THE HEALTH, WELL-BEING AND SAFETY FOR RESIDENTS IN ITS SERVICE AREA. THE HOSPITAL OFFERS ITS RESOURCES AND EXPERTISE TO SUPPORT AND STRENGTHEN COMMUNITY ASSETS IN A VARIETY OF PROGRAMS THAT FALL UNDER THE SCOPE OF COMMUNITY

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

BUILDING. STAFF MEMBERS ARE HIGHLY PARTICIPATIVE IN COMMUNITY PARTNERSHIPS AND COALITIONS, THE SUCCESS OF WHICH ARE GREATLY ENHANCED BY HOSPITAL COLLABORATION - MANY COMMUNITY INITIATIVES WOULD NOT BE AS EFFECTIVE WITHOUT THE HOSPITAL'S ADMINISTRATIVE AND CLINICAL STAFF IN-KIND INVOLVEMENT, SUPPORT AND EXPERTISE. AS COMMUNITY BUILDING PARTICIPATION IS FOCUSED ON HAVING A DIRECT IMPACT ON IMPROVING THE HEALTH OF THE COMMUNITY, IT MEETS THE CRITERIA FOR INCLUSION IN COMMUNITY BENEFIT AGGREGATE TOTALS. IN FY13 THE HOSPITAL'S COMMUNITY BUILDING ACTIVITIES TOTALED \$285,562 AND SERVED 1,105 INDIVIDUALS. EXAMPLES INCLUDE (BUT ARE NOT LIMITED TO):

" OPPORTUNITY KNOCKS (OK): A MULTIDISCIPLINARY COMMUNITY COALITION THAT INCLUDES 70+ COLLABORATORS COMPRISED OF LOCAL HEALTH AND SOCIAL SERVICE AGENCIES, EARLY CARE AND EDUCATION PROVIDERS AND PARENTS. THE GOALS ARE TO ENSURE THAT CHILDREN ENTER KINDERGARTEN PHYSICALLY AND EMOTIONALLY HEALTHY AND READY TO SUCCEED. SINCE ITS INCEPTION IN 2003, OK HAS SERVED APPROXIMATELY 8,900 CHILDREN AGES 0-5. MIDDLESEX HOSPITAL

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PROVIDES: FUNDING; THE PROGRAM PLANNER, A PHYSICIAN CHAMPION,
GRANT-WRITING SUPPORT, FISCAL ADMINISTRATION FOR THE FUNDING SOURCES AND
PARTICIPATION FROM MULTIPLE DEPARTMENTAL STAFF MEMBERS.

" DISASTER READINESS: FOR DISASTER READINESS, THE HOSPITAL PLAYS A
PIVOTAL ROLE BY WORKING IN COLLABORATION WITH KEY COMMUNITY PARTNERS TO
ENSURE THE SAFETY OF THE COMMUNITY AT LARGE DURING A POTENTIAL DISASTER.
TO PREPARE FOR DISASTERS, THE HOSPITAL PARTICIPATES IN SCHOOL SAFETY
COMMITTEES; COMMUNITY FLU PREPARATION COMMITTEES; STATEWIDE/REGIONAL
EMERGENCY MANAGEMENT COMMITTEES; REGULAR COLLABORATIVE COMMUNITY
EDUCATION AND DRILLS; AND HOSTS YEARLY RADIATION DRILLS FOR THE STAFF OF
A LOCAL NUCLEAR POWER PLANT. IN ADDITION, THE HOSPITAL PURCHASES AND
STOCK-PILES LARGE QUANTITIES OF EXTENSIVE PANDEMIC SUPPLIES TO BE USED
SHOULD A COMMUNITY-WIDE DISASTER OCCUR. INCLUDED IN THIS STOCK-PILE ARE
MEDICATIONS FOR INFECTIOUS DISEASE AND CHEMICAL EXPOSURE CURATIVES. THE
MAJORITY OF THE VALUE OF THE SUPPLIES, SPACE UTILIZATION AND COSTS
ASSOCIATED TO MONITOR AND REPLENISH PANDEMIC PRODUCTS (WITHIN EXPIRATION
DATES) ARE ABSORBED BY THE HOSPITAL.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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" SHORELINE MEDICAL CENTER MENTORING FOR CAREERS IN HEALTHCARE: THE HOSPITAL'S SHORELINE MEDICAL CENTER (SMC) HAS WELL-DEVELOPED EDUCATIONAL PROGRAMS FOR LOCAL STUDENTS INTERESTED IN MEDICAL CAREERS. SHORTAGES OF CERTAIN TRAINED MEDICAL PROFESSIONALS SUCH AS NURSES AND RADIOLOGIC TECHNOLOGISTS SERVED AS THE IMPETUS FOR STARTING THESE PROGRAMS. 1) CAREER DAY IS AN EXPERIENTIAL LEARNING EVENT WHERE HIGH SCHOOL STUDENTS INTERACT WITH STAFF MEMBERS FROM A VARIETY OF CLINICAL FIELDS AND PARTICIPATE IN INTERACTIVE MOCK DEMONSTRATIONS/SIMULATIONS. 2) INTERNSHIPS: SMC PROVIDES INTERNSHIPS FOR LOCAL HIGH SCHOOL STUDENTS. AMONG MANY OTHER EXPERIENCES, STUDENTS ARE INVOLVED IN PATIENT ROUNDS AND ARE EXPOSED TO HOW DIAGNOSES ARE MADE. 3) WORLD OF WORK IS AN EDUCATIONAL EXPERIENCE FOR MIDDLE SCHOOLS STUDENTS WHERE STUDENTS LEARN ABOUT SPECIFIC HEATH CARE FIELDS AND THE EDUCATION REQUIRED FOR EACH SPECIALTY. STUDENTS ALSO RECEIVE DEMONSTRATIONS ON HEALTH CARE MODALITIES.

PART III, LINE 2: THE BAD DEBT EXPENSE AMOUNT IN PART III, LINE 2 IS BASED ON CHARGES AND TIED TO THE HOSPITAL'S AUDITED FINANCIAL STATEMENTS.

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

THE HOSPITAL ACCOUNTS FOR DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS IN DETERMINING BAD DEBT EXPENSE BY REDUCING BAD DEBT BY RECOVERIES ON THE HOSPITAL'S FINANCIALS.

PART III, LINE 3: FOR PART III, LINE 3, THE HOSPITAL ESTIMATES THAT 10% OF ITS BAD DEBT EXPENSE IS ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. THE HOSPITAL HAS A WELL-ESTABLISHED PROCESS WITH ITS THIRD PARTY AGENCIES TO CAPTURE AS MANY PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE AS POSSIBLE AND AWARDS FINANCIAL ASSISTANCE TO THOSE PATIENTS IN COLLECTIONS WHO ARE KNOWN TO QUALIFY. ONCE IN COLLECTIONS, THERE ARE TWO METHODS WHICH ENABLE PATIENTS TO RECEIVE FINANCIAL ASSISTANCE AWARDS: 1) PATIENTS COMPLETE A FINANCIAL ASSISTANCE APPLICATION, MEET ELIGIBILITY CRITERIA AND ARE APPROVED; OR 2) THE THIRD PARTY ORGANIZATIONS THAT WORK ON BEHALF OF THE HOSPITAL TO COLLECT BALANCES SCREEN FOR FINANCIAL ASSISTANCE ELIGIBILITY. IN ORDER TO ENSURE THAT ALL PATIENTS IN COLLECTIONS ARE AWARE OF FINANCIAL ASSISTANCE AVAILABILITY, THE HOSPITAL REQUIRES THIRD PARTY ORGANIZATIONS TO FOLLOW

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
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THE HOSPITAL'S POLICIES REGARDING PATIENT NOTIFICATION ABOUT THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM. WITHIN THE POLICY THERE IS A PROVISION WHEREBY COLLECTION AGENCIES, USING GUIDELINES SET FORTH BY THE HOSPITAL, ASSIST THE HOSPITAL IN IDENTIFYING PATIENTS WHO DO NOT HAVE A MEANS TO PAY FOR SERVICES AND THEREFORE QUALIFY FOR THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM - WHILE THESE PATIENTS HAVE NOT GONE THROUGH THE FORMAL APPLICATION PROCESS, THEY MEET THE ELIGIBILITY GUIDELINES FOR FINANCIAL ASSISTANCE AS DEFINED BY THE HOSPITAL. THESE PATIENTS ARE THEN TRANSFERRED AND INCLUDED UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE UMBRELLA. WHILE THIS PROCESS CAPTURES THE MAJORITY OF THOSE WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE, THE HOSPITAL RECOGNIZES IT WILL STILL HAVE A POPULATION OF PATIENTS WHO COULD POTENTIALLY QUALIFY FOR FINANCIAL ASSISTANCE AND DO NOT RECEIVE AWARDS - THOSE WHO ARE UNCOOPERATIVE, UNRESPONSIVE OR HAVE MOVED AWAY.

BAD DEBT DOLLARS ARE NOT INCLUDED IN ANY OF THE HOSPITAL'S PROGRAMMATIC COMMUNITY BENEFIT VALUES AND, WHILE NOTED, ARE NOT INCLUDED IN THE

Part VI Supplemental Information

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HOSPITAL'S COMMUNITY BENEFIT TOTALS IN ANY HOSPITAL COMMUNITY BENEFIT PUBLICATION.

PART III, LINE 4: THE HOSPITAL ESTIMATES A RESERVE FOR UNCOLLECTIBLE ACCOUNTS AGAINST ITS PATIENT ACCOUNTS RECEIVABLES. WHEN BAD DEBTS ARE IDENTIFIED, THEY ARE ACCOUNTED FOR AS A COMPONENT OF THE OPERATING EXPENSE PROVISION FOR BAD DEBTS NET OF RECOVERIES. PAGE 15 OF THE MIDDLESEX HOSPITAL'S FY13 AUDITED FINANCIAL STATEMENT STATES: FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL, THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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DOUBTFUL ACCOUNTS.

PART III, LINE 8: THE MEDICARE COST REPORT IS THE COSTING METHODOLOGY SYSTEM USED TO DETERMINE THE AMOUNT REPORTED ON PART III, LINES 5 AND 6. THE HOSPITAL UTILIZES WORKSHEET 6 FOUND IN THE FORM 990 INSTRUCTIONS FOR SCHEDULE H TO CALCULATE ITS SUBSIDIZED SERVICES. THE INSTRUCTIONS STATE THAT "THE FINANCIAL LOSS IS MEASURED AFTER REMOVING LOSSES, MEASURED BY COST, ASSOCIATED WITH BAD DEBT, CHARITY CARE, MEDICAID AND OTHER MEANS-TESTED GOVERNMENT PROGRAMS". GIVEN THAT THE INSTRUCTIONS DON'T SUGGEST REMOVING LOSSES ASSOCIATED WITH MEDICARE, A PORTION OF MEDICARE IS INCLUDED IN THE HOSPITAL'S SUBSIDIZED SERVICE CALCULATIONS. SO AS NOT TO DOUBLE COUNT MEDICARE VALUES IN PART III, SECTION B, LINES 5 AND 6, THE PORTION OF MEDICARE SHORTFALL INCLUDED IN OUR SUBSIDIZED SERVICES CALCULATIONS HAS BEEN SUBTRACTED FROM THE MEDICARE REVENUE AND COSTS DERIVED FROM THE MEDICARE COST REPORT. THE VALUES INDICATED IN PART III, LINES 5 AND 6 ARE THEREFORE WHAT REMAINS AFTER THE MEDICARE REVENUE AND COSTS INCLUDED IN THE SUBSIDIZED SERVICES CALCULATIONS HAS BEEN

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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SUBTRACTED OUT. GIVEN THIS, THE RESULTING VALUES (PART III, LINES 5, 6 AND 7) WOULD NEED TO BE COMBINED WITH THE MEDICARE REVENUE/COSTS INCLUDED IN OUR SUBSIDIZED SERVICES TO GET THE FULL OVERVIEW OF MEDICARE REVENUE, COSTS AND ANY REMAINING SHORTFALL OR SURPLUS.

