

Exempt Organization Declaration and Signature for Electronic Filing

For calendar year 2015, or tax year beginning OCT 1, 2015, and ending SEP 30, 2016

2015

Department of the Treasury
Internal Revenue Service

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

Name of exempt organization

GREENWICH HOSPITAL

Employer identification number
06-0646659

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the type of return being filed with Form 8453-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 of 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-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a Form 990 check here	<input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	<u>381,590,713.</u>
2a Form 990-EZ check here	<input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a Form 1120-POL check here	<input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b	
4a Form 990-PF check here	<input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a Form 8868 check here	<input type="checkbox"/>	b Balance due (Form 8868, Part I, line 3c or Part II, line 8c)	5b	

Part II Declaration of Officer

6 I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) 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.


If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2015 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.


Sign Here  Date 8/5/17 Title SR VP

Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-file (MeF) Information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only	ERO's signature 	Date <u>8/11/17</u>	Check if also paid preparer <input type="checkbox"/>	Check if self-employed <input type="checkbox"/>	ERO's SSN or PTIN <u>P00315411</u>
	Firm's name (or yours if self-employed); address, and ZIP code	<u>YALE NEW HAVEN HEALTH SERVICES CORP</u>			EIN <u>22-2529464</u>
		<u>789 HOWARD AVENUE</u>			Phone no. <u>203-688-9585</u>
		<u>NEW HAVEN, CT 06519</u>			

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer Use Only	Print/type preparer's name	Preparer's signature 	Date <u>8/5/17</u>	Check <input type="checkbox"/> if self-employed	PTIN <u>P00741489</u>
	Firm's name	<u>KPMG LLP</u>			Firm's EIN <u>13-5565207</u>
	Firm's address	<u>345 PARK AVENUE</u>			Phone no. <u>212-758-9700</u>
		<u>NEW YORK, NY 10154</u>			

Form **990**

Return of Organization Exempt From Income Tax

OMB No 1545-0047

Department of the Treasury
Internal Revenue Service

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

▶ Do not enter social security numbers on this form as it may be made public.

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

2015
Open to Public Inspection

A For the 2015 calendar year, or tax year beginning **OCT 1, 2015** and ending **SEP 30, 2016**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization GREENWICH HOSPITAL Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 5 PERRYRIDGE ROAD City or town, state or province, country, and ZIP or foreign postal code GREENWICH, CT 06830	D Employer identification number 06-0646659
E Telephone number 203-863-3000		G Gross receipts \$ 384,548,082.
F Name and address of principal officer: NORMAN ROTH 5 PERRYRIDGE ROAD, GREENWICH, CT 06830		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)() (Insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
J Website: WWW.GREENWICHHOSPITAL.ORG		H(c) Group exemption number ▶
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1903
Part I Summary		M State of legal domicile: CT

1	Briefly describe the organization's mission or most significant activities: TO PROVIDE HEALTHCARE SERVICES.		
2	Check this box <input type="checkbox"/> 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	24
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	18
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	2054
6	Total number of volunteers (estimate if necessary)	6	715
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	6,233,549.
7b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.
8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
9	Program service revenue (Part VIII, line 2g)	8,402,281.	8,177,500.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	340,737,212.	357,650,227.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,155,848.	3,723,754.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	11,612,471.	12,039,232.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	365,907,812.	381,590,713.
14	Benefits paid to or for members (Part IX, column (A), line 4)	397,291.	381,724.
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)	164,159,732.	151,119,718.
b	Total fundraising expenses (Part IX, column (D), line 25)	0.	0.
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	3,205,124.	
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	167,474,118.	199,007,428.
19	Revenue less expenses. Subtract line 18 from line 12	332,031,141.	350,508,870.
20	Total assets (Part X, line 16)	33,876,671.	31,081,843.
21	Total liabilities (Part X, line 26)	Beginning of Current Year	End of Year
22	Net assets or fund balances. Subtract line 21 from line 20	494,263,689.	521,735,219.
		143,652,158.	174,820,369.
		350,611,531.	346,914,850.

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 EUGENE COLUCCI, SR VP Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name ROBERT ROBINSON	Preparer's signature <i>Robert Robinson</i>
	Firm's name ▶ KPMG LLP	Date 8/5/17
	Firm's address ▶ 345 PARK AVENUE NEW YORK, NY 10154	Check if self-employed <input type="checkbox"/> PTIN P00741489
		Firm's EIN ▶ 13-5565207
		Phone no. 212-758-9700

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: TO PROVIDE HEALTHCARE SERVICES.

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 250,367,210. including grants of \$ 381,724.) (Revenue \$ 367,999,947.) SEE SCHEDULE O

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 250,367,210.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

		Yes	No
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	X	
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	X	
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	X	
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	X	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	X	
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	X	

Note. All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Input box for Schedule O

Main table with columns for question numbers (1a-14b), Yes/No, and numerical responses (e.g., 493, 0, 2054).

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

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

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 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.	24	
b	Enter the number of voting members included in line 1a, above, who are independent	18	
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?	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?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	X	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?	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?	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?	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	X	
b	Each committee with authority to act on behalf of the governing body?	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		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?	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?	X	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	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	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	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	X	
13	Did the organization have a written whistleblower policy?	X	
14	Did the organization have a written document retention and destruction policy?	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	X	
b	Other officers or key employees of the organization	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?	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?	X	

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, address, and telephone number of the person who possesses the organization's books and records: **DENIS DONEGAN - 203-688-6088**
789 HOWARD AVENUE, NEW HAVEN, CT 06519

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below 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) PAUL J. APOSTOLIDES TRUSTEE	1.00 1.00	X						0.	0.	0.
(2) WILLIAM BERKLEY TRUSTEE	1.00 1.00	X						0.	0.	0.
(3) ALAN BREED TRUSTEE	1.00 2.00	X						0.	0.	0.
(4) NANCY BROWN TRUSTEE (END 10/15)	1.00 1.00	X						0.	0.	0.
(5) PETER DAPUZZO TRUSTEE	1.00 2.00	X						0.	0.	0.
(6) MARC GABELLI TRUSTEE (START 3/16)	1.00 2.00	X						0.	0.	0.
(7) ELIZABETH GALT TRUSTEE AND SECRETARY	1.00 1.00	X		X				0.	0.	0.
(8) ANNE JUGE TRUSTEE AND TREASURER	1.00 2.00	X		X				0.	0.	0.
(9) ROBIN KANAREK TRUSTEE	1.00 1.00	X						0.	0.	0.
(10) DONALD KIRK TRUSTEE (END 10/15)	1.00 1.00	X						0.	0.	0.
(11) SALLY LOCHNER TRUSTEE (END 9/16)	1.00 1.00	X						0.	0.	0.
(12) ARTHUR MARTINEZ TRUSTEE AND CO CHAIR	1.00 3.00	X		X				0.	0.	0.
(13) BARBARA MILLER TRUSTEE AND CO-VICE CHAIR	1.00 2.00	X		X				0.	0.	0.
(14) AMY MINELLA TRUSTEE	1.00 2.00	X						0.	0.	0.
(15) JACK MITCHELL TRUSTEE	1.00 1.00	X						0.	0.	0.
(16) DANIEL L. MOSLEY TRUSTEE (END 9/16)	1.00 3.00	X						0.	0.	0.
(17) CHRISTOPHER O'CONNOR TRUSTEE	1.00 39.00	X						0.	1,210,574.	388,215.

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) VENITA OSTERER TRUSTEE (END 9/16)	1.00 1.00	X						0.	0.	0.
(19) THOMAS PELLECHI TRUSTEE	1.00 1.00	X						0.	0.	0.
(20) CHRISTINE RANDOLPH TRUSTEE (START 9/16)	1.00 1.00	X						0.	0.	0.
(21) NORMAN ROTH TRUSTEE AND PRESIDENT	32.00 8.00	X		X				861,657.	215,411.	113,148.
(22) JIM SABETTA TRUSTEE	39.00 1.00	X						380,664.	0.	75,858.
(23) JOHN SCHMELTZER, III TRUSTEE (END 9/16)	1.00 1.00	X						0.	0.	0.
(24) JOHN TOWNSEND, III TRUSTEE AND CO CHAIR	1.00 4.00	X		X				0.	0.	0.
(25) BRUCE WARWICK TRUSTEE (END 9/16)	1.00 1.00	X						0.	0.	0.
(26) FELICE ZWAS TRUSTEE	1.00 1.00	X						0.	0.	0.
1b Sub-total								1,242,321.	1,425,985.	577,221.
c Total from continuation sheets to Part VII, Section A								5,987,845.	1,270,163.	994,678.
d Total (add lines 1b and 1c)								7,230,166.	2,696,148.	1,571,899.

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 **299**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
GREENWICH ULTRASOUND ASSOC. 67 HOLLY HILL RD, GREENWICH, CT 06830	ULTRASOUND SERVICE	3,237,657.
UNITEX TEXTILE RENTAL, 161 SOUTH MACQUESTEN PARKWAY, MOUNT VERNON, NY 10550	UNIFORM LAUNDERING	1,320,219.
CENTURY MANAGEMENT SERVICES 23 MAIDEN LANE, NORTH HAVEN, CT 06473	DEBT COLLECTION	1,061,019.
QUEST DIAGNOSTIC, 15 CAMPUS BOULEVARD, NEWTOWN SQUARE, PA 19073	MEDICAL COMPLIANCE	1,034,258.
NURSEFINDERS, 524 EAST LAMAR BLVD, SUITE 300, ARLINGTON, TX 76011	RECRUITING	730,147.

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 **55**

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) CHRISTINE BEECHNER VP	39.00 1.00			X				172,504.	0.	40,486.
(28) SUSAN BROWN SENIOR VP	39.00 1.00			X				387,981.	0.	58,492.
(29) EUGENE COLUCCI SENIOR VP	36.00 4.00			X				550,066.	61,119.	208,733.
(30) DEBORAH HODYS VP	39.00 1.00			X				477,880.	0.	42,764.
(31) MARC KOSAK VP	39.00 1.00			X				310,854.	0.	45,460.
(32) NANCY LEVITT-ROSENTHAL SENIOR VP (END 11/15)	32.00 8.00			X				353,088.	88,273.	154,114.
(33) SPIKE LIPSCHUTZ, M.D. VP	39.00 1.00			X				497,461.	0.	41,933.
(34) DANA MARNANE VP (START 10/15)	39.00 1.00			X				185,018.	0.	16,146.
(35) MELISSA TURNER SENIOR VP	20.00 20.00			X				205,444.	205,444.	147,594.
(36) JIM WRIGHT VP (START 10/15)	39.00 1.00			X				184,325.	0.	10,258.
(37) VICKI ALTMAYER DIRECTOR OF PATHOLOGY	40.00 0.00				X			592,666.	0.	56,786.
(38) DOROTHY BLACKMUN PATHOLOGIST	40.00 0.00				X			466,307.	0.	35,927.
(39) RICHARD EISEN DIRECTOR OF PATHOLOGY	40.00 0.00				X			430,572.	0.	22,977.
(40) ILEANA GREEN PATHOLOGIST	40.00 0.00				X			447,694.	0.	20,459.
(41) STEPHEN JONES CHIEF SAFETY OFFICER/DIRECTOR	40.00 0.00				X			388,191.	0.	62,225.
(42) FRANK CORVINO FORMER OFFICER (12/14)	0.00 0.00					X		0.	915,327.	3,640.
(43) BRIAN DORAN FORMER OFFICER (9/15)	0.00 0.00					X		337,794.	0.	26,684.
Total to Part VII, Section A, line 1c								5,987,845.	1,270,163.	994,678.

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	1,127,929.				
	d Related organizations	1d					
	e Government grants (contributions)	1e	163,571.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	6,886,000.				
	g Noncash contributions included in lines 1a-1f: \$		705,517.				
	h Total. Add lines 1a-1f		8,177,500.				
	Program Service Revenue			Business Code			
2 a OUTPATIENT PROGRAM SERVICES			621400	194,130,011.	194,130,011.		
b INPATIENT PROGRAM SERVICES			612990	152,942,803.	152,942,803.		
c OUTREACH LAB			621500	6,233,413.		6,233,413.	
d PATHOLOGY PATIENT REVENUE			621500	4,344,000.	4,344,000.		
e							
f All other program service revenue							
g Total. Add lines 2a-2f				357,650,227.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			530,134.		136.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	1,854,416.				
		(ii) Personal					
		b Less: rental expenses	141,088.				
		c Rental income or (loss)	1,713,328.				
	d Net rental income or (loss)			1,713,328.		1,713,328.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	4,821,825.	489,868.			
		(ii) Other					
		b Less: cost or other basis and sales expenses	2,118,073.	0.			
		c Gain or (loss)	2,703,752.	489,868.			
	d Net gain or (loss)			3,193,620.		3,193,620.	
	8 a Gross income from fundraising events (not including \$ 1,127,929. of contributions reported on line 1c). See Part IV, line 18	a	144,125.				
		b Less: direct expenses	698,208.				
c Net income or (loss) from fundraising events				-554,083.		-554,083.	
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses						
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances	a						
	b Less: cost of goods sold						
	c Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code					
11 a PATHOLOGY SERVICES		900099	2,640,233.	2,640,233.			
b IVF SERVICE INCOME		900099	1,918,839.	1,918,839.			
c CLINIC SERVICES		900099	1,007,573.	1,007,573.			
d All other revenue		900099	5,313,342.	4,783,075.		530,267.	
e Total. Add lines 11a-11d			10,879,987.				
12 Total revenue. See instructions.			381,590,713.	361,766,534.	6,233,549.	5,413,130.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	381,724.	381,724.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	8,262,268.		8,262,268.	
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	114,815,470.	88,256,442.	24,866,978.	1,692,050.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,025,214.	2,762,970.	262,244.	
9 Other employee benefits	16,452,202.	12,726,933.	3,219,134.	506,135.
10 Payroll taxes	8,564,564.	6,238,318.	2,206,645.	119,601.
11 Fees for services (non-employees):				
a Management	4,519,161.	3,360,942.	1,158,219.	
b Legal	566,762.	366,060.	126,148.	74,554.
c Accounting	233,013.	173,294.	59,719.	
d Lobbying	79,202.	79,202.		
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.)	75,465,976.	55,973,402.	19,281,204.	211,370.
12 Advertising and promotion				
13 Office expenses	5,939,632.	4,172,548.	1,437,907.	329,177.
14 Information technology	8,929,549.	6,640,989.	2,288,560.	
15 Royalties				
16 Occupancy	13,705,324.	9,990,312.	3,442,775.	272,237.
17 Travel				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	529,825.	394,036.	135,789.	
20 Interest	350,866.	260,942.	89,924.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	18,696,127.	6,535,073.	12,161,054.	
23 Insurance	2,706,069.	2,012,529.	693,540.	
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 PHARMACEUTICAL SUPPLIES	28,200,757.	20,973,166.	7,227,591.	0.
b MEDICAL SUPPLY EXPENSE	27,388,015.	20,368,722.	7,019,293.	0.
c EDUCATION & OTHER EMPL	6,527,643.	4,854,669.	1,672,974.	0.
d OTHER PATHOLOGY EXPENSE	4,344,000.	3,231,000.	1,113,000.	0.
e All other expenses	825,507.	613,937.	211,570.	
25 Total functional expenses. Add lines 1 through 24e	350,508,870.	250,367,210.	96,936,536.	3,205,124.
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 or note to any line in this Part X

		(A)		(B)	
		Beginning of year		End of year	
Assets	1 Cash - non-interest-bearing	24,997,890.	1	13,091,369.	
	2 Savings and temporary cash investments	74,483,889.	2	120,083,800.	
	3 Pledges and grants receivable, net		3		
	4 Accounts receivable, net	38,149,419.	4	38,130,498.	
	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	1,636,165.	8	1,962,864.	
	9 Prepaid expenses and deferred charges	6,244,397.	9	5,157,662.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 477,813,225.			
	b Less: accumulated depreciation	10b 249,895,877.	215,976,202.	10c	227,917,348.
	11 Investments - publicly traded securities	9,085,610.	11	7,067,871.	
	12 Investments - other securities. See Part IV, line 11	88,158,568.	12	68,101,913.	
	13 Investments - program-related. See Part IV, line 11		13		
	14 Intangible assets		14		
	15 Other assets. See Part IV, line 11	35,531,549.	15	40,221,894.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	494,263,689.	16	521,735,219.		
Liabilities	17 Accounts payable and accrued expenses	31,776,164.	17	38,248,735.	
	18 Grants payable		18		
	19 Deferred revenue		19		
	20 Tax-exempt bond liabilities	35,105,000.	20	32,070,314.	
	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	76,770,994.	25	104,501,320.	
	26 Total liabilities. Add lines 17 through 25	143,652,158.	26	174,820,369.	
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	298,677,899.	27	292,116,010.	
	28 Temporarily restricted net assets	41,782,451.	28	44,533,260.	
	29 Permanently restricted net assets	10,151,181.	29	10,265,580.	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30 Capital stock or trust principal, or current funds		30		
	31 Paid-in or capital surplus, or land, building, or equipment fund		31		
	32 Retained earnings, endowment, accumulated income, or other funds		32		
	33 Total net assets or fund balances	350,611,531.	33	346,914,850.	
	34 Total liabilities and net assets/fund balances	494,263,689.	34	521,735,219.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	381,590,713.
2	Total expenses (must equal Part IX, column (A), line 25)	2	350,508,870.
3	Revenue less expenses. Subtract line 2 from line 1	3	31,081,843.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	350,611,531.
5	Net unrealized gains (losses) on investments	5	1,631,000.
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	-36,409,524.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	346,914,850.

