BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 22: TRANSCRIPT OF PUBLIC HEARING

VERBATIM PROCEEDINGS

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.

PUBLIC HEARING

PROPOSED TRANSACTION BETWEEN BRISTOL HOSPITAL AND HEALTH CARE GROUP AND TENET HEALTHCARE CORPORATION

AUGUST 14, 2014

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BRISTOL HOSPITAL
41 BREWSTER ROAD
BRISTOL, CONNECTICUT 06011

. . .Verbatim proceedings of a proposed transaction between the Bristol Hospital and Health Care Group, Inc. public meeting, held at the Bristol Hospital, Hughes Auditorium, 14 Brewster Road, Bristol, Connecticut, on August 14, 2014, at 6:01 p.m. . . . .

SPEAKER THOMAS MONAHAN: Well good evening everybody. My name is Tom Monahan, I'm a member of the Board of Directors of Bristol Hospital and Health Care Group and I am serving as your moderator tonight. Thanks for joining us here in the auditorium. We may have a few people in the cafeteria, we're not sure, but there may be some people stopping by and if so, they will be able to watch the proceedings from there.

We are here tonight to conduct a public hearing. Our purpose is to provide information regarding the proposed acquisition of Bristol Hospital by Tenet Healthcare Corporation and Yale New Haven Health Services.

Let me take a moment to review our agenda for the evening. First, I will explain the regulatory process and timeline. Marie O'Brien, who is Chairman of the Board, will explain why we are joining a larger health system and why Tenet and Yale were selected. Dr. Bala Shanmugam, President of the medical staff, will highlight the scope of our clinical care services. Kurt Barwis, President and CEO, explains the terms and benefits of the sale to Tenet and also to Yale.

And finally, we will be providing a chance for your questions at the end with a panel from Bristol, also from Tenet and Yale. Now, the public hearing tonight is a legal requirement for the regulatory approval process being conducted by OHCA, that's the Office of Health Care Access, and the Attorney General; the hearing on the question and answer session to follow. The presentations are being recorded and transcribed and also will be reviewed as part of the record of our Certificate of Need application. Now please see Chris Boyle, and Chris is sitting right up in front here, if you have not signed up as yet and you'd like to speak. See Chris and he'll take

care of you from there. I will be calling speakers from a list.

Now please note, your comments should relate to Bristol Hospital's acquisition by Tenet Healthcare Corporation and also Yale New Health Services Corporation. Bristol Hospital and Health Care Group, Incorporated filed a Certificate of Need determination letter with the State back on July 21st. We are holding this hearing tonight as required within 30 days to explain the terms of this transaction as described in the CON determination letter. We will provide a written transcript to OHCA, and also to the Attorney General. OHCA and the Attorney General will determine whether this transaction, which includes the conversation of Bristol Hospital from a non-profit to a for-profit hospital, owned by Tenet requires approval. Connecticut law governs hospital conversations from non-profit to for-profit.

Hospitals must meet the requirements established under the law in order to gain approval from the Attorney General and OHCA. Bristol Hospital, Tenet and Yale have been working together throughout this process to

adhere to the letter of the law in order to gain approval. Now, Connecticut law also engages the Commissioner of Public Health. Standards by which our application that will be judged include the following: continued access to high quality affordable care; any proposed change impacting hospital staffing; a commitment to provide care to the uninsured and the underinsured; Certificate of Need guidelines measuring public need; the impact on financial strength of the state's health care system and whether it will improve quality, accessibility and cost effectiveness.

So what is the timeline for the completion? Each step in the process is mandated by State statutes. When Bristol Hospital filed the CON determination letter with the Attorney General and OHCA on July 21, it set the process in motion. Now, we expect OHCA and the Attorney General will require our application to be reviewed under the Certificate of Need and the conversion statutes. That means, we will receive a CON application from the Attorney General and OHCA, we estimate that will come within 45 days. Within 60 days of receiving the application we are required to file a completed Certificate of Need

application, which brings us to sometime in the month of November.

Now, the Attorney General and OHCA have 20 days to submit questions concerning our CON application. We are hopeful that our application will be deemed complete sometime in February. The AG and OHCA have 120 days to review and decide upon the application. OHCA and the Attorney General will conduct another public hearing and we do expect a final decision from the State by July of 2015. Now I'm pleased to introduce to you our next speaker, Marie O'Brien, Chairman of the Board of Bristol Hospital and Health Care Group. Marie will explain our decision to join a larger health care system.

MS. MARIE O'BRIEN: Thank you Tom. As Stewards of Bristol Hospital, the Board of Directors engaged in a lengthy evaluation to determine if joining a larger health system was the best for Bristol. Bristol Hospital is financially sound and has invested significantly in quality and patient safety in information technology and clinical services. Our understanding of the current health care financial environment and the

challenges ahead drove the Board's strategic decision.

Financial and regulatory pressures from the Affordable Care Act, cuts to Medicare and Medicaid funding, are evidence that the time is now to take advantage of this opportunity to align with Tenet and Yale. Bristol Hospital is not alone in the financial challenges our hospitals face across the state and the nation. An operating margin of four percent is the standard hospitals need to achieve in order to sustain care, staff, service, and invest in facilities and technology. Despite our best efforts at efficiency and savings, Bristol Hospital's operating margins have not exceeded one-half of one percent in the past five years.

Competition from in-state health systems is moving into and surrounding Bristol. We need the economies of scale from being part of a large investor-owned health system to maintain care we provide now and to plan for the future. The Board of Directors conducted a thorough and deliberative planning process to understand and evaluate our strategic options for the future of Bristol Hospital. We determined that Bristol could not continue as an

independent hospital. The Board sought proposals for a strategic capital partner and met with four institutions. We visited eight hospitals owned by for-profit companies seeking the best fit in their commitment to quality and patient safety.

The Board selected Vanguard Health System, now Tenet Healthcare Corporation, and Yale New Haven Health Services. As a result of our due diligence the Board found that the Tenet/Yale partnership gave us the best chance to preserve Bristol Hospital's mission of providing high quality, safe and accessible health care to our community. Our Board was most impressed by Tenet Health's record of receiving national awards for quality of care from such organizations as the American Heart Association and the National Institute of Health Care Quality. We were impressed with the capital investments Tenet makes in their hospitals that will help Bristol expand and improve community programs.

Tenet Health is one of the leading health systems in America with 80 hospitals coast to coast. Tenet's financial strength will enable Bristol Hospital to

invest in new medical technology and improve our facilities. Tenet will support significant investments in our hospital facility such as upgrades to patient rooms, the Emergency Department, the Surgical Care Center and Ambulatory Services. With our financial obligations of debt retired and pensions assumed by Tenet, Bristol Hospital becomes part of a high performance integrated hospital network with strong financial resources, clinical excellence and innovative new opportunities.

Our expanded partnership with Tenet builds on a long standing relationship we have enjoyed with Yale and its physicians. We are excited about the possibilities of greater collaboration with Yale New Haven Hospital and we anticipate improved access to a higher level of care required by our critically ill patients. We will continue to develop joint clinical care programs such as our enhanced and expanded urology services and we will benefit from the ability to attract and retain physicians through this Tenet/Yale relationship. All of these great benefits and of course yes, there's one more, we will still be called Bristol Hospital. Thank you. (Applause)

SPEAKER MONAHAN: Marie, thank you very much. We are fortunate to have a dedicated medical staff here at Bristol Hospital that has been engaged every step of the way in this process. As President of the medical staff on the Board of Directors, Dr. Bala Shanmugam has been very engaged representing physicians in the planning for the future of Bristol Hospital. Dr. Shanmugam is Board-certified in internal medicine and infectious disease. Doctor, please come up.

DR. BALA SHANMUGAM: Hi everyone. So Tom I know is very experienced in public speaking and doesn't break a sweat and I think he was okay until he realized he had to introduce me and had to say my name. So he practiced -- exactly, he practiced all night and he got it close and correct the last time.

So my role here is to represent the medical staff of Bristol Hospital as the President of the Medical Staff. But for those of you who don't know, medical staff means pretty much all the doctors and the allied health care providers who are involved in providing care to patients here. We as the medical staff want to absolutely

provide the best care possible to the community. Most doctors or fair to say all doctors over here trained at big hospitals, academic centers and then we chose to come here to practice in a community setting and obviously we would like to do so because that is our goal, to provide the best possible care to our community.

Having said that let me get to the slides. As you can see up over here, providing care locally is what Bristol Hospital is all about. It has a strong presence in the region with offices easily accessible to all our patients in Bristol and the surrounding communities and we believe that the Tenet/Yale affiliation positions Bristol Hospital to continue to provide care to the local population well into the future. Bristol Hospital has been around for 95 years serving the local community and their health care needs. There are about 1,600 staff and about 300 doctors and physicians who work over here.

We have the ability to provide care from birth all the way through Ingraham Manor, that's our extended care facility, to provide care throughout the continuum of life. And we also have the ability to provide

care at home through our health care agency. The list of services that we have currently you can see up on the slide over here. All of this can be provided right here in Bristol. You know, the last two -- sorry, the Sleep Center and the bariatric stuff, bariatric surgery services, has been developed since I came here about six years. That's completely new, it has been developed from scratch. And we already have a collaborative relationship with Yale New Haven Health System and it helps us provide the appropriate care for our more critically ill patients.

We have the ability to transfer them over seamlessly when we feel the need to. And that our doctors really like and I think it really helps us provide the best care for our patients. And we are excited and we do believe that this new partnership with Tenet and Yale and the affiliation with them will improve our ability to recruit doctors and bring more specialists that we feel we need into this community, which has always been a long standing challenge in this kind of setting. And we have developed a lot of new programs as the slide demonstrates. Our Orthopedic and Spine Center, we made a lot of

investments over the last few years to increase our specialty care services so that patients don't have to leave the community.

Having them close to home helps keep care local with familiar faces and places providing the care. And the staff at the Center for Orthopedic and Spine Health exemplify it and actually some of the procedures that they do is pretty advanced and cutting edge that you wouldn't expect a small hospital of our caliber to be able to provide. And then once you have the joint replacement, obviously we have the ability to provide the post-operative rehabilitation services. Most of the patients now are going home and getting it at home rather than nursing facilities and we can again, do that right here in Bristol.

Another great example as you'll see in this slide, is the Beekley Center for Breast Health and Wellness. It's a great example of how new services are going to be developed in the future. It's a very collaborative effort. From the beginning breast cancer survivors, patients, physicians and other health care providers were all involved right from the ground up in

designing the Center, which is not how it used to be before. And we're very proud to have Dr. Sai Varanasi, who is a member of our medical staff, to provide -- to lead the Center over there and provide breast surgery. And the Center is a member of the National Consortium for Breast Centers and that enables us to provide the highest level of care again, right here in Bristol.

Another example as you'll see in this slide is the newest effort to improve access to specialty care, which is just being built. Those of you who work here or visit here often will know, you can see it going up in the back parking lot. It's the Center for Wound Care and Hyperbaric Medicine. Again, bringing such comprehensive services to Bristol will mean patients will not have to travel outside the area to go get this type of care.

So going forward in the future in order to stay competitive and to meet the goals of what Bristol Hospital medical staff wants and what the community wants and Bristol Hospital wants, that is to provide the best possible care to our community. I really do think it's going to take significant investments in recruiting new

doctors, investing in new technology, and as the medical staff, and I'm here as their representative, we strongly believe that this proposed partnership with Tenet and Yale positions us and gives us the best opportunity to achieve that goal. Thank you very much. (Applause)

SPEAKER MONAHAN: Doctor, thank you so much. So what are the terms of the transaction of Tenant and Yale acquiring Bristol Hospital and Health Care Group? I'm pleased to introduce Kurt Barwis, our President and CEO. Kurt has led the hospital and has been part of the Bristol community for the past eight years and he will explain the details of the Certificate of Need letter of determination. Kurt Barwis.

MR. KURT BARWIS: Tom, thank you very much. Good evening and it's really great to see such a wonderful crowd here tonight in this room. You know, you set out to do this and you hope people show up, you know, and we walked in here and it's really positive to see everybody show up and be a part of this process.

I've been here for approximately eight years, almost exactly eight years now and I'm proud to say

that I live in Bristol. I live in this community that's served by the hospital and it's been a great experience for me to run into people in Stop & Shop and Price Chopper and all those other places and hear and get feedback about the services that we provide. So personally, this matters a lot to me not just because it's my job and that I walk in the door every morning and I think how lucky I am to be a part of this wonderful organization. It's also as a community member. So to our audience members in this room and in the cafeteria, and this is very difficult for me because those of you know me for me to read anything publicly and not speak from my heart and just say this stuff is a very difficult task.

So I'm going to read verbatim the slides you see on the screen that describe the terms of our transaction with Tenet and Yale as set forth in the Certificate of Need determination letter. Following each slide I will take a moment to share my thoughts about the terms to further explain the benefits of this transaction to Bristol Hospital and the community and the residents we serve. Excuse me, new glasses -- I have these glasses and

looking down there I realize this is in a bad position for me but I'll get through.

Bristol Hospital and Health Care Group, BHHCG, and I will use Bristol Hospital and Health Care Group throughout, I'm not going to read the acronym, is proposing to transfer certain assets of Bristol Hospital and Health Care Group and its affiliates and subsidiaries including Bristol Hospital, Inc., Bristol Hospital Multispecialty Group but excluding Bristol Hospital Development Foundation, to VHS Bristol Hospital Health Systems LS, LLC, to be formed a for-profit entity owned by a joint venture between Tenet Healthcare Corporation and Yale New Haven Health Services Corporation.

This purchase includes Bristol Hospital and Health Care Group, Inc.; Bristol Hospital, Inc., a licensed general hospital and home care provider; Bristol Hospital EMS, LLC, a licensed EMS organization; Bristol Health Care, Inc., including its subsidiary Ingraham Manor, a licensed chronic and convalescent and nursing home; Bristol Hospital and Health Care Group's interest in a number of joint ventures including Bristol MSO, LLC, Medworks, LLC,

Connecticut Occupational Medicine Partners, LLC, Total Laundry Collaborative, LLC, that's TLC, LLC, Central Connecticut Endoscopy Center, LLC, and Health Connecticut, LLC.

From my point of view I see a brighter future for Bristol Hospital and the patients who rely on us for the care in the Bristol community and as a result of this proposed transaction. From the beginning the Board and the medical staff and the executive team have kept our collective eyes on a common goal, to ensure that essential health care and services are vibrant, vital and sustained in this community. This transaction achieves our objectives. As part of the proposed transfer Bristol Hospital and Health Care Group and Tenet will restructure Bristol Hospital and Health Care Group's medical foundation, Bristol Hospital Multispecialty Group, Inc., and you see those signs all throughout the community and as Bala described in his slide with all those dots on the map, there's many, many locations.

Consistent with Connecticut law, this restructuring will take the form of a transfer of assets

and liabilities of Bristol Hospital MSG to a new medical foundation, the sole member of which will be Tenet or an affiliate of Tenet. The estimated purchase price is $50 million, less certain adjustments for capital leases, pension liabilities, retirement obligations and certain assumed liabilities. Tenet will own 80 percent of the membership interest in the joint venture and Yale will own 20 percent.

In general terms, this proposal will allow Bristol Hospital and Health Care Group to retire all of its existing debt, provide needed capital for improvements, provide greater opportunities for new and expanded service line developments, improve physician recruitment and retention, improve the Hospital's ability to respond to incentives under health care reform, realize economies of scale to reduce costs, realize operating efficiencies, improve the quality of care and services to patients in the Bristol Hospital and Health Care Group community. Restructuring of the Bristol Hospital Medical Specialty Group results in a new organization to employ the physicians. This improves our ability to attract and

retain physicians and continue to expand our service lines to provide more local care.

The $50 million purchase price pays off Bristol Hospital's debt, capital leases, pension liabilities and retirement obligations. Think of it this way, imagine the financial freedom you would feel from paying off your mortgage. We now have enhanced financial and operational resources to ensure -- we will now have enhanced financial and operational resources to ensure that Bristol Hospital can continue to improve the quality of care and services to our patients for years to come. There are a number of terms of the proposal that will significantly benefit the employees and the residents in the community served by Bristol Hospital and Health Care Group.

These terms include a commitment to preserve all essential Bristol Hospital services for at least 10 years, employment of all active Bristol Hospital and Health Care Group employees at compensation no less than current levels and with benefits consistent with those offered to employees at other hospitals operated by Tenet;

all collective bargaining agreements will be assumed and honored; assumption of the assets and liabilities of Bristol Hospital and Health Care Group retirement plan, a frozen, employee pension benefit plan; a commitment to maintain and adhere to Bristol Hospital's current policies of charitable care, indigent care, a community benefit, or adopt policies at least as favorable as Bristol Hospital's current policies.

We are pleased that our transaction recognizes the outstanding staff providing care on the front lines throughout our essential services. Employing all active Bristol Hospital and Health Care Group staff sends an important message to the community, that Bristol Hospital is here to stay. The same familiar faces who have cared for you and your families over the years will provide the continuity of care we value foremost. We are assured that Bristol Hospital will honor our commitment to charitable care, indigent care and community benefits. A commitment to provide care through the community-based health programs including cooperating with local organizations that sponsor health care initiatives to

address and identify community health needs and improve the health status of the community.

A commitment to maintain Bristol Hospital medical staff to ensure continuity of care in the community and to involve Bristol Hospital physicians in the strategic and capital planning process for Bristol Hospital to meet the needs of the medical staff and their patients. A commitment to maintain and enhance Bristol Hospital's historic commitment to quality, safety and patient satisfaction. Although the Attorney General will ultimately decide the role of the new foundation, it will take a new form as required by the conversion statute to support community-based care outside Bristol Hospital. The collaborative community health needs assessment that Bristol Hospital conducted last year may help define services to improve the health status of our community.

Our physicians have played an active role in the planning to help bring us to this point and we're happy to ensure their vital involvement going forward. This transaction will establish a local Board of Trustees for the Bristol Hospital consisting of four physician

members of the Bristol Hospital medical staff, five community leaders from the current Bristol Hospital and Health Care Group Board of Directors, and the Hospital CEO. The local Hospital Board will be responsible for and make recommendations on the establishment of Bristol Hospital policies, maintenance of patient quality care, medical staff credentialing and the provision of clinical services and community service planning in a manner responsive to community needs.

A commitment to spend in the next six years not less than $45 million on capital projects including routine and non-routine capital expenditures for our facility upgrades and renovations and the development and improvements of the Hospital ambulatory and other health care services in the community. The Bristol Hospital Board of Directors, medical staff and hospital leadership had many of the same questions that you would have about ownership of our cherished community asset by out of state investor-owned health system -- by an out of state investor-owned health system.

Local oversight and governance was

important to all of us. During our visits to other Tenet-owned hospitals we were assured by the local Board members that they were satisfied with their level of governance and the meaningful role they played in the hospital. Our local Board will ensure that patient quality care, our medical staff and clinical service and care for the community will continue.

Finally, we are delighted that $45 million will be invested in upgrading our hospital facility and improving the health care services we offer to the region. Tom, thank you.

SPEAKER MONAHAN: Thank you. (Applause)

Certainly a lot to digest. Well now is the time that we invite public comment and questions. I will call on those of you who have signed up to speak. Please see Chris Boyle here if you wish to sign in if you haven't done so as yet, and when I call your name please come to the microphone, state your name and where you live. We want everybody to have an opportunity to speak who wishes to do so. Please limit your comments to three minutes. Your comments should be directed to this proposed

transaction and the contents of the determination of need letter.

Our panelists of course are available to answer your questions as needed. Now I'm pleased to introduce the panelists. You've heard from some of them so far and we also welcome the guests from Tenet and from Yale. Kurt Barwis, President, Bristol Hospital; Marie O'Brien, Chairman of the Board, Bristol Hospital and Health Care Group; Dr. Bala Shanmugam, President of the medical staff and member of the Board of Directors; Trip Pilgrim, Senior Vice President, Tenet Healthcare; Erik Wexler, Chief Executive Officer, Tenet Healthcare Corporation in the northeast region; Vin Petrini, Senior Vice President, Yale New Haven Health Care Services Corporation.

Now for the first question, the first speaker tonight will be Jerry Rafaniello.

MR. JERRY RAFANIELLO: Hi, as Tom said my name is Jerry Rafaniello. I was born here in Bristol Hospital in 1943 and Bristol Hospital has been my only hospital in my whole life. I've been a Corporator for 30 plus years and when I asked Bill Barnes who asked me to be

a Corporator what a Corporator was, he said well a Corporator is an Ombudsman. I said Bill, nobody knows what an Ombudsman what's an Ombudsman?

He said well we expect you to be a liaison between the community and the hospital staff so that you can provide feedback to the community and feedback to the hospital so that we can continue to improve our services. And I forgot to mention the part about financial support also, but that's not a problem. But, you know, I immediately became a critic, a supporter, a defender of Bristol Hospital and over the last 30 years have lived through three generations of management, all the ups and downs, the lean years, the good years, and have witnessed with just great enjoyment what this current management team has done over the last eight years.

The growth and services of the Periop Center, the Cancer Center, the collaboration with Yale, improvements to the ER, based directly on patient feedback, and the radiation improvements, all the technology improvements, the conversation to digital records, have just been amazing for a non-profit organization to take on

and accomplish. The move from non-profit to for-profit can only continue to improve customer service.

People have said to me well, we're not going to get the same service with this for-profit. I said well if they're not giving good service they're not going to be for-profit very long. So I look forward to that extra level of investment and commitment to the people of Bristol. I just want to congratulate the current team for getting through this last couple of years of due diligence and all the things that have to be done to satisfy all these regulatory obligations, okay, and congratulate them again for their fierce dedication to improving patient service for the community of Bristol. Good luck.

(Applause)

SPEAKER MONAHAN: Robert Bianchi.

MR. ROBERT BIANCHI: Thank you, thank you for the opportunity to speak. My name is Robert Bianchi, I am a 34 year retiree of Bristol Hospital. I'm a pharmacist, former pharmacy Director, okay. I have several questions.

On the terms of the proposal, number one, a

commitment to preserve all essential Bristol Hospital services for at least 10 years. Are there any non-essential services that exist now that may be eliminated as a consequence?

MR. BARWIS: So it would be difficult for me to go through and think about non-essential services. I mean, we have a broad array of services that are necessary to serve the community here. I think that it's really important to recognize that that 10 year commitment is incredible for this Hospital and was -- the Board of Directors negotiated very hard with these gentlemen over here. So, you know, things change too, you know that Mr. Bianchi --

MR. BIANCHI: Certainly.

MR. BARWIS: -- from all your years in service. What we did when you were working here sometimes becomes -- you know, different technologies change and people need different things. So we have really tried hard to focus on adopting and going after services that this community needs and I don't see that changing at all.

I mean there is -- if you're asking

specifically is there a list of services that might go away --

MR. BIANCHI: Generally.

MR. BARWIS: -- there is no such list and, you know, we will continue to do what this community needs to serve it and evolve the health care services that we provide.

MR. BIANCHI: I was more concerned about there are services that are currently --

MR. BARWIS: Yeah -- no.

MR. BIANCHI: -- rather than future, okay.

MR. BARWIS: Yeah, I'm not -- we don't have any plans for that.

MR. BIANCHI: Alright. The Development Foundation is going to be spun-off into a separate organization and I believe it was September of 2013 you did a needs assessment in the health of the City of Bristol.

MR. BARWIS: Correct.

MR. BIANCHI: Is that going to be the goal of the Development Foundation or whatever this new organization is called --

MR. BARWIS: That's a great --

MR. BIANCHI: -- to promote that?

MR. BARWIS: -- I'm sorry?

MR. BIANCHI: To promote that or to put it into effect?

MR. BARWIS: Yeah, so that's a really, really good question and a great statement. We did do a community health needs assessment and there were many community members involved in that and it highlighted the things that need to be addressed. The process for the proceeds of the sale, we basically have the opportunity to make a recommendation to the Attorney General and the Attorney General in his sole discretion decides whether he accepts that recommendation or not.

And so we haven't finished the approval process for the recommendation but I would be -- I think it is safe to say that part of that community and maybe future community needs health assessments would be a part of our recommendation going forward. So it's a very, very good point.

MR. BIANCHI: In that same regard is it

going to be a stand-alone or part of a, for example main street foundation or --

MR. BARWIS: Sure, another great question. We can't -- we won't know. We can make a recommendation and the Foundation Board met yesterday and the full Board will meet shortly and finalize what its recommendation will be and the Board is -- the Foundation Board and the Board are doing their due diligence to look at all the options.

Again, it is not our decision it's solely the Attorney General's decision. He expects us to make a solid, well thought out, well due diligence recommendation and, you know, this Board of Directors will do that I can assure you.

MR. BIANCHI: I assume also that all of the directed funds or -- are going to come out of that into the Bristol Hospital?

MR. BARWIS: Any fund that has a specific purpose has to maintain that purpose.

MR. BIANCHI: Yes.

MR. BARWIS: Only the Attorney General can decide to repurpose that money and would have to go through

a process to do so.

MR. BIANCHI: Okay.

MR. BARWIS: So they're very strict guidelines. You know, one of the questions that comes up all the time is what about all the money for free mammograms? For anyone to repurpose that, you'd have to go back and ask every single donor that ever contributed to that fund.

And you can imagine, there's a lot of people, even kids that put up $5.00 and $10.00, that would be a very daunting task. Or, you'd have to go through a legal process to repurpose it. But it will move to the Attorney General with the restrictions that it had as it was here.

MR. BIANCHI: Okay.

MR. BARWIS: Great question, thank you.

MR. BIANCHI: Last question is certainly the issue of retiree benefits.

MR. BARWIS: Sure, so --

MR. BIANCHI: There are a number of us, a smaller number now -- that program was discontinued in the

mid-90's, that get a discount on a Medicare supplement. My greatest concern is for the individuals who are -- who worked in less than professional roles and didn't make a lot of money and are on a retired and fixed income, to lose that would certainly hurt.

MR. BARWIS: Yeah.

MR. BIANCHI: So I'm asking you all to consider maintaining that program for those of us who are left. To be a participant you would have to be at this point, at least 73 years old, because the program originally stated that the effective date was January 1, 1991.

You had to be at least 50 years old on that date to be part of the program. So us old-timers, and there's fewer and fewer of us, would certainly appreciate if you could take that under consideration.

MS. O'BRIEN: Mr. Bianchi, thank you very much for coming here tonight and also for all of your comments and questions and certainly the last one, and all of your past service to Bristol Hospital including continuing to live in this community as one of our retired

Bristol Hospital employees. Thank you for coming out tonight.

MR. BIANCHI: Thank you.

MR. BARWIS: Thank you. (Applause)

SPEAKER MONAHAN: Aretha Campbell.

MS. ARETHA CAMPBELL: Hello and good evening everybody. Welcome.

MS. O'BRIEN: Good evening.

MS. CAMPBELL: My name is Aretha Campbell, I am a resident of Bristol. I am also a certified phlebotomist in the outpatient lab and at the Bristol Hospital and have been working here for almost three years. I love the people I work with and I love my patients that we care for. I'm always smiling, every day here at Bristol Hospital. That's why I wanted to take my break this evening and come down and voice my support for the purchase of Bristol Hospital by Tenet Healthcare and the Yale New Haven Health System.

We have to believe in change. Change is the only way to keep moving and making yourself better. I'm a changed person since I worked here at Bristol

Hospital. And in no other industry is there more than change taking place than in the health care? You have to ask yourself that. The Tenet and Yale acquisition will help bring many clinical resources that will also enhance the care of the patients we serve at Bristol Hospital. And as a resident of Bristol, I am so thrilled to see that Tenet's commitment to the health and the wellbeing of the communities that they serve. This is a very exciting time at Bristol Hospital especially since I've been named the July employee of the month. (Applause)

I am so honored to win that award and I'm so thrilled to be part of the wonderful team that we have here. So I want to thank you all for allowing me to voice my opinion and my support for this exciting new venture with Bristol Hospital, Tenet Healthcare and the Yale New Haven Health System. Now my break is over, I need to go back upstairs to the lab and draw some more blood. Thank you all and good night. (Applause)

MR. BARWIS: Thank you. I have to tell you that in the eight years I've been here, the employee of the month gets to have lunch with me and she came and sang to

me. And she can sing, so an amazing person.

SPEAKER MONAHAN: Once again, if anybody who has not signed up would like to do so see Chris right here and we'll put your name on the list and off we go. John Beeler.

MR. JOHN BEELER: I need to begin by telling you that I'm a little unsteady but I'm really a little uncomfortable. It's the first time I've ever walked into this room without a tie and I don't need to sit that's fine, thank you.

I especially wanted to be here, I drove two hours to do this, and I worked here for 19 years and three months. I was an assistant administrator responsible for food service, laundry, security, safety, a whole bunch of stuff. I had the opportunity to go to a seminar with Homeland Security and the FBI and talking about how to really make sure your hospital is safe for terrorism, etc., etc., and the thing that always amazed me was every door coming into this place except for three is glass. So what do we do there? But that is an aside.

When I read the Certificate of Need, I got

a little excited and I then was wondering what is Tenet? So I did some research and Mr. Google is so smart. It tells me that along the southern border of the United States and up the eastern seaboard and some of the states there, there's a lot of people there. I also was amazed when I saw that stock low this year was around $38.00, now it's $52.00, projection may be $66.00. So maybe there is something to be said for that.

I also didn't realize I only had three minutes so I'll try to finish this very quickly, that I investigated Tenet because I had very serious example. Back in January I lost my wife at a Tenet hospital and all of a sudden I couldn't believe what was happening. Several guidelines and whatever, apparently it was proven to be a stroke, but the guidelines were such that nothing happened in time. We went to a hospital in Massachusetts, I live in Sudbury this was in Framingham, and there are two hospitals that were serviced by one CT scan tech. The person happened to be at another place, so we had to wait and we had to wait and the outcome was 24 hours later it was over.

So I began to ask a few questions and the

questions I asked is -- I know nobody wanted that to happen, I know in my heart nobody wanted that to happen. I remember as I was leaving the doctor on duty was crying and she explained to me, I am so sorry. And I understood that, but the fact remains that if in fact Tenet and Bristol are going to have a marriage then I think we need to be very sure that there is an expectation of service that every one of us has when we go into a hospital. And if in fact they are advertising themselves as a stroke center or whatever, why wasn't somebody there?

Now I think I know why because I've been to enough Board meetings, that sometimes whoever is keeping score on the matrix of labor said well, this happened at 4:30 in the morning and we have a little chart here that says very few people come in then so we're going to take a risk. And that does not sit well with me, so where are we at right now? I had a meeting with the President of the Hospital and certainly the doctor in charge of doctors for Tenet in that area, they were incredible people. They had absolutely no problem listening to me, listening to my son, trying to really share that experience.

And the reason I am bringing such a personal thing up is that you, all you folks, have this have this obligation to make sure that if you are going to be taking care of us then damn it, you better do it. And the other thing is that I have been asked to serve on their Community Awareness Group or whatever and I agreed to do that. And I agreed to do it because the 19 years I spent here, we were always in the 99 percentile of satisfaction and we were there because I refused to come in the building without my tie and wanting to make sure those people who had a rug on the floor had one.

And that's sort of a personal joke here but the fact is that I may not have my tie on, I may be getting just a tad weak and older, but the fact remains that this was my life. I loved this place, it did in fact help me pay my mortgage and that was really a celebration, and certainly in getting my children through college. So anyway, when I was looking at Tenet -- and just changing the subject a little bit, 105,000 employees, the CEO, I was reading some of his comments about the first quarter $1.9 billion dollars and I can't image that, but the fact is if

in fact they have the resources I hope you get your share of them.

So -- and thank you very much for listening. (Applause)

SPEAKER MONAHAN: Thank you.

MR. BARWIS: John, thank you very much.

SPEAKER MONAHAN: Anybody like to comment on that from Tenet?

MR. ERIK WEXLER: Yeah, I am aware actually of that case and I'm so grateful that you're going to be on our Patient Advisory Committee. And I met with Barbara Doyle who is the CEO there and, you know, Tenet -- I'm the CEO for that region, those hospitals are my responsibility so what you described tonight is ultimately my responsibility. We rely greatly on the people that are on the ground to make decisions for where we need resources and where we don't need resources.

So part of what I expect is that Kurt and his team just like Barbara and her team, will make the right decisions about where we need people by the bedside to care for patients. And so I'm personally committed to

that, I am very, very passionate about patient care, about service and ultimately about getting our loved ones back home. And I think your comments were beautiful and appreciated and I'm looking forward to talking with you hopefully after for a couple of minutes.

It's good to see you here, we should have driven down together because I also came from Boston. So thank you so much for being here.

SPEAKER MONAHAN: Tom LaPorte.

MR. TOM LaPORTE: Good evening, my name is Tom LaPorte and I live here in Bristol and I'm a Corporator for Bristol Hospital and also a Hospice volunteer.

Last month in July I had somewhat of a unique experience. A good friend and a close relative were both patients here in Bristol Hospital at the same time. Consequently, I spent a lot of time every day up at Bristol Hospital. And one of the things I thought I would do would be to speak with the people that worked there, the troops. You usually get the truth from the troops there as opposed to sometimes going higher. And I asked the question how they felt about the merger or potential merger with Tenet.

And to a person they were all extremely enthusiastic about it.

They felt that this was a golden opportunity to have new equipment, new techniques, it would improve their ability to do a better job and the one thing they didn't comment about was what was in it for them personally. It all seemed to be about what it was going to do for their job and how they could better serve the patients that they dealt with every day. And I thought this was very impressive and as I mentioned before, to a person. And I'm talking from nurses to aides to maintenance people, they all had the same common concept of what the eventual merger would bring to the hospital and also to their functions.

So that being said, I feel that when the troops feel that way that's a good indicator and a good barometer and it was good enough for me. I feel that ultimately the dynamics of the 21st Century health care is such that stand-alone community hospitals and private physicians are really a thing of the past and the only way to survive is to move forward and be part of an

organization that can make all these things happen in the future. Thank you. (Applause)

SPEAKER MONAHAN: Jim Gamache.

COURT REPORTER: Can you come to the --

MR. JIM GAMACHE: People know I don't need a microphone, believe me.

MALE VOICE: Tim, we need it for the record.

SPEAKER MONAHAN: Tim yeah, we need it for the record.

MR. GAMACHE: I didn't know you were going to make me do that. Some of these questions -- I have three questions, some of them have already been answered but I'm going to ask them again anyway because I'm asking them in a different fashion.

My first question is, is there actual language in the contract that guarantees all the collective bargaining agreements including that pensions will be honored? The second question --

SPEAKER MONAHAN: Tim, why don't we do them one at a time okay?

MR. GAMACHE: You want to do them one at a time, that's fine.

SPEAKER MONAHAN: Yeah, I think that's easier.

MR. GAMACHE: That's fine.

MR. BARWIS: Yes.

MR. GAMACHE: There is language in the contract?

MR. BARWIS: That the collective bargaining agreements will be honored.

MR. GAMACHE: Okay, thank you sir. And the second question is, will the hourly wage earners at the Hospital have representation on the Board of Trustees or the Oversight Commission and will that representative have voting privileges? Because I think you'll agree with me, short of voting privileges they wouldn't really have representation on that Board.

MR. BARWIS: Four community leaders, there's four physicians, myself and there's the Community Board of Directors that are on that Board. And the chances are that at least one of those physicians is going to be an

employee of the Hospital or the Foundation, which is the case right now. The President of the medical staff is on the Board of Directors and he is also an employee through the Medical Foundation so there's a very good chance that that will be true.

MR. GAMACHE: The hourly wage earners that I'm referring to probably are your electricians, the people who work on the phones, the pipefitters onboard and the people that do that type of labor, will they have any representation by these people that you're referring to?

MR. BARWIS: There is not a position on the Board for an hourly wage earner that you've described, no.

MR. GAMACHE: Are you going to give that any consideration?

MR. BARWIS: We -- there is no employee representation on the Board now.

MR. GAMACHE: There is none now.

MR. BARWIS: Correct.

MR. GAMACHE: Thank you. My last question and I think this has already been answered, but I'm going to play devil's advocate for a second here. It's hard for

me to wrap my head around the idea that once the Hospital becomes a for-profit hospital and you have to deal with the shareholders, that that's not going to have some sort of negative impact on the quality of patient care.

Now you're telling us otherwise and I sure hope that you're right but I'll be very honest with you, I'm still having a hard time wrapping my head around that.

MS. O'BRIEN: Tim, we hope that you will see as we go through this regulatory process that the measures that are put in place and the reporting that's required as it is required now in terms of quality metrics will convince you. But thank you very much for your comments.

MR. GAMACHE: I hope you're right, thank you.

MR. TRIP PILGRIM: And I'd like to respond to your last question as well in terms of for-profit versus not for profit and your question about quality.

You know, our mission statement as a company is basically that quality is number one. That's our number one focus. Financial performance is a lagging

indicator of how well you do. If you produce an inferior product you're financial performance is not going to be there. Our product is taking care of patients, period.

And, you know, you look at the Joint Commission, which is the body that accredits hospital across the country, Leapfrog which is another independent quality measurement organization, if you look at their scores in their 2013 surveys, our company's average scores are better than 75 percent of the hospitals in Connecticut today. And that's not to criticize Connecticut, that's just to say that we're very committed to quality as an organization because the one thing that in most markets and most places you go today, physicians are still independent, private practicing physicians that have a choice.

And if you come in and try to start cutting quality or substituting inferior trocars or other instruments in the OR, you're going to wake up one day and have no patients. So -- I mean, I think if you really look at the numbers and look at kind of how we approach it, we think that the best strategy for providing a return to either our shareholders or those who invested in our debt

is to provide absolutely the best quality possible.

MR. GAMACHE: I appreciate that. I'm just playing devil's advocate a little bit --

MR. PILGRIM: Oh, I understand.

MR. GAMACHE: -- because you know, I'm the guy at the coffee shop or the supermarket and this is the conversation that I hear and this basically provided me an opportunity to ask the people --

MR. PILGRIM: Thank you.

MR. GAMACHE: -- directly that question, and I appreciate your time.

MR. PILGRIM: Thank you very much.

MR. BARWIS: Thank you very much.

(Applause)

SPEAKER MONAHAN: Jim Albert.

MR. JIM ALBERT: Good evening, I'm Jim Albert, I'm current the President of the Bristol Chamber of Commerce as well as the seven city Central Connecticut Chambers of Commerce. Prior to my arrival at the Chamber of Commerce only seven months ago, I was also a senior hospital and health care executive for 16 years and helped

run four different health systems including Bristol Hospital, where I was born and my office was literally 50 feet down the hallway from maternity so my physical movement over life was measured in inches.

But anyway, over the 16 years in my health care career and -- currently I also teach by the way two health care graduate level classes at the University of Connecticut. So I'm kind of still living health care on a daily basis. But we -- all hospitals, every hospital in the country whether it's large or small or going through this same kind of discussion right now, and we see that here, we read it in the news every day, we read it today about Bradley Memorial, we read it about eastern Connecticut, Waterbury Hospital, St. Mary's, you name it, they're all in the same discussions. This is what health care is all about in the United States.

We've grown the health care dollar up to over 17 percent of the gross national product and it is scheduled to go up into about the 20 percent range thanks to all the gray hair that I have and several other people in the room have as well. So it became a national issue

quite a while ago. We watched Hillary Clinton try to tackle the issue and it's been going on and on and on for quite a while now, so this is not an unusual discussion. I'm firmly convinced through my own research for the last 16 years and discussions with consultants across the nation, that the minimum of a health care system to survive into the future because reimbursement rates are going to change, the market is changing, everything is -- technology is changing, the physical structure is changing, the business model is changing, everything is changing.

The minimum amount that they expect a health system to have just to survive is at least $5 billion of annual revenue. Bristol Hospital of course is not at that level so Bristol has to make a decision about who they're going to partner with or be acquired by. And in Connecticut the way that the sand is congealing at this point, you're looking at only a few handful of systems at best, same thing in Massachusetts where I was just recently at, you have the Hartford Health System, which we all know has purchased and acquired the New Britain Hospital of Central Connecticut, which includes Bradley and Hartford

and they've also had Windham Hospital. There's a number of hospitals coming together under the Hartford Health umbrella.

The Catholic systems have begun to do their consolidation in coming together mostly under St. Francis and then St. Vincent and others along the shore, St. Mary's in Waterbury. Danbury Hospital is also building a small network on the western side of the state. And somewhat on the southeastern side of the state is Lawrence Memorial in New London is building a small network of hospitals. But it's predicted that it's really going to boil down to probably three systems. It will be the Yale system, which along the shoreline at this point, the Hartford system, and the Catholic system, and then maybe one other system, most likely is going to be Danbury.

So Bristol has to kind of look at that market and go, who are we best suited to work with? I was here in 1998 and 1999 as the Chief Information Officer, senior executive position, and I actually left the hospital in 1999 without another job because of the decision to merge with St. Francis. I thought that was the wrong

decision because the culture and the business models that I could see were not compatible. And ironically I think I was right, but it was a little bit of a painful process. Kind of like walking in, quitting your job and saying, you know, take this job and shove it kind of thing.

But nonetheless, I am very familiar with the Yale system. I'm not as familiar with Tenet because Tenet is a national organization, but I'm very familiar with the Yale system. I've sat in hundreds of meetings with Yale people over my career. I probably know at least 50 of them personally, a lot of friends there. Yale is a class act. Yale is one of the internationally recognized renowned health systems in the world. Saudi Princes come to Yale New Haven Health System, it's just absolutely incredible. We're luck it's here in Connecticut and if Bristol Hospital can become part of that network, I'm all for it. So good luck to you, thank you. (Applause)

MS. O'BRIEN: Thank you Jim.

MR. VIN PETRINI: Thank you. Let me just say thank you for those comments on behalf of Yale New Haven Health System. I would just state the fact that we

are proud and excited about the partnership not only with Tenet but also with Bristol Hospital. We know of the great health care that's delivered in this community and we are looking very much forward to continuing that legacy.

We've got a great relationship already and we really think this is going to be an important asset for the community long into the future. So we're looking forward to it and thank you for your comments.

SPEAKER MONAHAN: Okay, Ellen Solek.

MS. ELLEN SOLEK: Good evening, Ellen Solek, Superintendent of Schools in Bristol, Connecticut. Many of you may be wondering why I'm here to speak on behalf of Bristol Health Care Systems and the merger with Tenet and Yale New Haven because after all what possible interest would a Superintendent have in the health care of Bristol.

And I'm here to assure you quite the opposite. We are two of the largest human service care providers in the City and we coexist for many, many reasons. But the main reason is that we are all focused on what is best for the health and welfare of students in the

community and the parents that we serve. And Bristol Hospital and the Bristol public schools do that hand in hand every single day. In addition to that, I'm privileged to serve as a member of the Board for Bristol Hospital and each and every meeting that I attend I learn a tremendous amount from both Marie and Kurt about the parallels between what we do to care and serve for students for Bristol and what this wonderful Hospital does.

And I believe wholeheartedly, particularly having met tonight the representatives from Tenet Healthcare and also Yale New Haven Hospital, that in addition to the financial resources that these fine gentlemen are going to provide for this merger and only strengthen our ability to serve this community I also understand the relationships that are being built with all of you sitting at that table tonight. And I think as we sit here and listen to what you have to say and how you say it, I'm so very impressed at the level of care and quality and investment that clearly comes through when I listen to you respond to the comments tonight.

So I'm here to say that I fully and

wholeheartedly endorse this merger, I think it is wonderful for the City, and most important I think it is wonderful for the community and the parents and the students of Bristol that we serve so well already. Thank you very much. (Applause)

SPEAKER MONAHAN: Mike Nicastro.

MR. MIKE NICASTRO: Hi gentlemen, I am his immediate predecessor so I am in the Chamber of Commerce but I mean, I've had the honor of this gentleman here after his 17 years. You know, I come from a business background so I look at this and I say -- I'm also a Corporator and a member of the Finance Committee here.

So when I look at it and I hear Marie say things to me like, you know, four percent operating margin that's great. Well, I ran publicly traded companies. Four percent operating margin would have -- you know, we'd have been on the pink sheets being traded as a one digit midget. That would have never flown so I look at this and I say there's importance to this because there's the need for capital and we want this local organization not only to stay, survive, but to thrive. And in order to thrive

you're going to need the capital to do that.

But I think you're hearing some of the concerns here in the room and I would tell you, you have to look at this historically because what you're hearing and seeing is a lot of Bristol names. I was born in this -- I was born here too and I look at this and I understand their concern. And their concern is, is that you can drive around this town and if you look at a couple of other industries you can see the outcome of mergers and acquisitions.

There's -- anywhere in downtown you can see Bristol Bank and Trust, Bristol Savings Bank, Bristol National Bank, all gone. You can be up on the hill and see what was formerly New Departure, GM took it over, gone. And so there's a little bit of once bitten, twice shy kind of mentality. So people are going to look at it from perspective. Now that's not -- Bristol is not alone. It's happened to every industrialized city in this state and throughout the northeast and throughout the country for that matter. But there's always that promise with merger and acquisition, that it's going to be better, right, it's

going to be great.

We're going to have all this capital, we're going to make it happen. And that's always the challenge because in the end it's still about making things work and having that surplus at the end. You're right, you can't run at a loss you've got to make money and you do have shareholders to satisfy. But I look at this and I say but you also have to have capital to operate and Bristol Hospital really needs the capital to operate. And I think they have been a fixture in this community a long time, I think they'll continue to be a good fixture. I think you've done contractually the right things to make sure that those things are in place.

My counsel to you is be very thoughtful about your Community Board that you put together. Now Tim asked an interesting question about representation there. I don't know that that's necessarily the way to do it but you should think very long and hard about that representation because they're going to need -- that connection between that Board of Trustees and the connection to the community to Tenet is going to be critical. And the more you drive

that the better you drive that. And the more that that looks like that has legs and is not just ceremonial, the better off you'll be in this transaction.

So thank you, I wish you all the best of luck and let's get this thing done. (Applause)

MR. PILGRIM: Thank you, could I --

MR. BARWIS: Did you want to make a comment?

MR. PILGRIM: Yeah.

MR. BARWIS: Go ahead, I'm sorry.

MR. PILGRIM: It's okay. Thank you for your comments and something that I wanted to emphasize and stress about how we look at health care, is that it's a local business. Patients are local, physicians are local, employees are local, life begins locally and ends locally. It happens within the community. And as a company we understand that. That's why we don't come in and put Tenet on the side of the Hospital. This is Bristol Hospital.

It's why our proposal in Waterbury about St. Mary's Hospital is going to continue to maintain the Catholic heritage of that facility. That's why the Baptist

Health System in San Antonio, Texas, which I happened to run for about seven years, is still recognized by the Baptist General Convention of Texas as a top faith-based organization. Health care is local, heritage is local, legacy is local. And you're right, there have been lots of examples of mergers and acquisitions all over the country where that local flavor is gone.

I mean, look at the downtown mom and pop hardware stores. My dad had a lighting fixture store. It's where I worked in high school. You know, I still have it running today barely, but I was kind of stubborn. I said I don't like Lowes and I don't like the Home Depot --

MALE VOICE: Walmart.

MR. PILGRIM: -- Walmart, but my point is is that what this brings to Bristol Hospital is an opportunity to take advantage of those big scale economics that you see a Lowes bring to town. The fact that you can tie into a supply chain and get bulk parts you're seeing and get those kinds of opportunities as a result of being a part of an 80 hospital system but at the same time not taking away that essence that made Bristol Hospital,

Bristol Hospital, it's still going to be local.

When you come to this Hospital the doctors that take care of you are going to be local. The nurses that take care of you are going to be local. Althea, the phlebotomist, is going to be taking you and smiling at the same time. So please know that yeah, we're a big company, yeah, we're publicly traded, but we also really understand the business we're in and that's taking care of people in their communities.

So thanks for the opportunity to respond, I appreciate it.

MR. BARWIS: So -- I'm sorry, I thought --

MR. PILGRIM: No.

MR. BARWIS: -- yeah, I'm sorry Trip. I just -- Mike, you mentioned the comments earlier about employees and as I've thought about it I think it would be important to share with you that for example, our nursing -- the whole entire nursing division has a self-governance model and they make decisions for themselves. And so I'll give you a great example of that to show you how it really works and the employees actually engage in making decisions

for the organization.

Four years back we had -- anybody could wear whatever they wanted in terms of their uniforms and it got very confusing for visitors, patients, the physicians especially didn't know who was a CNA and who was a nurse and who they could talk to about a problem. And so the Nurse Executive Council, not the administration of the Hospital, pulled together the nurses throughout the entire organization and wrestled that to the ground and actually made the decision to standardize the uniforms that they wear so that they could be readily identified when you walk on the unit as a CNA or a nurse and actually by Department. Each Department actually throughout the Hospital, even non-nursing Departments decided what color they were going to wear to represent themselves.

The other thing that I think is very important is that we do employee engagement surveys where we ask employees, and that information is shared directly with the Board of Directors. So it's an unwashed, summarized, they see the report and they can hold us accountable, the management accountable for our actions and

the way we interact with them. I personally do between 13 and 18 Town Hall meetings a quarter going around the clock and just about any breakfast, lunch or dinner you're going to find me having dinner with the environmental service people.

I pretty much know everybody by name in this Hospital and I've been here eight years and it's getting pretty hard to do that with my -- as I get older. But I started as a patient transport and I'll never forget that and a hospital gave me the opportunity to be in this position. They paid for my education and my roots are part of who I am and this Board supports that behavior. We don't put on airs, you know, our title is not important. It's us working together as a team. And I'm very proud of that.

I'm very proud of the fact that there's not a person in this place that's afraid to send me an e-mail at 8:00 or 11:00 or 1:00 in the morning and ask me a question about something that's really vitally important to themselves or the patients in this Hospital. So while we don't have a Board representative, there is a direct line

to the Board of Directors through the employee engagement survey and I serve on the Board of Directors and I have a vote on the Board of Directors.

And so I'm very, very comfortable that when employees have concerns in this organization, whatever it is, we are absolutely listening to them. So I thank you for your comments Mike and the earlier comments too. Thank you.

MS. O'BRIEN: As a representative of the full Board of Directors let me tell you that each of us hears from the community, employees, nurses, physicians, patients and their families, outside residents and others whenever we walk through the community and do our normal day to day activities.

And you've heard earlier whether it's in the grocery store or the pharmacy or you're down at the car dealership or wherever you are, each member of our Board acts as an ambassador and to some extent yes, Jerry's an Ombudsman still. But also as a conduit back to the administration whose responsibility it is to in fact be sure that they're implementing the guidelines and the goals

and objectives that the Board has set for our community.

So that's pretty active and vibrant and very much alive and takes a lot of Kurt's time.

SPEAKER MONAHAN: Jose Perez.

MR. JOSE PEREZ: Good evening, my name is Jose Perez. I'm a registered nurse and I worked for Connecticut Health Care Associates. Our Union represents hospital employees in Waterbury Hospital, about 550 nurses and technical employees. We're asking for this Hospital to agree to put in strong protections for the workers in case if this for-profit takeover takes place.

We need to put these protections in place and some of the protections that we think should be in place include creating an independent Community Advisory Board chosen by OHCA not the purchaser; to appoint an independent monitor through OHCA; to ban or strictly limit hospital facility fees for the patients; stop price inflation; to make cuts or any changes to hospital -- not to make any cuts or changes to the hospital staffing levels; to require Tenet to provide all the same information that non-profit provides such as the I-90 or

similar type of documents.

The Hospital should agree on an amount that must be minimally spent on the community hospital improvements and more and there should be baseline reporting on staffing and community benefits that includes reporting on employee benefits, salaries, as well as the overall impact on local jobs. And last but not least, a community benefit agreement that incorporates all of the community needs with the Hospital as well. Thank you.

SPEAKER MONAHAN: Any comments from the panel.

MALE VOICE: Thank you.

MR. BARWIS: Thank you very much.

SPEAKER MONAHAN: Catherine Addy.

MS. CATHERINE ADDY: Good evening, my name is Catherine Addy, I am a resident of Bristol for a change of pace I was not born in Bristol nor was I born in Bristol Hospital.

Having said that, I am coming to you as a representative of the community, as a representative of my own professional organization, Tunxis Community College, as

a former member of the Board of Directors of this Hospital, I served for nine years and it was at that point that I learned how highly complex this business is in health care and how highly regulated. So I have a greater appreciation now than I ever did when I was also a patient here more times than I care to count, about the work that has to be done.

I'm ready almost to nominate many of you for sainthood because you keep coming to work every day and do the work that you do. I want to say that I'm very much in favor of this transaction that is proposed and I hope it will go forward because I think it represents the Bristol Hospital community thinking about the future and trying to make sure that this Hospital will be here for the long-term. I fear that if this does not take place, an organization that we have taken for granted in this community because it's always been here, will not thrive and will not be able to provide the service to a community that is growing older and more diverse and needier in health care terms.

So I do support this and I hope it will go

forward and I think it represents a very sound financial decision and I won't repeat other points that have been made. As a final note I will say however that if this goes forward and it does succeed, as I'm sure it will, and as the fortunes of the State of Connecticut continue to decline, which in spite of Representative Betts they might, I would like to propose that you consider purchasing a fine high quality educational institution (laughter) also serving the people of the Bristol community and will be glad to talk to you at any point. Thank you. (Applause)

MR. PILGRIM: We actually do own a school in San Antonio, Texas. We have a nursing school, about 500 students, and I thought it a good idea at the time. It was a diploma granting school and we took it to degree and after going through that journey in six/seven years I decided that education was a heck of a lot harder than hospitals. So no thank you.

MS. ADDY: That's a no then I take it. (Laughter)

SPEAKER MONAHAN: That's what it sounded like. Thank you all for coming. We appreciate you coming

out and we had a real good turnout and we thank you for your comments and concerns and questions. And also thanks to the panel for a job well done.

VOICES: Thank you. (Applause)

(Whereupon, the hearing was adjourned at 7:21 p.m.)

HEARING RE: BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
AUGUST 14, 2014

AGENDA

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 23: CONNECTICUT POVERTY REPORT

Meeting the Challenge

The Dynamics of Poverty in Connecticut

CONNECTICUT ASSOCIATION FOR COMMUNITY ACTION
CONNECTICUT CENTER FOR ECONOMIC ANALYSIS
BWB SOLUTIONS

January 2013

New Opportunities, Inc. (NOI) weatherization project crew at Danbury's Beaver Street Apartments ceremony with U.S. Senator Chris Murphy and John Ferguson, NOI Weatherization Technical Coordinator. The weatherization workers had just completed 70 units, which included weatherization measures such as window replacements, air sealing, lighting, furnace replacements, and more to low-income housing units. In addition to conservation and energy efficiency measures, these workers are cross-trained to address health and safety issues in homes.

Connecticut Association for Community Action's (CAFCA) members, Connecticut's eleven Community Action Agencies (CAAs), continually strive to reduce the conditions of poverty through the identification and removal of social and economic barriers, the mobilization of community resources, advocacy, and the provision of direct services at the community level in all of the state's 169 cities and towns through cost-effective and community-based processes.

The Connecticut Center for Economic Analysis (CCEA), established in 1992, serves the people of Connecticut by improving their understanding of the state's economy -- past, present, and future. The Center focuses on providing timely information and reliable analyses about Connecticut's economy. By mobilizing and directing the expertise available at the University of Connecticut, state agencies and entities, and the private sector, CCEA equips the public and decision makers with the foundation for systematic, thoughtful debate of public-policy issues. The Center takes a long-term, strategic view of economic forces and is objective and transparent in its execution and delivery of studies.

BWB Solutions (formerly Brody Weiser Burns) has served hundreds of organizations since its founding in 1984. The organization's work focuses in three areas: planning; management and governance; and initiatives and partnerships.

BWB Solutions offers assistance with business, strategic, and sustainability planning. BWB's team can lead retreats, design organizational structures, prepare financial projections, offer market research and competitor analysis, and identify potential partners resulting in additional possibilities including: earned income ventures; new program collaborations; shared services and other cost efficiency measures; and, potential mergers and acquisitions.

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Executive Summary

Meeting the Challenge: The Dynamics of Poverty in Connecticut, hereafter referred to as the Connecticut Poverty Report, or CT Poverty Report, is one step toward describing, statistically and anecdotally, and in narrative and graphic form, just how deep and wide the conditions of poverty are that exist in Connecticut. This report includes details about the nature of poverty in Connecticut and suggests basic concerns for Connecticut's ability to employ more of its residents. In addition, this report offers recommendations for reversing the trend and, more importantly, making Connecticut a place where all citizens do not just survive—they thrive.

The CT Poverty Report characterizes the hidden—yet omnipresent—infrastructure of poverty in Connecticut, with an eye to catalyzing authorities and people of good will to help create a holistic system to bring every child and family in Connecticut within reach of self-sufficiency. Starting from 1990 as its basis and ending with 2010, the CT Poverty Report reveals that times were difficult for many in the State of Connecticut. During those two decades, the number of people who struggled with insufficient income grew sharply in our state's most populous towns.

As of 2010, there were more than 720,000 people living at or near poverty in Connecticut. **720,000 people!** Those 720,000 people represent 21% of all residents in the state who are either living in poverty or facing the uncertainty of falling into poverty. Every day, they face the struggle of living without the resources necessary to attain economic self-sufficiency, the ability to provide food, clothing, and shelter for themselves or their family, and many other challenges. Furthermore, they are not concentrated in just a few parts of the state. During the 20-year period assessed by this report, almost all Connecticut towns experienced a rise in poverty. Additionally, of Connecticut's 169 towns, just 38 towns saw a decrease in the number of Very Poor residents while 131 towns saw an increase.

Four primary factors contributed significantly to the growth of poverty in Connecticut during this 20-year period:

- First, Connecticut employment has stagnated for more than twenty years. Since 1990, there have only been eleven months during which the number of employed Connecticut residents exceeded the number employed in 1990.
- Second, Connecticut had the worst job creation record in the nation over the 1990-2010 period.[1] At the same time, the state's working age population grew by 120,000 people, driving unemployment rates up—particularly in our poverty-sensitive communities.
- Third, Connecticut missed out on the technology related job growth in the 1990's, which deprived the State of the foundations on which much employment at the national level grew after 2002.
- Lastly, Connecticut has not effectively created or supported educational opportunities or developed other conditions that support job creation.

Despite these findings, steps can be taken to reverse the situation by honoring one simple mantra: employment is the primary pathway out of poverty. Such steps include:

- The State should adopt and implement effective policies, planning and practices that other states have developed to drive economic development including: examining infrastructure needs to improve access to jobs for those most at risk; revisiting permitting and regulatory policies; and restructuring the multi-tiered business-to-business sales tax to attract jobs and employers.
- The State should align credential requirements with job-specific tasks and convene a Task Force to investigate "Barriers to Entry" for low wage jobs, particularly in education and healthcare. All current and proposed licensing requirements should also be evaluated to ensure their bases are truly related to job-specific tasks rather than generic credentials.
- The State should support education and training

Executive Summary, continued

initiatives, including: wraparound funding for early education to address the disparity between towns; prepare students for current and future work environments; and, work with employers to ensure training efforts are aligned with market needs.
- Finally, and equally as important, the State should create a data center to store, track and analyze economic and jobs-related data in an ongoing and consistent manner. Fully informed and thoughtful planning and decision making, necessary to adequately address job creation and employment, can only be accomplished with comprehensive, longitudinal data.

Conclusion

The CT Poverty Report not only describes the devastating effects of poverty for those who face it on a daily basis, but also how the struggles of poverty affect every citizen's ability to achieve prosperity and self-sufficiency. As a result, this report offers affordable, achievable and actionable solutions that can be pursued now, in 2013, to achieve results that can immediately help to improve all of Connecticut's future.

In addition to these recommendations, it is important to note that the current administration is executing on its stated commitment to invest and compete for new economic and business development. Governor Malloy, with his Commissioners and other state leaders, has begun the process to address the many barriers to self-sufficiency our most impoverished state residents face each and every day. We hope the information provided in this report will help inform his decisions as he continues to move the state forward.

Finally, this report's purpose has been to uncover causal influences, and while it does not address the many direct-line providers, advocates, and legislators who have tirelessly worked to make a difference in the lives of those who experience poverty, Appendix I provides some important insight about one group of providers who serve every one of the state's 169 cities and towns: Connecticut's Community Action Agencies. The caseworkers and customers who utilize services offered by Community Action Agencies were the witnesses for much of the anecdotal data included in this report. But for these organizations, many more citizens would face their days without food, shelter, warmth, job training and, hope.

Roderick Bremby

Introduction

Commissioner Roderick Bremby
Connecticut Department of Social Services

Whenever I hear speakers tell of having grown up on the wrong side of the tracks, I smile to myself. I grew up in a place so disconnected from economic opportunity that it didn't have tracks at all, let alone a right or wrong side!

But, I had a loving, devoted family, and we had a strong, caring community. As a result of such blessings, I had a solid foundation in life. And just as I have never forgotten the love and encouragement of my family, neither have I forgotten the compelling truth of community: that, sometimes, we're just better together. Sometimes, it takes a village.

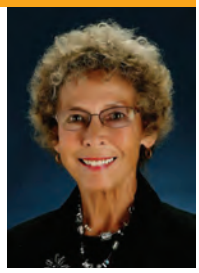
At its core and at its best, government is about just that: community. It's about partnering to do as a community that which we are less able – or fundamentally unable – to do as separate individuals. Today, as families and government alike face harsh fiscal realities, it is more important than ever that government and our partners contribute effectively and efficiently to better outcomes for struggling families. As CAFCA Chairman James Gatling and Executive Director Edith Pollock Karsky correctly note in their welcome, the heightened demand and limited resources for social services, combined with demographic trends, clearly demonstrate that the status quo is unsustainable.

The pivotal questions, then, are: what exactly is the status quo; and what –specifically – might we do to make our public policies and social service systems sustainable? This report is part of the vital process of addressing such questions. As you will read, there aren't any easy answers, and the conversation may be as difficult as it is essential.

The underpinnings of poverty are, of course, deeply woven into the level of economic opportunity available to our communities. You will read how Governor Dannel P. Malloy has seized on economic development as a central priority of his administration. You will also see a recurring theme of partnership and cost-effective action as Connecticut moves forward toward ensuring that every child and family lives on the right side of the tracks.

While my role as an executive branch agency head is not one of endorsing specific recommendations in the report, I do whole-heartedly applaud the spirit of partnership and collaboration in examining the issues and potential outcomes. As you read the report and share it with others, I hope you will join in this critical conversation and help to shape the future of our great state.


Dr. James H. Gatling


Edith Pollock Karsky

Introduction

Connecticut Association for Community Action
Dr. James H. Gatling, Board Chair, and Edith Pollock Karsky, Executive Director.

Connecticut stands at a crossroads unlike any in our history. Never before have economic, social, and political events combined to create so clear an opportunity to chart a new course. As a state, we find ourselves weathered by a painful recession and a frustrating recovery. We have seen fit to cast aside many familiar notions and comfortable assumptions because of the glaring contrast between the promise they once held and the reality of their impact. We have, quite frankly, been humbled by economic forces beyond our control.

Since the Great Recession began in 2008, demand for our agencies' anti-poverty programs has skyrocketed. Call them the new poor: people long accustomed to the comforts of middle-class life, who are now asking for public assistance for the first time in their lives—potentially for years to come. This economic condition we are currently facing has been designated the 'new normal'. A startling example of this 'new normal' is the increase in the case load of the Low Income Home Energy Assistance Program (LIHEAP), where customer demand for home heating assistance has increased by over 40% at most Community Action Agencies since the recession began. Of course, in addition to energy assistance, these families have multiple other needs as well.

In the midst of this social and economic turbulence, Connecticut's CAAs have come through as an integral part of our state's social safety net. We have helped families keep their homes, have nutritious meals on their tables, care for their children, and prepare for new careers. While providing services to meet immediate needs, our agencies also work with those in need to develop long-range plans for success.

Of course, this begs the question of what the future should and could look like for those who have been living in poverty for years and the new poor. Thus, in the field of human services and economic empowerment, we have come to know that a new course is not only possible, it is inevitable. We can trace fiscal and demographic trends and see clearly that the status quo is unsustainable. It is time to look anew at our approaches and programs, and time to chart a demonstrably better course for customers and communities alike, making data-driven decisions, developing systems strategically, and measuring meaningful outcomes.

continued...

Introduction from Connecticut Association for Community Action, continued

But, we cannot decide on a direction without first understanding where we are starting from—and that's where this report comes into play. Our state's progress will always be limited unless each and every family is empowered to reach its potential, and poverty is the single most corrosive way in which that potential is stifled. This report illuminates the hidden—yet omnipresent—face of poverty in Connecticut, allowing us to acknowledge the facts together and chart a course well aware of the terrain.

Some readers will be uncomfortable with the facts of this report. Some may be caught off guard by disturbing statistics and trends. Others might find that this report tells a familiar story which hits a bit too close to home. We commend all readers for facing the unpleasant truth in order to move forward responsibly. And, we submit for your consideration that the most disturbing aspect of this report is not the numbers or trends, but the fact that we—as a state—largely have allowed ourselves to dismiss poverty as something that happens to those people, over there, when in fact poverty is inflicting avoidable pain and harm on families, neighbors, and communities all around us. In the spirit of moving forward, we have included in this report recommendations based in evidence, and we hope every reader engages in the challenging, but essential, conversation about Connecticut's direction.

One final note. In his introduction to this report, Connecticut Department of Social Services Commissioner Roderick L. Bremby comments on the importance of leveraging partnerships to achieve greater social service outcomes in the face of increased demand and decreased funding. The publication of this report certainly has been one such exercise, and we are grateful to Commissioner Bremby and all of our partners for having made this a truly collaborative process. We know that this report represents not a conclusion but a beginning, and we look forward to the many cooperative efforts to come as we continue striving to ever more effectively empower Connecticut's families and communities toward greater economic security.

Connecticut Association for Community Action

I. Report Overview

Dynamics of Poverty in Connecticut

The two decades from 1990 to 2010 were difficult for many in the State of Connecticut. During those years, the number of people who struggled with insufficient income grew sharply in our state's most populous towns. Based on the 2010 American Community Survey, there are now more than **720,000 people** living at or near poverty[2]. Those 720,000 people represent 21% of all residents in the state—21% of the state's residents who live without the resources necessary to attain economic self-sufficiency, the ability to provide food, clothing, and shelter for themselves or their family, and who face many other challenges. **Why?**

In 2010, nearly 1 in 10 residents had incomes below the Federal Poverty Line (FPL), about $11,000 for an individual or $22,000 for a family of four. This report, as more fully explained below, refers to those subsisting below the FPL as "Very Poor". In 1990, 217,300 Connecticut residents met this definition, making up 6.8% of the state's population. **Throughout the 1990s the number of Very Poor grew 19%**, accounting for 7.9% of all state residents. The 2000s saw a continuation, even a quickening, of this trend. **The number of Very Poor increased 21% during the 2000s to over 314,000 people**, accounting for 9.2% of Connecticut's total population.

Why such significant increases in poverty in Connecticut? While this report makes no claim of having all the answers, it is clear that limited initiatives to attract new jobs and industries to our state played a big role over the most two recent decades.

Access to employment is crucial, as it is the only sustainable path out of poverty. However, Connecticut's overall record of creating and supporting the conditions and environments that attract business and jobs was, at best, ineffectual during the 20-year period studied. Due in part to a lack of cohesive economic development policies, complicated tax and regulatory environments, and arcane permitting processes, Connecticut saw a net loss of jobs even as its working age population grew by 120,000. Perhaps more important for Connecticut residents living in or near poverty, those 20 years saw a significant contraction in the number of lower wage jobs that provide the natural entry point for members of these households to become self-sufficient. Thus, part of the dynamic of the growth of poverty in the state is a long-term constriction of the pathway out of poverty: access to employment.

Connecticut had fewer jobs in 2010 than it did in 1990.

I. Report Overview

Meeting the Challenge: The Dynamics of Poverty in Connecticut examines Connecticut's experience with poverty over a 20-year period, from 1990 to 2010, and highlights demographic shifts related to poverty's growth and expansion. The report describes how the changing nature of employment opportunities has exacerbated these trends, and identifies state-level barriers to increased job growth.

Additionally, the report notes the ways in which the state's Community Action Agencies facilitate relief for those who struggle with poverty. This relief comes in the form of reinforcing behavior and processes to secure temporary assistance to meet basic needs and manage crisis, while at the same time providing support and training to enable long-term gains in the active struggle toward economic self-sufficiency.

Finally, this report offers some examples and suggestions to assist state policy makers in identifying what the state can do to reverse the troubling trends documented herein.

What does it mean to be poor in Connecticut?

For Robert, it meant losing his home and his independence when he lost his job. Following months of looking for work while staying with a friend, Robert came to an Emergency Shelter in Danielson run by Access, his local Community Action Agency. Upon his arrival, Robert and his case manager built an action plan that connected him with important resources to address his medical and mental well-being. Access referred Robert to CTWorks for skills assessments and training opportunities. Robert learned how to create a resume, rebuild his self-esteem, and re-launch his job search. Robert quickly found a full-time job at a restaurant in Brooklyn, and is now able to move out of the shelter "…so someone else who needs help can have the room." Robert is proud of his achievement and thankful for all the help he has received, but remains on the edge with income just above the poverty line.

Like so many across our state, Robert lives knowing that one life event, job loss, car accident, or health issue could see his return to poverty and homelessness.

Who helps our poorest citizens cope?

Robert's story reminds us of the important role played by the state's Community Action Agencies, who provide valuable services and connect their clients, Connecticut residents who need their assistance, to other services available from both public and private sources.

I. Report Overview

Definitions

This report takes an income approach to measuring poverty, with analysis based on the most comprehensive census data sets available for the review period—the decennial census of 1990, 2000, and 2010. Where appropriate, this study presents more current data or data from other sources. To measure and illustrate poverty in Connecticut, the report focuses on those living below 200% of the Federal Poverty Line. The Federal Poverty Line (FPL) may refer to one of two measures depending on the data source. Those measures are the Federal Poverty Threshold (FPT), a measure updated each year by the Census Bureau and used for statistical purposes, and the Federal Poverty Guidelines (FPG), a simplified version of the FPT used for program eligibility and updated each year by the U.S. Department of Health and Human Services.[3]

Because the majority of the data analyzed for this report comes from information collected and distributed by the Census Bureau, references in this report to the FPL will most often refer to the Census's FPT; however, as stated, the term may be used to refer to either measure.

The following chart presents the upper limit income levels for comparison of the FPG and the FPT.

"Poverty Definitions" for 2010 (Upper Limits)		HHS Poverty Guidelines (FPG)		Census Poverty Thresholds (FPT)	
	% of measure	1 Adult	2 Adults & 2 Children	1 Adult	2 Adults & 2 Children
Very Poor	Less than 100%	$ 10,830	$ 22,050	$ 11,139	$ 22,113
Poor	Less than 200%	$ 21,660	$ 44,100	$ 22,278	$ 44,226

In this report, "Very Poor" refers to those living below the FPL; that is, with incomes at or below 100% of the FPL. Recognizing that one individual or family can exhibit many of the traits of poverty - low food security, crime ridden neighborhoods, poor school performance, etc. - and yet still live in a household with an income greater than the FPL, the analysis looks at a second grouping. This group consists of individuals who live in households with incomes less than 200% of either of the federal poverty measures. In this report, "Poor" refers to those living at or below 200% of the FPL. 200% was chosen as the cutoff because this is a threshold at which there is sufficient data available in the decennial census; however, even incomes at this level may not allow one to meet all of a household's basic needs.

The Basic Economic Security Tables (BEST) for Connecticut 2012, a Permanent Commission on the Status of Women report,[4] showed self-sufficiency income levels both above and below the thresholds set by the Census Bureau that were used in this report, with the variables being geographic location and household make-up. For example, according to the BEST report, a family of four living in Greater New Haven would need an income of $52,943 to be self-sufficient versus the cutoff of $44,100 used in this report, while an individual living in the northwest corner of the state would need an income of at least $20,485 to be self-sufficient, versus the cut-off of $21,600 seen above. Overall, we believe that the figures presented above provide a fair upper-limit for incomes below which a household is in poverty or continually at risk. Households at the upper end of the limit may have trouble making ends meet, living one major event away from being very poor.

I. Report Overview

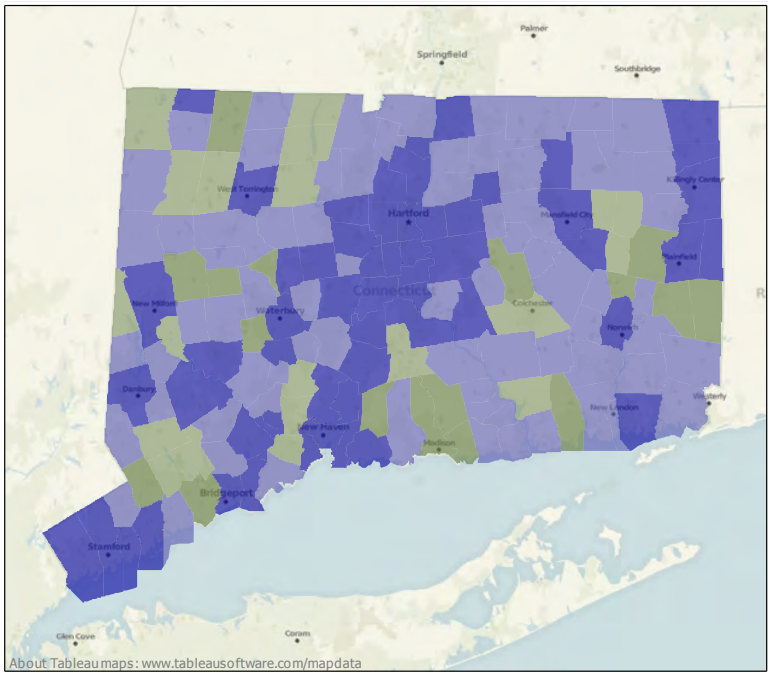
To illustrate the overall impact of poverty across cities and towns in Connecticut, there are two maps shown here. The first map shows the towns where there was a significant increase in the number of people who are Very Poor, from 1990 to 2010. With so many towns represented by dark blue, the indicator for change in the number of Very Poor residents, the majority of Connecticut towns (131 of them), experienced an increase in poverty during the 20-year period—a striking finding. Only 38 towns saw a decrease in the number of Very Poor residents.

Not only has the number of Very Poor residents grown in our major urban areas, but as the second map illustrates, the percentage of those struggling with poverty grew in some unexpected communities. Additionally, thirty towns saw increases greater than 100%—and these towns can be found in every county across the state, including even those we think of as financially secure; for example: Westbrook (129%), Somers (188%) and Southbury (220%).

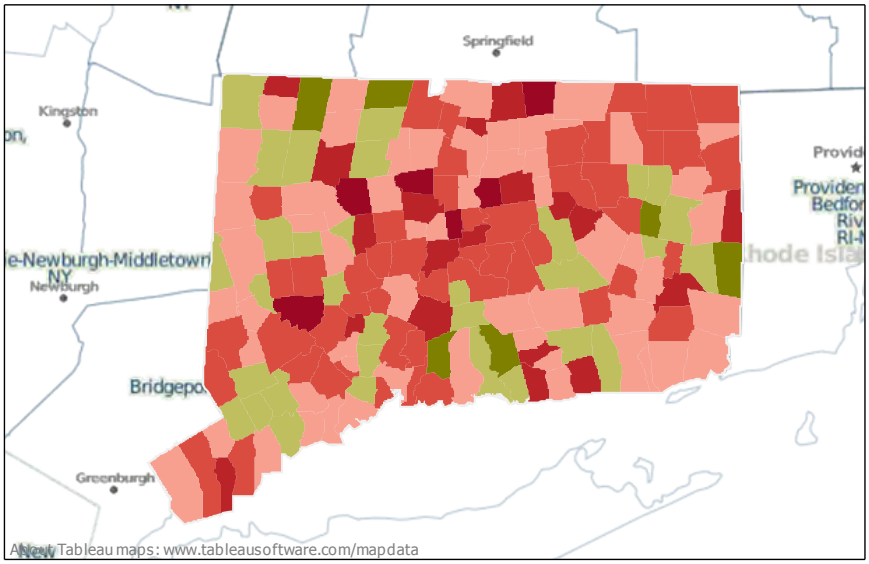
For purposes of this report, "Very Poor" means those individuals with incomes below $11,000 and families of four with incomes below $21,000. "Very Poor" people are those living below the Federal Poverty Line.

See chart on Definitions page.

Change in the Number of Very Poor Persons by Town-1990 to 2010



Percent Change in the Number of Very Poor Persons by Town-1990 to 2010



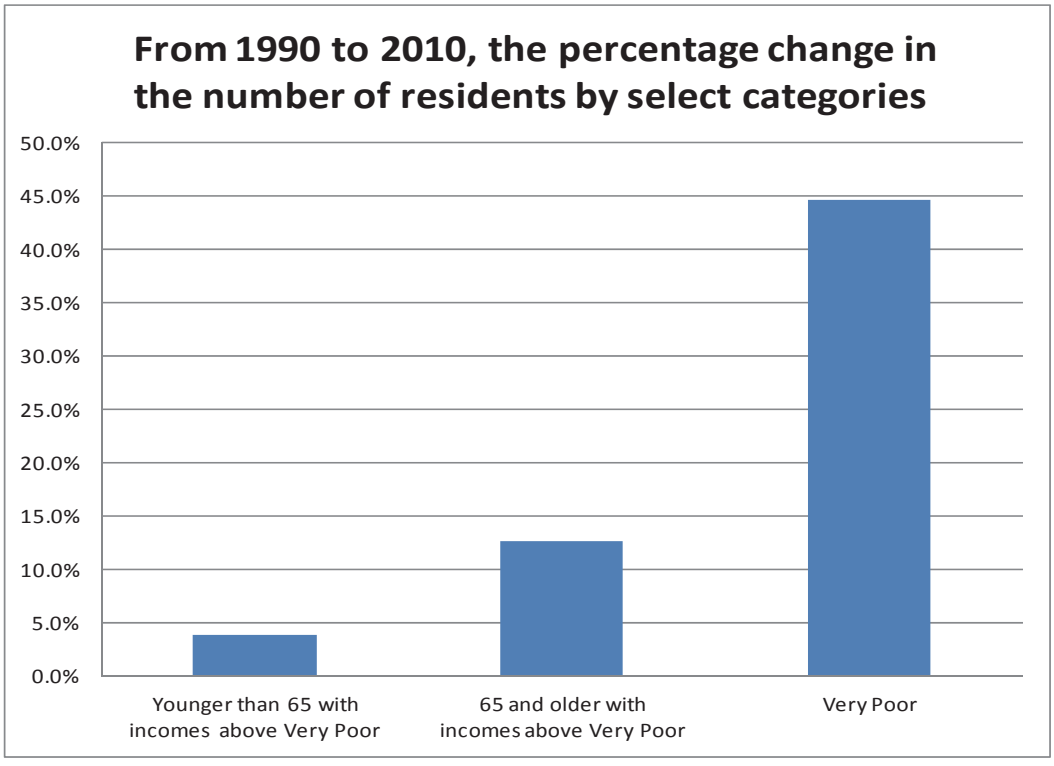
Maps courtesy of the Connecticut State Data Center, located at the University of Connecticut Babbage Library's Map and Geographic Information Services.

I. Report Overview

Key Finding – 1990 to 2010
Fewer Jobs, More Poverty

The number of Connecticut citizens in poverty has risen over the past twenty years while employment opportunities, particularly those at the lower end of the wage scale, fell during this same time period. Three demographic shifts—baby boomers entering retirement; skilled and educated young people looking out-of-state for employment opportunities; and the geographical concentration of poverty—exacerbate this trend.

A striking change over the 20-year review period is the modest growth in Connecticut's overall population contrasted against a 12% increase in those aged 65 and older, and a marked increase in the number of Very Poor Connecticut residents.



I. Report Overview

Key Findings

This report sets three key factors—a basic education, workforce training, and employment opportunities—that determine changes in the number and percentage of people living in poverty. In simple terms, when there are more jobs, there is less poverty.

Here are some of the research team's most significant findings:

- **Poverty in Connecticut increased significantly from 1990 to 2010**
  - The number of Connecticut residents who were Very Poor (incomes below the Federal Poverty Guideline, or FPG) increased 45% during the twenty-year period, with the percentage of all Connecticut residents who were Very Poor growing from under 7% in 1990 to over 9% by 2010.
  - Demographic changes exacerbate this trend; for example, the number of Connecticut residents age 65 and older is increasing at a rate nearly twice that of those aged 18 – 64, known as the "working age" group. A significant share of those 65 and older residents will live on fixed incomes below 200% of the FPL, an income level referred to as "Poor" in this report.

- **Poverty growth is closely tied to stagnant job creation within Connecticut**
  - Employment within the state has stagnated for more than twenty years. Since 1990, there have only been eleven months during which the number of employed Connecticut residents exceeded the number employed in 1990.
  - Connecticut has the worst job creation record in the nation over the 1990-2010 period.
  - Connecticut missed out on the technology related job growth in the 1990's, thus failing to create the foundation from which many of the national employment opportunities emerged in the most recent decade.
  - Connecticut has seen a significant contraction in the number of entry-level jobs most accessible to low-skill workers, restricting their ability to gain that crucial initial foothold on the employment ladder.

