

PUBLIC INSPECTION COPY

Form **990**

OMB No. 1545-0047

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
 ▶ Do not enter social security numbers on this form as it may be made public.
 ▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

A For the 2014 calendar year, or tax year beginning 10/01, 2014, and ending 9/30, 2015

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Danbury Hospital 24 Hospital Avenue Danbury, CT 06810-6099	D Employer identification number 06-0646597 E Telephone number (203) 739-7000 G Gross receipts \$ <u>695,533,868.</u>
--	--	--

F Name and address of principal officer: <u>Daniel DeBarba, Jr.</u> <u>24 Hospital Avenue Danbury, CT 06810</u>	H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
---	---

I Tax-exempt status: 501(c)(3) 501(c) () (Insert no.) 4947(a)(1) or 527

J Website: www.danburyhospital.org **H(c)** Group exemption number ▶

K Form of organization: Corporation Trust Association Other ▶ **L** Year of formation: 1885 **M** State of legal domicile: CT

Part I Summary

1 Briefly describe the organization's mission or most significant activities: To enhance through medical care, education and research the health and well being of individuals in Danbury, Connecticut and surrounding communities in partnership with those we serve.

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

3 Number of voting members of the governing body (Part VI, line 1a).....	3	9
4 Number of independent voting members of the governing body (Part VI, line 1b).....	4	8
5 Total number of individuals employed in calendar year 2014 (Part V, line 2a).....	5	3,666
6 Total number of volunteers (estimate if necessary).....	6	378
7a Total unrelated business revenue from Part VIII, column (C), line 12.....	7a	5,663,696.
b Net unrelated business taxable income from Form 990-T, line 34.....	7b	-371,649.

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h).....	23,605,157.	14,913,270.
9 Program service revenue (Part VIII, line 2g).....	507,620,940.	598,482,181.
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d).....	4,087,630.	4,838,153.
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e).....	3,515,639.	1,601,785.
12 Total revenue -- add lines 8 through 11 (must equal Part VIII, column (A), line 12).....	538,829,366.	619,835,389.
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3).....		
14 Benefits paid to or for members (Part IX, column (A), line 4).....		
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10).....	239,374,097.	280,914,729.
16a Professional fundraising fees (Part IX, column (A), line 11e).....		
b Total fundraising expenses (Part IX, column (D), line 25) ▶		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e).....	261,253,127.	343,750,186.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25).....	500,627,224.	624,664,915.
19 Revenue less expenses. Subtract line 18 from line 12.....	38,202,142.	-4,829,526.
	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16).....	838,062,311.	836,823,101.
21 Total liabilities (Part X, line 26).....	348,768,773.	360,086,728.
22 Net assets or fund balances. Subtract line 21 from line 20.....	489,293,538.	476,736,373.

Part II Signature Block

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

Sign Here	Signature of officer: Steven H. Rosenberg Type or print name and title.	Date: <u>8/4/2016</u> SVP/CFO
------------------	---	----------------------------------

Paid Preparer Use Only	Print/Type preparer's name Mike A. Cincotta	Preparer's signature 	Date 8/4/2016	Check <input type="checkbox"/> if self-employed	PTIN P01595811
	Firm's name ▶ ERNST & YOUNG US LLP Firm's address ▶ 200 Clarendon St. Boston, MA 02116-5072			Firm's EIN ▶ 34-6565596 Phone no. 617-2662000	

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

Cumulative e-File History 2014	
Federal	
Locator:	0141KV
Taxpayer Name:	Western Connecticut Medical Group, Inc.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	08/15/2016 11:07:11
Acknowledgement Date:	08/15/2016 11:56:05
Status:	Accepted
Submission ID:	02007720162285000003

Application for Extension of Time To File an Exempt Organization Return

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**
▶ Information about Form 8868 and its instructions is at www.irs.gov/form8868.

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

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

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

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

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

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

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions. Danbury Hospital	Employer identification number (EIN) or 06-0646597
File by the due date for filing your return. See instructions.	Number, street, and room or suite number, if a P.O. box, see instructions. 24 Hospital Avenue	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. Danbury, CT 06810-6099	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (section 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

● The books are in the care of ▶ Mary Jo Pawlak

Telephone No. ▶ (203) 739-8110 Fax No. ▶ _____

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 5/15, 20 16, to file the exempt organization return for the organization named above.

The extension is for the organization's return for:

- ▶ calendar year 20 ____ or
- ▶ tax year beginning 10/01, 20 14, and ending 9/30, 20 15.

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

3a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions	3a	\$	0.
b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit	3b	\$	0.
c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions	3c	\$	0.

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

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

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

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Enter filer's identifying number, see instructions Employer identification number (EIN) or
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

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

- The books are in the care of ▶
 Telephone No. ▶ _____ Fax No. ▶ _____
- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

- I request an additional 3-month extension of time until _____, 20____.
- For calendar year _____, or other tax year beginning _____, 20____, and ending _____, 20____.
- If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period
- State in detail why you need the extension

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

Signature and Verification must be completed for Part II only.

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

Signature ▶ *[Handwritten Signature]* Title ▶ *VP Corp Controller* Date ▶ *1-28-16*

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

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

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions. Danbury Hospital	Employer identification number (EIN) or 06-0646597
	Number, street, and room or suite number. If a P.O. box, see instructions. 24 Hospital Avenue	Social security number (SSN)
File by the due date for filing your return. See instructions.	City, town or post office, state, and ZIP code. For a foreign address, see instructions. Danbury, CT 06810-6099	

Enter the Return code for the return that this application is for (file a separate application for each return)..... **01**

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (section 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

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

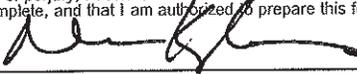
- The books are in the care of ▶ Mary Jo Pawlak
Telephone No. ▶ (203) 739-7000 Fax No. ▶ _____
- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN).... _____. If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

- 4 I request an additional 3-month extension of time until 8/15, 20 16.
- 5 For calendar year _____, or other tax year beginning 10/01, 20 14, and ending 9/30, 20 15.
- 6 If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return Change in accounting period
- 7 State in detail why you need the extension... Taxpayer respectfully requests additional time to gather information necessary to file a complete and accurate tax return.

8a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.....	8a	\$	<u>00</u>
b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.....	8b	\$	<u>00</u>
c Balance due. Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.....	8c	\$	<u>00</u>

Signature and Verification must be completed for Part II only.

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

Signature ▶  Title ▶ Controller Date ▶ 5/10/2016
BAA Form 8868 (Rev 1-2014)

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

1 Briefly describe the organization's mission:

TO IMPROVE THE HEALTH OF EVERY PERSON WE SERVE THROUGH THE EFFICIENT DELIVERY OF EXCELLENT, INNOVATIVE AND COMPASSIONATE CARE.

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

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

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

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

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

4a (Code:) (Expenses \$ 196,329,911. including grants of \$) (Revenue \$ 158,301,807.)
SEE SCHEDULE O

4b (Code:) (Expenses \$ 154,180,970. including grants of \$) (Revenue \$ 171,576,114.)
SEE SCHEDULE O

4c (Code:) (Expenses \$ 82,328,536. including grants of \$) (Revenue \$ 77,426,210.)
SEE SCHEDULE O

4d Other program services (Describe in Schedule O.)
(Expenses \$ 98,288,751. including grants of \$) (Revenue \$ 191,491,715.)

4e Total program service expenses ▶ 531,128,168.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A.</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I.</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II.</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III.</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I.</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III.</i>		X
9 Did the organization report an amount in Part X, line 21, 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? <i>If "Yes," complete Schedule D, Part IV.</i>		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V.</i>		X
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI.</i>	X	
b Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII.</i>	X	
c Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII.</i>		X
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX.</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X.</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X.</i>		X
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII.</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional.</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?	X	
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV.</i>	X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV.</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV.</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</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? <i>If "Yes," complete Schedule G, Part II.</i>		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III.</i>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H.</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	

Part IV Checklist of Required Schedules (continued)

	Yes	No
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government 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 or other assistance to or for domestic individuals 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	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a.</i>	X	
24b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
24c 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
24d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I.</i>		X
25b 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 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <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):		
28a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>		X
28b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>		X
28c 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	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
35b 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 or note to any line in this Part V

Table with columns for question number, question text, and Yes/No response boxes. Includes questions 1a-1c, 2a-2b, 3a-3b, 4a-4b, 5a-5c, 6a-6b, 7a-7h, 8, 9a-9b, 10a-10b, 11a-11b, 12a-12b, 13a-13c, 14a-14b.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include 1a (voting members), 1b (independent members), 2-9 (various governance questions).

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-16b (policies on chapters, conflict of interest, whistleblower, compensation, etc.).

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records:

MARY JO PAWLAK 24 HOSPITAL AVENUE DANBURY, CT 06810-6099

(203) 739-7000

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (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 M MURPHY, MD PRES/CEO, WCHN	40.00 9.00	X	X					1,402,828.	0	51,844.
(2) NEIL CULLIGAN, MD DIRECTOR	1.00 1.00	X						0	0	0
(3) DAVID KRAMER, M.D. DIRECTOR (TO 1/1)	1.00 1.00	X						0	0	0
(4) D. CYGANOWSKI DIRECTOR	1.00 1.00	X						0	0	0
(5) RICHARD G. JABARA DIRECTOR	1.00 4.00	X						0	0	0
(6) ANTHEA DISNEY DIRECTOR	1.00 1.00	X						0	0	0
(7) JOSEPH D. SKRZYPCZAK SECRETARY	1.00 3.00	X	X					0	0	0
(8) SPENCER HOULDIN DIRECTOR	1.00 3.00	X						0	0	0
(9) BRIAN C. WHITE DIRECTOR	1.00 3.00	X						0	0	0
(10) JAMES KENNEDY CHAIRMAN	3.00 5.00	X	X					0	0	0
(11) STEVEN H. ROSENBERG SVP/CFO, WCHN	40.00 17.00			X				779,114.	0	42,729.
(12) DANIEL DEBARBA, JR. EXEC VP/PRES-DH	35.00 12.00			X				966,102.	93,142.	57,347.
(13) DONNA KAPLANIS ASS'T SECRETARY	40.00 8.00			X				252,835.	0	51,331.
(14) MATTHEW A. MILLER, MD SVP & CHIEF MEDICAL OFFICER	40.00 4.00				X			308,356.	361,965.	45,992.

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) MOREEN O. DONAHUE SR VP/CHIEF NURSE OFFICER, WCHN	40.00 1.00				X			446,933.	0	50,720.
(16) MICHAEL DAGLIO CHIEF OPER OFFICER (TO 11/2)	5.00 43.00				X			550,572.	0	44,866.
(17) MORRIS GROSS VP OF FACILITIES/REAL ESTATE	40.00 2.00				X			360,940.	6,180.	51,603.
(18) KATHLEEN A. DEMATTEO CHIEF INFOR.OFFICER, WCHN	40.00 0				X			475,193.	0	32,274.
(19) PATRICK C. MINICUS VP OF FINANCE	20.00 22.00				X			476,177.	73,323.	50,314.
(20) JAMES VARRONE VP SUPPLY CHAIN	36.00 4.00				X			0	185,641.	30,014.
(21) LISA SCHMITTGALL SRVP STRATEGY-WCHN (TO 12/31)	40.00 1.00					X		724,800.	38,261.	31,469.
(22) DEBRA CARRAGHER VP OF OPERATIONS	40.00 0					X		325,179.	0	16,137.
(23) CAROLYN MCKENNA SR VP/GEN'L COUN	40.00 0					X		471,111.	0	37,202.
(24) RAMIN AHMADI, MD DIR. OF EDUC./RES.	40.00 0					X		330,757.	0	42,127.
(25) DAWN MYLES SRV,QUAL/PAT. SFTY	40.00 0					X		334,356.	0	22,081.
1b Sub-total								3,709,235.	455,107.	249,243.
c Total from continuation sheets to Part VII, Section A								5,219,268.	303,405.	521,319.
d Total (add lines 1b and 1c)								8,928,503.	758,512.	770,562.

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 ▶ 594

	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 ▶ 52

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	11,877,473.					
	e Government grants (contributions),	1e	2,730,032.					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	305,765.					
	g Noncash contributions included in lines 1a-1f: \$							
	h Total. Add lines 1a-1f ▶			14,913,270.				
	Program Service Revenue	Business Code						
2a ANCILLARY SERVICE			621400	297,090,886.	297,090,886.			
b MEDICARE/MEDICAID PAY'TS			621990	253,818,157.	253,818,157.			
c ROUTINE PATIENT			621990	37,037,912.	37,037,912.			
d CONTRACT LAB			621500	4,928,198.		4,928,198.		
e RENTAL INC.-AFFL. EXEMPT			532000	2,512,565.	2,512,565.			
f All other program service revenue				3,094,463.	3,094,463.			
g Total. Add lines 2a-2f ▶				598,482,181.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts). ▶			3,637,036.			3,637,036.	
	4 Income from investment of tax-exempt bond proceeds ▶			73,109.			73,109.	
	5 Royalties ▶			0				
	6a Gross rents	(i) Real	910,968.					
		(ii) Personal						
		b Less: rental expenses		178,610.				
		c Rental income or (loss)		732,358.				
	d Net rental income or (loss) ▶			732,358.	11,229.	721,129.		
	7a Gross amount from sales of assets other than inventory	(i) Securities	76,030,605.	150,500.				
		(ii) Other						
		b Less: cost or other basis and sales expenses		74,992,138.	60,959.			
		c Gain or (loss)		1,038,467.	89,541.			
	d Net gain or (loss) ▶			1,128,008.			1,128,008.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 a							
	b Less: direct expenses b							
c Net income or (loss) from fundraising events ▶				0				
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		465,750.						
	b Less: cost of goods sold b		466,772.					
	c Net income or (loss) from sales of inventory ▶			-1,022.			-1,022.	
Miscellaneous Revenue			Business Code					
11a NUTRITION AND DIETARY		561000	372,148.			372,148.		
b OTHER PATIENT SERVICES		900099	302,436.	302,436.				
c ADMINISTRATIVE SERVICES		561000	181,496.			181,496.		
d All other revenue		524298	14,369.		14,369.			
e Total. Add lines 11a-11d ▶			870,449.					
12 Total revenue. See instructions ▶			619,835,389.	593,867,648.	5,663,696.	5,390,775.		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	0			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	6,573,840.	1,740,254.	4,833,586.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	218,210,682.	179,674,676.	38,536,006.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	9,306,626.	7,663,076.	1,643,550.	
9 Other employee benefits	29,978,262.	24,684,101.	5,294,161.	
10 Payroll taxes	16,845,319.	13,870,436.	2,974,883.	
11 Fees for services (non-employees):				
a Management	195,167.		195,167.	
b Legal	2,643,881.		2,643,881.	
c Accounting	501,452.		501,452.	
d Lobbying	172,312.	141,882.	30,430.	
e Professional fundraising services. See Part IV, line 17.	0			
f Investment management fees	269,287.		269,287.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) <u>ATCH 2</u>	104,940,344.	86,407,879.	18,532,465.	
12 Advertising and promotion	1,262,780.	1,039,773.	223,007.	
13 Office expenses	7,793,028.	6,416,779.	1,376,249.	
14 Information technology	17,279,133.	14,227,638.	3,051,495.	
15 Royalties	0			
16 Occupancy	14,072,076.	11,586,947.	2,485,129.	
17 Travel	637,526.	524,939.	112,587.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	291,082.	239,677.	51,405.	
20 Interest	7,515,245.	7,515,245.		
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	45,346,522.	37,338,326.	8,008,196.	
23 Insurance	10,671,352.	10,110,640.	560,712.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>MEDICAL SUPPLIES</u>	91,868,331.	91,868,331.		
b <u>STATE OF CT HOSPITAL TAX</u>	24,402,044.	24,402,044.		
c <u>EQUIPMENT RENT AND MAINT.</u>	9,683,926.	7,973,745.	1,710,181.	
d <u>PROFESSIONAL MEMBERSHIP</u>	2,847,778.	2,344,860.	502,918.	
e All other expenses	1,356,920.	1,356,920.		
25 Total functional expenses. Add lines 1 through 24e	624,664,915.	531,128,168.	93,536,747.	
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 or note to any line in this Part X

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	39,492.	1	87,296.
	2 Savings and temporary cash investments	46,694,493.	2	21,119,887.
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	63,595,267.	4	76,938,200.
	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	2,476,284.	7	0
	8 Inventories for sale or use	10,027,585.	8	10,950,142.
	9 Prepaid expenses and deferred charges	3,728,278.	9	4,185,867.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 846,418,674.		
	b Less: accumulated depreciation	10b 452,257,825.	351,669,715.	10c 394,160,849.
	11 Investments - publicly traded securities	204,327,199.	11	64,573,120.
	12 Investments - other securities. See Part IV, line 11	0	12	102,260,022.
	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	155,503,998.	15	162,547,718.
16 Total assets. Add lines 1 through 15 (must equal line 34)	838,062,311.	16	836,823,101.	
Liabilities	17 Accounts payable and accrued expenses	67,327,475.	17	75,819,734.
	18 Grants payable	0	18	0
	19 Deferred revenue	3,183,583.	19	2,565,628.
	20 Tax-exempt bond liabilities	246,700,000.	20	244,850,000.
	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	0	23	0
	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	31,557,715.	25	36,851,366.
	26 Total liabilities. Add lines 17 through 25	348,768,773.	26	360,086,728.
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	412,096,873.	27	406,109,696.
	28 Temporarily restricted net assets	47,726,160.	28	36,051,363.
	29 Permanently restricted net assets	29,470,505.	29	34,575,314.
	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	489,293,538.	33	476,736,373.
	34 Total liabilities and net assets/fund balances	838,062,311.	34	836,823,101.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	619,835,389.
2	Total expenses (must equal Part IX, column (A), line 25)	2	624,664,915.
3	Revenue less expenses. Subtract line 2 from line 1	3	-4,829,526.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	489,293,538.
5	Net unrealized gains (losses) on investments	5	-6,685,508.
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	-1,042,131.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	476,736,373.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line 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.

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

DANBURY HOSPITAL

Employer identification number

06-0646597

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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations
 - g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			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) 2014

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) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (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) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (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 3 columns: Description, Percentage, and checkbox. Rows include: 14 Public support percentage for 2014; 15 Public support percentage from 2013 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2014; b 33 1/3% support test - 2013; 17a 10%-facts-and-circumstances test - 2014; b 10%-facts-and-circumstances test - 2013; 18 Private foundation.

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2013 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2014.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

b **33 1/3% support tests - 2013.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (<i>see instructions</i>).			
2 Activities Test. Answer (a) and (b) below.		Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	2a		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>	2b		
3 Parent of Supported Organizations. Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>	3a		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>	3b		

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

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

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

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

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).			

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2014 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
3 Excess distributions carryover, if any, to 2014:			
a			
b			
c			
d			
e From 2013			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2014 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6 Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7 Excess distributions carryover to 2015. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b			
c			
d Excess from 2013			
e Excess from 2014			

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

SCHEDULE 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

2014

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

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

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

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

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

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

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

Name of organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

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) 2014

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b Total lobbying expenditures to influence a legislative body (direct lobbying)														
c Total lobbying expenditures (add lines 1a and 1b)														
d Other exempt purpose expenditures														
e Total exempt purpose expenditures (add lines 1c and 1d)														
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width:65%;">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 separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total. Add lines 1c through 1i; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; b If "Yes," enter the amount of any tax incurred under section 4912; c If "Yes," enter the amount of any tax incurred by organization managers under section 4912; d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Blank lines for supplemental information.

Part IV Supplemental Information (continued)

SCHEDULE C, PART II-B - DESCRIPTION OF LOBBYING ACTIVITY

DUES WERE PAID TO CHA IN THE AMOUNT OF \$390,877, OF WHICH 15.43% OF THIS AMOUNT OR \$60,312 WERE EXPENDED ON LOBBYING. AHA DUES OF \$72,733 HAD 22.80% OR \$16,583 EXPENDED ON LOBBYING ACTIVITIES. BOTH AMOUNTS ARE REFLECTED ON 1F.

ONLY STATE AND LOCAL OFFICIALS WERE LOBBIED DURING 2015. AS PART OF THIS MISCELLANEOUS OFFICE EXPENSE SUCH AS PHONE, COMPUTER SUPPLIES, REFRESHMENT ETC. WERE INCURRED AND WERE REFLECTED ON LINE #1I ACCORDINGLY.

DIRECT CONTACT WITH LEGISLATORS AND STATE LEADERS WERE LOBBIED IN SUPPORT OF MAINTAINING PATIENT ACCESS TO ESSENTIAL SERVICES FOR BOTH THE UNINSURED AND UNDER INSURED.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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.

2014

Department of the Treasury Internal Revenue Service

Attach to Form 990.

Open to Public Inspection

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

Name of the organization

Employer identification number

DANBURY HOSPITAL

06-0646597

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 value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 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: Description, 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: Description, Amount. 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) Revenue included in Form 990, Part VIII, line 1, (ii) Assets included in Form 990, Part X. 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenue included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X.

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

Schedule D (Form 990) 2014

JSA 4E1268 1.000

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?

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

Table with 2 columns: Description, Amount. Rows: 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance.

- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?
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.

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows: 1a-1g (Beginning of year balance, Contributions, Net investment earnings, gains, and losses, Grants or scholarships, Other expenditures for facilities and programs, Administrative expenses, End of year balance).

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
a Board designated or quasi-endowment %
b Permanent endowment %
c Temporarily restricted endowment %
The percentages in lines 2a, 2b, and 2c should equal 100%.

- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
(i) unrelated organizations
(ii) related organizations
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.

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

Table with 5 columns: Description of property, (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, 1b Buildings, 1c Leasehold improvements, 1d Equipment, 1e Other, Total.

Part VII Investments - Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) COMMON COLLECTIVE FUNDS	77,271,753.	FMV
(B) HARD TO VALUE FUNDS	24,988,269.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶	102,260,022.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

ATTACHMENT 1	(a) Description	(b) Book value
(1)	457B ASSET	898,100.
(2)	BOND ESCROW FUND	1,868,178.
(3)	BOND ISSUANCE COST	3,192,086.
(4)	BULK ACCOUNTS NET OF RESERVE	684,627.
(5)	CSV ON OFFICER'S LIFE POLICY	1,806,700.
(6)	DUE FROM RELATED PARTIES	6,402,385.
(7)	INTEREST IN WCHN FOUNDATION	92,379,063.
(8)	INVESTMENT IN VCA	
(9)	INVESTMENT IN WHIC, LTD.	53,694,168.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶		162,547,718.

Part X Other Liabilities.

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

1.	(a) Description of liability	(b) Book value
(1)	Federal income taxes	
(2)	457B LIABILITY	898,100.
(3)	ASSET RETIREMENT OBLIGATION	411,783.
(4)	DUE TO 3RD PARTIES	18,231,699.
(5)	MALPRACTICE TRUST FUND RESERVE	10,246,000.
(6)	RESERVE FOR WORKERS COMPENSATION	7,063,784.
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶		36,851,366.

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-headers (2a-2d, 4a-4b), and totals (1, 2e, 3, 4c, 5).

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

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-headers (2a-2d, 4a-4b), and totals (1, 2e, 3, 4c, 5).

Part XIII Supplemental Information.

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

Series of horizontal dashed lines for providing supplemental information.

Part XIII Supplemental Information (continued)

ATTACHMENT 1

SCHEDULE D, PART IX - OTHER ASSETS

<u>DESCRIPTION</u>	<u>BOOK VALUE</u>
MORRISON DEPOSIT	96,418.
OTHER RECEIVABLES	1,525,993.
TOTALS	<u>162,547,718.</u>

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

Employer identification number

DANBURY HOSPITAL

06-0646597

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

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

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

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

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICA/CARIBBEAN	1.	1.	PROGRAM SERVICES	MALPRACTICE INS.	
(2) CENTRAL AMERICA/CARIBBEAN	1.	1.	INVESTMENTS	MALPRACTICE INS.	53,694,168.
(3) CENTRAL AMERICA/CARIBBEAN	1.	1.	PROGRAM SERVICES	MALPRACTICE INS.	10,080,158.
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total	3.	3.			63,774,326.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)	3.	3.			63,774,326.

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

Schedule F (Form 990) 2014

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

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

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

3 Enter total number of other organizations or entities.

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

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

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* Yes No

- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; do not file with Form 990)* Yes No

- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations (see Instructions for Form 5471)* Yes No

- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* Yes No

- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect To Certain Foreign Partnerships (see Instructions for Form 8865)* Yes No

- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713; do not file with Form 990)* Yes No

Part V Supplemental Information

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

SCHEDULE F, PART I, LINE 3F - METHOD OF ACCOUNTING

ALL INFORMATION FOR PART I, LINE 3, COLUMN (F) IS ACCOUNTED FOR ON THE

AUDITED FINANCIAL STATEMENTS ON THE ACCRUAL BASIS.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2014

Open to Public Inspection

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

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

DANBURY HOSPITAL

Employer identification number

06-0646597

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	
1b 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 type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>400.0000</u> %	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>600.0000</u> %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
5c 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	
6b 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)			12,551,226.	1,547,976.	11,003,250.	1.76
b Medicaid (from Worksheet 3, column a)		82775	98,753,200.	46,712,575.	52,040,625.	8.33
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		82775	111,304,426.	48,260,551.	63,043,875.	10.09
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	310	239099	297,710.	80,578.	217,132.	.03
f Health professions education (from Worksheet 5)	40	239	21,006,755.	7,249,420.	13,757,335.	2.20
g Subsidized health services (from Worksheet 6)	21	9645	2,854,080.	1,813,934.	1,040,146.	.17
h Research (from Worksheet 7)	1	126	2,329,841.	583,095.	1,746,746.	.28
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits	372	249109	26,488,386.	9,727,027.	16,761,359.	2.68
k Total. Add lines 7d and 7j.	372	331884	137,792,812.	57,987,578.	79,805,234.	12.77

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

Schedule H (Form 990) 2014

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	2		355.		355.	
3 Community support	1		152.		152.	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	47		9,169.		9,169.	
7 Community health improvement advocacy	3		4,697.		4,697.	
8 Workforce development						
9 Other						
10 Total	53		14,373.		14,373.	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
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.		
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)	209,181,129.
6 Enter Medicare allowable costs of care relating to payments on line 5	264,752,197.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	-55,571,068.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input checked="" type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	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	X	

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

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

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 2

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 DANBURY HOSPITAL 24 HOSPITAL AVENUE DANBURY CT 06810 WWW.DANBURYHOSPITAL.ORG 0039	X	X		X		X	X			
2 NEW MILFORD HOSPITAL CAMPUS 21 ELM STREET NEW MILFORD CT 06776 WWW.NEWMILFORDHOSPITAL.ORG 0039	X	X					X			
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group DANBURY HOSPITAL

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

Community Health Needs Assessment

Table with 3 columns: Question, Yes, No. Rows include questions 1 through 12b regarding CHNA requirements, implementation strategies, and excise taxes.

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group NEW MILFORD HOSPITAL CAMPUS

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

Community Health Needs Assessment

Table with 3 columns: Question, Yes, No. Rows include questions 1 through 12b regarding CHNA, website availability, and excise tax.

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group DANBURY HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>400</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	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 FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group NEW MILFORD HOSPITAL CAMPUS

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>400</u> % and FPG family income limit for eligibility for discounted care of <u>600</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	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 FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group DANBURY HOSPITAL

Table with 3 columns: Question, Yes, No. Row 19: Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? Row 20: Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19.