WE AGREE WITH THE CURRENT SUBSIDIZED SERVICES CALCULATION METHODOLOGY THAT ALLOWS THE INCLUSION OF MEDICARE SHORTFALL AS THE MEDICARE POPULATION COMPRISES AN IMPORTANT SEGMENT OF THOSE RECEIVING SUBSIDIZED SERVICES CARE. THE HOSPITAL TREATS ALL MEDICARE PATIENTS EQUALLY AND DOES NOT DISCRIMINATE AGAINST LOWER-MARGIN YIELDING SERVICES. AS A NOT-FOR-PROFIT HOSPITAL, MIDDLESEX HOSPITAL IS THE SAFETY-NET IN THE COMMUNITY FOR ALL MEDICARE PATIENTS, REGARDLESS OF LEVEL OF MEDICARE COVERAGE AND REGARDLESS IF A SURPLUS OR DEFICIT RESULTS. THIS OPEN ACCESS FOR MEDICARE PATIENTS PROMOTES ACCESS TO CARE, A FUNDAMENTAL TENET OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM. THE HOSPITAL'S PAST HEALTH ASSESSMENT FOUND THAT (FROM 2000-2006) THERE WAS 7.4% GROWTH IN MIDDLESEX COUNTY FOR AGE 65+ COMPARED TO <1% GROWTH IN THE STATE AND 20% GROWTH IN

Part VI Supplemental Information

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MIDDLESEX COUNTY FOR AGE 85+ COMPARED TO 15.9% GROWTH IN THE STATE. IN ADDITION, HIGH EMERGENCY DEPARTMENT USAGE FOR AMBULATORY CARE SENSITIVE CONDITIONS WAS FOUND IN THE 65+ AND 85+ AGE GROUPS, WHICH IS FURTHER CONFIRMATION OF THE HOSPITAL'S FUNCTION AS A SAFETY-NET PROVIDER FOR ITS COMMUNITY'S ELDERS. AS MIDDLESEX COUNTY HAS A DISPROPORTIONATE LEVEL OF COMMUNITY MEMBERS AGE 65+ AND 85+ WHEN COMPARED TO STATE AVERAGES, THE SHORTFALL THAT THE HOSPITAL EXPERIENCES IN PROVIDING CRITICAL HEALTHCARE SERVICES TO THE MEDICARE POPULATION SHOULD BE CONSIDERED A COMMUNITY BENEFIT WITHIN THE HOSPITAL'S SUBSIDIZED SERVICES, WHICH THOSE AGE 65+ ALSO RELY HEAVILY ON FOR CARE. THE HOSPITAL FILLS A HEALTHCARE DELIVERY GAP FOR MEDICARE PATIENTS, ONE WHICH WOULD BE DETRIMENTAL TO THE COMMUNITY IF THE HOSPITAL WAS NOT PRESENT.

PART III, LINE 9B: MIDDLESEX HOSPITAL HAS A WRITTEN DEBT COLLECTION POLICY STATES THAT PATIENTS WHO QUALIFY FOR FINANCIAL ASSISTANCE WILL BE RESPONSIBLE FOR PAYING ANY BALANCE REMAINING AFTER THE FINANCIAL ASSISTANCE ALLOWANCE HAS BEEN APPLIED (THAT IS, IF 100% FINANCIAL

Part VI Supplemental Information

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ASSISTANCE HAS NOT BEEN AWARDED). THE POLICY ALSO OUTLINES THE PROCESS FOR PAYING OUTSTANDING BALANCES SHOULD THE PATIENT BE FOUND TO HAVE THE MEANS TO PAY A PARTIAL AMOUNT AFTER THE HOSPITAL'S FINANCIAL ASSISTANCE DETERMINATION CRITERIA HAS BEEN APPLIED. FOR SUCH BALANCES, THE HOSPITAL WILL NOTIFY THE PATIENT OF HIS/HER LIABILITY. IF PAYMENT IS NOT MADE, THE POLICY STATES THAT THE HOSPITAL WILL USE APPROPRIATE METHODS TO PURSUE COLLECTION, WHICH MAY INCLUDE COLLECTIONS AGENCIES AND ATTORNEYS. THIS PRACTICE IS BROADLY UTILIZED FOR ALL PATIENTS WITH OUTSTANDING BALANCES. THE HOSPITAL MAKES EVERY EFFORT TO ENSURE THAT ALL PATIENTS KNOW PAYMENT PLANS ARE AVAILABLE FOR ANY BALANCE, INCLUDING THOSE PATIENTS WHO HAVE A BALANCE LEFT OVER AFTER A FINANCIAL ASSISTANCE AWARD HAS BEEN APPLIED. IN ORDER TO CAPTURE THE PATIENTS WHO ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE, THE HOSPITAL HAS PROVISIONS IN ITS COLLECTION POLICY. IN THE CASE WHERE PATIENTS WHO WOULD QUALIFY FOR FINANCIAL ASSISTANCE DO NOT COMPLETE A FINANCIAL ASSISTANCE APPLICATION AND ARE PLACED INTO COLLECTIONS, THE THIRD PARTY ORGANIZATIONS THAT WORK ON BEHALF OF THE HOSPITAL TO COLLECT BALANCES SCREEN FOR FINANCIAL ASSISTANCE ELIGIBILITY.

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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THE THIRD PARTY ORGANIZATIONS FOLLOW HOSPITAL POLICY BY ALERTING ALL PATIENTS IN COLLECTIONS TO THE AVAILABILITY OF THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM. WITHIN THE HOSPITAL'S COLLECTION POLICY THERE IS A PROVISION WHEREBY COLLECTION AGENCIES, USING GUIDELINES SET FORTH BY THE HOSPITAL, ASSIST THE HOSPITAL IN IDENTIFYING PATIENTS WHO DO NOT HAVE A MEANS TO PAY FOR SERVICES AND THEREFORE QUALIFY FOR THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM - WHILE THESE PATIENTS HAVE NOT GONE THROUGH THE FORMAL APPLICATION PROCESS, THEY MEET THE ELIGIBILITY GUIDELINES FOR FINANCIAL ASSISTANCE AS DEFINED BY THE HOSPITAL. THESE PATIENTS ARE THEN TRANSFERRED AND INCLUDED UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE UMBRELLA. THIS PROCESS WAS PUT IN PLACE BY THE HOSPITAL IN ORDER TO CAPTURE AS MANY PATIENTS WHO ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AS POSSIBLE.

PART V, SECTION B, LINE 1J: N/A

PART V, SECTION B, LINE 3: MIDDLESEX HOSPITAL WAS INVITED TO JOIN THE

Part VI Supplemental Information

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MIDDLESEX COUNTY COALITION ON COMMUNITY WELLNESS (MCCOCW), AN INCLUSIVE AND REPRESENTATIVE PARTNERSHIP COMPRISED OF CONSTITUENTS FROM THE SECTORS OF PUBLIC HEALTH, HEALTH CARE, SOCIAL SERVICES, COMMUNITY SERVICES AND EDUCATION. MCCOCW'S PURPOSE IS TO WORK COLLABORATIVELY, THROUGH A MULTI-SECTORIAL EFFORT, AS AGENTS OF CHANGE TO IMPROVE THE HEALTH AND WELLBEING OF THE COMMUNITIES IT SERVES. GOALS INCLUDE: 1) WORKING TOGETHER TO CONDUCT A MIDDLESEX COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA); 2) IDENTIFYING KEY ISSUES THAT IMPACT HEALTH AND WELLBEING; AND 3) DEVELOPING COLLABORATIVE PROGRAMS TO MEET IDENTIFIED NEED. MCCOCW'S CHNA WAS COMPLETED IN 2013.

MIDDLESEX COUNTY WAS A RECIPIENT OF CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) COMMUNITY TRANSFORMATION GRANT (CTG) FUNDING FOR PROJECTS THAT IMPROVE THE HEALTH AND WELLBEING OF COMMUNITIES, REDUCE CHRONIC DISEASE RATES AND REDUCE HEALTH DISPARITIES. THE CT DEPARTMENT OF PUBLIC HEALTH (DPH) WAS ONE OF 61 CTG NATIONAL RECIPIENTS AND SECURED FUNDING FOR CAPACITY BUILDING TO IMPROVE COMMUNITY HEALTH BY LAYING A

Part VI Supplemental Information

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SOLID FOUNDATION FOR COMMUNITY PREVENTION EFFORTS. CONNECTICUT DPH IDENTIFIED 5 OF THE 8 COUNTIES WITH POPULATIONS OF LESS THAN 500,000 TO RECEIVE FUNDING, ONE OF WHICH WAS MIDDLESEX COUNTY. CTG DELIVERABLES INCLUDED: THE STRENGTHENING OF MULTI-SECTORIAL, COUNTY-WIDE COALITIONS; THE COMPLETION OF POLICY SCANS TO IDENTIFY BEST PRACTICES AND GAPS (I.E. POLICIES, PROGRAMS, INFRASTRUCTURE); AND THE COMPLETION OF A COUNTY-WIDE HEALTH NEEDS ASSESSMENT. THE CHATHAM HEALTH DISTRICT PROVIDED THE OVERSIGHT FOR THE ADMINISTRATION OF THE CTG CAPACITY-BUILDING DELIVERABLES IN MIDDLESEX COUNTY IN PARTNERSHIP WITH THE CT RIVER AREA HEALTH DISTRICT, ESSEX HEALTH DEPARTMENT, THE MIDDLETOWN, DURHAM AND CROMWELL HEALTH DEPARTMENTS, MIDDLESEX HOSPITAL AND A WIDE ARRAY OF COMMUNITY PARTNERS REPRESENTING THE BROAD INTERESTS OF MIDDLESEX COUNTY. THE CHATHAM HEALTH DISTRICT DIRECTOR OF HEALTH AND THE MIDDLESEX HOSPITAL MANAGER OF COMMUNITY BENEFIT SERVE AS CO-CHAIRS OF THE COALITION.

THE COALITION IS MADE UP OF 75+ MEMBERS FROM MIDDLESEX COUNTY, INCLUDING THOSE WHO HAVE SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH AND

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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PERSONS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY(IES) SERVED BY
 MIDDLESEX HOSPITAL. COALITION MEMBERS INCLUDE: THE CHATHAM HEALTH
 DISTRICT; MIDDLESEX HOSPITAL; CT RIVER AREA HEALTH DISTRICT; ESSEX HEALTH
 DEPARTMENT; THE MIDDLETOWN, DURHAM AND CROMWELL HEALTH DEPARTMENTS; THE
 COMMUNITY HEALTH CENTER, MIDDLETOWN; MIDDLESEX COUNTY CHAMBER OF COMMERCE
 HEALTH CARE COUNCIL; MIDDLESEX COUNTY SUBSTANCE ABUSE ACTION COUNCIL;
 DURHAM MIDDLEFIELD YOUTH AND FAMILY SERVICES; MIDDLESEX COALITION FOR
 CHILDREN; NORTH END ACTION TEAM; MIDDLETOWN YOUTH SERVICES; YOUTH AND
 FAMILY SERVICES OF HADDAM-KILLINGWORTH; TOWN OF PORTLAND; ACES MIDDLESEX
 COUNTY EARLY HEADSTART PARTNERSHIP; MIDDLETOWN SCHOOLS; ST. LUKE'S
 ELDERCARE SERVICES; MIDDLESEX UNITED WAY; DURHAM MIDDLEFIELD YOUTH AND
 FAMILY SERVICES; OLD SAYBROOK YOUTH AND FAMILY SERVICES; PORTLAND
 LIBRARY; CONNECTICUT DENTAL HEALTH PARTNERSHIP; WESLEYAN UNIVERSITY;
 MIDDLETOWN YOUTH SERVICES BUREAU; CHESTER HEALTH DEPARTMENT; CONNECTICUT
 DEPARTMENT OF CHILDREN AND FAMILIES; LILY'S KIDS, INC.; ST. VINCENT DE
 PAUL, MIDDLETOWN; HADDAM SENIOR CENTER; PORTLAND SENIOR CENTER; PORTLAND
 YOUTH SERVICES; KILLINGWORTH HEALTH DEPARTMENT; OLD SAYBROOK PUBLIC

Part VI Supplemental Information

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SCHOOLS; EAST HADDAM FREE PUBLIC LIBRARY; MIDDLESEX YMCA; UHC CENTER FOR PUBLIC HEALTH AND HEALTH POLICY; UNIVERSITY OF CONNECTICUT HEALTH CENTER; MIDDLETOWN CITIZEN'S ADVISORY COMMITTEE; SHORELINE SOUP KITCHEN AND PANTRIES; CLINTON YOUTH AND FAMILY SERVICES; CONNECTICUT GENERAL ASSEMBLY; MIDDLETOWN MINISTERIAL ALLIANCE; MIDDLESEX COUNTY NAACP; PORTLAND PARKS AND RECREATION; EAST HAMPTON PUBLIC LIBRARY; OLD SAYBROOK SOCIAL SERVICES; COMMUNITY FOUNDATION OF MIDDLESEX COUNTY; CROMWELL SENIOR AND HUMAN SERVICES; CONNECTICUT HOUSE OF REPRESENTATIVES; EAST HAMPTON HUMAN SERVICES.

AS COMPLETING A COMMUNITY HEALTH NEEDS ASSESSMENT WAS A GOAL FOR THE MIDDLESEX COUNTY COALITION ON COMMUNITY WELLNESS, IT WAS A STANDING AGENDA ITEM FOR THE MONTHLY COALITION MEETINGS. THOSE WHO WERE UNABLE TO ATTEND THE MONTHLY MEETINGS WERE KEPT INFORMED AND ENGAGED VIA E-MAIL COMMUNICATIONS AS WELL AS MEETING MINUTES, AGENDAS AND PERTINENT DOCUMENTS. FOR CHNA PRIMARY DATA COLLECTION, THE COALITION CONDUCTED MULTIPLE KEY INFORMANT SURVEYS AND FOCUS GROUPS.