- **Connecticut can do a better job of creating and supporting educational opportunities and the conditions that support job creation**
  - State level policy decisions were made that did not create supportive environments for innovators to start new businesses, and hampered the state's ability to attract jobs and employers.
  - Connecticut has instituted entry barriers to employment at the lower end of the wage scale; e.g., increasing educational requirements for low-wage jobs in preschools and healthcare.
  - Errors in State level policy were due more to a lack of relevant data and analysis on which to base such decisions, than on partisan differences in job creation approaches.
  - Employment trainings within Connecticut have often not been aligned with actual job opportunities.
  - In Connecticut, there is a strong correlation between those living with a poverty level income and those who fail to attain a high school diploma. It is critical to note that during the review period, the rate of high school completion in Connecticut's major cities declined - virtually guaranteeing a continued and increasing struggle to avoid poverty.

I. Report Overview

Community Action Agencies Take a Holistic Approach

Those struggling with poverty often face multiple challenges, and the caseworkers at Connecticut's CAAs understand that to the highest level. When people enter the doors of a CAA they often enter in crisis, because one or more issues in their life has risen to such an unmanageable level that it can no longer be addressed without assistance. The CAA caseworker assigned to that person takes a holistic approach and examines their entire situation, knowing that a family unable to get that next oil delivery may have an empty cupboard, too.

Sally, a 35 year old single mother of a disabled 12 year old daughter and 9 year old son came to ABCD, the Community Action Agency in Bridgeport, seeking help with her gas heating bill. Sally was also out of work, and her income was limited to the monthly SSI payments she received for her daughter.

During her interview with a caseworker, Sally was relieved to learn that she qualified for Energy Assistance. The interview also led to the caseworker's discovery that Sally faced shut-off of her electric service after falling behind in her bills during the previous winter. Fortunately, ABCD was able to make an additional award under a separate program to help keep the lights on. With these two immediate needs met, Sally became emotionally distraught and began to cry. She confided in her worker that there had been a delay in processing her food stamp application, and she did not have any food at home for her two children. ABCD was able to issue her a food voucher for use at the local food pantry. The worker also was able to contact DSS for the client and get information on the situation with the client's food stamp case.

Sally was grateful for all the help she received at ABCD, and was relieved that not only will her gas and electric service remain on, but that her new payment plan would be manageable. However, what Sally really needs, what we all need, is a job. As a part of her interview with ABCD, Sally was referred to CTWORKS in the hope of finding a permanent, long-term solution…a job to support her family.

I. Report Overview

Meeting the Challenge
What Can Be Done About Poverty In Connecticut?

The research team has developed the following list of potential actions the state should consider and act upon to support the growth of employment opportunities in Connecticut, particularly those opportunities that provide the first steps to the pathway out of poverty.

- **Implement comprehensive economic development planning**
  - Examine infrastructure needs to improve access to jobs for those most at risk.
  - Look to successful programs in other states.
  - Consider simplifying the business-to-business tax rate.
  - Revisit permitting and regulatory environment.
- **Align credential requirements with job-specific task**
  - Convene a Task Force to investigate "Barriers to Entry" for low wage jobs, particularly in education and healthcare.
  - Evaluate all current and proposed licensing requirements to ensure they are based on solid evidence that they are truly related to job-specific tasks rather than generic credentials.
- **Support education and training initiatives**
  - Provide wraparound funding for early childhood education to address the striking disparities in education outcomes amongst Connecticut towns.
  - Support training that prepares students for current and future work environments.
  - Work with employers to ensure training efforts are aligned with market need.
  - Evaluate "best practices" developed and implemented in other states to incorporate short-term strategies and interventions that have measurable payoffs.
- **Create a data center to store, track, and analyze economic and jobs-related data in an ongoing and consistent manner**
  - Good policy flows from quality data and thorough analysis.
  - Investments in this data center should represent long-term commitment from the outset.
  - Modify Confidentiality and Freedom of Information rules to facilitate integration of data across different agencies, permitting appropriate analysis.
  - Assess and address critical IT infrastructure needs.
  - Institute a framework of iterative policy studies to facilitate public policy development and implementation.

II. Methodology

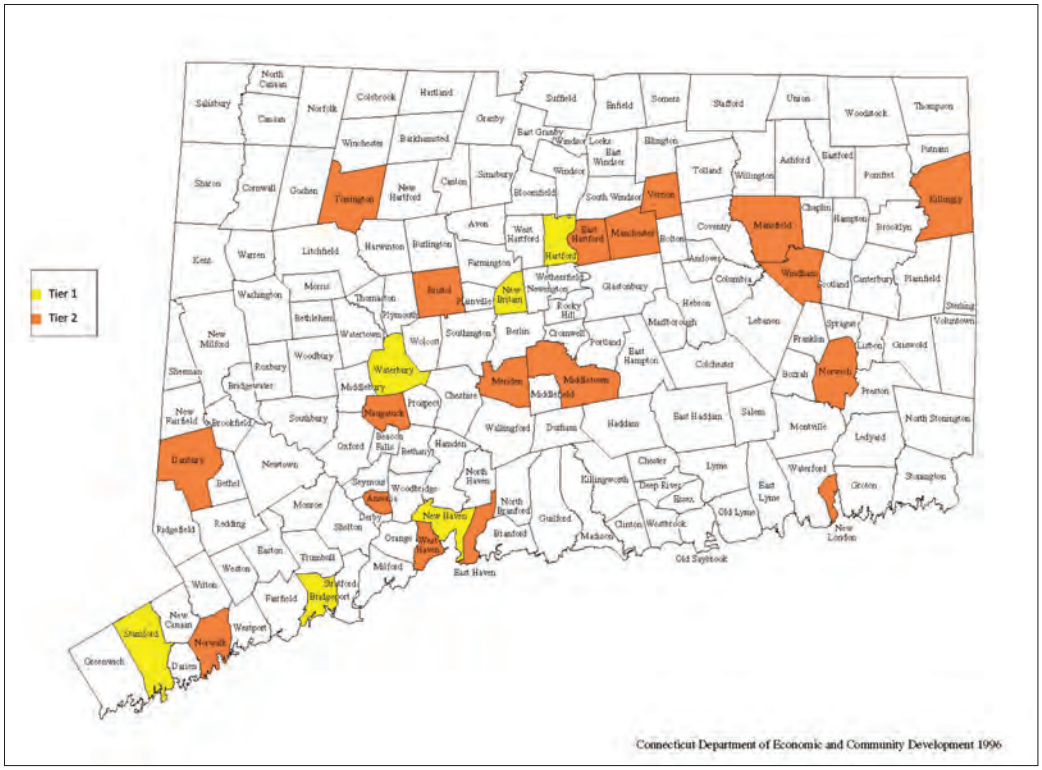
Tier 1 and Tier 2 Cities and Towns

To facilitate a well-rounded examination of the changing dynamics of poverty in Connecticut, the research team developed two "tiers", or groupings, of towns. The first group, Tier 1, consists of six of Connecticut's largest urban centers—the six cities with the largest number of Very Poor residents. The second group, Tier 2, provides a representative sample of other towns that also struggle with high levels of poverty. The two Tiers are defined and identified on the next page.

Although poverty in the state is disproportionally concentrated in large urban centers, the Tier 2 towns, where there is also a disproportionate concentration of low-income individuals, include at least one town from each of the State's eight counties.

This highlights the understanding that poverty is an issue which cuts across all segments of our population, including suburban and more rural areas.
By no means does this report suggest that towns not listed among our tiers are all doing fine; there are numerous towns with high rates of poverty, which were not included. For example, Willington, located in in Tolland County, with 16% of its population as Very Poor in 2010; or North Canaan, located in Litchfield County, with 14% of its population as Very Poor in 2010.

In our tier perspective, while 42% of Connecticut residents call Tier 1 and Tier 2 towns home, these same 24 towns account for 72% of Very Poor residents and 61% of Poor residents. Truly, many outside of our urban centers are "only one paycheck away."



While disproportionately concentrated in urban centers, poverty is an issue which cuts across all segments of our population.

II. Methodology

Tier 1 Cities

The first group, Tier 1, consists of six of Connecticut's largest urban centers—the six cities with the largest number of Very Poor residents. Although the two tier framing was originally conceived as a method for streamlining analysis, this approach has highlighted a geographical concentration of poverty within Connecticut, as will be more fully described in the next section, Demographics of Poverty.

Tier 1 Cities and Towns

Towns and cities with more than 10,000 Very Poor residents, arranged in descending order based on the percentage of residents classified as Very Poor (incomes below the FPL).

Based on 2010 American Community Survey, Five-Year Estimates

	County	Total Population	Number of Very Poor Residents	Percentage of Very Poor Residents	Number of Poor Residents	Percentage of Poor Residents
Hartford	Hartford	116,689	37,495	32.1%	29,431	25.2%
New Haven	New Haven	118,452	29,811	25.2%	23,554	19.9%
Bridgeport	Fairfield	138,854	28,876	20.8%	31,312	22.6%
Waterbury	New Haven	107,670	22,532	20.9%	22,023	20.5%
New Britain	Hartford	70,064	14,388	20.5%	14,761	21.1%
Stamford	Fairfield	119,686	13,301	11.1%	15,929	13.3%
Totals for Tier 1		671,415	146,403	21.8%	137,010	20.4%
Statewide Totals		3,434,901	314,306	9.2%	410,070	11.9%
Tier 1 Towns as % of Statewide		**19.5%**	**46.6%**		**33.4%**	
Statewide Total Poor & Very Poor			**724,376**	**21.1%**		

Note that although the six cities in Tier 1 comprise just 20% of the entire state's population, nearly half of the State's Very Poor call a Tier 1 town home. Similarly, Tier 1 towns account for 20% of total population, but 33% of the state's Poor—those living below 200% of the FPL.[5]

II. Methodology

Tier 2 Cities and Towns

Tier 2 consists of cities and towns with more than 1,500 Very Poor residents who make up 7.5% or more of the town or city total population. Cities and towns are organized in descending order based on the percentage of residents classified as Very Poor.

Together, Tier 1 & Tier 2 towns account for:

42% of the state's population

73% of the state's Very Poor

61% of the state's Poor.

Based on 2010 American Community Survey, Five-Year Estimates

	County	Total Population	Number of Very Poor Residents	Percentage of Very Poor Residents	Number of Poor Residents	Percentage of Poor Residents
Windham	Windham	22,494	5,130	22.8%	4,980	22.1%
Mansfield	Tolland	14,444	2,593	18.0%	1,740	12.0%
New London	New London	23,112	3,991	17.3%	5,458	23.6%
East Hartford	Hartford	50,425	7,467	14.8%	9,192	18.2%
Norwich	New London	38,988	5,610	14.4%	6,755	17.3%
Meriden	New Haven	59,152	8,191	13.8%	9,923	16.8%
Middletown	Middlesex	45,327	5,427	12.0%	6,594	14.5%
Torrington	Litchfield	35,765	4,040	11.3%	5,380	15.0%
Killingly	Windham	17,050	1,763	10.3%	3,234	19.0%
West Haven	New Haven	53,675	5,442	10.1%	10,173	19.0%
Ansonia	New Haven	19,003	1,837	9.7%	2,390	12.6%
Danbury	Fairfield	76,036	6,370	8.4%	11,793	15.5%
East Haven	New Haven	28,947	2,408	8.3%	3,549	12.3%
Norwalk	Fairfield	84,103	6,868	8.2%	9,202	10.9%
Manchester	Hartford	57,185	4,620	8.1%	8,140	14.2%
Vernon	Tolland	28,874	2,253	7.8%	3,332	11.5%
Bristol	Hartford	59,665	4,622	7.7%	7,585	12.7%
Naugatuck	New Haven	31,383	2,360	7.5%	4,995	15.9%
Totals for Tier 2		745,628	80,992	10.9%	114,415	15.3%
Statewide Totals		3,434,901	314,306	9.2%	410,070	11.9%

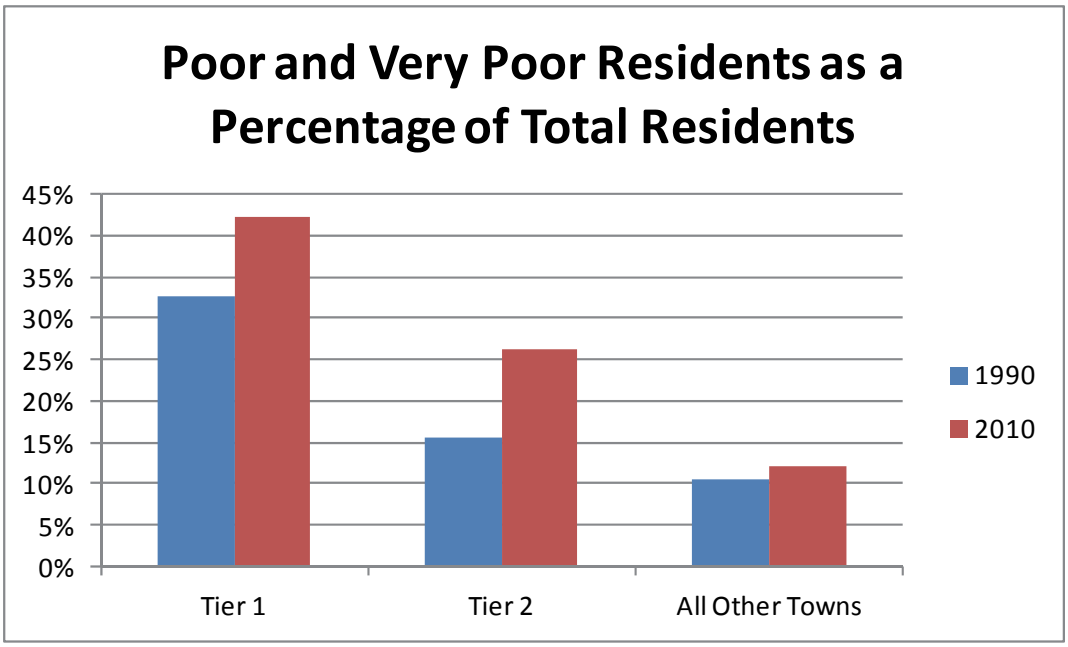
Tier 2 Towns as % of Statewide	**21.7%**	**25.8%**		**27.9%**
Statewide Total Poor & Very Poor		**724,376**	**21.1%**	

III. Demographics of Poverty in Connecticut

This section provides an overview of Poor and Very Poor populations in Connecticut, and discusses how the demographics of these populations (age, race, family structure, and education) have shifted or stayed the same during the 20-year review period.

From 1990 to 2010, the number of people living at or near poverty increased across the state; however, increases seen in Tier 1 and 2 cities and towns were staggering. During this 20-year period Connecticut's total population grew by about 8%, while the number of Poor and Very Poor increased by 40%—meaning 40% more people lived at or near poverty in 2010 when compared to 1990. In particular, Tier 2 towns saw an increase in the number of Poor or Very Poor residents. For Tier 2 towns as a group, the percentage of residents living below 200% of the Federal Poverty Line (FPL) increased from 15.5% to 26.2%, a jump of more than 10 percentage points.

The following chart helps to illustrate this dramatic shift:



Geographical Concentration of Poverty in Connecticut

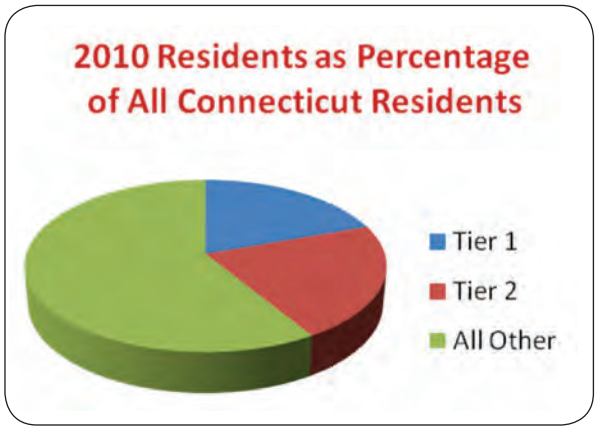
While it is true that, statewide, the number of Very Poor residents jumped 45% in 20 years and the vast majority of individual towns saw some increase in the number, there were still 38 cities and towns where the number of Very Poor dropped. In some instances, the drop was greater than 50%. This presents the question: what is going on? The answer is, poverty is highly concentrated in Connecticut's urban and semi-urban areas, most of which are included in either the Tier 1 or Tier 2 groupings.

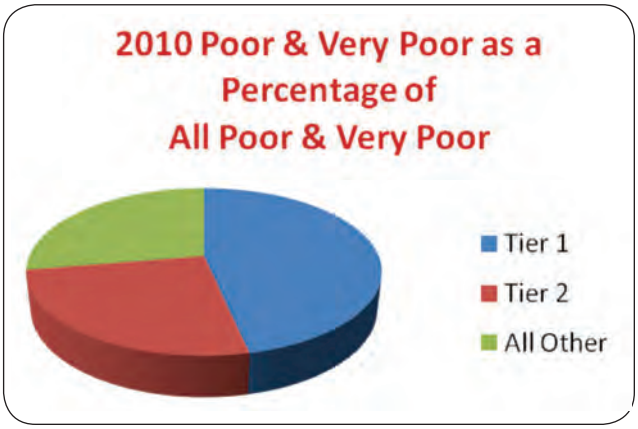
By glancing at pie charts on the opposite page, it is easy to see that most Connecticut residents live outside of the Tier 1 and Tier 2 areas. These individuals are represented in green.

III. Demographics of Poverty in Connecticut

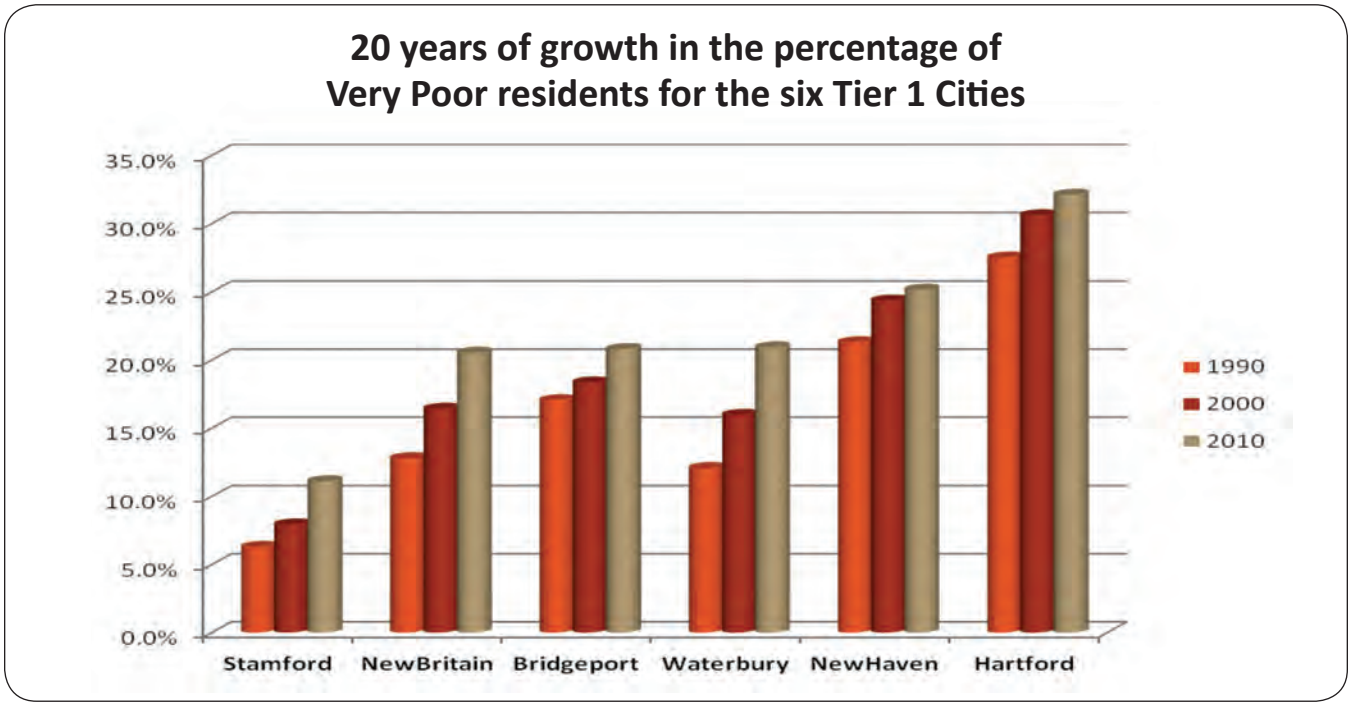
Most Connecticut residents, **59%**, lived **outside** the Tier 1 & Tier 2 Areas and, therefore, may not see poverty.

Most Poor and Very Poor Connecticut residents, **72%**, lived **within** the Tier 1 & Tier 2 Areas.





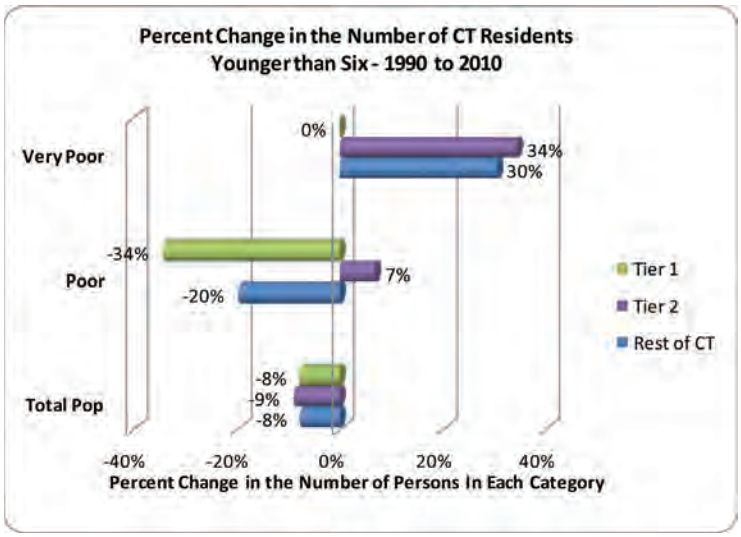
As seen in the graph below, the situation in some of our largest cities is glaring. In Hartford, 32% of residents lived below the Federal Poverty Line. Even in Stamford, a city with a median household income above $60,000 and a per capita income greater than $30,000, 11% of its residents lived in poverty in 2010—nearly double the 6% of Stamford residents who lived in poverty in 1990.

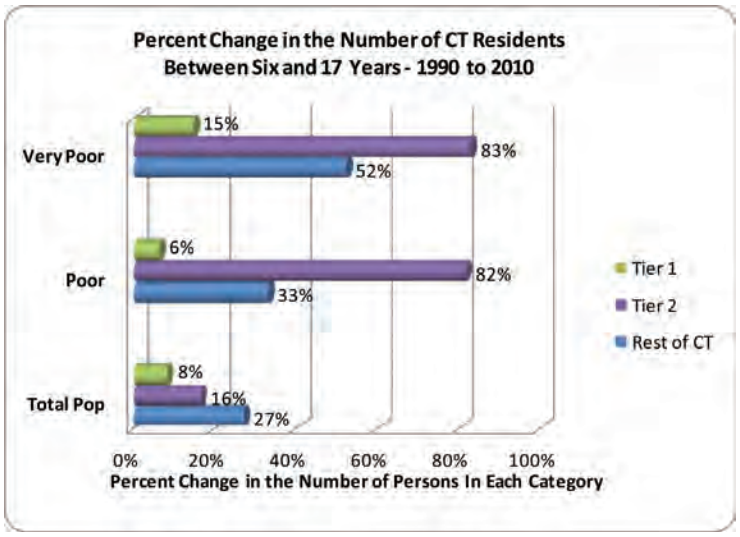


III. Demographics of Poverty in Connecticut

Age

This section describes shifts in Connecticut's population by age group. In particular, research for this report documented diminishing populations in a critical group, 18 to 44 year olds, explained in part by a growing trend of young people looking outside of Connecticut for employment and career growth opportunities as well as the parallel failure of the state's economy to generate jobs.





Preschool Children

Although the total population of children younger than six years has been diminishing, it is unclear if this trend will continue. When poverty is measured for these children, it is highly likely that federal and state programs provided additional resources—reducing the appearance of poverty for this most vulnerable group in our Tier 1 cities. For Tier 2 towns and Connecticut's other communities, however, additional advocacy may be needed to help these children succeed long-term.

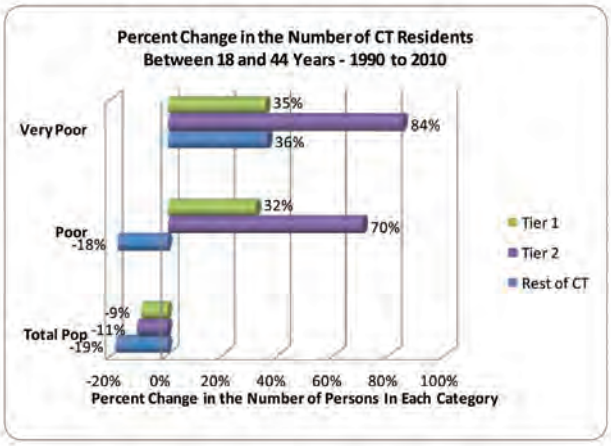
School Age Children

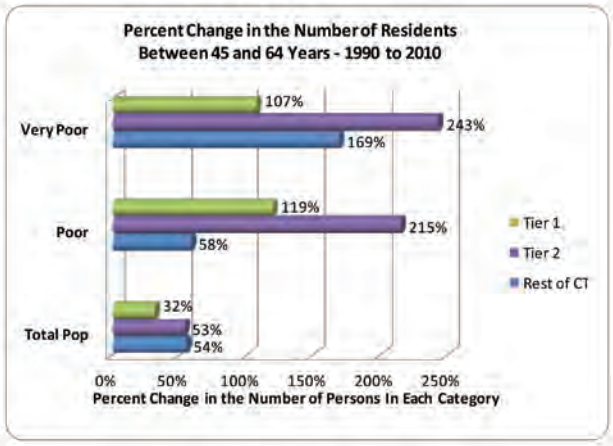
The total number of school age children grew at about three times the overall population growth rate, which was about 8% from 1990 to 2010. As can be seen at left, the rate of growth in the number of Very Poor school age children was greater than the rate of growth for all school age children, which held true for all three of the geographical groupings studied. One of the most striking findings is what has been happening in the Tier 2 towns where, over a 20-year period, the number of Very Poor school age children jumped by 83%. Clearly, this is very troubling. In addition and to give a sense of just how many children were affected between 1990 and 2010, the number of Very Poor school age children in Tier 2 towns almost doubled from 8,900 to 16,100. In the "Rest of CT," as shown at left, this number grew from 9,600 to 14,600 children.

III. Demographics of Poverty in Connecticut

Working Adults

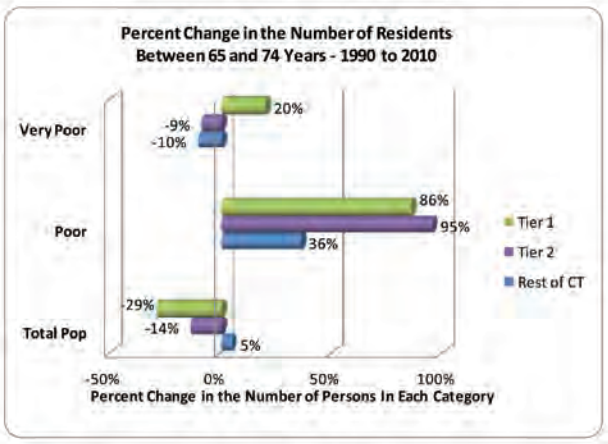
Connecticut saw population decreases in the critical age bracket of 18 to 44 year olds—a critical time when many people are in the process of setting their career goals and trying to execute on them. In part, this was due to young people with skills and education heading out-of-state for better employment opportunities. The growth of poverty for those who remained reflects the decrease in Connecticut employment. The total Very Poor population increased by nearly 50% during these two decades, from 84,000 to 123,000, with most of the growth in Tier 1 and Tier 2 towns.

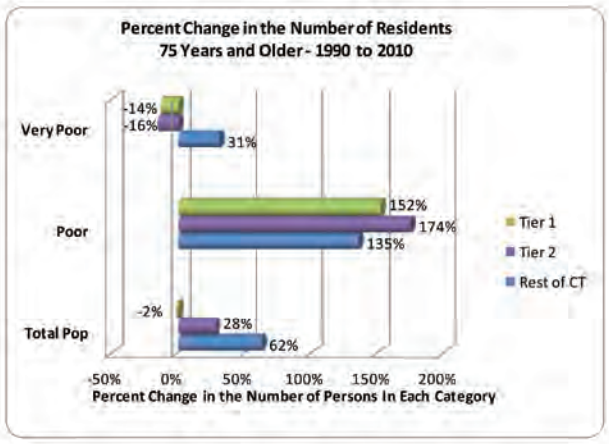




Retired Adults

Retirement age is typically a time when lower income adults move to the relative security of fixed incomes; however, those fixed incomes are woefully inadequate to pull individuals out of the Poor category. Reversing this trend over the long-term will require expanded, living-wage employment opportunities which allow individuals to save additional resources for their retirement years. In the shorter term, as the baby boomer generation moves into retirement with inadequate personal savings, Connecticut will continue to see growth in the number of retired adults who are Poor.



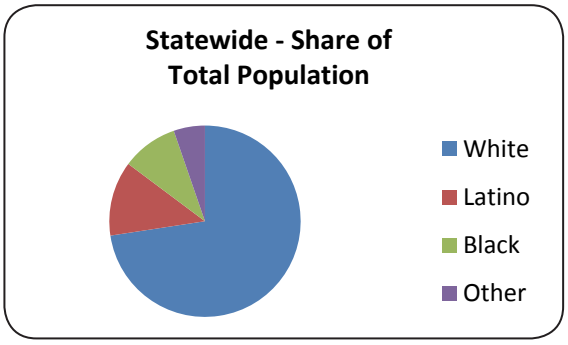


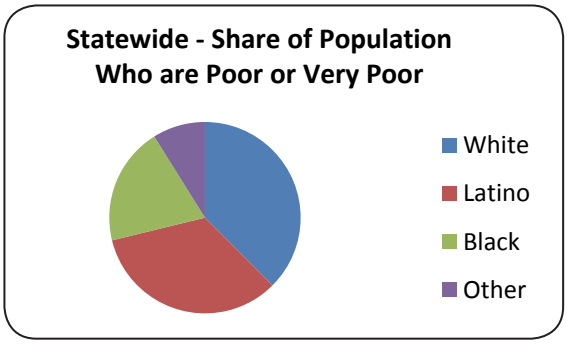
III. Demographics of Poverty in Connecticut

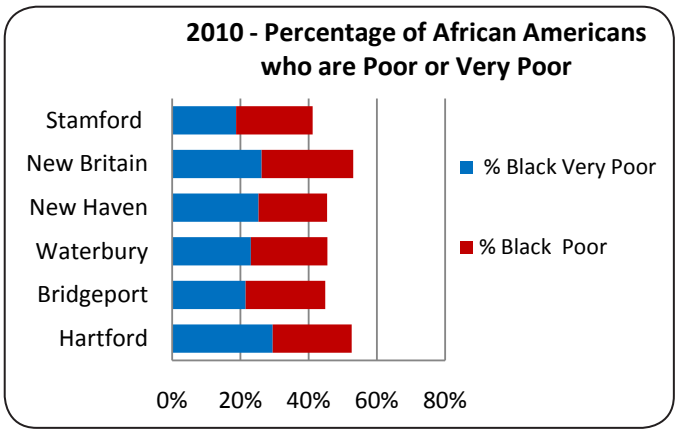
Race

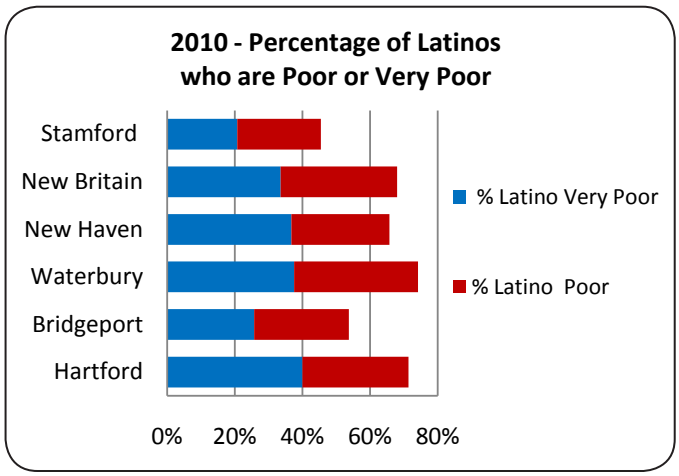
In Connecticut's major cities, a resident's chances of being Poor or Very Poor increases markedly if they are non-white; if Latino, there is an even greater likelihood their income will not be enough to remain self-sufficent.

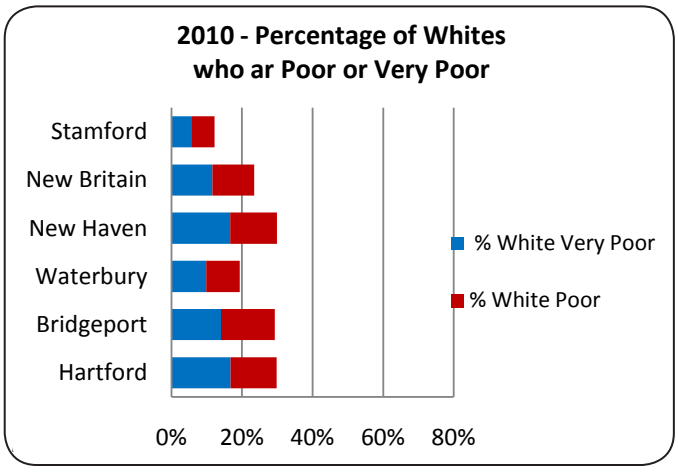
The three charts at the right make this trend glaringly obvious. These same trends are reflected in statewide averages in the two charts below. For example, while the Latino population makes up about 13% of the state's total population, they account for 34% of all those living below 200% of the Federal Poverty Line.[6]







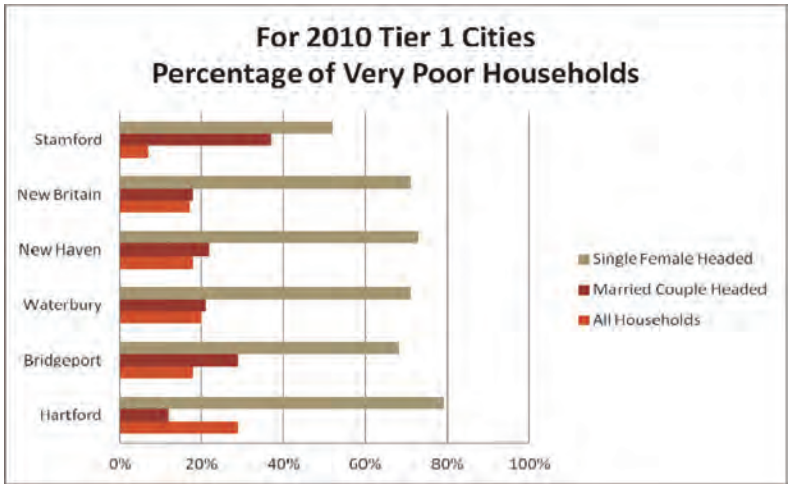




III. Demographics of Poverty in Connecticut

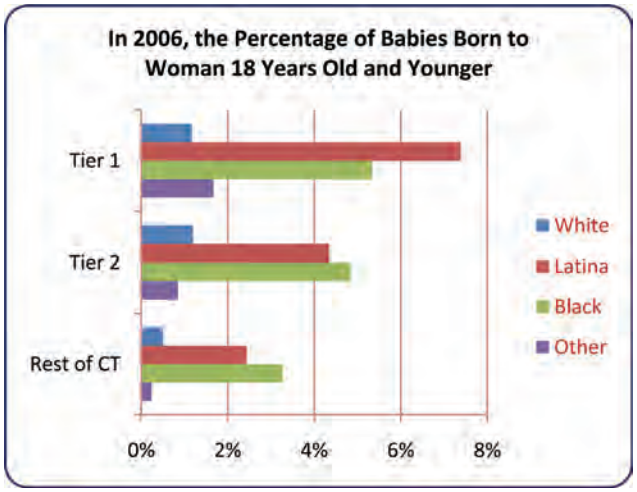
Family Structure

Family structure often forecasts the likelihood that the family unit lives in poverty. As more fully outlined in Appendix II, the research team has affirmed and quantified a significant statistical relationship between the percentage of single female households with children in a given town, and that town's level of poverty.[7] For example, in 2010, if you were a member of a single-female headed household in Hartford, there was nearly an 80% chance that your household was Very Poor.



In 2010, there was an 80% chance that an individual living in a single-female headed household in Hartford was Very Poor.

Research shows there is often strong interplay amongst the demographic variables of race, education, household type, and poverty. As national health studies report, "[a] child born to a teen mother who has not finished high school and is not married is nine times more likely to be poor than a child born to an adult who has finished high school and is married."[8] Within Connecticut's Tier 1 towns in the last decade, 58% of births to Latinas, on average, occur in women who are not yet 18 years old, while for African Americans this percent is 27% and for Tier 1 whites, 7%.[9] If we had more complete data, we could possibly see other poverty triggers at work, as well. Thus, encouraging Connecticut's young women to postpone childbirth until after completion of high school is a central element in any systemic effort to reduce poverty. As the Connecticut Department of Public Health registration report data shows (graphed at right), interventions are needed most in Connecticut's Tier 1 and Tier 2 towns.



"The Governor should inaugurate a standing committee to look at and evaluate best practices for interventions. We already know that quality early education has a major impact, but we cannot wait another generation to address the challenge of young, single motherhood and poverty. We must search constantly for the short-term strategies and interventions that provide measurable payoffs."

— Fred Carstensen, Economist, University of Connecticut as quoted for a story on National Public Radio, December 2012

III. Demographics of Poverty in Connecticut

A Future In-The-Making?

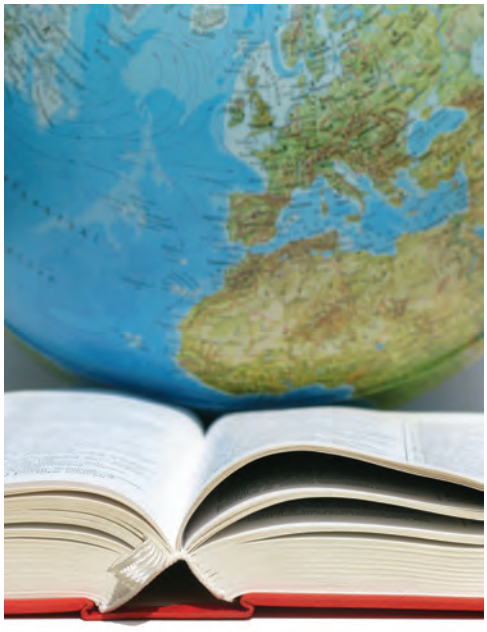
New Opportunities, Inc. (NOI), the CAA based in Waterbury, administers a job training program called In-The-Making (ITM). This twelve week job training program for unemployed, or under-employed, women in the greater Waterbury area is designed to help participants develop the work and living skills needed to become self-sufficient, while at the same time addressing barriers to employment.

After her release from jail, Tiffany had trouble finding work. Lacking a high school diploma or the equivalent, and with a criminal record, no one seemed willing to give her a chance. A caseworker at NOI worked with Tiffany to develop a plan, and she was enrolled in the ITM program. As a part of the program, Tiffany worked to identify the personal barriers that were keeping her from moving ahead in life and becoming self-sufficient. She found that her greatest barriers were her criminal record and her lack of a GED. Her inspiration from the program and the services she received while attending gave Tiffany the confidence she needed to sign up for a GED class. Each small success "In the Making" inspired Tiffany to reach ever higher. She eventually completed the GED program, and is currently awaiting a decision from the Board for Expungement.

In the meantime, Tiffany continued to meet with her case worker to build a resume and explore her options. She wanted a better future, and set a goal of preparing to get into a CNC program. With the assistance of the ITM case worker, Tiffany applied to the local Workforce Investment Board and received partial WIA funding to enroll in a certificate program at the local Community College. Due to her hard work and determination, Tiffany is now enrolled at Naugatuck Valley Community College and began classes this past summer.

"Based on 2010 data, men and women who lack a high school diploma or GED could expect to be Very Poor 67% and 72% of the time, respectively.

Also based on 2010 data, men and women who earned a B.A. could expect to have incomes above the state median 78% and 68% of the time, respectively."



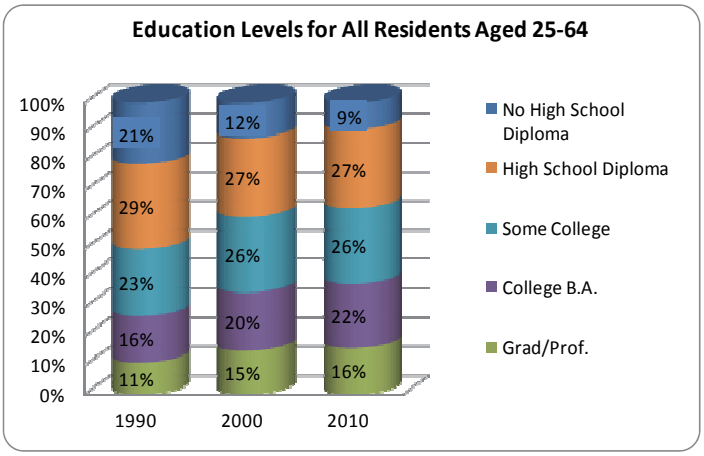
III. Demographics of Poverty in Connecticut

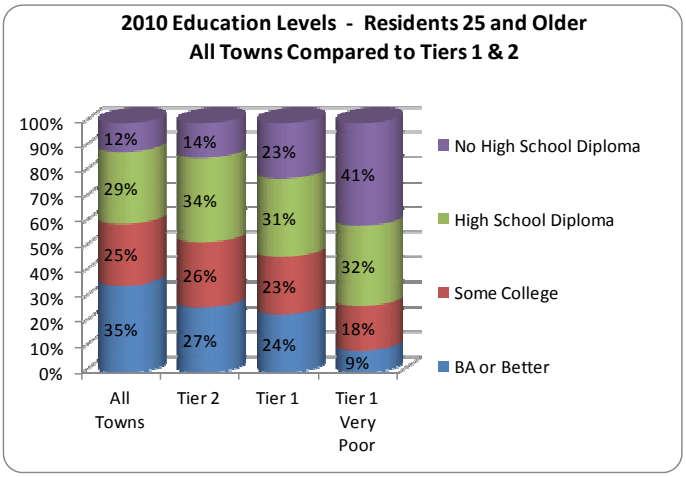
Education

Research for this report revealed strong correlations between educational outcomes and income levels. For example, completion of a B.A. or an advanced degree is highly correlated with incomes greater than the median. This correlation was stronger for men than for women. The likelihood that a Connectiuct male with a B.A. or advanced degree earns an income above the state median is 78%, while for women that number is 68%—both significant correlations. Conversely, failure to earn a high school diploma provides an almost as strong indication of the likelihood of being Very Poor. Connecticut females and males who lack a high school diploma or GED can expect to be Very Poor 72% and 67% of the time, respectively. The report's research team also found that in 2010, for every percentage point increase in the percentage of residents lacking a high school diploma or equivlent, the percentage of all residents classified as Very Poor would increase by 0.8 percentage points. These findings are instructive as we examine educational outcomes across the state.

On a statewide basis, Connecticut is making strides to improve its "educational attainment"—the percentage of students who earn a high school degree or better. However, Connecticut's poverty-dominated cities are losing ground rather than moving ahead in this struggle for self-improvement.

The chart at right reflects a significant increase in education outcomes across the state. For example, the percentage of 25-64 year olds with a bachelors degree or higher grew from 27% in 1990 to 38% in 2010, an incredible acheivment. Equally as impressive, the percentage of 25-64 year olds without a high school diploma fell to just 9% from 21% in 1990. By 2010, 91% of all Connecticut 25-64 year olds had, at least, a high school diploma.





The research team also drilled down further to examine how these acheivements played out in Connecticut's poorer towns and cities. As might be expected, the statewide averages are not reflected in the experience of our Tier 1 and Tier 2 towns.[10]

The chart at left clearly shows that those at the bottom of Connecticut's economic stratum are missing out on the educational gains seen elsewhere in the state.

Connecticut's major cities, in particular, struggle to attain educational outcomes that would enable its residents to move out of poverty through gainful, rewarding employment.

IV. Employment in Connecticut: 1990 to 2010

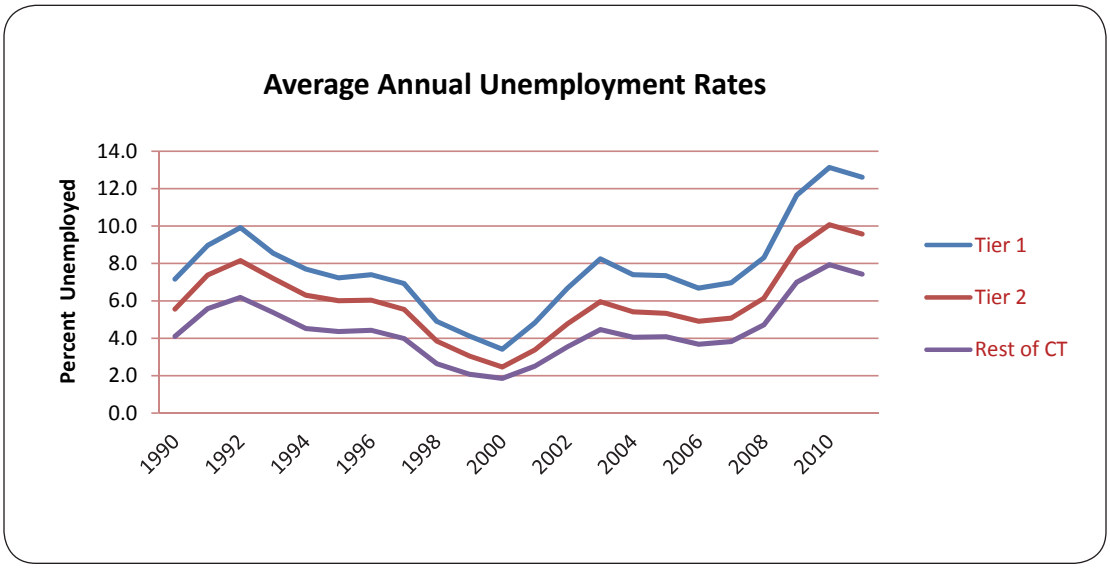
The availability of employment, particularly opportunities at the lower end of the economic ladder, is a primary, sustainable path out of poverty. This section relates several concerns about the relationship between employment and poverty, the continued high unemployment following the beginning of the 2008 Great Recession, the story of employment stagnation in Connecticut over the last 20 years, and the failure to identify low-wage jobs as key stepping stones out of poverty.

Earlier sections of this report paint an unsettling picture of the growth in poverty in Connecticut. According to the American Community Survey the number of national residents living below the Federal Poverty Line grew by approximately 29% from 1990 to 2010, while the comparable figure for Connecticut was 45%. Why is Connecticut, one of the wealthiest states, with easy access to markets and increasing educational outcomes, seeing increases in poverty far greater than the nation as a whole?

This report highlights the failure to create net new jobs, and while it is quite standard to encourage policy makers to compete for new industries (like bio-tech and advanced financial strategists), our research uncovered that the disappearance of lower-wage jobs—those which provide the critical first rungs on the ladder out of poverty—are highly correlated with the growth of poverty in the state.

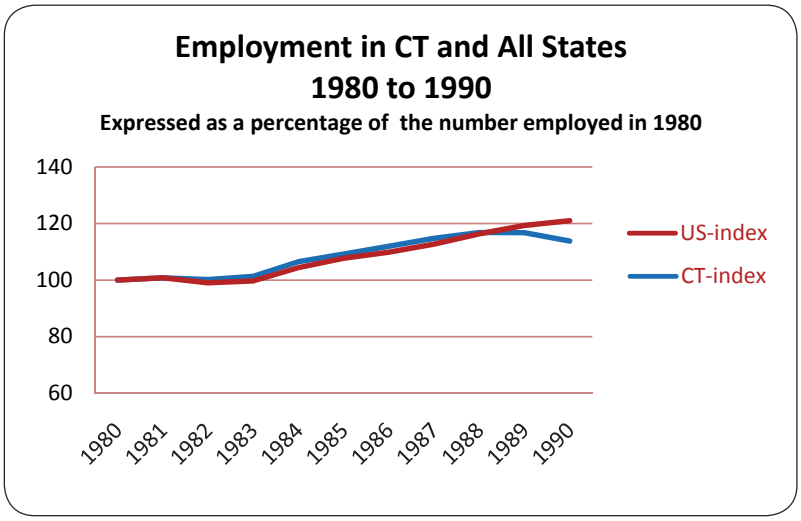
Unemployment Rates During the Review Period

As seen in Section III. Demographics of Poverty in Connecticut, the Tier 1 and 2 cities and towns tend to shoulder a disproportionate share of the symptoms of poverty. The unemployment rate is no different. The chart below shows that in particular, the Tier 1 towns had unemployment rates far greater than the average for those towns outside of the Tier 1 and Tier 2 groupings.

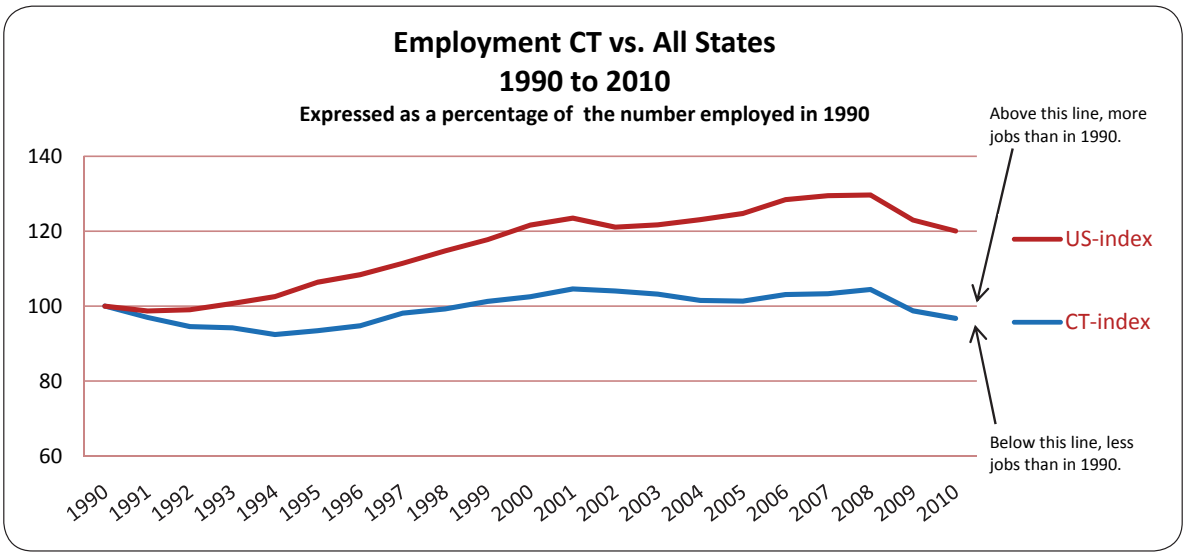


IV. Employment in Connecticut: 1990 to 2010

1990 to 2010, Zero Net New Jobs in Connecticut



Throughout the 1980s, changes in the number of employed persons in Connecticut mirrored changes at the national level. A dramatic divergence from this trend began in 1990. Beginning at that time and relative to the national picture, our state lost more jobs over a longer period of time and missed out on much of the steady job growth which began in the rest of the country in 1992. As can be seen in the chart below, by 1993 the nation as a whole had recovered from the job losses of 1990 and 1991; however, Connecticut continued to lose jobs until 1994, and did not recover all of its lost jobs until 1999.[11]



Since 1999, growth in Connecticut jobs has been anemic enough that by 2010, the after-effects of the Great Recession wiped out all gains since 1990. Although the nation as a whole also saw significant declines in the number of jobs following the Great Recession, the robust gains throughout the 1990s and additional growth in the mid-2000s allowed employment levels to remain 20% above 1990 levels. For Connecticut, the chart evidences two "lost decades"—20 years with no new jobs, while the total population grew 8%.

During the 1990s Connecticut also missed out on an opportunity to decrease poverty in the state, as the nation experienced a significant growth in tech-fueled jobs. This loss in high-tech jobs, as well as jobs in finance and insurance, contributed to job stagnation on the lower rungs of Connecticut's economic ladder. A 2003 CCEA study shows that for each "essential IT job", another 2.3 jobs are created in the Connecticut economy.[12] In turn, when Connecticut loses high paying jobs to other states, associated "downstream jobs" go with them. As a result, when these high paying Connecticut jobs are filled by non-residents, the normal ripple effect from demands for goods and services by in-state residents is lost.

IV. Employment in Connecticut: 1990 to 2010

Little solutions matter.

The tide washed ashore a great number of starfish and a woman was spotted returning some of them to the sea. A person approached her and said, “Why are you wasting your time? Don’t you realize that there are so many starfish here that you can’t make a difference?” At this, the woman bent down, picked up yet another starfish, and threw it into the ocean. As it met the water, she simply responded, “It made a difference for that one.”

What Can You Do With 25 Dollars?

John is a decorated Veteran who served in the War in Afghanistan. Following an honorable discharge in 2003, John found employment utilizing skills gained in the Army; but, was laid off in 2009 and has struggled to find full-time work since. John found that with a high school diploma and a one-year Electronics Technician certificate earned while in the military, he lacked the credentials employers were looking for.

After his unemployment benefits ended in 2010, John quickly found his life spiraling out of control. Unable to keep up with his debt payments, the bank foreclosed on his home, and his car was repossessed. John found himself alternating between “couch-surfing” and true homelessness while avidly seeking stable employment.

Thankfully, John reached out to Thames Valley Council for Community Action (TVCCA), the Community Action Agency serving Southeastern Connecticut. TVCCA was able to connect John to a Department of Labor Veteran’s Representative who saw John’s distress and potential and referred him to an On-The-Job Training program. While the training placement ended without full-time employment, John had some of his confidence back. He continued his job search and was lucky enough to be invited for a second interview. While this was a great opportunity for John, the company was in a different part of the state and he did not have the money to fill his tank to make the trip. Desperate, John contacted his TVCCA case manager who was able to secure a $25.00 gas card for John that same day. John attended the interview and was hired shortly thereafter as an Electronics Technician.

Within four weeks of starting the job, John was promoted to Technical Writer. The last time TVCCA heard from John there was talk of another promotion, this time to Assistant Operations Manager with a “healthy pay raise.”

John is back to dreaming about being a homeowner again, a dream he knows he can attain, **thanks in large part to a CAA employee and a $25.00 gas card.**

IV. Employment in Connecticut: 1990 to 2010

Putting Our Young People to Work

Tommy was referred by the Bristol Board of Education to the Bristol Community Organization, Inc. (BCO), the Community Action Agency (CAA) in Bristol. Tommy had just turned 17 and was living in public housing with his single mother. Like most 17 year olds, Tommy was thinking about his future, and was weighing a decision about finishing high school or dropping out to try and work full time. Tommy wanted to work, wanted more stability in his life, and wanted guidance and positive role models.

BCO's case manager was impressed with the young man who, when his ride was late, walked the two miles from his home to BCO to enroll in a Summer Youth Employment and Training program. BCO, and Tommy, were fortunate in that a former BCO client had donated $25,000 to expand this Workforce Board funded program from 50 to 60 slots, and Tommy secured one of those ten additional slots. Tommy was only too happy to make that four mile round trip walk many other times over the course of the summer program. The young man was a reliable worker, came in every day, and did his job. Following the holistic approach in use by all of the state's CAAs and by the Summer Youth program, Tommy's case manager helped him get a Department of Motor Vehicle ID, set up a bank account, and attend a course in money management.

Inspired by the program, Tommy found a part-time job at McDonalds. More importantly, Tommy was inspired by positive role models and became convinced that his employment opportunities would vastly increase if he finished his high school education. Tommy is doing just that, is learning to drive, and is saving his earnings to someday buy a car.

When Tommy finishes high school, will full-time employment be available to him?

Helping Families Reach Self-Sufficiency

Last year a family came to New Opportunities, Inc. (NOI), the Community Action Agency (CAA) serving the greater Waterbury area, looking for help. Regina, Derek, and their young child were only a few short months away from homelessness and felt they had nowhere to turn. The mother, who had worked full time as a bank teller, was recently laid off; the father, struggling to find a full time position after himself falling victim to layoffs, was working a part time job that paid minimum wage and did not make use of his vocational skills. The stress of mounting bills and foreclosure was taking a toll on the family.

The CAA's Family Development Specialist worked with the family to develop a budget and connected them with services that could save their house while supporting their continued search for gainful employment. Through the course of the CAA's engagement, Regina expressed her interest in returning to school but felt the family could ill afford it. Seeing the dedication in this young mother's plea, the CAA was able to connect her to a training center where she completed Business & Technology classes. After completing these classes, Regina set her sights on a C.N.A. program. Her dedication and determination to get certified and get a job pushed her to finish at the top of her class, where she graduated with high honors.

Regina was able to find a job after completing her C.N.A.; but, Derek is still looking. Although NOI helped Regina obtain employment, it will still be a great challenge for this family to reach financial self-sufficiency with one of them still out of work.

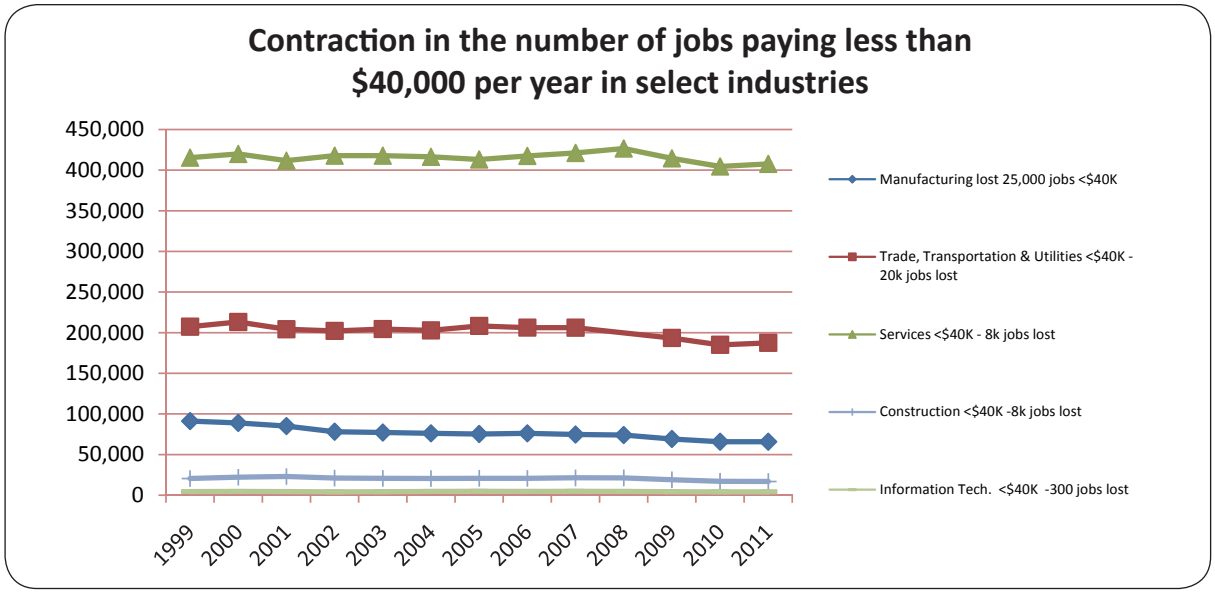
Poverty Growth in Connecticut is closely correlated with loss of jobs at the lower end of the wage scale.

IV. Employment in Connecticut: 1990 to 2010

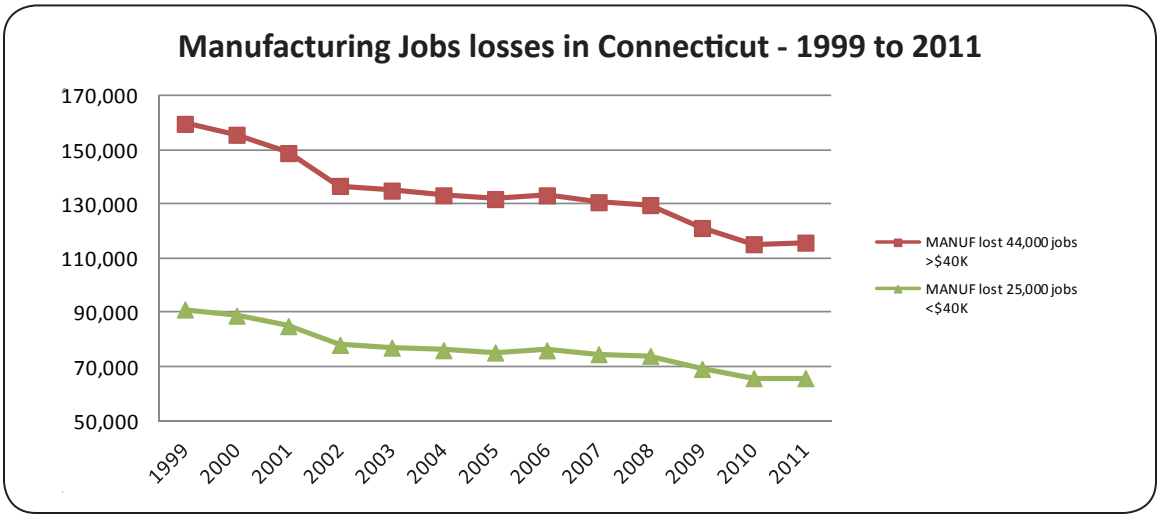
Contraction of the Employment Pathway out of Poverty

This section shows the significant contraction in jobs that pay less than $40,000 in the State of Connecticut. These jobs are important for a number of reasons; but, primarily, jobs at the lower end of the wage scale represent the lower rungs on the ladder leading to economic security for lower income residents.

Between 2002 and 2010, approximately 58,000 jobs paying less than $15,000 per year were lost. Additionally, 103,000 jobs paying between $15,000 and $40,000 per year were lost, a loss rate of 2.5% per year.[13]



Professor Harry J. Holzer of Georgetown University, writing for the Urban Institute in 2011, confirmed this loss of low-income jobs, the very jobs which offer a pathway out of poverty.[14] Manufacturing, a major though diminishing sector for Connecticut's workers, has seen job losses in both the above and below $40,000 categories. For less skilled workers, sources of good jobs are shifting away from the manufacturing sector to the administrative, construction and health-care sectors; however, only a fraction of the jobs lost have been replaced.



V. State Level Efforts at Workforce Development & Fostering Job Growth

This section offers a brief overview of Connecticut's efforts, from 1990 to 2010, to foster and support the types of investments that lead to employment growth. It also provides a thumbnail of how the current administration has worked to change course. This section then leads to Section VI, which provides some recommendations which, if acted upon, would continue and expand the good work already begun and provide the State with the information it needs to make policy decisions that create an environment in which jobs can be created.

There are numerous reasons as to why Connecticut has failed to create jobs over the past 25 years. Initially, job losses flowed from the dramatic reduction in the defense budget following the collapse of the Soviet Union. Added to this was the impact of the revolution in information technology that hit traditional, old-line financial services particularly hard. Finally, the continuing and accelerating trend in manufacturing, substituting capital equipment for workers and moving production off-shore, especially to China after 2000, also played a role.

To these external challenges, Connecticut itself has often been unresponsive or inattentive to how its own policies have limited growth. The examples are numerous:

- The state's business-to-business sales tax, which requires the seller to know the final use its customer plans for a given product in order to know what tax to charge.

- The difficult Department of Energy and Environmental Protection (DEEP) and Public Utilities Regulatory Authority (PURA) permitting processes, which left a New Haven business unable to distribute the electricity generated from a state-funded fuel cell to the building's tenants, and left a Naugatuck Valley business operating on a perennially extended "temporary" permit for over a decade.

- The failure, prior to 2010, to develop a robust pipeline of Sate level capital projects at a time when interest rates were low and excess labor capacity was high.

- A systemic lack of sufficient data collection and analysis to track the state's performance or to understand such a basic element of economic health as the pipeline of state and municipal capital projects, the dynamics of firm creation and closure, or the linkages in the education-workforce pipeline.

In the area of workforce development Connecticut has long recognized the importance of training programs, but has failed to connect these programs to current or projected business needs or invest heavily in them. (Consistent with a theme of this report, Connecticut is unable to project business needs because the data that would facilitate such projections is not collected in a systematic way.) Connecticut's workforce training system is largely made up by programs supported by the Workforce Investment Act, Wagner Peyser, Trade Adjustment Act and Jobs First Employment Services funding. According to the Connecticut Employment and Training Commission's 2009 Annual Report[15], while individual workforce training programs have placed many people into employment, the state's workforce training programs have generally been unsuccessful in moving significant numbers of people into middle-skill jobs that pay enough wages to sustain a living. 60%-80% of these people have success in finding employment; however, their average annualized earnings are just over $20,000, qualifying as Very Poor if trying to support a family or Poor if supporting an individual only. This argues for programs that provide continuing training to facilitate movement up the skills ladder.

V. State Level Efforts at Workforce Development & Fostering Job Growth

Connecticut's adult education programs have had similar issues in that although they may be capable at churning out trainees for low-wage jobs, they have not been successful in figuring out how to place their trainees into career ladders that lead out of the lowest salary stratum. Many of these programs are geared towards adults who lack basic skills, a high school diploma, or proficiency in the English language—all of which are components of basic employability, which makes these programs valuable. Average starting salaries for participants in the year following program completion is approximately $20,000, annually. While these programs tend to improve earning potential of participants, they are not adequate at preparing individuals for the types of jobs that lead to economic self-sufficiency. As a result, additional skills and education are needed beyond these programs to allow adults to compete and earn a decent living, confirming the point made above.

Although some readers may be able to explain away one or more of these examples, the preponderance of examples is more telling than any specific act or failure to act. The simple truth is that Connecticut paid little attention to the shifting competitive environment, actually abandoned the one institutional mechanism it had in place to evaluate its economic performance, let its liaison office with the U.S. Census disappear which left the state with no capacity to evaluate its own demographics, did not create a meaningful education-workforce pipeline, and failed to develop a consistent, coherent economic development strategy. Consistent with this record, a 2005 report on New England competitiveness[16] singled out Connecticut for having the worst marketing effort in the nation. Simply put, no one knew about the state and its assets.

Cleveland's NewBridge, a vocational training program, offers a good example of a training program whose success is dependent on remaining connected to the actual needs of local businesses. Those same businesses participate in the development of curriculum and provide internships to program participants. NewBridge expects to mirror results of a similar program in Philadelphia where 90% of participating youths graduate from high school and 85% of adult participants secure jobs after program completion.

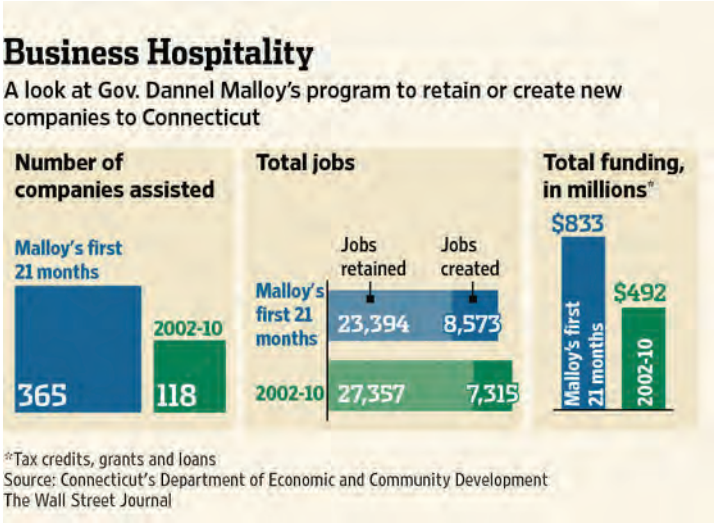
V. State Level Efforts at Workforce Development & Fostering Job Growth

Changes Since 2010

In contrast, the Malloy administration has and continues to address many of the failings discussed in this section. For example, the current initiative to market the state—the first in generations—has generated so much net new activity that it has paid for itself (measured in net new tax revenue). In the same vein, the large investment in biosciences—an unprecedented strategic public sector investment—was the basis on which the state captured the world-class Jackson Laboratories human genome research center. The major push to create a cutting-edge industry cluster in digital visualization, complete with a new department at the University of Connecticut devoted to this critical technology, is the sort of strategic investment and integration of the educational infrastructure with the needs of the business community that should be the hallmark of all efforts.

The Malloy administration has also allocated twice the resources as had been allocated in the previous eight years ($833 million vs. $492 million) to support economic development. These commitments have ranged across 365 companies and created or retained nearly 32,000 jobs in those firms. The multiplier effects more than doubled the number of jobs impacted in the state's economy. Finally, the expansion of the manufacturing training program from one community college to four demonstrates a clear understanding and commitment to linking educational programs to major competitive strengths in the state's economy.

Recognizing that economic development and the vitality of the business environment are central to a holistic response to the challenge of poverty in Connecticut, the research team believes there are four interrelated elements that the State must address. As just discussed, the Malloy administration has begun to build a solid foundation that speaks to these specific challenges.



VI. Meeting the Challenge

This section presents four recommendations and actions the State should begin or continue to address, and offers some practical steps which can begin today.

Continue developing and implementing comprehensive economic development planning

Recognizing that job creation is at the core of the effort to combat poverty, the current initiatives to make Connecticut's economy more competitive and to drive job creation are both welcome and essential. Special attention should continue to focus on the regions of the state suffering the highest rates of poverty, and should be linked with careful analysis of whether these regions have the infrastructure or mechanisms to give potential workers access to jobs. It is also important to support these efforts by developing thorough, long-term approaches to planning and job-growth strategies, including the increasing availability of job training programs linked to known job openings.

As part of this process, the State should consider whether a simplified tax and accelerated permitting structure would strengthen its competitive position. The current complex, confusing sales tax framework, with its hundreds of exceptions, is costly to business and virtually impossible to oversee properly. The tiered tax policy for business-to-business sales imposes particularly difficult standards on sellers, and misallocates the use of auditor time and attention. In addition, the current structure largely prevents the State from collecting tax on internet sales, even as nearly two dozen states now collect their tax because of uniform rates. A simple, uniform sales tax would save money for both businesses and the state, improve oversight and collection, and make Connecticut a more competitive environment. Where appropriate, adjustments should be made through rebates to retain complete transparency.

A lengthy and often opaque permitting system, which in some cases has continued for years, has complicated the business environment unnecessarily. This is particularly true in areas involving PURA, the result of which has been a virtual block on development of microgrids because of the absent of legal authority to create sub-metering regimes. Some legislation has been adopted to address these issues and the Department of Energy and Environmental Protection is alert to this challenge. More should be done to make the process transparent and to proceed within established time tables, as uncertainty is the enemy of enterprise.

Align credential requirements with job-specific tasks

A major challenge for many able-bodied poor is the barriers that the State creates with its formal credential requirements for specific jobs. In at least some cases, the credential is not clearly related to the job-specific tasks that a position in fact requires, and insofar as the credential is accessible only through formal education (e.g. a college degree), it may raise insurmountable financial barriers to poor individuals. Such formal requirements may also fly in the face of the wages paid in a particular sector; for example, child care tends to be a relatively low-wage sector, and imposing high generic educational requirements dramatically reduces the available workforce. Sector-specific training programs, like that supported by the Anne E. Casey Foundation through All Our Kin, have clearly demonstrated the effectiveness of focused training programs that give individuals the specific skill sets needed to deliver high quality services and has even opened the path for some of those individuals to then proceed to higher education.

The State should create a single, overarching policy advisory group that includes the Commissioner of the Department of Revenue Services, to evaluate all current and proposed licensing requirements to ensure that they are based on solid evidence of the relevance and importance of the requirement. The advisory group should be especially alert as to how the current or proposed requirements create significant barriers to low-skilled individuals who may have the required job-specific abilities. Additionally, when credentialing

VI. Meeting the Challenge

requirements are appropriate, the State should have a special responsibility for identifying the path that individuals may take to meeting those requirements. A generic requirement of a college degree fails that test.

Focus education-specific planning on state and agency-wide service integration, collaboration and the adoption/ application of best practices

Twin Cities Rise's (TCR) mission is to provide employers with skilled workers – primarily men from communities of color – by training under and unemployed adults for skilled jobs.

TCR developed a market-driven model, offering programs and classes in areas where one or more of its 150 hiring partners have identified a need.

TCR gets results by working closely with its hiring partners and by supporting its students. Two years post graduation, 71% of TCR graduates are still at their job.

The educational system is the focal point for critical interventions that give students both the skill sets and the attitudes needed to succeed and to minimize disruptions in the educational process, especially teenage pregnancy. Research has clearly established that the two crucial strategic investments are quality early childhood education (typically embedded within the child care system) and comprehensive "wrap-around" services in the school system. Interventions ought to begin before birth, with prenatal counseling for at-risk mothers. Wrap-around services make the school system the node from which social services are managed, as they involve collaboration with social work professionals and law enforcement.

To improve outcomes the state should also form an interagency initiative that brings together the Department of Education, the Department of Social Services, and other relevant agencies (e.g. Department of Public Health) to develop a plan to integrate services in collaboration with schools. To complement this work, the State needs to continually explore the short-term strategies and interventions that have measureable payoffs. To facilitate this exploration, the State should form a standing committee to evaluate current best practice. The New York City's public school system offers a good example, as its most successful schools include a team of full-time, professional social workers facilitating timely and constructive interventions that foster learning. Finally, both New Jersey and Massachusetts have significantly closed differences in educational outcomes with aggressive policies implementing similar wraparound services.

Develop comprehensive, integrated data systems; Implement a systematic, iterative policy process

Connecticut has been significantly handicapped by the absence of systematic, high quality data that is integrated into a single data architecture. This absence has meant that in many areas neither the Executive branch nor the Legislature is equipped to evaluate the implications of policy choices or to

VI. Meeting the Challenge

evaluate the effectiveness of the policies they have adopted. Good policy begins with good data; thus, the State should establish a State Data Council to provide broad oversight, articulation of policy standards, and leadership in addressing this challenge. New York City now integrates all data from all city departments into a single geographically based framework; it has over a thousand data elements for every parcel in all five boroughs, and is accurate within 12 inches of the curb line. It has been instrumental in identifying and addressing a host of issues in social policy, public health, and public safety. Along the same lines, the State should revive the first-in-the-nation longitudinal analysis of the education-workforce pipeline (*Next Steps* [17]) because of its ability to reveal and address a host of issues that directly impact at risk students.

A second element of this recommendation is that the State should formally commit to iterative studies of critical areas. In virtually every case, when studies such as this are done, they are done as one-off efforts. But, their value dramatically increases when they are part of a continuing, sustained effort to understand and evaluate the issue at hand. The iterative process is also crucial to educating policy leaders in both the Executive and Legislative branches to the fundamental nature of the challenges we face and to the policy options available. As part of this process, the State should be alert to monitoring "best practice" in other states. In many areas Connecticut has lagged behind other states (e.g. economic development, quality of administrative data, and educational data), at least in part because it was not attentive to such developments.

Freedom of Information Act, A Challenge to Better Data Collection

Michigan, Florida and other states have modified their Freedom of Information (FOI) laws to facilitate better information availability between agencies. Connecticut needs to work toward the same, to facilitate more complete studies of at-risk populations when our State Department of Education holds some of the data, and Department of Public Health a separate component or indicator.

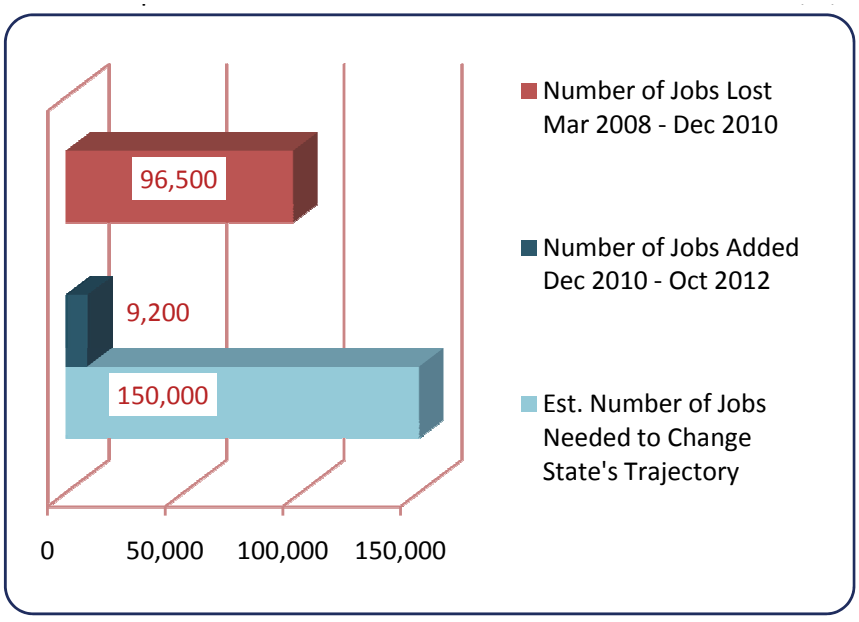
Connecticut was the 49th state to participate in the Labor Employment Household Dynamics (LEHD), which required integration between social security and the Department of Labor. Many states, like Connecticut, had prohibitions on sharing those data components and needed to initiate legislation to allow this cross-agency research collection.

Researchers across agencies also need to file confidentiality agreements with each agency from which they are requesting special enumerations. As poverty data crosses many agency repositories and in order to monitor progress for our many residents in poverty, Connecticut needs to amend FOI to encourage data sharing and reporting.

VII. Conclusion

From 1990 to 2010 Connecticut's total population grew by 8%, while the number of Poor & Very Poor residents jumped 40%. By 2010, 21% of Connecticut's population was living at or below 200% of the Federal Poverty Line (FPL), and nearly 1 in 10 residents were living below 100% of the FPL. This report shows that while the effects of poverty are geographically concentrated, that concentration extends beyond Connecticut's urban core and involves both medium and small sized towns in every county. Furthermore, the state is in real danger of witnessing a continuation of these trends due to demographic shifts that have seen young people leave the state in search of better opportunities, as well as the growth in the number of retirees as baby boomers reach and surpass age 65.

The section on Demographics of Poverty provides good lessons for policy makers, highlighting age, race, and educational differences that demonstrate poverty's grasp and point to areas where interventions can make a real difference. However, more importantly, this report illustrates that which lies behind poverty's growth: the stagnation of employment opportunities. From 1990 to 2010, Connecticut experienced a net loss in the number of jobs. During the 20 years examined, the state failed to create comprehensive policies or address structural barriers that stood in the way of employment growth, and made the state unattractive to companies looking to expand operations. These factors led to the dubious distinction of the worst job creation record in the nation, while Connecticut missed out on opportunities during critical periods of economic growth. During the 1990s and again in the 2000s, Connecticut lost jobs and/or created them more slowly when compared to other states and the nation as a whole. Particularly worrisome has been the contraction in lower wage jobs, which represent a low-income individual or family's best chance to escape poverty and become economically self-sufficient.



Based on data from the federal Bureau of Labor Statistics, Connecticut lost approximately 100,000 jobs during the Great Recession (measuring from March 2008 to December 2010). As made clear throughout this report, the state wasn't doing that well in March of 2008 either, with the number employed barely above that seen in 1990. Throughout the 2000s, Connecticut's job gains trailed national trends. Since that time, and due in part to the work of the State's current administration, 9,200 jobs have been added. Although a good start, this represents just 10% of jobs lost in the last few years. Therefore, the State needs to continue and expand its efforts to drive broad job recovery.

The research team estimates that approximately 150,000 jobs need to be created in the next three to five years to change the state's trajectory, both economically

VII. Conclusion

and demographically. The scale is daunting, but the incremental steps matter. For example, the Governor's First Five Initiative seeks to reward companies that create new jobs. While the job gains are counted in the hundreds, a complementary aim of the project is to provide incentives to companies to keep thousands of existing jobs in the state. As Governor Malloy described it, the state should help make large companies so dependent on the infrastructure and human capital they have in Connecticut that relocating is not an option.

This report also offers recommendations and action steps in four critical areas that can be taken now:

- Implement comprehensive economic development planning
- Align credential requirements with job-specific tasks
- Support education and training initiatives
- Create a data center to track, store and analyze economic and jobs-related data in an ongoing and consistent manner

As noted in this report, the state, under the current administration, has made good faith efforts and made significant investments to address many of the problems discussed. Governor Malloy came into office promising to improve Connecticut's attractiveness to employers and business, and has made progress; however, there is much left to do. To fully inform and ensure planning and decisions are achievable and to produce maximum impact, one critical need still relates to data. Connecticut is far behind other states in the area of data collection, tracking and analysis. While a couple of good examples do exist—notably the current efforts within the Department of Labor—state initiatives on data issues are fragmented and uncoordinated, and lack the IT and other infrastructure needed to be successful. A comprehensive plan for oversight, integration and investment is crucial to the development of an integrated state administrative data system. A State Data Council would have a broad brief to consider all of these issues, as well as how to address confidentiality and FOI restrictions that currently prevent completion of some critical studies. Without good data and strong, consistent, sustained analysis, the state's attempts at supporting job creation operate blindly, unable to forecast need or understand effects of and lessons from past efforts.