Policy Relating to Emergency Medical Care

Table with 3 columns: Question, Yes, No. Row 21: Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

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

Table with 3 columns: Question, Yes, No. Row 22: Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care. Row 23: During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? Row 24: During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group NEW MILFORD HOSPITAL CAMPUS

		Yes	No
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

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

22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input checked="" type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		X

Part V Facility Information (continued)

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

PART V, LINE 5 - ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE COMMUNITY

FACILITY: DANBURY HOSPITAL

DANBURY HOSPITAL IN CONDUCTING ITS MOST RECENT CHNA IN 2012 (COMPLETED AND APPROVED IN 2013), DEVELOPED EFFECTIVE STRATEGIES TO IMPROVE COMMUNITY HEALTH INVOLVE ACTIVE COLLABORATION AND COMMITMENT AMONG HEALTH PROVIDERS, PUBLIC AND COMMUNITY HEALTH AGENCIES, EDUCATORS, WORK SITES, COMMUNITY AND FAITH-BASED ORGANIZATIONS AND GROUPS, AND THE PUBLIC THEY SERVE.

THE HOSPITAL COLLABORATES WITH COMMUNITY PARTNERS FOR ASSESSMENT OF COMMUNITY HEALTH NEEDS AND ACTION PLANNING. DANBURY HOSPITAL, AND ITS NEW MILFORD HOSPITAL CAMPUS, PARTICIPATED IN THE DEVELOPMENT OF A COMMUNITY REPORT CARD FOR THE HOUSATONIC VALLEY REGION, A 10-DISTRICT MUNICIPALITY THAT INCLUDES DANBURY AND NEW MILFORD, CT. THE OTHER EIGHT TOWNS ARE BRIDGEWATER, BETHEL, BROOKFIELD, NEW FAIRFIELD, NEWTOWN, REDDING, RIDGEFIELD AND SHERMAN, CT, ALL TOWNS WITHIN THE PRIMARY SERVICE AREA OF BOTH HOSPITALS. DEVELOPING A PLAN FOR HEALTH IMPROVEMENT IN OUR REGION INVOLVES COLLECTIVE ACTION BY AND SHARING OF EXPERTISE AND RESOURCES ACROSS AGENCIES AND ORGANIZATIONS IN BOTH THE PUBLIC AND PRIVATE SECTORS.

PART V, LINE 6A - LIST OTHER HOSPITAL FACILITIES THAT JOINTLY CONDUCTED NEEDS ASSESSMENT

FACILITY: DANBURY HOSPITAL

DANBURY HOSPITAL, AND ITS NEW MILFORD HOSPITAL CAMPUS, PARTICIPATED IN

Part V Facility Information (continued)

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

THE DEVELOPMENT OF A COMMUNITY REPORT CARD FOR THE HOUSATONIC VALLEY REGION, A 10-DISTRICT MUNICIPALITY THAT INCLUDES DANBURY AND NEW MILFORD, CT.

PART V, LINE 6B - CHNA CONDUCTED BY ORGNIZATIONS OTHER THAN HOSPITAL FACILITY: DANBURY HOSPITAL

AS NOTED IN PART VI, LINE #2, NEEDS ASSESSMENT NARRATIVE, THE CHNA WAS CONDUCTED WITH VARIOUS COMMUNITY ORGANIZATIONS PARTICIPATING IN THE COMMUNITY FORUM AT DANBURY HOSPITAL AND ITS NEW MILFORD HOSPITAL CAMPUS.

PART V, LINE 2 - ACQUISTION OF FACILITY PLACED IN SERVICE

FACILITY: NEW MILFORD HOSPITAL CAMPUS

ON OCTOBER 1, 2014 (THE MERGER DATE), DANBURY HOSPITAL (THE HOSPITAL) RECEIVED A SINGLE PROVIDER LICENSE TO INCLUDE THE NEW MILFORD HOSPITAL INCORPORATED (NEW MILFORD HOSPITAL). AS A RESULT, NEW MILFORD HOSPITAL MERGED WITH THE HOSPITAL AND THE OPERATIONS OF NEW MILFORD HOSPITAL BECAME A CAMPUS OF DANBURY HOSPITAL EFFECTIVE OCTOBER 1, 2014. THE HOSPITAL WILL OPERATE AS ONE LICENSED FACILITY WITH TWO CAMPUSES.

PART V, LINE 5 - ACCOUNT INPUT FROM PERSON WHO REPRESENT THE COMMUNITY

FACILITY: NEW MILFORD HOSPITAL CAMPUS

NEW MILFORD HOSPITAL CAMPUS IN CONDUCTING ITS MOST RECENT CHNA IN 2012 (COMPLETED AND APPROVED IN 2013), DEVELOPED EFFECTIVE STRATEGIES TO IMPROVE COMMUNITY HEALTH INVOLVE ACTIVE COLLABORATION AND COMMITMENT AMONG HEALTH PROVIDERS, PUBLIC AND COMMUNITY HEALTH AGENCIES, EDUCATORS,

Part V Facility Information (continued)

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

WORK SITES, COMMUNITY AND FAITH-BASED ORGANIZATIONS AND GROUPS, AND THE PUBLIC THEY SERVE.

THE HOSPITAL COLLABORATES WITH COMMUNITY PARTNERS FOR ASSESSMENT OF COMMUNITY HEALTH NEEDS AND ACTION PLANNING. NEW MILFORD HOSPITAL AND DANBURY HOSPITAL CAMPUSES PARTICIPATED IN THE DEVELOPMENT OF A COMMUNITY REPORT CARD FOR THE HOUSATONIC VALLEY REGION, A 10-DISTRICT MUNICIPALITY THAT INCLUDES DANBURY AND NEW MILFORD, CT. THE OTHER EIGHT TOWNS ARE BRIDGEWATER, BETHEL, BROOKFIELD, NEW FAIRFIELD, NEWTOWN, REDDING, RIDGEFIELD AND SHERMAN, CT, ALL TOWNS WITHIN THE PRIMARY SERVICE AREA OF BOTH HOSPITALS. DEVELOPING A PLAN FOR HEALTH IMPROVEMENT IN OUR REGION INVOLVES COLLECTIVE ACTION BY AND SHARING OF EXPERTISE AND RESOURCES ACROSS AGENCIES AND ORGANIZATIONS IN BOTH THE PUBLIC AND PRIVATE SECTORS.

PART V, LINE 6A - LIST OTHER HOSPITAL FACILITIES THAT JOINTLY CONDUCTED NEEDS ASSESSMENT

FACILITY: NEW MILFORD HOSPITAL CAMPUS

NEW MILFORD HOSPITAL AND DANBURY HOSPITAL CAMPUSES PARTICIPATED IN THE DEVELOPMENT OF A COMMUNITY REPORT CARD FOR THE HOUSATONIC VALLEY REGION, A 10-DISTRICT MUNICIPALITY THAT INCLUDES DANBURY AND NEW MILFORD, CT. THAT INCLUDES DANBURY AND NEW MILFORD, CT.

PART V, LINE 6B - CHNA CONDUCTED BY ORGNIZATIONS OTHER THAN HOSPITAL

FACILITY: NEW MILFORD HOSPITAL CAMPUS

AS NOTED IN PART VI, LINE #2, NEEDS ASSESSMENT NARRATIVE, THE CHNA WAS

Part V Facility Information (continued)

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

CONDUCTED WITH VARIOUS COMMUNITY ORGANIZATIONS PARTICIPATING IN THE
COMMUNITY FORUM AT DANBURY HOSPITAL AND ITS NEW MILFORD HOSPITAL CAMPUS.
HOSPITAL AND ITS NEW MILFORD HOSPITAL CAMPUS.

PART V, LINE 7A - URL

FACILITY: DANBURY HOSPITAL

[HTTP://WWW.DANBURYHOSPITAL.ORG/ABOUT-US/ABOUT-DANBURY-HOSPITAL/COMMUNITY-BENEFIT](http://WWW.DANBURYHOSPITAL.ORG/ABOUT-US/ABOUT-DANBURY-HOSPITAL/COMMUNITY-BENEFIT)

PART V, LINE 7A - URL

FACILITY: NEW MILFORD HOSPITAL

[HTTP://WWW.NEWMILFORDHOSPITAL.ORG/ABOUT-US/ABOUT-US/COMMUNITY-BENEFIT](http://WWW.NEWMILFORDHOSPITAL.ORG/ABOUT-US/ABOUT-US/COMMUNITY-BENEFIT)

PART V, LINE 7B - URL

FACILITY: DANBURY HOSPITAL

[HTTP://WWW.CHIME.ORG/ADVOCACY/COMMUNITY-HEALTH/](http://WWW.CHIME.ORG/ADVOCACY/COMMUNITY-HEALTH/)

PART V, LINE 7B - URL

FACILITY: NEW MILFORD HOSPITAL

[HTTP://WWW.CHIME.ORG/ADVOCACY/COMMUNITY-HEALTH/](http://WWW.CHIME.ORG/ADVOCACY/COMMUNITY-HEALTH/)

PART V, LINE 10A - URL

FACILITY: DANBURY HOSPITAL

[HTTP://WWW.DANBURYHOSPITAL.ORG/ABOUT-US/ABOUT-DANBURY-HOSPITAL/COMMUNITY-BENEFIT](http://WWW.DANBURYHOSPITAL.ORG/ABOUT-US/ABOUT-DANBURY-HOSPITAL/COMMUNITY-BENEFIT)

Part V Facility Information (continued)

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

PART V, LINE 10A - URL

FACILITY: NEW MILFORD HOSPITAL

[HTTP://WWW.NEWMILFORDHOSPITAL.ORG/ABOUT-US/ABOUT-US/COMMUNITY-BENEFIT](http://WWW.NEWMILFORDHOSPITAL.ORG/ABOUT-US/ABOUT-US/COMMUNITY-BENEFIT)

PART V, LINE 16A - URL

FACILITY: DANBURY HOSPITAL

[HTTP://WWW.DANBURYHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING](http://WWW.DANBURYHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING)

PART V, LINE 16A - URL

FACILITY: NEW MILFORD HOSPITAL

[HTTP://WWW.NEWMILFORDHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING](http://WWW.NEWMILFORDHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING)

PART V, LINE 16B - URL

FACILITY: DANBURY HOSPITAL

[HTTP://WWW.DANBURYHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING](http://WWW.DANBURYHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING)

PART V, LINE 16B - URL

FACILITY: NEW MILFORD HOSPITAL

[HTTP://WWW.NEWMILFORDHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING](http://WWW.NEWMILFORDHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING)

PART V, LINE 16C - URL

FACILITY: DANBURY HOSPITAL

[HTTP://WWW.DANBURYHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING](http://WWW.DANBURYHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING)

Part V Facility Information (continued)

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

PART V, LINE 16C - URL

FACILITY: NEW MILFORD HOSPITAL

HTTP://WWW.NEWMILFORDHOSPITAL.ORG/PATIENT-AND-VISITORS-INFO/BILLING

PART V, LINE 16I - OTHER MEANS HOSPITAL FACILITY PUBLICIZED THE POLICY

FACILITY: DANBURY HOSPITAL

DANBURY HOSPITAL HAS MESSAGES ON ALL STATEMENTS PROVIDING INFORMATION REGARDING HOW THE PATIENT CAN GET ASSISTANCE WITH THEIR HOSPITAL BILL.

COUNSELORS ARE ALSO AVAILABLE TO PROVIDE FURTHER ASSISTANCE. AVAILABLE TO PROVIDE FURTHER ASSISTANCE.

PART V, LINE 16I - OTHER MEANS HOSPITAL FACILITY PUBLICIZED THE POLICY

FACILITY: NEW MILFORD HOSPITAL CAMPUS

NEW MILFORD HOSPITAL CAMPUS HAS MESSAGES ON ALL STATEMENTS PROVIDING INFORMATION REGARDING HOW THE PATIENT CAN GET ASSISTANCE WITH THEIR HOSPITAL BILL. COUNSELORS ARE ALSO AVAILABLE TO PROVIDE FURTHER ASSISTANCE.

PART V, LINE 22D - OTHER BILLING DETERMINATION OF INDIVIDUALS WITHOUT INSURANCE

FACILITY: DANBURY HOSPITAL

DANBURY HOSPITAL INTENDS TO BE IN COMPLIANCE WITH THE REGULATIONS REGARDING THE MAXIMUM AMOUNTS THAT CAN BE CHARGED TO FAP-ELIGIBLE INDIVIDUALS FOR EMERGENCY AND OTHER MEDICAL NECESSARY CARE BY THE EFFECTIVE DATE (10/1/2016).

Part V Facility Information *(continued)*

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

PART V, LINE 22D - OTHER BILLING DETERMINATION OF INDIVIDUALS WITHOUT
INSURANCE

FACILITY: NEW MILFORD HOSPITAL CAMPUS

NEW MILFORD HOSPITAL INTENDS TO BE IN COMPLIANCE WITH THE REGULATIONS
REGARDING THE MAXIMUM AMOUNTS THAT CAN BE CHARGED TO FAP-ELIGIBLE
INDIVIDUALS FOR EMERGENCY AND OTHER MEDICAL NECESSARY CARE BY THE
EFFECTIVE DATE (10/1/2016).

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 23

Name and address	Type of Facility (describe)
1 DANBURY HOSPITAL RIDGEFIELD SURG. CTR. 901 ETHAN ALLEN HIGHWAY RIDGEFIELD CT 06877	OUTPATIENT SURGICAL CENTER
2 BREAST IMAGING CENTER 20 GERMANTOWN ROAD DANBURY CT 06810	DIAGNOSTIC
3 MAIN STREET REHABILITATION CENTER 235 MAIN STREET DANBURY CT 06810	REHABILITATION
4 SIEFERT & FORD COMMUNITY HEALTH CTR. 70 MAIN STREET DANBURY CT 06810	OUTPATIENT-PHYSICIAN CLINIC
5 DANBURY HOSPITAL SLEEP LAB II 25 LAKE AVENUE-EXTENSION DANBURY CT 06810	DIAGNOSTIC
6 COMM. CTR. FOR BEHAVIORIAL HEALTH 152 WEST STREET DANBURY CT 06810	OUTPATIENT-PHYSICIAN CLINIC
7 SOUTHBURY CARDIOVASCULAR DIAGNOSTICS 22 OLD WATERBURY ROAD SOUTHBURY CT 06488	DIAGNOSTIC
8 PULMONARY SERVICES 33 GERMANTOWN ROAD DANBURY CT 06810	DIAGNOSTIC
9 THE ANTICOAGULATION CENTER 41 GERMANTOWN ROAD DANBURY CT 06810	DIAGNOSTIC
10 PHYSICAL MEDICINE CENTER OF SOUTHBURY 22 OLD WATERBURY ROAD, SUITE 101 SOUTHBURY CT 06488	OUTPATIENT-PHYSICIAN CLINIC

Schedule H (Form 990) 2014

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1 NEW MILFORD HOSPITAL BEHAVIORIAL HEALT 23 POPLAR STREET NEW MILFORD CT 06776	OUTPATIENT-PHYSICIAN CLINIC
2 DANBURY HOSPITAL LABORATORY 79 SANDPIT ROAD DANBURY CT 06810	DIAGNOSTIC
3 CENTER FOR CHILD & ADOL. TREAT. 152 WEST STREET DANBURY CT 06810	OUTPATIENT-PHYSICIAN CLINIC
4 DANBURY HOSPITAL LABORATORY CENTER NM 120 PARK LANE, SUITE A201 NEW MILFORD CT 06776	DIAGNOSTIC
5 DANBURY HOSPITAL SOUTHBURY LABORATORY 22 OLD WATERBURY ROAD, SUITE 101 SOUTHBURY CT 06488	DIAGNOSTIC
6 DANBURY HOSPITAL LAB CTR. IN BROOKFIELD 60 OLD NEW MILFORD ROAD, UNIT 1C BROOKFIELD CT 06804	DIAGNOSTIC
7 DANBURY HOSPITAL DIABETES EDUCATION CT 41 GERMANTOWN ROAD DANBURY CT 06810	EDUCATION CENTER
8 RIDGEFIELD SPECIMEN COLLECTION FACILI 10 SOUTH STREET RIDGEFIELD CT 06877	DIAGNOSTIC
9 BETHEL LABORATORY 68 STONY HILL ROAD BETHEL CT 06801	DIAGNOSTIC
10 NEWTOWN LABORATORY 14-18 CHURCH HILL ROAD NEWTOWN CT 06470	DIAGNOSTIC

Schedule H (Form 990) 2014

Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1 KENOSIA LAB 51-53 KENOSIA AVENUE DANBURY CT 06810	DIAGNOSTIC
2 DANBURY HOSPITAL RESEARCH INSTITUTE 131 WEST STREET DANBURY CT 06813	DIAGNOSTIC
3 NEW MILFORD INTEGRATED MEDICINE PRGM 30 ELM STREET NEW MILFORD CT 06776	OUTPATIENT-PHYSICIAN CLINIC
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART I, LINE 3C

ANNUAL INCOME AND LIQUID ASSETS ARE COMBINED TO DETERMINE ELIGIBILITY. IF FAMILY INCOME LIMIT FOR ELIGIBILITY IS BETWEEN 400% AND 500% THEN 50% WILL BE TAKEN OFF BASED ON A SLIDING SCALE. IF THE INCOME LIMIT FOR ELIGIBILITY IS BETWEEN 500% AND 600% THEN 100% WILL BE TAKEN OFF BASED ON A SLIDING SCALE.

SCHEDULE H, PART I, LINE 6A

PART I, LINE 6A & 6B: THE COMMUNITY BENEFIT REPORT IS REPORTED ON A NETWORK BASIS. IT CONTAINS THE ORGANIZATION'S COMMUNITY BENEFIT PROGRAMS AND SERVICES' DESCRIPTIONS AND FINANCIAL DATA. THE FORM IS MADE AVAILABLE TO THE PUBLIC ON THE OFFICE OF HEALTH CARE ACCESS' WEBSITE:

[HTTP://WWW.CT.GOV/DPH/LIB/DPH/OHCA/HOSPITALFILLINGS/2012/IRS990/DANBY990_HOSPITAL_2012.PDF](http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2012/irs990/danby990_hospital_2012.pdf)

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART 1, LINE #7

CHARITY CARE AT COST PERCENTAGE:

TOTAL GROSS PATIENT CHARGES WRITTEN OFF TO CHARITY (INCOME STATEMENT) *

PATIENT COST TO CHARGE % (SEE BELOW) = TOTAL COMMUNITY BENEFIT EXPENSE

TOTAL COMMUNITY BENEFIT EXPENSES - REVENUE FROM UNCOMPENSATED CARE POOLS

AND PROGRAMS (DHS * % OF COST OF UNCOMPENSATED CARE SHOWN ON THE OCHA

SCHEDULE 500) = NET COMMUNITY BENEFITS EXPENSES

NET COMMUNITY BENEFITS EXPENSES / TOTAL EXPENSES = % OF TOTAL EXPENSES

RATIO COST TO CHARGE CALCULATION

TOTAL OPERATING EXPENSES - NON-PATIENT CARE ACTIVITIES, MEDICAID PROVIDER

TAX, TOTAL COMMUNITY BENEFIT EXPENSE AND TOTAL COMMUNITY BUILDING EXPENSE

= ADJUSTED PATIENT CARE COST.

Part VI Supplemental Information

Provide the following information.

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

ADJUSTED PATIENT CARE COST DIVIDED BY GROSS PATIENT CHARGES= RATIO OF
PATIENT CARE COSTS TO CHARGES.

SCHEDULE H, PART I, LINE 7G

PART I, LINE 7G - COSTS ASSOCIATED WITH PHYSICANS CLINICS

THERE ARE NO PHYSICIAN CLINICS INCLUDED IN THIS AMOUNT.

SCHEDULE H, PART III, LINE #2

THE RATIO OF COST TO CHARGES IS APPLIED TO THE BAD DEBT EXPENSE ON THE
AUDITED FINANCIAL STATEMENTS.

SCHEDULE H, PART III, LINE #3

IT IS THE POLICY OF THE HOSPITAL TO PROVIDE NECESSARY CARE TO ALL PERSONS
SEEKING TREATMENT WITHOUT DISCRIMINATION ON THE GROUNDS OF AGE, RACE,
CREED, NATIONAL ORIGIN OR ANY OTHER GROUNDS UNRELATED TO AN INDIVIDUAL'S
NEED FOR THE SERVICE OR THE AVAILABILITY OF THE NEEDED SERVICE AT THE
HOSPITAL. A PATIENT IS CLASSIFIED AS A CHARITY CARE PATIENT BY REFERENCE
TO ESTABLISHED POLICIES OF THE HOSPITAL. ESSENTIALLY, THESE POLICIES

Part VI Supplemental Information

Provide the following information.

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

DEFINE CHARITY SERVICES AS THOSE SERVICES FOR WHICH NO PAYMENT IS ANTICIPATED. IN ASSESSING A PATIENT'S INABILITY TO PAY, THE HOSPITAL UTILIZES THE GENERALLY RECOGNIZED FEDERAL POVERTY INCOME GUIDELINES, BUT ALSO INCLUDES CERTAIN CASES WHERE INCURRED CHARGES ARE SIGNIFICANT WHEN COMPARED TO A RESPONSIBLE PARTY'S INCOME AND THEIR COUNTABLE ASSETS. THOSE CHARGES ARE NOT INCLUDED IN NET PATIENT SERVICE REVENUE FOR FINANCIAL REPORTING PURPOSES. BECAUSE THE HOSPITAL IS NOT PAID FOR THESE SERVICES, THEY ARE CONSIDERED TO BE COMMUNITY BENEFIT.

WHEN PRIVATE PAY PATIENTS ARE SENT TO THE COLLECTION AGENCY THEIR ACCOUNT IS CONSIDERED TO BE A BAD DEBT. SUBSEQUENTLY, MEDICAID MAY BE GRANTED FOR SOME OF THOSE PATIENTS. AT THAT TIME THOSE ACCOUNTS WOULD BECOME CHARITY CARE OR A COMMUNITY BENEFIT.

SCHEDULE H, PART III, LINE #4

THE HOSPITAL'S ESTIMATION OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IS BASED PRIMARILY UPON THE TYPE AND AGE OF THE PATIENT ACCOUNTS RECEIVABLE AND THE EFFECTIVENESS OF THE HOSPITAL'S COLLECTION EFFORTS. THE

Part VI Supplemental Information

Provide the following information.

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

HOSPITAL'S POLICY IS TO RESERVE A PORTION OF ALL SELF-PAY RECEIVABLES, INCLUDING AMOUNTS DUE FROM THE UNINSURED AND AMOUNTS RELATED TO CO-PAYMENTS AND DEDUCTIBLES, AS THESE CHARGES ARE RECORDED. ON A MONTHLY BASIS, THE HOSPITAL REVIEWS ITS ACCOUNTS RECEIVABLE BALANCES AND VARIOUS ANALYTICS TO SUPPORT THE BASIS FOR ITS ESTIMATES. THESE EFFORTS PRIMARILY CONSIST OF REVIEWING THE FOLLOWING:

HISTORICAL WRITE-OFF AND COLLECTION EXPERIENCE USING A HINDSIGHT OR LOOK-BACK APPROACH;

REVENUE AND VOLUME TRENDS BY PAYOR, PARTICULARLY THE SELF-PAY COMPONENTS;

CHANGES IN THE AGING AND PAYOR MIX OF ACCOUNTS RECEIVABLE, INCLUDING INCREASED FOCUS ON ACCOUNTS DUE FROM THE UNINSURED AND ACCOUNTS THAT REPRESENT CO-PAYMENTS AND DEDUCTIBLES DUE FROM PATIENTS;

CASH COLLECTIONS AS A PERCENTAGE OF NET PATIENT REVENUE LESS THE

Part VI Supplemental Information

Provide the following information.

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

PROVISION FOR UNCOLLECTIBLE ACCOUNTS; AND

TRENDING OF DAYS REVENUE IN ACCOUNTS RECEIVABLE

THE AMOUNT OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IS BASED UPON
MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS,
BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN MEDICARE AND MEDICAID HEALTH
CARE COVERAGE, AND OTHER COLLECTION INDICATORS.

THE HOSPITAL REGULARLY PERFORMS HINDSIGHT PROCEDURES TO EVALUATE
HISTORICAL WRITE-OFF AND COLLECTION EXPERIENCE THROUGHOUT THE YEAR TO
ASSIST IN DETERMINING THE REASONABLENESS OF ITS PROCESS FOR ESTIMATING
THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS.

THE HOSPITAL'S PRIMARY CONCENTRATION OF CREDIT RISK IS PATIENT ACCOUNTS
RECEIVABLE, WHICH CONSISTS OF AMOUNTS OWED BY VARIOUS GOVERNMENTAL
AGENCIES, INSURANCE COMPANIES AND PRIVATE PATIENTS.

Part VI Supplemental Information

Provide the following information.

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

THE HOSPITAL MANAGES THE RECEIVABLES BY REGULARLY REVIEWING ITS PATIENT ACCOUNTS AND CONTRACTS, AND BY PROVIDING APPROPRIATE ALLOWANCES FOR UNCOLLECTIBLE AMOUNTS. SIGNIFICANT CONCENTRATIONS OF GROSS PATIENT ACCOUNTS RECEIVABLE INCLUDE 30%, 13% AND 57% AND 37%, 13% AND 50% FOR MEDICARE, MEDICAID AND NON-GOVERNMENT PAYORS, RESPECTIVELY, AT SEPTEMBER 30, 2015 AND 2014, RESPECTIVELY.

SCHEDULE H, PART III, LINE #8

DANBURY HOSPITAL'S MEDICARE SHORTFALL SHOULD BE TREATED AS A COMMUNITY BENEFIT AS THE ORGANIZATION STRIVES TO PROVIDE 24/7 COVERAGE, IMPROVED PATIENT ACCESS, HIGHEST CLINICAL QUALITY AS WELL AS ADDRESSING THE NEEDS OF THE COMMUNITY BY OFFERING CRITICAL SERVICES TO OUR GEOGRAPHIC AREA. AS A RESULT, THE ORGANIZATION MUST BALANCE THE COST OF THESE PROGRAMS AGAINST THE CONTINUED DECREASING GOVERNMENT REIMBURSEMENT LEVELS, UNINSURED POPULATION AND COMMUNITY NEEDS.

A COST ACCOUNTING SYSTEM IS USED TO CALCULATE THE SHORTFALL, WHICH IS MEDICARE NET PATIENT REVENUE LESS APPLICABLE COSTS.

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART III, LINE 9B

IT IS THE POLICY OF DANBURY HOSPITAL TO PROVIDE "FINANCIAL ASSISTANCE"
 (EITHER FREE CARE OR REDUCED PATIENT OBLIGATIONS) TO PERSONS OR FAMILIES
 WHERE: (I) THERE IS LIMITED OR NO HEALTH INSURANCE AVAILABLE; (II) THE
 PATIENT FAILS TO QUALIFY FOR GOVERNMENTAL ASSISTANCE (FOR EXAMPLE
 MEDICARE OR MEDICAID); (III) THE PATIENT COOPERATES WITH THE HOSPITAL IN
 PROVIDING THE REQUESTED INFORMATION; (IV) THE PATIENT DEMONSTRATES
 FINANCIAL NEED; AND (V) DANBURY HOSPITAL MAKES AN ADMINISTRATIVE
 DETERMINATION THAT FINANCIAL ASSISTANCE IS APPROPRIATE.