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> 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?		X
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:			
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
2b	Were the organization's financial statements audited by an independent accountant?	X	
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:			
<input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
2c	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?	X	
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	X	
3b	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	X	

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

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

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

- 1 A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i).
2 A school described in section 170(b)(1)(A)(ii). (Attach Schedule E (Form 990 or 990-EZ).)
3 [X] A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii).
4 A medical research organization operated in conjunction with a hospital described in section 170(b)(1)(A)(iii). Enter the hospital's name, city, and state:
5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in section 170(b)(1)(A)(iv). (Complete Part II.)
6 A federal, state, or local government or governmental unit described in section 170(b)(1)(A)(v).
7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in section 170(b)(1)(A)(vi). (Complete Part II.)
8 A community trust described in section 170(b)(1)(A)(vi). (Complete Part II.)
9 An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See section 509(a)(2). (Complete Part III.)
10 An organization organized and operated exclusively to test for public safety. See section 509(a)(4).
11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See section 509(a)(3). Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
a Type I. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. You must complete Part IV, Sections A and B.
b Type II. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). You must complete Part IV, Sections A and C.
c Type III functionally integrated. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). You must complete Part IV, Sections A, D, and E.
d Type III non-functionally integrated. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). You must complete Part IV, Sections A and D, and Part V.
e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
f Enter the number of supported organizations
g Provide the following information about the supported organization(s).

Table with 6 main columns: (i) Name of supported organization, (ii) EIN, (iii) Type of organization, (iv) Is the organization listed in your governing document?, (v) Amount of monetary support, (vi) Amount of other support. Includes a Total row at the bottom.

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge ...						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources ...						
9 Net income from unrelated business activities, whether or not the business is regularly carried on ...						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2014 Schedule A, Part II, line 14	15	%

16a 33 1/3% support test - 2015. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

b 33 1/3% support test - 2014. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

17a 10% -facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ►

b 10% -facts-and-circumstances test - 2014. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ►

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

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge ...						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources ...						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2014 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2015. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

b 33 1/3% support tests - 2014. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

Schedule A (Form 990 or 990-EZ) 2015

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

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

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

Schedule B

(Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2015

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

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

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

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

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2015)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	<hr/> <hr/> <hr/>	\$ 10,091.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<hr/> <hr/> <hr/>	\$ 6,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	<hr/> <hr/> <hr/>	\$ 55,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	<hr/> <hr/> <hr/>	\$ 10,450.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
6	<hr/> <hr/> <hr/>	\$ 16,348.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	<hr/> <hr/> <hr/>	\$ <u>7,675.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
8	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	<hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
10	<hr/> <hr/> <hr/>	\$ <u>45,600.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
11	<hr/> <hr/> <hr/>	\$ <u>6,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	<hr/> <hr/> <hr/>	\$ <u>5,329.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	<hr/> <hr/> <hr/>	\$ 5,095.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
14	<hr/> <hr/> <hr/>	\$ 5,735.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
15	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	<hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	<hr/> <hr/> <hr/>	\$ 5,510.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
20	<hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	<hr/> <hr/> <hr/>	\$ 8,500.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
22	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	<hr/> <hr/> <hr/>	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25	<hr/> <hr/> <hr/>	\$ 5,500.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
26	<hr/> <hr/> <hr/>	\$ 50,825.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	<hr/> <hr/> <hr/>	\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	<hr/> <hr/> <hr/>	\$ 7,575.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37	<hr/> <hr/> <hr/>	\$ 5,020.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	<hr/> <hr/> <hr/>	\$ 9,555.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	<hr/> <hr/> <hr/>	\$ 7,375.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
40	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	<hr/> <hr/> <hr/>	\$ 7,000.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
42	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
<u>43</u>	_____ _____ _____	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>44</u>	_____ _____ _____	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>45</u>	_____ _____ _____	\$ <u>7,475.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
<u>46</u>	_____ _____ _____	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>47</u>	_____ _____ _____	\$ <u>5,060.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>48</u>	_____ _____ _____	\$ <u>5,000.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	<hr/> <hr/> <hr/>	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56	<hr/> <hr/> <hr/>	\$ 639,600.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59	<hr/> <hr/> <hr/>	\$ 83,333.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60	<hr/> <hr/> <hr/>	\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
61	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
62	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
63	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
64	<hr/> <hr/> <hr/>	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
65	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
66	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
67	<hr/> <hr/> <hr/>	\$ 10,645.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
68	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
69	<hr/> <hr/> <hr/>	\$ 25,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
70	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
71	<hr/> <hr/> <hr/>	\$ 8,960.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
72	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
73	<hr/> <hr/> <hr/>	\$ 10,325.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
74	<hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
75	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
76	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
77	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
78	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
79	<hr/> <hr/> <hr/>	\$ 250,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
80	<hr/> <hr/> <hr/>	\$ 5,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
81	<hr/> <hr/> <hr/>	\$ 52,650.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
82	<hr/> <hr/> <hr/>	\$ 8,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
83	<hr/> <hr/> <hr/>	\$ 135,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
84	<hr/> <hr/> <hr/>	\$ 39,703.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
85	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
86	<hr/> <hr/> <hr/>	\$ 13,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
87	<hr/> <hr/> <hr/>	\$ 25,650.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
88	<hr/> <hr/> <hr/>	\$ 9,300.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
89	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
90	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
91	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
92	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
93	<hr/> <hr/> <hr/>	\$ 11,175.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
94	<hr/> <hr/> <hr/>	\$ 8,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
95	<hr/> <hr/> <hr/>	\$ 10,200.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
96	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
97	<hr/> <hr/> <hr/>	\$ <u>6,200.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
98	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
99	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
100	<hr/> <hr/> <hr/>	\$ <u>9,000.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
101	<hr/> <hr/> <hr/>	\$ <u>40,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
102	<hr/> <hr/> <hr/>	\$ <u>5,200.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
103	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
104	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
105	<hr/> <hr/> <hr/>	\$ <u>5,460.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
106	<hr/> <hr/> <hr/>	\$ <u>6,580.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
107	<hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
108	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
109	<hr/> <hr/> <hr/>	\$ 25,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
110	<hr/> <hr/> <hr/>	\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
111	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
112	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
113	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
114	<hr/> <hr/> <hr/>	\$ 5,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
115	<hr/> <hr/> <hr/>	\$ <u>46,300.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
116	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
117	<hr/> <hr/> <hr/>	\$ <u>6,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
118	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
119	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
120	<hr/> <hr/> <hr/>	\$ <u>75,800.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
121	<hr/> <hr/> <hr/>	\$ 18,650.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
122	<hr/> <hr/> <hr/>	\$ 10,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
123	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
124	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
125	<hr/> <hr/> <hr/>	\$ 88,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
126	<hr/> <hr/> <hr/>	\$ 15,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
127	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
128	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
129	<hr/> <hr/> <hr/>	\$ <u>11,750.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
130	<hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
131	<hr/> <hr/> <hr/>	\$ <u>2,050,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
132	<hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
133	<hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
134	<hr/> <hr/> <hr/>	\$ <u>13,950.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
135	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
136	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
137	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
138	<hr/> <hr/> <hr/>	\$ <u>50,800.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
139	<hr/> <hr/> <hr/>	\$ <u>5,440.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
140	<hr/> <hr/> <hr/>	\$ <u>5,100.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
141	<hr/> <hr/> <hr/>	\$ <u>35,495.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
142	<hr/> <hr/> <hr/>	\$ <u>8,000.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
143	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
144	<hr/> <hr/> <hr/>	\$ <u>7,200.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
145	<hr/> <hr/> <hr/>	\$ <u>7,450.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
146	<hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
147	<hr/> <hr/> <hr/>	\$ <u>5,480.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
148	<hr/> <hr/> <hr/>	\$ <u>9,650.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
149	<hr/> <hr/> <hr/>	\$ <u>400,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
150	<hr/> <hr/> <hr/>	\$ <u>11,645.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
151	<hr/> <hr/> <hr/>	\$ <u>5,150.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
152	<hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
153	<hr/> <hr/> <hr/>	\$ <u>10,152.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
154	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
155	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
156	<hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
157	<hr/> <hr/> <hr/>	\$ <u>6,365.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
158	<hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
159	<hr/> <hr/> <hr/>	\$ <u>15,758.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
160	<hr/> <hr/> <hr/>	\$ <u>9,500.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
161	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
162	<hr/> <hr/> <hr/>	\$ <u>6,570.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
163	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
164	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
165	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
166	<hr/> <hr/> <hr/>	\$ 5,800.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
167	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
168	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
169	<hr/> <hr/> <hr/>	\$ <u>500,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
170	<hr/> <hr/> <hr/>	\$ <u>8,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
171	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
172	<hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
173	<hr/> <hr/> <hr/>	\$ <u>6,350.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
174	<hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
175	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
176	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
177	<hr/> <hr/> <hr/>	\$ <u>9,853.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
178	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
179	<hr/> <hr/> <hr/>	\$ <u>15,600.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
180	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
181	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
182	<hr/> <hr/> <hr/>	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
183	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
184	<hr/> <hr/> <hr/>	\$ 19,170.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
185	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
186	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
187	<hr/> <hr/> <hr/>	\$ <u>6,250.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
188	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
189	<hr/> <hr/> <hr/>	\$ <u>45,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
190	<hr/> <hr/> <hr/>	\$ <u>7,600.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
191	<hr/> <hr/> <hr/>	\$ <u>14,425.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
192	<hr/> <hr/> <hr/>	\$ <u>30,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
193	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
194	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
195	<hr/> <hr/> <hr/>	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
196	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
197	<hr/> <hr/> <hr/>	\$ 50,150.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
198	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
199	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
200	<hr/> <hr/> <hr/>	\$ 8,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
201	<hr/> <hr/> <hr/>	\$ 6,268.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
202	<hr/> <hr/> <hr/>	\$ 8,075.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
203	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
204	<hr/> <hr/> <hr/>	\$ 50,476.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
205	<hr/> <hr/> <hr/>	\$ <u>31,843.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
206	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
207	<hr/> <hr/> <hr/>	\$ <u>6,170.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
208	<hr/> <hr/> <hr/>	\$ <u>8,325.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
209	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
210	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
211	<hr/> <hr/> <hr/>	\$ <u>19,750.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
212	<hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
213	<hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
214	<hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
215	<hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
216	<hr/> <hr/> <hr/>	\$ <u>135,846.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
217	<hr/> <hr/> <hr/> <hr/>	\$ 27,725.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
5	200 GIFT CARDS OF \$50 EACH, AND A BABY ALPACA THROW	\$ 10,450.	06/25/15
7	HADLEY SLIPPER CHAIR	\$ 7,675.	03/04/16
9	AIR SYSTEM	\$ 7,500.	10/24/15
10	VARIOUS ART PIECES	\$ 45,600.	12/18/15
12	215 SH SUNOCO LOGISTICS PARTNERS LP CO.	\$ 5,329.	12/08/15
13	49 SH PPG INDUSTRIES INC.	\$ 5,095.	10/26/15

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
14	GIFT CARDS, MOVIES, WINE AND GIFT BAGS	\$ 4,540.	10/24/15
19	YELLOW AND GOLD DIAMOND LINK BRACELET	\$ 25,000.	10/24/15
21	MINK JACKET	\$ 8,500.	03/04/16
25	FAMILY PORTRAIT AND LUXURY HOTEL STAY	\$ 5,500.	10/24/15
39	SHAMPOO, CONDITIONERS, ETC.	\$ 7,375.	09/14/16
41	SALT WATER FISH TANK WITH EQUIPMENT AND LIVESTOCK	\$ 7,000.	10/21/15

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
45	ALTO SABRINA BAG	\$ 575.	06/25/16
48	PAINTING	\$ 5,000.	10/24/15
76	2 \$2500 GIFT CERTIFICATES	\$ 5,000.	10/24/15
87	GOLF AND LUNCH FOR 4, HUDSON NATIONAL	\$ 3,000.	10/24/15
88	300 LOVE AND COURAGE TRAYS (\$6300) AND GLASS PENDANTS (\$3000)	\$ 9,300.	06/25/16
93	\$240 WINE, \$9600 JUICERS	\$ 9,840.	10/24/15

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
95	SHAMPOO SAMPLES	\$ 10,200.	06/25/16
100	GIFT CERTIFICATES FOR PORTRAITS 3500 AND 5500	\$ 9,000.	03/04/16
108	SHOPPING SPREE	\$ 10,000.	10/24/15
119	LUXURY CAR RENTAL AND HOTEL STAYS, BOTH 2500	\$ 5,000.	10/24/15
126	LED TREATMENTS AND BOTOX TREATMENTS	\$ 2,450.	06/25/16
129	HOTEL STAYS AND TRIPS TO TOWER SUITES	\$ 11,750.	06/25/16

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
134	HOT COLD BAGS _____ _____ _____	\$ <u>450.</u>	<u>06/25/16</u>
139	WINE _____ _____ _____	\$ <u>140.</u>	<u>10/24/15</u>
142	GIANTS TICKETS _____ _____ _____	\$ <u>8,000.</u>	<u>06/25/16</u>
144	1 WEEK ESCAPE _____ _____ _____	\$ <u>7,200.</u>	<u>06/25/16</u>
145	BOWLING PARTY FOR KIDS AND WINE _____ _____ _____	\$ <u>585.</u>	<u>10/24/15</u>
150	WINE _____ _____ _____	\$ <u>170.</u>	<u>10/24/15</u>

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
153	WINE	\$ 100.	10/24/15
159	100 SH JOHNSON AND JOHNSON CO.	\$ 10,908.	04/05/16
160	ANTIQUA VICTORIAN DOLLHOUSE	\$ 9,500.	06/25/16
166	GUBELIN OF SWITZERLAND CLOCK	\$ 5,800.	10/24/15
179	12 MONTH INTRO MEMBERSHIP AND LODGING AND GOLF FOR TWO	\$ 15,600.	10/24/15
190	STAY AT THE RANCH	\$ 7,600.	10/24/15

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
201	PATRON PARTIES, AND ADMISSIONS TO GREENWICH WINE <hr/> <hr/>	\$ <u>5,743.</u>	<u>06/25/16</u>
202	RUGS <hr/> <hr/>	\$ <u>8,000.</u>	<u>10/24/15</u>
204	570 SH SKYWORKS SOLUTIONS INC. <hr/> <hr/>	\$ <u>48,976.</u>	<u>12/07/15</u>
216	VACCINES <hr/> <hr/>	\$ <u>135,846.</u>	<u>09/30/16</u>
217	VACCINES <hr/> <hr/>	\$ <u>27,725.</u>	<u>09/30/16</u>
	 <hr/> <hr/>	\$ _____	_____

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. 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	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

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

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

Name of organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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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.														
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width:65%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No												

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	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		500.
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		40,940.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		79,202.
j Total. Add lines 1c through 1i			120,642.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE AMOUNT REPORTED IN "OTHER ACTIVITIES" REPRESENTS A PORTION OF PROFESSIONAL DUES ATTRIBUTABLE TO LOBBYING DURING FY 2016.