While there is much to be done to assist Connecticut residents toward a brighter tomorrow, effective programs are already in place to mitigate the most severe consequences of poverty Connecticut residents face every day. While this report does not trumpet the many direct-line providers, advocates, and legislators who tirelessly work to make a difference in the lives of those who experience poverty, Appendix I provides some important insight into one group of providers who serve every one of the state's 169 cities and towns: Connecticut's Community Action Agencies (CAAs). But for these organizations, many more in our state would face their days without food, shelter, warmth, job training, or hope. To address the recommendations highlighted in this report, all partners must be deeply committed to making the necessary investments in our most important asset—our people.

Appendix I Connecticut's Community Action Agencies

Community Action Agencies: Empowering People, Building Communities, and Keeping Hope Alive

The Connecticut Association for Community Action, Inc. (CAFCA) is the umbrella organization of Connecticut's Community Action Agencies (CAAs), the federally designated anti-poverty agencies strengthening communities and empowering people throughout the state's 169 cities and towns. Our mission is to strengthen the capacity of our members to foster economic self-sufficiency, and the stability of families and communities.

Since the Great Recession began in 2008, demand for our agencies' anti-poverty programs has skyrocketed. Community Action Agencies and our partners have helped many families recover, but countless families have been down on their luck for a year or more. And for families who had always played by the rules, the deepest recession since the Great Depression created a perfect storm of job loss, foreclosure, exorbitant rate increases in credit and health care, and myriad other threats. As a result, families who had been struggling on their own and simply couldn't do it anymore began coming through our doors in droves.

In many policy circles, these customers are called the 'new poor' and the economic condition we are currently facing is called the 'new normal'. A startling example of this 'new normal' is the increase in the case load of the Low Income Home Energy Assistance Program (LIHEAP): customer demand for assistance in heating their homes has increased by over 40% at most Community Action Agencies since the recession began. Of course, in addition to energy assistance these families have multiple other needs as well.

In the midst of this social and economic turbulence, Connecticut's CAAs have come through as an integral part of our state's social safety net. We have helped families keep their homes, have nutritious meals on their tables, care for their children, and prepare for new careers. While providing services to meet immediate needs, our agencies also work with those in need to develop long-range plans for success.

A hallmark of the CAA Network is the provision of holistic case management to improve self-sufficiency and strengthen family economic security. To achieve the goals of better, more cost-effective service, the CAAs developed a customer-focused, integrated services approach that guides customers through the social service system using a universal intake form. For those who need our services, they can enter the Community Action Agency door and with only one universal intake and pre-assessment form, case managers can predetermine likely eligibility for all programs and services.

The Human Services Infrastructure System of Service Delivery

This service delivery paradigm is called the Human Services Infrastructure (HSI) and for the past 9 years, the CAAs have partnered with the Connecticut Department of Social Services to implement this customer-focused, integrated service delivery system across all programs. CAAs accept customers at any contact point and guide them through a complex service system, ensuring the most efficient and cost-effective delivery of services, and the best use of taxpayer dollars. The result is improved client outcomes across all state- and federally-funded programs, underscoring the value of integrating diverse funding streams at the local level. We have found that increasing our customers' access to as many support services as possible increases the likelihood that the individual or family will maintain hope and health and move towards self-sufficiency more quickly.

New Opportunities, Inc. (NOI) has fine-tuned this holistic approach and it is called the **Family Development Center.** The Center's approach helps individuals and families who require a concentration of services, interventions and programs to achieve economic stability. The Center serves as the entry point for walk-in customers seeking assistance from NOI at its Waterbury location. Customers can be directly assisted with applications for any of the program services available within the agency. Customers can also be assisted with the completion of state benefit assistance applications and the gathering of documentation required for employment. Customers

Appendix I Connecticut's Community Action Agencies

may also be referred to a network of community partners if requested services are not available within NOI. These initial services are designed to stabilize the family situation and meet immediate needs.

The next level of services available in the center involves the building of trust with the family and engaging them in services that support the family and contribute to healthy parent-child relationships. Family Development services begin with an assessment of the strengths that the family brings to the table and continues with the creation of a family development plan. This plan is jointly developed by the NOI direct service staff and the family and includes short, medium, and long term goals with responsibilities for both the staff person and family. Services provided by NOI include home visits and skill development workshops designed to empower the family as they move towards the achievement of their goals and increase their network of support within the community. Skill development workshop topics include financial education, conflict resolution, communication, parenting skills development and parent-child relationship building, early childhood education and self-evaluation. This ongoing work with families is designed to continue as long as the family maintains their commitment to the achievement of their identified goals.

Program Specific Models

While all eleven Community Action Agencies use the HSI case management approach to more comprehensively serve their customers, agencies are also experiencing demographic and customer preference changes that demand realignment and refocusing of resources to meet specific changing needs. As the Thames Valley Council for Community Action (TVCCA) recently reported in their **Food and Nutrition Services Programs**, their clients are changing from depression era seniors – a generation grateful to have any kind of food on the table at all—to baby boomers, whose eating habits include healthier choices and more variety. One of their biggest challenges is trying to maintain the nutrition and quality level of food at a time when more and more boomers are coming of senior age, at the same time food and energy costs are constantly rising. TVCCA is working with their funders to change how meals are prepared, purchasing equipment that enables them to keep up with the trend for fresh-prepared meals, working with their vendors to get the best food at the best prices, and planning to do more fund-raising events to help with costs and educate the community.

Additionally, in their **Women, Infants and Children (WIC)** program, they are experiencing more 'working poor' coming through their doors – especially those who have recently lost their jobs or gone from a two-person working household to a one-person with the family struggling to make ends meet. Many of these people have never used social services before and agencies are developing new service models to accommodate their needs—by extending program hours into the evening and Saturdays. Working moms choosing to breast feed and return to work have increased support from a staff of Certified Lactation Counselors and a new Peer Counselor Pilot, which assists their transition back to work.

Another critical area for the CAA network is in **Employment and Training Services**. Agencies' Employment and Training staffs are consistently challenged by customers who require assistance in developing effective job search skills that can give them a competitive edge in today's ever-changing job market. Helping them remove barriers to a successful employment search is the number one goal for HSI case managers and customer service specialists. Incorporating the HSI model at all of the CTWorks "One Stops" has assisted and will continue to assist many in meeting basic needs and becoming better equipped to re-enter the workforce.

One of the most important things that the Bristol Community Organization (BCO) is doing is developing and implementing programs that will help young people (ages 16-21) toward training that will lead to a living wage job. With a new grant from Capital Workforce Partners, BCO and Tunxis Community College have formed a collaboration to create a cohort of forty youth who will attend classes at Tunxis in the Allied Health Track. Currently, Tunxis does not have the capacity

Appendix I Connecticut's Community Action Agencies

to offer social services, lessons in good study habits, transportation and or work experience to low income youth. Many youth who dropped out of high school come back to local Adult Education programs to earn a high school diploma. They are in low paying jobs or searching for work. Some are leaving foster care, some are homeless. With the new program, youth who are placed in remedial coursework at Tunxis will be in classrooms with an I-BEST teaching model. The model includes team teaching, contextual learning and individual social services and student counseling. An employee from the community action agency will work with an adjunct professor to ensure individualized attention and expedited time in any remedial classes. It is expected that after two years, youth will be on their way to a certificate program, an associate degree and, perhaps a BS in the Allied Health field.

Summary

As one can see from the examples above, Connecticut's Community Action Agency (CAA) Network is a living, breathing network of community leaders and dedicated staff who work daily to assist low income individuals and families meet the ever-increasing needs they face in the deepest economic downturn the state has experienced since the Great Depression. While we are recognized in our communities for our experience and expertise, we are also seen as the community innovators and as economic development engines. We have the flexibility to respond to local community needs with tri-partite boards composed of local elected officials, business leaders and representatives of the low-income community. This local representation allows us to do regional community needs assessments and respond directly as needs are identified. Also, our agencies employ over 3,000 employees statewide and serve as a funnel for our vendors, especially oil and utility vendors in the energy assistance and weatherization programs.

This is a brief summary of the CAA Network. We know that the challenges we will continue to face are all too real, yet they are accompanied by a great opportunity to serve our state's most vulnerable residents ever more effectively and efficiently. We will embrace this opportunity by adhering to the Results Oriented Management and Accountability (ROMA) system, promoting our online Automated Benefits Calculator (ABC) to help ensure that all families understand their eligibility for needed programs, strengthening our partnerships, and continuing to advocate on behalf of those whose voices are so often unheard.

In this effort, we are grateful to the policymakers and partners who realize that funding CAAs' comprehensive anti-poverty efforts is a worthwhile investment. CAAs' proven programs put people to work and keep people healthy, saving the State the social and fiscal costs incurred when families suffer complete financial crisis. Throughout the CT Poverty Report, readers saw customers who have utilized programs and services offered at one of our CAAs report first-hand on what our programs and the integrated services approach has meant to them.

Finally, while we will continue our daily work helping families move away from the brink, we also have our sights set on longer-term solutions to the underlying systemic inequalities leading so many people to their local CAAs. We pledge to continue working with policymakers—informing them not only of CAAs' positive results, but also contributing to discussions of fundamental change and job creation… so fewer people need our help in the first place.

We have persevered through turbulent times before, and now, like then, we will collaborate and innovate to continue empowering people and building communities and keeping hope alive.

Appendix II Methodology for Econometric Analysis of Poverty

In order to test for relationships between poverty and job-related occurrences for Connecticut's working age population, the Connecticut Center for Economic Analysis (CCEA) employed two standard analysis methods.

A. Discussion

First, a state-level time series analysis used a Vector Autoregression (VAR) approach to confirm a relationship between the number in poverty (as measured by the change in the number of SNAP participants) and the unemployment rate. Results indicate a significant positive relationship between the number of SNAP participants and the unemployment rate.

- The significance of lag_{t-2} of the U Rate (.156**) means that the U Rate from 2 months earlier explains current SNAP distributions.

Thus, a higher level of unemployment, or fewer jobs, translates into a higher level of poverty.

Second, an Ordinary-Least-Squares statistical test (via a cross-sectional first difference formula) was run over two time periods, 1990-2010 and 2000-2010. As this report covers the two most recent decades, this test reviewed the percentage of each town's Labor Force that was employed, in patterns similar to the growth in the number and percent living with less that very poor income. (referred to as change_emp in Table 2). Again, results indicate a significant (extremely significant) negative relationship between the change in the percentage of the Labor Force that is employed and the change in the percentage of the town's population classified as very poor. Thus, the decrease in the percentage of labor force employed, or fewer jobs, translates to a higher level of poverty.

Also this test of Census year data employed additional measures, for their alignment with poverty:

- The analysis employs 5 potential explanatory variables – the percentage of the population classified as Hispanic, the percentage of the population classified as black, the percentage of the population classified within a single female household, the percentage of the population without a high school degree and the percentage of the labor force that is employed.
- For each individual year, the final model (inclusion of specific variables) is determined by the largest adjusted R2 value. Thus, while each of the five variables is initially significant, that significance is not robust to the inclusion of other variables; so those are excluded. Basically, only the variables that remain significant when paired with all other variables in the model are included.
- High R2 values show that these models explain a large portion of the variation in poverty levels across the state.

B. Econometric Models

1. Vector Autoregression Analysis (VAR) had the following model:

A state-level analysis, based upon 84 monthly observations spanning from July 2005 through June 2012, was developed to study the relationship between two data series - the evolution of the number living in poverty (SNAP participants) and the changing level of the unemployment rate. To properly estimate using a VAR, both data series need to be stationary. Therefore, Dickey-Fuller Tests and Augmented Dickey Fuller Tests were run to test for the presence of unit roots. Both types of tests identify the presence of a unit root in both series. To correct for this result, a first-differenced version of both series was generated. Finally, the minimization of the information criteria indicated the optimal lag values would be equal to two. Thus, the following two VAR processes were estimated:

$$y_{1,t} = c_1 + \alpha_{1,1}y_{1,t-1} + \alpha_{1,2}y_{2,t-1} + \beta_{1,1}y_{1,t-2} + \beta_{1,2}y_{2,t-2} + e_{1,t}$$

$$y_{2,t} = c_2 + \alpha_{2,1}y_{1,t-1} + \alpha_{2,2}y_{2,t-1} + \beta_{2,1}y_{1,t-2} + \beta_{2,2}y_{2,t-2} + e_{2,t}$$

Appendix II Methodology for Econometric Analysis of Poverty

Where:

- $y_{1,t}$ represents the number of SNAP participants at time t
- $y_{2,t}$ represents the unemployment rate at time t

2. The OLS econometric test had the following model:

For individual census years of 1990, 2000, and 2010, a cross-sectional Ordinary Least Squares (OLS) analysis across all 169 towns within Connecticut was implemented to discover poverty levels within the state. The following model was estimated for each decennial year:

$$\%povi = \beta1 + \beta2\ \%hispi + \beta3\ \%blacki + \beta4\ \%sf\_hhi + \beta5\ \%no\_hsi + ui$$

Where:

%povi = percentage of "very poor" within town i
%hispi = percentage of Hispanic residents within town i
%blacki = percentage of black residents within town i
%sf_hhi = percentage of single female households with children within town i
%no_hsi = percentage of residents without at least a high school degree within town i
%LF_Empi = percentage of town i's labor force that is employed
ui = error term

Further, to account for changes in socio-economic makeup of the state between census years, the following difference model is estimated for 1990 v. 2010 and 2000 v. 2010:

$$\Delta\%pov_i = \beta_1 + \beta_2\ \Delta\%hisp_i + \beta_3\ \Delta\%black_i + \beta_4\ \Delta\%sf\_hh_i + \beta_5\ \Delta\%no\_hs_i + u_i$$

Where:

$\Delta\%pov_i$ = change in the percentage of "very poor" within town i
$\Delta\%hisp_i$ = change in the percentage of Hispanic residents within town i
$\Delta\%black_i$ = change in the percentage of black residents within town i
$\Delta\%sf\_hh_i$ = change in the percentage of single female households with children within town i
$\Delta\%no\_hs_i$ = change in the percentage of residents without at least a high school degree in town i
u_i = error term

Correlation among our independent variables prohibits the inclusion of some specific variables being included in each decennial year. Thus, the final model for each individual census year is determined by achieving the highest adjusted R2 value. The following final models are estimated for each year:

1990: $\%Pov_i = \beta_0 + \beta_1*\%Hisp_i + \beta_2*\%Single\_Female\_HH_i + \beta_3*\%No\_HS_i + u_i$
2000: $\%Pov_i = \beta_0 + \beta_1*\%Hisp_i + \beta_2*\%Black_i + \beta_3*\%Single\_Female\_HH_i + \beta_4*\%No\_HS_i + u_i$
2010: $\%Pov_i = \beta_0 + \beta_1*\%Black_i + \beta_2*\%Single\_Female\_HH_i + \beta_3*\%No\_HS_i + u_i$

Racial composition of the state is found to have a positive significant relationship with poverty in each of the individual census years.[1] Specifically, in 2010, a 1% increase in the population of black residents in a town corresponds to a 0.09% increase in number of residents living in poverty.

[1]The year 2000 is the only year where there is not a significant correlation between the percentage of black residents and the percentage of Hispanic residents - hence, the inclusion of both explanatory variables for that year. For the other two years (1990 and 2010), the exclusion of one of those variables is necessary to obtain robust results with the highest adjusted R^2 values.

Appendix II Methodology for Econometric Analysis of Poverty

C. Econometric "Raw" Outputs:

VAR between SNAP & URate:

Vector autoregression

Sample: 3 - 84		No. of obs	= 82
Log likelihood = -630.2067		AIC	= 15.51724
FPE = 18798.8		HQIC	= 15.58794
Det(Sigma_ml) = 16238.52		SBIC	= 15.69334

Equation	Parms	RMSE	R-sq	chi2	P>chi2
DFsnap	3	1910.72	0.5778	112.203	0.0000
DFurate	3	.069378	0.7313	223.1704	0.0000

	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
DFsnap						
DFsnap L1.	.7243696	.0732444	9.89	0.000	.5808132	.867926
DFurate L1.	2913.299	1648.069	1.77	0.077	-316.8566	6143.454
_cons	584.7579	269.1067	2.17	0.030	57.31846	1112.197
DFurate						
DFsnap L1.	-3.28e-06	2.66e-06	-1.23	0.217	-8.49e-06	1.93e-06
DFurate L1.	.8879479	.0598409	14.84	0.000	.7706618	1.005234
_cons	.0153932	.0097712	1.58	0.115	-.003758	.0345444

OLS Difference Model 2010-2000:

Source	SS	df	MS
Model	.009180153	4	.002295038
Residual	.055155617	164	.000336315
Total	.06433577	168	.000382951

Number of obs	=		169
F(4, 164)	=		6.82
Prob > F	=		0.0000
R-squared	=		0.1427
Adj R-squared	=		0.1218
Root MSE	=		.01834

del_per_pov	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
del_per_hisp	.0066037	.0329364	0.20	0.841	-.0584303	.0716377
del_per_si~s	.1597203	.1912111	0.84	0.405	-.2178326	.5372733
del_per_no~s	-.0044039	.0114059	-0.39	0.700	-.0269253	.0181175
change_emp~t	-.5415936	.1046866	-5.17	0.000	-.7483008	-.3348863
_cons	-.0261955	.0068512	-3.82	0.000	-.0397235	-.0126675

Appendix II Methodology for Econometric Analysis of Poverty

D. Econometric Results presentation

Table 1. Census year Regression Results			
	1990	2000	2010
% Hispanic	.158* (.07)	.299*** (.04)	
% Black		.06* (.03)	.062* (.03)
% Single Female HH	.765*** (.03)	.298*** (.09)	.523*** (.11)
% No HS Degree	.095*** (.14)	.148*** (.04)	.806*** (.09)
# of Observations	169	169	169
R^2	.6854	.7997	.7099

Regressand is Percentage of Population living below .99FPG
Level of Significance: * denotes >95%, ** denotes >99%, *** denotes >99.99%
Blank areas indicate a correlation with the Regressand, that was removed from that decennial's OLS.
Numbers in parenthesis represent "Robust standard errors".
Intercepts are not reported.

Table 2. First-Difference Regression Results		
	2010-2000	2010-1990
Change in % Hispanic		.142*** (.04)
Change in % Black		.048* (.03)
Change in % No HS Degree		-.116*** (.03)
Change in % of LF Employed	-.535*** (.10)	-.599*** (.16)
# of Observations	169	169
R^2	.1376	.3173

Regressand is Change in the Percentage of Population living below .99FPG
Level of Significance: * denotes >95%, ** denotes >99%, *** denotes >99.99%
Blank areas indicate a correlation with the Regressand, that was removed from that decennial's OLS.
Numbers in parenthesis represent "Robust standard errors".
Intercepts are not reported.

Table 3. Correlations between the percentage of population living in poverty.			
	1990	2000	2010
% Hispanic	.7190	.8477	.6328
% Black	.5716	.6663	.5155
% Single Female HH	.8121	.7945	.7487
% No HS Degree	.6774	.7873	.8022
% LF employed	-.5530	-.7662	-.7295

Table 4. Vector Autoregression Results		
	SNAP	U Rate
• Lag_{t-1}	.472*** (.10)	.257* (.10)
• Lag_{t-2}	-.064 (.06)	.156** (.06)

Endnotes

[1] Flaherty, Patrick J. (2010). "Last but not Dead", The Connecticut Economic Digest, vol. 15, no. 2, p. 1.

[2] The Research Team calculated the number and percent change for people whose "ratio of income to poverty" identified them as (1) Very Poor, below .99 Federal Poverty Level (FPL), or (2) Poor, with incomes between 1.0 and 1.99 FPL, from Census Bureau reports released in 2010, 2000 and 1990. The Census reports on poverty by age groupings were also consulted for their additional income levels above the basic "ratio of income to poverty" distribution. The following Census data sets are the basis for the number and percent Very Poor and Poor residents described in this report: (a) 2010 American Community Survey 5-year Estimates, Table C17002, Ratio of Income to Poverty, and Table B17024, Age By Ratio Of Income To Poverty Level In The Past 12 Months; (b) 2000 Census, SF3, Table P088, Ration of Income to Poverty and Table PCT050: Age by Ratio of Income to Poverty Level; and (c) 1990 Census, STF3, Table P121, Ratio of Income to Poverty and Table 117, Poverty Status by Age.

[3] For more on the two measures of poverty see: (a) U.S. Health and Human Services - http://aspe.hhs.gov/poverty/; and (b) the U.S. Department of Commerce's Census Bureau: http://www.census.gov/hhes/www/poverty/about/overview/measure.html

[4] The Basic Economic Security Tables for Connecticut, 2012, written by Wider Opportunities for Women http://ctpcsw.files.wordpress.cm/2012/04/basic-economic-security-tables-index-for-connecticut-2012-2.pdf

[5] 1990 numbers for the "Poor" category were extrapolated from Census 1990, STF3, Table P121, Ratio Of Income In 1989 To Poverty Level. The original poverty by ages data is reported in 1990, STF3, Table P117, Poverty Status In 1989 By Age.

[6] The Census Bureau prepares its reports on Race and Ethnicity in separate tables, due to the overlapping nature of ethnicity across single or multiple races. For our purposes and adopting a practice of the Connecticut Department of Public Health Registration Reports' Table 3 (see more in Endnote 9), we studied the following five categories but reported only on the first three, due to very low counts for the last two groups: white alone, black alone, Latino or Hispanic together, Asian alone, and other races who are not Latino. Given the complexity of the data sets, our team reported only the 2010 profile of the three principal race and ethnicity data sets. (a) The 2010 American Community Survey 5-year estimates data on race or ethnicity in poverty are from the series: Table B17001: Poverty Status in the past 12 months by sex by age: Table B17001B, Black or African American alone, Table B17001D, Asian alone, Table B17001H, White alone, not Hispanic or Latino, and Table B17001I, Hispanic or Latino. Although we studied poverty in the previous decennial reports, we simplified by focusing on the current density in our Tier 1 towns. (b) 2000 Census SF3, in the following sub-series for Table: PCT075: Poverty Status in 1999 dollars by sex by age: PCT075B: Black or African American alone, PCT075D: Asian alone, PCT075H: Hispanic or Latino, and PCT075I: white alone, not Hispanic; and (c) Census data organized by the information delivery provider, Social Explorer, in their Tables T99 Poverty Status in 1989 by Race, for the population for whom poverty status is determined, and Table T105: Poverty Status in 1989 (Persons of Hispanic origin), for whom poverty status is determined.

[7] 2010 American Community Survey, 5-year estimates, Table 17010, Poverty Status in the past 12 months of Families by Family type by Presence of Related Children under 18 years of age of related Children; for twenty year changes, see 1990 Census Summary Tape File 3, Table P123: Poverty Status in 1989 by Family Type and Presence and age of [related] Children.

Endnotes

[8] Sullentrop, Katy (2010). "The Costs and Consequences of Teen Childbearing", National Center for Health Statistics, p. 5.

[9] Data for births by race and ethnicity are available from Connecticut's Department of Public Health, from their annual Registration Reports: http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598

[10] From the following data set, we reported on ages 25-64, the working age population: 2010 American Community Survey, 5-year Estimates, B15001, Sex by Age by Educational attainment for the Population 18 years and over.

[11] Census Business Dynamics Statistics, using "Economy wide" for US and State for Connecticut: http://www.census.gov/ces/dataproducts/bds/data_firm.html

[12] The Economic Impact of Connecticut's Information Technology Industry (4/7/03): http://ccea.uconn.edu/studies/Connecticut%20IT%20Impact.pdf

[13] U.S. Bureau of Labor Statistics (BLS) Occupational Employment Statistics, 1999 – 2011, organizing "major" occupation categories roughly into NAICS industry categories, while developing above and below $40,000 employment numbers from BLS quartiles.

[14] Holzer, Harry J. and Marek Hlavac (2011). A Very Uneven Road: US Labor Markets in the Past 30 Years. The Urban Institute: http://www.urban.org/UploadedPDF/1001606-A-Very-Uneven-Road-US-Labor-Markets-in-the-Past-30-Years.pdf

[15] Connecticut Employment and Training Commission, Annual Report (2009). A Talent-Based Strategy for Economic Competitiveness, The Commission. http://charteroakgroup.com/rbadownloads/09Report.pdf

[16] A. T. Kearney (2005) Sustainable Prosperity: an agenda for New England, p. 9

[17] Coelen, Stephen et al., (2008). Next Steps: Preparing a Quality Workforce, Department of Economics and the Connecticut Center for Economic Analysis, University of Connecticut, See: http://ccea.uconn.edu/studies/08apr_NextSteps.pdf

The Connecticut Poverty Report was funded by the Connecticut Department of Social Services with Community Services Block Grant funds. The project was directed by the Connecticut Association for Community Action (CAFCA). The firm of BWB Solutions developed the data graphics and collaborated with CCEA to assemble the report narrative and data explanation, with assistance from CAFCA in the editing process.

Meeting the Challenge

The Dynamics of Poverty in Connecticut

CONNECTICUT ASSOCIATION FOR COMMUNITY ACTION

CONNECTICUT CENTER FOR ECONOMIC ANALYSIS

BWB SOLUTIONS

January 2013

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 24: COMMUNITY HEALTH NEEDS ASSESSMENT

BRISTOL HOSPITAL

everyday extraordinary

Community Health Needs Assessment

Final Summary Report

September 2013

HOLLERAN

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Bristol Hospital led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Bristol, Connecticut beginning in 2013. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled Bristol Hospital to take an in-depth look at its greater community. The findings from the assessment were utilized by Bristol Hospital to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. Bristol Hospital is committed to the people it serves and the communities they live in. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

Research Components

- Secondary Statistical Data Profile of Bristol, Connecticut
- Bristol Hospital Utilization Data for Behavioral Healthcare
- Bristol Community Prioritization Session

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, Bristol Hospital plans to focus community health improvement efforts on the following health priorities:

- Mental Health & Substance/Alcohol Abuse
- Access to Care
- Senior Support
- Overweight/Obesity

Documentation

A final report of the CHNA was made public on September 30, 2013 and can be found on Bristol Hospital's website. The Bristol Hospital Board of Directors adopted the Summary Report and an Implementation Plan for community health improvement activities on September 12, 2013.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Background

Bristol Hospital is a not-for-profit organization serving the residents of greater Bristol, Connecticut since 1921. It is a 134-bed facility with a medical staff of more than 200 physicians, representing over 40 specialties. Bristol Hospital offers a full range of services including an emergency center, a surgical center, a single-room-model maternity unit, an award-winning ICU, a skilled nursing facility, a spine and pain center, a gastroenterology institute, behavioral health services, and an advanced diagnostic imaging department. The mission of Bristol Hospital is to "Enhance the health and well-being of our community. We will provide safe, quality care and services to our patients through our continuum of services and health promotions. We will collaborate with health professional and other organizations as advocates for our community. We will provide the opportunity for growth to our medical staff and employees in an environment where each individual is respected and valued." The vision of Bristol Hospital is to "aspire to be recognized as the best community healthcare provider in Connecticut." To achieve this vision, Bristol Hospital utilizes a core set of values which:

- Creates a culture of safety, quality and services that is embraced as an individual and team responsibility
- Ensures a user-friendly continuum modeled on providing patient-centered care and services
- Continually assesses and promotes new services and technology
- Serves as the responsible steward and advocate for the health of our community

Bristol Hospital defined their primary service area as the city of Bristol, located in Hartford County, Connecticut. Bristol is a suburban city with a population of 60,477. The population is slightly older and comprised primarily of English-speaking, White/Caucasian residents. The conclusions drawn from the various research components are based on findings representing all of Bristol.

Methodology

The CHNA was comprised of quantitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

Quantitative Data:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Bristol, Connecticut was compiled.
- Hospital Utilization Data for patients presenting to Bristol Hospital with behavioral health issues was collected and analyzed.

Research Partner

Bristol Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data

- Facilitated a Prioritization and Planning Session
- Prepared all reports

Community engagement and feedback were an integral part of the CHNA process. Bristol Hospital sought community input through the inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Following the completion of the CHNA research, Bristol Hospital prioritized community health issues and developed an implementation plan to address prioritized community needs.

Research Limitations

It should be noted that the availability and time lag of secondary data may present some research limitations. Bristol Hospital sought to mitigate limitations by including representatives of diverse and underserved populations through the prioritization and planning session.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in Bristol, Connecticut.

Secondary data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Healthy People 2020, and the Connecticut Department of Public Health. Data sources are listed throughout the report and a full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness
- Communicable Disease Statistics
- Mental Health Statistics
- Cancer Statistics
- Environmental Health Statistics
- Health Care Access Statistics
- Crime Statistics

A summary section is included at the end of the report to highlight strengths, opportunities, and differences for the town of Bristol. State and national comparative data is generally what determines if an indicator is a strength or opportunity within the community. However, it is still important for readers to interpret the data and make appropriate conclusions independent of the state and national comparisons.

Secondary Data Profile Key Findings

Population Statistics

Table 1. Overall Population (2010)

	U.S.		Connecticut		Bristol	
Population	308,745,538		3,574,097		60,477	
Population Change (00' - 10')	9.7%		4.9%		0.7%	
Gender	n	%	n	%	n	%
Male	151,781,326	49.2	1,739,614	48.7	29,143	48.2
Female	156,964,212	50.8	1,834,483	51.3	31,334	51.8

Source: U.S. Census Bureau, 2010

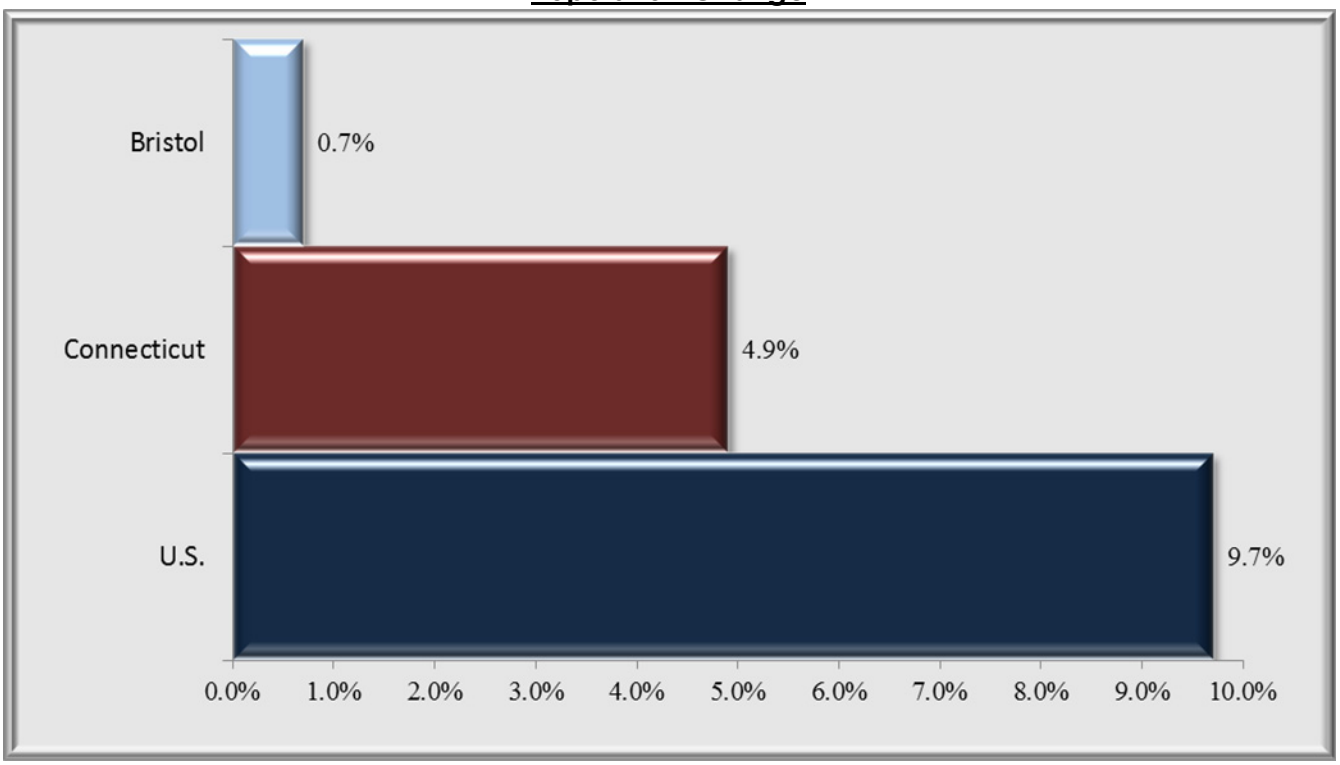


Figure 1. Percent population change, Bristol compared to Connecticut and the U.S. (2000 - 2010).

Table 2. Population by Age (2010)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Under 5	20,201,362	6.5	202,106	5.7	3,416	5.6
5 – 9	20,348,657	6.6	222,571	6.2	3,482	5.8
10 – 14	20,677,194	6.7	240,265	6.7	3,747	6.2
15 – 19	22,040,343	7.1	250,834	7.0	3,550	5.9
20 – 24	21,585,999	7.0	227,898	6.4	3,558	5.9
25 – 29	21,101,849	6.8	214,145	6.0	4,309	7.1
30 – 34	19,962,099	6.5	206,232	5.8	3,885	6.4
35 – 39	20,179,642	6.5	222,401	6.2	3,962	6.6
40 – 44	20,890,964	6.8	262,037	7.3	4,437	7.3
45 – 49	22,708,591	7.4	291,272	8.1	4,785	7.9
50 – 54	22,298,125	7.2	284,325	8.0	4,920	8.1
55 – 59	19,664,805	6.4	240,157	6.7	3,986	6.6
60 – 64	16,817,924	5.4	203,295	5.7	3,414	5.6
65 – 69	12,435,263	4.0	149,281	4.2	2,483	4.1
70 – 74	9,278,166	3.0	105,663	3.0	1,810	3.0
75 – 79	7,317,795	2.4	89,252	2.5	1,661	2.7
80 – 84	5,743,327	1.9	77,465	2.2	1,438	2.4
85 and over	5,493,433	1.8	84,898	2.4	1,634	2.7
Median Age	**37.2**		**40.0**		**40.3**	
% 18 years and over	**76.0%**		**77.1%**		**78.6%**	
% 65 years and over	**13.0%**		**14.2%**		**14.9%**	

Source: U.S. Census Bureau, 2010

Table 3. Racial Breakdown (2010)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
White	223,553,265	72.4	2,772,410	77.6	53,065	87.7
Black/African American	38,929,319	12.6	362,296	10.1	2,323	3.8
American Indian/ Alaska Native	2,932,248	0.9	11,256	0.3	117	0.2
Asian	14,674,252	4.8	135,565	3.8	1,173	1.9
Native Hawaiian or Other Pacific Islander	540,013	0.2	1,428	0.0	10	0.0
Two or more races	9,009,073	2.9	92,676	2.6	1,537	2.5
Hispanic or Latino[a]	50,477,594	16.3	479,087	13.4	5,829	9.6

Source: U.S. Census Bureau, 2010

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African-American Hispanic

Table 4. Language Spoken at Home, 5 Years Old and Older (2009 - 2011)

	U.S.	Connecticut	Bristol
Population 5 years old and over	289,077,942	3,372,311	57,281
English only	79.4%	78.8%	83.1%
Language other than English	20.6%	21.2%	16.9%
Speak English less than "very well"	8.7%	8.4%	6.4%
Spanish	12.8%	10.7%	6.9%
Speak English less than "very well"	5.7%	4.6%	2.8%
Other Indo-European languages	3.7%	7.6%	8.3%
Speak English less than "very well"	1.2%	2.6%	3.0%
Asian and Pacific Islander languages	3.2%	2.2%	1.3%
Speak English less than "very well"	1.6%	1.0%	0.6%
Other Languages	0.9%	0.6%	0.4%
Speak English less than "very well"	0.3%	0.2%	0.1%

Source: U.S. Census Bureau, n.d.

Household Statistics

Table 5. Households by Occupancy (2010)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Total housing units	131,704,730	100.0	1,487,891	100.0	27,011	100.0
Occupied units	116,716,292	88.6	1,371,087	92.1	25,320	93.7
Owner-occupied	75,986,074	65.1	925,286	67.5	16,387	64.7
Renter-occupied	40,730,218	34.9	445,801	32.5	8,933	35.3
Vacant units	14,988,438	11.4	116,804	7.9	1,691	6.3

Source: U.S. Census Bureau, 2010

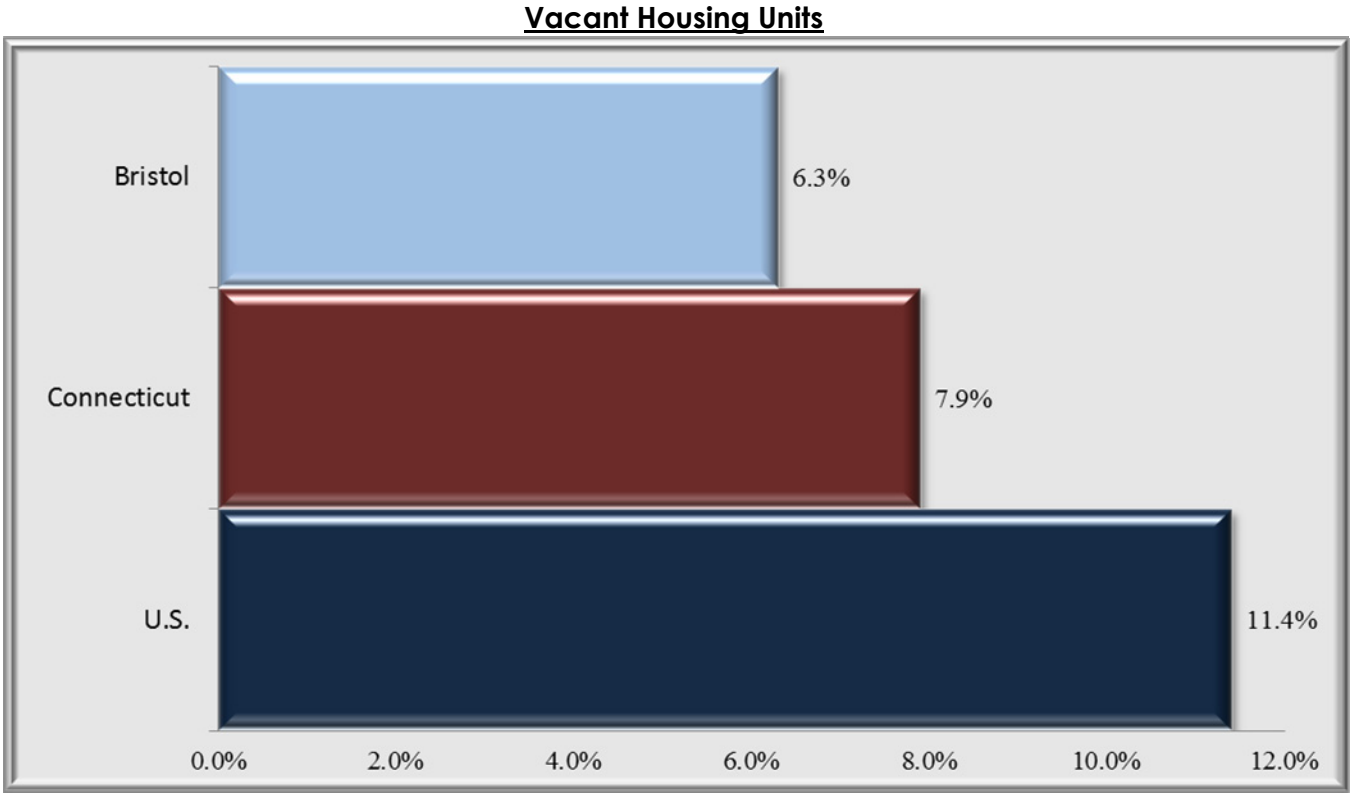


Figure 2. Percentage of vacant housing units, Bristol compared to Connecticut and the U.S. (2010).

Table 6. Households by Value for Owner-Occupied Units (2009 - 2011)

	U.S.	Connecticut	Bristol

	n	%	n	%	n	%
Less than $50,000	6,477,312	8.6	17,014	1.8	280	1.7
$50,000 to $99,999	11,489,800	15.3	21,317	2.3	365	2.2
$100,000 to $149,999	11,997,911	16.0	58,439	6.3	2,040	12.4
$150,000 to $199,999	11,417,607	15.2	129,744	14.0	4,409	26.8
$200,000 to $299,999	13,930,323	18.5	274,604	29.6	7,074	43.0
$300,000 to $499,999	11,943,665	15.9	262,712	28.3	1,978	12.0
$500,000 to $999,999	6,295,161	8.4	120,493	13.0	223	1.4
$1,000,000 or more	1,572,273	2.1	43,470	4.7	72	0.4
Median value	**$179,500**		**$285,800**		**$214,500**	

Source: U.S. Census Bureau, n.d.

Median Value for Owner-Occupied Units

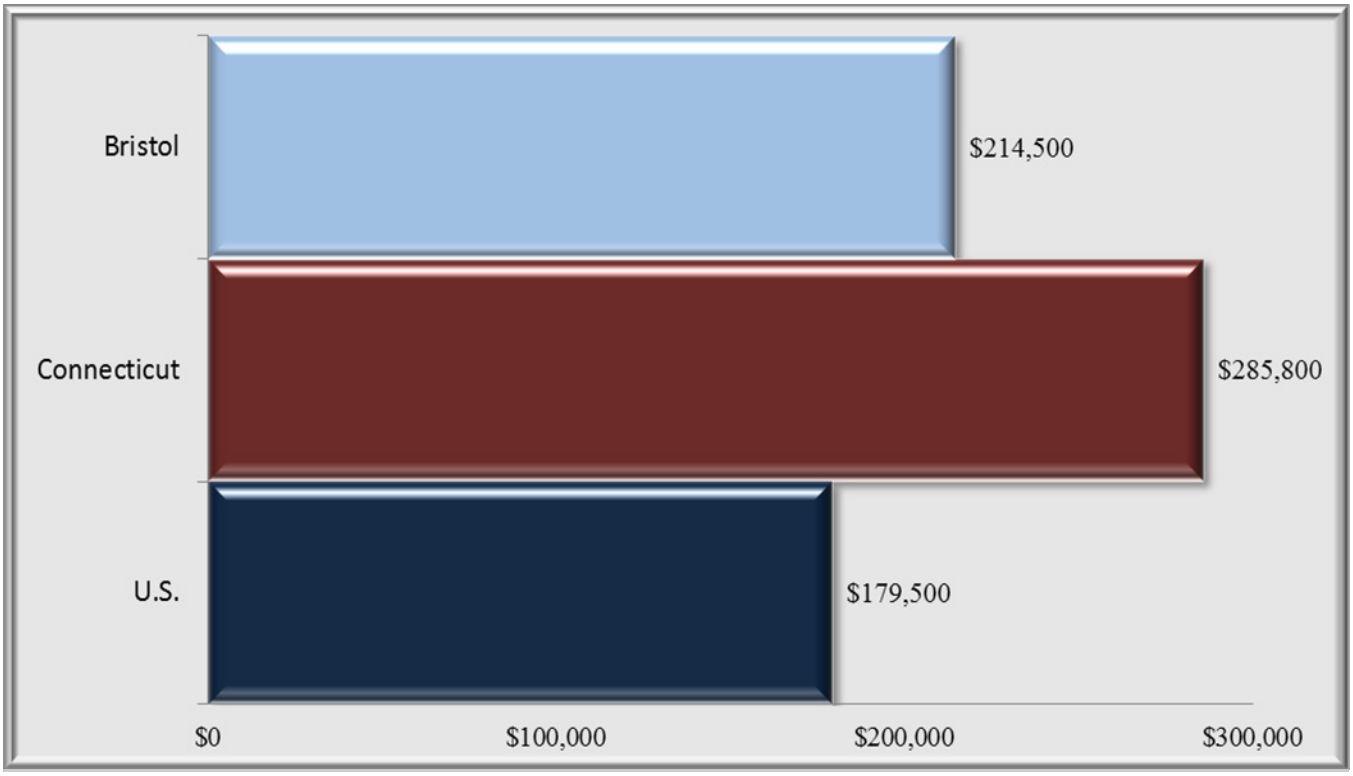


Figure 3. Median value for owner-occupied units, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Table 7. Households by Selected Characteristics (2009 - 2011)

Selected Characteristics	U.S.	Connecticut	Bristol

Lacking complete plumbing facilities	0.6%	0.4%	0.6%
Lacking complete kitchen facilities	1.0%	0.7%	0.7%
No telephone service available[a]	2.5%	1.4%	1.3%

Source: U.S. Census Bureau, n.d.
[a] Telephone service includes both landline and cell phone service

Table 8. Households by Type (2010)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Total households	116,716,292	100.0	1,371,087	100.0	25,320	100.0
Average household size	2.58	--	2.52	--	2.35	--
Average family size	3.14	--	3.08	--	2.95	--
Family households	77,538,296	66.4	908,661	66.3	15,833	62.5
Male householder, no wife	5,777,570	5.0	59,675	4.4	1,214	4.8
With own children under 18 yrs.	2,789,424	2.4	26,178	1.9	544	2.1
Female householder, no husband	15,250,349	13.1	176,973	12.9	3,230	12.8
With own children under 18 yrs.	8,365,912	7.2	97,651	7.1	1,803	7.1
Husband-wife families	56,510,377	48.4	672,013	49.0	11,389	45.0
Nonfamily households	39,177,996	33.6	462,426	33.7	9,487	37.5
Householder living alone	31,204,909	26.7	373,648	27.3	7,691	30.4

Source: U.S. Census Bureau, 2010

Table 9. Marital Status, 15 Years and Over (2009 - 2011)

	U.S.	Connecticut	Bristol
Never married	32.0%	32.4%	30.2%
Now married, except separated	49.0%	49.3%	48.4%
Separated	2.2%	1.5%	0.7%
Widowed	6.0%	6.2%	7.4%
Divorced	10.8%	10.6%	13.4%

Source: U.S. Census Bureau, n.d.

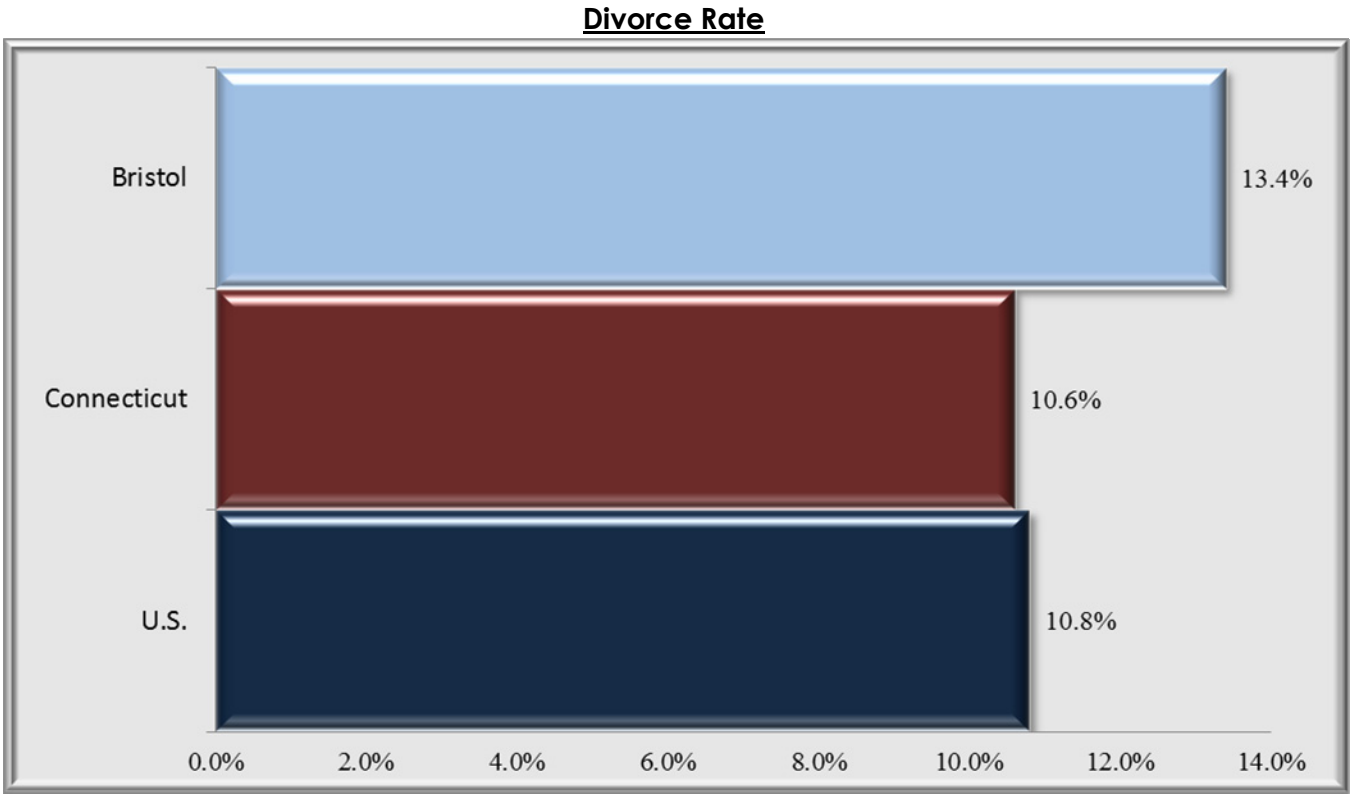


Figure 4. Divorce rate, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Income Statistics

Table 10. Household and Family Income in 2009 - 2011 Inflation-Adjusted Dollars

Household Income	U.S.		Connecticut		Bristol	
Total households	114,931,864		1,359,404		24,978	
	n	%	n	%	n	%
Less than $10,000	8,529,677	7.4	77,277	5.7	1,584	6.3
$10,000 to $14,999	6,472,374	5.6	56,969	4.2	975	3.9
$15,000 to $24,999	12,655,735	11.0	114,773	8.4	2,595	10.4
$25,000 to $34,999	12,136,499	10.6	108,338	8.0	2,445	9.8
$35,000 to $49,999	15,964,063	13.9	156,771	11.5	3,468	13.9
$50,000 to $74,999	20,987,130	18.3	228,341	16.8	4,975	19.9
$75,000 to $99,999	13,829,482	12.0	180,573	13.3	3,787	15.2
$100,000 to $149,999	14,188,747	12.3	222,896	16.4	3,281	13.1
$150,000 to $199,999	5,214,111	4.5	99,977	7.4	1,174	4.7
$200,000 or more	4,954,046	4.3	113,489	8.3	694	2.8
Median income	**$51,484**		**$67,427**		**$56,155**	
Mean income	**$70,909**		**$94,088**		**$68,784**	
Family Income	**U.S.**		**Connecticut**		**Bristol**	
Families	76,427,605		903,946		15,530	
Median income	**$62,735**		**$84,558**		**$70,615**	
Mean income	**$82,489**		**$112,444**		**$81,458**	
Worker Earnings	**U.S.**		**Connecticut**		**Bristol**	
Median earnings	**$29,819**		**$36,911**		**$36,411**	
Median earnings for male full-time, year-round	$47,208		$61,556		$51,514	
Median earnings for female full-time, year-round	$37,199		$46,677		$44,101	

Source: U.S. Census Bureau, n.d.

Table 11. Social Assistance Enrollment (2009 - 2011)

	U.S.	Connecticut	Bristol
With supplemental security income	4.7%	3.6%	2.6%
Mean supplemental security income	$8,811	$8,982	$7,970
With cash public assistance	2.8%	3.1%	4.9%
Mean cash public assistance income	$3,860	$4,496	$3,126
With Food Stamps/SNAP benefits in the past 12 months	11.7%	9.8%	12.3%

Source: U.S. Census Bureau, n.d.

Median Household Income

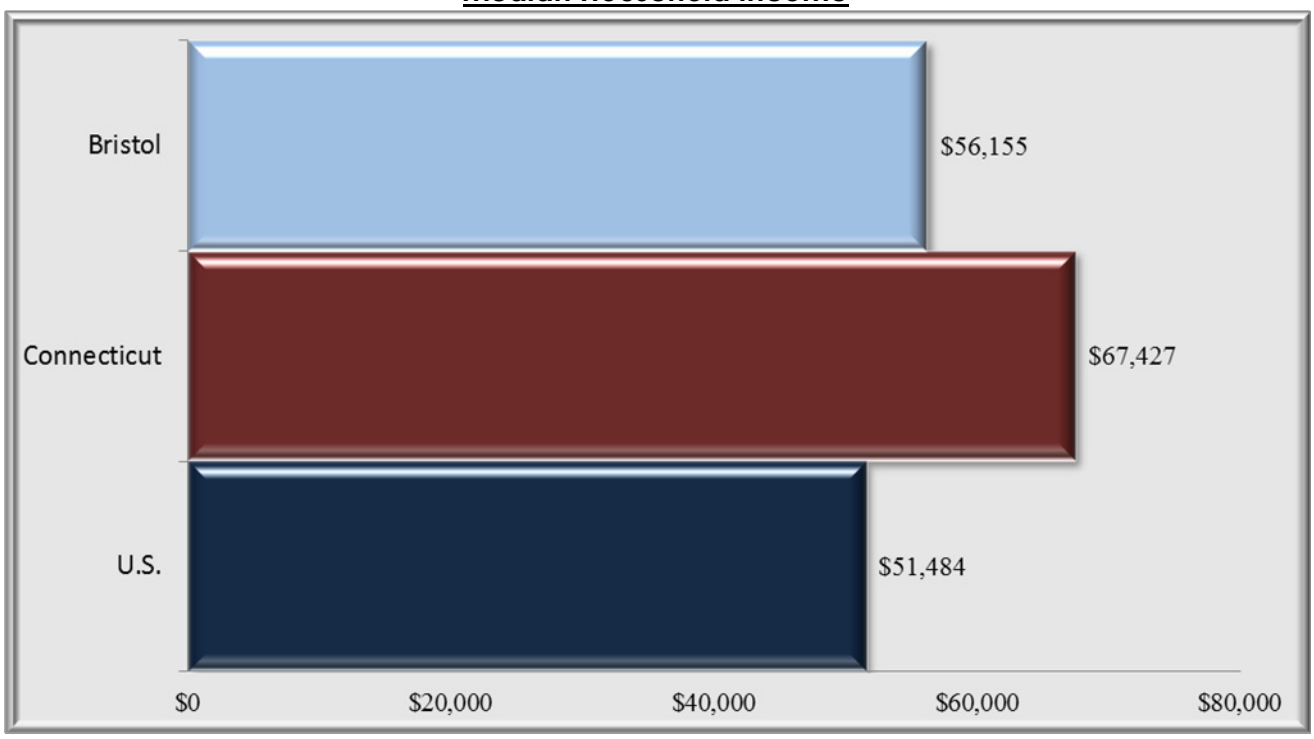


Figure 5. Median household income, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Median Family Income

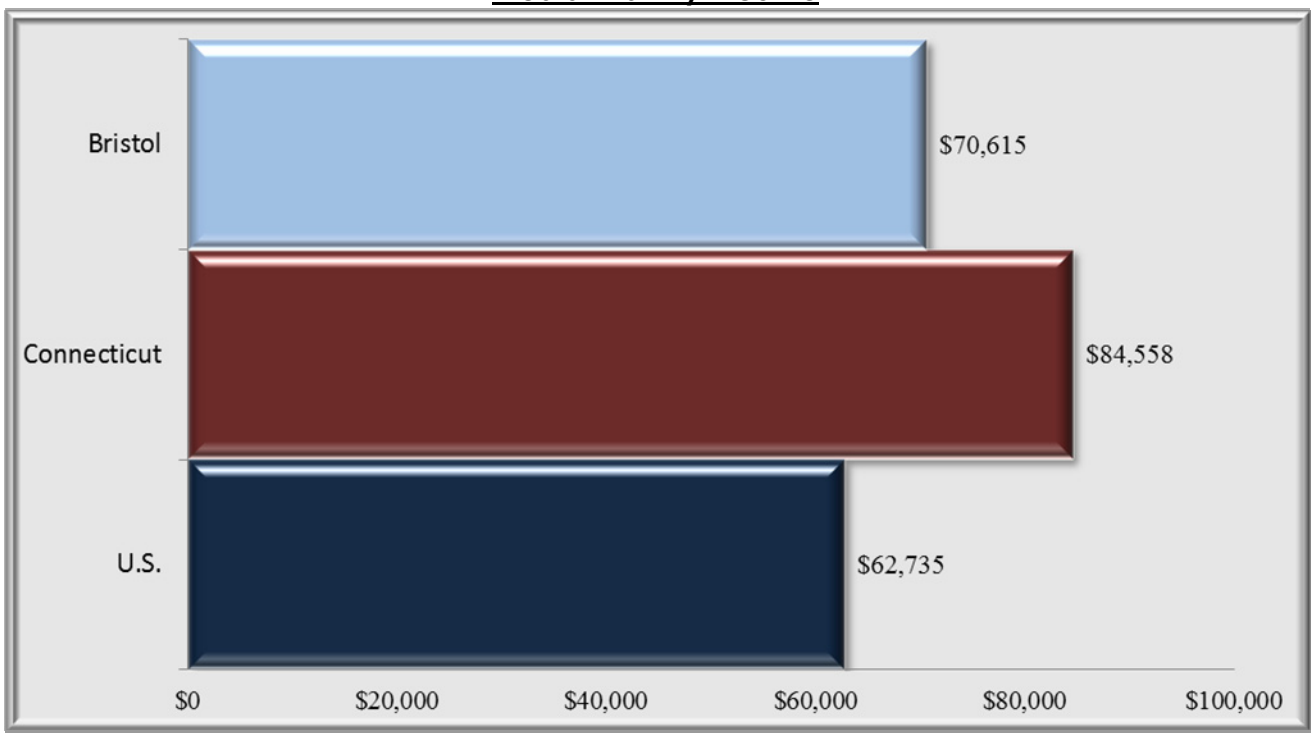


Figure 6. Median family income, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Table 12. Poverty Status of Families and People in the Past 12 Months (2009 - 2011)

	U.S.	Connecticut	Bristol
Families	11.1%	7.2%	9.2%
With related children under 18 years	17.6%	11.6%	13.4%
With related children under 5 years	18.8%	13.8%	14.5%
Married couple families	5.5%	2.6%	5.4%
With related children under 18 years	8.2%	3.6%	6.3%
With related children under 5 years	7.3%	4.4%	8.0%
Families with female householder, no husband present	30.3%	23.8%	23.1%
With related children under 18 years	39.5%	31.3%	30.7%
With related children under 5 years	47.0%	39.8%	45.7%
All people	15.2%	10.1%	10.3%
Under 18 years	21.4%	13.3%	12.7%
18 years and over	13.2%	9.1%	9.7%
65 years and over	9.3%	6.5%	7.8%
Unrelated individuals 15 years and over	26.2%	21.0%	14.9%

Source: U.S. Census Bureau, n.d.

Table 13. 2011 Health and Human Services Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$11,490	$14,350	$13,230
2	$15,510	$19,380	$17,850
3	$19,530	$24,410	$22,470
4	$23,550	$29,440	$27,090
5	$27,570	$34,470	$31,710
6	$31,590	$39,500	$36,330
7	$35,610	$44,530	$40,950
8	$39,630	$49,560	$45,570
For each additional person, add:	$4,020	$5,030	$4,620

Source: U.S. Department of Health and Human Services, 2013

Table 14. Students Eligible to Receive a Free or Reduced Lunch (2010 - 2011)

	Connecticut	Bristol School District
2010 - 2011	34.4%	40.0%

Source: Connecticut Department of Education, n.d.

Employment Statistics

Table 15. Employment Status (2009 - 2011)

	U.S.		Connecticut		Bristol	
Population 16 years and over	243,829,392		2,859,805		48,817	
	n	%	n	%	n	%
In labor force	157,326,655	64.5	1,951,971	68.3	34,140	69.9
Civilian labor force	156,201,959	64.1	1,943,192	67.9	34,016	69.7
Employed	140,145,661	57.5	1,746,793	61.1	30,413	62.3
Unemployed	16,056,298	6.6	196,399	6.9	3,603	7.4
Armed Forces	1,124,696	0.5	8,779	0.3	124	0.3
Not in labor force	86,502,737	35.5	907,834	31.7	14,677	30.1
Unemployed civilian labor force	**10.3%**		**10.1%**		**10.6%**	

Source: U.S. Census Bureau, n.d.

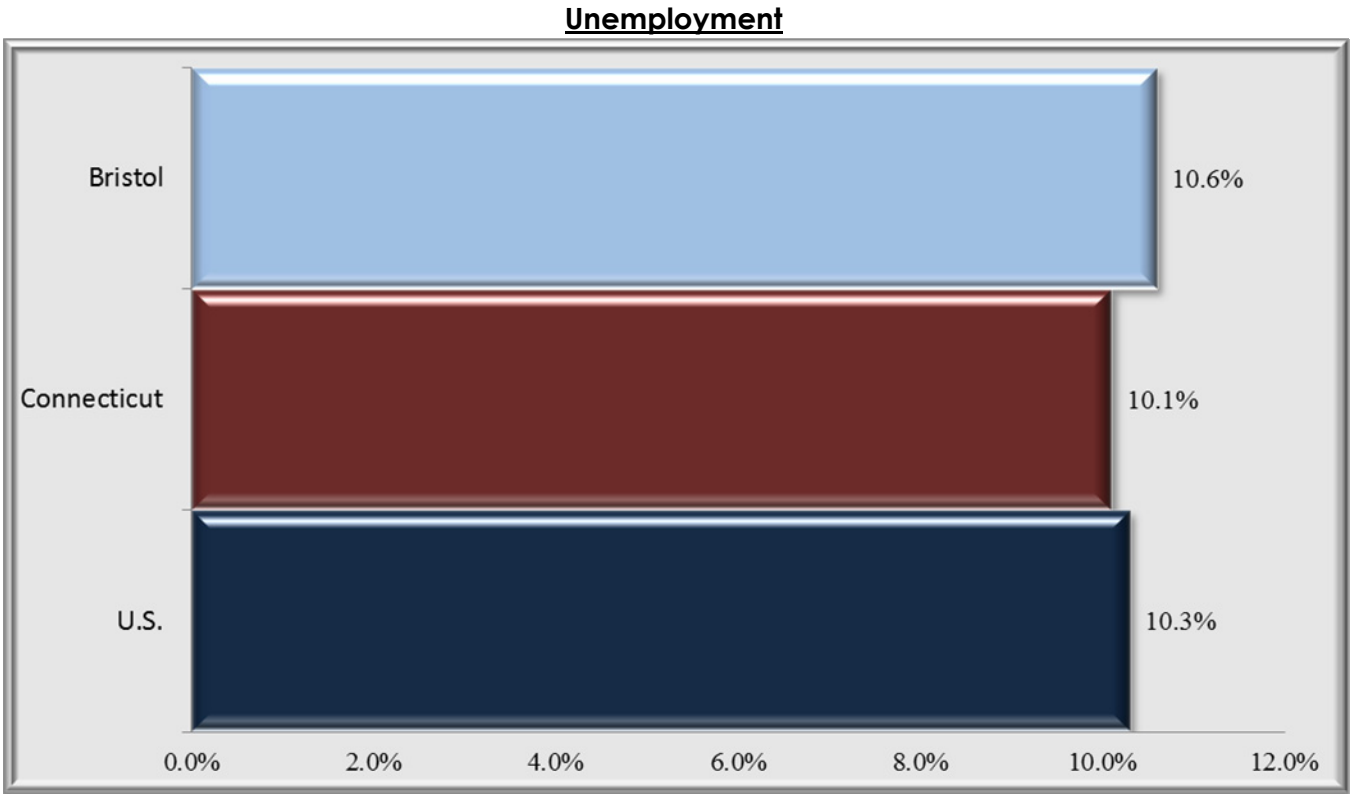


Figure 7. Unemployed civilian labor force, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Table 16. Commuting To Work Status, Workers 16 Years and Over (2009 - 2011)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Car, truck, or van -- drove alone	105,421,876	76.4	1,352,476	78.8	25,528	85.7
Car, truck, or van -- carpooled	13,573,630	9.8	144,197	8.4	2,549	8.6
Public transportation (excluding taxicab)	6,864,593	5.0	78,733	4.6	189	0.6
Walked	3,887,229	2.8	51,070	3.0	319	1.1
Other means	2,367,729	1.7	20,107	1.2	369	1.2
Worked at home	5,961,871	4.3	69,934	4.1	832	2.8
Mean travel time to work (minutes)	**25.3**		**24.7**		**23.0**	

Source: U.S. Census Bureau, n.d.

Table 17. Estimated Major Occupational Groups, Civilian Employed Population 16 Years and Over (2009 - 2011)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Management, business, science, and arts	50,372,150	35.9	711,202	40.7	10,055	33.1
Service	25,241,477	18.0	306,464	17.5	5,412	17.8
Sales and office	34,855,682	24.9	426,386	24.4	8,195	26.9
Natural resources, construction, and maintenance	12,899,471	9.2	132,964	7.6	2,455	8.1
Production, transportation, and material moving	16,776,881	12.0	169,777	9.7	4,296	14.1

Source: U.S. Census Bureau, n.d.

Table 18. Class of Worker, Civilian Employed Population 16 Years and Over (2009 - 2011)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Private wage and salary workers	109,938,596	78.4	1,391,251	79.6	24,598	80.9
Government workers	21,159,555	15.1	237,270	13.6	4,362	14.3
Self-employed workers in own not incorporated business	8,849,434	6.3	116,239	6.7	1,430	4.7
Unpaid family workers	198,076	0.1	2,033	0.1	23	0.1

Source: U.S. Census Bureau, n.d.

Table 19. Estimated Major Industrial Group Percentages, Civilian Employed Population 16 Years and Over (2009 - 2011)

	U.S.		Connecticut		Bristol	
	n	%	n	%	n	%
Agriculture, forestry, fishing and hunting, and mining	2,655,272	1.9	6,539	0.4	78	0.3
Construction	8,909,504	6.4	101,094	5.8	1,963	6.5
Manufacturing	14,640,244	10.4	193,152	11.1	4,715	15.5
Wholesale trade	3,979,663	2.8	43,227	2.5	660	2.2
Retail trade	16,246,356	11.6	189,948	10.9	3,138	10.3
Transportation and warehousing, and utilities	6,971,155	5.0	66,665	3.8	1,178	3.9
Information	3,057,887	2.2	42,113	2.4	1,442	4.7
Finance, insurance, real estate and rental and leasing	9,404,900	6.7	162,400	9.3	2,792	9.2
Professional, scientific, management, administrative and waste management services	14,906,696	10.6	189,609	10.9	2,159	7.1
Educational services, and health care and social assistance	32,376,279	23.1	459,714	26.3	7,924	26.1
Arts, entertainment, recreation, accommodation, and food services	12,956,562	9.2	144,326	8.3	2,032	6.7
Other services, except public administration	6,986,806	5.0	80,265	4.6	1,141	3.8
Public administration	7,054,337	5.0	67,741	3.9	1,191	3.9

Source: U.S. Census Bureau, n.d.

Education Statistics

Table 20. Educational Attainment, Population 25 Years and Over (2010)

	U.S.	Connecticut	Bristol
Less than 9th grade	6.1%	4.6%	5.0%
9th to 12th grade, no diploma	8.3%	6.7%	7.7%
High school graduate (includes equivalency)	28.4%	28.0%	38.4%
Some college, no degree	21.3%	17.7%	19.1%
Associate's degree	7.6%	7.3%	7.2%
Bachelor's degree	17.7%	20.2%	14.5%
Graduate or professional degree	10.5%	15.6%	8.0%
Percent high school graduate or higher	**85.6%**	**88.7%**	**87.3%**
Percent bachelor's degree or higher	**28.2%**	**35.8%**	**22.5%**

Source: U.S. Census Bureau, n.d.

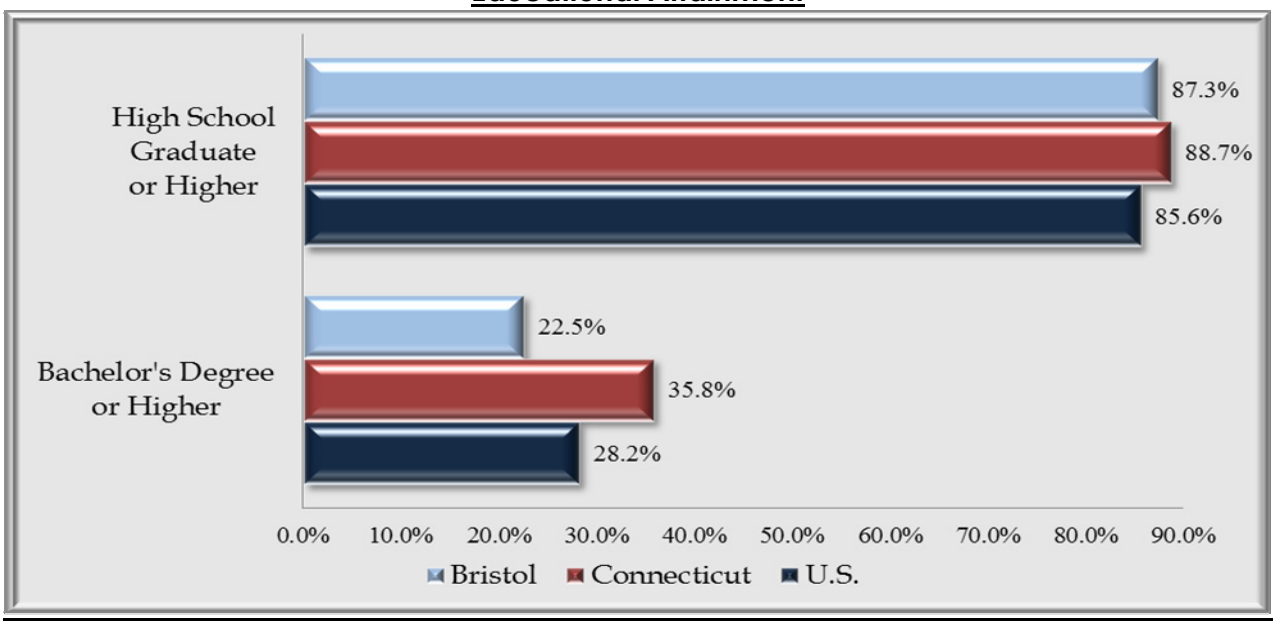


Figure 8. Educational attainment, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Table 21. School Enrollment, Population 3 Years and Over (2010)

	U.S.	Connecticut	Bristol
Nursery school, preschool	6.0%	6.4%	7.6%
Kindergarten	5.1%	4.5%	5.5%
Elementary school (grades 1-8)	39.8%	39.3%	42.7%
High school (grades 9-12)	21.0%	22.1%	19.5%
College or graduate school	28.1%	27.7%	24.6%

Source: U.S. Census Bureau, n.d.

Health Insurance Coverage Statistics

Table 22. Health Insurance Coverage for Civilian Non-Institutionalized Population (2009 - 2011)

	U.S.		Connecticut		Bristol	
Civilian non-institutionalized population	304,085,860		3,514,446		59,838	
	n	%	n	%	n	%
With health insurance coverage	257,803,646	84.8	3,201,882	91.1	53,977	90.2
Private health insurance	201,453,987	66.2	2,616,462	74.4	41,786	69.8
Public coverage	89,835,432	29.5	989,755	28.2	19,272	32.2
No health insurance coverage	46,282,214	15.2	312,564	8.9	5,861	9.8
Population under 18 years without health insurance coverage	5,940,027	8.0	26,368	3.2	331	2.6

Source: U.S. Census Bureau, n.d.

Population without Health Insurance

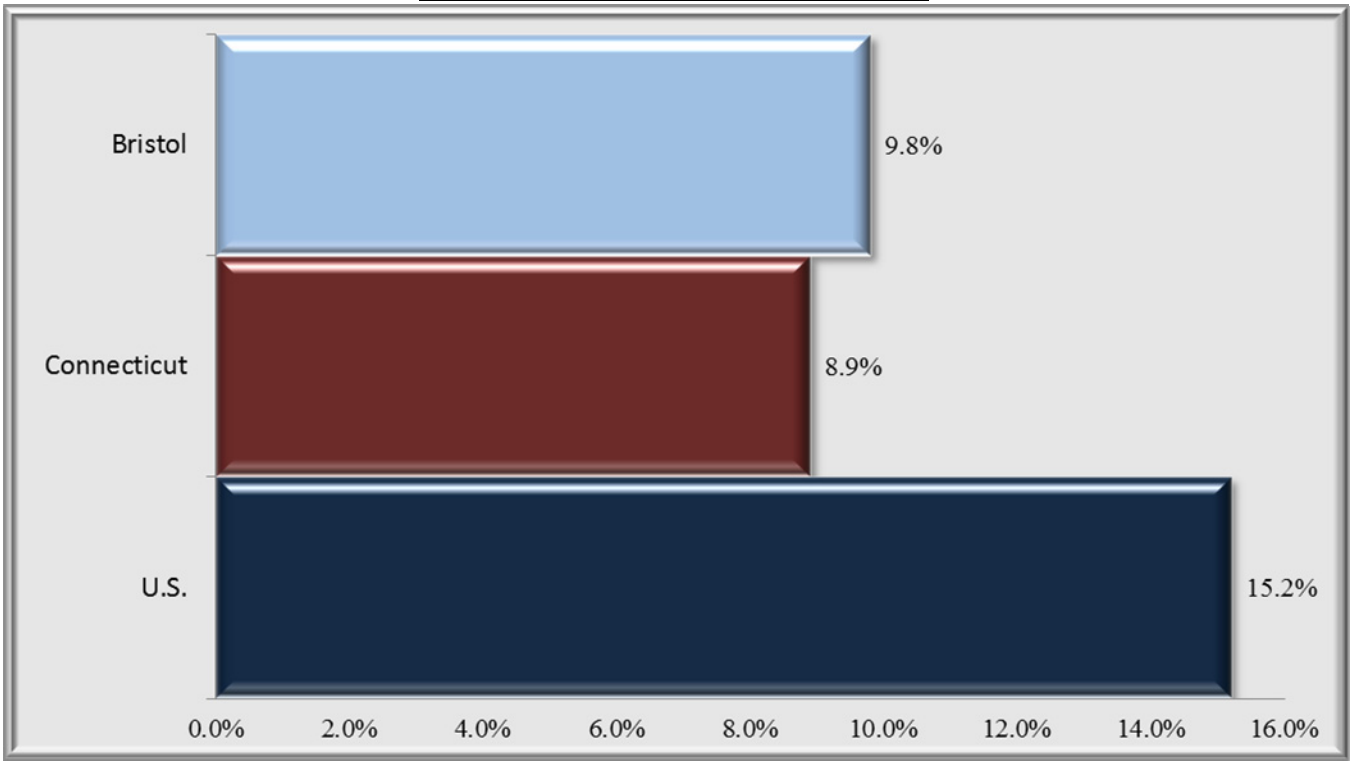


Figure 9. Civilian non-institutionalized population without health insurance coverage, Bristol compared to Connecticut and the U.S. (2009 - 2011).

Mortality Statistics

Table 23. Mortality, All Ages (2010; 2006 - 2010)

	U.S.	Connecticut	Bristol
Total deaths (2010)	2,468,435	28,597	553
Crude rate per 1,000 (2010)	8.0	8.0	8.8
Age-adjusted rate per 100,000 (2006 – 2010)	767.4	665.8	729.1

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013

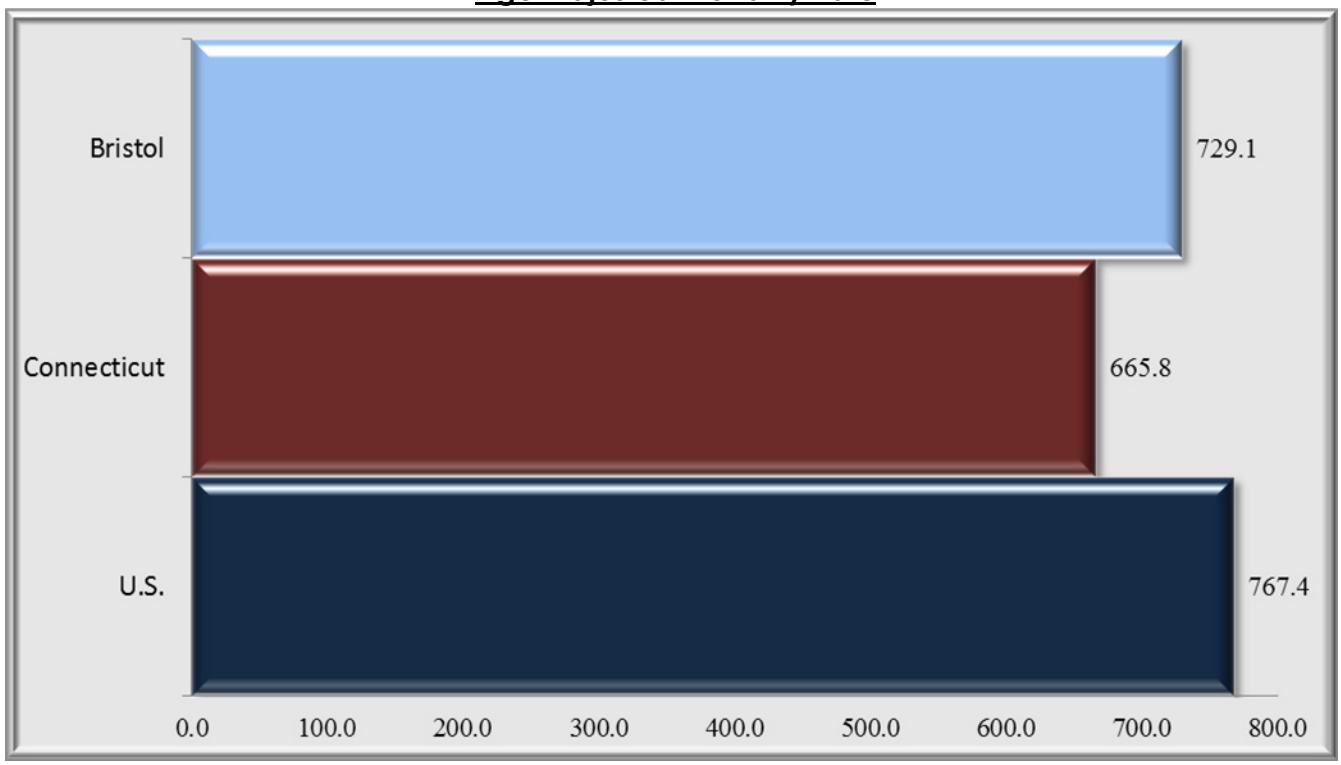


Figure 10. Age-adjusted mortality rate per 100,000, Bristol compared to Connecticut and the U.S. (2006 - 2010).

Table 24. Top 10 Leading Causes of Death, All Ages (2006 - 2010)

	U.S.	Connecticut	Bristol
The following are the top 10 leading causes of death in ranking order of the United States.			
Diseases of heart	25.0%	25.1%	26.8%
Malignant neoplasms (Cancer)	23.1%	23.8%	21.5%
Chronic lower respiratory diseases	5.5%	4.9%	6.8%
Cerebrovascular diseases (Stroke)	5.4%	5.0%	4.8%
Accidents (Unintentional injuries)	5.0%	4.5%	4.6%
Alzheimer's disease	3.2%	2.7%	2.1%
Diabetes Mellitus	2.9%	2.3%	2.5%
Influenza and pneumonia	2.2%	2.4%	3.3%
Nephritis, nephrotic syndrome and nephrosis	2.0%	2.0%	2.0%
Intentional self-harm (Suicide)	1.5%	1.0%	1.0%

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013

Deaths due to Diseases of the Heart

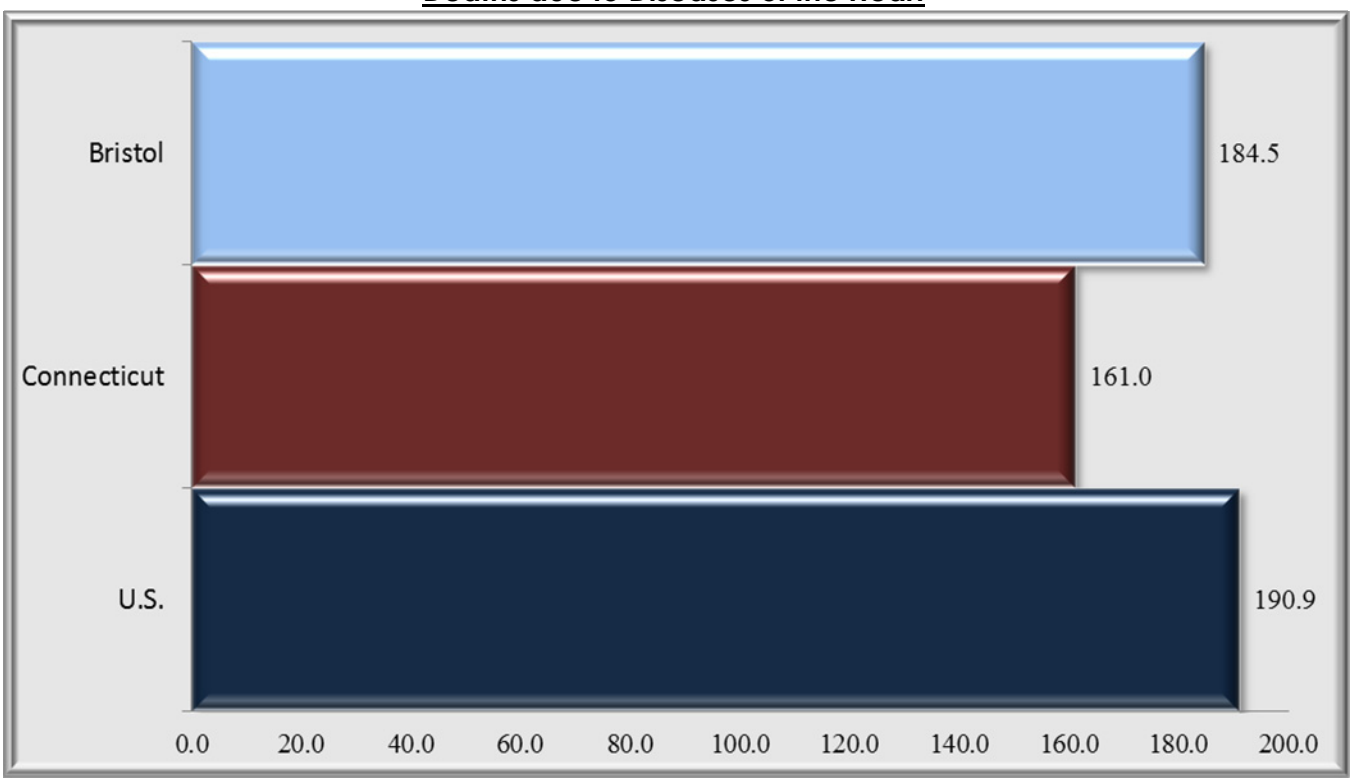


Figure 11. Diseases of the heart death rate per age-adjusted 100,000, Bristol compared to Connecticut and the U.S. (2006 - 2010).