Part VI Supplemental Information

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THE MIDDLESEX HOSPITAL BOARD OF DIRECTORS REVIEWED THE HOSPITAL'S
 COMMUNITY BENEFIT COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION
 STRATEGY FOR ADDRESSING FIVE PRIORITY AREAS IDENTIFIED IN THE MCCOCW 2013
 COMMUNITY HEALTH NEEDS ASSESSMENT AND APPROVED THE STRATEGY ON SEPTEMBER
 20, 2013.

PART V, SECTION B, LINE 4: N/A

PART V, SECTION B, LINE 5A: THE MIDDLESEX COUNTY COALITION ON COMMUNITY
 WELLNESS COMMUNITY HEALTH NEEDS ASSESSMENT 2013 (OF WHICH THE HOSPITAL
 WAS A COLLABORATIVE PARTNER), ALONG WITH THE MIDDLESEX HOSPITAL CHNA
 IMPLEMENTATION STRATEGY 2013 ARE LOCATED ON MIDDLESEX HOSPITAL'S WEB-SITE
 AT THE FOLLOWING URL:
 HTTP://MIDDLESEXHOSPITAL.ORG/MIDDLESEX-AND-THE-COMMUNITY/SERVING-OUR-COMMU
 NITY/COMMUNITY-HEALTH-NEEDS-ASSESSMENT.

Part VI Supplemental Information

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THE MCCOCW CHNA IS ALSO LOCATED ON THE CHATHAM HEALTH DISTRICT WEB-SITE

AT THE FOLLOWING URL:

[HTTP://WWW.CHATHAMHEALTH.ORG/PDF/SUPPORTINGDOCUMENTS/COMMUNITYHEALTHNEEDSASSESSMENTEVERSION.PDF](http://WWW.CHATHAMHEALTH.ORG/PDF/SUPPORTINGDOCUMENTS/COMMUNITYHEALTHNEEDSASSESSMENTEVERSION.PDF)

PART V, SECTION B, LINE 5C: IN ADDITION TO POSTING ON THE MIDDLESEX HOSPITAL'S WEB-SITE AND MAKING THE CHNA AVAILABLE UPON REQUEST, THE MIDDLESEX COUNTY COALITION ON COMMUNITY WELLNESS 2013 COMMUNITY HEALTH NEEDS ASSESSMENT (IN WHICH THE HOSPITAL WAS A COLLABORATIVE PARTNER), WAS DISTRIBUTED TO THE ENTIRE MIDDLESEX COUNTY COALITION ON COMMUNITY WELLNESS; THOSE WHO PARTICIPATED IN THE KEY INFORMANT SURVEYS AND FOCUS GROUPS; COMMUNITY MEMBERS; THE MIDDLESEX HOSPITAL MEDICAL STAFF VIA E-MAIL; THE MIDDLESEX HOSPITAL EXECUTIVE STAFF, MANAGERS AND SUPERVISORS VIA E-MAIL; AND THE MIDDLESEX HOSPITAL EMPLOYEE BASE THROUGH POSTING IN THE HOSPITAL'S WEEKLY NEWSLETTER. MIDDLESEX HOSPITAL STAFF WAS ASKED TO FREELY SHARE THE CHNA WITH COMMUNITY COLLEAGUES. IN ADDITION, COMMUNITY PRESENTATIONS WERE GIVEN ON THE RESULTS OF THE CHNA.

Part VI Supplemental Information

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PART V, SECTION B, LINE 6I: N/A

PART V, SECTION B, LINE 7: MIDDLESEX HOSPITAL RECOGNIZES THAT IT CANNOT FOCUS ON ALL THE HEALTH NEEDS IDENTIFIED IN THE MCCOCW 2013 COMMUNITY HEALTH NEEDS ASSESSMENT. GIVEN THE SIGNIFICANT RESOURCES AND IN-KIND TIME NEEDED TO ADDRESS HEALTH PRIORITY AREAS UNCOVERED BY A COMMUNITY HEALTH NEEDS ASSESSMENT, THE HOSPITAL ENGAGED IN A THOROUGH PROCESS OF DATA REVIEW AND DISCUSSION TO IDENTIFY THE AREAS OF GREATEST NEED, IMPACT POTENTIAL AND FEASIBILITY. THROUGH THE FINDINGS OF THE MCCOCW 2013 CHNA, MIDDLESEX HOSPITAL CHOSE TO ENGAGE IN FIVE INITIATIVES, THREE OF WHICH THE HOSPITAL WILL TAKE A LEADERSHIP ROLE AND TWO OF WHICH THE HOSPITAL WILL TAKE A SUPPORTIVE ROLE. OVERSIGHT OF MIDDLESEX HOSPITAL'S 2013 CHNA IMPLEMENTATION STRATEGY WILL RESIDE UNDER COMMUNITY BENEFIT, WHERE HOSPITAL STAFF WILL COLLABORATE WITH COMMUNITY AGENCIES WHENEVER POSSIBLE AND BUILD EVIDENCE-BASED PROGRAMS, WHERE NEEDED, WITH MEASURABLE, BENCHMARKED RESULTS AND THE GOAL OF ACHIEVING POSITIVE OUTCOMES. THE

Part VI Supplemental Information

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HOSPITAL'S PRIORITY AREAS FOCUS ON THE NEEDS OF THE FOLLOWING IDENTIFIED

VULNERABLE POPULATIONS: 1) PRIORITY AREA #1: MENTAL HEALTH - ACCESS AND CARE COORDINATION; 2) PRIORITY AREA #2: SUBSTANCE ABUSE - ACCESS AND CARE COORDINATION; 3) PRIORITY AREA #3: OLDER ADULTS - ACCESS AND CARE COORDINATION; 4) PRIORITY AREA #4: MCCOCW TOBACCO FREE LIVING - SUPPORT AND COLLABORATION; 5) PRIORITY AREA #5: MCCOCW CLINICAL PREVENTIVE SERVICES, HYPERTENSION - SUPPORT AND COLLABORATION

FOR THOSE AREAS OF IDENTIFIED NEEDS NOT ADDRESSED BY THE HOSPITAL, THE MCCOCW 2013 COMMUNITY HEALTH NEEDS ASSESSMENT WAS WIDELY DISSEMINATED TO MIDDLESEX COUNTY COMMUNITY AGENCIES WITH THE HOPE THAT THE STUDY WILL BE USED TO INITIATE FOCUS ON CHNA FINDINGS THAT ARE OUTSIDE THE SCOPE OF THE HOSPITAL'S SELECTED PRIORITY AREAS. AS MANY LOCAL COMMUNITY-BASED ORGANIZATIONS ARE DEDICATED TO MEETING THE NEEDS OF COUNTY RESIDENTS, THE HOSPITAL REALIZES THAT THESE ORGANIZATIONS MAY BE BETTER SUITED TO TAKE A LEADERSHIP ROLE IN IMPROVING CERTAIN HEALTH OUTCOMES. AS WITH OUR PREVIOUS COMMUNITY HEALTH NEEDS ASSESSMENT, THE HOSPITAL WILL CONTINUE TO

Part VI Supplemental Information

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BE A WILLING PARTNER, WHEN ABLE, FOR INITIATIVES NOT RELATED TO ITS

SELECTED CHNA PRIORITY AREAS.

PART V, SECTION B, LINE 12H: MIDDLESEX HOSPITAL'S SLIDING SCALE OUTLINES
THE FACTORS THAT IT USES TO DETERMINE FINANCIAL ASSISTANCE
DETERMINATIONS: THE FEDERAL POVERTY INCOME GUIDELINES AND NUMBER OF
PERSONS IN HOUSEHOLD.

PART V, SECTION B, LINE 14G: N/A

PART V, SECTION B, LINE 16E: N/A

PART V, SECTION B, LINE 17E: N/A

PART V, SECTION B, LINE 18E: N/A

PART V, SECTION B, LINE 21: N/A

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PART V, SECTION B, LINE 22: N/A

PART VI, QUESTION 2 - NEEDS ASSESSMENT: SINCE THE INCEPTION OF MIDDLESEX HOSPITAL'S COMMUNITY BENEFIT POLICY IN 2007, AND PRIOR TO THE MANDATE OF THE AFFORDABLE CARE ACT, CONDUCTING A COMMUNITY HEALTH ASSESSMENT (CHNA) IN ORDER TO PRIORITIZE SPECIFIC COMMUNITY BENEFIT INITIATIVES HAS BEEN A CORE ELEMENT OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM. IN ADDITION TO COMPLETING A CHNA, THE HOSPITAL ASSESSES THE NEEDS OF THE COMMUNITIES IT SERVICES ON AN ON-GOING BASIS THROUGH A VARIETY OF METHODS. EXAMPLES INCLUDE: 1) PARTICIPATION IN FOCUS GROUPS FOR LOCAL AGENCY-SPECIFIC PRIORITY SETTING, SUCH AS THE MIDDLESEX UNITED WAY, AND THE REGION 2 REGIONAL MENTAL HEALTH AND ADDICTION SERVICES & REGIONAL ACTION COUNCIL; 2) PARTICIPATION IN BROAD-BASED HEALTHCARE COALITIONS SUCH AS THE MIDDLESEX COUNTY COALITION ON COMMUNITY WELLNESS AND THE MIDDLESEX COUNTY CHAMBER OF COMMERCE HEALTH CARE COUNCIL; 3) CONTINUOUS ASSESSMENT AND ADJUSTMENTS, WHEN NECESSARY, OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAMS

Part VI Supplemental Information

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THROUGH SURVEYS AND PATIENT/PARTICIPANT FEED-BACK. HAVING A STRONG PRESENCE IN COMMUNITY COALITIONS AND PARTNERSHIPS, IN ADDITION TO BEING RESPONSIVE TO THE NEEDS EXPRESSED BY OUR COMMUNITY RESIDENTS, ALLOWS THE HOSPITAL TO CONTINUALLY ASSESS THE HEALTHCARE NEEDS OF OUR COMMUNITY IN BETWEEN COMMUNITY HEALTH NEEDS ASSESSMENT CYCLES.

Q3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE: GREAT CONCERN IS TAKEN TO ENSURE THAT PATIENTS ARE APPRISED OF THE AVAILABILITY OF FEDERAL/STATE/LOCAL GOVERNMENT PROGRAMS AND THE HOSPITAL'S FINANCIAL ASSISTANCE PLAN. NOTICE OF THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM IS DISPLAYED CONSPICUOUSLY IN ENGLISH AND SPANISH AT THE ENTRY OF EACH FACILITY AND AT ALL PATIENT REGISTRATION POINTS. THE NOTIFICATION INCLUDES AN OVERVIEW OF THE HOSPITAL'S FINANCIAL AID PROGRAM; THE AVAILABILITY OF FREE BED FUNDS AND OTHER FINANCIAL ASSISTANCE; SLIDING SCALE; AND FINANCIAL COUNSELOR CONTACT INFORMATION. AT THE TIME OF REGISTRATION, HOSPITAL ACCESS STAFF REVIEWS THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM AND ASKS THE PATIENT IF HE/SHE WOULD LIKE A FINANCIAL

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ASSISTANCE PACKAGE. BUILT INTO THE REGISTRATION DATA BASE IS A REQUIRED FINANCIAL ASSISTANCE FIELD WHICH MUST BE COMPLETED AS PART OF THE ADMISSIONS PROCESS. ONCE THE PATIENT EXPRESSES THE DESIRE TO RECEIVE A FINANCIAL ASSISTANCE PACKAGE, PAPERWORK WITH PATIENT NAME AND MEDICAL RECORD IS AUTOMATICALLY PRINTED AT THE REGISTRATION STATION AND HANDED TO THE PATIENT. OTHER METHODS OF COMMUNICATION TO INCREASE AWARENESS REGARDING THE FINANCIAL ASSISTANCE AND FREE BED FUND PROGRAM INCLUDE 1) A FINANCIAL ASSISTANCE BROCHURE THAT AIDS PATIENTS IN THE PROCESS, ANSWERS KEY QUESTIONS AND PROVIDES EASY ACCESS FOR HELP (AVAILABLE AT MULTIPLE HOSPITAL DEPARTMENTS AND LOCATIONS, INCLUDING KIOSKS AT EVERY HOSPITAL ENTRY POINT); 2) A SEPARATE AND DISTINCT FINANCIAL ASSISTANCE SERVICES SECTION ON THE HOSPITAL'S WEB-SITE (WWW.MIDHOSP.ORG) WHICH INCLUDES APPLICATION, INSTRUCTIONS, AND SLIDING SCALE; 3) INCLUSION OF FINANCIAL ASSISTANCE INFORMATION IN THE HOSPITAL'S INPATIENT ADMISSIONS BOOKLET; 4) NOTICE OF THE PROGRAM AND FINANCIAL COUNSELOR CONTACT INFORMATION ON EVERY BILLING STATEMENT; 5) NOTIFICATION AT DISCHARGE; AND 6) A LETTER OUTLINING THE PROGRAM SENT TO EVERY SELF-PAY PATIENT FOLLOWING

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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DISCHARGE.