ALSO, THE HEALTH SYSTEM OFFICIALS HAD MEETINGS AND CONTACTS WITH STATE GOVERNMENT OFFICIALS, INCLUDING STATE LEGISLATORS AND THEIR STAFF TO DISCUSS VARIOUS HEALTH CARE REFORM PROPOSALS.

Part IV Supplemental Information (continued)

GREENWICH HOSPITAL IS PART OF A CONTROLLED GROUP WITH THE FOLLOWING

LOBBYING EXPENSES:

YALE-NEW HAVEN HOSPITAL	EIN 06-0646652	\$1,099,541
BRIDGEPORT HOSPITAL	EIN 06-0646554	\$ 596,691
NORTHEAST MEDICAL GROUP	EIN 06-1330992	\$ 42,892
LAWRENCE + MEMORIAL HOSPITAL	EIN 06-0646704	\$ 97,147
LMW HEALTHCARE, INC.	EIN 46-0543230	\$ 66,063

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization: GREENWICH HOSPITAL; Employer identification number: 06-0646659

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two yes/no questions about donor property and grant fund usage.

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

Form with multiple questions (1-9) regarding conservation easements, including checkboxes for various purposes, a table for tracking easements at the end of the tax year, and questions about monitoring and expenses.

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

Form with questions (1a, 1b, 2) regarding reporting of art and historical treasures, including fields for revenue and assets.

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

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

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

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

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

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	83,683,000.	87,493,000.	78,904,000.	72,853,000.	64,905,000.
b Contributions	464,000.	388,000.	925,000.	125,000.	100,000.
c Net investment earnings, gains, and losses	6,271,000.	-783,000.	10,828,000.	8,395,000.	10,512,000.
d Grants or scholarships					
e Other expenditures for facilities and programs	4,236,000.	3,415,000.	3,164,000.	2,469,000.	2,664,000.
f Administrative expenses					
g End of year balance	86,182,000.	83,683,000.	87,493,000.	78,904,000.	72,853,000.

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

- a Board designated or quasi-endowment 51.91 %
- b Permanent endowment 27.73 %
- c Temporarily restricted endowment 20.36 %

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

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

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

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

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		6,333,484.		6,333,484.
b Buildings		229,891,330.	86,297,511.	143,593,819.
c Leasehold improvements		27,435,228.	11,492,983.	15,942,245.
d Equipment		204,960,359.	152,105,383.	52,854,976.
e Other		9,192,824.		9,192,824.

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) 227,917,348.

Part VII Investments - Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) OTHER SECURITIES	68,101,913.	END-OF-YEAR MARKET VALUE
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	68,101,913.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) OTHER RECEIVABLES	33,442,456.
(2) EPIC SHARED PROJECT	6,779,438.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	40,221,894.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE-3RD PARTY & OTHER PAYORS	12,935,284.
(3) EST LIABILITY-SELF INSURANCE	21,880,343.
(4) FORWARD INTEREST RATE SWAP	4,148,322.
(5) ACCRUED PENSION	64,829,371.
(6) OTHER ACCRUED EXPENSES AND CURRENT	
(7) LIAB.	708,000.
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	104,501,320.

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

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

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

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

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

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

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

Part XIII Supplemental Information.

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

PART V, LINE 4:

THE ENDOWED FUNDS' INTENDED USE IS TO GENERATE INCOME TO SUPPORT GREENWICH HOSPITAL PROGRAM SERVICE FUNCTIONS AND OTHER OPERATIONS IN ACCORDANCE WITH THE GREENWICH HOSPITAL POOLED INVESTMENT POLICY.

PART X, LINE 2:

THE CONSOLIDATED FINANCIAL STATEMENTS OF GREENWICH HOSPITAL AND SUBSIDIARIES INCLUDE THE FOLLOWING FIN48 DISCLOSURE:
 GH AND ITS SUBSIDIARIES, WITH THE EXCEPTION OF GASC, 900 KING STREET ASSOCIATES, LLC, GREENWICH CLINICAL PATHOLOGY ASSOCIATES, LLC AND GREENWICH PATHOLOGY ASSOCIATES, LLC ARE CONNECTICUT NONSTOCK CORPORATIONS GENERALLY EXEMPT FROM FEDERAL AND STATE INCOME TAXES PURSUANT TO SECTION

Part XIII Supplemental Information (continued)

501(A) OF THE CODE AS ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3) OF THE CODE.

AS QUALIFYING LIMITED LIABILITY COMPANIES, GASC, 900 KING STREET ASSOCIATES, GREENWICH CLINICAL PATHOLOGY ASSOCIATES, LLC AND GREENWICH PATHOLOGY ASSOCIATES, LLC ARE TREATED AS DISREGARDED ENTITIES FOR FEDERAL AND CONNECTICUT STATE TAX PURPOSES. ACCORDINGLY, GASC, 900 KING STREET ASSOCIATES, LLC, GREENWICH CLINICAL PATHOLOGY ASSOCIATED, LLC AND GREENWICH PATHOLOGY ASSOCIATES, LLC ARE SUBJECT TO CONNECTICUT BUSINESS ENTITY TAX OF \$250 ANNUALLY, AFTER WHICH ITS NET INCOME OR LOSS PASSES THROUGH TO GH.

UNDER U.S. GAAP, GH AND SUBSIDIARIES ARE REQUIRED TO EVALUATE TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN THE COURSE OF PREPARING GH AND SUBSIDIARIES'S TAX RETURNS TO DETERMINE WHETHER THE TAX POSITIONS ARE "MORE-LIKELY THAN-NOT" OF BEING SUSTAINED BY THE APPLICABLE TAX AUTHORITY BASED UPON THE TECHNICAL MERITS OF THE POSITION. GH AND SUBSIDIARIES RECOGNIZE THE EFFECT OF TAX POSITIONS ONLY IF THEY ARE MORE-LIKELY THAN-NOT OF BEING SUSTAINED. THIS EVALUATION HAD NO IMPACT ON THE OPERATIONS OF GH OR ANY SUBSIDIARIES AS OF AND FOR THE YEAR ENDED SEPTEMBER 30, 2016.

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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events	
		GALA	UNDER THE STARS	1	(add col. (a) through col. (c))	
		(event type)	(event type)	(total number)		
Revenue	1	Gross receipts	912,058.	270,037.	89,959.	1,272,054.
	2	Less: Contributions	852,733.	215,737.	59,459.	1,127,929.
	3	Gross income (line 1 minus line 2)	59,325.	54,300.	30,500.	144,125.
Direct Expenses	4	Cash prizes				
	5	Noncash prizes				
	6	Rent/facility costs	93,721.	29,376.	58,253.	181,350.
	7	Food and beverages	78,604.	66,363.	5,000.	149,967.
	8	Entertainment	9,250.	1,200.	2,500.	12,950.
	9	Other direct expenses	237,698.	58,558.	57,685.	353,941.
	10	Direct expense summary. Add lines 4 through 9 in column (d)				698,208.
11	Net income summary. Subtract line 10 from line 3, column (d)				-554,083.	

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

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

9 Enter the state(s) in which the organization conducts gaming activities: _____
 a Is the organization licensed to conduct gaming activities in each of these states? Yes No
 b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? Yes No
 b If "Yes," explain: _____

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

a The organization's facility	13a	%
b An outside facility	13b	%
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____
 Address ▶ _____

- 15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ _____ and the amount of gaming revenue retained by the third party ▶ \$ _____.
- c If "Yes," enter name and address of the third party:

Name ▶ _____
 Address ▶ _____

16 Gaming manager information:

Name ▶ _____
 Gaming manager compensation ▶ \$ _____
 Description of services provided ▶ _____

 Director/officer Employee Independent contractor

17 Mandatory distributions:

- a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? Yes No
- b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ _____

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

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2015

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

Name of the organization GREENWICH HOSPITAL	Employer identification number 06-0646659
--	--

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	<input checked="" type="checkbox"/>	
b If "Yes," was it a written policy?	1b	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>250</u> %			
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b		<input checked="" type="checkbox"/>
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %			
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	<input checked="" type="checkbox"/>	
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		<input checked="" type="checkbox"/>
6a Did the organization prepare a community benefit report during the tax year?	6a	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	6b	<input checked="" type="checkbox"/>	

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

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)		14,582	27,867,852.	923,887.	26,943,965.	7.69%
b Medicaid (from Worksheet 3, column a)		26,816	28,239,863.	13,993,849.	14,246,014.	4.06%
c Costs of other means-tested government programs (from Worksheet 3, column b)			0.	0.		
d Total Financial Assistance and Means-Tested Government Programs		41,398	56,107,715.	14,917,736.	41,189,979.	11.75%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	12	14,323	745,902.	0.	745,902.	.21%
f Health professions education (from Worksheet 5)	4	185	4,960,667.	1,230,199.	3,730,468.	1.06%
g Subsidized health services (from Worksheet 6)	2	9,554	5,579,566.	3,490,999.	2,088,567.	.60%
h Research (from Worksheet 7)	0	0	0.	0.		
i Cash and in-kind contributions for community benefit (from Worksheet 8)	4	889	158,515.	0.	158,515.	.05%
j Total. Other Benefits	22	24,951	11,444,650.	4,721,198.	6,723,452.	1.92%
k Total. Add lines 7d and 7j	22	66,349	67,552,365.	19,638,934.	47,913,431.	13.67%

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

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

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

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V</u>		
b <input checked="" type="checkbox"/> Other website (list url): <u>SEE PART V</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X
a If "Yes," (list url): <u>SEE PART V</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	X
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

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

	Yes	No
<p>Did the hospital facility have in place during the tax year a written financial assistance policy that:</p> <p>13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?</p> <p>If "Yes," indicate the eligibility criteria explained in the FAP:</p> <p>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>250</u> % and FPG family income limit for eligibility for discounted care of _____ %</p> <p>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</p> <p>c <input type="checkbox"/> Asset level</p> <p>d <input type="checkbox"/> Medical indigency</p> <p>e <input checked="" type="checkbox"/> Insurance status</p> <p>f <input checked="" type="checkbox"/> Underinsurance status</p> <p>g <input checked="" type="checkbox"/> Residency</p> <p>h <input checked="" type="checkbox"/> Other (describe in Section C)</p>	X	
14 Explained the basis for calculating amounts charged to patients?	X	
<p>15 Explained the method for applying for financial assistance?</p> <p>If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):</p> <p>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</p> <p>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</p> <p>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</p> <p>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</p> <p>e <input type="checkbox"/> Other (describe in Section C)</p>	X	
16 Included measures to publicize the policy within the community served by the hospital facility?	X	
<p>If "Yes," indicate how the hospital facility publicized the policy (check all that apply):</p> <p>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V</u></p> <p>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V</u></p> <p>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V</u></p> <p>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility</p> <p>h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</p> <p>i <input type="checkbox"/> Other (describe in Section C)</p>	X	

Billing and Collections

17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
<p>18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:</p> <p>a <input type="checkbox"/> Reporting to credit agency(ies)</p> <p>b <input type="checkbox"/> Selling an individual's debt to another party</p> <p>c <input type="checkbox"/> Actions that require a legal or judicial process</p> <p>d <input type="checkbox"/> Other similar actions (describe in Section C)</p> <p>e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted</p>		

Part V Facility Information (continued)

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

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

Policy Relating to Emergency Medical Care

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

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

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

Part V Facility Information (continued)

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

PART V, SECTION A:

THIS STATE LICENSE FOR THE HOSPITAL LOCATION LISTED IN SCHEDULE H, PART V, SECTION A, ALSO COVERS VARIOUS SATELLITE LOCATIONS OPERATED UNDER AND EXPRESSLY LISTED ON THE SAME STATE HOSPITAL LICENSE.

GREENWICH HOSPITAL:

PART V, SECTION B, LINE 5: COMMUNITY ENGAGEMENT AND FEEDBACK WERE AN INTEGRAL PART OF THE CHNA PROCESS. GREENWICH HOSPITAL SOUGHT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL THROUGH FOCUS GROUPS WITH COMMUNITY MEMBERS, KEY INFORMANT INTERVIEWS WITH COMMUNITY STAKEHOLDERS, AND INCLUSION OF COMMUNITY PARTNERS IN THE PRIORITIZATION AND IMPLEMENTATION PLANNING PROCESS. PUBLIC HEALTH AND HEALTH CARE PROFESSIONALS SHARED KNOWLEDGE AND EXPERTISE ABOUT HEALTH ISSUES, WHILE LEADERS AND REPRESENTATIVES OF NON-PROFIT AND COMMUNITY-BASED ORGANIZATIONS PROVIDED INSIGHT ON THE COMMUNITY SERVED BY GREENWICH HOSPITAL, INCLUDING MEDICALLY UNDERSERVED, LOW INCOME, AND MINORITY POPULATIONS.

GREENWICH HOSPITAL:

PART V, SECTION B, LINE 6B: THE GREENWICH HOSPITAL BOARD OF TRUSTEES IS DIRECTLY INVOLVED IN THE CHNA THROUGH A SUBCOMMITTEE CALLED THE COMMUNITY ADVISORY COMMITTEE. THE COMMUNITY ADVISORY COMMITTEE INCLUDES 30 MEMBERS WHO REPRESENT A VARIETY OF COMMUNITY ORGANIZATIONS SUCH AS THE UNITED WAY, YMCA, YWCA, HOUSES OF WORSHIP, LOCAL MUNICIPAL HEALTH DEPARTMENTS, HISPANIC HEALTH COUNCIL, FAMILY CENTERS, INC., YOUTH AND SENIOR SERVICES

Part V Facility Information *(continued)*

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

REPRESENTATIVES, NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE, HOUSING AUTHORITIES OF GREENWICH AND PORT CHESTER, CHAMBER OF COMMERCE, FEDERALLY QUALIFIED HEALTH CENTERS, GREENWICH EMERGENCY MEDICAL SERVICES AND OTHER PRIVATE AND CORPORATE GROUPS.

IN 2003, THE COMMUNITY ADVISORY COUNCIL ESTABLISHED THE GREENWICH COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP TO ASSIST WITH MEETING THE HEALTH NEEDS OF THE GREENWICH COMMUNITY. GREENWICH COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP MEMBERS INCLUDE REPRESENTATIVES FROM TOWN OF GREENWICH DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, THE UNITED WAY, BOARD OF EDUCATION, PTA, GREENWICH LIBRARY, LEAGUE OF WOMEN'S VOTERS, HOUSING AUTHORITY OF GREENWICH, CHILD GUIDANCE CENTERS, GREENWICH POLICE DEPARTMENT, FAMILY CENTERS, INC., PATHWAYS, YMCA, YWCA, COMMUNITIES 4 ACTION, LOWER FAIRFIELD REGIONAL ACTION COUNCIL SOUTHWEST REGIONAL MENTAL HEALTH BOARD, NATIONAL ALLIANCE ON MENTAL ILLNESS, GREENWICH EMERGENCY MEDICAL SERVICES, SENIOR AND YOUTH REPRESENTATIVES (BOYS & GIRLS CLUB, GREENWICH ADULT DAY CARE), GREENWICH ALLIANCE FOR EDUCATION AND NUMEROUS INTERESTED COMMUNITY MEMBERS.