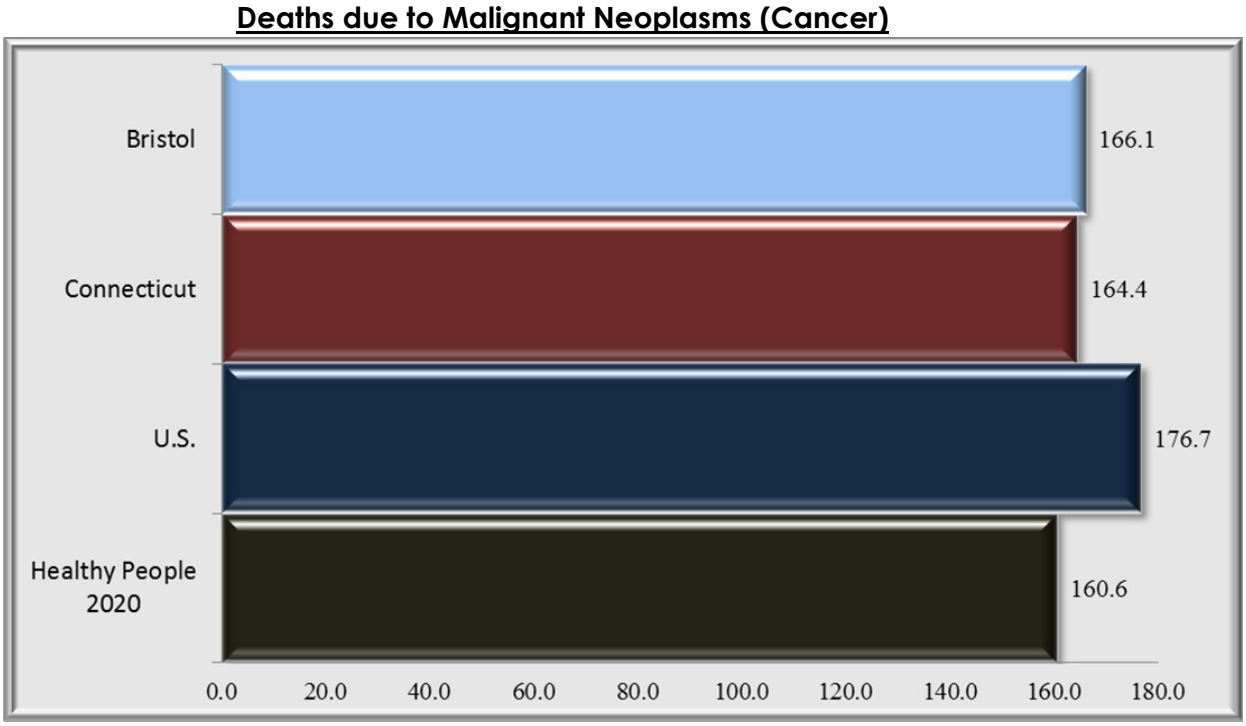


Figure 12. Malignant neoplasms (cancer) death rate per age-adjusted 100,000, Bristol compared to Connecticut, the U.S., and Healthy People 2020 (2006 - 2010).

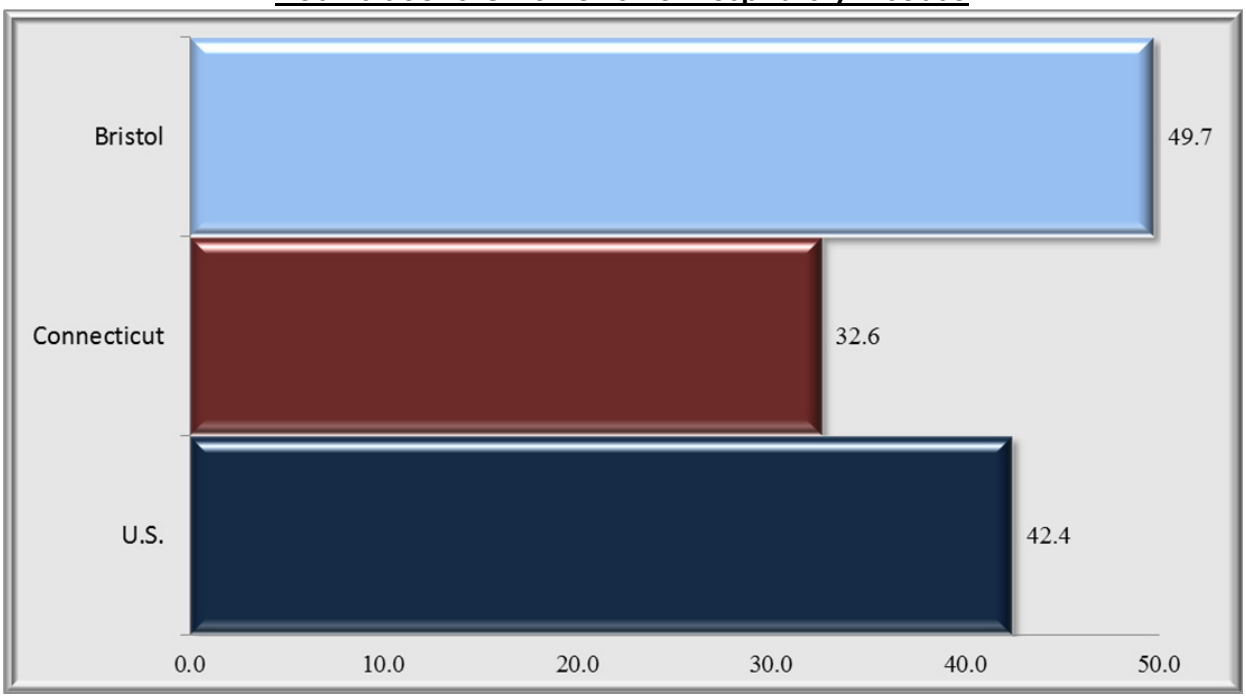


Figure 13. Chronic lower respiratory disease death rate per age-adjusted 100,000 population, Bristol compared to Connecticut and the U.S. (2006 - 2010).

Maternal and Child Health Statistics

Table 25. Live Births per 1,000 (2010)

	U.S.	Connecticut	Bristol
Total live births	3,999,386	37,713	666
Total birth rate	13.0	10.5	11.0

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013

Live Birth Rate

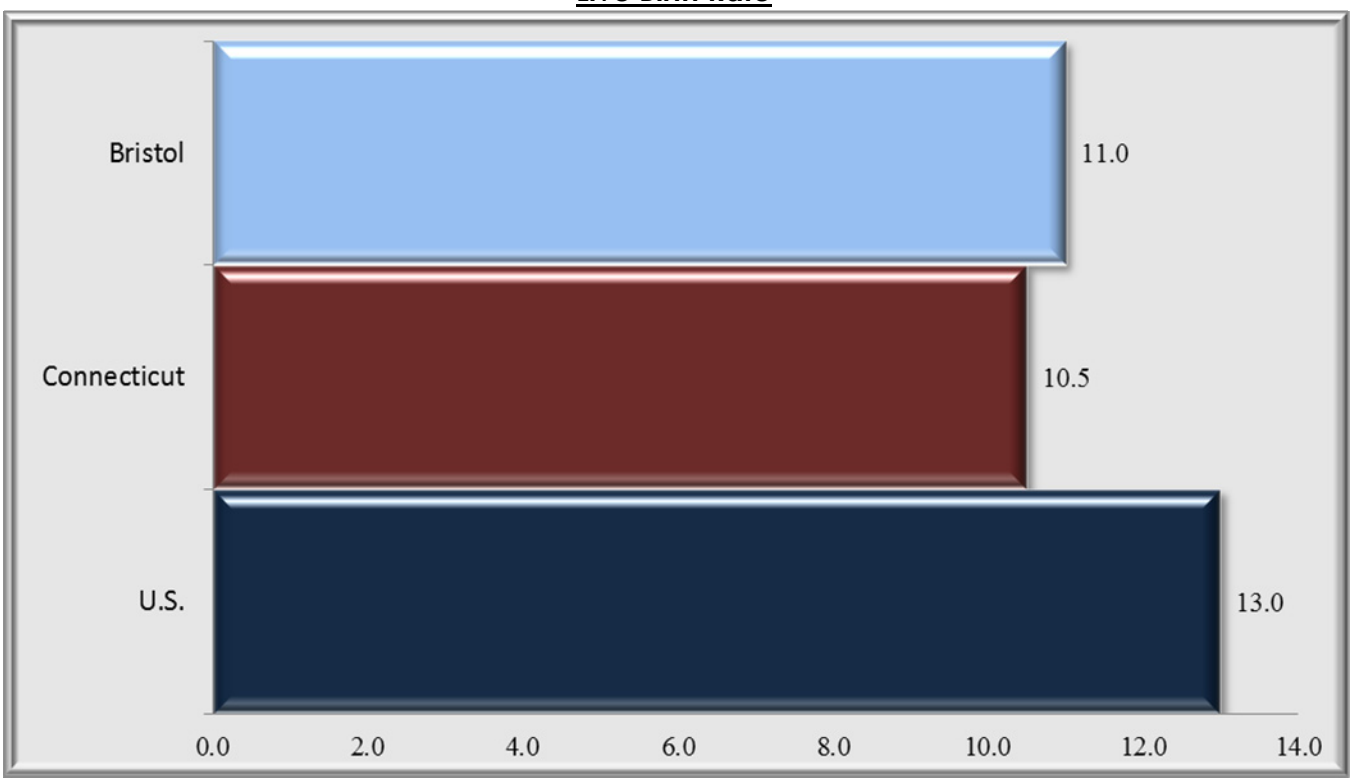


Figure 14. Live birth rate per 1,000, Bristol compared to Connecticut and the U.S. (2010)

Table 26. Birth Weight (2010)

	Healthy People 2020	U.S.		Connecticut		Bristol	
	%	n	%	n	%	n	%
Low birth weight	7.8	325,563	8.2	3,018	8.0	41	6.2
Very low birth weight	1.4	57,841	1.5	577	1.5	6	0.9

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013
Healthy People 2020, 2012

Low Birth Weight

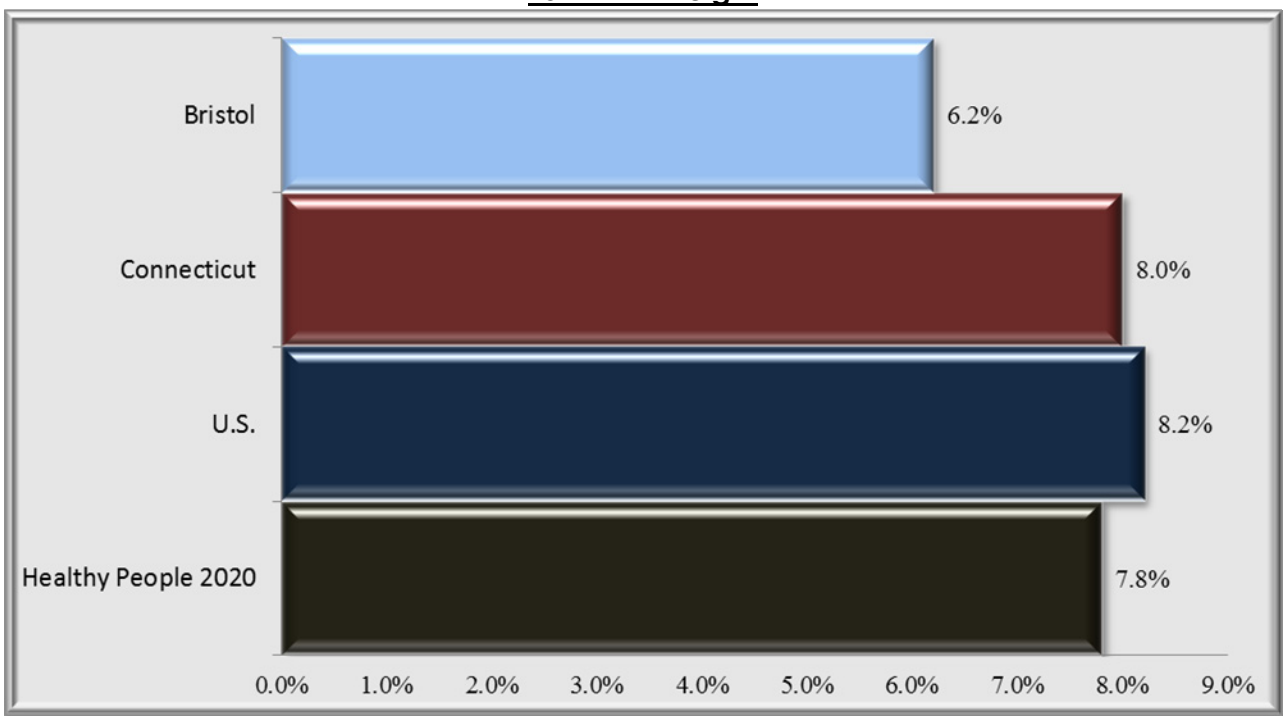


Figure 15. Percentage of infants born with low birth weight, Bristol compared to Connecticut, the U.S., and Healthy People 2020 (2010).

Table 27. Percent of All Births to Teenagers (2010)

	U.S		Connecticut		Bristol	
	n	%	n	%	n	%
<15 years	4,497	0.1	20	0.1	0	0.0
<18 years	113,670	2.8	642	1.7	8	1.2
<20 years	372,175	9.3	2,294	6.1	40	6.0

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013

Table 28. Prenatal Care Adequacy (2010)

	Healthy People 2020[b]	Connecticut	Bristol
Late or None[a]	N/A	12.8%	9.0%
White	N/A	8.9%	7.6%
Black	N/A	19.5%	N/A
Hispanic	N/A	19.5%	16.3%
Non-Adequate	N/A	20.2%	17.5%
White	N/A	17.0%	16.9%
Black	N/A	26.4%	15.2%
Hispanic	N/A	25.5%	21.2%
Adequate	77.6%	42.6%	36.7%

White		43.6%	36.7%
Black		38.3%	43.5%
Hispanic		41.2%	31.7%
Intensive		37.3%	45.9%
White		39.4%	46.4%
Black		35.3%	41.3%
Hispanic		33.3%	47.1%

Sources: Connecticut Department of Public Health, 2013
Healthy People 2020, 2012

[a] Late prenatal care defines mothers seeking prenatal care in the second or third trimester
[b] Healthy People 2020 represents the percentage of mothers who receive early and adequate prenatal care and is not a direct comparison to data provided for Connecticut and Bristol, which includes early and late prenatal care.

Mothers Receiving Late or No Prenatal Care

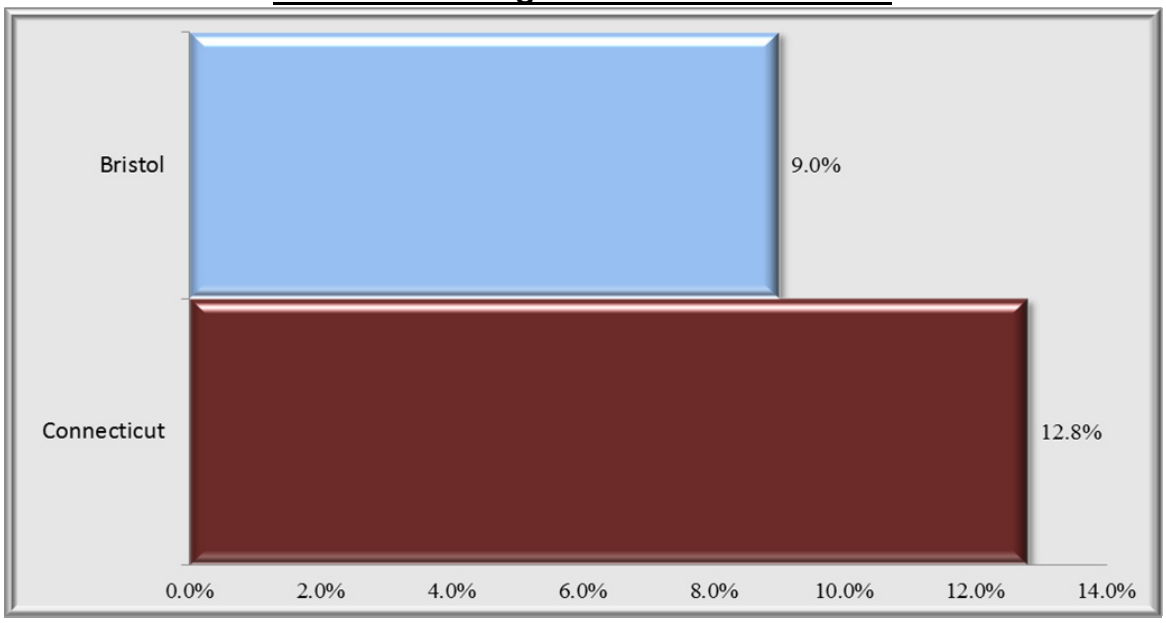


Figure 16. Mothers receiving late or no prenatal care, Bristol compared to Connecticut (2010).

Table 29. Infant Mortality per 1,000 live births (2010)

	Healthy People 2020	U.S.		Connecticut		Bristol	
	Rate	n	Rate	n	Rate	n	Rate
Infant	6.0	24,586	6.2	196	5.2	5	7.5
Neonatal	4.1	16,188	4.1	149	4.0	2	*
Postneonatal	2.0	8,398	2.1	47	1.2	3	*
Fetal	5.6	N/A	N/A	197	5.2	3	*

Sources: Center for Disease Control and Prevention, 2013
Connecticut Department of Public Health, 2013
Healthy People 2020, 2012 *Rates not calculated for counts less than 5

Infant Mortality Rate

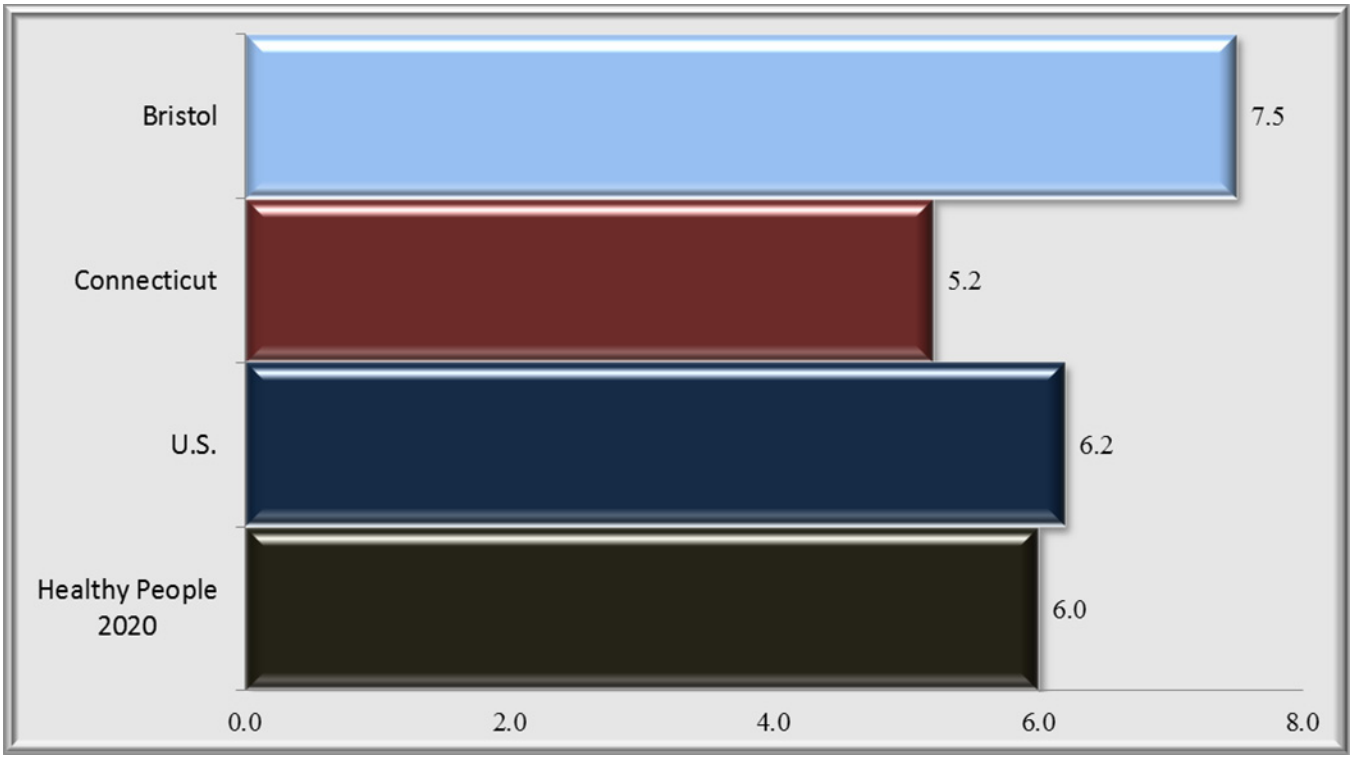


Figure 17. Infant mortality rate per 1,000 live births, Bristol compared to Connecticut, the U.S. and Healthy People 2020 (2010).

Sexually Transmitted Illness Statistics

Table 30. Sexually Transmitted Illness Cases per 100,000 (2009, 2011)[a]

	U.S		Connecticut		Bristol	
	n	Rate	n	Rate	n	Rate
HIV	49,273	15.8	348	9.7	2	*
Gonorrhea	301,174	98.1	2,554	72.6	17	27.8
Chlamydia	1,244,180	405.3	12,136	344.9	115	188.4
Primary/Secondary Syphilis	13,997	4.6	65	1.8	0	0.0

Sources: Center for Disease Control and Prevention, 2013
Connecticut Department of Public Health, n.d.

[a] All statistics represent 2009 data with the exception of HIV, which represents 2011 data

*Rates not calculated for counts less than 5

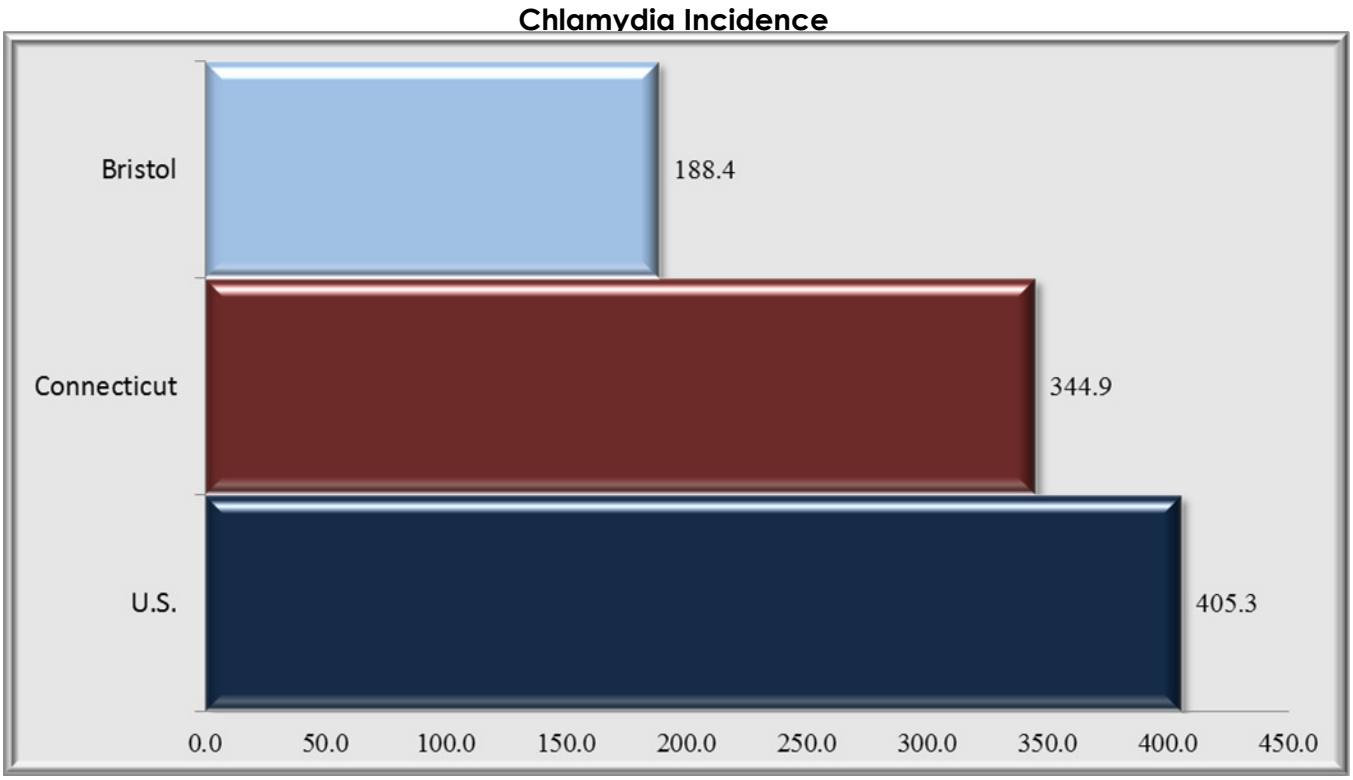


Figure 18. Chlamydia rates per 100,000, Bristol compared to Connecticut and the U.S. (2009).

Communicable Disease Statistics

Table 31. Hepatitis Cases per 100,000 (2011)

	Healthy People 2020	U.S[a]		Connecticut		Bristol	
	Rate	n	Rate	n	Rate	n	Rate
Acute Hepatitis A	0.3	1,670	0.5	18	0.5	0	0.0
Acute Hepatitis B	N/A	3,350	1.1	19	0.5	0	0.0
Chronic Hepatitis B	N/A	N/A	N/A	351	9.8	3	*
Acute Hepatitis C	0.2	850	0.3	47	1.3	3	*

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, n.d.
[a] Statistics represent 2010 data
*Rates not calculated for counts less than 5

Table 32. Influenza Cases per 100,000 (August 26, 2012 – May 11, 2013)[a]

	Connecticut		Bristol	
	n	Rate	n	Rate
Type A (2009 H1N1)	38	1.0	1	*
Type A (H1N1 seasonal)	0	0.0	0	0.0
Type A (H3N2 seasonal)	1,399	39.1	21	34.7

Total Cases	9,430	263.4	128	211.5

Source: Connecticut Department of Public Health, n.d.
[a]Rates calculated based on 2011 population estimates
*Rates not calculated for counts less than 5

Table 33. Confirmed and Probable Lyme Disease Cases per 100,000 (2012)

	U.S[a]		Connecticut		Bristol	
	n	Rate	n	Rate	n	Rate
	33,097	10.6	2,658	78.0	7	11.7

Sources: Center for Disease Control and Prevention, 2013
Connecticut Department of Public Health, n.d.
[a] Statistics represent 2011 data

Table 34. Tuberculosis Incidence per 100,000 (2011)

	U.S		Connecticut		Bristol	
	n	Rate	n	Rate	n	Rate
	10,528	3.4	83	2.3	1	*

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, n.d.

Mental Health Statistics

Table 35. Deaths Due to Suicide per 100,000 (2006 – 2010)

	Healthy People 2020	U.S	Connecticut	Bristol
Number of deaths	N/A	179,206	1,485	29
Crude rate	N/A	11.8	8.4	9.6
Age-adjusted rate	10.2	11.6	8.0	9.2

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013

Deaths due to Suicide

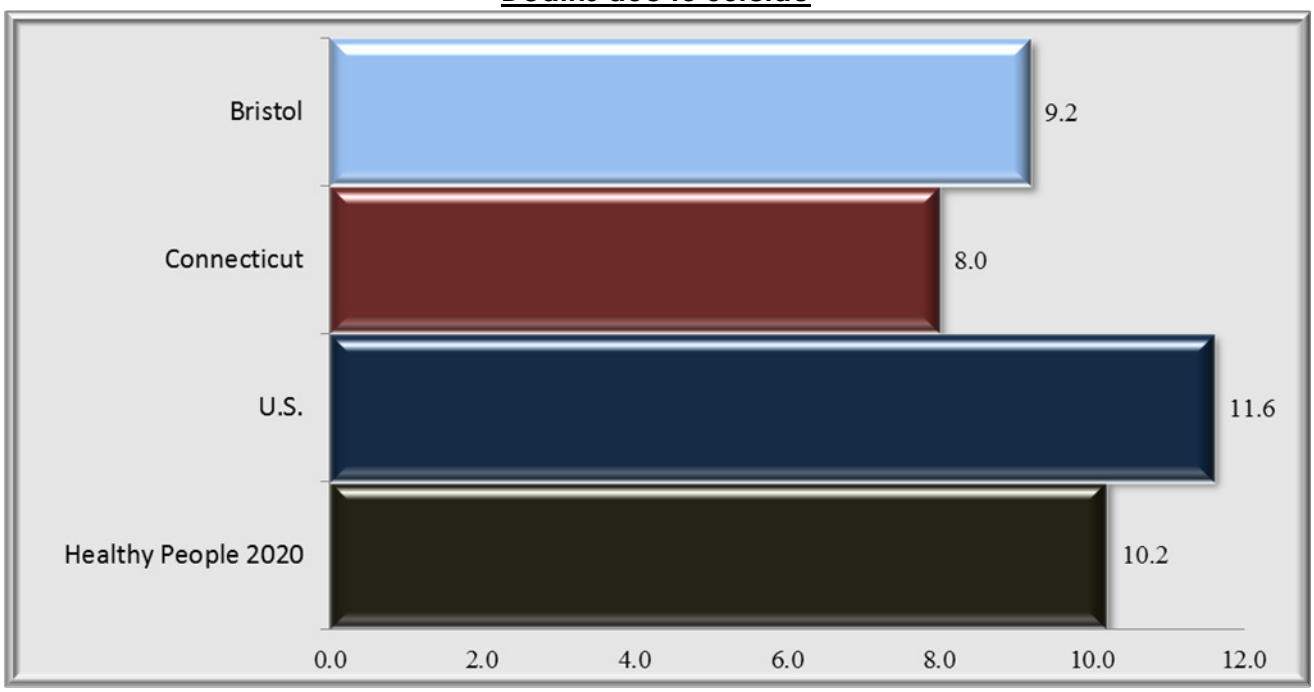


Figure 19. Suicide rates per 100,000, Bristol compared to Connecticut, the U.S., and Healthy People 2020 (2006 - 2010).

Table 36. Inpatient and Outpatient Behavioral Health Visits (June 1, 2011 – May 31, 2013)

	Inpatient	Outpatient	Total
All behavioral health issues			
Total patients	781	1,616	2,397 (4.0% of population)
Total visits	1,219	32,063	33,282
Co-occurring disorders			
Total patients	466	923	1,389 (2.3% of population)
Total visits	719	11,670	12,389

Source: Bristol Hospital, 2013

Table 37. Behavioral Health Patient Demographics (June 1, 2011 – May 31, 2013)

	Percentage
Gender	
Male	49%
Female	51%
Age	
18-24	15%
25-44	47%
45-64	33%
65+	5%

Marital Status	
Married	21%
Single	60%
Divorced	14%
Separated	2%
Widowed	3%
Race	
Non – Hispanic White/Caucasian	79.7%
Non – Hispanic Black/African American	5.4%
Non – Hispanic Asian	0.1%
Non – Hispanic Other/Unknown	0.9%
Ethnicity	
Non-Hispanic	86.2%
Hispanic	10.4%
Unknown	3.4%
Insurance Coverage	
Managed Care	32%
Government	62%
Self-Pay/Uninsured	5%

Source: Bristol Hospital, 2013

Table 38. Top Five Diagnosed Behavioral Health Disorders (June 1, 2011 – May 31, 2013)

	Percentage
Alcohol Dependence/Withdrawal	12%
Anxiety Disorders	11%
Episodic Mood Disorders	10%
Opioid Dependence	8%
Depressive Disorder	4%

Source: Bristol Hospital, 2013

Cancer Statistics

Table 39. Cancer Incidence by Site per 100,000 (2007)

	U.S.		Connecticut		Bristol	
	n	Rate	n	Rate	n	Rate
Female breast	207,908	122.5	2,854	155.6[a]	48	153.2[a]
Colorectal	146,936	46.6	1,795	51.3	36	59.1
Lung	211,539	67.6	2,602	74.3	64	105.1
Prostate	233,443	162.9	3,015	173.3[a]	44	151.0[a]
All Sites	**1,510,594**	**479.3**	**19,669**	**561.6**	**334**	**548.3**

Sources: Center for Disease Control and Prevention, 2013

Connecticut Department of Public Health, n.d.
[a] Rates based on 2010 population counts

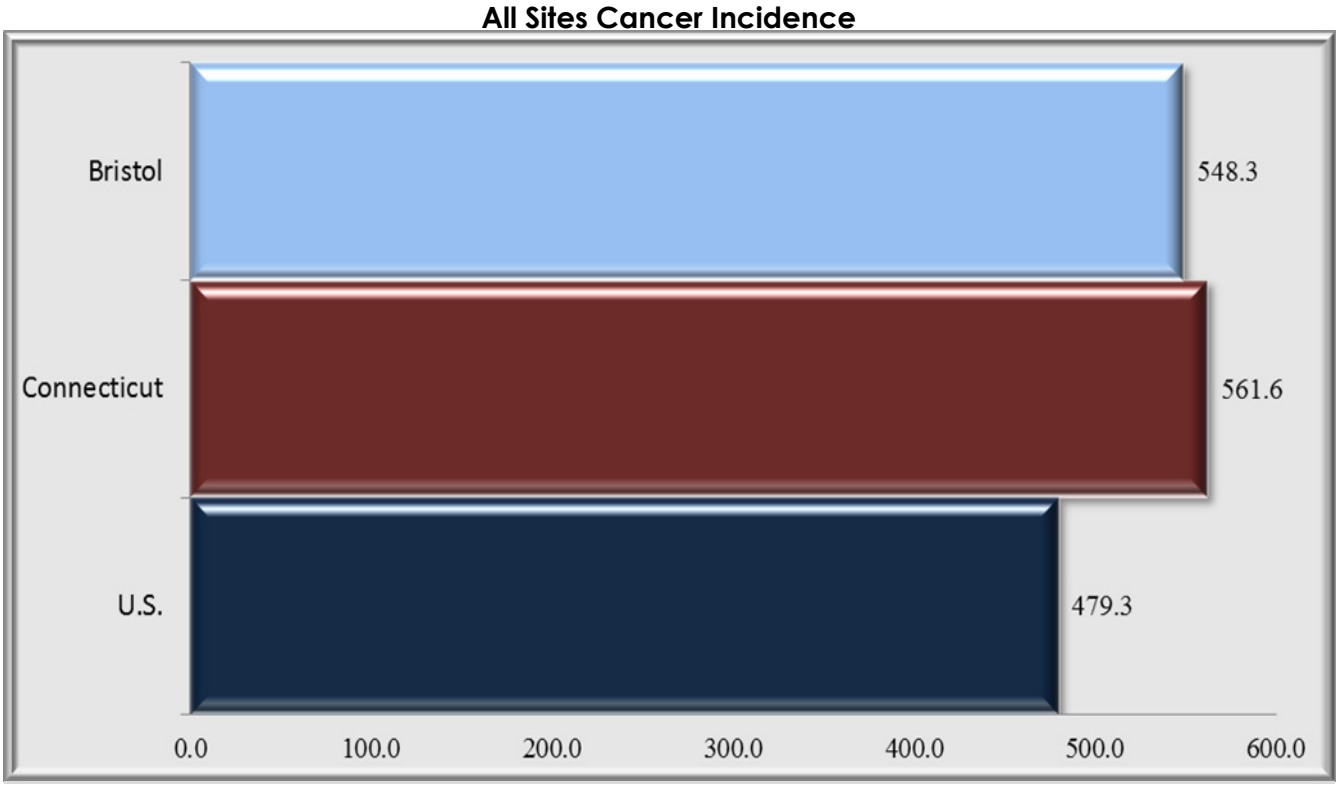


Figure 20. Cancer incidence per 100,000, Bristol compared to Connecticut and the U.S. (2007).

Table 40. Cancer Mortality by Site per age-adjusted 100,000 (2006 – 2010)

	Healthy People 2020	U.S.		Connecticut		Bristol	
	Rate	n	Rate	n	Rate	n	Rate
Female breast	20.6	203,683	22.7	2,517	N/A	42	N/A
Colorectal	14.5	265,472	16.6	2,919	13.8	51	13.4
Trachea, Bronchus, & Lung	45.5	792,556	49.5	8,916	43.7	200	56.2
Prostate	21.2	142,586	9.0	1,811	N/A	22	N/A
All Sites	**160.6**	**2,830,603**	**176.7**	**34,083**	**164.4**	**604**	**166.1**

Sources: Center for Disease Control and Prevention, 2012
Connecticut Department of Public Health, 2013

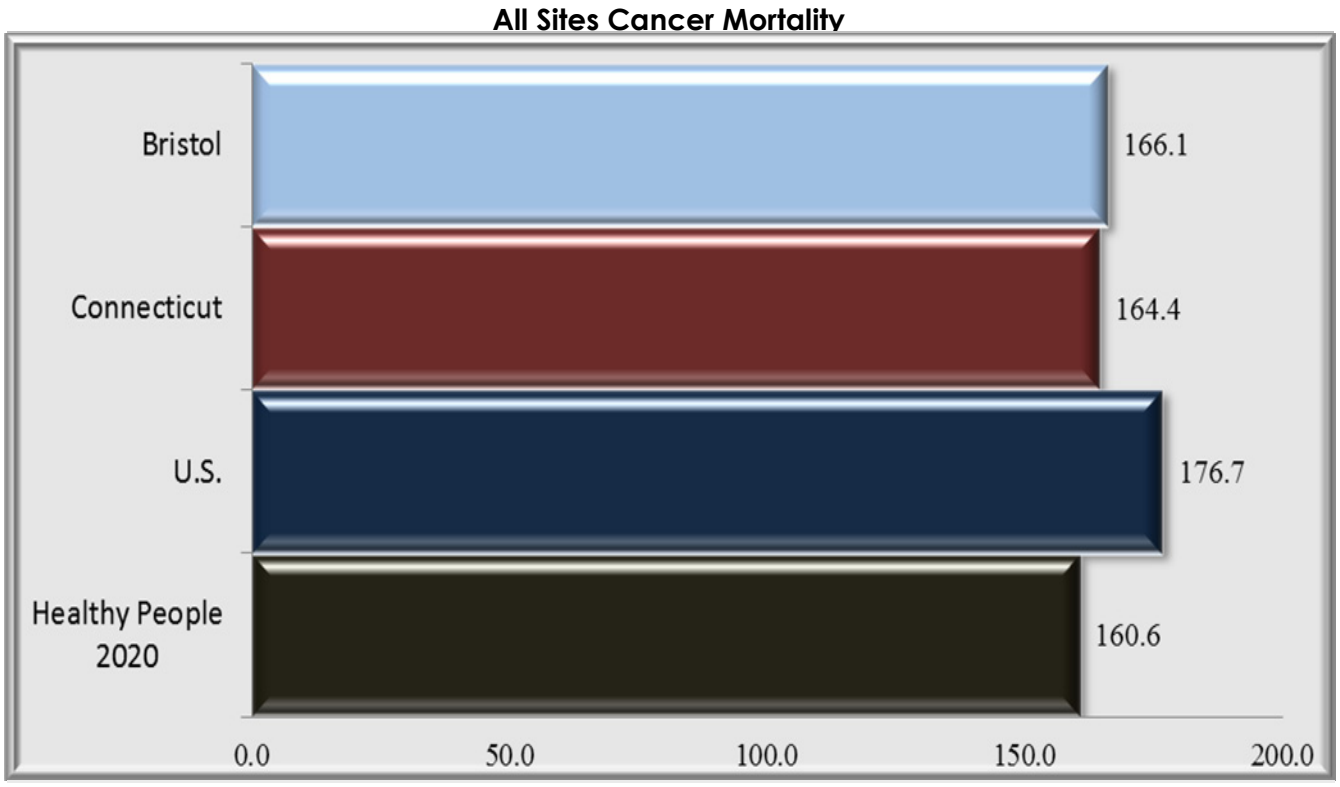


Figure 21. Cancer mortality per 100,000, Bristol compared to Connecticut, the U.S., and Healthy People 2020 (2006 - 2010).

Environmental Health Statistics

Table 41. Asthma Prevalence Rates among Public School Students per 100 (2006 - 2009)

	Connecticut		Bristol School District	
	n	Rate	n	Rate
Students with asthma	41,269	13.2	353	8.3

Source: Connecticut Department of Public Health, 2010

Table 42. Childhood Lead Screening by Age (2011)

	Connecticut		Bristol	
	n	%	n	%
Age 9 months – 2 years	55,960	67.6	843	61.1

Source: Connecticut Department of Public Health, 2012

Table 43. Childhood Blood Lead Levels ≥ 10µg among Children Under Age Six (2011)

	Connecticut		Bristol	
	n	%	n	%
Prevalence	619	0.8	9	0.9

Incidence	434	0.6	7	0.7

Source: Connecticut Department of Public Health, 2012

Crime Statistics

Table 44. Crime Offenses per 100,000 (2011)

	U.S		Connecticut		Bristol	
	n	Rate	n	Rate	n	Rate
Murder	14,612	4.7	129	3.6	1	1.6
Rape	83,425	26.8	688	19.2	12	19.0
Robbery	354,396	113.7	3,690	103.1	52	82.3
Aggravated Assault	751,131	241.1	5,380	150.3	55	87.1
Burglary	2,188,005	702.2	15,468	432.0	364	576.4
Larceny	6,159,795	1,976.9	55,357	1,546.0	1,028	1,627.9
Motor Vehicle Theft	715,373	229.6	6,620	184.9	114	180.5
Arson	52,333	18.2	379	10.6	9	14.3

Sources: Federal Bureau of Investigation, n.d.
Connecticut Department of Public Safety, 2013

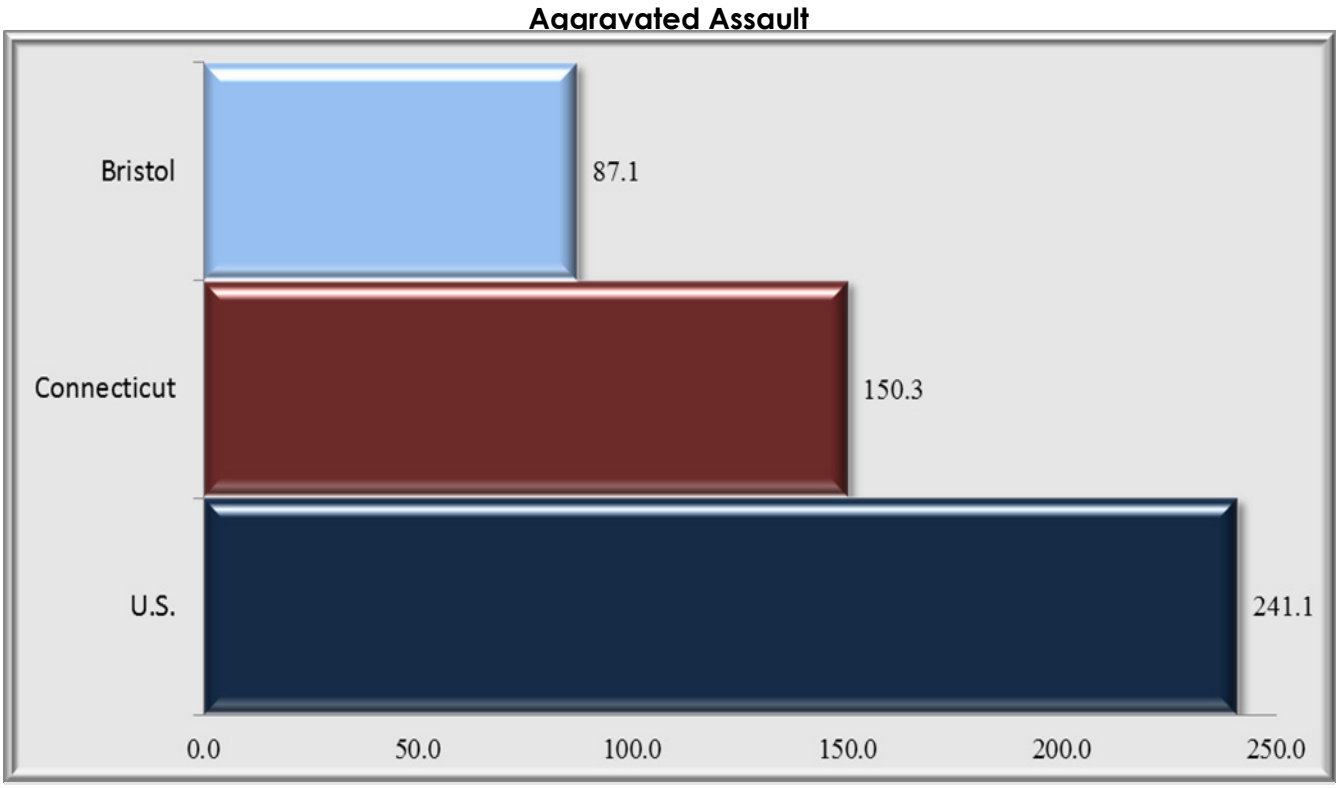


Figure 22. Aggravated Assault per 100,000, Bristol compared to Connecticut and

the U.S. (2011).

Secondary Data Profile Summary of Findings

The following conclusions are drawn from comparisons of Bristol to Connecticut and United States secondary data. They are categorized as either Areas of Strength, Areas of Opportunity, or Areas of Difference. Areas of Strength highlight factors in which Bristol has a more favorable outcome than Connecticut and/or the Nation. In contrast, Areas of Opportunity highlight factors that Bristol can improve upon in comparison to Connecticut and/or the Nation. Areas in which Bristol differs notably from Connecticut and/or the Nation, but that cannot be considered strengths or opportunities, are considered Areas of Difference. For example, if Bristol had a notably larger male population versus female population, it is neither a strength nor an opportunity, but it is an Area of Difference.

Areas of Strength

- **Income Statistics**
  - The percentage of Bristol families and individuals living in poverty typically falls between the percentages for Connecticut and the Nation; the percentage usually exceeds that of Connecticut and is less than that of the Nation. However, poverty percentages are lower than both Connecticut and the Nation for households headed by a female, children under 18 years, and unrelated individuals 15 years and over.

- **Health Insurance Coverage Statistics**
  - The percentage of Bristol residents who do not have health insurance coverage (9.8%) is higher when compared to Connecticut (8.9%), but notably less when compared to the Nation (15.2%). Residents of Bristol who are insured are more likely to have public coverage (32.2%) than residents of Connecticut (28.2%), and the Nation (29.5%).

- **Maternal & Child Health Statistics**
  - The low birth weight percentage in Bristol (6.2%) is lower than that of Connecticut (8.0%) and the Nation (8.2%) and exceeds the Healthy People 2020 goal of 7.8%.
  - The percentage of births to teenagers in Bristol is consistent with Connecticut, but notably less when compared to the Nation.
  - The percentage of mothers in Bristol receiving late or no prenatal care (9.0%) or non-adequate prenatal care (17.5%) is lower when compared to Connecticut (12.8%; 20.2%). In addition, the percentage of mothers receiving intensive prenatal care is higher for the entire population and all reported racial subgroups when compared to Connecticut.

- **Sexually Transmitted Illness Statistics**
  - The rates for sexually transmitted illnesses are lower in Bristol. In particular, the chlamydia rate per 100,000 in Bristol (188.4) is notably lower when compared to Connecticut (344.9) and the Nation (405.3).

- **Communicable Disease Statistics**

- The influenza rate per 100,000 in Bristol (211.5) is lower than all of Connecticut (263.4).

❖ **Mental Health Statistics**
- The suicide age-adjusted death rate per 100,000 in Bristol (9.2) exceeds that of Connecticut (8.0), but is notably lower than that of the Nation (11.6) and meets the Healthy People 2020 goal of 10.2.

❖ **Environmental Health Statistics**
- The percentage of students with asthma in Bristol School District (8.3%) is lower when compared to all Connecticut public school districts (13.2%).

❖ **Crime Statistics**
- The rates for all reported crimes (property and violent) are lower in Bristol than in the Nation. In addition, crimes rates are lower in Bristol than in Connecticut for all reported crimes except burglary, larceny, and arson.

Areas of Opportunity

❖ **Household Statistics**
- The percent of marriages that end in divorce is higher in Bristol (13.4%) than in Connecticut (10.6%) and the Nation (10.8%).

❖ **Income Statistics**
- In Bristol, the percentage of residents receiving cash public assistance (4.9%) and Food Stamps/SNAP (12.3%) is higher when compared to Connecticut (3.1%; 9.8%) and the Nation (2.8%; 11.7%).
- The percentage of students eligible to receive a free or reduced lunch during the 2010-2011 school year was higher in Bristol (40.0%) than in Connecticut (34.4%).

❖ **Employment Statistics**
- The unemployed civilian labor force in Bristol (10.6%) is slightly higher than in Connecticut (10.1%) and the Nation (10.3%).

❖ **Education Statistics**
- Residents aged 25 years and over in Bristol are less likely to have attained a bachelor's degree of higher (22.5%) when compared to Connecticut (35.8%), and the Nation (28.2%).

❖ **Mortality Statistics**
- The age-adjusted mortality rate per 100,000 in Bristol (729.1) is lower than that of the Nation (767.4), but notably higher than that of Connecticut (665.8).
- The age-adjusted mortality rate per 100,000 for chronic lower respiratory disease in Bristol (49.7) exceeds that of Connecticut (32.6) and the Nation (42.4). In addition, the age-adjusted mortality rate per 100,000 for diseases of the heart (184.5) exceeds that of Connecticut (161.0).

❖ **Maternal & Child Health Statistics**

- The infant mortality rate per 1,000 live births in Bristol (7.5) exceeds that of Connecticut (5.2), the Nation (6.2), and the Healthy People 2020 goal of 6.0. This is in contrast to the primarily positive findings regarding maternal health practices.

❖ **Mental Health Statistics**
- The top behavioral health diagnosis at Bristol Hospital is alcohol dependence/withdrawal (12% of all diagnoses), which suggests that substance abuse may be an area of concern in the community.

❖ **Cancer Statistics**
- The overall cancer incidence rate per 100,000 in Bristol (548.3) is consistent with Connecticut (561.6), but both rates are notably higher than that of the Nation (479.3).
- The lung cancer incidence rate per 100,000 in Bristol (105.1) is higher when compared to Connecticut (74.3) and the Nation (67.6). In addition, the lung cancer mortality rate per 100,000 in Bristol (56.2) is higher when compared to Connecticut (43.7), the Nation (49.5), and the Healthy People 2020 goal of 45.5.
- The colorectal cancer incidence rate per 100,000 in Bristol (59.1) is higher when compared to Connecticut (51.3) and the Nation (46.6).

❖ **Environmental Health Statistics**
- The percentage of children age nine months to two years in Bristol who have been screened for lead (61.1%) is lower when compared to Connecticut (67.6%).

Areas of Difference

❖ **Population Statistics**
- The population growth between 2000 and 2010 in Bristol (0.7%) was notably less than that of Connecticut (4.9%) and the Nation (9.7%).
- Bristol has a slightly older overall population, particularly in comparison to the Nation. The median age is 40.3 years and 14.9% of residents are 65 years of age and over. The Nation has a median age of 37.2 and 13.0% of the population is 65 years and older.
- Bristol is less racially diverse when compared to Connecticut and the Nation. The city has a higher proportion of White residents (87.7%) and a lower proportion of Black/African American (3.8%), Asian (1.9%), and Hispanic (9.6%) residents.
- In addition to being less racially diverse, fewer residents in Bristol speak a language other than English at home (16.9%) when compared to residents across Connecticut (21.2%) and the Nation (20.6%). Residents that do speak a language other than English at home are more likely to speak an Indo-European language.

❖ **Household Statistics**
- Bristol has a smaller average household size (2.35) and family size (2.95) when compared to Connecticut (2.52; 3.08) and the Nation (2.58; 3.14). In addition, a higher percentage of households in Bristol are nonfamily (37.5%) when compared to Connecticut (33.7%) and the Nation (33.6%).

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization Session

On August 20, 2013, approximately 40 individuals representing the Bristol community gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for the development of the hospital's Implementation Strategy. A list of attendees can be found in Appendix B.

Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the secondary data research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans.

Master list of community priorities (Presented in alphabetical order)

- Access To Care
- Cancer
- Heart Disease
- Mental Health & Substance/Alcohol Abuse
- Overweight/Obesity
- Respiratory Disease
- Senior Support
- Smoking/Tobacco Use

Key Community Health Issues

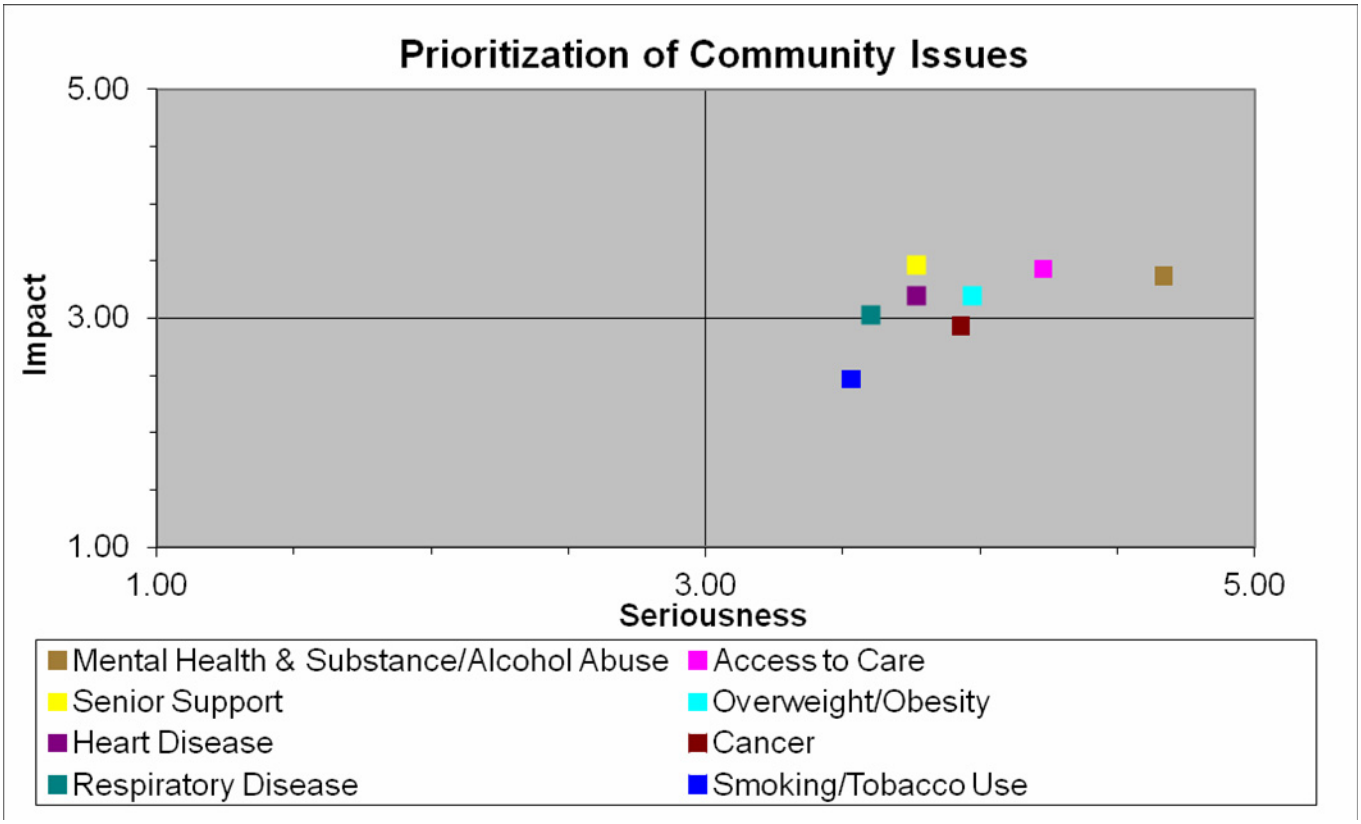
Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating	Impact Rating (average)	Average Total Score

	(average)		
Mental Health & Substance/Alcohol Abuse	4.67	3.37	4.02
Access to Care	4.23	3.43	3.83
Senior Support	3.77	3.47	3.62
Overweight/Obesity	3.97	3.20	3.59
Heart Disease	3.77	3.20	3.49
Cancer	3.93	2.93	3.43
Respiratory Disease	3.60	3.03	3.32
Smoking/Tobacco Use	3.53	2.47	3.00

The priority area that was perceived as the most serious was Mental Health and Substance/Alcohol Abuse (4.67 average rating), followed by Access to Care (4.23 average rating), and Overweight/Obesity (3.97 average rating). The ability to impact Senior Support was rated the highest at 3.47, followed by Access to Care with an impact rating of 3.43.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Bristol were adopted:

- Mental Health & Substance/Alcohol Abuse
- Access to Care
- Senior Support
- Overweight/Obesity

Goal Setting

Bristol Hospital's Implementation Strategy illustrates the hospital's specific programs and resources that will support ongoing efforts to address the identified community health priorities. This work will be supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, related objectives and strategies, and inventory of existing community assets and resources for each of the four priority areas are listed below.

1) Mental Health and Substance/Alcohol Abuse

Goal: Improve mental health and reduce substance and alcohol abuse to protect the health, safety, and quality of life of Bristol residents.

Objectives:

- Increase the number of points of access for referral to services
- Increase the proportion of adults with mental health disorders and/or substance/alcohol abuse who receive treatment
- Increase the proportion of children with mental health disorders and/or substance/alcohol abuse who receive treatment
- Increase mental health and substance/alcohol abuse screenings by primary care providers

Key Indicators:

- Number/Percentage of patients accessing mental health and/or substance/alcohol abuse services through the hospital Emergency Department
- Number/Percentage of Emergency Department patients presenting with mental health and/or substance/alcohol abuse issues who are transferred to inpatient or outpatient facilities
- Number/Percentage of patients successfully referred for mental health and/or substance/alcohol abuse services
- Number/Percentage of primary care providers providing mental health treatment or referrals
- Percentage of primary care providers screening for mental health and/or substance/alcohol abuse
- Number of mental health and/or substance/alcohol abuse community outreach programs conducted and number of participants
- Number/Percentage of individuals who utilize mental health and/or substance/alcohol services (inpatient and outpatient)

Bristol Hospital Strategies:

- Bristol Hospital, in collaboration with the Wheeler Clinic, provides a Youth Mental Health First Aid Instructor Certification training to provide practitioners, mental health professionals, and educators an understanding of the risk factors and warning signs mental health problems in youth and how to help youth in crisis or experiencing mental health and/or substance abuse challenges.
- The Bristol Hospital Emergency Department is a point of access for patients requiring behavioral health services. Patients who are identified as requiring services are directly referred to the behavioral health unit within the hospital.

Existing Community Assets to Address Need:

- Wheeler Clinic
- Department of Mental Health & Addiction Services
- Bristol Community Organization social services
- The North American Family Institute
- United Way 2-1-1 program

2) Access to Care

Goal: Improve equitable access to comprehensive, quality health services.

Objectives:

- Increase the proportion of persons with a usual primary care provider
- Increase the proportion of persons who have a specific source of ongoing care
- Increase the number of practicing primary care providers
- Increase the proportion of persons with health insurance

Key Indicators:

- Number/Percentage of patients who are admitted to the Emergency Department without a primary care provider and who are connected to a provider upon discharge
- Number/Percentage of patients who are admitted to the hospital without a primary care provider and who are connected to a provider upon discharge
- Emergency Department usage rate for non-emergency care
- Hospital admissions rates/Hospital readmission rates
- Cost savings for reduction in unnecessary Emergency Department usage and hospital readmission rates
- Number/Percentage of patients who attend scheduled appointments
- Primary care physician to resident ratio
- Number/Percentage of adults and children with health insurance

Bristol Hospital Strategies:

- Bristol Hospital provides a listing of available primary care and urgent care providers and their information to all patients entering the emergency department.
- Bristol Hospital promotes access to available physician groups in local communications (church bulletins, health fairs, community events, etc.).
- Bristol Hospital offers free classes entitled, "The Doctor Is In." In these classes, Bristol Hospital physicians host discussions on the causes, prevention, diagnosis, and

treatment of disorders like neck pain, lung disease, sleep apnea, cardiovascular disease, thyroid disease, etc.

Existing Community Assets to Address Need:

- United Way Prescription Discount Program
- Bristol Community Organization case management services
- The Navigator and Assister Outreach Program that will train assisters to educate community members about the health exchange and the options available to them through it

3) Senior Support

Goal: Improve the health, function, and quality of life of older adults.

Objectives:

- Increase the proportion of older adults with one or more chronic health conditions who report confidence in managing their conditions
- Reduce the proportion of older adults who have moderate to severe functional limitations
- Increase the number of practicing geriatric care providers
- Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities

Key Indicators:

- Number/Percentage of older adults with a chronic health condition who comply with recommended care techniques (i.e. medications, glucose-level monitoring, feet checks, etc.)
- Number/Percentage of older adults with a chronic health conditions who are admitted to the hospital and report a high-level of understanding of disease management upon discharge
- Number/Percentage of older adults who report having one or more activities of daily living limitations
- Geriatric care physician to senior resident ratio
- Number/Percentage of older adults who are counseled on suitable physical activities based on their physical and cognitive function and who engage in these activities

Bristol Hospital Strategies:

- Bristol Hospital hired a new geriatric physician within the community who will coordinate care among primary care physicians and specialists for seniors and offer free speaking engagements on senior topics throughout the community
- The Bristol Hospital Diabetes Center offers free educational presentations at senior centers regarding diabetes and nutrition.
- Bristol Hospital offers free balance screenings to seniors to evaluate their risk(s) of falling.
- Bristol Hospital Home Care and Hospice offer free blood pressure screenings and bereavement counseling to seniors.

- Bristol Hospital offers a free Alzheimer's support group.

Existing Community Assets to Address Need:

- United Way TRIAD program
- Bristol Senior Community Center
- Bristol Senior Services
- Connecticut Community Care, Inc.
- Bristol Community Organization Retired & Senior Volunteer Program

4) Overweight and Obesity

Goal: Promote health and reduce chronic disease through healthful diets and physical activity and maintenance of healthy body weights.

Objectives:

- Increase the proportion of primary care physicians who regularly measure the Body Mass Index (BMI) of their patients
- Increase the proportion of physician office visits that include counseling or education related to nutrition or weight
- Reduce the proportion of adults and children who are overweight or obese

Key Indicators:

- Number/Percentage of primary care physicians who report the BMI of their patients
- Number/Percentage of overweight and obese adults and children based on BMI
- Number of individuals participating in health education programs
- Number/Percentage of patients who report incorporating healthy lifestyles behaviors and techniques and/or increased knowledge of the components of healthy living/lifestyles
- Emergency Department/Hospital admissions/readmissions for chronic conditions

Bristol Hospital Strategies:

- Through the Parent and Child Center, Bristol Hospital offers the following programs free of charge:
  - Growing Healthy Families: Worth the Weight
  - Cooking Matters in the Store
  - Gardening for Health
  - Preparing Healthy, Toddler Friendly Snacks and Meals
- Through the Parent and Child Center, Bristol Hospital also offers a program entitled, Nutrition and Young Children. This program is offered at a reduced rate due to grant funding from the Petit Family Foundation and the Fuller & Myrtle Barnes Fund for Education.
- Bristol Hospital offers a bariatric weight loss surgery program and support group. The support group offers free seminars on topics like "Portion control," "Getting through the holidays," and "Eating on the run: Good choices."
- Registered Dieticians at Bristol Hospital offer the program, Nutrition and Cooking Fundamentals.

- Bristol Hospital provides an Overeaters Anonymous Support Group for individuals recovering from compulsive overeating.

Existing Community Assets to Address Need:

- Bristol/Burlington Health District
- United Way
- YMCA
- Private and public school systems

Approval from Governing Body

The Bristol Hospital Quality Improvement Committee of the Board of Directors met on September 12, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the Final Summary Report and the Implementation Strategy and provide the necessary resources and support to carry out the initiatives therein.

APPENDIX A: Secondary Data Profile References

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APPENDIX B: Prioritization Session Participants

Name	Organization
Paul Arbesman	Bristol Hospital Corporator
Linda Arbesman	Bristol Hospital Corporator
Len Banco, MD	Bristol Hospital Executive Leadership
Kurt Barwis	Bristol Hospital Executive Leadership
Jarre Betts	Main Street Community Foundation
Chris Boyle	Bristol Hospital
Ann Burch	Home Care
Pastor Tim Camerl	Beulah A.M.E.Zion church
Kimberly Carmelich	Bristol Hospital
Sara Castle	Imagine Nation Preschool Learning Center
Caren Chalfant	Home Care
Dennis Cleary	Wolcott Health Systems
Ken Cockayne	Bristol City Council
Karen Cornell	Bristol Hospital
Wendy DeAngelo	Wheeler Clinic
Jessica Dunn	Bristol Housing Authority
George Eighmy	Bristol Hospital Leadership Group
Karen Eisenhauer	Bristol Hospital
Gretchen E. Elder, MSW, LCSW	Continuum of Care, Inc
Jill Fitzgerlad	Office of Senator Jason Welch
Mary Lynn Gagnon	United Way of West Central Connecticut
Rev. Lisabeth Gustafson	Bristol Baptist Church
Rev. Bill Hawley	Plymouth Congregational Church
Pastor Beatrice Jones	Redeemers A.M.E.Zion church
Sheila Kempf	Bristol Hospital Leadership Group
Rev. Kristen J. Kleiman	The First Congregational Church United Church of Christ
Frank Kramer	Bristol City Council Candidate

John Leone	Bristol Hospital Board of Directors
Deanna Lia	Region 6 - Meriden, New Britain
Lexie Mangum	NAACP
Eileen M. McNulty, MSW	Bristol Youth Services
Thomas H. Morrow	Bristol Community Organization
Charles Motes, Jr., MS, MPH, RS	Bristol Burlington Health District
Marie O'Brien	Bristol Hospital Board of Directors
Lori Powell	St. Vincent Depaul Mission of Bristol, Inc
Susan Scully	Wolcott Chamber of Commerce
Jeffrey Shelton, MD	Bristol Hospital Medical Staff
Bethany Spada	Bristol Hospital
Susan Sadecki, MBA	Main Street Community Foundation
Linda Urbanski	Bristol Hospital Leadership Group

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 25: OPERATING EXPENSE WITHOUT BAD DEBT – CONNECTICUT HOSPITALS

Operating Expense Without Bad Debts per Equivalent Case - Adjusted by CMI

	Hospitals	FY 2010	FY 2011	FY 2012
1	Bristol Hospital	$ 5,864	$ 5,757	$ 5,575
2	The Charlotte Hungerford Hospital	$ 5,799	$ 5,700	$ 5,677
3	Windham Community Memorial Hospital	$ 6,145	$ 6,165	$ 5,681
4	Saint Mary's Hospital	$ 5,651	$ 5,791	$ 5,712
5	Manchester Memorial Hospital	$ 5,804	$ 5,775	$ 6,460
6	Day Kimball Hospital	$ 6,522	$ 7,278	$ 6,504
7	The William W. Backus Hospital	$ 6,519	$ 6,293	$ 6,632
8	Rockville General Hospital	$ 6,045	$ 6,837	$ 6,944
9	Johnson Memorial Hospital	$ 6,911	$ 6,753	$ 7,093
10	Lawrence & Memorial Hospital	$ 7,199	$ 7,399	$ 7,395
11	Midstate Medical Center	$ 7,483	$ 7,764	$ 7,651
12	Saint Francis Hospital and Medical Center	$ 7,109	$ 7,617	$ 7,780
13	The Hospital of Central Connecticut	$ 8,307	$ 8,019	$ 8,108
14	Griffin Hospital	$ 7,177	$ 8,298	$ 8,181
15	Middlesex Hospital	$ 7,976	$ 8,616	$ 8,208
16	Waterbury Hospital	$ 7,845	$ 8,652	$ 8,419
17	St. Vincent's Medical Center	$ 8,512	$ 8,334	$ 8,568
18	Milford Hospital	$ 7,530	$ 7,115	$ 8,647
19	Bridgeport Hospital	$ 8,168	$ 8,578	$ 8,783
20	New Milford Hospital	$ 7,951	$ 8,306	$ 9,229
21	The Stamford Hospital	$ 10,274	$ 9,417	$ 9,279
22	Danbury Hospital	$ 8,914	$ 9,155	$ 9,398
23	Greenwich Hospital	$ 8,470	$ 8,747	$ 9,512
24	Hartford Hospital	$ 9,965	$ 10,171	$ 10,341
25	Norwalk Hospital	$ 10,678	$ 10,258	$ 10,397
26	John Dempsey Hospital	$ 9,437	$ 9,863	$ 10,657
27	Yale-New Haven Hospital	$ 11,211	$ 11,497	$ 11,546
28	Connecticut Children's Medical Center	$ 12,448	$ 13,626	$ 13,305
29	Hospital of Saint Raphael	$ 9,060	$ 9,425	N/A
30	Connecticut Acute Care Hospitals Weighted Average	$ 8,760	$ 9,190	$ 9,094
	Simple Average of Hospital Values	$ 7,965	$ 8,180	$ 8,274
	Lowest	$ 5,651	$ 5,700	$ 5,575
	Median	$ 7,845	$ 8,298	$ 8,195
	Highest	$ 12,448	$ 13,626	$ 13,305

This analysis was produced from the data that resides in DataBank Model and OHCA Annual Report

Source: Certificate of Need Application Docket Number 14-31927-486 (OHCA) and 14-486-02 (AG) St. Mary's Health System, Inc. and Tenet Healthcare Corp. (Appendix V)

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 26: CURRICULUM VITAE - BHHCG

Kurt A. Barwis, FACHE

21 Lakewood Circle · Bristol, Connecticut 06010
Home Phone: (860) 585-7877 · Cell Phone (860) 940-7614
E-Mail: kbarwis@aol.com

Professional Experience

President & Chief Executive Officer
8/2006 to Current

Bristol Hospital and Health Care Group, Bristol, CT – Bristol Hospital is located in a highly competitive market with three large teaching tertiary care centers and one other community hospital, all within 20 miles. With combined revenue of $162.1 million, a government payer mix of 65% and primary service area market share of 49.6% - Bristol Hospital and Health Care Group consists of Bristol Hospital, a 134-bed private, not-for-profit community hospital; Bristol Hospital Multispecialty Group, a physician governed not-for-profit medical foundation comprised of 61 providers delivering 91,096 office visits in 2013; Ingraham Manor, a 128-bed, short-term rehabilitation and long-term care facility, and the Bristol Hospital Development Foundation.

For the fiscal year ending September 30, 2013, Bristol Hospital admitted 7,381 patients, provided care to 38,530 emergency patients and system wide employed approximately 1,600 people in the greater Bristol area. Bristol Hospital, Inc. reported excess of revenues over expenses of $2,301,326 and $2,190,756 in fiscal years ending 2012 and 2013 respectively. Bristol Hospital and Health Care Group reported excess of revenues over expenses of $1,200,365 and $1,195,440 in the fiscal years ending 2012 and 2013 respectively.

Job Responsibilities:
Reporting to a sixteen (16) member community Board of Directors, primary responsibilities include providing leadership, strategic guidance and the management direction necessary to fulfill the mission of the health system and its related entities.

Selected Accomplishments:

- Led the turnaround of the Hospital's financial performance. Reported gain (loss) from operations of ($9,440,732) and $6,486,253 in fiscal years ending September 30, 2006 and 2007 respectively. The years before and after my arrival. Successfully negotiated the terms of a forbearance agreement with Radian Asset Assurance as a result of the Hospital defaulting on its bond covenants in early 2007.

- Stabilized inpatient and emergency care center market share with more recent growth. Most recent two year primary service area growth, inpatient 47.3% to 49.6%, or 4.86% and emergency from 57.3% to 57.8%, or .87%

    - Patient satisfaction average mean scores for the same two year period improved inpatient 84.9% to 85.2%, or .35% and emergency from 78.9% to 85.7%, or 8.62%.
    - Launched a new comprehensive bariatric weight loss program in FY 2010, American College of Surgeons Level 1 Accredited Bariatric Center, "Full Approval" in October 2013 – Two year primary service area growth, 30.4% to 45.9%, or 51%. Two year secondary service area growth, 11.8% to 27%, or 128%.
    - Launched a new Center for Orthopedic and Spine Health program in 2013, recruiting a Director of Joint Replacement Surgery whom started in September of 2013. Major joint surgery primary service area market share for the first quarter grew from 3.6% to 32.6%, or 805%. We are on track to do 220 major joint cases in FY 2014, prior ten fiscal years the Hospital did not exceeded 130 in any individual year.

- Launched a new comprehensive outpatient Center for Geriatric Care in 2013, successfully recruited a fellowship trained director of the program.
- Opened the Beekley Center for Breast Health and Wellness in 2013, in part made possible through a one million dollar philanthropic donation. Successfully recruited a fellowship trained director of the program.

- Enhanced the organization wide culture of safety – daily safety huddles implemented and in place since November of 2012. All of the leadership team, 1006 plus staff and 114 physicians have completed a 3.5 hour patient safety class. I have personally taught five of these classes. We are in the process of implementing a Performance Management Decision Guide and are trending a 10% reduction in Serious Safety Events "SSEs" as well as a 10% increase the days between SSEs in FY 2014.

- Implemented a Lean Process Improvement Program during FY 2013 with 93% of organization wide executive team and directors completing Lean/Six Sigma training, with only four out of 51 missing for extraordinary circumstances. All of those trained participated in one of seven Lean/6 sigma teams and will qualify for Green Belt status in FY 2014.

- Participated in the Connecticut Community Care, Care Transition Program (CompPass2C) which was awarded funding by the Centers for Medicare and Medicaid Services to reduce Medicare readmissions for key diagnoses. During FY 2013 the readmission results were as follows:

  - Acute MI baseline 26.5%, FY 2013 16.2% a 39% reduction.
  - Heart Failure baseline 34.8%, FY 2013 20.8% a 40% reduction.
  - Pneumonia baseline 21.9%, FY 2013 16.8% a 23% reduction.

- Led the separation of our information technology systems from a shared service with St. Francis Hospital and Medical Center. Implemented all Meditech 6.0 clinical and financial modules on June 1 2011. On December 9, 2013, received HIMSS Analytics Stage 7 award, honoring hospitals operating in a paperless environment and representing best practices in implementing EMR. Bristol Hospital is the only Connecticut hospital to achieve this designation.

  - Implemented and hardwired evidenced based clinical best practice sepsis bundle in August 2013. Automated active surveillance demonstrates 76% of patients with the DRG for sepsis had the sepsis order set implemented.

- Bristol Hospital was accepted by the American Nurse Credentialing Center "ANCC", Magnet Recognition Program for the Magnet Journey. Having trended the required quarters of demonstrated improvement in our nursing quality indicators, our initial application will be submitted this summer. We have a fully formed, developed and engaged Nursing Professional Practice Council.

- In September 2013, the first primary care physician in our employed physician group earned the National Committee for Quality Assurance "NCQA," Level 3 Recognition, the highest level of Patient-Centered Medical Home "PCMH" recognition. By the end of FY 2014, all of our employed primary care practices will be NCQA, PCMH recognized.

- Successfully negotiated and finalized a Network Affiliation Agreement with the Yale New Haven Hospital in November of 2012. Our supply chain converted to the Yale System in 2011, this Network Agreement provided us with an $800,000 supply cost reduction in the first twelve months. In addition, we will shortly become part of the Yale System; Clinically Integrated Provider Network linking all of the employed physicians in our Medical Foundation and community based independent physicians through our Medical Foundation, for shared savings and risk based contracts. Care coordination and risk/population health infrastructure is being provided by Conifer Health Solutions, a Tenet Healthcare subsidiary.

- Led the Board and Medical Staff through an open and transparent strategic planning process in 2011 that concluded with a joint meeting of the Executive Committee of the Medical Staff and Board of Directors formally deciding to seek a partner. Engaged the investment banking firm Cain Brothers, with Market Launch of an Offering Memorandum during January of 2012. A Letter of Intent was executed with for-profit Vanguard Health Systems, in November of 2012. Subsequently, Vanguard Health Systems was acquired by Tenet Healthcare Corporation. The acquisition is pending/on hold awaiting the outcome of the State of Connecticut General Assembly's Proposed Hospital Conversion legislation.

Senior Vice President & Chief Operating Officer
10/2003 to 8/2006

St. Mary's Hospital of St. Mary's County, Leonardtown, MD – A 100-bed non-profit acute care hospital, with 904 employees, 7,527 admissions, 38,339 emergency visits and $78 million in net patient revenues for the fiscal year ending June 30, 2005.

Job Responsibilities:
Reporting to the President and Chief Executive Officer, primary responsibilities include the day-to-day leadership of all hospital, hospice and urgent care center operations, administrative and facility support services with the exception of finance, marketing and medical staff office.

Selected Accomplishments:

- Led a turnaround of the Hospital's financial performance. Prior to my arrival the Hospital experienced one of its worst financial years reporting operating income for the 2003 fiscal year of $3,334. In FY 2004, the Hospital ended 1.1 million ahead of its budget with total operating income of $2.3 million. In FY 2005, the budget was exceeded by 4.2 million with total operating income of $6.5 million. The Maryland Hospital Association Financial Condition Report dated June 2005 ranked St. Mary's Hospital's 8.2% FYE 2005 operating margin as the highest of all forty-nine Maryland hospitals. For the six months of FY 2006 ending December 2005, St. Mary's Hospital had a 12.44% operating margin and was $3.6 million ahead of its approved budget.

- Revised and re-energized the Hospital's Performance Improvement Program resulting in the Hospital achieving recognition for its clinical excellence by receiving the Medicare Excellence Award in 2004. In addition, the Hospital received the 2004 Press Ganey Compass Award for having the most significant improvement in emergency care patient satisfaction. Further, St. Mary's Hospital is frequently chosen by Delmarva (the Maryland Medicare Quality Improvement Organization) and the Maryland Patient Safety Center to participate in a variety of performance improvement collaboratives.

- Led the development of a comprehensive Information Systems Strategic Plan including detailed return-on-investment analysis which resulted in Board approval of a five-year, $12.1 million investment in advanced clinical information systems.

- As Chair of the Hospital's Joint Commission Task Force, led the Hospital through its first tracer methodology JCAHO survey. The survey was highly successful with the equivalent of no type one deficiencies being identified by the JCAHO.

- Successfully transitioned the Hospital's contracted adult Hospitalist program to an employed model resulting in increased medical staff utilization and an annual program cost reduction of approximately $300,000.

- Served as the lead negotiator in the creation of a new radiation oncology joint venture for the three Southern Maryland Hospitals (Calvert Memorial Hospital, Civista Medical Center and St. Mary's Hospital). The three Hospitals successfully purchased a 60% ownership interest in a radiation oncology center owned by Holy Cross Hospital and Adventist Health Services, and developed a second center in St. Mary's County.

- Consistently improved the Hospital's inpatient primary region market share from 68% for the twelve months ending September 2003, to 70.8% and 72.2%, in 2004 and 2005 respectively. For the six months of FY 2006 ending December 2005, St. Mary's Hospital admissions are running 25.38% above the actual admissions for the same period in FY 2005.

System Vice President – Managed Care and Business Development - *11/1998 to 10/2003*

Union Hospital of Cecil County, Elkton, MD – A 130-bed non-profit acute care hospital, with 864 employees, 8,655 admissions, 624 deliveries, 29,971 emergency room visits and $71 million in net patient revenues for the fiscal year ending June 30, 2003.