AFTER THE HOSPITAL DETERMINES THAT A PATIENT IS ELIGIBLE FOR FINANCIAL
 ASSISTANCE, THE HOSPITAL WILL DETERMINE THE AMOUNT OF FINANCIAL
 ASSISTANCE AVAILABLE TO THE PATIENT BY UTILIZING THE CHARITABLE
 ASSISTANCE GUIDELINES, WHICH ARE BASED UPON THE MOST RECENT FEDERAL
 POVERTY GUIDELINES.

DANBURY HOSPITAL SHALL REGULARLY REVIEW THIS FINANCIAL ASSISTANCE POLICY
 TO ENSURE THAT AT ALL TIMES IT: (I) REFLECTS THE PHILOSOPHY AND MISSION

Part VI Supplemental Information

Provide the following information.

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

OF THE HOSPITAL; (II) EXPLAINS THE DECISION PROCESSES OF WHO MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE AND IN WHAT AMOUNTS; AND (III) COMPLIES WITH ALL APPLICABLE STATE AND FEDERAL LAWS, RULES, AND REGULATIONS CONCERNING THE PROVISION OF FINANCIAL ASSISTANCE TO INDIGENT PATIENTS.

CONSISTENT WITH THIS MISSION, DANBURY HOSPITAL RECOGNIZES ITS OBLIGATION TO THE COMMUNITY IT SERVES TO PROVIDE FINANCIAL ASSISTANCE TO INDIGENT PERSONS WITHIN THE COMMUNITY.

IN FURTHERANCE OF ITS CHARITABLE MISSION, DANBURY HOSPITAL WILL PROVIDE BOTH (I) EMERGENCY TREATMENT TO ANY PERSON REQUIRING SUCH CARE; AND (II) ESSENTIAL, NON-EMERGENT CARE TO PATIENTS WHO ARE PERMANENT RESIDENTS OF ITS PRIMARY SERVICE AREA WHO MEET THE CONDITIONS AND CRITERIA SET FORTH IN THIS POLICY, WITHOUT REGARD TO THE PATIENTS' ABILITY TO PAY FOR SUCH CARE. ELECTIVE PROCEDURES GENERALLY WILL NOT BE CONSIDERED ESSENTIAL, NON-EMERGENT CARE AND USUALLY WILL NOT BE ELIGIBLE FOR FINANCIAL ASSISTANCE.

Part VI Supplemental Information

Provide the following information.

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

DANBURY HOSPITAL WILL COLLECT FROM INDIVIDUALS ON FINANCIAL ASSISTANCE IF THEY RECEIVED A PARTIAL CHARITABLE DISCOUNT. ALL PATIENTS CAN APPLY FOR CHARITABLE CARE ON BALANCES THEY FEEL THAT THEY CANNOT AFFORD.

SCHEDULE H, PART V

14 DIAGNOSTIC CENTERS

6 OUTPATIENT PHYSICIAN CLINICS

1 OUTPATIENT SURGICAL CENTER

1 REHABILITATION CENTER

1 EDUCATION CENTER

SCHEDULE H, PART VI, LINE 2

NEEDS ASSESSMENT: THE COMMUNITY FORUM HELD IN 2014 WAS ATTENDED BY 37 COMMUNITY STAKEHOLDERS FROM THE HOUSATONIC VALLEY REGION (HVR). THIS INCLUDED REPRESENTATIVES FROM 5 HEALTH DEPARTMENTS/DISTRICTS (DANBURY, NEW MILFORD, BETHEL, NEWTOWN, AND POMPERAUG), WESTERN CT HEALTH NETWORK, DANBURY EMS, THE BETHEL VISITING NURSE ASSOCIATION, THE UNITED WAY OF WESTERN CT, THE REGIONAL YMCA, THE HOUSATONIC VALLEY COALITION AGAINST

Part VI Supplemental Information

Provide the following information.

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

SUBSTANCE ABUSE, THE MID-WESTERN CT COUNCIL ON ALCOHOLISM, THE AMERCARES FREE CLINIC, THE CIFC COMMUNITY HEALTH CENTER, DOCTOR'S EXPRESS URGENT CARE CENTER, THE REGIONAL EDUCATIONAL SERVICE CENTER, THE DANBURY FIRE DEPARTMENT, THE NEW MILFORD SENIOR CENTER, AND THE PETER AND CARMEN LUCIA BUCK FOUNDATION. TWO COMMUNITY HEALTH CONVERSATIONS WERE HELD WITH KEY COMMUNITY STAKEHOLDERS IN OCTOBER 2012 - (DANBURY AND NEW MILFORD, CT) TO ENSURE ACCESSIBILITY BY KEY STAKEHOLDERS THROUGHOUT THE REGION. ATTENDEES INCLUDED A TOTAL OF 52 REPRESENTATIVES FROM HOSPITALS; COMMUNITY HEALTH CENTERS; SCHOOL-BASED HEALTH CENTERS; VISITING NURSE ASSOCIATIONS/SERVICES; MUNICIPAL HEALTH, EDUCATION, SOCIAL SERVICE, SENIOR CENTERS AND FIRE DEPARTMENTS; NON-PROFIT ORGANIZATIONS; AND A LEGISLATOR'S OFFICE. GEOGRAPHICALLY, ALL 10 HVR MUNICIPALITIES WERE REPRESENTED EITHER DIRECTLY OR THROUGH REGIONAL AGENCIES AND ORGANIZATIONS. THE PARTICIPATION AND INSIGHTS OF COMMUNITY LEADERS AND AGENCIES/ORGANIZATIONS WHO PROVIDE DIRECT PROGRAMS AND SERVICES FOR THE LOW INCOME/MINORITY MEMBERS OF THE COMMUNITY WAS IMPORTANT TO THE DATA COLLECTION AND ASSESSMENT PROCESS.

Part VI Supplemental Information

Provide the following information.

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

THE WESTERN CT HEALTH NETWORK (OF WHICH DANBURY HOSPITAL IS A PART)
CONDUCTED A PHYSICIAN RESOURCE ASSESSMENT TO EVALUATE THE SUPPLY OF
HEALTH CARE PROVIDERS WITHIN ITS COMBINED SERVICE AREA TOWNS. THIS IS
DONE TO DOCUMENT COMMUNITY NEED FOR HEALTH CARE PROVIDERS, AND TO DEVELOP
A PLAN TO MEET THE HEALTH CARE NEEDS OF THE COMMUNITY SERVED.

THROUGH WESTERN CT HEALTH NETWORK'S ANNUAL PLANNING PROCESS, AN
ENVIRONMENTAL ASSESSMENT IS CONDUCTED TO IDENTIFY HEALTH CARE GAPS AND
NEEDS OF THE SERVICE AREA COMMUNITY BROUGHT ABOUT BY LOCAL AND NATIONAL
TRENDS IN ECONOMIC, LEGISLATIVE, DEMOGRAPHIC, HEALTH CARE INDUSTRY AND
OTHER ENVIRONMENTAL FACTORS. THESE FORCES ARE CONSIDERED AND
INCORPORATED IN MEETING THE HEALTH CARE NEEDS OF THE COMMUNITY BY HELPING
TO FRAME THE PRIORITIES, GOALS AND INITIATIVES OF WESTERN CT HEALTH
NETWORK'S LONG RANGE AND ANNUAL STRATEGIC PLANS.

SCHEDULE H, PART VI, LINE 3

PART VI- PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE
THE HOSPITAL HAS MESSAGES ON ALL STATEMENTS PROVIDING INFORMATION

Part VI Supplemental Information

Provide the following information.

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

REGARDING HOW THE PATIENT CAN GET ASSISTANCE WITH THEIR HOSPITAL BILL.

ALSO SIGNS ARE POSTED THROUGHOUT THE HOSPITAL AND COUNSELORS ARE AVAILABLE TO PROVIDE FURTHER ASSISTANCE. ALL UNINSURED INPATIENTS ARE INTERVIEWED BY FINANCIAL COUNSELORS AND ASSESSED FOR ELIGIBILITY FOR ASSISTANCE PROGRAMS. THE HOSPITAL PROVIDES INFORMATIONAL HANDOUTS TO ALL UNINSURED PATIENTS AT THE TIME OF REGISTRATION WHICH REFERS THEM TO FINANCIAL COUNSELING IF THEY WOULD LIKE ASSISTANCE WITH THEIR BILLS. FURTHER, THE HOSPITAL MAILS NOTICES TO ALL SELF-PAY ACCOUNTS REFERRING THEM TO FINANCIAL COUNSELING IF THEY NEED ASSISTANCE. THE COLLECTION DEPARTMENT WILL ALSO REFER PATIENTS TO FINANCIAL COUNSELING WHEN A PATIENT INDICATES THAT THEY CANNOT AFFORD THEIR BALANCES; AND FINALLY, SCHEDULERS REFER UNINSURED PATIENTS TO FINANCIAL COUNSELING PRIOR TO THEIR TEST OR PROCEDURE. THE POLICY AND APPLICATIONS FOR ASSISTANCE ARE ALSO AVAILABLE ON LINE.

SCHEDULE H, PART VI, LINE 4

PART VI - COMMUNITY INFORMATION

COMMUNITY INFORMATION: DANBURY HOSPITAL AND THE NEW MILFORD HOSPITAL

Part VI Supplemental Information

Provide the following information.

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

CAMPUS SERVES AN AREA WITH A POPULATION OF ABOUT 280,000 PEOPLE. THE PRIMARY SERVICE AREA INCLUDES BETHEL, BRIDGEWATER, BROOKFIELD, DANBURY, NEW FAIRFIELD, NEW MILFORD, NEWTOWN, RIDGEFIELD, AND SOUTHBURY (IN CT), AND THE SECONDARY SERVICE AREA INCLUDES KENT, REDDING, ROXBURY, SHERMAN, WASHINGTON, WINGDALE, AND WOODBURY (IN CT) AND BREWSTER, NORTH SALEM, PATTERSON, AND PAWLING (IN NY). THIS SERVICE AREA IS COMPRISED OF A DENSELY POPULATED CORE OF THE URBAN/SUBURBAN CITY OF DANBURY SURROUNDED BY MODERATELY AFFLUENT RESIDENTIAL AND RURAL TOWNS. DANBURY IS ALSO LISTED AS A MEDICALLY UNDERSERVED AREA, OR MUA. DANBURY HAS A MEDIAN HOUSEHOLD INCOME OF \$65,981 AND A POVERTY RATE OF 11.1%, WHILE NEW MILFORD HAS A HOUSEHOLD INCOME OF \$49,575 AND A POVERTY RATE OF 15.6%. THE OVERALL UNINSURED POPULATION RATE FOR THE STATE IS ESTIMATED TO BE 3.8%. ALTHOUGH THE POPULATION OF THE PRIMARY AND SECONDARY SERVICE AREAS IS EXPECTED TO REMAIN VIRTUALLY LEVEL FROM 2010 TO 2020, THE COHORT AGED 65 AND OVER IS EXPECTED TO INCREASE BY 2.78% IN DANBURY AND 4.05% IN NEW MILFORD, WHILE THE AGE 20-44 AGE COHORT IS FORECAST TO SLIGHTLY INCREASE AT 0.68% IN DANBURY AND DECREASE BY 1.13% IN NEW MILFORD OVER THE SAME TIME PERIOD.

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART II: COMMUNITY BUILDING ACTIVITIES

RELATES TO LINE #6, COALITION BUILDING, TOTALING \$9,169:

WESTERN CONNECTICUT HEALTH NETWORK (WCHN) PARTICIPATES AS A MEMBER OF A REGIONAL COLLABORATIVE REPRESENTING THE HOUSATONIC VALLEY REGION AND TEN MUNICIPALITIES. A STEERING COMMITTEE COMPRISED OF HEALTH CARE PROVIDERS, COMMUNITY-BASED PROVIDERS, AND LOCAL GOVERNMENT AGENCIES MEETS NO LESS THAN TWICE A YEAR TO OVERSEE A COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) THAT WAS DEVELOPED UTILIZING DATA FROM A REPORT CARD AND PREVIOUS COMMUNITY CONVERSATIONS. FOUR PRIORITY HEALTH INDICATORS (PHI) ARE BEING ADDRESSED THROUGH A WORK GROUP STRUCTURE THAT INCLUDES A DESIGNATED LEADER WHO CONVENES THE GROUP TO FURTHER DEVELOP AND REFINE THEIR ACTION PLANS. COMMUNITY STAKEHOLDERS PARTICIPATED IN AN APRIL 2014 COMMUNITY FORUM FACILITATED BY THE CENTER FOR HEALTH SCHOOLS & COMMUNITIES @ EDUCATION CONNECTION. OVERALL, DATA OBTAINED FROM THE CONVERSATIONS PROVIDED HIGH QUALITY INFORMATION TO FRAME THE BEGINNING OF A COMMUNITY HEALTH IMPROVEMENT CHANGE PROCESS IN THE REGION.

Part VI Supplemental Information

Provide the following information.

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

1. PREVENTION AND EDUCATION OF MOST PREVALENT CHRONIC DISEASES/HEALTH

CONDITIONS: OBESITY, TYPE 2 DIABETES, AND HYPERTENSION WERE IDENTIFIED AS THE MOST PREVALENT HEALTH CONDITIONS IN THE COMMUNITY. THE PHI TEAM GOALS ARE TO INCREASE HEALTHY EATING OPTIONS, ENHANCE ACCESS TO PHYSICAL ACTIVITIES, AND PROMOTE A UNIVERSAL HEALTHY LIFESTYLE. IN JULY 2014, THE PHI TEAM RECEIVED THE YMCA DIABETES PREVENTION PROGRAM GRANT WHICH WAS USED TO FUND THEIR DIABETES PREVENTION PROGRAM. THE PROGRAM BEGAN IN OCTOBER 2014, AND THROUGH DECEMBER 2015 10 CLASSES HAD BEEN CONDUCTED (AVERAGE CLASS SIZE OF 5.4 PARTICIPANTS, AVERAGE AGE OF 59 YEARS, AND 75% OF THE REFERRALS WERE FROM PHYSICIAN OFFICES). PARTICIPANTS EXCEEDED THE TARGETED WEIGHT LOSS GOAL OF 7% (ACHIEVED 10.4%) WHICH WAS SUPPORTED BY CONSISTENT PROGRAM PARTICIPATION, PHYSICAL ACTIVITY AND FOOD TRACKER COMPLETION. THE TEAM ALSO PARTICIPATED IN NATIONAL WALK DAY, WHICH GARNERED OVER 150 PEOPLE FROM THE HOUSATONIC VALLEY REGION AND FORMATION OF 3 COMMUNITY WALKING GROUPS. THE COALITION FOR HEALTHY KIDS IS PILOTING A "WALKING SCHOOL BUS" PROGRAM WITH A LOCAL SCHOOL TO ENCOURAGE PHYSICAL ACTIVITY. A WELLNESS CAMPAIGN BUILDING ON THE "5, 2, 1, 0 LET'S GO" MESSAGING WAS IMPLEMENTED AND THE "KNOW YOUR NUMBERS" CAMPAIGN TRACKED

Part VI Supplemental Information

Provide the following information.

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

338 INDIVIDUALS WITH BLOOD PRESSURE MONITORING.

2. IMPROVING ACCESS/UTILIZATION TO SUBSTANCE ABUSE AND MENTAL HEALTH

SERVICES: MENTAL HEALTH ISSUES AND SUBSTANCE ABUSE CONTINUE TO BE PREVALENT ISSUES IN THE COMMUNITY. THIS PHI TEAM IS COLLABORATING WITH 12 LOCAL PREVENTION COUNCILS, THE CT PREVENTION FRAMEWORK, AND OTHER ENTITIES TO INCREASE OUTREACH EFFORTS. THEIR GOALS ARE TO IDENTIFY GAPS IN SERVICES AND ACCESS, PROVIDE EDUCATION, AND INCREASE AWARENESS REGARDING SERVICES AND PROGRAMS. THERE IS AWARENESS TO VULNERABLE TARGET GROUPS IN NEED OF ENHANCED SERVICES AND SUPPORTS, SUCH AS THE HOMELESS POPULATION AND YOUTH. THE TEAM WORKED TO IMPROVE EDUCATION AND INFORMATION DISSEMINATION, AND SUPPORTED INTEGRATION OF A "QUESTION-PERSUADE-REFER" MODEL FOR SUICIDE PREVENTION. AREAS OF FOCUS TARGETED PRESCRIPTION DRUG USE, SUPPORT FOR COMMUNITY "DROP BOXES" , OPIATE USE, UNDERAGE DRINKING, AND BEHAVIORAL HEALTH INITIATES IN PRIMARY CARE PRACTICES.

3. IMPROVE ASSESSMENT AND SERVICE PLANNING TO SENIOR HEALTH: SENIOR

Part VI Supplemental Information

Provide the following information.

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

CITIZENS, PARTICULARLY HOMEBOUND ELDERLY AND IMMIGRANTS, ARE IN NEED OF ASSESSMENT AND SERVICE PLANNING TO ADDRESS THEIR HEALTH, HOUSING, AND SOCIAL SUPPORT NEEDS. THE MAIN GOAL IS TO INCREASE AWARENESS, SERVICES, AND EDUCATION FOR SENIOR HEALTH. THIS TEAM IS SUPPORTING AND COLLABORATING WITH THE AGING IN PLACE INITIATIVES FUNDED BY THE PETER AND CARMEN LUCIA BUCK FOUNDATION, WHICH INCLUDES THE "SAFE AT HOME" PROGRAM THAT DELIVERS HOME SAFETY ITEMS TO SENIORS. EFFORTS CONTINUE TO MOVE THE DANBURY COMMUNITY AS A "LIVABLE" COMMUNITY AND TO SHARE LEARNINGS WITH ADJACENT COMMUNITIES.

4. IMPROVE AWARENESS AND UTILIZATION OF EXISTING HEALTH AND SOCIAL PROGRAMS/SERVICES: THIS TEAM FOCUSED ON ENHANCING AWARENESS AND UTILIZATION OF EXISTING PROGRAMS AND SERVICES IN THE COMMUNITY, INCLUDING SUPPORT OF INFOLINE 2-1-1 AND 5 HEALTH ACCESS CT ASSISTOR SITES BY TARGET POPULATIONS. IT ALSO ESTABLISHED A PARTNERSHIP WITH FAMILYWIZE TO PROVIDE PROMOTIONAL MATERIALS FOR DISTRIBUTION TO HEALTH PROVIDERS AND KEY COMMUNITY SITES.

Part VI Supplemental Information

Provide the following information.

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

THE INDIVIDUAL CHIP STEERING COMMITTEE MEMBERS, INCLUDING WCHN, SUPPORT THE IMPORTANCE OF SHARED COMMITMENT AND RESPONSIBILITY IN DEVELOPMENT AND EXECUTION OF ITS RECOMMENDED ACTION PLANS FOR HEALTH IMPROVEMENT.

TO THE BEST OF THE ORGANIZATION'S KNOWLEDGE, ALL PREVALENT ISSUES IN THE COMMUNITY ARE BEING ADDRESSED.

RELATES TO LINE #2, ECONOMIC DEVELOPMENT, LINE #3, COMMUNITY SUPPORT AND LINE #7, COMMUNITY HEALTH IMPROVEMENT ADVOCACY TOTALING \$5,204:

PART II: COMMUNITY HEALTH IMPROVEMENT ADVOCACY: LARGELY STATE AND LOCAL ELECTED OFFICIALS AND AGENCY HEADS WERE LOBBIED IN SUPPORT OF MAINTAINING PATIENT ACCESS TO ESSENTIAL SERVICES FOR THE UNINSURED AND UNDER INSURED. AS PART OF THIS EFFORT, MISCELLANEOUS EXPENSES ARE NOTED IN SCHEDULE C, PART II-B 1I.

SCHEDULE H, PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH. DANBURY HOSPITAL SERVED APPROXIMATELY 239,099 PERSONS THROUGH OVER 310 HEALTH EVENTS. ONE OF THE HIGHEST IMPACT

Part VI Supplemental Information

Provide the following information.

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

OUTREACH ACTIVITIES INCLUDES APPROXIMATELY 187,000 INDIVIDUALS SERVED THROUGH HEALTH TALK. HEALTH TALK WHICH AIRS TWICE A WEEK FOCUSES ON DISEASE PREVENTION, NEW TREATMENTS IN PULMONARY, EMBOLISM ATRIAL FIBRILLATION, PEDIATRIC ASTHMA, HEART HEALTH, COLON CANCER, EXERCISE AND WELLNESS TALKS, TO NAME A FEW EXAMPLES.

OVER 50% OF THE BOARD MEMBERS ARE INDEPENDENT AND DO NOT GET PAID BY DANBURY HOSPITAL. DANBURY HOSPITAL ALSO HAS AN OPEN MEDICAL STAFF.

SURPLUS FUNDS ARE USED TO PROVIDE INNOVATIVE TECHNOLOGY TO CLINICAL CARE IN ADDITION TO EXPANDING OUR SERVICE AREA.

PART VI-AFFILIATED HEALTH CARE SYSTEM ROLES AND PROMOTION
WESTERN CONNECTICUT HEALTH NETWORK (WCHN) IS AN INTEGRATED HEALTH CARE DELIVERY SYSTEM COMPRISED OF THREE COMMUNITY HOSPITALS AND THEIR AFFILIATED ENTITIES. IN ADDITION TO NORWALK HOSPITAL, DANBURY HOSPITAL AND ITS NEW MILFORD HOSPITAL CAMPUS, THE CONTINUUM OF CARE INCLUDES A LARGE MEDICAL GROUP, HOME HEALTH CARE SERVICES, A NATIONALLY RENOWNED

Part VI Supplemental Information

Provide the following information.

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

BIOMEDICAL RESEARCH INSTITUTE, THE WCHN AND NORWALK HOSPITAL FOUNDATIONS, AND OTHER RELATED AFFILIATES (THE NETWORK). WCHN'S MISSION IS TO IMPROVE THE HEALTH OF EVERY PERSON WE SERVE THROUGH THE EFFICIENT DELIVERY OF EXCELLENT, INNOVATIVE AND COMPASSIONATE CARE. FOR 2015, WCHN PROVIDED APPROXIMATELY \$19,826,631 IN TOTAL CHARITY CARE.

DANBURY HOSPITAL, ITS NEW MILFORD HOSPITAL CAMPUS AND NORWALK HOSPITAL PROVIDE MEDICAL SERVICES TO THE COMMUNITY REGARDLESS OF THE INDIVIDUAL'S ABILITY TO PAY. SERVICES INCLUDE ROUTINE INPATIENT ANCILLARY AND OUTPATIENT CARE IN SUPPORT OF THE NETWORK'S MISSION STATEMENT, AS NOTED ABOVE, FOR 2015, CHARITY CARE WAS PROVIDED IN THE FOLLOWING AMOUNTS: NORWALK HOSPITAL, \$7,649,926, DANBURY HOSPITAL AND ITS NEW MILFORD HOSPITAL CAMPUS, APPROXIMATELY \$11,003,250.

WESTERN CONNECTICUT MEDICAL GROUP/NORWALK HOSPITAL PHYSICIANS & SURGEONS: THE MISSION OF WESTERN CONNECTICUT MEDICAL GROUP IS TO PROVIDE SAFE, INNOVATIVE, CONVENIENT AND COORDINATED PRIMARY AND SPECIALTY HEALTH CARE IN THE COMMUNITIES THEY SERVE AND STRIVE TO BE AWARE OF AND RESPOND TO

Part VI Supplemental Information

Provide the following information.

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

THEIR PATIENTS' NEEDS. THEY SUPPORT A COMMITMENT TO ADVANCE THE HEALTH AND WELL-BEING OF INDIVIDUALS IN THEIR COMMUNITY BY DELIVERING QUALITY CARE, PARTICIPATING IN MEDICAL RESEARCH AND MEDICAL RESIDENCY PROGRAMS AND THE PROVISION OF MEDICAL SERVICES TO PATIENTS. FOR 2015, WCMG/NHP&S PROVIDED APPROXIMATELY \$1,023,000 IN CHARITY CARE.

WESTERN CONNECTICUT HEALTH NETWORK FOUNDATION INC.'S MISSION IS TO RAISE FUNDS, REINVEST AND ADMINISTER THESE FUNDS AND MAKE DISTRIBUTIONS TO DANBURY HOSPITAL AND ITS NEW MILFORD HOSPITAL CAMPUS AND OTHER DANBURY NOT-FOR-PROFIT HEALTH CARE AFFILIATES.

NORWALK HOSPITAL FOUNDATION'S MISSION IS TO RAISE FUNDS, REINVEST AND ADMINISTER THESE FUNDS AND MAKE DISTRIBUTIONS TO NORWALK HOSPITAL AND OTHER NOT-FOR-PROFIT NORWALK HOSPITAL AFFILIATES.

WESTERN CONNECTICUT HEALTH NETWORK AFFILIATES PRINCIPAL PURPOSE IS TO PROVIDE OUTPATIENT HEALTH CARE SERVICES IN VARIOUS LOCATIONS AND ALSO PROVIDE AMBULANCE SERVICES TO DANBURY AND SURROUNDING TOWNS, WHILE

Part VI Supplemental Information

Provide the following information.

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

SERVING THOSE THAT CANNOT AFFORD THE CARE.

WESTERN CONNECTICUT HOME CARE, INC. (WCHC) PROVIDES STATE OF THE ART
CLINICAL SERVICES RANGING FROM PEDIATRIC PATIENTS TO THE ELDERLY
UTILIZING BEST PRACTICE IN HOME CARE TO MEET THE NEEDS OF THEIR PATIENTS.
FOR 2015, WCHC PROVIDED APPROXIMATELY \$91,000 IN CHARITY CARE.

EASTERN NEW YORK MEDICAL SERVICES (ENYMS): THE MISSION AT ENYMS IS TO
PROVIDE SAFE, INNOVATIVE, CONVENIENT AND COORDINATED PRIMARY AND
GASTROENTEROLOGY HEALTH CARE IN THE COMMUNITIES WE SERVE AND STRIVE TO BE
AWARE OF AND RESPOND TO OUR PATIENTS' NEEDS.