IN NEW YORK, GREENWICH HOSPITAL COLLABORATES WITH THE COUNCIL OF COMMUNITY SERVICES OF PORT CHESTER, RYE BROOK, AND RYE TOWN TO PROVIDE COMMUNITY HEALTH OUTREACH ACTIVITIES.

SCHEDULE H, PART V, SEC B, LINE 7A AND 10A:

[HTTPS://WWW.GREENWICHHOSPITAL.ORG/ABOUT/COMMUNITY/
COMMUNITY-HEALTH/NEEDS-ASSESSMENT.ASPX](https://www.greenwichhospital.org/about/community/community-health/needs-assessment.aspx)

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SEC B, LINE 7B:

[HTTP://WWW.CT.GOV/DPH/LIB/DPH/OHCA/COMMUNITY_NEEDS_ASSESSMENT/](http://www.ct.gov/dph/lib/dph/ohca/community_needs_assessment/)

[CHNA/2016/2016_GREENWICH_HOSPITAL.PDF;](#)

[HTTP://WWW.CTDATAHAVEN.ORG/DATA-RESOURCES/](http://www.ctdatahaven.org/data-resources/)

[FAIRFIELD-COUNTY-COMMUNITY-WELLBEING-INDEX-GREATER-GREENWICH-CHNA-CHAPTER](#)

GREENWICH HOSPITAL:

PART V, SECTION B, LINE 11: IN MARCH 2016, COALITION MEMBERS, LOCAL

HEALTH DEPARTMENTS, AND COMMUNITY PARTNERS (INCLUDING THOSE WITH

KNOWLEDGE, INFORMATION, OR EXPERTISE RELEVANT TO THE HEALTH NEEDS OF THE

COMMUNITY OR MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS)

REVIEWED THE PRIMARY AND SECONDARY CHNA DATA AND DETERMINED, BY GROUP

CONSENSUS, THAT THE 2013 PRIORITIES WOULD BE MAINTAINED MOVING FORWARD FOR

THE 2016 CHNA. PARTICIPANTS DETERMINED THAT THE CANCER FOCUS AREA WOULD BE

INCLUDED WITH STRATEGIES AND ACTION STEPS OUTLINES IN THE HEALTHY

LIFESTYLES PRIORITY AREA IN 2016. THE COALITIONS, GREENWICH HOSPITAL AND

THE HEALTH DEPARTMENTS CONFIRMED THAT THERE WAS A NEED TO CONTINUE WORKING

IN THE 2013 FOCUS AREAS AS THESE WERE STILL THE TOP HEALTH PRIORITY AREAS

IN THE REGION. ALL PRIMARY AND SECONDARY DATA THAT WAS COLLECTED, ANALYZED

AND REVIEWED SUPPORTED THE CONTINUATION OF 2013 PRIORITY AREAS: HEALTHY

LIFESTYLES, ACCESS TO CARE AND MENTAL AND BEHAVIORAL HEALTH. TO LEARN MORE

ABOUT HOW GREENWICH HOSPITAL AND ITS COMMUNITY PARTNERS ARE MEETING THESE

NEEDS PLEASE REVIEW THE GREENWICH COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP

& COUNCIL OF COMMUNITY SERVICES' 2016 GREATER GREENWICH REGION GREENWICH

HOSPITAL COLLABORATIVE COMMUNITY HEALTH ASSESSMENT AND IMPLEMENTATION

STRATEGIES.

Part V Facility Information (continued)

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

GREENWICH HOSPITAL RECOGNIZES THAT PARTNERSHIPS WITH COMMUNITY AGENCIES HAVE THE BROADEST REACH TO IMPROVE COMMUNITY HEALTH ISSUES. AS SUCH, THE HOSPITAL IS PROVIDING FACILITATION SUPPORT FOR THE IMPLEMENTATION OF THE COMMUNITY-WIDE HEALTH IMPROVEMENT PLAN THAT WILL FOCUS ON ALL FOUR AREAS IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT.

GREENWICH HOSPITAL:

PART V, SECTION B, LINE 13H: THESE PROGRAMS COVER MEDICALLY NECESSARY CARE ONLY.

GREENWICH HOSPITAL:

PART V, SECTION B, LINE 22D: THE MAXIMUM AMOUNT CHARGED TO FAP-ELIGIBLE PATIENTS IS THE AMOUNT GENERAL BILLED TO INDIVIDUALS WHO HAVE INSURANCE COVERING THE CARE AT ISSUE (AGB). AGB IS CALCULATED ANNUALLY USING THE "LOOK BACK METHOD" AND BASED ON MEDICARE FEE-FOR-SERVICE RATES, INCLUDING MEDICARE BENEFICIARY COST-SHARING AMOUNTS AND ALL PRIVATE HEALTH INSURERS THAT PAY CLAIMS TO THE HOSPITAL FOR THE PRIOR FISCAL YEAR.

SCHEDULE H, PART V, SECTION B, LINE 16A, 16B AND 16C:

[HTTPS://WWW.GREENWICHHOSPITAL.ORG/PATIENTS-VISITORS/BILLING-INSURANCE/FINANCIAL-ASSISTANCE.ASPX](https://www.greenwichhospital.org/patients-visitors/billing-insurance/financial-assistance.aspx)

SCHEDULE H, PART V, SECTION D:

THE FACILITY LOCATIONS LISTED IN SCHEDULE H, PART V, SECTION D, INCLUDE

Part V Facility Information *(continued)*

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

OFF-CAMPUS OUTPATIENT HEALTH CARE FACILITIES THAT GREENWICH HOSPITAL
OPERATED DURING THE TAX YEAR UNDER ITS STATE HOSPITAL LICENSE.

Multiple horizontal lines for providing supplemental information.

Part V Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 17

Name and address	Type of Facility (describe)
1 PHYSICAL MEDICINE & REHAB CENTER 2015 WEST MAIN STREET STAMFORD, CT 06902	DIAGNOSTIC; LAB; REHAB
2 AMBULATORY SURGICAL CENTER 55 HOLLY HILL LANE GREENWICH, CT 06830	OUTPATIENT FACILITY
3 GREENWICH HOSPITAL HOME CARE 500 WEST PUTNAM AVENUE GREENWICH, CT 06831	HOME CARE
4 GREENWICH HOSPITAL LAB 49 LAKE AVENUE GREENWICH, CT 06830	BLOOD DRAW CENTER
5 GREENWICH HOSPITAL LAB 90 MORGAN STREET STAMFORD, CT 06905	BLOOD DRAW CENTER
6 HOSPITAL OUTPATIENT MEDICAL ONCOLOGY; 15 VALLEY DRIVE GREENWICH, CT 06831	CANCER CENTER; BLOOD DRAW
7 GREENWICH HOSPITAL LAB 159 WEST PUTNAM AVENUE GREENWICH, CT 06831	BLOOD DRAW CENTER
8 GREENWICH HOSPITAL OCCUP HEALTH 75 HOLLY HILL LANE GREENWICH, CT 06830	OCC HEALTH; WOMEN'S HEALTH; LAB
9 GREENWICH HOSPITAL LAB 40 CROSS STREET NORWALK, CT 06850	BLOOD DRAW CENTER
10 GREENWICH HOSPITAL LAB 90 SOUTH RIDGE STREET RYE BROOK, NY 10573	BLOOD DRAW CENTER

Schedule H (Form 990) 2015

Part V Facility Information *(continued)*

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

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

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

Name and address	Type of Facility (describe)
11 GREENWICH HOSPITAL LAB 1275 SUMMER STREET STAMFORD, CT 06902	BLOOD DRAW CENTER
12 GREENWICH HOSPITAL LAB 4 DEERFIELD DRIVE GREENWICH, CT 06830	BLOOD DRAW CENTER
13 GREENWICH HOSPITAL LAB 31 RIVER ROAD GREENWICH, CT 06830	BLOOD DRAW CENTER
14 GREENWICH HOSPITAL LAB 106 NOROTON AVENUE DARIEN, CT 06820	BLOOD DRAW CENTER
15 GREENWICH HOSPITAL LAB 148 EAST AVENUE NORWALK, CT 06850	BLOOD DRAW CENTER
16 GREENWICH HOSPITAL OUTPATIENT 260 LONG RIDGE ROAD STAMFORD, CT 06902	MEDICAL FACILITY
17 GREENWICH HOSPITAL MEDICAL CENTER 35 RIVER ROAD COS COB, CT 06807	INTEGRATIVE MEDICINE

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

THE FINANCIAL ASSISTANCE POLICY PROVIDES THAT THE PATIENT MUST SUBMIT A FINANCIAL ASSISTANCE APPLICATION.

PART I, LINE 7:

GREENWICH HOSPITAL ("THE HOSPITAL") USES A COST ACCOUNTING SYSTEM, STRATAJAZZ, TO CALCULATE THE AMOUNTS PRESENTED IN PART I, LINE 7. THE COST ACCOUNTING SYSTEM ADDRESSES ALL PATIENT SEGMENTS.

PART II, COMMUNITY BUILDING ACTIVITIES:

GREENWICH HOSPITAL ALONG WITH MANY OTHER HOSPITALS ACROSS THE COUNTRY UTILIZES THE COMMUNITY BENEFITS INVENTORY FOR SOCIAL ACCOUNTABILITY DATABASE DEVELOPED BY LYON SOFTWARE TO CATALOG ITS COMMUNITY BENEFIT AND COMMUNITY BUILDING ACTIVITIES AND THE GUIDELINES DEVELOPED BY THE CATHOLIC HOSPITAL ASSOCIATION (CHA) IN ORDER TO CATALOG THESE BENEFITS. THESE TWO ORGANIZATIONS HAVE WORKED TOGETHER FOR OVER TWENTY YEARS TO PROVIDE SUPPORT TO NON-FOR-PROFIT HOSPITALS TO DEVELOP AND SUSTAIN EFFECTIVE COMMUNITY BENEFIT PROGRAMS.

Part VI Supplemental Information (Continuation)

THE MOST RECENT VERSION OF THE CHA GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFIT DEFINES COMMUNITY BUILDING ACTIVITIES AS PROGRAMS THAT ADDRESS THE ROOT CAUSES OF HEALTH PROBLEMS, SUCH AS POVERTY, HOMELESSNESS AND ENVIRONMENTAL PROBLEMS. THESE ACTIVITIES ARE CATEGORIZED INTO EIGHT DISTINCT AREAS INCLUDING PHYSICAL IMPROVEMENT AND HOUSING, ECONOMIC DEVELOPMENT, COMMUNITY SUPPORT, ENVIRONMENTAL IMPROVEMENTS, LEADERSHIP DEVELOPMENT AND TRAINING FOR COMMUNITY MEMBERS, COALITION BUILDING, AND ADVOCACY FOR COMMUNITY HEALTH IMPROVEMENTS, AND WORKFORCE DEVELOPMENT. DURING FISCAL YEAR 2016, GREENWICH HOSPITAL PROVIDED \$291,158 IN FINANCIAL AND IN-KIND DONATIONS IN THE AREA OF COMMUNITY BUILDING ACTIVITIES. THE HOSPITAL CONSIDERS THESE INVESTMENTS PART OF ITS OVERALL COMMITMENT OF BUILDING STRONGER NEIGHBORHOODS. EXAMPLES BELOW FOCUS ON THE AREAS OF REVITALIZING OUR NEIGHBORHOODS AND CREATING EDUCATIONAL OPPORTUNITIES.

REVITALIZING OUR NEIGHBORHOODS

ONE OF SEVERAL COMMUNITY INITIATIVES UNDERTAKEN BY GREENWICH HOSPITAL TO ENHANCE ACCESS TO HEALTHY, AFFORDABLE FOOD IS COMMUNITY GARDENS. THIS PROGRAM IS ADMINISTERED IN COLLABORATION WITH THE COUNCIL OF COMMUNITY SERVICES, PORT CHESTER SCHOOLS AND AREA CHURCHES TO PROVIDE FRESH VEGETABLES TO PARTICIPANTS IN PORT CHESTER'S FOUR FOOD PANTRIES, SEVEN SOUP KITCHENS AND NUTRITION CENTERS. THE COUNCIL OF COMMUNITY SERVICES ORGANIZES VOLUNTEERS TO PLANT AND HARVEST THE CROPS. OVER THE PAST SEVERAL YEARS, THE PROGRAM HAS PROVIDED THOUSANDS OF LOW-INCOME PORT CHESTER FAMILIES WITH FRESH VEGETABLES. THE COMMUNITY GARDENS ENCOURAGE HEALTHY EATING HABITS, ENCOURAGE CHILDREN TO TRY NEW VEGETABLES, CONNECT CHILDREN TO NATURE AND THE ENVIRONMENT, AIM TO PREVENT CHILDHOOD OBESITY, AND PROMOTE PHYSICAL ACTIVITY WHILE ENCOURAGING NEW WAYS OF LEARNING AND PROMOTING HEALTH EDUCATION. THE HOSPITAL PROVIDES IN-KIND SUPPORT FOR THE INITIATIVE.

Part VI Supplemental Information (Continuation)

TO SUPPORT DRIVING SAFETY, GREENWICH HOSPITAL AND THE AARP CO-SPONSORED AN EDUCATIONAL DRIVING PROGRAM FOR OLDER ADULTS WITH APPROXIMATELY 350 WESTCHESTER AND FAIRFIELD COUNTY ADULTS ATTENDING THE PROGRAM. THE EDUCATIONAL DRIVING PROGRAM PROMOTES SAFETY AND IS INTENDED TO REDUCE ACCIDENT RATES AMONG DRIVERS AGE 55 AND OLDER.

GREENWICH HOSPITAL WAS ALSO THE RECIPIENT OF A DONATION OF FUNDS TO DEVELOP A COMMUNITY FLOWER GARDEN ON ITS PROPERTY TO BE OPEN TO THE PUBLIC. RECENT STUDIES HAVE PROVEN THE HEALTH AND WELLNESS BENEFITS ASSOCIATED WITH BEING IN NATURE. VARIOUS COMMUNITY CEREMONIES AND CELEBRATIONS ARE CONDUCTED IN THE GARDEN INCLUDING CANCER SURVIVOR PROGRAMS AND THE TREE OF LIGHT PROGRAM.

CREATING EDUCATIONAL OPPORTUNITIES

HIGHER EDUCATIONAL ATTAINMENT IS ASSOCIATED WITH BETTER HEALTH STATUS AND LONGER LIFE. FOR EXAMPLE, ADULTS AGED 25-50 YEARS WHO HAVE A COLLEGE DEGREE WILL ON AVERAGE LIVE FIVE YEARS LONGER THAN THOSE WITH LESS THAN A HIGH SCHOOL EDUCATION. TO ENCOURAGE THE PURSUIT OF HIGHER EDUCATION, GREENWICH HOSPITAL SPONSORED SEVERAL PROGRAMS TO INTRODUCE MIDDLE AND HIGH SCHOOL STUDENTS TO POTENTIAL HEALTH CARE CAREERS.

GREENWICH HOSPITAL, THROUGH A JOINT EFFORT WITH HIGH SCHOOLS IN PORT CHESTER AND GREENWICH, PROVIDED AN EDUCATIONAL PROGRAM INTRODUCING STUDENTS TO HEALTH CARE CAREER OPPORTUNITIES. A TOTAL OF 17 STUDENTS PARTICIPATED IN THE PROGRAM, WHICH IS AIMED AT EDUCATING AND INSPIRING STUDENTS TO PURSUE FULFILLING HEALTH CARE CAREERS.

PART III, LINE 2:

IN ACCORDANCE WITH THE ESTABLISHED POLICIES OF THE HOSPITAL, DURING THE REGISTRATION, BILLING AND COLLECTION PROCESS A PATIENT'S ELIGIBILITY FOR FREE CARE FUNDS IS DETERMINED. FOR PATIENTS WHO WERE DETERMINED BY THE

Part VI Supplemental Information (Continuation)

HOSPITAL TO HAVE THE ABILITY TO PAY BUT DID NOT, THE UNCOLLECTED AMOUNTS ARE BAD DEBT EXPENSE. THE HOSPITAL'S COST ACCOUNTING SYSTEM UTILIZES PATIENT-SPECIFIC DATA TO ACCUMULATE AND DERIVE COSTS RELATED TO THESE BAD DEBT ACCOUNTS.