Job Responsibilities:

Responsible for significant aspects of Union Hospital's strategic and operational activities, including outreach programs, surgical services, anesthesia, marketing, public relations, customer service, physician recruitment, human resources, facilities, environmental services, dietary, security, rehabilitation services, respiratory care, occupational medicine, cancer program, sleep lab, and outpatient access. Accountable for the Health System's for-profit joint venture with Physiotherapy Associates, Inc. (a subsidiary of Stryker Corp.), that provides access to physical therapy services through 13 freestanding clinics. Direct reports include the Vice President of Human Resources, Vice President of Facilities and Planning, Director of Surgical Services, Director of Patient Access, physician executive Director of the Maternal and Infant's Center/Managing Director of Women's Health Associates, and all employed primary care physicians.

Selected Accomplishments:

- Staffed and actively participated in the Hospital's Medical Staff Development Committee. Developed and successfully implemented an employed physician recruitment "incubator model" to support the community need for primary and specialty care physicians as identified in the Hospital's Medical Staff Development Plan. Successfully recruited, developed and converted four solo primary care practices and a two-physician OB/GYN practice from hospital employment to private practice. Successfully recruited many other physicians through income guarantee arrangements, including internal medicine, pediatrics, general surgery, ENT, and gastroenterology.

- Developed and enhanced obstetrical and infant care services to respond to community need and improve market share, including the recruitment of an obstetrical physician executive and recruitment of a pediatrician with neonatal expertise and focus.

- Actively participated in the development of the Health System's Strategic Plan including identification, justification and coordination of a Master Facility Plan. Lead the Master Facility Plan creative development with architects, consultants and engineering firms resulting in Board approval of a $24 million facility expansion project. Negotiated and executed all contracts related to the expansion project. Designed and recruited a facility management team to oversee the implementation of the Master Facility Plan and expansion project.

- As the Hospital's Cancer Program Administrator, lead the application and preparation process for a successful Community Cancer Program national accreditation by the Commission on Cancer of the American College of Surgeons. Developed a business plan for the creation of a Breast Health Center, achieved Board approval for the Center, established a community Board to provide input into the strategic development of the Center, developed the physical layout and recruited the Center's Medical Director.

- Led the successful reorganization of the Health System's for-profit physician Management Services Organization, both corporately and operationally, resulting in improved physician relations, growth and strengthened financial performance. Developed a cohesive management team and instilled pride and confidence in the MSO's services. Subsequent to the reorganization, the number of physicians contracting for either billing or full practice management services grew from 29 to 45, or by 55%.

Vice President Finance and Chief Financial Officer
5/1996 to 11/1998 (Part-time 1/1993 - 4/1998)

Renaissance Technology, Inc., Newtown, PA - Renaissance was an early-stage company that developed and marketed the IQ™ System, an FDA approved non-invasive cardiac diagnostic monitoring device.

Job Responsibilities:
Responsible for strategic financial management including finance, accounting, auditing, taxation, revenue cycle, purchasing, inventory, management information systems, investor due diligence and banking/investor reporting.

Selected Accomplishments:

- Successfully negotiated the terms of a $5.5 million private investment firm preferred stock purchase.

- Successfully engaged PricewaterhouseCoopers as the company's public accountants, prepared the company's financial statements, books and records for Security and Exchange Commission initial public offering (IPO) look back review.

- Developed extensive financial modeling tools utilized for strategy development, valuing opportunity spaces, assessing value capture arrangements and performing sensitivity analysis on key business drivers and design choices.

- Improved sales efficiency and effectiveness through the development of selling economic models and sales targeting tools that integrated HCIA, NIP and MedPar databases.

Previous Positions

- **General Manager - 5/1994 to 6/1996, Eastern Rail Systems, Inc., Newtown, PA**
  Eastern Rail is a small privately held niche manufacturer of high quality medical equipment rail, medical gas manifolds and related organizational products.
- **Chief Operating Officer - 7/1989 to 5/1994, Eastern Anesthesia, Inc., Newtown, PA**
  Eastern Anesthesia was a small privately held Mid-Atlantic medical products distribution, medical construction and biomedical engineering company.
- **Director, Patient Services Resources - 7/1986 to 7/1989, Jeanes Hospital, Philadelphia, PA**
  Jeanes Hospital is a 245-bed non-profit acute care hospital.
- **Auditor, Reimbursement Specialist, Consultant - 1/1984 to 7/1986, Coopers and Lybrand, Philadelphia, PA**.
- **Patient Transport, Outpatient Billing Clerk and General Accountant - 7/1978 to 12/1983, Jeanes Hospital, Philadelphia, PA.**

Education

1997 – La Salle University
Philadelphia, PA USA
M.B.A., Beta Gamma Sigma
MAJOR: Finance

1983 – The Wharton School of the University of Pennsylvania
Philadelphia, PA USA
B.A., Cum Laude
MAJOR: Accounting

Specialized Training, Licensure, Certification

Certified Public Accountant, Pennsylvania, November 17, 1999 (license is currently expired)
Fellow of the American College of Healthcare Executives
Registered Lobbyist, Connecticut

Professional & Civic Affiliations

American College of Healthcare Executives.

2012- Director, Qualidigm – The Medicare Quality Improvement Organization for the State of Connecticut
2009- 2013 Director, Vice President, President Elect, Connecticut Association of Healthcare Executives
2014- President – Connecticut Association of Healthcare Executives
2008- Director & CEO Forum Chairman for the State of Connecticut (last 3 years), Connecticut Hospital Association
2007- Committee Member, Finance Committee of the Connecticut Hospital Association
2007- Director and Co-Chair of the Governmental Affairs Committee, Bristol Chamber of Commerce
2005-2006 Strategic Planning Committee Member, Southern Maryland Navy Alliance
2004-2006 Director, Second Vice President and Chairman of the Governmental Affairs Committee, St. Mary's County Chamber of Commerce
2004-2006 Committee Member, Community Hospital Connection, Maryland Hospital Association
2004-2006 Committee Member, Legislative Policy Group, Maryland Hospital Association
2002-2003 Director, Elkton Alliance (Development and revitalization of downtown Elkton jointly funded by Union Hospital and the Town of Elkton)
2001-2003 Director, Triangle Health Alliance, Inc. (Union Hospital's physician MSO)
2000 Served on the Citizen's Budget Review Committee, Cecil County Government
1999-2003 Director, Treasurer, North East Little League Board of Directors (Enjoyed coaching and managing, accomplishments include the 2003 Maryland Junior Boys State Champions and 2001 Maryland District 5 Major Boys All-Star Champions)
1999-2003 Director, President of the Board of Directors (2003), Cecil County Chamber of Commerce Chairman of the Bylaws Committee and member of the Legislative Policy Committee

Personal

Married, to my wife Jean for thirty years, we have two children. Sean lives in Newtown, MA and is a clinical informatics specialist at Metro-West and St. Vincent Hospitals. Kimberly lives in Manhattan, NY and is a marketing specialist for News Corporation of America.

George W. Eighmy, CPA, FHFMA

7 Chauncey Dr • Oxford CT. 06478

Mobile: (860) 881-9596 • Office: (860) 585-3575 • Email: geighmy@comcast.net

Vice President of Finance, Chief Financial Officer

Healthcare Financial Executive with 25 years of progressive experience. Skilled in accounting, financial reporting, financial analysis, business intelligence, strategic planning, budgeting, reimbursement, revenue cycle, physician practice management, managed care and treasury functions. Demonstrated ability to develop and lead key strategies, manage professional staff, collaborate with peers, use strategic thought, and achieve goals.

Work Experience

9/2011 – present — **BRISTOL HOSPITAL AND HEALTH CARE GROUP** — **Bristol CT**

$165 million network with a 154 bed acute care hospital, 128 bed long term care facility, 60 physician and provider medical foundation, Emergency Medical Ambulance Service and a Charitable foundation.

Vice President of Finance, Chief Financial Officer: Responsible for 8 Direct Reports, 120 Employees encompassing accounting, finance, informational technology, strategic planning, budgeting, managed care contracting, reimbursement, treasury, decision support, revenue cycle, health information management, investments, supply chain, physician practice financial management, risk management, and clinical informatics.

12/2008 – 9/2011 — **ORANGE REGIONAL MEDICAL CENTER•** — **Middletown NY**

$350 million, 353bed, hospital employing 2,400 healthcare professionals and more than 600 doctors have privileges. ORMC is a Member of Greater Hudson Valley Health Network.

Administrative Director of Finance: Reported directly to the C.F.O. responsible for 4 directors in the following areas. General accounting, financial analysis and reporting, long range financial planning, treasury, cash management, budgeting, reimbursement, accounts payable, G.A.A.P. compliance, cost accounting, internal control, tax exempt bond compliance, taxes, external and regulatory reporting, payroll.

2000 - 2008 — **GREATER WATERBURY HEALTH NETWORK •** — **Waterbury CT.**

$250 million healthcare network with a 360 bed Teaching Hospital and Subsidiaries including; Imaging and Diagnostic Companies, Physician Groups, A Physician Management Company, Rehabilitation Service Company, and a Visiting Nurse Company.

2005-2008 **Administrative Director of Finance • Promoted, Responsibilities added** - Managed care, revenue cycle improvement, revenue compliance. Performance oversight of the Medical Records and Patient Accounting areas.

2000-2005 **Director of Finance** Reported directly to the C.F.O. Directs a professional staff of 16. General accounting, corporate accounting, G.A.A.P. compliance, cost accounting, accounts payable, treasury, cash management, internal control, tax exempt bond compliance, taxes, external and regulatory reporting, financial analysis and reporting,

long range financial planning, budgeting, reimbursement, managed care, revenue cycle improvement, revenue compliance, and financial information systems.

1993- 2000 **SAINT RAPHAEL HEALTH SYSTEM •** **New Haven CT**

$400 million healthcare network with a 511 bed Teaching Hospital. The Saint Raphael Health System is the holding company for the Hospital and several subsidiary companies.

1998- 2000 **Director Financial Planning and Decision Support** – Reported directly to the CFO/Vice President of Finance. Managed seven professional employees. Areas of responsibility include; long range financial planning, cost accounting, and budgets. Implemented, and managed the functions and activities related to the Hospital's Decision Support Systems. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

1996- 1998 **Manager of Financial Planning** – Reported to Director of Financial Planning. Managed three financial analysts. Areas of responsibility include; budget, cost accounting, and decision support systems. Planned, tested and implemented the introduction and rollout of new applications, products, and modules, related to Decision Support Systems.

1996- 1998 **Senior Managed Care Analyst** – Responsible for analysis and implementation of all commercial and managed care contracts, including rate setting and analysis. Supported contract negotiations. Discovered and received $1.8 million in payment recoveries from insurers. Designed a capitation reporting and analysis package.

1993- 1996 **Reimbursement Analyst** – Prepared all governmental cost reports and compliance filings. Regulatory and contractual allowance analysis.

1991- 1993 **ALR & CO •** **West Haven CT**

Senior Accountant – Audit, tax, and reimbursement issues for nursing homes and home health agencies, small to mid size companies and higher wealth individuals.

1989 – 1991 **PRICEWATERHOUSE •** **Stamford CT.**

Auditor – Perform audits, prepare financial statements, and analyze internal control systems for "Fortune 500" corporations and large partnerships.

Education

Marist College, Poughkeepsie NY • Currently Enrolled - Expected Graduation Spring 2015
Masters of Business Administration**.**

Quinnipiac University, Hamden CT • 1989
Bachelor of Science – Accounting.

University of Connecticut, Storrs CT • 1981
Bachelor of Science – Marketing.

Current Association Memberships

-American College of Healthcare Executives
-Healthcare Financial Managers Association (Fellow)

BALA SHANMUGAM MD, MRCP

2 Hendrickson Lane, Unionville, CT 06085
Tel: (203) 243 4801
Email: bala9999@hotmail.com

EDUCATION

Medical Degree *1994 - 2000*
Kasturba Medical College, Manipal, India

Membership of The Royal College of Physicians *2003*
London, UK

RESIDENCY TRAINING

Infectious Diseases Fellowship *Jul 2006 - Jun 2008*
Baylor College of Medicine, Houston, TX

Internal Medicine Residency *Jul 2003 - Jun 2006*
Yale University (Bridgeport) Internal Medicine Program
Bridgeport Hospital, Bridgeport, CT

Internal Medicine Residency *Feb 2002 - Jun 2003*
The Great Western Hospital, Swindon, UK

Emergency Medicine Residency *Aug 2001 - Jan 2002*
Princess Margaret Hospital, Swindon, UK

Internal Medicine Internship *Feb 2001 - Jul 2001*
Princess Margaret Hospital, Swindon, UK

AWARDS

Distinction for excellence in clinical sciences *May 1999*
Distinction for excellence in basic sciences *May 1996*

RESEARCH WORK

Original Article
Nicolasora N, Pannala R, Mountantanakis S, Shanmugan B, Amoateng-Adjepong Y, Manthous CA. Hospitalized patients want to choose whether to receive life-sustaining therapies. *J Hosp Med 2006;* 1:161-167

LICENSURE AND CERTIFICATION

Board Certification, American Board of Internal Medicine *2006*
ACLS Certification *June 2005*
Full Registration with The General Medical Council, UK *Feb 2001 - Sep 2003*

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Member, Infectious Disea,ses Society of America *Aug 2006 to date*
Associate, American College of Physicians *Aug 2003 to date*
Member, British Medical Association *Feb 2001 - Jan 2004*

SHEILA GLENNON KEMPF

20 Eighth Avenue 203 494 5805 (c)
Milford, CT 06460 sgkempf@aol.com

EDUCATION

PhD HEALTH CARE ADMINISTRATION, January, 2011
Capella University, Minneapolis, MN

MASTERS IN NURSING EDUCATION, May 1978
Teachers College, Columbia University, New York, NY

BACHELOR OF SCIENCE IN NURSING, May 1974
Villanova University, Villanova, PA

Finance & Accounting for Non-financial Managers, 1994
Wharton School of Business, Univ of Penn

Medical Marketing Executive Management Program, 1993
UCLA

PROFESSIONAL EXPERIENCE

BRISTOL HOSPITAL & HEALTHCARE SYSTEM, (154 beds) Oct, 2010 to present
Sr. Vice President, Patient Care Services/ Chief Nursing Officer
Senior executive in 154 bed hospital with responsibility for nursing, pharmacy, radiology, diagnostic services, perioperative center, oncology center, home care/ hospice, 128 bed nursing home/rehab center, Bristol EMS, and numerous outpatient services. Successfully developed bariatric service, orthopedic service, sleep center and breast health center.

ST. VINCENT'S MEDICAL CENTER, (400 beds). Bridgeport, CT July, 2007- Oct, 2010
Vice President, Cardiovascular Services
As a member of the senior executive team, responsible for $150M revenue, $32M expenses, and 300 staff. Units include inpatient telemetry, post interventional and open-heart units, outpatient services cardiac catheterization and electrophysiology labs, cardiac rehab, diagnostic testing, and CHF program. Responsible for hospital wide patient flow from admission through discharge.

WESTCHESTER MEDICAL CENTER, Valhalla, NY 2006 – 2007
Staff Nurse, Intensive Care Unit
1000 bed Level 1 Trauma Center, seven bed ICU with liver transplant program, major surgical service, bariatric, and trauma. Successfully transitioned back into Nursing.

HONEYWELL, INC, Minneapolis, MN 2003 – 2006
$29B diversified global corporation
Vice President, Global Strategic Marketing (2005 – 2006)
$800M global sensor business, managed six Marketing and Communications professionals.

Vice President & General Manager, Medical & Commercial Sensor Business 2003 – 2005
Responsible for $135M Global P&L for sensors used in medical products. Managed 2400 employees, three global manufacturing plants, remote and local engineering teams, and all support functions.

B. BRAUN MEDICAL INC., Bethlehem, PA 2001 – 2003
Vice President, Marketing
Responsible for domestic $500M diverse medical products business including intravenous solutions and sets, Infusion pumps, anesthesia epidural and spinal products, IV safety catheters, and pharmaceuticals. Managed 45 marketing and clinical education staff in three locations.

CHROMATICS COLOR SCIENCES, MEDICAL DIVISION, New York, NY 1998 – 2001
Vice President, General Manager
Start up company. Managed launch of infant jaundice diagnostic product, including development of clinical education program, marketing and sales strategies. Technology sold.

COROMETRICS MEDICAL SYSTEMS *(acquired by GE*), Wallingford, CT 1996 – 1998
Vice President, Marketing
Managed worldwide P&L for $60M fetal monitoring & neonatal cardiac monitoring products, including marketing, clinical education, customer service & sales support.

NELLCOR INC, *(acquired by TYCO)*, Pleasanton, CA 1991 – 1996
Director of Marketing, Sensors and Accessories Division
Managed Marketing & Clinical program for pulse oximetry sensor products ($200M).

FENEM, INC., *(acquired by Nellcor)* New York, NY 1988 – 1990
Vice President, Marketing
Start up company end–tidal CO2 product for intubation. Company successfully sold in two years. Coordinated product clinical research studies resulting in 23 publications.

QUANTIFIED SIGNAL IMAGING, INC., Toronto, Canada 1985 – 1988
Vice President, Operations and Sales Support
As founding partner, responsible for overall start-up functions of this neurological capital equipment company including regulatory, sales, clinical education, marketing and R&D.

NORWALK HOSPITAL *(400 beds)*, Norwalk, CT 1982 – 1985
Director of Nursing, Critical Care
Member of Nursing Executive Team. Managed Medical-Surgical ICU, CCU, Cardiac Telemetry, Respiratory Step-Down, 100 employees, seven Managers, $4M budget. Created and Chaired Equipment Standardization Committee streamlining purchased products with 10% - 15% reduction in Critical Care operating expenses.

MOUNT SINAI MEDICAL CENTER *(1200 beds*), New York, NY 1980 – 1982
Nursing Supervisor, Neurosurgery
32 bed Neurosurgical Unit and Weekend Administrative coverage for 256 bed Surgical Division. Division Editor for Nursing Newsletter and representative on Clinical Guidelines committee.

- Developed program for staffing based on acuity, upgrading clinical skills, and general management of unit increasing nursing retention rate from 22% to 70% in two years.

MONTEFIORE MEDICAL CENTER *(900 beds)*, New York, NY 1978 – 1980
Clinical Instructor, Critical Care Nursing
Clinical Education for 200 nurses in Critical Care Division (Medical Surgical ICU, Cardiothoracic, CCU, Pulmonary Step-down and Emergency Dept).

- Developed & executed Critical Care Advanced Course, Critical Care new graduate orientation, and Leadership Workshop for experienced nurses.
- Created ICU Patient Acuity program, Redesigned ICU documentation system.
- Instituted ACLS Course for NYC Dept of Emergency Medical Services as Advanced Life Support Instructor-Trainer

MOUNT SINAI MEDICAL CENTER 1974-1978
Senior Clinical Nurse (Nurse Manager) 17 bed Surg-Resp ICU (1976 – 1978)
Staff Nurse, Surgical-Respiratory ICU (1974 – 1976)

CERTIFICATIONS/LICENSURE/HONORS

SCCM - Advanced Fundamentals of Critical Care, 2006
Six Sigma Green Belt, 2004
Advanced Life Support, Instructor, 1978 – 1988
CCRN – AACN Certification Corporation; 1979 – 1990
Certificate of Appreciation, NYC Health & Hospitals Corp, 1980
Sigma Theta Tau, National Nursing Honor Society, Elected 1973
Registered Nurse, New York State and Connecticut , Current

PROFESSIONAL MEMBERSHIPS

American College Healthcare Executives
American Organization Nurse Executive
CT-ONE

NON-PROFIT EXPERIENCE

Coalition for the Homeless, Marin County, CA, 1992-1996
Academy Mount Saint Ursula, Board of Trustees, Bronx, NY 1996- 2002
St Gabriel School, Board of Trustees, Milford, CT 2003- 2010

PUBLICATIONS

Glennon Kempf, S. (2011). *Caring leadership attributes of RN CEOs and the relationship to patient satisfaction and quality* (Doctoral dissertation, Capella University). 123 pages

Glennon, S. A., (1992). "Mechanical Ventilation" in *AACN Clinical Reference for Critical Care Nurses*. 2nd Ed, Mc Graw-Hill, New York.

Matus, V. W. & Glennon, S. A., (1992). Respiratory Disorders, in *AACN Clinical Reference for Critical Care Nurses. 2nd Ed,* Mc Graw-Hill, New York.

Glennon, S. A. (1985). "Adult Respiratory Distress Syndrome. Video for Hospital Satellite Network.

Glennon, S. A., (1984), Preventing Acute Parenchumal Disorders in *Respiratory Dissorders,* Intermed Communications, 9:130-145.

Glennon, S. A. (1981). Toward Safer inflation of the Swan Ganz Balloon. Consultation STAT, *RN Magazine*, 44(12).

Glennon, S. A., Matus, V. W., Bryan-Brown, C. W. (1981). Respiratory Disorders. In *AACN Clinical Reference for Critical Care Nurses,* Kinney, M, et al Editors. McGraw-Hill:New York, 485-542.

PRESENTATIONS:

May 2014 *Keynote Speech*, **Quinnipiac University**, College of Nursing Pinning Ceremony.

May, 2014 *Safety Starts with Me: Principles of High Reliability*. Nursing Faculty Development, **Quinnipiac University**, College of Nursing.

Feb 2013 *Healthcare Reform and its Effect on Nursing* BSN Leadership program, **Quinnipiac University** College of Nursing,

Mar, 2013 *Using Business Planning to Your Advantage*. Pre conference Workshop. **American Organization of Nurse Executives.** Denver, CO.

Oct, 2012 *Value Based Purchasing: Its effect on Nursing. Using cost benefit analysis to justify resources.* Presentation to Doctor of Nursing Practice program, **Quinnipiac University, College of Nursing.**

Apr, 1985 *Home Care Hospital Care: Respiratory Management*. **Mt Sinai School of Continuing Education**

May, 1983 *Respiratory Management in ARDS*. **AACN – Fairfield County Chapter**

May, 1982 *Management of Acute Respiratory Failure*. **CCRN Preparation Course, AACN- New Jersey Chapter**

May, 1982 *Assessing Effectivenes of Mechanical Ventilation*
New Developments: Pulmonary Care
AACN National Teaching Institute, Anaheim CA.

Mar, 1982 *Hemodynamic Monitoring & Mechanical Assistance*
Direct & Derived Cardiac Parameters
AACN and American Edwards, New Haven CT

Apr, 1981 *Brainstem Evoked Potentials – Clinical Uses*
American Association of Neuroscience Nurse, Annual Meeting, Boston MA

May, 1980 *Hemodynamic Monitoring, Waveform Analysis, Cardiac Output, Clinical Uses*.
AACN National Teaching Institute, Atlanta GA

April, 1980 *Respiratory Management of the Neurosurgical Patient*
American Association of Neuroscience Nurses Annual Meeting, New York,

JEANINE F. RECKDENWALD, BA, MSHRD, SPHR

EDUCATION

MASTERS OF SCIENCE IN HUMAN RESOURCE DEVELOPMENT
Villanova University, Philadelphia, PA

BACHELOR OF ARTS IN PSYCHOLOGY
Western Connecticut St. University, Danbury, CT

Green Belt Certification

EXPERIENCE

September 2008 – Present

Bristol Hospital and Health Care Group

Vice President, Human Resources & Support Services (December 2010 - present)

Reporting directly to the President and CEO, serves as member of the Executive Leadership Team with overall responsibility for Human Resources and system wide operational responsibility for ancillary services including engineering, maintenance, food & nutrition services, bio medical engineering, safety & security and environmental services.

Assistant Vice President, Human Resources (September 2008 – December 2010)

Reporting directly to President and CEO had overall HR responsibility for the hospital system, which includes a 147-bed community hospital, long term care facility, physician practice group and an ambulance business.

February 2005 – October 2007

SCHOLASTIC INC., New York, NY

Director, Human Resources (October 2006 – October 2007)

Requested by Senior Vice President of Human Resources to assume all HR responsibility for the company's revenue generating divisions and multi-site locations: Scholastic Education, Classroom and Libraries Group, Book Clubs, Trade, Media and Entertainment, International, and eScholastic.

Senior Manager, Training and Development (February 2005 – October 2006)

Planned, organized, scheduled and oversaw ongoing Training and Development projects for NY/NJ/CT field offices.

August 1999 – February 2005

BUCCINI ASSOCIATES, Ossining, NY

Senior Consultant

Consulted with a wide range of client companies on behalf of a highly regarded boutique Human Resources consulting firm. Selected clients include Scholastic Inc, Richmond

Children's Center, ECHN, Burke Rehabilitation Hospital and Western Connecticut State University.

August 1999 – December 2001

WESTERN CONNECTICUT STATE UNIVERSITY, Danbury, CT

Academic Advisor

Provided counseling to students with undeclared majors, academic performance issues and general needs for assistance in navigating and managing their University experience.

October 1982 – January 1987

PEPPERIDGE FARM, INC., Norwalk, CT

Manager, Employee Relations

Held numerous positions of increasing responsibility including Benefits Assistant, Personnel Assistant, Supervisor of Staffing and Employee Relations and Manager, Employment in addition to Manager of Employee Relations.

PROFESSIONAL MEMBERSHIPS

- Society of Human Resource Professionals, SPHR
- American College of Health Care Executives, Member
- Executive Baard of the Bristol Education Foundation, Member

Curriculum Vitae

Kenneth K. Rhee, MD
PO Box 977
Bristol Hospital
Bristol, CT 06011-0977
Phone (860) 585-3528
Fax (860) 585-3768
Cell (860) 478-9751
Email krhee@bristolhospital.org

Work Experience

Chief Medical Officer and Senior Vice President of Bristol Hospital since 12/2013.

Kenneth K. Rhee, MD, PC, Bristol, CT. Employed as a full-time Ob/Gyn physician and owner from 10/99 to 12/2013.

Greater Bristol Ob/Gyn, PC, Bristol, CT. Employed as a full-time Ob/Gyn physician from 12/96 to 9/99.

Tunxis Ob/Gyn, PC. Bristol, CT. Employed as a full-time Ob/Gyn physician from 7/91 to 12/96.

Education

Residency in Obstetrics and Gynecology at St. Vincent's Medical Center in New York, N.Y. from 7/87 to 6/91.

University of Illinois College of Medicine, Chicago, Illinois. Received Doctorate of Medicine in 6/87.

University of Illinois at Urbana- Champaign, Illinois. Received Bachelor of Science in Biology in 5/83. Graduated with High Distinction for achievements in academics and research.

Honors

Certified Diplomat of the American Board of Obstetrics and Gynecology, Inc. since 11/93.

Fellow of the American College of Obstetrics and Gynecology since 3/95.

Chairman of Medical Review Committee of the Hartford County Medical Association from 1998 to 2000.

Physician Representative to the Executive Council of the Medical Staff and the Board of Directors of Bristol Hospital from 11/2008 to 1/2010.

President of the Medical Staff at Bristol Hospital from 1/2010 to 12/2013

Personal

Born and raised in Seoul, Korea until the age of eleven. Became U.S. citizen in 1980. Grew up in Glen Ellyn, a suburb of Chicago, Illinois. Presbyterian family background with strong belief in education and work ethics. Middle child of three children – all of them physicians. Married with two daughters. Main interests outside of medicine are skiing, hiking, music and reading.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 27: CURRICULUM VITAE - TENET

Erik G. Wexler

Seasoned leader with more than 20 years of broad executive experience spanning clinical and non-clinical operations, business development, physician recruitment, community outreach and fund raising. Distinguished record in clinical quality, physician relations, customer service, organizational development, strategy and financial outcomes. Known for having a strong passion for excellence, integrity and accomplishment, while maintaining values of caring, respect and teamwork.

PROFESSIONAL EXPERIENCE

TENET HEALTHCARE – New England Region, Southborough, Massachusetts

President **October 2013 – Present**

VANGUARD HEALTH SYSTEMS – New England Region, Southborough, Massachusetts

President **April 2012 – October 2013**

SAINT VINCENT HOSPITAL / VANGUARD HEALTH, Worcester, Massachusetts

President & Chief Executive Officer **July 2011 – October 2013**

Vanguard Health Systems (NTSE: VHS), Nashville, TN, is a Fortune 500 company with over $6.5 billion of net revenue in acute, post acute and ambulatory services. With 28 hospitals located in five regions across the country, the company has over 44,000 employees. The New England Region currently has three hospitals located in Worcester, Framingham and Natick Massachusetts. Two additional hospital acquisitions, Waterbury Hospital and Bristol Hospital, are nearing completion in Connecticut. With these acquisitions complete, the region will have over $1.5 billion of net revenue and 8,000 employees. Mr. Wexler initiated an affiliation with Tufts Medical Center, Boston, MA upon his appointment to the presidency of the New England Region and is in the final stages of completing that transaction. In addition, as part of the Accountable Care Act, the first COOP Insurance program in Massachusetts, MinuteMan Health, was formed under his leadership in conjunction with Tufts Medical Center and will launch in January 2014.

Saint Vincent Hospital is a 348 bed tertiary teaching hospital with annual net operating revenue of $400 million, 2,000 employees and 1200 members of the medical staff. It is the flagship hospital of for-profit Vanguard Health, Nashville, TN. The Hospital has 120 residents in various specialties and maintains independent residency programs and an academic affiliation with the University of Massachusetts School of Medicine. The hospital was recognized as a Thompson Reuters Top 100 Hospital in 2011, 2012, and 2013 and a Thompson Reuters Top 50 Hospital for Cardiovascular Care in 2012 and 2013. Major service lines for the institution include the Center for Musculoskeletal Services, Center for Cancer Care, and the Center for Heart & Vascular Services. As one of the first hospitals in Massachusetts to perform open heart surgery, the institution is known for outstanding clinical outcomes in cardiovascular care. Recognized as a "high value" provider, high efficiency and superb quality/safety measures exceed state benchmarks allowing the institution to be a "Tier 1" provider with every commercial payer in the market.

NORTHWEST HOSPITAL & LIFEBRIDGE HEALTH, Baltimore, Maryland

President & COO, Northwest Hospital & Senior Vice President, LifeBridge Health **Jan. 2004 – June 2011**

LifeBridge Health, "A" rated by Standard and Poors and "A2" by Moody's, is the fourth largest health system in Maryland with over $1.2 billion in net revenue, three hospitals with a total of more than 800 beds, long-term care, a nursing home, 7,000 employees, 200 employed physicians and teaching affiliation with Johns Hopkins School of Medicine. This fully integrated system has shared clinical programs in Brain and Spine, Oncology, Behavioral Health, and Cardiovascular Care. As Senior Vice President, and one of four top executives of LifeBridge Health, leads Northwest Hospital as its President and has corporate oversight of the following divisions: Capital Improvements (construction design / development and real estate), facility services (engineering, clinical engineering, protective services, transportation, and environmental services), Marketing/Outreach, and the Wellness Division (for-profit entities: LifeBridge Health & Fitness and LifeBridge Health Physical Therapy / Sports Medicine).

Northwest Hospital is a 246 bed general acute care hospital with net operating revenue of $220 million, 1,700 employees and 700 members of the medical staff. Inpatient services include medical/surgical, oncology, heart care, intermediate care, intensive care, sub-acute, psychiatry, and a fully dedicated hospice unit. Other major services include Advanced Minimally Invasive Surgery, Wound Care / HBOT, Cancer Care, Breast and Bone Health, Cardiac Rehabilitation, Pain Management, Women's Wellness, Sleep Disorders, and Physical Rehabilitation.

MIDSTATE MEDICAL CENTER, Meriden, Connecticut

Executive Vice President & Chief Operating Officer **Jan. 2000 - Jan 2004**

MidState Medical Center, a wholly-owned subsidiary of Hartford Health Care, is a 140 bed community acute care hospital with net operating revenue of approximately $140 million, 1,000 employees and 300 members of the medical staff. Reporting to the President & CEO, responsible for the operations of the hospital's two campuses, with direct oversight of clinical and non-clinical departments, managed care contracting, strategic business development, physician relations, and community outreach. Also served as Vice Chairman of the Hospital's Physician-Hospital Organization and responsible for oversight of two subsidiaries; The MidState VNA & Hospice and Meriden Imaging Partners.

GREATER WATERBURY HEALTH NETWORK & WATERBURY HOSPITAL, Waterbury, CT

Vice President, Business Development & Community Relations **1996 - 2000**
Vice President, Development and Community Relations **1992 - 1996**

Waterbury Hospital is a 350-bed teaching hospital (affiliated with the Yale University School of Medicine). Reporting to the President & C.E.O. of the health system, had oversight of various Hospital departments and 6 subsidiaries while responsible for coordinating the growth, development and marketing of the Corporation. Initial responsibilities included philanthropic support, marketing and the overall improvement of public opinion, government relations, and market share growth. Oversaw all external relations departments, including the Office of Development, Community Health Services, Volunteers, Department of Public Affairs, and Telecommunications. Also served as the Chairman of the Board of Access Rehab Centers and Home Care Professionals.

UNIVERSITY OF HARTFORD, West Hartford, CT

Director of Development / Executive Director, The Associates **1989-1992**
Associate Director of Development **1988-1989**
Presidential Administrative Intern and Development Officer **1985-1987**

As Director, responsible for overseeing all annual and capital fund raising activities, development-related public affairs, Institutional Advancement budgets, and philanthropic information systems. Total fund raising exceeded $7 million per year. In addition, managed the The Associates which consisted of 400 Hartford-area businesses that contribute to the University and sponsor two major fund raising events per year.

EDUCATION

Master of Business Administration
University of Hartford
West Hartford, CT 06117

Bachelor of Arts in Sociology
University of Hartford
West Hartford, CT 06117

AFFILIATIONS

United Way of Central Massachusetts, Worcester, MA
Campaign Cabinet, 2012 to 2013
Campaign Chairman 2013 to present
The Schwartz Foundation, Boston, MA
Annual Dinner Chairman, 2013
Anna Maria College, Paxton, MA
Member, Board of Trustees, 2012 - present
American Hospital Association, Regional Policy Board
2008 to 2011
Maryland Hospital Association, Women & Minority Business Task Force
Chairman, 2008 to 2011
Maryland Hospital Association, Committee on Government Relations
Member, 2005 to 2011

Stevenson University, Owings Mills, Maryland
Member, President's Advisory Board, 2010 - 2011
Howard S. Brown School of Business, Stevenson University
Member, Advisory Board, 2009 to 2011
The George Washington University School of Medicine & Health Sciences
Executive-In-Residence, 2007 to present
Baltimore County Work Force Development
Director, 2005 to 2011
Healthcare Workforce Sub-committee, Baltimore County Work Force Development
Chairman, 2007 to 2011
Owings Mills Corporate Round Table
Chairman, 2008 to 2011
Workers' Compensation Commission Advisory Board, State of Connecticut
Director, 1997 – 2004
Governor's Prevention Partnership
Vice Chairman, 1998 - 2004
Director, 1995 - 2004
The United Way of Central Naugatuck Valley
Chairman, 2001 – 2004
Vice Chairman, 1999 – 2001
Director, 1994 - 2004
Connecticut Hospital Association, Committee on Government
Member, 1997 - 2004
Meriden Chamber of Commerce
Director, 2001 – 2004
BankBoston Regional Advisory Board
Director, 1995 - 2000
Mattatuck Museum
Director, 1998 - 2000
The Salvation Army
Secretary and Director, 1995 - 1998

Mark R. Montoney, MD, MBA

[redacted]

PROFESSIONAL PROFILE

Results-oriented senior physician executive with proven experience in clinical quality performance improvement, patient safety, clinical resource management, research and innovation, medical education and physician leadership development. Demonstrated record of program development, driving successful change in large, complex healthcare organizations, resulting in local, state and national hospital system recognition. Ability to work effectively with a senior leadership team in developing strategy and connecting to a broad medical staff and other clinicians, across multiple clinical sites to implement and achieve organizational goals.

PROFESSIONAL EXPERIENCE

CHIEF MEDICAL OFFICER **2013 TO PRESENT**
Tenet Healthcare Corporation, Dallas, Texas

Started position with Tenet Healthcare in October 2013 as Corporate Chief Medical Officer. System-wide role and responsibilities include leadership of patient safety, clinical risk management, clinical quality improvement, organizational accreditation, pharmacy and clinical research. Tenet is an integrated healthcare delivery system operating 80 acute care hospitals and over 190 ambulatory facilities across the United States.

EXECUTIVE VICE PRESIDENT AND CHIEF MEDICAL OFFICER **2009 TO 2013**
Vanguard Health Systems, Nashville, Tennessee

Assumed position in January, 2009, with responsibilities including system leadership for clinical quality improvement, patient safety, physician alignment strategies and value-based health care delivery. Member of the executive leadership team with direct reporting to the President and Chief Operating Officer. Vanguard Health Systems operates 28 acute care hospitals and multiple ambulatory facilities across 5 states.

Program development and key achievements:

- Established the Vanguard Quality Council that served to drive organizational performance in clinical core measures, readmission rates, hospital acquired conditions and severity adjusted mortality. Statistically significant improvement noted in all indicators including top quartile national performance for core measures.

- Led the high reliability organization initiative resulting in a reduction of serious safety events by 76% from baseline over a 3 year period. In addition, central line infection rates decreased by 13% and hospital acquired pressure ulcers were reduced by 49% over this same time period. Realized a 20% reduction in annual excess malpractice insurance premium with cost savings of $1.1 M, due to improvement in patient safety.

- Developed a system-wide clinical council in 12 services lines focused on reduction of unnecessary clinical variation. This resulted in measureable improvement in clinical outcomes with lower cost, highlighted by $5.2 M cost savings in critical care in fiscal year 2013.

- Established a telemedicine model in several markets through the eICU in San Antonio, Texas, and tele-radiology services in Phoenix, Chicago and Detroit. The latter initiative enabled

significant reductions in clinical study turnaround times, staffing, subsides, 3rd party vendor expenses and improved quality with cumulative economic value of $7.2M in fiscal year 2013.

- Advanced palliative care model across Vanguard markets, highlighted by an ICU – Palliative Care project that resulted in a 6 fold increase in change of goals of care and code status with subsequent increase in hospice referrals. Also, a 30% relative reduction in 30 day readmissions was realized in this patient population.

- Established hospitalist services in all markets, highlighted by $3.3 M in cost savings generated through a system level agreement with Sound Physicians in Phoenix and San Antonio.

- Established Physician Leadership Councils in all Vanguard facilities enabling strategic planning development between hospital executives and medical staff leadership.

- Provided system clinical leadership in the establishment of five regional CMS ACO initiatives, including a Pioneer ACO in Detroit. The Pioneer ACO included 224 participating physicians and 18,455 attributed beneficiaries; the Detroit effort was one of the 13 pioneers with a successful first year that including cost savings of $8 M.

SYSTEM VICE PRESIDENT AND CHIEF MEDICAL OFFICER **2005 TO 2008**
OhioHealth Corporation, Columbus, Ohio

Appointed in July 2005 to provide leadership of system-wide clinical quality, patient safety, clinical resource utilization, clinical research and innovation, medical education and physician leadership development for OhioHealth Corporation, a $ 2 billion net revenue healthcare system, headquartered in Columbus, Ohio. OhioHealth is the leading provider of healthcare in the central Ohio region and is comprised of 8 member hospitals, 8 affiliate hospitals and 19 ambulatory sites. Member of the senior leadership team with direct reporting to the system Chief Operating Officer.

Program development and key achievements:

- Established the OhioHealth patient safety program, resulting in a reduction in adverse drug events of 57% and a reduction of sentinel events of greater than 50% over three years. This has contributed to system excess malpractice insurance premium reductions of 23% over the past two years.
- Led performance improvement in clinical quality, as assessed through CMS hospital core measures and HCAHPS, resulting in OhioHealth being ranked 10th in the nation among large hospital systems. (Source: *The Joint Commission Journal on Quality and Patient Safety,* June 2008)
- Responsible for launch of the OhioHealth Research and Innovation Institute, which supports over 500 ongoing clinical trials and established a technology transfer office which supports OhioHealth clinicians in the commercialization and product development process.
- Established the Clinical Excellence Committee, dedicated to driving evidence based, best practice standards across central Ohio campuses, resulting in cost savings of $4.1 million in fiscal year 2008.
- Redesigned the medical staff peer review structure in central Ohio hospitals with significant process improvement consistent with The Joint Commission standards.
- Established the OhioHealth Physician Leadership Academy, a leadership development program for physicians, consisting of a core curriculum and individual coaching modules. In the past two years, over 200 physicians have attended the Academy quarterly education sessions.
- Member of the senior leadership team responsible for launching Dublin Methodist Hospital in January 2008, a new 100 bed state-of-the-art digital acute care facility, which employs a full suite of integrated advanced clinical information technology applications, resulting in Dublin

being named one of the "most wired" hospitals in America. Currently involved with standardizing these applications across the other system hospitals.
- Executive leadership of the OhioHealth eICU program which provides centralized monitoring of 109 critical care beds across the system and has contributed to a 10.5% reduction in severity adjusted mortality rate in the ICU population.
- Development of an evolving state-wide stroke network program, employing telemedicine technology in a hub and spoke model to facilitate transfer and treatment of appropriate stroke patients to Riverside Methodist Hospital.
- Executive leadership of the OhioHealth Breast Health Institute, a system program, that has resulted in a 10 day reduction in days to detection (screening to final pathology) for breast tumor patients.
- Launched the OhioHealth Clinical Documentation Improvement program in the Fall 2007 in response to the CMS MS-DRG program. This initiative has led to a $1.9 million favorable financial impact through the end of fiscal year 2008 by improved physician documentation, as it relates to the new coding system.
- Launched a value-based PHO contracting model in collaboration with leaders from a 2,000 physician IPA (Medical Group of Ohio), aligning a physician pay for quality program with an OhioHealth associate health and wellness initiative. This has resulted in an increase in performance on preventive screening measures for the 16,000 OhioHealth employees and dependents and initiated efforts to achieve clinical integration.

VICE PRESIDENT, QUALITY AND CLINICAL SUPPORT **2000 TO 2005**
RIVERSIDE METHODIST HOSPITAL, COLUMBUS, OHIO

Primary responsibilities included the development of the Institute for Clinical Excellence at Riverside, committed to supporting best practice models of patient care with attention to clinical quality, patient safety, and clinical care coordination. Riverside is the 985 bed tertiary care flagship hospital of the OhioHealth system. Departmental responsibilities included quality outcomes management, clinical-fiscal informatics, and pain management and palliative care.

Program development and key achievements
- Established 109 pre-printed orders and 29 clinical pathways, standardizing patient care upon evidence-based medicine.
- Founded and chaired the Riverside Patient Safety Council and established Patient Safety Rounds and Work Plan as organizational priorities. Reduced adverse drug events due to opioids by greater than 40%.
- Established the Pain Management & Palliative Care Service resulting in hospital cost savings of approximately $434,000 over 18 months and improvement of pain scores better than target.
- Provided support for clinical process improvement initiatives resulting in achievement of better than target performance in 10 of 14 OhioHealth clinical quality indicators in fiscal year 2004.
- Founded the Hospital Medicine Council in April 2002 which evolved to the Medicine Clinical Operations Council. Established Co-Director Hospital Medicine positions, focused on establishing infrastructure support for hospitalist physicians. This enabled process improvement initiatives resulting in improved efficiency and quality of patient care.
- Served the Medical Executive Committee Redesign and Implementation Team, involved in creating a new infrastructure to support a more effective medical staff function and integration with hospital operations.
- Executive sponsor for launching the Riverside New Clinical Technology Committee; a physician driven forum designed to evaluate cutting edge technology in a clinically and fiscally responsible manner.
- Reduced managed care denials rate from 4.1% to 2.0% over two years through process improvement initiatives, resulting in a favorable net revenue impact of $5.3 million.

VICE PRESIDENT, PHYSICIAN CONSULTING **1999 TO 2000**
OHIOHEALTH SYSTEM SERVICES, COLUMBUS, OHIO

Developed and maintained clinical documentation programs in participating OhioHealth hospitals, resulting in documentation improvements to support accurate DRG coding. Developed documentation templates relevant to outpatient clinical areas that resulted in improved coding and compliance. Led the Diabetes Disease Management Team at OhioHealth Group, the system PHO, in improving the quality of care of diabetic patients across the continuum of care and developed a Diabetes Management Program that was utilized across the system. Provided consultative support in the development of documentation programs in hospitals in Pensacola, Florida, Columbia, South Carolina and Cleveland, Ohio.

ASSOCIATE MEDICAL DIRECTOR, PRIMARY CARE **1998 TO 1999**
GRANT MEDICAL CENTER/RIVERSIDE METHODIST HOSPITAL, COLUMBUS, OHIO

Provided physician support for the clinical documentation management program, resulting in a cross campus improvement in documentation and DRG coding. Served as Chairman for the Primary Care Clinical Process Improvement Committee on both campuses, involved in process improvement initiatives including implementation of a discharge communication process. Supported peer review processes in primary care at both the Grant and Riverside campuses.

REGIONAL PHYSICIAN MANAGER **1996 TO 1998**
BIRMAN & ASSOCIATES, INC., COOKEVILLE, TENNESSEE

Part-time position involved with leadership of medical staff at Knox Community Hospital (Mt. Vernon, Ohio) in regard to chart documentation as applied to DRG coding and hospital reimbursement. Developed a documentation educational program for the staff, resulting in improvement in the hospital case mix index. This contributed to Knox Community Hospital being ranked in the Solucient top 100 hospitals in the United States in 1997. Developed a physician utilization profile program for the KCH medical staff that was implemented in 1998.

MEDICAL DIRECTOR **1989 TO 1999**
HEALTHCARE CENTER AT THE FORUM RETIREMENT COMMUNITY, COLUMBUS, OHIO

Founding Medical Director of a 60 bed extended care facility. Developed policies and procedures for the facility while providing direction for the nursing and ancillary staff, as well as delivering direct patient care. Provided direction in the development of a 25 bed special care unit for patients with Alzheimer's disease.

ATTENDING PHYSICIAN
KNIGHTSBRIDGE INTERNAL MEDICINE & CARDIOLOGY INC., COLUMBUS, OHIO **1999 TO 2000**

Part-time member of a thriving group practice, delivering office-based care to general internal medicine and geriatric patients.

SENIOR PARTNER **1986 TO 1999**
CENTRAL OHIO MEDICINE, COLUMBUS, OHIO

Managing partner in a high volume internal medicine practice, directing 18 full-time employees. Developed a large practice with a focus on geriatric patients. Involved in the integration of the practice into Central Ohio Primary Care, Inc., (COPC), a 180-member primary care group. Served COPC as Chairman of the Medical Records Committee.

CLINICAL TEACHING EXPERIENCE

Teaching Faculty, Riverside Methodist Hospital Community Medicine 2000 to 2005

Clinical Assistant Professor of Medicine, the Ohio State University College of Medicine
1987 to 1996

Teaching Attending, Riverside Methodist Hospital Internal Medicine Residency Program
1985 to 1996

ADDITIONAL EXPERIENCE

- Adjunct Faculty Supervising PhD candidate, Central Michigan University, Mount Pleasant, Michigan – 2004
- MBA Coach, Franklin University, Columbus, Ohio 2004
- Examiner, Malcolm Baldrige National Quality Award (MBNQA) 2002 – 2003
- Examiner, Ohio Award for Excellence (OAE) 2001 – 2002
- Intermountain Health Care, Advanced Training Program in Healthcare Delivery Improvement, Salt Lake City, Utah – 2002
- OhioHealth Facilitator, The Quality Advantage Training Program (TQA) 2001 – 2002

EDUCATION / TRAINING

Regent University, Virginia Beach, Virginia 1997 to 2001
M.B.A.

Riverside Methodist Hospital, Columbus, Ohio 1982 to 1986
Internal Medicine Resident (1982 – 1985)
Chief Medical Resident (1985 – 1986)

University of Cincinnati College of Medicine, Cincinnati, Ohio 1978 to 1982
M.D.

Case Western Reserve University, Cleveland, Ohio 1974 to 1978
B.A., Psychology – Graduated Magna Cum Laude, elected to Phi Beta Kappa

BOARD CERTIFICATION

Recertified, Geriatric Medicine	2004
Certified, Added Qualifications in Geriatric Medicine	1994
Certified, American Board of Internal Medicine	1985

BOARD AND PROFESSIONAL AFFILIATIONS

- Past Board Chairman, Ohio Partnership for Excellence (State Quality Program)
- Member, American College of Physician Executives
- Past Board Member, Tennessee Center for Performance Excellence (State Quality Program)
- Board Member, Percuvision, Inc.
- Chair, Quality Committee, Federation of American Hospitals
- Member, Clinical Advisory Committee, Heritage Innovation Fund

HAROLD (TRIP) PILGRIM
[redacted] [redacted]

PROFILE

Proven health care business professional with executive and senior management experience in a variety of corporate and service capacities. Strong leadership, sales and marketing skills leveraged in roles that include operations, integrated delivery systems, management consulting, mergers and acquisitions, co-founder of a technology start-up, and health care investment banking.

EMPLOYMENT HISTORY

Tenet Healthcare — Dallas, TX

Tenet Healthcare Corporation, a leading healthcare services company, through its subsidiaries operates 80 hospitals, 193 outpatient centers and Conifer Health Solutions, a leader in business process solutions for healthcare providers serving more than 700 hospital and other clients nationwide.

October 2013 to present
Senior Vice President, Development
Oversees the company's strategic transactions, including acquisitions, divestitures and market development

Vanguard Health System — Nashville, TN

Vanguard Health Systems owns 28 general acute care hospitals in Illinois, Arizona, Texas, Michigan and Massachusetts.

Employed by Vanguard since **October 2001:**

July 2009 to September 2013
Chief Development Officer
Responsible for managing the operations of the mergers & acquisition function of the company.

- Company has grown from 15 to 28 hospitals and revenues have increased from $3 billion to $6.5 billion pro forma since 2009.
- Acquisitions include the Detroit Medical Center (8 hospitals, $2 billion in revenue), Valley Baptist Health System (2 hospitals, $400 million in revenue), and two hospitals out of the Resurrection System in Chicago.

Baptist Health System — San Antonio, TX

Baptist Health System is owned by Vanguard Health Systems

October 2005 through June 2009
President and Chief Executive Officer
Responsible for leading this urban based, comprehensive delivery system:

- 5 general acute care hospitals
- 1,700 licensed beds
- $950 million in net revenue
- 6,300 employees
- 7 OP imaging centers
- 2,400 medical staff membership

January 2003 to October 2005
Regional Vice President – Business Development
Responsible for new business development, marketing, communications, government relations, public relations,

physician recruiting, and community outreach.

October 2001 to December 2002
Vice President – Development/Investor Relations
Key member of corporate team responsible for acquisitions in new markets and for business development in existing Vanguard markets. Also initiated Vanguard's Investor Relations function, subsequent to the issuance of $300 million in public debt in July 2001.

VelocityHealth Capital — Nashville, TN

January 2001 to Oct 2001
VHC operates a specialty investment bank that assists companies with creating, building, and funding promising health care and technology opportunities. Advisory services include private equity assistance, merger & acquisitions, strategic planning and capital formation consulting.

Chief Development Officer
Responsibilities include client acquisition, developing strategic partnerships, and managing private equity, M&A and consulting engagements.

Highlights
- Established partnership with Communitech, Inc. in first month of employment.
- Coordinated Co-Sponsorship of the 10th Annual Innovative Drug Conference
- Successfully engaged early stage health care CRM company on retainer plus success fee in first month of employment.

Phyve Corporation (*www.phyve.com*) — Nashville, TN

Formerly Digital Medical Systems, Inc.
Formerly Vger Technologies, Inc.
April 1997 to August 2000

An eHealth enabler, Phyve Corporation provides technology solutions and services required by healthcare provider and payer organizations to enable the secure and efficient delivery and exchange of healthcare applications and information via the Internet.

Co-Founder & Senior Vice President, Corporate Development
Primary responsibilities included developing new business opportunities, financing activities, corporate strategic planning, financial oversight and establishing and managing strategic relationships.

Highlights
- Key point individual on early strategic sales efforts
- Raised $26 million in private equity capital over three years
- Negotiated two exclusive strategic partnership agreements
- Participant in CHIM working group to identify Federal lobbying initiatives for increased information technology development in health care
- Presented corporate overview at the annual Warburg Dillon Read 2000 equity conference
- Led the acquisition of Digital Medical Systems by Vger Technologies
- Recruited CFO, Corporate Controller, VP-Marketing/Product Development & VP-Emerging Technologies
- Co-coordinated company's participation at the annual HIMSS exhibitor conferences in 1999 and 2000
- Active participant in CHIM, HIMSS and the Nashville Health Care Council

OrNda Healthcorp — Nashville, TN

(Acquired by Tenet Health Systems 1/97)
OrNda Healthcorp, a $400 million revenue company at the time of its inception in 1992, was a $3 billion hospital management company at the time of the sale to Tenet.

Assistant Vice President, Acquisitions and Development
January 1996 to April 1997
Primary job functions included lead generation and development, proposal writing and managing the transaction processes to closing relating to:

- Hospital acquisitions
- Physician joint ventures
- Physician group practice development

Highlights

- Part of acquisition team that grew the Company from 46 to 55 hospitals
- Negotiated partnerships with large not-for-profit hospital system in Texas
- Gave multiple presentations to various medical staffs on Stark II and the benefits of group practice formation
- Member of the Public Relations and Legislative sub-committees of the Federation of American Health Systems

Director of Investor Relations
September 1995 to May 1996
Responsible for managing the investor relations function, including:

- Annual report production
- Quarterly earnings releases
- Press releases
- Communicating with sell-side and buy-side analysts
- Presentations for road shows and investor conferences
- Secondary common stock offering in November 1995

Highlights

- Part of road show team for $200 million secondary stock offering
- Led development of first corporate web site
- Active member of the National Investor Relations Institute

The Medstat Group/Inforum Nashville, TN
February 1995 to September 1995

Product Director
Responsible for designing and developing new market-focused decision support/information products for healthcare providers and managed care organizations, including:
-- Concept development
-- Managing the product development process
-- Led product teams of software applications engineers, programmers and other development staff

Ernst & Young LLP Birmingham, AL
August 1986 to February 1995

Manager, South Region Health Care Consulting Group
Managed and conducted consulting engagements including strategic planning, mergers and acquisitions, financial feasibility studies, software training, and third-party reimbursement assistance for a variety of healthcare clients throughout the southeastern United States. Additionally, gave recruiting presentations and conducted on-campus interviews for the region.

Current or Past Industry Affiliations, Community Organizations & Other Appointments

Current Board Chair, Baptist Health System, San Antonio, TX
Current member, Board of Directors, The Federation of American Hospitals
Current Chair, Legislative Sub-committee, The Federation of American Hospitals
Co-Chair, Valley Baptist Health System
Council on Policy Development, Texas Hospital Association, 2008-2009
Board member, Texas Hospital Association, 2008-2009
Former Chair and current board member, Greater San Antonio Hospital Council

Member, Governor Rick Perry's Task Force on Medicaid Reform, 2005
Member, Texas Hospital Association's Special Committee on Medicaid
Member, Greater San Antonio Chamber of Commerce's Health Care and Bioscience Subcommittee
Past Chair and, Public Relations Subcommittee of Federation of American Hospital Systems
Former Trustee, VIA Metropolitan Transit Authority

EDUCATION

Masters of Business Administration, 1986
Concentrations in *Finance* and *Marketing*
Vanderbilt University, Nashville, Tennessee

Bachelor of Arts, Political Science, 1983
Vanderbilt University, Nashville, Tennessee

CURRICULUM VITAE

KELVIN A. BAGGETT, M.D., M.P.H., M.B.A., F.A.C.P., F.A.C.H.E.

OFFICE ADDRESS

[redacted]

TELEPHONE NUMBERS

[redacted]

HOME ADDRESS

[redacted]

CERTIFICATIONS

Diplomat, American Board of Internal Medicine

MEDICAL LICENSURE

2002-present North Carolina
2006-present Tennessee

EDUCATION

1989-1993	B.S.	The University of North Carolina at Chapel Hill Chapel Hill, North Carolina
1994-1999	M.D.	East Carolina University School of Medicine Greenville, North Carolina
2002-2006	M.B.A.	The Fuqua School of Business Duke University, Certification in Health Sector Management Durham, North Carolina (Leave of Absence from 2003-2005 to complete fellowship training)
2003-2005	M.P.H.	The Johns Hopkins Bloomberg School of Public Health Baltimore, Maryland

POSTGRADUATE TRAINING

1999-2000 Intern, Department of Medicine, Yale University School of Medicine, Yale-New Haven Hospital
2000-2002 Resident, Department of Medicine, Yale University School of Medicine, Yale-New Haven Hospital
2002-2003 Fellow, Department of Medicine, Duke University Medical Center
2003-2005 Fellow, The Robert Wood Johnson Clinical Scholars Program, Department of Medicine, The Johns Hopkins Hospital
2005-2006 Fellow, Department of Medicine, Duke University Medical Center
2005-2006 Fellow, Duke Clinical Research Institute, Duke University Medical Center

PROFESSIONAL EXPERIENCE

Summer 2002 Consultant, Waterbury Hospital Health Center

2006-2007 Strategic Business Consultant, Hospital Corporation of America (HCA)
Developed market strategies for service line and product line development
Developed outpatient service line definitions based on diagnostic codes in order to quantify ambulatory volumes and financial performance
Provided strategic guidance on ED and OR efficiency
Worked with physicians to create and implement strategies for improved alignment
Supported assessments related to clinical asset liquidation

2007-2009 Consulting Associate, Duke University Medical Center

2007-2009 Chief Operating Officer & VP, Clinical Strategy, Clinical Services Group (HCA)
Responsible for the development and execution of clinical strategies for the enterprise, which spanned more than 160 acute care hospitals, more than 125 outpatient centers and physician practices
Led senior executives in the development and execution of clinical strategies that pertained to clinical performance improvement, provider certification, patient safety, physician engagement, commercial payor contract negotiation and the implementation of a system wide electronic health record
Served as the central clinical point of contact for all national managed care agreements that included clinical performance, risk based arrangements
Provided daily leadership of approximately 100 employees
Led in the development of management tools to evaluate and improve clinical performance
Development of the HCA "Getting to Green" Strategy that resulted in improvements in aggregate core measure clinical performance
Led the development and execution of a strategy to improve the patient's experience (HCAHPS)

2009-2012 Chief Medical Officer & SVP of Clinical Quality, Tenet Healthcare
Responsible for improving the quality, safety and efficiency of care provided throughout the system, which includes 49 acute care hospitals and more than 90 outpatient centers
Created the Clinical Innovation Award to foster and recognize significant advancements in the delivery of patient care

Oversight of the system wide implementation of an electronic health record
Liaison between the health care system and medical community

2012-2013 Chief Medical Officer & SVP of Clinical Operations, Tenet Healthcare
Responsible for setting the system wide clinical strategic priorities
Responsible for improving the quality, safety, efficiency and value of care provided throughout the system, which includes 49 acute care hospitals and more than 120 outpatient centers
Responsible for identifying opportunities to reduce clinical variability and waste and for designing and executing strategies to capture that opportunity
Responsible for clinical integration across the full continuum of care
Oversight of the system wide implementation of an electronic health record
Liaison between the health care system and medical community

2013 - Present Chief Clinical Officer & SVP of Clinical Operations, Tenet Healthcare
Member of the nine member Executive Leadership Team
Accountability for clinical operations performance, which includes quality, safety, service and reducing clinical waste and variability within 78 acute care hospitals, 170 outpatient centers and 5 health plans
Serve in a co-leadership model with the President, Hospital Operations (who also has responsibility for ambulatory care and physician services) to design and execute strategies that enhance Tenet's position as a leading value based provider of care
Create a clinical leadership infrastructure for physicians, Tenet health plans, hospitals and outpatient facilities
Provide leadership for clinical technology implementation, integration of care across the continuum and care innovation, including oversight for how and where we position Tenet strategically and how we deploy capital
Serve as a key external representative and spokesperson for the system
Direct reports include: Tenet's Chief Medical Officer (Acute Care), Chief Medical Officer, Physician Resources, Chief Medical Officer, Health Plans, National Director of Clinical Performance Excellence, Vice President, Care Experience
Co-Chair of the following Executive Committees: Analytics; Performance Excellence

AWARDS, HONORS, AND MEMBERSHIPS IN HONORARY SOCIETIES

1989-1993 Merit scholarship, Herbert Lehman Scholarship Award,
NAACP Legal Defense and Educational Fund
1991-1993 Merit scholarship, The Wellman Corporation
1994-1999 North Carolina Board of Governors Medical Scholarship
(Full scholarship covering medical school tuition, fees and annual stipend)
2002-2003 Merit Scholarship, The Fuqua School of Business
2003-2005 Health Disparities Scholar, National Center on Minority Health Disparities,
National Institutes of Health
2004-2005 Merit scholarship, The Johns Hopkins Bloomberg School of Public Health

2005-2006	Merit scholarship, The Fuqua School of Business
2011	Awarded as "40 under 40" honoree – Dallas Business Journal
	Awarded as Minority Business Leader – Dallas Business Journal
2012	Top 25 Minority Executives – Modern Healthcare
	Awarded as Top 50 Most Influential Physician Executives – Modern Healthcare #6
2012	Trailblazer Alumni Award – Fuqua School of Business, Duke University
2012	Acknowledged in the 100 Hospital and Health Systems CMO's-Becker's Healthcare
2013	Awarded as Top 50 Most Influential Physician Executives – Modern Healthcare #18
2014	Awarded as Top 25 Minority Executives in Healthcare – Modern Healthcare
2014	Top Blacks in Healthcare – BlackDoctor.org

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

2000-Present	Member, American College of Physicians
2006-Present	Fellow, American College of Physicians
2011-Present	Member, American College of Healthcare Executives
2012-Present	Fellow, American College of Healthcare Executives

RESEARCH ACTIVITIES AND INTERESTS

2002-Present Utilizing operational techniques to evaluate and improve clinical performance
Reducing variation in the secondary prevention of cardiovascular disease
The value and impact of Pay for Performance programs
Structuring Health Care Delivery to Promote Quality
Mentors/Co-Investigators: Drs. Neil R. Powe, Haya Rubin, Roger Blumenthal (Johns Hopkins University School of Medicine) and Kevin Schulman (Duke University School of Medicine)

PUBLICATIONS

2000	Baggett K., Grande K, Hsu S: Tender Nodules on the Legs of a Cardiac Transplant Recipient. Archives of Dermatology. 136: 791-796, 2000.
2007	Glickman S., Baggett K., Krubert C., Peterson E., Shulman K.: Promoting Quality: The Health-Care Organization from a Management Perspective. International Journal for Quality in Health Care. 19(6):341-348, 2007.
2009	Perlin, J., Baggett, K. Government, Health and System Transformation. In W.B. Rouse and D.A. Cortese (Eds.) Engineering the System of Healthcare Delivery (pp.415-434). IOS Press.

RESEARCH SUPPORT

Secondary Prevention of Cardiovascular Disease – A Resident Physician Barrier Survey
Principal Investigator: Haya R. Rubin, M.D., PhD.
Research Supported by the Robert Wood Johnson Foundation, Robert Wood Johnson Clinical Scholars Program Grant #047945
Role: Co-Investigator

National Institutes of Health, National Center on Minority Health Disparities, Health Disparities Scholar, (Grant # L32-MD 000442), June 2003- June 2005.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 28: CURRICULUM VITAE - YNHHS

GAYLE L. CAPOZZALO, FACHE

ADDRESS

Office: Yale New Haven Health
789 Howard Avenue
New Haven, CT 06519
(203) 688-2605

Home: 110 Lower Road
Guilford, CT 06437
(203) 453-9758

HEALTH SERVICES EXPERIENCE

1997-Present **Executive Vice President / Chief Strategy Officer. Yale New Haven Health System (YNHHS),** New Haven, Connecticut. Major regional multi-hospital system in Connecticut with assets and annual revenues in excess of $3.4 billion. Report to YNHHS President/CEO; a member of the System senior leadership team consisting of: The President/CEO of YNHHS/YNHH, Chief Operating Officer of Yale-New Haven Hospital the CEOs of Greenwich Hospital and Bridgeport Hospital and Chief Financial Officer of YNHHS. Responsible for leading and directing the growth, diversification, clinical and operational integration, strategy, innovation, markenting, communication, government relations, business development performance management and annual performance measurement process for the System.

Direct shared and corporate services, facilities, real estate and plant engineering, supply chain, leadership development, training and education, corporate compliance and privacy, strategy, government relations, emergency preparedness, grant development, marketing, communication and business development.

Member of the following YNHHS Boards of Directors:

- Greenwich Hospital and related corporations, Greenwich, CT
- Bridgeport Hospital and related corporations, Bridgeport, CT
- Ambulatory Services Corporation – provides radiology, surgery and recovery services in southern CT
- Shoreline Surgical Corporation – a joint venture with physicians (chair)
- Physician practice foundation for physician employment (chair)
- Continuing Services -- long term care and rehabilitation

Accomplishments:

- Led team to purchase assets of 500 bed academic medical center
- Established, developed and led non-profit physician foundation to employ physicians across the System
- Created clinical integrated physician network
- Created System to System strategic alliances
- Led the transition of a $40 million Ambulatory Services Corporation through turnaround and restructuring.
- Expanded System by adding hospitals, ambulatory centers and physician practices
- Created and directed the development of statewide service lines in Oncology, Cardiology and Pediatrics
- Facilitated the establishment and strategic direction of Yale-New Haven Hospital service lines in eight specialties
- Led the development of a full-service 80,000 square foot ambulatory care center, including ambulatory surgery, radiation therapy, satellite emergency services, laboratory services, physician offices and radiology services.
- Instrumental in the design and implementation of a Systemwide performance management strategy and structure to enhance clinical quality, patient safety and

operations performance. The strategy included the development of a performance management infrastructure, full-time performance management coordinators, an electronic balanced scorecard to provide managers with timely, detailed information to monitor, communicate and improve performance and an Institute for Excellence to develop leadership for the future. Responsible for directing and managing the effort.

- Created and direct the Institute for Excellence, Systemwide management development, succession planning and corporate leadership, training and education function.
- Led the integration and standardization of clinical service lines (heart, cancer, pediatrics, neurosciences) and administrative services across the System.
- Led the development of a Systemwide three-year standardization project that standardized 365 operational and administrative processes across the System.
- Created and manage Systemwide Office of Emergency Preparedness, Systemwide corporate compliance, Systemwide compensation and benefit management, and Systemwide strategic planning process to enhance collaboration, improve performance and create economies of scale.

1993 – 1997 **Senior Vice President. Organizational Development. Sisters of Charity of the Incarnate Word Health Care System (SCH),** Houston, Texas. Major Catholic multi-hospital system (14th largest health care system - $2 billion in assets) (3932 acute beds, 620 long-term care and residential beds and numerous health businesses and programs). Report to System President/CEO; a member of the senior leadership team of the System; interact regularly with System governance and member of Board Committees. Responsible for leading and directing Systemwide Leadership Development, System Organizational Development, Growth and Diversification of the Ministry, System Managed Care, System Human Resources, System Continuous Quality Improvement and Quality Assurance, System Strategic Planning and System Communications functions including staffs. Responsible for leading the System efforts in the development and operation of integrated community health networks (ICHN) and mergers and acquisitions.

Accomplishments:

- Instrumental in the design and implementation of a regionalization strategy for (SCH), health care centers and services in Southeast Texas.
- Instrumental in the design and implementation of a regionalization strategy for (SCH), health care centers and services in the state of Louisiana.
- Led the transition of the Sisters of Charity of the Incarnate Word to co-sponsorship of Catholic Healthcare West, including the transition of two (SCH), health care centers to CHW.
- Led the development, implementation and governance of a statewide joint venture triple option insurance product in Louisiana with Ochsner Clinic. The HMO grew from 70,000 to 130,000 lives in one year.
- Instrumental in the development, implementation and governance of a $100 million joint venture health network in Houston, Texas between (SCH), and Memorial Health System, the largest not for profit health care system in Houston. The $100 million health network includes physician practices, group practices, management services organization, clinics, home health, wellness services, and a PPO, TPA, HMO and indemnity insurance product
- Led the development, implementation and management of numerous physician hospital organizations (PHO) in Louisiana and Texas.
- Led the development, implementation, governance and management of a Louisiana statewide MSO, employing 75 physicians and managing 35 physician practices.
- Led the development, implementation, governance and management of a risk

insurance joint venture with Arkansas Blue Cross/Blue Shield.

- Directed a 25,000 enrollee Department of Defense HMO until its integration into the Memorial SCH Health Network.
- Member of governing board of two HMOs, PPOs and insurance companies. Member of governing board and officer of a 75-physician management services organization (MSO).
- Instrumental in the development and implementation of the reengineering of (SCH), corporate office resulting in a reduction of hierarchy, initiation of process work teams, reduction of costs and focus on strategic leadership and creating the System's future.
- Initiated and administered Systemwide leadership development program including education, succession planning, competency based behavior performance evaluations, etc.
- Led the development and administration of a systemwide initiative to fast track qualified women to senior leadership.
- Instrumental in the reduction of costs per weighted discharge by 25% in a three-year period.

1982 - 1993 **Strategic Development. SSM Health Care System**. St. Louis, Missouri. Major Catholic multi-hospital system (4,000 acute beds, 500 long term care and residential beds and numerous health businesses and programs).

1986 – 1993 **Senior Vice President** Reported to System President/CEO; a member of the senior leadership of the System; interacted regularly with System governance; directed Corporate Strategic Planning, Corporate Communications, Corporate Managed Care, Physician/Hospital Organization Directors and staffs. Member of Board of Directors for all System for profit corporations. Responsibilities included organizing and directing the System strategic planning process; developing strategic planning policies and marketing strategies for the System; directing research and development function of the System; directing managed care activities of the System; directing networking activities of the System, e.g., collaboration, acquisition and affiliation; directing communication function of the System including advertising and public relations. Instrumental in implementing Clinical Quality Improvement. Responsible for leading System cross functional teams in implementing a new System-wide strategic and financial planning process which incorporates Continuous Quality Improvement principles, implementing patient-focused care, developing integrated delivery networks in specific geographical areas and establishing System-wide customer feedback mechanisms for physicians. Responsible for managing and/or consulting in Continuous Quality Improvement, strategic planning, marketing, delivery system integration and managed care at twenty-four member institutions and programs. Responsibilities also included developing Continuous Quality Improvement implementation plans, curriculum and teaching Continuous Quality Improvement courses throughout the System. Lead the system efforts to regionalize all health care centers and services in the greater St. Louis area

1982 - 1986 **Corporate Director of Planning/Marketing**. Reported to President of the Governing Board of the System. Supervised corporate planning, marketing and managed care staffs. Responsibilities included organizing and directing the first system planning process and development of a new structure for the system. Responsibilities also included directing the marketing research, product development, marketing strategy development and alternative delivery activity of the system.

1981 – 1982 **Principal, Health Studies Institute. Inc.,** Columbia, Missouri. Consultant and Project Director for planning, management and education to health care organizations.

1980 - 1981 **Business Development Staff. St. Louis University Hospital and Clinics,** St. Louis, Missouri. Major responsibility included the development of an education subsidiary corporation. Reported to the Chief Operating Officer of the hospital.

1978 - 1980 **Faculty Member. University of Missouri-Columbia. Graduate Studies in Health Services Management.** Major responsibilities included developing and coordinating a baccalaureate degree program in Health Services Management; developing and teaching courses in health care delivery, management and planning. Other responsibilities included student advisement and curriculum design.

EDUCATION

Post Masters Post-Master studies: St. Louis University, Center for Health Services Education and Research, St. Louis, Missouri, specialized in Health Services Marketing and Administration. Doctoral comprehensive examinations completed.

MSPH Master of Science in Public Health (MSPH) with a concentration in Health Planning; University of Missouri-Columbia, Department of Health Services Management.

BA Bachelor of Arts; University of Maryland, College Park, Maryland.

APPOINTMENTS

Professional

- Immediate Past Chairman, American College of Healthcare Executives (ACHE) (2013-2014)
- Chairman, American College of Healthcare Executives (ACHE) (2012-2013)
- Member, Institute for Healthcare Improvement, Audit and Compliance Committee (2012 - 2013)
- Board Member, VHA New England (2001-Present); Chair (2010 – 2013)
- Board Member, Secretary, Past Chair, Connecticut Association of Healthcare Executives (2004-Present)
- Board Member, Greenwich Health Care Services. (1997-Present)
- Board Member, Bridgeport Hospital & Healthcare Services. (1997–Present)
- Alumni Board, University of Missouri-Columbia (2003–Present)
- American College of Healthcare Executives (ACHE) Regents Advisory Council– CT. (1999-Present)
- Co-Chair, The Leadership Institute (2008–2010)Board Member, Board of Governors, American College to Healthcare Executives (2007-2010)
- Board Member, Board of Overseers, Malcolm Baldrige National Quality Award (2006– 2009)
- Regent, American College of Healthcare Executives (Connecticut) (2004–2007)
- Program Committee, European Forum on Quality Improvement in Health Care. (1995-1999)
- Member, Review Board, Quality Management in Health Care Magazine. (1993-2006)
- Board Member, Institute for Healthcare Improvement. (1993-2001)
- Co-Chair, National Forum on Quality Improvement in Healthcare, sponsored by the Institute for Healthcare Improvement. (1992,1993,1994)
- Vice Chairperson, Executive Committee, Healthcare Quality Management Network, Institute for Healthcare Improvement. (1991-1994)
- Member, Holy Cross Health System, Board of Directors, Mission & Planning Committee (1990-1994)
- President, Catholic Health System Planners and Marketers. (1988-1989)
- Member, Strategic Planning Committee, Society of Healthcare Planning and Marketing (AMA) (1988-1989)
- Co-Chairperson, Membership Committee, Society of Healthcare Planning and Marketing (19851987)
- Chairperson, St. Louis Association of Women in Health Administration. (1984-1986)

- Vice Chairperson, ACHE Ad Hoc Committee of Women in Health Administration. (1982-1984)

Community
- Board Member, Planned Parenthood of Connecticut (2013-Present)
- Member, Project Advisory Group, Women in Healthcare Leadership, National Center for Healthcare Leadership (2013-Present)
- Board Member/Chair, Connecticut Public Broadcasting. (1999-Present)
- Board Member, International Festival of Arts & Ideas. (2008-2010)
- Board Member/Secretary, New Haven Symphony Orchestra. (1999-2007)
- Member, Executive Committee, National Migrant Worker Council, Inc. (1993-1995)
- Board Member, National Migrant Worker Council, Inc. (1992-1995)

Education Faculty
- Faculty Member, Yale University, Department of Epidemiology and Public Health. (2000-Present)
- Preceptor, University of Missouri-Columbia, Health Services Management (June 2003 – Present)
- Faculty Member, Institute for Healthcare Improvement, Boston, MA. (1992-Present)
- Adjunct Faculty Member, St. Louis University, Center for Health Services Education and Research, St. Louis, MO. (1985-Present)

PROFESSIONAL MEMBERSHIPS
- Fellow, American College of Healthcare Executives (ACHE)
- Member, Society of Healthcare Planning and Marketing (AHA).
- Member, American College of Health Care Marketing.

PRESENTATIONS AND PUBLICATIONS (since 2000)

2014 Capozzalo, Gayle. "Quality, Cost and Accountable Care: Models for the Journey." Healthcare Executive. May/June 2014

Presentation, American College of Healthcare Executives
ACQUISITION & INTEGRATION: LEARNING FROM ONE HOSPITAL'S SUCCESSFUL RESULTS EXPERIENCE

Publication: Contributor to The Transformation Takes Shape: Leadership in the healthcare industry during the next three years: Insights from the Oliver Wyman Healthcare CEO Survey 2014

2013 Presentation, American College of Healthcare Executives
LEADERSHIP FOR THE FUTURE

2012 Capozzalo, Gayle. "Successfully Leading Change: Innovation in Service Delivery." International Hospital Federation. Volume 28, Number 4.

Capozzalo, Gayle. "Challenging Assumptions." Modern Healthcare Magazine March 2012

Presentation, American College of Healthcare Executives
SUCCESSFULLY LEADING CHANGE
Panel, Modern Healthcare Women Leaders in Healthcare
LEADERSHIP IN TIMES OF CHANGE

2011

Presentation, American College of Healthcare Executives
ETHICS: A KEY DRIVER FOR TODAY'S HEALTHCARE ORGANIZATIONS
Presentations, American College of Healthcare Executives
SUCCESSFULLY LEADING CHANGE

Presentation, Long Island University, Westchester Campus
THE HEALTHCARE REFORM FALL-OUT: STRATEGIC CHOICES FOR HEALTHCARE LEADERS
Presentation, American College of Healthcare Executives
FORCES OF CHANGE: NEW LEADERSHIP TO IMPROVE HEALTHCARE IN AMERICA

2010

Presentation, Institute for Healthcare Improvement
ACHIEVING COMPREHENSIVE, SAFE PATIENT FLOW IN AN ACADEMIC MEDICAL CENTER
Presentation, Columbia University
MANAGEMENT CHALLENGES IN THE EVOLVING HEALTHCARE AND INSURANCE SYSTEM
Presentation, the Leadership Institute
YALE NEW HAVEN HEALTH AND EMERGING SOCIAL MEDIA
Presentation, American College of Healthcare Executives
ACHE, NEW JERSEY REGENT BREAKFAST
Presentation, American College of Healthcare Executives Rhode Island Chapter
THE CASE FOR ACHE IN 2010 AND BEYOND

2009

Presentation, the Leadership Institute
PERFORMANCE EXCELLENCE
Presentation, Yale School of Public Health
YALE HEALTHCARE MANAGEMENT PROGRAM
Presentation, Yale University School of Public Health, Class of '54 Reunion
HEALTHCARE REFORM

2008

Presentation, American College of Healthcare Executives
ACHE REFLECTIONS ON LEADERSHIP

2006

Presentation, Institute for Healthcare Improvement
USING MEASUREMENT TO GUIDE IMPROVEMENT

2005

Presentation, Institute for Healthcare Improvement
USING MEASUREMENT TO GUIDE IMPROVEMENT
Presentation, the Leadership Institute
HOSPITALS NOT FOR PROFIT STATUS
Presentation, University of Columbia-Missouri Alumni Meeting
HEALTHCARE IN THE 2000s
Presentation, the Leadership Institute
YALE NEW HAVEN HEALTH HEART INSTITUTE

2004

Presentation, SG2
TECHNOLOGY EVALUATION AND ADOPTION PLANNING
Presentation, Better Management LIVE Worldwide
ACHIEVING PERFORMANCE EXCELLENCE IN A COMPLEX HEALTHCARE DELIVERY SYSTEM

Presentation, the Leadership Institute
STRATEGY ORGANIZATION AND STAFFING:
LEADERSHIP INSTITUTE STRATEGISTS' FORUM
Presentation, Institute for Healthcare Improvement National Forum on Quality Management
A PERFORMANCE MANAGEMENT INITIATIVE:
YALE NEW HAVEN HEALTH SYSTEM'S STRATEGY

2003

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
STAYING AHEAD OF EMERGING SCIENCE AND TECHNOLOGY

2002

Presentation, National Committee for Quality Healthcare
USING TECHNOLOGY TO DELIVER QUALITY HEALTHCARE
Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
MEDICAL SCIENCE AND TECHNOLOGY: OPPORTUNITY OR THREAT

2001

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
WOMEN EXECUTIVES AND THE GLASS CEILING
Presentation, the Leadership Institute
LEVERAGING CLINICAL DEVELOPMENT TO CREATE AN ENTREPRENEURIAL ENVIRONMENT
Presentation, Modern Healthcare 2001 Healthcare IT Outsourcing Summit
LEVERAGING THE INTERNET TO ENHANCE CUSTOMER RELATIONSHIPS
Presentation, American College of Healthcare Executives
2020 VISION: USING SCIENCE AS THE BASIS FOR HEALTH SYSTEM STRATEGY

2000

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
WOMEN IN LEADERSHIP IN THE NEXT CENTURY
Presentation, VHA Northeast
TRENDS IN HEALTH SYSTEM DEVELOPMENT

CHRISTOPHER M. O'CONNOR, FACHE

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Hopkinton, MA 01748
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PROFESSIONAL EXPERIENCE

YALE NEW HAVEN HEALTH SYSTEM, NEW HAVEN, CT

Large academic health system with nearly $3.4 billion in revenue, 2,130 beds and over 19,000 employeess located in southern Connecticut

Executive Vice President, Chief Operating Officer (2012 – present)

Responsible for system operations of this large, academic multihospital integrated delvery system including overseeing the 300+ physician medical foundation.

- Integrated the employee health, occupational medicine and corporate health components into a consolidated and aligned business unit with gains in efficiencies and revenue performance.
- Leading the system's cost and value positioning effort to to improve our annual cost performance by more that $125 million on an ongoing annual basis. Chair of the system implementation steering committee that coordinates the four committees driving this project.
- Coordinating the effort to improve the operations through a system approach in the laboratory, pharmacy, care management, medical staff credentialing – these areas are under system development to meet operational benchmark targets as well as business plan opportunities.
- Leading the "big data" effort across the health system to ensure the capability to manage data and produce information meets the changing needs across the health care spectrum.

SAINT RAPHAEL HEALTHCARE SYSTEM, NEW HAVEN, CT

Large community teaching hospital (511 beds) affiliated with the Yale School of Medicine encompassing over $500 million in revenue, long term care and other ancillary services

President and Chief Executive Officer (2009-2012)

Reporting to the Board, oversaw all aspects of the health care system up to and including the asset sale of the system to Yale-New Haven Hospital in September of 2012.