THE HOSPITAL HAS A TEAM OF FINANCIAL COUNSELORS WHO ARE AVAILABLE TO ASSIST THE PATIENT THROUGH THE APPLICATION PROCESS EITHER BY PHONE OR VISIT. THE ROLE OF THE COUNSELORS IS TO HELP PATIENTS NAVIGATE THE HOSPITAL'S FINANCIAL ASSISTANCE PROCESS AND TO AID IN APPLICATION FOR MEDICAID/STATE PROGRAMS. ALL COUNSELORS RECEIVE DEPARTMENTAL TRAINING ON THE IMPORTANCE OF ASSISTING PATIENTS IN NEED OF STATE/GOVERNMENTAL OR HOSPITAL FINANCIAL ASSISTANCE, THE HOSPITAL'S FINANCIAL ASSISTANCE PROTOCOLS, SYSTEMS, NEW PROGRAM ENHANCEMENTS, AND HOW TO PROVIDE SUPPORT AND FOLLOW-UP FOR MEDICAID/STATE ENROLLMENT. THE HOSPITAL'S SOCIAL WORKERS ALSO ASSIST PATIENTS WITH COMPLETION OF HOSPITAL FINANCIAL ASSISTANCE APPLICATIONS AS WELL AS MEDICAID/STATE APPLICATIONS.

AN IMPORTANT ADDITION TO MIDDLESEX HOSPITAL'S FINANCIAL ASSISTANCE PROCESS HAS BEEN THE DEVELOPMENT OF THE FINANCIAL ASSISTANCE WORKGROUP SEVERAL YEARS AGO. WORKGROUP TASKS INCLUDE: INCREASING AWARENESS

Part VI Supplemental Information

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REGARDING FINANCIAL ASSISTANCE AVAILABILITY; CONTINUOUS MONITORING OF APPROPRIATENESS, FEASIBILITY AND ACCESSIBILITY OF THE HOSPITAL'S FINANCIAL ASSISTANCE PRACTICES; AND A COMPREHENSIVE COMMUNICATIONS STRATEGY FOR INCREASING AWARENESS FOR FINANCIAL ASSISTANCE. IN FY13, MIDDLESEX HOSPITAL GRANTED \$2,865,793 OF FINANCIAL ASSISTANCE TO 6,751 UNIQUE RECIPIENTS AND ABSORBED \$20,596,794 IN UNPAID COSTS OF MEDICAID (TOTAL OF MEDICAID INCLUDING MANAGED CARE AND LIA), SERVING 16,485 INDIVIDUALS.

Q4 - COMMUNITY INFORMATION: MIDDLESEX HOSPITAL IS THE SOLE HOSPITAL PROVIDER IN ITS SERVICE AREA, WHICH INCLUDES THE LARGE GEOGRAPHIC AREA OF MIDDLESEX COUNTY AND SURROUNDING TOWNS. IT ENCOMPASSES 24 MUNICIPALITIES, INCLUDING THE 15 TOWNS OF MIDDLESEX COUNTY (MIDDLETOWN, CROMWELL, PORTLAND, EAST HAMPTON, EAST HADDAM, HADDAM, MIDDLEFIELD, DURHAM, KILLINGWORTH, CHESTER, DEEP RIVER, ESSEX, OLD SAYBROOK, WESTBROOK, CLINTON) AND 9 TOWNS ON MIDDLESEX COUNTY'S PERIPHERY (ROCKY HILL, GLASTONBURY, HEBRON, MARLBOROUGH, COLCHESTER, SALEM, LYME/OLD LYME,

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MADISON, GUILFORD). THE MIX OF SUBURBAN AND RURAL TOWNS EXIST WITHIN A LAND MASS OF APPROXIMATELY 623 SQUARE MILES AND HAS A POPULATION OF APPROXIMATELY 250,000 [WITH A POPULATION OF 165,676 (2010 CENSUS) IN MIDDLESEX COUNTY PROPER]. MIDDLESEX COUNTY IS LOCATED IN SOUTHEASTERN CONNECTICUT AND RANKS 3RD OF THE EIGHT CT COUNTIES IN POPULATION SIZE. 72% OF THE COUNTY'S RESIDENTS LIVE IN URBAN AREAS WITH 28% LIVING IN RURAL ENVIRONMENTS. THE MAIN INDUSTRY INCLUDES: MIDDLESEX HOSPITAL, WESLEYAN UNIVERSITY, PRATT & WHITNEY AND THE SMALL BUSINESS COMMUNITY.

THE COUNTY'S RACIAL COMPOSITION IS 89.2% WHITE, 4.6% BLACK OR AFRICAN AMERICAN, 2.6% ASIAN PACIFIC, 0.2% NATIVE AMERICAN AND 3.4% OTHER/MULTI-RACE, WITH AN ETHNIC MAKE-UP OF 5.1% HISPANIC OR LATINO (2011). MIDDLETOWN IS THE LARGEST MUNICIPALITY IN THE COUNTY, WITH A POPULATION OF 47,648 (2010 CENSUS) AND DEMOGRAPHICALLY STANDS ALONE FROM THE OTHER TOWNS WITHIN MIDDLESEX COUNTY. MIDDLETOWN'S RACIAL COMPOSITION IS 76% WHITE, 12% BLACK OR AFRICAN AMERICAN, 4% ASIAN PACIFIC, 0.1% NATIVE AMERICAN AND 7.5% OTHER/MULTI-RACE, WITH AN ETHNIC MAKE-UP OF 6.8%

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HISPANIC OR LATINO (2010). REGARDING THE SOCIOECONOMIC MEASURES OF INCOME LEVEL, POVERTY RATE, AND EDUCATION ATTAINMENT: 1) THE AVERAGE ANNUAL HOUSEHOLD INCOME IS \$61,791 IN MIDDLETOWN AND \$74,627 IN MIDDLESEX COUNTY (2010); 2) THE POVERTY RATE IS 11.8% IN MIDDLETOWN AND 5.8% IN MIDDLESEX COUNTY (2009); AND 3) 10.3% OF ADULTS AGE 25 OR OLDER IN MIDDLETOWN DON'T HAVE A HIGH SCHOOL DIPLOMA COMPARED TO 7% IN MIDDLESEX COUNTY (2007-2011). IN 2013, THE PERCENT OF HOSPITAL DISCHARGES FOR MEDICAID/SAGA/UNINSURED COMBINED FOR THE FOLLOWING SERVICE LINES WERE: 14.8% INPATIENT; 37.6% NEWBORN; 12.3% OUTPATIENT SURGERY; 31.4% EMERGENCY DEPARTMENT NON-ADMISSION AND 14.7% OUTPATIENT OBSERVATION.

Q5 - PROMOTION OF COMMUNITY HEALTH: AS MIDDLESEX HOSPITAL IS A COMMUNITY HOSPITAL, INVOLVING COMMUNITY MEMBERS IN KEY FUNCTIONS HAS ALWAYS BEEN A PRIORITY. THE HOSPITAL'S BOARD IS COMPRISED MAINLY OF COMMUNITY MEMBERS WHO ARE NEITHER EMPLOYEES, FAMILY MEMBERS NOR CONTRACTORS OF THE ORGANIZATION, BUT ARE LONG-TERM RESIDENTS WHOSE PRIMARY INTEREST IS THE HEALTH AND WELL-BEING OF THE COMMUNITY AT LARGE. MIDDLESEX HOSPITAL

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EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY BASED ON THE HOSPITAL'S CURRENT AND PROJECTED PATIENT CARE, TEACHING AND RESEARCH NEEDS, AND OVERALL COMMUNITY NEED. MEDICAL STAFF INPUT AND PARTICIPATION IS HIGHLY VALUED BY THE HOSPITAL AS EVIDENCED BY INCLUSION IN THE HOSPITAL'S MEDICAL EXECUTIVE COMMITTEE, THE MEDICAL STAFF COUNCIL AND COUNTLESS OTHER WORKING COMMITTEES. THE HOSPITAL HAS A FORMAL PROCESS FOR ALLOCATION OF SURPLUS FUNDS; A MULTIDISCIPLINARY CAPITAL BUDGETING COMMITTEE MEETS AND SETS PRIORITIES FOR INVESTMENTS IN PATIENT CARE, EDUCATION AND RESEARCH, AND PHYSICAL STRUCTURE. THE APPROACH TAKES INTO CONSIDERATION PATIENT, COMMUNITY AND STAFF NEEDS. EACH YEAR THE HOSPITAL ALLOCATES A PORTION OF SURPLUS FUNDING TO A WIDE ARRAY OF COMMUNITY BENEFIT PROGRAMS AND SERVICE LINES, INCLUDING SUBSTANTIAL HEALTH AND WELLNESS ACTIVITIES AND INITIATIVES, SUBSIDIZED SERVICES, MEDICAL EDUCATION, RESEARCH AND HEALTH ASSESSMENT COSTS. CONTINUOUS DEDICATION TO THE COMMUNITIES IT SERVES REMAINS THE HALLMARK OF MIDDLESEX HOSPITAL'S VISION, MISSION, AND STRATEGIC PLANNING.

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AMBITIOUS COMMUNITY BENEFIT GOALS, THE INCORPORATION OF COMMUNITY BENEFIT INTO ANNUAL ORGANIZATIONAL PLANNING, AND THE PROVISION OF COMMUNITY BENEFIT PROGRAMS THAT TARGET THE COMMUNITY'S MOST VULNERABLE AND AT-RISK POPULATIONS HAS ALLOWED THE HOSPITAL TO PUT A FORMAL STRUCTURE AROUND ITS FUNDAMENTAL PURPOSE. THE HOSPITAL'S COMMUNITY BENEFIT TOTAL FOR FY13 WAS \$52,904,536 (EXCLUDING COMMUNITY BUILDING) WITH 82,400 SERVED (EXCLUDING COMMUNITY BUILDING). THE FOLLOWING IS AN OVERVIEW OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM:

COMMUNITY HEALTH IMPROVEMENT SERVICES: THE HOSPITAL UNDERWRITES A VAST RANGE OF COMMUNITY HEALTH EDUCATION AND HEALTH IMPROVEMENT PROGRAMS, NONE OF WHICH ARE DEVELOPED FOR MARKETING PURPOSES, ALL OF WHICH ARE SUPPORTED AS A MEANS OF FULFILLING THE HOSPITAL'S MISSION TO SERVE ITS COMMUNITY. ALMOST 100% OF THE TIME THESE SERVICES ARE OFFERED FREE OF CHARGE; IN THE RARE INSTANCE WHERE A NOMINAL FEE IS ASSESSED THE COST OF PROVIDING THE SERVICE IS NOT COVERED. COMMUNITY HEALTH EDUCATION IS PROVIDED TO THE COMMUNITY AT LARGE. SOME OF THE PROGRAMS REPRESENT ONE TIME EVENTS,

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HOWEVER MOST ARE ONGOING AND OVER THE YEARS HAVE BECOME ENTRENCHED IN THE COMMUNITY AS A SOURCE OF SUPPORT AND CONTINUED EDUCATION FOR A HEALTHFUL FUTURE. EXAMPLES OF COMMUNITY HEALTH IMPROVEMENT SERVICES INCLUDE (BUT ARE NOT LIMITED TO): 1) HEALTH EDUCATION (COMMUNITY EDUCATION PRESENTATIONS; HEALTH AND WELLNESS EVENTS/HEALTH FAIRS; SUPPORT GROUPS; LARGE SCALE CANCER AWARENESS AND EDUCATIONAL EVENTS; AND THE AVAILABILITY OF HEALTH LITERATURE); 2) COMMUNITY-BASED CLINICAL SERVICES (CLINICS AND SCREENINGS; ANNUAL FLU SHOTS; BLOOD PRESSURE CLINICS); AND 3) HEALTHCARE SUPPORT SERVICES OFFERED TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS, ESPECIALLY THOSE LIVING IN POVERTY AND/OR OTHER VULNERABLE POPULATIONS (CENTER FOR CHRONIC CARE MANAGEMENT DISEASE MANAGEMENT OUTPATIENT PROGRAMS FOR ADULT ASTHMA; CHILD ASTHMA; DIABETES EDUCATION AND DISEASE MANAGEMENT; MEDICAL NUTRITION THERAPY; SMOKING CESSATION; CHRONIC HEART FAILURE; AND CHILDHOOD WEIGHT MANAGEMENT). IN FY13, THE HOSPITAL'S COMMUNITY HEALTH IMPROVEMENT SERVICES SERVED 26,051 INDIVIDUALS AT A TOTAL COST OF \$4,165,765 TO THE HOSPITAL.