SCHEDULE H, PART VI, LINE 7

CT.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

DANBURY HOSPITAL

Compensation Information

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

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

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

OMB No. 1545-0047

2014

**Open to Public
Inspection**

Employer identification number

06-0646597

Part I Questions Regarding Compensation

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

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

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

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including 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 type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input 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), 501(c)(4), and 501(c)(29) 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
1a		
1b		
2		
3		
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) 2014

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 in column (B) reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	JOHN M MURPHY, MD PRES./CEO, WCHN	949,990.	450,000.	2,838.	12,750.	39,094.	1,454,672.	0
	(ii)	0	0	0	0	0	0	0
	STEVEN H. ROSENBERG	557,258.	200,000.	21,856.	12,750.	29,979.	821,843.	0
2	SVP./CFO, WCHN	0	0	0	0	0	0	0
	DANIEL DEBARBA, JR.	637,084.	310,000.	19,018.	12,750.	40,400.	1,019,252.	0
3	EXEC VP./PRES-DH	19,466.	0	73,676.	4,197.	0	97,339.	0
	DONNA KAPLANIS	193,923.	40,000.	18,912.	24,188.	27,143.	304,166.	0
4	ASS'T SECRETARY	0	0	0	0	0	0	0
	MATTHEW A. MILLER, MD	126,404.	175,000.	6,952.	12,750.	9,343.	330,449.	0
5	SVP & CHIEF MEDICAL OFFICER	168,034.	175,000.	18,931.	12,750.	11,149.	385,864.	0
	MOREEN O. DONAHUE	339,737.	100,000.	7,196.	20,400.	30,320.	497,653.	0
6	SR VP/CHIEF NURSE OFFICER, WCHN	0	0	0	0	0	0	0
	MICHAEL DAGLIO	404,582.	145,000.	990.	15,300.	29,566.	595,438.	0
7	CHIEF OPER OFFICER (TO 11/2)	0	0	0	0	0	0	0
	MORRIS GROSS	255,758.	100,000.	5,182.	25,500.	26,103.	412,543.	0
8	VP OF FACILITIES/REAL ESTATE	0	0	6,180.	0	0	6,180.	0
	KATHLEEN A. DEMATTEO	343,359.	110,461.	21,373.	22,950.	9,324.	507,467.	0
9	CHIEF INFOR.OFFICER, WCHN	0	0	0	0	0	0	0
	PATRICK C. MINICUS	375,651.	100,000.	526.	0	45,461.	521,638.	0
10	VP OF FINANCE	45,622.	0	27,701.	2,376.	2,477.	78,176.	0
	JAMES VARRONE	0	0	0	0	0	0	0
11	VP SUPPLY CHAIN	159,641.	26,000.	0	9,019.	20,995.	215,655.	0
	LISA SCHMITTGALL	384,629.	339,262.	909.	0	27,824.	752,624.	0
12	SRVP STRATEGY-WCHN (TO 12/31)	38,097.	0	164.	1,722.	1,923.	41,906.	0
	DEBRA CARRAGHER	249,594.	75,000.	585.	12,750.	3,387.	341,316.	0
13	VP OF OPERATIONS	0	0	0	0	0	0	0
	CAROLYN MCKENNA	344,800.	125,000.	1,311.	12,750.	24,452.	508,313.	0
14	SR VP/GEN'L COUN	0	0	0	0	0	0	0
	RAMIN AHMADI, MD	259,797.	70,000.	960.	12,750.	29,377.	372,884.	0
15	DIR. OF EDUC./RES.	0	0	0	0	0	0	0
	DAWN MYLES	253,756.	80,000.	600.	17,850.	4,231.	356,437.	0
16	SRV, QUAL/PAT. SFTY	0	0	0	0	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.

SCHEDULE J, PART I, LINE #4

SEVERANCE: DURING THE FISCAL YEAR ENDING SEPTEMBER 30, 2015, LISA SCHMITTGALL RECEIVED \$597,184 IN SEVERANCE PAYMENTS. A SEVERANCE BENEFIT OF ONE AND A HALF (1 ½) YEARS OF COMPENSATION WAS PAID IN A LUMP SUM WITHIN 60 DAYS OF THE TERMINATION DATE OF DECEMBER 31, 2014.

SUPPLEMENTAL EXECUTIVE RETIREMENT PLANS: WESTERN CONNECTICUT HEALTH NETWORK (WCHN) ESTABLISHED THREE SEPARATE SUPPLEMENTAL EXECUTIVE RETIREMENT PLANS (SERP). THESE PLANS PROVIDE SUPPLEMENTAL RETIREMENT BENEFITS TO KEY MEMBERS OF THE EXECUTIVE GROUP. UNDER THE AGREEMENTS FOR SERP PLANS #1 AND #2, AMOUNTS PROMISED TO ELIGIBLE EXECUTIVES ARE BASED ON TARGETED RETIREMENT BENEFITS AND THE PAYMENT OF BENEFITS IS SUBJECT TO VESTING. THE BENEFITS AT THE VESTED AGE ARE PROVIDED IN THE FORM OF AN ACTUARIAL EQUIVALENT LUMP SUM PLUS A TAX GROSS-UP AMOUNT TO THE PARTICIPANTS.

WCHN HAS ON ITS BOOKS AN ACCRUAL FOR THE PARTICIPANTS OF THE SERP, WHICH IS MAINTAINED SOLELY FOR ACCOUNTING PURPOSES AND IS UNFUNDED.

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.

SERP PLAN #1 - DURING THE FISCAL YEAR ENDING SEPTEMBER 30, 2015, DR. MATTHEW MILLER, CHIEF MEDICAL OFFICER AND PHYLLIS ZAPPALA, FORMER SENIOR VP OF HUMAN RESOURCES WERE THE ONLY PARTICIPANTS. UNDER THE TERMS OF SERP PLAN #1, A PAYMENT OF \$350,006 WAS MADE TO PHYLLIS ZAPPALA DURING THE YEAR.

SERP PLAN #2 - DURING THE FISCAL YEAR ENDING SEPTEMBER 30, 2015, NO PAYMENTS WERE MADE TO EITHER, DR. JOHN MURPHY, PRESIDENT/CEO OF WCHN AND STEVEN H. ROSENBERG, CFO OF WCHN, PARTICIPANTS OF SERP PLAN #2.

SERP PLAN #3 - EARNINGS AND LOSSES ON THE INVESTMENTS SELECTED BY PARTICIPANTS OF SERP PLAN #3 ARE ADDED TO THE BALANCE OF THE ACCOUNT. DURING THE FISCAL YEAR ENDING SEPTEMBER 30, 2015, NO PAYMENTS WERE MADE TO EITHER DANIEL DEBARBA, JR., EXECUTIVE VP/PRESIDENT OF DANBURY HOSPITAL AND MICHAEL DAGLIO, CHIEF OPERATING OFFICER, PARTICIPANTS OF SERP #3.

SCHEDULE J, PART I, LINE #6

SUMMARY OF EXECUTIVE INCENTIVE PLAN

Part III Supplemental Information

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

THE PLAN IS ADMINISTERED BY THE EXECUTIVE COMPENSATION COMMITTEE (THE COMMITTEE) OF WESTERN CONNECTICUT HEALTH NETWORK, INC. (WCHN). ELIGIBILITY TO PARTICIPATE IN THE PLAN IS LIMITED TO THOSE EXEMPT EXECUTIVES EMPLOYED BY WCHN AND ITS SUBSIDIARIES (THE NETWORK) DURING THE PLAN YEAR WHO ARE IN POSITIONS IN WHICH THEIR DECISIONS, ACTIONS AND COUNSEL SIGNIFICANTLY AFFECT THE OPERATIONS OF THE NETWORK.

THE COMMITTEE, WITH INPUT PROVIDED BY SENIOR MANAGEMENT OF THE NETWORK WILL DETERMINE WHICH ELIGIBLE EXECUTIVE EMPLOYEES OF THE NETWORK WILL PARTICIPATE IN THE PLAN.

PRIOR TO THE BEGINNING OF EACH PLAN YEAR, OR AS SOON THEREAFTER AS PRACTICABLE, THE COMMITTEE WILL ESTABLISH TARGET AND MAXIMUM AWARD OPPORTUNITY FOR THE PARTICIPANT, IN THE APPROPRIATE TIER IN THE PLAN, ALONG WITH A TEAM SCORECARD OF PLAN MEASURES.

SOON AFTER THE CLOSE OF THE PLAN YEAR, ACTUAL ORGANIZATION AND INDIVIDUAL PERFORMANCE AND RESULTS WILL BE MEASURED AND ASSESSED IN COMPARISON TO

Part III Supplemental Information

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

PUBLISHED GOALS AND EXPECTATIONS ESTABLISHED FOR SUCH PLAN YEAR.

RECOMMENDATIONS FOR INDIVIDUAL INCENTIVE AWARDS WILL BE PREPARED AND

SUBMITTED TO THE COMMITTEE FOR EVALUATION AND APPROVAL.

NOTWITHSTANDING ANY OTHER PROVISION OF THE PLAN, AT THE DISCRETION OF THE

COMMITTEE, AWARDS MAY NOT BE PAID UNDER THE PLAN FOR ANY PLAN YEAR IF THE

LEVEL OF PERFORMANCE SPECIFIED IN ONE OR MORE NETWORK LEVEL "CIRCUIT

BREAKER GOALS" IS NOT ACHIEVED DURING THE PLAN YEAR.

SCHEDULE J, PART III, ADDITIONAL INFORMATION

THE ORGANIZATION RELIED ON A RELATED ORGANIZATION, WESTERN CONNECTICUT

HEALTH NETWORK, INC. WHICH USED THE FOLLOWING METHODS DESCRIBED BELOW TO

ESTABLISH TOP MANAGEMENT'S COMPENSATION:

-COMPENSATION COMMITTEE.

-INDEPENDENT COMPENSATION.

-WRITTEN EMPLOYMENT CONTRACT.

-COMPENSATION SURVEY OR STUDY.

-APPROVAL BY BOARD OR COMPENSATION COMMITTEE.

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

DANBURY 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 CHEFA REV. BONDS, SERIES H	06-0806186	20774DCL7	03/16/2006	40,924,665. SEE PART VI FOR PURPOSE			X		X		X
B CHEFA (WCHN), SERIES M	06-0806186	20774U8A6	07/13/2011	45,523,137. SEE PART VI FOR PURPOSE			X		X		X
C CHEFA (WCHN), SERIES N	06-0806186	20774YEJ2	11/22/2011	40,735,995. SEE PART VI FOR PURPOSE			X		X		X
D CHEFA (WCHN), SERIES O	06-0806186		05/08/2015	122,120,000. SEE PART VI FOR PURPOSE			X		X		X

Employer identification number
06-0646597

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

Supplemental Information on Tax-Exempt Bonds
Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

Attach to Form 990.

Part II Proceeds

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Amount of bonds retired		1,945,000.				2,795,000.		
2 Amount of bonds legally defeased								
3 Total proceeds of issue		42,742,900.		45,576,281.		40,735,995.		122,120,000.
4 Gross proceeds in reserve funds		2,237,472.		7,328,241.				
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds		606,787.		908,228.		749,768.		797,294.
8 Credit enhancement from proceeds		828,469.						
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds		39,070,172.		37,339,812.				
11 Other spent proceeds						39,986,227.		121,322,706.
12 Other unspent proceeds								
13 Year of substantial completion	2007		2014		2011		2015	

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

Part III Private Business Use

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

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

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X			X				X
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?	X			X				X
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?		X						
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 government0100	%			%		%
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 government0100	%			%		%
6 Total of lines 4 and 5		X		X				X
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 non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				X
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of			%			%		%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X			X			X	

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

Part IV Arbitrage (Continued)

Table with 4 main columns (A, B, C, D) and sub-columns (Yes, No). Rows include questions about guaranteed investment contracts, provider names, GIC terms, and regulatory safe harbors.

Part V Procedures To Undertake Corrective Action

Table with 4 main columns (A, B, C, D) and sub-columns (Yes, No). Row asks about written procedures to ensure federal tax requirements are met.

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

Series of horizontal lines for providing supplemental information.

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

SCHEDULE K, ADDITIONAL INFORMATION

SERIES H BONDS (\$41,560,000): PROCEEDS FROM THE SALES OF SERIES H BONDS WERE USED, TOGETHER WITH OTHER MONIES AVAILABLE TO 1) FINANCE A PORTION OF THE COSTS OF THE SERIES H PROJECT, 2) TO FUND CAPITALIZED INTEREST, IF ANY ON THE SERIES H BONDS, AND 3) TO PAY CERTAIN COSTS OF ISSUANCE AND BOND INSURANCE PREMIUMS INCURRED IN CONNECTION WITH THE ISSUANCE OF SERIES H BONDS.

SERIES M BONDS (\$46,030,000): SERIES M BONDS WERE ISSUED CONCURRENTLY IN 2011 WITH SERIES L BONDS AND WERE USED TO FUND THE PLANNING, DESIGN, ACQUISITION, CONSTRUCTION, EQUIPPING AND FURNISHING OF DANBURY HOSPITAL'S NEW PATIENT TOWER, EXPANSION OF A PARKING GARAGE, CAPITAL IMPROVEMENTS AND TO FUND CAPITALIZED INTEREST.

SERIES N BONDS (\$39,880,000): SERIES N BONDS MATURE SERIALY FROM JULY 1, 2014 TO JULY 1, 2029. THE PROCEEDS WERE USED TO REFUND DANBURY HOSPITAL'S SERIES G BONDS WHICH WERE ISSUED ON SEPTEMBER 29, 1999.

SERIES O BONDS (\$122,120,000): SERIES O BONDS MATURE SERIALY FROM JULY 1, 2022 TO JULY 1, 2041. THE PROCEEDS WERE USED TO REFUND DANBURY HOSPITAL'S SERIES K AND SERIES L BONDS WHICH WERE FULLY REDEEMED AS OF

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

SEPTEMBER 30, 2015.

PART II, LINE #3 INCLUDES INVESTMENT EARNINGS OF \$1,818,235 FOR SERIES H BONDS.

PART II, LINE #3 INCLUDES INVESTMENT EARNINGS OF \$53,144 FOR SERIES M BONDS.

PART IV, LINE #2C

THE DATE THAT THE REBATE COMPUTATION WAS PERFORMED WAS MARCH, 2014 FOR SERIES H BONDS.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2014

Department of the Treasury
Internal Revenue Service

▶ 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.

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

Open To Public Inspection

Name of the organization
DANBURY HOSPITAL

Employer identification number
06-0646597

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) 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.

1	(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.

1	(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)					

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) KAUFMAN HALL & ASSOCIATES	SEE PART V	397,546.	CONSULTING FIRM		X
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCHEDULE L, PART IV, COL (C)

DURING THE YEAR THE FOLLOWING TRANSACTIONS ARE AT ARM'S LENGTH, ENTERED INTO THE ORDINARY COURSE OF BUSINESS AND IN COMPLIANCE WITH THE ORGANIZATION'S CONFLICT OF INTEREST POLICY:

DAVID M. CYGANOWSKI, A DIRECTOR AT DANBURY HOSPITAL IS A SHAREHOLDER OF KAUFMAN HALL & ASSOCIATES, INC., WHICH PROVIDES FINANCIAL AND FORECASTING SERVICES.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

DANBURY 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

2014

**Open to Public
Inspection**

Employer identification number

06-0646597

FORM 990, PART VII (ADDT'L INFORMATION)

FOR THOSE OFFICERS AND TOP 5 EMPLOYEES, FOR WHICH ONLY 40 HOURS IS NOTED
TO REFLECT PAID HOURS, ACTUAL HOURS WORKED EXCEEDED THIS AMOUNT.

NOTE: ALL AMOUNTS IN COLUMN F, OF PART VII, "ESTIMATED AMOUNT OF OTHER
COMPENSATION", REPRESENT BENEFITS, AND DO NOT REFLECT ANY COMPENSATION
FOR WHICH THE AVERAGE AMOUNT OF TIME WORKED CAN BE REFLECTED.

FORM 990, PART IX, COLUMN D

ALTHOUGH CONTRIBUTIONS ARE REFLECTED ON LINE #1 OF PAGE #1 ON FORM 990,
ALL FUNDRAISING EXPENSES WERE INCURRED BY THE WESTERN CONNECTICUT HEALTH
NETWORK FOUNDATION, INC.

FORM 990, PART VI, LINE 7A

THE SOLE MEMBER SHALL BE RESPONSIBLE FOR ELECTING, AT THE ANNUAL MEETING
OF THE MEMBERSHIP, THE MEMBERS OF THE BOARD OF DIRECTORS OF THE HOSPITAL
TO SERVE FOR THREE YEAR TERMS AND UNTIL THEIR SUCCESSORS ARE ELECTED AND
HAVE QUALIFIED.

FORM 990, PART III

ON OCTOBER 1, 2014 (THE MERGER DATE), DANBURY HOSPITAL (THE HOSPITAL)
RECEIVED A SINGLE PROVIDER LICENSE TO INCLUDE THE NEW MILFORD HOSPITAL
INCORPORATED (NEW MILFORD HOSPITAL). AS A RESULT, NEW MILFORD HOSPITAL
MERGED WITH THE HOSPITAL AND THE OPERATIONS OF NEW MILFORD HOSPITAL

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

BECAME A CAMPUS OF DANBURY HOSPITAL EFFECTIVE OCTOBER 1, 2014. THE HOSPITAL WILL OPERATE AS ONE LICENSED FACILITY WITH TWO CAMPUSES.

FORM 990, PART VI, SECTION B, 12A, 13 AND 14

THE POLICIES EXIST AT THE PARENT LEVEL, WHICH ARE FOLLOWED BY EACH ENTITY AND ARE APPROVED BY THE PARENT BOARD, BUT NOT EACH INDIVIDUAL BOARD. THIS EXCLUDES THE RECORD RETENTION POLICY, WHICH IS APPROVED ONLY BY THE PARENT AUDIT COMMITTEE.

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

MEDICAL SERVICE LINE

DANBURY HOSPITAL'S MEDICAL SERVICE LINE CONSISTS OF THE FOLLOWING SERVICES:

INPATIENT CASES:

GASTROINTESTINAL	1,925
INFECTIOUS DISEASE	1,199
INTERNAL MEDICINE	651
NEUROLOGY MEDICINE	509
RENAL/UROLOGY MEDICINE	802
PULMONARY MEDICINE	1,435
ALL OTHER INPATIENT	1,917

OUTPATIENT SERVICE LINE CASES:

O/P MEDICINE	9,685
--------------	-------

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

O/P MEDICINE COMM. CLINIC 31,667

O/P MEDICAL ONCOLOGY 10,448

O/P PULMONARY MEDICINE 5,125

DIGESTIVE DISEASES:

OUR DIGESTIVE DISEASE CENTER IS STAFFED BY RENOWNED FELLOWSHIP-TRAINED GASTROENTEROLOGISTS. WE USE ADVANCED DIAGNOSTIC AND TREATMENT TECHNOLOGY IN A COMPASSIONATE AND SUPPORTIVE MANNER. THE FOLLOWING SERVICES ARE PROVIDED: ABLATION THERAPY FOR BARRETT'S ESOPHAGUS, COLON CANCER SCREENING, COLONOSCOPY, CRYOTHERAPY, ENDOSCOPY, ENDOSCOPIC ULTRASOUND AND FINE-NEEDLE ASPIRATION,, LACTOSE TOLERANCE TESTING, LINX REFLUX MANAGEMENT SYSTEM FOR TREATMENT OF GERD, WIRELESS CAPSULE ENDOSCOPY AND LAPAROSCOPIC FUNDOPLICATION FOR GERD.

INFECTIOUS DISEASE:

DANBURY HOSPITAL'S INFECTIOUS DISEASE SPECIALISTS TREAT THE FULL RANGE OF INFECTIOUS DISEASES, INCLUDING CONDITIONS CAUSED BY LIVING ORGANISMS (BACTERIA, VIRUSES, FUNGI AND PARASITES), HIV, AND RELATED CONDITIONS, LYME DISEASE, CHRONIC AND WOUND-RELATED INFECTION, AND TRAVEL-RELATED INFECTION. OUR DOCTORS HAVE EXPERTISE IN THE PROPER USE OF ANTIBIOTICS AND OTHER ANTI-INFECTIVE MEDICINES TO TREAT DISEASE AND ALSO COLLABORATE WITH PRIMARY CARE DOCTORS, SPECIALISTS AND SURGEONS TO PROVIDE INDIVIDUALIZED TREATMENT FOR EACH PATIENT.

INTERNAL MEDICINE:

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

WHATEVER YOUR MEDICAL NEEDS, DANBURY HOSPITAL PROVIDES EXPERT CARE IN THE WARM, FOCUSED AND PERSONAL MANNER YOU DESERVE. SPECIALISTS IN PRIMARY CARE, OUR FAMILY MEDICINE PHYSICIANS TREAT INFANTS, CHILDREN AND ADULTS OF ALL AGES. SERVICES INCLUDE PREVENTIVE MEDICINE (INCLUDING VACCINES AND IMMUNIZATIONS), DIAGNOSIS AND TREATMENT OF CHRONIC AND ACUTE ILLNESSES AND INJURIES, AND COORDINATION OF SPECIALTY CARE. OUR FAMILY PHYSICIANS ARE TRAINED TO PROVIDE MEDICAL CARE FOR PATIENTS RANGING IN AGE FROM PEDIATRICS THROUGH ADULT AND GERIATRICS.

NEUROLOGY AND STROKE:

WE OFFER EXPERTISE IN TREATMENT OF NEUROLOGICAL DISORDERS, INCLUDING STROKE, EPILEPSY, HEADACHE, PARKINSON'S DISEASE, ALZHEIMER'S DISEASE AND VERTIGO. ONE OF THE NATION'S FIRST HOSPITALS TO EARN PRIMARY STROKE CENTER ACCREDITATION FROM THE JOINT COMMISSION, WE HAVE BEEN REGULARLY RECOGNIZED BY THE CONNECTICUT DEPARTMENT OF PUBLIC HEALTH FOR CONSISTENTLY DEMONSTRATING THE ABILITY TO RAPIDLY DIAGNOSE AND TREAT STROKE. COMMITTED TO REMAINING ON THE FOREFRONT OF RAPID AND EFFECTIVE STROKE CARE, WE CONTINUE TO INCORPORATE THE LATEST EFFECTIVE TREATMENTS.

UROLOGY:

OUR EXPERT UROLOGISTS TREAT CONDITIONS SUCH AS:

- FEMALE UROLOGIC DISORDERS, INCLUDING URINARY INCONTINENCE AND VOIDING DYSFUNCTION
- INFERTILITY
- KIDNEY, BLADDER, PROSTATE AND TESTICULAR CANCER

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

-KIDNEY STONES

-MALE SEXUAL DIFFICULTIES

-PROSTATE CANCER

-URINARY TRACT INFECTIONS

-VASECTOMY AND VASECTOMY REVERSAL

PROCEDURES WE PERFORM INCLUDE:

-EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY FOR KIDNEY STONES

-LAPAROSCOPIC NEPHRECTOMY

-MINIMALLY INVASIVE PHOTO-VAPORIZATION OF THE PROSTATE

-MINIMALLY INVASIVE SURGICAL TREATMENT FOR FEMALE INCONTINENCE

-PYELOPLASTY

PULMONOLOGY:

WE OFFER OUTSTANDING DIAGNOSIS, TREATMENT AND CARE FOR PATIENTS WITH ALL TYPES OF PULMONARY CONDITIONS. WE PERFORM SPECIALIZED SERVICES, SUCH AS CARDIOPULMONARY EXERCISE TESTING TO MEASURE DEGREE OF FITNESS AND AID IN THE ASSESSMENT OF SHORTNESS OF BREATH; SPECIFIC DIAGNOSTIC ASTHMA TESTING; AND TESTING TO DETERMINE THE NEED FOR SUPPLEMENTAL OXYGEN FOR EVERYDAY LIVING AND AIR TRAVEL.

ALL PROGRAMS ARE ADMINISTERED CONSISTENT WITH DANBURY HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

FORM 990, PART III - PROGRAM SERVICE, LINE 4B

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

SURGERY SERVICE LINE

INPATIENT CASES:

MAJOR JOINT REPLACEMENT	1,078
TRAUMA SURGERY	568
MINOR GI SURGERY	267
GENERAL SURGERY	325
UROLOGY SURGERY	158
COLON/BOWEL SURGERY	236
OBESITY SURGERY	164
SPINAL SURGERY	398
ALL OTHER INPATIENT SURGERY	571

OUTPATIENT SERVICE LINE CASES:

ABDOMEN GI SURGERY	1,426
BREAST SURGERY-NON PLASTIC	260
ENDOSCOPY	12,933
MISC. GENERAL SURGERY	3,765
ORAL SURGERY	111
OPHTHAMOLOGY	766
UROLOGY	988
PAIN INJECTION PROCEDURES	701
HEAD/NECK SURGERY	1,139
PLASTIC SURGERY	1,071
ALL OTHER OUTPATIENT SURGERY	1,342

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

GENERAL SURGERY:

DANBURY HOSPITAL'S SURGEONS ARE CONTINUALLY RECOGNIZED FOR THEIR EXPERIENCE, EXCELLENT OUTCOMES, AND EXPERTISE IN MINIMALLY INVASIVE SURGICAL TECHNIQUES. HERE ARE JUST SOME OF THE AWARDS WE'VE BEEN PRIVILEGED TO RECEIVE:

-INTERSOCIETAL ACCREDITATION COMMISSION'S VEIN CENTER ACCREDITATION FOR THE VASCULAR SURGICAL SERVICE (2015)

-PARTICIPANT, INSTITUTE FOR HEALTHCARE IMPROVEMENTS INTERNATIONAL JOINT REPLACEMENT LEARNING COMMUNITY (2014)

-MEMBER, INSTITUTE FOR HEALTHCARE IMPROVEMENT'S INTERNATIONAL JOINT REPLACEMENT LEARNING COMMUNITY (2015)

-JOINT COMMISSION TOP PERFORMER, AMERICA'S IMPROVING QUALITY AND SAFETY (2014/13)

-TOP 100 COMMUNITY VALUE LEADERSHIP AWARD FOR PROVIDING HIGH-QUALITY, HIGH-VALUE SERVICE AT AN APPROPRIATE COST, FROM CLEVERLY AND ASSOCIATES (2014)

-TOP 100 GREAT COMMUNITY HOSPITALS FROM BECKER'S HOSPITAL REVIEW (2012)

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

-RECERTIFICATION, JOINT COMMISSION DISEASE SPECIFIC CERTIFICATION IN HIP
ARTHROPLASTY, KNEE ARTHROPLASTY AND SPINE SURGERY (2015)

-THE CENTER FOR WEIGHT LOSS SURGERY HAS BEEN NAMED THE COMPREHENSIVE
CENTER WITH THE METABOLIC AND BARIATRIC SURGERY ACCREDITATION AND QUALITY
IMPROVEMENT PROGRAM (MBSAQIP) (2015 - 2018)

-A BARIATRIC CENTER FOR EXCELLENCE UNDER THE CLINICAL SCIENCE INSTITUTE
(CSI) OF OPTUM (2015)

-RECIPIENT OF THE AETNA INSTITUTE OF QUALITY BARIATRIC DESIGNATION
(2015)

AT DANBURY HOSPITAL OUR EXPERT SURGEONS EXCEL AT USING ADVANCED
TECHNOLOGY TO PERFORM MINIMALLY INVASIVE PROCEDURES, ALLOWING PATIENTS TO
UNDERGO SURGERY WITH LESS PAIN, SHORTER HOSPITAL STAYS, AND QUICKER
RECOVERY PERIODS. SURGEONS USE VERY SMALL INCISIONS, MEANING LESS TRAUMA
TO THE BODY, LESS BLOOD LOSS, SMALLER SCARS AND A LOWER NEED FOR PAIN
MEDICATION. OUR SURGEONS HAVE BEEN RECOGNIZED FOR EXCELLENCE IN
LAPAROSCOPIC TECHNIQUES PERFORMED IN MANY SURGICAL SPECIALTIES INCLUDING
WEIGHT LOSS, COLORECTAL, AND GENERAL SURGICAL PROCEDURES.