- Led the team to negotiate and ultimately execute a letter of intent and Asset Purchase Agreement with Yale-New Haven Hospital. This process included a full second request investigation by the Federal Trade Commission as well as a reviews by the Attorney General and the Office of Health Care Access regarding a Certificate of Need process.
- Implemented a broad strategy to investigate an opportunity to affiliate with a system that included national catholic systems, for-profit systems and systems within the state of Connecticut.
- Over the two year period managed to maintain operational focus and performance while managing through the purchase process while uncertain of the approval process.
- Improved profitability of the medical center by implementing widespread redesign and cost improvement targets.

CARITAS ST. ELIZABETH'S MEDICAL CENTER, BOSTON, MA

Flagship tertiary teaching hospital of a six-hospital system affiliated with Tufts School of Medicine, located in eastern Massachusetts with 340 licensed beds and 2,500 employees and nearly $400 million in net revenue.

President *(2006 – 2009)*
Chief Operating Officer *(2006)*

Responsible for medical center operations including strategic plan, operational performance and community engagement for this urban tertiary teaching hospital.

- Exceeded budgeted performance, earning progressively larger bottom-lines of 1.1%, 1.5% and 2% during the three fiscal years under my leadership.

- Successfully recruited more than 40 new physicians, including key leadership as well as clinical staff to facilitate clinical activity turnaround.
- Improved patient satisfaction from the 70th percentile to the 90th percentile by linking service, quality and access to leadership performance.
- Through a team approach, worked to improve quality goals in many areas including surgical care infection, cardiac outcomes, infection control and ventilator associated pneumonia. Facilitated the implementation of a transparent patient safety program with non-punitive reporting as well as a thorough root cause analysis process to ensure process improvements.
- Recognized as a Tompson Performance Improvement hospital in both 2007 and 2008 in the large teaching category.
- Improved quality outcomes, including benchmark performance in the surgical care infection program to over 95% compliance, and achieved distinction from the Institute of Healthcare Improvement.
- Facilitated programmatic expansion into hyperbaric wound care, neurosciences and robotic surgery. Oversaw milestone construction projects including: a new emergency department, operating suite renovations, a neuroscience and spine center and a multi-disciplinary wound center.
- Led the implementation of Leadership Development initiative across the system in conjunction with the "Achieving Exceptional Care" program – A Studer Group collaborative for over 600 system-wide leaders that focused on improving leadership tools.

OCHSNER HEALTH SYSTEM, NEW ORLEANS, LA

A non-profit, academic, multi-specialty healthcare delivery system dedicated to patient care, research and education. The system includes seven hospitals, more than 35 healthcare centers and 11,000 employees.

Vice President Clinical Operations (2003 – 2006)

Responsible for specialty clinical services including cardiac, oncology, digestive diseases, musculoskeletal, transplant, surgical and perioperative services. Included within these service lines are both clinic operations and hospital services for areas including infusion therapy, radiation therapy, endoscopy, cardiac cath labs and EP labs, 23 OR suites, 6 OR ASC, and 2 plastic surgical OR suites.

- Hurricane Katrina - Led the organization through its response to this national disaster. Ochsner was one of three hospitals to remain functional throughout the storm and flooding. Facilitated the emergency preparedness and response to this regional catastrophe including countless leadership and staff meetings and briefings for the 2,500 staff, patients and dependants sheltered at Ochsner. Assisted in communicating current operational status with media outlets. Assisted in coordination of assets and security needs with state and local emergency operations centers. Maintained a structured decision making process in the face of failing utilities, flooding, civil unrest and numerous operational and human resource issues.
- Assisted in the acquisition process that resulted in the purchase of three Tenet hospitals in the greater New Orleans region. Finalized planning for new cancer center and heart and vascular institute. Facilitated the operational opening of main campus ASC in January 2004.
- Facilitated the focus on patient satisfaction, patient safety and quality, including implementing quality metrics as well as improving patient satisfaction within the operating room setting by 50% over a 12-month period.
- Upon arrival, addressed significant resource shortage within Anesthesia. Implemented recruitment and retention tactics to increase CRNA staff, recruited a new chair and increased staffed anesthesia locations 20% within a year of implementation.
- Improved endoscopy scheduling by both resource allocation and process improvement that increased procedures from 50 to 70 per day.

HOSPITAL OF SAINT RAPHAEL, NEW HAVEN, CT

A 510 bed tertiary teaching hospital affiliated with the Yale School of Medicine in New Haven, Connecticut. St. Raphael's has more than 3,500 employees with a broad range of clinical programs with over $600 million in net patient revenue.

Vice President, Clinical Operations *(2001 – 2003)*
Administrative Director, Departments of Surgery and Emergency Medicine *(1999 – 2001)*
Administrator, St. Raphael Physician Organization *(1997 – 1999)*

Progressive responsibility focused on operational performance of major clinical departments including surgery, emergency medicine, radiology, pathology, gastroenterology, cardiac and oncology services. Responsible for more than 400 FTE's and $200+ million in net patient service revenue.

- Following 9/11, established the first regional emergency response agreement in Connecticut in collaboration with Yale New Haven Hospital and other local healthcare providers.
- Improved OR efficiency by both adding supply (from 19 OR suites to 23) and increasing production by $25 million in gross revenue. Improved cost per case by 5%, and increased OR utilization (saving approximately $3 million in both med/surg supplies and implant costs).
- Implemented OR information system (ORSOS) following a difficult period for both scheduling and preference cards.
- Implemented a capitated defibrillator agreement with Medtronic that enabled savings of more than $1.2 million in pacemaker and defibrillator implants in one year.
- Coordinated the integration of additional subspecialties within the practice, increasing gross professional revenue to $1.5 million.

SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD **(1995 – 1997)**

A large acute tertiary teaching hospital with nearly 500 beds and affiliated with the Johns Hopkins School of Medicine. It is the flagship for Lifebridge Health an two-hospital integrated healthcare delivery system.

Coordinator, Emergency Medicine Operations *(1996 – 1997)*
Administrative Resident *(1995 – 1996)*

Following post graduate residency, worked with then CEO Warren Green and the senior leadership team. Remained and managed this large emergency department, which at the time was seeing 65,000 patients annually with more than 20 physicians and PA FTE's.

AFFILIATIONS / BOARD MEMBERSHIPS / RECOGNITIONS

CONNECTICUT HOSPITAL ASSOCIATION, **Board Member** (2010-present)
Diversified Network Services, Board Member (2010-present)
Financial Oversight Committee, Member (2010-present)

VHA, NORTHEAST PURCHASING COALITION, **Board Member** (2012-present)

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES, **Fellow**
Member of Article of the Year Committee

AMERICAN HEART ASSOCIATION, Founders Affiliate, **Board Member** (2008)
Chair of the Heart Walk Leadership Committee

SAINT RAPHAEL LEADERSHIP AWARD, (September, 2012)

GOOD SCOUTING LEADERSHIP AWARD (October, 2012)

NEW HAVEN BUSINESS TIMES, **Forty under 40 Award** (September 2000)

EDUCATION

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC - 1996
Masters in Health Service Administration

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC - 1993
Bachelor of Arts, Economics

CURRICULUM VITAE

RICHARD D'AQUILA
282 Boston Post Road

Westbrook, CT 06498
Telephone (860) 669-0871

BUSINESS ADDRESS: Yale-New Haven Hospital
20 York Street
New Haven, CT 06510
Telephone: (203)-688-2606

PROFESSIONAL EXPERIENCE:

June, 2014 – President
President
Yale-New Haven Hospital
Executive Vice President
Yale-New Haven Health System

February, 2012 – June, 2014
President and Chief Operating Officer
Yale-New Haven Hospital
Executive Vice President
Yale New Haven Health System

May, 2006 to February, 2012
Executive Vice President and Chief Operating Officer
Yale-New Haven Hospital/Yale New Haven Health System

Organizational Profile

Yale New Haven Health System (YNHHS) is a 1597-bed delivery network formed in 1995 which consists of Yale-New Haven, Bridgeport and Greenwich Hospitals. YNHHS has revenues in excess of $2.3 billion in FY '11 based on 90,000 discharges and 1.3 million outpatient visits. Yale-New Haven Hospital is a 1,008-bed tertiary referral medical center that includes the 201-bed Yale New Haven Children's Hospital and the 76-bed Yale New Haven Psychiatric Hospital. Both Yale New Haven Health System and Yale-New Haven Hospital are formally affiliated with Yale University School of Medicine.

Responsibilities

Overall responsibility for all aspects of day to day operations for Yale-New Haven Hospital (YNHH) and the senior network leader at the Yale New Haven Health System

representing the YNHH delivery network. Hospital leadership responsibilities include direct accountability for the senior leadership team, strategic planning, organizational performance, quality improvement, labor relations and human resources management, system integrations, external relations and service line development. Senior leadership and implementation responsibility for all aspects of the hospital's annual business (operating) plan. Senior level oversight of the hospital's facility plan including construction of a 112-bed, $450 million Comprehensive Cancer Pavilion commencing construction in the fall of 2006.

August, 2000 to April, 2006

Senior Vice President/Chief Operating Officer
New York Presbyterian Hospital/
Weill Cornell Medical Center
New York, New York

Organizational Profile
New York Presbyterian Hospital is a 2,369 bed Academic Medical Center created from the merger between the New York Hospital and the Presbyterian Hospital in the City of New York. The Weill Cornell Medical Center consists of an 880 bed acute care facility in Manhattan and the 239 bed Westchester Division campus in White Plains specializing in behavioral health.

Responsibilities
Overall responsibility for all aspects of day to day operations for the Weill Cornell Medical Center and the Westchester Division, a two campus Academic Medical Center of 1120 beds. Direct responsibility for a total operating expense budget in excess of $450,000,000 and revenues of $850,000,000. Senior leadership and implementation for all aspects of the Medical Center's operating plan including quaternary and tertiary service development, medical staff relations and recruitment, employee relations and labor strategy. System level member of the Corporate Management Team with involvement in strategic and facilities planning, service line development, information technology and performance improvement.

May 1992 to June 2000

Executive Vice President/Chief Operating Officer
St. Vincent's Medical Center
Bridgeport, Connecticut

President
Vincentures, Inc.

President

St. Vincent's Development Corporation, Inc.

Chief Operating Officer of 391 bed, university-affiliated acute care hospital and health system. President/CEO of affiliated subsidiaries with management responsibility at the Medical Center and corporate level. Medical Center responsibilities including day to day operations oversight for patient care services; support services and facilities planning and development. Corporate responsibilities including information systems, ambulatory network development, managed care contracting network oversight and real estate/satellite facility development.

January 1987-April 1992 — **President/CEO**
Health Initiatives Corporation
Providence, Rhode Island

Chief Executive Officer of a consulting practice specializing in strategic planning, business development and project implementation assistance for acute care and specialty hospitals, state planning agencies and private investors. Specific responsibilities included:

- Practice Leadership
- Engagement Planning and Management
- Project Supervision and Control
- Client Interface
- Practice Marketing and Business Development

June 1984-December 1986 — **Vice President**
The Mount Sinai Hospital Corporation
Hartford, Connecticut

June 1981-June 1984 — **Vice President, Division of Planning and Community Services**
The Mount Sinai Hospital
Hartford, Connecticut

June 1979-June 1981 — **Assistant Executive Director**
The Mount Sinai Hospital
Hartford, Connecticut

January 1979-May 1979 — **Administrative Resident**
The Mount Sinai Hospital
Hartford, Connecticut

OTHER APPOINTMENTS:

November 2000 — **Member, Board of Directors**

To Present	Voluntary Hospitals of America/Metro New York New Rochelle, New York
January 1995- June 2000	**Member, Board of Directors** Goodwill Industries Bridgeport, Connecticut
December 1993- June 2000	**Founding Board Member** Park City Primary Care Center Bridgeport, Connecticut
May, 1992- June 2000	**Member, Board of Directors** St. Vincent's Development Corporation Vincentures, Inc. Omicron, Inc. Connecticut Health Enterprises Bridgeport, Connecticut
January 1992- December 1994	**Member, Board of Directors** Visiting Nurses Association of Fairfield County Bridgeport, Connecticut
January 1989- December 1991	**Member, Board of Directors** Easter Seal Society/Meeting Street Rehabilitation Center, Inc. of Rhode Island Providence, Rhode Island
January 1980- December 1989	**Member, Board of Directors** Combined Hospitals Alcohol Program Hartford, Connecticut
September 1985- December 1986	**President, Board of Directors** Regional Alcohol and Drug Abuse Resources, Inc. Hartford, Connecticut
September 1981- December 1986	**Adjunct Faculty/Lecturer** University of Hartford, Barney School of Business and Public Administration West Hartford, Connecticut
January 2001 - Present	**Adjunct Faculty/Residency Preceptor and Lecturer** Robert F. Wagner Graduate School of Public Service New York University New York, N.Y.
December 2000 - Present	**Adjunct Faculty/Lecturer** Weill Medical College of Cornell University Department of Public Health, New York New York, N.Y.
January, 2009 to Present	**Member, Board of Directors** Habitat of Greater New Haven

New Haven, Connecticut

February, 2012 to Present — **Member, Board of Trustees**
Yale-New Haven Hospital
New Haven, Connecticut

September 2012-
May 2013 — **Preceptor**
Fairfield University School of Nursing

EDUCATION:

Yale University School of Medicine
Graduate Program in Hospital Administration
Academic Distinctions: Research Excellence Award (1979)
1979 Graduate

Central Connecticut State University
Bachelor of Arts: Economics/Business
Academic Distinctions: Omicron Delta Epsilon
Economics Honor Society
1977 Graduate

PUBLICATIONS:

1. *Evidence-Based Management in Healthcare,* Kovner, Anthony R., Fine, David J., and D'Aquila, Richard. Health Administration Press Textbook, 2009.

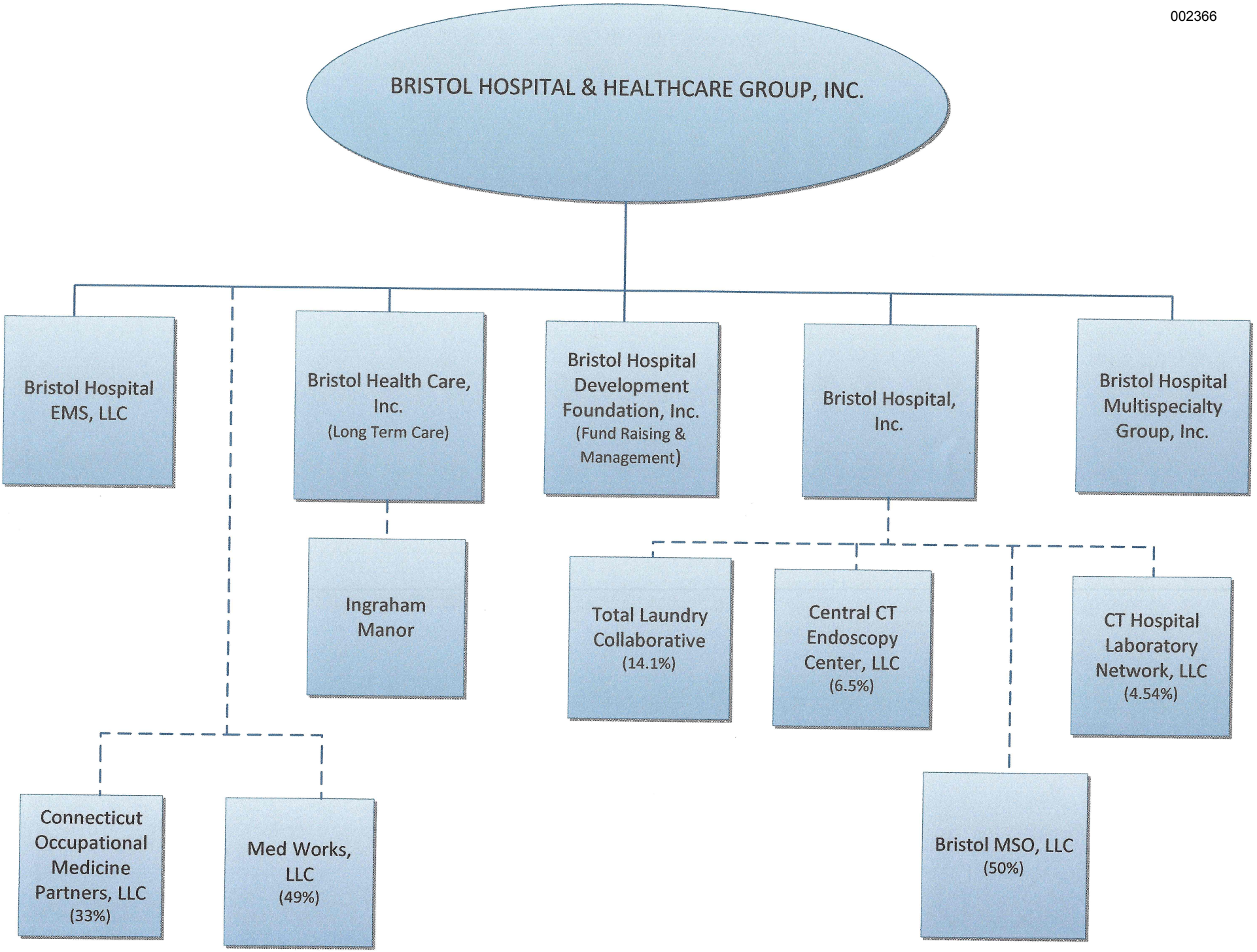
2. *Yale-New Haven Hospital's Asset Acquisition of the Hospital of St. Raphael: Pre-Close, Planning and Transition Activities,* D'Aquila, Richard; Aseltyne, William; Lopman, Abe; Jweinat, Jillian; Ciacco, Teresa; Comerford, Matthew; American Journal of Medicine, August 2013 (Accepted).

3. *Achieving Safe Patient Flow in an Academic Medical Center: A Quality Improvement Journey at Yale-New Haven Hospital;* The Joint Commission Journal on Quality and Patient Safety (Accepted).

PROFESSIONAL AFFILIATIONS:
Fellow, American College of Health Care Executives
Yale Hospital Administration Alumni Association
Connecticut Hospital Association

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 29: BHHCG'S ORGANIZATIONAL CHART PRIOR TO ASSET PURCHASE

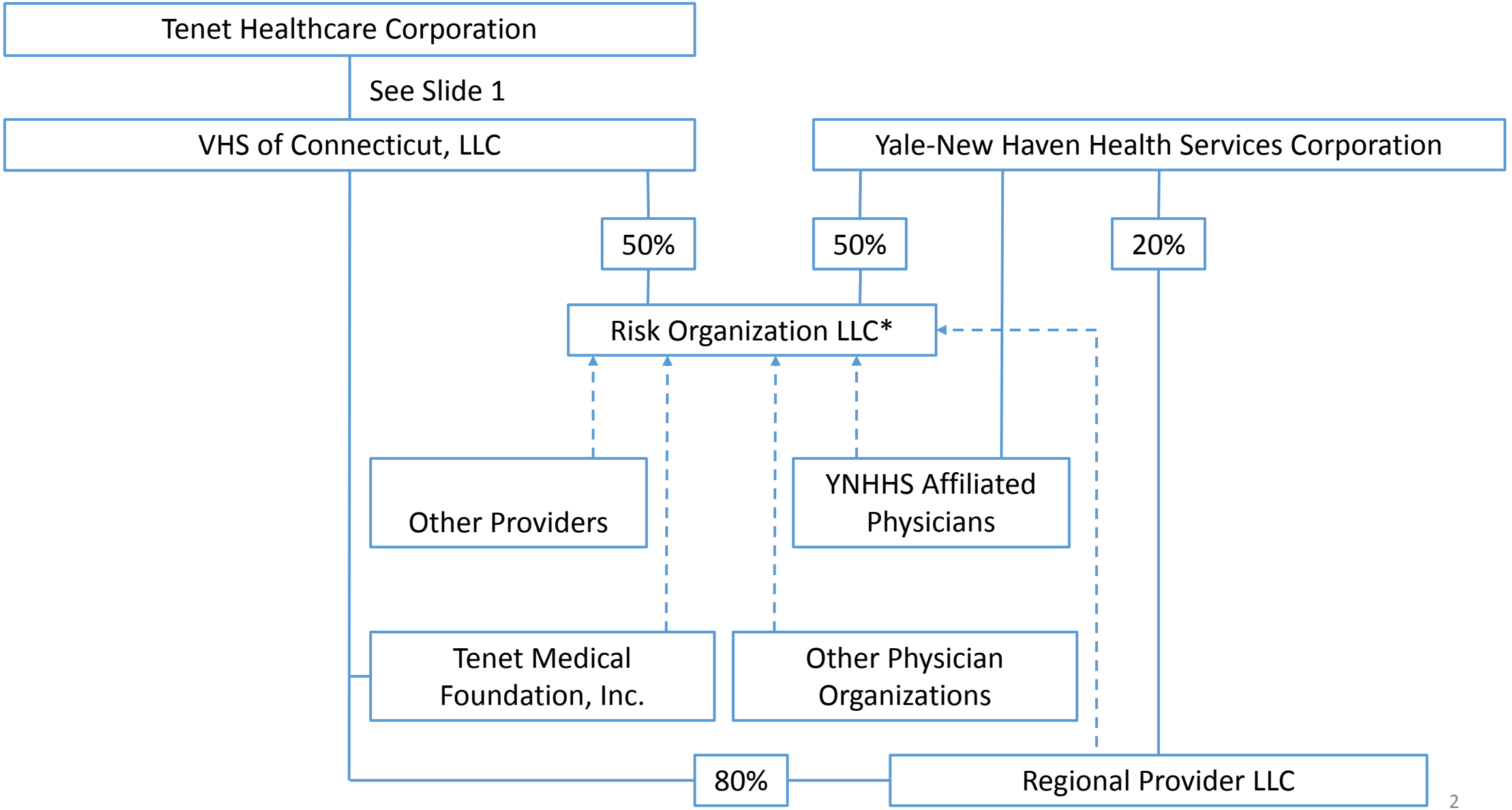

BRISTOL HOSPITAL & HEALTHCARE GROUP, INC.
Bristol Hospital EMS, LLC
Bristol Health Care, Inc. (Long Term Care)
Bristol Hospital Development Foundation, Inc. (Fund Raising & Management)
Bristol Hospital, Inc.
Bristol Hospital Multispecialty Group, Inc.
Ingraham Manor
Total Laundry Collaborative (14.1%)
Central CT Endoscopy Center, LLC (6.5%)
CT Hospital Laboratory Network, LLC (4.54%)
Connecticut Occupational Medicine Partners, LLC (33%)
Med Works, LLC (49%)
Bristol MSO, LLC (50%)

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 30: POST ASSET PURCHASE ORGANIZATIONAL CHART

Organization Chart 2

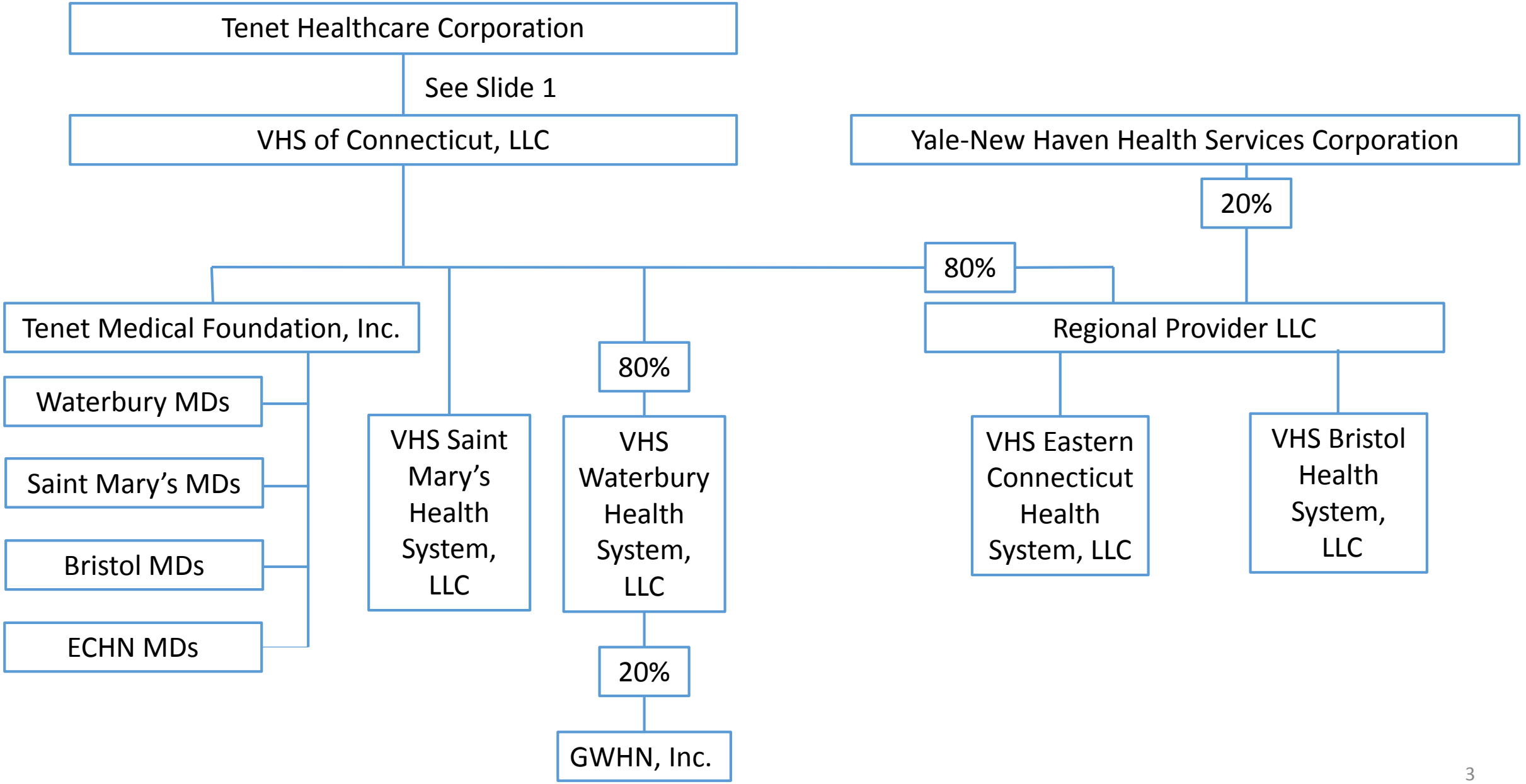
Organization Chart 2 (cont.)



*Equity interests may be issued to additional members

Organization Chart 2 – At Closing

002370



BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 31: FINANCIAL ATTACHMENT I(A)

Name Entity: Bristol Hospital and Healt Care Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics
Financial Attachment I (A) without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity	FY 2013	FY 2014	FY 2015	FY 2015	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**											
1	Total Gross Patient Revenue	$477,829,177	$497,934,568	$507,880,562	$5,091,630	$512,972,192	$518,025,222	$10,438,730	$528,463,952	$528,372,517	$16,051,046	$544,423,564
2	Less: Allowances	$313,081,711	$322,277,392	$330,504,789	$3,313,393	$333,818,182	$338,487,798	$6,820,870	$345,308,668	$345,248,922	$10,488,067	$355,736,990
3	Less: Charity Care	$5,306,457	$5,556,279	$5,667,263	$56,816	$5,724,078	$5,780,463	$116,482	$5,896,945	$5,895,925	$179,108	$6,075,033
4	Less: Other Deductions	($2,210,522)	($4,181,207)	($4,264,724)	($42,755)	($4,307,479)	($4,349,910)	($87,655)	($4,437,565)	($4,436,797)	($134,782)	($4,571,579)
	Net Patient Service Revenue	**$161,651,531**	**$174,282,104**	**$175,973,235**	**$1,764,176**	**$177,737,410**	**$178,106,871**	**$3,589,033**	**$181,695,904**	**$181,664,467**	**$5,518,653**	**$187,183,120**
5	Medicare	$53,509,264	$62,363,241	$61,631,642	$608,982	$62,240,624	$61,481,362	$1,238,911	$62,720,273	$62,709,422	$1,905,004	$64,614,426
6	Medicaid	$32,327,882	$32,948,244	$32,068,412	$323,987	$32,392,400	$32,708,963	$659,119	$33,368,082	$33,362,308	$1,013,489	$34,375,798
7	CHAMPUS & TriCare	$320,057	$346,138	$360,614	$3,643	$364,257	$367,817	$7,412	$375,229	$375,164	$11,397	$386,561
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$86,157,203**	**$95,657,623**	**$94,060,668**	**$936,613**	**$94,997,281**	**$94,558,142**	**$1,905,442**	**$96,463,584**	**$96,446,894**	**$2,929,890**	**$99,376,784**
9	Commercial Insurers	$72,393,696	$75,397,535	$78,550,669	$793,598	$79,344,267	$80,119,680	$1,614,492	$81,734,172	$81,720,030	$2,482,514	$84,202,544
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$340,603	$342,003	$356,306	$3,600	$359,905	$363,423	$7,323	$370,746	$370,682	$11,261	$381,942
12	Workers Compensation	$2,760,029	$2,884,943	$3,005,592	$30,366	$3,035,957	$3,065,627	$61,775	$3,127,402	$3,126,861	$94,989	$3,221,850
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$75,494,328**	**$78,624,481**	**$81,912,566**	**$827,563**	**$82,740,129**	**$83,548,729**	**$1,683,591**	**$85,232,320**	**$85,217,573**	**$2,588,763**	**$87,806,336**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$161,651,531**	**$174,282,104**	**$175,973,235**	**$1,764,176**	**$177,737,410**	**$178,106,871**	**$3,589,033**	**$181,695,904**	**$181,664,467**	**$5,518,653**	**$187,183,120**
14	Provision for Bad Debts	$6,182,431	$5,144,132	$5,246,883	$52,601	**$5,299,485**	$5,351,687	$107,842	**$5,459,529**	$5,458,585	$165,822	**$5,624,407**
	Net Patient Service Revenue less provision for bad debts	**$155,469,100**	**$169,137,972**	**$170,726,351**	**$1,711,574**	**$172,437,926**	**$172,755,184**	**$3,481,191**	**$176,236,375**	**$176,205,882**	**$5,352,831**	**$181,558,713**
15	Other Operating Revenue	$5,734,284	$4,963,183	$5,012,814	$0	**$5,012,814**	$5,062,943	$0	**$5,062,943**	$5,113,572	$0	**$5,113,572**
17	Net Assets Released from Restrictions	$0	$0	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	TOTAL OPERATING REVENUE	**$161,203,384**	**$174,101,155**	**$175,739,166**	**$1,711,574**	**$177,450,740**	**$177,818,126**	**$3,481,191**	**$181,299,317**	**$181,319,454**	**$5,352,831**	**$186,672,285**
B.	**OPERATING EXPENSES**											
1	Salaries and Wages	$73,893,829	$79,583,644	$80,361,575	$805,645	$81,167,220	$81,556,924	$1,643,454	$83,200,378	$82,770,053	$2,514,412	$85,284,464
2	Fringe Benefits	$21,368,688	$22,620,693	$22,841,810	($5,160,391)	$17,681,419	$23,181,574	($5,030,042)	$18,151,532	$23,526,391	($4,892,426)	$18,633,965
3	Physicians Fees	$5,010,391	$5,668,277	$5,781,643	$0	$5,781,643	$5,897,276	$0	$5,897,276	$6,015,221	$0	$6,015,221
4	Supplies and Drugs	$23,758,520	$26,410,372	$27,108,188	($644,308)	$26,463,880	$27,920,735	($371,765)	$27,548,971	$28,757,639	($79,476)	$28,678,163
5	Depreciation and Amortization	$7,216,366	$7,837,551	$7,533,446	$285,714	$7,819,160	$6,827,209	$571,429	$7,398,637	$6,029,708	$857,143	$6,886,851
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$1,681,759	$1,931,548	$1,814,555	($1,814,555)	$0	$1,700,512	($1,700,512)	$0	$1,583,025	($1,583,025)	$0
8	Malpractice Insurance Cost	$1,339,349	$1,733,256	$1,767,921	$0	$1,767,921	$1,803,280	$0	$1,803,280	$1,839,345	$0	$1,839,345
9	Lease Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
10	Other Operating Expenses	$26,243,592	$28,200,360	$28,804,155	$433,226	$29,237,380	$29,380,238	$412,892	$29,793,129	$29,967,842	$392,151	$30,359,993
	TOTAL OPERATING EXPENSES	**$160,512,494**	**$173,985,701**	**$176,013,293**	**($6,094,669)**	**$169,918,624**	**$178,267,747**	**($4,474,544)**	**$173,793,203**	**$180,489,225**	**($2,791,222)**	**$177,698,003**
	Provision for Income Taxes[c]	$0	$0	$0	$3,015,410	**$3,015,410**	$0	$3,005,061	**$3,005,061**	$0	$3,592,381	**$3,592,381**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$9,589,015**	**$9,884,552**	**$9,073,874**	**$6,277,403**	**$15,351,276**	**$8,078,100**	**$6,826,651**	**$14,904,752**	**$8,442,963**	**$7,418,171**	**$15,861,134**
	INCOME/(LOSS) FROM OPERATIONS	**$690,890**	**$115,453**	**($274,127)**	**$4,790,833**	**$4,516,705**	**($449,620)**	**$4,950,674**	**$4,501,053**	**$830,229**	**$4,551,672**	**$5,381,902**

Name Entity: Bristol Hospital and Healt Care Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics
Financial Attachment I (A) without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity	FY 2013	FY 2014	FY 2015	FY 2015	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NON-OPERATING INCOME / REVENUE	$853,360	$1,304,411	$1,330,499	(1,324,089)	$6,410	$1,357,109	(1,350,570)	$6,538	$1,384,251	(1,377,582)	$6,669
	NET INCOME / EXCESS(DEFICIENCY)OF REVENUE OVER EXPENSES	**$1,544,250**	**$1,419,864**	**$1,056,371**	**$3,466,744**	**$4,523,116**	**$907,489**	**$3,600,103**	**$4,507,592**	**$2,214,480**	**$3,174,091**	**$5,388,571**
C.	**Retained Earnings, beginning of year**	$28,607,725	$30,151,975	**$31,571,839**	**$0**	**$31,571,839**	**$32,628,210**	**$3,466,744**	**$36,094,955**	**$33,535,699**	**$7,066,848**	**$40,602,546**
	Retained Earnings, end of year	$30,151,975	$31,571,839	**$32,628,210**	**$3,466,744**	**$36,094,955**	**$33,535,699**	**$7,066,848**	**$40,602,546**	**$35,750,179**	**$10,240,938**	**$45,991,118**
	Principal Payments	$1,053,525	$1,938,897	$1,838,161	($1,838,161)	**$0**	$1,905,032	($1,905,032)	**$0**	$1,962,553	($1,962,553)	**$0**
D.	**PROFITABILITY SUMMARY**											
1	Hospital Operating Margin	**0.4%**	**0.1%**	**-0.2%**	**1236.4%**	**2.5%**	**-0.3%**	**232.4%**	**2.5%**	**0.5%**	**114.5%**	**2.9%**
2	Hospital Non Operating Margin	**0.5%**	**0.7%**	**0.8%**	**-341.7%**	**0.0%**	**0.8%**	**-63.4%**	**0.0%**	**0.8%**	**-34.7%**	**0.0%**
3	Hospital Total Margin	**1.0%**	**0.8%**	**0.6%**	**894.7%**	**2.5%**	**0.5%**	**169.0%**	**2.5%**	**1.2%**	**79.8%**	**2.9%**
E.	**FTEs**	**1,156**	**1,245**	1,257	13	**1,270**	1,251	25	**1,276**	1,245	38	**1,282**
F.	**VOLUME STATISTICS**[d]											
1	Inpatient Discharges	7,798	7,813	7,774	39	**7,813**	7,735	78	**7,813**	7,697	117	**7,813**
2	Outpatient Visits	294,479	297,713	299,202	1,489	**300,690**	300,698	2,999	**303,697**	302,201	4,533	**306,734**
	TOTAL VOLUME	**302,277**	**305,526**	**306,976**	**1,528**	**308,503**	**308,433**	**3,077**	**311,510**	**309,898**	**4,650**	**314,547**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 32: ASSUMPTIONS UTILIZED IN DEVELOPING FINANCIAL ATTACHMENT I(A)

FINANCIAL ASSUMPTIONS

Projected without CON

1. Main drivers that apply to each year:
    a. 0.5% decline in discharges each year;
    b. 0.5% increase in outpatient visits each year;
    c. 0.5% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions.
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 2.0% each year
    g. Bad debt expense remains consistent at 3.0% of net patient service revenues
    h. Increase of 3% in supplies and drugs pricing each year
    i. Inflation 2% each year
    j. Increase of 1% for other operating revenues each year

2. Other Factors/Assumptions/Adjustments for FY 2015
    a. $2.8 million cut in Medicare due to wage index
    b. $2.1 million cut in Medicaid payments
    c. No HITECH payments are expected to be received FY 2015. In FY 2014, $0.6 million was recognized.
    d. 18.5 additional FTEs are added to cover new services and to fill FY 2014 vacancies
    e. Planned changes to bariatric, sleep lap, wound care, and orthopedic service offerings are incorporated, representing $2.5 million of additional income
    f. $0.5 million of nonrecurring expenses related to partnership activities for consulting and legal fees are deducted from the expense structure
    g. $0.8 million in savings are recognized related to updated terms of contracted services and rental expenses

3. Other Factors/Assumptions/Adjustments for FY 2016
    a. $1.4 million cut in Medicare due to wage index

Projected with CON

1. Main drivers that apply to each year:
    a. Discharge volume is unchanged in each projected year;
    b. 1.0% increase in outpatient visits each year;

c. 1.0% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions;
e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
f. Net patient revenue per adjusted discharge increase of 2.0% each year;
g. Bad debt expense remains consistent at 3.0% of net patient service revenues;
h. Increase of 3% in supplies and drugs pricing each year;
i. Inflation 2% each year; and
j. Increase of 1% for other operating revenues each year.

2. Adjustments to financials resulting from CON
    a. Incremental volume drives the incremental revenue. Incremental expense associated with incremental volume is coupled with the assumptions below;
    b. Estimated sales and property tax are layered into the projected years;
    c. Supply expense is reduced by $1.3 million related to increased purchasing power from affiliating with Tenet;
    d. Non-operating Income is reduced by $1.3 million related to the absence of investment income and charitable contributions. Note that these sources of revenue would continue to be available to the Main Street Foundation;
    e. Other operating expenses are reduced by approximately $1.0 million reductions in purchased services;
    f. Fringe benefits expense is reduced by approximately $3.3 million as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    g. Pension expenses are deducted from Fringe Benefits;
    h. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    i. Interest expense is reduced to $0 as the standalone entity will not be levered; and
    j. Income tax layered into the expense structure assuming a 40% income tax rate.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 33: ANCILLARY STAFFING

Average Weekly Hours for Ancillary Care Providers

	Average Hours Per Week	Projected Average Hours Per Week		
Ancillary Caregiver by Department	Current Staffing Levels	Year 1	Year 2	Year 3
Anesthesia Technician				
01.6115 Anesthesiology	40	40	40	40
Athletic Trainer				
01.6162 Rehab 1	41	41	41	41
Bariatric Services Patient Representative				
01.6754 Bariatric Program	41	41	41	41
Bereavement Coordinator				
01.6251 Hospice	40	40	40	40
Cardiopulmonary Tech				
01.6150 Cardiology	67	67	67	67
Care Manager				
01-6019 IP Psych	86	86	86	86
01.6765 Medical Management	216	216	216	216
Crisis Intervention Clinician				
01.6225 Crisis Intervention	64	64	64	64
CT Scan Technologist				
01.6123 - CAT Scan	193	193	193	193
Diabetes Educator				
01.6240 Diabetes Care	8	8	8	8
Dietician				
01.6164- Nutrition	80	80	80	80
01.6167- Nutrition IP	90	90	90	90
01.6240 Diabetes Care	24	24	24	24
Discharge Planning Associate				
01.6765 Medical Management	80	80	80	80
Echocardiographer				
01.6150 Cardiology	63	63	63	63
Endoscopy Tech				
1.6111 Endoscopy	47	47	47	47
Home Health Aide				
01.6250 Home Care	296	296	296	296
01.6251 Hospice	40	40	40	40
Mammography Technologist				
01.6127 Mammography Center	76	76	76	76
Medical Assistant				
01.6158 Orthopedics	40	40	40	40
01.6350 GI Clinic	36	36	36	36
01.6647 Occupational Health	121	121	121	121
MRI Technologist				
01.6122 - MRI	105	105	105	105
MRI Aide				
01.6122- MRI	33	33	33	33
Nuclear Medicine Technologist				
01.6121 - Nuclear Medicine	104	104	104	104
Nurse Navigator				
01-6019 IP Psych	36	36	36	36
01.6158 Orthopedics	40	40	40	40
Nurse Practitioner				
01.6941 - Hospitalists	100	100	100	100
Occupational Therapist				

Average Weekly Hours for Ancillary Care Providers

	Average Hours Per Week	Projected Average Hours Per Week		
Ancillary Caregiver by Department	Current Staffing Levels	Year 1	Year 2	Year 3
01.6161 - Occupational Therapy Hospital	53	53	53	53
01.6163 - Occupational Therapy Rehab 2	82	82	82	82
01-6019 IP Psych	44	44	44	44
01.6250 Home Care	40	40	40	40
Patient Care Assistant				
01.6112 Ambulatory OR	89	89	89	89
01.6210 Hem/Oncology	74	74	74	74
01.6757 Float Pool	68	68	68	68
Phlebotomist				
01.6140 Laboratory	556	556	556	556
Physical Therapist				
01.6160- Physical Therapy	141	141	141	141
01.6162 - Rehab 1	82	82	82	82
01.6165- BHW Rehab 2	285	285	285	285
01.6171 - Rehab Pain Management	61	61	61	61
01.6250 Home Care	175	175	175	175
01.6251 Hospice	4	4	4	4
Physical Therapy Aide				
01.6160 Physical Therapy	62	62	62	62
01.6162 Rehab 1	40	40	40	40
01.6165 BHW Rehab 2	120	120	120	120
01.6171 Rehab Pain Management	40	40	40	40
Physician				
6941- Hospitalists	278	278	278	278
Polysomnographic Technologist				
01.6173 Sleep Center	121	121	121	121
Psych Nurse Therapist				
01.6310 The Counseling Center - OP	60	60	60	60
01.6313 The Counseling Center -Day Treatment	27	27	27	27
01.6314 The Counseling Center - ECDP	32	32	32	32
Psych Social Worker				
01.6310 The Counseling Center - OP	224	224	224	224
01.6313 The Counseling Center -Day Treatment	120	120	120	120
01.6314 The Counseling Center - ECDP				
Psychiatric Clinician				
01.6310 The Counseling Center - OP	2	2	2	2
01.6313 The Counseling Center -Day Treatment	20	20	20	20
01.6314 The Counseling Center - ECDP	68	68	68	68
Psychiatrist				
01.6313 The Counseling Center -Day Treatment	11	11	11	11
Psychologist				
01.6172 Pain Management Psych	32	32	32	32
Physician				
1.6647 Occupational Health	32	32	32	32
01.6941 - Hospitalists	278	278	278	278
Physician Addiction Specialist				
01.6314 The Counseling Center - ECDP	4	4	4	4
Physician Assistant				
01.6647 Occupational Health	45	45	45	45
Radiologic Technologist				

Average Weekly Hours for Ancillary Care Providers

	Average Hours Per Week	Projected Average Hours Per Week		
Ancillary Caregiver by Department	Current Staffing Levels	Year 1	Year 2	Year 3
01.6120 Diagnostic X-ray	464	464	464	464
01.6124 Rad-Spec Procedures	120	120	120	120
Registered Diagnostic Med Sonographer				
01.6126 Ultrasound	248	248	248	248
Registered Nurse				
01.6110 Operating Rooms	541	541	541	541
01.6111 Endoscopy	158	158	158	158
01.6112 Ambulatory OR	277	277	277	277
01.6114 PACU	312	312	312	312
01.6120 Diagnostic X-ray	121	121	121	121
01.6150 Cardiology	93	93	93	93
01.6151 Cardiac Rehab	34	34	34	34
01.6155 Intravenous Therapy	81	81	81	81
01.6170 Pain Management	40	40	40	40
01.6210 Hem/Oncology	206	206	206	206
01.6225 Crisis Intervention	82	82	82	82
01.6250 Home Care	524	524	524	524
01.6251 Hospice	204	204	204	204
01.6754 Bariatric Program	40	40	40	40
01.6757 Float Pool	111	111	111	111
Respiratory Therapist				
01.6154 Respiratory Care	461	461	461	461
Social Worker				
01.6019 IP Psych	52	52	52	52
01.6210 Hem/Oncology	40	40	40	40
01.6250 Home Care	45	45	45	45
01.6251 Hospice	32	32	32	32
01.6765 Medical Management	80	80	80	80
Speech Therapist				
01.6160 Physical Therapy	34	34	34	34
01.6165 BHW Rehab 2	18	18	18	18
Substance Abuse Counselor				
01.6314 The Counseling Center - ECDP	11	11	11	11
Surgical Technologist				
01.6110 Operating Rooms	389	389	389	389

Please Note: Staffing is subject to unit size, configuration, technology and staff experience.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 34: STAFFING PLAN

Nurse Staffing Plan
Bristol Hospital

The nurse staffing plan at Bristol Hospital is developed through a comprehensive process that draws upon multiple sources of data and input from registered nurses and other hospital staff members. The staffing plan is continuously evaluated throughout the year and formally reviewed and updated annually. The annual staffing plan reflects budgeted, core staffing levels for patient care units including inpatient services, critical care, and the emergency department. Actual staffing is adjusted on a daily or more frequent basis to meet patient care needs.

Considerations in Staffing Plan Development and Decisions

A broad range of factors are considered in the development of the core staffing plan and ongoing staffing adjustments, many of which are embodied in the American Nurses Association's (ANA) Principles for Nurse Staffing. Staffing plan development and decisions are carried out with consideration given to patient characteristics and acuity, the number of patients for whom care is provided, levels of individual patient as well as unit intensity, the geography/physical layout of the patient care unit, available technology, and level of preparation and experience of those providing care, among others.

In addition to the factors described above, Bristol Hospital considers historical staffing and patient data, staff input, patient care support services, and any plans for new programs, when developing the annual staffing plan.

1. **Professional Skill Mix For Patient Care units**
   The professional skill mix for each patient care unit is articulated in each department nurse staffing plan. The core staffing plan is adjusted as necessary to meet patient care needs using per diem/staff, on call staff, unit to unit floating, overtime and skill mix adjustments.

2. **Use of Traveling Staff Nurses**

   Bristol Hospital utilizes traveling staff nurses when necessary to ensure adequate levels of staffing to provide safe patient care. Such instances may include the inability to fill budgeted staff registered nurse positions due to shortages and limited availability of nurses with specific types and levels of expertise, and the need to temporarily fill positions when staff members are on leave. Travel staff is used as necessary after other options to fulfill staffing needs have been considered and with approval by Chief Nursing Officer.

3. **Administrative Staffing**
   The annual staffing plan is developed to provide adequate direct care staff for forecasted patient care needs exclusive of nursing management and inclusive of appropriate support.

4. **Review of the Nurse Staffing Plan**
   The staffing plan that reflects core staffing levels is formally established and reviewed annually and evaluated as necessary throughout the year. Review of the factors articulated in the section Considerations in Staffing Plan Development and Decisions above is conducted through a combination of input by staff nurses via unit staff meetings, nursing management council (responsible for resources to support shared governance) and various nursing leadership meetings. Reviews are conducted by Nursing leadership daily to ensure adequate staffing, monthly through NDNQI national benchmarking and biannually by the Nurse Executive Council and Nursing Leadership.

5. Direct Care Staff Input

Direct care staff input regarding the staffing plan is solicited via the Nursing Executive Committee (NEC) which has overall responsible for nursing strategic planning and evaluation. Membership is comprised of staff nurses across the healthcare system and all nursing staff council chairs. The NEC utilizes data through NDNQI and benchmarks actual nursing hours against national and regional standards. Nursing utilizes staff satisfaction and staff meeting input as well as quality improvement efforts to gain additional information.

Certification

This hospital nurse staffing plan has been developed through consideration of anticipated patient population care needs, unit geography, technology and support, and competency/expertise required of staff providing care. It has been reviewed and discussed by The Nursing Executive and management councils and nursing leadership and is appropriate for the provision of patient care as forecasted.

Sheila Kempf RN, PhD_____
Senior Vice President Patient Services and Chief Nursing Officer.

June 30, 2009
June 15, 2010
Revised Sept, 2014

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 35: CMS STATEMENTS OF DEFICIENCY – FILED ELECTRONICALLY ONLY

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 36: LEAPFROG SAFETY SCORES

Tenet Healthcare
LeapFrog Safety Scores
As Reported April 2014

A
California
DESERT REG MED CTR
DOCTORS HOSP OF MANTECA
FOUNTAIN VLY REG HOSP MED CTR
LAKEWOOD REG MED CTR
LOS ALAMITOS MED CTR
SAN RAMON REG MED CTR
SIERRA VISTA REG MED CTR
TWIN CITIES COMM HOSP
Central
DES PERES HOSP
SIERRA PROVIDENCE EAST MED CTR
ST FRANCIS BARTLETT MED CTR
ST FRANCIS HOSP
Florida
CORAL GABLES HOSP
DELRAY MED CTR
North Shore MC FLORIDA MED CTR Campus
NORTH SHORE MED CTR
PALM BEACH GARDENS MED CTR
ST MARY'S MED CTR
WEST BOCA MED CTR
Southern
ATLANTA MED CTR
BROOKWOOD MED CTR
NORTH FULTON REG HOSP
PIEDMONT MED CTR
Detroit
DMC Detroit Receiving Hospital
DMC Harper University Hospital
DMC Huron Valley-Sinai Hospital
DMC Sinai-Grace Hospital
San Antonio
Baptist Medical Center
Mission Trail Baptist Hospital
North Central Baptist Hospital
Northeast Baptist Hospital
St. Luke's Baptist Hospital
Northeast
MacNeal Hospital
Weiss Memorial Hospital
West Suburban Hospital
Saint Vincent Hospital
MetroWest Medical Center - Framingham Union
MetroWest Medical Center - Leonard Morse Hospital
B
California
DOCTORS MED CTR OF MODESTO
PLACENTIA-LINDA HOSP
Central
CENTENNIAL MED CTR
DOCTORS HOSP WHITE ROCK LAKE
HOUSTON NORTHWEST MED CTR

	LAKE POINTE MED CTR
	NACOGDOCHES MED CTR
	PARK PLAZA HOSP
	SAINT LOUIS UNIVERSITY HOSP
	SIERRA MED CTR
Florida	
	GOOD SAMARITAN MED CTR
	HIALEAH HOSP
	PALMETTO GEN HOSP
Southern	
	CENTRAL CAROLINA HOSP
	FRYE REG MED CTR
	HILTON HEAD REG MED CTR
	SPALDING REG MED CTR
Northeast	
	HAHNEMANN UNIV HOSP
Phoenix	
	Arrowhead Hospital
	Maryvale Hospital
C	
California	
	JOHN F KENNEDY MEM HOSP
Central	
	CYPRESS FAIRBANKS MED CTR
	PROVIDENCE MEM HOSP
Southern	
	COASTAL CAROLINA MED CTR
	EAST COOPER REG MED CTR
South Texas	
	Valley Baptist - Brownsville
	Valley Baptist Medical Center - Harlingen
Northeast	
	Westlake Hospital
Phoenix	
	Paradise Valley Hospital
	Phoenix Baptist Hospital
	West Valley Hospital
N/A	
Central	
	PLAZA SPECIALTY HOSP
Southern	
	SOUTH FULTON MED CTR
	SYLVAN GROVE HOSP
Detroit	
	DMC Children's Hospital of Michigan
	DMC Hutzel Women's Hospital
	DMC Rehabilitation Institute of Michigan
	DMC Surgery Hospital
Northeast	
	ST CHRISTOPHER'S HOSP FOR CHILDREN
Phoenix	
	Arizona Heart Hospital

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 37: TJC TOP PERFORMERS

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

002389

The Joint Commission recognizes the following accredited hospitals that attained excellence in accountability measure performance during calendar year 2012. As a *Top Performer on Key Quality Measures®*, the following hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported accountability measure performance data for 2012.

Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Alabama										
Shelby Baptist Medical Center	Alabaster	✓	✓	✓	✓					
Community Hospital of Andalusia, Inc.	Andalusia			✓	✓					
Anniston HMA, LLC	Anniston	✓	✓	✓	✓					
The Health Care Authority for Medical West, An Affiliate of UAB	Bessemer	✓	✓	✓	✓					
Affinity Hospital, LLC	Birmingham	✓	✓	✓	✓					
Brookwood Medical Center	Birmingham	✓	✓	✓	✓					
Hill Crest Behavioral Health Services	Birmingham								✓	
Princeton Baptist Medical Center	Birmingham	✓	✓	✓	✓					
North Alabama Regional Hospital	Decatur								✓	
Flowers Hospital	Dothan	✓	✓	✓	✓					
Hospital and Behavioral Health	Dothan								✓	
QHG of Enterprise, Inc.	Enterprise			✓	✓					
South Baldwin Regional Medical Center	Foley	✓	✓	✓	✓					
DeKalb Regional Medical Center	Fort Payne	✓	✓	✓	✓					
Greenville Hospital Corporation	Greenville			✓	✓					
Lakeland Community Hospital	Haleyville			✓						
Crestwood Medical Center	Huntsville	✓	✓	✓	✓					
Walker Baptist Medical Center	Jasper	✓	✓	✓	✓					
University of South Alabama Medical Center	Mobile	✓	✓	✓	✓					
Baptist Medical Center East	Montgomery	✓	✓	✓	✓					
Jackson Hospital and Clinic, Inc.	Montgomery	✓	✓	✓	✓					
East Alabama Medical Center	Opelika	✓	✓	✓	✓					
Russell County Community Hospital, LLC	Phenix City				✓					
The Health Care Authority for Baptist Health, An Affiliate of UAB	Prattville			✓						
Russellville Hospital	Russellville	✓		✓	✓					
Vaughan Regional Medical Center, LLC	Selma	✓	✓	✓	✓					
Helen Keller Hospital	Sheffield		✓	✓	✓					
Coosa Valley Medical Center	Sylacauga		✓	✓	✓					
Bryce Hospital	Tuscaloosa								✓	
DCH Regional Medical Center	Tuscaloosa	✓	✓	✓	✓					
Mary Starke Harper Geriatric Psychiatry Center	Tuscaloosa								✓	
Taylor Hardin Secure Medical Facility	Tuscaloosa								✓	
Tuscaloosa VA Medical Center	Tuscaloosa								✓	
Alaska										
Alaska Psychiatric Institute	Anchorage								✓	
Alaska Regional Hospital	Anchorage	✓	✓	✓	✓					
PeaceHealth Ketchikan Medical Center	Ketchikan			✓	✓					
Mat-Su Regional Medical Center	Palmer	✓		✓	✓					
Central Peninsula Hospital	Soldotna			✓	✓					
Arizona										
Western Arizona Regional Medical Center	Bullhead City	✓	✓	✓	✓					
Orthopedic and Surgical Specialty Company, LLC	Chandler				✓					
Banner Gateway Medical Center	Gilbert		✓	✓	✓					
Arrowhead Hospital	Glendale	✓	✓	✓	✓					
Banner Desert Medical Center	Mesa	✓	✓	✓		✓				
Carondelet Holy Cross Hospital, Inc.	Nogales				✓					
Banner Estrella Medical Center-Banner Health	Phoenix	✓	✓	✓	✓					
Maryvale Hospital	Phoenix	✓	✓	✓	✓					
Mayo Clinic Hospital	Phoenix	✓	✓	✓	✓					
Paradise Valley Hospital	Phoenix	✓	✓	✓	✓					
UBH of Phoenix, LLC	Phoenix								✓	
Banner Ironwood Medical Center	San Tan Valley			✓	✓					
Banner Boswell Medical Center	Sun City	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Arkansas										
Baptist Health	Arkadelphia			✓	✓					
Valley Behavioral Health System, LLC	Barling								✓	
Sparks Regional Medical Center	Fort Smith	✓	✓	✓	✓					
Helena Regional Medical Center	Helena		✓	✓						
Arkansas Heart Hospital	Little Rock	✓	✓	✓	✓					
Baptist Health Medical Center-Little Rock	Little Rock	✓	✓	✓						
BHC Pinnacle Pointe Hospital, Inc.	Little Rock								✓	
United Methodist Behavioral Hospital	Maumelle								✓	
Harris Hospital	Newport		✓	✓	✓					
Arkansas Surgical Hospital, LLC	North Little Rock				✓					
Arkansas Methodist Hospital Corporation	Paragould	✓	✓	✓	✓					
Riverview Behavioral Health	Texarkana								✓	
Crittenden Hospital Association	West Memphis		✓	✓						
California										
Kaiser Foundation Hospital-Orange County-Anaheim	Anaheim	✓	✓	✓	✓					
Kaiser Foundation Hospital-Antioch	Antioch	✓	✓	✓	✓					
Sutter Auburn Faith Hospital	Auburn			✓	✓					
Kaiser Foundation Hospitals-Baldwin Park Medical Center	Baldwin Park	✓	✓	✓	✓					
Eden Medical Center	Castro Valley	✓	✓	✓	✓					
Sharp Coronado Hospital	Coronado				✓					
CHCM, Inc.	Costa Mesa								✓	
Aurora Charter Oak-Los Angeles, LLC	Covina								✓	
Kaiser Foundation Hospital-Downey Medical Center	Downey	✓	✓	✓	✓					
Scripps Memorial Hospital-Encinitas	Encinitas	✓	✓	✓	✓					
Encino Hospital Medical Center	Encino			✓						
Fallbrook Hospital Corporation	Fallbrook			✓	✓					
Mercy Hospital of Folsom	Folsom			✓	✓			✓		
Kaiser Foundation Hospital-Fontana	Fontana	✓	✓	✓	✓					
San Joaquin General Hospital	French Camp	✓	✓							
Fresno Heart Hospital, LLC	Fresno	✓			✓					
Kaiser Foundation Hospital-Fresno	Fresno	✓	✓	✓	✓					
Garden Grove Hospital and Medical Center	Garden Grove	✓		✓	✓					
Glendale Adventist Medical Center	Glendale	✓	✓	✓				✓		
Kaiser Foundation Hospital-South Bay	Harbor City	✓	✓	✓	✓					
Kaiser Foundation Hospital-Hayward/ Fremont Medical Center	Hayward	✓	✓	✓	✓					
The Huntington Beach Hospital	Huntington Beach			✓	✓					
Centinela Hospital Medical Center	Inglewood	✓	✓	✓	✓					
Scripps Green Hospital	La Jolla	✓	✓	✓	✓					
Scripps Memorial Hospital-La Jolla	La Jolla	✓	✓	✓	✓					
Grossmont Hospital Corporation	La Mesa	✓	✓	✓	✓					
La Palma Intercommunity Hospital	La Palma	✓		✓	✓					
Lakewood Regional Medical Center	Lakewood	✓	✓	✓	✓					
VA Loma Linda Healthcare System	Loma Linda	✓	✓	✓	✓					
Miller Children's Hospital	Long Beach					✓				
Kaiser Foundation Hospital-Los Angeles Medical Center	Los Angeles	✓	✓	✓	✓					
Ronald Reagan UCLA Medical Center	Los Angeles	✓	✓	✓	✓					
Memorial Hospital Los Banos	Los Banos			✓						
Kaiser Foundation Hospital-Manteca/Modesto	Manteca	✓		✓	✓					
Doctors Medical Center of Modesto	Modesto	✓	✓	✓	✓					
Memorial Medical Center	Modesto	✓	✓	✓	✓					
Kaiser Foundation Hospital-Moreno Valley Community Hospital	Moreno Valley	✓	✓	✓	✓					
Mercy Medical Center Mt. Shasta	Mount Shasta			✓	✓					
El Camino Hospital	Mountain View	✓	✓	✓	✓					
Paradise Valley Hospital	National City	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Kaiser Foundation Hospital-Oakland/Richmond	Oakland	✓	✓	✓	✓					
Sutter East Bay Hospitals-Summit Campus	Oakland	✓	✓	✓	✓					
Children's Hospital of Orange County	Orange					✓				
Lucile Salter Packard Children's Hospital at Stanford	Palo Alto					✓				
Kaiser Foundation Hospitals-Panorama City Medical Center	Panorama City	✓	✓	✓	✓					
Mission Community Hospital	Panorama City		✓	✓	✓					
Aurora Behavioral Health Care/Las Encinas Hospital	Pasadena								✓	
Department of State Hospitals-Patton	Patton								✓	
Placentia-Linda Hospital	Placentia	✓		✓	✓					
Marshall Medical Center	Placerville		✓	✓	✓					
ValleyCare Health System	Pleasanton	✓	✓	✓	✓					
Pomona Valley Hospital Medical Center	Pomona	✓	✓	✓						
Prime Healthcare Services-Shasta, LLC	Redding	✓	✓	✓	✓					
Kaiser Foundation Hospital-Redwood City	Redwood City	✓		✓	✓					
Sequoia Hospital	Redwood City	✓	✓	✓	✓					
Riverside Community Hospital	Riverside	✓	✓	✓	✓					
BHC Alhambra Hospital	Rosemead								✓	
BHC Heritage Oaks Hospital	Sacramento								✓	
Kaiser Foundation Hospital-Sacramento	Sacramento	✓	✓	✓	✓					
Salinas Valley Memorial Hospital	Salinas	✓	✓	✓						
Kaiser Foundation Hospital-San Diego	San Diego	✓	✓	✓	✓					
Scripps Mercy Hospital	San Diego	✓	✓	✓	✓					
Sharp Memorial Hospital	San Diego	✓	✓	✓	✓					
VA San Diego Healthcare System	San Diego	✓	✓	✓	✓					
San Dimas Community Hospital	San Dimas			✓	✓					
California Pacific Medical Center-St. Luke's	San Francisco		✓	✓	✓					
Kaiser Foundation Hospital-San Francisco	San Francisco	✓	✓	✓	✓					
Kaiser Foundation Hospital-San Jose	San Jose	✓	✓	✓	✓					
Regional Medical Center of San Jose	San Jose	✓	✓	✓	✓					
Kaiser Foundation Hospital-San Rafael	San Rafael	✓		✓	✓					
Kaiser Foundation Hospital-Santa Clara	Santa Clara	✓	✓	✓	✓					
Kaiser Permanente Psychiatric Health Facility-Santa Clara	Santa Clara								✓	
Dignity Health	Santa Cruz	✓	✓	✓	✓					
Sutter Maternity & Surgery Center of Santa Cruz	Santa Cruz				✓					
Saint John's Health Center	Santa Monica	✓	✓	✓	✓					
Santa Monica-UCLA Medical Center and Orthopaedic Hospital	Santa Monica	✓	✓	✓	✓					
Kaiser Foundation Hospital-Santa Rosa	Santa Rosa	✓	✓	✓	✓					
Sutter Medical Center of Santa Rosa	Santa Rosa	✓	✓	✓	✓					
Sonoma Valley Health Care District	Sonoma			✓	✓					
Sonora Community Hospital	Sonora	✓		✓						
Kaiser Foundation Hospital-South San Francisco	South San Francisco	✓	✓	✓	✓					
Dameron Hospital Association	Stockton	✓	✓	✓	✓					
St. Joseph's Medical Center of Stockton	Stockton	✓	✓	✓	✓					
Twin Cities Community Hospital	Templeton		✓	✓	✓					
Los Robles Hospital and Medical Center	Thousand Oaks	✓	✓	✓	✓					
Providence Little Company of Mary Medical Center Torrance	Torrance	✓	✓	✓	✓					
Emanuel Medical Center	Turlock	✓	✓	✓	✓					
Kaiser Foundation Hospital-Vacaville	Vacaville	✓		✓	✓					
Kaiser Foundation Hospital and Rehabilitation Center-Vallejo	Vallejo	✓	✓	✓	✓					
Sutter Solano Medical Center	Vallejo	✓	✓	✓	✓					
Watsonville Community Hospital	Watsonville			✓	✓					
Citrus Valley Medical Center	West Covina	✓	✓	✓	✓					
Presbyterian Intercommunity Hospital	Whittier	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Colorado										
The Medical Center of Aurora	Aurora	✓	✓	✓	✓					
Platte Valley Medical Center	Brighton	✓		✓	✓					
Colorado Mental Health Institute at Fort Logan	Denver								✓	
Rose Medical Center	Denver	✓	✓	✓	✓					
Mercy Regional Medical Center	Durango	✓		✓	✓					
Poudre Valley Hospital	Fort Collins	✓	✓	✓						
Colorado Plains Medical Center	Fort Morgan			✓	✓					
Catholic Health Initiatives Colorado	Frisco				✓					
Valley View Hospital Association	Glenwood Springs	✓		✓	✓					
Grand Junction Veterans Affairs Medical Center	Grand Junction			✓	✓					
North Colorado Medical Center	Greeley	✓	✓	✓	✓					
Exempla Good Samaritan Medical Center, LLC	Lafayette	✓	✓	✓	✓					
OrthoColorado Hospital at St. Anthony Medical Campus	Lakewood				✓					
Highlands Behavioral Health System	Littleton								✓	
HCA/HealthOne, LLC, Sky Ridge Medical Center	Lone Tree	✓		✓	✓					
Avista Adventist Hospital	Louisville			✓	✓					
Haven Behavioral War Heroes Hospital @ St. Mary-Corwin	Pueblo								✓	
Sterling Regional MedCenter	Sterling				✓					
North Suburban Medical Center	Thornton	✓		✓	✓					
Exempla Lutheran Medical Center	Wheat Ridge	✓	✓	✓	✓					
Connecticut										
St. Vincent's Medical Center	Bridgeport	✓	✓	✓	✓					
Griffin Hospital	Derby	✓	✓	✓	✓					
John Dempsey Hospital	Farmington	✓	✓	✓	✓					
Albert J. Solnit Children's Center-South Campus	Middletown								✓	
Middlesex Hospital	Middletown	✓	✓	✓	✓					
The William W. Backus Hospital	Norwich	✓	✓	✓	✓					
Day Kimball Healthcare, Inc.	Putnam	✓		✓	✓					
Saint Mary's Hospital, Inc.	Waterbury	✓	✓	✓	✓					
Delaware										
Bayhealth-Kent General Hospital	Dover	✓	✓	✓	✓					
Dover Behavioral Health System	Dover								✓	
Beebe Medical Center	Lewes	✓	✓	✓	✓					
Meadow Wood Behavioral Health System	New Castle								✓	
VA Medical Center	Wilmington				✓					
District of Columbia										
Sibley Memorial Hospital	Washington			✓	✓					
Florida										
JFK Medical Center Limited Partnership	Atlantis	✓	✓	✓	✓					
Bartow HMA, LLC	Bartow		✓	✓	✓					
Bay Pines VA Healthcare System	Bay Pines	✓	✓	✓	✓					
Boca Raton Regional Hospital, Inc.	Boca Raton	✓	✓	✓	✓					
Bethesda Hospital, Inc.	Boynton Beach	✓	✓	✓	✓					
Blake Medical Center	Bradenton	✓	✓	✓	✓					
Manatee Memorial Hospital	Bradenton	✓	✓	✓	✓					
Brandon Regional Hospital	Brandon	✓	✓	✓	✓					
Brooksville & Spring Hill Regional Hospitals	Brooksville	✓	✓	✓	✓					
Oak Hill Hospital	Brooksville	✓	✓	✓	✓					
Morton Plant Hospital Association	Clearwater	✓	✓	✓	✓					
Windmoor Healthcare of Clearwater, Inc.	Clearwater								✓	
Cape Canaveral Hospital, Inc.	Cocoa Beach	✓	✓	✓	✓					
Coral Gables Hospital	Coral Gables	✓	✓	✓	✓					
Doctors Hospital, Inc.	Coral Gables		✓	✓	✓					
Broward Health Coral Springs	Coral Springs	✓	✓	✓	✓					
North Okaloosa Medical Center	Crestview	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Pasco Regional Medical Center	Dade City	✓	✓	✓	✓					
Heart of Florida Regional Medical Center	Davenport	✓	✓	✓	✓					
Halifax Health	Daytona Beach	✓	✓	✓	✓					
Florida Hospital Deland	Deland	✓	✓	✓	✓					
Delray Medical Center, Inc.	Delray Beach	✓	✓	✓	✓					
Mease Dunedin Hospital	Dunedin	✓	✓	✓	✓					
96th Medical Group	Eglin AFB			✓	✓		✓			
Englewood Community Hospital	Englewood			✓	✓					
South Florida Evaluation and Treatment Center (SFETC)	Florida City								✓	
Atlantic Shores Hospital	Fort Lauderdale								✓	
Broward Health Medical Center	Fort Lauderdale	✓	✓	✓	✓					
Fort Lauderdale Hospital Management, LLC	Fort Lauderdale								✓	
Holy Cross Hospital, Inc.	Fort Lauderdale	✓	✓	✓	✓					
North Broward Hospital District	Fort Lauderdale	✓	✓	✓	✓					
Lawnwood Regional Medical Center & Heart Institute	Fort Pierce	✓	✓	✓	✓	✓				
Fort Walton Beach Medical Center, Inc.	Fort Walton Beach	✓	✓	✓	✓					
North Florida Regional Medical Center	Gainesville	✓	✓	✓	✓					
Gulf Breeze Hospital	Gulf Breeze			✓	✓					
Palmetto General Hospital	Hialeah	✓	✓	✓	✓					
Hollywood Pavilion, LLC	Hollywood								✓	
Memorial Regional Hospital	Hollywood	✓	✓	✓	✓	✓			✓	
Memorial Healthcare, Inc.	Jacksonville	✓	✓	✓	✓					
River Point Behavioral Health	Jacksonville								✓	
St. Vincent's Medical Center Riverside	Jacksonville	✓	✓	✓	✓					
St. Vincent's Southside-St. Vincent's HealthCare, Inc.	Jacksonville	✓	✓	✓	✓					
Wekiva Springs Center, LLC	Jacksonville								✓	
Jupiter Medical Center	Jupiter	✓	✓	✓	✓					
Key West HMA, LLC	Key West	✓		✓	✓					
Osceola Regional Medical Center	Kissimmee	✓	✓	✓	✓					
Lake City Medical Center	Lake City		✓	✓	✓					
Largo Medical Center	Largo	✓	✓	✓	✓					
Palms West Hospital	Loxahatchee	✓	✓	✓	✓					
Northwest Medical Center	Margate	✓	✓	✓	✓					
Circles of Care, Inc.	Melbourne								✓	
Holmes Regional Medical Center, Inc.	Melbourne	✓	✓	✓	✓					
Viera Hospital, Inc.	Melbourne	✓		✓	✓					
Baptist Hospital of Miami	Miami	✓	✓	✓	✓			✓		
Kendall Regional Medical Center	Miami	✓	✓	✓	✓					
South Miami Hospital	Miami	✓	✓	✓	✓					
West Kendall Baptist Hospital	Miami	✓	✓	✓	✓					
Santa Rosa Medical Center	Milton	✓		✓	✓					
Memorial Hospital Miramar	Miramar	✓	✓	✓	✓					
Sacred Heart Hospital on the Emerald Coast	Miramar Beach	✓		✓	✓					
Twin Cities Hospital	Niceville			✓	✓					
Ocala Regional Medical Center	Ocala	✓	✓	✓	✓					
Raulerson Hospital	Okeechobee	✓	✓	✓	✓					
Florida Hospital Fish Memorial	Orange City	✓	✓	✓	✓					
Orange Park Medical Center	Orange Park	✓	✓	✓	✓					
Palm Bay Hospital	Palm Bay	✓	✓	✓	✓					
Palm Beach Gardens Medical Center	Palm Beach Gardens	✓	✓	✓	✓					
Florida Hospital Flagler	Palm Coast	✓	✓	✓	✓					
Gulf Coast Medical Center	Panama City	✓	✓	✓	✓					
Geo Care LLC South Florida State Hospital	Pembroke Pines								✓	
Memorial Hospital Pembroke	Pembroke Pines	✓	✓	✓	✓					
Memorial Hospital West	Pembroke Pines	✓	✓	✓	✓					
Naval Hospital Pensacola	Pensacola				✓		✓			
West Florida Regional Medical Center, Inc.	Pensacola	✓	✓	✓	✓					

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Plantation General Hospital	Plantation	✓	✓	✓	✓					
Westside Regional Medical Center	Plantation	✓	✓	✓	✓					
Broward Health North	Pompano Beach	✓	✓	✓	✓					
Fawcett Memorial Hospital	Port Charlotte	✓	✓	✓	✓					
St. Lucie Medical Center	Port Saint Lucie	✓	✓	✓	✓					
Charlotte Regional Medical Center	Punta Gorda	✓	✓	✓	✓					
St. Cloud Regional Medical Center	Saint Cloud		✓	✓	✓					
All Children's Hospital, Inc.	Saint Petersburg					✓				
Edward White Hospital	Saint Petersburg			✓	✓					
Northside Hospital	Saint Petersburg	✓	✓	✓	✓					
St. Petersburg General Hospital	Saint Petersburg	✓		✓	✓					
Central Florida Regional Hospital	Sanford	✓	✓	✓	✓					
Doctors Hospital of Sarasota	Sarasota	✓	✓	✓	✓					
Sebastian River Medical Center	Sebastian	✓	✓	✓	✓					
Florida Hospital Heartland Medical Center	Sebring	✓	✓	✓	✓					
Highlands Regional Medical Center	Sebring	✓	✓	✓	✓					
Shands Starke Regional Medical Center	Starke			✓						
South Bay Hospital	Sun City Center	✓	✓	✓	✓					
Capital Regional Medical Center	Tallahassee	✓	✓	✓	✓					
St. Joseph's Hospital, Inc.	Tampa	✓	✓	✓	✓					
Florida Hospital North Pinellas	Tarpon Springs	✓	✓	✓	✓					
Florida Hospital Waterman	Tavares	✓	✓	✓	✓					
Mariners Hospital	Tavernier			✓	✓					
North Brevard County Hospital District	Titusville	✓	✓	✓	✓					
Medical Center of Trinity	Trinity	✓	✓	✓	✓					
Venice HMA, LLC	Venice	✓	✓	✓	✓					
Wellington Regional Medical Center	Wellington	✓	✓	✓	✓					
West Palm Hospital	West Palm Beach			✓	✓					
Florida Hospital Zephyrhills	Zephyrhills	✓	✓	✓	✓					
Georgia										
Northside Hospital, Inc.	Atlanta		✓	✓	✓					
Wesley Woods Center of Emory University	Atlanta								✓	
Doctors Hospital of Augusta	Augusta	✓	✓	✓	✓					
Trinity Hospital of Augusta	Augusta	✓		✓	✓					
Fannin Regional Hospital	Blue Ridge			✓	✓					
Higgins General Hospital	Bremen			✓						
Gordon Hospital	Calhoun	✓	✓	✓	✓					
Northside Hospital-Cherokee	Canton		✓	✓	✓					
Tanner Medical Center, Inc.	Carrollton	✓	✓	✓	✓					
Cartersville Medical Center	Cartersville	✓	✓	✓	✓					
Hughston Hospital	Columbus				✓					
Rockdale Hospital, LLC	Conyers	✓	✓	✓	✓					
Crisp Regional Hospital, Inc.	Cordele	✓	✓	✓	✓					
Northside Hospital-Forsyth	Cumming		✓	✓	✓					
Georgia Regional Hospital at Atlanta	Decatur								✓	
Coffee Regional Medical Center	Douglas		✓	✓	✓					
Fairview Park Hospital	Dublin	✓	✓	✓	✓					
VA Medical Center-Carl Vinson	Dublin			✓						
West Georgia Medical Center, Inc.	Lagrange	✓	✓	✓	✓					
Gwinnett Medical Center	Lawrenceville	✓	✓	✓	✓					
Coliseum Medical Centers	Macon	✓	✓	✓	✓					
Coliseum Northside Hospital	Macon			✓	✓					
Coliseum Psychiatric Center, LLC	Macon								✓	
Colquitt Regional Medical Center	Moultrie		✓	✓	✓					
Perry Hospital	Perry			✓	✓					
RiverWoods Behavioral Health System, LLC	Riverdale								✓	
Redmond Park Hospital, LLC	Rome	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
North Fulton Medical Center, Inc.	Roswell	✓	✓	✓	✓					
Georgia Regional Hospital at Savannah	Savannah								✓	
Emory-Adventist Hospital	Smyrna			✓	✓					
Ridgeview Institute	Smyrna								✓	
John D. Archbold Memorial Hospital	Thomasville	✓	✓	✓	✓					
Southwestern State Hospital	Thomasville								✓	
Tanner Medical Center/Villa Rica	Villa Rica	✓		✓	✓					
Barrow Regional Medical Center	Winder			✓	✓					
Hawaii										
Sutter Health Pacific	Ewa Beach								✓	
Kaiser Foundation Hospital	Honolulu	✓	✓	✓	✓					
The Queen's Medical Center	Honolulu	✓	✓	✓	✓					
Castle Medical Center	Kailua	✓	✓	✓						
Idaho										
State Hospital South	Blackfoot								✓	
Saint Alphonsus Regional Medical Center	Boise	✓	✓	✓	✓					
West Valley Medical Center	Caldwell	✓		✓	✓					
Eastern Idaho Health Services	Idaho Falls	✓	✓	✓	✓					
Saint Alphonsus Medical Center-Nampa	Nampa	✓	✓	✓	✓					
St. Luke's Magic Valley Medical Center	Twin Falls	✓	✓	✓	✓					
Illinois										
Alton Memorial Hospital	Alton	✓	✓	✓	✓					
Saint Anthony's Health Center	Alton	✓		✓	✓					
St. Elizabeth's Hospital	Belleville	✓	✓	✓	✓					
MacNeal Hospital	Berwyn	✓	✓	✓	✓					
MetroSouth Medical Center	Blue Island	✓	✓	✓						
St. Mary's Hospital	Centralia	✓		✓	✓					
The Pavilion Foundation	Champaign								✓	
Chester Mental Health Center	Chester								✓	
Advocate Illinois Masonic Medical Center	Chicago	✓	✓	✓	✓					
Ann & Robert H. Lurie Children's Hospital of Chicago	Chicago					✓				
Aurora Chicago Lakeshore Hospital	Chicago								✓	
Louis A. Weiss Memorial Hospital	Chicago	✓	✓	✓	✓					
Rush University Medical Center	Chicago	✓	✓	✓	✓					
Kishwaukee Community Hospital	Dekalb	✓	✓	✓	✓					
Presence Saint Joseph Hospital-Elgin	Elgin	✓		✓	✓					
Alexian Brothers Medical Center	Elk Grove Village	✓	✓	✓	✓					
Little Company of Mary Hospital	Evergreen Park	✓	✓	✓	✓	✓				
Clay County Hospital	Flora			✓						
Riveredge Hospital	Forest Park								✓	
Gibson Community Hospital	Gibson City				✓					
Granite City Illinois Hospital Company, LLC	Granite City	✓	✓	✓	✓					
Adventist La Grange Memorial Hospital	La Grange	✓	✓	✓	✓					
VA Medical Center	Marion			✓						
Gottlieb Memorial Hospital	Melrose Park	✓	✓	✓	✓					
Silver Cross Hospital	New Lenox	✓	✓	✓	✓					
Ottawa Regional Hospital and Healthcare Center	Ottawa			✓	✓					
OSF Saint Francis Medical Center	Peoria	✓	✓	✓	✓					
The Methodist Medical Center of Illinois	Peoria	✓	✓	✓	✓					
OSF Saint James-John W. Albrecht Medical Center	Pontiac			✓	✓					
Blessing Hospital	Quincy	✓	✓	✓	✓					
Red Bud Regional Hospital, LLC	Red Bud			✓	✓					
Valley West Community Hospital	Sandwich			✓	✓					
Genesis Medical Center, Illini Campus	Silvis		✓	✓	✓					
St. Mary's Hospital	Streator			✓	✓					
CTCA at Midwestern Regional Medical Center	Zion				✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Indiana										
St. Vincent Anderson Regional Hospital	Anderson	✓	✓	✓	✓					
Bloomington Meadows Hospital	Bloomington								✓	
Bluffton Regional Medical Center	Bluffton			✓	✓					
St. Catherine Hospital, Inc.	East Chicago	✓	✓	✓	✓					
Evansville State Hospital	Evansville								✓	
Dupont Hospital, LLC	Fort Wayne			✓	✓					
Lutheran Hospital of Indiana	Fort Wayne	✓	✓	✓	✓					
Orthopaedic Hospital at Parkview North	Fort Wayne				✓					
The Orthopedic Hospital of Lutheran Health Network	Fort Wayne				✓					
VA Northern Indiana Health Care System	Fort Wayne			✓						
St. Vincent Frankfort Hospital	Frankfort			✓						
Valle Vista Health System	Greenwood								✓	
Huntington Memorial Hospital	Huntington			✓	✓					
Larue D. Carter Memorial Hospital	Indianapolis								✓	
Wishard Health Services	Indianapolis	✓	✓	✓	✓					
Wellstone Regional Hospital Acquisition, LLC	Jeffersonville								✓	
Parkview Noble Hospital	Kendallville			✓	✓					
St. Joseph Hospital & Health Center, Inc.	Kokomo		✓	✓	✓					
Logansport State Hospital	Logansport								✓	
Madison State Hospital	Madison								✓	
Indiana University Health Morgan Hospital	Martinsville			✓						
Saint Joseph Regional Medical Center	Mishawaka	✓	✓	✓	✓					
Indiana University Health Ball Memorial Hospital, Inc.	Muncie	✓	✓	✓	✓					
Brentwood Meadows, LLC	Newburgh								✓	
Dukes Memorial Hospital	Peru			✓						
HHC Indiana, Inc.	Plymouth								✓	
Gibson General Hospital, Inc.	Princeton			✓						
Harsha Behavioral Center, Inc.	Terre Haute								✓	
Terre Haute Regional Hospital	Terre Haute	✓	✓	✓	✓					
Kosciusko Community Hospital	Warsaw	✓	✓	✓	✓					
Iowa										
Mary Greeley Medical Center	Ames	✓	✓	✓	✓					
Sartori Memorial Hospital-Wheaton Franciscan Healthcare	Cedar Falls			✓	✓					
Mercy Medical Center, Cedar Rapids, Iowa	Cedar Rapids	✓	✓	✓	✓					
Mercy Medical Center-Clinton	Clinton	✓	✓	✓	✓					
Genesis Medical Center, Davenport	Davenport	✓	✓	✓	✓					
Mercy Medical Center	Des Moines	✓	✓	✓	✓					
Mental Health Institute	Independence								✓	
The University of Iowa Hospitals and Clinics	Iowa City	✓	✓	✓	✓					
Allen Memorial Hospital	Waterloo	✓	✓	✓	✓					
Covenant Medical Center-Wheaton Franciscan Healthcare-Iowa	Waterloo	✓		✓	✓					
Great River Medical Center	West Burlington	✓	✓	✓	✓					
Kansas										
Allen County Hospital	Iola			✓						
Rainbow Mental Health Facility	Kansas City								✓	
Lawrence Memorial Hospital	Lawrence	✓		✓	✓					
Saint John Hospital	Leavenworth			✓						
Osawatomie State Hospital	Osawatomie								✓	
Miami County Medical Center, Inc.	Paola				✓					
Shawnee Mission Medical Center	Shawnee Mission	✓	✓	✓	✓					
Stormont-Vail HealthCare, Inc.	Topeka	✓	✓	✓	✓					
Via Christi Hospital Wichita St. Teresa, Inc.	Wichita			✓	✓					
Wesley Medical Center, LLC	Wichita	✓	✓	✓	✓	✓				