PART III, LINE 3:

THE ORGANIZATION DOES NOT CURRENTLY HAVE A METHODOLOGY TO ACCURATELY QUANTIFY OR ESTIMATE THE AMOUNT OF BAD DEBT EXPENSE THAT WOULD BE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY.

PART III, LINE 4:

THE HOSPITAL'S COMMITMENT TO COMMUNITY SERVICE IS EVIDENCED BY SERVICES PROVIDED TO THE POOR AND BENEFITS PROVIDED TO THE BROADER COMMUNITY. SERVICES PROVIDED TO THE POOR INCLUDE SERVICES PROVIDED TO PERSONS WHO CANNOT AFFORD HEALTHCARE BECAUSE OF INADEQUATE RESOURCES AND/OR WHO ARE UNINSURED OR UNDERINSURED.

THE HOSPITAL MAKES AVAILABLE FREE CARE PROGRAMS FOR QUALIFYING PATIENTS. IN ACCORDANCE WITH THE ESTABLISHED POLICIES OF THE HOSPITAL, DURING THE REGISTRATION, BILLING AND COLLECTION PROCESS, A PATIENT'S ELIGIBILITY FOR FREE CARE FUNDS IS DETERMINED. FOR PATIENTS WHO WERE DETERMINED BY THE HOSPITAL TO HAVE THE ABILITY TO PAY, BUT DID NOT, THE UNCOLLECTED AMOUNTS ARE BAD DEBT EXPENSE. FOR PATIENTS WHO DO NOT AVAIL THEMSELVES OF ANY FREE CARE PROGRAM AND WHOSE ABILITY TO PAY CANNOT BE DETERMINED BY THE HOSPITAL, CARE GIVEN BUT NOT PAID FOR IS CLASSIFIED AS CHARITY CARE. TOGETHER, CHARITY CARE AND PROVISION FOR BAD DEBT REPRESENT UNCOMPENSATED CARE. THE ESTIMATED COST OF TOTAL UNCOMPENSATED CARE IS APPROXIMATELY \$13.9 MILLION AND \$12.3 MILLION FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND

Part VI Supplemental Information (Continuation)

2015, RESPECTIVELY. THE ESTIMATED COST OF UNCOMPENSATED CARE IS BASED ON THE HOSPITAL'S COST ACCOUNTING SYSTEM. THIS ANALYSIS CALCULATES THE ACTUAL PERCENTAGE OF ACCOUNTS WRITTEN OFF OR DESIGNATED AS BAD DEBT VS. CHARITY CARE WHILE TAKING INTO ACCOUNT THE TOTAL COSTS INCURRED BY THE HOSPITAL FOR EACH ACCOUNT ANALYZED.

THE ESTIMATED COST OF CHARITY CARE AND FREE CARE PROVIDED WAS APPROXIMATELY \$8.5 MILLION AND \$7.7 MILLION FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015, RESPECTIVELY. THE ESTIMATED COST OF CHARITY CARE IS DETERMINED BY THE HOSPITAL'S COST ACCOUNTING SYSTEM.

FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015, PROVISION FOR BAD DEBT, AT CHARGES, WAS APPROXIMATELY \$16.2 MILLION AND \$12.5 MILLION, RESPECTIVELY. FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015, BAD DEBT EXPENSE, AT COST, WAS APPROXIMATELY \$5.4 MILLION AND \$4.6 MILLION, RESPECTIVELY. THE PROVISION FOR BAD DEBT IS MULTIPLIED BY THE RATIO OF COST TO CHARGES FOR PURPOSES OF INCLUSION IN THE TOTAL UNCOMPENSATED CARE AMOUNT IDENTIFIED ABOVE.

THE CONNECTICUT DISPROPORTIONATE SHARE HOSPITAL PROGRAM (CDSHP) WAS ESTABLISHED TO PROVIDE FUNDS TO HOSPITALS FOR THE PROVISION OF UNCOMPENSATED CARE AND IS FUNDED, IN PART, BY AN ASSESSMENT ON HOSPITAL NET PATIENT SERVICE REVENUE. DURING THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015, GH RECEIVED APPROXIMATELY \$0.9 MILLION AND \$0.4 MILLION, RESPECTIVELY, IN CDSHP DISTRIBUTIONS, OF WHICH APPROXIMATELY \$0.6 MILLION WAS RELATED TO CHARITY CARE. GH MADE PAYMENTS INTO THE CDSHP OF \$19.5 MILLION AND \$14.0 MILLION FOR THE YEARS ENDED SEPTEMBER 30, 2016 AND 2015, RESPECTIVELY, FOR THE 1% ASSESSMENT. THESE ARE RECORDED IN NET PATIENT SERVICE REVENUE.

ADDITIONALLY, THE HOSPITAL PROVIDES BENEFITS FOR THE BROADER COMMUNITY, WHICH INCLUDES SERVICES PROVIDED TO OTHER NEEDY POPULATIONS THAT MAY NOT

Part VI Supplemental Information (Continuation)

QUALIFY AS POOR BUT NEED SPECIAL SERVICES AND SUPPORT. BENEFITS INCLUDE THE COST OF HEALTH PROMOTION AND EDUCATION OF THE GENERAL COMMUNITY, INTERNS AND RESIDENTS, HEALTH SCREENINGS AND MEDICAL RESEARCH. THE BENEFITS ARE PROVIDED THROUGH COMMUNITY HEALTH SERVICES, SOME OF WHICH SERVICE NON ENGLISH SPEAKING RESIDENTS, DISABLED CHILDREN AND VARIOUS COMMUNITY SUPPORT GROUPS.

IN ADDITION TO THE QUANTIFIABLE SERVICES DEFINED ABOVE, THE HOSPITAL PROVIDES ADDITIONAL BENEFITS TO THE COMMUNITY THROUGH ITS ADVOCACY OF COMMUNITY SERVICE BY EMPLOYEES. THE HOSPITAL'S EMPLOYEES SERVE NUMEROUS ORGANIZATIONS THROUGH BOARD REPRESENTATION, MEMBERSHIP IN ASSOCIATIONS AND OTHER RELATED ACTIVITIES. THE HOSPITAL ALSO SOLICITS THE ASSISTANCE OF OTHER HEALTH CARE PROFESSIONALS TO PROVIDE THEIR SERVICES AT NO CHARGE THROUGH PARTICIPATION IN VARIOUS COMMUNITY SEMINARS AND TRAINING PROGRAMS.

PART III, LINE 8:

THE ENTIRE MEDICARE LOSS PRESENTED SHOULD BE TREATED AS A COMMUNITY BENEFIT FOR THE FOLLOWING REASONS: THE IRS COMMUNITY BENEFIT STANDARD INCLUDES THE PROVISION OF CARE TO MEDICARE BENEFICIARIES, IRS REVENUE RULING 69-545 INDICATES THAT HOSPITALS OPERATE FOR THE PROMOTION OF HEALTH IN THE COMMUNITY WHEN IT PROVIDES CARE TO PATIENTS WITH GOVERNMENTAL HEALTH BENEFITS, THE HOSPITAL PROVIDES CARE TO MEDICARE PATIENTS REGARDLESS OF MEDICARE SHORTFALLS (REDUCING THE BURDEN ON THE GOVERNMENT), AND MANY OF THE MEDICARE PARTICIPANTS WOULD HAVE QUALIFIED FOR THE CHARITY CARE OR OTHER MEANS TESTED PROGRAMS ABSENT BEING ENROLLED IN THE MEDICARE PROGRAM. THE MEDICARE SHORTFALL REPORTED IS DETERMINED BY THE HOSPITAL'S COST ACCOUNTING SYSTEM, STRATAJAZZ.

PART III, LINE 9B:

Part VI Supplemental Information (Continuation)

IT IS THE HOSPITAL'S POLICY TO TREAT ALL PATIENTS EQUITABLY WITH RESPECT AND COMPASSION, FROM THE BEDSIDE TO THE BILLING OFFICE. THE HOSPITAL WILL PURSUE PATIENT ACCOUNTS, DIRECTLY AND THROUGH ITS COLLECTION AGENTS, FAIRLY AND CONSISTENTLY TAKING INTO CONSIDERATION DEMONSTRATED FINANCIAL NEED. AS PART OF ITS COLLECTION PROCESS, THE HOSPITAL WILL MAKE REASONABLE EFFORTS TO DETERMINE IF AN INDIVIDUAL IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER ITS FINANCIAL ASSISTANCE POLICY. IN THE EVENT A PATIENT IS ELIGIBLE FOR FINANCIAL ASSISTANCE, THE HOSPITAL WILL NOT ENGAGE IN ANY EXTRAORDINARY COLLECTION ACTION AS DEFINED BY LAW AND HOSPITAL POLICY.

PART VI, LINE 2:

COMMUNITY NEEDS ARE ROUTINELY REVIEWED AND ADDRESSED AS PART OF THE OPERATIONS AND SERVICE LINE TEAMS AT GREENWICH HOSPITAL. THESE MULTI-DISCIPLINARY GROUPS PROVIDE ANALYSIS AND INSIGHT INTO PATIENT UTILIZATION TRENDS ACROSS THE DELIVERY OF CARE AND ARE REVIEWED IN TANDEM WITH CARE MANAGEMENT AND PATIENT SATISFACTION RESULTS AND OTHER COMMUNITY FEEDBACK. COUPLED WITH THE RECENTLY COMPLETED COMMUNITY NEEDS ASSESSMENT, THIS INFORMATION ASSISTS WITH THE DEVELOPMENT OF NEW INITIATIVES, PARTNERSHIPS, PROGRAMS AND SERVICES TO BENEFIT OUR COMMUNITY.

PART VI, LINE 3:

GREENWICH HOSPITAL INFORMS INDIVIDUALS ABOUT ITS FINANCIAL ASSISTANCE PROGRAMS ON ITS WEBSITE, THROUGH VISIBLE POSTINGS AND COMMUNICATIONS AT POINTS OF REGISTRATION AND FRONT LINE ACCESS. THE FINANCIAL ASSISTANCE POLICY, APPLICATION AND SUMMARY ARE AVAILABLE ON REQUEST WITHOUT CHARGE BY MAIL, INCLUDING AT ADMITTING DEPARTMENT. FURTHER, PATIENTS RECEIVE A SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS, INCLUDING ELIGIBILITY REQUIREMENTS THROUGH A FIRST STATEMENT MAILER AS PART OF THE BILLING

Part VI Supplemental Information (Continuation)

PROCESS. THESE COMMUNICATIONS INCLUDE TELEPHONE NUMBERS AND POINT OF CONTACT FOR INDIVIDUALS TO VISIT OR CALL. THE HOSPITAL HAS RESOURCES TO ASSIST PATIENTS WITH STATE OF CONNECTICUT MEDICAID APPLICATIONS.

PART VI, LINE 4:

GREENWICH HOSPITAL'S COMMUNITY HEALTH IMPROVEMENT EFFORTS ARE SPECIFICALLY FOCUSED IN THE TOWNS WHERE THE HOSPITAL IS ENGAGED WITH COMMUNITY PARTNERS. THIS GEOGRAPHIC AREA INCLUDES THE TOWN OF GREENWICH, CONNECTICUT AND THE FOLLOWING TOWNS LOCATED IN THE STATE OF NEW YORK: ARMONK, BEDFORD, LARCHMONT, MAMARONECK, POUND RIDGE, PORT CHESTER / RYE BROOK, AND RYE. THE GREATER GREENWICH REGION HAS A POPULATION OF 173,202. THE MEDIAN AGE FOR BOTH THE POPULATION OF GREENWICH AND ALL NEW YORK STATE AREAS ARE HIGHER THAN THE STATE AS A WHOLE; BY CONTRAST, PORT CHESTER VILLAGE HAS A MEDIAN AGE OF 35.9 WHICH IS LOWER THAN THE STATE AVERAGE OF 40.3. THE TOWNS IN THE REGION VARY DRAMATICALLY IN TERMS OF THEIR RACIAL AND ETHNIC COMPOSITION. GREENWICH AND THE NEW YORK STATE AREAS (EXCLUDING PORT CHESTER VILLAGE) ARE CLOSE TO 80% WHITE AND 10% HISPANIC. BY CONTRAST, PORT CHESTER VILLAGE IS 30% WHITE AND 61% HISPANIC.

THERE ARE WIDE GAPS IN MEDIAN HOUSEHOLD INCOME RATES FOR THE GREATER GREENWICH REGION (\$125,567), FAIRFIELD COUNTY (\$83,163), AND CONNECTICUT (\$69,899). THE WIDEST GAP IS FOUND BETWEEN GREENWICH (\$135,528) AND PORT CHESTER VILLAGE (\$60,141). THE PROPORTION OF RESIDENTS IN THE GREATER GREENWICH REGION WITH A COLLEGE DEGREE OR HIGHER (60%) IS GREATER THAN THAT OF THE STATE OVERALL (37%) AND FAIRFIELD COUNTY (45%). ONLY 21% OF PORT CHESTER VILLAGE ADULTS HAVE A COLLEGE DEGREE OR HIGHER, COMPARED TO 66% OF GREENWICH ADULTS.

Part VI Supplemental Information (Continuation)

PART VI, LINE 5:

AS A COMMUNITY HEALTH CARE SERVICES PROVIDER, GREENWICH HOSPITAL REMAINS ATTENTIVE TO HEALTH AND WELL-BEING THROUGH EDUCATION, OUTREACH AND OTHER INNOVATIVE SERVICES. DURING FISCAL YEAR 2016, GREENWICH HOSPITAL PROVIDED \$51.5 MILLION IN COMMUNITY BENEFITS THROUGH FINANCIAL AND IN-KIND CONTRIBUTIONS IN FIVE WIDE-RANGING PROGRAMS - GUARANTEEING ACCESS TO CARE; PROMOTING HEALTH AND WELLNESS; ADVANCING CAREERS IN HEALTH CARE; RESEARCH; AND CREATING HEALTHIER COMMUNITIES.

GREENWICH HOSPITAL ALSO CONTRIBUTES TO THE COMMUNITY IN WAYS THAT ARE NOT QUANTIFIED AS PART OF COMMUNITY BENEFITS AND SERVES AS AN IMPORTANT COMMUNITY RESOURCE. THIS INCLUDES HAVING A COMMUNITY-BASED BOARD OF TRUSTEES WITH MANY OF THE BOARD MEMBERS RESIDING OR WORKING IN THE TOWN OF GREENWICH AND OTHER MUNICIPALITIES SERVED BY THE HOSPITAL. THE HOSPITAL ALSO EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITY. IN FISCAL YEAR 2016 THERE WERE A TOTAL OF 804 MEMBERS OF THE GREENWICH HOSPITAL MEDICAL STAFF.

GREENWICH HOSPITAL, FOUNDED IN 1903, IS A 206-BED COMMUNITY TEACHING HOSPITAL THAT HAS EVOLVED INTO A PROGRESSIVE REGIONAL HEALTHCARE CENTER, WITH MORE THAN 13,077 INPATIENT DISCHARGES AND 280,635 OUTPATIENT ENCOUNTERS LAST YEAR. THE HOSPITAL OFFERS A WIDE RANGE OF MEDICAL, SURGICAL, DIAGNOSTIC AND WELLNESS PROGRAMS. GREENWICH HOSPITAL IS ONE OF THE TOP FIVE EMPLOYERS IN GREENWICH WITH 1,848 EMPLOYEES IN 2016.