FOR ROBOTIC SURGERY, WE USE THE LATEST, MOST ADVANCED ROBOTIC TECHNOLOGY
AVAILABLE, THE DA VINCI SURGICAL SYSTEM. WE ARE COMMITTED TO STAYING AT
THE FOREFRONT OF INNOVATION, EQUIPPING OUR SURGEONS WITH SOPHISTICATED

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

TECHNOLOGY SO THEY CAN OFFER INNOVATIVE SURGICAL PROCEDURES HERE IN OUR COMMUNITY. OUR DA VINCI SURGICAL SYSTEM GIVES SURGEONS BETTER VISUALIZATION AND TOOLS THAT IMPROVE DEXTERITY. WITH MORE CONTROL THEY CAN OPERATE WITH GREATER PRECISION. OUR DOCTORS USE THIS ADVANCED TECHNOLOGY TO PERFORM A WIDE RANGE OF PROCEDURES, INCLUDING SINGLE-INCISION ROBOTIC SURGERY.

AS A LEVEL II TRAUMA CENTER, DANBURY HOSPITAL'S TEAM OF BOARD CERTIFIED SURGEONS PROVIDE IMMEDIATE, 24/7 CARE FOR ACUTE AND LIFE-THREATENING INJURIES TO CHILDREN AND ADULTS.

ORTHOPEDIC SURGERY:

OUR CENTER FOR ADVANCED ORTHOPEDIC AND SPINE CARE HAS EARNED THE "CENTER OF EXCELLENCE" DESIGNATION FROM THE JOINT COMMISSION FOR PROVIDING COMPREHENSIVE, MULTIDISCIPLINARY CARE, INCLUDING HIP, KNEE, SHOULDER, AND ANKLE REPLACEMENT.

OUR DANBURY HOSPITAL ORTHOPEDIC SURGEONS OFFER A WIDE ARRAY OF JOINT REPLACEMENT PROCEDURES. OUR CONTINUUM OF CARE INCLUDES:

-A CARE COORDINATOR WHO PROVIDES EDUCATION AND GUIDANCE EVERY STEP OF THE WAY, PRE-OP THROUGH YOUR REHABILITATION.

-PRE-ADMISSION TESTING IN OUR DEDICATED UNIT, DESIGNED TO MEET THE UNIQUE NEEDS OF JOINT REPLACEMENT PATIENTS AND FAMILIES. SERVICES INCLUDE

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

INDIVIDUALIZED PATIENT EDUCATION, NURSING AND ANESTHESIA ASSESSMENTS, AND COLLABORATION WITH YOU ON PLANNING A PAIN MANAGEMENT PROGRAM FOR YOUR SURGICAL RECOVERY.

-DEDICATED ORTHOPEDIC OPERATING ROOMS AND CLINICAL SUPPORT STAFF.

-A COMFORTABLE ORTHOPEDIC RECOVERY UNIT WITH PHYSICIAN ASSISTANTS, NURSING AND REHABILITATION STAFF SPECIALLY TRAINED TO CARE FOR TOTAL JOINT REPLACEMENT PATIENTS.

-ADVANCED, DIGITAL DIAGNOSTIC IMAGING TECHNOLOGY.

-ACUTE IN-HOSPITAL THERAPY

-OUTPATIENT PHYSICAL AND OCCUPATIONAL

-ACCESS TO HOME CARE SERVICES WITH WESTERN CONNECTICUT HOME CARE (FORMERLY DVNA).

DIGESTIVE DISEASE:

OUR EXPERT GENERAL AND DIGESTIVE DISEASE SURGEONS SPECIALIZE IN MAJOR AND MINOR SURGICAL PROCEDURES OF THE ABDOMEN, DIGESTIVE TRACT, ENDOCRINE SYSTEM, BREASTS, SKIN AND BLOOD VESSELS.

UROLOGIC SURGERY:

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

DANBURY HOSPITAL UROLOGISTS ARE KNOWN NATIONALLY FOR INNOVATION.

PROCEDURES PERFORMED INCLUDE: EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY FOR KIDNEY STONES; LAPAROSCOPIC NEPHRECTOMY, MINIMALLY INVASIVE PHOTO-VAPORIZATION OF THE PROSTATE; MINIMALLY INVASIVE SURGICAL TREATMENT FOR FEMALE INCONTINENCE AND PYELOPLASTY. DANBURY HOSPITAL'S COLON AND RECTAL SURGEONS TREAT A VARIETY OF ANORECTAL CONDITIONS USING SURGICAL INTERVENTION.

BARIATRIC/WEIGHT LOSS SURGERY:

DANBURY HOSPITAL HAS A LONGSTANDING REPUTATION FOR EXCELLENCE AND INNOVATION IN BARIATRIC SURGERY. WE WERE AMONG THE FIRST HOSPITALS IN CONNECTICUT TO RECEIVE 1A ACCREDITATION FROM THE AMERICAN COLLEGE OF SURGEONS, BARIATRIC SURGERY NETWORK. OUR EXPERT TEAM OF SURGEONS, NURSES, DIETITIANS, PSYCHOLOGISTS AND SPECIALLY TRAINED STAFF PROVIDE ENCOURAGEMENT AND SUPPORT EVERY STEP OF THE WAY.

NEUROSURGERY:

BOARD-CERTIFIED NEUROSURGEONS DIAGNOSE AND TREAT DISORDERS THAT AFFECT ANY PORTION OF THE NERVOUS SYSTEM, INCLUDING THE BRAIN, SPINAL CORD AND ITS SURROUNDING STRUCTURES AND THE PERIPHERAL NERVES. CONDITIONS INCLUDE BRAIN ANEURYSMS, CEREBRAL ANEURYSMS, CHRONIC SUBDURAL HEMATOMA, COMA, CONCUSSIONS, DEGENERATIVE DISC DISEASE, DISC HERNIATION, EPILEPSY, HEAD TRAUMA, SEIZURES, SPINAL COMPRESSION FRACTURES, SPINAL CORD INJURY, SPINAL CORD TUMORS, STENOSIS, STROKE, AND TORTICOLLIS.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

ACCREDITATION TO THE PRAXAIR CANCER CENTER, AMERICAN COLLEGE OF SURGEONS
COMMISSION ON CANCER, 2015.

ALL PROGRAMS ARE ADMINISTERED CONSISTENT WITH DANBURY HOSPITAL'S
FINANCIAL ASSISTANCE POLICY.

FORM 990, PART III - PROGRAM SERVICE, LINE 4C

CARDIOVASCULAR SERVICES

DANBURY HOSPITAL'S CARDIOVASCULAR SERVICE LINE CONSISTS OF THE FOLLOWING
SERVICES:

INPATIENT CASES:

CARDIAC MEDICINE	1,411
CARDIAC SURGERY	206
CARDIAC PCI MEDICINE	285
CARDIAC VASCULAR SURGERY	711
ALL OTHER INPATIENT CARDIOVASCULAR SERVS.	365

OUTPATIENT SERVICE LINE CASES:

ANTICOAGULATION CLINIC	13,012
CARDIAC DIAGNOSTIC CLINIC	10,075
NON INVASIVE VASCULAR LAB	7,228
CARDIAC REHABILITATION	3,922
ALL OTHER OUTPATIENT CARDIOVASCULAR SERVS.	7,924

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

DANBURY HOSPITAL OFFERS A PREMIER CARDIOVASCULAR PROGRAM TO MEET THE NEEDS OF PATIENTS WITH CARDIAC AND VASCULAR PROBLEMS. LED BY A SPECIALIST TEAM OF CARDIOLOGISTS, INTERVENTIONAL CARDIOLOGISTS AND VASCULAR SURGEONS, THIS PROGRAM HAS ACHIEVED WIDE ACCLAIM FOR PROVIDING LEADING-EDGE PREVENTION, DIAGNOSIS, TREATMENT AND REHABILITATION OF CARDIOVASCULAR DISEASE. AT DANBURY HOSPITAL'S PRAXAIR CENTER, WE PROVIDE EXPERT, COLLABORATIVE, MULTIDISCIPLINARY CARE, INPATIENT AND OUTPATIENT, FOR THE FULL RANGE OF CARDIOVASCULAR CONDITIONS, INCLUDING THOSE THAT AFFECT THE HEART, HEART VALVES AND THE VASCULAR SYSTEM. WE OFFER THE FULL SPECTRUM OF ADVANCED TREATMENTS AND PROCEDURES FOR CARDIOVASCULAR DISEASE IN THE AREAS OF:

- GENERAL CARDIOLOGY
- CARDIAC SURGERY
- VASCULAR SURGERY
- INTERVENTIONAL CARDIOLOGY
- ELECTROPHYSIOLOGY
- STRUCTURAL HEART

COMMON HEART & VASCULAR CONDITIONS WE TREAT:

- ATRIAL FIBRILLATION (IRREGULAR HEARTBEAT)
- CONGESTIVE HEART FAILURE
- HEART ATTACK
- CHEST PAIN

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

-CORONARY ARTERY DISEASE

-PERIPHERAL ARTERY DISEASE

OUR EXPERT PHYSICIANS, ADVANCED PRACTICE PROVIDERS, NURSES AND SUPPORT STAFF ARE SERIOUS ABOUT THEIR ROLE IN SUPPORTING THE HEART HEALTH OF EVERYONE IN OUR COMMUNITY. WHETHER FOR SCREENING, DIAGNOSTIC TESTS OR TREATMENT FOR A HEART OR VALVE CONDITION, WE PROVIDE COMPASSIONATE CARE THAT IS PERSONALIZED TO YOUR NEEDS.

DIAGNOSTICS AND TESTS WE OFFER INCLUDE:

-ANGIOGRAM

-CORONARY ANGIOGRAPHY

-DIAGNOSTIC ELECTROPHYSIOLOGY STUDIES (EPS)

-ECHOCARDIOGRAM

-HOLTER MONITOR

-STRESS TESTS

HEART AND VASCULAR TREATMENTS AND PROCEDURES

AMONG THE ADVANCED TREATMENTS AND PROCEDURES WE PROVIDE ARE:

-ABDOMINAL AORTIC ANEURYSM (AAA) SURGERY

-ANGIOPLASTY

-AORTIC VALVE REPLACEMENT

-CARDIOVERSION

-CATHETER ABLATION

-DEEP VEIN THROMBOSIS (DVT) THERAPY

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

- HEART BYPASS SURGERY
- HYBRID CONVERGENT PROCEDURE FOR ATRIAL FIBRILLATION (AFIB)
- MITRAL VALVE REPAIR/REPLACEMENT
- OPEN HEART SURGERY
- PACEMAKER AND ICD PLACEMENT
- STENT PLACEMENT
- TAVR
- THORACIC AORTIC ANEURYSM SURGERY, OPEN

AWARDS & ACCREDITATIONS

AT DANBURY HOSPITAL, OUR CARDIOVASCULAR PREVENTION, DIAGNOSIS, TREATMENT AND REHABILITATION STAFF AND PROGRAMS ARE HONORED TO HAVE EARNED THE FOLLOWING NATIONAL RECOGNITIONS AND AWARDS:

- CHEST PAIN CENTER ACCREDITATION* FROM THE SOCIETY OF CARDIOVASCULAR PATIENT CARE
- MISSION LIFELINE - EMS AWARD, AMERICAN HEART ASSOCIATION (2014)
- RE-ACCREDITATION - ECHOCARDIOGRAPHY, INTERSOCIETAL ACCREDITATIONS COMMISSION (IAC) (2014 - 2017)
- RE-ACCREDITATION - NUCLEAR MEDICINE, AMERICAN COLLEGE OF RADIOLOGY (2015 - 2018)
- ACCREDITATION FROM THE VASCULAR SURGERY VEIN CENTER, INTERSOCIETAL ACCREDITATION COMMISSION

ALL PROGRAMS ARE ADMINISTERED CONSISTENT WITH DANBURY HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

FORM 990, PART III, LINE 4D - OTHER PROGRAM SERVICES

AT DANBURY HOSPITAL DURING FYE2015, APPROXIMATELY 21,000 DISCHARGES AND 70,000 EMERGENCY ROOM VISITS OCCURRED.

EMERGENCY SERVICES:

EMERGENCY SERVICES - DANBURY HOSPITAL PROVIDES A COMPREHENSIVE RANGE OF HIGH-QUALITY EMERGENCY MEDICAL SERVICES, FOR THE MOST CRITICALLY ILL AND INJURED PATIENTS, FROM PRE-HOSPITAL EMS/PARAMEDIC SERVICES TO AN EMERGENCY DEPARTMENT FEATURING A LEVEL II TRAUMA CENTER TO A NATIONALLY RECOGNIZED CRITICAL CARE UNIT. OUR EMERGENCY DEPARTMENT FEATURES MODERN LIFESAVING TECHNOLOGY AND IS STAFFED BY BOARD-CERTIFIED PHYSICIANS AND EXPERIENCED NURSES WITH ADVANCED SKILLS. FOR PATIENTS EXPERIENCING A STROKE, DANBURY HOSPITAL IS CERTIFIED AS A STROKE CENTER BY THE JOINT COMMISSION. FOR PATIENTS EXPERIENCING AN ACUTE HEART ATTACK, DANBURY HOSPITAL IS CERTIFIED AS A PRIMARY ANGIOPLASTY CENTER. ONCE IDENTIFIED AS A CANDIDATE BY EMS OR BY THE EMERGENCY PHYSICIAN, A CRITICAL PATHWAY ENSURES THE RAPID EVALUATION OF THE PATIENT AND MOVEMENT TO THE CARDIAC CATH LAB FOR DEFINITIVE CARE TO MINIMIZE LONG-TERM CONSEQUENCES. IF NEEDED, IT'S COMFORTING TO KNOW THAT DANBURY HOSPITAL'S MARY ELLEN AND SAMUEL KLEIN, MD CRITICAL CARE UNIT HAS BEEN NATIONALLY RECOGNIZED FOR PROVIDING AN EXEMPLARY LEVEL OF CARE. WE ARE "LEAPFROG COMPLIANT," AN ELITE RANKING ACHIEVED BY APPROXIMATELY 15% OF THE NATION'S HOSPITALS; IN

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

RECENT YEARS, WE'VE ALSO EARNED THE BEACON AWARD FOR CRITICAL CARE EXCELLENCE BY THE AMERICAN ASSOCIATION OF CRITICAL CARE NURSES THREE TIMES.

AS A LEVEL II TRAUMA CENTER ACCREDITED BY THE AMERICAN COLLEGE OF SURGEONS, DANBURY HOSPITAL OFFERS EXPERT 24/7 CARE BY TRAUMA SPECIALISTS, INCLUDING TRAUMA SURGEONS AND EMERGENCY PHYSICIANS. WE HAVE BEEN RECOGNIZED FOR THE QUALITY OF OUR CARE ON MULTIPLE LEVELS, INCLUDING OUR CONSISTENTLY QUICK RESPONSE TIME, THE COMMITMENT OF OUR PHYSICIANS AND THE MULTIDISCIPLINARY CARE PROVIDED BY OUR NURSING STAFF.

WOMEN AND CHILDREN'S SERVICE

OUR WOMENS AND CHILDREN'S SERVICES FEATURES A TOP NOTCH TEAM OF OBSTETRICIANS, GYNECOLOGIST, PEDIATRICIANS, CERTIFIED MIDWIVES, PEDIATRIC HOSPITALISTS, NEONATOLOGISTS, PEDIATRIC SPECIALISTS, PHYSICIAN ASSISTANTS AND NURSES. OUR OBSTETRICIANS AND CERTIFIED NURSE MIDWIVES DELIVER BABIES IN THE HOSPITAL'S MODERN, HOME-LIKE CHILD BIRTH CENTER. THE CENTER FEATURES IN-SUITE AMENITIES, INCLUDING PRIVATE ROOMS, MASSAGE THERAPY FOR INFANTS AND MOTHERS AND WIRELESS INTERNET ACCESS. IN ADDITION ADVANCES, MINIMALLY INVASIVE ROBOTIC SURGERY FOR SEVERAL GYNECOLOGIC PROCEDURES, INCLUDING HYSTERECTOMIES, FIBROID REMOVAL, VAGINAL PROLAPSE CORRECTION, TO STOP MENORRHAGIA AND TO TREAT CERTAIN FORMS OF CERVICAL AND UTERINE CANCERS, ARE AVAILABLE AT THE HOSPITAL.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

AT DANBURY HOSPITAL, WE UNDERSTAND THAT A CHILD IS LIFE'S MOST PRECIOUS GIFT. NO PARENT SHOULD FEEL THE NEED TO CHOOSE BETWEEN EXPERT MEDICAL CARE AND A WARM, SUPPORTIVE, COMMUNITY ENVIRONMENT. WE ARE COMMITTED TO PROVIDING EXCEPTIONAL CARE IN A TENDER, LOVING MANNER TO THE CHILDREN OF OUR COMMUNITY.

FOR CHILDREN WHO NEED HOSPITAL CARE, OUR CHILD-FRIENDLY PEDIATRIC UNIT OFFERS A VARIETY OF SUPPORTS TO MAKE YOUR CHILD'S STAY AS COMFORTABLE AS POSSIBLE FOR BOTH OF YOU. AND MANY CHILDREN REQUIRE THE CARE OF A SPECIALIST AT ONE POINT OR ANOTHER; WE MAKE IT EASIER BY BRINGING EXCELLENT PEDIATRIC SPECIALTY SERVICES INTO ONE CONVENIENT LOCATION AT OUR CHILDREN'S HEALTH AND WELLNESS CENTER.

THE CHILDREN'S HEALTH AND WELLNESS CENTER IS A CHILD-FRIENDLY, INTERACTIVE ENVIRONMENT FOR WELLNESS AND HEALING. WITH YOUR CONVENIENCE IN MIND, WE OFFER A VARIETY OF PEDIATRIC SPECIALTY SERVICES IN ONE LOCATION.

AT DANBURY HOSPITAL WE ARE PROUD TO PROVIDE ADVANCED SUPPORT IN OUR LEVEL IIIB SPRATT FAMILY NEONATAL INTENSIVE CARE UNIT (NICU), STAFFED 24/7 BY EXPERIENCED NEONATOLOGISTS AND NICU NURSES.

WITH ADVANCED DIAGNOSTIC IMAGING AND A FULL STAFF OF PEDIATRIC SPECIALISTS, WE'RE PREPARED TO "EXPECT THE UNEXPECTED".

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

BEHAVIORIAL AND MENTAL HEALTH:

DANBURY HOSPITAL OFFERS INPATIENT PSYCHIATRIC CARE FOR ADULT AND GERIATRIC PATIENTS. OUR CRISIS INTERVENTION TEAM PROVIDES ACUTE PSYCHIATRIC AND BEHAVIORAL INTERVENTION FOR PATIENTS IN THE EMERGENCY DEPARTMENT. WE TREAT ADULT PATIENTS WITH THE FOLLOWING CONDITIONS:

- BIPOLAR DISORDER
- DEPRESSION
- ANXIETY
- PSYCHOTIC DISORDERS
- DUAL DIAGNOSES (MENTAL ILLNESS AND ADDICTION)

WE PROVIDE EXPERT, SUPPORTIVE CARE FOR HOSPITALIZED PATIENTS WITH MEDICAL/SURGICAL NEEDS AND ACCOMPANYING PSYCHIATRIC ILLNESS, DUAL-DIAGNOSIS (MENTAL ILLNESS, PLUS ADDICTION TO DRUGS OR ALCOHOL) OR WHO REQUIRE DETOXIFICATION.

OUR PSYCHIATRIC INPATIENT MULTIDISCIPLINARY TEAM INCLUDES PHYSICIAN-PSYCHIATRISTS, ADVANCED PRACTICE PSYCHIATRIC NURSES, SOCIAL WORKERS, ACTIVITY THERAPISTS, EXPERIENCED PSYCHIATRIC RNS AND SUPPORT STAFF. THE INPATIENT UNIT OFFERS A VARIETY OF SERVICES AIMED TO STABILIZE ACUTE PSYCHIATRIC SYMPTOMS.

RADIOLOGY/IMAGING:

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

DANBURY HOSPITAL IS KNOWN FOR EXCELLENCE IN IMAGING SERVICES. WE ARE PROUD OF OUR BOARD-CERTIFIED RADIOLOGISTS, ADVANCED TECHNOLOGY, AND MULTIPLE CONVENIENT LOCATIONS. OUR SERVICES INCLUDE MRI, SCANS, MAMMOGRAMS, X-RAYS, AND SPECIALIZED TECHNOLOGY FOR CARDIOVASCULAR AND CANCER DIAGNOSIS AND TREATMENT. DANBURY HOSPITAL OFFERS A VARIETY OF RADIOLOGY SERVICES INCLUDING, CT, PET/CT, CT LUNG SCREENING, VIRTUAL COLONOSCOPY, MRI AND OPEN MRI, ULTRASOUND, BONE DENSITY MEASUREMENT/OSTEOPOROSIS SCREENING, GENERAL XRAY, DIGITAL MAMMOGRAPHY, DIGITAL BREAST, BREAST MRI AND ULTRASOUND, STEREOTACTIC, MRI-GUIDED AND ULTRASOUND GUIDED BREAST BIOPSY, NUCLEAR MEDICINE, INTERVENTIONAL RADIOLOGY, CRYOABLATION, IMAGE-GUIDED BIOPSY, AND INTERVENTIONAL RADIOLOGY.

PATHOLOGY AND LABORATORY SERVICES:

DANBURY HOSPITAL'S DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE IS FOCUSED ON OPERATIONAL PROFICIENCY TO ASSURE THE ACCURACY AND QUALITY OF EVERY TEST.

DIRECTED BY FOUR BOARD-CERTIFIED PATHOLOGISTS WHO ARE ASSISTED BY MORE THAN A DOZEN CERTIFIED MEDICAL LABORATORY SCIENTISTS AND SUPPORTED BY A LARGE TEAM OF LABORATORY PROFESSIONALS, OUR LAB IS CLIA CERTIFIED (CLINICAL LABORATORY IMPROVEMENT AMENDMENTS). THE STATE OF CONNECTICUT HAS LICENSED US AS HIGH COMPLEXITY, MEANING WE ARE QUALIFIED TO PERFORM

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

NON-AUTOMATED TESTS THAT REQUIRE MULTIPLE STEPS AND A HIGH-LEVEL OF TRAINING AND CARE.

WE ARE PROUD OF OUR CERTIFICATIONS AND ACCREDITATIONS AND WILLINGLY PARTICIPATE IN UNANNOUNCED INSPECTIONS, ROUTINELY RECEIVING THE HIGHEST RATINGS. IN FACT, AS PART OF OUR QUALITY ASSURANCE PROCESS, WE PARTICIPATE IN RANDOM PROFICIENCY TEST SURVEYS FROM VARIOUS OUTSIDE AGENCIES TO CONSISTENTLY MEASURE AND EVALUATE THE PERFORMANCE OF OUR TESTING STAFF.

QUALIFICATIONS AND ACCREDITATIONS

OUR LABORATORY IS ACCREDITED BY CLIA (LICENSE #07D0101031), CAP (LICENSE #11931-01), CT STATE (LICENSE #HP0206), AABB AND NEW YORK STATE (LICENSE #3327 80700470). DANBURY HOSPITAL PARTICIPATES IN RANDOM UNANNOUNCED INSPECTIONS BY THESE AGENCIES AND ALWAYS RECEIVES THE HIGHEST SCORES. THE LABORATORY ALSO PARTICIPATES IN PROFICIENCY SURVEYS, WHICH ENSURE QUALITY RESULTS ARE ACHIEVED BY ALL TECHNOLOGISTS.

TEACHING:

DANBURY HOSPITAL IS PART OF A PREMIER PATIENT-CENTERED SYSTEM OF CARE DEDICATED TO IMPROVING THE HEALTH AND WELL-BEING OF OUR PATIENTS AND THE SURROUNDING COMMUNITIES OF WESTERN CONNECTICUT AND NEARBY NEW YORK STATE. AS A REGIONAL MEDICAL CENTER AND UNIVERSITY TEACHING HOSPITAL AFFILIATED

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

WITH THE UNIVERSITY OF VERMONT COLLEGE OF MEDICINE AND YALE UNIVERSITY SCHOOL OF MEDICINE, DANBURY HOSPITAL PROVIDES A DYNAMIC ENVIRONMENT FOR TEACHING AND RESEARCH FOR OUR GRADUATE MEDICAL EDUCATION TRAINING PROGRAMS. THE HOSPITAL RECEIVED ACCREDITATION WITH COMMENDATION FROM THE JOINT COMMISSION, AND IS APPROVED TO SPONSOR RESIDENCY/FELLOWSHIP PROGRAMS BY THE ACCREDITATION COUNCIL OF GRADUATE MEDICAL EDUCATION. DANBURY HOSPITAL SPONSORS RESIDENCY TRAINING IN INTERNAL MEDICINE, PRIMARY CARE, OBSTETRICS AND GYNECOLOGY, SURGERY, PATHOLOGY, DENTISTRY, AND A FELLOWSHIP IN CARDIOVASCULAR DISEASE. RESIDENTS AND FELLOWS ARE EXPOSED TO A BROAD RANGE OF CLINICAL AND DIDACTIC EXPERIENCES THROUGHOUT THEIR TRAINING, AND HAVE MANY OPPORTUNITIES TO PRESENT AT LOCAL AND NATIONAL MEETINGS AS WELL AS PUBLISH ORIGINAL RESEARCH.

A DISTINCTIVE COMPONENT OF OUR GRADUATE MEDICAL EDUCATION TRAINING PROGRAM IS OUR GLOBAL HEALTH TRACK. GLOBAL HEALTH OFFERS THE OPPORTUNITY FOR RESIDENTS TO PERFORM ROTATIONS IN THE DOMINICAN REPUBLIC, RUSSIA, UGANDA, VIETNAM AND ZIMBABWE.

RESEARCH:

STATE-OF-THE-ART COLLABORATIVE PRECISION MEDICINE PROGRAM IS TO BE INITIATED AT WCHN. THE PROGRAM WOULD LINK GYNECOLOGIC/ONCOLOGY PATIENT CLINICAL CARE AND GENOMIC INFORMATION TO IMPROVED TREATMENT AND SURVEILLANCE. THIS IS THE FUTURE OF HEALTH CARE WHERE PATIENT CARE WOULD EVOLVE FROM A ONE-SIZE-FITS-ALL TO A MORE PERSONALIZED APPROACH TOWARDS

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

DISEASE DIAGNOSIS AND TREATMENT. WE HOPE TO EXPAND THIS APPROACH TO THE DIAGNOSIS AND TREATMENT OF DISEASE IN OTHER THERAPEUTIC AREAS SUCH AS DIABETES AND CARDIOVASCULAR DISEASE. A PILOT PROJECT WILL BE INITIATED TO IDENTIFY EARLY MARKERS IN PRE-DIABETIC PATIENTS THAT REGULATE OR ALTER THE REGULATION OF METABOLIC PATHWAYS THAT CAN AFFECT METABOLIC FUNCTION AND CAUSE DYSREGULATION (SYNDROME X) PRIOR TO THE ONSET OF TYPE 2 DIABETES.

ANOTHER PROJECT THAT IS ONGOING AT THE RESEARCH INSTITUTE IS THE ANALYSIS OF EXOSOMAL NON-CODING RNA PROFILES IN PANCREATIC CANCER PATIENT AND THEIR ROLE AS A PROGNOSTIC BIOMARKER FOR THE DISEASE. THIS PROJECT WAS INITIATED BY A PHYSICIAN-ONCOLOGIST IN THE WCHN NETWORK WHO IS INTERESTED IN AN EARLY DIAGNOSTIC TO HELP SCREEN FOR HIGH RISK PANCREATIC CANCER PATIENTS. DATA WAS ACQUIRED FROM A TRAINING SET OF 50 PANCREATIC CANCER PATIENTS. THE VALIDATION IS CURRENTLY ONGOING WITH PATIENT SAMPLES BEING ACQUIRED FROM DANBURY AND NORWALK HOSPITALS. ANOTHER PILOT PROJECT WILL BE INITIATED TO SCREEN FOR MUTATIONS IN THE KRAS GENE IN CIRCULATING DNA IN PANCREATIC CANCER PATIENTS AS A POTENTIAL DIAGNOSTIC.