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Kentucky										
Ashland Hospital Corporation	Ashland	✓	✓	✓	✓					
Flaget Healthcare, Inc.	Bardstown			✓	✓					
Saint Joseph Berea	Berea			✓	✓					
Greenview Regional Hospital	Bowling Green			✓	✓					
Rivendell Behavioral Health Services of Kentucky	Bowling Green								✓	
Ephraim McDowell Regional Medical Center, Inc.	Danville	✓	✓	✓	✓					
Saint Elizabeth Medical Center, Inc.	Edgewood	✓	✓	✓	✓					
Saint Elizabeth Medical Center, Inc.	Fort Thomas	✓	✓	✓	✓					
Frankfort Regional Medical Center	Frankfort	✓	✓	✓	✓					
Parkway Regional Hospital	Fulton			✓	✓					
Harlan Appalachian Regional Hospital	Harlan		✓	✓	✓					
ABS LINCS KY, Inc.	Hopkinsville								✓	
Western State Hospital	Hopkinsville								✓	
Spring View Hospital	Lebanon			✓	✓					
Twin Lakes Regional Medical Center	Leitchfield			✓	✓					
Saint Joseph East	Lexington	✓	✓	✓	✓					
University of Kentucky Hospital	Lexington	✓	✓	✓	✓	✓				
Hospital of Louisa, Inc.	Louisa			✓	✓					
Middlesboro ARH Hospital	Middlesboro		✓	✓						
Saint Joseph Health System, Inc.	Mount Sterling			✓	✓					
Owensboro Health, Inc.	Owensboro	✓	✓	✓	✓					
Baptist Healthcare System, Inc.	Paducah	✓	✓	✓	✓					
Paul B. Hall Regional Medical Center	Paintsville			✓						
Bourbon Community Hospital	Paris			✓						
Logan Memorial Hospital	Russellville			✓						
Louisiana										
Oceans Behavioral Hospital of Alexandria	Alexandria								✓	
Rapides Regional Medical Center	Alexandria	✓	✓	✓	✓					
Earl K. Long Medical Center	Baton Rouge	✓	✓	✓	✓					
Woman's Hospital	Baton Rouge				✓					
Washington St. Tammany Regional Medical Center	Bogalusa		✓	✓	✓					
Oceans Behavioral Hospital of Lafayette	Broussard								✓	
Lakeview Regional Medical Center	Covington	✓	✓	✓	✓					
Oceans Behavioral Hospital-Deridder	Deridder								✓	
Southern Regional Medical Corporation	Houma	✓	✓	✓	✓					
Oceans Behavioral Hospital of Greater New Orleans	Kenner								✓	
Heart Hospital of Lafayette	Lafayette	✓			✓					
Lafayette General Medical Center, Inc.	Lafayette	✓	✓	✓						
The Regional Medical Center of Acadiana	Lafayette	✓	✓	✓	✓					
MBH of Louisiana, LLC	Mandeville								✓	
Minden Medical Center	Minden	✓	✓	✓	✓					
Progressive Acute Care Dauterive, LLC	New Iberia	✓		✓	✓					
Oceans Behavioral Hospital of Opelousas	Opelousas								✓	
Central Louisiana State Hospital	Pineville								✓	
Ochsner St. Anne General Hospital	Raceland			✓	✓					
Phoenix Behavioral Hospital of Eunice	Rayne								✓	
Ruston Louisiana Hospital Company, LLC	Ruston	✓	✓	✓	✓					
Maine										
MaineGeneral Medical Center	Augusta	✓	✓	✓	✓					
Southern Maine Medical Center	Biddeford	✓	✓	✓	✓					
Mid Coast Hospital	Brunswick	✓	✓	✓	✓					
Cary Medical Center	Caribou			✓	✓					
Maine Coast Memorial Hospital	Ellsworth	✓		✓	✓					
Franklin Memorial Hospital	Farmington			✓	✓					
Northern Maine Medical Center	Fort Kent			✓						
Sebasticook Valley Health	Pittsfield			✓						

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Maine Medical Center	Portland	✓	✓	✓	✓					
Mercy Hospital	Portland	✓		✓	✓					
Henrietta D. Goodall Hospital	Sanford			✓	✓					
Maryland										
Maryland General Hospital	Baltimore		✓	✓	✓					
The Johns Hopkins Hospital	Baltimore	✓	✓	✓	✓					
Upper Chesapeake Medical Center	Bel Air	✓	✓	✓	✓					
Spring Grove Hospital Center	Catonsville								✓	
Thomas B. Finan Center	Cumberland								✓	
Frederick Memorial Hospital	Frederick	✓	✓	✓	✓					
Brook Lane Health Services	Hagerstown								✓	
Harford Memorial Hospital	Havre De Grace			✓	✓					
Clifton T. Perkins Hospital Center	Jessup								✓	
Civista Medical Center, Inc.	La Plata		✓	✓	✓					
Doctors Community Hospital	Lanham	✓	✓	✓	✓					
MedStar Montgomery Medical Center	Olney	✓	✓	✓	✓					
Calvert Memorial Hospital	Prince Frederick	✓	✓	✓	✓					
Shady Grove Adventist Hospital	Rockville	✓	✓	✓	✓					
Holy Cross Hospital of Silver Spring, Inc.	Silver Spring	✓	✓	✓	✓					
Washington Adventist Hospital	Takoma Park	✓	✓	✓	✓					
Massachusetts										
Sturdy Memorial Hospital, Inc.	Attleboro	✓	✓	✓	✓					
Northeast Hospital Corporation	Beverly	✓	✓	✓	✓					
Beth Israel Deaconess Medical Center	Boston	✓	✓	✓	✓					
Brigham and Women's Faulkner Hospital	Boston		✓	✓	✓					
Franciscan Hospital for Children, Inc.	Boston								✓	
New England Baptist Hospital	Boston				✓					
Signature-Healthcare Brockton Hospital	Brockton	✓	✓	✓	✓					
Steward Carney Hospital, Inc.	Dorchester		✓	✓	✓					
Falmouth Hospital	Falmouth	✓		✓	✓					
MetroWest Medical Center	Framingham	✓	✓	✓	✓					
Fairview Hospital	Great Barrington			✓	✓					
Beth Israel Deaconess Hospital-Milton	Milton			✓	✓					
Newton-Wellesley Hospital	Newton Lower Falls	✓	✓	✓	✓					
North Adams Regional Hospital	North Adams			✓	✓					
Berkshire Medical Center	Pittsfield	✓	✓	✓	✓					
Walden Behavioral Care	Waltham								✓	
Noble Hospital	Westfield			✓	✓					
VHS Acquisition Subsidiary Number 7, Inc.	Worcester	✓	✓	✓	✓					
Michigan										
St. Joseph Mercy Hospital	Ann Arbor	✓	✓	✓	✓					
The University of Michigan Hospitals and Health Centers	Ann Arbor	✓	✓	✓	✓					
Mecosta County Medical Center	Big Rapids			✓	✓					
Caro Center	Caro								✓	
MidMichigan Medical Center-Clare	Clare			✓	✓					
BCA of Detroit, LLC	Detroit								✓	
Detroit Receiving Hospital and University Health Center	Detroit	✓	✓	✓	✓					
Borgess-Lee Memorial Hospital	Dowagiac			✓						
Newaygo County General Hospital Association	Fremont			✓	✓					
MidMichigan Medical Center Gladwin	Gladwin			✓						
Forest View Psychiatric Hospital	Grand Rapids								✓	
Beaumont Hospital, Grosse Pointe	Grosse Pointe	✓	✓	✓	✓					
WA Foote Memorial Hospital	Jackson	✓	✓	✓	✓					
Kalamazoo Psychiatric Hospital	Kalamazoo								✓	
Aspirus Keweenaw Hospital	Laurium			✓	✓					
St. Mary Mercy Hospital	Livonia	✓	✓	✓	✓					
Mercy Memorial Hospital System	Monroe	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
St. Joseph Mercy Oakland	Pontiac	✓	✓	✓	✓			✓		
St. Joseph Mercy Port Huron	Port Huron	✓	✓	✓	✓					
Spectrum Health Reed City Hospital	Reed City			✓						
William Beaumont Hospital	Royal Oak	✓	✓	✓	✓					
South Haven Community Hospital, Authority	South Haven			✓	✓					
Straith Hospital for Special Surgery	Southfield									✓
Oakwood Heritage Hospital	Taylor	✓	✓	✓	✓					
William Beaumont Hospital	Troy	✓	✓	✓	✓					
Walter P. Reuther Psychiatric Hospital	Westland								✓	
Spectrum Health Zeeland Community Hospital	Zeeland			✓	✓					
Minnesota										
Mayo Clinic Health System-Austin	Austin		✓	✓	✓					
Cambridge Medical Center	Cambridge			✓	✓					
Fairview Southdale Hospital	Edina	✓	✓	✓	✓					
Unity Hospital	Fridley	✓	✓	✓	✓					
VA Health Care System-Minneapolis	Minneapolis	✓	✓	✓	✓					
New Ulm Medical Center	New Ulm			✓	✓					
Owatonna Hospital	Owatonna			✓	✓					
St. Joseph's Area Health Services	Park Rapids				✓					
Fairview Northland Health Services	Princeton			✓	✓					
Mayo Clinic Health System in Red Wing	Red Wing			✓	✓					
Regions Hospital	Saint Paul	✓	✓	✓	✓					
St. Francis Regional Medical Center	Shakopee			✓	✓					
Lakeview Memorial Hospital	Stillwater				✓					
Child and Adolescent Behavioral Health Services	Willmar								✓	
Woodwinds Health Campus	Woodbury			✓	✓					
Fairview Lakes Medical Center	Wyoming			✓	✓					
Mississippi										
Amory HMA, LLC	Amory		✓	✓	✓					
Hancock Medical Center	Bay Saint Louis		✓	✓	✓					
81st Medical Group	Biloxi		✓		✓					
Biloxi Regional Medical Center	Biloxi		✓	✓	✓					
Baptist Memorial Hospital-Booneville	Booneville			✓						
Bolivar Medical Center	Cleveland			✓	✓					
Baptist Memorial Hospital-Golden Triangle	Columbus	✓	✓	✓	✓					
Garden Park Medical Center	Gulfport		✓	✓	✓					
Wesley Health System, LLC	Hattiesburg	✓	✓	✓	✓					
River Oaks Hospital, LLC	Jackson			✓	✓					
Woman's Hospital	Jackson				✓					
Alliance Health Center, Inc.	Meridian								✓	
Natchez Community Hospital	Natchez		✓	✓	✓					
Baptist Memorial Hospital-Union County	New Albany		✓	✓						
Baptist Memorial Hospital-North Mississippi	Oxford	✓	✓	✓	✓					
River Region Medical Center	Vicksburg	✓	✓	✓	✓					
Missouri										
Belton Regional Medical Center	Belton			✓	✓					
SSM DePaul Health Center	Bridgeton	✓	✓	✓	✓					
Harry S. Truman Memorial Veterans' Hospital	Columbia	✓	✓	✓	✓					
University of Missouri Health Care	Columbia	✓	✓	✓	✓					
SSM St. Clare Health Center	Fenton	✓	✓	✓	✓					
Cass Regional Medical Center	Harrisonville			✓	✓				✓	
Centerpoint Medical Center of Independence, LLC	Independence	✓	✓	✓	✓					
St. Mary's Health Center	Jefferson City	✓	✓	✓	✓					
Research Medical Center	Kansas City	✓	✓	✓	✓					
Research Psychiatric Center	Kansas City								✓	
SSM St. Joseph Hospital West	Lake Saint Louis	✓	✓	✓	✓					
Lee's Summit Medical Center	Lee's Summit	✓	✓	✓	✓					

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

002400

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Lafayette Regional Health Center	Lexington			✓	✓					
Moberly Hospital Company, LLC	Moberly	✓		✓	✓					
Perry County Memorial Hospital	Perryville			✓	✓					
John J. Pershing VA Medical Center	Poplar Bluff			✓						
SSM St. Mary's Health Center	Richmond Heights	✓	✓	✓	✓	✓				
SSM St. Joseph Health Center	Saint Charles	✓	✓	✓	✓					
Heartland Regional Medical Center	Saint Joseph	✓	✓	✓	✓					
Northwest Missouri Psychiatric Rehabilitation Center	Saint Joseph								✓	
Hawthorn Children's Psychiatric Hospital	Saint Louis								✓	
Saint Louis University Hospital	Saint Louis	✓	✓	✓	✓					
St. Louis VA Healthcare System	Saint Louis	✓	✓	✓	✓					
Lincoln County Medical Center	Troy			✓	✓					
Mercy Hospital Washington	Washington	✓	✓	✓	✓					
Royal Oaks Hospital	Windsor								✓	
Montana										
St. Vincent Healthcare	Billings	✓	✓	✓	✓					
Bozeman Deaconess Hospital	Bozeman	✓		✓	✓					
Holy Rosary Healthcare	Miles City			✓	✓					
St. Patrick Hospital	Missoula	✓	✓	✓	✓					
Providence St. Joseph Medical Center	Polson				✓					
Nebraska										
Bellevue Medical Center	Bellevue	✓		✓	✓					
Columbus Community Hospital, Inc.	Columbus			✓	✓					
Lincoln Regional Center	Lincoln								✓	
Community Hospital	McCook				✓					
Alegent Creighton Health Creighton University Medical Center	Omaha	✓	✓	✓	✓					
Regional West Medical Center	Scottsbluff	✓		✓						
Nevada										
Sierra Surgery Hospital	Carson City				✓					
Northeastern Nevada Regional Hospital	Elko			✓	✓					
Banner Churchill Community Hospital	Fallon			✓	✓					
St. Rose Dominican Hospitals-Rose de Lima Campus	Henderson	✓	✓	✓	✓					
Red Rock Behavioral Health Hospital	Las Vegas								✓	
SBH-Montevista Hospital	Las Vegas								✓	
Southern Hills Medical Center, LLC	Las Vegas	✓	✓	✓	✓					
Spring Mountain Treatment Center	Las Vegas								✓	
Sunrise MountainView Hospital	Las Vegas	✓	✓	✓	✓					
Mesa View Regional Hospital	Mesquite			✓	✓					
Renown Regional Medical Center	Reno	✓	✓	✓	✓	✓				
Renown South Meadows Medical Center	Reno			✓	✓					
VA Sierra Nevada Health Care System	Reno		✓	✓	✓					
Northern Nevada Adult Mental Health Services	Sparks								✓	
Northern Nevada Medical Center	Sparks	✓		✓	✓					
New Hampshire										
New Hampshire Hospital	Concord								✓	
Hampstead Hospital	Hampstead								✓	
Catholic Medical Center	Manchester	✓	✓	✓	✓					
Elliot Hospital	Manchester	✓	✓	✓	✓					
Southern New Hampshire Medical Center	Nashua	✓	✓	✓	✓			✓		
St. Joseph Hospital of Nashua New Hampshire	Nashua	✓	✓	✓	✓					
Portsmouth Regional Hospital	Portsmouth	✓	✓	✓	✓					
New Jersey										
AtlantiCare Regional Medical Center	Atlantic City	✓	✓	✓				✓		
Clara Maass Medical Center	Belleville	✓	✓	✓	✓					
Camden County Health Services Center	Blackwood								✓	
Our Lady of Lourdes Medical Center	Camden	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
The Cooper Health System	Camden	✓	✓	✓	✓					
Cape Regional Medical Center	Cape May Court House	✓	✓	✓	✓					
Englewood Hospital and Medical Center	Englewood	✓	✓	✓	✓					
Hackettstown Regional Medical Center	Hackettstown	✓		✓	✓					
Ancora Psychiatric Hospital	Hammonton								✓	
Bayshore Community Hospital	Holmdel	✓	✓	✓	✓					
Kimball Medical Center	Lakewood	✓	✓	✓	✓					
Greystone Park Psychiatric Hospital	Morris Plains								✓	
Saint Peter's University Hospital	New Brunswick	✓	✓	✓	✓	✓				
Newark Beth Israel Medical Center	Newark	✓	✓	✓	✓					
St. Mary's Hospital	Passaic	✓	✓	✓	✓					
Capital Health Medical Center-Hopewell	Pennington	✓	✓		✓			✓		
St. Luke's Warren Hospital Inc.	Phillipsburg	✓	✓	✓	✓					
Princeton HealthCare System	Plainsboro	✓	✓	✓	✓					
Forrest S. Chilton III Memorial Hospital, Inc.	Pompton Plains	✓	✓	✓	✓					
Valley Health System	Ridgewood	✓	✓	✓	✓					
Hudson County Meadowview Psychiatric Hospital	Secaucus								✓	
Shore Medical Center	Somers Point	✓	✓	✓	✓					
Holy Name Medical Center	Teaneck	✓	✓	✓	✓					
Ann Klein Forensic Center	Trenton								✓	
Capital Health System, Inc.	Trenton	✓	✓		✓			✓		
Christian Health Care Center	Wyckoff								✓	
New Mexico										
Carlsbad Medical Center	Carlsbad		✓	✓	✓					
Plains Regional Medical Center	Clovis			✓	✓					
Lea Regional Hospital, LLC	Hobbs		✓	✓	✓					
Memorial Medical Center	Las Cruces	✓	✓	✓						
Roswell Hospital Corporation	Roswell	✓		✓	✓					
Lincoln County Medical Center	Ruidoso			✓	✓					
Strategic Behavioral Health El Paso, LLC	Santa Teresa								✓	
New York										
Brunswick Hospital Center	Amityville								✓	
St. Mary's Healthcare	Amsterdam	✓	✓	✓	✓					
VA Healthcare Network Upstate New York at Bath	Bath			✓						
Bronx Psychiatric Center	Bronx								✓	
North Central Bronx Hospital	Bronx		✓	✓						
Kingsboro Psychiatric Center	Brooklyn								✓	
Lutheran Medical Center	Brooklyn	✓	✓	✓	✓					
New York Community Hospital	Brooklyn	✓	✓	✓	✓					
The Brooklyn Hospital Center	Brooklyn	✓	✓	✓	✓					
Sisters of Charity Hospital	Buffalo	✓	✓	✓	✓					
F. F. Thompson Hospital	Canandaigua	✓		✓	✓					
The Mary Imogene Bassett Hospital and Clinics	Cooperstown	✓	✓	✓						
Elmira Psychiatric Center	Elmira								✓	
Forest Hills Hospital	Forest Hills	✓	✓	✓	✓					
Geneva General Hospital	Geneva			✓	✓					
Community Memorial Hospital	Hamilton			✓	✓					
United Health Services Hospitals, Inc.	Johnson City	✓	✓		✓					
HealthAlliance of the Hudson Valley, Mary's Avenue Campus	Kingston				✓					
Central New York Psychiatric Center	Marcy								✓	
Schuyler Hospital, Inc.	Montour Falls			✓						
VA Hudson Valley Health Care System	Montrose								✓	
Northern Westchester Hospital	Mount Kisco		✓	✓	✓					
Mid-Hudson Forensic Psychiatric Center	New Hampton								✓	
Kirby Forensic Psychiatric Center	New York								✓	

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Manhattan Psychiatric Center	New York								✓	
New York Gracie Square Hospital	New York								✓	
NYU Hospitals Center	New York	✓	✓	✓	✓					
St. Luke's-Roosevelt Hospital Center	New York	✓	✓	✓	✓					
Nyack Hospital	Nyack	✓	✓	✓	✓					
South Nassau Communities Hospital	Oceanside	✓	✓	✓	✓					
Rockland Psychiatric Center	Orangeburg								✓	
St. Charles Hospital	Port Jefferson			✓	✓			✓		
Vassar Brothers Medical Center	Poughkeepsie	✓	✓	✓	✓					
Northern Dutchess Hospital	Rhinebeck			✓	✓					
Mercy Medical Center	Rockville Centre	✓	✓	✓	✓					
Ellis Medicine Ellis Hospital	Schenectady	✓	✓	✓	✓					
South Beach Psychiatric Center	Staten Island								✓	
Staten Island University Hospital	Staten Island	✓	✓	✓	✓					
Hutchings Psychiatric Center	Syracuse								✓	
St. Anthony Community Hospital	Warwick			✓	✓					
Jones Memorial Hospital	Wellsville			✓	✓					
Pilgrim Psychiatric Center	West Brentwood								✓	
Western New York Children's Psychiatric Center	West Seneca								✓	
White Plains Hospital Center	White Plains	✓	✓	✓	✓					
St. Joseph's Hospital	Yonkers	✓	✓	✓	✓					
North Carolina										
East Carolina Health	Ahoskie		✓	✓	✓					
Randolph Hospital, Inc.	Asheboro	✓	✓	✓	✓					
Mission Health System	Asheville			✓	✓					
Brunswick Community Hospital	Bolivia		✓	✓	✓			✓		✓
Carolinas Medical Center-Mercy & Carolinas Medical Center-Pineville	Charlotte	✓	✓	✓	✓					
NH Charlotte Orthopaedic Hospital	Charlotte				✓					✓
CMC-NorthEast	Concord	✓	✓	✓	✓	✓				
Duke University Hospital	Durham	✓	✓	✓	✓					
Durham Regional Hospital	Durham	✓	✓	✓	✓					
Cherry Hospital	Goldsboro								✓	
Wayne Memorial Hospital, Inc.	Goldsboro	✓	✓	✓	✓					
Moses H. Cone Memorial Hospital	Greensboro	✓	✓	✓	✓					
Brynn Marr Hospital	Jacksonville								✓	
Duplin General Hospital, Inc.	Kenansville		✓	✓	✓					
Kings Mountain Hospital	Kings Mountain			✓						
Scotland Health Care System	Laurinburg	✓	✓	✓	✓					
Caldwell Memorial Hospital, Inc.	Lenoir			✓	✓					
Carolinas Medical Center-Lincoln	Lincolnton		✓	✓	✓					
The McDowell Hospital	Marion		✓	✓	✓					
Carolinas Medical Center-Union	Monroe	✓	✓	✓	✓					
Lake Norman Regional Medical Center	Mooresville	✓	✓	✓	✓					
Blue Ridge HealthCare Hospitals, Inc.	Morganton	✓	✓	✓	✓					
Southwestern Health System, Inc.	Murphy			✓	✓					
The Outer Banks Hospital	Nags Head			✓	✓					
Wilkes Regional Medical Center	North Wilkesboro			✓	✓					
Duke Raleigh Hospital	Raleigh	✓	✓	✓	✓					
Rex Healthcare	Raleigh	✓	✓	✓	✓					
Davis Regional Medical Center	Statesville			✓	✓					
WestCare Health System	Sylva		✓	✓	✓					
East Carolina Health-Heritage, Inc.	Tarboro		✓	✓	✓					
Carolinas Anson Healthcare, Inc.	Wadesboro			✓						
Medical Park Hospital, Inc.	Winston Salem				✓					✓

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
North Dakota										
Saint Alexius Medical Center	Bismarck	✓	✓	✓	✓					
Sanford Medical Center Bismarck	Bismarck	✓	✓	✓	✓					
Fargo VA Health Care System	Fargo			✓	✓					
North Dakota State Hospital	Jamestown								✓	
Ohio										
Crystal Clinic Orthopaedic Center, LLC	Akron				✓					
Mercy Health-Clermont Hospital	Batavia		✓	✓	✓					
Univeristy Hospitals Geauga Medical Center	Chardon	✓	✓	✓	✓					
Mercy Hospital Anderson	Cincinnati	✓	✓	✓	✓					
Berger Hospital	Circleville			✓	✓					
Mercer County Joint Township Community Hospital	Coldwater			✓	✓					
Doctors Hospital	Columbus	✓	✓	✓	✓					
Grant Medical Center	Columbus	✓	✓	✓	✓					
Ohio Hospital for Psychiatry	Columbus								✓	
Riverside Methodist Hospital	Columbus	✓	✓	✓	✓					
The Ohio State University Hospital	Columbus	✓	✓	✓	✓					
Twin Valley Behavioral Healthcare	Columbus								✓	
Department of Veterans Affairs Medical Center, Dayton, Ohio	Dayton		✓	✓	✓					
Miami Valley Hospital (Main Site), Dayton OH	Dayton	✓	✓	✓	✓					
Mercy Hospital of Defiance, LLC	Defiance			✓	✓					
Grady Memorial Hospital	Delaware			✓	✓					
Ten Lakes Center, LLC	Dennison								✓	
Dublin Methodist Hospital	Dublin			✓	✓					
Euclid Hospital	Euclid		✓	✓	✓					
Atrium Medical Center	Franklin	✓	✓	✓	✓			✓		
Marymount Hospital	Garfield Heights	✓	✓	✓	✓					
University Hospitals Geneva Medical Center	Geneva			✓	✓					
Marion General Hospital, Inc.	Marion	✓	✓	✓	✓					
Craig and Frances Lindner Center of HOPE	Mason								✓	
Heartland Behavioral Healthcare	Massillon								✓	
Arrowhead Behavioral Health	Maumee								✓	
Southwest General Health Center	Middleburg Heights	✓	✓	✓	✓					
Joel Pomerene Memorial Hospital	Millersburg			✓	✓					
Licking Memorial Hospital	Newark	✓	✓	✓	✓					
Northcoast Behavioral Healthcare	Northfield								✓	
Allen Medical Center	Oberlin			✓	✓					
Bay Park Community Hospital	Oregon			✓	✓					
Lake Health	Painesville	✓	✓	✓	✓					
Southern Ohio Medical Center	Portsmouth	✓	✓	✓	✓					
Upper Valley Medical Center	Troy	✓	✓	✓	✓					
The Surgery Center at Southwoods, LLC	Youngstown				✓					
Oklahoma										
INTEGRIS Blackwell Regional Hospital	Blackwell			✓						
Marshall County HMA, LLC	Madill			✓						
Jack C. Montgomery VA Medical Center	Muskogee		✓	✓	✓					
INTEGRIS Baptist Medical Center	Oklahoma City	✓	✓	✓	✓					
Kay County Oklahoma Hospital Company, LLC	Ponca City		✓	✓	✓					
INTEGRIS Mayes County Medical Center	Pryor				✓					
AHS Southcrest Hospital, LLC	Tulsa	✓	✓	✓	✓					
Universal Health Services, Inc.	Tulsa								✓	
Woodward Regional Hospital	Woodward			✓	✓					
Oregon										
Kaiser Sunnyside Medical Center	Clackamas	✓	✓	✓	✓					
Peace Harbor Hospital	Florence			✓	✓					
Willamette Valley Medical Center	McMinnville	✓		✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Portland VA Medical Center	Portland	✓	✓	✓	✓					
Mercy Medical Center	Roseburg	✓	✓	✓	✓					
McKenzie-Willamette Regional Medical Center Associates, LLC	Springfield	✓	✓	✓	✓					
Pennsylvania										
CH Hospital of Allentown, LLC	Allentown				✓					
Lehigh Valley Hospital	Allentown	✓	✓	✓	✓					
Sacred Heart Hospital	Allentown	✓		✓	✓					
James E. Van Zandt VA Medical Center	Altoona			✓						
St. Luke's Hospital	Bethlehem	✓	✓	✓	✓					
Bryn Mawr Hospital	Bryn Mawr	✓	✓	✓	✓					
Holy Spirit Hospital	Camp Hill	✓	✓	✓	✓					
Clarion Psychiatric Center	Clarion								✓	
St. Luke's Hospital-Miners Campus	Coaldale			✓	✓					
Coatesville Hospital Corporation	Coatesville	✓	✓	✓	✓					
Charles Cole Memorial Hospital	Coudersport			✓	✓					
Delaware County Memorial Hospital	Drexel Hill	✓		✓	✓					
Ephrata Community Hospital	Ephrata			✓	✓					
UPMC Bedford Memorial	Everett			✓	✓					
Gettysburg Hospital	Gettysburg		✓	✓	✓					
UPMC Horizon	Greenville	✓	✓	✓	✓					
Hanover Hospital, Inc.	Hanover	✓	✓	✓	✓					
Pinnacle Health Hospitals	Harrisburg	✓	✓	✓	✓					
First Hospital	Kingston								✓	
St. Mary Medical Center	Langhorne	✓	✓	✓	✓					
The Good Samaritan Hospital	Lebanon	✓	✓	✓	✓					
Heart of Lancaster Regional Medical Center	Lititz			✓	✓					
Lock Haven Hospital and Haven Skilled Rehab & Nursing	Lock Haven			✓	✓					
UPMC McKeesport	McKeesport	✓	✓	✓	✓					
Riddle Memorial Hospital	Media	✓	✓	✓	✓					
Alle-Kiski Medical Center	Natrona Heights	✓	✓	✓	✓					
Montgomery County Emergency Service, Inc.	Norristown								✓	
Aria Health	Philadelphia	✓	✓	✓	✓					
Friends Behavioral Health System, LP	Philadelphia								✓	
Kirkbride Center	Philadelphia								✓	
Nazareth Hospital	Philadelphia	✓	✓	✓	✓					
Presbyterian Medical Center of the UPHS	Philadelphia	✓	✓	✓	✓					
Prime Healthcare Services-Roxborough, LLC	Philadelphia		✓	✓	✓					
St. Christopher's Hospital for Children	Philadelphia					✓				
Temple University Hospital, Inc.	Philadelphia	✓	✓	✓	✓					
St. Clair Memorial Hospital	Pittsburgh	✓	✓	✓	✓					
UPMC Mercy	Pittsburgh	✓	✓	✓	✓					
UPMC Passavant	Pittsburgh	✓	✓	✓	✓					
Pottstown Memorial Medical Center	Pottstown	✓	✓	✓	✓					
St. Luke's Quakertown Hospital	Quakertown			✓	✓					
St. Joseph Regional Health Network	Reading	✓	✓	✓	✓					
UPMC Northwest	Seneca	✓		✓	✓					
Roxbury Treatment Center	Shippensburg								✓	
Tyler Memorial Hospital	Tunkhannock			✓						
Williamsport Regional Medical Center	Williamsport	✓	✓	✓	✓			✓		
Main Line Hospitals, Inc.	Wynnewood	✓	✓	✓	✓					
OSS Orthopaedic Hospital	York				✓					
Puerto Rico										
Doctors' Center Hospital Manati	Manati	✓	✓	✓	✓					
Ashford Presbyterian Community Hospital	San Juan	✓			✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Rhode Island										
Memorial Hospital of Rhode Island	Pawtucket	✓	✓	✓	✓					
Emma Pendleton Bradley Hospital	Riverside								✓	
South County Hospital Healthcare System	Wakefield	✓		✓	✓					
South Carolina										
Patrick B. Harris Psychiatric Hospital	Anderson								✓	
Marlboro Park Hospital	Bennettsville			✓						
Bon Secours St. Francis Xavier Hospital, Inc.	Charleston		✓	✓						
Roper Hospital, Inc.	Charleston	✓	✓	✓						
Trident Health System	Charleston	✓	✓	✓	✓					
William Jennings Bryan Dorn VA Medical Center	Columbia		✓	✓	✓					
Baptist Easley Hospital	Easley	✓	✓	✓	✓					
Carolinas Hospital System	Florence	✓	✓	✓	✓					
Greenville Hospital System University Medical Center	Greenville	✓	✓	✓						
Patewood Memorial Hospital	Greenville				✓					
Greer Memorial Hospital	Greer			✓						
UHS of Greenville, LLC	Greer								✓	
Coastal Carolina Medical Center, Inc.	Hardeeville			✓	✓					
Springs Memorial Hospital	Lancaster		✓	✓	✓					
East Cooper Medical Center	Mount Pleasant			✓	✓					
Grand Strand Regional Medical Center, LLC	Myrtle Beach	✓	✓	✓	✓					
Newberry County Memorial Hospital	Newberry			✓	✓					
Hillcrest Memorial Hospital	Simpsonville			✓						
Colleton Medical Center	Walterboro		✓	✓	✓					
Three Rivers Behavioral Health, LLC	West Columbia								✓	
South Dakota										
Avera Queen of Peace	Mitchell			✓	✓					
Tennessee										
Western Mental Health Institute	Bolivar								✓	
Wellmont Bristol Regional Medical Center	Bristol	✓	✓	✓	✓					
Parkridge Medical Center, Inc.	Chattanooga	✓	✓	✓	✓				✓	
Clarksville Health System, GP	Clarksville	✓	✓	✓	✓					
Maury Regional Medical Center	Columbia	✓	✓	✓						
TriStar Horizon Medical Center	Dickson	✓	✓	✓	✓					
Dyersburg Hospital Corporation	Dyersburg	✓	✓	✓	✓					
Sumner Regional Medical Center	Gallatin	✓	✓	✓	✓					
TriStar Hendersonville Medical Center	Hendersonville	✓	✓	✓	✓					
TriStar Summit Medical Center	Hermitage	✓	✓	✓	✓					
Baptist Memorial Hospital Huntingdon	Huntingdon			✓						
Jackson, Tennessee Hospital Company, LLC	Jackson	✓	✓	✓	✓					
Jamestown Regional Medical Center	Jamestown			✓						
Franklin Woods Community Hospital	Johnson City			✓	✓					
Fort Sanders Regional Medical Center	Knoxville	✓	✓	✓	✓					
Fort Loudoun Medical Center	Lenoir City			✓	✓					
Lexington Hospital Corporation	Lexington			✓						
McKenzie Tennessee Hospital Company, LLC	McKenzie			✓	✓					
AMISUB (SFH), Inc	Memphis	✓	✓	✓	✓					
Baptist Memorial Hospital	Memphis	✓	✓	✓						
Lakeside Behavioral Health System, LLC	Memphis								✓	
Morristown-Hamblen Hospital Association	Morristown	✓	✓	✓	✓					
James H. Quillen VA Medical Center	Mountain Home	✓	✓	✓	✓					
Middle Tennessee Mental Health Institute	Nashville								✓	
Southern Hills Medical Center	Nashville	✓	✓	✓	✓					
Tennova Newport Medical Center	Newport			✓						
Henry County Medical Center	Paris			✓	✓					
Shelbyville Hospital Corporation	Shelbyville			✓	✓					
DeKalb Community Hospital	Smithville			✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
StoneCrest Medical Center	Smyrna	✓	✓	✓	✓					
NorthCrest Medical Center	Springfield	✓	✓	✓	✓					
Baptist Memorial Hospital-Union City	Union City			✓	✓					
Texas										
Big Bend Regional Medical Center	Alpine			✓						
Baylor Orthopedic and Spine Hospital at Arlington	Arlington				✓					
Medical Center Arlington	Arlington	✓	✓	✓	✓					
Millwood Hospital, LP	Arlington								✓	
Sundance Hospital	Arlington								✓	
Texas Health Heart & Vascular Hospital Arlington	Arlington	✓	✓		✓					
Austin State Hospital	Austin								✓	
Dell Children's Medical Center of Central Texas	Austin					✓				
Neuro Institute of Austin, LP	Austin								✓	
Seton Medical Center Austin	Austin	✓	✓	✓	✓					
Seton Southwest Hospital	Austin				✓					
St. David's Medical Center	Austin	✓	✓	✓	✓					
St. David's North Austin Medical Center	Austin	✓	✓	✓	✓					
St. David's South Austin Medical Center	Austin	✓	✓	✓	✓					
Texas Health Harris Methodist Hospital Azle	Azle			✓	✓					
Texas Health HEB Hospital	Bedford	✓	✓	✓	✓			✓	✓	
Scott & White Hospital Brenham	Brenham				✓					
Valley Regional Medical Center	Brownsville	✓	✓	✓	✓					
Brownwood Regional Medical Center	Brownwood			✓	✓					
Baylor Medical Center at Carrollton	Carrollton	✓	✓	✓	✓					
Cedar Park Regional Medical Center	Cedar Park			✓	✓					
Aspire Hospital, LLC	Conroe								✓	
Conroe Regional Medical Center	Conroe	✓	✓	✓	✓					
Montgomery County Mental Health Treatment Facility	Conroe								✓	
Corpus Christi Medical Center (Bay Area Healthcare Group, LTD)	Corpus Christi	✓	✓	✓	✓					
Baylor Heart and Vascular Center, LLP	Dallas	✓	✓		✓					
Baylor Medical Center at Uptown	Dallas				✓					
Baylor University Medical Center (BUMC)	Dallas	✓	✓	✓	✓					
Medical City Dallas Hospital	Dallas	✓	✓	✓	✓					
Methodist Charlton Medical Center	Dallas	✓	✓	✓				✓		
Methodist Dallas Medical Center	Dallas	✓	✓	✓				✓		
North Central Surgical Center	Dallas				✓					
UHS of Timberlawn	Dallas								✓	
UT Southwestern University Hospital	Dallas	✓	✓	✓	✓					
UT Southwestern Zale Lipshy Hospital	Dallas				✓					
Texoma Medical Center	Denison	✓	✓	✓	✓					
Denton Regional Medical Center	Denton	✓	✓	✓	✓					
University Behavioral Health of Denton	Denton								✓	
Fort Duncan Regional Medical Center	Eagle Pass		✓	✓	✓					
Las Palmas Del Sol Healthcare	El Paso	✓	✓	✓	✓					
Baylor Surgical Hospital at Fort Worth	Fort Worth				✓					
Plaza Medical Center of Fort Worth	Fort Worth	✓	✓	✓	✓					
Hill Country Memorial Hospital	Fredericksburg			✓	✓					
Centennial Medical Center	Frisco	✓		✓	✓					
Baylor Medical Center at Garland	Garland	✓	✓	✓	✓					
Harlingen Medical Center, LP	Harlingen	✓	✓	✓	✓					
Behavioral Health Management, LLC	Houston								✓	
CHRISTUS St. John Hospital	Houston	✓	✓	✓	✓					
Houston Northwest Medical Center	Houston	✓	✓	✓	✓					
Memorial Hermann Hospital	Houston	✓	✓	✓	✓					
Memorial Hermann Hospital System	Houston	✓	✓	✓	✓					
Methodist Willowbrook Hospital	Houston	✓	✓	✓	✓					

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

002407

The Joint Commission recognizes the following accredited hospitals that attained excellence in accountability measure performance during calendar year 2012. As a *Top Performer on Key Quality Measures®*, the following hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported accountability measure performance data for 2012.

Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Texas Orthopedic Hospital, Ltd.	Houston				✓		✓			
TOPS Surgical Specialty Hospital	Houston				✓					
West Houston Medical Center	Houston	✓	✓	✓	✓					
Woman's Hospital, LP	Houston				✓					
Memorial Hermann Northeast Hospital	Humble	✓	✓	✓	✓					
Las Colinas Medical Center	Irving	✓	✓	✓	✓					
Mother Frances Hospital-Jacksonville	Jacksonville			✓						
South Texas Regional Medical Center	Jourdanton			✓	✓					
CHRISTUS St. Catherine Hospital	Katy	✓	✓	✓	✓					
Memorial Hermann Katy Hospital	Katy		✓	✓	✓					
Texas Health Presbyterian Hospital Kaufman	Kaufman			✓	✓			✓		
Kingwood Pines Hospital	Kingwood								✓	
Memorial Hermann Specialty Hospital Kingwood, LLC	Kingwood				✓					
Laredo Texas Hospital Company, LP	Laredo	✓	✓	✓	✓					
Medical Center of Lewisville	Lewisville	✓	✓	✓	✓					
Covenant Children's Hospital	Lubbock					✓				
Woodland Heights Medical Center	Lufkin	✓	✓	✓	✓					
Seton Edgar B. Davis Hospital	Luling			✓						
Methodist Mansfield Medical Center	Mansfield	✓	✓	✓				✓		
Rio Grande Regional Hospital	McAllen	✓	✓	✓	✓					
BCA of the Permian Basin	Midland								✓	
North Hills Hospital Subsidiary, LP	North Richland Hills	✓	✓	✓	✓					
Baylor Regional Medical Center at Plano	Plano			✓	✓					
THE HEART HOSPITAL Baylor Plano	Plano	✓	✓		✓					
Methodist Richardson Medical Center	Richardson	✓	✓	✓	✓					
Texas Health Presbyterian Hospital Rockwall	Rockwall			✓	✓					
St. David's Round Rock Medical Center	Round Rock	✓	✓	✓	✓					
Lake Pointe Medical Center	Rowlett	✓	✓	✓	✓					
Rusk State Hospital	Rusk								✓	
San Angelo Community Medical Center	San Angelo	✓	✓	✓	✓					
Shannon Medical Center	San Angelo	✓	✓	✓	✓					
Methodist Hospital	San Antonio	✓	✓	✓	✓	✓				
Methodist Stone Oak Hospital	San Antonio	✓	✓	✓	✓					
Nix Health Care System	San Antonio			✓	✓					
South Texas Veterans Health Care System	San Antonio	✓	✓	✓	✓					
Texas Laurel Ridge Hospital, LP	San Antonio								✓	
Central Texas Medical Center	San Marcos			✓	✓					
Memorial Hermann Sugar Land Surgical Hospital	Sugar Land				✓					
Terrell State Hospital	Terrell								✓	
Trophy Club Medical Center	Trophy Club				✓					
DeTar Healthcare System	Victoria	✓	✓	✓	✓					
Weatherford Regional Medical Center	Weatherford			✓	✓					
Clear Lake Regional Medical Center	Webster	✓	✓	✓	✓					
Haven Red River Hospital, LLC	Wichita Falls								✓	
Kell West Regional Hospital, LLC	Wichita Falls				✓					
Utah										
IHC Health Services, Inc.	Cedar City			✓	✓					
Logan Regional Hospital	Logan			✓	✓					
Intermountain Medical Center	Murray	✓	✓		✓					
The Orthopedic Specialty Hospital	Murray				✓					
McKay-Dee Hospital Center	Ogden	✓	✓	✓	✓					
Ogden Regional Medical Center	Ogden	✓		✓	✓					
Mountain View Hospital	Payson	✓		✓	✓					
Utah State Hospital	Provo								✓	
Riverton Hospital	Riverton			✓	✓					
Primary Children's Medical Center	Salt Lake City					✓				
St. Mark's Hospital	Salt Lake City	✓	✓	✓	✓					

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

002408

The Joint Commission recognizes the following accredited hospitals that attained excellence in accountability measure performance during calendar year 2012. As a *Top Performer on Key Quality Measures®*, the following hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported accountability measure performance data for 2012.

Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Alta View Hospital	Sandy			✓	✓					
Vermont										
Central Vermont Medical Center	Berlin			✓	✓					
Northwestern Medical Center, Inc.	Saint Albans			✓						
VA Medical Center	White River Junction			✓	✓					
Virginia										
Inova Mount Vernon Hospital	Alexandria		✓	✓	✓					
Virginia Hospital Center	Arlington	✓	✓	✓	✓					
LewisGale Hospital Montgomery	Blacksburg	✓		✓	✓					
Catawba Hospital	Catawba								✓	
Southern Virginia Mental Health Institute	Danville								✓	
Emporia Hospital Corporation	Emporia	✓	✓	✓	✓					
Inova Fair Oaks Hospital	Fairfax	✓	✓	✓	✓					
Spotsylvania Regional Medical Center	Fredericksburg	✓	✓	✓	✓					
Warren Memorial Hospital	Front Royal			✓	✓					
Riverside Walter Reed Hospital	Gloucester	✓	✓	✓	✓					
Riverside Behavioral Health Center	Hampton								✓	
VA Medical Center-Hampton	Hampton				✓					
John Randolph Medical Center	Hopewell	✓	✓	✓	✓					
LewisGale Hospital Alleghany	Low Moor			✓	✓					
Bon Secours Memorial Regional Medical Center	Mechanicsville	✓	✓	✓	✓					
Riverside Regional Medical Center	Newport News	✓	✓	✓	✓					
Central State Hospital	Petersburg								✓	
Reston Hospital Center, LLC	Reston	✓	✓	✓	✓					
Bon Secours-St. Mary's Hospital	Richmond	✓	✓	✓	✓					
CJW Medical Center	Richmond	✓	✓	✓	✓					
Henrico Doctors' Hospital	Richmond	✓	✓	✓	✓					
LewisGale Medical Center, LLC	Salem	✓	✓	✓	✓					
Community Memorial Healthcenter	South Hill			✓				✓		
Riverside Tappahannock Hospital	Tappahannock		✓	✓	✓					
Virginia Beach Psychiatric Center	Virginia Beach								✓	
Eastern State Hospital	Williamsburg								✓	
Washington										
Overlake Health Care Association	Bellevue	✓	✓	✓	✓					
Harrison Medical Center	Bremerton	✓	✓	✓	✓					
Kennewick Public Hospital District	Kennewick		✓	✓	✓					
Harborview Medical Center	Seattle	✓	✓	✓	✓					
Swedish Medical Center	Seattle		✓	✓	✓					
University of Washington Medical Center	Seattle	✓	✓	✓	✓					
VA Medical Center	Spokane			✓						
Legacy Salmon Creek Hospital	Vancouver	✓	✓	✓	✓					
Providence St. Mary Medical Center	Walla Walla			✓	✓					
Central Washington Health Services Association	Wenatchee	✓	✓	✓	✓					
West Virginia										
VA Medical Center-Louis A. Johnson	Clarksburg			✓						
Fairmont General Hospital, Inc.	Fairmont	✓		✓	✓					
Cabell Huntington Hospital, Inc.	Huntington	✓	✓	✓	✓					
River Park Hospital	Huntington								✓	
VA Medical Center	Huntington		✓	✓	✓					
VA Medical Center	Martinsburg		✓	✓	✓					
Wetzel County Hospital	New Martinsville			✓						
Oak Hill Hospital Corporation	Oak Hill			✓	✓					
Pleasant Valley Hospital	Point Pleasant			✓	✓					
The Charles Town General Hospital	Ranson			✓	✓					
Stonewall Jackson Memorial Hospital Company	Weston			✓	✓					
Williamson Memorial Hospital	Williamson			✓	✓					

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

002409

The Joint Commission recognizes the following accredited hospitals that attained excellence in accountability measure performance during calendar year 2012. As a *Top Performer on Key Quality Measures®*, the following hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported accountability measure performance data for 2012.

Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Wisconsin										
Affinity Health System-St. Elizabeth Hospital	Appleton	✓		✓	✓					
St. Clare Hospital	Baraboo			✓	✓					
Black River Memorial Hospital, Inc.	Black River Falls			✓	✓					
Aurora Health Care Southern Lakes, Inc.	Burlington			✓	✓					
Mayo Clinic Health System-Eau Claire Hospital, Inc.	Eau Claire	✓		✓	✓			✓		
Aurora Health Care Southern Lakes, Inc.	Elkhorn			✓	✓					
Aurora Medical Center Grafton, LLC	Grafton	✓		✓	✓					
Aurora BayCare Medical Center	Green Bay	✓		✓	✓					
Aurora Medical Center of Washington County	Hartford			✓	✓					
Hudson Hospital & Clinics	Hudson				✓					
Aurora Medical Center Kenosha	Kenosha		✓	✓	✓					
Mayo Clinic Health System-Franciscan Medical Center, Inc.	La Crosse	✓		✓	✓					
Mendota Mental Health Institute	Madison								✓	
William S. Middleton Memorial Veterans Hospital	Madison	✓	✓	✓	✓					
Community Memorial Hospital of Menomonee Falls, Inc.	Menomonee Falls	✓	✓	✓	✓					
Good Samaritan Health Center of Merrill, Wisconsin, Inc.	Merrill				✓		✓			
Aurora Health Care Metro, Inc.	Milwaukee	✓	✓	✓	✓					
Clement J. Zablocki VA Medical Center	Milwaukee	✓	✓	✓	✓					
Froedtert Memorial Lutheran Hospital	Milwaukee	✓	✓	✓	✓					
Aurora Health Care Southern Lakes, Inc.	Oconomowoc	✓		✓	✓					
Aurora Medical Center of Oshkosh	Oshkosh	✓		✓	✓					
Mercy Medical Center	Oshkosh	✓		✓	✓					
Prairie du Chien Memorial Hospital Association, Inc.	Prairie du Chien			✓	✓					
Wheaton Franciscan Healthcare-All Saints, Inc.	Racine	✓	✓	✓	✓					
Lakeview Medical Center	Rice Lake			✓	✓					
River Falls Area Hospital	River Falls				✓					
Aurora Health Care Central, Inc.	Sheboygan	✓		✓	✓					
St. Nicholas Hospital	Sheboygan			✓	✓					
Stoughton Hospital	Stoughton			✓	✓					
Aurora Health Care North, Inc.	Two Rivers			✓	✓					
Waupun Memorial Hospital	Waupun			✓	✓					
Wyoming										
Wyoming Medical Center	Casper	✓	✓	✓	✓					
St. John's Medical Center	Jackson			✓	✓		✓			
Riverton Memorial Hospital	Riverton			✓	✓					
Department of Defense International Locations										
United Kingdom										
48th Medical Group RAF Lakenheath	Brandon, Suffolk						✓			

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 38: CHARITY AND COLLECTION POLICIES

Bristol Hospital	
Title: Charity Care and Patient Assistance Policy	Approved by: Revenue Cycle Committee Date approved: January 19, 2012 Responsible Party: Finance

Applies to:

☒ All

☐ Inpatient ☐ Peri-op ☐ OP/Amb Care ☐ Home Care ☐ Psych

☐ Department: _____

All policies and procedures represent our current knowledge and judgment regarding the issue covered by this policy. If you can think of a better way to handle the issue covered in this policy and procedure, or if this policy and procedure needs to be revised to reflect changes that have occurred, please bring your issues/concerns forward so that we may consider improving this policy and procedure accordingly.

PURPOSE

The purpose of this Plan is to define a process for ensuring that patients pay amounts for their care which they can afford.

POLICY STATEMENTS

BHHCG recognizes that the burden of health care costs on individuals is a national crisis. Decades of Hospital pricing, distorted by the unique billing requirements imposed by private and governmental payers and regulations, has resulted in a charge structure which unfairly burdens the individuals and families without or with limited insurance. BHHCG wishes to correct this unfairness by ensuring that all uninsured patient's charges are limited and capped at Medicare's payment levels. That discount level is defined as the ratio of Medicare Charge to Payments and listed on the most recent OHCA filing. The most current discount is **71%**. When a patient has no insurance, their bill will be immediately reduced by that percentage discount, using the charity care uninsured allowance code.

Patients, who have balances after insurance and require assistance in paying those bills, will be entitled to a Charity Care Patient Assistance discount, based on their income and family size, using the approved sliding financial assistance scale. The state of Connecticut has set recommended levels of charity care discounts which are stipulates that for families at or below 200% of federal poverty levels should be discounted to cost and that for families between 200% and 400% should be discounted to the commercial and or Medicare rate. BHHCG sliding scale will have greater discounts applied at lower levels of the Federal Poverty Income Levels.

Requirements

For Charity Care Uninsured Discount: Only requirement is that they have no access to insurance. The discount will be immediate and applied to all uninsured patients.

For Charity Care Patient Assistance: To qualify, the patient or family must owe a balance to the hospital after insurance. They must request assistance in paying their balance. They must submit their most recent pay stub and declare the number of family members living in their household.

Notification: We will post a notice of our financial assistance policy at all registration points and other visible locations throughout the hospital. We will also print a notice on all bills and statements informing patients and families to call us if the need financial assistance.

Published Statements: The following statement will be posted at all registration areas, in a highly visible manner, and be posted on all patient statements and bills. The statement will be published in English and Spanish.

"Bristol Hospital provides financial assistance to patients who are uninsured or need assistance in paying their balances after their insurance has paid. If you have no insurance, Bristol Hospital will apply an **"Uninsured Discount"** to your bill down to what the Hospital gets paid by Medicare, on an average basis.

If after that **"Uninsured Discount"** the patient still has difficulty in paying the bill, the patient may apply for a **"Patient Assistance Discount".** That discount is based on household income and family size. A sliding scale will determine the ultimate discount based on those factors. Please provide the most recent pay stub and declare the number of family members in the household.

If the Patient needs assistance in paying their balances after their insurance has paid, for coinsurances, co-pays or deductibles, the patient may apply for a **"Patient Assistance Discount".** That discount is based on household income and family size. A sliding scale will determine the ultimate discount based on those factors. Please provide the most recent pay stub and declare the number of family members in the household.

To apply for the **"Uninsured Discount"** or **"Patient Assistance Discount".** please call **860-585-3035** peak with the Financial Counselor or visit **Bristol Hospital's Finacial Counselor Located on Level C of the main hospital building.**

BRISTOL HOSPITAL everyday extraordinary	**Bristol Hospital & Health Care Group**
	Procedure for Credit and Collection
Approved By: Maria Simmone, Director of Revenue Cycle	
Responsible Party: Marylou L'etoile, Credit and Collections Supervisor	
Date Approved: 2/1/13	
X All ☐ PeriOp ☐ OP/Amb ☐ Home Care ☐ Psych ☐ Dept.:	

PURPOSE: To provide BH patient medical claim balances payment recovery, (Cardon Health) (VIA Healthcare) Credit Collection (American Adj).

CREDIT COLLECTION PROCEDURE

I. All Uninsured patient claims over $1000.00 are automatically transferred to Cardon Health upon discharge. Cardon Health contacts the patient and assists them with the State Assistance enrollment process. Patient accounts that do not qualify for assistance are returned weekly via email to the Pt. Receivables Manager. Agency codes are changed from Cardon Healthcare to VIA Health. Accounts are then sent to VIA Health electronically. VIA will produce patient statements, payment arrangements and Final Notice Letters. No less than two (30 day) statements and Final Notice Letter are mailed to the patients unless "Insufficient Addresses" are found. If there has been no payments and/or missed payments, VIA will close the claim and return to the business office electronically via email to the Pt. Receivables Manager. The Credit Collection collector will then place accounts with BH outside collection agency.

II. Effective 2/1/2013, 100% of Bad Debt Collection claims will be submitted to American Adjustment Bureau.

FOLLOW-UP PROCEDURE

To provide direction to the Credit Collection staff that are responsible for Bankruptcy Notices, Auto claims, Liability claims and Attorney requests. Ensuring all patient claims are handled timely and correctly while following all HIPPA requirements and those patients are billed appropriately for responsible balances

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I. Pending/Discharge of Debtor Bankruptcy notices are documented in Meditech and copies are sent to the Collection Agency, copy of the claim is printed and forwarded with the notice to the Pt. Receivables Manager for the Uncollectable W/O.

II. Attorney, Auto and Liability claim requests are reviewed to ensure there is a "Pt Authorization" letter signed and dated on file. If approved submit information and forward requests to other departments if necessary.

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	POLICY NO: 06012011-001
Title: POLICY PROCEDURE **CREDIT COLLECTION**	Approved by**: Revenue Cycle Director** **Maria Simmone** Date approved**: 6/1/2011** Date Reviewed: **5/1/2011** Date Revised: **2/1/2013**
Applies to: CREDIT COLLECTORS Department(s) **BH Business Office** Reports to: **Patient Receivables Manager**	

PURPOSE:

To provide BH patient medical claim balances payment recovery, (Cardon Health) (VIA Healthcare) Credit Collection (American Adj and Medconn).

POLICY STATEMENT:

It is our policy to provide the highest quality of collection services to our patients for services provided to them by Bristol Hospital.

SCOPE OF AUTHORITY / COMPETENCE

Patient Receivables Manager, Revenue Cycle Director

CREDIT COLLECTION PROCEDURE

To provide direction to the business office staff and to ensure consistency of approach for the following parameters that have been established through-out the Business Office.

I. All Uninsured patient claims over $1000.00 are automatically transferred to Cardon Health upon discharge. Cardon Health contacts the patient and assists them with the State Assistance enrollment process. Patient accounts that do not qualify for assistance are returned weekly via email to the Pt. Receivables Manager. Agency codes are changed from Cardon Healthcare to VIA Health. Accounts are then sent to VIA Health electronically. VIA will produce patient statements, payment arrangements and Final Notice Letters. No less than two (30 day) statements and Final Notice Letter are mailed to the patients unless "Insufficient Addresses" are found. If there has been no payments and/or missed payments, VIA will close the claim and return to the business office electronically via email to the Pt. Receivables Manager. The Credit Collection collector will then place accounts with BH outside collection agency.

II. Effective 2/1/2013, 100% of Bad Debt Collection claims will be submitted to American Adjustment Bureau.

FOLLOW-UP PROCEDURE

To provide direction to the Credit Collection staff that are responsible for Bankruptcy Notices, Auto claims, Liability claims and Attorney requests. Ensuring all patient claims are handled timely and correctly while

following all HIPPA
requirements and those patients are billed appropriately for responsible balances

I. Pending/Discharge of Debtor Bankruptcy notices are documented in Meditech and copies are sent to the Collection Agency, copy of the claim is printed and forwarded with the notice to the Pt. Receivables Manager.
for the Uncollectable W/O.

II. Attorney, Auto and Liability claim requests are reviewed to ensure there is a "Pt Authorization" letter signed and dated on file. If approved submit information and forward requests to other departments if necessary.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 39: OHCA FINANCIAL STATISTICS REPORT

Bristol Hospital

002418

Monthly Financial Measurement/Indicators	July-14 Current Month	July-14 YTD	July-14 Prior Year	August-14 Current Month	August-14 YTD	August-14 Prior Year	September-14 Current Month	September-14 YTD	September-14 Prior Year
A. Operating Performance									
Operating Margin	-2.6%	-0.52%	-0.77%	1.5%	-0.34%	-0.50%	5.9%	0.22%	1.03%
Non-Operating Margin	0.5%	1.05%	0.72%	0.4%	1.04%	0.61%	0.6%	1.00%	0.65%
Total Margin	-2.1%	0.53%	-0.05%	1.9%	0.70%	0.11%	6.5%	1.22%	1.68%
Bad Debt as % Gross Revenue	2.0%	2.86%	4.44%	0.5%	2.62%	4.43%	4.6%	2.80%	3.72%
B. Liquidity									
Current Ratio	1.56	1.56	1.30	1.35	1.35	1.29	1.40	1.40	1.39
Days Cash on Hand	80.84	80.84	92.98	77.02	77.02	88.22	91.76	91.76	104.54
Days in Net Accounts Receivables	50.35	50.35	52.65	43.79	43.79	44.50	44.48	44.48	46.73
Average Payment Period	56.53	56.53	76.88	60.44	60.44	70.64	68.48	68.48	74.80
C. Leverage and Capital Structure									
Long-term Debt to Equity	0.50	0.50	0.73	0.49	0.49	0.72	0.50	0.50	0.52
Long-term Debt to Capitalization	0.98	0.98	2.76	0.95	0.95	2.59	0.98	0.98	1.07
Unrestricted Cash to Debt	1.02	1.02	1.02	1.08	1.08	1.09	1.24	1.24	1.23
Times Interest Earned Ratio	0.92	0.92	0.81	1.47	1.47	1.18	2.18	2.18	2.50
Debt Service Coverage Ratio	2.22	2.22	2.00	2.71	2.71	2.61	3.05	3.05	3.12
Equity Financing Ratio	0.27	0.27	0.10	0.27	0.27	0.10	0.26	0.26	0.25
D. Additional Statistics									
Income from Operations	(284,250)	(558,488)	(756,232)	173,063	(445,815)	(604,396)	756,146	310,333	1,356,308
Revenue Over/(Under) Expense	(229,491)	569,820	(53,303)	218,115	914,389	134,301	831,438	1,745,829	2,209,877
EBITDA	475,631	7,102,199	6,404,253	695,353	8,686,686	8,364,180	1,081,643	9,768,331	9,999,347
Patient Cash Collected	11,357,718	112,421,452	104,964,241	11,630,893	124,052,345	116,744,425	11,426,947	135,479,292	126,059,228
Cash and Cash Equivalents	28,427,161.00	28,427,161	30,021,852	29,790,245.00	29,790,245	31,707,365	35,597,576.00	35,597,576	37,147,166
Net working Capital	11,212,161.00	11,212,161	7,520,445	8,298,845.00	8,298,845	7,424,544	10,672,901.00	10,672,901	10,254,143
Unrestricted Assets	17,107,829.00	17,107,829	(381,580)	17,733,717.00	17,733,717	177,685	17,942,626.00	17,942,626	16,796,213
Credit Ratings (S&P, FITCH and Moody's)		-	-		-	-		-	-

BHHCG

002419

Monthly Financial Measurement/Indicators	July-14 Current Month	July-14 YTD	July-14 Prior Year	August-14 Current Month	August-14 YTD	August-14 Prior Year	September-14 Current Month	September-14 YTD	September-14 Prior Year
A. Operating Performance									
Operating Margin	-3.8%	-1.05%	-0.91%	2.6%	-0.68%	-0.61%	4.7%	-0.21%	0.45%
Non-Operating Margin	0.4%	0.85%	0.68%	0.3%	0.86%	0.58%	0.5%	0.82%	0.63%
Total Margin	-3.4%	-0.20%	-0.23%	2.9%	0.17%	-0.03%	5.2%	0.61%	1.08%
Bad Debt as % Gross Revenue	2.2%	2.71%	4.32%	-0.6%	2.58%	4.32%	4.7%	2.91%	3.81%
B. Liquidity	0	0	0	0	0	0	0	0	0
Current Ratio	1.85	1.85	1.53	1.38	1.38	1.38	1.39	1.39	1.43
Days Cash on Hand	71.68	71.68	80.53	64.63	64.63	70.95	71.12	71.12	76.73
Days in Net Accounts Receivables	44.39	44.39	47.99	38.08	38.08	40.47	35.20	35.20	38.27
Average Payment Period	45.06	45.06	60.86	54.77	54.77	59.96	57.19	57.19	58.41
C. Leverage and Capital Structure	0	-	-	0	-	-	0	-	-
Long-term Debt to Equity	0.52	0.52	0.73	0.51	0.51	0.74	0.51	0.51	0.53
Long-term Debt to Capitalization	1.10	1.10	2.74	1.05	1.05	2.89	1.06	1.06	1.14
Unrestricted Cash to Debt	0.98	0.98	0.97	1.06	1.06	1.03	1.25	1.25	1.18
Times Interest Earned Ratio	0.79	0.79	0.78	0.96	0.96	0.97	1.35	1.35	1.68
Debt Service Coverage Ratio	2.23	2.23	2.22	2.81	2.81	2.88	3.17	3.17	3.33
Equity Financing Ratio	0.25	0.25	0.11	0.26	0.26	0.10	0.25	0.25	0.24
D. Additional Statistics	0	-	-	0	-	-	0	-	-
Income from Operations	(520,597)	(1,400,299)	(1,131,602)	367,263	(1,093,428)	(900,882)	726,501	(366,925)	729,227
Revenue Over/(Under) Expense	(465,582)	(267,612)	(284,954)	415,720	274,560	(38,606)	801,793	1,076,355	1,753,591
EBITDA	319,724	7,139,393	7,096,255	974,571	9,003,096	9,209,583	1,132,822	10,135,919	10,655,867
Patient Cash Collected	14,204,472	140,245,009	130,872,903	14,400,543	154,645,552	145,485,672	14,282,730	168,928,281	157,500,921
Cash and Cash Equivalents	31,624,293.00	31,624,293	32,847,350	33,902,446.00	33,902,446	34,722,746	40,748,119.00	40,748,119	40,582,008
Net working Capital	16,910,263.00	16,910,263	13,210,513	10,848,351.00	10,848,351	11,122,990	12,798,714.00	12,798,714	13,251,632
Unrestricted Assets	17,890,203.00	17,890,203	1,274,701	19,251,430.00	19,251,430	648,070	19,397,745.00	19,397,745	18,862,754
Credit Ratings (S&P, FITCH and Moody's)	-	-	-	-	-	-	-	-	-

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 40: IRS TAX FORM 990 FILED BY BHHCG AND THE HOSPITAL FOR TAX YEAR 2013

CLIENT'S COPY

002422

CARRYOVER DATA TO 2013

Name	Employer Identification Number
BRISTOL HOSPITAL, INC.	06-0646559

Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	3,003,977.
FEDERAL AMT NET OPERATING LOSS	298,192.
CT CURRENT YEAR NET OPERATING LOSS	298,192.

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL, CT 06011
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 15, 2014.

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

002424

OMB No. 1545-0047

2012

Open to Public Inspection

A For the 2012 calendar year, or tax year beginning OCT 1, 2012 **and ending** SEP 30, 2013

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
BRISTOL HOSPITAL, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) BREWSTER RD. | Room/suite

City, town, or post office, state, and ZIP code
BRISTOL, CT 06011

F Name and address of principal officer: KURT BARWIS
SAME AS C ABOVE

D Employer identification number
06-0646559

E Telephone number
860-585-3000

G Gross receipts $ 131,994,532.

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

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.BRISTOLHOSPITAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1920 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: TO ENHANCE THE HEALTH AND WELL-BEING OF OUR COMMUNITY. WE WILL PROVIDE SAFE, QUALITY CARE AND

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	16
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	13
5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	5	1392
6	Total number of volunteers (estimate if necessary)	6	253
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	348,034.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-298,192.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,338,407.	1,114,855.
9	Program service revenue (Part VIII, line 2g)	131,079,119.	129,286,883.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	477,499.	288,256.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,914,160.	1,225,255.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	136,809,185.	131,915,249.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	69,542,815.	68,831,487.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	64,943,488.	60,872,187.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	134,486,303.	129,703,674.
19	Revenue less expenses. Subtract line 18 from line 12	2,322,882.	2,211,575.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	112,654,038.	113,932,754.
21	Total liabilities (Part X, line 26)	102,022,703.	87,460,483.
22	Net assets or fund balances. Subtract line 21 from line 20	10,631,335.	26,472,271.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ GEORGE W. EIGHMY, VP & CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
RICHARD BUGGY			☐	P00512316

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP — Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 — Phone no. 860-678-9200

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
BRISTOL HOSPITAL IS COMMITTED TO PROVIDING THE BEST PATIENT EXPERIENCE IN THE REGION. OUR 134-BED, FULL-SERVICE HEALTH CARE INSTITUTION PROVIDES COMPREHENSIVE INPATIENT AND OUTPATIENT CARE FOR THE GREATER BRISTOL, CONNECTICUT AREA.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... Yes X No
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 X 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 $ 107,191,204. including grants of $) (Revenue $ 129,494,663.)
AS A SHORT-TERM ACUTE CARE COMMUNITY HOSPITAL, BRISTOL HOSPITAL PROVIDES A BROAD SPECTRUM OF HEALTHCARE SERVICES TO ANY INDIVIDUAL REGARDLESS OF THE INDIVIDUAL'S ABILITY TO PAY. THE HOSPITAL PROVIDED $5,306,456 IN CHARITY CARE DURING THE OPERATING YEAR. THE HOSPITAL ALSO PROVIDES EDUCATION AND WELLNESS PROGRAMS TO THE COMMUNITY. THESE ACTIVITIES TYPICALLY REACH ABOUT 1,600 INDIVIDUALS PER QUARTER. THESE ACTIVITIES INCLUDE: WELLNESS CENTER - SPECIAL CENTER FOR EDUCATIONAL OUTREACH PROGRAMMING SERVING HUNDREDS OF INDIVIDUALS PER MONTH. - COMMUNITY HEALTH SCREENINGS - ONGOING FREE AND REDUCED PRICE SCREENINGS FOR MAMMOGRAMS, BLOOD PRESSURE, CHOLESTEROL, PROSTATE CANCER, SKIN CANCER AND A FLU CLINIC PROVIDING FREE FLU SHOTS IN THE FALL. - SPEAKERS BUREAU - A COMMUNITY SERVICE WHERE THE HOSPITAL PROVIDES

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

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

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶ 107,191,204.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	82		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1392		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	16		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6			X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

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

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

Section C. Disclosure

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

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

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

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

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

GEORGE EIGHMY - 860-585-3000

BREWSTER ROAD, BRISTOL, CT 06011

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below 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) KENNETH BENOIT, M.D.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(2) MARK BLUM	2.00									
SECRETARY/TREASURER	2.00	X		X				0.	0.	0.
(3) BALA SHANMUGAM, M.D.	2.00									
DIRECTOR	40.00	X						0.	290,714.	0.
(4) JOHN J. LEONE, JR.	2.00									
VICE CHAIRMAN	2.00	X		X				0.	0.	0.
(5) GLENN HEISER	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(6) KURT BARWIS	60.00									
PRESIDENT & CEO	2.00	X		X				590,898.	0.	157,758.
(7) JOHN LODOVICO, JR.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(8) MARIE O'BRIEN	2.00									
CHAIRMAN	2.00	X		X				0.	0.	0.
(9) DOUGLAS DEVNEW	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(10) KAREN GUADAGNINI, M.D.	2.00									
DIRECTOR	40.00	X						18,680.	94,245.	3,280.
(11) MARY ANN CORDEAU, PHD, RN	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(12) FAWAD KAZI, M.D.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(13) THOMAS MONAHAN	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(14) ELLEN SOLEK	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(15) VALERIE VITALE, M.D.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(16) SHARON ADLER	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(17) GEORGE EIGHMY	40.00									
VICE PRESIDENT OF FINANCE/CFO				X				273,791.	0.	17,692.

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 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			
(18) LEONARD BANCO, M.D.	40.00									
CHIEF MEDICAL OFFICER					X			335,550.	0.	16,478.
(19) JEANINE RECKDENWALD	40.00									
VP, HUMAN RESOURCES AND SU					X			207,901.	0.	19,183.
(20) DAVE RACKLIFFE	40.00									
AVP INFORMATION TECHNOLOGY					X			169,453.	0.	19,213.
(21) SHEILA KEMPF, PHD	40.00									
SENIOR VP/PATIENT CARE SER					X			282,250.	0.	19,791.
(22) EVA WICKWIRE	40.00									
AVP CHIEF DEVELOPMENT OFFICER	2.00				X			164,030.	0.	8,122.
(23) PAUL SMITH	40.00									
DIRECTOR OF FACILITIES AND ENGINEERI						X		164,280.	0.	0.
(24) RUSSELL TUVERSON, M.D.	40.00									
OCCUPATIONAL HEALTH PHYSIC						X		164,030.	0.	1,637.
(25) MARIA SIMMONE	40.00									
DIRECTOR OF REVENUE CYCLE						X		138,288.	0.	8,372.
(26) LYNNE RAMER	40.00									
DIRECTOR OF CLINICAL OPERATIONS						X		133,659.	0.	15,370.
1b Sub-total ▶								2,642,810.	384,959.	286,896.
c Total from continuation sheets to Part VII, Section A ▶								131,304.	0.	8,467.
d Total (add lines 1b and 1c) ▶								2,774,114.	384,959.	295,363.

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 ▶ 56

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
MAYO COLLABORATIVE SERVICES, INC 200 SW 1ST STREET, ROCHESTER, MN 55905	LAB SERVICES	1,478,217.
IPC THE HOSPITALIST COMPANY INC PO BOX 844929, LOS ANGELES, CA 90084	MEDICAL SERVICES	734,164.
ACG NORTH AMERICA INC 120 HALCYON DRIVE, BRISTOL, CT 06010	GENERAL CONTRACTORS	530,056.
US FOODS, INC 222 OTROBANDO AVENUE, YANTIC, CT 06389	FOOD SERVICE	457,128.
TOTAL LAUNDRY COLLABORATIVE LLC 114 WOODLAND STREET, HARTFORD, CT 06105	LAUNDRY SERVICES	445,298.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 34

SEE PART VII, SECTION A CONTINUATION SHEETS

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 line)	(C) Position (check all that apply)						(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			
(27) MARIE MARCIANO DIRECTOR OF DIAGNOSTIC SERVICE	40.00					X		131,304.	0.	8,467.
Total to Part VII, Section A, line 1c								131,304.		8,467.

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e	1,114,855.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f				
	g Noncash contributions included in lines 1a-1f: $ 20,819.					
	h **Total.** Add lines 1a-1f		1,114,855.			
Program Service Revenue		Business Code				
	2a PATIENT SERVICE REVENUE	622110	126,808,091.	126,390,608.	417,483.	
	b MISC. PROGRAM AND HEALTHCARE REVE	621990	1,689,750.	1,689,750.		
	c OCCUPATIONAL HEALTH REVENUE	621990	789,042.	789,042.		
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		129,286,883.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		288,208.			288,208.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real / (ii) Personal				
	6a Gross rents: 271,852. /					
	b Less: rental expenses: 0. /					
	c Rental income or (loss): 271,852. /					
	d Net rental income or (loss)		271,852.			271,852.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory: 79,331. /					
	b Less: cost or other basis and sales expenses: 79,283. /					
	c Gain or (loss): 48. /					
	d Net gain or (loss)		48.			48.
	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					
	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					
	10a Gross sales of inventory, less returns and allowances	a				
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	Business Code				
	11a JOINT VENTURES	900099	555,814.	625,263.	-69,449.	
	b CAFETERIA	722210	397,589.			397,589.
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d		953,403.			
	12 **Total revenue.** See instructions.		131,915,249.	129,494,663.	348,034.	957,697.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,261,594.		3,261,594.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	51,842,571.	42,692,315.	9,150,256.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,108,585.	2,486,868.	621,717.	
9 Other employee benefits	6,627,425.	5,301,940.	1,325,485.	
10 Payroll taxes	3,991,312.	3,193,050.	798,262.	
11 Fees for services (non-employees):				
a Management				
b Legal	807,090.	7,353.	799,737.	
c Accounting	171,312.		171,312.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	1,019,025.	1,019,025.		
12 Advertising and promotion	1,227,954.	55,493.	1,172,461.	
13 Office expenses	13,337,492.	12,834,198.	503,294.	
14 Information technology	2,853,887.	197,347.	2,656,540.	
15 Royalties				
16 Occupancy	2,617,643.	2,224,997.	392,646.	
17 Travel	185,783.	137,169.	48,614.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	1,461,258.	1,461,258.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,328,212.	6,328,212.		
23 Insurance	2,134,447.	1,707,558.	426,889.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SERVICES FEES	13,999,619.	13,906,859.	92,760.	
b DRUGS	7,381,245.	7,376,353.	4,892.	
c REPAIR & MAINTENENCE	1,857,021.	1,811,792.	45,229.	
d COLLECTION FEES	1,168,027.	1,168,027.		
e All other expenses	4,322,172.	3,281,390.	1,040,782.	
25 **Total functional expenses.** Add lines 1 through 24e	129,703,674.	107,191,204.	22,512,470.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	9,376,449.	1	12,810,191.
	2	Savings and temporary cash investments	96,452.	2	96,526.
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	16,562,143.	4	16,887,452.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	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 instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	1,592,222.	8	1,445,186.
	9	Prepaid expenses and deferred charges	2,242,612.	9	2,321,980.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 150,523,259.			
	b	Less: accumulated depreciation — 10b: 111,762,978.	37,764,529.	10c	38,760,281.
	11	Investments - publicly traded securities	13,893,883.	11	13,766,654.
	12	Investments - other securities. See Part IV, line 11	13,377,950.	12	14,260,744.
	13	Investments - program-related. See Part IV, line 11	7,642,154.	13	7,150,033.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	10,105,644.	15	6,433,707.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	112,654,038.	16	113,932,754.
Liabilities	17	Accounts payable and accrued expenses	29,017,801.	17	29,340,577.
	18	Grants payable		18	
	19	Deferred revenue	630,235.	19	765,934.
	20	Tax-exempt bond liabilities	24,261,420.	20	23,842,748.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	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	297,961.	22	290,136.
	23	Secured mortgages and notes payable to unrelated third parties	1,957,753.	23	2,828,131.
	24	Unsecured notes and loans payable to unrelated third parties		24	
	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	45,857,533.	25	30,392,957.
	26	**Total liabilities.** Add lines 17 through 25	102,022,703.	26	87,460,483.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	-376,115.	27	15,896,282.
	28	Temporarily restricted net assets	4,079,847.	28	3,555,410.
	29	Permanently restricted net assets	6,927,603.	29	7,020,579.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	10,631,335.	33	26,472,271.
	34	Total liabilities and net assets/fund balances	112,654,038.	34	113,932,754.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	131,915,249.
2	Total expenses (must equal Part IX, column (A), line 25)	2	129,703,674.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,211,575.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	10,631,335.
5	Net unrealized gains (losses) on investments	5	518,644.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	13,110,717.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	26,472,271.

Part XII Financial Statements and Reporting

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

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

Form 990 (2012)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

002437 OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization	Employer identification number
BRISTOL HOSPITAL, INC.	06-0646559

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)) ..... 14 %

15 Public support percentage from 2011 Schedule A, Part II, line 14 ..... 15 %

16a **33 1/3% support test - 2012.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2011.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

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

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2012** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2011** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

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

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

Schedule of Contributors

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

002440
OMB No. 1545-0047

2012

Name of the organization	Employer identification number
BRISTOL HOSPITAL, INC.	06-0646559

Organization type (check one):

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

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

General Rule

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

Special Rules

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

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

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

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

Name of organization: BRISTOL HOSPITAL, INC.

Employer identification number: 06-0646559

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	CHILDREN'S TRUST FUND 25 SIGOURNEY STREET - 10TH FLOOR HARTFORD, CT 06106	$ 195,597.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	CT DEPARTMENT OF CHILDREN AND FAMILIES 505 HUDSON STREET HARTFORD, CT 06106	$ 53,411.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3	CT DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES 410 CAPITOL AVE HARTFORD, CT 06134	$ 15,339.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4	THE U.S. DEPARTMENT OF AGRICULTURE 1400 INDEPENDENCE AVE., S.W. WASHINGTON, DC 20250	$ 686,786.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
5	THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 200 INDEPENDENCE AVE., S.W. WASHINGTON, DC 20201	$ 51,608.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
6	THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 200 INDEPENDENCE AVE., S.W. WASHINGTON, DC 20201	$ 20,819.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II if there is a noncash contribution.)

Name of organization: BRISTOL HOSPITAL, INC.

Employer identification number: 06-0646559

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

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
6	VACCINES	$ 20,819.	09/30/13
		$	
		$	
		$	
		$	
		$	
		$	

Name of organization BRISTOL HOSPITAL, INC.

Employer identification number 06-0646559

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $

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

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

(e) Transfer of gift

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

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

(e) Transfer of gift

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

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

(e) Transfer of gift

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

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

(e) Transfer of gift

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

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

002444 OMB No. 1545-0047

2012

Open to Public Inspection

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

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

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

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

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

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

Name of organization	Employer identification number
BRISTOL HOSPITAL, INC.	06-0646559

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-.

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

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

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

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		1,770.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		75,557.
j Total. Add lines 1c through 1i			77,327.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE HOSPITAL IS A MEMBER OF THE CONNECTICUT HOSPITAL ASSOCIATION AND THE AMERICAN HOSPITAL ASSOCIATION. $21,557 REPRESENTS THE PORTION OF THE DUES PAID TO THESE ASSOCIATIONS WHICH WERE USED FOR LOBBYING PURPOSES.

THE HOSPITAL ENGAGED CAMILLIERE, CLOUD & KENNEDY, A CONNECTICUT

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

LOBBYING AND BUSINESS DEVELOPMENT FIRM, FOR CONSULTING SERVICES IN THE AMOUNT OF $54,000.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
BRISTOL HOSPITAL, INC.

Employer identification number
06-0646559

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

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

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
- ☐ Preservation of land for public use (e.g., recreation or education)
- ☐ Preservation of an historically important land area
- ☐ Protection of natural habitat
- ☐ Preservation of a certified historic structure
- ☐ Preservation of open space

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b Assets included in Form 990, Part X ▶ $ _____

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

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

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

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

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

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

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

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

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

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	18,397,107.	13,347,087.	13,491,685.	12,626,745.	13,867,227.
b Contributions		2,000,000.			570,728.
c Net investment earnings, gains, and losses	2,199,827.	4,675,975.	40,613.	1,587,194.	-523,731.
d Grants or scholarships					
e Other expenditures for facilities and programs	3,054,472.	1,625,979.	185,211.	722,254.	1,287,479.
f Administrative expenses					
g End of year balance	17,542,462.	18,397,083.	13,347,087.	13,491,685.	12,626,745.