PART VI, LINE 6:

THE YALE NEW HAVEN HEALTH SYSTEM'S FUNDAMENTAL MISSION IS TO ENSURE THAT THE DELIVERY NETWORKS ASSOCIATED WITH THE SYSTEM PROMOTE THE HEALTH OF THE COMMUNITIES THEY SERVE AND ENSURE THAT ALL PATIENTS HAVE ACCESS TO

Part VI Supplemental Information (Continuation)

APPROPRIATE HEALTHCARE SERVICES. THE YALE NEW HAVEN HEALTH SYSTEM REQUIRES ITS HOSPITALS TO INCORPORATE PLANS TO PROMOTE HEALTHY COMMUNITIES WITHIN THE HOSPITAL'S EXISTING BUSINESS PLANS FOR WHICH THEY ARE HELD ACCOUNTABLE. IN ADDITION, REGULAR REPORTING ON COMMUNITY BENEFITS IS REQUIRED ON A QUARTERLY BASIS.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**
Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.

▶ Attach to Form 990.

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

OMB No. 1545-0047
2015
Open to Public
Inspection

Name of the organization

GREENWICH HOSPITAL

Employer identification number
06-0646659

Part I General Information on Grants and Assistance

- 1** Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2** Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN CANCER SOCIETY 372 DANBURY ROAD WILTON, CT 06897	13-1788491	501(C)(3)	16,000.	0.			SUPPORT ORGANIZATION
BREAST CANCER ALLIANCE 48 MAPLE AVENUE GREENWICH, CT 06830	06-1453500	501(C)(3)	55,000.	0.			SUPPORT ORGANIZATION
GLOBAL LYME ALLIANCE 222 RAILROAD AVENUE STE 2B GREENWICH, CT 06830	06-1559393	501(C)(3)	7,500.	0.			SUPPORT ORGANIZATION
GEMS 111 E PUTNAM AVENUE RIVERSIDE, CT 06878	22-2721171	501(C)(3)	83,417.	0.			SUPPORT ORGANIZATION
HEALTH ASSISTANCE INTERVENTION 1210 MILL STREET EAST BERLIN, CT 06023	51-0642913	501(C)(3)	15,000.	0.			SUPPORT ORGANIZATION
ONS FOUNDATION 6 GREENWICH OFFICE PARK GREENWICH, CT 06831	26-1394760	501(C)(3)	57,500.	0.			SUPPORT ORGANIZATION

- 2** Enter total number of section 501(c)(3) and government organizations listed in the line 1 table **10.**
- 3** Enter total number of other organizations listed in the line 1 table **0.**

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

Schedule I (Form 990) (2015)

Part II Continuation of Grants and Other Assistance to Governments and Organizations in the United States (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED WAY OF GREENWICH ONE LAFAYETTE COURT GREENWICH, CT 06830	06-0646578	501(C)(3)	10,000.	0.			SUPPORT ORGANIZATION
YALE UNIVERSITY PO BOX 208239 NEW HAVEN, CT 06520	06-0646973	501(C)(3)	10,000.	0.			SUPPORT ORGANIZATION
YMCA - RYE 21 LOCUST AVENUE RYE, NY 10580	13-1740515	501(C)(3)	10,000.	0.			SUPPORT ORGANIZATION
YWCA OF GREENWICH 259 E PUTNAM AVENUE GREENWICH, CT 06830	06-0646992	501(C)(3)	26,000.	0.			SUPPORT ORGANIZATION

Part III

Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance

Part IV Supplemental Information. Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

PART I, LINE 2:

NONE OF THE AMOUNTS REPORTED ON SCHEDULE I, PART II ARE GRANTS. THESE AMOUNTS ARE DONATIONS AND SPONSORSHIPS GIVEN TO ORGANIZATIONS TO ASSIST IN THE FURTHERANCE OF THEIR CHARITABLE MISSION. GREENWICH HOSPITAL ("GH") CARRIES OUT DUE DILIGENCE IN PROVIDING MONETARY ASSISTANCE ONLY TO QUALIFYING 501(C)3 ORGANIZATIONS THAT COMPLEMENT ITS MISSION OR SUPPORT THE GREATER GOOD IN THE COMMUNITIES SERVED.

GH VERIFIES EACH ORGANIZATION'S EIN AS LISTED ON IRS FORM W-9 THAT HAS BEEN SUBMITTED TO GH. ASSISTANCE DONATED BY GH TO THESE QUALIFYING

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

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

2015

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

▶ Attach to Form 990.

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2015

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) CHRISTOPHER O'CONNOR TRUSTEE	(i) 0. (ii) 822,935.	0. 283,340.	0. 104,299.	0. 358,561.	0. 29,654.	0. 1,598,789.	0. 0.
(2) NORMAN ROTH TRUSTEE AND PRESIDENT	(i) 504,044. (ii) 126,011.	150,828. 37,704.	206,785. 51,696.	64,600. 16,150.	25,918. 6,480.	952,175. 238,041.	0. 0.
(3) JIM SABETTA TRUSTEE	(i) 332,445. (ii) 0.	22,239. 0.	25,980. 0.	39,344. 0.	36,514. 0.	456,522. 0.	0. 0.
(4) CHRISTINE BEECHNER VP	(i) 149,360. (ii) 0.	5,148. 0.	17,996. 0.	15,321. 0.	25,165. 0.	212,990. 0.	1,279. 0.
(5) SUSAN BROWN SENIOR VP	(i) 326,316. (ii) 0.	53,604. 0.	8,061. 0.	39,344. 0.	19,148. 0.	446,473. 0.	0. 0.
(6) EUGENE COLUCCI SENIOR VP	(i) 384,134. (ii) 42,682.	99,981. 11,109.	65,951. 7,328.	166,578. 18,509.	21,282. 2,364.	737,926. 81,992.	0. 0.
(7) DEBORAH HODYS VP	(i) 351,021. (ii) 0.	89,596. 0.	37,263. 0.	18,044. 0.	24,720. 0.	520,644. 0.	0. 0.
(8) MARC KOSAK VP	(i) 246,248. (ii) 0.	41,849. 0.	22,757. 0.	20,481. 0.	24,979. 0.	356,314. 0.	0. 0.
(9) NANCY LEVITT ROSENTHAL SENIOR VP (END 11/15)	(i) 253,266. (ii) 63,317.	66,587. 16,647.	33,235. 8,309.	114,661. 28,665.	8,630. 2,158.	476,379. 119,096.	0. 0.
(10) SPIKE LIPSCHUTZ, M.D. VP	(i) 402,323. (ii) 0.	58,589. 0.	36,549. 0.	16,470. 0.	25,463. 0.	539,394. 0.	0. 0.
(11) DANA MARNANE VP (START 10/15)	(i) 147,694. (ii) 0.	15,888. 0.	21,436. 0.	10,506. 0.	5,640. 0.	201,164. 0.	0. 0.
(12) MELISSA TURNER SENIOR VP	(i) 139,049. (ii) 139,049.	38,036. 38,036.	28,359. 28,359.	61,505. 61,504.	12,292. 12,293.	279,241. 279,241.	0. 0.
(13) JIM WRIGHT VP (START 10/15)	(i) 157,875. (ii) 0.	0. 0.	26,450. 0.	5,351. 0.	4,907. 0.	194,583. 0.	0. 0.
(14) VICKI ALTMAYER DIRECTOR OF PATHOLOGY	(i) 500,922. (ii) 0.	63,847. 0.	27,897. 0.	39,344. 0.	17,442. 0.	649,452. 0.	8,973. 0.
(15) DOROTHY BLACKMUN PATHOLOGIST	(i) 446,490. (ii) 0.	0. 0.	19,817. 0.	18,039. 0.	17,888. 0.	502,234. 0.	0. 0.
(16) RICHARD EISEN DIRECTOR OF PATHOLOGY	(i) 412,835. (ii) 0.	0. 0.	17,737. 0.	0. 0.	22,977. 0.	453,549. 0.	39,763. 0.

Part III Supplemental Information

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:

THE INDIVIDUALS LISTED BELOW ARE PARTICIPANTS IN A SUPPLEMENTAL
 NONQUALIFIED RETIREMENT PLAN. THESE ACCRUALS ARE INCLUDED IN THE AMOUNTS
 REPORTED IN PART II, COLUMN C (DEFERRED COMPENSATION) AND REPRESENTS BOTH
 THE REPORTING ENTITY'S AND RELATED ENTITY'S COMBINED AMOUNTS CONSISTENT
 WITH THE COMPENSATION REPORTING PER IRS INSTRUCTIONS.

SEVERANCE NONQUALIFIED EQUITY-BASED

CHRISTOPHER O'CONNOR	\$0	\$198,811	\$0
EUGENE COLUCCI	0	99,337	\$0
NANCY LEVITT-ROSENTHAL	0	74,576	\$0
MELISSA TURNER	0	69,659	\$0

INDIVIDUALS LISTED BELOW BECAME VESTED IN BENEFITS VALUED AT THE AMOUNTS
 RESPECTIVELY REPORTED BELOW DURING THE REPORTING YEAR. INCLUDED IN SECTION
 II, COLUMN B (III) ARE AMOUNTS VESTED DURING THE 2015 CALENDAR YEAR THAT
 WERE RECOGNIZED AS TAXABLE EVENTS AND REPORTED IN THE INDIVIDUALS' 2015
 CALENDAR YEAR FORM W-2.

BRIAN DORAN	\$214,691
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NORMAN ROTH	178,599
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Part III Supplemental Information

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

THE FOLLOWING FORMER OFFICERS RECEIVED A PAYMENT FROM A NONQUALIFIED PLAN.

THIS AMOUNT IS INCLUDED IN SECTION II, COLUMN B (III) THE FOLLOWING

PAYMENT WAS MADE DIRECTLY TO HIM FROM THE RABBI TRUST:

QUINTON FRIESEN \$127,684

FRANK CORVINO 63,668

THE SUPPLEMENTAL RETIREMENT INCOME PLAN (SRIP) IS DESIGNED TO ENSURE THE PAYMENT OF A COMPETITIVE LEVEL OF RETIREMENT INCOME WHEN ADDED TO OTHER SOURCES OF RETIREMENT INCOME IN ORDER TO ATTRACT AND RETAIN KEY MANAGEMENT EMPLOYEES SERVING AS CORPORATE OFFICERS. THE PLAN PROVIDES SUPPLEMENTAL RETIREMENT INCOME THROUGH AN UNFUNDED, NONQUALIFIED DEFERRED COMPENSATION ARRANGEMENT UNDER SECTION 457(F) AND THROUGH A DEFERRED COMPENSATION PLAN UNDER SECTION 409A OF THE INTERNAL REVENUE CODE AND A MANAGEMENT OR HIGHLY COMPENSATED EMPLOYEES' PLAN UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA).

PART I, LINE 7:

THE SHORT TERM INCENTIVE PLAN (STIP) IS A VARIABLE COMPENSATION PLAN WHICH

Part III Supplemental Information

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.

PROVIDES ONE-TIME PAYMENTS TO ELIGIBLE MEMBERS OF MANAGEMENT IN RECOGNITION OF THE ACCOMPLISHMENT OF KEY ORGANIZATIONAL AND INDIVIDUAL PERFORMANCE OBJECTIVES. PERFORMANCE LEVELS ARE ESTABLISHED AND REVIEWED ANNUALLY AT THRESHOLD, TARGET AND MAXIMUM LEVELS, ACCORDING TO PLANNED "STRETCH" GOALS AND OBJECTIVES. INCENTIVE AWARD OPPORTUNITIES ARE ESTABLISHED ACCORDING TO MARKET PRACTICES BASED ON EACH ELIGIBLE POSITION'S RESPONSIBILITIES, PERFORMANCE AND LEVEL OF AUTHORITY. PERFORMANCE RELATIVE TO STIP AWARD OPPORTUNITIES INCORPORATES A BROAD SPECTRUM OF PRE-DEFINED FINANCIAL AND NON-FINANCIAL METRICS THAT ARE ALIGNED WITH ORGANIZATIONAL MISSION AND VALUES.

**SCHEDULE K
(Form 990)**
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds
▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047
2015
Open to Public Inspection

Name of the organization
GREENWICH HOSPITAL

Employer identification number
06-0646659

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A CHEFA 2008 - SERIES C	06-080618620774UYC3		05/07/08	53,630,000.	REFINANCE SERIES 2006B		X		X		X
B											
C											
D											

Part II Proceeds

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Amount of bonds retired								
2 Amount of bonds legally defeased								
3 Total proceeds of issue								
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds			477,687.					
8 Credit enhancement from proceeds			72,256.					
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds								
12 Other unspent proceeds			53,091,372.					
13 Year of substantial completion								
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?	X							
15 Were the bonds issued as part of an advance refunding issue?		X						
16 Has the final allocation of proceeds been made?	X							
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X							
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?		X						
c Are there any research agreements that may result in private business use of bond-financed property?	X							
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?		X						
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government		1.86	%			%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government31	%			%		%
6 Total of lines 4 and 5		2.17	%			%		%
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of			%			%		%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X						

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

SCHEDULE K, SUPPLEMENTAL INFORMATION: REFINANCE ISSUANCE DATE 4/6/2006

PART III, LINE 3C

THE ORGANIZATION HAS IN-HOUSE LEGAL STAFF WHO PROVIDE ROUTINE REVIEW OF MANAGEMENT OR SERVICE CONTRACTS OR RESEARCH AGREEMENTS RELATING TO THE FINANCED PROPERTY TO ENSURE THAT SUCH AGREEMENTS ARE COMPLIANT WITH APPLICABLE SAFE HARBORS. IN-HOUSE COUNSEL CONSULT WITH THE HOSPITAL'S OUTSIDE BOND COUNSEL AS NEEDED, INCLUDING ON NON-ROUTINE ISSUES.

PART III, LINE 9 & PART V

THE ORGANIZATION HAS POLICIES AND PROCEDURES IN PLACE TO ENSURE COMPLIANCE WITH FEDERAL TAX LAW, AND TO TIMELY IDENTIFY NONCOMPLIANCE. IN THE EVENT OF NON-COMPLIANCE THE ORGANIZATION WOULD INVOLVE ITS LEGAL COUNSEL TO ADVISE REGARDING APPROPRIATE REMEDIATION.

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C

ISSUER NAME: CHEFA 2008 - SERIES C

DATE THE REBATE COMPUTATION WAS PERFORMED: 06/30/2009 & 06/30/2014

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
SUBST CONTR #35	VENDOR	200,078.	DEBT COLLEC		X
SUBST CONTR #134	VENDOR	237,805.	MEDICAL SER		X

Part V Supplemental Information

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: SUBST CONTR #35

(D) DESCRIPTION OF TRANSACTION: DEBT COLLECTION

(A) NAME OF PERSON: SUBST CONTR #134

(D) DESCRIPTION OF TRANSACTION: MEDICAL SERVICES

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2015

Open To Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization **GREENWICH HOSPITAL** Employer identification number **06-0646659**

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	X	4	50,600.	FAIR MARKET VALUE
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods	X		154,900.	FAIR MARKET VALUE
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded	X	4	70,308.	FAIR MARKET VALUE
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory	X	3	7,480.	FAIR MARKET VALUE
20 Drugs and medical supplies	X	2	163,571.	FAIR MARKET VALUE
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (MISCELLANEOUS)	X	587	136,243.	FAIR MARKET VALUE
26 Other ▶ (VACATION/ENT)	X	24	100,140.	FAIR MARKET VALUE
27 Other ▶ (PHOTOGRAPHY)	X	8	22,275.	FAIR MARKET VALUE
28 Other ▶ ()				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement **29**

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

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

Schedule M (Form 990) (2015)

Part II **Supplemental Information.** 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 M, PART I, COLUMN (B):

THE ORGANIZATION IS REPORTING IN PART I, COLUMN (B), THE NUMBER OF CONTRIBUTIONS RECEIVED.

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.