990, PART VI, LINE #2

RICHARD JABARA AND JAMES KENNEDY, BOTH DIRECTORS OF DANBURY HOSPITAL HAVE A BUSINESS RELATIONSHIP.

990, PART VI, LINE #6

WESTERN CONNECTICUT HEALTH NETWORK, INC. IS THE SOLE MEMBER OF DANBURY

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

HOSPITAL.

990, PART VI, LINE #7B

CERTAIN FUNDAMENTAL DECISIONS TO BE UNDERTAKEN BY THE HOSPITAL REQUIRE THE APPROVAL OF THE MEMBER.

A) THE ACTIONS LISTED BELOW, TAKEN FOR THE HOSPITAL OR IN ITS CAPACITY VOTING AS A SHAREHOLDER OR MEMBER OF A SUBSIDIARY ("DANBURY SUBSIDIARY") SHALL NOT REQUIRE APPROVAL BY THE BOARD AND ARE RESERVED SOLELY TO THE MEMBER:

- THE AMENDMENT OF THE HOSPITAL'S BYLAWS;
- THE ELECTION OR REMOVAL OF A DIRECTOR;
- APPROVAL OF INVESTMENT POLICIES;
- APPROVAL OF THE ADOPTION OF OR AMENDMENT TO ANY QUALIFIED OR ANY NON-QUALIFIED BENEFIT PLAN;
- APPROVAL OF THE ADOPTION OF OR ANY AMENDMENT TO THE POLICIES AND PROCEDURES GOVERNING A) INDEMNIFICATION OF DIRECTORS AND OFFICERS OF THE HOSPITAL OR ANY DANBURY SUBSIDIARY; B) CONFLICTS OR DUALITIES OF INTEREST; C) ACCOUNTING AND INVESTMENT STANDARDS AND PRACTICES AND D) SUCH OTHER POLICIES THE MEMBER MAY DETERMINE;
- APPROVAL OF SYSTEM-WIDE QUALITY, PERFORMANCE AND CREDENTIALING STANDARDS AND PROCEDURES TO WHICH THE HOSPITAL OR ANY DANBURY SUBSIDIARY IS EXPECTED TO ADHERE; AND
- APPROVAL OF REGULATORY COMPLIANCE AND METHODOLOGY FOR PHYSICIAN COMPENSATION ARRANGEMENTS.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

THE ACTIONS LISTED BELOW, TAKEN FOR THE HOSPITAL OR IN ITS CAPACITY VOTING AS A SHAREHOLDER OR MEMBER OF A DANBURY SUBSIDIARY, WHICH REQUIRE APPROVAL OF THE BOARD, MUST ALSO BE APPROVED BY THE MEMBER:

- THE ELECTION AND REMOVAL OF A DIRECTOR OF A DANBURY SUBSIDIARY;
- THE ELECTION OF THE OFFICERS OF THE HOSPITAL;
- APPROVAL OF ALL OPERATING AND CAPITAL BUDGETS OF THE HOSPITAL AND DANBURY SUBSIDIARY;
- APPROVAL OF ANY AMENDMENT OR RESTATEMENT OF THE HOSPITAL'S CERTIFICATE OF INCORPORATION, BYLAWS, OR OPERATING AGREEMENT OF ANY DANBURY SUBSIDIARY;
- APPROVAL OF ANY SALE, LEASE, EXCHANGE, OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL THE PROPERTY OR ASSETS OF THE HOSPITAL OR ANY DANBURY SUBSIDIARY;
- APPROVAL OF THE CREATION OF ANY CORPORATION OF WHICH THE HOSPITAL OR A DANBURY SUBSIDIARY IS THE SOLE OR CONTROLLING MEMBER OR SOLE OR CONTROLLING SHAREHOLDER; THE MERGER OR CONSOLIDATION OF THE HOSPITAL OR ANY DANBURY SUBSIDIARY WITH ANOTHER CORPORATION; AND THE REORGANIZATION, LIQUIDATION OR DISSOLUTION OF THE HOSPITAL OR ANY DANBURY SUBSIDIARY;
- APPROVAL OF ANY LOANS BY THE HOSPITAL OR ANY DANBURY SUBSIDIARY, OR THE INCURRING OF ANY INDEBTEDNESS, SECURED OR UNSECURED, WHICH EXCEEDS TWO MILLION DOLLARS (\$2.0 MILLION) OR WHICH HAS A TERM LONGER THAN ONE YEAR;
- APPROVAL OF UNBUDGETED EXPENDITURES IN EXCESS OF TWO MILLION DOLLARS (\$2.0 MILLION) OR ANY INCREASE IN ANY APPROVED ANNUAL OPERATING OR CAPITAL BUDGET.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

-APPROVAL OF ANY AGREEMENT OR TRANSACTION OF THE HOSPITAL OR ANY DANBURY SUBSIDIARY INVOLVING AN AMOUNT GREATER THAN TWO MILLION DOLLARS (\$2.0 MILLION) WITH ANOTHER INDIVIDUAL OR ENTITY;

-APPROVAL OF THE AFFILIATION OF THE HOSPITAL OR ANY DANBURY SUBSIDIARY WITH ANY OTHER ENTITY FOR THE PURPOSES OF THE JOINT CONDUCT OF BUSINESS;

-CREATION OF ANY COMMITTEE WHICH SHALL HAVE THE AUTHORITY TO ACT ON BEHALF OF THE BOARD OR ON BEHALF OF ANY DANBURY SUBSIDIARY;

-APPROVAL OF ANY CONVEYANCE OF, OR THE GRANTING OF MORTGAGES OR TRUSTS ON ANY REAL PROPERTY ASSETS OF THE HOSPITAL OR OF ANY DANBURY SUBSIDIARY;

-APPROVAL OF THE STRATEGIC PLAN OF THE HOSPITAL AND OF ANY DANBURY SUBSIDIARY; AND

-APPROVAL OF ANY COMMENCEMENT, CESSATION, LOCATION, RELOCATION OR CONSOLIDATION OF SIGNIFICANT CLINICAL SERVICES PROVIDED BY THE HOSPITAL OR ANY DANBURY SUBSIDIARY.

990, PART VI, LINE 11B

STEVEN ROSENBERG, SVP/CFO OF WESTERN CONNECTICUT HEALTH NETWORK, INC., WILL REVIEW THE 990 PRIOR TO IT BEING SENT TO THE IRS. A PRELIMINARY 990, IS PRESENTED TO THE AUDIT COMMITTEE IN JUNE, WHO REVIEWS IT ON BEHALF OF THE BOARD. E&Y IS ON HAND TO REVIEW THE 990 WITH THE AUDIT COMMITTEE AND ANSWER ANY QUESTIONS. PRIOR TO THE 990 BEING FILED WITH THE IRS, THE BOARD WILL RECEIVE A FULL AND ACCURATE COPY ON A SECURED WEBSITE FOR THEIR REVIEW.

990, PART VI, LINE 12C

THE ORGANIZATION'S PROCESS FOR MONITORING AND ENFORCING CONFLICTS OF

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

INTEREST

THE WESTERN CONNECTICUT HEALTH NETWORK AND ITS AFFILIATES' (THE NETWORK) CONFLICT OF INTEREST POLICY PROVIDES THAT ANNUALLY, ITS REPRESENTATIVES SHALL SIGN A STATEMENT AFFIRMING THAT THEY DISCLOSED ALL POTENTIAL CONFLICTS, AS DOCUMENTED IN THE CONFLICT OF INTEREST POLICY. IN ADDITION, GENERAL COUNSEL IS PART OF THE ROUTINE CONTRACTS REVIEW PROCESS AND WATCHES FOR POTENTIAL CONFLICTS WITH ANY OF THE NETWORK'S REPRESENTATIVES.

WHO IS COVERED BY THE POLICY

THE NETWORK'S CONFLICT OF INTEREST POLICY COVERS EACH DIRECTOR, OFFICER AND MANAGER OF THE NETWORK, ALSO REFERRED TO AS "REPRESENTATIVES".

LEVEL AT WHICH DETERMINATIONS OF WHETHER THERE IS A CONFLICT

IN CONNECTION WITH ANY ACTUAL OR POSSIBLE CONFLICT OF INTEREST, AN INTERESTED PERSON MUST DISCLOSE THE FACTS OF THE CONFLICT. THE COMPLIANCE OFFICER AND THE AUDIT COMMITTEE REVIEW AND EVALUATE EACH DISCLOSURE TO DETERMINE IF THERE IS A CONFLICT OF INTEREST.

AFTER PRESENTATION OF A POTENTIAL TRANSACTION OR ARRANGEMENT IS MADE BY AN INTERESTED PERSON, THE REMAINING DISINTERESTED BOARD OR COMMITTEE MEMBERS SHALL DECIDE IF A CONFLICT OF INTEREST EXIST.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

LEVEL THAT REVIEWS AND DETERMINES WHAT TO DO IF THERE IS A CONFLICT

AFTER EXERCISING DUE DILIGENCE THE FULL BOARD WOULD DETERMINE WHAT ACTIONS SHOULD BE TAKEN FOR ALL CONFLICTS BY OFFICERS AND DIRECTORS. ANY CONFLICTS OCCURRING BY A MANAGER ARE REVIEWED BY THE COMPLIANCE COMMITTEE TO DETERMINE WHAT FURTHER ACTION SHOULD BE TAKEN.

RESTRICTIONS ON THE CONFLICTED PERSON

NO DIRECTOR HAVING A CONFLICT OF INTEREST ON ANY MATTER SHALL VOTE ON THAT MATTER OR BE COUNTED IN DETERMINING THE QUORUM FOR THE MEETING AT WHICH THE VOTE IS TAKEN, EVEN WHEN PERMITTED BY LAW. NO REPRESENTATIVE HAVING A CONFLICT OF INTEREST ON ANY MATTER SHALL USE HIS OR HER PERSONAL INFLUENCE ON THE MATTER.

IF THE BOARD OF DIRECTORS, IN ITS SOLE DISCRETION, DETERMINES THAT ANY REPRESENTATIVE HAS CONFLICTS OF INTEREST SUFFICIENT IN NUMBER AND/OR IMPORTANCE THAT THE EFFECTIVENESS OF SUCH INDIVIDUAL ON BEHALF OF THE NETWORK MAY BE SIGNIFICANTLY IMPAIRED, THE BOARD MAY ASK THE INDIVIDUAL TO RESIGN.

PART V, LINE 15B

COMPENSATION FOR OTHER OFFICERS AND KEY EMPLOYEES:

IN ORDER TO ACHIEVE ITS MISSION AND ITS OVERALL PERFORMANCE OBJECTIVES,

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

WESTERN CONNECTICUT HEALTH NETWORK, INC. EMPLOYS A PERFORMANCE-BASED TOTAL COMPENSATION PROGRAM FOR ITS SENIOR EXECUTIVES THAT IS MARKET COMPETITIVE, COMPLIANT WITH REGULATORY GUIDELINES, AND REPRESENTATIVE OF BEST PRACTICES. ELIGIBLE EXECUTIVES ARE GENERALLY DIRECT REPORTS OF THE CEO ALONG WITH OTHER EXECUTIVES DESIGNATED BY THE CEO.

TO MEET WESTERN CONNECTICUT HEALTH NETWORK INC.'S TOTAL COMPENSATION OBJECTIVES FOR EXECUTIVES, THE FOLLOWING SURVEY SOURCES ARE USED FOR COMPARISON PURPOSES:

-BLEND OF NATIONAL CONFIDENTIAL SOURCE, IHS, AND HAY GROUP POINTS, HEALTH CARE DATA (WHERE DATA AVAILABLE), PLUS 15% GEOGRAPHIC DIFFERENTIAL. TITLE MATCH DATA CUTS SELECTED BASED ON REVENUE SIZE.

-FOR PHYSICIAN EXECUTIVES, SURVEYS COVERING PHYSICIAN COMPENSATION IN ACCREDITED MEDICAL SCHOOLS (AAMC) ARE USED IN COMBINATION WITH PROPRIETARY SURVEYS COMPILED BY NATIONALLY KNOWN CONSULTING FIRM, SULLIVAN COTTER AND THE MEDICAL GROUP MANAGEMENT ASSOCIATION (MGMA).

WESTERN CONNECTICUT HEALTH NETWORK, INC. TARGETS CASH COMPENSATION AT MARKET COMPETITIVE LEVELS. BASE SALARY PLUS SHORT-TERM (ANNUAL) INCENTIVE AWARDS (TOTAL CASH) APPROXIMATE MARKET COMPETITIVE LEVELS FOR TOTAL CASH COMPENSATION. EXECUTIVE PERFORMANCE IS EXPECTED TO MEET OR EXCEED PREDETERMINED OPERATIONAL AND FINANCIAL METRICS.

OTHER FACTORS, SUCH AS COMPETITIVE MARKET FORCES, JOB PERFORMANCE, UNIQUE

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

QUALIFICATIONS, AND/OR INDIVIDUAL JOB RESPONSIBILITIES ARE ALSO CONSIDERED IN WESTERN CONNECTICUT HEALTH NETWORK, INC'S EXECUTIVE COMPENSATION DECISIONS.

ROLES OF THE COMPENSATION COMMITTEE AND KEY EXECUTIVES IN THE EXECUTIVE COMPENSATION PROCESS

- THE COMPENSATION COMMITTEE IN CONSULTATION WITH THE CEO AND THE SVP HUMAN RESOURCES (HR) SELECTS THE OUTSIDE COMPENSATION CONSULTANTS. THE CURRENT CONSULTANT IS THE HAY GROUP, WHOSE PURPOSE IS TO PROVIDE A VALID INDEPENDENT ASSESSMENT OF THE RELEVANT MARKET RATES AND PAY PRACTICES FOR HEALTH CARE EXECUTIVES, PHYSICIAN EXECUTIVES AND FOR PHYSICIANS IN GENERAL.

- THE COMPENSATION CONSULTING FIRM COMPILES APPROPRIATE MARKET DATA, JOB EVALUATION AND RANKING INFORMATION FOR ALL EXECUTIVES AND PHYSICIANS OF THE ORGANIZATION, EXCLUDING THE CEO, AND WILL SUPPLY THIS MATERIAL TO THE CEO AND SVP HR FOR REVIEW AND AGREEMENT. ONCE THE REPORT IS FINAL, IT WILL BE SUPPLIED TO THE COMPENSATION COMMITTEE FOR THEIR CONSIDERATION AND ACCEPTANCE.

-THE COMPENSATION COMMITTEE DETERMINES THE CEO'S SALARY BASED ON OVERALL PERFORMANCE AND MARKET DATA SUPPLIED BY THE OUTSIDE COMPENSATION CONSULTANT.

THE LAST EXECUTIVE COMPENSATION EVALUATION BY AN OUTSIDE CONSULTANT WAS DONE IN DECEMBER, 2015.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

990, PART VI, LINE #19

THE INFORMATION THAT HAS BEEN POSTED ON DANBURY HOSPITAL'S WEBSITE FOR
2014 INCLUDES:

THE CODE OF BUSINESS ETHICS, INFORMATION ABOUT OUR COMPLIANCE PROGRAM,
AND A COPY OF OUR POLICY REGARDING PREVENTING OF FRAUD, WASTE AND ABUSE.

ALL GOVERNING DOCUMENTS REQUIRED BY LAW AND THE FINANCIAL STATEMENTS ARE
MADE AVAILABLE UPON REQUEST.

THE CONFLICT OF INTEREST POLICY IS AVAILABLE UPON REQUEST.

FORM 990, PART VII (COMMENTS ATTACHED)

NEIL CULLIGAN, MD

A STIPEND WAS PAID TO NEIL CULLIGAN, MD, A DIRECTOR, DURING THE YEAR FOR
STROKE PROGRAM DIRECTORSHIP AND CHIEF OF NEUROLOGY. IT WAS NOT REFLECTED
IN PART VII AS COMPENSATION, SINCE IT WAS IN BOX #6 RATHER THAN BOX #7 OF
THE 1099.

DAVID KRAMER, MD (TO 1/1)

DAVID KRAMER WAS A DIRECTOR TO JANUARY 1, 2015.

MIKE DAGLIO (TO 11/2)

MIKE DAGLIO WAS CHIEF OPERATING OFFICER OF DANBURY HOSPITAL UNTIL
NOVEMBER 2, 2014, WHEN HE BECAME THE PRESIDENT OF NORWALK HOSPITAL.

Name of the organization DANBURY HOSPITAL	Employer identification number 06-0646597
--	--

LISA SCHMITTGALL (TO 12/31)

LISA SCHMITTGALL'S EMPLOYMENT WAS TERMINATED ON DECEMBER 31, 2014.

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

CAPTIVE UBI	\$ -14,369.
CHANGE IN EQUITY INTEREST OF WCHNIC.	13,329,262.
CHANGE IN INVESTMENT OF WHNF.	-16,094,946.
EQUITY TRANSFER TO WCHN-W/O OF INTERCOMPANY.	-19,356,313.
EQUITY TRANSFER TO WCMG-W/O OF INTERCOMPANY.	-13,034,066.
NMH NET ASSETS TRFD TO DH.34,128,301.

TOTAL \$ -1,042,131.

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>
TOWERS WATSON PENNSYLVANIA PO BOX 8500 PHILADELPHIA, PA 19178-7482	CONSULTANTS	1,359,311.
ROBINSON & COLE, LLP 280 TRUMBULL STREET HARTFORD, CT 06103	ATTORNEYS	1,548,372.
DANBURY RADIOLOGICAL ASSOCIATES PO BOX 417407 BOSTON, MA 02241	RADIOLOGY SERVICES	927,782.
E4 SERVICES, LLC 60 NORTH CAROLINA AVE. SINKING SPRING, PA 19608	ITG CONSULTANTS	1,029,292.
PRICE, WATERHOUSE, COOPERS LLC PO BOX 7247 PHILADELPHIA, PA 19170	CONSULTANTS	1,899,925.

Name of the organization

DANBURY HOSPITAL

Employer identification number

06-0646597

ATTACHMENT 2FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	<u>(A)</u> TOTAL FEES	<u>(B)</u> PROGRAM SERVICE EXP.	<u>(C)</u> MANAGEMENT AND GENERAL	<u>(D)</u> FUNDRAISING EXPENSES
HEALTHCARE PROFESSIONALS	74,824,188.	61,610,236.	13,213,952.	
PURCHASED SERVICES	30,116,156.	24,797,643.	5,318,513.	
TOTALS	<u>104,940,344.</u>	<u>86,407,879.</u>	<u>18,532,465.</u>	

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

DANBURY HOSPITAL

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

2014

Open to Public
Inspection

Employer identification number

06-0646597

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

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

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	WEST. CT HEALTH NETWORK AFFILIATES 95 LOCUST AVENUE DANBURY, CT 06810 22-2594968	OP HLTHCR SVC	CT	501(C)(3)	9	WCHN	X	
(2)	WESTERN CT HEALTH NETWORK, INC. 24 HOSPITAL AVENUE DANBURY, CT 06810 22-2594977	PROGRAM DEVL P	CT	501(C)(3)	11, TYPE 2	N/A		X
(3)	WEST. CT HEALTH NETWORK FOUNDATION 24 HOSPITAL AVENUE DANBURY, CT 06810 23-7425557	ADMIN CONTRIB	CT	501(C)(3)	7	WCHN	X	
(4)	WESTERN CT HOME CARE, INC. 4 LIBERTY STREET DANBURY, CT 06810 06-0655138	HOME HLTHCARE	CT	501(C)(3)	9	WCHN	X	
(5)	WESTERN CT MEDICAL GROUP, INC. 14 RESEARCH DRIVE, SUITE 201A BETHEL, CT 06801 06-1137531	PHYSICIAN SVC	CT	501(C)(3)	9	WCHN	X	
(6)	EASTERN NY MEDICAL SERVICES, P.C. 14 RESEARCH DRIVE, SUITE 201A BETHEL, CT 06810 45-5431389	PHYSICIAN SVC	NY	501(C)(3)	9	WCHN	X	
(7)	THE NORWALK HOSPITAL ASSOCIATION 24 STEVENS STREET NORWALK, CT 06850 06-6068853	HEALTH SVCS	CT	501(C)(3)	3	NHSC	X	

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

Schedule R (Form 990) 2014

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

DANBURY HOSPITAL

Employer identification number

06-0646597

Open to Public
Inspection

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

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

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	NORWALK HOSPITAL, PHYS. AND SURGEONS 24 STEVENS STREET NORWALK, CT 06850 06-1522078	PHYSICIAN SVC	CT	501 (C) (3)	11, TYPE 2	NHSC	X	
(2)	NORWALK HEALTH CARE, INC. 24 STEVENS STREET NORWALK, CT 06850 22-2577722	INACTIVE	CT	501 (C) (3)	9	NHSC	X	
(3)	NORWALK HOSPITAL FOUNDATION 34 MAPLE STREET NORWALK, CT 06850 22-2577708	ADMIN CONTRIB	CT	501 (C) (3)	7	NHSC	X	
(4)	ADVANCED CTR. FOR REHAB. MEDICINE 24 STEVENS STREET NORWALK, CT 06850 06-1304799	INACTIVE	CT	501 (C) (3)	11, TYPE 2	NHSC	X	
(5)								
(6)								
(7)								

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

Schedule R (Form 990) 2014

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(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) NEW MILFORD MRI 27-1877801 21 ELM STREET	INACTIVE	CT	NMH	N/A	0	0		X	0		X	
(2) NORWALK SURGERY 27-2394942 40 CROSS STREET	SURGERY CENTER	CT	NH	RELATED	0	0		X	0		X	
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) WEST. CT HEALTH NETWORK INSUR. 23 LIME TREE BAY, P.O. BOX 105 GRAND CAYMAN, CT	MALPRACTICE	CJ	DH	C CORP	23,409,419.	132,830,968.	100.0000		X
(2) MEDICAL SERVICES OF DANBURY 24 HOSPITAL AVENUE DANBURY, CT 06811	INACTIVE	CT	WCMG	C CORP	0	0			X
(3) SMC CORPORATION 24 STEVENS STREET NORWALK, CT 06850	PHARMACY	CT	NHSC	C CORP	0	0			X
(4)									
(5)									
(6)									
(7)									

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

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?

	Yes	No
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)	X	
j Lease of facilities, equipment, or other assets to related organization(s)	X	
k Lease of facilities, equipment, or other assets from related organization(s)		X
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)		X
p Reimbursement paid to related organization(s) for expenses		X
q Reimbursement paid by related organization(s) for expenses		X
r Other transfer of cash or property to related organization(s)		X
s Other transfer of cash or property from related organization(s)		X

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	WEST. CT HEALTH NETWORK AFFILIATES	J	104,356.	COST
(2)	WEST. CT HEALTH NETWORK AFFILIATES	L	357,015.	COST
(3)	WEST. CT HEALTH NETWORK AFFILIATES	M	477,289.	COST
(4)	WEST. CT HEALTH NETWORK AFFILIATES	O	154,934.	COST
(5)	WEST. CT HEALTH NETWORK AFFILIATES	Q	5,906,776.	COST
(6)	WEST. CT HEALTH NETWORK AFFILIATES	S	6,324,920.	COST

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on 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.

Table with 4 columns: (a) Name of related organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved. Rows include WEST. CT HEALTH NETWORK FOUNDATION with various transaction types (C, J, K, O, Q, S) and amounts.

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on 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?

	Yes	No
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		1a
b Gift, grant, or capital contribution to related organization(s)		1b
c Gift, grant, or capital contribution from related organization(s)		1c
d Loans or loan guarantees to or for related organization(s)		1d
e Loans or loan guarantees by related organization(s)		1e
f Dividends from related organization(s)		1f
g Sale of assets to related organization(s)		1g
h Purchase of assets from related organization(s)		1h
i Exchange of assets with related organization(s)		1i
j Lease of facilities, equipment, or other assets to related organization(s)		1j
k Lease of facilities, equipment, or other assets from related organization(s)		1k
l Performance of services or membership or fundraising solicitations for related organization(s)		1l
m Performance of services or membership or fundraising solicitations by related organization(s)		1m
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		1n
o Sharing of paid employees with related organization(s)		1o
p Reimbursement paid to related organization(s) for expenses		1p
q Reimbursement paid by related organization(s) for expenses		1q
r Other transfer of cash or property to related organization(s)		1r
s Other transfer of cash or property from related organization(s)		1s

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	WESTERN CT HOME CARE, INC	L	154,967.	COST
(2)	WESTERN CT HOME CARE, INC	O	147,394.	COST
(3)	WESTERN CT HOME CARE, INC	Q	859,175.	COST
(4)	WESTERN CT HOME CARE, INC	R	250,000.	COST
(5)	WESTERN CT HOME CARE, INC	S	1,194,306.	COST
(6)	WESTERN CT MEDICAL GROUP, INC.	B	13,034,066.	COST

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on 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.

Table with 4 columns: (a) Name of related organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved. Rows include WESTERN CT MEDICAL GROUP, INC. with transaction types I, J, L, M, O, Q and corresponding amounts.

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on 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 related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved	Yes	No
(1)	WESTERN CT MEDICAL GROUP, INC.	S	1,622,201.	COST		
(2)	EASTERN NY MEDICAL SERVICES, P.C.	Q	169,718.	COST		
(3)	THE NORWALK HOSPITAL ASSOCIATION	I	1,012,175.	COST		
(4)	THE NORWALK HOSPITAL ASSOCIATION	J	416,543.	COST		
(5)	THE NORWALK HOSPITAL ASSOCIATION	L	5,792,729.	COST		
(6)	THE NORWALK HOSPITAL ASSOCIATION	O	9,606,088.	COST		

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on 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.

Table with 4 columns: (a) Name of related organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved. Rows include THE NORWALK HOSPITAL ASSOCIATION, NORWALK HOSPITAL PHYS. AND SURGEONS, and WEST. CT HEALTH NETWORK INSUR. CO., LTD.

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on 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.

Table with 4 columns: (a) Name of related organization, (b) Transaction type (a-s), (c) Amount involved, (d) Method of determining amount involved. Rows include WEST. CT HEALTH NETWORK INSUR. CO., LTD and SWC CORPORATION.

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(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).