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

a Board designated or quasi-endowment ▶ 39.71 %
b Permanent endowment ▶ 40.02 %
c Temporarily restricted endowment ▶ 20.27 %

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

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,595,276.		1,595,276.
b Buildings		58,597,130.	40,403,545.	18,193,585.
c Leasehold improvements		1,006,331.	753,488.	252,843.
d Equipment		83,654,370.	68,455,263.	15,199,107.
e Other		5,670,152.	2,150,682.	3,519,470.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				38,760,281.

Schedule D (Form 990) 2012

232052
12-10-12

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD FOR		
(B) MALPRACTICE		
(C) SELF-INSURANCE	6,934,622.	END-OF-YEAR MARKET VALUE
(D) ASSETS HELD IN TRUST BY		
(E) OTHERS	3,220,623.	END-OF-YEAR MARKET VALUE
(F) FUNDS HELD UNDER BOND		
(G) INDENTURE	2,506,471.	END-OF-YEAR MARKET VALUE
(H) DONOR RESTRICTED		
(I) INVESTMENTS	1,154,124.	END-OF-YEAR MARKET VALUE
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	14,260,744.	

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

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INVESTMENTS IN JOINT		
(2) VENTURES	969,890.	COST
(3) INTEREST IN NET ASSETS OF		
(4) FOUNDATION	6,180,143.	END-OF-YEAR MARKET VALUE
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	7,150,033.	

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

(a) Description	(b) Book value
(1) OTHER RECEIVABLES	2,653,347.
(2) DUE FROM AFFILIATES	1,022,462.
(3) ESTIMATED SETTLEMENTS WITH THIRD-PARTY PAYERS	2,757,898.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	6,433,707.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ACCRUED POSTRETIREMENT BENEFIT	
(3) LIABILITY	5,310,964.
(4) LINE OF CREDIT	3,125,000.
(5) ASSET RETIREMENT OBLIGATIONS	604,800.
(6) ACCRUED PENSION LIABILITY	18,682,813.
(7) OTHER LIABILITIES	2,669,380.
(8)	
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	30,392,957.

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

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

1	Total revenue, gains, and other support per audited financial statements			1	131,894,430.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	0.
3	Subtract line **2e** from line **1**			3	131,894,430.
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	20,819.		
c	Add lines **4a** and **4b**			4c	20,819.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	131,915,249.

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

1	Total expenses and losses per audited financial statements			1	129,703,674.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines **2a** through **2d**			2e	0.
3	Subtract line **2e** from line **1**			3	129,703,674.
4	Amounts included on Form 990, Part IX, line 25, but not on line **1**:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	0.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	129,703,674.

Part XIII Supplemental Information

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

PART V, LINE 4: THE HOSPITAL'S ENDOWMENT CONSISTS OF MULTIPLE FUNDS ESTABLISHED FOR A VARIETY OF PURPOSES, SUCH AS CAPITAL EXPENDITURES, OPERATING EXPENSES, AND OTHER SPECIFIED DONOR AND BOARD RESTRICTED USES.

PART X, LINE 2: THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES" WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE

Part XIII Supplemental Information *(continued)*

THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS SEPTEMBER 30, 2013 AND 2012. IT IS THE HOSPITAL'S POLICY TO RECORD PENALTIES AND INTEREST ASSOCIATED WITH UNCERTAIN TAX PROVISIONS AS A COMPONENT OF OPERATING EXPENSES. AS OF SEPTEMBER 30, 2013 AND 2012, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

NONCASH VACCINE CONTRIBUTIONS	20,819.

Part XIII Supplemental Information *(continued)*

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
DEBT SERVICE FUND	444,904.	COST

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

002454 OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

BRISTOL HOSPITAL, INC.

Employer identification number

06-0646559

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 250 %	3a	X	
b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☒ Other 800 %	3b	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a Did the organization prepare a community benefit report during the tax year?	6a		X
b If "Yes," did the organization make it available to the public?	6b		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			4434661.	3492477.	942,184.	.73%
b Medicaid (from Worksheet 3, column a)			23074764.	18000260.	5074504.	3.91%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			27509425.	21492737.	6016688.	4.64%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			151,340.	0.	151,340.	.12%
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			151,340.		151,340.	.12%
k **Total.** Add lines 7d and 7j			27660765.	21492737.	6168028.	4.76%

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 1,383,762.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 345,941.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	47,894,414.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	55,176,420.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-7,282,006.

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 BRISTOL MSO, LLC	RADIOLOGY SERVICES	50.00%	.00%	.00%
2 MEDWORKS, LLC	REHAB & OCCUPATIONAL HEALTH	50.00%	.00%	.00%
3 CT OCCUPATIONAL MEDICAL PARTNERS	OCCUPATIONAL HEALTH	33.00%	.00%	.00%
4 MEDCONN COLLECTION AGENCY	COLLECTION SERVICES	25.00%	.00%	.00%
5 TOTAL LAUNDRY COLLABORATIVE, LLC	LAUNDRY SERVICES	14.11%	.00%	.00%
6 CENTRAL CT ENDOSCOPY CENTER	MEDICAL SERVICES	6.50%	.00%	.00%
7 HEALTH CT LLC	MEDICAL SERVICES	5.40%	.00%	.00%

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

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

Name, address, and primary website address	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 BRISTOL HOSPITAL, INC. BREWSTER ROAD BRISTOL, CT 06010	X	X					X	X		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group BRISTOL HOSPITAL, INC.

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

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[ ] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		X
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website			
b	[X] Available upon request from the hospital facility			
c	[ ] Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	X	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)* BRISTOL HOSPITAL, INC.

		Yes	No
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: 250 %			
If "No," explain in Part VI the criteria the hospital facility used.			
11 Used FPG to determine eligibility for providing *discounted* care?	11	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: 800 %			
If "No," explain in Part VI the criteria the hospital facility used.			
12 Explained the basis for calculating amounts charged to patients?	12	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a [X] Income level			
b [ ] Asset level			
c [ ] Medical indigency			
d [X] Insurance status			
e [ ] Uninsured discount			
f [ ] Medicaid/Medicare			
g [X] State regulation			
h [X] Other (describe in Part VI)			
13 Explained the method for applying for financial assistance?	13	X	
14 Included measures to publicize the policy within the community served by the hospital facility?	14	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a [X] The policy was posted on the hospital facility's website			
b [X] The policy was attached to billing invoices			
c [X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d [X] The policy was posted in the hospital facility's admissions offices			
e [ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f [X] The policy was available on request			
g [ ] Other (describe in Part VI)			
Billing and Collections			
15 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Part VI)			
17 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	17	X	
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a [X] Reporting to credit agency			
b [X] Lawsuits			
c [X] Liens on residences			
d [ ] Body attachments			
e [ ] Other similar actions (describe in Part VI)			

Part V Facility Information *(continued)* BRISTOL HOSPITAL, INC.

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

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

Policy Relating to Emergency Medical Care

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

If "No," indicate why:

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

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

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

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

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

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

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 12

	Name and address	Type of Facility (describe)
1	BRISTOL BEHAVIORAL HEALTH SERVICES 10 N. MAIN STREET, SUITE 210 BRISTOL, CT 06010	BEHAVIORAL HEALTH
2	BRISTOL HOSPITAL CENTER FOR DIABETES 102 NORTH STREET BRISTOL, CT 06010	DIABETES MEDICAL CARE AND EDUCATION
3	BRISTOL HOSPITAL COUNSELING CENTER 440-C NORTH MAIN STREET BRISTOL, CT 06010	THERAPY AND COUNSELING
4	BRISTOL HOSPITAL WELLNESS CENTER 842 CLARK AVENUE BRISTOL, CT 06010	MEDICAL AND FITNESS SERVICES
5	BRISTOL RADIOLOGY CENTER 25 COLLINS ROAD BRISTOL, CT 06010	MAMMOGRAPHY AND MRI
6	MED HELP 539 FARMINGTON AVENUE BRISTOL, CT 06010	URGENT CARE
7	MEDWORKS, LLC 375 CEDAR STREET NEWINGTON, CT 06111	OCCUPATIONAL HEALTH SERVICES
8	PARENT & CHILD CENTER - BRISTOL HOSPI 9 PROSPECT STREET BRISTOL, CT 06010	CHILDREN AND FAMILY SERVICES
9	REHAB DYNAMICS 975 FARMINGTON AVENUE BRISTOL, CT 06010	PHYSICAL THERAPY AND SPORTS MEDICINE
10	BRISTOL HOSPITAL LABORATORY 641 FARMINGTON AVENUE BRISTOL, CT 06010	LABORATORY SERVICES

Part V Facility Information *(continued)*

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

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

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

Name and address	Type of Facility (describe)
11 BRISTOL HOSPITAL LABORATORY 27 MAIN STREET TERRYVILLE, CT 06786	LABORATORY SERVICES
12 BRISTOL HOSPITAL WIC PROGRAM 450 MAIN STREET NEW BRITAIN, CT 06051	NUTRITION FOR WOMEN AND CHILDREN

Part VI Supplemental Information

Complete this part to provide the following information.

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

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

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

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

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

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

PART I, LINE 3C: THERE IS AN APPROVED SLIDING SCALE FOR DISCOUNTS BASED ON INCOME LEVELS AND FAMILY SIZE.

PART III, LINE 4: USE OF ESTIMATES - THE PREPARATION OF FINANCIAL STATEMENTS IN CONFORMITY WITH GAAP REQUIRES MANAGEMENT TO MAKE ESTIMATES AND ASSUMPTIONS THAT IMPACT THE REPORTED AMOUNTS OF ASSETS AND LIABILITIES AND DISCLOSURE OF CONTINGENT ASSETS AND LIABILITIES AT THE DATE OF THE FINANCIAL STATEMENTS. ESTIMATES ALSO IMPACT THE REPORTED AMOUNTS OF REVENUES AND EXPENSES DURING THE REPORTING PERIOD. ACTUAL RESULTS COULD DIFFER FROM THOSE ESTIMATES. THE HOSPITAL'S SIGNIFICANT ESTIMATES RELATE TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND CONTRACTUAL ALLOWANCES ON PATIENT ACCOUNTS RECEIVABLE, VALUATION OF INVESTMENTS, ESTIMATED SETTLEMENTS DUE TO THIRD-PARTY PAYERS, RESERVES FOR SELF-INSURANCE LIABILITIES AND THE PENSION AND OTHER POSTRETIREMENT EMPLOYEE BENEFIT PLAN LIABILITY ASSUMPTIONS.

PART III, LINE 3: THE METHODOLOGY USED IN DETERMINING THE AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY ASSUMES, BASED ON PAST EXPERIENCE AND PATIENT

Part VI Supplemental Information

DEMOGRAPHICS, THAT 25% OF BAD DEBT ACCOUNTS ARE FROM INDIVIDUALS THAT WOULD HAVE QUALIFIED FOR FINANCIAL ASSISTANCE OR MEDICAID, HAD THEY FOLLOWED THROUGH PROPERLY WITH THE APPLICATION PROCESS. THIS AMOUNT SHOULD BE INCLUDED AS COMMUNITY BENEFIT.

PART III, LINE 8: THE CALCULATED MEDICARE SHORTFALL SHOULD BE CONSIDERED COMMUNITY BENEFIT BECAUSE IT REPRESENTS UNREIMBURSED COSTS FOR PATIENT SERVICES. THESE UNREIMBURSED COSTS ARE BRISTOL HOSPITAL EXPENSES THAT ULTIMATELY BENEFIT THE COMMUNITY BRISTOL HOSPITAL SERVICES.

PART III, LINE 9B: IT IS THE POLICY OF BRISTOL HOSPITAL TO PROVIDE EVERY PATIENT FROM THE COMMUNITY WE SERVE WITH MEDICALLY NECESSARY HEALTH SERVICES REGARDLESS OF THEIR ABILITY TO PAY. THE POLICY SETS SPECIFIC GUIDLINES FOR THE COLLECTION OF PATIENT PAYMENTS AND ESTABLISHES A HIERARCHY FOR PAYMENT METHODS THAT ARE BOTH FRIENDLY TO THE PATIENT AND BENEFICIAL TO THE HOSPITAL. PATIENTS WHO ARE UNABLE TO PAY THEIR LIABILITY ARE REFERRED TO A FINANCIAL COUNSELOR WHO WILL ASSESS THE PATIENT'S ELIGIBILITY FOR CHARITY CARE OR ALTERNATIVE FUNDING SOURCES. FUNDING SOURCES INCLUDE CHARITY CARE, OUTSIDE FINANCING, HOSPITAL PAYMENT PLANS, FEDERAL, STATE AND LOCAL PROGRAMS AND THE HOSPITAL FINANCIAL ASSISTANCE PROGRAM.

BRISTOL HOSPITAL, INC.:

PART V, SECTION B, LINE 3: COMMUNITY ENGAGEMENT AND FEEDBACK WERE AN INTEGRAL PART OF THE CHNA PROCESS. BRISTOL HOSPITAL SOUGHT COMMUNITY INPUT THROUGH THE INCLUSION OF COMMUNITY LEADERS IN THE PRIORITIZATION AND IMPLEMENTATION PLANNING PROCESS. PUBLIC HEALTH AND HEALTH CARE PROFESSIONALS SHARED KNOWLEDGE AND EXPERTISE ABOUT HEALTH ISSUES, AND

Part VI Supplemental Information

LEADERS AND REPRESENTATIVES OF NON-PROFIT AND COMMUNITY-BASED ORGANIZATIONS PROVIDED INSIGHT ON THE COMMUNITY, INCLUDING THE MEDICALLY UNDERSERVED, LOW INCOME, AND MINORITY POPULATIONS. FOR A COMPLETE LIST OF PARTICIPANTS, PLEASE SEE THE COMMUNITY HEALTH NEEDS ASSESSMENT - FINAL SUMMARY REPORT, AVAILABLE ON THE BRISTOL HOSPITAL WEBSITE.

BRISTOL HOSPITAL, INC.:

PART V, SECTION B, LINE 11: THERE IS AN APPROVED SLIDING SCALE FOR DISCOUNTS BASED ON INCOME LEVELS AND FAMILY SIZE.

BRISTOL HOSPITAL, INC.:

PART V, SECTION B, LINE 12H: BRISTOL HOSPITAL RECOGNIZES THAT THE BURDEN OF HEALTH CARE COSTS ON INDIVIDUALS IS A NATIONAL CRISIS. DECADES OF HOSPITAL PRICING, DISTORTED BY THE UNIQUE BILLING REQUIREMENTS IMPOSED BY PRIVATE AND GOVERNMENTAL PAYERS AND REGULATIONS, HAS RESULTED IN A CHARGE STRUCTURE WHICH UNFAIRLY BURDENS THE INDIVIDUALS AND FAMILIES WITHOUT OR WITH LIMITED INSURANCE. BRISTOL HOSPITAL WISHES TO CORRECT THIS UNFAIRNESS BY ENSURING THAT ALL UNINSURED PATIENTS' CHARGES ARE LIMITED AND CAPPED AT MEDICARE PAYMENT LEVELS. THIS DISCOUNTED LEVEL IS DEFINED AS THE RATIO OF MEDICARE CHARGE TO PAYMENTS AND IS LISTED ON THE MOST RECENT OHCA FILING. THE MOST CURRENT DISCOUNT IS 71%. WHEN A PATIENT HAS NO INSURANCE, THEIR BILL WILL BE IMMEDIATELY REDUCED BY THAT PERCENTAGE DISCOUNT, USING THE CHARITY CARE UNINSURED ALLOWANCE CODE. PATIENTS WHO HAVE BALANCES DUE AFTER INSURANCE AND REQUIRE FINANCIAL ASSISTANCE IN PAYING THOSE BILLS, WILL BE ENTITLED TO A CHARITY CARE PATIENT ASSISTANCE DISCOUNT BASED ON THEIR INCOME AND FAMILY SIZE, USING

Part VI Supplemental Information

THE APPROVED SLIDING FINANCIAL ASSISTANCE SCALE. THE STATE OF CONNECTICUT HAS SET RECOMMENDED LEVELS OF CHARITY CARE DISCOUNTS WHICH STIPULATES THAT FOR FAMILIES AT OR BELOW 200% OF FEDERAL POVERTY LEVELS SHOULD BE DISCOUNTED TO COST, AND THAT FOR FAMILIES BETWEEN 200 AND 400% SHOULD BE DISCOUNTED TO THE COMMERCIAL AND/OR MEDICARE RATE. THE BRISTOL HOSPITAL SLIDING SCALE HAS GREATER DISCOUNTS APPLIED AT LOWER LEVELS OF THE FEDERAL POVERTY INCOME LEVELS.

PART VI, LINE 2: THE HOSPITAL'S ASSESSMENT OF THE HEALTH CARE NEEDS OF THE COMMUNITY IS A DYNAMIC PROCESS THAT INVOLVES ALL LEVELS OF HOSPITAL ADMINISTRATION, STAFF, THE BOARD OF DIRECTORS, AND MEDICAL STAFF. VARIOUS COMMITTEES AND GROUPS AT THE HOSPITAL MEET PERIODICALLY TO DISCUSS THE NEEDS OF THE COMMUNITY, AS WELL AS THE RESOURCES AND SERVICES AVAILABLE AT THE HOSPITAL AND OTHER AGENCIES IN THE AREA. THE HOSPITAL IS REPRESENTED AT VARIOUS COMMUNITY ORGANIZATIONS AND GROUPS INVOLVED WITH ASSESSMENT OF COMMUNITY NEEDS. HOSPITAL RESOURCES ARE FREQUENTLY CALLED UPON TO PARTICIPATE IN PROGRAMS AND PROJECTS TO ADDRESS THOSE NEEDS.

PART VI, LINE 3: AT BRISTOL HOSPITAL, PATIENTS ARE NOTIFIED OF THEIR ABILITY TO DISCUSS FINANCIAL ASSISTANCE OPTIONS INCLUDING CHARITY CARE IN ALL OF THEIR BILLING STATEMENTS. THE HOSPITAL ENCOURAGES PATIENTS TO FIND OUT THEIR ELIGIBILITY FOR ASSISTANCE AND PROVIDES FINANCIAL COUNSELORS TO ASSIST PATIENTS IN APPLYING FOR CHARITY CARE. PATIENTS CAN CONTACT THE FINANCIAL ASSISTANCE DEPARTMENT WITHIN THE HOSPITAL AT 860-585-3878. THIS SUPPORT ALSO INCLUDES A REPRESENTATIVE THROUGH THE STATE OF CONNECTICUT (REPRESENTATIVE PAID BY BRISTOL HOSPITAL) TO ENSURE THAT ALL ASPECTS OF ASSISTANCE ARE PROVIDED FOR EACH PATIENT. THE FINANCIAL ASSISTANCE

Part VI Supplemental Information

DEPARTMENT ALSO DISCUSSES GOVERNMENT BENEFITS THAT THEY MAY BE ELIGIBLE FOR. CONTACT INFORMATION FOR OUR FINANCIAL COUNSELOR IS ALSO INCLUDED ON THE HOSPITAL WEBSITE FOR PATIENTS TO REFERENCE.

PART VI, LINE 4: THE HOSPITAL SERVES THE GREATER BRISTOL AREA. BRISTOL IS A SUBURBAN CITY LOCATED IN HARTFORD COUNTY, CONNECTICUT, 20 MILES SOUTHWEST OF HARTFORD. BRISTOL HAS A TOTAL AREA OF 26.8 SQUARE MILES AND A POPULATION OF APPROX 62,000. 84.2% OF THE PEOPLE SPEAK ENGLISH AND 4.8% OF PEOPLE SPEAK SPANISH. 54.6% OF PEOPLE ARE MARRIED, AND 92.2% OF RESIDENTS WERE BORN IN THE UNITED STATES.

COMMUNITY INFORMATION:

THE PRIMARY SERVICE AREA (PSA) FOR OUR HOSPITAL INCLUDES:

BRISTOL (ZIP CODE 06010,06011)- 2011 CENSUS 62,078

BURLINGTON (ZIP CODE 06013)- 2011 CENSUS- 10,011

PLAINVILLE (ZIP CODE 06062)- 2011 CENSUS 17,767

PLYMOUTH (ZIP CODE 06781,06782,06786)- 2011 CENSUS 12,605

THE TOTAL POPULATION FROM THE 2011 CENSUS FOR OUR PSA IS- 102,461

IN 2010, THE LATEST DATE DATA IS AVAILABLE, ,THE FOLLOWING INFORMATION WAS PROVIDED FOR THE FOLLOWING COMMUNITIES:

BRISTOL:

MEDIAN HOUSEHOLD INCOME: $57,781

FAMILIES BELOW POVERTY LEVEL- 5.6%

INDIVIDUALS BELOW POVERTY LEVEL- 7.7%

RACE: WHITE- 87.6%, BLACK OR AFRICAN AMERICAN- 3.6%, AMERICAN INDIAN OR ALASKA NATIVE- 0.3%, ASIAN- 1.8%, OTHER RACE- 3.9%

Part VI Supplemental Information

BURLINGTON:

MEDIAN HOUSEHOLD INCOME: $116,419

FAMILIES BELOW POVERTY LEVEL- 1.2%

INDIVIDUALS BELOW POVERTY LEVEL- 1.9%

RACE: WHITE- 98%, BLACK OR AFRICAN AMERICAN- 0.2%,AMERICAN INDIAN OR ALASKA NATIVE- 0.1%, ASIAN- 1.2%

PLAINVILLE:

MEDIAN HOUSEHOLD INCOME: $62,440

FAMILIES BELOW POVERTY LEVEL- 4.1%

INDIVIDUALS BELOW POVERTY LEVEL- 5.0%

RACE: WHITE- 93.1%, BLACK OR AFRICAN AMERICAN- 2.5%, AMERICAN INDIAN OR ALASKA NATIVE- 0.3%, ASIAN- 1.3%, OTHER RACE- 0.6%

PLYMOUTH:

MEDIAN HOUSEHOLD INCOME: $70,132

FAMILIES BELOW POVERTY LEVEL- 2.9%

INDIVIDUALS BELOW POVERTY LEVEL- 5.6%

RACE: WHITE- 96.7%, BLACK OR AFRICAN AMERICAN- 0.5%, AMERICAN INDIAN OR ALASKA NATIVE- 0.3%, ASIAN- 0.6%, OTHER RACE- 0.7%

THE SECONDARY SERVICE AREA (SSA) FOR OUR HOSPITAL INCLUDES:

FARMINGTON (ZIP CODE 06085,06087)- 2011 CENSUS 6,058

SOUTHINGTON (ZIP CODE 06489)- 2011 CENSUS 33,560

WOLCOTT (ZIP CODE 06716)- 2011 CENSUS 17,458

THOMASTON (ZIP CODE 06787)- 2011 CENSUS 8,512

HARWINTON (ZIP CODE 06791)- 2011 CENSUS 5,938

Part VI Supplemental Information

THE TOTAL POPULATION FROM THE 2011 CENSUS FOR OUR SSA IS- 71,526

BOTH THE PSA (PRIMARY SERVICE AREA) AND SSA (SECONDARY SERVICE AREA) ARE PRIMARILY SUBURBAN AND RURAL AREAS BUT ALSO INCLUDE SOME URBAN AREAS AS WELL.

SOME OF THE MAJOR HEALTH PROBLEMS PREVALENT IN OUR PSA ARE ASSOCIATED WITH BEHAVIORAL HEALTH, CHEMICAL DEPENDENCY, OBESITY, AND PULMONARY DISEASE.

PART VI, LINE 5: BRISTOL HOSPITAL TAKES GREAT PRIDE IN SERVING THE COMMUNITY. AS PART OF ITS MISSION, BRISTOL HOSPITAL INCORPORATES A BROAD ARRAY OF COMMUNITY OUTREACH AND WELLNESS ACTIVITIES, DELIVERING EDUCATIONAL MATERIAL AND COUNSELING, OFFERING FREE OR LOW COST HEALTH SCREENINGS AND HOSTING PATIENT AND FAMILY SUPPORT GROUPS. WE UNDERSTAND THE IMPORTANCE AND VALUE OF EMPHASIZING GOOD HEALTH, FITNESS, SAFETY AND THE PROMOTION OF EARLY DETECTION OF ILLNESS OR DISEASE. THEREFORE, ALL OF OUR OUTREACH EFFORTS REFLECT OUR STRONG DESIRE TO IMPROVE THE QUALITY OF LIFE FOR ALL WHO LIVE AND WORK IN THE COMMUNITIES WE SERVE.

BRISTOL HOSPITAL PROVIDES FINANCIAL SUPPORT AND ACCESS TO APPROPRIATE CLINICAL CARE FOR SEVERAL LIFE-SAVING INITIATIVES, INCLUDING THE BRISTOL COMMUNITY BREAST HEALTH PROJECT AND THE COLON CANCER AWARENESS PROJECT OF GREATER BRISTOL, WHICH ALLOW US TO OFFER FREE BREAST, AND COLORECTAL CANCER SCREENINGS TO THOSE WHO, DUE TO INSURANCE OR INCOME FACTORS, MIGHT NOT OTHERWISE HAVE ACCESS TO THESE VALUABLE DIAGNOSTIC SCREENING SERVICES. THE EYE CARE PROJECT OF GREATER BRISTOL PROVIDES VITAL ACCESS TO SERVICES FOR THOSE SUFFERING FROM VISION IMPAIRMENT.

Part VI Supplemental Information

AT BRISTOL HOSPITAL WE UNDERSTAND THE IMPORTANCE OF OUR ROLE AS AN EXEMPT HEALTHCARE PROVIDER TO THE COMMUNITY WE SERVICE. OUR LEADERSHIP TEAM IS COMMITTED TO PROVIDING OUTSTANDING PATIENT CARE AND PROMOTING THE HEALTH OF THE COMMUNITY. BRISTOL HOSPITAL ATTEMPTS TO PROMOTE OUR FREE AND NON-REVENUE GENERATING PROGRAMS IN A VARIETY OF WAYS. THREE TIMES A YEAR, THE HOSPITAL MAILS A "PATHWAYS TO YOUR HEALTH" CATALOG. THE CATALOG CONTAINS A LISTING OF PROGRAMS AVAILABLE TO THE GREATER BRISTOL COMMUNITY. THIS CATALOG IS MAILED TO OVER 60,000 RESIDENTS AND PROVIDES INFORMATION ON FREE HEALTH SCREENINGS, SUPPORT GROUPS, HEALTH EDUCATION, WELLNESS PROGRAMS, ETC. THE CATALOG IS ALSO INCLUDED ON OUR HOSPITAL WEBSITE TO PROVIDE INCREASED ACCESS TO PATIENTS. THE PATHWAYS CATALOG IS DELIVERED AND DISPLAYED IN EACH DEPARTMENT WITHIN THE HOSPITAL AND IS FREE FOR ALL PATIENTS TO TAKE.

PROGRAMS ARE ALSO LISTED ON OUR WEBSITE UNDER AN "EVENTS" SECTION WHERE PATIENTS CAN REGISTER FOR FREE, DIRECTLY ONLINE. WE ALSO PROMOTE OUR PROGRAMS MONTHLY IN THE BRISTOL PRESS, BRISTOL OBSERVER, HARTFORD COURANT AND PLYMOUTH CONNECTION.

WE SUBSCRIBE TO AN "ON-HOLD" SYSTEM FOR OUR PHONES WHICH ALLOWS US TO RECORD MESSAGES FOR PATIENTS WHEN THEY CALL THE HOSPITAL. MANY OF THESE MESSAGES ARE ABOUT FREE PROGRAMS AND SERVICES, HEALTH EDUCATION FACTS AND SERVICES TO THE COMMUNITY.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

002470 OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

BRISTOL HOSPITAL, INC.

Employer identification number

06-0646559

Part I Questions Regarding Compensation

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

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) BALA SHANMUGAM, M.D.	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	290,714.	0.	0.	0.	0.	290,714.	0.
(2) KURT BARWIS	(i)	458,938.	120,000.	11,960.	140,300.	17,458.	748,656.	0.
PRESIDENT & CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) GEORGE EIGHMY	(i)	234,402.	39,389.	0.	458.	17,234.	291,483.	0.
VICE PRESIDENT OF FINANCE/CFO	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) LEONARD BANCO, M.D.	(i)	285,780.	49,770.	0.	2,450.	14,028.	352,028.	0.
CHIEF MEDICAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) JEANINE RECKDENWALD	(i)	179,035.	28,866.	0.	1,842.	17,341.	227,084.	0.
VP, HUMAN RESOURCES AND SU	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) DAVE RACKLIFFE	(i)	148,260.	21,193.	0.	1,527.	17,686.	188,666.	0.
AVP INFORMATION TECHNOLOGY	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) SHEILA KEMPF, PHD	(i)	243,495.	38,755.	0.	2,450.	17,341.	302,041.	0.
SENIOR VP/PATIENT CARE SER	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) EVA WICKWIRE	(i)	140,120.	23,910.	0.	1,360.	6,762.	172,152.	0.
AVP CHIEF DEVELOPMENT OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) PAUL SMITH	(i)	153,000.	0.	11,280.	0.	0.	164,280.	0.
DIRECTOR OF FACILITIES AND ENGINEERI	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) RUSSELL TUVERSON, M.D.	(i)	164,030.	0.	0.	1,637.	0.	165,667.	0.
OCCUPATIONAL HEALTH PHYSIC	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 1A: THE HOSPITAL PAID $7,315 IN GOLF CLUB MEMBERSHIP FEES FOR THE HOSPITAL'S PRESIDENT, AS THE CLUB DID NOT HAVE A CORPORATE MEMBERSHIP CATEGORY.

THE HOSPITAL PAID $11,280 HOUSING ALLOWANCE FOR PAUL SMITH, DIRECTOR OF FACILITIES AND ENGINEERING.

PART I, LINE 4B: KURT BARWIS, PRESIDENT, PARTICIPATES IN THE HOSPITAL'S 457(F) DEFINED CONTRIBUTION PLAN.

PART I, LINE 6: THE COMPENSATION OF THE HOSPITAL'S PRESIDENT, CFO, AND KEY EMPLOYEES IS BASED IN PART ON THE NET EARNINGS OF THE HOSPITAL.

PART I, LINE 8: AMOUNTS WERE PAID TO KURT BARWIS PURSUANT TO A CONTRACT THAT WAS SUBJECT TO THE INITIAL CONTRACT EXCEPTION DESCRIBED IN REGS. SECTION 53.4958-4(A)(3). THE ORGANIZATION FOLLOWED THE REBUTTABLE PRESUMPTION PROCEDURE DESCRIBED IN REGS. SECTION 53.4958-6(C).

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

002473
OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization
BRISTOL HOSPITAL, INC.

Employer identification number
06-0646559

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

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

1 **(a)** Name of disqualified person	**(b)** Relationship between disqualified person and organization	**(c)** Description of transaction	**(d)** Corrected? Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

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

(a) Name of interested person	**(b)** Relationship with organization	**(c)** Purpose of loan	**(d)** Loan to or from the organization? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No
MORRIS LAVIERO		PURCHASE	X		350,000.	290,136.		X	X		X	
Total ▶ $						290,136.						

Part III Grants or Assistance Benefiting Interested Persons.

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

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of assistance	**(d)** Type of assistance	**(e)** Purpose of assistance

SEE PART V FOR CONTINUATIONS

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

Part V Supplemental Information

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

SCHEDULE L, PART II, LOANS TO AND FROM INTERESTED PERSONS:

(A) NAME OF PERSON: MORRIS LAVIERO

(C) PURPOSE OF LOAN: PURCHASE BUILDING

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
▶ **Attach to Form 990.**

002475 OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization: BRISTOL HOSPITAL, INC.

Employer identification number: 06-0646559

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art - Works of art				
2	Art - Historical treasures				
3	Art - Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities - Publicly traded				
10	Securities - Closely held stock				
11	Securities - Partnership, LLC, or trust interests				
12	Securities - Miscellaneous				
13	Qualified conservation contribution - Historic structures				
14	Qualified conservation contribution - Other				
15	Real estate - Residential				
16	Real estate - Commercial				
17	Real estate - Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies	X	1	20,819.	REPORT FROM DHHS
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ ( )				
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

29	Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement	29	0

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

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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
BRISTOL HOSPITAL, INC.

Employer identification number
06-0646559

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

SERVICES TO OUR PATIENTS THROUGH OUR CONTINUUM OF SERVICES AND HEALTH PROMOTION. WE WILL COLLABORATE WITH HEALTH PROFESSIONAL AND OTHER ORGANIZATIONS AS ADVOCATES FOR OUR COMMUNITY. WE WILL PROVIDE THE OPPORTUNITY FOR GROWTH TO OUR MEDICAL STAFF AND EMPLOYEES IN AN ENVIRONMENT WHERE EACH INDIVIDUAL IS RESPECTED AND VALUED.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

SPEAKERS ON A VARIETY OF TOPICS TO SERVE THE COMMUNITY'S EDUCATIONAL NEEDS. - PERIODIC COMMUNITY SERVICE PROJECTS - THE HOSPITAL HAS SPONSORED TWO MAJOR OUTREACH EFFORTS, ONE TO PROMOTE EARLY DETECTION OF BREAST CANCER AND ONE TARGETED TO PREVENT COLON CANCER. BOTH PROGRAMS HAVE INCREASED THE COMMUNITY'S COMPLIANCE WITH THE RECOMMENDED CANCER SCREENINGS AND HAVE BEEN RECOGNIZED WITH STATE, REGIONAL AND NATIONAL AWARDS.

FORM 990, PART VI, SECTION B, LINE 11: A COMPLETED 990 IS PROVIDED TO EACH BOARD MEMBER BEFORE IT IS FILED. THIS PROVIDES AN OPPORTUNITY FOR MEMBERS TO ASK QUESTIONS AND FOLLOW UP WITH THE FINANCE TEAM REGARDING ANY ISSUES OR CONCERNS. THE 990 IS ALSO REVIEWED INTERNALLY BY MEMBERS OF THE FINANCE AND MANAGEMENT TEAMS.

FORM 990, PART VI, SECTION B, LINE 12C: ANNUALLY, ALL APPLICABLE PARTIES ARE REQUIRED TO RECEIVE AND SIGN A STATEMENT ACKNOWLEDGING THAT THEY HAVE READ, UNDERSTOOD AND AGREE TO COMPLY WITH THE CONFLICT OF INTEREST POLICY.

Name of the organization: BRISTOL HOSPITAL, INC.

Employer identification number: 06-0646559

FORM 990, PART VI, SECTION B, LINE 15: THE EXECUTIVE COMPENSATION COMMITTEE IS AUTHORIZED UNDER THE BRISTOL HOSPITAL AND HEALTH CARE GROUP BYLAWS AND IS RESPONSIBLE FOR (1) DETERMINING THE OVERALL TOTAL COMPENSATION STRATEGY FOR ALL CORPORATE OFFICERS, (2) APPROVING ALL COMPENSATION AND BENEFITS DECISIONS FOR CORPORATE OFFICERS, AND (3) REPORTING SUCH ACTIONS TO THE FULL BRISTOL HOSPITAL AND HEALTH CARE GROUP BOARD ON AN ANNUAL BASIS. IN ADDITION, THE EXECUTIVE COMPENSATION COMMITTEE EXPRESSLY DETERMINES THE REASONABLENESS OF TOTAL COMPENSATION AND BENEFITS FOR ALL CORPORATE OFFICERS AND ASSURES THAT ALL OFFICER COMPENSATION DECISIONS ARE MADE AFTER THOROUGH CONSIDERATION OF AND COMPARISON TO THE MARKET PRACTICES OF OTHER SIMILARLY SITUATED NOT-FOR-PROFIT HEALTHCARE EXECUTIVES IN COMPARABLE ORGANIZATIONS. THE EXECUTIVE COMPENSATION COMMITTEE CONSISTS OF BOARD MEMBERS WHO DO NOT HAVE MATERIAL FINANCIAL INTERESTS THAT COULD BE AFFECTED BY THE OFFICER COMPENSATION DECISIONS MADE BY THE COMMITTEE. THE COMPARABILITY DATA USED TO ASSIST THE EXECUTIVE COMPENSATION COMMITTEE IN ITS COMPENSATION DELIBERATIONS ARE COMPILED BY AN INDEPENDENT, NATIONAL COMPENSATION CONSULTING FIRM THAT IS RETAINED BY AND REPORTS DIRECTLY TO THE EXECUTIVE COMPENSATION COMMITTEE. THE DATA COLLECTED BY THE CONSULTANT CONSISTS OF MARKET INFORMATION FOR EXECUTIVES IN FUNCTIONALLY SIMILAR POSITIONS IN SIMILARLY SITUATED NOT-FOR-PROFIT HEALTHCARE ORGANIZATIONS. THE DELIBERATIONS AND DECISIONS OF THE EXECUTIVE COMPENSATION COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED, REVIEWED AND APPROVED BY THE EXECUTIVE COMPENSATION COMMITTEE AND PROVIDED TO THE BOARD ON AN ANNUAL BASIS. THE LAST COMPENSATION REVIEW FOR THE CEO, OTHER OFFICERS AND KEY EMPLOYEES OCCURRED ON NOVEMBER 19, 2012.

FORM 990, PART VI, SECTION C, LINE 19: GOVERNING DOCUMENTS, CONFLICT OF

Name of the organization: BRISTOL HOSPITAL, INC.

Employer identification number: 06-0646559

INTEREST POLICY, AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

INCREASE IN PERMANENTLY RESTRICTED NET ASSETS	116,976.
TRANSFER TO BRISTOL HOSPITAL MULTISPECIALTY GROUP	-472,971.
PENSION CHANGES OTHER THAN NET PERIODIC BENEFIT COSTS	12,746,301.
CHANGES IN POSTRETIREMENT HEALTH & WELFARE BENEFITS	1,933,951.
CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION	1,695,168.
NONCASH VACCINE CONTRIBUTIONS	-20,819.
TRANSFER TO BRISTOL HEALTH CARE, INC.	-1,414,373.
TRANSFER TO BRISTOL HOSPITAL DEVELOPMENT FOUNDATION	-1,473,516.
TOTAL TO FORM 990, PART XI, LINE 9	13,110,717.

FORM 990, PART XI, LINE 2C:

THE HOSPITAL'S AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THE PROCESSES OF OVERSIGHT OF THE AUDIT AND SELECTION OF AN INDEPENDENT ACCOUNTANT HAVE NOT CHANGED FROM THE PRIOR YEAR.

SCHEDULE R (Form 990)
Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization
BRISTOL HOSPITAL, INC.

Employer identification number
06-0646559

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
HG PROPERTY HOLDINGS LLC - 27-2548373 41 BREWSTER RD BRISTOL, CT 06010	REAL ESTATE	CONNECTICUT	-22,070.	721,289.	BRISTOL HOSPITAL, INC.

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC. - 22-2577726, BREWSTER ROAD, BRISTOL, CT 06010	HEALTHCARE PARENT COMPANY	CONNECTICUT	501 (C) (3)	11B, TYPE II			X
BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC. - 22-2577740, BREWSTER ROAD, BRISTOL, CT 06010	FUNDRAISING	CONNECTICUT	501 (C) (3)	7	BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.		X
BRISTOL HEALTH CARE, INC. - 22-2577731 400 NORTH MAIN STREET BRISTOL, CT 06010	NURSING HOME	CONNECTICUT	501 (C) (3)	9	BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.		X
BRISTOL HOSPITAL MULTISPECIALTY GROUP, INC. - 06-1466555, BREWSTER ROAD, BRISTOL, CT 06010	HEALTHCARE SERVICES	CONNECTICUT	501 (C) (3)	9	BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
MEDWORKS, LLC - 06-1490483 375 EAST CEDAR STREET NEWINGTON, CT 06111	REHAB & OCCUPATIONAL HEALTH	CT		RELATED	14,279.	61,647.		X	N/A		X	50.00%
BRISTOL MSO, LLC - 06-1506024 25 COLLINS ROAD BRISTOL, CT 06010	RADIOLOGY SERVICES	CT		RELATED	603,176.	678,119.		X	N/A		X	50.00%

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
BRISTOL HOSPITAL EMS, LLC - 06-1547648 P.O. BOX 977 BRISTOL, CT 06011	EMERGENCY MEDICAL SERVICES	CT	BRISTOL HOSPITAL & HEALTH CARE	C CORP	0.	0.	.00%		X

SEE PART VII FOR CONTINUATIONS

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

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

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

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) BRISTOL HOSPITAL EMS, LLC	Q	474,883.	COST
(2) BRISTOL HOSPITAL EMS, LLC	O	109,706.	COST
(3) BRISTOL HEALTH CARE	Q	1,815,442.	COST
(4) BRISTOL HEALTH CARE	O	405,051.	COST
(5) BRISTOL HOSPITAL DEVELOPMENT FOUNDATION	O	310,925.	COST
(6) BRISTOL HOSPITAL MULTISPECIALTY GROUP	R	5,055,000.	COST

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) BRISTOL HOSPITAL MULTISPECIALTY GROUP	J	230,392.	COST
(8) BRISTOL HOSPITAL MULTISPECIALTY GROUP	O	169,889.	COST
(9) HG PROPERTY HOLDINGS, LLC	R	747,698.	COST
(10) BRISTOL HOSPITAL DEVELOPMENT FOUNDATION	C	324,705.	COST
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

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

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

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

Part VII Supplemental Information

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

PART IV, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS CORP OR TRUST:

NAME OF RELATED ORGANIZATION:

BRISTOL HOSPITAL EMS, LLC

DIRECT CONTROLLING ENTITY: BRISTOL HOSPITAL & HEALTH CARE GROUP

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL, CT 06011
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AUGUST 15, 2014
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

Form **990-T**

Department of the Treasury
Internal Revenue Service

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

For calendar year 2012 or other tax year beginning OCT 1, 2012 , and ending SEP 30, 2013

OMB No. 1545-0687

2012

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

A ☐ Check box if address changed	Print or Type	Name of organization (☐ Check box if name changed and see instructions.)	**D** Employer identification number (Employees' trust, see instructions.)
		BRISTOL HOSPITAL, INC.	06-0646559
B Exempt under section ☒ 501(c)(3) ☐ 408(e) ☐ 220(e) ☐ 408A ☐ 530(a) ☐ 529(a)		Number, street, and room or suite no. If a P.O. box, see instructions. BREWSTER RD.	**E** Unrelated business activity codes (See instructions)
		City or town, state, and ZIP code BRISTOL, CT 06011	812300 541380
C Book value of all assets at end of year 113932754.	**F** Group exemption number (see instructions) ▶		
	G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust		

H Describe the organization's primary unrelated business activity. ▶ LABORATORY, LAUNDRY AND COLLECTIONS SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 3

J The books are in care of ▶ GEORGE EIGHMY Telephone number ▶ 860-585-3000

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 1,813,079. b Less returns and allowances 1,395,596. c Balance ▶	1c	417,483.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	417,483.		417,483.
4a	Capital gain net income (attach Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5	-69,449.	STMT 1	-69,449.
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (see instructions; attach statement)	12			
13	**Total.** Combine lines 3 through 12	13	348,034.		348,034.

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	94,537.
16	Repairs and maintenance			16	3,296.
17	Bad debts			17	81,589.
18	Interest (attach statement)			18	
19	Taxes and licenses			19	
20	Charitable contributions (see instructions for limitation rules)			20	
21	Depreciation (attach Form 4562)	21	4,674.		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	4,674.
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	21,744.
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach statement) SEE STATEMENT 2			28	440,386.
29	**Total deductions.** Add lines 14 through 28			29	646,226.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-298,192.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 4			31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	-298,192.
33	Specific deduction (generally $1,000, but see 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	-298,192.

Part III Tax Computation

35	**Organizations taxable as corporations** (see instructions for tax computation). Controlled group members (sections 1561 and 1563) check here ▶ ☐ **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ **(2)** Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts taxable at trust rates** (see instructions for tax computation). Income tax on the amount on line 34 from: ☐ Tax rate schedule or ☐ 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)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Other (attach statement)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2011 overpayment credited to 2012	44a			
b	2012 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: ☐ Form 2439 ☐ Form 4136 ☐ Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2013 estimated tax** ▶ **Refunded** ▶			49	

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

		Yes	No
1	At any time during the 2012 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 Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here ▶		X
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 ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

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 (att. statement)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach statement)	4b					X
5	**Total.** Add lines 1 through 4b	5					

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 | Date | ▶ VP & CFO Title

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

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self- employed	PTIN
RICHARD BUGGY				P00512316

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP | Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 | Phone no. 860-678-9200

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 statement)
	(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	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

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	
			(a) Straight line depreciation (attach statement)	(b) Other deductions (attach statement)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach statement)	5. Average adjusted basis of or allocable to debt-financed property (attach statement)	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)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

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)					
				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).
Totals ▶				0.	0.

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 statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

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 cols. 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)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

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 cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

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 (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

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
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

FORM 990-T INCOME (LOSS) FROM PARTNERSHIPS STATEMENT 1

DESCRIPTION	AMOUNT
MEDCONN COLLECTION AGENCY, LLC	-37,654.
TOTAL LAUNDRY COLLABORATVE, LLC	-32,681.
CT HOSPITAL LABORATORY NETWORK, LLC	886.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	-69,449.

FORM 990-T OTHER DEDUCTIONS STATEMENT 2

DESCRIPTION	AMOUNT
LABORATORY SUPPLIES AND EXPENSES	150,293.
LABORATORY OVERHEAD ALLOCATION	290,093.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	440,386.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 3

CORPORATION'S NAME	IDENTIFYING NO
BRISTOL HOSPITAL AND HEALTH CARE GROUP	22-2577726

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/04	561,387.	0.	561,387.	561,387.
09/30/05	38,147.	0.	38,147.	38,147.
09/30/06	41,108.	0.	41,108.	41,108.
09/30/07	100,000.	0.	100,000.	100,000.
09/30/09	297,526.	0.	297,526.	297,526.
09/30/10	348,560.	0.	348,560.	348,560.
09/30/11	742,724.	0.	742,724.	742,724.
09/30/12	576,333.	0.	576,333.	576,333.
NOL CARRYOVER AVAILABLE THIS YEAR			2,705,785.	2,705,785.

- 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 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
	BRISTOL HOSPITAL, INC.	06-0646559
	Number, street, and room or suite no. If a P.O. box, see instructions. BREWSTER RD.	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BRISTOL, CT 06011	

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	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 ▶ GEORGE EIGHMY
  BREWSTER ROAD - BRISTOL, CT 06011
  Telephone No. ▶ 860-585-3000 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 AUGUST 15, 2014.

5 For calendar year _____, or other tax year beginning OCT 1, 2012, and ending SEP 30, 2013.

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
ADDITIONAL TIME IS NEEDED TO PREPARE A COMPLETE AND ACCURATE RETURN.

8a	If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Form 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	$	0.
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	$	0.

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 ▶ CPA Date ▶

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2012, or fiscal year beginning OCT 1 , 2012, and ending SEP 30 ,20 13

▶ **Do not send to the IRS. Keep for your records.**

002493
OMB No. 1545-1878

2012

Name of exempt organization

BRISTOL HOSPITAL, INC.

Employer identification number

06-0646559

Name and title of officer

GEORGE W. EIGHMY
VP & CFO

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a	Form 990 check here ▶ [X]	**b**	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	131915249
2a	Form 990-EZ check here ▶ [ ]	**b**	**Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a	Form 1120-POL check here ▶ [ ]	**b**	**Total tax** (Form 1120-POL, line 22)	**3b**	
4a	Form 990-PF check here ▶ [ ]	**b**	**Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a	Form 8868 check here ▶ [ ]	**b**	**Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize SASLOW LUFKIN & BUGGY, LLP to enter my PIN 75666

ERO firm name

Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 06237554566

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 01/13)

Form CT-990T EXT

Application for Extension of Time to File Unrelated Business Income Tax Return

See instructions. Complete this return in blue or black ink only.

00249 **2012**

Enter Income Year Beginning ▶ OCT 1 **, 2012, and Ending ▶** SEP 30, 2013

Taxpayer (Please type or print)	Organization name: BRISTOL HOSPITAL, INC.	**CT Tax Registration Number** ▶ 5475389-000
	Address (Number and street, PO Box): BREWSTER RD.	**DRS use only** ▶ - - 20
	City or town: BRISTOL, CT 06011 (State ZIP code)	**Federal Employer ID Number (FEIN)** ▶ 06-0646559

Request for six-month extension of time to file Form CT-990T only

Enter above the beginning and ending dates of the organization's income year, Connecticut Tax Registration Number, and FEIN.

Check type of organization: [X] Corporation [ ] Domestic trust [ ] Foreign trust [ ] Other

An application for an extension to file **Form CT-990T**, with payment of tax tentatively believed to be due, must be submitted whether or not an application for federal extension has been approved.

I request a **six-month extension** of time to file **Form CT-990T**, *Connecticut Unrelated Business Income Tax Return,* for calendar year 2012, or until 08/15/14 for fiscal year ending 09/30/13 .

A federal extension will be requested on federal Form 8868, Application for Extension of Time to File an Exempt Organization Return, for calendar year 2012, or fiscal year beginning OCTOBER 1 , 2012, and ending SEPTEMBER 30, 201 . [X] Yes [ ] No

If **No,** the reason for the Connecticut extension is _____

Notification will be sent only if extension request is denied

Tentative Return

Computation

1.	Tentative amount of tax due for this income year, including surtax if applicable. See instr.			1.		00
2.	*Reserved for future use*			2.		
3.	Total amount of tax due for this income year: Enter amount from Line 1			3.		00
4a.	Tax credits	4a	00			
4b.	Payments of estimated tax	4b	00			
4c.	Overpayment from prior year	4c	00			
4.	Total tax credit and payments: Add Lines 4a, 4b, and 4c			4.		00
5.	**Balance due with this return:** Subtract Line 4 from Line 3 ▶			5.	0	00

Make check payable to **Commissioner of Revenue Services.** Write the organization's Connecticut Tax Registration Number and "2012 Form CT-990T EXT" on the check and attach it to the return.

Mail this return to: Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014

Visit the DRS **Taxpayer Service Center (TSC)** at **www.ct.gov/TSC** to pay this return electronically.

www.ct.gov/DRS TSC Taxpayer Service Center

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Signature of officer or fiduciary	Title: VP & CFO	Date	Telephone number: 860-585-3000
Paid preparer's signature		Date	Preparer's SSN or PTIN: P00346435
Firm's name and address: SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089			FEIN: 06-1533253 Telephone number: 860-678-9200

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241911
01-18-13

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL, CT 06011
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	AUGUST 15, 2014
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 01/13)

Form CT-990T

Connecticut Unrelated Business Income Tax Return

002496

2012

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 , 2012, and Ending ▶ SEPTEMBER 30, 2013

Taxpayer (Please type or print)	Organization name (please type or print)	CT Tax Registration Number
	BRISTOL HOSPITAL, INC.	5475389-000
	Address number and street PO Box	DRS use only
	BREWSTER RD.	- - 20
	City or town State ZIP code	Federal Employer ID Number (FEIN)
	BRISTOL, CT 06011	06-0646559

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) **Return status:** ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: LABORATORY, LAUNDRY AND COLLECTIONS SERVICE
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut:

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2012 federal Form 990-T, Part II, Line 34	▶	1	-298,192 00
2. Federal net operating loss deduction from 2012 federal Form 990-T, Part II, Line 31	▶	2	00
3. Federal deduction for Connecticut tax on unrelated business taxable income	▶	3	00
4. **Total:** Add Lines 1, 2, and 3	▶	4	-298,192 00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income	▶	5	00
6. Unrelated business taxable income: Subtract Line 5 from Line 4	▶	6	-298,192 00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3**	▶	1	-298,192 00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places	▶	2	
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2	▶	3	-298,192 00
4. Operating loss carryover from *Schedule B*, Line 13 on page 2	▶	4	00
5. Income subject to tax: Subtract Line 4 from Line 3	▶	5	-298,192 00
6. **Tax:** Multiply Line 5 by 7.5% (.075)	▶	6	00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions	▶	1	00
2. *Reserved for future use*	▶	2	
3. Total Tax: Enter the amount from Line 1	▶	3	00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1**	▶	4	00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."	▶	5	0 00
6a. Paid with application for extension from **Form CT-990T EXT**	▶	6a	00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC,** & **ESD**	▶	6b	00
6c. Overpayment from prior year	▶	6c	00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c	▶	6	00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	▶	7	00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ **CT-1120I** Interest ▶ (8c) _____		8	00
9. Amount to be credited to 2013 estimated tax ▶ (9a) Refunded ▶ (9b)		9	00

For faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8 ▶	10	0 00

Visit the DRS website at **www.ct.gov/TSC** to pay electronically. www.ct.gov/DRS **TSC** Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Signature of officer or fiduciary	Date	May DRS contact the preparer shown below about this return? See instructions.
Keep a copy of this return for your records.	Title: VP & CFO	Telephone number: 860-585-3000	☒ Yes ☐ No
	Officer's email address		
	Paid preparer's signature	Date	Preparer's SSN or PTIN: P00512316
	Firm's name and address: SASLOW LUFKIN & BUGGY, LLP SIMSBURY, CT 06089	FEIN: 06-1533253	Telephone number: 860-678-9200

1019

241901 01-22-13

002497

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut	Column B Everywhere	Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories	00	00	
	(b) Tangible property	00	00	
	(c) Real property	00	00	
	(d) Capitalized rent	00	00	
	1. Total	00	00	
Receipts	2. (a) Sales of tangibles	00	00	
	(b) Services	00	00	
	(c) Rentals	00	00	
	(d) Other	00	00	
	2. Total	00	00	
Wages, salaries, and other compensation	**3. Total**	00	00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.			
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.			

Schedule B - Connecticut Apportioned Operating Loss Carryover

1. 2000 Connecticut net operating loss available for use in 2012	1.		00
2. 2001 Connecticut net operating loss available for use in 2012	2.		00
3. 2002 Connecticut net operating loss available for use in 2012	3.		00
4. 2003 Connecticut net operating loss available for use in 2012	4.	561,387	00
5. 2004 Connecticut net operating loss available for use in 2012	5.	38,147	00
6. 2005 Connecticut net operating loss available for use in 2012	6.	41,108	00
7. 2006 Connecticut net operating loss available for use in 2012	7.	100,000	00
8. 2007 Connecticut net operating loss available for use in 2012	8.		00
9. 2008 Connecticut net operating loss available for use in 2012	9.	297,526	00
10. 2009 Connecticut net operating loss available for use in 2012	10.	348,560	00
11. 2010 Connecticut net operating loss available for use in 2012	11.	742,724	00
12. 2011 Connecticut net operating loss available for use in 2012	12.	576,333	00
13. **Total:** Add Lines 1 through 12. Enter here and on *Computation of Tax*, Line 4	13.	2,705,785	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.	-298,192	00
2. Add back specific deduction from 2012 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.	-298,192	00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2012 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.	-298,192	00

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 5.x products, uncheck the "Shrink oversized pages to paper size" and uncheck the "Expand small pages to paper size" options, in the Adobe "Print" dialog. When using Acrobat 6.x and later products versions, select "None" in the "Page Scaling" selection box in the Adobe "Print" dialog.

CLIENT'S COPY

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	BRISTOL HOSPITAL AND HEALTH CARE GROUP BREWSTER ROAD BRISTOL, CT 06011
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 15, 2014.

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

002500 OMB No. 1545-0047

2012

Open to Public Inspection

A For the 2012 calendar year, or tax year beginning OCT 1, 2012 **and ending** SEP 30, 2013

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
BRISTOL HOSPITAL AND HEALTH CARE GROUP

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
BREWSTER ROAD

City, town, or post office, state, and ZIP code
BRISTOL, CT 06011

F Name and address of principal officer: KURT BARWIS
SAME AS C ABOVE

D Employer identification number
22-2577726

E Telephone number
860 585-3000

G Gross receipts $ 0.

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

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ N/A

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1984 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: PARENT ENTITY OF ORGANIZATIONS ESTABLISHED TO PROVIDE QUALITY HEALTHCARE SERVICES TO THE GREATER

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	16
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	13
5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	5	0
6	Total number of volunteers (estimate if necessary)	6	0
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	0.	0.
9	Program service revenue (Part VIII, line 2g)	0.	0.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	175.	0.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0.	0.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	175.	0.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	0.	0.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	0.	0.
19	Revenue less expenses. Subtract line 18 from line 12	175.	0.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	18,178,648.	28,607,725.
21	Total liabilities (Part X, line 26)	0.	0.
22	Net assets or fund balances. Subtract line 21 from line 20	18,178,648.	28,607,725.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ GEORGE W. EIGHMY, VP & CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
RICHARD BUGGY			☐	P00512316

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP — Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 — Phone no. 860-678-9200

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
PARENT ENTITY OF ORGANIZATIONS ESTABLISHED TO PROVIDE QUALITY HEALTHCARE SERVICES TO THE GREATER BRISTOL COMMUNITY.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ 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 $ including grants of $) (Revenue $)
HEALTHCARE PARENT COMPANY FOR BRISTOL HOSPITAL, INC., BRISTOL HOSPITAL MULTISPECIALTY GROUP, INC., BRISTOL HEALTH CARE, INC., BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC. AND BRISTOL HOSPITAL EMS, LLC.

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

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

4d Other program services (Describe in Schedule O.)
(Expenses $ including grants of $) (Revenue $)

4e **Total program service expenses** ▶

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

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

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

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	16		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6			X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

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

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

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ NONE

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

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

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

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

GEORGE EIGHMY - 860 585-3000
BREWSTER ROAD, BRISTOL, CT 06011

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below 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) KURT BARWIS	2.00									
PRESIDENT & CEO	60.00	X		X				0.	590,898.	157,758.
(2) MARK BLUM	2.00									
SECRETARY/TREASURER	2.00	X		X				0.	0.	0.
(3) KENNETH BENOIT, M.D.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(4) JOHN J. LEONE, JR.	2.00									
VICE CHAIRMAN	2.00	X		X				0.	0.	0.
(5) BALA SHANMUGAM, M.D.	2.00									
DIRECTOR	40.00	X						0.	290,714.	0.
(6) JOHN LODOVICO, JR.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(7) MARIE O'BRIEN	2.00									
CHAIRMAN	2.00	X		X				0.	0.	0.
(8) GLENN HEISER	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(9) DOUGLAS DEVNEW	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(10) KAREN GUADAGNINI, M.D.	2.00									
DIRECTOR	40.00	X						0.	112,925.	3,280.
(11) MARY ANN CORDEAU, PHD, RN	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(12) FAWAD KAZI, M.D.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(13) THOMAS MONAHAN	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(14) ELLEN SOLEK	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(15) VALERIE VITALE, M.D.	2.00									
DIRECTOR	2.00	X						0.	0.	0.
(16) SHARON ADLER	2.00									
DIRECTOR	2.00	X						0.	0.	0.

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 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			
1b Sub-total ▶								0.	994,537.	161,038.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								0.	994,537.	161,038.

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 ▶ 0

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
NONE		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 0

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns 1a				
	b Membership dues 1b				
	c Fundraising events 1c				
	d Related organizations 1d				
	e Government grants (contributions) 1e				
	f All other contributions, gifts, grants, and similar amounts not included above 1f				
	g Noncash contributions included in lines 1a-1f: $				
	h **Total.** Add lines 1a-1f ▶				
Program Service Revenue		Business Code			
	2a				
	b				
	c				
	d				
	e				
	f All other program service revenue				
	g **Total.** Add lines 2a-2f ▶				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶				
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties ▶				
		(i) Real / (ii) Personal			
	6a Gross rents				
	b Less: rental expenses				
	c Rental income or (loss)				
	d Net rental income or (loss) ▶				
	7a Gross amount from sales of assets other than inventory	(i) Securities / (ii) Other			
	b Less: cost or other basis and sales expenses				
	c Gain or (loss)				
	d Net gain or (loss) ▶				
	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 ▶				
	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 ▶				
	10a Gross sales of inventory, less returns and allowances a				
	b Less: cost of goods sold b				
	c Net income or (loss) from sales of inventory ▶				
	Miscellaneous Revenue	Business Code			
	11a				
	b				
	c				
	d All other revenue				
	e **Total.** Add lines 11a-11d ▶				
	12 **Total revenue.** See instructions. ▶	0.	0.	0.	0.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages				
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)				
9 Other employee benefits				
10 Payroll taxes				
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)				
12 Advertising and promotion				
13 Office expenses				
14 Information technology				
15 Royalties				
16 Occupancy				
17 Travel				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization				
23 Insurance				
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 _____				
b _____				
c _____				
d _____				
e All other expenses _____				
25 **Total functional expenses.** Add lines 1 through 24e	0.	0.	0.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	39,119.	1	39,119.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net		4	
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	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 instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use		8	
	9	Prepaid expenses and deferred charges		9	
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a			
	b	Less: accumulated depreciation — 10b		10c	
	11	Investments - publicly traded securities		11	
	12	Investments - other securities. See Part IV, line 11		12	
	13	Investments - program-related. See Part IV, line 11	18,139,529.	13	28,568,606.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11		15	
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	18,178,648.	16	28,607,725.
Liabilities	17	Accounts payable and accrued expenses		17	
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	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		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	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		25	
	26	**Total liabilities.** Add lines 17 through 25	0.	26	0.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	5,146,717.	27	18,001,943.
	28	Temporarily restricted net assets	6,104,328.	28	3,585,204.
	29	Permanently restricted net assets	6,927,603.	29	7,020,578.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	18,178,648.	33	28,607,725.
	34	Total liabilities and net assets/fund balances	18,178,648.	34	28,607,725.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	0.
2	Total expenses (must equal Part IX, column (A), line 25)	2	0.
3	Revenue less expenses. Subtract line 2 from line 1	3	0.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	18,178,648.
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	-6,772,821.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	17,201,898.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	28,607,725.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

002512
OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization	**Employer identification number**
BRISTOL HOSPITAL AND HEALTH CARE GROUP	22-2577726

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document? Yes	(iv) No	(v) Did you notify the organization in col. (i) of your support? Yes	(v) No	(vi) Is the organization in col. (i) organized in the U.S.? Yes	(vi) No	(vii) Amount of monetary support
BRISTOL HOSPITAL, IN	06-0646559	3	X		X		X		0.
Total 1									0.

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)) ..... **14** %

15 Public support percentage from 2011 Schedule A, Part II, line 14 ..... **15** %

16a **33 1/3% support test - 2012.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2011.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

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

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2012** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2011** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

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

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
BRISTOL HOSPITAL AND HEALTH CARE GROUP

Employer identification number
22-2577726

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

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

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
- ☐ Preservation of land for public use (e.g., recreation or education)
- ☐ Protection of natural habitat
- ☐ Preservation of open space
- ☐ Preservation of an historically important land area
- ☐ Preservation of a certified historic structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b Assets included in Form 990, Part X ▶ $ _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings				
c Leasehold improvements				
d Equipment				
e Other				
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				0.

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

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

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

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INVESTMENTS IN		
(2) SUBSIDIARIES	28,568,606.	COST
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	28,568,606.	

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	

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

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

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

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

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

Part XIII Supplemental Information

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

PART X, LINE 2: THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES" WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE CORPORATION MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION. THE CORPORATION DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS

Part XIII Supplemental Information *(continued)*

AS SEPTEMBER 30, 2013 AND 2012. IT IS THE CORPORATION'S POLICY TO RECORD PENALTIES AND INTEREST ASSOCIATED WITH UNCERTAIN TAX PROVISIONS AS A COMPONENT OF OPERATING EXPENSES. AS OF SEPTEMBER 30, 2013 AND 2012, THE CORPORATION DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE CORPORATION'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

002520 OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

BRISTOL HOSPITAL AND HEALTH CARE GROUP

Employer identification number

22-2577726

Part I Questions Regarding Compensation

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

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) KURT BARWIS	(i)	0.	0.	0.	0.	0.	0.	0.
PRESIDENT & CEO	(ii)	458,938.	120,000.	11,960.	140,300.	17,458.	748,656.	0.
(2) BALA SHANMUGAM, M.D.	(i)	0.	0.	0.	0.	0.	0.	0.
DIRECTOR	(ii)	290,714.	0.	0.	0.	0.	290,714.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 4B: KURT BARWIS, PRESIDENT, PARTICIPATES IN THE HOSPITAL'S 457(F) DEFINED CONTRIBUTION PLAN.

PART I, LINE 8: AMOUNTS WERE PAID BY A RELATED ORGANIZATION (BRISTOL HOSPITAL) TO KURT BARWIS PURSUANT TO A CONTRACT WITH THE HOSPITAL THAT WAS SUBJECT TO THE INITIAL CONTRACT EXCEPTION DESCRIBED IN REGS. SECTION 53.4958-4(A)(3). THE HOSPITAL FOLLOWED THE REBUTTABLE PRESUMPTION PROCEDURE DESCRIBED IN REGS. SECTION 53.4958-6(C).

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

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization
BRISTOL HOSPITAL AND HEALTH CARE GROUP

Employer identification number
22-2577726

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

BRISTOL COMMUNITY.

FORM 990, PART VI, SECTION B, LINE 11: THE FORM 990 IS REVIEWED INTERNALLY BY MEMBERS OF THE FINANCE DEPARTMENT AND MANAGEMENT.

FORM 990, PART VI, SECTION B, LINE 12C: THE ORGANIZATION REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY VIA THE USE OF ANNUAL DISCLOSURE STATEMENTS.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN TEMPORARILY RESTRICTED ASSETS	-1,286,534.
CHANGE IN PERMANENTLY RESTRICTED ASSETS	92,975.
NET INCOME OF SUBSIDIARIES	18,395,457.
TOTAL TO FORM 990, PART XI, LINE 9	17,201,898.

FORM 990, PART XII, LINE 2C:

THE ORGANIZATION HAS A COMMITTEE THAT ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THERE HAVE BEEN NO CHANGES TO THE OVERSIGHT OR SELECTION PROCESS DURING THE YEAR.

002524

SCHEDULE R (Form 990)
Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization
BRISTOL HOSPITAL AND HEALTH CARE GROUP

Employer identification number
22-2577726

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
BRISTOL HOSPITAL, INC. - 06-0646559 BREWSTER ROAD BRISTOL, CT 06010	HOSPITAL	CONNECTICUT	501 (C)(3)	3	BRISTOL HOSPITAL AND HEALTH CARE GROUP		X
BRISTOL HEALTH CARE, INC. - 22-2577731 400 NORTH MAIN STREET BRISTOL, CT 06010	SKILLED NURSING FACILITY	CONNECTICUT	501 (C)(3)	9	BRISTOL HOSPITAL AND HEALTH CARE GROUP		X
BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC. - 22-2577740, BREWSTER ROAD, BRISTOL, CT 06010	FUNDRAISING	CONNECTICUT	501 (C)(3)	7	BRISTOL HOSPITAL AND HEALTH CARE GROUP		X
BRISTOL HOSPITAL MULTISPECIALTY GROUP, INC. - 06-1466555, BREWSTER ROAD, BRISTOL, CT 06010	HEALTHCARE SERVICES	CONNECTICUT	501 (C)(3)	9	BRISTOL HOSPITAL AND HEALTH CARE GROUP		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
MEDWORKS, LLC - 06-1490483 375 EAST CEDAR STREET NEWINGTON, CT 06111	REHAB & OCCUPATIONAL HEALTH	CT		RELATED	0.	0.		X	N/A		X	
BRISTOL MSO, LLC - 06-1506024 25 COLLINS ROAD BRISTOL, CT 06010	RADIOLOGY SERVICES	CT		RELATED	0.	0.		X	N/A		X	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
BRISTOL HOSPITAL EMS, LLC - 06-1547648 P.O. BOX 977 BRISTOL, CT 06010	EMERGENCY MEDICAL SERVICES	CT	BRISTOL HOSPITAL AND HEALTH CARE	C CORP	0.	1,558,458.	100%		X

SEE PART VII FOR CONTINUATIONS

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

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

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

	(a) Name of other organization	**(b)** Transaction type (a-s)	**(c)** Amount involved	**(d)** Method of determining amount involved
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

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

Part VII Supplemental Information

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

PART IV, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS CORP OR TRUST:

NAME OF RELATED ORGANIZATION:

BRISTOL HOSPITAL EMS, LLC

DIRECT CONTROLLING ENTITY: BRISTOL HOSPITAL AND HEALTH CARE GROUP

- 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 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
	BRISTOL HOSPITAL AND HEALTH CARE GROUP	22-2577726
	Number, street, and room or suite no. If a P.O. box, see instructions. BREWSTER ROAD	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BRISTOL, CT 06011	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

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	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 ▶ GEORGE EIGHMY
  BREWSTER ROAD - BRISTOL, CT 06011
  Telephone No. ▶ 860 585-3000 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 AUGUST 15, 2014.

5 For calendar year _____, or other tax year beginning OCT 1, 2012, and ending SEP 30, 2013.

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
ADDITIONAL TIME IS NEEDED TO PREPARE A COMPLETE AND ACCURATE RETURN.

8a	If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Form 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	$	0.
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	$	0.

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 ▶ CPA Date ▶

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2012, or fiscal year beginning OCT 1 , 2012, and ending SEP 30 ,20 13

▶ **Do not send to the IRS. Keep for your records.**

002530
OMB No. 1545-1878

2012

Name of exempt organization	Employer identification number
BRISTOL HOSPITAL AND HEALTH CARE GROUP	22-2577726

Name and title of officer
GEORGE W. EIGHMY
VP & CFO

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a Form 990 check here ▶ [X]	**b** **Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	0
2a Form 990-EZ check here ▶ [ ]	**b** **Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a Form 1120-POL check here ▶ [ ]	**b** **Total tax** (Form 1120-POL, line 22)	**3b**	
4a Form 990-PF check here ▶ [ ]	**b** **Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a Form 8868 check here ▶ [ ]	**b** **Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize SASLOW LUFKIN & BUGGY, LLP to enter my PIN 46566
ERO firm name
Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 06237555666
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 41: COMMUNITY BENEFIT EXPENDITURES POST TRANSACTION

SCHEDULE H FY2013

	7 Charity Care and Certain Other Community Benefits at Cost						
	Financial Assistance and Means- Tested Government Programs	(a) Number of Activities or programs	(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	-	-	$4,434,661	$3,492,477	$942,184	0.73%
b	Medicaid (from Worksheet 3, column A)	-	-	$23,074,764	$18,000,260	$5,074,504	3.91%
c	Unreimbursed costs-other means tested government	-	-	-	-	-	-
d	**Means Tested Government Programs**	-	-	$27,509,425	$21,492,737	$6,016,688	4.64%
	Other Benefits						
e	services and community benefit operations	-	-	$151,000	$0	$151,000	0.11%
f	Health professions education	-	-				
g	Subsidized health services	-	-				
h	Research	-	-				
i	Cash and in-kind contributions to community groups	-	-				
j	**TOTAL. Other Benefits**	$0	$0	$151,000	$0	$151,000	0.11%
K	**TOTAL. Add Lines 7d and 7j**			$27,660,425	$21,492,737	$6,167,688	4.75%

	Part II. Community Building Activities	Complete this table if the organization conducted any community building activities					
		Activities or programs	(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	-	-			$0	0.00%
2	Economic development	-	-	N/A		#VALUE!	#VALUE!
3	Community support	-	-			$0	0.00%
4	Environmental improvements	-	-			$0	0.00%
5	Leadership development and training for community	-	-			$0	0.00%
6	Coalition building	-	-			$0	0.00%
7	Community health improvement advocacy	-	-			$0	0.00%
8	Workforce development	-	-			$0	0.00%
9	Other	-	-			$0	0.00%
10	**Total**	$0	$0	$0	$0	#VALUE!	#VALUE!

SCHEDULE H FY2014

7 Charity Care 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	-	-	$4,630,142	$3,200,000	$1,430,142	1.06%
b	Medicaid (from Worksheet 3, column A)	-	-	$23,074,764	$23,074,764	$5,074,504	2.28%
c	Unreimbursed costs-other means tested government programs	-	-	-	-	-	-
d	**Total Financial Assistance and Means Tested Government Programs**	-	-	$27,704,906	$26,274,764	$6,504,646	3.34%
	Other Benefits						
e	Community health improvement services and community benefit operations	-	-	$153,000	$0	$153,000	0.11%
f	Health professions education	-	-				
g	Subsidized health services	-	-				
h	Research	-	-				
i	Cash and in-kind contributions to community groups	-	-				
j	**TOTAL. Other Benefits**	$0	$0	$153,000	$0	$153,000	0.11%
K	**TOTAL. Add Lines 7d and 7j**			$27,857,906	$26,274,764	$6,657,646	3.45%

Part II.	Community Building Activities	Complete this table if the organization conducted any community building activities					
		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	-	-			$0	0.00%
2	Economic development	-	-	N/A		#VALUE!	#VALUE!
3	Community support	-	-			$0	0.00%
4	Environmental improvements	-	-			$0	0.00%
5	Leadership development and training for community members	-	-			$0	0.00%
6	Coalition building	-	-			$0	0.00%
7	Community health improvement advocacy	-	-			$0	0.00%
8	Workforce development	-	-			$0	0.00%
9	Other	-	-			$0	0.00%
10	**Total**	$0	$0	$0	$0	#VALUE!	#VALUE!

SCHEDULE H FY2015 PROJECTED

	7 Charity Care 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	-	-	$4,769,046	$1,200,000	$3,569,046	2.54%
b	Medicaid (from Worksheet 3, column A)	-	-	$23,074,764	$18,000,260	$5,074,504	3.62%
c	Unreimbursed costs-other means tested government programs	-	-	-	-	-	-
d	**Total Financial Assistance and Means Tested Government Programs**	-	-	$27,843,810	$19,200,260	$8,643,550	6.16%
	Other Benefits						
e	Community health improvement services and community benefit operations	-	-	$155,000	$0	$155,000	0.11%
f	Health professions education	-	-				
g	Subsidized health services	-	-				
h	Research	-	-				
i	Cash and in-kind contributions to community groups	-	-				
j	**TOTAL. Other Benefits**	$0	$0	$155,000	$0	$155,000	0.11%
K	**TOTAL. Add Lines 7d and 7j**			$27,998,810	$19,200,260	$8,798,550	6.27%

Part II.	**Community Building Activities**	Complete this table if the organization conducted any community building activities					
		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	-	-			$0	0.00%
2	Economic development	-	-	N/A		#VALUE!	#VALUE!
3	Community support	-	-			$0	0.00%
4	Environmental improvements	-	-			$0	0.00%
5	Leadership development and training for community members	-	-			$0	0.00%
6	Coalition building	-	-			$0	0.00%
7	Community health improvement advocacy	-	-			$0	0.00%
8	Workforce development	-	-			$0	0.00%
9	Other	-	-			$0	0.00%
10	**Total**	$0	$0	$0	$0	#VALUE!	#VALUE!

SCHEDULE H FY2016 PROJECTED

	7 Charity Care 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	-	-	$4,912,117	$1,212,000	$3,700,117	2.54%
b	Medicaid (from Worksheet 3, column A)	-	-	$23,767,007	$18,180,263	$5,586,745	3.83%
c	Unreimbursed costs-other means tested government programs	-	-	-	-	-	-
d	**Total Financial Assistance and Means Tested Government Programs**	-	-	$28,679,125	$19,392,263	$9,286,862	6.37%
	Other Benefits						
e	Community health improvement services and community benefit operations	-	-	$157,000	$0	$157,000	0.11%
f	Health professions education	-	-				
g	Subsidized health services	-	-				
h	Research	-	-				
i	Cash and in-kind contributions to community groups	-	-				
j	**TOTAL. Other Benefits**	$0	$0	$157,000	$0	$157,000	0.11%
K	**TOTAL. Add Lines 7d and 7j**			$28,679,125	$19,392,263	$9,286,862	6.47%

Part II.	**Community Building Activities**	Complete this table if the organization conducted any community building activities					
		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	-	-			$0	0.00%
2	Economic development	-	-	N/A		#VALUE!	#VALUE!
3	Community support	-	-			$0	0.00%
4	Environmental improvements	-	-			$0	0.00%
5	Leadership development and training for community members	-	-			$0	0.00%
6	Coalition building	-	-			$0	0.00%
7	Community health improvement advocacy	-	-			$0	0.00%
8	Workforce development	-	-			$0	0.00%
9	Other	-	-			$0	0.00%
10	**Total**	$0	$0	$0	$0	#VALUE!	#VALUE!

SCHEDULE H FY2017 PROJECTED

	7 Charity Care 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	-	-	$5,059,481	$1,224,120	$3,835,361	2.53%
b	Medicaid (from Worksheet 3, column A)	-	-	$24,480,017	$18,362,065	$6,117,952	4.03%
c	Unreimbursed costs-other means tested government programs	-	-	-	-	-	-
d	**Total Financial Assistance and Means Tested Government Programs**	-	-	$29,539,498	$19,586,185	$9,953,313	6.56%
	Other Benefits						
e	Community health improvement services and community benefit operations	-	-	$159,000	$0	$159,000	0.10%
f	Health professions education	-	-				
g	Subsidized health services	-	-				
h	Research	-	-				
i	Cash and in-kind contributions to community groups	-	-				
j	**TOTAL. Other Benefits**	$0	$0	$159,000	$0	$159,000	0.10%
K	**TOTAL. Add Lines 7d and 7j**			$29,539,498	$19,586,185	$9,953,313	6.66%

Part II.	**Community Building Activities**	Complete this table if the organization conducted any community building activities					
		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	-	-			$0	0.00%
2	Economic development	-	-	N/A		#VALUE!	#VALUE!
3	Community support	-	-			$0	0.00%
4	Environmental improvements	-	-			$0	0.00%
5	Leadership development and training for community members	-	-			$0	0.00%
6	Coalition building	-	-			$0	0.00%
7	Community health improvement advocacy	-	-			$0	0.00%
8	Workforce development	-	-			$0	0.00%
9	Other	-	-			$0	0.00%
10	**Total**	$0	$0	$0	$0	#VALUE!	#VALUE!

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 42: DIVERSITY PLAN

Bristol Hospital Diversity Team 2014 Strategic Plan (Board Approval April 2, 2014)

Goal Statement #1: ***Increase diversity in hospital governance and management which will be measured by the percent of diverse hospital board members and management staff and the change over time to reflect our community profile.***			
Practice Intervention	**Key Action Steps**	**Timeline/Status**	**Responsible Party**
1) Expand on current mechanisms to identify, cultivate, and place diverse governance candidates.	a) Identify diverse candidates for potential appointment to hospital sub-committees of the Board.	Ongoing	Governance Committee of BOD
2) Advance and sustain organizational governance and leadership that promotes CLAS Standards and health equity through policy, practices and allocated resources.	a) Distribute and discuss the CLAS standards at the Leadership and Board meetings. The discussion should include an assessment of where we are as an organization in meeting the standards and how we can improve. As an organization focus on #8 "Provide easy-to-understand print and multimedia material and signage in the languages commonly used by the populations in the service area."	Present 2014 Strategic Plan at upcoming board meeting. Discuss and strategize at LT and Director's Meetings.	Diversity Team Senior Leadership
3) Recruit, promote and support a culturally and linguistically diverse leadership and workforce.	a) Require contracted search/contingency firms to present diverse candidates. b) Post positions on niche web sites.	Ongoing.	HR Department
4) Develop high potential diverse employees for leadership positions	a) Identify candidates as mentors to provide mentorship as well as provide outside education and job learning opportunities.	Identify candidates at various times of year; especially at end of year review time.	Senior Leadership
Goal Statement #2: ***Improve cultural awareness and competence in the delivery of care by increasing the percent of staff who have received cultural competence training, increasing the number of programs, activities and messages on an annual basis.***			
Practice Intervention	**Key Action Steps**	**Timeline/Status**	**Responsible Party**
1) Educate and train both staff and physicians in culturally and linguistically appropriate policies and practices on an ongoing basis.	a) Distribute Education Message of the Month via email and post to WebLink. b) Conduct Nursing/Staff Grand Rounds on Culturally Competent Care. c) Participate in Clinical Mandatory days. d) Celebrate Diversity Month with Lunch & Learn. e) Post educational Resources to WebLink. f) Maintain Cultural Diversity bulletin board.	Ongoing September 2014 Fall 2014 October 2014 Ongoing Ongoing	Diversity Team Diversity Team and Clinical Educators Diversity Team Diversity Team Diversity Team Diversity Team

Practice Intervention	Key Action Steps	Timeline/Status	Responsible Party
2) Develop management competency in diversity and cultural competence.	a) Dedicate one Leadership Development training each year to furthering diversity and/or cultural competency.	Show diversity and disparity video at March Leadership group meeting with discussion.	Leadership & Diversity Team
3) Develop a language bank resource.	a) identify quality people inside and outside the organization who could help with patients and families from a variety of nationalities and ethnic backgrounds. Solicit members.	End of June 2014	Diversity Team
Goal Statement #3: ***Increase Supplier Diversity.***			
Practice Intervention	**Key Action Steps**	**Timeline/Status**	**Responsible Party**
1) Identify spend targets for minority businesses.	a) Provide education, tools, and resources on supplier diversity for hospital's supply chain managers. b) Identify target spending areas through Supplier Diversity Work Group and meeting group structure.	February onward	Supplier Diversity Lead
2) Utilizing state and national GPO supplier programs, implement increased purchasing from MBEs.	a) Provide access to MBE contracts for products and services in member identified target spending through CHA's GPO supplier diversity program.	Access newly created resource for minority vendors.	CHA & Supplier Diversity Lead