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HEALTH PROFESSIONS EDUCATION: HELPING TO PREPARE FUTURE HEALTH CARE PROFESSIONALS IS A LONG-STANDING COMMITMENT OF MIDDLESEX HOSPITAL AND DISTINGUISHING CHARACTERISTIC THAT CONSTITUTES A SIGNIFICANT COMMUNITY BENEFIT. THE HOSPITAL'S FAMILY MEDICINE RESIDENCY PROGRAM GRADUATES FAMILY PRACTICE PHYSICIANS, MANY OF WHOM CONTINUE TO PRACTICE IN THE MIDDLESEX COUNTY AREA AFTER THEIR TRAINING IS COMPLETE. THIS IS ESPECIALLY IMPORTANT GIVEN THAT MIDDLESEX COUNTY HAS BEEN DESIGNATED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) TO BE A MEDICALLY UNDERSERVED AREA EXPERIENCING A SHORTAGE OF SELECT HEALTH SERVICES WHICH INCLUDE TOO FEW PRIMARY CARE PROVIDERS. IN ADDITION, HRSA REPORTS THAT MIDDLESEX COUNTY IS A HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) FOR PRIMARY MEDICAL CARE. THE HOSPITAL ALSO WELCOMES MEDICAL AND NURSING STUDENT INTERNS AND PROVIDES ON-SITE TRAINING DURING CLINICAL ROTATIONS. NURSING STUDENTS FROM LOCAL COLLEGES AND PROGRAMS RECEIVE HANDS-ON MENTORSHIP IN THE MAJORITY OF CLINICAL SERVICE LINES YEAR-ROUND. OTHER HEALTHCARE PROFESSIONAL EDUCATION INCLUDES THE HOSPITAL'S RADIOLOGY SCHOOL (WHICH OPERATES AT A LOSS FOR THE HOSPITAL) AND

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CLINICAL/NON-CLINICAL EDUCATIONAL STUDENT TRAINING IN MULTIPLE FIELDS. IN

FY13, THE HOSPITAL'S HEALTH PROFESSIONS EDUCATION CATEGORY SERVED 1,304

INDIVIDUALS AT A TOTAL COST OF \$6,254,905 TO THE HOSPITAL.

SUBSIDIZED HEALTH SERVICES: THE HOSPITAL'S SUBSIDIZED HEALTH SERVICES REPRESENT A SIGNIFICANT PORTION OF MIDDLESEX HOSPITAL'S ANNUAL COMMUNITY BENEFIT AGGREGATE FINANCIALS AND NUMBERS SERVED. SUBSIDIZED SERVICES ARE PARTICULAR CLINICAL PROGRAMS PROVIDED TO THE COMMUNITY DESPITE A FINANCIAL LOSS, WITH NEGATIVE MARGINS REMAINING AFTER SPECIFIC DOLLARS (FINANCIAL ASSISTANCE AND BAD DEBT) AND SHORTFALLS (MEDICAID) ARE REMOVED. IN ORDER TO QUALIFY AS A SUBSIDIZED SERVICE, THE PROGRAM MUST MEET CERTAIN HEALTH DELIVERY CRITERIA; MEET AN IDENTIFIED NEED IN THE COMMUNITY; AND WOULD BECOME UNAVAILABLE OR THE RESPONSIBILITY OF A GOVERNMENTAL OR ANOTHER NOT-FOR-PROFIT AGENCY TO PROVIDE IF THE HOSPITAL DISCONTINUED THE SERVICE. MIDDLESEX HOSPITAL'S SUBSIDIZED SERVICES FOR FY13 INCLUDE FAMILY PRACTICE SERVICES, BEHAVIORAL HEALTH (INPATIENT AND OUTPATIENT), HOMECARE, CARDIAC REHABILITATION, PARAMEDICS, HOSPICE,

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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

DIABETES EDUCATION, WOUND CARE AND PULMONARY REHABILITATION. IN FY13 THE HOSPITAL'S SUBSIDIZED SERVICES SERVED 25,735 PEOPLE WITH A TOTAL COST OF \$17,367,945 TO THE HOSPITAL.

RESEARCH: MIDDLESEX HOSPITAL CONDUCTS RESEARCH IN THE DOMAINS OF CLINICAL AND COMMUNITY HEALTH. CLINICAL EXAMPLES INCLUDE NATIONAL TRIALS BY THE HOSPITAL'S CANCER CENTER FOR BREAST, LUNG, PROSTATE, COLORECTAL, AMONG OTHERS. FOR FY13, THE HOSPITAL'S ASSOCIATED COSTS FOR ALL RESEARCH PROJECTS TOTALED \$884,550 AND SERVED 123 INDIVIDUALS.

FINANCIAL AND IN-KIND CONTRIBUTIONS: MIDDLESEX HOSPITAL SUPPORTS THE COMMUNITY IN THE FORM OF FINANCIAL AND IN-KIND CONTRIBUTIONS. THE HOSPITAL'S IN-KIND CONTRIBUTIONS INCLUDE EQUIPMENT, FOOD, LINENS AND MEDICAL SUPPLIES THAT ARE DONATED BOTH LOCALLY AND GLOBALLY. OTHER IN-KIND DONATIONS INCLUDE CAFETERIA DISCOUNTS FOR YMCA RESIDENTS AND STAFF COORDINATION OF COMMUNITY SUPPORT DRIVES. THE HOSPITAL'S MAIN CAMPUS AND SATELLITE LOCATIONS MAKE MEETING SPACE AVAILABLE,

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

FREE-OF-CHARGE AND ON AN ON-GOING BASIS, FOR MANY COMMUNITY GROUPS THAT WOULD OTHERWISE STRUGGLE TO PAY FOR SPACE. IN ADDITION, EACH YEAR THE HOSPITAL MAKES SUBSTANTIAL CASH DONATIONS TO CAREFULLY SELECTED MISSION-DRIVEN COMMUNITY ORGANIZATIONS THROUGHOUT ITS SERVICE AREA. THE HOSPITAL'S FY13 SUPPORT FOR FINANCIAL AND IN-KIND CONTRIBUTIONS TOTALED \$364,882, SERVING 5,951 INDIVIDUALS.

COMMUNITY BENEFIT OPERATIONS: COMMUNITY BENEFIT OPERATIONS INCLUDE ACTIVITIES AND COSTS ASSOCIATED WITH COMMUNITY BENEFIT STRATEGIC PLANNING, ADMINISTRATION, ANNUAL GOAL ATTAINMENT, AND COMMUNITY HEALTH NEEDS ASSESSMENT PRODUCTION AND IMPLEMENTATION. MIDDLESEX HOSPITAL HAS A DEDICATED MANAGER OF COMMUNITY BENEFIT, ALONG WITH A COMMUNITY BENEFIT STEERING COMMITTEE (COMPRISED OF HOSPITAL LEADERSHIP) THAT OVERSEES COMMUNITY BENEFIT PLANNING AND OPERATIONS. OUTSIDE OF ON-GOING COMMUNITY BENEFIT ACTIVITIES, THE MAIN GOALS OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM IN FY13 CONTINUED TO FOCUS ON THE HEALTH ASSESSMENT PRIORITY AREAS AND COLLABORATING WITH COMMUNITY PARTNERS. THE HOSPITAL'S FY13

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

COMMUNITY BENEFIT OPERATIONS EXPENSE TOTALED \$403,902, WHICH INCLUDES THE COSTS ASSOCIATED WITH CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT.

Q6 - AFFILIATED HEALTH SYSTEM: N/A. MIDDLESEX HOSPITAL IS NOT PART OF AN AFFILIATED HEALTH CARE SYSTEM.

Q7 - COMMUNITY BENEFIT REPORT FILING: UNDER THE CONNECTICUT GENERAL STATUTES 19A-127K, HOSPITALS THAT HAVE A COMMUNITY BENEFIT PROGRAM IN PLACE, AS SPECIFIED BY THE STATUTE, ARE REQUIRED TO REPORT BIENNIALY TO THE STATE OF CT. THIS BIENNIAL COMMUNITY BENEFIT REPORTING IS CURRENTLY UNDER THE AUSPICES OF THE STATE OF CONNECTICUT'S OFFICE OF THE HEALTHCARE ADVOCATE. AS MIDDLESEX HOSPITAL MEETS THE STATUTE AS HAVING A COMMUNITY BENEFIT PROGRAM IN PLACE, IT REPORTS BIENNIALY TO THE STATE OF CT'S OFFICE OF THE HEALTHCARE ADVOCATE.

Q8 - FACILITY REPORTING GROUP: N/A

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

MIDDLESEX HOSPITAL

Employer identification number

06-0646718

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2012

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

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

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

| | (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation reported as deferred in prior Form 990 |
|----|--|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 | SUSAN MARTIN VP FINANCE TREASURER | (i) 332,712. (ii) 0 | 141,500. 0 | 895,645. 0 | 87,440. 0 | 3,230. 0 | 1,460,527. 0 | 958,020. 0 |
| 2 | ARTHUR MCDOWELL, MD VP CLINICAL AFFAIRS | (i) 381,737. (ii) 0 | 150,500. 0 | 127,652. 0 | 232,720. 0 | 7,488. 0 | 900,097. 0 | 340,109. 0 |
| 3 | HARRY EVERT SR. VP STRATEGIC PLANNING OPS | (i) 272,492. (ii) 0 | 99,500. 0 | 39,874. 0 | 55,000. 0 | 3,782. 0 | 470,648. 0 | 44,500. 0 |
| 4 | JESSE WAGNER, MD VP QUALITY AND PATIENT SAFETY | (i) 407,756. (ii) 0 | 0 0 | 4,220. 0 | 95,500. 0 | 6,142. 0 | 513,618. 0 | 15,000. 0 |
| 5 | GREGORY NOKES VP HUMAN RESOURCES | (i) 275,712. (ii) 0 | 108,000. 0 | 75,874. 0 | 143,300. 0 | 4,840. 0 | 607,726. 0 | 193,215. 0 |
| 6 | JACQUELYN CALAMARI VP NURSING | (i) 210,180. (ii) 0 | 69,500. 0 | 3,256. 0 | 68,200. 0 | 2,056. 0 | 353,192. 0 | 32,500. 0 |
| 7 | GARRETT HAVICAN VP OPERATIONS | (i) 220,397. (ii) 0 | 0 0 | 1,881. 0 | 56,000. 0 | 7,488. 0 | 285,766. 0 | 13,000. 0 |
| 8 | MICHAEL SAXE, MD CHAIRMAN EMERGENCY MEDICINE | (i) 359,372. (ii) 0 | 38,118. 0 | 5,458. 0 | 0 0 | 6,440. 0 | 409,388. 0 | 15,000. 0 |
| 9 | JONATHAN BANKOFF, MD PHYSICIAN EMERGENCY DEPARTMENT | (i) 266,690. (ii) 0 | 85,421. 0 | 0 0 | 0 0 | 5,642. 0 | 357,753. 0 | 77,565. 0 |
| 10 | RANDOLPH GOODWIN, MD CLINICAL DIR., INFECTIOUS DIS. | (i) 306,920. (ii) 0 | 23,225. 0 | 27,393. 0 | 0 0 | 1,225. 0 | 358,763. 0 | 5,767. 0 |
| 11 | MARIO CAPUZZI, MD MEDICAL DIR., EMERGENCY DEPT. | (i) 249,132. (ii) 0 | 70,610. 0 | 0 0 | 62,000. 0 | 6,552. 0 | 326,294. 0 | 0 0 |
| 12 | DAVID GIUFFRIDA VP, FACILITIES & SUPPORT SVCS | (i) 216,025. (ii) 0 | 40,000. 0 | 2,958. 0 | 0 0 | 0 0 | 320,983. 0 | 0 0 |
| 13 | DAVID CONSENTINO, MD MEDICAL DIR., EMERGENCY DEPT. | (i) 253,378. (ii) 0 | 64,922. 0 | 243. 0 | 0 0 | 5,147. 0 | 323,690. 0 | 66,224. 0 |
| 14 | ROBERT GRILLO, MD CHIEF, DEPT. OF PSYCHIATRY | (i) 258,840. (ii) 0 | 33,610. 0 | 19,781. 0 | 0 0 | 5,525. 0 | 317,756. 0 | 0 0 |
| 15 | VINCENT CAPECE, JR. PRESIDENT CEO | (i) 564,719. (ii) 0 | 176,500. 0 | 15,998. 0 | 354,750. 0 | 7,647. 0 | 1,119,614. 0 | 334,028. 0 |
| 16 | DAVID BAGGISH, MD CHIEF OF MEDICINE & SECRETARY | (i) 322,215. (ii) 0 | 8,554. 0 | 243. 0 | 0 0 | 5,037. 0 | 336,049. 0 | 0 0 |

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.