SCHEDULE R, PART III - PARTNERSHIP FULL NAME, ADDRESS, FEIN

NEW MILFORD MRI JV, LLC 27-1877801 21 ELM STREET NEW MILFORD, CT 06776

NORWALK SURGERY CENTER, LLC 27-2394942 40 CROSS STREET, #120 NORWALK,

CT 06851

PUBLIC INSPECTION COPY

Form **990-T**

Exempt Organization Business Income Tax Return (and proxy tax under section 6033(e))

OMB No. 1545-0687

2014

For calendar year 2014 or other tax year beginning 10/01, 2014, and ending 9/30, 2015

▶ **Information about Form 990-T and its instructions is available at www.irs.gov/form990t.**
▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

Open to Public Inspection for 501(c)(3) Organizations Only

Department of the Treasury
Internal Revenue Service

A <input type="checkbox"/> Check box if address changed B Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)	Print or Type	<input type="checkbox"/> Check box if name changed and see instructions. Danbury Hospital 24 Hospital Avenue Danbury, CT 06810-6099	D Employer identification number (Employees' trust, see instructions.) 06-0646597 E Unrelated business activity codes (See instructions.) 621500 531190
---	----------------------	--	--

C Book value of all assets at end of year 836,823,101.	F Group exemption number (See instructions.) ▶ G Check organization type: <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust
--	--

H Describe the organization's primary unrelated business activity.
▶ **Cont Lab. Servs./Prov. Of Ins To Comm phys**

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-sub subsidiary controlled group? ... Yes No
If 'Yes,' enter the name and identifying number of the parent corporation ... ▶ **See Statement 1**

J The books are in care of ▶ **Mary Jo Pawlak** Telephone number ▶ **(203) 739-7000**

Part I	Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
1 a	Gross receipts or sales ... <u>18,526,142.</u>			
b	Less returns and allowances ... <u>13,597,944.</u> c Balance ▶	1 c	4,928,198.	
2	Cost of goods sold (Schedule A, line 7)	2		
3	Gross profit. Subtract line 2 from line 1c	3	4,928,198.	4,928,198.
4 a	Capital gain net income (attach Schedule D)	4 a		
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4 b		
c	Capital loss deduction for trusts	4 c		
5	Income (loss) from partnerships and S corporations (attach statement)	5		
6	Rent income (Schedule C)	6		
7	Unrelated debt-financed income (Schedule E)	7	899,739.	178,610.
8	Interest, annuities, royalties, and rents from controlled organizations (Schedule F)	8		
9	Investment income of a section 501(c)(7), (9), or (17) organization (Sch G)	9		
10	Exploited exempt activity income (Schedule I)	10		
11	Advertising income (Schedule J)	11		
12	Other income (See instructions; attach schedule)			
	See Statement 2	12	14,369.	14,369.
13	Total. Combine lines 3 through 12	13	5,842,306.	178,610.
				5,663,696.

Part II	Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.)			
14	Compensation of officers, directors, and trustees (Schedule K)	14		
15	Salaries and wages	15		
16	Repairs and maintenance	16		
17	Bad debts	17		
18	Interest (attach schedule)	18		
19	Taxes and licenses	19		
20	Charitable contributions (See instructions for limitation rules)	20		
21	Depreciation (attach Form 4562)	21	27,329.	
22	Less depreciation claimed on Schedule A and elsewhere on return	22 a	27,329.	22 b
23	Depletion	23		
24	Contributions to deferred compensation plans	24		
25	Employee benefit programs	25		
26	Excess exempt expenses (Schedule I)	26		
27	Excess readership costs (Schedule J)	27		
28	Other deductions (attach schedule)	28	See Statement 3	6,035,345.
29	Total deductions. Add lines 14 through 28	29		6,035,345.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30		-371,649.
31	Net operating loss deduction (limited to the amount on line 30)	31	See Statement 4	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	32		-371,649.
33	Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions)	33		
34	Unrelated business taxable income. Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32	34		-371,649.

Application for Extension of Time To File an Exempt Organization Return

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**
▶ Information about Form 8868 and its instructions is at www.irs.gov/form8868.

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

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

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

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

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

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

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions. Danbury Hospital	Employer identification number (EIN) or 06-0646597
	Number, street, and room or suite number. If a P.O. box, see instructions. 24 Hospital Avenue	Social security number (SSN)
File by the due date for filing your return. See instructions.	City, town or post office, state, and ZIP code. For a foreign address, see instructions. Danbury, CT 06810-6099	

Enter the Return code for the return that this application is for (file a separate application for each return) 07

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (section 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ Mary Jo Pawlak

Telephone No. ▶ (203) 739-8110 Fax No. ▶ _____

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 8/15, 20 16, to file the exempt organization return for the organization named above.
The extension is for the organization's return for:

- ▶ calendar year 20 ____ or
- ▶ tax year beginning 10/01, 20 14, and ending 9/30, 20 15.

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

3 a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions	3 a \$	0.
b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit	3 b \$	0.
c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3 c \$	0.

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

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

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

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

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

- The books are in the care of Telephone No. Fax No.
- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____ . If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

- I request an additional 3-month extension of time until _____, 20__
- For calendar year _____, or other tax year beginning _____, 20__, and ending _____, 20__
- If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period
- State in detail why you need the extension

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

Signature and Verification must be completed for Part II only.

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

Signature  Title VP+Corp Controller Date 1-28-16

Part III Tax Computation

35 Organizations Taxable as Corporations. See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here <input checked="" type="checkbox"/> See instructions and:			
a Enter your share of the \$50,000, \$25,000, and \$9,925,000 taxable income brackets (in that order): (1) \$ 0. (2) \$ 0. (3) \$ 0.			
b Enter organization's share of: (1) Additional 5% tax (not more than \$11,750)..... \$ 0. (2) Additional 3% tax (not more than \$100,000)..... \$ 0.			
c Income tax on the amount on line 34.....		35 c	0.
36 Trusts Taxable at Trust Rates. See instructions for tax computation. Income tax on the amount on line 34 from: <input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041).....		36	
37 Proxy tax. See instructions.....		37	
38 Alternative minimum tax		38	
39 Total. Add lines 37 and 38 to line 35c or 36, whichever applies.....		39	0.

Part IV Tax and Payments

40a Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116).....	40 a		
b Other credits (see instructions).....	40 b		
c General business credit. Attach Form 3800 (see instructions).....	40 c		
d Credit for prior year minimum tax (attach Form 8801 or 8827).....	40 d		
e Total credits. Add lines 40a through 40d.....	40 e		0.
41 Subtract line 40e from line 39.....	41		0.
42 Other taxes. Check if from: <input type="checkbox"/> Form 4255 <input type="checkbox"/> Form 8611 <input type="checkbox"/> Form 8697 <input type="checkbox"/> Form 8866 <input type="checkbox"/> Other (attach schedule).....	42		
43 Total tax. Add lines 41 and 42.....	43		0.
44a Payments: A 2013 overpayment credited to 2014.....	44 a		
b 2014 estimated tax payments.....	44 b		
c Tax deposited with Form 8868.....	44 c		
d Foreign organizations: Tax paid or withheld at source (see instructions).....	44 d		
e Backup withholding (see instructions).....	44 e		
f Credit for small employer health insurance premiums (Attach Form 8941).....	44 f		
g Other credits and payments: <input type="checkbox"/> Form 2439 <input type="checkbox"/> Form 4136 <input type="checkbox"/> Other Total ...	44 g		
45 Total payments. Add lines 44a through 44g.....	45		0.
46 Estimated tax penalty (see instructions). Check if Form 2220 is attached..... <input type="checkbox"/>	46		
47 Tax due. If line 45 is less than the total of lines 43 and 46, enter amount owed.....	47		
48 Overpayment. If line 45 is larger than the total of lines 43 and 46, enter amount overpaid.....	48		
49 Enter the amount of line 48 you want: Credited to 2015 estimated tax <input type="checkbox"/> Refunded <input type="checkbox"/>	49		

Part V Statements Regarding Certain Activities and Other Information (see instructions)

1 At any time during the 2014 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here <u>Cayman Islands</u>	Yes	No
2 During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3 Enter the amount of tax-exempt interest received or accrued during the tax year <input type="checkbox"/> \$ 0.		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation FIFO

1 Inventory at beginning of year.....	1		6 Inventory at end of year.....	6	
2 Purchases.....	2		7 Cost of goods sold. Subtract line 6 from line 5. Enter here and in Part I, line 2.....	7	
3 Cost of labor.....	3				
4a Additional section 263A costs (attach schedule).....	4 a				
b Other costs (attach sch).....	4 b		8 Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?.....	Yes	No
5 Total. Add lines 1 through 4b.....	5				X

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

Signature of officer: Kevin Rosenberg Date: 8/4/2016 Title: SVP/CFO May the IRS discuss this return with the preparer shown below (see instructions)? Yes No

Paid Preparer Use Only

Print/Type preparer's name: Mike A. Cincotta Preparer's signature: Mike Cincotta Date: 08/04/16 Check if self-employed PTIN: P01595811

Firm's name: ERNST & YOUNG US LLP Firm's EIN: 34-6565596

Firm's address: 200 Clarendon St. Boston, MA 02116-5072 Phone no.: 617-2662000

Schedule C – Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1 Description of property		
(1)		
(2)		
(3)		
(4)		
2 Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)		
(2)		
(3)		
(4)		
Total		Total
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶		(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ▶

Schedule E – Unrelated Debt-Financed Income (see instructions)

1 Description of debt-financed property		2 Gross income from or allocable to debt-financed property	3 Deductions directly connected with or allocable to debt-financed property See St 5	
			(a) Straight line depreciation (attach sch)	(b) Other deductions (attach schedule)
(1) Rental of Hospital Space		899,739.	27,329.	151,281.
(2)				
(3)				
(4)				
4 Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5 Average adjusted basis of or allocable to debt-financed property (attach schedule)	6 Column 4 divided by column 5	7 Gross income reportable (column 2 x column 6)	8 Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		100.0000 %	899,739.	178,610.
(2)		%		
(3)		%		
(4)		%		
Totals ▶			Enter here and on page 1, Part I, line 7, column (A). 899,739.	Enter here and on page 1, Part I, line 7, column (B). 178,610.
Total dividends-received deductions included in column 8 ▶				

Schedule F – Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

1 Name of controlled organization	2 Employer identification number	Exempt Controlled Organizations			
		3 Net unrelated income (loss) (see instructions)	4 Total of specified payments made	5 Part of column 4 that is included in the controlling organization's gross income	6 Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					
Nonexempt Controlled Organizations					
7 Taxable Income	8 Net unrelated income (loss) (see instructions)	9 Total of specified payments made	10 Part of column 9 that is included in the controlling organization's gross income	11 Deductions directly connected with income in column 10	
(1)					
(2)					
(3)					
(4)					
Totals ▶			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).	

Schedule G – Investment Income of a Section 501(c)(7), (9), or (17) Organization (see instructions)

1 Description of income	2 Amount of income	3 Deductions directly connected (attach schedule)	4 Set-asides (attach schedule)	5 Total deductions and set-asides (column 3 plus column 4)
(1)				
(2)				
(3)				
(4)				
Totals	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).

Schedule I – Exploited Exempt Activity Income, Other Than Advertising Income (see instructions)

1 Description of exploited activity	2 Gross unrelated business income from trade or business	3 Expenses directly connected with production of unrelated business income	4 Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute columns 5 through 7.	5 Gross income from activity that is not unrelated business income	6 Expenses attributable to column 5	7 Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals	Enter here and on page 1, Part I, line 10, column (A).	Enter here and on page 1, Part I, line 10, column (B).				Enter here and on page 1, Part II, line 26.

Schedule J – Advertising Income (See instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1 Name of periodical	2 Gross advertising income	3 Direct advertising costs	4 Advertising gain or (loss) (col 2 minus col 3). If a gain, compute col 5 through 7.	5 Circulation income	6 Readership costs	7 Excess readership costs (col 6 minus col 5, but not more than col 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5))						

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1 Name of periodical	2 Gross advertising income	3 Direct advertising costs	4 Advertising gain or (loss) (col 2 minus col 3). If a gain, compute cols 5 through 7.	5 Circulation income	6 Readership costs	7 Excess readership costs (col 6 minus col 5, but not more than col 4).
(1)						
(2)						
(3)						
(4)						
(5) Totals from Part I						
Totals , Part II (lines 1-5)	Enter here and on page 1, Part I, line 11, column (A).	Enter here and on page 1, Part I, line 11, column (B).				Enter here and on page 1, Part II, line 27.

Schedule K – Compensation of Officers, Directors, and Trustees (see instructions)

1 Name	2 Title	3 Percent of time devoted to business	4 Compensation attributable to unrelated business
		0%	
		0%	
		0%	
		0%	
Total. Enter here and on page 1, Part II, line 14			

Client 1010

Danbury Hospital

06-0646597

8/03/16

04:46PM

Statement 1
Form 990-T, Line I
Name & I.D. Number of Parent Corporation

Western Connecticut Health Network, Inc. 22-2594977

Statement 2
Form 990-T, Part I, Line 12
Other Income

Ins To Community Phys.....	\$	14,369.
Total	\$	<u>14,369.</u>

Statement 3
Form 990-T, Part II, Line 28
Other Deductions

DIRECT LAB EXPENSES.....	\$	2,618,969.
INDIRECT LAB EXPENSES.....		3,416,376.
Total	\$	<u>6,035,345.</u>

Statement 4
Form 990-T, Part II, Line 31
Net Operating Loss Deduction

Loss Year Ending	Original Loss	Loss Previously Used	Loss Available
9/30/99	\$ 1,770,954.	\$ 172.	\$ 1,770,782.
9/30/01	173,633.	0.	173,633.
9/30/02	2,279,022.	0.	2,279,022.
9/30/03	3,304,119.	0.	3,304,119.
9/30/04	4,846,737.	0.	4,846,737.
9/30/05	4,081,949.	0.	4,081,949.
9/30/06	3,777,206.	0.	3,777,206.
9/30/07	2,554,000.	0.	2,554,000.
9/30/08	2,446,795.	0.	2,446,795.
9/30/09	4,273,838.	0.	4,273,838.
9/30/10	4,123,724.	0.	4,123,724.
9/30/11	3,233,803.	0.	3,233,803.
9/30/12	3,720,736.	0.	3,720,736.
9/30/13	3,755,534.	0.	3,755,534.
9/30/14	648,569.	0.	648,569.
Net Operating Loss Available.....			\$ 44,990,447.
Taxable Income.....			\$ -371,649.
Net Operating Loss Deduction (Limited to Taxable Income).....			<u>\$ 0.</u>

Statement 5
Form 990-T, Schedule E, Line 3b
Other Deductions Allocable to Debt-Financed Property

Rental of Hospital Space	
Rental Expense-Taxable Entities.....	\$ 151,281.
	Total <u>\$ 151,281.</u>

DANBURY HOSPITAL
YEAR ENDED 9/30/15
Schedule E Attachment

EIN: 06-0646597

Form 990T, Schedule E, Line #3a

	<u>DaVita Gold Garage</u>	<u>Walgreens Stroock Bldg.</u>	<u>Total</u>
Depreciation Expense for FYE2014	\$ 344,720	\$ 620,254	
Percentage Related to Applicable Space	5.70%	1.24%	
	<u>19,664</u>	<u>7,664</u>	
Allocation for Number of months rented	100.00%	100.00%	
Depreciation Reflected in Schedule E	<u>\$ 19,664</u>	<u>\$ 7,664</u>	<u>\$ 27,329</u>

Form 990T, Schedule E, Line #3b

Davita & Walgreens Rent Expense

Property Taxes	
Legal Expense	-
Maintenance	-
Operating and Utilities Expense	<u>151,281</u>
	151,281
 BSI Rental Expense	 -
DRA Rental Expense	-
	<u>\$ 151,281</u>

DANBURY HOSPITAL
YEAR ENDED 9/30/15
NOL WORKSHEET NOTE

EIN: 06-0646597

On October 1, 2014 (the merger date), Danbury Hospital (the Hospital) received a single provider license to include The New Milford Hospital Incorporated (New Milford Hospital). As a result, New Milford Hospital merged with the Hospital and the operations of New Milford Hospital became a campus of Danbury Hospital effective October 1, 2014. The Hospital will operate as one licensed facility with two campuses.

As a result of the above merger, New Milford Hospital's NOL carryforward of \$3,057,843 was added to the Hospital's Net Operating Loss as of 9/30/2015.

Danbury Hospital

EIN: 06-0646597

Section 1.263(a)-1(f) de minimis safe harbor election

Tax Year Ending 9/30/2015

Section 1.263(a)-1(f) de minimis safe harbor election statement

Taxpayer Name: Danbury Hospital ("Taxpayer")

Taxpayer Address: 24 Hospital Avenue, Danbury, CT 06810-6099

EIN: 06-0646597

The above-referenced Taxpayer is making the de minimis safe harbor election under Section 1.263(a)-1(f) for its tax year ending September 30, 2015.

Section 1.263(a)-3(n) Election Statement

Taxpayer Name: Danbury Hospital ("Taxpayer")
Taxpayer Address: 24 Hospital Avenue, Danbury, CT 06810-6099
EIN: 06-0646597

The above-referenced Taxpayer is making the election to capitalize repair and maintenance costs under Section 1.263(a)-3(n) for its tax year ending September 30, 2015.

Danbury Hospital
06-0646597

Statement Attached to and Made Part of Form 990T
Changes in Method of Accounting pursuant to Rev. Proc. 2015-20 for the Tax Year
Ended September 30, 2015

The above referenced Taxpayer is within the scope of Section 4.01 of Rev. Proc. 2015-20 and is choosing to follow the simplified procedures provided in Section 5 of Rev. Proc. 2015-20 when making accounting method changes to comply with the tangible property regulations for its tax year ended September 30, 2015. Specifically, the Taxpayer will make the applicable tangible property accounting method changes with an adjustment under section § 481(a) that takes into account only amounts paid or incurred, and dispositions, in taxable years beginning on or after January 1, 2014. Additionally, the Taxpayer will not file Form 3115, *Application for Change in Accounting Method* for any of the applicable TPR method changes covered by Rev. Proc. 2015-20. See section 5.01 of Rev. Proc. 2015-20.

Alternative Minimum Tax – Corporations

Department of the Treasury
Internal Revenue Service

▶ Attach to the corporation's tax return.
▶ Information about Form 4626 and its separate instructions is at www.irs.gov/form4626.

2014

Name Danbury Hospital	Employer identification number 06-0646597
---------------------------------	---

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1 Taxable income or (loss) before net operating loss deduction.....		1		0.
2 Adjustments and preferences:				
a Depreciation of post-1986 property.....		2 a		
b Amortization of certified pollution control facilities.....		2 b		
c Amortization of mining exploration and development costs.....		2 c		
d Amortization of circulation expenditures (personal holding companies only).....		2 d		
e Adjusted gain or loss.....		2 e		
f Long-term contracts.....		2 f		
g Merchant marine capital construction funds.....		2 g		
h Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only).....		2 h		
i Tax shelter farm activities (personal service corporations only).....		2 i		
j Passive activities (closely held corporations and personal service corporations only).....		2 j		
k Loss limitations.....		2 k		
l Depletion.....		2 l		
m Tax-exempt interest income from specified private activity bonds.....		2 m		
n Intangible drilling costs.....		2 n		
o Other adjustments and preferences.....		2 o		
3 Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o.....		3		0.
4 Adjusted current earnings (ACE) adjustment:				
a ACE from line 10 of the ACE worksheet in the instructions.....	4 a			
b Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions).....	4 b			
c Multiply line 4b by 75% (.75). Enter the result as a positive amount.....	4 c			
d Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). Note: You <i>must</i> enter an amount on line 4d (even if line 4b is positive).....	4 d		0.	
e ACE adjustment.				
• If line 4b is zero or more, enter the amount from line 4c.....		4 e		0.
• If line 4b is less than zero, enter the smaller of line 4c or line 4d as a negative amount.....				
5 Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT.....		5		0.
6 Alternative tax net operating loss deduction (see instructions).....		6		0.
7 Alternative minimum taxable income. Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions.....		7		
8 Exemption phase-out (if line 7 is \$310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):				
a Subtract \$150,000 from line 7 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-.....	8 a			
b Multiply line 8a by 25% (.25).....	8 b			
c Exemption. Subtract line 8b from \$40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-.....		8 c		
9 Subtract line 8c from line 7. If zero or less, enter -0-.....		9		
10 Multiply line 9 by 20% (.20).....		10		
11 Alternative minimum tax foreign tax credit (AMTFTC) (see instructions).....		11		
12 Tentative minimum tax. Subtract line 11 from line 10.....		12		
13 Regular tax liability before applying all credits except the foreign tax credit.....		13		
14 Alternative minimum tax. Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on Form 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return.....		14		

SCHEDULE O
(Form 1120)

(Rev December 2012)

Department of the Treasury
Internal Revenue Service

**Consent Plan and Apportionment Schedule
for a Controlled Group**

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-FSC, 1120-L, 1120-PC, 1120-REIT, or 1120-RIC.

▶ Information about Schedule O (Form 1120) and its instructions is available www.irs.gov/form1120

OMB No. 1545-0123

Name Danbury Hospital	Employer identification number 06-0646597
---------------------------------	---

Part I Apportionment Plan Information

- 1 Type of controlled group:
- a Parent-subsidiary group
 - b Brother-sister group
 - c Combined group
 - d Life insurance companies only
- 2 This corporation has been a member of this group:
- a For the entire year.
 - b From _____, _____, until _____, _____.
- 3 This corporation consents and represents to:
- a Adopt an apportionment plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on _____, _____, and for all succeeding tax years.
 - b Amend the current apportionment plan. All the other members of this group are currently amending a previously adopted plan, which was in effect for the tax year ending _____, _____, and for all succeeding tax years.
 - c Terminate the current apportionment plan and not adopt a new plan. All the other members of this group are not adopting an apportionment plan.
 - d Terminate the current apportionment plan and adopt a new plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on 9/30, 2015, and for all succeeding tax years.
- 4 If you checked box 3c or 3d above, check the applicable box below to indicate if the termination of the current apportionment plan was:
- a Elected by the component members of the group.
 - b Required for the component members of the group.
- 5 If you did not check a box on line 3 above, check the applicable box below concerning the status of the group's apportionment plan (see instructions).
- a No apportionment plan is in effect and none is being adopted.
 - b An apportionment plan is already in effect. It was adopted for the tax year ending _____, _____, and for all succeeding tax years.
- 6 If all the members of this group are adopting a plan or amending the current plan for a tax year after the due date (including extensions) of the tax return for this corporation, is there at least one year remaining on the statute of limitations from the date this corporation filed its amended return for such tax year for assessing any resulting deficiency? See instructions.
- a Yes.
 - (i) The statute of limitations for this year will expire on _____, _____.
 - (ii) On _____, _____, this corporation entered into an agreement with the Internal Revenue Service to extend the statute of limitations for purposes of assessment until _____, _____.
 - b No. The members may not adopt or amend an apportionment plan.
- 7 Required information and elections for component members. Check the applicable box(es) (see instructions).
- a The corporation will determine its tax liability by applying the maximum tax rate imposed by section 11 to the entire amount of its taxable income.
 - b The corporation and the other members of the group elect the FIFO method (rather than defaulting to the proportionate method) for allocating the additional taxes for the group imposed by section 11(b)(1).
 - c The corporation has a short tax year that does not include December 31.

Part II Taxable Income Apportionment (See instructions)

Caution: Each total in Part II, column (g) for each component member must equal taxable income from Form 1120, page 1, line 30 or the comparable line of such member's tax return.

(a) Group member's name and employer identification number	(b) Tax year end (Year-Month)	Taxable Income Amount Allocated to Each Bracket					(g) Total (add columns (c) through (f))
		(c) 15%	(d) 25%	(e) 34%	(f) 35%		
1 Danbury Hospital	06-0646597	2015-09	0.	0.	0.	0.	0.
2 Western Connecticut Health Network, Inc.	22-2594977	2015-09	0.	0.	0.	0.	0.
3 Western CT Health Network Foundation, Inc.	23-7425557	2015-09	0.	0.	0.	0.	0.
4 Western CT Health Network Affiliates, Inc.	22-2594968	2015-09	0.	0.	0.	0.	0.
5 Western Connecticut Home Care, Inc.	06-0655138	2015-09	0.	0.	0.	0.	0.
6 Western Connecticut Medical Group, Inc.	06-1137531	2015-09	0.	0.	0.	0.	0.
7 Eastern New York Medical Services, P.C.	45-5431389	2015-09	0.	0.	0.	0.	0.
8 The Norwalk Hospital Association	06-6068853	2015-09	0.	0.	0.	0.	0.
9 Norwalk Hospital Phys. & Surgeons, Inc.	06-1522078	2015-09	0.	0.	0.	0.	0.
10 Norwalk Health Care, Inc.	22-2577722	2015-09	0.	0.	0.	0.	0.
Total			50,000.	25,000.	62,503.		137,503.

BAA

Part II Taxable Income Apportionment (See instructions)

Caution: Each total in Part II, column (g) for each component member must equal taxable income from Form 1120, page 1, line 30 or the comparable line of such member's tax return.

(a) Group member's name and employer identification number	(b) Tax year end (Year-Month)	Taxable Income Amount Allocated to Each Bracket				(g) Total (add columns (c) through (f))	
		(c) 15%	(d) 25%	(e) 34%	(f) 35%		
1 <u>Norwalk Hospital Foundation</u> -----	22-2577707	2015-09	0.	0.	0.	0.	0.
2 <u>S.W.C Corporation</u> -----	22-2577718	2015-09	50,000.	25,000.	62,503.		137,503.
3 <u>Medical Services of Danbury</u> -----	06-1635945	2015-09	0.	0.	0.	0.	0.
4 <u>Advanced Ctr. for Rehab. Medicine</u> -----	06-1304799	2015-09	0.	0.	0.	0.	0.
5 -----							
6 -----							
7 -----							
8 -----							
9 -----							
10 -----							
Total							

BAA

Part III Income Tax Apportionment (See instructions)

(a) Group member's name	Income Tax Apportionment						(h) Total income tax (combine lines (b) through (g))
	(b) 15%	(c) 25%	(d) 34%	(e) 35%	(f) 5%	(g) 3%	
1 Danbury Hospital							
2 Western Connecticut Health Network, Inc.							
3 Western CT Health Network Foundation, Inc.							
4 Western CT Health Network Affiliates, Inc.							
5 Western Connecticut Home Care, Inc.							
6 Western Connecticut Medical Group, Inc.							
7 Eastern New York Medical Services, P.C.							
8 The Norwalk Hospital Association							
9 Norwalk Hospital Phys. & Surgeons, Inc.							
10 Norwalk Health Care, Inc.							
Total	7,500.	6,250.	21,251.		2,043.		37,044.

BAA

Part III Income Tax Apportionment (See instructions)

(a) Group member's name	Income Tax Apportionment						(h) Total income tax (combine lines (b) through (g))
	(b) 15%	(c) 25%	(d) 34%	(e) 35%	(f) 5%	(g) 3%	
1 Norwalk Hospital Foundation							
2 S.W.C. Corporation	7,500.	6,250.	21,251.		2,043.		37,044.
3 Medical Services of Danbury							
4 Advanced Ctr. for Rehab. Medicine							
5							
6							
7							
8							
9							
10							
Total							

BAA

Part IV Other Apportionments (See instructions)

(a) Group member's name	Other Apportionments				
	(b) Accumulated earnings credit	(c) AMT exemption amount	(d) Phaseout of AMT exemption amount	(e) Penalty for failure to pay estimated tax	(f) Other
1 Danbury Hospital					
2 Western Connecticut Health Network, Inc.					
3 Western CT Health Network Foundation, Inc					
4 Western CT Health Network Affiliates, Inc					
5 Western Connecticut Home Care, Inc.					
6 Western Connecticut Medical Group, Inc.					
7 Eastern New York Medical Services, P.C.		20,000.	8,000.		
8 The Norwalk Hospital Association					
9 Norwalk Hospital Phys. & Surgeons, Inc.					
10 Norwalk Health Care, Inc.					
Total		40,000.	150,000.		