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

OMB No. 1545-0047

2015

Open to Public
Inspection

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

FORM 990, PART III, LINE 4A, DESCRIPTION OF PROGRAM SERVICE:

A MEMBER OF YALE NEW HAVEN HEALTH SINCE 1998, GREENWICH HOSPITAL BROUGHT HIGH QUALITY, COST-EFFECTIVE CARE TO THOUSANDS OF RESIDENTS OF CONNECTICUT AND NEW YORK LAST YEAR. THE HOSPITAL INCREASED VOLUME IN TARGETED SERVICES, EXPANDED ACCESS AND REACH, AND IMPROVED PATIENT SAFETY AND QUALITY DURING THE YEAR.

FIFTY-TWO NEW PHYSICIANS JOINED THE MEDICAL STAFF, INCLUDING SPECIALISTS IN HYPERBARIC MEDICINE, SLEEP DISORDERS AND PAIN MANAGEMENT.

SAFETY AND QUALITY OF CARE REMAINED THE TOP PRIORITY. IN JULY 2016, GREENWICH HOSPITAL RECEIVED THE PRESTIGIOUS MAGNET DESIGNATION FROM THE AMERICAN NURSES CREDENTIALING CENTER (ANCC), PLACING IT AMONG APPROXIMATELY 7 PERCENT OF THE MORE THAN 5,600 HOSPITALS NATIONWIDE, AND ONE OF ONLY SIX IN CONNECTICUT. MAGNET DESIGNATION, THE HIGHEST HONOR OF NURSING EXCELLENCE ANY HOSPITAL CAN ACHIEVE, RECOGNIZES QUALITY PATIENT CARE, NURSING EXCELLENCE AND INNOVATIONS IN PROFESSIONAL PRACTICE.

THE HOSPITAL RECEIVED THE JOINT COMMISSION'S GOLD SEAL OF APPROVAL FOR ADHERING TO STRICT STANDARDS FOR EXCELLENCE AND SAFETY IN SPINAL FUSION AND TOTAL HIP AND KNEE REPLACEMENT. THE HOSPITAL ALSO RECEIVED THE AMERICAN HEART ASSOCIATION AND AMERICAN STROKE ASSOCIATION QUALITY ACHIEVEMENT AWARD FOR ITS HIGHER STROKE CARE STANDARD; THE WOMEN'S CHOICE AWARD FOR PATIENT SAFETY AND AN "A" SAFETY RATING FROM THE

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

LEAPFROG GROUP.

THE HOSPITAL OPENED ITS LARGEST, MOST COMPREHENSIVE OUTPATIENT SITE IN SEPTEMBER. THE LONG RIDGE MEDICAL CENTER, A NEW OUTPATIENT CENTER AT 260 LONG RIDGE ROAD IN STAMFORD IN AUGUST. THIS VENTURE, WHICH WAS A COLLABORATION WITH NORTHEAST MEDICAL GROUP'S PRIMARY CARE PHYSICIANS AND YALE MEDICINE'S CENTER FOR MUSCULOSKELETAL CARE, WAS THE HOSPITAL'S. LONG RIDGE OFFERS SERVICES IN REHABILITATION, LABORATORY, RADIOLOGY, RHEUMATOLOGY AND NEUROLOGY INFUSION.

ADDITIONALLY, THE HOSPITAL OPENED A FULL-SERVICE VASCULAR IMAGING CENTER FOR EVALUATION OF VENOUS AND ARTERIAL VASCULAR DISEASES, AS WELL AS THE YALE NEW HAVEN HEALTH WOMEN'S CARDIOVASCULAR CENTER AT 15 VALLEY DRIVE IN GREENWICH.

THE HOSPITAL ALSO UNVEILED THE TRUEBEAM RADIATION THERAPY SYSTEM, THE LATEST TECHNOLOGY AVAILABLE TO TREAT CANCER ANYWHERE IN THE BODY, INCLUDING LUNG, BREAST, PROSTATE AND HEAD AND NECK REGION. THE NEW LINEAR ACCELERATOR ZEROES IN ON MOVING TARGETS QUICKLY AND ACCURATELY, LEADING TO SHORTER TREATMENT TIMES.

PART I, LINE 4 & PART VI, LINE 1B

NUMBER OF INDEPENDENT VOTING MEMBERS OF THE GOVERNING BODY

THE ORGANIZATION SOUGHT TO CONFIRM THE INDEPENDENCE OF EACH VOTING MEMBER OF ITS GOVERNING BODY BY REQUESTING THAT EACH SUCH VOTING MEMBER RESPOND TO A QUESTIONNAIRE CONTAINING THE PERTINENT INSTRUCTIONS AND DEFINITIONS AND DESIGNED TO ELICIT THE INFORMATION NECESSARY TO DETERMINE INDEPENDENCE. BASED ON RESPONSES TO THE QUESTIONNAIRES

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

RECEIVED BY THE ORGANIZATION AND ANNUAL CONFLICTS OF INTEREST

DISCLOSURES, THE ORGANIZATION WAS ABLE TO CONFIRM THAT SEVENTEEN (17)

VOTING MEMBERS ARE INDEPENDENT. BASED ON OTHER INFORMATION KNOWN TO

THE ORGANIZATION, THE ORGANIZATION HAS NO REASON TO BELIEVE THAT THE

REMAINING ONE (1) VOTING MEMBER IS NOT INDEPENDENT.

FORM 990, PART VI, SECTION A, LINE 2:

THE ORGANIZATION'S CURRENT OFFICERS AND/OR TRUSTEES SERVE AS OFFICERS

AND/OR DIRECTORS OF TAXABLE AFFILIATES WITHIN THE ORGANIZATION'S CORPORATE

SYSTEM OR JOINT VENTURES IN WHICH THE ORGANIZATION'S CORPORATE SYSTEM HAS

AN OWNERSHIP INTEREST. THE INDIVIDUAL OFFICERS DO NOT HAVE PERSONAL

FINANCIAL INTERESTS IN THE TAXABLE AFFILIATE AND SERVE ONLY AS A FUNCTION

OF THEIR ROLES WITH THE ORGANIZATION OR WITHIN THE ORGANIZATION'S CORPORATE

SYSTEM.

FORM 990, PART VI, SECTION A, LINE 4:

THE HOSPITAL AMENDED ITS CORPORATE BYLAWS ON MAY 12, 2016 TO REFLECT THE

MERGER OF ITS PARENT COMPANY, GREENWICH HEALTH CARE SERVICES, INC. INTO THE

HOSPITAL AND FURTHER TO INCORPORATE AN AFFIRMATION OF ITS AFFILIATION

AGREEMENT WITH YALE NEW HAVEN HEALTH SYSTEM.

FORM 990, PART VI, SECTION A, LINE 6:

CLASSES OF MEMBERS OR STOCKHOLDERS:

THE HOSPITAL IS A CONNECTICUT NON-STOCK CORPORATION. ITS SOLE MEMBER IS

YALE NEW HAVEN HEALTH SERVICES CORPORATION ("YNHHS"), ITSELF A CONNECTICUT

NON-STOCK CORPORATION DESCRIBED IN SECTION 501(C)(3) OF THE CODE.

FORM 990, PART VI, SECTION A, LINE 7A:

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

ELECTION OF MEMBERS AND THEIR RIGHTS:

YNHHS HAS THE AUTHORITY TO DESIGNATE ONE REPRESENTATIVE OF YNHHS TO SERVE AS A TRUSTEE OF THE HOSPITAL AND APPROVE NOMINEES TO THE HOSPITAL'S BOARD OF TRUSTEES IN ACCORDANCE WITH THE HOSPITAL'S BYLAWS AND THAT CERTAIN SYSTEM AFFILIATION AGREEMENT (THE "AFFILIATION AGREEMENT") BY AND AMONG YNHHS AND THE HOSPITAL.

FORM 990, PART VI, SECTION A, LINE 7B:

DECISIONS SUBJECT TO APPROVAL OF MEMBERS:

THE HOSPITAL HAS RESERVED POWERS TO YNHHS.

YNHHS: IN ACCORDANCE WITH THE HOSPITAL'S BYLAWS AND THE AFFILIATION AGREEMENT, YNHHS HAS THE FOLLOWING RIGHTS, POWERS AND PRIVILEGES VIS-A-VIS THE HOSPITAL:

(A) TO DESIGNATE ONE REPRESENTATIVE OF YNHHS TO SERVE AS A TRUSTEE OF THE HOSPITAL AT THE PLEASURE OF YNHHS, WHICH DESIGNEE SHALL BE A VOTING MEMBER OF THE EXECUTIVE OR ANY SIMILAR COMMITTEE OF THE HOSPITAL;

(B) TO APPROVE THE NOMINEES TO THE BOARD OF TRUSTEES OF THE HOSPITAL IN ACCORDANCE WITH THE PROVISIONS OF SECTION 3.3 OF THE HOSPITAL BYLAWS AND SECTION 4.2 OF THE AFFILIATION AGREEMENT;

(C) TO DIRECT THE HOSPITAL BOARD OF TRUSTEES TO REMOVE ANY HOSPITAL TRUSTEE IN ACCORDANCE WITH PROVISIONS OF THE HOSPITAL BYLAWS AND THE AFFILIATION AGREEMENT;

(D) TO APPROVE THE HOSPITAL'S ANNUAL OPERATING AND CAPITAL BUDGETS AND STRATEGIC PLANS; AND

(E) TO CONSENT TO

(I) THE SALE OF ALL OR SUBSTANTIALLY ALL OF THE HOSPITAL'S ASSETS,

Name of the organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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(II) ANY MERGER OR CONSOLIDATION INVOLVING THE HOSPITAL,

(III) ANY CONTRACT TO MANAGE OR ADMINISTER THE HOSPITAL OR ANY SUBSTANTIAL PART OF THE BUSINESS OF THE HOSPITAL,

(IV) ANY LIQUIDATION OR DISSOLUTION OF THE HOSPITAL OR FILING FOR BANKRUPTCY OR SIMILAR PROTECTION, OR

(V) ANY CHANGE IN THE NAME OF THE HOSPITAL.

FURTHER, IN ACCORDANCE WITH THE HOSPITAL BYLAWS, YNHHS MUST EACH APPROVE ANY AMENDMENT TO THE HOSPITAL'S CERTIFICATE OF INCORPORATION OR BYLAWS.

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

THE ORGANIZATION'S PROCESS TO REVIEW FORM 990:

THE FORM 990 TAX RETURN AND ATTACHED SCHEDULES WERE PREPARED BY EMPLOYEES OF THE SYSTEM TAX DEPARTMENT. THE RETURN IS INITIALLY REVIEWED BY THE HOSPITAL DIRECTOR OF CORPORATE FINANCE. SUBSEQUENTLY, IT IS SENT TO KPMG LLP FOR THEIR INITIAL REVIEW. AFTER ALL COMMENTS FROM THE ABOVE GROUPS ARE RECEIVED AND REVIEWED, THE RETURN IS THEN REVIEWED BY THE CHIEF FINANCIAL OFFICER OF THE HOSPITAL AND A FINAL VERSION OF THE RETURN IS SENT BACK TO KPMG US LLP FOR FINAL REVIEW. PRIOR TO FILING, THE ORGANIZATION MADE AVAILABLE A COMPLETE COPY OF THE RETURN TO THE BOARD OF TRUSTEES BY WEB PORTAL.

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

GREENWICH HOSPITAL IS COVERED UNDER THE YALE NEW HAVEN HEALTH SYSTEM CONFLICT OF INTEREST POLICY. THE YALE NEW HAVEN HEALTH SYSTEM CONFLICT OF INTEREST POLICY (CC:R-7) AND INDIVIDUAL ANNUAL DISCLOSURE FORM APPLIES TO A POOL OF EMPLOYEES, BOARD MEMBERS AND NON-BOARD MEMBERS SERVING ON BOARD COMMITTEES. THESE "COVERED INDIVIDUALS" ARE REQUIRED TO COMPLETE A

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

CONFLICT OF INTEREST DISCLOSURE STATEMENT, UPON BEGINNING EMPLOYMENT OR OTHERWISE BECOMING A COVERED INDIVIDUAL AND ANNUALLY THEREAFTER. COVERED INDIVIDUALS ARE ALSO REQUIRED TO IMMEDIATELY REPORT MATERIAL CHANGES TO THEIR MOST RECENTLY COMPLETED DISCLOSURE STATEMENT. THESE DISCLOSURE STATEMENTS AND REPORTS ARE REVIEWED BY THE OFFICE OF PRIVACY AND CORPORATE COMPLIANCE AND/OR THE LEGAL AND RISK SERVICES DEPARTMENT TO ENSURE COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY. IF A POTENTIAL CONFLICT ARISES, THE PRESIDENT AND CEO WOULD CONSULT WITH THE BOARD CHAIRPERSON AND THE LEGAL AND RISK SERVICES DEPARTMENT AND TAKE ANY ACTIONS THAT HE DEEMS REQUIRED OR APPROPRIATE TO MANAGE OR RESOLVE A POTENTIAL CONFLICT OF INTEREST. FOR EXAMPLE, A VOTING BOARD OR COMMITTEE MEMBER WOULD BE REQUIRED TO RECUSE HIMSELF OR HERSELF FROM VOTING ON MATTERS RELATED TO THE POTENTIAL CONFLICT AND THE POTENTIAL CONFLICT WOULD BE DISCLOSED TO OTHER VOTING MEMBERS.

FORM 990, PART VI, SECTION B, LINE 15:

COMPENSATION PROCESS FOR TOP OFFICIALS:

THE TOP OFFICIAL IS AN EMPLOYEE OF YNHHS. THE EXECUTIVE COMPENSATION COMMITTEES OF GREENWICH HOSPITAL AND YNHHS STRIVE TO TAKE THE STEPS NECESSARY TO QUALIFY FOR THE "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER FEDERAL TAX LAW. THE EXECUTIVE COMPENSATION COMMITTEES ARE RESPONSIBLE FOR (1) DETERMINING THE OVERALL TOTAL COMPENSATION STRATEGY FOR THEIR RESPECTIVE CORPORATE OFFICERS, (2) APPROVING ALL COMPENSATION AND BENEFITS DECISIONS FOR RESPECTIVE CORPORATE OFFICERS, AND (3) REPORTING SUCH ACTIONS TO THE FULL GREENWICH HOSPITAL AND YNHHS BOARDS ON AN ANNUAL BASIS. IN ADDITION, THE EXECUTIVE COMPENSATION COMMITTEES EXPRESSLY DETERMINE THE REASONABLENESS OF TOTAL COMPENSATION AND BENEFITS FOR ALL CORPORATE OFFICERS, AND ASSURES THAT ALL OFFICER COMPENSATION DECISIONS ARE

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

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 COMMITTEES CONSIST OF BOARD MEMBERS WHO DO NOT HAVE MATERIAL FINANCIAL INTERESTS THAT COULD BE AFFECTED BY THE OFFICER COMPENSATION DECISIONS MADE BY THE COMMITTEES. THE COMPARABILITY DATA USED TO ASSIST THE EXECUTIVE COMPENSATION COMMITTEES IN THEIR COMPENSATION DELIBERATIONS ARE COMPILED BY AN INDEPENDENT, NATIONAL COMPENSATION CONSULTING FIRM THAT IS RETAINED BY AND REPORTS DIRECTLY TO THE EXECUTIVE COMPENSATION COMMITTEES. 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 COMMITTEES ARE CONTEMPORANEOUSLY DOCUMENTED, REVIEWED AND APPROVED BY THE EXECUTIVE COMPENSATION COMMITTEES, AND PROVIDED TO THE BOARDS OF YNHHS AND THE HOSPITAL.