SUPPLEMENTAL COMPENSATION INFORMATION

BENEFITS

SCHEDULE J, PART I, LINE 1A

FIRST CLASS TRAVEL - THE HOSPITAL'S POLICY AUTHORIZES FIRST CLASS TRAVEL

FOR THE CHIEF EXECUTIVE OFFICER ON TRIPS EXCEEDING FOUR HOURS IN

DURATION. NONE WAS USED DURING THE REPORTING PERIOD.

TRAVEL FOR COMPANIONS - THE HOSPITAL'S POLICY PROVIDES FOR SPOUSAL OR

"SIGNIFICANT OTHER" TRAVEL IN CERTAIN INSTANCES RELATED TO BUSINESS

ACTIVITIES AND PRESCRIBES THE PROPER TAX TREATMENT OF THAT BENEFIT. THIS

BENEFIT WAS TREATED AS TAXABLE COMPENSATION.

SOCIAL CLUB DUES - REPRESENTS A CORPORATE MEMBERSHIP AT A GOLF CLUB USED

FOR VARIOUS BUSINESS PURPOSES. TO THE EXTENT THIS MEMBERSHIP IS USED FOR

PERSONAL REASONS THE ASSOCIATED COST IS INCLUDED IN THE TAXABLE INCOME OF

THE EXECUTIVE STAFF MEMBER ACCORDING TO IRS RULES AND REGULATIONS. THIS

BENEFIT WAS TREATED AS TAXABLE COMPENSATION.

PERSONAL SERVICES - REPRESENTS TAX PLANNING AND/OR TAX PREPARATION FEES

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.

FOR TWO (2) MEMBERS OF THE EXECUTIVE STAFF. THIS BENEFIT WAS TREATED AS TAXABLE COMPENSATION.

SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

NONQUALIFIED RETIREMENT BENEFITS ARE PROVIDED AS PART OF A COMPETITIVE TOTAL COMPENSATION PROGRAM AND TO ENCOURAGE RETENTION OF KEY EXECUTIVES.

THE NONQUALIFIED RETIREMENT PLAN BENEFIT ACCRUES ANNUALLY AND THE PLAN PROVIDES THAT A PARTICIPANT VESTS AFTER THREE (3) YEARS OF SERVICE. THE AMOUNT OF THE VESTED BENEFITS IS CONSIDERED "INCOME" TO THE EXECUTIVE'S W-2 FORM AND IS TAXABLE. CERTAIN EXECUTIVES ALSO PARTICIPATE IN A FORMER PLAN, WHERE ACCRUALS CEASED IN 2010 AND THE VESTED BENEFITS WILL BE DISTRIBUTED ON TERMINATION OF EMPLOYMENT. THE FOLLOWING INDIVIDUALS PARTICIPATED IN THE NONQUALIFIED RETIREMENT PLAN. THE AMOUNTS REPORTED BELOW REPRESENT BENEFITS ACCRUED DURING CALENDAR YEAR 2012, NOT PAYABLE UNTIL RETIREMENT.

SUSAN MARTIN \$890,245

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.

| | |
|---------------------|-----------|
| ARTHUR MCDOWELL, MD | \$118,818 |
| GREGORY NOKES | \$70,486 |
| HARRY EVERT | \$27,700 |

THE FOLLOWING PARTICIPANTS HAD FUNDS CONTRIBUTED TO THEIR SERP ACCOUNT IN

2012:

| | |
|---------------------|-----------|
| ARTHUR MCDOWELL, MD | \$155,720 |
| DAVID GIUFFRIDA | \$22,000 |
| GREGORY NOKES | \$84,300 |
| VINCENT CAPECE | \$171,750 |
| SUSAN MARTIN | \$13,440 |
| GARY HAVICAN | \$20,000 |
| JESSE WAGNER, MD | \$34,000 |
| JACQUELYN CALAMARI | \$21,200 |

COMPENSATION CONTINGENT ON NET REVENUE

SCHEDULE J, PART I, LINE 6A

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.

THERE ARE FOUR (4) BROAD CATEGORIES OF EXECUTIVE INCENTIVE GOALS:
CLINICAL QUALITY AND PATIENT SATISFACTION (40%), FINANCIAL STRENGTH
(30%), WORKPLACE ENVIRONMENT (20%), AND COMMUNITY BENEFIT/CHARITABLE
MISSION EFFECTIVENESS (10%). WITHIN EACH CATEGORY ARE MORE SPECIFIC GOALS
WHICH ARE DETERMINED FROM OUR OWN PAST EXPERIENCE AS WELL AS STATE AND
NATIONAL BENCHMARK DATA. THE INCENTIVE COMPENSATION OF THE EXECUTIVE
STAFF IS DETERMINED WITH REFERENCE TO PERFORMANCE RELATIVE TO THESE
GOALS.

BONUS & INCENTIVE COMPENSATION - COLUMN B(II)

SCHEDULE J, PART II

THE AMOUNTS REPRESENT INCENTIVE COMPENSATION PAYMENTS MADE IN CALENDAR
YEAR 2012. PAYMENTS INCLUDE AMOUNTS EARNED IN 2011 AND DEFERRED, WHERE
APPLICABLE.

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

MIDDLESEX HOSPITAL

Part I Bond Issues

| (a) Issuer name | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price | (f) Description of purpose | (g) Defeased | | (h) On behalf of issuer | | (i) Pooled financing | |
|---|----------------|-------------|-----------------|-----------------|------------------------------------|--------------|----|-------------------------|----|----------------------|----|
| | | | | | | Yes | No | Yes | No | Yes | No |
| A STATE OF CT HEALTH & EDUCATIONAL FACILITIES AUTH. | 06-0806186 | 20774UGQ2 | 12/07/2006 | 23,613,507. | CONSTRUCTION OF NEW EMERGENCY ROOM | | X | | X | | X |
| B STATE OF CT HEALTH & EDUCATIONAL FACILITIES AUTH. | 06-0806186 | 20774UGR0 | 12/07/2006 | 16,620,000. | REFINANCE 11/15/2002 (SERIES K) | | X | | X | | X |
| C STATE OF CT HEALTH & EDUCATIONAL FACILITIES AUTH. | 06-0806186 | 20774YAM7 | 07/26/2011 | 33,803,383. | REFINANCE 10/9/1997 (SERIES H) | | X | | X | | X |

Employer identification number
06-0646718

**SCHEDULE K
Supplemental Information on Tax-Exempt Bonds**

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

OMB No. 1545-0047
2012
Open to Public Inspection

Part II Proceeds

| | A | | B | | C | | D | |
|---|------|-------------|------|-------------|------|-------------|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 Amount of bonds retired | | 2,250,000. | | 3,890,000. | | 3,775,000. | | |
| 2 Amount of bonds legally defeased | | | | | | | | |
| 3 Total proceeds of issue | | 24,649,762. | | 16,775,130. | | 33,803,651. | | |
| 4 Gross proceeds in reserve funds | | 1,625,617. | | 1,219,669. | | | | |
| 5 Capitalized interest from proceeds | | | | | | | | |
| 6 Proceeds in refunding escrows | | | | | | | | |
| 7 Issuance costs from proceeds | | 392,822. | | 256,847. | | 537,961. | | |
| 8 Credit enhancement from proceeds | | 720,290. | | 429,253. | | | | |
| 9 Working capital expenditures from proceeds | | | | | | | | |
| 10 Capital expenditures from proceeds | | 21,821,549. | | 14,869,361. | | 33,265,690. | | |
| 11 Other spent proceeds | | 89,483. | | | | | | |
| 12 Other unspent proceeds | | | | | | | | |
| 13 Year of substantial completion | 2008 | | 2007 | | 2011 | | | |
| 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 | | | | | | |
| 2 Are there any lease arrangements that may result in private business use of bond-financed property? | | X | | | | | | |

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

Schedule K (Form 990) 2012

Part III Private Business Use (Continued) SCHEDULE K

| | 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 | | | | | | |
| b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | | | | | | | | |
| c Are there any research agreements that may result in private business use of bond-financed property? | | X | | | | | | |
| d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? | | | | | | | | |
| 4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government | | % | | % | | % | | % |
| 5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government | | % | | % | | % | | % |
| 6 Total of lines 4 and 5 | | % | | % | | % | | % |
| 7 Does the bond issue meet the private security or payment test? | | | | | | | | |
| 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? | | | | | | | | |
| 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? | | | | | | | | |

Part IV Arbitrage

| | A | | B | | C | | D | |
|--|-----|----|-----|----|-----|----|-----|----|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 Has the issuer filed Form 8038-T? | | | | | | | | |
| 2 If "No" to line 1, did the following apply? | | X | | X | | X | | |
| a Rebate not due yet? | | | | | | | | |
| b Exception to rebate? | | | | | | | | |
| c No rebate due? | | | | | | | | |
| If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed | | | | | | | | |
| 3 Is the bond issue a variable rate issue? | | X | | X | | 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 VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions) (Continued)

TOTAL PROCEEDS OF ISSUE

SCHEDULE K, PART II, LINE 3 (ALL BONDS):

THE DIFFERENCE BETWEEN THE ISSUE PRICE AND THE TOTAL PROCEEDS IS INTEREST

IN THE AMOUNT OF: \$1,036,255 FOR COLUMN A BOND, \$155,130 FOR COLUMN B BOND AND \$268 FOR COLUMN C BOND.

ISSUANCE COSTS FROM PROCEEDS

SCHEDULE K, PART II, LINE 7 (COLUMN C BOND):

THIS AMOUNT WILL NOT TIE TO 8038 DUE TO ALLOCATION TO OBLIGATED GROUP.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization
MIDDLESEX HOSPITAL

Employer identification number
06-0646718

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

| 1 | (a) Name of disqualified person | (b) Relationship between disqualified person and organization | (c) Description of transaction | (d) Corrected? | |
|-----|---------------------------------|---|--------------------------------|----------------|----|
| | | | | Yes | No |
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

- 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ \$ _____
- 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ \$ _____

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

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

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|-------------------------------|---|--------------------------|------------------------|---------------------------|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |
| (5) | | | | |
| (6) | | | | |
| (7) | | | | |
| (8) | | | | |
| (9) | | | | |
| (10) | | | | |

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

Schedule L (Form 990 or 990-EZ) 2012

Part IV Business Transactions Involving Interested Persons.

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|--|---|---------------------------|--------------------------------|---|----|
| | | | | Yes | No |
| (1) ANNE CALAMARI-LCSW COORDINATOR | FAMILY MEMBER-J. CALAMARI | 63,312. | RECEIPT OF WAGES/COMPENSATION | | X |
| (2) STEVE MCDOWELL-PURCHASING MANAGER | FAMILY MEMBER-A. MCDOWELL | 100,027. | RECEIPT OF WAGES/COMPENSATION | | X |
| (3) VICTORIA MCDOWELL-REGISTERED NURSE | FAMILY MEMBER-A. MCDOWELL | 71,666. | RECEIPT OF WAGES/COMPENSATION | | X |
| (4) ESSEX FINANCIAL SERVICES | JOHN W. RAFAL/DIRECTOR | 626,850. | ENTITY MORE THAN 35% OWNED | | X |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| (10) | | | | | |

Part V Supplemental Information

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

BUSINESS TRANSACTIONS WITH INTERESTED PERSONS

SCHEDULE L, PART IV

ANNE CALAMARI, LCSW COORDINATOR, IS THE DAUGHTER OF JACQUELYN CALAMARI, VP NURSING. ANNE CALAMARI'S WAGES FOR 10/01/12 TO 09/30/13 TOTALED \$63,312.

STEVE MCDOWELL, PURCHASING MANAGER, IS THE BROTHER OF ARTHUR MCDOWELL, VICE PRESIDENT OF CLINICAL AFFAIRS. STEVE MCDOWELL'S WAGES FOR 10/01/12 TO 09/30/13 TOTALED \$100,027.

VICTORIA MCDOWELL, REGISTERED NURSE, IS THE SISTER-IN-LAW OF ARTHUR MCDOWELL, VICE PRESIDENT OF CLINICAL AFFAIRS. VICTORIA MCDOWELL'S WAGES FOR 10/01/12 TO 09/30/13 TOTALED \$71,666.

JOHN W. RAFAL, DIRECTOR, IS 40% OWNER OF ESSEX FINANCIAL SERVICES. DURING THE REPORTING PERIOD, \$626,850 OF MIDDLESEX HOSPITAL EMPLOYER CONTRIBUTIONS WERE TRANSFERRED TO ESSEX FINANCIAL SERVICES FOR MANAGEMENT IN 403(B) PLANS.