BAA

Part IV Other Apportionments (See instructions)

(a) Group member's name	Other Apportionments				
	(b) Accumulated earnings credit	(c) AMT exemption amount	(d) Phaseout of AMT exemption amount	(e) Penalty for failure to pay estimated tax	(f) Other
1 <u>Norwalk Hospital Foundation</u> -----					
2 <u>S.W.C Corporation</u> -----		20,000.	142,000.		
3 <u>Medical Services of Danbury</u> -----					
4 <u>Advanced Ctr. for Rehab. Medicine</u> -----					
5 -----					
6 -----					
7 -----					
8 -----					
9 -----					
10 -----					
Total					

BAA

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

2014

Department of the Treasury
Internal Revenue Service

▶ **Attach to your tax return.**
▶ **Information about Form 8865 and its separate instructions is at www.irs.gov/form8865.**
Information furnished for the foreign partnership's tax year beginning 01/01/2014, and ending 12/31/2014

Attachment
Sequence No. **118**

Name of person filing this return **THE DANBURY HOSPITAL** Filer's identifying number **06-0646597**

Filer's address (if you are not filing this form with your tax return) **THE DANBURY HOSPITAL**
A Category of filer (see **Categories of Filers** in the instructions and check applicable box(es)):
1 2 3 4
B Filer's tax year beginning 01/01/2014, and ending 12/31/2014

C Filer's share of liabilities: Nonrecourse \$ **NONE** Qualified nonrecourse financing \$ **NONE** Other \$ **147**

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

E Information about certain other partners (see instructions)					
(1) Name	(2) Address	(3) Identifying number	(4) Check applicable box(es)		
			Category 1	Category 2	Constructive owner

F1 Name and address of foreign partnership **BAIN CAPITAL FUND XI, L.P.**
JOHN HANCOCK TOWER, 200 CLARENDON STREET FL 41 BOSTON, MA 02116-5016
2(a) EIN (if any) **98-1060041**
2(b) Reference ID number (see instr.) **N/A**
3 Country under whose laws organized **CAYMAN ISLANDS**

4 Date of organization 06/26/2012	5 Principal place of business US	6 Principal business activity code number 523900	7 Principal business activity INVESTING	8a Functional currency USD	8b Exchange rate (see instr.) N/A
---	--	--	---	--	---

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

1 Name, address, and identifying number of agent (if any) in the United States **N/A**
2 Check if the foreign partnership must file:
 Form 1042 Form 8804 Form 1065 or 1065-B
Service Center where Form 1065 or 1065-B is filed: **FILED**

3 Name and address of foreign partnership's agent in country of organization, if any **MAPLES CORPORATE SERVICES LIMITED**
UGLAND HOUSE, SOUTH CHURCH ST, P.O. BOX 309 GEORGE TOWN, GRAND CAYMAN, CAYMAN ISLANDS, KY1-1104
4 Name and address of person(s) with custody of the books and records of the foreign partnership, and the location of such books and records, if different **BAIN CAPITAL FUND XI, L.P.**
JOHN HANCOCK TOWER, 200 CLARENDON STREET FL 41 BOSTON, MA 02116-5016

5 Were any special allocations made by the foreign partnership? **Yes** **No**
6 Enter the number of Forms 8858, Information Return of U.S. Persons With Respect To Foreign Disregarded Entities, attached to this return (see instructions) **N/A**
7 How is this partnership classified under the law of the country in which it is organized? **EXEMPTED LIMITED PARTNERSHIP**
8a Does the filer have an interest in the foreign partnership, or an interest indirectly through the foreign partnership, that is a separate unit under Reg. 1.1503(d)-1(b)(4) or part of a combined separate unit under Reg. 1.1503(d)-1(b)(4)(ii)? If "No," skip question 8b. **N/A** **Yes** **No**
b If "Yes," does the separate unit or combined separate unit have a dual consolidated loss as defined in Reg. 1.1503(d)-1(b)(5)(ii)? **N/A** **Yes** **No**
9 Does this partnership meet **both** of the following requirements?
• The partnership's total receipts for the tax year were less than \$250,000 and
• The value of the partnership's total assets at the end of the tax year was less than \$1 million. } **N/A** **Yes** **No**
If "Yes," **do not** complete Schedules L, M-1, and M-2.

Sign Here Only If You Are Filing This Form Separately and Not With Your Tax Return.
Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than general partner or limited liability company member) is based on all information of which preparer has any knowledge.
Signature of general partner or limited liability company member _____ Date _____

Paid Preparer Use Only
Print/Type preparer's name _____ Preparer's signature _____ Date _____
Check if self-employed PTIN _____
Firm's name _____ Firm's EIN _____
Firm's address _____ Phone no. _____

Schedule A

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

a Owns a direct interest

b Owns a constructive interest

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

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

Name	Address	Identifying number (if any)	Check if foreign person
N/A			

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

Schedule A-2

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

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

Schedule B Income Statement - Trade or Business Income

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

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

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

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

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

Schedule M Balance Sheets for Interest Allocation

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

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

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

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

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

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

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

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

SCHEDULE O
(Form 8865)

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 8865. See Instructions for Form 8865.

▶ Information about Schedule O (Form 8865) and its separate instructions is at www.irs.gov/form8865.

OMB No. 1545-1668

2014

Name of transferor THE DANBURY HOSPITAL		Filer's identifying number 06-0646597
Name of foreign partnership BAIN CAPITAL FUND XI, L.P.	EIN (if any) 98-1060041	Reference ID number (see instructions)

Part I Transfers Reportable Under Section 6038B

Type of property	(a) Date of transfer	(b) Number of items transferred	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Section 704(c) allocation method	(f) Gain recognized on transfer	(g) Percentage interest in partnership after transfer
Cash	VARIOUS		151,333				0.024282
Stock, notes receivable and payable, and other securities							
Inventory							
Tangible property used in trade or business							
Intangible property							
Other property							

Supplemental Information Required To Be Reported (see instructions):

Part II Dispositions Reportable Under Section 6038B

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 8865.

Schedule O (Form 8865) 2014

THE DANBURY HOSPITAL
06-0646597

BAIN CAPITAL FUND XI, L.P.
98-1060041
FORM 8865, PAGE 2 DETAIL

SCHEDULE A-2-AFFILIATE SCHEDULE

<u>NAME</u>	<u>ADDRESS</u>	<u>EIN NUMBER</u>	<u>TOTAL ORDINARY INCOME OR LOSS</u>	<u>CHECK IF FOREIGN PARTNERSHIP</u>
BVO HOLDINGS, LLC	200 STATE STREET BOSTON, MA 02109	47-2272036	N/A	
TOMS SHOES HOLDINGS, LLC	5404 JANDY PLACE LOS ANGELES, CA 90066	47-2208796	N/A	
BC-VCL INTEGRAL HOLDINGS, LLC	JOHN HANCOCK TOWER 200 CLARENDON STREET FL 41 BOSTON, MA 02116-5016	47-2275255	N/A	
VIRGIN CRUISES LIMITED	65 BLEECKER STREET, 6TH FLOOR NEW YORK, NY 10012	FOREIGN	N/A	X

Form **5471**

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

OMB No. 1545-0704

(Rev December 2012)

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

Department of the Treasury
Internal Revenue Service

Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **10/01, 2014**, and ending **9/30, 2015**

Attachment Sequence No. **121**

Name of person filing this return Danbury Hospital Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address) 24 Hospital Avenue City or town, state, and ZIP code Danbury, CT 06810	A Identifying number 06-0646597 B Category of filer (See instructions. Check applicable box(es)): 1 (repealed) 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 <input checked="" type="checkbox"/> C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period . 100.0000 %
Filer's tax year beginning 10/01, 2014 , and ending 9/30, 2015	

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

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

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

1a Name and address of foreign corporation Western Connecticut Health Network Ins. Co., LTD 23 Lime Tree Bay Avenue, P.O. Box 1051 Grand Cayman, Cayman Is,				b(1) Employer identification number, if any 98-0438151
				b(2) Reference ID number (see instructions)
				c Country under whose laws incorporated Cayman Islands
d Date of incorporation 10/01/2004	e Principal place of business Cayman Islands	f Principal business activity code number 524150	g Principal business activity Insurance	h Functional currency U.S. Dollar

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

a Name, address, and identifying number of branch office or agent (if any) in the United States N/A	b If a U.S. income tax return was filed, enter: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;">(i) Taxable income or (loss)</td> <td style="width:50%; vertical-align: top;">(ii) U.S. income tax paid (after all credits)</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)		
(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)				
c Name and address of foreign corporation's statutory or resident agent in country of incorporation Marsh Management Services Cayman, LTD. 23 Lime Tree Bay Avenue, P.O. Box 1051 Grand Cayman, Cayman Is,	d Name and address (including corporate department, if applicable) of person (or persons) with custody of the books and records of the foreign corporation, and the location of such books and records, if different Marsh Management Services Cayman, LTD 23 Lime Tree Bay Avenue, P.O. Box 1051 Grand Cayman, Cayman Is,				

Schedule A Stock of the Foreign Corporation		
(a) Description of each class of stock	(b) Number of shares issued and outstanding	
	(i) Beginning of annual accounting period	(ii) End of annual accounting period
Common	12,000.	12,000.

Schedule E Income, War Profits, and Excess Profits Taxes Paid or Accrued (see instructions)

(a) Name of country or U.S. possession	Amount of tax		
	(b) In foreign currency	(c) Conversion rate	(d) In U.S. dollars
1 U.S.			
2			
3			
4			
5			
6			
7			
8 Total			

Schedule F Balance Sheet

Important: Report all amounts in U.S. dollars prepared and translated in accordance with U.S. GAAP. See instructions for an exception for DASTM corporations.

Assets		(a) Beginning of annual accounting period	(b) End of annual accounting period
1 Cash	1	23,225,784.	28,696,682.
2a Trade notes and accounts receivable	2a		
b Less allowance for bad debts	2b		
3 Inventories	3		
4 Other current assets (attach statement)	4		
5 Loans to shareholders and other related persons	5		
6 Investment in subsidiaries (attach statement)	6		
7 Other investments (attach statement) See Statement 3	7	84,429,054.	93,296,630.
8a Buildings and other depreciable assets	8a		
b Less accumulated depreciation	8b		
9a Depletable assets	9a		
b Less accumulated depletion	9b		
10 Land (net of any amortization)	10		
11 Intangible assets:			
a Goodwill	11a		
b Organization costs	11b		
c Patents, trademarks, and other intangible assets	11c		
d Less accumulated amortization for lines 11a, b, and c	11d		
12 Other assets (attach statement) See Statement 4	12	16,048,063.	10,837,656.
13 Total assets	13	123,702,901.	132,830,968.
Liabilities and Shareholders' Equity			
14 Accounts payable	14	39,238.	31,529.
15 Other current liabilities (attach statement) See Statement 5	15	120,619.	
16 Loans from shareholders and other related persons	16		
17 Other liabilities (attach statement) See Statement 6	17	82,107,023.	79,105,271.
18 Capital stock:			
a Preferred stock	18a		
b Common stock	18b	12,000.	12,000.
19 Paid-in or capital surplus (attach reconciliation) See Statement 7	19	12,863,333.	12,863,333.
20 Retained earnings	20	28,560,688.	40,818,835.
21 Less cost of treasury stock	21		
22 Total liabilities and shareholders' equity	22	123,702,901.	132,830,968.

Schedule G Other Information

- | | | |
|---|--------------------------|-------------------------------------|
| | Yes | No |
| 1 During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership?
If 'Yes,' see the instructions for required statement. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2 During the tax year, did the foreign corporation own an interest in any trust? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3 During the tax year, did the foreign corporation own any foreign entities that were disregarded as entities separate from their owners under Regulations sections 301.7701-2 and 301.7701-3 (see instructions)?
If 'Yes,' you are generally required to attach Form 8858 for each entity (see instructions). | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4 During the tax year, was the foreign corporation a participant in any cost sharing arrangement? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5 During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6 During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4?
If 'Yes,' attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(3)(i)(G). | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7 During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8 During the tax year, did the foreign corporation pay or accrue any foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Schedule H Current Earnings and Profits (see instructions)

Important: Enter the amounts on lines 1 through 5c in **functional** currency.

1 Current year net income or (loss) per foreign books of account	1	12,258,147.
2 Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):		
a Capital gains or losses	Net Additions	Net Subtractions
b Depreciation and amortization		
c Depletion		
d Investment or incentive allowance		
e Charges to statutory reserves	5,905,087.	
f Inventory adjustments		
g Taxes		
h Other (attach statement) See Statement 8	1,071,115.	19,113,167.
3 Total net additions	6,976,202.	
4 Total net subtractions		19,113,167.
5a Current earnings and profits (line 1 plus line 3 minus line 4)	5a	121,182.
b DASTM gain or (loss) for foreign corporations that use DASTM (see instructions)	5b	
c Combine lines 5a and 5b	5c	121,182.
d Current earnings and profits in U.S. dollars (line 5c translated at the appropriate exchange rate as defined in section 989(b) and the related regulations (see instructions)). Enter exchange rate used for line 5d ▶	5d	0.

Schedule I Summary of Shareholder's Income From Foreign Corporation (see instructions)

If item D on page 1 is completed, a separate Schedule I must be filed for each Category 4 or 5 filer for whom reporting is furnished on this Form 5471. This schedule I is being completed for: **Danbury Hospital**

Name of U.S. shareholder ▶	Identifying number ▶	
1 Subpart F income (line 38b, Worksheet A in the instructions)	1	121,182.
2 Earnings invested in U.S. property (line 17, Worksheet B in the instructions)	2	
3 Previously excluded subpart F income withdrawn from qualified investments (line 6b, Worksheet C in the instructions)	3	
4 Previously excluded export trade income withdrawn from investment in export trade assets (line 7b, Worksheet D in the instructions)	4	
5 Factoring income	5	
6 Total of lines 1 through 5. Enter here and on your income tax return. See instructions	6	121,182.
7 Dividends received (translated at spot rate on payment date under section 989(b)(1))	7	
8 Exchange gain or (loss) on a distribution of previously taxed income	8	

- | | | |
|--|--------------------------|-------------------------------------|
| | Yes | No |
| • Was any income of the foreign corporation blocked? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| • Did any such income become unblocked during the tax year (see section 964(b))? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- If the answer to either question is 'Yes,' attach an explanation.

SCHEDULE J
(Form 5471)

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

Accumulated Earnings and Profits (E&P)
of Controlled Foreign Corporation

► Information about Schedule J (Form 5471) and its instructions is at www.irs.gov/form5471.
► Attach to Form 5471.

OMB No. 1545-0704

Name of person filing Form 5471 Danbury Hospital		Identifying number 06-0646597
Name of foreign corporation Western Connecticut Health Network Ins. Co., LT	EIN (if any) 98-0438151	Reference ID number (see instructions)

Important: Enter amounts in functional currency.	(a) Post-1986 Undistributed Earnings (post-86 section 959(c)(3) balance)	(b) Pre-1987 E&P Not Previously Taxed (pre-87 section 959(c)(3) balance)	(c) Previously Taxed E&P (see instructions) (sections 959(c)(1) and (2) balances)			(d) Total Section 964(a) E&P (combine columns (a), (b), and (c))
			(i) Earnings Invested in U.S. Property	(ii) Earnings Invested in Excess Passive Assets	(iii) Subpart F Income	
1 Balance at beginning of year.....	9,658,577.				4,627,175.	14,285,752.
2 a Current year E&P.....	121,182.					
b Current year deficit in E&P.....						
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a or line 1 minus line 2b).....	9,779,759.					
4 Amounts included under section 951(a) or reclassified under section 959(c) in current year.....					121,182.	
5 a Actual distributions or reclassifications of previously taxed E&P.....						
b Actual distributions of nonpreviously taxed E&P.....						
6 a Balance of previously taxed E&P at end of year (line 1 plus line 4, minus line 5a).....			0.	0.	4,748,357.	
b Balance of E&P not previously taxed at end of year (line 3 minus line 4, minus line 5b).....	9,779,759.	0.				
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.).....	9,779,759.	0.	0.	0.	4,748,357.	14,528,116.

BAA For Paperwork Reduction Act Notice, see the Instructions for Form 5471.

Schedule J (Form 5471) (Rev 12-2012)

SCHEDULE M
(Form 5471)

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

Transactions Between Controlled Foreign Corporation and Shareholders or Other Related Persons

► Information about Schedule M (Form 5471) and its instructions is at www.irs.gov/form5471.
► Attach to Form 5471.

OMB No. 1545-0704

Name of person filing Form 5471 Danbury Hospital		Identifying number 06-0646597
Name of foreign corporation Western Connecticut Health Network Ins. Co., LTD	EIN (if any) 98-0438151	Reference ID number (see instructions)

Important: Complete a *separate* Schedule M for each controlled foreign corporation. Enter the totals for each type of transaction that occurred during the annual accounting period between the foreign corporation and the persons listed in columns (b) through (f). All amounts must be stated in U.S. dollars translated from functional currency at the average exchange rate for the foreign corporation's tax year. See instructions.

Enter the relevant functional currency and the exchange rate used throughout this schedule ► **U.S. Dollar 1**

(a) Transactions of foreign corporation	(b) U.S. person filing this return	(c) Any domestic corporation or partnership controlled by U.S. person filing this return	(d) Any other foreign corporation or partnership controlled by U.S. person filing this return	(e) 10% or more U.S. shareholder of controlled foreign corporation (other than the U.S. person filing this return)	(f) 10% or more U.S. shareholder of any corporation controlling the foreign corporation
1 Sales of stock in trade (inventory)					
2 Sales of tangible property other than stock in trade					
3 Sales of property rights (patents, trademarks, etc)					
4 Platform contribution transaction payments received					
5 Cost sharing transaction payments received					
6 Compensation received for technical, managerial, engineering, construction, or like services					
7 Commissions received					
8 Rents, royalties, and license fees received					
9 Dividends received (exclude deemed distributions under subpart F and distributions of previously taxed income)					
10 Interest received					
11 Premiums received for insurance or reinsurance	9,603,833.	12,037,404.			
12 Add lines 1 through 11	9,603,833.	12,037,404.	0.	0.	0.
13 Purchases of stock in trade (inventory)					
14 Purchases of tangible property other than stock in trade					
15 Purchases of property rights (patents, trademarks, etc)					
16 Platform contribution transaction payments paid					
17 Cost sharing transaction payments paid					
18 Compensation paid for technical, managerial, engineering, construction, or like services					
19 Commissions paid					
20 Rents, royalties, and license fees paid					
21 Dividends paid					
22 Interest paid					
23 Premiums paid for insurance or reinsurance					
24 Add lines 13 through 23	0.	0.	0.	0.	0.
25 Amounts borrowed (enter the maximum loan balance during the year) — see instructions					
26 Amounts loaned (enter the maximum loan balance during the year) — see instructions					

Statement 2
Form 5471, Page 2, Schedule C, Line 16
Other Deductions

Actuarial Fees.....	\$ 187,000.
Audit Fees.....	30,024.
Government Fees.....	11,220.
Legal Fees.....	34,923.
Losses and Loss Adjustment Expense.....	9,749,483.
Management Fees.....	88,900.
Meeting Expense.....	34,520.
Other.....	11,947.
Reinsurance Premiums Ceded.....	2,530,000.
Risk Management Grant.....	541,951.
Unrealized Losses.....	1,071,115.
Total	<u>\$ 14,291,083.</u>

Statement 3
Form 5471, Page 3, Schedule F, Line 7
Other Investments

	<u>Beginning</u>	<u>Ending</u>
Mutual Funds.....	\$ 84,429,054.	\$ 93,296,630.
Total	<u>\$ 84,429,054.</u>	<u>\$ 93,296,630.</u>

Statement 4
Form 5471, Page 3, Schedule F, Line 12
Other Assets

	<u>Beginning</u>	<u>Ending</u>
Loss Recoverable.....	\$ 5,476,659.	\$ 0.
Other Assets.....	4,665.	9,427.
Premiums Receivable.....	249,477.	113,205.
Reinsurance Recoverable.....	10,317,262.	10,715,024.
Total	<u>\$ 16,048,063.</u>	<u>\$ 10,837,656.</u>

Statement 5
Form 5471, Page 3, Schedule F, Line 15
Other Current Liabilities

	<u>Beginning</u>	<u>Ending</u>
Due to Affiliates.....	\$ 120,619.	\$ 0.
Total	<u>\$ 120,619.</u>	<u>\$ 0.</u>

Client 1015

Danbury Health Systems Insurance Co, LTD

98-0438151

7/27/16

01:05PM

Statement 6
Form 5471, Page 3, Schedule F, Line 17
Other Liabilities

	<u>Beginning</u>	<u>Ending</u>
Loss Reserves.....	\$ 81,991,423.	\$ 78,851,613.
Losses Payable.....	0.	147,714.
Reserve for Unearned Premiums.....	115,600.	105,944.
Total	<u>\$ 82,107,023.</u>	<u>\$ 79,105,271.</u>

Statement 7
Form 5471, Page 3, Schedule F, Line 19
Paid-in or Capital Surplus

	<u>Beginning</u>	<u>Ending</u>
Additional Paid In Capital.....	\$ 12,863,333.	\$ 12,863,333.
Total	<u>\$ 12,863,333.</u>	<u>\$ 12,863,333.</u>

Statement 8
Form 5471, Page 4, Schedule H, Line 2h
Other Additions/Subtractions

	<u>Additions</u>	<u>Subtractions</u>
Change in Unearned Premiums VAP.....		1,930.
Change in Unrealized on Investments.....	1,071,115.	
Deposit Reclassifications.....		19,111,237.
Total	<u>1,071,115.</u>	<u>19,113,167.</u>

**Return by a U.S. Transferor of Property
to a Foreign Corporation**

Information about Form 926 and its separate instructions is at www.irs.gov/form926.
Attach to your income tax return for the year of the transfer or distribution.

Part I U.S. Transferor Information (see instructions)

Name of transferor: **Danbury Hospital** Identifying number (see instructions): **06-0646597**

1 If the transferor was a corporation, complete questions 1a through 1d.

- a** If the transfer was a section 361(a) or (b) transfer, was the transferor controlled (under section 368(c)) by 5 or fewer domestic corporations? Yes No
- b** Did the transferor remain in existence after the transfer? Yes No
- If not, list the controlling shareholder(s) and their identifying number(s):

Controlling shareholder	Identifying number

- c** If the transferor was a member of an affiliated group filing a consolidated return, was it the parent corporation? Yes No
- If not, list the name and employer identification number (EIN) of the parent corporation:

Name of parent corporation	EIN of parent corporation

- d** Have basis adjustments under section 367(a)(5) been made? Yes No

2 If the transferor was a partner in a partnership that was the actual transferor (but is not treated as such under section 367), complete questions 2a through 2d.

a List the name and EIN of the transferor's partnership:

Name of partnership	EIN of partnership

- b** Did the partner pick up its pro rata share of gain on the transfer of partnership assets? Yes No

- c** Is the partner disposing of its **entire** interest in the partnership? Yes No

- d** Is the partner disposing of an interest in a limited partnership that is regularly traded on an established securities market? Yes No

Part II Transferee Foreign Corporation Information (see instructions)

3 Name of transferee (foreign corporation) Western CT Health Network Ins. Co., LTD	4a Identifying number, if any 98-0438151
5 Address (including country) 23 Lime Tree Bay Avenue, PO Box 1051 Grand Cayman Cayman Islands	4b Reference ID number (see instr.)
6 Country code of country of incorporation or organization (see instructions) CJ	
7 Foreign law characterization (see instructions) Corporation	
8 Is the transferee foreign corporation a controlled foreign corporation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Part III Information Regarding Transfer of Property (see instructions)

Type of Property	(a) Date of Transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash			22,064,136.		
Stock and securities					
Installment obligations, account receivables or similar property					
Foreign currency or other property denominated in foreign currency					
Inventory					
Assets subject to depreciation recapture (see Temp. Regs. sec. 1.367(a)-4T(b))					
Tangible property used in trade or business not listed under another category					
Intangible property					
Property to be leased (as described in final and temp. Regs. sec. 1.367(a)-4(c))					
Property to be sold (as described in Temp. Regs. sec. 1.367(a)-4T(d))					
Transfers of oil and gas working interests (as described in Temp. Regs. sec. 1.367(a)-4T(e))					
Other property					

Supplemental Information Required To Be Reported (see instructions):

Part IV Additional Information Regarding Transfer of Property (see instructions)

9 Enter the transferor's interest in the foreign transferee corporation before and after the transfer:

(a) Before 100.0000 % (b) After 100.0000 %

10 Type of nonrecognition transaction (see instructions) ▶ IRC Section 351

11 Indicate whether any transfer reported in Part III is subject to any of the following:

- a Gain recognition under section 904(f)(3) Yes No
- b Gain recognition under section 904(f)(5)(F) Yes No
- c Recapture under section 1503(d) Yes No
- d Exchange gain under section 987 Yes No

12 Did this transfer result from a change in the classification of the transferee to that of a foreign corporation? Yes No

13 Indicate whether the transferor was required to recognize income under final and Temporary Regulations sections 1.367(a)-4 through 1.367(a)-6 for any of the following:

- a Tainted property Yes No
- b Depreciation recapture Yes No
- c Branch loss recapture Yes No
- d Any other income recognition provision contained in the above-referenced regulations Yes No

14 Did the transferor transfer assets which qualify for the trade or business exception under section 367(a)(3)? Yes No

15a Did the transferor transfer foreign goodwill or going concern value as defined in Temporary Regulations section 1.367(a)-1T(d)(5)(iii)? Yes No

b If the answer to line 15a is 'Yes,' enter the amount of foreign goodwill or going concern value transferred ▶ \$ _____

16 Was cash the only property transferred? Yes No

17a Was intangible property (within the meaning of section 936(h)(3)(B)) transferred as a result of the transaction? Yes No

b If 'Yes' describe the nature of the rights to the intangible property that was transferred as a result of the transaction:

Danbury Hospital
Attachment to Form 926
For the Fiscal Year Ended September 30, 2015

Information Required Pursuant to Regulation Section 1.6038b-1(c)

1. **Transferor:** Danbury Hospital
24 Hospital Avenue
Danbury, CT 06810
06-0646597

2. **Transferee:** Western Connecticut Health Network Ins. Co., LTD
23 Lime Tree Bay Avenue,
P.O. Box 1051
Grand Cayman, Cayman Island

(i) **Type of Transfer:** Cash in the amount of \$25,611,364.
(ii) **Date of Transfer:** Various dates between 10/01/2014 and 9/30/2015

3. **Consideration Received:** None

4. **Property Transferred:**
 - (i) **Active Business Property:** Cash
Business Conducted: Insurance
Number of Employees: Unknown
Rule: Not Applicable
 - (ii) **Stock and Securities** Not Applicable
 - (iii) **Depreciated Property:** Not Applicable
 - (iv) **Property to be Leased:** Not Applicable
 - (v) **Property to be Sold:** Not Applicable
 - (vi) **Transfers to FSC:** Not Applicable
 - (vii) **Tainted Property:** Not Applicable
 - (viii) **Foreign Loss Branch:** Not Applicable
 - (ix) **Other Intangibles** Not Applicable

5. **Transfer to Foreign Branch Loss with Previously Deducted Losses:**
 - (i) **Branch Operation:** Not Applicable
 - (ii) **Branch Property:** Not Applicable
 - (iii) **Previously Deducted Losses:** Not Applicable
 - (iv) **Character of Gain:** Not Applicable

6. **Application of Section 367(a) (5):** Not Applicable