FORM 990, PART VI, SECTION B, LINE 15B:

COMPENSATION PROCESS FOR OFFICERS

CERTAIN OFFICERS ARE EMPLOYEES OF YNHHS, OTHER OFFICERS ARE EMPLOYED DIRECTLY BY THE HOSPITAL. COMPENSATION DETERMINATIONS OF YNHHS EMPLOYEES ARE MADE BOTH BY THE COMPENSATION COMMITTEES AND BOARDS OF YNHHS AND THE HOSPITAL. COMPENSATION DETERMINATION OF THE HOSPITAL EMPLOYEES ARE MADE BY THE HOSPITAL'S COMPENSATION COMMITTEE AND BOARD. THE EXECUTIVE COMPENSATION COMMITTEES OF GREENWICH HOSPITAL AND YNHHS STRIVE TO TAKE THE STEPS NECESSARY TO QUALIFY FOR THE "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER FEDERAL TAX LAW. THE EXECUTIVE COMPENSATION COMMITTEES ARE RESPONSIBLE FOR (1) DETERMINING THE OVERALL TOTAL COMPENSATION STRATEGY FOR ALL THEIR RESPECTIVE CORPORATE OFFICERS, (2)

Name of the organization

GREENWICH HOSPITAL

Employer identification number

06-0646659

APPROVING ALL COMPENSATION AND BENEFITS DECISIONS FOR CORPORATE OFFICERS, AND (3) REPORTING SUCH ACTIONS TO THE FULL GREENWICH HOSPITAL AND YNHHS BOARD ON AN ANNUAL BASIS, AS APPLICABLE. IN ADDITION, THE EXECUTIVE COMPENSATION COMMITTEES, AS APPLICABLE, EXPRESSLY DETERMINE 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 COMMITTEES CONSIST OF BOARD MEMBERS WHO DO NOT HAVE MATERIAL FINANCIAL INTERESTS THAT COULD BE AFFECTED BY THE OFFICER COMPENSATION DECISIONS MADE BY THE COMMITTEES. THE COMPARABILITY DATA USED TO ASSIST THE EXECUTIVE COMPENSATION COMMITTEES IN THEIR COMPENSATION DELIBERATIONS ARE COMPILED BY AN INDEPENDENT, NATIONAL COMPENSATION CONSULTING FIRM THAT IS RETAINED BY AND REPORTS DIRECTLY TO THE EXECUTIVE COMPENSATION COMMITTEES. 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 COMMITTEES ARE CONTEMPORANEOUSLY DOCUMENTED, REVIEWED AND APPROVED BY THE EXECUTIVE COMPENSATION COMMITTEES, AND PROVIDED TO THE BOARDS OF YNHHS AND/OR THE HOSPITAL, AS APPLICABLE.

FORM 990, PART VI, SECTION C, LINE 19:

COPIES OF FORM 990, FORM 1023 (IF AVAILABLE) AND AUDITED FINANCIAL STATEMENTS ARE MAINTAINED IN THE SYSTEM TAX DEPARTMENT. OTHER CORPORATE GOVERNING DOCUMENTS ARE MAINTAINED BY THE LEGAL AND RISK SERVICES DEPARTMENT. THE CONFLICT OF INTEREST POLICY, WHISTLEBLOWER POLICY, AND DOCUMENT RETENTION POLICY ARE AVAILABLE TO ALL EMPLOYEES ON THE CORPORATE

Name of the organization GREENWICH HOSPITAL	Employer identification number 06-0646659
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INTERNAL WEBSITE. COPIES OF ALL DOCUMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

LAUNDERING SERVICE:

PROGRAM SERVICE EXPENSES	837,284.
MANAGEMENT AND GENERAL EXPENSES	288,538.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,125,822.

OTHER PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	44,545,246.
MANAGEMENT AND GENERAL EXPENSES	15,342,931.
FUNDRAISING EXPENSES	211,370.
TOTAL EXPENSES	60,099,547.

OTHER PROFESSIONAL FEES:

PROGRAM SERVICE EXPENSES	10,590,872.
MANAGEMENT AND GENERAL EXPENSES	3,649,735.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	14,240,607.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	75,465,976.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

PENSION ADJUSTMENT	-26,976,000.
AMORTIZATION	1,121,000.
TRANSFERS TO AFFILIATES	-12,360,000.
CHANGE IN FOUNDATION NET ASSETS	1,497,342.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No. 1545-0047

2015

Open to Public
Inspection

Name of the organization

GREENWICH HOSPITAL

Employer identification number
06-0646659

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
900 KING STREET ASSOCIATES, LLC - 26-0805259 5 PERRYRIDGE ROAD GREENWICH, CT 06830	BUILDING OPERATIONS	CONNECTICUT	0.	0.	GREENWICH HOSPITAL
GREENWICH CLINICAL PATHOLOGY ASSOCIATES, LLC - 26-2455578, 5 PERRYRIDGE ROAD, GREENWICH, CT 06830	HEALTHCARE SERVICES	CONNECTICUT	1,164,730.	214,411.	GREENWICH HOSPITAL
GREENWICH PATHOLOGY ASSOCIATES, LLC - 06-6140101, 5 PERRYRIDGE ROAD, GREENWICH, CT 06830	HEALTHCARE SERVICES	CONNECTICUT	3,178,626.	525,688.	GREENWICH HOSPITAL

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
ASSOCIATED SPECIALISTS OF SOUTHEASTERN CONNECTICUT, INC. - 20-8006123, 365 MONTAUK AVENUE, NEW LONDON, CT 06320	HEALTHCARE SERVICES	CONNECTICUT	501C3	LINE 11A, I	LAWRENCE + MEMORIAL HOSPITAL, INC.		X
BRIDGEPORT HOSPITAL - 06-0646554 267 GRANT STREET	HEALTHCARE SERVICES	CONNECTICUT	501C3	LINE 3	YALE NEW HAVEN HEALTH SERVICES CORP		X
BRIDGEPORT HOSPITAL AUXILIARY INC - 06-6042500, 267 GRANT STREET, BRIDGEPORT, CT 06610	SYSTEM SUPPORT SERVICES	CONNECTICUT	501C3	LINE 11A, I	BRIDGEPORT HOSPITAL		X
BRIDGEPORT HOSPITAL FOUNDATION, INC - 22-2908698, 267 GRANT STREET, BRIDGEPORT, CT 06610	SYSTEM SUPPORT SERVICES	CONNECTICUT	501C3	LINE 7	BRIDGEPORT HOSPITAL		X

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

Schedule R (Form 990) 2015

Part II Continuation of Identification of Related Tax-Exempt Organizations

(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 organization?	
						Yes	No
BRIDGEPORT HOSPITAL FRIENDS OF PEDIATRICS, INC. - 06-6048427, 120 COLUMBINE DRIVE, TRUMBULL, CT 06611	SYSTEM SUPPORT SERVICES	CONNECTICUT	501C3	LINE 11A, I	YALE NEW HAVEN HOSPITAL		X
GREENWICH HEALTH CARE SERVICES INC - MERGED WITH GH 5/12/2016 - 22-2593399, 5 PERRYRIDGE ROAD, GREENWICH, CT 06830	SYSTEM SUPPORT SERVICES	CONNECTICUT	501C3	LINE 11B, II	YALE NEW HAVEN HEALTH SERVICES CORP		X
L&M PHYSICIAN ASSOCIATION, INC. - 27-1094375, 365 MONTAUK AVENUE, NEW LONDON, CT 06320	HEALTHCARE SERVICES	CONNECTICUT	501C3	LINE 11A, I	LAWRENCE + MEMORIAL CORPORATION		X
LAWRENCE + MEMORIAL CORPORATION - 22-2553028 365 MONTAUK AVENUE NEW LONDON, CT 06320	PROMOTE HEALTHCARE	CONNECTICUT	501C3	LINE 9	YALE NEW HAVEN HEALTH SERVICES CORP		X
LAWRENCE AND MEMORIAL FOUNDATION, INC. - 22-2553026, 365 MONTAUK AVENUE, NEW LONDON, CT 06320	FUNDRAISING SERVICES	CONNECTICUT	501C3	PF	LAWRENCE + MEMORIAL CORPORATION		X
LAWRENCE + MEMORIAL HOSPITAL, INC. - 06-0646704, 365 MONTAUK AVENUE, NEW LONDON, CT 06320	HEALTHCARE SERVICES	CONNECTICUT	501C3	LINE 3	LAWRENCE + MEMORIAL CORPORATION		X
LMW HEALTHCARE, INC - 46-0543230 365 MONTAUK AVENUE NEW HAVEN, CT 06320	HEALTHCARE SERVICES	RHODE ISLAND	501C3	LINE 3	LAWRENCE + MEMORIAL CORPORATION		X
NORTHEAST MEDICAL GROUP INC - 06-1330992 99 HAWLEY LANE STRATFORD, CT 06614	HEALTHCARE SERVICES	CONNECTICUT	501C3	LINE 9	YALE NEW HAVEN HEALTH SERVICES CORP		X
NORTHEAST MEDICAL GROUP, PLLC - 35-2380180 99 HAWLEY LANE STRATFORD, CT 06614	HEALTHCARE SERVICES	CONNECTICUT	501C3	LINE 11A, I	NORTHEAST MEDICAL GROUP, INC		X
PERRYRIDGE CORPORATION - 06-1207316 5 PERRYRIDGE ROAD GREENWICH, CT 06830	SYSTEM SUPPORT SERVICES	CONNECTICUT	501C3	LINE 11B, II	SEE SCHEDULE R PART VII		X
SOUTHERN CONNECTICUT HEALTH SYSTEM PROPERTIES, INC. - 06-1297708, 267 GRANT STREET, BRIDGEPORT, CT 06610	TITLE HOLDING	CONNECTICUT	501C2		BRIDGEPORT HOSPITAL		X
THE GREENWICH HOSPITAL ENDOWMENT FUND INC - 06-1526642, 5 PERRYRIDGE ROAD, GREENWICH, CT 06830	SYSTEM SUPPORT SERVICES	CONNECTICUT	501C3	LINE 11B, II	SEE SCHEDULE R PART VII		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
SHORELINE SURGERY CENTER LLC - 90-0110459, 111 GOOSE LANE, GUILFORD, CT 06437	HEALTHCARE SERVICES	CT	N/A	N/A	N/A	N/A	N/A		N/A		N/A	N/A
SSC II LLC - 26-1709382 111 GOOSE LANE GUILFORD, CT 06437	HEALTHCARE SERVICES	CT	N/A	N/A	N/A	N/A			N/A			N/A
ORTHOAEDIC & NEUROSURGERY CENTER - 27-3477197, 55 HOLLY HILL LANE, GREENWICH, CT 06830	HEALTHCARE SERVICES	CT	GREENWICH AMBULATORY SURGERY CENTER, LLC	N/A	3,101,131.	801,276.			N/A		X	35.00%
TOTAL HEALTH CONNECTICUT, LLC - 47-4070024, 789 HOWARD AVENUE, NEW HAVEN, CT 06519	HEALTHCARE SERVICES	CT	N/A	N/A	N/A	N/A			N/A			N/A

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
YNHHS-MSO INC - 06-1467717 789 HOWARD AVE NEW HAVEN, CT 06519	MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
YALE NEW HAVEN AMBULATORY SERVICES - 06-1398526, 40 TEMPLE STREET, NEW HAVEN, CT 06510	HEALTHCARE SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
MEDICAL CENTER REALTY INC - 06-1110858 50 YORK STREET NEW HAVEN, CT 06511	RENTAL SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
GREENWICH FERTILITY & IVF PC - 30-0145464 5 PERRYDRIDGE ROAD GREENWICH, CT 06830	HEALTHCARE SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
YORK ENTERPRISES INC - 06-1110937 50 YORK STREET NEW HAVEN, CT 06511	TITLE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A		X

Part IV Continuation of Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
YNHH-PHYSICIANS CORP - 06-1202305 789 HOWARD AVE NEW HAVEN, CT 06519	ADMINISTRATIVE SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
MEDICAL CENTER PHARMACY INC - 06-1087673 50 YORK STREET NEW HAVEN, CT 06511	PHARMACY	CT	N/A	C CORP	N/A	N/A	N/A		X
GREENWICH OCCUPATIONAL HEALTH SERVICES OF NY, PC - 06-1540101, 5 PERRYBRIDGE ROAD, GREENWICH, CT 06830	HEALTHCARE SERVICES	NY	N/A	C CORP	N/A	N/A	N/A		X
GREENWICH OCCUPATIONAL HEALTH SERVICES OF NEW JERSEY - 45-3833883, 5 PERRYBRIDGE ROAD, GREENWICH, CT 06830	HEALTHCARE SERVICES	NJ	N/A	C CORP	N/A	N/A	N/A		X
PRIMARYNET OF CONNECTICUT, INC. - TERMINATED 9/30/16 - 06-1463534, 789 HOWARD AVE, NEW HAVEN, CT 06519	HEALTHCARE SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
CENTURY FINANCIAL SERVICES, INC. - 06-1110797, 23 MAIDEN LANE, NORTH HAVEN, CT 06473	DEBT COLLECTION SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
CENTURY MANAGEMENT SERVICES, INC. - 06-1303173, 23 MAIDEN LANE, NORTH HAVEN, CT 06473	RECEIVABLE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
L & M SYSTEMS, INC. - 22-2553037 365 MONTAUK AVENUE NEW LONDON, CT 06320	HEALTHCARE RELATED SERVICES	CT	N/A	C CORP	N/A	N/A	N/A		X
L&M HOME CARE SERVICES, INC. - 06-1389272 365 MONTAUK AVENUE NEW LONDON, CT 06320	HOME THERAPY	CT	N/A	C CORP	N/A	N/A	N/A		X
LAWRENCE & MEMORIAL INDEMNITY COMPANY LTD. - 98-1021436, PO BOX 1159 KY1-1102, GRAND CAYMAN, CAYMAN ISLANDS	INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A		X

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

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) GREENWICH HOSPITAL ENDOWMENT FUND	S	3,861,254.	FAIR MARKET VALUE
(2) PERRYRIDGE CORPORATION	K	1,690,798.	FAIR MARKET VALUE
(3) PERRYRIDGE CORPORATION	Q	612,493.	ACTUAL COST
(4) PERRYRIDGE CORPORATION	L	38,562.	FAIR MARKET VALUE
(5) PERRYRIDGE CORPORATION	S	3,647.	CASH
(6) GREENWICH HEALTH CARE SERVICES, INC.	S	5,699,959.	CASH

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-f)	(c) Amount involved	(d) Method of determining amount involved
(7)GREENWICH HEALTH CARE SERVICES, INC.	R	7,707,000.CASH	
(8)GREENWICH FERTILITY AND IVF CENTER, PC	J	123,220.CASH	
(9)GREENWICH FERTILITY AND IVF CENTER, PC	S	642,790.CASH	
(10)YALE NEW HAVEN HEALTH SERVICES CORP	M	1,368,623.FAIR MARKET VALUE	
(11)YALE NEW HAVEN HEALTH SERVICES CORP	L	53,468,472.FAIR MARKET VALUE	
(12)YALE NEW HAVEN HEALTH SERVICES CORP	Q	55,595,097.FAIR MARKET VALUE	
(13)YALE NEW HAVEN HEALTH SERVICES CORP	P	5,687,868.FAIR MARKET VALUE	
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

Part VII Supplemental Information

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

PART III, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS PARTNERSHIP:

NAME OF RELATED ORGANIZATION:

ORTHOPAEDIC & NEUROSURGERY CENTER

DIRECT CONTROLLING ENTITY: GREENWICH AMBULATORY SURGERY CENTER, LLC

PART II, IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS:

NAME OF RELATED ORGANIZATION:

GREENWICH AMBULATORY SURGERY CENTER

DIRECT CONTROLLING ENTITY: GREENWICH HEALTH CARE SERVICES, INC. THROUGH 5/12/2016, AFTER YALE NEW HAVEN HEALTH SERVICES CORPORATION.

NAME OF RELATED ORGANIZATION:

PERRYRIDGE CORPORATION

DIRECT CONTROLLING ENTITY: GREENWICH HEALTH CARE SERVICES, INC. THROUGH 5/12/2016, AFTER YALE NEW HAVEN HEALTH SERVICES CORPORATION.

NAME OF RELATED ORGANIZATION:

THE GREENWICH HOSPITAL ENDOWMENT FUND INC

DIRECT CONTROLLING ENTITY: GREENWICH HEALTH CARE SERVICES, INC. THROUGH 5/12/2016, AFTER YALE NEW HAVEN HEALTH SERVICES CORPORATION.