**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.**

OMB No. 1545-0047

2012

**Open To Public
Inspection**

Name of the organization

MIDDLESEX HOSPITAL

Employer identification number

06-0646718

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 | 8. | 557,840. | SELLING PRICE |
| 10 Securities - Closely held stock | | | | |
| 11 Securities - Partnership, LLC, or trust interests | | | | |
| 12 Securities - Miscellaneous | | | | |
| 13 Qualified conservation contribution - Historic structures | | | | |
| 14 Qualified conservation contribution - Other | | | | |
| 15 Real estate - Residential | | | | |
| 16 Real estate - Commercial | | | | |
| 17 Real estate - Other | | | | |
| 18 Collectibles | | | | |
| 19 Food inventory | | | | |
| 20 Drugs and medical supplies | | | | |
| 21 Taxidermy | | | | |
| 22 Historical artifacts | | | | |
| 23 Scientific specimens | | | | |
| 24 Archeological artifacts | | | | |
| 25 Other ▶ (_____) | | | | |
| 26 Other ▶ (_____) | | | | |
| 27 Other ▶ (_____) | | | | |
| 28 Other ▶ (_____) | | | | |

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**

| | Yes | No |
|--|-----|----|
| 30 a During the year, did the organization receive by contribution any property reported in Part I, lines 1-28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period? | | 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? | X | |
| 32 a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? | 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. | | |

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

Schedule M (Form 990) (2012)

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.

USE OF THIRD PARTIES TO SELL NONCASH CONTRIBUTIONS

SCHEDULE M, PART I, LINE 32B

DONORS OF STOCK ARE INSTRUCTED TO TRANSFER TO MERRILL LYNCH, IN WHICH

MERRILL LYNCH IS INSTRUCTED TO SELL STOCK IMMEDIATELY.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

MIDDLESEX HOSPITAL

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

2012

**Open to Public
Inspection**

Employer identification number

06-0646718

PROGRAM SERVICES

PROGRAM SERVICE #1, INPATIENT CARE

FORM 990, PART III, LINE 4A

INPATIENT CARE FROM REGISTRATION THROUGH DISCHARGE IS CAREFULLY MANAGED TO EXCEED REGULATORY REQUIREMENTS AND ENSURE QUALITY, PATIENT SATISFACTION, AND BEST PRACTICE WITH EACH ASPECT OF THE INPATIENT EXPERIENCE, INCLUDING ALL ELEMENTS OF CARE FROM NURSING COMPETENCY AND COMPASSION, TO MEAL QUALITY, LAB AND DIAGNOSTIC TESTING, SAFE AND SECURE PHYSICAL SURROUNDINGS TO PATIENT EDUCATION.

MIDDLESEX HOSPITAL, LICENSED FOR 275 BEDS AND 22 BASSINETS, PROVIDES ACUTE CARE FROM DEDICATED HEALTH CARE TEAMS WHICH INCLUDE SURGEONS, HOSPITALISTS, FAMILY PRACTITIONERS AND RESIDENTS, MEDICAL STAFF PHYSICIANS, MAGNET NURSES, PHYSICIAN ASSISTANTS, PATIENT CARE TECHNOLOGISTS, DIAGNOSTIC TECHNICIANS, PATHOLOGISTS, ADMINISTRATORS, ENVIRONMENTAL SERVICES, SECURITY, ENGINEERING AND A HOST OF OTHERS WORKING TOGETHER TO ENABLE THE ORGANIZATION'S SUCCESS.

THE HOSPITAL UNITS INCLUDING INTENSIVE AND CRITICAL CARE, MEDICAL SURGICAL, ONCOLOGY, ORTHOPEDIC, PULMONOLOGY, VASCULAR AND CARDIOLOGY, GASTROINTESTINAL, MATERNITY, A 20 BED PSYCHIATRIC FLOOR, AND HOSPICE SERVICES SPECIALIZE IN THE SPECIFIC NEEDS OF THEIR PATIENTS AND ARE STAFFED TO ACCOMMODATE THE UNIQUE TREATMENT REQUIREMENTS OF EACH. ALL ANCILLARY SERVICES INCLUDING LABS, RADIOLOGY, FOOD SERVICES, PATHOLOGY,

| | |
|--|--|
| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|--|

PHARMACY, MEDICAL TRANSCRIPTION AND INFORMATION SERVICES TOO ARE A PART OF THE HOSPITAL TEAM. PATIENT CARE IS DEVELOPED WITH FULL CONSIDERATION OF THE WHOLE INDIVIDUAL, AS THEY ARE ASSIGNED TO CONDITION SPECIFIC CARE PATHWAYS AND SERVICES TO SECURE BEST TREATMENT AND RECOVERY.

PROGRAM SERVICE #2, MIDDLESEX HOSPITAL EMERGENCY DEPARTMENT
FORM 990, PART III, LINE 4B

EMERGENCY CARE IS PROVIDED 24 HOURS A DAY, 7 DAYS A WEEK. THE DEPARTMENTS ARE SUPPORTED BY A BROAD SPECTRUM OF DIAGNOSTIC CAPABILITIES AND SOPHISTICATED INFORMATION SYSTEMS. IN ADDITION TO EMERGENCY CARE THERE ARE ALSO ISOLATION AND DECONTAMINATION AREAS IN THE EMERGENCY DEPARTMENT AND A HELIPAD ON SITE FOR LIFE STAR MEDICAL HELICOPTER TRANSPORTS.

MIDDLESEX HOSPITAL IS COMMITTED TO PROVIDING THE HIGHEST STANDARD OF CARE FOR BOTH THE PHYSICAL AND BEHAVIORAL HEALTH NEEDS OF OUR PSYCHIATRIC PATIENTS. THE EMERGENCY DEPARTMENT AT THE HOSPITAL HOUSES AN EIGHT BED EMERGENCY DEPARTMENT CRISIS UNIT. TREATMENT IS PROVIDED REGARDLESS OF THE PATIENT'S BACKGROUND OR STATUS. ED SERVICES ARE STAFFED WITH CLINICAL PERSONNEL SPECIFICALLY TRAINED TO CARE FOR THE UNIQUE NEEDS OF THEIR PATIENTS (PSYCHIATRISTS, STAFF NURSES, PATIENT CARE TECHNICIANS/MENTAL HEALTH WORKERS, SECRETARIES, NURSE EDUCATOR, SOCIAL WORKERS, COTAS, OT AND OTHERS). TOGETHER THE STAFF PARTNERS WITH HOSPITAL STAFF AND COMMUNITY RESOURCES TO DEVELOP THE BEST CARE PLAN FOR PATIENTS THROUGHOUT THEIR STAY IN THE HOSPITAL AND UPON DISCHARGE.

IN FYE 13, THE EMERGENCY ROOM ACTIVITY ACCOUNTED FOR 81,193 EMERGENCY

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| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
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DEPARTMENT VISITS. DEMAND CONTINUES TO RISE AND THE SERVICES PROVIDED CONTINUE TO BE RECOGNIZED FOR CONTINUOUS PATIENT SATISFACTION IN PARTICULAR AS A RECIPIENT OF THE PRESS GANEY SUMMIT AWARD FOR ACHIEVING A 99% CUSTOMER SATISFACTION RATING FOR THREE CONSECUTIVE YEARS.

PROGRAM SERVICE #3, AMBULATORY OR OUTPATIENT SURGERY
FORM 990, PART III, LINE 4C
AMBULATORY OR OUTPATIENT SURGERY IS PERFORMED AT MIDDLESEX HOSPITAL AND THE MIDDLESEX OUTPATIENT CENTER.

OTHER PROGRAM SERVICES
FORM 990, PART III, LINE 4D
OTHER SERVICES INCORPORATE A WIDE RANGE OF CARE PROVIDED TO PATIENTS THAT ARE NOT SPECIFICALLY CAPTURED IN THE OTHER CARE CATEGORIES. THIS DESIGNATION ACCOUNTS FOR 498,611 VISITS. THESE SERVICES INCLUDE CARE PROVIDED AT THE CANCER CENTER SUCH AS DIAGNOSTIC TESTING, TREATMENT AND SUCH SUPPORTS AS ALTERNATIVE MEDICINE THERAPIES/INTEGRATIVE MEDICINES, AND HEREDITARY RISK ASSESSMENTS.

PHYSICAL MEDICINE AND REHABILITATION SERVICES ALSO ARE FOLDED INTO THIS GROUPING. SERVICES ARE AVAILABLE AT MULTIPLE LOCATIONS WHICH OFFER COMPREHENSIVE REHABILITATION AND OCCUPATIONAL MEDICINE AND PHYSICAL THERAPY (INCLUDING HAND THERAPY) SERVICES. CARE IS DELIVERED BY EXPERIENCED, HIGHLY-QUALIFIED STAFF, WITH ADVANCED TRAINING IN PHYSICAL AND OCCUPATIONAL THERAPY, SPEECH LANGUAGE PATHOLOGY AND RELATED FIELDS.

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| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
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IN EACH CLINICAL CASE, PATIENTS ARE EVALUATED AND RECEIVE A UNIQUE TREATMENT PLAN, WHICH INCLUDES DESIRED GOALS, ANTICIPATED OUTCOMES AND THE TIME FRAME NECESSARY TO ACHIEVE CLINICALLY OPTIMAL RESULTS.

ADDITIONAL SERVICES ARE AVAILABLE BY THE WOUND AND SKIN TEAM AT MIDDLESEX HOSPITAL. THE MULTIDISCIPLINARY TEAM PROVIDES TREATMENT WHICH FOCUSES ON CLINICAL WOUND, OSTOMY AND SKIN ISSUES. THE HOSPITAL HAS CAREFUL AND ONGOING SERVICES FOR INDIVIDUALS WITH CHRONIC DISEASES. A SAMPLING OF SUCH PROGRAMS INCLUDE PULMONARY REHABILITATION SERVICES WHICH PROVIDE RESPIRATORY THERAPY AND CARE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE AS WELL AS DIABETES EDUCATION AND MEDICAL NUTRITION THERAPY AT THE CENTER FOR CHRONIC CARE MANAGEMENT PROVIDED TO INDIVIDUALS WITH A NEW DIAGNOSIS AND UNCONTROLLED DIABETES. MANY BEHAVIORAL HEALTH SERVICES ARE PROVIDED TO PATIENTS IN THE OUTPATIENT SETTING IN ADDITION TO COUNSELING AND SUPPORT GROUPS. PROGRAMS INCLUDE THE DAY TREATMENT PROGRAM (INTENSIVE OUTPATIENT SERVICES FOR ADULTS, GERIATRIC PATIENTS, AND DUALY-DIAGNOSED PATIENTS), SERVICES AT THE OUTPATIENT CENTER FOR BEHAVIORAL HEALTH (PSYCHOTHERAPY AND MEDICATION MANAGEMENT FOR ADULTS) AND THE FAMILY ADVOCACY PROGRAM (MENTAL HEALTH TREATMENT FOR PATIENTS UNDER 18 YEARS OLD AND THEIR FAMILIES).

THE HOSPITAL'S HOMECARE DEPARTMENT MAKES OVER 98,000 REVENUE GENERATING VISITS A YEAR TO COMMUNITY RESIDENTS. HOMECARE IS STAFFED WITH SPECIALTY NURSES, HOME HEALTH AIDES, PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS,

| | |
|--|--|
| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
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SPEECH THERAPISTS, MEDICAL SOCIAL WORKERS AND NUTRITIONISTS TO MEET THE PHYSICAL AND BEHAVIORAL HEALTH NEEDS OF PATIENTS CARED FOR IN THEIR HOMES AND OUTSIDE THE HOSPITAL SETTING. HOMECARE SERVICES INCLUDE: SPECIALIZED CARDIAC CARE; INCLUDING TELE MONITORING AND THE HEART SMART PROGRAM (A MULTIDISCIPLINARY PROGRAM WHICH INCLUDES THE FULL SPECTRUM CARDIAC SELF MANAGEMENT SUPPORT AND CLINICAL CARE), FULL SPECTRUM GERIATRIC CARE, INFUSION THERAPIES, LIFELINE SERVICES, AND A SIGNIFICANT RANGE OF RESPIRATORY, PULMONARY AND MEDICAL REHABILITATION SERVICES AS WELL AS PROVIDING OUTPATIENT HOSPICE AND PALLIATIVE SERVICES THROUGHOUT THE COMMUNITY. THE HOMECARE DEPARTMENT GENEROUSLY PROVIDES COMMUNITY HEALTH SERVICES INCLUDING FLU SHOTS, HEALTH FAIRS, AND COORDINATION OF LINKAGES WITH MEALS ON WHEELS, TRANSPORTATION, ADULT DAY CARE AND OTHER SERVICES ON CONTRACT WITH LOCAL ORGANIZATIONS.

MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, SECTION A, LINES 6, 7A AND 7B

THE SOLE MEMBER OF THE HOSPITAL SHALL BE MIDDLESEX HEALTH SYSTEM, INC., A CONNECTICUT NON-STOCK CORPORATION, OR ITS SUCCESSOR IN INTEREST ("SOLE MEMBER"), WHICH SHALL HAVE ALL OF THE MEMBERSHIP RIGHTS CONFERRED BY LAW, THE CERTIFICATE OF INCORPORATION OR THE MIDDLESEX HOSPITAL BY-LAWS, BY VOTE OF ITS BOARD OF DIRECTORS, ITS PRESIDENT, OR BY OR THROUGH ANY OTHER PERSON(S) DESIGNATED BY ITS BOARD OF DIRECTORS ON ITS BEHALF. ANY SUCH ACTION MAY ALSO BE TAKEN WITHOUT A MEMBERSHIP MEETING IF CONSENT THERETO IS CONFIRMED THROUGH A WRITTEN COMMUNICATION OF A DULY AUTHORIZED REPRESENTATIVE OF THE SOLE MEMBER ACTING WITHIN THE LIMITS OF SUCH REPRESENTATIVE'S AUTHORITY. ANY SUCH ACTION BY THE SOLE MEMBER OR ITS

| | |
|--|--|
| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
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DULY AUTHORIZED REPRESENTATIVE SHALL BE FILED WITH THE SECRETARY OF THE HOSPITAL. THE ANNUAL ELECTION OF THE BOARD OF DIRECTORS OF THE HOSPITAL BY THE DULY AUTHORIZED REPRESENTATIVE OF THE SOLE MEMBER SHALL BE DEEMED THE ANNUAL MEETING OF THE MEMBERSHIP OF THE HOSPITAL FOR ALL PURPOSES. THE SECRETARY OF THE HOSPITAL SHALL PROVIDE APPROPRIATE NOTICES TO THE SOLE MEMBER AS REQUIRED BY LAW IN ADVANCE OF ACTIONS BEING REQUESTED OF THE SOLE MEMBER BY THE BOARD OF DIRECTORS OF THE HOSPITAL.

FORM 990 REVIEW PROCESS

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

DRAFT FORMS OF THE 990, INCLUDING REQUIRED SCHEDULES, ARE PROVIDED TO EACH BOARD MEMBER FOR REVIEW. MEMBERS REVIEW THE DOCUMENTS, HIGHLIGHT ANY SIGNIFICANT CHANGES AND ATTEST THEIR APPROVAL. ANY QUESTIONS OR COMMENTS ARE PRESENTED TO EXECUTIVE MANAGEMENT PRIOR TO FILING. A COPY OF THE FINAL FORM 990 WILL BE PROVIDED TO THE BOARD PRIOR TO FILING WITH THE IRS VIA A WEB BASED COMMUNICATION PORTAL.

CONFLICT OF INTEREST POLICY

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

CONFLICT OF INTEREST FORMS ARE DISTRIBUTED ANNUALLY TO KEY EMPLOYEES, OFFICERS AND THE BOARD OF DIRECTORS. RESPONSES ARE RETURNED TO, TRACKED, AND REVIEWED BY THE COMPLIANCE OFFICER. INFORMATION REPORTED IS CONSIDERED PERSONAL AND CONFIDENTIAL AND ONLY DISCLOSED WHEN DEEMED NECESSARY TO PROTECT THE HOSPITAL AGAINST THE EFFECTS OF CONFLICTS OF INTEREST AND ONLY AFTER ADVISING THE REPORTING PERSON OF THE PROPOSED

| | |
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| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|--|

DISCLOSURE AND OF ITS EXTENT. MATERIAL CONFLICTS ARE REPORTED TO THE BOARDS AUDIT COMMITTEE FOR REVIEW AND DETERMINATION.

IN ADDITION TO COMPLETING THE ANNUAL CONFLICT OF INTEREST FORM, BOARD MEMBERS MUST IMMEDIATELY DISCLOSE ANY INTEREST AND ALL MATERIAL FACTS TO THE BOARD OF DIRECTORS. THE BOARD THEN REVIEWS THE FACTS AND MAKES THE DETERMINATION AS TO WHETHER A SIGNIFICANT CONFLICT OF INTEREST EXISTS. IF SO, THE BOARD FOLLOWS DISABLING GUIDELINES TO DETERMINE IF THE BOARD MEMBER SHOULD BE ASKED TO RESIGN OR BE REMOVED.

COMPENSATION POLICY

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

EXECUTIVE TEAM COMPENSATION IS REVIEWED ANNUALLY BY THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD. THE COMMITTEE HAS A CHARTER AND A POLICY STATEMENT SETTING FORTH A PROCESS AND CERTAIN GUIDELINES FOR DETERMINING COMPENSATION. EXECUTIVES RECEIVE A BASE SALARY AND HAVE THE OPPORTUNITY FOR INCENTIVE COMPENSATION WITHIN A RANGE SET BY THE POLICY. FOLLOWING THE CLOSE OF EACH FISCAL YEAR, THE COMMITTEE RECEIVES A MARKET ANALYSIS FROM INDEPENDENT CONSULTANTS REGARDING COMPENSATION AT PEER GROUPS OF COMPARABLE HOSPITALS AND HEALTH SYSTEMS. POSITIONS WITHIN THE EXECUTIVE TEAM ARE COMPARED TO BENCHMARK POSITIONS WITHIN THIS MARKET DATA AND THEIR COMPENSATION IS COMPARED TO THE DATA BOTH WITH RESPECT TO CASH COMPENSATION AND TOTAL COMPENSATION INCLUDING FRINGE BENEFITS. THE CEO RECOMMENDS THE INCENTIVE AWARDS AND BASE SALARY ADJUSTMENTS TO THE COMPENSATION OF THE EXECUTIVES WHO REPORT TO HIM, AND THE COMMITTEE

| | |
|--|--|
| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|--|

REVIEWS THOSE RECOMMENDATIONS, APPROVES OR MODIFIES THEM, AND ALSO DETERMINES ANY INCENTIVE AWARD AND BASE SALARY ADJUSTMENT FOR THE CEO. THE CONSULTANTS PROVIDE A WRITTEN OPINION ANNUALLY CONFIRMING THAT THE COMPENSATION OF THE EXECUTIVES, AS ADJUSTED BY THIS PROCESS, IS "REASONABLE" WITHIN APPLICABLE IRS GUIDELINES.

KEY EMPLOYEE COMPENSATION IS SET FOLLOWING THE GUIDELINES SET FORTH IN THE HOSPITAL COMPENSATION POLICY. THE OBJECTIVE OF THIS POLICY IS TO PAY EMPLOYEES BASED UPON HOSPITAL NEED, THE PROPER EXTERNAL LABOR MARKET AND PERFORMANCE.

PUBLIC DISCLOSURE

FORM 990, PART VI, SECTION C, LINE 19

MIDDLESEX HOSPITAL MAINTAINS A QUALITY AND COMPLIANCE SECTION ON ITS WEBSITE, MIDDLESEXHOSPITAL.ORG. THE HOSPITAL POSTS THE MOST CURRENT AUDITED FINANCIAL STATEMENTS THERE AS THEY BECOME AVAILABLE, AS WELL AS STATEMENTS FROM AT LEAST TWO PREVIOUS FISCAL YEARS. THE HOSPITAL'S CONFLICT OF INTEREST POLICY IS ALSO POSTED ON THE WEBSITE IN THE VENDORS AND SUPPLIERS SECTION. IN ADDITION, THE ORGANIZATION'S FORM 990 IS AVAILABLE AT WWW.GUIDESTAR.ORG AND UPON REQUEST.

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 9

| | |
|---------------------------------------|--------------|
| CHANGE IN ACCUMULATED PENSION CHARGES | \$74,406,000 |
| EXPENDITURES FOR INTENDED PURPOSES | (814,000) |

| | |
|--|--|
| Name of the organization MIDDLESEX HOSPITAL | Employer identification number 06-0646718 |
|--|--|

ROUNDING 38

TOTAL \$73,592,038

ATTACHMENT 1

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

| <u>NAME AND ADDRESS</u> | <u>DESCRIPTION OF SERVICES</u> | <u>COMPENSATION</u> |
|--|--------------------------------|---------------------|
| ARAMARK CORPORATION 66 OXFORD DRIVE FRANKLIN, MA 02038 | DIETARY/HOUSEKEEPING | 1,514,492. |
| QUEST DIAGNOSTICS 2025 COLLECTION CENTER DRIVE CHICAGO, IL 60693 | LABORATORY SERVICES | 1,334,934. |
| COMPANY 1 CONSULTING 6 CRAIG DRIVE MONROE, CT 06468 | INFORMATION SERVICES | 892,655. |
| TOBIN CARBERRY O'MALLEY P.O. BOX 58 NEW LONDON, CT 06320 | LEGAL SERVICES | 853,202. |
| PHILBRICK TRANSCRIPTIONS 59 CARMEL HILL ROAD BETHLEHEM, CT 06751 | TRANSCRIPTION SVCS | 823,110. |

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

MIDDLESEX HOSPITAL

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

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047
2012

**Open to Public
Inspection**

Employer identification number
06-0646718

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" to 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) | ----- | ----- | ----- | ----- | ----- | ----- |
| (2) | ----- | ----- | ----- | ----- | ----- | ----- |
| (3) | ----- | ----- | ----- | ----- | ----- | ----- |
| (4) | ----- | ----- | ----- | ----- | ----- | ----- |
| (5) | ----- | ----- | ----- | ----- | ----- | ----- |
| (6) | ----- | ----- | ----- | ----- | ----- | ----- |

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

| | (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|-----|---|-------------------------|--|----------------------------|---|----------------------------------|--|-------|
| | | | | | | | Yes | No |
| (1) | MIDDLESEX HEALTH SYSTEM, INC. 28 CRESCENT STREET MIDDLETOWN, CT 06457 22-2676137 | SUPPORT | CT | 501(C)(3) | 11, TYPE II | N/A | | X |
| (2) | MIDDLESEX HEALTH SERVICES, INC. 28 CRESCENT STREET MIDDLETOWN, CT 06457 22-2676140 | ASST. LIVING | CT | 501(C)(3) | 9 | MSX HLTH SYS | X | |
| (3) | MIDDLESEX HOSPITAL FOUNDATION 28 CRESCENT STREET MIDDLETOWN, CT 06457 27-3720822 | SUPPORT | CT | 501(C)(3) | 11, TYPE II | MSX HOSP | X | |
| (4) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |
| (5) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |
| (6) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |
| (7) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |

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

Schedule R (Form 990) 2012

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

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------------|--|------------------------------|------------------------------------|-----------------------------|--|----|
| | | | | | | | | Yes | No |
| (1) MIDDLESEX HEALTH RESOURCES, INC. 28 CRESCENT STREET MIDDLETOWN, CT 06457 05-1089925 | HEALTHCARE | CT | MSX HEALTH SYS | C CORP | | | | | |
| (2) INTEGRATED RESOURCES FOR THE MIDDLESEX 28 CRESCENT STREET MIDDLETOWN, CT 06457 05-1462230 | OUTPATIENT CARE | CT | MSX HEALTH SYS | C CORP | | | | | |
| (3) MHS PRIMARY CARE, INC. 28 CRESCENT STREET MIDDLETOWN, CT 06457 05-1472743 | HEALTHCARE | CT | MSX HEALTH SYS | C CORP | | | | | |
| (4) ----- | | | | | | | | | |
| (5) ----- | | | | | | | | | |
| (6) ----- | | | | | | | | | |
| (7) ----- | | | | | | | | | |

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

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
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)
- f** Dividends from related organization(s)
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s)
- j** Lease of facilities, equipment, or other assets to related organization(s)
- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)
- p** Reimbursement paid to related organization(s) for expenses
- q** Reimbursement paid by related organization(s) for expenses
- r** Other transfer of cash or property to related organization(s)
- s** Other transfer of cash or property from related organization(s)

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

| | (a) Name of other organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved | Yes | No |
|------------|-----------------------------------|-------------------------------|------------------------|--|-----|----|
| (1) | MIDDLESEX HEALTH SYSTEM, INC | B | 2,999,000. | | | X |
| (2) | MIDDLESEX HEALTH RESOURCES, INC. | K | 507,536. | | | X |
| (3) | MIDDLESEX HEALTH SERVICES, INC. | O | 136,203. | | | X |
| (4) | MIDDLESEX HEALTH SERVICES, INC. | D | 4,905,000. | | | X |
| (5) | MIDDLESEX HEALTH SERVICES, INC. | Q | 2,254,245. | | | X |
| (6) | MHS PRIMARY CARE, INC. | Q | 2,332,000. | | | X |

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

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?

Table with columns: Description (1a-1s), Yes, No. Rows include Receipt of interest annuities, Gift, grant, or capital contribution, Loans or loan guarantees, Dividends, Sale of assets, Purchase of assets, Exchange of assets, Lease of facilities, Lease of facilities, equipment, or other assets, Performance of services, Sharing of facilities, Reimbursement, and Other transfer of cash or property.

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.

Table with columns: (a) Name of other organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved. Row 1: MIDDLESEX HEALTH SYSTEM, INC., P, 976,340.

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

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

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